



**GIG**  
CYMRU  
**NHS**  
WALES

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

**INTEGRATED MEDIUM TERM PLAN  
2014/15 – 2016/17**

**CARING FOR PEOPLE;  
KEEPING PEOPLE WELL**

**FINAL**

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# 1. Executive Summary

## 1.1 Introduction

This 2014/15-2016/17 Plan is the first Integrated Medium Term Plan (IMTP) prepared by Cardiff and Vale UHB. The UHB produced its first [Integrated Business Plan](#) (IBP) in 2013/14 with the purpose of clearly setting out the UHB's ambition for change over the next three years. The benefits of developing an IMTP are

- **Integration** - plans for service change, quality, performance and delivery, finance, workforce and governance are brought together so that they are coherent.
- **Planning ahead** – the process of planning for three years supports delivery of longer-term transformational plans, as well as short-term, in-year objectives
- **Engagement** – the process of developing the plan enables alignment with partner organisations' objectives and effective engagement with stakeholders, including our staff.
- **Communication** – the published plan will enable the UHB to set out clearly for our staff, the public and our partners which services we are setting out to deliver for patients and how we will do this within the resources available, within one document.

## 1.2 Developing the 2014/15-2016/17 Integrated Medium Term Plan

The 2013/14 IBP was submitted to Welsh Government at the end of September 2013, and at that point the UHB had already started the process for developing this IMTP. The UHB has changed the terminology from a Business to a Medium Term Plan to reflect the longer term and strategic nature of the Plan, and to better reflect the way in which we plan and deliver services in Wales. This IMTP needs to be read in conjunction with the previous [IBP](#), which set much of the context and background for the UHB; why we are in the position we are in terms of service, finance, workforce and performance priorities and pressures and many of our aspirations moving forward. That detail is not repeated in this document.

The IMTP has been built from the following bases:

- Individual Clinical Board Plans - which reflect the outcomes of engagement with staff, patients, public and local communities and which set out local service needs and pressures;
- The UHB's Commissioning Intentions – which set out how, as an organisation we want to start commissioning services to reflect population health needs; and
- National priorities and policies.

Each Clinical Board and Corporate Department has produced its own IMTP, the key issues of which have been taken to develop this Plan. There is therefore a significant amount of detail behind this IMTP, and our expectation is that, once finalised, each of these individual Plans will be available on the UHB Internet site. Developing the individual Plans has been done through processes of ongoing engagement with staff, Trade Unions and partner organisations. In particular, with our local authority partners, we have jointly shared our outline service and finance proposals to enable an early and comprehensive understanding of potential service changes and pressures.

In developing this Plan we have started on the process of co-production, recognising that there is a significant amount of work to do to truly reflect this approach in our plans. However, this Plan should be one of no surprises to people within and outwith the UHB. Clinical Boards have reflected local needs and views of staff, patients, partners and the public in the preparation of their Plans. These have then been built up to form this overarching corporate UHB Integrated Medium Term Plan.

The UHB also received feedback from Welsh Government on our 2013/14-2015/16 IBP. Welsh Government commented that:

*“This plan is heading in the right direction. It is clear, stretching, and grounded in an honest assessment of where the organisation is now. The main area for development ..... is translating this high level ambition into a clear delivery plan.”*

This draft Plan seeks to address this, and other comments which have been received.

### **1.3 Organisational Challenges**

The UHB, along with other public sector organisations, faces significant and ongoing challenges during the lifetime of this IMTP. In summary these are:

- Making financial savings of approximately 7% per year for the next three years (about £50million/year);
- Ensuring that the services which we provide are safe within a reducing financial envelope;
- An estate which needs considerable investment just to maintain safety; updating our equipment to provide modern, technologically advanced care with a reducing capital allocation;
- Improving our performance to consistently meet Welsh Government and local targets;
- Increased demand on our services from an ageing and increasing population, and a population that will have significantly more health needs;
- Pressures and shortages in many areas of our workforce.

### **1.4 Meeting the Challenges**

The UHB intends to meet the challenges through a variety of routes, both long and short term, which are set out in the IMTP. Key to these will be:

- Developing our Organisational Strategy which clearly sets out our ambition for change over the next ten years, how we expect the UHB to look at the end of that time, and some of the key programmes of work we need to put in place to achieve that. Our Organisational Strategy will be dynamic, and in particular we recognise that we will need to respond to the recommendations of the Williams’ Review once these are confirmed. We are also considering the proposals put forward by the Bevan Commission on Prudent Healthcare. These will be invaluable to us as we develop our Organisational Strategy, and also our longer term Clinical Services Plan. We recognise that we need to take radical steps to change our services, and introduce a more prudent approach through increasing the quality of healthcare for those in need, rather than pursuing unattainable aspirations, desires and wants. We will further reflect and respond to these challenges during the course of this Plan.
- Transforming our services through developing a 5-10 year Clinical Services Plan – we recognise that it is difficult for our Clinical Boards to plan their services over a longer time period without a broader UHB wide context within which to plan. This Plan will be started during 2013/14 and start to be implemented during 2015/16. Maximising the integrated nature of our organisation will be crucial to the Clinical Services Plan.
- Establishing the Clinical Boards – Clinical Boards have been authorised during 2013/14, and this is one of the key mechanisms through which we will secure improved service change and delivery. We recognise that this is an evolving process, and as Clinical Boards mature and develop they will receive increased levels of delegated decision making and autonomy. We do expect, however, that the Boards will be central to our new and improved operating arrangements.
- Establishing and embedding commissioning - the UHB was established as a provider organisation with little expertise or capacity to develop a commissioning approach. This is an area where we have made a small amount of progress, but which we expect to strengthen and improve considerably upon during 2014/15 and beyond. We will use commissioning to focus on ensuring we commission evidence based services to meet population health needs, are of high quality and provide excellent value for money.
- Working with our partners – we have made noteworthy strides in formalising our partnership arrangements, particularly with local authorities and the third sector, during

2013/14 which are leading to improved outcomes in care. We will continue to build upon and strengthen these arrangements over the lifetime of the IMTP.

- Improving our internal efficiency and effectiveness – we recognise that there are many areas where we can improve the way in which we operate internally, to improve our “flow” of care; our quality of services and the way in which we use our resources. We have formal programmes of work to manage these improvements, and these will continue to be robustly managed, with new areas of potential built into the programme.
- Develop and grow the services we offer to reflect the needs of our local population - the citizen is at the heart of all that we do. The UHB is committed to delivery our services irrespective of age, disability, gender-reassignment, marriage and civil partnership, maternity and pregnancy, race, religion or belief, sex, sexual orientation, carer’s status or Welsh language issues, ensure that our services are accessible to all and tailored to meet individual need. As an inclusive organisation we aim to ensure that equality, diversity and human rights are embedded in all our functions and actions.
- Ensuring that we have the estate and infrastructure required to enable us to deliver care to the standards required, providing an excellent patient experience within fit for purpose accommodation – whether that is in the hospital or community.

### **1.5 Progress by March 2015**

By implementing the actions set out in this IMTP we will have achieved the following by the end of 2014/15:

#### Improved Health and Well Being

We will have made strides towards improving the health and well being of our population by:

- Offering smoking cessation support to everyone listed for surgery who is recorded as a smoker;
- Offering weight management support to everyone listed for surgery who is recorded as having a BMI of 40+;
- Improved our uptake of vaccinations and immunisations;
- Starting to reduce inequity of access to care for certain groups – eg people with diabetes; and
- Engaging with communities and stakeholders on the development of Shaping Our Future Well Being, our Clinical Services Plan which will be focused on improving people’s health through all levels of care.

#### Improved Service Integration

We will be on the way to achieving our vision of being the UK’s leading integrated care organisation by:

- Strengthening our locality and neighbourhood working;
- Planning and delivering more services conterminously with localities – eg district nursing and community mental health teams;
- Developing integrated care pathways across the continuum of our care, for example MSK, INR and diabetes and ensuring resources are appropriately aligned with the care pathways;
- Developing and implementing integrated service models for people across the health, social care and third sectors to improve the continuity and outcomes of care. We will also start to develop models of care with other sectors such as housing;
- Having a clear model of care for gerontology across the UHB which is aligned to care provided by partners enabling us to provide more care in or closer to people’s homes, maximising people’s independence and reducing the need for long term care;
- Developing a framework for older people in response to the Welsh Government policy incorporating the initiatives above; and
- Starting to implement our organisational strategy which will enable us to have a comprehensive integrated care delivery system through for example integrated care teams;

#### Improved Access to Services

We will improve access to our services with:

- A more responsive and efficient urgent care system which improves the flow of patients through the entirety of our services and means we meets the A&E waiting times standards;
- More efficient systems and use of technology to enable us to meet our waiting times targets;
- Patients accessing cancer services within timescales set by Welsh Government;
- Compliance against the stroke bundles leading to better outcomes of care;
- Agreeing and implementing integrated care pathways which help to reduce demand on hospital services;
- Developing plans to increase capacity where required – e.g. for neonatal services;
- Improved day surgery rates; theatre utilisation and admission on day of surgery; and
- Development of care delivery networks/alliances across LHB boundaries to implement the outcomes of the South Wales Programme.

#### Improved Patient Safety and Experience

We will continue our unrelenting focus on patient safety and quality, through:

- Delivering the Leading Improvements in Patient Safety Programme enabling clinical teams to improve the quality of care to patients and leading to reductions in Health Care Associated Infections, pressure damage, DVTs and incidents arising from Sepsis;
- Introducing an agreed set of quality triggers to assess whether we are providing safe care. Triggers will include RAMI (or other agreed mortality rates); failure to complete mortality reviews and incident or near miss reporting clusters;
- Responding to concerns and acting on patient experience feedback – and improving the timeliness with which we do this; and
- Improving the end of life experience for patients and improving their personal dignity at the same time.

#### Strengthening our Support to Service Delivery

The corporate functions which support our Clinical Boards deliver care will:

- Focus our investment of capital monies on improving our current estates, improving our IT and replacing outdated medical equipment;
- Make better use of technology to enable us to deliver care in more innovative ways and help us transform our services;
- Develop new roles and redesign our existing workforce to enable new models of care to be delivered;
- Support the delivery of all of our services within financial balance and meet the first year of the three year Financial Plan; and
- Work with stakeholders and Clinical Boards to develop a proactive and consistent approach to engaging with our communities so that our services better reflect their needs.

## 2. Health Board Profile

### 2.1. Overview

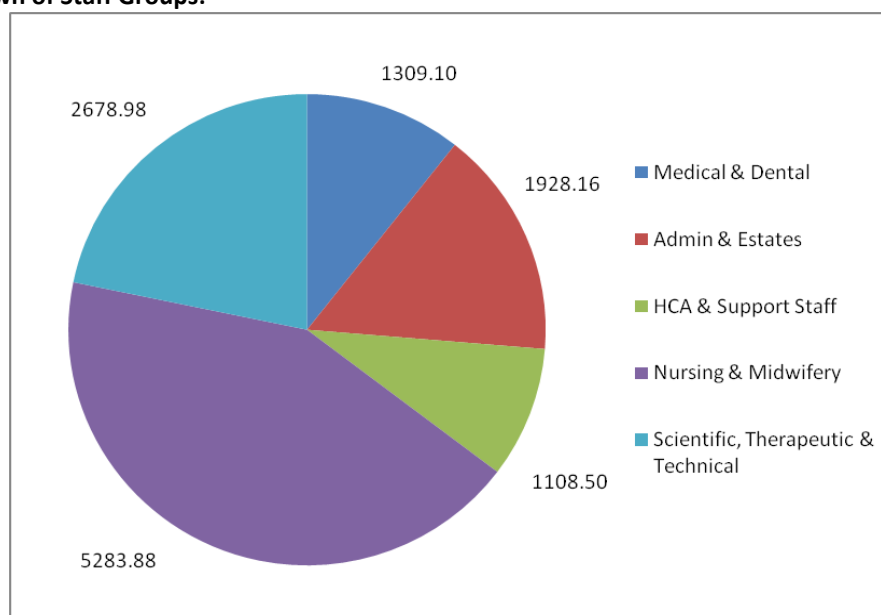
Cardiff and Vale University Health Board was established in October 2009 and is one of the largest NHS organisations in the UK. We have a responsibility for the health of around 472,400 people living in Cardiff and the Vale of Glamorgan, the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres and community health teams. Together, these provide a full range of health services for our local residents and those from further afield who use our specialist services.

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.

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; and enjoy strengthened links with the University of South Wales. Together, we are training the next generation of clinical professionals.

The Health Board employed, on average, 12,308.62 WTE staff (based on September 2012- September 2013) :

#### Breakdown of Staff Groups:





# Cardiff & Vale of Glamorgan

## Hospitals

- University Hospital of Wales
- University Dental Hospital
- Noah's Ark Children's Hospital for Wales
- University Hospital Llandough
- Whitchurch Hospital
- Rookwood Hospital
- Barny Community Hospital
- St David's Hospital
- Cardiff Royal Infirmary (Incl CAU, Links, Longcross)
- Cardiff Royal Infirmary West Wing
- Lowarth Jones Centre

## Mental Health Community Premises

- Amy Evans Centre
- Park Road
- Pen yr Ynys
- Pendina Centre FH
- The Hamadryad Centre
- The Phoenix Centre
- Avon House (Hafan Dawel)
- Nowland Street

## Community Health Centres & Clinics

- Broad Street Clinic
- Colcot Clinic
- Dinas Powys Health Centre
- Gabafta Clinic
- Grangtown Health Centre
- Llanedeyrn Health Centre
- Llanishan Clinic
- Park View
- Pentwyn Health Centre
- Radyr Health Centre
- Rhwybina Clinic
- Riverside Health Centre
- Roth Clinic
- Cadoxton Practice of Health
- Llanrumney Medical Centre
- Pensarth Health Centre
- Loudoun Square Medical Centre
- Rumney Primary Care Centre

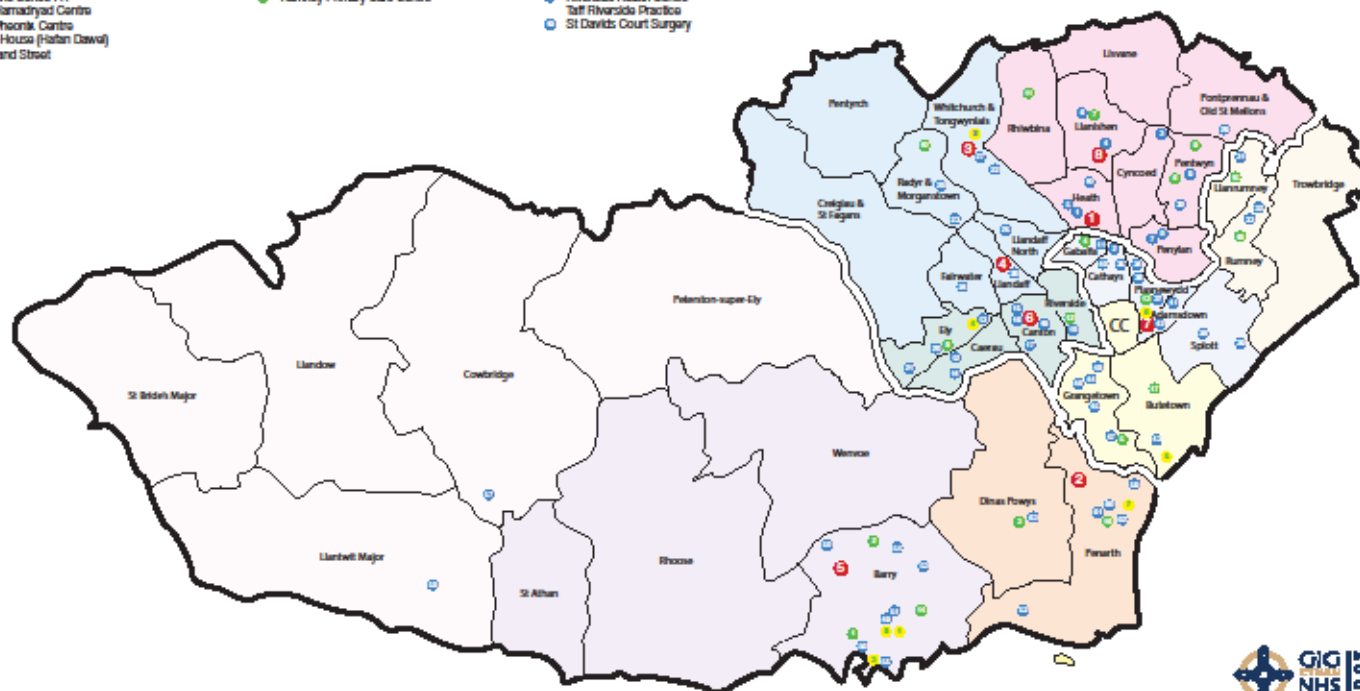
## GP Practices

- Birchgrove Surgery
- Cwrys Medical Centre
- Cyncoed Medical Centre
- Llanishan Court Surgery
- Llwynbadw Medical Centre
- North Cardiff Medical Centre
- Pentwyn Surgery
- Roth House Surgery
- St David's Medical Centre
- St Iwan Road Surgery
- Whitchurch Road Surgery
- Casau Lane Surgery
- Ely Bridge Surgery
- Grainmount Surgery
- Kings Road Surgery
- Maddygfa Cania Surgery
- Maddygfa Lansdowne Surgery
- Riverside Health Centre
- Taff Riverside Practice
- St David's Court Surgery

- Westway Surgery
- Woodlands Medical Centre
- Bishops Road Medical Centre
- Danescourt Surgery
- Fairwater Health Centre
- Llandaff North Medical Centre
- Llandaff Surgery
- Maddygfa Llwyniolyn Practice
- Whitchurch Village Practice
- Radyr Medical Centre
- Brindeswen Surgery
- Llanedeyrn Health Centre
- Llanrumney Medical Group
- Rumney Medical Practice
- Willowbrook Surgery
- Albany Surgery
- Cathays Surgery

- City Surgery
- Clifton Surgery
- Cloughmore Surgery
- Four Elms Medical Centre
- North Road Medical Practice
- Roadwell Surgery
- Cardiff Health Access Practice
- Bulstow Health Centre (Dr Saunders)
- Bulstow Health Centre (Dr Tward)
- Claire Road Medical Centre
- Corporation Road Surgery
- Grange Medical Practice
- Cardiff Bay Surgery (Grangefield)
- Saltmead Medical Centre
- Court Road Surgery
- Highgate Park Medical Practice

- Ravenscourt Surgery
- Sully Surgery
- The Practice of Health
- The Vale Family Practice
- The Waterfront Medical Centre
- West Quay Medical Centre
- Cowbridge & Vale Medical Practice
- Cowbridge & Western Vale Group Practice
- Ely Surgery
- Albert Road Surgery
- Radlands Surgery
- Stanwell Road Surgery
- Station Road Surgery
- The Family Practice
- The Group Practice



## 2.2. Range of Services

The UHB provides the full range of primary, community and secondary care services for our resident population. We also provide specialist services for people across South Wales and in some cases the whole of Wales. Each Clinical Board has prepared a service profile as part of its Integrated Medium Term Plan which has informed the business planning process. Details of all of our services were also included in the [2013/14 IBP](#).

## 2.3. Finance Summary

The table below shows the high level financial performance of the Health Board covering the period from 2010/11 to 2012/13. It also set out the forecast position for 2013/14.

Health Board Summary Financial Performance

	2010/11	2011/12	2012/13	2013/14
	£m	£m	£m	£m
Income	-1136	-1149	-1181	-1160
Expenditure	1136	1149	1181	1179
Performance against Revenue Resource Limit	0	0	0	19
Capital Resource Limit	64	57	47	58
Capital Expenditure	64	57	47	58
Performance against Capital Resource Limit	0	0	0	0

The Health Board has a planned deficit of £16m in 2013/14 which due to slippage on savings schemes is now forecast to be £19m. The three year Integrated Medium Term Plan aims to address this deficit and restore the Health Board back into financial balance by 2015/16. The plan also aims to deliver cumulative break even over the three year periods 2014/15 to 2016/17 and to repay all accumulated deficits by 2016/17. This can only be done through the continued delivery of substantial cost savings. Details of this and of the overall financial plan are contained in the Section 6 of this plan.

## 2.4. Achievements 2013/14

Progress against implementing the 2013/14 IBP was considered at the [November UHB Board Meeting](#), and this reports sets out the significant progress that had been made. Whilst not exhaustive, some of the UHB's key achievements and improvements during 2013/14 are set out below:

### Service Improvements and Innovation

- Significantly improved patient flow through our unscheduled care system resulting in reductions in average length of stay;
- Continued developments and enhancements to our Communications Hub which we run jointly with the Vale of Glamorgan Council;
- Enhancement and consolidation of our Community Resource Teams to support caring for people in their own homes;
- Improvements in cancer waiting times targets;
- Completion of a significant project supported by the King's Fund to support our ongoing integration with local authority partners;
- Ongoing development of our community based diabetes service;
- Development of a UHB wide dementia action plan.
- Full implementation of the Sepsis bundle
- A 75% reduction in falls for those on the Falls and Bone Health Programme.
- An increase in uptake of seasonal flu vaccine among healthcare staff, from 29.7% (2011/12) to 36.5% (2012/13)
- Successfully securing £6.8 million funding over five years for Families First Healthy Lifestyles and Early Years bids
- Downward trend in teenage conception rates. .
- Smoking ban approved on all sites
- Optimising outcomes policy implemented

#### Estates and Facilities Improvements:

- Improved parking at UHL
- First phase of EU remodelling project complete
- Funding agreed for new Adult Mental Health Unit at UHL
- New Primary Care Medical Centre in Dinas Powys
- Moved Alcohol Treatment Centre to new site in Cardiff. Over a three-month period 90% of alcohol-related, city centre Emergency Unit attendees diverted to the Alcohol Treatment Centre in Cardiff city centre

#### Awards:

Some of the Awards which staff from the UHB have received:

- **RCN Wales Nurse of the Year**, Cardiff and Vale UHB won in the following categories:
  - Wales Nurse of the Year Award - Ruth Owens, Ward Sister
  - Lifetime Achievement Award – Helen Bennett, Clinical Board Nurse Mental Health
  - Health Care Support Worker Award - The General Surgery, Urology and Head and Neck Quality and Standards Group
  - Health Care Support Worker Award Runner up - David Lomas, Health Care Support Worker for Assertive Outreach Service
  - Mental Health and Learning Disability Award - Andy Lodwick, Advanced Nurse Practitioner
  - Older People's Commissioner for Wales Award - Ruth Owens Ward Sister
  - Older People's Commissioner for Wales Award Runner-up - Sian Brookes, Ward Sister
  - Nurse Education Award Runner-up - Rachel Hart, Staff Nurse, Transplant Unit
- Kath Jones won the Outstanding Women Award from the Spinal Injuries Association, and colleagues OT Emma Wallace-Gibbons and Deputy Ward Manager Nurse Debbie Davies were also nominated.
- **The UHB won three NHS Wards in July 2013:**
  - Developing a Flexible and Sustainable Workforce Award - for training and employing people who have experienced mental health conditions to act as peer support workers for patients who need mental health care
  - Improving Quality Through Better Use of Resources Award - for reducing mortality from congenital heart disease in babies by introducing new screening during pregnancy, improved diagnosis and treatment
  - Promoting Clinical Research and Application to Practice Award - for the introduction of all Wales laparoscopic training scheme for colorectal cancer surgeons
- James Leaves awarded the **Terry Weston Memorial Prize** for achieving the highest examination mark in the Public Sector in Wales in the Certified Accountants final professional examinations.

#### Events and Media:

Some of the media and events coverage was:

- 80<sup>th</sup> Anniversary UHL
- Official opening of Stroke Unit at UHL by Minister for Health and Social Services
- Ministerial visits to Alcohol Treatment Centre, Stroke Unit, Children's Kidney Unit Wales, meet Sepsis patients
- Official opening of Mental Health Services for Older People unit in UHL

The UHB facilitated the following programmes:

- Nurses on Channel 5
- Midwives on BBC 2
- A Peace of Mind for BBC Wales

Aspects of the UHB's performance have significantly improved during 2013/14. Performance reports are provided at each of the UHB Board meetings and the latest is available [here](#).

## 1.2 Performance Management Arrangements

The UHB put new performance management arrangements in place in May 2013 as part of the transition to the Clinical Board structure. These evaluate progress against delivery of the objectives set out in the Integrated Business 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. Further detail on the Performance Management Framework is provided in section 12.2.

### 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 around performance information planned are as follows:

- 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 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. This will encompass actual activity trends and forecast population trends, changes to activity planned as a result of care pathway development and implementation of prudent medicine and will compare this to current capacity and anticipated future capacity when performance improvements are built in
- Further development of practice based information around referrals, hospital admissions etc which can be used to support practice visits which are planned to be extended from the focus on prescribing and QOF

### Expectations around performance improvement in 2014/15

In 2013/14 the UHB has significantly improved performance around key tier 1 targets in 2013/14, particularly A&E, cancer and stroke. The coding backlog has been almost eliminated which now means that our mortality metrics benchmark favourably compared to Wales and England peers. We have sustained our RTT position.

However there are areas where we need to improve our performance still, particularly:

- Stroke
- Mental Health
- Ambulance handovers
- HCAI

The priority for 2014/15 will be a further significant improvement in performance, whilst building sustainable capacity and efficient services:

- 31 and 62 day cancer targets will be met on a quarterly basis.
- The stroke bundles will be met from Q2 onwards.
- The mental health measures will be achieved in quarter 4.

- The 95% target for A&E will be met in quarters 2 and 3, with improved performance over the Winter period as we continue to develop our health and social care response to this period of enhanced demand.
- The RTT position will be improved so that we have no more than 500 patients waiting over 36 weeks, 0 patients waiting over 52 weeks and outpatient and diagnostics waits running at a sustainable level as at 31 March 2015. A detailed plan to deliver this is currently being developed and will be signed off by shortly. The internal expectation is that the majority of this will be delivered by November 2014 to avoid additional activity requirements during the winter period.
- Within this we are proposing to agree with WHSCC by no later than the end of February the rate of progress towards an 8 week cardiac surgery pathway
- Ensure 95% of all identified smokers are referred for smoking cessation support from Q1.
- Improve the processes that really matters for patients, including:
  - Cancellations of elective surgery,
  - HCAI (50% reduction on 2013/14 plan),
  - Hand Hygiene, Nutritional standards and patient engagement – all 12 standards to be achieved
  - Responding to concerns – backlog cleared in Q1 and then achieve full compliance with the standard from Q2 onwards
  - more effective management of DTOCs.
- Improve completion of PADR rates to 60%/70%/80%/85% by quarter
- Improve sickness rates to 4.49% across the year.

### 1.3 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, WHSCC 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 WHSCC relating to services for Cardiff & Vale residents commissioned on the UHB's behalf. The income and expenditure associated with these LTAs are summarised in the table below:

2014/15 LTA Income and Expenditure	£m
<b><u>Commissioning Income</u></b>	
WHSCC	179
Other NHS Organisations	80
<b>Total</b>	<b>259</b>
<b><u>Commissioning Expenditure</u></b>	
WHSCC	107
Other NHS Organisations	58
<b>Total</b>	<b>165</b>

### 2.7 Medical Education and Training

Under and post graduate medical education and training is managed through the Medical Director's Office. The UHB is required to deliver both the undergraduate and postgraduate education and training as set out in the SLA with both the Wales Deanery and Cardiff University School of Medicine. Each has the following core responsibilities and priorities for 2014/15 and beyond:

### Undergraduate Education

It is the aim of the Undergraduate Department to work in partnership with Cardiff University School of Medicine and the Wales Deanery to ensure that the UHB is a leading provider of high quality undergraduate medical education and training. The Undergraduate Education Strategy needs ongoing monitoring and updating to reflect any changes in the emphasis of education delivery whilst providing high quality services to patients. The Undergraduate Office is actively encouraging faculty development (which forms part of the Education Strategy) and has part funded clinical teachers to undertake further training in education delivery. This initiative will be further developed over the next twelve months in discussion with Cardiff University School of Medicine.

The UHB has worked towards the provision of performance reporting in the field of undergraduate education, which has raised awareness and demonstrated achievement within this important area of service delivered by the UHB. This reporting process allows education to appear on the UHB “dashboard” of performance indicators highlighting areas of excellence and concern. This will act as a driver to further enhance delivery of undergraduate education within the UHB and may serve as a means of encouraging improvement within the specific departments within the UHB.

Simulation teaching was introduced in 2011 and received excellent feedback from medical students; however, additional clinical staff support is required to deliver this. The UHB are supporting the purchase of simulation equipment in the Simulation Suite, Cochrane Building, UHW.

The Medical Work Observation Programme is successfully running within the UHB co-ordinated by the Undergraduate Centre. The UHB needs to expand the programme to meet the increasing demand.

A pilot scheme to deliver consultant led bedside and case based teaching by recently retired consultants was introduced in June 2011 to final year students. This was funded by SIFT and very well received. In particular the students found the small groups allowed a higher level of interaction.

#### Priorities for 2014/15:

- To ensure that all undergraduate medical students have access to appropriate high quality education and training;
- To ensure that personal development of education and training is aligned to meet wider goals in Undergraduate Medical training within the UK as well as the local needs of the UHB and the NHS in Wales;
- To amalgamate the Undergraduate and Postgraduate Departments in a unified Medical Education Department within the UHB;
- Cardiff University School of Medicine has undertaken a review of its education provision and as a result is in the process of implementing a new undergraduate curriculum, entitled C21, which commenced September 2013. The UHB will work closely with Cardiff University to enable the new curriculum to be delivered within the UHB, with high quality education enabling greater student satisfaction and an enhanced student experience;
- There have been significant service organisational changes to a number of specialities both locally and as part of service reconfiguration across Wales. Changes will require careful consideration by the UHB to enable the continued organisation that is necessary with a programme of this size;
- The timetable for the Undergraduate Examinations has changed and this will impact on outpatient activity;
- The GMC, as part of Tomorrow's Doctors 2009, requires the provision of ‘an assistantship’ for all final year medical students. This will form part of the harmonisation programme for seamless transition from year 5 medical school to foundation training;
- Support a 1 session post for Undergraduate lead (Senior Lecturer level) at UHW; and
- Develop potential funded overseas clinical placements jointly with Cardiff University and the Clinical Boards.

### Postgraduate Education

The primary function of the Postgraduate Department is to provide appropriate education and support for the 468 junior doctors within the UHB currently in Wales Deanery approved training posts (i.e. Foundation, Speciality and GP Training). This is achieved by the management and delivery of induction, relevant core curriculum teaching programmes, clinical and non-technical skills sessions and specific Royal College e-Portfolios. Annual funding is received by the Wales Deanery on a per capita basis for junior doctors in training and the Postgraduate Department also manages the study leave process for all Consultant and SAS Grade staff within the UHB, with a year on year increase in the number of applications.

Funding is received from the Deanery for the management and administration of the Foundation, GP and Dental Training schemes, and funding is also now received from the Deanery to support the continuing professional development of SAS Grades within the UHB and provide appropriate administrative support to the SAS Tutor.

Consultant appraisal rates are 23.67% (as at 30<sup>th</sup> September 2013), and 166 recommendations have been made for revalidation for medical staff with 149 having a positive recommendation and 17 (10.24%) having deferral recommended.

The service has the following priorities for 2014/15:

- To amalgamate the Undergraduate and Postgraduate Departments in a unified Medical Education Department within the UHB;
- To meet requirements of the SLA as set by the Wales Deanery via the annual commissioning process;
- To implement the GMC led Trainer Recognition and Approval system within the UHB;
- To meet requirements of various Royal College Curricula for junior doctors in training;
- To ensure compliance with, and address issues raised in, the GMC annual Trainee Survey;
- To develop the postgraduate facilities at University Hospital Llandough for the purpose of clinical skills teaching;
- To implement the On Line Leave Manager System (OLM) for Consultant/SAS Grade study within all specialties across the UHB;
- To develop opportunity for income generation via provision of 'commercial' educational sessions; and
- To ensure compliance with appraisal and revalidation requirements of medical staff.

### **2.8 Dental Education and Training**

The primary purpose of the care provided at the Dental Hospital and School is to educate the next generation of dental professionals balanced with delivery of dental services across primary, community and specialist dental services. The UHB is expecting an increase in student activity over the next 3 years to facilitate the current increase in years 2 – 5. We will work closely with the Chief Dental Officer in Welsh Government to ensure that there is alignment of student placements with the future workforce requirement for dental professionals in Wales.

The Dental Clinical Board will work very closely with the School of Dentistry to support the delivery of high quality education and provide the best possible experience for our students at both undergraduate and postgraduate level. The aim is to improve overall satisfaction and raise the profile nationally. This is aided by the fact that many of our specialist staff are responsible for the continuing education of the dental workforce and Continuing Professional Development provision for the wider dental team.

There is currently an increase in students in the years 3, 4 and 5 of the BDS programme (resulting from dental workforce planning undertaken several years ago). However the Chief Dental Officer is currently bringing together a task and finish group to look at reducing the number of BDS students in order to match with the number of Dental foundation training posts across Wales. It is likely that this reduction will be offset by an increase in the number of hygiene and therapy students. The Clinical Board Director for Dental Services will be part of this group which will assess the impact both in terms of curriculum and finance.



## 2 Summary of Population Health Needs and Actions Taken to Address Them

### 3.1 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 Appendix 1.

#### 1. Population size and composition

- The population of Cardiff and Vale is growing rapidly in size, projected to increase by 4% between 2013-17, significantly higher than the average growth across Wales. The population will pass 500,000 for the first time
- The population is ageing, with the number of over 85s increasing at a much faster rate than the rest of the population (10.4% increase between 2013-17)
- 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 one of the few centres in the UK designated as a receiving centre for people newly arrived in the UK who are seeking asylum

#### 2. Risk factors for disease

- Unhealthy behaviours which increase the risk of disease are endemic among adults in Cardiff and Vale
  - Nearly half (45-46%) drink above alcohol guidelines
  - Nearly two thirds (65-68%) don't eat sufficient fruit and vegetables
  - Over half (53-56%) are overweight or obese. This increases to two thirds (64%) among 45-64 year olds
  - Around three quarters (71-75%) don't get enough physical activity
  - Just over one in five (21%) 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

#### 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
  - 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
- The Annual Report of the Equality and Human Rights Commission highlights that of the 23% or people living in poverty in Wales, 46% are disabled, 43% are from minority ethnic communities, 27% are aged 16-25 years and 48% are lone parents (9/10 are women). There are clear links between socio-economic inequalities and those associated with particular protected characteristics who may have specific health needs to be met.

#### 4. Ill health in Cardiff and Vale

- The disease profile in Cardiff and Vale is changing
  - Chronic conditions including diabetes, respiratory and heart disease, are now common
  - Around 1 in 10 (9.4%) 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
- 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

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 2014-17, 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.

#### 3.2 Actions taken to address health needs

The four overarching needs facing the Cardiff and Vale population, listed below, impact on almost all services provided by the Local Health Board so it is vital that, firstly, all parts of the organisation assess this impact and plan their response:

- the population is increasing in size rapidly
- the population is getting older
- unhealthy behaviours are endemic
- stark inequalities exist

A set of specific actions to respond to or mitigate these needs has been drawn up by each Clinical Board and included in their plans for 2014-17.

Some Clinical Boards have already undertaken more detailed needs assessments for specific services, populations or disease areas. Each Clinical Board has identified further areas within their remit which would benefit from a more detailed needs assessment, which will contribute to an agreed programme of health needs assessment across the UHB during 2014-17.

There is also a specialist programme of health improvement, health protection and healthcare quality actions and advice for Cardiff and Vale, to improve the health and wellbeing of the local population. These focus on the areas of need described above, in addition to other key needs. The main areas of work are summarised in the table below; the first two are Tier 1 targets for the Health Board. These areas were chosen because, with targeted action, they will lead to the biggest health benefits for the local population.

#### Key priority areas agreed by the UHB and partner organisations for 2014/15-2016/17

Priority area	Key aims
Tobacco (Tier 1 WG target)	Reduce prevalence of smoking in Cardiff and Vale
Immunisation (Tier 1 WG target)	Improve uptake of scheduled vaccinations and implement changes to national schedule
Alcohol	Reduce prevalence of unsafe drinking behaviour
Physical activity	Increase levels of regular physical activity among adults and children

Priority area	Key aims
Food	Increase proportion of people eating healthily, and reduce prevalence of obesity and overweight in adults and children
Sexual health	Reduce the number of teenage conceptions and improve access to long acting reversible contraception (LARC)
Accidents and injuries	Reduce the harm from falls among over 65s
Health at work	Improve achievement by UHB and local organisations against Corporate Health Standard
Health protection	Improve and maintain standards of outbreak management
Commissioning evidence-based services and care pathways	Manage individual patient funding requests, interventions not normally undertaken, and support development of key clinical pathways across the UHB
Evidence-based care pathways	Implement UHB 'Optimising Outcomes' policy and support development of diabetes and dementia pathways across UHB

Topics are supported by [detailed action plans](#) with trajectory planning undertaken against headline performance indicators.

Making Every Contact Count (MECC) is a methodology which will run as a cross-cutting theme across many of the priority areas above. MECC aims to empower staff in the UHB and partner organisations to confidently and opportunistically discuss lifestyle issues, and signpost to appropriate support. Successful actions to protect and improve population health and tackle inequalities cannot be delivered by the UHB alone. Therefore effective partnership working with local authorities, third sector organisations and local communities is essential across our priority areas. The commissioning and delivery of a comprehensive package of substance misuse interventions are co-ordinated jointly across the two local authorities and the UHB, and the Local Public Health team also maintains and co-ordinates implementation of an annual plan to tackle poverty in the Health Board area on behalf of the UHB and partner organisations ('Reducing health inequity in children and families' plan). Work to reduce the number of low birth weight babies in the area is being prioritised within this plan.

## 4. The UHB's Strategic Direction

### 4.1 Shaping our Strategy for the Future

#### 4.1.1 Where are we now?

We are already clear what our job as a UHB is and we have defined our mission: '*Caring for people, keeping people well*'. This reflects our duty to the population and its health as a whole, as well as our potential to derive value from our integrated health care capability for the patients who need us. It also incorporates implicitly our responsibility to teach and to lead research in conjunction with our academic partners so that our mission can be sustained.

We know that in our system, society will, and should, continue to expect to receive high quality care – both for physical and mental health needs – even as its ability to fund traditional models of health care delivery becomes ever more challenged. Our population is changing at the same time, with increased numbers of older people and very young people and more people with long-term chronic conditions.

Our objectives have historically been focused around improving access to care through reducing waiting times; providing increasing volumes of care to reflect increased demand, whilst at the same time driving large savings programmes. This approach risks:

- Providing ever increasing amounts of care, without sufficient consideration of whether that care reflects health needs; is evidence based; is provided by the right person in the right place at the right time; and most importantly delivers improved outcomes for individual patients and the population within an appropriate level of resource; and
- Reducing cost at the expense of quality, rather than ensuring we deliver value through achieving health outcomes for our population and patients relative to the cost of achieving those outcomes.

We have begun the work to define what is important to us (our organisational values), although there is more to be done to clarify expectations and define the behaviour that these values require us to demonstrate consistently.

We know that we need to change our approach. We must now aim ourselves assiduously towards the goal of improved health and health care value for the people we serve, measured in terms of outcomes and with a financial strategy which supports delivery of these outcomes through measuring value rather than cost.

#### 4.1.2 Defining the Goal

The first step in solving any problem is to define the proper goal. **Picture the Future** revealed to us that many thought that the UHB existed as an organisation in order to manage health care finances. Access to poor care is not our objective nor is reducing cost at the expense of quality. Providing more care is too narrow, as we need to understand if the care we offer is of the right kind, at the right time. More is not always better.

In our favour we have:

- High quality clinical staff attracted to us by our standing as a prestigious academic health care organisation;
- A potential to organise health care that is integrated;
- Excellent working relationships with our key stakeholders including Universities and Local Authorities;
- An ability to offer influential advice to Government to help shape future health care policy;
- Large scale, including facilities, people and other resources;
- We work in a planned system of health care that is amenable to redesign that we can direct ourselves.

We also know that in our system, society will continue to expect to receive high quality health care, even as its ability to fund traditional models of health care delivery becomes ever more challenged.

Our population is changing at the same time, with increased numbers of older people and very young people and more people with long-term chronic conditions.

What we need to focus on now is our responsibility to provide value to the people we serve, where value is defined as achieving health outcomes that matter to our population or patients relative to the cost of achieving those outcomes. We can improve value by improving one or more outcomes without raising costs, or by lowering costs without compromising outcomes, or both. Failure to improve value means we will fail.

Our traditional ways of thinking and measuring success need to be adapted. We have never been against improving outcomes, but like many organisations we have focused much more on access to treatment, the bottom line of our financial position, the volumes of care that we deliver and a few high level process measures like the stroke bundle. We must now aim ourselves assiduously towards the goal of improved health and health care value for the people we serve.

#### **4.1.3 What will the UHB look like ten years from now?**

As part of the process of developing the Integrated Medium Term Plan, we have considered the following:

- Beyond managing our finances, delivering targets, meeting the Welsh Government's expectations, and generally keeping our heads above water as we face the challenges in front of us, what does the future hold for the UHB and so what will the UHB look like ten years from now?
- What must we be good at and so what kind of characteristic skills and capabilities will we need to develop as an organisation if we are to achieve our ambition?

We are developing a picture of our future, albeit with broad-brush strokes at this stage, so that all of our plans are aligned to a vision for the future of the services.

