

ABM University Health Board	
Date of Meeting: 29th March 2018 Name of Meeting: Health Board Part A Agenda item:	
Subject	<i>Approval of the Annual Plan 2018/19</i>
Prepared by	Nicola Johnson, Head of IMTP Development and Implementation Dorothy Edwards, Deputy Director of Recovery and Sustainability Val Whiting, Assistant Director of Finance Darren Griffiths, Assistant Director of Strategy
Approved by	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance
Presented by	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance

1.0 Situation

This is a covering paper for the Health Board's Annual Plan 2018/19 for Board approval for submission to Welsh Government. The paper:

- describes the changes that have been made since the Final Draft Annual Plan was considered by the Board in January, following completion of the further work required and feedback from Welsh Government;
- includes the Targeted Intervention performance trajectories and financial plan that have been approved by the Executive Team and assured by the Performance and Finance Committee;
- describes how the Recovery and Sustainability Programme will support the delivery of the Plan; and,
- describes how the delivery of the Plan will be assured.

2.0 Background

The Health Board considered the Final Draft Annual Plan at the January meeting. Due to the arrival of the new Chief Executive on 1st February 2018, Welsh Government agreed that submission of the plan could be deferred by up to a fortnight. Further work was completed to provide an Executive Summary and, following Chair's action the document was submitted to Welsh Government on 7th February 2018.

As set out in the January Board paper and previous Board discussions, the Plan was drafted to focus on the Health Board's need to improve our position against the key performance areas reflecting our Targeted Intervention status. The Plan also needed to be set within a broader strategic context of national legislation and policy and that we are updating our Clinical Services Strategy as well as the need to develop an Organisational Strategy. Welsh Government had been advised, and agreed, that the Plan would not necessarily comply with all of the requirements of the NHS Wales Planning Framework.

The covering letter to Welsh Government also laid out that there was further work to do to:

- Finalise our Quality and Safety priorities for 2018/19 which were in the process of being confirmed as part of the updating of the Quality Strategy, and to incorporate them into the Service Improvement Plans in the final Plan.
- Undertake further work on the expected performance improvements for 2018/19;
- Review the workforce plans with external support from the national Workforce, Education and Development Services (WEDS);
- Finalise the financial plan; and,
- Ensure that the delivery of the Recovery and Sustainability Programme is at the heart of our approach to delivering the overall 2018/19 Plan.

In addition, it was highlighted to the January Board that there was more work to do to prioritise the capital plan which would support the Recovery and Sustainability Programme.

Following submission of the final draft, we received written feedback from Welsh Government in early March 2018, followed up with a meeting between Welsh Government and Health Board officials on 13th March 2018 and a summary letter on 23rd March 2018. The feedback contained very detailed feedback on all national Policy areas despite our stated intention to focus on our Targeted Intervention priorities, however it was helpfully split into 'areas for essential improvement' and 'areas for strengthening' (mainly the Policy areas).

Some of the areas for essential improvement reflected the areas we had already set out that we were still developing, and were as follows:

- Review of the trajectories and expected performance improvements for planned and unscheduled care which needed further development and ambition;
- Clarity on our approach to, and the impact of, service remodelling and redesign;
- Clarity on the regional pathway work with Hywel Dda Health Board to support the development of a regional Hyper Acute Stroke Unit model;
- Feedback that quality, safety and patient experience needed to thread through plan; and,
- That our positive work on finance in 2017/18 was not reflected in draft plan and,
- Worked-up plans were required for each savings area within the financial plan and each of these would be need to translated into monthly delivery actions and savings profiles.

The advice from Welsh Government officials was that, notwithstanding our focus on our immediate priorities, in preparation for achieving our aim of developing an Integrated Medium Term Plan (IMTP) next year they would like to see improvement across all the areas for strengthening as well as the areas of essential improvement.

Welsh Government colleagues are aware that the Health Board's focus in this Annual Plan is to achieve our aim of improving our targeted intervention status and that as such we narrowed the focus of the Annual Plan to allow for greater emphasis on your targeted intervention criteria. However, we are also aware of the Board's desire to have a short, sharp document which lays out the strategic context,

progress, aims and objectives, delivery trajectories and plans, financial plan and assurance mechanisms.

In this context we have taken on board the feedback also provided in the letter of to further address the requirements of the Planning Framework and we have:

- Reviewed the Executive Summary which is included in the pack to ensure it meets the Board's requirements; and,
- Retained the structure of the Annual Plan as focusing on our targeted intervention status (noting the comment above that the Plan should be viewed as vehicle for de-escalation) but changed the structure of the document to be more traditional (ie the context and planning framework are now providing the background for our Service Improvement Plans); and,
- Included the pack of Narrative Appendices as support which includes the other Policy areas, and now includes sections on Research, Development and Innovation, the Welsh Language and our Delivery Plans.

3.0 Assessment

3.1 Documentation Format and Structure

The Annual Plan is in the format of four documents:

- **Appendix A - an Executive Summary** which summarises our aims and objectives, context, Service Improvement Plans including trajectories, financial plan, and assurance mechanisms.
- **Appendix B – the Annual Plan** – this is still built around the five Service Improvement Plans for the Targeted Intervention priorities and financial plan, but in line with Welsh Government feedback it now follows a more traditional IMTP structure, with more information on the strategic context and our Planning Framework up front.
- **Appendix C – Narrative Appendices** – this set of appendices now includes sections on all of the Welsh Government Policy areas including new sections on Research, Development and Innovation, the Welsh Language and Health Board Delivery Plans. Many of the existing appendices have also been strengthened and extended to reflect the Welsh Government feedback. The Board is advised that the Heart Disease Delivery Plan has not been completed and cannot be appended to the Plan as required by Welsh Government. This is being addressed by reviewing the Executive Director leads for the Delivery Plans, securing a new managerial lead and refreshing the Heart Disease Delivery Group. A plan will then be developed.
- **Appendix D – Mandatory Appendices** – This set of spreadsheets contains detailed information on our performance, revenue, capital and workforce plans as mandated by Welsh Government. They are complete with the exception of information on operating expense changes. The advice from the Finance department is that this information is not available in the format required to complete the Appendix but we are working on an alternative analysis to share with Welsh Government.

In addition **Appendix E** is the Welsh Government Feedback Template which has been completed to demonstrate how we have addressed the detailed feedback to accompany the submission of the Plan to Welsh Government.

3.2 Tone and Style

The feedback from Welsh Government included advice that the workforce and primary care sections were significantly better than previously and that we had not made enough of our achievements and good work in 2021/18. As a result the Finance section has been amended to reflect the good progress made this year and advice was sought from our Head of Communications on the tone and style of the Annual Plan document. Based on this advice, the Foreword has been redrafted to be more positive and examples of good practice have been inserted into each Service Improvement Plan.

3.3 Quality and Safety

Our Quality Priorities have now been agreed as part of the process of updating our Quality Strategy. There are 9 priorities which are closely aligned to our strategic Targeted Intervention Priorities as shown in the diagram.



The priorities, measures and alignment to our strategic priorities are described in a discrete section the Plan and are also threaded throughout our Service Improvement Plans. More information on our Quality Management System, quality improvement approach and the Quality Hub has also been included.

3.4 Performance Trajectories

The performance trajectories have been approved by the Executive Team and scrutinised by the Performance and Finance Committee for submission to Board. The Unscheduled Care, Planned Care and Healthcare Acquired Infections trajectories have changed since the submission of the Final Draft, due to the completion of our further work, and in response to the Welsh Government feedback.

The key areas of change are as follows: -

3.4.1 HCAI

Whilst the revision of the HCAI trajectories was not an ‘essential’ area for improvement, the Welsh Government feedback included a query as to whether the trajectories in the Final Draft Plan were realistic. In response, a detailed analysis of all Welsh Health Boards’ historical ability to improve infection rates has been undertaken, including our own. Feedback was also received from the Welsh Health Associated Infection Programme (WHAIP) on our proposed trajectories and this has also been taken into account. This data showed that our previous trajectories were over-optimistic and the Nurse Director has agreed that our performance aims and trajectories should be revised downwards as follows.

Infection	Final Draft Plan Target Improvement by the end of 2018/19	Final Plan Target Improvement by the end of 2018/19
C. difficile	20%	15%
Staph. aureus	20%	10%
E. coli	10%	5%

3.4.2 Planned Care

For planned care, more detailed modelling work has been undertaken and the preliminary numbers from this modelling are now available. This revised, more detailed modelling is highlighting a reduction in the sustainability gaps for both new Outpatients and treatments within the RTT system.

Further, the Health Board has been advised to continue to drive improvement in the planned care system by Welsh Government. Therefore the trajectories have been adjusted to reflect a more immediate commitment of the £2m within the financial plan to Quarter 1, to support this improvement. The plan assumes an ongoing commitment of just over £2m per quarter to support continued improvement through the financial year, however this resource is not yet secure and for clarity, this financial plan assumes £2m of internal investment to support improvement in Quarter 1, and a further £7m of funding from Welsh Government.

3.4.3 Unscheduled Care

The Executive Team felt that it was important that the ambition for the Emergency Department 4 hour performance level be challenged, particularly for the year end position to give a strong foundation for further improvement into 2019/2020. As a result there has been a modest increase in the percentage performance in the last three months of the year to reflect a more resilient unscheduled care system.

The detailed trajectories are set out in the main Plan document and the Executive Summary.

With regard to the areas for essential improvement, the description of the regional work on the stroke pathway to support the HASU has been strengthened. The description of our plans for service remodelling in mental health and general services have also been strengthened and the numbers of beds clarified. In 2017/18 the baseline reduction has been 97 beds across mental health and general services, with a reduction of up to a further 145 beds planned in 2018/19.

3.5 Workforce

The Workforce sections in both the Plan and narrative appendices have been redrafted in line with the Welsh Government feedback and further advice that was received separately from the Head of Workforce Strategy and Planning in the national Workforce, Education and development Service (WEDS). A strategic statement is now also included in the Foreword and more detail on organisational development is included in the Annual Plan document.

3.6 Capital

Our capital plan has been prioritised to support a number of aims; enabling the improvements required across the Targeted Intervention areas as part of our Recovery and Sustainability Programme, continuing to maintain and modernise the estate and replace clinical equipment, and accelerating strategic developments linked to local and regional service transformation and sustainability. The final draft capital plan is included.

3.7 Financial Plan

Further to the Board's consideration of the Final Draft Annual Plan, the 2018/19 Financial Plan has been revised to reflect the feedback from Welsh Government, which included additional analysis and queries received separately from the Welsh Government Finance Team, and the additional work undertaken by the Recovery and Sustainability Programme and Finance Team in this intervening period.

The Welsh Government feedback noted that:

- We are underselling the good work and positive progress made in 2017/18;
- There was not sufficient assurance around the delivery of savings;
- Noting the improvement in the 2017/18 forecast outturn, asking whether there would be further improvements in the Health Board's carried forward deficit;
- The need to expand the supporting information provided and ensure consistency between the narrative and financial appendices.

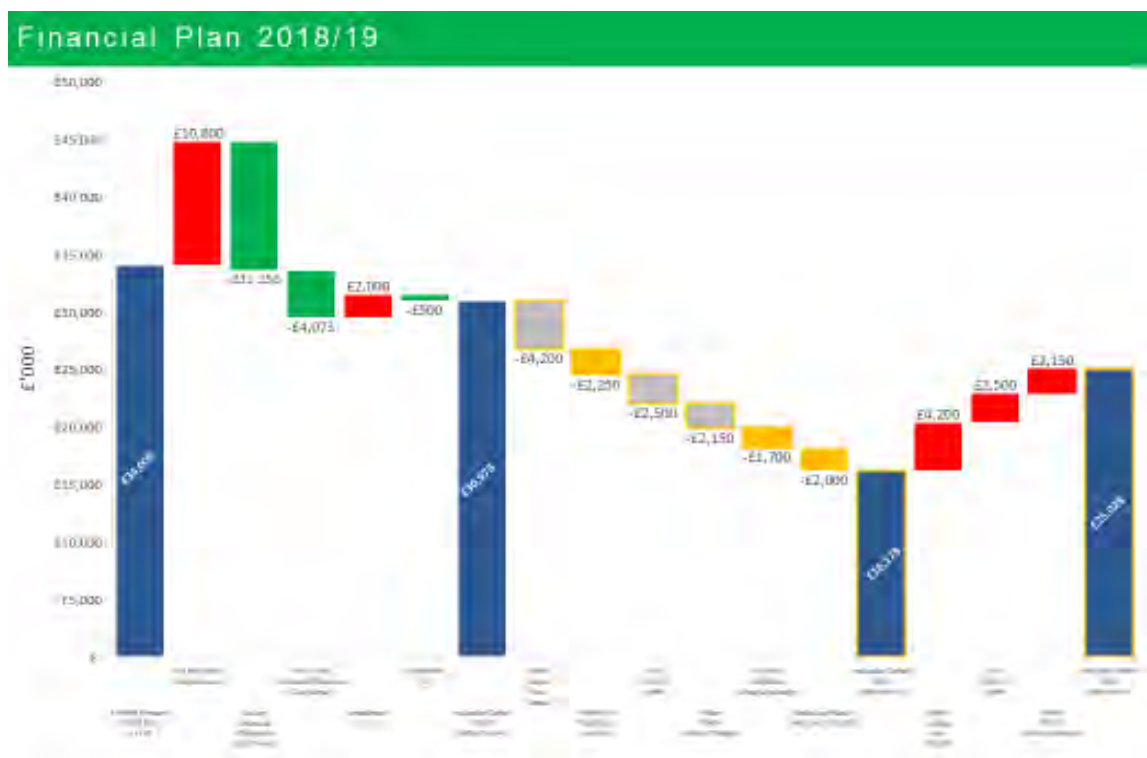
The changes to the Recovery and Sustainability Programme are captured in more detail below. However a key area to highlight from a financial planning and management perspective is that the Programme has been refreshed and its workstreams realigned to directly support each of the savings areas within the 2018/19 Financial Plan. This is intended to provide:

- greater transparency around accountability and delivery responsibility, with assigned Executive leads;
- assurance around the granularity, realism and deliverability of action plans;
- greater and ongoing visibility around progress and monitoring, including financial savings; quality, safety and performance impact; and wider benefits realisation; and,
- an escalation mechanism when delivery trajectories are not being met, to include recovery actions and remedial plans.

The Recovery and Sustainability work streams have been required to produce initial project outline documents to demonstrate the key actions and activities to be progressed to deliver the required financial savings. These have then been tested with each workstream's Executive lead to inform a delivery confidence assessment for each area.

3.7.1 Revised Financial Plan

On the basis of the above, the 2018/19 Financial Plan has been revised to show a deficit of £25m. This is an increase of £6m from the Draft Financial plan previously considered by the Board, but will still provide a material improvement of 26% in the forecast outturn deficit from the start of the year.



The key changes are:

- The Bridgend Service change opportunities (£2.150m) have been removed as in light of the potential Bridgend population transfer the proposed service changes are unlikely to be taken forward.
- The service redesign plans are not ready for implementation from April and the planned impact has been reduced by ¼ for 2018-19, requiring implementation from Q2. (£1.607m reduction)
- The ring-fenced service review impact is still being formulated and the impact has been reduced by a third in the 2018-19 plan. (£1.250m reduction)
- The workforce redesign impact will take some time to deliver and the impact on the 2018-19 impact has been amended to reflect delivery from P6. (£0.800m reduction).

It should be noted that the achievement of the year end forecast will require all other work streams will need to deliver their savings requirements in full.

3.7.2 Key Financial Assumptions

These remain largely unchanged from the Draft Plan and are shown below, but with further detail now included around the recent pay awards and Welsh Government funding to support planned care delivery:

- Recurrent savings from the current year are now captured at full year effect in the £34m carried forward deficit – these include service redesign savings which have not yet been implemented;
- The savings to be achieved in 2018/19 are shown at a full year impact, with the exception of the recent amendments to the Financial Plan as described above;
- Growth in demand will be fully absorbed by Delivery Units;
- Pay inflation is funded at 1%. Noting the A4C pay agreement reached in England on 21 March, we are assuming any agreement in Wales will be fully funded by Welsh Government. We are also assuming that the recently agreed changes to the GMS Contract will be fully funded by Welsh Government;
- No funding is earmarked for any additional costs of adherence to the Nursing Staffing Act ,and,
- As reflected in the Planned Care Service Improvement Plan, the positive progress in performance is predicated on additional investment throughout the year. This financial plan assumes £2m of internal investment to support improvement in Quarter 1, and a further £7m of funding from Welsh Government. We have not assumed any other additional income from Welsh Government at present in relation to the £168m that has not yet been allocated.

3.7.3 Underlying Deficit

In responding to the Welsh Government query around the carried forward deficit, our assessment that the opening position of £34m remains accurate given the level of non-recurrent benefit that has delivered the improvement in the current year's outturn. The Financial Plan also provides further detail on the underlying deficit. While there are a number of ways to analyse this, the following table shows where we have targeted investment over recent years in response to operating pressures.

Underlying Position Review	£m	Commentary
Unscheduled Care	12.0	Enhanced capacity, CEPOD, A&E staffing, discharge & therapy support to support service demand changes and patient flow

Underlying Position Review	£m	Commentary
Medical Staff Service Sustainability	5.5	Costs incurred to support the sustainability of current models of service and the Deanery training grade rota requirements. The key services impact are obstetrics & gynaecology, paediatrics, surgery, cardiothoracic and anaesthetics
Planned Care	9.0	Planned £9m spend to improve planned care performance. £7m of this has been invested in recurrent services eg theatre staffing, Morriston Trauma Assessment Unit, additional consultants, Musculoskeletal Clinical Assessment Service, diagnostics, orthopaedics sustainable plan, anaesthetic cover, Singleton Resident Medical Officer Model
Nurse Staffing	3.5	Additional nurse staffing to meet CNO guiding principles, additional critical care capacity & improved assessment unit capacity
Quality & Safety	1.0	Enhanced cleaning and catering staff & other infection control support
Management Structures	2.0	The Health Board organisational structures were changed as a response to the Andrews Report, Trusted to Care. These new structures provide enhanced leadership and visibility of management at each of the hospital sites and also enhanced clinical leadership and engagement through the triuneverate and clinical management structures
Informatics	1.0	Increasing licensing costs due to changes in licencing arrangements and increasing use of technology
Reported Underlying Position	34.0	

3.7.4 Delivery

The Recovery and Sustainability work streams will develop implementation plans and monitor the delivery of savings. In terms of translating the Financial Plan and savings requirements into budgets, we have changed our approach to budget setting. Key changes include:

- The rebasing of budgets to reflect the underlying deficit of £34m and moving away from traditional CIPs, allocating savings to where they are planned to materialize. This exercise has completed and initial allocations have now been shared with Units;
- Undertaking a revised approach to budget delegation and accountability, with delegation letters to issue from the Chief Executive by the end of March which will include expectations around financial, performance and workforce deliverables;
- Changing the way we manage reserves to reflect the policy signed off by the Performance and Finance Committee in January, which will allow for greater clarity on the central reserves and contingency being held centrally.

In addition, we are strengthening the internal financial reporting and governance processes. While the assurance frameworks for the Annual Plan and the Recovery and Sustainability Programme are detailed elsewhere, of particular note in relation to financial performance and grip:

- There are named finance leads assigned to each Recovery and Sustainability work stream to provide professional advice, financial analysis and scrutiny;
- The fortnightly financial recovery meetings with Units and corporate functions instigated in 2017/18 will remain and will continue to be led by the Director of Finance. These will include consolidated meetings with the Chief Operating Officer to consider performance on an alternating basis;
- A monthly Recovery and Sustainability Programme Board, which will assess delivery against milestones, risk management and escalation/remedial actions;
- The continuing use of the savings financial tracker, which monitors progress against delivery on a weekly basis;
- The introduction of a benefits monitoring tool to complement the savings tracker. This will report and monitor the non-financial benefits associated with all revenue and capital investments, to ensure that success and impact are reviewed and evaluated.

3.7.5 Key Delivery Risks

- Good progress has been made in stabilising and reducing the underlying position. However, this needs to continue from 1 April 2018 with no bounce back in pay and non-pay run rates;
- Ownership and recognition of rebased budgets by budget holders, and buy in to the scale of the ask;
- The ability of Units to deliver savings achieved in the current year recurrently, as some of these have only been part delivered or not delivered to date. These savings are assumed in the carried forward underlying position and our monitoring in the first quarter next year will need to ensure that run rates are at least maintained and there is no creep upwards in spend;
- The ability of Units to absorb any unfunded inflation and demand growth;
- The phasing of new savings delivery will be key, as the Financial Plan assumes a full year impact. This will be an issue for all Units and Workstreams and will need to include the identification of mitigating opportunities;
- Resourcing of the Recovery and Sustainability Programme and other key organisational developments. This requirement comes in the context of a requirement for the Corporate functions to deliver £1m of savings next year.

The key risk at this stage, however, remains as the requirement for detailed implementation plans for each savings area and for early action to be driven out at the start of next year to provide traction for delivery. While some work streams are making good and sustained progress, others are not as advanced and will require targeted focus and support over the next month to ensure that robust plans materialise.

The level of delivery confidence was discussed in detail at the Performance and Finance Committee on 21st March 2018. While further analysis is provided in the context of the Recovery and Sustainability Programme below, we are not able to provide full assurance at this point around the savings delivery from each work stream. We have made changes to the Financial

Plan based on our assessment of risk, with the particular challenges around work force redesign, some areas of service remodelling and mental health services being reflected in revised (reduced) savings requirements.

In terms of next steps, all work streams are required to produce weekly action plans for Q1. These are required to be in place for the next Recovery and Sustainability Programme Board in April, and the meeting will provide an opportunity for peer review and for further risk management arrangements/ actions to be agreed.

A summary assessment of the overall financial risks and opportunities are shown below. There will be a heightened focus in Q1 on the Unit/ Corporate financial performance reports and saving trackers, with a formal review at the end of each month. A suite of mitigating actions that can be deployed is being agreed and an update will be provided on this at the Board meeting.

2018/19 Financial Plan – Risks & Opportunities

Potential Risks & Opportunities	2018/19	
	Worst Case	Best Case
	£'000	£'000
Current Reported Financial Plan Outturn	-25028	-25028
Risks (negative values)		
Pay Negotiations above 1% not included in Financial Plan	TBC	
ChC Ombudsman full impact	-1,900	
Savings not delivered as planned	-5,000	
Operational Expenditure reductions not maintained	-2,000	
Total Risks	-8,900	0
Opportunities (positive values) (record value consistently and in both Worst and Best columns)		
Non Recurrent Benefits	2,000	4,000
Total Opportunities	2,000	4,000
Total Amended Forecast Plan Outturn Surplus/(Deficit)	(31,928)	(21,028)

The key risks & opportunities within the 2018/19 Financial Plan are:

- Pay negotiations agreeing an uplift above the 1% included within the financial plan. This has not been quantified by 1% is around £6.5m.
- The financial plan includes £1.5m for the settlement of ChC Ombudsman Phase 3 claims. If all claims are settled in 2018/19 in full then the impact could be above that included in the plan.
- Whilst an element of savings slippage has been included in the adjusted 2018/19 in-year plan, there is the potential for further slippage.
- Operational expenditure reductions reported in 2017/18 may not be sustained. It is essential that financial controls are maintained.
- Non-Recurrent benefits are recorded each year, these are often used to offset unforeseen cost pressures.

3.8 Recovery and Sustainability

As set out in the letter to Welsh Government in February, at the time of submission of the Final Draft Annual Plan, work was ongoing to reshape the Recovery and Sustainability Programme to support delivery and to achieve the aims of the Plan. The scope of the Programme has been broadened to reflect the nature of the Board's Targeted Intervention status. It was also agreed that it will focus on a smaller number of critical work streams aligned with the financial plan and should increasingly focus on a transformational programme, rather than 'business as usual'. It is likely that the 2018/19 will be a transition year in this respect, as there still remains a need to focus on transactional opportunities in a number of areas. All of the Recovery and Sustainability Workstreams are aligned with the financial plan and financial waterfall diagram areas.

The following table sets out the Workstreams as described in the Annual Plan including the Senior Responsible Owners (SROs) and key work packages:

Work Stream	Key Deliverables	Senior Responsible Owner
Workforce Delivery	- Reducing variable pay by 10% focusing on premium cost areas - Roll out of e-rostering and review of junior doctors rotas - Sickness management - Implementation of Invest to Save scheme to improve staff health and well being - Vacancy control - Recruitment strategy	Director of Workforce & OD
Workforce Redesign	- New workforce roles including role substitution in difficult to recruit areas - Skill mix opportunities in all clinical support areas - Efficiency through digital mobilisation - Opportunities for restructuring in critical areas - Optimised use of clinical workforce (Carter report)	Director of Therapies & Health Sciences
Service Remodelling	- New frailty models across the Health Board in line with Parliamentary Review - Service remodelling in Mental Health Services - Service remodelling in Learning Disabilities - Other service changes identified by individual units (including remodeling surgical care at Morriston)	Director of Strategy
Value Based Procurement	- Extending QVC (Quality, Value, Control) into clinical goods - Improved theatre stock utilisation and business case for Just-in-time stock management system - Enterprise car scheme - National Efficiency, Healthcare Value and Improvement Group areas - Areas of devolved spending eg. catering - Procurement compliance - Oxygen Scheme - Other opportunities identified in Carter review	Director of Finance
Mental Health Spending	- Reviewing spending on mental health services focussing on opportunities for delivering improved outcomes at lower cost - Secondary care prescribing	Director of Public Health

Work Stream	Key Deliverables	Senior Responsible Owner
Medicines Management	• Cost effective prescribing through use of biosimilar medicines (high cost drugs) • Switch of generic antiretroviral products through all Wales contract • Extending provision of medicines via Homecare • Potential business case (invest to save) in Cancer Services	Clinical Director for Pharmacy & Medicines Management
Reduction in waste, harm and variation	• Establishing a transformational programme to develop Value Based Healthcare (VBHC) incorporating prudent health care, pathway redesign and outcome collection • Opportunities for reducing cost in interventions that are classified as not normally funded (INNU) or Do not Do's identified by the National Institute for Clinical Excellence	Medical Director
Unit Cost Down	• Identifying opportunities for more traditional areas of cost improvement or income generation • Workforce delivery savings will directly benefit service delivery units	Service Directors

In addition to assuring delivery of the Workstreams, the Recovery and Sustainability Programme Board will oversee delivery across all targeted intervention areas which have been realigned to fit with Executive Director portfolios. Health Board-wide Improvement Boards will oversee a transformational approach to performance improvement across:

- Planned care
- Unscheduled Care and Stroke
- Cancer.

Detailed action to improve the Health Board's performance in reducing Healthcare Acquired Infections (HCAI) will continue to be delivered through the Infection Control Committee with assurance via the Quality and Safety Committee. Exception reports will come through the Recovery and Sustainability Programme Board to ensure system-wide overview of risk and delivery issues. The outpatient and theatres work stream will now report to the planned care board, and work from the patient flow work stream will be subsumed into the unscheduled care programme.

The Performance and Finance Committee (PFC) will provide Board assurance on delivery against all targeted intervention areas and there will be a standing update to the PFC on Recovery and Sustainability Programme delivery monthly. A risk register has been developed to support the identification and management of key risks to delivery both at an individual work stream level and Programme wide.

All SROs have been asked to complete a project outline document which sets out the scope, products, milestones and risks for their respective areas. A delivery assessment has been undertaken at the Recovery and Sustainability Board and was reported to the Performance and Finance Committee on 21st March 2018.

At this point, it is not possible to provide full assurance that the programme will deliver the totality of savings required. Further work is required to identify robust and detailed plans in a number of areas including workforce redesign; reducing waste, harm and variation; service remodelling (where gaps are identified); workforce delivery and mental health services. Executive Leads for these areas have been asked to provide a weekly update on progress in developing plans prior to the next Recovery and Sustainability Programme Board in April. Risk in these areas is being continually assessed, and contingency plans will be required to mitigate the impact of non-delivery.

3.9 Annual Plan Delivery Assurance

The Vice-Chair and Non-Officer Member with the lead for Finance have given advice about the assurance of the Plan that was expected before Board. As a result:

- The Performance and Finance Committee has, on behalf of the Board, assured the performance trajectories, delivery confidence and financial plan;
- The Executive Team has formally approved the Plan for submission to Board; and,
- The assurance arrangements for the delivery of the Plan are clearly set out.

The monitoring of the delivery of the Annual Plan will be the responsibility of the Finance and Performance Committee on behalf of the Board with escalation levels as set out below.

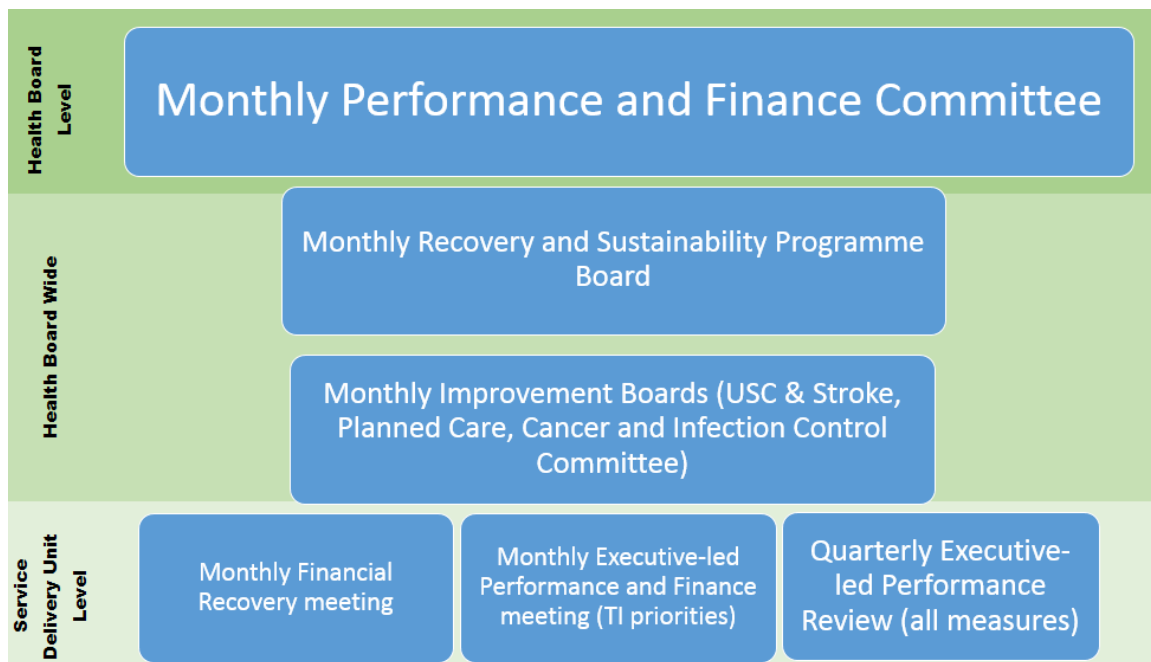
Stage 1 – Discussion, Review and Scrutiny. This is the Committee's everyday practice. In this stage the Chair of the committee will make known any concerns to the Chief Executive who will ensure that there is clear accountability and delivery by the Executive Team.

Stage 2 – Recovery Plan. The Committee requires the responsible Director to set out a plan and a profile to recover the performance and hit the target.

Stage 3 – If the Recovery Plan is not delivered to target or the profile is missed, the Committee will require the Director to attend each meeting and account for the management of the issue until it is resolved. At this stage the Chair of the Committee will raise the concerns directly to the Chief Executive.

Stage 4 – Continued poor performance will be formally referred to the Chairman and Chief Executive in order that the matter becomes a Board issue.

Below the Finance and Performance Committee, assurance will be provided at both a Service Delivery Unit and Health Board-wide level as shown in the diagram below.



In addition, the routine business of the Executive Team will receive and scrutinise in-week trajectories of performance for each service improvement plan area. The delivery of the Annual Plan as a whole will be reported quarterly by the Health Board, with reports forwarded to Welsh Government for assurance purposes.

4.0 Recommendations

The Health Board is asked to:-

- Note that the Annual Plan documents have been amended following completion of the further work required after submission of the Final Draft Annual and in response to feedback from Welsh Government;
- Note that the Annual Plan has been approved by the Executive Team and the performance trajectories and financial plan have been assured by the Performance and Finance Committee for submission to the Board; and,
- Approve the Annual Plan and supporting documentation for submission to Welsh Government.



GIG
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Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board



ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

Annual Plan 2018/19

Executive Summary

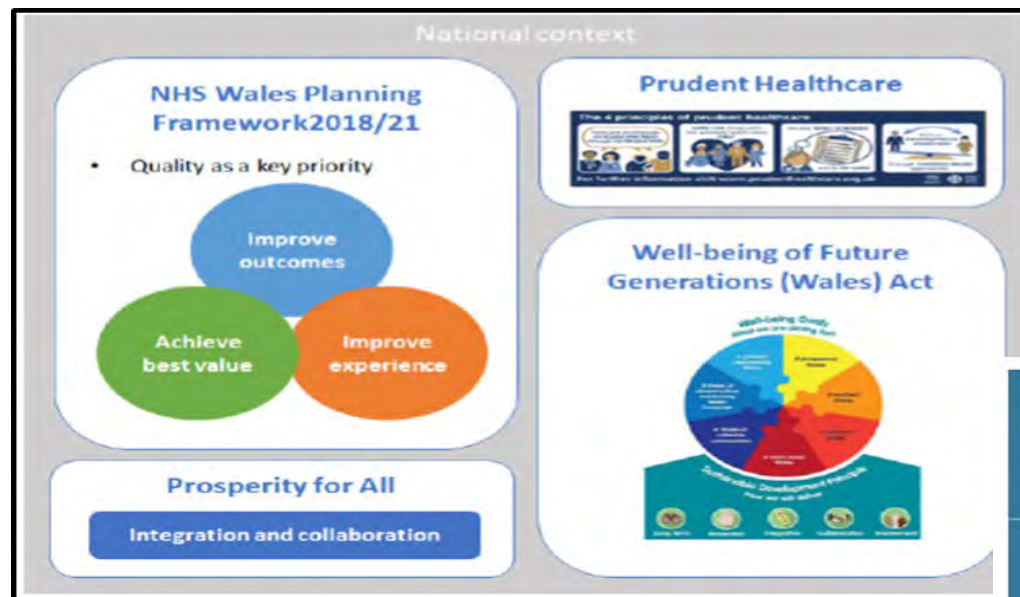


Strategic Context

Our Annual Plan has been developed within the national, regional and local health and care Strategic Context, including Prosperity for All, the Parliamentary Review of Health and Social Care, our Wellbeing and Area Plans developed through the Western Bay Regional Partnership Board and our regional planning work with Hywel Dda UHB and the ARCH Programme.

The Plan is designed to meet the challenges of demographic changes and health inequalities in the population we serve; to support the sustainability of primary care and promote a model of care which supports care 'Closer to Home' and address the imbalance in demand and capacity in our system. This context leads to significant performance, workforce and financial challenges which ultimately impact on the quality of services. We also need to update our Clinical Strategy and develop an Organisational Strategy to provide a clear strategic direction for the Health Board.

We intend this Plan to form the bridge to enable the Health Board to develop an Integrated Medium Term Plan and represents the start of our improvement drive through 2018/19 onwards.



Progress in 2017/18

Our plan is based on our achievements in 2017/18. We have made good progress on our Quality priorities to reduce the number of pressure ulcers and falls, our primary care access is improving and we largely comply with the Mental Health Measure. There are signs of resilience emerging in our unscheduled care system and we are on track to achieve the waiting times targets for diagnostics, therapies and outpatients.

We have more work to do to stabilise our workforce and to improve our unscheduled care performance, 36-week waiting times and cancer performance and reduce our infection rates. Our Plan for 2018/19 shows how we will do this.

We have stabilised our financial situation in 2017/18 and we are on track to achieve a figure below our financial control total. This has been supported by our Recovery and Sustainability Programme which will continue to underpin our work to further reduce our deficit in 2018/19.

Promoting and Enabling Healthier Communities

- Published our Children and Young People's Strategy
- Violence Against Women Domestic Abuse and Sexual Violence Act embedded
- Wellbeing Objectives agreed and Wellbeing and Area Plans in development
- Health Inequalities and low adherence to a healthy lifestyle remain
- New approach to tackling our challenges at scale, mobilising all of our workforce agreed
- Ongoing work to improve against our prevention priorities of vaccinations and immunisations, smoking cessation and obesity / physical activity

Securing a Fully Engaged and Skilled Workforce

- Our workforce challenges are a key driver of our financial and sustainability challenges
- Staff Engagement and Nursing and Midwifery Strategies approved
- We still have circa 800wte vacancies which is a key driver of our financial and sustainability challenges Nursing turnover is highest at over 9%, although it has reduced recently.
- Despite an initial improvement over the last 12 months, the sickness absence rate has started to increase again and is above target.

POSITION IN 2017/18

Delivering Excellent Patient Outcomes, Experience and Access

- The numbers of falls have decreased significantly in year.
- Our Universal Mortality Review performance is the best in Wales.
- Launched our Older Persons Charter
- Our Primary Care measures of access are improving and we largely comply with the Mental Health measures.
- We are continuing our work to roll out PREMs and PROMs
- **Unscheduled Care** - there was good progress with improving performance in the first 6 months of the year, particularly at Morriston, however performance has since deteriorated reflecting an increasing length of stay and numbers of Delayed Transfers of Care.
- **Stroke** - performance is on-track for the majority of the measures apart from the 4-hour bundle and thrombolysis.
- **Planned Care** - the Health Board is on target to meet the agreed trajectories for Outpatients, 52-week waits, Diagnostics and Therapies. Challenges remain in meeting the target for 36-week waits.
- **Cancer** – the non Urgent Suspected Cancer (nUSC) target is largely being met but the Health Board is off-track against the USC trajectory and a renewed performance improvement management regime has been put in place.
- **Health Care Acquired Infections (HCAIs)** - Numbers of c. difficile cases have risen in year and are above trajectory. We were on-track against the Staph. aureus trajectory until November when cases started to rise and the number of E. coli cases has steadily increased in year.

Demonstrating Value and Sustainability

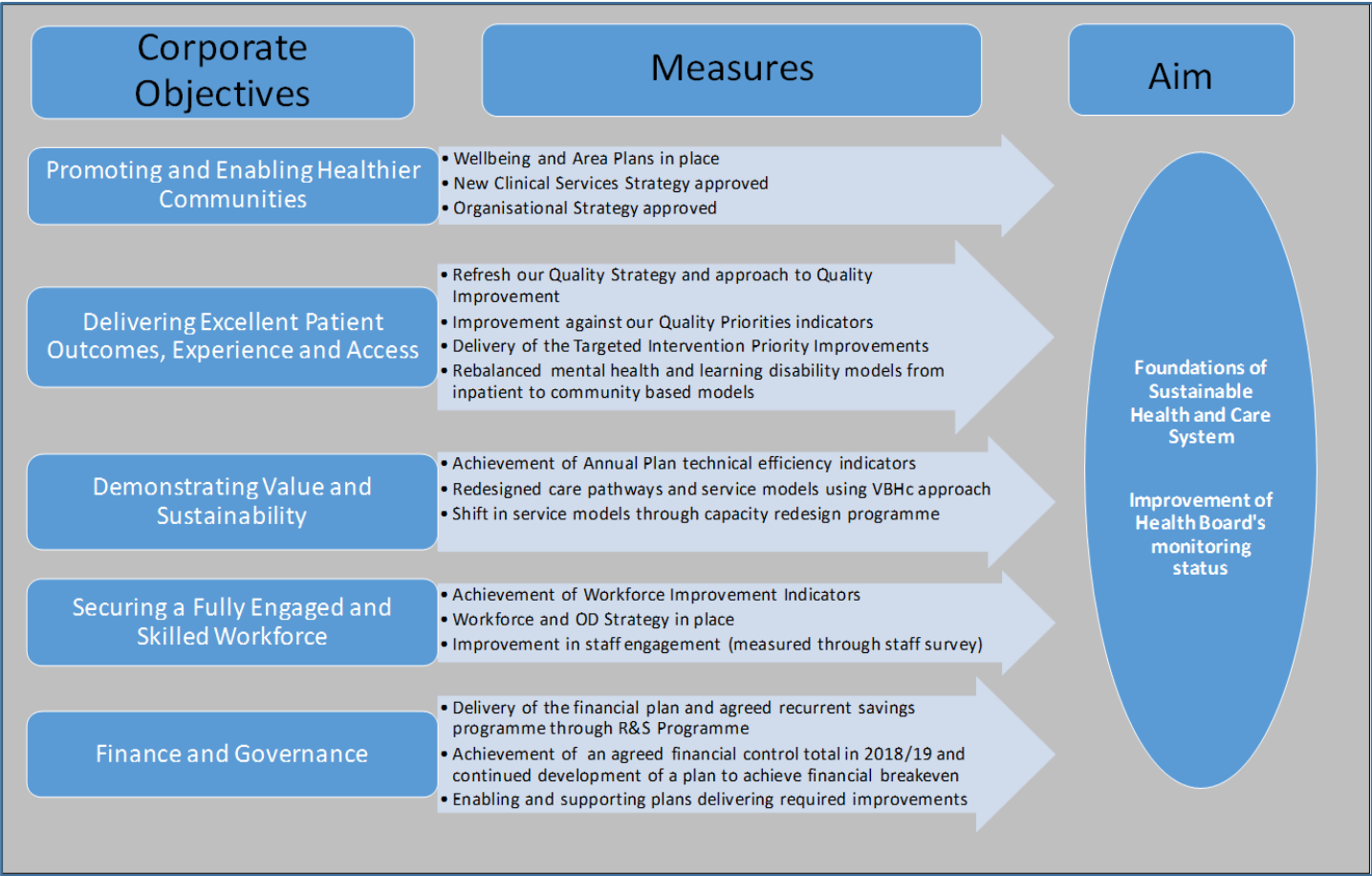
- Financial plan forecast remains on track to achieve a figure below our financial control total
- The Recovery and Sustainability (R&S) Programme is established with cross-cutting Workstreams
- Programme of Service Remodelling has delivered significant change in 2017/18 – plans in place to rebalance care into the community in acute, community and mental health services
- Service redesign using Value-Based Healthcare (VBHC) approach underway and been tested externally
- Primary and Community Services Strategy approved
- Draft Strategic Framework for adult Mental Health agreed

Embedding Effective Governance and Partnerships

- The Health Board remains in Targeted Intervention Status
- Implementation of the Deloitte's Governance Review is proceeding
- Regional Planning and Delivery mechanisms established through JRPDC
- Discharge process standards agreed through Western Bay
- Wellbeing and Area Plans on track to being agreed

Corporate Objectives and Aim of our Annual Plan

The aim of our Annual Plan is to put in place the foundations of a sustainable health and care system for our population. We also want to improve our Welsh Government monitoring status. We will do this through clear actions to achieve our Corporate Objectives and will use the measures of success shown in the chart.



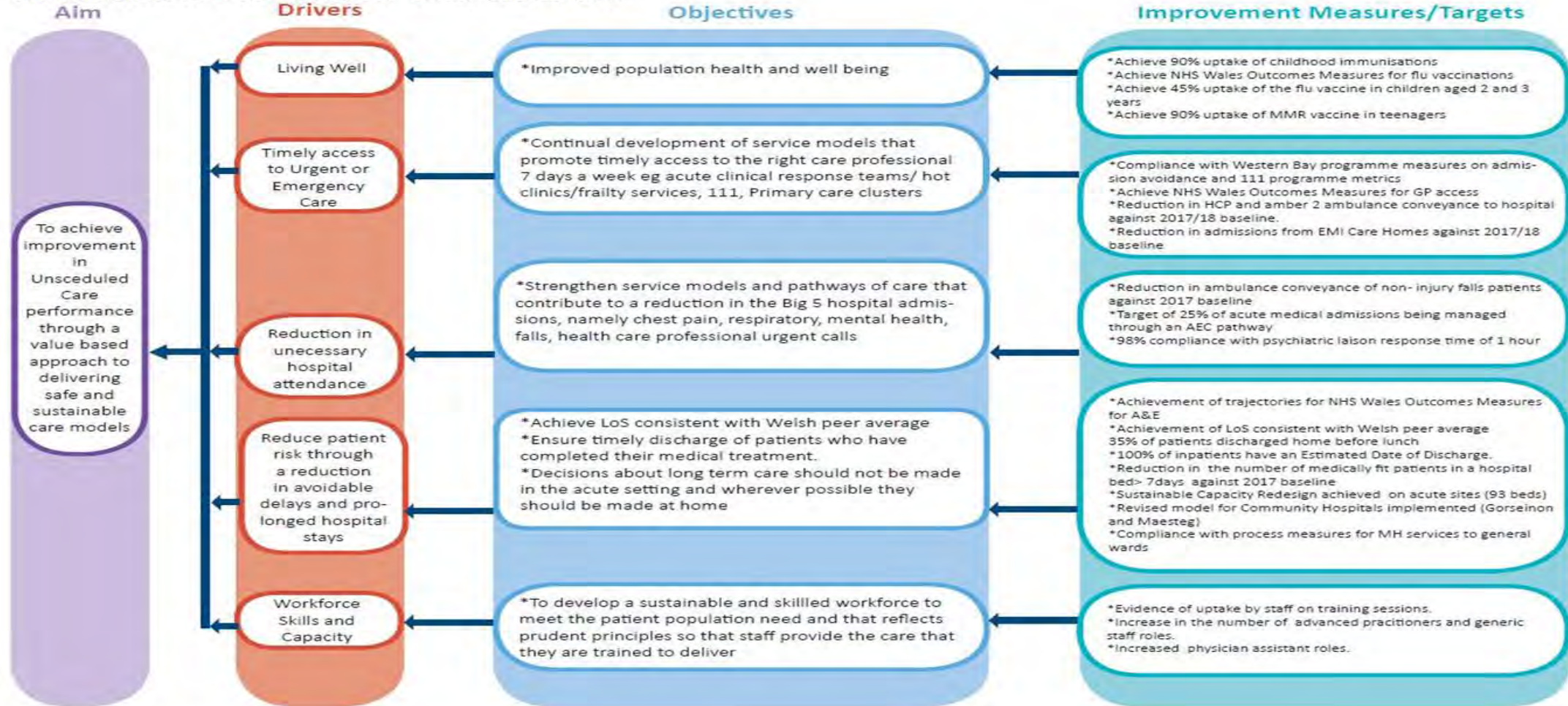
Demonstrating Value and Sustainability

Our Annual Plan is based on using our existing resources more effectively and we will demonstrate value and sustainability.

- ❖ Using Value Based Healthcare as an underpinning approach.
- ❖ Having a clear view of the System Demand / Capacity required to achieve sustainability, which will be further developed across the whole system during 2018/19.
- ❖ Using the external and internal benchmarking undertaken over the last 18 months to drive:
 - Technical Efficiency
 - Allocative Efficiency
 - Service Redesign and Pathway Change.
- ❖ Ensuring excellent Assurance and Delivery, underpinned by our Recovery and Sustainability programme.
- ❖ Our Plan is based on having an improving performance through our 5 Service Improvement Plans for our Targeted Improvement priority areas of Unscheduled Care, Stroke, Cancer, Planned Care and Healthcare Acquired Infections.
- ❖ Our Service Improvement Plans lay out the enablers of workforce, revenue, digital and capital infrastructure.

Unscheduled Care Service Improvement Plan

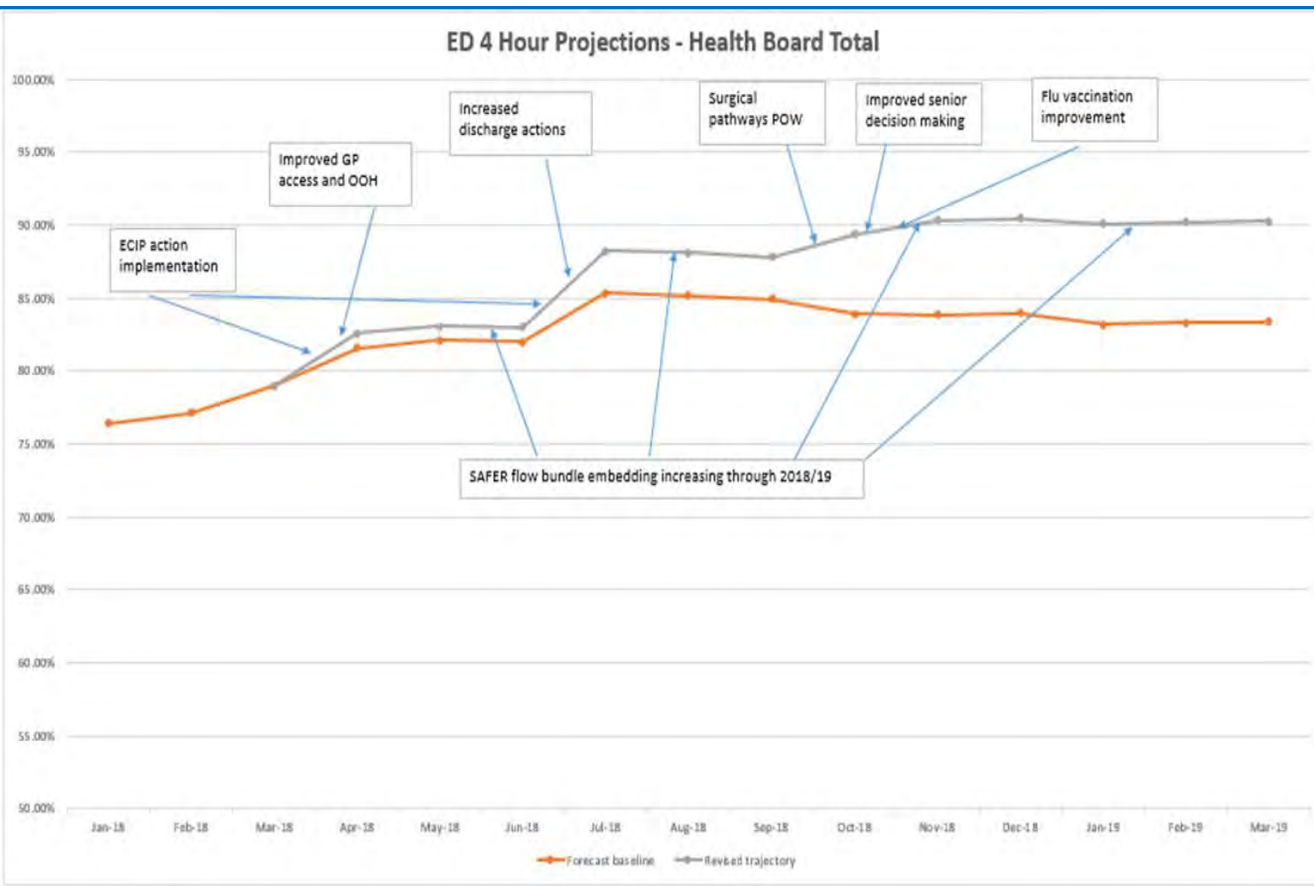
DRIVER DIAGRAM Service Area: Unscheduled Care



Unscheduled Care - Actions to Deliver our Plan

- **Living Well** – prevention actions on smoking, vaccinations and immunisations.
- **Timely access to Urgent Care** – maximise the 111 service and rebalance care to the community through sustainable primary care, Community Resource Teams and intermediate care.
- **Reduction in Hospital Attendance** – maximise Ambulatory Emergency Care (AEC) and reduce conveyances of falls to hospital.
- **Patient Flow** – operational improvement in Emergency Departments, improve frailty services, AEC, change hospital models of care and focus on reducing numbers of medically fit for discharge patients.
- **Capacity Redesign** – reduce our Length of Stay to the Welsh peer group average to underpin closure of further acute and community hospital beds.

Unscheduled Care Trajectories – 4 hour waits



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED	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%	82.6%	83.1%	83.0%	88.3%	88.1%	87.8%	89.4%	90.3%	90.4%	90.1%	90.2%	90.3%

Principal Service Action	Predicted Impact	Start Quarter
Unscheduled Care		
Increasing flu vaccinations for our population and our workforce	1.00%	Q3
Maintaining and improving timely access to primary care in hours and out of hours – telephone first, HUBS, redesign of OOH	0.25%	Q1
Maximising pathways that avoid admission to hospital – WAST, community resource teams, ambulatory emergency care, assessment units, hot clinics	0.25% to 1.25%	Q2
Improving patient flow through increased focus on compliance with safer bundle	0.45% to 1.90%	Q1 ramping up
Developing new integrated models of care to support timely discharge – discharge to assess, transfer of care teams, integrated step down facilities	1.00%	Q2
Improving senior decision making and support 24/7 – ED medical staffing, surgical assessment	1.00%	Q3
Reducing variation / ensuring consistency of the above in all areas	0.30% to 0.50%	Q1 ramping up

USC Trajectories - 12 hr waits and 1 hr Handover

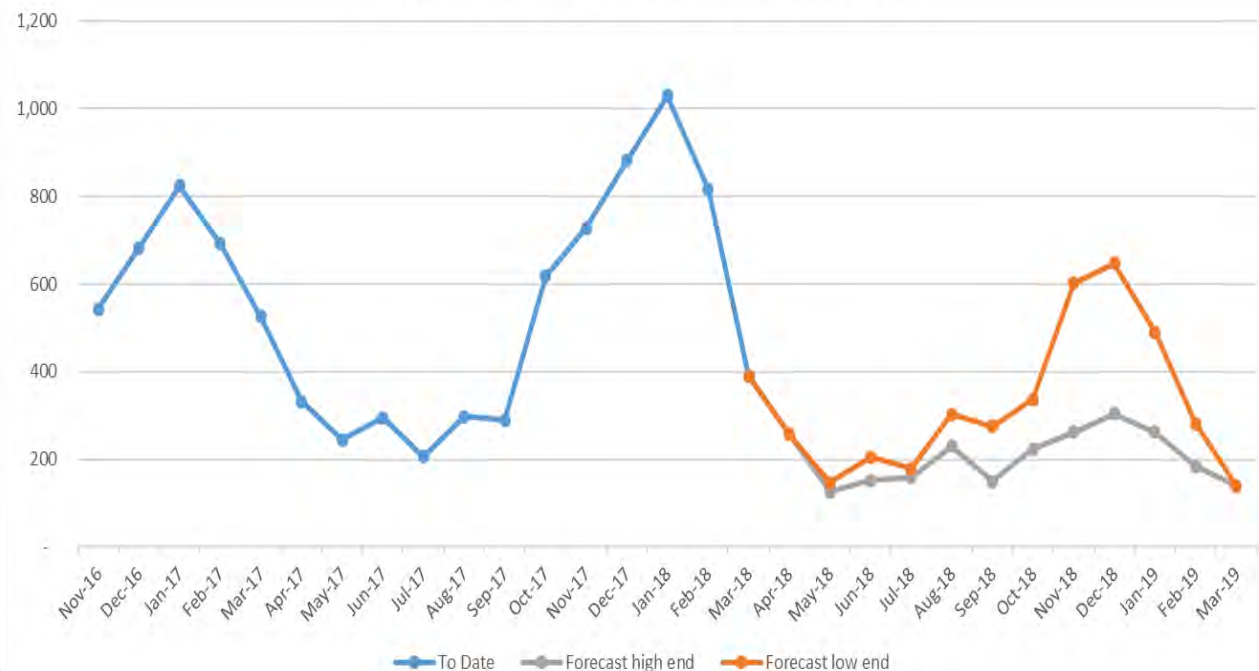
Forecasting total 59.64% reduction in breaches in 2018/19 over 2017/18

12 Hour Projections - Health Board Total



Forecasting total 59.85% reduction in breaches in 2018/19 over 2017/18

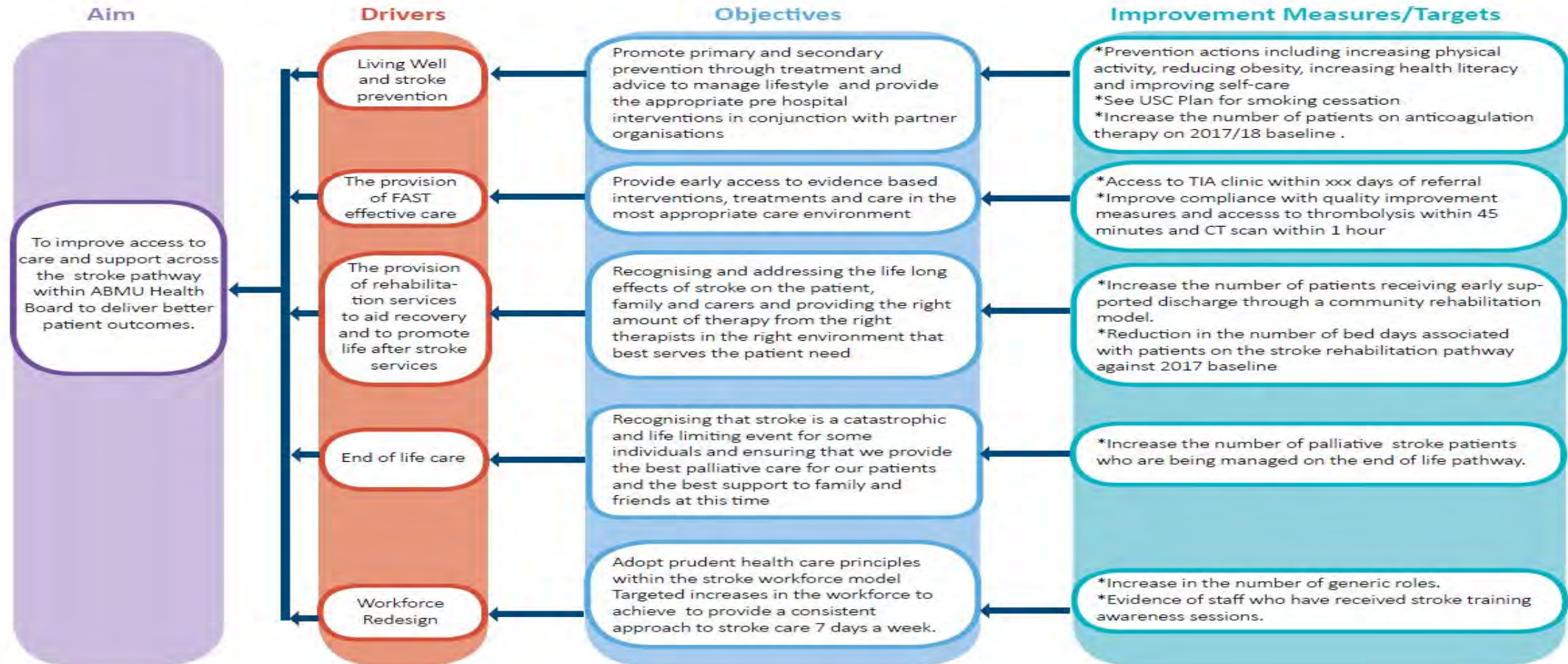
1 Hour Handover Projections - Health Board Total



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED	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	323	194	190	229	227	180	255	315	289	283	196	179
	Number of ambulance handovers over one hour	0	256	126	152	159	229	149	223	262	304	262	183	139

Stroke Service Improvement Plan

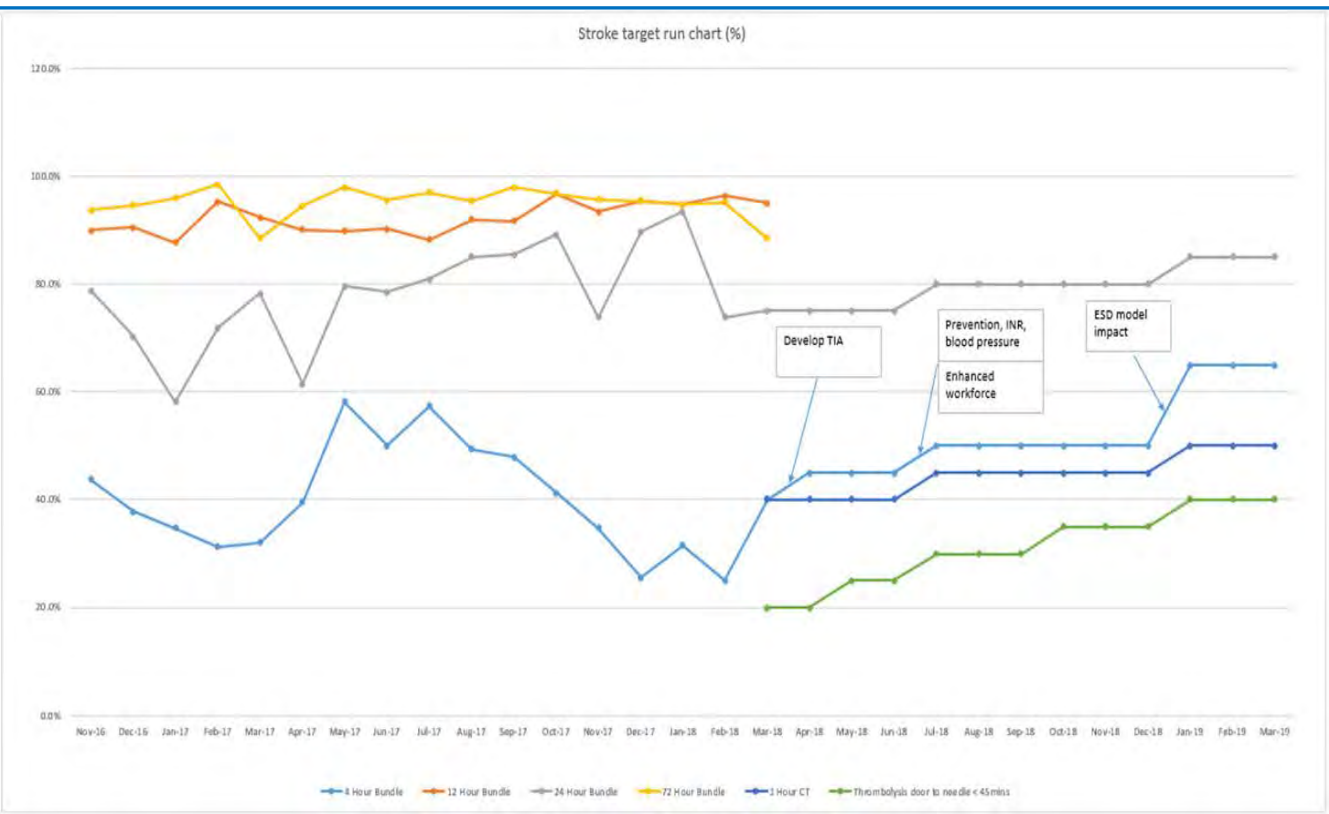
DRIVER DIAGRAM Service Area: Stroke Care



Stroke - Actions to Deliver our Plan

- **Living Well** – prevention actions on smoking and anti-coagulants (through enhanced primary care services).
- **Provision of FAST care** – linked to Unscheduled Care plans. Confirm arrangements for thrombectomy and continue to develop mini-stroke (TIA) service.
- **Rehabilitation** - explore providing Early Supported Discharge through Value-Based Healthcare approach (disinvest to reinvest).
- **End of Life** – maximise use of the End of Life pathway.
- **Workforce** – workforce redesign within resources to expand 7-day cover.
- Hyper-Acute Stroke Unit planning on a regional basis.

Stroke Trajectories

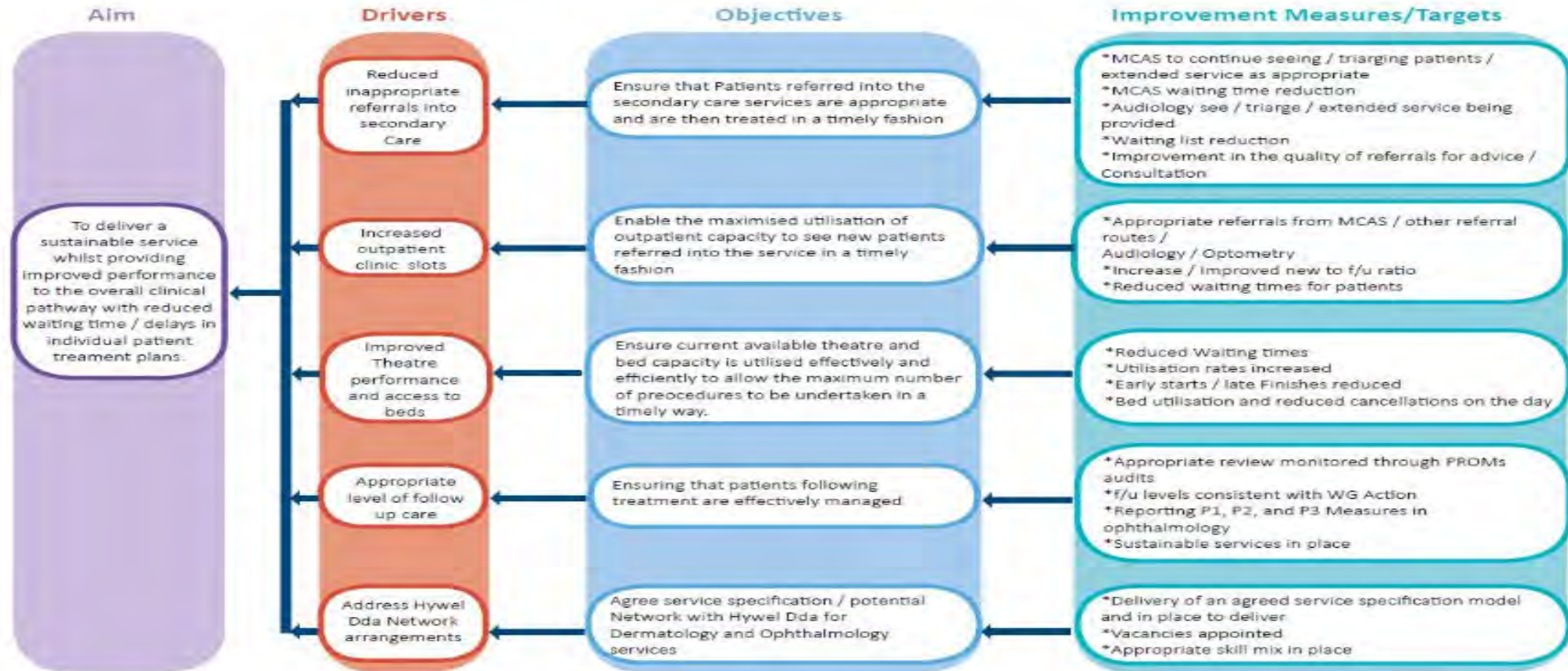


Principal Service Action	Predicted Impact	Start Quarter
Stroke		
Prevention - Improve no of patients on INR through DES in primary care & BHF-funded service for blood pressure reduction	2.50%	Q2
Continue to develop TIA services (all year)	5.00%	Q1
Recruit second SpR at Morriston – improve 4 hour bundle	2.50%	Q2
ESD embedding and full impact	15.00%	Q4

			Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Stroke	% compliance with stroke QIMs:	Direct admission to Acute Stroke Unit (<4 hrs)	The most recent SSNAP UK National quarterly average	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	65.0%	65.0%	65.0%
		CT Scan (<1 hrs)		40.0%	40.0%	40.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%
		Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)		75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	85.0%	85.0%	85.0%
		Thrombolysis door to needle <= 45 mins		20.0%	25.0%	25.0%	30.0%	30.0%	30.0%	35.0%	35.0%	35.0%	40.0%	40.0%	40.0%

Planned Care Service Improvement Plan

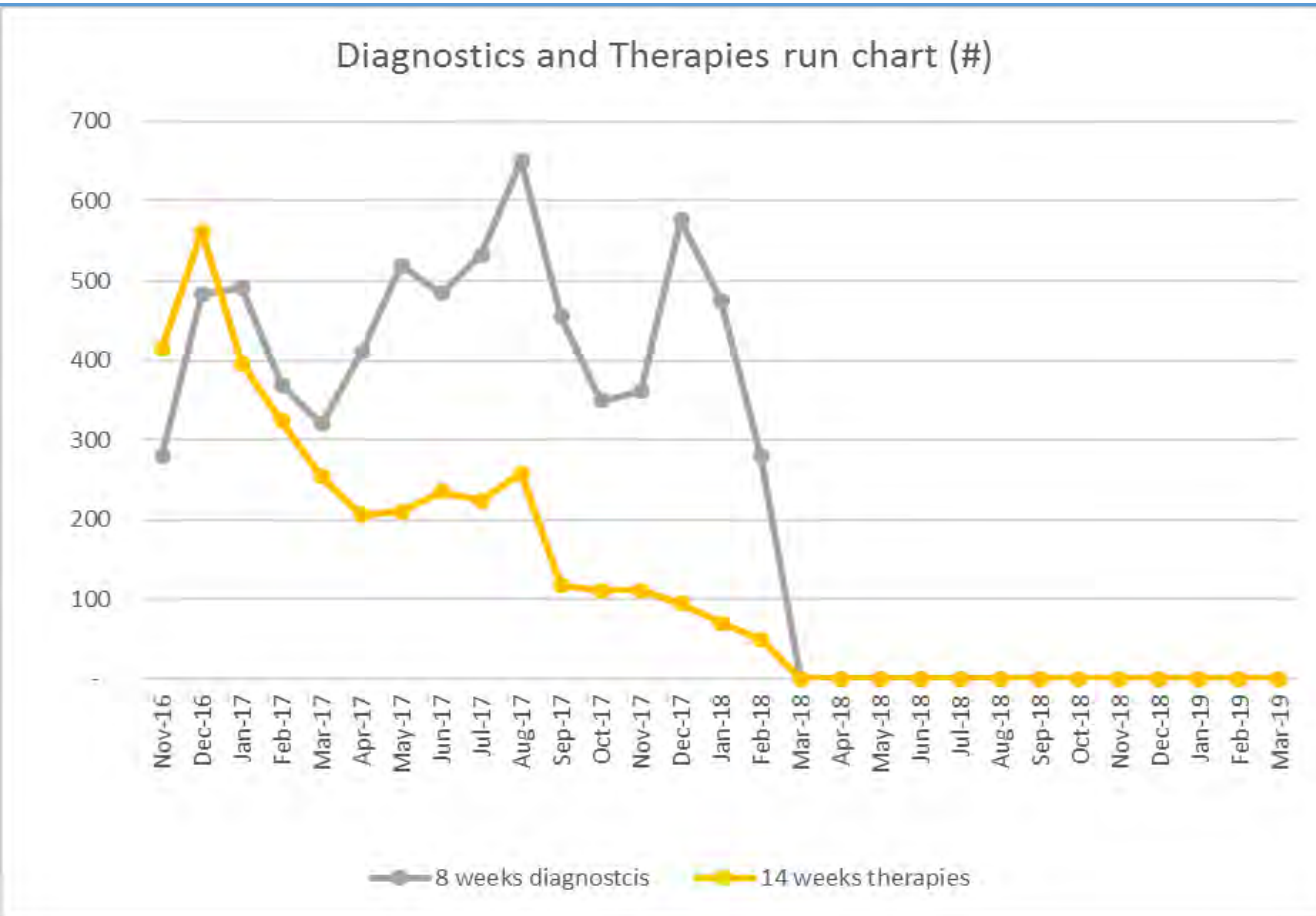
DRIVER DIAGRAM Service Area: Planned Care



Planned Care - Actions to Deliver our Plan

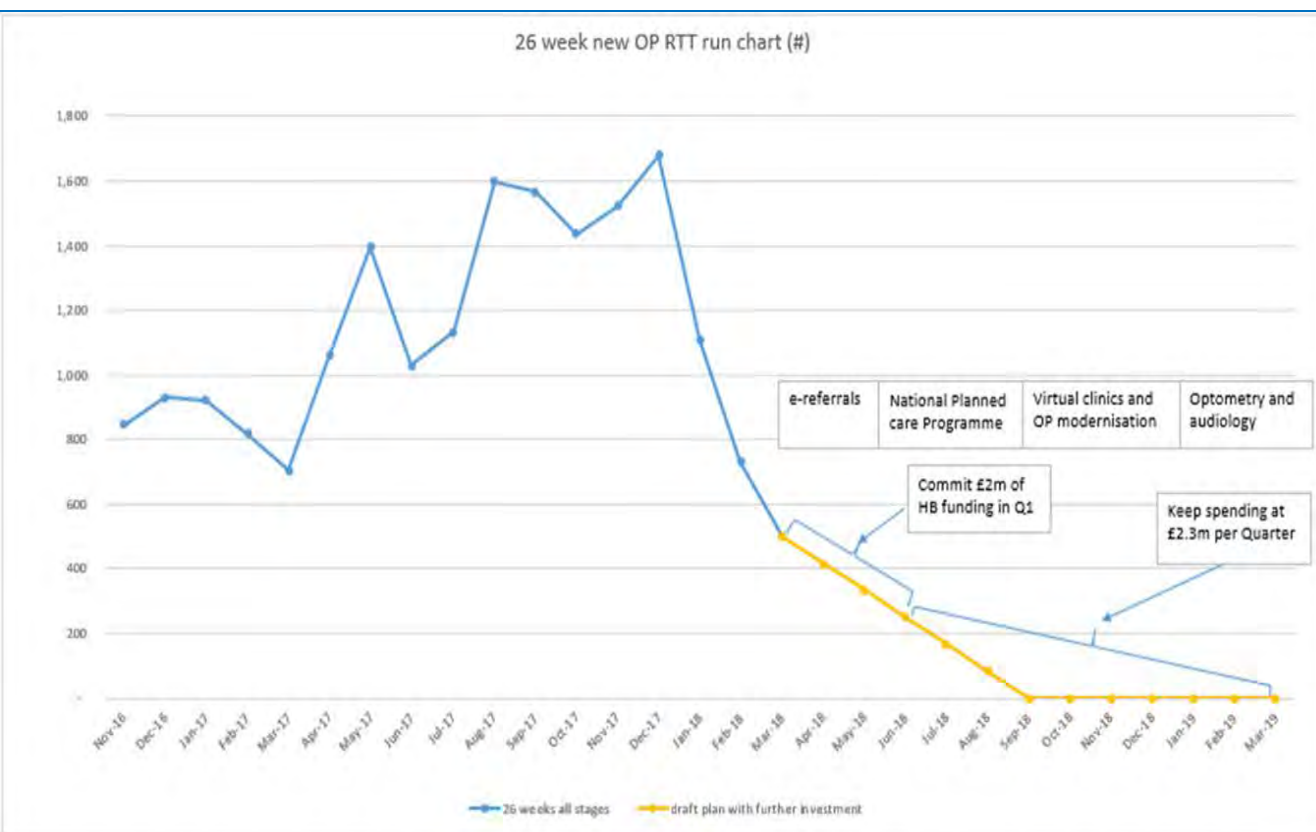
- **Reduced inappropriate referrals** – developing out of hospital care models and clearer referral criteria for use in primary care.
- **Increased outpatient clinic slots** – unsustainable service models (after managed demand) to have sustainable capacity to meet planned care and cancer demand.
- **Improved theatre performance and access to beds** – ensure surgery is carried out on most appropriate physical site and increase the use of technology to move from Inpatient based care to Daycase care.
- **Appropriate levels of follow up care** – implement national planned care programme models, virtual clinics and see-on-symptom models.
- **Hywel Dda UHB service models** – further enhance regional working to develop service specifications for some services and also consider value for money opportunities of jointly commissioned capacity.

Planned Care Trajectories – Diagnostics



- We plan to deliver 0 waits over 8 weeks for diagnostics and 14 weeks for therapies at the end of 2017/18 and continue to hold this position for 2018/19.
- There are currently waiting times in cardiology which are not required to be reported in 2017/18 but which will be reportable in 2018/19. A specific trajectory for those measures is currently being developed.

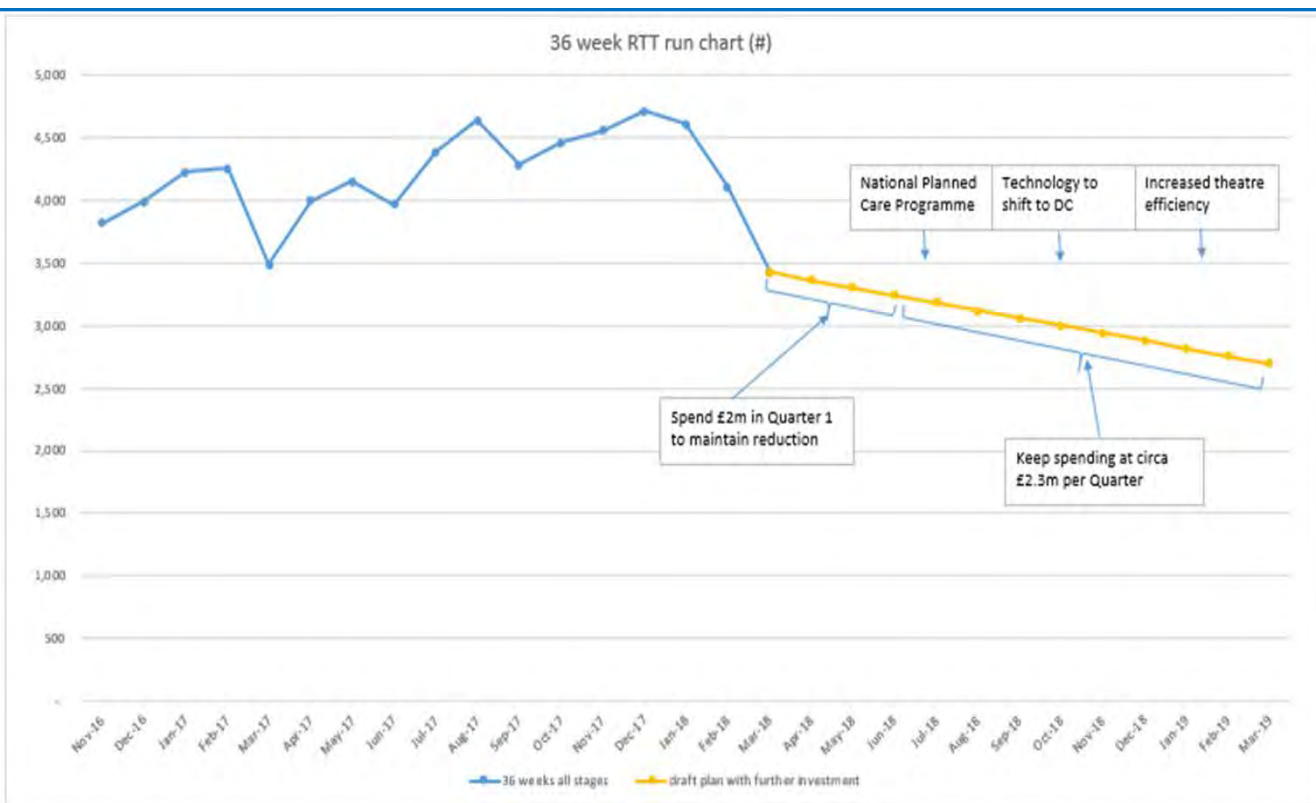
Planned Care Trajectories – 26 week New Outpatients



Principal Service Action	Predicted Impact	Start Quarter
Planned Care		
Roll out e-referrals - all year	TBC	Q1
Audiology / optometry improvements – all year	4,000 OP	Q1
Extend National Planned care programme to OMFS, Gynae, vascular surgery	5% efficiency	Q3
Other outpatient improvement in line with the national plan – virtual clinics, see on symptom, reduce follow up ratios	1,000 OP	Q1
Use of technology to shift to day cases	500 DC	Q1
Regional solutions to outsourcing in ophthalmology and orthopaedics	1,000 IP & DC	Q1
Repatriation pathways for regional specialties	Improved L.o.S.	Q2
National Planned care Plans	Included above	Q1

		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned Care	The number of patients waiting more than 36 weeks for treatment	0	3,365	3,305	3,244	3,183	3,122	3,062	3,001	2,940	2,879	2,819	2,758	2,697
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0	-	-	-	-	-	-	-	-	-	-	-	-
	The number of patients waiting over 26 weeks for a first new OP	0	417	333	250	167	83	-	-	-	-	-	-	-

Planned Care Trajectories – 36 weeks

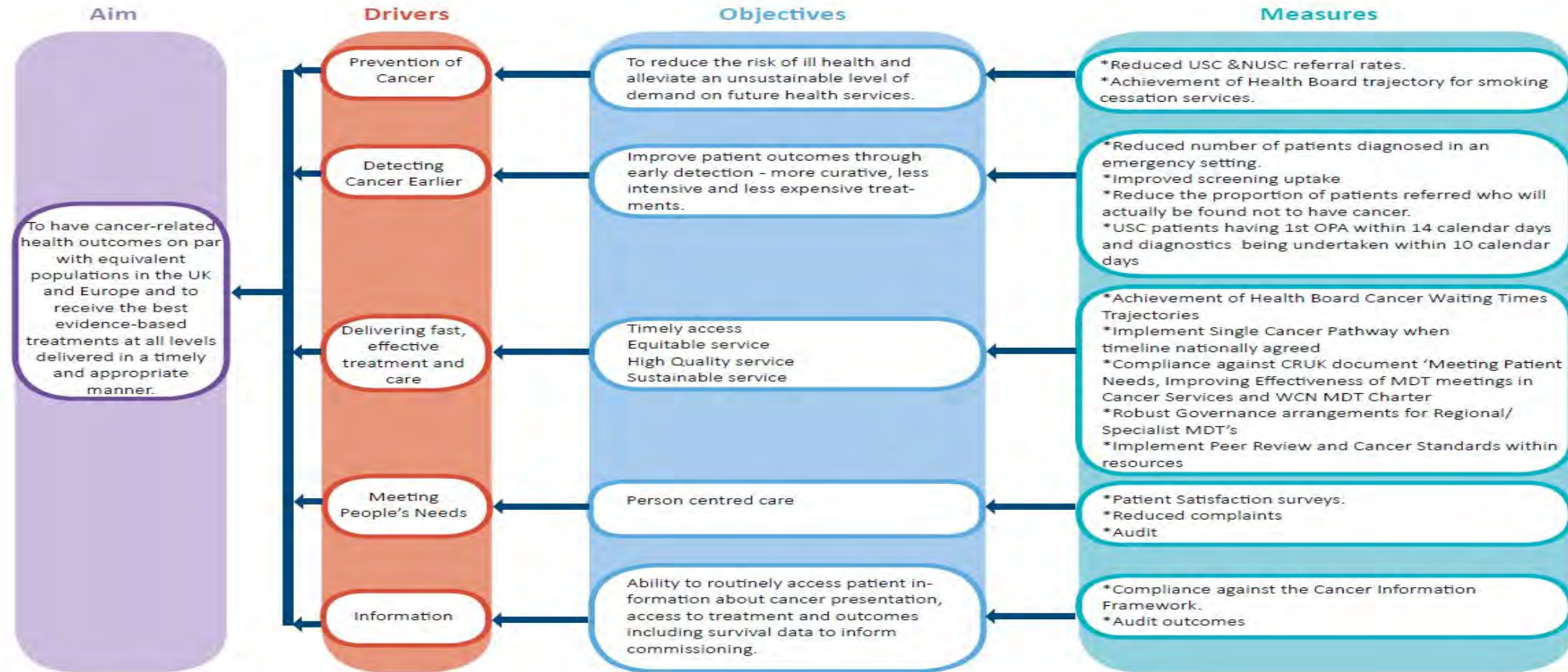


Principal Service Action	Predicted Impact	Start Quarter
Planned Care		
Roll out e-referrals - all year	TBC	Q1
Audiology / optometry improvements – all year	4,000 OP	Q1
Extend National Planned care programme to OMFS, Gynae, vascular surgery	5% efficiency	Q3
Other outpatient improvement in line with the national plan – virtual clinics, see on symptom, reduce follow up ratios	1,000 OP	Q1
Use of technology to shift to day cases	500 DC	Q1
Regional solutions to outsourcing in ophthalmology and orthopaedics	1,000 IP & DC	Q1
Repatriation pathways for regional specialties	Improved L.o.S.	Q2
National Planned care Plans	Included above	Q1

		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned Care	The number of patients waiting more than 36 weeks for treatment	0	3,365	3,305	3,244	3,183	3,122	3,062	3,001	2,940	2,879	2,819	2,758	2,697
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0	-	-	-	-	-	-	-	-	-	-	-	-
	The number of patients waiting over 26 weeks for a first new OP	0	417	333	250	167	83	-	-	-	-	-	-	-

Cancer Service Improvement Plan

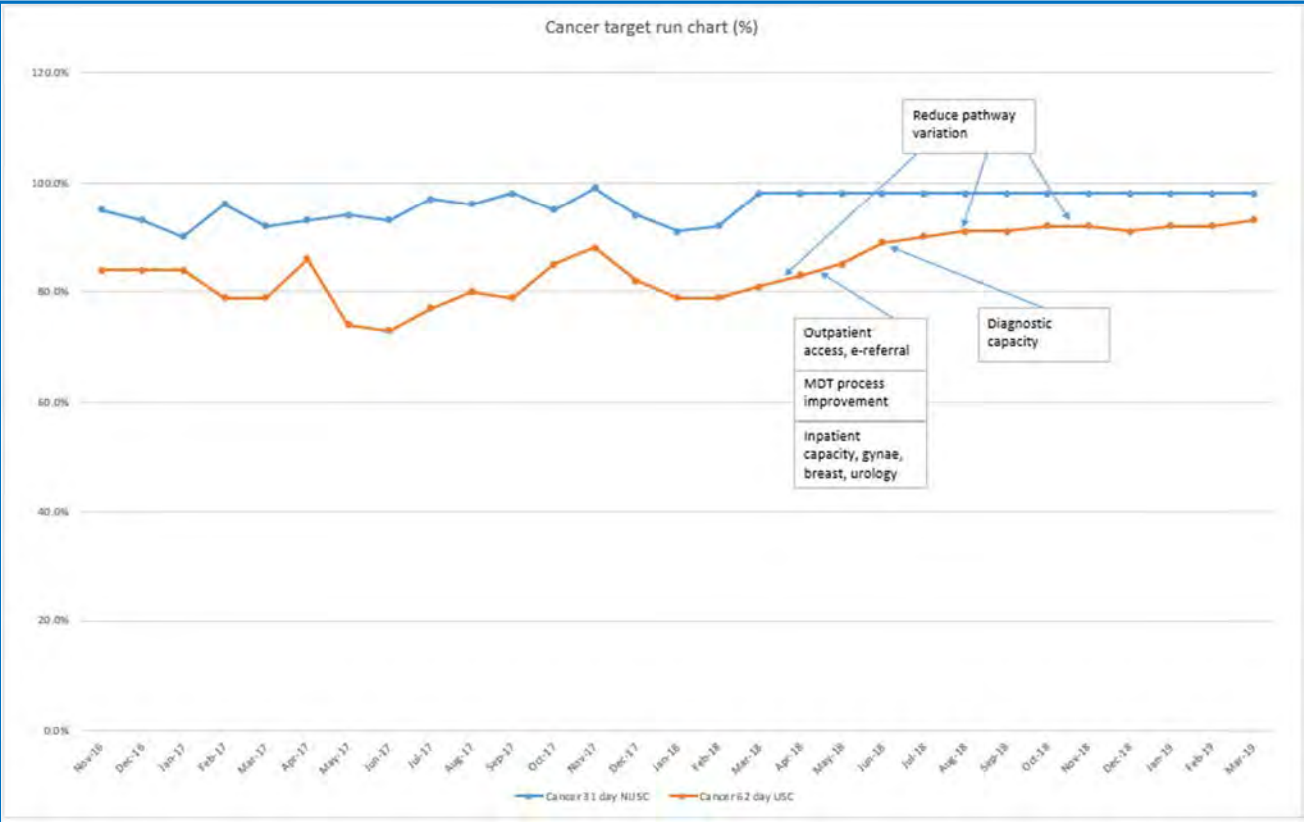
DRIVER DIAGRAM Service Area: Cancer



Cancer - Actions to Deliver our Plan

- Our plan is linked to the domains of Cancer Delivery Plan – within a refreshed Health Board performance management approach.
- In 2018/19 we will build a picture of the models of care and capacity needed to move to the single cancer pathway.
- **Prevention** – improve smoking, healthy eating, reducing obesity and physical activity.
- **Detecting Cancer Earlier** – improve endoscopy performance and outpatient capacity for cancer and centralise breast outpatients.
- **Delivery of care** – focus on breast, gynaecology, urology tumour site, improve performance management, improve MDT processes and implement our new regional Non-Surgical Oncology Strategy.
- **Meeting People's Needs** – deliver our End of Life Care Delivery Plan, appoint a Lead Nurse and focus on patient engagement.
- **Improving Information** – system and performance information development.

Cancer Trajectories

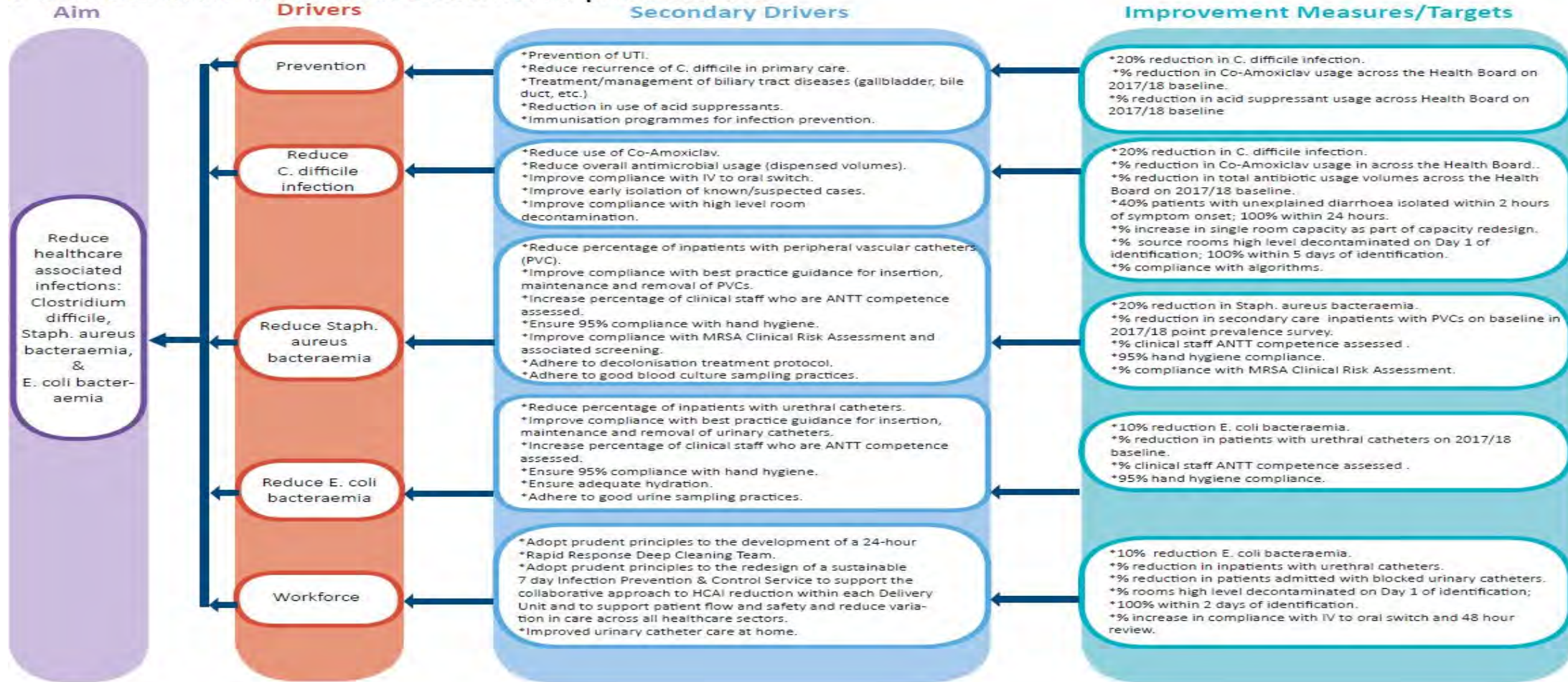


Principal Service Action	Predicted Impact	Start Quarter
Cancer		
Outpatients - Improve access through outpatients, particularly e-referral, improve re 10-day target, centralised OP centre at NPTH for breast outpatients	0.50%	Q1
Diagnostics - Capacity / demand improvement in endoscopy, pathology & gastroenterology, roll our Early Diagnostic Centre to 4 more Clusters, review processes around lung diagnostics	1.00%	Q2
MDT process – improve MDT processes in general, review urology MDTs, merge the 2 breast MDTs to 1.	0.50%	Q1
Inpatient capacity – improve Gynae theatre utilisation, focus on breast, urology and gynaecology, other planned care and USC actions	5.00%	Q1
Reduce variation in general (as USC)	1.00%	Q1 to Q4 ramping up

		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer	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%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	91.0%	92.0%	92.0%	93.0%

Healthcare Acquired Infections (HCAIs) Service Improvement Plan

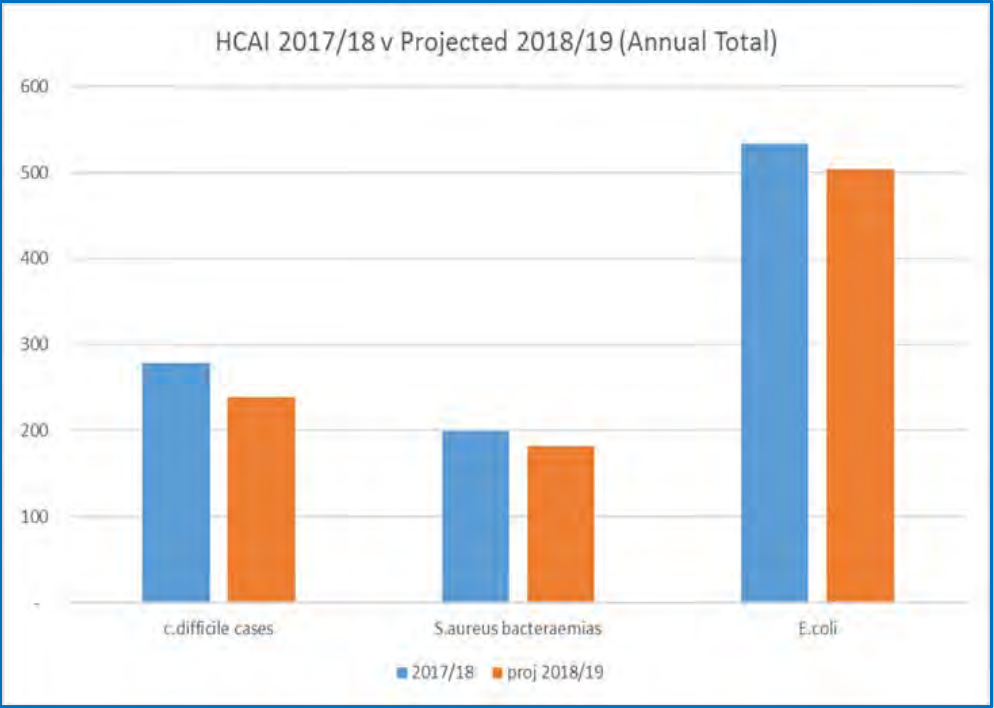
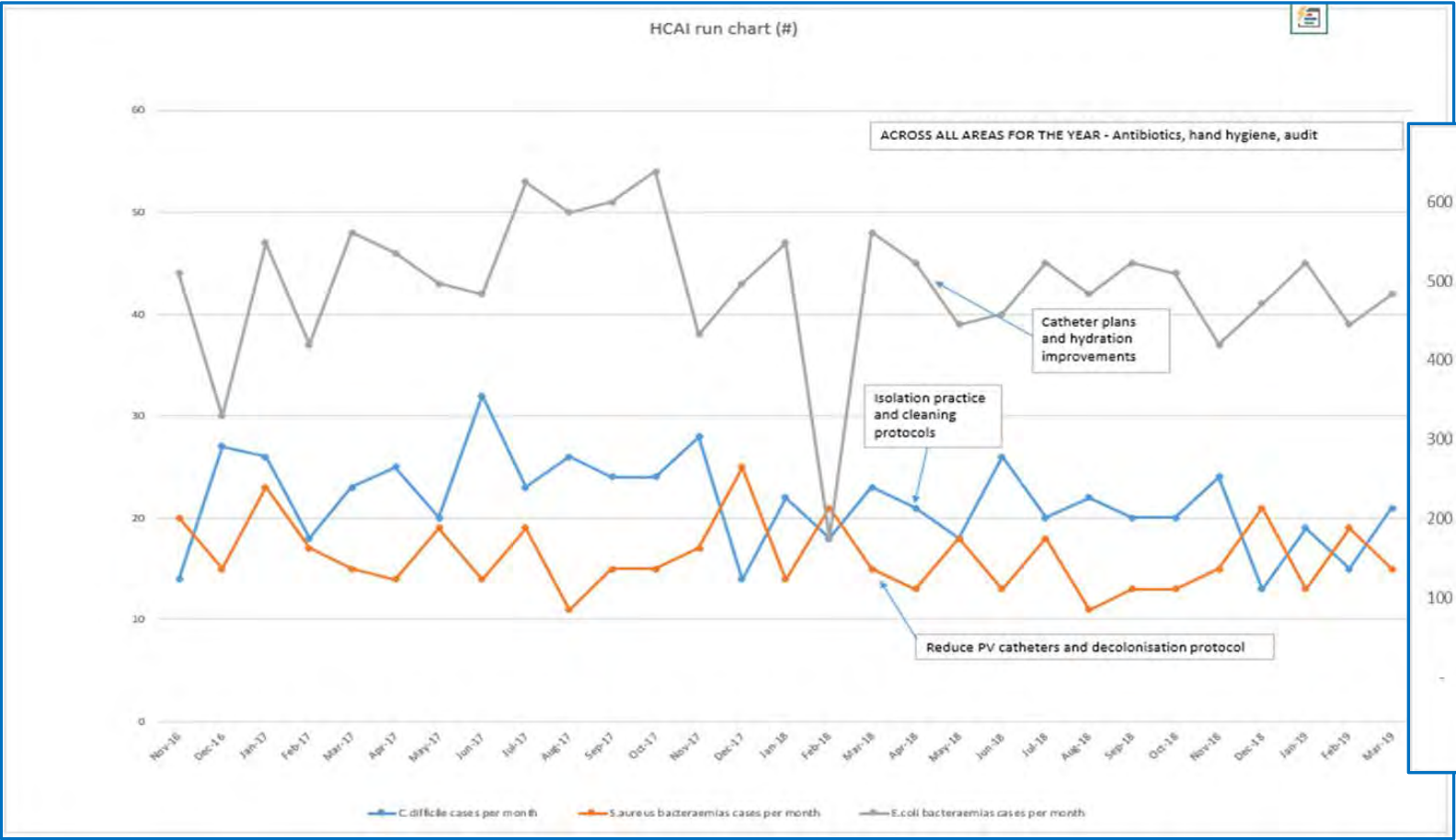
DRIVER DIAGRAM Service Area: Healthcare Acquired Infections



HCAI - Actions to Deliver our Plan

- Our plan is based on best practice and audit.
- **Prevention** – reduce the incidence of urinary tract infections and unnecessary use of catheters, reduce antibiotic usage, improve hand hygiene.
- **C difficile** – Anti-microbial reduction plan actions in secondary and primary care, audit and implement cleaning protocols.
- **Staph Aureus bacteraemias** – catheter actions, audit, improve decolonisation practice.
- **E. coli** – catheter actions, hand hygiene, cleaning actions.
- **Workforce** – training, 24 hour rapid response cleaning team, improved catheter care at home.
- Our trajectories are based on a 15% reduction in the number of c. difficile, a 10% reduction in staph. Aureus cases and a 5% reduction in the number of E.coli cases.

