

CARING FOR PEOPLE KEEPING PEOPLE WELL



Progressing Our Future

Integrated Medium Term Plan
2015/16 - 2017/18



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Pra
Cardiff and Vale
University Health Board

Our Mission is: (This is why we exist)

CARING FOR PEOPLE KEEPING PEOPLE WELL

Our Vision is: (This is what we want to do)

A person's chance of leading a healthy life is the same wherever they live and whoever they are

Our Strategy is: (This is our game plan)

Achieve joined up care based on 'home first', avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them

For Our Population (This is what we are offering to do)

Deliver Outcomes that Matter to People

Our Service Priorities (This is what we will focus on most)

Offer services that deliver the quality our population is entitled to expect

Sustainability (This is where we want to excel)

Join up what we do for the people we serve and strive for operational excellence so we make the best use of the resources we have

Culture (This is what we want working here and with us to be like)

Working better together across care sectors through people, innovation, research and technology

Being a great place to work and learn

OUR VALUES (These are what are important to us)

Care | Trust | Respect | Personal Responsibility | Integrity | Kindness



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Offer services that deliver the quality our population is entitled to expect

Join up what we do for the people we serve and strive for operational excellence so we make the best use of the resources we have

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Working better together across care sectors through people, innovation, research and technology

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Summary of reviews/amendments				
Version Number	Date Review Approved	Date Published	Review approved by	Summary of Amendments
1	12/10/14	12/10/14	AH	Peer Review Submission
2	22/01/15	22/01/15	AH	Updated as per Peer Review Feedback
3	26/01/15	30/01/15	AH	Updated as per Independent Member feedback
4	31/03/15	01/04/15	AH	Rewrite post WG feedback/UHB Board discussion

SECTION

Executive Summary



Executive Summary

Introduction

2014/15 has been a significant year for the NHS in Wales, with the launch of Prudent Healthcare and the first year running an integrated three year planning cycle. Throughout, a consistent message has been evident, and is captured in the Minister for Health and Social Services statement, following the launch of 'Our plan for a primary care service Wales up to March 2018'(WG):

"A prudent healthcare system, in which the avoidance of harm is our watchword, in which we pitch our interventions at the minimum necessary to address the problems which patients experience, will always have primary care at its heart"

These key national drivers are being supported by legislation including the Social Services and Wellbeing (Wales) Act; the Wellbeing of Future Generations Bill; and the Public Health Bill.

For Cardiff and Vale UHB, 2014/15 has also been a significant year strategically, with the development of a core set of strategic principles aligned to Prudent, the crystallising of the organisations strategic direction and importantly the security of working to an approved three year [integrated medium term plan](#) (IMTP). The requirement therefore for 2015/16 – 2017/18 is to secure and sustain the progress made last year, whilst refreshing our plan to reflect new national requirements, our local priorities and challenges and the desire to "fast-track" integration in line with our longer term vision.

Progressing Our Future - Developing the 2015/16-2017/18 Integrated Medium Term Plan

In our 2015/16 - 2017/8 IMTP we set out the challenges facing us over the next three years and the proposals we have for tackling these.

We have not delivered all we planned during 2014/15:

- Whilst significant savings (£29m) were delivered along with improvements in efficiency, our financial savings programme did not yield the full cash-releasing savings projected;
- We experienced some unpredicted and unpredictable additional service pressures; and
- Our performance - whilst improving in many areas – had not delivered on all required targets by year end.

In this updated plan, we set out in detail the achievements that were identified in last year's plan and a view of the challenges experienced. These include:

- The growth in our local population - particularly in Cardiff - is being felt more significantly, in terms of both the total population expansion, and the increasing number of older people, many of whom will require support. Over the next three years, the population will rise by a further 4% which will impact on demand for our services. Some communities are growing at much faster rate – including those seeking asylum;
- Our population continues to experience stark health inequalities which have not significantly reduced in recent years. A significant proportion of our the population we serve live in the most deprived communities in Wales, and lifestyle factors contribute significantly to poor health and a 10 year gap in life expectancy;
- We continue to experience difficulties with patient flow out of hospital following an unplanned admission, and the reductions in some council services resulting from local authority budget proposals are likely to further impact adversely in some areas;
- We believe we are cross subsidising some of the specialist services we provide to a larger catchment population, impacting on services to our local population. We have commissioned a short piece of external work to assess this;

- Staff shortages in some difficult to fill areas are exacerbating some of our capacity gaps and whilst we have made significant progress with recruitment, this has yet to be resolved; and
- Whilst we were able to address a number of the highest risks in relation to our estate, and medical and IT equipment during 2014/15, we still require a significant investment to address patient safety and capacity issues. The ability to invest in technology that will innovate the way we deliver care is limited.

Our plan for 2015/16 sets out in detail the actions we are planning to respond to these challenges. Some of these actions will impact in the first year of the plan, but others will take longer to implement (and may require formal engagement and consultation). The following provides a summary of the areas that we are progressing.

- We will continue to strengthen our GP cluster working, with the implementation of our nine cluster plans. Each plan varies slightly reflecting local priorities but include addressing population health priorities (in particular smoking), embedding the new diabetes model, and improving the management of long term conditions building on the end-to-end care pathways developed last year.
- Whilst many of our services benchmark well, in terms of both performance and cost, we know we have more to do to improve productivity and efficiency in some areas. We have developed plans that will ensure that we get the very best value from the services we provide. This alone, however, will not close the gap in capacity we have identified which is needed to meet projected patterns of demand.
- As identified in last year's plan, we will need to deliver very different models of care which rely much less on hospital based services, and which use technology to drive new approaches. Our clinical services strategy has developed considerably over the year - with design principles based on prudence and co-production underpinning our UHB wide strategy. This work is due to be completed in September and will inform our plans for 16/17; it is likely that we will need to engage and consult on some of the changes proposed.
- We have made a good start with developing outcome based commissioning and we will build on this in 2015/16. We will continue to develop our 'internal commissioning' processes as well as ensure we work with partner organisations (trusts, neighbouring LHBs and the local authorities) to develop integrated commissioning plans.
- We have set out plans with the two local authorities to take a much more ambitious step in our integration programme learning from the experiences of the last year, and informed by some external advice recently commissioned. This will mean that, together, we are better able to respond to the challenges we are experiencing in our unplanned care system.
- We have developed detailed plans to respond to unscheduled care. The plans are based on feedback from the Delivery Unit and our analysis of demand, capacity and 'system' flow. Our plans are based on the need to ensure that people receive the right care, in the right place, first time. As yet, we are not able to fully resource all of the plans. Some of the community based initiatives will continue by reshaping the Intermediate Care Fund programme, and we have identified the important role that a strengthened primary care will play. We will prioritise the plans to reflect the resources available.
- We plan to develop our community-based ambulatory sensitive conditions, building on the success of our diabetes pathway. This model of care will be applied in other areas as appropriate and will mean that we are able to increase the amount of 'planned care' provided in these areas by the prevention of deterioration and earlier intervention when a person's needs change - either temporarily because of a crisis, or permanently.
- We are strengthening some of our community models such as the provision of Community Resource Teams and will continue to work with third sector partners to ensure patients are sign-posted to the right care and support.
- In relation to planned care, we have analysed current patterns of demand and have implemented a number of initiatives which reduce demand by providing alternative service options such as the community diabetes model. Whilst our referral rates are low overall (based on benchmarking) there are areas where we can develop different models of care within primary care - we have started to do this in relation to eye care. We also know that, despite improvement in our productivity and efficiency, there are areas where we can do more. We will continue to deliver our theatre productivity programme, ensure more admissions happen on the day of surgery, and improve day case rates.

Despite these actions, there are some areas where capacity will not meet the predicted demand and we will need to address this through a combination of measures - including expanding capacity in key areas (particularly in relation to cancer treatment) and develop new ways of working. In addition, the Deanery has required a change in educational arrangements for junior doctors that will mean they will need to reduce their outpatient commitment in order to comply; without additional resource, this will inevitably impact on outpatient capacity. We are not able to resource all of the actions we need to take in order to improve our RTT position, and continue to firm up these plans.

- We will also continue to work with our partners in the South Central Acute Care Alliance formed to implement the recommendations of the South Wales Programme, recognising that the impact on services outside of the four that were consulted upon is significant and will result in more extensive service change across the region. These changes will need to be subject to the same levels of engagement and consultation. The new service model for paediatrics, neonatal and maternity services will be implemented towards the end of the year, subject to the capital funding needed to make the necessary changes to our estate. We will also have developed the model for emergency and acute medicine and started to implement the new models of service (subject to the capital needed to expand in key areas).
- We will provide an environment in which service improvement and innovation will flourish. We will continue to deliver our LIPS programme and implement the Clinical Innovation Partnership we have developed with Cardiff University. Linked to this, we will finalise our three year research and development plan reflecting the progress made last year, and drive the opportunities to further develop Cardiff as a centre of excellence for research.
- We will also refresh, in partnership with our workforce, our organisational development plan, reflecting the updated UHB wide strategy, and will continue to adopt new approaches to recruit in hard to fill areas.
- We will deliver a financial plan that moves towards financial balance, including the delivery of a 3% cost improvement programme year on year, building on the significant savings delivered in each of the last three years (**£111m in total**). However, achieving a balanced position will require structural disinvestment as year on year costs improvements alone will not secure the reduction in our expenditure we require.

The implementation of the actions set out above, we believe, will deliver the following in relation to Welsh Government requirements:

- Improve the health of the population by continuing to rigorously apply our Optimising Outcomes Policy – (focusing on smoking and BMI over 40), further improve our immunisation uptake and embed ‘making every contact count’ so that no opportunity is missed to support people to make positive choices about healthy lifestyles;
- Improve unscheduled care performance and ensure no-one waits in the emergency department for more than 12 hours before transition to the necessary bed if an admission is necessary;
- We will reduce the number of delayed transfers of care - aiming for a 25% reduction in the first quarter of the year, to enable bed capacity to be released;
- Ensure that no-one is waiting more than 52 weeks for elective treatment by the end of quarter 1 and sustain the position over the remainder of the year. Aiming to improve our position in relation to the total number of people waiting over 36 weeks for elective treatment by year end;
- Continue to improve cancer standards performance so that outcomes are as good as they can be for people with cancer;
- Continue to improve the delivery of stroke care in line with the bundles of care;
- Continue to meet the requirements of the mental health measure;
- Reduce our hospital acquired infections, sustaining the improvements we have made in relation to Clostridium difficile and improving our position in respect of MRSA (in line with our quality and safety plan);
- Continue to address the most significant risks in relation to our poor estate and out of date equipment (both medical and IT). Our priorities will be to address the poor environment at UHW, fully commission the new adult mental health unit and finalise plans for primary and community services to support the transformation of care signalled in our emerging clinical services strategy; and

- Improve our sickness absence rates to 4.8% by the end of the year and improve our PADR completion rates.

In developing this plan, we have carefully balanced the need to drive more savings and productivity out of the system and resourced some areas where we need to address capacity shortfalls and patient safety issues. Some of the savings proposals were not easy decisions for the UHB Board and still represent a significant delivery risk (£28.8m savings target for 2015/16), including some areas that may attract some negative reaction. In Chapter 6 of the plan, we set out the actions we believe are necessary to secure significantly improved performance against the key Welsh Government targets. However, we have prioritised our proposed actions to reflect the resource framework in which we are operating. This means that we are not yet able to deliver a balanced financial plan as we are forecasting a residual financial gap of £13.2m at 31st March 2016 reducing to £8.4m in March 2018.

SECTION

Progress in Delivering 2014/15 Plan

Chapters

- Progress in Delivering 2014/15 Plan
- Health Board Profile



1. Progress in Delivering 2014/15 Plan

1.1 Our Achievements in 2014/15

Year 1 of our three year integrated medium term plan set out an ambitious programme of change reflecting our need to improve the health of the population we service and deliver better health services. The journey of transformation and [progress](#) for the UHB against implementing the 2014/15 IMTP has been extremely challenging and clearly there is still a lot to do. However, a lot has been achieved during 2014/15 to improve the quality of the care we provide. These are summarised below (and are detailed in the mid year Board [report](#) on progress)

Improving Health and Wellbeing

- The successful launch of the UHB wide three year dementia action [plan](#) including establishing a new Community Dementia Support Programme in Barry.
- More equitable access to local care in diabetes, dental services, unscheduled care, ophthalmology and generic health visiting services.
- Improving our rates of immunisation and lifestyle change across the community. Our Seasonal 'flu vaccination – frontline staff highest uptake among health boards 2013/14 – 44.2%; 50% should be achieved in 2014/15.
- Rolled out the Optimising Outcomes [Policy](#) which supports people to stop smoking and achieve a healthy weight to improve health and the outcomes of a surgical intervention.
- Training for partners across all sectors in Making Every Contact Count methodology.

Maximising Integration

- Our GP cluster plans are further developed, with strong leadership driving improvements in the priorities identified for 14/15.
- We are engaged in a District Nursing Modernisation Programme, where staff are moving into new roles which are more appropriate to the model of care we wish to deliver in the community.
- Our new Gerontology model of care, which was subject to an extensive engagement exercise has been implemented, facilitating the closure of West Wing which was not considered fit for purpose.
- The new INR (Anti-Coagulant) pathway is now in place, which further develops the shift from secondary to primary care.
- A new [Framework](#) for Older People, developed with partners, has been agreed following an engagement process. It sets out at high level how we wish to see support and care develop over the next five years so that older people are able to live independent and fulfilling lives.
- Strengthened governance [structures](#) are in place (UHB, Cardiff & Vale Local Authorities, 3rd sector) to support Integrated Health and Social Care partnership arrangements.
- [IRIS](#) project - partnership with primary care, police and third sector to intervene sooner in domestic violence

Improving Access to Services

- The £5m refurbishment of the Emergency Unit at UHW has been completed and provides a significantly enhanced environment for the delivery of emergency care. This has improved the UHB's ability to manage emergency patients more efficiently and effectively thereby minimising risk and improving our care.
- We have installed 40 new Tele-dermatology facilities at GP practices which help to bring care closer to home and away from hospital. This is not only more convenient to patients but also releases valuable resources in hospital.
- A new world class Robotic surgery facility has been established for South Wales, following Welsh Government funding. We are now able to use [robotic](#) surgery for urology – a first in Wales, and can now be considered one of the specialist centres in the UK. The facility provides the opportunity for Wales to lead expansion of robotic surgery into new areas – building on the strong joint research programme we have developed with Cardiff University.

- We successfully obtained joint funding of over £6m Intermediate Care Fund with Cardiff City Council and Vale of Glamorgan Council to develop Single Access Gateways which has developed new integrated referral mechanism, jointly appointed numerous co-ordinators and therapists, trained staff and increased the use of technology whereupon around 82% of clients has now increased independence.
- Having agreed the recommendations of the South Wales Programme, we have embarked on detailed planning to support its implementation during 15/16.
- We have now increased the access to GP Out of Hours Service by enhancing the service and using advanced nurse practitioners as part of the multi-disciplinary workforce.
- We have introduced and implemented a Cystic Fibrosis tele-health model to enable services to be provided closer to home.
- We have strengthened locality leadership and GP clusters with cluster reports focussing on frailty, public health and access.
- A new care bundle approach has lead to measurable reduction in bed days; pathways include Atrial Fibrillation 22 %, Chronic Obstructive Pulmonary Disease 32%, Chronic Heart Failure 21%, accounting for a reduction in 3,054 bed days.
- A new Dental Care Model has been introduced to the Prison Service which helps to reduce waiting times to reflect the changing nature of the prison population.
- We have significantly improved access to primary care mental health services introduced as part of the mental health measure; targets for all parts of the measure hit since August 2014.
- We have increased the provision of community based mental health services for older people, facilitating the closure of a ward at St David's Hospital.
- We have piloted a third sector brokerage project with Community Resource Teams to increase signposting to third sector services.
- Our Mental Health Clinical Board has engaged with deaf and hearing impaired people to understand the model of care needed to address their needs.
- We have held public workshops with complainants to improve our concerns process.
- Use of hand held tablets and volunteers on the ward has supported a doubling in the number of patients completing feedback surveys.

Improving Patient Safety and Experience

- Our Leading Improvement in Patient Safety [programme](#) has been highly successful with two cohorts of 100+ having completed the programme.
- We have fully participated in a Peer Review for [Cancer](#) Services and Paediatric [Diabetes](#), both of which highlighted several areas of excellent practice.
- We have a robust [response](#) to Trusted to Care (Andrew's report – Getting Things Right for Patients) and are implementing our local recommendations.
- Through robust partnership working with third sector and local authority colleagues a new Patient Information and Support Centre was opened to the public in UHL in May 2014.
- Our [Annual Quality Statement](#) has been published, setting out for the public the area we have focused our attention during the year, reflecting both the things that have been the cause of concern or harm, and the areas where we perform well.
- We have developed a new Medicines Management Programme which improves systems, processes and appropriate drug management.
- We are developing new outpatient appointment systems and in some areas, such as the new Children's Hospital, electronic check in will be available.
- We are improving our discharging arrangements, with electronic discharge summaries provided to GPs from the Emergency Department to ensure appropriate ongoing care and support.
- Lowest number of bed days following admission from Nursing Homes than at any point in the last three years (equivalent to a reduction of 5 beds).
- Our Clostridium Difficile rate is currently the lowest in Wales and there is targeted work underway to try and achieve the target of 31/100,000 by September 2015.

- There have been a number of very positive unannounced visits by Health Inspectorate Wales providing a high level of assurance on the quality and safety of services in a variety of wards and departments across the UHB.
- Our internal audit inspection process has confirmed a substantial level of assurance for the processes in place to manage complaints and clinical negligence claims.
- Launched an Electronic Mortality Audit Tool to aid us in the review of all in-patient deaths.

Enabling Change (Workforce, Finance, Capital & Estate)

- We have opened a new internationally recognised Children’s Hospital with state of the art equipment and facilities. The budgeted figure for the Noah’s Ark Children’s Hospital of £70m has been achieved and the building was handed over January – March 2015. A number of departments relocated to the new building in February/March with the final move (Radiology) due to take place in April.
- The construction of the new Adult Mental Health Unit, at University Hospital Llandough (UHL) is progressing well and will be completed in January 2016.
- A Post Anaesthetic Care Unit has been established to provide intensive post operative care which will reduce the number of operations cancelled because of the lack of critical care beds.
- We are in ongoing discussions with Welsh Government on Specialist Neuro/Spinal Rehabilitation/Older People capital schemes (Rookwood replacement) and have made some improvements to existing facilities necessary because of the delay in securing the replacement facilities.
- Work is progressing to finalise plans for improving Cardiology Outpatient and Cardiac Physiology Suites at University Hospital Wales (UHW), which if funded, will dramatically improve patient experience and outcomes.
- The Cardiff Royal Infirmary Phase 1 is now complete and the Strategic Outline Plan for the next phase is now underway following several engagement events. This will improve the environment of the community and primary care, and provide local anticipatory and ambulatory care as part of shifting more care closer to home and away from the acute hospital.
- Our 10 year Clinical Services Strategy - ‘[Shaping Our Future Wellbeing](#)’ is in development, with design principles and priority areas agreed. Extensive engagement with the community, expert patients, stakeholders and staff is underway through a number of workshops.
- Our workforce change plan is in progress. It is delivering new ways of working and is supporting the development of new and enhanced roles which support our service transformation.
- We are developing a new Operating Theatre Management system and have refurbished Gynaecology and Orthopaedics Theatres.
- We have partnered with Coleg Gwent University to deliver new NVQ Apprenticeship Programme, the first in 20 years at the UHB and we are now looking to extend this programme.
- We have refurbished 2 wards at Llandough Hospital and one at St David’s to improve patient experience.
- We are continually developing a reduced energy programme including a LED lighting programme, pipe work insulation and temperature control.
- We have published a “wayfinding” signage document to standardise future signage and to improve the experience of visitors to our hospitals.
- We have disposed of a number of properties as part of our estate rationalisation programme.
- We have introduced some generic roles at Barry Hospital and extended the use of volunteers to improve the experience of patients, visitors, and staff.
- We have attained a favourable and positive review of our catering services through audits.
- We have invested over £2.5m in our IMT infrastructure to support the delivery of care.
- We have completed a comprehensive assessment of the state of our estate and equipment to inform the Welsh Government All-Wales Capital Review and our own estates strategic plan.
- We have developed a new partnership with Cardiff University to drive innovation and improvement across our organisations.
- Learning from our engagement processes during 2014/15 we have embarked on a wider community engagement programme, and have worked with the Cardiff and Vale of Glamorgan Community Health Council (CHC) to develop a shared approach to engagement and consultation on service change proposals.

1.2 Our Awards for Excellence

We are delighted that during the year, a number of our staff have been recognised at national and international level for the excellent care they provide. The most notable awards and achievements include the following:

- Sir John Crofton Prize from the Royal Society of Medicine – nurses from the TB Control Service including Sally Jones and Liz Weeks named runners-up.
- British Journal of Nursing Nutrition Nurse of the Year – Enteral Nutrition Nurse Team from Cardiff and Vale named winners.
- RCN Wales Awards:
 - Humanitarian Relief Award – Ann-Marie Ablett, Clinical Leader in Ophthalmology, won with Team Leader Kath Smith named runner up.
 - Innovation in Nursing Award – Wayne Parsons, Senior Nurse for Emergency Medicine, was the winner with Lisa Cordery, the Lead Nurse for Young Persons, named the runner-up.
 - Clinical Nurse Specialist Award – Delyth Tomkinson, Clinical Specialist Nurse Hepatology and Clinical Nurse Tara Rees were named joint winners.
 - Registered Nurse (Adult) Award – Staff Nurse Kathleen Farr named runner up.
 - Research in Nursing Award – Professor Lesley Lowes, Florence Nightingale Foundation Chair of Clinical Practice Research, Cardiff University, was the winner with Consultant Specialist Nurse Nicola West named runner-up.
- MBE's for Wil Evans Chief Medical Physicist and Judyth Jenkins, Head of Nutrition and Dietetics.
- Eisteddfod Genedlaethol Cymru/National Eisteddfod of Wales - Welsh Learner of the Year - Joella Price, ITU Nurse.
- Louis Schmidt Laureate awarded to Paul Crompton, UHB Media Resource Centre, for outstanding contributions to the progress of bio-communications (6th person ever in the UK to receive the Schmidt Award).
- Royal College of Psychiatrists 2014, Best Consultant Service Development prize - Dr Sabarigirivasan Muthukrishnan, Consultant Old Age Psychiatrist (Community REACT service).
- Bevan Prize for Health and Well-Being – Public Health Dietetic Team (Nutrition Skills for Life Programme).
- NHS Wales Awards
 - Working Seamlessly Across Organisations – Alcohol Treatment Centre (multi-agency partners);
 - Promoting Better Health and Avoiding Disease – Nutrition Skills for Life Programme (dietetic team).
- British Asian Women of the Year, professional category runner up – Cardiac Surgeon Indu Deglurker,
- 'Flu Fighter Champion 2014 – Nicola Bevan, Senior Occupational Health Nurse.
- National Hospital Broadcasting Awards
 - Radio Glamorgan (UHW) 2 Gold 1 Silver;
 - Rookwood Sound (UHL and Rookwood) 1 Gold, 1 Silver, 1 Bronze.
- International accolade for nutritional care practices in Intensive Care – recognised as best performing in the UK and 4th in the world.
- St David Award, Citizenship finalist – Lara Cowpe, Occupational Therapist and fundraiser for Teenage Cancer Trust.
- Public Service Community Champion, runner up – North East Community Mental Health Admin Team, nominated by client's mother.
- USA Presidential seal of approval given to UHB staff following NATO Summit.
- Diverse Cymru Excellence for Access Award – for development of the UHL Information and Support Centre (Patient Experience Team involving third sector organisations).

It can be seen that as well as caring for the community of Cardiff and the Vale of Glamorgan, the UHB is considered as a centre of excellence in many areas. The UHB leads a number of initiatives and services in Wales, but is also recognised as a leading centre in the UK and overseas. Whilst providing specialist services in

Wales for Spinal Services, Cancer and Neurosurgery, English residents also received services for Haemophilia, Organ Retrieval Services, Adult Congenital Heart Disease, Paediatrics and Acute Porphyria.

The achievements of our teams of multi disciplinary specialists are as a consequence of developing valued relationships. Through the development of many alliances with other health care professionals, institutions and organisations, universities, local authorities, charities and the general community, the UHB has been able to lead and offer support to a number of national initiatives. We are looking to enhance these valued relationships.

1.3 Challenges During the Year

We recognise that we do not always deliver to the high standards we or our peers expect for our community. We have strengthened our reporting of significant incidents and patient stories whilst continuing to discuss openly the challenges we face in an open and transparent manner.

In September 2014, following deterioration in our performance and slippage with delivery against our plan, the UHB took stock mid-year and prioritised five key areas of focus, these being: Unscheduled Care (USC), Cancer Care, Planned Care (RTT), Stroke Care and delivering our current financial targets.

Despite these significant challenges, the UHB is committed across all services to providing effective, efficient care and delivery to its patients and consistently actively participates in national benchmarking initiatives to compare its performance against peer organisations across Wales and England. This culture highlights potential service areas of waste, harm and variation as well as identifying examples of good and best practice in delivering excellent health outcomes.

At a high comparator level, the UHB demonstrates cost efficiency through the most recently published All Wales Cost benchmarking indices which places Cardiff and Vale UHB as second amongst providers in NHS Wales. In addition to this, the UHB's expenditure per head of population is the lowest in Wales; being 7.9% lower than the next lowest UHB. In acute service, this differential rises to 10.3%. When comparing the UHB's spend per head of population with 11 similar English populations, based on the ONS population classifications, the UHB is ranked 2nd in terms of lowest total spend per head of population in England and Wales.

Regrettably, the UHB's ambitious Cost Improvement Programme (CIP) has not delivered to its plan and targets which has adversely affected the UHB's overall financial performance. Consequently, the UHB has established a more robust process of identifying, planning, implementing and monitoring this programme together with the individual schemes. The operational costs are more closely monitored and a Recovery Plan is now in place.

Our assessment is that this slippage against our plans has arisen for a number of reasons:

- The timescale for some service change programmes slipped – engagement and communication took longer than expected, as well as lack of capital to progress some elements;
- Some of the savings schemes and service change programmes were over ambitious in the level of funding released;
- In some cases the changes resulted in cost avoidance rather than recurrent financial savings; and
- A number of schemes were compromised due to insufficient project management capacity.

The UHB has the lowest management costs in Wales. Additional short term management capacity was deployed during the final months of the financial year to accelerate progress.

The UHB strives to embed a continuous service improvement culture through the use of data and tools to facilitate best practice, improving outcomes for patients both within and beyond our local community.

2. Health Board Profile

2.1. Overview

Cardiff and Vale University Health Board (UHB) was established in October 2009 and is one of the largest NHS organisations in the UK. As a Health Board, we have a responsibility for around 475,000 people living in Cardiff and the Vale of Glamorgan (from Trowbridge/St Mellons in the East to Llantwit Major/St Bride's Major in the West). This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. Together, these provide a full range of health services for our local residents and those from further afield in both Wales and England who use our specialist services, where we are recognised as a centre of excellence. To deliver these highly diverse and complex services, we spend over £1.2 billion every year and employ around 14,000 staff.

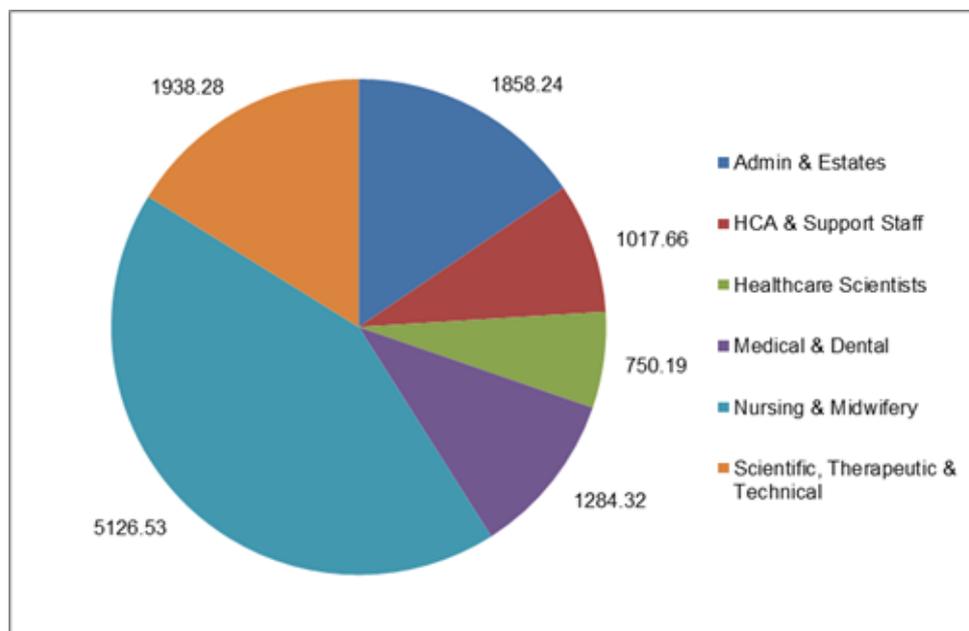
We are also a teaching Health Board with close links to Cardiff University, which boasts a high profile teaching, research and development role within the UK and abroad. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Together, we are training the next generation of clinical professionals in order that we develop our expertise and advance our clinical outcomes.

Detailed information about the services we provide and the facilities, from which they are run, can be found on the Health Board's website in the section [Our Services](#), and a map setting showing these is shown overleaf.

The UHB Board is made up of Executive Directors, who are employees of the UHB, and Independent Board Members (IMs), who were appointed to the UHB Board by the Minister for Health and Social Services via an open and competitive public appointments process.

The UHB employs, on average, 12,146 Whole Time Equivalent (WTE staff) in 2013/14 (based on September 2013 – September 2014; 162.2 WTE less than the same period 2012-13) which converts to around 14,000 staff in post. This reduction is as a result of improved efficiency and outcomes through technology enablers and improved clinical pathways. From a recent audit it is estimated that 10% of the UHB workforce have Welsh language speaking skills.

Breakdown of Staff Groups:



2.2 Range of Services

The UHB provides the full range of primary, community, mental health and secondary care health services for our resident population. We also provide specialist services for people across South Wales and in some cases the whole of Wales and England where we have developed specialist links with English Community Care Groups (CCGs), Area Teams and other teaching hospitals and Universities. Each Clinical Board has prepared a service profile as part of its Integrated Medium Term Plan which has informed the business planning process and is continually reviewed and progressed. Details of all of our services are available on our website <http://www.cardiffandvaleuhb.wales.nhs.uk/our-services>

As a University Health Board we have a significant contribution to education and teaching; we offer under and post graduate medical education and training, managed through the Medical Director's Office. The UHB is required to deliver this training as set out in the SLA with both the Wales Deanery and Cardiff University School of Medicine. In order to reflect wider developments within medical education and support the delivery of teaching and training, the separate under and post graduate departments were amalgamated into a single Department of Medical Education in January 2014. A joint medical education strategy is under development. We also train the largest number of Allied Health Professionals, Healthcare Scientists and Nurses of any health board in Wales.

2.3 Finance Summary

The table below shows the high level financial performance of the Health Board covering the period from 2010/11 to 2013/14. It also set out the forecast position for 2014/15.

Health Board Summary Financial Performance	2010/11	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m	£m
Income	-1136	-1149	-1181	-1160	-1182
Expenditure	1136	1149	1181	1179	1205
Performance against Revenue Resource Limit	0	0	0	19	23
Capital Resource Limit	64	57	47	58	84
Capital Expenditure	64	57	47	58	84
Performance against Capital Resource Limit	0	0	0	0	0

The Health Board had a planned deficit of £16m in 2013/14 which, due to slippage on savings schemes resulted in a £19m actual deficit. The 2014/15 – 2017/18 three year Integrated Medium Term Plan aimed to address this deficit and restore the Health Board back into financial balance by 2015/16. This plan has however slipped and the UHB is now forecasting a deficit of £23m for 2014/15.

The revised financial plan sets out the financial strategy of the UHB which supports delivery of the service strategy outlined in the Integrated Medium Term Plan. The context for the UHB will be a very challenging three years. After the additional allocation is made recurrent in 2015/16 the UHB is anticipating annual growth in 2016/17 and 2017/18 of 2%. This means that the UHB has to make savings to mitigate against the additional costs above growth funding for pressures of underlying deficits, cost pressures and service change investments. Over the three years starting in 2015/16 the UHB is aiming to make a further £78m of financial savings which is equivalent to 9.5% of relevant expenditure. Despite this ambitious savings plan, the UHB does not however, currently have a Financial Plan that manages to deliver a breakeven position over 2015/16 to 2017/18. This will be subject to further consideration at Board level and will need to be discussed with Welsh Government. Details of this and of the overall financial plan are contained in the Section 7 of this plan.

2.4 Performance Management

The UHB has formal performance management arrangements in place. These evaluate progress against delivery of the objectives set out in the Integrated Medium Term Plan and enable the UHB to determine whether it is achieving the proposed high level “direction of travel” and more detailed operational actions it has committed to undertaking. The UHB People Performance and Delivery committee ‘deep dives’ into issues where the UHB Board seeks more assurance in terms of governance. Further detail on the Performance Management Framework is provided in Section 10.

Integrated Performance Reporting

The integrated performance report presented to the Board covers all tier 1 targets including public health and has been agreed with the CHC. Performance reports are provided at each of the UHB Board meetings and the latest is available [here](#). An exception report on areas where the target is not being achieved is provided each month, focusing on actions to be taken to redress the position. These indicators, plus more detailed local indicators, are mirrored in the scorecard provided to each Clinical Board and Directorate each month. This then cascades into the ward dashboard which is available in real-time.

Key developments in 2014/15 which have supported developments in performance information are:

- Use of the CHKS All Wales information to enhance the performance information available to Clinical Boards, particularly around efficiency metrics such as length of stay, readmissions, DNAs etc, and around safety metrics such as complication rates, misadventures and mortality;
- Development of a range of nursing, patient safety and patient experience performance indicators. These include complaints and serious incident performance measures, patient survey feedback, Safeguarding information, hand hygiene data as well as infection prevention and control data;
- Development of commissioning information requirements from other LHBs and third party providers to enable more effective performance monitoring;
- Development of a capacity and demand model for the organisation to enable both better long-term planning and short-term performance management which encompasses actual activity trends and forecast population trends, changes to activity planned as a result of care pathway development and implementation of prudent medicine. This is being built upon to compare to current capacity and anticipated future capacity when performance improvements are built in. We are engaged with other Health Boards in Wales in sharing best practice both ways.
- Further development of practice based information around referrals, hospital admissions and A&E attendances which can be used to support practice visits - extended from the focus on prescribing and Quality and Outcomes Framework (QOF).

2.5 Long Term Agreements

The UHB has Long Term Agreements (LTAs) with other Welsh Health Boards to reflect services provided by the UHB for residents of other Health Boards (for which income is received), and services provided by other Health Boards for Cardiff and Vale residents. In addition, WHSSC is the responsible commissioner for Specialised Services for Wales. As the main provider of Specialist Services in Wales, the UHB has material income flows in relation to these services in addition to expenditure to WHSSC relating to services for Cardiff and Vale residents commissioned on the UHB’s behalf, any additional activity required is undertaken at a marginal cost rate.

The planning, procuring and providing of specialist services is complex, as recognised by other Health Boards who have specialist commissioning teams. The UHB has recruited an NHS health commissioner who will help to address this balance, by supporting the engagement with other health boards in providing services to our residents as well as the UHB providing services further afield.

The income and expenditure associated with these LTAs are summarised in the table below:

2014/15 LTA Income and Expenditure	£m
<u>Commissioning Income</u>	
WHSSC	180
Other Welsh NHS Organisations	82
Total	262
<u>Commissioning Expenditure</u>	
WHSSC	107
Other Welsh NHS Organisations	59
Total	166



SECTION

CARING FOR PEOPLE KEEPING PEOPLE WELL

Chapters
- Strategic Context



3. Strategic Context

2014/15 has been a significant year for the NHS in Wales, with the launch of Prudent Healthcare and the first year running an integrated three year planning cycle. Throughout, a consistent message has been evident, and is captured in the Minister for Health and Social Services statement, following the launch of 'Our plan for a primary care service Wales up to March 2018'(WG):

"A prudent healthcare system, in which the avoidance of harm is our watchword, in which we pitch our interventions at the minimum necessary to address the problems which patients experience, will always have primary care at its heart"

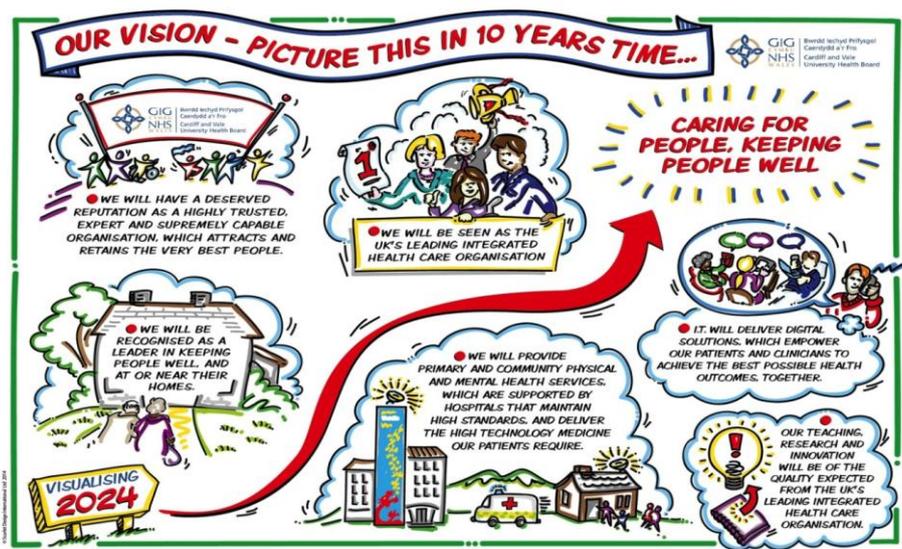
These key national drivers are being supported by legislation including the Social Services and Wellbeing (Wales) Act; the Wellbeing of Future Generations Bill; and the Public Health Bill.

For Cardiff and Vale UHB, 2014/15 has also been a significant year strategically, with the development of a core set of strategic principles aligned to Prudent Healthcare, the crystallising of the organisations strategic direction and importantly rolling forward of our three year integrated plan. The requirement therefore for 2015/16 – 2017/18 is to secure and sustain the progress made in 2014/15, whilst refreshing our plan to reflect the need to accelerate the pace of change, respond to new national requirements, our local priorities and the desire to "fast-track" integration in line with our longer term vision.

3.1 Shaping Our Strategy for the Future

The approved [Cardiff and Vale University Health Board Integrated Medium Term Plan 2014/15 - 2016/17](#) outlined the emerging strategic direction for the organisation captured pictorially and summarised in the high level vision statement:

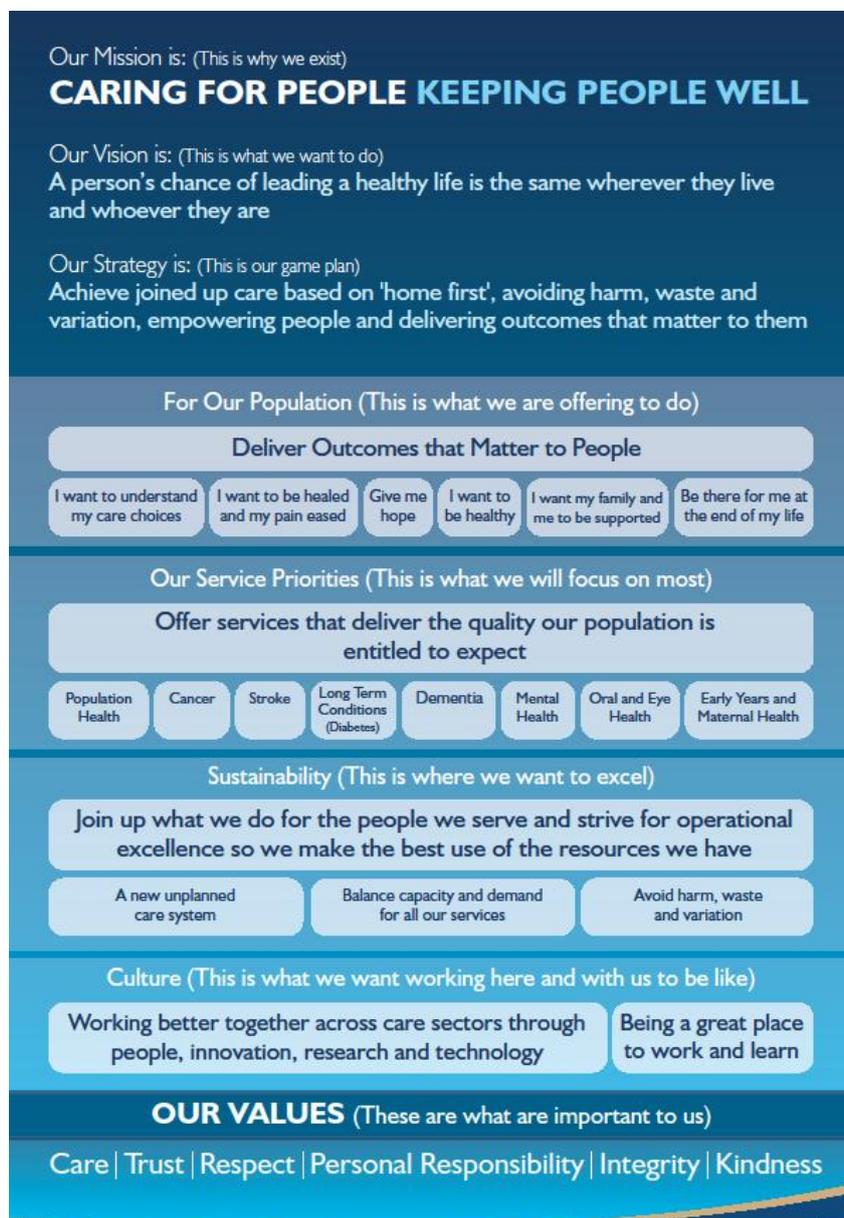
'In ten years time, the UHB will be seen as the UK's leading integrated health care organisation. It will have a deserved reputation as a highly trusted, expert and supremely capable organisation, which attracts and retains the very best people. The UHB will be acknowledged as a leader in keeping people well at or near home. It will provide primary and community physical and mental health services which are focused on delivering this and which are backed up by hospitals that maintain high standards and which are able to deliver the high technology medicine those patients require. IT will enable the delivery of technological solutions that will empower patients and the clinicians who work with them to achieve the best possible health outcomes. The quality of our teaching, research and innovation will be commensurate with our status as a leading integrated health care organisation.'



During the course of 2014/15, instigated by the UHB Executive team, a number of conversations, structured engagement sessions and focused pieces of work have been undertaken to provide clarity and “socialise the strategy”. This engagement has included citizens and patients, front line staff, the Clinical Senate and the UHB’s Stakeholder Reference Group, Local Partnership Forum, and Healthcare Professionals Forum; with feedback being incorporated to inform the final product.

Whilst citizens, patients and staff are proud to receive and provide care for an organisation who’s mission is “**Caring for people; keeping people well**”, a vision of integration does not inspire them, rather it is the benefits brought by integration which unifies and motivates. It is a vision that “**a person’s chance of leading a healthy life is the same wherever they live and whoever they are**” which resonates and our vision has been amended to reflect this. Integration is how we will deliver this and our ambition for the characteristics of the UHB 10 years from now remains unchanged [[14/15 IMTP Section 4 for more detail](#)].

Building on our mission and the work commenced under **Organising for Excellence (O4E)** to detail a medium to long term **Workforce and Organisational Development Plan** [Chapter 10 for more detail] and a **Clinical Services Plan** [Chapter 3.2 for more detail], we have developed and engaged widely in developing our strategy map.



3.2 A Plan for Clinical Services

The direction of the UHB's Clinical Services is being shaped through two significant strategic programmes. Together they describe an ambition to deliver services to both local and tertiary populations, who have and who will continue to be engaged with its development.

3.2.1 South Wales Clinical Change Programme

The South Wales Programme was established in January 2012 to review those services deemed "fragile" in terms of their ability to deliver safe and sustainable models of care. The immediate challenges identified across South Wales and South Powys was the sustainability of four services that would require regional solutions: consultant-led maternity and neonatal care, in-patient children's services and emergency medicine (A&E).



Details of the recommendations of the Programme, confirmed in March 2014, can be found on the [South Wales Programme website](#) and are summarised as:

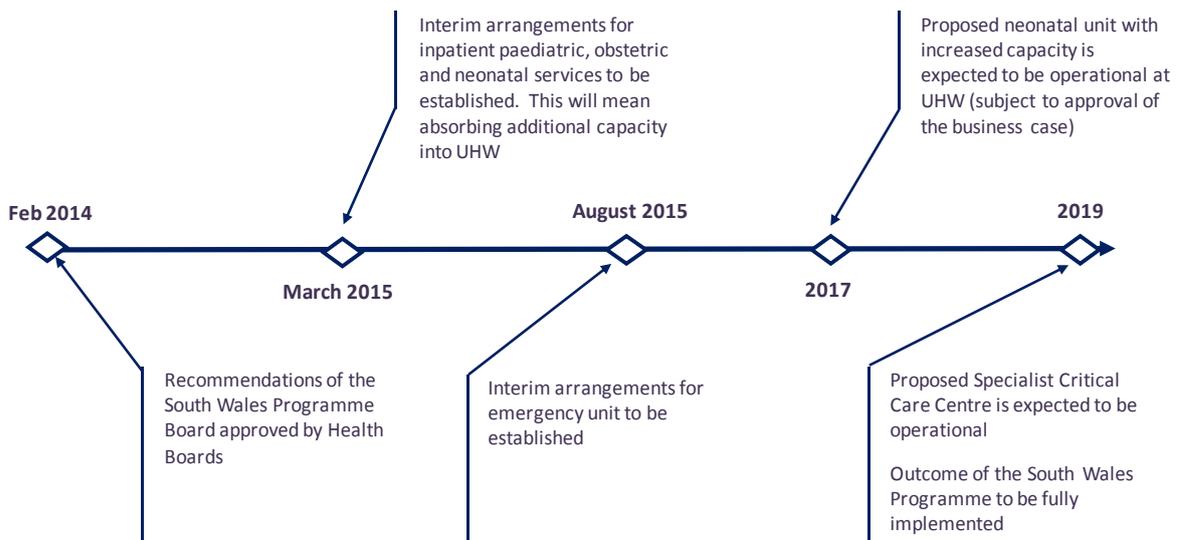
- New systems of care which network hospitals and their services more firmly together must be developed to strengthen the delivery of services across the whole of South Wales and South Powys;
- Three such networks or acute care alliances (ACAs) should be established for the wider South Wales area (including Hywel Dda) based around three “major acute” centres at Morriston Hospital, University Hospital of Wales(UHW) and the Specialist and Critical Care Centre(SCCC) (when built);
- Following the engagement and consultation exercise, Option 3 (University Hospital of Wales Cardiff; Morriston Hospital, Swansea; the planned Specialist Critical Care Centre, Cwmbran; Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend) is the recommended starting point for the transition to three alliances. This represents the start of a process of closer joint working across Health Boards to deliver new models of care that create sustainable services in the longer term;
- The South Wales Programme Clinical Reference Groups (CRGs) will be maintained, and others will be established, to ensure clinical leadership;
- All current and future decisions made about service reconfiguration will be consistent with the alliance model and the joint arrangements that will be established to strengthen local service delivery;
- The NHS in Wales will work with the Wales Deanery to align the allocation of trainees to the alliances so that education can be optimised - delivering an effective blend of learning across the full range of health services;
- Health Boards will work together urgently to collectively commission training providers to develop and deliver advanced practitioner roles locally to support the implementation of the new service models; and
- Health Boards and NHS Trusts will work together to develop new systems that facilitate cross-organisational working for clinical staff whilst preserving clear lines of governance and accountability to employers.

The governance arrangements established to implement the South Wales Programme are described below and see the establishment of a South Wales Clinical Change Programme to provide overall UHB leadership.

In addition to the four services originally considered by the South Wales Programme, the South Wales Health Collaborative has commenced a review of acute medical and surgical services in the region. Any future changes to the configuration of these services will require collaborative working to ensure that there are clear protocols in place to repatriate patients closer to their home as soon as it is clinically appropriate [Chapter 6 for more detail].



Indicative timeline for implementation of the agreed recommendations of the South Wales Programme



3.2.2 Shaping Our Future Wellbeing – Developing Our 10 Year Clinical Service Plan

2014/15 saw the establishment of a small, clinically lead team, whose purpose was to produce a high level clinical services plan by September 2015. This 10 year plan will support the delivery of the UHB ambition for health and wellbeing outcomes which are the best for our citizens and patients in Cardiff and Vale. Designed with the people who will use the service and with innovative best practice in mind, the work describes sustainable, cost effective, integrated services. It will reflect the significant opportunities presented by advances in technology to deliver patient support and care very differently. The digital revolution has already introduced new approaches improving communication, timely access to information and remote monitoring and virtual clinics; such as our regional cystic fibrosis service, where patients access the MDT (including physiotherapy support) from the comfort of their home (or place of work) through virtual clinics.

Following initial testing with the Clinical Senate, a set of principles have been iteratively developed and engaged upon. This process has seen discussions, presentations and workshops both internal and external to the UHB, informed by an extensive literature review. Detail underpinning the work can be found in the [pamphlet](#) launched during the UHB Annual General Meeting in September 2014. These principles were approved by the UHB Board as the foundation on which service change should be built.

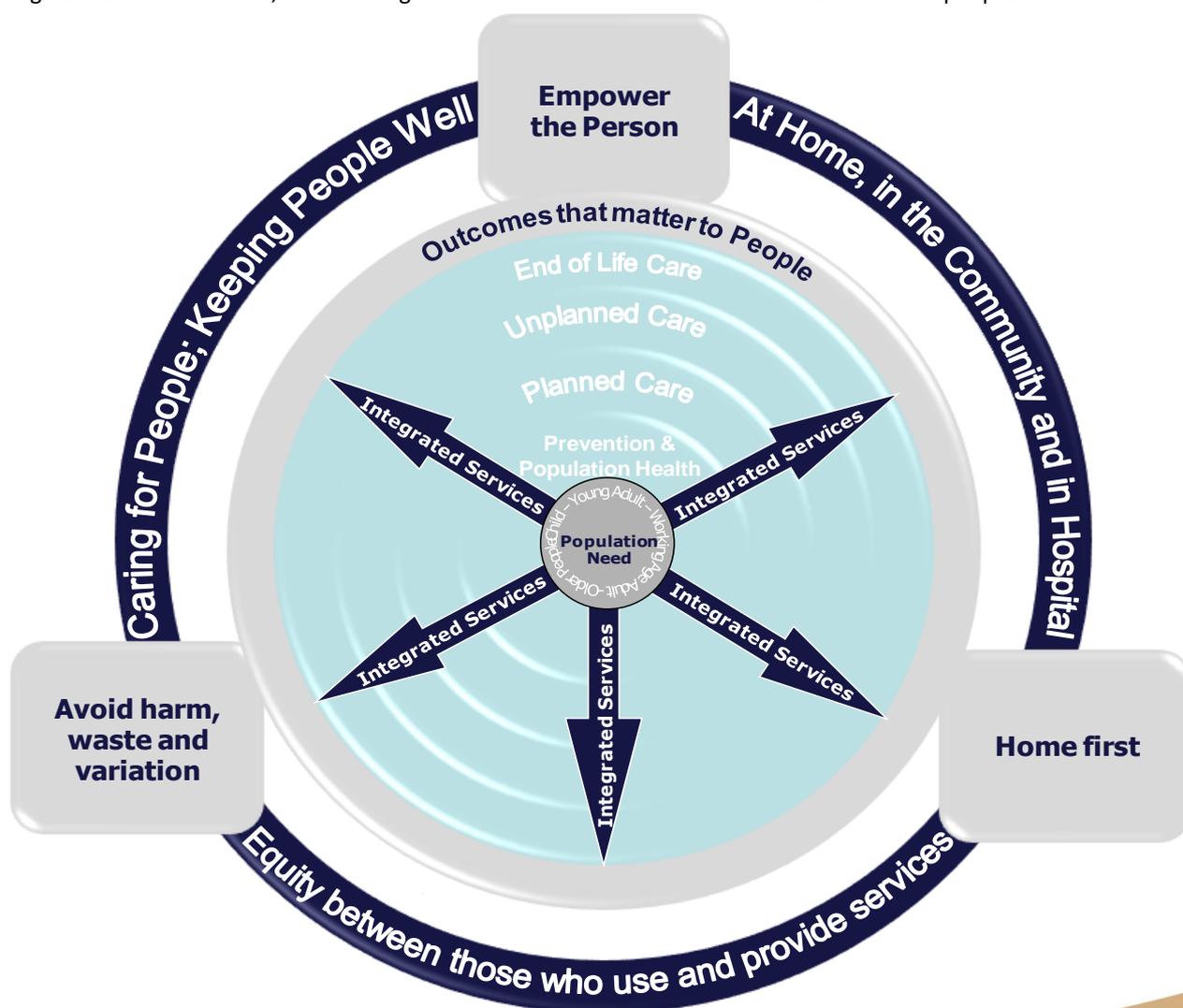


Alongside the development of these principles, a technical document has been produced setting out the drivers for change and the responses of key organisations to them; including Welsh Government and Royal Colleges. This review, gathering evidence of best practice locally and internationally, coupled with an assessment of the future needs of the population, has informed a clinical services framework to which the principles can be applied. This and other details of the programme can be found on the [Shaping Our Future Wellbeing website](#).

With the intention to deliver “Outcomes that matter to People”, the framework focuses on population health and wellbeing by placing the needs of the population at the centre. The integrated services which deliver these outcomes will give equal consideration to preventative, planned, unplanned and end of life care. Importantly, when provided by an integrated healthcare organisation, each of these elements of care should flow seamlessly.

Whilst the starting point for this work was to consider integration where diseases have similar risk factors, where there was current synergy in service models, or where there was clear population health benefits, this also meant that work already started in the UHB to improve preventative, planned, unplanned and end of life care would continue. As learning from these elements of care becomes available it will inform emerging service models and vice versa.

Taking all this into account, the Shaping Our Future Wellbeing Framework depicts how services, built on the Shaping Our Future Wellbeing Principles will, regardless of where and how we access services, or of which stage we are at in our lives, deliver integrated care which results in outcomes that matter to people.



Commissioning Across LHBs

Our arrangements for commissioning and providing services with neighbouring LHBs is primarily undertaken through an LTA and contracting basis, rather than a full understanding of why services are commissioned/provided across LHB boundaries. Arrangements are often as a result of historic patterns of flow, and any changes are often made in an isolated manner, without fully understanding the needs and full service specifications being provided. Over the next three years we will build a more mature approach to this.

Commissioning within the UHB

The UHB was set up as a provider organisation and as such, Clinical Boards tend to consider their role as providers of services rather than commissioners of care for the population they serve. Significant strides have been made to strengthen the population health focus with each Clinical Board undertaking a health needs assessment supported by a public health consultant to support the development of their own IMTP; and with our approach to developing integrated care pathways across the organisation and services. Again, this is a discipline that will be further developed in forthcoming years and will reflect the maturation of Clinical Boards.

Joint Commissioning with non-NHS Organisations.

The UHB continues to make progress in developing commissioning with partner organisations.

Working with the two local authorities (Cardiff and Vale of Glamorgan) and two Councils for Voluntary Services (Vale Centre for Voluntary Services – VCVS and Cardiff Third Sector Council – C3SC) a combined support system for service leads working across the five organisations is in place. This support has focussed on developing and implementing joint commissioning, in the first instance for:

- Older people – through Age Connects Cardiff and the Vale (formerly Age Concern);
- Children's Acute Mental Health Services (CAMHS);
- Cardiff and Vale Action for Mental Health;
- Children with Disability and Complex Needs; and
- Alcohol Related Brain Injuries.

These areas have been the focus during 2014/15 and this work will be completed in 2015/16. The initial support being to develop products which will assist the service leads to work consistently across organisations, in the form of FAQs; alternative options for procurement/provision; and specification/monitoring templates, drawing on the experience of the successful single commissioning strategy for substance misuse services which is in place. This will be supported by the development of an outcomes and evaluation framework.

The UHB has a [Strategic Framework for Working with the Third Sector](#) which determines the way in which we develop services with third sector partners. Following a robust review of all our Service Level Agreements with third sector providers during 2012/13, all Agreements which we hold with individual third sector organisations are now managed by service leads within Clinical Boards. This ensures that agreements are more responsive to local service needs, and can be reviewed and amended to reflect changing needs into the UHB's service delivery processes. All Service Level Agreements have been transferred to three year agreements.

Developing Commissioning

In 2015/16 developing commissioning is identified as central to support the ongoing implementation of [Organising for Excellence](#). O4E is clear that as a UHB we must ensure that our services are what people need (i.e. their ability to benefit), and that those services will make a difference to their health, wellbeing and care. The UHB is developing a commissioning plan which recognises local needs, responds to the changing population and drives service transformation. The priority areas for development in 2015/16 are:

1. WHSSC
 - Developing the organisational clarity on our provider position and our commissioner position;
 - Developing the interface with WHSSC and how internally we ensure our respective commissioner and provider structures around WHSSC are represented; and
 - Working with WHSSC to develop an implementation plan for the Strategic Quality Framework for tertiary and specialised services.

2. Shaping Our Future Wellbeing
 - Continue to develop commissioning view/benchmark/plans at a population health level; and
 - Continue to undertake whole system demand and capacity modelling from both population and provider perspective.

3. IMTP refresh for 2016/17
 - Following on from the development of Shaping Our Future Wellbeing, we will refine the commissioning strategy for 2016/17; and
 - Focus will be on outcomes, promoting preventative activities and Primary Care.

4. Demand Management 2015/16
 - Support Clinical Boards in their plans to deliver outcome based demand management; and
 - Support additional GP involvement in re-enablement.

5. Governance for Commissioning
 - Mental Health/Local Authority arrangements have been formalised;
 - All contracts/LTAs have a lead, SLA and appropriate contracting/performance management arrangements and KPIs including quality and safety. Contract monitoring will be further developed; and
 - Develop Clinical Boards role in commissioning and LTAs.

6. Care Pathways
 - Support implementation of care pathways agreed for 2015/16 and evaluate outcomes. Continue to monitor and develop those already implemented;
 - Agree care pathways to be prioritised for development for the future – based on population/public health priority, value for money or operational efficiency; and
 - Link development and implementation of these to performance review meetings.

7. Information to Support Commissioning and Benchmarking
 - Continue to significantly improve information so routine information is available on a population and practice basis about population health linked to hospital and community activity and benchmark it against appropriate peer groups; and
 - Continue to use this information to inform clinical services plan and other developments.

3.4 Progressing Our Future – Securing Improvement, Ensuring Sustainability and Transforming Care

In the IMTP for 2014/15 we outlined where we wanted to be and how we wanted to get there. **Organising for Excellence (O4E)** has set us on this journey and we will continue with developing our services in line with our O4E aims. Whilst being mindful of the work underway within **Shaping Our Future Wellbeing** [Section 3.2.2 for more detail] we will introduce fast track integration by focusing on groups with long term conditions including those with diabetes. However, we are clear on the need to also address our immediate concerns of improving the quality of care delivered to our community for Unplanned Care, Cancer, Planned Care (Referral to

Treatment (RTT)) and Stroke, and ensure we deliver the very challenging resource plan. We see this as an imperative to becoming a leading integrated healthcare organisation.

In summary, building on our achievements in 2014/15, for 2015/16 our focus will be in the following areas:

- Strengthening primary care, through the further development of our evolving GP clusters;
- RTT, Cancer, Unplanned Care, Stroke;
- Working within finance and workforce resource allocations;
- Fully embedding the integrated diabetes model of care; and
- Maximising staff attendance - addressing sickness absence; and
- Continue to drive high quality, safe care.

Application of the Shaping Our Future Wellbeing Principles to these areas of change will support alignment to the ministerial priorities of:

- Demonstrating evidence of shift to primary and community care;
- Demonstrating how we are managing both supply and demand through:
 - Co-production, Self management, Health improvement/illness prevention
 - Prudent healthcare
- Real time and dynamic workforce planning.

3.4.1 Fast Track Integration – Realising the System Potential, Developing a Locality Focus to Care

We have recognised the need to accelerate our programme for delivering integrated care, developing the opportunities presented by our integrated care system. During 2015/16 our focus will be on the following:

- Increased shift from secondary care to primary/community based care across agreed end to end care pathways – long term conditions (focusing initially on securing the improvements in diabetes), with emphasis on care wrapped round the individual and their family. To include associated resource shifts (revenue and workforce) and improved outcomes of care;
 - Increased pace and scale of the **Integrated Health and Social Care Programme** [Chapter 6 for more detail], ensuring people in our community are:
 - Involved in shaping future support and care;
 - Know who to contact and trust the reliability and sensitivity of our services;
 - Have care and support when / where they need it, without duplication, confusion or delay and in a way that prevents avoidable deterioration; and
 - Access sustainable support and care, planned and commissioned to meet their needs over the next 5 to 10 years.
 - Working with local authority and third sector partners to deliver effective community services to reduce hospital admissions, expedite discharge, facilitate recovery at home; refining and consolidating housing, health and social care initiatives established through Intermediate Care Fund;
 - Working with public health, local authority and third sector partners to enhance community resilience and reduce the need for future support and care;
 - In response to the Welsh Government's Primary Care Plan and our own requirements, further develop locality working, with plans setting out actions to improve specific local primary/community based services with a view to reducing un-necessary hospital admissions, and reduce the unwarranted variation in practice across primary care providers;
 - Further development of locality based budgets for primary and community based services with a framework for developing this further; and
 - Supporting the discharge and rehabilitation process so that patients are treated at or as near to home as possible.

To assist in driving this forward at pace, the Executive Leadership of the Integrated Health and Social Care Partnership (lead directors from the two local authorities, the UHB and the third sector) has commissioned from Whole System Partnership, a data driven, outcomes focused review of current and projected population demand, current services provision for older people and opportunities for future integration. The review compares demand with expenditure across the UHB, Cardiff City Council, The Vale of Glamorgan Council,

Cardiff Third Sector Council and Vale Centre for Voluntary Services in relation to adult health and social care. Whole System Partnership will report in April 2015 and this will form the basis for a prioritised delivery plan for integration over the next 3 years. [Chapter 6 for further details]

3.5 Responding to New Legislation

3.5.1 Social Services and Wellbeing (Wales) Act

The Act aims to improve the well-being of people who need care and support, carers who need support, and for transforming social services in Wales. It recognises the projected demographic changes facing our population along with the increased expectations from those who access care and support as well as continuing hard economic realities. The Act aims to address these issues and in doing so will give people greater freedom to decide which services they need while offering consistent, high-quality services across the country. The Act will promote equality, improve the quality of services and enhance access to the provision of information people receive. It will also encourage a renewed focus on prevention and early intervention. Most recently, the Act has been amended to include the need for Joint Population Needs Assessments to be undertaken by health and local authorities.

Planning for the implementation of the Social Services and Wellbeing Act is well underway and is being driven by the Health and Social Care Strategic Implementation Programme. The self-assessment on our preparedness identified that across the partnership, whilst there are some areas where more focused work is required, overall we are in a good position to implement the changes required.

The ongoing uncertainty around local government boundaries, and the financial challenges faced by the local authorities which will require reductions in some services, are identified as risks to the delivery of the requirements of the Act.

3.5.2 Wellbeing of Future Generations (Wales) Bill

This Bill seeks to strengthen existing governance arrangements for improving the wellbeing of Wales to ensure that present needs are met without compromising the ability of future generations to meet their own needs.

The Bill identifies seven foundations for the well-being of future generations if we are to create the 'Wales we Want' by 2050. These are:

- Children to be given the best start in life from very early years;
- Future generations need thriving communities built on a strong sense of place;
- Living within global environmental limits, managing our resources efficiently and valuing our environment is critical;
- Investing in growing our local economy is essential for the wellbeing of future generations;
- Well-being of all depends on reducing inequality and a greater value on diversity;
- Greater engagement in the democratic process, a stronger citizen voice and active participation in decision making is fundamental; for the well-being of future generations; and
- Celebrating success, valuing our heritage, culture and language will strengthen our identity for future generations.

The work on the clinical services plan and the wider UHB strategy is taking into consideration the main ambitions and requirement of the Future Generations Bill.

Progressing Our Future – Securing Improvement, Ensuring Sustainability and Transforming Care

2015/16 – 2017/18 Summary of priorities

Focus	What do we want to achieve?				Outcomes	
Improving health and reduced inequalities – our strategic goal					Measurable reduction in inequality gap	
Proactive Primary Care – enhancing role of primary care in integrated system. Further develop cluster working, building on progress to date.					Demonstrable shifting in balance of care	
Maximising integration – softening the boundaries between primary and secondary care; pooling resources with social care. Focus on long term conditions, frailty and dementia. A step change in the delivering integrated health and social care.					Right care, first time, every time. Pooled budgets Resource shifts USC measures	
Planned care	Shared decision making between patients and GPs	Treat - Equitable access to timely diagnosis and treatment	Support people (and carers) to recover quickly and receive the ongoing support they need		Care plans developed with patients and carers (where appropriate) and outcomes measured Deliver RTT and sustain	
Unplanned care	Prevent - Services in place (7 days) that prevent an unnecessary admission Proactive management of patients with complex needs (multiple morbidities)	Treat - Equitable access to timely acute care with emphasis on maintaining independence	Support people (and carers) to recover quickly and receive the ongoing support they need		Single care plans for those with multiple morbidities and outcomes measured Co-produced care plans where needed Deliver handover, 4 hour and 12 hour targets	
Cancer	Prevent - Improve lifestyle factors known to cause cancer	Increase early diagnosis Ensure timely access to treatment	Support people (and carers) to recover quickly and receive the ongoing support they need		Improved patient outcomes Cancer targets achieved and sustained	
Stroke	Prevent - Improve lifestyle factors known to increase risk of stroke	Equitable access to timely treatment – meeting all care bundles	Support people (and carers) to recover quickly and receive the ongoing support they need		Improved patient outcomes All care bundles achieved and sustained	
Financing our mission	Be prudent	Redesign models of care to achieve more value and better outcomes	Benchmark to identify opportunity	Steal with pride - best practice from elsewhere	Understand what we've achieved Baseline and expected outcomes for all change plans	
Priority pathways						
Dementia			Diabetes			
Enablers						
Engagement and communication	Technology and innovation	Quality and safety	Workforce modernisation	Research and teaching	Improved estate	IT
Effective business processes						
Robust planning and commissioning			Effective performance management			

SECTION

Deliver Outcomes that Matter to People

Chapters

- Local Health Needs and Challenges
- Quality Improvement



4. Local Health Needs and Challenges

4.1 Main Areas of Population Health Need

The key areas of population need for Cardiff and Vale are summarised below, based on a detailed profile given in the Appendix 1.

1. Population size and composition

- The population of Cardiff and Vale is growing rapidly in size, projected to increase by 10% between 2015-25, significantly higher than the average growth across Wales and the rest of the UK. An extra 50,000 people will live in Cardiff and Vale and require access to health and wellbeing services;
- The Cardiff and Vale population is relatively young compared with the rest of Wales, with the proportion of infants (0-4 yrs) and the traditional working age population (17-64) higher than the Wales average; however, the number of over 85s is increasing at a much faster rate than the rest of the population (32.4% increase between 2015-25); and
- The population is ethnically very diverse, particularly compared with much of the rest of Wales, with a wide range of cultural backgrounds and languages spoken. Arabic, Polish, Chinese and Bengali are the four most common languages spoken after English and Welsh. Cardiff is an initial accommodation and dispersal centre for asylum seekers.

2. Risk factors for disease

- Unhealthy behaviours which increase the risk of disease are endemic among adults in Cardiff and Vale:
 - Nearly half (44-45%) drink above alcohol guidelines;
 - Nearly two thirds (66-67%) don't eat sufficient fruit and vegetables;
 - Over half (55-57%) are overweight or obese. This increases to two thirds (64%) among 45-64 year olds;
 - Around three quarters (72-75%) don't get enough physical activity; and
 - Just over one in five (22%) smoke.
- Many children in Cardiff and Vale are also developing unhealthy behaviours:
 - Two thirds (66%) of under 16s don't get enough physical activity; and
 - Nearly a third (31%) of under 16s are overweight or obese.
- Around 1 in 10 adults are recorded as having high blood pressure in Cardiff and Vale.

3. Equity, inequalities and wider determinants of health

- There are stark inequalities in health outcomes in Cardiff and Vale:
 - Life expectancy for men is nearly 12 years lower in the most-deprived areas compared with those in the least-deprived areas;
 - The number of years of healthy life varies even more, with a gap of 22 years between the most- and least-deprived areas; and
 - Premature death rates are nearly three times higher among the most-deprived areas compared with the least deprived.
- There are also significant inequalities in the 'wider determinants' of health, such as housing, household income and education:
 - For example, the percentage of people living without central heating varies by area in Cardiff and Vale from one in a hundred (1%) to one in ten (13%).
- There are inequalities in how and when people access healthcare.

4. Ill health in Cardiff and Vale

- The disease profile in Cardiff and Vale is changing:
 - The number of people with two or more long term conditions in Cardiff and Vale has increased by around 5,000 in the last decade, and this trend is set to continue;
 - Around 1 in 7 (15%) people consider their day-to-day activities are limited by a long-term health problem or disability;
 - Many people with long term conditions are not diagnosed and do not appear on official registers; and
 - Due to changes in the age profile of the population and risk factors for disease, new diagnoses for conditions such as diabetes and dementia are increasing significantly.
- Around 1 in 5 adults have visited their GP within a 2 week period; and nearly three quarters visit a pharmacy over a year period;
- Rates of delayed transfer of care for social care reasons are nearly twice as high in Cardiff and Vale than the Wales average;
- Heart disease, lung cancer and cerebrovascular disease are the leading causes of death in men and women;
- Preventable illness and deaths:
 - Many (but not all) of the most common long term conditions and causes of death may be avoided by making changes in health-related behaviours.

In addition to understanding the overarching needs of the Cardiff and Vale population, an understanding of disease-, service- and population-specific needs is important when planning health care pathways. Previous needs assessments carried out, and plans for assessments during 2015-18, have been described within individual Clinical Board plans. Furthermore, comprehensive needs assessments have been carried out with the two local authorities (Cardiff and Vale of Glamorgan) to inform joint partnership plans, along with assessments to inform specific service redesign, such as joint commissioning of substance misuse services across the two areas.

4.2 Summary Demand and Capacity Analysis

Detailed demand and capacity analysis underpins the plan we have developed. We are further fine tuning this in light of plans submitted by Clinical Boards which will be represented in our final plan.

The UHB is in the process of completing its plans for elective care. An understanding of the recurrent position has been informed by the RTT modelling work completed for new outpatients, Endoscopy, treatments and radiology, presented in the appendix 3. Further work is progressing on assessing the demand for follow ups and our capacity available for delivering this, which we anticipate will be completed in the first fortnight of February.

The present model also provides an assessment of the Health Board's backlog reduction required to deliver a 36 week maximum waiting time for RTT, an 8 week component waiting time for diagnostics and Endoscopy and the urgent milestones required to meet the cancer targets, as at the end of December. It is the UHB's intention that this backlog is greatly reduced in the remainder of the calendar year and that consequently the backlog volumes will need to be re-appraised on a regular basis.

As can be ascertained from the modelling, there are a number of services which appear not to be in recurrent balance, the more significant of these are summarised below:

- General surgery has observed a growth in both breast and GI demand. Consideration is presently being given to replacing a consultant breast surgeon who retired at the start of 2014/15 and to providing further sessions in both lower and upper GI surgery. This resource would be in conjunction with an already assumed maintenance of the improvement in theatre productivity which has been factored into the core capacity.
- Paediatric surgery and gynaecology- Whilst there is an element of outpatient operating which has not been factored in to the capacity of both these specialties, (which is currently being quantified and

opportunities for extending it further are being assessed), the UHB is currently going through an internal business case and prioritisation process for assessing the options to get these services into balance.

- Discussion on the Adult and Paediatric Cardiac service LTAs are continuing with WHSSC, with the objective of agreeing the capacity required to enable UHB to meet the requisite component waiting times.
- Demand for oral surgery has increased over the course of the year. Despite activity in both outpatients and treatments increasing, waiting times have grown commensurately. Options for managing this are under consideration.
- In haematology, neurology and restorative dentistry further work is ongoing to understand the impact that service changes has had on the recording of activity and the reported imbalance, prior to any business decisions being made.
- There remain imbalances in both Endoscopy and radiology, with the key risks being cardiac, non obstetric ultrasound, and the vulnerability of the paediatric and neuro radiology services. Schemes for backlog reduction continued for the remainder of 2014/15, with consideration under way as to the initiatives that can be taken to prudently put these services into sustainable balance. Representations have also been made to WHSSC for their support in shoring up the vulnerable services.
- A more detailed assessment of the position in the care of the elderly sub specialties is to be undertaken to gain an understanding of the needs of these patients and opportunities for gains via productivity, pooling and alternative service models.

At the present time the UHB has identified a requirement to improve productivity and invest to ensure elective services are put on a more sustainable footing. An assessment of the cost of reducing waiting times to the target milestones has yet to be made.

5. Quality Improvement

5.1 Context

The quality of the care that we provide for patients continues to be a central focus to all that we do in the UHB. During 2014/15 we focused on responding to patient safety and quality the issues raised through the following:

- ‘Trusted to Care’ – with our own extensive review of the issues this raised, and assurance about our own position;
- Feedback from our internal ‘inspection’ processes and assurance mechanisms, including the Board safety Walkrounds, and our ward Board Rounds ;
- Responding to issues raised through our complaints and concerns, and incident reporting; and
- Mortality reviews, with focused work on particular areas of concern.

In responding to these issues our focus has been to improve our assurance mechanisms, ensure lessons are learnt and improvement actions are completed, and build the capacity and capability of our staff to improve patient care, through initiative such as LIPS (leading improvements in patient safety (referred to in more detail in chapters nine and ten)).

There has also been a significant focus on infection prevention and control – including hospital acquired infections, and whilst good progress has been made – particularly in relation to Clostridium Difficile (C Diff) – we have an action plan to further improve the position, recognising that some of our poor infrastructure has a significant impact.

We have also strengthened our approaches to listening to patients at many different levels, from engaging patients in the shaping our future models of service deliver (as per the development of our clinical services strategy), to completing our ‘two minutes of your time’ surveys to get real time feedback on the care people are receiving.

5.1.1 National Context

Together for Health published in 2011 remains the overarching strategic direction for the NHS in Wales. It reflected on the importance of bringing a sharper focus on quality and set the ambition that ‘over the next five years, systems for assuring high quality care will match the best in the world’. The Quality Delivery Plan 2012 – 2016 (QDP), described how the new quality improvement and assurance arrangements would operate in achieving this vision of excellence and how they would ensure better alignment of quality, performance and financial goals. We have been working within these frameworks to inform and drive our own quality and improvement work.

We acknowledge that the pressure on resources has never been greater which means that it is critical for us to ensure our staff work together in teams across all disciplines – clinical, managerial and financial. While it is accepted that services must be clinically, operational and financially viable, patient safety, quality and experience must be integral to all decision making.

The principles which underpin the Quality Delivery Plan are fully embedded within the UHB:

- Quality is key to the operating framework for the UHB, underpinned and aligned with financial, workforce and information plans and goals;
- Quality drives service and system improvement;
- Service delivery is focussed around the needs of the person - patient/ service user and not those within the organisation;
- Robust processes will be in place to provide assurance;
- Streamlined data collection – provided once, and put to multiple use;

- Alignment with social care and other partners to ensure that the care and treatment takes a whole person perspective; and
- Absolute transparency and information sharing with the public.

Safe Care, Compassionate Care – A National Governance Framework to enable high quality care in NHS Wales published in 2013, sets out the NHS Wales response to the Francis report with a pledge to build on the progress made and to ensure that the system is:

- Providing the highest possible quality and excellent patient experience;
- Improving health outcomes and reducing health inequalities; and
- Getting high value from all our services.

These are all reflected in the overarching strategy for the UHB which we have refreshed and refined this year.

The delivery of safe, high quality care is not just about systems, but also the culture, values and behaviours that exist within the organisation. We understand that it is this which has the greatest impact in ensuring all patients and service users get the very best standards of care. The Board is committed to ensuring that an appropriate culture exists and is cultivated within the organisation and that it reflects the core values of NHS Wales. This is reflected in the values of the organisation, our revised strategy which aims to ensure that we provide a great place to work. We want to know that:

- **staff put quality and safety above all else:** providing high value evidence based care for our patients at all times;
- **improvement is integrated into everyday working** and that we take positive steps to eliminate harm, variation and waste;
- **we focus on prevention, health improvement and inequality** as the key to sustainable development, wellness and wellbeing for future generations of the people of Cardiff and the Vale;
- **we work in true partnership** with partners and organisations and with our staff; and finally that; and
- **we invest in our staff** through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

Achieving Excellence – the Quality Delivery Plan for NHS Wales from the Welsh Government places improving patient and user experience central to the day to day activities of NHS Wales. This is reinforced and implementation is supported in the 1000 Lives Plus publication *The Listening Organisation*, which describes what is important to our users and why and how we should listen and act on the feedback.

‘Trusted to Care’ published in June 2014, followed an independent review at two hospitals in Abertawe Bro Morgannwg University Health Board into concerns raised about standards of care and practice. Specific issues of concern related to:

- Giving patients medication;
- Ensuring patients were adequately hydrated;
- Overuse of night sedation; and
- Continence care.

In response to the report a number of internal unannounced visits and inspections were carried out by UHB Board members, senior managers and senior and lead nurses. Members of the Community Health Council were also involved, this has provided assurance that the failings identified in the Trusted to Care report have not been identified in our Health Board. However, we will not be complacent on this issue and unannounced visits, inspections and Safety Walkrounds will continue to form an important part of our internal assurance mechanisms.

In March 2014, Welsh Government published the Evans report “Using the Gift of Complaints”. This described the concerns process which is often felt to be unfathomable to the public, slow in response and implementation of action(s); often with no transparent learning from issues raised. The report made numerous recommendations which are being taken forward by an All Wales group on which the UHB has representation.

5.2 Patient Quality and Safety

5.2.1 Patient Quality and Safety Priorities for 2015/16

We aim to continue to drive quality improvement through a system that provides robust quality assurance. To this end we are taking forward a number of actions, targeted to the areas of greatest risk. We have a significant and challenging Patient Quality, Safety and Experience agenda to progress across the organisation. We have already embedded arrangements to respond to the actions aligned to the strategic direction of NHS Wales and progress against these actions is being monitored through the Quality, Safety and Experience Committee of the Board, which has a comprehensive work programme developed to meet the requirements of national strategic drivers, as well as key quality and safety issues in the Corporate Risk Assurance Framework and the Healthcare Inspectorate Wales (HIW) Work Programme.

However, we recognise that like all NHS organisations the need to continue to pay increased attention to how we are going to improve the quality and safety of the services we provide as well as ensuring an excellent patient experience. *Organising for Excellence* has at its heart, arrangements to ensure services commissioned and provided by the Health Board have patients, the quality of their care, safety and care experience at its centre, and as an organisation we have clearly defined our mission as *Caring for People: Keeping People Well* – and this provides the golden thread through the organisation to ensure that those who use our services (now and in the future) are what matters most. What really matters for our patients carers and citizens must be central to our decision making, so that we can use our time, skills and other resources more wisely.

Our staff and those who we commission services from take this responsibility very seriously, and whilst we are rightly very proud of the excellent care provided in the majority of cases, there are times when we do not always provide the level of care expected or required.

There is compelling evidence that while healthcare brings enormous benefits to us all, errors occur and patients are harmed. The nature and scale of this harm is hard to comprehend and it is estimated that worldwide, hundreds of thousands of people die or experience severe harm as the result of a patient safety incident (Vincent, C, 2010. *Patient Safety*. 2nd edition). It is now widely established and accepted that in advanced healthcare systems, between 8 % and 12% of patients experience adverse events; half of which are probably preventable.

In Britain, the cost of preventable adverse events is in the order of £1 billion per annum in lost bed days alone, as on average, an adverse event leads to an extra week stay in hospital (Vincent C et al, 2001, *Adverse events in British Hospitals*. Preliminary retrospective record review, BMJ).

During 2013/14¹, our experience of preventable adverse incidents and harms is summarised as follow:

- 58 patients fell while in our hospitals resulting in serious injuries such as fractures and head injuries – most of which required further surgical intervention or treatment.;
- 15,000 patient safety incidents were reported in Cardiff and Vale UHB - most were minor. Of these, 97 were serious enough to report to Welsh Government;
- 1 in 25 of our patients will have a Healthcare Acquired Infection – in line with the healthcare average;
- About 2.3% of hospital patients and about 27% of intensive care patients have sepsis. We know that there are patient safety issues associated with the early identification and management of sepsis across the UK. This is serious because death rates are very high at 30-50%.;
- 3,939 reported incidents of patient slips, trips and falls;
- Drug errors are common and under-reported. Most were minor and cause no harm but there were eight serious drug errors and tragically two patients died as a direct result of a drug error; and
- 1800 concerns (1134 of which were formal) about care, with 100 cases referred to the Ombudsman.

¹ 2014/15 data will be collated at the end of the year and reflected in our Annual Quality Statement

The human cost to patients and families cannot be underestimated when care goes wrong. However it is also clear, that there are also significant financial costs associated with harm to patients as well as the impact on staff. We have actions set out in our quality and safety plan to secure improvements in all of these areas as part of our strategic focus on reduce harm, waste and variation. We recognise that these are key areas for improvement and considerable work is already underway within the organisation to address these patient safety issues.

5.2.2 Healthcare Inspectorate Wales (HIW)

HIW is the independent inspectorate and regulator for all health care in Wales. The core role of HIW is to review and inspect NHS and independent healthcare organisations in Wales so that independent assurance can be given to patients, the public, the Welsh Government and healthcare providers that services are safe and of good quality.

During 2014 -2015 there have been a number of announced and unannounced HIW monitoring visits to different wards and departments in the Health Board. These visits include both Dignity and Essential Care Inspections (DECI inspections) as well as Mental Health Act monitoring visits . These provide a very valuable form of external assurance in to the quality of clinical care being provided. Feedback generally has been very positive although there have been some areas of practice identified during two visits which required immediate improvement. Other actions are followed up to ensure completion through Clinical Board Quality and Safety arrangements and as well as periodic review and follow up by HIW. Regular assurance reports on the findings of external inspections are also presented to the Quality, Safety and Experience Committee.

5.2.3 Cardiff and Vale Community Health Council (CHC)

The CHC works closely with us to provide valuable independent feedback on patient experience through a number of mechanism, in particular service visits which are reported to CHC meetings, and advocacy support to the management.

5.2.4 Learning from Inquests

During the 2014/5 a number of Cardiff and Vale cases were considered by the Coroner, and we have taken action where necessary to address issues through the processes we have described in this chapter.

5.3 The Patient Experience

National and local evidence shows that the three, key determinants of a good patient experience are:

- First and lasting impressions of a service or care, including being treated with dignity and respect;
- Being cared for in a safe, supportive environment; and
- Being involved and understanding the care and treatment provided.

When we get it wrong, the experience may result in less than optimal care outcomes and a formal or informal complaint. As part of becoming a listening organisation, we use the feedback we receive to make improvements to the way we care for people.

The Health Board has an integrated system in place to ensure that it listens to all the feedback it receives through “**Putting things Right**”. Formal and informal concerns are analysed to identify the key themes, using the national service user experience framework and that these are linked with the UHB improvement methods and processes to address the commonly occurring themes across the UHB. This results in our ability to truly demonstrate learning alongside demonstrable improvements in patient experience.

We already have in place:

- A central **public and patient advice and liaison service** which aims to resolve informal concerns quickly and can signpost patients to appropriate support where necessary – this will directly impact on the number of formal concerns received and which need to be investigated by the Clinical Boards;
- A **bereavement support** service that supports, advises and trains Clinical Board staff to deliver compassionate, caring and safe care for the bereaved, linking with external support and third sector agencies where necessary – resulting in a low number of complaints and incidents relating to death and bereavement and increased positive feedback;
- A sustained **carers support**, information and involvement framework, delivered in collaboration with third sector and local government partners, that is understood and utilised by all staff coming into contact with carers and the people they support – resulting in more carers feeling that they are involved in decisions about the care of those they care for, more having a positive care-life balance and fewer neglecting their own health and feeling that they are discriminated against;
- A network of **information centres** on Health Board premises which work with clinicians and external providers to provide a consistent source of support and information for patients, families, carers and the public on a range of clinical, social and support matters – resulting in patients and the public having access to the right information at the right stage on their clinical or social pathway;
- Increasing number of **volunteers** in hospital and community settings who are available to complement and support clinical staff in their delivery of care as well as providing additional support such as sign posting, reading and talking to patients, music and arts – ensures that all patients receive an equitable level of support to complement their clinical and nursing care;
- Development of a **volunteer programme** for Allied Health Professional and Healthcare Scientist undergraduates; and
- A **spiritual care** service that supports patients, relatives and staff of all faiths and those with none – success will mean ensuring that all those who want a listening ear and the presence of someone who can provide this when it is needed.

