Meeting Date	31st January 2019	Agenda Item	2.1
Report Title	**Approval of the Clinical Services Plan 2019-24 and Annual Plan 2019/20**		
Report Author	Nicola Johnson, Interim Assistant Director of Strategy Kerry Broadhead, Head of Strategy and Value Darren Griffiths, Associate Director of Performance Val Whiting, Assistant Director of Finance		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance Richard Evans, Medical Director		
Presented by	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance		
Freedom of Information	Open		
Purpose of the Report	The Board are asked to approve the Clinical Services Plan 2019-24 and Annual Plan 2019/20		
Key Issues	The Health Board's Organisational Strategy was approved in November 2018. This is a covering paper for the Health Board's Clinical Services Plan which the Board is asked to approve. The Annual Plan 2019/20 is also submitted for approval for submission to Welsh Government, including our service, performance, workforce and capital plans for 2019/20. The finance chapter of the Annual Plan is not yet included in the appended Annual Plan document and will be To Follow early in w/c 28th January due to ongoing meetings with Welsh Government. An Assurance Letter regarding the Bridgend transfer will also follow. The planned care trajectories are also To Follow early in w/c 28th January due to more work required as requested by the Performance and Finance Committee.		

Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
				✓

Recommendations	Committee members are asked to: • Note the attached Accountability Letter (Appendix 1) • Approve the Clinical Services Plan (Appendix 2)

	- Approve the Annual Plan 2019/20 for submission to Welsh Government (Appendix 3a and 3b) - Note the finance chapter and templates and planned care trajectories are To Follow - Receive the NHS Wales Planning Framework Mandatory Templates (Appendix 4) - Note the Workforce templates will be submitted in February - Approve the Capital Plan (Appendix 5a and 5b) - Note that an Assurance Letter regarding the Bridgend transfer is To Follow - Note that the Quality Impact Assessment process has been assured by the Performance and Finance Committee - Note that a Stage 1 Equality Impact Assessment has been completed for the Clinical Services Plan and Annual Plan (Appendix 6)

APPROVAL OF THE CLINICAL SERVICES PLAN 2019-24 AND ANNUAL PLAN 2019/20

1.0 Situation

The Organisational Strategy was agreed by the Board in November 2018 and the organisation has been concurrently updating its Clinical Services Plan and developing an Annual Plan. These will show how the organisation plans to deliver its Strategic Objectives over their respective timespans. The Clinical Services Plan and Annual Plan have been approved for submission to the Board by the Executive Team and have previously been circulated in draft to Non-Officer Members for comment. The financial plan and performance trajectories were also considered by the Performance and Finance Committee at its meeting on 22nd January.

2.0 Background

The Joint Executive Team meeting on 12th December acknowledged the positive progress the Health Board has made across the full breadth of our 2018/19 Annual Plan. It was also positively noted that the Board approved our Organisational Strategy in November 2018, and that this will form a strong framework for developing our Clinical Services Plan and our future delivery plans.

It was recognised that we may not be ready to submit a fully approvable IMTP in January this year because we will be continuing to develop detailed delivery plans for our Clinical Services Plan (CSP), which are not able to be fully reflected, as the CSP will also be presented to the Board for approval in January. We will also not be able to submit fully completed mandatory Workforce Templates until the end of February due to the Bridgend transfer, and there is more work to do to improve our performance, particularly in unscheduled care.

As such, an Accountability Letter (Appendix 1) has been submitted to Welsh Government outlining that we are asking the Board to approve an Annual Plan. It

highlights that through the work we will drive through the Transformation Portfolio on detailed implementation plans for our Clinical Services Plan, and our ongoing efficiency and financial delivery improvements, we expect to be able to submit an approvable IMTP in the summer of 2019.

3.0 Assessment

3.1 Clinical Services Plan (CSP) 2019-24
The CSP is attached for approval at Appendix 2.

The CSP development process has actively engaged clinicians, staff and partners and been informed by the views of the Local Medical Committee for GPs, Cluster Networks, Clinical Cabinets and Clinical Senate Council. The Board has also received regular briefings on, and contributed to the development of, the CSP over recent months. This includes comments from members on the draft document.

Following Board approval of the CSP, attached at Appendix 2, the document will be professionally formatted for publication and any technical inaccuracies amended. This will not affect the strategic integrity of the document. There will be a formal launch of the CSP with staff and an on-going communications programme will be implemented to encourage continued clinical engagement.

The delivery of the CSP will form a substantial part of the Health Board Transformation Portfolio. A Clinical Services Plan Delivery Group is being established as part of this, alongside a rigorous project management and monitoring approach to ensure that the detailed implementation planning continues.

3.2 Annual Plan 2019/20
The Annual Plan 2019/20 is attached at Appendix 3a and 3b for approval for submission to Welsh Government.

3.2.1 Welsh Government Engagement
The Lead Executive and Assistant Directors met with Welsh Government on 11th January 2019 to discuss the Annual Plan and specifically the plans around performance, workforce and finance. A follow up meeting with Welsh Government took place on 23rd January to discuss the financial plan in further detail. The specific feedback has been taken into account in the final document. In the light of the intention to submit an Annual Plan, Welsh Government suggested that the Health Board may wish to consider submitting a much shorter document focussed on finance and performance in our Targeted Intervention (TI) priorities and primary care. However, as a Health Board we have made significant strides forward this year in agreeing our Organisational Strategy and developing our Clinical Services Plan. We feel it is important that this is recognised in the Plan, and sets us clearly in the direction of our ambition to submit an approvable IMTP in 2019/20. As such the Plan retains a population health focus, outlines our transformation opportunities and covers all of our service delivery areas, quality, workforce and digital plans as well as giving clear actions and deliverables for the TI areas and financial delivery.

3.2.2 Assurance

The Quality Impact Assessment process, performance and finance plans of the Annual Plan were considered by the Performance and Finance Committee on 22nd January 2019. The level of assurance and comments of the Committee are outlined in the relevant sections below.

3.2.3 Multi-Organisational Planning

The approach to Regional Planning has been agreed with Hywel Dda UHB and the detailed mapping of opportunities (clinical and non-clinical) for partnership working is included as an Appendix to the Plan. Our engagement plan has included both external and internal stakeholders and staff, including the Health Board's Partnership Forum and Community Health Council. As mandated in the NHS Wales Planning Framework, the Regional Partnership Board has also been engaged.

The issues around agreements on the WHSSC and EASC commissioning plans have been resolved and are included in our service and financial plans. This is also the case for the Velindre NHS Trust commissioning discussions.

3.2.4 Service Plans

The Annual Plan includes our service change and performance improvement plans for 2019/20, building on our achievements in 2018/19. These enable the delivery of our Organisational Strategy's Enabling Objectives, and Clinical Service Plan priorities in year one, as well as delivery of our performance trajectories. For each Enabling Objective a summary plan and summary of the enablers required (in terms of workforce, capital, revenue and digital) is also included.

3.2.5 Performance

The performance templates contain fewer mandatory targets than previous years, with no targets mandated for stroke services. However all of our Targeted Intervention profiles have been modelled and the Health Board's trajectories for 2019/20 are included in the document and in Appendix 4, with the exception of the planned care trajectories. The planned care trajectories are being reviewed following feedback from the Performance and Finance Committee regarding the ambition for efficiency improvements in year. The planned care trajectories will be circulated to members early in the week commencing 28th January to inform consideration of the Plan for submission to Welsh Government.

The performance trajectories have been modelled on the actions in the summary plans for our Targeted Intervention priority areas which are included in the Annual Plan, and the supporting enablers.

In summary we plan to:

- For planned care:
    - Use the resources available within the financial framework to ensure that we develop a sustainable model for treatments (patients requiring an operation). Currently under review, along with how we address the long waiting patient backlog.
    - Maintain zero 26 week outpatient waits.
    - Improve 8 week diagnostic tests and contain these to just cardiac CT and cardiac MRI.

- o Maintain 14 week therapy waits.
- Increase unscheduled care Emergency Department 4 hour waiting time compliance to 85% over the course of the year;
- Reduce the numbers of patients waiting over 12 hours in our Emergency Departments and waiting over 1 hour for ambulance handover significantly in 2019/20;
- Reduce variation and increase compliance in cancer performance whilst improving to sustainable delivery of the Urgent Suspicion of Cancer target;
- Increase performance across all 4 stroke metrics; and,
- Deliver annual reductions of 15%, 10% and 5% for c.difficile, S.aureus and E.coli infections respectively.

3.2.6 Workforce

The Workforce chapter describes the Health Board's emerging Workforce and Organisational Development Framework and the actions we will take to improve across the six domains shown below.

Shape of the Workforce	Workforce Resourcing	Workforce Efficiency	Leadership, Culture, Values	Pay and T&Cs	Core Workforce Function
Describing the workforce we need to achieve our plans	Describing how we secure and retain the right workforce	Describing how we will deploy our staff effectively and maximise workforce efficiency and productivity	Describing how we improve organisational performance through leadership, development and culture	Exploring opportunities to better reward our workforce	Developing the role and contribution of the workforce function in delivering our people plans – do the basics brilliantly

Due to the timings of the Bridgend transfer TUPE process the Workforce and OD Director has agreed with her counterpart in Welsh Government that the Workforce Mandatory Templates will not be submitted until the end of February. The Education Commissioning templates are included with the January submission.

3.2.7 Capital Plan

The discretionary capital plan is based on a balanced position for 2019/20 and is included at Appendix 5b. An initial draft discretionary financial plan was considered at the November meeting of the Investment & Benefits Group (IBG), with a balanced plan agreed at the December meeting, to reflect an alignment of funding to priorities. The Plan was submitted to the Performance and Finance Committee on 22nd January.

The plan includes an assessment on schemes which will be put forward for inclusion in the All Wales Capital Programme (AWCP), included as Appendix 5a. There are a number of schemes that have already received approval for funding from the 2019/20 AWCP for £14.915m. In getting to a balanced plan::

- A risk assessment of the existing asset base (equipment and buildings) was undertaken by the Capital Prioritisation Group (CPG). This reflected adjustments for the Bridgend Boundary change and additional discretionary allocations received from Welsh Government in December for digital refresh £1.7m and general discretionary £2m.
- Used the collated Unit and Digital IMTPs, including corporate assessment of prioritisation and likely sources of capital funding.
- No assumptions have been made on capital affordability in respect of additional Welsh Government funding from the AWCP.
- No assumptions has been made on revenue affordability in the revenue financial plan for schemes in development.
- There are a number of schemes within the five year AWCP, which require additional information on scope, feasibility and capital cost estimates. It has been assumed that further analysis will be undertaken over the next few months as the detail of the Clinical Services Plan is worked through.
- The removal of funding to reflect the Bridgend Boundary change has been confirmed as £3.450m. This provides a recurring discretionary allocation of £11.118m.
- The balanced plan assumes additional income will be received from Welsh Government to cover commitments of £1.434m being made on business case fees.
- There is a small contingency of £278k.

Table 1: Summary Discretionary Capital Plan 2019/20

Allocation Headings	Capital Plan Requirement	Less Approved Funding All Wales Capital Programme	Less Assumed Funding All Wales Capital Programme	Discretionary Capital Allocation
	£000			
PART A - FUNDING & EXPENDITURE COMMITMENTS				
A. Discretionary Funding & Disposal Income	11,443	0	0	11,443
SUB TOTAL FUNDING (PART A)	11,443	0	0	11,443
B. Discretionary Scheme Commitments b/f 2018-19	11,210	9,892	0	1,318
C. Discretionary Scheme Approved Commitments 2019/20	3,930	0	0	3,930
D. Invest to Save	2,252	1,710	0	542
SUB TOTAL EXPENDITURE COMMITTMENTS (Part A)	17,392	11,602	0	5,790
TOTAL ESTIMATED NET - UNDER / OVER COMMITMENT (Part A)	5,949	11,602	0	-5,653
PART B - FUNDING REQUESTS				
E. All Wales Programme Business Case Fees	1,105	0	400	705
F1 Unit IMTPs (Must Do)	2,662	0	2,662	0
F2 Unit IMTPs (Should Do)	1,243	0	1,080	163
G. Disposal Costs	295	0	0	295
H. Digital IMTP	3,670	270	3,120	280
I. Departmental Refresh	36,676	3,043	29,701	3,932
J. Contingency	1,478	0	1,200	278
K. Intermediate Care Fund (ICF)	834	0	834	0
SUB TOTAL EXPENDITURE COMMITTMENTS (Part B)	47,963	3,313	38,997	5,653
TOTAL ESTIMATED NET -UNDER / OVER COMMITMENT	53,912	14,915	38,997	0

Table 2: Summary All Wales Capital Programme 2019/20 to 2023/24

Scheme	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	Total £m
Part A - Approved Schemes	14.915	0.478	0.000	0.000	0.000	15.393
Part B - Unapproved Schemes	25.710	28.405	8.060	1.177	0.000	63.352
Total	40.625	28.883	8.060	1.177	0.000	78.745

3.2.8 Revenue Financial Plan

The Revenue Financial Plan is based on the achievement of a sustainable breakeven position in 2019-20. Iterations of the draft Plan have been considered by the Executive Team and our financial planning methodology, including our approach to savings and key financial assumptions and risks, was also considered by the Performance and Finance Committee (PFC) in December. The draft Financial Plan was considered by the Performance and Finance Committee in its meeting on 22nd January, where it was noted that a number of key revisions had been made as part of the Plan development, and also to reflect feedback from Welsh Government as follows:

- Removal of Bridgend population income and expenditure, to include assessment of an potential financial impact;
- Reviewing cost growth assumptions and estimates;
- Scrutiny of savings delivery plans;
- Further alignment of performance and financial plans;
- Scoping and initial financial analysis of the high value opportunities;
- Testing of assumptions regarding contractual uplifts from both a commissioner and provider perspective, for example, on the use of 1% additional funding for *A Healthier Wales;* and,
- Developments and changes supported by the £10m additional funding from Welsh Government.

In addition, the draft Financial Plan was considered at a meeting with Welsh Government on 23rd January, and further revisions are now being made to take account of both the Performance and Finance Committee's and Welsh Government's feedback.

In particular, the PFC and Welsh Government have been updated on progress on the removal of the Bridgend population income and expenditure, including the emerging assessment of the potential financial impact. Understanding the financial implications of the transfer of the Bridgend population is a highly complex and detailed undertaking, which is dependent on key processes, such as clinical service transfers, contracting arrangements and the transfer of staff. Whilst progress being made, more detailed work needs to be undertaken following clinical service models and staff transfer (numbers and grade mixes) becoming clearer and being finalised.

The Finance Chapter and mandated financial templates will be circulated in the week commencing 28th January.

4.0 Impact Assessment
4.1 Quality Impact Assessment (QIA)
Based on best practice, Quality Impact Assessment (QIA) is being used as a process to systematically review all service change and cost improvement schemes in the Annual Plan. The Performance and Finance Committee has been assured that there is a process in place to ensure that all savings schemes are tested for their impact on quality. The process of assessing all schemes is in progress and a further report will be received at Quality and Safety Committee in February, including scrutiny of the assessments, risks and mitigations. Our plans will be adjusted as required.

4.2 Equality Impact Assessment (EIA)
The Health Board seconded an external expert in Equality Impact Assessment from Welsh Government for a limited time period in 2018 and an overarching Stage 1 EIA for the Clinical Services Plan is attached at Appendix 5. This is also the EIA for the Annual Plan, which is the first year implementation plan of the CSP. Detailed EIAs will be developed for each change programme as appropriate as our detailed planning and engagement progresses.

5.0 Completion of the Annual Plan
Members are asked to note that the following information will be circulated in the week commencing 28th January:
- The finance chapter;
- Finance Mandatory Templates; and,
- Planned Care profiles.

The workforce templates will be submitted separately at the end of February. Prior to submission to Welsh Government final proof reading and formatting will also take place.

6.0 Recommendations
Board members are asked to:

- Note the attached Accountability Letter (Appendix 1)
- Approve the Clinical Services Plan (Appendix 2)
- Approve the Annual Plan 2019/20 for submission to Welsh Government (Appendix 3a and 3b)
- Note the finance chapter and templates and planned care trajectories are To Follow
- Receive the NHS Wales Planning Framework Mandatory Templates (Appendix 4)
- Note the Workforce templates will be submitted in February
- Approve the Capital Plan (Appendix 5a and 5b)
- Note that an Assurance Letter regarding the Bridgend transfer is To Follow
- Note that the Quality Impact Assessment process has been assured by the Performance and Finance Committee
- Note that a Stage 1 Equality Impact Assessment has been completed for the Clinical Services Plan and Annual Plan (Appendix 6)

Governance and Assurance							
Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities		Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce		Embedding effective governance and partnerships
	✓		✓	✓	✓		✓
Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience

The Annual Plan includes our Quality and Safety Priorities and improvement plans. The initial equality impact on patients of both plans has been assessed in the Stage 1 EIA. The paper outlines that a Quality Impact Assessment process has been agreed and will be used to manage the quality impact of the plans and to mitigate the risks and make adjustments as required.

Financial Implications

The aim of the 2019-20 Financial Plan is to deliver financial breakeven next year. Welsh Government has indicated that non-recurrent funding will become available if this is achieved.

The Board has previously been briefed on the financial planning methodology, risks, opportunities and scale of financial challenge. The approach to developing the Financial Plan has been straightforward:
- Reduce the underlying deficit;
- Embed stringent cost avoidance and cost control measures;
- Prioritise and deliver strategic "high value" efficiency opportunities.

This approach supports the direction of travel set out in the CSP, where the Health Board needs to deliver efficiencies (and savings) in year 1 as part of the drive for improvement and to create the operational headroom for change.

Legal Implications (including equality and diversity assessment)

The Health Board has written an Accountability Letter to Welsh Government to outline that the organisation will submit an Annual Plan for 2019/20 and seek to meet its statutory duty under the NHS (Wales) Finance Act 2014 to submit an approvable IMTP in the summer of 2019.

Staffing Implications

The Annual Plan 2019/20 includes our integrated workforce plans in the light of the Bridgend Transfer.

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

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

Report History	
Appendices	**Appendices**

	- Accountability Letter (Appendix 1) - Clinical Services Plan (Appendix 2) - Annual Plan 2019/20 (Appendix 3a and 3b) - NHS Wales Planning Framework Mandatory Templates (Appendix 4) - Capital Plans (Appendix 5a and 5b) - Stage 1 Equality Impact Assessment (Appendix 6)

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Our Ref: TCM/SHG/LH/es

Date: 11th January 2019

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Andrew Goodall
Director General Health and Social Services
NHS Wales Chief Executive
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Dear Andrew

Abertawe Bro Morgannwg University Health Board Plan 2019/20

I am writing to clarify our Health Board's position in respect of the submission of our three-year plan. We had a very helpful discussion at the Joint Executive Team meeting on 12th December in which we discussed the positive progress that the Health Board is making across the full breadth of our 2018/19 Annual Plan and particularly in our leadership, governance, performance, delivery and quality domains. We are also very pleased that the Board approved our Organisational Strategy in November 2018, and that this will form a strong framework for developing our Clinical Services Plan and our future delivery plans.

However, in the discussion we recognised that we may not be ready to submit a fully approvable IMTP in January this year. We will be continuing to develop detailed delivery plans for our Clinical Services Plan which are not able to be fully reflected in the timeline as the Clinical Services Plan will also be presented to the Board for approval in January. We also discussed the fact that will not be able to submit fully completed mandatory Workforce Templates until the end of February due to the Bridgend transfer and we have more work to do to improve our performance, particularly in unscheduled care.

- Chairman/Cadeirydd: Andrew Davies
- Chief Executive/ Prif Weithredydd: **Tracy Myhill**
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Bwrdd Iechyd ABM yw enw gweithredu Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg
ABM University Health Board is the operational name of Abertawe Bro Morgannwg University Local Health Board
www.abm.wales.nhs.uk

As such I am writing to formally outline that at the end of January we will be asking our Board to approve a financially-balanced Annual Plan for submission to Welsh Government. The narrative will comply with the guidance in the NHS Wales Planning Framework and will describe the three-year context and our plans to deliver our Clinical Services Plan and Organisational Strategy, as well as our one-year delivery actions. The document will also describe our Transformation Programme which will drive delivery of our Clinical Services Plan and high-value efficiency opportunities.

From February onwards we will be working at pace through the Transformation Programme to develop our detailed plans to delivery our Clinical Services Plan and we expect to have a clear critical path for our key service change programmes by the summer of 2019. This will include the submission of further Transformation Fund Bids before the end of the financial year for:

- A Hospital2Home service;
- Digital Transformation (including WCCIS); and,
- Learning Disabilities redesign.

We will also deliver our plans to improve performance and will have moved on from the immediate issues surrounding the Bridgend transfer. Based on our further detailed planning and delivery improvements our intention is to submit an approvable IMTP in the Summer of 2019 and we will continue to engage with you about our next steps and timelines as the Spring progresses.

I hope that this aligns with the conversation that we had on 12th December 2018 and I look forward to sharing our plans with you throughout the year.

Yours sincerely

TRACY MYHILL
CHIEF EXECUTIVE

c.c.   Siân Harrop-Griffiths, Director of Strategy
        Lynne Hamilton, Director of Finance
        Nicola Johnson, Interim Assistant Director of Strategy

CLINICAL SERVICES PLAN 2019-24

BETTER HEALTH • BETTER CARE • BETTER LIVES

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

FOREWORD

It is with enormous pleasure that we present the Abertawe Bro Morgannwg University Health Board Clinical Service Plan up-date for 2019 – 2024; a plan which is central to our organisational ambition to provide Better Health and Better Care to enable Better Lives for all in our communities.

In 2013 we engaged extensively with hundreds of patients, staff and partners to develop Changing for the Better; the Health Boards first five year clinical plan. It is from this foundation that we have engaged once again, to agree with clinicians, staff and stakeholders our exciting ambitions for clinical services over the next five years.

This has been done in the context of *A Healthier Wales*; *Our Plan for Health and Social Care* (2018), which sets a clear vision for the future of Wales through the quadruple aim; to improve population health and wellbeing, experience and quality of care, the wellbeing, capability and engagement of staff and the value we achieve for our patients through best practice and eliminating waste. Throughout this plan we have prioritized improving the quality, safety and value for patients of our services.

QUALITY
SAFETY
VALUE

We are delighted to present this plan which describes our ambitions and actions for working with our communities and partners to deliver the quadruple aim for the people we serve. It focusses on improving population health; meeting the needs of our patients as close to or in their homes; supporting self-care, delivering integrated physical and mental health services and maximizing well-being.

As a Health Board we are proud to provide an extensive range of hospital services for local, regional and national patients; treating some of the most complex and acutely ill people. Our exciting plans for our major hospital sites, to be delivered through engagement and consultation with our staff and communities, rightly focus on meeting the needs of the frailest, elderly and acutely ill patients and ensuring that we are at the forefront of ground breaking research and innovation in acute care.

In delivering our clinical service ambitions our organisational values; caring for each other, working together and always improving, stand as our compass in taking brave and positive actions to improve the health our of communities. We would like to thank all our staff and partners for their work in developing this plan and say how much we are looking forward to the exciting journey we have ahead.

Tracy Myhill
Chief Executive
Abertawe Bro Morgannwg
University Health Board

Richard Evans
Executive Medical Director
Abertawe Bro Morgannwg
University Health Board

> BETTER HEALTH   > BETTER CARE   > IECHYD GWELL   > GOFAL GWELL
> BETTER LIVES   > BYWYDAU GWELL

GIG CYMRU NHS WALES
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BETTER LIVES | BYWYDAU GWELL

1 - Our Ambition for Clinical Services

1.1 Our Organisational Ambition

Our Organisational Strategy describes our ambition for the Health Board over the next ten years; to deliver **Better Health, Better Care, Better Lives** for our population. We have excellent staff with a wealth of experience in delivering high quality care; together with our communities and partners we will build on these strengths to further improve people's health, so as they can stay well and ensure we provide high quality care when they need it.

The Clinical Services Plan, led by clinicians and developed with staff and stakeholders, is central to this ambition. It describes how we will transform wellness, primary and community services to underpin significant service change in our major hospitals; enabling them to dedicate their expertise to meeting the needs of those who most need their care, in particular the frail, elderly and acutely ill.

ALIGNING OUR STRATEGY AND PLANS

The Health Board is developing an Organisational Strategy, Clinical Services Plan and Three Year Plan which all have different, but aligned roles:

Our ORGANISATIONAL STRATEGY is about:
- Our contribution to the local and regional health and care economy
- Improving health and wellbeing
- Integration with partners and communities
- Maximising value and quality
- Sustainability

Our CLINICAL SERVICES PLAN is about:
- Improving our population's well-being, resilience and independence
- Prevention, self-care, care closer to home or at home
- Providing care as a regional and integrated system
- Enabling staff and creating new ways of working

Our THREE YEAR PLAN is about:
- Developing a place-based approach to improving population health through Cluster development
- Developing seamless community services with social care with an emphasis on care closer to home
- Improving outcomes, quality, patient experience and access in our key pathways
- Improving performance against NHS Wales priorities including our target interventions priorities
- Delivery as a regional health economy
- Improving value and efficiency, research development and innovation
- Maximising opportunities for digital transformation
- Redesigning our workforce to support new service models and a sustainable, healthy and engaged workforce

UNDERPINNED BY DETAILED ANNUAL OPERATIONAL PLANS

Health, wellbeing and prevention
Home based care and self-management
Local health and social care services
Hospital based care and treatment

2018

2028

Hospital based care and treatment
Local health and social care services
Home based care and self-management
Health, wellbeing and prevention

2 - How We Developed the Clinical Services Plan

1.2 Our Clinical Service Plan Principles

A Healthier Wales (2018), focusses on transforming care in Wales through delivering the 'Quadruple Aim;

- improve population health and wellbeing through a focus on prevention;
- improve the experience and quality of care for individuals and families;
- enrich the wellbeing, capability and engagement of the health and social care workforce; and
- increase the value from funding of health & care through improvement, innovation, best practice, and eliminating waste.

Our Clinical Services Plan principles, developed with our staff and stakeholders, align strongly to the quadruple aim and were developed to guide us in agreeing the Clinical Services Plan ambitions to become the care system we aspire to be;

CSP Planning Principles

Optimising patient outcomes through

1. One System of Care
Clinical pathway processes that cross Specialities, Departments and Delivery Units

2. My Home First
Pathways which enhance care delivery in or closer to the patients home where clinically safe

3. Right place, Right person, Right time
Workforce, estates, equipment, digitalisation

4. Better Together
Regional and local collaboration on networks of services that meet the care needs of patients

We have continuously referred to these principles to ensure our ambitions are aligned to what our staff and stakeholders told us were the right things to do in planning our service changes.

When delivering clinical services staff and stakeholders told us that the quality, safety and value of our care to the patient were central to meeting patient needs

QUALITY
SAFETY
VALUE

2.1 A Clinically Led Refresh Process

The development of this Clinical Services Plan started in 2018 and has been led by our Medical and Strategy Directorate colleagues working together with a wide range of clinicians and staff from across the health board, partner organisations and stakeholders.

Our Clinical staff have been at the forefront of shaping this plan, including but not exclusively through; their engagement in clinical redesign groups and the sharing of their ideas and views through electronic media, team and individual conversations with our Clinical Services Plan team.

2.2 Listening to Patients, Carers and Stakeholders

Everything we do, we do better when we work together with our patients and partners.

Changing for the Better (C4B) hosted an extensive engagement programme in 2013 with over three hundred staff, patient groups, service users and carers. The priorities and messages from this engagement work, which agreed seven priority themes for service improvement, underpin this up-dated Clinical Services Plan.

Between September and November 2018 stakeholders participated in a series of Clinical Redesign Groups for unscheduled care, surgical and regional services, where they shared their views and suggestions to further shape the ambitions within this plan. Our stakeholders also engaged in a range of meetings, workshops and presentations at which we were able to share and test the emerging clinical services plan principles and priorities and listen to their views and ideas on these.
Additionally, engagement findings from a range of local plans and strategies, which the Health Board engaged with staff and stakeholders on between 2013 and 2018, have informed the Clinical Services Plan. These include, but not exclusively, the Social

Services and Well Being Act, the well-being assessments to support the Well Being and Future Generations Act, the Primary & Community Care Strategy, Children & Young People's Strategy and the Adult Mental Health Strategic Framework.

2.3 Building on Changing for the Better

Our staff working with patients and partners, including through the ARCH Programme with Hywel Dda University Health Board and Swansea University, have made good progress in delivering the commitments we made in 'Changing for the Better' (C4B). However, they also told us that not everything that was agreed in 2013 has been put into action.
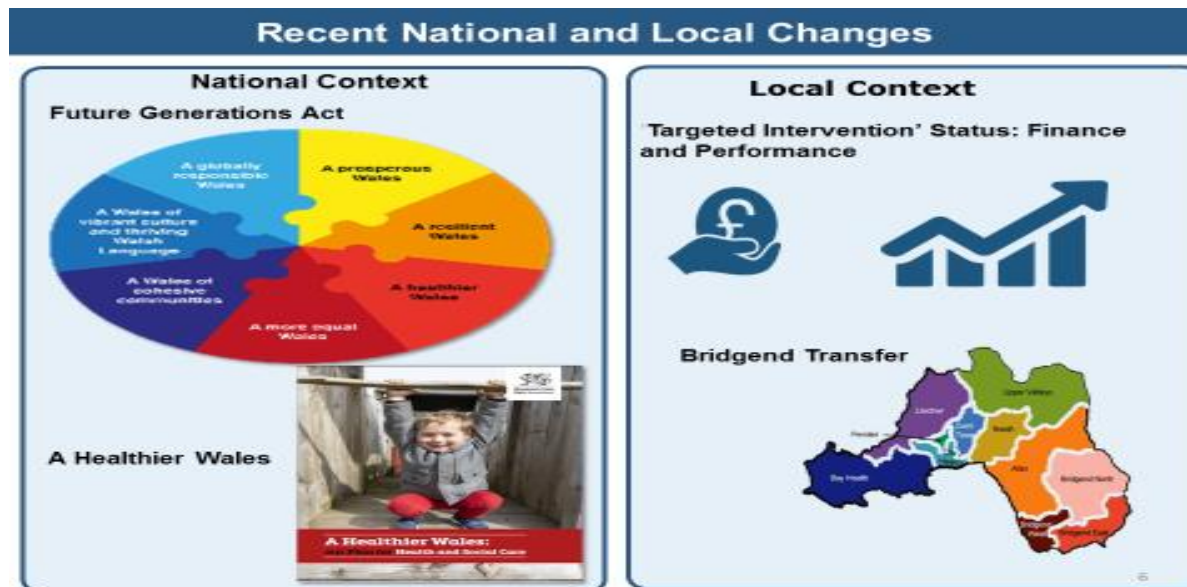
Recent national and local changes, including publication of *A Healthier Wales (2018),* also highlighted that there was a need for us to update C4B and write a Clinical Services Plan for the next five years which took account of these more recent developments.

We reaffirmed with staff and stakeholders the C4B priority areas and further development of these, where appropriate, to reflect recent changes, for example including mental health, learning disabilities and cancer in this refreshed plan.

Our neighbours, Hywel Dda University Health Board, joined us in our Regional Clinical Services Redesign Group to jointly create and agree a set of regional priorities for consideration by each Health Board. These reflected plans set out in the ARCH Portfolio Development Plan and within the Hywel Dda Health Board Clinical Services Strategy; A Healthier Mid and West Wales.

An Equality Impact Assessment process has run alongside the development of this Clinical Services Plan update and our Integrated Medium Term Plan (IMTP) development. The IMTP is the delivery plan for the first three years of our Clinical Services Plan. Our Equality Impact Assessment process will continue to run with patients, staff and stakeholders as we develop our detailed service change plans to ensure our service changes appropriately consider the equality rights of staff and patients.

2.4 Clinical Redesign Groups

A review of C4B, health board performance, recent changes in government planning guidance and local boundary changes highlighted three key areas where progress could significantly enhance outcomes that matter to patients, and the quality and safety of the care we provide for our patients and communities;

- o Unscheduled care
- o Surgical services
- o Regional services

Staff and stakeholders came together between September and November 2018 to participate in Clinical Redesign Groups for these service themes. Their work has significantly shaped the future hospital configuration and clinical services priorities set out within this plan.

2.5 Listening to our Staff

Our Clinical Services Plan staff engagement programme; *'Have Your Say'* was launched, by our Chief Executive, in September 2018 at our first staff Leadership Summit. At the Summit staff participated in shaping this Clinical Services Plan by sharing their ideas and suggestions for the future of clinical services.

The Leadership Summit was followed by a series of 'Frequently Asked Questions' and Intranet Briefings to keep staff up to date with progress and to answer their questions. Staff were encouraged to post their comments on the intranet as well as to email our '*Have Your Say'* account with their views and thoughts on the emerging clinical service plan priorities.

The clinical leads for the Clinical Services Plan hosted '*Have Your Say*' drop-ins for our staff in Neath Port Talbot, Singleton and Morriston Hospitals. Additionally, they met with members from the Local Medical Committee for GPs, Cluster Networks, and a range of clinical teams and some clinical forums such as the Planned Care Board, the Clinical Cabinets and Clinical Senate Council.

During these sessions we were able to share and test proposals from the Clinical Redesign Groups and hear staff views, suggestions and ideas on the proposed priorities and the options for reconfiguring the roles of our hospitals in relation to Frailty, Surgical and Acute services.

A programme of staff communication and engagement will be on-going as we move forward with Clinical Services Plan delivery.

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2.6 System Reconfiguration

The Clinical Redesign Groups reviewed information on our current and projected challenges and opportunities for unscheduled care, surgical and regional services. This showed that 'doing nothing' to change our current ways of working and hospital roles would continue to exacerbate the significant challenges faced by the Health Board (over the next five to ten years) in delivering outcomes that matter to people, high quality, safe and accessible services.

Our analysis of data on patient access and quality of care identified a number of areas with opportunities to improve;

• Surgical pre and post-operative lengths of stay in hospital	• Pace of discharge from hospital
• Patients admitted with conditions that can be treated without an admission	• Length of hospital stays
• Provision of day case surgical services	• Waits for out-patient and follow up appointments

Making these improvements is essential to the successful delivery of the Clinical Services Plan, however, they alone are insufficient to address the scale of the challenges we face. To ensure we have sustainable services able to deliver outcomes that matter to patients we need to make transformational change; particularly in primary and community services to enable more people to receive care close to home and deliver sustainable hospital services for surgical, frailty and acute care.

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3 - Our Clinical Service Plan Priorities

3.1 The Role of Integrated, Primary & Community Care

This Clinical Services Plan will radically change our approach to population health through the adoption of an **Integrated Cluster approach to care** which facilitates healthy lifestyles, preventative programmes, self-care and out of hospital care. Integrating primary and community services, physical and mental health services, with our partners, and transitioning care out of hospital into the community on a Cluster basis, where possible, will strengthen our care system as a whole. Focussing our attention on developing community resilience and well-being and delivering outcomes that matter to people will improve the health of our population.

The Role of Clusters
• Delivery of Primary, Community and Integrated Services • Planning and management of services best delivered at the Cluster level • Delivery of Care Closer to Home where this is safe to do so and adds value to patient outcomes and experience • Providing innovative alternatives to traditional outpatient or inpatient models of care • Support whole populations to develop healthy lifestyles, through preventative programmes, self-care and out of hospital care. • Integrating primary and community based services between Health, Social and voluntary sectors, physical and mental health services, with our partners, • Supporting the transition of care out of hospital into the community • Promoting University Research and Undergraduate and Postgraduate Education in a vibrant community setting

In line with ' *A Healthier Wales' (2018),* the Cluster approach will underpin our plan to reconfigure the roles of our major hospitals and support the effective delivery of timely, high quality hospital based care when it is needed. This is reflected in ambitions below.

3.2 The Role of our Major Hospitals

Options for the reconfiguration of our major hospital roles, underpinned by our plan to radically change our approach to integrated, primary and community care, were shared with staff and stakeholders before our Clinical Senate Council recommended the preferred option below. ***Preferred Major Hospital Roles Reconfiguration Option**

Role	Unscheduled Acute Medical Care	Surgery by complexity	Frailty (post assessment)
Hospital	**Morriston**	**Morriston, Singleton, Neath Port Talbot**	**Singleton and Neath Port Talbot**

*Detailed planning to further engage and possibly consult upon this option will be developed as part of delivering our ambitions as set out in section 3 below.

Major Hospital Roles

Neath Port Talbot : Local hospital and a centre of excellence for:

- Treatment centre for minor injuries
- Assessment and treatment of frail older people and ambulatory care support;
- Short stay low acuity elective surgery;
- Rapid diagnostic access and support;
- Rehabilitation and reablement services;
- Provision of some specialist services e.g. neuro-rehabilitation & Welsh Fertility Institute services

Singleton: Health Campus & Level 2 Hospital Centre of Excellence:

- Providing a wide range of diagnostic, rehabilitation & treatment services including ambulatory and frailty care
- An extensive range of elective surgery, including for high complexity patients with lower acuity
- Ophthalmology Services
- Strategic Hospital partner to Swansea University Medical School to build on the success of the Institute of Life Science and establish a Healthcare Technology Centre
- Teaching our future doctors, nurses and allied healthcare professionals
- The current provision of acute/inpatient Neonatal, Obstetric, Gynaecological and Cancer services will be relocated to the Morriston site in the longer term, whilst provision of ambulatory care will continue.

Morriston : A Health Campus and Level 4 Regional Centre :

- Regional Major Trauma Network and Trauma Unit lead;
- Short Term treatment of acutely unwell patients;
- Unscheduled and complex surgery across a broad range of specialties;
- Critical Care provision;
- Specialist diagnostic support and centralised Pathology;
- Provision of pediatric services
- Provision of some tertiary services including cardiology and the cardiac centre
- Research partner with Swansea University and development of Institute of Life Sciences on Morriston campus.

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3.3 Our Clinical Service Ambitions

Our ambitions for clinical services reflect the strategic intent set out above and have been informed by the refresh of our strategic needs assessment, national strategic policy drivers, sustainability opportunities identified through our clinical engagement and the key messages from staff and stakeholder engagement from both Changing for the Better and this up-date process.

Changing for the Better had several themes for service change. The ambitions set out below continue to reflect those themes with adjustments to take account of new policy, NHS priorities and the two strategic aims of our Organisational Strategy; supporting Better Health and Delivering Better Care. In total there are seven clinical service plan ambitions;

- Population Health
- Planned Care
- Older People
- Unscheduled care
- Maternity, Children & Young people
- Mental Health & Learning Disabilities
- Cancer

QUALITY
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Our ambition for Population Health; Integrated Clusters, Neighbourhood approaches and Wellness Centres underpin the Clinical Services Plan. This section describes how we will radically change the way primary and community care works with communities and partners to improve population health outcomes and the detrimental effects of inequality on the most vulnerable. Delivering this ambition is fundamental to delivering the remaining six ambitions we have. The detail on the context and delivery of our ambitions can be seen in the Annual Plan 2019-20 and the Integrated Medium Term Plan currently in development.

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1. POPULATION HEALTH: Our Ambition

As a health board we are committed to delivering our three well-being objectives; giving every child the best start in life, connecting communities with services and facilities, and maintaining health, independence and resilience of individuals, communities and families. The ambition and actions set out below for population health are fundamental to delivering these and the six other ambitions of this Clinical Services Plan.

To effectively improve health, reduce inequalities, maintain well-being and build resilient communities our patients, partners and staff told us to further improve prevention and self-care, and work with communities to provide care in or as close to their own home as possible. They agreed with the quadruple aims of *A Healthier Wales; Our Plan for Health and Social Care (2018)*

We want our population to experience improved health and well-being, with reduced inequalities between communities, which are themselves more resilient. We want to meet the expectations of our patients, partners and staff and further improve prevention and self-care, and work with communities to provide care in or as close to their own home as possible.

Our ambition is to deliver care that has a much greater focus on well-being, self-care, prevention, and access to care closer to home; delivering outcomes that matter to our patients and communities.

We have a strong base from which to deliver our ambition for population health, as the Western Bay Partnership has been delivering and further developing the optimum model for intermediate care; developing integrated plans for adult mental health services, "right sizing" care packages. In addition, with partners we deliver an extensive range of health prevention and promotion programmes and have commitments to extend this work in relation to childhood well-being, mental well-being, obesity, cholesterol, hypertension and diabetes in 2019. Additionally, the Public Service Boards are starting to support improved health and well-being and our Clusters have a strong track record in delivery and innovation, utilising their funds effectively, evaluating schemes and sharing good practice.

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'**Better together'** is the core principle for delivering our population health ambition; ensuring that with communities, patients and partners we co-produce plans, support self-care, and integrated services to improve community resilience and well-being. We will strive to become '**one system'** of health and social care working with communities and partners, providing care when possible in '**my home first'** and in a way that delivers the '**right care, in the right place, at the right time'**. '

POPULATION HEALTH : What we will do

OUR NEIGHBOURHOOD APPROACH

Our ambition, working with partners, is demonstrated by the New Western Bay Regional Offer: *Our Neighbourhood Approach*, which aims to radically change the way we all deliver services, through true co-production with citizens, based on a neighbourhood focus and building on community assets rather than deficits. This will support health and social care working together to deliver a whole system approach and provide radically different solutions for our citizens, based on their needs rather than providing a limited range of fixed options, which may or may not meet these needs. This will focus on supporting individuals and communities to take more control of their lives through supporting them by building on their individual and community strengths. . Specifically we will:

- Drive transformational improvements in wellbeing, health and care for the populations we serve through better practice, better services, better technologies and better use of resources.

- Change the way that we work with citizens away from paternalistic care to shared responsibility and co-production.

- Secure the delivery of seamless care which will meet the outcomes that matter to the people we serve and support through integration, earlier intervention and prevention

- Manage our common resources collaboratively and pool resources wherever we can.

This will require a fundamental change in the way that NHS and social care staff, in all settings, work with citizens, the voluntary sector and other organisations to understand and respond to their needs so as to enact the principles of prudent care.

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PRIMARY CARE : INTEGRATED CLUSTERS

Starting with the Cwmtawe and Neath Clusters, we will roll out across Swansea and Neath Port Talbot an ambitious plan to create *integrated multi-disciplinary teams* of health, local government and 3rd sector staff. Through this approach, we will expand the range of services available at home and in the community, including services for therapies, pharmacy and those that **support** *self-care and management of long term conditions*, such as Diabetes and Chronic Obstructive Pulmonary Disease.

The **Clusters will focus on improving well-being** across the age spectrum, from childhood to old age, working with patients, their families and communities to help keep people well in their own homes and build *community resilience*. We will ensure that the most vulnerable people living in a Cluster area are a key focus of this approach.

We will, in partnership with the community, design and deliver services to maximise *well-being*, *independence* and *care closer to home,* particularly for older and/or frail people. This will include new models of care that help to avoid hospital admissions for those that can be cared for at home or in the community.

Using integrated Cluster approaches, we will aim for any changes to become *self-sustaining* through service innovation and new ways of working described in the *Primary Care Model for Wales,* as well as by *rebalancing of resources* across the system.

PRIMARY CARE : SUPPORT FOR SYSTEM WIDE TRANSFORMATION

Delivering a progressive Integrated Cluster model will support the Health Board to deliver the ambitions set out in the rest of this Clinical Services Plan, including but not exclusively for;
- Planned care; new approaches to surgery, out-patient appointments and managing demand
- Unscheduled care; acute care at home or in community settings to avoid unnecessary hospital admissions
- Older People; delivering Hospital2Home services for older and/or frail people
- Maternity, Children & Young People; the Children & Young People's Charter and Strategy and the Maternity Plan
- Mental Health & Learning Disabilities: community resilience, dementia care, priorities of the three frameworks
- Cancer; approaches to prevention and early diagnosis of cancers

To ensure we are successful we will create a strong *Cluster leadership* model, which reflects the breadth of clinical expertise as well as facilitating the appropriate relationships with communities, partners and existing forums.

Transforming our primary care system will require us to roll out and embed the Cluster approach across Swansea and Neath Port Talbot. We will establish a robust *evaluation* programme to ensure that we learn from our experience and maximise on our successes.

PRIMARY CARE : DIGITAL

Cwmtawe Cluster will adopt a Digital Inclusion Charter and develop Digital Champions for the area from within key organisations and community groups to ensure that people can make the most of the information available to them digitally, and to develop digital solutions to providing support.

Clusters will develop and test innovative models of care, using data collected electronically by clinicians, including patient reported outcomes and experiences. We will ensure our mobile workforce is digitally connected to the health system to ensure staff work seamlessly to make "*Make Every Contact Count*".

CREATE NEW INTEGRATED WELLNESS CENTRES

We will create a new Wellness Centre, initially in Swansea City Centre and then in Neath Port Talbot following successful evaluation. These will be **co-designed with the Cluster community** and provide *health and wellness services* that promote health and well-being and support people to live healthy lives, managing their physical, mental and social wellness.

The Wellness Centres will support improving every child's start in life and promote personal independence and community resilience including for some of our most vulnerable people.

QUALITY SAFETY VALUE

RESEARCH AND EDUCATION IN CLUSTERS

We will work with Swansea University to promote Clusters as innovative clinical arenas for high quality research, education and training for undergraduates and postgraduates.

IMPROVE OUR LONG TERM CONDITIONS PATHWAYS

We know from our health needs assessment that levels of Diabetes, Respiratory related illnesses (such as asthma and COPD), Stroke and Heart Failure are causing significant harm and sometimes premature death in our population. The first part of a good care pathway starts with *prevention and helping people in the community to stay well and independent*.

However, once someone has developed a condition we know that their ability to *self-care* and manage their condition well and get the care they need at the 'right time, from the right person in the right place' is critical to their health and quality of life.

We will be working specifically on these key pathway areas in the coming year to do all we can to prevent disease and improve patient self-management; with care provided closer to home and with timely access to hospital care if needed.

We will also work to support patients with other long term conditions to enable them to maintain their health and wellbeing at home, minimising the need to visit hospital and getting people back to normal life as soon as possible.

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2. PLANNED CARE : Our Ambition

Our Planned Care ambition is to evolve our surgical services model to better meet patient needs and to reduce unnecessary travel to hospital.

Our engagement on planned care identified several priority themes, in particular; ensuring patients are seen at the '***right time, by the right person, in the right place'*** including '***my home first'*** though virtual clinics, information and telehealth which the patient can access at home or through new cluster based services.

Whilst our Planned Care Improvement Plan 2018/19 has made a difference to out-patients access, with fewer patients now on waiting lists than in 2017 and shorter waiting times, we recognise that we still have much to do.

Patients have frequently told us that they do not like traveling and waiting for routine appointments which don't help them. Our ambitions is to work '***better together'*** with staff and patient groups to change current 'routine' out-patient appointment approaches, where appropriate, to models that are responsive to the needs of the patient.

We know that timely access to planned care surgery improves health outcomes for our patients. Our surgical services ambition is to create a '***one system'*** approach to managing and delivering both planned and unscheduled surgical services across our hospital sites to minimise waiting times.

Our ambition for surgical services includes providing pre and post-operative care that improves well-being, recovery and patient self-care. We aim, through a new surgery by complexity model for surgical services to provide pre-assessment, surgery and post-operative care at the ***right time, by the right person, in the right place*** to ensure that patients are well informed and surgery is never cancelled or delayed.

PLANNED CARE : What we will do

IMPROVE OUT PATIENTS & DEMAND MANAGEMENT

Research into patient experience and outcomes and advancements in technology provide us with significant opportunities to both improve the quality of clinician to clinician advice for referrers, as well as ways to provide follow up care tailored to the patient's needs.

We want patients to coproduce and engage in making informed decisions about their care, to foster this will **co-design digital interactive engagement and feedback** mechanisms with patients for use in Cluster populations.

We will radically change our outpatient model over the next three years underpinning this will be our use of **digital technology, self-care, telemedicine, telephone and digital appointments** and removing follow-ups as a default model; avoiding routine follow ups at set intervals and moving to only arranging appointments when needed by the patient.

Out-patient appointments have historically been provided, in many cases, on the basis of limited transfer of information between clinicians. This can result in patients attending appointments unnecessarily and delaying access to routine care in the community. We will reduce unnecessary appointments and delayed access as a result of a clinician to clinician information through creation of a single point of contact for **professional advice**.

Understanding what matters most to our patients about their health is fundamental to delivering high quality, safe care that improve patient outcomes. We will work with clinicians to allow them to routinely collect **patient reported outcome measures**; delivering both the national value based healthcare priorities for PROMs collection in lung cancer, cataracts and heart failure as well as locally defined priorities such as orthopaedics, ENT, Breast Cancer, IBD and others. We will use the PROMs data with patients to agree their care and to inform the redesign of our services to increase their value to patients overall.

We will develop *digital solutions* to enable us to work better together with patients to design outpatient approaches that respond proportionally to patient need. This will include text messaging services and/or *virtual clinic* technologies which enable patients and their clinicians to share and receive healthcare information which supports *self-care and decision making* when further care may be needed.

Our work to improve outpatients will initially include a focus on some *key specialties* such as orthopedics, ophthalmology, neurology, diabetes and respiratory and later extend to other planned specialties. We will identify services that could be *safely delivered* at cluster level where this adds value to the patient's outcome or experience.

REMODEL SURGICAL SERVICES

Our aim is to improve access to planned surgery by increasing the amount of surgery we are able to provide outside of Morriston Hospital to enable it to focus on its role as the acute specialist, regional centre for South West Wales and beyond. This will improve patient waiting times and experience by making more efficient use of our theatres and bed capacity in Neath Port Talbot and Singleton Hospitals.

To realise the existing potential of our surgical system we will introduce a programme of *surgical efficiency optimisation* based on achieving best practice benchmarks for pre and post-operative assessment, length of stay and enhanced recovery approaches. Thereby improving patient access and reducing delays and cancellations.

To help us design a *new sustainable surgical model* for delivery across all our hospital sites, we will undertake a review by surgical speciality of our surgical patient case mix, including for patients who receive their surgery from hospitals other than our own.

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We will use this information, along with evidence of best practice, to *re-organise diagnostic, pre-operative, surgical, surgical support and post-operative services* across our hospital sites, and where appropriate for minor surgery, in primary and community services to ensure patients receive their care in the right place, by right person, at the right time according to the complexity of their care needs.

Where clinically safe to do so, we will separate the delivery of planned and unscheduled surgical services to maximise the efficiency of our surgical services and *improve patient experience, particularly in relation to waiting times, cancellations and out of area treatments.*

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We will embed *enhanced recovery after surgery* approaches including ensuring that all surgical patients have a standardised assessment and appropriate day case anaesthetic.

As part of this we will explore opportunities for improving surgical services through *regional working* with our colleagues in Hywel Dda University Health Board. This will include regional approaches to pre-habilitation and post-operative care.

We will identify services that could be **safely delivered at cluster level** where this adds value to the patient's outcome or experience.

*Please see our ambitions for **population health, older people, maternity, children & young people and mental health** which will also contribute to delivering our Planned Care Ambition.*

3. OLDER PEOPLE : Our Ambition

Real differences to older people's lives are made through shared commitments across health, social and voluntary sector services to work better together with older people to improve physical and mental wellbeing and create age friendly communities where older people are able to actively engage in family and community life. The ambitions set out in the population health and mental health sections for the improvement of well-being and integrated services, including physical and mental health services are particularly relevant to our ambitions for older people.

Our ambition is to provide genuinely integrated care, embracing the principles of comprehensive geriatric assessment required to meet the needs of older people. Older people access multiple health and social care services, the Health Board ambition is to over-come the traditional barriers between health and social care, primary and secondary care, physical and mental health and ensure that we are all working '**better together'**.

Clusters will be an ideal venue for much of the care and services for older people and will support the delivery of integrated care across health, social care and the 3rd sector.

The quality, capacity and responsiveness of each service impacts on how the whole health and social care system functions. Our integrated care model will engender collaborative working. Bold new models of care will be developed to address the interfaces, transitions, duplications and interdependencies between different components of care.

Whole system change with cross agency and inter-professional collaboration will ensure care is co-ordinated around older people's needs delivering the '*right care from the right person at the right time*'. More effective urgent care, post-acute rehabilitation and re-ablement will help to reduce inappropriate care and length of stay and allow for resources to be redeployed.

Frailty is a well described health state relating to the ageing process in which multiple body systems gradually reduce their in-built reserves. Around 10% of people over 65 have frailty, rising to between a quarter and a half of those aged over 85. Older people living with frailty are at increased risk of poor health outcomes and an apparent minor event can lead to a dramatic deterioration in

the patient's physical and mental well-being.

Our ambition is to have a clear Frailty Framework for the identification and management of frailty across the Health Board. Our aim is for **'one system'** of care whereby cohesive multi-disciplinary teams deliver this holistic model of care in a range of clinical settings across Swansea and Neath Port Talbot.

To meet older peoples care needs we will extend our integrated approaches, significantly improve our management of frailty and provide older people with access to the '**right care from the right person at the right time**' to optimise their well-being.

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OLDER PEOPLE : What we will do

DESIGN & DELIVER AN INTEGRATED OLDER PERSONS PATHWAY

A multi-disciplinary group will design and an integrated older persons pathway which addresses the Kings Fund report *'Making our health and care systems fit for an ageing population'* (2014), 10 components for delivering excellence in older peoples care:

1. Healthy active ageing and supporting independence
2. Living well with simple or stable long terms condition
3. Living well with complex co-morbidities, dementia and frailty
4. Accessible, effective support close to home at times of crisis
5. High quality person centered acute care when needed
6. Good discharge planning and post discharge support
7. Effective rehabilitation and re-ablement after acute illness or injury
8. High quality nursing and residential care for those who need it
9. Support, Choice and control at end of life
10. Integration to provide person centered integrated care

Supporting the well-being, healthy ageing and independence of older people is as important as meeting their acute care needs when they are ill. We will redesign and enhance our existing services to improve care in each of the ten components above, with a particular focus on improving **transition, duplication and interdependencies** between each component, as they currently fragment our older peoples care system.

Working closely with our stakeholders and partners we will develop and deliver **integrated approaches** to new service models, pathways, guidelines and standards of care for the above and starting with Frailty, Falls and Home2Hospital services including a

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single point of access and effective *rehabilitation and re-ablement approaches*.

Working with **clusters**, we will collaborate between professional groups, developing shared sovereignty and leadership to address the challenges of delivering *high quality holistic care* across all the key components and to agree outcomes measures which define success for the individual as well as the whole care system.

ESTABLISH A SINGLE FRAILTY MODEL (and Frailty Assessment)

The older persons integrated pathway will include developing models of care in community geriatrics, acute frailty/unscheduled care, ortho-geriatrics, older people undergoing emergency surgery and care home medicine.

Frailty can increase the risk of harm and reduce quality of life through physical, mental, social and environmental factors. We aim to improve the management of frailty by firstly supporting patients to reduce the impacts of frailty on their daily lives through *self-care and management approaches* where appropriate.

We will co-design with partners and stakeholders and agree adoption and roll out of a *Single Frailty Model* across Swansea and Neath Port Talbot, linking up existing staff and services from health, housing, mental health and social care sectors to provide frail people with a range of *physical, mental, social and environmental* (such as housing) support and care. Care of frail people will be managed by co-ordinated *multi-disciplinary* teams with *geriatrician expertise* to address medical, physical, psychological and social needs.

We will agree and implement a *Single Frailty Assessment Framework* for use by all staff across Swansea and Neath Port Talbot. This will enable them to appropriately identify and co-ordinate access to a range of investigations and treatments which will support frail people to stay in their own home where safe to do so or be cared for in hospital when they need a short stay admission.

The Frailty Assessment Framework will review and develop policy and guidelines covering the major frailty syndromes including *falls, delirium, dementia, urinary incontinence and polypharmacy.*

We aim to improve the management of frailty by supporting patients to reduce the impacts of frailty on their daily lives through *self-care* and management approaches where appropriate (for example; *exercise classes*).

Hospital2Home will also form a major component of our out-of-hospital frailty model.

DESIGN & DELIVER A RANGE OF 'Hospital2Home' SERVICES

We will address the findings of our Right Place Right Care Review (2018) which highlighted a number of opportunities for us to make significant changes to the way we provide care and improve the outcomes of older people, including;

- Avoiding unnecessary hospital admissions, particularly for patients requiring intravenous drugs through increasing the capacity and responsiveness of our existing *community based integrated Acute Clinical Teams.*
- Creatively using the expertise of our ACTs as a *Single Point of Access* working with our ambulance service colleagues;
- Establishing a *Hospital2Home* 'discharge to recover and assess' service. This service will provide a single assessment gateway for patients' for their ongoing needs assessing these at home and after /during reablement
- Making step changes towards delivering reablement at home instead of in a hospital setting by increasing capacity in *reablement at home services*

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We will deliver our Hospital2Home service model working in partnership with Swansea City Council and Neath Port Talbot County Borough Council to strengthen our existing Western Bay optimum model for integrated care. The new service will link closely with chronic conditions management services and pharmacy and medicines management as part of a *multi-disciplinary team approach supporting patients at home.* This will include Early Supported Discharge for COPD and will support further development of Early Supported Discharge for Stroke which is described in the Stroke Care Plan. We will use **clusters** as bases for designing and delivering services where it is safe and adds value to the patients' outcomes.

Hospital2Home will maximise the *independence* of older people and ensure care packages are 'right sized' before being put in place. It will be built around a trusted assessor model where assessment does not take place in a hospital bed and a strengths-based assessment approach aiming to assess patients before they reach a crisis point.

We will submit a *Transformation Bid* for the Hospital2Home service to Welsh Government with the aim of putting the service in place for the Winter 2019.

ENHANCE OUR FALLS PATHWAY

Working with our partners from the Welsh Ambulance Service we will implement a redesigned pathway for Falls to include a greater focus on *falls prevention* and ensuring those that have fallen are managed in their own home wherever it is safe to do so in order to optimise their recovery.

REGIONAL FRAILTY SERVICES

With our colleagues in Hywel Dda Health Board we will review opportunities to develop regional approaches to improving older people's healthcare, including access to timely care and specialised care.

*Please see our ambitions for **population health, unscheduled care and mental health** which also contribute to delivering our older peoples ambition.*

4. UNSCHEDULED CARE : Our Ambition

Our Ambition is to create '*one unscheduled care system'* which clearly supports patients and communities in knowing where and when they can get the care they need in an emergency and patients have access to '*the right person, in the right place, at the right time'* every time.

Excellent unscheduled care services start at home with individuals, families and careers feeling confident in knowing how to access the right service at the right time.

During our engagement we heard about the need to improve information and advice about when and where to access services and to increase access to unscheduled care in community based services and on a seven day basis. Many of these services may be planned and delivered in **clusters or groups of clusters**.

When emergency hospital care is needed we aim to respond rapidly to assess patient need and to work '*better together'* to coordinate resources and skills.

Where patients and their families are planning for end of life care we will ensure we have understood, communicated and acted on their wishes to avoid emergency admissions to hospital when a patients wish was to be with their families in their '*own home'.*

The following unscheduled care system image of the current and future states for unscheduled care is a product of the work clinicians and stakeholders participating in the Unscheduled Care Redesign Group undertook.
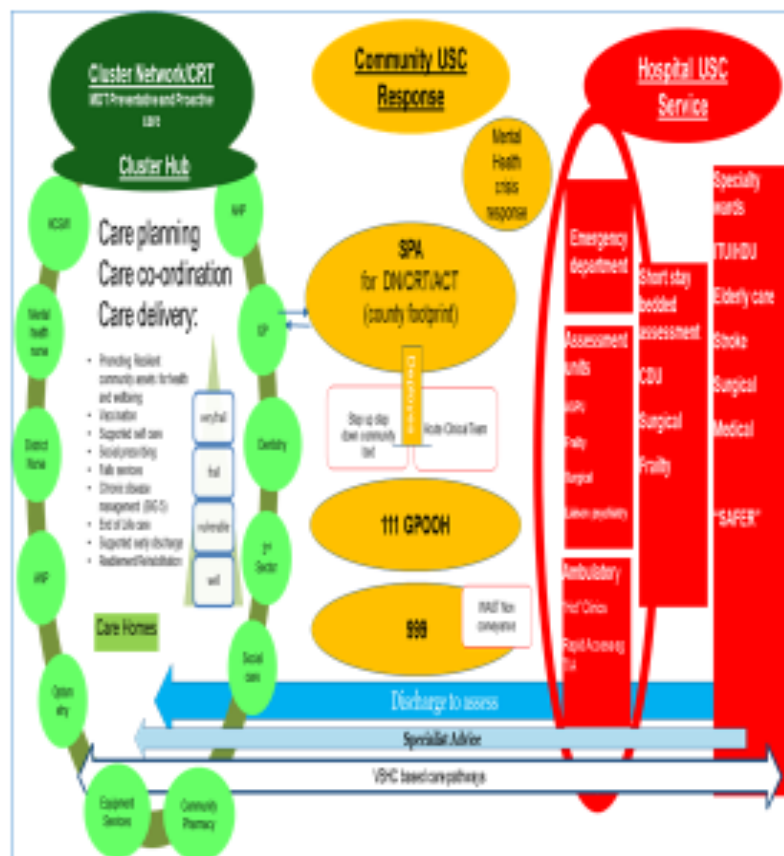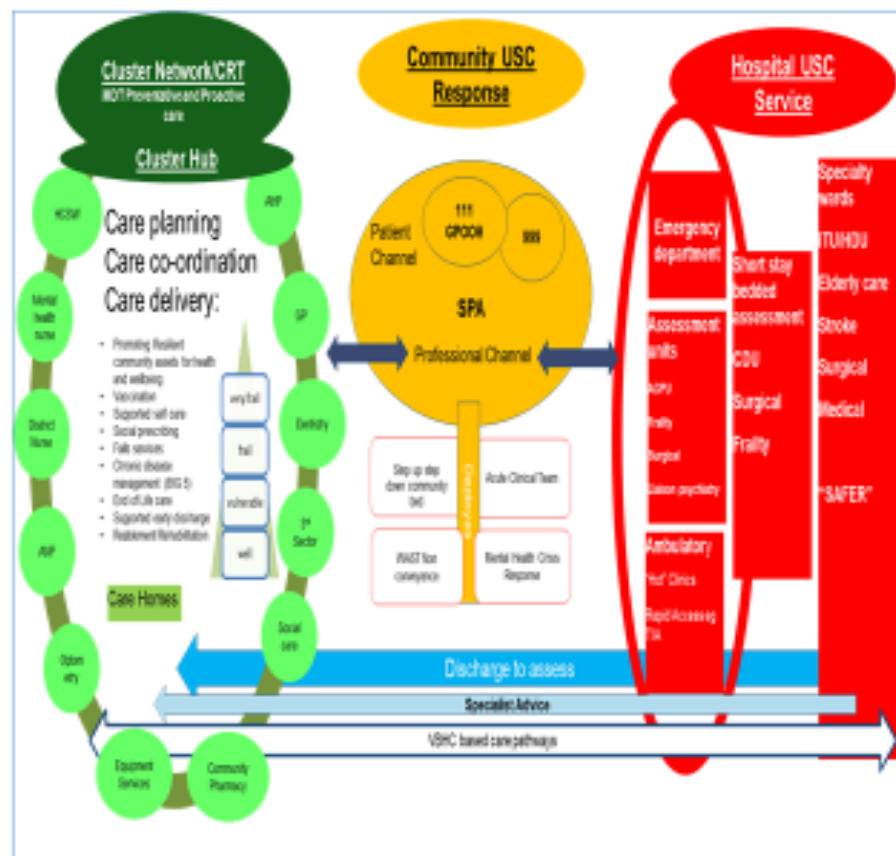
UNSCHEDULED CARE : What we will do

Effective unscheduled care begins at home with people feeling confident about when emergency care is needed and where to access it. Our proposals for Integrated **Clusters**, a Single Point of Access and a Sanctuary Model, described in our population health, older people's and mental health sections for example, are part of our approach to improving the quality and availability of emergency care information and services for patients, carers, families and communities.

The commitments we describe in these sections, to provide services that are better integrated, including for physical and mental health, will additionally improve the way we manage peoples care and reduce crisis situations arising.

ACUTE MEDICAL ASSESSMENT UNIT

We will plan a series of step changes to current services across all of our sites so as we can, in time, provide a *single acute medical assessment unit* at Morriston Hospital. This unit will sit alongside the emergency department and ensure that those with severe illness are investigated and treated without delay by staff with the appropriate resources.

A single acute medical admissions unit will transform our unscheduled care system; providing a single point of entry for *rapid assessment, investigation, admission and treatment* for life threatening illness without delay. This change will require a significant amount of planning with our patients, staff and colleagues from partner organisations, including the Ambulance Trust. It will require public engagement and possibly consultation for it to proceed.

Developing the *step-change plan* will require significant engagement with staff and partners, consideration of the Hywel Dda University Health Board Clinical Services Plan regarding Morriston Hospital, potential equality impacts for key characteristic groups, consultation with staff and the public and may potentially also require capital resource.

Our aim is to create a step-change plan for unscheduled care services across all our sites to support the transition to a single

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acute in-take at Morriston Hospital. This will be underpinned by delivering value for our patients; optimising their outcomes in line with national benchmarks for best practice and alignment with current capital plans, such as those for the new access road at Morriston Hospital.

REDESIGN STROKE PATHWAY & A NEW HYPER ACUTE STROKE UNIT

We will continue to develop and raise awareness with the public of *stoke prevention* interventions such as maintaining a heathy heart and will fully implement the roll out of appropriate *anticoagulation therapy* through primary and community services for patients with atrial fibrillation. We will provide services at **cluster** level when practices are unable to deliver it more locally.

We will develop a value based healthcare proposal for *Early Supported Discharge* Services for stroke patients, assessing the effectiveness of existing rehabilitation services and inpatient care prior to embedding a new model of care.

Where a patient has had a stroke we will ensure they are clinically assessed by expert staff within a new regional *Hyper Acute Services* Unit at Morriston Hospital, which will provide services for the residents of South West Wales. This unit will provide 24/7 expert specialist clinical assessment for up to 72 hours after admission. Including rapid imaging and the delivery of intravenous thrombolysis.

After discharge from hospital patients will be offered *Life After Stroke* follow-up care including digital support, post stroke reviews, communication and emotional support services as well as exercise based rehabilitation. These services will help to improve the outcomes and quality of life for stoke patients.

We will continue our workforce redesign programme within resources using Prudent

Healthcare principles to expand **7-day services** across our key sites.

To deliver these changes we will work regionally with Hywel Dda Health Board, the national Delivery Unit, Swansea University through ARCH and the Ambulance Trust to model the required service and staffing options.

END OF LIFE CARE

We will ensure that where appropriate, patients and their families will be given the opportunity to discuss their views and develop an explicit plan for their own further investigation and treatment and that this plan is reviewed regularly.

We will then seek to ensure that only interventions which are both agreed with the patient and their relatives and which are in the patient's best interests are completed. Whenever possible we will seek to ensure that patients are given the opportunity to die in comfort in their own home if that is their wish. This will include working closely with **care homes** to support their skills development in both assessing and planning escalation of care need.

*Please see our ambitions for **population health, planned care, older people, cancer and mental health** which will also contribute to delivering our Unscheduled Care Ambition.*

QUALITY SAFETY VALUE

5. MATERNITY, CHILDREN & YOUNG PEOPLE : Our Ambition

In December 2018 we refreshed and relaunched our Maternity Plan. In line with this and our existing ARCH Prospectus and Children & Young Peoples Strategies our strategic intention, in the coming years, is to initiate the transfer of obstetrics and neonatal care (as well as emergency gynaecology services) to Morriston Hospital, but in the meantime, we will continue to provide high quality neonatal and maternity care at Singleton Hospital.

We know that a healthy mother is essential to giving a baby a healthy start in life. Maternity services are fundamental to both the health of the mother, her baby and the society in which they live.

Our Ambition for maternity services focusses on working '***Better Together'*** with women, their families and our partners to proactively support care and advice at the '***Right time, with the Right person, in the right place'*** to give children the best start in life. This includes supporting the ***'my home first'*** principle to support more women to have their babies in or close to their own home and outside of an obstetric labour ward.

In 2018 we launched our Children's Charter and the Board approved our ambitions for children and young people set out in our Children & Young People's Strategy; for our children to be safe, healthy, and able to enjoy life and grow up achieving economic well-being and making a positive contribution.

We know that caring for children is the responsibility of everyone in the care system working together as '***One System'*** keeping children safe, well and able to develop to their full potential. This includes working '***Better Together'*** for the mental, social, economic and physical well-being of children and caring for them in or as close to '***my home first'*** wherever safe to do so. This will supported by **cluster** initiatives to reduce adverse childhood events, and improve early year's development.

MATERNITY, CHILDREN & YOUNG PEOPLE : What we will do

DELIVERING OUR MATERNITY PLAN : supporting babies with a healthy start in life

Singleton Hospital will open a new **Transitional Care Unit** where mothers and families will be supported to care for their babies themselves with 24hr professional midwife and maternity staff on hand. This will help those babies that whilst not needing neonatal intensive care to get the extra help they need when they need it.

Our maternity services staff will introduce new **foetal monitoring** services to check a baby's heart rate during labour and birth and respond quickly to manage any signs of significant distress.

QUALITY SAFETY VALUE

Our Midwifes will increase the number of **midwife led newborn examinations** they provide, working closely with mothers and their families to identify concerns early and ensure babies have a healthy start in life.

Working closely with public health and other key partners we will support more women to be as healthy as they can be during maternity particularly supporting women with maintaining a **healthy weight and smoking cessation.**

We will offer more women the opportunity to commence their **labour in or close to their own home** and outside of obstetric labour ward

Working closely with mental health, third sector and community services colleagues we will improve the level of support for the **emotional wellbeing** of women and their babies when needed

Working with local authorities we will provide additional *maternity support* to families with greater needs experiencing the impacts of health inequalities

QUALITY
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DELIVERING OUR CHILDREN & YOUNG PEOPLES STRATEGY : supporting a healthy, safe childhood and access to services

Children's services staff will be working closely with primary and community care colleagues on the development of our *Wellness Centers* in Swansea and Neath Port Talbot to ensure that Children and Young People's services are embedded within these and our Children's Charter underpins their work. Alongside the centers we will use **clusters** as bases for designing and delivering services where it is safe and adds value to the patients' outcomes.

We are aware from our engagement work that knowing how to access Children's Services can sometimes be confusing for parents and families. Morriston Hospital will undertake a feasibility review for a *single point of access* to pediatric services at Morriston Hospital

We will assess our current pediatric services, using the British Association for Community Child Health quality standards toolkit, and determine a baseline from which to develop a sustainable service model into the future for *community paediatric services* and a delivery plan to achieve this

Our *Neurodevelopment* team will develop a new model of care to centralise and improve access to these services for children and young people

REGIONAL WOMEN & CHILDREN'S SERVICES

Working closely with victims of sexual assault and rape, the police and third sector colleagues we will agree and deliver a sustainable service model for a *Sexual Assault & Rape Centre* across South West Wales.

Further development of *Perinatal Mental Health Services* for women and babies across South West Wales in line with Welsh Government planning priorities.

With our colleagues in Hywel Dda University Health Board we will review opportunities to develop *regional approaches* to improving women and child health, including access to timely Specialised care, and centralization of neonatal and maternity services.

Please see our ambitions for **population health and mental health** *which also contribute to delivering our maternity, children and young people's ambition.*

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6. MENTAL HEALTH & LEARNING DISABILITIES : Our Ambition

Our ambition for improving the emotional and mental wellbeing of our population is to maximise independence through a strengths based model that supports choice and responsibility, working alongside people and families within community settings or *'my home first'* with hospital based care the exception rather than the norm. We will use **clusters** as bases for designing and delivering services where it is safe and adds value to the patients' outcomes.

We aim to effectively support some of the most disadvantaged and vulnerable individuals in our society who are known to be poorer than the general population due to their increased likelihood of experiencing poverty, poor diet, less exercise and use of tobacco, alcohol and/or illegal substances. Additionally, people with severe mental illness or learning disabilities also experience significant health inequalities often as a consequence of difficulties they experience in accessing timely, appropriate and effective health care.

Our ambition is to deliver services that minimize these barriers to good mental and physical health by supporting people directly to access *'the right care, by the right person, at the right time'* and to ensure we make reasonable adjustments in how we provide health services so that people have equitable access and outcomes.

The achievement of our ambitions are dependent upon working as '**one system'** to effectively joint commission and work *'better together'* with local authorities, people with lived experience, carers, other public services and the third sector.

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MENTAL HEALTH & LEARNING DISABILITIES : What we will do

DELIVER THE ADULT MENTAL HEALTH STRATEGIC FRAMEWORK

Mental Health and the provision of services to support people has grown in importance in recent years with increased awareness and need for advice or help. To better respond to these changed circumstances *health and social care* services recognise we must redesign our services if we are to support people more effectively.

We have worked collaboratively with people with lived experience of mental health issues, carers and local authorities to agree a *Strategic Framework* for adult mental health that provides a clear direction of travel for enhancing the availability of services across health and social care to meet the needs of a wide range of individuals; from *building resilience at a community level* to address low level *wellbeing* difficulties or *isolation* to improving the range of *specialist services* available to people with the most complex needs, the strategic framework provides the basis for change for the coming years.

A long term *plan for implementation* will be agreed by the multiagency Wellbeing and Mental Health Board with focus in 2019/20 on;

- Development of *Community Mental Health Teams*, and ensuring that we have the right building blocks in place for community services, including medicines management in-put ;

- Ensuring the availability of *low level support* is increased and that it is provided in a non-stigmatised way to allow people living with mental and emotional distress to reach their full potential

- Planning on the same footprint between health and social care services with *Integrated Clusters* being the basic unit.

- Modernising *Day Services* and reviewing the availability of *drop in services*

- Further developing the response to crisis situations for people and dealing with distress through the introduction of a *sanctuary model*.

- Development of Adult Acute Business case to replace the not *fit for purpose estate* still in use at Cefn Coed Hospital as

part of the whole system of service provision. (Year 1 SOC, Years 2 & 3 OBC,FBC and commence work)

- Implementation of a sustainable service for providing high intensity **psychological therapies** in line with Welsh Government guidance and to meet new 26 week access target. (year 1 – recruitment to new roles, redesigned stepped model of care & pathway)
- Further development of **Perinatal Mental Health Services** for mothers and babies regionally across South West Wales
- Options for implementing a dedicated **secure service for women** as part of a mental health pathway for women. (Year 1 – women's low secure provision)
- Reconsideration of service model for **Older Peoples Mental Health in-patient care** with Local Authorities

AGREE AND DELIVER A DEMENTIA SERVICES IMPROVEMENT FRAMEWORK

The changing demographics in society has meant that the percentage of our population that is over 65 is continuing to increase which means that the number of people living with dementia is also increasing.

Together with other public services we are working to plan the implementation of the Welsh Government's National Dementia Strategy Action plan. Key objectives for Health Services is to improve the **identification** of dementia, to reduce the time between **referral** and **diagnosis** and to provide **support** for individuals and families for living well with dementia. Along with partners we will be looking at workforce development to support this in line with Good Work, a dementia learning and development framework for Wales.

We will be working within a **Western Bay Dementia group** to identify the use of funding targeted at developing dementia friendly communities and services for 2019/20. This will include supporting work on the **Integrated Older Persons** pathway development that will result in clearer clinical pathways and improved information regarding accessing services.

AGREE AND DELIVER A LEARNING DISABILITIES SERVICE

IMPROVEMENT FRAMEWORK

The Health Board is a provider of specialist learning disability services for 3 other Welsh Health Boards and we have worked with them to develop a Learning Disability specific *health needs assessment* as well as a common commissioning view that will be the basis of a modernisation plan that will now need to be worked up in partnership with local authorities for Merthyr, Rhondda Cynon Taf, Cardiff, Vale of Glamorgan, Bridgend, Neath Port Talbot and Swansea.

The population and health needs assessments provide clear evidence of *increasing demand* for Learning Disability services and the current model of service is not able to meet the changing needs of the population with a significant proportion of people are being placed in private placements, often many miles from their families which disrupts family life and removes people from their community support networks.

These placements can also be very expensive and place significant pressures on both local authority and NHS resources. *Together* with our partners across three health boards we will be:-

- Agreeing a joint statement on commissioning intent for learning disabilities and *common strategic framework* between 3 Health Boards and 7 local authorities
- Development and agreement of *multiagency* proposal for transforming Learning disability services which can be presented to Welsh Government for support and which will be informed by the all Wales improving lives programme for

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Learning Disability

- Discussion with Welsh Government about potential change programme bridging funding to invest in community expansion to facilitate changes in the whole system of *health and social care* services for people.
- Long term rationalisation of NHS learning disability estate to reduce number of isolated small inpatient units by *bringing units together* according to population needs.

*Please see our ambitions for **population health, older people, maternity children & young people** which also contribute to delivering our mental health and learning disabilities ambition.*

7. CANCER : Our Ambition

In 2018 we published the Non-Surgical Cancer Strategy for South West Wales setting out our ambition to *"provide the best possible cancer care for the people of South West Wales"* and to further develop the South West Wales Cancer Centre, which will see the center move to Morriston Hospital.

Together with ARCH partners, Hywel Dda University Health Board and Swansea University, it is our strategic intention to develop Mid & South West Regional Centre of Excellence Cellular Pathology Laboratory and Regional Diagnostic Immunology Laboratory at Morriston Hospital. Proposals include an Advanced Therapy and Treatment Centre to support future cell and gene therapy and promote our unique opportunity to be at the forefront of research into therapies for patients with challenging conditions.

Our ambition is to provide the best possible cancer care for the people of South West Wales and to improve patient outcomes, quality of life and care at end of life through delivering six core objectives;
1. Prevent or Detect Cancer Earlier
2. Improve the quality and availability of information
3. Deliver fast, effective Cancer treatment
4. Meet people's needs through delivering person centered care
5. Provide high quality end of life care
6. Improve access and opportunities for patients to participate in cancer research

We aim to deliver effective and efficient care, where patients feel cared for, safe and confident; delivering excellent care in the most appropriate setting. For the people of South West Wales we care for to have cancer outcomes on par with equivalent populations in the UK and Europe and to receive the best evidence based treatments at all levels, delivered in a timely and appropriate manner.

Prudent commissioning of services based on need and improving the emphasis on prevention, early detection, and the interface between primary and secondary care; developing new models of care with our partners to reduce and prevent cancer incidence

and deliver treatments that improve outcomes. This includes providing better support to those living with and beyond cancer.

This involves citizens and clinicians working together to make decisions to change services or pathways to ensure they optimise outcomes and experience and provide safe, compassionate care, in the most appropriate setting, that meets agreed national standards, is as good as it can be and creates cancer services fit for the future.

To deliver our ambition we will work as '**one cancer system'** providing timely access to **'the right care, by the right person at the right time'** and working **'better together'** with patients, their families, primary and secondary care and third sector partners to deliver our six objectives for cancer services. We will use **clusters** as bases for designing and delivering services where it is safe and adds value to the patients' outcomes.

Local implementation of the national single cancer pathway is an opportunity for us to transform how we provide our cancer services. Not only will it help us to improve outcomes for our patients but it will also improve how our patients experience their care.

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CANCER : What we will do

RAPID DIAGNOSTIC CENTRE

We have already piloted a Rapid Diagnostic Centre and more recently, based on the success of the model and its beneficial contribution to implementing a single cancer pathway secured funding from the Wales Cancer Network to extend the concept. We will be developing and embedding this model as part of our roll out of the single cancer pathway.

IMPLEMENT THE SINGLE CANCER PATHWAY

Overall, patients have a good experience of cancer services in Wales but survival rates are poor compared to similarly developed countries. Evidence shows that better individual and population outcomes for cancer patients are achieved through early diagnosis. We need to provide more open and quicker access to diagnostic tests and treatment.

The Single Cancer Pathway places a significant focus on waiting times, and will have a profound effect on the drive to detect cancer at an earlier stage.

We know from cancer patients that they want physical, emotional and social support with clear advice about what to expect when they go through diagnostic tests and treatment.

We will establish routine *liaison* mechanisms between primary and specialist care to provide patients with seamless transition from secondary to primary care, including support from pharmacy and medicines management services.

We will take a significantly enhance our approach to *cancer nursing* across Swansea and Neath Port Talbot by developing the role of Clinical Nurse Specialists to promote excellence in practice implementation and evaluation of patient centred and evidence

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based standards. Placing our patients at the heart of our care through individual needs identification will help patients feel well supported, informed and able to manage the effects of living with and after cancer.

As part of our commitment to delivering effective *recovery packages* we will ensure that 100% of people diagnosed with cancer in Swansea or Neath Port Talbot will be allocated a key worker to identify their individual needs and ensure prompt information, signposting and onward referral to wider health and social care teams is provided. We will use **clusters** as bases for designing and delivering services where it is safe and adds value to the patients' outcomes.

We will participate in ground breaking international *research opportunities* including delivery of trials of gene and cellular therapies.

IMPLEMENT PREVENTION OF LUNG CANCER INITIATIVES AND PATIENT REPORTED OUTCOME MEASURES

We will fully implement the *Help Me Quit* programme, including the development of a wider range of support options, particularly those which maximize the use of technology. We will take action to increase the proportion of smokers who are aware that quitting with the NHS help provides the best chance of success and will help health professionals to support smokers.

We aim to deliver year on year increases in the proportion of *children and young people* who are smoke free.

The Lung Cancer Multi-disciplinary Team will review and *redesign the lung cancer pathway*, ways of working and staffing to optimise opportunities to improve early diagnosis, patient experience and outcomes.

We have already initiated baseline *Patient Reported Outcome Measures* (PROMs) collection in one of our lung cancer clinics. This is our best opportunity to work with patients to co-produce care plans that deliver the outcomes that matter most to them and ensure we provide services that deliver 'value' for our patients. We will work closely with patients, colleagues from Hywel Dda

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VALUE

Health Board lung cancer teams and the All Wales cancer network to extend this collection to follow up PROMs and to use this data to plan patient care and service improvement.

IMPLEMENT BREAST CANCER SCREENING AND PATIENT REPORTED OUTCOME MEASURES

We will work alongside our partners to support the development of sustainable and accessible health and care systems focused on prevention and early intervention. This will include a focus on national population-based *screening* for Breast Cancer, reducing variation and inequality in care and supporting care moving closer to the home where possible.

Our Breast Cancer Team aspire to achieve the best possible Standards of Care and will initiate collection of *Patient Reported Outcome Measures* with patients to ensure patient care plans are tailored to delivering what matters most to their patients.

