

CLINICAL SERVICES PLAN 2019-24



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University Health Board

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Production

Abertawe Bro Morgannwg University Health Board Medical Illustration Department



FOREWORD

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

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

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



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



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

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



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1 - Our Ambition for Clinical Services

1.1 Our Organisational Ambition

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

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

ALIGNING OUR STRATEGY AND PLANS

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

Our ORGANISATIONAL STRATEGY is about:

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

Our CLINICAL SERVICES PLAN is about:

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

Our THREE YEAR PLAN is about:

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

UNDERPINNED BY DETAILED ANNUAL OPERATIONAL PLANS



2 - How We Developed the Clinical Services Plan


1.2 Our Clinical Service Plan Principles

A Healthier Wales (2018), focuses on transforming care in Wales through delivering the ‘Quadruple Aim’;

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

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

CSP Planning Principles



Optimising patient outcomes through

1. One System of Care Clinical pathway processes that cross Specialities, Departments and Delivery Units
2. My Home First Pathways which enhance care delivery in or closer to the patients home where clinically safe
3. Right place, Right person, Right time Workforce, estates, equipment, digitalisation
4. Better Together Regional and local collaboration on networks of services that meet the care needs of patients

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

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





2.1 A Clinically Led Refresh Process

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

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

2.2 Listening to Patients, Carers and Stakeholders

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

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

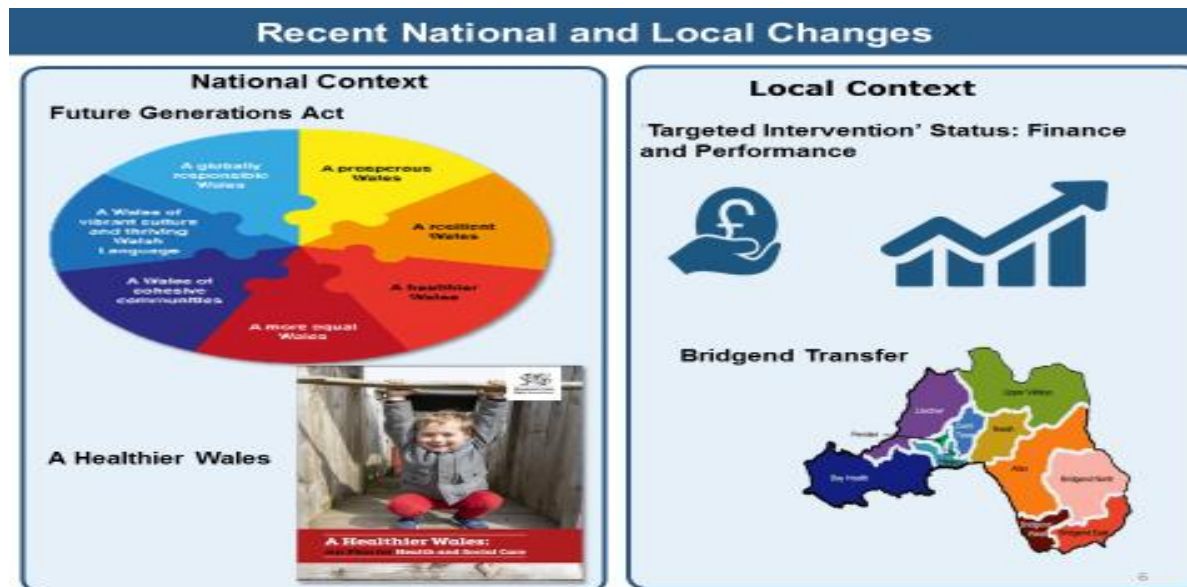
Between September and November 2018 stakeholders participated in a series of Clinical Redesign Groups for unscheduled care, surgical and regional services, where they shared their views and suggestions to further shape the ambitions within this plan. Our stakeholders also engaged in a range of meetings, workshops and presentations at which we were able to share and test the emerging clinical services plan principles and priorities and listen to their views and ideas on these.

Additionally, engagement findings from a range of local plans and strategies, which the Health Board engaged with staff and stakeholders on between 2013 and 2018, have informed the Clinical Services Plan. These include, but not exclusively, the Social

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

2.3 Building on Changing for the Better

Our staff working with patients and partners, including through the ARCH Programme with Hywel Dda University Health Board and Swansea University, have made good progress in delivering the commitments we made in 'Changing for the Better' (C4B). However, they also told us that not everything that was agreed in 2013 has been put into action.