During 2015/16 we are focusing on adopting a strategic approach to learning from patient experience feedback in partnership with Clinical Boards and other corporate departments to support and improve how we care for people.

The vision for the Patient Experience and Concerns team is that over the next three years the UHB will have in place a comprehensive range of **feedback methods** to ensure that:

- A sample of patients and service users in each service area are regularly asked for their views using the national survey with the results available “real time” to frontline staff;
- A promotional campaign that ensures that all patients and service users are made aware of the importance that the Health Board gives to their views, and are given the opportunity to share their experience through a wide range of channel;
- A number of annual themed large scale surveys;
- The widespread use of patient stories and the feedback from patient groups and third parties that is made available to Clinical Boards;
- A reporting framework for frontline staff, clinical services, the Board and the public to share the outcomes of feedback and actions taken; and
- An infrastructure that supports Clinical Boards to respond to concerns in a timely and appropriate manner whilst being aware of themes arising from concerns.

Success would be determined by the measures of patient experience improving, formal concerns relating to the patient experience reducing and that the general public demonstrate increasing confidence in the services we provide.

5.3.1 Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMS)

Patient Reported Experience Measures (PREMS) and Patient-reported Outcome Measures (PROMS) are methods which together can ascertain patients' views of symptoms, functional status, quality of life and patient experience.

The UHB has longstanding experience of using a methodology to gather PROMS and PREMS data via the Health Improvement and Patient Outcome (HIPO). This process historically was initially developed on a cost neutral basis due to the attraction of commercial support.

PROMS have been used in England, for example within the elective surgery areas of hip or knee replacement, groin hernia repair, and varicose vein surgery. Within the UHB we currently use PROMS in hip and knee surgery.

In 2015-16 the UHB will be scoping what would be required to develop a more systematic approach to the targeted use of HIPO and PROMS. It is hoped that this scoping exercise and conversations with industry realise the securing of resource to support an implementation phase. Should this again be successful future PROMS and PREMS data could be utilised in a variety of ways including informing commissioning intentions and improving service delivery.

5.4 Mortality

How are we doing?

The overall reported mortality position for the UHB is reported regularly to the UHB Board. A summary of figures reported is shown below.

Board Meeting Month	May-14	Jul-14	Sep-14	Nov-14	Jan-15	Mar-15
Reporting Month	Dec-13	Feb-14	Apr-14	Jun-14	Aug-14	Oct-14
Welsh RAMI 2013 Figure	92	90	89	88	88	88
Uncoded Position	3.9%	3.3%	3.1%	3.8%	4.1%	4.1%

The uncoded position has deteriorated marginally over this time, with no detriment to the reported mortality position. The deterioration has been stabilised and activity for the month of November 2014 was 95% complete by the end of February 2015. This data is due to be sent to CHKS in late March in accordance with the usual timetable. Activity for December 2014 was 85% complete by 2nd March 2015, ahead of schedule.

The UHB now needs to move to reporting mortality using the Welsh RAMI 2014 indicator and this will replace Welsh RAMI 2013. In addition, reporting to the UHB Board will continue on:

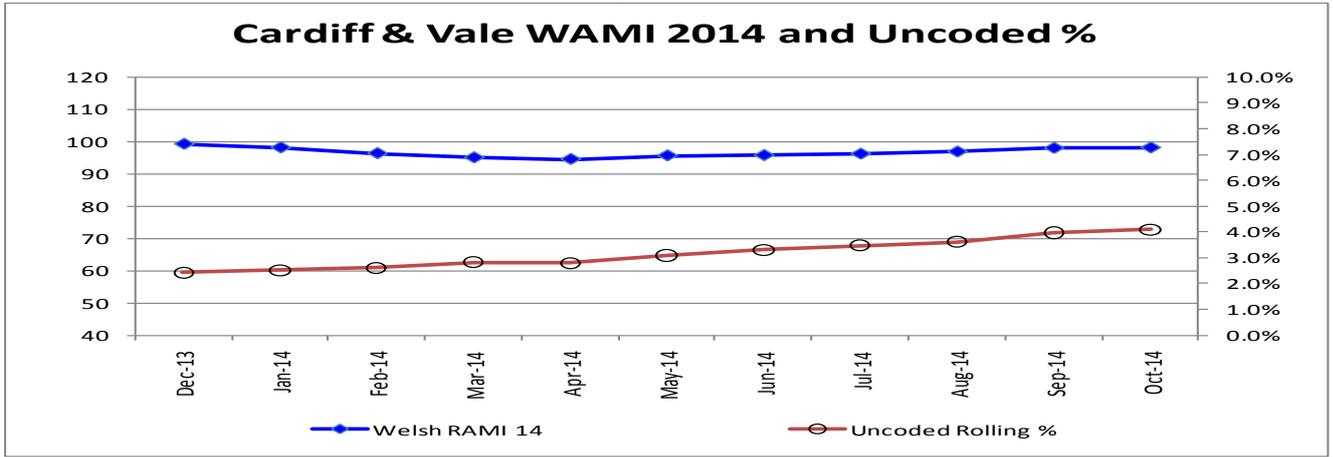
- Crude mortality (i.e. number of deaths) based upon rates of hospital activity (measured in hospital "spells"); and
- Condition specific mortality rates.

The UHB's Welsh Risk Adjusted Mortality Index (WAMI 2014) was 98 for the 12 months up to October 2014, which compares favourably against the index benchmark of 100 and is equal to the figure reported to the UHB Board in January for data up to the end of August 2014.

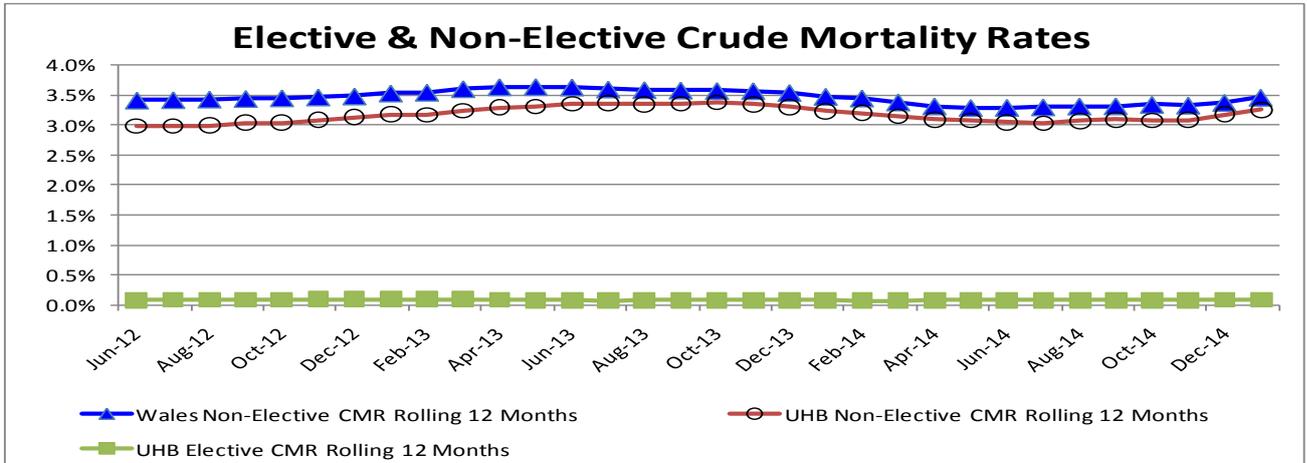
The UHB's non elective crude mortality rate was 3.26% for the 12 months to January 2015, which is above the previous level reported of 3.17%. This level is however consistent with January 2014, the trend is in line with the all Wales trend and the UHB level continues to be below the all Wales level.

Trends in performance over time and the condition specific mortality rates are shown in the figures below:

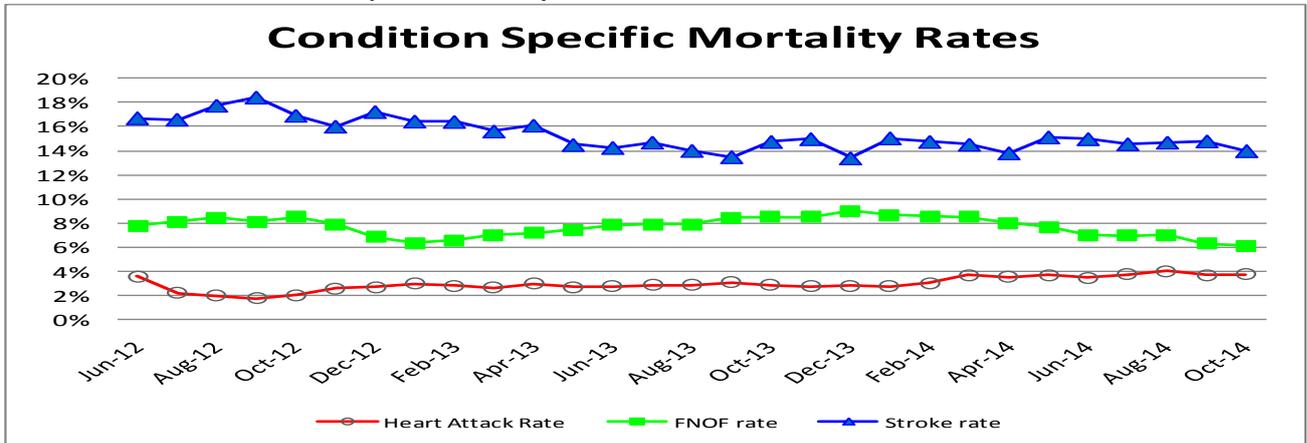
Cardiff and Vale UHB Welsh RAMI 2014 and % of Activity Uncoded



Cardiff and Vale UHB Crude Mortality Rates and All Wales Level

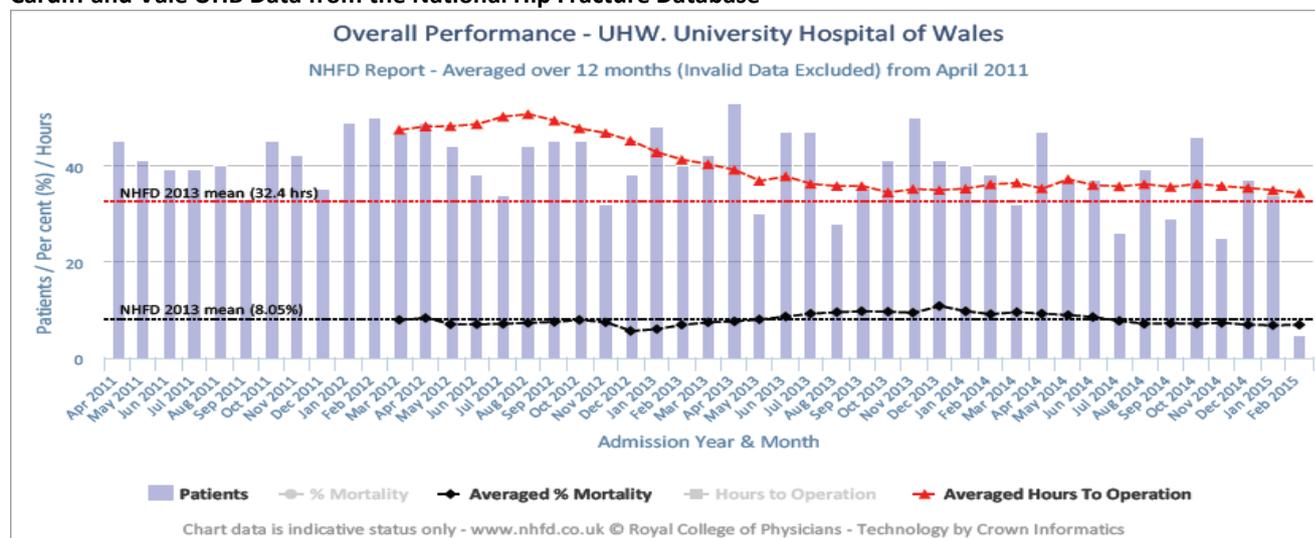


Cardiff and Vale UHB Condition Specific Mortality Rates



It is the case that all condition specific mortality rates have reduced, Stroke – 14%, Heart Attack – 3.7% and fractured neck of femur (#NOF) – 6.1%. Further detail from the National Hip Fracture Database is included in the table below.

Cardiff and Vale UHB Data from the National Hip Fracture Database



The mortality rate has fallen over the last three reported months.

Going forward data from the National Hip Fracture Database will be included within the UHB's performance report on a regular basis to track performance.

What actions are we taking?

The Electronic Mortality Audit Tool (EMAT) launched in September 2014 enables the recording of Death Certification details and the recording of both Level 1 (universal mortality reviews) and Level two mortality reviews against the patient record in and alongside PMS. Information will be available at UHB, Clinical Board, Directorate and individual consultant level, thus providing more comprehensive and useful clinical information to inform Level 2 reviews and mortality and morbidity meetings. Audit of Clinical Board/Directorate performance is taking place. The system has recently been demonstrated to the Quality Safety and Patient Experience Committee where it was very positively received. There will be regular reporting of outcomes to the Committee.

Changes to the way in which LHBs report mortality are still expected following the publication of Professor Stephen Palmer's review. WAMI 2014 is now reported as well as WAMI 2013. Cardiff and Vale is well represented on the Welsh Governments Mortality and Transparency Task and Finish Group led by the Deputy Chief Medical Officer, Dr Chris Jones. When it is clear as regards to the way forward following Professor Stephen Palmer's review, Cardiff and Vale has a number of systems in place, including EMAT, to develop mortality reporting over the next 1-3 years.

The UHB continues to work with the Welsh Government and other LHBs to finalise a suite of mortality measures. The importance of this review process is recognised both at both a national and local level. The UHB publishes revised data every three months on its Public Website of agreed mortality data with Welsh Government.

The #NOF mortality rate and clinical service is being reviewed regularly by the People, Performance and Delivery (PPD) Committee. This area of practice is receiving, and will continue to receive close scrutiny over the next twelve months with a plan from the Surgical Clinical Board to improve performance in this area.

5.5 Supporting Delivery of 2015/16 UHB Priorities

As highlighted previously, we are focusing on a number of key areas over the next year, and we have identified the specific actions we are taking to support the areas of improvement from a quality and safety perspective. These actions are detailed below.

Priority	Action
Referral to Treatment Times	<p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor concerns and patient safety incident data related to waiting times and access to services – applying learning as appropriate; • Monitor feedback from patient surveys – applying learning as appropriate; • focus on outcomes by developing high quality local audit to monitor outcomes in patients who exceed accepted waiting times for treatment; • Reviewing the workforce within Theatres; and • Further consider the role of Advanced Nurse Practitioners and Clinical Nurse Specialist roles as part of the development framework which supports the work of Nursing Productivity Group.
Cancer	<ul style="list-style-type: none"> • Development of the patient information centres to support shared decision making. <p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor concerns and patient safety incident data related to the care of patients with cancer – applying learning as appropriate; • Monitor mortality and morbidity data to monitor outcomes – applying learning as appropriate; • Participate in relevant National Audits; • Focus on outcomes by developing high quality local audit; and • Review the role of Advanced Practitioners in order to ensure that the patient receive timely care from appropriately trained practitioners.
Unscheduled Care	<ul style="list-style-type: none"> • Revising Safety Walkrounds to include a focus on ‘flow’. <p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor concerns and patient safety incident data related to unscheduled care with particular focus on patients who are delayed on ambulances or in the EU department – applying learning as appropriate; • Work with Welsh Ambulance Services Trust to develop feedback from Emergency Service Users – applying learning as appropriate; • Ensure that Infection Prevention and Control measures are maximised to reduce Hospital Acquired Infection rates and reduce extended hospital stays; • Ensure that single use equipment is available for – cannulations and catheterisation therefore reducing the risk of infection; • Explore workforce opportunities, in particular the nursing workforce to support the avoidance of hospital admission; • Develop and strengthen education and training in relation to advanced practice, chronic disease and district nursing; • Focus on outcomes by developing high quality local audit to monitor outcomes in emergency patients who are delayed in accessing necessary care; • Explore with EU, “carer failure” admissions or support carers to enable discharge to occur; and • Enabling expansion of volunteering in EU department to support patients and relatives.
Stroke	<p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor implementation of the Stroke Delivery Plan; • Complete integrated workforce planning, with recommendations for workforce redesign centred on patient requirements; • Monitor Section 16 requirements of PSOW report – applying learning as appropriate; • Monitor concerns and patient safety incident data related to the care of patients with stroke – applying learning as appropriate; • Monitor feedback from patient surveys – applying learning as appropriate; and

Priority	Action
	<ul style="list-style-type: none"> • Increase the number of volunteers to support patients, families and carers.
Finance	<ul style="list-style-type: none"> • Reviewing systems of work within the Temporary Staffing office including: <ul style="list-style-type: none"> ○ An option appraisal of future function and resource requirements; ○ Review of the IT support system for TSD-booking and availability; and ○ Increasing the fill rate for temporary staff. <p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Significantly reduce agency expenditure; • Review the Nursing establishments to ensure adherence to Chief Nursing Officer staffing principles; • Introduce Key Performance Indicators to monitor the disciplinary and suspension processing and reduce resolution timeframe; • Reviewing and exploring alternatives for 1:1 care; • Continue to review Nursing productivity on a 6 weekly basis with established forums; • Explore alternative ways to provide specialising for patients for example use of Therapeutic Care Volunteers; • Achieve early resolution of concerns under redress, decreasing the cost of successful clinical negligence claims; and • Deliver Safety Express (invest to save scheme to deliver savings in bed days and staff efficiencies).
Fully embedding the integrated diabetes model of care	<p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor concerns and patient safety incident data related to the care of patients with diabetes – applying learning as appropriate; • Participating in national audits; and • Focus on outcomes by focusing on high quality local audit to monitor outcomes in patients with diabetes.

5.6 Supporting Prudent Healthcare

We have already set out how UHB teams and services are already applying Prudent Healthcare principles in multiple ways. The Corporate Patient, Safety Quality and Experience team is committed to continuing work which directly supports prudent healthcare principles and will focus on the following actions during the period of this plan:

Principle	Action required
Do no harm	<p>Revitalisation of Safety Walkrounds.</p> <p>Supporting Clinical Boards to:</p> <ul style="list-style-type: none"> • Monitor compliance with patient safety alerts and evidence based practice; • Investigate and act on the lessons learned following patient safety incidents and concerns raised by patients; • Identify Leading Improvement in Patient Safety (LIPS) projects designed to deliver safer care; • Develop investigation skills by delivering Root Cause Analysis training to support staff in identifying root cause of patient safety issues; • Act on the reports from external inspections; • Provision of patient information and support: and • Ensure care provided is safe, including equipment.

Principle	Action required
Carry out minimum appropriate intervention	Supporting Clinical Boards to: <ul style="list-style-type: none"> • Introduce evidence based practice; • Monitor compliance with evidence based practice through clinical audit; • Monitor themes in concerns and patient safety incidents that indicate unnecessary interventions treatments; and • Promote Shared Decision making via the use of care pathways and patient/carer information.
Only do what only you can do	Supporting Clinical Boards to: <ul style="list-style-type: none"> • Use appraisal process to identify areas for development; • Monitor themes in concerns and patient safety incidents that indicate areas where staff are working outside of their competency; and • Identify LIPS projects – designed to look at alternative ways of delivering services.
Promote equity	Supporting Clinical Boards to: <ul style="list-style-type: none"> • Promote Active engagement with Minority Ethnic Community Health Fair ensuring all areas of UHB represented especially Primary, Community and Intermediate Care; • Deliver pertinent recommendations in Sensory Loss Standards; • Promote use of Translation and Interpretation Services; and • Implement relevant components of the Welsh Language Standards.
Remodel the relationship between user and provider on the basis of CO-PRODUCTION	<ul style="list-style-type: none"> • Acting on the reports from external inspections; • Delivering projects with service user engagement e.g. Information Centres; • Development of Peer Review Group for Concerns including Lay Members; • Identify and promote good practice in co-production across the organisation • Support patient and public involvement initiatives to engage with the Health Board such as Co-Creating Healthy Change • Implement the Carers Information and Consultation Strategy with partner organisations

5.7 A Framework for Patient Safety, Quality and Experience

Over the coming months we will develop a Quality, Safety and Improvement Framework which sets out a strategy to deliver the required improvements and to further embed a culture of openness and improvement across the organisation. The framework will set out how we will drive quality improvement within the UHB supported by a reliable system of quality assurance.

The Berwick Report 2013 – ‘A promise to learn – a commitment to act - Improving the Safety of Patients in England’, summarises the safety and quality issues being faced by the NHS on a daily basis. The framework will set out how we will deliver the recommendations of the Berwick Review and improve our systems to:

- Listen to and learn from the voices of staff and patients;
- Provide strong leadership;
- Build capacity and capability within our workforce so that we build on our strong culture of learning and further develop staff who have the skills to deliver quality improvement;
- Measure patient safety, quality and experience and improve the way that we analyse and triangulate data to help support quality improvement; and
- Increase our organisational learning and the more rapid spread of learning.

Actions to drive **quality improvement** will include:

- Further embedding and delivering the requirements set out in *Delivering Safe Care, Compassionate care*;

- Continuing to support Clinical Boards to ensure that patients and service users are at the centre of all that we do as equal partners;
- Implementing and embedding the revised Standards for Health Framework;
- Securing year on year increases in patient and staff satisfaction;
- Increasing the numbers of staff with improvement skills within the UHB;
- Strengthening the ways in which we manage and respond to the findings of large national evidence based reports and NICE Guidance;
- Strengthening of the current approach to Safety Walkrounds so that they are focused and themes and trends are identified and used to improve the quality of services; and
- Introduction of electronic reporting. We have already agreed a project plan which is underway and this will be fully implemented across the UHB during 2015-2016.

The UHB is committed within its O4E Strategy to create staff capacity and capability in leading improvements for patient safety, to deliver the outcomes that matter to people. The introduction of Leading Improvement in Patient Safety (LIPS) will help the UHB introduce an appropriate patient safety improvement capability, based on the work of the Institute for Healthcare Improvement (IHI), the work of the Health Foundation through its Safer Patient Initiative (SPI) and more recently the NHS Institute's own programme of LIPS.

This targeted and focused learning concentrates on how to improve safety and helps staff to acquire a skill set that is heavily associated with higher quality outcomes and lower cost. Skills delivered through LIPS include:

- Effective leadership skills;
- Collaborative problem solving skills;
- Measurement for improvement skills;
- Implementation skills;
- Communications skills; and
- Human factor management skills.

There have been 2 cohorts of staff, over 200 senior clinicians and managers who have already attended the programme during 2014/15 and further similar sized programmes planned for 2015/16.

Actions to drive **quality assurance** will include:

- Reacting and respond to the findings of external inspections to ensure that key themes and issues are identified and addressed;
- Ensuring that there a robust processes in place to provide our Board, Clinical Boards and teams with timely and meaningful information not only on our own services but also on those we commission from others;
- In addition to the agreed national Tier 1 priorities, the UHB will also introduce and monitor a range of quality indicators which will be adapted as quality triggers to inform its Annual Quality Statement.
- Increasing the number of serious incidents reported. We recognise that in comparison with our peers the UHB is a low reporter of Serious Incidents and will undertake a focused piece of work with Welsh Government to establish whether there is any evidence of areas of under –reporting or whether patient safety initiatives implemented over previous years are having impact and reducing the number of serious incidents in some areas. This work has already begun;
- Further embedding Quality assurance within our internal Performance Management arrangements;
- Strengthening the function of Clinical Audit so we gain continuous assurance that the services we are delivering are patient centred, evidence based, safe and are delivering excellent outcomes for our patients in line with or exceeding national best practice;
- Further development of mortality reviews. During 2014/15 the UHB has developed an Electronic Mortality Tool, an IT system that enables death certification data to sit alongside the Patient Management System information in the clinical information repository. This system enables electronic recording of death certifications and the findings of the universal mortality (stage 1) reviews. It identifies which patients should have a more in-depth stage 2 review and of those what the additional issues and learning is; and

- Developing a framework of nursing performance indicators which will demonstrate the provision of high quality nursing care within the Health Board. The intention is to provide ward based staff with an “at a glance” view of their performance building on a combination of existing and new key indicators. Work has already begun on this

Ensuring we are meeting required standards of effective care is vital. The evidence that reliable care processes lead to improved outcomes is often well understood, but not translated consistently into practice. Monitoring key areas where the process/outcome link is clear is an effective indicator of a wider commitment to delivering consistent care standards. The UHB will introduce an agreed set of measures to assess whether we are providing safe care. Safety measures can never be fail-safe, and can always be improved. Improvements should be detectable in reductions in avoidable mortality and harm while recognising that increasing levels of incident reporting can also be a strong positive indicator of safety awareness and focus.

The following areas are where quality triggers will be focused:

- Incidence of failure to observe patients i.e. National Early Warning Scores (NEWS) scores not done;
- Incidence of failure to act on deteriorating patients, measured through NEWS scores;
- Incidence of sepsis;
- Incidence of Venous Thrombo Embolism (VTE);
- Health Care Associated Infection (HCAI) clusters;
- Incidence of pressure ulcers;
- Increasing Crude and/or Risk Adjusted Mortality Indicators (RAMI) or specialty mortality rates;
- Incidence of failure to complete mortality reviews ;
- Clusters of themes from mortality and harm reviews ;
- Low levels of incident reporting;
- Incident and near miss reporting clusters;
- Complaint/concern clusters;
- Negative or deteriorating feedback from feedback gained via application of the National Service User feedback framework;
- Negative or deteriorating feedback from Fundamentals of Care (Health Standards) audits; Negative feedback from unannounced Dignity and Essential Care Inspections and WG Trusted to Care inspections; and
- Negative feedback from internal dignity spot-checks; Low levels of engagement in user feedback initiatives.

Many of the actions set out in this section were reflected in the Annual Quality Statement for 2013-2014. We set out the statement focusing our actions in seven areas:

- Staying Healthy;
- Providing safe care;
- Effective care;
- Timely care;
- Treating people as individuals;
- Dignity and respect; and
- Our staff and volunteers.

5.8 Infection Prevention and Control

Two key Welsh Government documents underpin the work of the UHB:

- Commitment to Purpose: Eliminating Preventable Healthcare Associated Infections (HCAIs). December 2011
<http://wales.gov.uk/docs/dhss/publications/111216commithcaien.pdf> ; and
- Code of Practice for the Prevention and Control of Healthcare Associated Infections. June 2014
<http://wales.gov.uk/topics/health/cmo/publications/cmo/2014/cmo-june14/?lang=en> .

Our approach to reducing HCAs is to ensure that is everybody's business and a zero tolerance of preventable infections is expected within the UHB. The Welsh Government code of practice outlines the minimum necessary arrangements and standards for NHS organisations and we have adopted these.

Following the publication of *Commitment to Purpose* we developed an action plan, which was monitored through our Infection Prevention and Control Group. The reorganisation to form Clinical Boards necessitated a change of approach and a framework document incorporating the requirements of the two documents above was agreed with the Clinical Boards in September 2014. During 2015/16, we will be translating the framework into practice across the whole system and to provide appropriate specialist support to the organisation.

Tier 1 targets for HCAI are focussed on *C. difficile* disease and MRSA bacteraemia. The current target due to be delivered by September 2015 is to achieve a population based rate of 31 per 100,000 population for *C.difficile* cases; and 2.6 per 100,000 population for MRSA bacteraemias. Our position against the targets at the end of December 2014 was as follows:

- **C. difficile:** There have been 136 cases between April to December 2014; rate per 100,000 population = 37.69, which is currently the lowest rate in Wales. Not currently on target to achieve the required rate of 31/100,000 population (+23 cases), but it is still possible to reduce to the required rate by September 2015; and
- **MRSA bacteraemia:** 33 cases between April to December 2014; rate per 100,000 population = 9.15, which is currently the highest rate in Wales. The maximum number of cases of MRSA bacteraemia to achieve the 18 month target has been exceeded; it is therefore not possible for the organisation to deliver the target for MRSA bacteraemia.

The burden of HCAI is greater than that represented by *C. difficile* disease and MRSA bacteraemia only. HCAs include post-surgical infections, infections secondary to intra-vascular catheters and other medical devices such as urinary catheters. HCAs harm patients, extend their length of stay in hospital, increase the cost of their treatments and hamper patient flow and service delivery. Preventing patients from developing HCAI is a key quality issue.

During 2014/15 we lost more than 500 bed days due to norovirus outbreaks across the organisation and additional pressures were felt during the winter period with the admission of many patients with influenza. Our inability to isolate patients effectively resulted in secondary cases occurring, blocking more beds through extended length of stay. The financial burden is difficult to quantify, but based on the estimated cost of MRSA bacteraemias and *C. difficile* cases alone, at £10,000 per case; with 169 cases occurring between April and December 2014, there has been a cost to the organisation of £1,690,000 as a minimum.

In order to keep our patients and staff safe from HCAs we are taking the following action:

- Ensure that evidence based practices to reduce the incidence of infection are implemented consistently across the organisation:
 - Hand hygiene;
 - Insertion and maintenance of medical devices;
 - Reduction of Surgical site infections through implementation of NICE guidance; and
 - Effective decontamination of all medical devices, for example surgical equipment, endoscopes and ultrasound probes.
- Train staff in practices to prevent HCAs and the spread of infections; and in the use of personal protective equipment to protect them;
- Investigate and manage outbreaks of infection rapidly;
- Place patients with infections appropriately within the organisation to prevent onward spread of infections;
- Clean our environment effectively;
- Develop an environment that minimises the risks of infection; and
- Practice Antimicrobial stewardship to minimise the risks of antimicrobial resistance and *C. difficile* disease.

Much has been achieved over the last year:

- Additional resource of 1wte band 7 nurse has been identified for the IP&C team. The full establishment of 7.2wte nursing staff was fulfilled from November 2014;
- Agreement for additional IP&C nursing resource for a fixed term to support additional winter pressures;
- The IP&C team resource has been allocated to support the Clinical Boards and develop key relationships with the Clinical Boards;
- Discussions are ongoing to establish a Director of Infection Prevention and Control post with additional sessional commitment beyond 4 sessions;
- Development of a HCAI and Antimicrobial Resistance Framework with engagement of the Executive Board and Clinical Boards - Clinical Boards are now in process of implementation;
- Appointment of an Antimicrobial Pharmacist;
- Antimicrobial Policy change November 5th 2014, aimed at reducing the increasing resistance to Co-amoxiclav (Augmentin) and the incidence of C. difficile. December figures are encouraging for C. difficile disease incidence (7 cases);
- The process of root cause analysis following cases of C. difficile and MRSA / MSSA bacteraemia is being undertaken more regularly by clinical teams, although there is a need to capture the learning more effectively across the organisation and to implement changes;
- MRSA bacteraemia RCA review meetings are being chaired by the CEO from January 2015;
- Purchase of four Hydrogen Peroxide Vapour (HPV) cleaning systems, which have been effectively deployed to bring outbreaks of C. difficile under control and to improve the cleaning of difficult to clean patient equipment;
- Monthly meetings are held between Estates / Capital Planning and IP&C;
- The IP&C team supports HCAI meetings held by the Clinical Boards. On occasions these are HCAI specific or incorporated into the Q&S meetings;
- Medical engagement with the HCAI agenda: The Associate Medical Director for Patient Safety has become a member of the Infection Prevention and Control Group; the Antimicrobial Group Lead has nominated leads / champions for the antimicrobial agenda and there is a plan to develop IP&C lead roles in the same way;
- To support the work to reduce MRSA / MSSA bacteraemia trials of peripheral vascular cannula insertion packs have occurred on some wards in medicine and specialist services. Feedback has been good – Clinical Boards are now asked to consider implementing these packs across their services in support of evidence based practice for inserting these cannulae; and
- Some deficits in decontamination identified through audit have been rectified (see challenges below).

There is a framework now in place to support the organisation to implement changes and interventions that are aimed at delivering a culture where zero tolerance to preventable infections is the everyday approach.

Improvements in HCAI reduction will be sustained through:

- Including HCAI as a key quality improvement issue linking it with current quality improvement programmes and work within the health board; and
- Continued regular monitoring of implementation of the framework through the performance reviews.

5.9 Operational Services Quality and Patient Experience

Our operational services (housekeeping, catering, portering and routine estates maintenance) play a vital role in providing a good patient experience, and contribute to the quality of the care we provide to patients and their carers. Our operational services operate a site management model allowing site users to have a single point of contact for any query. The main priorities for services in 2015/16 are:

Service	Priority	Improvement in Quality and Patient Experience
Estate Maintenance	Maintaining and replacing ageing plant and equipment that becomes older, less reliable and prone to breakdown.	Equipment works more efficiently; patient care and experience will not be compromised by old equipment continually breaking down. This will also allow estate maintenance staff to respond quicker to other demands for their services.
	Meeting client expectations from within available resources (recognising that resources benchmark well below Wales and UK levels) .	Contributes to a balanced financial position and an improvement in the patient experience.
	Apprentice training programme being developed to address shortage of suitably trained staff	Ageing workforce in estates, the apprenticeship scheme allows for succession planning and a suitably trained multi skilled workforce.
Helipad	Increasing the availability of Fire Fighter and Rescue staff to meet the demands of night landings.	Service faces the possible increase in patient activity if the UHW becomes the main Trauma unit as per the South Wales Collaborative. There is the risk of non compliance with Civil Aviation Authority regulations if there are insufficient suitably trained fire fighters. By increasing the number of suitably trained staff through flexible roles and retraining, an increased number of severely injured patients will be able to be transport by Air Ambulance to a major trauma facility for treatment.
Housekeeping	Continued implementation of Free to Lead Free to Care.	This will mean all ward housekeeping staff will be the direct responsibility of Nurse in Charge. This will allow the ward staff to decide on areas that require cleaning and the housekeeper being integrated into the ward team.
	Secure funding for a housekeeping rapid response team at UHL and UHW.	A RRT is a requirement of the National Cleaning Standards and will focus on areas of infection, bed spaces, curtain changes, public areas and improve the general cleanliness.
	Modernise roles to support service developments in new builds and improve flexibility of service delivery in all areas.	This will result in a flexible multi disciplined motivated workforce able to undertake a number of tasks. The initiative will be taken forward in partnership with staff representatives with the aim of providing improved services to patients, staff and visitors.
Linen	Assess the benefits of linen tagging system employed by Greenvale Laundry.	Greenvale were successful with a 'spend to save' bid to Welsh Government for a linen tagging system. The benefits to the UHB will include being able to track linen losses which in turn will allow the Laundry to return more clean line more frequently to the UHB. This should reduce linen shortages, improve the patient experience and the quality of care provided to patients.

Service	Priority	Improvement in Quality and Patient Experience
Patient Catering	Achieve a minimum Food Standards Agency rating of 4 or above	At an inspection the Environmental Health Officer will check three elements; how hygienically the food is handled, the condition and structure of the building, and how the business manages what it does. A Food Safety Agency rating of 4 is classed as Good with the maximum rating being 5 and Very Good.
	Review and evaluate option of procuring services from neighbouring UHB.	Based on information to date regarding the nutritional quality of meals and level of compliance with All Wales Menu Framework this is unlikely to proceed but work option still being assessed.
Patient Catering	Replace kitchen equipment on ward kitchens and in central processing areas.	New ovens, fridges, freezers, blast freezers to be purchased and installed in 2015-16. This will ensure continuity of service to patients, increase the opportunity to produce additional meals from the All Wales Menu Framework internally.
	Continue a ward based service to previously unfunded areas such as EU and Suite 19	This is a significant cost pressure but it is important to patients that whilst in hospital they receive a nutritious meal service.
	To provide a menu in line and fully compliant with the All Wales Menu Framework that meets dietary and therapeutic needs.	All menus have been analysed by dietetic staff to ensure compliance with Nutrition standards and texture modified meals comply with therapeutic requirements. The All Wales Menu Framework is based on previous work piloted and implemented by the UHB.
Portering	Support the unscheduled care pathway.	By ensuring that sufficient porters are available to EU it will assist in reducing the number of delayed transfers from EU to the ward.
	Train and increase the number of fire fighters to support the helipad.	By increasing the number of suitably trained staff through flexible roles and retraining, an increased number of severely injured patients will be able to be transport by Air Ambulance to the major trauma facility for treatment. This is in line with the EMRTs plans.
Restaurant Services	Achieve a minimum Food Standards Agency rating of 4 or above.	At an inspection the EHO will check 3 elements; how hygienically the food is handled, the condition and structure of the building, and how the business manages what it does. A FSA rating of 4 is classed as Good with the maximum rating being 5 and Very Good.
	Successful introduction of the Aroma brand.	Improvement in the facilities offered to staff and visitors all surpluses will be reinvested into patient care.
	Comply with Public Health agenda and 'UHB Restaurant Services and Retail Outlet Standards'.	Ensure that healthy eating options are available at all catering outlets operated by the UHB and in retail units managed by the UHB.

Service	Priority	Improvement in Quality and Patient Experience
Transport	Smooth transition of Hospital Courier Service to shared services as per outcome of McClelland Review.	The transfer of HCS to shared services will see an investment in technology to meet the performance needs of the UHB. This will include service provision to support the National Pathology Review.
	Replacement of seven vehicles at the Joint Equipment Store (JES) at West Point.	The current vehicles are operating at a level beyond economic repair. The JES provides beds, medical aids, and continence pads to patients in the community which facilitates early discharge from hospital. The replacement of the vehicles negates the risk of the current vehicles breaking down and thereby reducing the quality of the service provided to patients in the community.
Waste Management	Achieving full compliance with waste segregation in line with the Hazardous Waste Legislation.	Reduces the risk of prosecution by Natural Resources Wales and ensures that the UHB meets Welsh Governments Green Agenda. Appropriate segregated waste reduces the risk to patients and staff of sharps injuries.
	Implementing Cardboard Sharp boxes for IV giving sets.	There is a significant financial savings from this scheme which will contribute to the UHB financial savings for reinvesting in patient care.

5.10 General Medical Services (GMS)

Achievement against the Quality and Outcomes Framework (QOF) is one measure used to monitor the performance of General Practitioners. An All-Wales comparison of achievement within the UHB and externally against other Welsh LHBs areas is available on an annual basis. Further more detailed local analysis is undertaken annually and individual UHB practice QOF achievement is compared to identify low achievement and significant variance. This process also informs priority areas for the QOF programme of visits.

The UHB operates a three year rolling programme for visits. The programme of visits each year comprises;

- practices due a routine visit (so not visited in the preceding two years)
- revisit for practices visited in the previous year where performance issues were raised and remedial action recommended
- practices whose QOF achievement in the previous year reflected poor performance, or a significant variance to the previous years performance

Visits this year have been very positive. The practices we have revisited have been able to demonstrate improvement as a result of recommendations made last year. Any visits where issues have been highlighted will be considered by the team and recommendations for remedial action made. This could result in a revisit next year or sooner if deemed necessary. There is a broad agreement that a peer-to-peer (it is now largely a GP to GP discussion) approach that we now take to QOF visits makes the process much more constructive than they have been previously.

5.11 Safeguarding

Safeguarding is everyone's responsibility and all staff who, during the course of their employment have direct or indirect contact with children and families and vulnerable adults, or who have access to information about them, have a responsibility to safeguard and promote the welfare of children and vulnerable adults.

The Safeguarding Children Team and the Senior Nurse for Safeguarding Adults have now co-located, coming together to provide an integrated corporate safeguarding service. The team continues to provide assurance to the Board that the UHB is discharging its duties in line with Standards for Health in Wales, Standard 11 as well as conforming to UK legislation and WG guidance such as The Children's Act (1989) and (2004) and The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2013).

The Safeguarding Team delivers a comprehensive safeguarding training programme and provides safeguarding supervision to health Designated Lead Managers, nurses, midwives, health visitors, doctors and others involved in safeguarding cases. Section 28 of the Children Act 2004 places a duty on agencies to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Safeguarding Team will continue to support the UHB in the discharge of its statutory functions across the four key areas of training, supervision, advice and support, and audit.

Training is a key priority for the Safeguarding Team to ensure that the Clinical Boards and front line staff are aware of the current safeguarding agenda and have the knowledge and skills to signpost patients to relevant expert services. Safeguarding children and adults relies on effective interagency working and as such the Safeguarding Team works collaboratively with partner agencies that include the local authority, education and the police, to ensure the best outcomes for children and vulnerable adults.

Both Cardiff and Vale Local Safeguarding Children Board's (LSCB) have recently merged to form the Cardiff and Vale of Glamorgan LSCB, and a key priority for the Safeguarding Team will be to continue to support the merger and to ensure effective multiagency working continues, along with effective representation on the LSCB and its sub-groups. It will be necessary to follow a strategic approach in partnership with Clinical Boards to ensure that there is a two way exchange of pertinent information, and that this information is disseminated and acted upon appropriately, by the Clinical Boards.

The Executive Nurse Director is the UHB representative on the LSCB; the Deputy Executive Nurse Director along with the Named Doctor for Safeguarding Children are also members of the Board. The Deputy Executive Nurse Director is a member of the Local Safeguarding Adult Board (LSAB); members of the team will continue to contribute to all of the sub-groups and task and finish groups that come under the both the LSCB and the LSAB.

The LSAB has developed in line with the Ministerial directive which sets out the direction of travel for safeguarding arrangements in Wales. The UHB will respond and continue to participate in strategic activity aimed at promoting best practice in the field of safeguarding adults.

The Cardiff and Vale Deprivation of Liberty Safeguards (DoLS)/Mental Capacity Act (MCA) Team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff and Vale UHB, City of Cardiff Council and Vale of Glamorgan Council. This is a tripartite agreement undertaking the coordination of DoLS assessments as requested by managing authorities. Other activities undertaken include supervision and workload management of over forty multi-agency Best Interest Assessors, advice and support to health and social care teams across the sector in relation to DoLS/MCA issues and training.

Since the Supreme Court ruling in March 2014 when the legal test for a deprivation of liberty was revised, there has been an unprecedented request for assessments. Hospital settings are deemed to have a higher proportion of urgent authorisations; referrals for this setting are prioritised. However it is acknowledged the increased requests for assessments has impacted greatly upon the workload of the DoLS/MCA team.

Safeguarding children and adults relies on effective interagency working and as such the Safeguarding Team works collaboratively with partner agencies that include the local authority, education and the police, to ensure the best outcomes for children and vulnerable adults.

The Safeguarding Team supports the development of strategic direction and delivery of the agenda through the UHB Safeguarding Steering Group. This is a joint adult and children strategic group which works with Clinical Boards and Corporate functions to provide assurance to the executive lead that the UHB is compliant with statutory and best practice requirements.

The safeguarding agenda is now much wider than child protection and the protection of vulnerable adults: it involves all aspects of safeguarding including for example Child Sexual Exploitation, Neglect, Human Trafficking, Female Genital Mutilation, Domestic Abuse, PREVENT and Deprivation of Liberties Safeguards. The agenda has the ability to impact upon every Clinical Board and team within the UHB. It is recognised that there are many additional pressures facing Clinical Boards and frontline staff, and as such there is a clear need for the Safeguarding Team to support Clinical Boards in meeting their safeguarding responsibilities.

It is important to note that as the scale of the agenda grows so too does the complexity of the cases being handled through both the child protection process and the safeguarding vulnerable adults process. This has, and will continue to result in greater need for safeguarding supervision for staff directly involved in case management, and also the need for timely expert advice and support

As well as supporting and enabling the delivery of robust safeguarding advice, training and related activities to staff, the safeguarding team also plays a key role in providing advice and support to managers and Human Resource personnel in relation to professional abuse matters.

The team also participates in the Wales Safeguarding Children NHS Network which is chaired by the Safeguarding Children Service, Public Health Wales. The Network has issued a new Quality Outcomes Framework (QOF), the outcome of which will, it is expected, shape the children safeguarding activity across NHS Wales. The Safeguarding team has collated the response to the QOF through collaboration with each of the Clinical Boards and relevant corporate teams. It is expected that this process will continue on an annual basis. It is also expected that the QOF will support the UHB completion and submission of Standard 11, Standards for Health in Wales.

2015-2016 will see major changes in legislation within Wales with the introduction of the Social Services and Well-Being (Wales) Act. The Act is to introduce mandatory duties on organisations such as Health with regards to Safeguarding Vulnerable Adults. Introduction of the Act will lead to the necessity for staff training on a wide scale, which will in turn, potentially increase the number of safeguarding referrals relating to adults.

Challenges:

- Operational management of the PPN process (safeguarding communication from the police) is a significant challenge for the team, work is ongoing to ensure the timely management of the information (including risk assessment and categorisation) and dissemination to appropriate UHB staff;
- The current resource within the safeguarding team, in particular the Adult Safeguarding support, is being reviewed in light of the introduction of the Social Services Wellbeing(Wales) Act in 2016, that will place safeguarding vulnerable adults on a statutory footing, along with the growing domestic violence agenda, it is probable that the level of resource will require strengthening;
- The constraints of limited information sharing mechanisms (IT) are challenging and whilst the CJSM system has been adopted as a temporary measure pending provision of a secure portal arrangement, this system is not intended to be used long term, and is not appropriate for use on a wide scale and therefore will be subject to review;
- Welsh Government has recommended that UHB's adopt the 'Intercollegiate Document – Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (ICD) which leads to the necessity to review and update all current safeguarding children training packs that are

delivered by the safeguarding team, to ensure all relevant competences are addressed in line with the ICD; and

- Introduction of the Social Services Wellbeing (Wales) Act and Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Bill will lead to the necessity for staff training on a wide scale, which, potentially could increase the number of adult safeguarding referrals.

The UHB is currently considering the impact of the exponential rise in the number of DoLS referrals to ensure compliance with statutory timescales within the DoLS process.



SECTION

Offer services that deliver the quality our population is entitled to expect

Join up what we do for the people we serve and strive for operational excellence so we make the best use of the resources we have

Chapters

- Service Change Plans
- Finance
- Governing the UHB

6. Service Change Plans

6.1 Introduction

An important part of the exercise in developing our clinical service plans for 2015-16 has been reflecting on the experiences of the last 12 months to understand why some of our proposals for 2014-15 have worked well and why others have not delivered against our expectations.

In developing our local service priorities for 2015/16 – 2017/18 the UHB has reflected the following drivers for change:

1. Our population's diverse and changing needs – we are continuously engaging and involving our local and wider communities and stakeholders in an ongoing conversation to help shape our plans for meeting current and future need.
2. Local service pressures and challenges arising from local health needs and intelligence, as well as from joint working and plans with our partner organisations.
3. National priorities – working towards implementing Welsh Government's policy requirements and priorities.
4. Regional change - we will work across one or more Local Health Boards/Trusts to develop and deliver different models of care; most notably in response to the South Wales Programme outcomes and the further programme of work being progressed through the South Wales Collaborative.

Chapter 4 provides a high level analysis of the demography and needs of our local communities and it is therefore not repeated in this section, other than to reinforce the four key themes which underpin the commissioning, planning, delivery and improvement focus of the UHB's activities. These are:

- Our population is increasing rapidly in size and this is putting extra pressure on our whole system;
- Our population profile is changing – we have more elderly patients living longer with one or more chronic condition and, in Cardiff we have a higher proportion of young people due to the 64,000 students and significantly higher than national average increases in 5-16 year olds;
- Unhealthy behaviours are endemic in terms of diet, alcohol consumption, obesity and fitness; and
- There are stark inequalities in health outcomes for our resident population.

As noted in chapter 3, the detailed clinical services strategy is being developed following an extensive engagement exercise involving our service users, partners and clinicians. This process has produced a clear strategic framework that provides the context for the UHB's approach to both the commissioning and provision of services. The organisation will focus on the development of clinical service strategies in the service areas that were prioritised through this process and each is currently being developed using a 'whole pathway' approach i.e. each strategy for each service area will identify objectives, outcomes and measures for each stage of the pathway which will comprise prevention, unplanned care, planned care and end of life care (as appropriate).

The plans for service improvements and developments to meet the needs of our local and catchment population are framed within 2 distinct categories:

- Level 1: those priorities that we intend to progress in the context of the current financial allocation – recognising that there will still be a shortfall between our projected expenditure and the current allocation for 2015-16. It is also recognised that these developments will not provide the requisite capacity in some key areas of service provision in 2015-16 to achieve tier 1 targets. These priorities will enable the UHB to continue to maintain waiting times for treatment to under a year and maintain its improved position on performance against both the cancer and stroke targets as well as improve on current performance against the 4 & 12 hours targets; and
- Level 2: those priorities that would enable the organisation to best address local need to manage and meet projected demand with appropriate capacity across all services in primary, community and acute care services to meet tier 1 targets in 2015-16. It is recognised that, at this stage, additional investment would be required to secure this level of service performance.

Our intention will be to continue to work on improving the deployment of our resources to optimise performance and deliver the best financial position possible by 2018. Some of this will continue to be incremental, continuous improvement but it is clear that radical service redesign and restructuring is necessary to meet a continuing growth in the volume and range of health care needs within the projected financial envelope. This will only be achievable through a combination of optimal service efficiency and productivity alongside significant structural service redesign and disinvestment in less cost effective services. This translates into three levels of service redesign and cost reduction:

- Prudent operational service delivery and achievement of cost savings delivered an embedded culture of continuous improvement – ongoing;
- Leaner and Fitter Programme – targeting projects that will be driven at corporate level and embedded across clinical boards – this is being refreshed and retargeted to deliver through the corporately driven programme; and
- A review of substantial, radical service redesign, and/or service structural disinvestment options to identify opportunities to take out cost across the whole system. This plan does not describe at this stage what this will look like but the process for taking this radical, whole system action is being developed for the Board’s consideration before wider engagement and potential consultation during 2015-16.

To optimise the UHB’s plan for 2015-16, significant planning and analysis has been undertaken to model and quantify the likely demand and capacity requirements across the unscheduled and planned care pathways and our plans include assumptions on the delivery of challenging performance improvements that will deliver significant demand management, productivity, efficiency and cash-releasing gains. These are factored in to the underpinning clinical board delivery and service redesign plans that underpin the descriptions in this document.

This chapter outlines the priorities for the services that the UHB plans to commission and deliver in 2015-16 and these are outlined as follows:

- Primary and Community Care including Integrated Health & Social Care;
- Unscheduled Care;
- Planned Care;
- Cancer Care;
- Stroke Care;
- Long Term Conditions – focus on Diabetes;
- Dementia Care;
- Mental Health Care;
- CAMHS;
- Children and Younger People;
- Maternity Care; and
- Specialised Services

These service areas are outlined below in terms of context, performance and priorities for 2015-18 with focus on delivery in 2015-16.



6.2 Primary Care and Community Care

6.2.1 Context

National Strategic Context

Primary care provides the first point of care for over 90% of contact with the NHS with over 19 million contacts within primary care every year (for a population of three million) and 76 million prescription items dispensed in primary care. For Cardiff & Vale (population c475,000) this means 1.8 million GP appointments per year (excluding nursing/Health Care Assistants contacts) and 9,969,401 prescription items dispensed between 1st November 2013 and 31st October 2014.

In 2014, the Welsh Government issued 'Our plan for a primary care service for Wales up to March 2018' (WG, 2014). This reinforced the Ministers stated aim that 'this is the year of Primary Care' and the Welsh Governments commitment to ensuring primary care (in its widest sense) is a central focus within the whole system. The plan builds upon 'Setting the Direction' and 'Delivering Local Healthcare', emphasising prudent healthcare, local planning and delivery, workforce redesign and co-production. The Primary Care Plan is new in 2014/15 and has been pivotal to refreshing the planning of the Primary, Community & Intermediate Care Clinical Board for 2015/16 and beyond. The strategic drivers as set out in previous plans remain constant. Notably, these include:

- Improving health and reducing health inequalities;
- Proactive and robust primary care; and
- Realising the integrated system potential (both across primary and secondary care and further integration across health and social care).

The aim is to move to a "social" model of health, which promotes physical, mental and social wellbeing, rather than just the absence of ill health and draws in all relevant organisations service and people to ensure the root causes of poor health are addressed.

To support the transition to a more social model of health, the WG is bringing forward legislation to support better health and wellbeing. This includes the Social Service and Wellbeing (Wales) Act; the Wellbeing of Future Generations Bill; and the Public Health Bill.

The role of all of primary care is reinforced together with the co-ordinating role of access for people to the wide range of services in the local community to help their health and wellbeing needs. These include a wide range of staff – community and district nurses, midwives, health visitors, mental health team, health promotion teams, physiotherapists, occupational therapists, podiatrists, pharmacists, phlebotomists, paramedics, social services, other LA staff, third sector staff, dentists and optometrists.

Local Strategic Context

The national context reinforces the local direction of travel for primary and community care in Cardiff and Vale. The stated aim of the Primary, Community and Intermediate Care Clinical Board is as follows:

"To maximise the health and well-being of residents in the Clusters, ensuring that any requirements or interventions are undertaken by the most appropriate person in the right place in a timely manner."

From the patients' perspective, this is primary care as the first point of contact for health and wellbeing services with services delivered as close to home as possible. This continuum of care starts with people taking responsibility for their own health and well-being, then consideration of access to services at a local primary care level, through to Cluster level then Locality level to Cardiff and Vale wide and accessing services on a District General Hospital site.

Based upon the needs assessment and local challenges identified, and within the context that Primary and Community Services in Cardiff and Vale benchmark low in terms of cost/spend, there are a number of service issues to be addressed and/or areas to develop. Generally, it can be summarised that the needs assessment indicating the increasing elderly population and the capital city challenges combined with the reinforced

direction of travel to manage more patients in the community, results in the requirement for primary and community services to become central to the delivery of services to the UHB local population.

In the development of the IMTP for 2014/15 and 2015/16, a number of development sessions have been held to work through the vision for primary and community services in Cardiff and the Vale of Glamorgan. These sessions included public health, primary & community services, other Clinical Boards, corporate services and social services colleagues. These discussions have informed the plans for primary and community services outlined in this section but also there is further reach into the planned care and unscheduled care sections (see 6.3 & 6.4 to follow.)

Our Community Directors (Cluster Leads) set out a 'future state' to which they aspire, and the clusters provide a powerful vehicle to achieve this. This is summarised as follows:

Increased influence in commissioning/planning

- Primary care having a bigger role in influencing commissioning within the UHB;
- Ability to address/influence clear service gaps;
- Give practices the ability to shape service delivery in other settings;
- Agreement from across the health system to shift resources from secondary care to primary care settings (where this is proved as cost effective); and
- Ability to expand services practices provide i.e. use of Local Enhanced Services (LES).

Joint responsibility for service delivery

- Allow strategic development time for service improvement work for practices and clusters;
- Further develop cluster/community networks;
- Cross border working – decrease inequalities based on where patients live; and
- Co-location and integration of services where practical.

Extend patient advocacy into secondary care

- Develop an improved relationship with other Clinical Boards to allow for greater primary care influence in shaping secondary care services;
- Align cluster to specialities where appropriate. Learn from the implementation of a named consultant/virtual clinic model for diabetes; and
- Better control over patients when they are admitted to hospital.

Greater role of patient/carers (co-production)

- Increased use of Patient Related Experience Measures (PREMs) and Patient Related Outcome Measures (PROMs) in the reporting and evaluation of services;
- Increased patient monitoring and self management – co-production with patients e.g. INR monitoring; and
- Shared decision making.

Practice-based clinical dashboards

- Know when to intervene.

Integrated IT systems

- Improved access to information, improve knowledge management and sharing; and
- Improved information and join up across different health and social care settings.

Continued focus on evidence based practice

- Clinical pathways e.g. Ambulatory Care Sensitive pathways;
- Address variation through a focus on cluster quality improvement;
- Incentive and sanction – allow a system to encourage good behaviour; and
- Focus on reducing waste, harm and variation at a cluster level.

The above aligns well with the WG Primary Care Plan recently published and the cluster plans reinforces key aspirations identified. The cluster plans and subsequent direction of travel is set out later in this section.

Service Context

Primary and Community services in Cardiff & Vale UHB benchmarks as follows:

- Has the lowest spend per capita in Wales on General Medical Services;
- Below the average spend per capita in Wales on the GP Out of Hours (OOH) service;
- Continuing Health Care reported as the lowest in Wales (on Wales Audit Office report);
- Wales Audit Office report shows the UHB as having the third lowest number of district nursing staff available for patients aged 65 and over;
- Palliative Care have less clinical staff than other Health Boards;
- A benchmarking exercise in March 2014 showed the UHB as having the second lowest ratio of nurse assessors to nursing home beds across Wales; and
- Primary care prescribing spend data has been benchmarked with LHBs within Wales and also with Primary Care Trusts (PCTs) in England. Prescribing indicators benchmarking key quality/cost issues are also produced quarterly ranking LHBs, and practices within LHBs. Cardiff and Vale benchmarks well compared to other LHBs in Wales and with PCTs in the north east of England (which is considered demographically similar).

In addition, Wales has,

- More Emergency Medical Admissions/100 000 - but compared with NE England (which the Nuffield Trust argues is the true comparator) does much better; and
- less GPs per capita than all other UK countries - GPs that see more patients/ week than all the other UK countries (25/week more than the lowest)

Recognising the increasing population with the demographic and morbidity challenges outlined, together with the expectation that more patients are cared for in primary and community services, pressures are being experienced in the following services with service plans to address these pressures included later in this document. Of note are:

- Asylum Seeker Services – recent unprecedented levels arriving in Cardiff have placed significant pressures on a small service, with public health risks and concerns regarding destabilisation of GMS;
- Community Resource Teams – increasing demand due to population increases, complexity of case mix and the reduction in hospital beds;
- Primary Care OOHs – capacity gap identified to deliver a safe and response service;
- Sexual Health – specifically access but service requires full review to ensure safe and sustainable services; and
- District Nursing Services – increasing population and complexity leading to pressures on the service.

These pressures should also be considered within the following context:

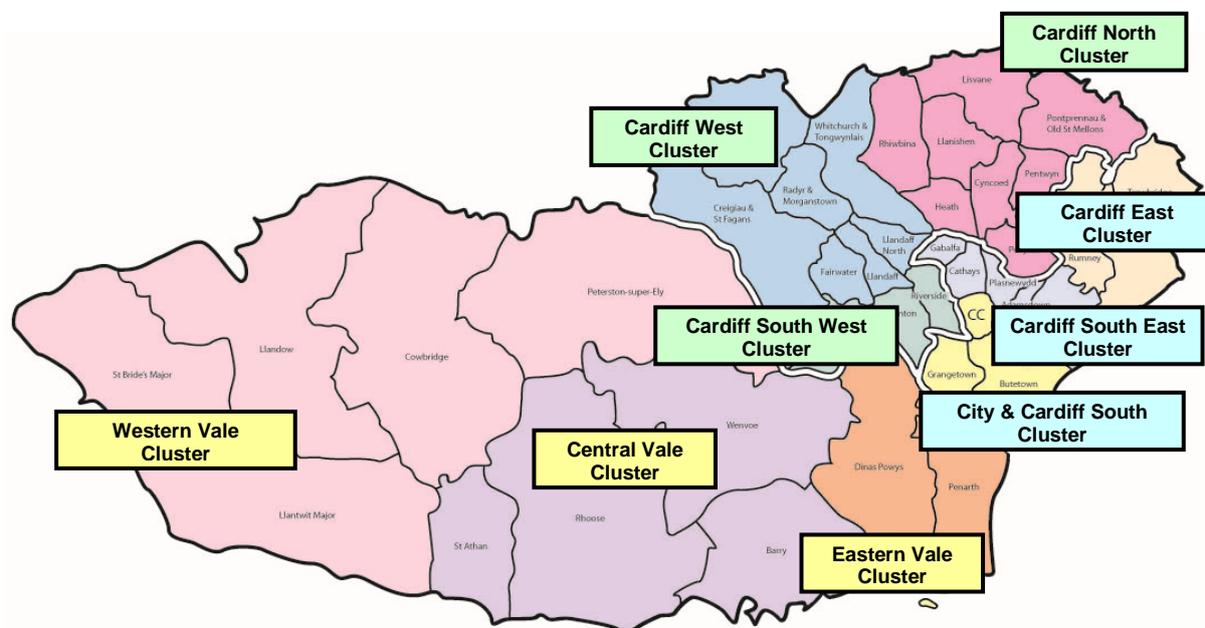
- The population is growing rapidly, especially in Cardiff. Between the 2001 and 2011 censuses, the number of people living in Cardiff increased by 13%, more than double the Wales average (5.5%); those aged over 85 years increased by 32% in the last 10 years;
- Over 100 languages and dialects are spoken in Cardiff; the most common of these are Urdu, Somali, Polish and Arabic; and
- Both Cardiff and Vale of Glamorgan Local Authorities predict a required housing growth within their Local Development Plans (LDPs) to respond to the population increase. The Cardiff LDP details plans for the development of 41,100 homes within Cardiff by 2026; this equates to approximately 94,530 residents, with estimates that 38% will be completely new to the city. Large strategic housing developments (4500+ homes) are proposed in the north east and north west of Cardiff together with smaller but substantial developments. The LDP for the Vale of Glamorgan is less advanced in terms of its development with proposals contained in the deposit plan for an additional 7,800 homes equating to 18,000 residents.

Whilst desktop exercises have indicated sufficient GP capacity within the Vale, overall in Cardiff additional GP capacity will be required to effectively manage the increase in population. There will also be an impact on

community and secondary care provision that is yet to be quantified. As a broad calculation based on one of the development sites (NW Cardiff 5,970 houses – 13,731 residents), financial modelling suggests that the UHB will require a pro rata increase in annual revenue funding in the region of £6m - £8m for the 5,218 residents new to Cardiff.

6.2.2 Primary & Community Services to date

Primary and Community Care Services are organised into nine clusters or neighbourhoods, with a cluster lead GP lead for each. These are aligned into three localities (three clusters to each locality) which have a supporting management structure including a lead locality GP. This is illustrated below.



Clusters provide an easily recognisable level of aggregation of practices. At this level, the pathways flowing across primary and secondary care can be readily reviewed to ensure the UHB is maximising quality and productivity and decreasing variation. To date, the UHBs focus has been to 'maximise the Neighbourhood/cluster potential' through working with key partners to ensure that the issues specific to the population of the cluster are identified and actions agreed in partnership.

Achievements to date include:

- Establishment of an integrated health and social care model in the Vale Locality;
- Cardiff West cluster has led on the establishment of a dementia café with partners;
- Cardiff South West cluster is leading on the use of technology within practices to promote public health and community health messages in patient waiting areas;
- Cardiff South East Cluster – Smoking Cessation, one practice trialled a new approach to Smoking Cessation which saw an increased number of patients referred to the scheme. This was shared with the other practices in the Cluster who have subsequently adopted this methodology;
- Cardiff City and South Cluster – targeted action to certain communities recognising the cultural and language barriers to ensure increased uptake of national screening programmes for bowel and cervical screening;
- Eastern Vale Cluster is piloting a telehealth approach;
- Western Vale Cluster is working across Health Board boundaries to improve patient pathways;
- Central Vale Cluster led on development of Customer Care Contact Centre with Local Authority and Third Sector partners; and
- Cluster working to establish inter-practice referrals for Long Acting Reversible Contraception (LARC).

From a health perspective, the above partnership work has been reinforced by a clear drive to reduce harm, variation and waste at all levels. Focused interventions have included:

- High Cost Practice Prescribing - build on the initial work undertaken to ensure that those practices identified as outliers within the cluster have their adverse variance reduced;
- Laboratory Testing - review the cluster data on haematology and biochemistry testing and reduce the variance (certain practices are more than 25% off the average) by clinical discussions and pathway development);
- QOF Quality and Productivity – support the review process with practices for outpatient routine referrals, emergency admissions and A&E attendances and as such:
 - Facilitate peer review meetings comparing individual practice data with comparable data from neighbouring practices for outpatient referrals, emergency admissions and A&E attendances;
 - Support practices to follow three outpatient routine referrals pathways and three emergency admission pathways and the production of a meaningful improvement plans for A&E attendances; and
 - Support the development of performance measures for routine referral pathways, emergency admission pathways and A&E improvement plans.

Collaboration also takes place on a wider level (at Locality or Cardiff & Vale wide). Notable examples are:

- CRT developments undertaken in parallel with both Vale of Glamorgan and Cardiff Social Services Departments and the Third Sector.
- WAST, Social Care, General Practice, Out of Hours and A&E working together to introduce scheduling of conveyances, develop 'see and treat' protocols for APPs and reduce nursing home admissions.
- Continuing NHS Healthcare plans developed in close collaboration with Social Care and other Clinical Boards with a view to progressing towards an integrated approach to the provision of long term care in the community.
- The UHB is working with the Independent Sector to undertake a consultative approach to the commissioning of long term care in care homes. Also, in 2014/15, a winter planning forum was established with nursing homes in order to ensure the community was prepared. This winter saw a formal commissioning of winter pressure capacity within nursing homes in Cardiff.

Some clear outcomes of maximising the potential of the integrated system are as follows:

- Clinicians from primary and secondary care collaborated on the development and implementation of QP pathways targeting the evidence based Ambulatory Care Sensitive Pathways that resulted in:
 - Clinical pathways targeting the evidence based Ambulatory Care Sensitive Pathways resulted in a reduction of 5,147 bed days equating to 14 beds; and
 - A reduction in bed days for AF by 22%, CHF by 21% and COPD by 32% accounting for a reduction in 3,054 bed days following the implementation of the pathways.
- Nursing Homes - admission rates from Nursing Homes across clusters lower in the first three quarters in 2014/15 than the same quarters in 2013/14. Lowest number of bed days following admission from Nursing Homes than at any point in the last three years (equivalent to reduction of 5 beds);
- Continuing Health Care - early intervention hospital bundles has seen an impact in terms of the number of CHC patients. When spread evenly across the year, would have prevented (at average costs) the decline of 45 patients to CHC equivalent to the reduction of 5 beds;
- Vale Integrated Health, Social Care and Third Sector model – the development of the Vale Customer Contact Centre has led to a significant reduction in response times for Social Care assessments. For standard referrals this is a reduction of over 75%. For priority referrals a reduction of 50%. Also, district Nursing call volumes (Aug – Dec 14) were lower than the same period the previous year by an average of 94 per week;
- Evidence of improved response times to support hospital discharges via Cardiff CRT; and
- Medicines management whole system pathways defined for COPD, asthma, diabetes management, over-active bladder and pain leading to improved performance on All Wales prescribing indicators, increased formulary compliance and improved quality, reduced duplication/waste across

primary/secondary care interface. An example to illustrate the impact of this is the work on respiratory inhalers on admission reduction. The following graphs demonstrate the impact of this.

Figure 10. COPD-related HRG episodes per 1,000 population against high-dose ICS prescribing

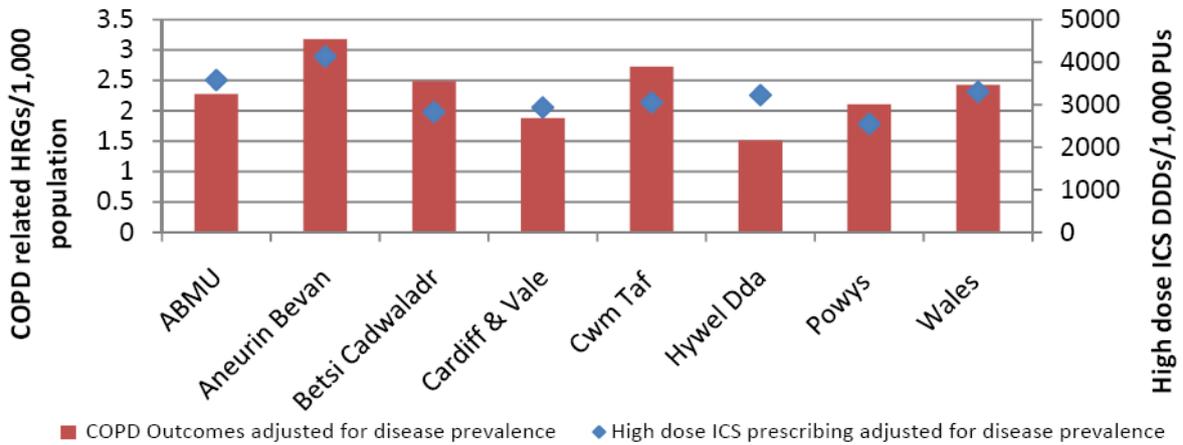
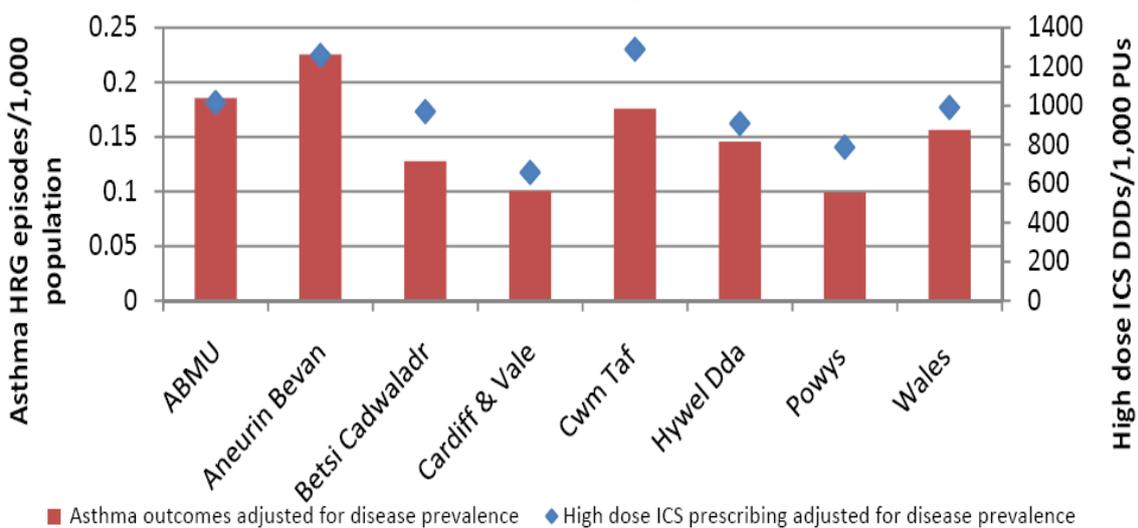


Figure 11. Asthma-related HRG episodes per 1,000 population against high-dose ICS prescribing



This list of achievements includes only the headlines from a programme of service improvements that have been driven forward through wide engagement, careful and inclusive organisation and dedication from the primary and community services teams and partners. Driver diagrams outlining these in more detail are included later.

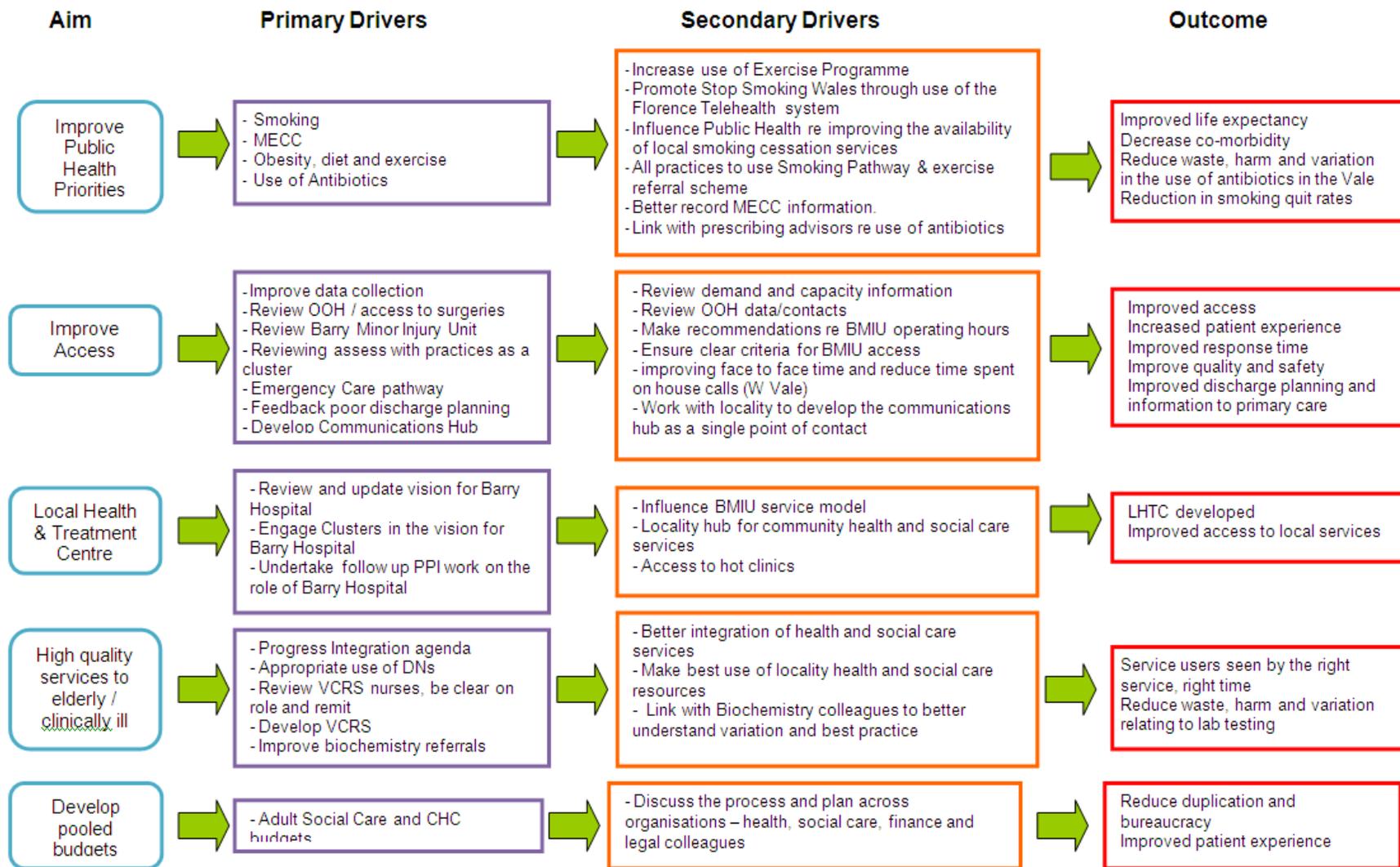
6.2.3 Primary and Community Priorities

The progress to date provides a solid foundation on which to develop primary and community alongside key partners. The Cluster Plans have enabled the UHB to bring primary care central to planning and developing services for the future. Following multi-disciplinary development sessions to consider the clusters by Locality,

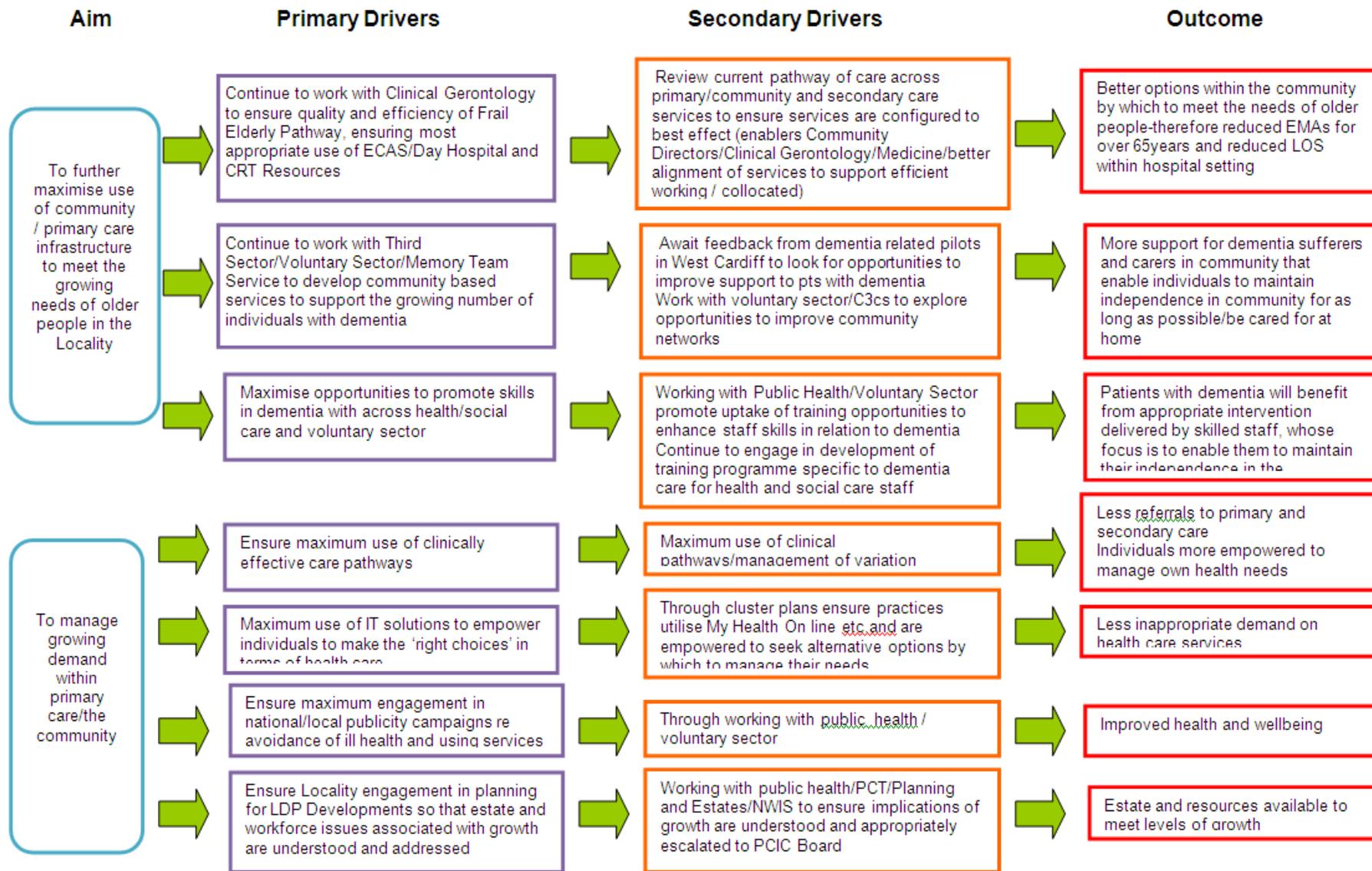
the driver diagrams were developed which identifies the issues specific to the Clusters population and the actions required in order to provide measurable outcomes. These are included overpage for:

- Vale Clusters – Western Vale, Central Vale & Eastern Vale;
- North West Cardiff Clusters – North West, West and South West; and
- South East Cardiff Clusters – City & South, South East and East.

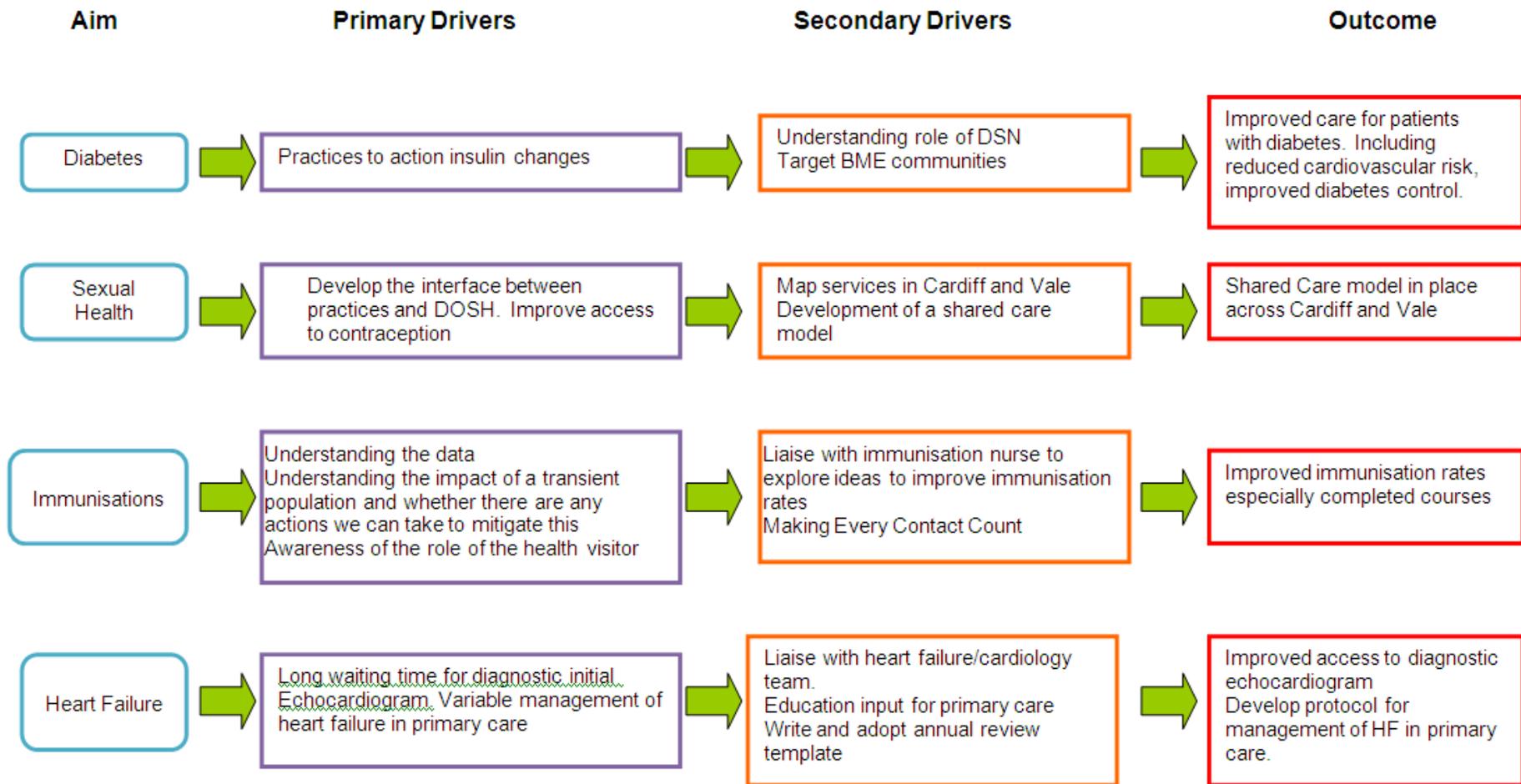
Vale Cluster Plans Top Priorities



North West Cardiff Cluster Plans Top Priorities



South East Cardiff Cluster Plans Top Priorities



It can be seen that some of the issues identified by the Cluster plans are specific to that population. These issues will be driven forward by the clusters and the partners they work with. For the actions that require funding, these are being prioritised by the Clusters and will be considered as part of the Welsh Government cluster funding.

It has emerged that some issues are common across the clusters and can be aggregated to a Cardiff and Vale wide level. This has informed the wider UHB planning for local population. Taking these issues together with the learning from key achievements to date within primary and community care services, the table identifies the priorities for service development that have emerged in the event of additional funding being secured through successful bidding against Welsh Government's allocation of £80m for primary care in 2015-16.