REGIONAL CANCER SERVICES

implement the commitments in Non-Surgical Cancer Strategy, including development and delivery of detailed plans (including capital plans) with partners for the further development of the South West Wales Non-Surgical Cancer Centre; co-location of Cellular Pathology and Diagnostic Immunology services at Morriston Hospital; Advanced Therapy and Treatment Centre support for future Cell and Gene Therapy at Morriston Hospital.

4 - Delivering our Plan

*Please see our ambitions for **population health and planned care** which also contribute to delivering our cancer ambition.*

4.1 Our Five Year Delivery Plan

We have worked with clinical colleagues to map our five year critical path for change. This is indicative and will be refined with clinical colleagues to reflect the prioritisation of some of the changes which require strategic planning e.g. oncology services. The critical path will be reviewed by our Clinical Senate Council and inform delivery of our Health Board wide Transformation Portfolio.

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working together / caring for each other / always improving / cydweithio / gwella bob amser / gofalu am ein gilydd

A roadmap diagram spanning years 2018/19 to 2023/24 with vertical axis "Healthcare Reconfiguration" and category rows: Population Health, Unscheduled Care, Planned Care, Older People, Mental Health & Learning Disabilities, Cancer, Maternity & Children.

Items shown include:

- Cluster Model phase 1; Diabetes, COPD pathway improvements; Cluster Model phase 2; Embed Cluster Model; Swansea Wellness Centre; Neath Wellness Centre; Neighbourhood model roll out; SAT implementation plan
- Single acute take (SAT) - options for consideration; SAT detailed modelling; SAT options scope; SAT option for consultation agreed; SAT Consultation; SAT B'case; HVO Phase 3; HASU Phase 2
- HVO Delivery Plan; HVO Phase 1; HVO Phase 2; HASU Consultation; HASU Phase 1 roll out; HVO Phase 3; HVO Phase 2
- HASU Modelling; HASU Model; HVO Phase 1 roll out; Embed New surgical model; Frailty Embed; H2H Evaluation; Cefn Coed B'case FBC; LD Framework implementation; Screening programmes; M&S WW regional centre operational; Neonates & Obs implementation roll out
- HVO Delivery Plan; Surgical Deep dive & service mapping (to specialty level); Scope Surgical model & options; Surgical option consultation; H2H Optimisation; Frailty phase 1 roll out; Cefn Coed B'case OBC; Psych Therapies recruitment; Commence M&S WW regional centre build; Neonates & Maternity transition plan consultation; Implement model for community paediatric services
- Falls Pathway H2H Delivery; LD Priorities agreed; Cefn Coed B'case SOC; Implement Single Cancer Pathway; M&S WW OBC submission; Centralise Neurodevelopment; Launch Foetal Monitoring Service
- Single frailty model agreed; Women's Low secure option agreed; Pilot treatment Summaries
- H2H Transformation Bid; LD Framework Approach agreed; Lung Cancer Plan

Bottom labels: Planned Care | Older People | Mental Health & Learning Disabilities | Cancer | Maternity & Children

Reconfiguration

4.2 How we will Deliver the Changes

To deliver the Organisational Strategy the Board has approved a Transformation Portfolio which includes delivery of the Clinical Services Plan.

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OUR WAY

Improving patient quality, safety and value

$$\frac{\text{Outcomes that matter to people}}{\text{Efficient use of our resources}} = value$$

To deliver the ambitions of this Clinical Services Plan we will support clinicians to lead service change with appropriate project management, planning, information, finance and improvement skills, as relevant to the scope of the change.

In delivering the 'Our Way' we will shift our improvement practice toward common approaches to pathway redesign, variation reduction, patient outcomes reporting and resource mapping. We will improve information availability for our clinical leads from which they can develop insights into our opportunities for improvement. We will develop a standardised approach to project management and the development of detailed delivery plans with milestones and agreed outputs; governance arrangements for monitoring and reporting our progress and benefits delivery for patients and communities, services and the wider system.

We recognise that digital technologies will play a significant role in standardising our working practices to adopt the 'Our Way' approach and in delivering more efficient services and patient independence and control over their healthcare.

5 - How we will Measure our Success

Resourcing our plan is something we have started to successfully progress; securing funding to initiate the population health Neighbourhood model, further develop the Rapid Diagnostic Centre and roll out the Integrated **Cluster** approach for example. We will continue to seek and secure additional funding for our plans wherever possible.

We are also fortunate to have identified opportunities to improve the efficiency of our current services and make better use of our existing resources by reducing variation in length of stay and introducing more effective ways of working in out-patients for example. These create opportunities for us to potentially rebalance our existing resources from acute to primary and community services to support the improvements we want to make.

However, the scale of the ambition of our clinical services plan will likely also require us to consider capital development requirements, as well as staff and stakeholder engagement and possible consultation with the wider public.

Implementing the Clinical Services Plan will therefore need all of our staff to work '***better together'*** as '***one organisation'*** and with our partners to make best use of their skills, expertise and resources and to shape the leaders of our future; developing the capability of our staff to be the best they can be for the people of Swansea and Neath Port Talbot.

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5.1 Measuring Our Success

With our staff, based on the ambitions set out in this plan we have identified a set of aims, deliverables and success measures by which we will judge the successful delivery of this plan. For each of these we are developing a clear measurable definition and a baseline, where appropriate, from which to measure our success.

Aims, Deliverables and Outcomes

Aims

1. Improved outcomes, quality and safety
2. Better patient experience
3. Appropriate access; right place, right time
4. Improved integration of services
5. Development of the workforce and improved staff experience
6. A financially and operationally sustainable health system

Deliverables

1. Single acute medical assessment unit
2. Single Point of Access & Hospital2Home Services
3. Frailty model
4. Surgery by complexity model
5. Integrated Clusters
6. Wellness Centers
7. Improved long term conditions pathways
9. Best Value delivery

Success Measures

1. Better patient experience and outcomes.
2. Admission avoidance
3. Prompt access
4. Reduced length of stay
5. Increased pre-assessment
6. Reduced cancellations
7. Increased day case rates
8. Increased theatre productivity
9. No serious incidents
10. Reduced re-admissions/ complications/mortality
11. Reductions in unnecessary follow ups
12. Better staff experience and skills

2

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OUR ANNUAL PLAN

2019/20

Message from the Chair and Chief Executive

We are pleased to introduce the Annual Plan for Abertawe Bro Morgannwg University Health Board (ABMU or the Health Board) 2019/20. The Health Board has, for a number of years, submitted and annual plan in place of a medium term plan as it focused on meeting the immediate pressures of financial stability and performance delivery. While we maintain a strong focus on these key areas we have also developed and strengthened our long term Organisational Strategy and the five year update of our previous Clinical Services Plan – Changing for the Better. The development of this plan is a key component of delivering these and achieving our long term ambition and aims.

To better facilitate regional and local alignment of Health Boards and Local Authorities, the provision of health services to the population of the Bridgend locality will, as of 1st April 2019 move to Cwm Taf University Heath Board. This change will not impact on service delivery or patient care, however we have considered the impact and implications of this change throughout our planning. This change has also resulted in the new identity for the Health Board with this plan becoming the first for the new University Health Board.

There have also been significant changes to the Board, both Executive and Non-Executive members, and we are delighted to introduce the new Board who will lead the Health Board to deliver its plans. Whilst these changes have been significant, the organisation has continued to strive to deliver the best possible care for the people we serve. This can be seen in the improvements made in performance across a number of areas such as the reduced time people are waiting for treatment with significantly fewer people waiting more than 26 weeks for treatment and fewer people waiting long periods (12 hours+) in Accident and Emergency Departments across the Health Board. We have also continued to lead the way in digital innovation, most prominently in the successful roll-out and uptake of our mobilisation project with over 3,000 members of staff now using their mobile phones or tablets (personal or business) to help streamline their working day. We have also led the way in implementing 'Patient Knows Best' which is helping empower patients to be more involved with their care by securely giving them access to their own health records.

It is vital that we continue to build on these successes, address areas for improvement and build an organisation fit for the future that can meet the needs of the population through effectively working in partnership with the public with Local Authorities, with the Third Sector and our NHS partners, building on the strong foundation of the Western Bay Regional Partnership Board and our Public Service Boards. Achieving this builds on our Wellbeing Objectives and this starts with a clear and consistent understanding of our organisational purpose, ambition and aim. This plan, its development and its delivery, therefore sits firmly within the context of our newly developed Organisational Strategy and is a core component of its delivery working to achieve our ambition of:

'Better Health, Better Care
Better Lives'

This will only be achieved with the continuing support and commitment of our excellent workforce and partners who everyday strive to deliver the highest standards of care to our patients, carers and public. We would like to take this opportunity to thank them for their work and we look forward to continuing to work collectively to deliver our ambition through implementation of our plans.

Andrew Davies
Chair

Tracy Myhill
Chief Executive

Contents

1. Strategic Overview

1.1 Our Organisational Strategy

2019/20 sets a new direction for the Health Board. We are a new organisation, as we now predominantly serve the populations of Swansea and Neath Port Talbot Local Authorities. 2018/19 has been a year of significant improvement and we are now moving into a period of sustainability enabling us to thrive.

STABILISE → RECOVER → SUSTAIN → THRIVE

To set a clear direction going forward we have developed an Organisational Strategy so that we are clear about our 'reason for being', our ambition, our aims and how we plan to achieve these. The Health Board has two equally important functions to fulfil; we must improve population health so that people can stay well and we must deliver high quality care when people need it. These are detailed in our strategy on a page.

Principles

The Health Board has established the following principles to underpin all that we do.

Values

Our ways of working are underpinned by our Values and Behaviours, which were developed following thousands of conversations with staff, patients, their relatives and carers.

Respecting peoples' rights – we are the only Health Board in the UK to have a Rights Charter for children and older people

People at the heart of all that we do

A focus on the Five Ways of Working
1. Prevention
2. Integration
3. Collaboration
4. Long Term
5. Involvement

Respecting peoples' rights

Prudent Care and the Quadruple Aim
1. Improved population health and wellbeing
2. Better quality and more accessible health and social care
3. A motivated and sustainable health and social care workforce
4. Higher value health and social care

CARING for each other | Working TOGETHER | always IMPROVING

Caring for each other in every human contact in all of our communities and each of our hospitals

We will: Be approachable, helpful, attentive to other's needs; be thoughtful and flexible about how to meet the needs of each person; be calm, patient, reassuring and put people at ease; protect others' dignity and privacy and treat others as we wish to be treated.

Working together as patients, families, carers, staff and communities so we always put patients first

We will: Listen closely; consider other's views and include people; appreciate others: be open, honest and clear; give constructive feedback and be open to and act on feedback ourselves; be supportive and say "thank you."

Always improving so that we are at our best for every patient and for each other

We will: Be vigilant about safety and risk; never turn a blind eye; look for opportunities to learn; enthusiastically share ideas and actively seek solutions; be accountable for our behaviour and hold others to account; keep promises; be positive, a role model and inspiration to others.

Our Strategy on a Page

PURPOSE

Together, improve wellbeing & healthcare for all

AMBITION

Better Health
Better Care
Better Lives

STRATEGIC AIMS

Support **better health** and wellbeing by actively promoting and empowering people to live well in resilient communities.

Deliver **better care** through excellent health and care services achieving the outcomes that matter most to people.

ENABLING OBJECTIVES

- Partnerships for Improving Health and Wellbeing
- Co-production and Health Literacy
- Digitally Enabled Health and Well-being
- Best Value Outcomes from High Quality Care
- Partnerships for Care
- Excellent Staff
- Digitally Enabled Care
- Outstanding Research, Innovation, Education and Learning

WELLBEING OBJECTIVES

- Connected communities with services and facilities across partners leading to demonstrable improvements in wellbeing and health
- Work with local communities, individuals and partners to build community resilience
- Give every child the best start in life

1. Long term
2. Prevention
3. Integration
4. Collaboration
5. Involvement

Applied across the Whole Life Course underpinned by sustainable development and the *Five Ways of Working*

1.2 Our Population's Health Needs and Wellbeing Assessments

POPULATION OF ABMU

386,000 APROX. POPULATION

MALE — FEMALE
Age range (0 to 90+)
20K   0   20K

Projected increase in population including +9% in Swansea (the third largest increase in Wales). The Welsh population structure is projected to change, with substantial rise in the older population and a projected fall in working-age adults.

LATER YEARS

DN: To be updated by Medical Illustrations

DEPRIVATION

>25%

ABMU has more deprived communities than average for Wales, with over a quarter of our communities falling into the most deprived categories. Urban parts of Swansea, NPT and upper valley communities are particularly deprived.

Upper Valleys

Swansea Bay

CANCER

40%

4 in 10 cancers are preventable

BURDEN OF DISEASE

The greatest causes of disease burden in Wales, as measured by the Disability Adjusted Life Year (DALY), are:

20% 1 in 4 people will have a **MENTAL HEALTH** problem at some time in their lives

19% Cancer

18% Cardiovascular Disease

??% Musculoskeletal Disorders

??% Substance Misuse

11% By 2030, 11% of people in ABMU will have a **DIABETES** diagnosis

CHILDREN AND YOUNG PEOPLE

>20% More than 1 in 5 children and young people aged under 20, live in poverty in Wales. Swansea West is one of the top 25 electorial wards with highest levels of child poverty in the UK.

LIFE EXPECTANCY CONTINUES TO RISE

82.3 YEARS **78.5** YEARS

...but the difference in life expectancy between the least and most deprived and most deprived areas is 9.7 years. Also, there is a >20 year (M) and 18 year (F) gap in *healthy life* expectancy

BEHAVIOURS AFFECTING HEALTH

19% 1 in 5 currently smoke (7% use e-cigarettes)

18% 1 in 5 currently drink over weekly guidelines

53% 1 in 2 active for 150 mins or more a week

23% 1 in 4 eat five or more portions of fruit or veg

60% 3 in 5 are overweight or obese

10% Followed 0 or 1 healthy behaviours

1.3 About the Health Board; Working across the Whole System

The Health Board has responsibility for assessing the health needs of our population in Swansea and Neath Port Talbot local authorities and then commissioning, planning and delivering healthcare for those people. We also have a joint responsibility for improving the health and wellbeing of our diverse communities and, with our partners in the Public Service Boards, we have undertaken wellbeing assessments, as well as care needs assessments for certain client groups with partners through the Western Bay Regional Partnership Board.

- **3** Major Hospitals
- **14,004** Members of Staff
- **XX** GP Practices
- **XX** Pharmacies
- **XX** Operations
- **XX** A&E Attendances
- **XX** Optometry Practices
- **XX** Dental Practices
- **XXXXXX** Outpatient Appointments
- **XXXXXX**

*Data as 2017/18 minus Bridgend

DN: To be updated by Medical Illustrations
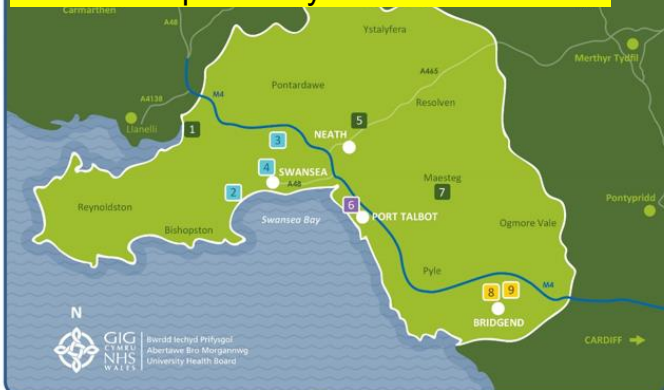
KEY:
1 Gorseinon
2 Singleton
3 Morriston
4 Cefn Coed
5 Tonna
6 Neath Port Talbot
7 Maesteg Community
8 Glanrhyd
9 Princess of Wales

Community Hospitals

Main hospitals by county

The Board's intent is to move to being a population health focused organisation, commissioning services to meet needs. Our two strategic aims **Supporting Better Health**; and **Delivering Better Care** and associated enabling objectives are clear in our ambition for change. We will become increasingly focused on working with partners to improve the wellbeing of our population. The Swansea and Neath Port Talbot **Public Service Boards'** Well Being Plans have clear and aligned priorities which we are actively engaged in. We have agreed our wellbeing objectives through the Organisational Strategy, and these are embedded in our plan:

- Connected communities with services and facilities across partners leading to demonstrable improvements in wellbeing and health
- Give every child the best start in life
- Work with local communities, individuals and partners to build community resilience

Joint Regional Planning and Delivery Committee

This Committee's focus is on addressing our common challenges, particularly the immediate operational and performance pressures. The priority areas include cardiology; orthopaedics; endoscopy; vascular and ophthalmology services.

The Health Board delivers a range of specialised services on a regional basis, including Burns and Plastic Surgery (South Wales and South-West England), Forensic Mental Health Services (South Wales) and Learning Disability Services (ABMUHB, Cwm Taf and Cardiff and Vale University Health Board areas), The Wales Fertility Institute and the Regional Neuro Rehabilitation Services (South West Area). We also host the South West Wales Cancer Centre, providing radiotherapy and oncology and other regional services such as specialised cardio-thoracic and pancreatic surgery.

- **Zone 1** – Primary, community, mental health, learning disability (also provided for Cwm Taf and Cardiff and Vale HB residents) and local DGH services
- **Zone 2** – Regional services for Mid and West Wales
- **Zone 3** – Plastic, bariatric and pancreatic surgery, cleft lip and palate
- **Zone 4** – Burns service catchment area

The Health Board is a key member of the **Western Bay Regional Partnership Board**, which has led the development of integrated services between health and social care in recent years. We have clear evidence of the impact of these services, for example:

Description of Scheme	Projected Outcomes and Outputs (Totals)	
Intermediate Care Services (underpinned by S33 agreement), Whole System Approach, Acute Clinical Response	Admissions avoided	2,919
	Number of bed days saved	29,190
	Cost of bed days saved	£3,669,600
Common Access Point	Number of people referred to Community Resource Team	7,424
Reablement – Discharge Facilitation	Discharges facilitated	957
	Number of bed days saved	2,817
	Cost avoided	£363,960

The relationships and integrated services we have developed have enabled us to be successful in securing RPB funding for a Transformation Fund Proposal; "Our Neighbourhood Approach". This is focused on enabling people and communities to become more self-supporting through a focus on maximising the assets we have through a place based approach. This, along with the **Cwmtawe Cluster**, which is a test case for how the national primary care model can be implemented sets out our expected future direction for focusing on wellbeing and prevention, with care, when required, planned and delivered as far as possible through a cluster based model of care.

Our joint working arrangements for these partnerships have been strengthened in 2018/19. The "Western Bay" arrangements have been reviewed to reflect the new planning arrangements without Bridgend, with a clearer set of strategic priorities to reflect A Healthier Wales, as well as simplified governance arrangements. Similarly, the Public Service Board priorities have been further refined and refocused to ensure we are delivering maximum value through these arrangements.

The key objectives and actions of these boards inform the planning and delivery of service in the Health Board and are set out in these plans:

- Western Bay Area Plan
- Swansea PSB Area Plan
- NPT PSB Area Plan

A priority area within the **Clinical Services Plan** is to further develop our regional plans and service pathways, particularly with Hywel Dda Health Board. Together with Swansea University, the two Health Boards continue to be committed to progressing the ARCH Programme to improve the health, wealth and wellbeing for the population of South West Wales. The programme has been refocussed during 2018/19, and with a larger programme management office is in a strong position to lead further change during the period of this plan. The detail of the ARCH programme is contained with the Portfolio Delivery Plan and the recent update on progress.

Hywel Dda UHB has recently approved its Clinical Services Plan "A Healthier Mid and West Wales", and together, we have ensured that both Clinical Services Plans (CSPs) support each other. There are mutual opportunities and challenges with both CSPs, the opportunity for more care to be delivered closer to people's homes in mid and west Wales through new pathways, workforce models and roles and technology; as well as challenges. We know that more people will need to be cared for in Morriston Hospital as the regional centre, particularly for acute medicine and complex surgery for people of high acuity. We know that any business case which Hywel Dda UHB develops will need to be accompanied by a jointly produced business case for additional capacity at Morriston.

Regional and Specialised Services Provider Planning Partnership with Cardiff and Vale UHB

Our two Health Boards have established this forum to progress improving service planning and delivery for those regional and specialised services for which we are the only providers in South Wales. We have established a set of principles which would determine which services should be considered on the basis of their sustainability; fragility; value and opportunity to bring care back to Wales. There is close engagement with WHSSC in this forum.

1.4 Achievements in 2018/19

Promoting and Enabling Healthier Communities

- ✓ Transformation Fund Bid approved for Neighbourhood Approach and primary Care Cluster Model in Cwmtawe and Neath Clusters
- ✓ Primary Care Pipeline funding agreed for Wellness Centres
- ✓ 'Making Every Contact Count' and Healthy Literacy approaches embedded across the Health Board
- ✓ Excellent progress in childhood vaccinations
- ✓ The best Health Board in Wales for staff flu vaccination Developing preventive approach to mental wellbeing, working with GP clusters, sports clubs and developing suicide prevention plans for NPT and Swansea with the PSBs
- ✓ Secured in-principle support from Health Board and Swansea Council to apply for re-designation as a WHO Healthy City for phase VII in 2019
- ✓ Maintaining our position as provider for the highest % of patients receiving dental care compared to all other Health Boards and significantly higher than the Welsh Average
- ✓ 111 service fully utilised across ABMUHB

Securing a Fully Engaged and Skilled Workforce

- ✓ We have recruited 140 qualified nurses and 43 HCSWs and reduced our turnover by 1.28%
- ✓ As a result our vacancy rate has decreased for the first time in two years to 7.5%
- ✓ 8 cohorts of PADR training have been delivered covering 148 managers since April 2018 and our PADR rate has increased to 65%
- ✓ Employee Relations strategy in development to support improved ER climate , including support from ACAS and review of complex cases
- ✓ Highest number of responses to staff survey to date and increase in engagement score
- ✓ Since April 2017 511 managers / supervisors have attended the award-winning Footprints behavioural leadership programme.
- ✓ Leadership development has been enhanced through the development of Bridges - a 4 day behavioural leadership programme targeted at senior managers

Delivering Excellent Patient Outcomes, Experience and Access

- ✓ More than 96% of patients who would highly recommend the Health Board to friends and family
- ✓ Continuing to reduce the number of falls with a 7% decrease on same period last year)
- ✓ Continuing to reduce incidence of pressure ulcers with a 13% reduction in HB-acquired pressure ulcers
- ✓ Development of integrated diabetes model: rolled out to 4 clusters covered population of 175,000. So far over 17,000 patients with, or at risk of, pre-diabetes now being screened.
- ✓ Consistently hitting or exceeding all requirements of sections 1, 3 and 4 of the Mental Health Measure
- ✓ Early intervention in psychosis service expanded
- ✓ Mental Health Crisis Teams expanded to 24 hours across Health Board
- ❑ **Unscheduled Care**
- ✓ 17% reduction in combined medicine length of stay over 18 month period
- ✓ Rate of readmissions continues to decrease and number of medical admissions has stabilised
- ✓ Improved frailty services across the Health Board, particularly at the Front Door
- ✓ Trialled new, evidence-based models through Winter Plan
- ✓ Bed Utilisation Survey and NHS Wales Delivery Unit audit of complex discharge undertaken
- ❑ **Stroke**
- ✓ Significant progress made in performance against stroke measures
- ✓ Following support from the NHS Wales Delivery unit, Task and Finish Groups established overseeing actions to address admission, flow and discharge.
- ❑ **Planned Care**
- ✓ Over 2,000 fewer patients waiting on our waiting lists than same period in 2017
- ✓ Number of patients waiting over 36 weeks lowest since June 2014 - achieved HB target at end Qu3
- ✓ Achieving targets for performance in outpatients, therapies and diagnostics
- ❑ **Cancer**
- ✓ Rapid Diagnostic Clinic concept achieved very positive evaluation and funded for 2019/20
- ✓ Significant improvements in our priority areas of urology and gynaecology pathways
- ✓ Roll out of 'live' pathway monitoring through the new Cancer Dashboard
- ❑ **Healthcare Acquired Infections**
- ✓ Significant progress against all three infection control target areas with improvement against our Annual Plan trajectories in all areas.

Demonstrating Value and Sustainability

- ✓ Successfully secured WG funding to embed and maximise use of Value-based Healthcare regional approach based on our ambition and expertise
- ✓ Key partner in the Pfizer Global Funded Partnership with Swansea University for value based healthcare
- ✓ Programme of Service Remodelling has delivered significant change and work continues to rebalance care into the community in acute, community and mental health service
- ✓ Reviewed range of digital opportunities to improve routine collection of PROMs.
- ✓ Rolled out our Patient Knows Best system to 100 patients and text reminder service has reduced DNAs
- ✓ Digital mobilisation enabled 33% more patients to be seen by DNs compared to last year
- ✓ 92% of referrals now prioritised electronically,
- ✓ Patient flow digital systems made measurable improvements in medical, pharmacy and administrative time
- ✓ Measurable quality improvements through e-pathology test requesting and digital dictation rollout

Embedding Effective Governance and Partnerships

- ✓ Renewed Board leadership with a stable Executive and Board
- ✓ Our Organisational Strategy has been approved by the Board
- ✓ Our Clinical Services Plan has been developed through strong clinical engagement for Board approval in January 2019
- ✓ Kings Fund Development Programme with the Board, Executive Directors and Service Directors progressing well
- ✓ Strategic partnership with Cardiff and Vale UHB established and working through a number of specialised services priorities
- ✓ Refocused ARCH programme delivering change
- ✓ South West Wales Joint Regional Planning and Delivery Committee maturing
- ✓ Developed approved Transformation Fund Bid proposals in partnership and review of Western Bay Partnership Board undertaken
- ✓ Strengthened leadership role regionally with the Health

1.5 Opportunities and Challenges in 2019/20-21/22

As previously set out, we will be a new organisation in April 2019. Having learned from the last two extremely challenging years, we are now able to plan to transform our organisation into one which will be sustainable into the future. There are still many improvements to be made, which we fully recognise, and we must continue to improve, to maintain confidence and to gain momentum to deliver the ambition set out in our Organisational Strategy. Based on our considerable achievements in 2018/19 we consider our opportunities and challenges to be as follows:

STRENGTHS	PRIORITIES
• A strong strategic direction for the Health Board with an agreed Organisational Strategy. • A Clinical Services Plan to underpin new service models, clinical sustainability and clinical engagement in transformation. • Renewed Leadership through a stable Executive Team and Board. • Demonstrable improvements in staff engagement evidenced through the Staff Survey, and our workforce indictors (e.g. vacancy rate) are improving • High quality clinical services in many areas, and quality indicators such as falls, pressure ulcers and HCAIs are improving. • Improvements in performance indicators and delivery of financial plan in last two years. • Excellent relationships with Hywel Dda University Health Board and strong regional and partnership working.	• Continuing to improve performance in key areas to deliver better access and quality of care for patients • Achieving financial balance.. • Redesigning and engaging our workforce so that we become sustainable, with significantly reduced reliance on temporary staff. • Strengthening our partnerships with local authorities, communities and individuals to plan and deliver more services in an integrated way on a Cluster basis, enabling improved health and wellbeing. • Implementing our Clinical Services Plan to improve access, quality, recruitment and retention. • Shifting the balance of care so more people receive care in their own homes to maintain their independence. • Securing an agreed IMTP during 2019/20 and achieving an improvement in our monitoring status.
OPPORTUNITIES	RISKS & THREATS
• Renewed leadership in a new organisational footprint will provide clear strategic direction and focus through our Transformation Programme. • Building on our mature partnership arrangements with local authorities through the Western Bay Regional Partnership Board to radically transform the out-of-hospital offer and performance. This includes approval for integrated Transformation Fund developments such as the Neighbourhood Approach, roll out of Cluster Model and Hospital2Home. • Maximising opportunities and efficiency across our healthcare system to become sustainable across all our services. • Engaging with local communities to understand what matters to them to make informed decisions about use of resources.	• Continued focus on short term pressures distracts from long term change and sustainability. • Impact of BREXIT. • Workforce shortages, particularly in nursing and some specialties make services highly fragile. • Ability to improve flow across the whole system may impede ability to transform services. • Resource commitment to managing the impact of the Bridgend transfer including extensive LTA/SLA monitoring and ongoing, medium term clinical and corporate disaggregation of services.

1.6 Clinical Services Plan

The Clinical Services Plan 2019-24, led by clinicians and developed with staff and stakeholders, is central to the ambition of our Organisational Strategy. It is an update of Changing for the Better (2013) our first clinical plan. It describes how we will transform wellness and primary and community services to underpin significant service change in our major hospitals; enabling them to dedicate their expertise to meeting the needs of those who most need their care, in particular the frail, elderly and acutely ill.

Principles

Our Clinical Services Plan principles align strongly to the Healthier Wales quadruple aim and were developed to guide us in agreeing the Clinical Services Plan ambitions to become the care system we aspire to be.

One System of Care	My Home First
Right Place, Right Time, Right Person	Better Together

Opportunities to Improve

Clinical Redesign Groups reviewed current and projected challenges and opportunities for unscheduled care, surgical and regional services. This showed that 'doing nothing' would continue to exacerbate the significant challenges faced over the next five to ten years in delivering outcomes that matter to people, high quality, safe and accessible services. Our analysis on patient access and quality of care identified a number of areas with opportunities to improve;

- Surgical pre and post-operative lengths of stay in hospital
- Patients being admitted with conditions that can be treated without an admission
- Provision of day case surgical services
- Pace of discharge from hospital
- Length of hospital stays
- Waits for out-patient and follow up appointments

Making these improvements is essential to the successful delivery of the Clinical Services Plan, however, they alone are insufficient to address the scale of the challenges we face. To ensure we have sustainable services able to deliver outcomes that matter to patients we need to make transformational change; particularly in primary and community services to enable more people to receive care close to home and deliver sustainable hospital services for surgical, frailty and acute care.

Our Clinical Service Plan Priorities

Role of Integrated Primary and Community Care

We will radically change our approach to population health through the adoption of an integrated approach to care which facilitates healthy lifestyles, preventative care, self-care and out of hospital care. Integrating primary and community based services, physical and mental health services, with our partners, and transitioning care out of hospital into the community where possible will strengthen our care system as a whole. Focussing our attention on developing community resilience and well-being and delivering outcomes that matter to people will improve the health of our population as a whole.

Role of Our Major Hospitals

Options for the reconfiguration of our major hospital roles, underpinned by our plan to radically change our approach to integrated, primary and community care, were shared with staff and stakeholders before our Clinical Senate Council recommended the preferred option below:

Role	Hospital
Unscheduled Acute Medical Care	Morriston
Surgery by Complexity	Morriston, Singleton, Neath Port Talbot
Frailty (post assessment)	Singleton and Neath Port Talbot

Clinical Services Ambitions

Our ambitions for clinical services reflect the strategic intent set out above and have been informed by the refresh of our strategic needs assessment, national strategic policy drivers, sustainability opportunities identified through our clinical engagement and the key messages from staff and stakeholder engagement from both Changing for the Better and this up-date process.

- Population Health
- Older People
- Maternity and Young People
- Cancer
- Planned Care
- Unscheduled Care
- Mental Health and Learning Disabilities

1.7 Our Operating Model and Transformation Programme

As we move into a new phase of development with a clear vision and strategic direction for the organisation established, the way in which we organise ourselves to ensure effective delivery is critical. In 2019/20, it is proposed that an overarching 'Transformation portfolio' is established to provide a clear home for all transformation work within the organisation and to move away from a number of disparate approaches. In this way, the Board will have a clear delivery mechanism that will oversee the delivery of both the Organisational Plan, Clinical Services Plan and other key priorities (such as embedding the new operating model). The overall portfolio is still being shaped but there are three key emerging themes:

- *Service & System Transformation* –focussed on priority programmes and projects that have emerged from the Clinical Services Plan. The individual Programmes will provide a means of ensuring that all system and service transformation efforts are aligned, allowing the Board to clearly plan and identify service change in a systematic way that maps interdependencies between service areas. It will focus on helping us to become a 'population health' organisation as well as planning a complex set of service changes to reshape our current models of hospital services. Embedded within these programmes will be a focus on high value opportunities – helping the organisation become more efficient in the way in which we deliver services.

- **Efficient and Effective Delivery** –dedicated programmes that focus on supporting the organisation to deliver efficient and effective care, maximising resource use and embedding digital solutions as part of this. There will be projects that focus on digital solutions as well as a focus on creating value, and minimising clinical variation. These programmes will encompass the exciting work that we have started with Hywel Dda University Health Board, Welsh Government and Swansea University to take forward Value Based Health Care, focussing on the delivery of care that maximises outcomes for patients.

- **Fit for the Future** - this theme focusses on the work that we need to do to become an effective and well governed organisation that operates effectively in the way in which we conducts business and makes decisions. This work will include developing appropriate performance management arrangements, streamlining decision making and Organisational Development.

Each programme is being scoped and the specific year one priorities ("products") are being collated. The Programmes will have both clinical and managerial leadership and lead roles are under consideration. A central Programme Management Office (PMO) will coordinate and oversee the portfolio and a number of programmes (for example older people, mental health, learning disabilities) will be joint programmes of work to be taken forward with partners and governed appropriately.

There are a number of critical enablers (such as our Digital Plan) and these will be integrated into the Programme arrangement to ensure alignment and effective oversight. The Programme arrangements will continue to evolve during the final quarter with a launch during March 2019.
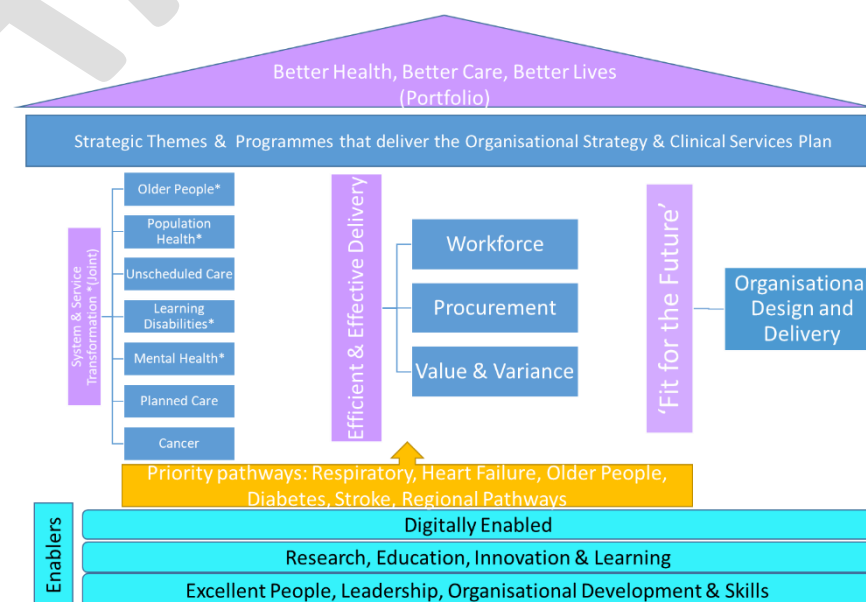
2. Achieving our Ambition:
Strategic Aim - Support better health and wellbeing by actively, promoting and empowering people to live well in resilient communities

2.1 Strategic Objective: Partnerships for Improving Health and Well-being

In 2018/19, we undertook a rapid review of our population health needs to provide a baseline for the development of our Clinical Services Plan. This was also used, along with our Wellbeing objectives and other information to develop a set of Commissioning Intentions to guide our planning. These are included in Appendix 1. The rapid review built on the regional Population Needs Assessment and the two Wellbeing Assessments undertaken by the Public Services Boards. As shown in the summary in Section 1.1, significant changes are required in the medium term to improve population health in Swansea and Neath Port Talbot and deliver improved, integrated services for our population in line with the goals of 'A Healthier Wales'.

During 2018/19, with partners, the Health Board has increasingly shifted from an individual level behavioural approach with a focus on a small number of lifestyle behaviours, to a more integrated, socio-ecological approach to population health. This has led to a number of new and innovative approaches, collaborations and successes during the year.
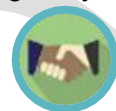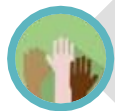
Prevention   Integration   Involvement   Collaboration   Long Term

This approach aligns with the Wellbeing of Future Generations (Wales) Act and Social Services Wellbeing Act and the establishment of local Public Services Boards (PSBs). The PSBs' respective Wellbeing Plans are being implemented to address the priorities and issues in each locality. There is considerable synergy between the different wellbeing plan priorities across the two local authority areas and we will continue to work closely using a place based approach to addressing health inequalities. Many of the actions within our plan are reflective of the importance of integration and taking a

long term, preventative approach to the commissioning and provision of health care locally, aligned to the five ways of working.

The Western Bay Regional Partnership Board is a well-established and mature primary delivery mechanism for integrated services which are founded in the Wellbeing of Future Generations (Wales) Act and Social Services Wellbeing Act. In 2018/19 a review of the Board's structures and priorities has been undertaken which are strongly aligned to our Annual Plan priorities, and are referenced throughout the document.

Key to this work is a shift to an asset-based community development approach to whole system thinking and working. The benefits for the health of community and individuals are highlighted in the following diagram:
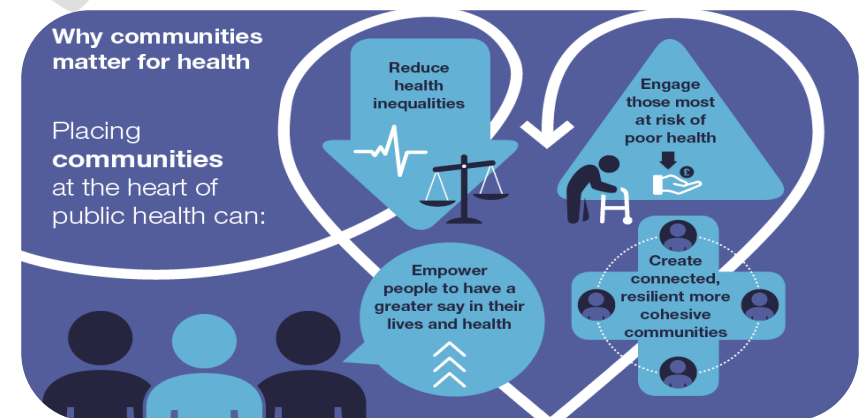
Source: PHE 2018

We will achieve a system change by implementing whole system values:

- Co-ordinating health and social care services seamlessly, wrapped around the needs and preferences of the individual, so that it makes no difference who is providing individual services
- Measuring the health and wellbeing outcomes which matter to people, and using that information to support improvement and better collaborative decision making
- Proactively supporting people throughout the whole of their lives, making an extra effort to reach those most in need to help reduce the health and wellbeing inequalities that exist
- Driving transformative change through strong leadership and clear decision making, adopting good practice and new models and developing open and confident engagement with external partners
- Promoting the distinctive values and culture of the Welsh whole system approach with pride, making the case for how different choices are delivering more equitable outcomes and making Wales a better place in which to live and work.

Underpinning all of this is the need to take action on improving and maintaining people's mental health and wellbeing. Our population health needs assessment confirmed that this is a significant issue across our area. Through Western Bay we recently agreed a strategic framework for adult mental health services which is based on supporting people with lower levels of need to prevent escalation. Our Neighbourhood Model of community resilience and our rollout of the Primary Care Model for Wales through all our Primary Care Clusters will also include a focus on promoting mental health and wellbeing.

The following diagram illustrates the relationship between these different facets and how illness is the end point of an accumulation of unfavourable factors and influences that drive behaviours which result in ill health. It also clearly illustrates the need to address mental wellbeing as part of any intervention and that this, in turn, is driven by our wider life context. The evidence base points to the need to intervene early in a person's life to be most cost effective, making pregnancy and the early years of a person's life a crucial time for intervening from a prevention perspective.

Taking on board these different drivers of action and learning from the last year's work programme, our plans for 2019/20-22 are focused on the following:
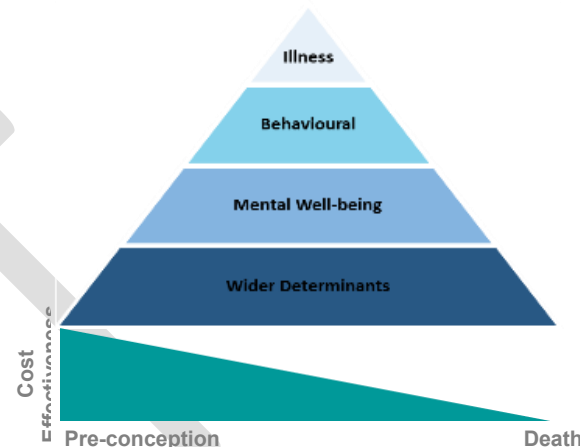
[Source: Public Health Wales IMTP 2019-22]

Addressing Behavioural and Clinical Risk Factors as Part of Reducing the Burden of Disease

Mental Health and Wellbeing

Through our Western Bay Regional Partnership Board Neighbourhood Approach (section 3.2), our plan is to develop an integrated (mental) wellbeing service with one front door into a range of opportunities within neighbourhoods which focus on building community resilience and social connectedness to address low level mental health issues and wider wellbeing including loneliness. Putting prevention and self-management at the heart of what we do will improve people's mental health and wellbeing. This plan includes mapping what we already have, and understanding and creating connections to enhance networks and working from an asset-based perspective.

Suicide and Self-harm Prevention

We are continuing to contribute to meeting the aims and objectives of the Welsh Government's Talk to Me 2 national suicide prevention strategy. This will continue to be of particular importance for the Neath Port Talbot area which has the highest suicide rate in Wales. Among males and females there is an association between suicide and area of residence-based deprivation, with rates being higher in our more deprived communities.

Last year's mid-point review of Talk to Me 2 found that excellent progress had been made in the development of local action plans for suicide prevention, good progress had been made in improving awareness and some progress has been made in responding to crisis, the management of self-harm and supporting those bereaved by suicide. The review reinforced that "no single organisation in isolation can prevent suicide and self-harm. National strategies allow for the co-ordination of action but there must be shared responsibility at all levels of the community, if it is to have a chance of success."

Locally, we have been active in the regional suicide prevention group with colleagues from Hywel Dda University Health Board and the local authorities as well as other public and third sector organisations. In 2019/20, we will develop and embed an action plan with stakeholders which is owned by all agencies for Swansea and Neath Port Talbot to reduce suicide and self-harm, working collaboratively and co-designing solutions to take it forward.

Substance and Alcohol Misuse

In addition to being a cause for concern due to the high rate of suicide, the Neath Port Talbot area has the second highest rate of drug-related deaths in the UK, and Swansea is the fourth highest. We will continue our work with partners to take a holistic approach to tackling these issues and our plans to address them through public health approaches are described in section 2.2.

Behavioural Science

We will develop tools and frameworks that enable routine application of evidence based behavioural science to address key challenges locally and nationally. We will take this forward using new capacity and capability within the Public Health team and developing a network of behaviour change agents and champions across all sectors of the Health Board and partner organisations.

Joint Work Programme with Public Health Wales

Through working jointly with Public Heath Wales we will take action to deliver the collective long term outcomes of:

- Reduced premature mortality (under 75) for the people of Wales, locally and nationally
- Increased average length of life that people in Wales spend without disability or disease/ in good health, locally and nationally

- Reduced inequalities in the length of life that people in Wales spend without disability or disease/ in good health, locally and nationally.

The focus has been agreed as being on the following clinical risk factors:

Obesity   Cholesterol   Hypertension   Fasting plasma glucose

More detail on our primary prevention actions to improve these clinical risk factors is included in section 2.2.

Releasing the potential for Resilient Communities (Wellbeing Objective)
The Western Bay Neighbourhood Approach: The Health Board supports the ambition of 'A Healthier Wales' through our strong, mature Western Bay partnership arrangements. The Western Bay Regional Partnership Board submitted a successful Transformation Fund bid to develop Our Neighbourhood Approach to community resilience in 2019/20. This will be supported by a strong public health improvement programme of work:

- Identifying and making visible communities' health-enhancing assets
- Seeing citizens and communities as the co-producers of health and wellbeing, rather than recipients of services
- Promoting community networks, relationships and friendships that can provide caring, mutual help and empowerment
- Identifying what has the potential to improve health and wellbeing
- Supporting individuals' health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge; and personal resources
- Empowering communities to control their futures and create tangible resources such as services, funds and buildings.

We envisage that the successful implementation of Our Neighbourhood Approach could reduce the cost of admissions to hospital, primary care and resident placements, which could be used to offset the roll-out of the model across the region. This will be subject to evaluation in 2020/21 but results may take longer to be evidenced.

We also envisage that once staff have moved to the new model for delivering the place based approach that this will be mainstreamed though realigned services. Additional staff appointed during the transition will be employed on a fixed term basis to support the development and implementation of the new

model. However detailed planning for the model is underway and the workforce models will be agreed in early 2019/20.

Embedding an Asset Based Community Development Approach (Wellbeing Objective)

Our aim is to embed an ABCD approach that empowers people and neighbourhoods to co-design services to meet their needs better and to focus on developing assets within communities. We will empower our staff to reduce the paternalistic relationship and empower communities to own the assets that will help them help themselves. This will facilitate people to provide support to members of their own community based on what matters to them, taking control of their own health and wellbeing.

Housing and Health

Housing is a setting which offers significant opportunities to intervene and support individuals, families and communities. Population health improvement priorities that can be progressed through housing include:

- Environmental (mould, damp, cold, indoor toxins, infestations, risk factors for falls)
- Socio-economic (energy efficiency, fuel poverty, overcrowding, smoking, loneliness)
- Planning (noise, lack of green space, long term conditions).

We will work with partners to future proof housing as people get older so that accommodation can be fit for purpose or flexible to meet their needs. Flexible housing meet different levels of care needs, and it is important to build flexible housing from the start that can adapt over the life course. Key target at risk groups are children, older people, those with existing Long Term Conditions and the unemployed. Our actions will include housing assessment/mapping to understand local housing stock and issues across the area; identification of key actions drawing on the national policy context; sharing of best practice; development of a work programme to address areas of common concern with key partners; joint working to prevent homelessness, falls, loneliness and isolation across the area; and, supporting project evaluation to demonstrate health and wellbeing benefits.

Health in All Policies Frameworks

We will work with partners to represent health in all policies to create healthier environments through planning and supporting the development of enhanced green and blue spaces using enhanced Green Infrastructure mapping undertaken. We will work with partners and communities on improvements in key areas, with a focus on areas of deprivation. In 2018/19, we appointed "Vital Energi" to undertake investment grade proposals for energy conservation schemes, and will use this assessment to develop plans.

Employment and Work and Wellbeing

The Health Board will support the Public Service Boards' collective priority to improve workplace wellbeing by delivering measurable improvements in sickness absence, staff health and wellbeing, employee engagement and productivity (see section 3.X). By doing this the organisation will contribute to the longer term agenda of a thriving local economy that supports good employment for all and is particularly important given our status as a major employer in the area. The Health Board already has the best rate of staff flu vaccination in Wales and we will continue to aim to be the best in 2019/20.

Giving Every Child the Best Start in Life (Wellbeing Objective)

Giving every child the best start in life is essential to reducing health inequalities across the life course and this is a high priority for the Health Board. and there are benefits to be gained from action taken at all ages and stages, the Health Board's focus on the early years, children and young people recognises the importance of getting this right in the first instance. Details of the plans for Maternity services and services for Children and Young People can be found in sections X and X.

Summary Plan - Partnerships for Improving Health and Well-being

Actions	Milestones 2019/20		Measures	Lead
Take asset based approach to build community resilience and social connectedness.	Q1	Map current assets	PHF_14	DPH
Agree multi-sectorial **Suicide and Self Harm Prevention** action plans	Q1	Develop of Action Plan	PHF_43 PHF_3a PH_3b	DPH
	Q2	Establish Multi-agency group		
	Q3	RPB approval of Action Plan		

	Q4	Implement Action Plan	HW_DP2	
Implement the **Neighbourhood Approach** Project Plan (see Bid for more detail)	Q1	Project Office in place	PHF_35a PHF_35b HW_DP1	DoS
	Q2	Outcome Measures Agreed		
	Q3	Implementation		
	Q4	Evaluation for potential roll-out		
Work with partners, targeting at risk groups to improve **Health and Housing** including environmental factors, flexible housing, homelessness and future proofing.	Q1	Assessment of housing stock/issues	PHF_17	DPH
	Q2	Identify key actions		
	Q3	Develop work programme		
	Q4	Implement work programme		
Develop **Health in All Policies Framework** with partners developing enhanced green and blue spaces using Green Infrastructure mapping.	Q1	Review assessment	PHF_18	DPH
	Q2	Develop Proposals		
	Q3	Develop Implementation Plan		
	Q4	Implement Plan		
Substance and Alcohol Misuse		(see Co-production and Health Literacy Section)		DPH
Implement the **Workplace / Staff Wellbeing Work Programme**		(see Workforce Plan)		WOD

Enablers

Workforce	Finance
Backfill and training as described in project plan for: • Social Workers • Community Services • Mental Health Workers • Substance Misuse Workers Appointment of programme office by April 2019. The approach will require an expansion to the Multidisciplinary team and additional investment in Physiotherapy, Advanced Nurse Practitioners, and practice based Pharmacists, Clinical Resource, Paramedics and Audiology. In addition, a community Phlebotomy service will be established in addition to the enhancement of other services such as Health Visiting, Speech and Language therapy and Mental Health. Detailed workforce plans to be developed following appointment of programme by Quarter 2 2019/20.	• Successful Transformation Fund bid approved - £5.920m.
Capital	**Digital**
• Transformation Fund Bid includes funding for facilities for the programme office	See Section 2 – Digitally Enabled Health and Wellbeing
Bridgend Transfer Implications	
A shadow infrastructure for the Local Public Health Teams is in development which includes draft handover plans. Cwm Taf UHB LPHT have given assurance that there will be on-going support and advice for a transitional period of time post March 2019.	

2.2 Strategic Objective: Co-Production and Health Literacy

Co-production

Co-production continues to become embedded in the design and delivery of services, for example our Strategic Framework for Adult Mental Health was produced following extensive engagement with service users and carers using a 'So Tell Us What You Think' methodology, and the report was provided to the Board as part of the decision to approve the Framework in November 2018. However, co-production is not yet systematised through all of our planning and delivery and this will be addressed through our Transformation Programme as we plan to deliver our Organisational Strategy and Clinical Services Plan to become a sustainable organisation.

Co-production for individual patients and patient groups will be entrenched through people designing services as a collective, using digital technology wherever possible. More detail on this is included in section 2.3. In 2018/19, we agreed a new approach to joint working between the Local Public Health Team (LPHT) and staff the Primary Care and Community Service Delivery Unit. Fundamental to this new way of working is the importance of co-production and co-design with the population. This is drawing on successful approaches seen in the WHO Healthy Cities network, Frome, North Karelia (CVD prevention success story) and Wigan Council.

Promoting Healthy Behaviours and Reducing Risk Factors

We will undertake a range of primary prevention activities in 2019/20:

Smoking Cessation

21% of our population smoke (with 8% using e-cigarettes) and we aim to improve on this by March 2022 with the aim that 3.5% of all smokers make a quit attempt in 2019/20. In 2019/20 we will continue to focus on improving per-natal health through further work undertaken to reduce maternal smoking by improving quit rates in pregnant women; and increasing smoking cessation rates in people with mental health problems. The Health Board will continue to promote the de-normalisation of smoking and smoke-free environments particularly in hospital grounds.

Childhood Immunisations and Screening

We made good progress in 2018/19 to improve the rates of childhood immunisations in our area. Over the next three years we aim to continually improve the uptake of childhood immunisations and screening from key target groups such as those in areas of deprivation which historically have a poorer uptake as part of our work to address health inequalities. We will do this through local teams analysing and addressing the patterns of uptake of screening and immunisation appointments. We will also improve the screening programmes we deliver for new born and infant physical examination, school age vision and hearing screening; and have programmes in place to quality assure these programmes. Our actions for childhood screening are included in our Maternity and Children and Young people's Plans in section [insert].

Flu Vaccination

We will continue our work between the LPHT and primary care teams to improve flu vaccination rates for our at risk populations. This is particularly important as part of our Respiratory Delivery Plan and Unscheduled Care Plan due to our high rates of respiratory disease. We are proud of our record of being the best Health Board in Wales with regard to staff flu vaccination and we will continue to improve our practice and to aim to be the top Health Board in Wales.

Physical Activity

In 2019/20 we will continue to implement our jointly agreed Physical Activity Strategy through the four sub-groups of the Physical Activity Alliance which will progress age relevant actions to increase physical activity across our area. As part of our Respiratory Disease Delivery Plan we will continue to address the issues caused by our high rate of respiratory disease by providing primary and community based Pulmonary Rehabilitation (PR) courses in all of the Primary Care Clusters across the Health Board. This includes exercise and other advice tailored specifically to those with chronic respiratory disease to promote activity and improve quality of life.

We have developed a unique collaboration with National Exercise Referral Scheme (NERS) to deliver the exercise component in order to provide consistency and continuity and achieve our aim to improve the long term benefits of the PR course.

Healthy Eating

Welsh Government will be publishing a new Obesity Pathway in the summer of 2019. It will require the Health Board to report on metrics and outcomes

which will enable us to benchmark our status with in Wales and as a result we will develop local strategies to improve outcomes.

Alcohol and Substance Misuse

We will continue to support our Liver Disease Delivery Plan by providing brief Intervention training for alcohol misuse has been developed and provided and in 2019/20 this will be rolled out to primary care settings. With the introduction of the Minimum Pricing for Alcohol Act in summer 2019 there will be awareness raising and promoting of safer consumption of alcohol across the Health Board area. In 2019/20, work will continue to focus on reducing Drug Related Deaths in our area by focusing on reducing delays to Opiate Substitute Therapy. We will also undertake an Areal Planning Board service review to improve the quantity and quality of interactions with local agencies and plans are in place to improve needle exchange provision.

Reducing Health Inequalities

Wellness Centres

We will be developing integrated Wellness Centres in Swansea and Neath Port Talbot with the Swansea City Centre Wellness Centre the first to be planned, in line with Welsh Government Primary Care Pipeline funding. A Strategic Outline Case is in development for consideration by the Health Board and Welsh Government in 2019. This is an area of high deprivation, with health needs related to inner city areas and vulnerable groups such as poverty, substance and alcohol misuse and sexual health issues. In 2019/20 In 2019/20 we will appoint a project manager, update the project plans and submit the Strategic Outline Case. For Neath Port Talbot we will explore securing Primary Care Pipeline to support Neath Wellness Centre and/or scope the feasibility of redeveloping the Port Talbot Resource Centre. In future years we will scope the feasibility of second Wellness Centre in Morriston, Swansea and consider submitting for capital Pipeline funding.

Making Every Contact Count (MECC)

In 2019/20 we will develop a full programme of MECC training, building on existing national MECC resources, which embeds health literacy approaches into the programme. MECC to be re-purposed to become a core competency for healthy conversations which lead to behaviour change. This will sit alongside lifestyle behaviours and other key messages, identified by and developed with communities and partners.

Ageing Well

Our public health approaches to ageing well include outcomes through eating healthily, increasing physical activity; reducing drug and alcohol consumption and mental health improvements as well as the work on flu vaccination and respiratory disease that has already been described.

Over the next three years we will deliver a joint work programme with Public Health Wales and Health Board to deliver collective outcomes of:

- Reduced premature mortality (under 75) for the people of Wales
- Increased average length of life that people in Wales spend without disability or disease/ in good health, locally and nationally
- Reduced inequalities in the length of life that people in Wales spend without disability or disease/ in good health, locally and nationally.

Transformation Opportunities

Integrated Wellness Centres

Wellness services are those services that promote health and well-being rather than diagnose and treat illness. They provide support to help people to live healthy lives in managing their physical, mental and social wellness. The establishment of integrated wellness centres facilitates delivery of a new and more collaborative model of primary care, founded upon a multi-sector and multi-disciplinary approach to integrated service delivery. The initial wellness centre is proposed for Swansea City Centre with further rollout to NPT following evaluation of the success in supporting the vulnerable groups. The strategic aim is to develop a Wellness Centre that can:

- Support improvement of health and well-being and reduction of health inequalities;
- Promote self-care and a preventative approach to improving population health, providing a range of well- being services;
- Address the sustainability of primary and community services by providing modern fit for purpose facilities to address the inverse care law.;
- Provide capacity for increased population growth in Swansea and support cluster based working in the city health cluster
- Maximise the opportunities presented through the digital health agenda; Support multi agency and multi-disciplinary working between and across public sector agencies and boundaries.
- Contribute to the strategic aims set out in the Swansea City Area Regeneration Framework to increase those living, working and visiting the City Centre and support the World Health Organisation (WHO) Healthy City designation of Swansea.

Summary Plan - Co-Production and Health Literacy

Actions		Milestones 2019/20		Measures	Lead
Continue to promote **smoking cessation** particularly among pregnant women and improving the 4 week CO2 monitored quit rates	Q1	Realign local smoking cessation services		NDF_6&7 PHF_20, 25 &28	DPH
Improve uptake of **childhood immunisations**, particularly for those in areas of high deprivation	Q4	Minimum 90% uptake childhoods imms, MMR vaccination in teenage population, HPV / Teenage booster. Improve uptake of Men ACWY in primary care		NDF_2 NDF_3 PHF_30	DPH
Improve **Flu Vaccination** uptake rates for Children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan	Q1	Evaluation of previous campaign		NDF_5 HW_DP1	DPH
	Q2	Develop Plan			
	Q3	Commence campaign			
Improve **healthy Eating** through pre-referral advice for Under 3's into flying start, Nutrition Skills for Life, pre-diabetes scheme and the Obesity pathway.	Q1	Expand the Nutrition Skills for Life programme.		NDF_4 PHF_33 PHF_38a PHF_38b	DPH
	Q2	Establish Nutrition and Dietetic service in Workplace Health Programmes			
	Q4	Increase dietetic capacity for Level 3 Obesity Service			
	Q4	Establish Foodwise programme within clusters			
Improve levels of **Physical Activity through** Exercise and Lifestyle Programme and Pulmonary Rehabilitation (PR) courses.	Q1	Review Exercise and Lifestyle programme pilot		PHF_19 PHF_24 HW_DP1	DPH
	Q2	Implement Roll-out if Pilot successful			
	Q4	Evaluate Rollout			
Alcohol Misuse and Substance Misuse	Q1	Area Planning Board Service Review		NDF_8 PHF_2, 26 &86	DPH
	Q2	Awareness campaign – Minimum Pricing Act			
	Q3	Roll out Brief intervention Training to Primary Care			
Develop **Integrated Wellness Centres** in Swansea and Neath Port Talbot areas	Q1	Finalise Strategic Outline Case		PHF3a,3b,4,5,6 a&b, 35a&b, HW_DP6	DPH
	Q2	Submit Strategic Outline case to Welsh Government			
Roll out comprehensive training programme for health and non-professionals based on **Health Literacy and MECC**	Q3	Develop a full programme of MECC training		PHF_19-26 PHF_35a-38b HW_DP4	DPH
	Q4	Roll out MECC Training Programme			
Peri-Natal Mental Health		(See maternity Plan in section X)			COO

Workforce	Finance
Aim to remain the best in Wales at vaccinating our staff against flu Training and support to roll out MECC - by 2022 10% of Health Board staff trained to. In addition, 300 community champions recruited.	None
Capital	**Digital**
Wellness Centres included in Primary Care Plan section.	See Section 2.3
Bridgend Transfer Implications	
See Section 2.1	

2.3 Strategic Objective: Digitally Enabled Health and Wellbeing

The Health Board Digital Plan, Destination Digital, was published in 2017/18. During 2018/19 there has been growing support within the organisation to move towards the vision outlined in the Plan;

> "Health, care and wellbeing activities carried out by everyone in our health economy will, with pace and scalability, be enabled using digital technology wherever optimal".

This plan is aligned with the Digital Health and Social Care Strategy for Wales, 'Informed Health & Care'. In 2019/20 we will continue to ensure there is a fundamental shift in organisational culture to move towards the realisation that our business is ICT-enabled healthcare.

Digital Inclusion
In 2018/19, the Health Board agreed to sign up to the Digital Communities Wales Digital Inclusion Charter. It recognises that digital literacy and access to digital solutions for our staff and patients is essential for service transformation and getting best value out of digital investment. Improving digital literacy has been shown to have a significant impact on improving health outcomes for patients by helping them to take control of their health and care. We are therefore committed to the principles of the charter and will ensure that the digital inclusion principles are embedded into our day to day activities.

Digital Partnerships
Our Partnerships with the Local Authorities under the Western Bay Programme are vital in our plans to support Integrated Care via digital transformation. particularly as we work together to roll out the Welsh CCIS programme to maximise benefit in terms of information sharing, integrated record keeping and mobilisation . The Health Board already has a strong record of digitally mobilising our community staff which has had quantifiable direct benefits in terms of releasing frontline staff to see more patients and help us achieve our aim of providing 'Care Closer to Home'.

We have also formed strong partnerships under ARCH umbrella with Hywel Dda UHB and Swansea University. Work with our ARCH partners will continue throughout 2019-22 to ensure the opportunities presented through greater collaboration and the Swansea Bay City Deal are realised to further the Digital Agenda to the benefit of the health of our citizens.
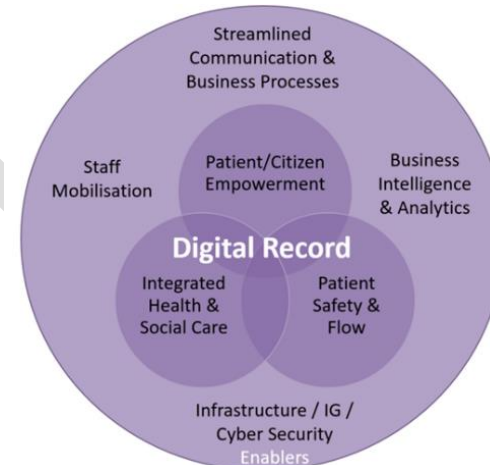
Supporting Place Based Work
As a Health Board we endeavour to use digital opportunities wherever possible and taking the opportunity to reduce digital exclusion as part of our work with communities. This work is closely aligned to our community assets development approach and can be seen through the Cwmtawe cluster development where they will adopt the Digital Inclusion Charter to develop Digital Champions for the area from within key organisations and community groups to ensure people can make the most of information available to them digitally, and to develop digital solutions to provide required support.

In addition, the cluster, in discussion with the Local Authority, has been involved in the development of a Clydach Community Hub, from which it is intended that local people will be able to access all Swansea Council services. The Hub was launched in November 2018 and will be a "digital gateway" for service users with low-level digital skills. There is also the possibility to access other partner organisations' services too, either digitally, or via volunteers. One aim of this is to improve community resilience and combat feelings of isolation within the community.

The Health Board wants to ensure that our coproduction and engagement is cemented with digital technologies. This will be fostered through co-design

of interactive engagement and feedback mechanisms for cluster population with a focus on digital.

Workforce Mobilisation
Mobilising the workforce with digital technology will facilitate the changing of clinical pathways allowing our staff to provide care closer to patients' homes and in a way that suits them. Aligning this to the theme of patient empowerment will mean that our workforce will be able to respond more flexibly to the needs of the patients and provide support through different mediums to the traditional face to face contact where appropriate.

A large focus of our work in this area has been the mobilisation of our community workforce which, until this project started, has been neglected in terms of digital in previous years. Our ambition is to mobilise our entire community staff base through the adoption of digital ways of working using tablet devices with approximately 2,400 staff mobilised by the end of 2018/19.

Patient/Citizen Empowerment
In 2019/20 we will continue to implement Patients Know Best (PKB) as a pilot solution working closely with services and teams to offer all patients a platform which they can receive their laboratory results, appointments, documents and letters directly from the national architecture and the ability to communicate and share their information with their clinical teams and

carers accordingly, empowering them to manage their health and well-being in a more effective way. We will also be continuing to work with the four key clinical services in the Swansea area on the implementation of the national architecture into the solution and exploring ways to embed the effectiveness of PKB within their services. A key part of 2019/20 will also include working with an external agency to evaluate the pilot which will require working alongside patients and staff. The results of this evaluation will determine how we proceed in 2020 and beyond.

Welsh Community Care Information System (WCCIS)
In 2019/20, we will continue to work with local, regional and national stakeholders in the readiness and planning of the nationally procured solution which aims to transform the way health and social care will work in the future. This platform will be based on the one nationally agreed identifier for the citizen, the NHS Number, and enable staff from both health and social Care to share key information relevant to their caseloads which aims to provide huge benefits for the outcomes of the citizen and teams involved. We will also be working with the preferred supplier, CareWorks, our stakeholders within ABMU and the regional teams within Western Bay, as well as the National team on developing and agreeing on our Deployment Order. The aim is to start implementation, dependant on funding availability, by the end of 2019/20.

Summary Plan – Digitally Enabled Health and Wellbeing

Actions	Milestones 2019/20		Measures	Lead
Develop a new **Digital Strategic Outline Plan** to support the first phase of the road map for the delivery of the digital plan in the new Health Board.	Q1	Draft Plan developed	HW_DP8	CIO
	Q2	Draft plan completed		
	Q3	SOP approved by HB		
	Q4	Implement SOP		
Support Integrated Care via **Digital Partnerships** and transformation, working together with Local Authorities to roll out WCCIS to maximise benefit in terms of information sharing, integrated record keeping and mobilisation.	Q1	Finalise deployment order	HW_DP6	CIO
	Q2	Deployment order complete		
	Q3	Commence 12 month readiness programme		
	Q4	Implement and monitor readiness programme		
Workforce Mobilisation: Mobilising the workforce with digital technology through the national Mobilisation Policy.	Q1	Evaluation report of Community Mobilisation project	HW_DP10	CIO
	Q3	Use National Mobilisation Policy to support roll out pilots of mobile systems such as Nursing Documentation and e-Prescribing.		

	Q1	Establish patients forums		
Patient/Citizen Empowerment through implementing Patients Know Best (PKB).	Q2	Evaluation of pilot phase	NDF_42 NDF_44	CIO
	Q3	Develop Business Case for further roll-out		
	Q4	Complete Business Case		

Enablers

Workforce	Finance
• ABMU are developing partnerships with the local colleges and universities to encourage the adoption of apprenticeships and vocational qualifications to develop the skills of existing staff and attract new staff with new skills. This will include the degree apprenticeships. • During the course of the IMTP the Informatics department will review its structure to ensure it meets the needs of our Digital ambition.	• The provision of a digital service to better support 24/7 clinical services will require a change in our service model that will require investment

Capital	Digital
• Delivery of the digital ambition of the HB over the next 3 years will require significant capital investment in the delivery of new digital solutions. It is estimated that his investment will be approximately £25.8m over the 3 years if the IMTP.	The programme of work to empower patients to manage their own health and wellbeing through the use of digital tools will rely on individual's ability to access and capability to use the tools we provide. ABMU is the first Health Board to sign up to the Digital Inclusion Charter and will invest and work with our partners in supporting our citizens and our staff to ensure they are able to use the digital services we provide.

Bridgend Transfer Implications
• Bridgend boundary change will have a significant impact on the delivery of informatics services and will be a risk to the delivery plans.

3. Achieving our Ambition:
Strategic Aim - Deliver better care through excellent health and care services achieving the outcomes that matter most to people.

3.1 Strategic Objective: Best Value Outcomes from High Quality Care

Achieving best value outcomes from high quality care is core to both delivering the best for our patients and population in terms of outcomes and experience and to developing sustainable services It is vital that our services work as a whole system to deliver seamless pathways of care wherever care is delivered; at home, in the community or in hospitals.

This section is includes our plans to improve and transform our core areas of delivery. Detailed Driver Diagrams and Performance Trajectories are included for our Targeted Intervention Priority Areas in Appendix. X Our Medium Term Financial Plan and capital and estates plans are included in Section X. All of our service plans are based on achieving the Clinical Services Plan efficiency assumptions and on using Value-based Healthcare and prudent approaches to transform services and achieve our enabling objectives.

3.1.1 Quality and Safety including Health Care Acquired Infections

Quality and Safety Priorities

Our extant Quality Plan expired in March 2018 and was extended for the coming year whilst a new plan is being developed and consulted upon. The new Plan is under development and will reflect our organisational values and be founded on the principles of Prudent and Value-Based Healthcare. There is a strong focus on Quality Improvement, engaging on every level with all our staff and services. The quality and safety plan is intended to l run concurrently with our new organisational and Clinical Services Plan. We have revised our board assurance framework and Quality Assurance features within the governance requirements of our organisation. We are continuing to further embed our culture of transparency and continuous improvement. Building further d on the Health Board's commitment to meet the current quality standards, measured within the health and care standards framework. Collaboration, co-production and benchmarking will form the basis of an integrated Health Board approach, working towards seamless quality outcomes. Using staff and patient experience as indicators to ensure good quality outcomes for our patients.

Older People
Reducing Length of Stay in Hospital

Ensuring safe and effective discharge for our patients remains a key quality priority. We continue to promote the benefits of multidisciplinary board rounds as a strong evidence base for safe and efficient discharge planning. SAFER consists of five elements of best practice:

S – Senior review of all patients before midday, informed by a multi-disciplinary assessment.
A – All patients, and their families involved in the setting of an Expected Discharge Date.
F – Flow of patients at the earliest opportunity from assessment units to inpatient wards.
E – Early discharge, with at least a third of patients discharged from inpatient wards by midday on their day of discharge.
R – Review involving multi-disciplinary team, patients and their families for those with extended lengths of stay.

Frailty Pathway - Comprehensive Geriatric Assessment

Given the population profile of our patient's older people who are admitted to hospital as emergencies and the way we care for them will continue to be an ongoing area for improvement. . Evidence suggests that elderly people that are admitted to hospital and receive a Comprehensive Geriatric Assessment (CGA) are significantly less likely to die or experience functional deterioration. As a result, such patients are also less likely to be admitted to an institution and more likely to be alive in their own homes at longer term follow-up compared with those receiving care without a CGA. We will continue to work to ensure that elderly people are assessed using a standardised comprehensive geriatric assessment across the Health Board.

Falls

The Health Board focused heavily on its falls improvement plan for 2018/19 and demonstrated a significant reduction, particularly in falls casing harm. We will continue to focus on further improving avoidable falls in particular those within the primary care environment. We are revising our falls strategic improvement group to ensure a wider multiagency representation and collaboration. We are aiming to build on the success of the dance for health programme that has demonstrated through external evaluation a significant impact on falls reduction in primary care. During 2019/20 we aim to scale up this initiative to gain wider benefits for our patients.

Improving Outcomes following Stroke

Our aim is to continue our progress on improving our stroke services as outlined in our Stroke Service Improvement Plan. This area of improvement is also included in our clinical service plan as one of the pathways that will be developed. We will build on our collaboration through ARCH to develop stroke rehabilitation for the future.

Improving End of Life Care

A greater focus needs to be given on improving end of life care and experience for our patients and their families. This are of care still features in our patient experience feedback and concerns. We are going to work more closely with care home to support their skill development in both assessing and planning escalation of care need. Featured within all of our clinical pathway priority areas end of life care and experience features as part of the pathway design learning lessons from some of our patient outcomes and experience has indicated that we need to improve our conversation with patients regarding future escalation of care.

Improving Cancer Pathways

This are features as part of our clinical service plan and our focus is on areas that need support to further improve recognising some pathways of excellence. This needs to be reassessed in the context of the exit from bridged. The infrastructure for a pathway of excellence is based on co dependant services and these will change post Bridgend.

Improving Surgical Outcomes

National Emergency Laparotomy Audit (NELA)

We have reviewed our audit programme and plan and the National Emergency Laparotomy Audit is a National Clinical Audit and features as one of our priority areas. We continue to perform in line with peer groups and are focusing on improving geriatric assessment and admission to intensive care units.

Lower Limb Major Amputation for Peripheral Arterial Disease

This remains a priority area as part of the Health Board audit programme. We have developed a training programme for general practitioners and therapists to improve their skills in the assessment and treatment of peripheral vascular disease. It is anticipated that as we roll out this programme there will be an improvement in the detection of this disease and a reduction in associated complication. In parallel we continue to promote our priority public health areas such as smoking reduction and weight management.

Enhanced Recovery after Surgery

The clinical services plan seeks to give each operative area a plan including some with a specific remit for day surgery. The expectation will be for all clinical staff to ensure patients have a standardised assessment and appropriate day case anaesthetic.

Reduce pressure ulcers

Reduction of acquired pressure ulcers both in hospital and the community.

Reduce Healthcare Acquired Infections

We have made significant progress in improving the number of patients with harm arising from all forms of Health Board attributable healthcare associated infection (HCAI), specifically Clostridium Difficile infection (C.Diff)

and Staphylococcus Aureus bacteraemia and Eschericia Coli (E.Coli) bacteraemia is a quality priority for the Health Board. Our plans are included in our HCAI Service Improvement Plan.

Quality Management System

We are aspiring to be a quality driven system supported by validated and timely information. We have now identified and appointed quality improvement leads and we are further developing how they will best integrate into the quality management system.

We need to use national standards such as NICE guidance relevant to the care pathway as our as our standards of care. Performance will be reviewed regularly at a service level and clinical teams will lead the areas of improvement. Using our patient experience outcomes to drive clinical and quality improvement will feature as part of every clinical team learning and development and will have a Quality Impact Assessment (QIA). A QIA panel chaired by the Director of Nursing and Patient Experience will test schemes against a risk matrix to ensure that we have assurance that the impact of proposed changes on quality are in the worst case neutral but at best should be aiming for an improvement in quality.

Quality Improvement Hub

There are a number of resources in the Health Board to support staff to engage in Quality Improvement but these are distributed across a number of sites and lines of reporting. Learning from global best practice, we will be bringing these resources together as far as is practical into a single Quality Improvement (QI) Hub to benefit from proximity to our staff and each other. We are coordinating our quality hub resources to develop a board wide approach.

Patient Experience

The Health Board's Director of Nursing and Patient Experience has responsibility for monitoring patient experience, which includes delivery of our patient experience plan and work plan. Patients/ relatives/ carers/ friends are able to provide their feedback in real time through the Friends and Family and comprehensive Patient Experience surveys. The number of feedback forms completed for Friends and Family continues to increase and is collected across 367 areas in the Health Board.

The graph below sets out the percentage of patients who would highly recommend the Health Board to friends and family. This was an average of 93% in 2016/17 and has increased for 2017/18 to 95%. (Year-end figures 2018-2019 not available until end March 2019)

We publish the Friends and Family feedback reports on our website and monthly and weekly reports are published in all ward and clinic areas in English and Welsh. We currently receive an average of 5,317 (This figure is from 1st April to 30th November 2018, there are still four months' worth of figures to be collected Dec, Jan, Feb, March) pieces of patient experience feedback every month. The Health Board has continued to use patient feedback as a mechanism for listening, learning and improving and each Board meeting starts with a patient story.

A real time alert system was developed using a list of buzz words which triggers an e-mail to the ward/unit manager and patient experience team if used in the response to the question 'What would have made your experience better?'

A clinical lead, as part of the national programme, has been appointed to support our participation in the spread of the PREMs/PROMs national programme. (Role only funded for 6 months only, currently no further funding for clinical lead)

We have developed a patient story toolkit, policy and guidance along with a specific SharePoint site to host ABM patient stories and improved the quality of digital stories presented to every board. Presentations of the new guidance and SharePoint site has been delivered to all the Delivery Units. During January and March we have planned to train key staff in all the service delivery units to undertake digital stories. These will feature as part of every units quality and safety committees. We have received very positive feedback from patients that have participated in developing a digital story about their care. These have been used to drive service improvement and have had a positive impact on concerns resolution.

Patient Experience Aims for 2018/19

- Improve the percentage of Family and Friends who would recommend the Health Board to 96 %consistently this would exceed the national average. (achieved 96% five times since April 2018)

- Improve the level of feedback as a percentage of discharges to 25% (since April 2018 we have achieved this target three times. June 30.1%, July 26.1% and August 26.8%)
- Integrate patient experience as a measure of care for all areas of clinical pathway development

We also have a well-developed Arts in Health Programme which aims to incorporate the Arts into everything we do so that patients, their families and staff experience excellent care in excellent surroundings. Further detail on this is found in **Appendix 2.**

We will develop a patient engagement plan to further enhance our methods of gaining feedback from patients to shape and improve services.

Learning from Concerns and Complaints & Incidents

A structured and transparent approach to ensure that we learn for feedback from our patients and families that comes through our complaints and concerns processes. Monthly audits are undertaken on closed complaint responses through the work of the Concerns, Redress and Assurance Group. The audits monitor the quality of the response and compliance with the Health Board's Values, as well as the Putting Things Right Regulations. Feedback on the audits is reported to the Assurance and Learning Group which includes the Delivery Unit Service Directors and Governance leads in order to share information and cascade learning within their respective Units. Complaints management performance is reported via the Quality and Safety Dashboard Report to the Quality and Safety Committee and Board meeting. During 2017/18 the Health Board has improved compliance against the target of responding to complaints within 30 working days to over a consistent response rate of 80% for the 2018 the number of re-opened complaints has also decreased significantly during 2017/18 when compared

to 2016/17. We have been targeting long standing complaints and reduced these to 19 complaints open over 6 months. There has been an increase in complaints referred to the Ombudsman in 2017/18 with 36 referred compared to 26 in 2016/17. We are reviewing the cases to identify any themes in the referrals to the Ombudsman and will be taking action to learn and improve following the findings. To date for this year from 1st April - 31st December 2018 the Ombudsman has currently received 29 cases.

Following a high number of Never Event incidents in the last financial year, the Health Board decided to trial a new reflective, multi-disciplinary approach to responding and learning from such incidents. Rather than the more traditional investigative approach to serious incidents, the Health Board piloted a more collaborative approach to learning by working with clinical teams using a reflective and learning event module to help staff understand what went wrong, and more importantly, how to make affective changes which improve our services and reduce risk to patients. Following a successful pilot of this approach, the revised methodology is being disseminated to all clinical areas for implementation and use across the Health Board.

The NHS Wales Delivery Unit have recently concluded their 90-day follow up review report, summarising progress made regarding recommendations relating to improving systems & processes for the management of serious incidents. Whilst work is ongoing to fully implement all of the recommendations, the report highlighted significant improvements made to the process of serious incident investigations undertaken corporately, with improved levels of scrutiny and shared learning across the Health Board following such events. To date, no Never Event incidents have been reported in this financial year.

Summary Plan and Enablers – Quality and Safety Including HCAI

Actions		Milestones 2019/20	Measures	Lead
To **improve surgical outcomes** all clinical staff ensure patients have a standardised assessment and appropriate day case anaesthetic.	Q1	Standardised assessments in place	As per report into NELA database HW_DP7	DoN
	Q2	Monitor compliance		
	Q3	Monitor compliance		
	Q4	Report, evaluate, recommend improvements		
Reduce acquired **pressure ulcers** both in hospital and the community	Q1-4	Monitor and initiate improvement actions as necessary	NDF_27	DoN

monitored via current mechanisms and ward to board Dashboard				
Improve outcomes for **older people**: reducing length of stay through promoting SAFER framework and ensuring Comprehensive Geriatric Assessments (CGA)	Q1	Audit of patients defined age group receiving CGA	LM_18	DoN
	Q2	Review Audit and develop recommendations/plan		
	Q3	Implement and monitor		
	Q4	Evaluate		
Reduce avoidable falls, particularly in community settings, through multi agency collaboration and scaling up the Dance for Health Programme	Q1	Revise Falls Strategic Improvement Group	NDF_29 HW_DP9	
	Q2	Scale up the Dance for Health programme		
Reduce Healthcare Acquired Infections				
Audits on time taken from onset of unexplained diarrhoeal symptoms to isolation, with feedback of results to Delivery Units for action.	Q1	Undertake baseline audit		DoN
	Q2-4	Quarterly spot-check audit		
Audit the time taken from obtaining diarrhoeal specimen and its receipt by the laboratory with feedback of results to Delivery Units for action.	Q1	Undertake baseline audit		
	Q2-4	Quarterly spot-check audit		
Undertake *C. difficile* ward round on key wards once weekly *(where possible) with feedback of results to Delivery Units for action.	Q1	Undertake baseline audit	NDF_14 NDF_15 NDF_16 NDF_21 NDF_22 NDF_23 NDF_24 NDF_25 NDF_26 LM_1	
	Q2-4	Quarterly spot-check audit		
Audit of compliance with MRSA Clinical Risk Assessment with feedback of results to Delivery Units for action.	Q1	Undertake baseline audit		
	Q2-4	Quarterly spot-check audit		
Support Delivery Units to improve management of HCAIs through ensuring Quality Improvement Leads for Infections are leading HCAIU Improvement Programmes in each Delivery Unit, Ensuring compliance with ANTT competence requirements and developing processes to determine avoidable versus unavoidable infections.	Q1	Quality Improvement Leads for Infection in place		DoN
	Q2	Develop process determining avoidable/unavoidable infections		
	Q3	Evaluate ANTT compliance		
	Q1-4	Thematic periodic surveillance of infections		
	Q4	IPC nursing workforce in Primary Care and Community		
Improve infection control: specimen collection protocols, business intelligence informing ward dashboards, a 4D programme for environmental decontamination and a Faecal Microbiota Transplant (FMT) process for patients with recurring C.difficile infection despite optimal medical therapy	Q1	Develop key specimen collection protocols		`
	Q2	Development '4D' Programme		
	Q3	Develop FMT process		
	Q4	Start ICNet work to inform dashboards reporting		
Develop, implement and monitor compliance with guidelines for antibiotic prescriptions without available guidelines for prescribers and to support restricted use of Co-amoxiclav in secondary and primary care settings	Q1	Monitor Co-amoxiclav guidelines in secondary care.	LM_2-8 NDF_19&20	DoN
	Q2	Develop specific Guidelines for antibiotic prescriptions with no available guidelines		
	Q3	Develop Primary Care Antimicrobial Guidelines which support the restricted use of Co-amoxiclav		
	Q4	Implement primary care guidelines and monitor compliance		
Demonstrate improvement and learning from **Patient Experience** through the implementation of the patient experience plan.	Q1	Integrate patient experience as a measure of care for all areas of clinical pathway development.	NDF_44 NDF_47 NDF_48 NDF_49 LM_27-29	DoN
	Q2	Develop a patient engagement plan		
	Q3	level of feedback as % of discharges at 25%		

Workforce Implications		Finance Implications
- Ensuring we have sufficient workforce to meet population needs in line with CNO principles is key to quality and safety. - Increase capacity for current specialist pharmacists to focus on ward based activities and direct patient care in secondary care and provide focused support to GPs and other prescribers in primary and community care to reduce HCAI.		None
Capital Implications		**Digital Implications**
		See section 3.3
Bridgend Transfer Implications		
Our performance trajectories for HCAIs have been calculated to take into account the Bridgend transfer.		