HCAI Trajectories



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
HCAI	The rate of laboratory confirmed C.difficile cases per 100,000 population	Performance against 18/19 local target. Local target shown as number of cases per month not rate per 100k population.	21	18	26	20	22	20	20	24	13	19	15	21
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population		13	18	13	18	11	13	13	15	21	13	19	15
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population		45	39	40	45	42	45	44	37	41	45	39	42

Quality and Safety Priorities

Our 9 Quality Priorities for 2018/19 have been agreed in the context of refreshing our Quality Strategy and are aligned to our strategic and Targeted Intervention priorities. Each priority has measures for success.

Our Quality Priorities are woven through our Service Improvement Plans e.g. reducing pressure ulcers and falls will have benefit in unscheduled care.

A Ward To Board Quality Dashboard has been developed and launched. The aim is to strengthen systems of quality management and assurance.

The Plan also describes our approach to quality improvement and our Quality Hub, and patient engagement.

Quality Priorities

1. SAFER Patient Flow
2. Comprehensive Geriatric Assessment
3. Reducing harm from falls
4. Improving outcomes following stroke
5. Improving cancer outcomes
6. Improving End of Life Care
7. Improving Surgical Outcomes
8. Reducing Pressure Ulcers
9. Reducing Healthcare Acquired Infections

Securing A Fully Engaged and Skilled Workforce

Our current workforce models are unsustainable with pressures across a range of professions. Our aim is to redesign services to improve quality and safety but also to reflect the future workforce picture to ensure sustainability.

Enhanced staff experience and a values culture which supports:

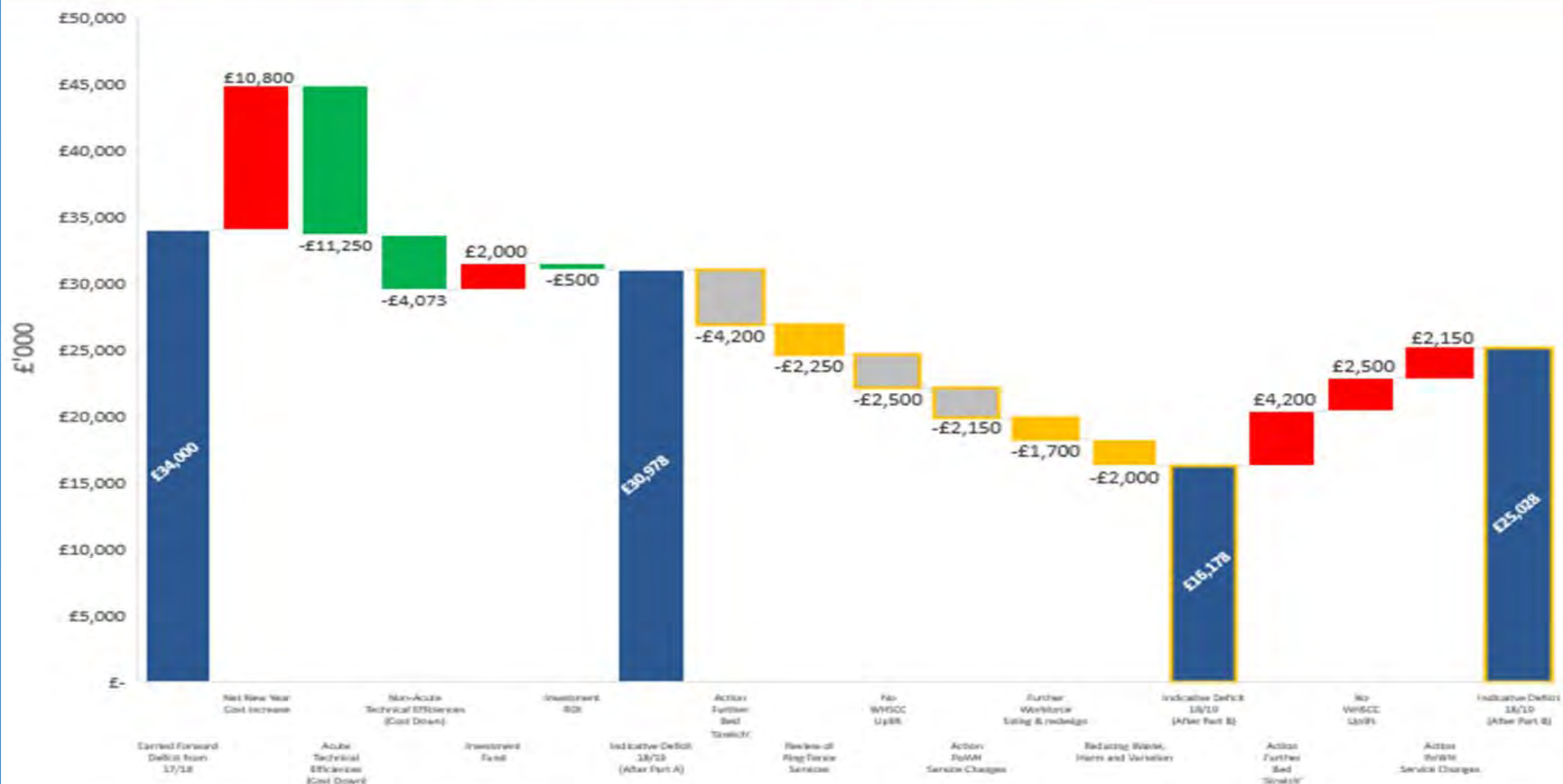
- ❖ Increased recruitment and retention
- ❖ A healthy workforce with reduced sickness absence
- ❖ Targeted training and development
- ❖ Workforce redesign to support service redesign
- ❖ Improved workforce efficiency
- ❖

Financial Plan – Approach

Our approach to strategic financial management has changed and in preparing our Plan we can demonstrate a tangible shift in our thinking and approach. We are consciously taking a whole system view to ensure that decisions and actions do not unintentionally undermine or put pressure on other parts of the organisation. Our approach is service and clinically-led and to ensure actions are considered from a truly integrated perspective to include the impact of potential changes on quality and safety, workforce, performance and finance.

This is a one-year financial plan which is intended to drive tangible, planned and sustainable progress in relation to the Health Board's financial well-being. The work is supported by a comprehensive Recovery and Sustainability Programme, which also aligns our potential actions in terms of impact on all of the targeted intervention areas. In taking this integrated approach, we are starting to look beyond 2018/19 to 2019/20 and beyond. There is a clear recognition that meeting the considerable short term pressures should not undermine the organisation's long term sustainability.

Outline Financial Plan 2018/19: Part A and Part B



Our Recovery and Sustainability Programme

Review of 2017/18

- ❖ Reviewed structure & delivery of 2017/18 Programme & lessons learned
- ❖ Identified what is 'business as usual' and doesn't need programme oversight in 2018/19 to free up Executive capacity to focus on key priorities
- ❖ Identified opportunities to strengthen workstream delivery and programme governance
- ❖ More capacity needed to support Executives in driving change
- ❖ Need more focus on staff engagement & communications
- ❖ Realigned Executive leads for better fit with portfolios

2018/19 Programme

- ❖ Focussed on a smaller number of workstream areas aligned to the waterfall savings plan
- ❖ Value Based Health Care as core underpinning driver to move from transactional into transformational
- ❖ Programme will include targeted intervention priorities to strengthen whole system working & oversight of delivery
- ❖ Realigned 'service optimisation' areas (e.g.. theatres) to drive changes

Assurance and Governance

The monitoring of the delivery of the Annual Plan will be the responsibility of the Finance and Performance Committee on behalf of the Board with escalation levels as set out below.

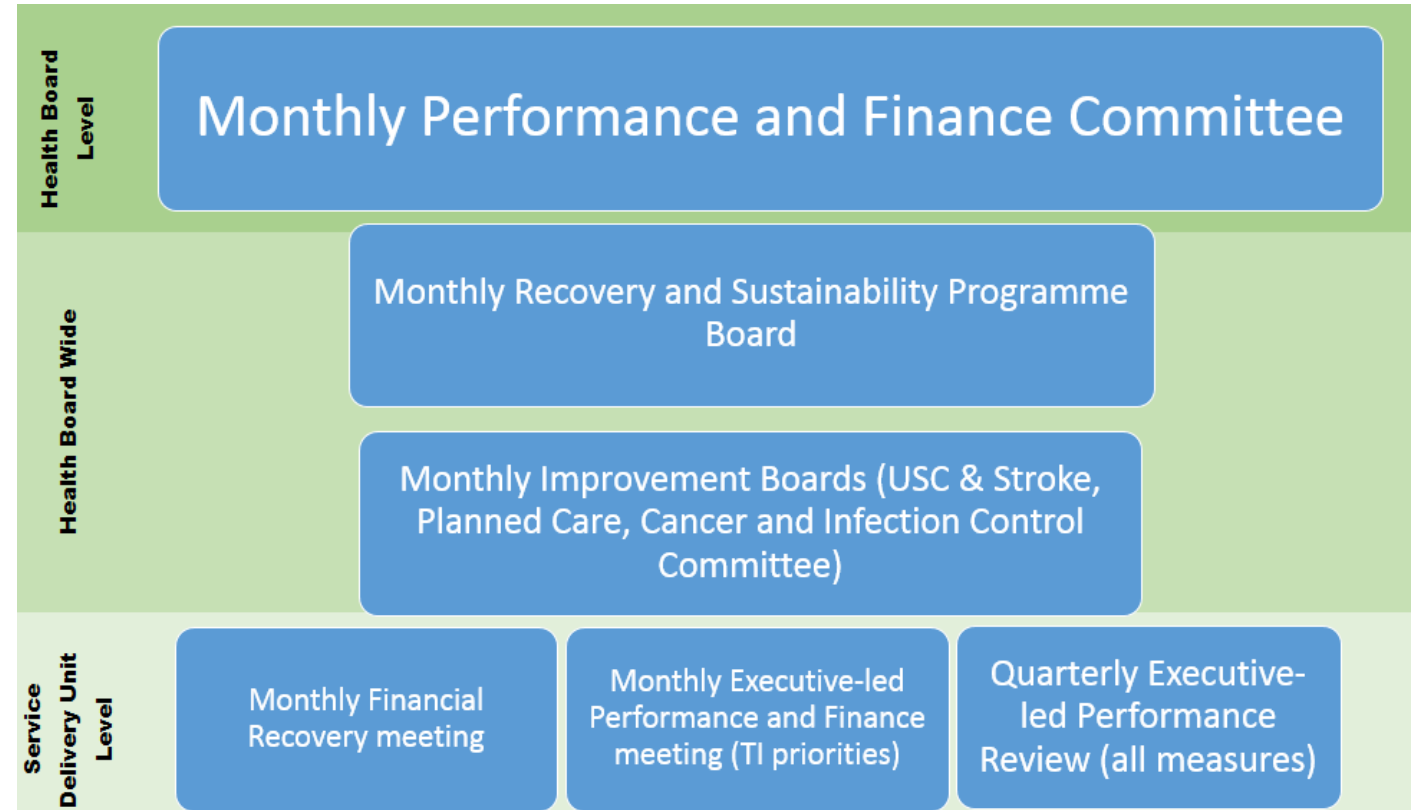
Stage 1 – Discussion, Review and Scrutiny. This is the Committee's everyday practice. In this stage the Chair of the committee will make known any concerns to the Chief Executive who will ensure that there is clear accountability and delivery by the Executive Team.

Stage 2 – Recovery Plan. The Committee requires the responsible Director to set out a plan and a profile to recover the performance and hit the target.

Stage 3 – If the Recovery Plan is not delivered to target or the profile is missed, the Committee will require the Director to attend each meeting and account for the management of the issue until it is resolved. At this stage the Chair of the Committee will raise the concerns directly to the Chief Executive.

Stage 4 – Continued poor performance will be formally referred to the Chairman and Chief Executive in order that the matter becomes a Board issue.

Below the Finance and Performance Committee, assurance will be provided at both a Service Delivery Unit and Health Board-wide level as shown in the diagram.





ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

Annual Plan 2018/19



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LIST OF APPENDICES (SEPARATE DOCUMENT)

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Appendix 10.	EASC AND NUSC TEMPLATE 3
Appendix 11.	DRAFT NON-SURGICAL CANCER STRATEGY IMPLEMENTATION PLAN
Appendix 12.	WELSH LANGUAGE
Appendix 13.	RESEARCH, DEVELOPMENT AND INNOVATION
Appendix 14.	ABMUHB DELIVERY PLANS

DOCUMENT CONTROL

Version No	Changes	Submitted To	Date
1.0	Working document		
1.1	AH, SHG, DG changes		
1.2		Executive Team	8.1.18
1.3		SHG	12.1.18
1.4	SHG / Executive Team changes	Health Board	25.1.18
1.5	Health Board changes	TM, EW	6.2.18
1.6		Welsh Government	7.2.18
1.7	WG Feedback changes	Executive Team	15.3.18
1.8	Executive Team and P&F Committee changes	Health Board	22.3.18
	Heath Board changes	Welsh Government	29.3.18

FOREWORD

Over the last 12 months the Health Board has continued to push forward changes and developments aimed at tackling a range of well-documented challenges which impact on the services we deliver. There are excellent examples of innovative, quality-driven and forward-thinking projects across the organisation which have really begun to make a difference, and some of these are highlighted in this Annual Plan.

However, there is still much to do to emulate and expand projects like these to really drive improvements forward, and at the pace necessary to meet demands. The Annual Plan for 2018/19 focuses on a number of key elements:

- strategic development
- improving quality and safety
- improving efficiency
- delivering improved performance through an integrated service, workforce and financial plan

Our 2018/19 plan is set within the context of *'Prosperity for All'*, the Parliamentary Review of Health and Social Care, and the Wellbeing of Future Generations Act (WBFGA) as well the wider strategic context, and it is based on delivering our Corporate Objectives which were reviewed last year.

The Annual Plan is assured through the delivery mechanism of our Recovery and Sustainability Programme. It sets out clear, timely, deliverable actions, using the WBFGA Five Ways of Working, through five specific Service Improvement Plans for our Targeted Intervention Priority Areas (Unscheduled Care, Stroke, Planned Care, Cancer and Healthcare Acquired Infections). These also include clear financial, workforce and infrastructure enablers.

The Plan is designed to meet the challenges of demographic changes and health inequalities in the population we serve; a model of care which is overly weighted towards inpatient services, and an imbalance in demand and capacity. These lead to significant performance, workforce and financial challenges which ultimately impact on quality of services. In the coming year, we will update our Clinical and Quality Strategies and then develop an Organisational Strategy to provide a clear strategic direction for the Health Board. This Annual Plan has been developed in the context of our baseline review for our Clinical Strategy to ensure it is aligned to our longer term strategic direction.

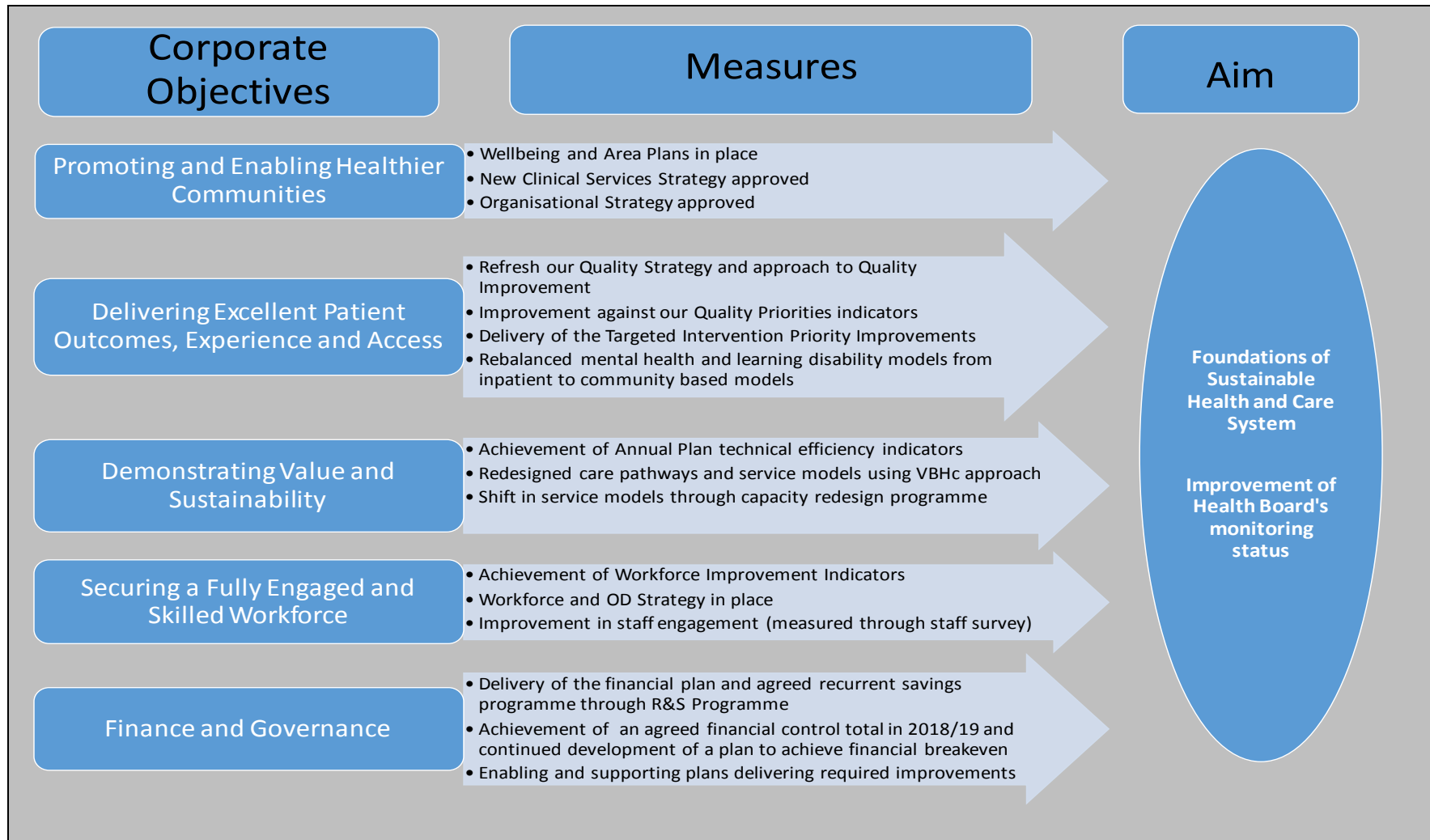
This is a critical year for the Health Board as we move forward under new leadership, with a Board and Executive Team which are substantially made up of new members. Whilst we have made improvements in many areas in 2017/18, most notably in stabilising our financial position, this plan is forward focussed to achieve our aims of laying the foundations for a sustainable health and care system and improving our targeted intervention monitoring status by the end of the year. To do this our Plan aims to deliver:

- Improved quality and safety of services which put patients at the centre of what we do;
- Improved performance against our Targeted Intervention priorities;
- Modernised service models and redesigned capacity to reflect improved length of stay underpinned by a Value-Based Healthcare approach;
- Increased sustainability of the workforce by enriching the wellbeing, capability and engagement of the workforce;
- Improved efficiency of our services;
- Fit with strategic direction of the Health Board; and,
- A reduced financial deficit.

We intend this Plan to form the bridge to enable the Health Board to develop an Integrated Medium Term Plan for 2019-2022. We are clear that whilst our trajectories below are based on improvements in quality, safety and access, this plan represents the start of our improvement drive and we are committed to further improvements after 2018/19 to move the health board closer to target levels.

We are in a significant period of change and we will ensure that we engage with our staff and manage change appropriately with expert support from our Workforce and Organisational Development team. Good change management practice will be embedded in the delivery of our Plan and we are taking steps to equip our leaders to lead through challenging times. Delivery of our Plan will be undertaken with full adherence to our organisational Values of 'Working Together; Always Improving; Caring for Each Other as well as requiring targeted management and assurance through our ongoing Recovery and Sustainability programme, excellent leadership and organisational development and a continuing focus on staff engagement and wellbeing.

CORPORATE OBJECTIVES AND AIM OF OUR PLAN



Promoting and Enabling Healthier Communities

- Published our Children and Young People's Strategy
- Violence Against Women Domestic Abuse and Sexual Violence Act embedded
- Wellbeing Objectives agreed and Wellbeing and Area Plans in development
- Health Inequalities and low adherence to a healthy lifestyle remain
- New approach to tackling our challenges at scale, mobilising all of our workforce agreed
- Ongoing work to improve against our prevention priorities of vaccinations and immunisations, smoking cessation and obesity / physical activity

Securing a Fully Engaged and Skilled Workforce

- Our workforce challenges are a key driver of our financial and sustainability challenges
- Staff Engagement and Nursing and Midwifery Strategies approved
- We still have circa 800wte vacancies which is a key driver of our financial and sustainability challenges Nursing turnover is highest at over 9%, although it has reduced recently.
- Despite an initial improvement over the last 12 months, the sickness absence rate has started to increase again and is above target.

POSITION IN 2017/18

Delivering Excellent Patient Outcomes, Experience and Access

- The numbers of falls have decreased significantly in year.
- Our Universal Mortality Review performance is the best in Wales.
- Launched our Older Persons Charter
- Our Primary Care measures of access are improving and we largely comply with the Mental Health measures.
- We are continuing our work to roll out PREMs and PROMs
- **Unscheduled Care** - there was good progress with improving performance in the first 6 months of the year, particularly at Morriston, however performance has since deteriorated reflecting an increasing length of stay and numbers of Delayed Transfers of Care.
- **Stroke** - performance is on-track for the majority of the measures apart from the 4-hour bundle and thrombolysis.
- **Planned Care** - the Health Board is on target to meet the agreed trajectories for Outpatients, Diagnostics and Therapies. Challenges remain in meeting the target for 36 and 52 week waits.
- **Cancer** – the non Urgent Suspected Cancer (nUSC) target is largely being met but the Health Board is off-track against the USC trajectory and a renewed performance improvement management regime has been put in place.
- **Health Care Acquired Infections (HCAIs)** - Numbers of c. difficile cases have risen in year and are above trajectory. We were on-track against the Staph. aureus trajectory until November when cases started to rise and the number of E. coli cases has steadily increased in year.

Demonstrating Value and Sustainability

- Financial plan forecast remains on track to achieve a figure below our financial control total
- The Recovery and Sustainability (R&S) Programme is established with cross-cutting Workstreams
- Programme of Service Remodelling has delivered significant change in 2017/18 – plans in place to rebalance care into the community in acute, community and mental health services
- Service redesign using Value-Based Healthcare (VBHC) approach underway and been tested externally
- Primary and Community Services Strategy approved
- Draft Strategic Framework for adult Mental Health agreed

Embedding Effective Governance and Partnerships

- The Health Board remains in Targeted Intervention Status
- Implementation of the Deloitte's Governance Review is proceeding
- Regional Planning and Delivery mechanisms established through JRPDC
- Discharge process standards agreed through Western Bay
- Wellbeing and Area Plans on track to being agreed

decisions about health provision across the Bridgend Council area should be made by Cwm Taf University Health Board instead of ABMU Health Board. A formal 12-week consultation about the principle of the boundary change has been undertaken and the outcome of this is likely to be known early in 2018/19. The consultation is focused on an administrative boundary change, and not service change, and therefore our Annual Plan 2018/19 is based on our current configuration of services and does not pre-empt the results of the consultation or any future decisions regarding the Bridgend Council area.

We also provide a range of specialised services which are provided on a regional basis, including Burns and Plastic Surgery (for the whole of South Wales and South-West England), Forensic Mental Health Services (for South Wales) and Learning Disability Services (for the ABMUHB, Cwm Taf and Cardiff and the Vale Health Board areas). We also host the South West Wales Cancer Centre, providing radiotherapy and oncology for this area and other regional services such as specialised cardio-thoracic and pancreatic surgery. We do not provide specialist Child and Adolescent Mental Health Services (CAMHS) for our population, these are provided by Cwm Taf University Health Board. The figure below illustrates the geography served by the Health Board:

- **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 and cleft lip and palate
- **Zone 4** – Burns service catchment area.



1.2 National Strategic Context

A detailed explanation of the changes in our strategic environment that this Plan responds to is included in **Appendix 1**.

We welcome the strengthening of the national strategic context during 2017/18 through the publication of '[Prosperity for All](#)' which lays out the headline commitments of the Welsh Government up until 2021. The long term aim is to build a Wales that is 'prosperous and secure, healthy and active, ambitious and learning and united and connected'. The aim informs the four themes of the strategy:

- Theme 1 – Prosperous and Secure
- Theme 2 – Healthy and Active
- Theme 3 – Ambitious and Learning
- Theme 4 – United and Connected.

The Health Board has a duty as part of the wider Welsh public service to lay the foundations for achieving these aims in the long term, based on the principles of prevention, involvement, collaboration and integration. As a health organisation we have a particular responsibility to work with partners to break the cycle of ill-health by strategically shifting the approach from treatment to prevention and this is reflected in our new approach to prevention and public health intervention is also part of our sustainability duty under the Wellbeing of Future Generations Act.

The final [Parliamentary Review of Health and Social Care](#) has also been published which provides welcome opportunities for us to further integrate services and develop new models of care, and we also await the NHS Strategy early in 2018/19. The principles of the Parliamentary Review signalled a potential change in the future organisation of health and social care in Wales. The report states that a limited set of new models should be trialled, evaluated and, if successful, scaled up rapidly. This will need to be supported by new workforce models with different skills and career paths as well as a boost in infrastructure. Governance, finance, and accountability arrangements would need to be streamlined with the aim of effectively integrating the health and social care system and offering higher quality care.

The principles of the Review inform our programme of service remodelling in 2018/19, which will focus on frailty, older people's mental health and learning disabilities. We will be building on the work that is already ongoing with partners to redesign our service models and to be prepared to access any Transformation Funding that is available. This includes our work with our housing colleagues through our Health and Housing Group.

With partners have reshaped the three Public Service Boards which we work with to be more strategic and be better able to respond to the [Well Being of Future Generations Act \(WBFGA\) \(2015\)](#). The Health Board has agreed our three Wellbeing Objectives as shown in the diagram.

The three draft Wellbeing Plans for our area will be published in May 2018 and the themes of these are woven throughout our Plan. We have woven the Five Ways of Working set out in the Wellbeing of Future Generations Act throughout our plans and are maximising the practical opportunities that the Act gives us to meet our sustainability challenges – eg through carbon reduction opportunities, sustainable travel and increasing the use of digital technology to deliver care in new ways closer to people’s homes, as well as improving the efficiency of our working practices and developing models of care that are increasingly focused on self-care and prevention at the earliest opportunity.

The Health Board is using the foundations of the [Social Services and Wellbeing Act \(Wales\) 2014](#) to accelerate our work in collaboration with partners to integrate our services and provide high-quality healthcare within a sustainable service model which rebalances care ‘Closer to Home’. The Western Bay Regional Partnership Board oversees the development of integrated services across the region for some of our most vulnerable groups and our draft [Area Plan](#) outlines our key priorities. Where appropriate, the detail of our plans and developments is included in our Service Improvement Plans.

The work programme has been reviewed in early 2018 to ensure priorities are still appropriate, with the aim being to focus on those areas where we can jointly deliver the greatest impact. This is critical as we enter the second year of our Recovery and Sustainability Programme where increasingly our focus is on developing new care models, particularly to support frail older people. The delivery of more care outside hospital settings is a critical aspect of the Recovery and Sustainability Programme and we are committed to working in partnership to achieve this. Fundamentally, improving patient flow through hospital and avoiding unnecessary hospital admissions is a key theme that runs through a number of



our plans and to improving performance in both planned and unscheduled care. The reduction of Delayed Transfers of Care is also a key theme of the Area Plan.

1.3 Collaborative Planning

Our national planning and commissioning work through WHSSC and EASC is described in detail in **Appendix 1**. This Appendix also includes our work with the NHS Wales Collaborative on major trauma, the Sexual Assault Referral Centres and other areas in the Collaborative workplan. Operational actions for specialised services, service development with the Welsh Ambulance Services Trust (WAST) and areas led by the NHS Wales Collaborative are shown in our Service Improvement Plans where they will impact on our Targeted Intervention priority areas. The remainder of this section focusses on our plans that are being driven through our collaborative regional planning and delivery programme with Hywel Dda University Health Board.

1.3.1 Regional Planning and Delivery

The regional planning and delivery agenda will continue to grow in importance in 2018/19 and will provide new opportunities for us to meet some of our difficult delivery challenges. We will also continue to plan services regionally as part of the South East Wales planning arrangements. The impact of regional planning and delivery is described in our Service Improvement Plans, and the overall approach is described more fully in **Appendix 1**.

ARCH

We are well placed to respond to 'Prosperity for All' as many of the themes within the strategy are being addressed through the ARCH (A Regional Collaboration for Health) programme, which is jointly run by ABMU and Hywel Dda University Health Boards and Swansea University, and which has underpinned much of our strategic planning. Whilst progress was slower than we would have wished for the first half of 2017/18 due to funding constraints, the three partners have demonstrated their commitment to the Programme by agreeing to jointly contribute to the ongoing funding of the Programme Management Office. We will be able to continue to jointly plan and deliver improvements to the health, wealth and wellbeing for the population of South West Wales through the four inter-related workstreams of:

- Service Transformation;
- Well Being;
- Skills and Education; and
- Research, Enterprise and Innovation.

Full details of the ARCH Programme are contained in the [Portfolio Delivery Plan](#) which is currently being considered by Welsh Government. We are also working with Swansea University and the City and County of Swansea to develop the business cases for

the developments of the Health Technology Centres/Institutes of Life Sciences at Singleton and Morriston, which are due to be submitted within the next few months. They will create significant opportunities for all of us in the strategic development of our services, the future education and training of our workforce and the future development of the health campuses as set out in the ARCH Portfolio Delivery Plan. The ARCH programme is also overseeing the development of the Wellbeing Centres for each of our three localities which have been funded through the Primary Care pipeline. The programme underpins the development of sustainable clinical and workforce models and must be viewed as an integral part of our overall approach to recovery and sustainability.

Joint Regional Planning and Delivery Committee

The focus on regional planning and delivery has increased significantly this year and forms a key part of our operational plans for 2018/19, particularly to improve delivery in Planned Care. Our regional delivery actions are included in our Service Improvement Plans and further detail on our regional planning approach and priorities is included in **Appendix 1**.

South West Wales

The relationship between the University Health Board and ABM University Health Board has been strengthened through the mechanisms and opportunities provided by ARCH and the Joint Regional Planning and Delivery Committee (JRPDC). The focus for the JRPDC is on shorter-term priorities and delivery whilst ARCH, which also includes Swansea University, focuses on the medium to long term.



The starting point for the development of collaborative activity is the [ARCH Portfolio Development Plan \(PDP\)](#) in order to deliver the vision of transforming the health, wealth and wellbeing of our population. The PDP identifies the service areas which the two University Health Boards are committed to developing on a regional basis, underpinned by a Value-based Healthcare approach. In addition Abertawe Bro Morgannwg University Health Board (ABMUHB) and Hywel Dda University Health Board (HDUHB) have agreed a set of joint regional planning and delivery intentions for 2018/19 and beyond. The alignment between the ARCH programme and the JRPDC work are shown in the diagram below.



The service areas where we are working closely together are in part based on a baseline regional needs assessment undertaken by Swansea University and also on a clinically led assessment of

regional service opportunities. To do this we have been sharing information on patient flows, where we commission services (national and local) and performance challenges and opportunities. The health needs assessment work is now also being used to support our Public Health work, and is to be further developed to allow a needs assessment at the level of our 7 localities.

The priority areas for South West Wales are shown in the box, these based on performance priorities, service pressure; workforce fragility; clinical governance risks or Welsh Government policy. More detail is included in **Appendix 1**.

SOUTH EAST WALES

- Continue to implement South Wales Programme
- **Ophthalmology** – take forward demand and capacity review
- **Orthopaedics** – complete demand and capacity reviews at sub-specialty levels to develop 3 year plans
- **Diagnostics**- undertake further demand capacity work for MRI and endoscopy
- Detailed planning for implementation of new centralised **ENT** model in 2018/19

South East Wales

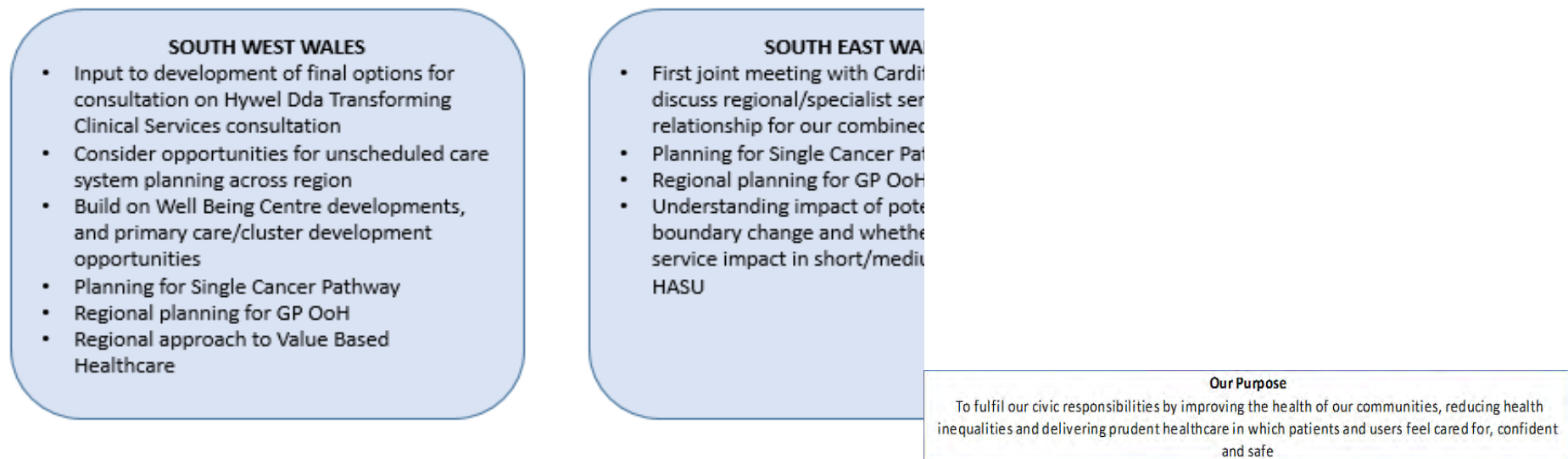
We are also a member of the Regional Planning and Delivery Forum for South East Wales. The structures are different in South East Wales with an overarching regional planning forum receiving reports from specialty/service specific groups and we are members of the groups and contribute fully to these discussions and plans. The priorities are show in the box with more detail in **Appendix 1**.

SOUTH WEST WALES

- **Orthopaedics** – reduce 52 week waiters
- **Ophthalmology** – VBHC service redesign to deliver sustainable service
- **General Surgery** – reduce 52 week waiters
- **Oral Maxillofacial** - long waits for outpatient access, new service model being developed
- **ENT** – reduce 52 week waiters in ABMU; 36 in Hywel Dda
- **Endoscopy** – Seek to continue arrangements in place in 17/18
- **Cardiology/Cath Labs** – secure clinical sign up to networked model and complete business case requirements
- **Pathology** – discussion SOC to be finalised
- **Vascular** – Pathways signed off, PBMA to start
- **HASU** – joint service specification and pathway being consulted on; d&c modelling underway

are

The next steps for regional planning for the both the South West and South East Wales regions are shown in the diagram below.



1.4 Local Strategy Development

We have a clear purpose, vision and set of Values which influence all that we do. We have also framed our Annual Plan around our Corporate Objectives which are shown in the diagram.

The organisation's **Clinical Strategy** will be updated by the Summer of 2018. This will build on the previously consulted upon and agreed Clinical Strategy, Changing for the Better (C4B), as well as reflecting national policy

Our Corporate Objectives				
Promoting and Enabling Healthier Communities	Delivering Excellent Patient Outcomes, Experience and Access	Demonstrating Value and Sustainability	Securing a Fully Engaged and Skilled Workforce	Embedding Effective Governance and Partnerships

changes and changes in the local environment since Changing for the Better was agreed in 2013. The update is being undertaken using a two-stage approach, with the first stage being a review of progress against C4B which has identified that a large number of the changes set out in C4B have been partially or fully implemented, however there is further work to do in terms of redefining our system characteristics, should work together based on changing service models and changed strategic context.

Two Stage approach agreed:

- **Stage 1** – review progress against C4B First report to inform Annual Plan 2018/19 and align with development of Clinical Services Strategy 2018-24
- **Stage 2** – undertake broader cross cutting work based on Monitor approach to more fully inform the Clinical Services Strategy 2018-24

The review has been used to develop our **Evolving Service Model** which is included in **Chapter 3.0**. This forms the basis for all of the service remodelling work which is described in our Annual Plan. Throughout the development of the Plan we have ensured that our Annual Plan aligns with the direction of travel that is emerging from the development of our Clinical Strategy.

Following the publication of our revised Clinical Strategy we will be developing an overarching **Organisational Strategy** during the latter half of 2018/19 to provide a clear, overarching strategic direction for the Health Board to guide all of our strategic choices. As planned in our Annual Plan 2017/18 we have continued our programme of Strategy development in-year to underpin this and we now have a range of clinical and corporate strategies which have been developed or are in the process of being developed as shown in the diagram. These will form the basis for the Organisational Strategy.

1.5 Recovery and Sustainability

The Health Board has faced a number of significant challenges over the past few years. These challenges led Welsh Government to increase the escalation status of the organisation in September 2016 to one of 'targeted intervention' and this has



remained in place during 2017/18. The issues that led to this position are outlined below:

- Unscheduled care access and performance, particularly at Morriston Hospital;
- Cancer access and performance;
- A lack of a sustainable and affordable plan for the organisation;
- Financial performance and delivery; and,
- Some concerns about governance and assurance.

We have changed our approach to strategic financial management in the context of continuing financial sustainability challenges driven by our changing demographics, the prevalence of chronic conditions in our population and increasing costs. Whilst we have made very good progress as a result of our new approach in stabilising the financial position in 2017/18, our focus is now widening to consider opportunities to drive service change and on new ways of working to deliver a sustainable financial base in addition to the efficiency gains and non-recurrent measures that we have relied upon previously. The plan has also been developed in the context of a restricted national capital environment.

The aim of our Annual Plan 2018/19 is to put in place the foundations of a sustainable health and care system and to improve our Welsh Government monitoring status. Although these challenges have been at the heart of the Health Board's plans over the last 12 months, progress with addressing the performance issues in 2017/18 has been mixed. Whilst there has been some evidence of stabilisation and improvement, there is still too much variability and fragility. Consequently, these delivery challenges will continue to feature strongly in our 2018/19 plan.

To drive the Health Board's response to these challenges in 2017/18 we established a Recovery and Sustainability Programme with a particular focus on addressing our deteriorating financial performance and to drive delivery of a £25m savings programme. This has been informed by lessons from national reviews such as the Carter review; the work of the National Efficiency and Value Board; local benchmarking information; and local reviews and reports commissioned by the Health Board. The Programme has adopted a matrix approach with a 'vertical' focus on clear Financial Recovery and Savings Plans for each Service Delivery Unit and Corporate Department, with 'horizontal' cross-cutting Workstreams to drive a standard approach, at pace, across the Health Board. The purpose of the Workstreams has been to add value, direction and energy into savings plans by unlocking obstacles, reviewing policy constraints, researching and rolling out good practice and setting organisation-wide standards and expectations. Each Workstream has an Executive Director Lead and nominated project management support.

The Programme has been reviewed and framed for 2018/19 to reflect learning from 2017/18 and to ensure alignment with the delivery of the Annual Plan. Its focus will shift focus from technical efficiency, reducing waste and improved controls (whilst these

continue to be delivered), to a greater focus on new pathways and models, and the outcomes and value we get for patients from the money we spend. This will be critical in enabling the Health Board to move from a 'recovery' focus to a more sustainable trajectory. The new work streams set out align directly with the financial plan for 2018/19 and the detail of the Recovery and Sustainability Actions are included in **chapter 3.0**. The refreshed Executive Leads are also shown below, including the new Director of Human Resources who will start in April 2018.

Theme	Workstream	Executive Lead
Redesigning Care & Services	Service Remodelling including Frailty, Mental Health and Learning Disabilities Services	Director of Strategy
	Workforce Redesign	Director of Therapies and Health Sciences
Using Resources Wisely	Value Based Procurement	Director of Finance
	Workforce Delivery	Director of Human Resources
Optimising Care	Outpatients	Interim Chief Operating Officer
	Theatres	
	Patient Flow	
Value Based Health Care	Prudent Health Care	Medical Director
	Pathway Redesign	
	Clinical and Administrative Commissioning	
	Medicines Management	Clinical Director for Pharmacy and Medicines Management
	Review of Mental Health Spending above ring fenced levels	Director of Public Health

2.0 OUR PLANNING FRAMEWORK

This chapter summarises the planning framework that we agreed in the 2017/18 for the development of our Annual Plan 2018/19. The aim was to take a different approach to previous years to ensure that our Plan addresses our Recovery and Sustainability challenges and meets our aim of improving our targeted intervention status.

2.1 Our Planning Framework

Our Annual Plan has been developed within a clear internal Planning Framework and direction set by the Board and then through a process of engagement with our Delivery Units and Corporate Departments on both a 'bottom-up' and top-down' basis.

The Plan aims to deliver our overall Aim and Corporate Objectives through five Service Improvement Plans for our Targeted Intervention Priority areas of Unscheduled Care, Stroke, Planned Care, Cancer and Healthcare Acquired Infections (HCAIs). Driver diagrams have been developed for all five service areas and these have been used to develop our drivers, objectives, measures, actions and trajectories. They are also being used to develop our underpinning quality and safety objectives and actions.

The planning principles that our plan is based on (and which were developed in Summer 2017) are:

- Quality and safety is our top priority and everything we do will be in line with our Organisational Values;
- The Health Board is developing an Annual Plan for 2018/19 in the context of our statutory duty to produce a three-year plan and a five year Clinical Services Strategy which is being updated.
- The Health Board and Units must demonstrate how services are planned and delivered on an integrated system wide basis and maximise our sustainability and integration under the Wellbeing of Future Generations and Social Services and Wellbeing Acts. Plans for 2018/19 and beyond need to clearly demonstrate inter-dependencies and benefits.
- The Health Board recently approved our Primary and Community Services Strategy and an implementation plan is being finalised. We will develop sustainable, standardised, integrated primary care and community services organised through Cluster Networks and these will form the basis for our future planning arrangements. We will expect to increasingly deliver care 'Closer to Home' in line with Evolving Service Model and through Cluster Networks with associated transfer of resource.
- We have differentiated the roles of our hospitals as laid out in our Evolving Service Model and plans should be developed on this basis.
- We will maintain Princess of Wales Hospital as a Level 3 District General Hospital until the conclusion of the consultation about the potential transfer to Cwm Taf UHB.

- We will re-focus our mental health and learning disabilities services to ensure that the balance is towards a community-led model. We will plan to deliver our Strategic Frameworks for Mental Health (by May 2018) and Learning Disabilities and develop our dementia plans in line with the national Dementia Strategy.
- We will demonstrate measurable benefits through integration (across primary and secondary care; physical and mental health; and health and social care).
- We will plan to deliver our agreed Children and Young People's Strategy.
- We will take all opportunities to maximise the benefits of our Digital Strategy to make our system sustainable.
- We will improve our efficiency over the next three years to peer group benchmarking levels.
- Our financial plans will be based on a robust deficit reduction plan and a new approach to budget setting.
- All plans must be delivered within delegated budgets and these will reflect the need to reduce our deficit and to internally manage all cost pressures over our allocation.
- There is no opportunity to 'bid' for additional revenue as part of the Annual Plan process. The only route for consideration of schemes outside a delegated budget envelope is through the Investment and Benefits Group and the Board have agreed a limited internal investment fund which is fully repayable over a 2 year period.
- Our workforce challenges are unlikely to change through recruitment approaches, and our Annual Plan is not based on recruiting to fill all our vacancies but instead on reducing vacancy levels by changing services and workforce models.
- We will use our agreed Value-Based Healthcare (VBHc) approach, the opportunities provided by Regional Planning and the principles of Prudent Healthcare to develop our plans.

2.2 Quality, Safety and Patient Experience

Quality and Safety Priorities

Our extant Quality Strategy expires in March 2018 and is being extended for the coming year whilst a new strategy is being developed and consulted upon. The new Strategy will reflect our organisational values and be founded on the principles of Prudent and Value-Based Healthcare, with a strong focus on Quality Improvement, engaging on every level with all our staff and services. It will run concurrently with our new clinical strategy and organisational strategy. Our Quality Assurance focus will be further embedded and a culture of transparency and continuous improvement will build on the Health Board's commitment to meet the current quality standards, measured by our Quality Indicators. Collaboration, co-production and benchmarking will form the basis of an integrated Health Board approach, working towards seamless quality outcomes.

The updated Strategy will have a focus on the health and social care responsibilities of our Health Board, working with partners to agree and apply timely and effective ways of working to support our whole population. Our aim is to improve outcomes and citizen experience by reducing variation to improve health and the delivery of safe services.

The Health Board's Quality Priorities for 2018/19 have been aligned to our areas of challenge which are our Targeted Intervention priorities and will focus on our five key priority programmes, whilst ensuring a focus on quality is also embedded across all that we do.

In 2018-19 we will focus on the 9 priorities shown in the box below.

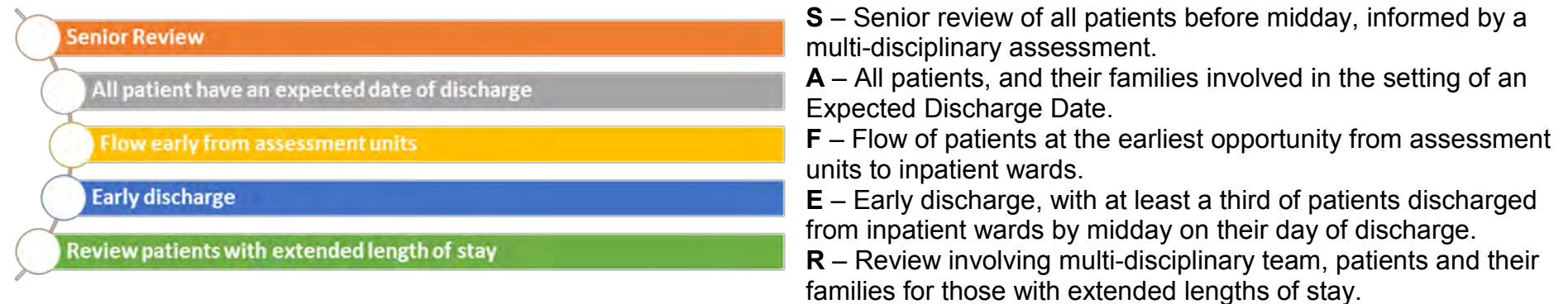


1. SAFER Patient Flow

We want to ensure that people don't have to stay in hospital any longer than is needed. This is important because there is evidence that staying in hospital for longer than necessary can be harmful as well as inconvenient. This is especially true for frail and elderly patients who can become very weak and decondition while in hospital which can lead to greater risk of falling or getting pressure sores and infections. We will work to make sure that we reduce any delays in hospital waiting for investigations and test

results and that when it comes to the time to go home we have planned what is required and made sure that everything is ready at discharge. We will aim to increase the percentage of patients discharged before noon.

SAFER consists of five elements of best practice as shown in the diagram.



<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Patient Flow metrics collected via Patient Flow Dashboard: • Stranded Patients – • Discharges before Midday • Length of stay • Expected date of discharge • Readmission rate	Unscheduled and Planned Care Service Improvement Plans. National Unscheduled Care Programme

2. Frailty Pathway - Comprehensive Geriatric Assessment

Older people admitted to hospital as emergencies are at especially high risk. 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 work to ensure that elderly people are assessed using a standardised comprehensive geriatric assessment across ABMUHB.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Audit of patients in defined age group receiving a Comprehensive Geriatric Assessment	Unscheduled Care Service Improvement Plan. National Older People and Frailty Programmes.

3. Falls

All falls, even those that do not result in injury, can cause older patients and their family to feel anxious and distressed. For those who are frail, minor injuries from a fall can affect their physical function, resulting in reduced mobility, and undermining their confidence and independence. Some falls in hospital result in serious injuries, such as hip fracture and head injuries and occasionally death. Falls prevention is a key issue in the improvement of health and wellbeing amongst older people as falls are a major cause of disability and death in older people in Wales. It is estimated that between 230,000 and 460,000 people over the age of 60 years of age fall in Wales each year.

In 2018/19 we will aim to:

- Reduce harm from falls in hospital;
- Promotion of falls prevention messages; and,
- Improve pathways for people who fall outside of hospital.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Via current mechanisms in Quality Dashboard and Ward to Board Dashboard (priority carried over from 2017/18).	Unscheduled Care Service Improvement Plan. 1000 Lives programme for falls prevention.

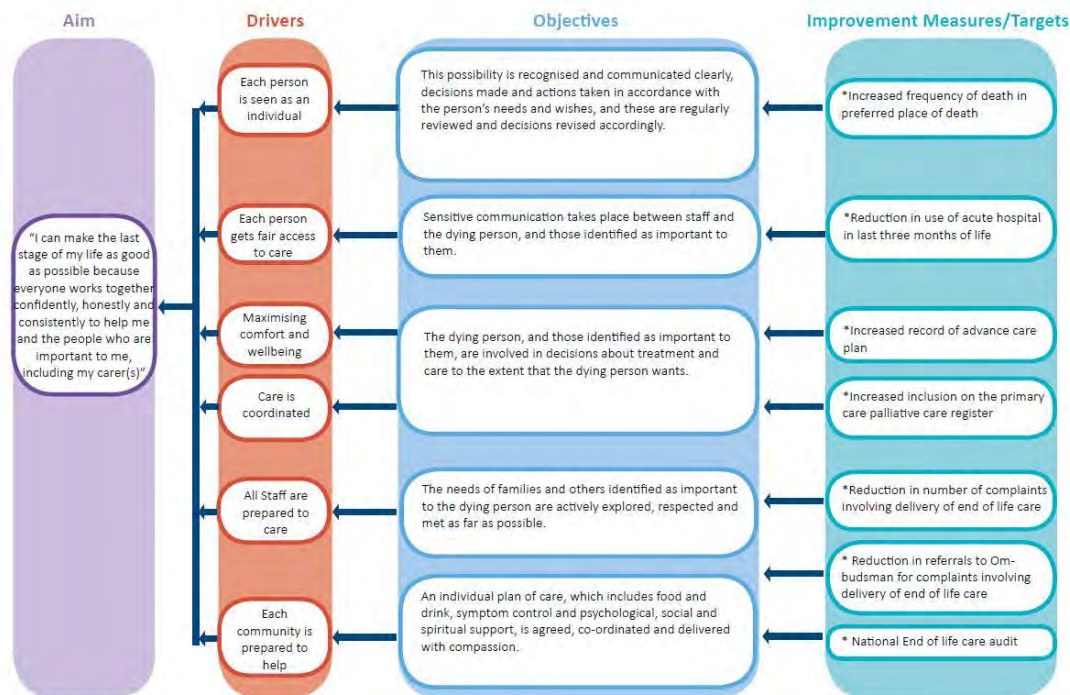
4. Improving Outcomes following Stroke

Our aim is to continually improve our stroke services as outlined in our Stroke Service Improvement Plan.

How we will measure this	Links to Service Improvement Plans and Strategic Priorities
Via the Performance Management Framework using NHS Wales Outcomes Measures (priority carried over from 2017/18).	Stroke Service Improvement Plan Stroke Major Health Conditions Delivery Plan

5. Improving End of Life Care

DRIVER DIAGRAM Service Area: End of Life Care



Our aim is to ensure that the possibility that a person may die within the coming days and hours is recognised and communicated clearly, that decisions about care are made in accordance with the person's needs and wishes, and that these are reviewed and revised regularly by doctors and nurses. Care should be tailored to the individual and delivered with compassion, with an individual care plan in place. A driver diagram has been developed to take forward our End of Life Care Priority and this will link with our work around the End of Life Care Delivery Plan.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Developing metrics to report via Quality Dashboard to Board and End of Life Care Delivery Board.	Unscheduled Care, Cancer, Stroke Service Improvement Plans Older People End of Life Care Delivery Plan

6. Improving Cancer Pathways

Our aim is to improving pathways for people referred with suspected cancer to ensure cancer diagnosis and treatment, or reassurance of no cancer, occurs at the earliest opportunity. Our plans are described in our Cancer Service Improvement Plan.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Via the Performance Management Framework using NHS Wales Outcomes Measures (priority carried over from 2017/18).	Cancer Service Improvement Plan Cancer Major Health Conditions Delivery Plan

7. Improving Surgical Outcomes

7.1 National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit is a National Clinical Audit commissioned by the Health Quality Improvement Partnership (HQIP). NELA is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NELA looks at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy and compares these against standards of care such as those detailed in recent NCEPOD reports, and the Department of Health/Royal College of Surgeons of England's "Higher Risk General Surgical Patient (2011)".

A comparatively large number of Emergency Laparotomies are carried out in ABMUHB at Morriston and Princess of Wales (>450 pa). This procedure carries a high mortality rate (locally around 13%), a high level of complications and there are significant variation in outcomes. The procedure carries prolonged length of stay (median ~13 days at Morriston and 9 days at POWH) and is often performed with elderly patients (~50%).

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Standard set of metrics reported contemporaneously into NELA database.	Unscheduled Care and Planned Care Service Improvement Plans Older People. National Quality and Safety Forum and 1000 Lives programme.

7.2 Lower limb major amputation for peripheral arterial disease

The National Vascular Registry (NVR) is a clinical outcome database commissioned by the Health Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) to measure the quality of care for patients who undergo vascular procedures in NHS hospitals. The NVR is designed to support quality improvement by providing data on provider activity, metrics on the process of care and clinical outcomes for the major vascular interventions including lower limb major amputation.

The metrics are drawn from a number of service guidelines, in particular, the Vascular Society of Great Britain and Ireland (VSGBI) “Provision of Vascular Services” document published in 2016, the VSGBI Quality Improvement Frameworks, and the National Institute for Health and Care Excellence guidelines on stroke and peripheral artery disease.

ABMUHB has the highest lower limb major amputation rate/1000 population in Wales (>3/1000) and undertakes the second highest number of these procedures in the UK. Over half of the amputations are carried out in patients with diabetes. These procedures carry a high in-hospital mortality rate (~10%) and the median length of stay is >20 days. Early recognition of peripheral arterial disease and prompt intervention is key to reducing the number of lower limb major amputations and improving patient outcomes.

<i>How will we measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Standard set of metrics reported contemporaneously into the NVR ABMUHB amputation rate in diabetic patients with peripheral arterial disease	Planned Care Service Improvement Plan Regional vascular pathways Diabetes Delivery Plan

7.3 Enhanced Recovery after Surgery

Most populations require surgery at some point within their lifetime. Many operations will be carried out in the elderly and in patients with numerous associated co-morbidities. Thus surgical care represents a significant patient safety risk and burden for the NHS.

The basic principles include ensuring the patient:

1. Is in the best possible condition for surgery
2. Has the best possible management during and after his/her operation
3. Experiences the best possible rehabilitation, has an optimal recovery and a timely discharge from hospital allowing them to return to their normal activities as soon as possible.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Developed metrics including length of stay, prescribing information and reporting of post-operative complications.	Planned Care Service Improvement Plan. National Planned Care Programme.

8. Reduce pressure ulcers

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

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
This will be measured and reported via current mechanisms and the Ward to Board Dashboard (priority carried over from 2017/18).	Unscheduled Care Service Improvement Plan Older People

9. Reduce Healthcare Acquired Infections

Our aim is reducing 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.

<i>How we will measure this</i>	<i>Links to Service Improvement Plans and Strategic Priorities</i>
Via our Performance Management Framework using NHS Wales Outcomes Measures.	HCAI Service Improvement Plan. National Infection Control Collaborative

Quality Management System

The intention is to further strengthen and refine our Quality Management System including our assurance processes around the domains of the Healthcare Standards and the requirements of the Older People's Commissioner to continue the development of our Ward to Board Quality Dashboard and Framework. The Dashboard has been launched and is now been aligned to the Nurse Staffing Act and will include the Quality Priorities indicators. The Ward to Board Quality Dashboard will be used to provide assurance to the Quality and Safety Committee of the Board.

The recommendations from the Delivery Unit Review of Serious Incidents and the Welsh Audit Structure Assessment will help direct this approach. The Health Board will initiate a Health Board Quality Improvement Hub as a driver for the revised Quality Strategy which will ensure that a relentless focus on quality improvement is embedded in all that we do. Through the Hub we will centralise the Health Board's quality management approach and ensure that learning from events and incidents drives continual improvement. We will also lead the strategic approach to quality and provide the capacity to support the delivery of key quality outcomes at the pace that is required.

We have agreed that all plans to reduce cost or remodel services to deliver services 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 will develop excellent digital communications to the Hub from across the Health Board and 'spokes' in other sites including community settings. It is proposed that the Hub will be located in the ILS@Morriston building in the initial stages of establishment and in the future there could be opportunities through ARCH for a purpose built facility.

There are also opportunities for collaboration with other partners across Wales and the global QI movement. This includes the Swansea Centre for Improvement and Innovation in Swansea University. There is a need for strong and dedicated senior clinical leadership for Quality Improvement to develop the Hub, drive up engagement in QI and deliver the benefits a QI Hub offers. It has

been agreed previously that when resources permit, a QI Director be appointed to lead the Hub with the option of a joint academic appointment with Swansea University to broaden the scope and ensure that QI in the Health Board is underpinned by best practice and knowledge sharing.

In building our workforce capacity and capability in quality improvement skills we have developed our QI 'dosing' principles; an ABMUHB framework to build improvement knowledge and practical application for every member of staff at all levels. The core content is the Improving Quality Together Bronze and Silver level awards with additional development on healthcare system engineering offered to managers, clinical leaders and team leaders.

Our mechanism for QI development is through structured teaching and/or work with specific teams, delivered flexibly to match their availability. In 2018/19, teaching on Value Based Healthcare (VBHc) and QI will be aligned, using a consistent language and delivered collectively.

Building general awareness, establishing a QI hub and having identified individuals with QI and VBHc expertise will generate a community of clinical leaders who are testing new ideas and supporting teams with implementation and spread. This approach will be fully aligned with the leadership development approach and culture through a more integrated people development strategy and encompassing learning programmes. Spreading success and learning will also be the focus of the Quality Improvement Team, supporting the staff engagement agenda.

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 strategy 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 333 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%.

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 5,000 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.

Patient Experience Aims for 2018/19

- Maintain the percentage of Family and Friends who would recommend the Health Board at 95%.
- Improve the level of feedback as a percentage of discharges to 25%.
- Develop a specific occupational therapy stroke survey and implement it to consider the results of the survey for service improvement.
- Develop a survey for Macmillan to capture feedback from the GP pathway and consider the results of the survey for service improvement.
- Inpatient surveys; in depth review of feedback for ophthalmology and cardiac services and consider the results for service improvement.

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**.

2.3 Operational Planning Principles

In order to become sustainable in the longer term in line with our statutory requirements under the Wellbeing of Future Generations Act we have changed our approach to prevention and public health intervention to include the principles of universalism and prudent healthcare, and to mobilise our whole workforce in this agenda as described in **Appendix 2**. We are also continuing our work in partnership to integrate our services and to agree and implement our Wellbeing and Area Plans with partners.

Our approach to operational planning in the context of developing a sustainable healthcare system for the population we serve is through a combination of approaches which interrelate and impact upon each other to differing degrees. Whilst the following three areas are inter-related, they set the context for the framework within which we have developed our plan.

Technical Efficiency

We will further embed and extend our work on technical efficiencies as we recognise that there is still considerable benefit to be gained from this. We have been clear on the expected improvements across the Health Board, e.g. on improving patient flow including reducing length of stay to improve outcomes and support Capita/PWC/Delivery Unit recommendations; theatre improvements; variable pay etc. This will enable us to ensure our workforce is supporting capacity in the right places and will also support workforce redesign in terms of skills and capacity. The good work undertaken in 2017/18 has provided a platform to build upon and significant savings have been realised in procurement, and our variable pay costs decreased prior to the winter period. We have a programme of work mapped for 2018/19 and have realigned our recovery and sustainability workstreams on outpatients, theatres and patient flow directly to our Improvement Boards so that they are working jointly to deliver efficiencies that will support performance improvements in the targeted intervention areas. We will also be focussed on implementing good practice and evidence reviews highlighted by the National Efficiency, Healthcare and Value Improvement Group.

Based on the Capita and PWC reports, and our own benchmarking work, the following efficiency indicators have been set for the Health Board. We have already improved length of stay, changed our service models and improved the quality of care for our patients, across our spectrum of services in 2017/18. These improvements have enabled us to reduce our baseline inpatient bed capacity by 97 beds by the end of 2017/18 (subject to engagement on permanent closure and the evaluation of impact). The benchmarked potential to achieve further improvement in patient flow and length of stay to underpin an additional programme of bed reductions in 2018/19 has been tested and is included as a key plank of our Annual Plan.

For 2018/19, we have set a stretching but achievable improvement targets for length of stay, theatre efficiency and outpatients, based on benchmarking, to achieve sustainability in our systems. These are all shown below and our actions to achieve them are included in our Service Improvement Plans.

Indicator	2018/19
Length of Stay	Improvement consistent with Welsh average benchmarking levels
Theatre Efficiency	90%
New OPs - DNAs	10% reduction
New OPs - Referrals	1% reduction (based on phased programme to balance the outpatients system)
New : Follow-Up ratios	Continuous Improvement consistent with CHKS peer group

The delivery of these measures will be assured through the dedicated Recovery and Sustainability Workstreams for Outpatients, Theatres and Patient Flow.

We have severe workforce challenges and are planning to improve our workforce through redesigning roles, and improving workforce efficiency and productivity to support new service models and models of care. The following workforce indicators will be used to measure our workforce improvements. Our workforce plan includes achieving the targets set out below, which will be delivered through the Workforce Delivery Workstream of the Recovery and Sustainability Programme; more detail is included in **Appendix 6**.

Indicator	Performance Measure	Origin
Vacancy Rate	5% for each staff group.	Health Board Target
Turnover within first 12 months of employment	Reduce from the March 2018 baseline figure.	Health Board Target
Sickness Absence	5%.	WG and Health Board target
Staff engagement	Improvement in the overall staff engagement score (bi-annually)	Welsh Government target
PADR compliance in last 12 months	85%	Welsh Government target
Compliance for each completed level 1 competency core skills and training framework	85%	Welsh Government target
Variable Pay	10% reduction from the March 2018 baseline figure.	Health Board Target

Alongside the improvement in these operational measures we will also continue our service and workforce redesign plans with our partners in the Local Authorities, Swansea University and Hywel Dda Health Board to transform our workforce models and reshape our approach to training and development. More detail on our transformational workforce agenda is included in **Appendix 6**. Specific workforce redesign schemes to support our Targeted Intervention priority areas are included in our Service Improvement Plans.

In 2018/19 there will be a new workforce redesign workstream within the Recovery and Sustainability Programme. This workstream will look at clinical roles across therapy, nursing and health sciences and will particularly focus on role redesign. The initial focus will be on areas where there are opportunities (due to workforce gaps and recruitment challenges) to consider new models, especially in areas where we are reliant on agency cover. The workstream will review skill mix opportunities within clinical support services where there is evidence that we have a 'richer' skill mix and will also consider other opportunities to drive efficiency – eg in management areas. It will also drive change through digital mobilisation and realising the benefits of the ongoing investment in digital infrastructure.

Allocative Efficiency

In 2018/19 we will refine and develop new service models using our approach to Value-Based Healthcare (VBHc). We are building on our detailed practical experience of using Programme Budget Marginal Analysis (PBMA) and Invest to Disinvest approaches to improve the allocative efficiency and quality of services and to become a Value-Based Healthcare organisation. These approaches have already been used successfully over the last three years to redesign our Musculo-skeletal Services pathways and to implement a pilot site project for the early diagnosis of cancer at Neath Port Talbot hospital.

VBHc places the focus entirely on one single overarching goal; improving health outcomes within benchmarked parameters and costs. Evidence suggests that, if implemented properly, VBHc can deliver value for patients, taxpayers and healthcare providers whilst also increasing the economic sustainability of the health care system. This goal is in line with *Prosperity for All* and the Wellbeing of Future Generations Act.

We have identified a programme of care pathway redesign across the whole system to support change in areas where there is clear variation in performance and outcomes across the Health Board, including, for example, changing models of out-patient care; reducing demand including thresholds for referral; limiting numbers of diagnostic tests; ensuring flexibility of the workforce to maximise service needs across the Health Board. This will be done within the context of service redesign to absorb/release costs and deliver care further upstream where possible.

The Deloitte's external review of our approach to Value Based Healthcare has now been completed. This confirmed that we have made good progress in a number of areas that we can build on and that we are focussed on a range of areas in which a VBHc approach can yield benefits. The review also highlighted that we need to expand the size of the programme and to be more ambitious if we want to drive substantial savings, and crucially, that we need to ramp up both capacity and capability in key areas such as programme management and data analysis. It also suggests that we need to take a programme-based approach to delivering transformed long term condition and planned care pathways.

The objectives of VBHc in ABMUHB are to:

1. Focus on what matters most to patients ie improving patient outcomes;
2. Support clinically led sustainable service change;
3. Incorporate delivery of the Prudent Healthcare principles;
4. Contribute to developing tools to align outcomes and cost analysis; and,
5. Inform and contribute to plans to deliver Health Board economic sustainability.

The pathways which we are focussing on redesigning in 2018/19 are:

- Ophthalmology/Ophthalmic Pathways;
- Cataracts;
- Diabetes Pathways Redesign;
- Respiratory Pathway Redesign (COPD, Asthma and Flu);
- Lung Cancer;
- Heart Failure;
- Pain Management; and,
- Vascular Limb at Risk Pathway.

We are also participating in the NHS Wales Strategic Alliance with ICHOM (International Consortium for Health Outcomes Measurement) which is supporting three outcome data collection projects for lung cancer, cataracts and heart failure.

The rollout of a VBHc approach requires organisational development linked to our training and development plans, and integrated with our Quality Improvement approach. The development of clinical leadership and champions is also essential to its success. Our Annual Plan commits to deliver the range of specific VBHc service change schemes outlined above which aim to deliver allocative and patient value and these are included in our Service Improvement Plans.

2.4 Service Change, Redesign and Demand and Capacity Planning

Technical efficiency and allocative efficiency are important foundations on which to build recovery and sustainability, however we know that we will not achieve financial balance through this work alone. Our Plan also sets out an ambitious programme of service change and reconfiguration because we know that the configuration of our services needs to change at pace in line with our Evolving Service Model to provide an operating model that fits within a sustainable workforce and financial envelope.

Acute and Community Services

In 2016 the Health Board commissioned Capita to undertake a system-wide demand and capacity review for acute and community inpatient services. The recommendations of the review were that demand would rise exponentially over the next five years due to an ageing population which will have disproportionately increasing demands for healthcare. To meet this demand whilst also achieving performance improvement in unscheduled and planned care there was large capacity gap in inpatient care, particularly in medical beds. However the review also identified that, compared to peers there was a significant opportunity to reduce length of stay, and that if improvement to only 50% of the peer average length of stay was achieved, capacity would exceed demand and savings could be released through service and capacity redesign.

During 2017/18 the Health Board has significantly improved patient flow and length of stay reductions, accompanied by new models of care both in the community and in hospitals which has underpinned a programme of capacity change. To date, the baseline has been reduced by 97 beds on a temporary basis, pending engagement and consultation, across all our services and acute and community sites. The changes have been subject to ongoing impact monitoring and there is evidence that in general services length of stay has decreased, particularly in Neath Port Talbot Hospital and Singleton. As a result, despite the reduction in bed numbers, the underlying indicators regarding bed occupancy are showing signs of resilience, cancelled operations (for reasons of bed availability), medical outliers and length of stay are either showing improvement, or are similar to the same period in 2016. This important learning came from our review of our winter planning arrangements. The changes in 2017/18 have also tested how we can improve our working with partners in light of the Parliamentary Review of Health and Social Care in Wales to radically change our service models. We believe that the changes we have made in 2017/18 have been a good test of our capability to remodel our services and we will use our learning to take forward our programme for 2018/19 and we believe that we can go further in testing new models of care with partners, e.g. through our joint work with housing, or Social Enterprise models for community care.

Our Annual Plan 2018/19 is based on a refreshed suite of benchmarking length of stay against the Welsh peer group, and this shows that there is still much room for improvement. This is a core plank of our Annual Plan through our Recovery and Sustainability Programme and will underpin a further programme of Service Remodelling of up to a further 145 beds across all our services and acute and community sites which will require significant change across all of our Delivery Units. In 2018/19, we will also focus on changing our models in frailty, mental health and learning disabilities to develop our community models to support a second phase of service remodelling and capacity redesign. The focus, with our Local Authority partners, will be on redesigning the pathways in line with evolving service models, including looking at 'discharge to assess' models and improved patient flow to alternative settings away from hospital.

Much of the longer term strategic direction is already set out – eg establishment of the single acute medical take at Morriston; renewed model of care for Singleton; implementation of the strategic framework for mental health and the primary and community services strategy and further options will be developed as part of the update of the Clinical Services Strategy. The service changes will also be underpinned by a targeted programme of digital improvement as described in our Service Improvement Plans and in **Appendix 8**, but within a restricted national capital environment as described later in Chapter 5.0.

However, two major risks to this programme are ensuring that we have sufficient capacity in community services to shift our Service Model 'Closer to Home' and the increasing number of medically fit for discharge patients in our beds. With regard to community and intermediate care services we have an agreed standard service model known as the 'Optimum Model' across the Western Bay Region. This is supported by Community Resource Teams under s33 agreements across all three Local Authority areas. In 2017/18, the Western Bay Regional Partnership commissioned Capita to undertake a review of community services to assess the model and recommendations for improvement. The standardisation of the model is being improved in line with the report and the recommendations to increase capacity through service improvement are being implemented. However, neither report was able to accurately confirm the overall volume of bed equivalents required in the community to support the Service Remodelling programme. Further external advice suggests that there are no 'off the shelf' models of bed equivalents available and therefore this will be a focus of local work in the early part of the year to facilitate the wholesale implementation of the capacity redesign programme to deliver the 50% benchmarked figure referenced by Capita.

To reduce the beddays lost through delays in transfers of care, the Health Board will also be focussing, through Executive to Executive engagement with partners, on maximising the operational benefit of the existing investment in community and intermediate care through Intermediate Care Funding, Pacesetters monies and our own previous IMTPs. Maximising the benefit of this investment to patient flow will be a key focus in 2018/19 and will include robust management of the discharge standards set by the Western Bay partners in 2017/18. Additionally, we will seek creative integrated and collaborative solutions to the difficult issues of domiciliary care and care home capacity through:

- Social Enterprise models;
- Further developing models of care with housing providers;
- Transfer of resources from inpatient care; and,
- Joint workforce arrangements.

Mental Health

In 2017/18 the Health Board commissioned an external Clinical Review of Older People's Services. This concluded that there was significant potential to improve the quality of care by rebalancing the service model from an inpatient to a community-based service. The report highlighted that Welsh peer group services have a 50:50 ratio of inpatient to community service, which in ABMUHB is a 70:30 ratio. To underpin the changing service model, the Health Board has invested approximately £1.5m in Older People's Community Mental Health services and this has supported a programme of changing service models with 18 beds being reduced in 2017/18 on a temporary basis pending consultation. Plans are in place within the overall Service Remodelling programme for a further reduction in 2018/19 which will be phased based on the ratio levels. Further detail on the plans for and impact of these changes is included in **Appendix 3**.

2.5 Our Evolving Service Model

Our Annual Plan has been developed on the basis of this Evolving Service Model which focuses on providing care 'Closer to Home'.

Evolving Service Model

An Interim Service Model, based on Prudent Principles and the Sustainability Principle as well as the work undertaken in Changing for the Better, the ARCH Portfolio Delivery programme, and the published or emerging service-specific strategies (mental health, non-surgical cancer, children and young people, primary and community services) has also been developed. This provides the context within which the detailed service changes in our Plan will need to be made. The Interim Service Model describes a continuum of care with the services also mapped to our delivery structures for clarity in developing our plans.



‘Closer to Home’ 



Health Board-wide Primary Care and Integrated Community Services supporting Wellbeing and Care ‘Closer to Home’

Patients will be able to access integrated services at home or as close to their homes as possible. The Health Board will design and deliver services so that health and social care professionals work with patients in:

- their home;
- their GP Practices ;
- community pharmacies, dental surgeries, high street opticians
- Health and Wellbeing Centres and venues in their neighbourhoods (in ‘Cluster Networks’);
- hospitals.

This will focus on:

- ‘place-based services’;
- seamless care provided by a few professionals, instead of multiple providers;
- integrated teams;
- keep people well and out of hospital for longer.

Patients will be able to:

Access primary care services 24 hours a day 7 a week where there is a demonstrable patient demand or need.

Transfer of traditional secondary health care to a community setting will occur only where this is safe and cost-effective to do so, and without destabilisation of existing primary care services.



Integration

Integrated mental and physical health community and intermediate care services based Pacesetter models, Community Resource Teams and the Western Bay Optimum Model.



Health Board-wide Mental Health and Learning Disabilities Services supporting all tiers of care

Older People’s Mental Health – rebalance care from hospital to community care in line with rest of UK.

Adult Mental Health – provide services across full spectrum of care needs (mild to severe); move from a medical to psychosocial model of care; more flexibility in accessing services; inpatient beds to be provided in the community (vacate Cefn Coed site).

Learning Disabilities – rebalance from institutional to home care – not a bed for life; repatriate our residents.

'Differentiated Hospital working within an Integrated Network'



Local Ambulatory Acute Care, Diagnostics and Rehabilitation with Excellent Training and Research

A Local Hospital at Neath Port Talbot with a specific focus on treating minor injuries, and a centre of excellence for:

- ➔ Assessment and treatment of frail older people and ambulatory care support for residents in Neath Port Talbot, as well as Bridgend and Swansea;
- ➔ Increasing levels of short stay elective surgery;
- ➔ Providing local rapid diagnostic access and support;
- ➔ Delivering rehabilitation services (including specialist neuro rehab);
- ➔ Delivering Wales Fertility Institute services.

A Health Campus including a Level 2 Hospital at Singleton acting as a Centre of Excellence for ambulatory emergency care with one front door housing a Singleton Assessment Unit that is GP-led which will:

- ➔ Become a centre of excellence for a range of diagnostic, rehabilitation & treatment services including ambulatory care;
- ➔ Undertake increasing levels of elective surgery – which may be of high complexity, but on patients with lower levels of acuity;
- ➔ Allow Swansea University's Medical School to build on the success of its Institute of Life Science (ILS) with the establishment of its Healthcare Technology Centre (HTC);
- ➔ Create new space to teach our future doctors, nurses and Allied Health Professionals.



Acute and Complex Care, Tertiary and Specialised Services with Excellent Training and Research

A Level 3 District General Hospital at Princess of Wales providing a full range of urgent and emergency care services, including:



- ➔ consultant led ED services inpatient paediatrics;
- ➔ consultant led obstetrics;
- ➔ local neonatal care services;
- ➔ Centre of Excellence for Ambulatory Emergency Care with assessment and treatment of frail older people.



A Health Campus including a Level 4 Regional Centre at Morriston for specialist emergency and complex care not only for the people of ABMU but also people from South and West Wales and further afield which will:

- ➔ Act as a Large Trauma Unit and lead the Major Trauma Network (subject to consultation) as well as providing a full ED service for the residents of Swansea, Neath Port Talbot and elements of Hywel Dda;
- ➔ Have the single acute medical intake for Swansea & Neath Port Talbot, which will include the Hyper Acute Stroke Unit for the region;
- ➔ Deliver complex surgery across a broad range of specialties, particularly for patients of high acuity;
- ➔ Provide Critical Care;
- ➔ Provide specialist diagnostic support and centralised Pathology;
- ➔ Provide consultant led Obstetrics, Neonatal & Gynaecological Services;
- ➔ Provide the Cancer Centre for SW Wales including Aseptic Unit;
- ➔ Provide some tertiary services including cardiology and cardiac centre – and develop stronger relationships with other specialist centres;
- ➔ Have strong research links with Swansea University.

2.6 Other organising principles and plans

The Organising Principles for public health and prevention, primary and community care, mental health and learning disabilities, older people, children and young people and maternity are included in **Appendix 2**. Our detailed plans for mental health and learning disabilities, children and young people and maternity services are found in **Appendices 3, 4 and 5**.

2.7 Alignment of the Annual Plan and Recovery and Sustainability Programme

Much of the delivery of the Annual Plan will be managed through our Recovery and Sustainability Programme. As set out previously, this has been reviewed, and the structure has changed to ensure alignment. The following tables show in more detail the key projects for the Programme for 2018/19 and which of the Recovery and Sustainability workstreams support the Plan's Service Improvement priorities, either directly or as an enabling project.

RECOVERY AND SUSTAINABILITY PROGRAMME Key Projects 2018/19					
SERVICE REMODELLING					
Service Redesign	Models of care – frailty, mental health and learning disabilities	Surgical services redesign	Service changes in areas including MIU, endoscopy	Pathways between acute and community settings	Western Bay & use of ICF funding
Workforce Redesign	Review of therapy staff – location and sizing	Review skill mix opportunities	Alignment with service remodelling	Role substitution	Community Nursing – sizing and skill mix and digital mobilisation
SERVICE OPTIMISATION					
Theatres	Efficiency & Performance	Pre assessment	Theatre manpower utilisation	Standard Operating Procedures	
Outpatients	Transformation /scale up of pilot schemes eg text reminders	DNA/CNA reduction	Efficiency & Productivity	New models of initial and follow ups	National planned care initiatives/good practice
Patient Flow	Discharge to Assess	Cultural change – moving from 'cwtch' culture	Pathway for non injured fallers	Relaunch of SAFER flow	Patient flow metrics
TECHNICAL EFFICIENCY					
Medicines Management	Homecare – expansion of services within haematology	Biosimilars – Humira, Infliximab	Antiretroviral	Potential use of Avastin for Wet AMD	Hepatitis C – being assessed
Value Based Procurement	Extend QVC into clinical goods including national initiatives	Stock management – reduction in stock wastage and business case for new stock management system	Procurement Compliance – no PO no pay	Decrease variation in clinical and non clinical supplies (Carter review)	Oxygen Finance pilot

RECOVERY AND SUSTAINABILITY PROGRAMME Key Projects 2018/19					
WORKFORCE – EFFICIENT AND EFFECTIVE DELIVERY					
Workforce Delivery	Bank and Agency spend (reducing variable pay)	Incentivising bank take up	Rostering efficiency – medical and nursing	Corporate Health and Well Being (reducing sickness absence)	Sickness Management and compliance
ALLOCATIVE EFFICIENCY					
Value Based Healthcare (including Prudent Health Care)	Respiratory pathway redesign (COPD, asthma and flu) Diabetes pathway Vascular limb at risk pathway	Ophthalmology/Ophthalmic pathways & Cataracts	Lung cancer	Heart failure	Pain Management
Clinical Variation	INNUs	Do Not Do's	Pathway variation by specialty/consultant	Variation in clinical supplies	
Review of Spending above Mental Health Ringfence	Projects being scoped				

MATRIX OF SERVICE IMPROVEMENT PRIORITIES AND RECOVERY AND SUSTAINABILITY PROJECTS

Recovery and Sustainability Programme Note 1	Service Improvement Priorities				
	Cancer	Unscheduled Care	HCAI	Planned Care	Stroke
Service Remodelling	○	●	●	●	●
Service Optimisation: Theatres	●	○	○	●	○
Service Optimisation: Outpatients	●	○	○	●	○
Service Optimisation: Patient Flow	●	●	●	●	●
Value Based Healthcare	●	●	○	●	●
Medicines Management	○	○	○	○	○

Recovery and Sustainability Programme Note 1	Service Improvement Priorities				
	Cancer	Unscheduled Care	HCAI	Planned Care	Stroke
Workforce Redesign	○	●	○	●	●
Workforce Delivery	○	○	○	○	○
Value Based Procurement	●	●	●	●	●
Clinical Variation	●	●	●	●	●

Note 1 Workstreams are being rescoped for 2018/19–
update in February 18

Directly supporting TI priorities

Enabling work streams

2.8 Service Improvement Plans

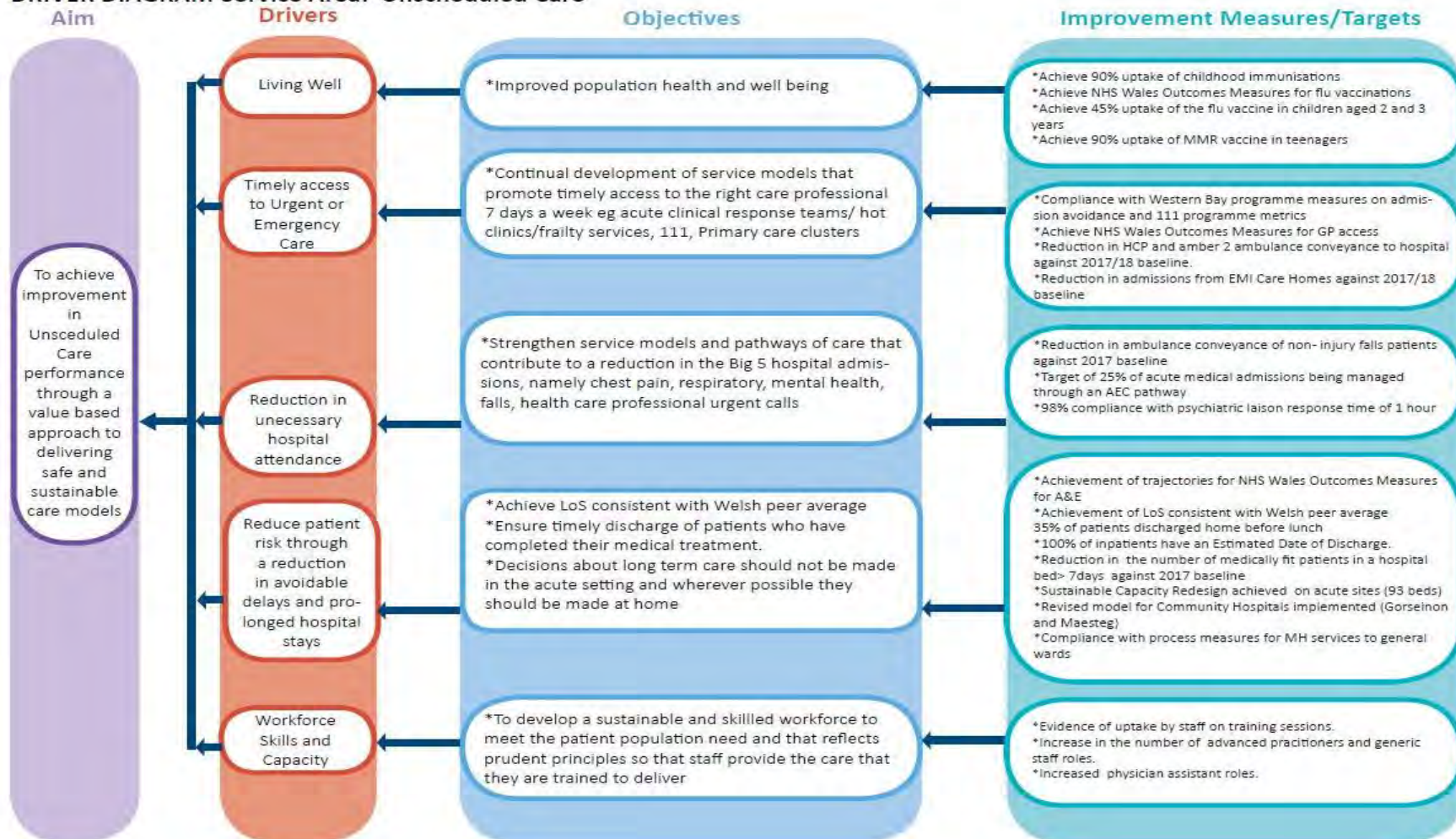
Our Annual Plan is based on five Service Improvement Plans for our Targeted Intervention priority areas of Unscheduled Care, Stroke, Planned Care, Cancer and Healthcare Acquired Infections. An analysis of the drivers of improvement has been undertaken for each area using a driver diagram diagnostic tool and the diagrams are included in each section. Our progress to date, approach, plans for 2018/19 and trajectories are also included in each section, as well as the specific enabling actions for each area, relating to workforce, capital infrastructure, digital health and revenue. For each area the detailed, SMART objectives, actions, measures, timescales and leads are included at the end of the document in **Annex 1**.

Our capital infrastructure enablers are indicative at this stage pending the finalisation of the Health Board's Capital Programme. All plans are based on performance improvement within our overall aim of reducing our vacancy gap, our financial control total and a restricted Welsh Government capital environment. Our work on our local Delivery Plans is referenced where appropriate through the Service Improvement Plans. Our Rare Diseases Delivery Plan weaves across all our work and is included in **Appendix 14**. Our Organ Donation and Transplantation Plan for 2018/19 will be produced by June in line with Welsh Government timescales. Our current 2017/18 plan is included in **Appendix 14**.

3.0 SERVICE IMPROVEMENT PLANS

3.1 UNSCHEDULED CARE SERVICE IMPROVEMENT PLAN

DRIVER DIAGRAM Service Area: Unscheduled Care



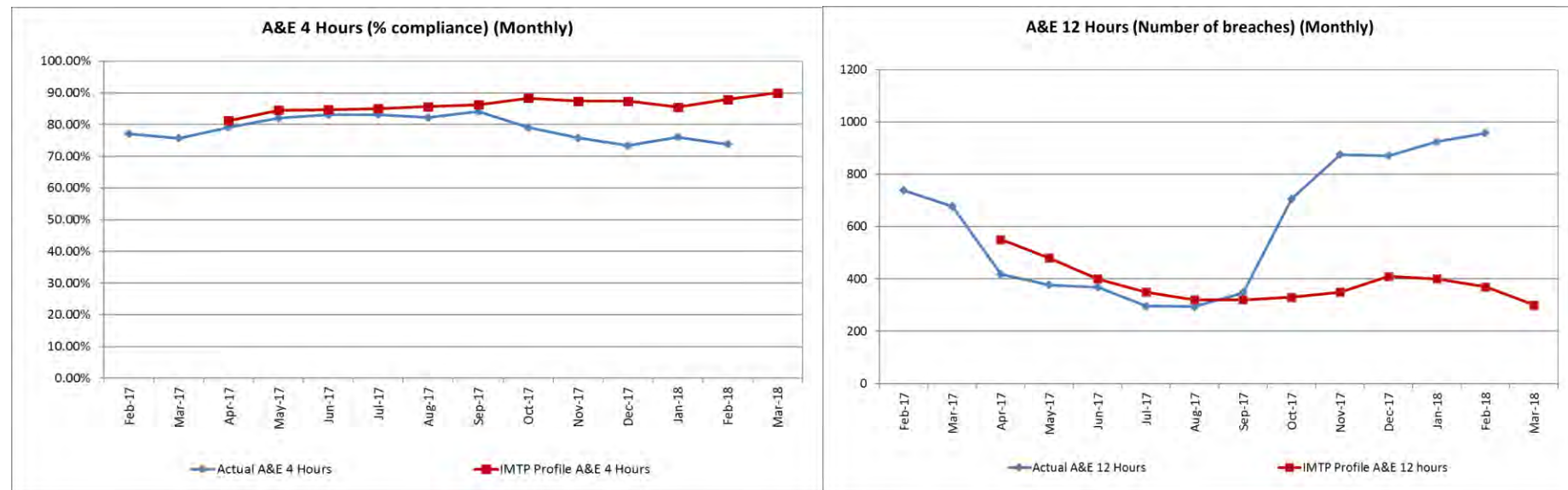
Baseline Position

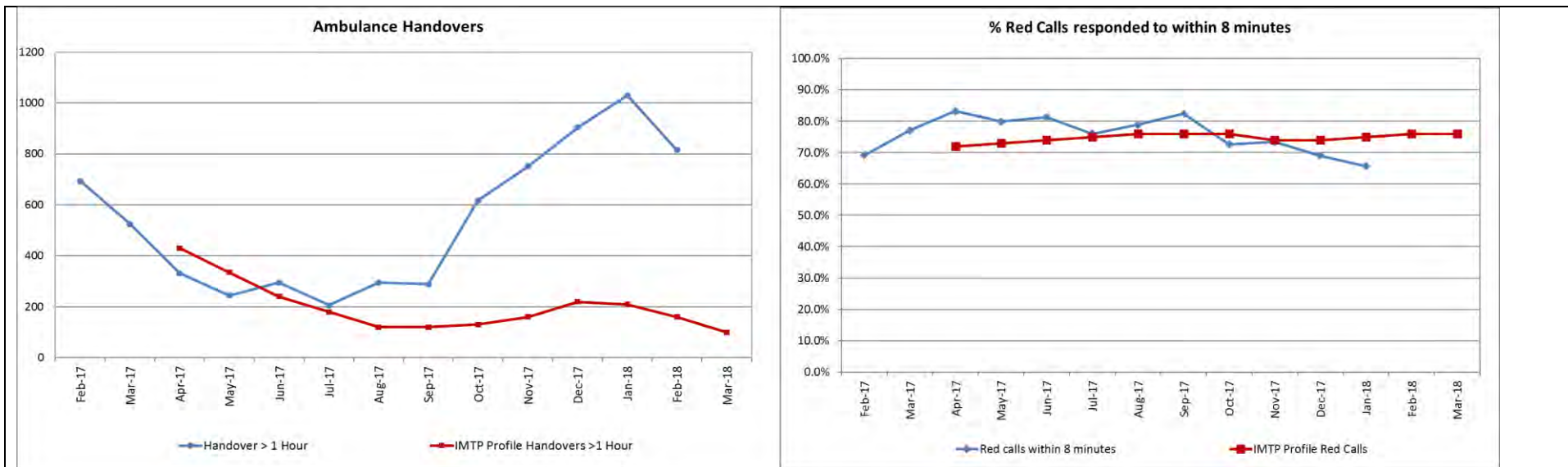
Demand

The number of ambulance conveyances to our emergency departments has increased by 1% in 2017/18, compared with the same period in 2016/17 but the nature of the demand has changed during this year. We have experienced a **25%** increase in the number of red calls and a **2.6%** increase in the number of amber calls, but a **16%** reduction in the number of green lower acuity / health professional calls, which is attributable to the successful implementation of the 111 service in our area and other pathway improvements implemented between WAST and the Health Board. These avoid the need to convey a patient to an emergency department and we are pleased that we now have the lowest proportion of green calls in Wales.

Performance

The Health Board made progress in relation to unscheduled care flow and performance in the first two quarters of 2017/18, due to changes to reduce our length of stay through the implementation of different models of care and our operational unscheduled care improvement programme which was described in our Annual Plan 2017/18.





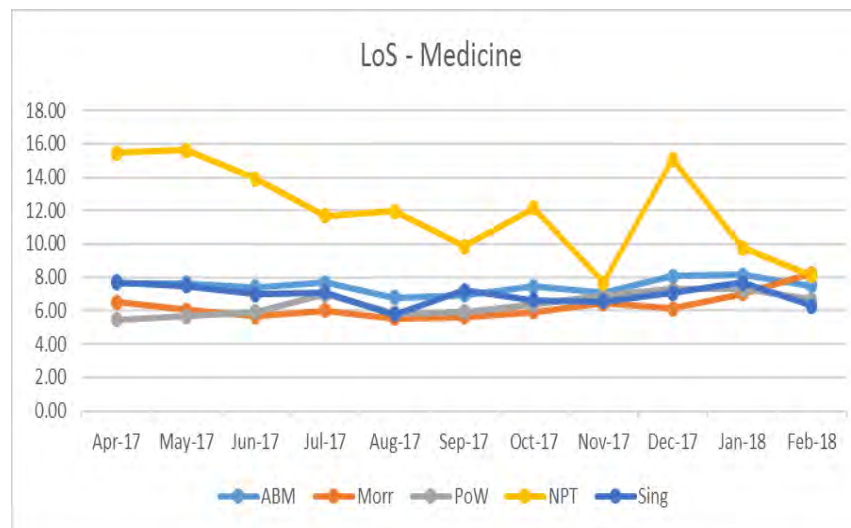
*Whilst ambulance handovers are reported against a 1 hour benchmark at the moment, the health board acknowledges that the target is to handover within 15 minutes and we will therefore recommence monitoring of this target.

Our performance in terms of 4-hour waits improved steadily from January 2017 to September 2017, with September showing the highest performance against this measure since September 2014. Similarly, overall Health Board performance for 12-hour waits improved in line with the Annual Plan trajectory until September 2017 but then deteriorated in the autumn and winter, in a trend which was not underpinned by an increase in overall demand. However, there has been a shift in demand towards attendances through our main Emergency departments, and reducing at our minor injuries units.

The nature of the demand over the winter months has also changed, as the patients presenting at our hospitals who require care and treatment have increased complexity and severity of conditions. The first two months of 2018 have seen significantly higher rates of admissions for patients with influenza than experienced for several years, which has impacted on patient flow and capacity across the health and social care system over this period. The month of February 2018 experienced a 10% increase in admissions in the over 80-year old population compared with February 2017.

However although the length of stay for medical patients has increased over the winter months, when compared with 2016/17, our

length of stay has reduced, as well as the number of medical outlying patients, which is a positive indicator of improving efficiency and flow.



The green shoots of sustainable improvement at Morriston hospital that were seen over the summer period were not experienced at Princess of Wales (POWH) hospital where there was a decline in performance over this period when compared with 2016/17. The improvement programme at Morriston was supported by the Emergency Care Improvement Programme (ECIP). Targeted assistance from ECIP has been secured to support improvement at POWH which commenced in January 2018.

Service Improvement Achievements

Our Annual Plan 2017/18 described our structured approach to improving Unscheduled Care based on the national Unscheduled Care programme, learning from NHS England (including the Ambulatory Care Network) and local external reviews (such as ECIP). Our plans included:

- Maximising the use of WAST pre-hospital alternatives to conveyance;
- Maximising the use of the investment in Intermediate Care through Intermediate Care Fund (ICF) funding and our Community Resource Teams;
- Implementing Ambulatory Emergency Care;

- Rolling out the SAFER care bundle and Comprehensive Geriatric Assessment; and,
- Implementing the ECIP review at Morriston.

In year, our work to improve Patient Flow was supported by the establishment of the Patient Flow Workstream of the Recovery and Sustainability Programme which developed suite of actions and measures to ensure standard implementation on all sites, standard operating procedures and policies, supporting workforce models and plans and the standardised use of a core set of flow metrics, This, together with the use of the Comprehensive Geriatric Assessment will be further embedded as Quality Priorities in the coming year. At Morriston hospital an electronic patient flow system has been developed using the existing functionality of the PAS system pending the implementation of a national Emergency Department (ED) system.

Service Redesign Achievements

In addition to a focus on good practice in patient flow, following capacity/demand modelling, benchmarking, and increasing sustainability issues in relation to medical and nurse staffing, the following changes to service models been implemented:

Primary and Community Care

- We already have in place a jointly agreed Optimum Model of Care for Intermediate Care.
- The 111 service has been successfully introduced in 2017/18 and is now embedded as core delivery for the Health Board, as a result we have the lowest number of Healthcare Professional (HCP) calls to WAST in Wales.
- The Neath Hub Pacesetter MDT model has been successful in supporting Cluster-level collaborative working and service sustainability and has informed the emerging national Primary Care model and the Health Board's Primary and Community Services Strategy.
- The rehabilitation pathway into Gorseinon community hospital has been redesigned resulting in a reduction in patient length of stay whilst maintaining the same level of activity within a reduced bed base.

Acute Care

EXAMPLES OF GOOD PRACTICE: Front door assessment for elderly patients



PROBLEM

Demographic changes means there is an increasing number of frail elderly patients needing NHS care. These patients often have complex care needs and long lengths of stay. It is estimated by one of our consultants that as many as 65% of elderly patients do not need to be in hospital.



SOLUTION

In Singleton and the Princess of Wales hospitals, new ways of 'front door assessment' are being introduced to better manage the care of these patients by avoiding admission wherever possible and for those who do go onto a ward, reduce their length of stay.

At Singleton Hospital, an acute frailty service has been piloted at the Singleton Assessment Unit. Front-door assessment is carried out by a multidisciplinary team including a doctor, physiotherapist, occupational therapist and pharmacist.

At the Princess of Wales Hospital, as the first phase of POWH's elderly care configuration, an Acute Frailty Unit was established on Ward 20. This is where patients admitted after assessment are cared for during the acute phase of their illness. They then transfer to a non-acute elderly care ward or go home, again with any necessary care provided by a community team.

RESULT

At Singleton, in the first three months of the pilot, 118 patients had front door assessment on arrival at the SAU. Of these, 38% did not need to be admitted, and spent on average two days in the unit.

At the Princess of Wales Hospital, the changes have seen the average length of stay on ward 20 reduce from, 17 to 11 days, and this has been sustained over 12 months.



pharmacy input which has underpinned a lasting reduction in length of stay on site.

Service Remodelling

The Capita whole system demand/capacity review which was undertaken in 2016 identified that the Health Board had significant opportunities to reduce length of stay and to improve sustainability through changing service models. The quality improvement and service redesign work described above has led to underlying reductions in length of stay, particularly at Singleton and Neath Port Talbot hospitals which has underpinned a programme of Service Remodelling through a formal Workstream of the Recovery and Sustainability programme. The decompensating effect on older people of an extended length of stay in hospital is well-evidenced

- Ambulatory care models have been implemented at Morriston, Singleton and POWH.

- Enhanced frailty services have been implemented at Singleton and POW hospitals, including the appointment of a new Acute Care Physician at Singleton and Care of the Elderly consultant presence at the POWH front door from January 2018.

- Psychiatric liaison has been fully implemented on all general hospital sites.

- Length of stay at Neath Port Talbot Hospital has decreased significantly as a result of the implementation of an Enabling Ward and the multi-disciplinary assessment team known as the Transfer of Care and Liaison Service (TOCALS) into Morriston hospital.

- The Enabling Ward at Neath Port Talbot has also included a significant change to the workforce model to a nurse/therapy ward with additional

and the Workstream has therefore supported a temporary reduction in inpatient capacity of 79 beds on general acute and community sites (as well as 18 beds in older people's mental health services) to improve the quality of care, and in line with our Evolving Service Model which promotes care 'Closer to Home'. The intention is to make these changes permanent following engagement and consultation in 2018/19.

Our Approach for 2018/19

The Health Board is fully engaged in the national improvement work through the [National Unscheduled Care Programme](#) and our plans for 2018/19 are based on the national approach and address the five national priorities which are:

- falls;
- breathing difficulties;
- chest pain;
- health care professional calls; and
- mental health.



We have made excellent progress in 2018/19 in implementing the Emergency Ambulance Five-Step pathway as evidenced in **Appendix 10** through new and enhanced services for:

- 111;
- Falls;
- Healthcare Professional (HCP) calls; and,
- Frequent callers particularly from care homes.

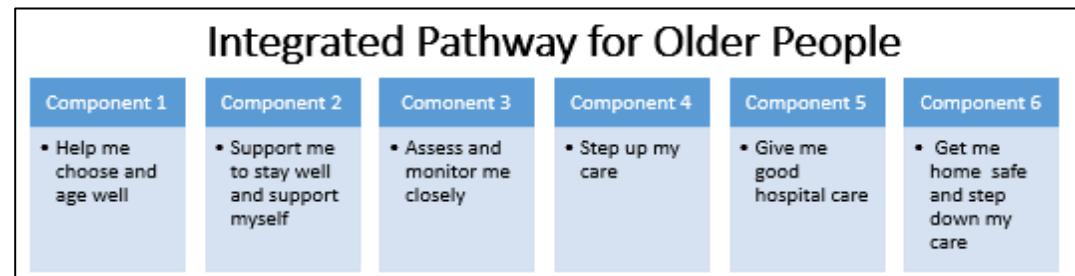
We will continue to implement innovative models with WAST partners in 2018/19, particularly maximising the benefits of linking the multi-disciplinary skills base in our Community Resource Teams (CRTs) with WAST services to reduce the number of conveyances for falls and other non-acute conditions.