Priorities for service development in the event of additional funding being secured

Learning from current practice	Planned development	Outcomes
<p>There is evidence to support the 1000 Lives/ Improvement methodology theory that incentivisation to improve quality-critical, process of care interventions for key ambulatory care sensitive (ACS) conditions is associated with a decrease in emergency admissions (BMJ 2014;349:g6423) of minus 10%; compared with an increase of 39% for none-incentivised ACSs and an increase of 41% for none-ACS conditions. Locally, eight ACS pathways were developed, agreed and implemented as part of the QOF QP pathways indicators. Initial data suggests implementation of QP pathways in Cardiff and Vale facilitated an overall reduction in bed days by 3,054 (2012-2014) with significant reductions in key ACS areas studied:</p> <ul style="list-style-type: none"> • COPD by 32%; • AF by 22%; and • HF by 21%. 	<p>This proposal seeks to secure funding to re-incentivise adoption of agreed ACS pathways and to expand the pathways in order to address King's Fund evidence that, as well as long term conditions and End of Life, key ACSs also include vaccine-preventable and paediatric (age under 5) acute illnesses. The range of pathways to be considered within the scheme include:</p> <ul style="list-style-type: none"> • Diabetes; • Advanced Care Planning; • Atrial Fibrillation; • COPD; • Heart Failure; • Dehydration and Gastroenteritis in under 5s; • Uptake of Pneumovax and influenza vaccine (At Risk Groups with highest risk of admission/ harm); and • Poly Pharmacy related to Falls. <p>We will aim to produce generic IT templates for Practices in order to minimise time/maximise quality of notes.</p> <p>For immediate implementation in 2015/16 subject to investment agreed to incentivise. Evaluation would commence after 12 months. Building upon the learning of 12 months, the portfolio of pathways would be reviewed in 2016/17 and extended if this was indicated by the learning. A full evaluation would occur every 12 months with a six month monitoring position.</p>	<p>Shift activity out of hospital. As early work indicates, the impact can be measured via a reduction in outpatient appointments and emergency attendances/ bed days.</p> <p>Benchmarking data on acute LOS indicates that a number of these conditions should be targeted for improved pathway management.</p> <p>GP MDT access will be increased via time released/ use of IT templates.</p> <p>Process measures can be assessed via limited use of READ codes (within the IT templates).</p> <p>The additional pathways can be measured through these indicators plus vaccination rates and reduction in waste.</p>

Learning from current practice	Planned development	Outcomes
<p>The Community Resource Team (CRT) model has been successful in both providing an integrated service to support reablement and rehabilitation for people discharged from hospital but also in preventing admission.</p> <p>The GP as the clinical lead, roots the CRT in primary and community care with support from clinical gerontology. This has proved to work well and reinforces the 'social' model of care and switches from a secondary lens to a primary lens.</p>	<p>Whilst the CRT model provides an appropriate level of care to the majority of patients, there are four areas that require further development:</p> <ul style="list-style-type: none"> • Increase in capacity in order to ensure the service is as responsive as possible. This requires increasing current staffing levels over the five day period (2015/16) but also moving to a six and a seven day service thereafter; • The needs of high acuity patients in the community merits further consideration. An extended CRT model (CRT+) could support these patients through a variety of measures to maintain these individuals in their usual place of residence and maximise their health, wellbeing and independence. Of note, this would include a 'wrap-around' MDT service to care homes; • Extension of the CRT to support specific pathways such as orthopaedic and trauma pathways, stroke and respiratory; and • Risk stratification and case management, specifically looking at roles that have been developed elsewhere such as Community Health Officers, Community Wellbeing Officers or Health & Wellbeing Co-ordinators. <p>There would a lead-in time to establishing the above, therefore if funding agreed then 2015/16 would see the start of the implementation of this extended CRT model. From 2016/17 onwards the model would be under continual review (as part of a PDSA cycle) to ensure that the service model (and how it aligns with other developments) meets the needs of the patient in the best way.</p>	<p>Improved GMS access by time released in supporting management of frail, complex patients.</p> <p>Reduction in hospital ALOS and emergency attendances/ admissions.</p> <p>Direct diversion from A&E/EU.</p> <p>Reduced OPD utilisation.</p> <p>Reduced institutionalisation/ discharge to usual place of residence.</p> <p>Shift emphasis of care to 'out of hospital'.</p> <p>Shift in balance from care home to home care provision.</p>
<p>Development of the community based 'Acute Response Team' to shift from acute to community has led to:</p> <ul style="list-style-type: none"> • Monitoring and management for <u>All</u> 'stable' INR within primary care; 	<p>Extend this service to support other pathways in the community. The further development of this service would be considered alongside the CRT plus development to ensure right service, time, and place.</p>	<p>Shift activity out of hospital.</p> <p>Reduction in bed days - earlier discharge.</p>



Learning from current practice	Planned development	Outcomes
<ul style="list-style-type: none"> Initiation/ management of slow loading Warfarin initiation within a primary care setting; Inter-practice agreements within clusters to manage <u>All</u> patients in both groups within a primary care setting; Step up advice via specialist/ Acute Response Team; and Step down/ peri-operative management via ART <p>With the following impact:</p> <ul style="list-style-type: none"> Closure of 1 INR hospital based clinic, 2nd minimal activity & planned to close in April 2015; Reduction in bed days - earlier discharge; and Partial funding transfer Secondary to Primary Care. 	<p>Early 2015/16 would see the learning from the implementation of the INR pathway and the scope of other potential pathways. A schedule of implementation would be agreed for 2015/16 and 2016/17, followed by a review of existing pathways and the proposed schedule for 2017/18.</p>	<p>Reduction in outpatients (potential closure of hospital clinics).</p> <p>Improved GMS access by time released in supporting management of acutely unwell/ unstable/ complex patients.</p> <p>Patients treated closer to home.</p>
<p>Vale Integrated Health, Social Care and Third Sector model – the development of the Vale Customer Contact Centre (funded via the ICF) re-engineered the referral process so that all Vale Community Resource Service referrals including therapy, home care, nursing and third sector are routed through a single point of contact. This has led to a significant reduction in response times for Social Care assessments. For standard referrals this is a reduction of over 75%. For priority referrals a reduction of 50%. Also, District Nursing call volumes (Aug – Dec 14) were lower than the same period the previous year by an average of 94 per week.</p>	<p>Continue to progress the Vale model and work with Cardiff Social Services to develop this model for Cardiff and Vale.</p> <p>Scope potential to ensure Telecare is considered for all reablement care.</p>	<p>Improved GMS access by time released in facilitating more rapid access to community health & social care services.</p> <p>Reduction in response times for Social Care assessments.</p> <p>Reduction in District Nursing call volumes.</p> <p>Released District Nursing time (eg equipment ordering).</p> <p>Improved management of deceased patients resulting in reduced numbers of deliveries of continence products.</p>
<p>The Community Diabetes Service Model has seen a real shift from acute to community care for diabetes. The following is in place:</p> <ul style="list-style-type: none"> Named Consultant allocated to each GP practice; 	<p>To maintain and expand this service model to all clusters; and use this service model as a template for other chronic conditions management to shift care from hospital to community.</p>	<p>Reduction in outpatient appointments.</p>



Learning from current practice	Planned development	Outcomes
<ul style="list-style-type: none"> • Rapid response e-mail support to practices; and • Prescribing visits (pharmacy, GP CD); variance reporting. <p>With the following impact:</p> <ul style="list-style-type: none"> • Integrated management pathways for diabetes care; • Access - confident care closer to home; • Education/ satisfaction: improved skills, confidence & satisfaction in management (T1 & T2) DM; and • Waste reduction <ul style="list-style-type: none"> ○ 30% reduction in OPD referrals; ○ No WL for new DM patients; ○ Reduced referrals for process measures; ○ Reduced referrals for Rx complications; ○ ^ Type 1 DM patient 'retrieval'; and ○ Primary Care drug budget movement. 		<p>Reduction in unplanned admissions/ attendances</p> <p>Improved efficiency. Reduction in harm, variation and waste (disease processes and prescribing).</p> <p>Increased access & care closer to home.</p> <p>Up-skilling of Cluster clinicians reducing time spent in seeking specialist advice/ interventions.</p> <p>Increased insight into GMS/ community services for hospital clinicians.</p>
<p>Medicines management:</p> <ul style="list-style-type: none"> • For the first time in Wales, active management of the negative effects of outlier secondary care prescribing on primary care clinical pathway/ prescribing variance; • Whole system pathways defined for COPD, asthma, diabetes management, over-active bladder and pain leading to improved performance on All Wales prescribing indicators, increased formulary compliance and improved quality, reduced duplication/waste across primary/secondary care interface; and • The “top 10 practices by cost” work has demonstrated that when increased dedicated prescribing advisor time is given to practices the level of trust and engagement increases and the advisor is able to influence more issues outside of the specific issue they are there to progress e.g. requests to prescribe 	<p>Increased dedicated prescribing advisor time in practice to include:</p> <ul style="list-style-type: none"> • Medication review of patients on polypharmacy focusing on medicines known to be associated with admission to secondary care. As part of this a practice’s care home patients could be included in this review as potential for inappropriate polypharmacy in this population is large – this is likely to result in significant cost savings and avoidance of harm; • Support of the practice in reviewing repeat prescribing processes to ensure that they are safe and reduce waste. Welsh Government estimated the cost of wasted drugs for Wales is £50M per year (included in the Wales Audit Office report on primary care prescribing) The York Health Economics Consortium estimate that between 30% and 50% is avoidable; • Pharmacy expertise aligned to CRTs to provide specific support 	<p>Reduction in harm, variation and waste e.g. polypharmacy.</p> <p>Reduction in falls risk for identified patients/reduced EMAs/mortality.</p> <p>Release of GP’s time/ reduced frustration; including at Primary/Secondary Care interface.</p> <p>Quality improvement & cost reduction in primary care drug budget.</p>



Learning from current practice	Planned development	Outcomes
from secondary care.	<p>to patients at risk of falls/requiring medication management as part of care package;</p> <ul style="list-style-type: none"> • Report back unnecessary prescribing variance initiated/ maintained by secondary care prescribers/ pseudo-prescribers; • Bespoke work in practice on issues specific to that practice; and • Early identification of prescribing interests that may be a future pressure such as new drugs and work can begin to minimise that pressure via pathway work. 	
<p>Promoting Public Health in Practice:</p> <ul style="list-style-type: none"> • All cluster plans reference public health priorities and there may be scope to further embed/support priorities. 	<p>Scope the potential impact of cluster/practice based public health champions who can provide direct support in terms of promoting public health campaigns/educating patients.</p> <p>Underpinning this work with be embedding Making Every Contact Count and reinforcing the 3 As approach (Ask, Advise and Act) across all our staff and extended members of the team (partners) in all interfaces with the population.</p>	<p>Improved health outcomes.</p> <p>Achievement of tier 1 targets.</p>
<p>District Nursing teams have recently been reconfigured in order to align with clusters. Early discussions on the role of community nursing, within the context of all of the above planned changes, further define the requirements of community nursing in the future.</p>	<p>Further discussion is required on the specific requirements for community wound healing, continence services and community phlebotomy in the context of the development of the Acute Response Team (as described above) and the recently reconfigured District Nursing team.</p>	<p>Maximise community infrastructure to support the outcomes listed above.</p>

These investment priorities will be progressed in the event of successful bids against central ring-fenced funding and therefore do not appear in the financial plan; the UHB assume a £0 net impact.



Redesigning services across Cardiff and the Vale of Glamorgan to align with the strategic direction will involve the expansion of capacity and resources in primary care. It will also need to support the creation of new community based models of care which integrate primary and community services with social services and the Third Sector. Work will be required across the health system to ensure that the skills and expertise available within hospital settings are more accessible in primary and community settings where appropriate.

Local Resource Centres (evolved from Local Health and Treatment Centres) will ensure access to services that help maintain health and independent living and working in support of local primary care teams outside of a hospital setting. They will enable the decentralisation of services away from the acute hospital and provide a base for those services that cannot be provided effectively within individual practices. The Local Resource Centre will serve a wider geographical area and population base than practice or cluster level (aggregating three clusters to the Locality level) and provide the critical mass to support the co-ordination and development of services to ensure that the fullest range of specialist, diagnostic and therapeutic services will be available to each locality.

Local Resource Centres will also provide an opportunity to bring together the delivery of health and social services care for a locality into one location. Taken together this will mean an expanded range of out of hospital services will be available more locally to support the network of primary care teams to respond to multiple needs.

The role of these Centres in supporting primary care and community service delivery will be consistent but the services provided may be different depending on the local needs as identified via the Cluster plans. The key benefits of Locality Resource Centres will be seen in the range of services delivered in the community, associated with a change in the patient pathway for a number of conditions and, in some case, needs being addressed by partners other than Health.

Within 2015-18 the Health Board will start to explore with its partners the development of capital infrastructure and funding to support this model of care within:

- Vale of Glamorgan;
- Cardiff South and East; and
- Cardiff North and West.

Of the above, the Vale of Glamorgan has a solid foundation on the Barry Hospital site which the Central Vale Cluster Community Director is championing from a clinical leadership perspective. With services such as the Community Resource Team, Elderly Care Assessment Service, Outpatients and Minor Injuries Unit there is a good foundation on which to develop a Local Resource Centre. The recent investment in x-ray equipment at Barry Hospital has been welcomed by the Vale clusters and the wider community.

Cardiff South and East have the opportunity of the Cardiff Royal Infirmary site to develop a Local Resource Centre and the next phases of the development could reinforce this commitment.

From a Cardiff North and West perspective, the use of the Whitchurch Hospital site is critical to the development of a Local Resource Centre to support the clusters in this area.

In addition to those already identified there are some other key priorities with different drivers:

- Sustaining Fragile Services – where services are under pressure due to increased demand or external factors. Notably, these include Asylum Seeker Service, Core GMS, Primary Care OOHs and Sexual Health; and
- Continuation of plans already in place – as noted in the three year plan (IMTP 2014/15 – 2016/17), a number of developments are already underway and this section identifies progress to date and planned next steps.

Sustaining Fragile Services: Priorities

Asylum Seeker Service

The past twelve months have been challenging for the Asylum Seeker Service with significant staff changes within the specialist team and increasing demand from the patient cohort. Priorities going forward are:

- Implement revised initial assessment service model and support the transition of GMS patients into mainstream practices;
- Implement and monitor an Enhanced Service for Asylum Seekers and Refugees;
- Delivery of services in line with communicable disease outbreaks and immunisation targets;
- Improve data/performance management;
- Develop a clinical competency framework and training opportunities for nursing and medical students;
- Develop a professional support framework and network;
- Contribute towards the development of a FGM pathway in Cardiff/Wales;
- Review and update the Information Governance framework/systems; and
- Contribute towards a vulnerable group 'plan' for Primary, Community and Intermediate Care.

Primary Care Out of Hours

Detailed demand/capacity modelling identified a significant increase in capacity was required to meet demand and deliver against the Carson Standards. The modelling identified a requirement for additional capacity at times of peak demand that often will otherwise default to A&E. Recruitment drives are regularly taking place to encourage more doctors/nurses/dental nurses to join the out of hours service and a full skill mix review has been undertaken and implemented. Governance processes have improved, which includes full written processes for all complaints, incidents and compliments. A staff forum has been set up, which is currently looking at values and behaviours within the workplace. Ongoing priorities include:

- Full implementation of the business case for additional capacity pending approval of investment;
- Recruitment of Advanced Nurse Practitioners (ANP's) to provide increased clinical capacity within the service;
- Pilot Advanced Nurse Practitioners (ANPs) seeing patients face-to-face in primary care centres and undertaking home visits, which will free up GP time in order to manage demand more effectively.;
- Recruit pharmacists to help with patient education with regards to repeat prescribing and the prescription pool during busy periods;
- Develop a plan to ensure delivery against the new standards released by Welsh Government ;
- In line with the new standards, clinicians and non-clinicians will be audited using the Royal College of General Practitioners toolkit with feedback provided; and
- Embedding the agreed 'Staff Charter' reinforcing agreed values and behaviours identified through the Staff Charter behaviours.

Sexual Health

Significant progress has been made since the Department of Sexual Health was transferred to the management of the South and East Locality in June 2013. The main focus of the last twelve months has been on the quality, safety and patient experience as well as improving access to services across the ten sites. The department has worked to a comprehensive action plan and now has robust quality and safety monitoring processes in place. The service has now truly integrated and is under one manager and organisational change has enabled a more flexible approach to providing clinics in CRI and the community. Priorities for the next three years include to:

- Take forward the learning from LIPS and introduce changes to the delivery of some contraception procedures;
- Conclude a full review of community clinics and implement changes to enable the service to maximise the available treatments in each location; and
- Continue reviewing and improve prescribing arrangements.

The focus of these three streams of work is to increase clinic capacity and introduce wider standardisation in community clinics to continue to improve patient safety and enhance the patient experience.

General Medical Services

This has been a challenging year for GMS with significant contract changes implemented in 2014 and key priorities to be achieved. The fragility of GMS services has been evident and within 2014 the primary care team has managed out two formal requests for practice list closure and a subsequent appeal; put in place measures to prevent the dissolution of three large GP practices providing GMS services to circa 28,000 patients and worked to support three large GP practices (23,000 patients) to manage clinical governance concerns maintaining and supporting practices as independent contractors

Areas of further progress include the delivery of a number of estates developments, the introduction of key access indicators used to RAG rate practices, assessing and working to manage variation in consultation rates, opening hours, and activity within the OOH service to provide targeted support and intervention (enabling a 50% reduction in the number of practices reporting a red rating elimination of half day closing and 100% compliance with Tier 1 target). There has also been improved collaborative working with secondary care clinicians resulting in reduced duplication and more patients receiving care closer to home.

Priorities going forward include:

- To fully review and assess the impact of GMS contract changes working in partnership with Locality Teams, Prescribing Teams, Finance, GMS contractors and the Local Medical Committee;
- To implement GMS contract changes and monitor compliance and impact;
- Undertake targeted work at practice and cluster level to consider alternatives to ensure the sustainability of GMS services and provision of care closer to home to include: workforce alternatives, alliance and federation working and cluster based service delivery and integration;
- Further targeted work to improve access to core GMS to include an access working group (with representation from GMS practices, OOH, EU and WAST), targeted practice development visits and service development via the Primary Care Foundation access work;
- To identify primary care infrastructure and service requirements as a result of the Local Development Plan and proposed population growth;
- To continue to work closely with Local Authorities through the Local Development Plan process ensuring that the primary care health needs of a growing population are met;
- Pursue all potential options to progress the developments identified within our Primary Care estates strategy;
- Maximise patient access to GMS services within core hours across all practices to ensure contractors are providing accessible, flexible and responsive care;
- Continue to monitor GMS budgets and ensure all spend is within allocation – ensuring all stakeholders are providing the most up to date, cost effective and evidence based care for Cardiff and Vale residents;
- Review and act on Post Payment Verification issues, identifying trends and themes relating to contractor claims and treatments; and
- Maintain a database of Welsh speaking GPs and provide details of Welsh speaking GPs on our website. Ensure Welsh Language signage on new primary care premises. Promote Welsh Language through the Practice Managers training sessions and “Iechyd Da!”- An introduction to language awareness in healthcare. Encourage staff to display the “The Working Welsh” (Iaith Gwaith) symbol



Continuation of Plans

Integrating Health and Social Care

The Integrated Health and Social Care (IHSC) Partnership is a progressive and dynamic partnership of the Health Board, City of Cardiff Council, Vale of Glamorgan Council, Cardiff Third Sector Council and Vale Centre for Voluntary Services. Together we are developing an exciting common agenda to improve the health and wellbeing of the population we serve and to find new and better ways of responding to increasing levels of demand for health and social care services.

The IHSC Partnership underpins the evolving relationship between the health and social care elements of our organisations. It seeks to support the integration of operational working practices on the ground, by ensuring the provision of cross-organisational enablers at a strategic level. It provides an agreed governance framework whereby partners can consider joint priorities impacting upon health and social care and agree co-ordinated plans to progress joint objectives for the Cardiff and Vale of Glamorgan population.

Key outcomes for the Partnership can be summarised as follows:

- People in our community:
 - Are involved in shaping future support and care;
 - Know who to contact for support and care;

- Have care and support when/where they need it without duplication, confusion or delay and in a way that prevents avoidable deterioration; and
- Access sustainable support and care, planned and commissioned to meet needs over the next 5 - 10 years.

Over the past year, the Integrated Health and Social Care Partnership has worked to establish an effective governance framework through which partners can work together to enable enhanced integration at a local level for health and social care. This coming year will see the establishment of a delivery framework to ensure the achievement of our identified outcomes. It will also facilitate the development and instigation of an agreed model for health and social care that is grounded upon the tenets of the various legislative and policy guidance described above. This overall plan will be dovetailed with operational plans for implementation, securing that work with long term funding wherever possible. Our focus on intermediate and community services to provide services closer to home will be paramount, understanding that this will have a beneficial impact upon wider planned and unscheduled patient flows through the Health Board. Within this, we will seek to focus upon community needs at a locality level, constantly seeking to place the individual at the centre of care and support.

In the last year, the Partnership oversaw the delivery of a wide array of community-focused initiatives funded by the Intermediate Care Fund and the Regional Collaboration Fund. The majority of these schemes have been invaluable in supporting vulnerable people in our community to keep them safe and well at home or their place of residence.

Critical integrated schemes that have been prioritised by the Partnership to be maintained and/or enhanced for 2015-16 pending successful early review in quarter 1 include:

- Development of single point of access for citizens and health and social care professionals (building on the good work already started with the Customer Contact Centre in the Vale of Glamorgan);
- Accommodation Solutions/Resettlement services – co-ordinating and provision (in some services) of the various professional/agency inputs required to provide appropriate accommodation to fast track discharge from hospital and reduce admissions;
- Community Resource Team Plus: provision of support by a multi-disciplinary team through step down facilities leading to active recovery and reablement; and
- Prevention/Intervention services – building on the Gateway service to address:
 - Income maximisation to improve well-being;
 - Prevention of social isolation through the provision of day opportunities;
 - Prevention of slips, trips and falls; and
 - Improved use of assistive technology.

There is a range of further schemes that the Partnership will review for continuation or redesign in 2015-16 pending review of performance in 2014-15 – some of these schemes have yet to report conclusive outcomes data.

Integrated Health and Social Care in the Vale

The Vale Locality Integration Project commenced in April 2014. The project aims to deliver the ambitious vision for a new and integrated approach to providing care in the community. It sets out a model where traditional boundaries and interfaces are eroded making the service much more accessible and responsive to our vulnerable population. Additional resources are currently being used for a time limited period through Welsh Government funding. This has enabled the development of the Customer Contact Centre that is already providing improved redirection and coordination of care across the health and social care system. This is however very much the beginning.

Future work streams are also required to ensure that the new services operate within a coherent whole. These work streams include:

- Developing the case for the use of a pooled budget;
- Implementation of the new assessment framework for older people;
- Development of a joint ICT solution through the implementation of the national Community Information System which support integrated working;
- Telecare/ Telehealth;
- Transforming District Nursing modernisation programme; and

- Organisational Development Programme to support and develop staff.

Aligning Health and Social Care in Cardiff CRTs

Following co-location of Cardiff Councils Reablement Service (START) and with the Cardiff CRTs, the priorities for next year are as follows:

- Organisational Development Programme to support and develop staff;
- Revision of Operational Policy reflecting priorities of both organisations and new service models within Medicine Clinical Board and ICF (e.g. Discharge Team/Independent Living);
- Evaluation of revised management arrangements for the Cardiff CRTs (health and social services);
- Continue with Organisational Development programme to support education and training of staff;
- Complete PARIS/WCCG developments to enable electronic referral to the service; and
- Progress actions associated with CSI review.

More strategically for 2015-18, a key focus will be the development of the CRT plus model and the customer contact centre as detailed previously.

Continuing Health Care

Maintain focus on those areas that have demonstrated success over the last two years, this includes:

- Good Governance for Assessment and Decision Making;
- Best use of CHC/FNC staffing resources;
- Commissioning and Securing Best Value in Packages of Care;
- Use of core services;
- Implementation of Sustainability Policy; and
- Review of CHC clients.

Priorities include:

- The use of the database will be enhanced with developments to undertake more clinical management through information that can be sourced from the database;
- The implementation of the revised Welsh Government Framework for Continuing NHS Healthcare commenced in October 2014 the impact of which will be monitored so that going into 2015-16 there can be a robust and evidenced estimate of CHC growth;
- Initiate multi-clinical board project to prevent decline and ultimately reduce demand from individuals requiring continuing NHS healthcare;
- Identifying the impact of the risk associated with the new framework of more patients with a Learning Disability who become eligible as a result of a change to the assessment of particular domains;
- Through the Closer to Home programme continue work with Cardiff and the Vale of Glamorgan Local Authorities to commission care locally for people with learning disability who have long term care needs; and
- The intention is that contracts will be in place for 1st April 2015 with agreed Continuing Health Care rates, inflationary mechanisms and a renewed approach to quality and safety through the service specification and the use of the Fundamentals of Care audit.

End of Life Care (EOL)

The UHB Palliative Care Delivery Group has implemented the Welsh Government End of Life Delivery Plan.

During 2015-16 there will be the opportunity to consider how to improve the quality of care that is provided to individuals in their own homes/usual place of residence with support from primary care professionals. This will be enabled by:

- Developing strong links of the newly appointed Macmillan GP facilitators with our Community Directors;
- Roll out of the Palliative Care module to Nursing Home matrons; and
- Integrated pathway End of Life plans across secondary care services.

Also, during 2015-16 the funding for hospices is likely to transfer from Welsh Government to Local Health Boards. This will provide the opportunity to review service level agreements and enter into a more robust partnership with hospice providers in Cardiff and Vale of Glamorgan.

As part of the work of Shaping Our Future Wellbeing, the End of Life Plan will be reviewed within a longer term context. From this, the current Delivery Plan will be refreshed to ensure alignment of actions in the short, medium and long term.

District Nursing Service

Significant progress has been made during 2014-15 in implementation of the work programme “Transforming District Nursing” which will continue into 2015-16. Following a process of staff engagement on the way forward for District Nursing, a model informed by staff views was consulted upon and the associated changes implemented. This involved significant change for staff as a new leadership model was required to manage larger teams with an improved focus on case management and GP liaison and a different treatment room model. The transformation programme has already had a positive impact. Initial indications from the Wales Audit Office (WAO) report on District Nursing provides evidence of increasing patient facing time by District Nurses, from 35% (Ernst & Young 2013) to 42% (WAO 2015) with an associated reduction in travel time from an average of 22% (Ernst & Young 2013) to 18% (WAO 2015).

One of the aims of the programme of change is to align District Nursing services with other service capacity in the community including the GP clusters and the CRTs to facilitate more seamless working between services. 2015-16 priorities include:

- Establishing a model to determine demand and capacity;
- Testing of the All Wales dependency tool for District Nursing in readiness for implementation 2016-17. The Fundamentals of Care Audit will continue to be tested in District Nursing Teams, again this is All Wales work and timescales and timescales are driven by this. Full implementation of the District Nursing toolkit will take place during 2016-17; and
- District Nurses currently use mobile technology via PARIS, for assessments and care planning. During 2015-16 steps will be taken to fully embed mobile working via PARIS across the service and also to develop a revised Nursing Assessment that is compliant with the requirements of Integrated Assessment.

The longer term plan for District Nursing will be reviewed within the context of the proposed development of Primary and Community services and how District Nursing is best aligned to meet the needs of the patient within a modernised community infrastructure.

Prison Services

This year has seen significant progress in the leadership, service development, governance and monitoring of services at HMP Cardiff. Key areas of progress include:

- Remodelling of dental service to meet patients needs;
- Implementation of a Service Level Agreement and performance management mechanisms for Community Dental Service;
- Agreement reached for the development of an integrated primary mental health team to support the service to meet the requirements of the Mental Health Measure; and
- Development of Substance Misuse roles to support the integration with community services for prisoners remanded to, or released from Prison.

On-going priorities for 2015-16 are:

- A Prison Services Strategy (service, financial and workforce) will be developed which will include a staff skill mix review and roles for supplementary prescribers and possibly advanced nurse practitioners;
- Complete service reviews and development of performance management frameworks for Mental Health, Sexual Health and Optometry;
- Complete integration of substance misuse services;
- Progression towards a Non-smoking Prison (staff and prisoners);
- Delivery of BBV and immunisation targets;
- Development of clinical staff competency frameworks;
- Review and update of the Information Governance framework/systems; and
- Development of business continuity plan.

Local Oral Health Plan (LOHP)

The Local Oral Health Plan (2013-18) was submitted in December 2013 and had very positive feedback from Welsh Government. It is intended that the LOHP is the driving force behind the planning and delivery of all dental services in the UHB and that it drives the move of services to primary care. The action plan for the LOHP is monitored by the Welsh Government annually ensuring that actions and deadlines are adhered to and completed. Through the work of Managed Clinical Networks (MCN), a number of pathways have been developed which look to develop services in primary care as the most appropriate place for treatment to be provided supported by the specialist services of both the Community Dental Service (CDS) and secondary care services in the University Dental Hospital.

An integrated care pathway for Domiciliary Dental Care, involving Primary Care and CDS has been developed by the SE Wales MCN for Special Care Dentistry and approved by the Cardiff and Vale Oral Health Action Group (OHAG). Integrated care pathways for special care patients, conscious sedation, general anaesthesia, bariatric patients, inherited bleeding disorders, cancer patients and a number of others have been developed or are in the process of being developed. This will require approval by the OHAG when complete ready for implementation.

Key priorities are:

- Continuing to work with GDS/PDS contract holders to improve the performance management of contracts to ensure that the highest quality care is provided to the maximum number of patients possible;
- Developing the plans and actions within the LOHP for the current year and implementing these actions within the timeframes agreed. The UHB will continue to work with dentists and their teams, and all other relevant stakeholders to develop and support delivery of our Local Oral Health Plan;
- Collaborating with colleagues in the Dental Clinical Board on the redesigning of pathways to improve the patient experience ensuring involvement of primary care providers and pathways which move care away from secondary care towards more locally provided care;
- Consider the best structure to support collaboration and maximise the benefits of an integrated organisation; and
- Recruiting a new Primary Care Dental Practice Advisor to work within the Primary Care Team to ensure strong clinical involvement in the management and monitoring of GDS/PDS contracts.

Optometry

Welsh Government has recently supported a bid for funding to support three interlinked schemes across Cardiff and the Vale. The aim of the schemes is to lay the foundations and principles to develop and implement agreed integrated care pathways that underpin new ways of working to deliver enhanced eye care services closer to home for eye care patients within Cardiff and the Vale of Glamorgan. This will be achieved by investing in a Primary Care Optometric Advisor to act as a 'Clinical Champion', providing professional and technical advice to support the development of pathways, engagement with secondary care clinicians and the shift of services into the primary care setting. As part of this role, two key pilots will be progressed to support the delivery of eye care closer to home;

- Post Cataract project – to reduce waiting times and free up secondary care capacity allowing up to 10 follow up or 5 new patients to be seen in secondary care. This will reduce the number of visits to secondary care for patients and use optometrists skills better; and
- Eye Casualty Project – a team of ten optometrists, each to undertake a half-day session, covering the whole week in eye casualty with a remit to work alongside the eye casualty team.

This will be evaluated to assess the costs and benefits associated with the capacity released in secondary care through more appropriate referral, new pathways and a greater confidence in discharging patients to follow-up in the community.

Other Eye Care plans

- E-referrals and Tele Medicine;
- The IM&T investment into primary care optometry services by WG over the next 12-18 months allows the introduction of electronic referrals directly into secondary care ophthalmology by primary care optometric services. It is envisaged that information sharing over the NHS Network will lead to:
 - Improved communications between healthcare professionals;
 - Reduced hospital referrals
 - Provision of timely datasets for business intelligence and clinical outcomes;

- Better services for the future; and
- Implementation of the Together for Health - Eye Health Care Delivery Plan.
- The Optometry Technology Refresh Project:
 - Improved IT and connectivity across all optometry practices in Wales;
 - Provide the network infrastructure to allow optometry practices to connect securely to the NHS network and NHS Wales services and NHS email; and
 - Enable optometry practices to purchase or upgrade existing IT and broadband to support E-referral and Tele Medicine.

Diabetic Retinopathy Screening Service Wales

For the first time in at least five decades Diabetic Retinopathy is no longer the leading cause of blindness in the working age population in Wales and England (BMJ, Feb 2014) – strong, independent evidence for the efficacy of Diabetic Retinopathy screening programmes.

2015-16 Priorities are:

- The main challenge to Diabetic Retinopathy Screening Service for Wales (DRSSW) is to deliver an annual screening programme to an ever growing diabetic population. The development and rollout of the new clinic model will continue in 2015-16 and the early evidence from this year is encouraging. However the plan relies on local cooperation, particularly for the provision of screening venues, and the maintenance of resources at least at historical levels;
- Business management tools will be enhanced to increasingly measure performance in terms of productivity, use of resources and value rather than just activity;
- Planning will begin for changes to screening intervals based on clinical risk, as recommended by UK National Screening Committee. This will require a project-based approach with additional short-term resources, yet to be identified; and
- The diabetic eye will be a focus of the Wales Diabetes Delivery Plan 2015, which will involve DRSSW heavily. Three specific areas have already been identified for taking forward: improved screening uptake, screening in pregnancy and communication of future screening interval changes. This will also support the work of the Wales Eye Care Strategy.

The possible transfer of DRSSW to Public Health Wales remains unresolved. If this were to proceed within 2015/16 it will inevitably draw resource and focus away from the above actions.

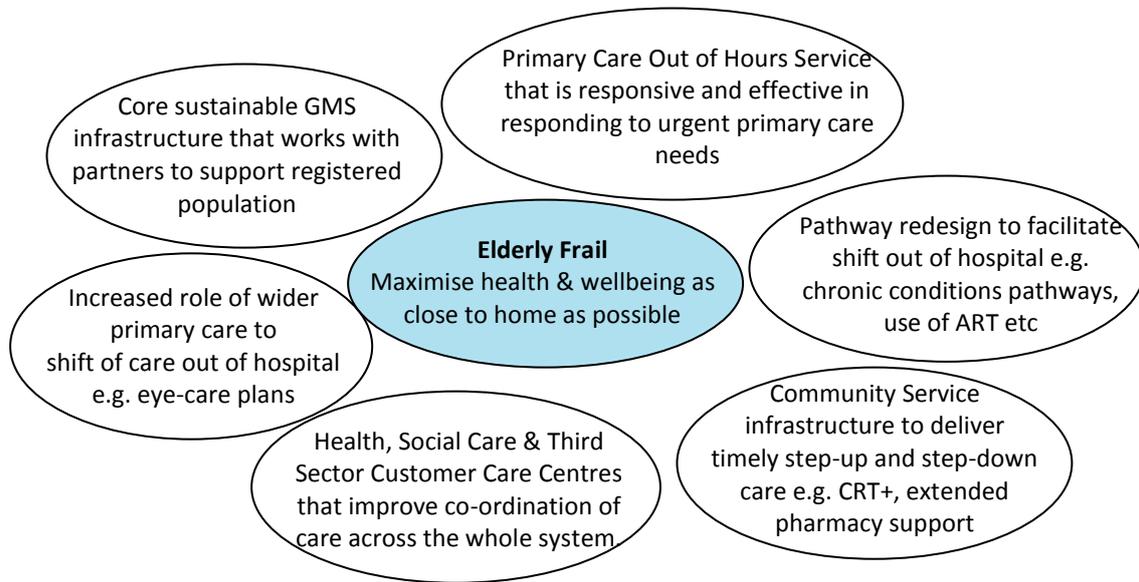
Oral and eye care are service areas that have been identified as priorities within the UHB's emerging Shaping Our Future Wellbeing Strategy and further work will be undertaken in year to further define the outcome and measures across the care continuum.

6.2.4 Maximising the Potential of an Integrated Organisation

In summary the following has been set out for primary and community care:

- The national context that primary care is core to delivering health care and the move towards a social model of health;
- A 'future state' set out by Cluster Leads within the context of the benchmarking data and the local pressures;
- The development of primary and community care in Cardiff and Vale and the significant achievements evidenced to date at Cluster level and at Locality/Cardiff and Vale level;
- The priorities identified by the Clusters. Prevention is a theme that runs across every cluster with specifics clearly driven by needs specific to the population of that cluster; and
- Planned developments informed by the Cluster Plans and building on achievements evidenced to date:
 - Priorities focussed on sustaining fragile services; and
 - Continuation of plans identified in the 2014/15 – 2016/17 IMTP.

The combined outcome of the above is a resilient primary and community infrastructure which enables the UHB to realise the potential of an integrated organisation and ensure we are well positioned to work with partners to maximise this. Taking the elderly frail as a target population to illustrate this:



6.3 Unscheduled Care

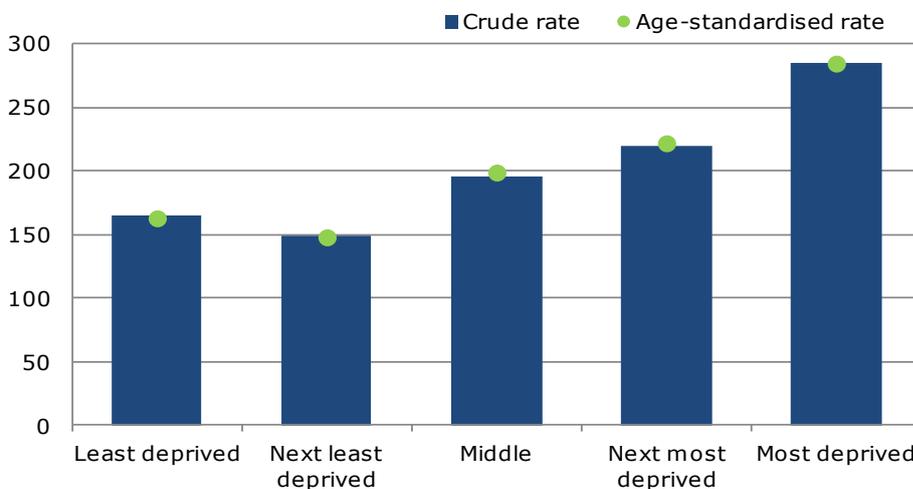
6.3.1 Context

The way that patients from Cardiff and Vale chose to access unscheduled care services highlights some significant areas of challenge for the UHB in terms of how we commission services, deploy our own resources and how we collaborate with other providers and partners to provide the most appropriate care in the right place at the right time. The developments outlined in chapter 4 (local need and public health plans) and 6.2 above provide an indication of the direction of travel for the UHB’s focus on reshaping and redeploying resources over time.

Rates of hospital utilisation in residents under 75 are similar to the rest of Wales but show interesting patterns in Cardiff. The rates of emergency hospital admission in Riverside, Grangetown and Butetown are statistically significantly higher than Wales but conversely, elective admissions are similar to, or lower than, Wales as a whole. This suggests healthcare access or utilisation patterns in these communities are different to other areas. Emergency Unit attendances are higher among people from more deprived communities – see table below.

Emergency Unit attendances, University Hospital of Wales, crude and European age-standardised rate per 1,000, Cardiff and Vale residents by deprivation fifth, 2013

Produced by Public Health Wales Observatory, using WIMD (WG), MYE (ONS) and UHW EU dataset (Cardiff & Vale UHB Information Dept.)



Nearly 1 in 5 adults (18%) in Cardiff and Vale visit their GP each fortnight, and over the period of a year around one third of adults (34%) visit an outpatient department. Self-reported attendance at a community pharmacy within the last year is higher in Cardiff and Vale (74%) than Wales as a whole (70%).

Age-standardised percentage of adults using NHS services in Cardiff and Vale and Wales in the prior 2 weeks to 1 year (Welsh Health Survey 2012-13)

NHS service	C&V	Wales
Family doctor (GP) (past 2 weeks)	18	17
Attended casualty (past 12 months)	16	17
Outpatients (past 12 months)	34	32
In hospital as an inpatient (past 12 months)	9	9
Pharmacist (past 12 months)	74	70
Dentist (past 12 months)	69	70
Optician (past 12 months)	52	50

Attendance at major Emergency Departments is below the Wales average (240 per 1,000 per year) for residents in the Vale (188) but higher in Cardiff (270) (Public Health Wales Observatory, 2013/14). In contrast, emergency admission rates are **lower** for both Cardiff (87 per 1,000) and the Vale (103) than the Wales average (112). Rates of delayed transfer of care for social care reasons are **nearly twice as high** in Cardiff and Vale than the Wales average (Cardiff 8.6 per 1,000; Vale 8.2 per 1,000; Wales 4.7 per 1,000). The impact of significant reductions in local authority funding is yet to be seen but these could adversely affect general and tailored support for vulnerable individuals in the community. This may result in an increase in hospital admissions where families or individuals are unable to cope, and place further pressure on resources in the community to support patients being discharged from hospital.

Around 1 in 5 patients who attend the Emergency Unit have two or more attendances in a year:

Number of patients having single or multiple episodes of attendance, University Hospital of Wales Emergency Unit (UHW EU) and University Hospital Llandough Medical Emergency Admissions Unit (UHL MEAU), 2013

	UHW EU*				UHL MEAU			
	Number of patients	% of patients	Number of episodes**	% of episodes	Number of patients	% of patients	Number of episodes	% of episodes
Patients with one episode	59,816	81.0	59,816	62.3	7,451	80.7	7,451	62.1
Patients with two episodes	9,839	13.3	19,678	20.5	1,242	13.4	2,484	20.7
Patients with three episodes	2,565	3.5	7,695	8.0	351	3.8	1,053	8.8
Patients with four episodes	880	1.2	3,520	3.7	86	0.9	344	2.9
Patients with five episodes	344	0.5	1,720	1.8	58	0.6	290	2.4
Patients with more than five episodes	432	0.6	3,609	3.8	47	0.5	379	3.2
Total	73,876		96,038		9,235		12,001	

Produced by Public Health Wales Observatory, using UHW EU / UHL MEAU dataset (Cardiff & Vale UHB Information Dept.)

* UHW EU includes major and minor stream only; paediatrics are excluded. Patients are included irrespective of residence.

** 95% of episodes at UHW EU involved a single attendance. There were 101,270 attendances in total at UHW.

The UHB's commissioning plans prioritise investment in those services that focus on promoting good health and preventing health deterioration, particularly for vulnerable groups who, with early and effective intervention will often do better and prefer to remain in their homes. There is strong evidence that demonstrates that better support for patients in the community can prevent avoidable admissions and facilitate earlier discharge and the health and social care pilots and proposed Community Resource Team expansion will focus on providing this type of support (see particularly sections 6.2 and 6.4).

The strategic context for the provision of unscheduled care services will take account of likely changes to acute services across the region as a result of the South Wales Programme decision regarding Paediatrics and A&E services and also further work emerging from the South Wales Health Collaborative regarding the:

- Future consolidation of emergency surgery to fewer District General Hospital sites;
- Changes to the acute medicine hospital model; and

- Proposed development of a formal major trauma network service for South Wales which will include the need to provide a major trauma centre for the population of South Wales.

In addition to this, the UHB will consider the implications of these wider strategic drivers to acute services (planned and unscheduled) under consideration by the South Wales Health Collaborative to review and design the configuration of acute services at UHW and UHL in order to ensure that acute services – tertiary and secondary - on both sites are organised on a sustainable basis. Any regional and local developments of this nature will be considered and discussed as part of a continuing conversation with our local population, partners and wider service stakeholders.

The UHB, in collaboration with partner organisations such as WAST and other local public and third sector services, has already implemented a range of developments to address demand for and access to unscheduled care within a range of service areas including primary and community care, mental health and secondary care. However, the nature of unscheduled care requires a whole-system programme of redesign, as incremental service changes in isolation tend to simply move the pressure to a different part of the system; this is often most visible as delays in GP triage response times, ambulance response times, handover delays at the Emergency Unit (EU), long waits in EU or high volumes of patients whose discharge is delayed. The UHB recognises that the challenge to redesign unscheduled care services requires a multi service/agency, whole system and whole pathway approach to redesign and, for this reason, has prioritised unscheduled care within its clinical services strategy, *Shaping Our Future Wellbeing*, to develop a prioritised, outcomes-focused plan for each area of the pathway.

There is also an urgent and parallel requirement to address the wider pathway pressures impacting on unscheduled care flow across the whole system. The UHB's unscheduled care strategic plan and supporting projects will be formally programme managed via a multi-partner board chaired by the UHB's Chief Operating Officer. This is currently being established and the programme plan will be developed taking account of the plans and proposals outlined in this chapter.

6.3.2 Performance

The UHB's primary care and community services provide the first response in meeting the increasing demand for unscheduled care and provide 85% of the UHB's unscheduled care contacts. These services have absorbed much of the underlying increase in demand from an increasingly elderly population in 2014-15 by providing improved access to GPs, district nurses, dentists, community-based pharmacists and optometrists and also by providing alternative support and signposting to services in the community provided by a range of health and social care professionals. There is a range of examples of these developments in many of the individual service sections in this document – see section 6.2 above for further detail.

New GP Out of Hours (OOH) triage systems implemented in December 2014 enabled the GP OOHs team to respond to a 23% increase in demand over the Christmas holiday period (compared to the same period last year) with only a 1.2% increase in emergency admissions. The increase in unscheduled care demand in primary care continues to place pressure on the whole system as the GP response times are under pressure and the secondary care services report that, whilst the hospital emergency attendances are not materially increasing in volume, they are increasing in complexity when it comes to discharge which is impacting particularly on nursing and therapy resources and also on bed utilisation.

Primary Care Performance

Cardiff and Vale of Glamorgan Out of Hours Monthly Statistics Report						
** Please note the percentages are rounded to the nearest whole number.						
Demonstrates that a standard has been achieved					Total OOH Service Calls	
Demonstrates that a standard is within 5% of being achieved					Logged = 10831	
Demonstrates that a standard has <u>not</u> been achieved					Jan-15	
Standard	Description	Target	Total	Result	Score	
Telephone Services						
Telephone Calls	Number of calls answered within set timeframes	75% ans. in 60 secs	10831	9477	87%	
		100% ans. in 120 secs	10831	9965	92%	
Abandoned Calls	Number of callers who abandon their attempt after 30 secs	No more than 5%	10831	679	6%	
Engaged Calls	Number of callers who receive an engaged tone	No more than 0.5%	10831	10831	0%	
Telephone Triage Services						
Urgent Triage	Number of urgent calls, triaged within set timeframes	90% triaged within 20 mins	2168	1789	83%	
		100% triaged within 30 mins	2168	1960	90%	
Routine Triage	Number of routine calls, triaged within set timeframes	90% triaged within 60 mins	5538	4452	80%	
		100% triaged within 120 mins	5538	4864	88%	
Immediate Life Threatening (ILT) Conditions						
Identification	Number of life threatening conditions identified	100% within 5 mins	185	185	100%	
Home Visiting						
HV P1 Emergency	The number of home visits completed within one hour	95% seen within one hour	30	27	90%	
HV P2 Urgent	The number of home visits completed within two hours	95% seen within two hours	219	148	68%	
HV P3 Less Urgent	The number of home visits completed within six hours	100% seen within six hours	385	282	73%	
Primary Care Centre Appointments						
PCC	The number of attendances completed within six hours	100% seen within six hours	2869	2869	100%	
Transmissions						
Transmissions	The number of reports sent to GP Practice by OOH	90% by 9am	10995	10995	100%	
		100% by 10am	10995	10995	100%	

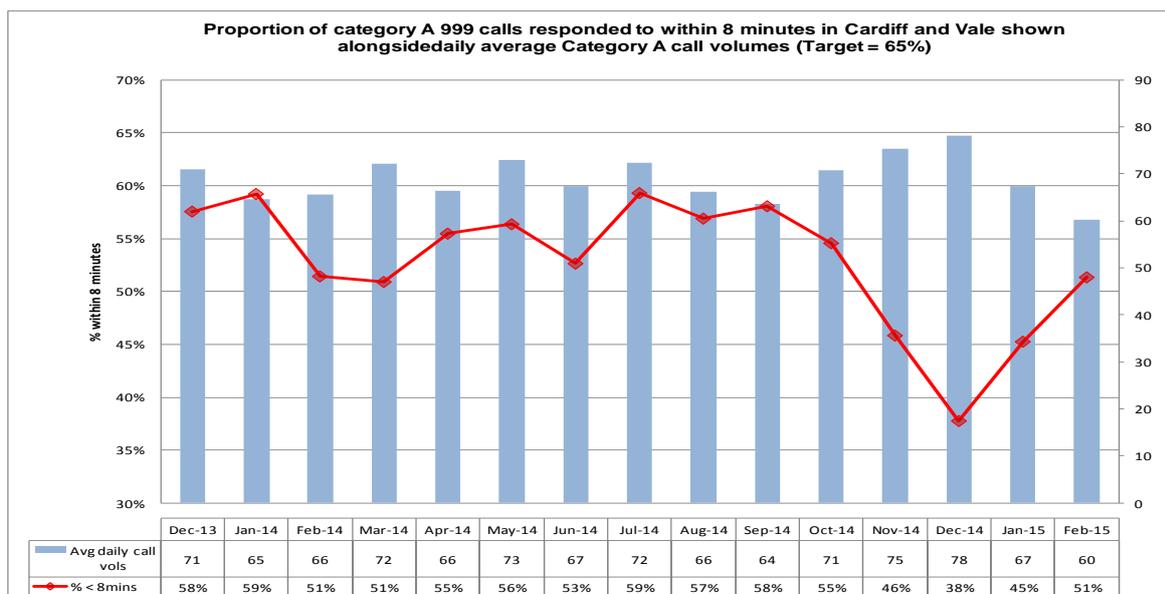
This table illustrates that, whilst improving, the response times for GPs to return a call to a patient in order to triage their care requirement are falling short of the 90 and 100% response targets. The capacity to provide home visits is currently inadequate to meet demand and plans for investment to support a redesign of this service to enhance capacity are included in Primary Care priorities for 2015-16.

However, the ambulatory care sensitive (ACS) conditions pathways that have been developed in the primary care teams has enabled many patients that might previously have been referred into secondary care to be managed effectively in the community as indicated in the table below.

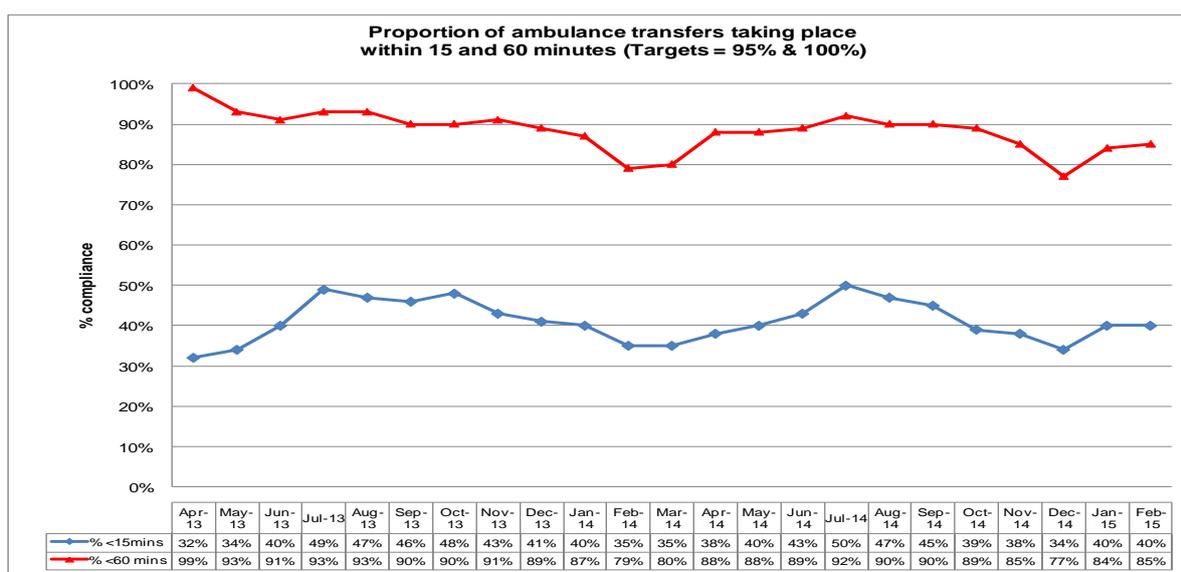
		Target	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14
Chronic Conditions - Reductions in Emergency Admissions (rolling 12 months)	Alzheimers	35	36	35	35	36	34	35	33
	Atrial Fibrillation	365	368	379	384	376	363	365	365
	Cardiovascular	1,594	1,752	1,724	1,677	1,651	1,597	1,594	1,600
	CVA	655	677	667	666	663	658	655	649
	Diabetes	254	248	254	249	249	245	254	245
	Musculoskeletal	419	400	403	401	391	409	419	404
	Neurological	205	241	247	233	223	215	205	193
	Other Symptoms	1,885	2,071	2,042	2,027	1,988	1,927	1,885	1,870
Chronic Conditions - Reductions in Emergency Readmissions within 1 year (rolling 12 months)	Respiratory	1,111	1,155	1,163	1,144	1,125	1,124	1,111	1,063
	Alzheimers	1	1	1	1	1	1	1	1
	Atrial Fibrillation	55	45	45	49	49	53	55	54
	Cardiovascular	185	207	207	206	202	191	185	188
	CVA	20	27	24	15	14	15	20	22
	Diabetes	60	52	53	58	58	61	60	58
	Musculoskeletal	25	31	30	26	26	26	25	22
	Neurological	70	76	75	75	75	76	70	64
Other Symptoms	202	196	194	195	199	198	202	212	
Respiratory	362	391	395	379	371	368	362	344	

WAST Performance

WAST services are dealing with increasing Category A call volumes with higher volumes in December 2014 and January 2015 than the same period last year.



The handover times in the Emergency Unit are still well below target and are, in part, indicative of the increasing acuity of patients presenting.



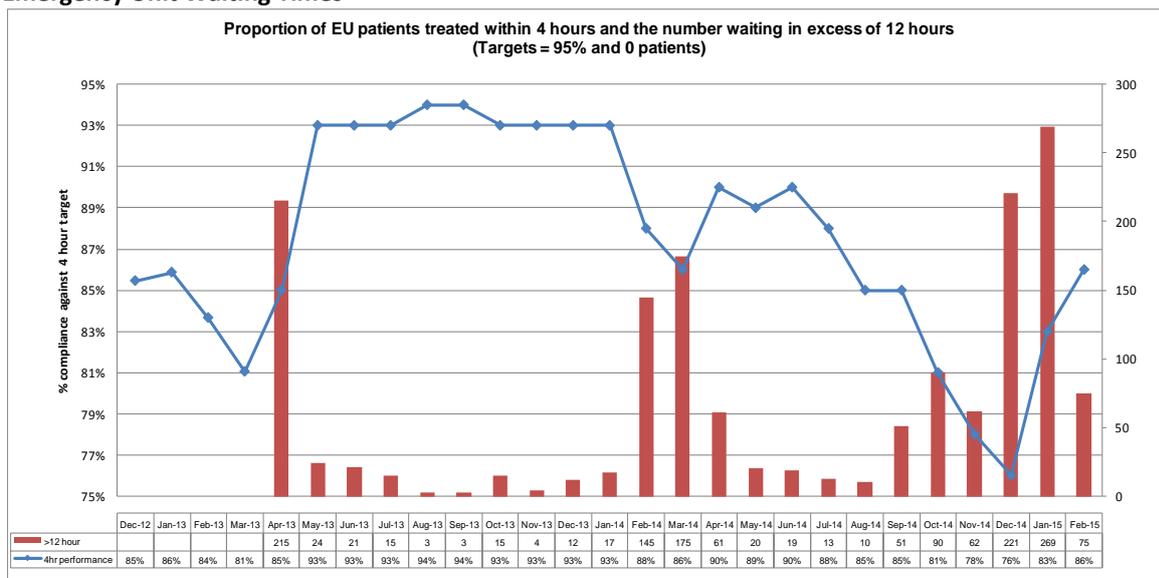
Whilst improving performance against these targets remains challenging, there is much collaborative work ongoing to address this. The pathway work involving primary and community services, WAST and secondary care clinicians working together to develop pathways is enabling more people to either stay at home, access an alternative and more appropriate service to EU or to bypass EU altogether and directly access the hospital service they urgently require. This pathway work is continuing through 2015-16 to develop more pathways to improve clinical outcomes for patients and improve both conveyance rates as well as handover times.

Currently the conveyance rate into UHW and UHL for patients calling WAST is 61% (all Wales = 64%) which is one of the best in the UK.

The handover times in EU remain a challenge and will be a key improvement objective in the collaborative pathway redesign work within the UHB's Unscheduled Care Programme.

Secondary Care Performance

Emergency Unit Waiting Times

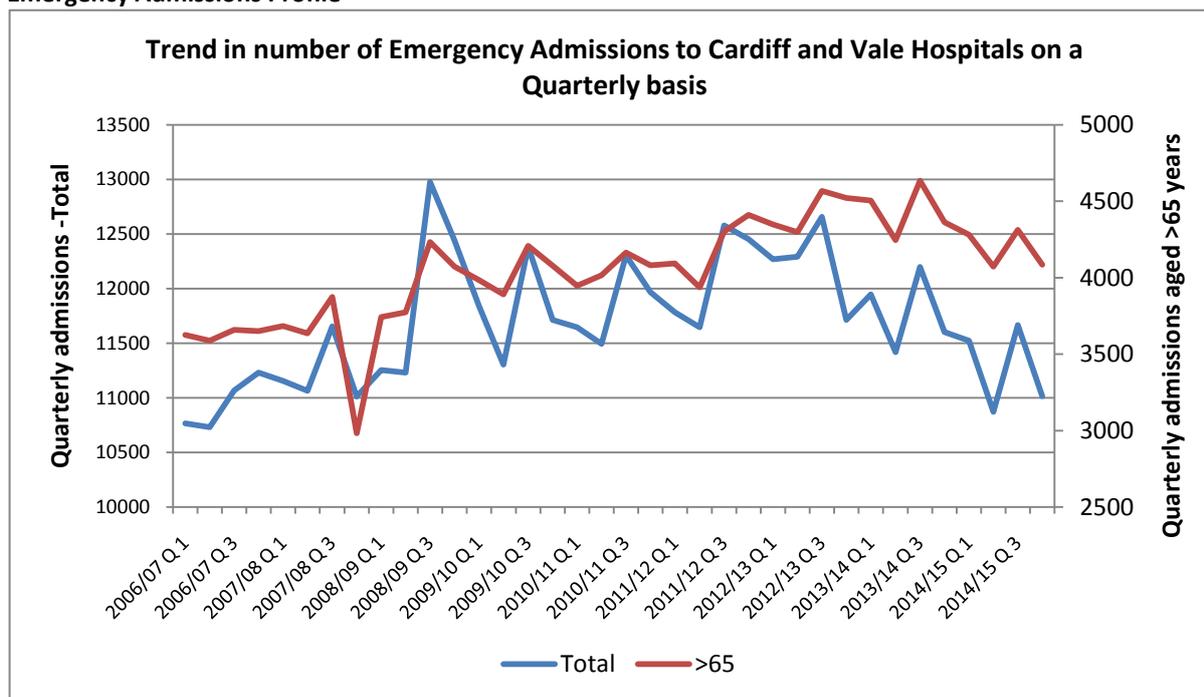


Waiting times in the Emergency Unit have deteriorated over the winter but some strong operational focus, improvements to streaming (minors) and emphasis on ‘pulling’ patients from the EU by clinical specialities has delivered some recent improvement.

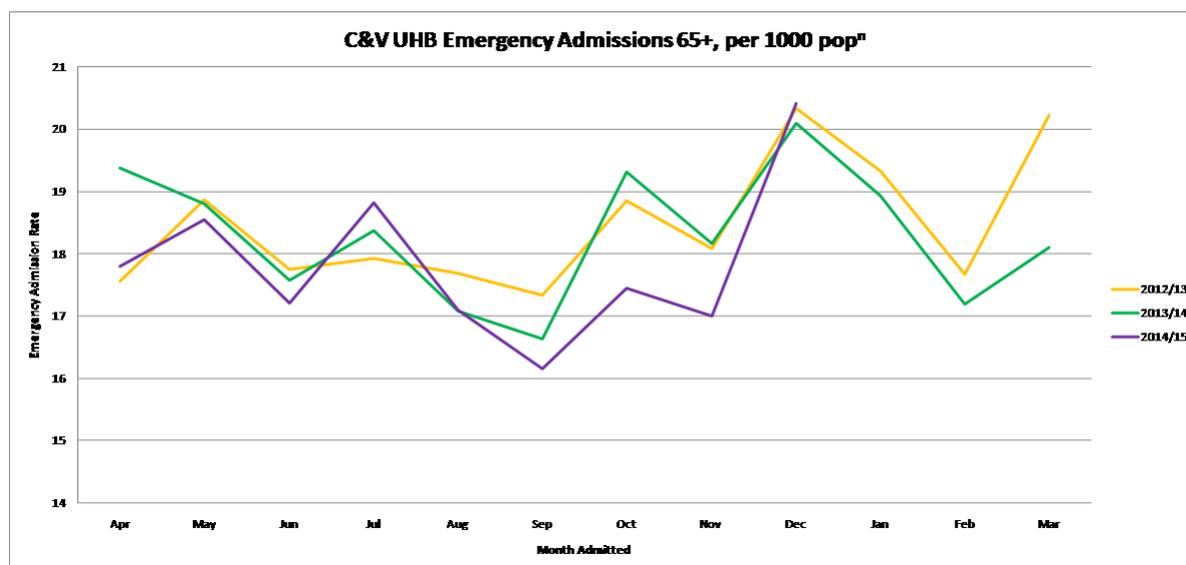
The age and acuity profile of patients is shifting to a more elderly patient, often with complex co-morbidities. This changing demographic requires a multi-agency response to make sure that services are redesigned to wrap around the patient to provide the most appropriate care for each individual. This often makes the discharge process more complex requiring a range of agencies and service sectors to work effectively to provide packages of care to support discharge in a timely and effective manner which is why the continued focus and reinforcement of these services is a major priority for the UHB and partners during 2015-16.

The tables that follow provide a high level indication of the profile and current resource consumption of unscheduled patient flow.

Emergency Admissions Profile



The table below illustrates the reduction in the emergency admission rate for the over 65s which is a positive trend indicating the benefits of joint working across clinical teams to maintain patients in the community and/or treat them on an ambulatory basis in secondary care.



However, this is a growing population group and whilst the underlying admission rate per 1000 population is dropping, the overall demand is not and the acuity of those patients who are subsequently admitted is higher resulting very often in a more complex discharge process and therefore a longer length of stay.

The average length of stay indicators (Risk adjusted Average Length of stay (RALOS – see table below) suggest that patients admitted as emergencies typically stay longer in the UHB’s acute hospitals than in peer hospitals. It should be noted that there are some systemic and statistical factors affecting the validity of a direct comparison based on mean, such as the:

- Lack of community based rehabilitation beds within peer Trusts in England;
- Transition of long stay inpatients to community care packages made over the period, which facilitated the closure of the West Wing beds on the CRI site and in doing so realised a large number of hospital spells with long lengths of stay to close; and
- Reduced number of admissions, which disproportionately reduced the volumes of patients admitted and staying less than 2 days.

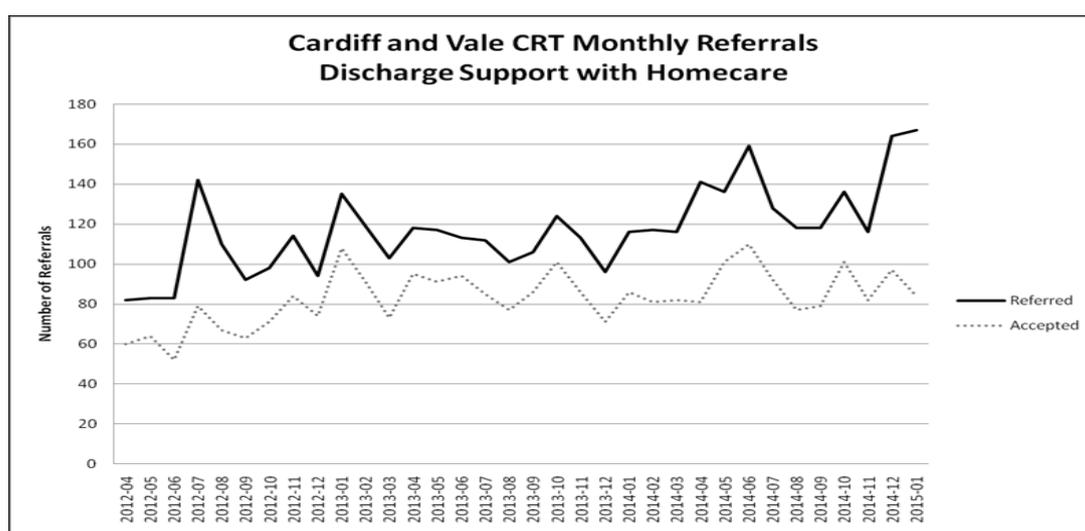
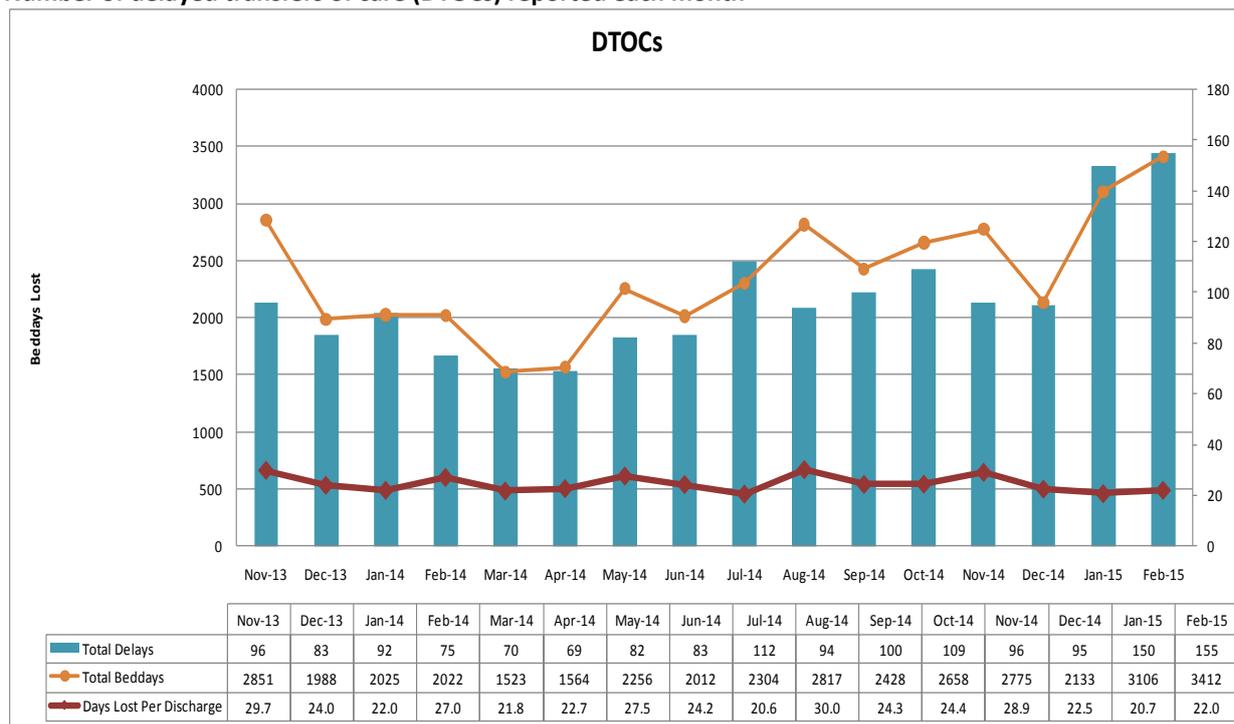
However, these benchmarking results have prompted a more detailed analysis at Healthcare Resource Group (HRG) level in the key specialities to support and target proposed service improvements and developments to reduce these lengths of stay. These developments include developing the CRTs to facilitate earlier supported discharge of stroke and respiratory patients in the community, investment in the hip fracture pathway and ortho-geriatric service and support for the critical care outreach team to provide safer more effective care for acutely unwell patients.

Emergency Admissions –Risk adjusted Average Length of Stay

Specialty	UHB RALOS	Peer RALOS
Non-elective General Medicine	10.4	6.8
Rehabilitation	64.2	21.9
Trauma	12.5	9.1
Geriatric Medicine	28.1	11.6
Non-elective Thoracic Medicine	7.9	6.3
Non-elective General Surgery	7.0	6.5
Non-elective Gastroenterology	11.8	6.6
Cardiothoracic surgery	19.3	15

A further very significant factor in the adverse variance in length of stay has been the observed increase in the number of patients assessed as being medically fit for transfer from a hospital bed and the number of Delayed Transfers of Care reported as a result (refer to chart below). There is a range of factors impacting the successful and timely discharge of these patients. It has become an increasing challenge for the UHB during 2014-15 and is a key performance improvement priority for the UHB in 2015-16. A target of 25% reduction in the first quarter of 2015-16 has been set and a proposal is being developed to implement a new approach to better managing this post-acute patient cohort. Some of the proposed enhanced and integrated community services developments (see section 6.2 above) will facilitate the delivery of this internal target but there will also be a change to the organisation of secondary care resources to better support the 'pull' from services in the community. None of this cohort require on-going hospital care; the emphasis will be to radically improve the discharge process and transfer these citizens to a more appropriate environment enabling the release of essential secondary care capacity. It is vital that this capacity is released in order to better support the bed capacity requirements for both planned and unscheduled care patients.

Number of delayed transfers of care (DTOCs) reported each month



These data illustrate the scale of the challenge; there are clearly pressures throughout the system, all of which can compound and transfer the effect to the next part of the pathway. These indicators will form part of the dashboard that will be developed through the Unscheduled Care Programme to transform and monitor the delivery of care across the unscheduled care system.

The work that has already commenced to improve unscheduled care services will continue and will be incorporated into the Unscheduled Care Programme and priorities for 2015-16 that have been identified in clinical service plans are summarised in section 6.3.3.

6.3.3 Priorities

The UHB and partners have placed a clear emphasis on:

- Providing advice, information and support to enable our population to make better lifestyle choices to stay well and to be better informed on the most appropriate choice of care to seek should they become unwell;
- Developing better signposting and integrated support in the home or in the community to maintain the health of vulnerable groups;
- Enhance capacity within primary and community care to provide timely alternatives to secondary care unscheduled care services;
- Developing integrated pathways for common conditions to ensure best outcomes for patients and better inform optimal deployment of resources across all provider services;
- Focus on flow within secondary care to improve outcomes and efficiency and enhance capacity; and
- Provision of enhanced and integrated community resource teams to support community based reablement and social care support.

Learning from current practice:

Whole system

- Continue working with the South Wales Health Collaborative and Acute Care Alliance (ACA) partners in the development of implementation plans to ensure emergency referrals are routed to the most appropriate environment of care and to develop appropriate capacity for any regional centralisation of services with the UHB e.g. SE Wales vascular service – UHW has been identified as the hub for vascular emergencies and complex care. There are also likely to be further changes to emergency flows following the implementation of a new model for Emergency and Acute Medicine in Royal Glamorgan Hospital in August 2015 as a consequence of the South Wales Programme implementation for which detailed implementation plans are being developed through the South Central ACA. Further developments for centralising emergency ENT services for the South Central ACA will also be progressed in 2015;
- Amplified focus on the hospital 'back door' to significantly reduce the numbers of patients whose discharge is delayed;
- Implementation of the Unscheduled Care Board to develop, monitor and assure delivery of the Unscheduled Care Programme for Cardiff & the Vale across the whole pathway; and
- Continuation of Chief Executive Officer -led focus on flow across the pathway through weekly holding to account through the 'Big Room'.

Health Promotion and illness prevention

Comprehensive and targeted action plans to tackle the priority areas of population health, particularly focusing on some of our more deprived communities as the higher users of unscheduled care services have been referenced earlier in this section and detailed action plans are described in the UHB's published Public Health Plan.

Primary and Community – including Health and Social Care integration

As detailed in section 6.2, the UHB is committed to focus on building on the significant improvements achieved within the primary and community based teams across the services including nursing, therapies, mental health, social care, community pharmacy, optometry and dentistry services; these services have undertaken significant remodelling and redesign work to enhance capacity, access and improve performance in 2014-15 and this will continue to be a major priority for the UHB in 2015-16.

The GP cluster plans for Cardiff and Vale include a wide range of proposals for a broader range of services closer to home. These will be delivered both at individual practice level and also working together on a hub and spoke basis for more specialist primary care services. They have emphasised and prioritised the requirement to continue to collaborate with colleagues in both primary and secondary care to build on the really encouraging work already undertaken to embed and further develop the emergency pathways – particularly for ambulatory care sensitive (ACS) conditions and enhanced access to diagnostics. The priorities are outlined in section 6.2 and will continue to be a focus for development.

The primary care out of hours services and integrated community resource teams have demonstrated significant successes in 2014-15 and are recognised as absolutely vital components of the unscheduled care system that are critical to maintain flow at both ends of the pathway. Benchmarking analysis shows that the UHB lengths of stay for some specific conditions are longer than those of our peer organisations and these are being targeted to further develop pathways for ACS conditions between primary and secondary care to improve prevention of exacerbations and facilitate earlier discharge through enhancing the capability and capacity of the Community Resource Teams.

Both the front and back ends of the unscheduled care pathway are under significant pressure and the UHB and partners intend, in the event of successful bids for additional funding, to further enhance the service models and capacity in these services that are already performing well but are at the limits of their current capacity. These are described in more detail in section 6.2.

Summary of key priorities for these services to improve unscheduled care in primary, community and integrated health and social care with prioritised additional investment include:

- Increasing GP OOHs capacity to meet demand – both for triage and home visits, improving timely access for patients and reducing emergency attendances in secondary care;
- Increasing capacity and range of services provided by the Acute Response Team and CRTs to incorporate 7 day working, stroke rehabilitation and management of respiratory conditions to increase the provision of care in the community/at home and reducing hospital bed occupancy;
- Additional support to enable an increased proportion of ambulatory care sensitive conditions to be managed in primary care;
- Improving access by enhancing and extending range of community services via the contact centre;
- Extending Primary Care Enhanced Services to provide equitable level of care to all nursing homes in Cardiff and Vale; and
- Additional capacity to manage patients eligible for continuing healthcare outside of the hospital environment.

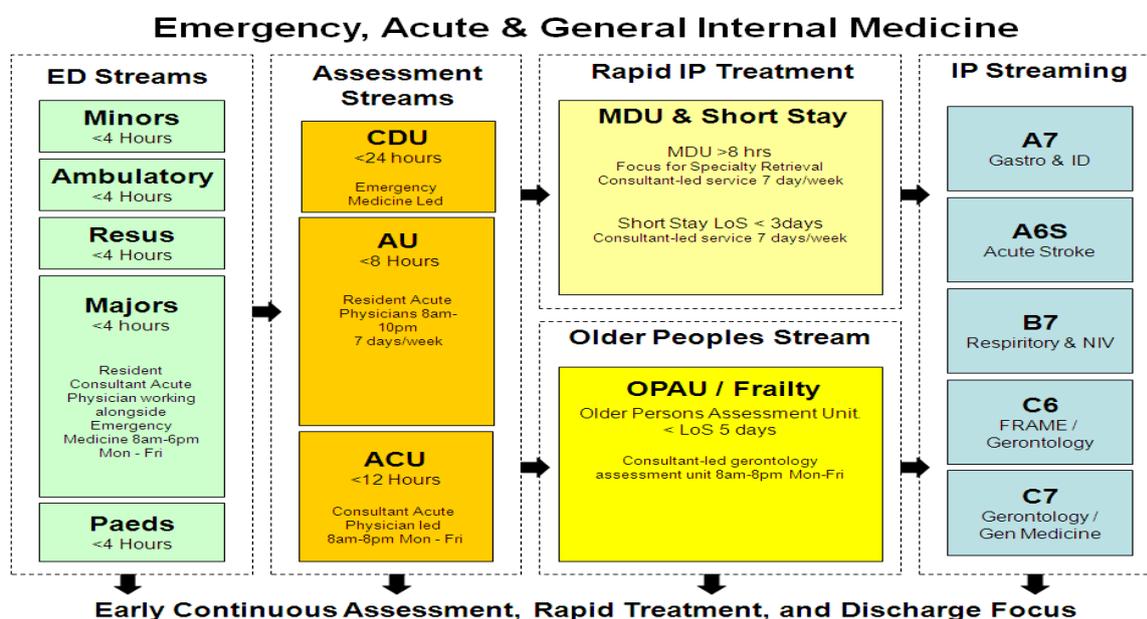
Secondary Care

In addition to ensuring appropriate focus on the front and back ends of the unscheduled care pathway, the scrutiny and performance management of the secondary care component of this system will continue. Whilst significant service developments have been delivered during 2014-15 – for example the relocation of West Wing services and consequent bed reduction along with the commissioning and redesign of the Emergency Unit at UHW - it is clear that the current pressures within the hospital system are continuing to adversely impact upon performance.

The developing clinical model for Emergency and Acute Medicine has been designed to deliver optimal and consistent senior medical cover in the key assessment and rapid treatment elements of the pathway, with a concurrent focus on maximising discharge and reducing length of stay. Patients should be assessed early and streamed to the most appropriate care environments to maximise rapid treatment and discharge.

Evidence, benchmarking and learning from other organisations through the Healthcare Financial Management Association (HfMA) review of 7-day services, and the 'Acute and emergency care: prescribing the remedy' joint Colleges' policy paper, describes the differential steps and input required depending on each organisation and models service baseline. Review of the evidence emerging from the early adopter sites in England confirms that the proposed model and direction of travel is the right one, and importantly must be seen in conjunction with the key focus of strengthening community and primary care unscheduled care service.

The following schematic illustrates the framework for Emergency and Acute Medicine streams to optimise the flow of patients once they arrive at hospital by providing the appropriate environment and resources to enable the right treatment, in the right place at the right time. This model has been adopted by surgery as well as medicine and a surgical assessment unit (SAU) and Surgical Short Stay Unit (SSSU) are also provided to facilitate optimal flow for patients requiring surgical assessment and/or intervention. Analysis and experience demonstrates that In order that the whole system can operate both efficiently and effectively there needs to be requisite capacity at each stage of the pathway otherwise bottlenecks occur.



Since the refurbishment and redesign of the Emergency Unit commissioned in the summer of 2015, the UHB has been able to partially introduce this model of care although some of this capacity is currently resourced with non-recurrent revenue funding. Detailed analysis of flows into and through this system have been undertaken to assess the demand across the streams to develop plans to shift or increase capacity in order to improve flow.

The following developments include the secondary care components of the UHB's Unscheduled Care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across parts of the pathway. These developments are presented in two categories:

1. Those priorities that the UHB will progress in 2015-16 in order to meet core clinical outcome requirements (i.e. reducing avoidable morbidity and eliminating avoidable mortality) and eliminate >12hour breaches by the end of Q1 - **these are factored, where appropriate, into the financial plan at section 7**; and
2. Those priorities that the UHB will implement *in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation* - to meet the 4 and 12 hour waits and handover targets.

1. The key priorities for these services to improve unscheduled care in secondary care include:		Target improvement
Scheme	Outcomes	All improve Clinical Outcomes
<ul style="list-style-type: none"> Continue to evolve critical care outreach Appointment of a Professor of Emergency Medicine and associated clinical fellows; Release essential core capacity through an integrated improvement programme focussed on reduction of delayed transfers of care and patients medically fit for transfer; 24/7 CT service in the Emergency Department; Increase in critical care capacity; Focussed improvement activities led by the newly established Patient Access Team; Review flow systems and ambulatory care models in partner health boards; and Using benchmarking evidence for benchmarking high volume conditions. 	<ul style="list-style-type: none"> To improve support to wards for the early identification of deteriorating patients and follow of patients post discharge from critical care; Improve training, research and reputation of the Emergency Medicine Department, with anticipated secondary benefits to increasing clinical decision maker capacity and ability to recruit and retain high quality clinicians; To provide improvement in flow from the EU. To support prompt diagnosis and support the effectiveness of the ambulatory care services; Enables delivery of National Emergency Laparotomy Audit (NELA) review recommendations, changes arising from the SWP and reduces cancellations due to lack of beds; Improve all areas of flow including inpatient streams; Prioritise, target and drive efficiencies in poor performing areas of the system to reduce avoidable admissions and reduce LOS; and To share best practice – accelerate and embed learning locally. 	<p>4 hour wait/ reduced length of stay.</p> <p>ED 4 & 12 hour access times and WAST Category 'A' 8 minute response performance.</p>

2. The key priorities for these services to improve unscheduled care in secondary care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
<i>EU streaming and capacity</i>		
<ul style="list-style-type: none"> Increase ENP capacity to provide 52 week cover for minors; Senior emergency medicine cover in EU 08-20.00 7 days a week; and Commission available resus capacity. 	<ul style="list-style-type: none"> Critical to improve streaming and EU flow and to deliver appropriate and timely senior decision making capacity in the EU; Provide consistent clinical leadership within the department and reduce avoidable admissions from EU; and 	<p>4 hour wait.</p> <p>4 hour wait & handovers.</p>

2. The key priorities for these services to improve unscheduled care in secondary care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
	<ul style="list-style-type: none"> To improve care for critically ill patient and provide some capacity to support anticipated changes from the South Wales Programme. 	Handovers.
<i>Assessment Stream</i>		
<ul style="list-style-type: none"> Additional Consultant Acute Physician cover based in EU Majors Mon-Fri 8am to 6pm alongside the EU teams; Increased Consultant Acute Physician cover based in Assessment Unit (AU) for 52 weeks on a 7 day basis from 8am to 6pm; and Consultant Acute Physician led chair and couch based Ambulatory Care Unit 52 weeks 5 days per week from 8am to 8pm. 	<ul style="list-style-type: none"> To provide early input and assessment of Medical cases avoiding double processing and improving timeliness of assessment, treatment and care planning; Overlapping with the on-call medical teams to support Continuous Consultant presence handover and care; and To provide additional and dedicated capacity to support the ambulatory treatment of appropriate patients. 	4 hour wait.
<i>Rapid Inpatient Treatment Stream</i>		
<ul style="list-style-type: none"> Implementation of a sustainable 52 week 7 day, Consultant Physician led Medical Decision Unit (MDU); and Implementation of a sustainable 52 week 7 day, Consultant Physician led cover for Medical Short Stay. 	<ul style="list-style-type: none"> To support pull and rapid treatment for patients who require longer than 8 hours in the Assessment Unit, with focus on consistent senior consultant input, treatment and discharge; and For patients requiring hospitalisation with a target turnaround of less than 3 days, focussing on consistent senior input, treatment and discharge decision-making decision making within 24 hours. 	4 hour wait. 12 hour wait.
<i>Inpatient Streams</i>		
<ul style="list-style-type: none"> Additional capacity to support the ortho-geriatric service and hip fracture pathway; 	To support patients with fractured neck of femur to improve outcomes and reduce LOS (supported by CHKS benchmarking and NOF pathway delivery requirements);	4 hour wait/ reduced length of stay and clinical outcomes National NOF database).
Provision of additional CEPOD capacity (currently funded through Winter Plan);	To improve outcomes and reduce lengths of stay for surgical patients	RTT Clinical Outcomes (NELA)
Implementation of a sustainable 52 week 7 day Consultant Respiratory Physician cover at UHW to support ward B7.	Focusing on conditions which represent the greatest volume medical patient admission activity (and where we benchmark poorly) and ultimately care for the most critically ill medical patients outside of ICU.	4 hour wait.
Flexible (Winter) beds.	To fully manage predicted variation and to provide flexibility for unpredictable demand surge including managing the spikes in demand when they occur during the winter months ;	4 hour wait/ RTT.

2. The key priorities for these services to improve unscheduled care in secondary care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
<i>Development of Surgical Assessment</i>		
Enhanced SAU cover – senior decision maker and extended hours to meet profiled demand.	To optimise the number of patients who can be assessed and treated on an ambulatory basis.	
<i>Aligned Diagnostic Capacity</i>		
Increase diagnostic capacity: <ul style="list-style-type: none"> • CT; • MRI; and • - Non-Obs Ultrasound. 	To meet modelled demand from unscheduled care to reduce avoidable delay in emergency assessment.	4 & 12 hour wait.

These system improvements and developments, combined with those with WAST, community and primary care services will provide the core of the Unscheduled Care Programme’s delivery plan to transform the performance of the service as well as outcomes for patients.

6.4 Planned Care and RTT (Referral to Treatment Times)

6.4.1 Context

The commissioning and delivery of elective and diagnostic services to meet national waiting times targets is a considerable challenge across Wales and also within Cardiff and Vale UHB.

The forecast year-end waiting list position at 31st March 2015 is presented by speciality below. The summary position is as follows:

	> 26 weeks	> 36 weeks	>52 weeks
New Outpatients	3400	0	0
Treatments	5000	2639	502
Total	11600	2639	502

Diagnosics & Therapies

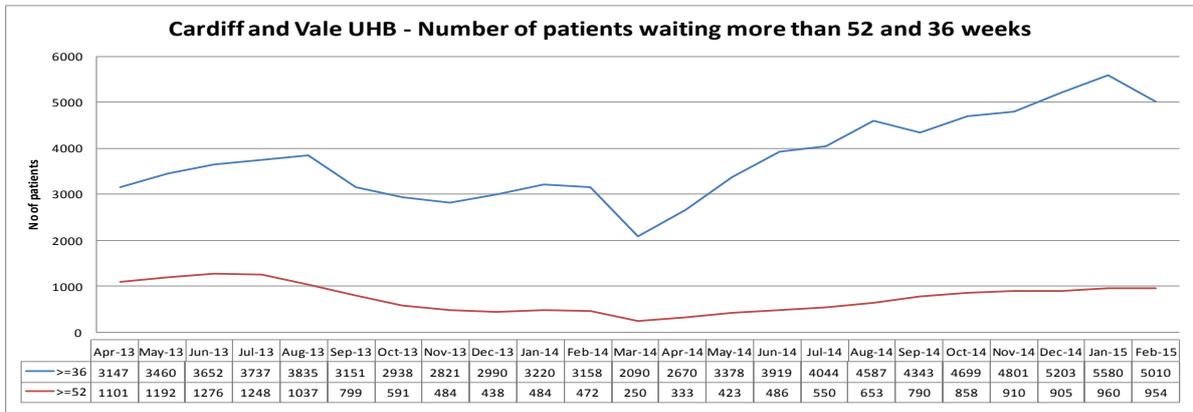
	> 8weeks	>14 weeks
Diagnosics	4000	
Therapies		1000

6.4.2 Performance

RTT

The UHB made provision for £4.2m to deliver an improved waiting time position during the course of 2014/15, which was subsequently increased with the provision of a further £1.7m by Welsh Government at the start of March 2015. It is forecast that £5.1m of this funding will have been used, and that consequently the UHB will start 2015/16 with circa 500 patients waiting over 52 weeks and 2,600 patients waiting over 36 weeks for treatment.

As shown in the chart below this does not reflect a standstill position over the course of the year, rather deterioration in the number of patients waiting in excess of 36 and 52 weeks in the first 10 months of the year and a marked improvement in the final two months of the year.