3.1.2 Primary and Community Care

As a Health Board we are committed to the delivery of the Primary Care Model for Wales. This is demonstrated through the timely implementation of our Pacesetter projects and we are fully committed to continue to work at pace to develop new models. We recognise the importance to learn from the National Pacesetter Programme engaging with other organisations as well as internally reflecting on what went well.

The Primary and Community Plan for the Health Board 2017-22 set out our ambition and provided an overarching direction for primary and community services operating within the wider Health Board context. It was written in the context of The Social Services and Well-being (Wales) Act, which required public bodies to think more about the long term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach to do things in a more sustainable way.

In addition, the Welsh Government publication Our Plan for a Primary Care Service for Wales set out the vision for primary care at the heart of the NHS, driving transformational change and ensuring patients' needs are met through a prudent approach to healthcare. Since we published the Plan, The Health, Social Care and Sport Committee Inquiry into Primary Care Clusters (2017) and Parliamentary Review of Health and Social Care in Wales (2018) have further helped to provide an even clearer vision of the action needed to transform health and care in Wales.

In response to the recommendations of the Parliamentary Review, the Welsh Government released a revised plan in June 2018, A Healthier Wales: Our Plan for Health and Social Care. The new plan sets out the ten-year vision of a whole system approach to health and social care, which is consistent the Health Board's Primary and Community Plan in aiming to bring services together so that they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well.

The transformational model for primary and community care, which is a whole system approach to sustainable and accessible local health and wellbeing care, supports the vision set out in Healthier Wales and has now been adopted nationally as the Primary Care Model for Wales.

The transformation of Clusters over the coming three years will embed a new way of providing care that is more sustainable, is closer to patients, and is more able to offer personal and population value. Learning has been shared across NHS Wales of the national Pacesetter programmes which will inform our project roll out over the next three years. We will ensure that all future pacesetter programmes incorporate the six recommendations made from the review;

1. The plans for pacesetter projects should be sufficiently developed for approval by all Directors of Primary Care and Community in the agreed timescales.

2. Projects will be based on all elements of the primary care model and adequately tested measures in place to demonstrate which element could have the greatest effect.
3. Projects should normally continue for 2 years with midterm analysis made available to approve continuation.
4. Project plans must include evidence of cross discipline agreement to continue with and scale up pacesetters that demonstrate positive outcomes. Processes for sharing of learning must also be in place.
5. All members of executive teams would be expected to be aware of new developments on commencement and incorporate proposals as part of IMTP returns.
6. Learning from all Wales projects should be owned at local level and successful projects adopted as appropriate without re testing.

Our internal assessment of our own pace setter programmes has been included in appendix X.

Contract reform in dental, community pharmacy and general medical services is helping move from a "reimbursement for treatment" to a "reimbursement for prevention" model, in turn incentivising better value healthcare. Shifting resources and patient pathways from secondary care models will complete the three-step process of different infrastructure / different incentives / different pathways of care to provide a long term sustainable healthcare operating model.

From 2019/20 the Health Board will contain eight Cluster areas, five in the City and County of Swansea and three in Neath Port Talbot. Each of these are characterised by diverse demography, physical geography and varying population needs. Each of the 8 Clusters have undertaken assessments of needs within their geographical area and have produced Cluster Plans that they intend to implement to achieve the better health and wellbeing for the individuals and communities within its area. These plans and priority areas for development were agreed in November 2018, with each Cluster developing an implementation planning framework and performance management structure to ensure a clear focus on service delivery and improvement. The Clusters are at differing stages of their development and we will be undertaking a phased approach to the rollout of the new model, ensuring that learning is undertaken at each phase to ensure the best possible outcomes are achieved.

Cluster Led Integrated Health and Social Care System
The Health Board submitted a funding proposal in July 2018 for the development of a transformed model of a cluster led, integrated health and social care system for the cluster population. This aligns well with the Primary and Community Plan, Healthier Wales and the Regional Partnership Board action plan. The initial bid for the Cwmtawe Cluster model was successful and is in implementation. More detail on the successful Transformation Fund Bid and the alignment with the new Western Bay Our Neighbourhood Approach can be found here.

We submitted a revised bid to scale up the model to cover all Cluster Networks within the Health Board. This is included in Appendix [XX]. The proposal has been based on the intent for this model to become self-sustaining through the improvement in health and wellbeing, co-production and use of social prescribing as an alternative to more traditional models of health and social care including a shift of resources where appropriate from secondary to primary care and this will be evaluated and assessed as the model is rolled out.

Integrated Community Services
Through the Western Bay Regional Partnership Board, ABMUHB worked with partners to design and deliver an optimum model of Integrated Community Services. Each Local Authority area within Western Bay has a Community Resource Team (CRT), with workforce from local authority, health and third sector, providing integrated care and support to improve the independence and wellbeing of our population. This model of service is financed from a pooled budget with a Section 33 (NHS (Wales) Act 2006)) agreement and thus improving the use of shared resources.

Since their conception the CRTs have continued to innovate, and during 2018/19 the Neath Port Talbot Acute Clinical Team (ACT) developed a model of work with the Welsh Ambulance Service Trust (WAST) that provided direct access for ACT staff to the WAST 999 active list. This allowed the ACT to provide an appropriate patient response that enabled the patient to be safely assessed, treated and cared for at home and released WAST capacity. This project was supported by and evidenced through the Bevan Exemplar programme and roll out will be included as part of the Hospital2Home Transformation Fund Bid included in our Unscheduled Care Plan in section [insert].

In addition to our ambitious and innovative response to A Healthier Wales, there are a number of other strategic imperatives:

Oral Health

From an oral health perspective, the aim is to remodel restorative and special care dentistry services. We will create an intermediate care model for the former and a Consultant-led adult and paediatric specialist delivered service in key new locations for the latter. Our Oral Health Delivery Plan is included in Appendix

Dentistry

A further rollout of the revised contractual model for general dentistry will see a further shift toward a more preventive approach for dental care. We will continue to be at the vanguard of service change in respect of oral health services and 2019/20 sees the final year of the three-year reinvestment plan that has been agreed with Welsh Government and our Executive Board. The contract reform process, coupled with changes in community and restorative dentistry, aims to introduce a significantly more preventive style of practice that will lead in the medium term to better oral health.

Out of Hours

In urgent out-of-hours primary care, the key strategic change is to reshape the staffing mix to reduce reliance on general practitioners, and introduce new types of practitioner such as paramedic, pharmacist and advanced nursing input. This will be completed in 2019/20 with public engagement undertaken on the changing model in line with CHC guidance.

Community Pharmacy

The community pharmacy plan is to ensure as many residents as possible can receive an enhanced range of services from their local pharmacy, including the continued rollout of existing enhanced services, but also the piloting of new and innovative services using pump priming funding. Changes to the community pharmacy contract have the potential to unlock fundamental changes in how the skilled workforce in the community can be utilised. Through the implementation of relatively simple but important steps such as further rolling out the common ailments scheme, increasing referrals to smoking cessation services, attendance at cluster meetings etc. the resource can be better integrated into overall care delivery.

Service and Pathway Redesign

The Clinical Services Plan and Transformation Programme Plan will allow a greater focus on care provided closer to home through pathway redesign, a shift in human, financial and capital resources from secondary to primary care and this will entail service and pathway redesign to ensure waste, variation and harm is minimised

We will also be working to deliver across a number of system priorities:

Primary Prevention

Further roll out of community pharmacy and other enhanced services in respect of smoking cessation, flu vaccination, prediabetes preventive measures such as social referral for activity and dietary management, and improved working with local authority and voluntary sector partners all form part of the enhanced Cluster services proposal.

Wellness Centres

Our plans to develop Integrated Wellness Centres, starting in Swansea are included in section 2.2.

Planned Care – Care Closer to Home

We will continue the shift of care to community settings, especially audiology, community optometry, endocrinology/diabetes. This work will be further developed through the Clinical Service Plan Transformation Programme.

Eye Care in the community remains a priority and our Eye Care Delivery Plan is included in Appendix. The Low Vision Service Wales [LVSW] is a Primary Care rehabilitation service for both adults and children with a vision impairment. Over two thirds of patients seen within the LVSW are over 80 years old. 24 (42%) of our optometry practices are now accredited to provide the service which assesses people with poor vision and provides them with appropriate aids to help their daily living, reducing risks associated with loss of independence, medicines management, falls and social isolation.

The Eye Health Examination Wales [EHEW] service supports patients through provision of the following three types of service:

- Investigation of acute eye care or annual check for patients at risk of developing eye disease;
- Further informing referrals to the hospital eye service, e.g. pre-cataract assessment; and,

- Review of patient following a Band 1 or for post-operative cataract monitoring.

The geographical coverage and percentage of EHEW practices in the Health Board remains, at 88%, considerably lower than across Wales as a whole (94%) and will remain so unless until more of the large supermarket-based Optometry practices support the scheme. However EHEW activity in the Health Board practices continues to be the highest level in Wales. Almost 23,000 patients received EHEW services the previous year and the trend of significantly increased uptake appears to have continued into the current year. There is an increase of 45% in the last two years.

Cancer

One of the core objectives aligned with Wales Cancer Delivery Plan is detecting cancer earlier. The Health Board successfully secured funding via the Wales Cancer Network to develop and deliver a 2 year pilot based on the Rapid Diagnostic Clinic (RDC) concept. The first patients were seen in June 2017. Based on the 12 month outcome data, the initial results from the pilot is very encouraging. The data reports 83 clinics held and 228 patients seen. Preliminary results also suggest that the model supports the single cancer pathway 28 day diagnostic metric, delivering a (non-histological) diagnosis on average within 4.4 days based on indicative data.

The outcome data with a 10.5% conversion rate for the clinic is extremely positive with evidence of a good patient and referrer experience. Despite the increasing referrals, as a result of excellent engagement and communication between primary and secondary care the conversion rate suggests that the system must trust the GP instinct and the service has not been flooded to date. The pilot has been extended following the successful evaluation with funding for 2019/20 confirmed from the Wales Cancer Network.

Social Prescribing

Implementation of revised MDT model at Cluster level will increase levels of social prescribing / social referral and improve access for patients with low to moderate mental health needs to supporting services and self-care. Professionals have access to a several online signposting tools including 111 Directory of Service, DEWIS and **Infoengine.** Clusters in ABMU recognise the added value of the Third Sector and the need, through a prudent healthcare approach, to support patients for social and non-medical issues which could impact upon their health and wellbeing in the longer term.

As such Clusters have commissioned through dedicated funding schemes, Third Sector and other partner agencies, to deliver on this agenda. Some of this work has been mainstreamed to be delivered via other funders or the community themselves.

Redesigning the Primary Care Workforce

Within the Health Board's Primary and Community plan 2017-2022, workforce redesign is a key driver to support service redesign. The plan seeks to blur traditional healthcare professional boundaries, with the development of new and innovative roles for health and social care professionals working alongside GPs. This will create more capacity in the community; provide continuity and timely access to care closer to home.

There has already been significant workforce diversification including Cluster Network-based pharmacists, pharmacy technicians, physiotherapists, mental health counsellors and primary care audiology services. Across Clusters, there are a mixture of cluster pharmacists, social prescribing link workers, cluster community nurses, paramedics, phlebotomists, physiotherapists, mental health workers, occupational therapist, exercise referral specialist, audiologists and primary care Early Years workers. This is being complemented by an increased provision of third sector services through the Heath Board grant scheme and through the use of cluster funds. Community services are delivered jointly with local authorities providing seamless care across Neath Port Talbot and Swansea. Future year's further workforce redesign plans are shown in the following diagram.

Estates

In 2019/20 we will complete our Primary and Community Services Estates plan. We will implement the GMS Access Action Plan and primary Care Pipeline Funding has already been agreed for the complete refurbishment of Murton and Penclawdd Primary Care Clinics. During the year we will develop proposals for Ystalyfera Primary Care Clinic and consider improvement works at Cwmavon and Cymmer Health Centre. WE will also develop proposals for hubs in Velindre/Penllergaer and Uplands.

With regard to the Swansea Integrated Wellness Centre, in 2019/20 we will appoint a project manager, update the project plans and submit the Strategic Outline Case. For Neath Port Talbot we will explore securing Primary Care Pipeline to support Neath Wellness Centre and/or scope the feasibility of redeveloping the Port Talbot Resource Centre. In future years we will scope

the feasibility of second Wellness Centre in Morriston, Swansea and consider submitting for capital Pipeline funding.

Additionally, to facilitate the move toward a more community oriented provision of care there needs to be a fundamental reappraisal of the Health Board's capital and estates. This will include the actions in the Unscheduled Care Plan to grow community services and to right-size our

Inpatient capacity. This will include reviewing our rehabilitation model, including service provided in community hospitals and care homes.

Performance

Our performance ambition against the national phase 2A primary care measures is set out in **Appendix**

Transformation Opportunities

Cluster-led, Integrated Health and Social Care System

In partnership, the Health Board has set out to deliver a whole system transformation plan through the development of a transformed model of a cluster led, integrated health and social care system. This proposal builds on the work to develop clusters over the past few years and will see them evolve from GP-led clusters to a fully integrated health and social care system, providing community based wellbeing services and healthcare to its local population

The eight Clusters within ABMU are at differing stages of development and we will be undertaking a phased approach to the rollout of the new model, ensuring that learning is undertaken at each phase to ensure the best possible outcomes are achieved. The proposed stages are as follows:

Phase 1/1a: Core Model Cwmtawe Cluster /Neath Cluster
Phase 2: Commenced within 6 months Lwchwr/Upper Valleys Clusters
Phase 3: Commenced within 12 months Afan/Bay/City/Penderi Clusters

This proposal will dovetail with the Western Bay programme of work to ensure that the Health and Social Care System is able to work together to deliver the whole system approach and provide the social care wrap around service to this proposed model.

Effective planning, implementation and roll out of this model will be undertaken through a programme management approach.

Redesigning the Primary Care Workforce

The development of long term care service teams made up of a number of different professionals including paramedics to free up GPs to see more complex patients

Further reinforce the community therapy and health science workforce to embed services within cluster networks with an emphasis on prevention, co-production and providing services closer to home

Develop the model of the "future GP" linking with the development of the Primary Care Academy at Swansea University

Continued Support of Nurses within GP practices to develop into Nurse Practitioner and Advanced Nurse Practitioner roles, in addition to minor illness roles to support GPs and reduce their workload

Audiologists being developed to expand their competencies to include non-medical referral for diagnostic imaging and micro-suction ear care

The development of new Advanced Nurse Practitioner roles and multi-skilled community professionals

The development of Physician Associate roles to take on the routine work of GPs

Redesign of the out of hours primary care to reduce reliance on an increasingly aging pool of GPS. This includes introducing nurse practitioners, pharmacists, and paramedics

The development of the Medical Assistant, an administrative role trained to deal with incoming correspondence usually handled by GPs

Further development of Clinical Pharmacists to provide direct support to patients

Acute outreach team delivering care at home through GP's and Advanced Nurses

Mobilising the workforce through the use of IT

Summary Plan and Enablers– Primary and Community Care

Actions	Milestones 2019/20		Measures	Lead
Roll out the Whole System Approach to **Cluster-led, Integrated Health and Social Care System** across all 8 Clusters (Funding dependent) including the further development of **Cluster Plans** and implementation of pace setter projects in line with	Q1	Phase 2: Llwchwr & Upper Valleys Clusters	NDF_52 NDF_53 NDF_54	COO
	Q2	Develop and embed, review		
	Q3	Phase 3: Bay, City, Penderi, Afan Clusters		

cluster priorities.	Q4	Develop and embed, review	NDF_48	
Improve health and wellbeing through **Primary care prevention** actions.	See Partnerships for Improving Health and Well-being section			
Develop **Integrated Community Service** Hospital 2 Home including, new discharge to assess model, expansion in reablement at home, expansion in acute clinical teams, Single Point of Access	See unscheduled care section (bookmark)			
Expand **Primary Care Audiology** capacity and coverage	Q1	Recruit and train staff in Cwmtawe Cluster	HW_DP7	COO
	Q2	New expanded service implemented and monitored		
	Q3	Recruit and train staff in Neath Cluster		
	Q4	New expanded service implemented and monitored		
Improve **oral health** of vulnerable groups (children, elderly, asylum seekers, homeless and housebound); Develop and implement integrated (GDS/CDS) domiciliary oral health pathway, targeting care; Increase access to general dental services (implementation of contract reform).	Q1	Review interim service	PHF_34 NDF_57	COO
	Q2	Continue to review		
	Q3	Review current pathway		
	Q4	Review current pathway to develop new pathway		
Remodel Urgent Primary Care service (**GP-led Out of Hours service**), creating multi-disciplinary model; reshaping the staffing mix to reduce reliance on GPs, and introducing new types of practitioner i.e. paramedic, pharmacist and advanced nursing input.	Q1	Finalisation of Plan	NDF_55 NDF_56	COO
	Q2	Implementation of multi-disciplinary model		
	Q3	Monitor implementation		
	Q4	Review and evaluate		
Develop **Integrated Wellness Centres**, starting in Swansea	included in Co-Production and Health Literacy section (bookmark)			DoS
Redesign **Primary Care Workforce** including further development of Advanced Nurse Practitioners, developing a framework and opportunities for staff rotation across primary and community care settings and develop the role of Community Paramedics within more urban settings	Q1	Undertake training needs analysis	NDF_52 NDF_48	WOD
	Q2	Identify training requirements and develop plan		
	Q3	Liaise with University providers		
	Q4	Develop a Health Board rotation plan		
Reduce reliance on face to face outpatient appointments for Oral Surgery/Cancer by introducing Primary Care oral medicine Clinician-led **Referral Management Centre**, supported by local implementation of new Oral Medicine programme	Q1	Introduce new pathway	NDF_62	COO
	Q2	Monitor new pathway		
	Q3	Review new pathway		
	Q4	Scope for additional pathway reform		
Reduce reliance on face to face ophthalmology outpatient appointments by further increasing number and percentage of patients receiving **pre-operative assessment and post op follow up in primary care** (Optometry) practice	Q1	Monitor new pathway	NDF_63 NDF_62	COO
	Q2	Review Pathway		
	Q3	Scope additional pathway reform		
	Q4	Develop plan for further pathway reform		
Continue to improve the **Primary Care Estate**	Q2	Complete refurbishment of Murton and Penclawdd.	NDF_48	DoS
	Q3	Consider improvements - Ytalafera, Cwmavon, Cymmer.		
	Q4	Proposals for hubs- Velindre/Penllergar and Uplands		
	Q4	Finalise Estates Plan		

Workforce	Finance
- Workforce Redesign as outlined in the PCS Plan - Embedding Therapy and Health Sciences staff within the Cluster Network Hubs. For example Advanced Primary Care Practitioners for Audiology who are able to undertake ear and hearing cases freeing up GPs. - Change the model of District Nursing to give them more control over patient care. - Support opportunities for Physician Associates including their potential involvement in the Chronic Pain service.	- Transformation Fund Bid approved for Cwmtawe Cluster Whole System Approach - £1.789m - £233k additional awaiting approval – Total £2.022m - Transformation Fund Bid submitted for roll out to all 8 Clusters–- £8.883m - Funding agreed from WCN to continue the Rapid Diagnostic Clinic for 2019/20 - £0.100m
Capital	**Digital**
- Submit SOC for Swansea Wellness Centre and develop proposals for NPT. In future years develop proposals for a further Wellness Centre in the Morriston area. - Implement the GMS Access Action Plan by completing the refurbishment of Murton and Penclawdd (funding agreed through Primary Care Pipeline). Develop proposals for Ystalyfera Primary Care Clinics, improvement works at Cwmavon and Cymmer Health Centre and develop proposals for hubs in Velindre/Penllergar and Uplands.	- Transformation Fund Bid for WCCIS - Mobilisation across community teams - Implement WCP and the introduction of MTeD and WGPR to improve communication and flow of patients between Primary and secondary care, improving efficiency and quality of care
Bridgend Transfer Implications	
Primary and Community Care Services face a particular challenge from the transition of service delivery to Cwm Taf University Health Board. Many service areas in the unit will transfer in their entirety, such as Community Nursing Teams and Maesteg Hospital. However, there are a substantial number of teams where service delivery is more difficult to disaggregate, especially where service delivery is currently unified across the Health Board or small bespoke teams delivering highly specialised care. There are further challenges in terms of probable reductions in funding for management and other support services. It is likely that the unit will have to restructure to ensure the correct alignment of management and staff resources with remaining care demand and available funding.	

3.1.3 Unscheduled Care

As a result of achievements over the last two years, our numbers of medical admissions have stabilised and our rates of readmissions have steadily decreased over the last 18 months. These changes, we well as changes to our surgical services models, allowed us to reduce our inpatient capacity in line with the benchmarking opportunities identified in our Annual Plan 2018/19.

Additionally our improvements in admission avoidance and hospital flow have changed our planning by highlighting two issues: the Emergency Department internal flow at Morriston needs to be improved; and the discharge difficulties at the back door of our hospitals are a major constraint to any further reductions in length of stay. The increasing number of DToC patients over the summer has been a barrier to achieving the full suite of service remodelling changes that we planned to make in 2018/19 as well as potentially causing harm to patients by prolonging their length of stay.

To tackle the Emergency Department (ED) issue, we are exploring the options to commission a targeted 10-week improvement programme in ED at Morriston in Quarter 4 of 2018/19 on which we can build our improvement programme in 2019/20.

With regard to the backdoor we have drafted our Frailty Model in conjunction with partners (see our Older People's section). In light of the growing number of patients in our hospitals who are medically fit for discharge we therefore commissioned a Right Care Right Place Bed Utilisation Survey with

Local Authority partners to ensure we have a shared, jointly owned understanding of the constraints and blockages in the system. Optimum Model of intermediate care to make a major step change in admission.

The Right Care Right Place review also identified that we have more opportunities within our own gift to improve flow through the national unscheduled care programme, reducing variation in implementing the SAFER flow bundle and service improvement actions around Estimated Date of Discharge, board rounds and clinical leadership. The NHS Wales Delivery Unit audit of complex discharge has also identified similar opportunities and, although we have achieved a great deal in rolling out these approaches over the last two years, we plan to implement a programme management approach to discharge as a priority for 2019/20. This approach will be overseen by our Unscheduled Care Service Improvement Board to ensure delivery in 2019/20 and in particular ahead of winter 2019/20.

The Clinical Services Plan has confirmed that we will improve our unscheduled care system with the aim of centralising the Acute Take for Swansea at Morriston Hospital. Whilst we do not yet have a detailed critical path for the centralisation of the Acute Take we will be working at pace during the first half of 2019 to agree this, and our plan is based on some of the major underpinning step changes we know we will need to make. In 2019/20, improving the efficiency of our unscheduled care system by reducing our length of stay and reducing bed occupancy at Morriston will be an essential step towards improving performance and releasing capacity on the site to centralise the service. This will also improve quality by reducing the likelihood of transmitting infections and the deconditioning effects on older people of a prolonged hospital stay.

The Clinical Services Plan also includes a Single Point of Access for patients and professionals to gain access to advice to avoid admission and to keep well at home and to improve communication. The provision of the SPoA is closely linked to the expansion in Acute Clinical Teams and reablement services which will be included in the Hospital2Home Transformation Bid and this is included in our plan for 2019/20.

Living Well
Working towards our Strategic Aim of supporting better health and wellbeing by activating, promoting and empowering people to live well in resilient communities through our population health, primary prevention and digital wellbeing plans are essential to achieve a sustainable unscheduled care system. Our plans to improve population health through implementing the Primary Care Model for Wales by rolling out the Primary Care Cluster Model, developing the Cwmtawe Neighbourhood Approach, the Swansea Wellness Centre and digital wellbeing are described in sections X.

The prevention actions regarding flu and smoking cessation described in section X are particularly important in the Health Board's area due to the high incidence of respiratory disease as evidenced in our rapid health needs review. Our plans to improve respiratory health are included in our Respiratory Disease Delivery Plan included in Appendix X. We have also been at the forefront in pushing the boundaries of the current restricting General Dental Service's contract which disincentiveses holistic oral health care through a range of new approaches which are included in our Oral Health Delivery Plan. This includes all of our continuing actions to improve oral health for children and adults in 2019/20.

Reduction in Unnecessary Hospital Attendance
Our plans for 2019/20 are based on our achievements over the last two years and the national approach to address the five national priorities which are:

- Falls
- Breathing difficulties
- Chest pain
- Health care professional calls
- Mental health.

We have tested innovation and improvement through our Winter Plan, a summary of which is included in Appendix 9, and made very good progress to implement the Emergency Ambulance Five-Step Pathway. Our plans for 2019/20 build on this learning with our ambulance and Local Authority partners. Our work through EASC is described in more detail in Appendix X and documented in the EASC and NUSC templates included in Appendix X. Our joint work to reduce frequent attendances to A&E through a multi-agency approach is now mainstreamed as part of our normal business.

A significant range of joint improvement initiatives are planned with the Welsh Ambulance Service Trust (WAST) to deliver sustained improvements in the quality of care and timeliness of 999 responses whilst also supporting improvements across the Health Board's wider Unscheduled Care system.

We will also be working with WAST colleagues to implement the recommendations of the WAST Amber review.

A core focus of the joint initiatives are to deliver prudent conveyances system with a demonstrable reduction in the number of patients conveyed to hospital by ambulance, where clinically safe and appropriate by enhancing access to alternative pathways of care, improving management of frequent service users and particularly improving services for managing falls. We will also increase the number of patients referred to a primary or community care setting for their ongoing care needs and avoiding an unnecessary admission to hospital. To achieve this we will:

- Work with the ambulance service to identify opportunities to enhance and develop alternative care pathways including jointly reviewing activity to improve the compliance with established care pathways and, where required, develop new care pathways to meet the needs of our patients and avoid unnecessary admissions into hospital.
- Continue the multi-disciplinary team approach to manage frequent service users including the regular review of activity data.
- Work closely with WAST clinical leads to pro-actively manage and reduce demand from patients who have fallen. This includes Health Board funding for the Joint Falls Response Vehicle and continuing to support the roll out of the 'IStumble' and 'I Fell Down' falls assessment toolkits across all Residential and Nursing Homes.
- Fully embed the additional 6 Advanced Paramedic Practitioner (APP) rotational roles providing specialist care within both a Primary Care setting (supporting the GP workload) and providing a WAST response to clinically appropriate 'Amber' and 'Green' 999 patients..
- Through the expansion of Hospital2Home we plan to embed the successful pilot, which is not currently funded, for the Acute Clinical Teams to take directly from the ambulance 'stack' to care for patients at home instead of redirect patients to services away from hospital, as described in the Primary Care plan.

We recognise that delays during hospital handover can deplete the availability of ambulance resources to respond to incoming 999 calls in the community. On top of the actions listed above to reduce the number of 999 patients taken to hospital, during peak periods of activity we will ensure that in line with the recommendations of the WAST internal audit report on hospital handover that robust operational management arrangements are in place to manage patient flow at the front door to enable the safe and timely handover of ambulance patients.

We will continue to engage and collaborate with the ambulance service to support service transformation / service change proposals through our existing joint planning mechanisms. This will include future changes to our Stroke models and the transition period of the Bridgend Locality boundary changes. In addition to our work with ambulance partners the Health Board will be continuing to drive towards treating 25% of A&E attenders through ambulatory care pathways.

We have also taken up the offer of the Care and Repair Wales (CRW) to support at Morriston and Neath Port Talbot hospital through a targeted Assessment Service during Quarter 4 2018/19 to pilot this approach. The objective of the three month pilot is to link health and housing services by enabling CRW case workers to join ward rounds to identify needs of older people before they are discharged. We know that over 80% of patients using the service in Princess of Wales have fallen before and that it provides significant support for secondary prevention of falls.

Timely Access to Emergency and Urgent Care
The work we have done to improve flow over the last 18 months has highlighted that internal flow issues within the Emergency Department at Morriston need to be better understood. Following the Bridgend transfer, around 70% of our A&E performance will be driven by performance through the Morriston department. Last year our Plan described the workforce issues within the department which requires investment of around £1.5m. This is not affordable within the Health Board's financial plan in 2019/20 but will need to be addressed as recruitment opportunities present in future years.

The priority for 2019/20 is a shared understanding with senior staff about the cultural, clinical leadership, workforce and system issues that are influencing the performance within the department. The Health Board has commissioned improvement programmes for vascular, fractured neck of femur and Acute Medical Assessment Unit pathways and these will have a positive impact on emergency department flow in 2019/20. The Health Board is exploring use of the same diagnostic and change approach in the Emergency Department to develop a holistic improvement plan for 2019/20.

Additionally, we have trialled new direct-to-specialty pathways for general medicine, cardiology, respiratory and neurology, including hot clinics, in 2018/19. We will be gaining the full-year benefit of in 2019/20 and these approaches are built into our performance improvement plans as well as providing evidence-based, quality services for patients with chronic conditions.

We will also be concluding our work to change the workforce model and put in place sustainable primary care Out of Hours services for the new Health Board within the year as described in the Primary Care Plan.

Reduced patient risk through reduction in avoidable delays and prolonged hospital stay

We have reduced our length of stay in combined medicine by 17% over the last eighteen months but benchmarking shows that we still have major opportunities to further reduce length of stay, improve quality and reduce bed occupancy across our system. We will be aiming to achieve the Capita efficiency length of stay benchmarks which underpin our Clinical Services Plan over the next three years. These validated the work we had already done to underpin our Annual Plan 2018/19 and we will continue to build momentum in service change to achieve reductions, using the organisational learning from the last two years.

Our plan includes a mixture of service improvement actions which are within our gift as a Health Board, and the development of new services including a major step change in integrated community service provision through an integrated Hospital2Home service which will which will build on our existing partnership arrangements and Western Bay Optimum Model of Intermediate Care.

Our service improvement plan is based on the recommendations of the NHS Wales Delivery Unit review of complex discharges and the Right Care Right Place bed utilisation survey, both of reported in the latter half of 2018/19. Both of these reports show that we can improve quality and use prudent healthcare approaches to reduce variation in our internal processes. Our action plan, which will be driven through the Unscheduled Care Service Improvement Board includes targeted, detailed actions to further improve:

- SAFER board rounds
- Senior review before midday
- MDT clinical management plans for each patient
- Use of Estimated Date of Discharge methodology
- Standardised identification of patients who are Medically Fit for Discharge;
- Assessment processes for Continuing Health Care
- The number of, and bed days used by, stranded patients
- Use of the Red2Green methodology to improve patient care.

We will also be improving our Psychiatric Liaison Service to improve services for patients with mental health problems in our general hospitals to improve the quality of care and support discharge arrangements. Additionally, we will also be revising our escalation policy for 2019/20 to build on the 'safety huddle' approach to managing patient flow which has been supported by the NHS Wales Delivery Unit in 2018/19. This will recognise the required changes in the patient flow process, improve the management across our unscheduled care system, improve quality by clarifying the additional capacity protocol to risk-assess the use of 'pre-empt' beds and also prepare for the Bridgend boundary transfer.

As well as this focus on service improvement within our hospital systems we have also undertaken continuous planning work during 2018/19 which underpin this three year unscheduled care plan. Based on the previous Capita demand/capacity analysis in 2016 a linked series of plans to reduce length of stay and bed occupancy at Morriston hospital by rebalancing the underlying medical bed deficit of 40 beds has been developed. Several components of this have been tested with Winter Plan monies in 2018/19 including the hot clinics, expansion of the frailty at the front door service (OPAS), and a trial of the pathway co-ordinators. Not all of these schemes are affordable within the Health Board's financial plan for 2019/20 but we will be continuing to explore innovative investment approaches through Invest to Save or Value-based Healthcare or other sources to develop sustainable solutions going forward.

We have also taken the opportunity to revisit our dialogue with partners about the back door flow, as the rising numbers of DToCs and constraints in social care provision have become increasingly apparent as our internal processes have improved over the last year.

To do this we undertook the Right Care Right Place bed utilisation survey in October 2018 in partnership with our Local Authority colleagues. This helped to promote cultural change as it included a multi-disciplinary, multi-agency team of 71 staff undertaking point prevalence survey and using the results to undertake multi-agency, collaborative planning. The main findings of the report are include in the Plan on a Page which is in Appendix X. As well as the service improvement actions around ward flow which have already been described this identified major out-of-hospital opportunities to:

- Increase admission avoidance, particularly with regard to patients admitted for IVs by increasing the capacity and responsiveness of the Acute Clinical teams as well creatively using the ACTs as the Single Point of Access and to work with WAST partners to take from the ambulance stack;
- Put in place a default Hospital2Home 'discharge to recover and assess' service which will be the only gateway to assessment for patients' ongoing needs, by assessing at home and after /during reablement;
- Make a step change towards a default position of reablement at home instead of in hospital by increasing capacity in reablement at home services, thereby moving towards our Clinical Services Plan aim of moving Care Closer to Home.

Local authority colleagues strongly advised that there were limited opportunities to increase capacity social care due to the workforce and financial environment. However, based on the work of Professor John Bolton's work at Oxford Brookes University on out of hospital care, there is collaborative support for a Hospital2Home service to right-size demand for social care and maximise the prudent use of the existing resources. A Transformation Bid for the Hospital2Home service will be submitted to Welsh Government in quarter 4 2018/19 with the aim of putting the service in place for the winter 2019. The new service will link closely with our chronic conditions management services including the existing Early Supported

Discharge for COPD and it will also support the further development of Early Supported Discharge for Stroke which is described in the Stroke Care Plan. We will also be implementing our Liver Disease Plan which is included at Appendix X.

Major Trauma
The plans for Major Trauma are included in Appendix X.

Transformation Opportunities

Hospital 2 Home
In partnership with Swansea City Council and Neath Port Talbot County Borough Council we will take forward a new project to strengthen the Western Bay optimum model to become a Hospital 2 Home service. This is an outcome of the Right Place Right Care review findings which highlighted there is a great deal of opportunity to make changes, both within Health Board services, and in partnership with the Local Authorities to improve flow through the whole system, to use our joint capacity effectively and to improve outcomes for older people

The development of an agile Hospital 2 Home service that has the ability to assess, care and reable patients at home is based on recent social care research undertaken by Professor John Bolton of Oxford Brookes University. This service will maximise the independence of older people and ensure care packages are right sized before being put in place. It will be built around a trusted assessor model where assessment does not take place in a hospital bed and strengths-based assessments taking place when the patient is not in crisis. It is felt that this service could help to maximise the use of the existing social care capacity to best effect and ensure there is flow across the system.

Demand and capacity modelling supported by the work undertaken in the Right Care Right Place review will ensure a clear evidence base to underpin partnership working that delivers the right care in the right place for Older People. A Transformation Bid for the Hospital2Home service will be submitted to Welsh Government in quarter 4 2018/19 with the aim of putting the service in place for the winter 2019

Summary Plan and Enablers– Unscheduled Care

Actions	Milestones 2019/20	Measures	Lead
Improve **Flu Vaccination** rates for at risk groups to meet WG targets.	See Co-Production and Health Literacy section.		
Implement the **Neighbourhood Model** (Cwm Tawe).	See Partnerships for Improving Health and Wellbeing		
Roll-out **Primary Care Cluster**	See Primary Care section.		

Description	Q	Action	Ref	Lead
Reduce **Unnecessary Hospital Attendance** through admission reduction for the Big 5 in partnership with WAST (see EASC and NUSC templates), continuing multi agency approach to manage frequent attenders, and Care and Repair Wales pilot scheme rollout. Including falls response vehicle to reduce un-necessary conveyance to hospital.	Q1	Reduction in frequent A&E attenders (2018 baseline)	NDF_76 NDF_77 NDF_78	COO
	Q1	Evaluation of Care and Repair pilot scheme		
	Q4	Reduction in medical admissions (March 18 baseline) Reduction in the conveyance of non-injury falls patients from 18/19 baseline.		
	Q4	25% patients seen in ambulatory care pathways		
Ensure **Timely Access to Urgent or Emergency Care** through implementing assessment recommendations for vascular, Fractured neck of femur, Acute Medical Assessment Unit (AMAU) and ED pathways, maximising use of Medicine Neurology and Respiratory Hot Clinics and flexible beds.	Q1	Implement recommendations Fractured neck of femur, AMAU, vascular improvement programmes	NDF_77 NDF_78	COO
	Q2-4	Monitor effectiveness of improvement programmes		
	Q2-4	Monitor effectiveness of Hot Clinics		
	Q4	Implement recommendations ED pathways		
Reduce patient risk through reduction in **avoidable delays and prolonged hospital stay** through Implementing the NHS Wales Delivery Unit complex discharge audit recommendations and Right Care Right Place review recommendations.	Q1	Implement key priorities from audit recommendations Reduce variation in SAFER flow bundle Discharge process improvements	LM_18 HW_DP10	COO
	Q1	Implement revised Escalation and patient flow policies.		
	Q3	Monitor impact and improvement		
	Q4	Improve Psychiatric Liaison service (funding required)		
Rebalance medical bed capacity at Morriston through maximising the use of Early Supported Discharge for COPD patients at Morriston and Singleton, and the use of community hospital frailty beds, pathway coordinators (funding dependent), Green to Go ward relocation (funding dependents) and implementing OPAS pus (funding dependent)	Q1	Maximise early supported discharge for COPD and use of community hospital frailty beds	LM_18 LM_19 LM_20 HW_DP9	COO
	Q2	Implement Pathway Coordinators (funding dependent)		
	Q2	Implement OPAS plus (funding dependent)		
	Q3	Implement Green to Go (funding dependent)		
Draft Transformation Fund Bid for **Hospital2Home** service including new discharge to assess and recover model, expansion in reablement at home, expansion in acute clinical teams & Single Point of Access.	Q1	Final bid and service model signed off by RPB	LM_18 LM_19 LM_20 NDF_31 HW_DP10	DoS
	Q2	Recruitment and communications plan		
	Q3	Prepare implementation		
	Q4	Implementation		
Centralise the Acute Medical Take at Morriston and align with continued planning for the HASU (subject to any engagement/consultation requirements)	Q1	Commence planning and Critical path	NDF_76 NDF_77 NDF_78 NDF_66 HW_DP8	DT/ DoS
	Q2	Plan for wraparound ward agreed		
	Q3	Plan for 2nd MRI scanner agreed		
	Q4	Planning for HASU and Acute Medical Take aligned		

Workforce	Finance
• Centralisation of the Acute Medical intake at Morriston Hospital will require the Health Board to redesign the workforce to support this service change. • Develop new workforce models to support unscheduled care including; ➢ Integrating therapy and mental health staff into A+E, to support the turn around and management of patients at the front door.	• Transformation Fund Bid for Hospital2Home Service to be submitted Qu 4 2018/19 • Emergency Department workforce plan not included in Financial Plan

➤ An integrated service and workforce model, for Hospital 24/7 care at Morriston Hospital (w) which will Release time of qualified staff to manage the sickest patients in the hospital. ➤ Development of a sustainable Minor Injuries Unit working closely with Morriston and Singleton DU to enable an integrated workforce model across the HB. ➤ Utilisation of Pharmacists to reduce prescription turnaround times by increasing ward based dispensing, and ensuring early involvement in discharge planning with other health care professionals. • Transformation Fund Bid for Hospital2Home Service to be submitted Qu 4 2018/19 • Emergency Department workforce plan not included in Financial Plan – will need to be addressed in the medium term	– will need to be addressed in the medium term • Roll out of schemes tested through Winter Plan will be tested through Invest to Save and Value-based Healthcare approaches
Capital	**Digital**
• 2019/20 Enhance the Acute GP Unit and Medical Day Case Unit at Singleton to increase ambulatory care pathways • 2020/21 SDMU/Wraparound Ward and 2nd MRI scanner at Morriston • Prepare for the centralisation of the Acute Take at Morriston in 2021/22 • Major Trauma Unit included in regional plans	See Digitally Enabled Care section
Bridgend Transfer Implications	
Transfer issues are being addressed with WAST and the performance trajectories have been calculated on the basis of the new Health Board footprint.	

3.1.4 Stroke

The Health Board is committed to the All-Wales stroke care pathway and our top priorities for 2019 -22 are aligned to the national Stroke Delivery plan. Our Local Stroke Delivery Plan will continue to focus on working towards delivering the refreshed All-Wales stroke care pathway priorities in conjunction with partner organisations as outlined below:

- Increased identification and management of patients with atrial fibrillation to reduce risk factors.
- Reconfiguration of stroke services including the development of a Hyper-Acute Stroke Unit (HASU) ASU model.
- The development of community rehabilitation and Early Supported Discharge services.
- Enhancing the existing infrastructure for stroke research and continuous support for research and collaboration at recruiting sites.
- Developing and responding to patient experience and outcome measures.
- The management of childhood stroke.
- The provision of a confirmed thrombectomy pathway for stroke patients.

In the new Health Board, all acute stroke patients for our population will be admitted to Morriston Hospital. The future flow-based stroke model is based on a Hyper-Acute Stroke Unit (HASU) at Morriston Hospital for the wider regional area including West Wales. Collaborative planning is taking place with Hywel Dda Health Board about the regional stroke model through ARCH and this will continue in 2019/20. The implementation of the HASU model is also closely aligned with the planned changes in our unscheduled care system in Swansea as part of the clinical plan to centralise the Acute Medical Take for Swansea at Morriston hospital. More detail is included in the South West Wales regional planning Section x.

To assist with the joint planning, the two Health Boards have agreed to remodel the capacity required to ensure optimal patient flow along the stroke pathway and assistance with this has been secured from the NHS Wales Delivery Unit. Delivering the HASU model is therefore a joint regional priority for both Health Boards, but requires further significant programmes of work to be progressed including:

- The change to the acute medical model in Swansea and Hywel Dda UHB which is likely to be subject to a capital build at Morriston hospital.

BETTER HEATH | BETTER CARE
BETTER LIVES

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

BETTER HEALTH | BETTER CARE
BETTER LIVES

- Appropriate access to diagnostic capacity in Morriston hospital (CT capacity will be a constraint in supporting all strokes and mimic strokes for the new Health Board and part of Hywel Dda HB population)
- Changes to workforce models across medical, nursing and therapy staff to deliver a 24 / 7 day service.
- Agreement across the stroke pathway on patient flows and transport arrangements e.g. ambulance capacity, repatriation arrangements
- The development of an ESD service with sufficient capacity to facilitate timely patient discharge within both Health Boards.

Living Well: Work closely with partners to support and promote initiatives that help people to live healthy and long lives.

Stroke Prevention: Promote primary and secondary prevention through the intervention of treatment and advice to manage lifestyle and provide the appropriate pre-hospital interventions.

Early Recognition and Transition Ischaemic Attack (TIA): Provide early access to evidence based interventions. To maintain our rapid access to our ambulatory TIA clinics with a plan to centralise services using electronic referrals.

Fast Effective Care: For those with confirmed stroke, rapid access to evidence based interventions, treatments and care in the most appropriate hospital and ward. Having a dedicated stroke consultant rota (local or regional) within and out of hours will help achieve early effective care to all stroke patients.

Rehabilitation, Recovery and Life after Stroke: Recognising and addressing the lifelong effects of stroke on the patient and their family and carers and providing the right amount of therapy from the right therapists in the environment, acute hospital, community hospital or home. Establishing an Early Supported Discharge (ESD) service is our top priority to aid flow within the acute services.

End of Life Care: Ensuring that we provide the best palliative and the best support to family and friends at this time. This has been accomplished from a recent SIG funded end of life project but ongoing support by regular medical and nursing teaching sessions is recognised as a priority to continuously improve the care delivered to our service users and their families.

Service Improvement

Our overall aim in 2019/20 is to achieve improvement with the NHS Wales Outcomes Measures for improved access to care and support for patients across the stroke pathway and to deliver better patient outcomes. Our drivers are:

Living well and stroke prevention	We will reduce risk factors through the wider prevention agenda and fully implement a DES for Anti-coagulant Therapy (DOAC) through our Primary and Community Services Unit.
The provision of FAST effective care	Our actions will be to continue to make incremental gains in our stroke pathways through service improvement and the actions in our Stroke Delivery Plan. Improved performance in the early phases of the pathway. The arrangements for thrombectomy services for South Wales will be agreed through WHSSC by the start of 2019/20 and we plan to continue to develop our services. During 2019/20 we will continue to work with our regional partners to developing a HASU model through ARCH.
The provision of rehabilitation services to aid recovery and to promote life after stroke services	We will develop an Invest to Save proposal for Early Supported Discharge Services for stroke by assessing the effectiveness of existing rehabilitation services and inpatient care using VBHc methodology. This may also include trialling new service models on a non-recurrent basis through the national Stroke Implementation Group monies. It is intended that this service will be in place towards the end of Quarter 2 of 2019/20 which will underpin an improvement in performance in Quarter 3 onwards.
End of life care	We will maximise the use of our End of Life pathway through our work on our End of Life Delivery Plan.
Workforce Redesign	We will continue our workforce redesign programme within resources using Prudent Healthcare principles to expand 7-day cover across our key sites, including medical recruitment as opportunities arise.

Summary Plan and Enablers– Stroke

Actions	Milestones 2019/20			Measures	Lead
Improve healthy behaviours, particularly smoking cessation	See Co-Production and Health Literacy section.				
Provide **Fast, Effective Care** through promotion of FAST, continued development of TIA services, exploring the provision of Capture Stroke System to support real time reporting and establishing a Thrombectomy pathway through WHSSC	Q1	Thrombectomy pathway in place		NDF_66 NDF_67 NDF_68 NDF_69 LM_18 LM_19 LM_20	DPH/ COO/ DoS
	Q2	Explore provision of Capture Stroke system			
	Q3	Monitor development of TIA services			
Develop the **HASU** Model through ARCH	Q1	Regional model including regional rehabilitation to be presented to Health Boards for approval			DoS
	Q3	Detailed implementation plan to be signed off			
Improve **Rehabilitation Services** through capturing patient reported outcomes, Life after Stroke clinics, early supported discharge service and service redesign opportunities to develop and Early Supported Discharge	Q2	Patient Reported outcomes captures			COO/ DoS
	Q2	Business case for ESD submitted for approval			
	Q4	Improved access to Life after Stroke Clinics in place			
Ensure that all stroke palliative patients are managed in accordance with the **End of Life Care** pathway	Q1	Undertake Audit of pathway compliance			DN
	Q2	Audit Recommendations considered			
	Q3	Recommendations implemented			
	Q4	Monitor and review improvements			
Implement **Workforce Redesign** exploring expanding targeted 7 day cover, recruitment to medical vacancies to support 4 hour bundle and continuing staff training and awareness sessions of stroke pathway.	Q1	Staff training and awareness schedules in place			COO
	Q4	7 day cover in place			
	Q4	Recruitment to support 4 hour bundles			

Workforce Implications	Finance Implications
• In the new Health Board, all acute stroke patients will be admitted to Morriston Hospital. This will require developing workforce models which will be based on more innovative multi-professionals working. • We are developing roles within our stroke wards i.e. Pathway coordinator roles to support qualified staff. • Continued training of our staff (for stroke pathway) will develop skills to provide the best care for patients.	• Invest to Save proposal for ESD for Stroke to be considered in Quarter 2
Capital Implications	**Digital Implications**
• Planning support for the HASU model through ARCH	See section 2.3
Bridgend Transfer Implications	
Future regional flows for stroke patients resident in the Bridgend area to be reviewed and agreed in the light of the transfer. Our performance trajectories have been calculated based on the new Health Board's resident population and service provision.	

3.1.5 Planned Care

The Health Board engages fully in the National Planned Care Programme and supports the delivery of outcomes that matter to patients through sustainable services delivering care closer to home where possible. Our ambition is to transform our surgical services model to better meet patient needs, reduce access times, to improve efficiency and to reduce unnecessary travel to and attendance at hospital appointments. We will continue to drive forward improvements based on our achievements in 2018/19.

Our aim is to have sustainable planned care services, and to improve patient outcomes and experience by changing our outpatient model, ensuring efficient use of resources, reducing waiting times for surgery and reducing cancellations of operations. In line with the Clinical Services Plan, we will modernise our outpatient model by using digital technology, self-care, telephone and digital appointments and removing follow-ups as a default model.

The Clinical Services Plan modelling undertaken by Capita identified that we have significant opportunities to improve theatre efficiency by using all of the Health Board's theatre capacity effectively. Our planned care plans are based on achieving the underpinning efficiency assumptions for the Clinical Services Plan for outpatients, day case rates and theatres over the medium term, with significant improvements in 2019/20.

Through our service remodelling work over the last eighteen months we have released bed capacity at Neath Port Talbot and Singleton hospitals which can be used to maximise the use of the vacant theatre capacity on both sites. Specifically we plan to increase the surgical presence for both ENT and General Surgery at Singleton Hospital for a range of cases suitable for the hospital infrastructure. A detailed plan to redesign our surgical model, in line with the Clinical Services Plan to separate elective and non-elective surgery as far as possible, based on clinical risk assessment, will be worked up in Quarter 4 of 2018/19, in readiness for implementation in April 2019.

Our aim is to stop our reliance on outsourcing for all specialties apart from orthopaedics by the end of 2019/20, with plans for orthopaedics to be in place for following years. We will use all of the opportunities we have identified regionally with Hywel Dda University Health Board to achieve this aim, as outlined in Appendix X but, due to the opportunities identified in both Health Board's revised demand and capacity modelling, we will not be pursuing an Elective Orthopaedic Centre as a standalone unit in the shorter term.

As described in our Primary Care Plan we will also be using all the opportunities afforded by the rollout of the Cluster Model to move to community-based planned care wherever possible for Eye Care, Oral Health and Audiology as well as putting in place our primary care diabetes model.

Demand and Capacity Modelling
We have undertaken demand and capacity modelling at a specialty level and have received expert input to this process from the All Wales Delivery Unit. Our approach has been to utilise efficiency and productivity gain, along with service change plans in outpatients, diagnostics and inpatients to move towards sustainable models. Whilst this approach does not achieve sustainability on its own, we are realistic that a level of investment will be required to increase baseline capacity and this is factored into the demand and capacity models. Our planning shows that we can achieve surgical sustainability from December 2019 (a position that the Health Board has previously never achieved). This allows a far more focussed and effective methodology for the reduction backlog to be developed and we plan to do this over a 24 month timeframe. This will also support a very direct approach to further driving efficiency and productivity in our theatres.

Regional Planning and Delivery
In line with the national priorities we will be driving best practice through the National Planned Care Programme plans and we will be working together with Hywel Dda University Health Board to maximise our opportunities. Our plans and deliverables described in the South West Wales regional planning section in Appendix X. The thoracic surgery centre and major trauma service developments are describe in the same Appendix in the NHS Wales Collaborative section.

Eye Care and Ophthalmology

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Our Eye Care Delivery Plan is included at Appendix x. In 2019/20, additional recruitment of staff will support the Health Board in meeting the required clinical timescales for our Glaucoma patients. We continue to work to put in place Ophthalmology Diagnostic and Treatment Centre (ODTC) services into primary care clusters with the ultimate aim for 75% of all Glaucoma patients being reviewed by an alternative to a doctor in their own communities.

In addition we have set up a Gold Command Task and Finish Group to review the backlog of all ophthalmology patients and will develop an action plan to address and reduce any potential risk / harm to patients. This will also require a focus on accommodation to deliver the proposed changes. We are planning to increase the level of virtual review of patients through the utilisation of new digital equipment that has been recently procured that will allow patients such as the ODTC Glaucoma / Diabetic retina activity to reviewed via a virtual clinical office arrangement thus freeing up additional clinic slots for dealing with our demand.

The Health Board will continue supporting the National Business Case for the roll out of the Ophthalmology Electronic Patient record system for improved communication, provision of advice, governance arrangements when patients are managed in primary care, improved recording and sharing of patients' records and general education.

Oral Maxillo Facial Surgery and Oral Health
Our Oral Health Delivery Plan is included in Appendix X. We also plan to implement an oral medicine service which will direct demand for this cohort of patients to a model outside of hospital and which will increase the sustainability of OMFS.

ENT and Audiology
The best practice guidelines that have been agreed within the National Planned Care group are being implemented however there remains an outstanding area of clinical review which is currently being undertaken. ENT equipment purchased during the last financial year is now delivering greater access to procedures being undertaken in outpatient clinics rather than main theatres and the full benefit of this will be maximised in 2019/20.

The Audiology Service investment agreed in 2018/19 will be fully up and running for referrals to be triaged by community-based audiologists rather than secondary care consultant teams which has added 1,800 slots to our baseline that we no longer have to cover through non-sustainable solutions.

Transformation Opportunity
Case Study: Outpatients
In 2017/18 we had 260k referrals and saw 206k outpatients and there were about 16,600 new outpatient DNAs per year. We had a recurring demand/capacity gap of 10k that had been stable for some time (there is a lot of attrition on the waiting list).

Efficiency Targets
In our 2018/19 Annual Plan we did our own modelling and set efficiency targets which were based on a three-year programme to achieve sustainability.

If we reduced our DNAs by 20% and our new referrals by 3% over 3 years this would put us back in balance (3,320 DNA slots and reduction of 7,000 referrals = 10,000 slots). 2018/19 targets were set of 10% reduction DNAs and 1% reduction in referrals.

Achievement
By November 2018 we had nearly achieved the 1% reduction in referrals through use of digital transformation - our e-referral system with Cluster Lead challenge and self-care through Patient Knows Best. We have reduced DNAs by almost 7%.

The Capita modelling for our CSP validated our own modelling – and therefore we're on our way to sustainability in outpatients.

Urology
The service continues to build on the number of patients who are seen in our virtual PSA clinics – at December 2018 this is now around 1,200 patients. In 2019/20 the service will introduce the "Patient Knows Best" (PKB) smartphone system to facilitate self-managed care which will allow appropriate PSA patients to access their own results via the PKB system.

The NICE Guidance on the use of mpMRI are currently under review. When approved this will lead to greater use of mpMRI within the clinical pathway and which potentially will reduce the need for more intrusive intervention and repeat outpatient appointments. This will feature in our diagnostic plans in future years.

Orthopaedics

The NWIS PROMs system is being rolled out for the patients who will be mainly discharged at 6 weeks post-surgery and then followed up through the NWIS PROMs system at agreed intervals which will release outpatient slots for greater numbers of patients to be seen. The MCAS service is reviewing the option of relocating Practitioner Physiotherapists into GP Clusters to enable them to review patients within their own communities. In addition we will be maximising the use of our own theatre and bed capacity to protect elective orthopaedic activity and reduce reliance on waiting list initiatives and outsourcing.

Dermatology

This remains an area of national and regional concern particularly around the medical manpower availability. A paper has recently been prepared by Clinical Chair of the National Dermatology Group to enhance arrangements for medical staffing within the specialty with recommendations to be rolled out during 2109/20. The service continues to support the electronic referral with photograph attachments to provide advice and guidance to General Practice thus saving patients having to be seen in a clinic.

Service Redesign to improve Efficiency
Outpatients

Our Planned Care Improvement Plan 2018/19 has already made a difference to outpatients' access with fewer patients now on waiting lists than in 2017 and higher numbers of patients with shorter waiting times. However, we recognise that we still have much to do both in using technology to provide virtual solutions and to improve waiting times. This includes:

- Better recording into systems of patients being seen as virtual patients / self-managed.
- DNA rates will continue to be reduced through an extension to the current Text Messaging service.
- The validation team will reduce appointments being sent to patients not requiring review but which are currently recorded as Follow Ups Not Booked (FunB).
- We will plan to implement a system to maximise the efficient use of the clinical rooms within outpatients departments

With our ambition to bring care closer to the home we will be working with the Cwmtawe Cluster as the pilot cluster to explore potential service shift in the following areas:

- Phlebotomy / Warfarin management services
- Rheumatology patients
- Surgical review clinics in the Cluster.

Theatres

The Health Board established a Theatre Board in 2018/19 to provide greater scrutiny of theatre performance. The Theatre Information Dashboard will be reviewed with reflective performance targets and proposed Theatre Improvement Targets as follows:

Area	Target	Current Position
Late Starts	No more than 25%	42%
Early Finishes	No more than 20%	41%
Cancelled on the day, patient	No more than 10%	30%
Cancelled on the day, clinical	No more than 10%	23%
Cancelled on the day, non-clinical	No more than 20%	47%
Increased Utilisation	85%	75%
Cancelled Operations	No more than 10%	24%
Sessions cancelled at short notice	No more than 5%	9%
Increase theatre productivity	By 10%	
Reduced additional ad hoc Waiting List initiative work / cost avoidance initiative	By 50%	

Centralising the Pre-Admission services in Morriston has facilitated better working arrangements with the booking teams in 2018/19 and we will maximise this approach in 2019/20. This will improve the performance of the pre-assessment services through ensuring all appropriate pre-assessments are undertaken prior to a patient being sent for admission, following agreed clinical guidelines for admission and surgery, screening patients and improved multidisciplinary working with clinical teams. In addition we will be introducing weekly collaboration meetings between the delivery unit theatre senior teams to ensure all resources are maximised to their full potential and reduced cancelled on the day patients.

Summary Plan and Enablers– Planned Care

Actions		Milestones 2019/20	Measures	Lead
Continue with MCAS arrangements and as appropriate extend service provision (i.e. Joint pain injections) - with waiting times to be maintained at 8 weeks maximum	Q1	New joint injection model to be implemented by end of Q1	HW_DP7	COO
	Q2	Complete further review of modernisation opportunities for MCAS model		
	Q3	Implement further actions identified through review.		
Extended use of e- referral / Tele dermatology for advice and support into General Practice and extend funding of additional clinical fellows across Wales as part of national action plan.	Q1	Continue roll-out e-referral/Tele dermatology to GP practice	HW_DP10	COO
	Q2	Finalise funding for clinical fellows		
	Q4	Recruitment of clinical fellows		
Introduce Audiology Pathway with referrals as appropriate directed into the Audiology Service.	Q1	Continue with monitoring new audiology pathway and reduction of referrals into secondary care	HW_DP6	COO
	Q3	Extend pathway arrangements		
Increased use of Optometry / Non-Medical services to monitor and refer patients following appropriate guidelines	Q1	Introduce ODTC into strawberry place/Cwmtawe Cluster	NDF_63 HW_DP7	COO
	Q1	Embed Ophthalmic Priority Measures across the Health Board.		
	Q2	Make available additional accommodation in Singleton for increased non-medical face to face contacts		
	Q3	Finalise manpower plan for ophthalmology/clinical nursing team		
	Q4	Appointments into new skill mix		
Implement Welsh Government priority arrangement to new and follow up patients.	Q1	Continue with implementation of planned care programme	NDF_62	COO
	Q1	Update WPAS to accommodate new definitions around virtual clinics, see on symptom and self-managed care		
	Q1	Agree investment into validation team into IBG		
	Q2	Appoint into validation team		
Improve Theatre efficiency and utilisation including ENT/ orthopaedics access to Singleton and Neath Port Talbot theatres	Q1	Agree and implement action plans with delivery units	LM_33 LM_34 LM_35 NDF_63	COO
	Q1	Agree information requirements with information team and delivery units		
	Q1	Re-energise existing theatre efficiency board		
	Q2	Monitor changes to efficiency and reallocate theatre sessions across delivery units as appropriate		
	Q2	Reallocate lost funded theatre session for urology to enable return to balanced service provision		
	Q2	Ensure Cataract throughput is equalised or improved upon in Ophthalmology.		
	Q2	Implement "Open Eyes" or equivalent to oversee PROMs activity / protocols in Ophthalmology		
	Q2	Introduce / Embed Virtual Clinics and build into Consultant / Non-Medical staff job plans.		
ENT access to Singleton theatres to utilise for routine and high activity capacity	Q1	Establish 1 all day ENT operating list at Singleton Hospital	LM_33 LM_34 LM_35	COO

General Surgery access to Singleton theatres to utilise for routine and high activity capacity	Q1	Establish 1 all day General Surgery operating list at Singleton Hospital and 1 all day list at Morriston	LM_33 LM_34 LM_35	COO
Implement a revised hand surgery model across plastic surgery and orthopaedics to stabilise capacity and demand	Q2	Consultant recruited and delivering agreed new job plan	HW_DP7	COO
Recruit 2 gastroenterology specialist nurses and 2 consultant gastroenterologists to increase sustainability of gastroenterology service	Q2	Post holders in place and delivering capacity	HW_DP8	COO
Ensure Cataract throughput is equalised or improved upon in Ophthalmology.	Q1 to Q4	Ensure delivery of revised baseline D&C model for sustainable ophthalmology cataract treatments	NDF_63 HW_DP7	Assoc Dir of Perf

Workforce Implications	Finance Implications
• Workforce changes have been implement and roles developed to reduce length of stay and demand in other parts of the service For example, Audiologists dealing with more complex cases which will reduce demand on ENT. • Advanced practitioners have been developed to lead clinics to reduce Consultant Waiting times. For example, Advanced Practice Physiotherapists. • Development of therapy roles to reduce length of stay for patients. For example, Dietitians ensuring nutritional optimisation prior to surgery.	
Capital Implications	**Digital Implications**
• HSDU Centralisation – by end 2021 • Third catheter laboratory at Morriston expansion in 2020 • JAD accreditation for endoscopy suite at NPTH to be reviewed • Thoracic surgery centre at Morriston – by end 2021 • Post-Anaesthetic Care Unit to be developed at Morriston in 2020/21 • Reviewing need for a Hybrid vascular theatre and new vascular laboratory at Morriston • Centre of excellence - utilise spare space in NPTH made available by endoscopy moving • Colonoscopes and associated equipment	See Section 3.3
Bridgend Transfer Implications	
The resilience of planned care services across the Health Board will be supported by detailed LTA and SLAs in development through the Bridgend transfer process. This includes services provided at Neath Port Talbot Hospital which will be supported by Cwm Taf UHB after the transfer.	

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3.1.6 Cancer

Our plans are based on the delivery of our Cancer Delivery Plan which is included in Appendix X. Our other priorities are described here which are to plan to deliver the Single Cancer Pathway and to improve our performance against the existing national Outcomes measures.

We are also supportive of the **Case for Investment in NHS Wales Cancer Services** which has been submitted to Welsh Government by the Wales Cancer Network (WCN).

Single Cancer Pathway (SCP)

The Health Board's Single Cancer Pathway Delivery Plan is in place to implement the Single Cancer Pathway by April 2019. All our delivery units are committed to improve compliance against the national cancer optimal pathways with recommendations and action plans being monitored and progressed through the Cancer Improvement Board.

It is estimated that, in order to diagnose all patients with suspected cancer within 28 days, an additional 20% diagnostic capacity (predominantly endoscopy, CT, MRI and pathology) is required. This is on top of a year-on-year increase in diagnostic demand of 8-10%. Work is ongoing within the Health Board, and with Hywel Dda colleagues to develop more robust capacity and demand models in order for us to have an accurate understanding of the additional capacity requirements, and to address the additional capacity required. Summary plans are included in the box below.

The Health Board will also have to track significantly more patients from the point of suspected cancer. In preparation for this we have developed a live Cancer Dashboard that will allow the user to access current queue information.

No single system will automatically capture point of suspicion to start a patient clock and prompt tracking. This is still the biggest risk at present, in terms of a tight process that identifies all patients. It also means that we are not able to establish the full size of the demand of patients who will need to information for all Computed Tomography (CT), MRI and Ultrasound scans for all urgent suspected Cancer, Urgent and Routine scan requests received in the Health Board. This will continue to be developed in 2019/20 and will allow us to power models of the system which will allow us to track patients

Pathology
- Introduce 'short cycle' rapid processing of biopsy samples.
- Work ongoing on a current queue dashboard.
- Implement the first Digital Whole slide scanner into Pathology.
- Continue with workforce redesign plans.

Radiology
- Projected 20% increase in demand will require:
  - Use of mobile MRI vans.
  - Increase Radiology and Radiographer establishment to support (including Sonographers).
  - Increase administrative support to fast track increased number of bookings.
  - Uplift in consumables and kit maintenance required.
  - More outsourced Radiology reporting.
  - 8am-8pm across cross sectional modalities.

Endoscopy
- Back log reduced by insourcing.
- Increase job planning sessions for Endoscopy.
- Ensuring that diagnostic targets are maintained through demand and capacity planning across the region.
- Maintenance of Bowel Screening targets.
- Increase workforce – Consultant Gastroenterologists and Nurse Endoscopists

effectively and to ensure we have enough capacity available to complete the diagnostic phase of the new single cancer pathway.

A full demand and capacity profiling exercise of USC, Urgent and Routine work has been undertaken for the Endoscopy service delivered via the NPTH, Singleton and Morriston units looking at delivery of bronchoscopies, gastroscopies, colonoscopies, flexible sigmoidoscopies or any dual combination of the previously mentioned procedures within those units. This work and intelligence will also be utilised to prepare for the introduction of Faecal Immunochemical Testing (FIT) from early 2019.

Straight to test protocols for patients referred to gastroenterology on suspicion of a lower gastrointestinal cancer, to reduce overall pathway waits has been implemented. We have already piloted a rapid diagnostic centre, and secured funding to extend the concept and more recently, based on the success of the model and its extremely beneficial contribution to implementing a single cancer pathway, secured further funding to provide timely access to diagnostic testing. We will be developing and embedding this model as part of our roll out of the single cancer pathway.

We will establish routine liaison mechanisms between primary and specialist care to provide patients with seamless transition from secondary to primary care. Whilst the Health Board expects to be able to mirror the SCP

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performance that is currently being submitted throughout 2019/20, the ongoing work around recording the Point of Suspicion will need to be completed to confirm this estimated position. There has been ongoing work by the WCN to refine the definitions of point of suspicion. Configuring our systems and implementing reporting matrix for the Health Board is time consuming and can only fully commence once the final definitions have been agreed. This has impacted on our originally planned timescales.

No single system will automatically capture point of suspicion to start a patient clock and prompt tracking. This is still the biggest risk at present, in be tracked and have diagnostics within the 28 days. Without timely notification of a patient being placed on the SCP, patients could be identified at such a late stage that delivery of the target would be unachievable. In the absence of a national solution to this, we are reviewing the National systems in use, such as WPAS; LIMS; RADIS and how we can establish local practices that would allow timely recording and/or identification of patients with a new suspicion of cancer.

The increase in diagnostics needs further analysis and demand and capacity assessment. Whilst these are not necessarily additional investigations, they will need to be provided in a far quicker timeframe and in most circumstances, non-cancer work is delayed to ensure cancer work is undertaken at the earliest opportunity. Demand and Capacity is a huge piece of work with so many components of a cancer pathway that also has a significant impact on non-cancer RTT. However good progress is being made by the local cancer improvement/information team to understand this in support of planning requirements.

Fundamental to the success of delivering the Cancer targets is the tracking process behind it, which pushes and pulls patients through the next step of their pathway. The tracking resource required to deliver this additional demand needs to be quantified, as we already know that tracking capacity has been a constraint in the management of cancer within the Health Board, and it often forms only one part of job plans. The increased volume of patients will undoubtedly burden the current staff in tracking posts with increased risk to specialties. Detailed assessment of this will be undertaken by the individual Delivery Units.

In terms of data capture, a number of component waits need to be reported. The WCN have asked Health Boards to submit a monthly dataset of confirmed malignancies treated in order to commence a review of these measures by HB and by tumour site. The Cancer Improvement/Information Team are pulling together the dataset required to ensure we can fully contribute when required. The Cancer Improvement/Information Team will commence work to scope automation of this data via the Cancer Information Portal/Dashboard for live monitoring and reporting purposes.

Aligned to the delivery of the single cancer pathway and fundamental to detecting cancer earlier is the establishment of demand and capacity modelling as core business in service delivery plans. This will support the identification of the diagnostic capacity required to achieve the diagnostic elements of the single cancer pathway.

Improving Performance

As highlighted in last year's plan the tumour sites with particular issues with regard to performance are gynaecology, urology and breast. During 2019/20 we will gain the benefit of pathway changes in urology which will minimise breaches in that specialty. We will also maximise the benefit of the Post-Menopausal Bleeding clinics in gynaecology which we introduced this year. Our breast services have also benefited from recruitment into key specialist posts. All of these actions will contribute to improving our performance of against the existing cancer targets. In addition we will be using PROMs as a mechanism for improving experience and access through our Value-based Healthcare work.

Improving Pathways

The Lung Cancer Multi-disciplinary Team will review and redesign the lung cancer pathway, ways of working and staffing to optimise opportunities to improve early diagnosis, patient experience and outcomes. A Macmillan Quality Improvement Manager was appointed at the beginning of September and has begun to review the lung cancer pathway in ABMU HB and will be establishing a joint collaborative with Hywel Dda for tertiary lung services following appointment of a Macmillan QI Manager at Hywel Dda.

We have already initiated baseline Patient Reported Outcome Measures (PROMs) collection in one of our lung cancer clinics. We will work closely with patients, colleagues from Hywel Dda Health Board lung cancer teams and the All Wales Cancer Network to extend this collection to follow up PROMs and to use this data to plan patient care and service improvement.

We will focus on national population-based screening for Breast Cancer, reducing variation and inequality in care and harm in its delivery and supporting care moving closer to the home. Our Breast Cancer Team aspire to achieve the best possible Standards of Care and will initiate collection of PROMs data with patients to ensure patient care plans are tailored to delivering what matters most to their patients.

One of the key priority areas to improve outcomes, reduce variation and support the implementation of the SCP is the development of common pathways across the NHS for specific cancer disease groups. Work has commenced with our Lung and Colorectal services to map and compare pathways against the optimal pathways to understand variance and consider improvements required at the various steps. This work will continue with the other tumour site groups.

Detecting Cancer Earlier: Improve patient outcomes through early detection - more curative, less intensive and less expensive treatments.

Delivering fast, effective treatment: Patients to receive prompt, effective high quality treatment and care in an equitable and sustainable service so that they have the best chance of optimising their quality of life and improving survival, reciprocated by patients taking responsibility for lifestyle choices that positively contribute to their treatment and care

Meeting Peoples Needs /Person Centred Care: Our patients to be placed at the heart of cancer health care with their individual needs identified and met so that they feel well supported, informed and able to manage the effects of living with and after cancer.

Improving Information Our Patients, health professionals and service planners will have access to appropriate information to help them make informed decisions about care and treatment. Ability to routinely access patient information about cancer presentation, access to treatment and outcomes including survival data to inform commissioning.

Cancer Strategy & Leadership: Development of a Health Board Cancer Strategy, that is clinically lead and supported by Executive Directors. Leadership and accountability for the delivery of the Cancer Delivery Plan defined.

Summary Plan and Enablers - Cancer

Actions	Milestones 2019/20		Measures	Lead
Improve **prevention** of cancer through improving healthy behaviours including smoking cessation, obesity prevention and reduction and prevention of alcohol related harm.	See Co-production and Health Literacy Section			
Detect Cancer Earlier through maintaining and expanding the service of the Rapid Diagnostic Clinic (RDC) (funding dependent), ensuring effective partnership working with primary care and Macmillan GP lead.	Q1	Rapid Diagnostic Yearly Outcome Report	NDF_64 NDF_65	COO
	Q2	Develop Business Case for RDC Expansion		
	Q4	Macmillan/Primary Care pilot areas identified		
Single Cancer Pathway Deliver the Single cancer Pathway Delivery Plan to implement the Single Cancer Pathway.	Q1	Stock & Flow modelling to establish capacity gaps	NDF_64 NDF_65	COO
	Q2	Review pathways against national optimal pathways		
	Q3	Unit action plans to comply with optimal pathways.		
	Q4	Unit action plans implemented		
Deliver fast, effective treatment including through ensuring robust Spinal Surgery Access for patients diagnosed with Metastatic Spinal Cord Compression (MSCC), and developing a strategic holistic plan regarding how the Acute Oncology Service will be developed and resourced.	Q1	MSCC Pathway agreed with C&VUHB	HW_DP6	COO
	Q2	Review of service and gaps identified		
	Q4	Acute Oncology Service Plan developed		
Deliver **Person Centred Care** through a transformational approach to cancer nursing ensuring that 100% of people diagnosed with cancer have a recovery	Q1	CNS review undertaken in cancer services	HW_DP5	DoN
	Q2	CNS review expanded - teams, activity, job plans		
	Q3	Evaluate efficiency and effectiveness of CNS teams		

package that includes a keyworker, Holistic Needs Assessment, associated care plan, treatment summary in Primary Care.	Q4	Report recommendations and key themes		
Improve **End of Life Care through** reducing admissions to Acute Hospitals at the end of life & supporting patients to remain in their place of residence, including through better utilising digital technology top capture information, better engagement and outcome measures.	Q1	Better utilise digital technology	HW_DP3	DoN
	Q2	Audit against national and local standards		
	Q3	Recommendations of Audit		
	Q4	Review admissions to acute hospitals at end of life		
	Q2	Live queue dashboards in endoscopy and radiology		
	Q3	Live queue dashboards in pathology/histology		
Strengthen **Cancer Planning & Leadership** through the development of a Health Board Cancer plan that is clinically lead and supported by Executive Directors and ensuring leadership and accountability for the delivery of the Cancer Delivery Plan is defined.	Q1	Finalise Cancer Plan	HW_DP8	COO
	Q2	Cancer plan in place and Cancer lead appointed		
	Q3	Implement Cancer plan		
	Q4	Review		

Workforce Implications	Finance Implications
• Expand Physiotherapy capacity in oncology treatment pathways e.g. thoracic to develop post op rehabilitation programmes (MDT) • Increase in Radiotherapy capacity by extending working day and staffing to HIW required levels to support current performance and a reduction in line with cancer standards. • Increased therapy input in to pre-habilitation to improve outcomes post treatment and to reduce length of stay, inappropriate admissions. • NMP pharmacists to strengthen and provide cross-cover within cancer. • Continue to develop cancer nursing posts to deliver the All-Wales Cancer Delivery Plan regarding key worker, holistic needs assessments, written care plans and patient experience • Increase in Radiotherapy capacity by extending working day and staffing to HIW required levels to support current performance and a reduction in line with cancer standards.	
Capital Implications	**Digital Implications**
• Convert and equip room to increase ultrasound capacity • PET/CT facility in order to provide clinical PET/CT imaging oncology patients requiring diagnosis, staging and treatment response. • Replacement of aging Radiotherapy Equipment (LinB, LinC, LinD and CT), possibly expand to a 5 linac cancer centre in Singleton • Consolidated services in fit for purpose facilities for Hywel Dda and ABMU Regional Histology and Laboratory Immunology for sustainable services to SW Wales • Ensure working group in place to work across all relevant deliverers of Systemic Anti-Cancer Therapies (SACT) • Source Outpatient clinic capacity and accommodation for one Day Unit merging High Dependency Unit and Chemotherapy Day Unit - New combined day Unit, and alternative accommodation for Haemophilia and Thrombosis staff and clinics. • Develop an Ambulatory Gynaecology Unit to include diagnostic, minor ops and outpatient facilities.	See Section 3.3
Bridgend Transfer Implications	
Breast cancer services at Neath Port Talbot Hospital will be supported to align with the MDTs for Swansea and Bridgend. Other support services will be included in the detailed LTA and SLA arrangements.	

3.1.7 Mental Health and Learning Disabilities

Learning Disability Services

At a national level new commissioning guidance has been issued in relation to learning disabilities and a new national programme for improving learning disability services is in place, run by the 1000 Lives Plus improvement team. The guidance emphasises the principle of starting from the point of helping individuals to lead an ordinary life with dignity, and co-producing appropriate solutions to help the individual and their family achieve the outcomes important to them.

A Learning Disability-specific health needs assessment has been developed as well as a common commissioning view that will be the basis of a modernisation plan from 2019/20 onwards. This will continue to be finalised in early 2019/20 in partnership with Cwm Taf UHB, Cardiff and the Vale UHB and the seven local authorities for Merthyr, Rhondda Cynon Taf, Cardiff, Vale of Glamorgan, Bridgend, Neath Port Talbot and Swansea.

The current model of service is not able to meet the changing needs of the population and a significant proportion of people are being placed in private placements, often many miles from their families. These placements can be very expensive and place significant pressures on both local authority and NHS resources. In order to deliver a modernised service that addresses these challenges and minimises the dependency on private services the Health Boards and Local Authorities will embark upon a transformation programme which will deliver a revised health and social care pathway. A clear and effective support pathway enables accessible information, and where required access to and provision of services and support.

Healthcare activities within the overall pathway

Within a high level pathway the Health Board delivers health related activity within a health and social care partnership that is focussed on overall outcomes in health and wellbeing. Our focus, in light of the guidance, existing policy and findings on our current service model is to:

- Shift existing balance of resources and provision to deliver more community based services.
- Deliver short term crisis interventions that are available 7 days per week to support people to remain in their own home.

- Deliver longer term support for people with complex co-morbidities that enables them to live as independently as possible.
- Provide education and training to support non-specialist services to better meet the needs of people with learning disabilities whether in primary or secondary care.
- Deliver inpatient NHS services that have a clear rationale and which form an integrated part of a person's overall care plan and where all other options for safe support have been ruled out.
- Deliver specialist forensic services for people with a learning disability that have close links with mental health services, probation and the police as well as providing placements where necessary as close to the person's support networks as possible.

Early Years Prevention

Expanding the availability of the Facing the Challenge Team (FTC) is a priority. FTC works in conjunction with partner agencies (Social Services, Education, Child Health, Voluntary Agencies, etc.) by providing an additional, specialist behavioural element to existing services. We aim to deliver a service that works across the age range to incorporate adolescence and young adults and supports smooth and effective transition. Transition is a process that takes place over time rather than a one off transfer of "case responsibility" and this multidisciplinary and multiagency service will support individuals, carers and families through this time.

Increased community services

Strengthening the size and skills available to all the Community Learning Disability Teams, enabling more individuals to remain at home during periods of crisis through early intervention and prevention. (There are 9 multi-disciplinary teams that include Psychiatry, Psychology, Nursing, Occupational Therapy, Physiotherapy and Speech and Language and also have access to specialist Dietetic advice and arts psychotherapy).

This will include:

- Refocusing the role of Community Learning Disability Nurses to support GP practices to ensure that all people with a learning disability have an Annual Health Check and are supported to access health services and interventions available to the whole population. This could be by

supporting GP practices to encourage attendance at appointments or carrying out follow up visits to service users where a health need has been identified.

- Support for existing Local Primary Mental Health Support Services to make reasonable adjustments to ensure the service is accessible for people with a learning disability and increasing access to psychological interventions for people with mild learning disabilities
- Support for early onset dementia services.
- Providing registered nurse input to enhanced supported accommodation schemes providing a supportive outreach function bridging the gap between mainstream and specialist services.
- Support for the production and implementation of Individual Development Plans (IDPs) for people with additional learning needs.

Liaison services
We aim to provide an acute hospital learning disability liaison service aimed at identifying and supporting vulnerable patients as soon as they are admitted to hospital and promoting better collaboration between the staff who look after them and to implement an Epilepsy pathway.

Short Term Crisis Services
There would be increased resources for the Specialist Behavioural Team and Extended Clinical Support services to provide a 24/7 Intensive Support Service to the most complex individuals in the community, with provision of crisis support. These services would be available across all Health Board areas and would work collaboratively with acute inpatient care as the gatekeeper for admission and facilitator of discharge. In conjunction with social services we will develop a 24 hour crisis line.

Appropriate inpatient provision
Provision of enhanced, specialist inpatient beds for people whose needs are highly complex and require a little longer to formulate a sustainable plan for them to be supported in an environment that they can call home. Including specialist settings for patients with autistic spectrum disorder, forensic needs and highly complex patients transitioning from child to adult services. This will include a continued but reduced capacity Acute Assessment Unit function to provide acute care for patients in crisis who cannot be supported in their home for a period until they return to an equilibrium where they can return home and continue to work on longer term plans. To deliver change

we are interdependent with partner agencies and require open communication with service users, families and the public.

The Transformation Fund bid will allow us to achieve our aims as follows:

Transformation Opportunity

The population and health needs assessments provide clear evidence of increasing demand for Learning Disability services. The current model of service is not able to meet the changing needs of the population with a significant proportion of people being placed in private placements, often many miles from their families, which disrupts family life and removes people from their community support networks. These placements can also be very expensive and place significant pressures on both local authority and NHS resources.

Together with our partners we will be:
- Agreeing a joint statement on the commissioning intent for learning disabilities and common strategic framework between 3 Health Boards and 7 local authorities.
- Developing and agreeing a multiagency proposal for transforming Learning Disability services which will be submitted to Welsh Government for support through the Transformation Fund.
- Securing change programme bridging funding to invest in community expansion to facilitate changes in the whole system of health and social care services for people with learning disabilities.
- Long-term rationalisation of our NHS learning disability estate to reduce number of isolated small inpatient units by bringing units together according to population needs.

Mental Health
Since 2012 the development and further improvement of mental health services within the Health Board has been framed by Together for Mental Health as the national wellbeing and mental health plan, and a drive for delivering quality care and support for some of the most vulnerable individuals in our communities.

In recent years this has been strengthened by the publication of the National Dementia Strategy as well as the introduction of the Social Services and Wellbeing Act and the principles embedded in the Wellbeing of Future Generations Act.

Our **Strategic Framework for Adult Mental Health** has been approved by the Board following further revision to incorporate the findings of a report commissioned by the Western Bay RPB on unmet Mental Health needs in our area. Developed with stakeholders and service users this strategic framework provides a clear direction of travel for enhancing the availability of services across health and social care that meet the needs of a wide range of individuals. It covers the whole spectrum of need; from building resilience at a community level to address low level wellbeing difficulties or isolation, to improving the range of specialist services available to people with the most complex needs.

A new model of services will be achieved by delivering a range of services which are available to everyone experiencing mental health problems, irrespective of the severity, aimed at prevention and earlier intervention. The new model aims to stop mental health problems occurring or getting worse, as well as providing earlier support for people whose mental health is deteriorating. This will include options to easily help people be confident to deal with problems themselves as much as possible and more complex interventions and approaches reserved for addressing more complex needs.