Recent national and local changes, including publication of *A Healthier Wales (2018)*, also highlighted that there was a need for us to update C4B and write a Clinical Services Plan for the next five years which took account of these more recent developments.

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



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

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

2.4 Clinical Redesign Groups



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

- Unscheduled care
- Surgical services
- Regional services

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



2.5 Listening to our Staff

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

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

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

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



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



2.6 System Reconfiguration

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

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

<ul style="list-style-type: none"> • Surgical pre and post-operative lengths of stay in hospital 	<ul style="list-style-type: none"> • Pace of discharge from hospital
<ul style="list-style-type: none"> • Patients admitted with conditions that can be treated without an admission 	<ul style="list-style-type: none"> • Length of hospital stays
<ul style="list-style-type: none"> • Provision of day case surgical services 	<ul style="list-style-type: none"> • Waits for out-patient and follow up appointments

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

3 - Our Clinical Service Plan Priorities

3.1 The Role of Integrated, Primary & Community Care

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

The Role of Clusters

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



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

3.2 The Role of our Major Hospitals

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

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

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

Major Hospital Roles	
<p>Neath Port Talbot : Local hospital and a centre of excellence for:</p> <ul style="list-style-type: none"> • Treatment centre for minor injuries; • Assessment and treatment of frail older people and ambulatory care support; • Short stay low acuity elective surgery; • Rapid diagnostic access and support; • Rehabilitation and reablement services; • Provision of some specialist services e.g. neuro-rehabilitation & Welsh Fertility Institute services. 	<p>Singleton: Health Campus & Level 2 Hospital Centre of Excellence:</p> <ul style="list-style-type: none"> • Providing a wide range of diagnostic, rehabilitation & treatment services including ambulatory and frailty care; • An extensive range of elective surgery, including for high complexity patients with lower acuity; • Ophthalmology Services ; • Strategic Hospital partner to Swansea University Medical School to build on the success of the Institute of Life Science and establish a Healthcare Technology Centre; • Teaching our future doctors, nurses and allied healthcare professionals; • The current provision of acute/inpatient Neonatal, Obstetric, Gynaecological and Cancer services will be relocated to the Morriston site in the longer term, whilst provision of ambulatory care will continue.
<p>Morriston : A Health Campus and Level 4 Regional Centre :</p> <ul style="list-style-type: none"> • Regional Major Trauma Network and Trauma Unit lead; • Short Term treatment of acutely unwell patients; • Unscheduled and complex surgery across a broad range of specialties; • Critical Care provision; • Specialist diagnostic support and centralised Pathology; • Provision of paediatric services; • Provision of some tertiary services including cardiology and the cardiac centre; • Research partner with Swansea University and development of Institute of Life Sciences on Morriston campus. 	



3.3 Our Clinical Service Ambitions

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

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

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



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

1. POPULATION HEALTH: Our Ambition

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

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

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

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

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



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

POPULATION HEALTH : What we will do

OUR NEIGHBOURHOOD APPROACH

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

- Drive transformational improvements in wellbeing, health and care for the populations we serve through better practice, better services, better technologies and better use of resources.
- Change the way that we work with citizens away from paternalistic care to shared responsibility and co-production.
- Secure the delivery of seamless care which will meet the outcomes that matter to the people we serve and support through integration, earlier intervention and prevention
- Manage our common resources collaboratively and pool resources wherever we can.

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



PRIMARY CARE : INTEGRATED CLUSTERS

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

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

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

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

PRIMARY CARE : SUPPORT FOR SYSTEM WIDE TRANSFORMATION

Delivering a progressive Integrated Cluster model will support the Health Board to deliver the ambitions set out in the rest of this Clinical Services Plan, including but not exclusively for:

- Planned care; new approaches to surgery, out-patient appointments and managing demand
- Unscheduled care; acute care at home or in community settings to avoid unnecessary hospital admissions
- Older People; delivering Hospital2Home services for older and/or frail people
- Maternity, Children & Young People; the Children & Young People's Charter and Strategy and the Maternity Plan
- Mental Health & Learning Disabilities: community resilience, dementia care, priorities of the three frameworks
- Cancer; approaches to prevention and early diagnosis of cancers

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

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

PRIMARY CARE : DIGITAL

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

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

CREATE NEW INTEGRATED WELLNESS CENTRES

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

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



RESEARCH AND EDUCATION IN CLUSTERS

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

IMPROVE OUR LONG TERM CONDITIONS PATHWAYS

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

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

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

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



2. PLANNED CARE : Our Ambition

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

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

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

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

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

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

PLANNED CARE : What we will do

IMPROVE OUTPATIENTS & DEMAND MANAGEMENT

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

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

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

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

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

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

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

REMODEL SURGICAL SERVICES

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

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

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



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

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



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

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

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

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

3. OLDER PEOPLE : Our Ambition

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

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

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

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

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

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

the patient's physical and mental well-being.