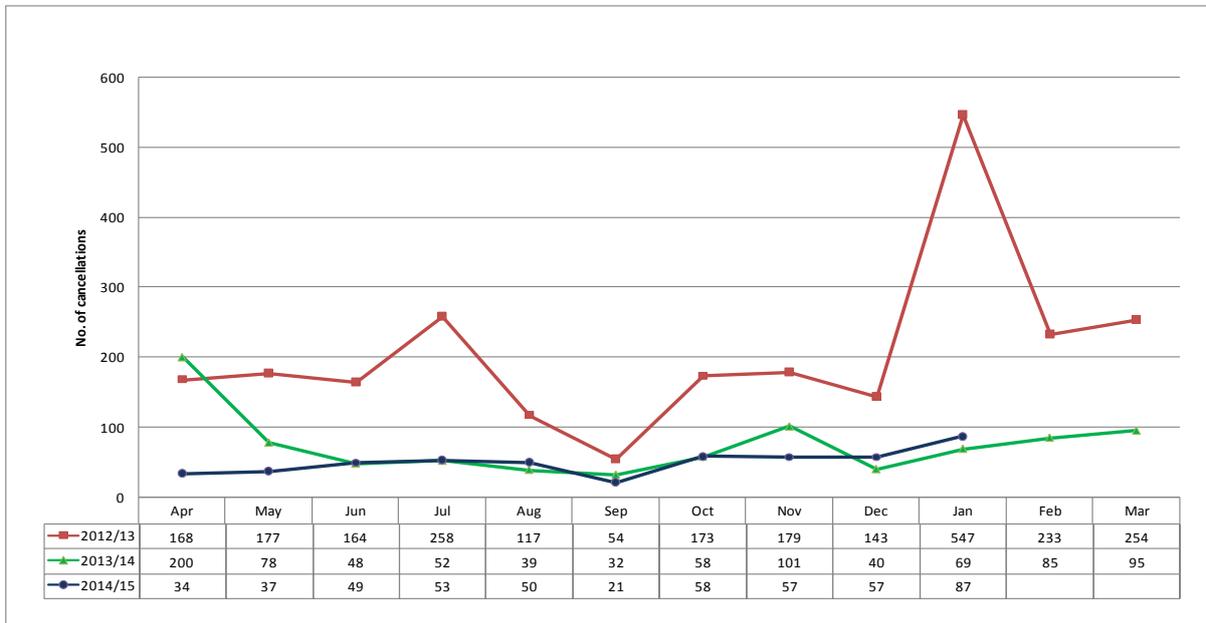


Specialty	Number of patients waiting more than 52 weeks	Number of patients waiting more than 36 weeks
ENT	30	312
General Surgery	100	401
Gynaecology	9	200
Ophthalmology	20	688
Orthopaedics	0	300
Paediatric Surgery	33	110
Urology	310	628
Total	502	2639

This position illustrates the impact that a number of system pressures have had on delivering an accessible and responsive elective care service. These pressures being:

1. Impact of the unscheduled care stream reducing available beds for elective capacity;

Admissions cancelled due to lack of beds



2. Utilisation of theatre capacity, both as a consequence of the continuing closure of a number of theatres due to estates problems such as flooding and hubris in the ventilation system, and a general shortfall in theatre staffing. These will be addressed in 2015/16 via a proposed capital solution to replace the plant in theatres and a recruitment drive to reduce the vacancies in the nursing and ODP workforce in theatres;

3. Lack of paediatric anaesthetists caused by a challenging environment for recruiting and retaining these specialists;
4. Capacity deficits in some key elective specialities where there is inadequate clinical resource to meet demand e.g. Urology, Breast and sub specialities in Orthopaedics and Gynaecology; and
5. The requirement to improve access times for surveillance and follow up patients, as a consequence of identifying significant backlogs of patients in these categories.

There has been a reduction in the number of admissions cancelled through lack of beds in 2014-15 compared to previous years that has been achieved largely through improvements in scheduling although the cancellation of surgery due to inadequate bed capacity continues to present a significant challenge.

Demand and capacity modelling

Considerable analysis and planning has been and will continue to be needed to model the demand and capacity requirements for all elective pathways. The methodology adopted uses a combination of time series forecasting and regression to project demand at a sub specialty level for 2015 / 16 based on historic trends and a bottom up approach at clinician level to determine capacity. Backlog is assessed taking into consideration historic urgency rates for demand, current waiting list shapes and the projected level of recurrent demand.

6.4.3 Priorities

Learning from current practice:

The UHB has already implemented some significant systemic improvements to improve and/or mitigate the RTT position. These include:

- Demand management:
 - Continuing focus on pathway development with GPs to optimise the number of patients that can be managed in primary care e.g. MSK, diagnostics pathways, or which can be directed straight to a diagnostic test without the need for an initial outpatient appointment;
 - Joint protocol development with secondary and primary care services to ensure patients are referred to appropriate service;
 - Further development of discharge and primary care support for patients in the ‘follow up cycle’;
 - Reviewing the application of guidance for surveillance and patients to ensure we have a prudent and safe balance for all patients; and
 - Reinstatement of the patient outcomes programme, to enable the cost effectiveness of the care to be objectively assessed and compared.
- Optimising appropriate patient uptake of surgery and outcomes through weight management and smoking cessation programmes;
- Performance and productivity improvements: These are under continuous review against prudent principles and good practice standards; the continued focus includes:
 - Providing ongoing monitoring in secondary care outpatient clinics in line with good practice to optimise capacity for new outpatients and ensuring opportunities for maximising the effectiveness of both tele and virtual care are realised;
 - Reducing outpatient DNAs through improvements to booking practices by using text reminders and targeting high risk patients;
 - Ensuring booking practices and waiting lists management are in line with good practice to ensure longest waiting patients are booked into routine elective capacity as a priority and that lists are routinely validated;
 - Aligning and monitoring clinicians’ job plans and theatre and clinic templates to ensure capacity is appropriately identified and delivered to support delivery of the IMTP;
 - Improvement to pre-assessment services to improve patients’ fitness and readiness for surgery in order to reduce avoidable cancellations;
 - Improvements to pre-scheduling theatre sessions to improve utilisation;
 - Provision of dedicated Post Anaesthetic Care Unit (PACU) to optimise elective surgical volumes and case-mix and clinical outcomes;

- Focus on theatre productivity through the 'Big Room' in order to continue the close scrutiny and assurance of ongoing efficiency gains; and
- Continuing emphasis on prudent intervention to ensure that all interventions are in line with the patient's needs and desired outcomes, clinical good practice and UHB policy.
- New ways of working – developing nursing, therapy and other appropriate healthcare professionals to undertake enhanced and extended roles to release medical capacity e.g. nurse-led flexi-cystoscopy service; and
- Delivery of flexible capacity: Short term additional capacity has been provided in a number of specialties in order to respond to non-recurring backlog pressures in order to reduce waiting times including additional bed capacity in the community and secondary care as well as some outsourcing.

There are significant 'hot spots' in elective surgical specialties and diagnostics that would require targeted additional capacity from the start of 2015 to ensure that the underlying capacity deficit is offset. The UHB will also face further challenges to the maintenance of existing elective capacity with changes to the education contract for trainees required by the Wales Deanery. This is required to enable the trainees to secure adequate operating experience to meet GMC requirements and, unless otherwise funded, will require a reduction in outpatient capacity to release the juniors to undertake more supervised operating.

The UHB's Planned Care Programme Board will lead the continued development, co-ordination, implementation and monitoring of the planned care improvement projects and initiatives to ensure that there is a coherent, whole system approach that will continuously inform the planning, delivery and continuous performance improvement cycle. This is a key component of the UHB's delivery structure.

Detailed planning continues to further refine the UHB's RTT commissioning and delivery plan for 2015-16.

Each service area for which there is a projected shortfall in recurrent capacity to meet demand will demonstrate the following for all high volume conditions:

- Prevention and public health opportunities are being explored and implemented;
- Pathway and other primary care based demand management tools are in place;
- Secondary care resources are being prudently deployed to deliver the outcome that matters to the patient; and
- Efficiency and productivity opportunities are optimised.

The following developments include the components of the UHB's Planned Care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- 1 Those priorities that the UHB will progress in 2015-16 in order to meet core clinical outcome requirements and eliminate > 52 week breaches by the end of Q1 - **these are factored into the financial plan, where appropriate at section 7**; and
- 2 Those priorities that the UHB will implement ***in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation*** - to eliminate any >36 week waits for elective specialties, > 8week waits for diagnostics and >14 week waits for therapies

1. The key priorities for these services to improve scheduled care include:		Target improvement
Scheme	Outcomes	
Continuation of the 2014/15 scheduled care delivery plan.		
To continue to work with primary care clusters to develop further planned care pathways for targeted conditions e.g. back pain.	Continue to reduce avoidable referrals to secondary care – releasing clinic capacity.	RTT < 52 weeks.
Extension of the programme for understanding patient outcomes and experiences (PROMS and PREMS).		Improved cost effectiveness of elective services.

Direct Listing for specific procedures e.g. hernia repair/gall bladder removal.	To increase clinic capacity.	RTT < 52 weeks.
Implement nurse led flexi-cystoscopy service.	To increase Urology operating capacity in main theatres.	
Benchmark intervention rates for high cost/high volume procedures.	To support clinical review to improve of effectiveness and efficiency.	RTT < 52 weeks.
Continue to improve theatre utilisation to meet internal 83% utilisation target.	To optimise recurrent elective capacity.	RTT < 52 weeks.
ALAS – redesign of service provision and increased capacity to meet demand.	To provide specialist wheelchair service to meet demand.	RTT < weeks.
Maintain PACU (currently non-recurrently funded).	To increase volume and case-mix of elective surgical capacity.	RTT < 52 weeks & 12 hour wait.
The following specialties all require some or all of the following in order to bridge a recurrent capacity shortfall in 2015-16 to maintain <52 week breaches - targeted productivity improvement (all), additional /replacement clinical appointments, additional sessions and/or external commissioning.		
Specialty	Additional capacity required	Target
<ul style="list-style-type: none"> Gynaecology. 	Backlog reduction: OP = 0; Treatment = 9. Recurrent capacity to maintain <52 weeks: OP = 347; Treatment = 594.	RTT <52 weeks.
<ul style="list-style-type: none"> Urology. 	Backlog reduction: OP = 0; Treatment = 310. Recurrent capacity to maintain <52 weeks: OP = 433; Treatment = 615.	RTT <52 weeks & Cancer.
<ul style="list-style-type: none"> General Surgery. 	Backlog reduction: OP = 0; Treatment = 120. Recurrent capacity to maintain <52 weeks: OP = 914; Treatment = 268.	RTT <52 weeks & Cancer.
<ul style="list-style-type: none"> ENT. 	Backlog reduction: OP = 0; Treatment = 30. Recurrent capacity to maintain <52 weeks: OP = 469; Treatment = 235.	RTT <52 weeks.
<ul style="list-style-type: none"> Ophthalmology. 	Backlog reduction: OP = 0; Treatment = 20. Recurrent capacity to maintain <52 weeks: OP = 156; Treatment = 365.	RTT <52 week.
<ul style="list-style-type: none"> Orthopaedics. 	Backlog reduction: OP = 0; Treatment = 0. Recurrent capacity to maintain <52 weeks: OP = 1074; Treatment = 384.	RTT <52 week.

<ul style="list-style-type: none"> Paediatric Surgery. 	Backlog reduction: OP = 0; Treatment = 33. Recurrent capacity to maintain <52 weeks: OP = 276; Treatment = 99.	RTT <52 weeks.
<ul style="list-style-type: none"> Diagnostics. 	Backlog reduction = 0; Recurrent capacity to maintain: = 9442.	RTT <52 week & 12 hour wait.
<ul style="list-style-type: none"> Endoscopy. 	OP = 362; Treatment = 2169.	RTT <52 week & Cancer.

2. The key priorities for these services to improve unscheduled care in secondary care with additional investment care include:		
Scheme	Outcomes	
The following specialties all require some or all of the following in order to bridge a recurrent capacity shortfall in 2015-16 to maintain <36 week breaches - targeted productivity improvement (all), additional clinical appointments, additional sessions and/or external commissioning.		
Specialty	Additional capacity required	Target
<ul style="list-style-type: none"> Gynaecology. 	Backlog reduction: OP = 1473; Treatment = 200. Recurrent capacity to maintain <36 weeks: OP = 347; Treatment = 594.	RTT <36 weeks.
<ul style="list-style-type: none"> Urology. 	Backlog reduction: OP = 1144; Treatment = 605. Recurrent capacity to maintain <36 weeks: OP = 433; Treatment = 615.	RTT <36 weeks & Cancer.
<ul style="list-style-type: none"> General Surgery. 	Backlog reduction: OP = 1598; Treatment = 371. Recurrent capacity to maintain <36 weeks: OP = 914; Treatment = 268.	RTT <36 weeks & Cancer.
<ul style="list-style-type: none"> ENT. 	Backlog reduction: OP = 0; Treatment = 312. Recurrent capacity to maintain <36 weeks: OP = 469; Treatment = 235.	RTT <36 weeks.
<ul style="list-style-type: none"> Ophthalmology. 	Backlog reduction: OP = 524; Treatment = 668. Recurrent capacity to maintain <36 weeks: OP = 156; Treatment = 365.	RTT <36 week.

• Orthopaedics.	Backlog reduction: OP = 742; Treatment = 300. Recurrent capacity to maintain <36 weeks: OP = 296; Treatment = 1074.	RTT <36 week.
• Oral Surgery.	Backlog reduction: OP = 0; Treatment = 0. Recurrent capacity to maintain <36 weeks: OP = 1291; Treatment = 703.	RTT <36 week.
• Diagnostics.	Backlog reduction = 9442; Recurrent capacity to maintain = 1109.	RTT <8 week & 12 hour wait.
• Endoscopy.	OP = 362; Treatment = 3305.	RTT <36 week & <8 week.
• Neurology.	Backlog reduction: OP = 522. Recurrent capacity to maintain <36 weeks: OP = 373.	RTT <36 week.
• Paediatric Surgery.	Backlog reduction: OP = 117; Treatment = 120. Recurrent capacity to maintain <36 weeks: OP = 276; Treatment = 99.	RTT <36 week.
• Paediatric Cardiology.	Backlog reduction: OP = 145. Recurrent capacity to maintain <36 weeks: OP = 106.	RTT <36 week.

The Planned Care Programme Board will sign off the detailed demand and capacity profile for each service that identifies the:

- Predicted recurrent demand at each stage of the pathway and underpinning assumptions;
- Non-recurrent demand i.e. waiting list backlog (based on the number of patients waiting above the RTT target); and
- Core capacity based on scheduled capacity (built bottom-up from job plans and clinical templates)

The Planned Care Programme Board will also identify and monitor:

- Internal targets for demand management in key services through the development of planned care pathways;
- Internal targets for delivery within core capacity that will be allocated to each service based on planned capacity including stretch productivity gains (currently being developed); and
- Any additional capacity plans (currently being developed in detail) to confirm the non-recurring and recurring solutions that are deliverable to achieve stepped improvements in the waiting times position.

6.5 Cancer Care

6.5.1 Context

The UHB is strongly committed to the Welsh Government Cancer Delivery Plan and its vision for people of all ages to have minimised risk of developing cancer and when it occurs, an excellent chance of surviving wherever they live in Wales. We are also striving to help Wales to have one of the best cancer incidence, mortality and survival rates in Europe. The UHB will continue to prioritise the commissioning and delivery of cancer services in 2015-16; it is one of the top 5 priorities within the UHB, under close scrutiny at the weekly 'Big Room' meeting and one of the six key service model themes within our 10 year strategy – Shaping our Future Wellbeing.

Incidence of top 3 newly diagnosed cancers in males in South Wales, 2007-2011. European age-standardised rate per 100,000 population. Source: Welsh Cancer Intelligence and Surveillance Unit (WCISU).

Cancer site	Year				
	2007	2008	2009	2010	2011
Prostate	125.5	118.7	106.9	110.1	104.8
Trachea, bronchus and lung	64.6	65.8	58.9	59.6	62.7
Colorectal	61.5	61.6	66.2	67.8	57.7
All excluding NMSC	471.5	465.2	440.2	448.2	444.9

Key: NMSC, non-melanoma skin cancer

Incidence of top 3 newly diagnosed cancers in females in South Wales, 2007-2011. European age-standardised rate per 100,000 population. Source: Welsh Cancer Intelligence and Surveillance Unit (WCISU).

Cancer site	Year				
	2007	2008	2009	2010	2011
Breast	122.2	126.1	128.7	131.4	116.9
Trachea, bronchus and lung	40.5	43.9	38.1	40.6	41.1
Colorectal	39.4	37.5	39.3	34.9	39.8
All excluding NMSC	379	384	390	390.8	382.1

Key: NMSC, non-melanoma skin cancer

- Causes of death

Top 5 causes of death in men, England and Wales 2012

Cause of death	EASR per million
Ischaemic heart disease	954
Trachea, bronchus and lung cancer	442
Cerebrovascular disease	341
Bronchitis, COPD	327
Pneumonia	260

Key: EASR, European age-standardised rate

Top 5 causes of death in women, England and Wales 2012

Cause of death	EASR per million
Ischaemic heart disease	426
Cerebrovascular disease	327
Trachea, bronchus and lung cancer	298
Breast cancer	239
Bronchitis, COPD	224

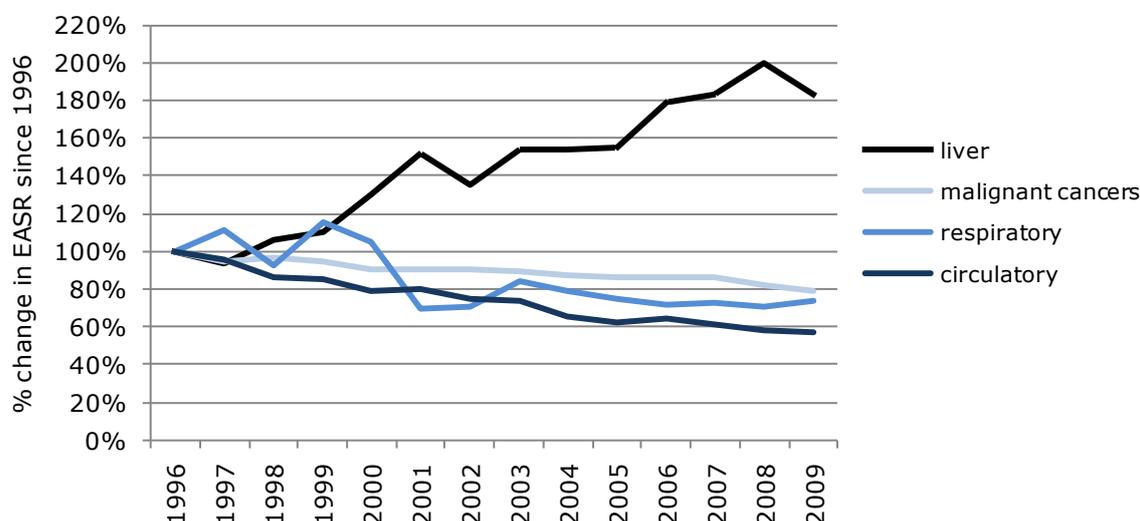
Key: EASR, European age-standardised rate

In Cardiff and Vale, although death rates from cancer, respiratory disease and heart disease overall are gradually decreasing, for some other conditions such as liver disease, mortality is increasing.

Changes in mortality rates for liver disease, cancer, respiratory disease and circulatory disease (Source: Public Health Wales Observatory, 2011)

Under 65 European age standardised mortality rates for various diseases, Wales, percentage change from 1996 baseline

Produced by Public Health Wales Observatory, using ADDE/MYE (ONS)



The cancer mortality rate continues to fall both in Cardiff and Vale and across Wales. This is perhaps the most important outcome of the cancer delivery plan and the Health Board will continue to work towards optimising early diagnosis and state of the art treatment for patients in Wales. In line with this, the one and five year survival rates are improving; these are slightly better for residents in Cardiff and Vale compared to the rest of Wales.

However, screening remains a challenge within the UHB resident population. Levels of uptake are lower in all programmes (breast, bowel and cervical screening) when compared the All Wales figures and it is clear that there is inequity in the uptake of screening with a lower uptake by residents living in more deprived areas. Reducing inequity is priority for Public Health Wales and this Health Board and a strategic approach to identifying and addressing these inequities is being implemented. The screening websites are being refreshed and a renewed focus put on digital communications and engaging with the population via social media.

A strong emphasis on supporting primary care oncology is evolving with the focus on developing pathways, supporting rapid diagnosis, improving fast-track access to diagnostics and the proposals for GP MacMillan facilitators.

The rates of smoking across Wales are continuing to fall and the population of Cardiff and Vale remain in line with this. There has been improvement in the number of patients setting a 'Smoking Quit Date' and there has

been a full no smoking ban across all hospital sites in Cardiff and Vale since 2012. Smoking cessation however, remains a challenge.

There have been some exciting innovations in new technologies with the successful implantation of robotic surgery for patients with prostate cancer that dramatically improves patient experience and outcomes. This approach will be rolled out to other specialties and to other Health Boards where appropriate.

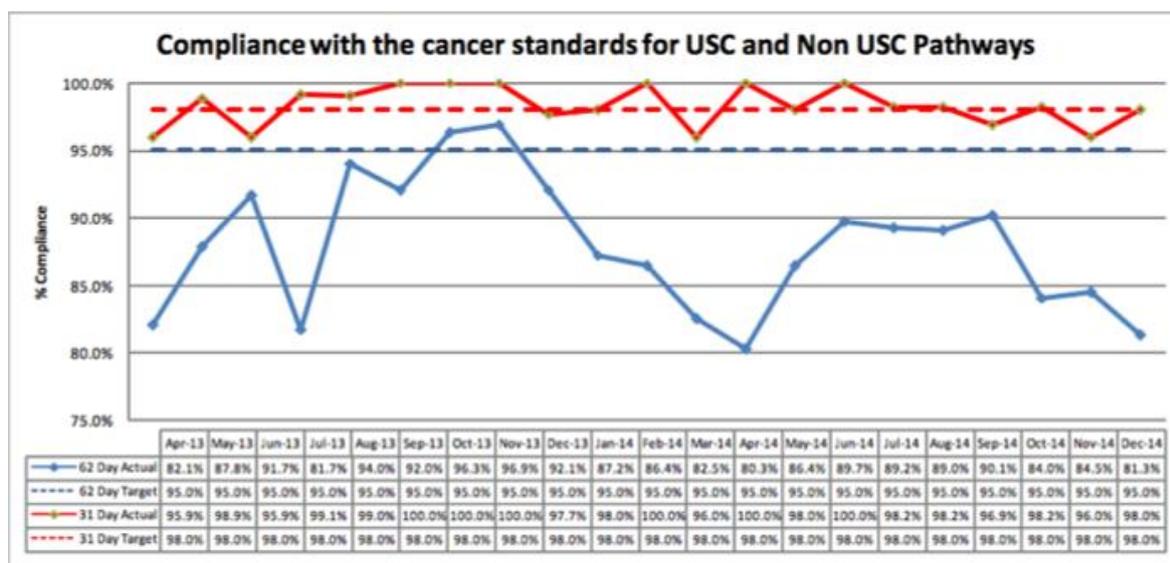
An Acute Oncology Service (funded by MacMillan) has been established to support those patients with acute complications of their treatment, metastatic spinal cord compression and those with metastatic disease from an unknown primary.

The implementation and delivery of the UHB's cancer action plan is led by the Medical Director and available at the UHB's website. The UHB has produced and submitted to Welsh Government a detailed Delivery Plan for Cancer and this section will highlight the performance profile and key actions planned to accelerate the delivery of the cancer action plan.

6.5.2 Performance

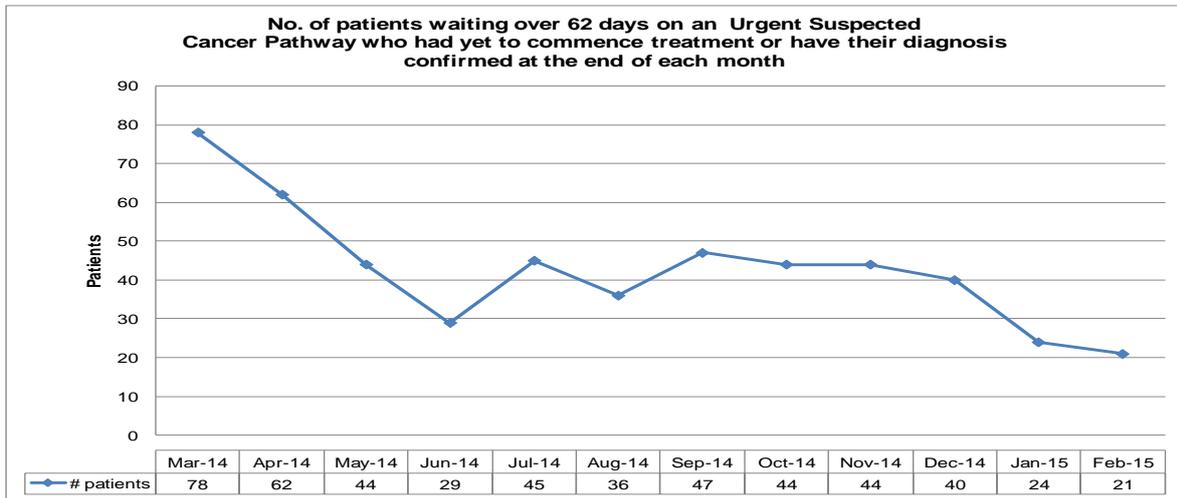
There is a strong focus on the performance against the cancer service targets within secondary care as Cancer is one of the UHB's priorities under continuous scrutiny by the CEO through the weekly 'Big Room' holding to account sessions. It is one of the six key service model themes within our 10 year strategy – Shaping Our Future Wellbeing.

The following table illustrates the UHB's performance against the 31 and 62 day targets; the organisation aims to recover the position that was reached in the autumn of 2013.



The pressure on beds over the winter period has put additional challenge into the system to maintain activity to meet the cancer targets but a continuous scrutiny and rigorous pathway management has enabled the UHB to achieve the best performance in Wales against the 31 day target.

The number of patients who had been waiting in excess of 62 days yet to commence treatment again continues to reduce and the UHB aims to reduce this number to 6 in order to deliver on a sustainable basis the UHB needs to reduce this backlog to circa 6 patients.



The main areas of challenge to meeting cancer targets are the backlog and capacity pressures particularly in Urology and Gastrointestinal specialties due to increasing demand and, in part in Urology, the impact of the robot – for which there is a much higher than predicted demand.

At an operational delivery level the main area of risk remains delivery of the urology and GI cancer pathways within 62 days, with excess waiting times noted at the admitted diagnostic (cystoscopy and endoscopy) and surgical treatment stages of the pathway due to increased demand. Despite these pressures there has been good focus on optimising existing capacity through continuous improvement in scheduling and productivity.

6.5.3 Priorities

Learning from current practice:

The Big Room focus has enabled the complex variables that impact on the delivery of Cancer care to be scrutinised with the wider clinical leadership responsible for different components of the pathway. From this process a range of pathway and capacity issues have been identified and are currently being addressed in order to reduce, and ultimately remove, the bottlenecks from this complex system and to ensure the most effective deployment of resources to deliver the pathway requirements.

The following developments include the secondary care components of the UHB's Planned Care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical outcome requirements and eliminate <31 day breaches by the end of Q1- **these are factored into the financial plan, where appropriate, at section 7**; and
- Those priorities that the UHB will implement *in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation* - to meet all priorities identified in the Cancer Delivery Plan.

1. The key priorities for these services to improve cancer care include:		Target improvement
Scheme	Outcomes	
Focus on improving pathways between primary and secondary care in collaboration with Velindre	To accelerate diagnosis and improve pathway management	<31 day wait NUSC
Appointment of MacMillan GP facilitators	To improve the primary care support for oncology services	<62 day wait USC
Implement nurse led flexi-cystoscopy service in Urology	Increased treatment capacity in Urology theatres	
Additional medical capacity in Urology, Colorectal and Endoscopy services	Addressing the underlying capacity deficit to meet demand for these specialties	
Continue to develop action plans for each tumour site to address recommendations from Peer Review visits to tumour sites	Identify resource requirements to deliver quality service improvements	
Continue to develop proposals for Teenage Cancer Centre	To inform commissioning negotiations for the development of this South Wales service	

2. The key priorities for these services to improve cancer care with additional investment include:		All improve Clinical Outcomes
Scheme	Outcomes	
Implement action plans for Peer Review visits	Cancer care services that will deliver all Cancer Delivery Plan standards.	
Full implementation of acute oncology service		

6.6. Stroke Care

6.6.1 Context

The development of Stroke Services in recent years has been a national priority for the NHS in Wales and a local priority for the UHB. Stroke has been identified as one of the UHB's top 5 priorities, and delivery of nationally set and agreed KPIs is a Tier 1 priority for the UHB in 2015/16.

Stroke is one of the top three causes of death. It is estimated that there are around 11,000 stroke events, including 6,000 new strokes, per year in Wales. This crudely translates to around 1,650 stroke events in Cardiff and Vale, including around 900 new strokes per year (incidence) and there is a higher risk for certain ethnic minorities. The UHB admits approximately 600 people with stroke per year. Outpatient activity highlights that 35 patients/month, who have a confirmed diagnosis of Transient Ischemic Attack (TIA), are assessed and treated. Our rate for Cardiff is lower than the all Wales rate, whereas the rate for the Vale of Glamorgan is higher than the all Wales rate. The Vale rate remains lower than eight other local authority areas of Wales. Around 25% of strokes occur in people who are under the age of 65. It is a leading cause of adult disability. Between 20 to 30% of people who have a stroke die within a month.

As outlined from the Daffodil database, the Cardiff & Vale population who has received treatment for a Stroke has increased, and is projected to continue to increase in future years.

Data for: Cardiff and Vale					
Table produced on 22/01/15 18:02 from www.daffodilcymru.org.uk version 5.0					
People aged 16 and over predicted to have received treatment for a stroke, by age and gender, projected to 2030					
	2013	2015	2020	2025	2030
People aged 16-24 who have received treatment for a stroke	378	380	359	363	391
People aged 25-34 who have received treatment for a stroke	373	392	428	432	410
People aged 35-44 who have received treatment for a stroke	303	308	332	376	411
People aged 45-54 who have received treatment for a stroke	618	619	593	583	624
People aged 55-64 who have received treatment for a stroke	1,260	1,294	1,417	1,457	1,404
People aged 65-74 who have received treatment for a stroke	1,874	1,984	2,190	2,298	2,530
People aged 75 and over who have received treatment for a stroke	3,790	3,895	4,322	5,163	5,897
Total population aged 16 and over who have received treatment for a stroke	8,598	8,873	9,641	10,672	11,667
Figures may not sum due to rounding. Crown copyright 2014					

Stroke prevalence

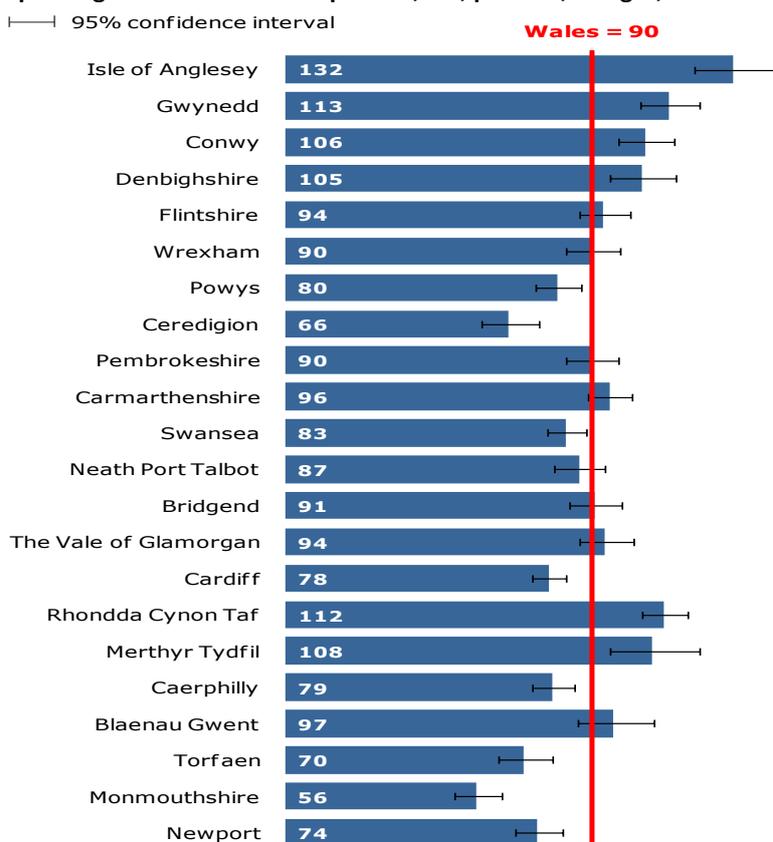
There were 1.3 % of patients on GP practice registers in Cardiff and Vale of Glamorgan in 2012 (age-standardised percentage) with stroke (see tables below). This is the 3rd highest percentage of the seven Health Board areas and is equivalent to the proportion of patients recorded in Aneurin Bevan Health Board.

Morbidity

Hypertension and atrial fibrillation are particularly important risk factors for stroke. The table below highlights the relative burden of recorded hypertension from GP Practice registers in 2012, grouped by the nine neighbourhoods/areas of Cardiff and the Vale of Glamorgan. Recorded hypertension the University Health Board area, at 10.9% of all patients, is lower than Wales at 11.1%.

Stroke emergency admissions, 2009/10-2011/12

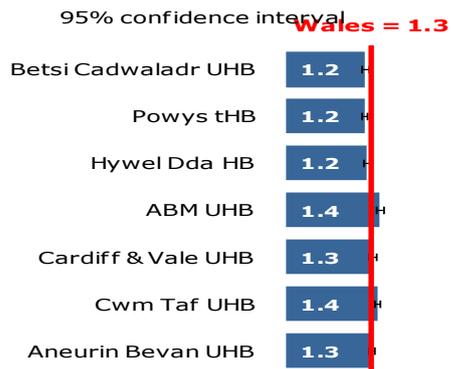
European age-standardised rate per 100,000, persons, all ages, Wales local authorities



Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

Proportion of patients with stroke on GP practice registers, age-standardised percentage, persons, all ages, Wales health boards, 2012

Produced by Public Health Wales Observatory, using (QOF) Audit + (NWIS)



Age-standardised % of patients on selected chronic conditions registers, Cardiff & Vale UHB, 2012

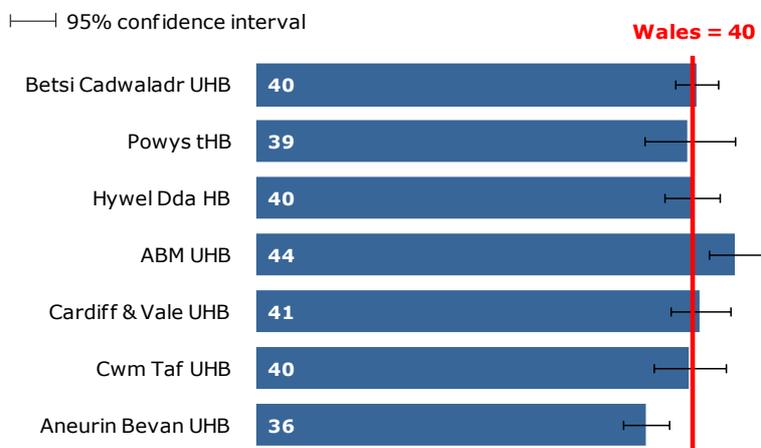
GP cluster	Age-standardised percentage of GP cluster patients on register						
	Asthma	Hypertension	CHD	COPD	Diabetes	Epilepsy	Heart Failure
Cardiff East	6.7	12.2	2.8	1.6	4.3	0.7	0.6
Cardiff North	6.5	10.4	2.2	0.9	3.2	0.5	0.6
Cardiff South East	5.7	11.3	2.6	1.7	4.3	0.6	0.6
Cardiff South West	7.2	11.4	2.6	1.6	4.4	0.6	0.5
Cardiff West	6.6	9.8	2.2	1.0	3.2	0.5	0.5
Central Vale	7.1	12.3	2.7	1.4	4.2	0.7	0.5
City & Cardiff South	6.0	11.8	2.6	1.5	5.8	0.6	0.6
Eastern Vale	6.2	9.6	2.2	0.9	3.3	0.5	0.4
Western Vale	6.1	9.6	2.2	0.9	3.0	0.5	0.7
Health Board	6.4	10.9	2.4	1.2	3.8	0.6	0.5
Wales	6.4	11.1	2.6	1.4	3.9	0.7	0.6

Produced by Public Health Wales Observatory, using Audit+ (NWIS)

Stroke mortality

Tables below provide the European age-standardised stroke mortality rate for 2009 – 2011 by Health Board. Cardiff and Vale UHB is above the Welsh average with the second highest stroke mortality of the 7 health boards, after ABM UHB.

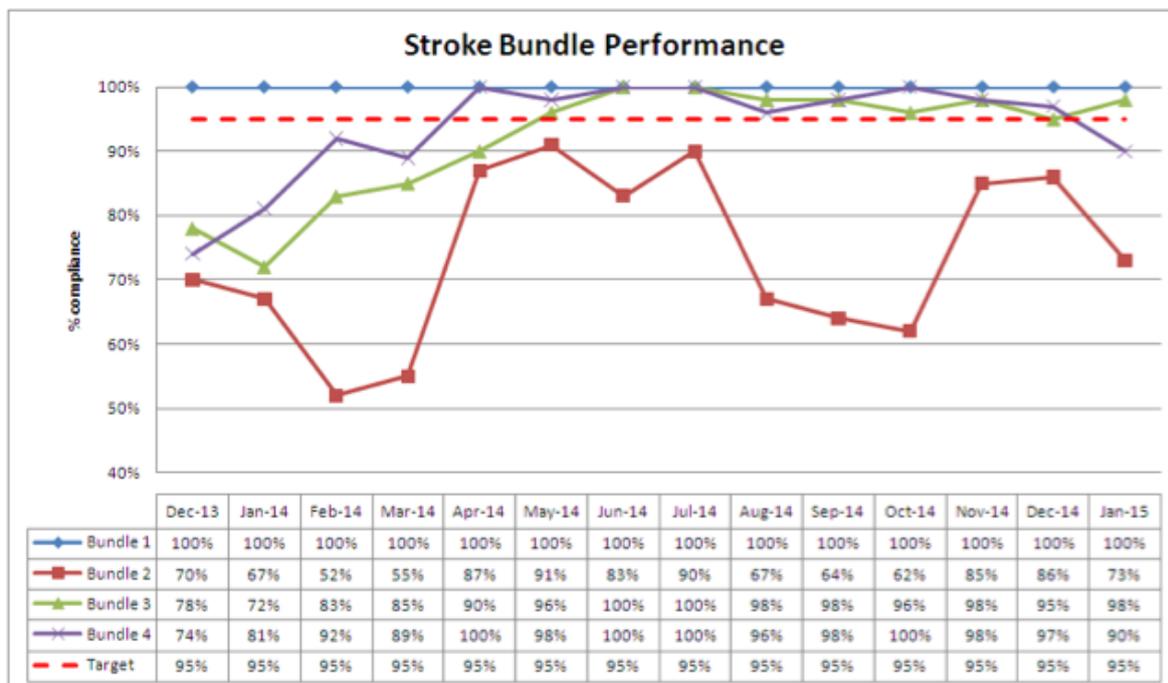
Stroke mortality, 2009-2011 Produced by Public Health Wales Observatory, using ADDE & MYE
European age-standardised rate per 100,000, adjusted for coding change, persons, all ages, Wales health boards



Our stroke 30 day mortality rate in 2013/14 was 17%, confirmed by thorough analysis of our patient data. The monitoring of and steady reduction in patient mortality has continued to be a top priority during 2013/14.

6.6.2 Performance

Stroke bundles are currently part of the Tier 1 performance set.



Delivery of bundle 2 is impacted upon by early diagnosis of stroke, availability of therapy staff and ability to transfer patients to the acute stroke unit. The UHB's performance against 3 out of the 4 bundles is consistently the best in Wales and is second best for the remaining bundle.

The UHB's current performance against the CPI's that will represent the Tier 1 target from 1st April 2015 is as follows:

Category	CPI 1st April 2015	Performance Dec 14
1 - Percentage of All Strokes Thrombolysed	N/A	15.5%
2 - Percentage of Eligible Patients Thrombolysed*	100%	55.6%
3 - Thrombolysed Patients with Door-to-Needle <= 30 mins	50%	22.2%
4 - Thrombolysed Patients with Onset-to-Needle <= 90 mins	90%	55.6%
5 - Thrombolysed Patients with Post Thrombo NIHSS Score	100%	100.0%
1. < 4 Hours Bundle	95%	27.6%
1b - Direct Admission to Acute Stroke Unit	95%	34.5%
1c - Swallow Screening	95%	48.3%
2 - < 12 Hours Bundle	95%	94.8%
2a - CT Scan	95%	94.8%
3 - < 24 Hours Bundle	95%	62.1%
3a - Assessed by Stroke Consultant	95%	75.9%
3b - Assessed by Stroke Nurse	95%	91.4%
3c - Assessed by One of OT, PT, SALT	95%	81.0%
4 - < 72 Hours Bundle	95%	65.5%
4a - Formal Swallow Assessment	95%	89.7%
4b - OT Assessment	95%	70.7%
4c - Physiotherapy Assessment	95%	96.6%
4d - SALT Communication Assessment	95%	89.7%

The UHB's key challenge will be the delivery of the 4 hour target and ensuring timely access to the Acute Stroke Unit. This is constrained by a number of key issues; the following have the biggest impact:

- Not having sufficient capacity at all times on the Acute Stroke Unit – a delay that is often exacerbated by the inability to transfer patients to the rehab unit; and
- Having insufficient capacity to provide 7 day service for therapy assessments.

Key to delivering against the whole system stroke pathway is ensuring sufficient capacity on the acute stroke unit that is entirely dependent on having sufficient capacity at the Stroke Rehabilitation Centre (SRC) and thereafter timely onward transfer to community teams.

Given the nature of Stroke and the key dependency of effective rehabilitation, ensuring that the appropriate level of therapy support is available at each stage of the pathway is critical to ensuring both effective flow and maximizing patient outcomes.

Benchmarking our stroke services has confirmed that the LOS is significantly above our peer organisations. This is certainly partly due to the lack of community hospital rehabilitation services but provides a focus for our development proposals within both secondary and integrated community services.

The other challenges to delivering the CPIs currently are associated with ensuring the right input from the required staff groups at the appropriate time within the pathway. This is a key challenge for Consultant and Therapy input in particular within 24 hours (where there is no Consultant cover at weekends), and Therapy input within 72 hours.

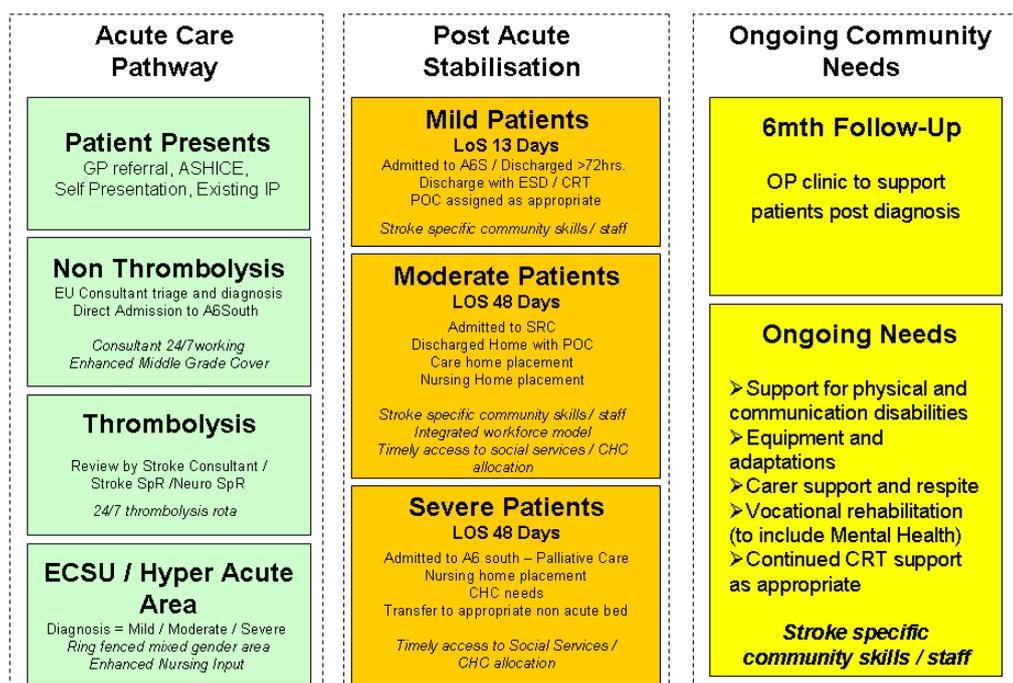
6.6.3 Priorities

Learning from current practice:

There is likely to be increasing demand via EU and also directly on the acute stroke unit as a result of proposed changes to the acute stroke pathways in neighbouring health boards. For this reason, the UHB will recommend that a joint scoping exercise is commissioned to identify the predicted demand and most appropriate model for hyper acute stroke care in South Wales in order to provide a sustainable model of care for this highly vulnerable group.

The Stroke team's current pathway and vision for comprehensive Stroke services is outlined on the schematic below with the pathway described in three distinct but inter-dependent stages – acute care, post acute stabilisation and ongoing community care:

Stroke Care Pathway



Deliver Care Performance Indicators & Maximise Patient Outcomes

Stroke performance within the UHB is improving. In order to achieve compliance with core performance targets there are a number of work-streams in place in order to develop and deliver the necessary improvements. This includes putting in place sustainable solutions to ensure Stroke services are on a stable footing on a recurrent basis.

Between November 2014 and March 2015 the UHB stroke group along with Executive leads reviewed and refreshed the 2014-15 stroke delivery plan setting out strategic objectives and required actions. The UHB's stroke MDT continues to:

- Use real time pathway information for understanding the needs of the patients as they progress along their care pathway;
- Use board rounds on the acute and rehab units to ensure that daily care plans are being delivered;
- Progress implementation of 'code stroke' in EU to improve standardisation of clinical management of stroke patients within EU; and
- Focus on supporting the discharge planning and enhancing stroke community rehabilitation flow of stroke patients into the community.

In addition to these national priorities Cardiff and Vale UHB highlights the following priorities for 2015/16 that reflect the needs of the local population.

Stroke Prevention

- To promote stroke risk reduction plans.

Detecting Stroke quickly

- To educate and raise awareness of citizens and healthcare profession also in stroke detection.

Delivering fast, effective care

- Agree and implement 'Code Stroke' including actions required to respond with urgency to facilitate timely conveyance with ASHICE, CT scan, Thrombolysis and admission to acute stroke unit;
- Working on a regional basis develop an evidence-based model for a sustainable high quality hyper acute stroke care;
- To undertake a review of capital equipment requirement for all areas of the pathway;
- Deliver an effective rehabilitation model;
- To identify the bed capacity required to deliver the stroke pathway;
- To strengthen integrated working with Local Authority partners; and
- Ensure compliance with All Wales repatriation policy.

Supporting Life after Stroke

- Embed delivery plan for Life after stroke and 6/12 follow up model.

Targeting research

- To develop a research and development delivery plan for stroke.

Improving information

- To ensure effective monitoring using a suite of performance and service improvement measures to meet requirements of WG and SSNAP monitoring.

Workforce planning

- Develop effective workforce planning to deliver integrated stroke pathway; and
- To ensure staff have the appropriate knowledge and skills to meet the needs of our service users.

Service user engagement plan

- Develop service user engagement plan;
- 3rd Sector Engagement; and
- Undertake EQIA assessment to support the Delivery Plan .

Leadership and Management

- To improve and implement an organisational structure which identifies clear lines of accountability and communication for clinical and operational delivery of the Stroke Pathway; and
- Engage with other LHBS re national and regional stroke developments including any implications for flow of patients to UHW.

For 2015/16 the following national priorities have been agreed:

- Management of atrial fibrillation – hence the continued incentivising of GPs to apply the AF pathway;
- Exploration of a hyper-acute stroke unit model/ enhanced acute stroke unit – the UHB will recommend that this should be progressed collaboratively on a regional basis; and
- Scoping of community rehabilitation and Early Supported Discharge services – to develop proposals to further enhance specialist support to extended community resource teams.

The following developments include the UHB's priorities for its stroke care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical outcome requirements to maintain current stroke performance - **these are factored, where appropriate, into the financial plan at section 7**; and
- Those priorities that the UHB will implement *in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation* - to meet the priorities identified in the UHB's internal Stroke business case.

1. The key priorities for these services to improve stroke care include:		Target improvement
Scheme	Outcomes	
Stroke Rehabilitation Beds	Improve flow within hospital pathway.	Bundle 2
Enhance community resource teams	Improve support to improve timely transfer from secondary care to community teams	Bundle 2

2. The key priorities for these services to improve stroke care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Additional medical capacity to provide 7 day medical cover	Developments recommended in the UHB's stroke business case to address capacity and deficits across all areas of the stroke pathway – these investment proposals would provide improvement against all of the bundles.	Bundle 3
Additional liaison and social care support		Bundle 1
Additional Specialist community nurse support		Bundle 1
Additional CT capacity		Bundle 2
7 day therapy capacity		Bundles 1 & 4
Dedicated SSNAP capacity		

6.7 Long Term Conditions (LTC) with the focus on Diabetes

6.7.1 Context

The importance of tackling diabetes was highlighted in the UHB's proposal for meeting future challenges, *Organising for Excellence*. A further focus on diabetes was included in the 2012 Director of Public Health Annual Report - *Getting the balance right: allocating resources for health and wellbeing*. In 2013, recognising obesity as an important risk factor for developing diabetes, the focus for the Director of Public Health Annual Report was *Obesity: the bigger picture*,

There are around 21,000 adults within Cardiff and Vale who are on a register with their GP with a diagnosis of diabetes (type 1 or type 2), more than 1 in 20 adults in the area. This corresponds to a rate of 42.7 per 1000 residents, compared with a Wales average of 52.0. However, because Cardiff in particular has a relatively young population, if these figures are adjusted to take account of the age structure, then the 'standardised' rate is 38.4 per 1000, compared with a Wales standardised rate of 39.3 per 1000.

The number of people currently diagnosed with diabetes across Cardiff and Vale, and recorded on the GP practice register, are shown below.

People with diabetes on GP registers in Cardiff and Vale

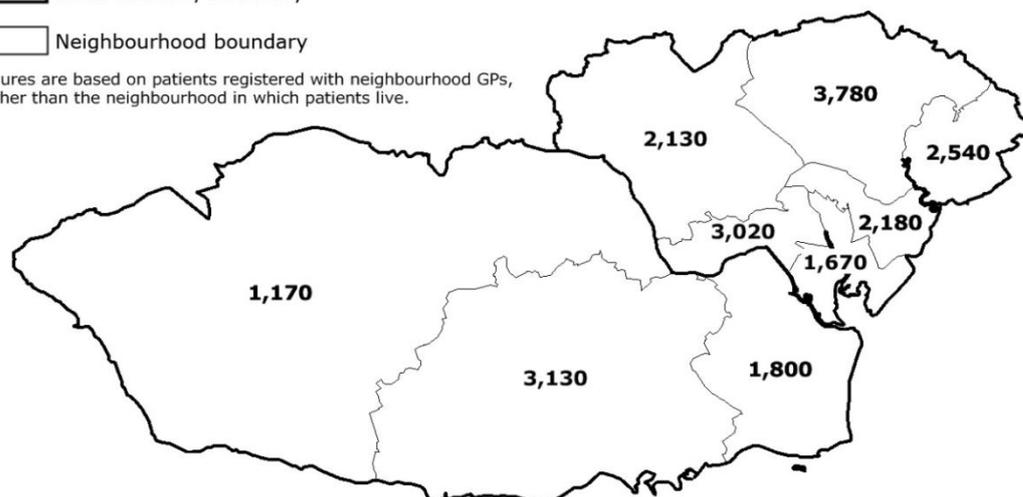
Number of people on GP diabetes registers, 2012

Neighbourhood management areas in Cardiff and The Vale of Glamorgan

 Local authority boundary

 Neighbourhood boundary

Figures are based on patients registered with neighbourhood GPs, rather than the neighbourhood in which patients live.



Produced by Public Health Wales Observatory, using Audit+ (NWIS)
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This is lower than the numbers who actually have the disease, in particular for type 2 diabetes. In a large regular survey of people living in Wales, 6% of adults living in Cardiff and Vale reported being treated for diabetes. Across Wales, this figure has been rising slowly over the last ten years, from 5% in 2003/4 to 7% in 2012. It has been estimated that there are actually 29,000 adults in Cardiff and Vale with diabetes, around 8% of the population. This suggests there is a shortfall in diagnosis of around 8,000 adults, or over a quarter of predicted cases. This unmet need represents people who are not currently diagnosed who would potentially benefit from early intervention to delay progression of their disease and its associated complications.

Recorded prevalence of diabetes varies significantly within areas of Cardiff with higher black and minority ethnic (BME) population. Since diabetes is more common in South Asian and black ethnic groups, higher recorded prevalence would be expected here. However, within the Cardiff City and South neighbourhood area, recorded prevalence varies between GP practices from 2.7% to 7.1%, hinting at under-diagnosis in some areas.

There are 220 children and young people with diabetes, aged under 17 cared for by Paediatric Diabetes Units in Cardiff and Vale, out of approx 1,500 children and young people with diabetes in Wales, and out of around 92,000 people in this age group in Cardiff and Vale. Although representing only a quarter of one percent of young people in Cardiff and Vale, diabetes in this age group presents a significant challenge and can be severe. There is increasing evidence that tracking of diabetes control occurs throughout childhood and into adulthood, hence the importance of getting care optimized early. In Wales control of blood sugar levels is poorer in children and young people than in England

The rate of type 1 diabetes in adults is roughly stable, but type 2 diabetes has been increasing significantly over the past few years, and with rates of overweight and obesity among adults rising this looks set to continue. Additionally, as the population becomes older this is likely to increase the number of complications seen in people with diabetes. Current projections are for the adult population with diabetes in Cardiff and Vale to increase from around 29,000 to around 40,000 by 2025, an increase of nearly 40%.

There has been a small increase in the rate of new cases of type 1 diabetes in children and young people, although the cause is unclear. The rate of type 2 diabetes in children and young people in Wales has remained at under 2% (less than 1 in 50 cases of diabetes in children) over the past 7 years and is not markedly increasing.

LTC prevalence GP clusters

Around 1 in 7 (15%) of the local adult population considered their day-to-day activities were limited a lot by a long-term health problem or disability. A third (32%) had a limitation of any sort. These rates are slightly lower than the Wales average of 16% and 34% respectively.

Age-standardised percentage of patients on selected chronic condition registers, Cardiff & Vale UHB, 2012, to indicate the relative burden of recorded disease across GP clusters having taken age into account.

Source: Public Health Wales Observatory (2013)

Area	Chronic condition					
	Asthma	CHD	COPD	Diabetes	Epilepsy	Heart failure
Cardiff East	6.7	2.8	1.6	4.3	0.7	0.6
Cardiff North	6.5	2.2	0.9	3.2	0.5	0.6
Cardiff South	5.7	2.6	1.7	4.3	0.6	0.6
Cardiff South East	7.2	2.6	1.6	4.4	0.6	0.5
Cardiff South West	6.6	2.2	1.0	3.2	0.5	0.5
Cardiff West	6.6	2.2	1.0	3.2	0.5	0.5
Central Vale	7.1	2.7	1.4	4.2	0.7	0.5
City & Cardiff	6.0	2.6	1.5	5.8	0.6	0.6
South	6.2	2.2	0.9	3.3	0.5	0.4
Eastern Vale	6.2	2.2	0.9	3.3	0.5	0.4
Western Vale	6.1	2.2	0.9	3.0	0.5	0.7
Cardiff and Vale	6.4	2.4	1.2	3.8	0.6	0.5
UHB						
Wales	6.4	2.6	1.4	3.9	0.7	0.6

Key: COPD, chronic obstructive pulmonary disease; CHD, coronary heart disease

Note: There are nine 'clusters' of GP practices across Cardiff and Vale, six in Cardiff and three in the Vale: Cardiff East, Cardiff North, Cardiff South, Cardiff South West, Cardiff West, City and South Cardiff; and Eastern Vale, Central Vale and Western Vale.

Inequalities

It is thought that the number of people who have been diagnosed with diabetes and appear on the GP registers, 21,000, is lower than the number who actually have the disease, in particular for type 2 diabetes. (Association of Public Health Observatories, 2011). It has been estimated that there are actually 29,000 adults in Cardiff and Vale with diabetes, around 8% of the population. This suggests there is a shortfall in diagnosis of around 8,000 adults, or over a quarter of predicted cases.

The percentage of people reporting being treated for diabetes has been rising steadily over the last ten years across Wales. Current projections are for the adult population with diabetes in Cardiff and Vale to increase from around 29,000 to around 40,000 by 2025, an increase of nearly 40%. Recorded prevalence of diabetes varies significantly within areas of Cardiff with higher black and minority ethnic (BME) population. Since diabetes is more common in South Asian and black ethnic groups, higher recorded prevalence would be expected here. However, within the Cardiff City and South neighbourhood area, recorded prevalence varies between GP practices from 2.7% to 7.1%, hinting at under-diagnosis in some areas.

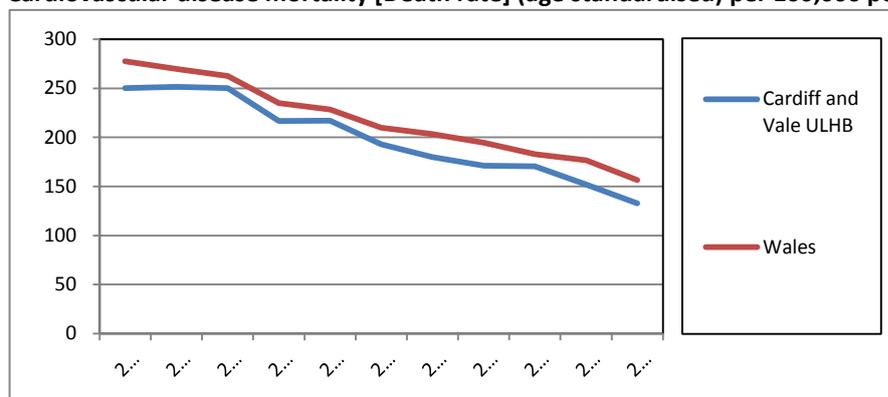
Cardiovascular mortality

Data interpretation

The first table below shows that the age-standardised cardiovascular death rate in Cardiff and Vale is lower than for Wales as a whole, and has gradually decreased between 2001 and 2011, which mirrors the pattern for Wales.

The following tables show that patients in Cardiff and Vale have a lower risk of myocardial infarction (heart attack) and stroke than for Wales, as well as a lower rate of death (see figure below).

Cardiovascular disease mortality [Death rate] (age standardised) per 100,000 population



Cardiovascular disease service priorities

Additional work is required to address variation in risk factor management for both primary and secondary prevention. Data analysis within the equity of access work stream will enable investigation of any inequities to enable targeting at the neighbourhood /area geographical levels.

Service improvement planning is on-going to deliver:

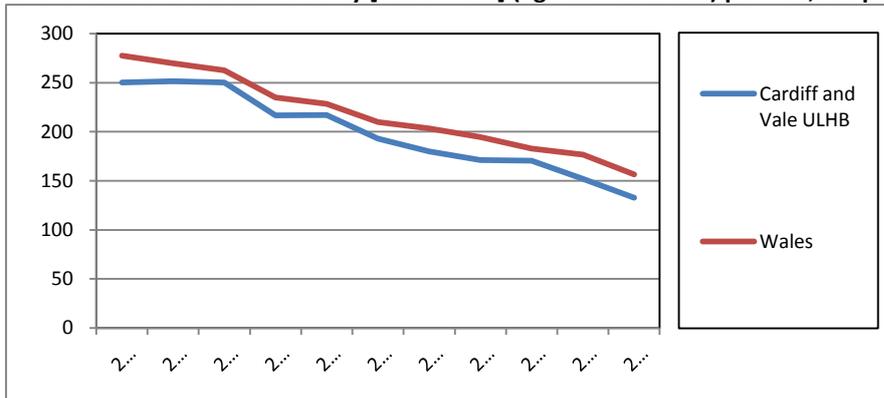
- Further pathway work between primary and secondary care including on alternatives to clinic referral
- Development of a new cardiology diagnostic department
- Further development on increasing capacity to improve access to revascularisation (percutaneous coronary intervention) and cardiac surgery
- Further development of heart failure services
- Further development of other services including ablation services, device services and services for adult congenital heart disease

6.7.2 Performance

As per the outcome indicators within the Welsh Government Diabetes Delivery Plan, the UHB Diabetes Annual Report October 2014 presents the following:

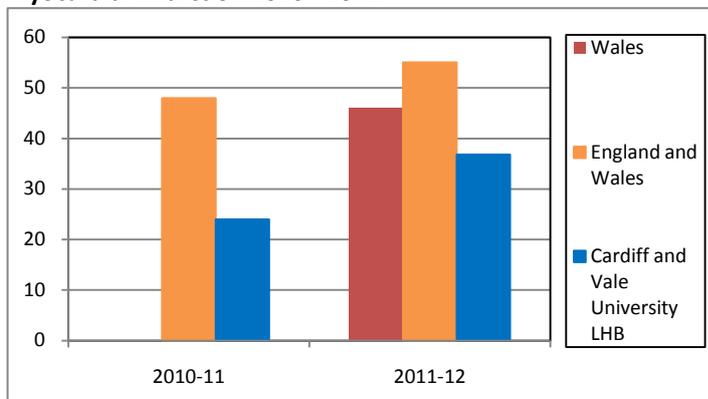
Cardiovascular disease (CVD) problems are between 1.5 and 4.3 times more likely in people with diabetes than the general population. Improved control of blood glucose, blood pressure and lipids will reduce the incidence of cardiovascular events.

Cardiovascular disease mortality [Death rate] (age standardised) per 100,000 population

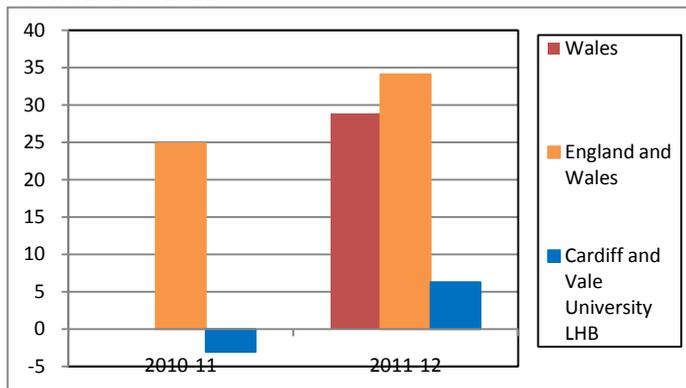


The age-standardised cardiovascular death rate in Cardiff and Vale is lower than for Wales as a whole, and has gradually decreased between 2001 and 2011, which mirrors the pattern for Wales. The following tables show that patients in Cardiff and Vale have a lower risk of myocardial infarction (heart attack) and stroke than for Wales, as well as a lower rate of death.

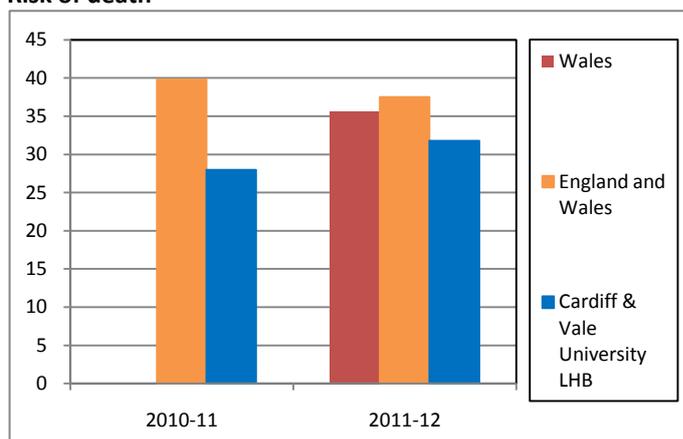
Myocardial Infarction 2010 - 2012



Stroke 2010 – 2012

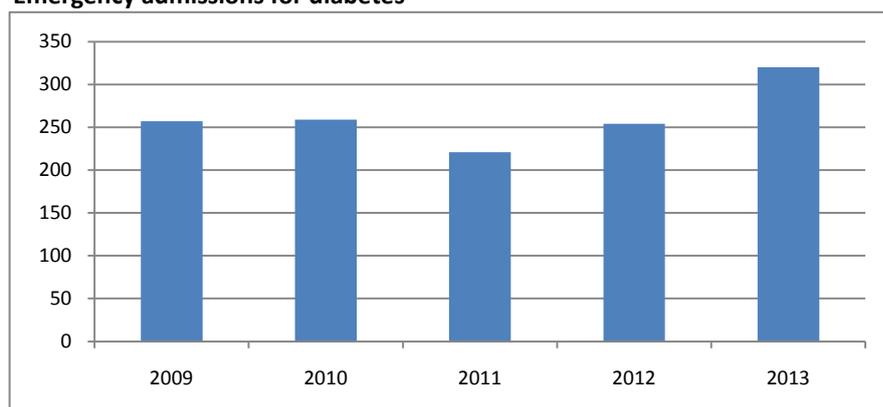


Risk of death



Emergency admission rates are an indication of how well diabetes patients are managing their condition. The table below highlights periods of increase in emergency admissions to Cardiff and Vale UHB due to diabetes during the period 2009 – 2013. Interpretation of numbers of hospital admissions is more difficult to interpret than a rate, which would account for changes in age structure in our population. Causes for emergency admissions are multiple and could relate to undiagnosed diabetics presenting with symptoms (then diagnosed on admission), extent of good personal control of diabetes, level of support in the community and the pattern and quality of primary and community care. Our community model for the management of diabetes, which focuses on the management and support of patients with type 2 diabetes should, together with other actions we are delivering, help control the number of emergency admissions from diabetes in the future.

Emergency admissions for diabetes



Chronic Conditions - Reductions in Emergency Admissions (rolling 12 months)

Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
254	248	254	249	249	245	254	245						245

Chronic Conditions - Reductions in Emergency Readmissions within 1 year (rolling 12 months)

Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
60													
60	52	53	58	58	61	60	58						58

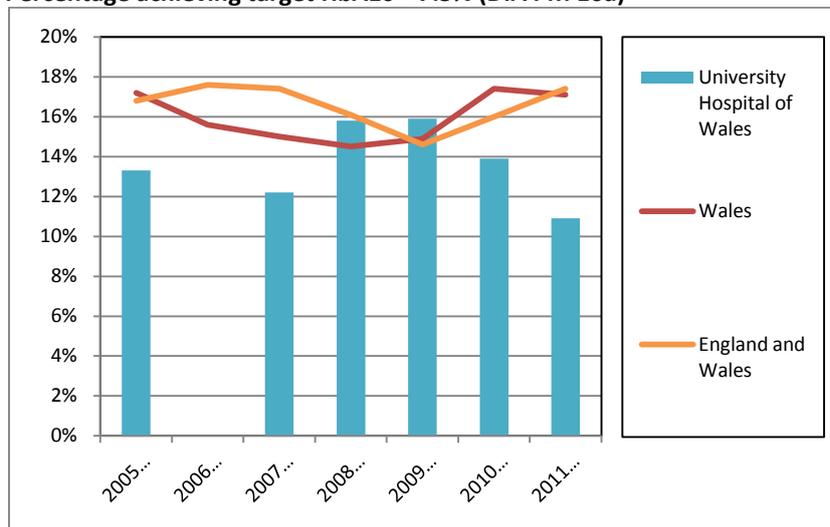
The UHB has introduced and implemented a single diabetes pathway with primary care including the establishment of a community diabetes service model.

Children and Young People

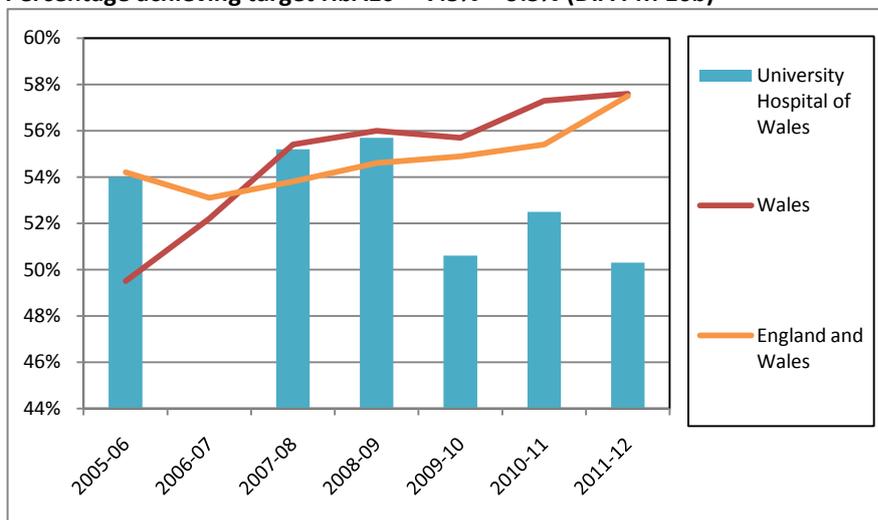
Type 1 diabetes is one of the most common chronic diseases in childhood. A key factor in reducing the impact of diabetes is good control of blood sugar levels, without frequent hypoglycaemic events. All children and young people (CYP) with newly diagnosed diabetes need a care pathway, which includes a structured education component to support and empower them and their families. We are using three NHS assurance measures to measure and track how well diabetes services are doing over time. These are:

Performance measure 1 - Percentage of children and young people achieving improved glycaemic control, through monitoring:

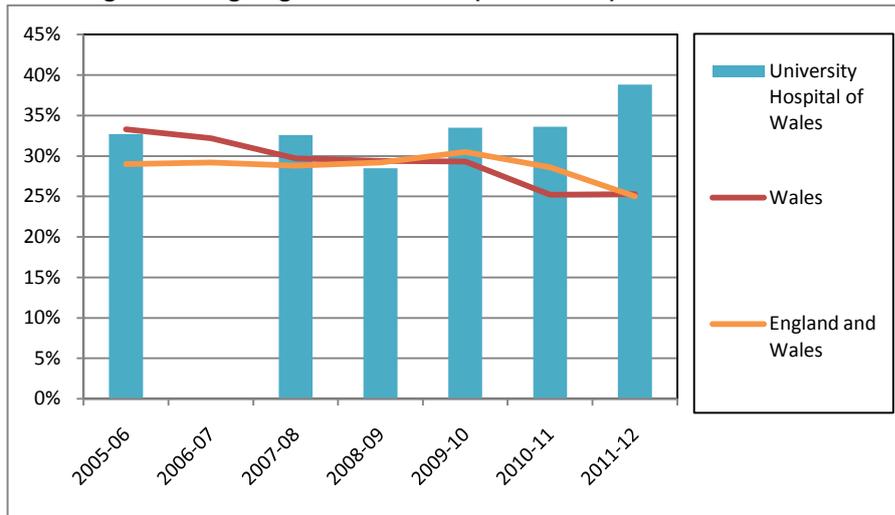
Percentage achieving target HbA1c < 7.5% (DIA PM 10a)



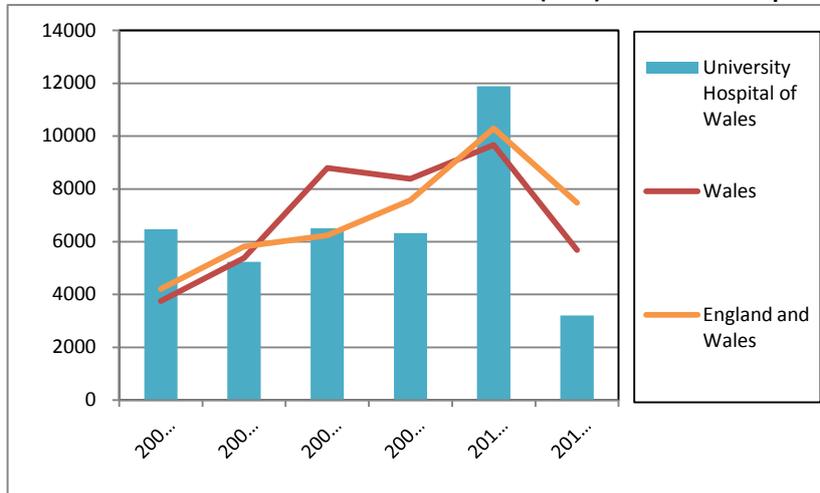
Percentage achieving target HbA1c >=7.5%<=9.5% (DIA PM 10b)



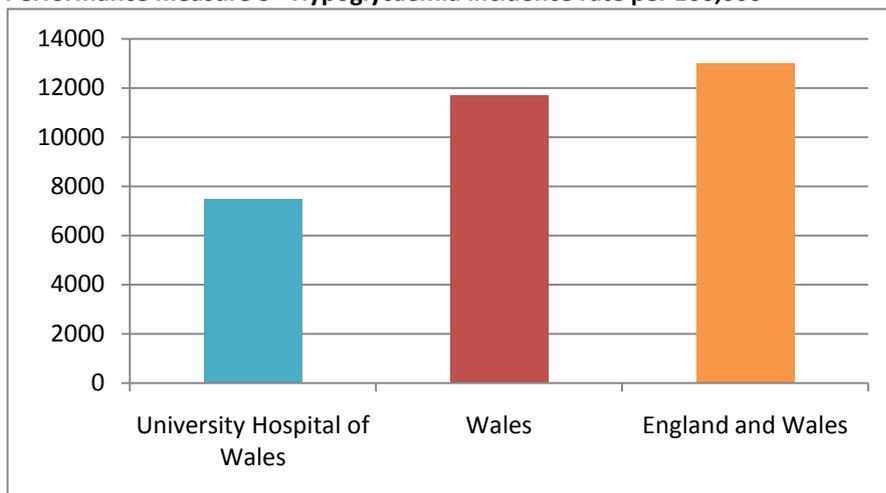
Percentage achieving target HbA1c >9.5% (DIA PM 10c)



Performance measure 2 – Diabetic ketoacidosis (DKA) incidence rate per 100,000



Performance measure 3 - Hypoglycaemia incidence rate per 100,000



The performance indicators for C&YP demonstrated in figures 8-12 are poor. In 2011-12 the UHB ranked as the poorest performing unit, as measured by HbA1c outcome, delivering care for diabetes in Wales and in the bottom 25% of units for England and Wales combined.

6.7.3 Priorities

Learning from current practice:

UHB Diabetes Service Improvement Group

The Group oversees Delivery of the Plan ensuring alignment with the all Wales priorities as well as addressing local need. Key achievements and on-going priorities include:

1. Improving care for children with diabetes (paediatric network; peer review for delivery of quality improvement of services); Over the past 12 months the UHB has worked on three major themes as recognised by the all Wales Paediatric Diabetes Group to improve outcomes:
 - a. Establishment of an all Wales Paediatric network; Network Coordinator recently appointed;
 - b. Quality assurance peer review programme of centres delivering care in Wales. The UHB was audited on 11th November 2014. Areas of improvement were identified particularly around psychological care, dietetic support and lack of out of hours expert diabetic advice. A UHB Paediatric Diabetes management group has been established to ensure actions are taken forward; and
 - c. Development of a structured education programme for type 1 diabetes in children.
2. Preventing diabetes (range of preventative work on food & physical activity; obesity pathway/ childhood obesity project; flagging in primary care patients with pre-diabetes & offering risk assessment in community pharmacies);
3. Strengthening and sustaining the community diabetes model;
4. Improve our foot care pathway for patients with diabetes (Audit; peer review; improvement action);
5. Review and enhance the diabetic retinopathy management pathways for residents of Cardiff and Vale (with PH, primary and secondary care services and also support work of the Wales Eye Care Strategy);
6. Implement Think Glucose in-patient glucose campaign;
7. Deliver a structured education programme for type 1 (DAFNE) and type 2 (X-pert) diabetes;
8. Develop and deliver a peer support programme for patients with Type 2 diabetes; and
9. Improve achievements against diabetes care processes in primary care (Medicines management pathway in place; diabetes noted as priority within cluster plans).

Further work in 2015-16 will include 1000 Lives supported workshops to build learning from the Prudent Healthcare approach into the community service model in the refreshed Diabetes Delivery Plan for 2015-16.

The following developments include the UHB's priorities for its diabetes care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities - **these are factored into the financial plan, where appropriate, at section 7**; and
- Those priorities that the UHB will implement ***in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation*** - to meet the priorities identified in the UHB's Diabetes delivery plan.

1. The key priorities for these services to improve diabetes care include:		Target improvement
Scheme	Outcomes	All improve clinical outcomes
Children's priority diabetes service improvements	<ul style="list-style-type: none"> Increased psychological support out of hours advice line Improved dietetic support 	
Continue to develop community service diabetes model	<ul style="list-style-type: none"> To improve access to services closer to home Reduction in outpatient referrals Reduced emergency admissions 	RTT & 4 hour wait
Think Glucose - Develop implementation plan and roll out within existing resources	To reduce diabetic complications for inpatients – improving outcomes and reducing LOS	
DAFNE - Develop implementation plan and roll out within existing resources	To deliver structured education for Type 1 patients	
Foot care Programme - Develop implementation plan and roll out within existing resources	To reduce avoidable morbidity for inpatients as a result of diabetic complications	

2. The key priorities for these services to improve diabetes care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
<ul style="list-style-type: none"> Implementation of insulin pump service for all patients meeting NICE criteria 	<ul style="list-style-type: none"> To fully meet NICE guidance 	

Areas that require further planning and development include:

- Working with education authorities to ensure policies are in place to manage diabetes in schools and to develop management systems to support individual pupils to play a full part at school; and
- Developing a transitional care plan to ensure appropriate and seamless transfer of care from paediatric to adult diabetes services – a national group will be set up to consider this.

Key enablers are the implementation of SCI (ICT system) and telehealth equipment to improve care for children and adults with diabetes in secondary care.

6.8. Dementia Care

6.8.1 Context

The number of people living with dementia is projected to rise significantly. The driver for this is mostly the increase in the over 85 population. There is evidence that the risk of developing dementia at any given age is actually starting to fall, but this decline does not sufficiently offset the rise in the population size.

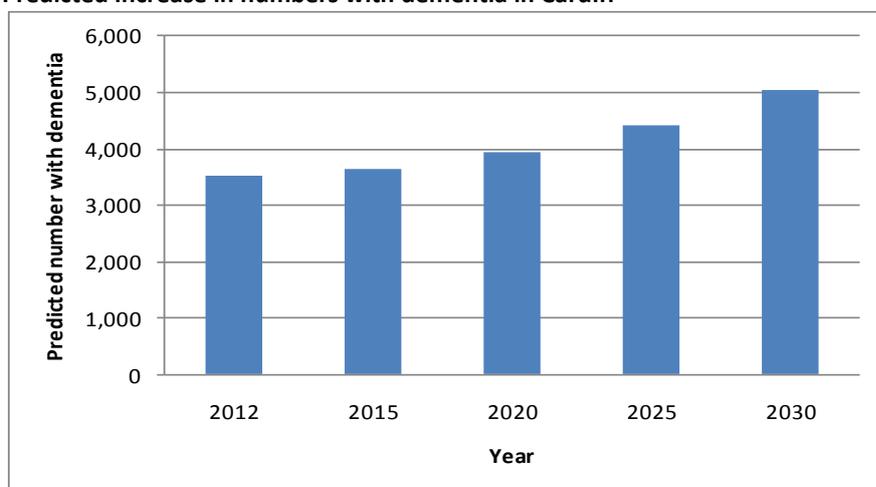
Similarly to diabetes, there are thought to be many people currently living with dementia whose condition has not yet been diagnosed.

Estimated number of people with dementia in Cardiff and Vale, 2012 to 2025 (Source: Daffodil Cymru)

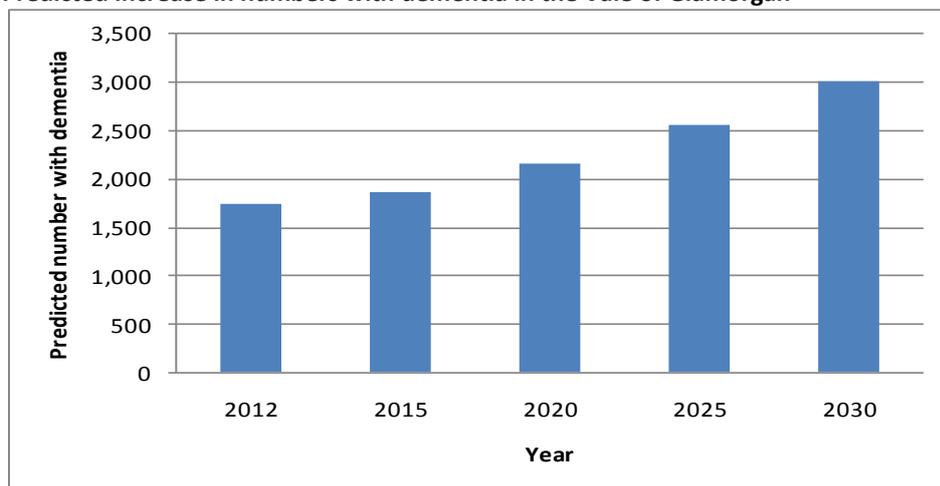
Age group	Year			
	2012	2015	2020	2025
30-64 yrs (early onset dementia)	107	109	116	121
65-69 yrs	255	282	269	291
70-74 yrs	433	465	576	554
75-79 yrs	780	813	894	1,110
80-84 yrs	1,242	1,262	1,375	1,540
85 yrs and over	2,435	2,565	2,875	3,355
65 yrs and over (total)	5,144	5,387	5,988	6,849

Estimates of future projections show that across Cardiff and Vale numbers will increase by 54% between 2012 and 2030. The proportional increase will be larger in the Vale of Glamorgan due to the larger increase in the elderly population size demonstrated in the tables below.

Predicted increase in numbers with dementia in Cardiff



Predicted increase in numbers with dementia in the Vale of Glamorgan



People with dementia on GP registers in Cardiff and Vale; and estimated total number of people with dementia, including those currently undiagnosed. Source: Public Health Wales Observatory (2013)

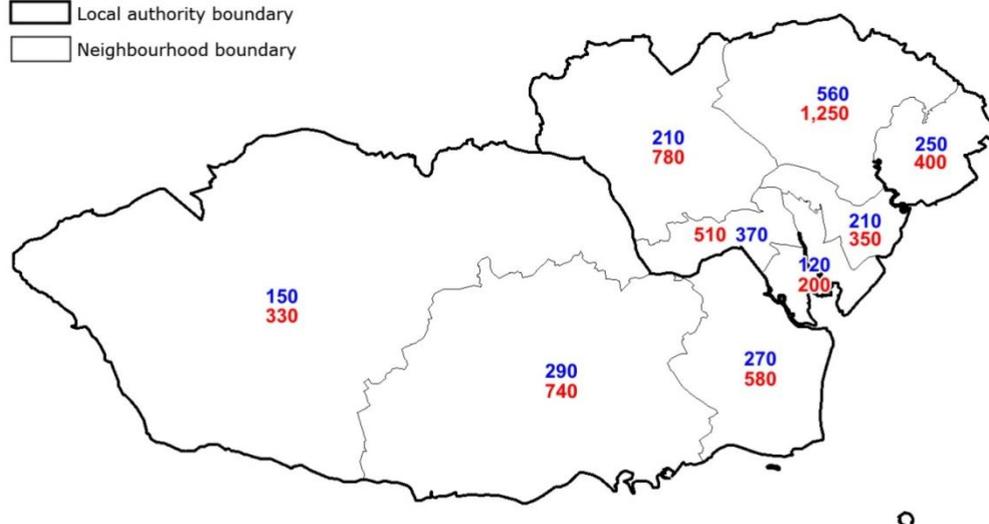
People with dementia, 2010 / 2012

Neighbourhood management areas in Cardiff and The Vale of Glamorgan

150 Blue labels show numbers of people on QOF dementia registers (2012)

330 Red labels show numbers of people estimated to have dementia (2010)

-  Local authority boundary
-  Neighbourhood boundary



Produced by Public Health Wales Observatory, using Daffodil (WG), MYE (ONS), Audit+ (NWIS)
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The UHB has a three year Plan (2014 – 2017) for people with dementia and their carers, which has been jointly developed between Cardiff and Vale UHB, Cardiff Council, Vale of Glamorgan Council and Third sector partners (including service user and carer representation). It aims to address the needs of people with dementia and their carers, as well as serving future population growth.

The plan builds on national strategic documents, including: The Dementia Action Plan for Wales, national Dementia Vision, How to Improve Dementia Guide, ‘Together for Mental Health’ (the national mental health strategy) and Stronger in Partnership. It also builds on local frameworks, including: The Mental Health Service User and Carer Involvement Framework and the Charter for Mental Health

It is premised on the objectives as set out in the national Dementia Plan and supported by a local action plan based on the following components:

- Making structural changes to economic, cultural and environmental conditions;
- Improving infrastructure and access to services for all;
- Strengthening communities; and
- Strengthening individuals.

Delivery is lead by a Taskforce chaired by Dame Deirdre Hine (President of Age Cymru) and five sub-groups. It is one of the six key service model themes within our 10 year strategy – Shaping our Future Wellbeing.