The Health Board, and Local Authorities within the Western Bay region have identified a series of priorities within the framework including:

- Increasing partnership working across Western Bay (pooling budgets, aligning, planning, commissioning and procuring services)
- Ensuring up to date, easily accessible information is available for service users, carers and professionals on help and support available
- Developing a single point of access for people requiring mental health services
- Strengthening progression pathways that prevent hospital admissions and promote early hospital discharge
- Delivering a strategic approach to ensure individual outcomes are met
- Strengthening the transition process
- Supporting people and carers in ways that promote independence
- Developing localised community support networks
- Developing a range of preventative services within the community
- Developing modern accommodation models
- Ensuring help and support packages are tailored to the needs of the individual and are reviewed appropriately

- Modernising day services
- Promoting an increasing the uptake of Direct Payments where appropriate
- Developing and strengthening support for people with substance misuse issues, particularly our prison population
- Developing clear pathways for people with dementia
- Promoting mental wellbeing and helping to build resilience for people, families and communities
- Working with people, families and communities to develop and provide mental health help and support.

Together we are developing a structured plan for putting these principles and priorities into practice. To support this we have aligned our Local Partnership Board and commissioning board into a single group involving service users, carers and officials across primary and secondary, health and local government. This new Board sits within the governance structure for the Regional Partnership Board, further strengthening our opportunities for delivering more integrated solutions to population-based issues.

Psychological Therapies

The delivery of Mental Health services is consistent with the requirements of Part 1 and Part 2 of the Mental Health (Wales) Measure (2010) and this has served to shape the development of services in recent years. The development and publication of Welsh Government guidance on psychological therapies, Matrics Cymru, has further enforced that there is a pressing need for coherency in the service model, with clear access routes and flow through the system, to ensure that people with assessed psychological needs are seen in the right place at the right time.

We are developing and implementing a project to increase the pace of access to High Intensity Psychological Therapy by taking a systemic approach and developing a psychological therapy service that provides a stepped model of care. It is intended that this will enable individuals identified as requiring psychological therapy to receive the most appropriate service to meet their expressed and assessed needs and to reduce variation in access to Psychological Therapies across our area.

With Welsh Government funding, in 2018/19 we have engaged with an external provider to undertake a psychological therapy waiting list initiative

that is addressing long waiting times, and have started our pathway redesign. Building on the pathway redesign, the plans for 2019/20 include investment in additional therapy resources that, based on current demand, will deliver a sustainable service to meet the new 26 week referral to treatment target for high intensity psychological therapies whilst also delivering improved access to low intensity psychological therapies.

Dementia and Older People's Mental Health

The continuing modernisation of services for older people with mental health problems will progress and be interweaved with the work of the Health Board's Older People's programme and the Western Bay's Dementia Action Plan working group.

The Health Board agreed that changes in the configuration of services for Older People with Mental Health care needs would be subject to multi-agency agreement through a cross locality group looking at the recommendations of the clinical review undertaken in 2017 and this group has been mapping existing service delivery to agree gaps for prioritising future change.

Following the investment of approximately £2m in community based health services in the last 2 years and the reduction of 52 inpatient beds for older people, it is important that we consolidate and evaluate the impact of the changes across the whole system. We will then continue to assess the opportunities in the areas of intensive short term services available 7 days per week to help people stay at home and simplifying pathways to support them and their families.

We are also clear that we need to look closely at our provision of memory assessment services in conjunction with primary care to help people who are worried about their memory to have timely access to diagnosis and subsequently receive practical and clinical support plans for them to live well with dementia.

We will positively contribute to the development of the Integrated Older Person's Pathway and Frailty Model across the Health Board. This will ensure we provide a person-centred approach to meeting the physical and mental health needs of frail older people through the development of mental health liaison within integrated teams and involvement in multidisciplinary care planning.

Summary of high level actions to implement our long term plans
- Development of Adult Acute Business case to replace the not fit for purpose estate still in use at Cefn Coed Hospital
- Reprovide the Psychiatric Intensive Care Unit within the new Health Board area
- A series of priorities for implementing the Adult Strategic Framework will be agreed by LAs and Health Board in partnership.
- Implementation of a sustainable service for providing high intensity psychological therapies in line with Welsh Government guidance and to meet new 26 week access target.
- Reconsideration of service model for Older People's Mental Health in patient care with local authorities as a result of boundary change
- Options for implementing a dedicated secure service for women as part of a mental health pathway for women
- Reviewing safe staffing across services and in particular as part of OPMHS further modernisation taking account of impact of legislation.

Substance misuse services
Alcohol and drug misuse are widespread throughout our society, and while the number of people with serious problems is relatively small, the impact on people's lives can be significant and is increasing. Our aim is to reduce the harm caused to individuals by substance misuse through our services, improve awareness and understanding of the dangers and to promote prevention, all by working collaboratively with partners.

We provide assessment, treatment and health based intervention services for people affect by substance misuse issues. We complement services provided by other agencies in line with the Working Together to Reduce Harm Strategy and the overall service is coordinated by the Area Planning Board for substance misuse which is hosted by NPT County Borough Council. Rather than being a separate service we have integrated the NHS substance misuse services within mental health and learning disabilities to join up provision more easily and in particular the comorbidity of mental health and substance misuse problems. We have incorporated Community Drug and Alcohol liaison workers within our General Hospital Liaison services to improve the advice and support available in the acute setting and also to provide a sustainable working environment for a small service.

We actively contribute to a Drug Related Deaths Task Group which reports to the Area Planning Board. In addition the Public Service Boards have instigated a multiagency Critical Incident Group in response to drug-related deaths and the threat posed by the phenomenon of 'County Lines' criminal gangs operating in our area.

Summary Plan and Enablers - Mental Health and Learning Disabilities

Actions	Milestones 2019/20		Measures	Lead
Suicide and Self Harm Prevention	(See section 2.1 Partnerships for Improving Health and Well-being)			
Long-term rationalisation of our NHS **learning disability** estate to reduce number of isolated small inpatient units by bringing units together according to population needs.	Q1	Agreement to joint statement on commissioning intent	NDF_9 PHF_3a PHF_3b PHF_6a PHF_6b	COO/ DoS
	Q2	Engagement with individual local authorities to share outline intent for change to the service		
	Q3	Development and agreement of multiagency proposal		
	Q4	Discussion about change programme bridging funding to invest in community expansion		
Development of Adult Acute Business case to replace the not fit for purpose estate still in use at Cefn Coed Hospital.	Q1	Development of Strategic outline Case (SOC)	PHF_3b PHF_6b NDF_30 NDF_87	COO/ DoS
	Q2	Submission of SOC & plan for development of Outline Business Case		
	Q3	Outline Business case development and stakeholder engagement.		
	Q4	OBC Work for submission in 2020/21		
Interim solution to reprovide **Psychiatric Intensive Care Unit.**	Q1	Interim solution scoped	PHF_3b PHF_6b HW_DP7	COO/ DoS
	Q2	Engagement with partners, public and staff		
	Q3	Plans developed for interim solution incorporating engagement.		
	Q4	Interim PICU solution implementation plan agreed and progressing.		
Implementation of the Adult Mental Health Strategic framework.	Q1	Identification of priorities within optimum model and agreement of phased change	PHF_3b PHF_6b NDF_30 NDF_72 NDF_87 NDF_88	COO/ DoS
	Q2	Formal sign off of priorities with local authorities for 2019/20 Development of investment plan for Welsh Government Health and Social care funding		
	Q3	Work streams established, phased delivery of service models planned Review of Third sector mental health provision to inform commissioning plan		
	Q4	Engagement/ consultation on service changes and identification of Capital requirements		
Implementation of a sustainable service for providing high intensity psychological therapies to meet new 26 week access target.	Q1	Complete demand and capacity analysis & recruitment to new roles for sustainable delivery	NDF_71 NDF_72 PHD_43	COO
	Q2	Redesigned stepped model of care & pathway		
	Q3	Implementation of revised service model		
	Q4	Routine performance monitoring to maintain 26 week wait and evaluation of impact.		
Reconsideration of service model for Older People's Mental Health in patient care with local authorities as a result of boundary change	Q1	Reviewing safe staffing across services ; Evaluation of occupancy and admission rates	PHF_3b PHF_6b NDF_46 NDF_72	COO/ DoS
	Q2	Agreement of multiagency modernisation plan for actions of National Dementia Strategy		
	Q3	Implement any further changes to community provision based on evaluation.		
	Q4	Commence implementation of revised service model for inpatient services		
Work with partners to ensure robust alcohol and substance misuse services are in place	Q1	Review of Service model by Area Planning Board.	NDF_8 NDF_86 PHF_21 PHF_26 HW_DP2	COO
	Q2	Outcomes of review considered for implementation		
	Q3	Multiagency agreement of revised service model		
	Q4	Agreement of modernisation plan for implementation of revised service model		

Workforce Implications	Finance Implications
• Education and training will be provided to support non specialist services to better meet the needs of people with learning disabilities whether in primary or secondary care. • Redesign OPMH inpatient services will require more workforce resource to be moved to the community. • Existing Learning disability inpatient capacity will be redesigned to deliver services that will meet more complex needs requiring additional staffing across all staff groups. • Refocused role of Community Learning Disability Nurses to support GP practices to ensure that all people with a learning disability have an Annual Health Check and are supported to access health services and interventions available to the whole population. • Potential prorata increase in pilot workforce to cover demand for our Swansea population in line with the dementia action plan.	
Capital Implications	**Digital Implications**
• Undertake anti-ligature work across all inpatient sites for MH & LD services. • Commence implementation of the agreed optimum model for Adult Mental health services as outlined in the Western bay Strategic framework for Adults with mental health problems. Provide an implementation plan for the plan over the next 3 years.	See 2.3 and 3.3
Bridgend Transfer Implications	
There are a small number of service that are provided across the whole health board and these will be delivered under SLAs for the population of Bridgend. Longer term issues to be considered include the availability of rehabilitation for women, the adult acute assessment unit and reduced flexibility in adult acute inpatient services.	

3.1.8 Maternity Services

We know that a healthy mother is essential to giving a baby a healthy start in life. Maternity services are fundamental to both the health of the mother, her baby and wider society.

In December 2018, we refreshed and relaunched our Maternity Plan to set out our plans for the coming years. Our vision is for maternity services is:

"To work proactively with our partners to support women and families to give their children the best start in life. We aim to provide high quality, safe and personalised care, which is delivered in an evidence based, responsive and compassionate way in order to meet the needs of women and families."

Maternity services in 2018/19 have continued to work towards the Welsh Government Maternity Services Strategy aiming to achieve key performance indicators and implement care and services in line with national guidance. This has been achieved with the support of a highly skilled and committed workforce who when necessary are prepared to be deployed to another unit or clinical to support clinical activity and need. We have successfully attracted 27 newly qualified midwives into the Health Board with no current midwifery vacancies.

The core areas of work in 2019/20 for maternity services are to:
• Support maternal health including healthy weights and smoking cessation
• Increase the number of women commencing labour outside an obstetric labour ward
• Ensure the emotional wellbeing of women and their babies
• Address health inequalities through working with Local Authorities to provide additional maternity support to families with greater needs through, Flying Start services in Neath Port Talbot and Jigso in Swansea
• Develop foetal monitoring services
• Increase midwife-led new-born screening
• Continue to deliver the new Transitional Care Unit in Singleton Hospital.

Maternal and Pregnancy Health

The immediate priorities to improve maternal and pregnancy health will be to achieve the key performance measures for maternity services including:

- Increasing number of women booked by 10 completed weeks.
- Increasing number of women who maintain a Healthy Weight gain in pregnancy.
- Increasing in the number of women who stop smoking in pregnancy.
- Reducing caesarean section rates.

With over 30 % of pregnant women reporting they have some mental health concern it is important that we ensure the emotional wellbeing of women and their babies are met to reduce the long term effects of mental illness on families. We have identified that there is currently an unmet need which a specialist midwife could support. This will be explored along with seeking to provide support to women who can be managed outside of the mental health services provision (PRAMS) and reviewing requirements to have a specialist midwife in Perinatal mental health to support the health and wellbeing of pregnant women. The service is also fully engaged in the development of the Peri-natal Mental Health Unit within the Health Board footprint, commissioned by WHSSC.

Birthing Services and Support

A priority achievement will be improving patient flow through reducing elective caesareans, reducing delayed elective caesareans and inductions and reducing postnatal length of stay through the use of transitional care beds. We will achieve this through a number of actions including:

- Ensuring decisions for induction of labour and caesareans are monitored
- Avoiding delays in procedures due to acuity
- Identifying appropriate parent accommodation with babies in NICU to support additional demands in Singleton Hospital.
- Investing in dedicated caesarean section operating lists and implementing the ERAS model (level of activity and investment for his is being explored in more detail)
- Seeking to secure investment in anaesthetic/ midwifery/ consultant/ theatre staffing to support in order :
  - Reduce pre-op length of stay.
  - Reduce complaints.
  - Reduce out of hours theatre activity
- Aiming for 45% of women to commence labour outside of labour wards.
- Increase midwife led new-born examinations.
- Delivering the Transitional Care Unit in Singleton Hospital
- Development of South Wales Mother and Baby Unit commissioned by WHSSC to compliment perinatal services.

We will also work on workforce development to support improving quality, patient outcomes and experience, service sustainability and flow. This includes:

- Increasing midwife numbers to meet the requirements of birth-rate plus, if funded through development of a business case.
- Maintaining the training and application in practice of the guidance in Gap & GROW.
- Working towards implementing the All Wales Foetal Monitoring Standards – which includes a minimum of 6 hours training of clinical staff
- Securing funding to obtain a central monitoring system for foetal heart recordings in labour through development of a business case
- Ensuring the correct skill mix on the postnatal ward and community teams through increasing the number of maternity care assistant
- Successfully implementing the 'PROMPT for Wales' multidisciplinary training.

Post Natal Care

We will work with local authorities to provide additional maternity support to families with greater need (Flying Start services in NPT and Jigso in Swansea) in addition to increasing electronic working in the community setting with the introduction of iPad to community teams. The Health Board will also retain its Baby Friendly Initiative (BFI) accreditation through seeking to gain the necessary financial support and implementing breast feeding peer supporters onto the postnatal ward and potentially continue a rolling programme of new supporters.

Work will also be undertaken with the Dietetics services to identify resources to support additional nutritional advice training for midwives in order to support discussions with women to maintain a healthy weight in pregnancy and to learn about ongoing healthy diets for themselves and their children.

3.1.9 Children and Young People

In 2018 we launched our Children's Charter and the Board approved our ambitions for children and young people set out in our Children and Young People's (CYP) Plan; for our children to be safe, healthy, and able to enjoy life and grow up achieving economic well-being and making a positive contribution.

As part of the Health Boards commitment to ensure that children's rights are respected in all aspects of care across all specialities a Youth Board has been developed, consisting of children and young people (CYP) aged 14-23 years. The Youth Board will be translating the plan into a language that CYP can understand and hold the Health board to account for services for CYP. Members have been involved in consultation around services for CYP and aim to improve services and ensure the voices of CYP are heard. The members will be reporting to the Health Board's Executive Team annually around services that affect them. They have also been involved in national projects with the RCPCH and will be presenting at the conference in March 2019. They have also developed the levels of care for the All Wales Paediatric Acuity Tool. The Youth Board is in its early stages of development and it is envisaged that this will develop to include social care.

Child Health Development
Good progress has been made in 2018/19 across a range of childhood programmes particularly in relation to early years' prevention and immunisation. The Health Board is committed to delivering improved performance against the measures of the Healthy Child Wales programme. Significant to this is the continued strengthening of multi-disciplinary working across school nursing, health visiting and GP practices to ensure children and their families are supported across services. A forum will be established as part of strengthening this joint working to improve communication specifically between health visitors and school nurses. We will also work to foster partnership working across communities and clusters in line with the Parliamentary Review of Health and Social Care in Wales. Key actions include:

- Sourcing alternative accommodation to Central Clinic to improve staff experience

- Implementing All Wales Child Health Database (CYPRAS) system to improve data accuracy
- Reviewing waiting list management processes for community paediatrics to improve the use of capacity.
- Increasing electronic working – use of Document Management Systems and iPads for Health Visiting.
- Ensuring Health Visiting practice utilises the FRAIT tool in assessing the resilience and needs of the family
- Development and implementation of the All-Wales acuity tool for Health Visiting across the Health Board

Community Paediatrics
Achieving the Facing the Future Standards for Child Health published by the Royal College of Paediatrics and Child Health is a core outcome for the Health Board across community and acute paediatrics. These standards ensure high-quality diagnosis early in the unscheduled care pathway providing care closer to home where appropriate. Key to the development of community paediatric services and the achievement of the Facing the Future Standards is the development of a sustainable service model. In 2019, the Health Board will undertake a baseline assessment of services using the British Association for Community Child Health (BACCH) Essential Standards Toolkit for Community Child Health Services. This assessment will provide a measure and benchmarking of services aligned to the Facing the Future standards. Key actions include:

- Baseline assessment and benchmarking of services
- Agreeing sustainable SARC services across South West Wales
- Reviewing workforce opportunities following consultant retirements
- Achieving sustainable service model for audiology medical cover
- Increasing specialist nurse input into the continence pathway
- Implementing psychology support (funding dependent)
- Reviewing opportunities to include School Nursing/ Health Visiting
- Support primary and community care with development of wellness centres in Swansea and Neath Port Talbot in conjunction with ARCH
- Implement the Document Management System.

Acute Paediatrics

The priority for acute paediatric services over the medium to long term as we plan the centralisation of the acute medical take will be the development and implementation of an integrated paediatric urgent and emergency care proposal. The proposal will centre on the development and provision of a single point of access for paediatrics to improve the care for children and young people attending acute and emergency paediatric services by integrating paediatric medicine with the paediatric assessment unit. The expected benefits include increased emergency department attendance volume with lower percentage breaches, a decrease in inappropriate paediatric admissions, potential decreased length of stay for paediatric admissions is proposals includes a short stay option, improved compliance with Facing the Future standards. We also would expect the development to potentially result in the reinstatement of paediatric emergency medicine training status and improved recruitment. The plan for this development will be finalised in 2019/20. Key actions include:

- Developing a critical path for a single point of access for emergency paediatrics
- Reviewing opportunities to create a sustainable consultant and middle grade workforce.
- Reviewing requirements to increase specialist nurse input to specialist paediatric services including respiratory and allergy. Include succession planning for all specialist nurse posts.
- Implementing Psychology support (awaiting Welsh Government funding)

Neonates

The Health Board's plan to improve neonatal care sets out actions to ensure the Health Board meets both the British Association of Perinatal Medicine (BAPM) standards for hospitals providing neonatal care and the Bliss Baby Charter. The key development is the completion of the Transitional Care Unit to provide increased capacity for high dependency and intensive care in line with recommendations of the South Wales programme. Key actions include:

- Complete the Transitional Care Unit
- Implement workforce planning proposals to increase medical and nursing cover and a Workforce Plan for Neonates to meet BAPM standards, if funding is secured.
- Develop monthly performance information to inform development.

- Increase midwife-led new-born examinations through increased midwifery time covering weekends, if funding secured.
- Increase therapy input into the neonatal unit in order to meet the BAPM standards, if funding is secured.
- Implement Psychology support for mothers and families.

Neurodevelopmental Service

The pathway is predominantly led by schools who refer via a weekly multi-disciplinary MDT, however, GPs and families can also refer direct on completion of the recommended referral documentation. The development of the service continues across Wales, and is monitored by the All Wales Neurodevelopmental National Steering Group under the umbrella of the "Together for Children and Young People" Programme. Key actions include:

- Centralise Neurodevelopmental Team to improve staff experience, efficiency and capacity and maintain RTT of 80%.
- Complete capacity and demand modelling.
- Review benefits of psychology input and increased Speech and Language and Occupational Therapy.
- Improve outcome data through the implement all-Wales data collection requirements.
- Improve patient experience through increase pre and post diagnostic support to families

Additional Learning Needs

The Additional Learning Needs and Educational Tribunal (Wales) Act will come into force in September 2020. Demand and capacity planning work is underway to identify the increased provision of service this will require and the Health Board is committed to appointing a Designated Education Clinical Lead Officer (DECLO).

Child and Adolescent Mental Health Services

Western Bay partners have an agreed Delivery Plan for Emotional Health & Wellbeing for Children and Young People. The Delivery Plan has an agreed strategic direction underpinned with a series of specific actions and priorities. The aims that will continue to be embedded into future Delivery Plans are as follows:

- Improved accessibility to CAMHS and specialist advice & support
- Sustainable and accessible local services (including tiers 1 & 2)
- Develop and sustain the NDD Service
- Develop a better range of services for all children with emotional difficulties and wellbeing or mental health issues including transition and single point of access to services
- Develop multi-agency arrangements for children with complex needs.

Action has been taken to stabilise the Service to maintain the improved position including additional waiting list clinics, however it has become clear that changes that are more radical are required to transform the service model to provide a sustainable service in the medium- to long-term. The proposed integrated model will include a single point of access / entry to the service via a telephone triage system, which will allow all professionals working with children and young people to access advice and consultation from CAMHS, and onward referral into CAMHS where appropriate. The service will use the Choice and Partnership Approach (currently embedded within Secondary CAMHS) to facilitate provision of the right support, at the right time, to the right children, young people and families, by the right clinician from across the service.

The diagram below highlights the milestones to achieve an integrated model:

Phase 1 2018/19	Pilot with 2 GP Clusters to deliver CAMHS clinics in the community	Review demand & capacity for the single point of access and contact	
Phase 2 2019/20	Single base for CAMHS and implementation of a Single Point of Access	Further roll-out of community clinics in locations across Swansea and NPT	Initiate discussions on the full integration of P&S CAMHS
Phase 1 2020/21	Fully Integration of Primary and Secondary CAMHS		

The benefits of the integrated model include:
- Improved access for patients with shorter waiting times;
- Advice and support for professionals
- Appointments delivered at non-stigmatised outreach accommodation
- Reduced impact of vacancies in CAMHS
- Consistent decision making on assessment of referrals to reduce the risk of children and young people 'bouncing' around the system
- Compliance against Welsh Government targets

Summary Plan and Enablers – Maternity and Children and Young People

Actions		Milestones 2019/20	Measures	Lead
Children's **Strategy** Board to ensure delivery of the children's plan closely linked to the work of the Western Bay Regional Partnership Board	Q1	Membership reviewed and meetings reinstated	PHF_3a PHF_6a PHF_32 PHF_40 HW_DP6	DON
	Q2	Commencement of work plan		
	Q3	Ongoing completion and monitoring of work plan		
	Q4	Review of achievement and agreement of next year's work plan		
Agile working and technology enhancements in **Child Health Development**	Q1	Source alternative accommodation to Central clinic	PHF_32 PHF_40	DON
	Q2	Review waiting list management process for community paediatrics		
	Q3	Health Visiting practice utilises the FRAIT tool		
	Q4	Implementation of the All Wales acuity tool		
Community Paediatrics sustainable service model	Q1	Baseline assessment and benchmarking of services	PHF_3a PHF_6a	DON
	Q2	Review workforce opportunities; increase specialist nurse input in continence pathway.		
	Q3	Sustainable service model for audiology medical cover		
	Q4	Implementing psychology support		
Developing a single point of access and sustainable workforce model for **Acute Paediatrics**	Q1	Review opportunities to create a sustainable consultant and middle grade workforce.	PHF_3a PHF_6a	DON
	Q2	Review requirements to increase specialist nurse input		

	Q3	Developing single point of access at Morriston Hospital for emergency paediatrics		
	Q4	Implement Psychology support		
Progressing work aligned to the **Neonates** Transitional Care unit and a Workforce Plan to meet BAPM standards.	Q1	Develop a suite of monthly performance information to inform service development.	PHF_3a PHF_6a PHF_31	DON
	Q2	Implement workforce planning proposal to increase medical and nursing cover including increased midwifery weekend cover.		
	Q3	Increase therapy input into the neonatal unit		
	Q4	Implement Psychology support		
Neurodevelopmental team development to improve staff and patient experience	Q1	Review benefits of psychology input and increased SLT and OT	NDF_70 LM_22	COO
	Q2	Complete capacity and demand modelling.		
	Q3	Increase pre and post diagnostic support to families		
	Q4	Centralise Neurodevelopmental team to a single site		
Required changes to meet the **Additional Learning Needs** and Educational Tribunal (Wales) Act	Q1	Complete capacity and demand modelling	PHF_8 PHF_9 PHF_10	COO
	Q2	Assure and verify data through regional partnerships		
	Q3	Develop job description and undertake recruitment to meet service need.		
	Q4	Appointment of a Designated Education Clinical Lead Officer		
Phase 2 of an integrated model for **CAMHS**	Q1	Review demand and capacity for the single point of access	LM_23 LM_24 LM_25	COO
	Q2	Further roll-out of community clinics in locations across Swansea & NPT		
	Q3	Initiate discussions on the full integration of Primary & Secondary CAMHS		
	Q4	Single base for CAMHS and implementation of a single point of access		

Workforce Implications	Finance Implications
- Develop sustainable response to ALN reform and statutory obligation for children and young people 0-25 years with identified needs to have timely and equitable access to Dietetic and Physiotherapy Services. Will require Additional capacity for these staff groups. - Develop in/outreach respiratory post to support complex patients with acute respiratory exacerbations in the community - Phased implementation for an Integrated paediatric urgent and emergency care service at Morriston Hospital will Improve recruitment to ED posts and support the reinstatement of paediatric Emergency Medicine training status - Development of the paediatric workforce; reviewing opportunities (consultant, middle grade) and increasing nurse input into specialist paediatric services. - There will be a need to recruit additional Midwives at singleton Hospital to Comply with Birth Rate + standards. - To support workforce redesign the number of Maternity Care Practitioners will be increased through additional training.	
Capital Implications	**Digital Implications**
- Integrating paediatric emergency medicine with the paediatric assessment unit, to provide single point of access in the medium term. - Development of the Mother and Baby Unit.	See Digitally Enabled Care section
Bridgend Transfer Implications	
Agreements will be required for pathways for neurodevelopmental children over 11 years of age and on the impact on management structures will need to be reviewed accordingly.	

3.1.10 Older People

Improving the care we provide for Older People is an important part of our quality and safety plan for 2019/20 including our Quality Priorities of reducing falls, pressure ulcers and end of life care. We will also focus on the roll out of Comprehensive Geriatric Assessment, improving end of life care and reducing our laparotomy rates in older people. Under the Transformation Programme our formal Older People's Programme has been enhanced by the appointment of a Consultant Geriatrician as our Older People's Clinical Lead and has renewed Executive leadership under the Director of Nursing. Through this programme we will take forward our draft Frailty Model which has been developed with partners and mapped to the national iPOP pathway. This includes all steps of the pathway, including hospital and community provision of best-practice frailty services.

During 2018/19 we also, with our Local Authority partners, analysed our Older People's care system by undertaking the bed utilisation survey which included 757 beds and bed equivalents. These included inpatient care in our acute and rehabilitation hospital settings, and our Western Bay Optimum Model provision of reablement at home, reablement in step up beds and our Acute Clinical Teams. Through the Older People's programme we will implement our action plan based on this analysis which includes improvement actions within our own services as well as the development of the Hospital2Home service which will form a major component part of the out-of-hospital frailty model.

We will also build on the work we have already started to remodel our Older People's Mental Health services to rebalance services towards the community in line with best practice and national benchmarking. Additionally we will be working with our partners to implement the Western Bay Dementia Action Plan and to improve support for carers as we develop our detailed plans to move more care closer to home in line with our Clinical Services Plan.

Integrated Pathway for Older People

Component 1	Component 2	Comonent 3	Component 4	Component 5	Component 6
• Help me choose and age well	• Support me to stay well and support myself	• Assess and monitor me closely	• Step up my care	• Give me good hospital care	• Get me home safe and step down my care

Our Older People's plans are threaded throughout our Annual Plan as shown in the table below:

Section	Plans
Our Operating Model and Transformation Programme	• Older People's Programme
Partnerships for Improving Health and Wellbeing	• Health and Housing
Co-Production and Health Literacy	• Flu vaccination of over 65s
Quality and Safety	• SAFER flow • Comprehensive Geriatric Assessment • Falls • Stroke • Pressure Ulcers • End of Life Care • National Elective Laparotomy Audit
Unscheduled Care	• Reduction in falls through joint approaches with WAST and working with Care and Repair • Reduction in length of stay through SAFER flow and other service improvements to reduce the deconditioning effect of longer hospital stays • Hosptal2Home service
Mental Health and Learning Disabilities	• Dementia and Older People's Mental Health

3.2 Strategic Objective: Partnerships for Care

This section includes our partnership arrangements within the Western Bay Regional Partnership Board and Public Services Boards for Swansea and Neath Port Talbot. Our other key plans and delivery actions through regional partnerships and national arrangements are described in Appendix [insert]:

Western Bay Regional Partnership Board and Public Services Boards

Our partnership arrangements with Local Authorities and other key partners have been in place since 2012. Making the transition to delivering the requirements of the Social Services and Wellbeing (Wales) Act and establishing the associated Western Bay Regional Partnership Board was in line with this previous work and enabled the Board to be based on solid foundations immediately.

Our Western Bay Population Assessment and subsequent Area Plan have been developed on an inclusive basis with the resulting priorities being incorporated into individual organisation's operational plans and the Commissioning Intentions that guided the development of this Annual Plan included the Area Plan priorities and our Wellbeing Objectives. We are jointly proud of our record of achievement, including implementing the Western Bay Optimum Model of Intermediate Care and developing the Adult Mental Health Strategic Framework. However, in the light of the population needs assessment, the publication of 'A Healthier Wales' and the Bridgend transfer which will change the partnership significantly, the Regional Partnership Board has taken he opportunity to revise the 'Western Bay Offer' and to review the priorities and structures. This will strengthen our partnership arrangements with Local Authorities in particular as move forward as a new Health Board.

Our joint vision is to:
- Enable individuals to live longer, happier lives and take more control of their own health and wellbeing, including supporting others in their local areas by developing partnerships with a wide range of organisations and people from the public, private, third sector and communities to deliver support to people in local areas.

- Provide health and care for people that need it from people that act as one team and work for organisations that behave as one system.

The Wellbeing of Future Generations Act outlined that all public bodies in Wales needed to work towards the 7 Wellbeing Goals. The new Health Board, Swansea Council and Neath Port Talbot County Borough Council aim to work collectively, with other partner organisations, stakeholders and local communities to transform its services, at pace to achieve these goals. In doing this we will ensure the five ways of working identified in the Act are embedded in all that we do and how we do it. The Health Board and individual Local Authorities have also worked together since the inception of the Wellbeing of Future Generations (Wales) Act on developing Public Services Boards on an even more inclusive basis, and developed the associated Wellbeing Assessments and Plans effectively. However through this, the overlap between these various areas of work, and potential for duplication and lack of clarity over accountabilities has become clearer.

The Western Bay Partnership has also been committed to embedding co-production into its principles and ways of working, with the establishment two years ago of a Citizen's Panel who consider the Regional Partnership Board's work. Increasingly the Citizen's Panel is involved in the full range of the Partnership's work, as evidenced by the co-produced Western Bay Mental Health Strategic Framework for Adults. Since 2012, Western Bay has concentrated on implementing the "What Matters to Me Model (below)," in particular the elements of improving the Intermediate Care Tier, and Specialist Care with regards to Reviewing Individuals with Complex Need, which this year was presented with two All Wales Continuous Improvement Awards for the work in Collaboration and as the best Local Government Initiative.

The Board identified and supported the implementation of the "Optimal Model" via the Integrated Care Fund to ensure that all citizens from the region received the same services whatever their postcode. However Western Bay has always identified that this tier is only part of the model of care and that the prevention tier would need further focus in order to avert individuals entering the health and social care systems.

The plan to make a system change in the population health and prevention approach in Tiers 1 and 2 through the revised Western Bay offer is included in section [insert] in successful 'Our Neighbourhood Approach' Transformation Fund Bid. In the light of 'A Healthier Wales' and the transfer of the Bridgend population a review has been undertaken of the Western Bay 'Offer' as shown below. The Board's collective ambition is to:

- Work together to improve health and care for the populations we serve
- Plan and deliver care which reflects outcomes that matter to the people we serve and care for – we will check this through measures which reflect individual experiences and system wide impacts
- Seamlessly integrate care through a place/locality based approach - we will do this through pooling budgets and resource (staff/assets) on a locality basis
- Collaborate to manage the common resources available to us rather than adopting a "fortress mentality" in which each organisation acts to secure its own future regardless of the impact on others
- Have a single and simple governance structure – we will do this by integrating and streamlining Public Service Boards, the Regional Partnership Board and sub-structures for the region.

The ambition has been shared with partner organisations and conversations will continue with our current partners and new partners as the programme develops. We will also be speaking with other Regions as we develop our programme and we already have establish the sharing of best practice of ICF Projects with West Wales and will continue to develop this relationship.

Area Plan

The Area Plan represents what the Western Bay Regional Partnership Board (RPB) will be delivering as a set of integrated regional health and social care priorities over the next 5 years, in response to the Population Assessment findings. Due to the review of Western Bay and the transfer of Bridgend, the Area Plan is being refreshed. Regional Partnership Board members agreed to focus on a smaller number of key priorities, where regional working will add the most value. The Area Plan is an important planning tool which will be a reference point for future funding decisions and monitoring of the work the Board will progress in future years. An Annual Report will be produced describing how the Regional Partnership Board has delivered against the Area Plan (and in particular the Action Plan). As far as possible the Area Plan, in setting out regional social care and health priorities, complements and links with the three Public Services Boards and their respective Wellbeing Plans. The Key Priorities agreed by partners for the Area Plan are shown in the table below.

Transformation Opportunities

'New Western Bay Offer' Quadruple Aim

Aim 1 - Improve the population health and wellbeing through a focus on prevention

- Increase the scale and pace of preventative programmes across the region for example "Wellbeing from Birth – First 1000 days"
- Increase and improve the collaboration and integration with partners such as 3rd Sector, Council for Voluntary Services, Providers, Education, Leisure, Housing
- Ensure clear communication across the region with all stakeholders

Aim 2 – Improve the experience and quality of care for individuals and families

- Further develop compassionate communities or neighbourhoods
- Increase the scale and pace of collaboration efforts through; the use of WCCIS, Effective Pooled Budgets, Multi-Agency and Disciplinary Teams
- Reduce harm by focusing services more effective to address key issues/problems within communities/neighbourhoods (e.g. substance misuse)
- By changing the questions and conversations with Citizens to "What Matters to You"

Aim 3 – Enrich the wellbeing, capability and engagement of the health and social care workforce

- Support the workforce within the community to look after themselves and ensure they feel valued
- Ensure timely and inclusive decision making and reduce conflict
- Allow the workforce time to work with citizens and explore opportunities

Aim 4 – Increase the value achieved from funding of health and social care through improvement, innovation, use of best practice and eliminating waste

- Review, develop and continually support the assets we already have in our community
- Invest in people – they are key to community based assets
- Review "Best Practise" within and outside of the "New Western Bay" to develop new ideas and opportunities
- Improve and develop the digital community

3.3 Strategic Objective: Digitally Enabled Care

Digital Strategic Outline Plan (SOP) 2019/20

Early in 2019/20 we will develop a new Digital SOP to support the first phase of the road map for the delivery of the digital plan in the new Health Board. In developing the SOP we will work closely with Welsh Government and the Health Board finance teams to ensure the funding mechanisms for its delivery are clearly understood and documented. This will build on the work already done in securing funding from schemes such at ETTF and Invest to Save as well as the recurrent commitment the Health Board has made from Discretionary Capital to support new developments. This partnership approach to the development of the SOP will go some way to addressing some of the recommendations in the Wales Audit Office review. The SOP will focus on the next range of developments that will take forward the themes and aims of the Health Board digital plan and we will ensure that there is wide involvement from our clinical leaders to ensure their needs are being met.

Supporting IT Service and Delivery

In 2019/20/21, we will work with partners to review how our IT services are delivered and supported. Particular attention will be paid to the changes now available in infrastructure provision through Cloud Services. The changing environment for IT software provision will also be explored and funding models changed to meet the commercial environment of IT services.

Empowering Patients
Patient Knows Best (PKB)

Our work on self-care through PKB is described in Section 2.3.

Patient Appointment Reminders

Throughout 2019/20 we will continue to capitalise on the success of the text reminder service which has the key objective of reducing DNA rates. Throughout 2018/19, the rollout of the solution contributed to a reduction in DNA rates for both new (from 7.1% to 6.7%) and follow up appointments (from 9.0% to 6.9%). The aim will be to expand the service areas that can adopt the reminder solution to include Community and Therapy appointments and further improve DNA rates by increasing the percentage of accurate mobile phone numbers in our patient administration systems and promoting the service to our patient population.

Empowering Clinicians
Digital Dictation

We will work to build a case for establishing a Health Board-wide digital dictation plan to address the administration capacity and efficiency constraints in line with the wider digital plan, particularly focusing on delivering technology to support digital dictation and voice recognition.

Hospital Electronic Prescribing and Medicines Administration (HEPMA)

The implementation of HEPMA will be fully complete across inpatient wards at two acute hospital sites (Neath Port Talbot and Singleton) by the end of 2019/20. The functionality will include integration with the Welsh Clinical Portal (WCP) to allow clinicians to prescribe electronically from within the patient's WCP record. Plans to implement to the rest of the Health Board will be dependent on the availability of funding and the progress of the national e-prescribing project. An evaluation of our project and the benefits will be conducted and used to inform the national approach. These benefits include the ability to provide a range of significant clinical, safety, informatics and management benefits to patients cared for by the Health Board that are not systematically achievable using current systems. These include reduced errors in prescribing, administration and transcription, improved formulary compliance and improved antimicrobial stewardship.

Welsh Results Reports Service (WRRS)

The Welsh Results Reports Service provides users of the Welsh Clinical Portal with the ability to view diagnostic reports and test requests for their patients regardless of where in Wales they were produced. Some historic results are already held within WRRS, the earliest date back to 2008.

In 2019/20 the Informatics Directorate will continue to work with our staff and the organisation to make all test results available nationally via the Welsh Clinical Portal, this will include ongoing work for radiology and cardiology reporting and test results. This work will support the following:

- Improved efficiency and timeliness of results reporting through visual status of test request and processing statuses.

- A reduction in duplication by providing an at-a-glance view of tests already requested and processed.

In 2019/20, the Informatics Directorate will continue to work with clinicians and legacy systems to ensure new and historic results are made available through the Welsh Results Reports Service to NHS Wales. This will include ongoing work for radiology and cardiology reporting and test results.

Patient Flow

The flow of patients into, through, between and out of our services is of utmost importance as it impacts on the quality of our care, the experience of our patients, the outcomes they achieve and the volume of patients we are able to care for. Digital has a number of roles to play in working to improve the flow through our system including: sharing of information through and across pathways and clinical boundaries, automating of processes, gathering of information, task and action management and providing real time business intelligence to facilitate decision making.

In 2018/19 significant progress has been made in a number of areas looking at improving the patient flow within our services:

Electronic Test Requesting (ETR)

The implementation of ETR means that clinicians are able to request and review progress of test electronically. This is more efficient and also reduces the number of duplicate test requests being made. ETR is now live in 79 locations across the Health Board which equates to 31% of all locations. It is planned that ETR will be rolled out across remaining locations in 19/20.

Admissions Discharges and Transfers (ADT) pilot

A key part of flow is being able to share information as patients are admitted, transferred and discharged from hospitals. Towards the end of 2018/19 the Health Board will pilot the use of electronic ADTs within WCP. (Previously this had been achieved through the ABMUHB clinical portal). This will facilitate the pilot of Medicines Transcribing and eDischarge (MTed) which will improve medicines management by allowing hospital pharmacists to transcribe patient medications electronically. This will support the patients from admission to discharge. e-Discharge (eD) will enable clinicians to record a summary about a patient's hospital stay which can be electronically sent to the GP. A key driver of this will be the Hospital Electronic Prescribing

and Medicines Management (HEPMA) project which will integrate with MTeD to automatically provide the requirement information.

Electronic referrals

We have continued to work with NWIS on the next phase of the project to enable the electronic prioritisation of secondary to secondary and secondary to tertiary referrals. ABMUHB (cardiology) has piloted this functionality.

Electronic nursing documentation pilot

In 2018 the Health Board piloted an in-house developed electronic nursing documentation system. The results of the pilot were very positive and reduced the length of time taken to complete the documentation. The solution is now being considered by NWIS to be included within the national solution for the provision of electronic nursing documentation across Wales to be implemented in 2019/20.

WCCIS and mobilisation

As outlined in Section2.3 mobilisation and WCCIS are pivotal in improving and managing the flow of patients from secondary care into the community. The implementation of the Welsh Community Care Information System (WCCIS) is key to supporting integrated working across Health and Social Care and to help to keep patients 'well' within the community in addition to facilitating safe, timely discharge from hospital. ABMUHB is playing a key role in progressing regional collaboration with Bridgend, Swansea and Neath Port Talbot Local Authorities and is taking the lead in data quality aspects of the national configuration. In ABMUHB the system will have a significant impact in further improving productivity across Community, Therapies and Mental Health services. We will have an approved business case to support WCCIS and will be taking strides towards signing a deployment order to allow implementation to start in 2019/20.

In 2019/20 the Informatics Directorate will also work with clinicians to implement a phlebotomy module in WCP with the anticipation of achieving the following outputs:

- Provide better patient information to laboratories
- Improve patient safety – no unnecessary samples collected.
- Reduce the number of unnecessary tests
- Reduce the turnaround time for tests
- Save time with ability to mark for 'Phlebotomy Sample Collection'

- Reduce unnecessary labels printed
- Improve feedback to clinicians following initial test request through phlebotomist comments being provided electronically in WCP.

Welsh Patient Referral Service (WPRS)

The Welsh Patient Referral Service (WPRS) is a safe and secure method of transmitting patient referral letters and referral information between Primary and Secondary Care Services. WPRS enables electronic referrals to go directly from a GP to a selected hospital. For WPRS eligible services, Health Records staff are able to send referrals to an electronic work list for a clinician to triage. In 2019/20, we will work with clinicians to progress the rollout of electronic referrals and prioritisation including the introduction of hospital to hospital referrals, allowing us to send electronic referrals within ABMUHB and across Health Board boundaries, including tertiary services. It is anticipated that the following outcomes will be achieved:

- Referrals will be received and processed in a more timely manner, improving patient safety and providing efficiencies to staff
- Electronic referrals will be available immediately in WCP for processing
- Consultants can prioritise referrals from any ABMUHB computer or from home, reducing the need to return to the office
- Inappropriate referrals can be returned to GP with information, reducing the need for paper letters to be sent
- Additional information can be requested from GPs electronically
- Consultants can redirect referrals to colleagues/place referral on hold if necessary

Welsh GP Record (WGPR)

The GP Record provide clinicians with a summary of important information taken from a patient's full GP medical record. The record can be accessed by health professionals caring for a patient wherever the patient is in Wales. A patient will give consent for the healthcare professional to access their record every time it is needed, and every access to a WGPR is automatically monitored. In 2019/20, we will continue to work with clinicians to raise awareness of the availability of WGPR and continue to support new doctor induction to raise awareness and to promote mandatory Information Governance training and essential WCP e-learning to enable access to eligible users. It is anticipated that the following outputs will be achieved:

- Increased patient safety by providing access to the GP summary record in secondary care
- Increased time efficiencies for clinicians and other healthcare providers by eliminating the need to contact GP practices by telephone to obtain information.
- ADTs and MTeD– Admissions, Discharges and Transfers and Medicines Transcribing and e-Discharge
- Admissions, Discharges & Transfers, Medicines Transcription and e-Discharge (ADTs & MTeD) will replace the functionality currently available in ABMU Clinical Portal with functionality available in WCP to admit/discharge patients, update patients' locations, and transmit discharge advice letters to primary care and store them within the patient record.

In 2019/2020 we will progress the implementation of live ADTs across the organisation. It is anticipated that the introduction of live ADTs will deliver the following outputs:

- Effective patient flow by providing the ability for WPAS records to be updated with live locations, episode and spell information.
- Increase the time to care for clinicians and other healthcare providers by reducing time locating patients and accessing multiple information systems

In 2019/20, we will continue to work to progress the transition of using the current method of transfer of care (EToC) to implement the national solution of MTeD which will replace EToC with a discharge advice letter across the organisation. Plans for ADTs and MTeD they are as follows:

- Extend pilot at Morriston to implement live ADT functionality across all sites with an estimated completion April/May 2019
- Implement transition from electronic transfer of care to MTeD alongside the introduction of e-prescribing at Neath Port Talbot Hospital, progressing to Singleton and Princess of Wales Hospitals
- Extend the scope of Mental Health and Learning Disabilities specialities
- GP Test Requesting (GPTR)

In 2019/20 we will agree a rollout plan which includes close working with the laboratories to pilot new functionality to be made available in the WCP.

PROMs and PREMs

In 2019/20, we will work with clinicians and the national PROMs programme to provide support to the All-Wales Patient Reported Outcomes Measures (PROMs), Patient Reported Experience Measures and Effectiveness Programme (PPEP) to support the new and ongoing implementation of Patient Reported Outcome Measures .The Health Board is currently engaged with the programme for collection in Orthopaedics, ENT, Lung Cancer and Cataracts. This will realise the following benefits:

- Improving effective calculation of treatments
- Better supporting the fulfilment of ICHOM partnership requirements
- Improving PROMs reporting activity

Business Intelligence

In 2019/20 we will develop and launch a Business Intelligence plan to compliment the Digital plan. The key components of the plan are:

- KPIs & Automated Reporting
- Predictive and Prescriptive Analytics
- Better decision making
- Quality improvement and service redesign
- Improved operational efficiency
- Reduced costs and waste.

Effective Systems

Hybrid Mail

Hybrid mail is mail that is delivered using a combination of electronic and physical delivery. It involves digital data being transformed into physical letter items at distributed print centres. In 2019/20, subject to approval of the Invest to Save case, we will move all patient letters from the WPAS into a hybrid mail solution. This will improve the quality of the process and release cost savings of £100k. Subject to the success of the deployment we will then adopt hybrid mail for our other systems such as DMS and RADIS. In 2020/21 we will then start to explore how hybrid mail can support the Health Board in communicating with our patients regarding their appointments using electronic delivery platforms such as e-mail, SMS and PKB.

Welsh Care Records Service (WCRS)

The Welsh Care Records Service is an electronic document repository within the Welsh Clinical Portal. In 2019/20 we will continue to work with staff to identify documents currently available to users of the Clinical Portal and other systems for prioritisation by our Clinical Reference Group and the national WCRS Project Board for upload to WCRS. This work will support the following:

- A reduction in requests for (and delay in receiving) paper case notes, freeing up clinical time to treat the patient.
- Making documents available to all users of WCP across Wales.
- A reduction in time spent by staff contacting other Health Boards/Trusts to obtain information that is stored and available electronically in WCRS

Intranet and Business Efficiency Core

In 2019/20 we will provide our staff and the organisation with an Intranet platform that will enable them to be more effective in the way that they deliver our business. The platform will be fully mobile enabled so that our staff can access this functionality wherever they are in the organisation and on whatever digital device they have available to them. The platform will provide the tools needed to enable and ensure:

- Staff are well informed on issues and successes of the organisation
- Staff can access the business information required to do their jobs
- People to collaborate and communicate effectively both within their teams, with the wider organisation and with external NHS partners
- Governance arrangements are visible, reportable and efficient
- Knowledge sharing
- Saving staff time to focus on value adding activities
- Facilitating the digitalisation of paper and e-mail driven business processes in an efficient, coordinated and coherent manner.

In 2019/20 the solution will deliver an intranet front page and subsequent supporting sites that focus on the core business of the corporate directorates. This will help facilitate the transitional work required to the support the boundary change as well as standardising key business processes and governance arrangements. In 2020/21 and 2021/21 the focus will shift to a roll out to incorporate the Service Delivery Units.

Digital tagging of Health Records

In 2019/20 we will continue to implement the Radio Frequency Identification (RFID) Solution across the Health Board. This implementation will improve

the clinical and logistical problems of a paper based health record whilst also modernising and improving the service which the Health Records Service provides.

Summary Plan and Enablers - Digitally Enabled Care

Actions		Milestones 2019/20	Measures	Lead
Expand **Patient Appointment Reminders** to service areas that can adopt the reminder solution to include Community & Therapy appointments.	Q1	Evaluation of outpatient appointment service	HW_DP4	CIO
	Q2	Assessment of opportunities for further roll out		
	Q3	Commence next phase (subject to approval)		
Empower Clinicians implementing **HEPMA** across inpatient wards at Neath Port Talbot and Singleton hospital sites.	Q1	Go live HEPMA in Neath Port Talbot	HW_DP8	CIO
	Q2	Go live HEPMA in Singleton		
	Q3	Complete HEPMA Implementation on 2 sites		
	Q4	HEPMA Business case and evaluation for Morriston		
Empower Clinicians through making all test results available nationally via the **Welsh Results Reports Service (WRRS)** and uploading records to the **Welsh Care Records Service (WCRS).**	Q1	Go live of additional diagnostic information and clinical documentation in WCP	HW_DP6	CIO
	Q2	Go live of additional diagnostic information and clinical documentation in WCP		
	Q3	Go live of additional diagnostic information and clinical documentation in WCP		
	Q4	Go live of additional diagnostic information and clinical documentation in WCP		
Complete rollout of **Electronic Test Requesting** to enable clinicians to request and review progress of tests electronically, reducing duplication.	Q1	Complete Singleton Inpatients Rollout	HW_DP6	CIO
	Q2	Commence and complete implementation in Morriston outpatients		
	Q3	Complete Singleton outpatients		
Implement **WCCIS**	Q2	Deployment order complete	HW_DP6	CIO
	Q3	Commence 12 month readiness programme		
Rollout electronic referrals and prioritisation via **WPRS** ensuring safe and secure transmission of patient referral letters and referral information between Primary, Secondary and Tertiary Care Services	Q1	Complete primary to secondary referrals implementation. 1st site live.	HW_DP6	CIO
	Q2	Evaluation of 1st site and plan agreed		
	Q3	Implementation across all specialties commences		
	Q4	Implementation across all specialties continues		
	Q2	Complete roll out to Morriston		
	Q4	Complete roll out to Singleton		
Roll out **PROMs** aligned to the Clinical Services Plan through a technical solution including information repository.	Q1	Alignment of PROMs roll out plan to Clinical Services Plan	NDF_44 HW_DP4	CIO
	Q2	Technical solution for Proms agreed including information repository		
	Q3	Commence roll out of PROMs		
	Q4	Continue roll out of PROMs		
Develop and launch a **Business Intelligence Plan**	Q1	Continued development of BI plan	HW_DP8	CIO
	Q3	Launch BI plan		
	Q4	Development of Implementation Plan		
	Q2	Solution to be procured	HW-DP7	

Implement a **Hybrid Mail System** moving all patient letters from the WPAS (Invest to Save dependent)	Q3	Implementation Plan Developed		CIO
	Q4	Implement solution		
Enable staff to be more effective through providing fully mobile enabled **intranet platform.**	Q1	Procure solution	HW_DP10	CIO
	Q2	Development of project plan.		
	Q4	Implement for Corporate Directorates		
Development or procure a **Document Management System** to be supplemented into WCP.	Q1	Start Assessment of requirement	HW_DP6	CIO
	Q3	Start redevelopment of product/procurement		
Deliver paper light outpatient clinics through implementation of **Electronic Outpatient Documentation**	Q1	Electronic continuation sheet available for roll out	HW-DP7	CIO
	Q2	Commence roll out electronic continuation sheet in 1st specialty		
	Q3	Establish road map and resources		
Ensure **Digital Infrastructure and Cyber Security** through approving a cyber-security plan and ensuring Windows 10 is rolled out,	Q1	Recruit	HW_DP10	CIO
	Q3	Develop and approve cyber security plan		
	Q4	Develop Cyber Security plan/ Rollout of Windows 10 Complete		
Produce a business case exploring the options for delivery of our data centres post boundary change and identify the model and investment required to meet the organisation's needs.	Q1	Business case to IBG	HW_DP8	CIO
	Q2	Develop project plan (subject to approval)		
	Q3	Commence procurement		
	Q4	Initiate project		
Review the need for the growth of **Digital support model** including 24/7 requirements.	Q3	Review clinical services model in light of digital support services	HW_DP10	CIO
Continue to implement the **Radio Frequency Identification** (RFID) Solution across the Health Board	Q2	System go live	HW_DP10	CIO
WEDs – the introduction of the digital solution for ED to facilitate the improvements required in the management of patient flow through the department	Q1	Assurance that national system is ready	HW_DP8	CIO
	Q2	Complete ABMU readiness		
	Q3/4	Implementation		
Further development of the **Theatre management system** (TOMS) to facilitate the improved utilisation of our theatres, increasing capacity and flow through our planned care pathways	Q2	Establish way forward for TOMs nationally	HW_DP8	CIO
Support NWIS in piloting the agreed product (developed by ABMU) selected to support the **electronic capture of nursing documentation** to improve the effectiveness and efficiency of patient monitoring and handover	Q1/2	Pilot national solution	HW_DP8	CIO
	Q3/4	Phased implementation across Health Board		
To continue the introduction of digital tools to help manage **patient flow** through our hospitals	Q1	Evaluate roll out of local initiatives to determine next steps	HW_DP8	CIO
	Q2-4	Support the national procurement process		

Eye care e-referral and electronic patient record system for Wales	Q4	Readiness for implementation following evaluation for Cardiff and Vale as early adopters	HW_DP9	CIO
Critical Care Clinical Information System (CCCIS)	Q2	NWIS award contract	HW_DP8	CIO
Dental referrals system	Q1	Implementation of dental system	HW_DP6	CIO
	Q2	Commence implementation of electronic dental referrals		

Workforce Implications	Finance Implications
- Digitally enabled Health and Wellbeing enables staff to meet patients' needs more effectively and provide care closer to home. It also allows staff to work at the top of their license, and add value and improves workforce efficiency and will lead to cultural changes in the way staff work, skill mix and location. Our workforce will need to be supported to develop both their digital and communication skills. - Systems such as WCCIS will change the way health and social care work in the future, leading to greater multi-disciplinary working and shared responsibility. - Informatics service capacity, coverage and capability will be challenged as the digital agenda grows and the focus on digital in the Swansea Bay city deal presents opportunities and threats to our recruitment and retention.	

Capital Implications	Digital Implications

Bridgend Transfer Implications
The disaggregation of the services and technologies serving the Bridgend area will be very complicated. It is expected that this disaggregation will take a considerable length of time and investment for both Health Boards. It is planned to have SLAs in place to provide service to Bridgend from April 1st the management of these SLAs and the complexities involved will mean that focus could be diverted from the delivery of programmes of work in the Plan into the provision of the new arrangements.

3.4 Strategic Objective: Outstanding Research, Innovation, Education and Learning

We are committed to outstanding research, innovation, education and learning this is demonstrated through our organisational value - always improving.

We will continue to strive for excellence in the areas of research, education and training and innovation. Our strong links between the UHB and both Swansea and Cardiff Universities continue to be productive, and we seek collaborative opportunities through ACCELERATE and the Institute of life Sciences (ILS).

We aim to provide excellent educational opportunities for undergraduate and postgraduate studies. It has been particularly gratifying to note the very positive feedback from undergraduate students and hope that their experience in our healthcare facilities has contributed to the rise in the national rankings of Swansea Medical School.

The appointment of a new Executive Medical Director provides an opportunity to refresh our approach to innovation and improvement and to establish novel means of aligning innovation, research, quality and value in delivering new models of care in order to achieve the aims of our Clinical Services plan.

Examples of the approach being adopted include:

Leadership.
We will be increasing the role of clinical leadership in the organisation and

appointing specific leads to take portfolios for Quality Improvement and Value-Based Healthcare. We will be promoting a culture in which innovation is encouraged, and provide an environment in which this can flourish.

QI and Value-Based Healthcare

Approaches to Quality Improvement and Value-Based Healthcare that will see clinical leaders in primary and secondary care paired together to work on discrete projects. While having specific objectives within the Quality/Value arena, it is expected that this joint working will also prove invaluable in streamlining pathways between hospital and community.

Medical Workforce

We recognise the challenges in recruitment and retention of staff, and particularly some medical posts in 'shortage specialties'. This year we will begin to adopt a different approach, whereby we involve our postgraduate trainees to a greater extent in the life of the organisation, and by doing so

aim to engender a sense of allegiance and belonging to the Health Board.

Innovation Hub

We will establish an innovation Hub for the UHB, with the intention that this should generate ideas and novel ways of thinking that contribute to the development of new clinical models. We consider that the function of this hub should be to 'hothouse' ideas for development, encouraging disruptive thinking. Successful small-scale tests will adopted and scaled-up incrementally.

Opportunities to share ideas

There is an opportunity, through our partnership for a, to share and test ideas across the region. There are well-established fora at which these can be tested with Hywel Dda Health Board through the ARCH project; and will look for wider opportunities to share ideas and to collaborate.

Summary Plan and Enablers- Outstanding Research, Innovation, Education and Learning

Actions		Milestones 2019/20	Measures	Lead
Increase in number of Health and Care Research Wales Clinical; Research Portfolio studies and commercially sponsored studies	Q1-4	Increase in both commercial and non-commercial studies open and recruiting	NDF_38 NDF_39	DOM
Increase in number of participants recruited into Health and Care; Research Wales Clinical Research Portfolio studies and commercially sponsored studies	Q1-4	Increase in both commercial and non-commercial number of participants	NDF_40 NDF_41	DOM
Quality and Value	Q1	Clinical leaders in post in primary and secondary care	HW_DP7 HW_DP8	DOM
	Q2	Projects under way aligned to organisational priorities		
	Q3	Delivering against plans, with crossover/expansion of work streams		
	Q4	Roll-out of improvement plans and preparation for Year 2		
Innovation	Q1	Establishment of Innovation Hub	HW_DP7 HW_DP8	DOM
	Q2	Work plan agreed, with mechanisms in place for testing		

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Workforce Implications	Finance Implications
- Allow our staff to work more efficiently and effectively reducing duplication. - Save staff time allowing them to focus on value adding activities - Utilising technology will allow us to redesign our workforce, develop new roles and relocate staff. - The mobilisation project has led to District Health Nurses in Bridgend seeing 33% more patients in Q1 2018/2019 in comparison with Q1 in 2017/2018. Number of to and from base travel routes reduced from an average of 6 to 2 return to base trips per day. - The Mobilisation project is also making significant progress in upskilling our community workforce.	

Capital Implications	Digital Implications
None	See 3.3

Bridgend Transfer Implications	
None	

3.5 Strategic Objective: Excellent Staff

This chapter sets out the key Workforce and Organisational Development priorities which:

- Align with Organisational Strategy, Clinical Services Plan, Medium Term Financial Plan, other plans and strategic change programmes and the delivery of service, quality and operational priorities.

Our people chapter is structured under six main headings, as follows:

Shape of the Workforce: The workforce we need in order to achieve our plans, support better health and provide better care.

Workforce Resourcing: How we secure and retain the right workforce.

Workforce Efficiency: How we will deploy our staff effectively and maximise workforce efficiency productivity.

Leadership, culture, values: How we improve organisational performance through leadership, development and culture

Pay and Terms and Conditions: Exploring better opportunities to reward our workforce

Workforce Function: The role and contribution of the workforce function in delivering our people plans

Shape of the Workforce
Current Workforce Profile
ABMU currently employs 14,173 FTE, an increase of 138.34 FTE over the last 12 months. This increase is mostly due to an increase in our employed nursing workforce. The age profile is challenging across many professions. Notably 37% of the nursing workforce is aged 50 or above. (Appendix 1).

Aligning Service and Role Redesign
Delivering this significant, ongoing and sustainable organisational change is a fundamental challenge for SWANSEA BAY HEALTH BOARD. The historical approach to service change, which required the recruitment of additional nurses or doctors, is no longer a viable option. We recognise our services are not sustainable in their current form and we know that to address the workforce challenge we will need to fundamentally reshape our service models and redesign our workforce across the Health Board.

The future shape of the workforce focuses on developing skills, roles and ways of working which have the greatest impact and traction to deliver sustainable change. The workforce plans address developing a sustainable approach to developing multi-disciplinary teams in primary and community

settings and rebalancing the workforce between in/out of hospital settings and aligning and integrating staffing solutions with social care.

The Health Board is currently developing its Clinical Services Plans through ongoing clinical engagement. Some of the emerging priorities include a single unscheduled care intake, single frailty model and clusters caring for patients at home when safe to do so. In order to support the plan we will need our workforce of tomorrow to look very different from the workforce of today, with staff needing to work differently. We need to have robust long-term workforce and education plans that develop a different workforce and shifts our workforce into community setting to provide care closer to home.

We recognise that we need to develop a far more strategic and co-ordinated approach to re-profiling and developing our non-registered workforce. One of the work streams within our Recovery and Sustainability programme focuses on redesigning our clinical workforce to improve operational productivity and performance by optimising the alignment of our scientific, therapeutic and technical staff.

Detail of our planned workforce developments are summarised in the sections below, as well as in the specific service thematic chapters.

Developing New and Extended Roles

The Health Board has developed a number of new and extended roles in a range of service areas, and continues to look to develop roles to align available resources for maximum impact to ensure professional staff skills are used to best effect. The new and extended roles we are developing are supporting the redesign of planned and unscheduled care include:

BMS staff trained to advanced practitioner level in dissection and reporting. Utilising Advanced Biomedical Scientist roles in Cellular Pathology to support services and release time to better utilise difficult to recruit Consultant Pathologists.
Consultant Pharmacist roles in a number of key areas such as unscheduled care, antimicrobial prescribing and cancer care, which will promote innovation and support prudency forging links with the University.
Neonatal Physiotherapy role developed to undertake specialist assessments previously undertaken by Consultants and working with Orthopaedics to develop extended practice Paediatric Physiotherapy roles.

Develop more reporting Radiographers and expand other areas of Advanced Practise in Radiographers to better utilise and develop skills and support shortages across radiology.
Two Physiotherapy Consultant posts one in critical care and the other in MSK to expand the research agenda and forge links with the University in line with ARCH.
Within Orthoptics non-medical staff roles are being extended within glaucoma, acute macular degeneration and diabetic retinopathy treatment and diagnosis
Within Medical Physics and Clinical Engineering, some tasks have moved from Consultant to other Health Care Science staff, in addition to the introduction of apprentices.
Development of a Neonatal Occupational Therapy role to undertake assessments traditionally undertaken by a Consultant.
Technologists, Medical Physics Experts and Consultant Clinical Scientists to take on roles traditionally undertaken by Consultant Oncologists.
Developing a Consultant Nurse in Fertility through the RCN Fertility Nursing Framework.
Two fast track trainees employed within Audiology, who will qualify as Associate Practitioners after 2 years.
Development of Advanced Practitioner Audiologist roles to shift demand from ENT to Audiology
Developing and extending First Contact Practitioner Roles in primary care across Therapy services.
Developing extended roles for Neurophysiology Practitioners to support fragile National and Regional services.
Physician Associate roles created across secondary and primary care with the potential to be further developed in the Chronic Pain Service.

Redesigning the Non-Registered Workforce

A significant amount of care is delivered by our non-registered workforce. We will undertake a review of Band 2, 3 and 4 roles to address qualified nursing deficits where this is appropriate taking into account the Safer Staffing Act. It is important that we develop the entire workforce and provide opportunities for further career progression and there are a number of examples where this is being undertaken across the Health Board, which will be further developed:

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Redesigning the Non-Registered Workforce

Development of band 3 scrub roles in Ophthalmology for efficient injecting services in addition to developing HCSW to take on additional roles

Band 3 and 4 roles have been developed with additional competencies to provide continuing care packages to children in the community

Pharmacy Technicians are being trained to safely administer oral medicines at some of our hospital sites to ensure safe and timely administration of medication and allow nurses to prioritise sick patients

Supporting Pharmacy Assistants and Technicians to achieve NVQ level 2 and 3

Health Care Support Workers are being developed in line with the Health Care Support Worker Framework

Development of a generic nursing/therapy Health Care support Worker role

Increased use of band 4 Associate Practitioner roles in place of qualified Biomedical Scientists

Medical Assistant/Care Navigator role developed to support GP practices

Supporting HCSWs in GP practices to undertake the QCF level 3 qualifications

Band 4 role developed within Occupational Therapy services

Training developed for a new Maternity Care Assistant band 3 role with Agored Cymru

Generic HCSW role developed to work within rehabilitation and the community

Implementation of the Nurse Staffing (Wales) Act (NSA)
An extensive nurse staffing level review has been undertaken and a task and finish group established to monitor the implementation and the organisation's requirements under the Nurse Staffing (Wales) Act.

Thirty-eight wards are identified as requiring consideration under the Act to achieve compliance with the legislation. Recognising that any uplift to nursing establishments will be challenging to deliver from both a workforce and financial perspective and because of the constraints that these specific challenges will pose full implementation of the requirements is likely to extend into 2019/20 in common with other Health Boards in Wales. The Health Board will progress with investing in additional nursing resource on an agreed priority basis.

The principles for safer staffing levels have been adopted in ABMU for District Nursing and work continues to align services to fully meet the requirement. The principles for Health Visiting are currently being scoped and drafted.

Workforce Resourcing
Developing workforce resourcing strategies and approaches to ensure we are able to secure the workforce needed to meet organisational needs is a key strategic challenge for the Health Board.

Vacancy levels
The challenges of current vacancy levels and recruitment issues are well rehearsed and are a UK wide, if not international challenge. There are acute shortages of both nursing and medical staff, which affect not only the Health Board's ability to meet financial and performance targets, but also impact on quality and safety.

As at December 2018 the total number of vacancies within the Health Board is 1086.52 WTE, across all the staff groups. Our registered nursing and midwifery staff group has the largest number of vacancies. This has improved significantly and stands at 364.93 WTE. This equates to a 7.5% vacancy level.

Medical vacancies currently stand at 238.74WTE and subject to an establishment verification exercise to ensure it accuracy. In recent years, there have been changes to the immigration rules applied to doctors within the UK plus changes to training and number of posts available. This has resulted in a reduction of overseas doctors wishing to come to the UK to train/work; there has also been a significant increase in the number of doctors requesting to train less than fulltime. Both of these situations have had a significant impact on rotas and delivery of service. In addition, SAS doctors in hard to fill areas are turning down posts and moving across to England as higher salaries are being offered.

The introduction of the Deanery Educational Contract has also had an impact on the Health Boards delivery of services and training, the main issue is the introduction of 1:11 rotas. The increase in the number of doctors required to work a 1:11 rota has resulted in vacancies that previously were not part of the Health Board establishment.

Consultants are a key part of the NHS workforce; they represent a significant investment for the individual Consultant and the Health Board. They are also a limited resource and the ability to recruit may be affected by the number of 'home-grown' training grades coming through the system to replace retiring Consultant and new Consultant posts. We also need recognise the impact of changes to the pension scheme on workforce planning assumptions and the impact of early (pension related) retirements. Detailed vacancy data is attached as appendix 2

As a result of recruitment difficulties and an aging GP workforce the number of GP practices within the Health Board footprint has reduced from 77 to 68 within recent years. This trend is expected to continue and a number of practices have already approached the organisation enquiring about possible mergers.

Turnover

The turnover rate for all staff within the Health Board (excluding junior medical and dental staff) currently stands at 7.71% (December 2018), falling by 1.3% over the last 12 months. A breakdown is attached as appendix 3

Whilst the overall turnover rate is not disproportionately high, an analysis has indicated that there are certain hot spot areas that need to be addressed and includes in particular the number of nursing staff that leave within two years of appointment.

Recruitment and retention

A comprehensive, multi- disciplinary Recruitment and Retention Plan is to be developed in early 2019. A suite of strategic approaches are being developed to address and improve the current situation and meet the challenges that are presented through employing a multi-generational workforce. This affects all aspects of the employment journey and changing employment aspirations of spanning baby boomer to millennial. These are described below.

Nurse Recruitment and Retention

Although vacancy levels and turnover rates are improving, significant focus will be given to these issues over the period of the plan to ensure the improvements are maintained and accelerated. In addition to working with Swansea University in relation to pre-registration opportunities and the CPD agenda, improvements in recruitment and retention will be developed through the following measures:

Work is underway to improve the support to nurses who are interested in working for us; this includes an enhanced preceptorship programme and clinical supervision.
Working longer readiness tool has been completed and the actions will be taken forward through the recovery and sustainability work streams.

Participation in the Welsh Student Streamlining project, which is aimed at developing a more efficient process of recruiting nurse students from Welsh universities without the need for formal interviews.
Further return to practice open evenings will been organised.
Local recruitment days regionally organised to avoid duplication. These are heavily advertised across social media platforms.
Implementation of our Nursing and Midwifery Strategy.
Analysis of leavers' data, particularly those in the first 12 to 24 months of commencing employment to identify hotspot areas.
Overseas recruitment campaigns to Europe and the Philippines have been undertaken with further options being explored in Dubai and India.
We will continue to 'grow our own' nursing workforce by supporting Health Care Support Workers to undertake either a part time Degree or Masters course
Further explore overseas recruitment initiatives in Dubai and India seeking nurses who are IELTS ready
Systematic, electronic exit interview process to highlight reasons for leaving and development of strategies to improve.
Establishment of an 'internal transfer window' to enable nurses to move within Swansea Bay UHB in a managed way rather than leave

Medical Recruitment and Retention

To counteract the number of medical vacancies that we have, the Health Board is working with MEDACS to support the recruitment of doctors to substantive vacancies. A comprehensive recruitment and retention plan for the medical workforce is being developed. Increasing the supply of the medical workforce is seen as key in resolving the issues associated with a high cost locum workforce and increasingly the sustainability of clinical services.

Therapies and Health Science Workforce

Recruitment to therapies and health science is patchy with some groups recognised as shortage occupations including radiographers, nuclear medicine practitioners, radiotherapy physics practitioners and scientists, sonographers, orthoptists and prosthetists. Particular shortages in therapeutic radiographers has led to radiotherapy backlogs. High vacancy rates in many professional groups lead to a review of organisational structure and possible efficiency gains with job planning and extending support roles.

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Strategies employed to overcome the shortages include targeted recruitment and staff development. There are a number of initiatives being taken to provide in-service training in Biomedical Science, to allow employment of science graduates and support top up to registration.

Unregistered workforce

Recruitment to the un-registered workforce is generally positive with no significant issues currently experienced. However, there will be a continual development of career paths and alternative routes to gain employment within the organisation including the Apprentice Academy, ensuring that recruitment of apprentice programmes align with future workforce plans and enable development of skills. More detailed is contained later in this chapter.

Internal Nurse Bank and beyond

The use of 'off contract' agency nurses has been eradicated but there remain high levels of on contract agency nurses to meet staff needs. There is scope to develop the current nurse bank service to expand the potential of the internal nurse bank to better meet staffing needs. Ways to better incentivise, market and promote nurse bank working will be developed including the introduction of weekly pay for bank staff which is recognised as a key incentive for staff.

In addition, the scope of the current nurse bank will be extended. The intention is for the current bank arrangements to become a multi-disciplinary Staff Bank including other clinical groups of staff and more widely for A&C staff, estates and ancillary staff groups. The potential to extend this to medical staff will also be explored in line with the wider all Wales initiative.

Workforce Efficiency

Improving the efficiency and effectiveness in how we utilise and deploy our workforce is a key area that will be addressed during the period of the plan. There are already a suite of plans in place which focus on this which will continue for the foreseeable future to ensure the required improvements are secured and embedded. These change programmes are outlined below.

Medical Workforce

Shortages in medical staff have a potential negative impact of quality and safety and service delivery. In addition expenditure on the contingent medical workforce is regularly reported and shows an increase in variable pay for medical staff compared to 17/18. Despite the introduction of the Welsh Government Agency Cap project while expenditure initially reduced

market forces are impacting negatively on this pushing rates and costs up. Efforts are being deployed to attempt to reverse this trend. The Health Board is implementing an electronic system "Locum on Duty" to introduce a digital booking and approval system to increase transparency and good intelligence to help scrutinize and challenge decisions and spend.

To secure improvements in quality, safety, performance and a reduction in variable pay a number of change projects are being implemented. The change projects are identified in the diagram below:
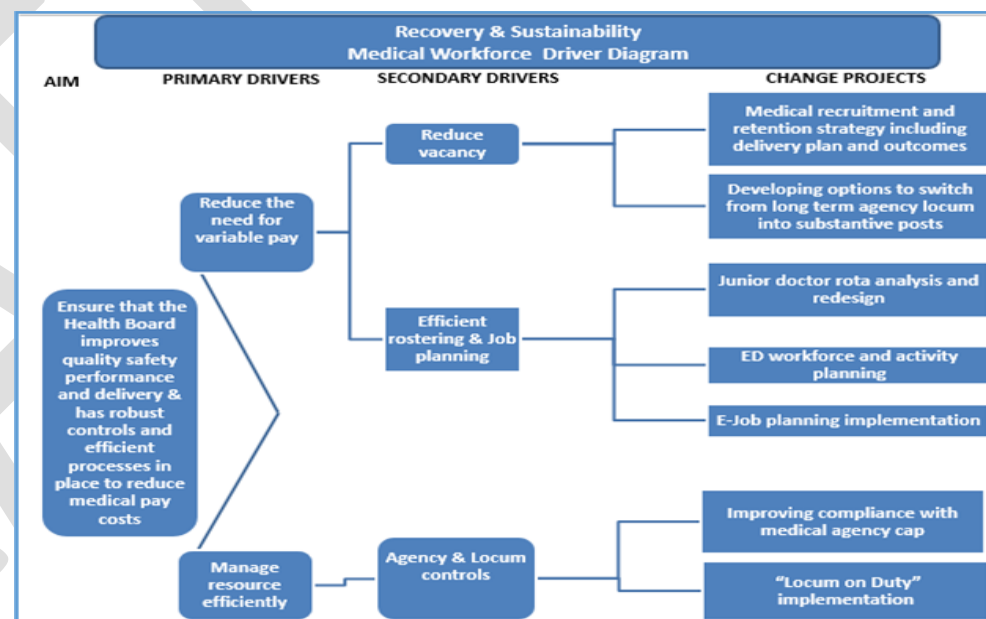
Driver Diagrams can be found in Appendix X

Nursing Workforce

To ensure the efficient and effective use of our nursing resource the Health Board is migrating all nurses to an e rostering system, integrated with the nurse bank module. The integrated system will assist compliance with the Nurse Staffing Act by providing a complete view of substantive rosters and temporary staff to ensure adequate staffing levels. The implementation of the e rostering system is aligned to a full review of shift patterns to ensure standardised shifts are established to meet service and patient needs. This work programme will be completed by late 2019. An additional module,

'Safecare,' will also be deployed which will provide a real time measure of patient acuity to ensure safe staffing levels are maintained.
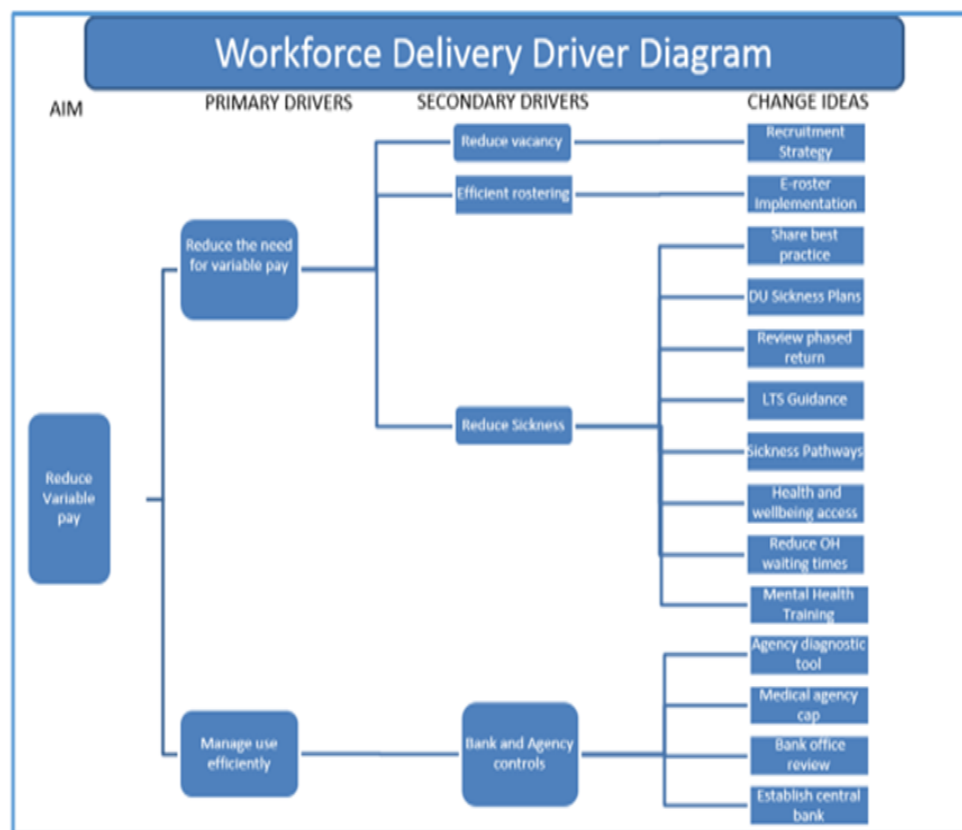
Sickness Absence

The current rolling 12-month performance as at November 2018 stands at 5.93%. The top reason for absence remains stress, anxiety, depression and other mental health illnesses, account for almost 32% of all absence. A detailed sickness analysis is contained in appendix 4.

Delivery Units have sickness absence management action plans aimed at reducing sickness to an interim target of 5%. A number of actions have been developed and implemented as part of an overall sickness reduction plan, including audits on the management of sickness absence, the development

of guidance on the management of long-term sickness, training and development and partnership working with Trade Union colleagues to build a collaborative action plan to improve attendance. The following specific actions are planned:

Educate managers in the use of the new all Wales Managing Attendance at Work policy to ensure we fully exploit opportunities to supporting staff back into work more quickly
Learning events and collaborative action plan with workforce, OH and TUs working in partnership to improve attendance
Develop plan for implementation of learnings from best practise case study conducted in three areas of good sickness performance
Develop and implement improvement plan for occupational health services based on data analysis and engagement with clinical teams
Create a cultural audit tool based on work from the Kings Fund
Provide workshops for employees in collaboration with Health and wellbeing
Review of Workforce resource allocation to support managers in the management of sickness absence

Staff Health and Wellbeing Plan

Keeping staff well in work and reducing sickness absence rates is a key area of ongoing focus and as such staff health and wellbeing will continue to be a priority. Improving access to health and wellbeing services in a timely manner is a key part of the solution. The driver diagram below demonstrates the change projects that will support improved access and reductions in sickness absence rates. The transformation of Occupational Health services will continue to include a more multidisciplinary approach using Allied Health Professionals and the Health Board is developing a sustainable service model. We will continue to develop the Invest to Save funded 'Staff Wellbeing Advice and Support Service' which provides staff with a single point of access to gain timely health and wellbeing support, particularly related to stress, anxiety and depression and musculoskeletal problems. This service development has been accepted as a Bevan Commission Exemplar project. Additionally, we will undertake the following measures to support the Health and wellbeing of our staff.

Occupational Health Process Improvement

Aim — Reduce the referral to report time for occupational health process to 2 weeks by gaining process efficiencies and using prudent healthcare principles

- Daily Triage Process
- Reduced time from up to 2 Weeks to 1 Day
- Increased appointment capacity
- Up to 50 more appointments
- Reduced waiting time from up to 5 Weeks to 2 Weeks
- Reports ready same day
- Reduced Admin time
- Reduced time From up to 2 weeks to 3 days
- Total Impact Referral to Report in 2 weeks
- Effective, Efficient and Prudent use of resources

Develop interventions to focus on mild to moderate mental health problems.
Continue to develop our network of 270 Wellbeing champions who can signpost colleagues to health and wellbeing services.
Implement training for managers to use the Health and Safety Executive Stress Management Standards alongside training in managing mental health in work.
Working closely with related organisation such as Time to Change Wales to reduce the stigma and discrimination of mental health.

Continue to deliver initiatives such as Schwartz Centre Rounds®, Lighten Up and Stress Awareness sessions
Work in partnership with Welsh Government to deliver the 'In Work Support' service which supports the health and wellbeing of employees in small-medium enterprises
The Health Board achieved revalidation of the Gold Corporate Health Standard in 2016 and a plan will be developed to asses our organisational readiness for the Platinum Award
Ensure that staff receive the flu vaccine, the rate, for 2017/18 was 58.5%. We hope to exceed the target of 60% in forthcoming years.

Variable Pay – this accounts for approximately 8% of our total pay expenditure. The main areas of variable pay spend, is unsurprisingly in medical and nurse staffing. The efficiency programmes outlined above relating to sickness absence, vacancy level, and rostering practices will all support directly or indirectly the achievement of the Health Board target of reducing variable pay by 5% in year from the March 2019 baseline figure.

Digital Workforce Productivity - The implementation of an integrated suite of digital workforce systems will enable us to realise further workforce productivity opportunities.

There has been recent investment in a number of digital workforce solutions, including e rostering, nurse bank system, Locum on Duty software, SafeCare and e Job planning. Unfortunately, the resource investment in ESR, which have been made in other organisations, has not been mirrored within ABMU. The impact of this position is that there is significant waste and duplication in many core workforce processes, and a lack of up to date workforce information and analytics to support evidence based practice. A digital workforce vision for the Health Board is currently in development alongside a business investment case to support the achievement of an integrated and sustainable digital way of working for ABMU, although it is acknowledged that this may take 3-4 years to achieve.