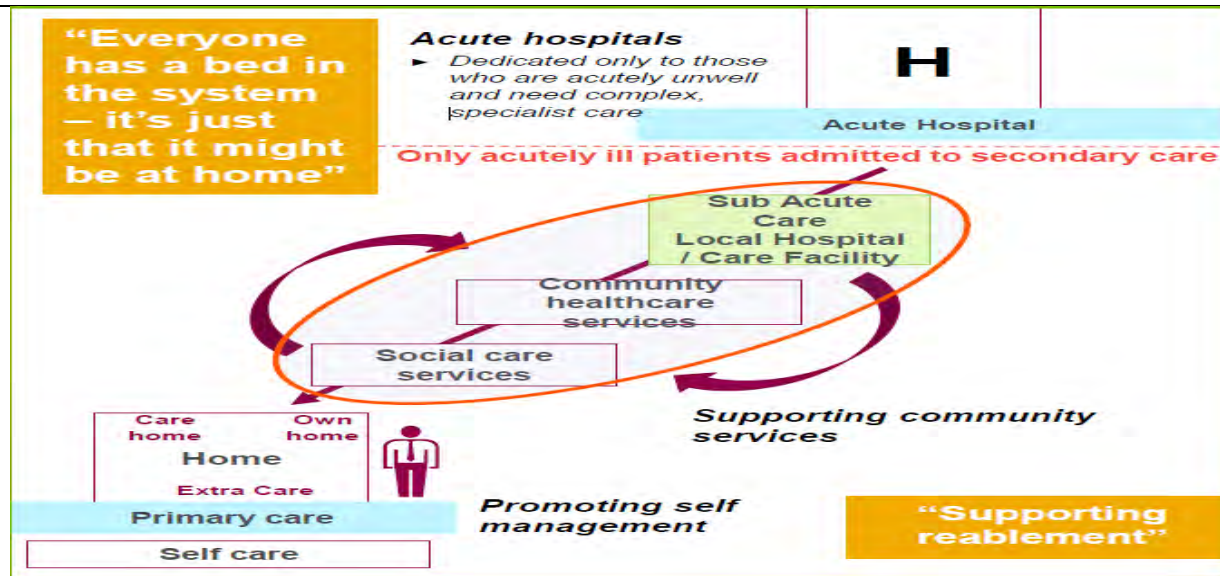
As part of collaborative working between Welsh Ambulance Service, ABMUHB and Local Authorities the Welsh Ambulance Services Trust (WAST) has developed a new toolkit called 'iSTUMBLE' for use in care homes when someone has had a fall. It is designed to provide a checklist for clarity when calling for help – and to help decide if it is necessary to call for an emergency ambulance. The Toolkit is intended to equip staff with the knowledge and processes required to manage falls and prevent residents having to travel to hospital unnecessarily. It is being cascaded to all care homes across our Health Board to ensure a consistency approach to falls

prevention and management.

The timely care for older people based on the national Frailty Pathway is also an underpinning element of our plans going forward. We already have in place a jointly agreed Optimum Model of Care for Intermediate Care for the whole Health Board population area which has been implemented through integrated Community Resource Teams underpinned by three s33 agreements (one for each Local Authority area). We also have s33 agreements in place for our two Integrated Community Equipment Services. In 2018/19 our focus will be to maximise the benefit of the investment in the CRTs through Intermediate Care Funding and our previous IMTPs. This will be supported by performance management of the discharge standards agreed through Western Bay this year and we will be reviewing the return on investment to ensure the best use of our resources to achieve performance and quality improvement in 2018/19.

We will continue to implement our agreed service model in 2018/19 which is based on the Capita work undertaken 2016 and the national programmes outlined above and which is shown in the following diagram.





As part of our winter plan, our “Breaking the Cycle” activities provided some rich learning and also resulted in the prevention of escalation of pressures across acute care. As part of our drive to be a learning organisation we have evaluated the winter plan and have found the following: -

- Positive impact of **strengthened frailty models** – evidence of increased admission avoidance and bed days saved.
 - Increased discharge to assess capacity
 - Accelerated Placement Team in NPT
 - Senior community nurse at Singleton SAU
 - Embedding redesigned frailty model in PoW
 - Frailty service in Morriston with increased physiotherapy support.
- Maintain and increase focus on patient flow – **SAFER** ‘Red to Green’ days, systematic daily board rounds, resolve internal delays, escalate external delays, increase discharges occurring before midday.
- Revisit **escalation actions/triggers** to support earlier de-escalation of risk.
- Earlier increase in unscheduled care pressures resulted in **acceleration of surge capacity plans**, plus additional surge capacity options were implemented mid-December/ early January.
- **Successful models** implemented to maintain clinically urgent/ cancer elective activity resulting in reduced patient cancellations – 56% reduction in January 2018 compared with January 2017.

We will ensure that we take this learning forward into 2018/19 and into our plans to manage winter pressures.

Our longer term aim remains to centralise our acute medical take for Swansea to Morriston hospital, as outlined in the ARCH programme. In 2018/19, the service remodelling work stream will begin a second phase which will look at changing community hospital models of care and the flow between hospital and community services, particularly targeting patients who require further assessment using a 'discharge to assess' principle and where patients are waiting for alternative care settings/packages. An innovative solution is currently being tested in NPT Hospital utilising winter pressures funding.

The change in demand that we experience in the winter may be related to the fact that the highest proportion of acute medical admissions are for respiratory disease and our Respiratory Disease Delivery Plan and clinical action group are key to managing this demand. Our Respiratory Diseases Delivery Plan will be refreshed following the publication of the new National Respiratory Diseases Delivery Plan in June 2018 and our existing three-year plan is appended in **Appendix 14**. Our work to improve outcomes, to improve our alcohol services and manage demand for liver disease is also included in our Liver Disease Delivery Plan which is included in **Appendix 14**.

We will also be implementing a suite of service redesign projects using the Value-Based Healthcare approach that will help us to achieve a sustainable unscheduled care system as follows:

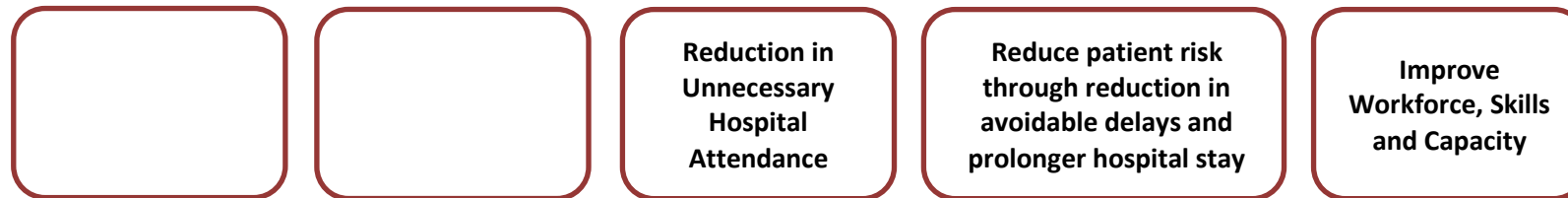
UNSCHEDULED CARE Service Redesign Projects	
Chronic Obstructive Pulmonary Disease (COPD) Pathway Early supported discharge, community service	Stroke PROMs data collection to inform pathway improvements
Flu & Asthma Extension to COPD	Heart Failure ICHOM Set 2
Asthma Lead design of standardised outcome data set	

To provide assurance on the delivery of our Service Improvement Plan in 2018/19 and to support development of our longer term plans, we will be reinstating the Unscheduled Care Board. The Service Remodelling and Patient Flow Work streams of the Recovery and Sustainability Programme will also be formally linked through revised programme management arrangements to

ensure that the quality and financial elements of this Plan are aligned.

Our Plans for 2018/19

Our overall aim in 2018/19 is to achieve improvement with the NHS Wales Outcomes Measures for Unscheduled Care whilst also delivering improved quality and sustainability. Our drivers are:



Our plans for unscheduled care service improvement in 2018/19 is to maintain our 2017/18 priorities as these largely reflect national priorities:

- Prevention actions;
- Working with WAST to signpost increased number of patients to alternative pathways that avoid Emergency Departments (particularly around falls not causing harm);
- Further increasing the number of patients following Ambulatory Emergency Care pathways;
- Increasing the number of patients having a Comprehensive Geriatric Assessment;
- Further improving compliance with SAFER flow bundles;
- Improving timely access to health and social care community support for admission prevention and timely discharge;
- Maximising the use of the investment made through the Intermediate Care fund monies and our Community Resource Teams; and,
- Ensuring our Delivery Units act as a network to provide an integrated approach to managing the Big 5 conditions and the Older Persons pathway.



Improvements in public health and our prevention actions are key components of our service model as demands upon our urgent and unscheduled care services continue to rise as a result of demographic and population health challenges. This priority includes our public health and prevention actions in the wider sense including oral health and mental wellbeing but our actions in 2018/19 also include improving our rate of vaccinations and continuing to improve flu immunisation rates. In 2017/18 we agreed our Dental Recovery Plan to ensure resources allocated for dental services are used to improve population health and we have been at the forefront in pushing the boundaries of the current restricting GDS contract which disincentives 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 2018/19 and is included in **Appendix 14**. We are also planning for our Wellbeing Centres in Bridgend and Swansea for which funding has been agreed through Primary Care Pipeline monies and which will service a new model of integrated care to promote good physical and mental health.



This driver ensures that our patients can access the right level of care for their needs through primary and intermediate care. Our actions include continuing to maximise the use of 111, ensuring patients have good access to general practice and maximising the investment that has been made in CRTs and our intermediate care model through the Western Bay Programme. During 2018/19 we will be reviewing the investment made through ICF and other funding streams into intermediate care to ensure there is maximum benefit to patient flow and will disinvest to reinvest if required.

based on the Capita and Cordis Bright reviews of community services we will be disinvesting in anticipatory care planning models, which have not proven effective, and reinvesting in other proven admission avoidance services to ensure that quality care is provided in line with our 'Closer to Home' ethos. We are also reviewing the skill mix within the teams using Prudent principles to make the best use of our resources. We also plan to implement changes to our Out of Hours services in 2018/19 (subject to CHC and public engagement/consultation) to ensure that we can provide a sustainable, responsive model.

The actions to achieve this driver strengthen our service models and pathways of care to reduce conveyances, attendances and admissions for the 'Big 5' unscheduled care priorities based on the WAST 5-step pathway, the Emergency Ambulance Service Committee's (EASC) Commissioning Intentions and the national Unscheduled Care Programme. The development of new models for patients who have fallen, but who are not injured, will be a particular focus of our work in 2018/19, based on the analysis of our conveyances and demand data with partners in the Local Authorities and WAST. Using the principles of Prudent Healthcare we will be working with WAST colleagues to link the multi-disciplinary skill base in our CRTs with WAST services to reduce conveyances for falls and other non-acute conditions as outlined in **Appendix 10**. Other enhanced or new services will include:

- Rolling out the frequent callers initiatives to prisons and a wider spread of care homes;
- Linking WAST and our mental health services to reduce conveyances of people in crisis;
- Continuing to roll our trials of community paramedics.

We will continue to maximise the use of Ambulatory Emergency Care across all our emergency care sites and will also be implementing a new measure for the psychiatric liaison services across the Health Board to ensure that services at the Front Door are timely and responsive.

Reduce patient risk
through reduction in
avoidable delays and
prolonger hospital stay

This driver includes actions to improve patient flow through our Emergency Departments (ED) and system. We will implement the recommendations of the ECIP reviews in Morriston and Princess of Wales Hospital (POWH), within available resources, to base our ED models on best practice, and will ensure that Minors stream processes are fit for purpose. There are Consultant doctor vacancies in ED at Morriston but our trajectories are based on service improvement within the current resources in the pathway. If it becomes possible to opportunistically recruit in year we will consider this through the Investments and Benefits Group within the context of the financial plan.

Our plan also includes improvement to the surgical assessment pathways in POWH by creatively using existing resources through Prudent principles. We will also continue to maximise our frailty models and ensure all patients over the age of 75 years have a Comprehensive Geriatric Assessment.

Our Respiratory Diseases Delivery Plan and Liver Disease Delivery Plan are critical to managing demand for these core groups of patients, and improving outcomes through targeted service improvement and pathway change. These Plans are included in **Appendix 14**. The Patient Flow Workstream programme will continue and we will ensure all parts of our system work as an integrated network to improve Unscheduled Care performance and to protect elective capacity. This includes maximising the impact of the SAFER flow bundle, and transfer measure and standards within our hospital network. As evidenced in 2017/18 improving our flow cannot be undertaken in isolation and we will be robustly managing our relationships with Local Authority partners to ensure that the discharge standards set out by Western Bay are met and that the numbers of medically fit for discharge patients decrease, as well as looking at new models of care.

As well as these operational improvements we know that structurally there are challenges with capacity in domiciliary care and care home capacity. We will putting in place creative solutions to address these issues through:

- Social Enterprise;
- Further developing models of care with housing providers;
- Transfer of resources from inpatient to community care; and,

- Joint workforce models.

Through these actions we will reduce our length of stay to be consistent with the Welsh peer average. This will improve quality outcomes by reducing the deconditioning effects of hospital stay on older people, promoting independence and reducing the chances of a transmission event for a healthcare acquired infection. The reduction in length of stay will also support a further programme of changing service models across community and acute health inpatient facilities, allowing us to move to a sustainable workforce and financial position by reducing or bed capacity by up to a further 145 beds. Parallel changes will also be actioned in mental health services to rebalance the older people's mental health service towards a community-based model.

We will also develop underpinning plans for a revised frailty model to ensure that we are complying with best practice and can implement standardised models across the Health Board.

**Improve
Workforce, Skills
and Capacity**

We

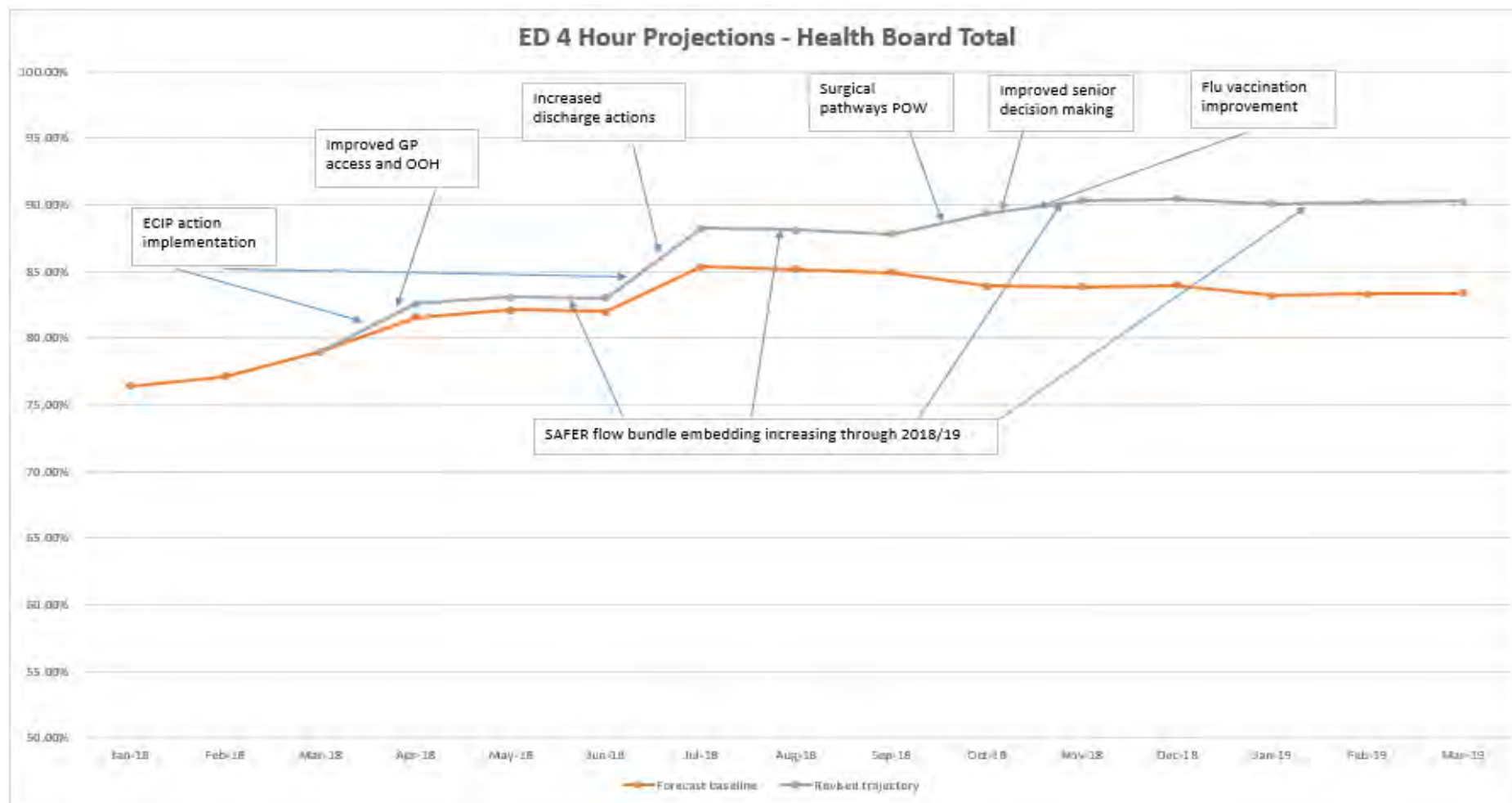
will implement a programme of local and Health Board-wide workforce redesign to support unscheduled care improvement and to secure sustainable services. This is outlined in the Enablers section below.

Trajectories

The overall trajectories for the NHS Wales Outcomes Measures for Unscheduled Care are found below. These are based on the actions in our Service Improvement Plan and the enabling workforce, capital and revenue assumptions included in our Annual Plan as shown below. The trajectories show the run of performance from November 2016 to provide the future performance levels in the context of recent performance. We are considering the precise nature of our plans at present and have presented each major trajectory with a higher performing and lower performing control limit. The table below sets out the principal actions we plan to undertake in this performance area and the 4 hour target chart which follows sets out when those impacts are planned to impact.

Principal Service Action	Predicted	Start

	Impact	Quarter
Unscheduled Care		
Increasing flu vaccinations for our population and our workforce	1.00%	Q3
Maintaining and improving timely access to primary care in hours and out of hours – telephone first, HUBS, redesign of Out Of Hours services.	0.25%	Q1
Maximising pathways that avoid admission to hospital – WAST, community resource teams, ambulatory emergency care, assessment units, hot clinics	0.25% to 1.25%	Q2
Improving patient flow through increased focus on compliance with safer bundle	0.45% to 1.90%	Q1 ramping up
Developing new integrated models of care to support timely discharge – discharge to assess, transfer of care teams, integrated step down facilities	1.00%	Q2
Improving senior decision making and support 24/7 – ED medical staffing, surgical assessment	1.00%	Q3
Reducing variation / ensuring consistency of the above in all areas	0.30% to 0.50%	Q1 ramping up

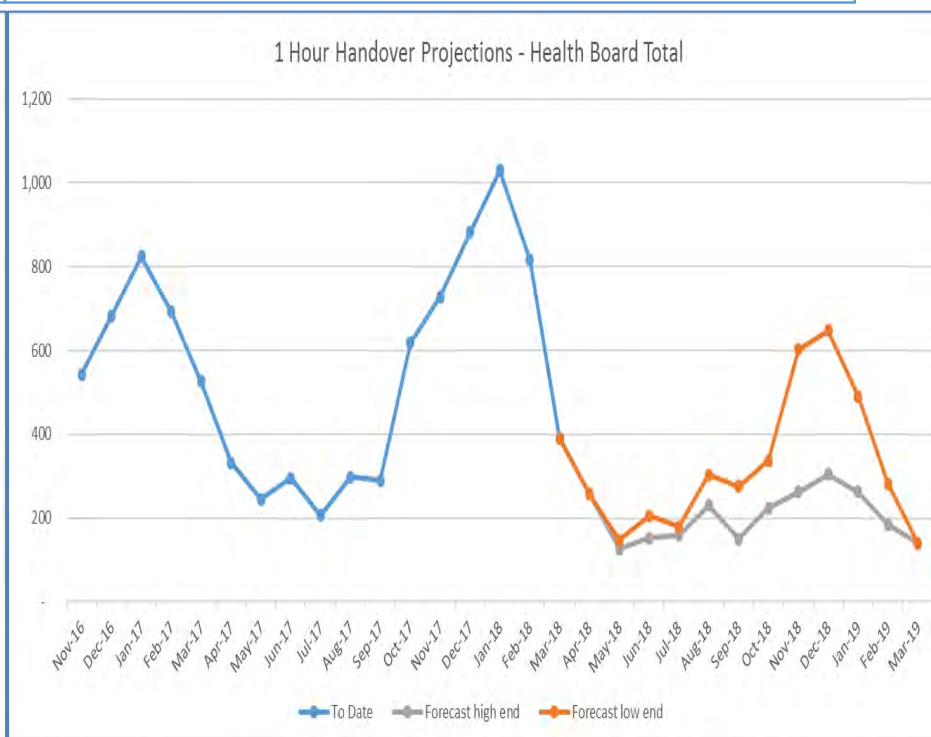


		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED	The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%	82.6%	83.1%	83.0%	88.3%	88.1%	87.8%	89.4%	90.3%	90.4%	90.1%	90.2%	90.3%

Forecasting total 59.64% reduction in breaches in 2018/19 over 2017/18



Forecasting total 59.85% reduction in breaches in 2018/19 over 2017/18



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED	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	323	194	190	229	227	180	255	315	289	283	196	179
	Number of ambulance handovers over one hour	0	256	126	152	159	229	149	223	262	304	262	183	139

Alignment with our Quality Priorities

Quality Priorities	Impact
1. SAFER flow 2. Frailty Pathway – Comprehensive Geriatric Assessment 3. Falls 5. Improving End of Life Care 8. Reducing pressure ulcers	• Reduction in length of stay and beddays used • Improved outcomes • Reduction in admissions of falls and older people

Enablers

All plans are based on performance improvement within our financial control total and a restricted Welsh Government capital environment.

Workforce	Impact
• Ongoing implementation of Front Door model in Singleton. • Rollout of enabling ethos and Transfer of Care and Liaison Service (TOCALs) at NPTH. • Implementation of Service Remodelling programme in acute hospitals and revised models for Community Hospitals. • Primary Care reinvestment (anticipatory care) • Consider alternative workforce models and develop extended and new roles. • Introduction of different skill mix models to offset Registrants. • Redesign of the Primary care workforce to support the treatment of patients closer to home and avoid admission to secondary care. • Recruitment and retention plans to fill current vacancies.	• Remodelling the front door service to include Nurse Practitioner and front door therapists. • Enables the remodelling of nursing rosters to work within establishment, and increased therapy input. • Supports the rebalancing of the nursing establishment, releasing medical time and other supporting workforce to reduce the vacancy gap. Could release upwards of 100 Whole Time Equivalent (WTE) posts. • Supports investment in Community Nursing in line with the Capita and Cordis Bright reports. • Development of Advanced Nurse Practitioner (ANP) and Enhanced Nurse Practitioner (ENP) posts to support medical rotas to maximise performance in Emergency Departments (ED). • Pharmacy Technicians trained to administer medication, development of generic nursing and therapy support workers and Ward Hostess roles to release nursing staff.

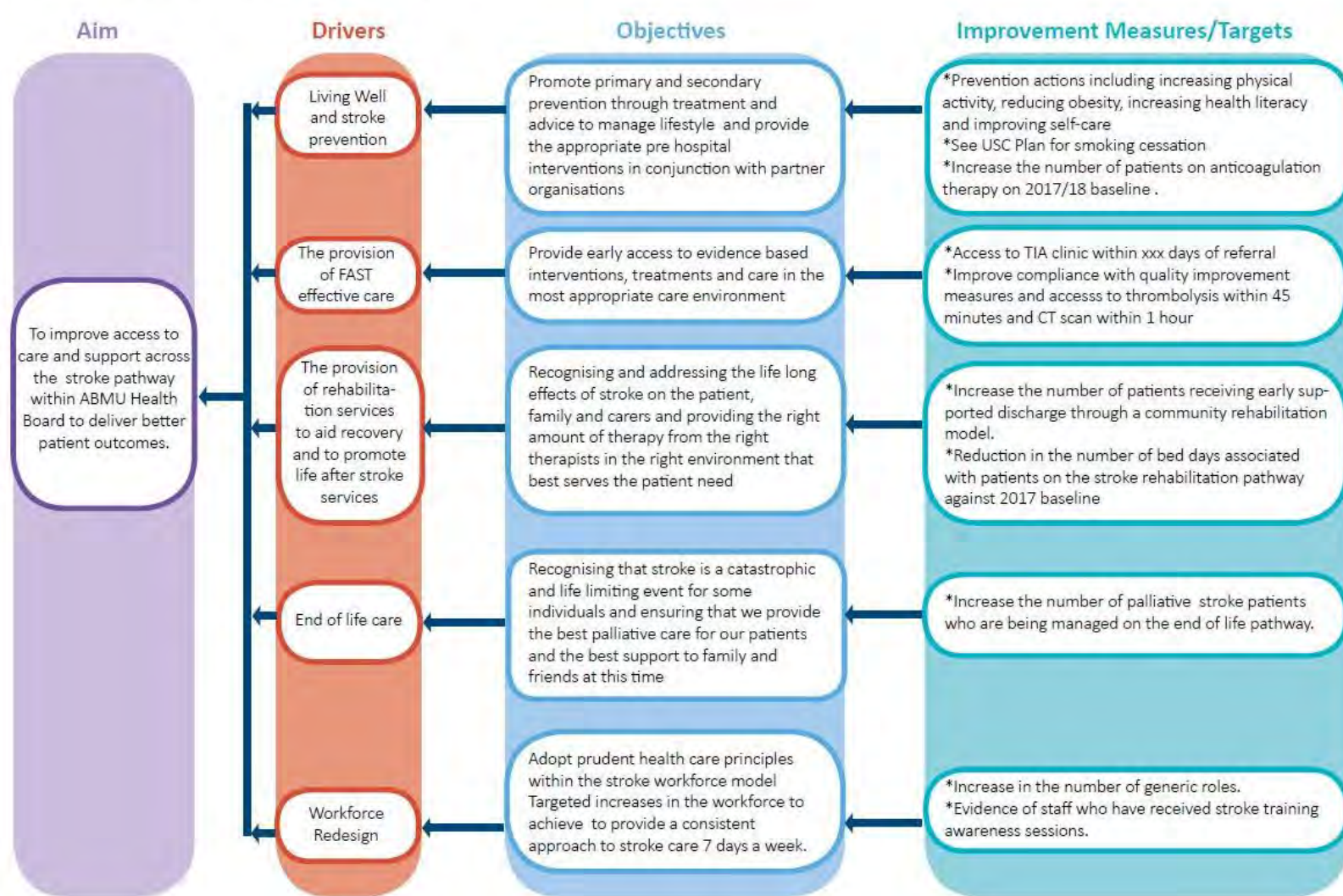
• Significant work to manage sickness absence and bank and agency usage.	• Internships for Physician Associates in our medical and surgical wards as well as ED to fill gaps on junior medical rotas. • Acute outreach team delivering care at home through GPs and Advanced Nurses. • Development of Nurse Practitioner and Advanced Nurse Practitioner roles to support GPs and reduce their workload. • Development of Cluster Network-teams which include Pharmacists, Physiotherapists, Counsellors, other Therapy professions and Audiologists. • Development of Nurse/Therapy led ward. • More efficient use of our workforce resource.
Capital Infrastructure	
• Primary Care and Community Estate • Flow and planned care at Morriston • Singleton Front Door Scheme final phase	• Implement Primary Care Estates plan for 2018/19, including the refurbishment of Penclawdd and Murton Clinic which have approved capital funding through the WG Primary Care pipeline. • Funding has been approved for the new Bridgend and Swansea Health and Wellbeing Centres through the WG Primary Care pipeline. Business Case to be produced which will require resources for project management and design fees, including production of Business Cases. • Planning for road infrastructure at Morriston (supports service redesign across whole site). • Planning for the future centralisation of the medical take for Swansea at Morriston • Consider the case to improve bed capacity on the Morriston site through temporary Vanguard units to provide space for additional trolleys.

	• Potential reduction in Length of Stay (LoS) and wait for theatre/operations. May need environmental changes to create potential assessment bay • Implementation of Front Door Redesign Action Plan Scope of capital works to be quantified and Business Case produced
Digital Health	
• Provision of an online citizen-held record which will allow us to share health information and care plans with our patients. • Implementation of inpatient electronic prescribing across two hospital sites. • Continuing to digitise the Health Record including digital dictation, nursing documentation, electronic test requesting and an implementation of an All-Wales view of the patient's diagnostic information and clinical documentation. • Provide access to a summary of the GP Record via the Welsh Clinical Portal (WCP). • Pilot the Admission, Discharge and Transfer module of the WCP at Morriston on behalf of NHS Wales in addition to adopting the National Discharge Summary Solution, MTED. • Integrate iCNET with Welsh Patient Administration System (WPAS) to provide e-alerts for patients with healthcare acquired infections. • Develop our business intelligence strategy which will include the provision of a new Executive Performance Dashboard and the promotion of our ward dashboard. • Prepare for the implementation of WCCIS in 2019.	• Patients will be enabled to take greater control of their health and have better ways to support them in doing so. This innovation is a scaled demonstrator to inform the National way forward. • Improve safety and efficiency for medication prescribing and administration. This is a pathfinder project on behalf of the national electronic prescribing programme. • Timely access to information enabling improved safety, quality and patient flow. • Improve patient safety and save time in ED (evidence from NHS England suggests 29 minutes per patient when admitting a patient to secondary care) • Improve patient flow. • Quicker response to treating infections to reduce length of stay and improve quality. • Enhance decision making and service improvement plans by becoming a data driven organisation. • Increased productivity, service improvement and data quality in community services. A key enabler for the delivery of integrated care. • Enables improved quality, safety and efficiency in our emergency departments

Including the mobilisation of the community workforce. • Prepare for the national rollout of Welsh Emergency Department System (WEDS)	
Revenue	
• Service Remodelling (acute)	-£5.0m
• Revised models for Community Hospitals	-£0.5m
• Primary Care reinvestment (anticipatory care and OOH)	-£0.5m

3.2 STROKE SERVICE IMPROVEMENT PLAN

DRIVER DIAGRAM Service Area: Stroke Care



Baseline Position

During 2017/18 we have delivered and maintained an overall improvement in our stroke performance in line with the service improvement work outlined in our Annual Plan 2017/18 to achieve incremental gains across the stroke pathway within the same resource base. Our work programme to deliver this improvement has included:

- implementing changes to our Trans-Ischaemic Attack (TIA) clinic models to improve capacity and access to care;
- improving access to diagnostic support;
- re-designing our stroke services workforce, which has included the provision of extended specialist nurse cover at the Princess of Wales hospital, and the development of a new generic nursing role in the acute stroke unit at Morriston hospital; and,
- Regular multi-professional review of individual stroke admissions to identify opportunities to further streamline and improve the stroke pathway.

The table below shows that there has been a 14% increase in confirmed stroke admissions in the first 11 months of 2017/18 compared with 2016/17.

	Apr 2016 – Feb 2017	Apr 17– Feb 2018	Increase
Princess of Wales	272	347	75 (27.5%)
Morriston	604	649	45 (7.5%)
Total	876	996	120 (14%)

This demand does not reflect the number of mimic stroke patients or TIA patients presenting to our hospitals, and who are also being managed by the stroke teams.

There was particularly high demand experienced in July and September when the number of confirmed stroke admissions were 67% and 55% higher than the same months in 2016. The remodelling of our demand will be essential to ensure that the development of the flow based Hyper Acute Stroke Unit (HASU) model will meet the future population need.

As shown in the following charts, due to the improvements achieved in our stroke pathways we are on-track with the majority of the measures for stroke. However, the timeliness of thrombolysis and compliance with the 4-hour quality measure continue to be

challenging in terms of delivering sustainable improvement. Performance against the 4-hour measure is affected by unscheduled care pressures and by operational changes to capacity within the multi-disciplinary stroke workforce as staff resources are not consistently available on a 24/7 basis, and are spread across our four acute hospital sites.

More recently, accessing a thrombectomy service for ABMU Health Board patients within Wales has become an increasing challenge, as this is a specialist intervention which is not provided locally. This service is currently being secured on an ad hoc basis with centres in England and sustainable commissioning arrangements are being taken forward by Welsh Health Specialised Services Committee (WHSSC).



EXAMPLES OF GOOD PRACTICE: Mini-stroke patients see specialist faster



PROBLEM

The TIA (Transient Ischaemic Attack or mini-stroke) clinic in Morriston Hospital was struggling with an increasing number of referrals. The clinic's waiting time was nine days. The rapid-access TIA clinic sees patients from across Swansea and most of Neath Port Talbot.

It was established in 2013 but did not have a dedicated space, instead using a side room in the medical admissions unit. At the time the number of referrals was around 550. By 2016 that had risen to almost 800, making it impossible to see people within the recommended seven days of referral.



SOLUTION

This turnaround is down to a quality improvement project led by ABMU's clinical lead for stroke services in Swansea. Referrals to the TIA clinic are made by the Emergency Department or a GP, depending on where the person first attended. Clinic sessions are run by a stroke consultant and specialist stroke nurse. The patient undergoes a range of tests and investigations, and the consultant then reviews the results.

For most people everything, including any medication changes or lifestyle advice, is done in that single visit. However, some may have to return to hospital at a later date if they need further investigation. Previously, clinics may have been cancelled because the consultant was either on call, dealing with a medical emergency or on leave. The new system to ensure another consultant is available should that happen.

The opening of a new TIA clinic in a converted rest room next to Ward F, Morriston's stroke ward, has also helped the team. Having this dedicated space provides flexibility to expand the number of patients the clinic can see. With the support of the Ward F sister, healthcare assistants also now carry out some investigations, such as blood pressure checks and ECGs, which were previously undertaken by the specialist nurses. This is good for the healthcare assistants as it means additional training and experience, and frees up nurses to focus on more seriously ill patients.



RESULT

People who have had a mini-stroke are being seen by a specialist in Swansea three times faster than they were just one year ago. waiting times for the clinic have now been reduced to just three days.

We have maintained our stroke performance during the latter period of 2017/18 through ongoing incremental operational improvement but we do not expect any further step-changes in performance in year. Further improvements in performance are constrained by the lack of additional resources to invest in Early Supported Discharge Services to improve flow, and also by our medical, nursing and therapies workforce capacity, which affects our ability to provide resilient and consistent cover during out of hours periods.

Our key achievements in 2017/18 have been:

- Prevention - the Primary and Community Services Delivery Unit is implementing a Directed Enhanced service for Anticoagulation Therapy (DOAC) which should contribute towards a reduction in the number of patients who are at risk of having a stroke.

- Ongoing workforce and service redesign by our Delivery Units to support the improvement across the stroke/TIA pathway,

including changes to TIA services to improve patient access to specialist care and the introduction of new generic nursing roles.

- Exploring the potential to develop Early Supported Discharge (ESD) services to support earlier discharge of patients who have suffered a stroke, as part of the work to redesign inpatient capacity. We are planning to review our rehabilitation models within the Health Board, and as part of this review, opportunities to develop Early Supported Discharge services based on a value-based approach will be assessed. ESD is an enabler for the development of the Hyper Acute Stroke

Unit/Acute Stroke Unit (HASU/ASU) model as it supports a decrease in length of stay, improves flow and ensures the availability of specialist beds.

- This is a major service redesign programme. Modelling the demand for stroke services across our respective Health Boards to inform the capacity required for a combined HASU model has commenced, and is being supported by the NHS Wales Delivery Unit.

Our Approach

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 regional HASU model.
- The development of community rehabilitation and Early Supported Discharge services.
- Supporting the development of a stroke research infrastructure/ network for stroke in Wales.
- Developing and responding to patient experience and outcome measures.
- The management of childhood stroke.
- The provision of a confirmed thrombectomy pathway for stroke patients.

The implementation of the stroke delivery plan will be underpinned by a value-based approach to health care, ensuring that stroke patients are managed and supported in the environment that is best suited to meeting their care needs along the stroke pathway of care.

Future Model of Care

- Currently, acute stroke patients are admitted to Morriston and Princess of Wales Hospitals. It has been agreed in principle by the JRPDC that 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. This has been agreed by the ABMUHB Health Board and is due to be considered for approval by the Hywel Dda Health Board. Collaborative planning is taking place with Hywel Dda Health Board about the regional stroke model through ARCH and the Joint Regional Planning Delivery Committee (JRPDC). The regional stroke specification completed and a draft has been circulated. The final model is expected to be agreed in April 2018.
- Consideration will also need to be given to patient flows from the Bridgend area following the outcome of the consultation on potential boundary changes. The implementation of the HASU/ASU model is also closely aligned with the planned changes

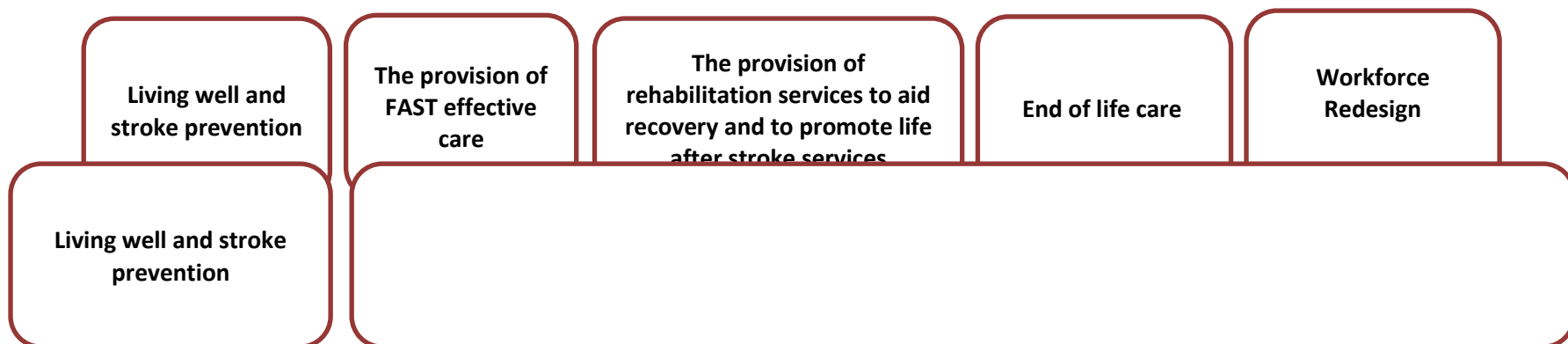
in our unscheduled care system in Swansea as part of the clinical strategy to centralise the medical take for Swansea at Morriston hospital.

To assist with the joint planning, ABMU and Hywel Dda University 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 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 which will be subject to a capital build at Morriston hospital.
- Appropriate access to diagnostic capacity in Morriston hospital (CT capacity will be a constraint in supporting all strokes and mimic strokes for ABMUHB and part of Hywel Dda HB population)
- Changes to workforce models across medical, nursing and therapy staff to deliver a 7 day service.
- Agreement across the stroke pathway on patient flows and transport arrangements e.g. ambulance capacity, repatriation arrangements
- The development of an Early Supported Discharge (ESD) service with sufficient capacity to facilitate timely patient discharge within ABMU and Hywel Dda University Health Boards.

Our Plans for 2018/19

Our overall aim in 2018/19 is to achieve improvement with the NHS Wales Outcomes Measures for access to care and support for across the stroke pathway to deliver better patient outcomes. Our drivers are:



We will reduce risk factors through the wider prevention agenda and also 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 2018/19 and we plan to continue to develop our Trans Ischaemic Attack (TIA) services. During 2018/19 we will also proceed with our regional planning for the Hyper Acute Stroke Unit (HASU) model through the ARCH and JRPDC mechanisms. We will also develop a specific occupational therapy stroke patient survey and implement it to consider the results of the survey for service improvement

**The provision of rehab
services to aid recovery
and to promote life
after stroke services**

We will develop a proposal for a disinvest to invest model for Early Supported Discharge Services for stroke by assessing the effectiveness of existing rehabilitation services and inpatient care using VBHc methodology.

End of life care

We will optimise our support for patients, and those important to them, in preparing for end of life by identifying and supporting individual patient's priorities through open conversation and advance care planning, in line with our End of Life Care Delivery Plan which is included in **Appendix 14**.

Workforce Redesign

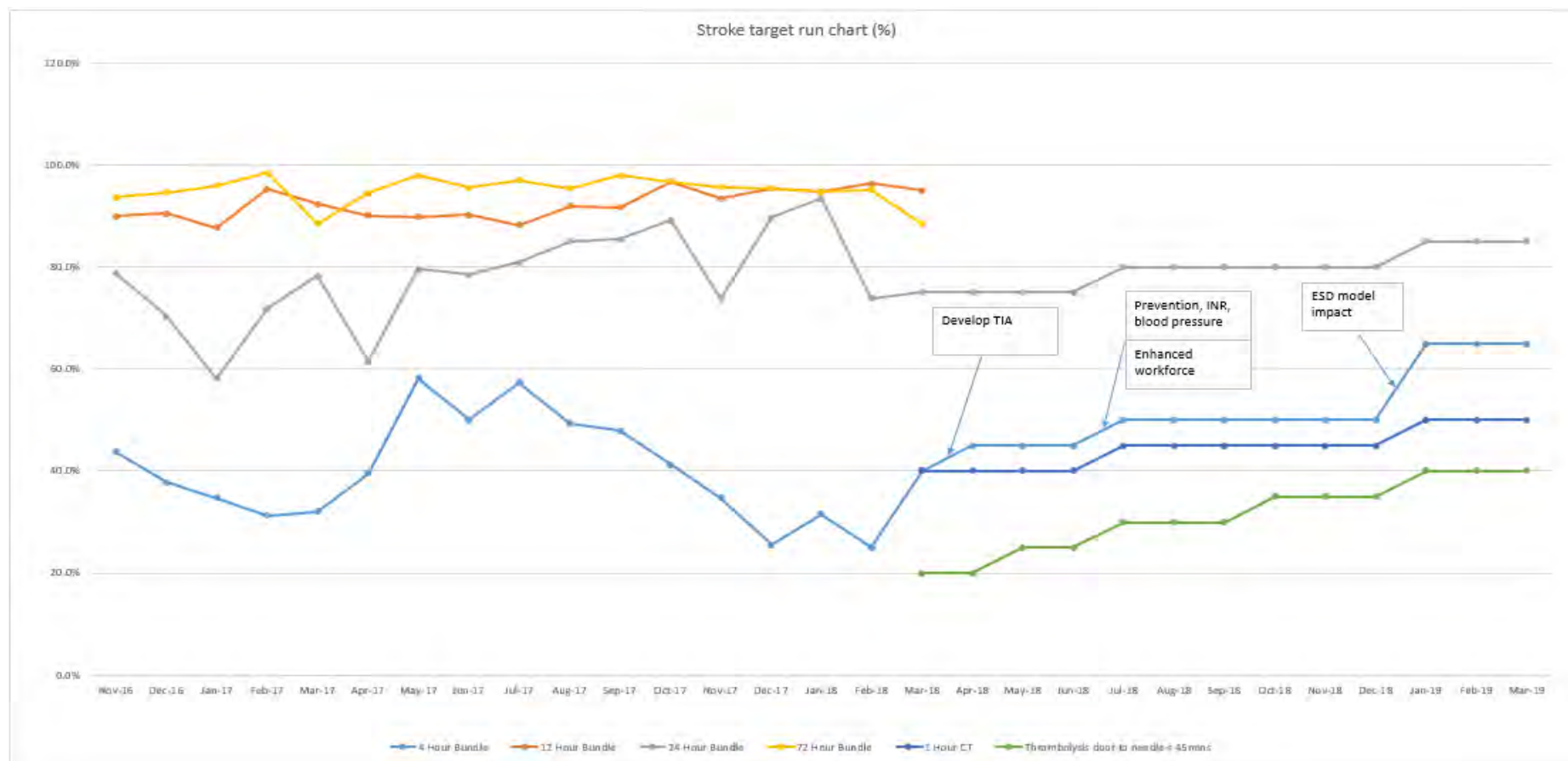
We will continue our workforce redesign programme within resources using Prudent Healthcare principles to expand 7-day cover across our key sites.

Trajectories

The overall trajectories for the NHS Wales Outcomes Measures for Stroke are shown below. These are based on the actions in our Service Improvement Plan and the enabling workforce, capital and revenue assumptions included in our Annual Plan as shown below. The trajectories show the run of performance from November 2016 to provide the future performance levels in the context of recent performance.

The table below sets out the principal actions we plan to undertake in this performance area and the target chart which follows sets out when those impacts are actions are planned to impact.

Principal Service Action	Predicted Impact	Start Quarter
Stroke		
Prevention - Improve no of patients on INR through DES in primary care & BHF-funded service for blood pressure reduction	2.50%	Q2
Continue to develop TIA services (all year)	5.00%	Q1
Recruit second SpR at Morriston – improve 4 hour bundle	2.50%	Q2
ESD embedding and full impact	15.00%	Q4



			Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Stroke	% compliance with stroke QIMs:	Direct admission to Acute Stroke Unit (<4 hrs)	The most recent SSNAP UK National quarterly average	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	65.0%	65.0%	65.0%
		CT Scan (<1 hrs)		40.0%	40.0%	40.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%
		Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)		75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	85.0%	85.0%	85.0%
		Thrombolysis door to needle <= 45 mins		20.0%	25.0%	25.0%	30.0%	30.0%	30.0%	35.0%	35.0%	35.0%	40.0%	40.0%	40.0%

Alignment with our Quality Priorities

Quality Priorities	Impact
4. Improving Outcomes Following Stroke	Improving outcomes and access

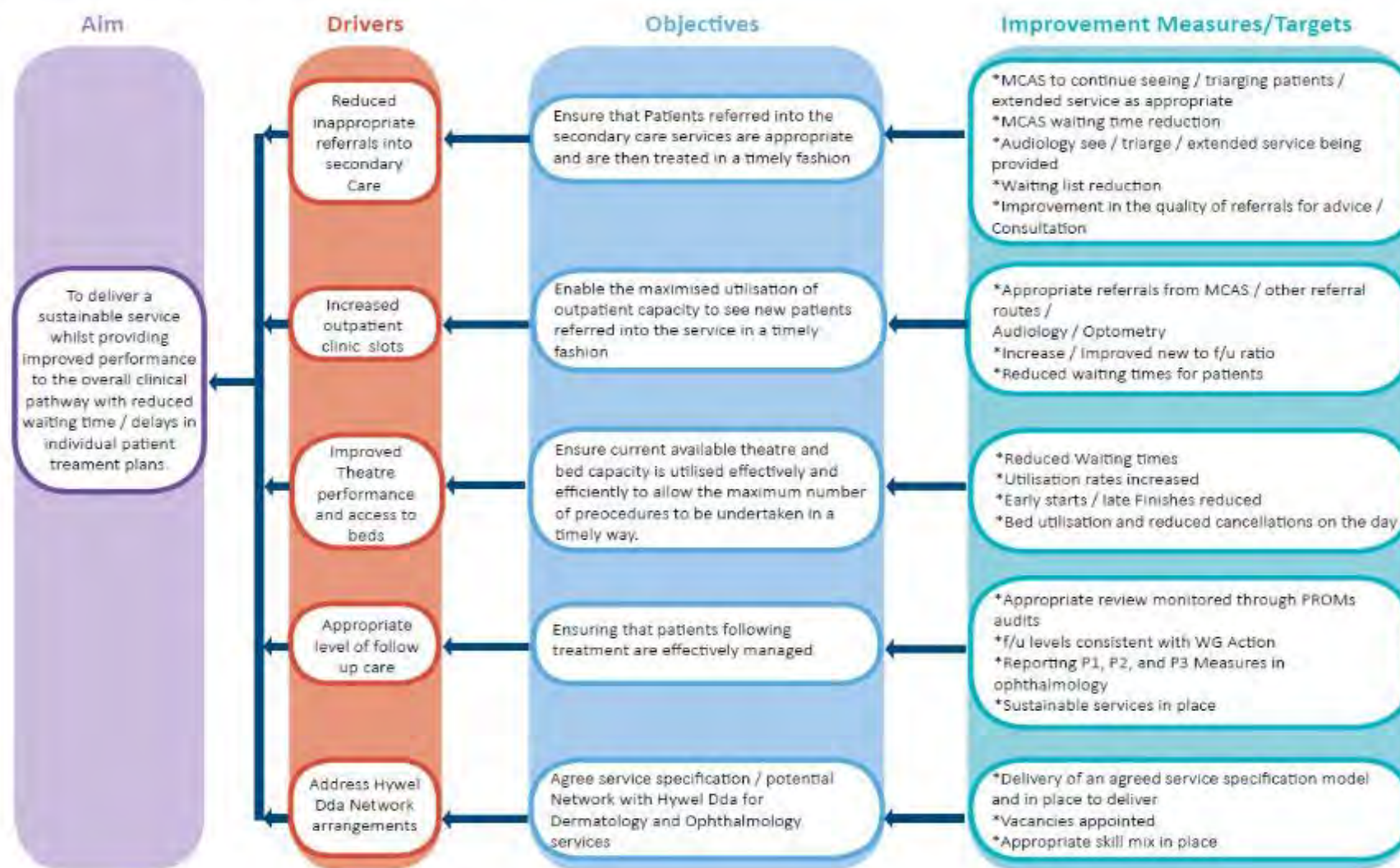
Enablers

All plans are based on performance improvement within our financial control total and a restricted Welsh Government capital environment.

Workforce	Impact
- Explore opportunities to expand targeted 7-day cover - Strengthening workforce competency and skill mix to improve 4 hour access standard in and out of hours. - Recruitment to 2nd SPR at Morriston to support 4 hour bundle. - Continue staff training and awareness sessions of stroke pathway.	- Therapy staff providing 7 day cover at Neath Port Talbot Hospital to promote flow and prevent avoidable deterioration in acute stroke patients to provide better outcomes. - Increase in the number of generic roles through workforce redesign and utilisation of other staff groups e.g. Pharmacists leading on a number of clinics including stroke and TIA. - Within resource base. - Staff training and development.
Capital Infrastructure	
None in year – apart from planning the HASU	Development of the business case for provision of a HASU will require business case fees
Digital Health	
As Unscheduled Care. In addition we will explore further digital means of supporting and monitoring the stroke pathway.	
Revenue	
Assessing potential to reinvest in Early Supported Discharge through service redesign	Within resource base

3.3 PLANNED CARE SERVICE IMPROVEMENT PLAN

DRIVER DIAGRAM Service Area: Planned Care



Baseline Position

Modelling work was undertaken at the start of 2017/18 to assess the sustainability of services within the planned care system for the Board. This modelling considered the work planned to improve efficiency and productivity during the year and then further considered what might need to be done close any demand and capacity gaps, but also then to reduce waiting times and volumes.

A substantial amount of improvement within existing resources was identified through the efficiency and productivity modelling and the level of this gain, now within the Health Board's baseline position, is set out below:

- New Outpatients 9,602
- Treatments 3,914
- Diagnostic tests 1,051

However, these efficiency and productivity gains did not provide sufficient improvement to deliver the performance improvement that the Health Board wished to deliver in 2017/18. Further, these efficiency and productivity gains, whilst material in scale, would not close the demand and capacity gap to a position where services are sustainable.

During 2017/18 the Board has successfully attracted funding from Welsh Government to improve waiting times which was agreed in two allocations. The funding allocation has come with clear delivery expectations for the Health Board as set out below:

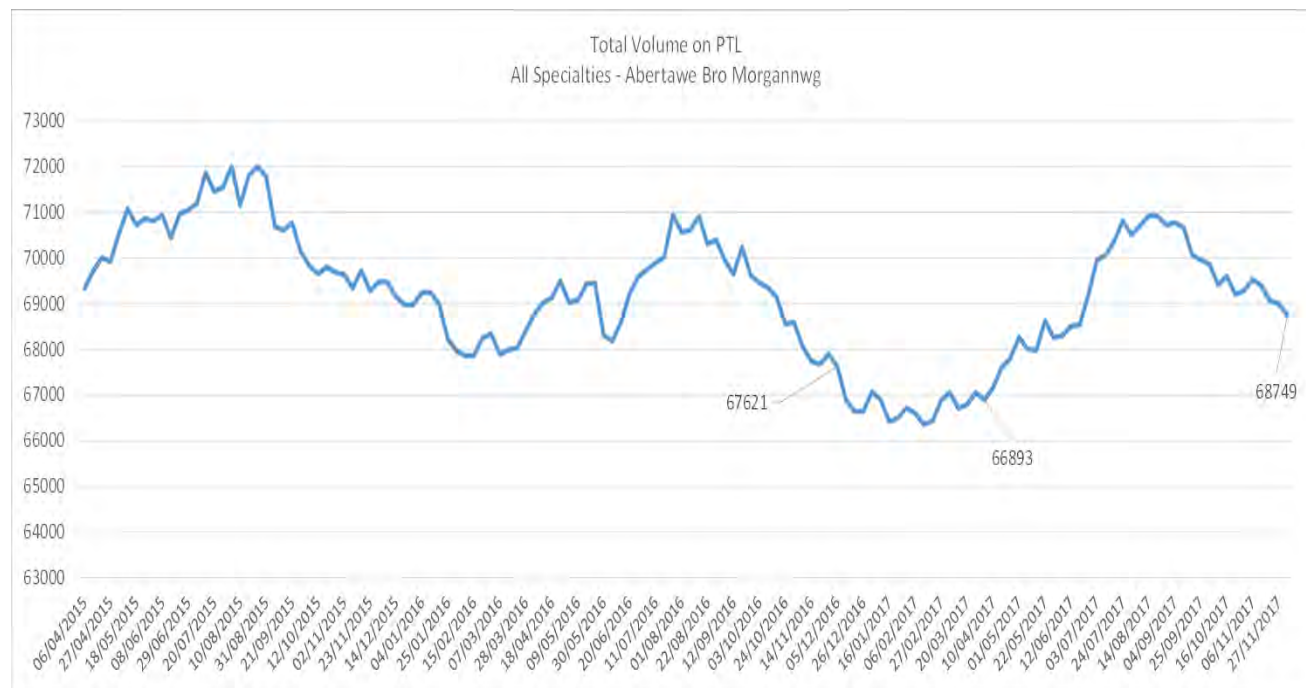
- New Outpatients – fewer than 1,000 patients waiting over 26 weeks
- 36 weeks – fewer than 2,640
- 52 weeks – fewer than 1,520
- 8 week diagnostics - Nil
- 14 week therapy waits - Nil

It is anticipated that Welsh Government will enact a 'clawback' mechanism for failure to achieve these target levels. In previous years the clawback has been primarily based on the 36 week target level. Every effort is currently being made to enable the Health Board to achieve the 2,640 maximum position by the end of March 2018. Our current projections against the target levels set out in the bullet points above are set out later in this section.

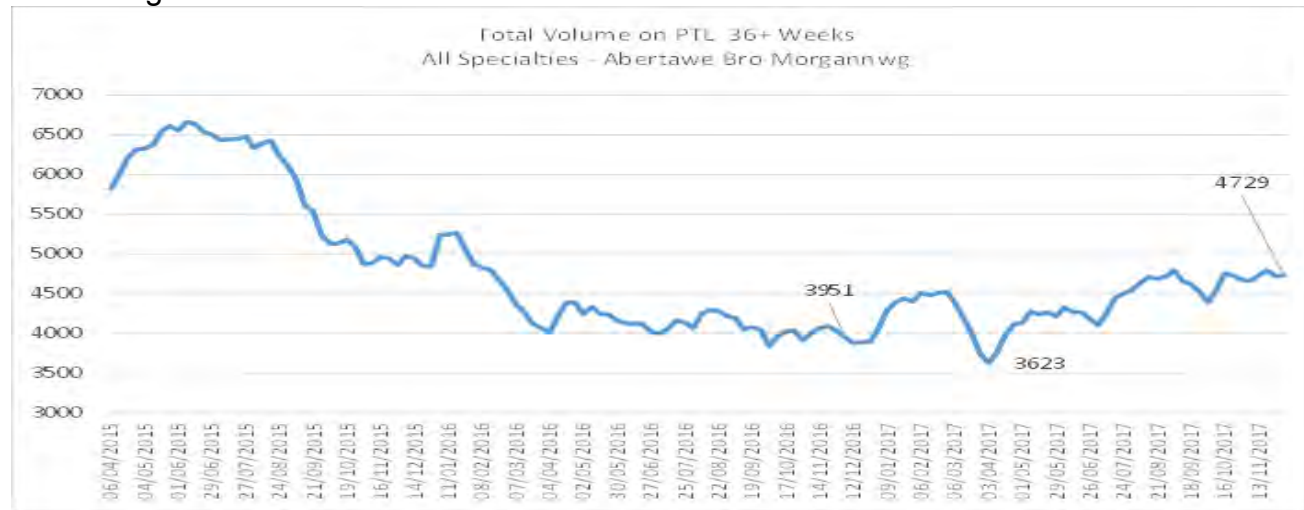
As part of our escalation status, the Health Board has received the benefit of support from the NHS Wales Delivery Unit in respect of the RTT element of planned care. The analysis carried out by the NHS Wales Delivery Unit has assisted with a change of focus for the health Board, particularly in the last Quarter of 2017/18.

The Delivery Unit has observed that:

Our total waiting list size remains relatively stable within control limits.



The number of patients waiting over 36 weeks has increased over the last 12 months.



The numbers of patients waiting over 52 weeks is also increasing



This extended waiting list tail is developing within the context of the total list size largely remaining the same size. This analysis suggests that the Health Board, at a very high level, is carrying out the right level of activity to meet demand, but that patients are being appointed from across the waiting list rather than at the longest waiting end. This behaviour could reflect increased levels of patient urgency, it certainly suggests that individual specialty and sub specialty level scrutiny of the way in which the Health Board selects patients for treatment in terms of length of time waiting would be beneficial and could dramatically improve the volumes of patients waiting an extended time for treatment.

This Treat in Turn philosophy is a key element of the range of options being worked through during Quarter 4 to improve current levels of performance and to move towards the Welsh Government required levels. The NHS Wales Delivery Unit is assisting the Health Board teams with the tools and skills to assess and increase Treat in Turn rates as part of a suite of actions being undertaken in Quarter 4. The main action points for Quarter 4 are as follows:

- Increase in Treat in Turn rates to be a significant focus across all Units with an expectation that clinical discussions take place and Treat in Turn is implemented.
- Scope potential opportunity for utilising primary care theatre facilities to support transfer of routine minor surgery work.
- Ensure that a robust procurement process is undertaken to allow insourcing of theatre staff (and/or medial staff) to cover fallow operating lists and potential full additional lists out of normal working hours to increase efficiency.
- Progress mini competition against the Crown Commercial Service Framework Agreement for external company to undertake validation of cohort patients.
- Targeted management of Do Not Do procedures.
- Ensure that operational grip remains tight during Quarter 4 through a weekly series of delivery meetings to be led by the Chief Operating Officer.
- Implement a cohort management approach to maximise capacity potential but ensure that Treat in Turn within cohort is in place.
- Clear outpatient 36 week cohort by end of January (with exception of Oral Maxillo-facial Surgery (OMFS))

The bullet points below set out the current forecast end of March 2018 position for the Board.

- New Outpatients – 500 patients waiting over 26 weeks (target < 1,000)
- 36 weeks – 3,239 (target < 2,640)
- 52 weeks – fewer than 1,520

- 8 week diagnostics - Nil
- 14 week therapy waits – Nil

Achievements

Over the duration of 2017/18 there have been a number of importance developments and achievements within planned care.

Examples of Good Practice:



Same day knee replacements introduced

People needing knee replacements can now have surgery at two ABMU hospitals and be home the same day. Princess of Wales and Neath Port Talbot hospitals are believed to be the first in Wales to offer day case surgery for both half and full knee replacements. Although not suitable for all patients it has definite benefits for those who are eligible – and will help free up hospital beds too. The first day case knee arthroplasties were carried out in the spring of 2017 the results have been excellent. Traditionally, patients having total knee replacements would have stayed in hospital for 14 days. Then in 2009 this was reduced to five days with the introduction of ERAS – Enhanced Recovery after Surgery. Now a multidisciplinary team led by an ABMU consultant orthopaedic surgeon has taken this even further. This follows a fact-finding visit to a hospital in the Netherlands, which has been carrying out day-case knee arthroplasties for several years.



Text reminders for outpatient appointments

We are currently rolling out a patient appointment reminder service across ABMU which will text patients a week and again two days before their appointment. The aim is that this will be implemented across the Health Board by the autumn, covering all Outpatient appointments and Radiology appointments.

This will reduce DNA rates and therefore mean that patients wait less time for an appointment. We are looking at systems that allow patients to request and change appointments more easily and get better information about their appointment. We are also investigating how we can send appointment letters digitally to get them out quicker and save postage.

We have worked hard to embrace the positive ethos of the [National Planned Care Programme](#) and we have implemented a wide range of actions resulting from our engagement in this work. We have also found the detailed modelling of capacity demand extremely beneficial and using this we have investment in additional audiology and ophthalmology services models to divert demand away from traditional consultant routes, to improve access for patients and to support the principles of prudent healthcare.

We have continued our investment in elective services with a total of £1.5m currently allocated to our units to support theatre staffing, a resident surgical officer

model at Singleton Hospital ongoing commitment to the Theatre Admissions Unit at Morriston Hospital which is supporting the treatment of long waiting patients along with providing crucial capacity to accommodate urgent surgical cases and cancer cases who might otherwise have found it challenging to access ward beds, particularly during times of high unscheduled care pressure.

By the year end we plan to have no patients waiting over 36 weeks at Singleton Hospital and it is our intention to continue this going forward. We have increased cataract efficiency have carried out around 400 more cataract procedures this year within existing resources. At Princess of Wales we will have removed long waits in ENT and gynaecology with progress being made in general surgery also.

At Morriston hospital we face a range of particularly challenging issues for routine elective capacity protection and through 2017/18 we have looked to our other sites to support the less complex work to allow Morriston to function as a regional centre. We have managed to sustain strong cardiac surgery performance with zero 36 week waiting patients planned by March 2018.

We are proud of our delivery of excellent access to diagnostics be they imaging or other diagnostic modalities. We have met the significant demand challenges in endoscopy in Swansea this year and by working through service model changes and by working regionally with colleague sin Hywel Dda Health Board we plan to deliver nil breaches by the end of March 2018. There is much to do in 2018/19 to achieve sustainability but our inroads into the backlog in 2017/18 will put us in good stead for this.

We have worked hard across a range of therapy services and we will achieve a zero 14 week wait position across all reportable therapy waits in 2017/18.

We are proud of these achievements but we recognise that we have much to do to reduce both the length and volume of long waiting patients in 2018/19.

Our Approach for 2018/19

For 2018/19 the Health Board is taking a different approach to its capacity and demand modelling. As a result of the Targeted Intervention status of the Health Board, the NHS Wales Delivery Unit is providing operational and planning support in respect of planned care.

For the purpose of this section of the plan, planned care comprises: -

- Traditional RTT access
- Diagnostic access
- Therapy services access
- Delayed follow up appointments access

The outputs of the modelling work undertaken have been aggregated to provide the trajectories set out later in this section. For assurance, behind the aggregate position sits detailed specialty plans signed off by Units and developed in conjunction with the NHS Wales Delivery Unit.

The emphasis for planned care, has previously been, and will continue to be, based on the drive to improve internal performance to move specialties to a sustainable footing. Over the last two years a substantial amount of work has been undertaken through the [National Planned Care Programme](#) focussing on orthopaedic, Urology, ENT and Ophthalmology service models. The Health Board has had much success embedding the service change elements of these plans into its local services and has provided modest investment in ophthalmology and audiology as a direct result of this work. It will be critical to the future sustainability of our planned care system that the Health Board continues to engage in the full breadth of the planned care programme and supports the implementation of the prudent models of care arising from this.

Our Eye Care Delivery Plans, Neurological Conditions Delivery Plan and Diabetes Delivery Plan are included in **Appendix 14**. These plans describe our actions to change our pathways for glaucoma, epilepsy, headache and routine diabetes patients to rebalance our demand and capacity and improve outcomes in line with the national Implementation Group priorities.

Where these gains can be quantifiable and deliverable, they are factored in to the performance trajectories set out later in this section.

However, this drive has not been of a sufficient scale to achieve sustainability and therefore in previous years the increased gap between capacity and demand has seen the Health Board require significant additional resource, beyond baseline allocation levels, to help reduce its RTT backlog. The Health Board is clear that its current access times and access volumes are too high and a clear focus on planned care as part of the integrated system will be a priority in 2018/19. In 2018/19 we will review our approach to demand and capacity planning as a core enabler within the Recovery and Sustainability Programme. Critically, we need to improve the way in which we look at the whole system demand and capacity plan including community services. We also recognise the need to ensure that job planning is an integral part of this process. There will be oversight of this approach through the Recovery and Sustainability Programme Board so that for 2019/20 we are able to evidence an integrated demand and capacity plan.

The nature of the way this system has worked has therefore traditionally seen the Health Board develop expensive, non recurrent solutions to service sustainability rather than invest in improvements which reduce demand and capacity gaps on an ongoing basis. The assumption within this plan, is that the level of improvement to be delivered through investment (after efficiency and productivity gains have been factored in to the plans) is best achieved on a smooth basis through the year based on early decisions around solutions which can be developed at optimal value for money. This could be further enhanced by plans that the Health Board has to work with Hywel Dda University Health Board as part of the regional planning system to commission any necessary outsourcing capacity (again after efficiency and internal solutions have been exhausted) on a joint basis and use this combined purchasing

power to drive value for money. It is planned that for 2018/19 the specialties most likely to benefit from this approach are:-

- Orthopaedics
- General Surgery
- ENT
- Ophthalmology

These specialties also carry the bulk of waiting times pressures in both organisations.

For clarity, whilst the Health Board plans to optimise, as far as possible, its internal efficiency and productivity alongside directing any available resource to internal solutions, it is likely that any improvement below the March 2018 end position will need to be built on these elements plus capacity to delivered on outsourcing capacity and/or insourcing support to increase capacity.

Service Redesign

A further stream of work that will help with the delivery of service sustainability in planned care is service redesign using VBHc. The Health Board has had some success recently over the last 12 months in moving services into more prudent models, saving resource and investing some savings back in to services through a variety of commissioning techniques. Further opportunities are set out in the table below and we will use these techniques to improve outcomes and manage our resource envelop accordingly.

PLANNED CARE SERVICE REDESIGN	
Regional Ophthalmology 5-year sustainable service redesign to include collection of cataract ICHOM data set	Diabetes Pathway Patient education, community service redesign
ENT/Audiology 5yr desk top forecasting, sustainable service planning	Fibromyalgia Self-care pathway
MSK Stage 2 Prevention service delivery & evaluation & outpatients redesign	Pain management Extension to Fibromyalgia project
ICHOM Overall Adult Health Contribute to design of standard outcomes data set	

From an assurance perspective the Health Board has reinstated its monthly Planned Care Board which will manage the final performance improvement trajectories and any mitigating actions required through the Year. The Board will bring in the national planned care programme outputs, service redesign and performance management discussions into one forum to ensure connectivity of plans and optimisation of scarce resources through the financial year. This will be underpinned by a series of operational grip meetings which meet more frequently to work through detail and assure delivery at a more granular level.

Our Plans for 2018/19

For planned care our overall aim in 2018/19 is for:

- Diagnostics and therapies to both achieve nil breaches at the end of March 2018 which will continue in 2018/19. Endoscopy in particular will need additional capacity to sustain.
- 26 week new OP will improve to < 500 at the end of March 2018 and this will clear within the first 6 months of 2018/19
- For 36 weeks the position is the same as 26 week new OP even when considering a further improvement from efficiency gain, additional resources will be required to achieve the trajectory level set out below. Our plan is to commit the limited resources that we have available to continue to reduce the volume of long waiting patients through quarter 1. At the end of quarter 1, further improvements in sustainability will be evident but they will not be sufficient to completely stabilise our system. We plan to work with Welsh Government colleagues to develop a further plan for these latter quarters with a view to agreeing some a range of service transformation actions and a plan to reduce backlog further. There will be a resource requirement to continue improvement beyond quarter 1.

Our drivers are:

**Reduced
inappropriate
referrals**

- **Developing out of hospital care models**
- **Ensuring clear, appropriate, prudent referral criteria**
- **Use of e-referral system**

The Health Board's outpatient model remains largely traditional and based on patients attending our hospitals. Through the

increased use of e-referrals systems with individual GP practices and clinicians providing advice and feedback, we plan to move away from these traditional models and to a more modern whole system approach to manage demand. As part of this process new clinical pathways will be developed that will manage demand into more appropriate settings. This will build on some of the success that the Health Board has already had with our MCAS musculoskeletal services, dermatology cameras, see on symptom models in Rheumatology and community cardiology services. Through the national planned care programme we plan to utilise the skills of our audiologists and optometrists to reduce the pressure on secondary care services and provide better access for patients in the community setting. The programme will be focussing on dermatology, oral maxilla-facial surgery (OMFS), vascular and gynaecology services in addition to orthopaedics, urology, ENT and ophthalmology at present.

Increased outpatient clinic slots (where appropriate)

- **Changing outpatient models to reduce demand / capacity gap**
- **Use of virtual clinics**
- **Prudent workforce design**

On the basis that we plan to reduce demand where appropriate we recognise that there will remain some specialties where demand for outpatient services will be higher than the physical clinic slots available. In 2018/19 we plan to introduce virtual clinics where patients will be actively monitored as opposed to a face to face contact with a medic in clinic. We plan to use our workforce more flexibly and through greater use of non-medical review we plan to free up capacity for consultants and medical teams to see those patients who require more senior review in a more timely manner. During 2018/19 we plan to implement a revised clinical pathway for oral medicine patients which will triage and treat large volumes of patients outside of the hospital setting. Alongside this we will consider which other specialties might benefit from a model such as this or such as our MCAS services where patients are seen by clinical professionals outside of the hospital setting.

Improved theatre performance and access to beds

- **Improve pre-assessment**
- **Improve utilisation of theatres across all sites**
- **Move from inpatient to daycase-based care**

We know that our theatre performance is below the levels we would like. We have established a theatre efficiency group within the Health Board and our plan is for this to gain traction and improve performance across a wide range of KPI's for theatres to increase

our productivity. We will then deploy this increased efficiency to our planned care models as part of our overall strategy to move every specialties onto a sustainable access time footing. This will enable then to focus more clearly on backlog removal and to treat those patients who we know are waiting too long for their surgery at present.

With regard to Pre-assessment there is a multidisciplinary group reviewing our existing pre assessment arrangements. In 2018/19 we will roll out a model of work which will deliver improved performance and scheduling of patients through theatres. We also plan for this to have a positive impact in reducing “on the day” theatre cancellations due to patients being unfit for surgery and to deliver a system which identifies patients who no longer require surgery prior to them attending for a procedure resulting in poor patients experience and a cancelled theatre slot.

We do not yet have a system where day case is the default expectation for surgery, indeed this may not be a suitable mind-set for some of our more complex surgical cases anyway, but we have been able to bring some procedures from a default IP system into a day case system by using technology and advances in theatre equipment to do so. In 2018/19 we will further explore where investment in technology will allow cases to be carried out outside of our regional centre (where our planned care system is facing significant service pressure) in our other hospitals within a network arrangement, thereby easing some pressure on beds but also reducing cancellations. We will also develop inpatient patient experience surveys to review of feedback for ophthalmology and cardiac services and consider the results for service improvement.

**Appropriate levels
of follow up care**

- **Implement national planned care programme models for follow-up care**
- **Utilise PREMs and PROMs to change services**

In 2017/18 we have introduced new models of follow up which have been supported on an All Wales basis through evidence and clinical buy in to change the way in which we manage follow up care. These exemplars can then be rolled out against other specialties within the Health Board during 2018/19. We know that we have high volumes of follow up patients and whilst we have pockets of excellence, as described under the inappropriate refers driver above, in 2018/19 we will ensure that this learning is shared and promote more widespread uptake of these new ways of working. This has had some traction in 2017/18 with the numbers of patients delayed beyond their follow up date now starting to reduce. We are working with our primary care teams to develop whole system solutions for the ongoing care and monitoring of our patients. We also plan to utilise PROMs and PREMs information to identify appropriate patients for follow up we have some digital solutions which are helping us to do this such using Amplitude in

Orthopaedics. From an Ophthalmology perspective, where follow up management is key to maintain eyesight for our patients, during 2018/19 we plan to implement a digital patient record specifically within Ophthalmology to support a process of clinical prioritisation to safely manage patients based on their clinical acuity.

Hywel Dda joint planning

- Joint outsourcing for orthopaedics and ophthalmology
- Pathway redesign in ophthalmology and orthopaedics through VBHc

Joint regional planning discussions have matured significantly during 2017/18 and plans to develop regional solutions for some of our most pressured planned care services have been discussed and developed during 2017/18 for implementation in 2018/19. We plan to have agreed joint outsourcing plans for orthopaedics and general surgery where we can commission actively evenly through the year and use our combined purchasing power to increase the value for money of any contracts to be let. We also have a capacity gap in ophthalmology across both organisations. The good work being undertaken to increase baseline capacity is currently being assessed to give final picture before discussions around either an insourcing or outsourcing model for ophthalmology can be concluded. A solution will be in place during 2018/19. We are also working across a wide range of pathway modernisation areas to ensure that patient flow is optimised and this is being supported by a revised set of Long Term Agreement (LTA) arrangements between our two organisations in 2018/19.

A common theme across all of the drivers above is that the Health Board is looking to modernise its planned care system to enable patients to receive more **timely, proportionate and accessible care**. We are looking to achieve this by developing patient pathways supported by a wide variety of our clinicians to allow them to work at the top of their licence in the most prudent way possible. This facilitates capacity in consultant job plans in particular to create clinical office time, to allow for far more clinical review of waiting lists and follow up lists by senior doctors reducing the requirement for some patients to attend hospital at all but still access a high quality safe service.

The Planned Care driver diagram represents the system wide approach to delivering improvement across our system in 2018/19.

Trajectories

The overall trajectories for the NHS Wales Outcomes Measures for Planned Care are found below. These are based on the actions in our Service Improvement Plan and the enabling workforce, capital and revenue assumptions included in our Annual Plan as shown below. The trajectories show the run of performance from November 2016 to provide the future performance levels in the context of recent performance.

The health board has retained around £2m of recurrent funding within its financial plan to utilise for planned care performance improvement.

The Health Board plans to commit this internal £2m in quarter 1 whilst working alongside Welsh Government and the All Wales Delivery Unit early in quarter 1 to explore the choices that will need to be made for the rest of the year. The health board acknowledges that its planned care performance, particularly for patients waiting over 36 weeks for their treatment, is not where it would like it to be and the plan is to deploy the £2m to make further improvements in both OP waiting times and volumes and over 36 week waiting times and volumes in quarter 1.

Our planned care position is constructed from individual specialty/service capacity and demand plans and they take into consideration the combined benefits (where relevant) of the actions set out above. In addition to this, specialities and services have assessed what further improvement they could make in terms of sustainability and backlog removal if additional resource were to be made available to present a “best case” position for the year. The charts below reflect the outputs from the modelling work carried out by the health board and there will be further, executive led scrutiny of the models at the end of March and through April to risk assess the plans and to look for further opportunities to improve access times.

The first chart below sets out the potential trajectory for planned care if around £1.5m of the planned care funding (£2m) were applied through a focussed deployment in quarter 1, using a blend of internal and external solutions. This could reduce the long waiting volumes by between 200 and 300 cases in the quarter (subject to validation of the specialty level capacity and demand plans). The long waiting patient volumes (i.e. those waiting over 36 weeks) are almost exclusively patients waiting for surgery (rather than OP or diagnostics) and the majority of these cases are complex and require a hospital stay. Further, the health board has used outsourcing as part of its overall plan to increase capacity to treat patients alongside a range of efficiency, modernisation and internal solutions first. In general, the types of patients suitable for outsourcing are the lower acuity patients on our waiting lists and whilst outsourcing is an important component of our capacity plans this generally means that our waiting lists are now more populated with higher acuity patients with longer theatre time requirements and potentially longer lengths of stay. We plan to treat these patients in our health board capacity but this increased case-mix of patients means that our improvement trajectories for 2018/19 are not proposing rapid recovery of the backlog position. We are considering how best to deploy the range of theatre

resources we have across our surgical sites to ensure that our complex long waiting but routine patients are accommodated within health board capacity and with access to all of the specialist services they will require for their care. The gradient of the improvement trajectory reflects the high surgical component and high clinical acuity of the patients waiting at the longest end of our waiting list.

For clarity, the sustainability gap for surgical specialties is 2,929 cases per annum based on our current modelling assumptions. This is the gap after taking into consideration efficiency gains and applying the outputs of the National Planned Care Programme. **The health board sees 2018/19 as a significant step in moving towards more sustainable service models and over the next three years the health board plans to address sustainability gaps in service whilst also working hard to reduce the backlog of long waiting patients.**

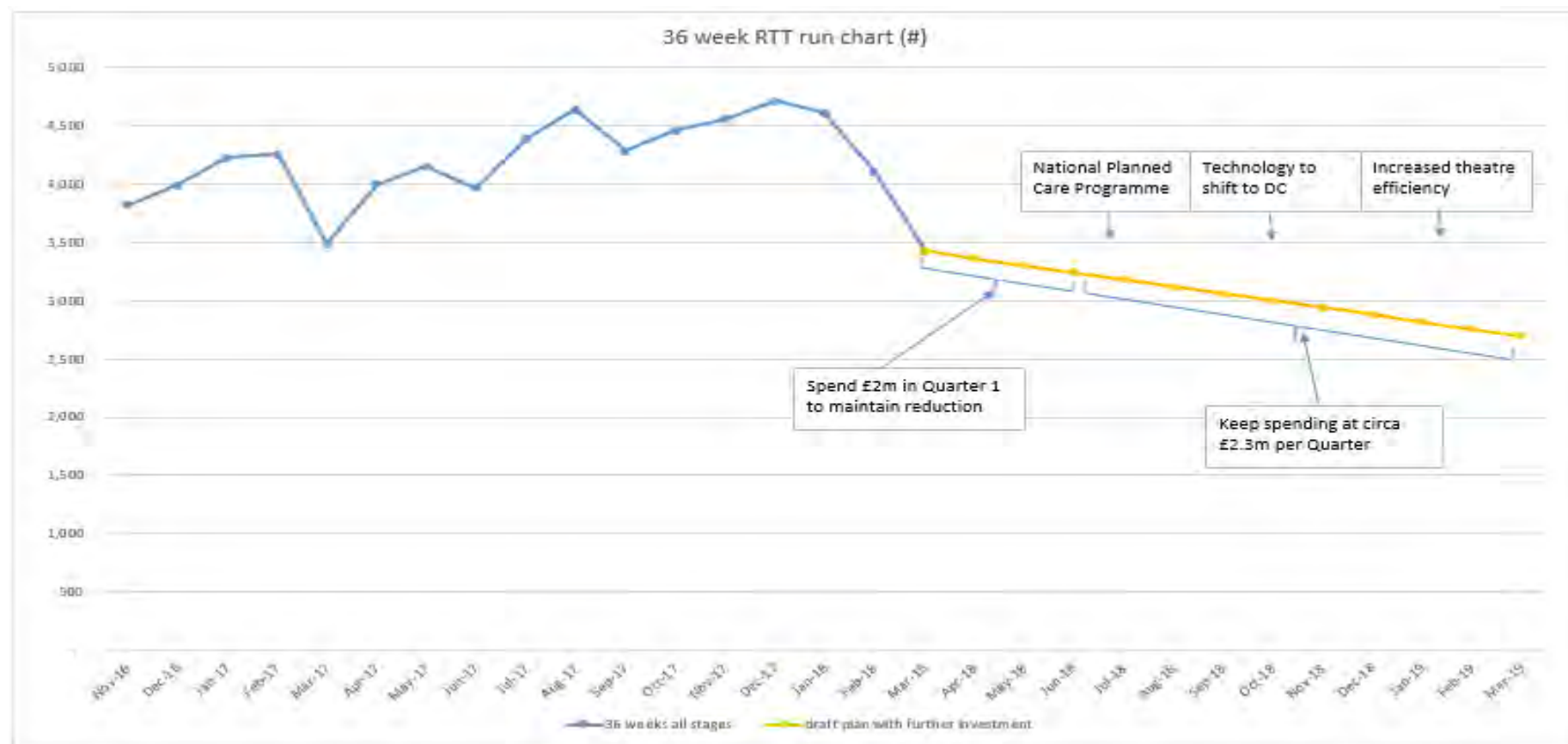
Meetings have been scheduled for April for the Chief Operating Officer, Director of Finance and Assistant Director of Strategy to visit the detail of the specialty plans at each of the Health Board's Delivery Units to see if further gain could be possible within the resource envelope. The health board would welcome and open book sharing of the modelling with Welsh Government to facilitate a discussion on further plans for the year to ensure that options for further reduction in waiting times after quarter 1 can be delivered.

For outpatients the position is similar to that set out for the 36 week system described above. At the end of 2017/18 the health board plans to have fewer than 500 patients waiting for a new outpatient appointment and all of this contained within oral maxillo facial surgery. The Health Board has invested in schemes to improve service sustainability and has supported revised clinical models in ophthalmology and audiology as evidence of this. We are working within the guidance of the national planned care programme in this regard. We plan therefore to have zero 26 week new outpatients by September 2018. However, whilst we have made strong inroads into sustainability in some specialty areas we still have some service models such as general surgery, oral maxillo facial surgery and gastroenterology which if left unsupported will generate 26 week breach patients (and quite quickly 36 week breach patients) if not addressed with additional capacity in year. The trajectory set out below assumes that the health board will continue to deliver capacity at the same rate in quarters 2, 3, and 4 as in quarter 1.

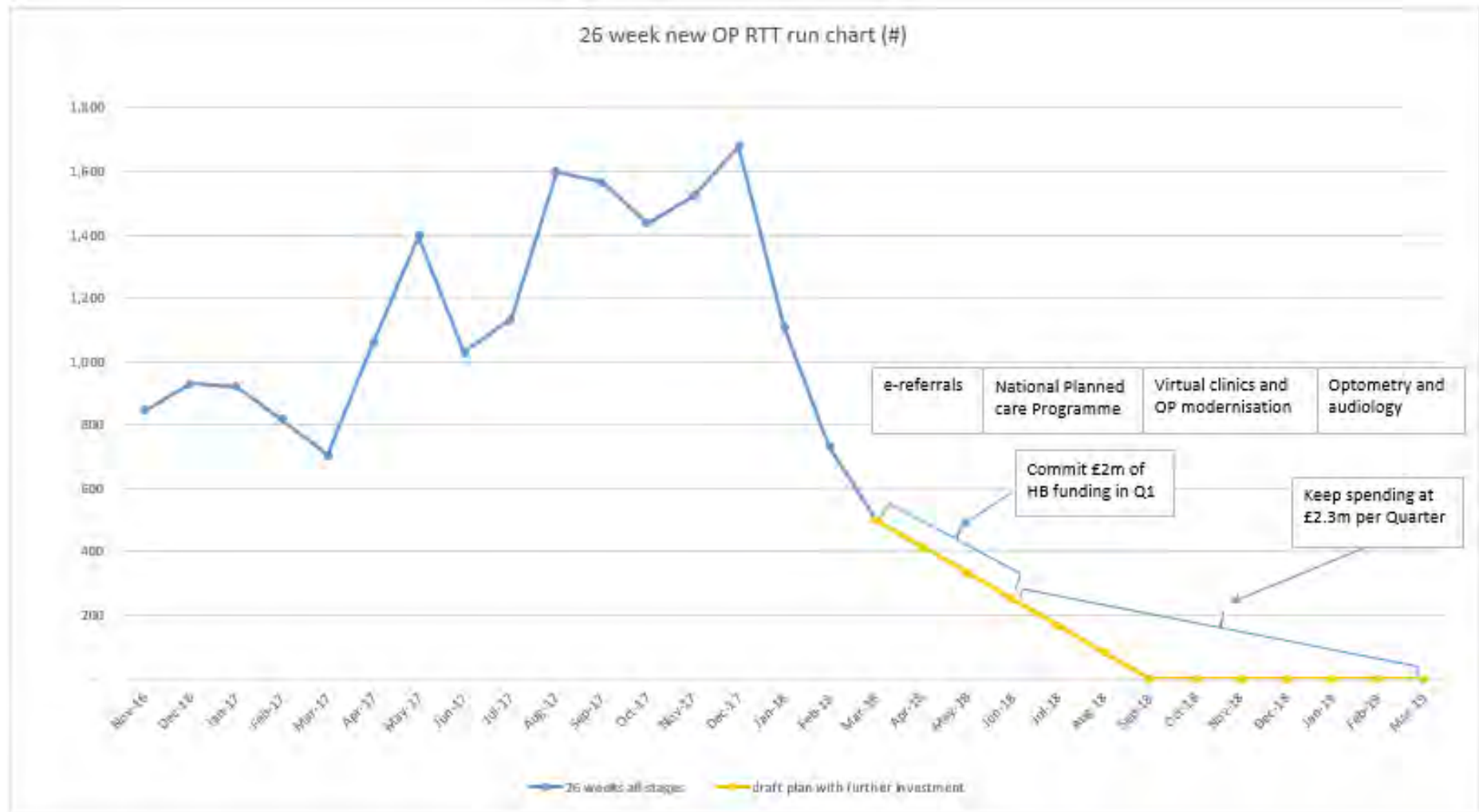
This plan therefore assumes an internal Health Board contribution to waiting times reduction of £2m complemented by additional resource of circa £7m to continue this trajectory. The £7m additional investment is excluded from the financial waterfall presented later in this document.

The table below sets out the principal actions we plan to undertake in this performance area and the target chart which follows sets out when those impacts are actions are planned to impact.

Principal Service Action	Predicted Impact	Start Quarter
Planned Care		
Roll out e-referrals - all year	TBC	Q1
Audiology / optometry improvements – all year	4,000 OP	Q1
Extend National Planned care programme to OMFS, Gynae, vascular surgery	5% efficiency	Q3
Other outpatient improvement in line with the national plan – virtual clinics, see on symptom, reduce follow up ratios	1,000 OP	Q1
Use of technology to shift to day cases	500 DC	Q1
Regional solutions to outsourcing in ophthalmology and orthopaedics	1,000 IP &DC	Q1
Repatriation pathways for regional specialties	Improved L.o.S.	Q2
National Planned care Plans	Included above	Q1



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned Care	The number of patients waiting more than 36 weeks for treatment	0	3,365	3,305	3,244	3,183	3,122	3,062	3,001	2,940	2,879	2,819	2,758	2,697
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0	-	-	-	-	-	-	-	-	-	-	-	-
	The number of patients waiting over 26 weeks for a first new OP	0	417	333	250	167	83	-	-	-	-	-	-	-





It is important to note that the diagnostics position set out above reflects the current reporting suite of diagnostics tests and modalities as reported in 2017/18. The Health Board is aware that there are new reporting standards being introduced in 2018/19 around cardiac tests. Preliminary meetings have been held with cardiac colleagues to understand the current position of these services in terms of waiting times and we are in the process of developing a specific set of trajectories for these cardiac measures for 2018/19.

Alignment to our Quality Priorities

Quality Priorities	Impact
1. SAFER flow 7. Improving Surgical Outcomes	Improving length of stay, outcomes and access

Enablers

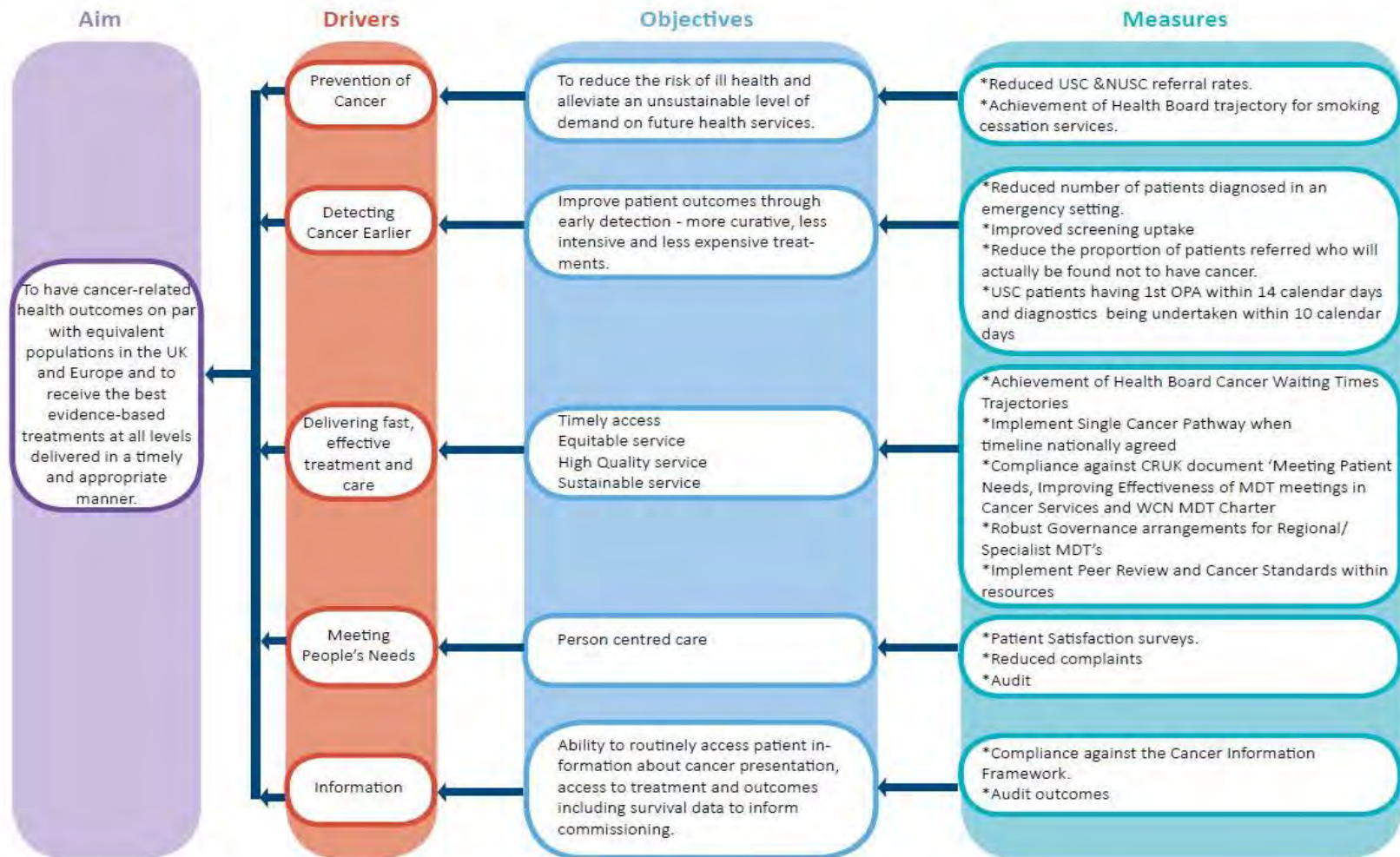
All previous plans have been based on performance improvement within our financial control total and a restricted Welsh Government capital environment. A number of trajectories have been developed for planned care in the charts above which show where performance will be based on baseline funding with increased efficiency and further improved delivery with investment.

Workforce	
• Workforce redesign across a range of specialties	• Workforce redesign within resources • Development of roles to support care that avoids surgical treatment e.g. appointment of Consultant Physiotherapist has reduced the need for surgical intervention for an Achilles tendon. • Development of Advanced Practitioner audiologist to shift demand from ENT to Audiology. • Extended HCSW roles in stoma care to support medical and nursing staff.
Capital Infrastructure	
• Consider investment in Omnicell within theatres • Fees for Elective Orthopaedic Unit • Consider a case for the POWH Pre-assessment Unit • POWH Theatre Refurbishment Programme	• Improve theatre efficiency • Continued development of the business case will require fees. No performance impact in 2018/19 • Improved pre-assessment for surgery • May be included in Environmental BJC2 with works being completed in 2018/19
Digital Health	
• Enhancement of the Welsh Patient Referral Service which allows for algorithm-based grading of GP referrals • Provision of an online citizen-held record which will allow us to share health information and care plans with our patients. • Establish an accelerated PROMS/PREMS programme	• Extension of the service for consultant to consultant referrals within secondary care to speed up hospital processes • Reduction in outpatient appointments for chronic conditions

aligned to value based healthcare • Modernising Outpatients – extend the text reminder service to radiology, community and therapies • Technology refresh of our Theatre Management System, TOMS. • Digital tagging of Health Records (RFID) • Ongoing digitisation of the Health Record.	• Collection and analysis of outcomes leading to improved patient outcomes and experiences • Releasing capacity through reduction in DNAs and efficiency improvements releasing administrative time • Supports and enables theatre safety and efficiency • Improve efficiency and effectiveness of our health record provision services and an essential component of our strategy for the electronic patient record • Reducing process delays, as Unscheduled Care.
Revenue	
• The planned care system is not yet sustainable without additional resources. Whilst the focus is on demand management, service redesign and increased efficiency, sustainability will not be achieved in full in 2018/19 for all services.	• Having a smooth investment plan through the year and joint commissioning with Hywel Dda through regional planning will reduce the level additional resource required to achieve target levels.

3.4 CANCER SERVICE IMPROVEMENT PLAN

DRIVER DIAGRAM Service Area: Cancer



Baseline Position

Performance

The incidence of cancer has continued to rise on average 1.5% a year, and demand is set to rise by at least 2% a year for the next 15 years. Overall cancer survival continues to increase in Wales:

- The long-term trend of increasing one- and five-year cancer survival continues for the most recent years of diagnosis.
- One-year survival increased by 3.3% over five years. Over ten years, this increase was 6.8%.
- Five-year survival also increased by 3.3% over five years. Over ten years this increase was 7.4%.

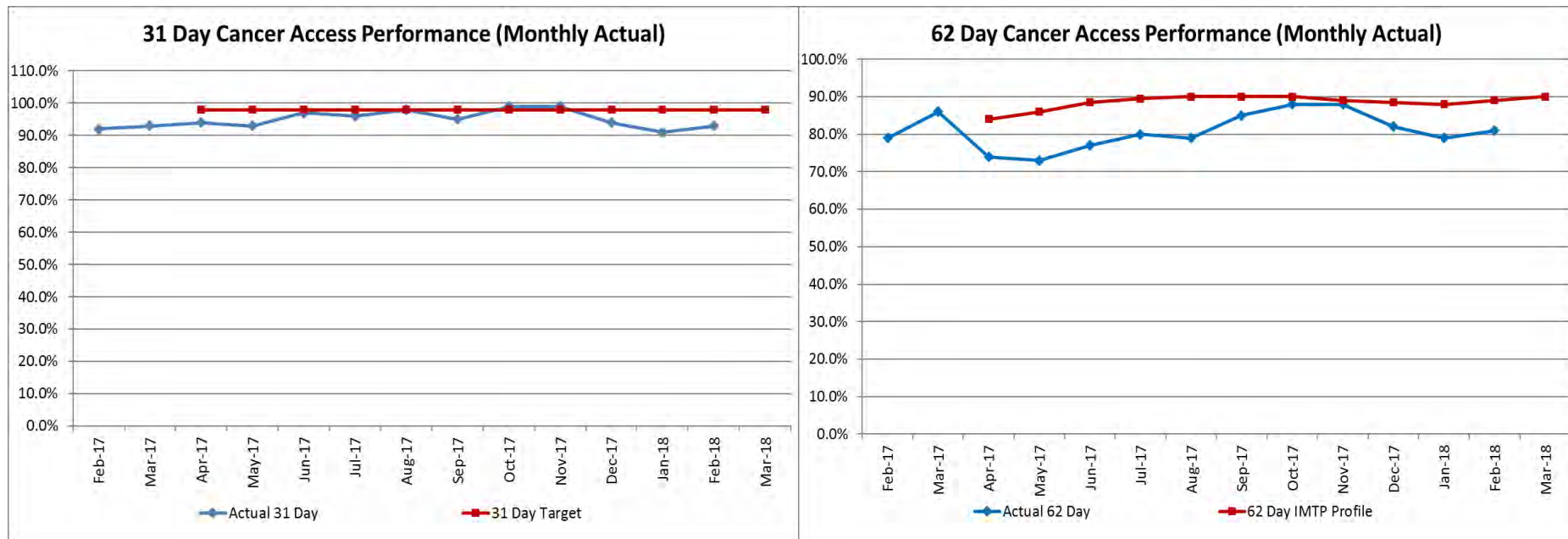
In February 2017, the Health Board commissioned Capita to undertake a review of cancer demand and capacity and our processes. The report recommended that there was a need to develop consistent pathways across the organisation particularly relevant in:

- information systems;
- cross-Unit services such as radiology (difference in access and reporting times);
- MDT activity and capacity and lack of consistency of MDT recording;
- an unusually high number of USC breaches at the outpatient stage despite their analysis showing that sufficient capacity was available;
- a lack of co-ordination across the whole pathway with staff aware of their responsibilities within their “bit” of the pathway, but no real joined up working; and,
- a high number of administrative breaches. Examples of these are; test requests not being marked as USC, delay on requesting an investigation, referral delays between one specialty and another, delays to grading, communication delays around pathways.

In terms of USC demand, dermatology, lower GI and breast tumour sites receive the highest number of referrals, although this does not directly drive our main tumour site performance challenges, which are breast, gynaecology and urology. The overall number of referrals has not changed significantly over the last year but the variability in referrals week on week can lead to problems with meeting the performance targets and recovering from weeks where referrals numbers exceeded the capacity available.

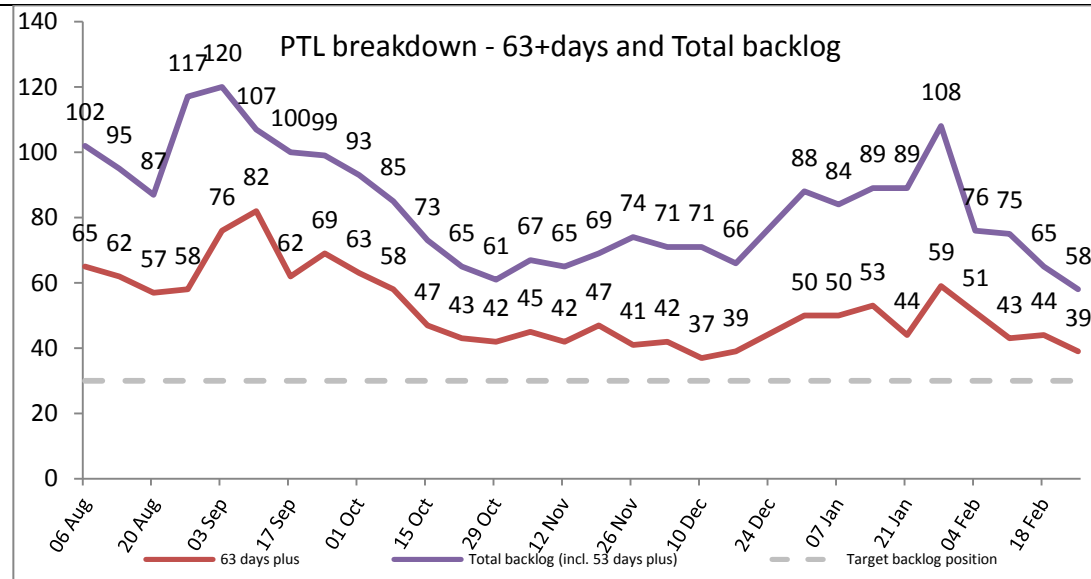
With regard to capacity, there is an upward trend over the last four years of the number of USC patients treated over the period, whilst the nUSC activity has remained static.