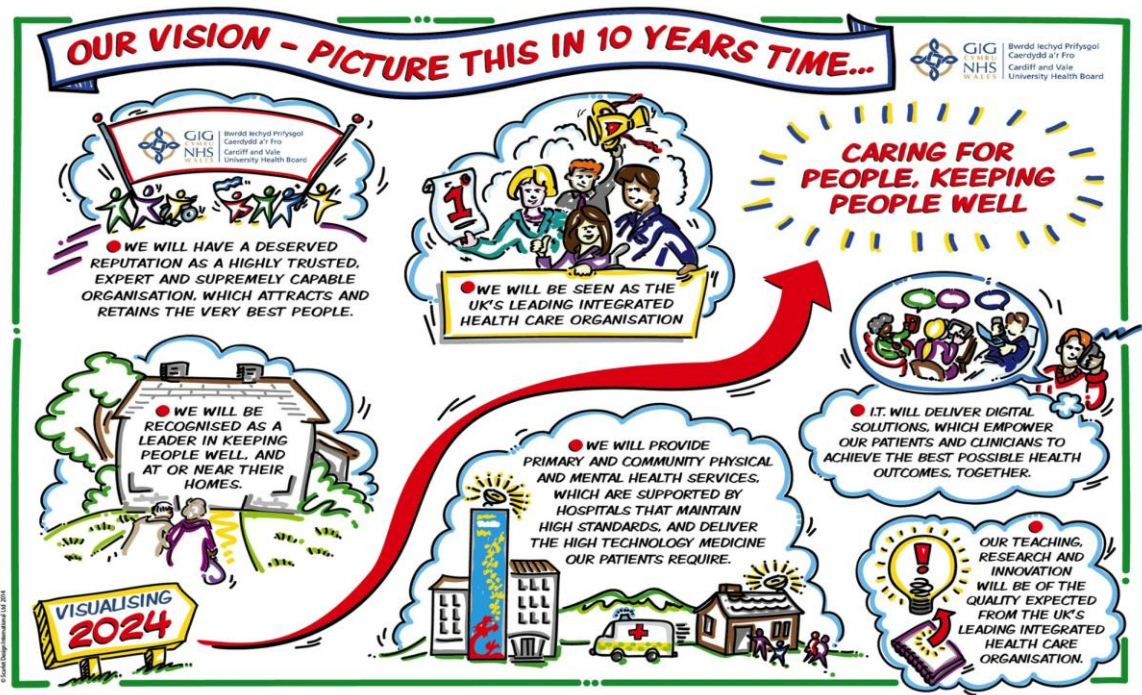
*We will work to reduce health inequalities and to improve the overall health of our population. To this end the following are features that will be characteristic of the UHB 10 years from now:*

- *We will have demonstrated a real and significant change of emphasis so that entire system will be tilted towards keeping people well and providing care in local and home based locations;*
- *We will take opportunities while people are in our care to support them leading healthier lives, and we will ensure services are provided in a way that supports improving the public health of the population*
- *Our services will be focussed around localities and networks of care;*
- *We will have integrated health and social care services for those people that will benefit and improved our joint working with other public services so that through working together we maximise care for people and value for the taxpayer*
- *Hospitals that deliver high intensity medicine will be rebalanced, with fewer inpatient beds and many more critical care beds;*
- *Our two acute hospitals will have clear and distinctive roles which support a focus on services being provided in primary and community care and that provide fertile ground for the best training and for recruiting and developing the best people to work in them;*
- *Our tertiary services will be tightly defined and will be enabled to work expertly at the top of their game;*
- *We will not run services that lack the necessary volume, infrastructure of people to do this well – instead we will commission such services from those who are better placed to deliver this for our residents;*
- *We will provide services at a time which is appropriate to patients' care needs with 24/7 working for services which need this to support care outcomes and other services planned at times to support access by patients which fits in with their lifestyles.*
- *Technology will be used to support patients in their own home, particularly in the areas of long term conditions, frailty and end of life;*

- *Our clinical information platform will enable clinicians at all parts of the system to understand the health status of their patients in real time;*
- *We will deploy technology and clinical expertise to support patients to do a better job of helping themselves stay well, avoiding unnecessary exacerbations and limiting unplanned access to hospital care;*
- *We will operate from a much smaller estate as we reduce the systems' over-reliance on hospitals;*
- *Our estate and the equipment we use will be affordable based on the new funding mechanisms we will have developed to make this possible;*
- *We will demonstrate leadership in a range of services to the extent that these are reference sites for the world;*
- *Our relationship with Cardiff University will enable us regularly to demonstrate how research is translating into practice at the leading edge;*
- *Our organisation will have a reputation for clinical excellence, innovation, high quality teaching and research that becomes a magnet for the best people;*
- *We will have demonstrated conclusively the benefits to patients and the population as a whole of an integrated organisation, that is an expert at delivering care (social as well as health) to support people in ways which are integrated around their needs;*
- *We will deploy evidence relentlessly to guide and shape access to health care and we will ensure that unwarranted variation is eliminated, that access to health care is governed by evidence of good outcomes;*
- *Patients will express a strong belief in the quality of care we provide and they will comment positively on their experience of being a patient;*
- *The public will regard the UHB as a trusted, safe and accomplished health care organisation that has their best interests at its heart.*

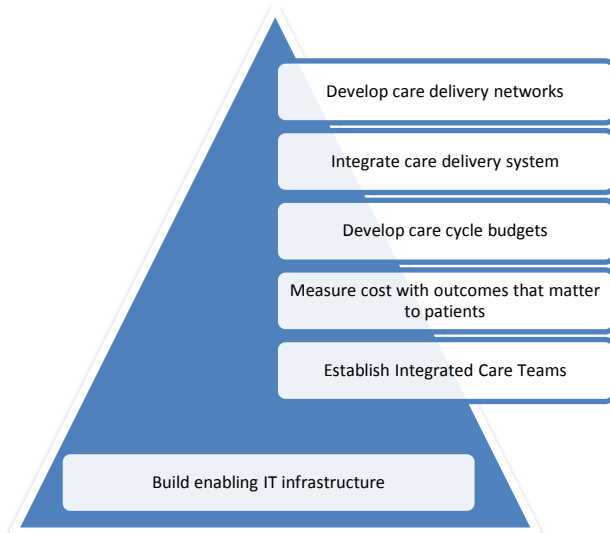
This can be summarised at a high level in the following vision statement.

***'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.'***



#### 4.1.4. The Strategy for Securing Population or Patient Value

In the UK there are few health care organisations that have our potential to show leadership in meeting these challenges (see text box above).



However, our system is heavily influenced by hospitals and targets associated with their performance. The system operates in ways that tend to reinforce this way of thinking with specialties pre-eminent, 'quality' defined as process compliance (4 hours in EU), costs attributed to procedures not pathways or outcomes, and IT systems that are underdeveloped or in silos.

Our future strategy must develop a set of new responses that will ultimately lead us to deliver the enhanced value we must secure for our population and our patients. There are six strategic characteristics that we will need to display if this goal is to be accomplished. These are described below.



### What is an Integrated Care Team?

- A. ICT is organised around a medical condition or a set of closely related conditions
- B. Care is delivered by a dedicated multi-disciplinary team of clinicians who devote a significant proportion of their time to the medical condition
- C. Everyone works as a member of the team
- D. The team takes responsibility for the full cycle of care encompassing outpatient, inpatient, rehabilitation and supportive care including social care
- E. Patient education and follow-up are integrated into care
- F. The team has a single management structure
- G. Care is often co-located in dedicated facilities
- H. A clinical team leader over sees each patients care process
- I. The team measures costs and outcomes using a common measurement platform
- J. The team meets formally and informally on a regular basis to discuss patients processes and results

### Establish Integrated Care Teams (ICTs)

In our system like all other health care systems, 15% of our residents are consuming 60% or more of our health care resources. Our strategic response to this must be to adopt an organisational model that is increasingly being used around the world. That is: we will choose in future increasingly to organise around the person and the need. Such a team involves clinical and non-clinical staff and is designed to be able to provide the full cycle of care for a patient. An ICT treats not only a disease but also the commonly occurring conditions, complications and circumstances that relate to it.

The UHB already has a number of teams that operate in ways very similar to these – the Breast Clinic, Cystic Fibrosis and Communities First teams for example.

Research suggests that such teams are strongly associated with increased productivity, lower costs and improved outcomes.

Our focus will be on developing ICTs to help us increase the value that we offer especially for current high volume users of our service and for the old and frail as we aim to convert high volume use into high health care value for each person.

### Measure Cost with Outcomes that Matter to Patients

We understand that rapid improvement in any field requires measuring results. Teams excel by tracking their progress over time and by comparing their results internally or externally with the best. In every field, rigorous measurement of value (outcome and cost) is strongly associated with better performance – and this is just as true for health care.

Our current measures of quality are inadequate, and usually say more about our reliability or reputation than they do about outcomes. In diabetes care for instance we might expect to track the reliability of cholesterol checks and haemoglobin A1c levels, even when the outcomes that matter to patients are whether they are likely to lose their vision, need dialysis, have a heart attack or stroke or undergo an amputation.

We need to move to using metrics which measure the following:

- Outcomes for patients, based on both how they feel and more clinical measures eg functional response to ensure that we are maximising the positive impact on patients
- Treatments and services against the clinical evidence base – to ensure that we are delivering care in a way which is evidenced by research and clinical practice
- Value of the outcome ie comparing cost to the benefit provided thus enabling prioritisation of resources

We will encourage teams to understand their costs and to report outcomes that matter to patients.



### Develop Care Cycle Budgets

In order to support the drive toward improved integration of care we will develop care cycle budgets. What does it cost to look after a group of patients with diabetes for a year? How could that cost be lowered, while improving or maintaining outcomes?

The purpose behind developing care cycle budgets is to facilitate agreement about the current state, to define a desired end state and then to enable responsibility and accountability to be defined in support of delivery. This will require change to be managed across vertical budgets and there is enabling work for us to do to develop an approach to this that is clear, non-bureaucratic and capable of supporting the change we require.

We must develop an enabling rules based framework that provides for gain share, and is explicit about how stranded costs are to be managed.

### Integrate Care Delivery System

We will capitalise on our ability to deliver care in an integrated way. Our *right patient, right time, right place* approach is something we will build on and extend. We aim to match the complexity and skills needed with the resource intensity of the location, which will not only improve cost but also productivity and utilisation.

Our integrated delivery system will specify how we:

- Define the scope of services we will provide – defining our tertiary and regional services, the balance between primary, community and secondary provision, and our goal to shift care closer to home where it makes sense to do so
- Focus volume in fewer locations – reduce our reliance on costly estate, driving up productivity and utilisation, extending the working week
- Select the right location for each service – ensuring that we make the best use of all of our locations, matching what is needed with the complexity and skills required
- Integrate care across locations – driven by the development of ICTs so that we ensure our offer to the user is always consistent independent of location.

### Develop Care Delivery Networks

We will operate across pan-LHB boundaries where it makes sense to do so and where this is in the interests of patients across South Wales. Developing the clinical service models and listening to the outcomes of engagement and consultation have clearly shown us that, for example:

- patients will travel across health board boundaries more frequently;
- centralising some fragile services onto more specialist sites will mean that we need new models for managing these services – people will need to work for a service, not a site;
- the South Wales Programme has only focused on a small number of services – more will need to be reviewed in a similar manner; and
- the way in which we govern our services at present will not support these new models of care.

We will use our ability to recruit and retain high quality clinicians to fuel the development of networked service models that contribute to optimal utilisation of South Wales infrastructure and which enable the UHB to secure the capacity it needs to deliver high-class tertiary services.

We will use our role as the principal tertiary provider and the prestige that goes with this for the benefit of the wider system. We will seek opportunities to grow the capability of the wider system by enabling clinicians outside of Cardiff to develop relationships with our teams, and we will foster a broader sense of team across our network. It is in our interest to do so as this is one of the ways the system around us will be sustained – which is a necessary pre-condition to our own success.

These networks will enable us to lead the development of high quality hospital treatment, backed by local development of capable primary and community care and strong local acute care.

#### Build an Enabling IT Infrastructure

Our whole strategy will be powerfully supported by developing an enabling IT infrastructure that will enable all parts of the system to work together, support good quality measurement and information about outcomes, and tie service delivery together on the ground.

Our IT will:

- Be centred on patients – the system will be able to follow patients across the care delivery system for the full cycle of care and the data is aggregated around the patient not solely departments, specialties or locations.
- Use common data definitions – so that the data can be interpreted consistently and used to discuss care at every level.
- Encompass all types of patient data – so that all the information a clinician needs to support a patient is located in one place.
- The medical record is accessible to all involved in care – including patients.
- The IT system architecture enables information to be obtained easily – including the ability for patients to report on their experience of care.
- Provide an accessible medical record to all involved in care – including patients. This will include information sharing across networks to support integrated care, within the boundaries of confidentiality.
- Include expert systems and protocols to guide best practice.
- Enable information to be obtained easily – including the ability for patients to report on their experience of care.
- Support effective decision making throughout the organisation – from individual patient care to strategic decisions
- Support efficiency in delivery of service through using technology eg to streamline processes, support on-line booking for patients

#### **4.1.5 What must we excel at in order to deliver on our vision?**

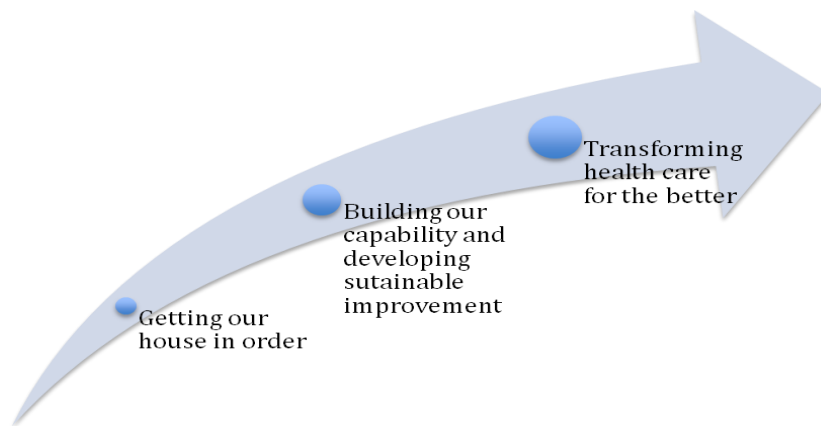
Over the course of the next 10 years we must develop the character of our organisation if it is to fulfil the aspirations in the vision. This means we must equip ourselves with the skills and capabilities, ways of working and behaving and carrying out our business together.

These organisational characteristics are detailed below:

- We have a clear strategy that is understood by everyone and which guides all our work;
- We are a highly capable organisation – that is we are able to work out what needs to be done and get it done in a highly disciplined way – we are supremely capable at delivery;
- As a result of our clear strategy and our commitment to delivery, we have leaders who are willing to drive our progress at every level and we have managers and teams of staff who are confident about making change happen;
- We work in a consistent way, and we pay attention to the behaviours required by our values – we recruit, promote, reward, discipline and develop our people based on these behaviours;
- Everyone knows what is required of them to be an employee and everyone knows what will be provided to them in the same way;
- We are adept at working in partnership together across the UHB and also with our partners;
- We have achieved a truly devolved organisational model, and we have confidence in the ability of our leadership teams to deliver

Our vision is ambitious and it will not be achieved overnight/ however, being clear about what we intent and then following a route to our destination in 3 year planning cycles will get us there, with persistence, discipline and perseverance.

The future is what we choose to make of it.



## 4.2 Developing our 10 Year Service Plan

At present, the UHB does not have an agreed Clinical Services Plan which reflects the totality of our care. A substantial programme of work has commenced and will continue throughout 2014/15 to enabling implementation from 2015/16 onwards. The details of how we will do this are currently being worked through with a detailed programme plan being developed. The UHB has recently advertised for a senior clinician to provide clinical leadership to the Plan – with interest sought across the Cardiff and Vale health community. Some high level milestones are set out below:

February 2014	Start discussions on design principles with Clinical Senate and Stakeholders
March 2014	Establish project structure and agree Project Outline Document
April 2014	Appoint Clinical Lead
May 2014	Agree services/pathways to be remodelled and establish workstreams
September 2014	High level clinical models/pathways agreed and elements for inclusion in 2015/16 IMTP
July 2015	Detailed redesign work completed
October 2015	Clinical Services Plan cut one complete and elements for inclusion in 2016/17 IMTP

Initial discussions through the Stakeholder Reference Group and Clinical Senate have recommended that we focus on health improvement and self care through all elements of the Plan – hence the title Shaping our Future Well Being, rather than focus just on a Clinical Services Plan which suggests a narrowly focused approach.

In starting to develop this Plan we know the drivers and challenges to which we will need to respond, including:

<b>Demographic changes</b>	A growing population with the overall population of Cardiff and Vale projected to increase significantly by 2025 with a growing number of older people.
<b>Epidemiology</b>	Changing patterns of disease, often as a result of lifestyle factors, and the ageing population.
<b>Financial climate</b>	We know that current austerity measures will continue until at least 2018, and very likely, well beyond this.
<b>Workforce</b>	We know that our workforce is changing: that there are going to be shortages in some specialties which will drive change; the increasing feminization of the workforce and the impact of the Y generation and

<b>Technological advances</b>	increasing approaches to flexible working. Similarly, there will be changes in professional roles which will change the way in which services are provided.
<b>Changes in Clinical Practice</b>	Which will drive changes in the way support, care and treatment is provided. This won't necessarily be driven by the NHS, it will be driven by technology companies - the challenge for us is to ensure that we adopt advances early in order to deliver new modes of access to care and treatment.
<b>Environmental impact</b>	Changes, for example 7 day working; providing increased levels of care in community based settings and potentially alternative care providers will need to be reflected in new models of care.
	Changes in climate patterns we are seeing will impact on our the way we deliver services; more extreme and less predictable variations in our weather patterns; requirements to consume less energy.

In the meantime, however, we have a strong base to build upon:

<b>2006</b>	Programme for Health Services Improvement (PHSI)
<b>2009</b>	5 Year Strategic Service Workforce and Financial Framework
<b>2010</b>	Making a Difference
<b>2011</b>	Making a Difference 2

In addition, a series of engagement events were held during 2012/13 and these provide the principles for developing our Clinical Services Plan:

- As an integrated health care system we must maximise our ability to deliver new models of care and a shift of resources from hospital to community based care which will result in improved efficiency, effectiveness, better patient outcomes and experience.
- We must seek to tackle the constraints that are mitigating against effective operational delivery, and ensure a whole system approach which will realise the benefits of improved patient flow.

If we are to reflect these principles in the Clinical Services Plan we must change the ways in which we think about the way in which we change our services:



If the UHB changed this focus, it would mean that we could completely change our approach to one where the person and their self care/health improvement is at the core of what we do:

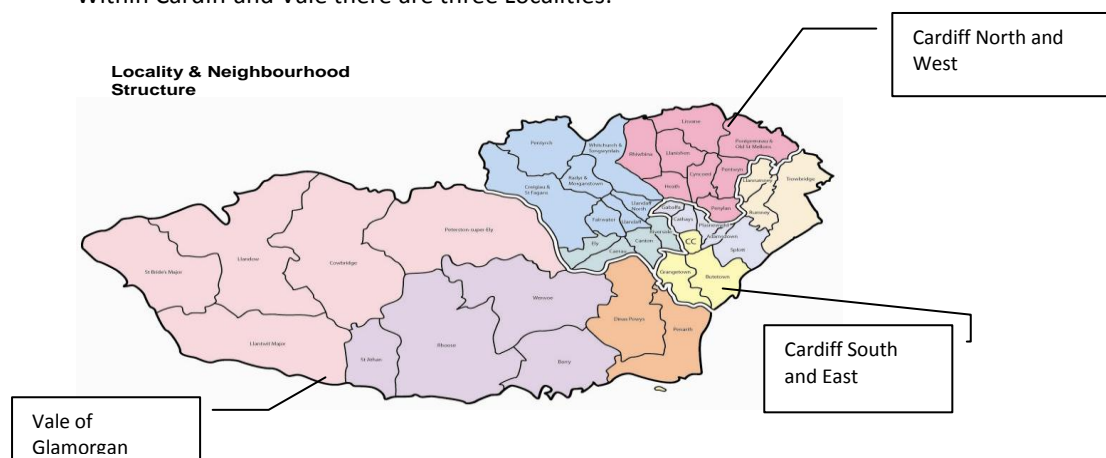


Developing the Plan will require a focus on sustainability of our services, and a reflection of the circular economy which is a concept developing momentum in both public and private sectors will be considered. The circular economy is a generic term for an industrial economy that is, by design or intention, restorative and in which material flows are designed to circulate at high quality without entering the biosphere. Its basis is within renewable energies, however, the concept of working within a system rather than as a linear process is relevant to our services and will be further explored in the development of the Plan.

### Developing a Locality Focus to Care

As a UHB, we know that we want to use localities and networks as the fundamental building blocks for our services (at the level above the GP practice), and have made noteworthy steps to establish localities across the UHB. These will provide a strong basis upon which we can develop our Clinical Services Plan.

Within Cardiff and Vale there are three Localities:



<sup>1</sup> Source: [The quest for integrated health and social care A case study in Canterbury, New Zealand. King's Fund](#)

The rationale for three Localities is as follows:

- Vale Locality – this is coterminous with the Local Authority boundaries and has a joint Locality Manager and Head of Adult Social Services.
- Two Cardiff Localities – the Public Health picture of Cardiff shows a ‘tale of two cities’ with a north western arc with a high proportion of older people and a south eastern arc that has high levels of deprivations and the highest proportion of vulnerable groups (asylum seekers, homeless etc) and BME communities.

There are many commonalities between the three localities, for example:

- each Locality has three neighbourhoods (as per the Setting the Direction definitions of communities between 50,000 and 80,000) which are consistent with the public sector Neighbourhoods in Cardiff and Areas in the Vale of Glamorgan local authorities;
- there is a GP lead for each neighbourhood who provides clinical leadership and has specific responsibilities around pathway development and variation management. This ensures that the locality networks have a very real impact on the delivery of services to their local population, ensuring that patients are cared for as close to their home and as consistently as possible.

However, the differing needs of each locality have resulted in differing priorities for each locality network, which have driven their development agendas. Different locality networks will therefore develop differently and at different paces. Further detail on the development of our locality based approach is provided in section 5.6.6.

The following ‘wordle’ was an output of development sessions held with the localities, demonstrating a focus on quality and care of the population.



As we develop our Clinical Services Plan we will actively consider how we can ensure that the strong foundations already in place in our localities, can inform and influence our future Plans.

#### 4.3 Developing our Commissioning Arrangements

The UHB has a [Planning and Commissioning Framework](#) which sets out the process for planning and commissioning health and health-related services in the UHB. This should be followed routinely when reviewing existing services and when new services or interventions, service development or disinvestments are being considered. We recognise that this is an iterative and evolving process, and we have committed to put additional resource and capacity into developing and embedding this function within the UHB starting in early 2014/15. There are several areas where the UHB needs to consider how to develop this approach:

##### *Commissioning Nationally*

The most obvious way in which we do this is with WHSC in terms of commissioning very specialist services for our resident population. Further detail on this is provided in section 5 of this Plan. We are also shaping discussions with other LHBs on how collectively we can develop our commissioning

approach and learn from each other in this regard. We have agreed to take the lead role in developing a commissioning approach and model for diabetes services, given that this is one of our top organisational priorities, and that our Chief Executive is Chair of the All Wales Diabetes Implementation Group.

#### *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 start to build a more mature approach to this.

#### *Commissioning within the LHB*

The LHB was set up as a provider organisation and as a collective, Clinical Boards tend to consider their role as delivery units rather than commissioners of care for the population they serve. Significant strides have been made this year with each Clinical Board undertaking a health needs assessment to support the development of their Plan, and our approach to developing integrated care pathways across the organisation. Again, this is a discipline that will need further development in forthcoming years and will reflect the maturation of Clinical Boards.

#### *Joint Commissioning with other non NHS Organisations.*

The UHB has made more progress in developing commissioning with partner organisations than in any other area.

Following a workshop held in June 2013, involving representatives from the UHB, 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), it was agreed that work would be taken forward to develop a combined support system for service leads working across the five organisations. This support would be to act as/develop an expert resource for developing and implementing joint commissioning, in the first instance for:

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

This work is being progressed and the initial support is to develop products which will assist the service leads work consistently across organisations, in the form of FAQs; alternative options for procurement/provision; templates etc, drawing on the experience of the very successful single commissioning strategy for substance misuse services which is in place.

The UHB has a [Strategic Framework for Working with the Third Sector](#) which was updated in October 2013, and determines the way in which we develop services with third sector partners. Following a robust review of all of our Service Level Agreements arrangements with third sector 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 becoming more integrated into the UHB's service delivery processes. All SLAs are either now, or will be transferred to, a three year agreement.

#### *Developing Commissioning*

In 2014/15 developing commissioning is identified as a central plank 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. There are six areas of focus, to enable the UHB to develop a commissioning plan which recognises local needs, responds to the changing population and drives service transformation.

The priority areas for development in 2014/15 are:

1. WHSSC
  - a. Confirm organisational clarity on our provider position and then our commissioner position
  - b. Clarify interface with WHSSC and how internally the UHB ensures our respective commissioner and provider structures around WHSSC are represented
2. Clinical Services Plan
  - a. Develop commissioning view/benchmark/plans at a population health level as the starting point
  - b. Undertake demand and capacity modelling from a provider perspective
3. IMTP refresh for 2015/16
  - a. The UHB will have a much clearer commissioning strategy for 2015/16 based on the developments of the Clinical Services Plan
4. Demand management 2014/15
  - a. Support PCIC and other CBs in their plans to deliver outcome based demand management
  - b. Support additional GP involvement in enabling
5. Governance re commissioning
  - a. Formalise Mental Health/Local Authority arrangements.
  - b. Ensure all contracts/LTAs have a lead, SLA and appropriate contracting/performance management arrangements and KPIs including quality and safety
  - c. Clarify CBs role in commissioning and LTAs
6. Care pathways
  - a. Support implementation of care pathways agreed for 2014/15 and evaluate outcomes
  - b. Agree care pathways to be prioritised for development for the future – based on population/public health priority, value for money or operational efficiency
  - c. Link development and implementation of these to performance review meetings
7. Information to support commissioning and benchmarking
  - a. 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 group
  - b. Use this information to drive clinical services plan and other developments.

Recognising that we are at an early stage of developing commissioning, nevertheless, the UHB has developed a set of commissioning intentions for 2014/15 to inform the development of this Plan, and these are set out in Chapter 5. This marks out intent to move towards developing our focus to be a commissioning led organisation.



## 5. DEVELOPING OUR SERVICE PRIORITIES AND CHANGE PLANS

### 5.1 SWOT Analysis

For the 2013/14 IBP the UHB Executive Directors undertook a SWOT analysis to provide a baseline as we moved forward. These have been reviewed to support the preparation of this IMTP, and some of the progress which has been made within this year is set out below:

Weaknesses	Progress
Lack of “flow” throughout the organisation: opportunities of Integrated Care have not been exploited fully by UHB and resources are not aligned to health priorities.	“Flow” has significantly improved across the organisation, enabling a reduction in the average length of stay of 2 days during this financial year. This has enabled the UHB to move towards right sizing our capacity with a reduction in the equivalent of 98 beds, to end of September 2013, and we are on track to reduce this by a further 23 beds by the end of the financial year in line with the 2013/14 IBP. This has been achieved by improved efficiency and effectiveness of services, and better alignment of resource to meet patient need.
The workforce do not have a joined up, collaborative culture. Constantly changing leadership and a perceived lack of focus in organisational direction have led to staff feeling jaded, making re-engagement harder to achieve.	The UHB has placed significant additional emphasis on staff engagement in the last six months, since the establishment of the Clinical Boards – each CB now has a Trade Union representative on the Board to support engagement. Each CB’s Plan also sets out how it has engaged with staff in its development. The UHB is currently running a “Pulse Survey” to gauge staff views across the UHB, and this will be used to inform further engagement actions.
There are concerns over the quality of unscheduled care and the quality of ICT and information and performance, making it difficult to measure the scale of the problem.	Performance in unscheduled care has improved significantly this year, despite the refurbishment of the EU which is well underway. The UHB has recognised the low level of ICT and information support, and has successfully received additional funding from WG to support investment in infrastructure. The UHB has also committed to additional investment in data analysts from 2014/15 to ensure that we are able to make best use of the wealth of data we have available to us.
The Board’s financial position for 2013/14 has caused limits to cash-flow and the lack of long-term financial and service plans makes other long term planning difficult.	The UHB has recognised this, and has developed a three year financial framework. We are developing a longer term Clinical Services Plan, and are working towards developing more robust integrated three year service, workforce and finance plans. This will be a maturing process over the lifetime of this and further IMTPs.

UHB does not have a track record of delivery.	As highlighted above, there have been significant improvements in performance this year. We will build on this, and are developing detailed action plans to support sustainable delivery of Tier 1 targets where these are not already being achieved.
Poor alignment of resource with health needs.	The UHB was established as a provider organisation, and allocated its resources based on historical usage rather than health need. Through focusing on a population health approach and establishing a commissioning model, and identifying equity of access to services as a strategic goal, the UHB has recognised the need to change the way in which we allocate resources within the organisation. This will be a developmental and iterative process over forthcoming years.

Threats	Progress
Lacking focus on the long term strategy could impede delivery; urgent care demands, other “reactive” issues or spending too much time looking inward could all distract from delivery.	The UHB will start to develop the Clinical Services Plan during 2013/14. Realistically, it will be 2015/16 before changes start to be implemented.
The culture of the organisation may not respond well to change; the workforce needs to engage in the strategy and be committed to it.	See above under weaknesses. Through implementing the Leading Improvements in Patient Safety (LIPS) programme we are also expecting large numbers of front line staff to develop the skills and capacity to implement local change. This will then start to develop the momentum for change more broadly across the UHB.
The model of clinical leadership is embryonic at best.	This has been recognised and the new Clinical Boards are crucial to developing this. Clinical leadership development programmes are running, to include the Clinical Board Directors and Clinical Directors as well as other senior leaders across the UHB.
Lack of political support or a desire from the WG to engage in an all-Wales agenda could impact upon delivery.	There are strong relationships with politicians locally and nationally, and with WG to support service change.
Significant demographic pressures (growth and ageing)	The UHB recognises this in the health needs assessment and associated actions, and is working closely with both local authorities in terms of the Local Development Plans, both for us to understand the impact on our residents and services, and also so that they understand our needs and expectations. Each CB has been asked to consider the demographic pressures on its services as they develop three year plans.

The financial constraints of the Plan may make it more challenging to achieve some ambitions.	This is recognised, and the UHB is ensuring that its plans are both ambitious and realistic.
Changing demographic in and around Cardiff may put new demands on services.	See above.
A lack of “flow” throughout the system and joined up working with other health and social care providers would impact upon the programme’s success.	See above re “flow”. The Integrated Health and Social Care programme has made significant developments this year, and is referenced elsewhere in the IMTP. There is a strong joint commitment to working together to deliver real actions in improved care for local people.
The quality of the UHB’s estate and IT systems could prove a barrier to successful delivery.	This threat remains, and is a risk for the UHB. There are a number of major new capital builds underway, however, we need to refocus our attention on ensuring our existing estate and IT infrastructure is fit for purpose.
The lack of a core clinical leadership team could hinder the programme’s progress.	See above.

## 5.2 Introduction

In developing our service priorities and change plans for 2014/15 – 2016/17 the UHB has reflected the following drivers for change:

1. National priorities – working towards implementing Welsh Government’s policy requirements and priorities.
2. Regional change - where we will work across one or more Local Health Boards/Trusts to develop and deliver different models of care.
3. Local service pressures and challenges arising from local health needs and intelligence, and from joint working and plans with our partner organisations.
4. Significant service change programmes already underway – for example the way in which our services will change as a result of major capital builds.
5. High level proposals for service change over years 2 & 3 of this Plan.

## 5.3 UHB Commissioning Intentions 2014/15

For the first time, the UHB has developed a series of Commissioning Intentions to guide the development of the IMTP and individual Clinical Board plans. These have been developed by the Health Systems Management Board; a Board chaired by the Chief Operating Officer and made up of representatives of all the Executive Directors (apart from the Chief Executive) and Clinical Board Directors. Whilst we have acknowledged that commissioning is in its infancy within the UHB, there is a clear recognition that this approach needs to guide and provide focus for the development of our Plan. The commissioning intentions for 2014/15 are:

- Three year and one year objectives for major services reflecting the UHB’s agreed strategic goals (set out below) and ideally with supporting evidence/plans in terms of outcomes, how plans relate to need, patterns of access/patient flows, cost and efficiency,
  - Ensure access to care is equitable throughout Cardiff and Vale, addressing the diverse health needs of our local population;
  - Develop a commissioning plan which recognises local health needs, responds to the changing population and drives service transformation;
  - Deliver services sustainably, earn the right to move from good to great by meeting all tier 1 standards and providing the right care in the right place at the right time – a high quality service;
  - Maximise the UHB’s resources to provide value for money, developing the workforce, estate, clinical leaders and IT systems to use these to their full extent;
  - Co-produce with staff, the public and partners to shape the best possible experience along integrated care pathways, from disease prevention and self-care to high-quality tertiary care;
  - Be absolutely clear about the services which we will commission and provide for our resident population and ensure they provide safe and effective care and efficient use of resources; and
  - ‘Maximise Cardiff’: build on the links with universities and research facilities and industry within the Cardiff city region to make the UHB a global centre for excellence, at the forefront of innovation, boosting the local economy and building on UHB’s reputation as an employer.
- One year supporting plans for finance which set out how they will achieve the above within their indicative financial envelope. This will include details of savings plans and bids for capital expenditure to support this.
- One year supporting plans for workforce which set out planned changes in staffing numbers, the method by which staffing changes will be delivered (OCP, redundancy, skill mix etc) and the proposals for engagement with TU representatives on this.
- One year supporting plans for moving from Good to Great.
- One year schedules of risks and opportunities, assumptions, consultation requirements (public or staff), expectations of other Clinical Boards and Corporate Departments.

The submitted plans will need to ensure the following:

- The expectation is that plans deliver national and local targets and standards (set out below) whilst at the same time meeting the requirements set out in the Financial Framework;
- Any Plan developed by a Clinical Board or Corporate Department considers its impact on others and is agreed with them. All Clinical Boards and Corporate Departments demonstrate how they are working together to support delivery of each other's plans.

#### Welsh Government targets

- Achieving Tier 1 targets (including Public Health) – the NHS Outcomes Framework will not be in place to support a changed focus for performance management and improvement for 2014/15;
  - Specifically deliver 26/36 weeks RTT compliance from 1 November 2014
  - All other Tier 1 targets to be delivered from 1 April 2014
  - It is recognised that some Tier 1 targets do not yet have a clear definition so we need to deliver plans which work towards the intended outcomes
- Implementing Welsh Government requirements, including service specific and cross cutting Delivery Plans, or setting out how these will be responded to, where appropriate;

#### Regulatory standards

- Compliance with statutory legislation
- Compliance with standards e.g. Healthcare Standards for Wales and relevant professional and quality standards

#### Specific UHB targets for 2014/15

- Ensure that any person listed for surgery has been offered smoking cessation and weight management support where appropriate, in line with the UHB's Optimising Outcomes Policy;
- More effectively commissioning services from primary care to reduce referrals/admissions into secondary care where appropriate; specifically these will include:
  - CRT delivery – support to discharge to reducing LOS, implementing palliative care pathways
  - Nursing and residential homes – reduce 999 calls through reviewing variation and support
  - Introduce practice visits to review variation in GP referrals, ambulatory sensitive conditions
  - Support reductions in secondary care follow ups through agreeing protocols with secondary care
  - Routine review of paediatric referrals
  - Improve the quality of GP referrals into secondary mental health services and improve liaison between primary care and mental health services
- Implementing the agreed care pathways/service models for diabetes, MSK, anti-coagulation, INR, dementia, falls and unscheduled care across the UHB's Clinical Boards;
- Close West Wing with effect from 1 April 2014
- Implement IT systems already agreed i.e. LIMS and e-discharge

The remainder of this Chapter sets out how the UHB will respond to the drivers for change and the UHB's Commissioning Intentions. There is a short summary of each theme, followed by tables with additional detail.

## **5.4 National Priorities**

### **5.4.1 Welsh Government Policy Directives and Priorities**

Welsh Government issued the [NHS Wales Planning Framework](#) in November 2013, which helpfully set out the strategic planning parameters within which we are operating. Within this, the key themes

from [Together for Health](#), the strategic vision for the NHS in Wales, are set out, along with how the Integrated Medium Term Plan will demonstrate that organisations are achieving these aims and the appropriate supporting key reference documents. These will not, therefore, be repeated within this Plan, as this Plan has implementing Together for Health at its core. This section sets out how other strategic drivers and requirements are being addressed. Further detail is provided in Table 1.

The UHB recognises that there is a Ministerial commitment to implement the combined screening test for Down's Screening from April 1<sup>st</sup> 2015. The UHB will liaise with other Health Boards across Wales to confirm when implementation dates for screening (the UHB will need at least 3 months notice of this requirement to enable laboratory capacity) and align the commencement of the local screening programme with other LHBs.

#### More than Just Words : A Strategic Framework for Welsh Language in Health and Social Care.

The More than Just Words Strategy is a Welsh Government policy with the aim of improving Welsh language in healthcare, which has a three-year action plan. The framework outlines key objectives that the organisation should work towards. These include implementing a systemic approach to Welsh Language services as an integral element of service planning and delivery.

#### Welsh Language Act 1993 and the 2011 Welsh Language (Wales) Measure

The UHB continues to work to meet its statutory obligation of delivering a Welsh language services to patients and the public through its Welsh Language Scheme. It will be expected to comply with the statutory obligations of the new Welsh Language Measure 2011 from 2017, which is monitored by the new Welsh Language Commissioner. There will be legal, financial and reputational risk if it fails to do so.

#### Welsh Government Delivery Plans

The Welsh Government (WG) has set out its national strategic direction for Health Boards and Trusts through a number of documents including the overarching *Programme for Government* and the NHS 5-year Strategy [Together for Health](#). These have been complemented by a number of more detailed strategies and plans, focused on key service areas or population groups. Within the UHB there is a process to identify the lead Clinical Board to drive forward the delivery plan; and develop the action plan in partnership with other relevant clinical boards and colleagues. The lead Clinical Board gains approval of the action plan by the UHBs (cross clinical board working) Health System Management Board (HSMB) prior to submission of the action plan to WG. The delivery plans are implicit within the development of each Clinical Board's individual IMTP. Oversight of the delivery of the actions is maintained by the Planning Department and presented to the UHB Board as part of the six monthly IMTP progress report.

The table below identifies the current status for the delivery plans.

Title	Lead	Current Progress
A Strategic Vision for Maternity Services in Wales	Children & Women Clinical Board	Revised action plan reviewed by Maternity Strategic Forum September 2013
Sexual Health & Well Being	Primary Community & Intermediate Care CB	Action plan in place – in process of being revised
Unscheduled Care	Medicine CB	Action plan in place
Eye Health Care	Surgery CB	Joint approach UHB, Primary Care and Delivery Unit. UHW ODT (ophthalmology diagnostic treatment centre) in place early 2014; next phase to develop in community settings.
Together for Mental Health	Mental Health CB	Local Partnership Board Plan and monitoring process in place
Cancer Delivery Plan	Medical Director	<a href="#">Action Plan</a> in place
Stroke Delivery Plan	Medicine CB	<a href="#">Action Plan</a> in place
Delivering End of Life Care	Primary Community & Intermediate Care CB	<a href="#">Action Plan</a> in place

Diabetes Delivery Plan	Medicine CB	Workshop held November 2013. Paper outlining process for development of plan to HSMB January 2014. Plan to WG by March 2014.
National Oral Health Plan	Dental CB	Plan approved at HSMB December 2013 prior to submitting to WG
Heart Disease Delivery Plan	Specialist Services CB	Plan in development; to HSMB for approval early 2014
Delivery Plan for the Critically Ill	Specialist Services CB	Plan in development; to HSMB for approval early 2014
Neurological Conditions	Specialist Services CB	Consultation document until 31 January 2014
Respiratory Health	Medicine CB	Consultation document

#### 5.4.2 National Service Change Pressures

Due to the UHB's role as a provider of tertiary services, and services across Wales in some instances, we need to respond to challenges which arise at a national level. These may be high profile challenges, such as the need to ensure people wait an appropriate length of time for cardiac surgery, to ensuring that services that we provide on a national basis are provided on a sustainable basis. Further detail is provided in Table 2.

#### 5.5 Regional Service Change

There will be service changes across Health Boards and Trusts in South Wales, (not including the South Wales Programme) based on WHSCC proposals, but also changing service models within and between organisations. This section sets out the changes the UHB is expecting to take place either as a result of WHSCC commissioning intentions, or those services which we as a UHB expect to change. It does not, at this stage, reflect changes which other UHBs/Trusts might be expecting to make which will impact on our services.

##### 5.5.1 WHSCC Commissioned Services

WHSCC has set out their expectations of Welsh providers for the next 3 years, the key points of which are summarised below.

- As with the commissioning plan for 2013/14, the plan for 2014/15 – 2016/17 will be underpinned by the Institute for Healthcare Improvement Triple Aim:
  - Improving patient experience of care (including quality and satisfaction);
  - Improving the health of the population; and
  - Reducing the per capita cost of health care
- Impact of Joint Committee decisions – the three year plan will continue reflect the impact of commissioning decisions made by the Joint Committee on the 2012/13 and 2013/14 Commissioning Plans. A summary of these decisions and their likely impact on providers has been provided to assist you in ensuring that these are acted on locally and reflected in your three year plan.
- Delivery of Tier 1 targets – Providers must ensure that their plans clearly demonstrate good waiting list management, and how they will achieve and maintain Tier 1 targets within the resources available. In those exceptional cases where providers are able to demonstrate that they cannot achieve this within the current contract baseline, they must submit a business case to WHSCC by the 13<sup>th</sup> December. As a principle, providers who are failing to achieve Tier 1 targets whilst underperforming against the contract baseline will be responsible for funding outsourced activity.
- Cost improvement plans – Providers will be expected to ensure that any local cost improvement plans for specialised services are clearly identified, and confirm that the plans will have no adverse impact of the quality or performance of the service.

5. There will be no additional funding for inflationary or service pressures, as it is assumed that the level of funding provided by the commissioning Health Boards will continue in line with the 2012/13 roll over baseline.
6. Repatriation of specialist activity where appropriate – WHSSC will continue to work closely with Welsh providers, in order to ensure that where it is clinically appropriate and cost effective, activity can be repatriated back into Welsh services. Welsh providers should identify opportunities for repatriation to existing or new services, in line with the IHI triple aim. Programme Teams will use this information to establish the volume of activity that can be repatriated, and to assess whether it would be clinically appropriate and cost effective.
7. Referral management – WHSSC will continue to work with Health Boards in developing referral management over the next three years, with the objective of ensuring that all referrals into English services are managed in accordance with the agreed pathways of care. WHSSC will require Welsh providers to continue to support this process, by working with the Programme Teams to identify and appoint clinical gatekeepers for out of area referrals to specialised services.
8. Collaborative commissioning – WHSSC will continue to work closely with Health Boards to explore the potential benefits in collaborative commissioning across the whole pathway of care. WHSSC will also build upon the existing work with service users and stakeholders to identify more opportunities for coproduction within specialised services.
9. Transfer of Services – the following principles have been agreed with Health Boards:
  - Non Specialist Services, contracted for by WHSSC on behalf of Health Boards, will be provided for in the WHSSC plan at the level established for the 12/13 baseline. Therefore, all growth, pressures and opportunities will need to be considered and provided for in individual Health Board plans.
  - Specialist Services funded directly by Health Boards will be provided for at 12/13 baseline within Health Board plans. Therefore all growth, pressures and opportunities will be considered within the WHSSC plan.

The key areas that the UHB has identified as requiring further discussions with WHSSC are set out in further detail in Table 3

### **5.5.2 Service Changes across LHBs/Trusts**

As well as providing services for other LHBs, the UHB also commissions services from other LHBs and Trusts for some of our residents. This may be due to a variety of factors including geography – where people live on the border of the UHB, they may access services at hospitals which are closer to where they live; history – GPs may refer to other hospitals and consultants due to particular consultant interests and in some instances – particularly for those services provided by specialist Trusts services cannot be provided by the UHB. There are some plans to change some of these services and flows during 2014/15 and beyond. Further detail is provided in Table 4.