Leadership, Culture and Staff Development
Getting this right is the key to organisational success and will make ABMU a great place to work and improve employee engagement and clinical engagement. Evidence demonstrates that organisational performance – quality, user satisfaction, mortality, financial, improvement, productivity, staff absenteeism - is directly linked to levels of employee engagement. The

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overall engagement score for staff from the 2018 Staff Survey demonstrates that it has increased form 3.68 in 2016 to 3.81 in 2018, which we will continue to build on. Our four pillars of work to achieve *excellence through our staff* are illustrated in the diagram below:
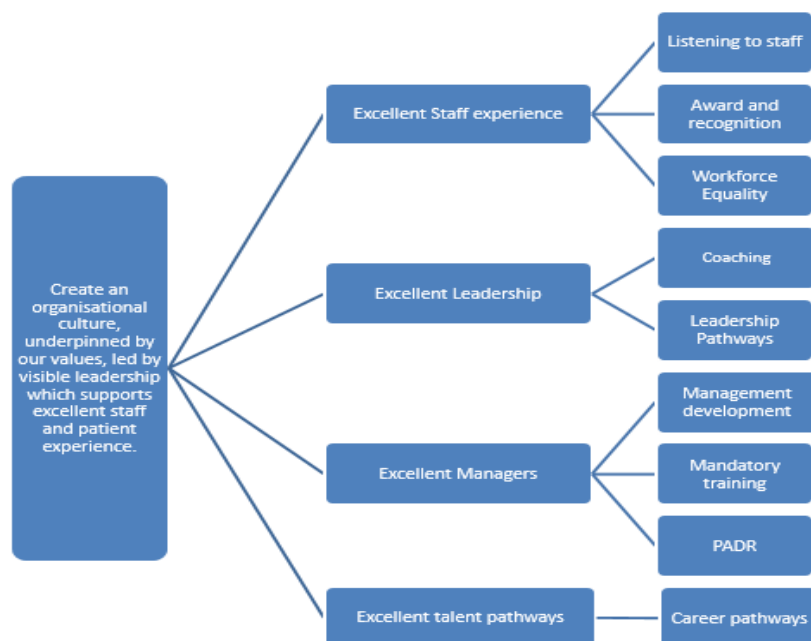
Excellent Staff Experience

We know that great staff experience results in great patient experience and that every role counts. What people do and how they do it matters. We want the very best people to work for us so we can provide the very best care for our patients and communities. We want our staff to feel proud about the care we provide and feel connected to the Health Board and the teams they work within. In 2017, we launched our first Staff Experience Plan "In Our Shoes: Creating Great Staff Experience at ABMUHB" and this continues to be an organisational priority. In delivering the Staff Experience Plan, our priorities are:
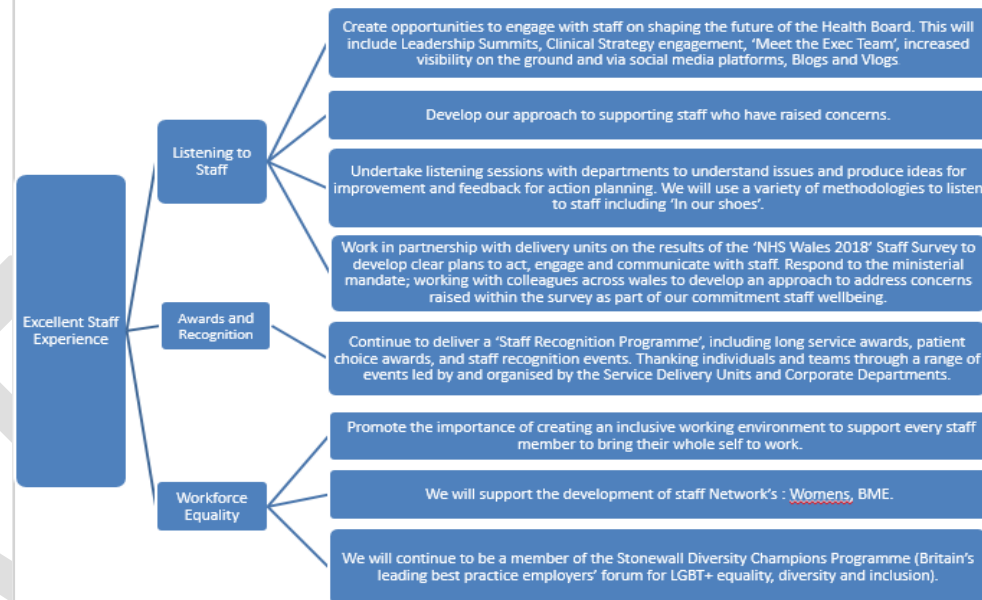
Excellent leadership

Developing values-based compassionate leadership capabilities is our priority; where leaders lead by example and demonstrate our Values and Behaviours in all that they do. We will achieve organisational success by equipping leaders with the tools to engage with staff, support and develop team working and empower our staff to have a real focus on improvement.

The 2018 staff survey results demonstrate that all scores on line managers have shown an improvement since 2016. The score on line managers being approachable about flexible working and on giving clear feedback has improved by 9% and 12% respectively. In addition, the score on staff agreeing that senior managers lead by example has increased by 7% and the question on effective communication between managers and staff has increased from 29% to 33%. As an organisation, we want to continue to build on these very positive results. To support our leaders to develop the required capacity and capabilities, the following actions are planned over the period of the plan.

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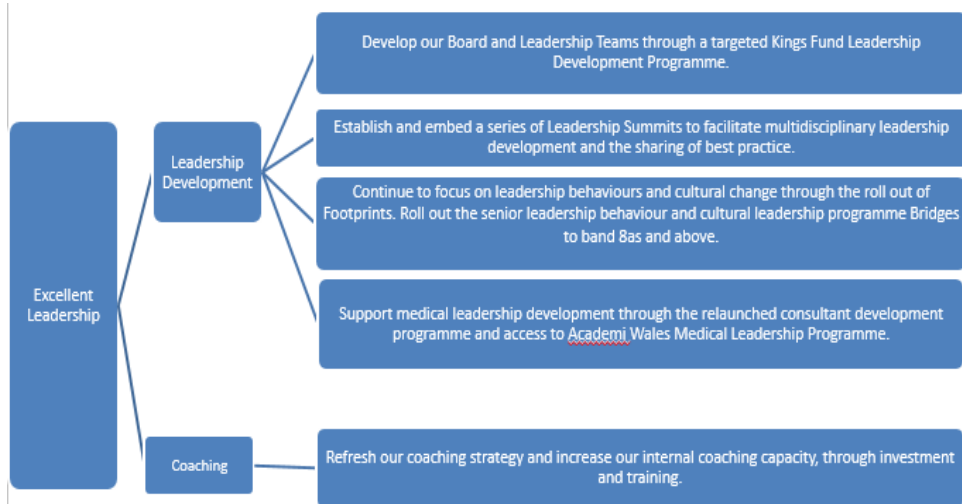
Excellent Managers

The development of core people management skills will continue at pace to ensure that all new and existing managers have the skills to effectively manage individuals, teams and services, underpinned by our organisational values. Our priorities areas are illustrated below:
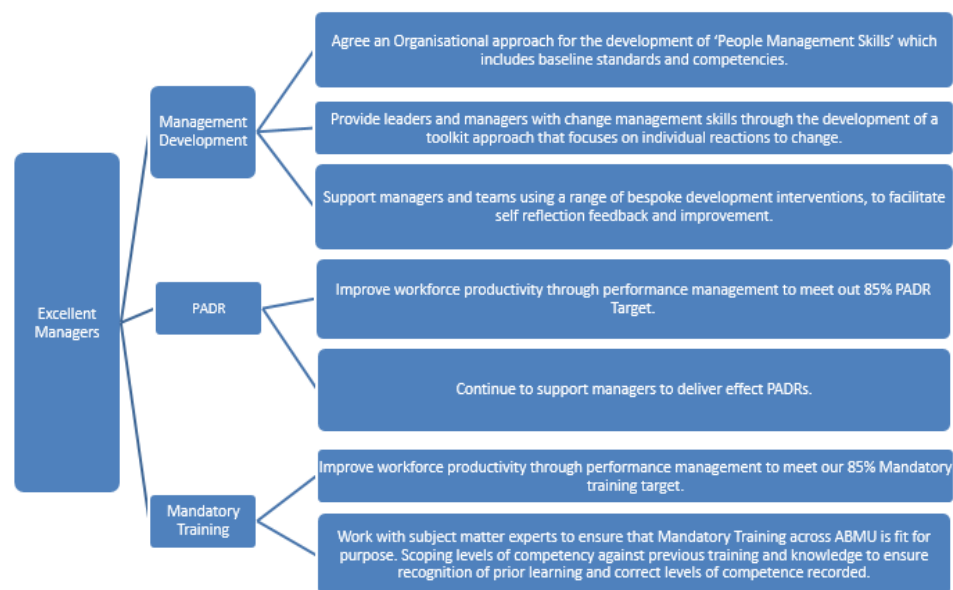
Team working - Research into the effectiveness of teams in Health Care identifies that the best and most cost-effective outcomes for patients and clients are achieved when multidisciplinary teams work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service. Within the recent staff survey, most of the scores on team working for the Health Board are above the NHS Wales scores. The response to the question on team members having a set of shared objectives has shown an improvement since of 9% since 2016. In order to support teams and improve team working we will continue to use evidence-based practice and develop our network of team based working facilitators to support team development and team working across the organisation.

Building improvement skills is a core component in developing values-based compassionate leadership. This will be a key development priority as we roll out our Value-based Healthcare approach.

PADR - The overall percentage of PADR's recorded within ESR for the Health Board is 65%. The rate for medical staff currently stands at 91%. The staff survey showed a significant increase in the number of staff answering positively to having a PADR within the last 12 months, which increased from 2016 by 13%. Further actions are in place to improve compliance. There is a continued focus on training managers to ensure incremental pay progression is achieved and further development and implementation of Values based PADR.

Statutory and Mandatory Training - Compliance against the core skills and training framework is currently 72.8% at the 31st December 2018. This is an improvement of 34.8% since April 2018. This increase accounts for an additional 86,000 competencies achieved by staff.

Equality - The Health Board Equality Plan mirrors the approach taken to develop the Welsh Government Strategic Equality Plan 2016-2020 and is purposefully strategic and signposts to the range of specific activities that will deliver our refreshed Equality Objectives. The Equality Objectives will also contribute towards the achievement of the well-being goals within the Well-Being of Future Generations (Wales) Act 2015. With the pace of change across the Health Board, it is vital that we assess the impact that these changes create. By coaching and mentoring individuals, Equality Impact

Assessment will become embedded into processes ensuring that the best decisions are made.

Excellent Talent Pathways

The demographics of the workforce is changing and we will soon have five generations in the workplace at once. Our future planning will therefore take account of these generational differences in terms of workforce behaviors, what motivates employees and that different generations need to interact and connect. These challenges are also set amidst an ageing UK workforce. More than ever before, we need to rethink familiar approaches to challenges around workforce planning, recruitment, staff development, talent management and succession planning. The future is about building a wider labour market of choice, about developing skills in the community and equipping people (not just staff but also people who use services, carers, volunteers and all who make up the support networks in our communities) with the right competences. We must also take into consideration specific groups who have the need to work flexibly to improve their work-life balance and to improve the retention of staff. We will work together with our partners to ensure that a skilled workforce is available to implement the Health Board priorities through widening access to roles, job and workforce redesign, appropriate and timely training and development of robust policies and procedures. In addition, we are ensuring that all our training and development programmes reflect our Health Board values and behaviours.

In order for us to meet the expectations set out within the Wellbeing of Future Generations Act (Wales) 2015, we will work to widen access to opportunities in the Health Board. The development of talent pathways will be complimented by internal identification of talent and the roll out of effective Talent Management and Succession planning toolkits. This will ensure that staff can see clear development routes and are able to proactively embrace opportunities. This will include:

Excellent Pathways → Career and Talent Pathways:

- Further develop and extend our ABMU Apprentice Academy, offering opportunities for new staff to join the health board and existing staff.
- Work with our partners to develop new and higher level apprenticeship pathways.
- Extend the role out of 'Project Search' into Swansea and Neath.
- Further develop our all age Vocational Training contracts and engagement contracts. Working with partners across the public and 3rd sector to engage our communities. Offer guaranteed interviews for those completing training pathways for apprenticeship roles.
- Further develop the ABMU internal graduate scheme.
- Work with HEIW to introduce NHS Wales Talent Management Scheme for Tiers 1-3 and consider local implementation of national principles for other levels of staff.
- Facilitate individual career pathways within ABMU by ensuring that there is delivery of a fit for purpose Values Led Induction Programme, opportunities for individuals to develop during employment and support preparation for retirement through the delivery of pre-retirement programme.

Pay and Reward

As a Health Board we must always seek ways to creatively reward our staff within the nationally agreed pay arrangements. It is also important to recognise that reward is not always aligned to pay and needs to be viewed in the broadest sense. A number of initiatives that will be explored during the forthcoming period are outlined below.

Incentivise bank arrangements to increase supply including weekly pay.
Creative design of junior doctor roles to enhance recruitment
GP retainer scheme to encourage GPs to continue in practice

Workforce and OD Function and Capacity

Resolving the workforce challenges of the Health Board requires an exceptional workforce team who have the capacity and capability to work with managers and staff to deliver the extensive range of workforce interventions outlined in this plan. Without this intensive focus on strategic workforce issues the Health Board will be unable to secure the organisational transformation outlined in this plan.

There has been a significant reduction in Workforce and OD staffing levels over the last decade which has had a negative impact on workforce performance and ultimately on organisational delivery and performance.

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Additional short term resourcing has been secured which will address a number of areas of key risk. Substantive funding will need to be addressed in the medium to long term. This is further exacerbated by the workforce resource transfer associated with the impact of the transfer of services to Cwm Taf. Following these changes the workforce function will be re-structured to better meet the requirements of new Health Board. Key 'core' workforce priorities are summarised in the diagram opposite:
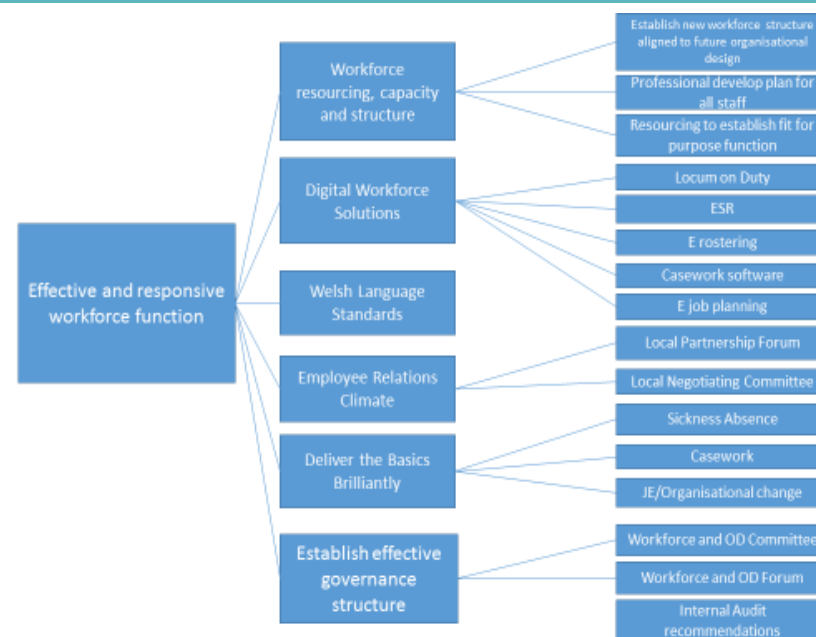
3.6 Capital and Estates

The Health Board continues its ambitious programme of improving its estate and modernising hospital facilities in 2019. The main focus of our modernisation plan remains the development of safer and more acceptable state-of-the-art clinical accommodation and supporting infrastructure.

Our capital plan has been prioritised to support a number of aims enabling improvements required across the Targeted Intervention Areas, continuing to maintain and modernise our existing estate and replace clinical equipment and accelerating strategic developments linked to our local and regional service transformation and stability. The final capital plan is included.

Putting Fire Safety First - replacing existing fascia over-cladding at Singleton Hospital – Following a detailed investigation by an independent Fire Engineer reviewed the existing cladding on Singleton Hospital's Main Ward Block, the recommendations in early 2019 was to remove the existing cladding and replace it with a design and materials that fully comply with

current fire regulations. This will involve some internal and external works but works will be coordinated with other projects ongoing and planned with the aim of maximising safety and minimising disruption to patients and staff and to delivery of patient services. An option appraisal is currently underway and will be reported to the Welsh Government when completed in February 2019.

Anti-Ligature works
The Health Board is committed to reduce the risk by undertaking a programme of works concentrating on high risk areas of low observation which includes installation of new anti-ligature alarmed doors, toilets, and modifications of any unobserved areas. HBN 35 have been used in scoping the anti-ligature works with planned work being undertaken in 19/20 20/21 dependent on funding from the Welsh Government.

New Road for the future development of Morriston Hospital

The Heath Board have acquired (with the Welsh Government support) a number of parcels of land to the North and East of the Morriston Hospital site in order to safeguard the future expansion of services. The Swansea Local Development Plan for 2010-2015 currently is being developed by the City and County of Swansea Council including the expansion of Morriston site with proposals being developed alongside appropriate new road and enhanced highways infrastructure.

Keeping the Lights On

Our Environmental Modernisations Programme Business Case. The Health Board is taking forward an ambitious 10-year programme of environmental modernisations on its acute hospital sites to address environmental safety, compliance and capacity to support our clinical and non-clinical services. The investment supported a number of environmental and estates infrastructure investments across all four acute sites, concluded in 2018; with the next Stage investment concentrates on Morriston Hospital and is split into two phases. When completed, Phases 1 & 2 will provide a much needed and fully compliant new Electrical Sub-station 6 with extra electrical capacity plus additional support for Morriston Hospital's chilling requirements. Phase 1 (£4.4m.) was approved by Welsh Government in December 2018. Works will commence works in early 2019. When the planned Phase 2 is completed, it will provide a permanent statutory solution with the following works requiring funding for replacement of Morriston's existing Sub stations 3 & 4, supporting modernisation of service delivery and patient friendly environments.

Prioritising Patient Safety & Comfort and Delivering on Infection Control

Our 2019 / 2020 Ward Refurbishment Programme will address our highest priority infection control risks within ABMU, focusing on Morriston Hospital's Nucleus designed wards without reducing bed capacity. Essential repairs and replacement of antiquated infrastructure within ward areas significantly improve clinical care environments. Since recent work was completed, Wards J and R have gone a full year since their last Healthcare Acquired c. difficile was reported. Ward B's improvement works are scheduled to be undertaken early 2019 to be followed by ward upgrades, including a refresh of patient bathrooms, sluice rooms and clean utilities, of Morriston's other priority areas - Wards A & S & Angelsey Ward during 2019/20.

Delivering our Clinical Services Plan - Several Primary Care projects are to be delivered locally under the Welsh Government's Wales' Pipeline Investment Plan funding route. These projects, which support development of a network of Wellness schemes, aim to improve quality outcomes for our population: A £1.869m. major refurbishment of Penclawdd Health Centre & Murton Community Clinic are set to commence in early 2019, and; The development of a £5m Health & Wellbeing Centre in Bridgend town centre in partnership with private investors is at an advanced planning stage, with works due to commence in mid-2019, and; the development of a £10m Wellness Centre in Swansea city centre is at planning stage.

Wrap-a-Round Ward at Morriston

The Health Board is planning innovative solutions for increasing beds and ward for medical and surgical services to meet current and future demand, with a new build single storey extension planned on the existing Surgical Day case Medical Unit with increased trolley space and treatment rooms.

Maternity and Neonatal

Planning for Acute-take centralisation of Maternity and Neonatal Care, and Acute Medicine Services at Morriston Hospital is at an advanced planning stage under ARCH and aims to deliver an acute hub for Swansea and Neath Port Talbot.

Surgery and Cancer

The Health Board is progressing development of Critical Care and Specialist Surgery Centres, a Cancer Centre, Imaging and Diagnostic.

Regional Cellular Pathology and Regional Immunology Services at Morriston Hospital.

The Arch Partners are committed to establishing a sustainable South West Wales Regional Cellular Pathology Centre of Excellence. This project is currently at SOC Stage and would be located within an acute hospital setting. ABMUHB and HDUHB have been working together to deliver a fit for purpose and co-located regional service for cellular pathology and for diagnostic immunology services at Morriston Hospital. Proposals for a capital solution new build include an Advanced Therapy and Treatment Centre (ATTC), shell and core area to support future cell and gene therapy and the promotion of research and development for patients with challenging conditions.

Major Trauma Centre

The Health Board is working with WHSSC to establish a Major Trauma Centre at Morriston Hospital in support of the Trauma Network Programme in Wales. This project is at planning stage with leads developing a business case to take this project forward.

Regional Thoracic Services

Following the conclusion of WHSSC's engagement process to decide the future configuration of Thoracic Surgery Services in South Wales ABMUHB have been working with commissioners and the Royal College of Surgeons to improve Thoracic surgery at Morriston Hospital. Plans are being worked up to provide capacity and state-of-the-art facilities and services at planning stage.

Hybrid Theatre at Morriston Hospital

A planning application has been approved by Swansea local authority for an extension to the existing theatre complex to accommodate new storage and changing room facilities and Hybrid theatre. This involves a new build light weight structure to accommodate the displaced changing room facilities and increase plant room facilities to reconfiguration of internal rooms to support the provision of the Hybrid Theatre.

Regional & National Priorities

Construction is well under way on transforming Swansea's Local and Regional Neonatal Services at Singleton Hospital to provide much needed additional capacity and improved services for babies that need extra care. This £9.7 million investment expands our neonatal intensive care and high dependency capacity and provides a new 'transitional care' unit and a fully compliant special care unit. It provides an infrastructure solution that is more acceptable to mothers and carers by achieving full compliance with Environmental Health Standards, WHTM & WHBN, and the Equality Act requirements, and is fully compliant with NICU services' environmental guidance. It provides foundations, steelwork/deck support structure and installation of mechanical ventilation ductwork and AHUS within the area at ground floor level between the corridor tunnel and the corner of west wing and main wing;

A 3rd Catheterisation Laboratory is being proposed at Morriston Hospital which consist of upgrade of the existing outdated lab with full replacement of equipment to cope with current and future capacity demands.

Sexual Health and Referral Centre (SARC) is being developed to provide multi-disciplinary and specialised facilities in partnership with other agencies to provide victims of rape and sexual violence with immediate help and support.

All Wales Parental Unit is being proposed at either Tonna Hospital or NPT. The Health Board has proposed Tonna Hospital as a site that could be refurbished to meet the full requirements of the environmental service standards for a four-bedded unit. The ward area is available for immediate refurbishment and sketch plans have been signed off by the users if this option goes forward. A New build option is being proposed at NPT that meets all requirements with detailed design required now to take it for full planning approval and is estimated at 6-8months design and 12-14momths construction.

The All Wales Capital Programme Summary Plan is included in Appendix X

3.7 Financial Planning

- *To Follow*

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3.8 Governance

The Health Board's governance and assurance arrangements have been established in accordance with our standing orders and standing financial instructions. Further information on the Governance Framework is included in the Health Board's Annual Accountability and Governance Report, Annual Report and the Annual Quality Statement. The Health Board's current governance structure can be seen in Appendix X

In September 2016 the Health Board was escalated by Welsh Government to "targeted intervention" status under the NHS Wales Escalation Framework arrangements. This increased level of monitoring has continued and the Health Board has strived to make the required improvements in relation to unscheduled care, cancer, Referral to Treatment (RTT) times, infection control and the financial management. The Health Board has made some progress in addressing the areas of targeted intervention and continues to focus on strengthening its governance and assurance arrangements, which has been reviewed and referenced by the Wales Audit Office, within their annual structured assessment process.

The system of internal control is informed by the work of Internal Auditors, Clinical Audit and the Directors within the organisation who have responsibility for the development and maintenance of risk assurance and internal control frameworks. Comments on this are made by External Auditors in their Annual Audit Report and other reports. In addition, the work of Healthcare Inspectorate Wales (HIW) in both their planned and unplanned work and other regulators is utilised.

The Health Board recognises the challenges highlighted in the Deloitte Financial Governance Review published in 2017 and the Wales Audit Office Structured Assessment Report 2017/18. The Health Board has made positive progress in addressing the recommendations of these reports and we will continue to make these improvements in 2019/20.

In April 2018 the Delivery Unit (DU) issued their report *Intervention into Systems & Processes for the Management of Serious Incidents at Abertawe Bro Morgannwg University Local Health Board* ('the intervention'*)*. The Health Board has made good progress in relation to the approach taken in investigating serious incidents and the approach to learning amongst staff

has significantly improved to support a culture where risk and harm are reduced as much as possible.

The Health Board has developed a detailed improvement plan to take forward the intervention's recommendations; progress is monitored via the Quality and Safety Committee. The impact of improvements to processes, sharing learning, and improving culture will take time to become embedded, however, there are emerging signs of overall improvement. The Health Board is continuing to address the areas of risk and improvement in relation to Serious Incident Reporting which is being monitored by the Health Board Quality and Safety Committee.

The Health Board's governance and assurance arrangements have been further developed in 2018/19 with a maturing Performance and Finance Committee and progress has been made in a number of areas, demonstrating a step change from previous years. The Health Board will ultimately approve and oversee implementation and delivery of the Annual Plan. Central to implementation and delivery of the Plan is robust local scrutiny and assurance arrangements.

The key sub-committees of the Board involved in monitoring and scrutinising delivery of the Plan will include, but not be limited to; the Performance and Finance Committee, Quality and Safety Committee and Workforce and OD Committee, with regular updates provided to the Executive Board and Health Board on progress.

The Board Assurance Framework (BAF) is in development and will enable the Board to: identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are needed, action plans are in place and are being delivered; provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place.

In conjunction with the development of the Board Assurance Framework, the Health Board has refreshed and is strengthening the risk management process and systems in the organisation. As part of this refresh, the Health Board has established a Risk Management Group and a new Corporate Risk Register. The management of risk is a key priority for the Health Board in 2019/20 and beyond.

The BAF will provide a framework to inform the Board on principal risks threatening the delivery of the Health Board's objectives. The BAF aligns principal risks, key controls, its risk appetite and assurances on controls alongside each objective following the three lines of defence model. Gaps are identified where key controls and assurances are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gaps.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers; these are supplemented by internal sources such as clinical audit, internal management representations, performance management and self-assessment reports.

The Health Board has been through a period of significant change with a new Chief Executive taking up post in 2018, a number of new Executive Directors and Independent Members, who have brought a very welcome level of rigour, scrutiny and challenge to the Health Board. During 2018/19 the Health Board has put in place a development programme to support all new board members to ensure that new ideas and perspectives can be built into the improving governance arrangements for the Health Board.

Welsh Language

The implementation of the 'standards', a statutory requirement set out in the Welsh Language (Wales) Measure 2011, means that the Health Board will be required to take a more proactive and strategic approach to mainstreaming the Welsh language. The Welsh language standards provide clarity for both organisations and members of the public on provision.

The Health Board has been issued with our Draft Compliance Notice by the Welsh Language Commissioner and we have submitted our response following a consultation period of the Draft Compliance Notice. It is anticipated that the Welsh Language Commissioner will issue the Final Compliance Notice and imposition dates in November 2018. We will further support improvement in Welsh language services within the health sector and build on the good work undertaken and the objectives of 'Mwy na Geiriau'… 'More than just words'...

The importance of meeting language needs and the impact this can have on the delivery of safe, high quality care and a positive patient experience cannot be underestimated. The Health Board aims to provide safe quality services, and continues to seek to ensure service users are treated with dignity and respect by ensuring that we, the service provider, offer Welsh language services to people without them having to ask for them, the 'active offer'.

The principle of the 'active offer' provides a solid foundation to improve services for Welsh speakers and help to achieve the vision of Cymraeg 2050, empowering patients to be equal partners in their care ensuring that their each individual physical, psychological, social, cultural, language and spiritual needs are addressed.

In particular, the concept of the 'active offer' in relation to the Welsh language and a workable set of Welsh language standards has the potential to bring about a positive change. We continue to use population assessments in line with the Social Services and Well-being (Wales) Act 2014 to keep us informed how services assess the needs of Welsh speakers and this data is underpinning our plan for service development.

The Welsh Language Standards are sufficiently clear in terms of their purpose in delivering the new legislative framework for NHS Wales. They provide the regulatory factors required to ensure that the Welsh language is not treated any less favourably than English.

The Health Board fully supports the intention of developing a truly bilingual NHS for Wales as we:

- Continue to encourage staff to input their language skills into ESR and make it possible for staff to access ESR via their own Tablets/mobile phones. Our delivery units are working to identify who and where are all their bilingual staff as well as those who want to learn to speak Welsh;
- Promote the free-on line Welsh Language course designed especially for healthcare to encourage existing staff to improve/refresh their Welsh Language skills;
- Have a Bilingual Skills plan that aims to increase the focus that is given to Welsh Language skills in terms of vacancies, particularly for patient-facing roles;
- Bolster our in-house translation capacity and plan for the actions arising from Welsh Language Standards by proceeding with a second translation post. In addition, we are also recruiting an apprentice Welsh Language translator;
- Ensure that all uniforms for Welsh speaking staff have the 'Iaith Gwaith 'logo;
- Endeavour to ensure, where patient-facing systems are in place, that language requirements are met. For example, outpatient self-check-in

system at Morriston Hospital offers patients a choice of whether to transact in Welsh or English;

- Whilst encouraging staff to learn Welsh and refresh their Welsh language skills, also encourage staff to learn everyday phrases that they can use in conversation with patients, as often a word of comfort is all that is needed;
- Continue to work in partnership with Swansea University and Coleg Cymraeg Cenedlaethol, local higher education facilities, schools and Careers Wales, promoting and participating in taster sessions as to what students can expect if they study Nursing and Midwifery through the medium of Welsh;
- As part of our responsibility to send bilingual correspondence to service users, where language preference has not been identified, continue to

Civil Contingencies Act (2004):- Civil Protection Duties
- Assess local risk
- Preventing and responding to emergencies
- Warning and informing
- Share information
- Cooperate with local responders
- Corporate arrangements for business continuity management

make progress in terms of the letters we issue for outpatient appointments. As of the Spring 2018 our systems have been able to issue bilingual outpatient letters with the intention of ensuring 100% compliance by the end of 2018;
- Establish the Regional Forum to work collaboratively with other health boards/trusts helps us to implement the Welsh Government's Strategic Framework, 'More Than Just Words.....'
- Have active Welsh language Twitter and Facebook accounts which help us to promote Welsh language services and events;
- Continue to hold awareness sessions on Welsh language issues for GPs and Practice Managers and continue to work with them to increase the number of referrals setting out patient language needs.

The Health Board's Welsh Language Scheme sets out our commitment to developing and supporting our staff to deliver a bilingual service for our patients and service users whilst we are awaiting the publication of the Welsh

Language Standards. Our Bilingual Skills plan and its action plan will help mainstream the Welsh language into all of our internal processes.

Emergency Preparedness Resilience and Response, (EPRR)

Delivery of a robust emergency preparedness resilience and response work programme will ensure that;

- There is a fully engaged workforce in resilience matters.
- We maximise and provide effective patient outcomes when patients are treated as part of an emergency incident.
- There is effective governance and continued multi-agency partnership working in civil protection duties.
- We deliver safe patient care by securing a risk based foundation, undertaking a business impact assessment and including appropriate mitigation measures.
- We evaluate against National Resilience Standards; 1 - 12 in order to meet expectations and lead practice to build on and complement the statutory duties under the Civil Contingencies Act 2004 and other relevant legislation.

The EPRR Strategy Group focusses its work programme on ensuring the Health Board is meeting its civil protection responsibilities as a Category 1 Responder, as defined in the Civil Contingencies Act 2004. This work is undertaken through the principles of integrated emergency management, which is a cyclical approach to preventing and managing emergencies, with

a risk based approach at its foundation. All EPRR related work is discussed, agreed and endorsed within the EPRR Strategy Group. Twice a year an update on this work, the risks being faced, and the way in which these challenges are being considered, is prepared for the Health Board.

Brexit

The Health Board has recognised the potential impact of Brexit and we are working on preparedness as an organisation, utilising existing business continuity plans as the basis of preparedness. The EPRR Strategy Group is overseeing the process with the involvement of all Delivery Units, service departments and corporate directorates. A special workshop was held with to focus on the main risks and issues for the organisation. A risk assessment has been carried out by all Delivery Units, services and departments, with low / medium / high risk scores agreed. Further work will continue in the following areas;

- Reviewing existing business continuity plans to ensure they are fit for purpose for Brexit
- Where business continuity plans have yet to be finalised, ensuring these are completed as a matter of urgency
- Gaining clarity on national preparedness and understanding the assurance this gives for us and identifying any gaps in preparedness
- Risks identified across the organisation being collated into risk matrix
- Identifying and agreeing mitigation measures which can be implemented to reduce the risks identified in the assessment

Summary Plan – Enablers (Workforce, Capital, Finance, Governance)

Actions		Milestones 2019/20	Measures	Lead
Shape of the Workforce action plan to meet the requirements under the Nurse Staffing Act.	Q1	Undertake a review of Band 2, 3 and 4 nursing roles to address qualified nursing deficits taking into account the Nurse Staffing Act.	HW_DP10 NDF_94 NDF_92 NDF_93 NDF_96	DON
	Q2	Develop and commence a phased implementation plan meet the requirements under the Nurse Staffing Act.		
	Q3	Continued delivery of the phased implementation plan for the Nurse Staffing Act		
	Q4	Continued monitoring of the organisations compliance with the Nurse Staffing Act		
Workforce resourcing, reducing vacancies and turnover within the first 24 months of employment (particularly nursing staff).	Q1	Develop action plans to reduce vacancy rate and turnover in 24 months	NDF_94 NDF_92 NDF_93 NDF_96	WOD
	Q2	Commence action plans to reduce vacancy rate and turnover in 24 months		
	Q3	Continued delivery of action plans to reduce vacancy rate and turnover in 24 months		
	Q4	Review success of action plans to reduce vacancy rate and turnover in 24 months		

Workforce Efficiency through effective rostering and a sustainable digital way of working.	Q1	Full review of shift patterns to ensure standardised shifts are established to meet service and patient needs	NDF_94 NDF_92 NDF_93 NDF_96	WOD
	Q2	Implementation of the e-rostering system		
	Q3	Development of a digital workforce vision for the Health Board and a business investment case		
	Q4	Reduce sickness absence sickness to an interim target of 5%. Reduction in variable pay by 5% in year from the March 2019 baseline figure.		
Leadership, Culture and Staff Development	Q1	Continued focus on training managers to ensure incremental pay progression is achieved.	NDF_94 NDF_92 NDF_93 NDF_96	WOD
	Q2	Further development of Values based PADR.		
	Q3	Further implementation of Values based PADR.		
	Q4	Improvement in 2019/20 PADR compliance and improve mandatory and statutory training compliance by 10% in year from the March 2019 baseline figure.		
Development of the **Board Assurance Framework**	Q1	New corporate risk register fully embedded	HW_DP8 LM_9	DOC G
	Q2	Board Assurance Framework in place.		
	Q3	Implementation of required action plans monitored through the Risk Management Group		
	Q4	End of year assessment of benefits achieved by enhanced management of risk and the Board Assurance Framework.		
Welsh Language embedded into the core business of the Health Board	Q1	Ensure our systems have been able to issue bilingual outpatient letters	NDF_83	DOC G
	Q2	Bilingual Skills plan in place to increase the focus on Welsh Language skills particularly for patient-facing roles		
	Q3	100% compliance issuing bilingual outpatient letters		
	Q4	Have active Welsh language Twitter and Facebook accounts which help us to promote Welsh language services and events		
Ensure the Health Board is suitably prepared for the outcomes of **Brexit**	Q1	Review existing business continuity plans to ensure they are fit for purpose for Brexit	LM_9 HW_DP9	DOS
	Q2	Risks identified across the organisation collated into risk matrix.		
	Q3	Implement mitigation measures to reduce the risks		
	Q4	Undertake assessment of effectiveness of mitigation measures		
Delivery of **Financial savings** through delivery of the underlying deficit, management of cost pressures and delivery of high value opportunities	Q1	Phased implementation of the Financial Plan	HW_DP10	DOF
	Q2	Continued implementation of the Financial Plan		
	Q3	Assessment of targeted actions required to achieve delivery of Financial plan.		
	Q4	Focused interventions to ensure delivery of financial plan.		
Improving estates and modernising hospital facilities enabling improvements required across the Targeted Intervention Areas.	Q1	Commence agreed plan following option appraisal on cladding on Singleton Hospital's Main Ward Block.	HW_DP7	DOF
	Q2	Completion of Phases 1 & 2 of Morriston Environmental Modernisations Programme.		
	Q3	Continued implementation of the 2019 / 2020 Ward Refurbishment Programme.		
	Q4	Planning and development of Hybrid Theatre at Morriston Hospital.		

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> BYWYDAU GWELL

OUR ANNUAL PLAN APPENDICES

2019/20

Contents

Appendix 1 Commissioning Intentions 2019/22

Commissioning
Intentions Draft v4.c

Appendix 2 Major Health Conditions Delivery Plans

Cancer Delivery Plan	Cancer Delivery Plan_IMTP Template_
Critically Ill Delivery Plan	Critically Ill Delivery Plan - Morriston 201
Diabetes Delivery Plan	Diabetes Delivery Plan 201922.docx
Eye Health Delivery Plan	Eye Care Delivery Plan 201920 FINAL.d
Heart Disease Delivery Plan	**In Development**
Liver Disease Delivery Plan	MHC Delivery Plan_IMTP Template_
Mental Health Delivery Plan	2018 ABMU Area T4MH Annual updat
Neurological Conditions Delivery Plan	**In Development**
Oral Health Delivery Plan	Oral Health Delivery Plan 201920 MS KD a
End of Life Care Delivery Plan	
Rare Diseases Delivery Plan	Rare Diseases Delivery Plan 201920
Respiratory Health Delivery Plan	MHC Delivery Plan_IMTP Template_
Stroke Care Plan	Stroke - MHC Delivery Plan_IMTP T

Appendix 3 Targeted Intervention Priority Area Driver Diagrams and Performance Trajectories

DRIVER DIAGRAM   HCAI PERFORMANCE

Drivers	Objectives	Measures
Aim (left column): Reduce healthcare associated infections: Clostridium difficile, Staph. aureus bacteraemia, & Gram negative bacteraemia, e.g. E. coli bacteraemia		
Prevent & Reduce *C. difficile* infection	Improve patient outcomes through: early detection; timely isolation; appropriate treatment / management effective decontamination of patient equipment and environment.	15% reduction in *C. difficile* infection (against 2017/18 profiles) 10% reduction in recurrent *C. diffi*cile cases (against 2018/19 baseline). Quarterly % improvement in samples sent to the laboratory within 24 hours of onset of symptoms. Quarterly % improvement in patients isolated within 2 hours of onset of unexplained diarrhoea. Quarterly % improvement in source bays decanted, deep cleaned and disinfected 95% compliance with hand hygiene
Prevent & Reduce *Staph. aureus* bacteraemia	Improve patient outcomes through: prevention of device related infections; MRSA Clinical Risk Assessment; accurate diagnosis; appropriate treatment	10% reduction in *Staph. aureus* bacteraemia (against 2017/18 profiles) Quarterly % improvement in ANTT competence assessed clinical staff. Quarterly % improvement in compliance with MRSA Clinical Risk Assessment against 2018/19 Q4 baseline. 95% compliance with hand hygiene
Prevent & Reduce *E. coli* bacteraemia	Improve patient outcomes through: prevention of UTI; accurate diagnosis of UTI; appropriate treatment of UTI	5% reduction in *E. coli (and other gram negative)* bacteraemia (against 2017/18 profiles) Quarterly % improvement in ANTT competence assessed clinical staff. 95% compliance with hand hygiene compliance with UTI prescribing guidelines
Improve antimicrobial stewardship (AMR)	Improve patient outcomes through: preventing infections; improving compliance with "Start Smart, Then Focus" audit & feedback of antimicrobial prescribing data.	50% reduction in Co-amoxiclav prescribing in secondary care (against 2017/18 baseline data) ≥55% total antibiotic consumption (DDD) in secondary care in WHO Access category Reduction in the proportion of antibiotics prescribed for which there are no specific Health Board antimicrobial guidelines.
Information	Improve quality of local healthcare associated infection data through ongoing support and use of ICNet electronic surveillance system, and its interface with Ward to Board Dashboards	Health Board to continue to fund use of ICNet Provision to Delivery Units of monthly data on HCAI, Informatics to scope with Public Health Wales & ICNet interface to facilitate import of HCAI data to inform Ward to Board Dashboard.

Actions

Undertake baseline audit & subsequent quarterly spot-check audit on time taken from onset of unexplained diarrhoeal symptoms to obtaining a sample, with feedback of results to Delivery Units for actioning.
Undertake baseline audit & subsequent quarterly spot-check audit on time taken from obtaining diarrhoeal specimen and its receipt by the laboratory, with feedback of results to Delivery Units for actioning.
Undertake baseline audit & subsequent quarterly spot-check audit on time taken from onset of unexplained diarrhoeal symptoms to isolation, with feedback of results to Delivery Units for actioning.
Undertake *C. difficile* ward round on key wards once weekly (dependent on availability of Public Health Wales Consultant Microbiologist).
Undertake baseline audit & subsequent quarterly spot-check audit of compliance with MRSA Clinical Risk Assessment, with feedback of results to Delivery Units for actioning.

Delivery Units to continue to ensure compliance with the number of relevant clinical staff that have been ANTT competence assessed in accordance with All Wales ANTT Policy.
Delivery Units Quality Improvement Leads for Infection to lead on HCAI Improvement Programmes within each Delivery Unit.
Develop specific Health Board Antimicrobial Guidelines for those antibiotic prescriptions that have been identified through bimonthly audits as not having dedicated guidelines available for prescribers.
Continue to identify compliance with restricted use of Co-amoxiclav in secondary care.
Develop Primary Care Antimicrobial Guidelines which support the restricted use of Co-amoxiclav.
Informatics to include within their IMTP a resource to scope out the development work required to import data from ICNet to inform the Ward to Board Dashboards.

HCAIS – Performance Trajectories

ABMU Clostridium difficile Infection Reduction Expectation 2019/20
(15% reduction)

177

151

Cumulative Cases Profiles 2018/19 — Cumulative Trajectory Profiles 2019/20

ABMU Staph. aureus Bacteraemia Reduction Expectation 2019/20
(10% reduction)

168

151

Cumulative Cases Profiles 2018/19 — Cumulative Trajectory Profiles 2019/20

ABMU E. coli Bacteraemia Reduction Expectation 2019/20
(5% reduction)

476

452

Cumulative Cases Profiles 2018/19 — Cumulative Trajectory Profiles 2019/20

Drivers	Objectives	Measures
Aim To achieve improvement in Unscheduled Care performance through a value based approach to delivering safe and sustainable care models.		
Living Well	Improved population health and well being	Acheivement of the NHS Wales Outcome Measures for Staying Healthy
Reduction in Unnecessary Hospital Attendance	Strengthen service models and [pathways of care that contribute to an admission reduction for the Big 5 hospital admissions in partnership with WAST	Reduction in medical admissions on March 2018 baseline Reduction in frequent attenders on March 2018 baseline Achieve target of 25% patients being seen through ambulatory care pathways
Timely Access to Urgent or Emergency Care	Continual development of service models that promote timely access to the right care professional 7 days a week e.g. acute clinical response teams, hot clinics, frailty services, 111, Primary care clusters	Achieve target of 25% patients being seen through ambulatory care pathways Reduction in admissions of patients for IVs Reduction in over 65s assessed at hospital (ACT to take from ambulance stack)
Reduce patient risk through reduction in avoidable delays and prolonged hospital stay	Implement NHS Wales Delivery Unit complex discharge audit recommendations and Right Care Right Place review recommendations. Rebalacing medical bed capacity at Morriston.	Achievement of trajectories for NHS Wales Outcome Measures for A&E Achievement of LoS consistent with Welsh peer average Improvement on patient flow measures against 2018/19 baseline Achievement of DTOC (excluding mental health) consistent with annual plan trajectory

Actions

Evaluation of Care and Repair Wales pilot scheme and assessment of suitability for roll out
Recommendations of assessment of vascular, #NOF and AMAU effectiveness pathways to be implemented
Implement recommendations of assessment of ED pathways if supported in Q4 2018/19
Maximise use of Medicine Hot Clinics
Maximise use of Respiratory Hot Clinics
Maximise use of Cardiology Pathways
Maximise use of Neurology Hot Clinics and Flexible Beds
SAFER board rounds
Senior review before midday
MDT clinical management plans for each patient
Use of EDD methodology
Standardised identification of patients who are Medically Fit for Discharge
Improving assessment process for CHC
Focus on stranded patients
Use of Red2Green methodology

Improve Psychiatric Liaison service with aim of gaining RCPsych accreditation (if funding secured)
Revise the Escalation Policy and maximise use of the 'safety huddle' approach
Maximise use of Early Supported Discharge for COPD patients at Morriston and Singleton
Maximise use of community hospital frailty beds
Pathway Co-ordinators at Morriston (if funding agreed through Invest to Save)
Green to Go ward relocation (if funding agreed through Invest to Save)
OPAS plus to be implemented at Morriston (if funding agreed through Invest to Save)
Commence planning for the centralisation of the Acute Medical Take at Morriston by agreeing the Critical Path for change
Draft Transformation Fund Bid for Hospital2Home service to be submitted to WG for consideration including new discharge to assess and recover model, expansion in reablement at home, expansion in acute clinical teams & Single Point of Access.
Plan for the wraparound ward to be agreed.
Plan for the 2nd MRI scanner to be agreed.

Unscheduled Care – Performance Trajectories

DRIVER DIAGRAM   PLANNED CARE

Drivers	Objectives	Measures
Reduced inappropriate referrals into secondary Care	Ensure that Patients referred into the secondary care services are appropriate and are then treated in a timely fashion	MCAS to continue seeing / triaging patients / extended service as appropriate MCAS waiting time reduction Audiology see / triarge / extended service being provided Waiting list reduction Improvement in the quality of referrals for advice / Consultation Primary Care ODTC model to be implemented
Increased outpatient clinic slots	Enable the maximised utilisation of outpatient capacity to see new patients referred into the service in a timely fashion	Appropriate referrals from MCAS / other referral routes / Audiology / Optometry Increase / Improved new to f/u ratio Reduced waiting times for patients Primary Care ODTC model to be implemented - releasing additional capacity in secondary care Implement PROMs with Orthopaedics (Hips / Knees)
Improved Theatre performance and access to beds	Ensure current available theatre and bed capacity is utilised effectively and efficiently to allow the maximum number of preocedures to be undertaken in a timely way.	Reduced Waiting times Utilisation rates increased Early starts / late Finishes reduced Bed utilisation and reduced cancellations on the day
Appropriate level of follow up care	Ensuring that patients following treatment are effectively managed	Appropriate review monitored through PROMs audits f/u levels consistent with WG Action Reporting R1, R2, and R3 Measures in ophthalmology Implement PKB within Urology PSA Services - self management roll out Sustainable services in place
Maximise use of all Health Board capacity for orthopaedics	Protect elective orthopaedic activity to improve efficiency, improve performance and reduce overall waiting times for patients needing surgery	Delivery of Clinical Services Plan aim to protect elective activity by splitting elective and non-elective surgery where possible across Health Board sites, based on complexity
Maximise West Wales Network arrangements	Agree service specification / potential Network with Hywel Dda for Dermatology and Ophthalmology services	Delivery of an agreed service specification model and in place to deliver Vacancies appointed Appropriate skill mix in place

Aim

To deliver a sustainable service whilst providing improved performance to the overall clinical pathway with reduced waiting time / delays in individual patient treament plans

Actions

Continue with MCAS arrangements and as appropriate extend service provision (ie Joint pain injections) - with waiting times to be maintained at 8 weeks maximum
Develop pathway referral processes and agree with Primary care
Use of e- referral / Tele dermatology for advice and support into General Practice
Introduce Audiology Pathway with referrals as appropriate directed into the Audiology Service.
Increased use of Optometry / Non Medical services to monitor and refer patients following appropriate guidlines
Reallocate f/u slots from introduction of Welsh Government priority action to new patients
Introduce Outpatient Modernisation actions
Bring on line the additional Ophthalmology Clinic space
utilise the new Ophthalmology equipment and resource staffing for virtual clinics - Reallocated f/u slots to new patients
Use of Tele dermatology
Ensure timely access to Beds
Improve Theatre efficiency and utilisation
Maximise use of all Health Board capacity and protect elective activity where possibel, base don complexity - including for orthopaedics
Continue with TNO utilisation and treatments directed to Outpatients in ENT
ENT access to Singleton theatres to utilise for routine and high activity capacityContinue with MCAS arrangements and as appropriate extend service provision (ie Joint pain injections) - with waiting times to be maintained at 8 weeks maximum
Develop pathway referral processes and agree with Primary care
Use of e- referral / Tele dermatology for advice and support into General Practice
Introduce Audiology Pathway with referrals as appropriate directed into the Audiology Service.
Increased use of Optometry / Non Medical services to monitor and refer patients following appropriate guidlines
Reallocate f/u slots from introduction of Welsh Government priority action to new patients
Introduce Outpatient Modernisation actions
Bring on line the additional Ophthalmology Clinic space

Utilise the new Ophthalmology equipment and resource staffing for virtual clinics - Reallocated f/u slots to new patients
Use of Tele dermatology
Ensure timely access to Beds
Improve Theatre efficiency and utilisation
Maximise use of all Health Board capacity and protect elective activity where possibel, base don complexity - including for orthopaedics
Continue with TNO utilisation and treatments directed to Outpatients in ENT
ENT access to Singleton theatres to utilise for routine and high activity capacity
Reallocated lost Funded theatre session in Morriston for Urology to enable return to a balanced service provision
Ensure Cataract throughput are equalised or improved upon in Ophthalmology.
Implement current agreed best practice in follow up management as agreed at the National Planned Care Board / Welsh Government priority
Implementation of NWIS systems to oversee PROMs activity and protocols in Orthopaedics
Implementation of "Open Eyes" or equivalent to oversee PROMs activity / protocols in Ophthalmology
Introduce / Embed Virtual Clinics and build into Consultant / Non Medical staff job plans.
Embed Ophthalmic Priority Measures across the Health Board.
Reallocated lost Funded theatre session in Morriston for Urology to enable return to a balanced service provision
Ensure Cataract throughput are equalised or improved upon in Ophthalmology.
Implement current agreed best practice in follow up management as agreed at the National Planned Care Board / Welsh Government priority
Implementation of NWIS systems to oversee PROMs activity and protocols in Orthopaedics
Implementation of "Open Eyes" or equivalent to oversee PROMs activity / protocols in Ophthalmology
Introduce / Embed Virtual Clinics and build into Consultant / Non Medical staff job plans.
Embed Ophthalmic Priority Measures across the Health Board.

Planned Care – Performance Trajectories

To Follow

DRIVER DIAGRAM   STROKE

Drivers	**Objectives**	**Measures**

Aim
To improve access to care and support across the stroke pathway to deliver better patient outcomes.

Drivers	Objectives	Measures
Living Welll and stroke prevention	Promote primary and secondary prevention through treatment and advice to manage lifestyle and provide the appropriate pre hospital interventions in conjunction with partner organisations	Prevention actions including increasing physical activity, reducing obesity, increasing health literacy and improving self-care See USC Plan for smoking cessation Increase the number of patients on anticoagulation therapy on 2018/19 baseline
The provision of FAST effective care	Provide early access to evidence based interventions, treatments and care in the most appropriate care environment	Access to TIA clinic within 2 days of referral Improve compliance with quality improvement measures and accesss to thrombolysis within 45 minutes and CT scan within 1 hour Business case agreed for HASU
The provision of rehabilitation services to aid recovery and to promote life after stroke services	Recognising and addressing the life long effects of stroke on the patient, family and carers and providing the right amount of therapy from the right therapists in the right environment that best serves the patient need	Increase the number of patients receiving early supported discharge through a community rehabilitation model. Reduction in the number of bed days associated with patients on the stroke rehabilitation pathway against 2018 baseline
End of life care	Recognising that stroke is a catastrophic and life limiting event for some individuals and ensuring that we provide the best palliative care for our patients and the best support to family and friends at this time	Increase the number of palliative stroke patients who are being managed on the end of life pathway.
Workforce Redesign	Adopt prudent health care principles within the stroke workforce model Targeted increases in the workforce to achieve to provide a consistent approach to stroke care 7 days a week.	Increase in the number of generic roles. Evidence of staff who have received stroke training awareness sessions

Actions

Full implementation of the anticoagulation local enhanced service
Increased uptake on smoking cessation programmes
Continuing work to improve physical activity and reduce obesity
Confirm thrombectomy pathway for ABMU residents
Promote FAST in the identification of strokes adult and children
Continue to develop TIA services
Explore the provision of Capture stroke system to support real time reporting.
Develop Joint Business case for the HASU at Morriston with Hywel Dda HB

Capture patient reported outcomes
Improved access to Life after stroke clinics
Deliver the business case for an early supported stroke discharge service and use service redesign opportunities to develop an ESD service.
To ensure that all stroke palliative patients are managed in accordance with the end of life care pathway
Explore opportunities to expand targeted 7 day cover through workforce redesign.
Recruitment to medical vacancies at Morriston to support 4 hour bundle.
Continue staff training and awareness sessions of stroke pathway

Stroke – Performance Trajectories

Direct admission to acute stroke unit within 4 hours

Legend: 4 hours actual, Low end forecast, High end forecast

Patients who are diagnosed with a stroke who receive a CT scan within 1 hour

Legend: CT Scan Actual, Low end forecast, High end forecast

Patients who are assessed by a stroke specialist consultant physician within 24 hours

Legend: 24 hour assessment actual, Low end forecast, High end forecast

Thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes

Legend: 45 min thrombolysis actual, Low end forecast, High end forecast

DRIVER DIAGRAM   CANCER

Drivers	Objectives	Measures

Aim

To have cancer-related health outcomes on par with equivalent populations in the UK and Europe and to receive the best evidence-based treatments at all levels delivered in a timely and appropriate manner.

Prevention of cancer → Support the development of a sustainable health and care system focused on prevention and early intervention →
By 2030, by working with Welsh Government and others and by involving people in our decision-making, Public Health Wales will have:
delivered year on year increases in the proportion of children and young people who are smoke free and helped an increasing number of smokers to quit.
Implementation of a new national obesity prevention and reduction strategy.
Development of a new comprehensive programme of prevention of alcohol related harm

Detecting Cancer earlier → Improve patient outcomes through early detection - more curative, less intensive and less expensive treatments.Reduce new cancer diagnoses made in an emergency setting →
Established Rapid Diagnostic Clinic
Improved diagnostic capacity to achieve the diagnostic part of the pathway within time scales stipulated in the SCP(20%)
Improved bowel cancer outcomes by optimisation of the bowel screening programme and the development of sustainable endoscopy services
Seamless handover between primary and secondary care.
Delivery and developed evidence based national population screening programmes in line with UK National Screening Committee and WG Recommendations

Delivering fast, effective treatment and care → Our patients receive prompt, effective high quality treatment and care in an equitable and sustainable service for their cancer so that they have the best chance of optimising their quality of life and improving survival, reciprocated by patients taking responsibility for lifestyle choices that positively contribute to their treatment and care →
Implementation of the Single Cancer Pathway including pathway standardisation and detecting cancer early programme.
Compliant with all agreed national optimal cancer pathways.
Patients with Metastatic Spinal Cord Compression (MSCC) diagnosed have a whole spine MRI within 24 hours and then a surgical opinion within 6 hours
Achievement of Cancer Waiting Times Targets
Compliance with Peer Review Programme
Robust Governance arrangements for Regional/Specialist MDT's

Meeting People's Needs → Our patients to be placed at the heart of cancer health care with their individual needs identified and met so that they feel well supported, informed and able to manage the effects of living with and after cancer. →
Framework on the strategic direction of Clinical Nurse Specialists caring for patients with cancer.
100% of people diagnosed with cancer in ABMU will be allocated a Keyworker
100% of people diagnosed with cancer will be offered a Holistic Needs Assessment (HNA) and associated care plan at key times of need. This will include adopting an opt-out approach to offering Welfare Benefits Advice (WBA).
100% of people diagnosed with cancer in ABMU will have a Treatment Summary to support patients in primary care beyond their cancer treatment and recovery
Established Cancer Information and Support Service

End of Life → Reduce admissions to Acute Hospitals at the end of life & supporting patients to remain in their place of residence →
Increase in patients dying in their preferred place of care.
Reduce admission to hospital for care in the last days of life where appropriate
Outcomes measures that more accurately reflect the experience of the patient
Patients have access to Bereavement care & appropriate facilities

Improving Cancer Information → Access to automated data in a useable, extractable, visual based format which tells the user the current health of the component parts of the SCP . →
Demand & Capacity Vitals Charts programme used across planned stages within the SCP.
Implementation of the cancer information solution to replace the CaNISC functionality and the developments to improve Tracker 7 to support the implementation of the Single Cancer Pathway

Research → Our patients affected by cancer should have equitable access to participate in clinical trials and other well designed studies, including opportunities to be involved in and engaged in research →
Over the next three years increase the number of trials open to recruitment

Cancer Strategy & Leadership → A Cancer Strategy, that is clinically lead and supported by Executive Directors. Leadership and accountability for the delivery of the Cancer Delivery Plan defined. →
A Cancer Strategy, that is clinically lead and supported by Executive Directors. Leadership and accountability for the delivery of the Cancer Delivery Plan defined.

Actions

Fully implement the existing Help Me Quit programme.
Maximize the use of technology to develop a wider range of support options
increase the proportion of smokers who are aware that quitting with NHS help provides the best chance of success and help health professionals support smokers to access the best help for them.
Continued implementation of social marketing programme.
To support Welsh Government to develop and implement a new national obesity prevention and reduction strategy and to implement fully the current 10 Steps to a Healthy Weight programme.
Develop a new comprehensive programme of prevention of alcohol related harm
The Cancer Improvement Board to support/agree the business case to secure funding to maintain and expand the RDC service.
Establish Demand & Capacity planning/modelling as core business in service delivery plans.
Ensure service delivery plans account for the capacity required for the introduction of a new first-line Faecal Immunochemical Test (FIT).
Establish routine liaison mechanisms between primary and specialist care
We will work alongside our partners to support the development of sustainable and accessible health and care systems focused on prevention and early intervention. This will include a focus on national population-based screening, reducing variation and inequality in care and harm in its delivery and supporting care moving closer to the home.
Provide capacity for bespoke Stock & Flow modelling of services to establish if any capacity gaps for SCP are present within the existing service .
Agreed MSCC pathway between ABMU & C&V
Cancer Improvement Board to focus on immediate performance issues as well as sustainable improvement
Support and Challenge Panels to continue to ensure constructive challenge; update and support to each MDT.
Continue participation in the cancer peer review programme and deliver on peer review action plans
Provide regional models of delivery, innovation, intergrated pathways, create economies of scale and provide more specialist treatment closer to home
Clear plans to deliver compliance with the single suspected cancer pathway by June 2019
Governance arrangements for regional/specialist MDT's to be agreed and MUO's to be implemented as recommended by WCN.
Finalise and implement Non surgical Cancer Strategy.
On recommendations of ICHOM take value based health care approaches forward.
To further develop Acute Oncology Service and plan for the sustainability of the service
Develop a framework for support, development and ultimately transformation of not only Macmillan CNS posts, but for all cancer nursing roles, improving delivery on key worker, holistic needs assessments, written care plans and patient experience.
Name and date of Keyworker is to be recorded electronically on a yet to be identified system.
Implementation of the e-HNA across the tumour site teams in the Health Board.
Encourage co-production -patients agreeing a joint set of actions aligned to their values and to achieve their personal expectations of

Provide services as locally as is feasible
Ensure prompt information provision, signposting and onward referral to wider health and social care teams such as TYA service, learning difficulties and where to access welfare benefits advice.
To establish a steering group within the health board to provide direction and accountability for the establishment of CISS within Singleton, Morriston and Neath Port Talbot Hospital delivery units.
Establish routine liaison mechanisms between primary and specialist care to meet people's ongoing and post-treatment care needs and ensure seamless handover between primary and secondary care.
To Identify processes to support the enquiry and recording of preferred place of care and preferred place of death.
Identify and understand current pathways and how these may be modified to optimise patient and family support.
Enhance transition from paediatric to adult specialist palliative care service
Enhance Hospice at Home provision for children
Work with All Wales PREMs, PROMs and Effectiveness Programme to identify All Wales solution to PROMs
Identify current services involved in supporting bereavement care.
Enable our experienced clinical staff to deliver an enhanced educational experience with potential links with local universities to provide the appropriate support to education around delivery of end of life care.
Increase understanding of current delivery of end of live care across all care setting through audit against national and local standards
Better utilising digital technology to ensure that end of life information is captured in a way that supports the delivery of better care
Promote delivery of end of life care on the neonatal unit
Complete first OPA queue dashboard for the SCP, embed dashboards into management process for each area.
Realise live queue dashboard views for endoscopy and radiology across the health board
Realise live queue dashboard views for pathology/histology part of the diagnostic pathway
Assess current position of dashboard developments realised in q1-3 and fine tune existing products where required.
Realise ambition of live queues for patients currently waiting for chemotherapy.
Start to link up all of the component stage queues in order to model how stage level changes in one part of the system effect all other parts
Agree Phase one research clinic becomes permanent
Aim to increase the number of Commercial trials open
Seek funding for a Research assistant to support the set up process
Seek funding for a Research support worker to support clinical requirements of pharmaceutical trials
Secure further funding from April 2020 to support the Radiotherapy Research Strategy
Seek funding for a second research radiographer
Work with Cancer Clinicians to write the Medical Oncology Research Strategy to compliment the Radiotherapy research strategy
Recommendations submitted to the Executive Team to be taken forward Role of the Corporate Cancer Information Team and Health Board Cancer Lead defined and clarified

Cancer – Performance Trajectories

% of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days of diagnosis (regardless of referral route)

Legend: 31 day actual — HB Total (Best Case Profile)

% of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral

Legend: 62 day actual — HB Total (Best Case Profile)

Appendix 4 Transformation Fund Bid for Whole System Rollout

Whole System
Transformation Roll
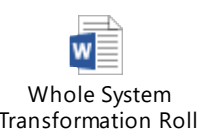
Appendix 5 Phase 2A National Primary Care Quality and Delivery Measures

A report on our performance against the measures is included on the hyperlink below.

http://howis.wales.nhs.uk/sites3/Documents/743/3iv.%20Primary%20Care%20Measures%20Report.pdf

Appendix 6 Review of ABMUHB Primary Care Pacesetter Programme

ABMU Submission
Pacesetters final 18.

Pacesetter Summary
v2 draft.docx

Appendix 7 Primary Care Transformation Questionnaire

IMTP Questionnaire - Primary Care Transformation

Component of PC Transformation	Evidence of Transformation	Please complete relevant column			Reflective notes
		Fully referenced (IMTP page numbers) **PAGE NUMBERS TO BE UPDATED**	Partially referenced (IMTP page numbers)	No reference in IMTP	
1. Informed Public	The IMTP evidences Cluster Communication and Engagement Strategies, with systems for public engagement and communication	31			Health Board is committed to the use of the 'So Tell Us What You Think' methodology.
2. Empowered Citizens	The IMTP highlights plans for active engagement and involvement of service users, with systems to capture user feedback	40			Co-production for individual patients and patient groups will be entrenched through people designing services as a collective, using digital technology wherever possible.
3. Support for Well-being, Disease Prevention and Self Care	The IMTP references cluster plans that promote well-being and self-care using technology, social prescribing, signposting / navigation systems for information and support	27			Our aim is to embed an ABCD approach that empowers people and neighbourhoods to co-design services to meet their needs better and to focus on developing assets within communities.
4. Community Services	The IMTP references plans for a wide range of community services, providing both clinical and non-clinical care and support, accessed through self-referral, social prescribing or clinical triage systems	59-61			Through the Western Bay Regional Partnership Board, ABMUHB has worked with partners to design and deliver an optimum model of Integrated Community Services

5. Cluster Working *5.1 Cluster planning*	Cluster plans are integral to the IMTP, underpinned by population needs assessments. Gaps in cluster services are being actively addressed	58		Each of the 8 Clusters have undertaken assessments of needs within their geographical area and have produced Cluster Plans that they intend to implement to achieve the better health and wellbeing for the individuals and communities within its area.
5.2 Integration	Integration and partnership working are actively promoted within the IMTP, with examples of new services that evidence integration of health and care agencies	26-27		Western Bay Neighbourhood Approach evidenced throughout the plan with examples of new services that evidence integration of health and care agencies.
5.3 Sustainability	The IMTP describes planned improvements in the organisation and function of Primary Care Support Units, particularly in relation to the short-term sustainability of GP practices			
	The IMTP reflects the central role of workforce planning to develop capacity / capability across primary and community care, ensuring medium- to long-term sustainability of primary care clusters	61 144- 153		Within the Health Board's Primary and Community Strategy 2017-2022, workforce redesign is a key driver to support service redesign. The strategy seeks to blur traditional healthcare professional boundaries, with the development of new and innovative roles for health and social care professionals working alongside GPs. This will create more capacity in the community; provide continuity and timely access to care closer to home
5.4 Cluster development	The IMTP supports cluster development and functioning through appropriate cluster governance arrangements and support for MDT professional development	61 144- 153		As above
5.5 Evaluation	The IMTP makes a commitment to improve access to information and health intelligence for cluster teams, enabling evaluation of cluster progress, innovation, quality and safety of their services	156-158		Evidenced throughout the Digitally Enabled Care chapter.

5.6 MDT working	The IMTP promotes the transformation of primary care through real increases in workforce capacity and capability across all clusters, improving access to services through integrated multi- professional teams	61 144- 153			Within the Health Board's Primary and Community Strategy 2017-2022, workforce redesign is a key driver to support service redesign
6. Call-handling, Signposting, Clinical Triage / Telephone First Systems	The IMTP highlights the importance of safe and effective triage processes within clusters, directing people to the appropriate professional and service and outlines plans to support practices to consider new ways of telephone access	60			Professionals have access to a several online signposting tools including 111 Directory of Service, DEWIS and **Infoengine**.
7. 111 and Out-of-Hours Care	The IMTP plans for systems-level integration of in- and out-of-hours services to ensure continuity of care, with standards applied	59-60			
	The IMTP promotes the delivery of OOH services by multi-professional teams, using standardised pathways for common issues	59-60			
8. Shifting Resource	The IMTP references plans to actively move services / resources out of hospitals into the community, underpinned by financial systems that locate resources where service users need them	58-61 85 100			Evidenced in a number of the service plans including; • Mental Health • Planned Care • Children and Young People
9. Complex Care in the Community	Reference is made to developing Clinical Outreach Services for people needing specialist / complex care in the community, delivered by multi-	100-101			Specific reference made for Mental Health and Learning Disabilities

	professional teams with access to community diagnostic services				
10. Infrastructure to support Transformation	The IMTP sets out plans to invest in a sound primary care and community infrastructure to support transformation: cluster IT systems & new technologies; estates and facilities, community diagnostic services	61 156-158			
11. Further comments the Health Board wishes to be noted in the IMTP Review:					

Appendix 8 Right Care Right Place Review Plan on a Page

RIGHT PLACE RIGHT CARE REVIEW

Themes
- Maximise capacity in partnership
- Whole system approach
- Support Frail patients to receive the right care in the right place

OBJECTIVES

1. Assess appropriateness of bed utilisation

2. Identify alternative care pathways, including rehabilitation

3. Support planning of 'Care Closer to Home'

KEY FINDINGS

80% of all patients surveyed are aged 65+	62% of patients surveyed were on multiple drugs	20% of Morriston and Singleton Hospital did not meet the clinical criteria for admission	25% of Morriston and Singleton patients alternatives to admission identified as Home & Specialist Nurse (ACT- Rapid Response). 16% of patients admitted for IV only	39% Neath Port Talbot Hospital alternatives to admission identified as Home & Social Care/Home and Rehab	19% of Neath Port Talbot Hospital alternatives to admission identified as Long Term Placement	40% of Gorseinon patients alternatives to admission identified as Home & Social Care

65% Swansea ACT under their care for over 3 weeks compared to 10% in Neath ACT	59% of Morriston and Singleton Hospital patients surveyed did not meet the clinical criteria on the day	55% of patients surveyed were deemed medically or functionally fit on the day of care	Alternatives on the day of care Acute Hospitals Home & Social Care - 45%. Rehabilitation bed - 36%. Long	Alternatives on the day of care Swansea Residents Home & Social Care - 50%. Long Term Placement - 23%	Alternatives on the day of care Neath Residents Home & Social Care - 30%. Long Term Placement - 28%

WORKFLOWS

Phase 1 Qu4	Phase 2 Qu1	Phase 3 Qu2	Phase 4 Qu3
Staying well in the Community	**Avoiding acute admissions**	**Improving hospital internal processes**	**Hospital 2 Home**
Governed through	Governed through	Governed through	Governed through
2 Promotion of the importance of keeping mobile through cluster networks	3 Work closely with WAST to prevent admission	1 Redefine role/purpose of ward round to provide consistency around clinical management plans	1 Strengthen the Western Bay optimum model to become Hospital 2 Home service
1 Reducing demand and maximising capacity within social care through partnership working	3 Improve diagnostic access at the front door to prevent admission	1 Clarify what EDD means. Focus on the predicted date the patient is medically safe - use evidence of what works	1 Hospital 2 Home is an agile service to assess, care and reable patients at home maximising independence and ensuring care packages are right sized
4 Focus on support for Carers and the respite offer to keep individuals at home	2 Improve communication and trust between secondary care and community	2 Documentation that is transferable across all parts of the patient pathway- mobilisation in hospitals	1 Trusted assessor model where assessment does not take place in a hospital bed
4 Western Bay medicines management group to review medicines managements by social carers	2 Improve hospital and primary care staff knowledge of ACT, what it can provide and how to access it	3 Frailty and Therapy services provided within Emergency Departments	1 Strength based assessments not "need" assessments taken place when patient is not in crisis
3 Prevent admission into hospital for assessment only	1 Standardise ACT model around best practice and right size capacity for rapid response	3 Agree our rehabilitation model and capacity	2 Rebalancing resources between secondary care and community provision

Opportunity to work in partnership to bring care closer to home

Appendix 9 EASC and NUSC Tables and Winter Plan Evaluation

NUSC v1 EASC
ABMUHB March sub

FINAL EASC v2
Commissioning Tem

Winter Pressures
MASTER FINAL 22.1.

Appendix 10 Regional and National Planning Arrangements

1.0 South West Wales Region including ARCH and Swansea City Deal

Our plans to improve the health and wellbeing of our population and through our joint regional planning and delivery mechanisms with Hywel Dda University Health Board, and Swansea University (through ARCH) are laid out in detail in the document embedded below.

Regional Narrative
HD ABMU ARCH v7 I

2.0 South-East Wales Region and Cardiff and Vale University Health Board

We are also a member of the Regional Planning and Delivery Forum in South East Wales. The structures are different in South East Wales with an overarching regional planning forum receiving reports from specialty/service specific groups. We are members of following groups and contribute fully to these discussions and plans:
•   Concluding implementation of the outcome of the South Wales Programme;
•   Ophthalmology;
•   Orthopaedics;
•   Diagnostics; and
•   ENT service redesign.

Implementation of the South Wales Programme
As part of the implementation of the recommendations from South Wales Programme ABMUHB has been working with Cwm Taf and Cardiff Vale University Health Boards to plan together the future flows of paediatrics, obstetrics and neonatal services. Our responsibilities in this arena will change significantly after the Bridgend transfer although we will still be involved to manage any pathway effects of change in the Bridgend region into obstetric and neonatal services at Singleton hospital.

Joint Work with Cardiff and Vale University Health Board
As well as the formal work through the South East Wales Regional Forum, NHS Wales Collaborative and WHSSC, the Health Board is engaged with Cardiff and Vale University Health Board around a range of specialised or fragile services to explore opportunities for joint working and improving sustainability.

3.0 Welsh Health Specialised Services Committee (WHSSC)

3.1 Overview
The Health Board continues to work closely with The Welsh Health Specialised Service's Committee (WHSSC) in the development of its Integrated Commissioning Plan (ICP) and acknowledges the importance of aligning our Annual Plan with the ICP.

The 2019-22 ICP has been developed in the context of more patients requiring specialised services due to an ageing population and advances in medical technology within what remains a challenging financial environment .In response WHSSC have adopted the approach of increasing engagement and co-production with patients, clinicians and the public, ensuring that its plan meets the requirements of the prudent healthcare agenda whilst driving the development of patient pathways and services.

The development of the ICP has been underpinned by an extensive programme of baseline review, horizon assessment, risk assessment and prioritisation that was concluded in December 2018.

3.2 Financial Impact
The agreement of a balanced financial plan has been a challenging process but ABMUHB has adopted a considered approach to prioritisation across specialist commissioned and locally delivered services and consequently agreed to fund its share of the WHSSC ICP as detailed below:

	Abertawe Bro Morgannwg UHB £m
2019/20 Opening Allocation (inc. Perinatal allocation)	72.746
Topsliced: Genetics Test Directory	0.290
2019/20 Opening Baseline	73.036
M8 18/19 - Forecast Performance	(0.548)
Reinstate Non Recurrent Writebacks	1.295
Adjustments for Non Recurrent Performance	0.386
Full Year Effect of Prior Year Investments	0.356
New Cost Pressures / RTT / Growth in IPC	0.805
Mandated High Cost drugs	0.154
Mandated ATMP	0.544
VBC workstreams	(0.403)
Underlying Deficit & Growth	2.589
CIAG Schemes	0.546
Strategic Specialist Priorities	0.089
New Commissioned Services	0.150
NHS England tariff uplift (inc. pay)	0.087
NHS Wales 2% provider inflation	1.100
NHS Wales 1% Healthier Wales uplift	0.000
2019/20 WHSSC Additional Requirement	4.561
HB Previously Stated Provisions	4.455
New Provision	4.561
Current Gap for IMTPs	(0.000)

The net pressure of for £4.56 represents an uplift of 6.2% on the baseline.

The magnitude of the uplift is explained by the inclusion of a number of exceptional step up costs:
- The introduction of new advanced therapeutic medical products
- The inclusion of strategic priority investments in Cystic Fibrosis and Neonatal transport
- The expansion of WHSSC's commissioning portfolio to include Thrombectomy.

Other developments have been subject to a prioritisation process undertaken by the Clinical Impact Assessment Group (CIAG) incorporating independent Health Board medical representatives and WHSSC Management Group Members. CIAG has assessed, and prioritised:

- New Clinical Interventions identified through horizon scanning and brought forward by a Prioritisation Panel;

- Schemes prioritised but not funded during 2017/18; and,
- New schemes identified by commissioners and providers.

The schemes that have been funded through the ICP are as follows:

High Priorities (Over 20 Score)

CIAG Mean Score	Clinical Impact Schemes score > 20	ABM UHB SHARE
23.38	PET new indications	0.037
22.07	TAVI	0.124
22.00	AAC	-
21.99	BCU P&M - wheelchairs	0.050
21.70	Paeds Endocrine	0.064
21.62	BCU ALAS - war veterans	-
21.54	Cleft lip and palate	0.045
21.31	Paeds Rheumatology	0.036
20.70	Genetic test directory (Funded by WG))	-
20.08	BAHA & Cochlears replacement & maintenar	0.045
	Total	0.400

Medium Priorities (>19.5<20 Score)

CIAG Mean Score	Clinical Impact Schemes score < 20	ABM UHB SHARE
19.93	Neuro-oncology	0.014
19.92	Adult Congenital Heart Disease	0.054
19.77	Paeds MRI	0.011
19.54	Neuro rehabilitation	0.016
19.53	IBD project trials saving + service model	0.050
	Total	0.146

The plan only includes High and Medium priority schemes. A further tranche of schemes was categorised as low priority and their financial impact not included in the plan:

Table 9c - Lower Priorities NOT FUNDED		ABM Share
19.47	Paeds Ketogenic Diet	0.009
19.33	Micro Processor Knees	0.043
19.00	Anakinra	0.050
18.46	Inherited Metabolic Disease	0.007
17.31	Neuro Endocrine Tumours	0.054
15.45	LVA	0.007
	Total	0.171

The consequences of not progressing these schemes will continue to be monitored through the WHSSC Risk Management framework.

3.3 Affordability and Risk
The agreement of the plan was underpinned by a number of key assumptions:

- Current level of Cardiology growth levels off
- Current Cardiac Surgery Underperformance is not made good.
- The development of perinatal Mental Health Services will be funded from Mental Health Funding not yet allocated to Health Boards
- Health Boards will be able to access funds held centrally for the provision of AAC equipment.
- Health Boards will be able to access centrally held critical care funding to cover AICU growth pressures included in the plan.
- HRG4+ and CQUIN risk is outside of the plan at this point pending further Welsh Government consideration of the final position on these matters.
- There is no requirement for commissioners to fund the revenue consequences of the Major Trauma Centre during 2019/20.

All of these assumptions carry varying levels of risk which will require close monitoring as the year progresses.

3.4 Provider Perspective
Included in the funded CIAG priorities are key ABMUHB provider developments:

TAVI - Funding to accommodate activity levels appropriate for the revised WHSSC commissioning polices and resource to establish the service on a sustainable basis.
Cleft Lip and Palate - Funding sustain robust MDT arrangements and develop the service for non-cleft Velopharyngeal dysfunction (VPD)
IBD Service Model - Funding made available to address a number of deficiencies in Haemophilia service provision across Wales.

In addition ABMUHB will be engaging with Cardiff & Vale UHBin the development of network arrangements facilitated by additional funding for:

- Paediatric Endocrinology
- Paediatric Rheumatology
- Adult CHD.

3.5 Whole Pathway Working

The development of Value-based whole pathway working underpins the both the ABMUHB Annual Plan and WHSSC's ICP and it is important that a coordinated approach is adopted for those pathways partly commissioned by WHSSC. A particular priority will be to ensure that the local Diagnostic and Rehabilitation pathways are in place to support the commissioning of Thrombectomy.

ABMUHB will be seeking to engage with the value based project being developed by WHSSC in partnership with Welsh Government's value based healthcare team and the Value Based Procurement Team in Shared Services on the pathway of stroke care and aortic stenosis / heart valve disease the key components of which will be:

- Analysis of variation
- The range of products and differential cost
- The variety of processes across services and opportunities for improvement
- The measurement of patient outcomes including clinical outcomes and patient reported outcomes.

4.0 Emergency Ambulance Services Committee (EASC) and National Programme of Unscheduled Care (NPUC)

4.1 EASC

EASC as a Joint Committee of the Health Boards is responsible for the commissioning of the following services:

- Emergency Medical Services (EMS)
- Non-Emergency Patient Transport Services (NEPTS)
- Emergency Medical Retrieval and Transport Services (EMRTS)

Quality and Delivery Frameworks

EASC sponsors the use of CAREMORE®as its collaborative commissioning method focusing on **C**are Standards, **A**ctivity, **R**esources **E**nvelope, **M**odel of care, **O**perational arrangements, **R**eview of performance and **E**valuation. This establishes Quality and Delivery Frameworks via the National Collaborative Commissioning Unit (NCCU) on behalf of EASC to detail what does good look like (commissioning);how assurance is given for 'what is required' (quality); and how the 'what is required' will be achieved (delivery). These Quality and Delivery Frameworks enable the philosophy of Prudent Healthcare and its associated values to be applied.

Commissioning Intentions

The NCCU on behalf of EASC develops Commissioning Intentions for EMS and NEPTS. The Commissioning Intentions are set of high level expectations from which there are specific requirements for WAST to:

- work with the NCCU to update the Framework Agreement;
- improve performance; and,
- jointly improve performance in collaboration with Health Boards.

The process for Alignment of EASC Commissioning Intentions has been detailed to NHS Wales' organisations and to the EASC meeting in November 2018. The Health Board is fully engaged with the work of EASC and our Unscheduled Care Service Improvement Plan has been

developed in alignment with the EASC 5-Step Pathway (below). We have taken into account the EMS Commissioning Intentions and have worked with WAST colleagues to complete the monitoring Tables 2 and 3 for the WAST joint initiatives and national unscheduled care priorities initiatives that we are intending to develop and continue in 2019/20. Our unscheduled care plan describes in detail the work that we will be continuing to improve our prudent conveyances system to improve the quality of care for patients and reduce demand across the unscheduled care system.

The EASC and NPUC Tables are embedded in Appendix 9.

4.2 NPUC

Alongside its support to EASC for IMTPs as described above, the NCCU undertakes complimentary work for the NPUC. This includes the requesting and collating of service change initiatives from home to Emergency Departments which the Health Board is considering commissioning in support of improving the local Urgent and Emergency Care system. ABMUHB service change initiatives are detailed in the standardised national form known as Urgent & Emergency Care: service change initiatives (Table 3).

The Urgent & Emergency Care: service change initiatives (Table 3), is the same as the table included within the Allocation of Additional Winter Delivery Funding 2018/19 issued on 8 November 2018 by the Welsh Government. As stated in the letter this supports an understanding of the impact of local actions; enables the sharing of lessons and good practice following the winter period, and a consistent approach for evaluation. In order to ensure initiatives are shared, evaluated and learnt from on a national basis the Health Board's Table 3 and Additional Winter Delivery Funding 2018/19 Evaluation Table is included within the EASC IMTP and will also be reported to the NPUC Board.

Development Process 2019/20

EASC itself, its sub groups and the NPUC have supported the development of Commissioning Intentions and their alignment with IMTPs 2019/20 and the summarised position across each EASC commissioned service area is provided below.

4.3 EMS

o   Inflationary uplifts for 18/19 and 19/20 pay awards and other planned uplifts for growth and healthy Wales plan – in accordance with Welsh Government assumptions provided to Health Boards.
o   Adjustments for any non-recurrent items brought forward from 2018/19 and those known for 2019/20.
o   Potential National pay issues for holiday pay on overtime and the impact of the pension discount rate change with the assumption that funding with flow through EASC from Welsh Government.
o   Continued funding flow for pre 2018/19 initiatives to continue eg Band 6 Paramedics.
o   Health Boards to make provision for recurrent effect 2019/20 of part year 2018/19 Welsh Government funded initiatives for (1) APPs and (2) Clinicians in Control; with (3) Falls having the ability to be funded on a non-recurrent basis at the discretion of each individual Health Board. *ABMUHB has agreed, based on the evaluation shared with the Health Board to fund a Joint Falls Response Vehicle a result of (3).*
o   Health Boards to review the 60 joint WAST & Health Board performance improvement service changes which are at various stages of development (as at Nov. 2018) against the key joint performance improvements of: (i) HCPs; (ii) alternative to ED locations; (iii) referrals to alternative pathways following 'hear & treat' & 'see & treat', (iv) notification to handover delays, (v) use of '111' / NHS Direct – and identify those to be progressed, stopped, added. This aligns with the Amber Review finding re *NHS Services must improve and simplify their offering of alternative services*; plus WAST must ensure benefits across their service offerings are clear.

The EMS Joint Performance Improvements for the Health Board (Table 2) has been included within the EASC IMTP and for ease of reference is embedded in Appendix 9.