Despite this trend of increasing activity, performance for USC has been off track in 2017/18 and remains a top priority for improvement as described in this Service Improvement Plan. Tackling variability in matching demand and capacity on tumour site by tumour site basis will be a key focus in 2018/19. The Health Board generally complies with the non-USC trajectories.



Backlog

The backlog of patients waiting <62 days is an important indicator for the Health Board and is monitored on a monthly basis. Modelling suggests that in order to maintain a sustainable cancer system, there needs to be no more than 30 patients in the backlog queue on a Health Board-wide basis. The backlog is showing a downward trend which sets a good foundation for performance in 2018/19.



The Health Board's refreshed approach in year has been to work with our Delivery Units and tumour site leads to develop improvement trajectories associated with clear improvement actions and this approach will be continued into 2018/19.

Achievements

Through our refreshed approach, in 2017/18 we have:

- Reduced our backlog of patients waiting over 62 days.
- Implemented a culture that allows Delivery Units to access self-service cancer information to assist with their planning and performance management using the Cancer and Radiology Dashboards.
- Gained approval to recruit and appoint a Health Board Cancer Lead Strategic/transformational nurse.
- Improved the effectiveness and efficiency of MDTs.
- Implemented a robust Cancer Peer Review policy.
- Implemented a strategic framework for Macmillan proposals/funding.
- Implemented a Memorandum of Understanding framework for regional MDTs.

- Agreed a plan to align managed Breast pathways across the Health Board.
- Widened the remit of the Rapid Diagnostic Clinic.
- Progressed with the Service Measures set out in the Wales Cancer Delivery Plan 2016 – 2020 and our local Cancer Major Health Conditions Delivery Plan.
- Developed an implementation plan for the agreed Non-Surgical Cancer Strategy developed on a regional footprint with Hywel Dda UHB.
- Started planning for the implementation of the Single Cancer Pathway.
- Received the recommendation from WHSCC for a Single Thoracic site at Morriston Delivery Unit Site

EXAMPLES OF GOOD PRACTICE: Innovative new clinic helps faster cancer diagnosis



PROBLEM

Not everyone with cancer has easily spotted 'red flag' symptoms which indicate the disease. As many as one in two might present with vague symptoms, or symptoms which are commonly found in a range of other conditions.

For these patients, the road to a cancer diagnosis can be a long one, as they go from one specialist to another. Their GP may suspect cancer, but getting a firm diagnosis can take time, and that can mean a delay on their treatment starting.



SOLUTION

The new fast-track Rapid Diagnosis Centre at Neath Port Talbot Hospital, which opened in June 2017, aims to cut through this. It lets patients know if they have cancer either the same day, or within a week if they need additional tests. Patients are referred by GPs who suspect they may have cancer.

If a patient does have cancer, they are then referred on to a specialist team for treatment. If they are found not to have cancer, but a chronic illness instead, they will again be referred for the right treatment for their condition.



RESULT

Within three months of the service starting, 13 patients have been seen, and three have been diagnosed with cancer. By February, 2018, the number of cancer diagnosis had reached double figures. This pilot scheme started in the Neath Port Talbot area, but now covers Swansea. It has already progressed from one clinic a week to two a week.

- Implemented a new Linear Accelerator, to be commissioned in March.

- Implemented a new revised Post-Menopausal Bleed Pathway.

- Established primary care direct access to CT Thorax for respiratory patients.

- Established a One-Stop Urology Clinic established – this includes haematuria, prostate and testicular cancer patients.

- Demonstrated an improved patient experience on the 2017 Wales Cancer Patient Experience Survey and are now in line with other HB results.

Peer Review

Peer Review of cancer services in Wales is a quality assurance programme that assess the quality of the service being delivered by multidisciplinary teams and Health Boards across Wales. The peer

review process is set against a framework of specific health care standards and national guidelines. It combines self-assessment with independent expert review not only to ensure structures and processes are in place to deliver high quality care, but that clinical teams are working effectively together and that there is service improvement ethos based on treatment outcomes and patient experience.

Over the next few years, Acute Oncology and Primary Care Oncology will be incorporated into the process. These areas are considered to be an important aspect of quality cancer services, both in terms of prevention and early diagnosis together with surveillance, rehabilitation and survivorship initiatives.

The Health Board has fully engaged with the peer review process since its implementation, and we are currently participating in the second cycle of reviews for Head & Neck and Gynaecology. Each site specific service has developed an action plan to address concerns raised, which is monitored by the Health Board Cancer Lead Managers and Cancer Improvement Team. From the Health Board's perspective. Peer Review has been a positive experience. It has provided an opportunity for clinical and management teams to address any adverse findings with a prudent approach, reviewing services together to resolve quality and safety issues where needed and work to maintain, improve and transform services as needed.

Our Approach for 2018/19

Performance Improvement

Our performance improvement approach for 2018/19 will be to continue the structured approach from 2017/8 to set improvement trajectories on a Delivery Unit and tumour site basis. Our top three tumour site areas for improvement are urology at PoW, breast and gynaecology. We will also continue our targeted action plans and a programme of quality improvement to make incremental gains across all tumour site areas and to stabilise tumour sites where small numbers of breaches can lead to a large percentage variation in compliance with the target. The underlying backlog for USC cases has started to decrease in 2017/18 and we know this is a core indicator for providing a sustainable improvement in performance; this will continue to be a key focus of our work in 2018/19.

The Cancer Improvement Board has been re-established and will continue to provide assurance of delivery in 2018/19.

Single Cancer Pathway

The Health Board has established a Scoping and implementation Group to lead on the preparation for the implementation of the Single Cancer Pathway. The Group will advise on process, guidance on monitoring and reporting and mechanisms for the collection

of data. A firm timeline for the national implementation has not yet been set but we understand it is likely to be in early 2019.

Cancer Services Strategic Priorities for 2018/19

These are linked to our Cancer Delivery Plan and are:

- To improve the health of our community and to deliver effective and efficient healthcare where our patients and users feel cared for, safe and confident.
- For the people of South West Wales served by Abertawe Bro Morgannwg University Health Board 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.
- To prudently commission services based on need.
- To improve the emphasis on prevention, early detection, and the interface between primary and secondary care.
- To create new models of care and service configurations with partners which shift care to the left side of the pathway, aiming to reduce and prevent future demand rather than simply managing existing demand
- To engage citizens as well as clinicians in decisions to change or remove elements of service or pathways in the system.
- To provide care that is safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it can be.

ABMUHB Cancer Delivery Plan

Our priorities are aligned with the Wales Cancer Delivery Plan for 2018 -19 as follows:

- Prevention opportunities in secondary care and screening uptake;
- Diagnosing cancers earlier, supported by detecting cancer early and framework for cancer programmes;
- Meeting cancer waiting times and implementing the single cancer pathway;
- Delivering and responding to cancer peer review;
- The sustainability of Acute Oncology Services;
- E-prescribing, the replacement of CaNISC and the development of the cancer performance framework; and,
- The regional planning of services.

Non-Surgical Cancer Strategy for South West Wales

Through ARCH and the JRPDC mechanisms we have jointly, with Hywel Dda UHB, developed a Non- Surgical Cancer Strategy for South West Wales. The strategy focuses on delivering excellent care, improved outcomes and supporting those living with and

beyond cancer. It is aligned to the Cancer Delivery Plan for Wales (2016 – 2020) and its vision is '*to provide the best possible care for the people of South West Wales.*' An implementation plan has been developed to progress in 2018/19 and beyond.

Thoracic Surgery Review

In addition, Lung Cancer Site Specific (LCCSSG) Groups have been developed to address the actions in the internally commissioned Thoracic Surgery review action plan. The groups will:

- Establish a structure for ensuring overall consistency of service provision and development for the lung cancer pathway across ABMU and HD UHBs.
- Ensure patient pathways are equitable, and where possible common and consistent, published and available to primary care and patients.
- Ensure there is a care plan/pathway for patient.
- Ensure the integration of the MDT team across the whole care pathway.
- Undertake audit, including:
 - A timed and monitored pathway for each patient
 - A common basic audit plan
 - Snapshot audit of MDT outcomes
- Comply with the recommended data collection requirements.

The outcome of the WHSSC Thoracic Review may also require further service change.

Upper Gastrointestinal Cancer Surgery

The Health Board is also engaged with the work through the NHS Wales Collaborative to review the Upper GI cancer surgery pathways across South Wales.

Service Redesign

We will use our Value-Based Healthcare approaches to improve outcomes and allocative efficiency in lung cancer which has been identified by NHS Wales as the first of two ICHOM standard outcome data sets to be collected as shown in the table below. To achieve this ICHOM are currently working with Lung Services at Morriston.

CANCER

ICHOM Lung Cancer PROMS data collection to inform pathway improvements

Our Plans for 2018/19

Our overall aim in 2018/19 is 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.

Our drivers are:

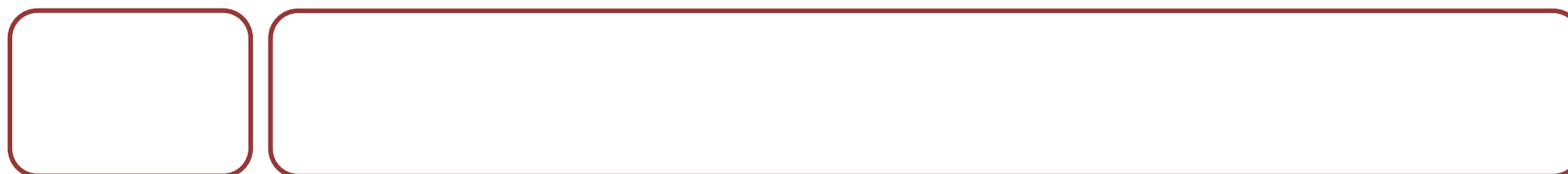
			Meeting People's Needs	

Our cancer prevention actions include Making Every Contact Count to reduce the risk factors for cancer which include smoking, alcohol intake, healthy eating physical activity and obesity. We will also promote smoking cessation through our targeted programmes and promotion of the uptake of the Human Papilloma Virus vaccine for boys which is a risk factors for some head and neck cancers.

Detecting cancer earlier is a key factor in improving survival outcomes for our patients. Our actions in 2018/19 to improve in this area include expanding the Rapid Diagnostic Service and undertaking targeted demand /capacity and improvement work in other diagnostic services such as endoscopy, radiology and pathology. We also know that improving compliance with the 14-day standard for referral to outpatient appointment is critical and this will be a focus of our work in year across all tumour sites. Additionally we will be focussing on pathway improvement in the key areas of breast, urology and gynaecology, including centralising breast outpatient services and providing the MyoSure procedure for removal of intrauterine tissue without removal of the uterus.	
Our work to improve the delivery of care will focus on the key tumour sites of breast, urology and gynaecology and will be driver through rolling performance improvement through the Cancer Improvement Board. We will be continuing our programme of Multi-Disciplinary Team (MDT) improvement as timely MDT processes are critical to improving outcomes and performance. This will include aligning Breast pathways across the Health Board to ensure an efficient and effective pathway for all patients. We will plan for the implementation of the Single Cancer Pathway in April 2019, in readiness for the replacement of the current Cancer Waiting Time Targets, and we will implement our regional Non-Surgical Oncology Strategy. The implementation plan is included in Appendix 11. Additionally we will be participating in the national ICHOM work on lung cancer and will be fully participating in the national Peer Review programme.	
Meeting People's Needs	

- **Deliver End of Life Care Delivery Plan**
- **Appoint a Lead Nurse**
- **Focus on patient engagement**

We will be taking a range of actions to improve patient satisfaction including around end of life care. We will optimise our support for patients, and those important to them, in preparing for end of life by identifying and supporting individual patient's priorities through open conversation and advance care planning, in line with our End of Life Care Delivery Plan which is included in **Appendix 14**. Our Clinical Nurse Specialist staff are highly valued in this area and we will be reviewing this group of posts using Prudent principles to ensure standardisation and best use of resources across the Health Board. We will also be appointing a Lead Nurse for Strategic Transformation in cancer services and we will develop a survey for Macmillan to capture feedback from the GP pathway and consider the results of the survey for service improvement.



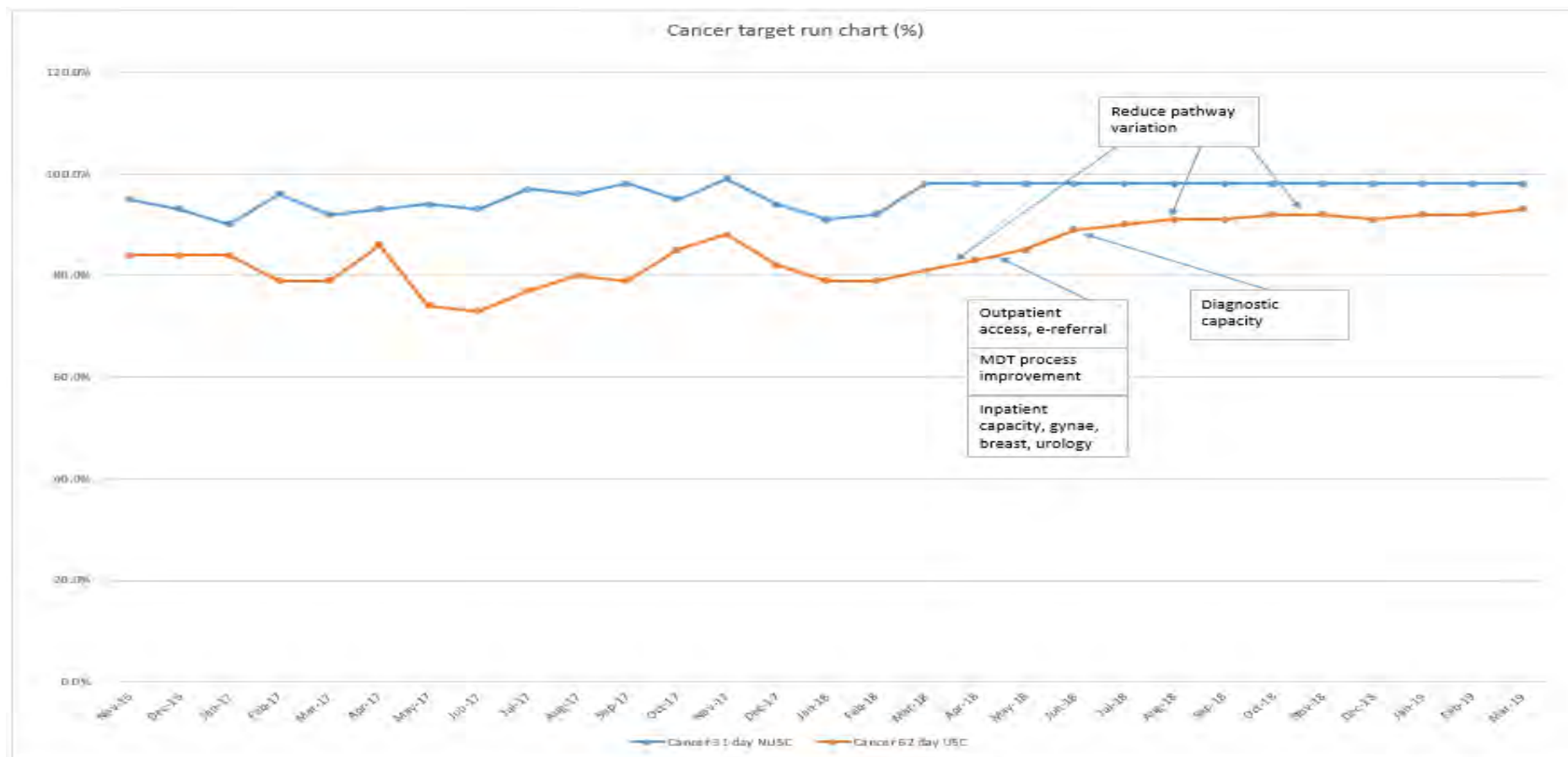
Information is an important tool in both clinical care and performance improvement for cancer. We will be improving the Cancer Dashboard in year and will also be working with others to plan for are placement for CaNISC. Our work will also include participating in national Cancer Audits and ensuring our patients have access to clinical trials.

Trajectories

The trajectories for the NHS Wales Outcomes Measures for Cancer are found below. These are based on the actions in our Service Improvement Plan and the enabling workforce, capital and revenue assumptions included in our Annual Plan as shown below. The trajectories show the run of performance from November 2016 to provide the future performance levels in the context of recent performance.

The table below sets out the principal actions we plan to undertake in this performance area and the target chart which follows sets out when those impacts are actions are planned to impact.

Principal Service Action	Predicted Impact	Start Quarter
Cancer		
Outpatients - Improve access through outpatients, particularly e-referral, improve re 10-day target, centralised OP centre at NPTH for breast outpatients	0.50%	Q1
Diagnostics - Capacity / demand improvement in endoscopy, pathology & gastroenterology, roll our Early Diagnostic Centre to 4 more Clusters, review processes around lung diagnostics	1.00%	Q2
MDT process – improve MDT processes in general, review urology MDTs, align breast pathways.	0.50%	Q1
Inpatient capacity – improve Gynae theatre utilisation, focus on breast, urology and gynaecology, other planned care and USC actions	5.00%	Q1
Reduce variation in general (as USC)	1.00%	Q1 to Q4 ramping up



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer	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%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	91.0%	92.0%	92.0%	93.0%

Alignment to our Quality Priorities

Quality Priorities	Impact
6. Improving Cancer Pathways	- Improving outcomes and access

Enablers

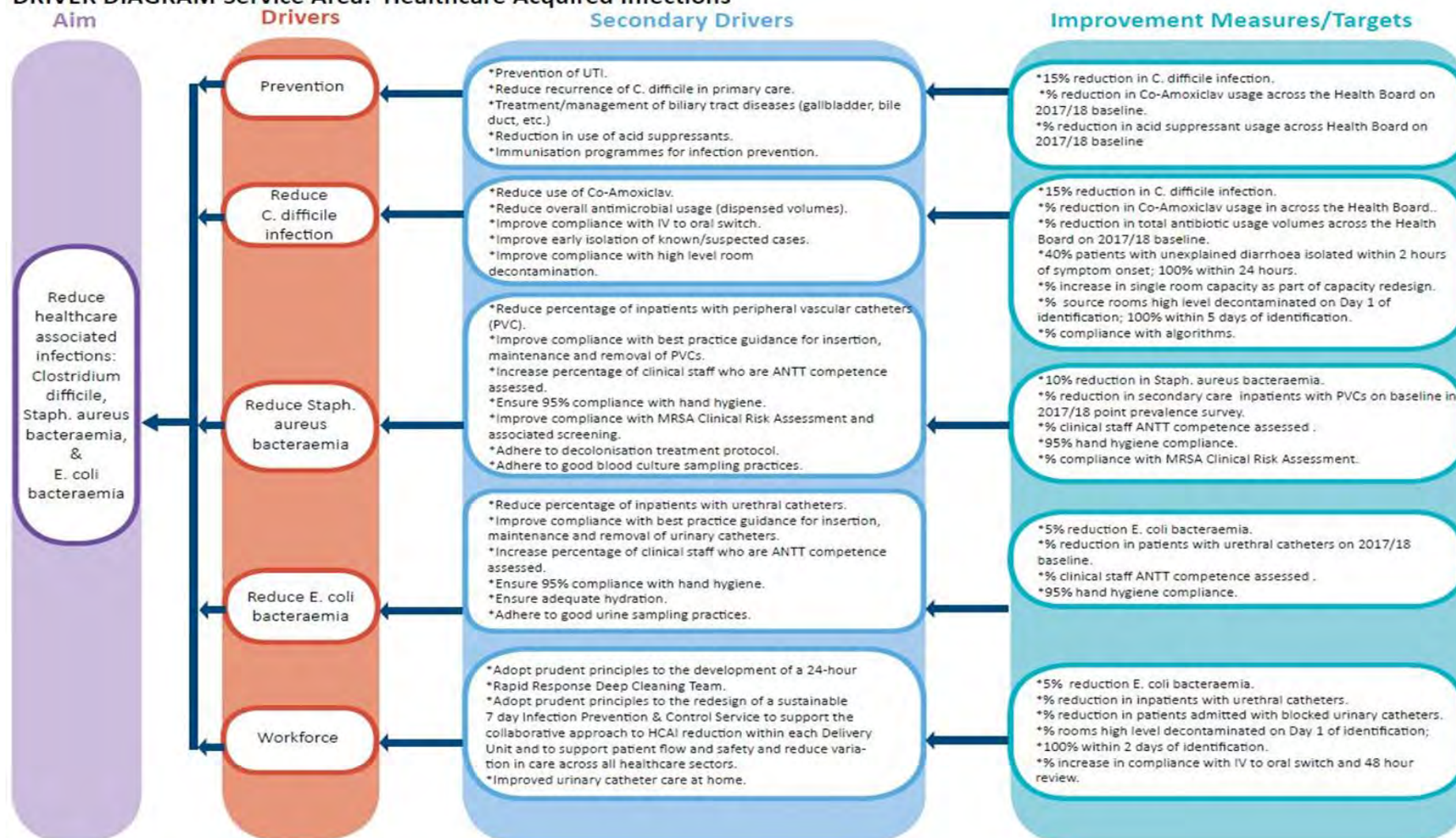
All plans are based on performance improvement within our financial control total and a restricted Welsh Government capital environment.

Workforce	
- Approved business case for advanced radiotherapy - Three-year staffing plan for Linear Accelerator replacements agreed in business case	- Engineering and scientific support - As updated three year plan
Capital Infrastructure	
- Linear Accelerator replacement programme at Singleton - Regional Pathology centralisation at Morriston - Business case to be developed for Gamma Camera replacement - Start planning for centralisation of non-surgical oncology at Morriston	- Replacement of Linear Accelerator A, through approved AWCP business case, due to be fully commissioned by Sept 2018. - Business case to be submitted for replacement of Linear Accelerator B. - Continued development for Regional Business Case will require capital funding for fees - Three Gamma Cameras are all significantly past their recommended replacement date. Bids for replacement have been submitted through the National Imaging replacement programme. - Start planning (no impact in 2018/19)
Digital Health	
All-Wales improved access to cancer patient information through the Welsh Clinical Portal	During 2018/19 WCP will provide clinicians with an all-Wales view of diagnostic results as well as other

• Modernising Outpatients – extending the text reminder service (subject to funding), rollout of electronic referral service on behalf of NHS Wales and Electronic Test Requesting. • Business Intelligence functionality	key documents for cancer patients • For cancer, will improve the 10-day GP referral treatment cancer guidelines • Further development of the Cancer Dashboard for performance management
Revenue	
• None	

3.5 HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN

DRIVER DIAGRAM Service Area: Healthcare Acquired Infections



Baseline Position

Welsh Health Circular (WHC/2017/011) in March 2017, required Health Boards in Wales to continue to drive down all preventable HCAs and to achieve the following infection reduction expectations for:

- ***C. difficile***, a rate of 26/100,000 population by end March 2018.
- ***S. aureus* bacteraemias**, a rate of 20/100,000 population by end March 2018.
- ***E. coli* bacteraemias**, rate of 67/100,000 population by end March 2018.

Achievements

Our Annual Plan for 2017/18 included the following actions which have been progressed throughout the year:

- improving antimicrobial prescribing in primary and secondary care;
- implementation of the Antimicrobial Resistance Plan (included in **Appendix 14**);
- implementation of the decontamination review;
- adoption of Aseptic non-touch technique (ANTT) across the Health Board;
- revision of Infection Prevention and Control (IPC) policies;
- implementation of electronic surveillance of microorganisms (facilitating trend analysis);
- provision of negative pressure isolation facilities on acute hospital sites.

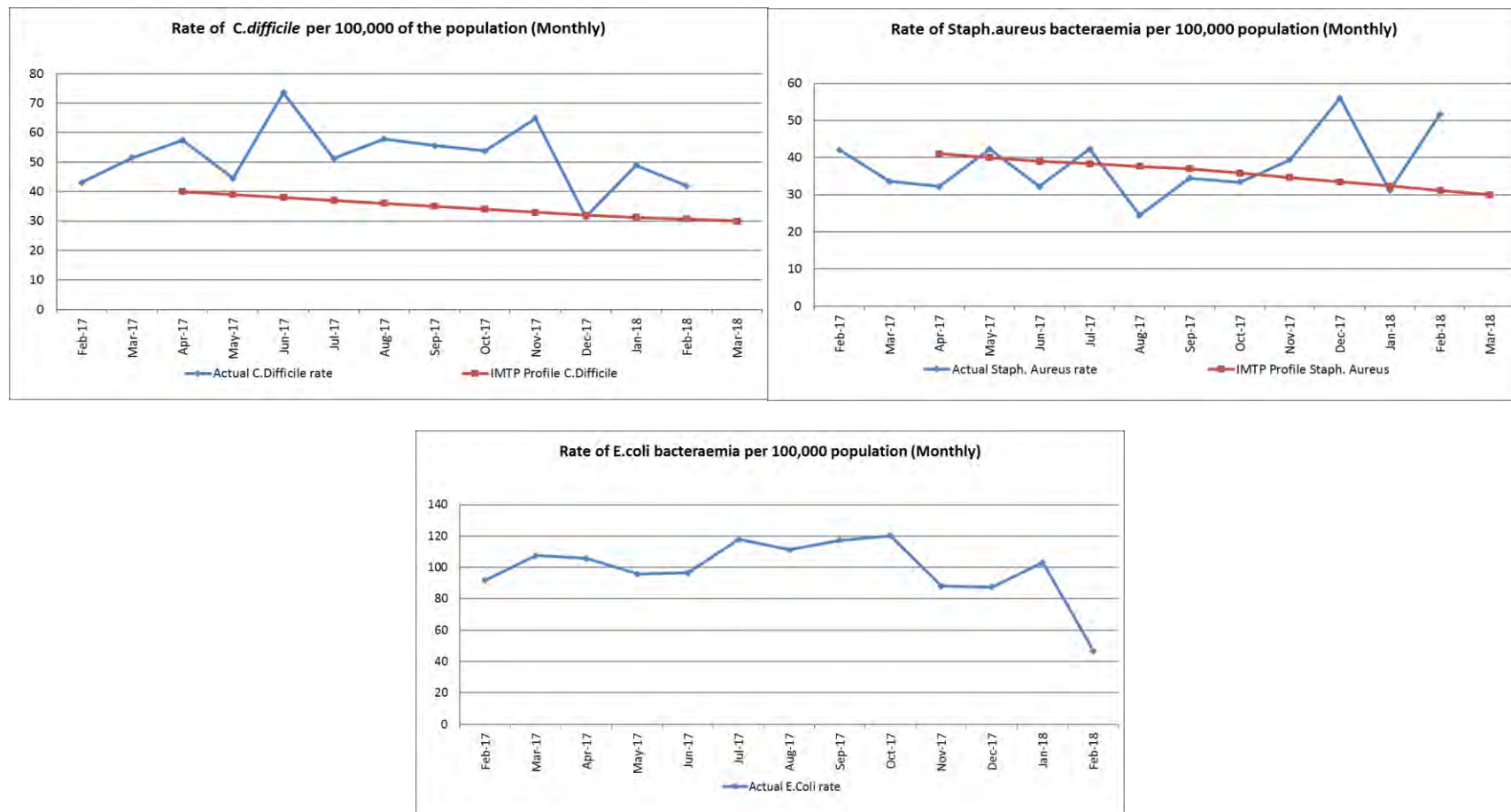
The focus in 2017/18 has been on slowing the rate of infection increase that had been seen during the first six to eight months. There has been progress on this front, for each of the following infections:

- *C. difficile* infection – the rate of increase in the first 8 months, compared with the same period in 2016/17 was 47%; the rate of increase slowed and the 11 month comparison had slowed to a 24% increase.
- *Staph. aureus* bacteraemia – the Quarter 1 increase was 48%; this had slowed to 19% by the end of Quarter 2; the cumulative increase April 2017 to February 2018 had slowed to 11%.
- *E. coli* bacteraemia – the Quarter 1 increase was 32%; this had slowed to 22% by the end of Quarter 2; the cumulative increase April 2017 to February 2018 had slowed to 15%.

The good work that has been done to control the rate of infection in the latter half of 2017/18 is the foundation of our plans for 2018/19.

Performance

The Health Board's progress in relation to healthcare acquired infection (HCAI) is shown in the following charts. The number of c. difficile cases rose until December when there was a significant decrease followed by a sharp increase in January. The number of Staph. aureus infections has been largely on trajectory all year with the exception of November and December and the number of E.coli infections rose throughout the year until November when they decreased until a further increase in January.



The projected position for the Health Board by the end of March 2018, based on our improvement actions and the current monthly averages within the Health Board is as follows:

Healthcare associated infection	Projected total cases by by 31.03.2018	Projected Cumulative Rate/100,000 population by 31.03.2018
<i>C. difficile</i>	281	53.48
<i>Staph. aureus</i> bacteraemia	202	38.44
<i>E. coli</i> bacteraemia	530	100.86

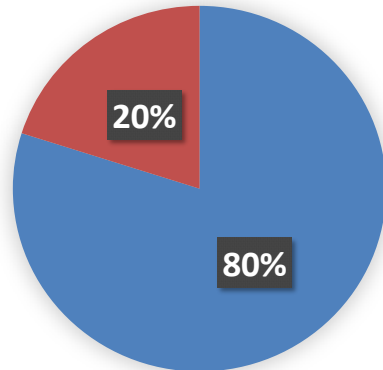
Our Approach for 2018/19

The Health Board is participating in the 1000 Lives national HCAI Collaborative, which promotes the use of quality improvement methodologies to improve HCAI rates. The use of a collaborative approach facilitates organisations learning together and learning from each other and from recognised experts. The Health Board has established a local HCAI Collaborative Faculty, which will provide expert support to the Delivery Unit HCAI improvement programmes, which aim to achieve infection reductions within ABMUHB for 2018/19. These improvement programmes will be Health Board specific, but will reflect the national collaborative programme.

Assurance to the Board is provided by the Health Board's Infection Prevention and Control Committee which is a sub-committee of the Quality and Safety Committee of the Board.

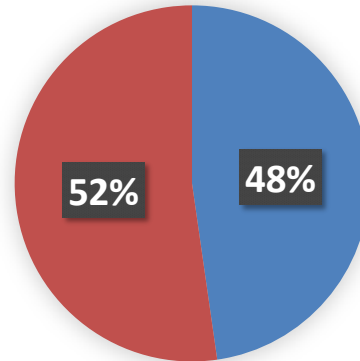
Healthcare associated infection is a Health Board-wide issue. This is demonstrated in the following pie charts for *Clostridium difficile*, *Staph. aureus* bacteraemia and *E. coli* bacteraemia. These pie charts depict the results of localised surveillance for these infections between April and September 2017, and show the proportions that were identified as community acquired infections and hospital acquired infections.

Clostridium difficile cases in ABMU Health Board
2017/18 FY (to 13.12.17)



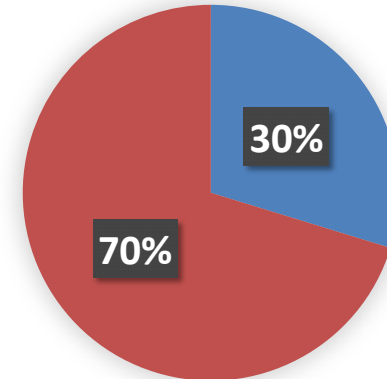
■ Hospital Acquired *C. difficile*
■ Community Acquired *C. difficile*

Staph. aureus bacteraemia in ABMU Health Board
2017/18 FY (to 13.12.17)



■ Hospital Acquired *Staph. aureus* bacteraemia
■ Community Acquired *Staph. aureus* bacteraemia

E. coli bacteraemia in ABMU Health Board
2017/18 FY (to 13.12.17)



■ Hospital Acquired *E. coli* bacteraemia
■ Community Acquired *E. coli* bacteraemia

During 2017 we also undertook a Point Prevalence survey of patients with one or more infections, patients with devices and patients on more than one antibiotic across all our sites, in line with the HCAI Collaborative methodology and to allow benchmarking of these risk factors for HCAI with the all-Wales averages. This data has informed our improvement priorities and plans for 2018/19.

Our Plans for 2018/19

Our overall aim in 2018/19 is to reduce healthcare associated infections for *Clostridium difficile*, *Staph. aureus* bacteraemia and *E. coli* bacteraemia.

Our drivers are:



The HCAs driver diagram represents the system wide approach to delivering improvement across our system in 2018/19. Our prevention and reduction actions are interlinked across the drivers and are summarised below.

1. Reduction in the use of key broad spectrum antibiotics, such as Co-Amoxiclav.
2. Reduction in overall antibiotic usage volumes.
3. Improved compliance with *C. difficile* infection case management, including early isolation and high level room decontamination.
4. Improved compliance with best practice guidance for insertion, maintenance and removal of invasive devices, such as urinary catheters and peripheral vascular catheters (PVCs).
5. Increase numbers of clinical staff who have been trained and competency assessed in relation to Aseptic Non-Touch Technique (ANTT).
6. Establish Delivery Unit peer review programmes for hand hygiene compliance.

The improvement methodologies to achieve reductions in these infections will focus activities on the following areas:

- Implementation and monitoring of more restrictive antimicrobial guidelines (prevention);
- reducing the volume of antimicrobial usage in primary and secondary care (prevention);
- improved compliance with *C. difficile* case management (optimal management);
- effective decontamination of the environment (prevention and optimal management);
- appropriate insertion, maintenance and removal of invasive devices (prevention and optimal management);
- improved compliance with effective hand hygiene practices (prevention).

Infection impact on Flow

We know that HCAs have a significant impact on patient quality outcomes and our refreshed Quality Strategy will reflect our aim to reduce the rate of infection as a core indicator. We also know that they impact on the delivery of patient care within hospitals. A 2012 study identified that, in the UK, each episode of *C. difficile* infection was associated with approximately 14 days of additional hospital stay. The table below uses this data to model the impact on capacity in relation to the cases of *C. difficile* that have been identified in ABMU Health Board inpatients over the last three years. Whilst this is a reducing trend, in 2017/18 this equated to 2030 beddays (5 beds). Achieving our target reduction of 20% will reduce this to 4.3 beds. Therefore whilst there is a

significant benefit in reducing the rate and reducing harm, the impact on patient flow is not as significant.

	2015/16		2016/17		2017/18 (to 30.11.17)	
	No. CDI cases	Add ¹ LoS ¹ (14 days)	No. CDI cases	Add ¹ LoS ¹ (14 days)	No. CDI cases	Add ¹ LoS ¹ (14 days)
Morr	95	1,330	78	1,092	63	882
NPTH	9	126	11	154	5	70
POW	57	798	39	546	49	686
Sing	39	546	39	546	28	392
ABMU	206	2,884	172	2,408	145	2,030

¹ PN Wiegand, D Nathwani, MH Wilcox et al (2012) Clinical and economic burden of *Clostridium difficile* infection in Europe: a systematic review of healthcare-facility-acquired infection; Journal of Hospital Infection 81 (2012) 1-14

However our Service Remodelling plans do take into account the evidence on the link between bed occupancy and infection rates. A Nuffield Trust analysis (2016) showed that increasing bed occupancy could threaten achievements in infection control. Bed occupancy and infection rates data is monitored by the Service Remodelling Workstream of the Recovery and Sustainability programme to ensure that the quality impacts of our Unscheduled Care and Service Remodelling plans are fully understood and managed, and we will also take all opportunities to include the increasing provision of single rooms within our plans.

Training and development for our whole workforce are key improvement methodologies for infection prevention and control. We will continue our rolling programme of targeted training, particularly relating to ANTT and hand hygiene. A business case will also be prepared for the Investment and Benefits Group to consider regarding the dedicated Infection Prevention and Control team.

Trajectories

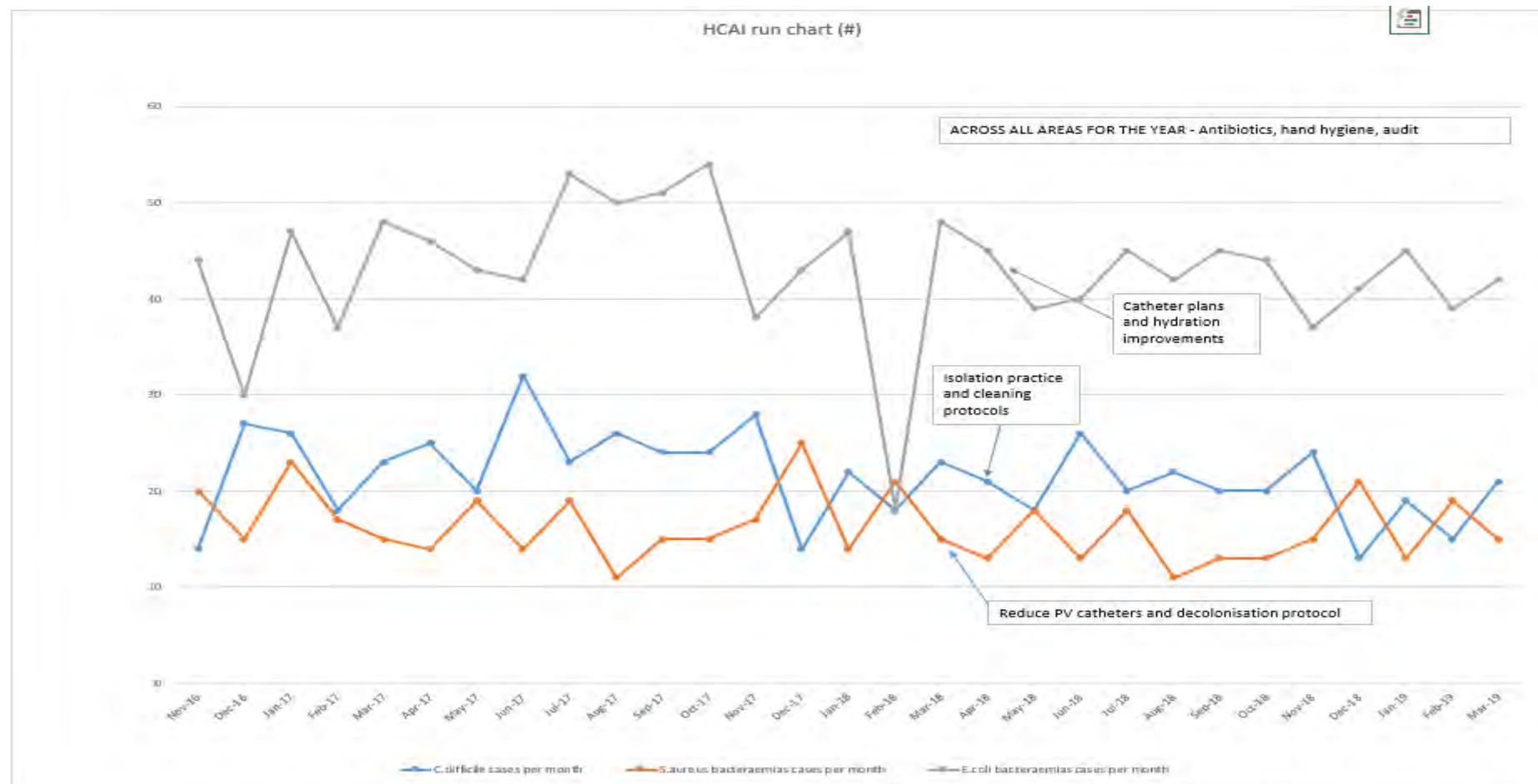
The overall trajectories for the NHS Wales Outcomes Measures for HCAs are found below. Local targets are based on number of cases per month as a more useful operational measure rather than a rate per 100,000 population. The reduction targets are based on historical data on the rates of improvement in the Health Board, advice from WHAIP, benchmark analysis of improvement achievements in the five other major Health Boards in Wales since 2010/11, seasonal trends and our actions in our Service Improvement Plan, and the target cases per month are modelled to the overall annual reduction targets. We are committed to building on the proposed reductions in 2018/19 beyond this to reduce infection rates further in future years. The trajectories show the run of performance from November 2016 to provide the future performance levels in the context of recent performance. Our

plan is to achieve the following minimum percentage improvement in annual infection numbers by the following percentages and this is shown in the run chart and annual comparison chart below.

- 15% reduction in C. difficile infection
- 10% reduction in S. aureus bacteraemia
- 5% reduction in E. coli bacteraemia

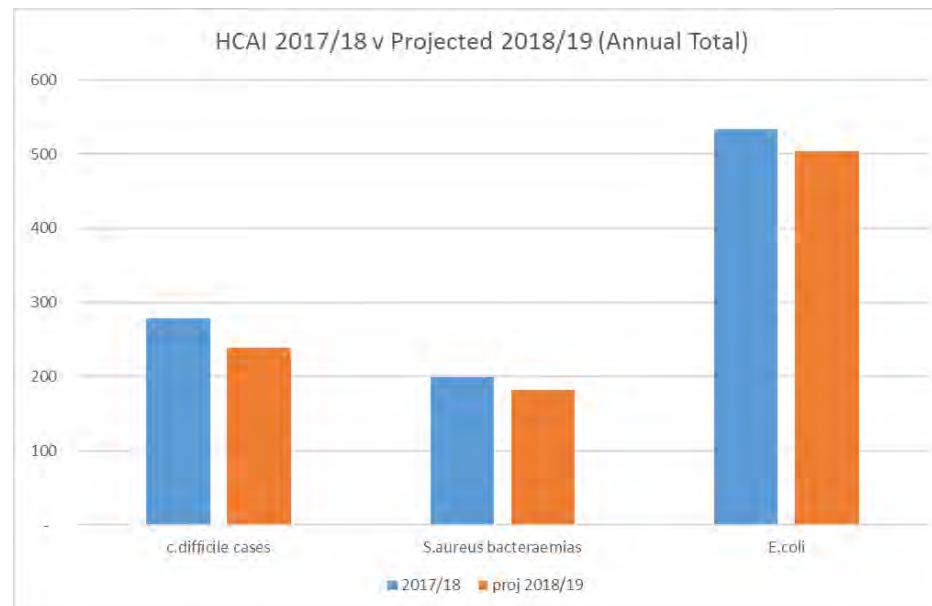
The table below sets out the principal actions we plan to undertake in this performance area and the target chart which follows sets out when those impacts are actions are planned to impact.

Principal Service Action	Predicted Impact	Start Quarter
HCAI		
Underpinning improvement in antibiotic reduction, hand hygiene, training, audit and compliance	5.00% (2.50% E.coli)	Q1 ramping up
C. diff – reduce antibiotic usage (AMR Plan), compliance with isolation practice, cleaning protocols and treatment algorithms	10.00%	Q1 ramping up
Staph aureus – reduce unnecessary use of peripheral venous catheters (PVC), compliance with decolonisation protocol	5.00%	Q1 ramping up
E. coli – reduce use of urethral catheters, improvement in patients' hydration (to prevent UTIs and thereby use of catheters), improve use of urethral catheters at home	2.50%	Q1 ramping up



		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
HCAI	The rate of laboratory confirmed C.difficile cases per 100,000 population	Performance against 18/19 local target. Local target shown as number of cases per month not rate per 100k population.	21	18	26	20	22	20	20	24	13	19	15	21
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population		13	18	13	18	11	13	13	15	21	13	19	15
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population		45	39	40	45	42	45	44	37	41	45	39	42

The chart below uses the same data as the chart above but simply shows the annual predicted reduction in infections.



Alignment to our Quality Priorities

Quality Priorities	Impact
9. Reduce Healthcare Acquired Infections	Improving outcomes and length of stay

Enablers

All plans are based on performance improvement within our financial control total and a restricted Welsh Government capital environment.

Workforce	
• Dedicated microbiology support at Morriston • Enhanced red cleaning team at Morriston • Review funding allocation for Delivery Unit Rapid Response Teams, to undertake the cleaning/ decontamination of all equipment and environment, releasing nurses' time for patient care activities. • Develop a business case for consideration by IBG for a 7 day Infection Prevention & Control Service, that reflects the Delivery Unit structures and provides a sustainable workforce to support work streams of the HCAI Collaborative Drivers.	• Contribution to achievement of improvement targets within resources
Capital Infrastructure	
• Refurbishment programme across acute sites	• Contribute to achievement of improvement targets by improving environment and reducing the likelihood of transmission events
• Consider creating a negative pressure isolation room in Morriston ED	• Working towards compliance with WG guidelines on the number of isolation rooms required per DGH.
Digital Health	
• Integration of iCNet with Welsh Patient Administration System (WPAS) to provide early warning alerts for IPC team and support the digitisation of the Health Record	• Quicker treatment of patients with Healthcare Acquired Infections and better data to support service improvement
Revenue	
• None	• Improvements within resource base

4.0 WORKFORCE

Staff engagement and experience is key to keeping our workforce motivated and to ensuring that a high quality of care is provided for our patients. Our specialist Workforce and Organisational Development team has a crucial role in supporting us to manage the significant challenges and change that we will be undertaking this year. We will be supporting our leaders at all levels to manage change in line with good practice and to recognise the needs of our staff.

We continue to experience serious workforce challenges, and realise that our historical approach to service change, which required the recruitment of additional nurses and doctors, is no longer an option. We are planning to fundamentally reshape our service models as we undertake a number of transformational changes over the coming year and we will equip our leaders with Organisational Development (OD) skills to manage and embed these changes.

As part of our OD plans we will continue to embed our values to enhance staff experience. Developing values-based compassionate leadership capabilities is our priority, where leaders lead by example and demonstrate values and behaviours in all that they do. Following on from our work on Trusted to Care we know that equipping leaders with the tools to engage staff and have a focus on improvement is essential to our recovery and sustainability. In addition, these skills will contribute to the health and wellbeing of our staff alongside improving access to health and wellbeing services and enabling managers to recognise and support staff with mental health and stress issues.

We will continue to endeavour to recruit and retain the staff that we have, especially in those areas where we are having difficulty recruiting particularly to nursing and medical vacancies. The service changes detailed in our Annual Plan will also require us to reconfigure our workforce in terms of numbers and location, which will help to fill some of our vacancies.

Alongside redesigning our workforce and developing new and extended roles, we want to ensure the efficiency and productivity of our current workforce is improved through a number of measures including improved rostering processes and job planning, tighter controls on the use of bank and agency staff, development of a recruitment strategy and the development of skills to effectively manage sickness absence.

Our workforce plans are summarised on the next page and more detail on our work to achieve our Corporate Objective of Securing a Fully Engaged and Skilled Workforce is included in **Appendix 6**.

Workforce Priorities

- Enhanced staff experience and a values culture through compassionate leadership to support management of change
- Workforce redesign to support service redesign
- A healthy workforce with reduced sickness absence.
- Increased retention and improved recruitment.
- Targeted training and development
- Improved workforce efficiency.

Workforce Redesign

- Targeted local Workforce Redesign as laid out in Service Improvement Plans
- Redesign our primary and community workforce to develop multi-professional teams including Pharmacists, Therapists and Paramedics.
- Develop new and extended roles to support the shortage professional groups.
- Develop the non-registered workforce to allow

Enhanced Staff Experience and Embedding our Values

- Monitor our staff experience strategy “In our Shoes; Creating Patient Care through Great Staff Experience”
- Continued use of recognition schemes.
- Improve management and leadership.
- Continued membership of Stonewalls diversity champions programme.
- Embed the listening model from our values based “in our/your shoes” model.
- Further develop values based recruitment.
- Deliver team climate and culture sessions.

Recruitment and Retention

- Increased number of students in relevant health and life science courses.
- Local and overseas recruitment campaigns for Nursing and Medical staff.
- Develop our Recruitment Strategy.
- Implement our Nursing and Midwifery Strategy.
- Implement the working longer readiness tool.
- Maximise our Retire and Return policy.
- Monitor our Staff Experience Strategy.
- Support staff to train more flexibly to become registered.
- Support the Welsh Government initiative “Train, Work, Live”
- Undertake exit interviews and develop action plans from the results.

Workforce Productivity

- Develop options to incentivise Nurse bank take up.
- Reduce recruitment timescales.
- Improve and monitor nurse rostering.
- Implement the All-Wales Nurse agency contract framework.
- Review junior Doctors rotas, job planning and medical study leave to reduce reliance on agency staff.
- Roll out E-job planning for medical staff.
- Apply the All Wales agency caps for internal and external medical locums.
- Develop action plans following completion of an agency monitoring diagnostic tool.

Measures of Success

- Vacancy rates reduced to 5%.
- Turnover reduced from 2018 baseline
- Reduce variable pay by 10%.
- PADR compliance rate of 85%.
- Improvement in the overall staff engagement score.
- Sickness Absence target of 5% achieved.
- Increase level 1 skills compliance to 85%.

Training and Development

- Widen access to opportunities within the Health Board.
- Develop value based leadership capacity and capability at all levels.
- Further develop and embed our Apprentice Academy.
- Improve PADR and mandatory and statutory training rates.
- Support the public services Wales Graduate Scheme.
- Integration of compassionate leadership

Health and Wellbeing

- Develop a single point of access to provide timely health and wellbeing
- Provide training in dealing with stress and mental health issues at work.
- Further develop the Wellbeing Champion role.
- Exceed the Welsh Government target for the proportion of staff which receives the flu jab.
- Implement plans for 5% sickness absence target.

5.0 INFRASTRUCTURE INVESTMENT

The Health Board has shaped its infrastructure investment plan over the recent period on the requirements emerging from a number of strategies, including *Changing for the Better*, the South Wales Programme and ARCH. ARCH in particular has been a key vehicle in terms of developing and co-ordinating a coherent narrative for our strategic investment. This is both in relation to the enabling infrastructure at a regional level in conjunction with our strategic delivery partners, as well as across different primary, community and secondary care settings within the Health Board. In terms of current projects, we are finalising details of the collaborative proposals to be submitted to Welsh Government for consideration as part of the Swansea Bay City Deal which are being led by Swansea University and Swansea Council in relation to the Life Science and Well Being Proposals at Singleton and Morriston Health Campuses.

We have identified a number of key investments to be taken forward over the coming year. These are intended to support a number of aims; enabling the improvements required across the Targeted Intervention areas as part of our Recovery and Sustainability Programme, continuing to maintain and modernise the estate and replace clinical equipment, and accelerating strategic developments linked to local and regional service transformation and sustainability. Further details are provided in **Appendix 7**. We are progressing some developments via our discretionary funding where possible in 2018-19, with investment of £3.6m planned in 2018/19, prior to further engagement around the potential for additional funding with Welsh Government. Our priorities include:

- Supporting the Recovery and Sustainability Programme including investment in the redesign of Learning Disabilities and Mental Health accommodation to support new ways of working, the patient information service in Neath Port Talbot Hospital and a ward refurbishment programme at Morriston and Princess of Wales Hospitals;
- Environmental Infrastructure: finalising BJC 2 under the approved SOP, with a focus on improving electrical supply capacity at Morriston Hospital;
- Delivering improvements in areas of potential high risk, such as the cladding at Singleton Hospital and improving the anti-ligature environment in our mental health facilities;
- As part of ARCH, developing proposals to support site infrastructure approach and access at Morriston; and,
- Accelerating regional service proposals in relation to thoracic surgery, orthopaedics, the Large Trauma Unit and pathology at Morriston.

We have also identified funding requirements to continue with delivery of the NHS Wales National Programmes and our priorities for national funding are:

- Primary and community care: finalising our proposals to deliver our pipeline of projects, as announced by the Cabinet Secretary for Health & Social Services, in Swansea, Bridgend, Murton, and Penclawdd;
- The next replacement of major radiotherapy equipment replacement, Linear Accelerator B, at the South West Wales Cancer Centre in Singleton Hospital requiring investment of £4m;
- Digital Health development, including the continued implementation of key modules within the Welsh Clinical Portal (£0.5m) and completion of the procurement and initial implementation of the Welsh Community Care Information System (£0.865m); and,
- The next replacement of high cost imaging equipment. Following the submission of 2018-19 Imaging Programme requirements of £8.9m to Welsh Government, the Health Board has prioritised the replacement of two MRI Scanners at Singleton and Neath Port Talbot Hospitals (£3.6m).

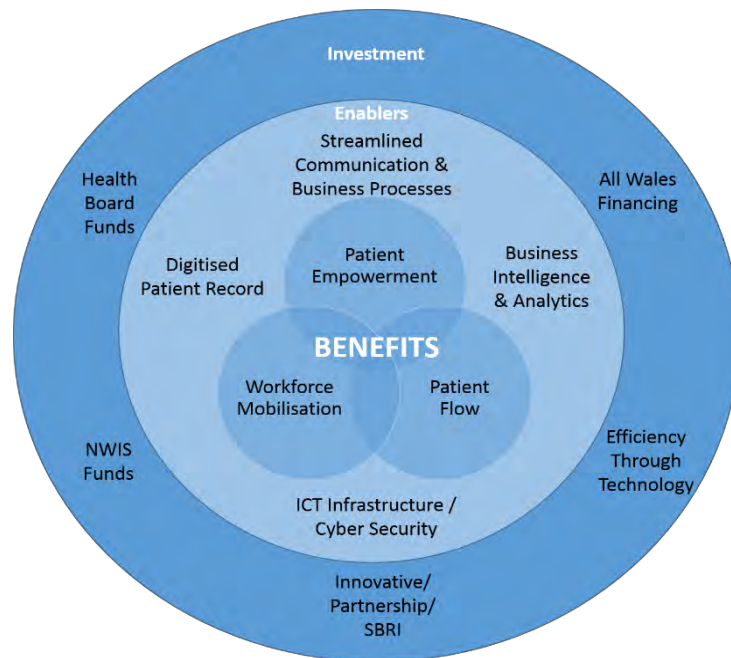
Recognising the continuing pressures on the availability of capital funding across NHS Wales, we are assessing the relative priority of these key investments and this will be completed in time to inform the final version of our Annual Plan. This will enable us to focus our discretionary capital funding to the areas of most need and impact, as well as signal the most urgent investment from the All Wales Capital Programme in 2018/19, subject to Welsh Government's consideration and approval.

Over the coming year, in addition to the delivery of key projects, the Health Board will be reassessing and further refining its infrastructure requirements to support the recovery and sustainability agenda. This will be particularly important in terms of enabling the new clinical strategy and any resulting changes in service delivery models. An essential part of this will be continuing to make progress in becoming digitally enabled. We will also be considering how our infrastructure plan can be supported via alternative funding models. The Health Board is keen to tie into the national work underway in this regard and to further test opportunities to work with delivery partners on innovative funding proposals.

6.0 DIGITAL HEALTH

Digital Strategy and Context

The Health Board published our Digital Strategy '[Destination Digital](#)' during 2017/18, which describes our vision of becoming a digitally-enabled organisation and is aligned with the Digital Health and Social Care Strategy for Wales, 'Informed Health & Care'. The digitisation of our services is also a key enabler of our service change programme and underpins our Recovery and Sustainability Workstreams through increasing productivity and efficiency and providing targeted management information to underpin the actions undertaken by the Workstreams. There are also specific savings schemes associated with health records and reducing telecommunications costs.



Our strategy aims to improve the health, care and wellbeing of our population through the widespread adoption of digital technology. It sets out where we are now and where we would like to be in 5 years' time across a range of capability areas and the impact/outcomes that could have to our citizens and our Health and Care teams in their health and wellbeing focussing on 4 stages of their journey: Support me; Assess me; Treat me; Coach me.

ABMUHB was the first NHS Wales organisation to develop an Informatics Strategic Outline Programme (SOP), setting out a programme of strategic investment in digital enablement to support the provision of high quality care and facilitate service change and modernisation across the Health Board. The SOP was approved by Welsh Government in 2015, and refreshed in August 2016. It details the information and digital technology required to deliver our medium term plans and is, therefore, integral to the success of the Health Board's strategic plan for clinical services and its workforce. Our SOP Investment Objectives are available in **Appendix 8**.

The Health Board is committed to exploring all opportunities to increase resources for Informatics year on year, reflecting the Wales Audit Office (2015) assessment which identified that the spend on ICT in our Health Board is lower than the recommended 2% of total revenue expenditure and significantly below the all Wales average. This growth is required to ensure sustainable service models and to underpin the organisation's aspiration to deliver digital-first services. The Health Board will continue to invest a significant proportion of its discretionary capital in digital and also seek to acquire funds from the All Wales Capital for the Digital Strategy via

business cases under our SOP. The Health Board will also continue to take the opportunity to bid for additional sources of funding such as: Invest to Save, Efficiency Through Technology Fund (ETTF) and the Innovate UK Small Business Research Initiative (SBRI) process. The recent WAO report on Informatics in NHS Wales, highlighted the need for Investment to deliver the vision for digital transformation and we welcome the opportunity to work with Welsh Government, NWIS and other Health Boards and Trusts in order to address this.

By May 2018 we will provide a refresh of our SOP, providing a full progress update and incorporating the ambition of the digital strategy and the opportunity to accelerate intra Health Board digital adoption as part of the potential boundary change with Cwm Taf. In line with the 2019/20 IMTP development process we will construct a new five year SOP, providing a digital roadmap and investment plan to underpin the Digital Strategy.

In 2018/19 the Health Board will also have to ensure it is compliant with significant changes in legislation that apply to the management and security of our information and information systems as follows.

General Data Protection Regulations (GDPR) will come into force on 25th May 2018 and will be directly applicable as law in the UK. It will replace the Directive that is the basis for the UK Data Protection Act 1998. Although in general the principles of data protection remain similar, there is greater focus on evidence-based compliance with specified requirements for transparency. It introduces a principle of 'accountability' and more extensive rights for data subjects and considerably harsher penalties for non-compliance up to 4% of turnover per breach. We have completed an All Wales position statement on GDPR that will be considered by the Wales Information Governance Board (WIGB). The Information Governance team have also completed an internal detailed gap analysis and action plan. The action plan has been approved by our Information Governance Board and resources are being prioritised in order to reach compliance.

The Network and Information Systems (NIS) Directive was adopted by the European Parliament on 6th July 2016. Member States have until 9th May 2018 to transpose the Directive into domestic legislation. The NIS Directive is aimed at bolstering cyber security across sectors that rely heavily on information and communications technology. ABMU Informatics are working closely with Welsh Government (WG), NWIS and other Health Board/Trust Leads to finalise the reporting and implementation plans. The onus will be on ABMU to demonstrate to WG that appropriate measures are being applied to manage the risks to networks and information systems that fall within the set thresholds.

Our digital plans are summarised below, shown by the themes of our Digital Strategy and cross-referenced to our Service Improvement Plans. More detail is included in **Appendix 8**.

Our Digital Health and Informatics Plans 2018/19

Patient Empowerment

- Provision of a Citizen Held Record through Patients Know Best – scaled demonstrator in POWH including integration with national systems
- Accelerated programme for PREMS/PROMS aligned to VBH
- Develop new Internet presence via MURA

Workforce Mobilisation

- Focus on delivering mobile and digital enabled business change across GP/Community Clusters and Mental Health Services through the deployment of mobile devices
- Rollout of Wales Community Care

Digitised Health Record

- Digital tagging of Health Records (RFID)
- Accelerate WCP implementation (Results, documents, reports, images, GP Summary Record)
- Planning for rollout of digital dictation based on pilot in Morriston

Patient Flow

- Continue rolling out Electronic Test Requesting (ETR) across the Health Board
- Pilot the Admission, Discharge and Transfer (ADT) module of WCP at Morriston on behalf of NHS Wales
- Continue the rollout of the electronic referral system – in 2018/19 this will include consultant to consultant referrals
- Scaled up pilot and evaluation of electronic nursing documentation/assessments as part of National Programme
- Prepare for national rollout of the WEDS ED system in 2019/20
- Prepare for rollout of Welsh Community Care Information System (WCCIS) including completion of Business Case and alignment with national programme

Information Governance: Ensure we address the requirements of GDPR and NIS Directive, maintain robust digital infrastructure and ensure cyber security

Quality and Safety

- Implementation of inpatient electronic prescribing (JAC) across two hospital sites as a pathfinder project on behalf of NHS Wales.
- Integrate iCNET with the Welsh Patient Admin System to improve speed of identification of patients with Healthcare Acquired Infections and ensure data quality

Modernising Outpatients

- Extend text reminder service to radiology, community and therapies.
- Rollout of e-referral and ETR

Streamlining Communication and Business Processes

- Rollout of LIMS Blood transfusion and mortuary modules in line with national programme.
- Subject to funding, delivery of a new Intranet information / communication hub
- Continued rollout of Skype for Business
- Continued to develop Business Intelligence functionality – including Executive Performance Dashboard

7.0 FINANCE

Good progress has been made in 2017/18 in terms of stabilising the financial position and we are on track to deliver a year-end outturn of £30m which will be a significant improvement on the control total set by Welsh Government.

Our work in the last year has focussed on delivering efficiencies and implementing a planned programme of service redesign across the organisation which will deliver recurrent savings and reduce our cost base. We will start 2018/19 with a reduction in our underlying deficit, which now stands at £34m. This reflects the positive actions to control our operating expenditure and to stabilise and reduce our run rates. It reflects particular progress in managing our pay bill which is now running under the 2016/17 average. However, the drive to meet the required financial outturn has meant that we have previously relied on work being finance-led. We have also benefitted from the use of non-recurrent measures to help manage the overall financial position and the net consequence of this is that we are not expecting to see further improvement at this stage in the carried forward deficit position of £34m.

The key components of the underlying deficit are shown in the table below:

Underlying Position Review

	£m	Commentary
Unscheduled Care	12.0	Enhanced capacity, CEPOD, A&E staffing, discharge & therapy support to support service demand changes and patient flow
Medical Staff Service Sustainability	5.5	Costs incurred to support the sustainability of current models of service and the Deanery training grade rota requirements. The key services impact are obstetrics & gynaecology, paediatrics, surgery, cardiothoracic and anaesthetics
Planned Care	9.0	Planned £9m spend to improve planned care performance. £7m of this has been invested in recurrent services eg theatre staffing, Morriston Trauma Assessment Unit, additional consultants, Musculoskeletal Clinical Assessment Service, diagnostics, orthopaedics sustainable plan, anaesthetic cover, Singleton Resident Medical Officer Model
Nurse Staffing	3.5	Additional nurse staffing to meet CNO guiding principles, additional critical care capacity & improved assessment unit capacity
Quality & Safety	1.0	Enhanced cleaning and catering staff & other infection control support
Management Structures	2.0	The Health Board organisational structures were changed as a response to the Andrews Report, <i>Trusted to Care</i> . These new structures provide enhanced leadership and visibility of management at each of the hospital sites and also enhanced clinical leadership and engagement through the triuneverate and clinical management structures
Informatics	1.0	Increasing licensing costs due to changes in licencing arrangements and increasing use of technology
Reported Underlying Position	34.0	

Approach

Our approach to strategic financial management has changed and in preparing this Plan we can demonstrate a tangible shift in our thinking and approach. We are consciously taking a whole system view to ensure that decisions and actions do not unintentionally undermine or put pressure on other parts of the organisation. Our approach is now service and clinically-led and to ensure actions are considered from a truly integrated perspective to include the impact of potential changes on quality and safety, workforce, performance and finance.

What We Will Deliver

This is a one-year financial plan which is intended to drive tangible, planned and sustainable progress in relation to the Health Board's financial well-being. This work is supported by a comprehensive Recovery and Sustainability Programme, which also aligns our potential actions in terms of impact on all of the targeted intervention areas. In taking this integrated approach, we are starting to look beyond 2018/19 to 2019/20 and beyond. There is a clear recognition that meeting the considerable short term pressures should not undermine the organisation's long term sustainability.

The 2018/19 financial plan focusses on improving our Welsh Government escalation status by demonstrating a material reduction in the underlying deficit position by circa 26% from the start of the year. We are building on the delivery of forecast savings of £17m in 2017/18 to gross savings of £21m in 2018/19. Beyond 2018/19 the intention is to deliver recurring financial balance as quickly as possible, and work has now started on the future financial strategy linked to the development of our new clinical and organisational strategies, the National Efficiency Framework and our ambitions around embedding value-based principles as the bedrock of all of our activities.

Context and Methodology

The financial environment continues to be difficult and is grounded in issues facing all NHS bodies across the UK, including increasing demands due to population size and age, the increasing prevalence of chronic conditions and the consequent increase in costs. Despite sustained additional investment by Welsh Government in the NHS over past years, the availability of funding is outstripped by growing and changing patterns of need, public expectations and the challenges of securing a sustainable workforce.

As a Health Board in targeted intervention, it is clear that we need to make continuous improvements in our financial position, particularly in the next year and the extent of the requirement is significant. Welsh Government has been clear in its expectation that we need to actively plan to return to balance and on-going financial sustainability.

In preparation for the year ahead, our methodology has included:

- Proactive and systematic use of the wealth of analysis and findings from the external reviews undertaken in acute, community and cancer services to highlight areas of opportunity and focus;
- Early and sustained engagement with all parts of the organisation to consider the impact of these opportunities on quality and safety, performance, workforce and finance, and to consider deliverability;
- Moving away from an internal focus on securing additional resources and instead encouraging our Delivery Units to use what they have differently – this reflects the ambition of wanting to secure best value rather than additionality;
- Embedding and maturing the Recovery and Sustainability Programme to develop and co-ordinate a matrix approach to delivering savings, looking at Service Unit delivery as well as underpinning enabling work streams such as procurement and workforce; and,
- The development of a 'plan on a page' for each Delivery Unit which highlights how all of the key requirements interrelate, including targeted intervention performance, workforce, finance, individual Unit plans and actions.

How We Will Deliver

A key issue to highlight is that the workstreams within the Recovery and Sustainability Programme have been realigned to support each element of the savings plan shown below in the waterfall diagram. This is intended to provide:

- greater transparency around accountability and delivery responsibility, with assigned Executive Leads;
- assurance around the granularity, realism and deliverability of action plans;
- greater and ongoing visibility around progress and monitoring, including financial savings; quality, safety and performance impact; and wider benefits realisation; and,
- an escalation mechanism when delivery trajectories are not being met, to include recovery actions and remedial plans.

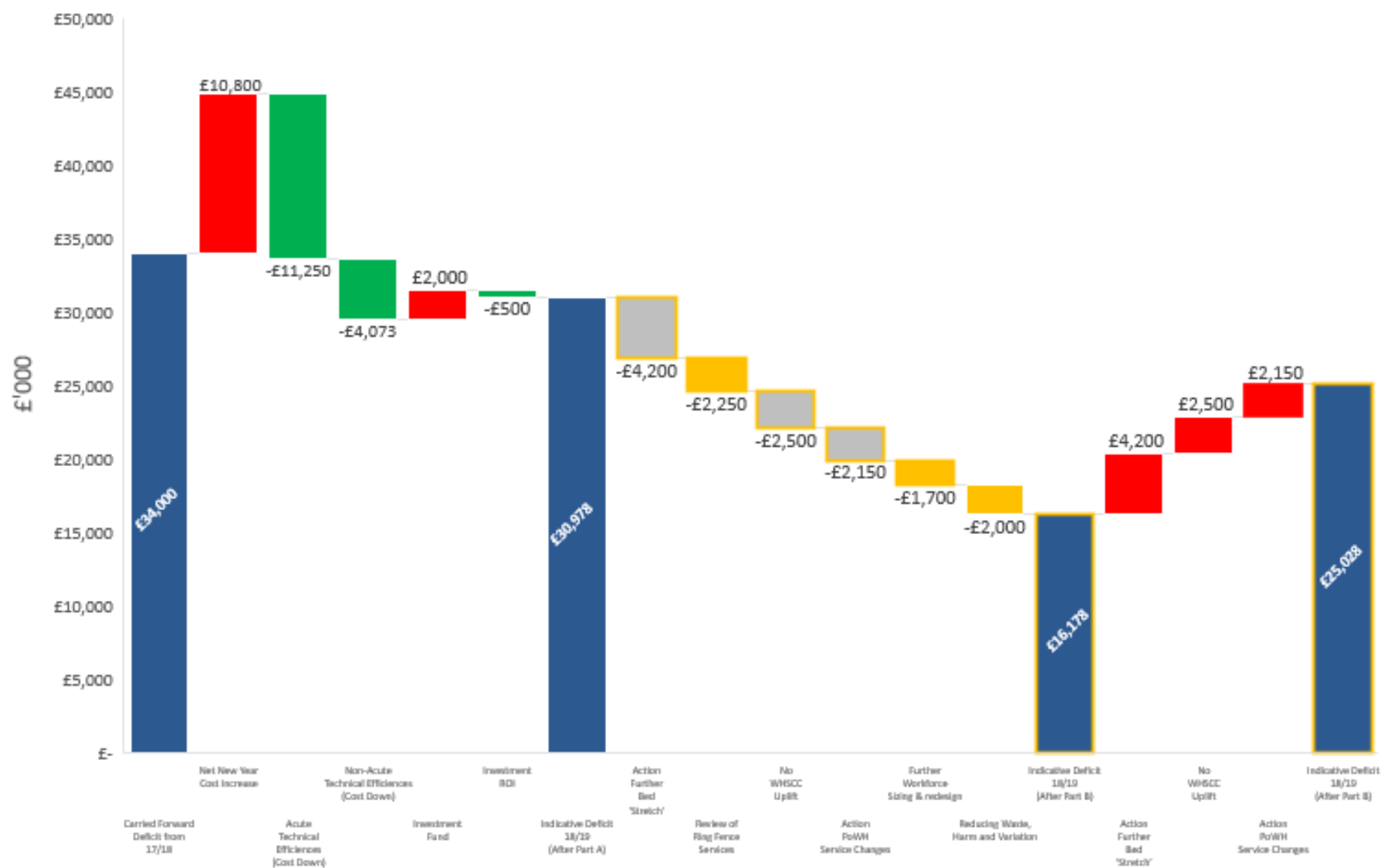
Work is continuing on agreeing detailed plans for each savings area, with individual plans translated into monthly profiles to support visibility, risk management, control and recovery actions. In addition, we are strengthening our approach to budget management and planning. Key deliverables here include the rebasing of budgets to reflect the improved underlying position and recurrent savings delivered in the current year, moving away from traditional cost improvement programmes (CIPs) to reflect the planned savings programme which will manifest in targeted budget reductions, a new reserves management policy and revising budget delegation and accountability arrangements.

Financial Plan Overview

v1.8

The 2018/19 Financial Plan is shown below in summary as a waterfall diagram on the next page.

Outline Financial Plan 2018/19: Part A and Part B



The Financial Plan has been updated to take account of the organisation's delivery confidence and progress in developing savings implementation plans via the Recovery and Sustainability programme. The forecast deficit has increased by £5.8m from the Draft Annual Plan, with a revised forecast deficit of £25m. This remains an ambitious, stretching and deliverable target and takes account of the following issues:

- reflecting the potential outcome of the consultation for the Bridgend Boundary transfer, whereby developments need to be reassessed in conjunction with Cwm Taf University Health Board (an increase of £2.150m);
- recognising that service redesign activities need further development and are now planned to deliver from quarter 2 (an increase of £1.607m);
- mental health redesign activities are planned to deliver from month 5 (an increase of £1.250m);
- workforce savings will deliver from month 6 (an increase of £0.800m); and,

Key Financial Assumptions

- Recurrent savings from the current year are now captured at full year effect in the £34m carried forward deficit – these include service redesign savings which have not yet been implemented;
- The savings to be achieved in 2018/19 are also shown at a full year impact, with the exception of the service redesign savings noted above;
- Growth in demand will be fully absorbed by Delivery Units;
- Pay inflation is funded at 1%. Noting the A4C pay agreement reached in England on 21 March, we are assuming any agreement in Wales will be fully funded by Welsh Government. We are also assuming that the recently agreed changes to the GMS Contract will be fully funded by Welsh Government;
- No funding is earmarked for any additional costs of adherence to the Nursing Staffing Act ,and,
- As reflected in the Planned Care Service Improvement Plan, the positive progress in performance is predicated on additional investment throughout the year. This financial plan assumes £2m of internal investment to support improvement in Quarter 1, and a further £7m of funding from Welsh Government. We have not assumed any other additional income from Welsh Government at present in relation to the £168m that has not yet been allocated.

Key Financial Risks and Opportunities

These are set out below:

2018/19 Financial Plan – Risks & Opportunities

Potential Risks & Opportunities	2018/19	
	Worst Case	Best Case
	£'000	£'000
Current Reported Financial Plan Outturn	-25028	-25028
Risks (negative values)		
Pay Negotiations above 1% not included in Financial Plan	TBC	
ChC Ombudsman full impact	-1,900	
Savings not delivered as planned	-5,000	
Operational Expenditure reductions not maintained	-2,000	
Total Risks	-8,900	0
Opportunities (positive values) (record value consistently and in both Worst and Best columns)		
Non Recurrent Benefits	2,000	4,000
Total Opportunities	2,000	4,000
Total Amended Forecast Plan Outturn Surplus/(Deficit)	(31,928)	(21,028)

The key risks & opportunities within the 2018/19 Financial Plan are:

- Pay negotiations agreeing an uplift above the 1% included within the financial plan. This has not been quantified by 1% is around £6.5m.
- The financial plan includes £1.5m for the settlement of ChC Ombudsman Phase 3 claims. If all claims are settled in 2018/19 in full then the impact could be above that included in the plan.
- Whilst an element of savings slippage has been included in the adjusted 2018/19 in-year plan, there is the potential for further slippage.
- Operational expenditure reductions reported in 2017/18 may not be sustained. It is essential that financial controls are maintained.
- Non-Recurrent benefits are recorded each year; these are often used to offset unforeseen cost pressures.

Key Delivery Risks

The delivery of the Financial Plan will be challenging and contains a number of material risks, some of which relate to the assumptions above including the ability of Units to deliver the required level of savings from this year recurrently and to absorb demand growth.

However, the main risk relates to ability and capacity to firm up delivery plans for each specific area in the waterfall and to drive actions at pace to see an early release of savings. As would be expected at this stage, some delivery plans are more advanced than others and one of the main challenges ahead is to ensure that all areas are making timely progress. The prominence of the Recovery and Sustainability Programme in the organisation demonstrates the importance of and our focus on delivery.

Internal Investment Fund

While we are actively building on the actions we have undertaken regarding cost control and internal reporting and monitoring to deliver sustainable and controlled improvement, we recognise that service transformation will require additional targeted financial support. To this end, our Annual Plan includes an Investment Fund to pump prime key initiatives (using the Welsh Government's Invest to Save principles and investment criteria), and to signal the organisation's intentions around self-help and scale of ambition.

8.0 RISKS AND ASSURANCE

Risks

Effective risk management is integral to enabling the Health Board to achieve our aims and objectives and deliver safe, high quality services and patient care. The Board is in the process of reviewing the strategic risks which will form part of the Board Assurance Framework for ABMUHB. During 2018/19 the Board Assurance Framework will be developed which will show a clear alignment from the corporate risks through to the Framework.

During the development of the Annual Plan the operational and corporate risks to the organisation in achieving our aims and Corporate Objectives have been used as the basis for many of the actions to be undertaken and the current Corporate Risk Register is included in **Appendix 9**.

The risks which specifically apply to the delivery of this Annual Plan are outlined in the following table.

Risk No	Description
1	Delivery of Unscheduled Care targets
4	Infection Control
9	Access to services
New entry	CAMHS
11	Older People
16	Delivery of Waiting Times Targets
3	Workforce Planning
47	Primary Care
42 and 2	Delivery of financial targets
39	Development of an IMTP

The Corporate Risk Register also includes the decision-making and assurance committees that enable the Health Board to manage and put in place corrective action, where necessary, to mitigate these risks.

It will be important to continue to monitor the risks and the delivery confidence of the actions underpinning the improvement plans. In order to manage this, each monthly improvement board will establish and manage its own risk register.

Governance and Assurance

The Health Board is an organisation which is ambitious to provide excellent health services and to work with local communities to improve the health of all citizens.

Our Health Board is made up of a Non Officer Chairman and Vice Chairman, with a Chief Executive, Executive Directors and Non Officer Member (NOM) / Independent Members (IM) and Associate members. Our Board is responsible for:

- Setting the strategic direction of the organisation within overall policies and priorities of the Welsh Government and the NHS
- Establishing and maintaining high standards of corporate governance
- Ensuring delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility
- Ensuring effective financial stewardship by effective administration and economic use of resources
- Ensuring effective communication between the organisation and the community including stakeholders regarding planning and performance and that these arrangements are responsive to the locality's health needs
- Appointing, appraising and remunerating executives

Our Board functions as a corporate decision-making body and its principal role is to exercise effective leadership, direction and control. Executive Directors and NOMs are full and equal members sharing corporate responsibility for all the decisions of the Board. Our Board meets every other month in public, details of meetings are posted on the Board's internet site. The Board also holds bi-monthly development sessions to consider its development needs and discusses future development proposals.

Board Governance

One of the Corporate Objectives for the Board is Embedding Effective Governance and Partnerships. Governance is led and overseen by the full statutory Board. The Board governs a large and complex system of healthcare and the expectations of Welsh Government and the public are always increasing, therefore enabling the Board to do its job through the creation of the right accountable committees is seen as a priority. The role of the Board in deciding on strategy, making strategic decisions and holding the executive to account for delivering safe services can only be carried out if discussion of some of the important detail is

undertaken by committees. Committees can escalate issues to the Board and the Board can delegate issues to committees. In order to conduct its business efficiently and effectively and particularly given its size and complexity the Board relies on the advice of the committees.

As part of changes to the Board and the Executive Team, the priorities for 2018/19 include:

- A Governance Stocktake of current Board and Committee structure to consolidate the e recommendations of the Financial Governance Review including strengthening the system of internal control and designing a Governance Framework which is fit for purpose in the light of these recommendations;
- Develop the Board Assurance Framework which will include an alignment with the Corporate Risk Register and the systems and processes to manage risk; and,
- The delivery of a Board Development Programme and Executive Development Programme.

Assurance of Delivery of the Annual Plan

The final approved service improvement plan trajectories have been approved by the Performance and Finance Committee on behalf of the Board. The monitoring of the delivery of the Annual Plan will be the responsibility of the Finance and Performance Committee on behalf of the Board with escalation levels as set out below.

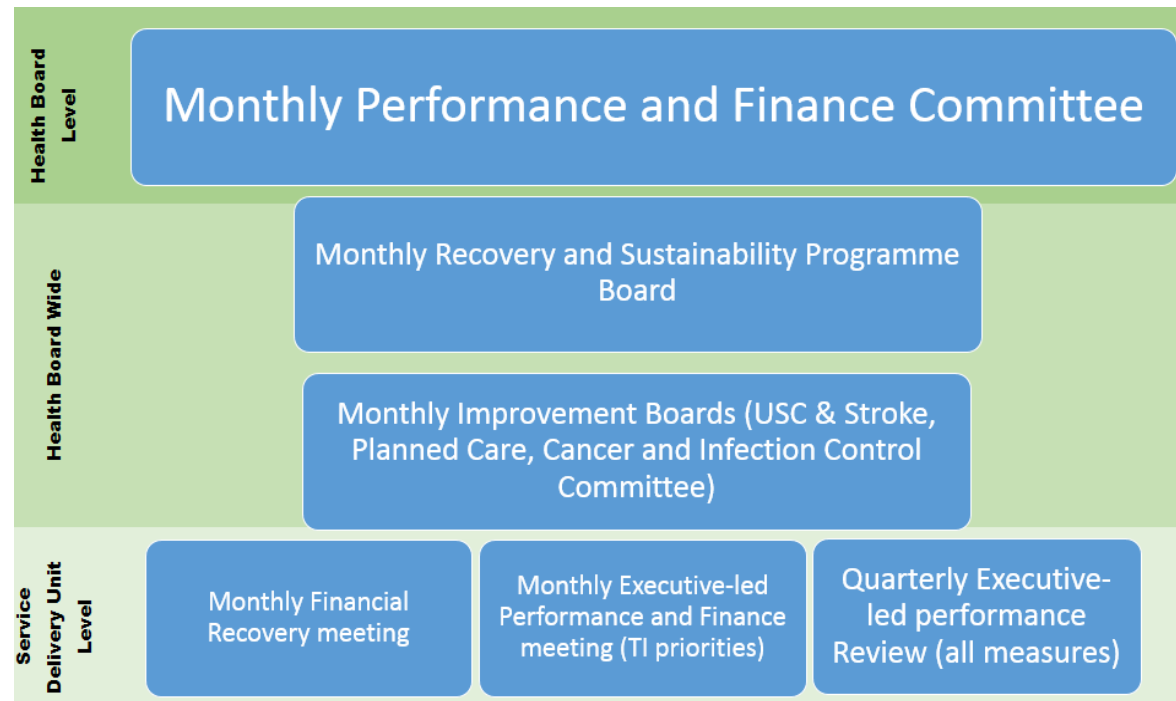
Stage 1 – Discussion, Review and Scrutiny. This is the Committee’s everyday practice. In this stage the Chair of the committee will make known any concerns to the Chief Executive who will ensure that there is clear accountability and delivery by the Executive Team.

Stage 2 – Recovery Plan. The Committee requires the responsible Director to set out a plan and a profile to recover the performance and hit the target.

Stage 3 – If the Recovery Plan is not delivered to target or the profile is missed, the Committee will require the Director to attend each meeting and account for the management of the issue until it is resolved. At this stage the Chair of the Committee will raise the concerns directly to the Chief Executive.

Stage 4 – Continued poor performance will be formally referred to the Chairman and Chief Executive in order that the matter becomes a Board issue.

Below the Finance and Performance Committee, assurance will be provided at both a Service Delivery Unit and Health Board-wide level as shown in the diagram below.

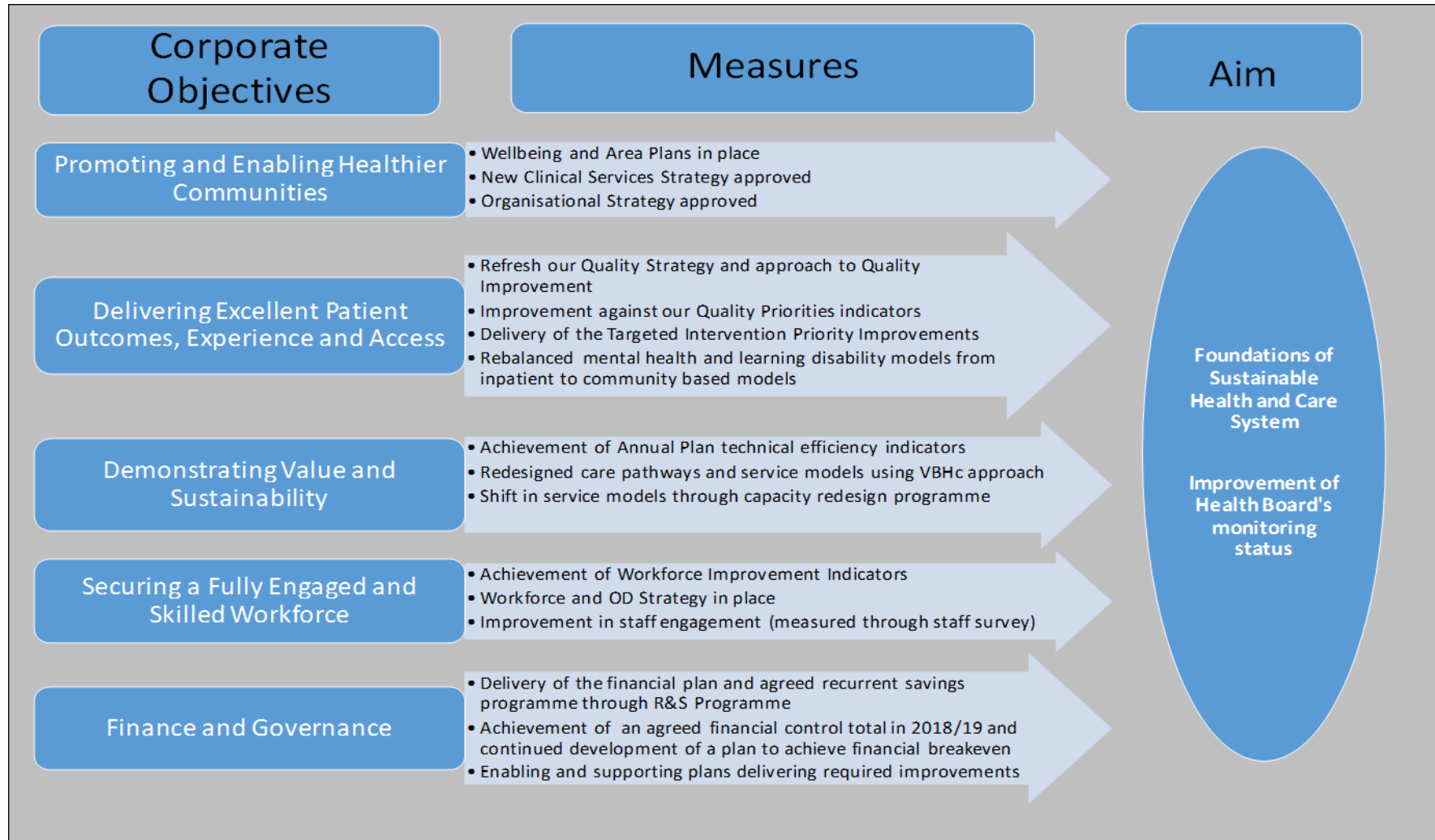


In addition, the routine business of the Executive Team will receive and scrutinise in-week trajectories of performance for each service improvement plan area. The delivery of the Annual Plan as a whole will be reported quarterly by the Health Board, with reports forwarded to Welsh Government for assurance purposes.

Our plans and trajectories are built from service level upwards and reflect the considered positions of our unit plans. The assurance and delivery structures above will enable us to build accountability with our units to ensure that the plan is implemented and that the required benefits and outcomes are put into place. Units will be issued with accountability letters clearly setting out the expectations of delivery in relation to the unit's plans across quality, safety, access and finance.

9.0 MEASURING SUCCESS

To measure the success of our Plan we have set out our Corporate Objectives with their measures and contribution to the delivery of our overall Aim as shown in the diagram below.



Annex 1 – Our Service Improvement Plans 2018/19

1. UNSCHEDULED CARE SERVICE IMPROVEMENT PLAN							Executive Lead: Chief Operating Officer	
Corporate Objectives	Drivers	Actions	Q1	Q2	Q3	Q4	Measures	Lead
Promoting and Enabling Healthier Communities		Increase uptake of all childhood vaccinations. Local Public Health Team to support increased uptake in the following ways: • Deliver immunisation awareness training for pre-school settings to promote key vaccination messages • Contribute to the implementation of recommendations made in the “MMR Immunisation: process mapping of the child’s	x	x	x	x	• Achieve minimum 90% uptake for childhoods immunisations as measured by quarterly COVER stats in children aged 0-5yrs, aiming for 95% • To achieve WG target of 55% vaccine uptake rates for those aged 6 months to 64yrs in an at risk group • To achieve 45% uptake rate of the flu vaccine in children aged 2 and 3 years in Primary Care by March 2019 • Aim for 90% uptake of MMR vaccination within teenage population. • Achieve 90% uptake for HPV / Teenage booster • Improve uptake of the MenACWY vaccine within primary care	DPH

		journey” report - Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins - Develop local resources/ products to share good practice						
		Reduce prevalence of smoking for targeted population groups including: - Patients with respiratory conditions & heart disease, - pre-operative care - Staff	x				- Review of Tobacco Control against National Tobacco Delivery Plan - Review of ABMU HB cessation services. - Achievement of Health Board trajectory for smoking cessation services.	DPH
		Increase flu immunisation uptake for people with chronic			x	x	- Increase uptake to 55% from 45% - To achieve Welsh Government target (75%) for individuals aged 65 yrs and over	DPH

		conditions and people over 65: • Contribute to agreed actions/activities within the primary care flu action plan						
		Improve access to dental care				x	• Improve on 2017/18 baseline as measured through national GDS statistics	COO
		Improve primary care screening for chronic conditions	x	x	x	x	• Reduce variation practice to practice by Cluster Network	COO
		Improve access to services to support mental wellbeing as part of the implementation plan for the Strategic Framework for Adult Mental Health and the plans for the new Health and Wellbeing Centres				x	• TBC as part of development of Health and Wellbeing Centres	DoS
Delivering Excellent Patient	Achieve our Annual Plan improvement trajectories against the NHS Wales		x	x	x	x	• Achievement of our improvement trajectories against the NHS Wales Outcomes Measures	COO

Outcomes, Experience and Access	Outcomes Measures						Achievement of Length of Stay consistent with Welsh peer group	
	Timely Access to Urgent or Emergency Care	Maximise use of 111 model	x	x	x	x	Achieve improvement measured through the 111 metrics	COO
		Improve access to GP care including changes to OOH services	x	x	x	x	- Meet NHS Wales Outcomes Standards for GP Access - Rollout Integrated Hub model of Primary Care - Reduction in Healthcare Professional and Amber 2 ambulance conveyances to hospital on 2017/18 baseline - Implement OOH changes - Implementation of primary care Estates plans for 2018/19	COO
		Increase access to pharmacy-led care, maximising the use of the new Pharmacy contract	x	x	x	x	Measures TBC	COO
		Maximise impact of Community Resource Teams and community rapid response models on patient flow	x	x	x	x	- Achieve agreed Western Bay programme measures for admission avoidance - Complete review of investment in intermediate care and CRTs to maximise return on investment	COO
		Reinvest resources from anticipatory care planning into core community nursing teams		x			Reinvestment completed and technical efficiencies released (£0.5m)	COO

		Review skill mix in community nursing and implement changes recommended by Cordis Bright and Capita		x			95% of recommendations implemented	COO
		Development of EMI care home in-reach services to support care home staff in management of mental health needs of residents and avoid need for referral to ED or admission to acute or psychiatric inpatient care.			x	x	Reduction in admissions from EMI Care Homes on 2017/18 baseline	COO
	Reduction in Unnecessary Hospital Attendance	Implement joint Wales Ambulance Services NHS Trust (WAST) / Health Board initiatives outlined in Appendix 10	x	x	x	x	Reduce conveyances to hospital for non-acute the 'Big 5' conditions against the 2017/18 baseline	
		Implement revised falls			x		Reduce conveyances for non-injured falls patients against	

		pathway across the Health Board					2017/18 baseline	
		Continue to develop ambulatory care models across the Health Board	x	x	x	x	25% of patients of acute medical admissions to be managed through an AEC pathway	COO
		Implement changes to surgical unscheduled care pathways at POW within resources, eg 'chole quick', ENT pathways, trauma and gynaecology pathways		x			Contribution towards achievement of HB target for 4-hour waits	COO
		Psychiatric liaison service measures to be introduced	x				98% compliance with 1 hour response time from referral to assessment for psychiatric liaison services - Reduction in numbers of frequent mental health attenders on 2017/18 baseline	COO
		Improve advance care planning for individuals who have advanced, progressive life limiting illnesses	x	x	x	x	Optimise support for our patients and those important to them	DoT
	Reduce patient risk through reduction in	Implement ECIP plan within resources at	x				Contribution to achievement of HB target for 4-hour waits on site	COO

		Morrison						
		Implement ECIP plan within resources at POWH		x			Contribution to achievement of HB target for 4-hour waits on site	COO
		Ensure Minors streams meet 4-hour standard	x				100% of patients categorised as Minors to be managed within 4-hours	COO
		Consistently implement SAFER flow bundle on all wards as a Quality Priority	x	x	x	x	35% of patients discharged home before lunch 100% of inpatients have an Estimated Date of Discharge - Compliance with other metrics measured through the Patient Flow Workstream	COO
		Roll out TOCALS model to Singleton and POWH	x				Model rolled out	COO
		Implement measures for mental health services to general wards	x				- Improvement in compliance with same day assessment by psychiatric liaison team on 2017/18 baseline - Reduction in numbers of patients on general wards awaiting a MH bed	
		Implement comprehensive geriatric assessment for all patients >75 years (Quality Priority)	x				95% of patients over 75 years to have a CGA	COO
		Implement	x				Compliance with the measures	COO

		measures for new Western Bay discharge standards						
		Trial innovative ways to address deficits in domiciliary care and care home delays		x	x	x	Sustained reduction in Medically Fit For Discharge patients > 7 days on 2017/18 baseline	COO
		Develop Health Board-wide deconditioning strategy – linked to SAFER flow bundle as a Quality Priority		x			Strategy developed	COO
		Develop early supported discharge rehabilitation model			x		Model developed	DoT
		Implement Service Remodelling programme in acute hospitals		x			Service remodelling schemes implemented in line with financial plan	COO/DoS
		Implement new service models for Community Hospitals		x			Community Hospital models implemented in line with financial plan	COO/DoS
A Fully Engaged and Skilled Workforce		Implement the local and Health Board-wide programme of	x	x	x	x	- Achievement of Workforce Improvement indicators - Achievement of actions outlined above.	COO/DoHR

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2. STROKE IMPROVEMENT PLAN				Executive Lead: Chief Operating Officer				
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Who
Delivering Excellent Patient Outcomes, Experience and Access		change approaches including MECC to improve health and related outcomes						
		Develop a proposal for BHF funding to support blood pressure reduction	x				Proposal developed and considered by the BHF	TBC
		Achieve our trajectories for the NHS Wales Outcomes Measures for Stroke	x	x	x	x	%age of patients who are diagnosed with a stroke who have a direct admission to the acute stroke unit within 4 hours % of thrombolysed stroke patients with a door to needle time of less than or equal to 45 minutes %age of patients who are diagnosed with a stroke who receive a CT scan within 1 hour %age of patients who are assessed by a stroke specialist consultant physician within 24 hours.	COO
		Confirm thrombectomy pathway for ABMUHB residents	x				Improve compliance with quality improvement measures and access to thrombolysis within 45	COO
		Promote FAST in the	x	x	x	x		COO

2. STROKE IMPROVEMENT PLAN				Executive Lead: Chief Operating Officer				
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Who
		identification of strokes					minutes and CT scan within 1 hour	
		Continue to develop TIA services	x	x	x	x	Access to TIA clinic within a number of days from referral (TBC)	COO
	The provision of rehabilitation services to aid recovery and to promote life after stroke services	Capture patient-reported outcomes through occupational therapy patient survey	x	x	x	x	Increase in use of PROMs	DoN
		Improve access to 'life after stroke' clinics			x		Reduction in the number of bed days associated with patients on the stroke rehabilitation pathway against 2017/18 baseline	COO
		Refresh the business cases for ESD services and to assess opportunities to reinvest existing resources to improve services			x		Increase the number of patients receiving early supported discharge through a community rehabilitation model, on 2017/18 baseline	COO

2. STROKE IMPROVEMENT PLAN							Executive Lead: Chief Operating Officer	
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Who
	End of life care	Ensure all stroke palliative patients are managed in accordance with the All Wales Care Decision Tool for care in the last days of life.	x	x	x	x	Increase in number of patients who are managed in accordance with the All Wales Care Decision Tool against 2017/18 baseline	DoT
A Fully Engaged and Skilled Workforce	Workforce Redesign	Explore opportunities to expand targeted 7-day cover through workforce redesign.	x	x	x	x	Increase in the number of generic roles.	DoHR
		Recruitment to 2nd SPR at Morriston to support 4 hour bundle.		x			SpR appointed	COO
		Continue staff training and awareness sessions of stroke pathway.	x	x	x	x	Evidence of staff who have received stroke training awareness sessions.	DoHR
		Continue training and awareness in communication skills and advance care planning.	x	x	x	x	Improve End of Life Care	DoT

3. PLANNED CARE SERVICE IMPROVEMENT PLAN	Executive Lead: Chief Operating Officer

Corporate Objectives	Drivers	Actions	Qu1	Qu2	Qu3	Qu4	Measures	Who
Delivering Excellent Patient Outcomes, Experience and Access	Reduced inappropriate referrals	Roll out and developed use of E-Referrals	x	x	x	x	All referrals submitted through e-referral route	COO / DoT
			x	x	x	x	Monitoring of advice given to Practices from secondary to build resilience and reduce demand	COO / DoT
		Build whole system pathways	x	x	x	x	Identify key pathways with Primary care to develop improved management of patient activity – enabling the patient to be treated and managed appropriately	COO / DoT
		Planned care programme delivery of changed pathways of care	x	x	x	x	Audiology initiative to be in place reducing referrals into secondary care Build Optometry links for supporting Glaucoma activity	COO / DoT
		Extend the Planned Care Programme to additionally cover OMFS, Gynaecology and Vascular Surgery as part of the roll out programme.	x	x	x	x	Initialise new planned Care programme groups within the Health Board – working with the National programme roll out.	COO / DoT
			x	x	x	x	Set up appropriate data sets to create base line and develop models of care consistent with national evidence. Develop a resilient and sustainable plan	
	Increased	Develop experience	x	x	x	x	Virtual clinics already	COO / DoT

3. PLANNED CARE SERVICE IMPROVEMENT PLAN							Executive Lead: Chief Operating Officer	
Corporate Objectives	Drivers	Actions	Qu1	Qu2	Qu3	Qu4	Measures	Who
	outpatient clinic slots	gained from current virtual clinics and share across other specialties					developed in planned care programme activities – share knowledge and develop approaches for increased use in other specialties across the Health Board where appropriate.	
		Develop non-medical solutions for patient review – extended workforce skills for Nursing and other professionals	x	x	x	x	Continue with Audiology / Optometry / Therapies / Dentistry and extended Nurse Practitioners across range of services.	COO / DoT
		Review New to follow up ratios	x	x	x	x	Ratios meeting national best practice	COO / DoT
		Develop clinical office sessions in job plans for key clinicians	x	x	x	x	Greater throughput and active monitoring rather than face to face contacts	COO / DoT
	Improved theatre performance and access to beds	Develop Theatre Efficiency Board role in improving performance across sites	x	x	x	x	Challenging Performance and building best evidence base line performance measures.	COO / DoT
		Develop and implement best practice agreed solutions to improving pre assessment arrangements	x	x	x	x	Develop and agree best practice Finalise and introduce revised SoP's Agree and Implement proposed changes	COO / DoT

3. PLANNED CARE SERVICE IMPROVEMENT PLAN							Executive Lead: Chief Operating Officer	
Corporate Objectives	Drivers	Actions	Qu1	Qu2	Qu3	Qu4	Measures	Who
				x	x	x	Reduced on the day cancellations / eliminate not fit for surgery patients and those that no longer require treatment. – increased slots available.	
		Review theatre scheduling of activity	x	x	x	x	Look to introduce IT to improve selection / planning and communication between departments of theatre lists.	COO / DoT
		Review areas where new equipment / technology could shift activity to Day Case or Outpatient procedure / other hospitals within ABMUHB not compromised for beds	x	x	x	x	Review current activity performed in Morriston that could be completed safely in Singleton.	COO / DoT
			x	x	x	x	Review procedures that would be best performed as day case	
		Work with partner Health Boards to identify regional solutions to deliver routine elective surgery in protected capacity	x	x	x	x	Less cancel procedures Timely access and reduced RTT waiting times pressures	COO / DoT
		Clear full year capacity plans in place to deliver agreed year end position	x				Signed off plans in place	COO
							Resources agreed	COO / DoF
		Implement inpatient patient surveys in		x			Accountability letters issued Surveys in place	COO - DoF DoN

3. PLANNED CARE SERVICE IMPROVEMENT PLAN						Executive Lead: Chief Operating Officer			
Corporate Objectives	Drivers	Actions	Qu1	Qu2	Qu3	Qu4	Measures	Who	
		cardiac services and ophthalmology							
	Appropriate levels of follow up care	Ensure that roll of F/U Priority Actions from planned care are sustainable	x	x	x	x	Reduced backlog in FunB / appropriate and timely monitoring of patients	COO / DoT	
		Roll out experience and best practice across other specialties to reduce FunB pressures.	x	x	x	x	Agree with clinical teams programme of work – initially reviewing – OMFS / Vascular Surgery and Gynaecology.	COO / DoT	
		Identify appropriate IT solutions such as Amplitude / other PROM's based systems to assist monitoring and planning of reviews.	x	x	x	x	Continue roll out of PROM's systems	COO / DoT	
			x	x	x	x	Support NWIS developments and identify alternative options such as in Ophthalmology		
		Review Discharging arrangements to safely discharge patients / and facilitate See on symptom arrangements	x	x	x	x	Discharge arrangements reviewed and plan implemented	COO / DoT	
	x		x	x	x	See On Symptom arrangements in place.			
	x		x	x	x	Ensure Primary Care services involved and aware			
	Embedding Effective Governance and Partnerships	Address Hywel Dda Network arrangements	Agree joint outsourcing package and implement commission of the activity	x	x	x	x	Contracts in place	COO
				x	x	x	x	Commission of activity underway	
Agreed LTA in place for both organisations as a commissioner			x					Signed agreed documents	DoS / DoF

3. PLANNED CARE SERVICE IMPROVEMENT PLAN							Executive Lead: Chief Operating Officer	
Corporate Objectives	Drivers	Actions	Qu1	Qu2	Qu3	Qu4	Measures	Who
		Agree models of service where workforce can be shared		x			Consultants and other staff working across boundaries	DoS / COO
		Agreed repatriation pathways in place for key pressured services, vascular, cardiology (unscheduled care benefits also)		x			Signed off pathways in place and operational	COO

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
Promoting and Enabling Healthier Communities		Provide information verbally and non-verbally and Making Every Contact Count about what the risk factors for cancer are and how to reduce them - smoking, alcohol, obesity and physical activity.	x	x	x	x	- Reduced USC and NUSC referral rates. - Achievement of Health Board trajectory for smoking cessation services.	DPH /COO
		Capacity and Demand work to be undertaken in Endoscopy and Pathology Services in preparation for the introduction of FIT testing from early 2019.			x			COO
		Progress on tackling risk factors for cancer to be	x	x	x	x		DPH

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		monitored and reported through the Public Health Outcomes framework by health boards and trusts.						
		Review ABMUHB smoking cessation services and align with National Tobacco Delivery Plan.		x				DPH
		Head & Neck services to continue actively promoting Human Papilloma Virus vaccination for boys in Wales.	x	x	x	x		COO
Delivering Excellent Patient Outcomes, Experience and Access		To support symptom awareness campaigns, collaborate with Primary Care to make available risk assessment tools, training materials and provide access to specialist advice.		x			- Reduced number of patients diagnosed in an emergency setting. - Improved screening uptake - Reduce the proportion of patients referred who will actually be found not to have cancer. - USC patients having 1st OPA within 14 calendar days and diagnostics	COO
		Using CAPITA report and benchmarking information implement demand/capacity plans for endoscopy and gastroenterology		x				COO

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
							being undertaken within 10 calendar days	
		Profiling of endoscopy, imaging and pathology demand to ensure sufficient capacity is in place to support compliance with cancer waiting times and the introduction of the single cancer pathway		x	x	x		COO
		Expansion of Rapid Diagnostic Centre (RDC) service - increase clinics and GP clusters to 4.		x				COO
		Increase sustainable outpatient capacity for USC patients.	x					COO
		Implement centralised breast outpatient/diagnostic centre for NPTH and POWH patients and align breast pathways across the Health Board	x					COO

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Review the performance and the pathways in PoW Urology services, in line with All Wales peers.		x				COO
		Deliver revised Post-Menopausal Bleeding pathway		x				COO
		MyoSure activity to be introduced to Singleton and Neath.			x			COO
	Delivering fast, effective treatment and care	Achievement of Health Board Cancer Trajectories	x	x	x	x	- Achievement of Health Board Cancer Trajectories - Implement Single Cancer Pathway when timeline nationally agreed - Compliance against Cancer Research UK document 'Meeting Patient Needs, Improving Effectiveness of MDT meetings in Cancer Services and WCN	COO
		Cancer Improvement Board to focus on immediate performance issues as well as sustainable improvement - breast, gynaecology and urology	x					COO/DoS

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Support and Challenge Panels to evolve to ensure constructive challenge; update and support to each MDT.	x				- MDT Charter - Robust Governance arrangements in place for Regional/Specialist MDT's - Implement Peer Review and Cancer Standards within resources	COO
		Action plans to improve Cancer Performance to be delivered by each Unit at tumour site level in 30, 60, 90 day view	x					COO
		Recommendations following the MDT review to be implemented and audited.		x				COO
		Implementation of revised MDT Operational policy and MDT Co-ordinator job description	x					COO
		Provide regional models of cancer delivery, innovation, integrated pathways, create economies of scale and provide more specialist treatment closer to home				x		COO / DoS

4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Clear plans to deliver compliance with the single suspected cancer pathway by April 2019				x		COO
		Governance arrangements for regional/specialist MDT's to be agreed and MUO's to be implemented		x				COO
		Implement Non- Surgical Cancer Strategy.	x	x	x	x		DoS/COO
		Continue participation in the cancer peer review programme 2018/19 - Gynaecology; Thyroid, Breast, Sarcoma; Skin; Acute Oncology and Teenage, young adults and infants	x	x	x	x		COO
		On recommendations of ICHOM take value based health care approaches forward in Lung	x	x	x	x		DoS/MD
		Deliver on peer review	x	x	x	x		COO

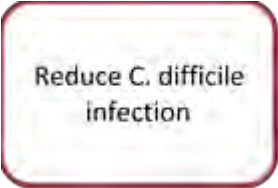
4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		action plans, within resources						
		Increased focus on Gynaecology theatre booking and utilisation	x					COO
		Review of order of lung diagnostics and need to return to MDT for discussion post-test (esp CPEX and CT Guided biopsy)		x				COO
		Review of pathways and implementation of improvements	x	x	x	x		COO
		To further develop Acute Oncology Service and plan for the sustainability of the service		x				COO/DoS
	Meeting People's Needs	Develop a framework for support, development and ultimately transformation of not only Macmillan CNS				x	Measure patient satisfaction through Patient Satisfaction	COO

4. CANCER SERVICE IMPROVEMENT PLAN				Executive Lead: Director of Strategy				
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		posts, but for all cancer nursing posts, improving delivery on key worker, holistic needs assessments, written care plans and patient experience.					surveys. • Reduced complaints • Audit	
		Appointment of HB Cancer Strategic T Transformation Lead Nurse.	x					COO
		Implement survey developed for Macmillan of patients in primary care				x		DoN
		Identify common issues and themes of patient input to steer service development.				x		COO
		Ensure all patients are routinely informed where to access welfare benefits advice.				x		COO
		Establish routine liaison mechanisms between primary and specialist care to meet people's ongoing and post-treatment care needs and ensure seamless				x		COO

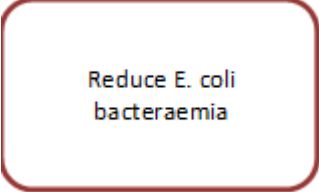
4. CANCER SERVICE IMPROVEMENT PLAN				Executive Lead: Director of Strategy				
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		handover between primary and secondary care.						
		Implement project looking at the identification of adult patients in the last year of life and facilitating their signposting to relevant services. Implement Advanced Care Planning project to improve engagement and uptake alongside education around advance care planning				x		COO
	Improving Information	To further develop the Cancer Dashboard, to allow Units to self-service cancer information to assist with their planning and performance management.		x			- Compliance against the Cancer Information Framework. - Audit outcomes	COO
		To work in collaboration with Velindre NHS Trust, WCN, NWIS and PHW to coordinate the development of a permanent solution to the replacement of CaNISC.	x	x	x	x		MD
		Work in collaboration and	x	x	x	x		DoNQ

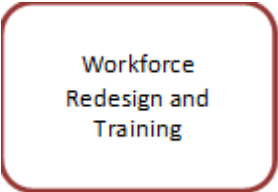
4. CANCER SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Strategy	
Corporate Objectives	Priority	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		support the HB Clinical Lead for PREMS and PROMS						
		Cancer Audit participation	x	x	x	x		MD
		Opening high-quality trials including radiotherapy and surgical trials.	x	x	x	x		MD

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN							Executive Lead: Director of Nursing and Quality	
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
Promoting and Enabling Healthier Communities		Promoting Water Keeps you Well campaign in primary care	x				20% reduction in C. difficile infection data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance). % reduction in Co-Amoxiclav usage across the Health Board in 2017/18 baseline. % reduction in acid	DPH
		Adopt All Wales Urinary Catheter Passport.		x				DPH/DoNQ
		Develop and implement restrictive antibiotic policy	x					DPH/DoNQ
		Audit & feedback of antimicrobial usage.	x					DPH/DoNQ
		Review pathways for patients with biliary tract disease (Simon Weaver - POW)	x					DPH

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN Executive Lead: Director of Nursing and Quality								
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
							suppressant usage across Health Board on 2017/18 baseline	
Delivering Excellent Patient Outcomes, Experience and Access		AMR actions as above.					20% reduction in C. difficile infection. % reduction in Co-Amoxiclav usage across the Health Board on 2017/18 baseline	DPH/DoNQ
		Clinician audits to identify reasons for high usage and recommend & implement audit actions	x				% reduction in total antibiotic usage volumes across the Health Board (primary care to improve on 2017/18 baseline; 5% reduction in secondary care).	DPH
		Isolate patients with unexplained diarrhoea within 2 hours of symptom onset.	x				40% patients with unexplained diarrhoea isolated within 2 hours of symptom onset; 100% within 24 hours.	DoNQ
		All single and multi-bedded source rooms to be emptied temporarily to enable deep cleaning and high	x				% source rooms high level decontaminated on Day 1 of identification; 100% within 5 days of	DoNQ/COO

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN Executive Lead: Director of Nursing and Quality								
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		level decontamination following identification and isolation of C. difficile.					identification.	
		Adhere to C. difficile treatment algorithms, reflecting assessment of disease severity.	x				% compliance with algorithms.	DPH
	Reduce Staph. aureus bacteraemia	Baseline audit of PVC incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of PVCs.		x			20% reduction in Staph. aureus bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance). . % reduction in secondary care inpatients with PVCs on baseline in 2017/18 point prevalence survey. - Increase in %age clinical staff ANTT competence assessed measured	DPH/DoNQ
		ANTT Direct Observation of Practice Assessors to competence assess clinical staff undertaking aseptic technique.	x					DoNQ
		Establish a programme of peer review hand hygiene audits across specialty groups within Delivery Units	x					DPH/DoNQ

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN Executive Lead: Director of Nursing and Quality								
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Audit & feedback of MSRA Clinical Risk Assessment, & implementation of audit actions.		x			by Care Metrics for nursing staff; Unit Medical Directors to confirm process for medical staff).	DPH
		Education on revised decolonisation protocol. Consider decolonisation treatment for patients requiring repeated vascular access, e.g. dialysis, chemotherapy, haematology patients		x			95% hand hygiene compliance. % compliance with MRSA Clinical Risk Assessment.	DPH
	 Reduce E. coli bacteraemia	Baseline audit of urethral catheter incidence in Delivery Units. Reinvigorate STOP campaign. Adhere to best practice guidance for insertion, maintenance and removal of urethral catheters.	x				10% reduction in patients with E. coli bacteraemia; data to be reported for each Delivery Unit by hospital acquired cases and community acquired cases (as identified through localised surveillance).	DPH/DoNQ
		Hand hygiene actions as above.					Hand hygiene measures as above.	DoNQ

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN Executive Lead: Director of Nursing and Quality								
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Education programme on hydration, urine sampling. Adoption of All Wales Urinary Catheter Passport. Development and implementation of Blocked Catheter guidelines		x			% reduction in patients with urethral catheters on 2017/18 baseline.	DPH
A Fully Engaged and Skilled Workforce		Review funding allocation for Delivery Unit Rapid Response Teams, to undertake the cleaning/ decontamination of all equipment and environment, releasing nurses' time for patient care activities.		x			All measures as above.	DPH
		Develop a business case for consideration by IBG for a 7 day Infection Prevention & Control Service, that reflects the Delivery Unit structures and provides a sustainable workforce to support work streams of the HCAI Collaborative		x				DPH

5. HEALTHCARE ACQUIRED INFECTIONS SERVICE IMPROVEMENT PLAN Executive Lead: Director of Nursing and Quality								
Corporate Objectives	Drivers	Action	Qu1	Qu2	Qu3	Qu4	Measures	Lead
		Drivers.						
		Review outreach service models to provide appropriate and safe urinary catheter care at home		x				DPH
		Antimicrobial stewardship training across the Health Board	x					DPH
		Consider alternative models for antimicrobial review in relation to the Focus element of "Start Smart, Then Focus", e.g. nurse/pharmacist prescribers.		x				DPH

ABERTAWE BRO MORGANNWG HEALTH BOARD
ANNUAL PLAN 2018/19
APPENDICES

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VERSION CONTROL

Version No	Changes	Submitted To	Date
1.4	SHG / Executive Team changes	Health Board	25.1.18
1.5	Board changes		
1.6		Welsh Government	7.2.18
1.7	Following WG feedback	Executive Team	15.3.18
1.8	Following Executive Team approval and Performance and Finance Committee assurance	Health Board	22.3.18
	Health Board feedback	Welsh Government	29.3.18

Appendix 1. STRATEGIC CONTEXT

This Annual Plan responds to the changes in our strategic environment since the previous Annual Plan was published in March 2017. Importantly, some of key drivers have not changed, but our response to them in this plan has changed; notably our workforce challenge, our quality and safety approach and our approach to prevention and public health.