**Table 1 Welsh Government Policy Directives and Priorities**

Service	Rationale	Impact	Outcome	Risks
<b>Consider the impact of the Organ Donation Bill (2015)</b>	Welsh Government will implement the Organ Donation Bill from 2015 onwards.	This will potentially have significant impacts on critical care services. Details will be considered and worked through for the 2015/16 Plan.	Increased numbers of donation/lives saved.	Risks to be confirmed, but critical care capacity, which is already under pressure, will be impacted.
<b>Implement the new flu immunisation programme.</b>	A national directive has been given that all 4-18 year olds should be offered the flu vaccine over a three year period.	Circa 3800 vaccinations will need to be delivered to school aged children, requiring administrative support for the full target population of patients immunised in schools and primary care.	Significant health improvements in children who are at risk and potential reduction in number of hospital admissions/morbidity.	There are time and staff risks associated with this campaign, and a sustainable finance and workforce model will need to be developed for future years.
<b>Review Sexual Assault Referral Centres (SARC)</b>	Welsh Government is undertaking a review of SARC services across Wales, the findings of which will be implemented during 2014/15 and beyond.	The UHB manages the only NHS run SARC service across South Wales, and the impact of the review could be significant.	Improved quality of care for women and children across the region who suffer sexual assault.	This service is at significant financial risk as it is funded through a multitude of different, short term funding routes. The review should help develop a sustainable solution.
<b>Develop an integrated genomic infrastructure which would meet the clinical, research and economic needs of Wales.</b>	Creation of a major research and clinical asset for Wales through the capture, storage and analysis of large amounts of genetic and genomic information which is easy to use for research, clinical and other purposes.	Availability of infrastructure which: <ul style="list-style-type: none"> <li>• supports the rapid and reliable capture of genetic information at scale, including from existing pre-consented material;</li> <li>• maximise creative interchange between academic, clinical, and business communities, with an emphasis on research impact, translation and commercialisation;</li> </ul>	Ability to link genetic and genomic information with other large scale data, including e-health and service data, particularly in Wales but also internationally leading to long term health benefits.	Capital investment required in estate, IT infrastructure and genomic sequencing technology. Strategic Outline Programme to be developed by summer 2014.
<b>WG funding to purchase robotic</b>	Current evidence shows that	Robotic surgery is cost effective	Improved clinical outcomes	Commitment from other LHBs

Service	Rationale	Impact	Outcome	Risks
<b>surgical equipment to undertake laparoscopic prostatectomies</b>	there are considerable benefits to using this approach over traditional open surgery or laparoscopic surgery resulting in less pain and fewer intra and post-operative complications with consequent shorter hospital stays and a faster return to normal activities for the patient.	based on 150 cases a year and the system should be based in centres where the caseload is greater than 150 per year and the expectation is that Cardiff and Vale UHB will undertake 200 procedures per year.	for patients receiving treatment.	to support ongoing revenue funding is a risk.
<b>Implement the More than Just Words Strategy: Welsh Language in Healthcare Framework</b>	The framework's aim is to improve the level of Welsh Language healthcare offered by NHS services. For example, to ensure that frontline service offers a language choice of either Welsh or English.	A three year action plan has been presented by Welsh Government to the organisation that will be implemented over three years (beginning in April 2013).	Improve quality, safety and patient experience for Welsh speaking patients and service users. More importantly, for young children and older people.	The Welsh Language Commissioner will also be monitoring the organisations implementation.  Failure to implement the strategy could lead to reputational, legal and financial risks.
<b>All Wales Standards for Accessible Communication and Information for people with Sensory loss</b>	Health Minister has stated that all UHB's need to take positive action so that all access and communication needs are met	The UHB will work with interested stakeholders to implement the standards	Improved access to services and less concerns.	Ability to meet the Standards within available resources

**Table 2 National Service Change Pressures**

Service	Rationale	Impact	Outcome	Risks
<b>Increase the volume of cardiac surgery and reduce waiting times for cardiac surgery to a maximum 10 week pathway by November 2015.</b>	Patients are waiting a disproportionately long time for treatment, leading to poorer patient outcomes, and potentially dying before they are treated.	Additional activity is required in the future to meet existing demand and improved waiting times for patient.	Improved clinical outcomes and access to services	Deaths on Cardiac Surgery waiting list. Provision of Cardiac Surgery – including ability to meet 36 week RTT. Potential requirements for additional investment in medical staff, CITU nursing and perfusion staff and additional physical capacity.
<b>Provision of standardised clinical genetics services to all LHBs across Wales.</b>	Annual increasing demand for the numbers of send out tests due to greater awareness of cancer genetics and genetic disorders.	Development of a robust framework that supports the service.	This should enable a single, standardised high quality service for Wales, with clear and agreed service specifications aligned to demand.	There are potential cost pressures associated with this review, and the staff risks are significant given the specialised nature of the service.
<b>Enhance and appropriately resource the Lymphoma Review Panel.</b>	The review will assess changes in practice over previous years of funded activity and identify areas of activity which have not initially been considered and funded.	A successful review should ensure that funding reflects activity and demand, and that there are improved turnaround times for cancer reports.	Improved access times to care with improved efficiency of service.	Need to develop a business case for funding from WHSCC. There could be a reduction in service level provided to balance funding provision otherwise.
<b>Review All Wales Posture and Mobility Service</b>	The All Wales Posture and Mobility Partnership Board sets standards for services which the UHB must meet on behalf of other Health Boards.	Activity is delivered within timescales set: <ul style="list-style-type: none"> <li>• 90% of standard wheelchairs issued within 21 days</li> <li>• 90% of complex wheelchairs issued within 26 weeks RTT</li> <li>• Childrens NSF referral to assessment – 6 weeks</li> <li>• Childrens NSF delivery to service to delivery to client – 8 weeks</li> </ul>	Improved access to services.	Ability to deliver the targets within the available resources

**Table 3 Regional Service Changes – WHSSC Commissioned Services**

Service	Rationale	Impact	Outcomes	Risks
<b>Review thoracic surgical services across South Wales</b>	The strategy for Thoracic Surgery is underpinned by a requirement to meet the Cancer standards and through the Thoracic Surgery Implementation Group (TSIG) appropriately commission and plan both malignant and non-malignant thoracic surgery for the South Wales population.	Current demand is being met for urgent cancer cases and electively against a 36 week RTT. Future capacity will be required to deliver 26 week RTT. Possible changes to consultant workforce to support any new model of care.	Improved access to services. Improved patient outcomes.	Sustainability of thoracic surgery and consultant workforce availability.
<b>Agree business case for Adult Congenital Heart Disease</b>	There is increasing demand for services based on assessed population need.	Expansion to the Adult Congenital Heart Disease service and recruit to a new consultant and associated support staff during 2014/15 with a further expansion to the service planned for years 3-5.	Improved clinical outcomes and access to services.	Business case is not supported.
<b>Develop a business case to expand the Bone Marrow Transplant service.</b>	Waiting times for patients is too long. Capacity within the service is under pressure, and services are separate from each other.	Co-location of ward and day unit and improved access to services.	Improved access to services. Improved patient outcomes.	Unacceptable waiting times for BMT; increase in number of patients requiring BMT; pressures on capacity. Patients relapsing on waiting list with potential for poor clinical outcomes.
<b>Renegotiate LTAs for Haematology and Clinical Immunology</b>	There is currently a mismatch between funded demand and activity.	This would enable a sustainable service model.	Improved quality of care. Improved patient experience.	Inadequate capacity within the Haematology Day Unit cramped and risk of cross infection which can potentially compromise care.
<b>Develop the transplant programme</b>	The overarching strategy and vision is aligned to the National	<ul style="list-style-type: none"> <li>To further develop the transplant programme to</li> </ul>	Improved patient outcomes.	Potential financial pressures. Service pressures with increase

Service	Rationale	Impact	Outcomes	Risks
	Service Framework 'Designed to Tackle Renal Disease in Wales' (2007). The incidence of renal disease is rising and will continue to do so, in part due to the increasing age of the population (associated with a decline in renal function) but also as a result of an increase in the patients with diabetes and cardiovascular disease (associated with renal problems).	<p>include an increase in activity (specifically live donors), become the centre of referral for HLAi transplants, and maintain graft survival.</p> <ul style="list-style-type: none"> <li>• Increase the number of pancreatic transplants undertaken at UHW, through providing incompatible transplants for North Wales and by attracting referrals and additional income from England.</li> <li>• Expansion of the National Organ Retrieval Service and establish a dedicated on call scrub team.</li> </ul>	Improved access to services.	in activity
<b>Develop the neurophysiology service.</b>	The overarching strategy and vision builds on the outcome and recommendations from the Steers & Axford reviews and the Making a Difference Strategic Change Plan. National Public Health Service Health Needs Assessments and the prevalence of neurological diseases were considered as part of the Steers & Axford reviews.	A safe and sustainable neurophysiology service will be provided across South Wales.	Improved clinical outcomes of care. Improved patient experience. Improved access to care.	
<b>Agree strategy for future provision of WHSSC paediatric services, specifically focussing on:</b>	Services are fragile due to loss of tertiary consultant (endocrine) and under-commissioning (cardiology)	Services should be delivered on a safe and sustainable basis if properly funded. Clear and agreed service specifications developed for	Improved access to care through sustainable service model. Clearer outcomes of care.	<ul style="list-style-type: none"> <li>• WHSSC will not support this review</li> <li>• Lack of WHSSC support to right sizing the service to</li> </ul>

Service	Rationale	Impact	Outcomes	Risks
<ul style="list-style-type: none"> <li>• Paediatric endocrine services</li> <li>• Paediatric cardiology</li> </ul>		services. Demand and capacity will be in balance.	Service responsive to health needs.	deliver an agreed standard of service and level of activity within resources available. <ul style="list-style-type: none"> <li>• Review of services suggesting need for significant investment</li> <li>• Review of services suggesting that service are not sustainable locally</li> <li>• Other LHBs not supporting review of outreach services</li> </ul>
<b>Review commissioning arrangements for foetal medicine.</b>	Contribute to the WHSSC regional review of Foetal Medicine Services which includes: <ul style="list-style-type: none"> <li>• Repatriating AB patients currently managed by Bristol to Wales.</li> <li>• Review the demand and capacity of the Foetal Medicine Service in Cardiff &amp; Vale UHB</li> <li>• Modernise the service and maximise efficiency.</li> </ul>	Alternative use of workforce when clinics are not running. Appropriate patients only being managed by the Foetal/Medicine team. Care can be delivered more locally with the advice and support of the FM clinical team in Cardiff and Vale	Improved local access to care. Improved patient experience.	Ensure no impact on LTA and reduction in income. Modernisation of foetal medicine practice is essential to support this.
<b>Review demand for spinal rehabilitation beds at Rookwood Hospital.</b>	The Business Case for the provision of spinal and neuro-rehabilitation services is with Welsh Government for approval. Changing service models mean that the demand for spinal rehabilitation beds can be reviewed.	Consider the demand for spinal rehabilitation beds and the potential to establish an in reach/outreach service as an alternative model and reduce the number of commissioned beds.	Improved clinical outcomes. Patients receive care closer to home.	There should not be risks associated with this, as long as WHSSC support the proposal for a changed service model. The risk is associated with the sustainability of services at Rookwood Hospital whilst decisions on the business case are made.

**Table 4 Service Changes with Other LHBs and Trusts**

Service	Rationale	Impact	Outcome	Risks
<b>UHB to take a lead role in coordinating discussions for the delivery of complex oral and maxillofacial surgery to patients in other LHBs.</b>	Develop agreed commissioning framework for complex services, to enable WG targets to be met and Delivery Plan to be implemented.	Services will reflect the National Oral Health Plan enabling Tier 1 cancer targets to be met.	An enhanced patient experience and improved access to care.	Increasing demand for complex services; inability to agree appropriate level of service and alignment of resources; inappropriate use of Dental SIFT; inability to meet Tier 1 targets.
<b>Review stroke services with other LHBs</b>	New stroke services are being developed to reflect the Stroke Delivery Plan and ongoing service developments. LHBs need to work collaboratively to reflect changes.	Services will be more effectively commissioned across South Wales to fully reflect population needs, pathways of care and appropriate care provided in the best hospital.	Improved outcomes of care with care provided at the right time and in the right place.	Any changes will need to reflect the outcomes of the South Wales Programme, recommendations of the All Wales Group, and secure individual LHBs' commitment.
<b>Transfer upper GI service from Hywel Dda LHB</b>	Hywel Dda LHB has asked the UHB to provide all upper GI services on its behalf.	The service will be run through a "network" type approach, with all in-patient care provided by the UHB, and with consultants from Hywel Dda working with Cardiff and Vale consultants.	The full impact of the change is still being worked through but is expected to result in improved clinical outcomes for patients.	This could have significant pressure on our services. Whilst resources to support the transfer will be recognised, the impact on the UHB's capacity both in terms of beds and theatres will need to be managed.
<b>Review provision of neuro-radiology services with Abertawe Bro Morgannwg UHB.</b>	Neuro-Radiology services are a key component of Neuro-Surgery services and the neuro-radiology service is suboptimal in particular the neurovascular pathway. The future provision of this fragile service will be discussed ABMU.	Development of a safe and sustainable service.	Improved patient outcomes and clinical improvements to care.	There could be financial and service risks associated with not making changes. High level discussions between the two UHBs are likely to be required to secure change
<b>Repatriate adult acute in-patient mental health</b>	Services have been provided by ABMU on behalf of the UHB for	Co-terminosity of clinical pathways, and support the further	Equitable access to services for residents of Cardiff and	ABM UHB engagement; possible consultation required; matching

Service	Rationale	Impact	Outcome	Risks
<b>services from ABMU from April 2014 for Western Vale residents</b>	this client group on a historical basis. The UHB is now in a position to be able to provide these services within our own facilities.	development of CMHTs on a locality basis.	the Vale, and more people are able to receive care at home.	resource to demand; relationships with primary care will need to be managed.
<b>Confirm commissioning arrangements and service model for CAMHS service with Cwm Taf LHB.</b>	There have been concerns over quality of care and lack of a clear service specification from a commissioner perspective.	Clear service specification for care.	Improved quality of care and clinical outcomes, leading to Improved patient experience.	Clinical incidents if service model and clinical cover not confirmed. Financial shortfall identified by Cwm Taf LHB.
<b>Develop a new model of care for lung cancer patients with Velindre NHS Trust</b>	There is a historic SLA in place based on historical activity with potential clinical duplication and not best use of resource.	Clear pathway and specification for service resulting in more streamlined service and better value for money.	Consistent pathway should result in improved patient outcomes and experience.	None identified.
<b>Develop new models of care with Wales Ambulance Services NHS Trust</b>	Developing new models of care which enable more people to be cared for at home rather than in hospital requires joint working across the UHB and with WAST.	Specific areas of development will include: <ul style="list-style-type: none"> <li>• Support to Nursing homes including alert system for the ACP pathway</li> <li>• Supporting early morning discharges</li> <li>• Implementing Falls pathway</li> <li>• progress PGDs with the Advanced Paramedic Practitioners</li> </ul>	Improved outcomes for patients to ensure they receive care in the right place and more often in their own homes. Consistency of care pathways will result in better use of resources and experience.	Engagement of WAST and independent sector in the development and implementation of new models of care is crucial. Possible resource implications.
<b>Agree and implement a vascular network for SE Wales</b>	The Vascular Society standards require the establishment of a network model for vascular services to ensure the best possible patient outcomes.	Agreement of the service model (hub and spoke) has been agreed by clinicians. A business case needs to be developed to support its implementation.	More efficient use of resources and improved patient outcomes.	Agreement of financial flows and governance arrangements between LHBs. Capital requirements – hybrid theatre development.



## 5.6 Specific UHB Targets Based on Commissioning Intentions

Many of the UHB proposals for service change are inter-linked and co-dependent upon each other. This section seeks to separate out specific actions, both in relation to commissioning intentions and other areas of service change, however, the co-dependencies and inter-relationships must be recognised. For example, development of care pathways across the UHB will impact upon services for urgent and acute medicine; whilst the development of the Community Resource Teams will be dependent upon changes to integrated care pathways and will support the development of new models of urgent and acute medicine. All will impact upon, and determine, our overall capacity and flow through the entirety of our system, and in some cases the wider health and social care system. Any proposed changes to right size in-patient capacity will also be dependent upon developments of the CRTs and a new model of care for gerontology.

### 5.6.1 Ensure that any person listed for surgery has been offered smoking cessation and weight management support where appropriate, in line with the UHB's Optimising Outcomes Policy

#### **Rationale**

The UHB approved the [Optimising Outcomes Policy](#) at its Board meeting in July 2013, and an [update](#) was prepared for the People, Performance and Delivery Committee in October 2013. The specific policy statements are:

#### Smoking

Anyone to be listed for an elective intervention who is recorded as a smoker must have been offered, accepted and completed smoking cessation support prior to being put on the waiting list.

#### Weight Management

Anyone to be listed for an elective intervention who has recorded a BMI of 40 or above must have been offered, accepted and completed weight management support prior to being put on the waiting list.

The UHB has adopted this policy to systematically address "lifestyle" risk factors before surgery, and aims to ensure that patients experience the best possible results from their surgery. The policy was tested during the summer of 2013, with full implementation across the UHB from 1 December 2013.

#### **Impact**

The total numbers of patients affected cannot be accurately quantified at this stage, but a modelling exercise, which applied population rates of smoking and BMI of 40+ to the number of non-urgent surgical referrals received in the last financial year, was used to estimate the potential impact full policy implementation might have on services. The exercise estimated the following referral numbers annually:

- 5500 patients who smoke.
- 400 patients with a BMI 40+.
- 100 patients with both a BMI 40+ and who smoke.

The ongoing impact of the Policy will be reviewed at least annually and reviewed as appropriate in the light of evaluations.

#### **Outcomes:**

- Improved clinical outcomes for patients following surgery

#### **Risks:**

- There is a reputational risk if escalating waiting times adversely affect access to services for both the UHB's priority area of Diabetes and the Optimising Outcomes Policy.
- There is also a cost pressure associated with implementing this Policy which will need to be covered by Clinical Boards

### 5.6.2 Implementing the agreed care pathways/service models for diabetes, MSK, anti-coagulation, INR, dementia, falls and unscheduled care across the UHB's Clinical Boards;

#### ***Rationale***

A series of care pathways and service models have been developed across the UHB, however, the benefits of implementing these to secure service change and integration needs to be maximised. This business planning cycle has provided the UHB with an opportunity to formalise these arrangements, providing benefits in terms of integrated care pathways across Clinical Boards, improved patient outcomes and better use of resources.

This is the first time that the UHB has sought to bring all the elements of care pathways and service models for specific services together in the same place to inform our internal commissioning and business planning approach.

Progress on implementing the care pathways/service models included, and the plans for further development, are set out below:

#### Diabetes

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), although it has been estimated the 'true' number of cases is 29,000. With up to one in five medical patients having diabetes, and diabetes becoming more common, it is essential that clinicians across all care settings (in primary, community, secondary and tertiary care) are competent in managing diabetes and provide care along an integrated care pathway. There are inequities in access to services and the [Director of Public Health Report 2012](#) (chapter 4) clearly set out why seeking to reduce the incidence of diabetes, and then helping people maintain their health is such a high priority for the UHB. Diabetes will be used as the model for demonstrating how inequities in access to health care will be addressed. This will be started in 2014/15.

The key strategic drivers are to provide better quality care; ensure people receive care in the right place at the right time and by the right person; reduce levels of inappropriate hospitalisation and ensure better use of resources. This is a 3-5 year plan, building on the Diabetes NSF and the WG Diabetes Delivery Plan published in September 2013. The focus is about providing care in a better way through reconfiguring care, and working with partner organisations, as well as patients and carers.

There have been significant developments in diabetes services across the UHB in recent years. A new model of diabetes care started in Cardiff and Vale in the autumn of 2012 with a shift of care into the community by medical consultants specialising in diabetes care working with GPs within their local practices and communities. The benefits of this new integrated approach are both to primary and secondary care with:

- patients being treated in the appropriate setting;
- initial data shows a 30% reduction in referrals to secondary care, although there may be a possible increase in primary care prescribing costs;
- enhanced skills/knowledge and experience for GPs; and
- a release of consultant time with potential for redirection into the prevention agenda.

In 2014/15 the UHB will continue to build upon the progress already made to develop and implement a holistic integrated care pathway across the full spectrum of prevention through to treatment and ongoing maintenance, whilst addressing the known inequities and the requirements of the Diabetes Delivery Plan. Of particular importance is the commitment of new funding to implement structured education for all new onset type 2 adults with diabetes and address the backlog.

### Musculo-Skeletal

The MSK Care Pathway has been reviewed and agreed and the model for funding the new regime is to be completed. It is clear that an integrated approach to include a single point of access will provide a better and holistic pathway for patients with an MSK condition (spinal and hand pathway excluded), and developing and implementing this work is being led by an integrated approach between the PCIC and CD&T Clinical Boards. The preferred model is to develop a multidisciplinary triage and treatment clinic to include a GP with a specialist interest, physiotherapist and podiatrist in the community setting with the following objectives:

- Enhance good quality management of MSK services in primary care for cases where effective interdisciplinary working should improve outcomes;
- Improve patient access to MSK service appropriate to the patient's level of need
- Provide the patient with the necessary information to make informed choices and a number of option grids have already been developed
- Optimise the number of appropriate referrals for diagnostics and specialist secondary care referrals
- Enhance good quality management of MSK services in primary care for cases where effective interdisciplinary working should improve outcomes.

The pathway and any associated internal resource transfers will be implemented during 2014/15.

### Anti-coagulation/INR

A business case has been developed for this service which is being led by the Specialist Services Clinical Board. This will be translated into an end to end pathway implemented across primary/secondary care within Specialist Services, Medicine, PCIC and CD&T Clinical Boards, with resultant transfer of resources aligned to the service model. This pathway and service model is one of the key focuses for the recently established LMC Primary/Secondary Care Task Force, chaired by the Chief Operating Officer.

This pathway, and any associated internal resource transfers will be implemented during 2014/15.

### Dementia

Dementia is a rapidly increasing illness, particularly as our population ages. In Cardiff and the Vale of Glamorgan, in 2011, there were an estimated 5,182 people living with dementia, and this figure is due to increase by 55% by 2030. People with dementia who are admitted to hospital with physical illness or injuries stay in hospital longer than people who do not have dementia.

The UHB has now drafted a 3 year plan to improve the way in which we plan and deliver dementia care, to help our population avoid, delay and cope best with dementia. There will be three main elements to the Plan:

- How do we up skill our staff to care for people with mild to moderate dementia?
- How can we develop dementia supportive communities?
- How do we more clearly articulate and differentiate between specialist dementia care and general care for people who have dementia?

Following approval by all partners, the plan will formally be initiated in spring 2014.

This Plan will ensure that we:

- provide better quality care;
- ensure people receive care in the right place at the right time and by the right person; and
- reduce levels of inappropriate hospitalisation and ensure better use of resources.

Quantitative benefits are to be confirmed, although it is expected that there will be a reduction in inappropriate hospitalisation. Other improvements will be measured through the Dementia Intelligent Targets.

## Falls

The following pathways are available for elements of the falls service:

- Commissioning Intentions
- QP Falls Pathway
- Revised GP Falls Pathway
- Falls Prevention for Adult In-Patients
- Action following an In-patient Fall

Each Clinical Board will implement elements of the Pathway. The PCIC Plan will evaluate the impact of the Falls Alternative Care Pathway on attendance at EU.

## Unscheduled Care Pathways

As part of the development of our service model for urgent and acute medicine (set out in further detail later in the chapter), the following pathways have been identified as priorities for development and implementation across the UHB in 2014/15 and beyond:

- End of Life (Advanced Care Planning)
- COPD
- Atrial Fibrillation

## **Outcomes:**

- Improved patient outcomes through streamlined provision of care
- Providing care in the right place, at the right time, by the right person
- Aligning resources to patient need and flow

## **Risks:**

- Securing clinical support and agreement to new care pathways
- Implementing new models of care
- Realigning resources to reflect new care pathways

### **5.6.3 More effectively commissioning services from primary care to reduce referrals/admissions into secondary care where appropriate; specifically these will include:**

- CRT delivery – support to discharge to reducing length of stay implementing palliative care pathways
- Nursing and residential homes – reduce 999 calls through reviewing variation and support
- Introduce practice visits to review variation in GP referrals, ambulatory sensitive conditions
- Support reductions in secondary care follow ups through agreeing protocols with secondary care
- Routine review of paediatric referrals
- Improve the quality of GP referrals into secondary mental health services and improve liaison between primary care and mental health services

### CRT delivery – support to discharge to reducing length of stay implementing palliative care pathways

The aims of the CRTs are to support people to regain and maintain their independence in the community (thus reducing the demand on secondary care when clinically appropriate). In 2014/15, the focus for CRTs will be to:

- maximise support improve flow through the unscheduled care system, including support to nursing homes (working with WAST and the third sector);

- working across Clinical Boards to implement the falls, dementia and frail older people pathways;
- 'Make Every Contact Counts' initiative;
- Work with both local authorities to support the continued development of reablement and discharge services;

In Cardiff, the priority will be to combine and integrate the resources of the CRTs and those within the Cardiff Council's own reablement service (START) so as to maximise the collective capacity of these services and deliver seamless care to service users, with the aspiration of creating an 'intake model' over time. For the Vale, there is a plan to maximise integration at all levels and services (health, social services and third sector).

#### Nursing and residential homes – reduce 999 calls through reviewing variation and support

The UHB will agree a quarterly based performance report with WAST, so that "performance" between nursing homes can be analysed, enabling support to manage variances where appropriate. This support may take a variety of forms, for example:

- Directing nurse assessors to work with GPs and care home staff to review patients;
- Identify opportunities for training nursing home staff;
- Establishing Locality Nursing Home Forum to strengthen communication; and
- Strengthen the ED/Locality Lead Nurse communication.

The UHB will also promote the use of Advanced Care Planning in Care Homes for patients with capacity, supported by Neighbourhood Community Directors.

#### Introduce practice visits to review variation in GP referrals, ambulatory sensitive conditions

The QP process is driven by the Neighbourhood Community Directors and the Locality Managers, focussing on outpatient referrals and emergency admissions.

Currently practices are required to review progress against their chosen pathways using the data provided nationally by NWIS. This data does not provide a true reflection of achievement and outcomes for the individual care pathways. Therefore, a proof of concept exercise will be undertaken with NWIS for two of the nine care pathways that have been developed.

This proof of concept exercise will involve extracting data from GP systems for a defined patient cohort and linking it with secondary care data. This will allow the practices to examine further the link between chronic condition management and secondary care referrals and admissions assisting with meaningful demand management.

The pilot exercise will facilitate peer review of the management of defined patient cohorts at both a primary and secondary care level. The care bundle assessment, together with data on the impact on secondary care will be used to assess the effectiveness of the management of patients through agreed patient pathways.

#### Support reductions in secondary care follow ups through agreeing protocols with secondary care

##### Routine review of paediatric referrals

##### Improve the quality of GP referrals into secondary mental health services and improve liaison between primary care and mental health services

#### **Rationale**

The UHB has invested significant efforts in improving flow within secondary care, and will continue to follow this through. We also believe that we need to address demand management, commissioning new pathways of care which will maximise the benefits of being an integrated care organisation and reduce referrals/admissions into secondary care where appropriate.

Pathways are being developed to support this commissioning intention, under the workstreams of unscheduled care, scheduled care, mental health, paediatrics and dental services – and the interventions and outcomes are identified for each pathway within this. High level versions of these are shown at Appendix 2, and there is considerable detail behind the rationale for identifying these:

- Whilst 85% of urgent care contacts take place in primary care, the pressure on secondary care is unrelenting and whilst there have been significant improvements in performance, the UHB still struggles to achieve and maintain its Tier 1 targets for A&E services.
- There are wide variations in referral rates and practices amongst GP practices, often for very good reason. However, as one of our strategic goals is to ensure equity of access to services for people across Cardiff and Vale, we must ensure that people are being referred for the right reasons.

The pathways identified within these workstreams all either relate to:

- significant volumes of patients attending out-patients or unscheduled care where we feel a better pathway could be developed and implemented;
- care pathways at formative stages of development which could have a significant impact on care if two or more Clinical Boards jointly implemented them. This might be in terms of quality of care for patients; receiving care much closer to their home and improving access to services; reducing demand on secondary care; making best use of clinicians' expertise; and
- services which could lead to significant health improvement benefits.

The care pathways which have been developed/will be further developed for implementation during 2014/15 and beyond are:

Pathway
<b>Pathways Agreed</b>
Paediatric: <ul style="list-style-type: none"> <li>• constipation</li> <li>• incontinence</li> <li>• behaviour management</li> <li>• ADHD</li> </ul>
Work with GDS to develop care pathways for patients that: <ul style="list-style-type: none"> <li>• are vulnerable</li> <li>• have specific anxieties about treatment</li> </ul>
Review pathways across Community/General/University Dental Services
GP referrals to secondary mental health care
<b>Pathways Agreed for Development</b>
Unscheduled Care: <ul style="list-style-type: none"> <li>• falls</li> <li>• anticoagulation (also scheduled care)</li> <li>• End of Life (Advanced Care Planning)</li> <li>• IVABs</li> <li>• COPD</li> <li>• Hip Fracture</li> <li>• Atrial fibrillation</li> <li>• Heart Failure</li> <li>• Falls (WAST</li> </ul>
Scheduled Care: <ul style="list-style-type: none"> <li>• Diabetes Management</li> <li>• MSK (OA hips/knees)</li> </ul>

Pathway
<ul style="list-style-type: none"> <li>• Anticoagulation (also unscheduled care)</li> <li>• Shoulder</li> <li>• Cataract</li> <li>• Smoking</li> <li>• HIV</li> <li>• ENT Hearing/Nasal/Sore Throat</li> <li>• LUTS</li> <li>• Heavy Cyclical Bleed</li> <li>• Lifestyle</li> </ul>
<b>Further Pathways to be Developed and Agreed</b>
Supporting secondary care ophthalmology by engagement of primary care optometrists "Focus on Ophthalmology"
Integrate pathways of care, working with LAs and CRTs to increase pull of patients to community from hospital.
Work with the EU Teams and consider liaison services and different models of care to achieve swift appropriate referrals into the MH service
Agree care pathway for patients with acute kidney injury.
GP referrals to cardiology
Pathways for acute cardiology – especially PPCI to enable repatriation to host DGH
Redesign complex vascular surgery pathway
Redesign trauma pathway and enhance therapy input
Integrate and streamline (Health Board wide) continence referral pathway to reduce demand for new outpatients and follow ups.

There is an agreed timetable for implementing the pathways for paediatrics, mental health and dental services during 2014/15. The other pathways will be further developed in early 2014/15, with agreed phased approaches to implementation.

#### **Outcomes:**

Outcomes will reflect those set out under 5.6.2 above. In addition:

- More people will be able to receive care in community settings, reducing the impact on secondary care.
- Released capacity in secondary care will enable patients requiring treatment in hospital to receive their care in a more timely way.
- GP referrals will be more consistent and of a higher quality across the UHB area

#### **Risks:**

Risks will mirror those set out under 5.6.2. In addition:

- Securing change is reliant upon engagement and agreement with the independent sector and Wales Ambulance Services NHS Trust to change models of care with nursing homes.
- Engagement with, and commitment of, GPs is required to change referral patterns and establish additional services in primary care settings.
- Agreements with local authorities will be required to further develop the Community Resource Teams

#### 5.6.4 Develop our Gerontology Clinical Model

##### **Rationale**

The new clinical model of care for gerontology which is described in 5.6.6 (Services for Frail Older People) will enable the right sizing of in-patient capacity for this patient group. West Wing Hospital is not fit for purpose for the delivery of modern healthcare, with inappropriate facilities that do not support optimum standards of care. The implementation of the model will enable the closure of West Wing Hospital.

##### **Impact:**

The new model of care will enable services to be delivered more effectively and to a higher standard from fewer physical sites. This will enable the closure of the West Wing site from 1 June 2014.

##### **Outcomes:**

- Patients will receive care in facilities which are fit for purpose, which should result in better outcomes of care.
- Concentration of services on fewer sites will support improved staffing and quality of care

##### **Risk:**

This is an ambitious date for the closure of this facility, and will need considerable planning, engagement and potentially consultation.

#### 5.6.5 Implement IT systems already agreed i.e. LIMS and e-discharge

##### **LIMS Rationale**

The implementation of an All Wales Laboratory Information System has the following aims:

- replace ageing computer system
- promote standardisation across Wales
- facilitate laboratory networking.

##### **Impact**

The new system will be implemented from May 2014, with costs identified as £290,034 pa, compared to current Telepath costs of £143, 906. No additional funding is identified to support this initiative.

An integrated system for the whole of Wales will mean that any work from within Wales will not need to be manually processed, which should result in a release of staff time. It should also enable an improved turnaround time for other Wales LHBs for referred work.

The implementation is underway on the assumption that NWIS will pick up dual running costs associated with keeping Telepath running.

There is also an opportunity to integrate digital voice recognition solution to cellular pathology services alongside TrakCare Lab LIMS which could result in potential cost savings due to a reduction in the staff required to undertake the work. This would also reduce turnaround times for cancer specimens and diagnostic repost.



**Outcomes:**

- Ability to share standardised data across Health Boards
- The data will provide a rich dataset for the analysis of pathways and outcomes.

**Risk:**

The UHB needs an agreed implementation date for the plan, and agreed funding for the revenue costs.

**E-Discharge Rationale:**

Medicines Transcribing eDischarge (MTeD) will enable quicker and more accurate notification to a patient's prescriptions on discharge.

**Impact**

The system 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 the patient's GP via the Welsh Clinical Communications Gateway as the patient is discharged from the ward.

The pilot is due to complete on time and a role out plan is required.

#### **5.6.6 Other UHB Priorities for Service Change**

The UHB has identified other priorities for change as follows:

- Developing our Locality Based Approach to Care
- Urgent and Acute Medicine
- Right-sizing our in-patient Capacity
- Improving Cancer Services
- Redesign Some of Our Services to Improve Efficiency and Effectiveness

The rationale, impact, outcomes and risks associated with these are set out below in greater detail.

#### **Developing Our Locality Based Approach to Care**

**Rationale**

We have set out earlier in the IMTP how the UHB has developed the Locality and Neighbourhood approach to support community based care, which is responsive to local needs. There are plans to further develop this approach during 2014/15 and beyond, both within the Primary, Community and Intermediate Care Clinical Board, but also through other Clinical Board plans. This will strengthen the roles of the localities to be seen as the core building blocks of our services.

Discussions with localities to inform the development of this Plan have set out the following areas for further development:

- Increased influence in commissioning/planning;
- Joint responsibility for service delivery;
- Workforce modernisation (e.g. generalist/specialist balance);
- Extend patient advocacy into secondary care;
- Greater role of patient/carers (co-production);
- Practice-based clinical dashboards;
- Integrated IT systems (info/pt); and
- Continued focus on evidence based practice.

Each locality has also identified specific areas for its own development, based on assessed needs and knowledge of local service pressures. These areas of focus have been identified as:

*Vale Locality* - the elderly population, community engagement, access, involvement, improved IM&T solution, deprivation, preventative, integrated, signposting, pathways

*South East Cardiff Locality* – services to vulnerable people. For example, the city centre has a significant homeless population as well as a number of asylum seekers. As the capital of Wales, how we deliver these services and the extent to which we do so in partnership with the local authority and third sector matters.

*North West Cardiff Locality* – significant planned population growth, older population with specific attention on diabetes, dementia and alcohol consumption for this population.

Each locality has a Community Resource Team, initially established to support the Wyn Campaign (services for frail older people), to help older people maintain and retain their independence in their own homes. Further detail on the developments of the CRTs is provided under the section on UHB specific targets within the commissioning intentions.

Other services will also be aligned with localities during 2014/15:

- District nursing teams will be aligned with localities and neighbourhoods to support the implementation of Delivering Local Healthcare.
- The Integrated Sexual Health service will be reviewed across the UHB with future models of care being delivered on a locality basis.
- Mental Health Services for Older People sectors will move from four sectors to three to be coterminous with localities.
- Health visiting services will be reviewed to more closely link with Flying Start services, and the potential of aligning with localities will be investigated.

*Outcomes:*

- Services are responsive to local health needs on a locality basis.
- Improved access to care.
- Improved patient outcomes.

*Risks:*

- Commitment from partner organisations to work in partnership to develop the model of care at locality level
- Engagement of staff representatives and agreement between the representatives of staff from other organisations
- Maintenance of staffing establishments
- Repayment of Invest to Save monies to Welsh Government
- Ability for services to absorb additional activity
- GP engagement with the locality model for newly aligned services

### **Urgent and Acute Medicine**

*Rationale*

Our vision is to have:

*“A responsive and efficient urgent care system delivering appropriate clinical outcomes based on a single point of emergency access, and treating patients in a timely, cost efficient, and appropriate way”.*

With an increasing population, and an increasingly elderly population, the pressures on our urgent and acute medicine services will continue to grow. Despite having made significant improvements to our performance during 2013/14 we need to continue to improve services across the UHB to ensure we have a sustainable service model which will enable care to be provided in the right place, at the right time and by the right professional.

*How will we do this?*

The development of a Future Model for Urgent and Acute Medicine is being taken forwards through four work-streams:

***Development of Ambulatory Care services***

- Review current function and formalise existing pathways;
- Expand capacity and stream through adopting high volume Ambulatory Care Service pathway work (included in section on pathways);
- Develop separate unit as 'stand alone' at UHW; and
- Long term option to locate at UHL with Minor Injuries Unit as part of wider Acute Take realignment.

***Establishment of a Medical Decisions Unit***

- Establish from December 2013 to test and refine;
- From April 2014 onwards establish a sustainable model of care and potential to expand to support single site and increased FOPAL functions (aligned with development of CRTs referred to previously).

***Improvement of Inpatient Ward Efficiency***

- Focus on Delayed Transfers of Care and long stay patients linked to UHB Commissioning Intentions to ensure capacity to pull through appropriate patients from Emergency Unit, Assessment Unit, Medical Decisions Unit and Short Stay.
- Implementation of 7 day consultant model to support improved quality, 'no surprises', and improved weekend flow.

***Patient Access and Streaming***

- Review and revise GP and 999 catchment and take definitions for UHL and UHW.
- Allocation of patients in the clinical/ward area best able to support specialist care needs and therefore shortest length of stay.
- Potential short stay patients focused to appropriate ward A4.
- Patients directed to specialist input areas where optimal (Cardiology, Respiratory, Gastroenterology etc).
- Pulling patients from Short Stay areas where 0-2 day potential is no longer likely.
- Acceptance and pull of patients requiring ongoing specialist input to specialist wards.
- Stream patients to wards based on both specialty and length of stay expectation.

***Impact***

Specific impacts will be measured through achievement of Tier 1 targets, however, we will also be able to assess improvements in terms of "flow" through the entire UHB and integration of services.

***Outcomes:***

- Improved clinical outcomes
- Improved access to care
- Patients receive care in the right place at the right time from the right person

*Risks:*

- National performance standards for A&E not met
- Delay in ambulance handovers
- Failure to reduce delayed transfers of care
- Patients delayed in inappropriate environments impacting on patient experience
- Financial impact
- Risk to RTT

**Rightsizing the UHB's In-Patient Capacity**

*Rationale:*

2013-14 (year 1) of reconfiguring our bed stock enabled a complex set of capacity plans to be aligned and deliver significant bed reductions and financial savings. This resulted in an appropriately reduced bed base with a reduction in bed occupancy, patients receiving care in the 'right' bed at the 'right' time and an improvement in patient /hospital flow.

This delivered not only an improved patient experience, but has also enabled a reduction in the number of patients staying in an acute setting longer than required and a significant reduction in the number of acute beds occupied by non-elective patients. The project has facilitated a reduction in the UHB bed stock by 98 beds (as at October 2013 – in line with the project plan), against the forecast reduction of 123 beds by March 2014. At the same time a Winter Flex Plan has been developed and agreed with WAST, the two local authorities and two CVCs; designed to build on the improvements and continue to support the flow of both elective and non-elective patients over the winter period.

*How Will We Do This?*

In 2014/15 phase 2 of the Strategic Bed Plan will be taken forward with further bed capacity right sizing efficiencies for surgery and medicine and changes in Mental Health services in line with the Service Change Plan for mental health as outlined later in this Chapter.

Current proposals can be broken down as follows:

Medicine – right sizing enabling net closure of 46 beds

- Gerontology - Closure of 2 wards and site rationalisation, through closure of beds in West Wing

Specialist Services – closure of 10 beds previously commissioned by Medicine

Surgery – right sizing enabling closure of 25 beds on a phased basis

- 15 trauma beds from May 2014.

As well as bed capacity requirements, there are also significant pressures on our critical care capacity. During 2014/15 we will:

- Develop a Post Anaesthetic Critical Care Unit, which will provide sufficient capacity to support the elective surgical stream of care;
- Review demand for neuro-surgical critical care, advanced respiratory care and emergency demand, resulting in a complete demand/capacity model to enable understanding of infrastructure requirements to inform future business plans over 3-5 years.
- Expand the role of the Critical Care Outreach team, supporting early identification of deteriorating patients and follow up of discharged patients in line with the Critical Care Quality Requirements and Delivery Plan for the Critically Ill.

A significant programme of redesign is underway to review the UHB's theatre capacity and efficiency of usage. It is expected that the outcome of this work could result in the equivalent efficiency gain of three theatres across the UHB.

Delivering this right sized in-patient capacity, and changes to critical care capacity, will require a range of interdependencies between different services and their infrastructure and estate requirements. In addition, there are IM&T- requirements for changes to service models and use of technology to deliver additional services within the community.

*Impact:*

The UHB Financial Framework for 2014/15 includes challenge around further bed capacity efficiencies and financial savings (100 beds - £4.5m), and further work will be required to model the impact if reductions equate to less. These changes will also mean the workforce will need to be re-profiled and re-modelled to support new models of care. The impact of additional theatre capacity will play a significant part in the UHB meeting its Tier 1 targets, and will need to be reflected in the overall bed capacity programme.

*Outcomes:*

- Improved access to care
- More people are able to receive care in their own homes
- Improved patient outcomes for people needing critical care

*Risks:*

- Ability to right size capacity and maintain patient flow and escalation levels at acceptable level
- Ability to right size capacity at levels expected and maintain performance for RTT
- Ability to modernise theatre management to secure additional capacity
- Ability to develop additional critical care capacity within estate and financial constraints

**Improving Cancer Services**

*Rationale:*

To meet the needs of people at risk of cancer or affected by cancer, the key areas that need to be achieved by 2016 are:

- Preventing cancer - People live a healthy lifestyle, make healthy choices and minimise risk of cancer.
- Detecting cancer quickly - Cancer is detected quickly where it does occur or recur.
- Delivering fast, effective treatment and care - People receive fast, effective treatment and care so they have the best chance of cure.
- Meeting People's Needs - People are placed at the heart of cancer care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of cancer.
- Caring at the End of Life - People approaching the end of life feel well cared for and pain and symptom free

*How Will We Do This?*

We will work across Clinical Boards to enable:

- Cancer Delivery Plan compliance by 2016;
- 100% compliance against national cancer standards;
- Information requirements for National Clinical Audits;
- Achieve cancer waiting times targets;
- Develop action plans to address the findings/recommendations following Peer Review visits to tumour sites within the UHB;
- Strengthen engagement with Primary Care and Public Health;

- Work with Patient Experience and Macmillan to address any actions highlighted by the Macmillan/Welsh Government patient experience survey due for release in December 2013;
- Small scale surveys across the tumour sites for compliance against keyworker implementation throughout the year;
- The use of patient stories and feedback from patient groups and third parties; and
- Work closely with South Wales Cancer Network.

*Impact:*

By undertaking these actions, we will ensure increased compliance against:

- Cancer Delivery Plan
- 100% compliance against National Cancer Standards
- Positive reports following Peer review visits
- Achieving Tier 1 targets.

*Outcomes:*

- Improved patient outcomes
- Improved quality of care
- Improved access to care

*Risks:*

- Accommodation requirements for cancer services staff
- Sufficient staffing to provide MDT support across all the tumour sites
- Appropriate engagement across the UHB to enable development of integrated services

**Redesigning Our Services to Improve Efficiency and Effectiveness**

*Rationale*

Clinical Boards have identified a large number of services which they believe could be provided in more efficient and effective ways, providing improved patient outcomes and experience and better value for money.