6.8.2 Performance

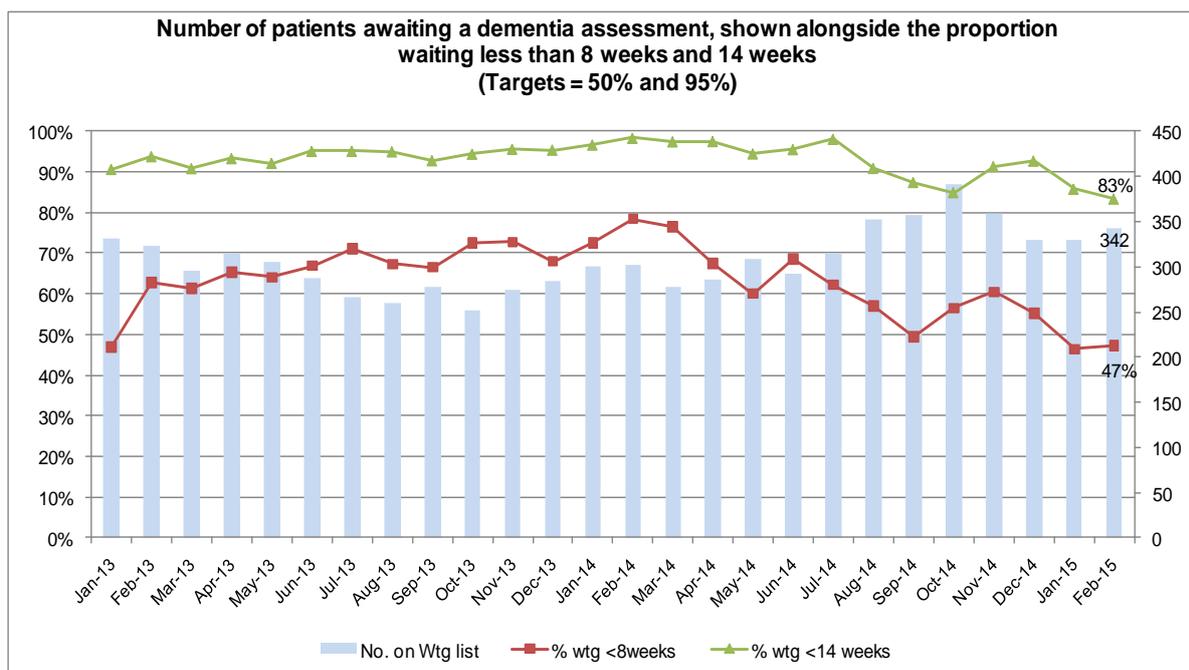
Chronic conditions – reductions in emergency admissions and readmissions (rolling 12 months) 2014/15

Alzheimer’s	Target	Apr	May	June	July	Aug	Sept	Oct	Nov	YTD
Admission	33	36	35	35	36	34	35	33	35	33
Readmission	1	1	1	1	1	1	1	1	1	1

To improve memory assessment services

Target - 50% seen within 8 weeks and 95% seen within 14 weeks

Performance - 47% waiting less than 8 weeks (target not achieved) and 83% seen within 14 weeks at the end of February 2016.



The existing memory team service is unable to generate sufficient capacity to meet current demand in addition to which, the target will reduce to 95% patients receiving assessment within 6 weeks that will not be deliverable with current backlog and current resources.

6.8.3 Priorities

Learning from current practice:

The performance of the UHB’s service delivery against the dementia targets, whilst variable, should be considered in the context of the National Audit that shows that Cardiff and Vale UHB has the highest dementia diagnosis rate in Wales, sees the most patients and at the lowest staff cost per patient seen (£331, compared to average cost per UHB in Wales of £559 and in England of £1145).

The following developments include the UHB’s priorities for its dementia care plan that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities - **these are factored into the financial plan, where appropriate, at section 7**; and
- Those priorities that the UHB will implement **in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation** - to meet the priorities identified in the UHB’s dementia plan.

1. The key priorities for these services to improve dementia care include:		Target improvement
Scheme	Outcomes	All improve clinical outcomes
Promoting Public Health in Practice - all cluster plans reference public health priorities and there may be scope to further embed/support priorities for these vulnerable patients (see s.6.2)	<ul style="list-style-type: none"> Scope the potential impact of cluster/practice based public health champions who can provide direct support in terms of promoting public health campaigns/educating patients. Underpinning this work with be embedding Making Every Contact Count and reinforcing the 3 As approach (Ask, Advise and Act) across all our staff and extended members of the team (partners) in all interfaces with the population. 	95% < 6 weeks
Embed Intelligent Target schemes of work and 3 year dementia plan for C&V with the support of the dementia faculty	Embed within core care across the UHB's clinical services to improve quality of care to this vulnerable group	95% < 6 weeks
MHSOP - through service redesign - to create increased investment in community service teams in collaboration with primary care	<ul style="list-style-type: none"> To better address any unmet need/increased demand for dementia services Earlier diagnosis and improved support in the community 	95% < 6 weeks
Scope future possibilities around new build provision for Dementia Village Social Enterprise provision with different levels of continuing health care on one site.		
Fully participate in Dementia Faculty and three year Dementia Plan initiative to deliver dementia support across multi health and agency pathways.	To accelerate development of integrated practices to improve efficiency and effectiveness of joint packages of care	
Making Every Contact Count - Develop implementation plan and roll out within existing resources	To improve diagnosis rates to improve quality of care and improve discharge planning	
Expand REACT and Care Homes Liaison Services through redeployed resources	Ease pressure on acute assessment beds and divert social admissions	
Young Onset Dementia – establish male 5 bedded YOD inpatient unit in St Baruc's Ward, Barry Hospital	Alternative, more appropriate service provision for this patient cohort through existing service redesign	

2. The key priorities for these services to improve dementia care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Cardiff memory team – additional capacity address excess waiting times	To reduce backlog and increase recurrent capacity to enable the target to be met	95% < 6 weeks

Year 2 priorities for 3 year Dementia Plan

- Spread the training of 'Providing Care for Individuals with Dementia' and Psychological Wellbeing courses across the DGH setting and appropriate training across care homes;
- Identify multi-disciplinary dementia leads;
- Identify dementia leads for the Butterfly scheme;
- Review Day Hospital and Day Care provision across partner agencies;

- Roll out the ethos of person-centred dementia care using quality improvement vehicles such as Dementia Care Mapping (DCM) or the Care and Social Services Inspectorate Wales (CSSIW) Short Observational Framework for Inspection) 'SOFI' tool, targeting extended assessment wards and specialist nursing and residential care homes for people with dementia; and
- Consolidate the alcohol related brain injury service to integrate health and social care provision.

A key enabler will be a capital scheme to provide the Young Onset Dementia unit in St Baruc's ward at Barry hospital.

6.9 Mental Health

6.9.1 Context

- 4,111 people are on the primary care register for serious mental illness (including schizophrenia, bipolar disorder and other psychoses), around 0.8% of the GP list size in Cardiff and Vale;
- 2,485 people are recorded on GP practice registers in Cardiff and Vale as living with dementia;
- In general, people with a psychotic illness have fewer qualifications and are more likely to have left school before the age of 16 with no qualifications, compared with other groups. The percentage of Year 11 school leavers who were known to be not in education, employment or training (NEET) in 2013 in Wales was 3.7%, with local rates of 3.8% in the Vale of Glamorgan and 4.9% in Cardiff;
- 43% of people accessing homelessness projects in England had a mental illness. The number of households in Cardiff who were deemed to be eligible, unintentionally homeless and in priority need was 690 in 2013/14, and 195 in the Vale;
- The BME community proportion is 10% higher in Cardiff than the Welsh average. Research shows that the incidence of psychosis is higher in the African Caribbean and Black African populations;
- Deprivation is associated with poorer mental health outcomes. In Cardiff and Vale the most deprived areas are clustered around Barry and the southern arc of Cardiff as shown in Section 6.2 (reference the maps under Primary and Community Care)
- The standardised rate for suicide among women in Cardiff (5.8 per 100,000) is above the Wales average of 5.3, with rates for men and in the Vale below the Wales average;
- Cardiff is a both an initial accommodation centre and dispersal centre for UK asylum seekers. In this capacity, around 100-180 individuals seeking asylum in the UK enter Cardiff each month, and around 6 in 10 of those dispersed in the South West and Wales area live in Cardiff. The number of new asylum seekers is expected to grow between 8-15% per annum. There are thought to be around 900 asylum seekers living in Cardiff at any one time. Many asylum seekers have complex health and social care needs; and
- Pregnant women, unaccompanied children, those with significant mental health problems, and those who have experienced traumatic events such as rape or torture, are likely to be particularly vulnerable. Asylum seekers are located across Cardiff but historically more in the 'southern arc'.

The 10 year Welsh Government strategy 'Together for Mental Health' (2012) along with a prescribed delivery plan for 2012 to 2016 set the national strategic context within which the UHB is taking forward the development of mental health services in Cardiff and the Vale of Glamorgan. The approach has been to place service users and carers in the driving seat of these partnership arrangements and holding us directly to account for progress against our collaborative strategy.

The plan for 2015/16 has been developed within the context of the changing population, the prevalence of mental health issues, health inequalities and unhealthy behaviours which impact on the demands placed on the service, as described above. The plan continues to focus on developing recovery models of care which support each individual to become more empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a positive sense of belonging to, and an opportunity to contribute to, their communities. This strategy puts the Mental Health Measure at the centre of service planning and delivery.

During 2014, a 'feedback fortnight' was led by service users and carers, relating their experience of mental health services and recommending areas for priority within the Together for Mental Health Strategy. These

recommendations were presented to the Mental Health Partnership Board, involving a variety of agencies including public health, housing, education, police, service users and carers, to agree how these should be taken forward during the coming year. Key areas include:-

- For the general public - the promotion of mental wellbeing; where possible prevention of mental health problems developing; and improving individual and community resilience; and
- Develop with service users a clearer strategic direction for integrated working across services and agencies; develop greater service user involvement in commissioning, service planning and staff recruitment; improve access to services, experience and outcomes; and continue the drive to reduce stigma and discrimination through the Time to Change campaign.

The UHB's portfolio of mental health services comprises the following:

- Mental health services for adults, including substance misuse services;
- Mental health services for older people;
- Neuropsychiatry; and
- Psychology and counselling.

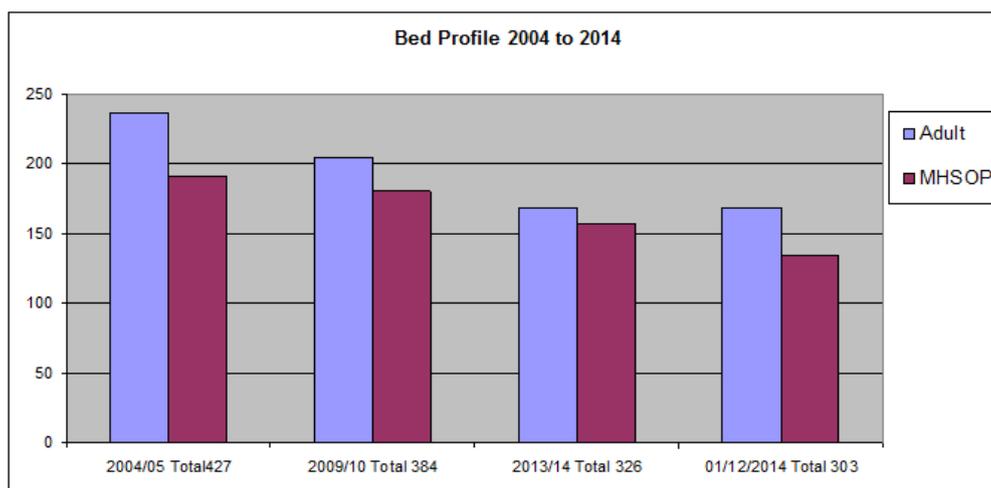
These services are delivered across the primary, community, inpatient and tertiary levels of care and include core mental health services along with a number of tertiary and specialist services including neuropsychiatry, substance misuse, and low secure services.

Over the past 12-18 months, the UHB has delivered a number of radical changes to services, including:

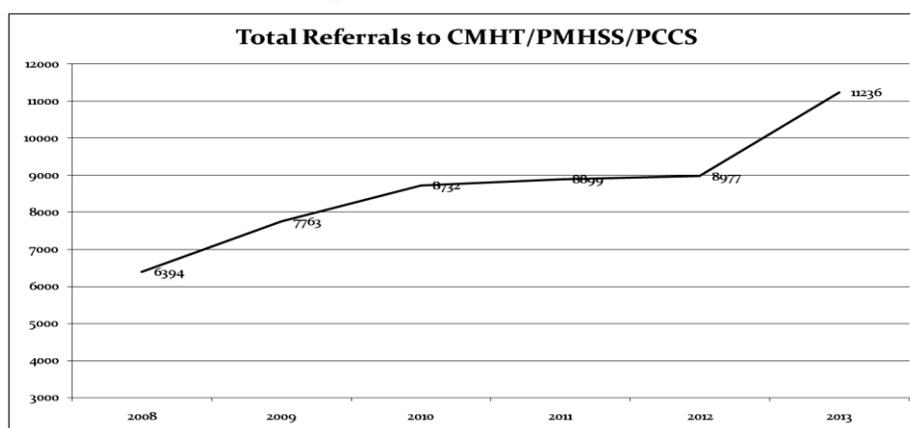
- New models of inpatient and crisis management for people suffering from severe and enduring mental health problems; and
- Provision of better access to psychological and evidence based interventions for people with mild to moderate mental health issues.

The next phase for mental health services is to provide a period of stability for the new inpatient service models to be embedded, and undertake an efficiency and productivity review of community based mental health services to ensure prudent delivery of safe, high quality services delivering the outcomes that matter to our population.

The graph below shows the progressive reduction in beds across adult and Mental Health Services for Older People (MHSOP) services over the last 10 years and the second graph shows the continuing rise in Community Mental Health Team (CMHT) referrals.



Six Year Analysis of referrals to MH



Continuing healthcare is an ongoing issue for UHB with the number of CHC privately placed patients averaging 130 through 2012/13 and 2013/14. As of March 2015 there are 143 patients with in year growth being driven by patients stepping down from medium secure to low secure placements and this is anticipated to continue through 2015/16.

6.9.2 Performance

Activity levels for the last 3 years, across the adult and older people services are shown below, along with the forecast figures for 2015/16. The UHB has delivered a new clinical model for adult inpatient services with the closure of 40 beds within the last year. The forecast figures for 2015/16 reflect the impact of this new model particularly in terms of reduced inpatient activity supported by the new crisis assessment ward. The table also demonstrates the impact of the Mental Health Measure on community services, where the primary mental health support service (PMHSS) works alongside GPs to assess and treat patients at a primary care level while ensuring appropriate secondary care referrals are made to CMHTs. This has allowed CMHTs to focus on delivering a greater level of support to more complex service users, who require secondary care. From April 2014, mental health services for residents of the Western Vale were transferred to the UHB, mostly impacting on community activity. This data has been excluded from the tables below.

Adult Service Activity and Forecast Demand

Activity	2012/13	2013/14	2014/15 Forecast	2015/16 Forecast	Demand Change
Inpatient/Day Care					
Adult Inpatient Bed days (inc. Rehab)	51,865	54,123	44,200	44,200	Bed days reduced from 2013/14 figure due to reduction of 19 adult acute beds in December 2013 and 3 Mother and Baby beds in July 2013. Demand expected to remain stable through 2015/16.
Crisis Assessment Ward – Bed days	-	1,134 (3months)	4,804	4,800	New service commenced in January 2014
Crisis Resolution Home Treatment Referrals/Assessments	1,909	2,628	2,302	2,500	Demand expected to remain stable across majority of Cardiff and Vale area. No increase to date following proposed Western Vale transfer.
Crisis Recovery Unit Attendance	2,008	2,699	2,786	2,700	Optimal attendance
Day Care		4,248	5,112	5,000	Includes CAU and Park Lodge data
Community					
PMHSS Assessments/Activity	-	4,501 Service	7,580	9,600 Based on	Demand within this service steadily increasing month on month. Appears to be meeting previously unmet

Activity	2012/13	2013/14	2014/15 Forecast	2015/16 Forecast	Demand Change
Inpatient/Day Care					
		introduced Oct 2014		current demand	demand for mild to moderate mental health problems. CB currently monitoring impact on referral rate into secondary care services as part of its transformational redesign.
New OPs - CMHTs	1,701	1,917	1,302	1,400	Reduction from 2013/14 related to new ways of working and MH Measure. Reducing medical OP numbers to focus more on complex patients
Follow-up OPs - CMHTs	12,169	12,940	11,708	11,800	
CMHT Referrals	5,995	6,332	6,320	6,300	Significant increase in GP referrals to CMHTs over last 10 years but plateaued in the last 2-3 years.
CMHT Caseload	4,457	4,211	3,632	4,000	Reduction in caseload due to new ways of working/MH Measure. Currently excludes Western Vale data.
CMHT Contacts	59,057	33,176	35,139	36,000	Excludes Western Vale data
Day Care	5,948	4248	5,112	5,000	Includes CAU and Park Lodge data

MHSOP Service Activity and Forecast Demand

Activity	2012/13	2013/14	2014/15 Forecast	2015/16 Forecast	Demand Change
Inpatient/Day Care					
MHSOP Inpatient Bed days	54,799	54,366	53,252	50,000	Reduced inpatient activity based on proposed EPA ward closure
Crisis Service (REACT) - assessments	364	311	449	550	Increased activity based on additional investment in REACT team to shift balance of care from inpatient to community services.
Day Care	10,651	8,122	6,116	6,000	Morfa Day Unit opening reduced from 5 days to 2 in 2014/15
Community					
New OPs	358	375	370	400	Western Vale service transfer to C&V
Follow up OPs	1,375	1,350	1,010	1,200	Western Vale service transfer to C&V
CMHT Referrals	863	888	857	880	Western Vale service transfer to C&V
CMHT Caseload	Info not available in same format	200	240	240	Western Vale service transfer to C&V

Benchmarking

The 2014 mental health benchmarking exercise involved 66 provider organisations across England and Wales. The final report for MHSOP is not yet available. Key messages from the adult report include:

- Overall adult acute beds per 100,000 have reduced since 2013. C&V were in the upper quartile in 2013, but in 2014 were repositioned to the mean of the scale;
- C&V CMHTs continue to have much lower than average caseloads and provide a lower number of contacts than the average per 100,000 population;
- C&V CMHTs have marginally lower than average referral rates and have a very low percentage of referral acceptance as a percentage of total referrals made;
- The psychiatric intensive care unit (PICU) length of stay has increased to 27 days but is still well below the average of 43 days;
- The balance of financial investment between community and inpatient services continues to be weighted significantly towards inpatient services (the 4th highest in the study). The average balance in the study is 51% community/49% inpatient compared to C&V split of 40%/60% ;
- Delayed transfers of Care remain high in Cardiff and Vale in the context of Wales and the UK; and
- While MHSOP admission rates have reduced, total admissions are significantly above average.

Continuing Health Care

The number of CHC privately placed patients averaged 130 through 2012/13 and 2013/14. As of March 2015 there are 143 patients with in year growth being driven by patients stepping down from medium secure to low secure placements and this is demonstrated below. The process for managing the repatriation and step down of patients is closely monitored by the UHB's Mental Health Clinical Board.

Placement	Growth in numbers of CHC Privately Placed Patients during 2014/15	Total Number of CHC Privately Placed Patients as at March 2015
Medium – Low Secure	17	11
Low Secure	7	47
Community	8	67
Neuropsychiatry	2	12
Young Onset Dementia	10	6
Total	35	143

Performance Against Tier 1 Targets.

Mental Health Measure

Area	Target	2013/14				2014/15			
		June	Sept	Dec	March	June	Sept	Dec	March
Part 1 Assessment within 28 days referral	80%	67	15	7	5	17	94	98	
Part 2 Care & Treatment plan for secondary MH users	90%	90	83	85	88	92	93	90	
Part 3 Assessments of former users of secondary MH services	100%	100	100	100	100	100	100	100	
Part 4 Mental Health Advocacy	100%	100	100	100	100	100	100	100	

Part 1 performance recovered in 2014/15 where demand was in excess of combined CMHTs. Demand continues to increase and will require a capacity solution. There is particular success with Acceptance and Commitment Therapy for mild to moderate mental health problems. Part 2 focus in 2014/15 was on the quality of completed care and treatment plans.

Delayed Transfers of Care

Area	Target	2013/14				2014/15			
		June	Sept	Dec	March	June	Sept	Dec	March
Delayed transfers of care	27	37	26	26	13	12	26	31	

A key factor when reducing bed numbers was to reinvest resources for the 'move on' team to optimise the impact. Solution focussed approach for move on housing issues is in place based on a multi-agency tenancy model.

Waiting Times

Area	Target	2013/14				2014/15			
		June	Sept	Dec	March	June	Sept	Dec	March
No. waiting >14 weeks for IP/DC treatment	0	0	0	0	0	0	0	0	
No. waiting >10 weeks for OP treatment	0	0	8	6	9	25	31	19	

These are local targets for mental health services. The approach being taken by the UHB is to discharge service users back to primary care where appropriate and deliver a more responsive service to GPs by providing

greater capacity within the primary mental health support service. This will increase the capacity of senior mental health clinicians to meet the needs of complex service users.

6.9.3 Priorities

The key challenges for mental health in 2015/16 will be the continuous review of prudent responses to meet the demands placed on it by the changing population, the prevalence of mental health issues, health inequalities and unhealthy behaviours. In parallel, the UHB will focus effort on service delivery to meet demand for services, particularly in terms of patient flow through the system and repatriation of continuing health care patients. Service changes will be developed within the context of co-production with service users and taking forward priorities highlighted through the ‘feedback fortnight’ in 2014.

The following developments include the UHB’s priorities for its mental health services that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities- **these are factored into the financial plan, where appropriate, at section 7** ; and
- Those priorities that the UHB will implement **in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation** - to meet the priorities identified in the UHB’s mental health services plan.

1. The key priorities for these services to improve mental health care include:		Target improvement
Scheme	Outcomes	
<ul style="list-style-type: none"> • Embed the redesigned service model for adult inpatients • Prepare for the transfer of inpatient services from Whitchurch Hospital and the Llanfair Unit 	To ensure readiness for clinical and operational commissioning of the new Adult Mental Health Unit, Hafan y Coed at UHL – this model will enable a more integrated service for mental health patients who require interventions for physical health care	MH Measures
Reduction in length of stay from 170 to 100 days in MHSOP, with focus on the top 10 longest stays and reducing DTOCs	Ease pressure on acute MHSOP inpatient services and reduce access times for patients requiring IP services	MH Measures <DTOCs
Further develop the MHSOP crisis service (REACT) and the care home liaison service (through redeployment of resources)	<ul style="list-style-type: none"> • to provide advice and support services for patients in the community • reduce avoidable admissions 	MH Measures
Continuing Health Care repatriation and step down/move on	A new structure being put in place to support timely assessment, review and contract management and consequent revenue savings	
Establish a Male Young Onset Dementia Unit – a 5 bedded unit in Barry Hospital for extended assessment of YOD males to complement the recently established female 5 bedded unit.	This development will divert patients from the current system of out of area placements. (Minor remodelling works to the current ward accommodation – St Baruc’s at Barry Hospital - will be required.)	Dementia Target MH Measure
Review of CMHTs for adults and older people	To develop proposals for remodelling to ensure that the whole pathway is consistent with the pull model of care, supports patient flow through the system and is sufficiently resilient to meet increasing strategic and population demands, while ensuring equity of access, particularly for hard to reach groups.	MH Measures

Development of psychological therapies through the medium of languages other than English, in collaboration with third sector service providers, improving access to services for hard to reach groups.	Improve equity of access	
PMHSS website will be designed and commissioned to provide self help material, signposting and information on statutory and third sector services		

2. The key priorities for these services to improve mental health care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Increase MH nursing establishment	To meet skill mix recommendations	

6.10 Child and Adolescent Mental Health Services (CAMHS)

6.10.1 Context

The services provided to improve the emotional and mental health of children and young people in Cardiff and the Vale are supported by the Specialist Child and Adolescent Mental Health Service (CAMHS) which is managed by Cwm Taf LHB. There are a number of pressures relating to availability of services to meet local need, such as the increasing population, deprivation and unhealthy behaviours, and the UHB board is actively involved in developing a programme to take forward these services to meet the increase in demand for mental health services for children and young people.

Population projections - younger people and birth rates

Current and projected population age structure, Cardiff and Vale and Wales, 2015-2025. Source: StatsWales (2014)

Age (yrs)	Proportion of population			
	2015		2025 (projected)	
	All Wales	C&V	All Wales	C&V
0-4	5.9%	6.3%	5.4%	6.1%
5-16	13.2%	13.1%	13.7%	14.0%
17-64	60.8%	65.1%	58.3%	62.7%
65-84	17.5%	13.2%	19.1%	14.5%
>85	2.6%	2.2%	3.5%	2.7%

0-4s higher than Wales average.

The significant increase in the size of the population is driven principally by net in-migration to Cardiff, and a birth rate which has historically been both increasing and higher than the death rate.

Historic birth rate and net migration into Cardiff and Vale, 2007-2013. Source: StatsWales (2014)

	Annual births	Net migration into Cardiff and Vale
2007-08	6,016	3,538
2008-09	6,053	3,173
2009-10	6,125	1,758
2010-11	6,207	1,863
2011-12	6,279	708
2012-13	5,910	1,711

Modifiable risk factors

Among children and young people, overweight and obesity is also a problem (Table 7). The child measurement programme has found that over a fifth (22.1%) of children in reception year in the Vale of Glamorgan are overweight or obese, and nearly a quarter (24.3%) of those in Cardiff (Child Measurement Programme for Wales, 2012/13).

Percentage of 0-15 year olds with particular lifestyle characteristics, Cardiff and Vale. Source: Welsh Health Survey (2013).

Area	Self-rated health status			Lifestyle characteristic			
	Good / Very good general health	Long-standing illness	Limiting long-standing illness	Physically active on 5 or more days	Physically active on 7 days	Overweight or obese	Obese
The Vale of Glamorgan	95	21	5	54	36	26	14
Cardiff	94	17	5	48	33	34	20
Cardiff & Vale UHB	94	18	5	50	34	31	18
Wales	94	19	6	52	36	35	19

Suicide mortality rates per 100,000 population, persons aged 15-24, 2002-2011

Data source: MYE & ADDE (ONS)

At UHB level, suicide rates per 100,000 population for the 15-24 year age group are seen to be lowest in the Aneurin Bevan area (5.7) and Cardiff and Vale area (5.9). The highest rate is seen in the Abertawe Bro Morgannwg area (13.9). These three rates are all statistically significantly different to the Wales average.

ESTIMATES OF THE NUMBER OF CHILDREN (AGED 5-16 YEARS) WITH MENTAL DISORDERS IN CARDIFF, 2012

Mental Disorder	5-10 yr olds		11-16 yr olds		All children (5-16 year olds)	
	Boys	Girls	Boys	Girls	Boys	Girls
Emotional disorders	251	277	456	669	708	947
Conduct disorders	789	311	924	560	1712	870
Hyperkinetic disorders	309	44	274	44	582	88
Less common disorders	251	44	182	121	434	165
Any disorder	1166	566	1437	1130	2603	1696

Source: Office for National Statistics (2004); Population: Office for National Statistics 2012 estimates

ESTIMATES OF THE NUMBER OF CHILDREN (AGED 5-16 YEARS) WITH MENTAL DISORDERS IN THE VALE OF GLAMORGAN, 2012

Mental Disorder	5-10 yr olds		11-16 yr olds		All children (5-16 year olds)	
	Boys	Girls	Boys	Girls	Boys	Girls
Emotional disorders	95	105	193	285	289	390
Conduct disorders	299	117	392	238	691	356
Hyperkinetic disorders	117	17	116	19	233	35
Less common disorders	95	17	77	51	173	68
Any disorder	443	213	609	482	1052	695

Source: Office for National Statistics (2004); Population: Office for National Statistics 2012 estimates

The services provided to improve the emotional and mental health of children and young people in Cardiff and the Vale are supported by the Specialist Child and Adolescent Mental Health Service (CAMHS) which is managed by Cwm Taf LHB. There are a number of pressures relating to availability of services to meet local need and the Clinical board is actively involved in a programme of work in this area.

The services purchased by Cardiff and Vale UHB currently include:

- Primary mental health workers who work at the interface between specialist CAMHS and other professionals involved with children and young people. This service will work closely with the new 'all age' primary mental health services provided by Cardiff and Vale UHB as part of the implementation of the mental health measure; and
- Generic CAMHS services (Tiers 2/3) which are provided from St David's Children's Centre and the Children's Centre in University Hospital Llandough.

Services commissioned by WHSSC from Cwm Taf include:

- The Community Intensive Therapy team (CIT) which works across the Cardiff and Vale area and provides care and treatment for young people who have more complex problems; and
- Regional services including the CAMHS South Wales Inpatient Unit, the Tier 3 Forensic Service and Tier 3 CAMHS Learning Disability Service.

All funding for specialist CAMHS services in Cardiff and Vale flowed through WHSSC up until April 2013. There was no agreed service specification although previous planning networks had tried to agree on a national specification. In 2014/2015 a local service specification was developed utilising Welsh Government planning guidance, the requirements of the Mental Health Measure and discussions with colleagues in the UHB and other partner agencies. In 2015/2016 the emphasis will change to performance and delivery against the service specification.

An option appraisal exercise has recently been undertaken to determine the preferred way forward in relation to future hosting arrangements for the Primary Mental Health service which is currently commissioned from the Cwm Taf CAMHS service, as part of the adult all age Part 1 Team or within a Community Child Health Team. The exercise sought to establish the best solution to meet Part 1 of the Mental Health measure and to deliver the most effective service and the outcome was that the service should be commissioned separately. It was concluded that the best option to meet all the requirements and provide the UHB with assurance to deliver on the Part 1 requirement is to move towards an implementation plan to host the service in Community Child Health. This will form part of a whole system of care for Children and Young People with emotional health and wellbeing issues and encompass early assessment and community-based support for children and young people exhibiting risky behaviours, but not currently requiring access to CAMHS services.

The pathways of care for Children with Neuro-developmental disorders present a specific challenge that impact on the delivery of Specialist CAMHS services. In 2015/2016 a multi agency pathway for the diagnosis and care of children with Attention Deficit Hyperactivity Disorder will be developed to ensure appropriate joined up care for this population of children and young people.

A number of serious incidents have been reported where children and young people who require admission for emotional and mental health issues have experienced unacceptable delays accessing the assessment and clinical care that they require. This is particularly acute for young people aged 16 – 18, and incidents fall into two categories.

- A young person requiring admission to a mental health unit; and
- A young person requiring admission via the Emergency Unit for significant self-harm requiring urgent medical care.

In the first instance, delays may occur where no inpatient CAMHS bed is available in the specialist inpatient unit at Ty Lydiard, or if the young person does not meet the WHSSC criteria for admission. Admitting children and young people to a mental health unit should only occur where there is no appropriate community intervention that can support them, and there is a clear mental health disorder. Significant work has been carried out by WHSCC in 2014/2015 which will improve access to specialist provision.

In the second case, delays occur due to lack of clear effective pathways for urgent and emergency care between the Child and Adolescent Mental Health Service, Child Health, Adult Mental Health, Primary care and other UHB services and social care

For children and young people who self harm, there is an agreed multiagency pathway. The aim is to provide early community support and prevent an escalation requiring admission, but this is not always successful and there can be delays in obtaining a CAMHS assessment. Work is underway on agreeing a multiagency risk management approach to caring for these young people as part of the CAMHS commissioning work programme. When a young person does require admission for medical care and/or to ensure a place of safety until an urgent mental health assessment and management plan can be agreed, caring for them in an appropriate environment at UHW is challenging. The UHB is in discussion with Cwm Taf LHB regarding the income shortfalls reported by Cwm Taf HB.

6.10.2 Performance

Mental Health Measure (Part 2) - Monthly CTP Submission Proforma 2014/15 - CAMHS

Indicator	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Total number of patients resident in LHB with a valid CTP at the end of the month [end of month census snapshot]	121	98	107	106	103	102	125	118	114	133		
Total number of patients resident in LHB new to secondary Mental Health services within the month [monthly count]	5	2	6	6	9	8	25	6	12	8		
Number of patients resident in LHB discharged/transferred out of secondary Mental Health services within the month [monthly count]	3	2	6	10	5	5	12	4	7	5		
Total number of patients resident in LHB currently in receipt of secondary Mental Health services at the end of the month (i.e. the caseload) [end of month snapshot]	160	160	160	156	160	163	176	178	183	186	186	186
Total number of patients resident in LHB currently in receipt of secondary Mental Health services at the end of the month (i.e. the caseload) [end of month snapshot]	160	160	160	156	160	163	176	178	183	186	186	186
Total number of patients resident in LHB in receipt of secondary Mental Health services as at the 31st March 2014 [end of month snapshot]	158											

As the CAMHS service is commissioned by the UHB from Cwm Taf HB, the performance information is held by Cwm Taf.

As part of the commissioning discussions Cwm Taf have been asked to develop a dash board of performance indicators across the quadrants of the scorecard; public health, use of resources, quality and safety experience access and Tier 1 performance to enable us to better monitor the services we purchase.

6.10.3 Priorities

Additional investment of £150k will be made to improve access to tertiary inpatient care for young people who require admission for emotional and mental health issues.

Further priorities for the UHB for 2015-16 include developing local responses to address the following:

- Stopping unnecessary referral to specialist CAMHS;
- Development of a core service specification for Specialist NHS CAMHS (with Cwm Taf);
- Work with WHSSC to ensure seamless care between local and specialist services;
- Develop a pathway of care for children with neuro-developmental disorders;
- Finalisation of an agreed pathway for children aged 16-a8 requiring mental health support;
- Reducing cases presenting in the Emergency Department;
- Supporting families closer to home and avoiding family breakdown and out of county placement;
- Providing services that matter to users and their families in a holistic way based on a co-productive model;
- Ensuring appropriate prescribing and monitoring of medication only when this is clinically indicated to support children with ADHD/ASD; and
- Ensuring shared care for stable long term management.

6.11 Children and Young People Services

6.11.1 Context

The UHB's Children and young people services provide a diverse range of acute, community and specialist/tertiary services including neurology, gastroenterology, oncology, cardiology, Ear Nose Throat (ENT), renal, Neonatal Intensive Care Unit (NICU), Paediatric Intensive Care Unit (PICU) and specialist and general surgery.

The strategic context for the provision of children and young people's services takes account of the increasing population for under four year olds, the increasing obesity and unhealthy lifestyles, implementation of the outcome of the South Wales programme, the increasing need for unscheduled care/primary care interface and the need to streamline inpatient activity in relation to minimised length of stay and increased day of surgery admission.

Population projections (see section 6.2.2) - younger people and birth rates

Current and projected population age structure, Cardiff and Vale and Wales, 2015-2025. Source: Stats Wales (2014) - 0-4s higher than Wales average

Age (yrs)	Proportion of population			
	2015		2025 (projected)	
	All Wales	C&V	All Wales	C&V
0-4	5.9%	6.3%	5.4%	6.1%
5-16	13.2%	13.1%	13.7%	14.0%
17-64	60.8%	65.1%	58.3%	62.7%
65-84	17.5%	13.2%	19.1%	14.5%
>85	2.6%	2.2%	3.5%	2.7%

The significant increase in the size of the population is driven principally by net in-migration to Cardiff, and a birth rate which has historically been both increasing and higher than the death rate.

Modifiable risk factors

Among children and young people, overweight and obesity is also a problem. The child measurement programme has found that over a fifth (22.1%) of children in reception year in the Vale of Glamorgan are overweight or obese, and nearly a quarter (24.3%) of those in Cardiff (Child Measurement Programme for Wales, 2012/13).

Percentage of 0-15 year olds with particular lifestyle characteristics, Cardiff and Vale. Source: Welsh Health Survey (2013).

Area	Self-rated health status			Lifestyle characteristic			
	Good / Very good general health	Long-standing illness	Limiting long-standing illness	Physically active on 5 or more days	Physically active on 7 days	Overweight or obese	Obese
The Vale of Glamorgan	95	21	5	54	36	26	14
Cardiff	94	17	5	48	33	34	20
Cardiff & Vale UHB	94	18	5	50	34	31	18
Wales	94	19	6	52	36	35	19

Inequalities including Immunisation

Areas of deprivation in Cardiff are mainly in the southern arc, with around one in six of Cardiff's neighbourhoods within the 10% most deprived in Wales. In contrast, most deprivation in the Vale is around Barry, and around 1 in 15 neighbourhoods in the Vale are in the 10% most deprived in Wales.

The 'wider determinants' of health including income, quality and availability of housing, employment, education and community safety show large variation across Cardiff and Vale and, in particular, within Cardiff. Two examples are given below:

- The UHB has linked in with the local needs assessments carried out as part of the Local Service Board arrangements, and works closely with partners in delivering targeted services to areas of deprivation such as Flying Start and Families First; and
- Child Health community clinics are run as close to neighbourhood areas as possible. The work with primary care on improving pathways will identify areas of greatest referral and will support targeted intervention.

Uptake of childhood vaccinations varies considerably across Cardiff and Vale. For example, the ratio of the average uptake of the teenage booster between the top 10 practices in the UHB area and the bottom 10 practices, is 1.87. This reflects average uptake of 93.2% in the top 10 performing practices compared with uptake of 49.2% in the bottom 10 practices. A recent analysis of equity of uptake of immunisations by ethnicity in Cardiff and Vale found significantly lower uptake of childhood immunisations in BME groups compared with non-BME children. Actions, including a community development programme in South Cardiff, are being taken to address this finding.

Commissioning and Partnership Working

The UHB will continue to implement the commissioning intentions, and in particular this will focus on delivering equitable care and working to transform services to meet local need with an emphasis on delivering sustainable services.

Clear service specifications will be developed with regard to the workforce required to deliver these, ensuring leadership opportunities, training and the development of new roles where appropriate. This will ensure that there is absolute clarity about what UHB will deliver for its local population and in conjunction with WHSSC, and for the South Wales population. This will need to be reviewed as the impact of changes driven by the South Wales Collaborative become clearer, and negotiations with South Central Alliance neonatal teams regarding future models and sustainability are taking place.

The UHB is already involved in a significant amount of partnership and commissioning activity by the nature of the services it provides to the whole population of Children/Young People and Women. Members of the Board play a pivotal role in local Partnership arrangements, taking the lead for the Children and Young People with a Disability, Emotional and Mental Health issues, Families First and Flying Start. This activity is driven by national strategies aimed at improving outcomes for Children and Families and work commissioned jointly has been influenced directly by partners and service users.

On a regional basis the Board has been involved in supporting the commissioning of the SARC, working with ABMU on Children's Advocacy services, and managing 3rd sector consortia contracts for Bobath and Ty Hafan on behalf of other Welsh Health Boards

Local Strategic Partnership and Commissioning

Families First and Flying Start are major Welsh Government policy commitments, designed to deliver targeted interventions to children and families, to improve life chances of children. Members of the UHB have been instrumental in the local planning, commissioning and monitoring of these services through established multiagency governance arrangements.

Immunisations Programme

The Welsh Government Flu Immunisation Campaign has continued since September 2013. Rollout continues to be phased over 3 years, and implementation continues to impact both CH2000 and the School Health Nursing Service.

Through the School Health Improvement Programme (SchIP) School Health Nursing has been significantly remodelled and resized to deliver a core programme of statutory and legal requirements (with the exception of drop in sessions).

However in order to deliver Phase 2 of the immunisation programme, a more sustainable workforce and financial model has been developed.

The increasing importance of immunisation targets within the Tier 1 target regime has highlighted that the current system for generating this data is highly labour intensive and creates duplication of effort. All Wales NWS support is required to ensure linkages between the CH2000 system and GP systems is developed to reduce unnecessary data input. With significant up-scaling of the volumes of paediatric immunisations improved mechanisms for onsite data entry need to be developed to support the efficient capture of data.

Children's Community Nursing Service (CCNS)

New continuing care guidance for children and young people was issued in November 2012. This guidance applies to children and young people whose health needs cause them to require a bespoke multi-agency package of continuing care that cannot be met by existing universal or specialist services alone. Although the main reason for such a package will derive from the child or young person's health needs, they are likely to require multi-agency service provision; enabling the child or young person to function optimally within their family, community, education or care setting.

Within the UHB processes have been put in place to improve the assessment, case management and on-going monitoring of care by the Child Health directorate

Demand for this service is increasing and there is a significant forecast financial pressure in 2015/16 on Continuing Health Care (CHC) growth, being a combination of patients managed within CCNS and those requiring external packages.

Disability and Complex Needs Services

The needs of Children and Young People with disabilities and complex needs are such that they cannot be met by any one agency in isolation. This area of work is also reflected in the Cardiff Council Corporate Plan 2014-2017.

There is a whole programme of dedicated work with partners to improve outcomes for this population and ensure that cost effective joint services can be delivered which is being reviewed and refreshed in the light of changes to local partnership arrangements, and in response to regional work to meet the requirements of the new Social Services and Wellbeing Act currently in process in Welsh Government. Work in this area is led with the full engagement of partners, parents and young people, and forms part of the UHB's three-year work programme for Children and Young People with disability

South Wales Programme

Children and young people services will also need to take account of the changes to paediatric and neonatal services as a result of the South Wales Programme decision to consolidate services onto fewer sites to ensure sustainability. Whilst clarity is still sought around the final configuration of services such as Paediatric Assessment Units and day case provision, the UHB anticipates that a significant additional workload of unscheduled general paediatric and surgical paediatric activity will flow into the UHW site.

This has major implications, for the UHB, in terms of increased flows and activity and the UHB is developing a Cardiff and Vale plan to implement both interim and long term arrangements for paediatric, neonatal and obstetric services in the region as part of the South Central Acute Care Alliance plan.

These plans will also addresses a number of other issues around local capacity provision where demand for cots frequently exceeds capacity resulting in high risk mothers and babies being moved to other units in Wales and England, and also in relation to infection rates which have, in the past, been found to be at unacceptable levels, as benchmarked against the Vermont-Oxford network (an international network of neonatal units allowing benchmarking with units of similar activity levels and workload). This plan would require additional revenue support to deliver.

The UHB has obtained agreement from WG to progress the development of a business case in the form of a Business Justification Case (BJC), given the immediacy of the situation. The UHB intends to submit the BJC to WG by the end of May 2015, however given that additional cots need to be in place by August 2015, Welsh Government is asked to identify a fast track process to secure capital funding required to implement the proposed additional neonatal cot capacity at UHW.

As well as capacity and environmental issues the UHB has developed a plan to achieve the Neonatal Standards (2nd Edition) to ensure compliance. The UHB compares better than most Neonatal Units in Wales, and its areas of improvement are mainly associated with 12 hour Consultant cover, therapies support to the NICU and registered nursing in the SCBU cots. This plan would have additional resource implications.

Paediatric Intensive Care Unit (PICU) Sustainability

The paediatric intensive care units in both Wales and South West England have offered high-quality, reliable transport services for more than ten years. However, a combination of internal and external pressures means that reconfiguration of each team - individually - is inevitable. A unique opportunity exists, therefore, to combine the services, establishing an independent transport team covering the whole of South Wales and South West England and a business case has now been developed to provide this essential service

The Development of the Noah's Ark Children's Hospital for Wales

The development of the second phase of the NACHfW will be completed during 2015 and will provide a flagship hospital which will enable the delivery of modern efficient ways of working.

This phase will complete the development of a child focussed hospital providing high quality, responsive and integrated paediatric care with dedicated facilities to support surgical, diagnostic, outpatient and critical care services fully integrated with those provided in the first phase of the development.

The revenue shortfall associated with the new service models has now been reassessed and managed through the work of the UHB's Paediatric Service Redesign Steering Group.

It will not be possible to move all services to the NACHfW as there are a number of outstanding cost pressures associated with this development, in relation to uncommissioned activity, which is the subject of on-going discussion with WHSSC.

Service Specific Commissioning

There is a need to develop clear service specifications right across the services it provides tertiary, secondary and community based services. This will ensure the delivery of measurable outcomes. In 2015/16 there will be specific focus on:

- Sustainable tertiary paediatrics;
- Health Services to the new special school (Ysgol Y Deri) in Penarth; and
- School-Based Paediatric Therapy services, building on the work undertaken in Speech and Language therapy which has developed a new joint service model with education and single point of referral. Therapy leads meet on a regular basis with a parents group at a special school in Cardiff to inform this work, and a similar group will be part of finalising the specification at Ysgol Y Deri.

Individual Patient Commissioning

There are two elements of service within the UHBs responsibilities that require clear and cost effective processes for commissioning services for individual patients. These are:

- Individual care packages for Children with Continuing Health Care status. The Board is collaborating with the Procurement Team to ensure appropriate governance and contracting arrangements are in place for joint care packages with the Local Authority are being developed; and
- Care for Looked After Children from Cardiff and the Vale, who are placed out of county, for whom the UHB is the responsible commissioner and Looked After Children from other geographical areas placed within Cardiff or the Vale for whom costs should be recharged to the responsible placing organisation. The new development in Penarth of Ysgol-Y Deri offers the opportunity to develop a local multiagency respite facility and planning based on local need assessment across Health Social Care and Education will be driven forward in 2015/2016.

Regional Collaborative Fund Sexual Assault Resource Centre (SARC)

The UHB currently manages the SARC which provides services for both adult and children and young, people, and is the only Health managed SARC in Wales. The service is currently funded through a variety of income sources (Welsh Government, Police, ABHB, Home office Grant) on an annual basis, with no recurrent income stream secured. The Welsh Government have commissioned an All Wales SARC review to provide safe and sustainable services throughout Wales. This is currently being led by the South Wales Collaborative. The outcome of this review is likely to have a significant impact on the services that will be provided within Cardiff and Vale. The Welsh Government have provided Regional Collaboration Funding to support the delivery of the service within Cardiff and Vale whilst a sustainable model is established. However, this income is now at risk and forms part of the underlying deficit. A plan is currently being considered as to the level of SARC service that can continue to be provided within the reduced allocation.

Fetal Medicine

WHSSC are currently undertaking a full review within Fetal Medicine. This will review its commissioning responsibilities and will help the UHB to build a more sustainable model that meets demand, good governance, and relevant income from all referrers to support true tertiary work. This plan will consider the paediatric cardiology and neonatal implications of providing a robust fetal medicine service.

Diabetes Improvement

Type 1 diabetes is one of the most common chronic diseases in childhood. A key factor in reducing the impact of diabetes is good control of blood sugar levels, without frequent hypoglycaemic events.

All children and young people (CYP) with newly diagnosed diabetes need a care pathway, which includes a structured education component to support and empower them and their families. All CYP must also receive all key care processes recommended by the National Institute for Health and Care Excellence (NICE). The priorities for 2015-16 are included in the Long Terms Conditions Chapter at 6.7.

Paediatric Cancers

The three most common cancer types in children are leukaemia, brain, other central nervous (CNS) and intracranial tumours and lymphomas. Leukaemia is the most common childhood cancer accounting for around a third of all cases. The UHB delivers excellent compliance against both the 31 and 62 day pathway targets and is committed to working with service users and their families to ensure that care pathways are timely, holistic and in line with NICE guidance and WHSSC specifications.

6.11.2 Performance

The Health Board is reviewing the WHSSC LTA with a view to rebasing based on 12/13 outturn. This will significantly alter the commissioned level of activity, but will give the Clinical Board an LTA that can be monitored based on deliverable activity.

RTT 2014/15 and Cancer

Due to largely to theatre capacity constraints, the predicted outturn at March 2015:

- 0 OP >36 week waiters in General Paediatrics;
- 0 >52 week waits; and
- < 100 > 26 week waits in Paediatric Surgery

Outpatient waiting times - The UHB aims to maintain a maximum 14 week wait for OPs in all Paediatric outpatient services.

Cancer

Specific Target	Target	April	May	June	July	Aug	Sep
Delivery of the 62 day target for USC							
Children's cancer	95%	100%	100%	100%	100%	100%	100%
Delivery of the 31 day target for NUSC							
Children's cancer	98%	100%	100%	100%	100%	100%	100%

Paediatric cancers are rare but the service delivers excellent compliance against both the 31 and 62 targets.

Local Tier 1 Targets

Outpatient Utilisation

Specific Target	Target	April	May	June	July	Aug	Sep	Oct
New Outpatient Utilisation (Child Health)	90%	95%	93%	95%	96%	96%	92%	89%

Work has been undertaken to review outpatient utilisation to understand the reported variance on a weekly basis looking forward as well as reviewing the most recent week's performance.

Outpatient Efficiency

Specific Target	Target	April	May	June	July	Aug	Sep
New DNA Rates Core Paediatrics	11%	10.6%	9.3%	7.9%	11.4%	12.0%	8.8%

These services generally perform well against the indicators which illustrates the prudent delivery of outpatient services.

A 'call-remind' system has been implemented in Child Health services to assess impact on DNA rates. Results available to date indicate that the system has brought DNA rates down to below target.

Inpatient Efficiency

Inpatient efficiency performance is exceeding target across the dashboard.

Specific Target	Target	April	May	June	July	Aug	Sep	Oct
Non Elective ALOS Paediatrics	3.5	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Non Elective ALOS Paediatric Surgery	4.8	1.4	1.5	1.5	1.5	1.5	1.4	1.3

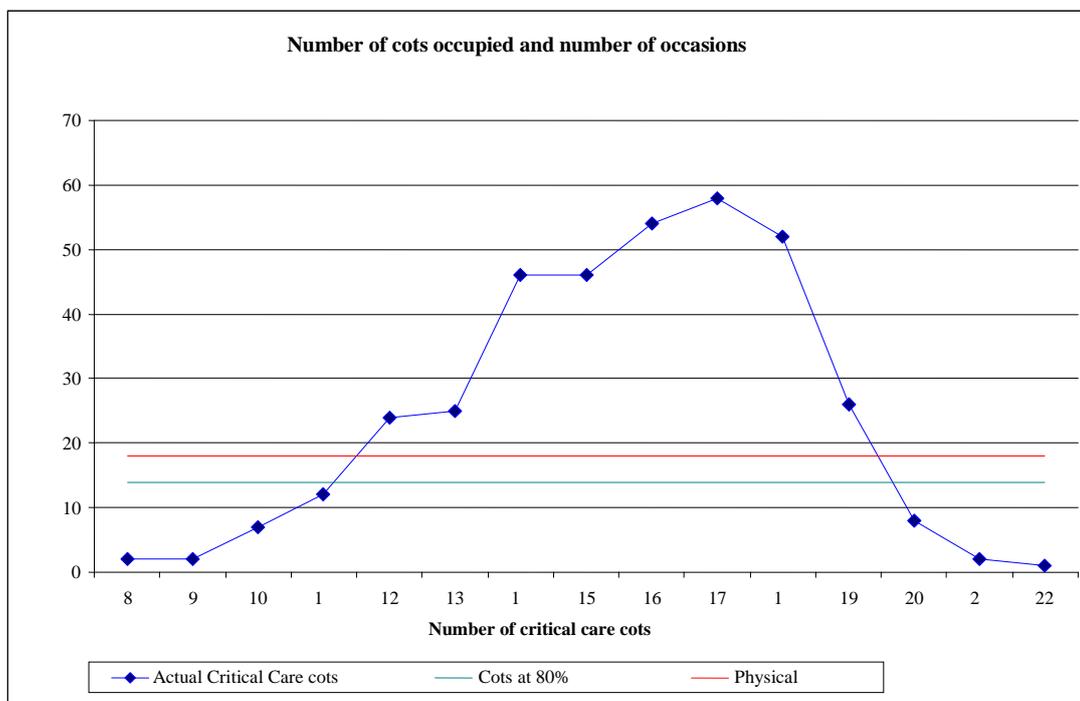
Going forward into the NACHfW opportunities exist to improve Day of Surgery admission and overall Day Case rates with better parent accommodation and the possibility of patient hotels.

Neonatal

WHSSC Activity

Specialty	Bed days LTA
NICU – ICU	3,743
NICU – HDU	2,134
Total NICU	5,877

The graph below illustrates the occupancy levels for 13/14 in terms of critical care cots utilised and the number of days operating at that level.



The graph illustrates that the demand for cots varies significantly. On 26 occasions in 2013/14, the unit opened a 19th cot and on 8 occasions a 20th cot was opened, and so on. In addition, approximately one mother per week has been transferred out of the UHW unit, either to other Welsh units, or to England because demand has exceeded the 20 cots.

Children’s Community Nursing Service Activity

Date	Number of children on CCNS caseload	Total numbers of hours of care agreed at Panel
03/2004	13	300
03/2005	17	449
03/2006	24	460
03/2007	29	518
03/2008	31	579
03/2009	42	810
03/2010	44	748
03/2011	47	1189
03/2014	53	1339
09/2014	58	1,503
01/2015	69	1,975

The table above demonstrates the growth within the service and upward trend in both numbers of children but also of hours of care provided. There is an increase in more complex and technology dependent children. The current nursing establishments do not have the capacity to provide for this level of care packages. This will result in a “waiting list” for packages to be commenced and for larger packages of care this can take up to 6 months. This does not comply with the Children’s Continuing Care Guidance.

Diabetes

The performance indicators for C&YP demonstrated in chapter 6.7 are poor. In 2011-12 the UHB ranked as the poorest performing unit, as measured by HbA1c outcome, delivering care for diabetes in Wales and in the bottom 25% of units for England and Wales combined. Over the past 12 months we have worked on a number of themes as recognised by the all Wales Paediatric Diabetes Group to improve outcomes:

- Establishment of an all Wales Paediatric network; Network Coordinator recently appointed;
- Quality assurance peer review programme of centres delivering care in Wales; and

- Development of a structured education programme for type 1 diabetes in children.

6.11.3 Priorities

The following developments include the UHB's priorities for its children and young people's services that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across all parts of the pathway. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities **these are factored, where appropriate, into the financial plan at section 7**; and
- Those priorities that the UHB will implement ***in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation*** - to meet the priorities described.

1. The key priorities for these services to improve children and young people's care with include:		Target improvement
Scheme	Outcomes	All improve clinical outcomes
Paediatrics		
Review all caseloads with chronic conditions and frequent fliers	Instigate case management plans to reduce avoidable admissions	
Review and develop plans for same day surgery / pre admission	To identify extent of opportunity to improve day case rates.	
Develop workforce plan to support single point of entry for children presenting as emergencies	To improve integration of services and most efficient deployment of clinical resources	<4 hour wait
Review children's community services to develop hospital at home specification	To identify extent of opportunity to improve care for sick children in the community	
Agree plans with ACA partners for additional capacity required to meet the requirements of the SWP	To accommodate the transferred patient flows in emergency and inpatient services	
Diabetes	See section 6.7	
Paediatric Cancers		
Review care pathways in line with NICE guidance	To identify requirements to improve compliance with NICE guidance	
Review the provision of paediatric anaesthesia	To identify requirements to optimise deployment of scarce specialist resource	
Ensure that the patient population characteristics (e.g. BMI) are reflected in the service specifications agreed with neighbouring HB	To inform commissioning negotiations to ensure resources are sufficient to deliver the required capacity.	
Electronic prescribing – roll out	Enabling use of the e-prescribing software by clinicians in Paediatric Oncology to prescribe all chemotherapy and supportive medication. Pharmacists will clinically check these prescriptions electronically and manufacture /dispense from the worksheets produced. Nursing staff will be able to check and schedule patient's chemotherapy using the system	
Neonatal		
Agree the Business Case for the provision of additional capacity to meet the requirements of the SWP in collaboration with ACA partners	To accommodate the transferred patient flows in Neonatal services	

2. The key priorities for these services to improve children and young people's care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Identify commissioning support and agree plans for the increased capacity and associated clinical resources in Neonatal services to safely meet local demand as well as improving the environment to provide additional space between cots to alleviate infection issues	<ul style="list-style-type: none"> Improved resilience to manage variation in demand Reduced infection rates Improved recruitment and retention of clinical workforce 	

Key enablers include – Neonatal and obstetrics capital development to provide regional accommodation solution and contribution to parents' accommodation in respect of the NACHFW

6.12 Maternity Services

6.12.1 Context

The strategic drivers impacting the provision of maternal services include the increasing birth rate and population size. Also, the implications of the SWP decision to remove consultant led obstetrics services from neighbouring Royal Glamorgan Hospital, whilst interim measures are currently in place, will ultimately increase demand for more complex obstetrics led births at UHW.

The proportion of the population aged 0-24 in Cardiff is significantly above the Wales average, at 35.5% (122,600 people) compared with 30.3% nationally. The figure for the Vale of Glamorgan is in line with the national average. The local birth rate has been steadily increasing each year by around 50-70 births, and overall the population aged 0-16 is projected to rise by 4.5% during the period 2013-17, partly due to additional inward migration.

Historic birth rate and net migration into Cardiff and Vale, 2007-2013. Source: StatsWales (2014)

	Annual births	Net migration into Cardiff and Vale
2007-08	6,016	3,538
2008-09	6,053	3,173
2009-10	6,125	1,758
2010-11	6,207	1,863
2011-12	6,279	708
2012-13	5,910	1,711

The population served by the UHB exhibit significant unhealthy behaviours and the emergency stream is seeing increasing numbers of pregnant women with health problems related to obesity such as diabetes, alcohol, mental health and substance misuse which adversely impacts on outcomes.

In July 2012, Welsh Government issued a set of outcome indicators and performance measures for NHS maternity care, as had been described in 'A Strategic Vision for Maternity Services in Wales' (Sept 2011).

The overall aim of the standards is to reduce inequalities in health, examine how well we are reducing the gaps (between areas of deprivation and age groups), and compare with Wales and internationally.

The UHB has developed a Local Delivery Plan to support implementation and provide assurance of progress with the outcomes.

The outcomes include; effective engagement with service users, healthy mothers and babies, fewer premature and low birth weight deliveries, obesity in pregnancy, smoking in pregnancy, teenage pregnancy rates, alcohol in pregnancy, complex social needs in pregnancy, promotion of breastfeeding and perinatal mental health. The service changes (linked to the Shaping Our Future Wellbeing Priority - Maternal Health), will major on delivering these outcomes.

The combined effect of increased local demand and the predicted significant impact of the SWP service changes will require additional medical and transfer of resources from Cwm Taf to Cardiff in order to support the changes to patient flows.

6.12.2 Performance

Activity performance trends for 2010 - 2014

	2010	2011	2012	2013	2014
Total CLU Deliveries	5033	5026	4736	4676	4674
Total MLU Deliveries	1060	1254	1254	1245	1144
Total Planned Home Deliveries	13	50	17	70	101
Total Unplanned Home Deliveries	56	26	64	56	68
Total C/S Deliveries	1386	1310	1350	1275	1221
Total Deliveries	6162	6356	6071	6047	5987

Overall the number of deliveries has slightly decreased with the drop in CLU deliveries and the increase in MLU and home deliveries being due to the employment of additional community midwives.

In terms of occupancy, there has been a slight increase over the last 2 years and there is anecdotal evidence to show that the complexity of cases have increased. This level of detail is now being picked up through the Maternity Outcome Indicators – see section below:

- 2013/14 - 92% occupancy level
- 2014/15 - 96% occupancy level

Maternity Outcome Indicators

The UHB has now addressed a number of issues raised in the March 2014 WG review which include:

- Cardiocotography (CTG) compliance is now 100% and is fully compliant;
- Day consultant cover – opportunities within the plans for the implementation of the SWP; and
- A perinatal mental health midwife has now been in post for a year.

Compliance with each of the indicators and performance measures, and necessary work programmes to improve delivery is shown below:

Indicator	Current Performance	Future work Required
Indicator 1 - % who smoke during pregnancy (at booking)	A third of women access smoking cessation Two thirds stop smoking during pregnancy There is access to specialist staff to support women to stop smoking Clinical teams have access to CO2 monitors to advise of the impact of smoking	Definition required to include e-cigarettes and nicotine substitutes
Indicator 1 - % who misuse substances during pregnancy	When women disclose, they are referred to a specialist midwife and an individual plan is implemented	The definition needs to be clarified as to whether it includes women on managed programmes

Indicator	Current Performance	Future work Required
Indicator 1 - % of women who drink 5 or more units of alcohol per week in pregnancy (at booking)	Disclosure to drinking alcohol in pregnancy appears to be low. Women referred to disclosure are referred to consultant clinic where initial assessment is undertaken by Specialist Midwife.	The maternity team is working with Public Health Wales to actively promote openness and educate women on the number of units consumed.
Indicator 1 - % who have a BMI 30+ (at booking)_	The service has introduced community scales, and moved booking appointments into the community. Women are weighed pre delivery but data is not currently collected electronically. Pathways are in line with NICE and MBRRACE in effect for 30-34.9, 35-39.9 and 40+ BMI.	Plans in place to ensure every midwife has access to scales in community. The UHB is proposing the options to collect data electronically to improve real time analysis.
Indicator 3 - % of babies exclusively B/F at 10 days	The data shows a slight drop in performance. Previous data submitted included both exclusively B/F babies and those who received 75/25 split. The Postnatal pathway data show a rate of 36% and HV report a rate of 40.5% in 2014. The Directorate are currently validating the data.	Future work – Plan to ensure greater ward and community support for breastfeeding mothers, through our Patient Experience Delivery Plan
Indicator 4 - % of women and partners who felt confident to care for their baby	This is currently captured in paper format via the '2 mins of your Time' Tool. This is reviewed daily by ward sister and all women have the opportunity to complete a 2 mins of your Time audit. The UHB has the support of MSLC to engage patients in this way. The UHB has implemented an email account and telephone line for reporting concerns, and listening to patient's feedback.	
Indicator 5 - % of Healthy Births	The UHB reported 55 cases this last quarter, much lower than expected and further understanding is needed.	Future work is required with WG to ensure a workable and meaningful definition for a Healthy Birth.

Performance Measure	Current Performance	Future work Required
Performance Measure 1 – C/S Robson Groups	Our current yearly elective caesarean section is rate 10.0% and emergency rate 10.9%, with an annual cumulative of 20.9% The UHB performs well but are concerned with the potential impact of the South Wales Alliance, given caesarean section rates in neighbouring Health Boards. There has been an increase in the homebirths from 2013 and 2014 of 44%.	Need to maintain current rates and ensure acquisition of additional Health Board activity have buy in to C&V practices.
Performance Measure 2 - % of women whose initial assessment has been carried out before 10	Performance is steadily improving. This has been achieved by booking women in community.	Acquisition of handheld devices (netbooks) will further improve this performance.

Performance Measure	Current Performance	Future work Required
weeks of pregnancy.		
Performance Measure 3 - % of women with existing mental health conditions with a care plan	A Perinatal Mental Health Midwife is now in place, working with a named consultant. Serious cases are identified and a personalised care plan is put in place within 4 weeks of being seen. Training and support is in place for community midwives in supporting women with less complex or historical mental health concerns.	The UHB is working towards a plan to increase service to provide 7 day support.
Performance Measure 4 - % of women and partners who said they were treated well by maternity services.	This is currently captured in paper format via the '2 Mins of your Time' tool. Patient Safety Walkabouts are in place to gain real time feedback.	Electronic feedback is the way forward and the UHB is exploring options.
Performance Measure 5 - % of women who gave up smoking during pregnancy	There is a steady rise in the number of women who have given up with access to better smoking cessation support. The UHB also continue to work with Stop Smoking Wales	This measure will be extended to other smokers in each household who will also be educated and supported to give up.
Performance Measure 5 - % of women who gave up drinking \geq 5 units of alcohol per week.	There is limited evidence here and the UHB's Maternity and Public Health teams are working together to improve reporting and compliance.	Alcohol awareness plastic beakers to demonstrate alcohol units in drinks to be provided to all community midwives to help with the Health Education agenda
Performance Measure 5 - % of women who gave up substance misuse in pregnancy	Rates are improving but the numbers are very small hence measuring a significant change in first half of the year. Specialist midwife develops individualised care plans for these women. This role is unique to Cardiff & Vale and provides excellent links with MH midwife	The UHB advocates a maternity indicator around disclosure of domestic violence, which may well link to this indicator.
Performance Measure 5 - % of women who gained more than recommended amount of weight in pregnancy	The data is currently being collected in paper format. Not all women are being weighed at 36 weeks, and work continues to improve measuring this outcome. Motivational Interviewing is now in place to gain this information.	The UHB aims to report an improvement with introduction of mobile devices.

Key areas of focus for prudent service redesign and delivery include:

- Improve home birth rates by supporting this choice more readily;
- Improve MLU rates by managing clinical variation;
- Reduce unnecessary test ordering;
- Implement electronic booking in;
- Police the protocols for consultant led antenatal care to reduce duplication and save unnecessary appointments;
- Streamline the management of pathology results to reduce Midwife time;
- Benchmark with other Transitional Care Units and review the model;
- Review the Induction of Labour pathway; and
- Review the information given to pregnant mothers and make it more real time – with the potential to seek advice via email/website/telephone to avoid attendance at OAU.

6.12.3 Priorities

Safe compassionate care of the woman and family in pregnancy, accompanied with effective and mindful communication has the potential to deliver improved outcomes, and an improved patient experience. Feedback from patient engagement groups from the Clinical Strategy Services, and Clinical Board groups shows that when staff work in partnership with women they feel that they have more control over the decisions that they make and feel that they are being listened too. This in turn gives them more control over their choices and in control. This can reduce interventions and improve outcomes.

The following developments include the UHB's priorities for its maternity services that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across services. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities **these are factored into the financial plan, where appropriate, at section 7**; and
- Those priorities that the UHB will implement **in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation** - to meet the priorities described.

1. The key priorities for these services to improve maternity care include:		Target improvement
Scheme	Outcomes	All improve clinical outcomes
Agree plans with ACA partners for additional capacity required to meet the requirements of the SWP	To accommodate the transferred patient flows for consultant-led deliveries	
Review doctor and anaesthetic cover for labour ward	To identify requirements for improving compliance against RCOG standards	

2. The key priorities for these services to improve maternity care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Invest in additional midwifery staff	Comply with the WG workforce requirements identified by 'Birthrate Plus Midwifery Workforce Planning System'	
Implement Mobile Devices Business case	Improve access to community and home booking	

6.13 Specialist Services

Context

The UHB offers specialist clinical care to people with complex health needs and serious disease. It functions within a complex commissioning environment, operating as both a commissioner and provider of specialist and tertiary services to the local health economy and also the South East region and wider all Wales populations. The UHB continues to focus on delivery of specialist services within a strategic context that forecasts continued growth in demand for services driven by:

- Demographic and age related population factors;
- Developments in sub specialisation and specialist commissioning;
- Patient choice agenda; and
- Continuing regional reconfiguration of acute emergency and complex elective services through NHS Wales Collaborative work programme.

The specialist services provided by the UHB are predominantly commissioned by The Welsh Health Specialised Services Committee (WHSSC) who, on behalf of the seven health boards in Wales responsible for meeting the health needs of their resident population, has delegated responsibility for commissioning a range of specialised and tertiary services to bring equity and excellence to their provision. Health Needs Assessment (HNA) is the process by which WHSSC considers the requirements for specialised services at a national level to consider health needs and identify inequalities.

HNA is a critical process that informs:

- Commissioning and planning services;
- Inequalities assessments;
- Evidence base;
- Population projections; and
- Modifiable risk factors.

As the leading provider of specialist services in Wales specialist services are delivered, in the main, through the UHB's Specialist Services Clinical Board structure comprising seven Directorates:

- Cardiothoracic Services;
- Critical Care;
- Haematology and Clinical Immunology;
- Medical Genetics;
- Nephrology and Transplant;
- Neurosciences; and
- Artificial Limb and Appliance Service (ALAS).

Health Needs Overview

Along with most of the UHB's services, the main public health considerations for the provision of Specialist services are the increasing population and changes to age profile, unhealthy lifestyles and inequalities in health. There are some considerations that are specific to individual services that include:

- Cardiothoracic - inequalities in outcomes and access - in particular lower than expected access rates to services from Cwm Taf population. A detailed HNA can be found for Cardiothoracic services in the Heart Disease Delivery Plan. A HNA for Thoracic surgery will be completed as part of commissioning cycle through the TSIG;
- Medical Genetics - the increasing publicity about and availability of genetic testing opportunities through new technologies (e.g. the 'Angelina Jolie' effect has caused >40% increase in cancer referrals), expanded population screening for genetic disorders and the increasing 'across the counter' testing that may have implications for individuals and extended families.

The UHB works with WHSSC to demonstrate how these services are:

- Being organised around the principles of prudent healthcare;
- Systematically pursuing quality improvement to ensure better outcomes for patients and their carers;
- Underpinned by practical actions to build strong, resilient services; and
- Delivering priority performance targets.

The estimated commissioning and delivery of UHB services for 2015/16 is organised as follows:

	WHSCC	Non WHSCC
	£000	£000
C&V - provider	193.3	84.9
C&V – commissioner	112.7	60.8

The UHB will continue to work with its commissioners to understand commissioner priorities which include a need for affordable growth and the capacity to sustainably deliver national performance targets and priorities. Both Specialist and non specialist services have challenging financial constraints which will influence priorities, service development funding and new opportunities as technological and innovation improvements become available.

The UHB is committed to continue to work in partnership, recognising the need to ensure NHS Wales has excellent and sustainable specialist services, addressing many of the areas requiring developments, and consolidating and growing the UHB's role as the leading provider of these services to NHS Wales.

2014/15 represented the start of several major service change programmes that will be completed during the next 3 years. These work programmes are:

- Commencement of an Epilepsy Surgery Programme, initially commissioned on a cost per case basis via WHSCC;
- Development and implementation of a Post Anaesthetic Care Unit (PACU) to support the elective surgical services;
- Development of a business case to commission additional Cardiac Surgery activity, including an expansion in infrastructure;
- Implementation of a Critical Care Outreach programme at UHW and development of a proposal to extend the service to the UHL site to improve clinical outcomes and improve performance in support of unscheduled care; and
- Planning and for the transfer of Specialist Rehabilitation services from Rookwood to UHL.

The UHB aims to commission and deliver outcomes for all specialist services that compare with the best in the UK and, in some cases internationally, to comply with national recommendations in specialist practice and deliver these outcomes with financial efficiency.

Performance

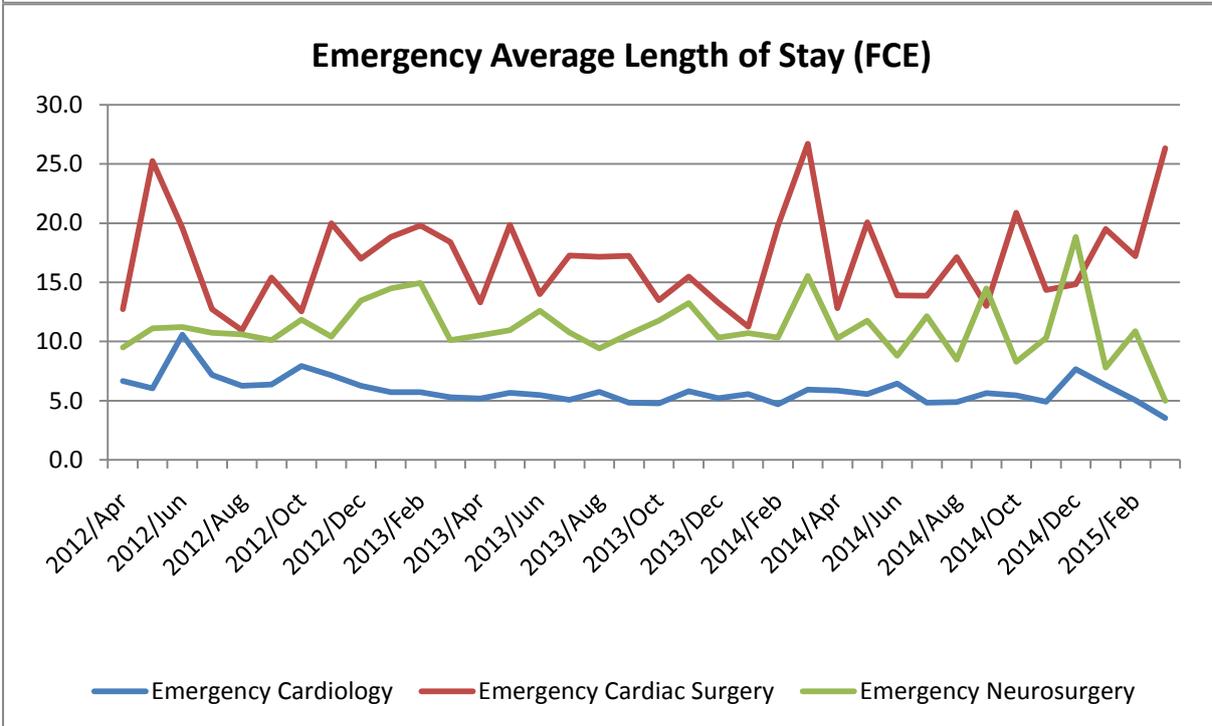
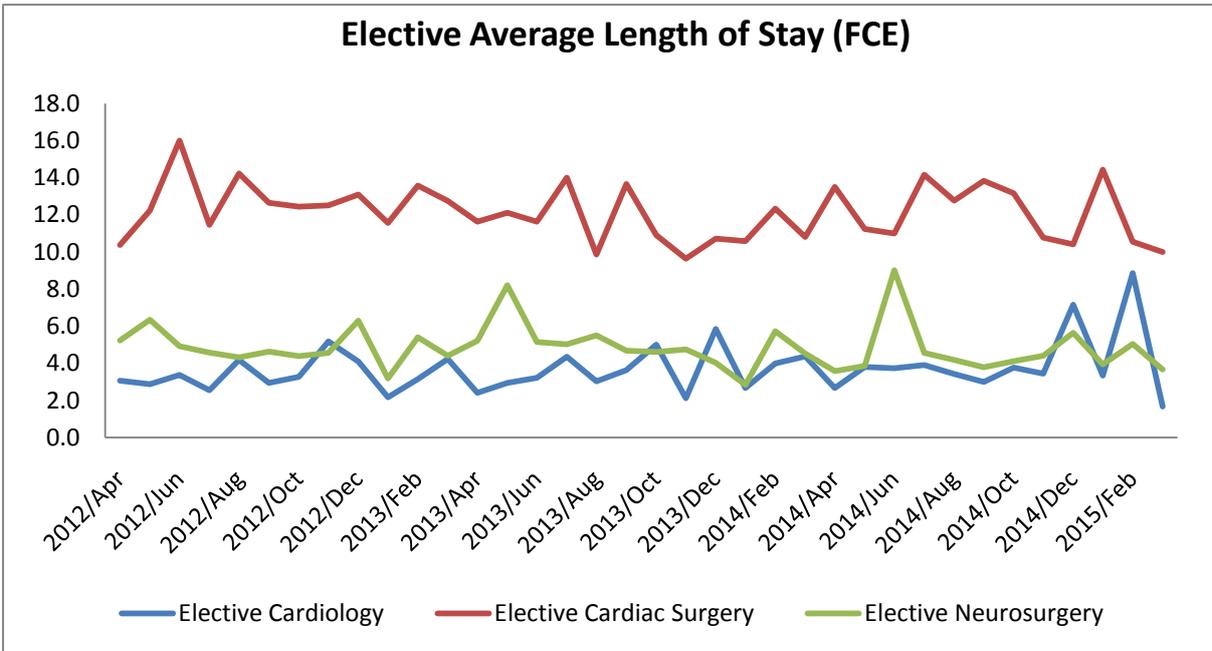
The UHB has plans to continue to optimise access to these critical services by increasing capacity through targeted efficiency and productivity improvements based on benchmarking our services with comparable peers. There will be a requirement to align capacity with demand through increases in resources either through role redesign and/or with targeted investment in some areas. In some specialist services, balancing demand and capacity to achieve clinical and national policy targets on a day to day basis presents a significant challenge to date.

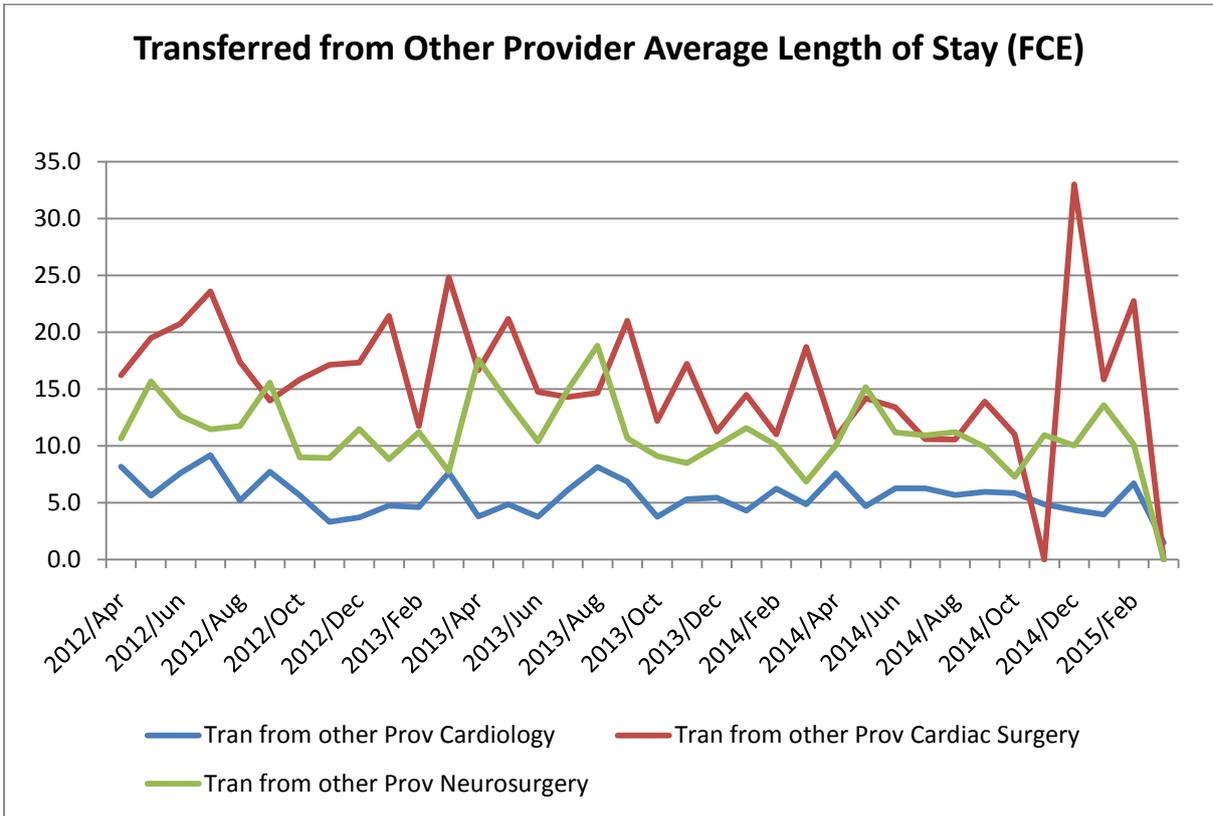
Nationally there are a number of shortages within key staff groups such as specialist nurses and consultants, which have led to international recruitment drives. These market forces impact lead times, skill mix availability, competition and require mature workforce planning to ensure there is appropriate training and development.

In respect of cardiac surgery whilst the implementation of the PACU has supported the management of elective patients post operatively the Clinical Board is working to mitigate the risks in relation to the CITU infrastructure coming online partway through the year and also working with the Surgery Services Clinical Board to identify a solution to the workforce challenges of recruiting and training cardiac theatre scrub staff.

Whilst it is recognised within Neurosurgery the need to maintain access to emergency theatres for time critical cases constrains the service from ensuring the elective stream always has adequate capacity and this is a key issue for 2015-16.

RTT performance for these specialties is included at Chapter 6.4.





Benchmarking LOS for elective and emergency LOS that highlights the following key issues in relation to Cardiology, Cardiac Surgery and Neurosurgery:

- Cardiology** - Most elective cardiology is admitted on day of surgery and undertaken through the Day Unit, a review of the pathway management arrangements for non Cardiff and Vale residents will be undertaken to ensure they are treated effectively and repatriated efficiently and appropriately to their local Health Board for ongoing care. Repatriation of these patients when escalation across the whole system is high works efficiently but needs to be embedded as “business as usual”. Regional non-elective patients tend to stay unnecessarily with the UHB for their entire pathway causing capacity constraints; and
- Neurosurgery** - Neurosurgery activity compares well against peer organisations despite having a reduced bed base and the service generally has good elective flow. However, despite this there is an underperformance against the LTA as theatre resource constraints impact on access to emergency theatre resulting in elective lists being cancelled. Compounding this is the lack of capacity in neuroradiology and recent WHSSC approval for the recruitment of a third neuro-interventional radiologist in 2015-16 will enable an extension of the provision of services to support increased cover during out of hours periods.

During 2014/15 the UHB has seen a marked improvement in the 62 and 32 standard for the cancer sites within the specialist clinical Boards portfolio with all targets, being consistently met. The exception to this, the lung cancer 62 day target, has been the focus of on-going negotiation via with WHSSC and a joint appointment of an additional thoracic surgeon has recently been approved between the UHB and ABMU.

Critical Care

CONCLUDED CRITICAL CARE EPISODES Apr 13 - Feb 15						Concluded Episode's Level Bed Days	
	Total Concluded Episodes	Episodes Delayed	Episodes Delayed >=24 Hours	% Delayed	% Delayed >24 Hours	LVL 2 Days	LVL 3 Days
Apr-13	151	103	31	68.2%	20.5%	220	662
May-13	24	0	0	0.0%	0.0%	19	124
Jun-13	129	92	21	71.3%	16.3%	168	632
Jul-13	124	97	31	78.2%	25.0%	223	730
Aug-13	139	108	21	77.7%	15.1%	187	1080
Dec-13	108	78	23	72.2%	21.3%	175	733
Jan-14	102	78	29	76.5%	28.4%	193	728
Feb-14	126	100	35	79.4%	27.8%	219	698
Mar-14	131	91	34	69.5%	26.0%	256	860
Apr-14	134	95	24	70.9%	17.9%	273	573
Jun-14	134	104	21	77.6%	15.7%	263	630
Jul-14	134	108	35	80.6%	26.1%	283	627
Aug-14	131	100	37	76.3%	28.2%	265	726
Dec-14	145	98	27	67.6%	18.6%	217	797
Jan-15	130	92	24	70.8%	18.5%	257	831
Feb-15	124	92	23	74.2%	18.5%	210	668
Grand Total	1966	1436	416	73.0%	21.2%	3428	11099

NB DATA SOURCE - CRITICAL CARE EXTRACT FROM SERVICE USED FOR WAG SUBMISISON

Together for Health – a *Delivery Plan for the Critically Ill* (2013) sets out the Welsh Government's expectations of Health Boards in making the best use of critical care beds and ensuring that those who are critically ill have timely access to high quality care in an appropriate environment. Currently in Wales timely access is not always possible as the current numbers of critical care beds in Wales are the lowest in Europe. On average, there are 3.2 beds per 100,000 people in Wales, while in England there are 4. The average across the whole of Europe is 11 beds per 100,000 people. This average of 3.2 beds in Wales masks even lower numbers in some Health Boards, where the beds number below 3 per 100,000 people.

This under provision has significant implications and puts critical care beds under high pressure. The Intensive Care Society (ICS) recommends in its Standards for Intensive Care Units that critical care units should operate at a maximum of 75% occupancy in order to manage peaks in demand that every unit can expect. The all-Wales occupancy for critical care is greater than 80%, with many Health Boards (HB's) reporting higher than 100% occupancy on occasions (i.e. where critically ill patients are cared for in non-designated areas).

Within the Health Board the pressures facing Critical Care provision across Wales are clear and the points made in the UHB's Critically Ill Local Delivery Plan (February 2014) are well recognised.

The service delivery proposals, phases 2 and 3 of the critical care expansion plan, are based on the need to address issues identified within a realistic, deliverable and affordable model ensuring that the Critical Care service provides best value for money. There is therefore, a staged approach to implementation of the key service reconfiguration changes.

These proposals however only address the current demand for critical care to support the known demand for elective and emergency care, they do not address, or respond to the impacts of service developments, reconfigurations and consolidation of service provision across the region or as part of the South Wales Collaborative workstreams, such as the EMRTS service or the implementation of the Major Trauma Network. The UHB is undertaking a demand and capacity modelling exercise to assess the impact of these and other strategic changes and clinical models, including robust repatriation processes, to develop proposals to address the known shortfall in critical care provision within Cardiff and Vale as the lead provider of specialist services.

Priorities

Some of the key challenges in the commissioning and provision of specialist services are well rehearsed whilst others, in relation to the impact of reconfigurations across care alliances are yet to be fully understood.

Operating within an environment of unprecedented economic challenge the UHB priorities and plans have developed against this context with a focus on:

- An ongoing dialogue with WHSSC regarding key developing and/or challenged specialist services to develop an integrated approach to commissioning and developing sustainable service models;
- Supporting commissioners in reducing growth in demand by working with them on identifying alternative models of provision and service redesign;
- To continue to benchmark and review existing service provision with peers to continuously improve outcomes and efficiency;
- As the key provider we will actively participate with the NHS Collaborative and other Trust and Health Board partners in the strategic redesign of specialist and tertiary services for the region and Wales.

Against the UHB's strategic themes, and in partnership with commissioners and the care alliance, the UHB has identified on-going priorities to transform the delivery of specialist provision, many of which are linked to other prioritised work streams and pathways.

Priorities in 2015-16, with a particular emphasis on integration and best practice to ensure the best possible patient experience and most efficient use of resources, and include:

ALAS

The main areas of focus for performance management are the delivery of standard wheelchairs, adult complex wheelchairs and the achievement of the NSFP1 and NSFP2 targets.