1.0 National Strategic and Policy Context

The national strategic context has been strengthened in 2017/18 with the publication of the national Strategy '[Prosperity for All](#)' and the Interim Parliamentary Review of Health and Social Care. In many respects these publications build on the foundations of the Wellbeing of Future Generations Act and Social Services and Wellbeing Acts to further emphasise the unique characteristics of the health and social care system in Wales, the potential to make change happen at scale within a relatively small population base and the opportunities afforded by our statutory duties to collaborate, integrate and to involve all our partners to become sustainable for the long term.

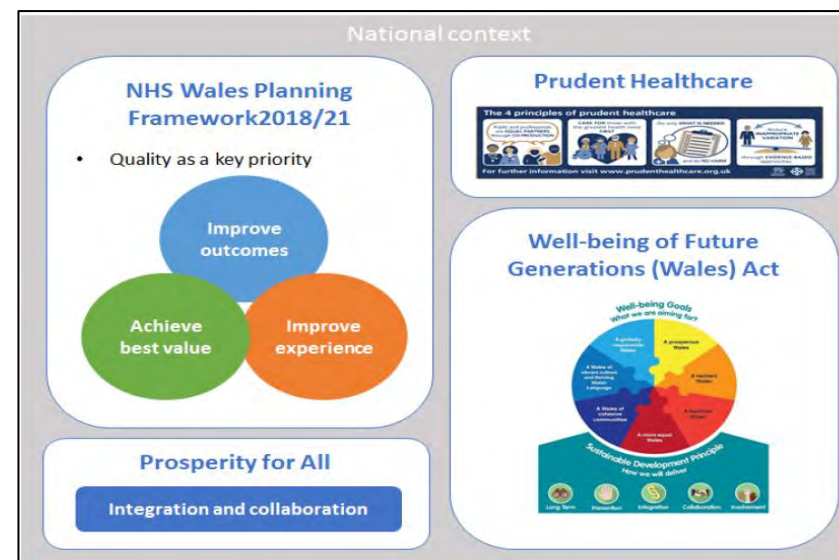
This legislative and strategic framework will be reflected in our emerging revised Clinical Strategy and the strategic direction of this Annual Plan. Additionally, at a practical level the statutory sustainability principle and our duty to involve others, to collaborate and integrate have been used as opportunities to unlock areas of challenge in our recovery and sustainability programme, such as delayed transfers of care in our Service Remodelling workstream. These areas are threaded throughout our plans, particularly for unscheduled care, primary and community services and mental health and learning disabilities.

Prosperity for All

The national strategy '*Prosperity for All*' lays out the headline commitments of the Welsh Government up until 2021. The long term aim is to build a Wales that is 'prosperous and secure, healthy and active, ambitious and learning and united and connected'. The aim informs the four themes of the strategy:

- Theme 1 – Prosperous and Secure
- Theme 2 – Healthy and Active
- Theme 3 – Ambitious and Learning
- Theme 4 – United and Connected.
-

The Health Board has a duty as part of the wider Welsh public service to lay the foundations for achieving these aims in the long term, based on the principles of prevention, involvement, collaboration and integration. As a health organisation we have a particular responsibility to work with partners to break the cycle of ill-health by strategically shifting the approach from treatment to prevention and this is reflected in our new approach to prevention and public health intervention is also part of our sustainability duty under the Wellbeing of Future Generations Act.



Prosperity for All outlines five priority areas around the principles of early intervention:

1	2	3	4	5
Early Years	Housing	Social Care	Mental Health	Skills and Employability

Our work to improve life chances in the Early Years has been confirmed as a Health Board strategic focus through the publication of our Children and Young People's Strategy, which was developed collaboratively with our partners and is one of our top three prevention and public health priorities. We are also in the process of remodelling our mental health services to focus on community models of care and provide responsive services across the spectrum of care needs in line with our emerging Strategic Framework for Mental Health (which will be complete in May 2018). This has been developed following with the involvement of patients and in

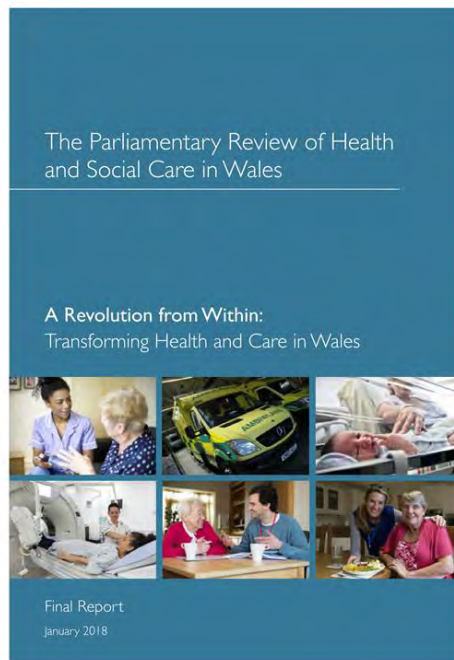
collaboration with our partners. Our skills development programmes in conjunction with Swansea University through the ARCH programme is also described in **Appendix 2**.

We have an established Health and Housing Group which has led proposals on the use of technology to improve care at home, and which has secured ICF funding, led proposals on improving services for people who are homeless, and also led discussions on opportunities to develop more integrated models of care with Housing Associations which will support discharge to assess services. The Health Board understands the wider role of the organisation in making a contribution across all of the four themes of the Strategy in the long term. However, in the short term, our financial challenge has meant that we are accelerating our change programmes in line with the aims of Theme 2 – Healthy and Active in order to become a sustainable provider of high-quality health services. The aims of this theme (as follows) are reflected in the update of our Clinical Strategy and in our emerging Interim Service Model as well as the detail of our plans:

- Delivering quality health and care services for the future;
- Accelerating the standardisation of models;
- Providing care 'Closer to Home';
- Improving the standard of quality and timeliness of delivery;
- Integrating health and social care;
- Continuing the shift of care into the community;
- Providing Community Health and Care Centres; and,
- Pooling budgets and commissioning jointly.

We are also continuing our work to provide good health and wellbeing for everyone including our staff through our Staff Wellbeing Services, the implementation of our partnership Physical Activity Strategy and our digitisation programmes for self-care. We are also continuing to build healthier communities in a better environment through our programme of primary care capital development including future plans for two Health and Wellbeing Centres in Bridgend and Swansea.

Parliamentary Review of Health and Social Care



The Parliamentary Review of Health and Social Care is an independent report which presents a strong case for change building on the principles of the Wellbeing of Future Generations Act (WBFGA), Social Services and Wellbeing Act (SSWBA) and prudent healthcare. The recommendations of the Review signalled a potential change in the future organisation of health and social care in Wales. The report stated that a limited set of new models should be trialled, evaluated and, if successful, scaled up rapidly. This would need to be supported by new workforce models with different skills and career paths as well as a boost in infrastructure. Governance, finance, and accountability arrangements would need to be streamlined with the aim of effectively integrating the health and social care system and offering higher quality care.

The principles of the Review will inform our programme of service remodelling in 2018/19, which will focus on frailty, older people's mental health and learning disabilities. We will be building on the work that is already ongoing with partners to redesign our service models and access the Transformation Funding that has been announced. This includes our work with our housing colleagues through our Health and Housing Group.

2.0 The Wellbeing of Future Generations (Wales) Act 2015 and Wellbeing Plans

The Wellbeing of Future Generations (Wales) Act 2015 required the establishment of statutory Public Service Boards (PSBs) in each Local Authority area to promote wider collaboration and integration across public services to improve economic, social, environmental and cultural wellbeing of local populations in the long term. Statutory members of PSBs are the relevant Local Authority, ABMU Health Board, Mid & West Wales Fire and Rescue Authority and Natural Resources Wales as well as arrange of invited participants. The Health Board participates in three PSBs which had a statutory duty to prepare Wellbeing Assessments by May 2017; these have been used to develop Local Wellbeing Plans for each area by May 2018. Each public sector organisation also has duty to agree a set of Wellbeing Objectives to inform delivery and planning for the long term.

The Health Board approved the Wellbeing Assessments and the Health Board's Wellbeing Objectives in March 2017. Our Wellbeing Objectives are aligned to some of the key themes of '*Prosperity for All*' and are shown in the diagram.



Maintaining health, independence and resilience of individuals, communities and families

We have also woven the Wellbeing of Future Generations' Act 'Five Ways of Working' throughout our plans and we are maximising the practical opportunities that the statutory foundation of the Act gives us to meet our sustainability challenges. Our Wellbeing Objectives are reflected in our Public Health and Prevention, Mental Health and Learning Disabilities, Children and Young People's and Maternity Plans.

Wellbeing Plans

A Wellbeing Plan should to set out a long-term vision for the PSB area and priorities for action over initial stages.

The PSBs' Wellbeing Plans have all been developed differently but there is significant commonality of wellbeing objectives which have been identified in the Plans, as detailed below.

Bridgend	Neath Port Talbot	Swansea
Best start in life	Support children in their early years, especially children at risk of adverse childhood experiences	Children have the best start in life to be the best that they can
Support communities to be safe and cohesive	Create safe, confident and resilient communities, focusing on vulnerable people	Build stronger communities
	Tackling digital exclusion	
Healthy choices in a healthy environment	We value our green infrastructure and the contribution it makes to our wellbeing	Working with nature
	Put more life into our later years	People live and age well
Reduce social and economic inequalities (skills and employment)	Promote wellbeing through work and in the workplace	

It is clear from the draft Wellbeing Plans that there are strong links between the priorities of each Public Services Board (PSB) and those of the regional Western Bay Area Plan. All three PSBs reference four priority areas and whilst the specific detail varies, there is a strong focus on the following as common themes:

- Ensuring children receive the best start in life during their early years
- Building strong communities that are resilient and safe
- Enabling citizens to live and age well within their communities and promote wellbeing

- Sustaining natural environments and reducing the carbon footprint

Full draft plans are available on the links below and final drafts are due to be signed off by participating organisations by May 2018:

<http://www.swansea.gov.uk/psb>

<https://www.npt.gov.uk/5808>

<http://www.bridgend.gov.uk/services/public-services-board.aspx>

The Health Board is committed to taking all reasonable steps to achieve the Wellbeing Objectives for the organisation as well as those in the Wellbeing Plans to ensure there is progress against these and the seven national wellbeing goals in the long term. To achieve this we know that the way in which we make decisions and our planning processes and the way in which our Plan is developed will need to change to place the Wellbeing Objectives at the heart of the organisation's work, as envisaged in the Wellbeing of Future Generations Act, as well as being reflected in the priorities and work programmes of our Delivery Units and Corporate Departments.

3.0 Social Services and Wellbeing Act 2014

Our relationships with our Local Authority partners in Bridgend County Borough Council, Neath Port Talbot County Borough Council and the City and County of Swansea have developed and matured since 2014 when the Western Bay Regional Partnership Forum was established on a non-statutory footing to maximise the benefits of collaboration and the integration of services through the ambitious Western Bay Health and Social Care Programme. The Programme has many Workstreams including Community Services; Prevention and Wellbeing; the Welsh Community Care Information System (WCCIS) and Procurement and Contracting for care homes. The partnership was formally established in 2016 as the Western Bay Regional Partnership Board following the duty introduced in the Social Services and Wellbeing Act to establish a statutory Regional Partnership Board. The region covered is the geographical area covered by the Health Board and the three Local Authority areas.

The Social Services and Wellbeing (Wales) Act 2014 required that local authorities and Health Boards must jointly carry out a Population Assessment on a regional basis through the Regional Partnership Boards. The purpose of the Population Assessment is to create a single evidence base which supports the delivery of the functions of all organisations in the Partnership and also inform planning and operational decisions. A [Population Assessment report](#) was prepared for the Western Bay Regional Partnership Board area and in line with the statutory guidance, the Assessment is structured within the core themes as shown in the diagram.



The Partnership Board has produced an Area Plan which will be published by 1st April in line with the statutory requirements that reflects the Population Assessment and the priorities of the partnership organisations. It is the overarching regional plan for integrated health and social care joint working.

The Area Plan is split into two sections. This first section is the longer-term five-year plan (2018-2023) and includes the regional priorities to be overseen by the Regional Partnership Board. The second section is the corresponding Action Plan which is a one-year transition plan (2018/2019), which includes a number of key actions that work towards addressing the regional priorities. A one year action plan has been developed, instead of a longer term plan due to the potential health boundary changes for the Bridgend locality. Both plans can be found here: www.westernbay.org.uk/areaplan.

The Area Plan represents what 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. RPB 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.

Theme	Key Priorities
Older People	▶ Develop and maintain a sustainable range of services that meet demand, enabling individuals to remain at home while maintaining their independence for as long as possible and receiving appropriate support at times of need. ▶ Develop and provide a range of future accommodation options to meet demand and enable

	people to remain independent for as long as possible. ▶ Develop community resilience and cohesion to tackle social isolation in areas where older people live. ▶ Develop an optimum model for older peoples mental health services (including relevant components of the Welsh Government All Wales Dementia Strategy/Plan)
Children and Young People	▶ 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 robust multi-agency arrangements for children with complex needs
Mental Health	▶ 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, ▶ Ensure placements for people with complex needs are effective, outcome based and appropriate
Learning Disabilities and Autism	▶ Develop 'age-blind' person-centred models of care to ensure prevention and early intervention through multi-disciplinary services, by remodelling services away from establishment based care into community-based services.
Carers	▶ Ensure work continues to promote early recognition of all Carers so that they are signposted to information and support in a timely manner ▶ Develop and continue to provide information, advice, assistance and support to all Carers enabling them to make informed choices and maintain their own health and well-being ▶ Co-produce with all Carers on an individual and strategic basis so that their contribution is acknowledged and their voices are heard.

In addition there were a number of cross-cutting themes that emerged through the Population Assessment exercise and which inform the priorities of the Area Plan, in addition to the cross-cutting priority of Carers, as follows:

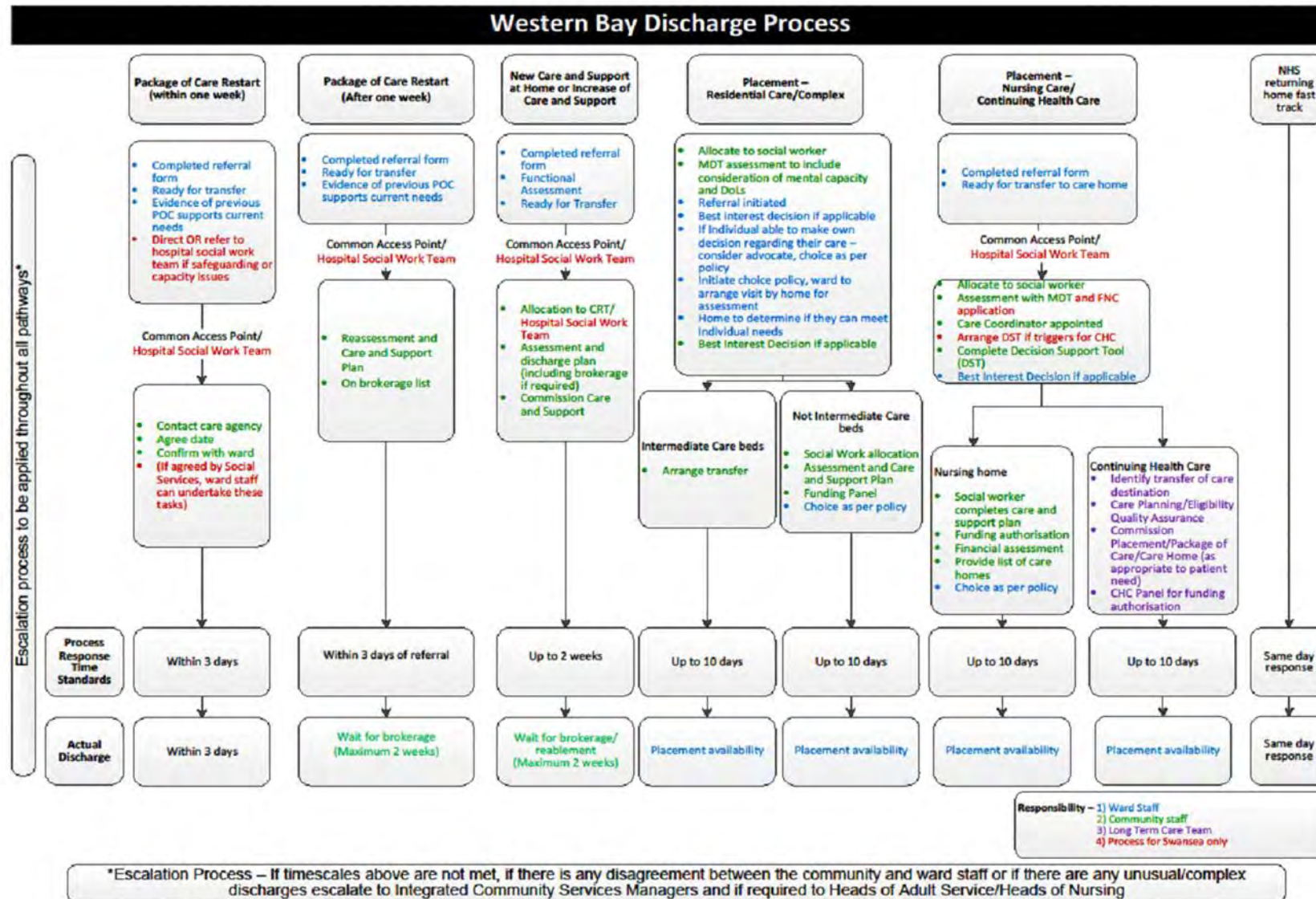
- **Transport and Access to Services:** Work is underway to consider where strategic planning for transport could be considered and progressed regionally (potentially linking with the two City Regions), with a view to address the issues highlighted within the population assessment being progressed as specific actions in the Area Plan.
- **Housing:** There were a significant number of different housing issues captured in the Population Assessment. In order to address the significant number of issues raised, it has been acknowledged that a more strategic approach needs to be taken in relation to housing, health and social care in Western Bay. Building on the work of the Regional Collaborative Committee for Supporting People and the ABMU Health Board's Health and Housing Group, discussions are underway to ensure future ICF

capital funding opportunities in relation to housing, health and social care are more coordinated. In this way, capital infrastructure proposals can be considered in a more strategic way and on a longer term basis which will deliver more improvements for our residents.

- **Substance Misuse:** Substance Misuse was agreed as a cross cutting priority. There is development of a S33 agreement for the Regional Area Planning Board for Substance Misuse in relation to Welsh Government grant funding. There are also links to the Integrated Family Support Services.
- **Delayed Transfers of Care (DTOC):** Delayed transfers of care have also been highlighted as an issue, with patients who are fit to be discharged from hospital having to remain there while packages of care are organised to provide their support needs or care home placements become available for when they leave hospital. This can affect people of any age, but mostly impacts older people and those with mental health problems. Delays can occur because care providers don't have staff available to provide the care needed or funding difficulties exist. Western Bay partners will work together to identify the barriers that prevent people from being discharged in a timely manner, working with other partners to reduce delays.
- **Data Collection, Information sharing and Improving Digital Services to Support Better Care Delivery:** The Welsh Community Care Information System (WCCIS) will be implemented across the four statutory organisations and partners in the region to ensure that the system is developed in a coordinated way to the benefit of our users of services by better supporting regional and local service arrangements. Bridgend County Borough Council were the first organisation in Wales to go live on WCCIS and the other three organisations (ABMU, Neath Port Talbot, Swansea) in the Western Bay Region are committed to implementing WCCIS. This development will support a consistent approach to record keeping and the ability to share appropriate information between services that will enable better coordination of services and improve the delivery of integrated care.
- **Workforce:** Workforce is a key element of the Western Bay Programme with the workforce development initiatives overseen by the Western Bay Workforce Development Steering Group There are a number of workforce changes initiated by Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA), for example, extension of the registration of the social care workforce to include home care workers and new responsibilities for "Responsible Individuals."

These priorities feature throughout the Annual Plan, for example, with regard to DTOCs, during this year the Western Bay Regional Partnership Board has agreed a joint discharge process with timelines and the performance management of the process features in our Unscheduled Care Service Improvement Plan. This is shown on the next page.

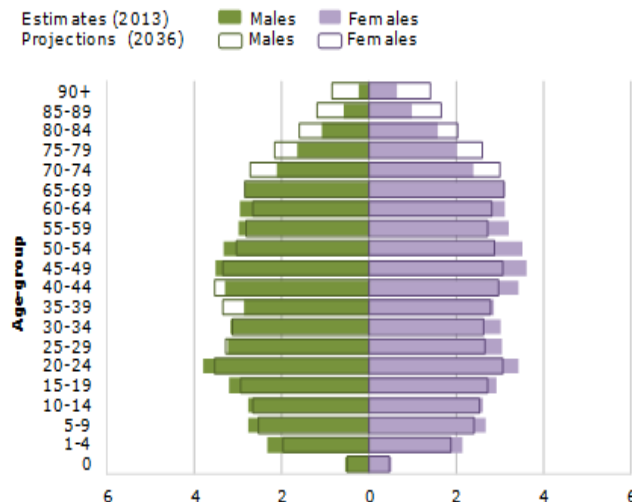
Additionally, our joint work to develop Strategic Frameworks for Mental Health and Learning Disabilities through the Partnership arrangements is also described later in the document and the work to implement WCCIS is described in our digital plans.



4.0 Health Needs

Our most recent [Joint Strategic Needs Assessment](#) (JSNA) was published in 2015 to describe the health needs of our resident population to inform our planning. In 2017/18, in addition to the population and wellbeing assessments already described, a joint regional wellbeing assessment was undertaken for the ARCH region as a whole to inform our regional planning with Hywel Dda Health Board. The Assessment was undertaken to underpin the ARCH case for change by identifying common issues that would benefit from a regional approach to planning. The main messages of the Assessment were very similar to the previous JSNA, being:

Population Growth & Change in the ABMU Area



indicators is marginal and are roughly in line with the national picture.

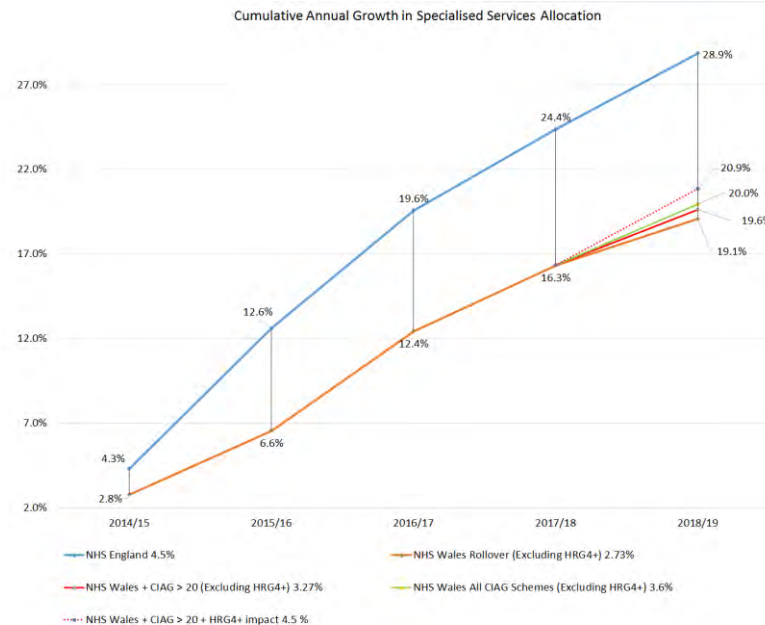
- Full adherence to a healthy lifestyle is rare – across the region most people report only having two of the five healthy lifestyle behaviours (ie following the recommendations on smoking, drinking alcohol, eating fruit and vegetables, healthy weight and physical activity). Our health needs assessment has been used to underpin our service change and redesign programme, including the choice of care pathways to be reviewed through Value based healthcare approach.

- The health of each individual is a key determinant of wellbeing.
- The region is a patchwork of deprivation - levels of deprivation vary geographically across the region with the highest concentration in areas in and around the Valleys, north east Bridgend, and central Swansea with smaller areas visible around Port Talbot and Llanelli.
- The population is ageing and will continue to age – as the population becomes increasingly older, the younger population will decrease in number.
- The outcomes of this assessment are being progressed through the ARCH Well Being and Service Transformation workstreams.
- The population is marked by multi-morbidity – long term conditions are more likely to occur in older people and the oldest people in the region are more likely to have 8 or more long-term conditions.
- A fifth of the population rates their health as 'poor' or 'fair' which is marginally higher than the Welsh average.
- The health and wellbeing challenges are common across both Health Boards – the statistical differences in many of the key health

5.0 National Planning and Commissioning

5.1 Welsh Health Specialised Services Committee

WHSSC has produced an analysis showing that investment in specialist services in Wales has lagged behind that in England as shown in the graph. Since 2013/14, the cumulative gap in annual growth has increased to a range of between 8-10% depending on the funding uplift approved for Wales in 2018/19.



If growth had remained on parity with NHS England during this period, the additional 8% growth over 5 years would equate to a recurrent baseline increase of £45m above the closing 2017/18 allocation.

The Welsh Health Specialised Service's Committee (WHSSC)'s Integrated Commissioning Plan (ICP) is demonstrably commissioner-led and the process for developing it is designed to ensure that there is continuity with previous ICPs. The aim of the process is to ensure that there is full alignment between the ICP and the Local Health Board Integrated Medium Term Plans, both at a financial and service level. The lessons learned from the previous three years of the ICP cycle are built into the process. These include:

- Developing clear WHSSC commissioning priorities;
- Accelerating the relative prioritisation of schemes requiring evidence appraisal;
- Building in the risk-assessment of schemes regarding service issues and sustainability;
- Allowing sufficient time for examining opportunities for savings and repatriation and to consider the application of prudent healthcare to specialised services;
- Consideration of Health Board priorities for specialised services; and,
- Integrating scrutiny and good governance.

An extensive programme of baseline review, horizon assessment, risk assessment and prioritisation concluded in December 2017 and the results were shared with Health Boards in order to facilitate inclusion within their IMTPs. The WHSSC ICP was considered by the Joint Committee on 29th January and submitted to Welsh Government to meet the end of January deadline.

The prioritisation process was undertaken by the Clinical Impact Assessment Group (CIAG) incorporating independent Health Board medical representatives and WHSSC Management Group Members. The 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 have been categorised as follows:

High Risk Schemes

CIAG Mean Score	Clinical Impact Schemes score > 20 + Exceptional Risks	ABM Impact
22.19	AAC	0.080
21.43	Cardiac ablation for AF & VT (ABM)	0.140
21.43	Cardiac ablation for AF & VT (C&V)	0.003
21.17	Porphyria	0.010
21.00	P&M - wheelchairs	0.077
20.96	TAVI	0.142
20.86	PET new indications (in rollover baseline)	-
20.76	BPA for CTEPH	0.008
20.15	MIMVS (first time surgery)	0.031
17.72	Spinal rehabilitation	0.034
17.14	Additional PICU capacity	0.070
Total		0.596

Note: Spinal and PICU schemes were subsequently included due to escalation of their high risk.

RTT Schemes

CIAG Mean Score	RTT Clinical Impact Schemes	ABM Impact
19.71	Cochlear and BAHA RTT (included in rollover)	-
19.28	P&M - RTT BCU (included in 17/18 baseline)	-
17.57	Cleft lip and palate RTT	0.081
16.00	IVF sustain 26 weeks RTT	0.050
15.99	Neurosurgery RTT	0.086
Total		0.217

Other Lower Risk Schemes

Planning Ref	Clinical Impact Schemes score < 20	ABM Impact
19.57	PET capacity to achieve target rates	0.048
19.03	Treatments for GvHD	0.012
18.57	Cystic fibrosis	0.199
18.43	Cleft lip and palate	0.029
18.14	BCU ALAS - war veterans	-
17.95	LVA (included in rollover baseline)	-
17.85	Fetal medicine	0.003
17.00	Bevacizumab (V.S. in neurofibromatosis type 2)	0.002
15.86	Neuro rehabilitation	0.023
14.71	Neuro-oncology	0.023
14.43	NICU - ABM HDU capacity	1.451
11.28	Neuroendocrine tumours	0.050
Total		1.841

The plan will result in varying degrees of liability across Health Boards and for ABMUHB the Annual Plan provision would cover the underlying deficit, plus the High Risk and partially cover the RTT schemes. However, it is acknowledged that a small number of the schemes, whilst not prioritised as a risk score of >20 and therefore outside the plan, will potentially become an in-year pressure. The Cystic Fibrosis service has been identified as the highest priority of these potential in-year pressures.

There were a number of schemes not scored and removed from the process as outlined below:-

- Bariatric Surgery – unclear need for further investment;
- Neonatal Transport – further work required on the governance issues;
- Neuro-modulation – should be explored through the value work; and
- Paediatric Endocrinology – service model needs clarifying.

These will be dealt with through the WHSSC work programme.

WHSSC has continued to develop commissioning strategies for a number of specialised services listed below, in order to inform recommendations on a whole pathway basis and address issues such as equity of service provision and access to services across the whole population.:-

- Thoracic surgery
- Specialised neurosciences
- Gender dysphoria
- Perinatal services
- Specialised adult eating disorders services

The aim of the Commissioning Strategies is to provide a five year commissioning plan which will inform the development of WHSSC's ICPs and Health Boards IMTPs over that period.

5.2 Emergency Ambulance Services Committee

The Health Board is fully engaged with the work of EASC and our Unscheduled Care Service Improvement Plan has been developed based on the EASC 5-Step Pathway. We have taken into account the EASC Commissioning Intentions and have worked with WAST colleagues to complete the monitoring templates 2 and 3 for the WAST joint initiatives and national

unscheduled care priorities initiatives that we have developed or intending to undertake in 2018/19. Template 3 is included in **Appendix 10**.

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 early 2019. Detailed service changes which could impact upon NEPTS will be discussed with service provider and commissioners as required as part of change management.

5.3.1 Emergency Medical Retrieval and Transfer Service (EMRTS)

EMRTS Cymru provides Consultant and Critical Care Practitioner-delivered pre-hospital critical care across Wales. It was launched at the end of April 2015 and is a partnership between Wales Air Ambulance Charity, Welsh Government and NHS Wales. The service is hosted by Abertawe Bro Morgannwg University Health Board (ABMUHB) and is commissioned by the Emergency Ambulance Services Committee (EASC). The services provided by the team are based on two elements:

- Pre-hospital critical care for all age groups (i.e. any intervention/decision that is carried outside standard paramedic practice).
- Undertaking time-critical, life or limb-threatening adult and paediatric transfers from peripheral centres (Inc. Emergency Departments, Medical Assessment Units, and Minor Injury Units) for patients requiring specialist intervention at the receiving hospital.

In addition, there is also a service provision for the enhancement of neonatal and maternal pre-hospital critical care (both for home deliveries and deliveries in free-standing midwifery-led units (MLUs). The service ensures that 100% of the Welsh population will be able to access critical care within 30 minutes by air and 60% of the Welsh population within 30 minutes by road

EMRTS Cymru has been developed to bring a series of benefits to Wales as follows:

- **Equity** - prior to the introduction of EMRTS Cymru, many patients were transferred to the nearest acute hospital and experienced a significant decline in their condition due to delayed secondary transfer and access to specialist care. With the introduction of the service, a Senior Clinician and Critical Care Practitioner are able to deliver advanced clinical interventions anywhere in Wales and are able to make a decision as to the appropriate receiving hospital. This could mean bypassing the

nearest District General Hospital and travelling directly to the required specialist centre - ensuring more timely access to specialist care for the patient and avoiding costly secondary transfers.

- **Health Gain** - International evidence suggests that early interventions, particularly those interventions provided outside of normal paramedic practice by EMRTS Cymru, are starting to show an improvement of patients' functional outcomes following a major trauma or cardiac arrest. Evidence also points to a reduction in mortality from the initiation of timely advanced interventions and decision making prior to the arrival in hospital or a specialist centre and a reduction in the length of hospital stays. Therefore this should result in an increase in the number of 'unexpected' survivors.
- **Clinical and Skills Sustainability** - There are a number of unfilled, vacant consultant posts throughout Wales, especially in Emergency Medicine. EMRTS is becoming a world-class service which is attracting recruitment from in and outside Wales. EMRTS supports the Pre-Hospital Emergency Medicine (PHEM) training programme in Wales and in order to address the matter of vacant posts that are difficult to recruit to, EMRTS is now supporting a number of 'Clinical Fellow' programmes across Wales (Betsi Cadwaladr and ABUHBs have recruited to date). Discussions are also ongoing with a number of the other Health Boards. In addition the EMRTS team hosts a number of CPD events with stakeholder organisations with the aim of raising awareness of the service, improving the skills and education of colleagues from other agencies and strengthening these relationships.
- **Governance** - The organisational governance structure consists of an EMRTS Delivery Assurance Group (DAG) which sits as a sub-committee of EASC. The DAG is responsible for the delivery, direction and performance of the Service. The EMRTS Cymru National Director is accountable to the DAG for the delivery and performance of the Service and to the ABMUHB Chief Executive for organisational and clinical governance.

Progress in 2017/18

Fourth Aircraft

The Wales Air Ambulance Charity has invested in a fourth aircraft which has been operational since summer 2016 and is fully funded by the Charity. In addition to funding the aircraft and fuel, investment has also been made in terms of the infrastructure at the new base at Cardiff Heliport, the recruitment of 4 dedicated Helicopter Transfer Practitioners, and the dual pilot model to meet paediatric intensive care transfer standards (PICS). This project will be evaluated on an ongoing basis and the Charity has committed to funding this to the end of March 2019.

Service Evaluation

The independent EMRTS Cymru Service Evaluation is being undertaken working with Swansea University with the aim evaluating the Service and its outcomes.

EMRTS base at Caernarfon

The new base at Caernarfon airport was officially opened by Cabinet Secretary in August 2017. This was an important development for the service as it provided equity across Wales in terms of service provision. As part of this project 5 new Critical Care Practitioners (CCPs) were recruited.

New fleet of Airbus 145s

The new fleet of WAA Airbus H145's were introduced at the three bases from April 2017. The new aircraft provides a larger cabin, quicker travel speeds and longer flight times without refuelling, ultimately future-proofing a 24-hour air operation.

Other developments have included:

- EMRTS won the 'Special Incident Award' at the same national Air Ambulance Awards of Excellence ceremony (November 2017)
- Continued the EMRTS PHEM car initiative
- Introduced the CCP car pilot
- Commenced the Clinical Attendant programme
- Coordinating or attending many stakeholder and CPD events.

Gateway Review

A Welsh Government Gateway Review was undertaken in May 2017 and an Amber/Green rating was given. Recommendations made by the Review Team were:

- Increase the resources available to support the commissioning and commissioner's oversight.
- Review the stakeholder analysis and develop the engagement strategy especially to establish strong links to all health boards.
- Ensure that the voice of primary care is seen to be properly reflected in the wider governance of EMRTS and its development.
- Strategic direction for EMRTS with options and planning scenarios to deliver the strategy.

Plans for 2018/19

Whilst some of these recommendations have been fully addressed, work is still required on others. A further strategic review will be completed once the changes at Caernarfon had been fully implemented and once a clearer picture has emerged of where EMRTS would be expected to further expand.

The service, in collaboration with EASC, are focusing on the following main focal points in the development of the services provided, these are:

- The newly appointed EMRTS National Director, Professor David Lockett, to commence with the service in April 2018.
- Obtaining stakeholder agreement to the preferred strategic direction for EMRTS with options and planning scenarios to deliver the strategy.
- Proceeding with developing the case for extending air cover to 24/7 utilising night hours for patient transfers and enabling more patients to receive critical care intervention and disposition at the appropriate healthcare facility for their needs. This will be essential when the South and West Wales trauma network comes into existence and will be key to the development of other relevant network pathways and is critical in facilitating Health Boards' strategic transformations.
- Ongoing data analysis and evaluation of the service, working with Swansea University
- Expansion of research activities working in partnership with Welsh Ambulance Service and academic institutions
- The EASC-led development of the EMRTS Quality and Delivery Assurance Framework will be based around a five step model of service delivery presented below.

EMRTS five step model of service delivery

The aim of the five step model is to focus on patient flow and to provide a clear framework for the delivery of the service in line with patient need. WAST will use various service improvement methodologies to improve the patient experience over all five steps.

The current service provides pre-hospital critical care and retrieval from its Llanelli, Welshpool and Caernarfon bases, 12 hours per day, seven days a week. The fourth transfer aircraft is based at Cardiff Heliport, again 12 hours per day, seven days a week. As per the Welsh Government Gateway Review recommendation, “work should commence on obtaining stakeholder agreement to the preferred strategic direction for EMRTS with options and planning scenarios to deliver the strategy”. This will be undertaken with support of the Commissioners to further explore the strategic vision and direction of the service.

5.3 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

The consultation on the major trauma network for South and West Wales has been completed and the recommendations are being considered by all Health Boards at the end of March 2018. The major trauma pathway includes pre-hospital care, acute and tertiary care, specialist rehabilitation and ongoing care, many elements of which are provided by our health Board for our catchment population and that of the wider regional areas. WHSSC will lead the commissioning of the new arrangements and a regional implementation plan is being developed.

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. However, issues have subsequently emerged on a range of areas from partners and the Health Board has also communicated issues regarding the site of the existing adult hub in Swansea as to partners and to the Collaborative. The final report of the review and the implementation arrangements are therefore in the process of being agreed with the involvement of the lead organisation (Cardiff and Vale UHB) and all partners.

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.

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.

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 Regional Planning and Delivery

The focus on regional planning and delivery has increased significantly this year and forms a key part of our operational plans for 2018/19, particularly to improve delivery in Planned Care.

South West Wales

The relationship between the University Health Board and ABM University Health Board has been strengthened through the mechanisms and opportunities provided by A Regional Collaboration for Health (ARCH) and the Joint Regional Planning and Delivery Committee (JRPDC). The focus for the JRPDC is on shorter-term priorities and delivery, whilst ARCH which also includes Swansea University focuses on the medium to long term.

The starting point for the development of collaborative activity is the [ARCH Portfolio Development Plan \(PDP\)](#), in order to deliver the vision of transforming the health, wealth and wellbeing of our population. The PDP identifies the service areas which the two University Health Boards are committed to developing on a regional basis, underpinned by a Value-based Healthcare approach. Our approach is as follows:

- To build on the good relationships and foundations of joint working already agreed through the ARCH programme, securing together our longer-term strategy for regional collaboration between University Health Boards and with our University partner, Swansea University. In particular, the JRPDC will ensure there is alignment with the longer term transformational plans being progressed through the ARCH Service Transformation programme;
- To focus on our common challenges and maximise the impact of working together where there are opportunities for improvement through collaborative working, and;
- To drive a rolling programme of work to support planning, delivery and service improvement in the short and medium terms.

Our regional planning and delivery priorities and the interrelationships between the ARCH programme and the JRPDC are shown in the diagram. In addition to 2017/18 in-year joint working, Abertawe Bro Morgannwg University Health Board (ABMUHB) and Hywel Dda University Health Board (HDUHB) are working towards a set of joint regional planning and delivery intentions



The service areas where we are working closely together are in part based on a baseline regional needs assessment undertaken by Swansea University and also on a clinically led assessment of regional service opportunities. To do this we have been sharing information on patient flows, where we commission services (national and local) and performance challenges and opportunities. The health needs assessment work is now also being used to support our Public Health work, and is to be further developed to allow a needs assessment at the level of our 7 localities.

These priority areas are aligned to the work programme of the JRPDC [<hyperlink>](#), which has recommended the following service areas as priority for action for delivery improvement in 2018/19:

- Orthopaedics – reduce 52 week waiters in both University Health Boards
- Ophthalmology – Significant service imbalance in ABM University Health Board
- General Surgery – reduce 52 week waiters in both University Health Boards
- Oral Maxillofacial - long waits for outpatient access

- ENT – reduce 52 week waiters in ABM University Health Board; 36 in the University Health Board
- Endoscopy - Significant service imbalance in ABM University Health Board

These are based on service pressure; workforce fragility; clinical governance risks or Welsh Government policy.

In regards to medium planning, the ARCH priorities in terms of improvement to patient pathways that will be addressed in 2018/19 include:

- Vascular - Regional work to change the pathways for vascular surgery and to reduce the amputation rate in ABMUHB (which is much higher than peers) is underway and will continue in 2018/19.
- Ophthalmology (cataracts; AMD; glaucoma)
- Orthopaedics – a regional review of demand and capacity is being undertaken with support of the Delivery Unit and this will inform patient pathways, opportunities for sharing resources
- Cardiology – a regional needs assessment position has been produced for the catheter labs in both Health Boards and plans are being progressed to develop business cases for the tertiary elements of the services which are commissioned by WHSSC.
- Non-surgical oncology – a South West Wales Non-Surgical Cancer Strategy has been agreed by the Health Boards and an Implementation Plan is in place (see **Appendix 11**), with a regional mechanism to monitor and oversee progress.
- Pathology- A South West Wales Regional Pathology Project Group has been established to work on drafting a Discussion Strategic Outline Business Case (DSOC) to develop a sustainable regional strategy for pathology services in Mid and South West Wales, consistent with the preliminary recommendations from the All Wales Pathology Collaborative
- Stroke including Hyper Acute and thrombectomy - Service model options for SW Wales are being reviewed based on a refreshed demand /capacity analysis and options are being developed for consideration by Health Boards in early 2018/19.
- Sexual Assault Referral Centre
- Neurology – a regional neurological service conditions service model has been developed to provide safe, effective and equitable access for the population
- Interventional Radiology – work to establish a sustainable service model for IR provision for the region

All of these services are based on planning for a million population; meeting ARCH criteria; service fragility; or prudence in terms of opportunities for maximising the use of capacity across the region. How all of these service work programmes interrelate is shown diagrammatically as follows:

All this work also requires alignment to the priority action areas for the National Planned and Unscheduled Care Boards, and the National Primary Care Board as well as NHS Wales Health Collaborative workstreams and networks.

In addition to the service transformation programme within the ARCH portfolio, there are three key workstreams which also have to be addressed through regional working:

1. Wellbeing Programme which aims to develop:
 - Llanelli Health and Wellbeing Village, as referenced under Prosperity for All
 - Swansea Health & Wellbeing Centre
 - Bridgend Health & Wellbeing Centre
 - Neath Health & Wellbeing Centre
 - Cross Hands Health & Wellbeing Centre
2. Research Enterprise and Innovation Programme which aims to develop:
 - Regional Institute of Life Sciences (ILS) Llanelli
 - ILS Healthcare Technology & Innovation
 - Centre at Singleton
 - Regional ILS Morriston
 - Intellectual Property Commercialisation
3. Skills and Education Programme which aims to develop:
 - Regional Workforce Planning
 - Nurse Recruitment and Training; Overseas nurses CPD/UK Nurse Registration
 - Increase medical school numbers
 - Workforce retention and pipeline development
 - Talent Bank and Apprenticeships
 - Integrated Care Academy and Health & Wellbeing Academy
 - ARCH-i (innovation)
 - Advanced Administrator
 - Physicians Associates.

A joint plan for delivering improved performance in these speciality areas is in preparation and will be included as part of the final plan.

South West Wales Regional Stroke Services

Service model options for SW Wales are being reviewed based on a refreshed demand /capacity analysis and options are being developed for consideration by Health Boards in early 2018/19.

South West Wales Regional Non-Surgical Oncology

The Non-Surgical Oncology Strategy has been agreed by the Health Boards and an Implementation Plan has been agreed, with a regional mechanism to monitor and oversee progress.

South West Wales Regional Cardiology

A regional demand and capacity position has been produced for the catheter labs in both Health Boards and plans are being progressed to develop business cases for the tertiary elements of the services which are commissioned by WHSSC.

South West Wales Vascular Surgery

Regional work to change the pathways for vascular surgery and to reduce the amputation rate in ABMUHB (which is much higher than peers) is underway and will continue in 2018/19.

South West Wales Pathology

A South West Wales Regional Pathology Project Group has been established to work on drafting a Discussion Strategic Outline Business Case (DSOC) to develop a sustainable regional strategy for pathology services in Mid and South West Wales, consistent with the preliminary recommendations from the All Wales Pathology Collaborative. The All Wales Pathology Collaborative in November 2015 supported an 'optimum' one-site solution for the delivery of Regional Cellular Pathology services. The primary investment objectives relate to accreditation, recruitment and strategic fit.

This builds on the planning previously underway within ABMUHB to relocate Cellular Pathology services from Singleton Hospital to Morriston Hospital. The multi-organisational project group is made up of management and clinical representation from Hywel Dda UHB, ABMU and Public Health Wales. The solution would bring together laboratory and medical staffing whilst maintaining the essential clinical presence at hospital sites to support medical and surgical services. Medical microbiology has been the subject of discussion between the two UHBs and Public Health Wales and it has been agreed that at present the balance of argument supports the retention of local microbiology labs. There may still be a case for the centralisation of certain tests but this can be managed without capital development at this stage.

Central to the project is an assurance of an equal, equitable and easily accessible service for both Health Boards, clinicians and patients. There is a need to ensure there will be a clinical presence in HDUHB to provide clinico-pathological correlation, input face to face to MDT meetings, education, and audit. Also there is an expectation at present to provide an autopsy service in the refurbished mortuary facility in Glangwili that would see Pathologists continuing to support all aspects of the autopsy service.

This project has the potential to complement the UK's develop of a network of emerging Advanced Therapy Treatment Centres (ATTCs) and the promotion of gene or cell therapy Advanced Therapy Medicinal Products (ATMPs) research and development. A co-located and integrated Regional Pathology service and ATTC would benefit the region and optimise opportunities for carrying out clinical trials to develop "novel medicines" and stimulate domestic and international investment.

Additionally, we have been taking an active part in the Digital Cellular Pathology Programme and await the outcome of the pre-tender work, as this will provide detail of the implementation resource requirements and scale of benefits for the Health Board. It is recognised that the implementation of this solution in its initial phase will provide benefits relating to workforce flexibility. It is also envisaged that future phases could allow more detailed clinical slide analysis to take place. The work of the programme is recognised in the Regional DSOC (SOC) being developed between ABMUHB and Hywel Dda UHB.

South East Wales

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

The South Wales Programme Board made their recommendations in relation to the provision of consultant-led maternity and inpatient paediatric services in 2014. The outcome, based on an extensive consultation exercise, was that in order to address the fragility of these services, there would be a reduction in the number of sites delivering this level of care.

The Health Board has been fully engaged in the work to redesign these services and to implement the recommendations of the consultation exercise. A business case has been submitted for the transitional neonatal plan in Swansea, however we are aware that this is unlikely to receive all Wales capital until at least 2019/20.

South East Wales Regional Ophthalmology

A baseline assessment of demand and capacity plans from each organisation has been completed and reviewed and will be taken forward in 2018/19.

South East Wales Regional Orthopaedics

In 2017/18, a review of each Health Board's plans was undertaken and confirmed that there were limited opportunities for quick improvement on a regional footprint. However, moving forward into 2018/19, demand and capacity plans will be finalised at sub-specialty level for the next 3 years to identify key gaps and opportunities to address on a regional basis.

South East Wales Regional Diagnostics

Undertaking further work, particularly around MRI and endoscopy demand and capacity.

South East Wales Regional ENT Centralisation

A planned transformation of ENT services, with delivery of a hub and spoke model and all emergency ENT services centralised at UHW is expected to be finalised by the end of 2017/18, with a view to implementation of the new model in 2018/19.

The next steps for regional planning for the both the South West and South East Wales regions are shown in the diagram below.

SOUTH WEST WALES

- Input to development of final options for consultation on Hywel Dda Transforming Clinical Services consultation
- Consider opportunities for unscheduled care system planning across region
- Build on Well Being Centre developments, and primary care/cluster development opportunities
- Planning for Single Cancer Pathway
- Regional planning for GP OoH
- Regional approach to Value Based Healthcare

SOUTH EAST WALES

- First joint meeting with Cardiff and Vale HB to discuss regional/specialist service provider relationship for our combined population
- Planning for Single Cancer Pathway
- Regional planning for GP OoH
- Understanding impact of potential Bridgend boundary change and whether any potential service impact in short/medium term – eg HASU

7.0 Workforce

We continue to experience high levels of vacancies across all staff groups, with 835 WTE vacancies (around 4.5% of our workforce) at the current time. Over half of our vacancies are in nursing and this may be further exacerbated by the Nurse Staffing Act and the UK's withdrawal from the European Union. Despite the many recruitment initiatives we have undertaken our vacancy levels have remained fairly static over the last two years due to the high rate of turnover and we do not expect this position to change. We also have high sickness absence rates and the three factors of the vacancy rate, turnover rate, and sickness rate are major drivers of our variable pay bill which underlies our financial deficit.

We are taking a different approach to our workforce challenge in our Annual Plan this year and we are not planning to address these challenges through recruitment, as this has not been proven to be effective. Our plans reflect the need to change our workforce and service models to achieve sustainability within an affordable and realistic staffing baseline.

8.0 Delivery Challenges

The Health Board has been facing a number of significant challenges over the past few years. These challenges led Welsh Government to increase the escalation status of the organisation in September 2016 to one of 'targeted intervention' and this has remained in place during 2017/18. The issues that led to this position are outlined below:

- Unscheduled care access and performance, particularly at Morriston Hospital;
- Cancer access and performance;
- A lack of a sustainable and affordable plan for the organisation;
- Financial performance and delivery; and,
- Some concerns about governance and assurance.

Although these challenges have been at the heart of the Health Board's plan over the last 12 months, progress with addressing these issues in 2017/18 has been mixed. Whilst there has been some evidence of stabilisation and improvement, there is still too much variability. Consequently, these delivery challenges continue to feature strongly in our 2018/19 plan.

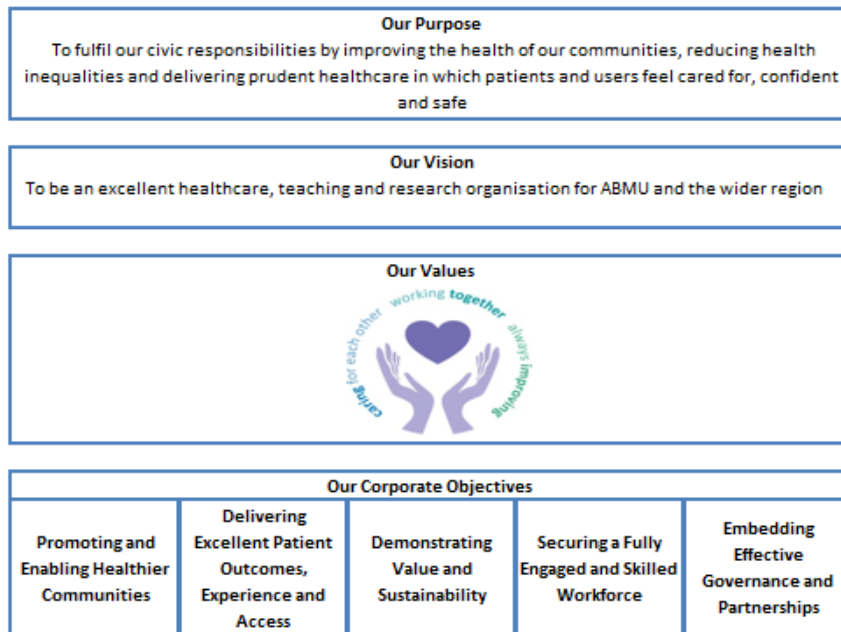
9.0 Welsh Government Capital Programme

The availability of Welsh Government capital will be restricted in the next three years due to national strategic developments. At the time of writing the national capital programme does not include any funding for the Health Board and our plans have been developed on this basis. Our discretionary allocation is not expected to change and will be prioritised to deliver our required improvements. We will also be maximising the use of other sources of funding such as the Primary Care Development Fund, Efficiency Through Technology Fund and Integrated Care Fund monies.

10.0 Consultation on the Proposed Boundary Change for the Bridgend Council Area

In July 2017 Welsh Government set out proposals to secure resilience and renewal in local government in Wales following consultation on the Reforming Local Government White Paper. The White Paper included specific proposals about partnership arrangements for Bridgend Council. To ensure clarity and consistency in arrangements Welsh Government has proposed that decisions about health provision across the Bridgend Council area should be made by Cwm Taf University Health Board instead of ABMU Health Board. A formal 12-week consultation about the principle of the boundary change is currently underway and the outcome of this is likely to be known early in 2018/19. The consultation is focused on an administrative boundary change, and not service change, and therefore our Annual Plan 2018/19 is based on our current configuration of services and does not pre-empt the results of the consultation or any future decisions regarding the Bridgend Council area.

11.0 Local Strategies



We have a clear purpose, vision and corporate objectives and a set of values which influence everything that we do.



Organisational Strategy
We will be developing an overarching **Organisational Strategy** during the latter half of 2017/18 to provide a clear, all of these

Organisational Strategy during the latter half of 2018/19 to provide overarching strategic direction for the Health Board to guide our strategic choices. As outlined in our Annual Plan we have continued our programme of Strategy development to underpin this and we now have a range of clinical and corporate strategies which have been developed or are in process of being developed as shown in the diagram, and will form the basis for our organisational strategy.

Clinical Strategy

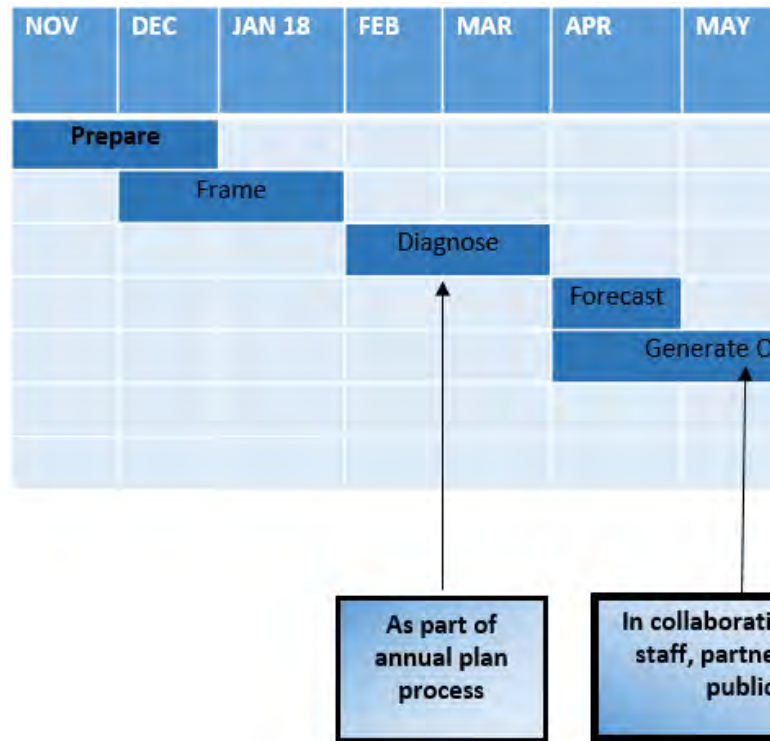
The organisation's **Clinical Strategy** is in the process of being updated by the summer of 2018. This will build on the previously consulted upon and agreed Clinical Strategy, Changing for the Better (C4B), as well as reflecting national policy changes and changes in the local environment since Changing for the Better was agreed in 2013. The update is being undertaken using a two-stage approach, with the first stage being a review of progress against C4B.

The review will inform the updated Strategy and has informed the Evolving Service Model. The changes included in this Annual Plan have been planned in line with the Strategy review and with the Evolving Service Model to ensure that our plans in the forthcoming year align with our longer term strategic direction. The strategy review has identified that a large number of the changes set out in c4B have been partially or fully implemented, however there is further work to do in terms of redefining our system characteristics, our system, and how all parts of our system should work together based on changing service models and a changed strategic context.

Two Stage approach agreed:

- **Stage 1** – review progress against C4B First report to inform Annual Plan 2018/19 and align with development of Clinical Services Strategy 2018-24
- **Stage 2** – undertake broader cross cutting work based on Monitor approach to more fully inform the Clinical Services Strategy 2018-24

The timeline for updating the Clinical Strategy and alignment with the development of the Annual Plan is shown below.



A set of system characteristics has also been agreed by the Board to inform the updated Clinical



Strategy and our Annual Plan in line with national legislation, strategy and policy and with quality and best outcomes of care in all that we do.

Our new [Primary and Community Services Strategy](#) was agreed by the Board in 2017/18 and was developed in recognition of the essential contribution of our primary and community services to changing our service models to rebalance our system from an acute hospital focus to providing care 'Closer to Home'. We will develop sustainable, standardised, integrated primary care and community services organised through Cluster Networks and these will form the basis for our future planning arrangements. The strategy also describes the need to ensure that our primary care services remain sustainable in their own right by changing the model of care to a multi-disciplinary model in hubs with a clinical triage (Telephone First) access model in place which aligns to the national Transforming Primary Care Plans for Wales.

We have also collaboratively developed a [Children and Young People's Strategy](#) in 2018/19 with the involvement of our partners. The Strategy is in line with the Early Intervention priorities of '*Prosperity for All*', and our Wellbeing Objectives. It describes our aims over the next five years to focus on the Early Years agenda, minimise reliance on hospitals, provide alternatives to admission and to provide sustainable secondary care services.

In partnership with Hywel Dda Health Board and Swansea University, through the ARCH programme we have developed a [Non-Surgical Oncology Strategy](#) for the region to build on the existing hub-and-spoke model of service and to ensure there is a standardised, evidence-based approach to care across the South West Wales region.

We are developing a **Strategic Framework for Adult Mental Health** to be completed by May 2018 following the extensive involvement of patients and the public and in partnership with others through the Western Bay mechanisms. The emerging issues and lessons have been used to inform our Mental Health plans with the emerging priorities being to provide services across the full spectrum of care needs (mild to severe); to move from a medical to psychosocial model of care; to provide more flexibility in accessing services, and for inpatient beds to be provided in the community. The work to develop our **Strategic Framework for Learning Disabilities** is being planned with partners, and this will be published in 2018/19.

We also developed a **Clinical Strategy for Princess of Wales Hospital** in 2017/18 but approval 'has been put on hold pending the consultation being undertaken by Welsh Government on the future of the Bridgend locality. Our Annual Plan does outline the costs of maintaining Princess of Wales hospital as a Level 3 DGH in line with the South Wales Programme during 2018/19 as changes required to make the site sustainable within the ABMUHB footprint have been put on hold pending the results of the consultation.

Our [Digital Strategy](#) was agreed in 2017/18 and the digitisation of the organisation is a key priority and opportunity for us to improve quality and meet our sustainability challenges. Our new approach to Quality and Safety, linked to our targeted intervention priorities is described later and our existing **Quality Strategy** is being updated. Many of our sustainability challenges are driven by our workforce challenges as well as the changing needs and aspirations of our existing workforce and our work to improve staff engagement is being driven through the implementation of our new **Staff Experience** and **Nursing and Midwifery Strategies**.

11.1 Evolving Service Model

An Evolving Service Model, based upon the work undertaken in Changing for the Better, the ARCH Portfolio Delivery programme, and the published or emerging service-specific strategies (mental health, non-surgical cancer, children and young people, primary and community services) has also been developed. This provides the context within which the detailed service changes in our Plan will need to be made. The Evolving Service Model describes a continuum of care with the services also mapped to our delivery structures for clarity in developing our plans. The Service Model is shown in the following diagrams.

Evolving Service Model

An Interim Service Model, based on Prudent Principles and the Sustainability Principle as well as the work undertaken in Changing for the Better, the ARCH Portfolio Delivery programme, and the published or emerging service-specific strategies (mental health, non-surgical cancer, children and young people, primary and community services) has also been developed. This provides the context within which the detailed service changes in our Plan will need to be made. The Interim Service Model describes a continuum of care with the services also mapped to our delivery structures for clarity in developing our plans.



'Closer to Home'



Health Board-wide Primary Care and Integrated Community Services supporting Wellbeing and Care

'Closer to Home'

Patients will be able to access integrated services at home or as close to their homes as possible. The Health Board will design and deliver services so that health and social care professionals work with patients in:

- their home;
- their GP Practices ;
- community pharmacies, dental surgeries, high street opticians
- Health and Wellbeing Centres and venues in their neighbourhoods (in 'Cluster Networks');
- hospitals.

This will focus on:

- 'place-based services';
- seamless care provided by a few professionals, instead of multiple providers;
- integrated teams;
- keep people well and out of hospital for longer.

Patients will be able to:

Access primary care services 24 hours a day 7 a week where there is a demonstrable patient demand or need.

Transfer of traditional secondary health care to a community setting will occur only where this is safe and cost-effective to do so, and without destabilisation of existing primary care services.



Integration

Integrated mental and physical health community and intermediate care services based Pacesetter models, Community Resource Teams and the Western Bay Optimum Model.



Health Board-wide Mental Health and Learning Disabilities Services supporting all tiers of care

Older People's Mental Health – rebalance care from hospital to community care in line with rest of UK.

Adult Mental Health – provide services across full spectrum of care needs (mild to severe); move from a medical to psychosocial model of care; more flexibility in accessing services; inpatient beds to be provided in the community (vacate Cefn Coed site).

Learning Disabilities – rebalance from institutional to home care – not a bed for life; repatriate our residents.

'Differentiated Hospital working within an Integrated Network'



Local Ambulatory Acute Care, Diagnostics and Rehabilitation with Excellent Training and Research

A Local Hospital at Neath Port Talbot with a specific focus on treating minor injuries, and a centre of excellence for:

- Assessment and treatment of frail older people and ambulatory care support for residents in Neath Port Talbot, as well as Bridgend and Swansea;
- Increasing levels of short stay elective surgery;
- Providing local rapid diagnostic access and support;
- Delivering rehabilitation services (including specialist neuro rehab);
- Delivering Wales Fertility Institute services.

A Health Campus including a Level 2 Hospital at Singleton acting as a Centre of Excellence for ambulatory emergency care with one front door housing a Singleton Assessment Unit that is GP-led which will:

- Become a centre of excellence for a range of diagnostic, rehabilitation & treatment services including ambulatory care;
- Undertake increasing levels of elective surgery – which may be of high complexity, but on patients with lower levels of acuity;
- Allow Swansea University's Medical School to build on the success of its Institute of Life Science (ILS) with the establishment of its Healthcare Technology Centre (HTC);
- Create new space to teach our future doctors, nurses and Allied Health Professionals.



Acute and Complex Care, Tertiary and Specialised Services with Excellent Training and Research

A Level 3 District General Hospital at Princess of Wales

providing a full range of urgent and emergency care services, including:

- consultant led ED services inpatient paediatrics;
- consultant led obstetrics;
- local neonatal care services;
- Centre of Excellence for Ambulatory Emergency Care with assessment and treatment of frail older people.



A Health Campus including a Level 4 Regional Centre at Morriston

for specialist emergency and complex care not only for the people of ABMU but also people from South and West Wales and further afield which will:

- Act as a Large Trauma Unit and lead the Major Trauma Network (subject to consultation) as well as providing a full ED service for the residents of Swansea, Neath Port Talbot and elements of Hywel Dda;
- Have the single acute medical intake for Swansea & Neath Port Talbot, which will include the Hyper Acute Stroke Unit for the region;
- Deliver complex surgery across a broad range of specialties, particularly for patients of high acuity;
- Provide Critical Care;
- Provide specialist diagnostic support and centralised Pathology;
- Provide consultant led Obstetrics, Neonatal & Gynaecological Services;
- Provide the Cancer Centre for SW Wales including Aseptic Unit;
- Provide some tertiary services including cardiology and cardiac centre – and develop stronger relationships with other specialist centres;
- Have strong research links with Swansea University.

Appendix 2. ORGANISING PRINCIPLES

1.0 Our Approach to Public Health and Prevention

The determinants of ill-health in our catchment population have not changed significantly since last year. Based on the principles in 'Prosperity for All,' the Wellbeing of Future Generations Act and Prudent Healthcare, we know we need to take a very different approach to improve the health of our population and to become sustainable in the long term. Based on the principles of 'Health and its Determinants in Wales (2018)' our public health and prevention approach within our catchment population is changing focus from individual behaviours to community capacity and participation and the reduction in health inequalities which is an underpinning principle of all our work. We know that to achieve success we must move away from targeting geographical pockets of ill-health and focus on maximising our impact on health inequalities across our whole catchment population area. Our new approach is based on the evidence-based model shown below.



The ABMUHB local public health team (LPHT) and Health Board are developing our plans in a more integrated way, as a population health system, taking a socio-ecological approach to population health issues across the ABMUHB area. This will be underpinned by a needs-led, evidence-based, proportional universalism approach, to achieve maximum return on investment, in terms of population health gain. The LPHT will build on existing assets, locally and nationally, in a variety of settings, to develop and progress interventions that are appropriate for our local populations. We will also carry out robust evaluation of the interventions to build our evidence base. It is important that our plans are based on a sound understanding of needs and what is important to the people of ABMUHB, in order to achieve sustainable solutions for these issues – addressing the wider determinants that impact on health and well-being, as well as reducing the impact on health care.

Our plans are developed in the context of the Public Health (Wales) Act and based on 3 key strategic areas of focus/objectives which align closely to the themes of 'Prosperity for All,' and our Wellbeing Objectives, particularly with regard to the focus on the Early Years, children and young people and improving health and community resilience. Our work in communities will be undertaken with the involvement of others through co-production and

collaboration.

- 1. Children and Young People** – maximising children’s potential and achieving optimal health and wellbeing outcomes. The work within this theme will prepare children and young people for their future through:
 - Improving perinatal health – maternal and neonatal;
 - Increasing uptake of all childhood vaccinations; and,
 - Reducing children’s exposure to Adverse Childhood Events and developing their resilience.
- 2. Reducing the burden of disease** – through using a needs based approach with targeted interventions where appropriate, based on defined need:
 - Healthy ageing – from working age to older age;
 - Reducing prevalence of smoking;
 - Preventing and managing high blood pressure;
 - Healthy weight & nutrition, including reviewing the obesity pathway; and,
 - Prevention and self-management of long-term conditions.

The ABMUHB tobacco lead works closely with the national tobacco lead and ensures that all smoking cessation activity, service provision and marketing activity is aligned to Help Me Quit branding and development. Our cessation services are working collaboratively and linked into the national work, and integration agenda being progressed -as outlined with the All-Wales Tobacco Control Strategy, including minimum data sets, service standards, service pathways, training and education.

With regard to obesity a review paper on the obesity pathway (including physical activity and healthy eating) has been developed and a series of recommendations on the progression/improvement across all 4 levels of the pathway identified. This is pending review by the Executive Team and Board, with direction of travel to be agreed which will inform more detailed objectives for work in 2018/19. This work will align to the forthcoming Obesity Strategy. The wider determinants agenda including creating supportive environments - planning, transport, travel are included in the Public Health Team’s work plan.

- 3. Supporting the development of resilient communities** – through partnership working and co-production with communities, using an assets based approach:
 - Understanding, measuring and improving health literacy within the population, both as part of a preventative approach and as a self-care tool:

- Raising awareness and improving mental wellbeing, as part of developing individuals' and communities' resilience; and,
- Working through and with PSBs to improve health across the life course.

We will use the principle of prudent healthcare, particularly 'do only what you can do' to maximise the impact of our public health interventions through the use of two system enablers to achieve improvements in population health outcomes namely:

Workforce development – as part of a joined up and preventative approach to population health across our whole workforce, ensuring that across the health and wider public health system there is:

- An understanding and awareness of the key risks to health, the burden of disease and the role of prevention;
- Development of capability and understanding of an evidence-based approach and robust evaluation techniques;
- Development of an understanding and application of behaviour change approaches to interventions; and,
- Development of an understanding and application of techniques to improve Health Literacy and ensuring that Making Every Contact Count (MECC) is used at every opportunity.

Specialist public health technical expertise – through a range of specialist skills and expertise within the LPHT, we will support:

- Assessments of needs and assets: providing the foundation of knowledge about what's required and what can be built on;
- Insights generation: bringing understanding and clarity to complex health and wellbeing issues in order to generate sustainable solutions;
- Value based healthcare: by supporting cost-effective and evidence-based, prudent healthcare; and,
- Maintaining capacity and specialist public health skills in order to meet the challenges of population health, taking into consideration the wider determinants of health, as well as health care provision.

The specific actions we will undertake in 2018/19 are included in the Service Improvement Plans and also shown below in the Local Public Health Team's Work Plan.

Objective	Measure	Priority Area								
		Unscheduled Care	Planned Care	Stroke	Cancer	HCAI	Other	Quality & Safety	Workforce	Rev
Theme 1 - Children and young people: maximising children’s potential and achieving optimal health and wellbeing outcomes. The work within this theme will prepare children and young people for their future										

Objective	Measure	Priority Area								
		Unscheduled Care	Planned Care	Stroke	Cancer	HCAI	Other	Quality & Safety	Workforce	Rev
1.1 Improving peri-natal health	10% increase in pregnant mothers receiving flu vaccine - Developmental work around reducing smoking in pregnant women at 36 weeks gestation						✓			
1.2 Increasing uptake of all childhood vaccinations. LPHT supporting increased uptake in the following ways:	- Achieve minimum 90% uptake for childhoods imms as measured by quarterly COVER stats in children aged 0-5yrs, aiming for 95% - To achieve WG target of 55% vaccine uptake rates for those aged 6months to 64 yrs in an at risk group - To achieve 45% uptake rate of the flu vaccine in children aged 2 + 3 years in Primary Care by March 2019 - Aim for 90% uptake of MMR vaccination within teenage population. - Achieve 90% uptake for HPV / Teenage booster - Improve uptake of Men ACWY within primary care	✓	✓						✓	
- Deliver immunisation awareness training for pre-school settings to promote key vaccination messages - Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report - Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins - Develop local resources/ products to share good practice										

Objective	Measure	Priority Area								
		Unscheduled Care	Planned Care	Stroke	Cancer	HCAI	Other	Quality & Safety	Workforce	Rev
1.3 Adoption of policies and practices to focus on First 1000 days child life and prevent ACE's and reduce the harm to health, wellbeing and life chances associated with ACE's Develop ACE preventing parenting programmes	- ACE awareness and support service review - Complete a first 1000 days needs assessment		✓				✓			
Theme 2 - Reducing the burden of disease: through using a needs based approach with targeted interventions where appropriate, based on defined need.										
2.1 Reducing prevalence of smoking for targeted population groups including: - Patients with respiratory conditions & heart disease, - pre-operative care - Staff	- Review of Tobacco Control against National Tobacco Delivery Plan - Review of ABMU HB cessation services	✓	✓	✓	✓				✓	
2.2 Increasing levels of physical activity in key target groups, including staff	- Action plan developed in response to Physical Activity Strategy		✓	✓	✓				✓	
2.3 Increasing proportion of population of a healthy weight	Obesity pathway review		✓	✓	✓					
2.4 Increasing flu imms uptake for people with chronic conditions and people over	- Increase uptake to 55% from 45% - To achieve Welsh	✓	✓							

Objective	Measure	Priority Area								
		Unscheduled Care	Planned Care	Stroke	Cancer	HCAI	Other	Quality & Safety	Workforce	Rev
65: Contribute to agreed actions/activities within the primary care flu action plan	Government target (75%) for individuals aged 65 yrs and over									
Theme 3 - Supporting the development of resilient communities:- through partnership working and co-production with communities, using an assets based approach										
3.1 Continuing to improve on health literacy within the population as part of a preventative approach: - Develop an instrument to measure health literacy locally, working in partnership with university colleagues and communities - Co-produced plan to improve health literacy across ABMU communities in place - Identify health care training programmes	Plan in place		✓	✓	✓					
3.2 Raising awareness and improving mental wellbeing as part of developing individuals and communities resilience	Scoping of mental wellbeing assets and approach		✓							
3.3 Reducing number of suicides through a partnership approach	Suicide prevention strategy for each Local Authority in place						✓			

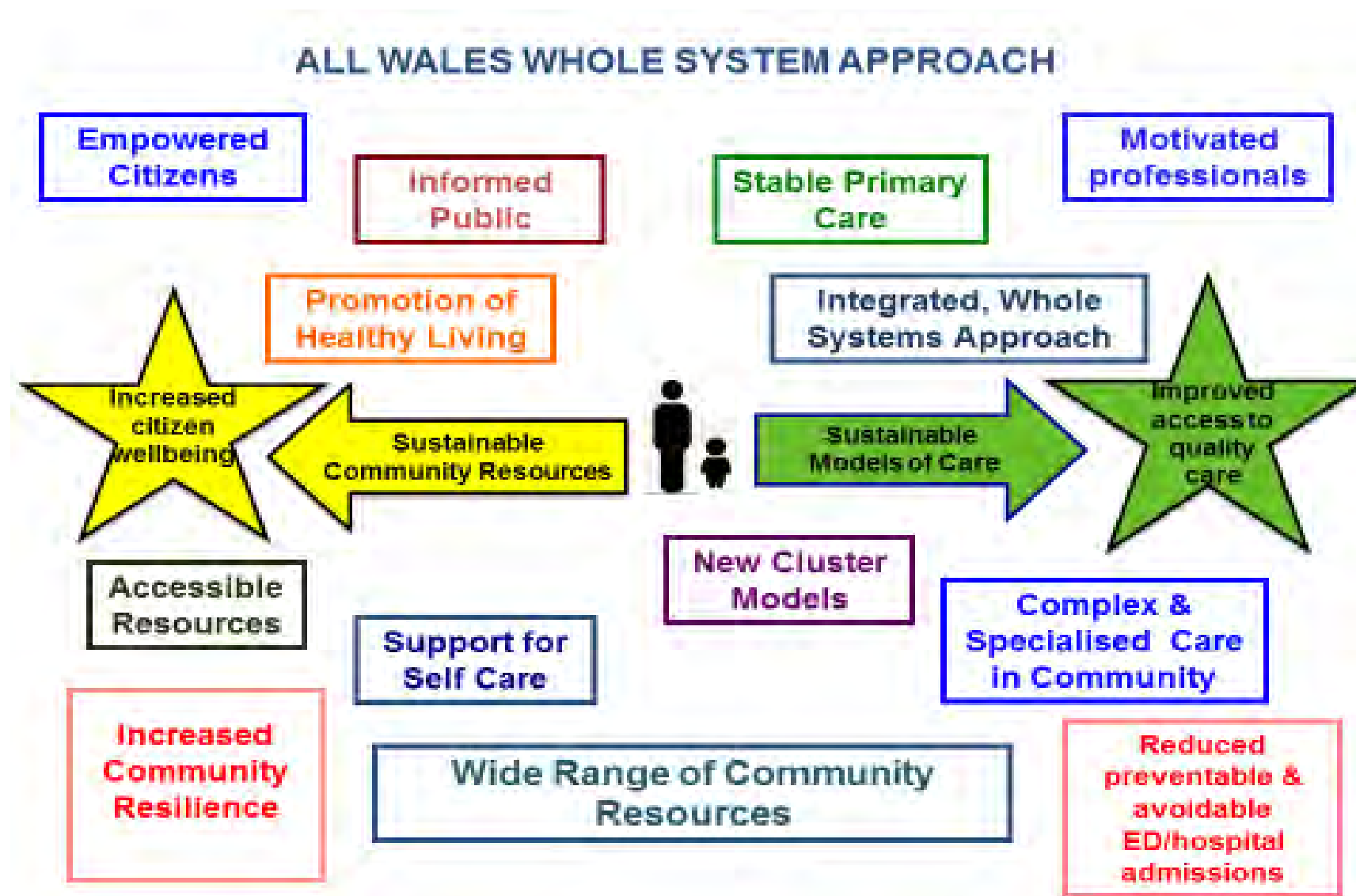
Objective	Measure	Priority Area								
		Unscheduled Care	Planned Care	Stroke	Cancer	HCAI	Other	Quality & Safety	Workforce	Rev
3.4 Use evidence based and behaviour change approaches including MECC to improve health and related outcomes Develop training and supporting materials on behaviour change principles/approaches for wider workforce and partners	Training materials developed and tested		✓	✓	✓					
3.5 Influencing environmental and social determinants of health and wellbeing through PSBs and partnerships:	- Evaluation of MECC approach - Evaluation findings used to develop further work				✓					

2.0 Providing Sustainable Primary Care and Community Services

The [Primary and Community Services Strategy](#), adopted by the Board in May 2017, describes the Health Board's Primary and Community Services overarching strategy for the next five years. The strategy was developed in line with national policy and strategy including the [Plan for Primary Care Services for Wales](#), the national Primary Care Delivery Plan, the transformational model for primary care in Wales and the development of Cluster Networks as the foundation for future service planning and delivery. Work is now progressing to finalise an Implementation Plan to support the delivery of the strategy over the next five years and this will also take into account the 'Inquiry into Primary Care: Clusters' report that was recently published by the National Assembly for Wales and the Parliamentary Review of Health and Social Care in Wales.

Our Strategy sets out the ambition and direction for primary and community services operating within the wider Health Board context and recognises that the status quo is no longer an option. In the last two years the number of GP practices in the area has reduced from 73 to 67 and the Health Board's plans are based upon a smaller number of larger practices working with others within geographically defined Cluster Networks. In the face of rising demand and austerity, the model of general practice and delivery of community services must change if the challenges of promoting self-care, preventing ill health, providing easier access to

healthcare and the rising demands of complex technological healthcare are to be met. There are significant opportunities to implement radical changes to the delivery of primary and community services through; changing the service and workforce model; use of technology to provide more care 'Closer to Home'; integration and joint working across partner agencies and maximising the use of community assets. The strategy describes the implementation of initiatives designed to improve provision in a number of key areas and has been designed under the overarching principles of prudent healthcare and of delivering safe and effective health services which patients and staff value and trust.



The Strategy has been developed to help sustain and support service delivery through innovative delivery. The creation of a network of primary care multi-disciplinary hubs, with clinical triage (Telephone First) access systems, at scale, across the Health Board which will be staffed by multidisciplinary (MDT), integrated teams has been tested through the Pacesetter pilot in the Neath Cluster. The pilot has demonstrated the significant opportunity to work prudently to improve the sustainability of general practice by clinically triaging patients into alternative, quality pathways away from face-to-face GP consultation to most appropriate member of the wider MDT based on the presenting needs. This has the twin benefits of improving the sustainability of general practice whilst reducing demands on acute and secondary care provision, and providing the infrastructure to support system shift and pathway redesign to move care 'Closer to Home'. By releasing GPs to spend more time with the most complex patients, this will lead to fewer conveyances to hospital, reduced secondary care demand, and better patient outcomes.

Of equal importance in the strategic approach is maximising the use of our resources to promote healthy lifestyles and seek public health benefits. We are working with colleagues in Public Health Wales and Welsh Government to introduce a revised general dental contract. This seeks to reward dentists for activities that promote good oral health and a planned approach to care, as opposed to reimbursing purely for treatment activity. Changes to community pharmacy contracts will also see the continuation of a process to reward practices for additional and enhanced service provision. Finally, revised general medical services contractual arrangements have seen substantial additional financial investment to reward new ways of working, such as through the commissioning of new enhanced services and the development of Cluster Networks.

In terms of enabling actions, many of the changes envisaged in the strategy are based on Welsh Government capital investment through badged funding in the Primary Care Pipeline. In line with '*Prosperity for All*', new Health and Wellbeing Centres will be funded, with a centre in each Local Authority area. Funding has already been announced for Health and Wellbeing Centres in Swansea and Bridgend and detailed planning will take place in 2018/19 and through the establishment of more mature MDTs to support care and flow across the whole system. Alongside this investment will be a requirement to transfer staff – for example, therapists, specialist nurse / nurse practitioner roles – from intermediate and secondary care to primary care.

We are also adopting the principles of Value Based Healthcare to review service delivery. For example, in the area of community nursing, the unit is making significant efforts to improve efficiency informed by the CAPITA and Cordis Bright reports. Some of the improvement initiatives relate to technical efficiency – such as the use of modern technology to mobilise the workforce; other initiatives are looking at the allocative efficiency of our skill mix and workforce models, and the relative demand for and resourcing of the three community teams. The Unit's plans for 2018/19 also include recommissioning and reinvesting in areas such as; mainstreaming anticipatory care planning into core ways of working reviewing and reconfiguring the basket of GMS and pharmacy enhanced services to maximise value, redesigning out of-hours services and changing the use of the Community Hospitals in Gorseinon and Maesteg.

Additionally, we will be reviewing the provision of healthcare to Swansea prison to improve the robustness of the services. This includes working with Welsh Government and Public Health to agree National Priorities for Her Majesty's Prison and Probation Service (HMPPS) and Partners.

The coming three years are therefore likely to see a step-change in the way primary care and community services are provided, a range of changes to our relationship with primary care contractors and the radical changes to the workforce model.

In terms of primary care estates, there are a number of planned developments which seek to support general practice sustainability as well as facilitate the transfer of care from a secondary care environment to a more local setting. In the coming 12 months we are aiming to implement:

- A relaunched and renewed Hub for local services in Neath;
- Significant progress on the Health and Wellbeing Centre in Sunnyside Bridgend;
- Developing proposals for the Health and Wellbeing Centre for Swansea City Centre;
- Refurbishment of two GP branch sites and Health Board clinic space in Murton and Penclawdd community clinics;
- Redesign and remodelling of Port Talbot Resource Centre to maximise wellbeing provision;
- Improvements to and rationalisation of GMS estate in Cornelly coupled with the provision of community clinic space leading to the co-location of NHS services and the potential closure of the old clinic site;
- completion of the refurbishment works of Ystalyfera community clinic to consolidate GMS delivery across the Upper Valleys border area; and
- Progression on site and completion of the capital developments in Porthcawl and Vale of Neath; and,
- To support improved performance against the Targeted Intervention Priorities.

The specific actions for primary and community services in 2018/19 are found in our Service Improvement Plans.

3.0 Improving Care for Older People

Following the Trusted to Care Review we undertook a structured programme of organisational change to ensure that we provide compassionate and dignified care for older people. The provision of high quality care for older people will continue to be a top priority for the Health Board in the future.

Our service change plans to improve our services for older people are a 'golden thread' which runs throughout this Annual Plan. Our work to develop integrated services for frail older people is a major feature of our partnership work through the Western Bay

Regional Partnership Board. The impact of the ageing population on the provision of our services is one of the greatest sustainability challenges we face and the majority of patients on our wards are over 75 years of age.

Wales has led the way in ageing policy in the UK and Europe by establishing:

- The Strategy for Older People in Wales;
- The world's first Older People's Commissioner; and
- The Declaration of Rights for Older People in Wales.

Our priorities for improving our care for older people in 2018/19 are to:

- Provide safe, dignified, compassionate care for older people;
- Work in collaboration with our partners to help people retain their independence and provide care 'Closer to Home'; and,
- Ensure hospitals are seen as a place to last resort unless clinically required.

The Older People's Strategic Framework has been established with the involvement of our partners in the Western Bay Partnership, and in 2017 a new Practice Development Nurse for Older People was established to support and enable developments in care for older people across the Delivery Units. The Health Board has pledged to become a rights-respecting organisation and as part of this we have developed an [Older Person's Charter](#) which will be published in early 2018/19. We have involved the community and stakeholders to develop this Charter based on the Declaration of Rights for Older People.

Here are some examples of the feedback received which was taken into account in developing our Charter:



The Charter reflects our values and reinforces our commitment to older people. It is intended that the Charter will recognise diversity and reinforce the existing right of older people who are living in, and being served by the Health Board.

The Health Board is developing a Ward to Board Quality Dashboard which will include the Older People's Commissioner's Standards and the current Older People's Dashboard. This will provide higher acuity validated data, that is easily accessible at all levels, Ward, Delivery Unit, Directors and

Executive Team. The Dashboard currently include data on pressure ulcers and falls and will continue to be developed to also include:

- The Older People's Commissioner's requirements;
- Patient Experience data for dignity, hydration, nutrition and pain management;
- Medication Errors;
- Safer Staffing Act Requirements; and
- The Quality Assurance Framework.

The Quality Assurance Framework provides the overall governance structure to provide assurance about the requirements of the Older People's Commissioner for Wales, and the Health Care Standards for Wales within the Health Board. Audits will be in place in all acute Delivery Units by March 2018. The Ward to Board Quality Dashboard will be used to provide assurance to the Quality and Safety Committee.

Our specific plans for Older People are found in our Service Improvement Plans.

4.0 Arts In Health

We have a strong Arts in Health programme which is part of our patient and staff engagement programme. Our plans for 2018/19 are as follows.

Vision:

To incorporate the Arts into everything we do so that patients, their families and staff experience excellent care in excellent surroundings.

Strategic Aims:

1. Experience & engagement : To contribute to people's wellbeing through facilitating participation in the Arts
2. Environment improvement : To create environments that provide positive experiences for patients and staff
3. Heritage: To value and learn from the past
4. Sustainability: To create an Arts programme which is evidence based and has reliable resourcing

Aim	Objective	Project	Outcomes
1	Develop projects in Primary and Community Care & Mental Health	Dance to Health	Falls prevention for 100 older people Evaluation by Sheffield Hallam University

		Storytelling for Wellbeing cafe Storytelling groups in mental health	Mental health support
		Performing Medicine	Building staff resilience
1	Deliver a music programme in all Hospitals and build sustainable local ownership	Monthly concerts Music festivals Music therapy	Relief from boredom in hospitals Encouraging mobility Therapeutic work in neurology
1	Ensure Patient Story programme is effective, sustainable and resourced	Patient story governance & training Patient stories for directors meeting	Listening to patients, families and staff Learning and improving services
2	To build Art projects into patient facing capital schemes	Three capital schemes at any one time – Traumatic Brain Injury Service, Mammography room, Cefn Coed hospital, renal dialysis, theatre corridors, visitor and family rooms.	Improved patient, staff and visitor experience
2	To involve patients, staff and the local community in all capital and smaller arts projects		Shorter hospital stays
2	Ensure good governance and sustainability		Better staff retention
3	Ensure that the Artworks and Heritage that we own are preserved and shared	NHS@70 celebrations Support National Heritage Group	Improving staff and patient experience
3	Heritage Lottery funded project	Cefn Coed Hospital project	Preserving memories and learning from past mental health practice
4	To create a sustainable Arts programme that is evidence based and has reliable resourcing. Through research projects, funding applications, developing partnerships and programme promotion.	Website and newsletter development Research application for performing medicine	Sustainability Building evidence Increased numbers of patients benefitting

Appendix 3. MENTAL HEALTH AND LEARNING DISABILITIES PLAN 2018/19

3.1 Strategic Approach

Adult Mental Health

The overall strategic direction for mental health within the Health Board remains unchanged, reflecting the current all-Wales Strategy for Mental Health and Wellbeing, Together for Mental Health (T4MH), and extant policy guidance. The Health Board is fully engaged in delivering the Together for Mental Health Delivery Plan and the Mental Health Measure 2010.

The current version of our T4MH Delivery Plan and progress report is included below and is included in **Appendix 14**.