*How Will We Do This?*

There are detailed service plans to support all of these service redesign schemes, however, the main services to be reviewed are:

<p><b>Dental:</b></p> <ul style="list-style-type: none"> <li>• Community dental services for special care patients; older people and domiciliary care.</li> <li>• Patients with chronic denture problems</li> </ul>	<p><b>PCIC:</b></p> <ul style="list-style-type: none"> <li>• Commission additional GDS activity</li> <li>• New model of care for Emergency Hormonal Contraception</li> <li>• Improve commissioning and new pathways of care for CHC.</li> </ul>
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<p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li>• Opportunity to develop an integrated mental health liaison service;</li> </ul>	<p><b>Medicine:</b></p> <ul style="list-style-type: none"> <li>• Develop integrated gastroenterology and endoscopy services</li> <li>• Sustainable hepatology service</li> <li>• Expand use of technology to support change in respiratory medicine; stroke; rheumatology and dermatology</li> </ul>
<p><b>Surgery:</b></p> <ul style="list-style-type: none"> <li>• implement standard 6 hour treatment for ankle fractures</li> <li>• Introduce primary care OT led hand service</li> <li>• Redesign orthopaedic services and with use of virtual clinics and primary care hand OT service</li> <li>• Redesign surgery services including SAU model; day of surgery admission as norm; direct listing for minor cases and appraise intestinal failure service.</li> <li>• Redesign urology services including day of surgery admission; hot clinics; one stop PSA clinics and facility for flexi-cystoscopies.</li> <li>• Redesign ENT services including development of decontamination unit; non-medical follow ups and day of surgery discharge.</li> <li>• Redesign ophthalmology service including glaucoma ODT; nurse led out-patient cataract service and improved management of lists.</li> </ul>	<p><b>Specialist Services:</b></p> <ul style="list-style-type: none"> <li>• Evaluate service models for sickle cell and thalassaemia; venous thromboembolism prevention and management; paediatric BMT, immunology and 22q11 services.</li> <li>• With Medicine, establish a robust response for patients with Acute Kidney Injury</li> <li>• Implement the Epilepsy Surgery Programme.</li> <li>• Redesign the pain service</li> <li>• Re-establish psychology support to the nephrology and transplant directorate.</li> <li>• Review biochemistry and haematology/blood transfusions services at UHL.</li> </ul>
<p><b>Children and Women:</b></p> <p>Modernise gynaecology services by transferring all gynaecology out-patients and in-patient services from UHL to UHW:</p> <ul style="list-style-type: none"> <li>• Increase out-patient operating instead of in-patients</li> <li>• Develop nurse led telephone follow up rather than out-patient attendance</li> <li>• Provide telephone advice to support GP decision making</li> <li>• Change follow up arrangements for gynaecology cancer</li> <li>• Manage out-patient demand for gynaecology tertiary services</li> <li>• Develop service specifications for paediatric therapy services and school based services to Ysgol y Deri (special school)</li> </ul>	<p><b>Clinical Diagnostics &amp; Therapeutics:</b></p> <ul style="list-style-type: none"> <li>• Reduce number of examinations by histology by educating service users.</li> <li>• Review biochemistry and haematology/blood transfusions service at UHL</li> <li>• Introduce genetic testing for stratified medicine in oncology</li> <li>• Implement new health records structure</li> <li>• Review dispensing arrangements for out-patient prescriptions</li> <li>• Manage demand and capacity for chemotherapy and PN</li> </ul> <p>The CD&amp;T Clinical Board will focus on becoming a great internal supplier of services to other Clinical Boards, and will introduce a robust trading framework support internal SLAs, which will be a new approach to internal commissioning within the UHB.</p>

*Outcomes:*

- Improved patient outcomes
- Improved access to care
- Services more appropriately reflect health needs

*Risks:*

- Staff engagement to support service redesign
- Capital and estate resource to support changes
- Timeframes to implement change and secure benefits

### **5.7 Service Change Plans Already Underway**

In addition to the service changes set out previously in this chapter the UHB also has a large number of service change plans already underway. Many of these were set out in detail in the [UHB's 2013/14 IBP](#). In summary there are:

- Developing the CRI as a Locality Health and Treatment Centre
- Adult Mental Health Services
- Increasing Neonatal Capacity
- Making a Difference: The Re-Provision of Specialist Spinal and Neuro Rehabilitation Services
- Noah's Ark Children's Hospital for Wales
- Remodelling the Emergency Unit at UHW

#### **Developing the CRI as a Locality Health and Treatment Centre**

The current construction work at CRI encompasses the following services, which were all approved by WG for capital funding from the All Wales Capital Programme. The planned completion dates will be phased during the early part of 2014, with the final works completed in the spring of 2014:-

- General Medical Services;
- Out-of-hours GMS and dental services; Cardiff Health Access Practice (CHAP) providing health screening and healthcare to asylum seekers, the Alternative Treatment Centre (ATC) for potentially violent patients; and outpatient clinic accommodation
- Integrated sexual health services

The future of the CRI is currently the subject of discussions with key stakeholders, particularly in terms of its role in enabling the UHB to meet the health needs of the local residents and the wider population served by the UHB in an innovative manner. The development will offer the UHB an opportunity to take a broad view of how we can transform our services to deliver more integrated models of care which will improve health outcomes and provide the best possible experience for patients, deliver care in locally based facilities, ensure access to care is equitable and meet the challenges faced by the UHB. The CRI will support the UHB's approach to developing locality based services, as set out in Chapter 4 of the IMTP, and also be an important foundation of our Clinical Services Plan.

These discussions will result in the identification of the scope of services for the CRI and inform the development of a Strategic Outline Programme (SOP), which will provide the basis for the development of future business cases to access All Wales Capital Funding. As the SOP and further business cases are developed the detailed workforce and revenue implications of any change will be worked through and contained within future years' IMTPs. This is an extremely complex strategic service change programme and timeframe required to complete this work is longer than originally



anticipated. The Strategic Outline Programme will therefore be submitted to Welsh Government at the end of 2014/early 2015.

More detailed information is available [here](#) (page 39)

### **Adult Mental Health Services**

The UHB currently delivers primary, community, inpatient and tertiary mental health services out of five hospital sites and twelve community bases through over 64 integrated teams. The range of services includes core mental health services such as adult and older peoples community mental health multi-disciplinary teams and aligned in patient beds but also support, specialist and tertiary services.

We now provide **Primary Mental Health Support Services** working into Primary care services meeting the needs of low and medium intensity mental health support alongside **Assertive Outreach Services** including provision for the City Centre and Homeless. Our **Early Intervention** efforts to detect and intensively treat first episode psychosis support the work of the generic adult services. Also in support of these cornerstone services are the Tier 3 **Eating Disorders** Specialist Team, Tier 3 **Borderline Personality Disorder** Support Team, **Perinatal** Specialist Service and the **Specialist Rehabilitation** teams across Cardiff and Vale to support recovery and move on. A **Post Traumatic Stress Disorder** team is closely aligned with the all Wales **veteran services** hosted by Cardiff and Vale. A Range of **Low Secure and Forensic** services, including in patient beds, community team and criminal justice liaison services are available with a range of **substance misuse** services including NHS inpatient provision. The mental health service continues to provide support collaboratively across the UHB with **Liaison services** present in EU, general hospital wards, poisons and elderly wards. Elderly mental health specialist services include **Crisis Resolution (REACT)** community older people's team – one of the few across the UK, working alongside the **Memory team** and **Young Onset service** and **Nursing Home Liaison**. The **delivery of Psychological Therapies** is becoming increasingly embedded in core services with specialist support. The Clinical Board is responsible for the care and treatment of over 120 **Continuing HealthCare** patients placed with private providers.

Over the last ten years we have developed our services in line with needs of our service users and our commissioner requirements, and this will continue.

We have developed specialist community services and increased community mental health team productivity to see and treat people as soon as possible closer to where they live. These services include:

- Primary mental health support service
- Two adult crisis resolution home treatment teams
- Crisis recovery unit
- Crisis beds run in partnership with the Third sector
- MHSOP REACT crisis team
- Assertive outreach team
- Day opportunities and recovery service and expanded community rehab team

As the productivity of community mental health teams has increased, fewer people need admission to hospital so we have reduced the number of inpatient beds. Ten years on we have 80 less beds.

Over the coming year, the Clinical Board for Mental Health will continue to strengthen services around the person's home and rationalise buildings based services. Where appropriate, the CB will consolidate services for people suffering with serious and enduring mental health problems, while responding to new opportunities for service expansion and development as they arise. This includes people suffering with specialist needs whilst focusing on recovery and health promotion. Work to strengthen existing partnerships within the 'Time to Change' initiative and develop new partnership arrangements will be pursued to help deliver a better range of integrated services. The potential to

develop alternative operating models to enable the provision of high quality care more innovatively and efficiently will be taken forward.

There is an intention to promote mental wellbeing and where possible prevent mental health problems developing, improving individual and community resilience. Discussions with partners, communities and service users have set out the following priorities in these areas:

#### Public

- Enhancing emotional resilience through education and awareness-raising
- Prevention through targeted health promotion
- Mental health wellbeing employment promotion and workplace initiatives
- Good quality and secure housing enhancing well-being
- Reducing social isolation
- Improved mental health services signposting and organisation links

#### Service Users

- Clearer strategic direction involving the Department for Work and Pensions, Education, Housing, Criminal Justice, acute healthcare and advisory agencies.
- Enhanced integrated working leading to a seamless model of care through the use of pooled budget arrangements
- Greater service user involvement with commissioning, service development and recruitment
- Realigning resources to reflect needs driving value for money
- Education and awareness raising for staff ensuring core values are promoted
- Expanded advocacy support specifically within the community
- Improving communication and signposting links between primary and secondary care
- Continued drive for improvements in access, experience and outcomes ensuring patient centred services
- Reducing stigma and discrimination, barriers for service users will soften

Detailed design work for the new adult mental health unit (AMHU) being constructed at UHL will continue along with the associated introduction/embedding of new service models. The AMHU will bring together the adult mental health inpatient services currently delivered from Whitchurch Hospital and the Llanfair Unit at UHL into a single Unit. Welsh Government approval for the Full Business Case has been received along with the associated capital funding from the All Wales Capital Programme.

As this Service Change Plan is of such significance to the UHB in the forthcoming years, more detailed information is contained within Appendix 3a.

The capital plan also reflects the need to provide replacement accommodation for one of the CMHTs due to the poor environment offered by the existing accommodation.

#### **Neonatal Capacity**

The Neonatal Network has now published its second version of Neonatal Standards aimed at improving care and outcomes for babies. It provides a quarterly report to WHSC against compliance with the standards. The Network is also reviewing the Neonatal Retrieval Service with a view to extending the service to 24/7, and a proposal from the Network is currently with WHSC. Whilst accepted as a valid clinical aspiration, this is not supported by the Clinical Board due to the excessive cost per patient, and the inability of the UHB to support it from a medical and nursing perspective even with the additional resource identified.

The UHB recognises that capacity is a significant constraint if the Neonatal Standards are to be achieved and safe levels of capacity for ITU, HDU, surgical babies, and SCBU are able to be provided going forward in light of recurrent demand, a raising birthrate and the backdrop of the South Wales Programme.

A business case is currently being developed for an expanded unit that will meet future requirements and will also address the outstanding governance issues associated with the ongoing pseudomonas infections in the current unit. The business case is likely to be completed towards the end of 2015. This will be a significant service development for the UHB requiring considerable all Wales capital funding, as well as a review of service and staffing models. Engagement with WHSCC and neighbouring health boards will play a major part in the plan.

As the requirement for increased capacity for neonatal services is identified as such a significant risk for the UHB, further detail is provided in Appendix 3b.

#### **Making a Difference: The Re-development of Specialist Neuro and Spinal Rehabilitation Services**

The UHB is still committed to taking forward the redevelopment of specialist neuro and spinal rehabilitation services, to enable in-patient care to transfer from Rookwood Hospital to UHL. This proposed change has been subject to formal public consultation, and will enable significantly enhanced care for this group of patients from across South and Mid Wales.

At present the UHB is awaiting approval of the Outline Business Case from Welsh Government, and further detail is available in last year's [IBP](#) (page 44).

#### **Noah's Ark Children's Hospital for Wales**

The second phase of the Noah's Ark Children's Hospital for Wales will complete the development of a child focussed hospital providing high quality, responsive and integrated paediatric care. This phase will integrate all paediatric inpatient and outpatient services into a single environment thereby reducing service boundaries and facilitating efficient patient pathways through both service and professional co-location. Dedicated facilities will be provided to support surgical, diagnostic, outpatient and critical care services fully integrated with the services established in the first phase.

. The services to be provided in Phase 2 are:

- Paediatric theatres to support the anticipated range of surgical procedures, from day/case ambulatory care to complex specialised surgery, this includes a dedicated dental theatre.
- A paediatric critical care service combining the paediatric intensive care unit and the paediatric high dependency unit, with the capacity to support the paediatric retrieval service.
- Inpatient accommodation for surgical beds and ambulatory care/overnight beds.
- Co-location of children's assessment unit and children's investigation unit.
- Inpatient accommodation for renal/cardiac beds.
- Dedicated paediatric outpatient department to enable integration of specialised outpatient clinics and enhance MDT working.
- Radiology department for basic imaging, ultrasound, MRI and fluoroscopy.
- Dedicated academic and teaching facilities for child health services.
- An age-appropriate environment across all services including enhanced play and educational facilities.

The [Full Business Case](#) was approved by Welsh Government in December 2011. Construction is due to end in late 2014, with occupation in March 2015. As this scheme is of such significance to the UHB, and other LHBs across Wales, further information is provided in Appendix 3c.

### **Remodelling the Emergency Unit at UHW**

Over the last year there has been significant construction work to remodel the EU Department at UHW, to provide increased capacity, and enable improved patient care. This remodelling is due to be completed in June 2014. Further detail is available in last year's [IBP](#) (page 52).

### **Development of Genomic Services in Wales**

In June 2013 the Welsh Government set out their strategic objectives for the development of an integrated genomic infrastructure which would meet the clinical, research and economic needs of Wales.

It is envisaged that the infrastructure needed to achieve these objectives will require capital investment in estate, IT infrastructure and genomic sequencing technology and it has been agreed that this development is best taken forward through the initial production of a Strategic Outline Programme (SOP). The SOP will set out the overall costs, anticipated benefits and risk profile of the totality of the strategy along with a comprehensive option appraisal of all of the required projects aligned to the critical path for delivery of the whole programme. The timescale for the development of the SOP is September 2014.

As this strategy involves the development of a number of different, but interlinked, strands involving clinical and academic services the initial SOP will be delivered through a collaborative approach between Cardiff and Vale UHB, Cardiff University, Public Health Wales and Swansea University.

### **Robotic Surgery for Prostate Cancer**

The UHB has received funding from Welsh Government to purchase robotic surgical equipment to undertake laparoscopic prostatectomies. This reflects current evidence which shows that there are considerable benefits to using this approach over traditional open/laparoscopic surgery resulting in less pain and fewer intra and post-operative complications with consequent shorter hospital stays and a faster return to normal activities for the patient.

The current draft NICE guidance notes the results of the published cost-utility analysis shows that robotic surgery is cost effective based on 150 cases a year and that this system should be based in centres where the caseload is greater than 150 per year and the Cardiff and Vale UHB is therefore based on undertaking 200 procedures per year. To ensure financial viability Aneurin Bevan Health Board and Abertawe Bro Morgannwg University Health Board have been asked to contribute to the additional revenue costs of the procedures.

A second bid is currently being developed to fund the purchase of a dual controller, along with an associated training package, to enable training to take place during procedures. The bid will also fund theatre refurbishment and reconfiguration works to enable the robot and associated equipment to be accommodated in main theatres.

### **Ward Modernisation**

The University Hospital Wales (UHW) and University Hospital Llandough (UHL) sites will be the major acute sites for the UHB for the foreseeable future. To prolong their useful life it has been necessary to consider the infrastructure of the buildings and condition of the wards in terms of their ability to meet the requirements of patients and their care needs in line with this strategy. The requirement for capital investment to support this will be detailed in a Strategic Outline Programme (SOP) which will be submitted to Welsh Government (WG) in the autumn of 2014. The SOP will verify the holistic fit and synergies with overarching policies, strategies and other programmes and provide a framework for the programmes constituent projects going forward.

### Cardiology Diagnostic Suite

A Business Justification Case (BJC) will be submitted to Welsh Government (WG) in September 2014 seeking capital investment to support the centralising of cardiology diagnostic functionality within the University Hospital of Wales. Cardiology diagnostic services are accessed by a complex flow of outpatients and inpatients from cardiology and cardiac surgery as well as a wide range of other clinical disciplines across the UHB.

Services are currently delivered from disparate sub-optimal facilities within different ward blocks in UHB which do not meet minimum standards e.g. privacy and dignity. Centralisation of these services, within a dedicated purpose designed suite, will support the delivery of capacity to meet the current and future demand in a quality environment meeting national access requirements and those of patients and supporting opportunities to further expand service provision aligned to estate utilisation plans.

It is envisaged that the capital requirement will be circa £2m.

### Healthier Connections

The launch of Round 2 of the WG Health Technology Fund in November 2013 introduced a specific focus on telehealth and community practice. The UHB has ambitions to lead Wales in the roll-out of telehealth technologies and practices at both scale and pace and submitted bid against this funding in January 2014.

The bid, with a total capital project value of £3.125m, represents a key component of the UHB's digital health care programme 'Healthier Connections'. This is a coalition of Cardiff-based organisations, working together to optimise healthcare across Cardiff and the Vale of Glamorgan enabled by technology. As such, this proposal represents a partnership bid across health, social care, academia and commercial-sector partners and seeks investment to procure integration technologies and technical infrastructure that will provide a foundation for the management of data across systems.

The bid focuses on the delivery of a sustainable programme of transformation, applicable to, and transferable across, the whole of Wales. A key component of the project will be the fundamental design / redesign of the health and social care pathways to deliver improved health and care at lower cost in non-hospital settings to, initially, discreet cohorts of patients within the *frail elderly, young diabetic and end of life care streams*.

The project will deliver a short, high impact process of baseline review, future care pathway design and implementation of modernised pathways which will be enabled by this technology for these 3 priority care pathways to deliver the desired benefits both from an IT Integration perspective and to support patients in their own homes by implementing IT integration *across existing and future patient records, utilising a cloud based platform and integration technologies to:*

- Delivering integrated care - Providing a foundation to support the management of patient data across systems and software;
- Supporting care provision and decision-making - This will directly support patient care and interventions;
- Providing a platform to deliver current and future care and care technologies.

### 5.8 Headline Service Changes for 2015/16-2016/17

In developing this IMTP we have considered service change priorities during 2015/16-2016/17. Many of the service changes referred to previously within this Chapter will be ongoing for the duration of the IMTP and have not been separated out separately. Clarity on longer term changes will also be clearer once the UHB's Organisational Strategy and Clinical Services Plan have been more fully developed. Next year's IMTP will therefore be clearer on longer term change requirements. However, there have been a number of areas where we know that services will need to be reviewed over a

longer term basis – some within the Cardiff and Vale UHB, some with local partners, and some on a wider geographical basis. Those that have been identified are set out at a very high level below.

- Changing Demography
- Service Changes Across South Wales
- Cardiff and Vale UHB Service Changes

### **Changing Demography**

The health needs assessment clearly sets out the pressures which will be placed upon our services, and the way in which we will need to respond in future years. All of these will continue to have an impact over the lifetime of the IMTP.

#### *Services for older people*

We will need to ensure that our localities and Community Resource Teams continue to mature and develop integrated services within and across the UHB through the evolution of integrated care pathways and with local authorities and 3<sup>rd</sup> sector organisations to enable people to remain at home.

- The Community Dental service will expand the elderly care oral health programme which promotes and maintains the oral health of elderly patients through good nursing and care, and making a real difference to individual health, wellbeing, recovery from illness and overall quality of life which is necessary to comply with Fundamentals of Care (Welsh Assembly Government 2003).
- Service redesign for Mental Health Services for Older People to create increased investment in community services, together with the implementation of an integration agenda with PCIC will help address any unmet need/increased demand for dementia services due to improved diagnosis rates.
- Future possibilities around new build provision for Dementia Village Social Enterprise provision with different levels of continuing health care on one site will be scoped.
- The good partnership arrangements have developed with Housing Associations and Local Authorities to consider how to develop new approaches to accommodation for our elderly population will be further built upon and refined.

#### *Services for Children with Complex Needs*

Whilst not identified as one of the “top 3” health needs for the UHB, these are nevertheless an extremely vulnerable group of people who have complex needs over the entirety of their life, usually provided by a multitude of partner organisations.

Recognising the Social Services and Well Being Bill, the UHB, working with colleagues in Children’s Social services has agreed to progress work on integrated services for children requiring care. We will develop and implement a joint programme of work which will see the refocus of the Cardiff Strategy for Disabled Children across Cardiff and the Vale of Glamorgan, and the development of a joint implementation plan which supports the delivery of services under the new bill.

A key element of this work will focus on the joint provision of equipment between the UHB and our partners. This will involve defining criteria related to specialist children’s equipment to support discharge and ongoing care at home, and working with partners to pool equipment budgets to support timely and cost effective provision.

In 2014/2015 the Clinical Board will plan to implement a new model of care to provide overnight respite support to children with Complex Needs and Continuing Health Care in partnership with the Local Authority and 3<sup>rd</sup> sector providing choice and cost effective provision.

### **Service Change across South Wales**

#### *South Wales Programme*

The UHB is a member of the [South Wales Programme](#) and is awaiting the outcome of the public consultation on the future configuration of some acute hospital services across South Wales. Whilst the UHB will continue to provide the services consulted upon (Emergency Medicine, In-patient Paediatrics; Maternity and Neonatology), the outcome will potentially have a significant effect in two ways:

- There may be significant additional activity in the services consulted upon which have to be provided on the UHW site. This cannot be quantified at present, but may well impact on other services currently provided from the site.
- Residents of Cardiff and the Vale of Glamorgan may need to travel elsewhere to receive some of the services they currently receive at UHW, if services need to be displaced from the UHW site.

Immediate changes resulting from the outcomes of the consultation will probably need to be implemented during 2014/15, however, a longer term implementation plan will also need to be prepared for 2015/16 and beyond.

#### *Regional Arrangements/Networks of Care*

Some specific areas where networks will need to evolve (irrespective of the South Wales Programme) are:

- Enhance the special care, bariatric and sedation pathways for patients requiring treatment through the University Dental Hospital, in order to ensure that patients are treated in the most appropriate setting.
- Particular service areas, including Neonatal and Paediatric Endocrinology/Diabetes, where opportunities exist to consider opportunities to enhance and develop Networks. In addition to the medical workforce there are also other services with expertise not shared in other Health Boards in terms of Nursing and Allied Health Professionals.
- Focused work in 2014/15 will improve the CAMHS service through the existing Network. Longer term work will concentrate on the multiagency delivery of services to support early intervention and support throughout key stages of a child and young person's lifetime.
- Critical care - annual growth is anticipated in level 3 care especially from residents of other LHBs. Future plans are required to improve capacity model for level 2 care especially post surgical care across the UHB. The future impact of the outcome of the South Wales Programme is also a key consideration for future physical capacity plans.
- The UHB provides a regional Sexual Assault Referral Service for adult and paediatric patients who require forensic examination outside of the C&V UHB area. Over the next three years we will continue to work with the Executive Board to ensure a sustainable service model, with clearly aligned financial resource is commissioned for patients across the region and provided by the UHB.

### **Cardiff and Vale UHB Service Changes**

The UHB recognises that it will continue to face increased levels of demand given the changes in our demography outlined previously. As part of the development of our integrated care pathways we will therefore need to ensure that primary and secondary prevention measures are built in to enable us to manage these demands. These pathways and service specifications will also need to be clearly evidence based, identify clinical thresholds to secure the best clinical outcomes of care and value for money.

We recognise that we have substantial further work to do to fully work through the service changes over the next three years, however, the following areas have been identified at this stage.

*Increased Demand for Services and associated Lack of Capacity*

We anticipate that continuing rising demand and pressures on our capacity, will place further pressure on the following services:

Service / Specialty	3 Year Outlook
Cardiac Surgery	Current LTA delivery pressures against increasing demand and growing waiting lists. Additional activity is required in the future to meet existing demand and improved waiting times for patient. Additional physical and staff capacity will be required for this service.
Thoracic Surgery	Current demand being met for urgent cancer cases and electively against a 36 week RTT. Future capacity will be required to deliver 26 week RTT.
Secondary Care Cardiology	Increasing capacity required in outpatient and diagnostics in response to demand changes from increasing primary care referrals and NICE guidance for chest pain and heart failure. Cardiac MRI and CT are key areas where demand is significantly exceeding capacity. Capacity reviews are also required to ensure appropriate service provision across both UHW and UHL for acute cardiology admissions.
Neurology	Increasing demand for neurology outpatients will require additional capacity or repatriation of activity back to local Health Boards.
Neurophysiology	Current capacity constraints require future demand modelling across the South Wales Health Boards to support the existing hub and spoke arrangement.
General Haemato-oncology	Increasing annual demand for this service especially from out of area and linked to BMT issues. Specific pressures around myeloma and lymphoma due to capacity constraints.
Bone Marrow Transplantation	Further increases in demand are potentially anticipated over next 3 years given the level of growth experienced in 2013/14 due to the successful outcomes, range of treatment regimes available and improved donor rates. Capacity is a major constraint for this service and will need new physical infrastructure to meet future demand.
Renal Transplantation	Renal Transplant numbers are volatile but are anticipated to increase up to 160 per annum. There is sufficient capacity to meet this demand.
Renal Surgery	There is small increasing demand in this area primarily linked to the vascular access pathway.
ALAS - Wheelchairs	Annual pressure on volume of wheelchairs especially complex chairs. Increasing expectation on the quality of wheelchairs and waiting time targets of 26 weeks is anticipated to increase capacity required. Improvements in the activity recording and contracting system are required to further understand the demand and capacity analysis.

*Increased Demand - Available Capacity*

Service / Specialty	3 Year Outlook
Haemophilia	Annual increases are anticipated as new patients join the cohort, surgical needs of patients and potentially through high risk patients developing an inhibitor. Capacity is not normally a constraint for this service.
Clinical Immunology	Annual increases of between 16-24 patients are anticipated to join the existing patient cohort for this high cost treatment. Delivery is primarily through private homecare providers in addition to some hospital based infusion. Annual capacity should not be a major constraint in meeting this demand however affordability is a key issue.
Renal Surgery	There is small increasing demand in this area primarily linked to the vascular access pathway.
External Genetics Testing	Annual increasing demand for the numbers of send out tests due to greater awareness of cancer genetics and genetic disorders.
ALAS – Limbs	Key demand issue relates to enhanced products and war veterans. Improvements in the activity recording and contracting system are required to further understand the demand and capacity analysis.



### *Changing Models of Care*

<b>Service / Specialty</b>	<b>3 Year Outlook</b>
Cardiology - Revascularisation	Further growth is anticipated based on current intervention rates than national indications and in response to growth in the primary PCI pathway and increasing referrals from secondary care for ACS. This is consistent with changing population health needs across South Wales.
Cardiology - Arrhythmia	Further growth expected annually due to improved diagnosis at local hospitals and the replacement programme for box changes.
Orthodontics	Working in conjunction with PCIC, ensure Orthodontic treatments are delivered in the right place at the right time throughout Cardiff and Vale.
Surgery	<ul style="list-style-type: none"> <li>• Development of ENT community clinics in Cardiff</li> <li>• Development of day of surgery discharge for paediatric tonsillectomies</li> </ul>
Ophthalmology	<ul style="list-style-type: none"> <li>• Review oculoplastics referral criteria (reduce outpatient referrals by 10% and theatre activity by 5%)</li> <li>• Develop ODT clinic in community</li> <li>• Develop community diabetic clinics (as part of integrated diabetes pathway)</li> <li>• Implement 3rd phase of wet related macular degeneration (estimated to double the number of patients treated)</li> <li>• Parallel cataract theatres</li> </ul>

### *Changing Case Mix/Increased Complexity of Care*

<b>Service / Specialty</b>	<b>3 Year Outlook</b>
Neurosurgery	Whilst demand is not anticipated to increase annually however the changing case mix is a key issue especially in relation to neuro-interventional work where capacity is limited and will need resolution. Further capacity will be required non-recurrently if we are required to deliver 26 week RTT.

## **5.9 Capital, Estates and Facilities**

The UHB has a significant challenge in ensuring that our infrastructure (buildings and equipment) remain fit for purpose to deliver the services we are planning. As described in the finance section found later in this document, we have a significant estates maintenance and IT and medical equipment replacement backlog.

Our strategy of 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.

We will achieve this by continuing to implement the major capital schemes already in progress (including those in SOP development) to replace estate that is not fit for the deliver of care. We will also reduce our estate footprint where appropriate – facilitated by new models of care and new ways for working – so that we in a better position to maintain our estate. We will also be improving the delivery of estates maintenance function using benchmarking information to identify areas for targeted activity.

### *Discretionary Capital*

The development of the IMTP has identified a list of capital developments and equipment requirements totalling over £30m, which is significantly above the annual discretionary capital allocation. 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 (as detailed in the finance section).

- Ensuring that all business cases seek to minimise the footprint of UHB buildings, while meeting the operational needs of the UHB, including flexibility.
- Addressing potential catastrophic equipment failures (IT and medical equipment)
- Addressing statutory compliance maintenance issues.
- Developments that are critical to the deliver 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 CRL 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 spend in future years.

Further detail is provided in section 6.6 of the Financial Plan.

#### *Strategic projects*

In the three years 2013-2016 the UHB's capital spend on strategic projects is forecast to be £113m, peaking in 2014/15 at £51m. Currently there are four large projects on site including the:

- £59m Noah's Ark Children's Hospital for Wales at University Hospital of Wales; and
- £88m Adult Mental Health Unit at Llandough;

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 section 6.6 of the Financial Plan.

All strategic capital projects are reported into the Capital Project Group which meets monthly, chaired by the Director of Planning. There are also separate Project Boards that meet on each project, again chaired by the Planning Director. 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	Outline Business Case awaiting WG approval	January 2016 (subject to business case approvals)
CRI Phase II	Development of Strategic Outline Programme	End 2014/early 2015
Neonatal Intensive Care Capacity	Development of Strategic Outline Case	Business Case Completion due end 2015
Cardiology Out Patients Department	Development of Business Justification Case	Sept 2014
Ward Refurbishment Programme (UHW/UHL)	Development of Strategic Outline Programme	March 2015

Genomics	To be determined	To be determined
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These schemes are all of significant strategic importance to the UHB, however, none has yet received Welsh Government agreement to provide capital funds to support their development. The schemes will continue to be reviewed against other emerging priorities and the outcomes from the clinical services plan.

#### *Estates*

The annual budget allocation for estates maintenance is circa £5m, with a ring fenced allocation to address compliance 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.

#### *Operational Services*

Operational services will move towards a site management model allowing site users to have a single point of contact for any query. The main priorities for services in 2014/14 are:

- Explore external options relating to the CPU facility and switchboard services
- Re-align security services within Operational Services.
- Return the stores to UHB control.
- Cease post collection and delivery to non clinical areas

Further examine opportunities for the:

- Centralisation of Portering Services.
- Removal of the reimbursement of parking charges for staff not based at UHW.
- Working with external options for the provision of a Residences service.
- Working with external options for the provision of Staff restaurant facilities

The key areas of risk that have been identified in delivering these services are:

- Annual financial break even position.
- South Wales Programme.
- Age of the Estate / Plant.
- Fire Risk associated with compartmentation and smoking issues.
- Legionella risk associated with risk assessment remedial actions and Planned Preventative Maintenance not undertaken.
- Asbestos risk associated with accidental disturbance of Asbestos Containing Materials during maintenance activities, projects or operational duties.
- Energy cost risk associated with energy tariff rises, consumption increases or failure of Central Heating Plants at UHW or UHL.
- Breakdown/major failure of Estates plant and equipment due to age of engineering infrastructure.
- CHfW remaining contingency allocation.
- Operational Services risks associated with McClelland review.

### **5.10 IT and Information**

The IM&T implementation programme for the UHB is aligned with the requirements of the Clinical Boards, National strategies and O4E full details are set out in the IM&T IMTP.

The IM&T Department is made up of a number of highly specialist teams that provide support and an enabling function which is and will continue to be very important to the delivery of the objectives set

## Information Technology

- Information (Business Intelligence and Analytics)
- Clinical Coding

The department has a large number of programmes underway which have been set as priorities both nationally and locally. The IM&T IMTP sets out how the three areas listed above are planning to support delivery of the UHB three year plan within the financial constraints of the UHB and the allocation to the IM&T Department over the three years 2014/15 – 2016/17.

Four key priorities for IM&T have been identified:

- 1. Sustaining and refreshing an enormous IT Infrastructure and supporting in excess of 10,000 users - 'keeping the lights on'**
- 2. Contributing to planning and delivery 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**

Details of each of the initiatives to support the above priorities are attached at Appendix 4.

A significant number of additional priorities have also been identified as bids against the discretionary capital programme, and these will be reviewed against the discretionary capital fund.

The key challenges facing the department are:

- Sustainability – ensuring that there is an appropriate level of risk based targeted investment to refresh a huge infrastructure
- Supporting a huge (and increasing) but aging infrastructure with capital / revenue investment levels way below the expected norms
- Embracing and exploiting emerging trends and technologies in a resource constrained environment to help modernise the UHB
- Ensuring that there is a governance mechanism and appropriate staffing levels to deliver the IM&T priorities of Clinical Boards.
- Achieving an appropriate balance between the delivery of IM&T National and Local IM&T priorities
- Delivering the WAO strategic recommendations in relation to IT Security and Business Continuity within the IT Department and Clinical Boards
- Skills and knowledge of both the department and wider service relating to IM & T
- Organisational capacity to adopt the self service principle

There are also a significant number of risks associated with delivering such a complex programme:

- Achieving statutory break even duty;
- Delivering sustainable financial balance;
- Failure to secure sufficient capital investment to address priority infrastructure risks
- Ensuring the right level of staffing with the correct skill mix to support the CSBs IM&T requirements
- Ensuring the right level of staffing with the correct skill mix to support the expanding infrastructure
- Ensuring the right level of staffing with the correct skill mix to deliver the IM&T programme in a timely manner.

Clinical Boards have also specifically identified opportunities in terms of using this technology for the following services:

- dermatology
- respiratory medicine
- stroke
- rheumatology.

## 6 Financial Plans

### 6.1 Summary financial plan

The financial plan presented below 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. The UHB is likely to be within a flat cash environment which means that the UHB has to make savings to fund both the elimination and repayment of the deficit and to cover cost pressures and service investments.

Over the three years starting in 2014/15 the UHB will

- Move from a deficit in 2013/14 of £19.3m to a recurring surplus in 2015/16;
- Clear and repay its accumulated deficit by 2016/17;
- Deliver significant levels of savings through improving provider efficiency, prudent healthcare and generating benefits from innovative use of technology.
- Reinvest in service transformation to support more effective and higher quality delivery of services
- Make a start on shifting funding from secondary care into primary care and community recognising that specialised commissioning is also a future area of likely growth
- With assistance from Welsh Government on capital support to enable delivery of the plan, make a start on reducing the significant level of capital infrastructure backlog around estate, medical equipment and information management and technology;
- Develop an internal financial flows framework which supports appropriate management of demand, treating patients in line with care pathways and service efficiency

This plan is dependent on the following key assumptions:

- An additional £11m discretionary capital over and above the current allocation in 2014/15 to support provide the capital support to service transformation to deliver the plan;
- Funding for VERS of £6m to be made available in 2014/15 via Invest to Save from Welsh Government (repayable in 2016/17);
- No loss of income from the SIFT review recently commissioned by Welsh Government; over the period of the plan; this approach has recently been confirmed by Welsh Government
- Negotiations on national terms and conditions of service will be able to release savings equivalent to the cost of the anticipated wage award and incremental drift.

### 6.2 Income and expenditure

Prior year income and expenditure outturns for the UHB are shown in the following table:

#### Income and Expenditure 2010/11 to 2013/14

	<b>Actual 2010/11 £m</b>	<b>Actual 2011/12 £m</b>	<b>Actual 2012/13 £m</b>	<b>Forecast 2013/14 £m</b>
<b><u>Income</u></b>				
Revenue resource limit - HCHSP	(622.2)	(642.1)	(676.5)	(678.7)
Revenue resource limit - Brokerage	0.0	(12.0)	6.0	6.0
Revenue Resource Limit - Non recurrent Support	(28.4)	0.0	(26.2)	0.0
Revenue resource limit - Contractor services	(102.5)	(105.1)	(107.6)	(109.3)
Income from other NHS bodies	(237.0)	(244.3)	(249.9)	(258.8)
Other income	(145.5)	(145.4)	(126.8)	(119.3)
<b>Total Income</b>	<b>(1,135.7)</b>	<b>(1,148.8)</b>	<b>(1,181.0)</b>	<b>(1,160.2)</b>
<b><u>Expenditure</u></b>				

Pay and employee benefit expenses	499.9	515.3	519.2	519.1
Primary Care Contractors	106.5	110.1	112.0	114.3
Commissioned services	176.5	174.6	182.3	162.1
Other non pay	352.8	348.8	367.3	384.0
<b>Total expenditure</b>	<b>1,135.6</b>	<b>1,148.8</b>	<b>1,180.9</b>	<b>1,179.5</b>
<b>Surplus/ (deficit)</b>	<b>(0.0)</b>	<b>(0.1)</b>	<b>(0.1)</b>	<b>19.3</b>

The 2012/13 position was achieved through £26m of non-recurrent funding from the Welsh Assembly Government. Without this the UHB would have delivered a £26m deficit.

For 2013/14, recognising the significant underlying deficit of £90.0m, the UHB agreed with Welsh Government a three year recovery plan. In the first year, 2013/14, a deficit of £33.0m was planned based on achievement of a significant savings plan of £56.7m (7% of the relevant expenditure of £808m). The plan for this year included no contingency or headroom or investment into services other than funding for staff change (VERS), delivery of targets (unscheduled care and RTT). This meant that the significant improvements in performance and quality achieved in 2013/14 were achieved with minimal investment. Very limited progress was made in terms of improving the capital infrastructure (IM&T, estates and medical equipment).

The 2013/14 forecast deficit reduced to £16.3m after a non recurrent allocation made by Welsh Government. The majority of which has now been made recurrent. Due to slippage on achievement of savings, the forecast deficit increased to £19.3m in January 2014. When this is taken into account, the UHB will forward in recurrent balance of £0.9m but with no contingency or headroom.

The projected income and expenditure forecasts over the period of the plan are shown in the following table:

#### **Income and Expenditure 2013/14 to 2016/17**

	<b>Forecast 2013/14 £m</b>	<b>Year 1 2014/15 £m</b>	<b>Year 2 2015/16 £m</b>	<b>Year 3 2016/17 £m</b>
<b><u>Income</u></b>				
Revenue resource limit - HCHSP	(672.7)	(649.0)	(652.3)	(661.0)
Revenue resource limit - Contractor services	(109.3)	(109.3)	(109.3)	(109.3)
Income from other NHS bodies	(258.8)	(261.0)	(261.8)	(262.5)
Other income	(119.3)	(118.3)	(121.4)	(122.8)
<b>Total Income</b>	<b>(1160.2)</b>	<b>(1137.5)</b>	<b>(1144.9)</b>	<b>(1155.6)</b>
<b><u>Expenditure</u></b>				
Pay and employee benefit expenses	519.1	517.8	509.5	493.6
Primary Care Contractors	114.3	114.7	114.7	114.7
Commissioned services	162.1	164.8	166.2	167.6
Other non pay	384.0	355.8	341.3	358.2
<b>Total expenditure</b>	<b>1179.5</b>	<b>1153.0</b>	<b>1131.6</b>	<b>1134.0</b>
<b>Surplus/ (deficit)</b>	<b>19.3</b>	<b>15.5</b>	<b>(13.2)</b>	<b>(21.6)</b>

Whilst the UHB is committed to achieving in year financial balance as soon as possible, and £47.9m (5.9%) of savings for 2014/15 has been targeted, the 2014/15 savings plans are some £15.5m short of the amount required to achieve financial balance.

This table therefore shows the UHB making a deficit in 2014/15 and surpluses in 2015/16 and 2016/17. Over the three year period of the plan the UHB will have delivered break even and repaid all accumulated deficits. The UHB continues to work on identifying further savings in order to secure

delivery of the 2014/15 financial plan and reduce savings requirements in future years. Whilst the UHB has a planned deficit of £15.5m in 2014/15, the level of planned savings at 5.9% is above those savings levels deemed deliverable by WG (4%) and comparable to those achieved by high performing NHS organisations. To deliver break even in 2014/15 would require the delivery of £63.4m savings (7.8%) which the Board believes is unachievable in a single year.

In order to deliver planned savings in 2014/15, there needs to be additional investment in change to support ongoing service transformation and capacity building, both capital and revenue. The UHB is requesting financial support from the WG to enable this.

### 6.3 Savings Programmes

Income over the three years of the plan is expected to be broadly flat (see detail later). In order to fund the recovery of the deficit and the cost pressures set out in the income and cost assumptions, the UHB has to make savings.

These savings plans average £49m pa across the three years of the plan with broadly the same savings requirement each year.

The below table summarises the current savings plans to 2016/17 (as per Welsh Government category) and have been used for financial modelling purposes.

Savings plans have been scoped through a range of benchmarking exercises and peer comparisons. To date, these have been predominantly provider based and for 2014/15 the plans will continue to focus on improving provider efficiency both within and across Clinical Boards and Corporate Departments. However during 2014/15 research and population based benchmarking will be undertaken to enable savings for future years to be targeted on a commissioning and prudent healthcare (e.g. through managing demand) as well as continuing expectations of provider efficiency. In 2016/17 these areas of focus will continue and in addition, there is the expectation that through a systematic programme of implementation of new technology, that further savings can be made from this.

#### Summary of actual and planned savings from 2010/11 to 2016/17

Summary as per WG categories	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
Pay	10,397	18,899	8,918	19,009	22,135	30,350	35,700
Non Pay	31,415	23,608	13,967	8,908	14,221	8,400	8,800
Primary care Contractors	0	0	0	0	400	500	500
Medicines Management	4,006	5,597	7,014	8,271	4,077	3,000	2,000
CHC and FNC	3,810	5,197	1,509	5,801	2,991	3,000	1,000
Income	4,414	5,499	4,243	5,663	4,116	4,750	2,000
<b>Total</b>	<b>54,042</b>	<b>58,800</b>	<b>35,651</b>	<b>47,652</b>	<b>47,940</b>	<b>50,000</b>	<b>50,000</b>
<b>% Savings of relevant budgets</b>	<b>6.7%</b>	<b>7.3%</b>	<b>4.4%</b>	<b>5.9%</b>	<b>5.9%</b>	<b>6.2%</b>	<b>6.2%</b>

For 2014/15, budget holders have so far identified savings of £41.2m and the UHB has set a stretched target of £47.9m. Whilst this poses a risk, it is believed that further savings are possible based on budget holder plans that are not yet finalised. The expectation is that the stretched target of £6.7m will be identified in the first quarter of the year. This additional savings requirement is shown in non pay in the previous table. The profiling of identified savings plans is relatively flat throughout the year with most schemes starting in the first quarter.

The three year savings plans are set out in more detail below. This shows how over the period the focus of savings will move from provider efficiency to prudent healthcare and then benefits of investment in new technology.



**Savings by scheme 2014/15 to 2016/17**

<b>Savings Scheme</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>	<b>Total</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>
General efficiencies	13.7	14.5	19.5	47.7
Prudent Healthcare	1.9	7.0	7.0	15.9
Manage impact of pay award	4.7	4.7	4.7	14.1
Better procurement	3.9	4.0	4.0	11.9
Right place first time - bed transformation	3.2	2.0	1.0	6.2
Income generation	2.0	2.0	2.0	6.0
Manage impact of incremental drift	2.0	2.0	2.0	6.0
Better primary care prescribing	2.1	2.0	1.0	5.1
Upstream management of patients	3.0	1.0	1.0	5.0
Benefits of technology	0.0	0.5	4.0	4.5
Nursing productivity	3.0	1.0	0.0	4.0
Better secondary care prescribing	2.0	1.0	1.0	4.0
Medical productivity	1.6	2.0	0.0	3.6
Theatres efficiency	1.0	1.5	0.0	2.5
Booking and scheduling	0.0	1.0	1.0	2.0
Estate rationalisation	1.0	0.5	0.5	2.0
Streamlining admin	1.2	0.5	0.0	1.7
Energy and utilities	0.2	1.0	0.4	1.6
Executive Directorates	0.5	0.5	0.4	1.4
Contractor services	0.4	0.5	0.5	1.4
Reduce unnecessary outpatient follow ups	0.3	0.5	0.0	0.8
Lose costs of decommissioned activity	0.2	0.3	0.0	0.5
<b>Total</b>	<b>47.9</b>	<b>50.0</b>	<b>50.0</b>	<b>147.9</b>
<b>% Savings of relevant budgets</b>	<b>5.9%</b>	<b>6.2%</b>	<b>6.2%</b>	<b>18.3%</b>

Whilst some of the savings are transactional, the majority are delivered through programmes of service transformation (e.g. shifting care from hospital into the community and improving the efficiency of operating theatres).

The work programme to deliver these is led by the Chief Operating Officer, supported by the Finance Director. A formal programme management structure is in place with weekly meetings with representation from all Clinical Boards and workstream leads. This monitors 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 workstream. Key performance metrics, both financial and non financial, are also in place.

Whilst it remains the ambition of the UHB to deliver a break even position as soon as possible, the delivery of a £63.4m savings in 2014/15 is not considered achievable. The delivery of the £47.9m savings will in itself be significantly challenging and will require continued attention and focus in order to ensure delivery. The UHB will however continue to identify additional savings in order to minimise its deficit in 2014/15.