The financial commitment to EASC in respect of EMS services included in the ABMU IMTP is summarised as:

WAST	Abertawe Bro Morgannwg UHB £m
18/19 Commissioned Services baseline (WAST)	20.983
Adjust for Bridgend Boundary Transfer	(5.687)
Restate non recurrent adjustments: ESMCP (19/20 impact)	0.003
19/20 Opening WAST Commissioned Services baseline	15.300
2% Discretionary Uplift	0.305
18/19 & 19/20 Pay Award Through Commissioners	0.344
Agreed Developments:	
Clinical Desk Enhancements (full year impact of 18/19 development)	0.085
APP (full year impact of 18/19 development)	0.120
19/20 ARRP Adjustment	(0.017)
19/20 Additional Investment WAST	0.837
19/20 WAST Requirement through EASC	16.137

- Inflationary and Pay award funding will be passed on in compliance with the national framework.
- Clinical Desk Enhancement and APP developments funded in the winter of 2018/19 will be funded recurrently.
- A further development relating to the provision of a Falls Vehicle will be funded pending a cost benefit review of the 2018/19 pilot
- Further discussions will be held in respect of the application of the 1% Healthier Wales allocation.

The total financial value above contributes to the total financial sum available to EASC for EMS. Payment is made via WHSSC to WAST.

4.4 NEPTS
We are a member of the Non-Emergency Patient Transport Service (NEPTS) Delivery Assurance Group (DAG) and have an ongoing commitment to participate. We fully support the funding mechanism that have been agreed through the DAG. We recognise the new Commissioning Model which has been led by EASC and the expectation that there will be a mixed economy, with ABMUHB services transferring to the new model in during 2019. Detailed service changes which could impact upon NEPTS will be discussed with service provider and commissioners as required as part of change management. We also commit to working with WAST colleagues and the NCCU during

2019/20 to identify measures across the respective EMS and NEPTS pathways which are important for the populations served in order to improve services and pathways.

The NEPTS Joint Performance Improvements for the Health Board (Table 2) has been included within the EASC IMTP and in Appendix 9.

The financial consequences and timing of the transfer of commissioning responsibility are still subject to confirmation.

4.5 Emergency Medical Retrieval and Transfer Service (EMRTS)
Following the request from the Chief Executive, NHS Wales to explore the options and opportunities to extend the EMRTS in order to advise the Cabinet Secretary, a Service Expansion Review document has been prepared with the EMRTS Delivery Assurance Group (DAG). Since the Welsh Government Gateway Review in May 2017 there have been many discussions at EMRTS DAG meetings where Health Board representatives have had the opportunity to confirm the key challenges for their organisations. During these discussions, a number of national and regional programmes have been identified that have implications for EMRTS and for completeness these have been included in the service review. The principle of the review has been to establish a case for change based on a set of key strategic drivers underpinned by the analysis of current unmet demand over the 24 hour period. Following a robust process, a preferred option has been identified that will include:

- **2000-0800: Consultant and CCP at Caernarfon airport** with a Rapid Response Vehicle
- **2000-0800: Consultant and CCP at a South Wales base** with a Rapid Response Vehicle
- **Double Pilot crew and aircraft available at the South Wales base** to support the population of Wales and ensuring equality of service
- **Consultant, CCP and RRV operating 1400-0200** along the M4 corridor to meet the main peak of unmet demand
- **Extension of operating hours of Air Support Desk to cover whole 24 hour period**

It should be noted that the above will be additional to the existing 12 hour (0800-2000) service currently provided across 3 bases. The above will be implemented in a phased approach with an indicative timescale of 12 months per operational rota. All regions of Wales will benefit from each implementation phase and the 3 operational rotas included within the preferred option demonstrate a commitment to ensuring equity for the population of Wales, in line with the key investment objectives. The Health Board has committed, through EASC to support the expansion of EMRTS, on a part-year basis in 2019/20. The financial consequences of the above for EMRTS are as follows:

EMRTS	Abertawe Bro Morgannwg UHB £m
18/19 Commissioned Services baseline (EMRTS)	0.583
Adjust for Bridgend Boundary Transfer	(0.159)
Restate non recurrent adjustments: ABM inflation transfer	0.007
19/20 Opening EMRTS Commissioned Services baseline	0.431
2% Discretionary Uplift	0.009
EMRTS expansion plan	0.018
19/20 Additional Investment EMRTS	0.027
19/20 EMRTS Requirement through EASC	0.457

The total financial value above contributes to the financial sum available to EASC for EMRTS. Payment is made via WHSSC to ABMUHB as the host body of EMRTS.

Our financial plan for 2019/20 supports the agreements reached at the PDEG meeting on 15th January including continuing funding for the additional Advanced Practice Paramedics, the clinical desk enhancements and, in 2019/20 the agreed part-year effect of the EMRTS expansion. We have also committed to funding a Joint Falls Response Vehicle based on the positive evaluation of the service which was put in place during the winter of 2018.

5.0 NHS Wales Collaborative

The NHS Wales Collaborative undertakes planning for national and regional services which are not directly commissioned by WHSSC. Many of these services directly impact on our population and these are described in this section.

Major Trauma - **Wales Trauma Network -** The Health Board is the lead for developing the Major Trauma Network and will also host a Large Trauma Unit at Morriston Hospital. The Cabinet Secretary for Health and Social Services has agreed to provide funding for the programme management costs and this includes programme management support in ABMUHB for the development of the Major Trauma Network. Following the development of a detailed working plan, the Network Board has agreed the indicative timeline for the establishment of the Trauma Network by April 2020. It should be noted that this indicative timeline is ambitious, with a number of assumptions and dependencies, and subject to a critical path of activities.

WHSSC will lead the commissioning of the new arrangements and a regional implementation plan is being developed. The Morriston team will continue to work closely with UHW to agree how our role as trauma unit with specialised services can support the major trauma centre in Cardiff. This will include detail pathways being agreed for; plastic surgery and spinal surgery in support of trauma cases.

Sexual Assault Referral Centres (SARCs) - A review of SARC arrangements across mid and South Wales was undertaken in 2016 and a hub and spoke model was initially agreed including the provision of a hub for both adult and children's services in Swansea. Since this time the paediatric support for the children's provision in Gwent and the ABMUHB area has proved unsustainable due to retirements. The board is currently working to implement an interim service whereby children's SARC assessments are carried out in Cardiff for the whole of South Wales. Adult SARC services continue to be provided form the existing hub in Swansea however this site is proving increasingly unsuitable. Capital funding has been obtained from Welsh Government from the VAWDASV grant fund and Western Bay ICF funding to purchase a standalone building which will be refurbished specifically for this client group.

Upper Gastro-Intestinal (GI) Surgery Review - A review of Upper GI surgery in South Wales was completed in September 2017 and the recommendations have been considered by the Collaborative and the Cancer Implementation Group. A dedicated implementation group for the prioritised recommendations of the review is being established. Upper GI surgery is undertaken within the Health Board as well as supporting services and MDTs. This shape of the Upper GI services across South Wales may change on a networked basis as a result of the group's work and the Health Board will be fully engaged on a clinical and corporate level.

Adult Thoracic Surgery Review - A review of thoracic surgery has also been completed and the Health Board is working to implement the recommendations at Morriston Hospital. Consultation on the outcome of the review of thoracic surgery has also been completed. This concluded that the surgical part of the pathway should in future be delivered only at Morriston hospital for South Wales. Morriston is working with UHW and other Health Boards across South Wales to ensure that the new service can be implemented in a timely fashion.

Other Areas - The Health Board is also engaged on the other planning work being undertaken by the NHS Wales Collaborative including regional work around pathology and immunology.

6.0 Velindre NHS Trust

Velindre NHS Trust provide two core services, non-surgical tertiary oncology and blood and transplantation services which are commissioned by the Health Board to meet the needs of our population. The flows from our Health Board area will decrease with the Bridgend transfer although we will still be a commissioner through WHSSC or directly of some regional services. Our commissioning relationship continues to mature and we will continue to align our plans and service priorities to enable us to meet the future needs of the people we serve. ABMUHB will meet national inflation and pay award commitments in line with All Wales agreements and engage in discussion around the application of Healthier Wales funding.

7.0 NHS Wales Shared Services Partnership (NWSSP)

NHS Wales Shared Services Partnership services are critical enablers to service change across Wales. When models of care change within the Health Board this has an impact on our recruitment, procurement and estates infrastructure. NWSSP can also provide valuable intelligence to organisations highlighting areas through procurement that they can make non-pay savings through reducing inappropriate variation. We will continue to work with colleagues in NWSSP to improve recruitment, procurement and best practice in use of our estates infrastructure.

Appendix 11 Workforce Profiles

Excellent Staff - Workforce Profile

ABMU currently employs 14,173 FTE, an increase of 138.34 FTE over the last 12 months. This increase is mostly due to an increase in our employed nursing workforce.
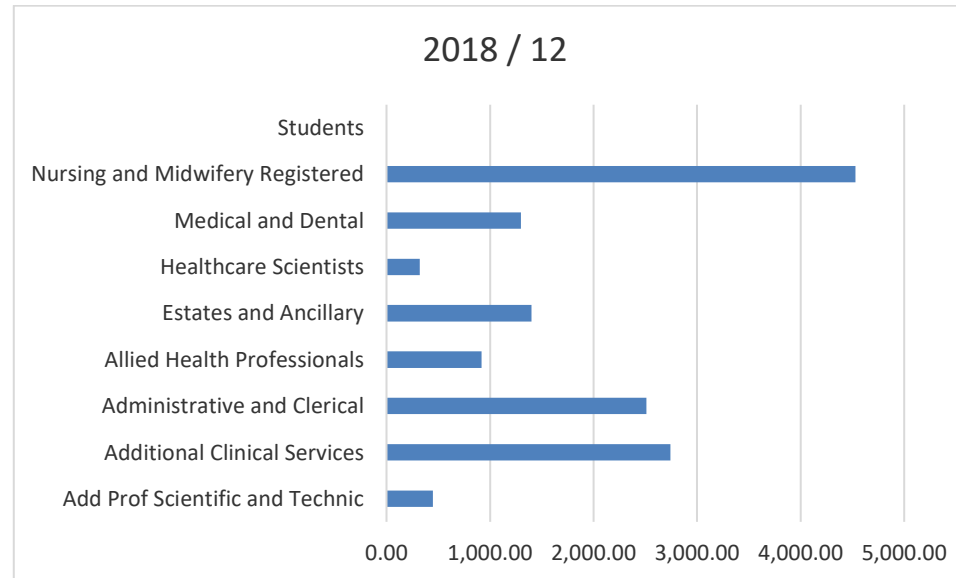
The age profile is challenging across many professions. Notably 37% of the nursing workforce is aged 50 or above. This is representative of the age profile of the total workforce as shown in the graph below.

Age Profile – Figure 1

Skill Mix Profile of Total Workforce
by ABM UHB - (All Grades)

% of Selected Workforce (HC)

ABM UHB

As at Mar-18
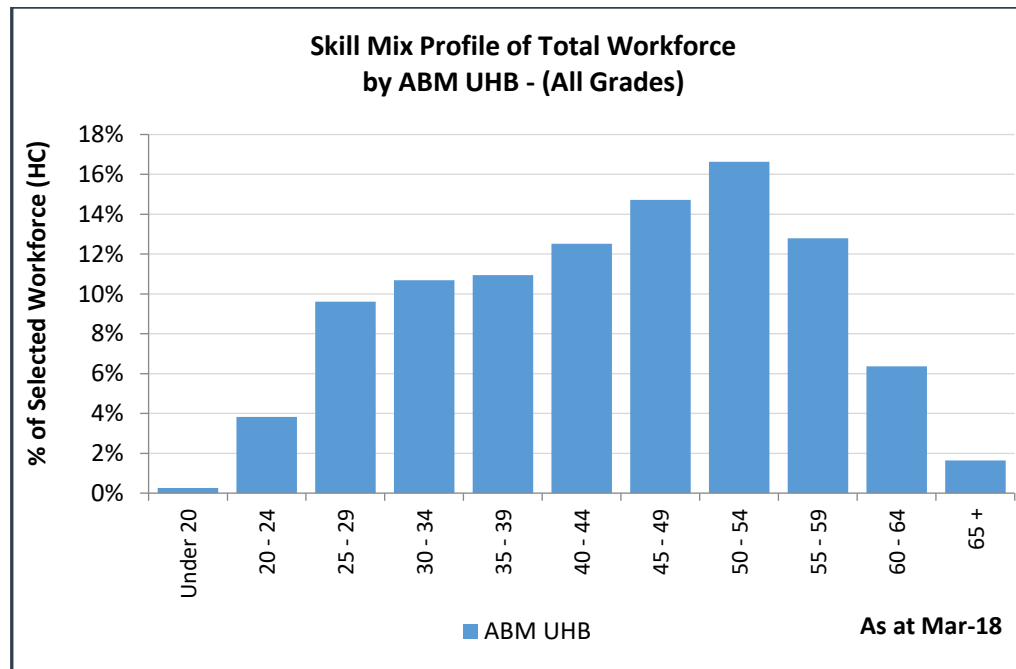
Vacancies – Figure 2
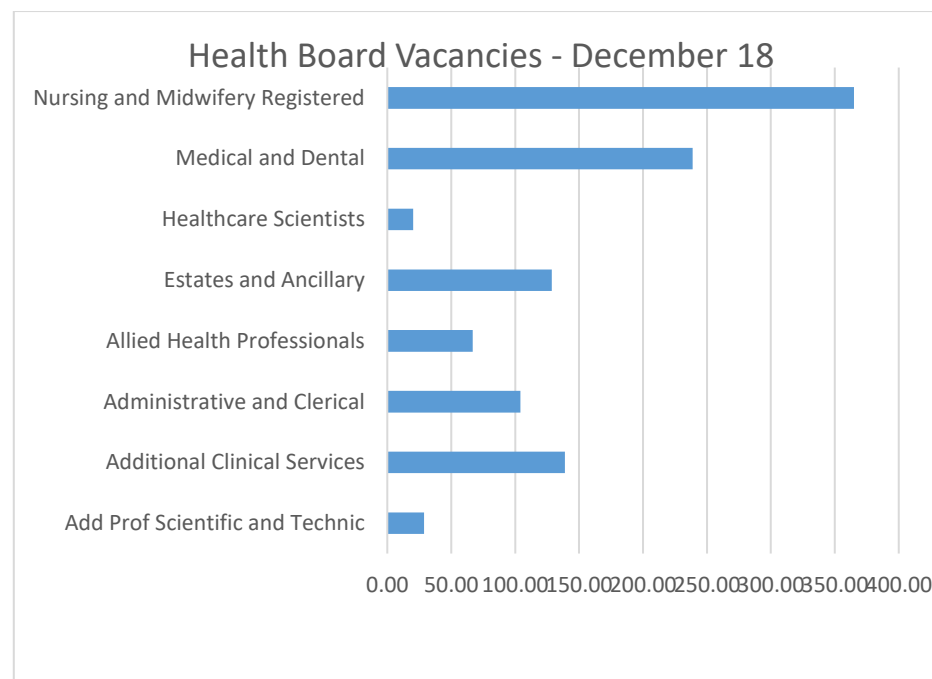
As at December 2018 the total number of vacancies within the Health Board was 1086.52 WTE, across all the staff groups. Our registered nursing and midwifery staff group has the largest number of vacancies. This has improved significantly and stands at 364.93 WTE. This equates to a 7.5% vacancy level. The graph above shows our vacancy levels for each of the staff groups. Medical vacancies currently stand at 238.74WTE

Turnover – Figure 3

Staff Turnover - Health Board
- 1 Jan 2018 to 31 Dec 2018

Staff Group	FTE	Headcount
Add Prof Scientific and Technic	8.65%	8.74%
Additional Clinical Services	7.47%	8.05%
Administrative and Clerical	7.39%	7.65%
Allied Health Professionals	9.82%	10.20%
Estates and Ancillary	4.66%	5.20%
Healthcare Scientists	7.22%	7.70%
Medical and Dental	10.83%	12.17%
Nursing and Midwifery Registered	7.94%	8.30%
Students	14.58%	28.24%

The turnover rate for all staff within the Health Board excluding junior medical and dental staff currently stands at 7.71% (December 2018), which has fallen by 1.3% over the last 12 months.

Sickness Absence – Figure 4

The current rolling 12-month performance as at November 2018 stands at 5.93% which is up from 5.90% in the previous month. Our in Month rate is 6.20%, which is an increase from 6.19% for October 2018. Our top reason for absence remains stress, anxiety, depression and other mental health illnesses, accounting for almost 32% of all absence.   The graph below provides a breakdown of the rolling sickness absence levels for the last 12 months.

Rolling Abs FTE%
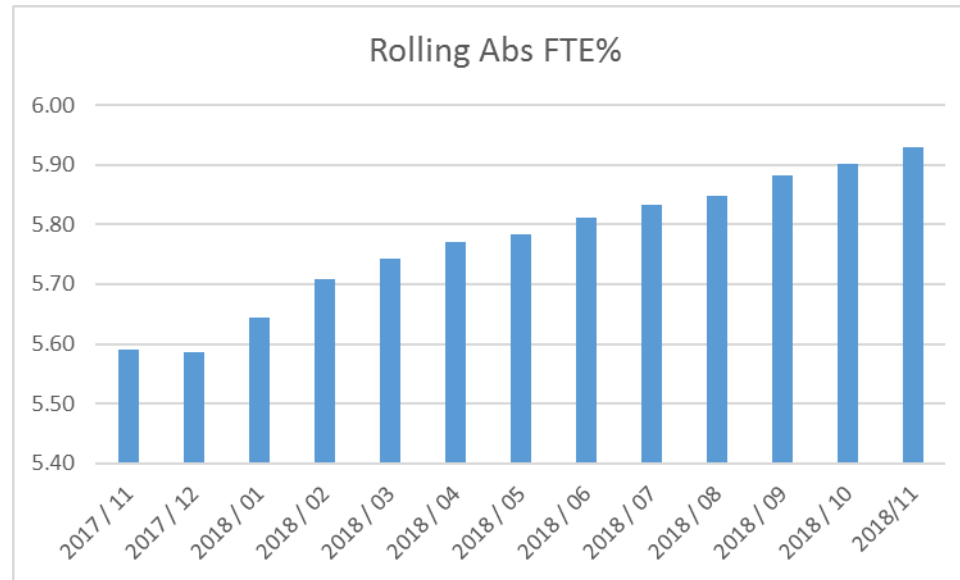
Appendix 12 Workforce and OD Framework Driver Diagrams

Workforce Challenges – Shape of the Workforce

- Align service and workforce redesign
  - Development of workforce plans to deliver Organisational Strategy and Clinical Service Plans and financial viability
    - Redesigning the Primary Care Workforce
    - Rightsizing staffing establishments to need
    - Developing New and Extended Roles
    - Redesigning the Non-Registered Workforce
  - Support development of new organisational design and structure

Workforce Challenges – Workforce Resourcing

Develop workforce resourcing strategies and approaches to ensure we are able to secure the workforce needed to meet organizational needs

- **Reduce turnover rates**
  - Implement consistent organizational wide exit interview process
  - Ensure excellent staff experience (see additional slide)

- **Improve recruitment and reduce vacancy levels**
  - Develop Therapy and Health Science Recruitment Action Plan
  - Develop Nurse Recruitment Action Plan to meet the needs to the Nurse Staffing Act
  - Develop Medical Recruitment Action Plan

- **Develop internal staff bank**
  - Extend bank operations to become a multi-disciplinary staff bank
  - Explore creation of a single all wales staff bank in partnership with NWSSP

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Workforce Challenges – Leadership, Culture, Values

45
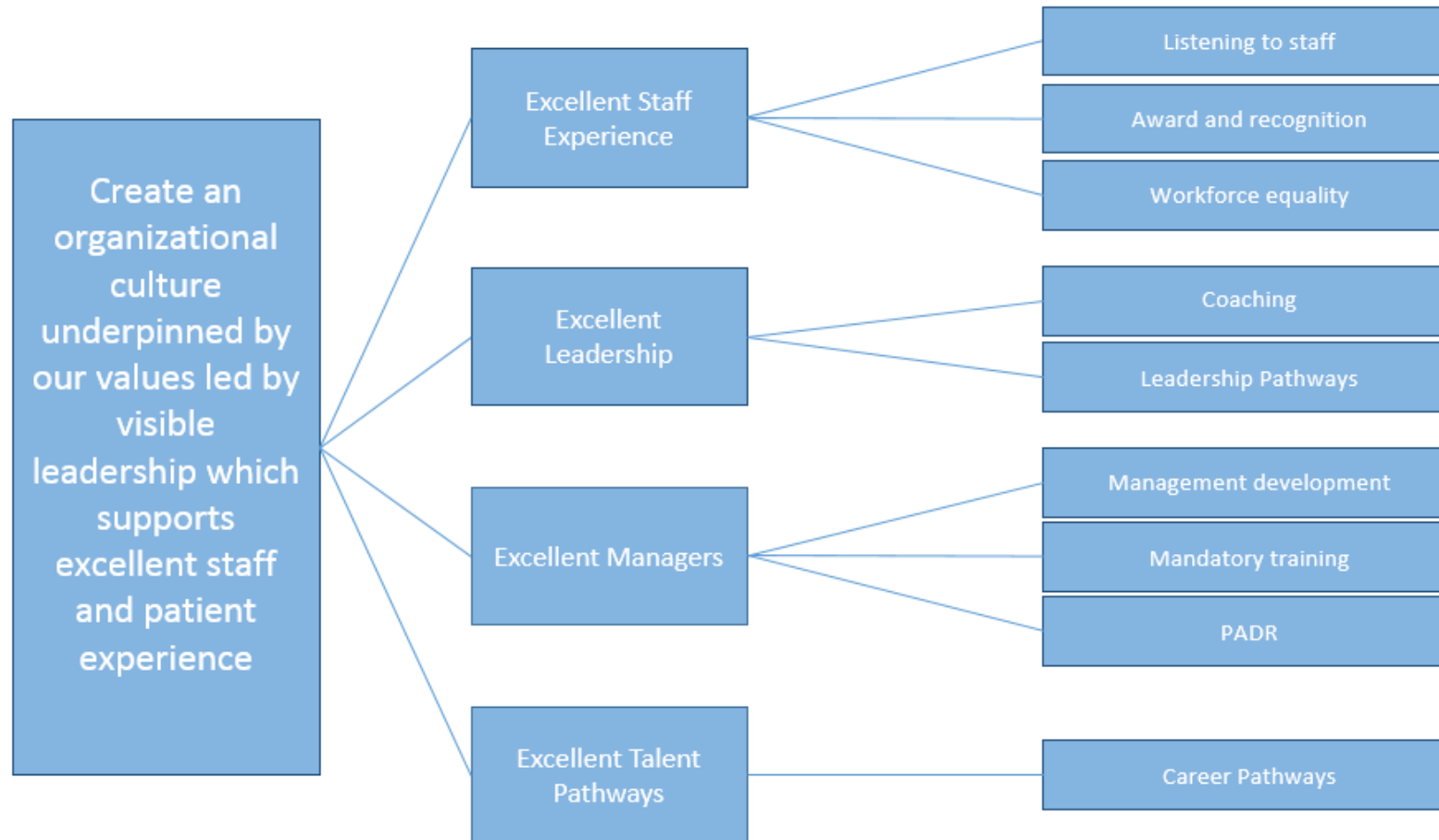
Workforce Challenges - Reward

Pay and T&Cs

Exploring opportunities to better reward our workforce

Incentivise bank arrangements to increase supply	Creative design of junior doctor roles to enhance recruitment	GP retainer scheme to encourage GPs to continue in practice

Workforce Challenges – Workforce Function

Effective and responsive workforce function

- **Workforce resourcing, capacity and structure**
  - Establish new workforce structure aligned to future organisational design
  - Professional develop plan for all staff
  - Resourcing to establish fit for purpose function

- **Digital Workforce Solutions**
  - Locum on Duty
  - ESR
  - E rostering
  - Casework software
  - E job planning

- **Welsh Language Standards**

- **Employee Relations Climate**
  - Local Partnership Forum
  - Local Negotiating Committee

- **Deliver the Basics Brilliantly**
  - Sickness Absence
  - Casework
  - JE/Organisational change

- **Establish effective governance structure**
  - Workforce and OD Committee
  - Workforce and OD Forum
  - Internal Audit recommendations

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Appendix 13 List of Measures

List of Measures
v1.xlsx

Appendix 14 All Wales Capital Programme

A5a AWCP 5 Year
Capital Programme 2

Appendix C - IMTP Mandatory & Discretionary Templates 2019/20 to 2021/22

Mandatory Templates - Sheets

C1   Outcomes Framework - Delivery of Measures
C2   Service Shift from Secondary to Primary and Community Care
C3   Finance – Statement of Comprehensive Net Income/Expenditure – 3 yrs
C4   Finance – Statement of Comprehensive Net Income/Expenditure NET profile
C5   Finance – Financial Plan Summary
C6   Finance – RP Assumptions
C7   Finance – Revenue Resource Limit Assumptions
C8   Income and Expenditure Assumptions (Wales NHS)
C9   Finance – Year 1 Savings Plan
C10   Finance – Years 2 & 3 Savings Plan
C11   Finance – Risks and Opportunities
C12   Asset Investment Summary
C13   Asset Investment Approved
C14   Asset Investment Unapproved
C15   Revenue Funded Infrastructure
C16   Workforce - WTE
C17   Workforce - £'000
C18   Workforce - Recruitment Difficulties
C19   Educational Commissioning information
         C19.1 Nursing & Midwifery
         C19.2 AHPs
         C19.3 HCS
         C19.4 Pharmacy
         C19.5 Other Professions
         C19.6 Medical & Dental

Discretionary Template - Sheet

C20   Delivery - LHB & Trust Specific Internal Service Delivery Plans & Measures

Additional Mandatory Templates (Supplementary Table) - Separate File

C21   Finance - Supplementary Master Savings Review Template

Other

C22   Hyperlinks

NHS Organisation		Date Updated	

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Quarterly	Percentage of children who received 3 doses of the '6 in 1' vaccine by age 1	95%	96.0%		96.0%			96.0%			97.0%			97.0%		98.0%	98.0%	Profiles provided by Nina Williams. Estimates are based on action plans achieving their outcomes which requires different ways of working and cultural shift to prevention focus and reducing inequality in uptakes.
	Percentage of children who received 2 doses of the MMR vaccine by age 5		89.5%		89.5%			90.0%			92.0%			93.0%		95.0%	96.0%	

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Monthly	The percentage of patients waiting less than 26 weeks for treatment	95%																
	The number of patients waiting more than 36 weeks for treatment	0																
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0		480	400	390	370	330	250	180	150	130	100	50	0			
	The number of patients waiting more than 14 weeks for a specified therapy	0		0	0	0	0	0	0	0	0	0	0	0	0			
	Number of ambulance handovers over one hour	0		320	233	201	220	193	200	208	248	241	176	148	145			
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date — Ophthalmology	Reduction (12 month trend)	Projected March 2019 position not submitted due to complexities involved in disaggregating the Bridgend/ POWH elements from the current HB performance. March 2019 projections for current HB will differ to performance/ profiles from April 2019 onwards.	8,128	7,677	7,226	6,775	6,324	5,873	5,421	4,970	4,519	4,068	3,617	3,166			Modelling based on eradicating FuNB for high-risk sub-specialties first'
	Trauma & Orthopaedic			2,053	2,000	1,947	1,894	1,841	1,788	1,735	1,682	1,629	1,576	1,523	1,470			Modelling based on eradicating FuNB for high-risk sub-specialties first'
	ENT			1,152	1,048	943	838	733	629	524	419	314	210	105	0			Modelling based on eradicating FuNB for high-risk sub-specialties first'
	Dermatology			1,396	1,269	1,142	1,015	888	762	635	508	381	254	127	0			Modelling based on eradicating FuNB for high-risk sub-specialties first'
	Urology			2,612	2,508	2,405	2,301	2,197	2,093	1,989	1,885	1,782	1,678	1,574	1,470			Modelling based on eradicating FuNB for high-risk sub-specialties first'
	The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%		77.1%	80.0%	81.9%	83.8%	84.6%	85.5%	85.7%	84.3%	84.4%	85.0%	86.2%	86.0%			
	The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0		484	374	273	283	266	238	273	279	211	185	187	180			
	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	98%		98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%			
	The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral	95%		76.1%	94.7%	88.6%	95.7%	96.6%	86.7%	88.9%	89.7%	87.2%	81.6%	83.5%	94.2%			
	Percentage of patients who have a direct admission to an acute stroke unit within 4 hours	Most recent SSNAP average (Mar-18- Jun 18) 59.7%		76%	77%	78%	78%	79%	80%	80%	81%	82%	82%	83%	84%			
	Percentage of patients who receive a CT scan within 1 hour	Most recent SSNAP average (Mar-18- Jun 18) 54.4%		47%	52%	50%	53%	51%	58%	53%	58%	55%	58%	56%	60%			
	Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	Most recent SSNAP average (Mar-18- Jun 18) 80%		87%	89%	92%	89%	91%	94%	91%	93%	96%	93%	95%	96%			
	Percentage of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes	12 month improvement trend		20%	25%	25%	30%	30%	30%	35%	35%	35%	40%	40%	40%			

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Monthly	Number of non-mental health HB DToCs	Reduction (12 month trend)		70	65	65	60	60	55	50	50	50	60	50	50			
	Number of mental health HB DToCs	Reduction (12 month trend)	As above	27	27	27	27	27	27	27	27	27	27	27	27	27	27	
	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	95%		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	New Medical Examiner roles are meant to be in place by April 2019, it is not clear how these roles will impact these figures.

DIGNIFIED CARE - I am treated with dignity & respect & treat others the same

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Quarterly	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	75%	80.0%		80.0%			80.0%			80.0%			80.0%		80.0%	80.0%	

SAFE CARE - I am protected from harm & protect myself from known harm

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Monthly	The rate of laboratory confirmed C.difficile cases per 100,000 population (rolling 12 months)	HB Specific		17	29	41	56	68	77	89	101	113	126	140	151	128	109	Profiles provided by Delyth Davies. Cumulative numbers not rolling 12 months
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population (rolling 12 months)	HB Specific	As above	11	25	37	50	62	73	84	99	114	124	140	151	136	122	Profiles provided by Delyth Davies. Cumulative numbers not rolling 12 months
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population (rolling 12 months)	HB Specific		41	77	114	154	192	231	271	303	337	377	413	452	429	408	Profiles provided by Delyth Davies. Cumulative numbers not rolling 12 months
	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	90%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%	85.0%	90.0%	90.0%	90.0%	

OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them

Measure		Target	Projected end of March 2019 position	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-21	Mar-22	Comments
Monthly	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training) - (This data is available via the Shared Services Workforce dashboard)	85%	68.0%	68.0%	68.0%	70.0%	71.0%	71.0%	75.0%	77.0%	79.0%	79.0%	81.0%	83.0%	85.0%	90.0%	95.0%	Profiles provided by Kay Myatt. Figures based on PADR being a mandatory component of Pay Progression of Pay Progression. Also consideration of impact of Bridgend Boundary change and Management Restructure
	Percentage compliance for all completed Level 1 competency with the Core Skills and Training Framework		75.0%	76.0%	77.0%	78.0%	79.0%	79.0%	80.0%	81.0%	82.0%	82.0%	83.0%	84.0%	85.0%	88.0%	90.0%	Profiles provided by Kay Myatt. Figures based on Mandatory and Statutory Training being a mandatory component of Pay Progression in new pay deal

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This template can be adjusted to suit local need. What is important that service change and service shift priorities and the key risks, benefits and milestones associated with them are identifiable.

LIST IN ORDER OF PRIORITY / IMPORTANCE

ID	CHANGE/SCHEME & Ref in IMTP	Detailed description of Service Change & Service Shift	Status & Timetable (see Note)	Expected impact on activity in different settings of care (volume and type of activity) and pathway stage.	Workforce changes to deliver service change and service shift (FTEs and skill mix)	Financial consequences - funding service change and service shifts and costs/savings	Key Risks & Mitigating Actions	Measurable Benefits
1	CLUPRIM.001: Whole System Transformation programme (Clusters)	This will build on the work to develop Clusters and will see them evolve from GP led clusters to a fully integrated Health & Social Care system, providing community based wellbeing services and healthcare to the local population.	The eight Clusters within ABMU are at differing stages of development and there will be a phased approach to the rollout of the new model (Phase 1: Cwmtawe/Neath....Phase 2: Lwychwr/Upper Valleys........Phase 3: Afan/Bay/City/Penderi) during 19/20.	Improved population health and wellbeing. Better quality and more accessible health & social care services. Higher value health & social care. A motivated and sustainable health & social care workforce.	For Neath Cluster - 2.0 Local Area Coordinator, 2.0 Physio, 1.0 SALT, 1.45 Pharmacist, 0.45 Audiology and 0.2 audiology tech, 1.4 MH workforce (actual type tbc). Workforce model for each Cluster will be based on these professional groups, however, increases in workforce will vary depending on existing workforce in each cluster as the roll out occurs	Confirmed funding from WG (original Cwmtawe bid) £1,265k for 19-20; Additional funding requested for Cwmtawe for 19-20 = £216k; Remaining 7 Cluster Bid (to go to RPB this month Jan 19) = £2,956k for 19-20.	Access to available workforce. Partnership working across agencies. Reblancing of resources within ABMU to enable sustainable service model beyond the Transformation funding period.	A Performance Measures database will be developed to include measures for number of patients accessing prescribing activities/number of clinical sessions, reduction in hospital admissions for 75+/improved BP/HBAIC control/number of care home visits/improved uptake of immunisations/increase in brief interventions
2	CLUPRIM.008: Swansea Wellness Centre	Develop Wellbeing Centres in Swansea and NPT in conjunction with the ARCH team, with clear phased plans to complete by the end of 2021/22. The centres will be multi-disciplinary and will accommodate a significant number of services on one site eg general medical, community dental, community based nursing and therapies and Third Sector.	Appoint a project manager, update project plans, submission of strategic outline case. NPT; secure capital pipeline funding to support Neath Wellness Centre or scope feasibility of redevelopment of PTRC. Scope Feasibility of second wellness centre in Moriston Swansea, submission of capital pipeline funding.	To support a shift in service delivery from secondary care to primary care led centres. Whilst the volume may not change, there will be a more modern and sustainable service established.	Existing workforce resources	Revenue consequences not yet calculated as project only at SOC stage.	Securing site for capital development - SOC is undertaking review and will identify mitigation	Improved efficiency, increased patient satisfaction and the ability to absorb increased demands in areas such as GMS patient growth
3	NONPRIM.001: Improve the Oral Health of Vulnerable groups	Improve the oral health of vulnerable groups specifically children, the elderly and housebound. Develop and implement integrated (GDS/CDS) domiciliary oral health pathway, targeting Care Homes in first instance. Also the transformation of the Design to Smile programme focussing on younger children.	Complete implementation plan for new Domiciliary service and implement new pathway - phase 1 (eg one county/care homes or general homes first - TBC) during 19/20. Ensure that all relevant GDS practices are trained and engaged on the new younger children's programme, including the 'Lift the Lip' campaign	Significant improvement in the quality of care delivered to these vulnerable groups with improved, faster access, the investment in an integrated oral health education and service delivery pathway (CDS and GDS) will ensure they receive dental treatment that is not generally being provided across ABMU	1 x FT Band 4 dental coordinator (dental nurse)post will be appointed into the referral management team	funding will be allocated via ring fenced dental primary care budget.	No risks identified	Increase in number of people receiveing Dental assessment and treatment in a Domicillary setting - trajectory to be developed in from Q2 2019/20
4	NONPRIM003: Increase access to General Dental services through implementation of contract reform programme	The PCS Unit has previously been given permission to invest up to the level of the WG allocation for Dental services, and 2019/20 sees the final year of the three year reinvestment strategy that has been agreed with WG and ABMU Executive team. The contract reform process, coupled with changes in community and restorative dentistry, aims to introduce a significantly more preventive style of practice that will lead in the medium term to better oral health.	First wave of Contract Reform reform programmes in early 19/20 (6 practices) all with further reductions in UDA target in line with achievement of progress against objectives around access and prudent skill mix	Increased access by adults and children to the GDS in contract reformed and "prototype" practices demonstratable skill mix changes and higher levels of preventative work eg fluoridisation.	additonal primary care resource required as the national programme rolls out across ABM and the programme expands and moves into phase 2	funding allocated to this project via the primary care dental ring fenced budget.	risk: initial reduction in patient charge income into Health Board/possibilty WG may agree to offset costs via increased dental allocation dependent on evidence of HB	Demonstrating that eliminating the Unit Dental Activity target-driven approach will result in greater access and more holistic care.
5	NONPRIM.010: Remodel GP-led Out of Hours service	Remodel Urgent Primary Care service (GP-led Out of Hours service), creating multi-disciplinary model. Reshape the staffing mix to reduce reliance on general practitioners, and introduce new types of practitioner such as paramedic, pharmacist and advanced nursing input.	Workforce diversification is ongoing to recruit to non-GP posts	The principle objective is to increase the number of suitable, competent, non-GP clinicians. This will enable more Urgent Care demand to be met in an appropriate fashion, which will in turn reduce inappropriate ED and next-day GP attendance.	WAST SLA for 84 hours per week of Paramedic. 4.0 WTE of registered nurse. 1.6 WTE Pharmacist. 0.85 HCSW (initial pilot via Winter monies in WAST). Reduction in GP hours to complement the increased MDT	remodelling funded via WG Invest to Save fund.	Key risks are to timescales for training and development of wider skill mix of staff. Additional project management support being invested in project through Invest to Save funds.	Improved access to Urgent Primary Care. Improved sustainable model of Urgent Primary Care via MDT. Improved cost effective service provision via lower workforce costs.
6	NONPRIM015: Reduce reliance on face to face OP appointments for Oral Surgery/Cancer	Reduce reliance on face to face OP appointments for Oral Surgery/Cancer by introducing Primary Care oral medicine Clinician-led Referral Management Centre, supported by local implementaton of new Oral Medicine programme (proposed)	Recruit to Oral Medicine Trainee post in collaboration with HEIW. Confirm Oral Medicine pathway with OMFS.	Reduced referral to secondary care, and more appropriate referrals, will allow those with highest care needs to be treated sooner and accords with prudent care princples.	possible additional primary care managerial support for implemntation of new dental pathways	possible additional primary care managerial support for implemntation of new dental pathways	Inability to attract / retain sufficient contractors to engage with new ways of working; mitigated through leadership of Dental Director and colleagues	Cancer targets met; less hospital OP appointments with higher proportion of cancer patients;
7	NONPRIM.016: Reduce reliance on face to face opthalmology outpatient appointments	Reduce reliance on face to face ophthalmology outpatient appointments by further increasing number and percentage of patients receiving pre-operative assessment and post op follow up in primary care (Optometry) practice	To date only three schemes are being progressed - one to outreach some aspects of Glaucoma clinics to Cwmtawe cluster; one to ensure stroke patients are screened by optometrists (rather than hospital based orthoptists), the third exploring various options to reduce FUNB	Schemes to be developed jointly with Singleton Delivery Unit to deliver much more upstream assessment and service delivery pathways, reducing the risk of poor eye health impacting on an individuals overall health and treating patients in a primary care setting that are currently reliatn on	1x FT Band 6 additonal primary care management resource/additional optometry advisor sessions required to support shift/delivery of new services into primary care setting.	no available optometry budget within primary care to fund additonal services /additonal posts within primary care . Funding will need to follow shift of services to support	Engagement with secondary care clinicians to ensure robust pathway, including any training required for community based clinicians is provided	Reduced waiting times and reduction of major risks associated with number of patients on FUNB lists
8	AUD.001: Expand Primary Care Audiology capacity and coverage	Recruiting and training Audiology staff to work within the Clusters - shifting the service from hospital based ENT services	Rollout in line with the phased development of the Whole System Transformation programme	Increase in total number of patients seen in Primary Care settings and not hosptial based ENT service. Providing rapid access to assessment of symptoms.	Staff recruited By 2021/22 (5wte@Band 4, 5wte @Band 7 and 1 wte @Band 8A)	Funding is part of Whole System Transformation	Long term sustainablility for service provision after Transformation funding. Requires rebalancing of resources to Primary Care.Small risk around the availablity of appropriately trained staff	Number of patients assessed in a Primary Care setting

NOTE

1 **Status & Timetable**
Status - What is **currently being implemented** and what is **in the pipeline (forward look)**
Timetable - expected timetable for **implementation** and **completion**.

Select Organisation from Drop Down Menu

Enter Date of Submission: **31/01/2019**

STATEMENT OF COMPREHENSIVE NET INCOME/EXPENDITURE

This Table is currently showing errors

Please note that this Table is populated automatically from Table C4

		Annual Plan 2019/20	Annual Plan 2020/21	Annual Plan 2021/22
	Revenue/Income (positive entries)	**£'000**	**£'000**	**£'000**
1	Revenue Resource Limit	0	0	0
2	Miscellaneous Income - Capital Donation\Government Grant Income	0	0	0
3	Miscellaneous Income - Other (including non resource limited income)	0	0	0
4	Welsh NHS Local Health Boards & Trusts Income	0	0	0
5	WHSSC Income	0	0	0
6	Welsh Government Income	0	0	0
7	**Total Revenue/Income**	**0**	**0**	**0**
	Operating Expenses (positive entries)			
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	0	0	0
9	Primary Care - Drugs & Appliances	0	0	0
10	Pay	0	0	0
11	Non Pay (excluding drugs & depreciation)	0	0	0
12	Secondary Care - Drugs	0	0	0
13	Healthcare Services Provided by Other NHS bodies	0	0	0
14	Non Healthcare Services Provided by Other NHS bodies	0	0	0
15	Continuing Care and Funded Nursing Care	0	0	0
16	Other Private & Voluntary Sector	0	0	0
17	Joint Financing and Other	0	0	0
18	Depreciation/Impairments	0	0	0
19	Other	0	0	0
20	**Total Operating Expenses**	**0**	**0**	**0**
21	**Forecast Surplus/(Deficit)**	**0**	**0**	**0**

Select Organisation from Drop Down Menu

31 January 2019

31 January 2019

31 January 2019

MONTHLY SUMMARISED STATEMENT OF COMPREHENSIVE NET EXPENDITURE

This Table is currently showing 0 errors

Enter Current YTD Month 9

		Current Year				Year 1														Year 2					Year 3				
		YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position	AV 1-3 Average month Q1	AV4-6 Average month Q2	AV7-9 Average month Q3	AV 10-12 Average month Q4	Forecast year-end position	AV 1-3 Average month Q1	AV4-6 Average month Q2	AV7-9 Average month Q3	AV 10-12 Average month Q4	Forecast year-end position
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Revenue Resource Limit		0		0													0					0					0
2	Miscellaneous Income - Capital Donation\Government Grant Income		0		0													0					0					0
3	Miscellaneous Income - Other (including non resource limited income)		0		0													0					0					0
4	Welsh NHS Local Health Boards & Trusts Income		0		0													0					0					0
5	WHSSC Income		0		0													0					0					0
6	Welsh Government Income		0		0													0					0					0
7	**Income Total**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	Primary Care - Drugs & Appliances		0		0													0					0					0
10	Provided Services - Pay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	Provider Services - Non Pay (excluding drugs & depreciation)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Secondary Care - Drugs		0		0													0					0					0
13	Healthcare Services Provided by Other NHS Bodies		0		0													0					0					0
14	Non Healthcare Services Provided by Other NHS Bodies		0		0													0					0					0
15	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Other Private & Voluntary Sector		0		0													0					0					0
17	Joint Financing and Other		0		0													0					0					0
18	DEL Depreciation\Accelerated Depreciation\Impairments		0		0													0					0					0
19	AME Donated Depreciation\Impairments		0		0													0					0					0
20	Non Allocated Contingency		0		0													0					0					0
21	Profit\Loss Disposal of Assets		0		0													0					0					0
22	**Cost - Total**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
23	**Net surplus/ (deficit)**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table C4.1 - Net Expenditure Profile Analysis

A. PROVIDER PAY EXPENDITURE ANALYSIS

	Pay - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
24	Establishment		0		0													0					0					0
25	Variable		0		0													0					0					0
26	Agency/Locum		0		0													0					0					0
27	Inflationary/Cost Growth		0		0													0					0					0
28	Demand/Service Growth		0		0													0					0					0
29	Local Service/Cost Pressures		0		0													0					0					0
30	Committed Reserves		0		0													0					0					0
31	Other		0		0													0					0					0
32	**Total Gross Expenditure**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
33	Establishment Savings		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
34	Variable Pay Savings		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35	Locum		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
36	Agency/Locum Paid at a Premium Savings		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
37	Changes in Bank Staff		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
38	Other Workforce Savings		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
39	**Total Workforce Savings**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40	Unidentified Savings		0		0													0					0					0
41	Mitigating Actions to be Identified		0		0													0					0					0
42	**Total Savings / Mitigating Actions to be Identified**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
43	Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

B. NON PAY (excluding drugs & depreciation) EXPENDITURE ANALYSIS

	Non Pay - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
44	Non Pay		0		0													0					0					0
45	Non Pay Other		0		0													0					0					0
46	Inflationary/Cost Growth		0		0													0					0					0
47	Demand/Service Growth		0		0													0					0					0
48	Local Service/Cost Pressures		0		0													0					0					0
49	Committed Reserves		0		0													0					0					0
50	**Total Gross Expenditure**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
51	Non Pay Savings		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52	Unidentified Savings		0		0													0					0					0
53	Mitigating Actions to be Identified		0		0													0					0					0
54	**Total Savings / Mitigating Actions to be Identified**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55	Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

C. DRUGS EXPENDITURE ANALYSIS

	Current Year				Year 1													Year 2					Year 3				
	9				1	2	3	4	5	6	7	8	9	10	11	12		AV 1-3	AV4-6	AV7-9	AV 10-12		AV 1-3	AV4-6	AV7-9	AV 10-12	
Drugs/Medicines Management - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position Q4	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
56 Primary Care Drugs	0			0													0					0					0
57 Secondary Care Drugs	0			0													0					0					0
58 Inflationary/Cost Growth	0			0													0					0					0
59 Demand/Service Growth	0			0													0					0					0
60 Local Service/Cost Pressures	0			0													0					0					0
61 Committed Reserves	0			0													0					0					0
62 Total Gross Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
63 Medicines Management Savings	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
64 Unidentified Savings	0			0													0					0					0
65 Mitigating Actions to be Identified	0			0													0					0					0
66 Total Savings / Mitigating Actions to be Identified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
67 Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0		0	0	0	0	

D. PRIMARY CARE CONTRACTOR (excl drugs, incl Non Resource Limited) EXPENDITURE ANALYSIS

	Current Year				Year 1													Year 2					Year 3				
	9				1	2	3	4	5	6	7	8	9	10	11	12		AV 1-3	AV4-6	AV7-9	AV 10-12		AV 1-3	AV4-6	AV7-9	AV 10-12	
Primary Care Contractor - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position Q4	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
68 Primary Care Contractor Expenditure	0			0													0					0					0
69 Primary Care - Agency/Locum Paid at a Premium	0			0													0					0					0
70 Inflationary/Cost Growth	0			0													0					0					0
71 Demand/Service Growth	0			0													0					0					0
72 Local Service/Cost Pressures	0			0													0					0					0
73 Committed Reserves	0			0													0					0					0
74 Total Gross Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75 Primary Care Savings	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
76 Unidentified Savings	0			0													0					0					0
77 Mitigating Actions to be Identified	0			0													0					0					0
78 Total Savings / Mitigating Actions to be Identified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
79 Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

E. CONTINUING HEALTHCARE/ FUNDED NURSING CARE EXPENDITURE ANALYSIS

	Current Year				Year 1													Year 2					Year 3				
	9				1	2	3	4	5	6	7	8	9	10	11	12		AV 1-3	AV4-6	AV7-9	AV 10-12		AV 1-3	AV4-6	AV7-9	AV 10-12	
Continuing Healthcare / Funded Nursing Care - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position Q4	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
80 Continuing Healthcare / Funded Nursing Care	0			0													0					0					0
81 Inflationary/Cost Growth	0			0													0					0					0
82 Demand/Service Growth	0			0													0					0					0
83 Local Service/Cost Pressures	0			0													0					0					0
84 Committed Reserves	0			0													0					0					0
85 Total Gross Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86 Continuing Healthcare / Funded Nursing Care Savings	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
87 Unidentified Savings	0			0													0					0					0
88 Mitigating Actions to be Identified	0			0													0					0					0
89 Total Savings / Mitigating Actions to be Identified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
90 Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

F. COMMISSIONED SERVICES (Health Care & Non HealthCare) EXPENDITURE ANALYSIS

	Current Year				Year 1													Year 2					Year 3				
	9				1	2	3	4	5	6	7	8	9	10	11	12		AV 1-3	AV4-6	AV7-9	AV 10-12		AV 1-3	AV4-6	AV7-9	AV 10-12	
Commissioned Services - Expenditure Profiles	YTD	YTD Monthly Average	FY FC	FY Monthly Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position Q4	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position	Average month Q1	Average month Q2	Average month Q3	Average month Q4	Forecast year-end position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
91 HealthCare Services Provided by Other NHS Bodies	0			0													0					0					0
92 Non HealthCare Services Provided by Other NHS Bodies	0			0													0					0					0
93 Other Private & Voluntary	0			0													0					0					0
94 Joint Financing & Other	0			0													0					0					0
95 Inflationary/Cost Growth	0			0													0					0					0
96 Demand/Service Growth	0			0													0					0					0
97 Local Service/Cost Pressures	0			0													0					0					0
98 Committed Reserves	0			0													0					0					0
99 Total Gross Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
100 Commissioned Services Savings	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
101 Unidentified Savings	0			0													0					0					0
102 Mitigating Actions to be Identified	0			0													0					0					0
103 Total Savings / Mitigating Actions to be Identified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
104 Net Expenditure (as per Table C4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0		0	0	0	0	

INTEGRATED MEDIUM TERM PLAN SUMMARY - 2019/20 to 2021/22

This Table is currently showing 0 errors

		2019/20		2020/21		2021/22	
		In Year	Recurring Full Year Effect (N/R items enter 0)	In Year	Recurring Full Year Effect (N/R items enter 0)	In Year	Recurring Full Year Effect (N/R items enter 0)
		£'000	£'000	£'000	£'000	£'000	£'000
1	Revenue Resource Limit (RRL) LHB only (positive values)		0		0		0
2	Income (For Trusts)/Other Income (positive values)		0		0		0
3	Total Revenue Allocation/Income	0	0	0	0	0	0
	High Level Summary						
4	**1. Underlying Position b/f**						
5	1.1 b/f Recurring Cost Pressures (by speciality) / Developments (by title) - (negative values):						
6	Primary Care		0		0		0
7	Mental Health		0		0		0
8	Continuing HealthCare		0		0		0
9	Commissioned Services		0		0		0
10	Scheduled Care		0		0		0
11	Unscheduled Care		0		0		0
12	Children & Women's		0		0		0
13	Community Services		0		0		0
14	Specialised Services		0		0		0
15	Executive / Corporate Areas		0		0		0
16	Support Services (inc. Estates & Facilities)		0		0		0
17	Total Underlying Position b/f: Deficits and Cost Pressures (negative)/ Surplus (positive)	0	0	0	0	0	0
18	**2. New Cost Pressures (negative values)**						
19	2.1 Cost Growth						
20	Pay Inflation						
21	- Pay Award						
22	- Increments						
23	- Pensions & Other Pay Oncost Changes						
24	- Terms & Conditions (incl T&S)						
25	Other…..Specify						
26							
27							
28							
29	Sub Total Pay Inflation	0	0	0	0	0	0
30	Non pay Inflation						
31	Statutory Compliance and National Policy						
32	Continuing Heath Care						
33	Funded Nursing Care						
34	Prescribing						
35	GMS						
36	Quality & Safety Developments						
37	Other……Specify						
38							
39							
40							
41							
42							
43							
44	Total Inflationary/Cost Growth	0	0	0	0	0	0
45	2.2 Demand / Service Growth (negative values)						
46	Primary Care Contractor						
47	NICE and New High Cost Drugs						
48	Continuing Heath Care						
49	Funded Nursing Care						
50	Prescribing						
51	Specialist Services - Direct						
52	Specialist Services - via WHSSC						
53	Welsh Risk Pool						
54	EASC						
55	RTT (associated with planned activity stated in IMTP)						
56	Treatment Fund (associated anticipated funding to be reported in Section 5)						
57	Demographic / Demand on Acute Services: Please Specify below						
58							
59							
60							
61							
62							
63							
64							
65	Other……Specify						
66							
67							
68							
69							
70							
71							
72	Total Demand/Service Growth	0	0	0	0	0	0
73	2.3 Local Service/Cost Pressures (negative values)						
74	Other……Specify						
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89	Total Local Cost Base Challenge	0	0	0	0	0	0
90	Total Opening Financial Challenge (Deficit)/Surplus	0	0	0	0	0	0
91	3. Identified Savings Plans (positive values)						
92	Continuing Care and Funded Nursing Care	0	0	0	0	0	0
93	Commissioned Services	0	0	0	0	0	0
94	Medicine Management (Primary and Secondary Care)	0	0	0	0	0	0
95	Non Pay	0	0	0	0	0	0
96	Pay	0	0	0	0	0	0
97	Primary Care	0	0	0	0	0	0
98	Total Identified Savings Plans	0	0	0	0	0	0
99	Total Savings/Mitigating Actions Yet To Be Identified (positive value)						
100	Total Net Income Generation (positive value)						
101	Total Planned Accountancy Gains (positive value)						
102	Total Unallocated Reserves (positive value)						
103	Total In Year Performance/Position Before Repayment of Prev Years Deficit - (Deficit)/Surplus	0	0	0	0	0	0
104	4. Repayment of Previous Years Deficit (negative value)						
105	Total In Year Performance/Position After Repayment of Prev Years Deficit - (Deficit)/Surplus	0	0	0	0	0	0
106	5. Revenue Assistance\Funding Requested (positive values) (breakdown to be provided in Commentary)						
107	Recurring - Inflation						
108	Recurring - Other						
109	Non Recurring						
110	Total WG Assistance	0	0	0	0	0	0
111	Net Financial Challenge - (Deficit)/Surplus	0	0	0	0	0	0

N.B. To ensure cost pressures are not over inflated, the values reported with Table C3 must be net of any identified 'Mitigating Actions'.

Resource Planning Assumptions

		Local Resource Planning Assumptions Used		
	Inflationary Pressure	**2019/20 % Cost**	**2020/21 % Cost**	**2021/22 % Cost**
1	**Cost Growth**			
2	Pay Inflation (inc. awards, T & Cs inc. Travel etc)			
3	Incremental Drift			
4	Pensions & Other Pay Oncost Changes			
5	Non pay Inflation			
6	Statutory Compliance and National Policy			
7	Continuing Heath Care			
8	Funded Nursing Care			
9	Prescribing			
10	GMS			
11	Quality & Safety Developments			
13	**Total Cost Growth**	0.00%	0.00%	0.00%
14	**Demand / Service Growth**			
15	Primary Care Contractor			
16	NICE and New High Cost Drugs			
17	Continuing Heath Care			
18	Funded Nursing Care			
19	Prescribing			
20	Specialist Services - Direct			
21	Specialist Services - via WHSSC			
22	Welsh Risk Pool			
23	EASC			
24	RTT			
25	Treatment Fund			
26	Specialist Services			
27	Demographic / Demand on Acute Services			
28	**Total Demand / Service Growth**	0.00%	0.00%	0.00%
29	**Total Inflationary Pressure**	0.00%	0.00%	0.00%

		2019/20		2020/21		2021/22	
	Pay Related Cost Assumptions - Local	**£'000**	**%**	**£'000**	**%**	**£'000**	**%**
1	**Pay Awards**						
2	- A 4 C Staff		0.00%		0.00%		0.00%
3	- Misc Pay (Non AfC / Non Medical)		0.00%		0.00%		0.00%
4	- Junior Medical Staff		0.00%		0.00%		0.00%
5	- Staff Grades / Associate Specialists		0.00%		0.00%		0.00%
6	- Consultants		0.00%		0.00%		0.00%
7	**Total Pay Awards**	0	0.00%	0	0.00%	0	0.00%
8	**Increments**	**£'000**	**%**	**£'000**	**%**	**£'000**	**%**
9	Cost of Increments						
10	- A 4 C Staff		0.00%		0.00%		0.00%
11	- Misc Pay (Non AfC / Non Medical)		0.00%		0.00%		0.00%
12	- Junior Medical Staff		0.00%		0.00%		0.00%
13	- Staff Grades / Associate Specialists		0.00%		0.00%		0.00%
14	- Consultants		0.00%		0.00%		0.00%
15	- Consultant Commitment Awards		0.00%		0.00%		0.00%
16	**Total Increments**	0	0.00%	0	0.00%	0	0.00%
17	**Pensions & Other Pay Oncost Changes**	**£'000**	**%**	**£'000**	**%**	**£'000**	**%**
18	**1 - NHS Pension Discount Rate Change - 3.0% to 2.8%**						
19	From 2019/20		0.00%		0.00%		0.00%
22	**Total Pensions**	0	0.00%	0	0.00%	0	0.00%
23	**Comparator**						

Revenue Resource Limit Assumptions

	LHB COMPLETION ONLY	2019/20 £'000	2020/21 £'000	2021/22 £'000
1	**RRL used in SCNE profiled analysis**	0	0	0
	Made up of:-			
2	**Allocation Letter/ Resource Planning Figure**			
3	**Plus the following additional anticipated allocations:-**			
4	**DEL- Funded in Previous Years:**			
6	Substance Misuse			
7	Clinical Excellence/Distinction Awards			
8	Orthopaedics			
9	Immunisations (Vaccine & GMS fees) & HPV			
10	Treatment Fund - *see note at foot of table*			
11	Other….specify			
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24	**Sub Total - Funded in Previous Years**	0	0	0
25	**DEL New Funding Issues**			
26	**1.Recurring**			
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43	**Sub Total - New Funding Issues - Recurring**	0	0	0
44	**2. Non Recurring**			
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59	**Sub Total - New Funding Issues - Non Recurring**	0	0	0
60	**AME**			
61	Donated Depreciation			
62	Impairments			
63	Other…specify			
64				
65				
66				
67				
68	**Sub Total - AME**	0	0	0
69	**Total RRL used in SCNE profiled analysis**	0	0	0
70	***Check total = zero***	0	0	0

N.B. Treatment fund should be reported within Section 5 of Table C5 to offset
the associated costs reported on within Section 2.2 (Line Ref 80) of Table C5

Select Organisation from Drop Down Menu

Income and Expenditure Assumptions (Wales NHS)

This Table is currently showing 0 errors

A. Annual Forecast 2019/20

	LHBs / Trusts	Contracted Income £'000	Non Contracted Income £'000	Total Income £'000		Contracted Expenditure £'000	Non Contracted Expenditure £'000	Total Expenditure £'000
1	Abertawe Bro Morgannwg			0				0
2	Aneurin Bevan			0				0
3	Betsi Cadwaladr			0				0
4	Cardiff & Vale			0				0
5	Cwm Taf			0				0
6	Hywel Dda			0				0
7	Powys			0				0
8	Public Health Wales			0				0
9	Velindre			0				0
10	Welsh Ambulance			0				0
11	WHSSC			0				0
12	EASC			0				0
13	HEIW			0				0
14	Total	0	0	0		0	0	0

Select Organisation from Drop Down Menu

31 January 2019

This Table is currently showing 0 errors

NOTE: Tables to be populated with indentified savings plans only

YEAR 1 SAVINGS PLANS - All Positive Entries													
To include Cost Improvement & Cost Containment schemes													

Savings Plans:-	Year 1												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
1 Continuing Care and Funded Nursing Care													0
2 Commissioned Services													0
3 Medicine Management (Primary and Secondary Care)													0
4 Non Pay													0
5 Pay													0
6 Primary Care													0
7 **Total Savings Plans**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Pay Savings: Analysis

Pay Category	Year 1												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
8 Changes in Staffing Establishment													0
9 Variable Pay													0
10 Locum													0
11 Agency / Locum paid at a premium													0
12 Changes in Bank Staff													0
13 Other (Please Specify in Narrative)													0
14 **Total Pay Savings: Analysis**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

15 *Check - Agrees to Savings Plan Line 5*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Agency/Locum paid at a premium Savings: Analysis

Agency/Locum paid at a premium	Year 1												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
16 Reduced usage of Agency/Locums paid at a premium													0
17 Replacing 'off contract' with 'in contract'													0
18 Impact of Agency pay rate caps													0
19 Other (Please Specify in Narrative)													0
20 **Total Agency/Locum paid at a premium Savings: Analysis**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

21 *Check - Agrees to Savings Plan Line 11*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Select Organisation from Drop Down Menu   ############

This Table is currently showing 0 errors

NOTE: Tables to be populated with indentified savings plans only

YEAR 2 & 3 SAVINGS PLANS - All Positive Entries
To include Cost Improvement & Cost Containment schemes

Savings Plans:-	Year 2					Non Recurring	Recurring	FYE of Recurring	Year 3				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	£'000	£'000	£'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
1 Continuing Care and Funded Nursing Care					0								0
2 Commissioned Services					0								0
3 Medicine Management (Primary and Secondary Care)					0								0
4 Non Pay					0								0
5 Pay					0								0
6 Primary Care					0								0
7 **Total Savings Plans**	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay Savings: Analysis

Pay Category	Year 2					Non Recurring	Recurring	FYE of Recurring	Year 3				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	£'000	£'000	£'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
8 Changes in Staffing Establishment					0								0
9 Variable Pay					0								0
10 Locum					0								0
11 Agency / Locum paid at a premium					0								0
12 Changes in Bank Staff					0								0
13 Other (Please Specify in Narrative)					0								0
14 **Total Pay Savings: Analysis**	0	0	0	0	0	0	0	0	0	0	0	0	0
15 *Check - Agrees to Savings Plan Line 5*	Yes	Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes	Yes

Agency/Locum paid at a premium Savings: Analysis

Agency/Locum paid at a premium	Year 2					Non Recurring	Recurring	FYE of Recurring	Year 3				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	£'000	£'000	£'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
16 Reduced usage of Agency/Locums paid at a premium					0								0
17 Replacing 'off contract' with 'in contract'					0								0
18 Impact of Agency pay rate caps					0								0
19 Other (Please Specify in Narrative)					0								0
20 **Total Agency/Locum paid at a premium Savings: Analysis**	0	0	0	0	0	0	0	0	0	0	0	0	0
21 *Check - Agrees to Savings Plan Line 11*	Yes	Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes	Yes

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Select Organisation from Drop Down Menu   ############

Overview Of Worse & Best Case Positions

		2019/20		2020/21		2021/22	
		Worst Case	Best Case	Worst Case	Best Case	Worst Case	Best Case
		£'000	£'000	£'000	£'000	£'000	£'000
	Current Reported Financial Plan Outturn	0	0	0	0	0	0
1	Risks (negative values)						
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21	Total Risks	0		0		0	
22	Financial Challenge excluding opportunities	0	0	0	0	0	0

		2019/20		2020/21		2021/22	
		Worst Case	Best Case	Worst Case	Best Case	Worst Case	Best Case
	Opportunities (positive values) (record value in Worst column and Best column will populate automatically)	£'000	£'000	£'000	£'000	£'000	£'000
23			0		0		0
24			0		0		0
25			0		0		0
26			0		0		0
27			0		0		0
28			0		0		0
29			0		0		0
30			0		0		0
31			0		0		0
32			0		0		0
33			0		0		0
34			0		0		0
35			0		0		0
36			0		0		0
37			0		0		0
38			0		0		0
39			0		0		0
40			0		0		0
41			0		0		0
42	Total Opportunities	0	0	0	0	0	0
43	Total Amended Forecast Plan Outturn Surplus/(Deficit)	0	0	0	0	0	0

Property & Asset Investment

Summary

	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Gross Capital Expenditure	**52.718**	**40.551**	**19.728**	**12.845**	**11.668**
less: Receipts	0.925	0.5	0.5	0.5	0.5
Disposals:					
Net Capital Expenditure	**51.793**	**40.051**	**19.228**	**12.345**	**11.168**

	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Welsh Government Funding					
Discretionary (Group 1 - CRL / CEL)	11.168	11.168	11.168	11.168	11.168
Approved Schemes (Group 2 - CRL / CEL)	14.915	0.478			
WG Funding Required (approved)	**26.083**	**11.646**	**11.168**	**11.168**	**11.168**
Funding for identified schemes not approved by Welsh Governme	25.710	28.405	8.060	1.177	0.000

Key Performance Indicators

	2016-17 as per EFPMS	2022-23 Forecast
	£m	£m
High Risk Backlog Maintenance		
	%	%
Physical Condition: % in Category B or above		
Statutory, Safety & Compliance: % in Category B or above		
Fire Safety Compliance : % in Category B or above		
Functional Suitability: % in Category B or above		
Space Utilisation: % in Category F or above		
Energy Performance: % with Energy B or better		

Property & Asset Investment

Capital Expenditure

DISCRETIONARY	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
IT					
Equipment					
Statutory Compliance					
Estates					
Other	11.168	11.168	11.168	11.168	11.168
Sub total DISCRETIONARY	11.168	11.168	11.168	11.168	11.168

Revenue Implications (Incremental consequences)

Discretionary Non Cash Costs	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Discretionary Other Revenue Costs					
Discretionary Revenue Savings					
Discretionary Net Revenue					

APPROVED SCHEMES	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Scheme 1 -Environmental Modernisation Programme (SOP)					
Environmental Modernisation BJC2 (Phase	2.583				
Scheme 2 - Implications of the South Wales Plan					
Increase Neo Natal Capacity Singleton	4.71				
Scheme 3 - National Imaging Programme					
Replacement of MRI , NPT	3.043				
Scheme 4 - Primary Care National Pipeline					
Penclawdd Refurbishment	1.026				
Murton Refurbishment	0.593				
Scheme 5 -NWIS					
National WEDCIMS	0.270				
National Clinical Systems	0.068				
Scheme 6 - Spend to Save					
Health Records Modernisation (RFID) 2017	0.023				
Automated Stock Management in Theatres	1.71	0.478			
Scheme 7 - National Radiotherapy Replacement Programme					
Replacement programme for Linear Accele	0.889				
Scheme 8 -					
Scheme 9 - INSERT TITLE					
Scheme 10 - INSERT TITLE					
Scheme 11 - INSERT TITLE					

Approved Schemes	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Scheme 1 -Environmental Modernisation Programme (SOP)					
Scheme 1 - Non Cash - DEL	0.014	0.06	0.06	0.06	0.06
Scheme 1 - Non Cash - AME	1.673				
Scheme 1 - Other Revenue Costs					
Scheme 1 - Revenue Savings					
Scheme 1 - Net Revenue					
Scheme 2 - Implications of the South Wales Plan					
Scheme 2 - Non Cash - DEL	0.113	0.434	0.434	0.434	0.434
Scheme 2 - Non Cash - AME	2.805				
Scheme 2 - Other Revenue Costs					
Scheme 2 - Revenue Savings					
Scheme 2 - Net Revenue					
Scheme 3 - National Imaging Programme					
Scheme 3 - Non Cash - DEL		0.259	0.259	0.259	0.259
Scheme 3 - Non Cash - AME	0.557				
Scheme 3 - Other Revenue Costs					
Scheme 3 - Revenue Savings					
Scheme 3 - Net Revenue					
Scheme 4 - Primary Care National Pipeline					
Scheme 4 - Non Cash - DEL	0.019	0.054	0.054	0.054	0.054
Scheme 4 - Non Cash - AME	0.603				
Scheme 4 - Other Revenue Costs					
Scheme 4 - Revenue Savings					
Scheme 4 - Net Revenue					
Scheme 5 -NWIS					
Scheme 5 - Non Cash - DEL	0.715	1.181	1.181	1.181	1.181
Scheme 5 - Non Cash - AME					
Scheme 5 - Other Revenue Costs					
Scheme 5 - Revenue Savings					
Scheme 5 - Net Revenue					
Scheme 6 - Spend to Save					
Scheme 6 - Non Cash - DEL	0.197	0.498	0.646	0.646	0.646
Scheme 6 - Non Cash - AME					
Scheme 6 - Other Revenue Costs					
Scheme 6 - Revenue Savings					
Scheme 6 - Net Revenue					
Scheme 7 - National Radiotherapy Replacement Programme					
Scheme 7 - Non Cash - DEL		0.342	0.342	0.342	0.342
Scheme 7 - Non Cash - AME	0.701				
Scheme 7 - Other Revenue Costs					
Scheme 7 - Revenue Savings					
Scheme 7 - Net Revenue					
Scheme 8 -					
Scheme 8 - Non Cash - DEL					
Scheme 8 - Non Cash - AME					
Scheme 8 - Other Revenue Costs					
Scheme 8 - Revenue Savings					
Scheme 8 - Net Revenue					
Scheme 9 - INSERT TITLE					
Scheme 9 - Non Cash - DEL					
Scheme 9 - Non Cash - AME					
Scheme 9 - Other Revenue Costs					
Scheme 9 - Revenue Savings					
Scheme 9 - Net Revenue					
Scheme 10 - INSERT TITLE					
Scheme 10 - Non Cash - DEL					
Scheme 10 - Non Cash - AME					
Scheme 10 - Other Revenue Costs					
Scheme 10 - Revenue Savings					
Scheme 10 - Net Revenue					
Scheme 11 - INSERT TITLE					
Scheme 11 - Non Cash - DEL					
Scheme 11 - Non Cash - AME					
Scheme 11 - Other Revenue Costs					
Scheme 11 - Revenue Savings					
Scheme 11 - Net Revenue					

Scheme 12 - INSERT TITLE						Scheme 12 - INSERT TITLE					
						Scheme 12 - Non Cash - DEL					
						Scheme 12 - Non Cash - AME					
						Scheme 12 - Other Revenue Costs					
						Scheme 12 - Revenue Savings					
						Scheme 12 - Net Revenue					
Scheme 13 - INSERT TITLE						Scheme 13 - INSERT TITLE					
						Scheme 13 - Non Cash - DEL					
						Scheme 13 - Non Cash - AME					
						Scheme 13 - Other Revenue Costs					
						Scheme 13 - Revenue Savings					
						Scheme 13 - Net Revenue					
Scheme 14 - INSERT TITLE						Scheme 14 - INSERT TITLE					
						Scheme 14 - Non Cash - DEL					
						Scheme 14 - Non Cash - AME					
						Scheme 14 - Other Revenue Costs					
						Scheme 14 - Revenue Savings					
						Scheme 14 - Net Revenue					
Sub Total Approved Schemes Total	**14.915**	**0.478**	**0**	**0**	**0**						

Other Capital Expenditure:						Other Capital Expenditure:					
Donated Assets Additions	0.5	0.5	0.5	0.5	0.5	Non Cash Costs					
Capital Grants	0.1					Other Revenue Costs					
Other	0.325					Revenue Savings					
Sub Total Other Capital Expenditure	**0.925**	**0.5**	**0.5**	**0.5**	**0.5**	**Net Other Capital Expenditure**					

Gross Capital Expenditure	**52.718**	**40.551**	**19.728**	**12.845**	**11.668**
Receipts					
Land & Property Disposals (list individually)	0.325	0	0	0	0
Capital Grants Received	0.1				
Donations	0.5	0.5	0.5	0.5	0.5
Other					
Sub Total Receipts	**0.925**	**0.5**	**0.5**	**0.5**	**0.5**
Net Capital Expenditure	**51.793**	**40.051**	**19.228**	**12.345**	**11.168**

	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**
Land and Property Disposals	**£m**	**£m**	**£m**	**£m**	**£m**
Coelbren	0.165				
Ogmore Vale	0.160				
Cefn Coed Future Phases - Approved		TBC	TBC	TBC	TBC
Resolven		TBC			
Glyneath		TBC			
Total	0.325	0	0	0	0

UNAPPROVED SCHEMES

UNAPPROVED SCHEMES	Business Case Position (inc if scoping discussion held)	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	Business Case Status	Internal Approval Process Status
Priority Scheme 1 - Primary Care National Pipeline								
Swansea Wellbeing Centre	Yes	tbc	tbc	tbc			Swansea - SOC in Development	
Neath Wellness Centre	No	tbc	tbc	tbc	tbc	tbc		
Morriston Wellness Centre	No	tbc	tbc	tbc	tbc	tbc		
Primary Care Refurbishment (various). Future schemes to be scoped Ystalyfera, Cwmavon	No	tbc	tbc	tbc	tbc	tbc		
Priority Scheme 2 - Infrastructure	No							
Singleton Cladding		tbc	tbc				Cladding - Business Case in development	
Anti- Ligature, Metal Health		1.530	2.393	tbc			Anti Ligature - pre tendered costs submitted	
Priority Scheme 3 - Regional Cancer Cent	No							
CT SIM (National Radiotherapy Replacement Programme)		1.08						
Replacement programme for Linear Accelerators C (Nationa		0.053	4.447					
Replacement programme for Linear Accelerators D (National Radiotherapy Replacemer			4.5					
New PET/CT Imaging Suite Singleton		tbc	tbc	tbc	tbc	tbc		
Priority Scheme 4 - National Imaging Repl	No							
DR Rooms		0.95	2.842	tbc	tbc	tbc		
MRI Morriston		3.112						
Gamma Camera Morriston		0.61						
Gamma Camera NPT			0.66					
Gamma Camera Singleton		0.78						
Gamma Camera Singleton		0.78						
Flouroscopy Room Morriston		0.84					Submitted as National Imaging priorities	
Flouroscopy Room Morriston			0.6					
Flouroscopy Room Singleton			0.75					
Flouroscopy Room NPT			0.64					
CT Morriston		1.26						
CT Morriston			1.26					
CT Singleton			1.08					
CT NPT			1.08					
Scheme 5 - Informatics Modernisation (SC	Yes							
Boundary change implementation								
Data centre reconfiguration		0.05	3					
Dental referrals		0.08						
Digital Dictation		0.05	0.3					
Digitisation of nursing documentation		0.15						
Mobilisation		1						
Patient Flow/ TroCar		0.5						
Single sign on - Smart Card strategy		0.524						
TOMs		0.125						
WEDs		0.18						
Welsh Community Care Information System (WCCIS)		0.773	1.319	1.31	1.177			
Scheme 6 - Arch Enabling Phases	Yes							
Morriston New Road Access		0.7	tbc	tbc	tbc	tbc		
Land Purchase		1.2						
Scheme 7 - Environmental Modernisation	Yes							
Environmental Modernisation BJC2 (Phase2)		7.899	1.434					
Decant Ward		tbc	tbc					
Environmental Modernisation Future BJCs				tbc	tbc	tbc		
Scheme 8 - Arch Main Phases	No							
Single Accute Medical Take Morriston		tbc	tbc	tbc	tbc			
Centralisation of HSDU Services Morriston				tbc	tbc	tbc		
Scheme 9 - Mental Health - RMHSS/Disposal of Old Cefn Coed								
RMHSS P3 Acute Mental Health Unit		tbc	tbc	tbc	tbc			
RMHSS P7 Mental Health Day Facilities	Yes		tbc	tbc	tbc		Approved SOP	
Reprovision of PICU (Psychiatric ICU) from POW		tbc	tbc	tbc	tbc	tbc		
Scheme 10 -Health Vision Swansea	Yes							
HVS1B, Car Park and Regional Entrance		tbc	tbc	tbc	tbc		Approved SOP	
Scheme 11 - Cardiac Centre Morriston	No							
Third Cathator Laboratory			0.25	2.25				
Hybrid Vascular Theatre		tbc	tbc	tbc				
Relocation of Vascular Laboratory		tbc	tbc	tbc				
Scheme 12 - JAG Accreditiation (Endosc	No							
JAG Accrediated Scopting Suite NPT		tbc	tbc	tbc				
Scheme 13 - TI/ Clinical Services Plan	No							
SDMU/Surgical Short Stay Wrap Around		0.6	2.4					
Second MRI Scanner		0.05	3.95					
Scheme 14 -Regional Services								
Regional Pathology, Morriston	Yes	tbc	tbc	tbc	tbc	tbc	Discussion SOC shared with WG	
Major Trauma Unit, Morriston	No	tbc	tbc	tbc	tbc	tbc		
Single Thoracic Surgery Centre	No	tbc	tbc	tbc				
Relocate PAU - Develop SARC (Childrens)	No							
All Wales Perinatal Unit	No	tbc	tbc					
Scheme 15 - Other Capital Schemes	No							
Centralise Neurodevelopmental Service		tbc						
HASU Unit		tbc	tbc	tbc				
Surgical Services Strategy								
Post Anaesthetic Care Unit								
Expanded MDU footprint								
Regional Delivery of Endoscopy Services								
SACT								
Purchase of chairs for increased delivery of SACT								
Development of Ambulatory Gynaecology Unit								
Swansea Bed Contract				tbc				
Scheme 16 -Intermediate Care Fund	No							
Co-location of IAS, MAPSS, CAMHS, ND		0.563					Bid approved in principle	
Tonna Hospital Refurbishment - relocation of Gelligrón (NPTBCB facility)		0.271						
Sub Total unapproved Schemes Total		25.71	28.405	8.06	1.177	0		

Unapproved Schemes (Revenue)

Unapproved Schemes	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m
Priority Scheme 1 - Primary Care National Pipeline					
Scheme 1 - Non Cash - DEL					
Scheme 1 - Non Cash - AME					
Scheme 1 - Other Revenue Costs					
Scheme 1 - Revenue Savings					
Scheme 1 - Net Revenue					
Priority Scheme 2 - Infrastructure					
Scheme 2 - Non Cash - DEL	0.057	0.243	0.392	0.392	0.392
Scheme 2 - Non Cash - AME					
Scheme 2 - Other Revenue Costs					
Scheme 2 - Revenue Savings					
Scheme 2 - Net Revenue					
Priority Scheme 3 - Regional Cancer Centre					
Scheme 3 - Non Cash - DEL		0.154	0.154	0.5215	0.889
Scheme 3 - Non Cash - AME			0.825	0.825	
Scheme 3 - Other Revenue Costs					
Scheme 3 - Revenue Savings					
Scheme 3 - Net Revenue					
Priority Scheme 4 - National Imaging Replacement Programme					
Scheme 4 - Non Cash - DEL	0.086	1.191	2.143	2.143	2.143
Scheme 4 - Non Cash - AME	0.498				
Scheme 4 - Other Revenue Costs					
Scheme 4 - Revenue Savings					
Scheme 4 - Net Revenue					
Scheme 5 - Informatics Modernisation (SOP)					
Scheme 5 - Non Cash - DEL		0.512	1.057	2.032	2.032
Scheme 5 - Non Cash - AME					
Scheme 5 - Other Revenue Costs					
Scheme 5 - Revenue Savings					
Scheme 5 - Net Revenue					
Scheme 6 - Arch Enabling Phases					
Scheme 6 - Non Cash - DEL					
Scheme 6 - Non Cash - AME					
Scheme 6 - Other Revenue Costs					
Scheme 6 - Revenue Savings					
Scheme 6 - Net Revenue					
Scheme 7 - Environmental Modernisation Programme (SOP)					
Scheme 7 - Non Cash - DEL		0.108	0.163	0.163	0.163
Scheme 7 - Non Cash - AME	0.716	2.916			
Scheme 7 - Other Revenue Costs					
Scheme 7 - Revenue Savings					
Scheme 7 - Net Revenue					
Scheme 8 - Arch Main Phases					
Scheme 8 - Non Cash - DEL					
Scheme 8 - Non Cash - AME					
Scheme 8 - Other Revenue Costs					
Scheme 8 - Revenue Savings					
Scheme 8 - Net Revenue					
Scheme 9 - Mental Health - RMHSS/Disposal of Old Cefn Coed					
Scheme 9 - Non Cash - DEL					
Scheme 9 - Non Cash - AME					
Scheme 9 - Other Revenue Costs					
Scheme 9 - Revenue Savings					
Scheme 9 - Net Revenue					
Scheme 10 -Health Vision Swansea					
Scheme 10 - Non Cash - DEL					
Scheme 10 - Non Cash - AME					
Scheme 10 - Other Revenue Costs					
Scheme 10 - Revenue Savings					
Scheme 10 - Net Revenue					
Scheme 11 - Cardiac Centre Morriston					
Scheme 11 - Non Cash - DEL			0.068	0.272	0.272
Scheme 11 - Non Cash - AME		0.385			
Scheme 11 - Other Revenue Costs					
Scheme 11 - Revenue Savings					
Scheme 11 - Net Revenue					
Scheme 12 - JAG Accreditiation (Endoscopy) Programme					
Scheme 12 - Non Cash - DEL					
Scheme 12 - Non Cash - AME					
Scheme 12 - Other Revenue Costs					
Scheme 12 - Revenue Savings					
Scheme 12 - Net Revenue					
Scheme 13 - TI/ Clinical Services Plan					
Scheme 13 - Non Cash - DEL			0.355	0.355	0.355
Scheme 13 - Non Cash - AME		1.130			
Scheme 13 - Other Revenue Costs					
Scheme 13 - Revenue Savings					
Scheme 13 - Net Revenue					
Scheme 14 -Regional Services					
Scheme 14 - Non Cash - DEL					
Scheme 14 - Non Cash - AME					
Scheme 14 - Other Revenue Costs					
Scheme 14 - Revenue Savings					
Scheme 14 - Net Revenue					
Scheme 15 - Other Capital Schemes					
Scheme 14 - Non Cash - DEL					
Scheme 14 - Non Cash - AME					
Scheme 14 - Other Revenue Costs					
Scheme 14 - Revenue Savings					
Scheme 16 -Intermediate Care Fund					
Scheme 14 - Non Cash - DEL		0.023	0.023	0.023	0.023
Scheme 14 - Non Cash - AME					
Scheme 14 - Other Revenue Costs					
Scheme 14 - Revenue Savings					
Scheme 14 - Net Revenue					

Revenue Funded Infrastructure (including Primary Care Pipeline 3PD and Mutual Investment Model (MIM) investments)

	Scheme Capital Value	Annual Revenue Repayment				
		2019-20	2020-21	2021-22	2022-23	2023-24
Prioritised Schemes (to be named individually)	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Scheme 1						
Scheme 2						
Scheme 3						
Scheme 4						
etc						
Total	0	0	0	0	0	0

Health Board　　　　　　　　　　　XXX

Workforce Plans - WTE

	A	B		C	D	E	F		F	G
	Actual Workforce @ 31/12/2018 WTE	**Planned WTE @ 31/03/2019 WTE**		**2019/20 Profiled Workforce at end of each Quarter**					**Workforce at end of**	
				30/06/2019 WTE	**30/09/2019 WTE**	**31/12/2019 WTE**	**31/03/2020 WTE**		**31/03/2021 WTE**	**31/03/2022 WTE**
Core workforce:-										
Board Members										
Medical & Dental										
Nursing & Midwifery Registered										
Additional Professional, Scientific and Technical										
Healthcare Scientists										
Allied Health Professionals										
Additional Clinical Services										
Administrative and Clerical (inc Senior Managers)										
Estates and Ancillary										
Students										
Sub total	0			0	0	0	0		0	0
Variable Workforce:-										
Board Members										
Medical & Dental										
Nursing & Midwifery Registered										
Additional Professional, Scientific and Technical										
Healthcare Scientists										
Allied Health Professionals										
Additional Clinical Services										
Administrative and Clerical (inc Senior Managers)										
Estates and Ancillary										
Students										
Sub total	0			0	0	0	0		0	0
Agency/Locum:-										
Board Members										
Medical & Dental										
Nursing & Midwifery Registered										
Additional Professional, Scientific and Technical										
Healthcare Scientists										
Allied Health Professionals										
Additional Clinical Services										
Administrative and Clerical (inc Senior Managers)										
Estates and Ancillary										
Students										
Sub total	0			0	0	0	0		0	0
Total workforce plans	0			0	0	0	0		0	0

NOTES

Column A: Baseline actual WTE

Column B - G: Projected WTE (funded/budgeted WTE)

Core Workforce: Total Staff WTE with a contract of employment including fixed term, temporary and contracted locums

Variable Workforce: Hours worked above contract including additional hours worked at plain time, overtime, bank, additional sessions for medical staff.