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

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



OLDER PEOPLE : What we will do

DESIGN & DELIVER AN INTEGRATED OLDER PERSONS PATHWAY

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

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



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

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

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

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

ESTABLISH A SINGLE FRAILTY MODEL (and Frailty Assessment)

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

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

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

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

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

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

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

DESIGN & DELIVER A RANGE OF 'Hospital2Home' SERVICES

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

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





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

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

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

ENHANCE OUR FALLS PATHWAY

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

REGIONAL FRAILTY SERVICES

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

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

4. UNSCHEDULED CARE : Our Ambition

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

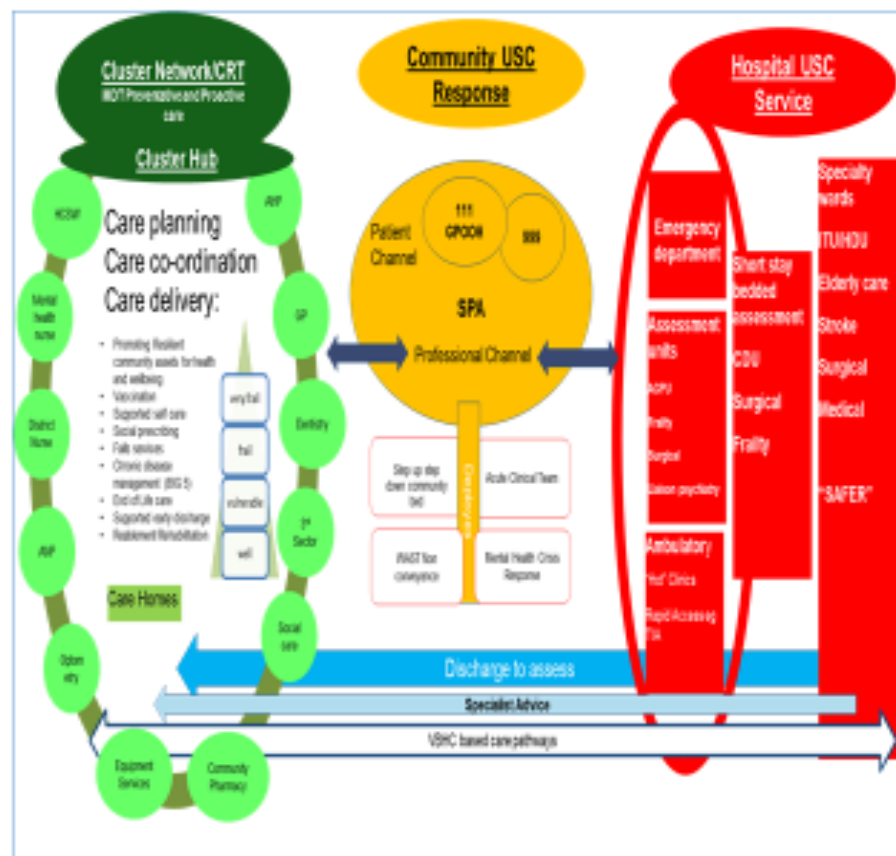
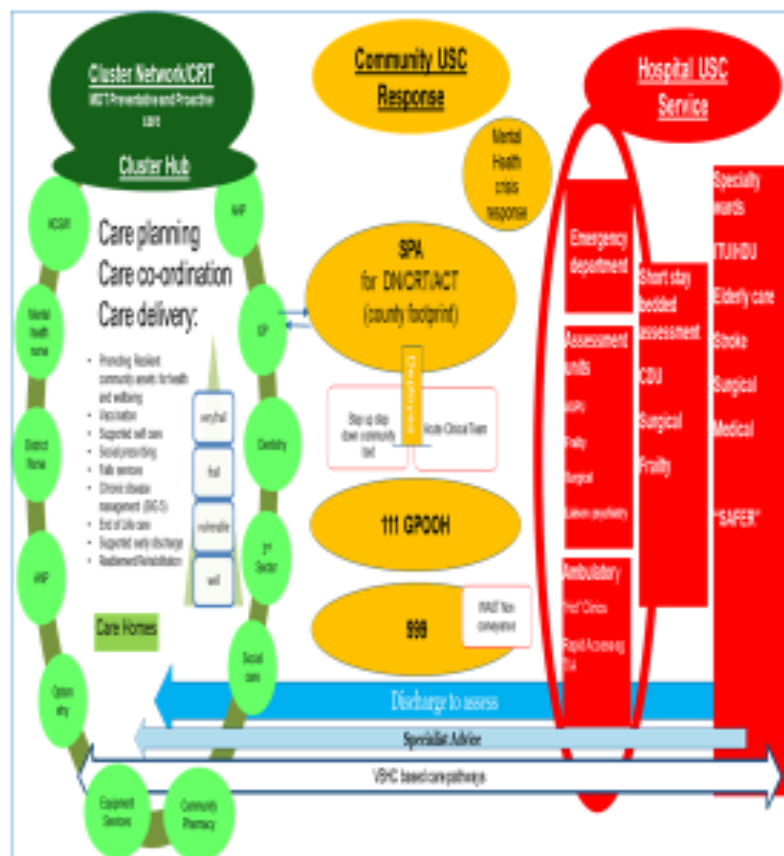
Excellent unscheduled care services start at home with individuals, families and careers feeling confident in knowing how to access the right service at the right time.