T4MH update v6-
ABMU Health Board

As planned in our Annual Plan 2017/18, during the year the Health Board has engaged with stakeholders and involved service users and carers in an extensive engagement exercise to develop a Strategic Framework for Adult Mental Health to inform our future service direction. This process was co-designed and co-produced with elected service user and carer representatives from our T4MH Local Partnership Board and included in-person feedback from more than 105 individuals and 170 other people or organisations through an online survey and group discussions. The process has been managed through our Commissioning Board for Mental Health and Learning Disabilities which includes wide range of stakeholders from within the Health Board, Local Authority and partner organisations. A number of wide-ranging themes were identified through the engagement exercise and the top priorities identified by service users and carers through the process are shown in the diagram.



The principles of the future optimum service model are:

- Focus on positivity – people’s abilities not disabilities
- To be based on a psychosocial model focusing on the holistic needs of individuals;
 - More emphasis on wellbeing at work;
 - Early intervention, education and prevention underpinning all services;
 - Ensuring that service users, their carers and families are central to all we do and central to resolving their issues as well as being meaningfully involved in, and influencing how and where services are developed, and their evaluation;
 - Services deliver advice, support and care that maintains and promotes self-determination and independence;
 - Providing a straightforward way for people to access the range of services they need, which suits them rather than us as

organisations;,

- Timely access to services which are needs-led, including in rural areas, and primary care; and,

- Holistic care delivered through partnership working between health, social care and third sector services including user-led services.

There is agreement across all agencies that the views shared through the engagement process will influence the Strategic Framework and our joint priorities and there is an agreed commitment to change. A Working Group between the three Local Authorities and the Health Board has been formed to develop an optimum service model and this will also include the findings of the Alder Advice's Report, commissioned by the Western Bay Partnership into Unmet Need in Mental Health.

The emerging Strategic Framework was agreed by the Health Board in November and consultation on the final draft Framework will begin in March 2018. We will set out an agreed optimum model in the final draft Framework against which existing services will be compared and this will be agreed through the local T4MH Partnership Board. The final Strategic Framework will be approved by the Health Board and Regional Partnership Board in May 2018, with an implementation plan and transformation programme in place. The emerging priorities and principles form the basis for our plans for 2018/19 and the implementation of the Framework has been included in the Western Bay Area Plan 2018-23 as a key priority with a requirement for programme management to ensure implementation. All partners, including service users and carers are clear that the level of change we would like to effect is undoubtedly challenging, but it is imperative that, to repay the people who have invested their time in telling us what they think will make a difference, we jointly agree and deliver on some early changes over the next 12 months. The joint priorities that are emerging for early action include:

- A single point of access for all services and ages;
- Direct provision of a crisis sanctuary service offering an out-of-hours listening and safe space service. This would be contracted from the third sector as an additional service to what we have, and will respond directly to an issue people have told us is a gap;
- Information, which is readily available for service users and carers and other professionals, in accessible formats on the range of services available to help and support them; and,
- A range of third sector peer / activity groups and support networks through a Clubhouse approach, based on a non-clinical co-production approach giving its members a place to go, meaningful work, meaningful relationships and a place to return.

Any additional ring-fenced monies allocated by Welsh Government for Mental Health will be treated on the same basis as last year. It is proposed that these available funds could helpfully be used to strengthen the low-level support, particularly in the evenings and weekends, which is currently only patchily available, across the ABMUHB area. This would allow us to start developing an earlier intervention / more preventative approach to mental health services which is an underpinning principle of the Strategic Framework.

Older People's Mental Health

The all-Wales Dementia Strategy has now been published and there is an understanding that there will be funding for the accompanying action plan for its implementation. Mental health services are already engaged in the development of the Older Person's Charter, in dementia awareness and dementia care training. We are aware that the local actions to implement the Dementia Strategy are likely to focus on education and awareness raising in all sectors, availability of information, timely response to memory assessment, care home in-reach, and increasing the availability of psychosocial and psychological interventions. The overall response to the Dementia Strategy will be overseen by our multiagency Dementia Group for the Western Bay area to ensure that improvements in care and experience for people with dementia covers all sectors and is not just seen as the role for mental health services.

During 2017/18 the Health Board commissioned an external Clinical Review of our Older People's Mental Health services and started a transformational programme of change to improve the quality and outcomes of services and to provide care 'Closer to Home'. The Clinical Review confirmed that the service model in the Health Board is too weighted towards inpatient rather than community models of care with approximately a 70% to 30% ratio of services. The report recommends remodelling towards a balance of 50:50 to support patients and their families in the community and reduce the reliance on long term healthcare. In addition, benchmarking by the NHS Wales Delivery Unit also identified that despite judging the overall care on the wards to be of a good standard with some examples of excellence they were *"not assured that the current service model consisting of 13 wards is sustainable in relation to the staffing establishment required"*.

In 2017/18 we invested £1.6m (FYE) in Older People's community services to drive a move to a service model focused more on community rather than inpatient services. These monies have been invested in nursing, physiotherapy, occupational therapy and psychology staff to enhance our early intervention, diagnosis and treatment provision in the community in line with best practice. The process undertaken to agree the investment framework was carried out to ensure the development of a consistent community model across the three localities that addressed identified service gaps in each Local Authority area.

The overall aim is to implement a service model that would reduce the reliance on in-patient services, with more emphasis on early, community based intervention and keeping people in their own homes for as long as it is safe to do so. This reduces the risk to patient safety as it has been identified by the External Review that our current distribution of wards across multiple sites is not sustainable.

We have started to re-model services based on the investment in community services outlined above, changing our clinical models and training and development of staff. There have been reductions in length of stay which have supported the temporary closure of

a suite at Tonna hospital (18 beds) in the summer of 2017. Since then the occupancy of older people's mental health wards has continued to reduce as changes to operational and clinical practice became normalised. Consequently this offers opportunities for efficiencies through further reconfiguration of the inpatient model, supported by the development of community services, during 2018/19.

Children and Adolescent Mental Health Services (CAMHS)

The provision of specialist Child and Adolescent Mental Health Services (CAMHS) has caused concerns historically because of long waiting times and the lack of support for professionals to support Children and Young People's emotional health and wellbeing. As a result, since April 2016 a new approach to tackling these issues has been taken with the Assistant Director of Strategy and Partnerships leading a new commissioning approach to these services. Both in conjunction with Cardiff & Vale and Cwm Taf University Health Board commissioners, in partnership with existing Cwm Taf CAMHS and with the relevant Delivery Units within ABMU Health Board to deliver operational responsibilities where required as services are increasingly being directly provided by ABMUHB rather than all through Cwm Taf's services.

There have been discussions through the Western Bay partnership about the importance of CAMHS being seen as a multiagency problem, which will only be resolved by a multiagency response. As a result Western Bay, for the first time, has agreed that CAMHS is a joint priority for the Regional Partnership Board consisting of ABMU Health Board and the three Local Authorities plus third sector partners. Plans are being developed to provide support for the emotional health and wellbeing of children and young people, including the joint agency development of tier 1 and 2 interventions to avoid referral into specialist CAMHS where this is not appropriate.

ABMUHB has a Delivery Plan for Services to Support the Emotional Health & Wellbeing of Children and Young People for 2017-19 with the following high-level priorities:

- Improved accessibility to local CAMHS services
- Development of a sustainable and fit for purpose workforce
- Development of NDD Service
- Securing appropriate accommodation for specialist CAMHS in Bridgend, Neath Port Talbot and Swansea areas

Cwm Taf UHB are committed to a set of principles for CAMHS and they are included within the Health Board's IMTP as follows:

1. Implementing CAPA which is a partnership approach with parents where professionals work together with families to determine what changes they are looking for and enabling them to make informed decisions about treatment options.
2. Improving links with other agencies as described above.

3. Prioritising urgent cases both through Crisis teams and robust management of waiting lists.
4. Making the best use of skills and resources by improving working relationships with primary health and with third sector colleagues who now join secondary care colleagues in intake meetings and take on those cases for whom they offer the most appropriate intervention.
5. Aim to ensure that only what is needed to be done is done by adhering to best evidence based practice through monitoring compliance with NICE guidelines and working towards reducing levels of prescribing where appropriate.
6. Introducing the regular use of ROUTINE Outcome Measure's (ROM'S) to ensure clinical practice is effective and that service users can feed back about their experience of the service.

Learning Disabilities

National commissioning guidance for learning disabilities was published in 2017 and has provided the first new national strategic guidance for a considerable time. The Health Board provides Learning Disability services for three Health Board areas and it has been agreed corporately, through a joint commissioning group including Cwm Taf, Cardiff and Vale and ABMU Health Boards, that a joint Strategic Framework is developed for the modernisation of services.

At the same time the Health Board has, as part of the Recovery and Sustainability Programme, identified a range of service changes which could be implemented to deliver quality improvement, care 'Closer to Home' and better use of resources including financial savings. These include the reconfiguration of inpatient facilities to improve the quality of care for our resident populations by repatriating some of the most challenging Autistic Spectrum Disorder and complex needs patients from out of area placements, and providing care 'Closer to Home' for new patients in the future.

In order to progress these initiatives the agreement of the three commissioning Health Boards is required and a joint process has been established to take this forward, with plans to be implemented in 2018/19 as part of a longer 5 year plan.

3.2 Our Plans for 2018/19

This section describes our objectives and plans for delivery of mental health and learning disabilities in 2018/19. Specific actions relating to Unscheduled Care and Planned Care are included in the relevant Service Improvement Plans.

Priority Area	Objectives	Measures

Implementation of a Strategic Framework based on Optimum Model of services for Adult Mental Health.	Delivery of Optimum Model implementation plan in conjunction with partners. Joint priorities to be agreed for early delivery in the first 12 months. Development of business case for Acute Assessment facilities and decommissioning of Cefn Coed Hospital. Increasing access to Psychological Therapies across all ages. Simplified routes to services Increased availability of advice information and support that helps avoid requirement for secondary care services.	Improvement in performance for access targets. Reduction in waiting times for psychological therapies. Service user satisfaction.
Redesign of Learning Disability Services	Develop a Strategic Framework for Learning Disability that is shared by the 3 Health Boards commissioning NHS learning disability services. Enhance skills and function of community learning disability teams to support people at times of crisis to increase likelihood of remaining in existing accommodation rather than escalating to higher levels of care. Establish a clear function for existing NHS Specialist Residential Units. Identify and establish appropriate provision of acute assessment beds based on population and need analysis. Support market development with partners to increase availability of enhanced supported	Reduction in numbers of out of area placements. Reduction in CHC spend.

	accommodation to facilitate patient flow.	
Implementation of the Actions for Health Boards included in the Dementia Action Plan for Wales (issued Feb 2018 and currently awaiting further guidance from Welsh Government on the governance arrangements in relation to the implementation and monitoring of the plan)	More people are diagnosed earlier, enabling them to plan for the future and access early support and care if needed. Those diagnosed with dementia and their carers and families are able to receive person-centred care and support which is flexible. Each local authority area will review of actions for areas of work specific to them by Q1 for inclusion in revised Locality Plans. (The delivery plan will be revised and amended accordingly).	Dementia diagnosis rates recorded as part of QOF.
Further development of Older People's Mental Health Services.	Improving patient outcomes by reducing the deconditioning effect of a hospital stay. Rebalancing the ratio of inpatient to community service resources. Shifting the Health Board's populations standardised benchmarked inpatient provision towards the UK mean thereby reaching a greater percentage of the population. Consistency in the availability of appropriately skilled staff. Future proofing the services for the increasing	Quality of life, Functional abilities measures, patient & carer satisfaction measures. Resource ratio & UK Benchmark information Use of Bank and Agency Unmet demand & occupancy levels

	demands associated with changing demography	
Development of Regional Secure Service for Women	Improve the experience and effectiveness of secure services through gender appropriate care. To inform all Wales decision making by undertaking scoping exercises to: identify demand and capacity; explore potential clinical models; and understand service users and carer perspectives of a possible service.	Developmental stage. Desired outcome will be to get to a position where WHSSC are able to make a decision about development.
Increased capacity for gender specific locked rehabilitation provided by ABMU Health Board.	Reduce the need for locked rehabilitation placements contracted with the private sector. Provide services closer to their home area for a specific cohort of individuals with complex needs that cannot be met in a community or open rehabilitation environment due to risk issues.	Patient related Outcome Measure through use of the Recovery star. Reduction in CHC costs.
CAMHS	Potential transfer of primary care level child and adolescent mental health services from Cwm Taf to ABMU Health Board. Redesign service pathway to improve compliance with access target for LPMHSS for children, reducing waiting times for assessment	Patient related Outcome measure through application of WG prescribed questionnaire. Waiting time for primary mental health assessment <28 days. Waiting time to commence intervention following assessment.
Quality and Safety	Quality Improvement programme to use QI methodology across adult acute wards to:- • Reduce variation in risk assessment, formulation and management • Strengthen carer involvement in care and engagement in services	TBA

	• Improve record keeping • Increase use of evidence based pathways • Improve person/family centred approaches to care Development and implementation of a regional suicide Prevention action plan with partners in line with Talk To Me 2.	
Development of service to fit with the all Wales integrated Autistic Spectrum Disorder service.	Develop and implement multi-disciplinary services, assessments, proportionate to risk that are person centred. Launch of the Integrated Autism Service for the Western Bay region by November 2018	Measurement of progress against the National Standards in the IAS Model. Following launch time from referral to assessment.
Mental Health Measure	Continue to comply with the Mental Health Measure indicators taking into account the inclusion of CAMHS and Learning Disabilities data	NHS Outcomes Measures - Mental Health Measure
Workforce	Reduce sickness absence rates across the Delivery Unit Implement and reinforce ABMUHB values based culture. Undertake development work with service managers within new management structure.	Attendance levels. Reduction in vacancies. Improvement in staff satisfaction.
Revenue	Deliver financial target within ring-fenced allocation for Mental Health and Learning Disabilities.	Break even position for the Delivery Unit.
Unscheduled Care	Contribute to achieving the Health Board's targets for unscheduled care through the delivery of Psychiatric	1 hour response time performance. Reduction in numbers of frequent

	Liaison services. Achievement of 1 hour target from referral to assessment by Liaison Service in ED. Achievement of same day assessment by Liaison Service following urgent referral from acute hospital Wards. Psychiatric liaison to work with emergency department colleagues and partners to better address mental health / substance misuse needs of frequent attenders. Further development of Psychiatric care home in reach services to support care home staff in management of mental health needs of residents and avoid need for referral to ED or admission to acute or psychiatric inpatient care. Development of pathways for adults and older people requiring transfer from acute hospitals to a mental health bed to ensure that transfers take place in a timely manner and patients are cared for in the most appropriate environment.	attenders. Length of stay of people with mental health diagnosis in acute settings (data set to be defined). Inter hospital transfers.
Planned Care	Reduction in waiting times for high intensity psychological therapies.	Performance against 26 week access target

Appendix 4. CHILDREN AND YOUNG PEOPLE'S PLAN 2018/19

4.1 Strategic Approach



There are approximately 118,300 children and young people up to 18 years old (2011 census) in the Abertawe Bro Morgannwg University Health Board and we want those who are doing well to continue to do so. However, there is evidence that despite significant investment over many years, there is insufficient progress being made to improve the lives of our most marginalised and disadvantaged children and young people. In line with '*Prosperity for All*', our Wellbeing Objectives, the Bevan Commission 2013 and the Social Services and Wellbeing Act (2016), the Health Board is committed to improving the life chances of children and young people in our area and ensuring that services are delivered within a prudent approach. We will build upon the relationship between children and young people their families and partner agencies (including third sector organisations) to work together as equal partners; co-producing services and solutions that best fit children and young people's health and social care needs whilst empowering them and their families to gain greater control over their own lives (Social Services and Wellbeing Act 2016). Our maternity plans in the next section also describe our work to engage parents and families before birth and in the first 1000 days.

CYP services are diverse, encompassing the ages from birth to 18 years, across a wide range of specialities including secondary care paediatrics, neonatology, community and primary care and mental health services. Abertawe Bro Morgannwg University Health Board will deliver accessible services for children and young people through the provision of high quality universal services ensuring that those children and young people who are most vulnerable receive targeted interventions as appropriate.

The *United Nations Convention on the Rights of the Child* sets out the minimum entitlements and freedoms that children everywhere have the right to expect; this includes "the right to enjoyment of the highest attainable standard of health and to

facilities for the treatment of illness and rehabilitation of health”. With the extensive involvement of children and young people, the Health Board developed and adopted the first [Children’s Charter](#) in Wales in 2017. In collaboration with the University of Wales Swansea, Abertawe Bro Morgannwg University Health Board and the Observatory we are further developing the concept of the charter, through a base line assessment involving professionals and children and young people to inform further research and to improve the outcomes for this client group. This will also lead to the development of performance indicators, to hold the Health Board to account in the assurance that children’s rights are being upheld.

During the year we will also build on the work we have done during 2017 to develop children and young people’s involvement and engagement in service provision as follows:

- The establishment of our Children and Young People’s Youth Board;
- Children and Young people’s involvement in the 15 Steps Programme; and,
- Digital Children’s Patient Stories being used as part of our patient experience programme.

Finally, we published our [Children and Young People’s Strategy](#) in September 2017. The aim of the CYP Strategy is to set a clear direction for the improvement of the health and wellbeing of children and young people within our Health Board from conception to adulthood, in line with ‘Prosperity for All’ and our Wellbeing Objectives. Meaningful and sustained change will take time. Our pledge is to deliver on a shared vision for all our children and young people over the five years and our success will be measured by improved outcomes in key areas of our children and young people’s lives. The Strategy is also structured around the journey of the child and the United Nations Convention on the Rights of the child (UNCRC) and aims to include services delivered at the following levels:

- Early Years;
- Primary Care;
- Secondary Care;
- Early intervention and prevention; and,
- Keeping children/young people safe.

An implementation plan for the Strategy is being developed and will be completed in early Summer 2018.

4.2 Progress to Date

The table below provides an overview of the achievements to date.

	Key Priority	Progress to date
1.	Baseline review of governance structure	Governance structure in place – ➤ Childrens Services Board – bi monthly meeting senior management team and wider stakeholders including therapies and primary care ➤ Quality & Safety Committee ➤ Assurance & Learning Committee ➤ Monthly clinical meetings - Acute Paediatrics and Community Paediatrics ➤ Lead and facilitate - Paediatric Surgical Committee
2.	Children and Young People's Strategy approved by the Health Board	➤ Partnership working to develop the strategy across all sectors and key stakeholders ➤ Informed Local Authority integrated plans ➤ Youth Board (ABMYouth) established and work programme agreed ➤ Swansea University Observatory – working in partnership to develop a baseline assessment and to explore children's rights within healthcare settings ➤ Children and Young People's Strategy approved by the Health Board in September 2017
3.	Support to South Central Acute Care Alliance and implementation of recommendations following South Wales Programme	➤ Membership Paediatric Task & Finish Group ➤ Membership Neonatal Task & Finish Group ➤ Membership Paediatrics Obstetrics & Neonatal Board
4.	Neonatal service	➤ Transitional Care Unit (TCU) capital business case submitted to Welsh Government October 2017 – supports implementation of South Wales Programme recommendations ➤ Neonatal Study – reduction in antibiotic use – Winner NHS Award October 2017,

		Finalist BMJ Awards ➤ Neonates family integrated care ➤ Increased provision of Speech & Language therapy to Neonatal unit Singleton ➤ Neonatal unit Singleton retained training status as second unit in Wales ➤ Host of 3rd Annual Perinatal Symposium May 2017 Liberty Stadium ➤ Agreed 2 consultant sessions from SIFT funds for student training
5.	Acute Paediatrics service	➤ Baseline review of medical staffing rotas completed ➤ Diabetes services - Investment in psychology, dietetics, additional specialist nurse, phlebotomy, and educator post, following peer review ➤ Proposal agreed to establish a project to take forward a review of future workforce requirements utilising Skills for Health workforce planning tool ➤ Attendance at Manchester learning event to benchmark Paediatric Assessment Units ➤ Review of plans to redevelop paediatric areas at Morriston to develop project plan ➤ Initial meeting held with representatives of primary care to begin joint working priorities with GP Network Cluster hubs ➤ e-TOC performance improved 90%+ at Morriston ➤ Funded "Professor"/Chair in Paediatrics post agreed with Swansea University ➤ Additional support to Gastro Network services at Cardiff and Vale ➤ Maintained medical rotas ➤ Agreed 2 consultant sessions from SIFT funds for OSCE's training
6.	Community Paediatrics	➤ Neurodevelopmental team in place and additional clinics provided to reduce waiting times for assessment. Progress in implementation of all-Wales pathway across three local authority areas working closely with education ➤ Review of service provided by child health department and recommendations going forward ➤ Agreed retire/return x 4, pending wider workforce review ➤ Expansion of palliative care regional services provided to Hywel Dda following additional funding from End of Life Board ➤ Agreed funding with NPT local authority for continuation of fostering advice ➤ Agreed 2 consultant sessions from SIFT funds for medical student training
7.	Financial governance	➤ Review of medical staffing rotas and associated agency spend

		➤ Review of drugs expenditure – new clinical guidance completed for high cost drug Alimemazine to reduce use and associated spend ➤ Review of medical/surgical supplies and equipment and stock levels ➤ Successful SIFT bids ➤ Plan developed to reduce charitable funds balances across all areas and routinely review
8.	Workforce Staff Engagement	➤ Development of SharePoint site for Childrens Services ➤ Group “Values” sessions provided for all Child Health Staff ➤ Implementation of Group PADR ➤ Attendance at National event to benchmark Paediatric Assessment Unit (PAU) services ➤ Consistent 10% increase in PADR performance ➤ Successful nurse recruitment days – 10 posts offered ➤ Appointed two Consultant Paediatricians at Morriston ➤ Adopted skills for health tool to workforce plan in paediatrics

4.3 Key Priorities – 2018/19

Key Priority	Measure/Outcome	Timeframe
Strategic Direction – CYP Strategy		
Produce an implementation plan for Childrens Strategy Board	Clear strategic direction Build profile of service group within and across organisational boundaries	June 2019
Support development of ABMYouth Board	Build profile of Childrens services Patient input into service planning and redesign	Board in place
South Central and South West Alliance - ongoing support to regional planning forum – advise, and implement, regional recommendations	Effective communication and input into regional planning priorities	Ongoing
Review performance scorecard to incorporate ‘Facing	Improved data collection in PAU	Complete in readiness

Key Priority	Measure/Outcome	Timeframe
the Future' standards for Acute and Community paed, Child Health Department performance data including Community waiting times, and Badgernet data for Neonates	Effective waiting times management of both Acute and Community paed Effective data collection to inform service change Service group and SDU ownership of Badgernet data	for April 2018
Acute Paediatrics		
Produce a business case to upgrade existing paediatric wards, paediatric assessment unit and paediatric HDU facility at Morriston	Meet Facing the Future standards Efficient use of workforce Improved patient experience	April 2018
Carry out a baseline assessment against revised Facing the Future standards and respond to Facing the Future Audit results following November 17 visit	Meet Facing the Future standards Inform service change and redesign Inform workforce priorities	July 2018
Establish a project team to review future workforce requirements across acute and community paediatrics in Swansea utilising the Skills for health workforce planning tool Will incorporate succession planning for fragile services including Neurology; Gastroenterology; Cardiology; Audiology. Seek alternative roles such as nurse practitioner roles where appropriate	Meet Facing the Future Standards Efficient use of workforce Improved patient experience	Inaugural session undertaken in December 2017. Action plan completed work ongoing
RTT – review current clinic templates and redesign to both reduce follow-up backlog and reduce number of clinics where appropriate to provide more senior cover on the ward and PAU. Use job planning to support the process.	Efficient use of workforce Meet Facing the Future Standards Maximise efficiency targets	Ongoing
Collaborative forum established with primary care to	Meet Facing the Future Standards	Started January 2017.

Key Priority	Measure/Outcome	Timeframe
work closely with cluster leads to review: Potential to develop an Obesity service with Bridgend cluster Review potential benefits of email advice to GPs Review potential to develop specific referral pathways	Efficient use of workforce Improved patient experience Maximise efficiency targets – new referrals, new to follow up ratio, FUNB	Planning underway. Work ongoing
1 x funded Roald Dahl nurse to support acute Gastroenterology service	Meet Facing the Future standards Improved management at home and reduced admissions Facilitate early discharge Empowering families	Submissions agreed January 2018 and returned to the charity. Awaiting response.
Community Paediatrics		
Use British Association for Community Child Health (BACCH) toolkit to undertake a baseline assessment of service and benchmark to inform sustainable service model	Meeting BACCH standards Meet Facing the Future standards	April – June 2018
Meet statutory obligation to safeguard CYP - Review sustainability of sexual abuse rota and links to wider regional intentions for the Sexual Assault Referral Centre (SARC)	Safeguarding - Statutory requirement	Ongoing
Meet statutory obligation to safeguard CYP - Review sustainability of Child Protection Rota following retirements	Safeguarding - Statutory requirement	Ongoing
Joint project team to review future workforce requirements across acute and community including paediatrics in Swansea utilising the Skills for Health workforce planning tool Will incorporate succession planning for fragile services including Neurology; Gastroenterology; Cardiology; Audiology, and	Meet Facing the Future Standards Efficient use of workforce Improved patient experience	To be completed September 2018

Key Priority	Measure/Outcome	Timeframe
sustainability of sexual abuse and child protection rotas. Seek alternative roles such as nurse practitioner roles where appropriate		
Review of Consultant workforce following retirements and establish long term plan to fill vacancies and reduced sessions (linked to skills for health planning)	Effective use of workforce Meet facing the future standards	April 2018
School Nursing Service		
Maintain and build on uptake rates for all vaccination programmes delivered in school utilising funding made available by WG to support a dedicated Immunisation team who will deliver universal programmes and offer catch up sessions in an approach that will meet locally identified needs.	Uptake % rates as reported via PHW COVER reports Follows on from First 1000 Days work and meets expectations of Healthy Child (Wales) Programme & WG (2017) School Nursing Framework Immunisation Standard & Children's Rights under UNCRC Article 6	Ongoing
Maintain and build on uptake of reception class school screening for height, weight and Child Measurement Programme	Uptake % rates as reported in CMP Annual Report and service specific data	Ongoing
Maintain and build on uptake of reception class universal vision screening programme	Uptake % rate as reported in Orthoptic Departments annual audit Meets the expectations of the WG National Screening Pathway, Healthy Child (Wales) Programme & the School Nursing Framework	Ongoing
Offer nutrition and health eating sessions to all primary schools to support addressing obesity issues	Uptake % rate by school site and number of pupils receiving a session as reported via SN Service specific data collection Meets expectations of WG (2017) Framework for School Nursing Service & Children's Rights under UNCRC Articles 6 & 13	Ongoing

Key Priority	Measure/Outcome	Timeframe
Set a process utilising the WASPI accord process to ensure Local Authorities advise the HB of electively 'home educated' children and young people who may currently have no oversight by any statutory agency as there is no obligation on parents to inform the Local Authority they intend home educating their child and when they do inform there is no responsibility on the local Authority to inform health. These families may not be aware of routine vaccinations that will become due throughout their child's school aged years and there is also the possibility of a safeguarding risk for these currently 'invisible' children.	Individual electively home educated children and young people will be identified by/to the health board whether or not the parents have informed the Local Authority. The family will be advised of the universal services their child would have been offered had they enrolled at a mainstream state school. Meets expectations of Healthy Child (Wales) Programme, WG (2017) Framework for School Nursing Service & Children's Rights under UNCRC Articles 6 & 13	April 2019
Health Visiting Services		
Review of implementation of Healthy Child Wales Programme underpinned by resilience assessment (FRAIT)	Participate in the 2 WG evaluation programmes	January 2017 and 2018
Address local public issues and priorities	HMP Swansea HV Model piloted	Pilot evaluation June 2018
	Perinatal Mental Health HV service model developed in partnership with adult mental health team (Swansea)	2 nd phase review March 2019
	<i>Lift the lip</i> oral health pilot	Evaluation April 2018
	Hello Baby antenatal programme in partnership with Mat services; roll out across HV	April 2019
Review of Flying start models due to budget allocation reduction	Plans being developed to address anticipated 5 % reductions & risk manage operational impact	November 2018

Key Priority	Measure/Outcome	Timeframe
Integrated models of care	BCBC commissioning programme of work to incl HV post to support families at risk of children being accommodated	Appoint HV by May 2018
	In each of the 3 LA Child and Family social services teams HV model in progress within the intake teams/Single point of access	Funding until 2019 NPT and Bridgend Reduced model for Swansea for 2019
	1000 days events held in Bridgend and Swansea with ongoing evaluations at CYP strategic partnership approaches feeding into PSBs (ACES agenda)	NPT event: 2019
Workforce mobilisation	Paperlite approach development ongoing with IPAD deployment; to support transition into WCCIS	2019
Chid Health Department		
Implement revised structure when approved	% turnover Improved sickness and absence Improved PDR compliance	April 2018
Establish a child health forum with health visiting, school nursing, GP practices	Improve immunisation uptake Improve communication between stakeholders Increase department profile Improve engagement	April 2018
Carry out a benchmarking exercise with other child health departments to inform future structure of department	Efficient use of resources	April – June 2018
Review options to relocate from Central Clinic	Health and safety compliance Improve communication between administrative function and clinical team	Ongoing

Key Priority	Measure/Outcome	Timeframe
Review digital options to support department functions	Efficient use of resources	Summer 2018
Neurodevelopmental Service		
Recruit to vacant posts	Sustainable service delivery Achieve waiting times targets	By April 2018
Produce a Service Specification	Sustainable service delivery	April – June 2018
Implement the updated project plan with clear timescales (Capacity and demand/standardised info)	Sustainable service delivery Efficient use of workforce Improve patient experience	Plan agreed January 2018
Neonates		
Implement Transitional Care Unit once business case approved	Implement SW Programme recommendations BAPM Standards	Ongoing
Building on transfer of 2 HDU cots from POWH to Singleton, implement WHSSC business case for additional HD cots x 3 if agreed	Implement SW Programme recommendations BAPM Standards	Submitted November 2017
Support proposal to extend transport service 24x7	Implement SW Programme recommendations BAPM Standards	Ongoing – WHSCC
Increase input of midwife led newborn examinations service 7 days per week on neonatal unit	BAPM Standards	April 2018
Provide dual consultant of the week model on neonatal unit as per national guidance	BAPM Standards	By April 2018
Appoint Roald Dahl x 1 neonatal outreach nurse if approved	BAPM Standards	Submitted December 2017
Financial Governance		

Key Priority	Measure/Outcome	Timeframe
Ongoing review of drugs expenditure	Effective governance Increase income	Ongoing
Support procurement strategy group	Effective governance Increase income	Ongoing
Continue to seek out new income streams – eg. fostering income from Swansea and Bridgend LA	Effective governance Increase income	Ongoing
Workforce		
Skills for Health	Improve % turnover Reduce sickness rates Efficient use of workforce Vacancy rates	March 2019
PADR Performance	% turnover rates Sickness and absence rates PADR target compliance Vacancy rates	March 2019
Mandatory Training compliance	% turnover rates Mandatory training target compliance Sickness and absence rates Vacancy rates Reduced incidents	March 2019
Job Planning	Efficient use of resources Increase in activity Maintain RCPCH standards	March 2019
Staff engagement - Establish regular Children's Symposium to build profile of service group and encourage wider engagement	Establish regular Children's Symposium to build profile of service group and encourage wider engagement	1 st December 17 and ongoing
Team Building – develop programme of sessions for 2018 with support from OD	% turnover rates Sickness and absence rates	April 2018

Key Priority	Measure/Outcome	Timeframe
	Vacancy rates	

Appendix 5. MATERNITY SERVICE PLAN 2018/19

5.1 Strategic Approach

There are 6,000 babies born in ABMU Health Board every year. We aim to ensure all women and their babies receive the best standards of care in order to achieve the best start possible. We know that a healthy mother is the first step in giving any baby a healthy and 'good' start in life, in line with the focus on Early Years as described in '*Prosperity for All*' and our Wellbeing Objectives, and we know that maternity services have a unique contribution to make to ensure healthy outcomes for mothers, their babies and the wider family.

'A Strategic Vision for Maternity Service in Wales- Health in Wales (2011) continues to set the direction for maternity services across Wales ensuring women receive the highest standards of care. Our priorities for maternity care for 2018/19 are:

- To improve women and families' experience of maternity services
- Improve safety within maternity service

There are 6000 babies born in Abertawe Bro Morgannwg University Health Board (ABMUHB) every year.

ABMUHB aims to ensure all women & their babies receive the best standards of care in order to achieve the best start possible. We know that a healthy mother is the first step in giving any baby a healthy and 'good' start in life.

The annual plan will acknowledge the unique contribution maternity services can make to ensure healthy outcomes for mothers, their babies and the wider family.

'A Strategic Vision for Maternity Service in Wales- Health in Wales WG (2011) continues to set the direction for maternity services across Wales ensuring women receive the highest standards of care.

ABMUHB priorities for maternity care for 2018/19 are:

- ✓ To improve women and families' experience of maternity services
- ✓ Improve safety within maternity service

Background

The provision of maternity care in the Health Board is as follows:

- **Singleton Hospital** provides obstetric led births to women in the locality, however as there is a Level 3 neonatal unit responsible for caring for extremely premature babies the unit will also receive women from neighbouring Health Boards. The unit also supports midwifery led care in a dedicated alongside midwifery led unit

- **Princess of Wales Hospital** provides obstetric led services and has a single alongside midwifery led room for women with low risk pregnancies. The hospital has a level 2 neonatal unit and cares for babies born above 32 weeks gestation. The unit does not have a dedicated alongside midwifery led unit.
- **Neath Port Talbot Birth Centre** is a freestanding midwifery led unit providing care to women with low risk pregnancies. There are consultant led antenatal clinics provided in the unit.
- **Community based antenatal/ postnatal care and home births** provided by community midwives to approximately 5000 women living in the Health board area. More than 60% of all women will commence all their antenatal care with the midwife being their lead professional. There are currently 5% of women having home births and 10% of women having their babies in the freestanding midwifery led unit.

The provision of maternity care is challenged by the following factors:

- The impact of women having babies over the age of 40 has increased in the last 10 years with the associated risks of complications of pregnancy.
- The increasing number of mothers with a raised Body Mass Index (BMI) adds to the complexity of pregnancy. Adult obesity in the Health Board population is approximately **26%**
- Smoking in pregnancy can cause complications during labour and increase the risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. The current (2017) smoking rate in the HB amongst pregnant women is **17%**.
- The caesarean section rate across Wales ranges from 15 to 33% within the Health Board we have rates of **27%**. This has an impact on the maternity services and future pregnancies and the Health Board has an improvement plan to reduce these rates over the next 3 years.
- Stillbirth rates in the United Kingdom have remained largely the same for more than 15 years and are still amongst the highest in Europe, with Wales having a higher rate than the rest of the UK.

5.2 Our Plans for 2018/19

Key Action 1

- Maternity services to continue to work towards our **six strategic aims**:
 - ✓ promote good maternal and family health for the local Health Board communities
 - ✓ ensure we have a fully engaged and skilled maternity workforce

- ✓ strive to achieve excellent outcomes and experience for the women and families
- ✓ ensure the maternity services are sustainable and accessible to the local population
- ✓ Effective Governance to ensure we provide safe and appropriate care
- ✓ Work to promote strong partnerships with women and others involved in care, social and wellbeing services.

Key Action 2

- Continue to work towards achieving the **key performance indicators in the Maternity Strategy** for Wales and ensure any changes made to the strategy when it is reviewed in 2018 following the national stakeholder event being held in November 2017 by Welsh Government, are fully implemented. Including:
 - ✓ **Percentage of women whose initial assessment is carried out by 10 completed weeks of pregnancy.**
Aim to increase to >80% by end of 2018
 - ✓ **Percentage of women who have a BMI 30+ at booking assessment**
In ABMUHB 26% of pregnant women have a BMI 30 +
BMI is calculated in 98% of all women at initial assessment
Improvements required in weight recording at 36 weeks in order to demonstrate effectiveness of informing all women of the requirements to maintain a healthy weight during pregnancy
To improve nutritional guidance and healthy life styles discussions with women, by providing midwives with training on meaningful discussions (motivational interviewing)
 - ✓ **Percentage of women who smoke during pregnancy**
In ABMUHB 17% of women smoke in pregnancy
In line with NICE guidance midwives are responsible for establishing if women smoke, advising them on the key actions for a Safer Pregnancy to reduce risk of stillbirth.
Measuring women's carbon monoxide (CO) levels at least twice during pregnancy – **Further action required** to improve in CO monitoring during pregnancy and post birth
 - ✓ **Percentage of babies exclusively breastfed at birth**
In ABMUHB 63.7% of women breast feed their babies at birth this is an increase from 61% in 2016/17
Aim to increase rates to >65% by end of 2018
The importance of breast feeding for the future population is significant both for lifelong health, but also excellent economics. Breastfeeding is a child's first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity" Breastfeeding is itself a measure of the quality of care received. Not only is it an indication that women have received appropriate care related to feeding, but breastfeeding is affected by the care that

women receive more broadly in pregnancy, during labour and birth, and postnatally. Breastfeeding rates therefore act as a measure of the quality of maternity and neonatal care more broadly.

All Maternity units in ABMUHB have been accredited with the UNICEF UK Baby Friendly Initiative (BFI) award which has been to ensure basic standards of care to breastfeeding mothers are maintained and improved.

ABMUHB Maternity Services were reaccredited in February 2017. The highly valued award of Baby Friendly accreditation is achieved through a rigorous external assessment process which gathers evidence that the standards have been implemented. The cost for reaccreditation for the 3 sites was **£8200**. Further action required to maintain the BFI standards and work towards developing 'Gold Status' with BFI.

Areas to focus attention to continue to promote breast feeding rates across ABMU include:

- Policy and guideline development to support staff & training
- Development of local champions in all areas
- Information to women and their families including introduction of 'Hello baby' campaign and 'Your baby's first gift'
- Additional support from midwives and other professionals working in flying start and family first communities
- Specialist breast feeding clinics
- Development of breast feeding peer support is a priority and is seen as best practice for maintaining breast feeding rates in the early postnatal period
- Access the implications to the service of removing formula milk from the maternity units, encouraging mothers to consider breast milk or alternatively requiring parents to bring their own formula into hospital.

- ✓ **Caesarean section Rate - Welsh Government performance target to have a rate below 25%**
ABMUHB current rate 28% in 2016/7 the rate was 27%

To reduce the Caesarean section rate to below 25%, we will aim to:

- Keep the first birth normal
- Increase the number of women who achieve a Vaginal Birth After Caesarean (VBAC)
- Increase the number of women who commence labour outside the obstetric units. Based on the available evidence from the birth place study, the place of birth is a major contributor to decreasing the Caesarean section rates and particularly important in keeping the first birth normal.

- Implement into practice the HB 'Promise to move' campaign which promotes the importance of keeping pregnancies normal where ever possible in order to maximise the number of women who achieve normal births and avoid interventions (Prudent Maternity Care)

✓ **Perinatal mental health**

According to the National Institute for Clinical Excellence (NICE, 2014), at least 1:10 women are affected by mental disorders in pregnancy and during the postnatal period. Approximately 11% of pregnant women and 13% of early postnatal women experience depressive symptoms, with 5% experiencing a major depressive disorder. ABMUHB maternity and mental health services provide care to women during pregnancy and following the birth of their baby who experience mental ill health.

- ABMUHB are represented on the All Wales Perinatal Steering Group who are currently working towards developing an Unified Integrated Perinatal Pathway and agreeing with WG Key Performance outcome measures for Perinatal mental services

✓ **Workforce requirements for Safe maternity care**

Medical workforce

Compliance with RCOG standard for 60 hour consultant labour ward cover:

Singleton – compliant

Princess of Wales – non compliant: **Further action required** to completed job plans for all current consultants in order to achieve the 60 hour standard.

Midwifery workforce

Welsh Government require HB's to assess the midwifery workforce requirement for all their maternity services and be compliant with the recommended staffing level. Birth Rate plus is the workforce tool used across the UK and endorsed by the Royal College of Midwives. ABMUHB underwent an assessment in spring 2016 and the following was identified:

Princess of Wales – compliant

Neath Port Talbot and community midwifery services – compliant

Singleton – non compliant, with a shortfall of 6wte midwives: **Further action required** to continue working on the 4 key areas identified as an outlier in Singleton in order to have a more prudent service. The prudent work streams are focusing on antenatal care/ induction of labour / postnatal length of stay / reduction in caesarean sections. The

shortfall is highlighted on the Maternity Risk register and controls in place is the use of the Maternity Escalation policy to manage high levels of activity and acuity.

Key Action 3

- **Prudent Maternity Care in Wales – aim that within 5 years 45% of all women will commence their labours outside of Obstetric labour wards**

Implement the WG recommendations to ensure all women in Wales are informed of the evidence to support choices for women of birthing outside of Obstetric labour ward if pregnancy is normal and uncomplicated.

There are implications for midwives/ women (information and preparation) and suitable environments of care (POW does not have a midwifery led care facility)

Normal Birth Strategy Action Plan:

Short Term Plans to be achieved in 2018/19

Increase the number of women commencing their labours outside the obstetric units to 35%, currently 22%, by improving the environment of the midwifery led areas at the Princess of Wales Hospital and the development of another 'low risk' room.

Continue to promote high standards of information giving to ensure women are aware of the evidence to support their choices for place of birth

Review the criteria for consultant led care to ensure women are appropriately referred in order to increase the number of women commencing pregnancy and then labour are under the care of a midwife

Provide individual community midwifery teams with performance targets to improve the number of midwifery led births

Medium Term to be achieved by 2019/20

Evaluate the outcomes for women with BMI's of 35 to 39.9 to offer midwifery led care setting births

Implement the new All Wales Midwifery Led criteria for midwifery led births in order to increase the percentage of women to 40%

Key Action 4

- **Implement recommendations from the WG Survey of maternity services – 'Your Birth we Care' (Oct 2017).**

Key recommendations for Health board to focus on include:

- ✓ Information on Birthplace decisions
- ✓ Marketing of midwifery led care for women with uncomplicated pregnancies and the availability of appropriate environments

- ✓ provision for parent education;
- ✓ continuity of care by a maximum of 2 midwives during routine antenatal care

Key Action 5

- Plan and implement the new **All Wales Antenatal Screening programme for NIPT** (non-invasive prenatal testing) in April 2018. Which will offer :
 - ✓ combined screening for Down's, Edwards' and Patau's syndromes, in singleton and twin pregnancies
 - ✓ either NIPT or invasive procedures for women with singleton pregnancies
 - ✓ Invasive testing that will routinely only give a result for Down's, Edwards' and Patau's syndromes.

Funding for 2018/19 has been secured through technology funding. From April 2019 funding will be via WHSSC.

Implications for Health Board are in relation to:

- Requirement for training midwifery and medical staff ,
- information and gaining consent from women
- Increase in scanning requirements.
- Anticipated that the number of invasive tests such as amniocentesis and CVS will reduce, which will have an impact on the minimum required procedures to be undertaken per clinician to maintain competency.

Key Action 6

- **Reducing the stillbirth rate** across Wales and within the Health Board in line with the National Stillbirth Working Group initiatives:
 - ✓ early detection of babies at risk in utero of being small for gestational age using the Perinatal Institute programme GAP & GROW
 - ✓ management of altered fetal movements & the implications on ultrasound scanning availability in the Health Board
 - ✓ Implementation of the Maternity network guidance on future CTG training requirements

Key Action 7

- **Vaccinations in pregnancy**

Midwives are responsible for ensuring all pregnant women are informed of the evidence to support receiving vaccinations in pregnancy for flu and pertussis. Midwives are not responsible for administering the vaccinations this remains the responsibility of General Practice to give the vaccination and report on the number of vaccinations given to pregnant women. The data recorded by GP's continues to be inaccurate and as a consequence Public Health Wales support Health Boards to

undertake an annual one week audit of all births. ABMUHB has exceeded the Welsh Government target of a **75%** uptake rate.

Further Action required to continue to promote awareness of the importance of vaccinations in pregnancy

Data for previous audits are as follows:

ABMUHB	2015/2016	2016/17
Flu	80.9%	81%
Pertussis	77.5%	83.1%

Key Action 8

➤ Safeguarding

All staff working within maternity services have a role in identifying and ensuring children are protected from harm. Maternity staff have significant contact with families who may require support and interventions in relation to safeguarding children, staff are aware of national and local procedures and their responsibility in relation to these.

- **Domestic abuse;** all midwives are required to undertake routine enquiry asking every woman about domestic abuse at least twice during pregnancy in accordance to the “Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015).

Current data for 2017 confirms that:

- 90% of women asked routine enquiry question on one occasion
- 45% on second occasion

Safeguarding midwife leading on improvement plan to ensure all women asked twice during pregnancy

- **Ask & Act**

The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015) received Royal Assent on 29 April 2015. It is a landmark law, the first of its kind in the UK. One of the key mechanisms for delivering the Act is the National Training Framework on violence against women, domestic abuse and sexual violence.

Midwives in ABMUHB have all been trained in Ask and Act

- all midwives have undertaken group 1 training – eLearning
- 95% have attended group 2 training (3 hour face to face training)

- Plans are currently being devised for the update training required on a two yearly basis. There is a concern in maternity services what format of the uptake will take as this has to be proportionate to other clinical and professional skills required.

Key Action 9

➤ Information Technology

Maternity information for clinical outcome measures and performance monitoring is currently obtained from the Myrddin Maternity module. The information is inputted by midwives at various stages of pregnancy.

Community midwifery services have access to information systems in local community settings however there is no point of care information systems which results in duplication of effort as all booking information is collected and then inputted by midwifery staff at a later time. There is an aim through the mobilisation project within the Health Board to consider community midwives to have hand held devices.

Further action required is for maternity and IT services to find a solution to providing community midwives with the devices to enable them to complete initial booking information requirements onto maternity PAS at point of contact.

Central Monitoring System for fetal heart recordings in labour – maternity services previously included the requirement for a central monitoring system into the local IMTP but no funding was available. The system is required to assist in earlier detection of abnormal fetal heart tracings in labour and also provides an electronic archiving system for safely storing fetal heart recordings which are often required for redress and litigation cases. It is identified through Welsh Risk Pool that the misinterpretation of fetal heart recordings continues to be the highest cause of litigation claims and subsequently highest costs to the health service. Lost paper copies of the fetal heart recordings have occurred and without these being available can result in cases where the Health Board is unable to defend particular case.

Further action required is for the updated bid to be completed and forwarded to both Princess of Wales and Singleton Delivery Units for consideration and action. Lack of the system remains on the maternity services risk register.

Appendix 6. WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Workforce Priorities

- Enhanced staff experience and a values culture through compassionate leadership
- Workforce redesign to support service redesign
- A healthy workforce with reduced sickness absence.
- Increased retention and improved recruitment.
- Targeted training and development

Workforce Redesign

- Targeted local Workforce Redesign as laid out in Service Improvement Plans
- Redesign our primary and community workforce to develop multi-professional teams including Pharmacists, Therapists and Paramedics.
- Develop new and extended roles to support the shortage professional groups.
- Develop the non-registered workforce to allow registrants to work at the top of their license.

Enhanced Staff Experience and Embedding our Values

- Monitor our staff experience strategy “In our Shoes; Creating Patient Care through Great Staff Experience”
- Continued use of recognition schemes.
- Improve management and leadership.
- Continued membership of Stonewalls diversity champions programme.
- Embed the listening model from our values based “in our/your shoes” model.

Recruitment and Retention

- Increased number of students in relevant health and life science courses.
- Local and overseas recruitment campaigns for Nursing and Medical staff.
- Develop our Recruitment Strategy.
- Implement our Nursing and Midwifery Strategy.
- Implement the working longer readiness tool.
- Maximise our Retire and Return policy.
- Monitor our Staff Experience Strategy.
- Support staff to train more flexibly to become registered.
- Support the Welsh Government initiative “Train, Work, Live”
- Undertake exit interviews and develop action plans from the results.

Workforce Productivity

- Develop options to incentivise Nurse bank take up.
- Reduce recruitment timescales.
- Improve and monitor nurse rostering.
- Implement the All-Wales Nurse agency contract framework.
- Review junior Doctors rotas, job planning and medical study leave to reduce reliance on agency staff.
- Roll out E-job planning for medical staff.
- Apply the All Wales agency caps for internal and external medical locums.
- Develop action plans following completion of an agency monitoring diagnostic tool.

Measures of Success

- Vacancy rates reduced to 5%.
- Turnover reduced from 2018 baseline
- Reduce variable pay by 10%.
- PADR compliance rate of 85%.
- Improvement in the overall staff engagement score.
- Sickness Absence target of 5% achieved.
- Increase level 1 skills compliance to 85%.

Training and Development

- Widen access to opportunities within the Health Board.
- Develop value based leadership capacity and capability at all levels.
- Further develop and embed our Apprentice Academy.
- Improve PADR and mandatory and statutory training rates.
- Support the public services Wales Graduate Scheme.
- Integration of compassionate leadership into

Health and Wellbeing

- Develop a single point of access to provide timely health and wellbeing
- Provide training in dealing with stress and mental health issues at work.
- Further develop the Wellbeing Champion role.
- Exceed the Welsh Government target for the proportion of staff which receives the flu jab.
- Implement plans for 5% sickness absence target.

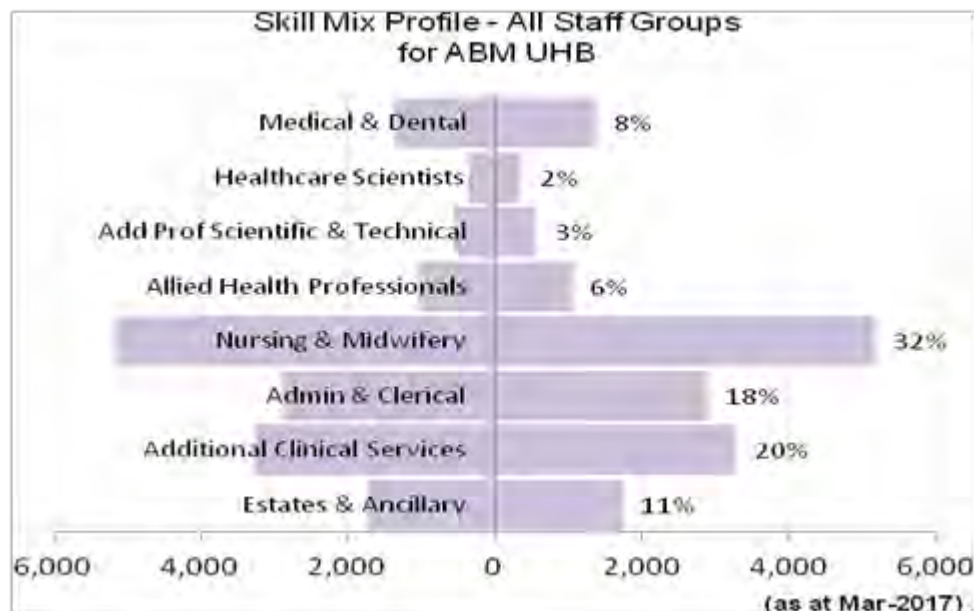
This Workforce and Organisational Development (OD) section summarises our challenges in more detail and highlights our actions to overcome them through the Recovery and Sustainability Programme and by ensuring that quality and safety are at the heart of our planning. Our new Executive Director of Human Resources will be starting in April 2018.

6.1 Workforce Profile and Analysis

The workforce analysis shows the main drivers of our workforce plan, the workforce redesign and workforce delivery Workstreams of the Recovery and Sustainability Programme, and underpinning service remodelling and strategic change required to provide sustainable services that is described in the Annual Plan.

Overview

The Health Board employs approximately 16,000 staff. The graph below demonstrates the proportion of staff in each staff group by head count.



Source: Skill mix analyser tool

Vacancies

Over the last year, the Health Board has undertaken work to be able to accurately assess the number of vacancies against establishment at any given time. The total number of vacancies that currently exist within the Health Board is 835.57 WTE across all the staff groups. Our registered nursing and midwifery staff group has the largest number of vacancies (313WTE Band 5 vacancies) and the analysis demonstrates the largest number exist within Morriston Hospital. However, vacancies across all staff groups have fallen in year with the exception of administration and clerical (A&C) staff and the Professional Scientific and Technical staff group. The increase in A&C vacancies is due to the scrutiny being applied through the recovery and sustainability controls.

Turnover

The turnover rate for all staff within the Health Board excluding junior medical and dental staff currently stands at 8.95%. The rate has been fluctuating around 9% for most of 2017 so this is a slight reduction. Nursing turnover remains the highest of the staff groups and stands at 9.97% although this has reduced over the last two months.

PADR

The overall percentage of PADR's recorded within ESR for the Health Board is 62.09%, however the all Wales target is 85%. ESR suggests that there has been continued gradual improvement in the recording of PADRs via the system, however continued improvement remains essential as a number of areas have been identified as having less than 30% PADRs recorded. Actions are in place to improve compliance.

Sickness

The current rolling 12-month performance as at October 2017 stands at 5.56%. Whilst the rolling 12 month sickness absence rate has decreased over the last year, it has started to increase again over the last four months. Our top reason for absence remains stress, anxiety, depression and other mental health illnesses which accounts for just under 30% of all absence in October 2017.

Whilst it is recognised that the increase in the prevalence of some common health problems, musculoskeletal disorders (MSDs) and cardiovascular disease with age is part of the normal ageing process and happens to people whether they are working or not, we cannot ignore these factors given that almost 40% of our workforce is over 50. In this respect we are likely to see a disproportionate effect of these types of conditions on our workforce. A 2011 HSE report also concluded that symptoms associated with work-related stress and burnout appear to increase with age but peak at 50-55 years old and then decrease with older age. We also have a predominantly female workforce and women may be more likely to report work-related stress than men, possibly due to the demands of their work, having multiple roles outside work and generally being more ready to admit to stress.

Analysis shows that 17 out of the 25 reasons for absence are highest in our 51 to 60 age band with 15 of them in the 51 to 55 band.

Variable Pay

A comparison of variable pay between the first eight months of 2017/18 compared to the same period in the previous financial year has shown a reduction in variable pay of £3.860m. The Welsh Government cap on medical agency and internal cover rates, which came into effect from mid-November, has had little impact on costs to date, however modelling work undertaken indicates savings of around £1.5m in a full year. The non-medical variable pay spend reduction has been driven by reductions in agency and overtime expenditure.

6.2 Workforce Risks and Challenges

Recruitment

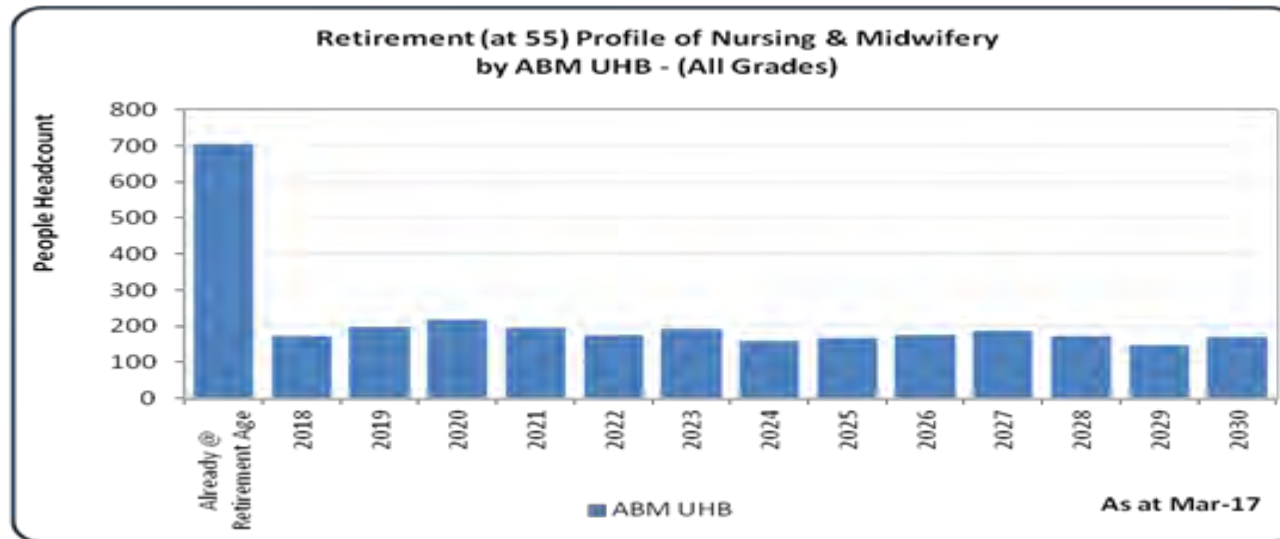
We have a significant number of vacancies across all staff groups, particularly nursing, and medical and dental staff. This position is a core driver of our deficit financial position and leads to higher levels of variable pay, particularly in inpatient areas. The Health Board has vacancies for a number of other staff groups including Allied Health Professionals 36wte, Healthcare Scientists 7wte, and Additional Professional and Scientific at 32wte. We also experience difficulty in recruiting domestic staff. In addition, GP vacancies along with the age profile is having an impact on the sustainability of GP practices. As a result, the number of practices is likely to reduce by 5% from the 2017/18 baseline position of 73 practices.

The full extent of the UK's withdrawal from the European Union (EU) for its current EU staff and future recruitment is also unclear at this point. The Government published a policy paper in June 2017 setting out its proposals to secure the rights of European workers post exit from the European Union. However, these are only proposals at this point and are subject to agreement with EU member states.

Retention

As we can see from the workforce analysis section, turnover for our registered nursing workforce remains the highest of all our staff groups. The Health Board has undertaken overseas recruitment to support nurse recruitment however; attrition of EU nurses is around 48%. Attrition rates for this staff group have largely been impacted on by the NMC requirement to achieve level 7 in the English Language Test (IELTS). Despite some of the challenges of overseas recruitment, if the Health Board had not engaged with this recruitment we would have over 100 additional nurse vacancies. The turnover of our workforce is also exacerbated by the age profile. An analysis of leavers for nurses by length of service demonstrates the highest proportion of leavers are those with 30 or more years of service. The second highest rate of leavers are those with one year's service or less.

The graph below shows the number of the current nursing workforce that the Health Board would lose each year if nursing staff retired at the age of 55. In addition the age profile of nurses in GP practices is of concern, 60% of this current workforce is aged 45 or over. Our plans for reducing this level of turnover are set out later in the chapter.



Source: Age retirement tool WEDS

Sickness Absence

The table below highlights that the last quarter has been poor in terms of seeing any improvements, with performance stagnating and in October worsening. The table below is based on our Annual Plan 2017/18 target trajectory. Unless we see a marked improvement in performance through the winter compared to last year we will fall short of the 5% recovery and sustainability target by between 0.25% and 0.5%. Our actions to support staff health and wellbeing and manage sickness absence are detailed in our workforce and OD plan below.

	Projected end of March 2017 position	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Target	5.7	5.65	5.6	5.55	5.5	5.45	5.4	5.35	5.3	5.25	5.25	5.2	5.15
Actual	5.7	5.65	5.59	5.54	5.53	5.54	5.54	5.56					

6.3 Organisational Development and Workforce Plans for 2018/19

The high cost of agency and locum staff is a key factor driving the Health Board's overspend, as well as affecting the quality of our services and is therefore a focus of our Workforce Delivery Workstream within the Recovery and Sustainability programme. Three projects exist within the Workforce Delivery Workstream including Employee Health and Wellbeing, Premium Cost, and Improved Rostering. In developing our strategic workforce plan, we recognise that we need to address these immediate challenges and stabilise our workforce through ongoing recruitment and retention to reduce vacancies in key clinical areas; roster effectively and ensure that job planning meets the needs of our services; manage sickness absence effectively and redesign our workforce to support service redesign.

In addition, there is a Workforce Redesign workstream of clinical staff, which aims to undertake a baseline assessment by profession or service against benchmarks and scope robust service models, which are sustainable. The specific workforce redesign plans for each targeted Intervention area are included in the Service Improvement Plans.

The following sections provide more detail on our plans to deliver a fit-for-purpose workforce model across the full breadth of the factors which affect our sustainability.

6.3.1 Organisational Development Plans

Embedding our Values

The Embedding our Values Programme is essential to support a number of key areas including recruitment, retention and engagement and is connected to other work, within Learning and Development, Staff Experience, Staff Well-being and

Organisational Development. As well as on-going work to listen to and act on the experiences of staff, work is ongoing to embed values and behaviours into the way we work and our systems and processes. We are further developing:

- Values-based recruitment after a successful pilot project within the Mental Health and Learning Disabilities Delivery Unit.
- Working with delivery units on the results of the 'In Our Shoes 2017' Staff Survey, to develop clear plans to act, engage and communicate with staff.
- Undertaking listening sessions with departments to understand issues and produce ideas for improvement and feedback for action planning.
- Planning Team Climate and Culture Sessions across delivery units to understand any bullying within the workforce and to support the delivery units to action plan and develop any interventions that may be required.

Staff Experience

As part of our Values programme 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 March 2017, we launched our Staff Experience Strategy "In Our Shoes: Creating Great Staff Experience at ABMUHB", setting out 5 goals to improve Staff Experience:

- **Ensuring every role counts, through clear goals and purpose**
- **Listening to our staff and enabling involvement in decision making**
- **Valuing and appreciating our staff**
- **Delivering great leadership, management and team work**
- **Promoting healthy workplaces and wellbeing services and initiatives**

Our actions and priorities include:

- Staff Recognition Programme, including long service awards, patient choice awards, and staff recognition events. Thanking individuals and teams through a range of events led by and organised by the Service Delivery Units and Corporate Departments.
- Promote the importance of creating an inclusive working environment to support every staff member to bring their whole self to work. We will continue to be a member of the Stonewall Diversity Champions Programme (Britain's leading best practice employers' forum for LGBT+ equality, diversity and inclusion)

In recognising the impact of listening to staff on their satisfaction and engagement, we plan to take the following actions:

- Use our Values-based 'in our / your shoes' listening model as our approach to engage with and listen to staff's feedback and ideas for improvement. This will be embedded through our Service Delivery Units and role modelled by leadership teams and departmental managers, with a focus on visible leadership
- Develop enhanced working with staff side colleagues through listening into action workshops with Executive Team and Triumvirate Leadership Teams.
- Identify and address priority areas across the Health Board to listen to staff through Team Climate Culture Tool, as appropriate. Local and national Staff Survey results will be used to identify priority areas.
- Increase frequency of e-bulletins to all doctors from the Medical Director
- Creation of an e-bulletin to all staff (including doctors) from CEO office
- Use the results of the Medical Engagement Scale to learn and improve
- Review and evaluate our values-based induction arrangements and follow-up with staff 3 months into post to understand their experiences
- Continue to roll-out an annual Values Survey with the results from the initial survey in 2016 used as the base-line measure.

Implementing our Nursing and Midwifery Strategy 2017-2020

Our Nursing and Midwifery Strategy 2017/20 is strongly influenced by The Code (Nursing and Midwifery Council, 2015) and our values, meets the Health Board's overarching strategic aims and plans and is linked to and underpinned by our OD plan and approach. The Strategy describes an ambitious programme to provide patients with safe, effective, compassionate and dignified care in an environment which supports professional and career development for nurses, midwives and healthcare support workers. It is embedded below.



Nursing
Strategy_Final.pdf

The three- year strategy is strongly influenced by The Code (Nursing and Midwifery Council, 2015) and "Our Values " and meets the Health Board's overarching strategic aims and plans. Feedback gained at the nursing and midwifery engagement events are categorised into six themes within the strategy document:

- Professionalism, voice and leadership
- Workforce and Education

- Quality and Safety of Care
- Research, development and innovation
- Informatics
- Promoting population health and well-being.

The Year 1 Outcomes that we are working on in 2018/19 are shown below.

	Year 1	Year 2	Year 3
Professionalism, Voice and Leadership	50% of Ward sisters will adopt the supervisory role in Acute Medical and Surgical in-patient wards. 90% of qualified nurses will receive clinical supervision. To ensure there are sufficient mentors for pre-registrants, a review will be completed to identify the number of nurses and midwives who have completed a mentorship programme followed by annual updates.	75% of Ward sisters will adopt the supervisory role in Acute Medical and Surgical in-patient wards. 90% of nurses 1 - 10 years post registration will receive clinical supervision. Based on recommendation of the previous year's review, prepare a work plan to implement recommendations.	90% of Ward sisters will adopt the supervisory role in Acute Medical and Surgical in-patient wards. 90% of nurses 10+ years post registration will receive clinical supervision. Implement the actions in the previous year's work plan.
	Student Evaluation: We will liaise with the University Nursing and Midwifery Education Leads to ensure a robust process is in place to ensure student evaluation is used to acknowledge good practice and to ensure students are adequately supported and enjoy a good quality learning experience in every placement.		
Workforce and Education	100% of nurses and midwives who leave within 1 year of employment will have exit interviews completed. Sickness rates should meet the Staff and Resources requirements set in the Health and Care Standards 2015.	100% of nurses and midwives who leave within 1 to 5 years of employment will have exit interviews completed.	100% of nurses and midwives who leave within 5 to 10 years of employment will have exit interviews completed.

	Year 1	Year 2	Year 3
Research, Development and innovation	Scope research currently being undertaken by nurses and midwives: • Masters Degree • PhD / Professional Doctorate Provide University-led engagement events to promote scholarship and research among nurses and midwives. Put the patient/service user at the heart of new knowledge creation by ensuring that nurses and midwives select research topics relevant to the needs of the service, providing direct benefit of health and wellbeing.	Ensure that nurses and midwives who receive funding to undertake a research degree share their findings verbally to their manager and peers and provide an electronic copy. Increase the number of nurses and midwives writing and publishing their research in professional and academic journals. Provide University-led opportunities for nurses and midwives to present their research findings.	Increase the number of nurses and midwives submitting bids for external funding as a principal investigator or member of a multidisciplinary team. Include the patient/ service user in the co-production of new knowledge creation by promoting public involvement and engagement in research.
Promoting Population Health and Wellbeing	90% of newly qualified nurses will receive a "de-brief" and opportunity for reflection following involvement in a critical incident. Influenza Immunisation: At least 50% of front-line staff will receive the influenza vaccine. At least 75% of priority groups will receive the influenza vaccine.	90% of nurses 1 to 10 years post registration will receive a "de-brief" and opportunity for reflection following involvement in a critical incident.	90% of nurses 10+ years post registration will receive a "de-brief" and opportunity for reflection following involvement in a critical incident.

ARCH

Through the ARCH programme, which is detailed in **Appendix 2**, a number of measures will be implemented across the region to address immediate workforce challenges to re-orientate the education system to deliver a workforce with the right skills to deliver next generation healthcare. Some of the next priorities for the program include;

- Faster implementation of new optimal and electronic rostering systems;
- Explore a pan-region programme to improve motivation & decrease unwarranted absence;
- Explore establishment of regional nursing bank which aligns to the recommendation from the independent review into NHS Wales workforce; and,
- Train future doctors, through the Graduate Entry Medicine (GEM) where graduates can be ready to work in the NHS in 4 years.

Leadership and Teams

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. This is essential to recovery and sustainability, equipping leaders with the tools to engage with staff and have a real focus on improvement. Research suggests that effective leadership is linked to the retention of staff, employee wellbeing and engagement and effective team working; which in turn leads to improved patient outcomes and a positive patient experience.

We need leaders that recognise and are able to address the impact of the changing local and national landscape in which we work and the effect it has on our staff.

In supporting our leaders to develop the required capacity and capabilities, we will take the following action over the next 3-5 years:

- Develop our Board and Leadership Teams within the Service Delivery Units through a targeted leadership development programme
- Establish and embed a master class leadership forum so that leaders from all disciplines and at all levels can come together to learn and share best practice.
- Integrate compassionate leadership into existing leadership development programmes.
- Continue to focus on the importance of leadership behaviours and cultural change through the roll out of 'Foot Prints' (What Impression will You Leave?) People Management Programme. Currently targeted at middle managers; a hybrid programme will be offered to new and existing Consultants, Senior Managers and clinical leaders to commence early 2018.
- Support medical leadership through Academi Wales Medical Leadership Programme and the commissioning of medical leadership development

- Provide leaders and managers with change management skills through the development of a toolkit resource, with particular emphasis on staff engagement, involvement and contribution of ideas through effective listening.
- Grow our leadership talent for the future through the alignment of talent management schemes to our appraisal and ESR processes.
- Involvement in shaping National Talent and Succession Management Framework and Toolkit
- Continued recruitment as part of our Internal Graduate Scheme
- Continued Apprentice Academy events to allow current apprentices to develop behaviours in line with Values and Behaviour Framework and leadership skills.
- Undertake a comprehensive evaluation to identify the qualitative and quantitative impact and confirm return on investment from the actions outlined.

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 (Aston University, 2005). When this is not the case and team working breaks down, the results can be catastrophic, leading to higher patient mortality rates, increased clinical errors, higher cases of stress and anxiety amongst staff, sickness absence and increased staff turnover.

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.

Improvement Skills

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. VBHC and Quality Improvement approaches will be aligned and will be delivered through:

- Our Quality Improvement (QI) approach, targeting levels of knowledge of and skills with improvement concepts, methods and tools through a variety of delivery mechanisms
- Building general awareness throughout all our roles, culminating with identified individuals with QI and VBHC expertise who can guide leaders in testing new ideas and supporting teams with implementation and spread.

This approach will be fully aligned with the leadership development approach and culture through a more integrated people development strategies and encompassing learning programmes. Spreading success and learning will also be the focus of the Quality Improvement Team, with the support of the VBHC lead, supporting the staff engagement agenda.

Health and Wellbeing

Staff health and wellbeing will continue to be a priority and a focus of our Recovery and Sustainability Programme and a specific project within the Workforce Delivery Workstream. Our focus will be on improving access to health and wellbeing services in a timely manner, enable managers to recognise and support staff with mental health and stress and improve occupational health referral and service processes to support a return to work. We will do this through the development of a 'Staff Wellbeing Advice and Support Service' which will provide 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 will utilise the experience and expertise of the Wellbeing through Work team, along with Occupational Health Nursing and Counselling and will provide staff with a breadth of professional advice and support aimed at supporting health and wellbeing in the workplace and a return to work if absent from work. The service will be partially funded through Welsh Government Invest to Save funds and the future delivery of this model will be dependent on continued funding through Invest to Save monies.

Additionally, other services and interventions are being developed with a focus on mild-moderate mental health problems (stress, anxiety and depression) due to this being the main reason for staff taking long term sickness absence. These include The Wellbeing Champion Network as this has proven to be successful to date with 150 Wellbeing Champions having been trained and the concept being accepted as a Bevan Commission Exemplar. The Wellbeing Champions receive additional training in order to 'signpost' colleagues to staff health and wellbeing services and to promote related campaigns in their workplace and we aim to support every department and service in the Health Board to ensure they have their own Wellbeing Champion.

In order to enable line managers to support the wellbeing of their staff, we will develop training for managers to enable them to use the Health and Safety Executive Stress Management Standards in the workplace. This will increase the confidence and enhance the skills of managers to assess, manage and monitor stress in the workplace and will contribute to the Health Board's plans to promote wellbeing in the workplace and reduce sickness absence. The promotion of mental health in the workplace will be enhanced through working closely with related organisations and the work of Time to Change Wales will be integrated within the organisation to aid reducing stigma and discrimination related to mental health in the Health Board. We also continue to deliver a number of initiatives aimed at addressing stress, anxiety and depression including Schwartz Centre Rounds®, Lighten Up and Stress Awareness sessions, supporting Delivery Units in their bespoke staff-wellbeing plans and the annual 'Wellbeing Week'. New, evidence based initiatives and programmes that may help us meet the challenge of supporting staff emotional health and wellbeing will be explored and considered as part of the ongoing plan to improve services for staff.

Occupational Health services will be developed to include a more multidisciplinary approach using Allied Health Professionals to undertake related work and the Health Board aims to develop an electronic staff Occupational Health record to improve efficiencies and reduce waiting times for staff. The Health Board achieved revalidation of the Gold Corporate Health Standard in 2016 and a plan will be developed to assess our organisational readiness for the Platinum Award. All of this work is being undertaken within the context of our values and behaviours programme.

Flu Immunisation

We are committed to ensuring as many staff as possible receive the flu vaccine and each year the Health Board has consistently improved its vaccination rate, resulting in 57.4% of front line staff being vaccinated in 2016/17, exceeding the Welsh Government Tier One target of 50%. We will continue to build on this success with a focused six week campaign aimed at promoting the vaccination to staff using an extensive social media campaign, professional leadership and a network of over 120 Flu Champions and hope to exceed the Tier One Welsh Government target year on year.

6.3.2 Workforce Plans

Implementation of the Nurse Staffing (Wales) Act (NSA)

The Health Board has established a task and finish group to monitor the implementation and the organisation's requirements under the Nurse Staffing (Wales) Act. A baseline review has commenced to enable the Health Board to meet its responsibilities under the Act. This has entailed looking at the current position and approach across all Service Delivery Units for calculating and reporting nurse staffing requirements and Levels. The baseline review has identified 20 ward areas that meet current reporting requirements within the guidance definition and established a clear methodology and recording structure to support future reporting responsibilities. The Task and Finish group will develop systems and processes to capture data required by the Act and ensure that there are robust workforce plans, recruitment strategies, and structures and processes in place to ensure appropriate nurse staffing levels across the organisation. No monies are included in our financial plan as our assessment shows that we are broadly compliant with the CNO Guiding Principles of the NSA.

The actions that have been completed in preparedness for the Act are as follows:

- ✓ **Representation** on the all-Wales Nurse Staffing Group and its sub groups.
- ✓ Contributed with the work undertaken at an all-Wales level on Acuity levels of care.
- ✓ **Undertaken** a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted.

- ✓ **Presented** a Health Board position status paper to the Development Board in December outlining the preparedness for the Nurse Staffing Act (Wales).
- ✓ **Conducted** a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce & redesign, training and development.
- ✓ **Designed** a Health Board reporting template and risk assessment which has been completed by the Service Delivery Units, to assess readiness.
- ✓ **Developed** a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience.
- ✓ **Provided** acuity feedback sessions to all Service Delivery Units included in the June audit.
- ✓ **Representation** in the recent All-Wales Nursing Conference.
- ✓ **Hosted** an evening seminar event in Moriston's education centre in conjunction with the Royal College of Nursing (RCN).
- ✓ **Formally** launched the Nurse Staffing (Wales) Act Guidance.
- ✓ **Raised** the issue regarding IT barriers around the capture of data required for the Act on an All- Wales and Health Board basis.
- ✓ **Distributed** the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads.
- ✓ **Confirmed** the clinical areas that fall within the Act and that are to be reported to Welsh Government.
- ✓ **Produced** an Establishment review and GAP analysis of reporting wards.
- ✓ **Produced** an Operational framework and escalation plan.

In addition we have planned the following next stages in preparation for the Act:

- **Implement** mobile devices to be used within adult acute medical and surgical wards included within the Act.
- **Engage** with the Stakeholder reference group regarding informing patients.
- **Prepare** for the requirements needed to implement the Act within paediatric services.
- **Transfer** clinical nursing areas to electronic rostering.
- **Provide** the Board with first bi-annual report due April 2018.

The Chief Nursing Officer for Wales has also issued interim District Nurse (DN) Guiding Staffing Principles which follow on from the work the Welsh Government committed to in the Nurse Staffing Levels (Wales) Act 2016. Assessment from the All Wales Nurse staffing review used to shape the interim District Nurse (DN) guiding staffing principles has highlighted that ABMUHB has a lower number of DN staff per population than many other Health Boards, at the second lowest in Wales. However this is contrary to the Capita report commissioned by Western Bay and requires more analysis. ABMUHB is in a positive position in achieving some

aspects of the DN staffing principles however, there remains considerable work to do, using a Value-based approach to making the best use of our resources.

Recruitment

As indicated, recruitment and retention is a challenge. However, the Health Board has set a target to reduce current vacancies by 5% for each staff group in year and turnover from the March 2018 baseline figure. Recruitment and retention of our nursing workforce will also be promoted through our Nursing and Midwifery Strategy.

To support the reduction in vacancies the Health Board is continuing with the recruitment of overseas nursing staff. There are currently 107 overseas nurses working within the Health Board. Of these, 71 are working as Registered Nurses whilst the remainder await registration with the Nursing and Midwifery Council (NMC) and/or achieve their English Language Test (IELTS). In addition a further 8 are expected to start in January 2018, and 9 in February/ March 2018. In addition to overseas recruitment the Health Board has arranged a number of in-house recruitment events which have resulted in the employment of nursing staff and further events will be held in 2018.

The Health Board is also supporting a number of flexible routes to nurse registration. Currently, 11 Health Care Support Workers (HCSW) have been recruited to a part time degree in nursing which commenced September 2017. The new registrants will be expected to work within the Health Board for four years after qualifying. Thirteen Healthcare Support Workers have also been successful in gaining places on a 2 year Masters programme. Eight HCSW with overseas registration are commencing a programme developed with Swansea University to become registered nurses in the UK. If this programme evaluates successfully other HCSWs will be offered the same opportunity.

The Health Board has also pursued a variety of alternative options for the recruitment of medical staff from overseas including participation in the British Association of Physicians of Indian Origin (BAPIO) recruitment scheme to source more doctors in India. We have so far appointed 50 doctors from this initiative. The Health Board is due to participate in a second BAPIO recruitment initiative towards the end of 2017. Going forward this scheme will be central to our overseas recruitment strategy due to the costs associated with international recruitment.

We know that to underpin this approach we must offer a good experience for all staff and a robust induction, pastoral and mentorship support to introduce the new doctors into the NHS and culturally into a new life in Wales. It is equally important for nursing staff that they have a good experience whilst training with us. The Day Surgery Unit at the Princess of Wales Hospital has recently been honoured with an Excellence award at the Mentor Conference held by the University of South Wales. As a result we

successfully recruit the majority of student nurses from partner Universities who have their clinical placements within ABMUHB. As an organisation it is important that we also recruit staff with the right values and behaviours and as previously mentioned we are piloting values based recruitment.

The Health Board is also heavily involved in the Welsh Government initiative of promoting Wales as the place to work through the slogan 'Train, Work, Live.'

Schemes to support other staff recruitment include a fast track Associate Audiology Scheme which encourages individuals with a scientific background to become Associate Audiology Practitioners who can undertake a range of basic audiology tasks in a short period of time to help alleviate the increased demand on this professional group. We are also pleased that the new National Imaging Academy will be open in 2018 to train the next generation of radiologists and imaging professionals in Wales. In common with all other Health Boards, this is a current area of shortage for us.

A Recruitment Strategy is in development as part of the Recovery and Sustainability Programme.

Retention

Retaining our nursing staff is a particular challenge as outlined previously. There are a number of reasons for this including the age profile and the buoyant job market which enables nurses to move much more freely than in the past.

Due to this we are taking the following actions:

- Analysis of leavers' data, particularly those in the first 12 to 24 months of commencing employment to identify hotspot areas.
- Based on the outputs of the analysis design and run some focus groups in order to identify particular issues leading to unintended turnover.
- 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.
- Development of a revised exit interview questionnaire and process aimed purely at the nursing workforce. This will assist in the production of more robust data regarding nurse leavers.
- Revision of the Retire and Return policy to enable individuals to continue working after "normal" retirement.
- Due to NHS pension changes, we are in the process of completing the Working Longer assessment tool (developed by NHS Employers). This will help us to identify further initiatives to assist people to stay working for longer.

A number of initiatives are being implemented to support retention for nursing staff including embedding our values and behaviours into the way we work, an increase in the number of exit interviews with leavers, improvements to the clinical supervision programme as detailed in the Nursing and Midwifery Strategy. In addition the retirement policy is being maximised and its application monitored to encourage retire and return especially in relation to nursing staff.

To support GP retention, a Primary Care Academy within Swansea University will be developed through ARCH, to reinforce local recruitment and longer term retention.

Sickness Absence Management

Our Delivery Units have individual sickness absence management action plans aimed at reducing sickness to 5%. To date we have developed and implemented a number of actions 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, and training and development. However the majority of this activity has been focussed on the management of sickness and if we are to sustain improved performance in this area we need to shift the emphasis to preventing sickness which will require more cultural change interventions.

To assist in this we have implemented a Staff Experience strategy in line with our values programme. There is significant evidence to suggest that an engaged workforce will be more productive and effective and will generally experience lower levels of absence due to sickness. It is for this reason that the effective implementation of the Staff Experience Strategy is key to the prevention of sickness within ABMUHB. The strategy sets out a number of key actions under each goal and one of the measures of success will be the impact on sickness absence.

We are currently developing interventions that promote 'upstream' preventative approaches to staff health and wellbeing highlighted in the Health and Wellbeing section above. Additionally we are looking at some other longer term interventions that could be considered for further investigation and implementation. The evidence base of these approaches will be reviewed along with the cost/benefits of such models.

- Development of a single point of access for managing staff sickness absence which supports staff from day one of their sickness, signposts them to relevant intervention services at the earliest opportunity and ensures the sickness absence policy is followed.
- The work of our Invest to Save Team has demonstrated that a multi-disciplinary approach to managing the Health Board's 'Hotspot' sickness areas has resulted in reductions in long term sickness absence. This approach could be developed and

enhanced to include the addition of Occupational Health alongside HR, Physiotherapy and Occupational Therapy colleagues to support long term sickness absentees' and those at risk of becoming long term sickness absentees'. This approach will be 'tested' as a pilot to develop the evidence base for an 'investment on return' model through the realisation of reduced sickness related costs.

Reducing Variable Pay

In addition to redesigning our workforce we must ensure that we are maximising the efficiency and productivity of our current workforce. The Health Board has set a target of reducing variable pay by 10% in year from the March 2018 baseline figure.

Due to the difficulties in filling medical and nursing vacancies, variable pay has increased, and reducing this is a key work stream of the Recovery and Sustainability Programme not only to improve the Health Board's financial position but also to improve the care that we provide to our patients. We have two projects within the Workforce Delivery Workstream designed to reduce variable pay and improve rostering practices. The Health Board has undertaken a number of measures which will support recovery and sustainability and include:

- Job planning for productivity and the roll out of E-job planning to improve reporting and compliance.
- Review of Junior Doctors rotas with the aim of reducing reliance on agency staff.
- A work stream has been established to digitise the management of all leave taken by medical staff to ensure effective planning and minimise the need for cover.
- Undertaking a review of annual leave calculations for medical staff who work a compressed week and setting a financial cap on medical study leave.
- Developing a framework of internal locum rates dependent on speciality and intensity to reduce internal competition and inflated rates of pay.
- Implement the All Wales agency caps for internal locums and external agency locums on an all Wales basis.
- Working with Medacs through its Vantage and Direct Engagement models which has improved the supply of external medical locums in most areas, and in some cases they will source permanent recruits subject to a finding fee. A further work programme is now being planned which may involve the creation of a Medical Bank.
- The Health Board has undertaken a programme of work to improve the efficiency of nurse rosters in addition to ensuring tighter control measures in the use of bank and agency staff.
- Completion of an agency monitoring diagnostic tool to develop an action plan on the use of the tool, scope, objectives and Key Performance Indicators.
- In order to improve the number of registered nurses who join our bank, a number of options are being considered to incentivise joining as part of our Recovery and Sustainability work.

- A series of bulletins, advice and guidance will be issued to reduce the timescales for recruitment. Additional support will be provided to the worse performing areas.

The Health Board has updated the Nurse Roster Policy in line with recommendations from the Carter review and developed a framework to monitor performance.

Service Redesign

Our historical approach to service change, which required the recruitment of additional nurses or doctors, is no longer an option. 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 whilst implementing our Evolving Service Model.

The Health Board has made significant improvements in patient flow and length of stay, which has resulted in the reduction of non-mental health beds on a temporary basis subject to pending engagement/consultation. A further programme of Capacity Redesign is underway which will involve a further substantial number of acute beds across acute and community sites. In addition, the standardisation of some of our community and intermediate care services, alongside service improvement will increase capacity within the community so that we can shift our service model closer to home.

Alongside changes to secondary and primary care, the Health Board has been undertaking work to redesign Older People's Mental Health Services to rebalance inpatient services to a community-based service.

The service changes included in our Annual Plan will not only affect the workforce configuration in terms of numbers and location, but will also allow us to redesign our workforce as detailed below. The net effect on our vacancy gap is included in our technical workforce plan. The remodelling of services could release upwards of 100WTE posts to help fill some of our vacancies.

It is unclear what impact the proposed Health Board boundary changes could have on healthcare services being delivered within Bridgend subject to the outcome of the extant public consultation. Our technical workforce plan therefore assumes the status quo at this stage.

Workforce Redesign

Workforce redesign is critical to support the redesign of our services and our recovery and sustainability programme. One of the projects within our Recovery and Sustainability programme focuses on redesigning our clinical workforce to improve operational productivity and performance by optimising the role of our nursing, scientific, therapeutic and technical staff.

We will achieve this through systematic workforce planning across professions to support efficiency, sustainability and reduce spend. Examples include reporting radiographers in radiology, reporting biomedical scientists in histology and the development of multi-disciplinary teams to support general practices. Further detail is contained in the sections below.

Redesigning the Primary Care Workforce

Within the Health Board's Primary and Community Strategy 2017/2022, workforce redesign is a key driver to support service redesign. The strategy looks 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. The Primary and Community Services Strategy which has been developed to help sustain and support service delivery is detailed further in **Appendix 2**.

There has already been significant workforce diversification including Cluster Network-based pharmacists, pharmacy technicians, physiotherapists, mental health counsellors and primary care audiology services. Going forward the strategy highlights further workforce redesign to include:

- 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. .
- The development of new Advanced Nurse Practitioner roles and multi-skilled community professionals.
- Further development of Clinical Pharmacists to provide direct support to patients.
- The development of Physician Assistant roles to take on the routine work of GPs.
- The development of the Medical Assistant, an administrative role trained to deal with incoming correspondence usually handled by GPs.
- 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.
- Mobilising the workforce through the use of IT.
- Supporting 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.
- Acute outreach team delivering care at home through GP's and Advanced Nurses.

- Development of Advanced Practitioner Audiologist roles to shift demand from ENT to Audiology.

The Health Board is also working with the care home sector to develop it as a key part of the nursing career pathway, including providing peer and professional support to nurses working in care home. We work collaboratively with Swansea University and support Student Nurse placements in care homes across ABMUHB. Five designated care homes have been supporting two student placements each, however this has been so successful a further 10 homes have been identified to support future Student Nurse placements going forward. Placements within these environments help student nurses form their opinions about career prospects within these organisations.

The Health Board provides a wide range of training opportunities for all care home staff, some examples are Wound Care groups led by the Tissue Viability Nurses, Pressure Ulcer Forums, Immunisation and Vaccination training, End of Life and Frailty in the Elderly and staff are included on all training conferences.

A Western Bay approach working with partner agencies across the area to develop a regional training programme for care homes is being progressed. The registered nurses working in the care home sector have equal opportunity to access evidenced based training, increasing their knowledge and skills which has direct impact on the quality of care provided. In addition ABMUHB Nurses support the professional discussions required for NMC revalidation for care homes nurses.

We are currently looking at ways we can work with and support the care home sector to develop a sustainable approach to recruitment and retention of qualified nurses in the independent sector, implementing a recruitment campaign utilising the HB recruitment events as a platform to raise this profile.

Mental Health and Learning Disabilities

In common with other areas there are recruitment difficulties in mental health and learning disabilities nursing with an ageing workforce. We are using retire and return where appropriate and have a specific recruitment and retention task and finish group. The Health Board has piloted recruitment days using social media and a geographical approach which have been successful with recruitment to 100% of posts and increased RMN and Learning Disabilities nurses onto the bank at the first of these.

We are leading a programme of work on safeguarding that includes a practice development and research theme in collaboration with USW.

To support the programme of change in the Unit a Leadership and Development programme is in place with 23 nurses are undertaking a 18 month leadership programme consisting of a L5 qualification in Leadership and Management via Gower college, a QI project and shadowing senior team.

Developing New and Extended Roles

The Health Board has developed a number of new and extended roles in a range of areas, and continues to look to develop such roles to align available resources for maximum impact, and ensuring 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, in addition to primary and community services, and include:

- Consultant pharmacist roles in a number of key areas such as unscheduled care, antimicrobial prescribing and cancer care, which will promote innovation and support prudence forging links with the University.
- 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.
- Six Physician Associate students, who have undertaken their second year training within the Health Board from Worcester University, have been offered a one year internship. In addition the organisation is supporting the training of Physician Associate students from Swansea University via the ARCH Programme.
- 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.
- Two fast track trainees have been employed within Audiology, who will qualify as Associate Practitioners after 2 years.
- Utilising Advanced Biomedical Scientist roles in place of difficult to recruit Consultant Pathologists.

Redesigning the Non-Registered Workforce

A significant amount of care is delivered by our non-registered workforce. During 2018/19 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:

- Band 3 and 4 roles have been developed with additional competencies to provide continuing care packages to children in the community.
- Health Care Support Workers are being developed in line with the Health Care Support Worker Framework.

- Supporting Pharmacy Assistants and Technicians to achieve NVQ level 2 and 3.
- 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.
- Development of a generic nursing/therapy Health Care support Worker role.
- Increased use of band 4 Associate Practitioner roles in place of qualified Biomedical Scientist.
- Medical Assistant/Care Navigator role developed to support GP practices.
- Supporting HCSWs in GP practices to undertake the QCF level 3 qualifications.

Volunteering Strategy 2018 - 2021

Our vision is to transform the way volunteers contribute to the Health Board. Volunteers will contribute in mutually beneficial ways that improve the experience of people using our services, improving the health and wellbeing of our communities. The strategy has been developed co-productively with each goal and priority shaped by volunteers and employees throughout the Health Board. Our Volunteering Strategy Group will continue to be central to shaping how we deliver the strategy.

Our three year strategy has four strategic objectives;

Goal 1 - To embed a leading, innovative and positive volunteering culture within the Health Board

Goal 2- : To grow volunteering by inspiring more individuals from our diverse communities to participate

Goal 3 – To enhance the volunteer experience

Goal 4 – Develop collaborative partnerships to improve outcomes through volunteer activity.

Training and Development

We are facing a different future in terms of demographics within the Health Board 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 behaviours, what motivates employee engagement and the tools and practices 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 and recruitment. It is crucial that workforce planning is considered broadly and 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. This will include

- Continuation of partnership working with local further education providers to (where possible) support joint roles for the delivery of projects.
- Work with ARCH and Regional Learning Skills Partnerships to influence the regional learning agendas.
- Engagement with local communities including those who are known as difficult to reach to showcase opportunities within the Health Board.
- Engagement and partnership working to provide opportunities to 'Talent Bank' students.
- Widening our work experience programmes.
- Continue to work in partnership with Swansea University to develop the role of the Physician Associate.
- Further development of our Adult Vocational Training Contracts, Traineeships and Engagement contracts. Working with partners across the public and third sector to engage our local communities. Those successfully completing at least 9 months of their programme will be given guaranteed interview on application for apprentice roles.
- Further develop and embed our 'Apprentice Academy'. Offering opportunities for those wishing to pursue a different route to a career within the Health Board. Working with services to identify opportunities for apprenticeships and to map pathways of development. Develop procedures to ensure that apprentices successfully completing at least 9 months of their programme will be given guaranteed interview on application for appropriate Agenda for Change roles or higher level apprenticeships.
- Development of higher level apprenticeships with the support of partners.
- Continued commitment to the Welsh Government Lift Scheme. Those successfully completing their programme will be given guaranteed interview on application for apprentice roles.
- Further development of the Health Board internal Graduate Scheme with cohorts being recruited on an annual basis.
- Involvement in the launch of the new 'Public Services Wales Graduate Scheme'
- The development of part time study and flexible routes into universities.

The development of these external entry 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.

6.4 Welsh Language

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 Strategy and its action plan will help mainstream the Welsh language into all of our internal processes.

Through our plan we will offer appropriate training, guidance and support for members of staff in relation to the development of Welsh language awareness and skills, initially targeting such resources to areas of greatest need. We will utilise our workforce planning processes, to ensure that future employees have the skills necessary to deliver a quality and professional bilingual service or are willing to work towards development of such skills.

Our scheme also provides guidance to ensure future recruitment processes develop bilingual capability within the workforce we employ. This will ensure we build upon current bilingual workforce numbers to seek to meet the needs of our service users. The implementation of the action plan associated with the Bilingual Skills Strategy is monitored via an annual report to the Health Board's Workforce and Organisational Development Committee (WOD) with a progress update at each meeting.

6.5 Equality

The Health Board has taken a different approach to our second Equality Plan mirroring the approach taken to develop the Welsh Government Strategic Equality Plan 2016-2020. The ABMU University Health Board Strategic Equality Plan 2016-2020 is purposefully strategic and sign posts to the range of specific activities that will help to deliver our Equality Objectives which were refreshed using engagement and firm evidence in 2016. The high level actions to drive forward progress towards achieving them 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.

The use of technology through high quality workforce systems will be a crucial element in the delivery of this plan. In order to ensure that we have the data to enable us to workforce plan, evaluate our progress and roll out specific projects staff will be

supported to access the Electronic Staff Record. In order to ensure that we are meeting the needs of the different generations within the workforce we will develop our use of technology to:

- deliver learning interventions (working with national partners)
- use social media as a way to engage staff
- explore the use of apps and videos.

We note the overall need to improve workforce productivity through performance management to meet our targets:

- 85% of staff with completed quality Personal Appraisal Development Reviews (PADR)
- 85% of staff compliant with the UK Core Skills Mandatory Training.

The Health Board is on course with medical appraisal arrangements and revalidation in secondary care and work has begun to embed values into the appraisal process. Around 90% of our doctors have been appraised in the last 12 months and it is anticipated this rate will be maintained going forward.

6.6 Working Longer

NHS pension changes introduced in April 2015 aligned the normal pension age with the state pension age. This means that the majority of our current workforce will have an increased retirement age of between 65 and 68. A local Working Longer Group has been established to work in conjunction with the Working Longer Steering Group (Wales) to raise age awareness and develop an action plan to address the issues identified.

The Group's purpose is to assess organisational readiness in relation to age awareness by completion of the organisational readiness tool. This required an analysis of current practices in the following broad areas:

1. Age profiling
2. Workforce and service planning
3. Employment policy and practice
4. Occupational health, safety and wellbeing
5. Job design and the working environment
6. Pension education and retirement planning
7. Learning and development

8. Staff experience

The completed readiness tool will inform the development of an action plan which will identify areas of development required to mitigate risk around the working longer agenda. The action plan will address how the organisation will:

- Raise and maintain age awareness with managers.
- Engage widely with the organisation in terms of age awareness.
- Develop and implement tools, training and approaches to ensure service managers understand and manage the implications for their service.
- Develop and implement tools to enable staff to be proactive in managing their careers and their health and wellbeing and support them to be able to work longer.

6.7 Workforce Plans Summary

The workforce agenda continues to be challenging for the Health Board and will require a significant amount of transformational change in the coming year, linked to our Recovery and Sustainability Programme. We want to equip our leaders with the OD skills to manage and embed the changes that we are supporting which include; redesigning the workforce to support the movement of our services closer to home, ensuring that we work in an integrated way across health and social care and developing the non-registered workforce across the sector. We will ensure that we recognise the importance of health and wellbeing of our staff throughout these significant changes.

A summary of our workforce plans for 2018/19, to support the achievement of our corporate objectives and the Recovery and Sustainability programme is included in the table below.

Aim	Measure	Actions
Embedding our Values & Behaviours to Support Recruitment, Retention and Staff Experience	Improvement in our overall engagement score	• Ensure the values programme is connected to other work within Learning and OD, Staff Experience and Well-Being through work. • Embed values and behaviours into our systems and processes such as; values based recruitment, induction, consultant appraisal and PADRs. • Following our 'In Our Shoes 2017' Staff Survey, we will develop clear plans to act, engage and communicate with staff. • Delivering Team Climate and Culture Sessions across delivery units to understand bullying within the workforce and support delivery units to action plan and develop interventions. • Develop value-based compassionate leadership capabilities.

Aim	Measure	Actions
Increased Recruitment	Vacancy levels reduced to 5%	• Increase the number of students in relevant health and life science courses through the ARCH Skills and Education Programme. • Maintain focus on recruitment through local and overseas recruitment campaigns for nursing and medical staff. • Participate in the BAPIO scheme to recruit medical staff from India. • Support the Welsh Government initiative “Train, Work, Live” to recruit medical and nursing staff. • Offer NVQs, apprenticeships and traineeships across the Health Board. • Support HCSWs to train flexibility to become registered nurses. • Support HCSWs with an overseas registration to become registered nurses in the UK. • Participate in the student streamlining project for nurses which offer students a job in their second year. • Provide an excellent mentoring experience for student nurses. • Develop and implement a Recruitment Strategy as part of the Recovery and Sustainability Programme. • Implement the Nursing and Midwifery Strategy 2017-2020 • Implement innovative ways to support recruitment such as the Associate Audiology scheme.
Improved Retention	Turnover reduced from 2018 baseline figure	• Increase the numbers of nurses receiving clinical supervision to achieve a target of 90%. • Implement rotational programmes to enhance skills, experience and learning. • Undertake exit interviews for nursing staff leaving within 12 months of joining the organisation and increase this for staff with 1 to 5 years by year 2 and 5 to 10 years of employment by year 3. • 90% of newly qualified nurses will receive clinical supervision. • Implement our plans to ensure Ward sisters can fulfil their supervisory role. • Participate in the development of a Primary Care Academy with Swansea University through ARCH to support the recruitment and retention of GPs. • Provide a good induction; pastoral and mentorship care for medical staff. • Working Longer Review -Implement the working longer readiness tool and develop an action plan in response to the outcomes to support staff to work longer. • Maximise the retire and return policy and monitor usage especially for nursing staff. • Monitor our Staff Experience Strategy. • Improve PADR and Mandatory training rates.
Reduced Sickness Absence and Increased Health and Well Being	Sickness absence levels reduced to 5%	• Development of a staff Wellbeing Advice and Support Service with a single point of access to provide timely health and wellbeing support. • Training managers to make early-intervention reasonable adjustments in the workplace. • Training to help managers engage with staff more effectively in relation to stress and mental health at work with the view of reducing related sickness absence. • Further development of the Wellbeing Champion role to support teams with increasing awareness of Staff Health and Wellbeing support, ensuring early intervention and health promotion in the workplace • Supporting the Delivery Units and local services and teams in Wellbeing and health promotion initiatives.

Aim	Measure	Actions
		• Developing a more multi-disciplinary approach to the delivery of occupational health services. • Develop a plan to achieve revalidation of the Corporate Health Standard at platinum level. • Exceed the Welsh Government target for the proportion of front line staff who receive the flu vaccine. • Implement Delivery Unit action plans to achieve the 5% sickness absence target.
Enhanced Staff Experience	Impacts on recruitment, retention, sickness absence and engagement targets	• Implement and monitor our staff experience strategy “In our Shoes: Creating Patient Care through Great Staff Experience in ABMUHB” • Continued use of recognition schemes at local and Health Board level. • Utilise Staff Surveys to measure and continue to improve staff experience. • Improve the management and leadership of staff. • Continued membership of the Stonewalls Diversity Champions Programme. • Embed the listening model from our value based ‘In our/your shoes’ model to engage and listen to staff.
Targeted Training and Development	PADR compliance at 85% Increased level 1 competency core skills compliance to 85%	• In line with the Wellbeing of future Generations Act (Wales) 2015 widen access to opportunities in the Health Board through a number of measures. • Develop value based leadership capacity and capability at all levels. • Roll out talent management and succession planning toolkits. • Develop a network of team based working facilitators. • Maintain the 90% appraisal rate for medical staff. • Further develop and embed our Apprentice Academy. • Develop higher level apprenticeships. • Support the public services Wales Graduate Scheme.
Reduction in Variable Pay and Improved Efficiency	Reduction in variable pay by 10%	• Develop options to incentivise bank take-up. • Implement a number of measures to reduce recruitment timescales. • Implement the All-Wales Nurse agency contract framework which reduces the need to use off-contract agencies that are more expensive. • Completion of an agency monitoring diagnostic tool to develop an action plan against each of the components of the tool. • Continue with a programme of work to improve the efficiency of nurse rosters, in addition to ensuring tighter control measures in the use of bank and agency staff. • Review junior doctors rotas, job planning and the medical study leave policy. • Develop a framework of internal locum rates for medical staff. • Job planning for productivity and the roll out of E-job planning to improve reporting and compliance. • Implement the All Wales agency caps for internal locums and external agency locums. • Implementation of vacancy control process to scrutinize applications to advertise posts and revalidation of posts. • Roll out of the electronic nurse documentation across Wales.