Whilst the UHB has identified a challenging savings requirement over the period of the plan it also intends to invest significant amounts in future years to cover cost increases due to inflation and growth pressures. The planned investments between 2014/15 and 2016/17 are set out in the following table.

#### Planned Investment 2014/15 to 2016/17

Investment Area	2014/15 £'000	2015/16 £'000	2016/17 £'000	Total £'000
Pay Inflation	6,700	6,700	6,700	20,100
Non pay Inflation	5,700	3,800	3,800	13,300
Cost of Specialist Services	3,800	1,400	1,400	6,600
Continuing Healthcare Growth	4,400	2,000	2,000	8,400
Secondary Care Medicines	4,200	2,500	2,500	9,200
Primary Care Prescribing	5,500	2,500	3,500	11,500
Demographic growth	5,000	3,500	3,500	12,000
Service improvements	6,300	5,000	7,500	18,800
Transformation / Contingency	7,000	5,000	5,000	17,000
<b>Total Investment</b>	<b>48,600</b>	<b>32,400</b>	<b>35,900</b>	<b>116,900</b>

This shows that a large proportion of planned future savings will be reinvested to address cost and service pressures but with some non recurring investment into costs of change (eg VERS, project management and in some cases buying in external expertise to support more rapid change) and repayment of the deficit. The 2014/15 investment into the winter plan is also made recurring and an allocation has been made for the delivery of RTT in year.

## 6.4 Detailed Financial Plan

### Income & Cost assumptions

The UHB has used the All Wales National Cost Assessment to inform and validate its local assessment of cost pressures. These are generally based upon a combination of detailed assessments and historic trends. The following table shows the income and expenditure assumptions used within the model:

### Financial Assumptions

Increase / (Decrease)	2014/15 £'000	2015/16 £'000	2016/17 £'000
<b><u>Income Assumptions</u></b>			
Revenue Resource Limit - HCHSP	0	0	0
Revenue Resource Limit - contractor services	0	0	0
Income from other NHS Bodies	-1,400	-700	0
Education, training and research	-1,600	0	0
<b><u>Expenditure Assumptions</u></b>			
Pay award (1%)	4,700	4,700	4,700
Incremental drift	2,000	2,000	2,000
Primary care contractors cost pressures	800	500	500
General non pay inflation / stat compliance	4,900	3,300	3,300
Medicines inflation and growth	9,700	5,000	6,000
CHC and FNC inflation and growth	4,400	2,000	2,000
Growth in specialist services	3,800	1,400	1,400
Demographic growth	5,000	3,500	3,500

Additionally the UHB is assuming:

- No loss of funding as a result of the recent engagement around the WG SIFT review and the WG response;
- Additional discretionary capital of £11m in 2014/15 to support service transformation to deliver the plan;

- No change as a result of the decision around the South Wales Programme (the impact of the options has been modelled separately and will be included once the way forward is known);
- Commissioner growth in specialised services is in line with the WHSCC assumptions including a significant investment in cardiac surgery over the period to reduce cardiac surgery waiting times to 8 weeks;
- WHSCC rebasing is cost neutral to the UHB and delivers its aim of ensuring that income for each service matches cost so that more effective cost benchmarking can be undertaken;
- Flat cash inflation for all providers including WAST and other UHB LTAs;
- There is only a limited cost pressure arising from the transfer of the Welsh Risk Pool to UHBs in any of the three years of the plan;
- Welsh Government makes available £6m funding for VERs (via I2S, repayable in future years);
- Welsh Government funds the increase in pensions costs in 2015/16 and 2016/17;
- £15.5m cash support in 2014/15 is non repayable..

## Income

The projected income over the next three years is shown in the following table.

### Health Board Income 2013/14 to 2016/17

	<b>Forecast 2013/14 £m</b>	<b>Year 1 2014/15 £m</b>	<b>Year 2 2015/16 £m</b>	<b>Year 3 2016/17 £m</b>
Revenue resource limit - HCHSP	(678.7)	(649.0)	(652.3)	(661.0)
Revenue resource limit - Brokerage	6.0	0.0	0.0	0.0
Revenue resource limit - Contractor services	(109.3)	(109.3)	(109.3)	(109.3)
WHSCC income	(178.9)	(178.9)	(178.9)	(178.9)
Income from other NHS bodies	(80.0)	(82.1)	(83.0)	(83.6)
Education, training and research	(49.9)	(48.9)	(50.5)	(51.1)
Other income	(49.3)	(49.3)	(50.9)	(51.6)
Non cash limited income	(20.1)	(20.1)	(20.1)	(20.1)
<b>Total Income</b>	<b>(1,160.2)</b>	<b>(1,137.5)</b>	<b>(1,144.9)</b>	<b>(1,155.6)</b>

Over this period income is broadly flat with the following key movements:

- Funding in 2014/15 reduces as impairment funding from WG reduces – this is matched by expenditure so has no impact on the overall financial position.
- The WG will fund any increases in pensions costs;
- There is no other uplift from WG on the 2014/15 published allocation for future years and that any additional allocations will be matched by additional expenditure.
- Funding in 2015/16 and 2016/17 is expected to grow by an allocation from WG to cover the additional cost of pensions
- No assumption is made of a reduction in SIFT funding as the result of the recent WG report and engagement
- Income assumptions are in line with the assumptions and cost table.
- Specialised services provided by the UHB are assumed to grow slightly over the period but this income is expected broadly to be matched by additional investment and therefore neither income nor expenditure growth are shown in this model from a provider perspective. . This will be updated through an in-year budget change when the WHSCC LTA is agreed for 2014/15.

## Operating Costs

The forecast operating costs are set out below.

## Health Board Operating Costs 2013/14 to 2015/16

	Forecast 2013/14 £m	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m
Pay and employee benefit expenses	519.1	517.8	509.5	493.6
Non pay	148.9	156.6	141.1	153.0
Primary Care Contractors	114.3	114.7	114.7	114.7
Medicines Management	130.4	131.4	133.4	137.4
Non pay - CHC & FNC	46.5	45.9	44.9	45.9
Commissioned services	162.1	164.8	166.2	167.6
Non pay - capital charges & technical	58.2	21.8	21.8	21.8
<b>Total Expenditure</b>	<b>1,179.5</b>	<b>1,153.0</b>	<b>1,131.6</b>	<b>1,134.0</b>

The key movements here are as follows:

- Cost increases are in line with the assumptions table
- It is assumed that the pay award (1%) and incremental drift are funded via national changes to terms and conditions ie there is no net cost increase
- Increases in prescribing are attributable to the 6% increase set out within inflationary assumptions offset by savings achievement of £2.3m per annum.
- The reduction in pay (Employee Benefit Expenditure) is largely derived from forecast achievement of savings plans offset by the costs of the anticipated wage award and pensions increases.
- Savings within Other Expenditure relate to Clinical Supplies and Other Non Pay (specifically concerning Estate Reconfiguration and Clinical Board CIP plans).

## 6.5 Shifting the financial profile through incentives and levers

### Shifting funding from acute to primary/community care

The UHB has an ambition to move funding from hospital services to primary care and the community to support care being closer to home. Some progress will be made with this over the next three years because lower savings targets are being set in primary/community care than in hospital care. At the same time there is expected to be growth in specialised services which the UHB provides for the whole of Wales. The UHB does not hold the budgets for public health expenditure so cannot show trends in this areas. The change in funding profile expected in 2014/15 is set out in the table below ie an increase of 2.6% in the budget in the context of flat cash overall and we anticipate that this will continue in future years.

	£m
PCIC Budget 2013/14	264.4
2014/15 growth	11.3
2014/15 CIPs	(4.4)
PCIC budget 2014/15	271.3
Growth	6.9
<b>% increase</b>	<b>2.61%</b>

There will be a consequent reduction in secondary hospital based care, however within the plan as set out above is an assumption that specialised care grows over the period of the plan, driven both by the aging population and by advances in technology and care.

## Financial incentives and levers

To support delivery of these financial plans the UHB is developing a financial framework of incentives and levers. These recognise the UHB's aspiration to move to system of activity based budgets rather than historical based budgets, and make a start on developing enablers to move towards the aspiration.

The principles behind this are that the framework should be:

- Fair (given the start point)
- Recognise other Clinical Board services are not a 'free good'
- Support good clinical care and pathway working/reduction in unnecessary clinical variation
- Support making savings through demand management and waste reduction
- Focus on influenceable change not just getting back to a historic activity baseline
- Incentivise Clinical Boards to work together
- Do not unpick any agreement already in place without good reason
- Have clear baselines, metrics and performance framework
- Over/under performance reflects cost not profit

The UHB already has excellent patient level costing which is used to inform benchmarking. This is being further developed 2014/15 when the following will also be implemented:

- Trading frameworks for pathology and radiology designed to reduce variation in demand
- Trading frameworks for theatres so that overperformance above the agreed baseline number of lists and weeks is paid for by the Clinical Board using it (subject to delivery of operational efficiency)
- Incentives for hospital Clinical Boards to ensure that correct prescribing pathways are followed which support prescribing savings in primary care
- Incentives for hospital Clinical Boards to identify at the point of admission those patients who will need enhanced case management to enable them to return to their place of residence rather than require CHC placements
- Gain sharing across Clinical Boards of savings which require joint action
- Devolution of remaining provider activity contracts to Clinical Boards so that the benefits and risks of delivery are held by those providing the service
- Focus on variation in primary care similar to that currently in place around prescribing to review demand for unscheduled and planned care
- Move towards pathway budgeting, focusing initially on diabetes which is a UHB priority for 2014/15, with the aim of developing expenditure budgets which relate to pathway rather than speciality or activity costs.

This framework will be developed further in 2015/16 and 2016/17 building on evidence based models from across the UK and internationally. This will include further work to set budgets based on value rather than cost and/or activity.

## 6.6 Capital Expenditure

The UHB has a significant backlog of infrastructure equating to approximately £178m which is set out below. The cost of replacing all the medical equipment which is currently beyond its recommended life is £54m, for IM&T this is £12m and for estates it is £112m. These figures are used as an estimate for need going forward but it is a proxy as the UHB will not necessarily need to replace everything it has at present in the future and equally there will be new requirements for the years ahead.

### Backlog Replacement

	Medical Equip £m	IM&T Equip £m	Other Equip & Estates £m	Total £m
Gross Replacement costs of Fixed Assets	92	15	504	611
Net book value of Fixed Assets	23	4	491	518
Backlog replacement as at March 15	54	12	112	178
Planned reduction based on approved schemes	0	0	-34	-34
Improvements through increased disc. capital 14/15	-2	-2	-2	-6
Improvements through increased disc. capital 15/16	-3	-2	-1	-6
Backlog replacement as at March 16	49	8	75	132

The WG has confirmed a significant investment in capital over the next two years for the UHB which will replace several of those buildings which are in the worse condition i.e. Whitchurch Hospital, the CRI and the Children's Hospital. This will reduce the backlog maintenance requirement by £34m and is a helpful contribution to improving services provided from these facilities.

However the UHB has £7.8m discretionary capital available annually. This has not been sufficient over the last few years to fund any replacement of medical equipment or IT on a systematic basis. It has been prioritised towards statutory compliance, the highest priority estates maintenance, emergency failures and a very small number of core service transformation schemes. This is no longer a sustainable position as the level of failures of the estate, IM&T and medical equipment are becoming one of the highest risks facing the UHB in relation to patient quality and safety. It is therefore urgent to improve the position in 2014/15 and agree a sustainable strategy moving forward.

The UHB recognises that discretionary capital will be limited over the next few years. The UHB will be developing early in 2014/15 a long-term clinical services strategy which will include the approach to estates, IM&T and medical equipment. At high level it is anticipated that the strategy will be buildings light, but with intensive usage and with investment in technology i.e. medical equipment and IM&T to support service change and care closer to home.

However whilst this strategy is being developed, there is a need for interim capital to support the service transformation required to deliver the challenging savings plans outlined in this document and to make some inroads into the highest risk areas of infrastructure i.e. estates, medical equipment and IM&T replacement. The current level of funding will only cover the highest priority areas in terms of:

- Statutory compliance
- Prior commitments
- Systems at risk of critical failure in IT
- Small contingency for medical equipment replacement

### Capital plan 2014/15

FUNDING		14-15
		Total £k
	Welsh Government discretionary capital allocation (tbc)	7,806
	Rookwood 14-15	134
	Rookwood slippage reinstated	220
Property / land disposal:		

	Trowbridge Health Centre	250
	Carville House	147
	UHL surplus land (garage)	150
	Radyr Health Centre	120
	Carville Land	582
<b>TOTAL FUNDING</b>		<b>9,409</b>
<b>EXPENDITURE PROGRAMME</b>		<b>14-15</b>
		<b>Total £k</b>
Schemes B/F:		
CD11	Iorwerth Jones heating	41
CEDQ	UHB R22 Gas replacement	50
CD11	UHW Road crossing - outside Multi Car Park	10
CD11	UHW Roads and markings	60
CEEM	Rookwood Works (WG funded)	354
CEEE	Welsh Government HTF - Genomic Facility	289
CEC7	UHW EU Remodelling Emergency Unit	921
CEEF	Theatre Corridor Works	50
CEEP	Renal	120
	Sub-Total	1,895
Annual commitments		
CD93	UHB Capitalisation of Salaries	440
CEDB	UHB Director of Planning Staff	165
CDN8	UHB Revenue to Capital	215
CDH9	UHB Accommodation Strategy:	200
CD09	UHB Misc / Feasibility Fees	100
	Sub-Total	1,120
IMTP priorities		
CEEG	Theatre 15 (Gynae Theatre) (b/f)	630
CDY4	UHL wards west 3 and 4 (b/f)	477
CDY4	C1 Consultants & admin Duthie Library (Theatre 15)	25
CDY4	St Davids Hymadryad Ward	250
tbc	Medicines Management policy	23
		1,405
IM&T priorities (high risk of failure)		
CDR8	Virtual Server infrastructure	140
	Replacement & upgrading of the Cardiac Services Hardware/Software Platforms that are end of life	950
	Backup Infrastructure including switchboard servers and wifi	260
	Storage Infrastructure	150
	The upgrading of the "core" data network at the UHW and Infrastructure Environmentals	190
	Replacement of the PARIS community and mental health hardware platform that is end of life	450
		2,140

Statutory Compliance		
CDP7	UHB Strategic Business Case Preparation	100
CDP7	UHB Statutory Compliance Asbestos/Legionella	200
CDP7	UHB Plant replacement and refurbishment	800
	Sub-Total	1,100
Other:		
CD07	Medical Equipment Contingency	503
tbc	Lease Buy out	122
tbc	UHB Strategic capital payback	1,124
	Sub-Total	1,749
<b>TOTAL EXPENDITURE</b>		<b>9,409</b>

This does not therefore provide a satisfactory support for the delivery of the financial plan and does not deliver the capital requirements to support service transformation and expansion, replacement of very poor estate or provide sufficient headroom to manage IT or equipment failure risks.

The UHB has requested from Welsh Government an increase in its discretionary allocation of £11m in 2014/15 to support the above. This additional funding is critical to the successful delivery of this plan and sustaining estates, IT and medical equipment safely through 2014/15 whilst longer term plans are developed. The headlines of this plan are set out below with details of what is required and headline benefits:

WG Additional Funding		Commentary	£'000
	A&E Equipment to open the new facility	Shortfall in funding for the increased A&E capacity, funding by WG, on which work is due for completion in June 2014 and which will significantly improve the ability of the UHB to deliver the A&E Tier 1 target and ensure that ambulance handovers are not delayed	200
	Theatres transformation – to support shorter length of stay, day of surgery admissions	The UHB has a major transformation programme in 2014/15 which will increase day of surgery and daycase admissions to upper quartile and reduce unnecessary patient stays. However the current theatres admission lounge is not sufficiently large to enable admissions on the day and this needs capital investment to deliver.	2,000
	Booking and Scheduling	The UHB is aiming over the next three years to transform the current arrangements around outpatient booking and scheduling which is one of the major cases of complaints and concerns coming into the UHB. It links to a major programme of delivering RTT Tier 1 targets for, ensuring that outpatient letters are with GPs and the patient on a timely basis, and reducing follow up waiting lists to sustainable levels. Investment in IT systems to support an accurate and timely flow of information to enable this is key as well as investment in digitising all health records and enabling digital dictation by consultant staff. Digitalisation is being piloted by the UHB in conjunction with NWIS and the Welsh Care Records System programme and the aim is to roll this out faster across the UHB to support the right health record wherever the patient comes from to be available to a clinician at the point of review.	500



WG Additional Funding		Commentary	£'000
	Duthie Library - cardiology OP and diagnostics – replace poor quality estate	The current cardiology OP and diagnostics facility is an incredibly poor environment, very cramped with patients waiting in corridors with limited privacy. The CHC has repeatedly raised this with the UHB as a major area of concern (and has written to WG to express concerns). The scheme would be to move this key service into the former Duthie library, supporting delivery of tier 1 targets for RTT but critically also improving significantly the environment in which this large group of patients are treated. During 2014/15 the UHB expects to have to bring down cardiology waiting times to support reductions in cardiac surgery treatment times and thus potential mortality while waiting. Delivering this scheme enables the UHB to have the capacity to deliver this.	2,000
	Cardiac Services Expansion- in line with WHSSC business case	This is the capital requirement to expand beds and equipment to enable the UHB to treat 1000 open heart patients at UHW annually rather than the 800 at present. This is reflected in the business case submitted to WHSSC on 28 February and will help avoid patients having to travel outside Wales for treatment in future.	500
	Estates backlog	As set out above, the UHB has a high level of backlog maintenance and a generally poor quality environment, particularly at UHW. The funding available for 2014/15 has been prioritised as set out above, but the estates expenditure must focus on statutory compliance leaving limited if any funding to carry out backlog maintenance and patient environmental improvements. This leaves the UHB in a position where responding to concerns raised by patients around the environment is challenging.	1,000
	Equipment replacement	As set out above, the UHB is in a position where equipment is replaced as it fails rather than through a systematic programme of replacement. Capital for new equipment enabling advances in technology or efficiency is therefore extremely limited although can be accessed via other funding routes eg WG Invest to Save or Health Technologies Fund. This capital would enable the UHB to take a more systematic risk based approach to equipment replacement in 2014/15 whilst longer term opportunities around the approach to this (eg managed service) are explored within the UHB and across Wales.	1,000
	Primary Care premises improvement	This responsibility has been devolved to the UHB in 2014/15 with no additional funding. Many of our primary care premises have environmental challenges and the UHB sees improvement in the environment as key both to quality and safety of the patient experience but also crucial as part of ensuring that practices play a full role in caring for their patients at home and avoiding hospital admissions.	800
	Critical care expansion to support tertiary plan and critical care	Over the winter in 2014/15, the UHB has successfully avoided the number of elective cancellations apparent in previous years due to pressure of winter unscheduled care admissions. However this has highlighted a major shortfall in critical care capacity	1,500

WG Additional Funding		Commentary	£'000
		requirements which is being validated through benchmarking. As the key tertiary hospital for Wales it is vital that critical care facilities are available to support the most ill patients. A needs assessment is being carried out at present but an expansion of the facilities is anticipated to be required. This will need to be undertaken in partnership with WHSSC.	
	Vascular Intervention Room	The limited capacity for vascular intervention is hindering the ability of the UHB to deliver RTT diagnostics and elective targets. An expansion in capacity is therefore required.	1,500
<b>TOTAL Welsh Government additional funding proposal</b>			<b>11,000</b>

The risks of this additional funding not being delivered are as follows:

- Savings plans around theatres
- Risk to delivery of tier 1 targets particularly RTT and A&E
- Risk to cardiac surgery business case with patients continuing to go out of area for surgery rather than being treated in Wales
- Risk of serious failure of estate, equipment and/or IT meaning that the UHB would not be able to deliver services in full or to the required quality, resulting in either higher waits or requirement for patients to be treated in other areas
- Risk that primary care will not be able to provide a service in an inappropriate environment leading to greater pressure on hospital care
- Risk that patient and CHC concerns around particular areas eg cardiology facilities, outpatient booking and scheduling and cancelled surgery and OP appointments lead to reputation damage for the UHB and loss of patient confidence

There is limited mitigation the UHB can take to manage these risks, as this additional capital is so key to business plans; the impact of not getting the capital is a potential deterioration in the revenue deficit as revenue options would need to be considered to implement the changes above.

The table below details historical and forecast capital expenditure for the Health Board, inclusive of the requested additional £11m discretionary capital in 2014/15. It includes the current schemes approved in the All Wales Capital Programme. It is recognised that the All Wales Capital Programme has limited funding and the UHB will therefore expect to work with Welsh Government to prioritise funding to the above which may mean limiting further expenditure on new capital requirements.

#### Capital Expenditure 2010/11 to 2015/16

	10/11	11/12	12/13	13/14	14/15	15/16	16/17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
<b><u>All Wales Capital Programme</u></b>							
Llandough EMI	17,232	23,429	5,441	360	0	0	0
Integrated Stroke Unit	1,289	4,087	4,223	1,859	0	0	0
CRI Conservation	0	6,145	2,620	1,168	0	0	0
CRI Development	4,360	409	4,859	10,661	120	0	0
CRI Remedial Works	0	0	0	270	1,271	0	0
Children's Hospital	6,243	3,786	9,564	21,855	12,765	406	0
Specialist Rehab	26	212	242	270	15,244	0	0
Adult Acute Mental Health	247	2,651	10,624	12,117	38,539	24,049	0
Neurosciences	8,057	1,358	110	10	2,510	598	0
Scanner	2,576	0	0	0	0	0	0

Renal Transplant Unit	2,000	0	0	0	0	0	0
Women's Unit	1,350	0	0	0	0	0	0
Pendine CMHT	260	0	0	0	2,561	238	0
Remodelling EU	0	0	0	3,074	0	0	0
Renal Unit Merthyr	0	0	0	2,058	0	0	0
HTF-Genomic Facility	0	0	0	1,179	0	0	0
HTF - Robotic Surgery	0	0	0	2,146	0	0	0
Other major capital schemes	185	167	444	3,628	0	0	0
<b><u>Discretionary</u></b>							
IT	688	2,972	1,292	668	2,140	1,500	1,500
Equipment	5,488	5,582	856	712	825	1,500	1,500
Statutory Compliance	623	890	1,099	268	1,100	806	806
Estates	13,587	6,195	5,439	3,633	14,866	4,000	4,000
Other	0	0	3,260	0	1,124	0	0
<b><u>Other Funded schemes</u></b>	1,299	368	2,325	0	354	0	0
<b><u>Less Disposals &amp; Donated Equipment</u></b>	-1,798	-901	-5,236	-6,875	-1,249	0	0
<b>Total Capital Expenditure</b>	<b>63,712</b>	<b>57,350</b>	<b>47,162</b>	<b>59,061</b>	<b>92,170</b>	<b>33,097</b>	<b>7,806</b>

## 6.7 Balance sheet

The project balance sheet for the period is shown below. The major anticipated movements relate to the capital expenditure programme/depreciation and the UHB income and expenditure performance impact on cash balances.

### UHB Projected Balance Sheet

	31st March 2013 £m	31st March 2014 £m	31st March 2015 £m	31st March 2016 £m	31st March 2017 £m
Non current assets	531.1	564.7	634.1	650.6	636.7
Current assets	98.6	106.2	106.6	106.0	105.3
<b>Total assets</b>	<b>629.7</b>	<b>670.9</b>	<b>740.7</b>	<b>756.6</b>	<b>742.0</b>
Current liabilities	183.1	184.3	185.4	187.5	195.0
<b>Net assets less current liabilities</b>	<b>446.6</b>	<b>486.6</b>	<b>555.3</b>	<b>569.1</b>	<b>547.0</b>
Non current liabilities	24.6	25.8	25.1	24.4	23.7
<b>Total assets employed</b>	<b>422.0</b>	<b>460.8</b>	<b>530.2</b>	<b>544.7</b>	<b>523.3</b>
Financed by:					
<b>Tax payers equity</b>	<b>422.0</b>	<b>460.8</b>	<b>530.2</b>	<b>544.7</b>	<b>523.3</b>

## 6.8 Cash flow

An analysis of historical and projected cash flow is shown in the following table.

### Cash Flow Forecast 2013/14 to 2016/17

	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
<b>Receipts:</b>				
WG Revenue Funding	730,141	736,466	739,783	748,508
WG Capital Funding	63,162	92,170	33,097	7,806
WG Cash support	27,880	15,500	(15,500)	(27,880)
Other (incl Non Cash limited)	519,435	492,650	496,700	498,700
<b>Total Receipts</b>	<b>1,340,618</b>	<b>1,336,786</b>	<b>1,254,080</b>	<b>1,227,134</b>
<b>Payments:</b>				
Revenue	1,157,795	1,131,155	1,107,805	1,105,665
Capital	69,806	92,170	33,097	7,806
Other	113,441	113,441	113,441	113,441
<b>Total Payments</b>	<b>1,341,042</b>	<b>1,336,766</b>	<b>1,254,343</b>	<b>1,226,912</b>
<b>Net Cash Inflow / outflow</b>	<b>(424)</b>	<b>20</b>	<b>(263)</b>	<b>222</b>
<b>Bank &amp; Cash B/F</b>	<b>961</b>	<b>537</b>	<b>557</b>	<b>293</b>
<b>Bank &amp; Cash C/F</b>	<b>537</b>	<b>557</b>	<b>293</b>	<b>515</b>

Important points to note are:

- The UHB inherited a weak balance sheet that increases the difficulty in managing cash flow in March;
- The UHB received £21.8m cash assistance in 2012/13 (not resource) to assist in cash management;
- The UHB has received a further £27.9m cash assistance in 2013/14 which is essential to sustain payments to year end. Whilst this is modelled in the cash flow table as being repaid in 2016/17, given the weakness of the balance sheet the UHB will be requesting that this is made recurrent and non repayable;
- Further resource or cash assistance will be required in 2014/15 to support the planned financial deficit of £15.5m.

## 6.9 Financial Risks

### Achievement of savings targets

The forecast out-turn position planned for the period of this plan is only deliverable based on achievement of the Health Board'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 and achieve the stretched target in 2014/15.

### VERS

The delivery of this plan is dependent on £6m of VERs funding being achieved from the Welsh Government Invest to Save scheme. This application for this has been submitted.

## **Inflationary and Cost Pressure Assumptions**

The list of inflationary assumptions is built into section 2.4 of this document. There is a risk that any of these inflationary estimates may end higher than initially predicted. CHC and prescribing are areas of particular risk based on historic trends.

### **SIFT**

The Health Board currently benefits from £26.3m of Infrastructure SIFT 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 confirmed that the planning assumption should be that there will be no impact over the period of this plan.

### **WHSSC risk**

It will be important for the success of the UHB and its commissioners that there is early alignment on commissioning and financial plans, that demand management schemes are 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. The UHB and WHSSC have shared commissioning and provider intentions for 2014/15 and have agreed a timescale to achieve a signed LTA and it is crucial that this is delivered and that there remains alignment in-year.

The UHB and WHSSC have agreed that the service income will be rebased to match cost from 1/4/2014 and it is assumed that this will be cost neutral as agreed with WHSSC.

The key commissioning and provider risk relates to cardiac surgery where there will be a significant number of patients waiting over 36 weeks at the end of March 2014 and where there will need to be a financial commitment to reduce this in 2014/15 and 2015/16. This is currently unquantified but the aim is to agree a plan with WHSSC as soon as possible, both as commissioner and provider.

### **Capital**

The delivery of savings in this plan is dependent on £11m discretionary capital for 2014/15 and 2015/16 being made available by Welsh Government.

### **Inter LHB transactions**

The UHB has a significant number of inter UHB transactions. The key risks for 2014/15 are that the transfer of mental health services from ABMU from the 1<sup>st</sup> of April is delayed and that the casemix of patients across all LTAs continues to become more complex with agreement to changes in the financial tariff.

### **NISCHR**

The UHB has lost funding from NISCHR over the last three years resulting from a change to UHB allocations. The UHB has significantly increased its R&D activity during this period, but this has not resulted in a similar increase in funding. Whilst some recognition of this has been made in the 2014/15 allocation, due to the complexities of recording trial data on a timely basis and the resultant lack of inclusion of this activity within the NISCHR formula, the UHB still believes that it is under funded for the activity it undertakes.

## **6.10 Sensitivity analysis**

This has been completed and is included in the risk management section of the IBP.

## 7. Quality and Safety

### 7.1 Context

Together for Health states that 'Over the next five years systems for assuring high quality care will match the best in the world'. The [Quality Delivery Plan](#) (QDP), sets out how the new quality improvement and assurance arrangements will operate in achieving this vision of excellence.

### 7.2 The NHS Wales Quality Delivery Plan

The Quality Delivery Plan (QDP) is Welsh Government's approach to ensure better alignment of quality, performance and financial goals. The pressure on resources has never been greater which means that it is critical for the NHS to work together as a team across all disciplines – clinical, managerial and financial. It must be accepted that services must be clinically, operational and financially viable but must have patient safety and quality integral to all decision making. The new NHS financial plan will set out the way in which the UHB needs to manage resources going forward to ensure it spends money to maximise quality.

The development of the QDP is therefore underpinned by the following basic principles:

- That it is key to the operating framework for the NHS, underpinned and aligned with financial, workforce and information plans and goals;
- It will drive 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;
- There will be streamlined data collection – provided once, and put to multiple use;
- It will promote alignment with social care and other partners; and
- Absolute transparency and information sharing with the public.

The QDP outlines 11 actions that Welsh Government and NHS Wales will take forward between 2012 – 2016;

- The National Quality and Safety Forum will provide oversight and strategic direction in determining areas needing a national focus and attention;
- 1000 Lives Plus will continue to be the core NHS improvement programme, ensuring a common and consistent language and approach to improvement;
- Welsh Government will establish a Good Practice and Innovation Panel in summer 2012;
- Health Boards and Trusts will agree a plan to train 25% of their directly employed and contractor workforce in quality improvement methodology (at basic, expert or leadership level) by the end of March 2014, supported by 1000 Lives Plus;
- During 2012 Welsh Government will develop a national approach to measuring health service user experience;
- In 2012/13 Welsh Government will publish an annual rolling programme of clinical audit and outcome reviews;
- NISCHR will publish a delivery framework by 1 September 2012 to monitor Health Boards and Trusts progress against its national objectives. NISCHR will also support a number of schemes to promote and facilitate opportunities for innovative ideas to be utilised in the NHS for patient benefits;
- During 2012 Health Boards and Trusts will work together to put effective processes in place to ensure the prompt uptake of evidence based new technologies that maximise benefit and value;
- During 2012, HIW will support and facilitate the introduction of peer review against the standards in specific services, beginning with cancer care and end of life care;
- The Welsh Government will work with the NHS to develop Quality Triggers and a standard template for the Annual Quality Statement by October 2012 in readiness for organisations to report for the first time at the end of 2012/13; and
- Welsh Government will work with the NHS to develop an initial Outcome Indicator Framework, supported by service specific measures by summer 2012.

### 7.3 Patient Quality and Safety in the Health Board

The University Health Board has arrangements in place 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 & Experience Sub-Committee of the Board and, where appropriate, its related sub groups. However, it is recognised that like all NHS organisations we will need to pay increased attention to how we are going to improve the safety of the services we provide.

Organising for Excellence has at its heart, arrangements to ensure services commissioned and provided by the Health Board have patients, their quality, safety and care experience at its centre, with the guiding principle of Caring for People: Keeping People Well.

This reminds us to focus on what really matters for our patients and citizens, so that we can use our time, skills and other resources more wisely.

Awareness of the care we commission and provide patients and their carers, every time they enter our services, whether they are in hospital, community or primary care, always impacts greatly on that patient and their family. 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.

But, if we are truly '**Caring for People, Keeping People Well**' then this has consequences for the way we run services. One aspect of this is to make sure that the Health Board is clinically-led. Clinical Boards have been introduced, ensuring clinicians have more authority and responsibility to lead, plan and deliver improved services to patients and their carers. This approach is underpinned by the newly introduced and evolving authorisation process.

The University Health Board has a strong foundation to continue to build upon in relation to delivering its arrangements for quality and safety and improving the patient experience in the coming years. This foundation is enhanced by work undertaken with NHS Wales and Welsh Government to help inform this important agenda. This includes:

- Membership and active participation in the National Quality & Safety Forum;
- Continuing to ensure the Standards for Health Services in Wales are embedded across clinical teams and used as a basis to inform our Governance & Accountability arrangements;
- Ensuring Fundamentals of Care Standards and related audits are embedded within the UHB and that the Standards become more meaningful to the wider UHB workforce and not just its nursing staff;
- The development of a National Quality Delivery Plan and a local Patient Quality & Safety Improvement Framework that supports delivery of the UHB priorities along with those identified within the QDP;
- The introduction of Putting things Right/NHS Redress, revised Regulations to guide NHS Wales' investigation and response to concerns about patient care, with an increased focus on putting things right;
- The introduction of an Annual Quality Statement (from 2013) informed by Quality Triggers, using data for improvement, not judgement;
- The 1000 Lives + Programme, NHS Wales' quality improvement programme for reducing mortality and avoidable harm and improving outcomes for patients across a range of different work areas, this work will be reinforced and complimented by the UHBs delivery of a Leading Improvement in Patient Safety (LIPS) Programme; and
- The development of a National Governance Framework, with a UHB Board Assurance Framework adopted to reflect these arrangements.

### 7.4 A Framework for Patient Safety & Quality

The 2013/14 IBP set out the national and local context of the quality and safety agenda, identifying key priorities for the UHB within the domain of quality, safety and professional standards of practice. The unrelenting focus on quality and safety will continue during 2014/2015 as we work collaboratively

to ensure that services are delivered in a safe, effective, dignified and timely way. As such, the key areas for action from a quality and safety perspective remain unchanged.

Over the next three years, the Health Board will be clear about its arrangements for;

- Patient Safety;
- Effectiveness; and
- Capturing and responding to the Patient Experience

Patient quality and safety improvement will be the key driver to cost reduction, with disciplined execution of agreed change at scale, with data used to inform improvement. Safety will be driven by a 'zero tolerance' to avoidable harm and a deliberate focus on reducing mortality and related key safety measures.

The Board will continue to ensure that an appropriate culture, which is values and behaviours based, is nurtured across the UHB, these include;

- Getting things right for patients:
- We need to put patients first, every time
- We need to manage patient flow better
- We need to work better with partners
- We need to invest in our community services

In addition to the agreed national Tier 1 priorities, the UHB will also introduce and monitor the following indicators which will be adapted as quality triggers to inform its Annual Quality Statement.

#### Leading Improvement in Patient Safety (LIPS)

The UHB is committed within its O4E Strategy to create staff capacity and capability in leading improvements for patient safety, to deliver the components identified in the ***"Getting it Right" and "Patient/Citizen"*** channels described within **Organising for Excellence**. Following the publication of the Mid Staffordshire NHS Trust Public Inquiry, the introduction of 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 leading improvements in patient safety (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. This is because the skill set that is acquired is really an improvement skill set. It is also important to understand and measure harm. Therefore LIPS will include:

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

The Executive Nurse Director, supported by the corporate team, will work with the Clinical Boards to enable the delivery of the Leading Improvement in Patient Safety programme (LIPS). The LIPS programmes will be aimed at supporting clinical teams, who by understanding what matters to patient/service users and the public, will drive improvements in areas such as Health Care Associated Infection (HCAI), pressure damage, reducing DVTs and significant harm or death from Sepsis. These are all recognised as Tier 1 targets as set by Welsh Government. In addition to these specific areas there will also be scope for clinical teams to identify and focus on local priorities which impact upon patient outcomes and experience of care and treatment.

#### Developing and monitoring UHB Quality Triggers

The UHB will introduce an agreed set of measures to assess whether we are providing safe care. Safety measures can never be fail-safe, but they can always be improved. Improvements should be



detectable in reductions in avoidable mortality and harm. Increasing levels of incident reporting can also be a strong positive indicator of safety awareness and focus.

Intelligence on what is about to 'go wrong' can also be obtained in real time by 'staff reported quality measures'. The following areas are where quality triggers will be focused;

- 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

The UHB will also ensure that we are continuously improving patient/user experience. The best judge of service quality is the recipient. Positive methods of user feedback are continually improving, but monitoring and acting on incidents, complaints and claims remains critically important. The following areas are where quality triggers will be focused:

- Complaint/concern clusters;
- Negative or deteriorating feedback from routine user feedback monitoring;
- Negative or deteriorating feedback from Fundamentals of Care audits;
- Negative feedback dignity spot-checks; and
- Low levels of engagement in user feedback initiatives.

Ensuring we are meeting required standards of effective care is also important. 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 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; and
- Incidence of pressure ulcers.

With the above in mind and taking into account the key information requirements to support production and monitoring of Quality Triggers and the publication of an Annual Quality Statement, arrangements have been considered internally with Clinical Boards which have helped to inform this central work.

The success of the monitoring arrangements and delivery of the targeted UHB improvement work will be dependent on robust information systems and triangulation of information, much of which will be extracted via the UHB Clinical Dashboard, a useful tool to monitor and capture such indicators to help review progress from a UHB, Clinical Board, Directorate/Locality, clinical area level. Interpretation and analysis of such information will be important if the UHB is to make sense of its information and use it to continuously improve outcomes for patients.

## 8. Research and Development

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 2011-12). In 2013 it was agreed by the UHB Research Governance Group that the UHB should adopt the South East Wales Academic Health Science Partnership (SEWAHSP) five year Strategy for R&D. The strategic priority themes of SEWAHSP are:

- Cancer
- Cardio-respiratory and diabetes
- Genetics and genomics
- Health Services and Delivery Research
- Infection, inflammation and immunity
- Neuroscience and mental health
- Primary care and public health
- Regenerative medicine and healthcare
- Healthcare education and healthcare education research

These nine themes were chosen by the partners of SEWAHSP on the basis that they reflect national policy priorities in health and economic development and represent the greatest degree of overlap in their strengths and strategic priorities. Research in the priority themes will cover the breadth of health science: fundamental, clinical and translational.

As part of the NISCHR Welsh Government Performance Metrics, targets have been set in relation to number of research studies undertaken by the UHB. These data are based on historical data but will be based on prospective 2013 data collection for 2014-15

- Increase of 10% per annum of the number of NISCHR Clinical Research Portfolio (NISCHR 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
- 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 1<sup>st</sup> April to 1<sup>st</sup> June 2013 shows that the UHB is on target to achieve the desired performance included 100% compliance with 'time to approval' However it is difficult to project whether this reveals any real increase in activity or whether the apparent improved performance was due to researchers recognising the advantages of registering their studies on the NISCHR-CRP for the first time. Any further increases in activity are likely to represent real increases rather than increased reporting. An increase in the number of projects and recruitment to those projects is currently driven mainly by individual researchers.

The expectation is that each Clinical Board will have its own R&D strategy, under the UHB adopted SEWAHSP strategy, building on its individual strengths and, in some instances, previously untapped resources. It is envisaged that the Clinical Boards will wish to balance a non-commercial and commercial portfolio of projects, as well as retaining a balance between NISCHR CRP adopted studies

and pathway to portfolio studies. It is also envisaged that the Clinical Boards will develop strategies to ensure recruitment to studies is delivered on time and to target.

The role of the R&D Department will be to support the Clinical Boards to deliver their strategies by ensuring projects are approved in a timely manner, whilst retaining appropriate governance checks and controls at a corporate level. Any increase in commercial studies as the Clinical Boards look to maximise income will increase demand on the R&D Department.

With current financial pressures, it is anticipated that Clinical Boards will be looking to maximise their income through participation in commercially sponsored studies, led by both the pharmaceutical, medical device and biotechnology sectors. The role of the Clinical Research Facility will be to support Clinical Boards undertaking these earlier phase research studies – in particular those requiring overnight stays. The CRF provides a safe, accredited environment with appropriately trained and experienced staff and infrastructure to support this type of work. These studies have the potential to provide improvement for the organisation and patients. It will provide patients with access to therapies that they would previously have had to travel to Manchester and/or London to access; it will provide additional income to the CRF for the nurse time (early phase work is paid a premium) and it has the potential to decrease the drug budget of the Clinical Boards (especially for high cost drugs) as treatment for patients is provided free of charge in commercially funded studies.

Demand on the R&D Department will also differ depending on the number as well as the proportion of different project types. For example, if there is an increase in the number of UHB led grant applications to external funding bodies, which would be in line with SEWAHSP strategy, demand on the office will increase. An increase in the number of studies initiated and thus sponsored by the UHB will also increase resource demand.

The priorities for the Research Department during 2014/15 and beyond are to:

- meet performance metrics in terms of increasing the quantity of high quality (non-commercial and commercial) research undertaken by the UHB
- meet performance metrics in terms of times to approval and recruitment of first patient in research projects
- 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 to replace existing 'at risk' databases, to reduce administrative burden, 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
- 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
- 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.
- have leave to appoint to funded clinical research nurse posts received by Principal Investigators in national / international competition – currently 2 part-time posts in system. These posts are managed through the CRF and allow for additional and flexible capacity in times of peak activity

Key risks associated with these changes have been identified as:

- Non-compatibility with NISCHR all-Wales solution
- Loss/ incomplete transfer of existing data from the legacy database
- Sufficient staffing to ensure existing system runs in parallel whilst implantation of new system is ongoing.

## 9. Engaged NHS

### 9.1 Introduction

We set out our approach to Engagement with patients, the public and staff in last year's [IBP](#) (page 95). Our [Strategic Framework for Communication and Engagement](#) sets out the principles of our approach which has not substantially changed. We do, however recognise, that we need to take a more proactive and consistent approach towards the way in which we engage with our communities so that we are responsive to the public as citizens and not just as users of our services. We will use the development of our Clinical Services Plan as way of kick starting this work, recognising that this is a complex and evolutionary process. Developing links through, for example the Neighbourhood Management Teams will provide some mechanisms which we can build upon, and we will also work with our partners in the local authorities and third sectors to develop mutual approaches to reduce duplication. Working with communities, and recognising their different needs will also help us to truly start co-producing services with people and enhancing their ability to care for themselves.

### 9.2 Patient Engagement and Feedback

Significant progress has been made in the last two years to formalise the process of gathering, presenting and acting on patient feedback to support the delivery of person centred care. The Board was the first in Wales to include a patient story at each Board meeting and a discrete report on patient experience. Patient stories are also used widely in Clinical Boards and other Health Board committees.

The Patient Experience team has also ensured that a wide range of support is utilised to engage with patients, carers and families and provide non clinical support. This includes increased use of volunteers, provision of spiritual care, support in bereavement, development of a patient and public information centre at UHW and support for carers

The UHB is committed to fully implementing the Welsh Government Patient Feedback framework<sup>2</sup> which consists of:

- A description of patient experience in three domains. These three domains are consistent, and can be cross referenced with, the evidence based themes identified by the Institute of Medicine, the Picker Institute and NICE. The domains are:
  - First and lasting impressions, including dignity and respect.
  - Receiving care in a safe, supportive, healing environment.
  - Understanding of and involvement in care.
- A four quadrant framework for describing the methods of obtaining patient feedback which balances real time, retrospective, proactive and balancing information. The intention is that the UHB should never rely on one source or type of information to listen to patients but should use a variety of methods to allow triangulation of information.
- A set of core questions, used across Wales and in all clinical settings that allow patients to give their opinion on the key aspects of a good experience.

In addition the Patient Experience team will be working with Clinical Boards and other corporate teams to develop a framework which aligns and reports other sources of feedback and intelligence about patient experience against the three domains. This additional intelligence includes:

- Assessments against Fundamentals of Care
- Assessments against NICE guidelines on patient experience
- Information from concerns, complaints and compliments
- Information from Transforming Care Surveys
- Information from claims and litigation
- Information from formal and informal walk rounds etc.

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<sup>2</sup> Framework for Assuring Service User Experience April 2013 <http://www.wales.nhs.uk/governance-emanual/public-and-patient-involvement>

- consultant revalidation
- CHC visits/ Hospital Patient Environment audits

The methods currently in use in the UHB, which were described in the [2013/4 IBP](#), provide the UHB with a wide range of information about the patient experience, however it is recognised that there are still significant areas for development and many gaps, which reflect both the size and comprehensive nature of the services for which the UHB is responsible. The key aim for 2014/5 is to consolidate the use of the core questions across the UHB and to use these together with other feedback to drive improvements in the patient experience.