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

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

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

The following unscheduled care system image of the current and future states for unscheduled care is a product of the work clinicians and stakeholders participating in the Unscheduled Care Redesign Group undertook.



UNSCHEDULED CARE : What we will do

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

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

ACUTE MEDICAL ASSESSMENT UNIT

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

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

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

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

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

REDESIGN STROKE PATHWAY & A NEW HYPER ACUTE STROKE UNIT

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

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

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

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

We will continue our workforce redesign programme within resources using Prudent





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

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

END OF LIFE CARE

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

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

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

5. MATERNITY, CHILDREN & YOUNG PEOPLE : Our Ambition

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

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

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

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

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

MATERNITY, CHILDREN & YOUNG PEOPLE : What we will do

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

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

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



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

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

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

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

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



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

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

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

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

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

REGIONAL WOMEN & CHILDREN'S SERVICES

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

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

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

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



6. MENTAL HEALTH & LEARNING DISABILITIES : Our Ambition

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

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

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

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



MENTAL HEALTH & LEARNING DISABILITIES : What we will do

DELIVER THE ADULT MENTAL HEALTH STRATEGIC FRAMEWORK

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

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

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

- Development of **Community Mental Health Teams**, and ensuring that we have the right building blocks in place for community services, including medicines management in-put.
- Ensuring the availability of **low level support** is increased and that it is provided in a non-stigmatised way to allow people living with mental and emotional distress to reach their full potential.
- Planning on the same footprint between health and social care services with **Integrated Clusters** being the basic unit.
- Modernising **Day Services** and reviewing the availability of **drop in services**.
- Further developing the response to crisis situations for people and dealing with distress through the introduction of a **sanctuary model**.
- Development of Adult Acute Business case to replace the not **fit for purpose estate** still in use at Cefn Coed Hospital as

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

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

AGREE AND DELIVER A DEMENTIA SERVICES IMPROVEMENT FRAMEWORK

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

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

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

AGREE AND DELIVER A LEARNING DISABILITIES SERVICE IMPROVEMENT FRAMEWORK

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

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

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

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



Learning Disability

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

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



7. CANCER : Our Ambition

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

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

Our ambition is to provide the best possible cancer care for the people of South West Wales and to improve patient outcomes, quality of life and care at end of life through delivering six core objectives;

1. Prevent or detect cancer earlier
2. Improve the quality and availability of information
3. Deliver fast, effective cancer treatment
4. Meet people’s needs through delivering person centered care
5. Provide high quality end of life care
6. Improve access and opportunities for patients to participate in cancer research

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

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

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

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

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

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



CANCER : What we will do

RAPID DIAGNOSTIC CENTRE

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

IMPLEMENT THE SINGLE CANCER PATHWAY

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

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

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

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

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

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

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

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

IMPLEMENT PREVENTION OF LUNG CANCER INITIATIVES AND PATIENT REPORTED OUTCOME MEASURES

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

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

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

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



data to plan patient care and service improvement.