Aim	Measure	Actions
Workforce Redesign	Supports recruitment and retention targets and achievement of Operational Plans	• Implement targeted workforce redesign as described in the Targeted Intervention Priority Area Service Improvement Plans • Continue to develop new and extended roles to support workforce shortages and the prudent health agenda. • Redesign the non-registered workforce to support registered staff to work at the top of their license and provide career progression. • Redesign and develop the wider primary care workforce to counter workforce deficits and support the move to providing more services in the community. • Implement a tool-kit that can be used to redesign and plan the workforce in specific areas.

Appendix 7. CAPITAL INFRASTRUCTURE

Work is continuing with the service to identify capital investment priorities for 2021-22 and beyond, taking into account the limited availability of capital resources. An initial assessment of the capital requirements of each of our Service Improvement Plans is included in the Annual Plan document and a draft summary capital programme for 2021-25 is embedded below.

Indicative WG Capital Programme Requirements - ABMU IMTP (One Year Delivery Plan) 2021-22

Scheme	Site	Business Case Approvals	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m	Total £m
Discretionary Allocation	All	Approved	14.618	14.618	14.618	14.618	14.618	73.090
PART A - APPROVED SCHEMES								
1. Health Vision Swansea		Approved SOP						
HVS 1B, Main Entrance & Outpatients	Morr	Approved FBC	0.180					0.180
2. Renal								
Renal Ward Refurbishment	Morr	Approved FBC	0.474					0.474
3. NWIS								
National WEDCIMS	HB	Approved National BJC	0.045	0.270				0.315
4. Implications of the South Wales Plan								
Increase Neo Natal Capacity Singleton	Sing	Approved BJC	5.000	4.710				9.710
SUB TOTAL APPROVED SCHEMES			20.317	19.598	14.618	14.618	14.618	83.769
PART B - UNAPPROVED SCHEMES								

Scheme	Site	Business Case Approvals	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	Total £m
1. Primary Care National Pipeline		Approved						
Penclawdd Refurbishment	HB		0.773					0.773
Murton Refurbishment	HB		0.386					0.386
Bridgend Wellbeing Centre	Bridgend		0.500	1.500	3.000			5.000
Swansea Wellbeing Centre	Swansea		0.250	3.000	6.750			10.000
2. Infrastructure								
Singleton, Cladding	Sing		0.250	tbc	tbc			0.250
Anti-Ligature, Mental Health	HB		1.500	tbc	tbc			1.500
3. Radiotherapy Programme								
Replacement programme for Linear Accelerators B	Sing		4.077	0.023				4.100
Replacement programme for Linear Accelerators C	Sing			4.500				4.500
Replacement programme for Linear Accelerators D	Sing				4.500			4.500
4. Imaging Programme								
National Replacement Programme	HB		3.600	10.196	12.548	3.000	3.000	32.344
5. Informatics Modernisation Programme (SOP)		Approved SOP						
WCCIS	HB		0.865	0.764				1.629
WCP	HB		0.500	0.487				0.987
6. ARCH - Enabling Phases								
Morrison New Road Access	Morr		0.450	0.250	0.075	5.025	5.000	10.800
Land Purchase	Morr		1.200					1.200
7. Environmental Modernisation Programme (SOP)		Approved SOP						

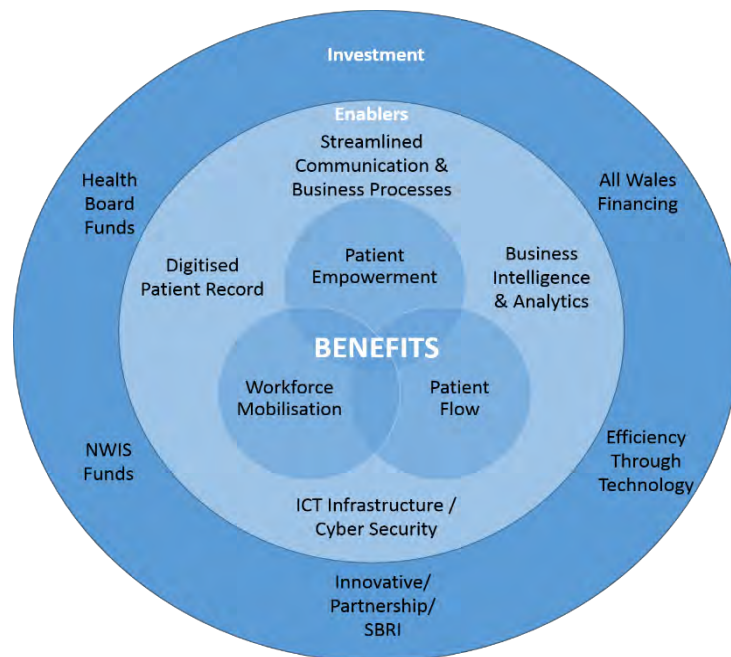
Scheme	Site	Business Case Approvals	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	Total £m
Environmental Modernisation Future BICs	HB		2.000	6.000	6.000	6.000	6.000	26.000
8. ARCH - Main Phases								
Regional Pathology, Morriston	Morr		1.000	3.800	31.980	15.990		52.770
Regional Orthopaedic Centre, Morriston	Morr		0.800	2.100	17.933	8.967		29.800
Large Trauma Unit, Morriston	Morr		tbc	tbc	tbc	tbc	tbc	tbc
Combined Acute Medical Take, Morriston	Morr		0.250	1.750	13.633	27.267		42.900
Reprovide HSDU (allow increase in CC capacity)	Morr				5.537	5.537	5.537	16.611
9. Mental Health - RMHSS/Disposal of Old Cefn Coed		Approved SOP						
RMHSS P3 Acute Mental Health Unit	HB		0.300	1.700	7.500	9.900		19.400
RMHSS P7 Mental Health Day Facilities	Phillips Parade			0.100	1.227	1.327		2.653
10. Health Vision Swansea		Approved SOP						
HVS 1B, Car Park & Regional Entrance	Morr		0.250	1.000	15.750	3.000		20.000
11. Cardiac Centre, Morriston								
3rd Catheter Laboratory	Morr			2.500				2.500
Hybrid Theatre	Morr			3.000				3.000
12. JAG Accreditation (Endoscopy) Programme								
JAG Accredited Scoping Suite	POW			1.500				1.500
13. Regional Services								
Development of All Wales Andrology Service - SWARU	NPT		0.400					0.400
Thoracic Surgery	Morr		tbc	tbc	tbc	tbc		tbc

Scheme	Site	Business Case Approvals	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m	Total £m
Relocate PAU - Develop SARC (Childrens)	Sing		tbc	tbc				tbc
14. Other Capital Schemes								
2nd CEPOD Theatre	Morr				tbc			tbc
SUB TOTAL UNAPPROVED SCHEMES			19.351	44.170	126.433	86.013	19.537	295.503
GRAND TOTAL			39.668	63.768	141.051	100.631	34.155	379.272

Appendix 8. DIGITAL HEALTH

Digital Strategy and Context

The Health Board published our Digital Strategy '[Destination Digital](#)' during 2017/18, which describes our vision of becoming a digitally-enabled organisation and is aligned with the Digital Health and Social Care Strategy for Wales, 'Informed Health & Care'. The digitisation of our services is also a key enabler of our service change programme and underpins our Recovery and Sustainability Workstreams through increasing productivity and efficiency and providing targeted management information to underpin the actions undertaken by the Workstreams. There are also specific savings schemes associated with health records and reducing telecommunications costs.



By 'digitally-enabled' we mean that all of the following will be available in digital form and on appropriate devices:

- Information - health advice, patient record, test results, prescriptions;
- Communication - messages, appointments, virtual clinics, RFID tags, dictation, telecommunications;
- Entertainment - while in care, as an aid to recovery;
- Workflow - the clinical and business process, documentation, systems, tools chain;
- Intelligence - decision-support information needed to run the Health Board; and,
- Analytics - decision-support information needed to change our services and systems.

Together, these elements, when available on appropriate devices, will transform the Health Board's ability to provide benefits to citizens at each of their life stages, enabling active participation in their own health and wellbeing goals and in care and treatment decision-making.

Our strategy aims to improve the health, care and wellbeing of our population through the widespread adoption of digital technology. It sets out where we are now and where we would like to be in 5 years' time across a range of capability areas and the impact/outcomes that could have to our citizens and our Health and Care teams in their health and wellbeing focussing on 4 stages of their journey: Support me; Assess me; Treat me; Coach me.

Our aim is that, in our Health Board, by using digital technology, citizens and patients will be able to receive and share information online about their health and wellbeing. They will also be able to communicate with us by audio, video, secure electronic messaging, and participate in peer-to-peer support groups, in trials, and in their health and care decision-making with their clinicians. Our staff will use digital technology to become more data-driven and evidence-based, with robust and ever-expanding decision-support capability. This will provide the capability for patients to access services at a time and place which is convenient for them and their families or carers.

ABMUHB was the first NHS Wales organisation to develop an Informatics Strategic Outline Programme (SOP), setting out a programme of strategic investment in digital enablement to support the provision of high quality care and facilitate service change and modernisation across the Health Board. The SOP was approved by Welsh Government in 2015, and refreshed in August 2016. It details the information and digital technology required to deliver our medium term plans and is, therefore, integral to the success of the Health Board's strategic plan for clinical services and its workforce. Our SOP investment Objectives are shown in the next section.

Our Digital Strategy and our SOP fully commit to, and augment, the development and delivery of national ICT products and services provided by the NHS Wales Informatics Service (NWIS). In 2015, ABMUHB and NWIS developed a 'Concordat for Partnership Working' to establish a new way of working between the two organisations to deliver the accelerated transformation of clinical services through the acquisition, development, deployment and effective utilisation of modern technologies, and for this approach to be transferrable across NHS Wales. Key projects currently being taken forward, such as the scaled demonstrator of an online citizen held record portal (Patients Know Best) and the implementation of inpatient e-prescribing across 2 hospital sites, are great examples of this model working with ABMU innovating on behalf of NHS Wales.

Our Partnerships with the Local Authorities under the Western Bay Programme are vital in our plans to support Integrated Care via digital transformation. As are the partnerships we have formed under the ARCH umbrella with Hywel Dda and Swansea University. We have recently signed a MOU with the Royal College of Physicians (RCP) and the Swansea University Medical School (SUMS) to work together on improving the quality and safety of services provided by the health board to the local population. The project, named TroCAR (Transfer of Care collaboration), is a digital transformation project which aims to improve the quality, speed and usefulness of information sent to GPs when patients are discharged from hospital.

The initiative we have demonstrated to drive forward the digital agenda has been well received by NWIS and Welsh Government and has resulted in significant progress across the seven themes and enablers depicted in the diagram above. We will continue to implement a range of technology and information solutions to support the delivery of this Annual Plan, and our medium term

strategic intentions, supporting significant service modernisation and efficiencies across primary, secondary, tertiary and community care. We will need to grow our capacity and capability and embrace innovative technologies and approaches whilst maintaining our existing infrastructure.

Our strategic enabling programme requires investment to improve the use of electronic information in support of our plans for clinical service development and modernisation and to support effective operational management. The programme has a robust and rigorous approach to the identification and realisation of the benefits associated with this investment, thus ensuring that, where possible, all financial and qualitative benefits are being realised across services. This enables further service improvement and transformational advances to release further investment opportunities. This approach supports the ambition of becoming a 'benefits-driven' organisation.

Whilst there are benefits directly associated with the delivery of the programme (cash releasing savings from the availability of electronic health records for example), the majority of benefits (both financial and non-financial) are attributed to the introduction of new service models that the Informatics delivery enables. These financial benefits are being used to support the costs of delivering transformational change across the Health Board's strategic improvement initiatives.

The Health Board is committed to ensuring that benefits are at the heart of our investment proposals and our Informatics and Finance teams will continue to take an active part in the recently formed NHS Wales Directors of Finance Benefits Sub-Group. We have invested in an ABMU benefits methodology, which we are currently implementing across our mobilisation programme and plan on expanding the model across the Health Board.

The Health Board is committed to exploring all opportunities to increase resources for Informatics year on year, reflecting the Wales Audit Office (2015) assessment which identified that the spend on ICT in our Health Board is lower than the recommended 2% of total revenue expenditure and significantly below the all Wales average. This growth is required to ensure sustainable service models and to underpin the organisation's aspiration to deliver digital-first services. The Health Board will continue to invest a significant proportion of its discretionary capital in digital and also seek to acquire funds from the All Wales Capital for the Digital Strategy via business cases under our SOP. The Health Board will also continue to take the opportunity to bid for additional sources of funding such as: Invest to Save, Efficiency Through Technology Fund (ETTF) and the Innovate UK Small Business Research Initiative (SBRI) process. The recent WAO report on Informatics in NHS Wales, highlighted the need for Investment to deliver the vision for digital transformation and we welcome the opportunity to work with Welsh Government, NWIS and other Health Boards and Trusts in order to address this.

By May 2018 we will provide a refresh of our SOP, providing a full progress update and incorporating the ambition of the digital strategy and the opportunity to accelerate intra Health Board digital adoption as part of the potential boundary change with Cwm Taf. In line with the 2019/20 IMTP development process we will construct a new five year SOP, providing a digital roadmap and investment plan to underpin the Digital Strategy.

In 2018/19 the Health Board will have to ensure it is compliant with significant changes in legislation that apply to the management and security of our information and information systems as follows.

General Data Protection Regulations (GDPR) will come into force on 25th May 2018 and will be directly applicable as law in the UK. It will replace the Directive that is the basis for the UK Data Protection Act 1998. Although in general the principles of data protection remain similar, there is greater focus on evidence-based compliance with specified requirements for transparency. It introduces a principle of 'accountability' and more extensive rights for data subjects and considerably harsher penalties for non-compliance up to 4% of turnover per breach. We have completed an All Wales position statement on GDPR that will be considered by the Wales Information Governance Board (WIGB). The Information Governance team have also completed an internal detailed gap analysis and action plan. The action plan has been approved by our Information Governance Board and resources are being prioritised in order to reach compliance.

The Network and Information Systems (NIS) Directive was adopted by the European Parliament on 6th July 2016. Member States have until 9th May 2018 to transpose the Directive into domestic legislation. The NIS Directive is aimed at bolstering cyber security across sectors that rely heavily on information and communications technology. ABMU Informatics are working closely with Welsh Government (WG), NWIS and other Health Board/Trust Leads to finalise the reporting and implementation plans. The onus will be on ABMU to demonstrate to WG that appropriate measures are being applied to manage the risks to networks and information systems that fall within the set thresholds.

Each organisation across Wales has also had funding from the ETTF fund to appoint a Senior Nurse Lead for 12 months to support the All-Wales development of Nursing Documentation and e-Programmes. The Health Board has successfully appointed into this post and will ensure alignment with our other digital projects.

Strategic Outline Programme

Our ambitions for becoming a digitally-enabled organisation are underpinned by our Strategic Outline Programme (SOP) investment objectives below, which reflect the strategic objectives of the organisation as follows.

SOP Investment Objective	Description
Improve access	To maintain and develop the ICT infrastructure to provide access to information at the point of care across healthcare settings for staff, patients and carers
Increase robustness and resilience	To ensure the technical infrastructure is robust, resilient, sustainable and highly available for access to clinical resources at all times.
Provide patient centred electronic record	To provide joined-up electronic information at the point of care and significantly reduce the need for the paper casenote and the associated risks.
Streamline and automate processes (clinical and non-clinical)	To significantly reduce duplication, error and process inefficiencies by automating and streamlining current working practices through the better use of Information, Communication and Technology. Exploiting technology to support a more virtual way of working e.g. using skype for patient consultations. To innovate and respond rapidly to clinical developments with effective tools for recording and displaying information that support operational workflow.
Support improvements in patient safety and quality	To significantly reduce clinical risks by providing instant access to complete and up-to-date information. Improve the way we collect and analyse information so that it is available to clinicians, managers, the Board and the public when it is needed to aid decision making, improve standards and hold individuals and services to account and support service improvement
Alignment with national strategy	To ensure products and services support the delivery of national and Health Board priorities.

Progress against Objectives in the 2017/18 Digital Health and Informatics Plan

Examples of Good Practice:

**TROCAR**

TROCAR, an electronic system for recording patient information, has been introduced on a medical ward in Morriston Hospital but will eventually be rolled out across the health board. It's the first project to be undertaken as part of a collaboration between ABMU, Swansea University Medical School and the Royal College of Physicians in London. TROCAR aims to improve the quality, usefulness and speed of information sent to GPs when patients are discharged from hospital. Clinicians use a variety of paper-based and electronic systems to access clinical information and investigations for hospital patients. In most cases these systems are not connected. When a patient is ready to go home, a doctor has to write up a discharge summary which is then sent to the patient's GP.

But it is not yet possible to electronically import the information which was previously collected. So doctors have to spend time collating the various notes and writing a summary from scratch. This is time-consuming but, more importantly, could potentially lead to compromised care, delays and risk through the slow or incomplete transfer of information. TROCAR (Improving Transfer of Care) involves recording all information electronically from the moment the patient arrives in hospital. The doctor writing the discharge summary will have instant access to all this information, meaning the summary can be produced in minutes.

**Ordering tests**

We have deployed Electronic test requesting in Neath Port Talbot hospital, avoiding the need for a paper form to be completed. We will roll out online test requesting over the next 18 months. This saves time for the clinicians and alerts them to unnecessary or duplicate tests, which is better for the patient and saves money. Test results are already available via the ABMU clinical portal and pathology results from across NHS Wales results are available through the Welsh Clinical Portal.

**Patient Knows Best**

Is designed to let patients have their own results, letters and records. We know this helps people understand and get involved in their care, and after all it is their information. In NHS England, it is normal to copy letters to patients and this has been shown to be positive.

Patients spot that a referral hasn't been made or a mistake in a referral letter, for example. They come to know more about their health and can self-manage much better. We don't want to increase the number of letters we have to post, so we are using an app called Patients Know Best. This app gives patients secure access to their records on their personal mobiles/tablets/PC and allows patients decide who to share the records with.

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
Theme: Patient Empowerment		
Take forward a scaled up demonstrator of the citizen held record model across Princess of Wales Hospital, including integration with a National Integration Platform. The solution and benefits will be fully evaluated with a view to enabling the rest of Wales to adopt the model.	We have initiated a contract with Patients Know Best (PKB) for the provision of a Patient Held Record for our patients. The Health Board has been working with NWIS and PKB to ensure the integrations required, to allow feeds of patient results and patient correspondence from national systems is available within the patient portal, in a planned and phased approach in the project. We signed a contract with PKB in November 2017 to commence a 2-year pilot within the Bridgend area focussing on the delivery of the Patient Portal within 10 service areas.	The implementation of the pilot will continue into 2018/19 where the phased approach to national integration will continue. Service change requirements and benefits realisation work will continue to assess the viability of expansion across services and sites within ABMUHB.
Extend the use of PROMs and PREMs to measure health gain and capture patient experience in different clinical areas by working with NWIS on the adoption of a national solution.	NWIS are working with Service Teams in ABMUHB to agree the initial adoption of the national solution in specific specialties. We are also working with Amplitude within the Musculoskeletal (MSK) Directorate in Moriston Hospital for a further 1-year extension of the current pilot.	The implementation of the pilot in MSK with Amplitude will continue until end December 2018/early January 2019. In relation to the NWIS, national solution the plan is to work with key service areas to agree the initial service for piloting.
Theme: Workforce Mobilisation		
Throughout 2017/18 COPE iPads will be deployed to a further 2000 community staff and BYOD will continue to be promoted across the Health Board, with the aspiration that all Health Board staff, wishing to use their own Smartphone or tablet device to access ABMUHB resources, will have the ability to work in this way by the end of March 2018. The aim is also to have mobile application and SharePoint development programmes in place during 2017/18, with widespread access to clinical information systems via mobile devices during 2018/19	At the end of September 2017, 750 COPE iPads have been deployed and there were 1895 active BYOD users. At the start of the year, a review of the benefits realisation model for the project was commissioned and undertaken to ensure that benefits are maximised from the project from the Community mobilisation implementation. The project have now acted on a number of the recommendations with a view that an additional 1,750 iPad will be procured this financial year to support community staff. An evaluation on the deployment of devices to date has suggested that some teams using the devices are saving up to 142hrs per week (across a team of 9) therefore providing additional capacity to treat more patients.	Roll out to further clusters and Mental Health will continue in 18/19 alongside the identification of further requirements for digital ways of working with the Community and Primary Care and Mental Health SDUs.

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
Theme: Patient Flow – ED and inpatients		
Facilitate the transition to the national Welsh Clinical Portal (WCP) as the “platform” for the digital record, incorporating the national system (MTeD) for managing discharges and transfers of care and continuing the rollout of Electronic Test Requesting (ETR).	Implementation of ETR has completed in NPT in both inpatient and outpatient settings. Uptake continues to increase on a monthly basis. 9,044 electronic test requests were processed in November 2017, this is an increase of 5,000 requests in comparison with December 2016. Viewing of results from WCP has also increased. 86,000 results were viewed in WCP in November 2017 an increase of 46,000 since December 2017. 97% of all GP referrals are now prioritised electronically in WCP. During November 2017 8,900 referrals were processed electronically in comparison with 3,000 referrals in December 2016.	Continue with the implementation of ETR across the Health Board. In addition, we (Morriston) will pilot the Admission, Discharge, Transfer (ADT) module of WCP on behalf of NHS Wales. Pending a successful evaluation the Health Board will start to migrate users from ABMUHB portal to WCP. An added benefit to be provided by WCP in FY 18/19 is integration of WCP with the hospital e-prescribing system (JAC). ABMU are trailing this functionality on behalf of Wales with a view the evaluation will inform the all Wales e-prescribing procurement. In addition, an electronic continuation sheet will be made available for pilot by dermatology colleagues. This is a key enabler in supporting paper lite working across the Health Board.
Implementation of e-prescribing across Neath Port Talbot and Princess of Wales hospitals in 2017/18 will integrate with the WCP to provide a fuller evaluation of the national way forward.	A business case to secure capital investment from Welsh Government (WG) to implement HEPMA at 2 hospital sites was submitted to WG and £945k was awarded to ABMU in September 2017. . Work is now underway to finalise the delivery plan and the contract with the supplier with a view the implementation across site 1 will complete in 2018/2019 and implementation at site 2 will commence in 2018/2019.	Complete implementation at site 1 during 2018/2019. Commence implementation at site 2 during 2018/2019.
Take forward a pilot of electronic observations, patient flow and bed management during 2017 to inform the work of the national Patient Flow Programme NePFM	Due to funding and resource constraints, this project was deprioritised for 2017/18.	Subject to availability of funding, it is envisaged that this project will be reinstated for 2018/19 – see section 3 below.
An improved, nationally procured, electronic system to quickly and effectively identify and manage	Phase 1 of the ICNET implementation was completed in July 2017 with Phase 2 due for completion in December. Further work, however is required to ensure the software integrates with the national systems.	During Q1 18/19, we will integrate iCNET with the Welsh Patient Admin System (WPAS) to support the sending

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
patient infections will be implemented within ABMU Health Board throughout 2017.	Benefits in terms of efficiencies from within the infection control teams are being realised including: - the prompt identification of patients requiring attention - speedy reporting for onward patient management via the system (avoiding the need to traditional manual data capture) - supports the progress towards an electronic patient record	of demographic information from WPAS to iCNET.
Develop a national theatre management system, based on the TOMS system, with a view to implementing the product further across Wales.	In 2017 Informatics have developed and implemented a theatre scheduling application to improve the efficiency of managing theatre sessions and improve the information available for decision making around theatre session utilisation. Discussions are ongoing with NWIS for the further development of the TOMS system with a view to making it available across Wales.	Develop TOMs into a system suitable for adoption across Wales.
The expansion of WEDS to all unscheduled care Assessment Unit environments will follow the implementations in the emergency departments/minor injuries unit and is currently planned for 2017/18	There have been a number of issues with the implementation of the WEDs system culminating in the supplier (EMIS Health) being issued with a non-conformance report in July 2017. Since this date NWIS and the Health Board have been working with EMIS towards obtaining a successful resolution, however plans for implementation of WEDs within ABMU will not progress in 17/18 or 18/19. As a result ABMU (Morriston ED) have adopted the WPAS 505 ED module, using it to better support improvements in ED performance e.g. electronic triage. The system went live on the 8 th of November and project evaluation is underway which is expected to conclude in March 2018. Plans to replace the PoW ED system with WPAS 505 are underway with a view PoW ED department will upgrade to WPAS 505 during Q1 2018/2019.	Supplier proposals at this stage of discussions suggest that the system may be available in quarter 3 of 2018. We will test the application once available and continue working with ED colleagues on revised implementations plan such that a single instance of WEDS would be implemented in FY 19/20.
Theme: Patient Flow – Community and Mental Health Services		
WCCIS Business Justification Case within ABMUHB in early 2017. A phased rollout is planned, commencing in 2017/18 aligned to our Local Authority partner organisations implementation plans.	ABMUHB WCCIS Business Case is being finalised with a view it will be submitted to the Investment Benefits Group in April 2018. Significant work has also been carried out to establish local and regional governance arrangements.	Complete Business Case and sign the Deployment Order with Careworks in 2018. Continue working with Regional and National groups from both Health and Social care to align the programme to the delivery of WCCIS within ABMUHB including local readiness plans and baselining of current processes. Agree a date for go-live of WCCIS within ABMUHB which feeds

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
		into the Regional Implementation Plans.
Theme: Patient Flow – Modernising outpatients		
The Patient Appointment Reminder service is scheduled to expand to cover all outpatient booking scenarios by the end of 2017	The project is on track to deliver to the Text Reminder service to all hospital outpatient scenarios by end of March 2018. Plans to expand to cover other environments, such as Radiology appointments and Community & Therapies appointments will be drawn up and prioritised in line with other Informatics projects over the next few months.	If prioritised and agreed for action, plans to scope the work programme for Radiology, Community & Therapies text reminders will be developed.
ETR will be rolled out to all outpatient areas during the coming year, enabling clinical staff to effectively and safely electronically request tests throughout the Health Board by the end of 2018/19.	Implementation of ETR has completed in NPT in both inpatient and outpatient settings. Uptake continues to increase on a monthly basis. 9,044 electronic test requests were processed in November 2017, this is an increase of 5,000 requests in comparison with December 2016. Viewing of results from WCP has also increased. 86,000 results were viewed in WCP in November 2017 an increase of 46,000 since December 2017. 97% of all GP referrals are now prioritised electronically in WCP.	Continuation of the roll out of ETR and the Phlebotomy module.
The WPRS rollout will be completed across the Health Board by July 2017, enabling the more efficient management of referrals and facilitate electronic communication relating to referrals between secondary and primary care clinicians.	98% of all electronic referrals received from a GP are prioritised electronically. Morriston Burns and Plastics and Cardiology West outstanding with a view they will complete by the end of March 2018.	Continue 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.
Theme: Digitised Health Record		
2017 will be the first pivotal year in the 5 year Digital Clinical Records System programme with the introduction of RF-ID tagging of the paper casenotes and the 'Scan Go-Forward' model.	A business case for the Clinical Digital Records Management System was submitted to WG in December 2016. No formal feedback has been provided by WG on the case but discussions with them indicate that, although they are supportive of the case in principle, the lack of available funding has meant that the case has not been approved. As a result alternative sources of funding have been acquired to deliver a scaled down version of the case which focusses on the delivery of RFID within the Health Records libraries.	Project will be commenced in 2018/19 – see section 3 below
Full roll-out of WCP across the organisation delivering access to Pathology results, Radiology images and reports, the GP	All specialities will be live on WPRS by the end of March 2018. . 2m DMS documents were made available in WCP at the end of December along with an additional 10m documents from across Wales, allowing clinicians to view clinical correspondence for their patient regardless of	We will pilot the Admission, Discharge, Transfer (ADT) module of WCP on behalf of NHS Wales. Pending a successful evaluation the Health Board

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
Record (WGPR), ECGs and Diabetes records, amongst others.	where in Wales it was produced. The roll out of WGPR has commenced and will continue throughout the year. Diagnostic information e.g. all Wales pathology results are now available at the point of clinical decision making in WCP.	will start to migrate users from ABMUHB portal to WCP. An added benefit to be provided by WCP in FY 18/19 is integration of WCP with the hospital e-prescribing system (JAC). ABMU are trialling this functionality on behalf of Wales with a view the evaluation will inform the all Wales e-prescribing procurement. In addition, an electronic continuation sheet will be made available for pilot by dermatology colleagues. This is a key enabler in supporting paper lite working across the Health Board.
Combining the digital dictation with integrated workflow, leading to increased efficiencies, visibility of dictation volumes and the ability to prioritise workload.	The focus of the digital dictation implementation for 2017/18 has been within Morriston and specifically within the new Administration building. The roll out of the solution is continuing throughout 2017/18 and phase 1 is due for completion by the end of the financial year.	Implementation for radiology and community appointments.
Theme: Streamlining Communication & Business Processes		
Continue to work with NWIS and CareStream to maintain the rollout of the all Wales LIMS modules – Blood Transfusion and Mortuary by the end of 2017	Work is ongoing with NWIS and CareStream to plan for the testing and implementation of the blood transfusion and mortuary modules of LIMS.	Proposed ABMUHB blood bank go-live date is May 2018.
Implementation of the national Radiology Information Management system RADIS for 2017.	The implementation process for RADIS is progressing well and is on track for delivery by end of May 2018	Implement RadIS at Morriston and Singleton in May 2018.
Microsoft SharePoint 2013 will be used to deliver core business functions, including the re-development of the ABMUHB Intranet during 2017	An options paper and project initiation document has been produced with a view to complete a business case document for consideration by the end of 2017/18. Subject to approval the project could be initiated in April 2018 with the focus on the delivery of a new Intranet.	Subject to availability of funding it is envisaged that this project will be taken forward in 2018/19 – see section 3 below.
Use of Skype for Business will	Use of Skype in Business actively being promoted across the Health	

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
also be increased during 2017 to realise efficiency savings as well as supporting clinical practice and communication with patients.	Board.	
Theme: ICT Infrastructure & Cyber Security		
Review of WPAS servers and essential cyber security upgrades to firewalls, servers and web filtering services will continue during 2017/18.	WPAS servers will be hosted in national infrastructure in national data centres by end of February 2018. This means that the Health Board has avoided a requirement for circa £500K capital to replace out of support hardware and software with a relatively small increase in revenue costs for the NWIS Myrddin Service Level Agreement. The firewalls and web filtering replacement work was completed with advanced detection and remediation systems in place to help counter the threat of cyber security.	
Increase IT security awareness for all staff offering improved training resources and increased compliance with mandatory training, along with the rollout of Microsoft products in line with the new Enterprise Agreement, to ensure benefits from new functionality are realised, software continues to be "patched" and protected against exploitations of vulnerabilities inherent in unpatched software	Completed Welsh Cyber Assurance Process (WCAP) self-assessment to ascertain compliance levels on a number of controls including user training. All Wales NHS work ongoing to audit WCAP controls and assess organisation compliance with Cyber Essentials, GDPR and ISO 27001. Options for delivering IT Security training are being considered. A case is being made for investment in training material to help assess staff Cyber Security awareness and targeting users who put the organisation at risk. This is reliant on appropriate funding. Microsoft Office 2016 rollout commenced in order to address security risks of unsupported software (Microsoft Office 2007) and increase availability of Skype For Business which will facilitate efficient meetings, training sessions etc. to reduce travel time and associated travel costs. The rollout will complete at end of March 2018. A dashboard has been developed to show patch level compliance across all servers hosted by ABMUHB. In terms of the Wannacry incident which affected NHS England, this highlighted the need to ensure devices are patched to latest levels in order to reduce risk of cyber attack.	
Introduction of single sign-on solutions will increase efficiency, security and audit trails in accessing our key clinical	Whilst the WEDS rollout is on hold. The new Myrddin A&E module was implemented at Morriston Hospital in November 2017. This included the use of single sign-on and fast switching access in the Morriston Emergency Department.	

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
systems. This will be piloted in our Emergency Departments as part of the WEDS implementation project and then rolled out further as part of the drive to provide easy and robust system access to all working in busy clinical environments		
Completion of the Wi-Fi rollout to all sites is planned for 2017/18	Cefn Coed, Princess of Wales, NPT and Morriston Hospitals already have full wireless infrastructure. In 2017/18 this was extended to Gorseinon and Glanrhyd Hospitals. Tonna, Maesteg and Singleton hospitals are due to be complete by end of March 2018.	
Delivery of the tech-refresh programme over the next three years	£1.335m allocated for predominantly replacing the Health Board Server and Storage equipment based at Morriston, NPT and Princess of Wales Hospitals which deliver the clinical and administrative systems. This is necessary to ensure minimum downtime and reliability of services.	Draft Tech refresh paper for 2018/19 circulated to Capital Finance managers. Final paper will be taken to Capital Investment board for consideration
Theme: Business Intelligence & Analytics		
Launch and implementation of the Business Intelligence strategy,	Initial scoping exercise undertaken to establish requirements. Change of personnel in key areas has meant that the development of the strategy is on hold. Further discussions on the role of BI in the Health Board taking place with a view to take this work forward in early 18/19	Identification of a Business Intelligence lead to undertake further strategy development and implementation plan.
Redesign of the Business Intelligence SharePoint portal, providing a single point of access for BI resources using 'self-service' access as a key strategic principle	Discussions taking place with the Director of Finance and Planning / Strategy colleagues which will establish a roadmap for BI and as a consequence the redesign of the BI Portal.	Implementation of the BI roadmap, of which one product will be a BI Portal using the most appropriate technology.
The expansion of the Data Warehouse focussing on data acquisition and data linkage to provide pathway views across the care spectrum.	New Data has been extracted from the following systems: - Datix - Tracker 7 (Cancer) Scoping exercise undertaken on CASPA (Pharmacy) and SNAP 11 (Patient Experience).	Data Acquisition of PROMS Data relating to ABMUHB, along with Cancer Data (CANISC system) and E-Prescribing. Further evaluation of ESR data extraction opportunities.

Objectives in 2017/18 Annual Plan	Progress	Plans for 18/19
Further development of Dashboards using relevant BI software to continue the targeting of service improvement efforts and the monitoring of performance across a range of key business critical areas.	The Information Department has released Dashboards in the following areas in 2017/18: • Clinical Variation Toolkit • Theatres (new release) • Ward to Board (part of the Ward Dashboard) • Cancer	Development of a Management and Executive Dashboard to allow a holistic view of the Health Board environment, incorporating key indicators from existing dashboards and new data sources. Further development of the Ward to Board Dashboard, refresh of the Clinical Variation Toolkit and a new release of the Cancer Dashboard.
The organisation will also be developing a capacity and capability plan with a focus on developing core skills for both our Informatics staff and the wider organisation.	In house SQL training courses developed and provided to information colleagues. Launch of the Information Revolution Day in Morriston DU a great success.	Further tailored courses required locally for Informatics colleagues and re-launch of Information Revolution Days for remaining SDUs.
Commence work on Cancer Pathway in line with national and local requirements	Cancer dashboard established locally to aid patient flow.	Ongoing discussions Nationally to provide a sustainable solution in the development of the Cancer Pathway

In addition to the objectives identified in the 17/18 plan the following projects have been progressed:

Cardiology PACS - a new Cardiology PACS system has been implemented across the Health Board, providing a more robust solution to the existing ageing system. Images from the new system will be uploaded into the Welsh Results Reports Service (WRRS) by the end of March 2018, facilitating access to all ABMUHB Cardiology PACS images irrespective of hospital location.

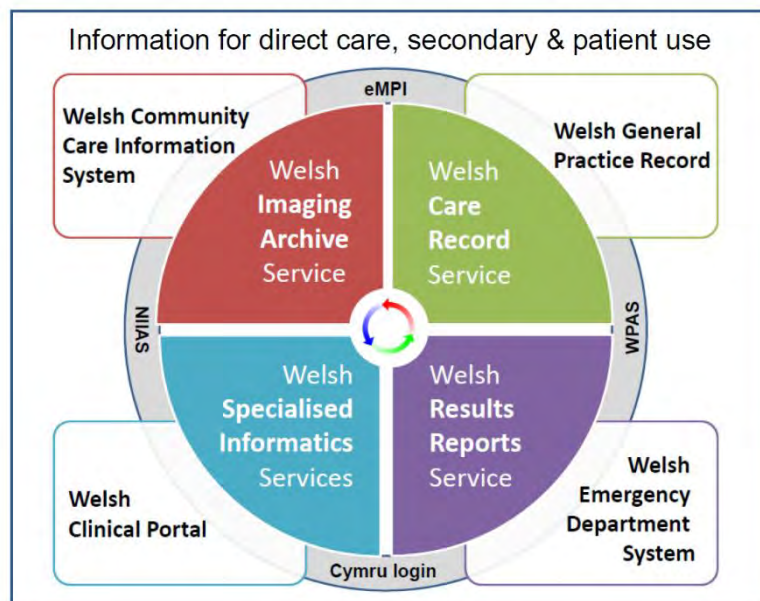
Catering App - a proof of concept project took place on one Hostess-supported ward in Morriston Hospital, with the aim of demonstrating that, via the use of mobile technology and an App to manage food ordered, delivered, consumed and wasted, the level of food waste could be significantly reduced. The project proved that during its 7-week duration, wastage from “main meals” dropped from 10% to 4% (the all Wales national directive is to achieve 5%). The projection based on this outcome would deliver a £12k annual saving across all Morriston wards and a case is being prepared for roll out.

Digital Health and Informatics Plan 2018/19

This section outlines our digital and informatics plans for 2018/19.

Digitised Health Record

The cornerstone of the Health Board's digital ambition is the digitisation of the paper record and the widespread adoption of the Welsh Clinical Portal (WCP) underpinned by the national patient record repositories for documents, results and images depicted below as the 'Once for Wales' Approach. This will facilitate new ways of working for the transcription of clinical letters by combining digital dictation with integrated workflow, leading to increased efficiencies, visibility of dictation volumes and the ability to prioritise workload. This model will deliver a step change in the viewing and capture of clinical information and is a vital first step to achieving a digitally transformed organisation, with an ultimate objective of being virtually paperless by 2022.



The transformation will be supported by the implementation of a health records tracking management RFID (Radio Frequency Identification) solution for our paper casenotes, enabling a more efficient and effective Health Records service. The RFID solution is being part-funded by the Welsh Government Invest To Save scheme.

Patient Empowerment

It is well recognised that in order to sustainably improve the health and wellbeing of the resident population of ABMU Health Board, citizens must be engaged and supported to become active participants in their own health and wellbeing.

The Health Board is fully aligned with the e-Health and Care Strategy Implementation agenda and is playing an active part in the "Information for You" workstream. Under the workstream, the Health Board is implementing at scale the citizen held record solution, Patients Know Best, across the Bridgend Locality. Patients in this area will be able to review their test results, clinical letters and upcoming appointments as well as interact with the clinicians involved in their care. Clinicians will be able to develop shared care plans with patients, monitor progress against the plan and receive feedback from patients on the outcomes of prescribed treatments. Previously this information would only be shared during outpatient appointments and would therefore be historic rather than allowing clinicians to intervene at the most appropriate time. The expected outcomes of this will be higher quality of care and

reductions in the number of outpatient appointments required due to more information being available to both the patient and clinician to facilitate joint decision making on care pathways. Patients will also have the ability to share this information with other people involved in supporting their health and wellbeing, facilitating joined up ways of working for all those involved. The project will also provide an opportunity to empower patients to take control of their own health and to offer different and better ways of supporting patients with chronic conditions.

As part of this work, Informatics colleagues are collaborating with NWIS to establish a “Once For Wales” integration model to provide patients access to their own results and documents. The solution and benefits will be fully evaluated with a view to enabling the rest of Wales to adopt the model.

ABMUHB has also continued to take forward PROMS in Musculoskeletal services. Patients are able to share important information about their progress with clinicians who are able to monitor their health after the patient has been discharged. Previously this information would only be able to be provided at outpatient appointments and on readmission. Clinicians are able to support patients more effectively, intervene sooner if any issues arise as well as monitor their own performance and identify areas for improvement. Building on this work ABMUHB has also been working closely with NWIS on the initial adoption of the national PROMs solution in a number of specialties. The Health Board is looking to significantly extend its use of PROMs and PREMs in 2018/19 as part of our Values Based Healthcare approach.

Workforce Mobilisation

The importance of providing our staff with the right tools, at the right time and with the right connectivity is essential for driving quality, effectiveness and efficiency in the services the Health Board provides.

An ambition of the Health Board is to mobilise our entire community staff base through the adoption of digital ways of working using tablet devices. We have already deployed 750 devices which are already providing significant benefit. Community staff were previously reliant on paper records whilst in the field and had to return to base to complete simple administrative and clinical noting tasks. Now they are able to access patient results and radiology reports on the WCP, use FaceTime to seek expert advice, share videos and knowledge on condition management with the patient, order equipment whilst with the patient and show them what to expect, take ECG readings using the iPad, using digital dictation and manage caseloads and referrals electronically.

After spending some time in researching effective approaches to business change, we will continue towards our ambition in 2018 by completing the mobilisation of 2,500 community staff. Staff will immediately benefit from the use of mobile applications and

access to the Welsh Clinical Portal. They will also be digitally enabled ready for the introduction of the Welsh Community Care Information System.

Other areas where mobile ways of working have been introduced include: -

- Estates – now use iPads to manage their work loads and monitoring of completion rates. Previously staff would have had to physically report back to the centre to record work as completed pick up their next job.
- Translation for the deaf – ABMUHB has successfully trialled the use of the iPad to provide sign language interpretation to deaf patients over Face time. Previously an interpreter would have had to be booked to be on site and all consultations would have to be planned well in advance. Whilst this works well in an outpatient environment, it is not always appropriate in an inpatient or unscheduled care setting. Feedback on the pilot was very positive from all parties involved.
- Catering pilot – ABMUHB has also developed and piloted an app to reduce the amount of food wastage on wards in Morriston Hospital. The app allows ward hosts to record patients' dietary requirements and send this information to the kitchen to ensure the correct type and volume of food are delivered to the ward. An evaluation of the success of the pilot is currently being conducted to determine whether it can be rolled out further.

The Health Board is also leading the way on “hospital site” mobilisation. With plans to conclude WIFI implementations on all hospital/community sites by the end of March 2018, ABMUHB Informatics have been asked to lead on the development of a mobile device policy for NHS Wales with Welsh Government. An early success for this piece of work was the approval of £1.8m to be provided to WIFI enable the other Health organisations across Wales. The policy for mobile devices will be delivered during 2018.

Patient Flow - Hospital Emergency Department & Inpatient flows

The Health Board has been proactively involved in the development of national programmes such as the Welsh Clinical Portal (WCP), Welsh Emergency Department System (WEDS), Patient Flow and e-Prescribing. The aim of these programmes is to introduce the electronic management of patients throughout their journeys within our hospitals and the electronic transfer of clinical/physiological data through the use of Smart medical devices.

In collaboration with NWIS, the Health Board is taking forward a pathway finder project for Hospital Electronic Prescribing and Medicines Management (HEPMA) which is planned for implementation across two hospital sites during 2018/19. This work will provide early evaluation and learning to inform the national WHEPPMA Programme and will enable quality and efficiency improvements across prescribing and medicines administration processes within ABMUHB.

Plans are in place to facilitate the transition to the national Welsh Clinical Portal (WCP) as the “platform” for the digital record, incorporating the national system (MTeD) for managing discharges and transfers of care and continuing the rollout of Electronic Test Requesting. The TroCAR transformation project in collaboration with the RCP and Swansea university, will further focus on the quality and timeliness of clinical data capture throughout the patients stay and the resultant information we provide to primary care.

NHS Wales has committed to designing, developing, testing and implementing an integrated digital record of nursing care across the Health Board/Trusts in Wales using a nationally agreed set of documents and data standards. This is a requirement to be delivered and this is being monitored by the Welsh Government Public Accounts Committee.

As an integral part of the electronic patient record, digitising the nursing record will enable ‘live’ data capture at the bedside, improve patient safety, enable better data quality and reduce duplication, resulting in increased time to care for patients. In order to standardise nursing e documentation across Wales and to facilitate this, the implementation will require access to the appropriate hardware and IT infrastructure to ensure that there is sufficient availability of devices to accommodate numbers of staff and patients.

Digitisation of the nursing record will transform the way that nurses work and will require significant business change to support nursing with the transition to electronic ways of working. This will incorporate the need to up skill existing staff with digital skills with appropriate training and support mechanisms provided as a core component of the business change.

Each Health Board/Trust has identified the requirement for a lead nursing post (8B 1.0 wte) to lead the local project implementation. Non recurrent funding has been identified for a 12 month period (from 1 January 2018) from the Welsh Government ETTF bid for the lead nursing informatics roles to support this project. For ABMU, this will enable us to progress with the standardisation of nursing e docs during this period. Moving to the next phase we will need to identify funding through the IMTP from January 2019 and beyond as the Nursing Informatics lead is critical for the ongoing development of clinical informatics in each Health Board/Trust – to work with the medical information officers.

We are also eager to take forward a pilot of electronic observations, patient flow and bed management during 2018/19 to inform the work of the national Patient Flow Programme NePFM. This would fully support the board round process and provide real-time tracking and management of the inpatient pathway from assessment through to discharge planning, thereby delivering a live bed state across our hospitals. Our ability to do this in 2018/19 will depend upon available investment options.

In conjunction with Cwm Taf Health Board and NWIS, we are also modernising our theatre management system, TOMS, to further support theatre safety and efficiencies, also with a view to implementing the product further across Wales.

Patient Flow - Community Nursing, Therapies and Mental Health Services

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 improving productivity across Community, Therapies and Mental Health services.

The Health Board is finalising its business case with a view to commencing with a 9-18 month phased implementation project in 2018/19 aligned to our Local Authority partner organisations implementation plans.

Patient Flow - Modernising outpatients

Improving the quality and effectiveness of outpatient services through the introduction of digital ways of working - from how we modernise our appointments processes and take forward the patient flow model already implemented in Morriston hospital to the provision of remote/virtual clinics where appropriate.

ABMUHB is actively implementing a patient reminder service to improve the process for appointment management and make better use of resources within the Health Board. Benefits of this new way of working include a reduction in the DNA rate, improved patient experience (ability to respond at time that suits the individual), better use of staff resource and improved efficiency of clinic time slots.

Following the successful completion of the electronic test requesting implementation at Neath Port Talbot Hospital, ETR will be rolled out to all outpatient areas during the coming year, enabling clinical staff to effectively and safely electronically request tests throughout the Health Board by the end of 2018/19.

Business Intelligence & Analytics

As part of the Digital Strategy, the organisation is also been developing its Business Intelligent (BI) strategy. The strategy will outline the vision of a 'data-informed' organisation, where information is used to underpin and inform decision making at all levels across the organisation. This strategy will be developed during 2018 along with a delivery and resource plan.

Working with stakeholders and the Advisory Board (an international organisation composed of accomplished experts offering innovative advice and dynamic perspectives on health strategies and approaches), the organisation has completed a baseline assessment of the Business Intelligence Maturity Index. This work provides the starting point to inform the future vision and delivery plan.

From the baseline assessment a priority area will be the focus on developing data literacy skills for our workforce. The aim is to improve the quality, safety and efficiency of our services by enabling staff to use and understand data and use measurement techniques and advanced analytics. This approach will support operational and performance management and reinforce service improvement through the benchmarking and adoption of improvement science techniques.

Significant progress has been made in the roll out and use of BI dashboards across the Health Board to inform evidence based decision making and process improvements. Technology such as Qlikview and QlikSense have been used in the development of agile dashboards for Clinical Variation, Coding, Cancer and Ward to Board. An Executive level and Service Delivery Unit performance scorecard model is currently being developed to ensure we have an effective and consistent way of monitoring and managing performance across the organisation.

A key piece of work being undertaken for early delivery in 2018/19 is the provision of a new Executive Performance Dashboard.

Streamlining Communication & Business Processes

As part of the digital strategy, it is clear that communications and business processes need to be effectively facilitated through the use of consistent Informatics solutions throughout the organisation and in conjunction with NWIS.

The use of video conferencing in administrative and clinical environments provides opportunities to transform patient care by enabling professionals to see citizens/patients at home remotely, supporting virtual multi-disciplinary team meetings, allowing two or more people to collaborate on the same information in a single system at the same time, and incorporating real-time presence

information to let staff working in the community know which colleagues are available to provide advice or assistance. Skype for Business (S4B) – a desktop videoconferencing solution has been deployed to enable more effective communications with staff both within the Health Board and also the wider world. The use of Skype for Business will also be increased during 2017 to realise efficiency savings as well as supporting clinical practice and communication with patients.

The Health Board has commenced the development and pilot of Microsoft SharePoint solutions to support business processes. Our ambitions are to develop a SharePoint business efficiency “Core” in 2018/19 which will put our intranet at the centre of ABMUHB business communications and processes.

ICT Infrastructure & Cyber Security

It is well recognised that a strong and secure digital infrastructure is essential to underpin the organisational development and innovation that ABMUHB is striving to achieve. Key deliverables in this area include the refresh of hardware and networks to ensure our IT systems are stable and secure.

In 2017/18 NHS Wales managed to avoid any significant fallout from the Wannacry cyberattack. However, the Health Board must ensure that it takes all necessary precautions moving forward to mitigate against further attacks. Locally we have firmed up on a number of processes to ensure our infrastructure is kept up to date with security updates. We have also been collaborating nationally with NWIS and other the Health Boards to procure external consultancy to review our current status with regards to cyber security. The recommendations from the review will be addressed throughout 2018.

A key deliverable envisaged in our digital strategy is the wide-scale move from traditional desktop and laptop devices (there are around 9,350 devices and 16,800 staff) to mobile devices and mobile applications. This will better enable staff to communicate, learn, do their work and participate in helping to tackle digital exclusion.

Alignment with the Health Board’s Targeted Intervention Priorities 2018/19

The Digital and Informatics Plans for 2018/19 are aligned to the Health Board’s Targeted Intervention and Recovery and Sustainability priorities as follows.

TI Priority Area	Objective	Action	Measure

TI Priority Area	Objective	Action	Measure
Unscheduled Care	Replacement of the Emergency Department system at Princess of Wales and Neath Port Talbot providing a more robust, better supported system to ED users. <u>Access to the GP Record</u> Providing all our users in ABMU will access to the Welsh GP record. <u>Patient Flow</u> Better manage the patient flow process including a safer more timely discharge of patients from hospital	ABMUHB informatics will continue to work with NWIS and EMIS to test the application with a view we will implemented it in FY 19/20. A summary of the patients' GP record will be made available via the Welsh Clinical Portal, providing users with access to key information e.g. medications, allergies, active problems. This will provide a more comprehensive electronic record, particularly in emergency and out of hour's settings where access to GP information can often be limited. Take forward a number of pilots supporting the patient flow process including: - The TRoCAR project which aims to improve the quality, speed and usefulness of information sent to GPs when patients are	Access to this information will: - Improve Patient Safety – clinical decisions taken with fuller understanding of a patient's current health record - Time saving – reduction in clinical and administrative time spent contacting the GP surgery (or other departments). Evidence collected in England where access to the GP record was made available suggests that a clinician can save up to 29 mins per patient when admitting a patient to secondary care where they had access to the summary GP record. This functionality will be further rolled out across ABMUHB during FY 18/19.

TI Priority Area	Objective	Action	Measure
	<u>Business Intelligence</u> Whole systems approach to understanding patient flow.	discharged from hospital Digitisation of nursing documentation which will avoid duplication of information and time spent transcribing, allowing more time for patient care. The development in incorporation of key indicators (such as medically fit, DTOCs etc.) into the patient flow dashboard as agreed by the Unscheduled Care work stream.	
Planned Care	<u>The Welsh Patient Referral Service</u> This service currently allows for the more timely electronic grading of GP referrals. The service is widely available in ABMUHB. <u>Digitisation of the paper record</u> WCP will introduce new electronic forms to support the electronic capture of information generated in an outpatient setting, therefore making this information available in the electronic patient record	Enhancements to this service during FY 18/19 will see the introduction of electronic secondary to secondary referrals allowing secondary care clinicians to electronically refer or request advice from each other. ABMUHB (cardiology) will pilot this functionality on behalf of Wales. A Hepatitis C outpatient consultation record will be implemented in ABMUHB during Q1 FY 18/19. This form will act as a complete Hep C patient record, integrating with data from a number of systems (including WPAS and LIMS) and providing a method to calculate scores e.g. child pugh scores from information previously recorded. We will implement radiology requesting forms, made available in WCP during Q2 FY 18/19. In addition, ABMUHB will pilot an electronic continuation sheet with a small number of dermatology consultants to support the electronic capture and subsequent sharing of this information, reducing the reliance on paper.	Enhancements to this service during FY 18/19 will see the introduction of new functionality to support patient flow.

TI Priority Area	Objective	Action	Measure
	<u>Patient Empowerment</u>	All Wales diagnostic information e.g. cardiology reports and clinical letters will become increasingly available from Q1 such that ABMUHB will have access to patient information regardless of where in Wales care was provided. ABMUHB will pilot and evaluate Patient Knows Best across 10 specialties providing patients with access to their diagnostic information, clinical letters and care events. An evaluation of the pilot will inform next steps including an implementation across the Health Board if successful.	The successful adoption of PKB will deliver significant benefits including: • Creation and recording of shared care plans and real-time monitoring • PKB is widely integrated with health & fitness apps and devices for patient self-management and symptom tracking, providing a platform for home monitoring and telehealth, particularly for patient cohorts with long-term conditions. • Remote monitoring and symptom tracking will facilitate timely interventions, improving outcomes for the patient and potentially reducing unplanned admissions.
Stroke	As Unscheduled Care		
Cancer	<u>Improved access to cancer patient information from across Wales</u> For example; Acute oncology often requires expert opinion from regional specialists such as neurosurgery, orthopaedic and clinical/medical oncology. This cannot	An implementation of RadIS 2 at Singleton scheduled to take place in May 2018 will enable the viewing of these results in WCP. In addition to, All Wales radiology reports and images being made available in WCP during FY 17/18, WCP will provide all Wales cardiology reports and clinical documentation regardless of where in Wales it was produced during	

TI Priority Area	Objective	Action	Measure
	happen without immediate availability of all the relevant imaging and reconstructions. Regional MDTs require all the imaging and diagnostic information when staging and advising on the patient's best management. Radiotherapy planning requires diagnostic imaging to be available at the time of planning with all the image reconstructions when the radiologist and the oncologist discuss the patient's plan. <u>The Welsh Patient Referral Service</u> This service currently allows for the more timely electronic grading of GP referrals. The service is widely available in ABMUHB (23 out of 25 specialties are now live). Specifically for cancer patients, this will continue to improve the 10 day GP referral to treatment cancer guidelines. <u>Business Intelligence</u> Informed decision making and patient monitoring for cancer patients	2018/2019. This will support acute oncology providing images across Wales through a single user interface. It will also support local and regional MDT meetings as well as radiotherapy planning sessions.	A Cancer dashboard, based on the information contained in a module of WPAS (Tracker 7) has been incorporated into the Information repository and a Qlikview dashboard created for use in the cancer services and the Service Delivery Units.
Healthcare Acquired Infections	We have successfully implemented an infection control, clinical decision support surveillance system (iCNET), during FY 17/18.	During Q1 18/19, we will integrate iCNET with the Welsh Patient Admin System (WPAS) to support the sending of demographic information from WPAS to iCNET allowing for: a) Early warning alerts for the Infection Prevention and Control team which can be	

TI Priority Area	Objective	Action	Measure
		matched to the current patient location, which will highlight where immediate infection prevention action is required. b) Reduced incidences of incorrect demographic details per patient record as demographics are automatically updated in both systems at present. c) Support progress towards a fully integrated electronic patient record.	
Other	WCCIS Approval of the ABMUHB WCCIS business case with a view associated funding is secured, enabling us to sign the deployment order and formalise our commitment to the WCCIS programme of work.	The implementation of WCCIS across the region will introduce significant benefits including: a) Increased Productivity Clinicians/Practitioners/Professionals save time and have real time access to records and required resources, allowing immediate decision and avoiding duplicate data entry or wasting time re-entering and other administrative tasks. b) Service Improvement • Improvements in delivery of care as Clinicians/Practitioners/Professionals access more comprehensive records and can make better decisions • Clinicians/Practitioners/Professionals accessing more comprehensive records leads to more informed decision-making and increased patient/client confidence in the service • Clinicians/Practitioners/Professionals may spend more time with patients per appointment as they will spend less time on 'low value' activities such as transferring notes or rekeying information. Patients will feel more engaged and 'in control' of their own care.	

TI Priority Area	Objective	Action	Measure
		- Reduce waiting times to receive treatment as Clinicians/Practitioners/Professionals can book and confirm appointments with the patient at the point of care/contact. c) Data Quality - Reduction in human error and reliance on paper based records, as data is entered at point of care/contact. (I.e. confirm details, spelling, etc.). Quality Improvement by minimising the risk of miss-filing paper records in the wrong patient and the risk of errors misspelling data (surname, NHS number, etc.).	
Quality and Safety	<u>Improved compliance and enhanced safety with the introduction of pathology requests</u> The Health Board wide implementation of electronic pathology test requesting will improve safety and CPA compliance. During September 2017, 15% of all <u>paper</u> pathology requests had an unknown or illegible entry recorded against lead consultant and therefore the associated result didn't have a clinical lead reported against it. <u>Business intelligence</u> Improve the monitoring and awareness of quality and safety issues to ensure they are managed appropriately	A Health Board wide implementation of electronic test requesting during FY 18/19 will increase patient safety given request information will be stored as part of the electronic patient record, the request will include the name of the lead clinician in addition to the date and time sample was collected. A number of quality and safety measures such as the number of falls and pressure ulcers has been included into the Ward to Board module of the Ward Dashboard. This Data has been extracted from Datix and is now incorporated into the information repository. This module is currently in the UAT (User Acceptance Testing) stage with a view to release to the wider organisation in December 2017.	During October 2017, 15% of all paper requests had either an illegible or no lead clinician name noted against it. ETR will improve that process whereby all requests raised electronically will have a lead clinician against it, in line with CPA requirements.
Workforce	Ensure the structure of the informatics department meets the needs of the Health Board in the short to medium		Complete the work undertaken in 2017/18 to ensure the structure of the Informatics department addresses and

TI Priority Area	Objective	Action	Measure
	term. <u>Business Intelligence</u> To better inform decision making and planning of the ABMUHB workforce		supports the changes in ways of working required to improve its effectiveness and efficiency. To determine the requirements of the HB to deliver the Digital Strategy in the medium term and meet the increasing demands for digital ways of working and associated increasing support requirements. To develop a recruitment and retention plan for the directorate to reflect the increasing demand for Informatics skills within and outside the department. Further work to be undertaken in 18/19 to establish whether data from ESR can be extracted into the information repository for inclusion in future dashboards development / releases.
Revenue	To reduce Telecoms costs for the Health Board. To reduce costs of the provision of Health Records and improve effectiveness of the department.		To finalise the implementation of SIP telecom project costs to release savings of £200k pa from fixed line communications. Subject to funding availability – to introduce the RFID tagging of the paper health record and instigate the business change required to reduce costs and improve the effectiveness of the Health Records Department.

Appendix 9. CORPORATE RISK REGISTER



CRR - MASTER
05.03.2018.xls

Appendix 10. EASC AND NUSC TEMPLATE 3



Table 3 NUSC EASC
ABMUHB March sub

Appendix 11. DRAFT NON-SURGICAL CANCER STRATEGY IMPLEMENTATION PLAN

The plan has been agreed and developed on a regional basis between ABMUHB and Hywel Dda University Health Board.

	Objective	Task	Milestones & Key outcomes	Executive & Project Lead	Cap / Rev Finance Implications	Timescale
1.	Integrate management and leadership of non-surgical cancer services across the region	Develop a framework of understanding between Health Boards to deliver a regional approach to cancer services in South West Wales A joint approach to commissioning, employment and standards of care is needed to create a truly regional service.	A new SLA/MOU agreed across the Health Boards for the management of cancer services <i>Greater recruitment and retention opportunities</i> <i>Greater scope for staff to develop</i> <i>Greater control of budgets</i> <i>Centralised management of services</i>	HB Exec Teams	Nil	Timescales are being worked through with Service Leads
2.	Increase the number and type of local venues where citizens can receive their treatment and care either in their local hospital, in primary care or in mobile treatment units	Work with the Primary Care teams to establish venues that can be released for delivery of SACT in community areas of need Work with Tenovus to see if venues can be found to deliver SACT more locally and centralised for groups of citizens Work with Units and Macmillan to see if staff resource can be developed to deliver the actions above	Additional venues for delivery in Hywel Dda and ABMUHB Staffing resource to be identified to support delivery with of care away from hospital <i>Improved RTT times</i>	HB Primary Care Group Service Team Pharmacy	Potential for approach with Macmillan to be cost neutral based on drug savings but savings need to follow staff otherwise revenue cost to service	

	Objective	Task	Milestones & Key outcomes	Executive & Project Lead	Cap / Rev Finance Implications	Timescale
3.	Deliver more care in or nearer citizen's homes where appropriate, for example, the administration of SACT through the development and expansion of homecare delivery teams	Develop plan to expand the support function for increase in current use of Healthcare at Home (or appropriate supplier) in the ABMUHB area Develop plan to increase the support function further for introduction of Healthcare at Home (or appropriate supplier) in the Hywel Dda area	Increase in treatments delivered nearer the citizen home in Primary Care or mobile units across the region Increase in treatments delivered in the citizen home <i>Improved RTT times</i>	HB Primary Care Group Service Team Pharmacy	As above	
4.	Create citizen information hubs locally which will allow citizens to be signposted to appropriate support – both within our own services but also to services offered by the third sector and social care to do this we will develop stronger links with primary care, community and third sector services	Liaise with all stakeholders to collate all available support networks for citizens. Gather this information and make available for all stakeholders to access in a common, open, accessible and appropriate means Greater access to information about services such as access to transport, emotional support, family and any other necessary advice Ensure that Healthcare staff are aware of the accessibility of information available for citizens regardless of where they visit to deliver treatment or consultation	Create database of stakeholders and services available for citizens Capture all information available at individual sites from all partners and ensure this is made available on all sites to our citizens regardless of where they visit for their treatment or consultation Greater support for citizens Improved citizen experience <i>Improved citizen experience</i>	Health Board PALS/CISS Cancer Network	Nil	
5.	Improve communication and information channels to support clinical teams across the region to provide seamless and equitable	Produce a cancer staff centred regional forum to allow teams to share new information, best practice, new initiatives and events across South West Wales	Open a cancer forum on ARCHi, a web based discussion platform, as a means of contacting and sharing good practice Improved citizen experience	ARCH Skills & Workforce Group	Nil	

	Objective	Task	Milestones & Key outcomes	Executive & Project Lead	Cap / Rev Finance Implications	Timescale
	care for citizens		Introduce a regional cancer newsletter <i>Improved citizen experience</i>			
6.	Ensure earlier referrals to rehabilitation and therapy services to improve access to curative treatments which will give the best chance of gold standard clinical outcomes	Establish a programme of work to review the pathways and identify where therapy services could be introduced earlier in to the pathway to enable earlier rehab or prehab for citizens undergoing treatment Pilot across 2 or 3 tumour sites to measure effectiveness of earlier interventions	Agreed pathways developed with earlier therapy services intervention <i>Improved citizen experience</i> <i>Better outcomes</i> <i>Improved staff experience</i>	Service Team Cancer Network	Nil	
7.	Develop a regional plan that identifies the workforce needs (skills, roles, and training/ education requirements) and working with the university and other providers to ensure we are producing and developing staff who have generalist as well as specialist skills, who can work effectively in teams across the whole region	Carry out a gap analysis of the workforce across the region to identify where the greatest need is for recruitment and training of staff to meet minimum standards Identify where new roles can be developed to deliver sufficient knowledge and care for citizens where traditional roles would not allow sufficient need to ensure/maintain competency Identify where new roles can be developed to support the current and future processes to ensure citizens are moved through the system as quick and safely as possible Identify where roles can be developed to allow healthcare	Complete a workforce gap analysis in cancer service and produce a report to outline the details that can go to relevant Health Board Executive Teams for support. Produce a plan to address the outcomes of the gap analysis with clear actions to address recruitment and training issues <i>Improved citizen experience</i> <i>Improved RTT times</i> <i>Improved patient outcomes</i> <i>Improved staff experience</i>	ARCH Skills & Workforce Group	Nil	

	Objective	Task	Milestones & Key outcomes	Executive & Project Lead	Cap / Rev Finance Implications	Timescale
		professionals to work to the top of their license creating a satisfied and more sustainable workforce Work with the University the develop training and courses to develop staff to fill gaps identified in the system				
8.	Apply the highest standards and share best practice from across the region in all units	Develop a programme of work to determine the best practices in care from across the region and share with others to drive up the standards of care for our citizens across the care pathway	Introduction of regional standardised competency based courses for roles across the disciplines <i>Reduction in DATIX incidents & complaints</i> <i>Improved citizen experience</i>	ARCH Skills & Workforce Group	Nil	
9.	Greater use of information technology to assist with more virtual or remote clinics to reduce citizen travel times and increase the information which can be accessed and shared	Build on pilot conducted to expand use of Skype as a means of virtual clinic appointments Engage with IM&T in HBs to drive the technology use and make accessible wherever required to meet the needs of healthcare staff and the citizen Examine the potential for appropriate appointments to be conducted whilst the citizen is at home Create VC facilities in more local healthcare venues, hospitals or primary care, to reduce travel for	Introduction of virtual clinics as mainstream option across the region Protocols for conducting virtual clinics Improved citizen experience Virtual clinic consultations in citizen home where appropriate Virtual clinic consultations between consultant location and other suitable identified location <i>Improved citizen experience</i>	HB IM&T Teams	Dependant on venues and locations, capital costs to create/ refurb facilities for suitable VC. Where Skype used no licensing costs but VC units or Polycom could incur capital expenditure	

	Objective	Task	Milestones & <i>Key outcomes</i>	Executive & Project Lead	Cap / Rev Finance Implications	Timescale
		patient to appropriate appointments	<i>Reduce patient travel</i>			
10.	Develop tumour site-specific citizen information pathways	Work with MDTs from across the region to map out pathways and attach relevant information to all appropriate areas for citizens to feel informed throughout their journey. Information should include local and National sources to offer choice to fit the need of the individual	Creation of citizen accessible webpages with associated information collated <i>Improved citizen experience</i>	Service Teams MDT Leads	Nil	
11.	Develop the innovative use of technology such as ChemoCare, virtual video clinics and remote radiotherapy planning/approval to reduce citizen waiting times	Utilise technology to improve communication lines between healthcare professionals and also between citizens and partners where appropriate. Communication protocols should be developed to help reduce the delays in the system/processes to improve waiting times	Lowering in waiting times for outpatient appointments and subsequent treatments <i>Improved RTT times</i>	HB Radiotherapy Lead Service Imp Team	Nil	
12.	Develop our existing links with Swansea University through the ARCH partnership to ensure we maximise emerging cutting edge research	Develop a research group with interested parties from across Health Boards and the University and its partners to help maximise the opportunities available through research to drive up standards and outcomes for our population. Nominate a Research Lead to chair and lead this work	Introduction of an innovations group that links HBs with University <i>Improved patient outcomes</i>	HB Research Lead	Potential for sessional costs to release from primary role	

	Objective	Task	Milestones & <i>Key outcomes</i>	Executive & <i>Project Lead</i>	Cap / Rev Finance <i>Implications</i>	Timescale
13.	Benchmark all aspects of our care and outcomes against other UK and global cancer services to ensure it is as efficient as possible and gives citizens the best experience possible	Ensure that systems such as Mosaiq and ChemoCare have their datasets mandated and benchmarked against UK National datasets Where National audits are in place, continue to participate and strive for improvement against peers across Wales and UK	All appropriate systems supplying a data feed to National datasets <i>Improved citizen experience</i> <i>Improved RTT times</i> <i>Improved patient outcomes</i>	HB ChemoCare Lead HB Cancer Information Teams	Nil	
14.	Better use the information and data we have to plan services to meet the expected increases in demand	Work with the University to utilise the SAIL database to further develop the ability to plan to meet the future need of our population	Establish a working group to examine the possibilities for exploitation of the SAIL database <i>Improved patient outcomes</i>	HB Exec Teams	Nil	

Appendix 12. WELSH LANGUAGE

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. We want to provide safe quality services whilst ensuring that our service users are treated with dignity and respectfully offering services in Welsh for those that want and need this without the need to ask for it – the active offer. This is at the heart of our plan for providing a quality Welsh language service empowering the patient to be equal partners in their care ensuring that their each individual physical, psychological, social, cultural, language and spiritual needs are addressed.

In order to provide the necessary foundations to support such services we are working with GPs to include such details in referrals, raising the issue at outpatient appointments and via the admission process for in-patients and daycases. We have also taken steps to improve the correspondence we send to patients which is generated by our patient administration systems by making this available bilingually until we are able to operate systems which can recognise the need for either a Welsh or an English letter. We are also introducing new systems to remind patients about their forthcoming appointments which are also bilingual. At the same time we are continuing to increase the range of patient information that is produced bilingually via leaflets, posters, questionnaires, on our website and via social media etc as well as encouraging service feedback through the medium of Welsh.

The Strategy Cymraeg 2050 A million Welsh speakers sets a challenge of achieving a million Welsh speakers by 2050 and calls for far-reaching changes. Boundaries need to be pushed and ambitious action taken to enable more people to learn and use Welsh. The strategy builds on existing foundations and moves us on to the next stage in our language journey. Three strategic themes have been identified by Welsh Government to achieve this vision:

1. **Increasing the number of Welsh speakers**
2. **Increasing the use of Welsh**
3. **Creating favourable conditions – infrastructure and context**

The Well-being of Future Generations (Wales) Act 2015 includes the duty of “sustainable development” and the process of improving the economic, social, environmental and cultural well-being of Wales, by taking action in accordance with the sustainable development principle aimed at achieving well-being goals. In preparing and delivering our local well-being plans Welsh language issues will be given due consideration reflecting the official status of the language in Wales and the National well-being goal of ‘a thriving Welsh language’.

In 2013 the Welsh Language Commissioner conducted an inquiry into the Welsh language in primary care in Wales. The aim was to investigate the experience of Welsh speakers receiving or failing to receive services in Welsh from primary care providers in Wales. The final report of the inquiry recommended the production of baseline statistics concerning Welsh Language primary care services. The link provides a statistical summary for Abertawe Bro Morgannwg University Health Board's [profile](#).

Based on the evidence gathered, it was evident across the sector that the Welsh language is an intrinsic part of the quality of healthcare and that a Welsh language or bilingual service is vital for the welfare of Welsh speaking patients.

Implementing our Bilingual Skills Strategy is a key component in our commitment to deliver quality care and to treat all of our community with dignity and respect. It fits within our organisational values and is a vital part of the way we will seek to deliver on the requirements set out in the draft Welsh Language Standards. This is reflected in the Workforce section as well.

We are pleased that we achieved the highest level of registrants (amongst all public sector organisations in Wales) in terms of the all-Wales 10 hour on-line Welsh Language course which shows the significant level of interested amongst our staff in learning the language. We are now in the process of following this up with individual staff so that we can convert this enthusiasm into positive action for our service users.

Our Welsh Language Officer continues to work across the Health Board providing advice and support to individual teams and departments to continually improve the plans we have in place to improve bilingual services. Close links are also being maintained with colleagues in other Health Boards so that it is possible to share learning between organisations. We also continue to receive a Welsh Language themed patient story at least on an annual basis at the start of our Board meetings.

There has been much activity in improving the provision of bilingual services in recent years and we are striving to build upon this important work and in so doing meet many of the requirements in the soon to be published Welsh Language Standards. The consultation on the Welsh Language Standards came to an end in October 2016 and once finalised will replace Welsh Language Schemes, setting out how we as an organisation are expected to deliver bilingual services.

The Welsh Language Standards have now been drafted with the aim of:

- Improving the services Welsh-speakers can expect to receive from organisations in Welsh
- Increasing the use people make of Welsh language services
- Making it clear to organisations what they need to do in terms of the Welsh language

- Ensuring that there is an appropriate degree of consistency in terms of the duties placed on organisations in the same sectors

We are planning to implement the Standards in preparation for the expected compliance notices that will be issued by the Welsh Language Commissioner. The Standards fall into the following categories and are specified in the Regulations:

Service-delivery standards will be imposed in relation to the delivery of services in order to promote or facilitate the use of the Welsh language, or to ensure that it is treated no less favourably than English.

Policy-making standards will require organisations to consider what effect their policy decisions will have on the ability of persons to use the language and on the principle of treating Welsh no less favourably than English.

Operational standards deal with the internal use of Welsh by organisations.

Record-keeping standards will make it necessary to keep records about some of the other standards, and about any complaints received by an organisation. These records will assist the Commissioner in regulating the organisation's compliance with standards

Standards that deal with supplementary matters.

In order to showcase the various examples of good work that is ongoing within the Health Board, we have developed a category in our annual Chairman's Awards around Bilingual Services.

Appendix 13. RESEARCH, DEVELOPMENT AND INNOVATION

13.1 Research and Development

Progress in 2017/18

Target	WG target	Annual Plan 17/18 trajectory	September 2017	March 2018
Increase in research activity for people of all ages Number of Health and Care Research Wales Clinical Research Portfolio studies and commercially sponsored studies	Increase by 10% - non-commercial, 5% commercial No. of Clinical Research Portfolio studies: 120 No. of Commercial studies: 38	Non-Commercial studies based on 4yr average – 101 studies. Commercial (based on 4yr average) 34 studies	Approx. 75 studies open and recruiting – non-commercial Approx 22. studies open and recruiting - Commercial	101 studies –non-commercial 34 studies - commercial
Number of participants recruited into Health and Care Research Wales Clinical Research Portfolio	Increase by 10% non-commercial, 5% commercial No. of patients	No. of patients recruited to non-commercial portfolio studies (based on 4 yr average) 2886	No. of patients recruited to non-commercial studies: Approx. 1266	2886 –non-commercial

studies and commercially sponsored studies	recruited to non-commercial studies: 3,062			
	No of patients recruited to commercial studies: 232	No of patients recruited to commercial (based on 4yr average) 277	Commercial: Approx. 138	277- commercial

Examples of Research and Development progress aligned to Health Board and Service Delivery Unit specific priorities include:

- **Enable and empower more people to care for themselves** - supporting patients to self-monitor blood glucose levels through the SMBG research programme. Also the Health Board supported a pilot service-evaluation study which has shown that watching short health information films online helps people living with type 2 diabetes reduce their HbA1c – an established marker of diabetes control. The report published in the international journal Primary Care Diabetes, shows a clinically significant improvement in HbA1c among those patients who watched one or more of the PocketMedic 'Living with Diabetes' films on their computer, tablet or smartphone.
- **Improve access to care** – increase in clinical trial access enabling access to improved treatments.
- **Contribute to improving financial position** - we have 15 cancer studies active where drug is provided free of charge or at reduced rate. This has provided drugs savings in some cases of approximately £60,000 per patient recruited for example in the Trilogy Study. Revenue generation from commercial trial income has enabled appointment of more Joint Clinical Research Facility medical posts who also maintain a clinical workload. Outpatient costs are reduced whilst a patient is on trial. In order to participate in the PHOTO trial the Urology department in Morriston needed equipment for the photodynamic diagnosis, specifically the specialised blue light cystoscopic equipment needed for the experimental arm of the study. This piece of equipment cost £54,026 and was purchased through an Excess Treatment Cost application and is now also available to the Urology team to use outside of clinical trials.

- **Reducing harm** – ABMUHB health visiting team are undertaking research with Prime Centre Wales on the roll out of the FRAIT tool, which provides Health visitors with a framework to assess family resilience, work is now progressing to licence the tool across the NHS in Wales and England with potential for licence revenue generated from the ABMU share in the Intellectual Property (IP).
- **Quality Priorities - Pressure Ulcers:** Development of pressure ulcer app to support the management of pressure ulcers within the community through use by community staff and patients self-care to monitor symptom – work led by ABMUHB Rehab engineering dept. in collaboration with Fujitsu.
- **Quality Priorities - Suicide prevention:** Prof Ann John led research into exploring the social and psychological factors and mechanisms that trigger a suicide cluster, the 'Cherish' study which completed in 2016 will help inform the development of appropriate policy to identify and respond to suicide clusters at an earlier stage, aid planning of appropriate service provision, and inform appropriate advice to communities experiencing a cluster. *We also contribute to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*
- **Quality Priorities - Falls:** The R&D team worked with Prof Helen Snooks and the Welsh Ambulance Services Trust on the SAFER 2 study. The Support and Assessment for Fall Emergency Referrals (SAFER) 2 study aimed to assess the costs and benefits of new protocols for paramedics to assess older people following a fall, with an option to leave them at home with a referral to a community falls service. They compared what happened to patients attended by paramedics with the new protocols (intervention group) with what happened to patients attended by paramedics delivering usual care (control group).

The intervention group were less likely to make further emergency service calls. Although only 8% of patients were referred directly to falls services by paramedics, overall this meant that fewer patients were left at home without further care. The intervention was as safe as usual practice. Patients were generally happy with the care they received and paramedics found that the protocol increased their confidence.

The SAFER 2 study findings indicate that ambulance services may introduce this new pathway safely and at low cost, and expect reductions in further emergency service calls. (Health Technology Assessment, No. 21.13. Snooks HA, Anthony R, Chatters R, et al. Southampton (UK): [NIHR Journals Library](#); 2017 Mar.)

Quality Priorities - PROMS/PREMS: *Examples of relevant studies currently supported include 'PROMISCR – The Patient Reported Outcome Measure in Skin Cancer Reconstruction. CI – Prof Iain Whitaker. The aim of this study is therefore to use patient-reported outcome measures (PROMs) to explore patients' views of the different types of reconstruction available and to investigate if currently available questionnaires are sensitive enough to be used in research and routine clinical practice. All eligible*

patients seen at the Welsh Centre for Burns and Plastics and who are diagnosed with a skin cancer on their head or neck will be invited to take part in the study.

‘PROMIS – Delivery of Patient Reported Health Status Questions in Stroke ‘

The Assessment of Patient Reported Health Status Questions via Four Different Methods of Administration, in Stroke Survivors. A Randomised Controlled Trial.

At present, the NHS in England, Scotland and Wales are required to offer every stroke survivors a 6 month post stroke follow-up appointment. Currently, the information collected at this 6 month review is not from the patient’s perspective and the best method of collecting this information has not been established. The aim of this research is to understand if there is a difference between 4 methods of administration using a grouping of Patient Reported Health Status Questions (PRHSQs) in people who have had a stroke.

- **Routine Data:** ABMU Pharmacy have implemented an automated download of all discharge prescriptions as patients are discharged from secondary care. The data identifies the drugs that patients were admitted on that are to continue post-discharge, those that were stopped and any new meds which must continue post-discharge. The aim is to upload this data to SAIL to enable a complete mapping of prescribing across Wales that can be linked to patient diagnoses, admissions, pathology data and patient outcomes. This will give a unique research opportunity to examine the gaps in patient care, perform pharmacovigilance, support the prudent agenda and aid the development of precision medicine in Wales and a Pharmacy Research Laboratory centred at Swansea University.
- **Stroke:** Following success of ALiveCor study on the early identification of AF through the use of mobile technology monitoring, phase 2 is being developed - Piloted 2 studies one included in the Stroke discharge pathway and one for the Outreach team in CIMLA – which assesses elderly patients at home (assessing its usefulness in identifying AF and being used for monitoring heart rate once medication has been prescribed for AF). Other opportunistic screening will also be undertaken using the AliveCor – study planned in Community Pharmacies where patients collecting medications can have an AliveCor reading. Other areas are being discussed. Our portfolio of stroke research studies is strong and we have over 7 studies open to recruitment, looking at early treatment with a glyceryl trinitrate patch in a 999 setting (RIGHT-2), the use of antithrombotics following stroke (RESTART) and interventions to improve rehabilitation following stroke (LOTS2CARE). We are recognised as a successful site for recruitment into stroke studies and our research nurse was invited to speak at the UK Stroke Research forum to share good practice in recruitment into the RESTART trial.
- **Health Wise Wales** We are actively supporting patient and public sign up to the Healthwise Wales Study. This study aims to look at ways to prevent and treat long-term health conditions, such as heart disease, diabetes, cancer, mental health and

dementia. The information will help the NHS in Wales plan for the future, but it also encourages the people of Wales to engage more with the health research agenda in Wales. In ABMU we have developed a recruitment plan to ensure as many people as possible living in the ABMU HB catchment are given the opportunity to join the study.

- ***Mental Health:*** We are also supporting recruitment into Post Traumatic Stress Disorder studies.
- ***Improve patient pathway/Enhance diagnostic pathway:*** Research developing a blood test to early detect colorectal cancer led by Prof Dean Harris is underway and has the potential to significantly improve the care and service pressures of managing patients presenting with bowel cancer symptoms. ABMU Trauma Physiotherapy team are developing the roll out of predictive risk assessment tool for the management of blunt chest wall trauma, work has potential to rollout to Ambulance service which may reduce numbers going to A&E.
- ***Children & Young People*** –Within R&D we have a dedicated paediatric research nurse and support a wide range of studies in neo-natal and child health.

Overview of Plans for 2018/19

As part of the regional agenda, there are opportunities to closer align working between ABMUHB and Hywel Dda Research and Development departments. Through City Deal plans, there is also a focus on the wellbeing agenda through the expansion of the Joint Clinical Research Facility (JCRF) to the Llanelli Wellness Village. The shape of the JCRF will provide a basis for future expansion to support community based research linking to the wellbeing of future generations agenda. For example, building on initiatives of community research partnerships such as the work underway by the ABMUHB clinical psychology team.

Dr Zoe Fisher's Ser Cymru II fellowship application on 'Co-constructing and improving models of health care for people with chronic conditions through strategic healthcare/university/community partnerships will support the creation of '... health ecosystems that keep people well and out of our acute hospitals where possible. A core feature of the research proposal is the argument that health is a bio-psych-social enterprise that cannot be achieved in isolation of the networks and systems that surround people...Chronic conditions often lead to reduced participation, social isolation and loneliness.' Such examples of Health Board and community partnerships will enable a shift to focus on how to improve health outcomes through community initiatives and the social prescribing agenda.

We will also maintain focus on our areas of clinical trial excellence, the ongoing industry collaboration in fields of both pharma and Med-tech will continue to provide the opportunity to improve the health and wealth of the local population through job creation and access to innovative medicines and technologies, notably in areas of diabetes, cardiology and cancer.

With regard to Nursing Research, Development and Innovation, our Nursing and Midwifery Strategy 2017 sets out the following outcomes and measures which we will be implementing.

	Year 1	Year 2	Year 3
Research, Development and innovation	Scope research currently being undertaken by nurses and midwives: • Masters Degree • PhD / Professional Doctorate Provide University-led engagement events to promote scholarship and research among nurses and midwives. Put the patient/service user at the heart of new knowledge creation by ensuring that nurses and midwives select research topics relevant to the needs of the service, providing direct benefit of health and wellbeing.	Ensure that nurses and midwives who receive funding to undertake a research degree share their findings verbally to their manager and peers and provide an electronic copy. Increase the number of nurses and midwives writing and publishing their research in professional and academic journals. Provide University-led opportunities for nurses and midwives to present their research findings.	Increase the number of nurses and midwives submitting bids for external funding as a principal investigator or member of a multidisciplinary team. Include the patient/ service user in the co-production of new knowledge creation by promoting public involvement and engagement in research.

Plans for 2018/19

Priority Area	Objective	Measure
Unscheduled Care	Increase use of cardio-protective drugs through clinical	Reduction of admission

Priority Area	Objective	Measure
	trials in the management of high risk type 2 diabetes patients which will contribute to reduction in hospitalisation for Heart failure.	
Planned Care	Engage with studies which focus on reducing time for diagnosis and treatment. Enhance service delivery through sessional support funded by commercial trial activity	No. of studies No of clinical sessions funded through research income.
Stroke	Support improvement in AF pathways through roll out of ALIVECOR phase 2 study – planned in Community Pharmacies where patients collecting medications can have an AliveCor reading. Other areas are being discussed.	Successful implementation of ALiVeCor technology
Cancer	Continue to support national cancer trial targets. Manage demand pressures for cancer trial imaging through use of ILS2 Imaging facilities.	Number of cancer studies open. Number of patients scanned within ILS2.
Healthcare Acquired Infections	Further develop collaboration with Fujitsu on development of pressure ulcer app to support improved management of pressure ulcers within the community.	Roll out of app across the region
Other	Develop clear pathway for knowledge transfer through	No of innovations successfully supported.

Priority Area	Objective	Measure
	the implementation of the IP Policy management framework and referral to AGORIP scheme. Ensure research implications from GDPR are fully addressed.	Successful implementation of new DPA requirements into research governance processes.
Quality and Safety	Increase research studies focussing on PROMs/PREMS such as development of listening outcome measure for cochlear implant patients. Continue to work with Involving People network via Health and Care Research Wales infrastructure to ensure appropriate PPI engagement in Trial development groups.	No. of studies with Proms/PREMS integral to study design led by the HB. No. of HB sponsored studies with PPI representation.
Workforce	Increase in clinical academic recruitment due to research enhanced JD and link to Med School in Swansea University. Increase in Research SPA sessions Increase number of Clinical Research Time awards Support ongoing service based posts with a research focus.	No. of Clinical academics appointed. No. of SPA sessions dedicated to research. No. of Clinical Research time awarded. No. of research support posts in place.
Revenue	Support application to national research revenue schemes such as ETTF, RfPPB, HTA which require upfront support from the HB thereby demonstrating corporate commitment to research.	Amount of revenue secured via such schemes.

13.2 Innovation

Much of our structured innovative work is being progressed through the ARCH programme which is run jointly between ABMUHB, Hywel Dda UHB and Swansea University. Together we aim to improve population health by reducing variation and providing access to excellent care. We want to improve the wellbeing of the region through focused interventions to improve the engagement of the public with their own health and wellbeing and also promote a vibrant economy through investment, innovation and sustainability of employment. We know that people who have jobs, good housing and are connected to families and community feel, and stay, healthier.

In terms of the economy, ARCH aims to:

- Mobilise the NHS capacity to innovate and translate ideas for the economic benefit of region;
- Create open innovation environments and culture, co-locating truly world leading science, practice and enterprise; and,
- Harness, retain, nurture and adopt indigenous life science enterprises while attracting global innovators for sustainable economic and health benefit.

Both Health Boards are highly ambitious and are driven to deliver excellence. Staff will work and train in a highly innovative health service, with great opportunities for professional development and collaboration, and the support to drive innovation and service improvements for the benefit of patients.

ARCH is also reacting to the requirement to build a shared responsibility for tackling the challenges facing public services, and the need for innovation, to develop a wider conversation about necessary reform by designing and implementing models which can deliver change at scale and at pace.

The life science and health sector in Wales employs 11,000 high-value jobs in more than 350 companies. Overwhelmingly, these companies are Small, Medium-sized Enterprises (SMEs) with a modest number of large global enterprises creating significant employment.

The majority of economic activity is in a sub-set of life science called medical technology (often referred to as medtech or healthcare technology).

ARCH has fostered relationships between Talent Bank and Fujitsu and Intel to ensure that local students can be immersed in an

innovation-rich environment working with leading industry, health and life science partners. Education needs collaboration and support from the industry to ensure the right skills development for young people, to lead to future employment opportunity. Fujitsu have supported the project by setting up an Innovation Hub to provide students with digital skills development.

The economic “accelerator partnership” of ARCH will cement the region’s role as a test bed for new health technologies, particular through expanding our successful Institute of Life Science. We will continue to nurture and create high quality jobs and bring prosperity to South West Wales.

ARCH has been built on the belief that by strategically integrating and regionally planning our approach to health service development, skills and education, and workforce development as well as research and innovation in the health and life science sector, we will deliver improved wellbeing for the population and increase the benefits.

There are already examples of collaborative work delivering measurable benefits in terms of service delivery, education, research, innovation, and enterprise. These are now being built on within the ARCH Portfolio. For example the Research, Enterprise and Innovation (R, E and I) strand builds on the successes achieved by the ILS network – whereby 800 skilled jobs and £42 million of investment have been secured. The expectation is that delivery of the nine schemes within the R, E and I strand will translate to an additional 2,563 jobs in the life sciences sector within 10 years and an increase in GVA in the South West Wales economy by £347million over the same period.

We have also developed AgorIP to unlock innovation in the NHS and to provide a support service to drive innovation and realise the huge value from Intellectual Property generated across the ARCH region. It will provide a support framework to bring ideas to market and support our Health Boards in realising their commercial value. AgorIP will open a pipeline of untapped valuable opportunities to work with researchers and NHS staff to disclose concepts with development potential. It is a £13.5million European Union-supported scheme which is also backed by £6.7million from Welsh Government and funding from Swansea University, which brings together clinicians, academics and industry to pioneer research into cutting-edge technologies. Led by Swansea University through ARCH, AgorIP will work with NHS and industrial collaborators across North and West Wales and the South Wales Valleys to turn innovative research into new products, processes and services.

An example of how this works in practice is the work being carried out by ABMUHB’s Rehabilitation Engineering Unit. Dr Lorna Tasker and her team are developing an app to improve patient care and reduce the huge challenges caused by pressure ulcers. The app is being developed in partnership with Welsh Government and Fujitsu and will provide accessible expert advice to prevent ulcers getting worse and to promote healing without surgery, allow clinicians to remotely screen patients and help decide who

needs to be seen most urgently.

The ARCH Digitisation Programme is also just starting up which aims to:

- Underpin the ARCH Programme Work Streams
- Support the Joint Regional Planning and Delivery work to support service redesign through digitisation in key pressure eg Ophthalmology, ENT, Orthopaedics and General Surgery;
- Inform our future Clinical Strategies – ABMUHB is refreshing our Clinical Strategy and Hywel Dda UHB are about to go to consultation;
- Support Recovery and Sustainability through digital work programmes to improve the use of our resources; and,
- Through ARCH, provide the foundations for joined up business and investment proposals to boost the economic growth of the area.

Appendix 14. ABMUHB DELIVERY PLANS

Our Cancer and Stroke Delivery Plans are included as the Service Improvement Plans in the Annual Plan document. The other plans are embedded as thumbnails below.

The Leads for Respiratory Disease and Organ Donation have advised that the Planning Framework timelines do not align with the Implementation Group timescales. The 2017/18 Plans are appended. The Organ Donation Plan for 2018/19 will be completed by June following receipt of the Health Board's data and the Respiratory Disease Plan will be completed after the new National Delivery Plan is issued. Our Heart Disease Delivery Group is being refreshed and will take then forward the completion of the local plan.

Our assurance regarding the Delivery Plans has been reviewed and will be undertaken through the Quality and Safety Committee going forward. Assurance on delivery is provided through the Annual Plan assurance mechanisms.



AMR

Implementation Plan

Critically Ill Delivery
Plan - Morriston 2018/19Critically Ill Delivery
Plan - POWH 2018/19Diabetes Delivery
Plan 2018/19.docx2018/19 ABMUHB
Diabetes Delivery PlanEnd of Life Care
Delivery Plan 2018/19



Eye Care Delivery
Plan 201819.docx



Liver Disease
Delivery Plan 201819



Neurological
Conditions Delivery



Oral Health Delivery
Plan 201819.docx



Organ Donation
Delivery Plan 201718



Rare Diseases
Delivery Plan 201819



Respiratory Delivery
Plan Annual Report



T4MH update v6-
ABMU Health Board

Appendix C - IMTP Mandatory & Discretionary Templates 2018/19 to 2020/21

To Update

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 Undergraduate Education
 - C19.2 PostGraduate Education
 - C19.3 Assistant Practitioners & HCSW
 - C19.4 Medical & Dental

WEDS 22/9
WEDS 22/9
WEDS 22/9
WEDS 22/9

Discretionary Template - Sheet

- C20 Delivery - LHB & Trust Specific Internal Service Delivery Plans & Measures

Additional Mandatory Templates

- C21 Supplementary Analysis of Changes in Operating Expenses - Summary
- Additional Discretionary Template - Sheet**
- C21a Supplementary Analysis of Changes in Operating Expenses - Workings

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

NHS Organisation		ABMUHB		UPDATED		07.02.18												
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
Quarterly	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	95.0%	95.0%			96.0%			96.0%			96.0%					
	Percentage of children who received 2 doses of the MMR vaccine by age 5		92.0%	92.0%			93.0%			93.0%			93.0%					
	The percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual target	2.2%	0.8%			1.6%			2.4%			3.2%					
	The percentage of those smokers who are co-validated as quit at 4 weeks	40% annual target	40%	40.0%			40.0%			40.0%			40.0%					
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
Monthly	The percentage of patients waiting less than 26 weeks for treatment	95%	89.5%	89.8%	90.2%	90.6%	89.5%	88.8%	88.1%	87.4%	86.7%	86.0%	85.3%	84.6%	83.9%			
	The number of patients waiting more than 36 weeks for treatment	0	3,426	3,365	3,305	3,244	3,183	3,122	3,062	3,001	2,940	2,879	2,819	2,758	2,697			
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0	-	-	-	-	-	-	-	-	-	-	-	-	-			
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date	Reduction (12 month trend)	59,739	58,749	57,759	56,770	55,780	54,790	53,801	52,811	51,821	50,832	49,842	48,852	47,862			
	% compliance with stroke QIMs:	Direct admission to Acute Stroke Unit (<4 hrs)	The most recent SSNAP UK National quarterly average	40.0%	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	65.0%	65.0%	65.0%		
		CT Scan (<1 hrs)		40.0%	40.0%	40.0%	40.0%	45.0%	45.0%	45.0%	45.0%	45.0%	50.0%	50.0%	50.0%			
		Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)		75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	85.0%	85.0%	85.0%			
		Thrombolysis door to needle <= 45 mins		20.0%	20.0%	25.0%	25.0%	30.0%	30.0%	30.0%	35.0%	35.0%	35.0%	40.0%	40.0%	40.0%		
	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%	79.0%	82.6%	83.1%	83.0%	88.3%	88.1%	87.8%	89.4%	90.3%	90.4%	90.1%	90.2%	90.3%			
	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	450	215	194	190	229	227	180	255	315	289	283	196	179			
	The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%			
	Number of ambulance handovers over one hour	0	389	171	126	152	159	229	149	223	262	304	262	183	139			
	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%	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%	90.0%	83.0%	85.0%	89.0%	90.0%	91.0%	91.0%	92.0%	92.0%	91.0%	92.0%	92.0%	93.0%			
	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%			
	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%			
For HBs with OOH services: Percentage of urgent calls that were logged & patients started their clinical definitive assessment within 20 mins of initial calls being answered For HBs with 111 services: Percentage of P1 calls that were logged & patient started their clinical definitive assessment within 20 mins of the initial calls being answered	98% (OOH)	Data Not Available																
	Improvement (12 month trend) (111)																	
For HBs with OOH services: Percentage of patients prioritised as very urgent and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage For HBs with 111 services: Percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage	90% (OOH)	Data Not Available																
	Improvement (12 month trend) (111)																	
Quarterly	Percentage of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	100%	100%	100.0%			100.0%			100.0%			100.0%					
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
Monthly	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	90%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%			
	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
Monthly	Number of mental health HB DTOCs	At least a 10% reduction on the 2017/18 position	30	30	29	28	27	30	28	27	28	28	29	28	27			
	Number of non-mental health HB DTOCs	At least a 5% reduction on the 2017/18 position	40	38	40	38	38	47	60	51	57	46	45	40	39			
	Percentage of episodes clinically coded within one month post discharge end date	95%	95.0%	95.0%	96.0%	96.0%	95.0%	95.0%	95.0%	95.0%	96.0%	95.0%	96.0%	96.0%	96.0%			
	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	95%	95.0%	95.0%	95.0%	95.0%	96.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%			
Quarterly	All new medicines must be made available no later than 2 months after NICE and AWMMSG appraisals	100%	100.0%	100.0%			100.0%			100.0%			100.0%					
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
Bi-annual	Percentage of NHS employed staff who come into contact with the public who are trained in an appropriate level of dementia care	85%	Data not available															
Quarterly	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Reduction (4 quarter trend)	Data not available															
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	75%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%			
SAFE CARE - I am protected from harm & protect myself from known harm																		
Measure		Target	Profile															
			Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21	
@BCL @70062FAC.xlsx																		

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

Measure		Target	Projected end of March 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21		
Monthly	The rate of laboratory confirmed C.difficile cases per 100,000 population	Performance against 18/19 local target. Local target shown as number of cases per month not rate per 100k population.	281	21	18	26	20	22	20	20	24	13	19	15	21				
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population		202	13	18	13	18	11	13	13	15	21	13	19	15				
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population		530	45	39	40	45	42	45	44	37	41	45	39	42				
	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	90% - NB. We understand this is an error and the target is 80%.	85.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%				
	Number of new Never Events	0	3	0	0	0	0	0	0	0	0	0	0	0	0				
	Number of grade 3, 4 and unstageable healthcare acquired (both hospital and community) pressure ulcers reported as serious incidents	Reduction (12 month trend)	120	10	10	10	10	10	10	10	10	10	10	10	10				
	Number of administration, dispensing and prescribing medication errors reported as serious incidents		1	0	0	0	0	0	0	0	0	0	0	0	0				
	Number of patient falls reported as serious incidents		18	2	2	2	2	2	2	2	2	2	2	22	2				
Quarterly	Fluroquinolone, cephalosporin, clindamycin and co-amoxiclav items as a percentage of total antibacterial items prescribed	Reduction (4 quarter trend)	Data not available																
	Non steroid anti-inflammatory drug (NSAID) average daily quantity per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)		1,492	1,492			1,492			1,492			1,492						
	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)		320	320			320			320			320						
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 2018 position	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Mar-20	Mar-21		
Monthly	The percentage of patients who did not attend a new outpatient appointment	Reduction (12 month trend)	6.10%	6.01%	5.95%	5.90%	5.85%	5.80%	5.75%	5.70%	5.65%	5.60%	5.55%	5.50%	5.49%				
	The percentage of patients who did not attend a follow-up outpatient appointment		8%	7.94%	7.87%	7.80%	7.74%	7.67%	7.60%	7.54%	7.47%	7.40%	7.33%	7.27%	7.20%				
	Number of procedures that do not comply with selected NICE 'Do Not Do' guidance for procedure of limited effectiveness (selected from a list agreed by the Planned Care Board)	0		0	0	0	0	0	0	0	0	0	0	0	0				
	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	85%	60%	63%	66%	68%	70%	70%	70%	72%	74%	74%	76%	78%	80%				
	Percentage compliance for all completed Level 1 competency with the Core Skills and Training Framework		40%	43%	46%	48%	48%	48%	50%	52%	54%	56%	58%	60%	62%				
Quarterly	Biosimilar medicines prescribed as percentage of total 'reference' product plus biosimilar	quarter on quarter improvement	Data not available																

SERVICE CHANGE & SHIFT OF SERVICES / ACTIVITY / WORKFORCE / FINANCE FROM SECONDARY CARE TO PRIMARY & COMMUNITY CARE - HIGH LEVEL MILESTONES

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.