In 2014/15 the Patient Experience and concerns teams will be brought together under the Assistant Director Patient Experience. The new team will develop a strategic approach in partnership with Clinical Boards and other corporate departments to support and improve the patient experience. This will include using the resources available in a co-ordinated way to provide maximum support to patients and Clinical Boards. The services included are:

- Concerns, claims and litigation
- Patient Feedback
- Volunteers
- Bereavement support
- Patient and Public Information services
- Carer support
- Spiritual Care
- Infection Prevention and Control team
- Links with 3<sup>rd</sup> sector and wider community especially relating to carers, info services , bereavement and spiritual care

The vision for the new team is that over the next three years:

- The UHB has a comprehensive range of **feedback methods** in place to ensure that it has in place:
  - A sample of patients and service users in each service area are asked for their views using the national survey with the results available “real time” to frontline staff with any issues raised acted upon locally and promptly
  - An ongoing 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 channels
  - A number of annual themed large scale surveys
  - Widespread use of patient stories and the feedback from patient groups and third parties
  - A reporting framework for frontline staff, clinical services, the Board and the public to share the outcomes of feedback and actions taken
- The UHB has an integrated system in place to ensure that it listens to all the feedback it receives through “**Putting things Right**”, that 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 – resulting in the UHB being able to truly demonstrate learning alongside demonstrable improvements in patient experience.
- The UHB has in place **central public and patient advice and support** services which aim to support the resolution of informal concerns quickly and which 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 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 works 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.
- The UHB has an 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 – this will ensure that all patients receive an equitable level of support to complement their clinical and nursing care.
- The Health Board has developed and is delivering a **single, clear vision for person centred care**, with strong leadership and direction brought about by a close, integrated working relationship between clinical boards and the skills and expertise in Patient Experience, Corporate Nursing, Quality and Safety, Innovation and Improvement and Learning Education and Training – success will be reflected in the feedback from patients, families and carers.

#### Work plan for 2014/15

The work plan for 2014-5 draws on the requirements of Putting Things Right, Welsh Government priorities and the operational and strategic needs of the UHB. The Patient Experience and concerns team will:

- Use the individual Clinical Board IMTPs to identify the key areas for focus over the next three years;
- Introduce automating processing and scanning of surveys both to speed up analysis and create capacity for continued roll out of these basic surveys;
- Actively promote the use of online surveys and introduce additional surveys as required;
- Test the use of tablet pc based software for direct data entry by patients and service users in specific settings;
- Test innovative methods of allowing patients to give feedback, including social media;
- Implement suitable methods for ensuring that feedback can be given by those with communication difficulties, sensory impairment and seldom heard groups;
- Expand the number of volunteers involved in obtaining feedback.
- Develop and implement a revised model for concerns management in line with Putting Things Right, including the development of methods to allow quicker identification and resolution of concerns locally by clinical teams
- Increase the range of roles and numbers of volunteers in the UHB
- Develop information centres at University Hospital Llandough and Barry Hospital in collaboration with third sector partners
- Work with third sector and other statutory bodies to engage with and support carers

### **9.3 Staff**

The UHB highly values its strong relations with Trade Unions and Professional Organisations. The UHB has established a number of fora for strategic issues to be discussed including the UHB Local Partnership Forum (LPF), Local Negotiating Committee (LNC) and Clinical Board/Locality Partnership Forums. Our partnership working relationships are based upon a number of set principles and agreed policies and protocols, including,

- The UHB's Partnership and Recognition Agreement and Consultation Protocols;
- Section 26 Joint Consultation Machinery;

- Annex A1 Principles and Best Practice of Partnership Working;
- Partnerships and Managing Change, Agreement of the Workforce Partnerships Council 2012; and
- NHS Wales Organisational Change Policy.

As part of the commitment to partnership working, strong and effective working relationships exist between senior leaders and senior/lead staff representatives. This continues to be driven through the Chief Executive, Director of Workforce & OD and the Senior Workforce Team. These relationships enable close communication and involvement in major issues and challenges facing the UHB, ensuring solutions are found and delivered in partnership wherever possible.

The UHB has a Trade Union Non Executive Board Member to maintain openness and involvement at the most senior level of the organisation, and to provide assurance to the UHB Board on matters relating to the effectiveness of partnership working arrangements and staff involvement.

Each Clinical Board also has a lead trade union representative to work closely with the leadership team, demonstrating senior level commitment to the principles and ethos of partnership working, building trust and mutual respect, ensuring openness and transparency in communications and ensuring early involvement in discussions relating to the planning and use of resources (including the workforce) and delivery of services.

The UHB has continued to work closely with its local authority and third sector partners in Cardiff and the Vale of Glamorgan. Within the auspices of the Integrated Health and Social Care Programme, the “Wyn” Work-stream was developed to provide better care for the elderly and frail population. As part of this over-arching Work-stream a workforce development sub group was formed to enable a more cohesive approach to developing workforce plans across health and social services. This culminated in a number of workshops held during 2012 to develop an integrated workforce development plan which has been signed off by Directors within the Health Board and the Director of Social Services, Vale of Glamorgan and Chief Officer, Adult Services, Cardiff Council. The work to deliver against the plan continues, with particular emphasis on the development of the Community Resource Teams.

In July this year the UHB won a National Award in the UK Healthcare People Management Awards (HPMA), **“Developing a Workforce for Wyn”** in the category **“Workforce productivity to support service transformation”**. It was one of only three Welsh entries shortlisted.

The UHB has climbed 100 places in two years in the list of most gay friendly places to work published by lesbian, gay and bisexual charity Stonewall. The UHB is currently ranked 193rd out of 369 employers in the UK but has been encouraged by Stonewall assessors who say the health board is making good progress. These values are transmitted through support for lesbian, gay and bisexual staff through our Rainbow Group, which also comments on health board policies.

#### 9.4 Engagement with the Public and Third Sector

The UHB’s approach to engaging with the public was set out in last year’s [IBP](#) (page 98), and our approach to working with the Third Sector is set out in the [Strategic Framework for Working with the Third Sector](#). There are a large number of actions contained within this to strengthen our engagement during 2014/15, including training for third sector organisations in Making Every Contact Count, which will support our approach to health improvement and self care.

During 2013/14 we have undertaken a significant public consultation exercise with our CHC and other Local Health Boards across South Wales as part of the South Wales Programme. The way in which we have undertaken this has been complimented by many participants, including the CHC. We recognise that we need to develop and improve the way in which we engage and consult with the public in an ongoing manner, and the development of our neighbourhood and locality approaches to care support this.



The UHB is undertaking a proactive role in the Neighbourhood Management Teams in Cardiff (with further detail provided in 9.5) This will significantly enhance our moves towards co-production, enabling a greater dialogue with communities about all of our services, including self care. We expect to build on these relationships as we develop our Clinical Services Plan, and as develop our ongoing medium term plans. We are working with the Vale of Glamorgan local authority and third sector organisations to identify the best ways of engaging with other local communities.

Our Plan has been developed from operational teams, with individual Directorates and Clinical Boards responding to feedback and views from patients and the public about how services need to evolve. In the preparation of this IMTP, we have identified that the following potential service changes will require engagement, and some may require more formal consultation with the CHC, public and partner organisations:

#### ***Mental Health Services***

- Further development of the Crisis Team in the community for older people with mental health problems which will enable the right sizing our in-patient capacity with possible reduction of Continuing Health Care beds.
- Provision of all adult mental health care for Cardiff and Vale residents by Cardiff and Vale UHB, requiring the transfer of care from Abertawe Bro Morgannwg UHB.

#### ***Children & Women's Services***

- Proposed changes to WHSSC commissioned paediatric outreach care may require consultation

#### ***Medicine Services***

- Right sizing of in-patient capacity following improvements to the “flow” of patients through our care and efficiency of our services which will enable the reduction of two in-patient wards and resulting in closure of West Wing Hospital which may requires discussion with the Community Health Council (CHC).

#### ***Primary Community and Intermediate Care Services***

- Consultation with Public Health Wales/Community Pharmacy Wales and engagement with the CHC, on the review of Emergency Hormonal Contraception to provide services only to areas that have high teenage pregnancy rates. This will result in decommissioning services from pharmacies in certain areas.
- Engagement with the Independent sector on the management of Continuing Health Care procurement.
- Commitment to undertake patient survey of the Out of Hours Communications Hub with the CHC to inform future developments.
- Consultation with Staff representatives/CHC/GPs on the development of neighborhood based district Nursing Teams.
- Engagement with the CHC on the proposal to consolidate the provision of Integrated Sexual Health services.

## **9.5 Partnerships with Local Authorities**

### **Our Approach**

The demographic profile of our population, in particular the large variation in deprivation and health outcome, 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 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', the UHB works collaboratively with its partners on a shared agenda of better outcomes, 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](http://www.cardiffproudcapital.co.uk)

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](http://www.valeofglamorgan.gov.uk/communitystrategy)

The UHB is a joint signatory to both strategies, which are aligned to UHB plans. The priorities in these 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 the UHB in the development of our Clinical Board and UHB 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 unitary 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 is being demonstrated is the joint approach that has been adopted within both unitary authority areas to Welfare Reform. The UHB has been involved in shaping local action plans which have 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. At present, the community is exploring

opportunities for greater joint working between the LSBs as part work funded by the Regional Collaboration Fund. Following a series of interviews and workshops, which the UHB actively participated in, a set of practical next steps for ways in which further partnership working could be implemented in 2014/15 will be agreed to achieve savings and improve outcomes across the region. The UHB will be fully involved in taking any changes forward.

The UHB is represented on the Regional Collaboration Fund 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.

**In Cardiff**, there is a new approach to Neighbourhood Partnerships (6) which focus on 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 led neighbourhood networks, with two being co-chaired by UHB Locality Managers. A sponsorship relationship between other Clinical Boards and Neighbourhood Partnerships is being developed to increase understanding of the communities we serve, encourage a co-production approach, strengthen cross sector working as well as support whole systems working within the UHB. 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 2014/15 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 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.

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 [IBP](#).

Clearly, as the outcomes of the Williams Review become clearer, the impact upon the way in which we engage with our local authority partners may change. However, we will continue to work closely with them as the way forward emerges.

#### Cardiff and Vale Integrated Health and Social Care Programme Board (IHSC)

Perhaps the most obvious example of partnership working to draw upon to date is [the Wyn Campaign](#). This work has been focused upon delivering improved services for Older People promoting, where appropriate, a model of self care that enables Wyn to regain and retain independence. The recommendation from the Williams Review on moving forward quickly on integrating health and social care is one to which all partners aspire.

The UHB, two local authorities and two Councils for Voluntary Services have now agreed to work towards a closer, more integrated partnership, marking a fundamental step forward in strategic intent. The Integrated Health and Social Care Programme Board (IHSCPB) has played a key role in bringing partners together over the past 2 years, agreeing a Collaborative Agreement through which a series of specific community-focused workstreams have been developed to advance integrated working at an operational level within all organisations. Now, following the completion of an external review by The Kings Fund and the Welsh Institute for Health and Social Care, we have reached a position where we have agreed to increase the scale and pace of our collaboration. Our ambition is to provide the best possible health and social community care by bringing our services together in a way that best fits peoples' needs.

#### *Rationale:*

Given the projected increase in the older population, together with an associated rise in co-morbidities in the face of reducing resources, the Programme has chosen to prioritise Older People as the key population on which to focus effort. However, discussion is also underway about services for: Children with Complex Needs; people with Learning Disabilities and people with Mental Health problems as other potential workstreams for the future.

#### *Focus:*

The Integrated Health and Social Care Programme is being designed to assist the development of a closer, more formal partnership with the following aims:

- i Facilitate all partner debate to clarify the overall vision for the emerging partnership;
- ii Act as the information conduit for communications on the emerging vision for integration;
- iii Ensure that planned outcomes meet the needs of our community in as effective and efficient a way as possible;
- iv Facilitate a workforce that is fit for practice to work in partnership through skills and information management development;
- v Ensure that we work with citizens to centre services around their needs.

#### *Consequences for Workforce*

Funding from the Regional Collaborative Fund has been made available to provide a dedicated head of service or senior responsible officer and a team to support and coordinate the transformational work underway across the organisations. The funding will enable development work, including training, development of care pathways, option appraisals, pilot projects, research analysis and engagement events.

In the longer term, there will potentially be significant workforce implications arising from the review and options for integration. There may be opportunities for joint roles, TUPE might apply, and roles and responsibilities will need to be confirmed. Changes to workforce numbers can't be determined at this stage.

#### *Consequences for Finance*

Financial projections have not yet been determined and will emerge as service changes/models are agreed.

However, the lifespan attributable to specific enabling funding streams will require agility to respond quickly to new funding streams, along with a flexibility to proceed with necessary appointments 'at risk' where recurrent funding remains to be confirmed.

#### *Risks:*

##### **Lack of effective governance and ownership across the 5 partners**

Ensuring effective accountability and governance arrangements across 5 individual organisations will no doubt raise challenges as work progresses. This can be helped in part by an effective Collaborative Agreement but will also require investment in cross organisational team development practices to build the long term trust required to take forward integration at scale and pace.

##### **Workforce issues arising from new working arrangements**

The Partnership will need to consider how Trade Union inclusion within initial developments might be built in to ensure that staffing concerns are accounted for.

##### **Finance**

Whilst funding is available for this work currently, provision to meet the needs of this long term investment remains unsettled.

##### **IM&T Risk**

The procurement of a new IM&T system to support social services may unstable the current system in place (PARIS)

## Services for Frail Older People

### *Rationale*

As outlined in the health needs assessment, our population is becoming increasingly old and frail, (the numbers of over 85s is increasing at a much faster rate than the rest of the population) with people living longer and with multiple co-morbidities. People over the age of 85 make up by far the largest proportion of emergency admissions to hospital, and there will be a number of strands of work to support our ability to care for this group of people.

### *How Will We Do This?*

The Integrated Health and Social Care programme has chosen to prioritise Older People as the key population group on which to focus effort, and the work previously initiated by the Wyn Campaign to integrate services forms a fundamental component of this future direction. A cross partner Development Team, led by the Director of Health and Social Care for Cardiff Local Authority is currently preparing a 10 year Framework for Older People. On completion, this Framework will chart the intended shape and direction for older people's services across Cardiff and the Vale of Glamorgan, to include the services commissioned and provided by the UHB, two Local Authorities and two Councils for Voluntary Services. In effect, it will provide the delivery plan through which the Statement of Intent on Integrated Care for Older People (required by the Welsh Government in January 2014) will be fulfilled. As this next phase of work for Older People is developed, work plans developed as part of the initial Wyn Campaign will continue with the aim of integrating the majority of actions as part of day-to-day business.

It is planned to complete this Framework during the summer of 2014/15, to be implemented on a phased basis during the remainder of 2014/15 and beyond.

### *Impact:*

This will result in improvements in patient care and experience across the UHB and partner organisations. More specifically, we would expect to be able to measure the following:

- A range of quantitative hospital admission data relating to non-elective re/admissions
- Numbers of Delayed Transfers of Care
- Permanent admissions to residential care/000 pop
- Expenditure by local authorities on nursing/residential/home care
- Proportion of people dying in their preferred place; deaths at home/hospital
- Reduction in hospital utilisation i.e. outpatient usage for >65s
- Measurement of Ambulatory Care Sensitive conditions as a subset of emergency admissions
- Track Tier 1 targets relevant to quantitative measurement
- Concentration of in-patient beds on a smaller number of sites, and specifically the closure of West Wing Hospital.
- The successful delivery of improvements as a result of the implementation of the key integrated care pathways being taken forward across Clinical Boards.

### *Outcomes:*

- Older people receive improved quality of care.
- Care for older people is seamless across organisations
- More older people are able to receive care in their own homes or in their local communities
- This programme will not result in additional demand for services and should enable us to manage the predicted increased demand more effectively.

- Services for frail older people are disjointed across organisations and do not provide optimum levels of care
- Agreement on integrated care pathways across organisations and within the UHB
- Agreement on resources allocation, and potential to move towards pooled budgets
- Possible requirement for engagement and public consultation if significant service change.

### Children's Services

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 UHB 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.

The number of Children in Cardiff and Vale with increasingly complex needs who require support from the Community Child Health multidisciplinary team, is increasing, as are the numbers of children who may ultimately require funding to support 52 week placements, under the Looked After children legislation. As part of its 3 year Plan, the UHB will be looking to work with local Authority and Education partners to ensure cost effective services and meet the requirements in the new Social Services and Well-being (Wales) Bill.

This increase is borne out by the increasing numbers in special schools in Cardiff who require therapy and nursing support in order to provide access to education but the Clinical Board will do further work as part of its needs assessment programme to inform planning. New specialist provision is being developed, and in 2013/14 the Clinical Board will be working with the Vale of Glamorgan in developing a service model for Health input to the new Penarth Learning Campus development.

The UHB will also be reviewing its arrangements for individual patient commissioning 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. In 2014/2015 we will agree a pathway and charging system which ensures that the UHB statutory functions are met and that all income is recovered.

### Civil Contingencies

The UHB is committed to working in partnership to ensure the Safeguarding agenda is comprehensive and robust. To this end strong links have been developed with the Home Office; South Wales Local Resilience Forum and the Welsh Extremism and Counter Terrorism Unit. Specialist areas of safeguarding including Counter terrorism, anti radicalisation, Human Trafficking and Enslavement agendas are being progressed. During 2013/14 work is being targeted toward the development of specific referral pathways with implementation scheduled for 2014/15.

## 10. LEADERSHIP AND WORKFORCE

### 10.1 Workforce and organisational development

#### Workforce & Organisational Development Plan

One of the four component parts of the **Organising for Excellence** Strategy is **Good to Great**. This defines the Organisational Development focus for the organisation for the coming three years and recognises the component parts of the interventions, developments and processes staff and managers need to focus on in order to enable the UHB to perform to its full potential. The components of Good to Great are:-

- 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 as follows:



#### 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 the summer of 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.

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 in full the All Wales Management Passport when it is launched in April 2014. 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
- **Maximising Potential Framework** to identify and put in place appropriate development plans for staff with leadership potential.

To ensure that Clinical Boards are able to discharge their responsibilities under these arrangements there is a twice yearly 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.

#### Values & Behaviour

A further central component of '**Good to Great**' and one that will have significant impact on delivering effective services is the integration of the UHB values and behaviours throughout the employment journey from recruitment to retirement using all UHB communications, performance management and human resource processes (including induction, appraisal, education programmes) to do so.

The Francis Report highlighted the impact of negative culture on organisational performance and patient outcomes. To address these issues a values based recruitment process will be introduced within the organisation within the three year planning cycle. This will enhance the emphasis on skills and experience currently embedded in recruitment and introduces processes that test an individual's values and how they align to those of the organisation. This will support both internal and external recruitment. To further support the ability of the organisation to use its values to select the best individuals a research project is being scoped to consider the link between personality factors and values and how they apply to specific job roles and competencies.

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** is being used to develop the focus of Clinical Board and the nature of the actions they must prioritise during the lifetime of the three year plan. This work will focus on **PADRs** and using them as the baseline vehicle for enhanced engagement supported by Team Based working which will provide the links between organisational objectives and process for implementation within specific services.

## 10.2 Workforce key performance indicators

The information included in Table 1 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. Performance is also monitored locally within the Clinical Board and Directorate management structure.

**Table 1:**

	Local reporting - data at 31-Mar-2013				
	Headcount	Contracted FTE	12-Month Turnover Rate	12-Month Cumulative Absence Rate @ 28.2.2013	PADR Compliance @ 28.4.2013
Cardiff & Vale Uni LHB	14,590	12,455	6.46%	5.55%	49.27%

	Local Reporting - data at 31-Nov-2013				
	Headcount	Contracted WTE	12-Month Turnover Rate	12-Month Cumulative Absence Rate @ 31/10/13	PADR Compliance
Cardiff and Vale Uni LHB	14,337	12,284	7.66%	5.54%	60.28%

Table 1 was provided in the first version of the IBP with data @ March 2013 and a further update is shown @ 31 November 2013. In the period 31 March 2013 to 31 November 2013, the headcount has reduced by 253; the contracted full time equivalent has reduced by 171; turnover has increased; sickness absence has reduced very slightly and UHB PADR compliance has increased by 11%.

#### Tier 1 Targets:

The UHB considers reducing **sickness absence as the number one workforce priority** and has developed a comprehensive Action Plan to deliver the 1% target reduction set by Welsh Government in the next two years. This plan will support the reduction of the UHB cumulative percentage from 5.49% to 4.49% over the period. This is the minimum reduction we are aiming for and a stretch target of 4% has been set to challenge Clinical Boards to deliver more. Each Clinical Board and corporate

function has re-set its target reduction so that we reach this overall UHB position. The Plan recognises that a holistic employee and health and well-being approach is instrumental in being able to deliver against this target and is developed around 4 themes:

- Leadership, Performance Management & Accountability
- Data/Tools to do the Job
- Culture and Attitude
- Absence Management Practice and Policy.

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. Complex case reviews take place with Occupational Health, and actions to keep individuals who are presently out of the workplace, connected with work and maximise their opportunities to return at the earliest possible time (subject to appropriate medical advice).

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 re-set its target to 85% for annual compliance and is currently reporting through its internal recording system a compliance rate of 60.28%. Since 2011 the UHB compliance levels have increased from 6% to 60.28%. 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 process which will be implemented from April 2014 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.

#### NHS Wales Benchmarking

The information in Table 2 provides benchmarking against organisations within NHS Wales.

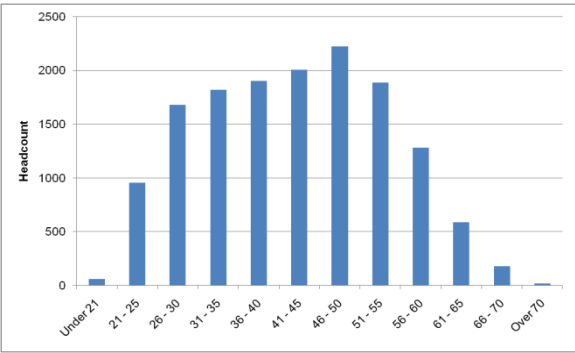
**Table 2:**

NHS iView - data at 31-Oct-2013 (Sep-2013 for Sickness)				
	Headcount	Contracted FTE	12-Month Turnover Rate	12-Month Cumulative Absence Rate
Abertawe Bro Morgannwg Uni LHB	15,105	13,095	8.09%	6.31%
Aneurin Bevan LHB	12,455	10,655	7.83%	5.21%
Betsi Cadwaladr Uni LHB	15,990	13,780	7.36%	5.16%
Cardiff & Vale Uni LHB	14,025	12,290	10.01%	5.80%
Cwm Taf LHB	8,040	7,030	7.32%	5.75%
Hywel Dda LHB	8,755	7,515	8.09%	4.72%
Powys Teich LHB	1,660	1,325	9.22%	5.39%
Public Health Wales	1,440	1,260	6.84%	3.64%
Velindre	3,165	2,885	8.35%	4.29%
Welsh Ambulance Services	2,980	2,835	4.67%	7.88%
<b>NHS Wales</b>	<b>83,490</b>	<b>72,665</b>	<b>6.13%</b>	<b>5.54%</b>

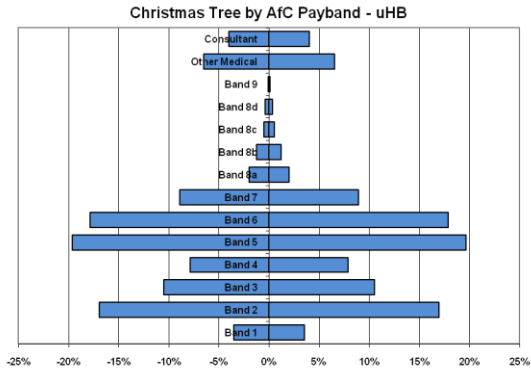
[Note: the figures above differ to those included in local data in table 1 as the benchmarking comparison is available for a different period i.e., October 2013 and September 2013 for sickness. This does show a reduction in sickness for C & Vale from September to October.]

The following charts provide an overview of the UHB staffing profile on age, pay-band, full/part-time, and ethnicity.

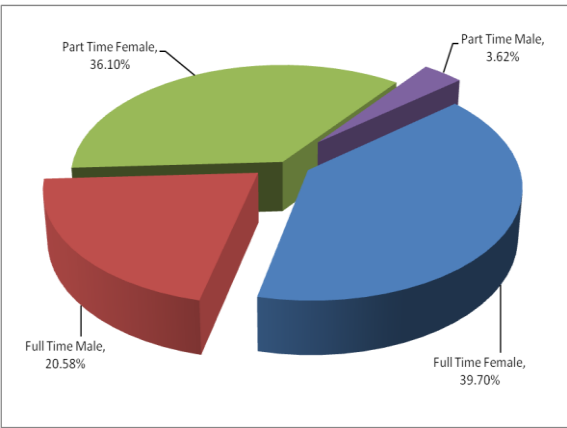
Age Profile



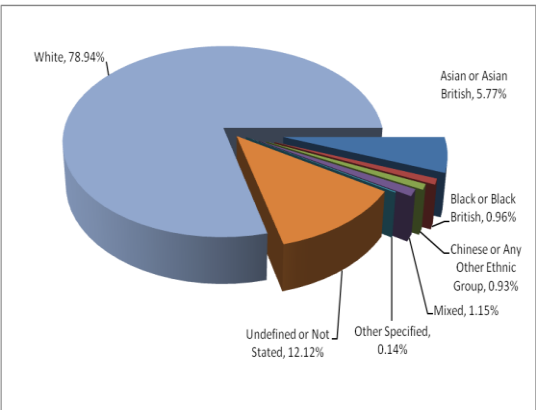
Pay Banding Profile



Gender



Ethnicity



### 10.3 HR Plan

#### Workforce & OD Management Arrangements

The Executive Director of Workforce & Organisational Development, reporting to the Chief Executive, is responsible for strategy and policy advice to the Chief Executive and to the Board and Executive Directors.

The Workforce & OD function is being reorganised to respond and meet the needs of the new organisation operating model; namely a clearer role for Headquarters, setting up of Clinical Boards and embedding corporate and Professional Services wherever feasible.

A new role has been established as Head of Workforce & Organisational Development within the Clinical Boards. This key role assists the UHB in meeting its objectives as it is specifically aligned to the Chief Operating Officer, reporting to the Head of Operations & Delivery; and forms part of the senior leadership team for each Clinical Board. There is also an Assistant Director of HR role which has professional accountability for the senior roles within the Clinical Boards. These appointments were made in June 2013.

The Executive Director of Workforce & OD is professionally accountable for the Head of Workforce & OD, but does not line manage these posts. In turn, this enables a more focused Headquarters role and broader strategic positioning. Within HQ, the Executive Director of Workforce & OD is supported by an Assistant Director of Workforce and an Assistant Director of OD.

The workforce functions which sit within Professional Services are specialist, expert and those which benefit the UHB as a whole to maximise economy of scale and expertise.

In 2012, the Operational HR team was re-organised to give a specific focus to key, complex operational HR issues, such as employee relations (particularly disciplinary), sickness and change management. An HR Advisory Team provides line managers and staff with support and guidance on general HR and terms and conditions enquiries.

Under the new arrangements, the operational team sits within Professional Services, with a greater emphasis on improving the fundamentals of good people management at all levels, equipping line managers with the skills, confidence and knowledge required to manage, encourage and involve their teams effectively. This builds upon learning from the experiences of Mid Staffordshire Hospitals Trust and the outcomes of the Francis Report, and the evidence base that links good people management practice with improved quality and care, and lower mortality rates.

The Workforce Modernisation team, created in 2010, is a small team supporting innovation and new ways of working; role re-design; research; workforce transformation projects; strategic workforce planning; driving forward information e-systems and technological advancements. The ongoing modernisation is now being embedded within Clinical Boards and through the development of lead specialist roles and roles which sit within Professional Services.

The UHB has a centralised Medical Workforce function which provides a range of professional services including recruitment, monitoring of terms and conditions and contractual obligations; EWTG & New Deal compliance; and Medical Revalidation.

To support the increased focus on staff health and wellbeing the organisation is redeveloping its Occupational Health and Employee Wellbeing Services into an Integrated Health and Wellbeing Service. This will provide advice and support to managers and staff through Occupational Health, Physiotherapy and Counselling Services. It will also support the wider wellbeing agenda by leading on the implementation of the Staff Health Wellbeing Charter, the Corporate Health Standard Gold

Revalidation in February 2014 and Platinum Assessment in March 2014. This service uses intelligence gathered from a correlation between workforce, health and safety and risk data to identify hotspots within the organisation via an integrated pathway involving Learning and Development Professionals providing organisational health assessments. Interventions are then developed to support improvement in Health and Wellbeing within these teams or services.

The Education and Development Team also leads on a wide range of clinical and non-clinical education including mandatory and statutory training. This team has a significant focus on the development of management capacity and capability within the organisation including the development of skills required to compete successful Personal Appraisal Development Reviews.

Recruitment and Payroll Services are supplied and managed via NHS Wales Shared Services.

#### Workforce Planning 2013 - 2016

Key to the development of the Workforce Plans is the need to deliver against the following UHB objectives:

<b>GETTING IT RIGHT</b>	<i>What will we do to improve most?</i>
<b>RESOURCES</b>	<i>What will we do to better manage our resources?</i>
<b>GOOD TO GREAT</b>	<i>What will we do to complete this improvement journey?</i>

The UHB recognises the austere context within which Workforce Plans are being developed and the unprecedented scale of challenge required to deliver with pace and high impact over the coming 3/5 years. There are two fundamental parts to the Workforce Plan which identify the actions the UHB is taking:

- a detailed one year **Operational Workforce Change Plan** (currently being updated to reflect 14/15)
- a longer term **Workforce Transformation Plan** which focuses on years 2 and 3 of the IMTP.

Both parts of the Plan integrate finance, service and activity requirements with workforce resources needed to deliver safe, high quality care, and balance short term measures to meet the immediacy of the operational challenge with the need to plan for longer term sustainability of services.

This year, as part of the UHB IMTP process the Workforce & OD profession has produced its own IMTP. As well as further outlining the new operating model as described above, the Workforce & OD Profession IMTP has reviewed its services against demand, strategic drivers and its core purpose which is to ***“Ensure staff are able to be the best they can be in Caring for People and Keeping them Well”***. A detailed Work-Programme has been developed against the 5 Workforce Objectives which underpins the focus on the agenda linked to the UHB strategic objectives. The Workforce & OD Profession IMTP is a separate document and can be accessed via the Workforce & OD Department.

#### Operational Workforce Change Plan (Reshaping Our Workforce) 2013/14

The 2013/14 Operational and Financial Plans committed the UHB to saving £22.5 million in workforce savings over the 12 months. Delivering the 2013/14 Operational and Financial Plans would enable the UHB, for the first time, to balance its recurring expenditure with its recurring income.

Within this context, each Clinical Board identified a set of proposals to achieve the required savings, (some of which were subject to formal consultation in line with the NHS Wales Organisational Change Policy, and statutory collective consultation requirements). The impact upon the workforce of these wide ranging proposals can be broadly categorised as follows:

- Reduction in posts and headcount related to proposed changes to bed configuration and service redesign and modernisation aimed at improving and accelerating access to and quality of care;
- Reduction in posts and headcount related to management and administrative restructurings;
- Reconfiguration of the workforce through proposed changes to skill mix;

- Actions to reduce variable pay expenditure, including plans to tackle absence levels and reduce by 1% across the UHB, to manage medical locum usage and demand, and reduce specialising costs and nurse bank / agency usage.
- The estimated impact on the workforce is a reduction of 304.96 WTE

Clinical Board proposals, some of which were subject to collective consultation, were brought together into the UHB's Operational Workforce Change (Reshaping our Workforce) Plan 2013/14, which detailed the proposals made, the risks and implementation issues associated with the proposals and allowed for some detailed analysis to be undertaken of the predicted impact by staff group and Clinical Board. On a more practical note, it also enabled a greater degree of control and oversight in the management and monitoring of proposed workforce changes at local and at UHB level.

The UHB is committed to following the consultation provisions of the NHS Wales Organisational Change Policy in the implementation of any proposed workforce changes, and to ensure compliance with its statutory obligations in this respect. All possible steps have been and continue to be taken, as far as practicable, to minimise or avoid any compulsory redundancies. Consequently the UHB put in place measures to ensure robust control of recruitment activity through the introduction of a central clearing house process, maximising all opportunities to deploy existing and at risk staff to existing vacancies, and/or to facilitating the release of individuals who have expressed an interest in taking voluntary early release.

#### **Update of Progress of 2013/14 Workforce Plans**

From March 2013 to December 2013 the UHB saw a **net** reduction of 301 worked WTE. The total **worked WTE** is expected to be 12,189 by year end.

Whilst a number of the Plans identified that made up the workforce change plan for 2013/14 were either withdrawn or fell away, a net reduction of 369 worked WTE is expected to be delivered. This has been achieved through productivity and efficiency gains, natural wastage opportunities, opportunistic and planned VER (84.88 WTE) and successful redeployment of "at risk" staff (54.04 WTE).

#### **Redundancy/Appointment Criteria**

Following the issuing of the formal notice under section 188(4) of the Trade Union and Labour Relations (Consolidation) Act 1992, a set of Redundancy/Appointment Selection Criteria has been developed. This is based on the suggested criteria in the NHS Wales Organisational Change Policy (OCP). As part of the development of the criteria, the UHB engaged with local Trade Union representatives, Regional Trade Union Officers and National Officers and has taken comments and incorporated these into the final criteria. Trade Union representatives recognise the need for selection criteria and can see the connection and consistency with the OCP. In confirming that they would not approve the selection criteria the trade unions acknowledged that the Health Board needed to proceed and were content that the proposals would be taken forward for approval. The Redundancy/Appointment Selection Criteria were discussed at the Management Executive Meeting on 16 December 2013 and approved by the People, Performance and Delivery Committee on 28 January 2014.

A comprehensive **Equality Impact Assessment** has been undertaken on the Redundancy/Appointment Criteria, with comments received from the Trade Union Staff Representative for the UHB Equality Diversity & Human Rights Sub Committee.

#### **Operational Workforce Change Plan 2014/15 (detailed first year of three year plan)**

The workforce plan aims to ensure that the UHB has the right workforce in place to support high quality service delivery. Each Clinical Board has developed a workforce plan to support delivery of service transformation, savings and investment. Plans include:

- Proposed WTE reduction
- Staff groups affected

- Quality and equality impact assessments
- Risk rating
- Implementation plans and milestones
- Consultation start date and end date
- Potential numbers of staff at risk
- Organisational development and workforce redesign implications

A high-level UHB wide change plan profiled through the year will assist in planning, consultation and focusing of the change resource input required to enable delivery across the organisation throughout the period of the plan.

The workforce change proposals will be presented for engagement and formal consultation with staff, staff representatives and other key stakeholders as appropriate, with a view to delivering change as early in the next financial year as possible. This work has commenced in some cases, and is being led by Clinical Boards, supported by the Workforce and Organisational Development teams.

Extensive work has been undertaken to identify a range of opportunities to reshape the workforce and deliver a reduction in the pay-bill during 2014/15. To date approximately £22.1m savings have been identified, to be delivered through a range of proposals to change services, restructure and/or re-profile skill mix within departments and teams, and opportunities to make routine efficiencies. These proposals will be presented for consultation with staff, staff representatives and other key stakeholders, with a view to delivering change as early in the next financial year as possible. Some of this is already underway.

The numbers of 'worked' whole time equivalents as at 31<sup>st</sup> March 2013 and forecast for March 2014 and 2015 are shown in the table below. For 2014/15, this is based on the £41.2m of savings identified to date.

**Actual and forecast worked Whole Time Equivalents (WTE)**

	Actual Worked WTE 31/03/2013	Forecast Worked WTE 31/03/2014	Planned Worked WTE 31/03/2015
Board Members	21	22	22
Medical & Dental	1,280	1,245	1,241
Nursing & Midwifery Registered	3,728	3,587	3,532
Additional Professional, Scientific and Technical	722	714	706
Healthcare Scientists	411	394	394
Allied Health Professionals	743	709	712
Additional Clinical Services	2,553	2,496	2,432
Admin and Clerical (inc Senior Managers)	1,902	1,856	1,803
Estates and Ancillary	1,186	1,145	1,103
Students	11	21	21
<b>Total</b>	<b>12,558</b>	<b>12,189</b>	<b>11,966</b>

The proposed changes to established WTE posts by Clinical Board in 2014/15 are summarised in the table below.

#### Analysis of 2014/15 workforce plans

Clinical Board	Proposed WTE Increases	Proposed WTE reductions	Net planned WTE changes
Surgery	13	-76	-63
Medicine	69	-130	-61
CD&T	2	-44	-42
Specialist Services	22	-7	15
Mental Health	22	-36	-14
Children & Women	0	-17	-17
PCIC	0	-5	-5
Dental	12	-7	5
Operational Services	0	-45	-45
Executives	9	-5	4
<b>Total</b>	<b>149</b>	<b>-372</b>	<b>-223</b>

This shows that whilst there are plans to reduce workforce numbers by 372 WTE, this is partially offset by planned increases of 149 WTE, due to service developments and increased qualified nursing establishments in response to Chief Nursing Officer (CNO) standards, leading to a planned net reduction of circa 223 WTE. It is anticipated that planned WTE reductions will increase as the final £6.7m stretched savings target is identified.

The movement in actual WTE posts identified to date is largely due to the following main proposed programmes of change:

- **Clinical Diagnostic & Therapeutics Clinical Board** proposes a reduction in posts as a result of the Health Records Modernisation Project;
- **Surgical Services Clinical Board** - the shift in post numbers relate to proposals to improve efficiency and flow, allowing for a reduction in bed capacity and reductions in theatre capacity as utilisation is increased;
- **Medicine Clinical Board** projects an overall reduction in WTE as a result of the development of Clinical Gerontology Services, enabling the decommissioning of West Wing. This reduction in posts will be offset by a planned increase in establishment due to the increased CNO standards;
- **Children & Women Clinical Board** are proposing to modernise Gynaecology Services, review administrative and management structures and take forward pathway redesign for a number of services;
- **Mental Health Clinical Board** is proposing to invest and improve community services which will allow for the closure of the Glan Ely Ward. They fully expect to absorb displaced staff into existing vacancies. Plans are also progressing to bring back the Western Vale services, with an associated TUPE transfer of staffing;
- **Dental Clinical Board** proposes to increase the number trainee dental nurses and to realise workforce savings through skill mix and administrative efficiencies, and also a proposed restructuring of the Community Dental Service;
- **Specialist Services Clinical Board** also proposes to realise workforce savings through skill mix and administrative efficiencies. They project an increase in WTE due to the proposed TUPE



transfer in of staff currently employed by other Health Boards working on the genetics network;

- **PCIC Clinical Board** proposes a broad programme of integration and pathway redesign but it is difficult to quantify the actual impact on the workforce at this time. The modernisation of district nurse services is currently underway;
- **Planning, Estates and Operational Services** will see a reduction in WTE linked to other Clinical Board service and capacity changes, for example, Clinical Gerontology Services and West Wing. Proposals to restructure across the whole service are also being developed;
- **Other Executive Functions** will see a small increase in agreed funded posts offset by planned decreases in other parts of the Executive Directorates.

Heads of Workforce and OD are working within their Clinical Boards and across the UHB to support the development of detailed implementation plans, including consultation requirements; to ensure adequate assessment of the equality impacts of proposals; to facilitate a partnership approach to change; and ensure a clear understanding of the associated workforce implications.

To assist in delivery, consultation timescales and approach have been agreed with Trade Unions, to enable focussed delivery of change within policy and legal requirements.

#### **Consultation Timelines 2014/15**

The UHB is committed to following the consultation provisions of the NHS Wales Organisational Change Policy (OCP) in the implementation of proposed workforce changes, and to ensure compliance with its statutory obligations in this respect. All possible steps will be taken, as far as practicable, to minimise or avoid compulsory redundancy. Following a review of consultation practice last year, the UHB is recommending it will consult through the OCP for a period of 30 days from the start date specified in the written notification; and if it becomes necessary, a further period of consultation under Section 188 TULRCA 1992 before a first dismissal takes effect.

This agreement has been agreed in principle by the People, Performance and Delivery Committee (PPD) and Trade Union has confirmed their acceptance of this approach. Formal approval is now required and, given that the PPD is not scheduled to meet again until 13 May, the Board is requested to approve the approach outlined within the documentation at its meeting on 25 March 2014.

The flow chart below in Figure 1 demonstrates what the process over the 30 days would look like.

Whilst it appears a challenging and ambitious timeframe, the ability to deliver against these timescales is contingent on the service area ensuring robust planning and preparation at the pre consultation phase, engagement of the Trade Unions in this process, and commitment to adequately resource and manage the process during the agreed timescales to ensure effective meetings with staff affected take place.

#### **Monitoring:**

Progress towards operational delivery will be monitored at Clinical Boards level, through individual Clinical Board owned detailed workforce plans, with support from the corporate workforce team on issues of compliance, trade union engagement, and co-ordination of staff moves through the clearing system.

Monitoring the delivery of workforce plans will be undertaken at a number of levels

- Within each of the Clinical Boards through the Heads of Workforce & OD and Heads of Finance, and according to Clinical Board performance management arrangements, which may vary.
- Through the production of a monthly Workforce/Finance Scorecard which identifies the WTE budgeted target, actuality and variance, for review by the Chief Operating Officer and discussion at the monthly Executive Performance Reviews held with each Clinical Board.
- Monthly Workforce Performance reports into the Management Executive

- IMTP progress updates to the Board
- Workforce Trend analysis through PPD

**Risk:**

The ability to deliver against timescales requires robust planning and preparation at the pre consultation phase, when services are expected to undertake detailed destination mapping of individuals at risk across existing vacancies and VER opportunities and natural wastage, to ensure the risk of redundancies and trigger of statutory consultation obligations can be managed.

In 2013/14, proposals to reduce the workforce resulted in the trigger of statutory consultation processes under s.188 TULRCA. The statutory obligation to consult comes into effect where organisational change includes or leads to a proposal to dismiss 20 or more staff as redundant (within the meaning of TULRCA) at one establishment within 90 days or less. Robust planning and preparation within the agreed local (OCP based) consultation framework will enable the UHB to mitigate against this risk.

High level assessment undertaken so far of proposals made, indicates that the proposed WTE reduction can be delivered without the requirement to enter into a statutory consultation process, and can be managed through turnover, filling vacancies and VER opportunities. This position remains subject to change as each proposal works through the consultation process and individual 1-1 discussions. The impact of this will be closely monitored centrally by the corporate workforce team.

**Figure 1 Local Employment Change Consultation Process Flow Chart**

<p><b>Pre Consultation &amp; Engagement Phase</b> – is not time limited, and must be undertaken in partnership with trade union colleagues. Will include the preparation of a proposal that will outline:</p> <ul style="list-style-type: none"> <li>• The proposed changes and reasons for the change.</li> <li>• The staff group and numbers that are likely to be affected, including how any staff who are likely to be identified as ‘surplus to requirements’ will be afforded ‘Suitable Alternative Employment’ opportunity.</li> <li>• Timescale for consultation and implementation.</li> <li>• Stakeholder map.</li> <li>• EQIA &amp; Quality Impact.</li> <li>• Risks.</li> <li>• Consultation Process</li> <li>• Identification of relevant Trade Unions for staff involved.</li> </ul> <p>Essentially the proposal document should include enough information to enable Trade Union Reps and staff to fully understand the proposed change and potential implications, before decision to commence formal consultation under the OCP.</p>
<p><b>Day 1 to 14 – Consultation on Proposed Change.</b></p> <ul style="list-style-type: none"> <li>• Expect to issue communication and consultation documents.</li> <li>• Group meetings with staff affected.</li> <li>• Staff to consider proposals and feedback to deadline (suggest by day 10).</li> <li>• Management team to consider feedback received.</li> <li>• Management decision to be taken and communicated (with rationale if appropriate) to staff and Trade Unions by day 14. (re-affirm to staff they are at risk).</li> </ul>
<p><b>Day 15 to 20 – Individual 1-1 Consultation with At Risk Staff.</b></p> <ul style="list-style-type: none"> <li>• Set up and hold individual / group staff meetings (as per previous planning).</li> <li>• Individuals to make informed decisions their right to representation</li> </ul>

**Day 21 – 27 - Review Period.**

- Consider and review outcomes from staff discussions. This may include a review of any selection processes that may be required as a result.
- Consider and review any further issues arising that would impact quality and equality impact assessments

**Day 28 - 30 – Final Decision Making and Communication.**

Note, the above stages do not take account of any statutory collective consultation timescales. However, at this point there should be sufficiently robust information available to enable an assessment of the impact and likelihood of redundancies, and numbers affected to inform the decision making process around s.188 consultation obligations. Consideration will also be given to issuing notice to affected staff should the statutory thresholds not be met to trigger collective consultation. Staff consultation will only be triggered when the UHB is proposing to dismiss as redundant 20 or more employees within 90 days or less.