Agency/Locum: WTE estimate of agency/locum use.

Health Board   XXX

Workforce Plans - £'000

	2019/20 Workforce Quarterly Profile				Workforce Annual	
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	2020/21 £'000	2021/22 £'000
Core workforce:-						
Board Members						
Medical & Dental						
Nursing & Midwifery Registered						
Additional Professional, Scientific and Technical						
Healthcare Scientists						
Allied Health Professionals						
Additional Clinical Services						
Administrative and Clerical (inc Senior Managers)						
Estates and Ancillary						
Students						
Sub total	0	0	0	0	0	0
Variable Workforce:-						
Board Members						
Medical & Dental						
Nursing & Midwifery Registered						
Additional Professional, Scientific and Technical						
Healthcare Scientists						
Allied Health Professionals						
Additional Clinical Services						
Administrative and Clerical (inc Senior Managers)						
Estates and Ancillary						
Students						
Sub total	0	0	0	0	0	0
Agency/Locum: -						
Board Members						
Medical & Dental						
Nursing & Midwifery Registered						
Additional Professional, Scientific and Technical						
Healthcare Scientists						
Allied Health Professionals						
Additional Clinical Services						
Administrative and Clerical (inc Senior Managers)						
Estates and Ancillary						
Students						
Sub total	0	0	0	0	0	0
Total workforce plans	0	0	0	0	0	0

NOTES

Core Workforce: Total staff £ - with a contract of employment including fixed term, temporary and contracted locums
Variable Workforce: £ hours worked above contract including additional hours worked at plain time, overtime, bank, additional sessions for medical staff
Agency / Locum £

Integrated Planning Framework - Recruitment Difficulties Summary
This pro-forma links to Planning Stage 1

In the below section, a recruitment difficulty is defined as a post/specialty which you have advertised for recruitment more than once, with no appointment having been made due to:

• no applications being received;
• no suitable candidates being identified from those who did apply; or

Professional Group	Role	Specialty	Band / Grade	Reason / impact
Additional Clinical Services				
Additional Professional, Scientific & Technical		Psychologists		Additional investment in Mental Health services is creating greater demand.
Allied Health Professionals		Orthoptics with interest in AMD	6	unable to recruit to fixed term posts, therefore leaving establishment under resourced as HB unable to commit funds to permanent staff
		Dietetics	5	Only 1 opportunity a year to recruit so having to over establish
		OT	5	As above
		Physiotherapy	5 plus paediatrics	As above and increasing demand for Paeds
		Speech therapy	6	no suitable applicants
		Radiography	all	Supply unable to meet demand
Admin & Estates (Inc. Managers, Senior Managers and VSMs)				
HCA and Support Staff				

Health Care Scientists		Embryologists	STP	Few are trained and attracted to work in Wales.
		Andrologists	STP	National shortage
		Physical scientists and Biomedical Engineering	STP	National shortage
Medical & Dental	GP			Difficulty in filling posts
	Consultant	Radiology		Difficulty in filling posts
	Consultant	Neurophysiology/OG cancer/COTE/ED		Difficulty in filling posts
	Consultant and Middle grade middle & junior grades	Haematology/Oncology/Palliative Care/Obstetrics&Gynaecology medicine/acute Paediatrics/		Difficulty in filling rotas.
				Difficulty in filing rotas.
	Speciality Doctors	COTE		Limited applicants
Nursing & Midwifery		Difficulty in recruiting to nursing posts especially within medical wards. Mental health and Learning Disability nursing posts are also difficult to recruit to along with community nurses.	band 5	There is a lack of supply of nurses to meet demand. Investment in mental health services has led to increased demand for mental health nurses which supply cannot meet. The fact that a learning disability nursing course is not run in Swansea is also adding to recruitment difficulties in this part of the organisation.

In addition, please specify any posts or specialties that you anticipate **future difficult** to recruit:

Professional Group	Role	Specialty	Band / Grade	Reason / impact
Additional Clinical Services				
Additional Professional, Scientific & Technical				
Allied Health Professionals	Dietetics		all	ALN bill will have an impact on future demand with no resource to meet in addition to planned retirements
	OT Physiotherapy			As above As above
Admin & Estates (Inc. Managers, Senior Managers and VSMs)				
HCA and Support Staff				
Health Care Scientists				
Medical & Dental				
Nursing & Midwifery		Difficulty in recruiting to nursing posts especially within medical wards. Mental health and Learning Disability nursing posts are also difficult to recruit to along with community		This will continue to be an on-going problem. Especially for community nursing as more services move to primary and community care.

		nurses.		

For Academic intake 2019/20

Advanced Practice/Extended Skills

Full MSC/PGCert/PGDipTitle Please choose from list below if the education is not on the list please complete new Education requirements table below	Numbers Required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
Advanced Clinical Practitioner (MSc)	7	Swansea University	Primary Care Health Board Employed
Advanced Practice (MSc)	5	Swansea University	Primary Care Non Health Board Employed
Long Term & Chronic Condition Management (MSc)	2	Swansea University	Primary Care Non Health Board Employed
Advanced Clinical Practitioner (MSc)	2	UniversitySW	Primary Care Health Board Employed
Advanced Clinical Practice (MSC)	4	Swansea University	Secondary Care
Advanced Clinical Practice (MSC)	1	Year 2 Candidate USW	Secondary Care
Long Term & Chronic Condition Management (MSc)	1	Year 2 Candidate USW	Secondary Care
Advanced Clinical Practice (MSC)	1	Year 1 Candidate Swansea University	Secondary Care
Long Term & Chronic Condition Management (MSc)	1	Year 1 Candidate Swansea University	Secondary Care
Enhanced Professional Practice MSc	3	Educational contract, Southampton Univesty for 2 ANNP courses	Secondary Care
Advanced Clinical Practice (MSC)	2	Swansea University	Primary Care Health Board Employed
Advanced Clinical Practice (MSC)	2	Swansea University	Secondary Care
			Please Choose
			Please Choose

Advanced Practice/Extended Skills

Full Module Title Please choose from list below if the education is not on the list please complete new Education requirements table below	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
Minor illness management	8		Primary Care Non Health Board Employed
Optimizing asthma management	2		Primary Care Non Health Board Employed
Dermatology for Health professionals online distance learning	2		Primary Care Non Health Board Employed
Leadership / Quality / Innovation and Change	6		Secondary Care
Quality Improvement	8		Secondary Care
Emergency Practitioner	2		Secondary Care
Assessment Prevention and Management of Falls	2		Secondary Care
Leadership / Quality / Innovation and Change	1		Secondary Care
Emergency Practitioner	2		Secondary Care
Clinical Patient Assessment	1		Secondary Care

Foundations in Advanced Clinical Assessment for Healthcare Professionals	1			Secondary Care
Foundations in Physiology and Heath Assessment	1			Secondary Care
				Please Choose
				Please Choose

For Academic intake 2019/20

Course Title	Course duration	Year of output	Numbers Required	HEI Provider
Medical Ultrasound/Sonography	1-2 years	2020/2021		University West of England

For Academic intake 2019/20

PRESCRIBING

Course Title	Course duration	Year of output	Numbers Required	HEI Provider

Independent prescribers: may prescribe for any medical condition within their area of competence
Supplementary prescribers: can only prescribe in partnership with a doctor or dentist.
Limited Prescribing: Prescribing by Community Practitioners from the Nurse Prescribers' Formulary for Community Practitioners.i.e District Nurses and Health Visitors, are able to prescribe independently from a limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.
Postgraduate Certificate in Blood Component Transfusion enables experienced non-medical Healthcare Practitioners to make the clinical decision and provide the written instruction for blood component transfusion to patients within their own clinical specialty, and within their own areas of competence and expertise.

Full Independent Prescribing	1 year	2020	18	Swansea University or USW
Supplementary Prescribing	1 year	2020	20	Swansea University
Limited Independent Prescribing	1 year	2020		
PGCert in Blood Component Transfusion (NABT)	1 year	2020	1	**Swansea University**

For Academic intake 2020/21

SPECIALIST PRACTICE QUALIFICATION OR COMMUNITY HEALTH STUDIES AWARDS

Students can undertake specialist community nursing education on a part time or modular basis to achieve either a Specialist Practice Qualification (SPQ) as recognised by the Nursing and Midwifery Council (NMC) or BSc/PG Dip Community Health Studies degree.
Part time: usually completed over a period of 2 years.
Modular: allows students to undertake one or more specific taught modules over an undefined period of time. Students following the modular route complete the Fundamentals of Community practice, as their first module.

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
District Nursing (Part-time)	2 years	2022	9		
District Nursing Modules (in modules)	3-6 months	2021	10		
Practice Nursing (Part-time)	2 years	2022	6		
Practice Nursing Modules (in modules)	3-6 months	2021	10		
Community Paediatric Nursing (Part-time)	2 years	2022	1		
Community Paediatric Nursing Modules (in modules)	3-6 months	2021	1		
CPN (Part-time)	2 years	2022	6		
CPN Modules (in modules)	3-6 months	2021	6		

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count		
CLDN (Part-time)	2 years	2022	4		
CLDN Modules (in modules)	3-6 months	2021	4		
Additional Modules	1 year	2021	0		
For Academic intake 2020/21					

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
NURSING & MIDWIFERY					
Bachelor of Nursing (B.N.) Adult	3 years	2023	195		There are significant nursing vacancies within the Health Board with demand outstripping supply. This will be exaccerbated to meet the requirements of the Nurse Staffing Act.
Bachelor of Nursing (B.N.) Child	3 years	2023	35		
Bachelor of Nursing (B.N.) Mental Health	3 years	2023	74		This figure has been reduced to take account of the boundary change.
Bachelor of Nursing (B.N.) Learning Disability	3 years	2023	51		Persistant difficulites in recruiting Learning Disabilites Nurses particularly which may be improved if a BSC in Learning Disabilities Nursing was available in Swansea University.
Shortened Nursing Degree Programme-Adult	2 years	2022	8		
Shortened Nursing Degree Programme-Child	2 years	2022	0		
Shortened Nursing Degree Programme-Mental Health	2 years	2022	8		Recruitment and retention difficulties may be reduced by giving opportunities to existing HCSW staff.
Shortened Nursing Degree Programme-Learning Disability	2 years	2022	12		Recruitment and retention difficulties may be reduced by giving opportunities to existing HCSW staff.
Bachelor of Nursing (B.N.) Adult (Part-time)	4 years	2024	18		Preferred route for existing HCSW
Bachelor of Nursing (B.N.) Child (Part-time)	4 years	2024	0		
Bachelor of Nursing (B.N.) Mental Health (Part-time)	4 years	2024	8		Recruitment and retention difficulties may be reduced by giving opportunities to existing HCSW staff.
Bachelor of Nursing (B.N.) Learning Disabilities (Part-time)	4 years	2024	12		Persistant difficulites in recruiting Learning Disabilites Nurses particularly which may improved if a BSC in Learning Disabilities Nursing was available in Swansea University.
B.Sc. Midwifery Direct Entry	3 years	2023	19		
B.Sc. Midwifery Conversion Programme	18 months	2022	0		
Return To Practice	6 months	2021	36		
For Academic intake 2020/21					

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
SPECIALIST COMMUNITY PUBLIC HEALTH NURSING					
Specialist Community Public Health Nurse (SCPHN) courses are registerable NMC qualifications **Full time**: takes the student up to 52 weeks to complete **Part time**: usually completed over 2 years **Modules:** Students undertake one or more specific taught modules over an undefined period of time.					
Health Visiting (Full-time)	1 year	2021	12		
Health Nursing (Part-time)	2 years	2022	0		
Health Visiting (modules)			1		
School Nursing (Full-time)	1 year	2021	1		
School Nursing (Part-time)	2 years	2022	1		
School Nursing (modules)			0		
Occupational Health (Full-time)	1 year	2021	0		
Occupational Health (Part-time)	2 years	2022	2		

For Academic intake 2020/21

Programme	Level 2 Numbers required	Level 3 Numbers required	Level 4 Numbers required	Comments	Indicate any Recruitment Difficulties / Reason for commissions
HEALTHCARE SUPPORT WORKER					
HCSW Clinical Induction	300				
Diploma in Health and Social Care	38	75			
Diploma in Clinical Healthcare Support	38	263			
Diploma in Maternity and Paediatrics Support		23			
Diploma in Perioperative Support		23			
Level 4 education for HCSW's to access Yr 2 of nurse training			25		
Units for learning specific to role	75	150			

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Is This Advanced / Extended Practice Education?	Numbers Required	HEI/Provider	Reason for Request
Tissue Viability	6 months	Yes	8	Swansea University	Complex/Simple wound care LES requirement within General Practice
Assessment of the Older Person	Stand Alone	No	6	Swasnea University	Enhacing assessment skills of teams

Respiratory Assessment and Management in Primary Care	Stand Alone	No	1	Swansea University	New CNS
Meeting the Specific Needs of People with Parkinson's Disease and their Carer	Stand Alone	No	1	Swansea University	Care of the Eldely skills
Tissue Viability	Stand Alone	No	1	Swansea University	Succession planning
Challenges in the care of the older person with mental health problems	Stand Alone	No	2	USW	Specific skills for new service
Paediatric critical care	12 weeks	No	3	Currently Bristol	requirement to meet standards

Provider
Swansea University
Swansea University
Swansea University
Swansea University
Swansea University

Swansea University
Swansea University

Swansea University

MSC Course	Advance Pratice Courses	Extended Practice
Advanced Clinical Practice (MSC)	Advanced Assessing & Decision Making	Yes
Advanced Clinical Practitioner (MSc)	ANP Research Methods	No
Advanced Practice (MSc)	Assessment Prevention and Management of Falls	
Advanced Practice in Health Care (PGDip)	BSCCP Nurse Colposcopist	
Advanced Specialist Blood Transfusion (MSc/PGCert/PGDip)	Clinical Assessment and Diagnostics	
Ageing Health and Disease (MSC)	Clinical Endoscopist Training Programme	
Anticoagulation Management Theory and Practice (MSC)	Clinical Examination/Pathology	
Critical Care (MSc)	Clinical Patient Assessment	
Education for Health Professions (MSc/PGDip/PGCert)	Clinical Risks	
Enhanced Professional Practice MSc	Consultation & History Taking	
Ergonomics in Health and Community Care (MSc/PGCert/PGDip)	Dermatology for Health professionals online distance learning	
Gastroenterology (MSC/PGDip)	Developing Advanced Practice	
Health Informatics (MSc/PGCert/PGDip)	Emergency Practitioner	
Infection, Prevention & Control (MSc)	Ethics in Health and Social Care	
Long Term & Chronic Condition Management (MSc)	Foundations in Advanced Clinical Assessment for Healthcare Professionals	
Managing Care in Perioperative and Anaethesia Practice (MSc)	Foundations in Physiology and Heath Assessment	
Midwifery and Women's Health (MSc)	Leadership / Quality / Innovation and Change	
Play Therapy (MSc)	Leadership and Negotiated Module	
Professional Practice (MSc)	Leading Quality Improvement	
Public Health (MSc)	Maternity Ultrasound Anomalies	

Respiratory Medicine (MSc/PGDip)	Medical Education Practice module - MSE4031 Teaching Settings Evaluation
Rheumatology (MSc/PGDip)	Minor illness management
Systemic Psychotherapy (MSc)	Neuropsychology
Systemic Psychotherapy (MSc)	Optimizing asthma management
Understanding Domestic and Sexual Violence (MSc)	Patient safely and clinical risk
	Quality Improvement
	Research Methods
	Research Methods and Health Improvement in Health and Social Care
	Specialist Certificate in Clinical Transfusion Practice
	Transforming Care, Systems and Leadership

Identity Settings
Please Choose
Community Hospital

Primary Care Health Board Employed
Primary Care Non Health Board Employed
Community Care e.g. District Nursing etc.
Secondary Care

For Academic intake 2019/20

Advanced Practice/Extended Skills

Full MSC/PGCert/PGDipTitle	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
Enhanced Professional Practice MSc	8	Swansea University	Secondary Care
Radiographic Reporting (PGDip/PGCert)	12		Secondary Care
Advanced Practice in Heath Care (MSc/PGDip)	6		Secondary Care
Computed Tomography (Radiographers) PGCert	6		Secondary Care
Nuclear Medicine (MSc/PGCert/PGDip)	2		Secondary Care
Healthcare Management (MSc)	6		Secondary Care
Ageing Health and Disease (MSC)	1	Swansea University/ Cardiff University	Secondary Care
Occupational Therapy (MSc)	4	Swansea University	Secondary Care
Long Term & Chronic Condition Management (MSc)	4	Swansea University	Secondary Care
Advanced Practice (Dietetics) (MSC)	1	Swansea University	Secondary Care
Enhanced Professional Practice MSc	4	Swansea University	Primary Care Health Board Employed
Advanced Clinical Practice (MSC)	5	tbc	Secondary Care
Advanced Practice (MSc)	5	tbc	Secondary Care
Long Term & Chronic Condition Management (MSc)	3	tbc	Secondary Care
Ageing Health and Disease (MSC)	3	tbc	Secondary Care
Advanced Clinical Practice (MSC)	2	Swansea University	Secondary Care
Leadership for Healthcare Professionals (MSc/PGCert/PGDip)	1	Swansea University	Community Hospital
Musculoskeletal Ultrasound (PGCert)	4		Community Care e.g. District Nursing etc

Advanced Practice/Extended Skills

Full ModuleTitle	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
The Social Aspects of Long Term and Chronic Illness	1	Swansea University	Please Choose
Theory and Practice of long term and chronic conditions management	1	Swansea University	Please Choose
Health Psychology of Long Term and Chronic Illness	1	Swansea University	Please Choose
Leadership & Professional Module	1		Please Choose
Nutrition and Dietetics in common paediatric Disorders	1	Swansea University	Please Choose
Clinical Dietetics for children and infants	1	Swansea University	Please Choose
Understanding Cancer: Patient and Professional Perspectives (HCT150)	1	Swansea University	Please Choose

Course Title	Duration	Provider	Status
Appendicular/Axial Image appreciation (HCT208)	6		
Assessing your current practice	3		
Developing Advanced Practice Module	3		
Developing Leadership, Innovation and Change	6		
Evidence based practice and assessment PTY40002	3		Please Choose
Image guided Interventional procedures of the breast	3		
Image interpretation and reporting in Mammography (HCT119)	3		
PMLM Developing Leadership, innovation and change/mentoring and supervision	3		
Strategy and leadership	3		
Injection therapy course	5		
Achieving Excellence in Care of Older People	2		
Leadership & Professional Module	2	swansea University	
Injection therapy course	3	swansea University	

For Academic intake 2019/20

Course Title	Course duration	Year of output	Numbers Required	HEI Provider
Medical Ultrasound/Sonography	1-2 years	2020/2021	6	University West of England

For Academic intake 2019/20

PRESCRIBING

Independent prescribers: may prescribe for any medical condition within their area of competence
Supplementary prescribers: can only prescribe in partnership with a doctor or dentist.
Limited Prescribing: Prescribing by Community Practitioners from the Nurse Prescribers' Formulary for Community Practitioners.i.e District Nurses and Health Visitors, are able to prescribe independently from a limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.
Postgraduate Certificate in Blood Component Transfusion enables experienced non-medical Healthcare Practitioners to make the clinical decision and provide the written instruction for blood component transfusion to patients within their own clinical specialty, and within their own areas of competence and expertise.

Course Title	Course duration	Year of output	Numbers Required	List AHP Staff Groups	University
Full Independent Prescribing	1 year	2020	4	Physio	
Supplementary Prescribing	1 year	2020	13	Physio/dietetics/ra	
Limited Independent Prescribing	1 year	2020			
PGCert in Blood Component Transfusion (NABT)	1 year	2020			**Swansea University**

For Academic intake 2020/21

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
ALLIED HEALTH PROFESSIONALS					

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
B.Sc. Diagnostic Radiography	3 years	2023	20		radiography on shortage occupation list
B.Sc Therapy Radiography	3 years	2023	8	2	Graduates are often employed in a private hospital in Newport
B.Sc. Human Nutrition - Dietician	3 years	2023	5		
PG Diploma Human Nutrition - Dietician	2 years	2022	1		
PG Diploma Medical Illustration	2 years	2022	2		
B.Sc. Occupational Therapy	3 years	2023	35		
B.Sc. Occupational Therapy (Part time)	4 Years	2024	0		
PG Diploma Occupational Therapy	2 years	2022	6		
Degree in ODP	3 years	2023	7		
B.Sc. Physiotherapy	3 years	2023	30		
B.Sc. Podiatry	3 years	2023	2		
B.Sc Orthoptist	3 years	2023	2		Reduced by 1 due to boundary change
PhD Clinical Psychology Doctorate	3 years	2023	14		Requirement due to Welsh Government funding in mental health services.
B.Sc. Speech & Language Therapy	3 years	2023	7		
B.Sc. Speech & Language Therapy - Welsh Language	3 years	2023	2		
Ambulance Paramedics	2 years	2022	4		
Ambulance Paramedics - EMT conversion	1 year	2021	0		

For Academic intake 2020/21

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority	Indicate any Recruitment Difficulties / Reason for commissions
RADIOGRAPHY - Assistant Practitioners					
Assistant Practitioners Radiography - Diagnostic	1 year	2021	6		radiographers nationally short in supply
Assistant Practitioners Radiography - Therapy	1 year	2021	0		

For Academic intake 2019/20

Programme	Level 2 Numbers required	Level 3 Numbers required	Level 4 Numbers required	Comments	Indicate any Recruitment Difficulties / Reason for commissions
HEALTHCARE SUPPORT WORKER					

HCSW Clinical Induction	6	7			shortfall in radiographers requiring better HCSW support, also supports band 4 AP training.
Diploma in Health and Social Care		6			
Diploma in Clinical Healthcare Support		6			
Diploma in Dietetics Support		4			
Diploma in Occupational Therapy Support		55		22	3 from level 4 and 10 from level 3 have been added to CT form
Diploma in Physiotherapy Support	5	15	10		
Diploma in Maternity and Paediatrics Support					
Diploma in Perioperative Support					
Certificate in Clinical Imaging		6			
Units for learning specific to role					

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Is this Advanced/Extended practice education?	Numbers Required	HEI/Provider	Reason for Request
Diploma in Ophthalmology, new Agored course for HCSW	2 years	No	13	Agored	new initiative, approx 13 ABM, 7 Bridgend
Masters module in prescribing exemptions	1 year	Yes	7	Liverpool and Sheffield Universities	7 remaining in ABM, 7 transfer to CT. New module created to bring existing staff in line with new graduates from 2020
Leadership, Management and Innovation in health care	3	yes	3	Swansea university	
Sensory Integration	1	yes	8	Swansea university	
Neuro Rehabilitation	1	yes	2	Swansea university	
Dietetic mgt. of inherited metabolic disorders - ADV720 BDA Paediatric Module 4 - 1 place required	module	yes		Swansea university	
Neonatal Nutrition - AD744 BDA Paediatric Module 5 - 1 place required	module	yes		Swansea university	
Advanced clinical educators course - 1 place	module	yes		Swansea university	

MBA Healthcare Management	2-3yrs	Yes	2	TBC	Support efficient and effective operational management of Radiology services through application of business methodologies.
Assistant Practitioner Podiatry (technical role)		Yes		2 Cardiff Met	Skill mix

NPTH/OT	
NPTH/OT	primary
NPTH/OT	Priamary
NPTH/OT	secondary
Dietetics	secondary
Dietetics	secondary
Dietetics	secondary

Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Radiography	secondary
Physio/Jmahon	
Physio/Jmahon	
Sbloomfiled	
Sbloomfiled	

4Physio
1 Dietetics/2radiography/10physio

7 required for CT

7 required for CT
NPTH/OT
NPTH/OT
NPTH/OT

Dietetics
Dietetics
Dietetics

Radiography
Sbloomfield

MSC Course	Advance Practice Co	Identity Settings	Extended Practice
Advanced Practice (Dietetics) (MSC)	Achieving Excellence in Care of Older People	Please Choose	Yes
Advanced Clinical Practice (MSC)	Advancing complex assessment, decision making and care management (HCT 201)	Community Hospital	No
Advanced HEMS Practice (MSc/PGCert/PGDip)	Analysis and interpreting advanced practice	Primary Care Health Board Employed	
Advanced Manipulative Physiotherapy (MSC)	Appendicular/Axial Image appreciation (HCT208)	Primary Care Non Health Board Employed	
Advanced Physiotherapy (MSc)	Applied Research Methods	Community Care e.g. District Nursing etc.	
Advanced Practice (MSc)	Assessing your current practice	Secondary Care	
Advanced Practice in Heath Care (MSc/PGDip)	Assessment and Treatment of Sports Injuries HCT022)		

Advanced Professional Practice in Neurological rehabilitation (MSc)	Assistive Technology in Health and Social Care
Advanced Specialist Blood Transfusion (MSc/PGCert/PGDip)	Bone Health, falls and fraility
Advancing Healthcare Practice (MSc)	Cardio-Respiratory Physiology and Pathophysiology
Ageing Health and Disease (MSC)	Cardiovascular disease and diabetes
Autism and Related conditions (MSC/PGCert/PGDip)	Changing Health Behaviour & Reflection for Advanced Professional Practice
Biomedical Science (Clinical Data Interpretation) (MSc)	Clincial Kinaesiology and Tissue Pathology
Child Public Health (MSc/PGCert/PGDip)	Clinical assessment for Health Care Scientists
Community & Primary Healthcare Practice(MSC/PGCert/PGDip)	Clinical Assessment in Advanced Practice (20 cr)
Computed Tomography (Radiographers) PGCert	Clinical Competence in Mammography (HCT053)
Diabetes (MSC/PGCert/PGDip)	Clinical Decision Making
Diagnostic Imaging (PGCert)	Clinical Dietetics for children and infants
Dietetics (MSc)	Clinical Patient Assessment
Diploma in Paediatric Dentistry (Online)	Critically Exploring Professional Practice Transforming Health Service Delivery Service

Enhanced Professional Practice MSc	Developing Advanced Practice Module
Expert Practice in Immunocytochemistry (PGDip)	Developing Expertise
Health and Public Service Management (MSc)	Developing Leadership, Innovation and Change
Healthcare Management (MSc)	Developing yourself as a leader
Higher Specialist Diploma in Cellular Pathology	Diabetes in Pregnancy
Language and Communication Impairment in Children (MSc/PGCert/PGDip)	Epidemiology
Leadership for Healthcare Professionals (MSc/PGCert/PGDip)	Ethics
Long Term & Chronic Condition Management (MSc)	Ethics in Health and Social Care
Managing care in perioperative and anaesthesia practice (MSC)	Evidence based practice and assessment PTY40002
MSc Diagnostic & Interventional Ultrasound (MSc)	Evidencing Learning in Specialist Professional Practice
Musculoskeletal Medicine (MSc)	Extended Scope Practice
Musculoskeletal Studies (MSc/PGCert/PGDip)	Facilitating Learning and Teaching (Non-NMC)
Musculoskeletal Ultrasound (PGCert)	Foundation in advanced clinical assessment

Nuclear Medicine (MSc/PGCert/PGDip)	Foundations in ADV Clinical Assessment for Health Care Professionals
Occupational Therapy (MSc)	Foundations in neuroscience
Paediatric Physiotherapy (MSc)	From assessment to practice
Pharmaceutical Technology and Quality Assurance (MSc)	Global Public Health
Physiotherapy (MSc)	Health Policy and Economics
Professional Practice (MSc)	Health Psychology of Long Term and Chronic Illness
Public Health(MSc)	Healthcare professionals: end of life care
Radiographic Reporting (PGDip/PGCert)	Histopathology BMS Reporting
Radiography (CT) PGCert	History Taking and Colsultation
Respiratory Medicine (MSc)	Image guided Interventional procedures of the breast
SLT Advanced Practitioner (MSc in Public Health)	Image interpretation and reporting in Mammography (HCT119)
Stem Cells and Regeneration (MSc)	Independent Study
Systemic Practice in Psychotherapy (PGDip)	Injection therapy course
Theory of Podiatric Surgery (MSc)	Insulin pump
Vision and Strabismus (MMedSci/Dip	Introduction to image appreciation and evaluation

Wound Healing & Tissue Repair (MSc)	Leadership & Professional Module
	Lower Quadrant Neuromuscular Physiotherapy Dysfunction
	Management of Parkinson's disease related conditions
	Masters Certificate of Professional Development in Medicines Use in Paediatrics and neonates (20 Credits)
	Minor illness management
	Motivational Interviewing: Strategies for Lifestyle Changes
	Musculoskeletal Diagnosis and Treatment
	Neuromusculoskeletal I (Upper Quadrant)
	Neuropsychology
	Neurorehabilitation – A Theoretical Basis
	Nutrition and Dietetics in common paediatric Disorders
	Nutrition for the Older Adult
	Occupational Science and Occupational Therapy Theory and application

Paediatric cardiorespiratory physio
Paediatric Dietetics
Paediatric Hearing Impairment (Speech and Language Therapy)
Patient safely and clinical risk
Philosophy, ethics & medicine SHPM48
PMLM Developing Leadership, innovation and change/mentoring and supervision
Policies & practice for an ageing population
Practice of joint and soft tissue injection PTY40015
Public health, health economics and policy
Quality and Safety Module (Radiographers)
Research methods
Research Methods & Health Improvement in Health and Social Care
Research Methods and Leadership & Professional Module

Science of performance & Injury in sport
Society of Muscularskeletal Medicine (SOMM modules)
Special Tests in MSK Medicine
Sport and Exercise Participation
Strategy and leadership
The Social Aspects of Long Term and Chronic Illness
Theory and practice of injection therapy
Theory and Practice of long term and chronic conditions management
Transforming Care, Systems and Services through Leadership

Transforming Individual Practice Module

Understanding Cancer: Patient and Professional Perspectives (HCT150)

For Academic intake 2020/21				
Course Title	**Course duration**	**Year of output**	**New Graduates Required - Employed workforce - Head count (In Service Applicants)**	**Indicate any Recruitme comr**
HIGHER SPECIALIST SCIENTIST TRAINING - HSST				
Physical Sciences				
Clinical Biomedical Engineering	5 years	2025	0	
Medical Physics	5 years	2025	1	
Life Sciences				
Genetics-Genomics	5 years	2025	0	
Molecular Pathology of Infection	5 years	2025	0	
Molecular Pathology of acquired Disease	5 years	2025	0	
Histopathology and Immunology	5 years	2025	0	
Embryology and Reproductive Science	5 years	2025	0	
Physiological Sciences				
Audiology	5 years	2025	0	
Vascular Science	5 years	2025	0	

For Academic intake 2020/21				
Course Title	**Course duration**	**Year of output**	**New Graduates Required - Employed workforce - Head count**	
			Direct Applicant	**In service Applicant**
SCIENTIST TRAINING PROGRAMME-STP				
Physiological Sciences - STP				
M.Sc. Clinical Science in Neurosensory Sciences - Audiology	3 years	2023	2	
M.Sc. Clinical Science in Neurosensory Sciences - Neurophysiology	3 years	2023	2	1
M.Sc. Clinical Science in Neurosensory Sciences - Cardiac Physiology	3 years	2023	0	
Life Science -STP				
M.Sc. in Infection Science - Clinical Microbiology	3 years	2023	0	
M.Sc. in Blood Sciences - Clinical Immunology	3 years	2023	0	
M.Sc in (Blood Sciences) Haematology and Transfusion Science	3 years	2023	0	
M.Sc in (Blood Sciences) Histocompatibility and Immunogenetics	3 years	2023	0	
M.Sc. in Blood Sciences - Clinical Biochemistry	3 years	2023	1	
M.Sc. in Blood Sciences - Genomics (formally Genetics)	3 years	2023	0	
M.Sc. in Blood Sciences - Cancer Genomics	3 years	2023		
M.Sc in Genomic Counselling (formerly Genetic Counselling)	3 years	2023	0	

Course Title	Course duration	Year of output	New Graduates Required	
M.Sc in Cellular Sciences - Reproductive Sciences - Clinical Embryology and Andrology	3 years	2023	3	
M.Sc in Cellular Sciences - Histopathology	3 years	2023	0	
M.Sc in Cellular Sciences - Cytopathology	3 years	2023	0	
Physical Sciences and Biomedical Engineering - STP				
M.Sc. in Clinical Science - Medical Physics-Radiotherapy Physics	3 years	2023	1	National Shortage
M.Sc. in Clinical Science - Medical Physics-Imaging with Non Ionising Radiation	3 years	2023	1	National Shortage
M.Sc. in Clinical Science - Medical Physics-Imaging with Ionising Radiation	3 years	2023	1	National Shortage
M.Sc. in Clinical Engineering - Rehabilitation Engineering	3 years	2023	1	National Shortage
M.Sc. in Clinical Engineering - DRMG	3 years	2023	0	1
Clinical Bio Informatics -STP				
MSc in Clinical Bioinformatics (Health Informatics)	3 years	2023	0	
MSc in Clinical Bioinformatics (Genomics)	3 years	2023	0	
M.Sc in Clinical Bioinformatics (Physical Sciences)	3 years	2023	1	
Post Graduate Education				
MSc Genomic Medicine (This is not an STP)	2 Years	2022	0	0

For Academic intake 2020/21

Course Title	Course duration	Year of output	New Graduates Required - Employed workforce - Head count	
			Direct Applicant	In service Applicant
HEALTHCARE SCIENTIST				
Physiological Science - PTP				
B.Sc. (Hons) Healthcare Science - Cardiac Physiology	3 years	2023	6	
B.Sc. (Hons) Healthcare Science - Audiology	3 years	2023	2	
B.Sc. (Hons) Healthcare Science - Respiratory and Sleep Science	3 years	2023	4	
B.Sc. (Hons) Healthcare Science - Neurophysiology	3 years	2023	3	

Physical and Biomedical Engineering - PTP				
B.Sc. (Hons) Healthcare Science- Clinical Engineering in Rehab	3 years	2023	**This programme is only for employed staff**	1
B.Sc. (Hons) Healthcare Science - Clinical Engineering (Medical Engineering)	3 years	2023		2
B.Sc. (Hons) Healthcare Science - Nuclear Medicine & Radiotherapy Physics	3 years	2023	2	
Life Science - PTP				
B.Sc. (Hons) Healthcare Science - Biomedical Science - Blood,	3 years	2023	1	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Infection	3 years	2023	1	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Cellular	3 years	2023	1	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Genetics	3 years	2023	0	

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Is this Advanced/Extended Practice Education?	Numbers Required	HEI Provider
M.S.c in Reconstructive Science	**3 years**	Yes	**1**	tan University and Kings College
Conversion of B4 to B5 -additional BSc modules required	1 year	No	2	Swansea University
Hcert Audiology for Band 3	18 monhs	No	1	Swansea University
STP Sleep Science	3	Yes	1	Manchester Metrolitan University
HSST - Cardiac Science	5	Yes	1	Mancherster University
Cellular Pathology Advanced Practice		Yes	1	University of Ulster
M.Sc. in Clinical Science - Medical Physics-Radiation Safety Physics	3 yes		1	

STP cardiac Science   3   yes   1 Newcastle University

nt Difficulties / Reason for nissions

Indicate any Recruitment Difficulties / Reason for commissions

Having trainees builds resilience in the service as very few trained embryologists are attracted to work in Wales - "growing our own" is the best method of acquiring staff. Current workforce is young and mobile and prone to leaving when better opportunities arise. One of teh STPs will be in andrology to support a growing service. The is a huge national shortage of properly qualified andrologists as androlog STP has only been running for 2 years so none have graduated and there number is very small <5.

Reduced from 3 due to boundary change

Reason for Request
recruitment issues in highly specialist area
Expansion of Audiology roles
Expansion of Audiology roles
Retirements within Dept
Retirement and succession planning
Support internal staff to advance

National Shortage

Extended Practice

Yes
No

For Academic intake 2019/20

Advanced Practice/Extended Skills

Full MSC/PGCert/PGDipTitle Please choose from list below if the education is not on the list please complete new **Education requirements** table below	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
Full Module Title Please choose from list below if the education is not on the list please complete new Education requirements table below	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Please choose from list below if the education is not on the list please complete new Education requirements table below			
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose
			Please Choose

For Academic Intake 2021/22

Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	New Graduates Required - Independent Sector/ Local Authority
Pre Reg Pharmacy -Hospital programme	1 year	2022	8	
Pre Reg Pharmacy - Combined programme	1 year	2022	4	

Pharmacy Diploma	2 years	2023	11	
For Academic intake 2020/21				
Pharmacy Technician	2 years	2022	9	
For Academic intake 2019/20				

PRESCRIBING

Independent prescribers: may prescribe for any medical condition within their area of competence
Supplementary prescribers: can only prescribe in partnership with a doctor or dentist.
Limited Prescribing: Prescribing by Community Practitioners from the Nurse Prescribers' Formulary for Community Practitioners.i.e District Nurses and Health Visitors, are able to prescribe independently from a limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.
Postgraduate Certificate in Blood Component Transfusion enables experienced non-medical Healthcare Practitioners to make the clinical decision and provide the written instruction for blood component transfusion to patients within their own clinical specialty, and within their own areas of competence and expertise.

Course Title	Course duration	Year of output	Numbers Required	HEI/Provider
Full Independent Prescribing	1 year	2021	12	Swansea, Cardiff & Other Universities
Supplementary Prescribing	1 year	2021		
Limited Independent Prescribing	1 year	2021		
PG Cert in Blood Component transfusion (NABT)	1 year	2021		Swansea University

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Is this Advanced/Extended practice education?	Numbers Required	HEI/Provider
MSc in Clinical Pharmacy	1-year	Yes	2	Cardiff University
MSc Ageing, Health and Disease	1-year	Yes	1	Cardiff & Swansea University
Certificate Psychotherapeutics	1-year	Yes	1	Aston University
Education and training for tutors or ?prescribing practition	module	Yes	5	Cardiff, Swansea & Other Universities

MSc	HCS Module
Advanced Specialist	Specialist
Blood Transfusion	Diploma
Clinical Data reporting	
Quality Management	
MSc	

Identity Settings

Please Choose

Community Hospital

Primary Care Health Board Employed

Primary Care Non Health Board Employed

Community Care e.g. District Nursing etc.

Secondary Care

Extended Practice

Yes
No

For Academic intake 2020/2021			
Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count
Diploma in Dental Hygiene	2 years	2022	2
Degree in Dental Hygiene & Therapy	3 years	2023	1
Physicians Associates	2 years	2022	13

Additional / new education requirements

Please complete the table below with details of any additional / new education require

Course Title and Educational Level	Course duration	Is this Advanced/Extended practice education?	Numbers Required
Certificate in Dental Sedation Nursing	9 months	Yes	4
Certificate in Special Care Dental Nursing	9 months	Yes	4

Indicate any Recruitment Difficulties / Reason for commissions

ments

HEI/Provider
NEBDN
NEBDN

no response
no response
no response received from Delivery Units. Figure
has been reduced from 16 in line with what we
are going out to advert in January for internships.

2 nurses per (by 2020/21) year to deal with CDS specialised
services

message left for L indsay Davies

2 nurses per (by 2020/21) year to deal with CDS specialised
services

re split.

Practice

Medical and Dental

Information to inform education commissioning of Medical & Denta

Information on organisations' anticipated future requirement for medical and de
inform education commissioning decisions. In addition to the information on Pr
Dental Care Practitioners requested in the previous pages, please complete th

Please note:

- In each of the tables, please record what your organisation anticipates will
- "Net change" means the anticipated increase/decrease in the size of that
    - In other words, if an organisation anticipates that it will simply r
      leavers on a "one for one" basis (i.e. with a new doctor/dentist (
      grade/specialty), then the "net change" would be zero.
    - However, if the organisation anticipates that it will replace all ret
      for one" basis and also recruit an additional doctor (1.0FTE) in a
      then the "net change" for that specialty would be +1.0FTE.

- The following should be excluded from the tables on the next few pages:
    o Training grade doctors entering/leaving an organisation as a normal par
    o Doctors moving organisations under TUPE arrangements.

- Please record all figures as Full Time Equivalent (FTE)

1) Medical/Dental Consultants (FTE)

Group	Specialty
	Acute Medicine
	Allergy
	Audiological Medicine
	Cardiology
	Clinical Cytogenetics & Molecular Genetics
	Clinical Genetics
	Clinical Neurophysiology
	Clinical Pharmacology & Therapeutics
	Dermatology
	Endocrinology & Diabetes
	Gastroenterology
Medicine	General (Internal) Medicine

Group	Specialty
	Genito-Urinary Medicine
	Geriatric Medicine
	Infectious Diseases (& Tropical Medicine)
	Medical Oncology
	Neurology
	Occupational Medicine
	Palliative Medicine
	Rehabilitation Medicine
	Renal Medicine
	Respiratory Medicine
	Rheumatology
	Sport & Exercise Medicine
Pathology	Chemical Pathology
	Haematology
	Histopathology (includes Neuropathology)
	Immunology
	Medical Microbiology
Paeds	Paediatrics
	Paediatric Cardiology
	Paediatric Neurology
Psychiatry	Child & Adolescent Psychiatry
	Forensic Psychiatry
	General Psychiatry
	Old Age Psychiatry
	Psychiatry of Learning Disability
	Psychotherapy
Radiology	Clinical Oncology
	Clinical Radiology
	Nuclear Medicine
Surgery	Cardiothoracic Surgery
	General Surgery
	Neurosurgery
	Maxillofacial Surgery
	Otolaryngology (ENT)

2) Medical/Dental Consultants (FTE) *(continued)*

Group	Specialty

	Paediatric Surgery
	Plastic Surgery
Surgery *(cont'd)*	Trauma & Orthopaedic Surgery
	Urology
	Anaesthetics
	Intensive Care medicine
	Emergency Medicine
Other medical specialties	Obstetrics & Gynaecology
	Ophthalmology / Medical Ophthalmology
	Public Health (excluding Dental)
	Dental Public Health
	Dental & Maxillofacial Radiology
	Endodontics
	Oral Surgery
	Oral & Maxillofacial Pathology
Dental specialties	Oral Medicine
	Oral Microbiology
	Orthodontics
	Paediatric Dentistry
	Periodontics
	Prosthodontics
	Restorative Dentistry
	Special Care Dentistry
TOTAL CONSULTANT WORKFORCE	

2) GPs and Dentists *(excluding Consultants)* (FTE)

These figures should include all GPs and Dentists, including those working in
practices and those directly employed by the Health Board/Trust (including loc
- *The only exception is for Consultants working in the Hospital Dental Servic*
- *Commissioning requirement for Dental Care Practitioners and Practice Nur*
  on pages 1-2 of this document.

Type of doctor/dentist	**Anticipated net change**
	2019/20
General Practitioners (GP)	
General Dental Service (GDS) Dentists	
Community Dental Service (CDS) Dentists)	
Other Dentists *(excluding HDS Consultants)*	

3) Non-Consultant doctors (FTE) *(all specialties combined)*

Please give a broad overview of how your organisation's overall non-consultan
likely to change in size during the next three years. It is recognised that the si:
training grade workforce is not entirely within its control; the forecasts provided
therefore be triangulated against information from the Wales Deanery.

While specialty-specific information has not been requested below, please feel
additional information (e.g. if the bulk of the forecasted increases/decreases and
specific specialties)

Type of doctor	Anticipated net change
	2019/20
Non-Consultant Career Grade doctors	2
Training Grades: Foundation Grades	
Training Grades: Core level (ST1-ST2)	
Training Grades: Higher level (ST3+)	2

ll Staff

ental staff is needed to
actice Nurses and
e tables overleaf.

be the net change of its medical/dental workforce during the next three
workforce (in Full Time Equivalent) compared to the previous years.
eplace all retirees /
of the same

tirees/leavers on a "one
a particular specialty,

t of their rotation.

Anticipated net change in the size of the workforce during each year		
(Full Time Equivalent)		
2019/20	2020/21	2021/22

ll Staff

ental staff is needed to
actice Nurses and

1		
1		

Anticipated net change in the size of the workforce during each year		
(Full Time Equivalent)		
2019/20	2020/21	2021/22

3	3	
5	3	0

ndependent GP/dental
ums).
e (HDS), who should be recorded in the table above.
ses should be recorded

in the size of the workforce during each year (Full Time Equivalent)		Projected change
2020/21	2021/22	2024

t medical workforce is

ze of an organisation's

l by organisations will

l free to provide

re anticipated to be in

in the size of the workforce during each year (Full Time Equivalent)		Total
2020/21	2021/22	(2019-2022)

Projected change 2024	Recruitment Difficulties / Reason

2024	Recruitment

Projected change 2024	Recruitment Difficulties / Reason

Recruitment Difficulties / Reason

Additional Comments	Recruitment Difficulties / Reason (Please specify specialty)

LHB & Trust Specific Internal Service Delivery Plans & Measures

Each Trust should identify their proposed delievery areas from both the national outcome/delivery domains and their local needs assessment

NOTE - Discretionary Template

Measure		Target	Projected end of March 2018 position	Profile											
				Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Monthly															
Monthly															
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Quarterly assessment															
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C22

Please use this template to provide links to key documents

Document
National Strategic Context
Wellbeing and Area Plans
Delivery Plans
Links to National Programme Boards
Needs Assessments
Regional clinical or service strategies
Other SBUHB documents

Hyperlinks

, delivery and programme plans which you reference in your IMTP.

Hyperlink	Section
Healthier Wales	Annual Plan
Prosperity for All	Annual Plan
Parliamentary Review of Health and Social Care	Annual Plan
Wellbeing of Future Generations Act	Annual Plan
Social Services and Wellbeing Act	Annual Plan
Facing the Future Standards for Child Health	Annual Plan
Association for Community Child Health (BACCH) Essential Standards T	Annual Plan
Primary Care Plan for Wales	Annual Plan
http://www.swansea.gov.uk/psb	Annual Plan
https://www.npt.gov.uk/5808	Annual Plan
www.westernbay.org.uk/areaplan.	Annual Plan
Inserted as thumbnails	Appendix 2
National Unscheduled Care Programme	Annual Plan
National Planned Care Programme	Annual Plan
Western Bay Population Assessment	Appendices
Joint Strategic Needs Assessment	Appendices
Rapid Population Health Needs Review	Annual Plan
Organisation Strategy and Clinical Services Plan	Annual Plan
ARCH Portfolio Delivery Plan	Annual Plan
Primary and Community Services Strategy	Annual Plan
Children and Young People's Strategy	Annual Plan
Strategic Framework for Adult Mental Health	Annual Plan
Digital Strategy	Annual Plan
Digital Communities Wales Digital Incusion Charter	Annual Plan
Our Neighbourhood Approach to community resilience in 2019/20	Annual Plan
Western Bay Our Neighbourhood Approach	Annual Plan
A Healthier Mid and West Wales	Annual Plan
Older Person's Charter	Annual Plan
Children's Charter	Annual Plan
Welsh Language profile	Annual Plan

Page ref

Page refs to be updated

Appendix 5a: All Wales Capital Programme 2019/20 to 2023/24

Scheme	Site	Business Case Approvals	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	Total £m
PART A - APPROVED SCHEMES								
1. Environmental Modernisation Programme (SOP)		Approved SOP						
Environmental Modernisation BJC2 (Phase 1)	HB	Approved BJC	2.583					2.583
2. Implications of the South Wales Plan								
Increase Neo Natal Capacity Singelton	Sing	Approved BJC	4.710					4.710
3. National Imaging Programme								
Replacement of MRI, NPT	NPT	Approved BJC	3.043					3.043
4. Primary Care National Pipeline								
Penclawdd Refurbishment	HB	Approved BJC	1.026					1.026
Murton Refurbishment	HB	Approved BJC	0.593					0.593
5. NWIS								
National WEDCIMS	HB	Approved National BJC	0.270					0.270
National Clinical Systems	HB	National Funding	0.068					0.068
6. Spend to Save								
Health Records Modernisation (RFID) 2017/18	HB	Approved WG I2S 17/18	0.023					0.023
Automated Stock Management in Theatres I2S		Approved WG I2S 18/19	1.710	0.478				2.188
7. National Radiotherapy Replacement Programme								
Replacement programme for Linear Accelerators B	Sing	Approved BJC	0.889					0.889
SUB TOTAL APPROVED SCHEMES			14.915	0.478				15.393
PART B - UNAPPROVED SCHEMES								
1. Primary Care National Pipeline		Approved						
Swansea Wellbeing Centre	Swansea	SOC	tbc	tbc	tbc			tbc
Neath Wellness Centre	Swansea		tbc	tbc	tbc	tbc	tbc	tbc
Morriston Wellness Centre	Swansea		tbc	tbc	tbc	tbc	tbc	tbc
Primary Care Refurbishment (Various) Future schemes to be scoped Ystalyfera, Cwmavon, Cymmer,	Swansea		tbc	tbc	tbc	tbc	tbc	tbc
2. Infrastructure								
Singleton, Cladding	Sing		tbc	tbc				tbc
Anti-Ligature, Mental Health	HB		1.530	2.393	tbc			3.923
3. Regional Cancer Centre								
CT SIM (National Radiotherapy Replacement Programme)	Sing		1.080					1.080
Replacement programme for Linear Accelerators C (National Radiotherapy Replacement Programme)	Sing		0.053	4.447				4.500
Replacement programme for Linear Accelerators D (National Radiotherapy Replacement Programme)	Sing				4.500			4.500
New PET/CT Imaging Suite	Sing		tbc	tbc	tbc	tbc	tbc	tbc
4. National Imaging Replacement Programme								
DR Rooms	HB		0.950	2.842	tbc	tbc	tbc	3.792
MRI	Morr		3.112					3.112
Gamma Camera	Morr		0.610					0.610
Gamma Camera	NPT			0.660				0.660
Gamma Camera (Regional Cancer Centre)	Sing		0.780					0.780
Gamma Camera (Regional Cancer Centre)	Sing		0.780					0.780
Flouroscopy Room	Morr		0.840					0.840
Flouroscopy Room	Morr			0.600				0.600
Flouroscopy Room	Sing			0.750				0.750
Flouroscopy Room	NPT			0.640				0.640
CT	Morr		1.260					1.260
CT	Morr			1.260				1.260
CT	Sing			1.080				1.080
CT	NPT			1.080				1.080
5. Informatics Modernisation Programme (SOP)		Approved SOP						
Boundary change implementation	HB		tbc					tbc
Data centre reconfiguration	HB		0.050	3.000				3.050
Dental referrals	HB		0.080					0.080
Digital Dictation	HB		0.050	0.300				0.350
Digitisation of nursing documentation	HB		0.150					0.150
Mobilisation	HB		1.000					1.000
Patient Flow/ TroCar	HB		0.500					0.500
Single sign on - Smart Card strategy	HB		0.524					0.524
TOMs	HB		0.125					0.125
WEDs	HB	National BJC Approved	0.180					0.180
Welsh Community Care Information System (WCCIS)	HB		0.773	1.319	1.310	1.177		4.579

Scheme	Site	Business Case Approvals	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	Total £m
6. ARCH - Enabling Phases								
Morriston New Road Access	Morr		0.700	tbc	tbc	tbc	tbc	0.700
Land Purchase	Morr		1.200					1.200
7. Environmental Modernisation Programme (SOP)		Approved SOP						
Environmental Modernisation BJC2 (Phase 2)	HB		7.899	1.434				9.333
Decant Ward	Morr		tbc	tbc				tbc
Environmental Modernisation Future BJCs	HB				tbc	tbc	tbc	tbc
8. ARCH - Main Phases								
Single Acute Medical Take	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Centralisation of HSDU Services	Morr		tbc	tbc	tbc	tbc	tbc	tbc
9. Mental Health - RMHSS/Disposal of Old Cefn Coed		Approved SOP						
RMHSS P3 Acute Mental Health Unit	HB		tbc	tbc	tbc	tbc	tbc	tbc
RMHSS P7 Mental Health Day Facilities	Phillips Parade			tbc	tbc	tbc	tbc	tbc
Reprovision of PICU (Psychiatric ICU) from POW	tbc		tbc	tbc	tbc	tbc	tbc	tbc
10. Health Vision Swansea		Approved SOP						
HVS 1B, Car Park & Regional Entrance	Morr		tbc	tbc	tbc	tbc	tbc	tbc
11. Cardiac Centre, Morriston								
Third Cardiac Catheter Laboratory	Morr			0.250	2.250			2.500
Hybrid Vascular Theatre	Morr		tbc	tbc	tbc			tbc
Relocation of Vascular Laboratory	Morr		tbc	tbc	tbc			tbc
12. JAG Accreditation (Endoscopy) Programme								
JAG Accrediated Scoping Suite	NPT		tbc	tbc	tbc			tbc
13. TI/Clinical Services Plan								
SDMU/Surgical Short Stay Wrap Around	Morr		0.600	2.400				3.000
Second MRI Scanner	Morr		0.050	3.950				4.000
14. Regional Services								
Regional Pathology, Morriston	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Major Trauma Unit, Morriston	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Single Thoracic Surgery Centre	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Relocate PAU - Develop SARC (Childrens)	Sing		tbc	tbc	tbc	tbc	tbc	tbc
All Wales Perinatal Unit	TBC		tbc	tbc				tbc
15. Other Capital Schemes								
Centralise Neurodevelopmental Service	TBC		tbc	tbc	tbc	tbc	tbc	tbc
HASU Unit	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Surgical Services Strategy	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Post Anaesthetic Care Unit	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Expanded MDU footprint	Sing		tbc	tbc	tbc	tbc	tbc	tbc
Regional Delivery of Endoscopy Services	Sing		tbc	tbc	tbc	tbc	tbc	tbc
Development of Ambulatory Gynaecology Unit	Sing		tbc	tbc	tbc	tbc	tbc	tbc
Swansea Bed Contract	Swansea		tbc	tbc	tbc	tbc	tbc	tbc
16. Intermediate Care Fund								
Co-location of IAS, MAPSS, CAMHS, ND	Mixed	Submitted to WG	0.563					0.563
Tonna Hospital Refurbishment - relocation of Gelligron (NPTBCB facility)	Tonna	Submitted to WG	0.271					0.271
SUB TOTAL UNAPPROVED SCHEMES			**25.710**	**28.405**	**8.060**	**1.177**		**63.352**
GRAND TOTAL			**40.625**	**28.883**	**8.060**	**1.177**		**78.745**

Appendix 5b: Detailed Discretionary Capital Plan 2019/20

PART A - FUNDING & EXPENDITURE COMMITMENTS	Capital Plan Requirement	Less Approved Funding All Wales Capital Programme	Less Assumed Funding All Wales Capital Programme	Discretionary Capital Allocation
	£000	£000	£000	£000
A. DISCRETIONARY FUNDING				
Discretionary Capital Funding (Recurring)	11,118	0	0	11,118
Coelbren Disposal	165	0	0	165
Ogmore Vale Disposal	160	0	0	160
Sub Total	**11,443**	**0**	**0**	**11,443**
B. DISCRETIONARY SCHEME COMMITMENTS B/F 2018-19				
National Digital Strategy Pathfinder (inpatient e-prescribing)	402	0	0	402
I2S - Health Records Modernisation (RFID)	276	0	0	276
Isolation Room ED , Morriston	390	0	0	390
Replacement of Linear Accelerator B	889	889	0	0
Environmental Modernisation BJC2 (Phase 1)	2,583	2,583	0	0
Increase Neo Natal Capacity Singelton	4,710	4,710	0	0
Penclawdd Refurbishment	1,026	1,026	0	0
Murton Refurbishment	593	593	0	0
National Clinical Systems	68	68	0	0
Health Records Modernisation (RFID) 2017/18	23	23	0	0
Carry forward schemes	250	0	0	250
Sub Total	**11,210**	**9,892**	**0**	**1,318**
C. DISCRETIONARY SCHEME APPROVED COMMITMENTS 2019/20				
Capital Planning Project Management	630	0	0	630
Informatics Project Management	927	0	0	927
Refit Cymru Green Growth	62	0	0	62
PFI Lifecycle Replacement, Neath Port Talbot	2,311	0	0	2,311
Sub Total	**3,930**	**0**	**0**	**3,930**
D. INVEST TO SAVE				
Automated Stock Management System	2,252	1,710	0	542
Sub Total	**2,252**	**1,710**	**0**	**542**
Sub Total Expenditure Commitments (Part A)	**17,392**	**11,602**	**0**	**5,790**
Total Estimated Net -Under/Over Committment (Part A)	**5,949**	**11,602**	**0**	**-5,653**

PART B - FUNDING REQUESTS	Capital Plan Requirement	Less Approved Funding All Wales Capital Programme	Less Assumed Funding All Wales Capital Programme	Discretionary Capital Allocation
	£000	£000	£000	£000
E. ALL WALES CAPITAL PROGRAMME BUSINESS CASE FEES (where schemes have commenced design or are part of National Programme Funding)				
Morriston New Road Access	705	0	0	705
Cladding, Central Ward Block, Singleton	0	0	0	tbc
Environmental Modernisation BJC 2	400	0	400	0
Sub Total	**1,105**	**0**	**400**	**705**
F1. Unit IMTPs [Must]				
Anti-Ligature works across MH & LD services	1,529	0	1,529	0
Replacement of Linear Accelerator C	53	0	53	0
Replacement of CT SIM	1,080	0	1,080	0
Sub Total	**2,662**	**0**	**2,662**	**0**
F2. Unit IMTPs [Should]				
All Wales Perinatal Unit	840	0	840	0
RMHSS P3 Adult Acute Mental Health Unit	20	0	20	0
RMHSS P7 Mental Health Day Facility Phillips Parade	20	0	20	0
Single Medical Take	50	0	50	0
SDMU / SSS Wrap Around Unit, Morrriston	50	0	50	0
Second MRI Scanner, Morriston	50	0	50	0
Regional Delivery of Endoscopy Services	113	0	0	113
New PET/CT Imaging Suite	50	0	50	0
Purchase of chairs for increased delivery of SACT	50	0	0	50
Sub Total	**1,243**	**0**	**1,080**	**163**
G. DISPOSAL COSTS				
Cefn Coed - Disposal Costs	200	0	0	200
Cefn Coed - Decommissioning	75	0	0	75
Coelbren Disposal	10	0	0	10
Ogmore Vale Disposal	10	0	0	10
Sub Total	**295**	**0**	**0**	**295**
H. DIGITAL IMTP				
Boundary change implementation	0	0	0	tbc
Data centre reconfiguration	50	0	0	50
Dental referrals	80	0	80	0
Digital Dictation	50	0	0	50
Digitisation of nursing documentation	150	0	150	0
Mobilisation	1,000	0	1,000	0
Patient Flow/ TroCar	500	0	500	0
Single sign on - Smart Card strategy	524	0	524	0
TOMs	125	0	125	0
WEDs	450	270	0	180
Welsh Community Care Information System (WCCIS)	741	0	741	0
Sub Total	**3,670**	**270**	**3,120**	**280**
I. DEPARTMENTAL REFRESH ALLOCATIONS				
Decontamination/Infection Control	465	0	0	465
Ward Refurbishments	700	0	0	700
Estates	22,697	0	21,950	747
Medical Equipment (Wards, Theatres & Outpatients)	474	0	0	474
Pathology	13	0	0	13
Pharmacy	500	0	0	500
Radiology	10,947	3,043	7,751	153
Informatics	850	0	0	850
DDA	30	0	0	30
Sub Total	**36,676**	**3,043**	**29,701**	**3,932**
J. PROPOSED NEW SCHEMES (General)				
Morriston Land Purchase	1,200	0	1,200	0
Campuses City Deal Morriston Management Centre	0	0	0	tbc
HQ, 2nd Floor Works	0	0	0	tbc
Contingency	278	0	0	278
Sub Total	**1,478**	**0**	**1,200**	**278**
K. Intermediate Care Fund (ICF)				
Co-location of IAS, MAPSS, CAMHS, ND	563	0	563	0
Tonna Hospital Refurbishment - relocation of Gelligron (NPTBCB facility)	271	0	271	0
Sub Total	**834**	**0**	**834**	**0**
Sub Total Expenditure Commitments (Part B)	**47,963**	**3,313**	**38,997**	**5,653**
TOTAL ESTIMATED NET -UNDER / OVER COMMITMENT	53,912	14,915	38,997	0

Abertawe Bro Morgannwg University Health Board Clinical Services Plan: Equality Impact Assessment, Stage 1, December 2018

Proposals relating to the Clinical Services Plan 2019 - 2024

Assess the impact of the proposed ambition for change to the distribution of medical patients, planned surgery, emergency surgery, and frailty services across the three main hospital sites set out in the Clinical Services Plan.

The purpose of this Stage 1 Equality Impact Assessment (EIA) is to develop the evidence base, and describe our current understanding of the potential impact of the proposed service changes based on that evidence base. A Stage 2 EIA will be produced that incorporates analysis of feedback from our engagement activity with stakeholders, and any new evidence identified. The Equality Impact Assessment will remain a draft throughout as changes and updates are made as new evidence is incorporated.

As the Clinical Services Plan forms the framework for the Annual Plan 2019/20 which lays out the initial plans for delivering services in line with the Clinical Services Plan, this Equality Impact Assessment also forms the equality impact assessment framework for the Annual Plan. It is important to note that separate Equality Impact Assessment documents for each programme to deliver the Clinical Services Plan and Annual Plan will be developed as detailed plans are developed and implemented.

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Clinical Services Plan 2019 – 2024 and Annual Plan 2019/20: Equality Impact Assessment, Stage 1

1. Introduction

The purpose of this document is to identify and assess the equality impact of the proposed service changes under consideration in the Clinical Services Plan 2019-2024 and also applies to the Organisational Strategy 2019-2029 and the Annual Plan 2019/20.

The Equality Act 2010 places a positive duty on public authorities to promote equality for protected groups. The Equality Act 2010 requires Welsh public bodies to demonstrate how they pay 'due regard' to equality when carrying out their functions and activities. There is a specific duty in Wales to assess the impact of existing and new services or policies on each of the nine protected characteristics[1] in order to:

- Eliminate unlawful discrimination.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Equality is about making sure people are treated fairly. It is not about treating everyone in the same way but recognising that everyone's needs are met in different ways. Our age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant should not disadvantage us. These different characteristics are protected under the Equality Act 2010.

At Abertawe Bro Morgannwg University Health Board (ABMUHB) we are committed to demonstrating our core organisational values (Caring for Each Other, Working Together and Always Improving). To ensure that we "live" our values and that we make the best decisions, which are fair for all our communities, we need to go beyond the requirements of the Equality Act 2010. To achieve this, we place importance on putting human rights at the heart of the way in which our services are designed and delivered. For example, we understand that many people have caring responsibilities which can affect the way they access services and/or employment. We believe that socio-economic status is a key factor affecting healthy outcomes and we take steps to consider these areas as part of our decision making processes. In addition, we recognise that Wales is a country with two official languages, Welsh and English. The importance of bilingual healthcare for all patients in Wales is fundamental and particularly important for people with mental health problems, people with learning disabilities as well as older and younger people.

This Stage 1 EIA seeks to help the organisation to answer the following questions:

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[1] The Protected Characteristics outlined in the Equality Act 2010 are: Age; Disability; Gender; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Religion and Belief (including non-belief); Race and Sexual Orientation.

- Do different protected characteristics groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential for or evidence that the proposed changes will promote equality.
- Is there potential for or evidence that the proposed changes will affect different groups differently (positively or negatively)?
- If potential negative impact is identified, what changes can be made to eliminate or minimise the impact?

This report is not intended to be a definitive statement on the potential impact of the proposed changes on protected characteristic groups, but to describe our understanding at this point in the process. The EIA process will help us to identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders. The EIA will be updated as further information becomes available.

2. Background

Background and rational for service change

In 2011 the Welsh Government published *Together for Health*[2], which described unprecedented challenges for the NHS in Wales. *Together for Health* called upon health boards to create services that were safe, sustainable and comparable with the best anywhere, and identified the following challenges facing the NHS in Wales.

- Quality of care that can be inconsistent and does not always meet the standards or give the outcomes of the very best.
- Rising numbers of older people and increasing frailty and complexity of needs
- More people with chronic ill health.
- Lifestyle choices that are worsening population health and will add further demand on the NHS in the future.
- Widening health inequality between rich and poor.
- Difficulties in recruiting several groups of clinical staff, particularly some types of doctors.
- Constrained spending on the NHS in Wales with falling revenue and capital in real terms.

In *Changing for the Better: Why your local NHS needs to change*[3] ABMUHB set out the scale of the challenge it faced in addressing the issues highlighted by *Together for Health*. In response to the identified challenges, in 2012 ABMUHB produced its *Changing for the Better* [4]programme, a five year plan to review and redesign its services. The scale of the challenge was further emphasised in 2016 when ABMUHB were placed in Targeted Intervention, demonstrating the need for strategic, sustainable solutions on a range of issues including performance in key areas, as well as clinical and financial sustainability.

Currently there are two sites in ABMUHB that offer acute/emergency medical intake. There are insufficient staff to run these services, and ABMUHB as with other Health Boards, are struggling to recruit the necessary acute medicine specialist staff. To address the current staff shortfall, ABMUHB are having to rely on employing locums. This is not cost effective due to the much higher cost of employing locums. The shortage in acute medicine specialist staff also has a negative impact on patient care, as it creates significant delays before the patient can see the relevant consultant. Over a third of patients at Morriston Emergency Department typically wait over 4 hours and up to 10% over 12 hours.

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[2] Welsh Government. (2011). *Together for Health. A Five Year vision for the NHS in* Wales. Cardiff: Welsh Government.
https://gov.wales/docs/dhss/publications/111101togetheren.pdf
[3] Abertawe Bro Morgannwg University Health Board. (2012). *Changing for the Better:You're your local NHS needs to* change. Port Talbot: Abertawe Bro Morgannwg University Health Board.
http://www.wales.nhs.uk/sitesplus/documents/863/Why%20your%20local%20NHS%20needs%20to%20change.pdf
[4] thttp://howis.wales.nhs.uk/sites3/Documents/743/C4B%20Phase%201%20Summary%20report.pdf
Abertawe Bro Morgannwg University Health Board (2013). *Changing for the Better*

In addition, the current service structure does not make best use of equipment and support services. Where acute/emergency care and planned surgical services are co-located there are negative impacts for patients, for example co-location can result in a high number of cancellations of planned surgery due to the demands of acute emergency care. There are on average approximately 30 cancellations for each planned procedure day across Morriston, Singleton, and NPT sites with the most common reason being "Emergency Case Taking Priority" (12%).

ABMUHB operates three different frailty services across its three sites. Each of these frailty services operated different admission practices which creates confusion for patients and organisations referring patients. The three frailty services also differ in the range of services they can offer patients onsite. The move to a single frailty model would improve the service offered to patients by ensuring access to a range of support services and specialists, providing a consistent admission practice across the ABM footprint.

The 2019-2024 Clinical Services Plan under review for this EIA is a refresh of the five year plan developed in 2013's *Changing for the Better*. ABMUHB commissioned Capita to develop the 2019-2024 Clinical Services Plan. Capita focused on three areas, Unscheduled Care, Surgical Services and Regional Services. Capita worked with stakeholders creating Clinical Design Groups for each of the three areas, and employed a whole-system analytic and evidence-based approach to identify the priorities that would underpin the Clinical Services Plan. Using this approach Capita identified the following priorities for the plan:

- Single Unscheduled Care Acute Medical Take.
- One integrated single point of access & care co-ordination for patients and professionals.
- Single frailty model (and frailty assessment unit).
- Separation of planned and emergency surgery, or based on complexity of surgery.
- Seven day services including wrap around services, mental health and social care.
- Clusters caring for patients at home when safe to do so.

With the above priorities in mind Capita developed eight options[5] based on the distribution of medical patients, planned surgery, emergency surgery, and frailty services across the three main hospital sites.[6] Each of the eight options were then tested against initially three scenarios modelled by Capita. The initial three scenarios were:

1. No change – services continue to work in the same way and no provision is made for the expected changes. This scenario was discounted as unrealistic and not considered further.

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[5] See Appendix A for a list of the eight options.
[6] Princess of Wales Hospital was excluded from the modelling as responsibility for delivery of health services to the population of Bridgend County Borough will be transferred to Cwm Taf University Health Board from April 2019.

2. Efficiency – services change some aspects of the way they work to reduce their demands on beds and theatre space.
3. Transformation – services transform their practices so that ABMUHB can achieve 25% peer performance.

Proposed service change

Based on the modelling work done by Capita and a consideration of the pros and cons of each of the eight options, the ABMUHB Clinical Senate met on 14th December 2018 and members approved Option Eight o to be recommended to Board as the preferred option for the reconfiguration of our major hospital sites. The ambitions set out in Option Eight are:

- Morriston Hospital to become the single site for admission of emergency medical and surgical patients as well as the centre for high risk surgery.
- Singleton Hospital to become the major centre for ambulatory, non-emergency care as well as completing low/medium risk surgery.
- Neath Port Talbot Hospital to become the major low risk day case surgery with an element of post assessment frailty service.

Benefits and disadvantages of the proposed service change

The identified advantages of the proposed service changes in relation to the priorities set for the Clinical Services Plan are:

- Each centre has a clear purpose.
- Each unit can develop a new operational model.
- Good match to existing facilities.
- Centralisation of all emergency/high risk activity with critical care resource.
- Good access for emergency patients.

Identified disadvantages to this approach are:

- Does not fully separate planned and emergency surgery.
- Will require some shifts in equipment/workforce.

3. Assessment of relevance and impact on the public

The Equality Act 2010 places a positive duty on public authorities to promote equality for protected groups. The Equality Act 2010 requires Welsh public bodies to demonstrate how they pay 'due regard' to equality when carrying out their functions and activities. There is a specific duty in Wales to assess the impact of existing and new services or policies on each of the nine protected characteristics[7] in order to:

- Eliminate unlawful discrimination
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The following sections within this chapter considers the potential for impact upon the public by each protected characteristic and highlights where further exploration / engagement is necessary.

Age

Table 1 and Table 2 below provides 2017 population estimates for residents living in the ABMUHB area.[8] Bridgend is excluded from all ABMUHB population information presented in this report (where it has been possible to disaggregate data) as responsibility for delivery of health services to the population of Bridgend County Borough will be transferred to Cwm Taf University Health Board from April 2019.

Table 1 shows that within the ABMUHB area Swansea has the largest population of the local authorities. Table 2 shows that the distribution of the age bands across the local authorities is very similar. In the ABMUHB area as whole the bulk of the population is aged between 25 – 64 years (51 per cent), this age range accounts for 52.0% of the population in Neath Port Talbot.

Of the local authorities Neath Port Talbot has the highest proportion of its population aged 65 years and over (20.6 per cent).

The demographic data in Table 1 shows that for adults aged 65 years plus, there are more women than men in each age band, and this is true for each of the local authorities in the ABMUHB area. Across ABMUHB area (and in Neath Port Talbot separately) women account for 55 per cent of all residents aged 65 years plus.

The higher proportion of women than men in the ABMUHB area would suggest that the proposed service changes will potentially affect women slightly more than men.

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[7] The Protected Characteristics outlined in the Equality Act 2010 are: Age; Disability; Gender; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Religion and Belief (including non-belief); Race and Sexual Orientation.
[8] Source:
https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=31#

Table 1: 2017 Population estimates for ABMU local authorities for residents (ONS Crown Copyright Reserved, from NOMIS on 24 August 2018)

Region	Age	Female	Male	Total
Neath Port Talbot	Under 1 year	700	700	1,400
	1 - 4 years	3,000	3,100	6,100
	5 - 14 years	7,700	7,900	15,600
	15 - 24 years	7,400	8,400	15,800
	25 - 39 years	13,200	13,200	26,400
	40 - 54 years	14,500	13,900	28,400
	55 - 64 years	9,700	9,400	19,100
	65 - 84 years	13,600	12,000	25,600
	85 and over	2,400	1,200	3,600
	Total	**72,200**	**69,800**	**142,000**
Swansea	Under 1 year	1,200	1,200	2,400
	1 - 4 years	5,000	5,500	10,500
	5 - 14 years	12,700	13,900	26,600
	15 - 24 years	16,900	20,200	37,100
	25 - 39 years	22,700	24,300	47,000
	40 - 54 years	22,900	22,600	45,500
	55 - 64 years	15,100	13,700	28,800
	65 - 84 years	22,400	18,800	41,200
	85 and over	4,100	2,300	6,400
	Total	**123,000**	**122,500**	**245,500**
ABMUHB	Under 1 year	1,900	1,900	3,800
	1 - 4 years	8,000	8,600	16,600
	5 - 14 years	20,400	21,800	42,200
	15 - 24 years	24,300	28,600	52,900
	25 - 39 years	35,900	37,500	73,400
	40 - 54 years	37,400	36,500	73,900
	55 - 64 years	24,800	23,100	47,900
	65 - 84 years	36,000	30,800	66,800
	85 and over	6,500	3,500	10,000
	Total	**195,200**	**192,300**	**387,500**

Source: NOMIS

Table 2: 2017 Age band as percentage of total local authority. Population estimates for ABMU local authorities for residents (ONS Crown Copyright Reserved, from NOMIS on 24 August 2018).

Region	Age	Female	Male	Total
Neath Port Talbot	Under 1 year	1.0%	1.0%	1.0%
	1 - 4 years	4.2%	4.4%	4.3%
	5 - 14 years	10.7%	11.3%	11.0%
	15 - 24 years	10.2%	12.0%	11.1%
	25 - 39 years	18.3%	18.9%	18.6%
	40 - 54 years	20.1%	19.9%	20.0%
	55 - 64 years	13.4%	13.5%	13.5%
	65 - 84 years	18.8%	17.2%	18.0%
	85 and over	3.3%	1.7%	2.5%
	Total	**100%**	**100%**	**100%**
Swansea	Under 1 year	1.0%	1.0%	1.0%
	1 - 4 years	4.1%	4.5%	4.3%
	5 - 14 years	10.3%	11.3%	10.8%
	15 - 24 years	13.7%	16.5%	15.1%
	25 - 39 years	18.5%	19.8%	19.1%
	40 - 54 years	18.6%	18.4%	18.5%
	55 - 64 years	12.3%	11.2%	11.7%
	65 - 84 years	18.2%	15.3%	16.8%
	85 and over	3.3%	1.9%	2.6%
	Total	**100%**	**100%**	**100%**
ABMUHB	Under 1 year	1.0%	1.0%	1.0%
	1 - 4 years	4,2%	4.5%	4.4%
	5 - 14 years	10.5%	11.3%	10.9%
	15 - 24 years	12.0%	14.3%	13.2%
	25 - 39 years	18.4%	19.4%	18.9%
	40 - 54 years	19.4%	19.2%	19.3%
	55 - 64 years	12.9%	12.4%	12.7%
	65 - 84 years	18.5%	16.3%	17.4%
	85 and over	3.3%	1.8%	2.6%
	Total	**100%**	**100%**	**100%**

Source: NOMIS

Figure 1 and Figure 2 show the population distribution by age across the 327 LSOAs in the ABMUHB area (includes Bridgend population data).

Figure 1: Population distribution by age (65-84 years) and LSOA in ABMU Health Board area, 2014.

Estimated population aged 65 - 84 years, ABM UHB, 2014

LSOA, percentage
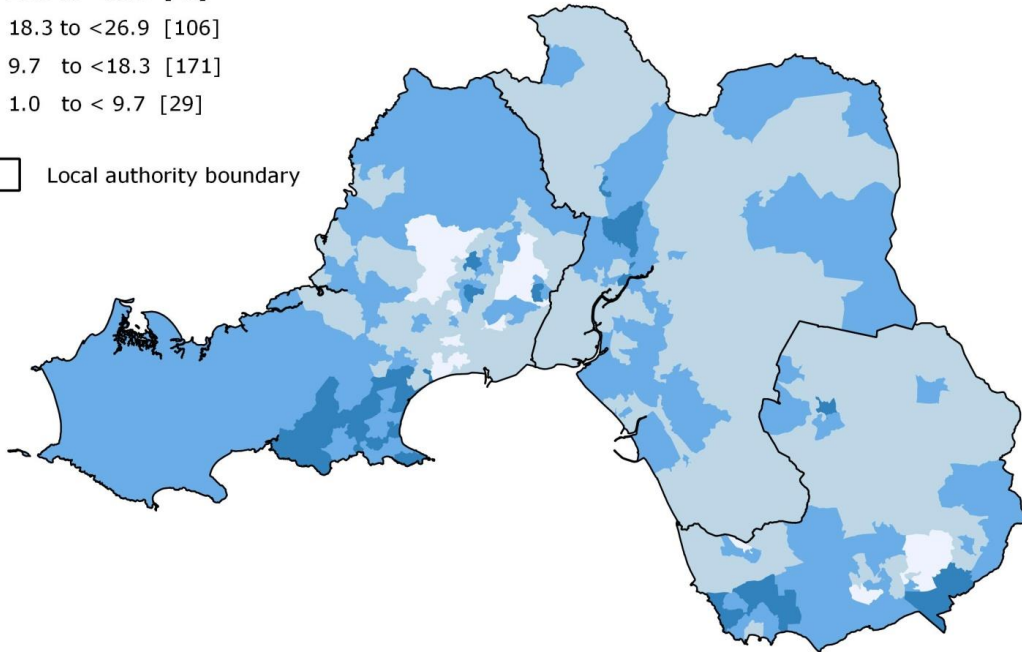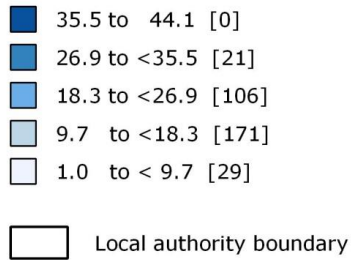
- 35.5 to 44.1 [0]
- 26.9 to <35.5 [21]
- 18.3 to <26.9 [106]
- 9.7 to <18.3 [171]
- 1.0 to < 9.7 [29]

Local authority boundary

Produced by Public Health Wales Observatory, using MYE (ONS)
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Figure 2: Population distribution by age (85 years plus) and LSOA in ABMU Health Board area, 2014 (includes Bridgend population data)

Estimated population aged 85+, ABM UHB, 2014

LSOA, percentage
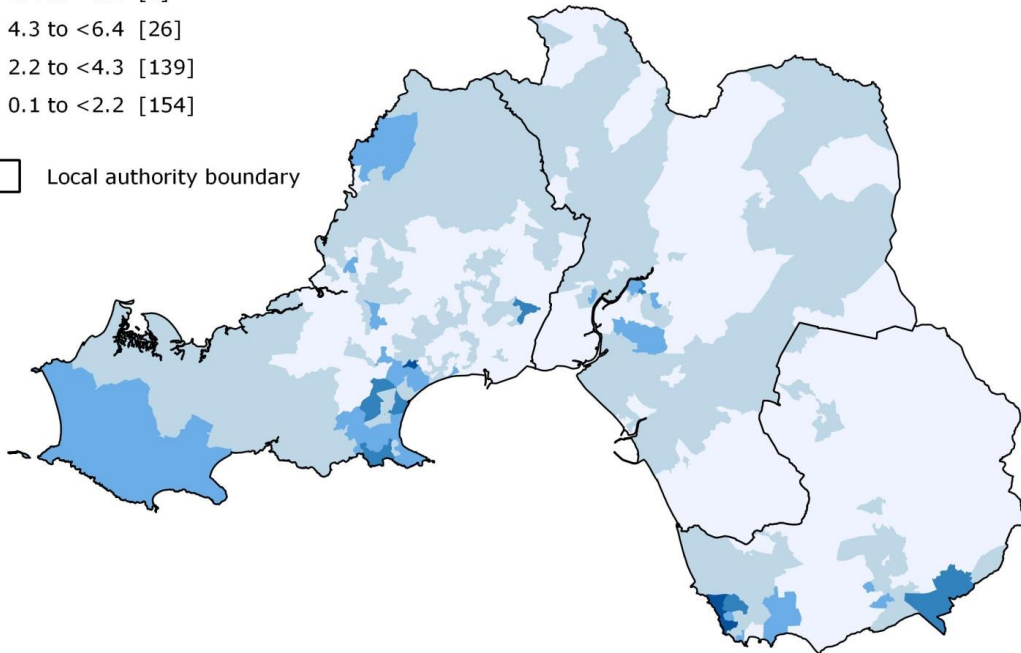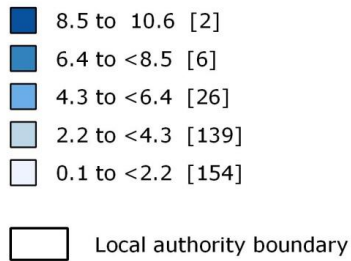
- 8.5 to 10.6 [2]
- 6.4 to <8.5 [6]
- 4.3 to <6.4 [26]
- 2.2 to <4.3 [139]
- 0.1 to <2.2 [154]

Local authority boundary

Produced by Public Health Wales Observatory, using MYE (ONS)
© Crown Copyright and database right 2016, Ordnance Survey 100044810

Figure 3: Population projections by age group (includes Bridgend population data)

Population projections by age group, percentage change since 2011, ABM UHB, 2011-2036

Produced by Public Health Wales Observatory, using 2011-based population projections (WG)
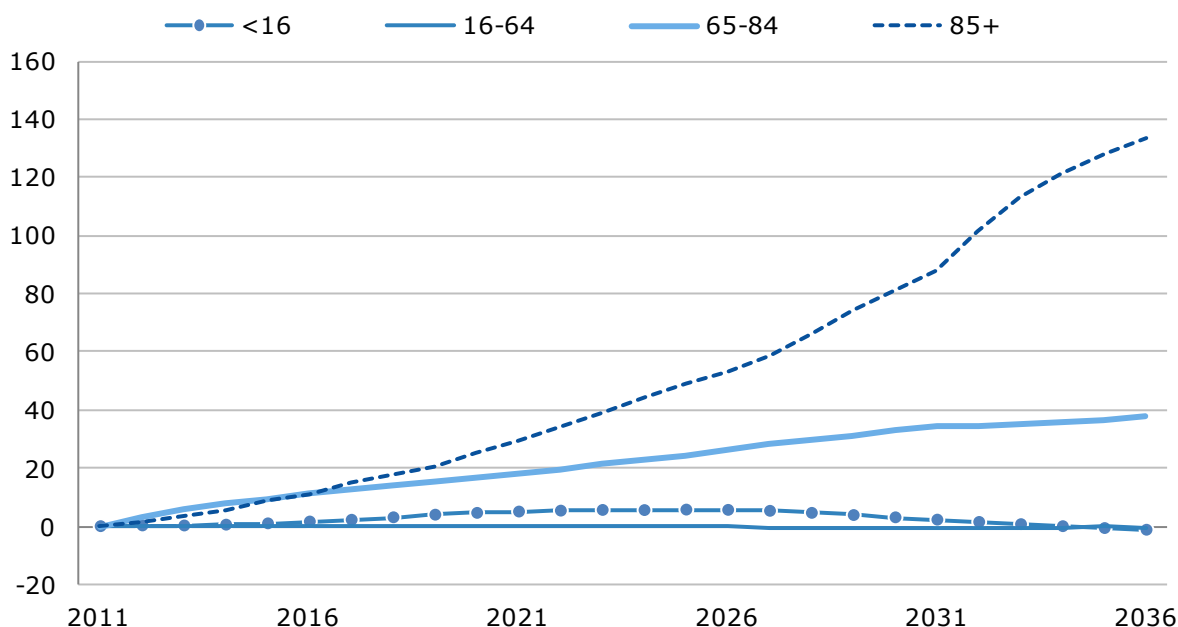
Table 2 highlighted that within ABMUHB area the 65 years plus age group accounts for a fifth of the overall population. Figure 3 above shows that this age group is projected to increase by approximately 30 percentage points between 2016 and 2036.