The key priorities for this service are:

- Redesign working practices to improve; and
- Implementation of a streamlined referral registration processes to address system issues to achieve the performance required based on demand and capacity assessments.

These targets remain a significant challenge and additional resources, in addition to the above action, will be required.

Cardiac Surgery

Significant progress has been made in reducing the total number of cardiac surgery patients waiting over 36 weeks. The priority for the service is to deliver the increased WHSSC activity for Cardiac Surgery in line with waiting times targets to support planned care and RTT. Operational delivery of the planned activity requires investment in Cardiac ITU capacity and regular review of all out of area patients and repatriation when and where appropriate for ongoing hospital care.

Cardiac Magnetic Resonance Imaging

Through the Cardiac MRI Commissioning Group, WHSSC has developed commissioning intentions and an implementation plan, which Health Boards have been asked to adopt within their IMTPs. The commissioning intentions set out a 5 year plan to increase population access rates to cardiac imaging to those recommended by best practice guidelines with a two step approach for implementation. It is proposed that in year 1 capacity is increased within existing providers while a detailed options appraisal is undertaken to determine the long-term service model. The outcome of this development will inform the development of implementation plans for years 2 to 5 of the commissioning plan.

To support this work the UHB will also need to consider, with commissioners, if there is a need to procure an additional MRI Scanner at the UHW to be used for Cardiac Imaging to support a regional CMR service at UHW in keeping with UK recommendations for a tertiary cardiac centre.

Cardiology Outpatients and Cardiac Physiology Services

THE UHB is developing a Business Justification Case for capital investment to enable the development of a cardiology outpatients and Cardiac physiology facility at UHW. The current delivery of these services is split across three areas of UHW and provided from a very poor environment compromising the patient experience in terms of quality, privacy and dignity.

Develop and implement an E-referral and E-advice service to better stream cardiology referrals and redesign workforce roles to deliver nurse and physiology led clinics.

Cardiac Catheterisation - Replacement of 2 cardiac Catheter laboratories and associated equipment at UHW.

There are three catheter laboratories at UHW, which are known as Cath labs A, B and C. Cath Lab A was upgraded 3-4 years ago. A Business Justification Case in support of the replacement of Labs B and C has been developed in collaboration with NHS Wales Shared Services and is part of the all Wales Programme for Catheterisation Laboratory replacements; it does not include any service expansion; it will ensure the physical infrastructure requirements to enable the UHB to meet the requirements of the Cardiac Disease NSF (2009) and Heart disease Delivery Plan (2013) and meet the needs of their local population.

Critical Care

The *current* demand for critical care services for both emergency and elective care presents the UHB with 3 main challenges:

- Meeting the requirements of the UHB to provide critical care for elective surgery;
- Ensuring appropriate emergency critical care capacity to meet peaks in demand; and
- Providing safe and appropriate staffing levels to meet emergency and elective demand in line with national standards and existing resources.

The UHB has developed a three phase approach to the reconfiguration and expansion of critical care at UHW which that address issues in respect of safety and compliance with NICE guidelines to support the surgical elective stream and also to respond to increasing demand for emergency critical care. Phase 1 of the plan, the creation of a PACU at UHW is online with subsequent phases, 2 and 3 to further expand the critical care area planned. However this planned expansion *does not* address the demand and capacity requirements currently being modelled in relation to a number of known strategic priorities such as the impact of the EMRTS services, the SWP clinical flows or future models for neonatal services, acute surgery and emergency medicine or the establishment of a major trauma centre, all of which will have an impact on the demand for critical care provision.

Nephrology and Transplant

Taking Organ Transplantation to 2020

On 1 December 2015, Wales will be the first UK country to introduce an opt-out system for organ and tissue donation. The aim of the act is to increase the number of organs and tissues available for transplant in support of The Wales Action Plan publish in January 2014 which set out what needs to happen to deliver the 2013 strategy to improve organ transplantation rates in Wales, "Taking Organ Transplantation to 2020".

Priorities for Nephrology and Transplant in 2015/16 include the ongoing implementation of the UHB's Organ donation delivery plan to ensure that organ donation is part of usual end of life care and that every patient has the possibility explored. There have been positive changes which have influenced improvements within the UHB to date to ensure we routinely provide excellent care in support of organ donation and that every effort is made to ensure that each donor can give as many organs as possible, The action plan addresses the four key strategies of:

- Increasing consent rates;
- Increasing transplantable organs;
- Increasing donors per million population; and
- Increasing transplant rates.

Key objectives include establishing closer working relationship with clinical staff to increase referral rates from such areas as Paediatric Intensive care (PICU), expanding the current teaching programme to incorporate competencies to be developed between specialist nurses and practice educators and continue to provide training and education for all doctors as part of their training and development programme.

Pathway for patients with acute kidney failure

In response to NICE guidelines and the interaction between long term medical conditions, medication and inter-current illness often complicated by acute kidney injury the UHB is progressing its implementation of an acute kidney injury pathway across specialties to reduce the risk and burden of acute kidney injury as it is estimated that one in five emergency admissions into hospital are associated with acute kidney.

The aim of the pathway is to ensure that patients who develop acute kidney injury are appropriately managed and supported to reduce further deterioration, long-term disability and death, this will be achieved through:

- Ensuring that appropriate education and training programmes are developed, shared and available for all healthcare professionals based on best available evidence;
- Ensuring awareness of the importance and risks of acute kidney injury and appropriate local strategies to reduce the burden of acute kidney injury are developed; and
- Involving and supporting patients and their families and the public in understanding the risk of acute kidney injury and preventative measures through education and appropriate access to personal information.

South East Wales Haemodialysis

- To continue to work with the Welsh Renal Clinical Network as lead organisation on the procurement exercise for replacing the unit haemodialysis contract in South East Wales;
- Within this tender to replace the CRI West Wing dialysis unit with a facility on the South of Cardiff; and
- To develop a BJC for the remodelling of Suite 19 Dialysis unit at UHW in support of the clinical model for dialysis on the UHW site.

Neurology

As highlighted in the performance section the RTT performance for Neurology is projected to improve however capacity has reduced slightly as clinics are cancelled due to consultant “hot weeks” when they are based in UHW, although it has been agreed that their UHW scheduled clinics will take place. This has caused an issue in Cwm Taf where clinics are cancelled and an inequality in waiting times has developed between general neurology, with patients waiting longer to be seen at Aberdare, and specialist neurology, where patients are referred to, and seen at UHW. To address this in the short-term waiting list initiatives are planned and the job planning exercise will address the capacity and access issues in the medium term.

Neurological and Interventional Neuroradiology Service

The UHB recognises that there are a number of challenges to the sustainability of the provision of neuroscience services, including compliance to the Neurological Conditions delivery plan, and is committed to developing plans to address these challenges in conjunction with commissioners (WHSSC) within a neurosciences strategy for Wales. The Health Board is also exploring options around how our medical workforce can be better utilised. The review will include consideration of how our middle grade doctors can better develop their skills and experience, taking on additional responsibilities in line with their skills and with appropriate supervision. The aim of the medical workforce review is to provide better opportunities for our staff and to improve our recruitment and retention, thus building a more sustainable service for the future.

Neuro and spinal rehabilitation

The OBC for the re-provision of specialist neuro and spinal rehabilitation and gerontology services was formally submitted to WG in January 2013. The OBC preferred option will provide dedicated facilities for specialist neuro and spinal rehabilitation services on the UHL site, (into the vacated women’s unit), the transfer of gerontology services from the Rookwood Hospital site to SDH and the consolidation of south Cardiff outpatient physiotherapy from its current two locality clinics, Longcross House (LCH) CRI and SDH, together with the occupational therapy and services from LCH, into a single re-furnished clinic at CRI, (the former integrated sexual health accommodation). The service models and proposed delivery configurations in respect of these services have been retested and remain valid, and are aligned with both the strategic clinical and estate objectives of the UHB.

Hybrid Theatre

Increasingly vascular procedures are being undertaken in a new type of operating theatre termed a ‘hybrid theatre’ which allows for minimally invasive and open surgery all enabled by high tech imaging systems that are installed in the theatre itself rather than in another room. A business Case is currently being developed to develop a Hybrid theatre at UHW to support the SE Wales Vascular service plan of vascular centralisation in order to comply with core clinical standards to improve clinical outcomes for vascular surgery. As part of the development process the UHB is also evaluating the additional utility that would be provided by such a facility to a range of other specialties; these will form part of the investment proposal.

Thoracic Surgery

The All Wales Thoracic Surgery Task and Finish Group made recommendations for a phased increase in the commissioned level of thoracic surgery over 3 years, to match the upper quartile for cancer networks in England, and to put in place the required surgical capacity to address the persistently low rates of resection in Wales. WHSCC'S recently approved appointment of a 5th Surgeon in South Wales, to work across the two sites, will deliver the immediate improvements in access and provision recommended by the task and finish groups

However proposals have been made from both ABMJU and ourselves independently to increase capacity to achieve improvements. Key elements of the Cardiff and Vale UHB proposals would be to increase the consultant establishment to 4 WTE in two phases:

- The first phase would see the appointment of a 3rd surgeon to provide cover for MDTs, theatres and the on call rota (acknowledging a 1 in 3 rota does not allow for cover for leave and therefore cannot be permanent); and
- Phase 2 would see the appointment of a 4th surgeon, plus infrastructure to increase the capacity of the service to the required level and ensure a sustainable on call rota and cross cover all MDTs.

The UHB is supportive of the development of a single service for Thoracic Surgery in South Wales and is keen to ensure appropriate links are made to other strategic change programmes particularly the work on Major Trauma. The UHB will be pursuing this proposal with WHSCC through the strategic review of the service model.

Haematology

The Bone Marrow Transplant (BMT) service has strategic importance to the UHB in the delivery of secondary care to the residents of Cardiff and Vale and tertiary specialist services for the whole of South Wales. The demand for transplantation, and general and malignant Haematology, has grown steadily over recent years. This has resulted in increased waiting times for admission to the ward and delays in transplantation. This has direct implications for morbidity, mortality and resources, including inpatient and outpatient facilities and staffing. There are documented disease relapses while awaiting transplant.

The UHB will, in 2015/16 develop a business case for investment to commission and build a new Blood and Marrow and Haematology Integrated Unit with increased capacity at UHW in response to the issues arising from the current unsuitable environment that has been criticised in the The Joint Accreditation Committee-International Society for Cellular Therapy and European Society for Blood and Marrow Transplantation (JACIE) and Human Tissue Authority (HTA) inspection reports 2013. There is an urgent need to improve and increase the accommodation for the BMT service to minimise clinical governance risks and ensure JACIE accreditation is maintained and Cardiff and Vale UHB is able maintain its status as a transplant centre.

The service is also negotiating via WHSCC in respect of the lymphoma service provision at both Cwm Taf and Cardiff. Both Health Boards currently have different approaches to service delivery and commissioning direction is required to agree an equitable and sustainable model for the service. The UHB will also progress discussions in 2015/16 with commissioners to progress haematology oncology being included in their service profile.

Medical Genetics

In Wales a Genomic Strategy (in partnership between Cardiff University, Public Health Wales and the NHS) was requested by Welsh Government, and has been developed. It encompasses the service infrastructure, research, and future opportunities for Genomics in Wales. This strategy is now under external review. During 15-16, the All Wales Genetics Service must respond to the Welsh Implementation Plan for Rare Diseases, particularly for the requirements of testing for rare genetic diseases, and the implementation of next generation sequencing technologies and associated bioinformatics. Infrastructure requirements demand a Laboratory Information Management System for the Genetic Laboratory, and suitable accommodation for both Clinical and Laboratory arms of the service. As developments in our understanding of the Genomic Medicine increase, so do the applications in healthcare; there is therefore a requirement for responsible commissioning of new services. During 14-15, a substantial increase in BRCA gene testing was commissioned in response to NICE guidance. However, services for rare genetic diseases, prenatal arrays, and stratified medicine remain outstanding for commissioning; these services are all provided in the rest of the UK.

NHS England, Genomics England and major funders (e.g. Innovate UK, CR-UK, MRC) are focussed on initiatives for the development and implementation of Stratified (Precision- or Personalised-) Medicine. As a leader in this field, Cardiff (and Wales) must take the opportunity to develop academic and NHS services. The All Wales Genetics Laboratory continues to be a Stratified Medicine Technology Hub for CR-UK, a joint application has been made for the MRC Molecular Pathology Nodes (shortlisted), and Cardiff has been shortlisted for the Precision Medicine Catapult. It is essential that the infrastructure and staff of the Genetics service are supported to ensure success in these highly competitive calls.

The management of the Teenage Cancer Unit on the UHW site will be transferred to the UHB's Specialist Services Clinical Board on the 1 April 2015. Teenage cancer targets are currently being met.

In summary the following developments include the UHB's priorities for specialist services that have been reviewed in the context of 2014-15 experiences, observations and analysis of key capacity gaps across services. These developments are presented in two categories:

- Those priorities that the UHB will progress in 2015-16 in order to meet core clinical priorities - **these are factored into the financial plan, where appropriate, at section 7**; and
- Those priorities that the UHB will implement ***in the event of additional resources being available – either through cash-releasing efficiency gains or additional revenue allocation*** - to meet the priorities described.

1. The key priorities for these services to improve specialist care include:		Target improvement
Scheme	Outcomes	All improve clinical outcomes
Backfill capacity in Critical Care released by implementation of PACU	Improved critical care support to unscheduled care	<12 hour wait
ALAS – re-engineer and increase capacity to better align with outcome of demand and capacity analysis	Improved performance against targets	

2. The key priorities for these services to improve specialist care with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Expand BMT service	To achieve core clinical standards including JACIE accreditation	
Expand critical care outreach	To roll out to UHL	
Additional Cardiac Care capacity	To meet increased and increasing demand	<12 hour wait
Additional cardiology nurse practitioners	To offset reduced commitments from junior doctors (in order to address Deanery requirements for changes to junior doctors' training)	RTT
Phase 3 critical care expansion		<12 hour wait
Additional Lymphoma consultant appointment	To meet demand and address sustainability pressures for this single-handed consultant led service.	RTT

3. The key priorities for these services to improve specialist care agreed with WHSCC with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
Additional cardiac surgery and cardiac HDU capacity	To reduce waiting times and provide required capacity to deliver LTA	
Implement Adult Congenital Heart Disease service	To meet national recommendations	

4. The key priorities for these services to improve specialist care requiring support via WHSCC with additional investment include:		
Scheme	Outcomes	All improve Clinical Outcomes
To develop and acute heart failure service to provide daily assessment in the EU and the acute medical ward	This would help to reduce inpatient admissions and enable selected patients to be managed in nurse led optimisation clinics	
Expand Cardiac MRI	To increase core capacity to better meet demand	

7. Finance

7.1 Introduction

The financial environment in which the UHB has been operating has been extremely challenging for a number of years. The UHB has had to make significant efficiencies to meet the costs of unfunded inflation and other cost pressures. The cash releasing efficiencies made by the UHB in recent years is summarised in the following table.

Cash Releasing savings made 2012/13 to 2014/15

	Actual 2012/13	Actual 2013/14	Forecast 2014/15
Savings made	36	46	29
% saving of relevant baseline	4.4%	5.6%	3.5%

These savings are amongst the highest made in NHS Wales and reflect the good progress made in mitigating financial risks faced by the UHB. Notwithstanding delivery of these savings, the UHB has struggled to deliver its statutory break even duty. Over the same time period, the UHB:

- Managed to break even in 2012/13 but only through £26.2m of non-recurrent financial support provided by Welsh Government;
- Had a £19.2m deficit in 2013/14; and
- Is forecasting a £22.8m deficit in 2014/15.

In considering this, it should be noted that the UHB compares well on provider efficiency against other Welsh LHBs and has the **lowest spend per head of resident population in NHS Wales**.

Looking ahead, the scale of the financial challenge is also significant as demonstrated in the following table.

Summary of Financial Challenge 2015/16 to 2017/18

	Annual Plan 2015/16 £m	Annual Plan 2016/17 £m	Annual Plan 2017/18 £m
Underlying position b/f	(22.0)	5.1	(0.9)
Allocation Uplift	17.6	12.7	13.0
Net Cost Pressures	(20.8)	(29.2)	(21.6)
Investments / Contingency	(16.9)	(12.3)	(11.3)
Savings requirement	(42.0)	(23.8)	(20.8)
	5.1%	2.9%	2.5%

This shows that after the UHBs share of the additional allocation in 2015/16, the UHB is still bringing forward a significant underlying deficit into 2015/16. This, together with the results of previous years and benchmarking indicators, points to the UHB having a structural financial problem that it is finding difficult to overcome. This is supported by the recent update to the Townsend direct needs formula which indicates that the current UHB Discretionary allocation is 8% lower than the updated Townsend formula share, which is based on recently updated datasets. The UHB's three year Integrated Medium Term plan therefore, needs to be considered in this context.

7.2 Overview of the Financial Plan

The Financial Plan sets out the financial strategy of the UHB which supports delivery of the service strategy outlined in the Integrated Medium Term Plan. The context for the UHB will be a very challenging three years.

After the additional allocation is made recurrent in 2015/16, the UHB is anticipating a 2% uplift in its revenue allocation in 2016/17 and 2017/18. This means that the UHB has to make savings to mitigate against the pressures of an underlying deficit, and cost pressures and service change investments above allocation increase levels.

Over the three years starting in 2015/16 the UHB is aiming to make a further £78m of financial savings which is equivalent to 9.5% of relevant expenditure. Taken together with the amount made in the last three years would equate to a £189m over a six year period with an average saving of over £31.5 per year. Despite this ambitious savings plan, the UHB does not however, currently have a Financial Plan that manages to deliver a breakeven position over 2015/16 to 2017/18. This will be subject to further consideration at Board level and the options to secure financial sustainability will need to be discussed with Welsh Government.

The Financial Plan will:

- Deliver significant levels of savings through improving provider efficiency, prudent healthcare and whole system changes;
- Support service transformation to achieve more effective and higher quality delivery of services closer to home;
- Continue to redesign services that are closer to home and make further progress in shifting resources from secondary care into primary care and community recognising that specialised commissioning is also a future area of likely growth;
- Support the planned improvements set out against the key Tier 1 priorities;
- With confirmation of capital funding from Welsh Government, enable service improvements contained in the plan, and make a start on reducing the significant level of capital infrastructure backlog around estate, medical equipment and information management and technology; and
- Further develop an internal financial flows framework which supports appropriate management of demand.

This plan is dependent on the following key assumptions:

- The UHB will not be required to repay its forecast 2014/15 year end deficit;
- The UHB will be successful in securing its provider share of the £200m additional allocation made recurrent in 2015/16 (this is £4.3m);
- The financial risks in the changes in the allocation and reimbursement of costs for Post Graduate Medical and Dental Education are mitigated or are made cost neutral (this is a £1.1m risk);
- A further £42m discretionary capital funding will be made available to assist the delivery of key priorities;
- Funding for VERS to be made available in 2015/16 via Invest to Save from Welsh Government (which is consistent with previous years);
- No loss of income from the SIFT review recently completed by Welsh Government. This approach has previously been confirmed by Welsh Government; and
- The commissioning approach from WHSSC does not further destabilise the UHB. There is particular concern about the approach WHSSC continues to take on the commissioning of specialist services and the financial and service pressures that this places on the UHB.

7.3 Underlying Deficit

The UHB entered 2013/14 with a significant underlying deficit and agreed a planned position with Welsh Government which was a deficit of £16.3m. Due to slippage on achievement of savings, the forecast deficit increased to £19.2m at the year end.

The plan developed by the UHB in 2014/15 aimed to address this underlying financial deficit and bring the UHB back into financial balance over the period of the three year plan. This plan was supported by Welsh Government and in its first year, in line with the approach taken elsewhere, additional funding was provided in line with the plan. The UHB is however forecasting a deficit of some £22.8m above this plan in 2014/15. The main causes for this are shortfalls in the delivery of savings schemes of £14.3m and net operational pressures of £8.5m.

The underlying deficit carried forward into 2015/16 is £4.4m and this is shown in the following table.

2015/16 Underlying Deficit

	Annual Plan 2015/16
	£m
Forecast deficit 2014/15	(22.8)
Non recurrent adjustments	0.8
Commissioner Allocation Uplift	13.3
Net Provider share of Allocation Uplift	4.3
Net Underlying Deficit	(4.4)
	0.5%

A key assumption in the underlying deficit is that the UHB will be able to secure its net provider share of the additional £200m allocation made available across NHS Wales. This additional resource was issued to support financial sustainability across the NHS and as a net provider, the UHB will be seeking an equivalent % uplift to its provider LTAs, acknowledging that it also will need to increase its commissioner LTA on the same basis. The overall increase was circa 4.4% which represents a net inflow of funds of £4.3m. It is recognised that this will not be widely welcomed by other NHS organisations and the support of Welsh Government might therefore be required.

7.4 Resource Planning Assumptions

The UHB has used detailed bottom up information in order to assess its inflationary and demand pressures for 2015/16 and this has been tested and validated. The UHB has used the All Wales National Cost Assessment to help inform and validate its local assessment of cost pressures and to inform the expected cost pressures in 2016/17 and 2017/18.

The following table shows the new income and expenditure pressures used within the financial plan.

Assessed Cost Pressures

	2015/16 Cost £'000	2016/17 Cost £'000	2017/18 Cost £'000
Cost Growth			
Pay Inflation	4,623	2,350	2,350
Incremental Drift	1,587	1,300	1,200
Pensions Costs	1,000	7,600	2,300
Non pay Inflation	1,014	2,200	2,200
Statutory Compliance and National Policy	265	1,000	1,000
Continuing Health Care	400	400	400
Funded Nursing Care	300	75	75
Total Cost Growth	9,189	14,925	9,525
Demand / Service Growth			
NICE and New High Cost Drugs	2,805	5,950	3,000
Continuing Health Care	4,385	2,244	2,000
Funded Nursing Care	350	225	225
Prescribing & Community Pharmacy	1,107	1,700	2,600
Specialist Services	1,043	1,400	1,400
Local cost pressures	4,661	2,500	2,500
Demographics / Demand on acute services	7,554	3,900	3,900
Total Demand / Service Growth	21,905	17,919	15,625
Other Cost Pressures			
Welsh Risk Pool	1,100	700	700
Income reductions	1,800	1,000	1,000
Transformation & Service Improvements	5,286	4,000	3,000
Contingency	3,000	3,000	3,000
Total Other Cost Pressures	11,186	8,700	7,700
Total Inflationary and Cost Pressures	42,280	41,544	32,850

These pressures, together with an assessment of the underlying deficits have been scrutinised and tested with all primary budget holders. This has resulted in an improvement in the UHB's forecast deficit.

The UHB is however, having to take a number of remedial actions in order to mitigate against cost pressures in 2015/16. These actions include:

- Prioritising and managing expenditure on new NICE drugs. There are a number of new exceptionally high cost NICE drugs that will be available in 2015/16. It will be difficult to fully implement these given the UHB challenging financial position and the knock on effect that this would have to the provision of other services. The UHB is therefore planning for a staged implementation and would welcome an all Wales approach to the management of this;
- The UHB also faces significant pressures in other areas of medicines and is taking cost avoidance measures in order to mitigate against these financial risks. This includes exploring alternative delivery methods and drug therapies;
- The UHB has identified the management of 'Delayed Transfers of Care' as a key improvement area. It is planning to coordinate and centralise the management of these patients and over the first six months of the year release the equivalent of two wards of capacity. This released resource of circa £1.5m will then be used to support the delivery of other Tier 1 priorities; and
- The new year costs of delivering the UHB's Referral to Treat (RTT) plans is significant and currently stands at £5.3m to deliver and maintain 0 >52 week waits. Whilst this assessed cost is currently being validated, the UHB will target a further 0.5% savings above previous levels in order to identify a source of funding for this additional cost. The delivery of this comes with some considerable risk.

The UHBs financial plan also assumes the following:

- No net adverse financial impact as a result of the decision around the South Wales Programme;
- WHSCC rebasing is cost neutral to the UHB as both a provider and commissioner and delivers its aim of ensuring that income for each service matches cost so that more effective cost benchmarking can be undertaken;
- WHSCC risk shares are only changed if they are done on a cost neutral basis;
- There is a 2% inflationary uplift to allocations in 2016/17 and 2017/18; and
- Any further allocations received from the £80m monies set aside at the WG will be fully expended on the relevant improvements and development areas set out in the plan.

7.5 Savings Programme

In order to mitigate against the UHB's underlying deficit and new cost pressures the UHB will again need to find significant savings. These savings plans total 9.5% across the three years of the plan. Given the achievements made in recent years, this is the most that at the UHB thinks is now deliverable. Savings opportunities have been scoped through a range of benchmarking exercises and experience of what has been deliverable in previous years.

To date, these have been predominantly provider based and for 2015/16 the plans will continue to focus on improving provider efficiency both within and across Clinical Boards and Corporate Departments. Savings opportunities have however been identified in other areas, such as prudent healthcare and pathway redesign, as areas of traditional transactional efficiency are becoming exhausted. A summary of savings opportunity by theme is shown in the following table.

Savings Opportunity by Theme

Savings Scheme	2015/16 £m	2016/17 £m	2017/18 £m	Total £m
General efficiencies	6.1	5.0	5.0	16.1
Prudent Healthcare / pathways / integration	5.0	5.0	5.0	15.0
Better procurement	4.0	4.0	4.0	12.0
Income generation	1.0	1.0	1.5	3.5
Manage impact of incremental drift	1.6	1.3	1.2	4.1
Better primary care prescribing	2.0	1.2	1.2	4.4
Upstream management of patients	2.0	1.0	1.0	4.0
Benefits of technology	0.5	2.0	2.0	4.5
Nursing productivity	1.0	0.0	0.0	1.0
Better secondary care prescribing	1.6	1.2	1.0	3.8
Medical productivity	1.0	0.5	0.5	2.0
Theatres efficiency	1.0	0.0	0.0	1.0
Booking and scheduling, admin, outpatients	1.0	1.0	1.0	3.0
Energy & Estate rationalisation	1.0	0.6	0.6	2.2
Executive Directorates	0.0	0.5	0.5	1.0
Lose costs of decommissioned activity	0.0	0.4	0.2	0.6
Total	28.8	24.7	24.7	78.2
% Savings of relevant budgets	3.5%	3.0%	3.0%	9.5%

The approach taken in the UHB's Financial Framework for 2015/16 is for Clinical Boards and other budget holders to be tasked with managing their underlying deficit and relevant new year cost pressures. In order to achieve this budget holders have had to:

- Review 2014/15 savings plans to see if any of the schemes that slipped could be taken forward in 2015/16;
- Critically review the major operating pressure that arose in 2014/15 and identify mitigating actions; and
- Assess the savings opportunities to see what can supplement the above.

Work continues within Clinical Boards and Corporate Departments to identify savings opportunities in order to deliver the challenge set. Reasonable progress has been made in respect of this especially in the identification of the initial 3% savings target. The stretched target of an additional 0.5% to support RTT delivery does however come with some considerable risk and further work through the first quarter of the year will be required to identify the means to support this.

The next steps to strengthen delivery will entail a programme-managed approach to:

- Apply downward pressure on expenditure including new investments to support delivery of the plan;
- Drive hard on UHB cross cutting savings themes and to exploit the prudent healthcare opportunities available; and
- Continue to identify service areas that would significantly benefit from redesign and transformation.

The UHB is also putting in place mechanisms and capacity to support the delivery of this. The work programme to realise the savings opportunities is being led by the Chief Operating Officer, supported by the Finance Director. A formal programme management structure has been put in place to support this with work stream leads. This will monitor the planning and delivery of service transformation and savings schemes delivery. Project management resource and supporting finance and analytical resource has been identified for each major work stream.

7.6 Income and Expenditure

The UHB recognises that it is somewhat adrift from delivery of its previous three year plan. In addition, the financial environment, opportunities and challenges have moved on considerably in the last twelve months. This has necessitated the recasting of its three year financial plan from 2015/16. Applying its financial framework and financial assumptions already set out in this financial plan provides the UHB with a projected income and expenditure forecasts over the period of the plan. This is shown in the following table.

Income and Expenditure 2014/15 to 2017/18

	Forecast Outturn 2014/15	Annual Plan 2015/16	Annual Plan 2016/17	Annual Plan 2017/18
Income	£m	£m	£m	£m
Revenue Resource Limit	792.0	798.9	816.2	830.5
WHSSC income	180.2	193.3	193.3	193.3
Income from other Welsh NHS bodies	82.5	84.9	83.9	82.9
Other income	104.1	104.0	105.0	105.0
Non cash limited income	22.0	22.0	22.0	22.0
Total Income	1,180.8	1,203.1	1,220.5	1,233.7
Expenditure				
Pay	515.5	526.6	532.8	536.4
Primary Care Contractor	117.0	122.6	124.7	126.9
Prescribing	74.6	73.7	74.2	75.3
Healthcare Services Provided by Other Welsh NHS bodies	166.4	173.5	174.9	176.3
Continuing Care and Funded Nursing Care	47.9	51.3	53.3	53.0
Other	282.3	268.7	272.8	274.2
Total Expenditure	1,203.6	1,216.4	1,232.7	1,242.1
Forecast Surplus/(Deficit)	(22.8)	(13.2)	(12.3)	(8.4)

Whilst the UHB is committed to achieving in year and recurrent financial balance as soon as possible, it does not believe however, given the level of savings previously made and the scale of financial opportunity still available, that it is possible to deliver savings in excess of those included in the plan, without adversely impacting service delivery. The achievement of 3.5% in 2015/16 will prove to be a significant challenge and this stretched target presents the UHB with a significant risk to manage and will take rigorous and concerted management attention to deliver. The 2015/16 savings plans are some 1.6% (£13.2m) short of the amount required to achieve in year financial balance and this has a recurrent knock on effect in 2016/17 and 2017/18.

This table therefore shows the UHB is currently forecast it will have a deficit of circa £13.2m in the first year of the plan and this reduces to a £8.4m deficit in year 3. The delivery of this however does not come without some considerable risk as the UHB plan requires further savings of £78m over the period of the plan. The delivery of the statutory break even duty is at considerable risk and will be subject to further consideration at Board level. Further discussions with Welsh Government will be required to explore the options available to mitigate this risk to deliver financially sustainable services.

7.7 Shifting Funding from Acute to Primary/Community Care

The UHB continues with its ambition to move services and funding from hospital services to community and primary care with the aim of providing safe and sustainable services closer to home. A major theme of the three year plan is a focus on community and primary care. The UHB has set out its plans to develop and enhance community and primary care services should investment funding become available in 2015/16 and beyond and these are set out in section 6.2. It is envisaged that investment in 2015/16 will drive further transformational changes in 2016/17. The UHB intends to focus greater attention and capacity into this area to ensure that this is achieved.

7.8 Capital Expenditure

The UHB has confirmed capital funding of £24.681m for All Wales Capital Schemes and £9.914m for discretionary capital schemes. The details of this are shown below.

2015-16 Approved All Wales Schemes			
Priority	Scheme	2015-16 £m	2015-16 £m
	Adult Acute	20.333	
	CHfW	3.429	
	Rookwood essential maintenance	0.110	
	JAG Accreditation	0.809	
	Neurovascular Intervention Room	0.979	
			24.681
TOTAL EXPENDITURE			24.681

2015-16 Draft Discretionary Capital Programme			
Category	Scheme	2015-16 £m	2015-16 £m
Funding	WG Annual Funding		9.914
	Total Funding		9.914
Expenditure	Annual Commitments:		
	UHB Capitalisation of Salaries	0.440	
	UHB Director of Planning Staff	0.165	
	UHB Revenue to Capital	0.215	
	UHB Accommodation Strategy:	0.200	
	UHB Misc / Feasibility Fees	0.100	
			1.120
	Schemes commenced in 2014-15:		
	PACU	0.100	
	Lift Lobby lighting (UHW)	0.092	
	Isolation Rooms	0.316	
	UHW Ward Bathroom replacements	0.500	
	BMT Database	0.300	
	Ward Moves	0.250	
	Blast Freezers	0.034	
	Rationale Ovens	0.024	
	Decontamination UHL	0.057	
	Cardiac Equipment	0.561	
	Automated ward drug storage	0.030	
	Relocate long cross house to CRI	0.150	
			2.414
	Statutory Compliance:		
	Dedicated Team	0.200	
	Asbestos / Legionella	0.250	
	UHB Plant Replacement / Surveys	2.350	
			2.800
	Other Schemes:		
	Ronald McDonald House charity (parent accom prev commitment)	0.650	
	Backlog IM&T	0.356	
	Backlog Med Eqpt	1.000	
	Backlog Estates	1.000	
	Theatre refurbishment programme	0.500	
	Contingency (Balancing Figure)	0.075	
			3.581
	Total Expenditure		9.914

Upon request from the Welsh Government, the UHB has completed a ten year capital plan and submitted it for comment and consideration in June 2014. During 2014 the UHB undertook a comprehensive assessment of the

state of the estate and equipment as part of the WG's All Wales review of capital. The UHB review identified that a significant level of funding would be needed to bring our estate and equipment to the functional level needed to provide modern sustainable services. The annual discretionary capital allocation will only cover the highest priorities identified in the 10-year capital plan. The UHB will therefore be seeking additional discretionary funding from WG to support the key risks identified in the capital review and other capital priorities. A prioritised list of capital requirements includes:

- Essential statutory estates compliance;
- Essential IM&T investment;
- Critical equipment replacement;
- Urgent SWP requirements to provide the capacity to accommodate increased activity that will flow into the UHB; and
- Urgent changes to support service development and delivery of the IMTP.

The UHB has identified an additional £41.739m funding requirement on top of confirmed discretionary funding. The UHB has experienced numerous difficulties and incidents relating to the age and condition of its estate in the last three months of the year which had an impact on operational delivery. A large proportion of this additional funding is required to sustain the UHB's estate and equipment which is now ageing and requires modernising and replacement. Full details of additional capital funding requirements are set out in the following programme. Further discussions are needed with Welsh Government to confirm any additional funding that may be available and therefore this programme is provisional at this stage.

2015-16 Capital Requirement (In addition to Disc Capital Programme)				
Priority	Scheme	2015-16 £m	2015-16 £m	Key Benefits
1	Statutory Compliance:			
	Remedial Works identified following surveys	1.000		- undertake essential equipment repairs to the estate to meet statutory requirements
	Theatres Estate Infrastructure	5.000		- replacement of equipment which is 25 years old and is functionally substandard - will bring existing theatre infrastructure more in line with current HTM requirements - improve continuity of service (current remedial measures are a temporary solution and cannot be guaranteed)
	Bone Marrow Transplant redevelopment business case	0.500		- JACIE accreditation achieved - increased capacity - safe accommodation to HBN standards reducing clinical risk - increased accommodation will result in reduction of current waiting times - improved staff recruitment and retention - increase in stem cell transplantation procedures generate considerable income gains
			6.500	
2	Critical Service Continuity:			
	Rookwood Business Case	0.750		- patients treated in high quality purpose designed accommodation - improved outcomes for patients as new service models are fully implemented and access to services improved - co-located services optimising clinical adjacencies and supporting service models - rapid access to clinical support services to aid timeliness of diagnosis and decision making - harnessing technology to improve clinical service delivery
	Backlog IM&T	1.400		- increase in planned replacement programme of IM&T equipment, erver and back-up infrastructure as recommended by the Wales Audit Office - improved robustness of IM&T infrastructure to reduce risk of system failure and loss of data - improved network connectivity, including security, speed, mobile technologies - faster and more reliable access to clinical and business systems
	Backlog Med Eqpt	2.500		- increase in planned replacement of highest priority medical equipment to support the delivery of modern, safe, sustainable, efficient and effective services - improved risk relating to potential serious failure of equipment and consequent increase in waiting times for patients - optimised health outcomes, improved patient experience, patient safety, service quality, service continuity - ability to implement new and innovative technologies which would improve clinical benefits, patient outcomes and provide better value for money - allow standardisation as equipment is replaced enabling a longer term strategic view to be taken for the management of medical equipment - reduction in maintenance costs
	Backlog Estates	2.000		- increase in planned maintenance and modernisation of the UHB's estate and extend operational life of our building assets - improved reliability of mechanical and electrical installations, maintenance costs and consequent continuity of services - improved energy efficiency - improved functionality of clinical facilities - prevention of further deterioration of the estate - compliance with HBN, fire, health and safety, DDA and Health Inspectorate Wales standards
	MRI	4.360		- replacement of equipment which is 13 years old and has a recommended asset life of 7 years. The current equipment and software will shortly be declared obsolete and will no longer be maintained or supported by the current supplier - replacement of the scanners will reduce the risk of a catastrophic breakdown and loss of service - faster scanning and set up times of modern equipment will increase throughput and reduce waiting times for patients - reduced waste/lost activity due to equipment failure and last minute cancellations - improved diagnostic accuracy due to reduced scan times, improved clinical imaging sequences and new diagnostic features - availability of high fidelity and high sensitive imaging to support highly specialist services provided as part of the All Wales Network - improvement of patient experience, quality of care and reduction in exposure to radiation
	Helipad replacement for night flying	2.000		
	Health Centres community premises	0.250		- upgrading and refurbishment of health centre/community care premises to modern healthcare standards - care delivered in fit for purpose accommodation supporting the delivery of modern health care - improved environment for patients, especially privacy and dignity - compliance with HBN, fire, health and safety, DDA and Health Inspectorate Wales standards - anticipated reduction in maintenance costs and improved energy efficiency
			13.260	

Priority	Scheme	2015-16 £m	2015-16 £m	Key Benefits
3	Support Tier 1 Delivery:			
	Theatres Transformation	1.730		<ul style="list-style-type: none"> - improved theatre efficiency - theatre utilisation optimised at 85% - reduction in waiting times due to better utilisation of capacity - reduction in cost due to improved LoS and fewer cancellations - risk of hospital acquired infection reduced - improved flexible working and job satisfaction for staff - speedier recovery is promoted - improved patient outcomes - vastly improved patient experience
			1.730	
5	Strategic Imperative:			
	Critical Care Expansion Phase II	0.093		<ul style="list-style-type: none"> - expansion of post operative anaesthetic critical care unit (PACU) for high risk elective surgical patients - potential revenue savings resulting from a reduced requirement to 'special' post surgical patients on general wards - reduced DTOCs for elective surgical patients on critical care, improved patient flow - improved theatre utilisation, reduction in cancelled operations due to lack of critical care bed - beds released from the main CCU will provide additional resilience to support increasing emergency pressures - improved outcomes for patients booked for critical care, early identification and management of complications - improved RTT compliance, shorter waiting times for patients - improved performance against 31 and 62 day cancer standards
	Critical Care Expansion Phase III	0.156		<ul style="list-style-type: none"> - further expansion of critical care capacity to meet increasing demand for both unplanned and planned critical care - ability to deal with increasing trend to implement network approaches to care for e.g. vascular, cardiac, upper GI - ability to respond to increasing demand arising from 'winter pressures' - critically ill patients cared for by specialist staff on the critical care unit, rather than on general/recovery wards, timely admissions from the emergency unit and/or wards - cohorted area provided for long term weaning of ventilated patients - supported transfer of patients from cardiac ITU who will require on-going general critical care management - reduction in patients requiring readmission - implementation of a data information system to support more accurate and precise clinical monitoring of critically ill patients, improving patient management particularly in terms of quality, safety, reduction in harm. Efficiencies will include increased staff time for direct patient care, cost effective drug prescribing, reduction in paper records
	Robotic Theatre	2.400		<ul style="list-style-type: none"> - will allow for future expansion of robotic surgery to undertake procedures in urology, colorectal, head and neck and gastrointestinal and rectal surgery - will allow for other Welsh HBs to utilise facilities providing a partial realisation of a Welsh Robotic Surgery Centre - maximises beneficial use in terms of patient outcome and economically - will support efficient use of bed capacity through day of surgery admission, reduced length of stay and early discharge - creates additional theatre space through relocation of non theatre activity to outpatient settings to meet increasing surgical demand - provides a flagship facility for training purposes
			2.649	
6	Patient Acceptability / Environment:			
	Cardiology OPD	1.000		<ul style="list-style-type: none"> - delivery of modern purpose designed facilities to consolidate services to enable one stop shop pathways - efficient use of resources through appropriate appropriately configured and flexible facilities - will enable an increased scope of service delivery to provide an anaesthetic suite and recovery area supporting the delivery of tier 1 targets to support reductions in cardiac surgery treatment times - appropriately configured clinical areas that take account of clinical adjacencies will support the mitigation of clinical risk - promotion of patient privacy and dignity
			1.000	
8	Functional suitability and Modernisation:			
	UHW Main Building Refurbishment (business case preparation)	0.100		<ul style="list-style-type: none"> - major refurbishment and upgrading of the infrastructure and building fabric to the clinical areas at UHW - will support the delivery of improved models of care and reduce clinical risk - improved clinical areas which meet current standards in terms of space, layout and health and safety - revised bed configurations to enable improved bed flexibility and management based on clinical need and demand - improved patient environment, privacy and dignity - improved efficiency and effectiveness of the infrastructure - reduced leaks through roof and pipework, reduced risk from legionella and other preventable infections, reduced maintenance costs, reduced energy consumption
			0.100	
Sub-Total Expenditure (excluding South Wales programme & Renal)			25.239	

Important points to note are:

- The UHB received £10.5m cash assistance in 2014/15 which is repayable;
- The UHB's balance sheet is weak which will mean cash management will be difficult towards the end of each financial year of the plan; and
- Cash assistance will therefore be required in each of the three years of this Financial Plan. This will be equivalent to the forecast annual deficit.

7.10 Financial Risks

The UHB is facing a number of financial risks in the delivery of its Integrated Medium Term Plan. The key risks for are set out below:

Balancing the Financial Plan

The Financial Plan is currently out of balance by circa £13.2m in year 1 falling to £8.4m by year 3. The management of this will require further Board level and Welsh Government consideration. Further discussions with Welsh Government will be required to explore the options available to mitigate this risk to deliver financially sustainable services.

Funding assumptions

The UHB has assumed that it will be funding for its net provider share of the additional £200m allocation which was made available across NHS Wales. The plan for 2015/16 is assuming that this increase of circa 4.4% will be applied to LTAs representing a net inflow of funds of £4.3m. It is recognised that this will not be widely welcomed by other NHS organisations and therefore Welsh Government support for this may be required.

The UHB is also assuming growth of 2% per annum on its Health Board revenue allocation for 2016/17 and 2017/18. This is consistent with Welsh Government guidance. The UHB has also modelled two different scenarios:

- 0% uplift over this two year period; and
- 2% allocation increase plus funding to cover the costs of ending of the Employers contracted out 3.4% rebate for salary related pension schemes.

This modelling is shown in the following table which shows that the financial position would significantly deteriorate if it had flat cash for 2016/17 and 2017/18. Conversely if the position would improve significantly if it had funding for pension cost increases in 2016/17 to a point where recurrent balance would just about be restored by 2017/18.

Funding Assumptions for 2016/17 and 2017/18

	Annual Plan 2015/16	Annual Plan 2016/17	Annual Plan 2017/18
	£m	£m	£m
Current assumptions at 2% growth	(13.2)	(12.3)	(8.4)
Flat Cash - 0% uplift	(13.2)	(25.0)	(34.1)
2% growth plus pensions costs funded in 16/17	(13.2)	(4.7)	(0.8)

The level of actual growth funding is therefore a critical risk and opportunity in the delivery of this IMTP.

Achievement of savings targets

The forecast out-turn position planned for the period of this plan is only deliverable based on achievement of the UHB's savings targets. This will require both acceptance and buy in from the areas concerned and the Board's continued commitment to monitor and identify further savings to replace any slippage. Given the scale of the savings required, and the context that savings delivery gets harder year on year, this is the key financial

risk in delivering the plan. The current plans have been recently been stretched by 0.5% for 2015/16 and the delivery of this is at considerable risk and will be a focus of considerable attention.

Inflationary and cost pressure assumptions

The list of inflationary assumptions is built into section 7.4 of this document. There is a risk that any of these inflationary estimates may end higher than initially predicted. CHC, prescribing and NICE are areas of particular risk based on historic trends. In addition, growth on medicines also takes account of cost avoidance plans that the UHB is developing to mitigate against the significant costs pressures in this area. The delivery of these cost avoidance plans places greater risks in managing within the assessed cost growth levels.

VERS

An enabler to help deliver this plan is securing further VERs funding from the Welsh Government Invest to Save scheme. The UHB has applied for £2.6m funding and this is assumed within the plan. The Health Board has been successful in securing this funding in the past and it is assuming that this will continue.

SIFT

The Health Board currently receives £26.3m of Infrastructure SIFT funding which is considered core funding. There is a risk that this income could be subject to re-distribution, forcing the Health Board to recover any re-distributed income as additional savings. However, Welsh Government has previously confirmed that the planning assumption should be that there will be no impact over the period of this plan.

Post Graduate Medical and Dental Education (PGDME)

Notice has already been given that changes will be made to the funding arrangements of PGMDE. Whilst the UHB currently assesses that that in total the funding received broadly equates to costs, the key risk for the UHB is changes to the funding of rotational costs (for which the UHB is overfunded), without corresponding changes to the basic salary costs for which the UHB is underfunded. A one sided adjustment poses a £1.1m income risk for which the UHB. The application of the surplus generated by this change has yet not been determined. The UHB will make representation to the Welsh Government to mitigate against this income risk so that resource neutrality is maintained.

WHSSC risk

It will be important that there is early alignment on commissioning and financial plans between the UHB and WHSSC. Any demand management schemes need to be realistic and that the level of savings required from specialised services as a provider is acknowledged by commissioners and not double counted as a commissioner saving. Provider savings will need to be retained to offset unfunded cost pressures. There are concerns that the approach WHSSC continues to take on the commissioning of services will adversely impact upon the financial sustainability of the UHB. The UHB and WHSSC have started the process of sharing commissioning and provider intentions for 2015/16 and will need to agree a timescale to achieve a signed LTA and it is crucial that there is early resolution of unaligned assumptions. The UHB and WHSSC are working towards rebasing income to match costs and it is assumed that this will be cost neutral. There is a real risk that this will not be the case. In addition, work is being progressed by WHSSC to realign the risk sharing agreement. The UHB has again assumed that this will be cost neutral.

Capital

The delivery of the Integrated Medium Term Plan is partly dependent upon confirmation of capital funding where Capital is an enabler of service sustainability, improvement and transformational change. The UHB has identified a requirement for a further £42m capital funding in 2015/16.

Inter LHB transactions

The UHB has a significant number of inter UHB transactions for which WHSSC is the most significant. The key risks for 2015/16 are that the case-mix of patients across all LTAs continues to become more complex without agreement to changes in the financial tariff

South Wales Plan

Despite best endeavours, there is a possibility that whole services could transfer in an unplanned way that could present capacity, service and financial pressures outside of an agreed process or mechanism. The UHB is being proactive to try to avoid this and is working with partner organisations to ensure that this risk is minimised.

Summary

As highlighted in this section of the plan, there are a number of financial risks that could impact upon the successful delivery of this plan. The Health Board recognises this and is taking mitigating actions in order to ensure that these risks are appropriately managed. To help manage this risk the UHB has also set aside a contingency reserve in each year of the plan, albeit this is set only at a modest level.

8. Governing the UHB

8.1 Strategic Direction

In Chapter 3 we set out clearly the 5 – 10 year strategy we are developing for the UHB, which is based on our vision for improving the health divide that persists in our communities, the drive for excellence in the way we deliver our services and the need to establish a new approach to partnership with the people who use our services.

The Board has shaped the emerging strategy – agreeing a clear set of design principles on which the strategy would be based (home first, empower the person, outcomes that matter to people and reducing harm, waste and variation).

The Board has also set clear expectations for engaging local communities and patients in shaping services for the future, as described in more detail in Chapter 9. A wider range of stakeholders, including the public are involved in the development of our strategy, and we are establishing process for strengthening engagement on an on-going basis.

Delivery of our strategy requires two things:

- Clear delivery plans (as set out in this IMTP, with a process for knowing where we are again the outcomes we have agreed, and for taking action where things are not on track.
- Developing the culture of the organisation, so that innovation can thrive (recognising that typically only 13% of a workforce exhibits can do behaviours), and people have the skills to make improvements happen at all levels of the organisation.

8.2 Integrated Planning System

A planning system has been established (which is still evolving) to ensure that over the course of the year, all the key milestones are achieved for the development and delivery of our IMTP. This builds on the process put in place last year and recognises that planning is an on-going cycle, with the production of a plan being an annual exercise.

In July 2014 the Board agreed the timetable and key milestone for the production of the 2015/16 plan. Whilst there have been some minor amendments to this timetable, the key milestones were as follows:

- September 2014 – Commissioning intentions were developed setting out the key priorities for securing improvements in the health our population and in the services we provide;
- November 2014 – first draft Plans submitted by Clinical Boards and Corporate Departments;
- December 2014 – Board Development session focuses on priorities for 2015/16 and reflecting on 2014/15;
- January 2015 – Board considers UHB draft IMTP prior to submission to the Welsh Government by 31 January 2015;
- End of January 2015 – Clinical Boards and Corporate Departments submit final plans;
- Jan – March 2015 – Plan scrutiny and refinement; and
- March 2015 – Final IMTP approved by the Board prior to submission to the Welsh Government by 31 March 2015.

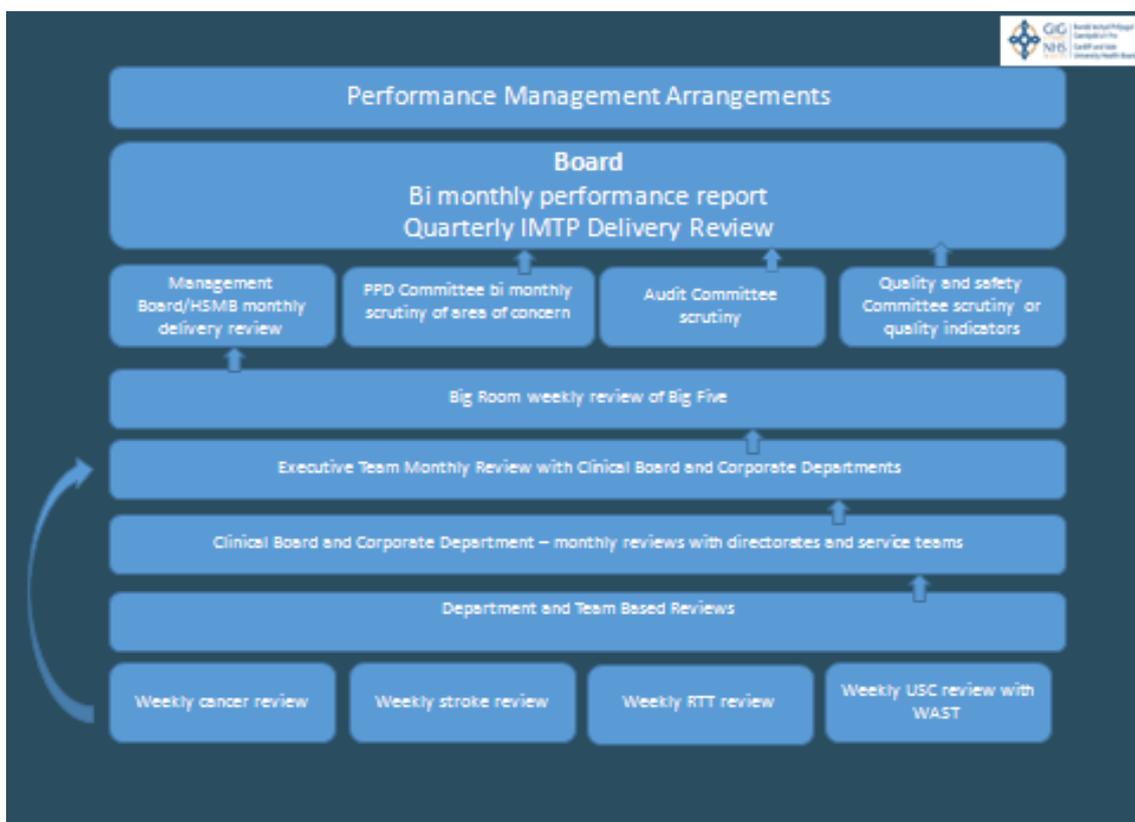
Throughout the process, both the Local Partnership Forum and the Stakeholder Reference Group have been engaged in shaping the key priorities in response to the challenges we are facing and the difficult choices we need to make.

8.3 Governing Delivery

In addition to the programme management approach described in Chapter 9 which is designed to ensure that we are able to deliver the service transformation programme through a number of cross cutting themes as set out in our Strategy, we have strengthened our performance management arrangements.

During 2014/15, a revised performance management framework was agreed by the Board that set out the arrangements for providing assurance about delivery from Board right down through the organisation to individual annual performance reviews. Following a mid-year review, new arrangement were introduced in October, led by the Chief Executive, to provide a sharper focus on a weekly basis on our five key priorities.

Reflecting on our experience of the Big Room, and challenges we faced during 2015, we are refreshing the performance framework and developing a more sophisticated performance dashboards for key areas of delivery, linked to a balanced score-card that will track deliver of our strategy (see Chapter 9). The regular pattern of scrutiny and assurance discussions is set out in the table below. This process includes the development of contingency plans where there is a risk of failure to deliver as per the plan.



8.4 Equality Duty

We are strengthening our approach to assessing any equality impact (as described in legislation) of any of the changes set out in our IMTP. At clinical board level, equality impact assessments are undertaken for key service changes or significant policy changes to ensure that we can understand and where possible mitigate impact on the groups defined in the equalities legislation. An internal audit report of our processes in 2014/15 identified where good practice was being established and the areas where we needed to make more progress. Once finalised, an EQIA will be undertaken on the whole of the IMTP.

The EQIA process is also referenced in the engagement flow chart and process we have developed with our Community Health Council [further information Chapter 9].

The actions being taken forward during 2015/16 in relation to the Welsh Language Act are set out in Chapter 10 - Organisational Development.

8.5 Corporate Governance

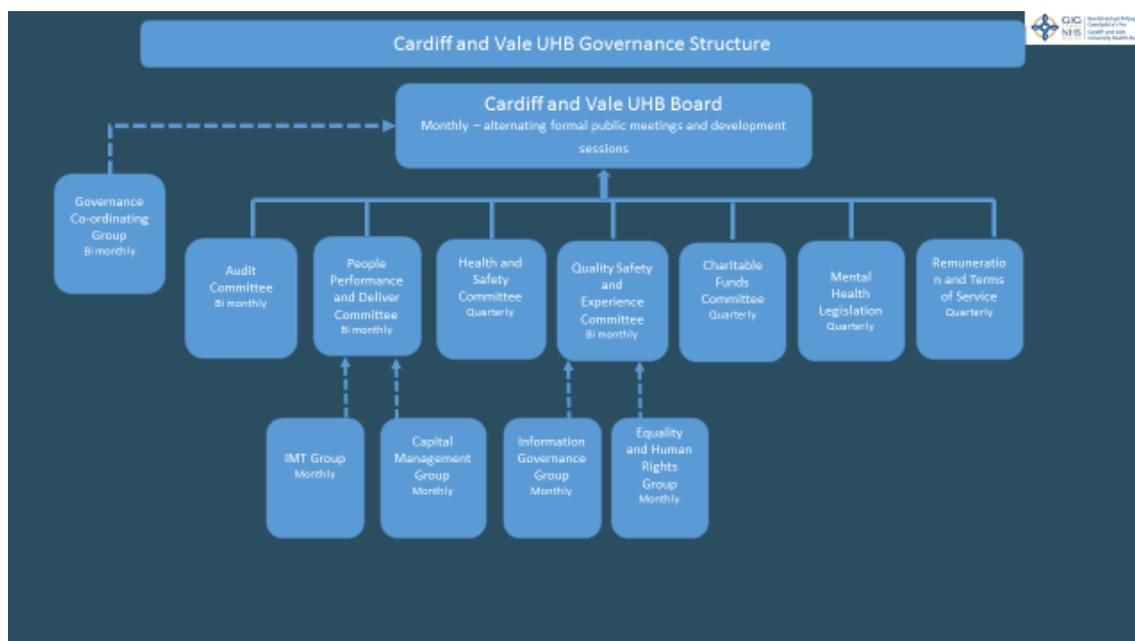
Our governance and assurance arrangements are maturing and are reviewed annually as part of the Wales Audit Offices Annual Structured Assessment. Last year's assessment confirmed that there were sound governance arrangements in place overall and also highlighted where further improvements could be made – which have been reflected in strengthened programme and performance management arrangements, and the working arrangements of the committees.

Each Committee is chaired by an Independent Member of the Board, and has an annual work programme agreed through the Governance Co-ordinating Group (chaired by the UHB chair) which is aligned to the annual business cycle of the Board. At each meeting the Committee will consider matters for more detailed scrutiny referred from the Board, and will flag up issues to be referred to the Board for consideration. A number of other Independent Members form the membership of the Board, with lead Executive Directors in attendance.

There are a number of groups operating below the Board Committees which report into the Committees on a regular basis, but which may also report into the Management Executive. For example, the Capital Management Group is currently chaired by the Chief Executive because of the level of risk associated with the estate, is attended by the Independent Member with an interest in capital, and reports on a regular basis into the People, Performance and Delivery (PPD) Committee.

Clinical Boards are asked to present regularly to Board Committees either on a particular topic of interest, or through the Chief Operating Officer, account for an area of performance under scrutiny.

The Board Committee Structure is detailed below.



The system of internal control is supported by annual internal audit programme agreed with our Internal Auditors, and which reflects the risks identified in the Corporate Risk Register. The work programme will reflect the risks identified through the development of the IMTP and the ongoing risk assessment processes.

The annual clinical audit programme also supports our system of internal control, and is agreed annually by the Quality and Safety Committee, with key audit outcomes being reported to the Committee. In addition to our own internal clinical audit programme, we participate in a number of national peer audits, the outcome of

which is used to inform where we need to make improvements. For example, the national paediatric diabetes audit highlighted a number of issues to be addressed which have been reflected in this IMTP.

8.6 Risk Management

We have a well establish Corporate Risk and Assurance Framework (CRAF) which enables us to understand the key risks racing the organisation, and ensure that appropriate action is being taken to manage the risks identified. Our approach to risk management is detailed in our Risk Assessment and Risk Management Procedure, the objectives of which are to:

- Define what we mean by a risk assessment, risk register and other associated terms commonly used;
- Clarify who is responsible throughout the process from identification to resolution;
- Specify how risks will be considered, prioritised and managed within the UHB;
- Provides a mechanism to identify if a risk is tolerable taking into account the risk rating and the actions being taken to deal with the risk;
- Provides guidance to ensure consistent scoring when used by staff from a variety of roles and professions; and
- Ensures capability for assessing a wide range of risks including clinical, health and safety, financial and reputational.

We are adopting the four 'Ts' approach to how we manage the risks we identify.



The CRAF identifies where further action is required to manage/mitigate a risk, what that action will look like, how the Board will know that the action taken is effective (how it is assured), and any gaps that require closing and any further action being taken. It is constantly reviewed and every Committee receives an update regarding the management of these risks at every meeting. In preparation for the 2015/16 assurance cycle the annual Audit Committee sponsored workshop, scheduled for February 2015, will provide the opportunity for the UHB Board to focus on the highest risks within the CRAF and satisfy itself that the IMTP has adequately responded to these risks. It will also allow it to ensure that it is sighted regarding the potential risks of non-delivery of any aspect of the IMTP. The Board and Committee work plans will also be agreed with a view to ensuring that they receive adequate assurance during the year.

8.7 Financial Controls to Support Delivery of the Financial Plan

Overall financial performance against the plan is managed via monthly Executive Director led performance reviews with Clinical Board teams. These reviews consider year to date and forecast financial performance, key financial performance indicators and actions to mitigate against risks. Performance against the key savings plan themes are managed via the Leaner and Fitter project structure where programme management arrangements and dedicated support will be provided to the key savings opportunities.

Financial controls to support the delivery of the plan include the following:

- Dedicated Clinical Board finance teams to provide financial advice, reporting, analysis and support to assist financial delivery;
- All vacancy replacements to be authorised as affordable and within budgeted establishment;
- Enhanced non pay controls over committing expenditure with a tight scheme of delegation ;
- Enhanced and standardised monthly workforce scorecard including variance to WTE budget and sickness;
- Contracts framework with identified Clinical Board leads;
- Consultant business case scrutiny;
- Further developing the internal framework to manage demand on support services;
- Issuing an accountability letter to all Clinical Boards which they will then cascade to budget holders;
- Strict protocols regarding LTA variations and changes; and
- All investments to be prioritised and subject to scrutiny with clearly set out benefits that will be monitored to ensure best value is delivered.

Financial performance is core Health Board business and this will be reported and considered at all Health Board meetings with supplementary discussion at development sessions as necessary. The Board will have early notice of any risks to deliver with options presented as to mitigating actions for it to consider.

SECTION

Working better together across care sectors through people, innovation, research and technology

Being a great place to work and learn

Chapters

- Building Our Capacity to Deliver
- Organisation Development



9. Building Our Capacity to Deliver

9.1 Introduction

Our emerging 10 year strategy and this three year plan describe a significant programme of change needed in order to meet our statutory obligations, tackle the health inequalities gap which has been stubborn to change, and secure sustainable services that meet the changing needs of our population and deliver Welsh Government requirements. Delivering the scale of will require us to work in very different ways. The principles of prudence give us the mandate to really challenge the way that we currently meet the needs of patients, providing people with the tools to manage their own health, only intervening when this will do more good than harm, and aggressively driving out un-warranted variation in the way people access care, and the treatment we provide.

The people who will deliver the change are our 14,000 strong workforce, so we are investing in our people to build our capability for delivering service improvement at scale. Our chapter 7 on organisational development has already set out the actions we are taking to create a core of individuals and teams skilled with the tools to change the way we provide services – building this capacity right across our organisation. This chapter describes the other important enablers that will enable us to successfully deliver the actions and ambitions we have set out in this plan.

Learning from last year, we are also establishing new internal processes to accelerate the pace at which we are able to deliver change. This will ensure that there is a clear line of sight from our longer-term overarching strategy to our operational management where are driving change on a daily basis. This means being clearer about our priorities and expectations, and having a clear rationale for the things we must stop doing.

Strong relationships with partners – Cardiff and South Wales Universities, the local authorities, neighbouring health boards and trusts, the third sector, and our Community Health Council – are essential to us to working differently. We are working right cross the care continuum, and using technology to deliver better models of care and support.

This chapter includes an outline of our approach to strengthen our delivery capability. There is a clear intent for all the functions and/or initiatives outlined in this section to collaborate even more closely over the coming year to align to the delivery of the UHB strategy.

9.2 Driving Successful and Sustainable Change

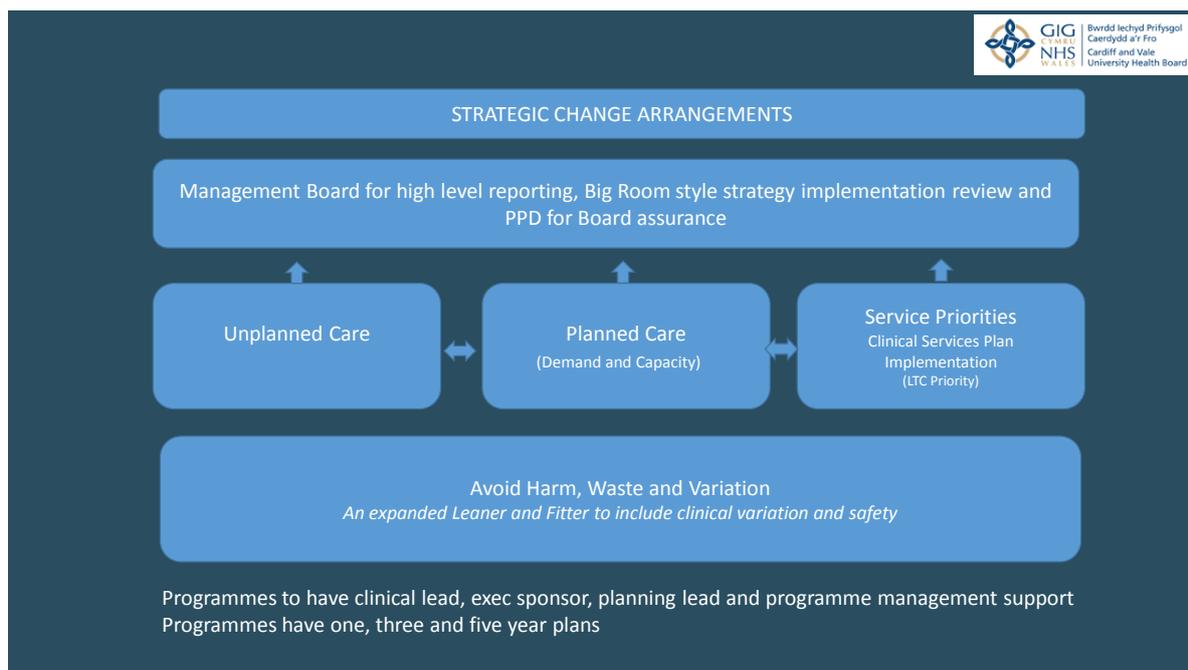
Our experience of delivering change last year demonstrated that our plans took longer to come to fruition than intended, we were not maximising the opportunities presented by the integrated nature of our organisation and that we were not being radical enough in our approach to transforming care and shifting the focus more significantly to out of hospital (acknowledging our ‘home first’ strategic design principle). Our performance management system focused more on the tier 1 numbers than on the changes needed to achieve the targets on a sustainable basis, and did not reflect fully the interdependency between the clinical boards and corporate departments.

To strengthen our internal process we are taking a number of actions informed by a Board Development programme in 2014/15 by the Institute of Healthcare Improvement, as follows:

- Refreshing our longer term strategy (initially set out in Organisation for Excellence), and redesigning the clinical models for the six key areas identified in Chapter 4 in order to achieve better health outcomes;
- Taking action to ensure that our strategy is well embedded within the UHB through a series of workstreams. These pieces of work increase staff awareness and personal ownership of delivering the strategy, including supporting staff to understand the role we all play to deliver the strategy. This work ensures that there is a “Golden Thread” from UHB objectives to the objectives of every team and ultimately every member of staff;
- Building a balanced score card that connects the outcomes we have agreed to operational delivery, with a comprehensive reporting system and dashboard that means we know where we are and what more we need to do providing a direct link between our strategy delivery and performance

management frameworks. We have strengthened our information, business and performance capacity to support this work;

- Defining the outcomes that matter to people, using outcomes based accountability methodology to better align what we do to the outcomes we want to achieve, linked to the development of our Balanced Scorecard;
- Establishing transformation programmes for unscheduled care and balancing capacity and demand (planned care) to drive forward the changes set out in Chapter 6, and strengthening the clinical leadership in these areas. See diagram below;
- Strengthening our Leaner and Fitter programme which is driving a series of work streams that will improve our productivity, reduce waste and variation, and harm (resulting in savings and freed-up resources). Our Leaner and Fitter programme last year delivered measurable success to support our financial plans for limited investment;
- Building our improvement capability as referenced in the introduction. A further 200 people will be supported through our Leading Improvement in Patient Safety programme during 2015-16 whilst, the UHB provides silver Improving Quality Together (IQT) practitioner training for up to 60 staff per year and silver foundation level training to the Clinic Leaders programme. To date 10 per cent of staff have improvement knowledge at bronze and silver level and a small number are gold level advisors/trainers. We plan to accelerate our improvement capacity and capability in 2015/16 and reach 20 per cent and we will ensure that the impact of the first two cohorts of the LIPS programme can be assessed in terms of the difference it is making;
- Continuing to change the culture of the organisation so that people are empowered to make changes and feel that changes are managed successfully (as described in greater detail in Chapter 10); and
- We will continue to use PESTLE (political, social, economic, technological, legislative and environment) to understand the changing context in which we are taking forward change and to assess the impact.



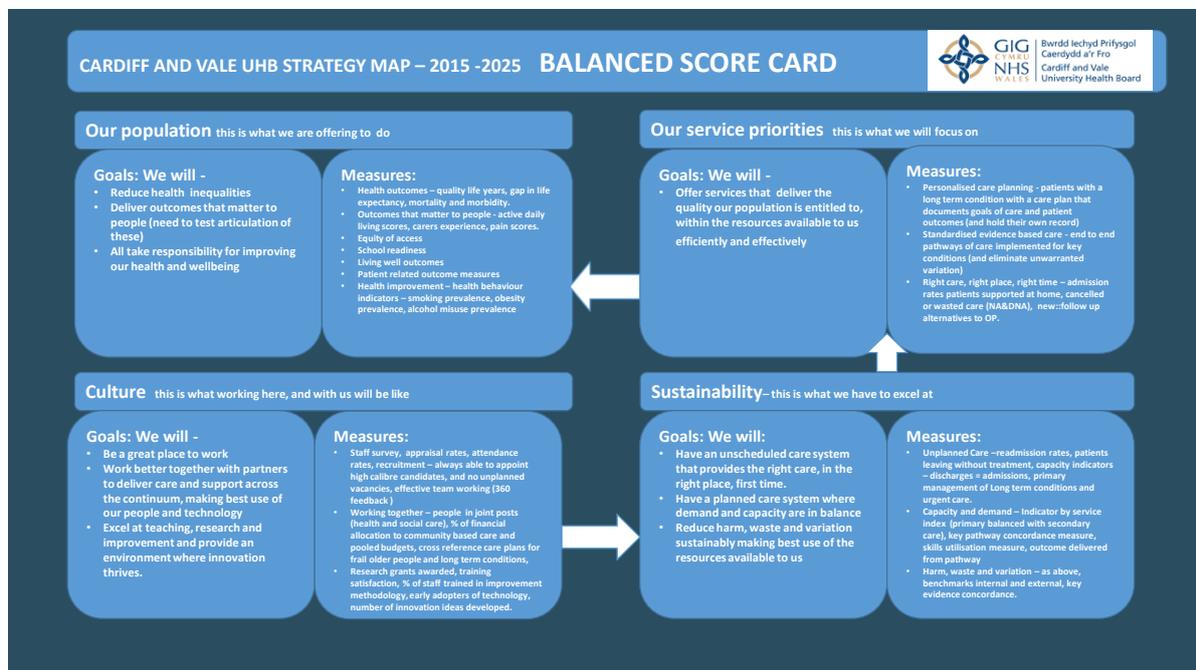
Strategy Development and Delivery Through Alignment

Our strategy has been developed through extensive conversations with patients, partners and staff and paying attention to external factors such as our obligations to Welsh Government and changes in the environment in which we operate. We now have a strategy in place that sets out the UHB’s direction through a clearly defined Mission, Vision, Values and Objectives. All our change work is fully aligned to the delivery of our Mission and Vision and it is essential that all of our day to day business has a direct line to these. As our “refresh” work is quite recent we recognise there is much more to do throughout the year. There are some specific pieces of work underway for early 2015/16 to increase the pace of delivery. These are:

- Developing a strategic stakeholder management plan and implementing it [Further information in Chapter 9.5];
- Developing a communication and engagement plan and implementing it [Further information in Chapter 9.5];
- Refreshing our corporate and business processes. This work will initially begin with a refresh of our current “top tier” meetings to ensure that the method of operating is directly aligned to strategy delivery, with a cascade planned once this has been achieved; and
- Branding, Language and Visibility. This work will re-align and increase the consistency of our corporate branding; the strategy will also be more visible throughout all of our sites.

The UHB now has clear organisation-level objectives which are shown in the scorecard below. It is intended that these objectives are cascaded throughout the organisation in 2015/16 starting with the Executive team. The ultimate aim is that they will frame front line staff’s personal objectives so there is a clear line of sight from front line with the UHB Board and vice versa. This will increase the impact of delivery as every team and eventually every member of staff can clearly link the work they do to the organisations aims.

The balanced scorecard is being developed following Kaplan and Norton’s model of strategy execution. The steps of developing the strategy map and the UHB objectives are complete. Work is now underway to refresh the measures we use within our performance dashboards to drive the changes that we seek.



Change and Programme Management

To deliver the organisational change required in chapters 6, best practice will be applied from the disciplines of change management and programme management. Our Change Management approach depends on the collaboration of many corporate functions to support Clinical Boards to deliver the strategy. The UHB’s intention is that this collaboration will increase as the refreshed strategy continues to embed.

The Programme Management Office

The Programme Management Office (PMO) is available as a small, skilled resource which is responsible for increasing the impact and delivery of changes by:

- Ensuring the Cardiff and Vale methodology for project and programme management is adopted and followed for agreed change programmes;
- Increasing change and project management capability through training, buddying and mentoring;
- Providing oversight of the delivery and benefits realisation of specific change programmes that are system wide and/or cover more than two Clinical Boards;

- Bringing together colleagues from across Clinical Boards and Corporate Functions (Continuous Service Improvement, Finance, Information, Patient Experience, Communications) to collaborate and align to deliver specific projects;
- Providing skilled resource to manage specific programmes that are system wide and/or cover more than two Clinical Boards; and
- PMO activity is restricted by the number of people working in the team, currently a total of 3 project managers with administration support, therefore prioritisation of PMO support or oversight activity is required.

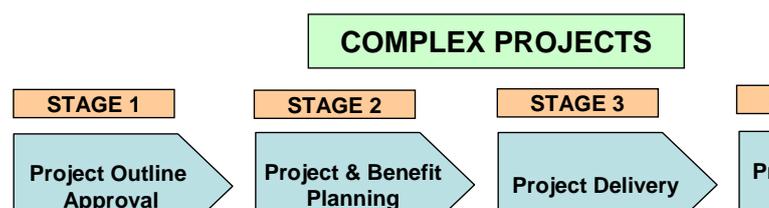
During 2014/15 the PMO had considerable success, particularly considering the available resources. There are many achievements to mention and some highlights that Leaner and Fitter delivered with PMO support are:-

- Supported the delivery of over £9 million of Clinical Board savings. This is significant when taken in the context of anticipated total UHB savings of £28.8 million;
- Delivered multiple efficiency improvements such as:
 - Developed an “app” to improve Medicines Management;
 - Redesigned 13 high impact prescribing pathways;
 - Increased impact of the feedback to junior doctor prescribers;
 - Developed a framework to increase consistency for Clinical Nurse Specialist;
 - Undertook an audit of how E-Rostering and Specialising were being deployed;
 - Began the roll out of new outpatient booking processes and appointment reminders;
 - Introduced new approaches and technology for more efficient booking and utilisation of operating theatres;
 - 95% medical consultants now have a job plan;
 - Introduced “Intrepid” system for consultants to book leave;
 - Oversaw changes to Gerontology;
 - Began the roll out of E-Datix to improve incident reporting; and
 - Worked in partnership with Unison to start a staff ideas scheme, now being adopted by other Health Boards.

In addition to this the wider PMO team:

- Produced a first cut of the Shaping Our Future Wellbeing Strategy [further details Chapter 3] which prepared the key principles of the UHB level strategy;
- Published a monthly newsletter with over 500 “hits” per month; and
- Provided project management training to over 100 members of staff.

There is an established project management methodology for Cardiff and Vale which is built on Prince2 and Association of Project Management best practice. This methodology covers project/programme governance, change leadership, implementation/benefits planning, implementation/benefits reporting and closure. The methodology ensures a consistency in the quality of change work, supported by standardised process and templates. In summary the Cardiff and Vale way of managing projects is



In 2015/16 the PMO will oversee and/or support:

- Completion of the Shaping our Future Well Being Strategy which is aligned to the “Service Priority” theme of the UHB strategy [further details Chapter 3];
- Development of any plans which are prioritised following completion of the Integrated Medium Term Plan;
- Leaner and Fitter programme which is a key delivery mechanism for the “Avoid Harm Waste and Variation” strand of the UHB sustainability strategy. The programme consists of 14 projects:
 - Medical Productivity Phase 3;
 - Optimising Re-ablement;
 - Attendance Managing;
 - Streamlining Recruitment;
 - Improving Temporary Staffing Processes;
 - E-Datix for Better Incident Reporting;
 - Medicines Management Phase 3;
 - Improving Theatre Efficiency;
 - Improving Non-Pay Influence and Control;
 - Booking and Scheduling;
 - New to Follow Up Appointments;
 - Implementation of E-Systems; and
 - Records Management (to be confirmed).

PMO support and/or oversight to the delivery of Unplanned and Demand and Capacity strategic change programmes is currently being considered as part of finalising the delivery model and prioritising resources.

9.3 Accelerating Innovation and Improvement

As a teaching university health board, we already have strong and interdependent relationships with Cardiff University, Cardiff Metropolitan University and South Wales University. We will be building on the work initiated with Cardiff University last year to strengthening our approach to innovation, as one of the key drivers for improving how we treat and care for patients.

Acknowledging the challenges we are facing², we recognise the importance of searching for and applying innovative approaches to delivering healthcare, and that this must become an integral part of the way we do business. As one of the biggest employer in the region, and big consumer of goods and services, we also have a major roles as an investor and wealth creator South Wales. We know that our success in adopting innovation helps support growth in the life sciences industries, of which there are many within the region, which in turn leads to investment in developing the technology and other products by us and the NHS more widely. However, we are currently significantly under-powered in this area – for a teaching university health board, delivering a broad spectrum of services from primary care to very specialist tertiary services, we should be seeing many more ideas for service and technology improvements and innovations being generated by our workforce. Without creating the space and enthusiasm, or a clear pathway through which to develop ideas, we are not maximising the opportunities that exist.

We are therefore establishing more formally a clinical innovation partnership with Cardiff University under leadership of a Joint Director of Clinical Innovation with a joint team that will be responsible for creating a better climate for innovation, developing a clinical innovation centre, with a single entry point for people to take ideas and enable them to progress the idea through the most appropriate route. The success of the Welsh Institute for Minimal Access Therapy (WIMAT) as a world leading training centre and incubator for ideas (resulting in several spin off companies) will be the exemplar demonstrating what can be achieved. The joint Clinical Innovation Team will have reach right across the university. Linking with primary care and public health to ensure that the focus is not just on improving hospital based care; ideas and knowledge will be brought together from the medical school, the wider Bio and Life Sciences College, the Business School, engineering, mathematics and computer science disciplines.

Building on the work of the Quality Improvement Faculty, this new collaboration will bring a co-ordinated

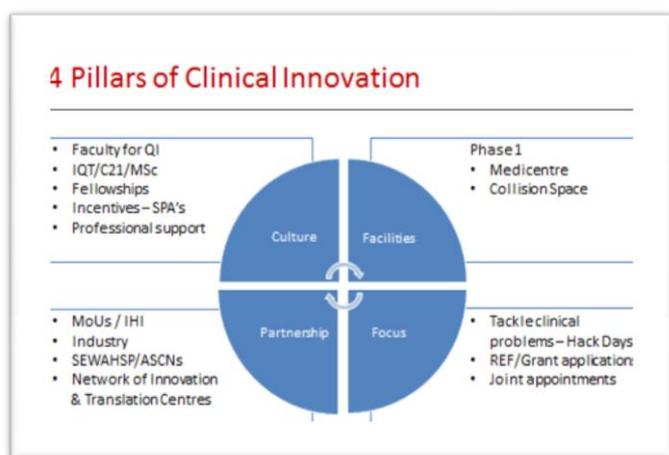
² Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS, 2011

approach to acquire specialised, high quality support by bringing together academics, scientists, researchers from different disciplines, clinicians, managers and students to create, develop and test ideas.

We have set ambitious goals for the Clinical Innovation Partnership related to the number of ideas generated, income generated and impact on job creation. The first phase of this collaboration will focus on the following areas:

- Engage and inspire the students and workforce to create a knowledge transfer and translation culture which improves patient care Create a physical environment to pursue discovery without boundaries.
- Collaborate creatively to advance clinical innovation, research, science, education and training.
- Create future workforce capacity and capability.
- Accelerate translation for health and wealth and job creation.

The diagrams below illustrate the themes under which the work will be taken forward, and the activities that will be progressed.



We are also in early discussions with NESTA about establishing a health collaboration in Wales.

We will also be taking an active leadership role in progressing the work across Wales, in response to the Welsh Government signalling the importance of clinical innovation to its aim of strengthening economic growth in Wales. With over 100,000 employees and an annual expenditure of close to £10 billion³, the healthcare sector in Wales has many valuable assets and opportunities with which to make a much greater contribution to economic growth and wealth creation. The Health Board, in collaboration with other health boards and Universities in Wales will ensure that the developments we are taking forward with Cardiff University form part of a coherent network of innovation activities designed to realise more of the potential in Wales. To this end our Chief Executive is taking personal responsibility for leading the work across Wales, and with Welsh Government colleagues a business case for investment to support this work is being developed.

The work of the Quality improvement Faculty will be extended and aligned to our clinical innovation strategy. The NHS Award winning Faculty signalled our intent to create a dynamic environment that contributes to the health and wellbeing of our patients and citizens. The Faculty is the engine to drive discussion, generate enthusiasm and action for transformational change. Importantly it also supports and develops collaborative relationships with partner organizations, locally, nationally and internationally to ensure vitality, creativity and sustainability. The focus for 2015/16 is based on 3 primary drivers:

³ Health and Wellbeing Best Practice and Innovation Board, NHS Social Care and Business Workstream, Recommendations on Health and Wealth in Wales.

³ State of Innovation – Welsh Public Services and the Challenge of Change, Matthew Gatehouse and Adam Price, NESTA

- Increase the quality, reliability and effectiveness of care by focussing efforts on programmes that tackle the reduction of harm, waste and variation (refer to the continuous service improvement team's work programme);
- Develop a culture of sustainable continuous improvement to support capacity and capability in healthcare improvement methodology and delivery, at the coal face and in educational settings (embedding IQT through LIPS, Silver Practitioner, Clinical Leadership and the C21 education and training programmes); and
- Build and maximize collaborative relationships with partnership organisations that seek to advance and promote innovations in promoting and delivering healthcare (Public Health Wales - Patient Flow; IQT; NHS Award applications; develop our clinical innovation strategy in partnership with Cardiff University and support for the Welsh Wound Innovation Centre and continue the pursuit of excellence in grant applications to the Health Foundation and NISCHR).

The work of the continuous service improvement team (CSI) underpins our improvement and transformational change agenda such that we achieve and sustain system improvement. The approach builds on the Model for Improvement Logic Model, the backbone of IQT, and employs a number of improvement tools and techniques to reduce unwarranted harm, waste and variation. The work programme will continue to underpin our transformation priorities planned to improve patient pathways through the use of lean methodologies. The work will support our transformation programmes for unscheduled and planned care, for example continuing to progress our patient flow programme, improving out discharge communication with GPs, ensure the efficient use of our theatres and streamlining cancer pathways (particularly urology where demand has risen) to support the delivery of cancer diagnostic and treatment access times.

Advisory Board for Leadership and Improvement Programme.

The programme aims to develop the leadership skills for all senior clinical and non-clinical leaders which are most critical to the UHB's strategic, development and performance objectives.

<p>Modules covered to date include:</p> <ul style="list-style-type: none"> • Effective Problem Solving • Leading Through Vision • Instilling Accountability • Facilitating Effective Teamwork • Spurring Innovation • Leading amidst Uncertainty • Managing Disruptive behaviour 	<p>Modules planned for April, May, June and July 2015 include:</p> <ul style="list-style-type: none"> • Developing Emerging leaders • Strengthening Physician Relationships • Leading Change • Towards a higher standard of safety <p>After which there will be a further 6 modules In year 3 – the content of which is currently being finalized.</p>
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9.4 Expanding Research and Development (R&D)

Nationally, a coordinated approach to Government policies has placed research in the life science sector at the centre of the programme for economic renewal. The all Wales R&D budget has been increased in recent years to enhance Wales' competitiveness in R&D (£43m in 2013-4), with the UHB receiving £5.575.m in 2014/15.

An expansion in R&D within the UHB supports services priorities in “delivering the quality our population is entitled to expect” whilst improving the sustainability by “joining up what we do for the people we serve and striving for operational excellence so we make the best use of the resources we have”. In turn this will help foster a culture where the UHB is considered “a great place to work and learn”

Through its strategic objectives, the UHB has described “an environment where innovation thrives”; this will be achieved by building on key 2014/15 infrastructure developments:

- Clinical Research Facility – the provision of full time medical cover and the appointment of a Clinical Lead;
- R&D Office – job planned Clinical Board R&D Leads, appointment of two Research Liaison Managers and a second Contracts/Commercial Trials Manager; and
- Links with Higher Education Institutes (HEI) - Joint appointment with Cardiff University of Chair in Emergency Medicine.

As part of the Welsh Government National Institute for Social Care and Health Research (NISCHR) Academic Health Science Collaboration (AHSC) Performance Metrics, targets have been set in relation to number of research studies undertaken by the UHB:

- Increase of 10% per annum of the number of NISCHR Clinical Research Portfolio (CRP) studies being undertaken within the UHB;
- Increase of 5% per annum of the number of commercially sponsored studies being undertaken within the UHB;
- Increase of 10% per annum of the number of patients recruited into NISCHR Clinical Research Portfolio studies being undertaken within the UHB; and
- Increase of 5% per annum of the number of patients recruited into commercially sponsored studies being undertaken within the UHB.

Funding from NISCHR is now received by the UHB in accordance with an activity based funding model. Funding is retrospective, based on the previous year's activity. However, the assumption that an increase in activity – both in terms of number of studies or recruitment to each study – will necessarily result in an increase of income to the UHB is complicated by the fact that the total NISCHR budget is unlikely to increase and other NHS organisations in Wales also have to deliver against the same performance metrics.