**Implementation Phase.****Education Commissioning 2014/15**

A draft set of UHB education commissioning numbers has been developed for the draft January 2014 IBP submission as contained in the 2014/15 appendix templates.

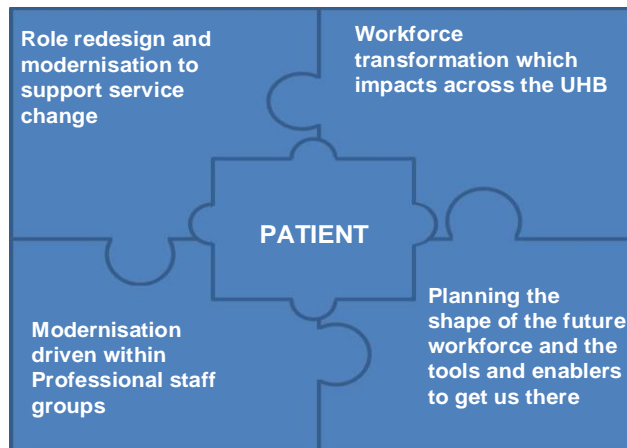
**Workforce Transformation Plan – Workforce Sustainability**

The former UHB Five Year Integrated Workforce Plan (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. The IWP was completed at the end of May 2013 and will now cease to be a separate process as it has become part of the IMTP process. The Workforce Transformation Plan reflects the shape of the UHB's predicted workforce over the next five years and details how the UHB will facilitate the delivery of service transformation and change through the implementation of its strategic workforce objectives:-

- A transformed, redesigned workforce
- An engaged workforce
- An affordable workforce
- A productive and efficient workforce
- A flexible, sustainable and skilled workforce

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:



Recent examples of some of the work ongoing to redesign roles and modernise workforce include:

**Paediatric SALT** – Re-structuring paediatric SALT workforce in line with needs based assessment of children’s speech disability (graduated response) developed jointly by education and health. The severity of the child’s disability is graded 1-5. Levels 1 and 2 are now dealt with by teachers leaving the experts to deal with the children with the most severe disabilities.

**Children Community Nursing Service** – Review of structure with a view to merging this service with the Children’s Acute Community Service in order to provide a more flexible workforce and service which maintains the skills of the staff and can respond to the needs of the service user more efficiently. Also introduced level 4 training to develop un-registered workforce with a view to potentially develop staff in band 4 roles as there is some difficulty recruiting band 5s in this area.

**Wound and Continence Service** – Review of working practices to integrate two teams into one flexible workforce, aligning processes and stripping out duplication. Team now able to work as one and taking opportunities not to replace vacancies where it is possible.

**Integrated Discharge team** - Integrating the discharge liaison nurses, social work team and age concern into one team to aid the discharge of patients from hospital.

**Play Therapy** - Working with the Business Manager and Play Specialist Manager to review how the team can work differently and add value to paediatric services.

There are examples of workforce transformation projects that impact across the whole UHB and set out to achieve greater integrated working with Local Authorities and the Third Sector, including the ‘Wyn’ Frail and Elderly Campaign, and Transforming Clinical Administration.

#### **Advanced Practice**

In July 2013, the UHB participated in a Review of the utilisation of the NHS Wales Advanced Practice Framework. This Framework was developed for Advanced Nursing, Midwifery and Allied Health Professional Practice in 2010. The UHB has a significant number of staff who evidence working at the Advanced Practice 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.

### **Maximising the Use of Workforce Technology**

The key priorities which form the Workforce Information Strategy are to implement roll out plans for:-

- a. ESR Managers Self Service/ Employee Self Service (MSS/ESS)
- b. E-Expenses
- c. Rosterpro Central

We aim to implement MSS/ESS throughout the UHB by the end of March 2015. The NHS Wales Workforce Information Systems (WfIS) target is 80% self service users by March 2015. This is a challenging roll out plan in the timescale. 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. Further plans are being progressed with current training being undertaken in Anaesthetics Theatres, SSSU Day Surgery & Endoscopy, Operational Services, Mental Health Adult Services, Planning and Estates. We are also currently revisiting our plans to achieve an ESS roll out plan more quickly.

### **South Wales Programme**

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 extending roles for example Advanced Nurse Practitioners.

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**

In July 2013 the Welsh Government issued a response to the Francis report in which the Minister for Health and Social Services emphasised the importance of having the right staffing levels to meet patient needs. This statement was supported by the Ministerial announcement of an additional £10 million for NHS Wales intended to enable the recruitment of medical and surgical nurses, of which Cardiff and Vale UHB was allocated £1.4 million. The Minister has announced that the acuity tool for adult acute areas will be in place and ready for implementation by 1 April 2014. 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 of additional acuity tools for use in Mental Health settings, Community Nursing and Health Visiting. It is expected that these tools will be available in 2014/15.

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 Executive Nurse Director has been liaising with the Clinical Boards, who are responsible for delivery of inpatient and community nursing services, to ensure the necessary action plans, reviews and monitoring of quality and safety indicators is being undertaken. It is expected that a review against progress of such action plans will be available in January 2014.

## Revalidation

From 2012/13, all licensed doctors are required to undergo revalidation by the General Medical Council (GMC) at 5-yearly intervals. The UHB has been making very good progress in meeting its revalidation plan. In January 2013 the UHB implemented the Medical Appraisal Revalidation System (MARS) for all non training grade doctors (including GP's). Since October 2012 the UHB has trained 186 (AQMAR trained) doctors as Appraisers in the Non GP system and since January 2013 has made available over 30 Appraisee awareness training sessions.

The total number of doctors to be Revalidated by the UHB is 1108 (includes GP's). In Year 1, April 2013 - March 2014, 261 doctors will be due to Revalidate (including GP's). As at 31 December 2013, 186 doctors have Revalidated and 14 have been deferred. There have been no instances of non-engagement in the UHB. In Year 2, 401 doctors will expect to Revalidate.

The UHB is noting, with interest, the current Nursing & Midwifery Council (NMC) development of Revalidation of Nurses and Midwives in the UK by the end of 2015. Whilst wider public consultation will be undertaken it is understood that the model will be covered by current legislation whereby nurses and midwives are required to renew their registration every 3 years and declare they have practised for 450 hours.

## Future Workforce

As part of the UHB strategic workforce planning objectives the organisation has been reviewing the challenges and opportunities for the future workforce. Recent multi-professional discussions have been held with the Medical Director, Nurse Director, Therapies and Health Science Director and Director of Workforce and OD against the context of the **"Big Picture Challenges"** report produced by the Centre for Workforce Intelligence in October 2013. This Executive group has now commissioned baseline work to be undertaken of the main future workforce issues through each of the professions, with the aim of bringing together a multi-professional debate/event in 2014.

### 10.3 Agency arrangements and recruitment hotspots

#### Variable Pay

Table 4 provides information on variable pay expenditure during 2012/13. The overall total expenditure was 5.46% of the fixed pay bill, covering all staff groups.

Table 4:

Workforce Variable Pay 2012/13	
Pay Bill - Agency	£5,655,170
Pay Bill - Nursing Bank	£8,381,253
Pay Bill - Nursing OT	£338,768
Pay Bill - Non-Nursing OT	£2,985,421
Pay Bill - Locum Medical - Dental	£4,700,525
Pay Bill - Waiting List Initiatives - Medical	£2,435,588
Pay Bill - On-Call	£2,379,224
<b>Pay Bill Total Variable</b>	<b>£26,875,949</b>
<b>Variable Pay Bill as % of Fixed Pay Bill</b>	<b>5.46%</b>

The majority of spend is associated with nurse and medical cover. Bank and Agency usage for non nursing and non medical staff groups is only used in exceptional circumstances and for very specialist skills. Overtime is used to flex staffing resources to meet capacity requirements i.e. RTT targets and accounts for 2% of the total other staff pay bill

#### Nursing Workforce

Expenditure on temporary nurse staffing accounts for 5.2% of total Nurse 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. As a result, although the overall nurse staffing cost reduction programme delivered savings, expenditure on temporary nurse staffing increased by approximately £1m from 2011/2012 to 2012/13. Total expenditure on Agency staffing remained

fairly static in comparison to the previous year at £1.9m, although there has been a sharp reduction in expenditure on high cost nursing agencies such as Thornbury and Richmond.

To ensure that the UHB utilises its total nurse staffing resources effectively, the UHB has established a Nurse Productivity Group which is 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 products that support Clinical Boards to analyse their levels of productivity in nursing and increase productivity and cost effectiveness. Key areas for development and implementation in 2014/2015 include:-

#### **Clinical Nurse Specialists Framework**

- Over the next year it is expected that Clinical Boards will extend the activities of the Phase 1 project to include all of the CNS employed by the Health Board. This work will be based around the seven principles identified in Phase 1.
- Implement changes to PAS and data recoding that will measure CNS clinic activity, identify any duplication with other clinicians.
- Sign off and implement Impact Framework and toolkit to deliver the 7 principles. This is an enabler for Clinical Boards
- Further develop KPIs for measurement of CNS contribution
- Measure the impact by reporting the delivery of enablers and products to agreed dates (milestones), the adoption of tools/products by Clinical Boards.

#### **Embedding E-Rostering**

- Undertake a first audit on an additional 29 wards and feedback to Clinical Board Nurses
- Agree further changes based upon the results of the audit, including sanctions and changes to the performance management system.
- Discuss the feasibility of bespoke report writing within the Roster-Pro system, building a standard report which includes the 9 checks included in the compliance audit.
- Continue working with individual ward sisters and Clinical Board Nurses to improve compliance
- Liaise with suppliers to determine if they can offer any further solutions/savings to use of Roster Pro System
- Implement Roster Pro sickness as a “live” sickness management function

#### **Advanced Nurse Practitioner Framework**

- Further the implementation of Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales
- Implementation of scrutiny process for the development of ANP posts (Advanced Nurse Practitioner)
- Development and implementation of core job descriptions

#### **Framework and Toolkits**

- Implementation of Framework and Toolkit for the Delivery of Nursing and Midwifery Standards in line with Workforce Pressures
- Consideration of development of further toolkits as identified by Clinical Boards to maximise the contribution of the nursing, providing safe care whilst meeting financial expectations.
- Development of KPIs to enable monitoring of delivery of the project’s toolkits at Executive Performance Reviews

#### **Medical Workforce**

Expenditure on temporary medical staff accounts for 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 2012/13 at month 6 the UHB was forecasting a year end increase of £3m in expenditure on variable pay in comparison to the previous year. The Medical Director established a Variable Pay Task and Finish group of the Medical Productivity Pay which oversaw the implementation of a number of

actions to contain temporary medical staffing expenditure and improve controls for the future, These actions reduced the forecasted overspend by £1.5M. The group also reinforced:

- 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 also established a Medical Productivity Group in November 2012 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;
- 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**

The UHB has been working with Price Waterhouse Coopers (PwC) and Liaison Financial Services (LFS), to introduce a model that provides the UHB with a VAT 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 will provide expert, in-house support to analyse and manage the UHB’s demand profile for agency spend, and will 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 will expect to bring the UHB a number of benefits which include: better management information and improved controls over agency spend; increased knowledge of demand profile and pressures; increased transparency over rates charged by locum doctors; increased transparency in commercial arrangements with agencies and commission rates (now fixed); more accurate financial reporting of temporary staff expenditure; no VAT charge on the cost of these temporary staff; a dedicated, on-site implementation team; a dedicated Senior Analyst presence on site to review current data and engage with Workforce & OD, Finance, Medical Workforce, and Directorate Teams to identify areas for savings. Savings will be monitored through weekly monitoring via the Clinical Boards.

#### **Controlling Recruitment Activity and Performance**

In September 2013 the UHB advertised posts for 127.95 WTE. In October we saw a significant decrease with 53.27 WTE advertised and 76.05 WTE in November 2013. On average we have been advertising and seeking to recruit to approx 81.69 WTE per month. As a consequence, in November 2013, 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.



Clinical Boards are still expected to exercise robust scrutiny of requests to fill vacancies, and will be challenged to demonstrate, through a robust business case within the VAC1, the need to fill vacancies (and at what grade), particularly where these require external advertisement.

Although recruitment to general nursing posts is buoyant, the UHB continues to experience difficulty in recruiting nurses to a small number of areas including Specialist Theatres and Mental Health for Older Persons. The UHB has introduced a number of staff rotational programmes to attract staff to these areas and these initiatives appear to be having a positive impact particularly in Mental Health Services and Theatres.

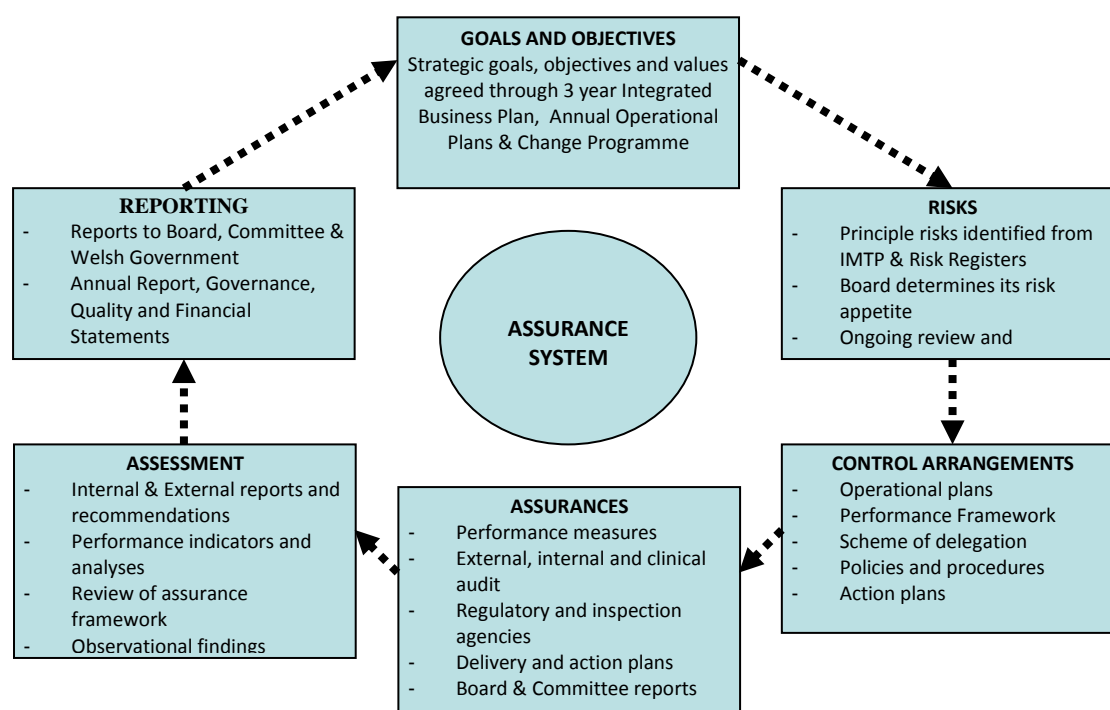
There continues to be a number of medical recruitment shortages within the UHB; notably within the Emergency Unit and in Psychiatry and these areas remain a recognised UK wide issue. A recent recruitment campaign has successfully resulted in a new Consultant to the UHB Emergency Unit joining in November. Further plans are being developed to support the 24/7 Medical Model. The UHB continues to monitor the recruitment and retention issues relating to Junior Doctors and has established good communication links with the Wales Deanery to manage any rota gaps; and also its commitment to improving the educational experience for trainees.

## 11. Risks

### 11.1 Managing Risk across the UHB

The Corporate Risk Assurance Framework (CRAF) provides assurance to the Board on the delivery of its core purpose of “Caring for People; Keeping People Well” through robust risk management processes. The CRAF brings together the former Board Assurance Framework (BAF) and corporate risk management processes as recommended in a *Healthy NHS Board*<sup>3</sup>

The CRAF supports the Annual Governance Statement (AGS) and is the subject of annual review by the Wales Audit Office as part of the Structured Assessment process. The UHB purpose is achieved through its priorities and strategic goals which are calibrated against principal risks.



The CRAF is designed to provide evidence to the Board about the successful realisation of its strategic goals and values. The framework also serves to inform the Board on principal risks threatening the delivery of the objectives associated with the strategic goals. The CRAF aligns principal risks, key controls and assurances on controls alongside each objective. Gaps are identified where key controls and assurances are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gaps.

The CRAF is principally established from the risks associated with the changes described in the IMTP and reconciled against the Clinical Board and corporate department Risk Registers by the Management Executive and then reviewed by the Board for coverage and consistency with regard to the principal risks.

Each of the proposals contained within the IMTP has been risk assessed to ensure it can be delivered without impacting on patient care and quality.

### 11.2 Financial Risk Analysis

The key financial risks have been included in section 6 and are summarised below:

- Achievement of savings target
- Inflationary assumptions (cost and demand growth)

<sup>3</sup> [The Healthy NHS Board: Principles for Good Governance](#)

- VERS Funding
- SIFT redistribution
- WHSSC risks
- Capital funding
- Inter LHB transactions
- NISCHR

This section of the plan is included in order to test the robustness of the financial projections described in earlier sections. It summarises the risks in relation to each of the main assumptions on which the financial modelling is based.

### 11.3 Financial Sensitivity Analysis

It is clear that the delivery of the savings plan is of paramount importance to delivering the financial plan. These savings are required to address inflationary and other cost pressures and to provide the resources to make key service investments. A sensitivity analysis against the achievement of the savings set out in this plan is shown in the following table.

#### Cost Savings Achievement

	2014/15 £m	2015/16 £m	2016/17 £m
Cost Savings Value at 100%	(47.9)	(50.0)	(50.0)
Forecast (Surplus) / Deficit	15.5	(13.2)	(21.6)
Cost savings achievement at 70%	(33.5)	(35.0)	(35.0)
Change from Plan	14.4	15.0	15.0
Forecast (Surplus) / Deficit at 70%	29.9	1.8	(6.6)
Cost savings achievement at 90%	(43.1)	(45.0)	(45.0)
Change from Plan	4.8	5.0	5.0
Forecast (Surplus) / Deficit at 90%	20.3	(8.2)	(16.6)
Cost savings achievement at 110%	(52.7)	(55.0)	(55.0)
Change from Plan	(4.8)	(5.0)	(5.0)
Forecast (Surplus) / Deficit at 110%	10.7	(18.2)	(26.6)

The level of cost savings required to deliver the plan are £47.5m in 2014/15 and £147.9m over the period of the plan. The above table shows levels of achievement from 70% to 110% based upon the current plan value. The lowest point of achievement (70%) would leave the Health Board with an cumulative shortfall of £44.4m against its financial plan. At 90% the cumulative deficit against the plan would be £14.8m. It is therefore critical that the Health Board achieves 100% delivery in order to break even and restore recurrent financial balance. This shows how important achievement of savings plans will be to the stability of the Health Board. This will remain of paramount focus with regular monitoring so that any slippage can be recovered through additional schemes to allow financial balance. An overachievement of 10% would provide the Health Board with £14.8m headroom over the three year period which could be used to enhance services.

The Health Board has made a series of financial assumptions around inflationary and growth figures (see section 6). These assumptions include both cost pressures and demand and service pressures.

A sensitivity analysis on cost growth is shown in the following table.

### Cost Growth

	2014/15 £m	2015/16 £m	2016/17 £m
Cost Growth Assumptions at 100%	13.5	24.6	19.3
Forecast (Surplus) / Deficit	15.5	(13.2)	(21.6)
Cost Growth Assumptions at 110%	14.9	27.1	21.2
Change from Plan	1.4	2.5	1.9
Forecast (Surplus) / Deficit at 110%	16.9	(10.7)	(19.7)
Cost Growth Assumptions at 90%	12.2	22.1	17.4
Change from Plan	(1.4)	(2.5)	(1.9)
Forecast (Surplus) / Deficit at 90%	14.2	(15.7)	(23.5)

The main areas of cost growth are estimates on pay and non pay inflation and increases in pension costs. A 10% variation would have a £5.8m impact upon the three year plan. The variation in any one year however is relatively small and is therefore, unlikely to have a material impact upon delivery of the plan.

The Health Board has also made assumptions around demand and service growth as part of its three year plan. The main components of this are NICE drugs, continuing health care, prescribing, demand for specialist services and demographic changes. A sensitivity analysis on this area is shown in the following table.

### Demand and Service Growth

	2014/15 £m	2015/16 £m	2016/17 £m
Demand & Service Growth Assumptions at 100%	21.0	11.5	12.5
Forecast (Surplus) / Deficit	15.5	(13.2)	(21.6)
Demand & Service Growth Assumptions at 110%	23.1	12.7	13.8
Change from Plan	2.1	1.2	1.3
Forecast (Surplus) / Deficit at 110%	17.6	(12.1)	(20.4)
Demand & Service Growth Assumptions at 90%	18.9	10.4	11.3
Change from Plan	(2.1)	(1.2)	(1.3)
Forecast (Surplus) / Deficit at 90%	13.4	(14.4)	(22.9)

This shows that a 10% variation to the assumptions made would lead to financial change of £4.6m against the three year plan. Again, this indicates that variation on this will not materially impact upon delivery of the plan.

### 11.4 Other Key Financial Risks

The other key financial risks are mainly income related and impact on the first year of the plan. An assessment of these financial risks is set out below:

- £6m VERS Funding
- £2m Commissioner risks
- £5m capital funding
- £3m Welsh Risk pool funding

These total some £16m and therefore present the UHB with a significant risk. These risks however may not materialise and the UHB will work with the Welsh Government and other key partners to mitigate against these happening and on the impact they may have on the Health Board.

### 11.5 Summary

As demonstrated in this section of the plan, the key financial risks that could impact upon the successful delivery of this plan are:

- Delivery of the savings programme
- Managing income risks.

The Health Board recognises the importance of these two areas and is taking mitigating actions in order to ensure that these risks are appropriately managed.

## 12. Governance, Performance Management and Improvement

### 12.1 Governance Arrangements

Last year's [IBP](#) (page 124) set out the detailed management and governance arrangements for the UHB. These new arrangements have been embedded during 2013/14 and provide the Board with robust assurance that the UHB is meeting its statutory responsibilities. All of the UHB's public [Board](#) meeting and sub-committee papers are available.

As part of these arrangements we have introduced the Equality, Diversity & Human Rights sub-committee to ensure that Clinical Boards and Corporate Departments fully supports the delivery of our strategic equality objectives. As part of our commitment to embedding equality actions in all that we do, the sub-committee has recommended that a themed approach to focussing on certain areas is adopted. We have decided that for 2014/15 the focus will be on improving access to our services for people with sensory loss. This will include undertaking improvement activities to address concerns reports which contain information on sensory loss, and engaging with third sector sensory loss groups when designing or redesigning services – which must form part of the Equality Impact Assessment process. Our [Strategic Equality Plan](#) sets out in more detail how we will plan and deliver improvements.

During 2013/14 the UHB has also established our Clinical Boards, through a robust authorisation process, which is one of the key signals of the UHB to change behaviour, purpose, roles and responsibilities to enable decentralisation and speed of decision making by those best placed to do so.

To support authorisation, each Clinical Board was required to support a suite of supporting evidence and documentation which is set out in Appendix 5a. The documents in bold were considered essential requirements for this first phase of authorisation, although additional documentation could be submitted if available. This documentation was reviewed by a corporate team, and each Division/Clinical Board then participated in a "Review Panel", chaired by the Chief Executive with other Executive Directors – the Chief Operating Officer, Director of Finance, Director of Workforce &OD, Director of Planning and at least one (and usually more) Clinical Executive Director. These panels were held during late September/early October 2013 with individual feedback meetings between the Clinical Board, Director of Workforce &OD and Chief Operating Officer in November. The Chief Executive has written to each Clinical Board Director setting out the level at which they will be authorised (Appendix 5b), with each Clinical Board now working to a development plan which will enable them to reach the next level of authorisation. The next round of the authorisation evaluation process will be held in May 2014 with Clinical Boards presenting their IMTP for formal agreement as part of this process.

Elements of the IMTP such as workforce, finance and tier 1 targets are reviewed at each monthly Performance Review meeting between Executive Directors and Clinical Boards/Corporate Departments. In order to strengthen arrangements for implementation of the IMTP, progress against delivery of each Clinical Boards'/Corporate Departments' IMTP will be reviewed on a quarterly basis.

To support the development of mature Clinical Boards there is a requirement for robust development plans to be in place for all leaders that align to the requirements within the authorisation process and the assurance that Clinical Board are fully formed with all roles appropriately filled. To further support this the UHB is working in partnership with the Advisory Board Company, an international health care research and development organisation who are providing a challenging and stretching development environment for senior leaders.

Proposals for [Clinical Board Governance Arrangements](#) were agreed by the UHB at its meeting on 2<sup>nd</sup> July 2013. In confirming the approach towards authorisation, the UHB was mindful of both the requirement to ensure robust governance arrangements – reflecting the recent Wales Audit Office report on governance arrangements in Betsi Cadwaladr UHB – and the commitments set out in Organising for Excellence to empowering Clinical Boards and engaging them in decision making.

Learning from the WAO report into governance arrangements in BCUHB the following areas were addressed through the Clinical Board Authorisation Process, as well as ongoing performance and accountability arrangements. The key areas that Clinical Boards needed to demonstrate are:

Issue	Response through Authorisation Process
That there is no “gap between the ward and the Board”,	<p>Evidenced through:</p> <ul style="list-style-type: none"> <li>• Examples and/or plan of how they actively engage with and respond to front line staff <ul style="list-style-type: none"> <li>• response to Staff Survey</li> <li>• Quality &amp; Safety governance arrangements</li> <li>• Performance management arrangements</li> </ul> </li> </ul>
Arrangements to hold Clinical Programme Groups to account on key aspects of financial and clinical governance are strong	<p>Evidenced through:</p> <ul style="list-style-type: none"> <li>• CB Operational Plan</li> <li>• Month 4 Finance and Performance Report</li> <li>• Profiled financial forecast and recovery plan</li> <li>• Performance management arrangements, including examples of recovery plans where key targets not being hit.</li> <li>• Copy of actions against Standards for Health Services.</li> </ul>
Arrangements through which concerns are escalated within the Health Board are robust, with a bottom up approach to quality and safety.	<p>Evidence through:</p> <ul style="list-style-type: none"> <li>• Actions and plans to respond to concerns.</li> <li>• Plan to implement the Patient Experience Framework.</li> <li>• Examples of engagement with patients, carers and communities</li> <li>• Response to Staff Survey</li> <li>• Examples and/or plan of how they actively engage with and respond to front line staff</li> </ul>

In section 9.5 we have set out our governance arrangements in terms of working with local authority and partner organisations to ensure delivery of the Single Integrated Plans. Delivery of these priorities is primarily through the Clinical Board plans, and progress against these plans will be managed through the Performance Review process.

## 12.2 Performance Management Arrangements

The UHB Board formally agreed a revised Performance Management Framework in November 2013 which reflects these arrangements. The PMF extends to all UHB activities undertaken by staff, both collectively as members of agreed groups or as individuals, in accordance with authority granted under the Scheme of Delegation in UHB Standing Orders. The scope of the PMF includes the following:

- Discharging all statutory responsibilities, including implementation of recommendations made by regulatory bodies with statutory powers
- Delivery of all requirements mandated by WG directly in relation to UHB.
- Delivery and performance management of contracts entered into by UHB with third parties to deliver healthcare services on their behalf.
- All other commissioner, provider and public health responsibilities

The key areas covered in the PMF are:

- Who is responsible for doing what?
- What structures are there to do this and how do they work?
- How does the UHB know if there is a problem?
- How is this resolved?

Formal performance meetings are held with every Clinical Board each month with the Chief Operating Officer, Director of Finance, Director of Nursing and Director of Workforce and Organisational Development. The Chief Operating Officer and the Director of Finance then hold formal performance review meetings with Corporate Departments every other month.

The key development for 2014/15 in relation to the performance management framework is to extend it to ensure that arrangements for managing performance commissioned from other LHBs and third party providers are clear and in particular the arrangements around monitoring the quality of service are standard and allow escalation where appropriate.

The Integrated Medium Term Plan is clearly identified as a key source document against which the UHB can determine whether it is achieving the proposed high level “direction of travel” and more detailed operational actions it has committed to undertaking.

### **12.3 Organising for Excellence**

O4E is our response to the 2012/13 listening exercise “Picture the Future”. Two programmes form part of the delivery of the O4E vision; Delivering Organising for Excellence (DO4E) and Becoming Leaner and Fitter. These transformation programmes are intended to be a comprehensive suite of important improvement activities that, taken together, will help us secure the kind of future we want to offer to the people we serve. These programmes are not intended to capture everything we do (in fact the great majority of what we do is conducted in our day to day roles as we discharge our responsibilities right across the UHB), but will support Clinical Boards to focus on some specific areas. Taken as a whole the programmes will work in the following areas:

#### *Clinical Services Plan – A Focus on Integration*

We know that we have a huge opportunity in Cardiff and the Vale to develop integrated services both within the Health Board and with our partners to develop and deliver new and better models of care for people. In particular we want to change the way that services for older people and people with certain long term conditions (particularly heart failure, diabetes, COPD and dementia) are organised.

Successfully changing the way that services for these people are provided will require us to work together in new ways –so we are creating a strong clinically led team to develop the plan we need.

Our goal is to improve the interface between primary, secondary and tertiary care provision, to drive up the quality and safety of care for these patients and to shift resources from secondary care to primary and community services.

We will do this by starting to develop a Clinical Services Plan for the UHB, building on work already in train, and by embedding the key characteristics of integrated care across the UHB.

#### *Good to Great*

Following on from “Picture the Future”, we aspire to become the organisation that the people working for it want it to be. Good to Great is the work required to enable the Health Board to undertake this journey of improvement; embedding the values and behaviours described in the Organising for Excellence response and supporting deliver of the Health Board’s seven strategic goals. The Good to Great aims are:

- Growing and developing new and existing clinical leaders who will take us forward;
- Reconnecting with our staff so we feel one team together;



- Supporting and further developing an ambition for excellence;
- Working more successfully with our partners;
- Finding a way to implement technology to help us do a better job;
- Creating the climate for innovation to flourish; and
- Training developing and recruiting the best managers.

A key workstream within Good to Great will be *Leading Improvements in Patient Safety*. We want to make our services as safe as possible. We understand that health care is complex and not amenable to simple top-down instructions “to do better”. We want to grow the capacity and capability of clinical teams throughout the UHB to understand safety and how to improve it.

We also believe that transparency – sharing the good and bad of how we are doing – is a powerful driver for improvement. We will publish our progress in our Citizen’s Report quarterly for everyone to see whether we are making the progress we need to.

Our LIPS programme is an ambitious plan to do develop our capacity and capability for improvement at scale. During May 2013, the UHB Board developed a small number of Key Safety Goals which were subsequently reviewed and critiqued by the newly formed Clinical Senate during their inaugural meeting in July 2013. Our first cohort of 150-200 LIPS trainees – drawn from all ranks and based on clinical teams will participate in the launch safety training in April 2014.

#### *Commissioning*

We must ensure that our services are what people need<sup>4</sup> and that those services will make a difference to their health, wellbeing and care. To do this we have to understand the health of our citizens and patients, what affects their health and what the best interventions are both now and into the future.

We will do this through the translation of population need into service plans and outcomes based service specifications for each service area linked to performance. Further detail is provided in Chapter 4. 3.

#### *Becoming Leaner and Fitter*

The more we look at how our services compare with others, the more we are able to see where we can improve our productivity and effectiveness. During 2014/15, we will build on the progress made in 2013/14; moving into phase 2 in some areas of work, as well as adding new areas of activity. New and continued areas of focus are:

- Whether we have the right numbers of beds caring for the right people in the right place;
- Whether we support people to make the right choice when access our healthcare services;
- Reviewing the efficiency and effectiveness of our outpatient services;
- Improving the effectiveness of our medicines management;
- Reviewing our nursing and medical productivity;
- Making best use of our theatre capacity;
- Improving delivery to front line services by the support functions in IM/T, finance, estates and workforce;
- Make best use of our non-pay spend, focusing on how we procure goods and services; and
- Improving the management of our Continuing Healthcare provision.

### **12.4 Continuous Service Improvement**

The Continuous Service Improvement (CSI) team work very closely with the Clinical Boards and Directorates to ensure that agreed operational improvement priorities are delivered in a evidenced, timely and sustainable manner and at the same time make certain that there is transference of skills, tools and techniques such that the improvement becomes the modus operandi i.e. ‘the way that we do things’ here. Further, in discharging the UHB’s responsibility for improvement skills capacity

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<sup>4</sup> Need – ability to benefit

building the team is the sole provider of the Silver Level (foundation and practitioner) training programme for the organisation.

The diagram below captures the key programmes that the CSI are engaged in and how they are aligned to Organising for Excellence.



# **PROFILE OF POPULATION AND HEALTH NEEDS, CARDIFF AND THE VALE OF GLAMORGAN**

## **1. Population size and composition**

### **Key points**

- The population of Cardiff and Vale is growing rapidly in size, projected to increase by 4% between 2013-17, significantly higher than the average growth across Wales. The population will pass 500,000 for the first time
- The population is ageing, with the number of over 85s increasing at a much faster rate than the rest of the population (10.4% increase between 2013-17)
- 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

### **(i) Population size, structure and projected change**

**Table 1.** Population projections for Cardiff and Vale by broad age group, 2013-2017. Source: StatsWales (2013)

Age group	Year					Increase 2013-2017	
	2013	2014	2015	2016	2017	Persons	%
0-4	30,476	30,836	31,159	31,455	31,724	1,248	4.1%
5-16	63,110	63,599	64,143	64,998	66,067	2,957	4.7%
17-64	314,841	317,264	319,731	322,064	324,112	9,271	2.9%
65-84	62,399	63,598	64,798	65,910	67,144	4,745	7.6%
>85	10,479	10,738	11,010	11,277	11,565	1,086	10.4%
All	481,305	486,035	490,841	495,704	500,612	19,307	4.0%

% increase in population	Year			
	2014	2015	2016	2017
Annual	1.0%	1.0%	1.0%	1.0%
Cumulative	1.0%	2.0%	3.0%	4.0%

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

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 local population is projected to increase in all age groups, with the highest increase in 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 only limited growth for children aged 5-16. The overall increase in the population is over double the overall Wales increase, at 4% for Cardiff and Vale between 2013-17 compared with 1.6% for Wales as a whole.

**Table 2.** Current population age structure, Cardiff and Vale and Wales; and projected change in population age groups, 2013-2017. Source: StatsWales (2013)

Age (yrs)	Proportion of population in 2013		Projected absolute increase in population 2013-17	
	All Wales	C&V	All Wales	C&V
0-4	5.8%	6.3%	-0.4%	4.1%
5-16	13.4%	13.1%	0.7%	4.7%
17-64	61.3%	65.4%	-0.1%	2.9%
65-84	17.0%	13.0%	7.7%	7.6%
>85	2.5%	2.2%	10.6%	10.4%
All	-	-	1.6%	4.0%

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.

## (ii) Birth and in-migration rates

**Table 3.** Historic birth rate and net migration into Cardiff and Vale, 2007-2012. Source: StatsWales (2013) from Census 2011

	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

## (iii) Ethnicity and languages spoken

**Table 4.** Ethnicity, Cardiff and Vale. Source: StatsWales (2013) from Census 2011

Ethnicity	Population count	Population %
English/Welsh/Scottish/Northern Irish/British	397,010	84.0%
White		
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 5.** Most common main language spoken in Cardiff and Vale. Source: StatsWales (2013) from Census 2011

Main language spoken	Cardiff	Vale	C&V	% of total population
English or Welsh	304,729	120,026	424,755	93.5%
Arabic	3,561	83	3,644	0.8%
Polish	2,650	199	2,849	0.6%
Chinese	2,321	213	2,534	0.6%

Bengali (with Sylheti and Chatgaya)	2,431	46	2,477	0.5%
Urdu	1,214	29	1,243	0.3%
French	766	93	859	0.2%
Portuguese	682	32	714	0.2%
Punjabi	643	37	680	0.1%
Spanish	597	82	679	0.1%
Gujurati	610	39	649	0.1%
Tamil	325	20	345	0.1%

## 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 (45-46%) drink above alcohol guidelines
  - Nearly two thirds (65-68%) don't eat sufficient fruit and vegetables
  - Over half (53-56%) are overweight or obese. This increases to two thirds (64%) among 45-64 year olds
  - Around three quarters (71-75%) don't get enough physical activity
  - Just over one in five (21%) 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

### (i) Lifestyle and other health-related risk factors

**Table 6.** Percentage of adults with particular lifestyle characteristics, Cardiff and Vale, 2010-2011.

Source: Welsh Health Survey (2012).<sup>27</sup>

Lifestyle characteristic	Area		
	Cardiff	Vale	Wales
Smoker	21	21	23
Non-smoking adults regularly exposed to passive smoke indoors	19	17	21
Consumption of alcohol: above guidelines	45	46	44
Consumption of alcohol: binge drinking	28	28	27
Consumption of fruit and vegetables: meets guidelines	35	32	34
Exercise or physical activity done: meets guidelines	25	29	30
Overweight or obese	53	56	57
Obese	20	22	22

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.

**Table 7.** 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.

**Table 8.** 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

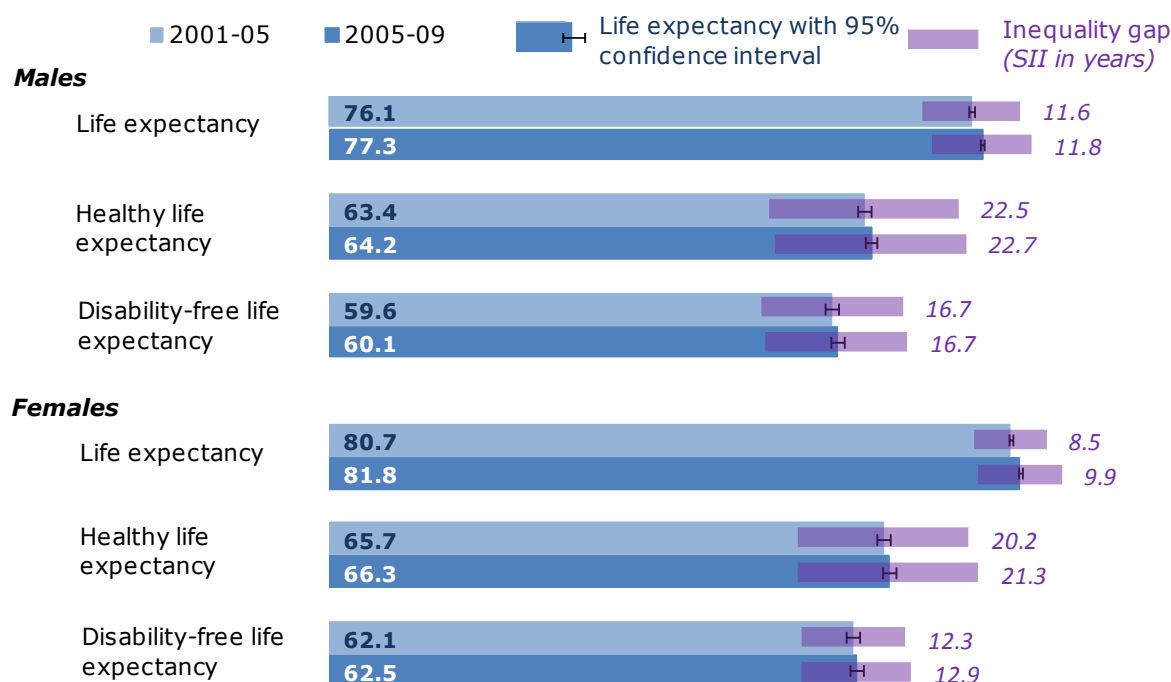
### 3. Equity, inequalities and wider determinants of health

#### 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

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.

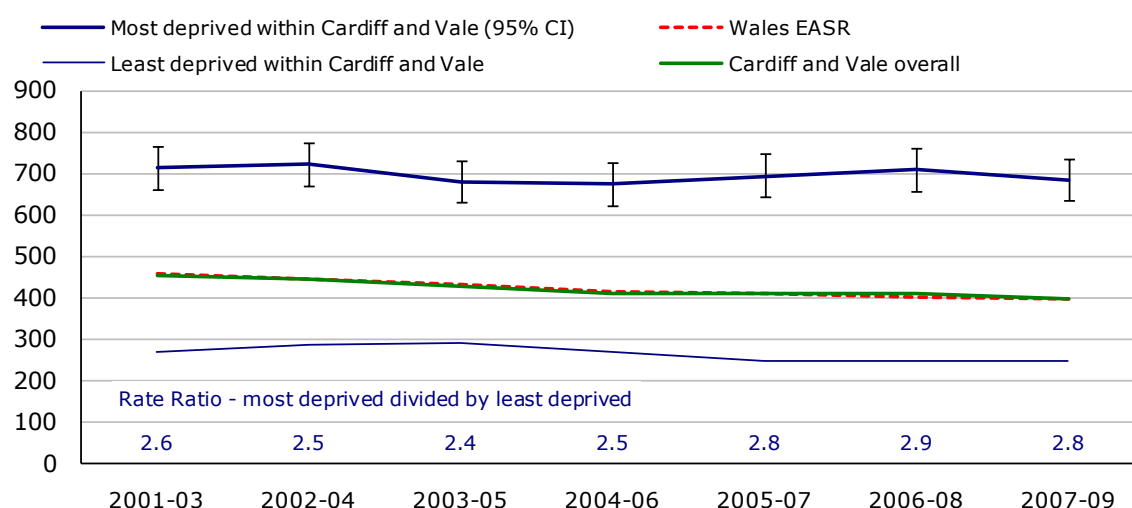
**Figure 1.** Life expectancy in years, in Cardiff and Vale. Source: Public Health Wales Observatory (2011).<sup>1</sup>



**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

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.