The 85 years plus age group (2.5 per cent of total ABMUHB area population in 2016) is projected to show a percentage change of approximately 120 percentage points between 2016 and 2036. This is the largest percentage change of all age groups.

Demographic changes and improvements in life expectancy mean that there is an expected increase in the overall number of people with dementia. In 2015, approximately 6,979 people in Western Bay had a diagnosis of dementia. By 2030, this is predicted to rise by 48% to 10,295.

There is evidence that the need for healthcare increases disproportionately over the age of 75 years (Capita report 2016). This is supported by analysis of Wales Ambulance Service Trust data on ambulance callouts in Table 3 below.

Table 3: Valid Ambulance call outs in ABMUHB area by age of service user

Quarter	Months	0 - 64	65 and Over	Unknown
Q4 2015	Oct - Dec	46.1%	42.2%	11.7%
Q1 2016	Jan - Mar	43.4%	45.3%	11.3%
Q2 2016	Apr - Jun	43.8%	44.8%	11.4%
Q3 2016	Jul - Sep	43.9%	44.8%	11.2%
Q4 2016	Oct - Dec	42.9%	46.3%	10.8%

Q1 2017	Jan - Mar	43.6%	45.9%	10.5%
Q2 2017	Apr - Jun	43.8%	45.5%	10.8%
Q3 2017	Jul - Sep	44.5%	43.7%	11.8%
Q4 2017	Oct - Dec	42.4%	46.4%	11.2%
Q1 2018	Jan - Mar	40.5%	49.2%	10.3%
Q2 2018	Apr - Jun	44.5%	43.8%	11.7%

Source: Wales Ambulance Service Trust, Health Informatics Team
*Includes Bridgend population information as data has been aggregated

The ambulance call out data shows that while the 65 years and over population in the ABMUHB area is 20% of the total population, it accounted for on average 45% of all valid call outs over the period reported.

Mortality rate

Data produced by Public Health Wales for 2012-14 shows that the ABM ULHB all-cause mortality rate per 100,000 population for under 75s at 407 is higher than the Wales rate of 376, and is the second highest of the Welsh Health Boards.

Neath Port Talbot has the fourth highest mortality rate (415), and Swansea the 10th highest mortality rate (397) per 100,000 population for under 75s in Wales.

Figure 4: Under 75 all-cause mortality age-standardised rate per 100,000 persons, 2012-14. (Source: Public Health Wales Observatory)[9]

All-cause mortality, European age-standardised rate per 100,000, persons, under 75, Wales local authorities and health boards, 2012-14

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)

⊢⊣ 95% confidence interval   **Wales = 376**

Isle of Anglesey	356
Gwynedd	339
Conwy	370
Denbighshire	401
Flintshire	352
Wrexham	397
Powys	305
Ceredigion	310
Pembrokeshire	343
Carmarthenshire	350
Swansea	389
Neath Port Talbot	428
Bridgend	415
Vale of Glamorgan	337
Cardiff	382
Rhondda Cynon Taf	435
Merthyr Tydfil	455
Caerphilly	403
Blaenau Gwent	457
Torfaen	405
Monmouthshire	293
Newport	380
Betsi Cadwaladr UHB	368
Powys THB	305
Hywel Dda UHB	340
ABM UHB	407
Cardiff and Vale UHB	366
Cwm Taf UHB	439
Aneurin Bevan UHB	385

Figure 5 sets out the position in relation to the all-cause mortality rate in Wales per 100,000 population for all ages. The data shows that for 2012-14 the ABMUHB (includes Bridgend population data) all-cause mortality rate per 100,000 population for all ages at 1,096 is higher than the Wales rate of 1.042, and is the second highest of the Welsh Health Boards.

Neath Port Talbot has the sixth highest mortality rate (1,141), and Swansea the eleventh highest mortality rate (1,061) per 100,000 population for all ages in Wales.

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[9] http://www.publichealthwalesobservatory.wales.nhs.uk/demography-overview

Figure 5: All Ages all-cause mortality age-standardised rate per 100,000 persons, 2012-14. (Source: Public Health Wales Observatory)[10]

All-cause mortality, European age-standardised rate per 100,000, persons, all ages, Wales local authorities and health boards, 2012-14

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)

⊢⊣ 95% confidence interval   **Wales = 1,042**

Area	Rate
Isle of Anglesey	973
Gwynedd	929
Conwy	976
Denbighshire	1,137
Flintshire	1,018
Wrexham	1,061
Powys	899
Ceredigion	881
Pembrokeshire	956
Carmarthenshire	1,049
Swansea	1,050
Neath Port Talbot	1,134
Bridgend	1,141
Vale of Glamorgan	963
Cardiff	1,034
Rhondda Cynon Taf	1,191
Merthyr Tydfil	1,155
Caerphilly	1,131
Blaenau Gwent	1,254
Torfaen	1,091
Monmouthshire	880
Newport	1,085
Betsi Cadwaladr UHB	1,011
Powys THB	899
Hywel Dda UHB	986
ABM UHB	1,096
Cardiff and Vale UHB	1,010
Cwm Taf UHB	1,184
Aneurin Bevan UHB	1,079

Life expectancy and healthy life expectancy at birth.

Table 4 below provides a breakdown of the life expectancy and healthy life expectancy estimates for the populations in ABMUHB and Wales. Life expectancy is an estimate of the average number of years newborn babies could expect to live, assuming that current mortality rates for the area in which they were born applied throughout their lives. Healthy life expectancy is an estimate of the average number of years that newborn babies could expect to live in good health, assuming that current mortality rates and levels of good health for the area in which they were born applied throughout their lives.

Table 4 shows that of the counties in ABMUHB, only Swansea has life expectancy and healthy life expectancy figures for male and females that are higher than the figure for Wales. As such the life expectancy and healthy life expectancy figures for ABMUHB as a whole are lower than the figure for Wales.

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[10] http://www.publichealthwalesobservatory.wales.nhs.uk/demography-overview

Table 4: Life expectancy and Healthy life expectancy at birth for ABMUHB and Cwm Taf UHB Board (Source: StatsWales)[11]

Region	Female		Male	
	Life expectancy*	Healthy life expectancy	Life expectancy*	Healthy life expectancy
ABMUHB	**81.7**	**65.0**	**77.4**	**63.9**
Neath Port Talbot	81.2	62.4	77.0	61.9
Swansea	82.4	66.8	77.8	65.5
Wales	**82.3**	**66.7**	**78.3**	**65.3**

* Data is based on a 5 year average and is intended to provide context for the 5 year average on Health life expectancy.

The proposed changes in the Clinical Services Plan, in particular changes to the frailty service offered by ABMUHB, will have direct relevance to ABMUHB's older residents.

Disability

The disability[12] profile in the ABMUHB area (25%) is higher than the figure for Wales as a whole (23%). The proportion of people in the ABMUHB area categorised as having their 'Day-to-day activities limited a lot' is 2% higher in ABMUHB than Wales.

At a local authority level there is noticeable difference between local authorities. Swansea has the lowest levels of people classed as disabled (23%), while Neath Port Talbot has the highest (28%).

Neath Port Talbot has the highest proportion of its population categorised as having their 'Day-to-day activities limited a lot' (16%) in Wales. Neath Port Talbot also has the second highest proportion of its population categorised as having their 'Day-to-day activities limited a little' (12%) in Wales. Consequently, within Wales Neath Talbot has the smallest proportion of its population categorised as not being disabled i.e. 'Day-to-day activities not limited' (72%).

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[11] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Life-Expectancy/lifeexpectancyandhealthylifeexpectancyatbirth-by-localhealthboard-localauthority

[12] Under the Equality Act 2010 disabled is defined as individuals that have a physical or mental condition/illness lasting or expected to last for 12 months or more, which affects their ability to carry out day-to-day activities either a lot, or a little.

Table 5: Long-term health problem or disability by ABMU Health Board area

Region	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited	Total (%)	Total
ABMUHB	**15%**	**12%**	**75%**	**100%**	**378,835**
Neath Port Talbot	16%	12%	72%	100%	139,812
Swansea	13%	11%	77%	100%	239,023
Wales	**12%**	**11%**	**77%**	**100%**	**3,063,456**

(Source: Table QS303EW 2011 Census, ONS)

At the LSOA level, the percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem are at highest range at 42% in the Neath North area of Neath Port Talbot (Neath Port Talbot LSOA 008D).

These are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Castle area of Swansea, Sandfields East, Sandfields West and Neath North areas of Neath Port Talbot and the Caerau area in Bridgend.

The latest disability prevalence estimates for England and Wales (Office for Disability Issues, 2014) show that the prevalence of disability rises with age (16% working age adults and 45% adults over state pension age).

Based on current data the changes proposed in the Clinical Service Plan will potentially have an impact on disabled people, particularly in relation to ease of access to services as services move to specific sites, rather than multiple sites across ABMUHB.

Gender

The gender split (see Table 6) for the ABMUHB area mirrors very closely the gender split for Wales as a whole. Approximately a 50:50 split with slightly more females (50.3%) than males (49.7%). The variation between local authorities within the ABMU Health Board Area is small.

Table 6: Gender by unitary authorities in ABMU Health Board area

Region	Female	Male	Total
ABMUHB	**50.4%**	**49.6%**	**387,600**
Neath Port Talbot	50.7%	49.3%	142,000
Swansea	50.1%	49.9%	245,500
Wales	**50.7%**	**49.3%**	**3,125,200**

(Source: NOMIS Population Estimates/Projections, Local Authority based 1981 to 2017)[13]

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[13]

https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=31

As previously noted (see Table 2 above), for the over 65 years age group the proportion of females to males increases as the population ages. 52% of people in ABMUHB area aged 65-69 years are female, while 64.9% of the people aged 85 years plus are female.

Data from the 2011 Census shows that 90% of the lone parent households in Wales are female. Lone parent households experience some of the lowest levels of wealth in Wales.[14] As such any additional travel costs incurred due to service reconfiguration will have significant impact upon service users and staff from this group. The 2011 Census data shows that only 18.3% of female lone parent households in the ABMUHB area are in full-time employment, 32.2% are in part-time employment, and 40.3% are not in employment.

Gender Reassignment

Transgender or trans is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth.

No data is available on the size of the transgender population in the ABMUHB area.

In *'It's just Good Care: A guide for health staff caring for people who are Trans' 2015-19,* trans people must be accommodated in line with their gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. The wishes of the trans person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements.

The EHRC note in *How fair is Britain?* that one in seven transgender people who responded to a survey felt that they had been treated adversely by healthcare professionals because of their transgender status.[15]

Research suggests transgender people are likely to experience risk of harassment when attempting to access healthcare. A survey by Press for Change (2007)[16] found 36.8% (277) of trans people (aged 18 to 75) who chose to present their acquired gender permanently, experienced negative comments while out socially, because of

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[14] Wales Institute of Social and Economic Research Data and Methods. (2011). *An anatomy of economic inequality in Wales.* Cardiff: EHRC.

[15] Equality and Human Rights Commission. (2010). *How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review.* Manchester: Equality and Human Rights Commission.

[16] Whittle, S., Turner, L., and Al-Alami, M. (2007). *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination.* London: Press for Change.

their acquired gender. Only 27% of respondents in the survey recorded they had not experienced anything of the above while out in public spaces. This means that 73% of respondents experienced comments, threatening behaviour, physical abuse, verbal abuse or sexual abuse while in public spaces.

Further work will need to be done to explore the proposals in respect of potential differential impact (positive/negative) on people who identify as transgender.

Marriage and civil partnership

Under the Equality Act 2010 protections for the protected characteristic Marriage and Civil Partnership only apply to discrimination in the workplace.

Pregnancy and Maternity

Data from the ONS on live births in Wales for 2015 (see Table 7) shows that there were 3,975 births in the ABMUHB area. Hospital births account for the majority of all births in the ABMUHB area (96.0%) and in Wales as a whole (96.9%).

Low birth weight is a key health indicator for early years and is a major cause for infant mortality in developed countries, including the UK. The percentage of births in the ABMUHB area that are low birth weight (i.e. below 2,500 grams) is consistent with the figure for Wales as a whole (6.8%).

Among the Welsh Health Boards Cwm Taf Health Board has the highest proportion of low birth weight births (8.2%). ABMUHB has the second lowest proportion of low birth weight births (6.0%).

At the local authority level there is some variation within the ABMUHB area, Swansea (6.3%) and Neath Port Talbot (5.7%) are ranked 15th and 19th in Wales in terms of low birth weight rates (where rank 1 is the highest low birth weight rate).

Based on current data the changes proposed in the Clinical Service Plan will potentially have an impact on this protected characteristic, particularly in relation to ease of access to services as services move to specific sites, rather than multiple sites across ABMUHB.

Table 7: Births in 2015 by location and number of live births with low birth weight by ABMU Health Board area

Region	NHS hospital birth	At home, non-NHS hospital or elsewhere	Number of live births with birth weight under 2,500 grams	Percentage of live births with birth weight under 2,500 grams	Total
ABMUHB	**3,839**	**136**	**243**	**6.0%**	**3,975**
Neath Port Talbot	1,434	44	85	5.7%	1,478
Swansea	2,405	92	158	6.3%	2,497
Wales	**31,878**	**1,021**	**2,253**	**6.8%**	**32,899**

(Source: Stats Wales)[17, 18]

Race

The 2011 census data for the Black and Minority Ethnic (BME) population across the Health Board shows an above average BME population in Swansea at 6.0% and lower percentage in Neath Port Talbot 1.9% (see Table 8). These proportions have all increased from the 2001 census data as there was evidence that ethnicity was under reported in 2001 and there have been increases in migrant workers within all three areas.

Table 8: Ethnic group by ABMU Health Board area

Region	White	Mixed / Multiple ethnic group	Asian / Asian British	Black / African / Caribbean / Black British	Other ethnic group	Total (%)	Total
ABMUHB	**96.0%**	**0.8%**	**2.1%**	**0.5%**	**0.6%**	**100%**	**378,835**
Neath Port Talbot	98.1%	0.7%	1.0%	0.2%	0.1%	100%	139,812
Swansea	94.0%	0.9%	3.3%	0.8%	1.0%	100%	239,023
Wales	**95.6%**	**1.0%**	**2.3%**	**0.6%**	**0.5%**	**100%**	**3,063,456**

(Source: Table KS201EW Census 2011, ONS)

Where English is not a patient's first language the ability of patients to receive and communicate about their health care provision in the language of their preference, may be affected. This is a particular issue for older patients with dementia where patients ability to communicate in English with staff may be compromised.

Further work will need to be undertaken to explore whether there is potential for differential impact with regard to race, language and culture.

Religion and Belief (including non-belief)

ABMUHB area population profile closely mirrors Wales as a whole, however there are some slight variations. The proportion of Christians in the ABMUHB area (55.7%) is slightly lower than in Wales (57.6%). The population proportion with 'No religion', in ABMU (34.7%) is higher than the figure for Wales (32.1%). In general, the ABMU Health Board area and Wales, have high numbers of people who either identify as 'Christian' (55.7%) or 'No religion' (34.7%), with very low proportions of the other religion categories.

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[17] https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Births-Deaths-and-Conceptions/Births/Maternities-by-Area-PlaceOfConfinement
[18] https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Births-Deaths-and-Conceptions/Births/LiveBirthsWithLowBirthWeight-by-Area

At the local authority level Neath Port Talbot (57.7%) has the highest population proportion categorised as 'Christian' – in line with the figure for Wales (57.6%). While Swansea (55.0%) has Christian population proportion lower than Wales.

Swansea (2.3%) has the highest population proportion categorised as 'Muslim' in the ABMUHB area, this is the third highest in Wales. While the Neath Port Talbot (0.4%) the 'Muslim' population is both below the figure for Wales (1.5%)

Further consideration is needed to explore whether there is any potential for differential impact relating to access to services. However, based on the currently available evidence, no impact is anticipated on this protected characteristic group.

Table 9: Religion by unitary authorities in ABMU Health Board area

Region	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated	Total (%)	Total
ABMUHB	**56.4%**	**0.3%**	**0.2%**	**0.1%**	**1.3%**	**0.1%**	**0.4%**	**33.90%**	**7.3%**	**100.0%**	**378,835**
Neath Port Talbot	57.7%	0.2%	0.1%	0.0%	0.4%	0.1%	0.4%	33.8%	7.3%	100.0%	139,812
Swansea	55.0%	0.4%	0.3%	0.1%	2.3%	0.1%	0.4%	34.0%	7.5%	100.0%	239,023
Wales	**57.6%**	**0.3%**	**0.3%**	**0.1%**	**1.5%**	**0.1%**	**0.4%**	**32.1%**	**7.6%**	**100.0%**	**3,063,456**

(Source: Table KS209EW Census 2011, ONS)

Sexual Orientation

Sexual orientation is not asked for by the Census so in order to estimate the Lesbian, Gay and Bisexual (LGB) population in Wales we need to use data from the ONS's Integrated Household Survey (see Table 10). The Integrated Household Survey does not report findings by local authority, but by regional groupings, and some cells are not reported as they could either identify individuals or they are not sufficiently robust for publication.

From the Integrated Household Survey data, we can see that the majority of the population in Wales and the regions making up the ABMUHB area identify as heterosexual (c.a. 95%). The percentage of the population identifying as LGB is approximately 1.5% in the ABMUHB area, this is higher than the value for Wales as a whole (1%) due to the higher LGB populations in Swansea (2%).
LGBT people are more likely to experience mental disorder, have issues with substance misuse, deliberate self-harm and commit suicide than the general population due to long term issues of discrimination and living in an unsympathetic society.

Table 10: Sexual orientation by ABMU Health Board area

Region	LGB	Hetero-sexual	No response	Other	Don't know /Refusal	Total (%)	All people aged 16+
Bridgend and Neath Port Talbot	1%	95%	2%	*	2%	100%	221,500
Swansea	2%	95%	1%	*	1%	100%	193,200
Wales	**1%**	**94%**	**1%**	**0%**	**3%**	**100%**	**2,456,400**

(Source: Integrated Household Survey 2012)[19]
* The data item could disclose identity or not sufficiently robust for publication.

Further work is needed to explore whether there is potential differential impact in respect of sexual orientation in respect of access to services. However, based on the currently available evidence, no impact is anticipated on this protected characteristic group.

Other characteristics considered
The following characteristics described below are not Protected Characteristics under the Equality Act 2010. However, we believe they are key factors that influence healthy outcomes and underpin our organisational values. We will, therefore, endeavour to explore any potential differential impact in respect of the following:

- Welsh Language
- Unpaid carers
- Socio-economic status

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[19] https://statswales.wales.gov.uk/Catalogue/Equality-and-Diversity/Sexual-Identity/SexualIdentity-by-Area-IdentityStatus

Welsh Language

Welsh language skills in the ABMUHB area are lower than in Wales as a whole (see Table 11). While the ABMUHB area is comparable to the Welsh figure for the proportion of the population that can understand spoken Welsh only, (5.4% vs 5.3% for Wales), it is significantly lower than Wales as a whole when considering 'Can speak Welsh' (12.0% vs 19.0%) and 'Can read and write Welsh' (8.6% compared to 14.6%).

Table 11: Welsh language profile by ABMU Health Board area

Region	Can understand spoken Welsh only	Can speak Welsh	Can speak, read and write Welsh	Total
ABMUHB	**5.4%**	**12.0%**	**8.6%**	**500,978**
Neath Port Talbot	*6.4%*	*15.3%*	*10.8%*	*135,278*
Swansea	*5.5%*	*11.4%*	*8.1%*	*231,155*
Wales	**5.3%**	**19.0%**	**14.6%**	**2,955,841**

(Source: Table KS208WA 2011 Census, ONS. All usual residents aged 3 years and over)

At the local authority level there are noticeable differences between the local authorities. Neath Port Talbot has the highest rates of Welsh language proficiency.

It is anticipated that any impact the proposed service changes may have relating to the Welsh Language is upon the ability of patients to receive and communicate about their health care provision in the language of their preference, as staff may not be Welsh language speakers. Data from the 2018 NHS Wales Staff Survey shows that only 10% of ABMUHB staff speak Welsh (see Figure 13 in Chapter 4) and that only 5% use Welsh in the workplace "Most of the time". 53% of ABMUHB staff either use Welsh in the workplace "Rarely" (34%) or "Never" (19%) (see Figure 14 in Chapter 4).

Unpaid Carers

The majority of residents in the ABMUHB area (86.8%) and Wales (87.9%) provide no unpaid care. This is relatively consistent across the health board. The 2011 Census data shows that the proportion of people providing unpaid care in the ABMUHB area is around 7% for one to 19 hours of unpaid care, decreasing to 2% for 20 to 49 hours of unpaid care, but then increasing to 4% to 5% for 50 or more hours of unpaid care.

At a health board level, ABMUHB and Cwm Taf have the highest proportions of unpaid care provision, both reporting 2.0% for 20 to 49 hours of unpaid care, and 4% for 50 or more hours of unpaid care.

At a local authority level for 20 to 49 hours of unpaid care, Neath Port Talbot and Blaenau Gwent have the highest proportion of unpaid care, both reporting 2.3%. For

50 or more hours of unpaid care at a local authority level, Neath Port Talbot has the highest proportion (4.8%).

Data from Carers UK[20] shows that:

- 58% of carers are women, and 42% are men
- Over 1 million people care for more than one person.
- 72% of carers responding to Carers UK's State of Caring Survey said they had suffered mental ill health as a result of caring.
- 61% of carers responding to Carers UK's State of Caring Survey said they had suffered physical ill health as a result of caring.
- Over 1.3 million people provide over 50 hours of care per week.

Socio-economic status

There is a strong correlation between the protected characteristics and low socioeconomic status, as demonstrated by the findings of numerous research studies. In Wales, research by the Wales Institute for Social and Economic Research, Data and Methods (WISERD, 2011)[21] has demonstrated:

- Disadvantage in education, and subsequently in employment and earnings attaches particularly to young people, those of Bangladeshi and Pakistani ethnicity, and people who are work limiting and Disability Discrimination Act (DDA) defined disabled. Within each of these groups, women are generally more disadvantaged.
- People who are both DDA disabled and have a work limiting condition experience most disadvantage in relation to employment. Seventy four per cent are not employed. This is more than three times the overall UK proportion of 22%.
- Women are disadvantaged in employment terms: in almost all population groups women face an above-average incidence of non-employment. This is particularly the case for some ethnic minority groups in Wales, particularly women of Indian, Bangladeshi and Pakistani and Chinese ethnicity.
- Approximately a fifth of the Welsh population live in poverty (measured after housing costs). Those living on the lowest incomes are the youngest, disabled people, those of Pakistani and Bangladeshi ethnicity and those living in rented accommodation. However, lone parents are the most susceptible group, with almost half living in poverty.
- Being in work does not necessarily provide a route out of poverty, with 13% of in-work households in Wales living in poverty. In-work poverty is most prevalent among lone parent households, Asian households and those who are renting.
- Levels of wealth are lowest among young people, lone parents and single households, non-white households and those with a work-limiting illness or disability.

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[20] https://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures
[21] Wales Institute of Social and Economic Research Data and Methods. (2011). *An anatomy of economic inequality in Wales*. Cardiff: EHRC.

Many health researchers regard socio-economic status as the fundamental factor affecting health. Socio-economic status is the pivotal link in the causal chain through which social determinants connect up to influence people's health. Socio-economic status marks the point at which social factors, such as the structure of the labour market and education system, enter and shape people's lives, influencing the extent to which they are exposed to risk factors that directly affect their health, such as workplace hazards, damp housing and a poor diet.

The World Health Organisation (2004)[22] notes that:

"*The social conditions in which people live powerfully influence their chances to be healthy. Indeed factors such as poverty, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries*"

ABMUHB covers a large geographical area and is one of the most densely populated Health Boards in Wales with 466 persons per square km. Within ABMUHB there are almost twice as many people living per square km in Swansea compared to Neath Port Talbot.

Table 12: Population density for ABMU Health Board area (includes Bridgend population data)

Locality	Population per km^2
Swansea	603.2
Neath Port Talbot	310.6
Bridgend	534.1
ABMU Health Board	**466.3**

The Welsh Index of Multiple Deprivation (WIMD)[23] is the Welsh Government's official measure of relative deprivation for small areas in Wales. It is designed to identify those small areas where there are the highest concentrations of several different types of deprivation in Wales. WIMD is currently made up of eight separate domains (or types) of deprivation. Each domain (listed below) is compiled from a range of different indicators:

- Income
- Employment
- Health
- Education
- Access to Services
- Community Safety
- Physical Environment
- Housing

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[22] World Health Organization. (2004). *Commission on social determinants of health*. Geneva: World Health Organization.
[23] https://gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en

The WIMD rank score is constructed from a weighted sum of the deprivation score for each domain. The weights reflect the importance of the domain as an aspect of deprivation, and the quality of the indicators available for that domain.

Of the 1,909 Lower Super Output Areas (LSOA) in Wales ranked by WIMD, 382 are ranked as being the *Most Deprived* (0-20%). The ABMUHB area (including Bridgend population data) contains 84 LSOAs ranked as being in the *Most Deprived* (0-20%) LSOAs in Wales. The ABMUHB area therefore accounts for just over a fifth (22%) of all LSOAs in Wales ranked as being the *Most Deprived* (0-20%).

The ABMUHB area contains 327 LSOAs. The 84 LSOAs ranked as being in the *Most Deprived* (0-20%) therefore mean that 26% of all LSOAs in ABMUHB area are ranked as being the *Most Deprived* (0-20%). Only Cwm Taf University Health Board has a higher proportion of its LSOAs ranked as the *Most Deprived* in Wales (30%). ABMUHB is joint second highest with Aneurin Bevan University Health Board at 26%.[24]

In addition, 70 LSOAs in the ABMUHB area (21% of all LSOAs in the ABMU Health Board area) are ranked as being in the *Next Most Deprived* (20-40%) LSOAs in Wales.

Figure 6 shows the geographical distribution of the WIMD multiple deprivation fifths across the ABMUHB area.

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[24] See
Appendix for a list of the 84 LSOAs.

Figure 6: Welsh Index of Multiple Deprivation, ABM UHB, 2014

Welsh Index of Multiple Deprivation, Abertawe Bro Morgannwg UHB, 2014

LSOA, national fifths of deprivation

- Most deprived (84)
- Next most deprived (70)
- Middle (53)
- Next least deprived (42)
- Least deprived (78)

Local authority boundary
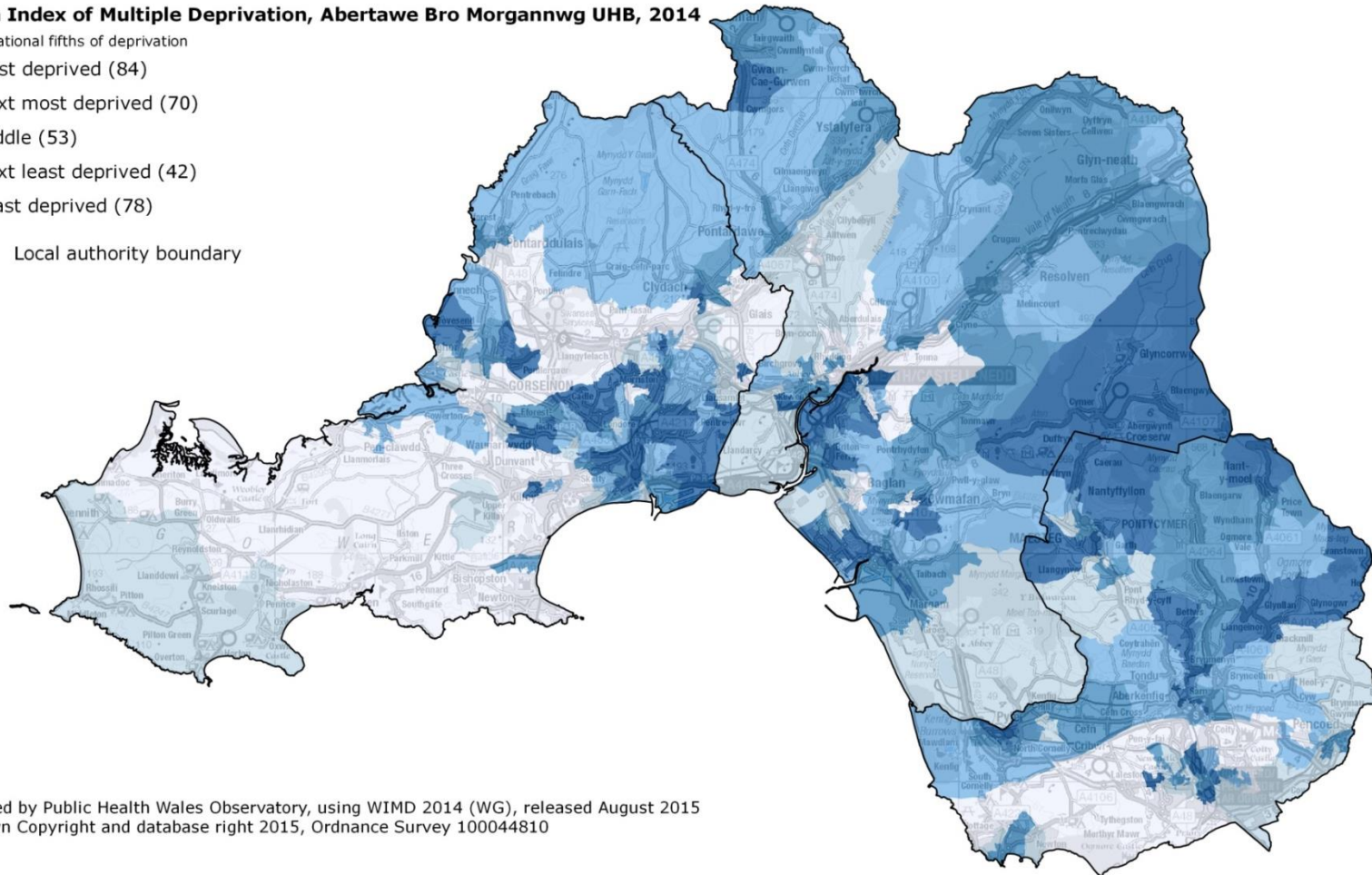
Produced by Public Health Wales Observatory, using WIMD 2014 (WG), released August 2015
© Crown Copyright and database right 2015, Ordnance Survey 100044810

Table 13 and Table 14 show that within the ABMUHB area Neath Port Talbot has the highest levels of multiple deprivation. 60% of Neath Port Talbot's LSOAs are classed as being in the *Most Deprived* (0-20%) or *Next Most Deprived* (20-40%) LSOAswhile Swansea has only 38%.

Table 13: LSOAs in ABMU Health Board area (including Bridgend population data) ranked as Most Deprived (0-20%), WIMD 2014

Local Authority	LSOAs ranked Most Deprived (0-20%)	LSOAs as %age of all LSOAs in local authority
Bridgend	20	23%
Neath Port Talbot	27	30%
Swansea	37	25%

Table 14: LSOAs in ABMU Health Board area (including Bridgend population data) ranked as Next Most Deprived (20-40%), WIMD 2014

Local Authority	LSOAs ranked Most Deprived (20-40%)	LSOAs as %age of all LSOAs in local authority
Bridgend	24	27%
Neath Port Talbot	27	30%
Swansea	19	13%

4. Assessment of relevance and impact on ABMUHB Staff

The preceding chapter focused on the potential for impact upon the public by each protected characteristic. This chapter explores the potential impact of the proposed service changes on ABMUHB staff. This information includes staff that will transfer employment to Cwm Taf UHB from 1st April 2019 as it is not possible to disaggregate the data.

As noted above the proposals for change in Option Eight will require some shifts in workforce.

Age

Table 15 describes the age profile of ABMUHB staff. The data shows that the largest age group is 51-55 years (17%). The age profile data also shows that 18% of ABMUHB staff are aged above 55 years, the earliest age that NHS staff can retire.

Table 15: ABMUHB staff by age band (Source: ABMUHB ESR)

Age Band	Count	%age
16-20	78	0%
21-25	859	5%
26-30	1,629	10%
31-35	1,700	11%
36-40	1,776	11%
41-45	2,067	13%
46-50	2,426	15%
51-55	2,658	17%
56-60	1,878	12%
61-65	806	5%
66-70	175	1%
71 & above	44	0%
Total	**16,096**	**100**

Disability

From Table 16 we can see that the proportion of ABMUHB staff that report they are disabled is very low at 1%. However, this figure should be treated with caution, as 48% of staff did not specify whether they are, or are not disabled.

Table 16: ABMUHB Staff by disability status (Source: ABMUHB ESR)

Disabled	Total	%age
No	8,130	51%
Not Declared	43	0%
Prefer Not To Answer	1	0%
Unspecified	7,701	48%
Yes	221	1%
Total	**16,096**	**100**

Figure 7 and Figure 8 show the responses of 27% ABMUHB staff to the 2018 NHS Wales Staff Survey questions on disability.

The data from the 2018 NHS Wales Staff Survey shows that 18% of staff reported having a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more. Of that 18%, 61% reported that their condition or illness reduced their ability to carry-out their day-to-day activities either a little (54%), or a lot (7%). Based on the data from the 2018 NHS Wales Staff Survey this would equate to 11% being classed as disabled according to the Equality Act 2010 definition of disability.[25] This figure is a lot higher than the one recorded on the ESR (1%), but is comparable to the rate reported across the NHS in Wales.

Figure 7: Staff with physical or mental health conditions or illnesses lasting or expected to last for 12 months or more? (Source: NHS Wales Staff Survey 2018)

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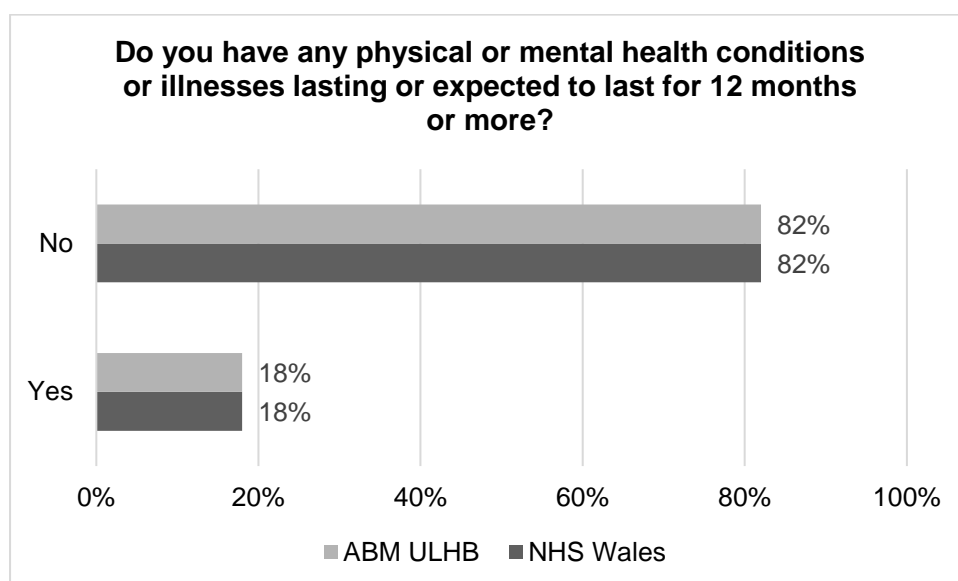
[25] Under the Equality Act 2010 disabled is defined as individuals that have a physical or mental condition/illness lasting or expected to last for 12 months or more, which affects their ability to carry out day-to-day activities either a lot, or a little.

Figure 8: Staff with a condition or illness that reduces their ability to carry-out their day-to-day activities (Source: NHS Wales Staff Survey 2018)
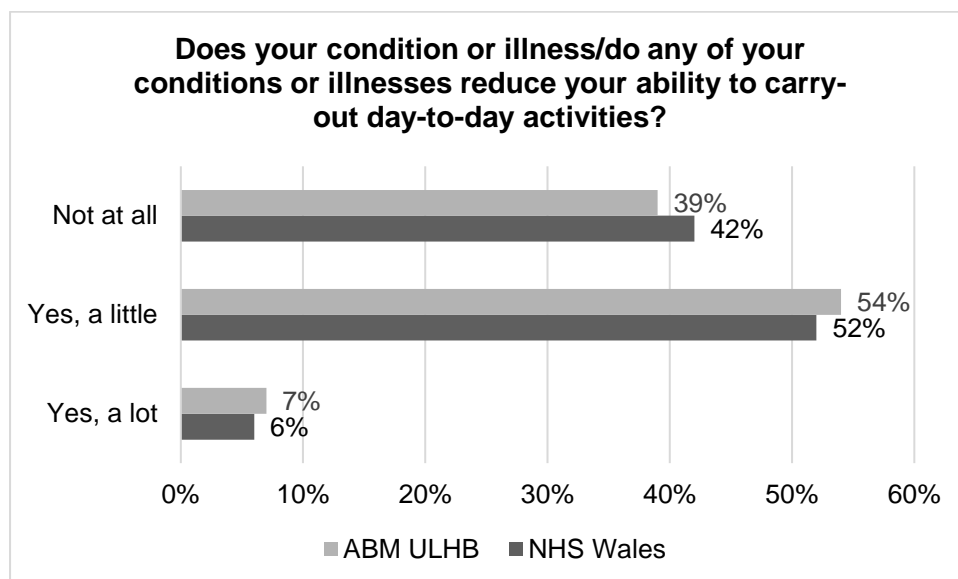
Gender

Table 17 shows that the majority of ABMUHB's staff are in the Nursing and Midwifery staff group (32%). The next highest staffing group is Additional Clinical Services (20%).

Table 17: ABMUHB staff numbers by staff group (Source: ABMUHB ESR)

Staff Group	Count	%
Additional Professional Scientific and Technical	500	3%
Additional Clinical Services	3,157	20%
Administrative and Clerical	2,858	18%
Allied Health Professionals	1,041	6%
Estates and Ancillary	1,708	11%
Healthcare Scientists	356	2%
Medical and Dental	1,389	9%
Nursing and Midwifery Registered	5,078	32%
Students	9	0%
Total	**16,096**	**100%***

*Total does not add up to 100% due to rounding

Table 18 below breaks down ABMUHB staff groups by gender. The data shows that ABMUHB staff is predominantly female (78%). ABMUHB employs more females than males in all staff groups apart from Medical and Dental, where 60% of staff are male.

Table 18: ABMUHB staff group by gender (Source: ABMUHB ESR)

Staff Group	Female		Male		Total
	Count	%age	Count	%age	%age
Add Prof Scientific and Technic	349	70%	151	30%	100%
Additional Clinical Services	2,561	81%	596	19%	100%
Administrative and Clerical	2,419	85%	439	15%	100%
Allied Health Professionals	875	84%	166	16%	100%
Estates and Ancillary	981	57%	727	43%	100%
Healthcare Scientists	209	59%	147	41%	100%
Medical and Dental	558	40%	831	60%	100%
Nursing and Midwifery Registered	4,621	91%	457	9%	100%
Students	9	100%	0	0%	100%
Total	**12,582**	**78%**	**3,514**	**22%**	**100%**

Table 19 describes the proportion of each gender in the ABMUHB pay grades. For the majority of the pay grades the proportions of females and males in each band is relatively equal, with the majority of pay grades showing a 0-4 percentage point difference. However, three pay grades show notable differences between the genders:

- 24% of all female staff work in Band 5 compared to only 11% of all male staff.
- 1% of all female staff work as a Consultant compared to 12% of all male staff.
- 1% of all female staff work as a Speciality Registrar compared to 7% of all male staff.

Table 19: ABMUHB pay grade by gender (Source: ABMUHB ESR)

Pay Grade	Female		Male	
	Count	**%age**	**Count**	**%age**
Band 1	570	5%	162	5%
Band 2	2,455	20%	754	21%
Band 3	1,326	11%	339	10%
Band 4	1,029	8%	210	6%
Band 5	**2,979**	**24%**	**381**	**11%**
Band 6	1,894	15%	371	11%
Band 7	1,169	9%	251	7%
Band 8a	326	3%	94	3%
Band 8b	96	1%	41	1%
Band 8c	69	1%	39	1%
Band 8d	16	0%	11	0%
Band 9	6	0%	8	0%
Associate Specialist	27	0%	42	1%
Consultant	**188**	**1%**	**413**	**12%**
Dentist	12	0%	4	0%
Foundation Year 1&2	75	1%	63	2%
Hospital Practitioner		0%	1	0%
Non A4C	104	1%	44	1%
Senior House Officer	1	0%	3	0%
Specialist Registrar	1	0%		0%
Specialty Doctor	47	0%	42	1%
Specialty Registrar	**187**	**1%**	**233**	**7%**
Staff Grade Practitioner		0%	3	0%
Vocational Dentist	5	0%	5	0%
Total	**12,582**	**100%**	**3,514**	**100%**

Table 20 shows that there is a gender split with regards to work pattern amongst ABMUHB staff. Overall, men are more likely than women to work full-time (86% of men, compared to 54% of women).

Table 20: ABMUHB staff group by working pattern and gender (Source: ABMUHB ESR)

Staff Group	Female				Male			
	Full-time		Part-time		Full-time		Part-time	
	Count	%age	Count	%age	Count	%age	Count	%age
Add Prof Scientific and Technic	223	64%	126	36%	130	86%	21	14%
Additional Clinical Services	1,301	51%	1,260	49%	522	88%	74	12%
Administrative and Clerical	1,316	54%	1,103	46%	401	91%	38	9%
Allied Health Professionals	509	58%	366	42%	146	88%	20	12%
Estates and Ancillary	178	18%	803	82%	558	77%	169	23%
Healthcare Scientists	119	57%	90	43%	136	93%	11	7%
Medical and Dental	419	75%	139	25%	750	90%	81	10%
Nursing and Midwifery Registered	2,734	59%	1,887	41%	392	86%	65	14%
Students	8	89%	1	11%	0	0%	0	0%
Total	**6,807**	**54%**	**5,775**	**46%**	**3,035**	**86%**	**479**	**14%**

Table 21: ABMUHB contract type by working pattern and gender (Source: ABMUHB ESR)

Contract type	Female				Male			
	Full-time		Part-time		Full-time		Part-time	
	Count	%age	Count	%age	Count	%age	Count	%age
Fixed Term Temp	759	63%	455	37%	528	87%	78	13%
Non-Exec Director/Chair	2	67%	1	33%	3	60%	2	40%
Permanent	6,046	53%	5319	47%	2,504	86%	399	14%
Total	**6,807**	**54%**	**5775**	**46%**	**3,035**	**86%**	**479**	**14%**

The Estates and Ancillary staff group has the lowest proportion of female staff working full-time (18%), while 77% of males in the same staff group work full-time. This is the lowest proportion of men working full-time (ignoring students where there are no male students) across the staff groups. All the other staff groups for males have at least 86% working full-time. In contrast the staff group (ignoring students) with the highest proportion of females working full-time is Medical and Dental at 75%, and this is also the staff group with the lowest proportion of female staff (40%). The majority of staff grades for females are in the range 51% - 59% working full-time.

Table 21 provides a breakdown of contract type by gender and working pattern. The data shows that males are more likely than females to be working full-time on Fixed Term Temporary, and Permanent contract types. At the Non-Exec Director/Chair level proportionally more females than males are working full-time, but as the numbers for this contract type are so low the actual percentage difference is negligible.

From Table 21 we can see that 6,046 females have a permanent full-time contract, this equates to 48% of the total female workforce in ABMUHB. In contrast, 2,504 or 71% of the total male workforce have a permanent full-time contract.

Due to the gender make-up of ABMUHB staff it is very likely that any shifts in workforce will have a greater impact on females than males. This is significant, because as previously highlighted, females are more likely than males to be lone parents, and are more likely than men to be a carer. Should working patterns or work travel requirements change, carers and lone parents are groups that are likely to face challenges in accommodating those changes.

Gender Reassignment
No data is held by ABMUHB's ESR on the number of ABMUHB staff that are transgender.

Data from the 2018 NHS Wales Staff Survey (see Figure 9) indicates that of the 27% of staff that responded, 5% of ABMUHB staff identify as transgender. This figure is comparable to the rate reported across the NHS in Wales.

Figure 9: Staff that identify as transgender (Source: NHS Wales Staff Survey 2018)

Is your gender identity different to the sex you were assumed at birth?

	ABM ULHB	NHS Wales
Yes	5%	5%
No	93%	93%
Prefer not to say	2%	2%

■ ABM ULHB ■ NHS Wales
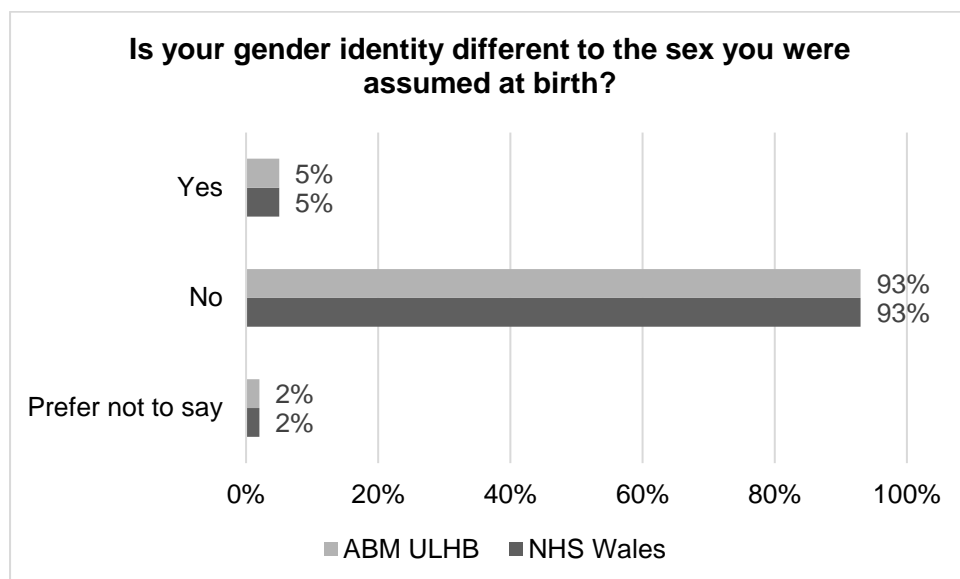
Marriage and civil partnership

Table 22 shows that the majority of ABMUHB staff are Married (53%), with the second largest relationship status being Single (31%).

Table 22: ABMUHB staff by marriage and civil partnership (Source: ABMUHB ESR)

Marital Status	Female	Male	Total	%age
Civil Partnership	109	34	143	1%
Divorced	1,005	106	1,111	7%
Legally Separated	66	17	83	1%
Married	7,165	1,392	8,557	53%
Single	3,875	1,136	5,011	31%
Unknown	105	750	855	5%
Widowed	111	6	117	1%
Undefined	146	73	219	1%
Total	**12,582**	**3,514**	**16,096**	**100%**

Pregnancy and Maternity

The protection against discrimination in the workplace lasts for a specific period of time called the protected period. This starts when a person become pregnant and ends when the maternity leave ends, or when the mother returns to work if this is earlier. All employees have the right to take maternity leave.

As of September 2018, ABMUHB ESR shows that 320 (2%) of the ABMUHB's 16,096 staff are on maternity career break.

Race

Table 23 shows that the majority of ABMUHB staff are White (60%), and only 4% are from a Black & Minority Ethnic Group. As with disability, this figure should be treated with caution as 36% of staff opted not to share any data on their ethnicity.

Table 23: ABMUHB staff by ethnic group (Source: ABMUHB ESR)

Ethnic Origin	Count	%age
White	9,613	60%
Black & Minority Ethnic Groups	709	4%
No Data/Not Stated	5,774	36%
Total	**16,096**	**100%**

Data from the 2018 NHS Wales Staff Survey, to which 27% of ABM UHB staff responded (see Figure 10), on the proportion of ABMUHB staff that are from a Black & Minority Ethnic Group is comparable to ESR, with the survey reporting 5% as BME. However, the proportion of staff identifying as White in the 2018 NHS Wales Staff Survey is higher at 94%, than the figure reported on the ESR (60%). The ABMUHB ethnicity proportions are comparable to the proportions reported across the NHS in Wales.

Figure 10: Staff ethnic group (Source: NHS Wales Staff Survey 2018)
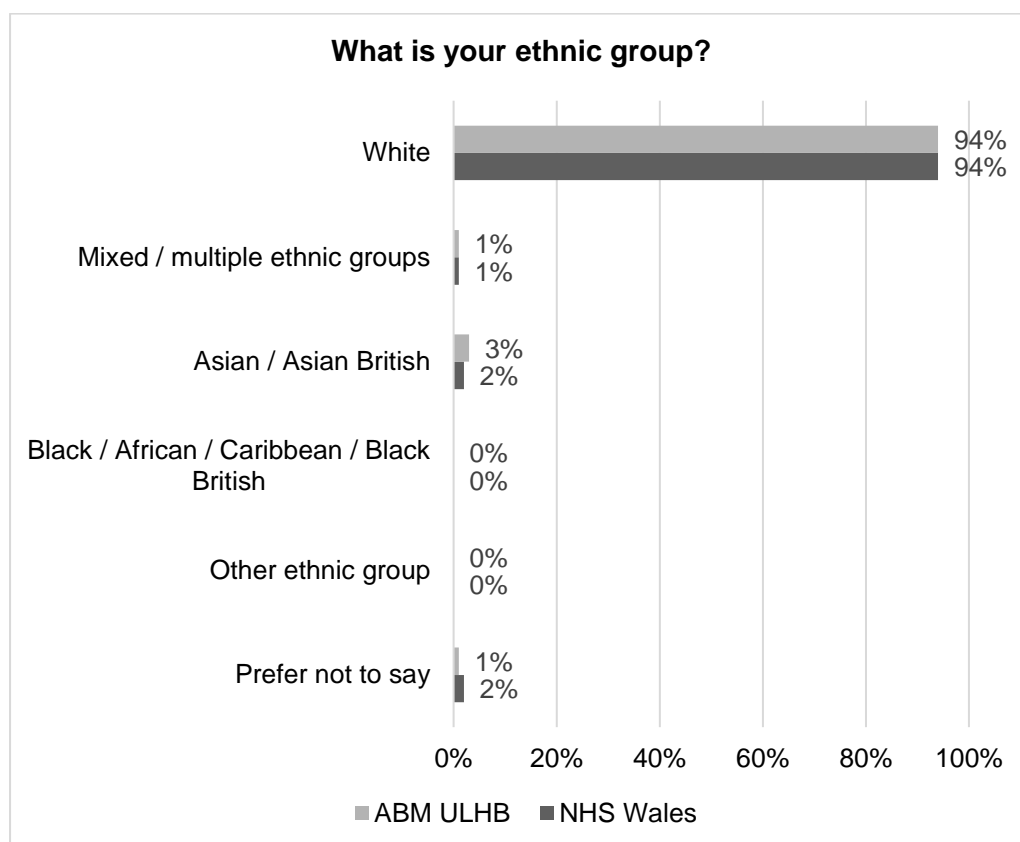
What is your ethnic group?

	ABM ULHB	NHS Wales
White	94%	94%
Mixed / multiple ethnic groups	1%	1%
Asian / Asian British	3%	2%
Black / African / Caribbean / Black British	0%	0%
Other ethnic group	0%	0%
Prefer not to say	1%	2%

Harassment on public transport may become a more significant concern if staff are required to travel further than they currently do if staff are required to work in a different location than they currently do.

A Freedom of Information request by The Independent newspaper obtained data from British Transport Police data for 2013 to 2018 which shows an increase in the number of hate crimes reported. Race hate crimes jumped from 1,453 to 2,566 over the five-year period.[26]

Religion and Belief (including non-belief)

Table 24 provides a breakdown of ABMUHB staff by religion and non-belief. The table shows that the majority of staff have not reported their religious or non-belief status, and are categorised as Undefined (42%). The next largest status is Christianity (34%). The remaining religious or non-belief statuses are all below 10%.

Table 24: ABMUHB staff by religion (Source: ABMUHB ESR)

Religious Belief	Count	%age
Atheism	1,391	9%
Buddhism	27	0%
Christianity	5,396	34%
Hinduism	77	0%
I do not wish to disclose my religion/belief	1,141	7%
Islam	103	0%
Jainism	1	0%
Judaism	2	0%
Other	1,225	8%
Sikhism	11	0%
Undefined	6,722	42%
Total	**16,096**	**100%**

The categories of religion reported via the 2018 NHS Wales Staff Survey vary slightly from the categories recorded on the ESR (see Figure 11). The Staff Survey, to which 27% of ABM UHB staff responded, shows a higher proportion of staff identifying as Christian (52%), than reported on the ESR (34%). For the other religions reported the Staff Survey and ESR report similar staff proportions. The Staff Survey indicates that 43% of ABMUHB staff do not identify with any religion (this is not equivalent to the ESR category of "Undefined" which refers to staff records where no data is held).

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[26] https://www.independent.co.uk/news/uk/crime/hate-crimes-public-transport-homophobic-religion-racist-uk-attacks-tube-train-bus-a8291761.html

Figure 11: Staff religion or non-belief (Source: NHS Wales Staff Survey 2018)
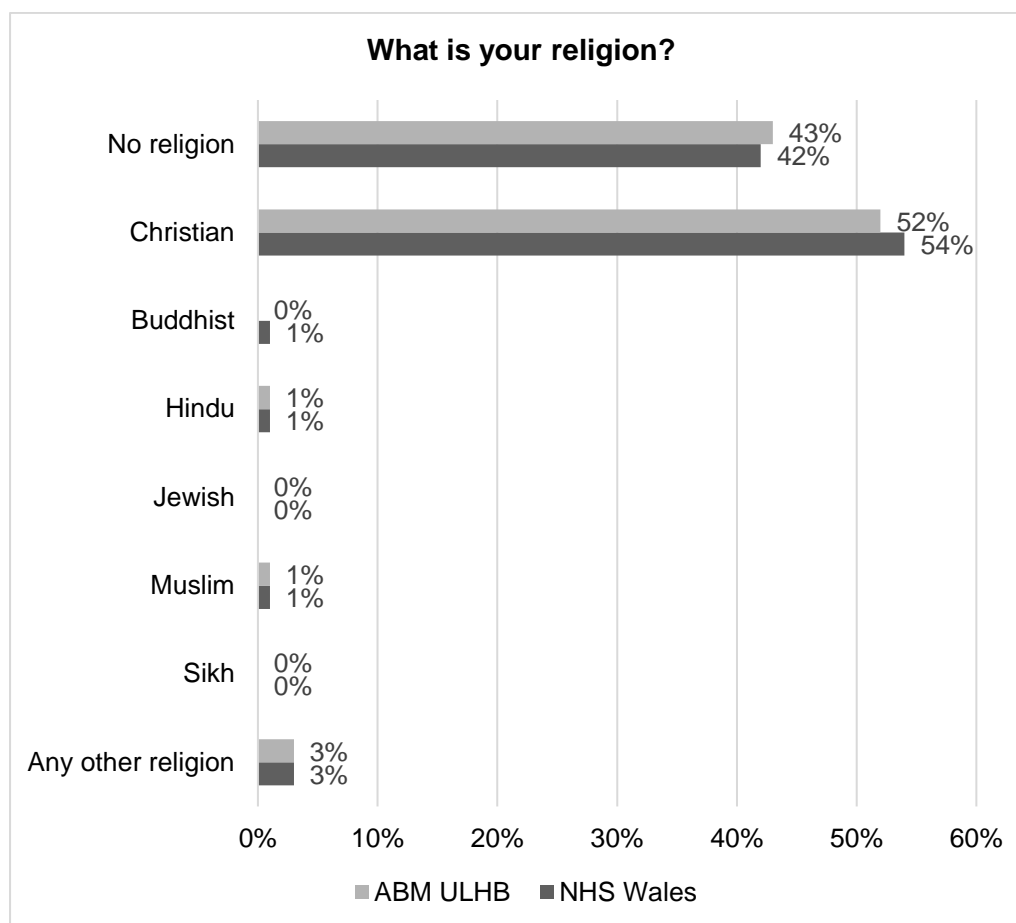
ABMUHB does not differ significantly from the figure reported for staff across NHS Wales with regard to religion.

Harassment on public transport may become a more significant concern if staff are required to travel further than they currently do if staff are required to work in a different location than they currently do.

A Freedom of Information request by The Independent newspaper obtained data from British Transport Police data for 2013 to 2018 which shows an increase in the number of hate crimes reported. Faith-linked attacks more than quadrupled from 64 in 2013 to 294 over the five-year period.[27]

Sexual Orientation
Table 25 provides a breakdown of ABMUHB staff by sexual orientation. The table shows that the majority of staff have not reported their sexual orientation as Heterosexual or Straight (54%). Only 1% of staff identified as Gay or Lesbian, but due to the high proportion of staff who have opted not to disclose their sexual orientation (42%), the proportion of LGB staff may be higher.

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[27] https://www.independent.co.uk/news/uk/crime/hate-crimes-public-transport-homophobic-religion-racist-uk-attacks-tube-train-bus-a8291761.html

Table 25: ABMUHB staff by sexual orientation (Source: ABMUHB ESR)

Sexual Orientation	Count	%age
Bisexual	52	0%
Gay or Lesbian	140	1%
Heterosexual or Straight	8,669	54%
Prefer not to say	497	3%
Undefined	6,738	42%
Total	**16,096**	**100%**

Data from the 2018 NHS Wales Staff Survey (see Figure 12), to which 27% of ABM UHB staff responded, shows that the proportion of staff that identify as Heterosexual/Straight at 92%, is higher than recorded on ESR (54%). The proportion of staff that identified as LGB or "Other" on the Staff Survey (4%) is also higher than recorded on the ESR (1%).

Figure 12: Staff sexual orientation (Source: NHS Wales Staff Survey 2018)
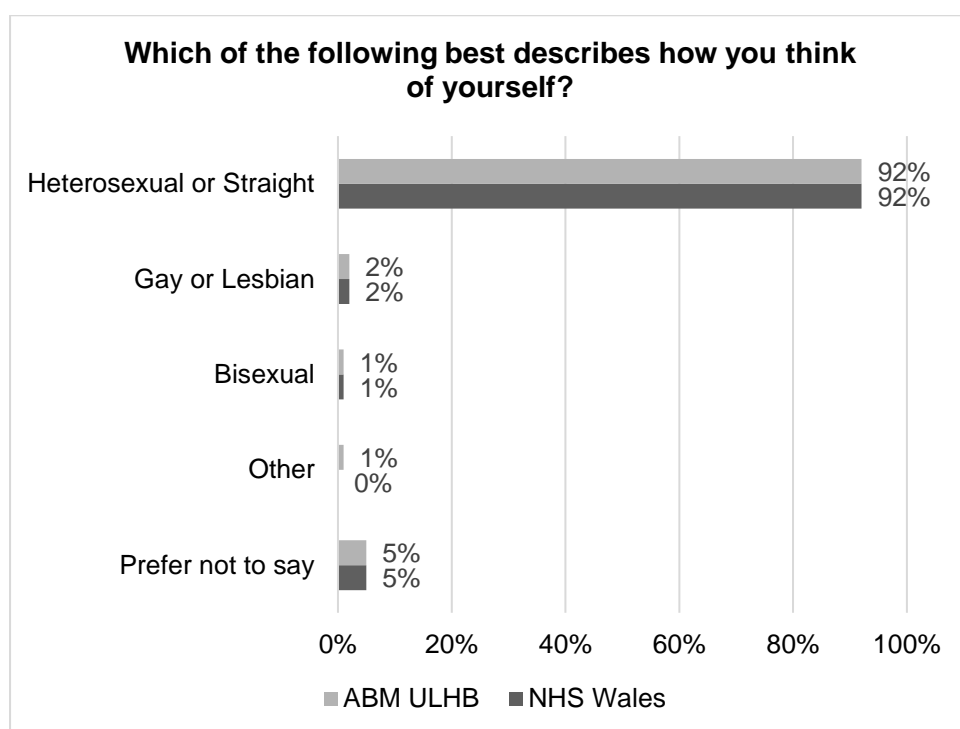
No direct impact upon staff due to their sexual orientation is anticipated.

The 2018 National LGBT Survey[28] found that:

The most common places where cisgender respondents had avoided being open about their sexual orientation were on public transport (65%) and in the workplace (56%).

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[28] https://www.gov.uk/government/publications/national-lgbt-survey-summary-report/national-lgbt-survey-summary-report

Harassment on public transport may become a more significant concern if staff are required to travel further than they currently do if staff are required to work in a different location than they currently do.

A Freedom of Information request by The Independent newspaper obtained data from British Transport Police data for 2013 to 2018 which shows an increase in the number of hate crimes reported. The number of gay, lesbian or bisexual victims on the road and rail network trebled from 139 to 416.[29]

Further work is needed to explore whether there is the potential for additional differential impact in respect of sexual orientation.

Welsh Language
Figure 13 and Figure 14 show the proportion of staff (27% of ABM UHB staff) that reported in the 2018 NHS Wales Survey that they can speak Welsh, and how often they use Welsh in the workplace.

The data from the Staff Survey indicates that only 10% of ABMUHB staff can speak Welsh (Figure 13). This proportion is lower than the proportion reported for NHS Wales (15%).

Figure 13: Staff that can speak Welsh (Source: NHS Wales Staff Survey 2018)
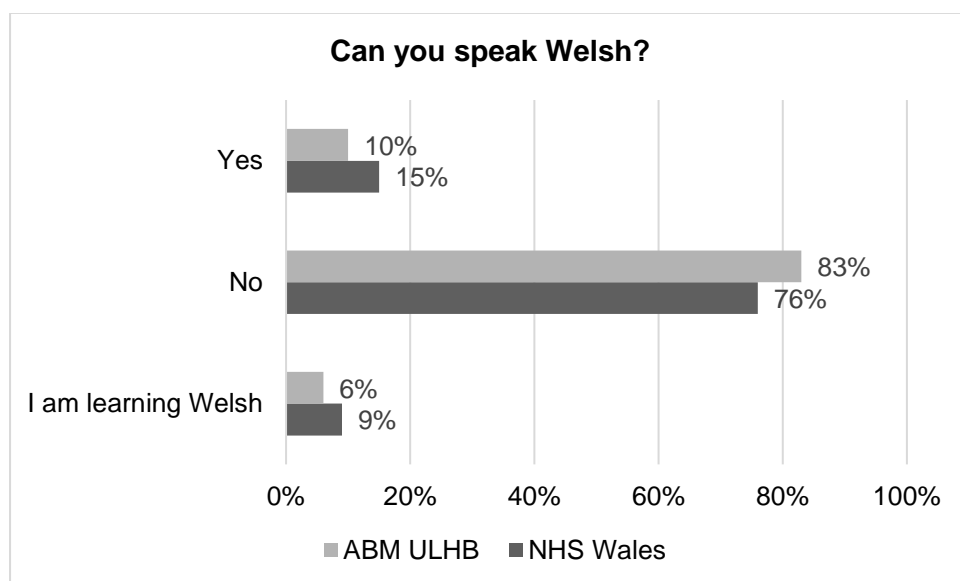
Use of Welsh in the workplace by ABMUHB staff is lower in ABMUHB than in the NHS across Wales. Only 5% of ABMUHB staff use Welsh in the workplace "Most of the time" compared to 20% of staff in NHS Wales.

Similarly staff in ABMUHB are more likely than staff in NHS Wales to use Welsh in the workplace "Rarely" (34% compared to 28&) or "Never (19% compared to 12%).

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[29] https://www.independent.co.uk/news/uk/crime/hate-crimes-public-transport-homophobic-religion-racist-uk-attacks-tube-train-bus-a8291761.html

Figure 14: How often staff use Welsh in the workplace (Source: NHS Wales Staff Survey 2018)
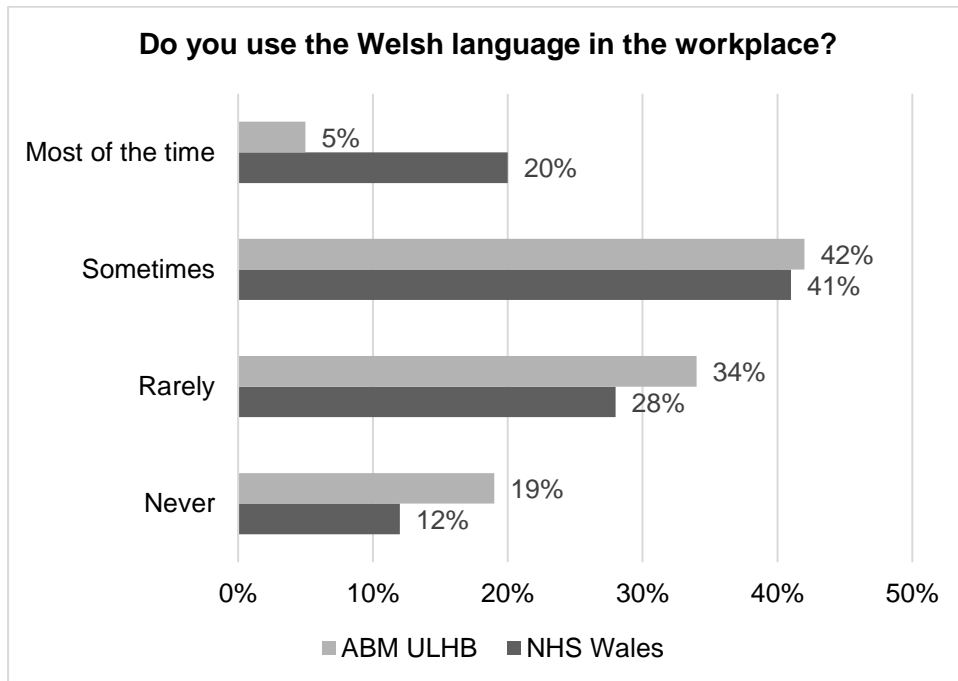
Do you use the Welsh language in the workplace?

Category	ABM ULHB	NHS Wales
Most of the time	5%	20%
Sometimes	42%	41%
Rarely	34%	28%
Never	19%	12%

■ ABM ULHB ■ NHS Wales

Based on the available evidence we do not anticipate that the proposed service changes will affect staff's rights to use the Welsh language.

5. Human Rights

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998[30] as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

In producing this EIA we have considered the potential of the proposed service changes to impact upon the following rights under the Human Rights Act 1998:

- Article 2: The right to life
- Article 3: The right to freedom from torture or inhuman or degrading treatment
- Article 5: The right to freedom and liberty
- Article 6: The right to a fair trial
- Article 7: The right to no punishment without law
- Article 8: The right to respect for private and family life, home and correspondence
- Article 9: The right to freedom of thought, conscience and religion
- Article 10: The right to freedom of expression
- Article 11: Freedom of assembly and association.
- Article 12: The right to marry and found a family
- Article 14: The right not to be discriminated against in relation to any of the rights contained in the European Convention

Based on the available evidence we do not anticipate that the proposed service changes will impinge upon patients' or staff's rights protected under the Human Rights Act.

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[30] https://www.legislation.gov.uk/ukpga/1998/42/contents

6. Summary of impact

Potential impact on the public

The patient and demographic data presented in this report has identified that the proposed service changes will have direct relevance to the following protected characteristics:

- Age
- Disability
- Gender
- Pregnancy and maternity

Based on the data currently available, we do not anticipate a direct impact on the remaining protected characteristics (e.g. gender reassignment, marriage and civil partnership, race, religion and belief, and sexual orientation), but we will continue to monitor the proposed service changes with respect to these protected characteristics.

In addition to the above protected characteristics it is anticipated that the service changes may affect unpaid carers, the Welsh language and people with low socio-economic status.

With regards to the nature of the impact (i.e. positive, neutral or negative), the changes proposed as part of the Clinical Service Plan are intended to provide patients with a better service and in doing so promoting equality of outcome. For example the centralisation of services in theory should:

- help reduce delays in accessing services and seeing consultants,
- reduce the number of cancelled planned surgeries,
- enable a more consistent and reliable service by ensuring the necessary staff numbers are maintained on site to provide services,
- provide patients with access to the necessary equipment and support services thereby reducing the need for patients to be transferred to other sites,
- provide a consistent admission practice for a one-stop frailty service, ensuring access to this service does not vary by region i.e. promoting equality of opportunity.

In centralising services it is recognised that there is the potential for a negative impact on patients as in some instances they will be required to travel further than they currently do to access a service. This travel burden will have a greater impact on patients from low-income households (e.g. lone parents, disabled, carers.)

No impact is anticipated upon patients' absolute rights protected under the Human Rights Act 1998 however consideration should be given to Article 8 of Human Rights Act, right to respect for private and family life. Although not an absolute right centralisation of services may impact patients' rights to maintain relationships

with their family whilst in hospital, Further exploration of this will be undertaken in the stage 2 EIA.

Potential impact on ABMUHB staff

Due to the gender structure of the ABMUHB workforce the data presented strongly suggests that any changes in workforce will affect female staff more than male staff. This in turn, suggests that carers will be impacted as more women than men are carers.

- 78% of ABMUHB staff are female.
- 54% of female staff work full-time compared to 86% of male staff.
- 48% of female staff have a permanent full-time contract compared to 71% of male staff.

Based on the data currently available, this EIA has also identified potential areas of concern in relation to race, religion and sexual orientation.

No impact is anticipated upon staffs' rights protected under the Human Rights Act 1998.

However, at this stage of the EIA process feedback from patients, wider stakeholders and staff has not been captured. The anticipated impacts on the protected characteristic groups will be updated once that feedback has been collected via the proposed engagement activities.

Clinical Services Plan and the Annual Plan 2019/20

It should be noted that while the Clinical Services Plan sets out an overarching framework for the ambition for services delivered by ABMUHB, the impact the Clinical Services Plan has on service users will be determined by the manner in which the Clinical Services Plan is itself implemented. The initial plans for delivering services in line with the Clinical Services Plan is contained within the Annual Plan 2019/20. Further detail will be developed as part of ongoing work of the Health Board's Transformation Programme in addition to a programme of engagement and consultation with staff, stakeholders and the public, and in the Integrated Medium Term Plan which will be submitted during 2019.

7. Next Steps

The following actions are proposed to inform the Stage 2 Equality Impact Assessment.

- Review and update findings on impact based on the development and implementation of plans in the Annual Plan 2019/20 and subsequent development of an IMTP.
- Explore options for further engagement activity with patients, wider stakeholders and staff through the Transformation Programme.
- Incorporate patients, wider stakeholders and staff feedback on proposed changes.
- Update the Equality Impact Assessment with mitigation options, as necessary, based on wider stakeholders and staff feedback on proposed changes.
- Identify relevant Key Performance Indicators and develop a monitoring plan to capture any impact of the proposed service changes.
- Consider the recommendations to appoint a dedicated Impact Assessment Manager as part of the Transformation Programme.

Appendix A: Eight options developed by Capita

Table 26: Clinical Service Plan Options

Option	Description	Advantages	Disadvantages
1	**Morriston Hospital** receives all emergency admissions and completes only emergency surgical cases. **Singleton Hospital** becomes the single centre for planned surgery within ABM **Neath Port Talbot Hospital** becomes the single centre for frailty services within ABM	• Each centre can concentrate on a single operational model. • Services concentrated in single sites. • Separation of planned and emergency care. • Single frailty model allows closer working with Local Authorities.	• Major service change with transfer of equipment. • Threats to workforce through need to relocate. • Would require major new theatre complex at Singleton Hospital. • Requires critical care build at Singleton.
2	**Morriston Hospital** becomes the centre for all emergency admissions and emergency surgery. **Singleton Hospital** becomes the single centre for frailty services. **Neath Port Talbot Hospital** becomes the single centre for planned surgery.	• Each centre can concentrate on a single operational model. • Services concentrated in single sites. • Separation of planned and emergency care. • Single frailty model allows closer working with Local Authorities.	• Major service change with transfer of equipment. • Threats to workforce through need to relocate. • Would require major new theatre complex at NPT Hospital. • Requires critical care build at NPT.
3	**Morriston Hospital** becomes the centre for all emergency admissions and emergency surgery. **Singleton Hospital** becomes the centre for half the planned surgery within ABM **Neath Port Talbot Hospital** becomes the centre for half the planned surgery within ABM and a centre for frailty services.	• Each centre can develop a new operational model. • Services concentrated in fewer sites. • Separation of planned and emergency care. • Single frailty model allows closer working with Local Authorities.	• Need for a large number of patients to be transferred. • Would require major new theatre build in both NPT and Singleton. • Likely need for critical care build in both NPT and Singleton.
4	**Morriston Hospital** becomes the centre for all emergency admissions and emergency surgery. **Singleton Hospital** becomes the centre for frailty services in ABM and completes half planned surgery within ABM **Neath Port Talbot Hospital** completes half the planned surgery in ABM.	• Each centre able to develop a new operational model. • Services concentrated in fewer sites. • Separation of planned and emergency care. • Single frailty model allows closer working with Local Authorities.	• Major shift of services • Planned surgery on two sites. • Need for major theatre build on both NPT and Singleton sites. • Likely need for critical care build on Singleton site.

5	**Morriston Hospital** becomes the centre for all planned surgical services. **Singleton Hospital** takes all emergency medical and surgical patients. **Neath Port Talbot Hospital** becomes the centre for frailty services within ABM	• Each unit has a clear purpose. • Each unit can develop a new operational model. • Emergency and planned surgery are separated.	• Singleton Hospital has poor access for emergency services. • Major disruption to current services. • Critical care build at Singleton. • Major ward build required at Singleton.
6	**Morriston Hospital** becomes the single centre for frailty services. **Singleton Hospital** becomes the single centre for emergency medical and surgical services. **Neath Port Talbot Hospital** becomes the centre for all planned surgery.	• Each unit has a clear purpose. • Each unit can develop a new operational model. • Emergency and planned surgery are separated.	• Serious imbalance with current estates means major building work required. • Singleton site has poor access for emergency services.
7	**Morriston Hospital** becomes the centre for all emergency admissions and emergency surgery. **Singleton Hospital** becomes a major centre for ambulatory care. **Neath Port Talbot Hospital** becomes a centre for day case surgery and frailty services.	• Each unit has a clear purpose. • Each unit can develop a new operational model.	• Emergency services split between two sites. • Access to Singleton poor for emergencies. • Would require a large expansion of the primary care workforce in Singleton.
8	**Morriston Hospital** becomes the single site for all emergency medical and surgical patients as well as the centre for high risk surgery. **Singleton Hospital** becomes the major centre for ambulatory, non-emergency care as well as completing low/medium risk surgery. **Neath Port Talbot Hospital** becomes the major low risk, day care surgery with an element of post assessment frailty service.	• Each centre has a clear purpose. • Each unit can develop a new operational model. • Good match to existing facilities. • Centralisation of all emergency/high risk activity with critical care resource. • Good access for emergency patients.	• Does not fully separate planned and emergency surgery. • Will require some shifts in equipment/workforce.

Appendix B: List of Most deprived LSOAs in ABMUHB Area *includes Bridgend population data

Table 27: Most deprived (0-20%) LSOAs in ABMUHB area, WIMD 2014.

Name	Code	LHB Rank (of 327)	Wales rank (of 1909)	Deprivation
Caerau (Bridgend) 1	W01000991	1	6	0-10%
Penderry 1	W01000830	2	21	0-10%
Cymmer (Neath Port Talbot) 2	W01000921	3	22	0-10%
Castle 2 North	W01001955	4	27	0-10%
Townhill 1	W01000862	5	29	0-10%
Castle 1	W01000742	6	33	0-10%
Penderry 3	W01000832	7	34	0-10%
Townhill 2	W01000863	8	41	0-10%
Mynyddbach 1	W01000817	9	43	0-10%
Caerau (Bridgend) 2	W01000992	10	44	0-10%
Penderry 4	W01000833	11	45	0-10%
Townhill 3	W01000864	12	49	0-10%
Townhill 6	W01000867	13	50	0-10%
Townhill 5	W01000866	14	64	0-10%
Sandfields West 2	W01000962	15	72	0-10%
Aberavon 4	W01000886	16	79	0-10%
Bettws (Bridgend)	W01000975	17	90	0-10%
Sandfields East 2	W01000958	18	98	0-10%
Bonymaen 1	W01000738	19	102	0-10%
Neath North 2	W01000939	20	112	0-10%
Morriston 9	W01000814	21	116	0-10%
Brackla 3	W01000981	22	117	0-10%
Morriston 5	W01000810	23	119	0-10%
Neath East 1	W01000934	24	122	0-10%
Briton Ferry West 1	W01000896	25	123	0-10%
Sandfields West 3	W01000963	26	133	0-10%
Morfa 2	W01001022	27	136	0-10%
Morriston 7	W01000812	28	140	0-10%
Sarn 1	W01001055	29	141	0-10%
Penderry 6	W01000835	30	142	0-10%
Aberavon 3	W01000885	31	145	0-10%
Neath East 2	W01000935	32	148	0-10%
Penderry 7	W01000836	33	150	0-10%
Aberavon 2	W01000884	34	166	0-10%
Blackmill 2	W01000977	35	171	0-10%
St. Thomas 1	W01000849	36	176	0-10%
Gwynfi	W01000930	37	177	0-10%
Caerau (Bridgend) 3	W01000993	38	179	0-10%
Cornelly 4	W01001002	39	189	0-10%
Llansamlet 8	W01000801	40	207	10-20%
Sandfields West 4	W01000964	41	212	10-20%
Coedffranc Central 3	W01000914	42	216	10-20%
Cockett 8	W01000762	43	217	10-20%
Penderry 5	W01000834	44	218	10-20%
Cockett 2	W01000756	45	224	10-20%

Ynysawdre 1	W01001057	46	225	10-20%
Landore 3	W01000789	47	234	10-20%
Penderry 2	W01000831	48	246	10-20%
Pyle 2	W01001049	49	248	10-20%
Neath South 2	W01000942	50	249	10-20%
Maesteg West 3	W01001019	51	254	10-20%
Penyrheol (Swansea) 4	W01000844	52	264	10-20%
Llansamlet 6	W01000799	53	269	10-20%
Landore 4	W01000790	54	271	10-20%
Sandfields East 1	W01000957	55	278	10-20%
Glyncorrwg	W01000924	56	284	10-20%
Oldcastle 1	W01001035	57	287	10-20%
Castle 3	W01000744	58	292	10-20%
Caerau (Bridgend) 4	W01000994	59	293	10-20%
Sketty 4	W01000856	60	295	10-20%
Blackmill 1	W01000976	61	298	10-20%
Landore 2	W01000788	62	302	10-20%
Maesteg East 2	W01001015	63	303	10-20%
Bryn and Cwmavon 3	W01000900	64	310	10-20%
Port Talbot 3	W01000951	65	315	10-20%
Maesteg West 4	W01001020	66	319	10-20%
Briton Ferry East 2	W01000895	67	323	10-20%
Clydach 3	W01000752	68	325	10-20%
Neath East 3	W01000936	69	328	10-20%
Bonymaen 2	W01000739	70	331	10-20%
Mynyddbach 2	W01000818	71	332	10-20%
Neath North 3	W01000940	72	334	10-20%
Morriston 6	W01000811	73	336	10-20%
Neath East 4	W01000937	74	340	10-20%
Morfa 3	W01001023	75	342	10-20%
Nant-y-moel 1	W01001024	76	347	10-20%
Bryntirion Laleston and Merthyr Mawr 3	W01000990	77	352	10-20%
Sandfields East 4	W01000960	78	354	10-20%
Gwaun-Cae-Gurwen 2	W01000929	79	355	10-20%
Castle 4	W01000745	80	356	10-20%
Tai-bach 2	W01000967	81	361	10-20%
Penllergaer 2	W01000838	82	369	10-20%
Cymmer (Neath Port Talbot) 1	W01000920	83	372	10-20%
Bonymaen 4	W01000741	84	380	10-20%