The NISCHR AHSC Monitoring Framework now circulates the NHS Research Data Reports to NHS organisations on a quarterly basis to enable them to manage their performance against the targets as well as the 'time to approval' for studies. The first quarter report for the UHB 1st April to 1st June 2014 showed that the UHB is on target to achieve the desired performance including almost 100% compliance with 'time to approval'.

Moving forward, the R&D aims align to the UHB strategic themes as follows:

For Our Population:

- Improve the health and well-being of patients and the wider population by promoting and supporting innovation and research translation for the better understanding of diseases and human behaviours; and improved treatments, healthcare provision, and preventative programmes.

Our Service Priorities

- Building research capacity and strategically align research and service planning and delivery;
- Assist Clinical Boards and individual Directorates with their own R and D strategies and delivery;
- Improve the capacity of the Clinical Research Facility to undertake complex specialist studies e.g. Cardiac, Ophthalmology, Gastroenterology etc; and
- Development of Paediatric Clinical Research Facility for Wales.

Sustainability

- Comply with NISCHR WG metrics including use of its ABF allocation for research delivery;
- Build a skilled workforce capable of advancing high quality multidisciplinary research which is population and people centred and leads to quality improvements in healthcare and public health;
- Increase commercial income from its present level of ~£1m per annum towards the UK average for a UHB of £6m over the next 5 years with the aim of increasing research capacity;
- Contribute to economic prosperity, by developing existing and new partnerships with industry in the pharmaceutical and technical sectors to grow the commercial research portfolio; and
- Ensure patient safety by compliance with all Regulatory and Clinical Governance requirements.

Culture

- Create a culture and research environment to develop and sustain the reputation of the UHB for research excellence in clinical and translational medicine; and
- Add value and enhance impacts by creating new synergies between the UHB and HEI organisations especially Cardiff University with the aim of increasing innovative development with possible commercial exploitation.

The priorities for the Research and Development Department during 2015/16 and beyond are to:

- Streamline processes for setting up and delivering recruitment to commercial studies in order to gain a reputation UK and worldwide as a centre of excellence for the placement of commercial studies, enhancing the opportunities for Clinical Boards to maximise opportunities for patients to participate in high quality studies as well as generating additional revenue;

- Introduce a new R&D database management system (EDGE) to replace an existing 'at risk' databases, to reduce administrative burden, speed up study set up times, streamline data collection and move to an organisation wide accessible database assisting research teams in their collection of patient related (unidentifiable) data;
- Develop a closer working relationship with the R&D functions of the UHB's main academic partner, Cardiff University, with the expected outcome of an improved service to the research community including investigators, grant funding bodies and industry. We have just commenced regular meeting with the aim of developing a joint R and D Office between the two organisations to speed up contract approvals and ultimately study set up times;
- Pump prime a clinical research fellow post in the Clinical Research Facility (CRF) for 1 year to provide in house medical cover to increase the number of Phase 1 studies undertaken. This has been agreed as a research fellow post as it may aid recruitment to these clinical/research posts which are currently funded by the UHB. It has proved difficult to recruit to these in the last two years (at least 1 post unfilled annually) and this has an impact on Hospital at night cover and compliance with the EU working hours directive;
- Increase in the CRF nursing staff workforce to allow for more high income overnight stay studies to be undertaken with the resultant benefit to the organisation and patients; and
- Increase the proportion of early phase studies being conducted in the CRF and thereby increase income. This is dependent on the appointment of additional staff.

9.5 Teaching the Next Generation

There are strong academic, teaching and clinical practice links with Cardiff University, Cardiff Metropolitan University and the University of South Wales for a range of clinical professions at undergraduate and postgraduate levels. This is as well as ensuring opportunities for a variety of development pathways including apprenticeships, graduate interns, an infrastructure for Advanced Practitioners and appropriate leadership and management development programmes (with Academi Wales), that provide for effective succession planning.

The UHB is committed to training and developing the right numbers of staff with the right skills, competences and motivation to provide safe, modern, flexible services to the health economy it serves. We recognise the increasing need to develop a future workforce which will involve healthcare professionals leading and delivering new ways of integrated multi-professional working, with core skills and competences aligned to the UHB strategy map and contributing to achievement of our priorities. This will drive the transformational change we need, based on the minimum appropriate intervention delivered by the appropriate health professional at the correct part of the health care pathway. To transform the workforce structure/infrastructure will require radical interventions undertaken through the process of workforce planning and organisational development [further details see Chapter 10].

Opportunities for education, service and workforce modernisation have been identified across professions and include:

- Introduction of **extended/advanced practitioner** and consultant Healthcare Scientist and AHP roles in substitution of traditional medical roles including a Radiographic Discharge Service and a Consultant Physiotherapist role;
- Introducing a **7 day model of working** for therapy services;
- Developing an **integrated workforce pathway** for stroke to challenge traditional roles;
- Development pathways in place to ensure **HCSWs** have the skills to work at their maximum ability – e.g. Clinical Imaging Apprentice to relieve Radiographers of some duties, maximise the opportunities presented by Modernising Scientific Careers including the new Healthcare Scientist Apprenticeship Framework;
- Introduction of new **technology and a redesign of roles** Health Records modernisation;
- Educating the next generation of dental professionals, balanced with delivery of dental care across primary, community and specialist dental services;
- Specialist dental staff responsible for continuing education of the dental workforce and CPD provision for the wider dental team;
- Developing a joint undergraduate and postgraduate medical education strategy;

- UHB involvement in C21 - Cardiff University undergraduate curriculum redesign and delivery of phase 1a of the C21 course;
- Delivering high-fidelity simulation (UHW – C21 and postgraduate) and low-fidelity self directed learning (UHL – C21);
- Medical education within the UHB performance dashboard, highlighting areas of excellence and concern;
- Providing education and support for the 630 junior doctors in the Wales Deanery approved training posts (Foundation, Core, Speciality and GP training);
- Publishing a Nursing and Midwifery Strategic Framework 2014-2017 - high level road map aligned to our strategy map - Caring for People, keeping people well, and our core values;
- The Vale Integrated Health, Social Care and Third Sector model – integrated approach to providing care in the community;
- Transforming District Nursing – leadership model aligning services in the community including with GP clusters and Community Resource Teams;
- Role redesign in planned care such that enhanced care is provided closer to home e.g. Optometrists and post cataract care;
- Implementing a Clinical and Capacity Model for Gerontology and Older Peoples’ Services;
- Joint development of roles and generic working in Community Mental Health teams – UHB, Local authorities and third sector; and
- Use of volunteers to provide additional interactions and activities for patients.

9.6 Transforming Information Technology

During 2014/15, we used discretionary funding to improve our IT infrastructure to both shore us fragile facilities, and increase our capability for using IT to drive new models of care (such as virtual clinics) and provide accurate and timely information to support operational delivery and service evaluation. We have a three year IM&T IMTP in place which sets out the changes we need to make to secure service improvement, and implemented our longer term service strategies. The four key priorities for IM&T 2015/16 have been identified:

1. Sustaining and refreshing an extensive IT infrastructure, supporting in excess of 10,000 users - ‘keeping the lights on’
2. Contributing to plan and deliver of the National IM&T Programme – working with colleagues in Wales to deliver integrated cost effective systems to support Wales Information and Technology strategic priorities
3. Working with Clinical Board and Corporate Departments to identify and prioritise technology, analytics and coding requirements to support service change and more effective decision making.
4. Embracing and exploiting new technological opportunities to support service change

The UHB is committed to progressing implementation of the national programmes for IT. Our position highlighted in the slides below (presented to NIMB in March 2015) demonstrates significant progress with no outstanding implementation commitment issues.

Current Position for Cardiff & Vale - February 2015

Secondary Care	WCP Path Reporting	WCP Path Requesting	Myrddin	Radis2	National PACS	EMPI	LIMS Blood Sciences Micro	LIMS Blood Transfusion	LIMS Histology	LIMS WTAIL	LIMS Mortuary
University Hospital of Wales			N/A							N/A	
Llandough			N/A							N/A	

Secondary Care	GP Links (IUVO)	PACS Image Sharing	WCP HERS2	WCP IHR View	WCP MTed	WCCG Phase 2	ED System	Community	Audit Tool	WCRS	National TRRR
University Hospital of Wales											
Llandough											

Primary Care	Child Health	IHR (Out of Hours)	WCCG Referrals	MHOL	CAS	GPTR	GP Systems Implementation
CARDIFF & VALE					N/A		

Completed
 Started and/or plan in place
 Agreement to implement - plan not in place
 Implementation agreement/approach outstanding
 New Initiatives
 N/A **Not Applicable**

Key for Systems	
WCP	Welsh Clinical Portal
RaDIS	Radiology Information System
PACS	Picture Archiving and Communications System
EMPI	Electronic Master Patient Index
LIMS	Laboratory Information Management System
HERS2	Hospital Electronic Referrals
IHR	Individual Health Record
MTED	Medicines Transcribing and e-Discharge
MHOL	My Health Online
CAS	Common Ailments Service (Community Pharmacy)
WCCG	Welsh Clinical Communications Gateway
GPTR	GP Test Requesting
WCRS	Welsh Care Records Service
National TRRR	National Test Requesting Results Reporting

The current position for the NWIS Programme implementation is:

Secondary Care

Welsh Clinical Portal – Pathology Test Requesting and Results Reporting (TRRR)

- Readiness/Planning commenced. Work has started on the validation plan for the pathology results backlog into the TRRR database;
- Regular planning meetings with NWIS commenced;
- Visit to Cwm Taf HB arranged;
- UHB Stakeholder Meeting to be arranged; and
- Pilot expected to commence with one ward initially.

Radis2

- Radis 2 implemented in May 2014.

National PACS

- UHB has Agfa PACS;
- Contract due to end January 2016;
- Replacement options are being discussed at executive level including the implementation of the national Fuji PACS procured by NWIS and the option to progress an integrated end to end imaging solution as part of the PACS replacement and image sharing is being explored with NWIS;

PACS Image Sharing

- See National PACS above – under discussion.

Enterprise Master Patient Index (EMPI)

- EMPI has been implemented and is linked with our Patient Management System (PMS).

Laboratory Information Management System (LIMS) – TrakCare Lab

- Core LIMS modules – Microbiology and Blood Sciences went live during 2014;
- NWIS report that the Histology/Mortuary module will be available to the UHB in July 15 and Blood Transfusion in December 15;
- NWIS will pay the Telepath double running costs during 2015/16;
- UHB has received invoices for full amount of Trak implementation, however not all modules have been delivered (as above). Finance Department is negotiating the level of payment with NWIS.

New National GP Links

- Delivers test results from secondary to primary care; and
- Pilot in Cwm Taf Health Board has started. NWIS are planning a rapid rollout after pilot completes.

Welsh Clinical Portal (WCP) – Hospital e-Referrals2 (HeRs2)

- Pilot commenced in on 11th March with 2 specialties – Cardiology and Neurology;
- An Evaluation will be carried out after 3 weeks of pilot;
- HeRs2 has ‘advice request’ functionality which allows secondary care clinicians to seek advice/further information from GPs whilst prioritising referrals; and
- Other specialties are expressing an interest in the product.

Welsh Clinical Portal (WCP) – Individual Health Record (IHR) View

- IHR is in use on the MTED pilot wards;
- Welsh Information Governance Board and GPC Wales have agreed that the IHR can be rolled out further within the UHB now that the National Intelligent Integrated Audit Solution (NIIAS) is available;
- Functional test of the audit reports carried out on 24th February;
- Medical Director and Information Governance and Assurance Lead require the NIIAS audit reports to be linked to the Electronic Staff Record before satisfactory reports can be produced. NWIS report that the NIIAS/ESR link is expected to be available during April 2015.

Welsh Clinical Portal – Medicines Transcribing & E-Discharge (MTED)

- MTED continues to be used on the pilot wards;

- Rollout is dependent on the NIIAS audit reports being available (as above);and
- Rollout is also dependent on WCP v3.5 which will deliver a version of MTED that can be used without pharmacy support during out of hours. V3.5 will not be available before July 2015.

Welsh Clinical Communications Gateway (WCCG) Phase 2

- WCCG Clinical Reference Group has prioritised the implementation of the electronic delivery of clinical letters from secondary to primary care
- C&V has submitted a request to NWIS to be included in this project during 15/16
- C&V would also like to see WCCG e-Advice Requests (primary to secondary care) included in Phase 2.

Emergency Department Clinical Information Management Solution (EDCIMS)

- EU Department uses the A&E Module of PMS;
- NWIS have procured the Symphony System;
- Before the UHB could migrate from PMS to Symphony in EU a comparison of the functional specification of the PMS A&E Module and the Symphony system would need to be carried out to identify potential disadvantages/benefits and inform any decision; and
- EU personnel are to arrange a meeting with the Supplier to include a demo and question and answer session with a view to undertaking an options appraisal.

The UHB is committed to the one Wales approach to implement the Emergency Department Clinical Information Management System (ref: WHC 2015 007) the implementation plan is under development.

Community Care Information System (CCIS)

- UHB uses the PARIS system which is pervasive across all Community and Mental Health services. The only health board to have such a system;
- NWIS have procured a national CCIS. CareWorks has been chosen as the successful supplier; and
- Cardiff and Vale Health and Social Care community are committed to the deployment of CCIS; and will agree an implementation date as part of the national programme.

National Intelligent Integrated Audit Solution (NIIAS)

- A NIIAS has been procured by NWIS; and
- Please see IHR and MTED update above.

Welsh Care Record Service

- NWIS invited tenders, however both interested suppliers were unable to manage the required infrastructure; Procurement has subsequently stopped; and
- As a result NWIS plan to build on the Welsh Clinical Portal document repository.

National TRRR

- Renamed Diagnostics Reports Service; and
- Work underway to support the South Wales Programme.

HTTF – Open Eyes

- Open Eyes supplier were unable to deliver by 31st March 2015. Therefore the national programme is on hold; and
- Optometry e-Referrals project will continue using WCCG. Requires Hospital e-Referrals (HeRs) development in UHB.

Primary Care

IHR Out of Hours

- In use since 2011.

WCCG e-Referrals

- In use since 2009; and
- 80% of GP referrals for an outpatient appointment are received in the UHB by WCCG.

My Health Online (MHOL)

- Implemented at 59 GP practices;
- Allows patients to book appointments and order repeat prescriptions online;
- Remaining practices are either interested and planning to take MHOL or waiting until they have their GP system upgrade before implementation; and
- NWIS are planning Phase 2 of this project.

GP Test Requesting (GPTR)

- NWIS are piloting this functionality at present.

GP Systems Implementation

- All GP practices will have migrated to one of two national GP systems by July 2015.

Digital Health and Social Care Strategy

- The UHB has committed to this national strategy and is committed to contribute to its implementation.

Supporting UHB Priority Areas

In building on our achievements for this year the IM&T Department will focus its efforts on supporting the five priority areas of Unscheduled Care, Cancer, RTT, Stroke and Financial Savings.

In addition to the essential investment in sustaining services and “Keeping the Lights on” further investment opportunities have been identified which will be assessed for their potential to support UHB priorities. These opportunities are broken down into themes and mapped against UHB priorities in the tables below:

THEME	BENEFIT REALISATION							
	PRIORITY AREA							
	RTT	USC	STROKE	CANCER	FINANCIAL SAVINGS	PATIENT SAFETY	PRIMARY CARE	
Theme 1 - Keeping the lights on								
1.1 Keeping the lights on A programme aimed at sustaining and refreshing the IT Infrastructure to protect the UHB from system interruption risks. <ul style="list-style-type: none"> Virtual Server Infrastructure Backup Infrastructure Storage Infrastructure Desk Top Infrastructure Mobile Infrastructure The upgrading of the data network The increased development of the UHB Wi-Fi with additional access points in clinical areas 	<ul style="list-style-type: none"> Improved patient safety Improved continuity of service Less disruption of services Improved Risk Management Improved Data Safety Improved System Performance Improved compliance with IT Security Standards Improved Disaster Recovery capability 							
Theme 2 - Booking & Scheduling								
2.1 Digital Health Record (DHR) The vision is to digitise Medical Records used in outpatient clinics and implement a Paper Lite System within Cardiff and Vale UHB	<ul style="list-style-type: none"> Improved access to patient records improving quality of care delivered Cost savings within the health board through the introduction of a paper light system Reduced costs for future support from Health Records for additional clinic activity Reduced number of lost clinic slots due to the increased availability of the Health Record Improved efficiency elsewhere within the organisation through the availability of health records electronically 	✓	✓		✓	✓	✓	✓
2.2 Enabling system mobile access (backend) The procurement of a solution to enable the safe and secure connection of 1000 users to browser Clinical and Business "anywhere any time"	<ul style="list-style-type: none"> Access to Business and Clinical Information on personal devices safely and securely. Access "any where any time" Improve employee productivity and patient care Able to retain control over securing the network Allows staff to use the devices that they prefer for work purposes A sustainable model for provision and maintenance of devices 	✓	✓	✓	✓	✓	✓	✓
2.3 Mobile devices to access clinical systems Provision of mobile devices to access clinical systems in a variety of settings securely via the WiFi network	<ul style="list-style-type: none"> Will result in improved timeliness and availability of relevant clinical and business information Will contribute significantly to the evolving electronic patient record supporting accessibility, accuracy and security of patient data 	✓	✓	✓		✓	✓	✓
2.4 Patient Self Check - In system rollout Develop and roll out patient self booking-in and waiting room management system.	<ul style="list-style-type: none"> Increased efficiency when running outpatient clinics Improved communication between the consultant and the patient Link to COM will improve RTT compliance Burden on reception staff relieved to improve communication between reception staff and patients A more streamlined and improved service for both patients and clinicians In house development leads to reduced cost and increased flexibility 	✓				✓	✓	✓
2.5 Software implementation – booking systems for Outpatients	<ul style="list-style-type: none"> Improved clinic efficiency Increased throughput Fewer DNAs 	✓			✓	✓	✓	✓
2.6 Patient Reminder system Text message based system for reminding patients of their outpatient appointments	<ul style="list-style-type: none"> Increased efficiency of clinics through a decrease in DNAs and increased clinic throughput Improved communication with patients Increased clinic capacity 	✓				✓	✓	✓
2.7 Enhance and mandate COM system The Clinicians Office Management (COM) module's primary role is to record clinical decisions that have an effect on the Referral to Treatment (RTT) clock at the time the decision is made. It was originally designed to be used outside of the normal data capture areas e.g. Consultant's office, although it became obvious that it could be easily integrated in clinic and many other areas.	<ul style="list-style-type: none"> Currently clinical decisions are recorded, in outpatient settings, on paper using the Clinical Outcome Form (COF) which is passed to administration staff and input to the Trust's Patient Management System (PMS). The COM can be used as an electronic replacement for the COF in this setting. The COM can be used to add patients directly onto the IPWL, request followup appointments and notes can be recorded against the review. Currently under development is an electronic discharge letter which will be delivered directly to GP etc. The COM can be customised to make specialty specific Integral module within the Patient Call system. 	✓			✓	✓	✓	✓

<p>2.8 Auto-booking Project Auto-book all patients into a clinic before issuing an attendance letter with a request that they ring in to confirm. This replaces the old style write to patient first and expect them to ring in before booking. The most significant change to the process is providing flexibility to directorates in the use of their capacity within outpatient clinics in order to maximise the impact on waiting times for both routine and urgent patients.</p>	<ul style="list-style-type: none"> Increased efficiency as can fill clinics to capacity and subsequently cancel appointments 6 days before if no confirmation has been received (with a cancellation letter sent to the patient and the GP notified). Addresses triple offer to patients because i) initial letter, ii) second letter sent prior to appointment and iii) call reminder action undertaken Stage 2 of development will allow directorates to manage their outpatient capacity directly and provide a simulation modelling tool for forecasting future capacity/demand that can be used to inform the clinic booking rules. <p>The directorates would decide a baseline for the percentage of slots that would be available for both routine and urgent patients. This would be the available capacity after excluding the slots required for cancer patients. In addition to this the directorates would set a target time in which each group of patients would be seen. For example it may be clinically appropriate for urgent patients to be seen within 4 weeks and routine within 14 weeks.</p> <p>By defining the baseline for the two patient groups the system will be able to demonstrate with the current levels of capacity what the waiting times for the patients will be in the future. The functionality should also include the option for this capacity to be flexed at clinic/consultant/specialty level as often as required so that the directorate can react to waiting time pressures for both routine and urgent patients.</p>	✓			✓	✓	✓	✓	✓
<p>2.9 Implement HeRs Phase 1 of the HeRs System is integrated with the WCCG and the UHB's PMS so that e-Referrals can be quickly routed from primary to secondary care and added to a hospital waiting list without the need for manual administration. HeRs Phase 2 will support online prioritisation by clinicians and clinical teams using the Welsh Clinical Portal and clinical dialogue between secondary care clinicians and GPs.</p>	<ul style="list-style-type: none"> HeRs contributes significantly to patient safety, patient treatment processes and business processes in the following ways: Safe, secure and fast electronic transmission of patient data between clinicians, health records and administrative staff Reduction in the time taken to add patients to a waiting list and, ultimately, a reduction in the time taken to initiate appointment booking Integration with the Welsh Clinical Communications Gateway (WCCG) Integration with the UHB's patient administration system (PMS) Multi-user workflow functionality for processing referrals in medical records department(s) / patient appointment centres / administration teams (before clinical review and prioritisation of referral) Flexibility – e-referrals can be processed by staff in devolved or other areas that are away from the main Health Records Department Significant reduction in turn around time between admin and clinical functions Improved security of referral – i.e. referrals will not be lost or mislaid Contributes significantly to the evolving electronic patient record thereby providing accessibility, accuracy and security of patient data. Improved Primary/Secondary Care communications on current patient state Improved clinical triage management Improved data accuracy. Lean efficient and cost effective administrative processes Online viewing and prioritisation of referrals by clinicians Ordering of tests and investigations at point of clinical prioritisation Messaging back to primary care HeRs will support e-advice requests which may result in a reduction in the number of referrals 	✓	✓		✓	✓	✓	✓	✓
<p>2.10 Mandate 100% eReferrals 75% of referrals are currently sent electronically. By mandating eReferrals the aim is to increase this to 100% by working with non-compliant GPs and some specialities</p>	<ul style="list-style-type: none"> Decrease in the manual handling of referrals Faster transfer of referral documents to the receiving site Increased efficiency of referral administration e.g. reduced telephone calls An increase in the relevance and completeness of patient clinical data within the e-Referral due the introduction of a structured template Knowledge of referral status is shared amongst clinicians in primary and secondary care Full audit capability 	✓			✓	✓	✓	✓	✓
<p>2.11 Theatre System Improvement Projects Theatre system improvements and interface with PMS as part of the theatres modernisation project.</p>	<ul style="list-style-type: none"> Improved Theatre utilisation Reduced late starts Improved Transparency Improved booking and scheduling Improved performance information 	✓	✓	✓	✓	✓	✓	✓	✓

Theme 3 – Unscheduled Care							
<p>3.1 Implement MTeD/IHR UHB wide</p> <p>MTeD facilitates the electronic production of an e-discharge advice letter, which includes patients' current medication list. The e-discharge advice letter is sent securely to a patient's GP via the Welsh Clinical Communications Gateway as the patient is discharged from the ward.</p> <p>The IHR is being made available to secondary care doctors and pharmacists in Cardiff and Vale as part of a pilot supported by NWIS. The IHR will support the use of the Medicines Transcribing and E-Discharge (MTeD) module of the Welsh Clinical Portal. The IHR includes patients' current medication list. The list can be accessed by pharmacists and eliminates the need to phone the GP practice. The IHR includes other important clinical details, including past medical history, which can be accessed by doctors on pilot wards.</p>	<ul style="list-style-type: none"> The implementation of MTeD will reduce medication transcription errors Compliance with the formulary will be increased The effectiveness of medicines reconciliation will be increased An electronic discharge advice letter will be produced which will result in fast transmission of structured and complete data to primary care. GPs will have an up to date medication list for their patients on discharge from hospital Improved discharge efficiency 						
<p>3.2a Sharing key clinical events between uHB Community (PARIS) and Acute (PMS) service</p> <p>Delivers both clinical practice improvements and efficiency improvements, through the enablement (within PARIS and within PMS) of a view/screen of 'Key' events i.e. greater understanding of the patients history, allergies, plus professional/clinical involvements and appointments across the uHB.</p>	<ul style="list-style-type: none"> Reduction in Clinician admin time Informed healthcare across patient settings. Closer to goal of fully electronic patient record. 						
<p>3.2b e-referring between Acute and Community teams (currently undertaken by fax or telephone message). Enabling the interchange of nursing/clinical assessments between settings.</p>	<ul style="list-style-type: none"> Reduction in Clinician admin time Reduction in clinical errors due to transcribing of messages, misunderstandings Closer to goal of fully electronic patient record. 						
<p>3.2c Euroking to PARIS interface</p> <p>Delivers efficiency of service via auto patient creation of the c6000 annual births in Cardiff and Vale from Euroking to PARIS (currently a manual and error prone task).</p>	<ul style="list-style-type: none"> Reduction in uHB duplicate record entry/admin time Provides the immediate visibility of the birth record between acute and community services. Closer to goal of fully electronic patient record. 						
<p>3.3 EU eDischarge</p> <p>Implement and mandate the ability to produce electronic discharge notifications from EUWS in a manner similar to Clinical Ward Workstation.</p>	<ul style="list-style-type: none"> Improved patient movement within the EU improving patient care Accurate management of patient data allowing greater breach avoidance. Reduction in letter production costs. Reduction in Clinician admin time Closer to goal of fully electronic patient record Enhanced audit on patient care. An electronic discharge advice letter will be produced which will result in fast transmission of structured and complete data to primary care. Improved discharge efficiency 						
<p>3.4 Mandate Ward Clinical Workstation</p> <p>WCWS is a central application and launch pad for inpatient clinical and business management. It provides for real time clinical management of inpatients and their data. It allows for all standard administration such as admission, discharge and transfer but additionally maintains significant clinical functionality including for example clinical notes, maintenance and management of reports, handover (nurses and Doctors), letter production on discharge, Nutrition & Hydration, etc. Mandating the ADT aspect of this system will facilitate live bed management capability.</p>	<ul style="list-style-type: none"> Reduction in time between discharge and availability of information to primary care teams Reduction in letter production costs. Reduction in Clinician admin time Closer to goal of fully electronic patient record Enhanced audit on patient care. Real time bed management possible if all users input information promptly and accurately Notes/activities are recorded against the patient - if the patient is transferred notes are immediately available to the receiving wards. Notes can be retrieved for subsequent admissions. Supports discharge planning process and provides the necessary information to resolve long lasting issues around ATOC 						



Theme 4 – Order Comms							
<p>4.1 Implement TRRR Test Requesting and Results Reporting Project (TRRR) will introduce electronic pathology test requesting functionality within WCP.</p>	<ul style="list-style-type: none"> • Clinicians are able to request tests across pathology disciplines • Clinicians have immediate access to reports and investigations • There is a comprehensive audit trail • Clinicians are able to create a Top 10 list of their most requested pathology tests, to speed up the requesting process • Clinicians are able to view previously ordered tests to avoid duplication of test request 	✓	✓	✓	✓	✓	✓
Theme 5 – Outpatient ePrescribing							
<p>5.1 Outpatient ePrescribing Cardiff and Vale UHB secured funding from WG for an Outpatients E-Prescribing System (as did Cwm Taf HB previous year) and has procured a system for printing prescriptions for patients to take to Community Pharmacies. Doctors are currently unable to send patients to community pharmacies until the UHB has a system that can print WP10 prescriptions. The E-Prescribing system will link to the Hospital Pharmacy System and Formulary and helps to manage costs and workflow, benefiting the health board in both areas.</p>	<p>Benefits are clinical, operational and patient safety, financial/resource utilisation and facilitation of audit and peer review. Specifically, the implementation of the E-prescribing:</p> <ul style="list-style-type: none"> • Will reduce the risk of prescribing errors as all complex dosage calculations are completed automatically by the system, and a record of individual drug/dose adjustments is retained for future reference. • Will improve communication between clinicians regarding changes in treatment plans both within the health board and for patients whose treatment may be given in another health care setting outside C&V. • Allows immediate access to pathology and other results • Will enable clinicians to access details of the drugs received by patients. Access to accurate contemporary information is key to patient safety and would only be possible through an electronic prescribing system. • Will significantly reduce potential prescribing errors, improve the service for patients, and lower workload for staff. • Will deliver financial benefits through improved patient scheduling and more effective prescribing. • It will significantly reduce cost associated with avoidable drug wastage. • Reduced phone calls • Improved adherence to formulary and reduced drug costs 	✓	✓	✓	✓	✓	✓
Theme 6 – Medical Records lite/paper lite NHS							
<p>6.1 Implement eCommunications WCCG Phase 2 will provide capability to transfer clinical information securely from secondary to primary care via WCCG. The Clinical Reference Group and the NWIS Delivery and Implementation Group have agreed the priorities for Phase 2. These are:</p> <ul style="list-style-type: none"> • e-Clinic Letters / e discharge pilots (for HBs without MTED) • Supplementary Messages pilot – BCU • Powys Cross Border Referrals – roll out to continue firstly to remaining Powys practices followed by agreed English Border Trust • A small pilot sending referrals to dental specialties. 	<ul style="list-style-type: none"> • Staff efficiencies • Paper and postage savings • Improved communication • Communication of real time information • Savings in primary care 	✓	✓	✓	✓	✓	✓
<p>6.2 Upgrade Existing Medicode Software to Full Server Installation</p>	<ul style="list-style-type: none"> • Upgrade recommended in recent WAO audit of clinical coding. • Would provide UHB with same toolset as other LHBs and would be more efficient from a coding and maintenance perspective. • The increase in efficiency would increase productivity of coders in turn improving data quality 	✓	✓	✓	✓	✓	✓
<p>6.3 Data Quality Analytics Solution for Clinical Coding. This module enables the introduction of e-coding.</p>	<ul style="list-style-type: none"> • Live solution for identifying areas where clinical coding is incomplete or potentially inaccurate; designed to reduce risks of inaccurate reporting. • System would have to pay for itself in future years through improved efficiency within the Department. • This would be the first installation in Wales and could help re-establish the UHB as the leading organisation amongst the Celtic nations. Dependent on upgrading to a server installation. 	✓	✓	✓	✓	✓	✓



Theme 7 – Post free/paper lite NHS									
<p>7.1 Implement eCommunications</p> <p>WCCG Phase 2 will provide capability to transfer clinical information securely from secondary to primary care via WCCG. The Clinical Reference Group and the NWIS Delivery and Implementation Group have agreed the priorities for Phase 2. These are:</p> <ul style="list-style-type: none"> • e-Clinic Letters / e discharge pilots (for HBs without MTED) • Supplementary Messages pilot – BCU • Powys Cross Border Referrals – roll out to continue firstly to remaining Powys practices followed by agreed English Border Trust • A small pilot sending referrals to dental specialties. 	<ul style="list-style-type: none"> • Staff efficiencies • Paper and postage savings • Improved communication • Communication of real time information • Savings in primary care 							✓	✓
Theme 8 – Patient Safety									
<p>8.1 Implement WCP</p> <p>WCP gives doctors and nurses a single immediate view of the important data needed to support vital clinical decision making. It will also enable them to carry out key tasks e.g. ordering tests, prioritising referrals and preparing discharge notifications.</p>	<ul style="list-style-type: none"> • Implementation of the WCP will result in improved timeliness and availability of relevant clinical information • The production and administration of paper results will be reduced or eliminated • The transcription of pathology and radiology orders will be reduced or eliminated • The ordering of unnecessary tests will be decreased, resulting in reduced costs to the organisation • Telephone transcription of urgent results will be reduced or eliminated • Implementation of the WCP will contribute significantly to the evolving 	✓	✓	✓	✓	✓	✓	✓	✓
<p>8.2 Patient Wristband system</p> <p>The UHB is non-compliant with a national patient safety agency mandate that patients should be identified by bar coded wristbands. A proposal has been submitted to the Quality and Safety Committee to implement this initiative.</p>	<ul style="list-style-type: none"> • Improves the accuracy of patient identification • Decrease in medical errors due to patient misidentification • Fast patient identification allows medical staff to work more efficiently • Easy capture and storage of patient information 							✓	✓
<p>8.3 eDatix</p> <p>Support the implementation of the upgrade of the eDatix System</p>	<ul style="list-style-type: none"> • Effective incident and complaint reporting enables quality improvement through shared learning • Datix allows the user to compare, contrast and prioritise the incidents that occur in their organisation 							✓	✓
Theme 9 – TeleHealth									
<p>9.1 – Microsoft Lync VC for Virtual Clinics, MDTs, nursing homes and staff training</p> <p>Video-conferencing has the potential to dramatically improve communications within the UHB, the wider NHS Wales and with our patients. Early trials using Jabber and Webex have established a body of knowledge, creating a proof-of-concept from which to pilot the pending national solution, Microsoft Lync. Microsoft will be supporting the pilot infrastructure through a third party at zero cost whilst the NWIS infrastructure is established. Microsoft Lync integrates with Office 365, Microsoft's subscription-based model; as such this pilot will include a pilot for Microsoft Office 365.</p> <p>It is proposed that the UHB pilot the use of "Lync" in four areas – Virtual Clinics, Virtual Multidisciplinary Team Meetings, Nursing Home Communications and Webinar Staff Training. It is anticipated that each usage scenario will demonstrate distinct benefits</p>	<p>Nursing Homes</p> <ul style="list-style-type: none"> • Reduces unnecessary admissions and reliance on ambulance transfers to hospital <p>Virtual MDTs</p> <ul style="list-style-type: none"> • Avoids unnecessary travel • Supports timely discharge with quicker release of 'blocked' beds • To enable healthcare professionals to efficiently plan their interventions based on the symptomatic needs of the service user <p>Virtual Clinics</p> <ul style="list-style-type: none"> • Avoids unnecessary travel for both patients and clinicians • Reduces DNA rate • More efficient use of specialist Clinician resource in remote locations <p>Webinar staff training</p> <ul style="list-style-type: none"> • Avoids unnecessary travel • Increases attendance at training sessions • Improves corporate training policy compliance 							✓	✓
<p>9.2 – Bluespир</p> <p>The development of an interfacing portal to support pre-op and post-op T&O activity would allow information to be collected remotely over the internet via secure interfacing between the UHB and Bluespир</p>	<ul style="list-style-type: none"> • A decrease in the number of outpatient appointments required • Improve communication of clinical outcomes to the patient • Ability to audit the benefits of surgical procedures post operatively 	✓						✓	✓

9.3 - Florence Simple Telehealth Florence Simple Telehealth enables long-term trending of a patient's condition with a minimum of clinician involvement, enabling patient's to better manage their long term conditions, and providing clinicians with rich data on which to base clinical decisions. The initial license purchase is being made by the Executive Director for Public Health, and will need implementation support for the pilot and wider roll-out.	<ul style="list-style-type: none"> To educate service users on their chronic condition, symptoms and triggers that require the input of a health care professional To enable individuals to take greater control of their life with an improvement / increase in quality of life To increase the ability of individuals with chronic conditions to live safely and independently for as long as possible in their own homes Improved identification of negative trends in patient health enabling early interventions Reduced demand on emergency care with shorter hospital stays More efficient use of specialist Clinician resource in remote locations To enable out of hours teams to access information regarding a patients 'steady state' and triage more effectively using up to date vital signs and symptom data. 						✓	✓	✓
9.4 - Time for Medicine <ul style="list-style-type: none"> Immunology - roll out of immunology project Tele-dermatology - explore the potential for time for medicine in dermatology 	<ul style="list-style-type: none"> A decrease in unnecessary referrals 	✓					✓	✓	✓
Theme 10 – BYOD/Apps development									
10.1 Real time access to results and clinical portal development (and any other relevant clinical business systems) The IM&T Department will explore the potential for the delivery of Clinical and Business Apps for BYOD devices. In the first instance this will involve exploring the development of an App that is that is connected securely and safely to the BYOD solution and able to view a "blood result" that is rendered correctly onto a mobile phone. This will pilot the concept of "apps" that support access to Clinical and Business applications that cannot be directly viewed by a browser on the personal device.	<ul style="list-style-type: none"> Access to Business and Clinical Information on a personal devices safely and securely. Access "any where any time" Improve employee productivity and patient care Able to retain control over securing the network Allows staff to use the devices that they prefer for work purposes A sustainable model for provision and maintenance of devices 						✓	✓	
Theme 11 – Corporate Systems Initiatives									
11.1 ESR Self Service Within Wales, the priorities for the development and implementation of ESR functionality have been set by the All Wales Workforce Information Systems Board. These priorities primarily related to the roll out of the Manager/Employee Self Service/Organisational Learning (MSS/ESS/OLM) modules of ESR within the Finance, IM&T and Workforce and Organisational Development Functions of UHB's.	<ul style="list-style-type: none"> Cost savings – direct & Indirect Empowerment of Managers Improved workforce intelligence (more real time data) Empowerment of staff re completion and validation of personal data Reduced data input by payroll Standardised learners' processes Managers/staff able to book training on line. 						✓		
11.2 eExpenses Roll out of e-expenses system across the UHB and ongoing maintenance.	<ul style="list-style-type: none"> Cost savings Standardised /leaner processes 						✓		

9.7 Improving our Infrastructure

During 2014/15, we completed a comprehensive assessment of the state of our estate. It confirmed that we have a significant challenge in ensuring that our infrastructure (buildings and equipment) remain fit for purpose to deliver the services we are planning. Many of the facilities in which we deliver care are not of the standard we would like, reflecting that they are no longer functionally fit for today's healthcare, and have not been maintained to the levels necessary. Inspections, reviews and CHC visits often highlight poor estate as a concern. As described in Section 8 – Finance, we have a significant estates maintenance and equipment (IT and medical) replacement backlog, which was risk assessed during 2014/15 to inform future plans.

Our strategy over the next three years is to address the urgent priorities for equipment replacement and estates maintenance as the importance of good quality facilities to patient outcomes and infection prevention is well recognised, whilst supporting the UHB to provide modern and effective services that provide good service user experience. This builds on the significant progress made in 2014/15 to address some of the major estate and equipment risks, supported by additional discretionary funding received during the year.

Over the course of this IMTP, we will continuing to implement the major capital schemes already in progress (including those in SOP development) to replace estate that is not fit for the delivery of modern care. We will also continue to reduce our estate footprint where appropriate – facilitated by new models of care and new ways of working – so that we are in a better position to maintain our estate going forward. During 2015-16 it is proposed to further rationalise the UHB assets. It is currently planned to dispose of the following properties which are not needed for the delivery our operations:

- CRI West Wing;
- Lansdowne Hospital;
- Colcot Clinic Barry; and
- Radyr Health Centre.

We will also be improving the delivery of estates maintenance function using benchmarking information to identify areas for targeted activity to improve productivity and outcomes.

We are also looking further ahead to develop a ‘masterplan’ for our estate, reflecting the requirements falling out of our clinical services strategy, the SWP and opportunities for collaboration with partners – particularly Cardiff University and Cardiff Council and the Vale of Glamorgan Council – to develop shared assets in the community where possible.

Discretionary Capital

The review of our estate and equipment has identified a list of capital developments and equipment replacement requirements totalling over £153m. Despite the additional discretionary capital allocation which is being made recurrent, the investment needed is significantly above the funding available. Therefore a prioritisation framework has been agreed by the Major Capital Working Group to guide the allocation of funding. In order to address the most urgent priorities and to deliver the developments needed to support achievement of our service change and financial savings plans, additional discretionary capital is being sought from Welsh Government.

Over the next three years our aim is to:

- Ensure that all business cases seek to minimise the footprint of UHB buildings, while meeting the operational needs of the UHB, including flexibility of use.
- Address potential catastrophic equipment failures (IT and medical equipment)
- Address statutory compliance maintenance issues.
- Prioritise developments that are critical to the delivery of service change and saving plans.
- Ensure Clinical Boards have direct involvement in the management of the UHB discretionary Capital Programme. This will be achieved via wider membership arrangements of the Discretionary Capital Management Group.
- Ensure the UHB mandatory Capital Resource Limit target is achieved.

The UHB recognises that it needs to make significant investment in refurbishing the existing estate, both in the community and hospitals, to enable us to provide care from fit for purpose accommodation. This will need to be a significant call on our spending in future years. The need to expand primary care facilities to respond the rapidly growing population, either by with developing existing practices or establishing new provision (and probably both) has become a higher priority and we are looking to work closely with Welsh Government officials to agree the most appropriate routes to address this issue.

Further detail is provided in Chapter 7.

Strategic Projects



Currently there are four large projects in development including the following:

- The Children’s Hospital for Wales Phase 2 is a state of the art building measuring 15,500m² dedicated to child health within Wales. The project with a capital cost of circa £70m was handed over January – March 2015. A number of departments relocated to the new building in February/March with the final move (Radiology) due to take place in April;
- £88m Adult Mental Health Unit (Hafan y Coed) at Llandough (UHL) is now taking shape – 2015/16 will see the building completed and the service preparing for the move (April 2016);
- Redevelopment of the entrance to UHL (completion due summer 2015) to provide improved patient and visitor information and experience through the development of a space for exhibiting art – linked to our art and health work – and a coffee shop and retail outlets; and
- The bathroom replacement programme reinstated in 2014/15 following feedback from Trusted to Care, HIW, CHC and internal inspections will be continued – the scale of the programme will be determined by the capital available and the impact on operational service delivery.

There are also a number of future projects currently being developed through the WG full business case procedure that are in the early stages of planning and development. Further detail on all these schemes is contained in previous sections, and detail on the expenditure of all major capital schemes is set out in Chapter 7.

All strategic capital projects are reviewed monthly at the Capital Management Group, which is chaired by the Chief Executive and reports into the People, Performance and Development Committee of the Board. There are also separate Project Boards that meet on each project, chaired by the Director of Planning. There are also a number of sub project groups that provide user input and guidance.

A number of schemes are also in the planning stage, including:

Scheme	Stage	Anticipated Completion Date
Making a Difference: Redevelopment of specialist spinal and neuro-rehabilitation services.	Unapproved Outline Business Case with WG.	January 2016 (subject to business case approvals).
Programme Business Case for Locality Health and Treatment Centres across UHB footprint: <ul style="list-style-type: none"> • CRI Phase II; • Whitchurch; and • Barry. 	Overarching Programme Business Case development. Strategic Outline Case (SOC) for CRI Phase II Locality Health and treatment Centres.	In discussion with WG.
Neonatal Intensive Care Capacity (critical to delivery of South Wales Programme).	Process to be agreed with Welsh Government.	Business Case Completion May 2015.
Cardiology Out Patients Department & Cardiac Physiology Suite at UHW.	Development of Business Justification Case.	2015/16.

Ward Refurbishment Programme (UHW/UHL).	Development of Strategic Outline Programme.	Summer 2015.
Bone Marrow Transplant Unit.	Development of Business Justification Case following WHSCC activity business case approval.	2015/16.
Renal Dialysis Unit (relocation from CRI West Wing & refurbishment Suite 19 UHW).	Development of Business Justification Case.	2015/16.
SWP Implementation (South Wales Health Collaborative).	Development of programme to deliver necessary changes.	Delivery required in first 6 months of the year.
Theatre refurbishment.	BJC to address urgent need to replace old plant and ventilation systems.	April 2015.

We have also identified in Chapter 7 the priorities for which capital will be required during 2015/16. The priorities exceed the funding available through the discretionary capital allocation.

Maintaining our Estates

The annual budget allocation for estates maintenance is just over £5m, with a ring fenced allocation to address estates backlog issues annually of £250,000. Each year, the department undertakes 14,985 planned preventative maintenance tasks, along with 37,876 break-down requests – in 43 individual buildings. The department will focus on local management on the major UHB sites and an increased emphasis on maintenance of community buildings, through increased flexibility and efficiency across the workforce. The Department clearly demonstrates good value for money in that the maintenance of their estate is a much less than all of their peers. Annual benchmarking information suggests that the UHB spends considerable less per square metre on maintenance than other health boards in Wales or peer organisations in England. The restructuring of the estates function – which will be completed in 2015/16, will ensure that the resource is delivering the best possible outcomes as investment in maintenance (with the exception of statutory maintenance) is not currently affordable within the financial constraints we are working in.

Hospital/Trust/UHB	Floor Area M ²	Maintenance Budget £	WTE	£m ²
Barts and the London NHS Trust	295,290	11,920,234	126	40.40
Imperial College Healthcare NHS Trust	294,591	7,855,583	152	26.63
Central Manchester University	279,514	10,338,644	121	36.92
Leeds Teaching Hospital NHS Trust	522,323	11,161,298	217	22.32
Nottingham University Hospitals NHS Trust	310,463	8,109,737	161	26.16
University Hospital of Leicester NHS Trust	278,747	5,598,254	126	20.14
Oxford Radcliff Hospitals NHS Trust	316,688	8,634,772	148	27.30
Average	350,000	6,903,456	141	26.58
Cardiff and Vale UHB	349,725	5,375,955	114	15.36
University Hospital of Wales	185,875	2,191,144	74	11.78
UHL, Barry and CRI	56,732	1,525,883	28	26.89
Whitchurch, Rookwood, Community	107,118	1,658,928	12	15.48
All Wales Average	1.675,142			24.85

Table: Comparison 2013-14 Estates Services cost and workforce comparison

Our priorities for 2015/16 are to continue to develop the estates maintenance function to it is responsive to the needs of the clinical boards, and to ensure that our statutory maintenance programme is progresses, using specialist expertise where necessary.

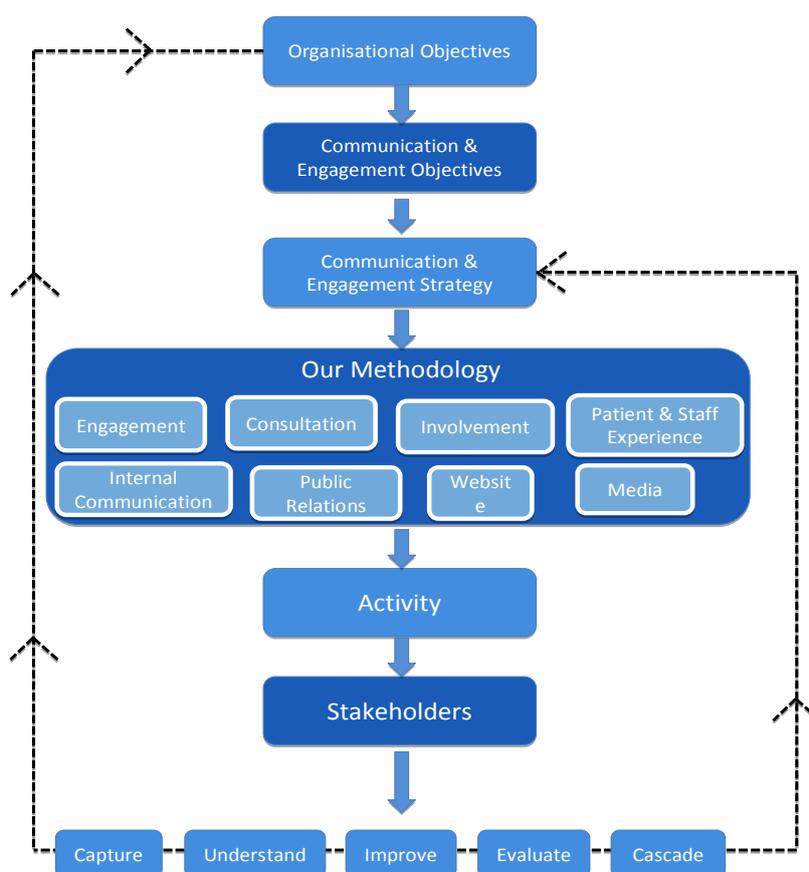
9.8 Continuous Engagement and Communication

9.8.1 Good Communications Matters

We know that effective communication and engagement makes a significant contribution to improving organisational performance – “Leadership and engagement for improvement in the NHS. Together we can.” Report from The King’s Fund Leadership Review 2012. The UHB’s stakeholders need to have informed and support our mission and vision, and understand the changes needed to make the vision a reality for the people of Cardiff and the Vale of Glamorgan, and the wider population we provide care for. We are embedding the principles of co-production into the way we do business to make sure our services are designed around the people who need them and not necessarily how we chose to set them up in the past.

At the end of 2014/15, we used the findings of our communication survey to assess how well we currently communicate across the organisation and have revised the communication strategy to reflect the feedback we received. We know that good staff communication is important so that there is a shared understand of what it is we want to achieve and how we are going to achieve it. From a financial perspective, the benefits of an engaged workforce are compelling, with numerous studies linking employee engagement with improved productivity – and our communication survey and regular staff surveys tell us we have more to do.

Our approach to communication within the UHB and outwith stakeholders is summarised in the diagram below:



Our communication objectives for the 2015/18 period, as detailed in our Communication Strategy and Action Plan, are to:

- Communicate our revised vision and strategy effectively so that a person's chance of leading a healthy life is the same wherever they live and whoever they are;
- Increase the avenues for promoting our goal of improving health and wellbeing and reducing health inequalities;
- Provide a professional communications input into transformation programmes and service priorities.
- Development of a robust stakeholder engagement programme to inspire confidence in the care its offers and services provided;
- Improve staff communication and engagement across the health board and provide support for work to recruit and retain the best staff and initiatives to reduce the sickness absence level, measured through HR performance metrics and staff surveys;
- Support the quality and safety agenda by championing the sharing of information, learning, best practice and celebration of success across the UHB;
- Enhance our reputation as a highly trusted, expert and competent organisation by providing a professional, highly skilled, resilient corporate communications support, with increased positive media coverage of our work;
- Showcase our work in leading research and innovation locally, across the UK and on the global stage; and
- be innovative and creative in the deployment of health-related communications – using all forms of communication, to help achieve our goals.

9.8.2 Continuous Engagement on Challenges, Choices and Change

This plan sets out a programme of change on which we are engaging with stakeholders, including those who use our services (or who may do in the future). Some of the changes may require us to undertake more formal engagement and consultation in line with good practice and Welsh Government expectations and requirements. Across the organisation, efforts are being made to strengthen our approach to continuous engagement with citizens and stakeholders based on the principles of co-production.

This work is part of a wider range of communication and engagement activities we are taking forward following a Board Development session held in June 2014, facilitated by Participation Cymru. This gave board members the opportunity to explore issues around the purpose of engagement, who we want to engage with, and how we want to engage, and has shaped the approach we are taking in 15/16. The board expressed a desire to be more visible in our communities, as reflected in the communication objectives listed above and views are directing the UHB approach, and a more personal approach to engagement. Our Chair and Vice Chair are leading a programme of engagement events - conversations - with local community and third sector organisations. These involve discussing the challenges and choices facing the UHB and exploring issues of interest or concern about local health services. This has included sessions with 50+ Forums in both Cardiff and the Vale of Glamorgan, and workshops with Cardiff Youth Council and Vale Youth Forum and the programme will continue in 15/16.

'Challenges and choices' was also the theme of the AGM in September, where the formal part of the event was followed by an interactive and networking session where our clinical boards began to engage on issues and ideas for service change that they are looking to progress this year, and which have informed their IMTP.

We have also been working collaboratively with our strategic partners through the 'Cardiff Debate'⁴, the current consultation on the future of public services in Cardiff, designed to change the way of doing things to ensure key services are based on the needs of local communities and are sustainable in the long term. This enabled us to have conversations with the public about the challenges and choices facing the public sector as a whole. By piggy-backing on to community events and running some interactive drop-in workshops, partners have started to share information about the scale of the challenges, identify people's service priorities and

⁴ The Cardiff Debate is three years of events, workshops and discussions on the future of public services in Cardiff; it is supported and represented by the member organisations of the Local Service Board.

encourage the public to help identify different ways of delivering services. The Vale Local Service Forum, an annual stakeholder event hosted by the Local Service Board, also provided an opportunity to share challenges being faced by partners and explore opportunities for working together to deliver services differently. These events have informed this plan.

Engagement on Service Change

During 2014/15 we worked closely with the Community Health Council to undertake engagement on specific change proposals which have now been implemented. Building on our shared lessons learned from our engagement work, and reflecting on the Ann Lloyd review⁵, we have been working with the Cardiff and Vale Community Health Council (CHC) to clarify shared expectations and place more rigour around processes to support decision-making on implementation of service change, and to facilitate agreement on what requires further engagement or consultation.

A flow chart has been jointly developed by the UHB and the CHC that sets out the process and decision-making arrangements that have been agreed between the two organisations, to support engagement on service change. The chart illustrates expectations around themes of continuous engagement and co-production and seeks to demonstrate how effort expended on these can lead to a reduced need for more formal engagement or consultation.

In addition, we have produced an internal Practical Guide to Engagement which provides advice about how to undertake engagement when a need for service change has been identified. It is accompanied by a set of resources including template documents e.g. Engagement Plan template and 'Starter for Ten' list of local stakeholders and a guide to third sector organisations that support protected characteristic groups, produced collaboratively with the Health and Social Care Facilitators in both County Voluntary Councils. The approach is based on the [National Principles for Public Engagement in Wales \(2011\)](#) developed by Participation Cymru and adopted by the UHB in 2012. Both the flow chart and practical guide highlight the importance of undertaking engagement work in tandem with Equality Impact Assessment activity.

An example of a significant piece of engagement undertaken in 2014 was work to support improvements in services for Older People, which led to a reshaping of clinical gerontology services. The UHB worked with the CHC and third sector colleagues to engage with a wide range of staff, service users and their families and wider stakeholders to share the rationale for change and facilitate service redesign and improvement.

We are also developing stronger links between the clinical boards and the CHC to foster good working relationships and shared understanding of the issues and risks.

Engagement with the Third Sector

We recognise that it has never been more important for us to work closely with partners to deal with serious health challenges facing our population and to work together to develop solutions. Third sector organisations in Cardiff and the Vale of Glamorgan are some of our key partners and our relationships with them are many and varied. They are a source of volunteers, information, advice and expertise; they assist us in engaging with geographical communities and communities of interest; and we commission them to deliver range of services to some of our most vulnerable citizens on our behalf. Our engagement work on our clinical services strategy has had good input from a range of third sector organisations and the emerging models of care reflect the very important contribution that the voluntary sector plans in delivery patient care and supporting people in the community.

Co-production

To support the development of our ten year Clinical Services Strategy, 'Shaping Our Future Wellbeing', we have been holding a series of co-production workshops involving clinicians and service users and carers in shaping future service models. Following conversations with public, partners and staff, the UHB has agreed a set of clinical services principles which will set the direction to enable us to 'Care for People; Keep People Well'. Starting with some examples of patient experience, the workshops have provided an opportunity to test what these principles mean in practice and to identify the outcomes that really matter to people. A visual

⁵ 'Lessons Learned Review into NHS Service Change Engagement and Consultation Exercise by Health Boards'

minute taker has been capturing discussions; the outcome of the workshops will inform the next iteration of the Strategy which will be the subject of further engagement in the spring. Feedback from the workshops is demonstrating that participants have liked the format of the events and that everyone is learning from each other.

The UHB Stakeholder Reference Group (SRG) is growing in influence and confidence with a consistent membership from a diverse set of partner organisations and sectors. The SRG is a way for us to engage with an informed group of stakeholders and use their input to help shape future plans and service models. The group has been regularly updated on the development of the IMTP and has provided advice on key messages to share with the public and partners.

We are now into the third year of implementing our Strategic Framework for Working with the Third Sector. This sets out our ambitions for working collaboratively with the third sector to enhance the lives of our population. It focuses on strengthening partnership working and seeking more integrated solutions to addressing increasingly complex needs. These ambitions are set around 4 priority themes with a corresponding action plan to take forward key pieces of work:

- Promoting and Improving Health and Well-Being – an increased role for the third sector in supporting action to prevent ill health and encouraging individuals to take responsibility for their own health. It aligns with the national drive for Prudent Healthcare which is all about achieving better care and value for money;
- Engagement with the Third Sector – effective partnership working between third sector, health and local government that enables better integrated planning and delivery of citizen-centred services;
- Service Design and Redesign – commissioning of co-ordinated and sustainable third sector provision which is outcomes focused, aligned to UHB priorities and provides value for money;
- Volunteering – creating a cohesive and innovative approach to volunteering in the UHB that ensures a safe, friendly and professional environment for the public to give of their free time to support clinical services and improve patient experience

An annual Keeping in Touch with the Third Sector event this year gave UHB staff the opportunity to talk to a range of Third Sector organisations, learn about how they are supporting our services, and how to signpost patients and carers to their services. During 2015/16 we will be building on our partnership with the third sector as we continue to shift the balance of care closer to home. We will be looking to secure external funding to support new approaches to enabling people to access the support available from the third sector in a more co-ordinated way.

9.8.3 Progressing Partnerships with our Local Authorities

Joint Planning to Meet Local Needs

Chapter 3 of this plan set out in detail how our population is changing, and outlined the key characteristics of our communities that shape demand for services. In particular the large variation in deprivation and health outcome, the significant numbers of children living in poverty and the growth in our older population, dictates the need for a strong working relationship with partners to ensure the wider determinants of health are being actively tackled. It also requires an alignment of service provision. The purpose of our joint working is twofold, to:

- Secure an improvement in health inequality within our community; and
- Meet the citizen and patient expectations of seamless service provision regardless of the host organisation.

In line with Welsh Government guidance on integrating partnerships and plans set out in 'Shared Purpose – Shared Delivery', we work closely with our partners on a shared agenda of securing better outcomes for the, with an emphasis on priorities, pace and performance.

In Cardiff, a collective vision and a set of high level priorities for the city are set around seven shared citizen outcomes. The Cardiff 'What Matters 2010:2020' ten year strategy and Delivery Plan can be found at

www.cardiffproudcapital.co.uk. Priority workstreams are currently being reviewed to ensure they continue to align to partner organisation priorities. Current programmes are: families and young people; education development; safer and cohesive communities; older people; emotional, mental health and wellbeing; healthy living; thriving and prosperous economy; urban environment.

In the Vale of Glamorgan, an integrated Community Strategy has been prepared around ten overarching priority outcomes. The Vale of Glamorgan Community Strategy 2011-2021 and Delivery Plan can be found at www.valeofglamorgan.gov.uk/communitystrategy. The Delivery Plan 2014-18 is structured around the three themes of the Welsh Government Tackling Poverty Action Plan; the three workstreams are: preventing poverty; helping people into work; mitigating poverty. This work sits alongside existing work to deliver the Community Strategy being undertaken through the LSB partnerships.

We are a joint signatory to both strategies, which are aligned to this plan, and our range of plans that sit below the IMTP, such as those improving mental health, developing dementia care, tackling smoking, obesity and unsafe drinking. The priorities reflect our local population assessment and needs and the public health priorities contained within the local public health plans. The Single Integrated Plans are key documents for us and inform our Clinical Board and UHB wide IMTPs; likewise, the changing needs which emerge from the development of our ongoing planning processes are fed into and inform the Integrated Plans on an iterative basis.

In both local authority areas, the development of integrated strategies has led to the establishment of new models of joint working that aim to provide a more effective and streamlined means of addressing the major challenges. Embedded within them is an emphasis on delivering outcomes, a business intelligence function, locality working, effective performance management and personal accountability. Partners typically include local authorities (social services, education, housing, economic regeneration), third sector, police, probation, fire and rescue, independent sector.

One example of where the strength of local partnership working has been demonstrated is the joint approach that has been adopted within both unitary authority areas to Welfare Reform. The UHB was involved in shaping local action plans which included innovative joint training sessions to front line staff and the introduction of staff and patient support on hospital sites.

Engaging with partners to help shape UHB service change plans is crucial to ensuring they are sustainable and that the impact of proposed change is explored collaboratively. The UHB is working with local authority colleagues to consider Council budget savings proposals in order to develop a shared approach to managing impact and mitigating risks.

Local Authority Local Development Plans (LDPs) are another key area of partnership working where a far more proactive approach has been established early on in the process to embed a commitment to health improvement outcomes into the LDPs and to involve UHB Clinical Boards in identifying infrastructure and service capacity implications. There has been significant input from the UHB to ensure that health and access to healthcare services is embedded across the plans including work to ensure a commitment to broader health improvement outcomes, access to well-maintained quality open spaces, active travel, access to health care facilities and access to a food growing environment. There is a commitment to work collaboratively to explore the development of multi-functional use community facilities that include health services and the use of the Community Infrastructure Levy to fund some elements of these facilities.

Co-production in the design and delivery of services is an approach increasingly being adopted by all partners in Cardiff and the Vale of Glamorgan. Notable examples where this is shaping service development locally include: Community Resource Team development with local authority and third sector partners to support people to regain and maintain their independence in the community; joint work with Welsh Ambulance Service, social care, General Practice and the hospital assessment units to produce pathways such as the Falls Pathway; and work with the Independent Sector on the commissioning of long term care in care homes.

Local Service Boards

Each Local Authority currently hosts a Local Service Board. Details of how they operate and priority work programmes can be viewed via the web links above. A Cardiff and Vale Joint Local Service Board has now been established with the purpose of working collaboratively across organisational boundaries to agree joint action to achieve better outcomes for citizens in Cardiff and the Vale of Glamorgan, in line with the Cardiff *What Matters* Strategy 2010-2020 and the Vale of Glamorgan Community Strategy 2011-2021. The joint LSB is overseeing a work programme that includes the redesign of health and social care (see Regional Collaboration Fund below), targeted focus on preventative interventions with vulnerable groups and embedding co-production and citizen engagement in the development and delivery of services. The joint LSB also provides a forum for informing and shaping local responses to the Public Services Reform agenda including forthcoming legislation - the Social Services and Well-being (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Bill. It will also be the vehicle for working through the implications of the Welsh Government response to expressions of interest in voluntary local authority merger submitted at the end of 2014.

We are represented on the Regional Collaboration Fund (RCF) Board, and three of the projects have direct involvement of the NHS – Integrated Health and Social Care; Sexual Assault Referral Centre and the Alcohol Treatment Centre. A joint LSB response to a 50% reduction in the 2015/16 RCF grant has been agreed for next year; work with Welsh Government and wider partners to agree sustainable delivery solutions are being urgently pursued.

In Cardiff, 6 Neighbourhood Partnerships provide a focus for developing local solutions to local issues identified through quantitative and qualitative needs assessment. These six groups have a clear link to the UHB Locality Teams and are aligned to the GP clusters, with two being co-chaired by UHB Locality Managers. Neighbourhood Intelligence Reports are updated every six months and provide access to local intelligence that can support tailoring of services to better meet local need.

In the **Vale of Glamorgan**, an updated Unified Needs Assessment has been co-ordinated by the Vale LSB Business Intelligence Group to support the development of a Delivery Plan for 2014 – 18. This needs assessment has been shared with UHB Clinical Boards, facilitating alignment of the Delivery Plan with IMTP service change plans.

There have been open discussions with both local authorities during the development of our Plans for 2015/16 so that we each understand each others' service, workforce and financial pressures, and to consider how we can support services together during this time. We have also agreed that we will share any proposed changes to, for example, SLAs/contracts with Third Sector organisations so that we can understand whether there will be a disproportionate impact on any due to our collective actions. Conversations with local authority colleagues have emphasised the need to establish a collaborative approach to managing the issues around the co-dependencies of our services and how we can work in an integrated way to deal with the severe financial pressures while minimising the risks to the population we jointly serve. There is recognition that there is a real opportunity to use the need to make savings as a catalyst to be much more radical on the integration front.

We also continue to work closely with other cross boundary groups such as the Area Planning Board for substance misuse services and the Local Safeguarding Children Board, as set out in last year's IMTP.

10. Organisational Development

10.1 Achievement in 2014/15

Workforce achievements are integrated within Section 1 of the IMTP and further examples are contained throughout this section. Achievement against the workforce savings plan in 2014/15 of approx £22.1m (including £6.7m from national agreements) is outlined in section 7.8. Whilst the UHB has achieved a significant WTE reduction during 2014/15 of 263.72, not all the schemes have been delivered as yet and some will be delivered by quarter 4 and others rolled over into 15/16. It is also noted that workforce investments have been made through 14/15 to deliver against emergency measures, USC and RTT.

10.2 Workforce Planning Assumptions

The high level workforce assumptions over the IMTP 3 year period include:

- Continuing requirement to reduce workforce cost to underpin 10% savings identified in financial framework;
- Meeting short term capacity requirements, especially in nursing; and need to flex workforce recruitment to support winter pressures and unplanned capacity requirements [further outlined in Chapter 10.8];
- Increasing need to develop future workforce; new ways of working and innovative workforce transformational change;
- Workforce impact and drivers associated with reconfiguration of Acute Services identified in the South Wales Programme;
- Increasing need to engage with workforce as demand for service increase;
- Increasing need to develop organisational leadership and management skills;
- Increasing need to embrace new technology; and
- Increasing need for accurate workforce information and analysis.

10.3 Strategic Organisational Development

The UHB strategic context and vision is outlined in Chapter 3. During 2014 the UHB has begun to articulate further its longer term ambition to be a leading integrated health and care organisation. Fundamental to achieving this ambition is the **culture** and **sustainability** of our workforce. By reinforcing our values we aim to create a great place to work and invest in leadership and management development to enable us to deliver the best service and change to Empower the Person: Staff, Patient and Citizen.

One of the four component parts of the **Organising for Excellence** Strategy is **Good to Great**, which aims to:

- Grow and develop new and existing clinical leaders who will take us forward;
- Train, develop and recruit the best managers;
- Reconnect with our staff so we feel we are one team together;
- Help staff develop improvement skills and do improvement work;
- Support and further develop an ambition for excellence;
- Work more successfully with our partners;
- Find a way to implement technology to help us do a better job; and
- Create the climate for innovation to flourish.

In order to deliver Good to Great, assumed demand and expectation of the UHB, we have developed a number of **high level workforce objectives illustrated below**. These also align with the NHS Wales Working Differently, Working Together Framework. These objectives have been the principles of the workforce framework used by Clinical Boards during the 2015/16 IMTP refresh.

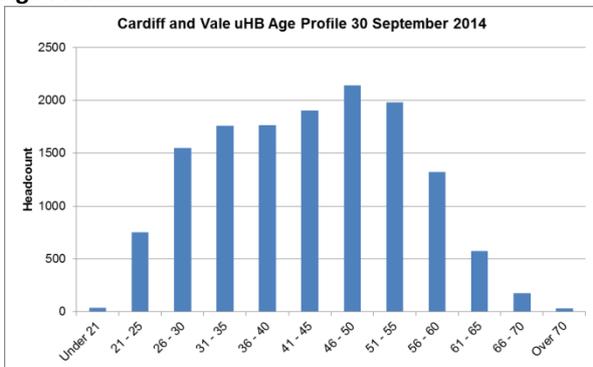


During 2013, the Workforce and OD team was reorganised to respond and meet the needs of the new organisation operating model. The new roles established as Head of Workforce & Organisational Development for each Clinical Board are now embedding. During 2014 the structure was strengthened by the appointment of Assistant Heads of Workforce & OD, Band 7. These appointments were made from within the existing team. The Workforce & OD Profession IMTP outlines the structure and objectives more fully.

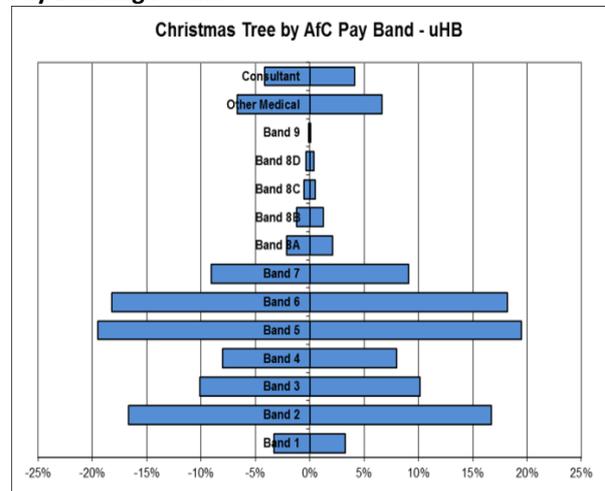
10.4 Workforce Profile

The following charts provide an overview of the UHB staffing profiles.

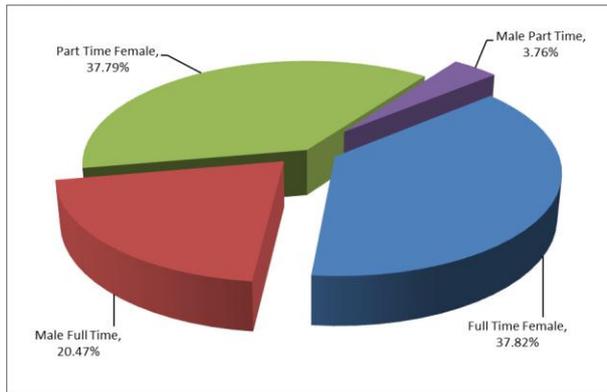
Age Profile



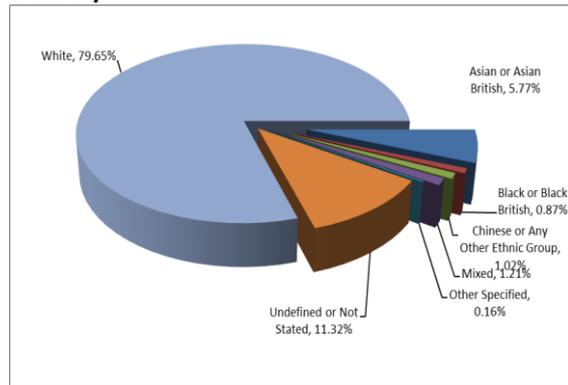
Pay Banding Profile



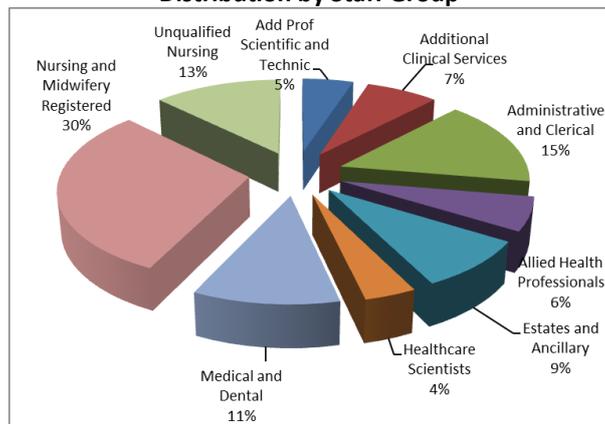
Gender



Ethnicity



Distribution by Staff Group



10.5 Engaging Leaders and Culture Change

Developing Leaders and Managers

Within **Organising for Excellence** there are clear mechanisms for ensuring that responsibility for delivery rests at the levels most appropriate for effective decision making and assurance mechanisms that will link accountability for those decisions through the management structure of the organisation. This process will enable frontline clinicians and support staff to serve the public with structures and process built around them to support them.

It has been recognised that to achieve the goals set out within Organising for Excellence there is a need for a robust Clinical Leadership Development Pathway which has been designed to provide the appropriate skills at all levels of leadership from the front line to Clinical Board Director and Executive Director levels.

Following the appointment of Clinical Board Directors and Heads of Operations and Delivery in 2013, work has taken place to identify the necessary development interventions required to support this change. Many of these development requirements will be individual to the leader concerned; however there are core requirements which will enable a consistent understanding and practice of leadership and management behaviours and skills which can best be addressed through group learning activities. To ensure that Clinical Boards are able to discharge their responsibilities under these arrangements there is an authorisation process which requires them to present evidence of Board maturity. The seven criteria used for this process are based on leadership skills, engagement with staff and stakeholders, embedding values and behaviours and form a robust assessment framework to identify current maturity and integrated development plans to address any gaps in Clinical Board performance. The process was refreshed during 2014 and a further set of development needs identified.

The organisation has also given a clear commitment to provide Clinical and Community Directors along with Clinical Board Directors access to the best quality training, mentoring and coaching to ensure they can best realise their individual potential and also work together to achieve changes needed within the organisation. It is the stated intention of the UHB to support leaders within Clinical Boards with access to cutting edge, evidence based leadership development which would bring best practice into the UHB and support those leaders through the development of mature Clinical Boards.

This is then reiterated through every level of Leadership and Management Development with the commitment to align programmes with the Francis Report Recommendations in respect of Management competencies and the plan to implement the All Wales Management Passport. In addition the organisation will be implementing a system that supports the identification and development of leadership potential demonstrated by more junior clinical staff to ensure effective succession planning to support the future of the clinical leadership model.

The mechanisms and roles described above will be further supported by a **Board level development programme** to ensure that the Board acts together to discharge its key strategic and accountability role. The programme encompasses diagnostic tools to facilitate a team development process using the identification of behaviours which manifest themselves within the Board and which support or are detrimental to effective team decision making with appropriate interventions being designed to support the continuous improvement and performance of the Board. The results of a Board Maturity Analysis will be used in addition to interventions reinforcing models of service improvement that challenge the status quo in terms of service delivery and achievement of clinical targets and support a climate of continuous improvement integrating the detailed recommendations from the Francis Report.

Integral to **Organising for Excellence** is the **performance and accountability management process** to ensure strong governance and delivery. This process will influence individual performance management arrangements at local levels through Personal Appraisal Development Reviews and Consultant Appraisals. Objectives will be aligned to the objectives of Clinical Boards which in themselves are aligned to the clear and focussed objectives of the organisation within the organisational strategy.

There are key education and development frameworks which underpin the development of performance, skills and culture over the three year planning cycle. These are:

- **'Improving Quality Together'** the Cardiff and Vale model for enhancing service improvement skills and competencies across all staff groups and at all levels within services;
- **Coaching Framework** to develop and sustain a coaching culture where staff are constructively challenged and developed by line managers; and
- **Maximising Potential Framework** to identify and put in place appropriate development plans for staff with leadership potential.

During 2014/15 the UHB delivered the following:

- IQT, 1354 staff trained in service improvement - Bronze/Silver practitioner levels;
- Coaching, 189 staff trained in coaching skills (ILM); and
- Clinical Leadership, 357 staff completed internal clinical leadership courses.

Valuing and Caring for our Staff

During 2014/15 we placed great emphasis on further developing a set of UHB values with staff that would help positively influence behaviours. The Francis and Andrew Reports highlighted the impact of negative culture on organisational performance and patient outcomes and we recognise the impact the same culture can have on staff morale and engagement within the UHB. To further embed our values, many Clinical Boards are now introducing discussions on organisational values into their selection processes, and also PADR with staff. UHB job descriptions also now incorporate detail of the UHB values and behaviours. Centrally, work is ongoing to develop a UHB wide values based recruitment process, learning from the experience of others in NHS England. This will be rolled out in 2015/16. The UHB has produced Management Guidance to support the embedding of UHB Values and Behaviour into every day practice. During 2015/16 we will be further developing this work.

During March 2014, the UHB held its third Annual Staff Recognition Awards and is already planning for these again during 2015. The 2014 event was a big success, and demonstrated the pride we have in our staff which helps raise morale. With more nominees than ever, there were 14 Categories, with 77 individuals and 17 teams being nominated by their peers. Award Example:

- **Chair and Chief Executive Award**

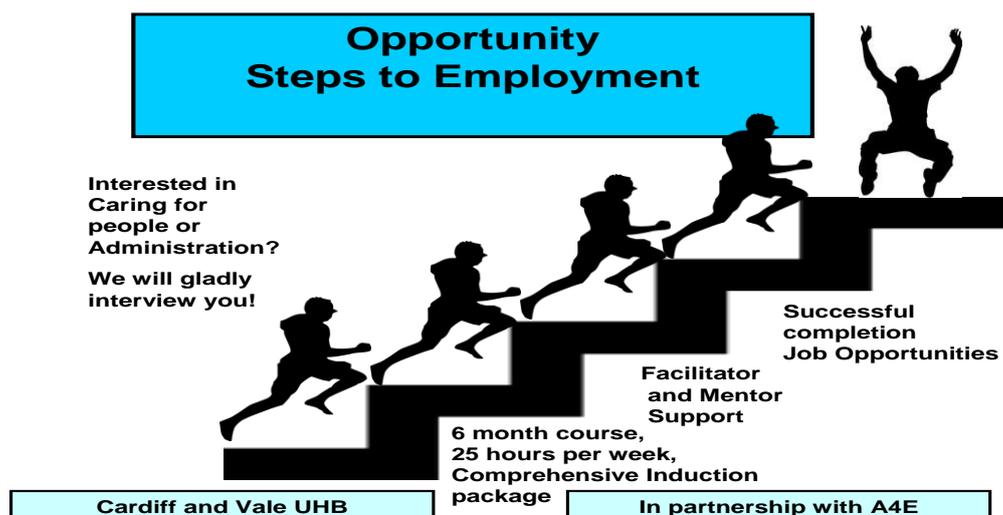
Caring for people and keeping them well – to recognise an individual who, day in day out, demonstrates the UHB’s core values of kindness, care, honesty, integrity, respect and personal responsibility. An award specifically for our Unsung Heroes.



Improving levels of employee engagement is core to the development plans of Clinical Boards and their action for improved performance and outcomes. To support this, the results of the **2013 National Staff Survey and November 2013 Engagement Pulse Survey** were used to develop the focus of Clinical Boards and the nature of the actions they prioritise. This work focused on **appraisals** and using them as the way to enhance engagement supported by Team Based working, which will provide the links between organisational objectives and process for implementation within specific services. Individual Clinical Boards also undertake their own local Pulse surveys to assist in understanding morale across and within service areas.

10.6 Flexible & Sustainable Future Workforce

Corporate Health Standard (Platinum)



During 2014, the UHB achieved the Platinum Corporate Health Standard which is the highest level of the Standard, and recognises the organisation's sustainable development and corporate social responsibility work, in addition to continued efforts to improve the health and well-being of our employees. As part of the 6 criteria within the standard, the Health Board presented a case study on its 'Steps to Employment' programme, which enables people from disadvantaged groups to develop the skills and knowledge required in support worker roles. The programme enables the UHB to work with a range of partner organisations, and has also supported candidates through its dyslexia assessment service. A further 90 individuals are expected to be supported through the programme in 2015. This programme supports the NHS Wales/Public sector LIFT programme commitment to provide education and training opportunities for people living in workless households by end of 2017.

Equality, Diversity and Human Rights

In May 2014 the UHB Board approved the proposal to take a focused approach to an equality theme in 2014/15. Given the launch of the national standards it was agreed that a focus on sensory loss was timely and needed. This approach has been warmly welcomed and in December 2014 a Sensory Loss Workshop was held with Clinical Board representatives and external representatives from the third sector, local authorities and Community Health Council. The output of this workshop will help us progress against the implementation of the *All Wales Standards for Communication and Information for People with Sensory Loss*.

Examples of other successes during 2014 have included:

- Progress against the UHB aim of being in the Top 100 employers Stonewall Workplace Equality Index (WEI). At June 2014 the UHB was 193rd out of 380 organisations – this had seen a progress increase in UHB's ranking from 293 in September 2011;
- The UHB has been named one of Wales' most gay-friendly employers, appearing in Stonewall Cymru's Top 10 Employers for the first time;
- Progress with embedding the Equality Impact Assessment (EQIA) into service planning and decision making;
- Equality and Welsh Language training delivered to GP and Practice Managers coordinated by PCIC
- Welsh Language skills have been assessed in each GP surgery, and the information is publicly available on the UHB website; and
- Establishment of a group lead by the UHB Chair with a number of BME consultants to consider mentoring and support to increase opportunities in leadership, research and award.



Welsh Language

The UHB approved its Welsh Language Scheme in 2010 with the aim of providing good quality bilingual healthcare for the people of Cardiff and the Vale of Glamorgan. The UHB recognises that members of the public can express their views and describe their symptoms and needs better in their first language, and that enabling them to use that language is a matter of good practice rather than a concession. In context, 11% of the people who live in the Cardiff and Vale area are Welsh speakers and following recent audit work, it is estimated that 10% of the UHB workforce has Welsh speaking language skills.

Due to the new Welsh Language Measure 2011, the organisations' Welsh Language Scheme will be replaced in 2015 with the new Welsh Language Standards. The Welsh Language Commissioner will expect the UHB to comply with these standards, which cover all aspects of healthcare and public services provided. They will also expect the organisation to increase the opportunities for staff to use the language internally.

The UHB is committed to ensuring the services patients receive, policies and initiatives are consistent with the Welsh Language Scheme and to support this the Equality Impact Assessment process includes a section to identify how service changes impact on Welsh speakers. The UHB is committed to the Welsh Government

More Than Just Words Strategy and has put in place Corporate and Clinical Board action plans to meet the requirements of the strategy and improve bilingual patient information, recruitment of Welsh speaking staff; and education awareness and training.

The Wayfinding Group, set up by the organisation to improve the quality of public signage, continues with its aims and objectives of developing best practice; examples of improved signage across the organisation can be found in the development of new capital projects:

- New car parking complex at University Hospital Llandough;
- New In-patient mental health unit at University Hospital Llandough; and
- The second development phase of the Children's Hospital, UHW.

The organisation has also taken steps to congratulate and support staff members who have provided excellent care through the medium of Welsh. The annual staff excellence awards have a specific Welsh language category for staff members who have been found to provide good quality healthcare or develop excellent practice.

Welsh Language Key Priorities for 2015/16

There are 3 key priorities for the UHB during 2015/16:

- Making further progress of the provision of bilingual patient information leaflets and letters. Although we have achieved some recent progress during 2014/15 it is recognised that we have a long way to go with this work. A detailed roll out plan has been put in place to deliver against this commitment during 2015/16 and this is being monitored through the Equality, Diversity and Human Rights Committee;
- Development and implementation of the UHB Bilingual Skills Strategy; and
- The continuing development of the More than Just Words Strategy (Welsh Language in Healthcare Framework Strategy), including the development of active choice for patients and services users.

Education Commissioning 2015/16

Workforce Education and Development Services (WEDS) provides funding for Advanced Practice (AP) education programmes across Wales in support of the implementation of the Advanced Practice Framework. This was endorsed by the then Health Minister and issued to organisations in 2010. The following priorities were identified:

- Emergency medicine
- Unscheduled care
- Paramedic AP roles
- Neonatology

For the past two years the UHB has taken up these opportunities and during 2014/2015 26 nurses and 26 Allied Health Professionals have undertaken advanced practice modules. Similar numbers will be attending in 2015-2016.

Recruitment Difficulties

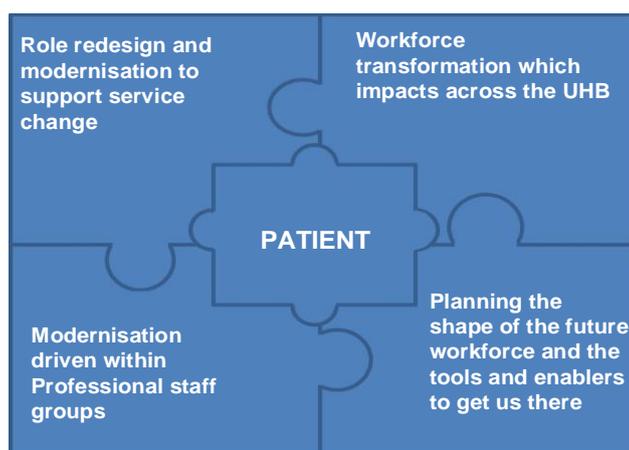
A summary of recruitment difficulties across the UHB is supplied within the appended templates. During 2014 the Heads of Workforce & OD undertook an analysis across the Clinical Boards of the recruitment challenges and hard to fill roles. A number of strategies were developed to improve the short, medium and long term recruitment availability of Speech Therapists, Sonographers, Radiologists, Cardiac Scrub Nurses, Paediatric Anaesthetists, Recovery Practitioners, Anaesthetics Clinical Fellows, Perfusionists, GP Sessions in Out of Hours, Sexual Health Medical Staff, Community Directors, Qualified Mechanical and Electrical tradesmen, Consultants and Middle Grade Doctors in Emergency Medicine and a number of other sub-speciality posts.

10.7 Building Capacity and Capability

Future Workforce Transformation

Previous UHB Five Year Integrated Workforce Plans (IWP) provided a strategic and longer term approach to planning the UHB workforce, specifically aimed at the importance of transformation and longer term role redesign and workforce profiling. Workforce Transformation is necessary to underpin the achievement of the ten year vision for the UHB as described in Chapter 3 of the IMTP and within the emerging clinical services strategy “Shaping our Future Wellbeing”.

The longer term Workforce Transformation Plan is set within the context of the UHB Strategic and Financial Framework and a number of strategic drivers including Making a Difference and Making Difference 2, Mental Health Services Review, Setting the Direction & Service Transformation, Together for Health, South Wales Programme, Working Differently – Working Together. There are four themes to the UHB’s longer term Workforce Transformation Plan:



As part of the UHB strategic workforce planning objectives, during 2014, the organisation reviewed the challenges and opportunities to influence the future workforce. Engagement was undertaken with Executive Directors, Assistant Directors and Senior Clinical Professional Leads to gain a collective view of what the workforce vision should look like. This multi-professional dialogue focuses on patient, citizen and population need. The emerging themes outline a vision whereby our workforce:

- Respond to Patient, Citizen and Population need;
- Are highly motivated, capable and hold the values we aspire to;
- Are skilled in caring for patients, especially the frail and elderly who may not need care but do need support to remain independent in their own homes;
- Work in partnership with patients taking joint decisions and holding joint responsibility;
- Achieves the right balance between specialist and generalist skills to care for patients holistically;
- Has expertise held by a much broader range of workers and providers than clinicians, alongside a growing role for “advocates”;
- Support people living longer and the wellness model and help people live with chronic illness;
- Are comfortable working within a multiplicity of providers in health, social care, independent contractors and voluntary sector; and
- May be working longer and therefore may take many different routes within their own long term careers and many job changes.