IMPLEMENT BREAST CANCER SCREENING AND PATIENT REPORTED OUTCOME MEASURES

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

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

REGIONAL CANCER SERVICES

Implement the commitments in Non-Surgical Cancer Strategy, including development and delivery of detailed plans (including capital plans) with partners for the further development of the South West Wales Non-Surgical

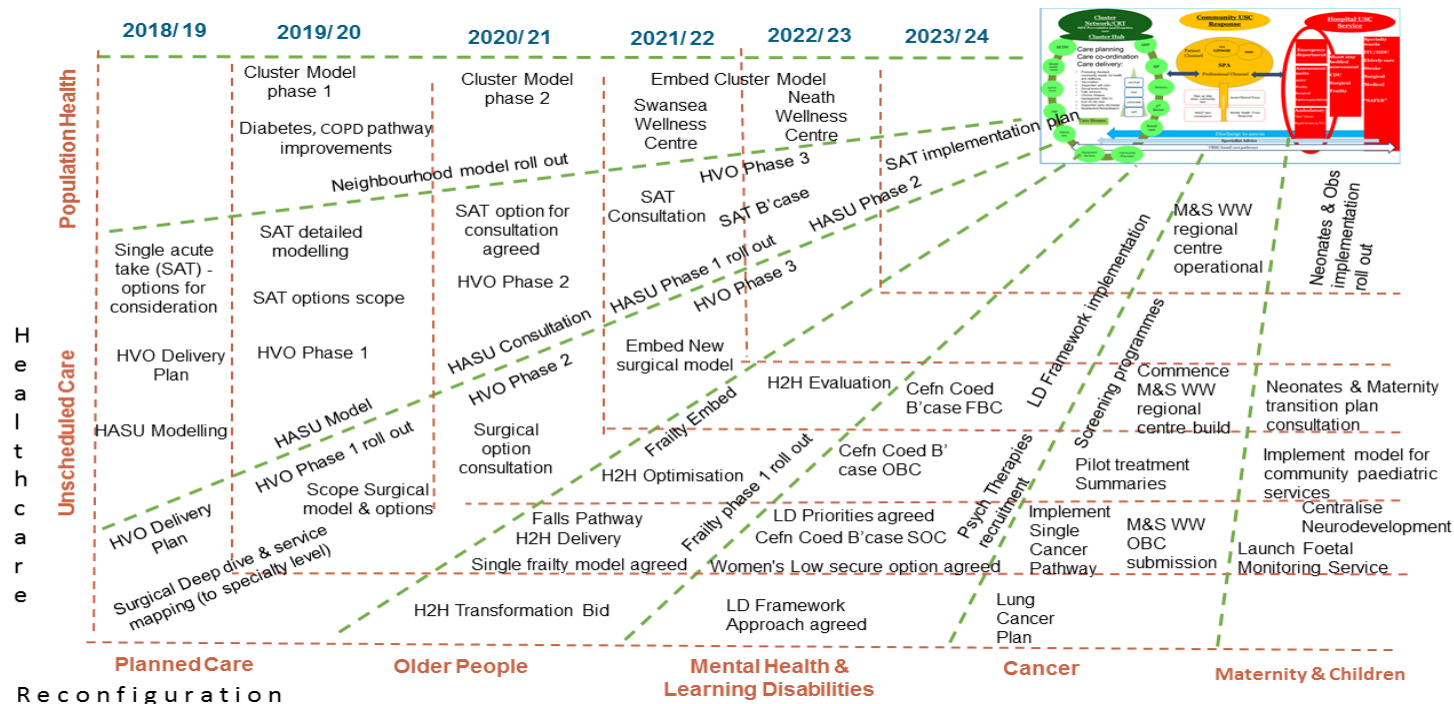
Cancer Centre; co-location of Cellular Pathology and Diagnostic Immunology services at Morriston Hospital; Advanced Therapy and Treatment Centre support for future Cell and Gene Therapy at Morriston Hospital.

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

4 - Delivering our Plan

4.1 Our Five Year Delivery Plan

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





4.2 How we will Deliver the Changes

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

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

OUR WAY

Improving patient quality, safety and value

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

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

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

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

5 - How we will Measure our Success

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

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

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



5.1 Measuring Our Success

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

Aims, Deliverables and Outcomes

Aims

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

Deliverables

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

Success Measures

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