LISTED IN ORDER OF APPEARANCE IN DOCUMENT

ID	Ref in Annual Plan Annex 1.	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	1. USC Service Improvement Plan	Improve access to dental care through Dental Recovery Plan	Chief Dental Officer and HB have agreed a plan to improve access to dental care and other initiatives around oral health. There will be further planned changes to general dental contracts, pathway changes eg around procedures for children under general anaesthesia, premises / practice improvements, a new contract for services in Neath etc	Qu 4	Access to general dentistry improved; access for specialist denture activity	3 additional A&C approved 17/18 - induction 2018/19. New staff model for Community Dental Service under consultation	Separate 3 year investment strategy has been agreed with WAG from within ring-fenced funding for oral health	Key risk is insufficient management capacity to deliver new projects - additional staffing has been approved but is pending.	Reduction in numbers of residents expressing difficulty in accessing services; reduction in waiting times for specialist dental services; reduction in children undergoing treatment under GA, improvements in DMFT scores and oral health measures
2		Improve primary care screening for chronic conditions	Increase number of residents taking part in national and local screening programmes such as bowel cancer screening, aortic aneurysm, etc. Improved cluster based scrutiny of relative rates of screening	Ongoing all year	Earlier detection of cancer and other symptoms will reduce care needs, reduce referrals when patients have more advanced treatment needs etc	None required as opportunity cost of external contractors	Shift away from secondary care if uptake of screening increased; reduced burden from late diagnosis of disease	Key risk is ability of primary care providers to focus on this issue given sustainability and workload issues	Increased screening uptake; earlier diagnosis and treatment of cancer and other symptoms
3		Health and Wellbeing Centres in Swansea and Bridgend (Primary Care Pipeline ARCH Wellbeing centres)	Outline approval for new H&W Centres has been given by WAG £10m and £5m capital secured respectively. These 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 therapy as well as Third Sector etc. Well-being centres to be opened in 2021. OBC / FBC to be progressed during 2018/19 and submitted via IBG to the Board for approval.	Qu 3/4	Volume not likely to change, but provides more sustainable and modern services in one . Supports shift of service delivery from secondary care to primary care centres, for example, diabetes care, detail of schemes to be delivered in the centres to be confirmed in 2018/19	existing staffing resource	Likely to be broadly revenue neutral if capital funding provided for build costs; may be an element of revenue / cost sharing with other partners eg housing association	Key risk is project management capacity, and reluctance of the partners involved to commit fully	Improved efficiency, increased patient satisfaction and ability to absorb increase demands eg GMS patient growth
4		Improve access to PC OOH including changes to services and workforce diversification. Establishment of a OOH Training Academy.	Difficulties in recruiting sufficient GPs to populate OOH shifts necessitates a significantly different staffing and service delivery model. Workforce diversification required to align with the All Wales Framework for Primary Care and the creation of a MDT to support in hours GMS service delivery. the OOH service will look to match this and diversify its workforce to include - pharmacists, paramedic, ANPs, nurses etc. also learning for the 111 Clinical Hub pilot work in ABMU HB. Public engagement will also be progressed in relation to changes in the delivery sites for the OOH service across the HB area.	workforce diversification ongoing all year. Public engagement Q1/2 2018/19	Volume of activity likely to be constant, or may even increase if pressures in GMS in hours continues and work spills over to OOH service. Improved access will lead to fewer conveyances to hospital and improved patient satisfaction etc	Recruitment of nurses, paramedic practitioners, pharmacists etc. Invest to Save case approved for OOH Academy to be established in-year (£442k)	Likely to be cost reducing as alternative prudent staff model is approx. half cost of GP delivered service. Benefits realisation from direct reductions in staffing budgets and also indirect opportunity costs through less conveyances to secondary care and WAST activity	Key risk is service instability whilst new model is constructed and populated and inability to recruit and train alternative MDT workforce	Improved timeliness of access to OOH care
5		Increase pharmacy-led care through use of new pharmacy contract	Developments in community pharmacy contract require increased commissioning of enhanced services, such as smoking cessation, flu vaccination etc. New / increased services to be commissioned throughout year including minor ailments scheme vi the Choose Pharmacy platform, which will see workload reductions for GP and increased self help through a more informed public	Ongoing all year in terms of Enhanced Service remodelling. Choose Pharmacy platform for minor ailments implemented across all 11 clusters by Q3	Increased volume in community pharmacy reducing workload burden for GP in hours and GP OOH service at evenings and weekends	None - commissioned service from independent contractors	Self-funding through pharmacy contract reform; potentially cost reducing if services currently undertaken by GP are now commissioned from pharmacies	Key risk is sufficient management capacity to safely commission and monitor revise ES, fully skilled community pharmacy workforce to deliver the basked of Enhanced Services commissioned, public acceptance and attendance at the pharmacy to access services	Increased attendance at pharmacy indicating the workload and demand shift from general practice and GP OOH

Abertawe Bro Morgannwg ULHB

Enter Date of Submission: 3/31/2018

STATEMENT OF COMPREHENSIVE NET INCOME/EXPENDITURE

This Table is currently showing 0 errors

Please note that this Table is populated automatically from Table C4

	Annual Plan 2018/19	Annual Plan 2019/20	Annual Plan 2020/21
	£'000	£'000	£'000
Revenue/Income (positive entries)			
1 Revenue Resource Limit	1,091,789	0	0
2 Miscellaneous Income - Capital Donation\Government Grant Income	0	0	0
3 Miscellaneous Income - Other (including non resource limited income)	51,050	0	0
4 Welsh NHS Local Health Boards & Trusts Income	80,125	0	0
5 WHSSC Income	105,168	0	0
6 Welsh Government Income	5,774	0	0
7 Total Revenue/Income	1,333,907	0	0
Operating Expenses (positive entries)			
8 Primary Care Contractor (excluding drugs, including non resource limited expenditure)	152,090	0	0
9 Primary Care - Drugs & Appliances	103,474	0	0
10 Pay	624,736	0	0
11 Non Pay (excluding drugs & depreciation)	130,900	0	0
12 Secondary Care - Drugs	71,223	0	0
13 Healthcare Services Provided by Other NHS bodies	158,789	0	0
14 Non Healthcare Services Provided by Other NHS bodies	0	0	0
15 Continuing Care and Funded Nursing Care	59,310	0	0
16 Other Private & Voluntary Sector	14,672	0	0
17 Joint Financing and Other	12,698	0	0
18 Depreciation/Impairments	31,109	0	0
19 Other	0	0	0
20 Total Operating Expenses	1,359,001	0	0
21 Forecast Surplus/(Deficit)	(25,094)	0	0

Abertawe Bro Morgannwg ULHB

Saturday, March 31, 2018

Saturday, March 31, 2018

MONTHLY SUMMARISED STATEMENT OF COMPREHENSIVE NET EXPENDITURE

This Table is currently showing 3 errors

	Current Year				Year 1												Year 2				Year 3							
	Enter current YTD Month				1	2	3	4	5	6	7	8	9	10	11	12	Forecast year-end position				AV 1-3	AV4-6	AV7-9	AV 10-12	Forecast year-end position			
	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	AV4-6	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	
1. Revenue Resource Limit	790,526	87,836	1,109,365	92,447	90,982	90,982	90,982	90,982	90,982	90,982	90,982	90,982	90,982	90,982	90,982	90,982	1,091,789	0	0	0	0	0	0	0	0	0	0	
2. Miscellaneous Income - Capital Donations/Government Grant Income	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	
3. Miscellaneous Income - Other (including non resource limited income)	43,277	4,809	48,940	4,078	4,254	4,254	4,254	4,254	4,254	4,254	4,254	4,254	4,254	4,254	4,254	4,254	51,050	0	0	0	0	0	0	0	0	0	0	
4. Welsh NHS Local Health Boards & Trusts Income	55,500	6,167	78,554	6,546	6,677	6,677	6,677	6,677	6,677	6,677	6,677	6,677	6,677	6,677	6,677	6,677	80,125	0	0	0	0	0	0	0	0	0	0	
5. WHSIC Income	75,291	8,396	103,106	8,592	8,764	8,764	8,764	8,764	8,764	8,764	8,764	8,764	8,764	8,764	8,764	8,764	105,168	0	0	0	0	0	0	0	0	0	0	
6. Welsh Government Income	4,543	483	5,790	483	481	481	481	481	481	481	481	481	481	481	481	481	5,774	0	0	0	0	0	0	0	0	0	0	
7. Income Total	968,937	107,660	1,346,365	112,196	111,189	111,189	111,189	111,189	111,189	111,189	111,189	111,189	111,189	111,189	111,189	111,189	1,333,987	0	0	0	0	0	0	0	0	0	0	
8. Primary Care Contractor (excluding drugs, including non resource limited expenditure)	111,875	12,431	153,090	12,757	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	12,674	152,090	0	0	0	0	0	0	0	0	0	0	
9. Primary Care - Drugs & Appliances	70,613	8,513	103,974	8,684	8,623	8,623	8,623	8,623	8,623	8,623	8,623	8,623	8,623	8,623	8,623	8,623	103,474	0	0	0	0	0	0	0	0	0	0	
10. Provided Services - Pay	463,851	51,539	626,974	52,248	52,623	52,623	52,623	52,179	51,976	51,816	51,816	51,816	51,816	51,816	51,816	51,816	624,736	0	0	0	0	0	0	0	0	0	0	
11. Provider Services - Non Pay (excluding drugs & depreciation)	96,887	10,654	132,083	11,007	10,889	10,889	10,889	10,818	10,802	10,802	11,002	11,002	11,002	11,002	11,002	11,002	130,800	0	0	0	0	0	0	0	0	0	0	
12. Secondary Care - Drugs	50,486	5,610	70,461	5,872	5,972	5,972	5,972	5,951	5,920	5,920	5,920	5,920	5,920	5,920	5,920	5,920	71,223	0	0	0	0	0	0	0	0	0	0	
13. Healthcare Services Provided by Other NHS Bodies	116,055	12,895	156,139	13,012	13,232	13,232	13,232	13,232	13,232	13,232	13,232	13,232	13,232	13,232	13,232	13,232	158,769	0	0	0	0	0	0	0	0	0	0	
14. Non Healthcare Services Provided by Other NHS Bodies	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	
15. Continuing Care and Funded Nursing Care	42,045	4,672	60,484	5,040	4,980	4,980	4,980	4,980	4,938	4,922	4,922	4,922	4,922	4,922	4,922	4,922	59,310	0	0	0	0	0	0	0	0	0	0	
16. Other Private & Voluntary Sector	5,932	659	12,172	1,014	1,223	1,223	1,223	1,223	1,223	1,223	1,223	1,223	1,223	1,223	1,223	1,223	14,872	0	0	0	0	0	0	0	0	0	0	
17. Joint Financing and Other	8,016	891	13,198	1,100	1,058	1,058	1,058	1,058	1,058	1,058	1,058	1,058	1,058	1,058	1,058	1,058	12,098	0	0	0	0	0	0	0	0	0	0	
18. DEL Depreciation/Accelerated Depreciation/Impairments	23,802	2,645	35,019	2,918	2,592	2,592	2,592	2,592	2,592	2,592	2,592	2,592	2,592	2,592	2,592	2,592	31,109	0	0	0	0	0	0	0	0	0	0	
19. AME Donated Depreciation/Impairments	456	51	18,841	1,570	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
20. Non Allocated Contingency	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	
21. Profit/Loss Disposal of Assets	(79)	(9)	(79)	(7)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
22. Cost - Total	99,840	10,949	138,355	11,194	113,866	113,866	113,866	113,330	113,038	112,862	112,862	113,062	113,062	113,062	113,062	113,062	1,389,001	0	0	0	0	0	0	0	0	0	0	
23. Net surplus/ (deficit)	(26,003)	(2,888)	(36,090)	(3,696)	(2,707)	(2,707)	(2,707)	(2,172)	(1,879)	(1,703)	(1,703)	(1,903)	(1,903)	(1,903)	(1,903)	(1,903)	(25,094)	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	Current Year				Year 1												Forecast year-end position	Year 2				Forecast year-end position	Year 3				Forecast year-end position		
	YTD	YTD Monthly Average	FY FC	FY Monthly Average	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			
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Average month Q1	Average month Q2	Average month Q3	Average month Q4		Average month Q1	Average month Q2	Average month Q3	Average month Q4			
					£'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	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000		£'000	£'000
24. Establishment	433,451	48,161	581,114	48,426	48,190	48,190	48,190	48,190	48,190	48,190	48,190	48,190	48,190	48,190	48,190	48,190	578,274												
25. Variable	20,254	2,250	30,893	2,574	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	30,890												
26. Agency/Locum	14,556	1,617	19,956	1,663	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	19,200												
27. Inflationary/Cost Growth		0	0	0	702	702	702	702	702	702	702	702	702	702	702	702	8,424												
28. Demand/Service Growth		0	0	0	83	83	83	83	83	83	83	83	83	83	83	83	1,000												
29. Local Service/Cost Pressures		0	0	0	25	25	25	25	25	25	25	25	25	25	25	25	300												
30. Committed Reserves		0	5,614	468													0												
31. Other		0		0													0												
32. Total Gross Expenditure	468,261	52,029	637,978	53,132	53,190	53,190	53,190	53,190	53,190	53,190	53,190	53,190	53,190	53,190	53,190	53,190	637,198	0	0	0	0	0	0	0	0	0	0	0	
33. Establishment Savings	2,042	227	3,597	300	358	358	358	358	690	843	963	963	963	963	963	963	9,347	0	0	0	0	0	0	0	0	0	0	0	
34. Variable Pay Savings	2,368	263	7,007	584	119	119	119	230	281	321	321	321	321	321	321	321	3,116	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	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	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	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	0	0	
39. Total Workforce Savings	4,410	490	10,604	884	477	477	477	921	1,124	1,284	1,284	1,284	1,284	1,284	1,284	1,284	12,462	0	0	0	0	0	0	0	0	0	0	0	
40. Undeclared Savings		0	0	0													0												
41. Mitigating Actions to be Identified		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												
43. Net Expenditure (as per Table C4)	463,851	51,539	626,974	52,248	52,623	52,623	52,623	52,179	51,976	51,816	51,816	51,816	51,816	51,816	51,816	51,816	624,736	0	0	0	0	0	0	0	0	0	0	0	

B. NON PAY (excluding drugs & depreciation) EXPENDITURE ANALYSIS

Non Pay - Expenditure Profiles	Current Year				Year 1												Year 2				Year 3			

C4 .SCNLE Net Profiles

Abertawe Bro Morgannwg ULHB

INTEGRATED MEDIUM TERM PLAN SUMMARY - 2018/19 to 2020/21

This Table is currently showing 0 errors

		2018/19		2019/20		2020/21	
		£'000	% of Budget	£'000	% of Budget	£'000	% of Budget
1	Revenue Resource Limit (RRL) LHB only (positive values)	1,091,789					
2	Income (For Trusts)/Other Income (positive values)						
3	Total Revenue Allocation/Income	1,091,789		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):	(34,000)					
6	If there is insufficient space, list all areas >£1m with balance consolidated within 'Other'						
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35	Other (please specify within supporting Plan narrative)						
36	1.2 b/f recurring baseline contingencies (positive values):						
37							
38							
39							
40							
41	Total Underlying Position b/f: Deficits and Cost Pressures (negative)/ Surplus (positive)	(34,000)	-3.1%				0.0%
42	2. New Cost Pressures (negative values)						
43	2.1 Cost Growth						
44	Pay Inflation						
45	- Pay Award	(6,824)					
46	- Increments	(700)					
47	- Pensions & Other Pay Oncost Changes	(900)					
48	- Terms & Conditions (incl T&S)						
49	Other Specify						
50							
51							
52							
53	Sub Total Pay Inflation	(8,424)	-0.8%				0.0%
54	Non pay Inflation	(4,000)					
55	Statutory Compliance and National Policy						
56	Continuing Health Care	(1,268)					
57	Funded Nursing Care	(175)					
58	Prescribing						
59	GMS						
60	Quality & Safety Developments						
61	Other Specify						
62							
63							
64							
65							
66							
67							
68	Total Inflationary/Cost Growth	(13,867)	-1.3%				0.0%
69	2.2 Demand / Service Growth (ineactive values)						
70	Primary Care Contractor						
71	NICE and New High Cost Drugs	(3,500)					
72	Continuing Health Care						
73	Funded Nursing Care						
74	Prescribing						
75	Specialist Services - Direct						
76	Specialist Services - via WHSSC	(3,500)					
77	Welsh Risk Pool						
78	EASC						
79	RTT (associated with planned activity stated in IMTP)						
80	Treatment Fund (associated anticipated funding to be reported in Section 5)						
81	Demographic / Demand on Acute Services: Please Specify below	(1,000)					
82	Other Commissioner Pressures	(1,000)					
83							
84							
85							
86							
87							
88							
89	Other Specify						
90							
91							
92							
93							
94							
95							
96	Total Demand/Service Growth	(8,000)	-0.8%				0.0%
97	2.3 Local Service/Cost Pressures (negative values)						
98	Other Specify						
99	Local Invest to Save	(2,000)					
100	Local Invest to Save Payback	500					
101	CHC Provision Movement	(1,000)					
102							
103							
104							
105							
106							
107							
108							
109							
110							
111							
112							
113	Total Local Cost Base Challenge	(2,500)	-0.2%				0.0%
114	Total Opening Financial Challenge (Deficit)/Surplus	(59,367)	-5.4%				0.0%
115	3. Identified Savings Plans (positive values)						
116	Continuing Care and Funded Nursing Care	450					
117	Commissioned Services	1,350					
118	Medicine Management (Primary and Secondary Care)	1,938					
119	Non Pay	5,073					
120	Pay	12,462					
121	Primary Care						
122	Total Identified Savings Plans	21,273	1.9%				0.0%
123	Total Savings/Mitigating Actions Yet To Be Identified (positive value)		0.0%				0.0%
124	Total Net Income Generation (positive value)		0.0%				0.0%
125	Total Planned Accountancy Gains (positive value)		0.0%				0.0%
126	Total Unallocated Reserves (positive value)		0.0%				0.0%
127	Total In Year Performance/Position Before Repayment of Prev Years Deficit - (Deficit)/Surplus	(38,094)	-3.5%				0.0%
128	4. Repayment of Previous Years Deficit (negative value)	0					
129	Total In Year Performance/Position After Repayment of Prev Years Deficit - (Deficit)/Surplus	(38,094)	-3.5%				0.0%
130	5. Revenue Assistance/Funding Requested (positive values)						
131	Recurring	13,000					
132	Non Recurring						
133	Total WG Assistance	13,000	1.2%				0.0%
134	Net Financial Challenge - (Deficit)/Surplus	(25,094)	-2.3%				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'.

Abertawe Bro Morgannwg ULHB

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Resource Planning Assumptions

		Local Resource Planning Assumptions Used		
		2018/19 % Cost	2019/20 % Cost	2020/21 % Cost
Inflationary Pressure				
1	Cost Growth			
2	Pay Inflation (inc. awards, T & Cs inc. Travel etc)	0.69%	0.70%	0.70%
3	Incremental Drift	0.07%	0.07%	0.07%
4	Pensions & Other Pay Oncost Changes	0.09%	0.71%	0.00%
5	Non pay Inflation	0.41%	0.41%	0.41%
6	Statutory Compliance and National Policy	0.00%	0.00%	0.00%
7	Continuing Health Care	0.13%	0.13%	0.13%
8	Funded Nursing Care	0.02%	0.02%	0.02%
9	Prescribing	0.00%	0.00%	0.00%
10	GMS	0.00%	0.00%	0.00%
11	Quality & Safety Developments	0.00%	0.00%	0.00%
13	Total Cost Growth	1.41%	2.04%	1.33%
14	Demand / Service Growth			
15	Primary Care Contractor	0.00%	0.00%	0.00%
16	NICE and New High Cost Drugs	0.36%	0.36%	0.36%
17	Continuing Health Care	0.00%	0.00%	0.00%
18	Funded Nursing Care	0.00%	0.00%	0.00%
19	Prescribing	0.00%	0.00%	0.00%
20	Specialist Services - Direct	0.00%	0.00%	0.00%
21	Specialist Services - via WHSSC	0.36%	0.36%	0.36%
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	0.72%	0.72%	0.72%
29	Total Inflationary Pressure	2.13%	2.76%	2.05%

		2018/19		2019/20		2020/21	
		£'000	%	£'000	%	£'000	%
Pay Related Cost Assumptions - Local							
1	Pay Awards						
2	- A 4 C Staff	5,476	0.56%	5,523	0.56%	5,550	0.56%
3	- Misc Pay (Non AfC / Non Medical)	71	0.01%	72	0.01%	72	0.01%
4	- Junior Medical Staff	242	0.02%	244	0.02%	245	0.02%
5	- Staff Grades / Associate Specialists	146	0.01%	148	0.02%	150	0.02%
6	- Consultants	889	0.09%	898	0.09%	900	0.09%
7	Total Pay Awards	6,824	0.69%	6,885	0.70%	6,917	0.70%
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	205	0.02%	210	0.02%	210	0.02%
14	- Consultants	198	0.02%	205	0.02%	205	0.00%
15	- Consultant Commitment Awards	297	0.03%	300	0.03%	300	0.00%
16	Total Increments	700	0.07%	715	0.07%	715	0.07%
17	Pensions & Other Pay Oncost Changes	£'000	%	£'000	%	£'000	%
18	1- Auto Enrolment						
19	Balance of Full Year Effect - Oct 2017 part year included in 2017/18	900	0.09%	0	0.00%	0	0.00%
20	2 - NHS Pension Discount Rate Change - 3.0% to 2.8%						
21	From 2019/20	0	0.00%	6,968	0.71%	0	0.00%
22	Total Pensions	900	0.09%	6,968	0.71%	0	0.00%
23	Comparator	984,505		984,505		984,505	

Abertawe Bro Morgannwg ULHB

Revenue Resource Limit Assumptions

LHB COMPLETION ONLY		2018/19 £'000	2019/20 £'000	2020/21 £'000
1	RRL used in SCNE profiled analysis	1,091,789	0	0
	Made up of:-			
2	Allocation Letter/ Resource Planning Figure	1,073,228		
3	Plus the following additional anticipated allocations:-			
4	DEL- Funded in Previous Years:			
6	Substance Misuse	3,106		
7	Clinical Excellence/Distinction Awards	777		
8	Orthopaedics			
9	Immunisations (Vaccine & GMS fees) & HPV	251		
10	Treatment Fund - <i>see note at foot of table</i>	2,866		
11	Other....specify			
12	Pre Reg Pharmacists	147		
13	Dental VT's	2,143		
14	GP Refresh	1,284		
15	HPV Immunisation	33		
16	ICF Autism	232		
17	SpRs	438		
18	WHSCC ARRP	283		
19	Performance Funding	7,000		
20				
21				
22				
23				
24	Sub Total - Funded in Previous Years	1,091,789	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	1,091,789	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

Abertawe Bro Morgannwg ULHB

31 March 2018

Income and Expenditure Assumptions (Wales NHS)

This Table is currently showing 0 errors

A. Annual Forecast 2018/19

		Contracted Income	Non Contracted Income	Total Income
	LHBs / Trusts	£'000	£'000	£'000
1	Abertawe Bro Morgannwg	0	0	0
2	Aneurin Bevan	1,172	1,590	2,762
3	Betsi Cadwaladr	0	462	462
4	Cardiff & Vale	12,089	4,519	16,609
5	Cwm Taf	4,151	1,539	5,691
6	Hywel Dda	31,754	2,747	34,501
7	Powys	8,206	1,422	9,628
8	Public Health Wales	3,035	1,743	4,778
9	Velindre	0	5,114	5,114
10	Welsh Ambulance	0	580	580
11	WHSCC	102,791	2,378	105,168
12	EASC			0
13	Total	163,198	22,095	185,293

Contracted Expenditure	Non Contracted Expenditure	Total Expenditure
£'000	£'000	£'000
0	0	0
295	1,146	1,441
0	272	272
8,911	2,541	11,452
4,814	2,078	6,892
4,037	315	4,352
1,121	275	1,396
0	4,361	4,361
4,927	20,089	25,016
3,757	15	3,772
119,855	82	119,937
		0
147,717	31,173	178,890

Abertawe Bro Morgannwg ULHB

31 March 2018

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 - 2018/19													
	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)	(0)	(0)	(0)	42	58	58	58	58	58	58	58	450
2 Commissioned Services	113	113	113	113	113	113	113	113	113	113	113	113	1,350
3 Medicine Management (Primary and Secondary Care)	125	125	125	146	177	177	177	177	177	177	177	177	1,938
4 Non Pay	359	359	359	430	446	446	446	446	446	446	446	446	5,073
5 Pay	477	477	477	921	1,124	1,284	1,284	1,284	1,284	1,284	1,284	1,284	12,462
6 Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
7 Total Savings Plans	1,073	1,073	1,073	1,609	1,901	2,077	2,077	2,077	2,077	2,077	2,077	2,077	21,273

Pay Savings: Analysis

Year 1 - 2018/19													
Pay Category	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	358	358	358	690	843	963	963	963	963	963	963	963	9,347
9 Variable Pay	119	119	119	230	281	321	321	321	321	321	321	321	3,116
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	477	477	477	921	1,124	1,284	1,284	1,284	1,284	1,284	1,284	1,284	12,462

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

Year 1 - 2018/19													
Agency/Locum paid at a premium	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

Abertawe Bro Morgannwg ULHB

31 March 2018

This Table is currently showing 0 errors

NOTE: Tables to be populated with identified savings plans only

YEAR 2 & 3 SAVINGS PLANS - All Positive Entries

To include Cost Improvement & Cost Containment schemes

Savings Plans:-

	Year 2 - 2019/20					Year 3 - 2020/21				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'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

Pay Savings: Analysis

Pay Category	Year 2 - 2019/20					Year 3 - 2020/21				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'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

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 - 2019/20					Year 3 - 2020/21				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total

		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'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
21	Check - Agrees to Savings Plan Line 11	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Abertawe Bro Morgannwg ULHB

31 March 2018

Overview Of Worse & Best Case Positions

		2018/19		2019/20		2020/21	
		Worst Case	Best Case	Worst Case	Best Case	Worst Case	Best Case
		£'000	£'000	£'000	£'000	£'000	£'000
Current Reported Financial Plan Outturn		-25093.814	-25093.814	0	0	0	0
1	Risks (negative values)						
2	Pay Negotiations above 1% not included in Financial Plan	TBC					
3	ChC Ombudsman full impact	-1,900					
4	Savings not delivered as planned	-5,000					
5	Operational Expenditure reductions not maintained	-2,000					
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21	Total Risks	-8,900	0	0	0	0	0
22	Financial Challenge excluding opportunities	(33,994)	(25,094)	0	0	0	0
		2018/19		2019/20		2020/21	
		Worst Case	Best Case	Worst Case	Best Case	Worst Case	Best Case
		£'000	£'000	£'000	£'000	£'000	£'000
23	Opportunities (positive values) (record value consistently and in both Worst and Best columns)						
24	Non Recurrent Benefits	2,000	4,000				
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42	Total Opportunities	2,000	4,000	0	0	0	0
43	Total Amended Forecast Plan Outturn Surplus/(Deficit)	(31,994)	(21,094)	0	0	0	0

Property & Asset Investment

Summary

	2018-19	2019-20	2020-21	2021-22	2022-23
	£m	£m	£m	£m	£m
Gross Capital Expenditure	47.517	57.528	141.551	101.13	34.655
less: Receipts	0.515	0.160	0	0	
Disposals:					
Net Capital Expenditure	47.002	57.368	141.551	101.13	34.655

	2018-19	2019-20	2020-21	2021-22	2022-23
	£m	£m	£m	£m	£m
Welsh Government Funding					
Discretionary (Group 1 - CRL / CEL)	14.618	14.618	14.618	14.618	14.618
Approved Schemes (Group 2 - CRL / CEL)	5.699	4.980	0	0	0
WG Funding Required (approved)	20.317	19.598	14.618	14.618	14.618
Funding for identified schemes not approved by Welsh Governme	19.351	44.17	126.433	86.012	19.537

Key Performance Indicators

	2016-17 as per EFPMS	2022-23 Forecast
	£m	£m
High Risk Backlog Maintenance	1015000	1350045
	%	%
Physical Condition: % in Category B or above	79	88
Statutory, Safety & Compliance: % in Category B or above	90	90
Fire Safety Compliance : % in Category B or above	100	100
Functional Suitability: % in Category B or above	90	90
Space Utilisation: % in Category F or above	97	97
Energy Performance: % with Energy B or better	436	410

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C12. Asset Investment Summa

Property & Asset Investment**Capital Expenditure**

DISCRETIONARY	2018-19	2019-20	2020-21	2021-22	2022-23
	£m	£m	£m	£m	£m
IT	4.245				
Equipment	1.911				
Statutory Compliance					
Estates	7.458				
Other	1.004	14.618	14.618	14.618	14.618
Sub total DISCRETIONARY	14.618	14.618	14.618	14.618	14.618

Revenue Implications (Incremental consequences)

Discretionary Non Cash Costs	2018-19	2019-20	2020-21	2021-22	2022-23
	£m	£m	£m	£m	£m
Discretionary Other Revenue Costs					
Discretionary Revenue Savings					
Discretionary Net Revenue					

	2018-19	2019-20	2020-21	2021-22	2022-23
APPROVED SCHEMES	£m	£m	£m	£m	£m
Scheme 1 - Health Vision Swansea					
HVS 1B, Main Entrance & Outpatients	0.180				
Scheme 2 - Renal					
Renal Ward Refurbishment	0.474				
Scheme 3 - NWIS					
National WEDCIMS	0.045	0.270			
Scheme 4 - Implications of the South Wales Plan					
Increase Neo Natal Capacity Singleton	5.000	4.710			
Scheme 5 - INSERT TITLE					
Scheme 6 - INSERT TITLE					
Scheme 7 - INSERT TITLE					
Scheme 8 - INSERT TITLE					
Scheme 9 - INSERT TITLE					
Scheme 10 - INSERT TITLE					
Scheme 11 - INSERT TITLE					

	2018-19	2019-20	2020-21	2021-22	2022-23
Approved Schemes	£m	£m	£m	£m	£m
Scheme 1 - Health Vision Swansea					
Scheme 1 - Non Cash - DEL	0.019	0.019	0.026	0.026	0.026
Scheme 1 - Non Cash - AME					
Scheme 1 - Other Revenue Costs					
Scheme 1 - Revenue Savings					
Scheme 1 - Net Revenue					
Scheme 2 - Renal					
Scheme 2 - Non Cash - DEL	0.118	0.152	0.152	0.152	0.152
Scheme 2 - Non Cash - AME	1.818				
Scheme 2 - Other Revenue Costs					
Scheme 2 - Revenue Savings					
Scheme 2 - Net Revenue					
Scheme 3 - NWIS					
Scheme 3 - Non Cash - DEL		0.382	0.765	0.765	0.765
Scheme 3 - Non Cash - AME					
Scheme 3 - Other Revenue Costs					
Scheme 3 - Revenue Savings					
Scheme 3 - Net Revenue					
Scheme 4 - Implications of the South Wales Plan					
Scheme 4 - Non Cash - DEL			0.87	0.348	0.348
Scheme 4 - Non Cash - AME		2.805			
Scheme 4 - Other Revenue Costs					
Scheme 4 - Revenue Savings					
Scheme 4 - Net Revenue					
Scheme 5 - INSERT TITLE					
Scheme 5 - Non Cash - DEL					
Scheme 5 - Non Cash - AME					
Scheme 5 - Other Revenue Costs					
Scheme 5 - Revenue Savings					
Scheme 5 - Net Revenue					
Scheme 6 - INSERT TITLE					
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 - INSERT TITLE					
Scheme 7 - Non Cash - DEL					
Scheme 7 - Non Cash - AME					
Scheme 7 - Other Revenue Costs					
Scheme 7 - Revenue Savings					
Scheme 7 - Net Revenue					
Scheme 8 - INSERT TITLE					
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					

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

						Scheme 11 - Non Cash - AME					
						Scheme 11 - Other Revenue Costs					
						Scheme 11 - Revenue Savings					
						Scheme 11 - Net Revenue					

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

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	5.699	4.98	0	0	0						

Other Capital Expenditure:					
Donated Assets Additions	0.5	0.5	0.5	0.5	0.5
Capital Grants					
Other - disposal receipts	0.515	0.16			
Sub Total Other Capital Expenditure	1.015	0.66	0.5	0.5	0.5
Gross Capital Expenditure	51.358	62.238	141.551	101.13	34.655
Receipts					
Land & Property Disposals (list individually)	0.515	0.160	0	0	0
Capital Grants Received					
Donations					
Other					
Sub Total Receipts	0.515	0.16	0	0	0
Net Capital Expenditure	50.843	62.078	141.551	101.13	34.655

Other Capital Expenditure:					
Non Cash Costs					
Other Revenue Costs					
Revenue Savings					
Net Other Capital Expenditure					

	2018-19	2019-20	2020-21	2021-22	2022-23
	£m	£m	£m	£m	£m
Land and Property Disposals					
Scheme 1 - Fairwood - Approved	0.350				
Scheme 2 - Cefn Coed Future Phases - Approved		TBC	TBC	TBC	TBC
Scheme 3 - Morriston Land		TBC	TBC	TBC	TBC
Scheme 4 - Coelbren	0.165				
Scheme 5 - Ogmores Vale		0.160			
Scheme 6 - Ty Penfro		TBC			
Scheme 7 - Resolven		TBC			
Scheme 8 - Glyneath		TBC			
Scheme 9					
Scheme 10					
etc					
Total	0.515	0.16	0	0	0

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

	Business Case Position (inc if scoping discussion held)	2018-19	2019-20	2020-21	2021-22	2022-23	Business Case Status	Internal Approval Process Status		2018-19	2019-20	2020-21	2021-22	2022-23
UNAPPROVED SCHEMES		£m	£m	£m	£m	£m			Unapproved Schemes	£m	£m	£m	£m	£m
Scheme 1 - Primary Care National Pipeline	Yes / No						BJC in development		Scheme 1 - Primary Care National Pipeline					
Pencelwedd Refurbishment	Yes	0.773							Scheme 1 - Non Cash - DEL		0.044	0.142	0.434	0.430
Murton Refurbishment	Yes	0.386							Scheme 1 - Non Cash - AME	0.271		2.700		
Bridgend Wellbeing Centre	Yes	0.500	1.500	3.000					Scheme 1 - Other Revenue Costs					
Swansea Wellbeing Centre	Yes	0.250	3.000	6.750					Scheme 1 - Revenue Savings					
									Scheme 1 - Net Revenue					
Scheme 2 - Other Capital Schemes	Yes / No								Scheme 2 - Other Capital Schemes					
Singleton Cladding	No	0.250	TBC	TBC					Scheme 2 - Non Cash - DEL		0.15	0.15	0.15	0.15
Anti-Ligature - Mental Health	No	1.500	TBC	TBC					Scheme 2 - Non Cash - AME					
									Scheme 2 - Other Revenue Costs					
									Scheme 2 - Revenue Savings					
									Scheme 2 - Net Revenue					
Scheme 3 - Radiotherapy Programme	Yes / No						BJC in development		Scheme 3 - Radiotherapy Programme					
Replacement programme for Linear Accelerators	National Programme	4.077	0.023						Scheme 3 - Non Cash - DEL		0.085	0.341	0.708	1.075
Replacement programme for Linear Accelerators	National Programme		4.500						Scheme 3 - Non Cash - AME		0.692	0.825	0.825	
Replacement programme for Linear Accelerators	National Programme			4.500					Scheme 3 - Other Revenue Costs					
									Scheme 3 - Revenue Savings					
									Scheme 3 - Net Revenue					
Scheme 4 - Imaging Programme	Yes / No						Updated priorities submitted to WG January 2018		Scheme 4 - Imaging Programme					
National Imaging Programme	National Program	3.600	10.196	12.548	3.000	3.000			Scheme 4 - Non Cash - DEL		0.435	1.666	3.182	3.544
									Scheme 4 - Non Cash - AME	0.252	0.713	0.878	0.21	0.21
									Scheme 4 - Other Revenue Costs					
									Scheme 4 - Revenue Savings					
									Scheme 4 - Net Revenue					
Scheme 5 - Informatics Modernisation Programme	Yes / No						BJC in development		Scheme 5 - Informatics Modernisation Programme (SOP)					
WCCIS	National Project	0.865	0.764						Scheme 5 - Non Cash - DEL			0.523	0.523	0.523
WCP	National Project	0.500	0.487						Scheme 5 - Non Cash - AME					
									Scheme 5 - Other Revenue Costs					
									Scheme 5 - Revenue Savings					
									Scheme 5 - Net Revenue					
Scheme 6 - ARCH - Enabling Phases	Yes / No						BJC in development	Board approval as part of ARCH PDP submission	Scheme 6 - ARCH - Enabling Phases					
Morrison New Road Access	No	0.4500	0.2500	0.0750	5.0250	5.0000			Scheme 6 - Non Cash - DEL					
Land Purchase	No	1.2000							Scheme 6 - Non Cash - AME					
									Scheme 6 - Other Revenue Costs					
									Scheme 6 - Revenue Savings					
									Scheme 6 - Net Revenue					
Scheme 7 - Environmental Modernisation Programme	Yes / No						BJC in development		Scheme 7 - Environmental Modernisation Programme (SOP)					
Environmental Modernisation Future BJC	Yes	2.000	6.000	6.000	6.000	6.000			Scheme 7 - Non Cash - DEL			0.225	0.45	0.675
									Scheme 7 - Non Cash - AME		1.5	1.5	1.5	1.5
									Scheme 7 - Other Revenue Costs					
									Scheme 7 - Revenue Savings					
									Scheme 7 - Net Revenue					
Scheme 8 - ARCH - Main Phases	Yes / No						SOC in development		Scheme 8 - ARCH - Main Phases					
Regional Pathology, Morriston	No	1.000	3.800	31.980	15.990				Scheme 8 - Non Cash - DEL					4.319
Regional Orthopaedic Centre, Morriston	Yes	0.800	2.100	17.933	8.966				Scheme 8 - Non Cash - AME				29.451	5.114
Large Trauma Unit, Morriston	No	TBC	TBC	TBC	TBC	TBC			Scheme 8 - Other Revenue Costs					
Continence and mental health care, Morriston	No	0.250	1.750	13.633	27.267				Scheme 8 - Revenue Savings					
Repridive HSDU (allow increase in CC capacity)	No			5.537	5.537	5.537			Scheme 8 - Net Revenue					
Scheme 9 - Mental Health - RMHSS/Disposal of Old Cefn Coed	Yes / No						SOC in development		Scheme 9 - Mental Health - RMHSS/Disposal of Old Cefn Coed					
RMHSS Phase 3 Acute Mental Health Unit	No	0.300	1.700	7.500	9.900				Scheme 9 - Non Cash - DEL					0.584
RMHSS P7 Mental Health Day Facilities	No		0.100	1.227	1.327				Scheme 9 - Non Cash - AME				6.997	
									Scheme 9 - Other Revenue Costs					
									Scheme 9 - Revenue Savings					
									Scheme 9 - Net Revenue					
Scheme 10 - Health Vision Swansea	Yes / No						SOC in development		Scheme 10 - Health Vision Swansea					
HVS 1B, Car Park & Regional Entrance	Yes	0.250	1.000	15.750	3.000				Scheme 10 - Non Cash - DEL					0.108
									Scheme 10 - Non Cash - AME				7.005	
									Scheme 10 - Other Revenue Costs					
									Scheme 10 - Revenue Savings					
									Scheme 10 - Net Revenue					
Scheme 11 - Cardiac Centre, Morriston	Yes / No						BJC in development		Scheme 11 - Cardiac Centre, Morriston					
3rd Catheter Laboratory	No		2.500						Scheme 11 - Non Cash - DEL		0.068	0.574	0.574	0.574
Hybrid Theatre	No		3.000						Scheme 11 - Non Cash - AME		0.773			
									Scheme 11 - Other Revenue Costs					
									Scheme 11 - Revenue Savings					
									Scheme 11 - Net Revenue					
Scheme 12 - JAG Accreditation (Endoscopy Programme)	Yes / No								Scheme 12 - JAG Accreditation (Endoscopy Programme)					
JAG Accredited Scoping Suite			1.500						Scheme 12 - Non Cash - DEL			0.119	0.119	0.119
									Scheme 12 - Non Cash - AME		0.35			
									Scheme 12 - Other Revenue Costs					
									Scheme 12 - Revenue Savings					
									Scheme 12 - Net Revenue					
Scheme 13 - Regional Services	Yes / No								Scheme 13 - Regional Services					
Development of All Wales Andrology Service	No	0.400							Scheme 13 - Non Cash - DEL		0.02	0.02	0.02	0.02
Thoracic Surgery	No	TBC	TBC	TBC	TBC	TBC			Scheme 13 - Non Cash - AME					
Relocate PAU - Develop SARC (Children)	No	TBC	TBC						Scheme 13 - Other Revenue Costs					
									Scheme 13 - Revenue Savings					
									Scheme 13 - Net Revenue					
Scheme 14 - Other Capital Schemes	Yes / No								Scheme 14 - Other Capital Schemes					
2nd CEPOD Theatre	No			TBC					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 unapproved Schemes Total		19.351	44.170	126.433	86.012	19.537								

Revenue Funded Infrastructure (including Primary Care Pipeline 3PD and Mutual Investment Model (MIM) investments)

	Scheme Capital Value	Annual Revenue Repayment				
		2018-19	2019-20	2020-21	2021-22	2022-23
Prioritised Schemes (to be named individually)	£m	£m	£m	£m	£m	£m
Brynhyfrd Primary Care Centre		0.016	0.016	0.016	0.016	0.016
Mayhill Primary Care Centre		0.012	0.012	0.012	0.012	0.012
Vale of Neath Primary Care Centre		TBC	TBC	TBC	TBC	TBC
Porthcawl Primary Care Centre		TBC	TBC	TBC	TBC	TBC
etc						
Total	0	0.028	0.028	0.028	0.028	0.028

Health Board**XXX****Workforce Plans - WTE**

	A	B	C	D	E	F	F	G
	Actual Workforce @ 12/31/2017 WTE	Planned WTE @ 3/31/2018 WTE	2017/18 Profiled Workforce at end of each Quarter				Workforce at end of	
			30/06/2018 WTE	30/09/2018 WTE	31/12/2018 WTE	3/31/2019 WTE	31/03/2020 WTE	31/03/2021 WTE
Core workforce:-								
Board Members	19	19	19	19	19	19	19	19
Medical & Dental	1,289	1,468	1,478	1,478	1,476	1,476	1,485	1,494
Nursing & Midwifery Registered	4,381	4,714	4,690	4,666	4,630	4,631	4,631	4,631
Additional Professional, Scientific and Technical	437	414	415	417	419	419	419	419
Healthcare Scientists	320	332	332	332	328	328	328	328
Allied Health Professionals	894	947	958	962	962	962	962	962
Additional Clinical Services	2,714	2,871	2,849	2,842	2,845	2,845	2,845	2,845
Administrative and Clerical (inc Senior Managers)	2,424	2,466	2,465	2,466	2,464	2,464	2,464	2,464
Estates and Ancillary	1,383	1,512	1,512	1,512	1,512	1,512	1,512	1,512
Students	8	9	9	9	9	9	9	9
Sub total	13,867	14,752	14,728	14,704	14,665	14,666	14,675	14,684
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	-	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-	-
Total workforce plans	13,867		14,728	14,704	14,665	14,666	14,675	14,684

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

	2018/19 Workforce Quarterly Profile				Workforce Annual	
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	2019/20 £'000	2020/21 £'000
Core workforce:-						
Board Members	471	471	471	471		
Medical & Dental	39,062	39,062	39,009	39,009		
Nursing & Midwifery Registered	51,697	51,429	51,039	51,050		
Additional Professional, Scientific and Technical	4,893	4,916	4,940	4,940		
Healthcare Scientists	4,084	4,084	4,025	4,025		
Allied Health Professionals	10,707	10,756	10,756	10,756		
Additional Clinical Services	18,933	18,886	18,905	18,905		
Administrative and Clerical (inc Senior Managers)	18,751	18,758	18,743	18,743		
Estates and Ancillary	9,356	9,356	9,356	9,356		
Students						
Sub total	157,953	157,717	157,245	157,256	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	157952.8153	157717.3682	157244.6813	157255.7038	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

This has been replaced by C19.1-19.6 Do not complete

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				
Allied Health Professionals				
Admin & Estates (Inc. Managers, Senior Managers and VSMs)				
HCA and Support Staff				
Health Care Scientists				
Medical & Dental				
Nursing & Midwifery				

- i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

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				
Admin & Estates (Inc. Managers, Senior Managers and VSMs)				
HCA and Support Staff				
Health Care Scientists				
Medical & Dental				
Nursing & Midwifery				

For Academic intake 2019/20					
Advanced Practice/Extended Skills					
Full MSC Title	Duration	Year of Output	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
Advanced Practice in Healthcare MSc	3	2022	2	Swansea University	Secondary care
Advanced Practice in Healthcare PG Dip	2	2021	2	Swansea University	Secondary care
Advanced Clinical Practitioner	3	2021	4	USW	Secondary care
Advanced Practitioner Course	3	2021	2	Swansea University	Secondary care
Gerontology	3	2021	1	Swansea University	Secondary care
Long Term conditions management	3	2021	1	Swansea University	Secondary care
Advanced Fertility practice	3	2021	1	Edge Hill University Liverpool	Secondary care

Advanced Practice/Extended Skills					
Full Module Title	Credits	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?	
Theatre Module Core Concepts	20	16	Swansea University	Secondary care	
Anaesthetic/Recovery Practice	40	16	Swansea University	Secondary care	
Intra operative practice	40	16	Swansea University	Secondary care	
Care of the Acutely ill child	40	6	Bristol University	Secondary care	

For Academic intake 2019/20				
Course Title	Course duration	Year of output	Numbers Required	Indicate any Recruitment Difficulties / Reason for commissions
PRESCRIBING				
Full Independent Prescribing	1 year	2020	10	
Supplementary Prescribing	1 year	2020		
Limited Independent Prescribing	1 year	2020	2	
Non Authorisation of Blood transfusion	1 year	2020	6	

For Academic intake 2019/20					
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
COMMUNITY HEALTH STUDIES					
District Nursing (Part-time)	2 years	2021	20		
District Nursing Modules (in modules)	3-6 months	2020	10		
Practice Nursing (Part-time)	2 years	2021	2		
Practice Nursing Modules (in modules)	3-6 months	2020	5		
Community Paediatric Nursing (Part-time)	2 years	2021	3		
Community Paediatric Nursing Modules (in modules)	3-6 months	2020	3		
CPN (Part-time)	2 years	2021	10		
CPN Modules (in modules)	3-6 months	2020	6		
CLDN (Part-time)	2 years	2021	4		
CLDN Modules (in modules)	3-6 months	2020	4		
Additional Modules	1 year	2020	0		
Return To Practice	6 months	2020	40		

For Academic intake 2019/20					
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					

					There is significant difficulty in recruiting to band 5 nursing posts in general medicine/surgery/theatres/stroke/Respiratory/vascular/T&O, Paediatrics/learning disabilities/mental health/community hospitals & District nurse going forward as a result of fewer completing the DN course.
Bachelor of Nursing (B.N.) Adult	3 years	2022	240	No comments	
Bachelor of Nursing (B.N.) Child	3 years	2022	54		national shortage and age profile particular problem in Neonates
					Difficulty in recruiting to back fill promotions as a result of Welsh Government funding also age profile of workforce
Bachelor of Nursing (B.N.) Mental Health	3 years	2022	110		
					Difficulty in recruiting as a result of higher salaries in the private sector which is exacerbated as there is currently no LD nursing course run at Swansea
Bachelor of Nursing (B.N.) Learning Disability	3 years	2022	40		
Shortened Nursing Degree Programme-Adult	2 years	2021	10		
Shortened Nursing Degree Programme-Child	2 years	2021	0		
Shortened Nursing Degree Programme-Mental Health	2 years	2021	10		
Shortened Nursing Degree Programme-Learning Disability	2 years	2021	10		
Bachelor of Nursing (B.N.) Adult (Part-time)	4 years	2023	22		This is likely to be the preferred route for our existing HCSWs
Bachelor of Nursing (B.N.) Child (Part-time)	4 years	2023	0		
Bachelor of Nursing (B.N.) Mental Health (Part-time)	4 years	2023	5		
Bachelor of Nursing (B.N.) Learning Disabilities (Part-time)	4 years	2023	5		
B.Sc. Midwifery Direct Entry	3 years	2022	26		
B.Sc. Midwifery Conversion Programme	18 months	2021	0		
Health Visiting (Full-time)	1 year	2020	20		No change no current recruitment difficulties
Health Nursing (Part-time)	2 years	2021	0		
					Limited ability to support any increase due to limited turnover of staff and ability to redesign the workforce
Health Visiting Modules (in modules)	1 year	2020	2		
School Nursing (Full-time)	1 year	2020	1		
School Nursing (Part-time)	2 years	2021	2		
School Nursing Modules (in modules)	3-6 months	2020	1		
Occupational Health (Full-time)	1 year	2020	0		
Occupational Health (Part-time)	2 years	2021	2		
Surgical Care Practitioner	2 Years	2021			
Medical Ultrasound/Sonography	2 years	2021			
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	400				
Diploma in Health and Social Care	50	100			
Diploma in Clinical Healthcare Support	50	350			
Diploma in Maternity and Paediatrics Support		30			
Diploma in Perioperative Support		30			
Level 4 education for HCSW's to access Yr 2 of nurse training			25		
Units for learning specific to role	100	200			

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Year of Output	Numbers Required	HEI/Provider	Reason for Request

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

For Academic intake 2019/20					
Advanced Practice/Extended Skills					
Full MSC Title	Duration	Year of Output	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
MSC Advanced Practice	3	2021	3	swansea	Secondary care
MSC Advanced Practice	3	2021	3	swansea	Secondary care
MSC Advanced Practice	3	2021	3	swansea	Community Care E.G District Nursing etc
MSC Enhanced Practice	3	2021	3	swansea	Community Care E.G District Nursing etc
MSC Neonatal Care	3	2021	1	tbc	Secondary care
MSC Healthcare Management	3	2021	2	swansea	Secondary care
MSC Ageing , Health & Disease	3	2021	2	swansea	Community Care E.G District Nursing etc
MSC Occupationa & Health	3	2021	1	cardiff	Community Care E.G District Nursing etc
MSC Long Term and Chronic Conditions Management	3	2021	2	swansea	Community Care E.G District Nursing etc
MSc Leadership in Healthcare	3	2021	1	Swansea	Primary Care Health Board employed
MSC Enhanced Professional Practice	3	2021	1	swansea	Primary Care Health Board employed
MSC Autism and Related Conditions	3	2021	1	swansea	Primary Care Health Board employed
MSC Advanced Practice	3	2021	1	cardiff	Primary Care Health Board employed

Advanced Practice/Extended Skills					
Full Module Title	Credits	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?	
SI Module 2 Clinical Reasoning in SI assessment	30	4	Ulster & SI Network	Community Care E.G District Nursing etc	
SI Module 3 From Assessment to Intervention	30	1	Ulster & SI Network	Community Care E.G District Nursing etc	
SI Module 4 Advanced Clinical Practice	30	2	Ulster & SI Network	Community Care E.G District Nursing etc	
SI Module 5&6 Research Prep and Evidence	30	1	Ulster & SI Network	Community Care E.G District Nursing etc	
Leadership in Practice	30	2	swansea	Secondary care	

For Academic intake 2019/20					
Course Title	Course duration	Year of output	Numbers Required	AHP Staff Group	Indicate any Recruitment Difficulties / Reason for commissions
PRESCRIBING					
Full Independent Prescribing	1 year	2020	3	Physiotherapy	
Supplementary Prescribing	1 year	2020	1	Dietetics	
Limited Independent Prescribing	1 year	2020			
Non Authorisation of Blood transfusion	1 year	2020			

For Academic intake 2019/20					
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					
B.Sc. Diagnostic Radiography	3 years	2022	20		Difficulties in recruiting all Radiographers to bands 5, 6 and 7 Ultrasonographers
B.Sc Therapy Radiography	3 years	2022	8		
					Increasing difficulty in recruiting to all grades. In addition mental health and learning disabilities require highly specialised skills and experience.
B.Sc. Human Nutrition - Dietician	3 years	2022	4		
PG Diploma Human Nutrition - Dietician	2 years	2021	2		
PG Diploma Medical Illustration	2 years	2021	2		

					Figure reflects the Health Boards needs and also the Health Board recruits on behalf of local authority and third sector
B.Sc. Occupational Therapy	3 years	2022	41		
B.Sc. Occupational Therapy (Part time)	4 Years	2023	0		
PG Diploma Occupational Therapy	2 years	2021	9		
Degree in ODP	3 years	2022	15		Difficult to recruit to theatres
					High turnover for band 5 & 6 staff with national shortage. A number of retirements are expected over the next 3 years especially within mental health and Learning disability
B.Sc. Physiotherapy	3 years	2022	42		
B.Sc. Podiatry	3 years	2022	2		
B.Sc Orthoptist	3 years	2022	3		workforce are over the age of 55
					Lack of supply of newly qualified staff (band 7). Loss of candidates to independent sector in LD. Geographical spread of services in Learning Disabilities-more likely to recruit to urban areas
PhD Clinical Psychology Doctorate	3 years	2022	24		
					Lack of applicants with appropriate dysphasia competence and fixed term contracts due to fixed term funding is not attractive to applicants.
B.Sc. Speech & Language Therapy	3 years	2022	10		
					Expansion in welsh medium education means that treatment cannot always be provided through the medium of Welsh
B.Sc. Speech & Language Therapy - Welsh Language	3 years	2022	2		
					Paramedics will be utilised to support the sustainability of primary care services and within the out of hours model
Ambulance Paramedics	2 years	2021	4		
Ambulance Paramedics - EMT conversion	1 year	2020	0		
Surgical Care Practitioner	2 Years	2021			
Medical Ultrasound/Sonography	2 years	2021			

For Academic intake 2019/20

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	2020	4		
Assistant Practitioners Radiography - Therapy	1 year	2020	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					
Diploma in Health and Social Care					

Diploma in Clinical Healthcare Support					
Diploma in Dietetics Support					
Diploma in Occupational Therapy Support	18	20			
Diploma in Physiotherapy Support	10	40			Numbers reduced as turnover of this staff group is quite low
Diploma in Maternity and Paediatrics Support					
Diploma in Perioperative Support					
Certificate in Clinical Imaging		4			
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	Year of Output	Numbers Required	HEI/Provider	Reason for Request
MA Digital Media	3yrs	2023	1	Swansea University	A large proportion of our workload is digital output The basic creation skills are taught at 1st degree level, but the skills needed for the integration of medical input/outputs need further study
Advanced Clinical Reasoning (MalcomESS)	4 days	2019	30	Malcomess	Continuing the work around co-production and prudent rolling out to teams

For Academic intake 2019/20					
Course Title	Course duration	Year of output	New Graduates Required - Employed workforce - Head count (In Service Applicants)	Indicate any Recruitment Difficulties / Reason for commissions	
HIGHER SPECIALIST SCIENTIST TRAINING - HSST					
Physical Sciences					
Clinical Biomedical Engineering	5 years	2024	0		
Medical Physics	5 years	2024	1	er requested includes clinical biomedical engineering. Career pathways.	
Life Sciences					
Genetics-Genomics	5 years	2024	0		
Molecular Pathology of Infection	5 years	2024	0		
Molecular Pathology of acquired Disease	5 years	2024	0		
Histopathology and Immunology	5 years	2024	0		
Embryology and Reproductive Science	5 years	2024	1	to aid in recruitment and retention and assist with succession planning	
Physiological Sciences					
Audiology	5 years	2024	0		
Vascular Science	5 years	2024	0		
For Academic intake 2019/20					
Course Title	Course duration	Year of output	New Graduates Required - Employed workforce - Head count		Indicate any Recruitment Difficulties / Reason for commissions
			Direct Applicant	In service Applicant	
SCIENTIST TRAINING PROGRAMME-STP					
Physiological Sciences - STP					
M.Sc. Clinical Science in Neurosensory Sciences - Audiology	3 years	2022	1		Expansion in the demand on audiology services and the development of primary care audiology services to reduce demand on GPs are creating shortages for this workforce.
M.Sc. Clinical Science in Neurosensory Sciences - Neurophysiology	3 years	2022	2		
M.Sc. Clinical Science in Neurosensory Sciences - Cardiac Physiology	3 years	2022	3		
Life Science -STP					
M.Sc. in Infection Science - Clinical Microbiology	3 years	2022	0		
M.Sc. in Blood Sciences - Clinical Immunology	3 years	2022	0		
M.Sc in (Blood Sciences) Haematology and Transfusion Science	3 years	2022	0		
M.Sc in (Blood Sciences) Histocompatibility and Immunogenetics	3 years	2022	0		
M.Sc. in Blood Sciences - Clinical Biochemistry	3 years	2022	0		
M.Sc. in Blood Sciences - Genomics (formally Genetics)	3 years	2022	0		
M.Sc in Genomic Counselling (formerly Genetic Counselling)	3 years	2022			
M.Sc in Cellular Sciences - Reproductive Sciences - Clinical Embryology and Andrology	3 years	2022	3		positions in the entire UK - Wales has an ISO accredited service and will need high quality staff to
M.Sc in Cellular Sciences - Histopathology	3 years	2022	0		
M.Sc in Cellular Sciences - Cytopathology	3 years	2022	0		
Physical Sciences and Biomedical Engineering - STP					
M.Sc. in Clinical Science - Medical Physics-Radiotherapy Physics	3 years	2022	1		succession, ARCH development of split-site working. Recruitment exceptionally difficult at B7.
M.Sc. in Clinical Science - Medical Physics-Imaging with Non Ionising Radiation	3 years	2022	0		
M.Sc. in Clinical Science - Medical Physics-Imaging with Ionising Radiation	3 years	2022	1		succession, ARCH development of split-site working. Recruitment exceptionally difficult at B7.
M.Sc. in Clinical Engineering - Rehabilitation Engineering	3 years	2022	0		

Confirmed S Ryde - No change

Confirmed Rhys Meredith- no change

M.Sc. in Clinical Engineering - DRMG	3 years	2022	0	1	anticipate member of staff seeking to pursue MSc to further career in ABMU
Clinical Bio Informatics -STP					
MSc in Clinical Bioinformatics (Health Informatics)	3 years	2022	0		
MSc in Clinical Bioinformatics (Genomics)	3 years	2022	0		
M.Sc in Clinical Bioinformatics (Physical Sciences)	3 years	2022	1		
Post Graduate Education					
MSc Genomic Medicine (not STP)	2 Years	2021	0	0	

For Academic intake 2019/20

Course Title	Course duration	Year of output	New Graduates Required - Employed workforce - Head count		Indicate any Recruitment Difficulties / Reason for commissions
			Direct Applicant	In service Applicant	
HEALTHCARE SCIENTIST					
Physiological Science - PTP					
B.Sc. (Hons) Healthcare Science - Cardiac Physiology	3 years	2022	8	0	Local recruitment and retention issues
B.Sc. (Hons) Healthcare Science - Audiology	3 years	2022	3	0	Expansion in the demand on audiology services and the development of primary care audiology services to reduce demand on GPs are creating shortages for this workforce.
B.Sc. (Hons) Healthcare Science - Respiratory and Sleep Science	3 years	2022	4	0	Increasing work load and retirements.
B.Sc. (Hons) Healthcare Science - Neurophysiology	3 years	2022	3	0	
Physical and Biomedical Engineering - PTP					
B.Sc. (Hons) Healthcare Science- Clinical Engineering in Rehab	3 years	2022		1	succession, skill set for REU is unique
B.Sc. (Hons) Healthcare Science - Clinical Engineering (Medical Engineering)	3 years	2022		2	'grow your own', succession
B.Sc. (Hons) Healthcare Science - Nuclear Medicine & Radiotherapy Physics	3 years	2022	2	0	succession, ARCH development of split-site working
Life Science - PTP					
B.Sc. (Hons) Healthcare Science - Biomedical Science - Blood	3 years	2022	1	0	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Infection	3 years	2022	1	0	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Cellular	3 years	2022	1	0	
B.Sc. (Hons) Healthcare Science - Biomedical Science - Genetics	3 years	2022	0	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	Year of Output	Numbers Required	HEI Provider	Reason for Request
Audiology Certificate in Education	18 months	2020	1	Swansea University	
Apprenticeship, Electrical & Electronic Engineering, L4	4y	2023	2	Neath PT College	Succession; also need training costs (e.g. books, equipment, additional training courses etc.)
Apprenticeship BTec L3, HNC Mechanical Engineering	3y	2022	1	Various	succession planning
M.Sc. in Reconstructive Science	3 years	2022	1	tan University and Kings College	recruitment issues in highly specialist area
STP Cardiac Science	3	2022	3		All Wales request - approval already in progress with WEDS for 2018 intake

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

For Academic intake 2019/20				
Advanced Practice/Extended Skills				
Full Module Title	Credits 0-60 locked	Numbers required	HEI/Provider	Please identify what setting the education requested is for using options in drop down box?
BTEC Level 4 Professional Diploma in Pharmacy	120	1	Bradford	Secondary care
BTEC Level 4 Professional Diploma in Pharmacy	120	1	Bradford	Primary Care Health Board employed
Minor illness Module	n/a	3	Max	Primary Care Health Board employed
MSc Advanced practice	variable	3	Cardiff/Swansea	Secondary care
Certificate Psychotherapeutics	60	2	Aston	Secondary care

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
Pre Reg Pharmacy - Hospital programme	1 year	2021	18	
Pre Reg Pharmacy - Combined programme	1 year	2021	1	
Pharmacy Diploma	2 years	2022	7	
For Academic intake 2019/20				
Pharmacy Technician	2 years	2021	7	

For Academic intake 2019/20					
Course Title	Course duration	Year of output	Numbers Required	Indicate any Recruitment Difficulties / Reason for commissions	Please identify what setting the education requested is for using options in drop down box?
PRESCRIBING					
Full Independent Prescribing	1 year	2020	10	within the HB setting. Expansion	Secondary care
Supplementary Prescribing	1 year	2020			Please Choose
Limited Independent Prescribing	1 year	2020			Please Choose
Non Authorisation of Blood transfusion	1 year	2020			Please Choose

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Year of Output	Numbers Required	HEI/Provider	Reason for Request

- i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

For Academic intake 2019/20				
Course Title	Course duration	Year of output	New Graduates Required - Employed Workforce - Head count	Indicate any Recruitment Difficulties / Reason for commissions
Diploma in Dental Hygiene	2 years		2	
Degree in Dental Hygiene & Therapy	3 years		1	
Physicians Associates	2 years		16	To support medical rotas and expansion in primary and community care

Additional / new education requirements

Please complete the table below with details of any additional / new education requirements

Course Title and Educational Level	Course duration	Year of Output	Numbers Required	HEI/Provider

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

Medical and Dental

Information to inform education commissioning of Medical & Dental Staff

Information on organisations' anticipated future requirement for medical and dental staff is needed to inform education commissioning decisions. In addition to the information on Practice Nurses and Dental Care Practitioners requested in the previous pages, please complete the tables overleaf.

Please note:

- In each of the tables, please record what your organisation anticipates will be the net change of its medical/dental workforce during the next three years
- "Net change" means the anticipated increase/decrease in the size of that workforce (in Full Time Equivalent) compared to the previous years.
 - In other words, if an organisation anticipates that it will simply replace all retirees / leavers on a "one for one" basis (i.e. with a new doctor/dentist of the same grade/speciality), then the "net change" would be zero.
 - However, if the organisation anticipates that it will replace all retirees/leavers on a "one for one" basis and also recruit an additional doctor (1.0FTE) in a particular speciality, then the "net change" for that speciality would be +1.0FTE.
- The following should be excluded from the tables on the next few pages:
 - Training grade doctors entering/leaving an organisation as a normal part of their rotation.
 - Doctors moving organisations under TUPE arrangements.
- Please record all figures as Full Time Equivalent (FTE)

1) Medical/Dental Consultants (FTE)

Group	Speciality	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Projected change 2024	Recruitment Difficulties / Reason
		2018	2019	2020		
Medicine	Acute Medicine	2				
	Allergy					
	Audiological Medicine					
	Cardiology					
	Clinical Cytogenetics & Molecular Genetics					
	Clinical Genetics					
	Clinical Neurophysiology					
	Clinical Pharmacology & Therapeutics					
	Dermatology	1				
	Endocrinology & Diabetes					
	Gastroenterology	2				
	General (Internal) Medicine					
	Genito-Urinary Medicine					
	Geriatric Medicine	1.5				
	Infectious Diseases (& Tropical Medicine)					
	Medical Oncology					
	Neurology					
	Occupational Medicine					
	Religious Medicine					
	Rehabilitation Medicine					
	Renal Medicine					
	Respiratory Medicine					
	Rheumatology					
	Sports & Exercise Medicine					
Pathology	Chemical Pathology					
	Haematology					
	Histopathology (includes Neuropathology)	1	1			
	Immunology					
	Medical Microbiology					
Paeds	Pediatrics	4.5				
	Pediatric Cardiology					
	Pediatric Neurology					
Psychiatry	Child & Adolescent Psychiatry					
	Forensic Psychiatry					
	General Psychiatry					
	Old Age Psychiatry					
	Psychiatry of Learning Disability					
	Psychotherapy					
	Clinical Oncology					
Radiology	Clinical Radiology					
	Nuclear Medicine					
	Cardiothoracic Surgery					
Surgery	General Surgery					
	Neurosurgery					
	Maxillofacial Surgery					
	Otolaryngology (ENT)					

2) Medical/Dental Consultants (FTE) (continued)

Group	Speciality	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Projected change 2024	Recruitment Difficulties / Reason
		2018	2019	2020		
Surgery (cont'd)	Pediatric Surgery					
	Plastic Surgery					
	Trauma & Orthopaedic Surgery					
Other medical specialities	Urology					
	Anaesthetics					
	Intensive Care medicine					
	Emergency Medicine	3	3	3		19 National shortage
	Obstetrics & Gynaecology	2				
	Ophthalmology / Medical Ophthalmology					
	Public Health (excluding Dental)					
	Dental Public Health					
	Dental & Maxillofacial Radiology					
	Endodontics					
Dental specialities	Oral Surgery					
	Oral & Maxillofacial Pathology					
	Oral Medicine					
	Oral Microbiology					
	Orthodontics					
	Pediatric Dentistry					
	Periodontics					
	Prosthodontics					
	Restorative Dentistry					
	Special Care Dentistry					
TOTAL CONSULTANT WORKFORCE		17	4	3		

2) GPs and Dentists (excluding Consultants) (FTE)

These figures should include all GPs and Dentists, including those working in independent GP/dental practices and those directly employed by the Health Board/Trust (including locums).

- The only exception is for Consultants working in the Hospital Dental Service (HDS), who should be recorded in the table above.
- Commissioning requirement for Dental Care Practitioners and Practice Nurses should be recorded on pages 1-2 of this document.

Type of doctor/dentist	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Projected change 2024	Recruitment Difficulties / Reason
	2018	2019	2020		
General Practitioners (GP)					
General Dental Service (GDS) Dentists					
Community Dental Service (CDS) Dentists					
Other Dentists (excluding HDS Consultants)					

3) Non-Consultant doctors (FTE) (all specialities combined)

i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

Please give a broad overview of how your organisation's overall non-consultant medical workforce is likely to change in size during the next three years. It is recognised that the size of an organisation's training grade workforce is not entirely within its control; the forecasts provided by organisations will therefore be triangulated against information from the Wales Deanery.

While specialty-specific information has not been requested below, please feel free to provide additional information (e.g. if the bulk of the forecasted increases/decreases are anticipated to be in specific specialties)

Type of doctor	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Total (2018-2020)	Additional Comments	Recruitment Difficulties / Reason (Please specify specialty)
	2018	2019	2020			
Non-Consultant Career Grade doctors	2	2	0	4	Cases submitted and attempting to recruit. Current gap to sustainable rota and compared with comparable units	Novel jobs being advertised to improve including joint EMERTS posts
Training Grades: Foundation Grades						
Training Grades: Core level (ST1-ST2)						
Training Grades: Higher level (ST3+)	3	2	0	5	Aim to recover lost PEM ST7 post plus recruit additional ST4 to enable rota compliance	Difficult recruitment but increased numbers in ACCS and ST1-2 hope to improve. Note ST3 cannot take charge of emergency department

LHB & Trust Specific Internal Service Delivery Plans & Measures

Each Trust should identify their proposed delivery areas from both the national outcome/delivery domains and their local needs assessment

NOTE - Discretionary Template

Measure	Target	Profile												
		Projected end of March 2018 position	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														
Monthly														
Monthly														
Monthly														
Monthly														
Monthly														
Monthly														
Monthly														
Quarterly assessment														
Quarterly assessment														
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IMTP - 2018/19 Financial Plan - Supplementary Analysis of Changes in Operating Expenses

	Planned Care	Unscheduled Care, Frailty, Long Term Care	Primary and Community	Mental Health	Clinical Support	Non-Clinical Support	Commissioning / Other Healthcare Providers	Across Service Areas	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Baseline Operating Expenses									0
Cost Growth - Pay	0	0	0	0	0	0	0	0	0
Cost Growth - Non Pay	0	0	0	0	0	0	0	0	0
Demand / Service Growth	0	0	0	0	0	0	0	0	0
Local Service/Cost Pressures	0	0	0	0	0	0	0	0	0
Gross Operating Expenses	0	0	0	0	0	0	0	0	0
Identified Savings Plans (-)	0	0	0	0	0	0	0	0	0
Unidentified Savings Plans (-)									0
Total Operating Expenses	0	0	0	0	0	0	0	0	0
Total to Baseline - Change									
Value	0	0	0	0	0	0	0	0	0
Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

NOTE

Supplementary analysis aims to combine the movement in operating expenses, as per C3 Financial Plan Summary, Total Operating Expenses from C5 SCNIE, with the headings developed/used in the Efficiency Framework

Working Paper - Detailed Build up of Summary tab Lines

	Planned Care £'000	Unscheduled Care, Frailty, Long Term Care £'000	Primary and Community £'000	Mental Health £'000	Clinical Support £'000	Non-Clinical Support £'000	Commissionin g / Other Healthcare Providers £'000	Across Service Areas £'000	Total £'000
Cost Growth - Pay									
- Pay Award									0
- Increments									0
- Pensions & Other Pay Oncost Changes									0
- Terms & Conditions (incl T&S)									0
Other.....Specify									0
Sub Total - Cost Growth - Pay	0	0	0	0	0	0	0	0	0
Cost Growth - Non Pay									
Non pay Inflation									0
Statutory Compliance and National Policy									0
Continuing Health Care									0
Funded Nursing Care									0
Prescribing									0
GMS									0
Quality & Safety Developments									0
Other.....Specify									0
Sub Total - Cost Growth - Non Pay	0	0	0	0	0	0	0	0	0
Demand / Service Growth									
NICE and New High Cost Drugs									0
Continuing Health Care									0
Funded Nursing Care									0
Prescribing									0
Specialist Services									0
Demographic / Demand on Acute Services									0
Other.....Specify									0
Sub Total - Demand / Service Growth	0	0	0	0	0	0	0	0	0
Local Service/Cost Pressures									
Other.....Specify									0
Sub Total - Local Service/Cost Pressures	0	0	0	0	0	0	0	0	0
Identified Savings Plans									
Improved Controls & Cost Reduction									0
Workforce Models, Workforce Management,									0
Recruitment & Retention									0
Efficiency & Productivity									0
Value, Pathways, Referrals and Treatment									0
Thresholds, Clinical Decision Making									0
Service Reconfiguration, Premises									0
Rationalisation									0
Sub Total - Identified Savings Plans	0	0	0	0	0	0	0	0	0

NOTE

Although this is not a formal requirement the Working paper may help in completing the Summary return

- i. To receive and approve a report on the Annual Plan & its delivery through the Recovery & Sustainability Programme 2018/19 (to follow)

c22 Hyperlinks

Please use this template to provide links to key documents, delivery and programme plans which you reference in your IMTP.

Document	Hyperlink	Document	Page ref
National Strategic Context	Prosperity for All	Annual Plan	10
	Parliamentary Review of Health and Social Care	Annual Plan	10
	Wellbeing of Future Generations Act	Annual Plan	11
	Social Services and Wellbeing Act	Annual Plan	11
	Primary Care Plan for Wales	Appendices	46
Wellbeing and Area Plans	http://www.swansea.gov.uk/psb	Appendices	9
	https://www.npt.gov.uk/5808	Appendices	9
	http://www.bridgend.gov.uk/services/public-services	Appendices	9
	www.westernbay.org.uk/areaplan	Annual Plan	11
Delivery Plans	Inserted as thumbnails	Appendix 14	
Links to National Programme Boards	National Unscheduled Care Programme	Annual Plan	49
	National Planned Care Programme	Annual Plan	80
Needs Assessments	Western Bay Population Assessment	Appendices	10
	Joint Strategic Needs Assessment	Appendices	15
ABMUHB / regional clinical or service strategies	ARCH Portfolio Delivery Plan	Annual Plan	12
	Primary and Community Services Strategy	Appendices	36
	Children and Young People's Strategy	Appendices	36
	Non-Surgical Oncology Strategy	Appendices	36
	Digital Strategy	Annual Plan	125
Other ABMUHB documents	Older Person's Charter	Appendices	51
	Children's Charter	Appendices	66
	Welsh Language profile	Appendices	158

General Comments and Observations

- Some aspects of the plan have improved from last year, particularly workforce and primary care.
- Comprehensive list of achievements from 2017/18 included within the plan, but would benefit from further reflection on how the organisation has measured the impact of those achievements, and adopted the learning gained from them.
- Digital and Data Plan - the organisation's plan recognises the potential for digital to deliver care in new ways closer to people's homes, as well as improving the efficiency of working practices and developing models of care that are increasingly focused on self-care and prevention.
- The financial plan presents a positive ambition to reduce the organisation's overall deficit.
- Encouraging to see mental health noted as a high level priority.
- Planned care colleagues were particularly pleased with the driver diagram on page 43, this is a good summary of the vision and areas of action.
- Reference is made to the proposed Bridgend boundary changes, noting that the consultation is still underway.

- However, the plan is challenging to navigate and is disconnected. Overall, it does not reflect much of the good work in train.
- The plan's structure does not flow well, and although the focus of the plan is clear in that it concentrates on the five areas of targeted intervention, it lacks a cohesive overview and reads more like a list of things that need doing.
- The Annual Plan should be viewed as a vehicle for de-escalation.
- The plan contains insufficient detail on priority actions to be taken, predicted impact on performance and associated workforce and finance implications, particularly in the targeted intervention areas.
- Colleagues felt there was an over-reliance on appendices, with many areas currently housed within appendices needing to be brought into the main plan, none more so than the detail on regional planning.
- The plan references a number of reviews, but does not make clear how the organisation is going to undertake them. Additionally, there have been three separate reviews into reducing length of stay, but the Enabling Ward which has delivered reductions, is not discussed within the main plan.
- Little detail is included on collaboration and integration with public service partners.
- The plan was very light on references and alignment to the Well-being of Future Generations and Social Services & Well-being Acts.
- Detail on commissioning is light.
- No mention is made of the NHS Wales Collaborative.
- The plan references the organisational strategy, but it is unclear what the relationship is between the strategy and annual plan.
- Much more work to be done in reflecting how to embed existing positive work.

Abertawe Bro Morgannwg University Health Board – Collective Review Feedback – Revised March 2018

Note on the Structure of the Document

Welsh Government colleagues are aware that the Health Board's focus in this Annual Plan is to achieve our aim of improving our targeted intervention status and that as such we narrowed the focus of the Annual Plan to allow for greater emphasis on our targeted intervention criteria. Colleagues will also be aware of the Board's desire to have a short, sharp document which lays out the strategic context, aims and objectives, progress, delivery trajectories and plans, financial plan and assurance mechanisms.

In this context we have taken on board the feedback also provided in the letter of 23.3.18, to further address the requirements of the Planning Framework and to ensure that quality runs as a thread throughout the Plan. The Quality issues are now threaded through the Plan, and with regard to the structure of the document, in order to balance the need for detail with the need for brevity we have:

- Reviewed the Executive Summary and included in the pack;
- Retained the structure of the Annual Plan as focusing on our targeted intervention status (noting the comment above that the Plan should be viewed as vehicle for de-escalation) but changed the structure of the document to be more traditional (i.e. the context and planning framework are now providing the background for our Service Improvement Plans); and,
- Included the pack of Narrative Appendices as support which includes the other Policy areas, and now includes sections on Research, Development and Innovation, the Welsh Language and our Delivery Plans.

We have also taken on board the detailed feedback below and have addressed throughout the documents.

Essential: FOR ACTION - This feedback must be addressed prior to resubmission of final draft plan

	Issue to be addressed	How/Where has this been addressed by the organisation? NB This column is to be completed by health board/trust when the final plan is submitted in March.	Policy comments
	Significant concerns around demand and capacity planning. The DU are not undertaking this – they are work only providing the	Submitted plan based on extrapolation of quarters 3 and 4, DU have helped to shape advice on the capacity and demand approach and tools for 2018/19.	

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	tools. Further clarification is needed about how and when this work will be completed. RTT trajectories are unacceptable. The plan needs to set out an acceptable improvement trajectory. USC profiles are unambitious and need more focused priorities. Need to understand the link between initiatives and impact on performance. Bed reductions need clarification and service impact set out.	Process uses weekly profiling, derived demand and bottom up (job planned capacity). Modelling will identify gains and internal solutions. £2m within health board financial plan will be first call to implement improvements and sustainable solutions. Submissions closed 2nd March and scrutiny process took place on 7th March. See comments later in document re profiling and trajectories. The unscheduled care plan has been refreshed. We are clear that we need to agree a trajectory which is realistic but which is also stretching and challenging recognising the current performance levels within the Health Board. The Chief Operating Officer is clear that opportunities exist within existing resources to deliver improvement and is completing work to ensure that the actions set out drive increased quality and safety, but also they directly link to performance improvement. Through our service remodelling work stream of our recovery and sustainability programme, a significant amount of work has been undertaken since the submission of the draft annual plan to develop the service remodelling plan for the	

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		health board. Project plans have been developed and the delivery and financial impact and risks are currently being assessed. These are based on benchmarked Length of Stay, developing community based services and improving flow compared to Welsh peers. Numbers have been checked for consistency and service impacts set out in Chapter 3 (general beds) and Appendix 3 (Older People's Mental Health beds). Regional stroke specification completed and draft of this specification currently circulated. Final model expected to be agreed in April 2018. Pathway group to work through detail by June 2018 and Delivery Unit to complete capacity and demand modelling work scheduled for June 2018. Funding secured from Stroke Implementation Group for joint project manager across the two Health Boards to further develop regional plan. A quality and safety programme built around 9 Quality Priorities has been agreed since the submission of the draft annual plan. The plan drives quality and safety and maps the work through to measurable impacts on targeted	
	Reference is made to the future siting of the HASU. This has not been yet approved. Further clarification needed Quality & Safety and patient experience needs to be a thread through the plan		

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	Positive work on finance is not reflected in document. Further assurances are required <u>Further details are set out below</u>	intervention areas. Each individual quality priority area has a clear driver diagram setting out how delivery will be achieved and how it will be measured (not all of these have been include in the document). The programme has been approved by the Executive Team and woven through the Service Improvement Plans. Revised finance section included based on all the WG feedback received. See Finance section below.	
Improvement areas – These should be strengthened before final submission.			
	Feedback	How/Where has this been addressed by the organisation? NB This column is to be completed by health board/trust when the final plan is submitted in March.	Policy comments
Digital change and innovation	<u>Data & Digital</u> Whilst digital colleagues were	Investment to deliver the digital transformation vision across NHS Wales is an issue, as	

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Contact: Frances Duffy	pleased with the ambitious nature of the organisation's digital strategy, there are some concerns around its affordability. <u>Innovation</u> Colleagues felt that the plan lacked sufficient detail on innovation and this should be addressed within the next iteration of the plan.	identified in the recent WAO report on NHS Wales Informatics. This point has been addressed in the Digital Health section in Appendix 8. Examples of AMBU Health Board leading on innovations on behalf of All Wales have been highlighted. Unscheduled care Service Improvement Plan; Digital Health section; Appendix 8	
Finance Contact: Alun Lloyd	Finance colleagues were pleased that the plan presented a positive ambition to reduce the organisation's overall deficit. However, there was a general concern that the finance aspect of the plan lacked detail and felt quite light, underselling some of the good work the organisation is undertaking. The ambitious savings plan does not give provide sufficient assurances around delivery. Plan sets out an improved financial position (by £6m) but the underlying deficit remains the same.	Now included in Finance Section to illustrate actions underway. In addition, we have received more detailed comments in the Finance to Finance comments sent by WG on 1 March as part of the month 10 Monitoring Return reply. A separate response will issue on these points of detail. Now included in Finance Section and reflected in amended forecast deficit position of £25m. 2017-18 forecast outturn has improved by £6m. This reflects savings schemes and reduced operating expenditure. However, as set out in the Plan, a key feature of this are the non-recurrent benefits. Work is on-going in March regarding the opening position of £34m	

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	Positive work on finance is not reflected in document. Further assurances are required.	Since submission, detailed discussions have taken place to further scope out the future financial strategy and to assure the individual components of the financial plan. Recovery and Sustainability work stream has been redesigned and realigned to specifically support the individual savings packages, and accountabilities have been clarified to underpin delivery. Deloitte's were commissioned in December to test for further savings opportunities and deliverability and draft report being considered. Review to carry forward financial position nearing completion to reflect recent improvements in health board monthly run rate, and to provide a robust basis for budget allocation. Review of financial narrative to strengthen reflection on improvements in 2017/18 and how lessons learned can be carried forward. Budget allocation and delegation process being finalised to link financial allocations to delivery performance, workforce and benefits realisation.	
Healthcare Quality Contact: Janet Davies	The Plan has a poor level of evidence for patient engagement. Although referenced in some parts of the plan quality and safety should be threaded throughout the plan.	Quality, Safety and Patient Experience section completed. The quality section has been significantly updated following the conclusion of work to agree our quality priorities and our intention to refresh our Quality Strategy. Our approach is aligned to our targeted intervention priorities and our quality priorities have been threaded through	

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	Good focus on the Service Improvement Plan for AMR/HCAI's. Pleasing to see that there is also a chapter devoted to how the organisation plans to improve through their financial, workforce and infrastructure enablers. However, clarification is required as to whether the HCAI trajectories are realistic. Reference made to the initiation of a health board Quality Hub as part of the Health Board's quality strategy, which will centralise the HB's quality management approach. Clarity required on how this will ensure quality and safety is at the forefront of everything the organisation does and not just to meet its priority areas. No reference to capacity building and empowering staff through Improving Quality Together (IQT). No reference to the	our Service Improvement Plans. The HCAI trajectories are based on a detailed bottom-up analysis of the drivers for improvement, our current position and our historical ability to improve our position. Unit plans are in place to achieve the overall Health Board trajectories. We have compared our trajectories to historical trends across all Health Boards and have revised our trajectories accordingly. Further explanation of Quality Hub included, including links to Quality Improvement. Now included in Quality, Safety and Patient Experience Section. Falls prevention included as one of our top Quality Priorities. More detail on the	

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	adoption/implementation of NICE guidelines and quality standards – link to the Health and Care More detail needed on falls prevention, especially in regards to care home settings. Little reference to patient experience work apart from in relation to patient outcomes No evidence of use of Framework for Assuring Service User Experience and similarly for information about concerns/complaints.	collaborative iStumble approach to preventing falls in care homes included in the Unscheduled Care Service Improvement Plan. Section on patient experience included and specific actions included in Service Improvement Plans.	
Mental Health Contact: Tracey Breheny/ Nicola Evans/ Ainsley Bladon	Mental health colleagues were pleased to see mental health was noted as a high level priority. However, there were concerns around the level of detail within the plan on mental health. The plan also felt unambitious. Plan notes that the organisation ‘will deliver Strategic Frameworks for Mental Health, Learning Disabilities and Dementia’. How and when these frameworks will be delivered needs to be detailed.	The Plan has been reviewed and our Together For Mental Health (T4MH) Delivery Plan is now also included which contains more detail. More detail on the process and timescales for developing the Strategic Frameworks for Adult Mental Health and Learning Disabilities included in Appendix 3. More detail on our dementia plans linked to the national Dementia Strategy also included in this section. Explanation of impact and more detail included in section on Older People’s Mental Health in	

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	The proposed £1.5m investment in older people's community mental health is positive, but no detail on how to balance bed reductions contained. General concern around the lack of progress within the organisation around mental health.	Appendix 3. The comment is contrary to advice we have received separately on our progress with our T4MH Plan. The T4MH Plan is now included as a thumbnail in Appendix 3 and Appendix 14 (Delivery Plans).	
Nursing Contact: Paul Labourne	The plan does discuss quality of care and patient outcomes however there is no mention of patient experience, patient feedback and how it would be utilised. No detail on nursing innovation. Commentary on disinvestment in anticipatory teams and reinvestment in core community nursing teams. There is no discussion however as to how this will support any phased or incremental transition to the interim district nurse staffing principles. References to care home support, however no recognition of the potential impact the	A section on patient experience has been added to the Quality and Safety section. Our patient experience work has also been woven through the Service Improvement Plans. Included in Appendix 14. The reinvestment is being managed in line with the service remodelling work and a case is being developed to ensure that the reinvestment maximises the opportunities for admission avoidance or discharge support. Now added to the primary care workforce section of our Workforce plans in Appendix 6.	

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	Regulation and Inspection of Social Care Act may have on community nursing services or on 25A and the need to support care home and home care workforce planning. There is no discussion on how workforce planning is being supported in the care home sector. There is no narrative on primary care nursing and how this will be supported and developed as part of the primary care provision. Very limited on wider community service support such as prison service. No references to mental health nursing. Maternity and early years work across sectors including public health and public service boards	See primary care section in Workforce Appendix 6 – this describes our vision for a multi-disciplinary primary care workforce linked to our Primary and Community Services Strategy. Parc prison is a private facility and as such the NHS does not provide healthcare to the site. We will be reviewing our provision in Swansea in 2018/19 to improve the robustness of the service. Inserted into Primary and Community Services section in Appendix 2. Section inserted into the Workforce Appendix 6. Noted. Noted.	

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	to improve future generation health is welcomed. Pleased to see narrative around skillmix and workforce planning. Little reference to health visiting and school nursing services in children and young people's plan. This is imperative and needs to be linked to first 1000 days and future generations. Good maternity plan in relation to key performance indicators Only one reference to the Nurse Staffing Act in the plan which is specifically about aligning the organisation's dashboard to the Act. No detail about what has been done in reference to 25A since April 2017 and nothing significant about preparation towards 25B and C. No funding is earmarked for any additional costs of adherence to the Nurse Staffing Act (NSA).	Sections on health visiting and school nursing included in the children and young people's plan. Noted. Detail on the Nurse Staffing Act is included in the Workforce Appendix 6 including what has been done and remaining actions. No monies are included in the financial plan as our assessment shows that we are broadly compliant with the CNO Guiding Principles of the NSA. Now stated in the finance and workforce sections.	
Performance Contact:	The plan successfully links some initiatives to performance, which is pleasing to see.	Unscheduled care trajectory assessed by Executive Team and Performance and finance committee. Modest improvement made to ED 4	

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Martyn Rees	Generally performance colleagues felt the plan was unambitious and does not always address issues. The plan contains many measurements of outputs, however does not give sufficient detail of measurements of inputs. The trajectories set for unscheduled care feel unambitious. No link to primary care in RTT. Clarity needed around the figures included in the RTT graph. Plan feels very secondary care focused, with very little input from primary and community care, especially when taking into account multiple unscheduled care solutions rest with community services. The plan makes note of the removal of 89 beds and also	hours at tail end. Plan document is clear on targeted intervention improvement areas. Input have been used to model services. See essential improvement section. Reference to e-referral and planned care programme where primary care is implied. Narrative will be updated to make this explicit. HB has revised agreed profiles which are clear. Unscheduled care driver diagram sets out reference to population health, 111, CRTs, frailty services, admission reduction etc. these are primary care/community care led and delivered services, Numbers have been checked for consistency – the baseline reduction in 2017/18 is 97 beds of which 79 are general beds and 18 are OPMH beds.	

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	mentions a figure of 80. Clarity needed as to whether that's 80/89 beds removed or a future 80 planned for removal. The plan gives little confidence that the organisation is assured of ownership of pathways. Some good intentions on stroke, however a lot of these intentions are subject to the development of HASU, which has not yet been approved.	Further detail on our pathway work through the Planned care programme and our Delivery Plans has been inserted into the Planned Care section. Noted. This is a deficit reduction plan so there are no resources to invest in Early Supported Discharge or other step changes – the plan is based on incremental performance improvement within resources.	
Planned Care Contact: Lesley Law	Planned care colleagues were particularly pleased with the driver diagram on page 43. This is a good summary of the organisation's vision and areas of action. There are however some areas that are missing, including clinical and patient engagement in the process and a commitment to clinical outcomes and a prudent approach. Good acknowledgement of the planned care programme within the plan and the areas for	Noted. Patient experience will be used a tool for change in cardiac and ophthalmology and orthopaedics in 2018/19. Noted.	

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	improvement. At this stage there is no real commitment to the national PREMS and PROMS programme, while the organisation has local amplitude for T&O we have not seen much coming from this work. The plan indicates the organisation's commitment to ICHOM for cataract and overall adult health. Is the organisation committed to deliver an outcome focused service? Need to see more clinical commitment expressed in the service delivery models being driven by commitment to improved patient outcomes and experience. Some mention on page 52 related to follow-up, but it could also help in demand management and appropriate referrals. While the plan talks about initiatives and service redesign for a number of pathways and areas, these are only related to RTT (page 50 our plans for 18/19).	The Health Board is committed to value based healthcare and has a range of initiatives underway in this regard. Value based healthcare relates outcomes and cost and we have developed an excellent understanding of the power and challenges of working in this way. We are developing our value based healthcare capability which will take us fundamentally into work on outcomes. We are looking at pathway changes in cancer services and our value based healthcare work is focussed on pathway redesign across unscheduled, stroke, scheduled and cancer care. Each of these areas is subject capacity and	

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	What plans are in place for service improvements and the sustained delivery of diagnostics and therapies going forward? Where is the clinical and patient service redesign across each service area? Has each clinical group/service area reviewed their demand flows, discussed with local referrers and come up with a plan to use improved processes? Have they been engaged in the clinical redesign to improve appropriate demand that then flows into a system to meet the clinical outcomes within timelines? The plans are operational, there needs to be more evidence of clinical support for these changes to support sustained delivery and doing things differently.	demand modelling and agreement of plans to provide sustainable services. These will be tested through the assurance process planned for April At a high level this will sit within the work of our Clinical Strategy work and at micro levels we involve clinicians and patients in our value based healthcare redesign work. Demand flows are well understood for unscheduled and scheduled care. There are a variety of ways in which the board undertakes this work in an engaged way. See above. All of our fundamental service redesign has clinical support. Plans pass through unit clinical boards before being considered corporately. We deploy service improvement methodologies to support this also. Yes, for ophthalmology and orthopaedics.	

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	Are there clinical and patient groups to support both the local and the regional work with Hywel Dda?		
Population healthcare Contact: Gareth Hewitt	From a population healthcare perspective, the Plan felt difficult to navigate and lacks detail, with little focus on planning regional services Although not a requirement for the annual plan, colleagues were pleased to note that the plan includes a reference to a revised fibromyalgia pathway and having pain services as an extension to it. Colleagues welcomed the references to a Children and Young People's Strategy. Stroke and cancer plans are detailed and strong, but the remainder of delivery plan areas are missing (barring briefs mentions of diabetes and respiratory). Critical Care capacity issues are not addressed within the plan and	Section on regional planning now included in the main Annual Plan as well as the Appendices. Noted. Noted. Delivery Plans are now included in Appendix 14 and woven through the Service Improvement Plans. End of Life now woven through the Stroke and Cancer Service Improvement Plans.	

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	the same for End of Life Care.		
Primary Care Contact: Karin Phillips	Primary care colleagues felt that the plan was a distinct improvement on last year. The lack of measurable timescales and milestones within the plan was concerning however. Although appreciated that the organisation spells out five key improvement areas, which are all focused toward secondary care, it is concerning that there is no mention of primary care within the Executive Summary. There is little on the improvements to be made to primary and community services, little reference to the Primary Care Plan and the emerging model. The Plan also refers to a “recently Board approved Primary and Community Services Strategy.” However this is not included in the Annexes. Plan states expectation to deliver care closer to home, in line with the evolving service model and through clusters, however it	The Health Board Primary and Community Services Strategy 2017/2022 is hyperlinked into the Annual Plan document and contains milestones for delivery over the next five years. The Board recognises that that the Annual Plan covers one year only and the key strategic tasks for delivery over the 2018/19 planning year are included in the PCS Unit Delivery Plan. This point is noted and the Exec Summary has been edited to include reference to Primary Care. The Board Primary and Community Services Strategy 2017/22 (endorsed by the Board in May 2017) is hyperlinked in the Annual Plan and the section on Primary Care in the Appendix and the Mandatory Appendices. The primary Care section in the Appendices has been strengthened to reflect links to the national Plan and model. The Strategy details the strategic direction for Primary Care over the next five years which has been informed by the national work to develop the emerging model and aligns with national strategic direction for primary care. The section has been strengthened.	

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	would be good to see more on the how around this work. The plan could do more to outline how the organisation views primary care's role in meeting the health board's corporate objectives. The plan undersells the organisation's position in regards to dentistry. No reference to the dental contract reform where the health board is leading the way in terms of embracing change. Nothing on Choose Pharmacy, Common Ailments Scheme or New Treatment Fund within the plan.	The Health Board work on dental services has been described more in the Unscheduled care Service Improvement Plan and the Oral Health Delivery Plan is included in Appendix 14. The pharmacy strategy work programme, including the roll out of the Common Ailments Scheme which will be completed by August 2018, is referenced in the Primary and Community Services Strategy 2017/22. Pharmacy improvement work and the New Treatment Fund investment plans is one of the six key work programmes for the PCS Unit over the next 12 months 2018/19 as part of the core work programme.	
Public Health Contact: Irfon Rees	In general the plan contains only very limited reference to health inequalities and lacks detail on specific planned actions to reduce inequalities.	The reduction of inequalities is an underpinning principle to all work, Our new approach is based on the recommendations of the Determinants of Health in Wales work (not to target geographical areas of poor health outcomes but to provide intervention across our whole catchment population). The LPHT work plan has now been included which gives more detail on many of the issues raised here. However it is, as explained	

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	In relation to obesity/physical activity, the plan is weak on detail and does not identify how progressive work will be undertaken. No identification on work around healthy eating or diet. No mention of the forthcoming obesity strategy and limited links to the obesity strategy There is no mention of the Substance Misuse Strategy or Delivery Plan which alcohol	in the section a prioritised work plan on the lines of prudent healthcare. A review paper on the obesity pathway (including physical activity and healthy eating) has been developed and a series of recommendations on the progression/improvement across all 4 levels of the pathway identified. This is pending review by the Exec Team and Board, with direction of travel to be agreed which will inform more detailed objectives for work in 2018/19. This work will align to the forthcoming obesity strategy as outlined in the paper The wider determinants agenda including creating supportive environments - planning, transport, travel are included in this year's work plan Likewise the ABM physical activity alliance is progressing the development of a physical activity action plan, with the detail of the work for 2018/19 to be agreed As above The focus of the PET group has been on children and young people and substance misuse. Alcohol prevention activities are include in our Liver Disease Delivery Plan which is included at Appendix 14.	

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	prevention falls within. There are significant gaps in terms of alcohol prevention within the plan. More detail around this area is needed. Plan doesn't demonstrate an awareness of Public Health (Wales) Act 2017 No evidence within the plan of planning being underway to achieve the elimination requirements for Hepatitis (B&C) set out in WHC/2017/048. Whilst there is evidence of planning for seasonal flu from an immunisation perspective there is no evidence of wider work. In particular with regards to pharmacies and social services. Whilst there is evidence of planning for HCAs there is little in relation to responding to	The plan has considered the PH (Wales) Act. The workplan includes areas of action for example within tobacco regarding smoke free children's areas and hospitals development of the obesity strategy and health impact assessment. One of the top five priorities of our Liver Disease Delivery Plan is to take forward the legacy of the Blood Borne Viral Hepatitis Action Plan in all relevant settings and continue the effort to eradicate viral hepatitis with improvements in access to testing, treatment and harm reduction services (see Appendix 14). There are actions in the ABM Primary Care Plan which includes working with pharmacies and wider work to include partners The Annual Plan is aimed at improving our targeted intervention status. The LPHTs work plan has been prioritised and does not specifically include work on air quality or gambling.	

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	community outbreaks. No reference to air quality. No reference to the consequences of gambling within the plan. As smoking cessation services are reviewed, it will be important to link with Help Me Quit, the new first point of contact/triage for smoking cessation services in Wales, and to align any marketing activity with this brand.	The ABM tobacco lead works closely with the national tobacco lead and ensures that all smoking cessation activity, service provision and marketing activity is aligned to Help me quit branding and development. ABM cessation services are working collaboratively and linked into the national work, and integration agenda being progressed -as outlined with the All Wales tobacco control strategy, including minimum data sets, service standards, service pathways, training and education etc	
R&D Contact: Carys Thomas	Very little reference within the plan to R&D. What R&D references are made, are made at a very high level and always under the ARCH programme. R&D colleagues felt that the organisation is underselling their position on R&D by not including other progressive activity in plan.	A section on progress and plans in Research and Development has been added in Appendix 13. This includes progress to date and examples of good practice.	
Science and therapies Contact: Rob Orford	There is little mention of Diagnostics and nothing on the vision for the future for services in this area. Also no mention of POCT, Genomics. The plan recognises the	The Director of Therapies has reviewed the plan in the light of the feedback and amended the content of the whole plan to reflect the important contribution of Healthcare Scientists and therapists. We are involved with the Digital Cellular	

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	importance of digital developments, however there is no mention of Digital Cellular Pathology developments at the UHB and it would be helpful to see progress made to date and the future intention could be highlighted. There is no mention of the National Imaging Academy Development and the opportunities that this will provide	pathology programme and this is now included in the section on regional pathology in the Appendices. Now included in the workforce section.	
Substance Misuse Contact: Rhys Davies	No references to substance misuse or co-occurring within the annual plan and references to alcohol are linked to cancer treatment and prevention. The appendices attached to the plan have just one reference to substance misuse.	Now also included in the section on the Area Plan. Alcohol prevention activities are included as the top priority in our Liver Disease Delivery Plan (Appendix 14).	
Welsh Language Contact: Sioned Rees	It is disappointing to note that the plan includes little information in relation to how it is addressing the Welsh language in assessment, strategic context or workforce planning and skills.	A full Welsh Language section has now been included in Appendix 12. Our plans around our Bilingual Skills Strategy is included in the Workforce section.	
Workforce Contact: Ian Owen	Workforce colleagues found the plans layout difficult to navigate however were content that the plan provided a broad overview of workforce challenges, and	The layout has been changed to make it easier to navigate and further comments from Jayne Dando have been incorporated included a strategic statement in the Foreword.	

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	gave some good detail. The plan is not well defined around shifting skill sets and the shape of the workforce. References made to the ARCH programme but the priorities are not clear. Positive to see the organisation's assessment of the total number of vacancies within the appendices. Plan gives a headline that the will commit to resolving recruitment issues by reforming services, but this is a superficial statement and lacks detail within the plan. Gives a commitment to the redesign of the primary care workforce but does not set out specific actions and timescales. Concerns that the workforce templates are incomplete, information missing on variable pay costs and WTE in agency and locum. The recruitment challenges template is also	This work is currently being developed through the workforce redesign work stream, as part of the recovery and sustainability programme. A paragraph has been inserted to highlight the priorities to develop the future workforce through ARCH. Noted. This detail has been added within the service redesign section. Redesigning the primary care workforce is part of the strategy to develop the service. The details of the plan and timescales are currently being developed. Financial colleagues have advised this information is not readily available in this format. Recruitment challenges are included in the education commissioning template. Advised by WEDs that the separate template did not need to be completed.	

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	incomplete.		