During 2015 this work will be further developed alongside the Shaping Our Future Wellbeing. (see Chapter 3).

Advanced Practice

The UHB has a significant number of staff who evidence working at the Advanced Practice (AP) level and a current exercise is being undertaken to review the baseline number of staff and the areas in which they work.

The Electronic Staff Record (ESR) has also been developed recently to enable more accurate data collection and comparison across Wales. There are several examples of AP good practice within the UHB, one of which is the introduction of an Advanced Physiotherapist Practitioner for Multiple Sclerosis and Neurology. The role has provided an additional facet to the clinical care of this patient group and led to the transformation of the patient pathway. The Advanced Practitioner triages patients in clinic, leads care where the patient's problems are physical and liaises with the consultant as required. In addition the Advanced Practitioner's expertise facilitates patient reviews in their homes, which was not previously possible. A range of benefits are being realised including reduced referrals to secondary care and release of Consultant time to meet RTT.

Primary Care Workforce

During 2014 the UHB undertook a high level analysis of the workforce data available of the GP workforce in Primary Care. At October 2013, there were 69 practices, across Cardiff and the Vale, and the high level data is identified in the following table:

Summary of GP workforce within GP practices across Cardiff and Vale		
	Headcount	Whole Time Equivalent (WTE)
GP Partners	278	205.33
Salaried GP's	40	40
Registrars	32	25.53
Retainer	7	4.33
Practice Nurse	178	116.36
Health Care Support Worker	53	21.89
Practice Managers	79	69.72
Practice Receptionists	664	451.2
Totals	1331	934.36

Against a backdrop of change across all clinical/service areas, the workforce priorities for Primary Care for 2014/2015 were:

- *An engaged workforce* (increase staff voice, improve engagement index, involve staff in organisational and cultural change);
- *A transformed workforce* (integrated working along pathways, role redesign);
- *A skilled and flexible workforce* (skills, development and training to meet service needs); and
- A productive and efficient workforce (achieve tier 1 targets for PADR and sickness absence, maximise use of technology).

Against each of the headings significant progress has been achieved including:

- Organisational Health review and development of a values based Staff Charter in Primary Care Out of Hours service;
- Active engagement of staff enabling successful delivery of a number of change schemes including: Transforming District Nursing, Integrating Health and Social Care in the Vale of Glamorgan and the development of the Integrated Mental Health Team in the Prison;
- Major workforce changes across the three CRTs involving the devolvement of Therapy staff to PCIC, Integrated Health and Social care working in the Vale of Glamorgan and the co-location of Health and Social Care staff across the CRTs in Cardiff;
- Changes to the Clinical Leadership infrastructure across the Clinical Board including the introduction of Lead CDs, CD for Primary Care and Dental Advisor role; and
- Team based objectives agreed for Prison, Out of Hours and District Nursing Teams.

Primary and Community Care Workforce Priorities for 2015/2016

Looking ahead to 2015/16 the scope and opportunities for workforce development and change continues to be significant across Primary and Community Care. The challenges and complexity staff face are significant,

and their part in population health and helping the UHB to deliver against the top priorities and Integration agenda is crucial.

Key to the workforce plans will be the application of the principles of prudent healthcare and in particular the principle “only do what only you can do”. In doing the UHB will consider how roles work together across the health and social care system to ensure rigid demarcation is avoided and that patients receive their care from teams that works well together across clinical pathways. The UHB sought engagement with the public at the UHB’s AGM on the question: “Does it matter who you see as long as the person is skilled and competent to do the job”. The feedback received indicates an appetite to explore new models of working in Primary Care moving away from traditional ways of working and developing different models of care.

Collaboration with staff and stakeholders, including patients, is key to the success of the Clinical Board and will underpin a number of key strategies to support the transformation agenda moving forward. The development of strong, trusting relationships that enable to co-creation of shared aims and visions will facilitate the identification of new solutions to existing problems.

Given the workforce profile and transformation agenda the primary and community Workforce Priorities for 2015/2016 are:

Primary Care – Independent Contractors

- Whilst GP recruitment is not an issue in Cardiff and Vale, the sustainability of GMS is becoming a pressure exploring economies of scale within and across clusters and skill mix and will be a key priority and using the practice development plans to undertake a baseline assessment for use in workforce planning. We will use some of the learning to support core GMS eg: use of prescribing advisors;
- Role definition and recruitment to pharmacy support dedicated to practices (intelligence suggests ability to recruit locally); and
- Extend this learning to other primary care contractors.

Primary Care – Out of Hours

- Embed the use of different roles in Primary Care Out of Hours and explore further opportunities; and
- Embed and sustain the culture change in the Prison and Primary Care Out of Hours through agreed projects to empower the staff and support the use of the Staff Charter to reinforce behaviour change.

Cluster Development

- Cluster development has been at a variable pace per cluster but can be described as storming in year one for all nine clusters and moving to norming (now for some clusters) and performing (now for some clusters). The Clinical leadership model to support the development of clusters in the planning of services needs further consideration and an OD programme for primary care, cluster leads and locality management is required.

Building the Community Resilience

- Significant workforce issues specifically for the CRT as follows:
 - Recruitment to increased capacity to meet existing demand;
 - Progress workforce developments to support 7 day working;
 - Consider extended roles and advanced practice (e.g. CRT Therapies); and
 - Opportunities for care co-ordination roles to support and signpost to patients along the pathway. Further explore existing roles elsewhere such as Community Health Officers, Community Wellbeing Officers or Health & Wellbeing Co-ordinators.
- Explore how community nursing fits within this model in the future;
- Work up role of cluster/practice based public health champions;
- OD requirements to support the embedding of Every Contact Counts;
- Build on the ‘Roadmap to Integration’ strategic workforce planning process with partners to redesign and develop an integrated workforce with a flexible skill set that is able to deliver care based on

population needs and to understand the impact of the workforce that is not directly employed e.g. Primary Care, Voluntary Sector; Carers: Patients;

- Maximise the opportunities to move away from historical models of care and explore the use of different roles delivering care closer to home (e.g. Optometry); and
- To undertake training needs assessment in community services and deliver joint training with partner organisations to develop flexible skill sets and culture change.

Asylum Seeker Service

- Build on the learning in Primary Care Out of Hours to review and increase skill mix/capacity in Asylum Seeker service to meet service demand.

Sexual Health Service

- Role redesign to support changes in the pathway across multi professions in primary and community services, exploring the use of more generic roles.

South Wales Programme/Acute Care Alliance (ACA)

As previously set out the South Wales Programme is designed to reconfigure services across South Wales in four specialist services: - Obstetrics, Paediatric and Neonatal Services, Accident & Emergency. The workforce implications of these changes will be significant and will help address a number of shortfalls and recruitment issues in terms of the medical workforce; as well as providing opportunities for new ways of working and extended roles. The Workforce Group recently established for the South Central ACA will be supporting the implementation of the service models and short term workforce solutions.

One of the key drivers within the South Wales Programme Consultation is to strengthen services to provide high quality timely care for patients in the most appropriate place. Evidence shows the potential of 24/7 services to deliver improved outcomes for patients and service users (*source: Centre of Workforce Intelligence Reports*). This will almost certainly mean a move forward to ensure working hours are responsive to this need and underpin services being available seven days a week.

Assessing Nursing and Midwifery Staffing

- Chief Nursing Officer, Delivering Safe Care, Compassionate Care

The first round of auditing using the All Wales Acuity Tool was undertaken at the UHB in June 2014 and 36 of the 37 intended wards completed the national audit. Across the Clinical Boards the results have suggested areas of both over and under establishment. Taken in isolation it would be difficult to come to any reliable conclusions as to the significance of this. It is important to consider that the *Adult Acute Nursing Acuity & Dependency Tool* provides just one aspect of information required to assist in the determination of optimal nurse staffing levels. Triangulation of the workforce, flow data and nurse sensitive quality indicators is recommended to inform the work force planning process.

It is intended that the acuity audit is repeated twice a year in order to build up an evidence base and the next round of auditing will commence January 2015. In the meantime a set of core staffing principles for adult acute care areas, initially issued in Cardiff and Vale UHB in May 2012, are being used to inform nurse staffing levels. Work is also underway on the development and testing of additional acuity tools for use in Mental Health settings, Community Nursing and Health Visiting. The initial benchmarked position submitted to Welsh Government in February 2013 indicated an additional 75.65 WTE registered nurses were required in the Surgery and Medicine Clinical Boards with a reduction of 25.24 WTE Healthcare Support Workers; and the total cost of this was in the region of £2.4 million. The same exercise was repeated in November 2014 and indicated that 14.8 WTE registered nurses were required with a reduction of 14.86 WTE HCSW in medicine and an additional 6.58 WTE HCSW required in Surgery, which would indicate a significant change in the workforce numbers.

Revalidation

From 2012/13, all licensed doctors have been required to undergo revalidation by the General Medical Council (GMC) at 5-yearly intervals. Progress to date in the UHB identifies 546 doctors have revalidated, with 65

deferred. Since October 2012 the UHB has trained approx 177 (AQMAR trained) doctors as Appraisers in the Non GP system and delivered 70 MARS (Medical Appraisal Revalidation System) training sessions.

The UHB is currently planning its approach to the implementation of the Nursing & Midwifery Council (NMC) Revalidation in the UK by the end of 2015.

10.8 Productive, Efficient and High Performing Workforce

Workforce key performance indicators (KPIs)

The information included in the table below provides UHB level data for KPIs which include staff numbers, turnover, sickness absence and appraisal. Performance against these KPIs is monitored on a monthly basis through the UHB Executive Performance Management meetings with Clinical Boards and also locally within the Clinical Board and Directorate management structure. During 2014, the Workforce Team developed a fuller set of KPI's with the aim of providing a more holistic view and analysis of UHB performance. Examples of these include employee relations (disciplinary, grievance and dignity at work); engagement and development indicators; employee well-being information and occupational health service performance; equality and diversity; medical and locum indicators; variable pay etc. During 2015/16 we plan to continue to develop the workforce KPI's and look at methods and systems which triangulate these with other key data, e.g. patient concerns.

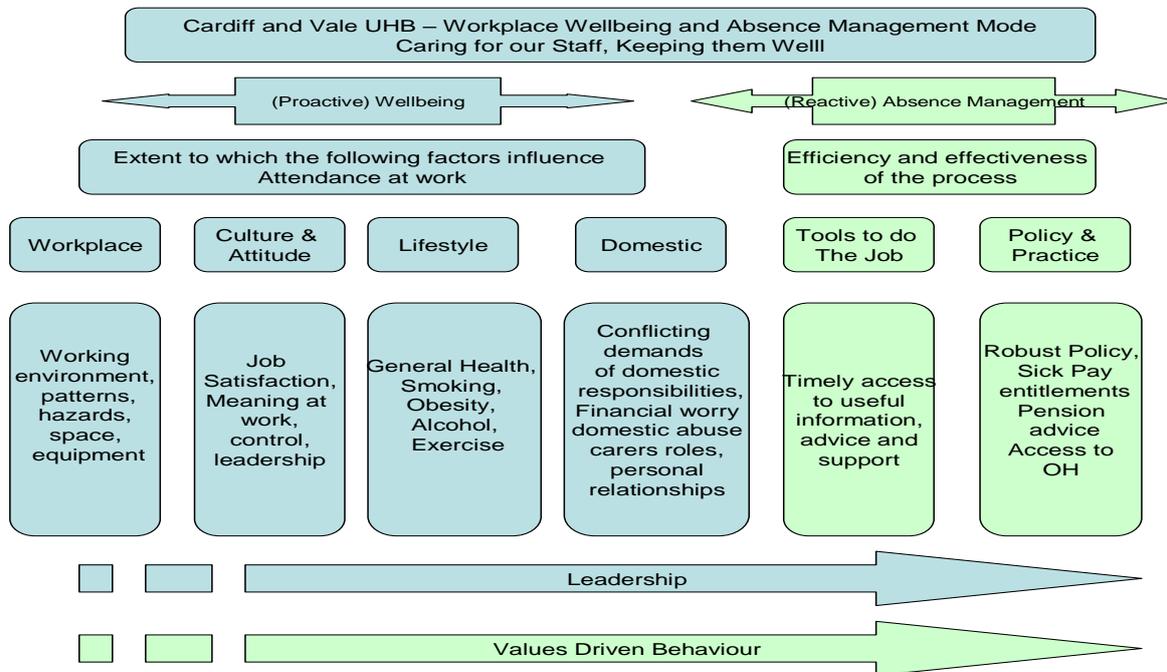
	Workforce Key Performance Indicators				
	Headcount	Contracted WTE	12-Month Turnover Rate	12-Month Cumulative Absence Rate	PADR Compliance
@ 30 September 2014	14,002	11,975	7.96%	5.74%	54.86%
@ 31 March 2013	14,590	12,455	6.46%	5.55%	49.27%

The table provides data contained in the first version of the University Health Board's IBP @ March 2013 and a further update @ 31 September 2014. **During this period the headcount has reduced by 588;** the contracted full time equivalent has reduced by 480; turnover has increased; sickness absence has increased by 0.19% and UHB PADR compliance has increased slightly.

Tier 1 Targets – Sickness and Personal Appraisal Development Review (PADR)

Absence Management

The UHB considers reducing **sickness absence as the number one workforce priority** and during 2014 developed an improvement plan to underpin delivery of the 1% target reduction set by Welsh Government. The UHB target is set at 4% and each Clinical Board and corporate function has its target reduction so that we reach this overall UHB position. The Plan recognises a holistic employee and health and well-being approach as illustrated in the UHB model below. During 2014 the UHB has been monitoring its absence levels closely and despite a number of very proactive interventions there is no sign of significant improvement. During 2014 the UHB implemented a new Sickness Advisory Team (SAT) in a number of pilot areas. The key aim of this service is to promote earliest healthy return to work and members of staff, within the pilot areas, are contacted by the SAT on days 1, 3 and 10 of their sickness absence. A database of information to assist the team in providing this advice/information was developed with the support of Occupational Health, Employee Wellbeing and Physiotherapy Services. Early evaluation of this strategy indicates good progress is being made in Mental Health Clinical Board and within the Estates team. There are plans over the coming year to continue to implement this service across the UHB.



There remains a strong focus on providing direct support to line managers in handling difficult or complex cases and there is also greater join up between supporting services such as Occupational Health; Learning, Education and Development and Wellbeing Services e.g., access to counselling or mediation services. Where appropriate and practical, there is fast tracking to treatment available for employees across all specialities.

Personal Appraisal Development Review (PADR)

The organisation recognises the importance of annual appraisals for all staff and has measures in place to monitor **Personal Appraisal Development Review (PADR)** compliance on a weekly basis. The UHB has a target of 85% for annual compliance and as at 28 February 2015, is 57.7%. Since 2011 the UHB compliance levels have made steady increase from 6% to around 55-60%. The national staff survey respondents have indicated that 67% of staff have had a PADR in the last twelve months which compares to a national average on the survey of 55%.

In recognition of the role that effective Appraisal plays in staff engagement, wellbeing and delivering safe and effective services the UHB process has been redesigned to ensure it is aligned to the organisational goals. The team PADR process will embed objective setting at every level of the organisation and ensure that the annual cycle links these objectives through all services. This will also introduce a more varied approach where individual and team based appraisals are used in appropriate situations. In 2014, the Team Development/ PADR process has been piloted in Surgery Clinical Board and is currently being rolled out to other Clinical Boards into 15/16.

NHS Wales Benchmarking

The information in the table provides benchmarking against organisations within NHS Wales.

NHS iView - data at 31-Aug-2014 (Jul-2014 for Sickness)				
	Headcount	Contracted FTE	12-Month Turnover Rate	12-Month Cumulative Absence Rate
Abertawe Bro Morgannwg Uni LHB	15,040	13,070	8.68%	5.96%
Aneurin Bevan LHB	12,460	10,650	8.71%	5.25%
Betsi Cadwaladr Uni LHB	16,270	14,025	6.72%	5.13%

Cardiff & Vale Uni LHB	13,670	11,970	10.79%	5.77%
Cwm Taf LHB	7,915	6,925	8.27%	6.01%
Hywel Dda LHB	8,605	7,405	9.19%	4.97%
Powys Teach LHB	1,660	1,320	8.94%	4.90%
Public Health Wales	1,465	1,285	7.38%	3.61%
Velindre	3,140	2,865	9.19%	3.67%
Welsh Ambulance Services	3,005	2,840	5.20%	7.95%
NHS Wales	83,110	72,360	6.72%	5.49%

[Note: the figures above differ to those included in local data on page 224 as the benchmarking comparison is available for a different period i.e., August 2014 and July 2014 for sickness).

Workforce Saving – Reshaping our Workforce

Key to the development and implementation of the Workforce Plans over 2014/15 has been, and continues to be the need to support delivery of UHB objectives and appropriate action and alignment of adequate resource to address the 5 key areas of the required agenda, namely: Stroke, Cancer, USC (Flow management), RTT (planned care) and finance.

The UHB recognises the austere context within which service and workforce plans continue to be delivered and the unprecedented scale of challenge required to be delivered with pace and high impact.

In March 2014 the UHB Board approved the Integrated Financial and Workforce Plan 2014/15. This Plan identified a range of service and workforce developments across the Clinical Boards, which, when delivered would result in:

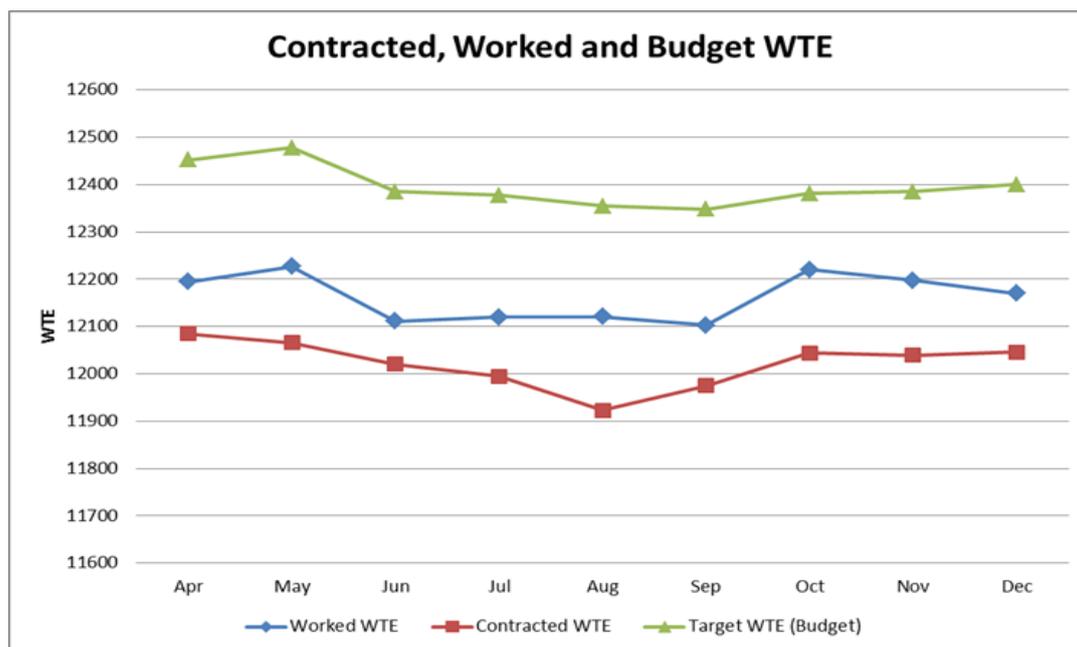
- A reduction in WTE of 372 (subsequently adjusted down to 358 WTE);
- A WTE increase of 149 as a result of identified service developments, TUPE transfers and planned increases to nursing establishments in response to the Chief Nursing Officer (CNO) standards;
- An overall proposed net WTE reduction of 223 WTE (at the time);
- Total savings from workforce of approx £22.1m (including £6.7m from national agreements).

The table below summarises expected achievement against 2014/15 plans at Clinical Board level in terms of movement in workforce numbers.

Clinical Board	Identified WTE Reduction 2014/15 (adjusted)	Delivered WTE Reduction	Balance (yet to be delivered)
Children & Women's	22.30	16.70	5.60
Surgery	54.64	12.56	42.08
Specialist Services	4.86	4.86	0.00
Mental Health	31.49	31.49	0.00
Medicine	130.12	130.12	0.00
PCIC	24.44	22.79	1.65
CDT	44.15	22.20	21.95
Planning, Estates, Operational Services	46.00	23.00	23.00
Total	358.00	263.72	94.28

It should be noted that the original target identified @ March 2014 was 372 WTE, which has been adjusted to 358 WTE. The difference is as a consequence of plans being modified during implementation.

The graph below illustrates delivery against plans to October 2014, and shows the trends of budgeted WTE (inclusive of the WTE reductions planned in the 2014/15 IMTP), contracted WTE and worked WTE (as produced by Finance).



Between April and August 2014, actual (i.e. contracted and worked WTE) broadly followed the same trend as planned. However, in September and October 2014 we began to see an increase in the overall WTE staffing numbers. This came as a result of Executive decisions to invest in and recruit to nursing establishments to ensure safe staffing levels, as pressure and demand on services increased into the winter period.

Implementation of some 2014/15 plans and the resulting changes in workforce numbers have not been delivered to planned timescales and required levels. A high-level UHB wide change plan and monthly workforce scorecard reports with profiled changes in workforce numbers across the year have enabled us to identify risks and track delays to delivery presented by a range of factors including timing of consultation and engagement processes and availability of trade union representatives to support the change process.

The following is a brief narrative of progress made towards delivery of the 2014/15 workforce change plans to end December 2014:

- **Clinical Diagnostic and Therapeutics Clinical Board** commenced an ambitious programme of service and pathway redesign in 2014 aimed at delivering improvements to services and quality in 2015/16. Proposals to modernise Health Records, were profiled to deliver a reduction in workforce across 2014/15 and have only part-delivered due to implementation and engagement challenges. The remainder will be delivered in 2015/16;
- **Surgical Services Clinical Board** originally identified a number of proposals to improve efficiency and flow, allowing for a reduction in bed capacity, and improvements in theatre capacity as utilisation is increased. In reality 2014/15 has seen significant operational bed pressures across the Clinical Board and the system as a whole, resulting in increased capacity requirements at times rather than reductions. The Theatre Efficiency Project delivery has also run beyond its planned conclusion, and will now feature in the Clinical Boards 2015/16 IMTP;
- **Medicine Clinical Board's** planned review and management restructure was delivered in May 2014, and development of Clinical Gerontology Services, enabling the decommissioning of West Wing, achieved in September 2014. The latter part of the financial year (Quarter 4) will see the introduction of a new Nursing Framework, which includes defined roles and responsibilities of a supervisory sister, changes to establishments to ensure CNO standards are met, and changes to shift patterns;
- **Children and Women Clinical Board** proposed and achieved the modernisation of Gynaecology Services in October 2014 and implemented a new management structure in November 2014 with a

programme of transforming administrative services ongoing. These transformation programmes achieved a reduction in workforce through natural wastage;

- **Mental Health Clinical Board** planned to bring back the Western Vale Services to Cardiff and Vale UHB in 2014. This was achieved in June 2014 with an associated TUPE transfer of staffing into the Board. The plan to invest in and improve community services to enable the closure of the Glan Ely Ward originally planned for summer 2014, was achieved in December 2014 with existing staff

	Workforce @	Planned WTE @	Planned Change	2015/16 Profiled Workforce at end of each Quarter				Planned Change
	31/12/2014	31/03/2015	1/1 to 31/3/15	30/06/2015	30/09/2015	31/12/2015	31/03/2016	1/4/15 to 31/3/16
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Children & Women's	1516.86	1602.31	85.45	1607.57	1599.22	1599.22	1599.22	-3.09
CDT	1802.21	1852.11	49.90	1853.11	1853.11	1853.11	1853.11	1.00
Dental	379.88	412.46	32.58	413.07	413.07	413.07	411.07	-1.39
Execs	669.55	676.85	7.30	671.28	665.71	664.71	664.71	-12.14
Medicine			0.00					0.00
Mental Health	1118.01	1217.74	99.73	1231.26	1231.26	1231.26	1231.05	13.31
PCIC	633.50	697.28	63.78	689.15	689.15	689.15	689.15	-8.13
Planning	976.24	971.52	-4.72	970.02	966.02	960.02	960.02	-11.50
Specialist Services	1468.03	1517.46	49.43	1522.26	1522.26	1522.26	1522.26	4.80
Surgical Services	1677.84	1792.20	114.36	1758.23	1758.23	1758.23	1758.23	-33.97
Total	10242.12	10739.93	497.81	10715.95	10698.03	10691.03	10688.82	-51.11

affected being absorbed into current vacancies;

- **Dental Clinical Board** experienced a planned increase in the number trainee dental nurses and realised workforce savings through skill mix and administrative efficiencies with no loss of posts. The Board also completed a review of its Community Dental Service;
- **Specialist Services Clinical Board** realised workforce savings through skill mix and administrative efficiencies in 2014. However, the planned transfer in of staff currently employed by other Health Boards working on the genetics network was delayed and will now take place in the Summer of 2015;
- **PCIC Clinical Board** commenced an ambitious programme of integration and pathway redesign, which will begin to deliver benefits over a longer timescale. The planned modernisation of district nurse services was completed;
- **Planning, Estates and Operational Services** achieved a reduction in WTE linked to developments in the Clinical Gerontology Services and West Wing, among others, with affected staff being absorbed into existing vacancies across the service. Proposals to restructure across the Estates and Capital Planning will be implemented on a phased basis from Quarter 4 and into 2015/16; and
- **Other Executive Functions** identified a small increase in agreed funded posts offset by planned decreases in other parts of the Executive Directorates.

Forecasted Workforce Reductions in 2015/16

The financial framework savings opportunity is identified within Chapter 7.4. This is showing a savings requirement of 3% for 2015/16, which includes both non pay and pay saving. Currently, of the UHB £16.8m savings identified, £6.795m are related to workforce savings; the detail of which continues to be worked through by Clinical Boards and Corporate areas. The common themes emerging from within Clinical Board plans, include a continued focus on reducing agency expenditure through strengthening nursing establishments and delivering a reduction in sickness absence, and continued efforts to streamline administrative processes to deliver greater efficiency; as well as service restructuring opportunities. The prudent healthcare, pathways and integration opportunities is also expected to impact on workforce saving. The table provides the latest workforce wte plan forecast by Clinical Board, but remains a work in progress. It should be noted that Medicine Clinical Board remains outstanding.

Reducing Workforce Variable Pay Cost

The table below provides information on variable pay expenditure during 2013/14 and the 6 month period to September 2014. The overall total expenditure was 4.68% for the full year 2013/14, covering all staff groups; showing an increase in trend for the first 6 months of 2014/15.

Workforce Variable Pay	Full Year 2013-14	6 month period Apr - Sep 2014
Pay Bill – Agency	£3,660,691	£1,792,982
Pay Bill – Nursing Bank	£8,226,028	£5,250,382
Pay Bill – Nursing over time	£462,887	£748,577
Pay Bill - Non-Nursing over time	£2,521,579	£1,734,249
Pay Bill - Locum Medical – Dental	£4,931,749	£3,382,348
Pay Bill - Waiting List Initiatives - Medical	£1,257,752	£1,176,727
Pay Bill - On-Call	£2,267,803	£1,010,214
Pay Bill Total Variable	£23,328,489	£15,095,478
Variable Pay Bill as % of Fixed Pay Bill	4.68%	6.20%

The majority of spend is associated with nurse and medical cover. Overtime is used to flex staffing resources to meet capacity requirements i.e. RTT targets.

Medical and Nursing Productivity (Leaner & Fitter Programme)

Nursing Workforce

Expenditure on temporary nurse staffing accounts for around 5-6% of total Nurse and Midwifery Pay expenditure and is directly linked to sickness rates, the numbers of substantive vacancies, specialising, service demand, and the delivery of RTT. In recent years, in an attempt to manage the above variances, areas have adopted a more flexible approach to staffing.

To ensure the UHB utilises its total nurse staffing resource effectively, the UHB continues to drive these issues through its Nurse Productivity Group, chaired by the Executive Director of Nursing. Its role is to support the delivery of cost reduction programmes whilst ensuring that nursing standards are maintained and high quality care delivered. Specifically the project team is developing tools that support Clinical Boards to analyse their levels of productivity in nursing and increase productivity and cost effectiveness. In 2014/15 the financial achievement against Nursing Productivity to date is £2.6 million; with many saving schemes still planned to take effect in the final quarter. The savings opportunity identified for 2015/16 is £2 million. Key areas for development and implementation in 2015/2016 include:-

Advanced Practice

- Expanding in the work undertaken to date to include:
 - Generic job descriptions;
 - Audit all posts to ensure they comply with all pillars of the Framework;
 - Work with other professions to develop AP roles;
 - Liaise with Cardiff University with regard to delivery of specialised educational programmes and bridging programmes; and
 - Continue to work with WEDS to influence and support the All Wales AP agenda.

E-Rostering

- Ensure that the newly agreed and signed off nursing establishments are represented exactly on each wards' rosterpro and performance manage Sisters/Charge Nurses accordingly;
- Liaise with suppliers to determine if they can offer any further solutions/savings to use of Roster Pro System; and
- Implement Roster Pro sickness as a "live" sickness management function.

Going forward 2015/2016 Leaner and fitter will focus on:

Nurse Bank

- Scope the current demand and supply via the Nurse Bank Office;
- Process map the current and required processes for filling bank and agency shifts;
- Review options for communicating with Bank staff to increase fill rate;
- Continuous recruitment to Registered and Unregistered bank staff;
- Represent the UHB on the All Wales B&A Contract group; and
- Reduce and eliminate the use of high cost agencies.

Nurse Recruitment

- Continue with one stop recruitment events;
- Implement a live vacancy tracker so that the information is always up to date;
- Ensure the process of recruitment is leaner with reductions in the time to get staff into post; and
- Identify recruitment and retention hotspots across the Health Board and ensure a process is in place to ensure business-as-usual proactive management of these.

Specialling

- Review the model being utilised in South Tees where volunteers support close observation and activities with some patients;
- Identify any trends and show areas of good and poor practice; and
- Move specialling assessments and decisions onto Clinical Workstation to allow for monitoring and audit.

Medical Workforce

Expenditure on temporary medical staff accounts for approximately 8% of the total pay bill for medical staff and is directly linked to sickness and vacancy rates and waiting list initiative payments required to deliver RTT. In 2012, the Medical Director established a Medical Workforce Productivity Group and part of this group is a focus on variable pay to contain temporary medical staffing expenditure and improve controls for the future. The group also reinforces:

- The introduction of tighter controls on the authorisation and usage of NHS and Agency Locums;
- Limited agency usage to those companies within the existing framework and the price agreed with the agency should **not exceed** contract rates; and
- The development of an electronic authorisation and payment process for NHS Locums facilitating greater visibility and control over NHS locum expenditure and payment arrangements.

The UHB Medical Workforce Productivity Group aims to:

- Support Clinical Boards to derive maximum benefit in service delivery terms from the NHS Wales Consultant Contract;
- Ensure robust and high quality Job Plans for the Clinical workforce, matched to patient activity which deliver productivity requirements to a high standard;
- Revise and develop current processes to support job planning process; and
- Improve process so that it is considered equitable and transparent.

Key actions to date include:

- The establishment of a central shared folder which holds details of job plans and can be readily accessed for relevant parties and recording of job plans on ESR;
- The delivery of **BIS/CHKS Training** for Directorate management teams on using the CHKS data for job planning purposes; and
- The development of **Data Productivity Packs** that reflect the KPIs relevant the areas of clinical performance and the issuing of these to directorates.

Medical Locums – Implementation and Maximisation of PwC’s “STAFFflow” & Medacs’ “Vantage” Projects

Working with Price Waterhouse Coopers (PwC) and Liaison Financial Services (LFS), in 2014, the UHB introduced a model that provides the UHB with a cost efficient means of engaging and controlling locum medical staff expenditure. This model is known as “STAFFflow”. The UHB has also engaged with MEDACS, as the primary supplier of medical locums to the UHB, over their “Vantage” solution. Through Vantage, MEDACS provide expert, in-house support to analyse and manage the UHB’s demand profile for agency spend, and work closely with us to reduce this spend, and develop alternative internal solutions, such as an internal locum bank.

We have been successful in bringing MEDACS and PwC together to work to support us to maximise the use of medical locums in a more cost efficient way, and are the first Health Board / Trust in the UK to do so. This is bringing us a number of benefits which include: better management information and improved controls over

agency spend. **During 2014/15 year to date savings have amounted to approximately £310k.** Savings continue to be monitored through the Clinical Boards.

Controlling Recruitment Activity, Recruitment Strategy and Performance

During 2014 the UHB saw a significant increase in recruitment activity and the Chief Operating Officer introduced a robust centralised scrutiny of vacancy requests, to take place at the same time as a review of the potential for posts to be used for redeployment purposes, for staff at risk. This scrutiny has been devolved back to Clinical Boards where authorisation can only be given within agreed staffing establishment levels and within budget. Recruitment is one of our key priorities. At the time of writing there is a substantive vacancy gap and a need for extra capacity has been identified to support winter pressures therefore requiring additional registered nurses. An overarching nurse recruitment plan is required to address the vacancy gap and short term capacity required. A Recruitment Task and Finish group has been established to deliver this overarching nurse recruitment programme so that the Health Board substantively recruits nurses to agreed workforce plans and reduces the time to hire. A high level assessment and consideration is also being given to over-recruiting Band 5 nurses so that the UHB is ahead of any natural turnover occurring, any future need for extra capacity and almost eliminate the use of bank and agency. Recruitment campaigns are being driven through January and the work will be monitored through the Task and Finish Group, headed by the Interim HR Director.

Maximising the Use of Workforce Technology

The key priorities which form the Workforce Information Strategy are to implement roll out plans for:

- ESR Managers Self Service/ Employee Self Service (MSS/ESS);
- E-Expenses; and
- Rosterpro Central.

The UHB is aiming to reach the NHS WfIS target of 80% implementation of MSS/ESS by the end of December 2015. This is a challenging plan in the timescale, however, during 2014, the UHB made a considerable improvement from 17% to 36% of areas with self service functionality. To date roll out has been completed in the areas of Community Dental, Corporate and Hospital Dental, Laboratory Medicine & Toxicology Lab, OPAIC Directorate, Media Resources Directorate, Pharmacy, Critical Care, Finance, Workforce & OD, IM&T, Mental Health Clinical Board. Further work is currently ongoing within Primary Community and Intermediate Care and within Operational Services and Estates. A full roll out plan has been developed. Further development work has been undertaken in 2014 and all Job Plans are now recorded on ESR. Current developments also include the interface with Occupational Health system.



SECTION

Appendices



Appendix 1.

Overview of health and wellbeing needs for Cardiff and the Vale of Glamorgan, 2015-2025

1. Population size and composition

Key points

- The population of Cardiff and Vale is growing rapidly in size, projected to increase by 10% between 2015-25, significantly higher than the average growth across Wales and the rest of the UK. An extra 50,000 people will live in Cardiff and Vale and require access to health and wellbeing services
- The population is ageing, with the number of over 85s increasing at a much faster rate than the rest of the population (32.4% increase between 2015-25).
- The Cardiff and Vale population is relatively young compared with the rest of Wales, with the proportion of infants (0-4 yrs) and the traditional working age population (17-64) higher than the Wales average
- The population is ethnically very diverse, particularly compared with much of the rest of Wales, with a wide range of cultural backgrounds and languages spoken. Arabic, Polish, Chinese and Bengali are the four most common languages spoken after English and Welsh. Cardiff is an initial accommodation and dispersal centre for asylum seekers

(i) Population size, structure and projected change

Table 1. Population projections for Cardiff and Vale by broad age group, 2015-2025. Source: StatsWales (2014)

Area	Age group	Year				Additional people 2015-25
		2015	2018	2020	2025	
Cardiff	0-4	24,013	24,800	25,180	26,017	2,004
	5-16	46,269	49,439	52,142	57,210	10,941
	17-64	242,384	249,072	253,036	263,948	21,564
	65-84	42,250	44,500	46,164	51,450	9,200
	>84	7,427	7,928	8,326	9,495	2,068
	All	362,343	375,739	384,848	408,120	45,777
Vale	0-4	7,146	7,148	7,073	6,816	-330
	5-16	17,874	17,889	18,199	18,184	310
	17-64	77,347	76,876	76,291	75,063	-2,284
	65-84	22,548	23,979	24,890	27,116	4,568
	>84	3,583	3,909	4,150	5,085	1,502
	All	128,498	129,801	130,603	132,264	3,766
C&V	0-4	31,159	31,948	32,253	32,833	1,674
	5-16	64,143	67,328	70,341	75,394	11,251
	17-64	319,731	325,948	329,327	339,011	19,280
	65-84	64,798	68,479	71,054	78,566	13,768
	>84	11,010	11,837	12,476	14,580	3,570
	All	490,841	505,540	515,451	540,384	49,543

Table 2. Projected percentage increase in population of Cardiff and Vale by broad age group, over 3, 5 and 10 years from 2015. Source: StatsWales (2014)

Age group	Projection year		
	2018	2020	2025
0-4	2.5%	3.5%	5.4%
5-16	5.0%	9.7%	17.5%
17-64	1.9%	3.0%	6.0%
65-84	5.7%	9.7%	21.2%
>84	7.5%	13.3%	32.4%
All	3.0%	5.0%	10.1%

The Cardiff and Vale population is relatively young compared with the rest of Wales, with the proportion of infants (0-4 yrs) and the traditional working age population (17-64) higher than the Wales average. A large student population of around 60,000 contributes to this. Cardiff also has a prison with around 800 inmates, slightly above the average UK prison size.

The local population is projected to increase in all age groups, with the highest increase in the over 85s. This is in contrast to the national Wales projections which predict contraction among 0-4 year olds and 17-64 year olds, and lower growth for children aged 5-16. The overall increase in the population is over double the overall Wales increase, at 10.1% for Cardiff and Vale between 2015-2025 compared with 4.1% for Wales as a whole. The projected 10 year growth in the Cardiff population (12.6%) is also higher than the England average (7.0%) and that of the nine regions within England, including London as a whole (11.9%) and the South East (7.7%). The likely reasons for this are discussed below.

On the assumption that the health needs of the additional people projected to reside in Cardiff and Vale in the future due to population growth are similar to those of the existing population, this would translate into a 1% year-on-year growth in service demand (3% over 3 years), and considerably higher for services for some age groups (e.g. 5% growth for 5-16 year olds, and 7.5% for over 84 year olds, both over 3 years).

Figure 1 (a) Proportion of population by age and sex, Cardiff compared with Wales using ONS data 2013 (Public Health Wales, 2014)

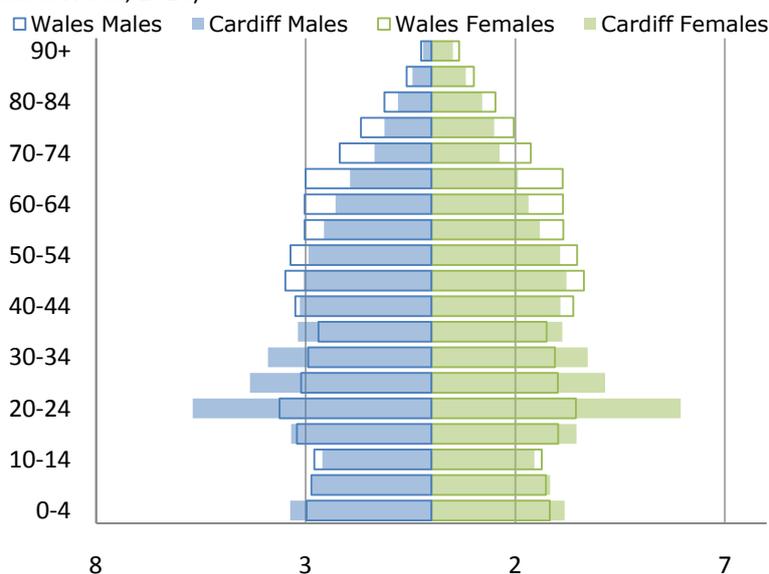


Figure 1 (b) Proportion of population by age and sex, Vale compared with Wales using ONS data 2013 (Public Health Wales, 2014)

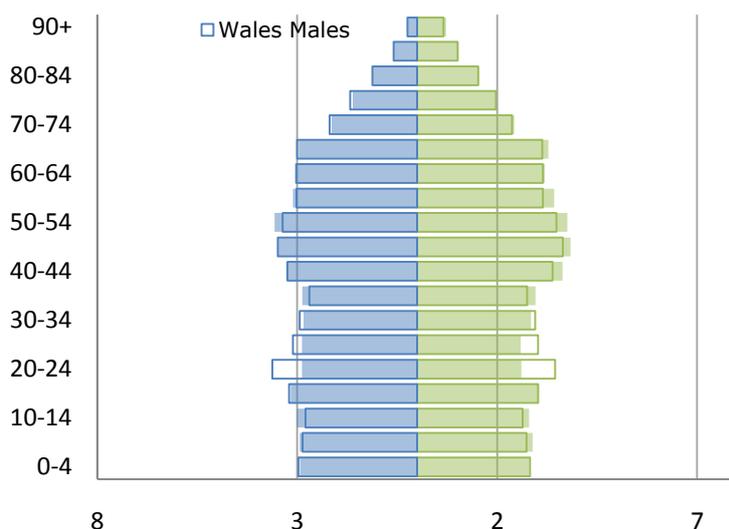
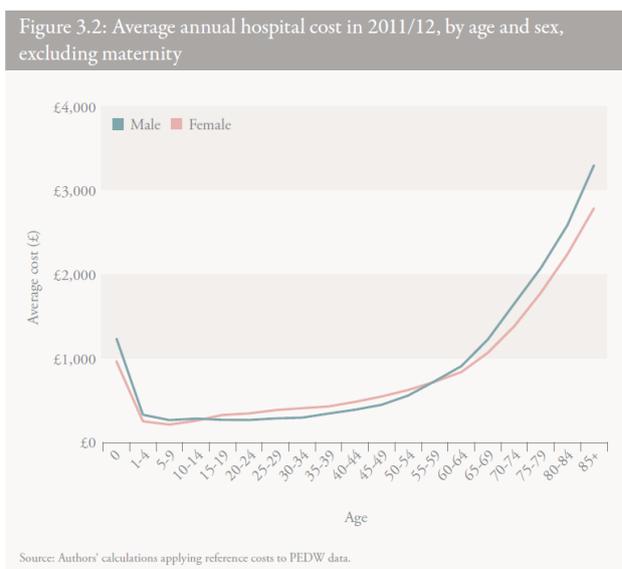


Table 3. Current and projected population age structure, Cardiff and Vale and Wales, 2015-2025. Source: StatsWales (2014)

Age (yrs)	Proportion of population			
	2015		2025 (projected)	
	All Wales	C&V	All Wales	C&V
0-4	5.9%	6.3%	5.4%	6.1%
5-16	13.2%	13.1%	13.7%	14.0%
17-64	60.8%	65.1%	58.3%	62.7%
65-84	17.5%	13.2%	19.1%	14.5%
>85	2.6%	2.2%	3.5%	2.7%

The increase in the older population is significant from a healthcare resource perspective, because hospital use and costs rapidly increase with age in this group (Figure 2).

Figure 2. Annual hospital cost in Wales by age and sex, excluding maternity. (Graph courtesy of Nuffield Trust, taken from Roberts, A and Charlesworth, A. 2014. A decade of austerity in Wales).



Across Wales, the increase in population alone is projected to contribute to an increase in spend on acute care by 1.2% each year in the period 2010-2025 (Nuffield Trust).

While the Cardiff local authority area is almost entirely an urban one with a high population density, the Vale of Glamorgan is predominantly rural, with five small urban centres and a large number of villages and hamlets. Based on draft local development plans (LDP), for Cardiff the predicted housing growth is 41,100 new homes between 2006 and 2026 and for the Vale, the predicted housing growth is 9,960 new homes between 2006 and 2026. The LDP takes into account projected population growth so should not be a driver itself of additional growth.

(ii) Birth and in-migration rates

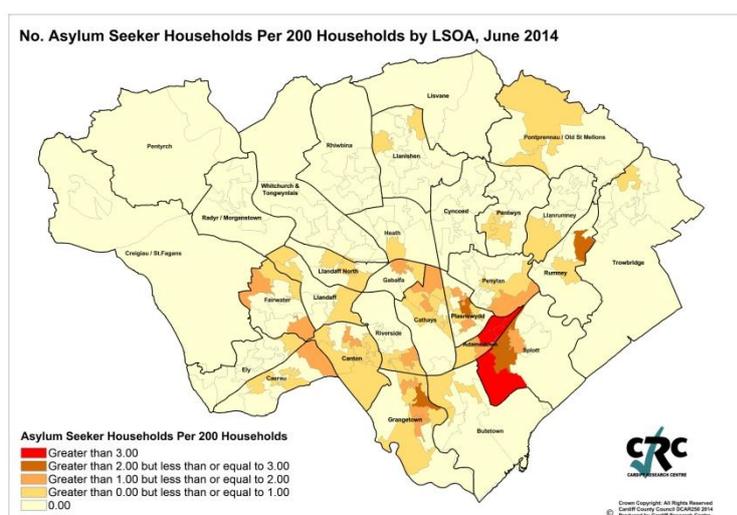
The significant increase in the size of the population is driven principally by net in-migration to Cardiff, and a birth rate which has historically been both increasing and higher than the death rate.

Table 4. Historic birth rate and net migration into Cardiff and Vale, 2007-2013. Source: StatsWales (2014)

	Annual births	Net migration into Cardiff and Vale
2007-08	6,016	3,538
2008-09	6,053	3,173
2009-10	6,125	1,758
2010-11	6,207	1,863
2011-12	6,279	708
2012-13	5,910	1,711

Cardiff is a both an initial accommodation centre and dispersal centre for UK asylum seekers. In this capacity, around 100-180 individuals seeking asylum in the UK enter Cardiff each month, and around 6 in 10 of those dispersed in the South West and Wales area live in Cardiff. The number of new asylum seekers is expected to grow between 8-15% per annum. There are thought to be around 900 asylum seekers living in Cardiff at any one time. Many asylum seekers have complex health and social care needs. Pregnant women, unaccompanied children, those with significant mental health problems, and those who have experienced traumatic events such as rape or torture, are likely to be particularly vulnerable. Asylum seekers are located across Cardiff but historically more in the ‘southern arc’.

Figure 3. Geographical spread of asylum seeker households in Cardiff (Courtesy of CRC, 2014)



(iii) Ethnicity and languages spoken

Table 5. Ethnicity, Cardiff and Vale. Source: StatsWales (2013) from Census 2011

Ethnicity	Population count	Population %
English/Welsh/Scottish/Northern Irish/British White	397,010	84.0%
Other White	14,214	3.0%
Indian	8,452	1.8%
Pakistani	6,570	1.4%
Other Asian	5,249	1.1%
African	5,378	1.1%
Bangladeshi	4,959	1.0%
Chinese	4,622	1.0%
Arab	4,881	1.0%
White and Black Caribbean	4,270	0.9%
White Irish	3,186	0.7%
White and Asian	2,890	0.6%
Other Mixed	2,577	0.5%
Any other ethnic group	2,325	0.5%
White and Black African	1,989	0.4%
Other Black	1,738	0.4%
Caribbean	1,574	0.3%
Gypsy or Irish Traveller	542	0.1%
<i>Total population</i>	<i>472,426</i>	<i>100.0%</i>

Table 6. Most common main language spoken in Cardiff and Vale, over 3s. Source: Nomis (2014) from Census 2011

Main language spoken	C&V	%
English or Welsh	424755	93.5%
Arabic	3644	0.8%
Polish	2849	0.6%
Chinese	2534	0.6%
Bengali	2477	0.5%
African language (any)	2095	0.5%
West/Central Asian language (any)	1982	0.4%
Urdu	1243	0.3%
French	859	0.2%
Portuguese	714	0.2%
Panjabi	680	0.1%
Spanish	679	0.1%
Gujurati	649	0.1%
Tamil	345	0.1%

Table 7. Most common non-English, non-Welsh main languages spoken in Cardiff and Vale by age group. Source: Nomis (2014) from Census 2011

3 to 15 yrs	16-64 yrs	>65 yrs
Arabic	Arabic	African language (any)
Bengali	Polish	Bengali
African language (any)	Chinese	Chinese
Polish	Bengali	Gujurati
West/Central Asian language (any)	West/Central Asian language (any)	Urdu

Around 1 in 10 (8%) of people in Cardiff and Vale can read, write and speak Welsh, significantly below the rate in the rest of Wales (15%) (Census 2011).

2. Risk factors for disease

Key points

- Unhealthy behaviours which increase the risk of disease are endemic among adults in Cardiff and Vale
 - Nearly half (44-45%) drink above alcohol guidelines
 - Nearly two thirds (66-67%) don't eat sufficient fruit and vegetables
 - Over half (55-57%) are overweight or obese. This increases to two thirds (64%) among 45-64 year olds
 - Around three quarters (72-75%) don't get enough physical activity
 - Just over one in five (22%) smoke
- Many children in Cardiff and Vale are also developing unhealthy behaviours
 - Two thirds (66%) of under 16s don't get enough physical activity
 - Nearly a third (31%) of under 16s are overweight or obese
- Around 1 in 10 adults are recorded as having high blood pressure in Cardiff and Vale

Table 8. Percentage of adults with particular lifestyle characteristics, Cardiff and Vale, 2012-13. Source: Welsh Health Survey (2014).²⁷

Lifestyle characteristic	Area		
	Cardiff	Vale	Wales
Smoker	23	18	22
Consumption of alcohol: above guidelines	44	45	42
Consumption of alcohol: binge drinking	27	26	26
Consumption of fruit and vegetables: meets guidelines	34	33	33
Exercise or physical activity done: meets guidelines	25	28	29
Overweight or obese	55	57	59
Obese	21	19	23

A breakdown of these figures by age shows some interesting patterns, including significantly higher overweight and obesity among adults aged 45-64, at nearly two thirds of this age group (64%) across Cardiff and Vale (Welsh Health Survey 2009-12). Overweight (defined as a body mass index 25-30) is increasing predominantly in men rather than women; but obesity (BMI over 30) is increasing in both sexes, predominantly among 16-64 year olds.

Among children and young people, overweight and obesity is also a problem (Table 7). The child measurement programme has found that over a fifth (22.1%) of children in reception year in the Vale of Glamorgan are overweight or obese, and nearly a quarter (24.3%) of those in Cardiff (Child Measurement Programme for Wales, 2012/13).

Table 9. Percentage of 0-15 year olds with particular lifestyle characteristics, Cardiff and Vale. Source: Welsh Health Survey (2013).

Area	Self-rated health status			Lifestyle characteristic			
	Good / Very good general health	Long-standing illness	Limiting long-standing illness	Physically active on 5 or more days	Physically active on 7 days	Overweight or obese	Obese
The Vale of Glamorgan	95	21	5	54	36	26	14
Cardiff	94	17	5	48	33	34	20
Cardiff & Vale UHB	94	18	5	50	34	31	18
Wales	94	19	6	52	36	35	19

There are an estimated 8,000 people aged 16 and over in Cardiff and Vale with a BMI over 40 (1.9%), including 800 with a BMI over 50 (0.2%).

Over 30,000 people in Cardiff and Vale classified themselves in 'bad' or 'very bad' health, a rate of 6.4%. This compares favourably with the Wales average of 7.6%. The broad ethnic group with the most people rating themselves in 'bad' or 'very bad' health is white, at 6.7%; all other ethnic groups are below the average of 6.4%, with Asian/British Asian ranking the lowest, with 3.7% rating their health as bad.

The proportion of people who self report 'bad' or 'very bad' health is lower in Cardiff and Vale among people who can read, write and speak Welsh (1.9%) compared with people without Welsh language skills (7.4%) (Census 2011).

Table 10. Age-standardised percentage of patients on GP register for hypertension, Cardiff & Vale UHB, 2012. Source: Public Health Wales Observatory (2013)

Area	% adults with hypertension recorded
Cardiff East	12.2
Cardiff North	10.4
Cardiff South East	11.3
Cardiff South West	11.4
Cardiff West	9.8
Central Vale	12.3
City & Cardiff South	11.8
Eastern Vale	9.6
Western Vale	9.6
Cardiff and Vale UHB	10.9
Wales	11.1

3. Equity, inequalities and wider determinants of health

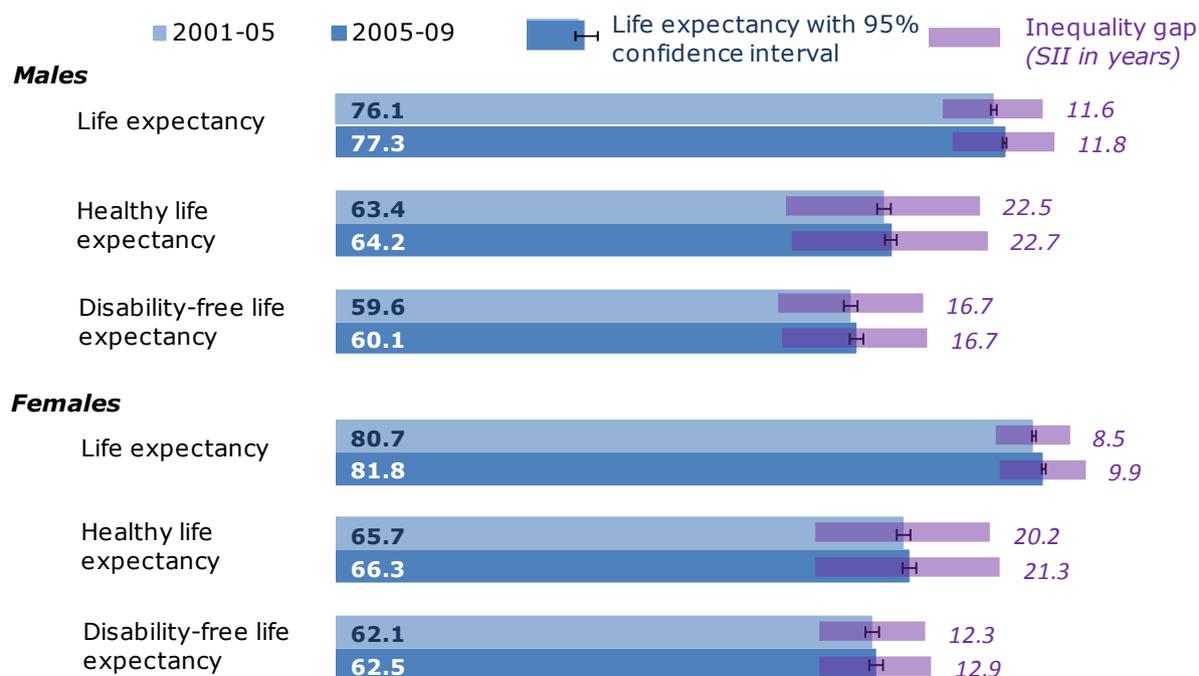
Key points

- There are stark inequalities in health outcomes in Cardiff and Vale
 - Life expectancy for men is nearly 12 years lower in the most-deprived areas compared with those in the least-deprived areas
 - The number of years of healthy life varies even more, with a gap of 22 years between the most- and least-deprived areas
 - Premature death rates are nearly three times higher among the most-deprived areas compared with the least deprived
- There are also significant inequalities in the 'wider determinants' of health, such as housing, household income and education
 - For example, the percentage of people living without central heating varies by area in Cardiff and Vale from one in a hundred (1%) to one in ten (13%)
- There are inequalities in how and when people access healthcare

(i) Health equity and inequalities

Life expectancy for men is nearly 12 years lower in the most-deprived areas compared with those in the least-deprived areas. The number of years of healthy life varies even more, with a gap of 22 years between the most- and least-deprived areas.

Figure 4. Life expectancy in years, in Cardiff and Vale. Source: Public Health Wales Observatory (2011).¹



Key: SII, Slope Index of Inequality. The Slope Index of Inequality (SII) measures the absolute gap in years of life expectancy between the most and least deprived, taking into account the pattern across all fifths of deprivation within the Local Authority

Risk factors and mortality for many common conditions is also adversely affected by deprivation, with a significant inequality 'gap' between those in the most- and least-deprived communities.

Figure 5. Obesity in Cardiff and Vale by deprivation fifth (Public Health Wales, 2014)

Percentage of adults reporting to be obese, by deprivation fifth, all persons, Cardiff and Vale UHB

Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

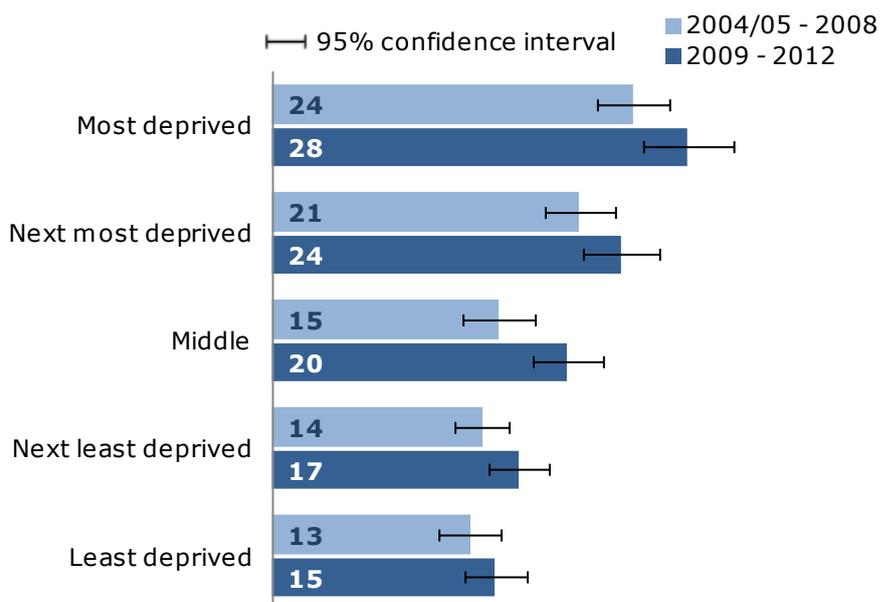
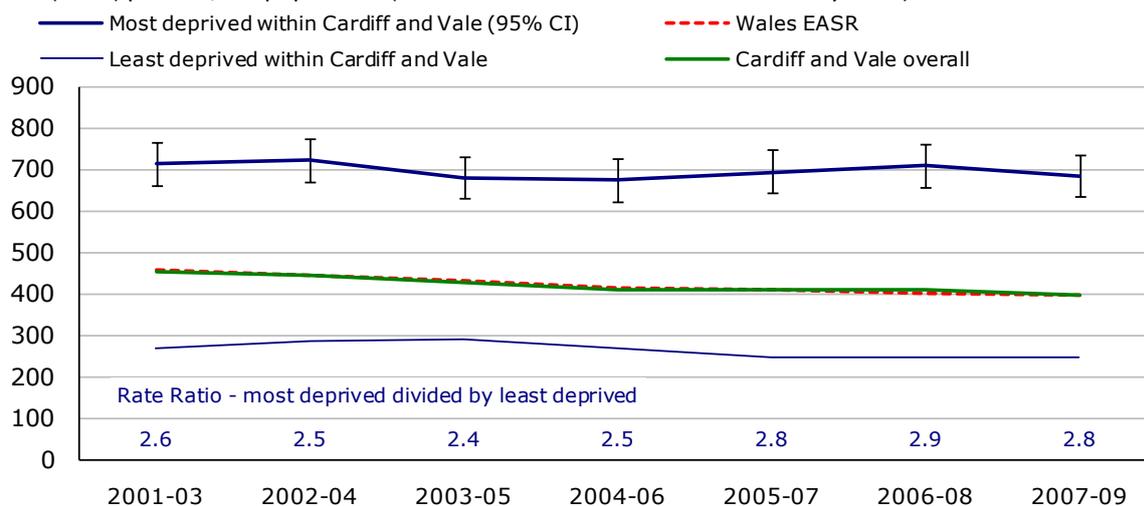


Figure 6. Premature mortality in males in Cardiff and Vale by deprivation fifths. European age-standardised rates (EASR) per 100,000 population (Source: Public Health Wales Observatory 2013)



Uptake of childhood vaccinations varies considerably across Cardiff and Vale. For example, the ratio of the average uptake of the teenage booster between the top 10 practices in the UHB area and the bottom 10 practices, is 1.87. This reflects average uptake of 93.2% in the top 10 performing practices compared with uptake of 49.2% in the bottom 10 practices.

Areas of deprivation in Cardiff are mainly in the southern arc, with around one in six of Cardiff's neighbourhoods within the 10% most deprived in Wales. In contrast, most deprivation in the Vale is around Barry, and around 1 in 15 neighbourhoods in the Vale are in the 10% most deprived in Wales.

The 'wider determinants' of health including income, quality and availability of housing, employment, education and community safety show large variation across Cardiff and Vale and, in particular, within Cardiff. Two examples are given below.

Figure 7. Areas of deprivation in Cardiff and Vale, based on the Welsh Index of Multiple Deprivation (WIMD) 2008. Source: Public Health Wales Observatory (2011).¹

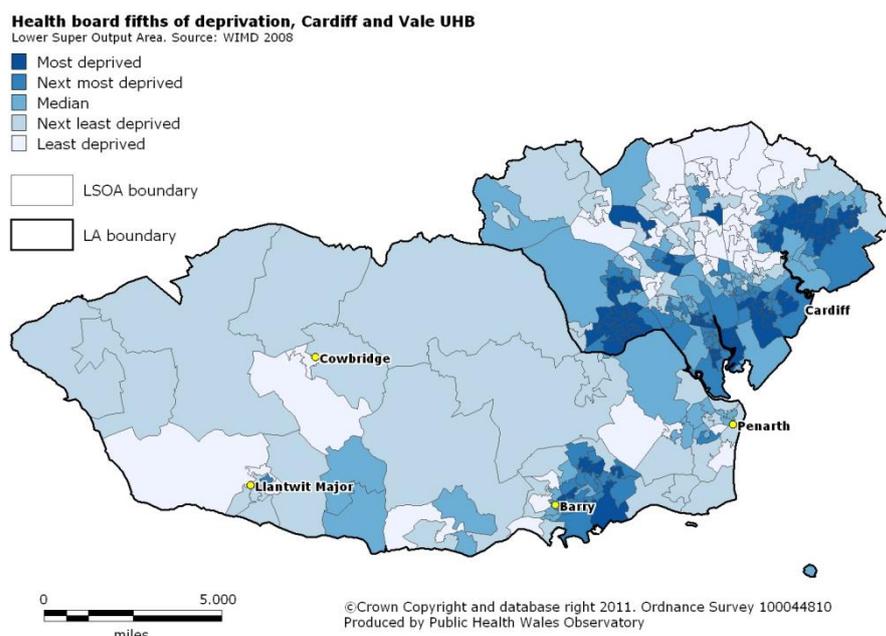
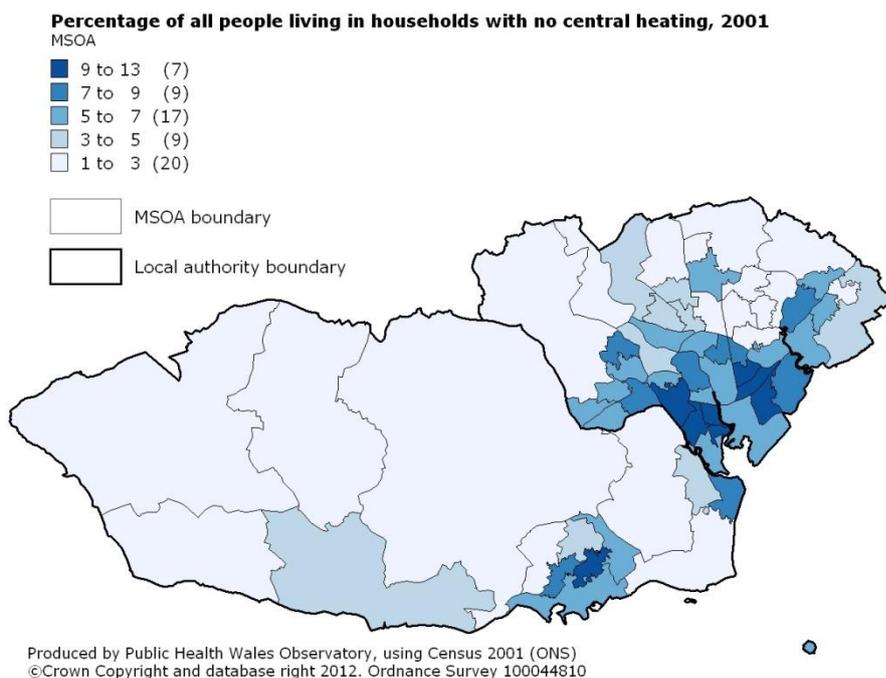


Figure 8. Percentage of people living in households with no central heating. Source: Public Health Wales Observatory (2012) from Census 2011 data.



Further data is available in a Public Health Wales Observatory report (2012) on wider determinants.

Rates of hospital utilisation in residents under 75 are similar to the rest of Wales but show interesting patterns in Cardiff. The rates of emergency hospital admission in Riverside, Grangetown and Butetown are statistically significantly higher than Wales but conversely, elective admissions are similar to, or lower than, Wales as a whole. This suggests healthcare access or utilisation patterns in these communities is different to other areas.

(ii) Protected characteristics

The basis for any planning, particularly from an equality perspective, is a systematic and robust consideration of the Equality Act's duties and 'protected characteristics' during all stages of policy or practice development. It is also about taking account of the UHB's Strategic Equality Plan and Objectives. This is not just about collecting data, but reviewing both qualitative and quantitative information on how a service will work in practice. It is also about training, awareness and education.

There is work to do to help staff feel more comfortable about discussing equality related issues and questions in terms of sexual orientation, religion and gender-reassignment and for our patients to understand why this information is so important. There are well documented issues which impact on certain communities more than others e.g. diabetes, hypertension and organ donation among black and minority ethnic (BME) communities.

One of our priorities identified is working with those with a disability caused by sight loss, hearing loss and deafness or a combination of both. The UHB has recognised that it has to work more effectively with those patients, relatives, carers who have a hearing or sight loss. We will continue to use our data to inform our plans and policies. However as a UHB we need to engage more with the people in the community that these issues affect, and others, so that we are able to better understand how we can positively influence our communities and patient care.

4. Ill health and service use in Cardiff and Vale

Key points

- The disease profile in Cardiff and Vale is changing
 - The number of people with two or more chronic illnesses in Cardiff and Vale has increased by around 5,000 in the last decade, and this trend is set to continue
 - Around 1 in 7 (15%) people consider their day-to-day activities are limited by a long-term health problem or disability
 - Many people with chronic conditions are not diagnosed and do not appear on official registers
 - Due to changes in the age profile of the population and risk factors for disease, new diagnoses for conditions such as diabetes and dementia are increasing significantly
- Around 1 in 5 adults have visited their GP within a 2 week period; and nearly three quarters visit a pharmacy over a year period
- Rates of delayed transfer of care for social care reasons are nearly twice as high in Cardiff and Vale than the Wales average
- Heart disease, lung cancer and cerebrovascular disease are the leading causes of death in men and women
- Preventable illness and deaths
 - Many (but not all) of the most common chronic conditions and causes of death may be avoided by making changes in health-related behaviours

(i) Burden of disease across GP clusters

Around 1 in 7 (15%) of the local adult population considered their day-to-day activities were limited a lot by a long-term health problem or disability. A third (32%) had a limitation of any sort. These rates are slightly lower than the Wales average of 16% and 34% respectively.

Table 11. Age-standardised percentage of patients on selected chronic condition registers, Cardiff & Vale UHB, 2012, to indicate the relative burden of recorded disease across GP clusters having taken age into account.

Source: Public Health Wales Observatory (2013)

Area	Chronic condition					
	Asthma	CHD	COPD	Diabetes	Epilepsies	Heart failure
Cardiff East	6.7	2.8	1.6	4.3	0.7	0.6
Cardiff North	6.5	2.2	0.9	3.2	0.5	0.6
Cardiff South East	5.7	2.6	1.7	4.3	0.6	0.6
Cardiff South West	7.2	2.6	1.6	4.4	0.6	0.5
Cardiff West	6.6	2.2	1.0	3.2	0.5	0.5
Central Vale	7.1	2.7	1.4	4.2	0.7	0.5
City & Cardiff South	6.0	2.6	1.5	5.8	0.6	0.6
Eastern Vale	6.2	2.2	0.9	3.3	0.5	0.4
Western Vale	6.1	2.2	0.9	3.0	0.5	0.7
Cardiff and Vale UHB	6.4	2.4	1.2	3.8	0.6	0.5
Wales	6.4	2.6	1.4	3.9	0.7	0.6

Key: COPD, chronic obstructive pulmonary disease; CHD, coronary heart disease

Note: There are nine 'clusters' of GP practices across Cardiff and Vale, six in Cardiff and three in the Vale: Cardiff East, Cardiff North, Cardiff South, Cardiff South West, Cardiff West, City and South Cardiff; and Eastern Vale, Central Vale and Western Vale.

(ii) Service use

Nearly 1 in 5 adults (18%) in Cardiff and Vale visit their GP each fortnight, and over the period of a year around one third of adults (34%) visit an outpatient department. Self-reported attendance at a community pharmacy within the last year is higher in Cardiff and Vale (74%) than Wales as a whole (70%).

Table 12. Age-standardised percentage of adults using NHS services in Cardiff and Vale and Wales in the prior 2 weeks to 1 year (Welsh Health Survey 2012-13)

NHS service	C&V	Wales
Family doctor (GP) (past 2 weeks)	18	17
Attended casualty (past 12 months)	16	17
Outpatients (past 12 months)	34	32
In hospital as an inpatient (past 12 months)	9	9
Pharmacist (past 12 months)	74	70
Dentist (past 12 months)	69	70
Optician (past 12 months)	52	50

Attendance at major Emergency Departments is below the Wales average (240 per 1,000 per year) for residents in the Vale (188) but higher in Cardiff (270) (Public Health Wales Observatory, 2013/14). In contrast, emergency admission rates are lower for both Cardiff (87 per 1,000) and the Vale (103) than the Wales average (112). Rates of delayed transfer of care for social care reasons are nearly twice as high in Cardiff and Vale than the Wales average (Cardiff 8.6 per 1,000; Vale 8.2 per 1,000; Wales 4.7 per 1,000).

The impact of significant reductions in local authority funding are yet to be seen but these could adversely affect general and tailored support for vulnerable individuals in the community. This may result in an increase in hospital admissions where families or individuals are unable to cope, and place further pressure on resources in the community to support patients being discharged from hospital.

(iii) Change in disease profile

The proportion of people with chronic illness rises with age (Figure 9). While this pattern has not altered significantly over the past 10 years, because the population is getting older on average this manifests as a trend of an increasing average number of illnesses per individual in the population (Figure 10). Over the past 10 years there are around 13,000 additional individuals with one chronic illness and 5,000 with two or more chronic illnesses. This trend is set to continue.

Figure 9. Percentage of individuals in Wales with 1, 2 or more illnesses by age group (Welsh Health Survey, 2013)

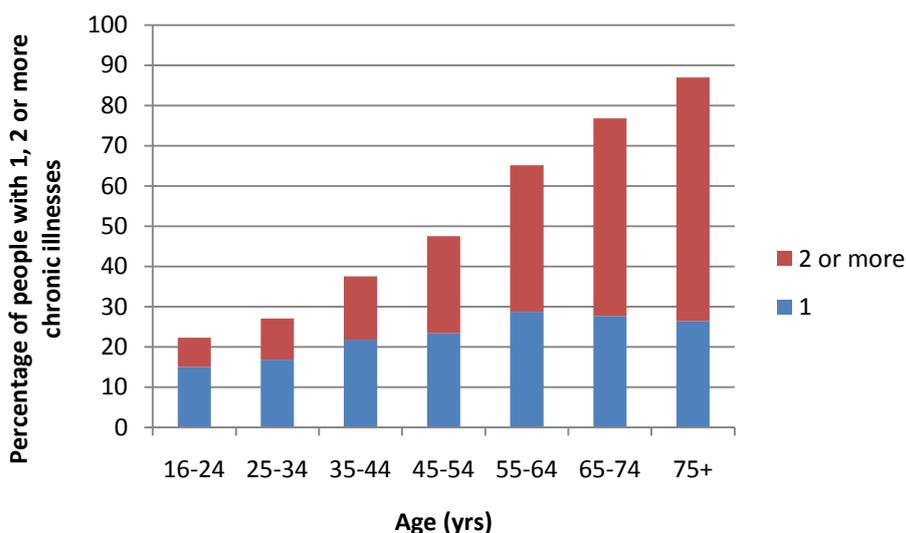
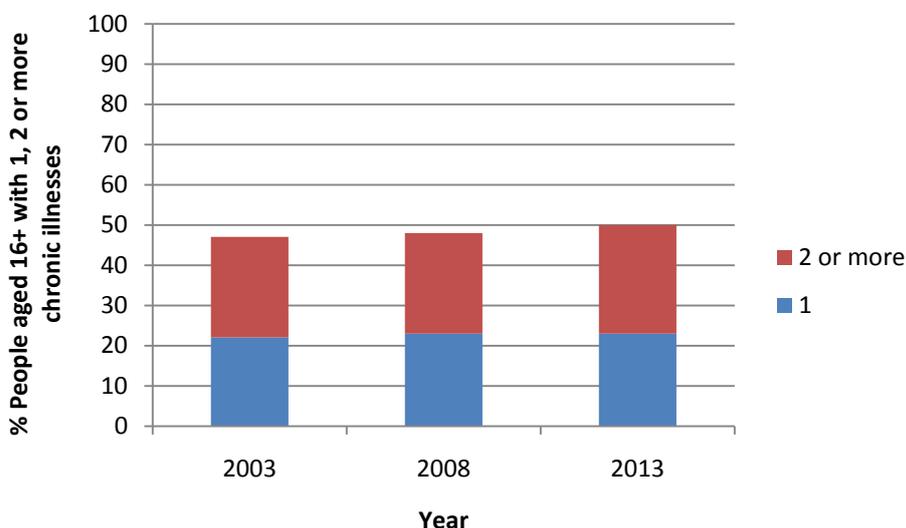


Figure 10. Percentage of individuals in Wales with 1, 2 or more illnesses by year (Welsh Health Survey, 2003-2013)



The profile of disease in Cardiff and Vale is changing. Examples are given for two common diseases – diabetes and dementia – which affect many people, including their families, friends and carers. In both cases many (but not all) instances of the disease could be prevented by modifying behaviours such as diet and physical activity.

Diabetes

It is thought that the number of people who have been diagnosed with diabetes and appear on the GP registers, 21,000, is lower than the number who actually have the disease, in particular for type 2 diabetes. (Association of Public Health Observatories, 2011). It has been estimated that there are actually 29,000 adults in Cardiff and Vale with diabetes, around 8% of the population. This suggests there is a shortfall in diagnosis of around 8,000 adults, or over a quarter of predicted cases.

The percentage of people reporting being treated for diabetes has been rising steadily over the last ten years across Wales. Current projections are for the adult population with diabetes in Cardiff and Vale to increase from around 29,000 to around 40,000 by 2025, an increase of nearly 40%. Recorded prevalence of diabetes varies significantly within areas of Cardiff with higher black and minority ethnic (BME) population. Since diabetes is more common in South Asian and black ethnic groups, higher recorded prevalence would be expected here. However, within the Cardiff City and South neighbourhood area, recorded prevalence varies between GP practices from 2.7% to 7.1%, hinting at under-diagnosis in some areas.

Dementia

The number of people living with dementia is also projected to rise significantly. The driver for this is mostly the increase in the over 85 population (see above). There is evidence that the risk of developing dementia at any given age is actually starting to fall, but this decline does not sufficiently offset the rise in the population size. Similarly to diabetes, there are thought to be many people currently living with dementia whose condition has not yet been diagnosed.

Table 13. Estimated number of people with dementia in Cardiff and Vale, 2012 to 2025 (Source: Daffodil Cymru)

Age group	Year			
	2012	2015	2020	2025
30-64 yrs (early onset dementia)	107	109	116	121
65-69 yrs	255	282	269	291
70-74 yrs	433	465	576	554
75-79 yrs	780	813	894	1,110
80-84 yrs	1,242	1,262	1,375	1,540
85 yrs and over	2,435	2,565	2,875	3,355
65 yrs and over (total)	5,144	5,387	5,988	6,849

Figure 11. People with dementia on GP registers in Cardiff and Vale; and estimated total number of people with dementia, including those currently undiagnosed. Source: Public Health Wales Observatory (2013)

People with dementia, 2010 / 2012

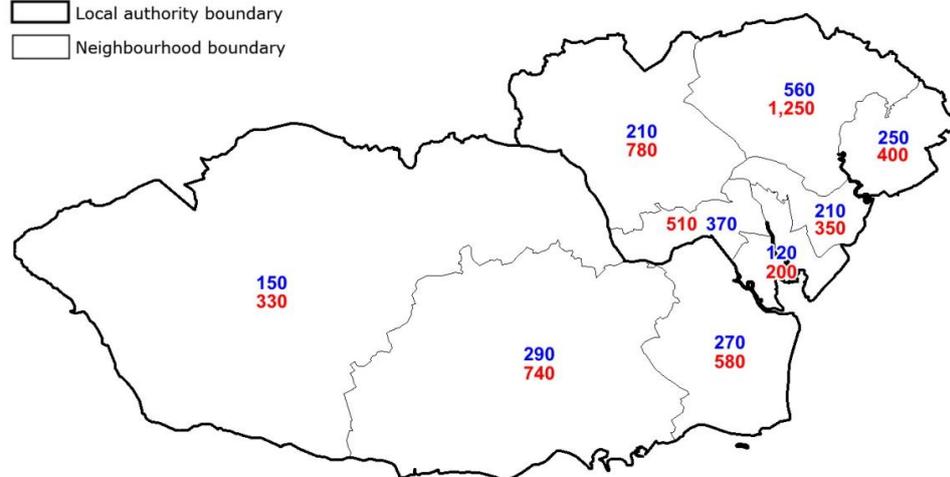
Neighbourhood management areas in Cardiff and The Vale of Glamorgan

150 Blue labels show numbers of people on QOF dementia registers (2012)

330 Red labels show numbers of people estimated to have dementia (2010)

Local authority boundary

Neighbourhood boundary



Produced by Public Health Wales Observatory, using Daffodil (WG), MYE (ONS), Audit+ (NWIS)
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Mental health

4,111 people are on the primary care register for serious mental illness (including schizophrenia, bipolar disorder and other psychoses), around 0.8% of the GP list size in Cardiff and Vale.

In general, people with a psychotic illness have fewer qualifications and are more likely to have left school before the age of 16 with no qualifications, compared with other groups. The percentage of Year 11 school leavers who were known to be not in education, employment or training (NEET) in 2013 in Wales was 3.7%, with local rates of 3.8% in the Vale of Glamorgan and 4.9% in Cardiff.

43% of people accessing homelessness projects in England had a mental illness. The number of households in Cardiff who were deemed to be eligible, unintentionally homeless and in priority need was 690 in 2013/14, and 195 in the Vale.

The standardised rate for suicide among women in Cardiff (5.8 per 100,000) is above the Wales average of 5.3, with rates for men and in the Vale below the Wales average.

(iv) Cancer incidence

Table 14. Incidence of top 3 newly diagnosed cancers in males in South Wales, 2007-2011. European age-standardised rate per 100,000 population. Source: Welsh Cancer Intelligence and Surveillance Unit (WCISU).

Cancer site	Year				
	2007	2008	2009	2010	2011
Prostate	125.5	118.7	106.9	110.1	104.8
Trachea, bronchus and lung	64.6	65.8	58.9	59.6	62.7
Colorectal	61.5	61.6	66.2	67.8	57.7
All excluding NMSC	471.5	465.2	440.2	448.2	444.9

Key: NMSC, non-melanoma skin cancer

Table 15. Incidence of top 3 newly diagnosed cancers in females in South Wales, 2007-2011. European age-standardised rate per 100,000 population. Source: Welsh Cancer Intelligence and Surveillance Unit (WCISU).

Cancer site	Year				
	2007	2008	2009	2010	2011
Breast	122.2	126.1	128.7	131.4	116.9
Trachea, bronchus and lung	40.5	43.9	38.1	40.6	41.1
Colorectal	39.4	37.5	39.3	34.9	39.8
All excluding NMSC	379	384	390	390.8	382.1

Key: NMSC, non-melanoma skin cancer

(v) Causes of death

Table 16. Top 5 causes of death in men, England and Wales 2012

Cause of death	EASR per million
Ischaemic heart disease	954
Trachea, bronchus and lung cancer	442
Cerebrovascular disease	341
Bronchitis, COPD	327
Pneumonia	260

Key: EASR, European age-standardised rate

Table 17. Top 5 causes of death in women, England and Wales 2012

Cause of death	EASR per million
Ischaemic heart disease	426
Cerebrovascular disease	327
Trachea, bronchus and lung cancer	298
Breast cancer	239
Bronchitis, COPD	224

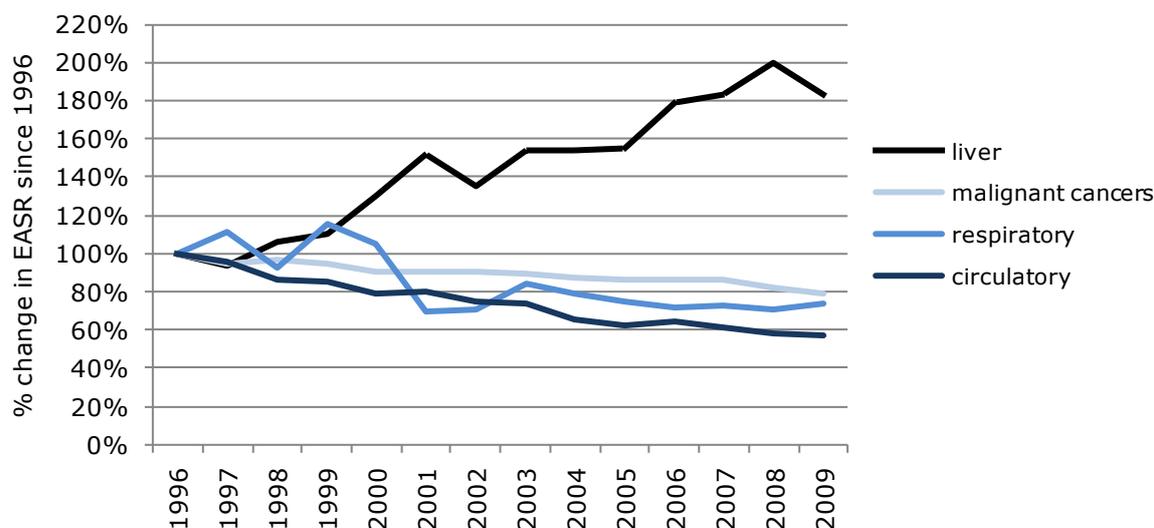
Key: EASR, European age-standardised rate

In Cardiff and Vale, although death rates from cancer, respiratory disease and heart disease overall are gradually decreasing, for some other conditions such as liver disease, mortality is increasing.

Figure 12. Changes in mortality rates for liver disease, cancer, respiratory disease and circulatory disease (Source: Public Health Wales Observatory, 2011)

Under 65 European age standardised mortality rates for various diseases, Wales, percentage change from 1996 baseline

Produced by Public Health Wales Observatory, using ADDE/MYE (ONS)



5. Working in partnership with our local residents

Information and views gathered through the extensive engagement, consultation and equality impact assessment work undertaken to support the South Wales Programme in 2012/13 continues to inform emerging local and regional service delivery plans. This links with activity to shape a long term UHB Clinical Services Strategy ('Shaping our future wellbeing'), using co-production workshops to involve service users and clinicians in shaping future service models which focus on identifying outcomes that are important to people. In addition, the UHB is sharing platforms with Local Service Board colleagues as part of the Cardiff Debate and Vale Viewpoint survey, which seek to engage local people in dialogue about the issues facing public services locally. A Cardiff and Vale Big Lottery funded project, 'Co-creating Healthy Change' is also facilitating seldom heard voices to influence services at an operational level.

A theme emerging across engagement activity is the importance of communication, including improving access to personalised information and support that can enable people to be more in control of their health and well-being.

A current gap in our knowledge of our local area relates to community 'assets'. An understanding of assets is important not only to balance the traditional 'deficit' model of assessing a community's health, but also because without this the Health Board and public and third sector partners are missing the opportunity to work more closely with the community, building on and making best use of its current strengths and co-producing solutions to health issues. An asset mapping process is planned as part of the development of the Clinical Services Strategy.

Note on scope of profile

This profile relates to the needs of the population of Cardiff and the Vale of Glamorgan to inform the Health Board's principal role to secure and deliver services for the local population. Where the UHB provides services for individuals residing outside Cardiff and the Vale, population need is assessed by the relevant commissioner (another Local Health Board, the Welsh Health Specialised Services Committee, or English Clinical Commissioning Group).