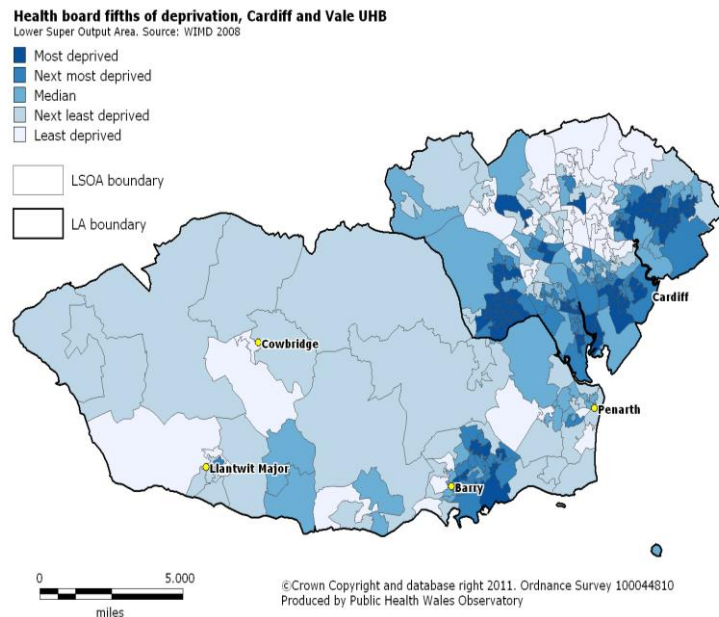
**Figure 2.** Premature mortality in males in Cardiff and Vale by deprivation fifths. European age-standardised rates (EASR) per 100,000 population (Source: Public Health Wales Observatory 2013)



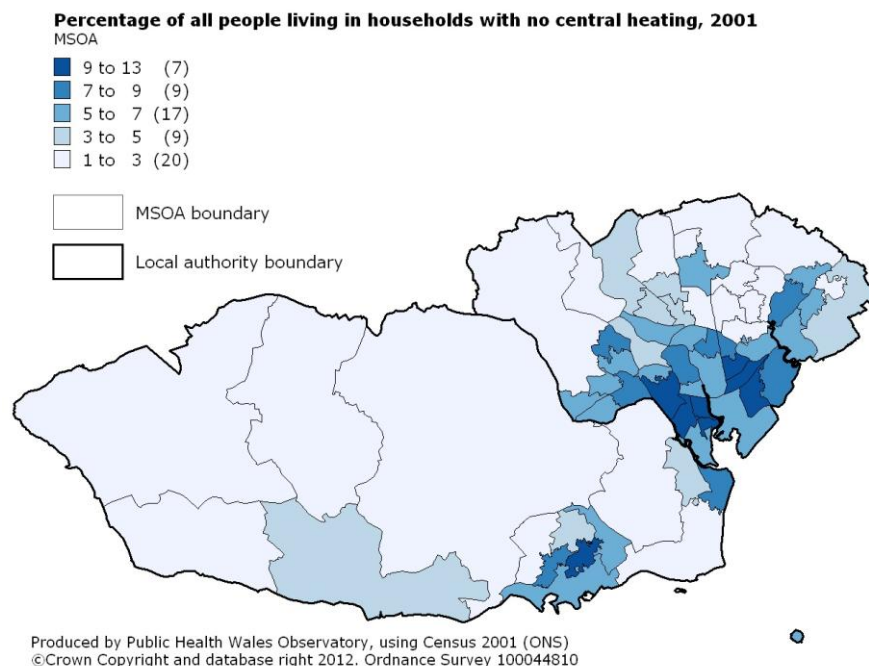
Uptake of childhood vaccinations varies considerably across Cardiff and Vale. For example, the ratio of the average uptake of the teenage booster between the top 10 practices in the UHB area and the bottom 10 practices, is 1.87. This reflects average uptake of 93.2% in the top 10 performing practices compared with uptake of 49.2% in the bottom 10 practices.

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 3.** Areas of deprivation in Cardiff and Vale, based on the Welsh Index of Multiple Deprivation (WIMD) 2008. Source: Public Health Wales Observatory (2011).<sup>1</sup>



**Figure 4.** 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.



#### 4. Ill health in Cardiff and Vale

##### 4. Ill health in Cardiff and Vale

- The disease profile in Cardiff and Vale is changing
  - Chronic conditions including diabetes, respiratory and heart disease, are now common
  - Around 1 in 10 (9.4%) 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
- 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

Just under 10% (9.4%) of the local population considered their day-to-day activities were limited a lot by a long-term health problem or disability. Around 88,000 (19%) had a limitation of any sort. These rates are lower than the Wales average of 11.9% and 22.7% respectively.

**Table 9.** 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 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) Change in disease profile

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. 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 10.** 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 5.** 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)

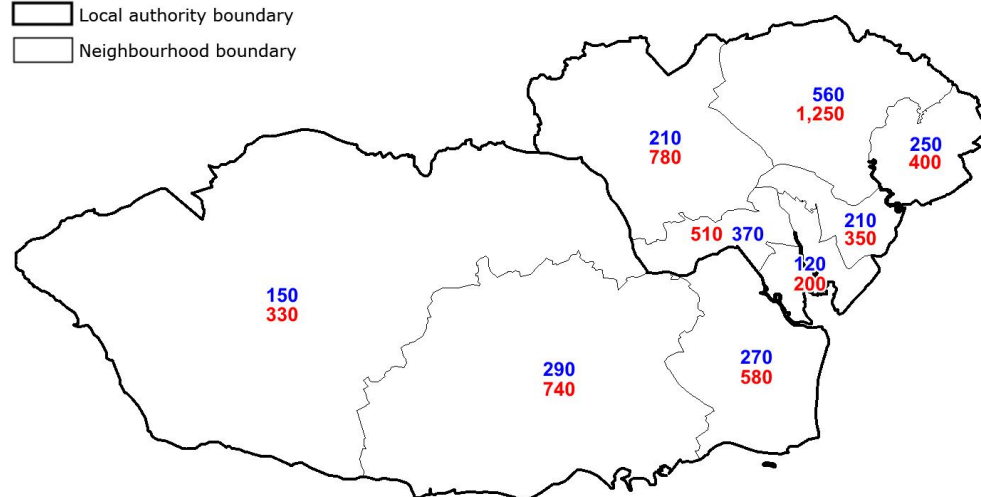
### People with dementia, 2010 / 2012

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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### (iii) Cancer incidence

**Table 11.** 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 12.** 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

#### (iv) Causes of death

**Table 13.** 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 14.** 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

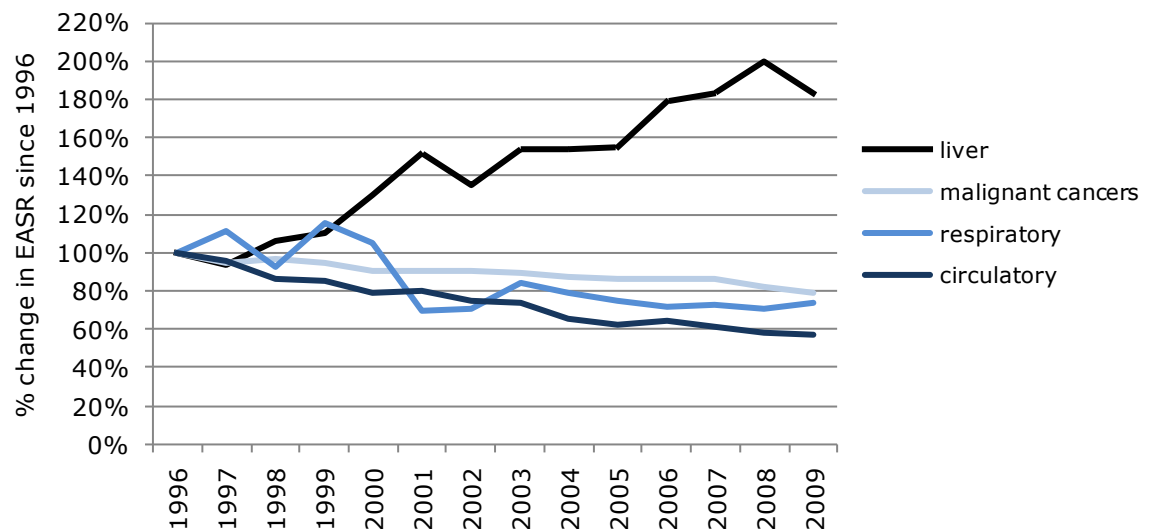
**Key:** EASR, European age-standardised rate

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

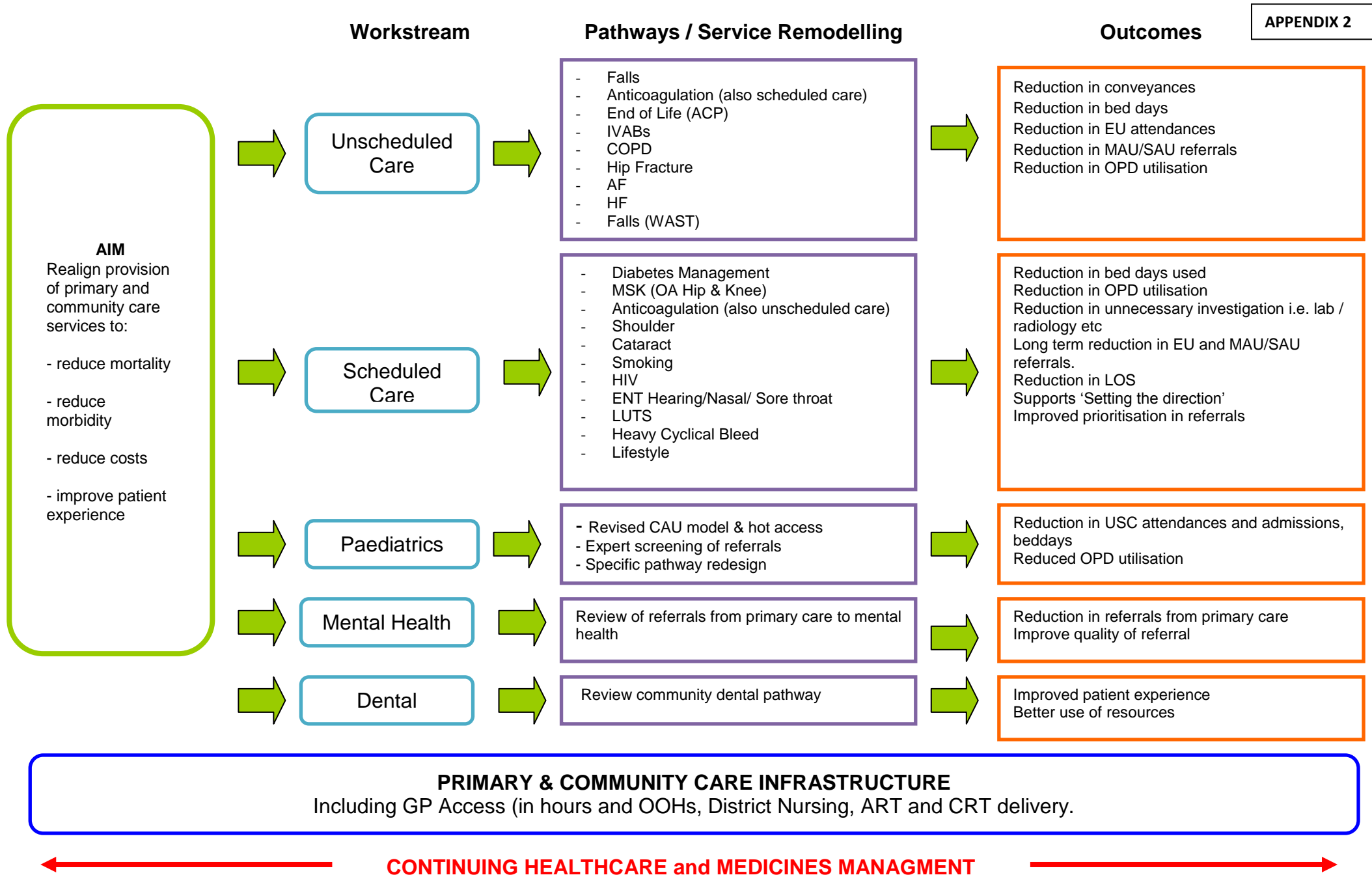
**Under 65 European age standardised mortality rates for various diseases, Wales, percentage change from 1996 baseline**

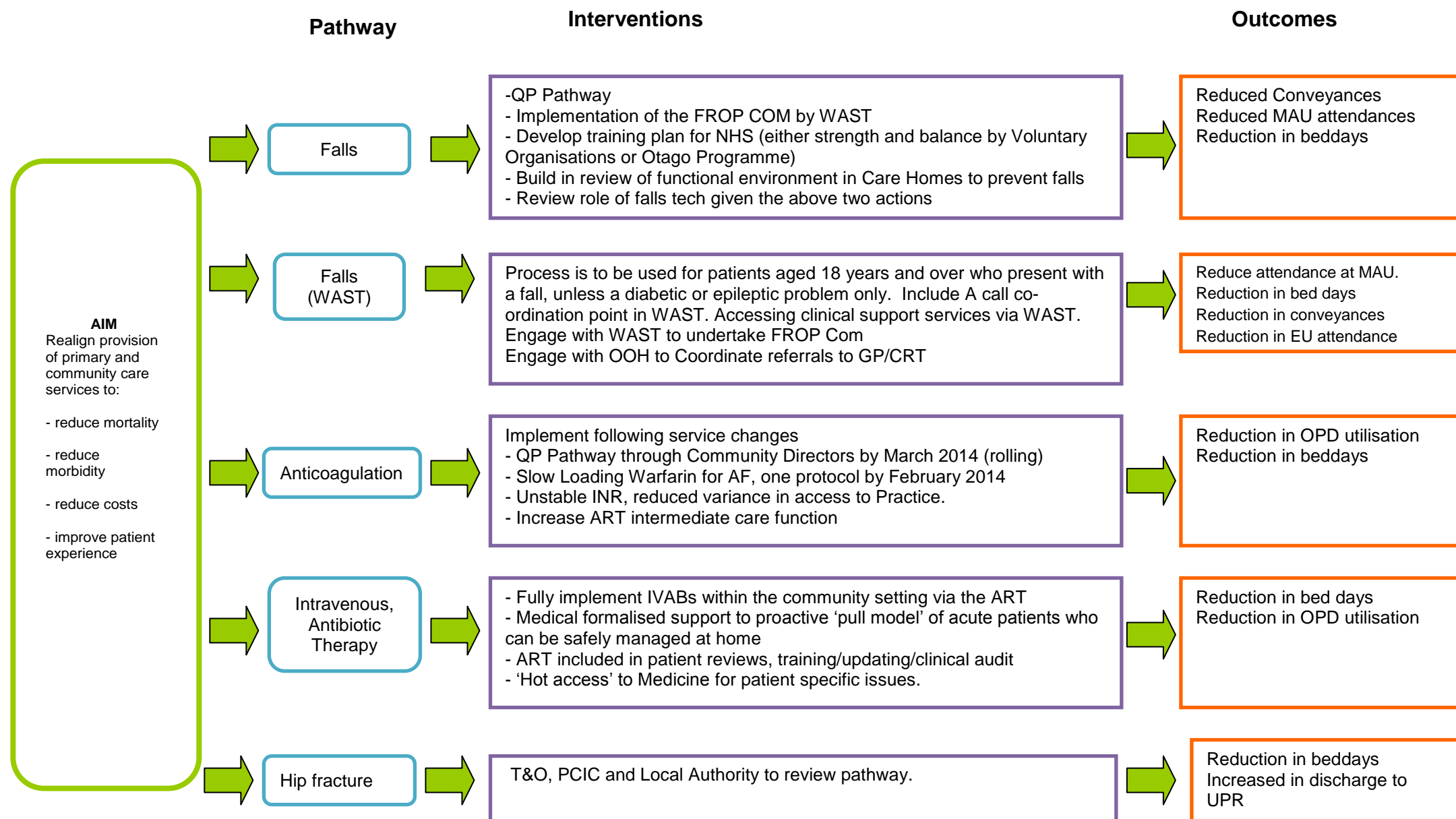
Produced by Public Health Wales Observatory, using ADDE/MYE (ONS)



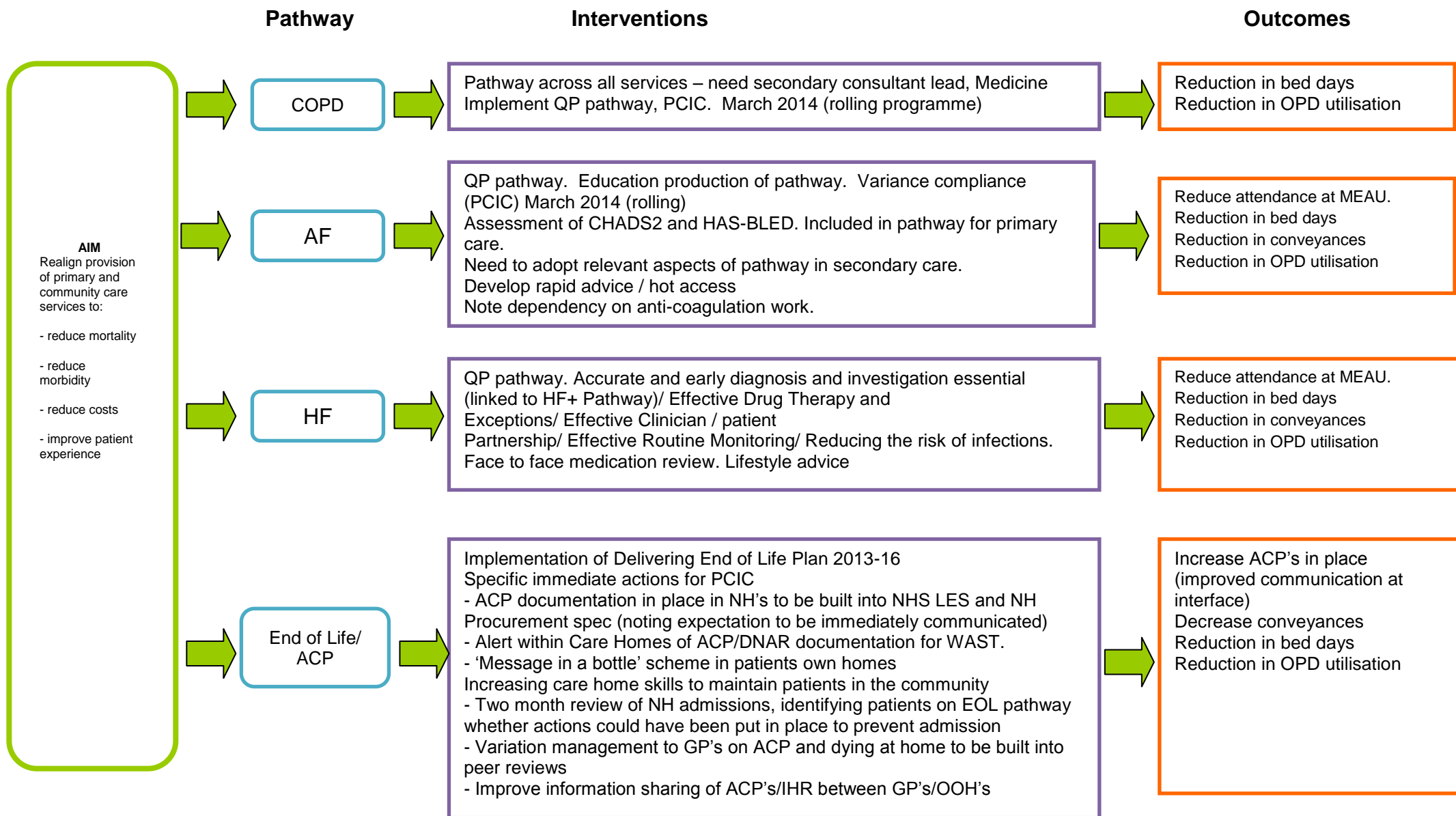
**5. Disease-, service- and population-specific needs assessment**

This profile gives an overview of some of the common health and health-related needs of the population of Cardiff and Vale. 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 2014-17 are described within individual Clinical Board plans.

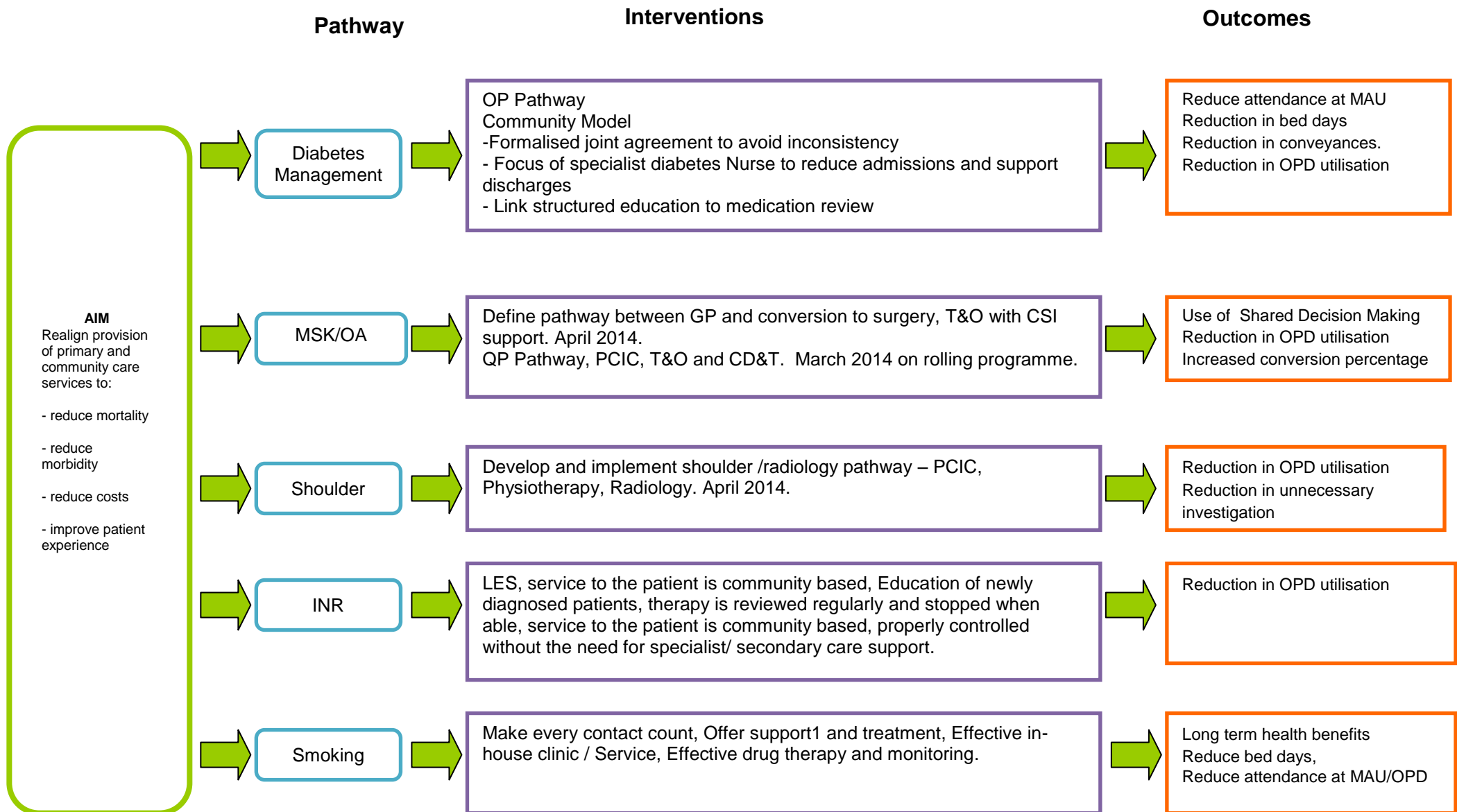




## UNSCHEDULED CARE continued



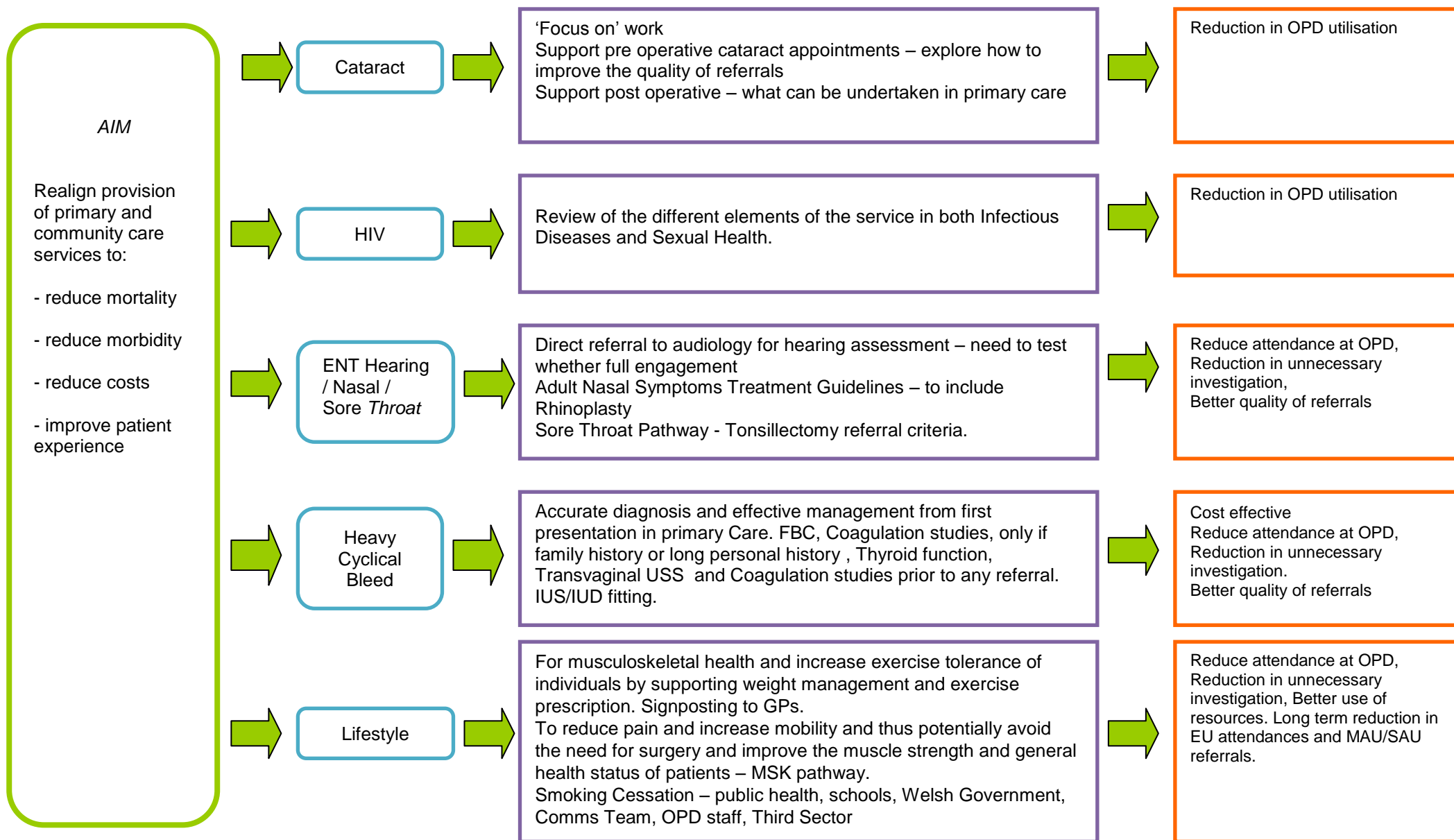
## SCHEDULED CARE



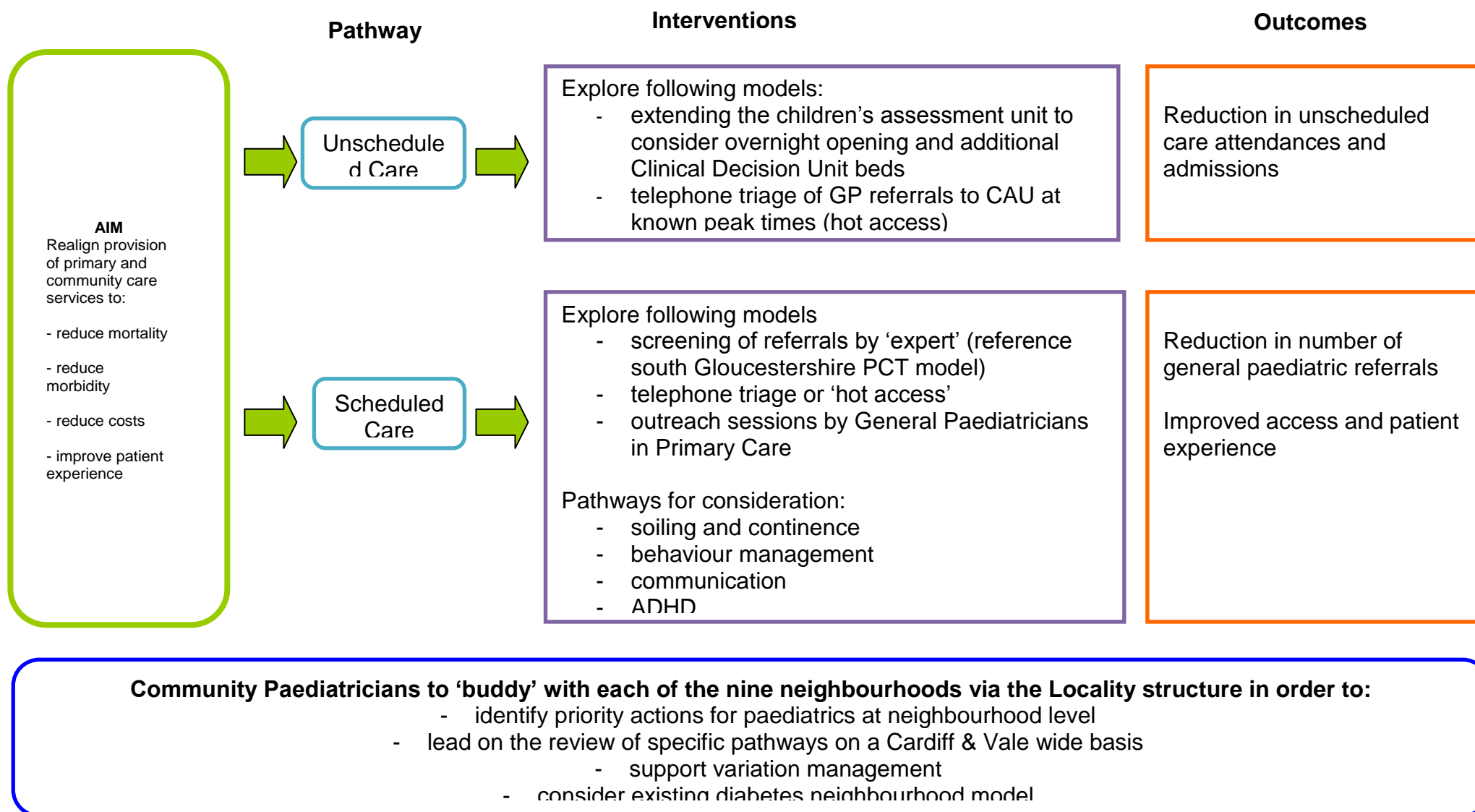


## SCHEDULED CARE

Cont



## PAEDIATRICS – jointly agreed 12/12/13

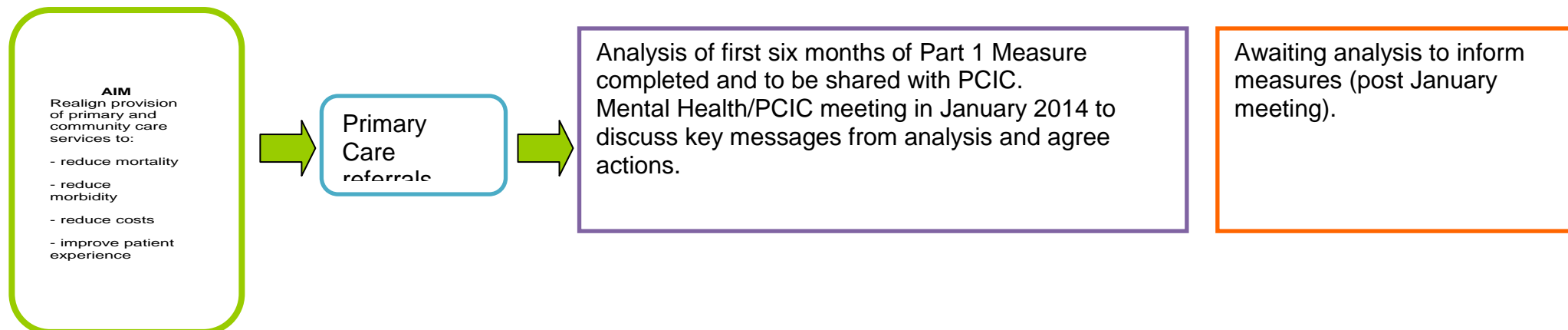


## Pathway

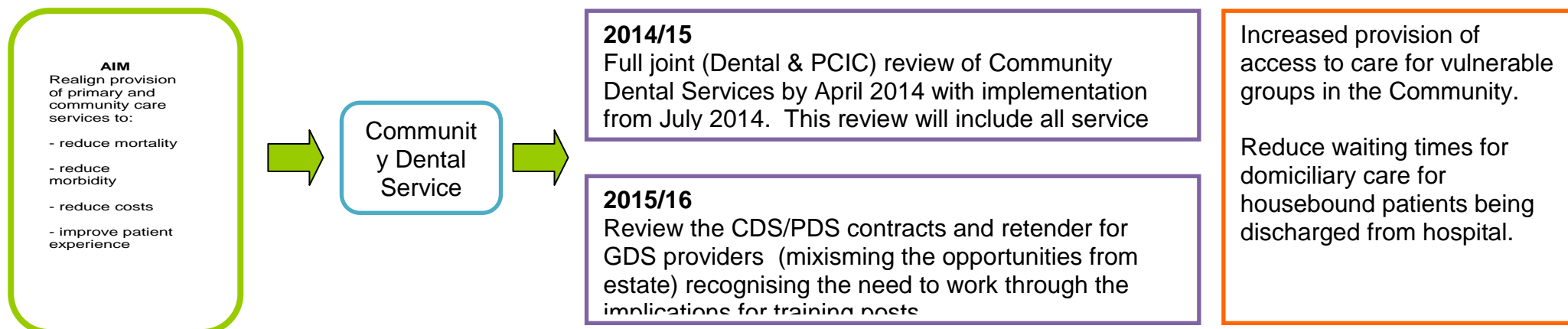
## Interventions

## Outcomes

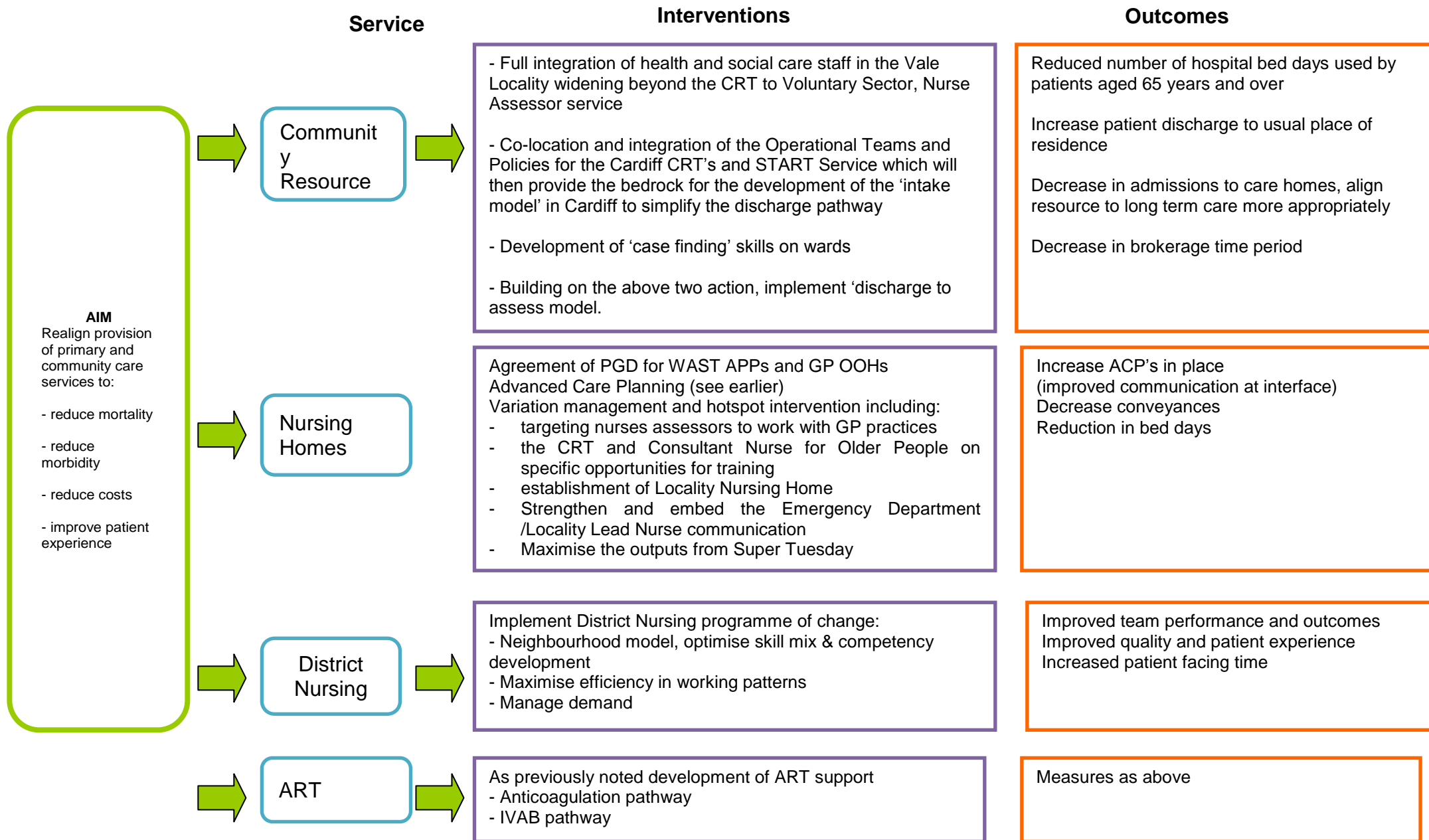
### MENTAL HEALTH – jointly agreed on 11/12/13



### DENTAL SERVICES – jointly agreed on



## PRIMARY & COMMUNITY INFRASTRUCTURE

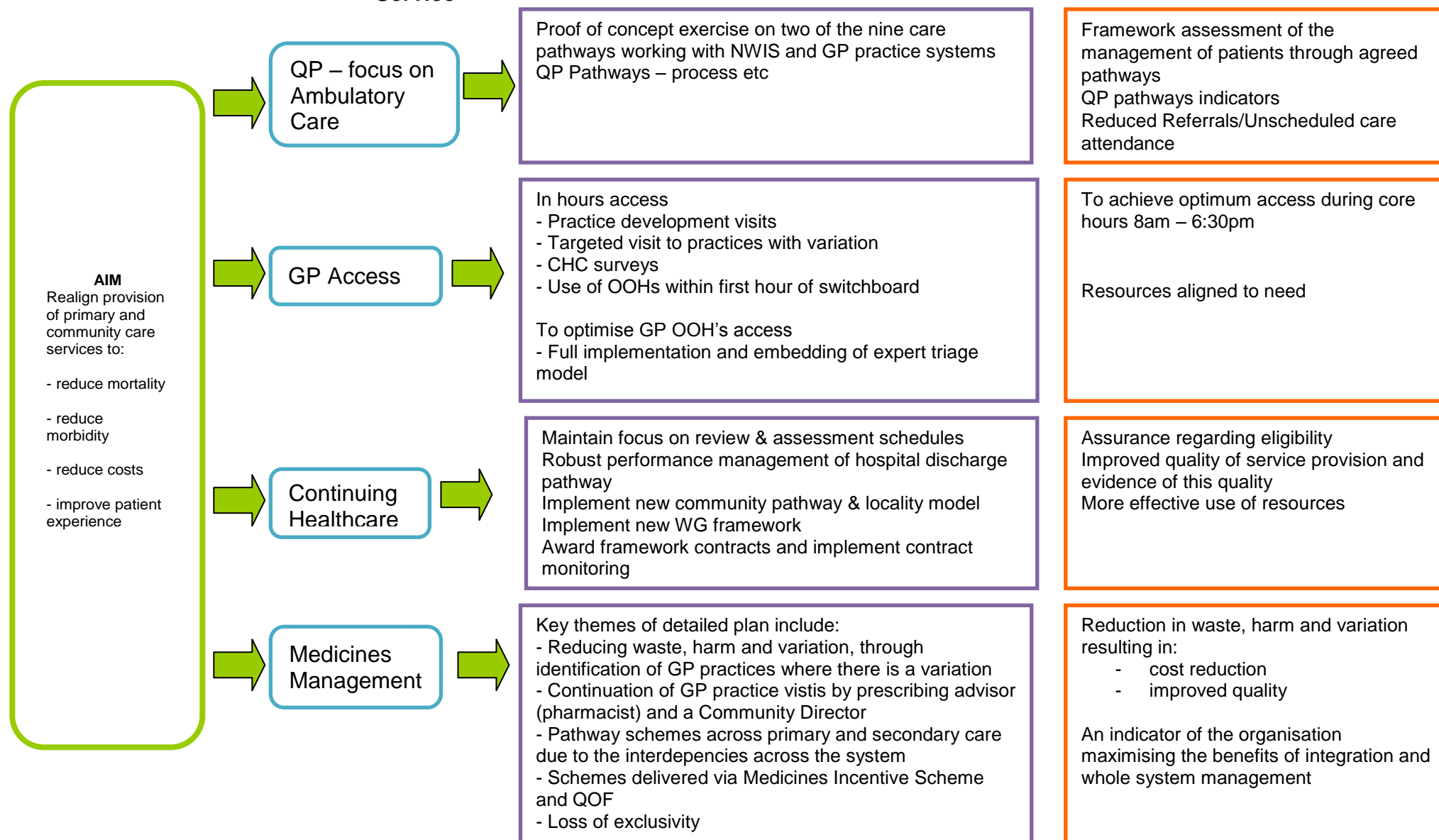


## PRIMARY & COMMUNITY INFRASTRUCTURE continued

### Service

### Interventions

### Outcomes



## **APPENDIX 3A**

### **SCP - ADULT MENTAL HEALTH SERVICES**

Over the coming year, the Clinical Board for Mental Health will continue to strengthen services around the person's home and rationalise buildings based services. Where appropriate, the CB will consolidate services for people suffering with serious and enduring mental health problems, while responding to new opportunities for service expansion and development as they arise. This includes people suffering with specialist needs whilst focusing on recovery and health promotion. Work to strengthen existing partnerships within the 'Time to Change' initiative and develop new partnership arrangements will be pursued to help deliver a better range of integrated services. The potential to develop alternative operating models to enable the provision of high quality care more innovatively and efficiently will be taken forward.

Detailed design work for the new adult mental health unit (AMHU) being constructed at UHL will continue along with the associated introduction/embedding of new service models. The AMHU will bring together the adult mental health inpatient services currently delivered from Whitchurch Hospital and the Llanfair Unit at UHL into a single Unit. Welsh Government approval for the Full Business Case has been received along with the associated capital funding from the All Wales Capital Programme.

#### **Health Needs**

An assessment of the mental health needs of the local population indicates that:-

- A higher proportion of mental disorders develop between the ages of 14 – 20 and due to the large numbers of students, Cardiff may have greater incidence of mental illness;
- Cardiff has a greater proportion of people from the BME community at 15% than the Wales average of around 4%. Research shows that the incidence of psychosis is higher in the African Caribbean and Black African populations
- In general, people with a psychotic illness have fewer qualifications compared to other groups. The percentage of Year 11 school leavers in Cardiff not in education, training or employment was high at 8.8% compared with the Wales average of 5.4%
- Statistically, those who are homeless are more likely to have a mental health issue (research shows that 43% of those accessing homelessness projects in England were suffering mental illness). In 2010/11, there were 825 judged to be unintentionally homeless and in priority need in Cardiff and 235 in the Vale
- Among the GP registered population in Cardiff and the Vale, in March 2012, there were 4,039 people with a diagnosis of a serious mental illness
- 1 in 4 people are likely to have a mental illness at any one time. The Welsh Health Survey (2010/11) shows that 11% in Cardiff and 10% in the Vale are being treated for a mental illness, representing an under treatment of mental illness in the community
- Deprivation is associated with poor mental health and data shows that within the Vale 6.4% of areas fall in the 10% most deprived in Wales. In Cardiff 15.8% of areas fall in the 10% most deprived in Wales

#### **Key Strategic Drivers/Benefits**

The focus of the mental health strategy is the continued implementation of the recovery and reablement model of care and placing the Mental Health Measure at the centre of service planning and delivery. The following key drivers and priorities have been identified:-

- Promotion of mental health well-being, prevention of mental health problems developing, and improving individual and community resilience;
- Enhanced integrated working with partners leading to a seamless model of care;
- Greater service user involvement with commissioning, service development and recruitment;
- Improved communication and signposting links to other services;
- Reducing stigma, discrimination and barriers for service users;
- Provision of mental health services, including specialist community services, closer to home; and
- Continued improvements when benchmarked against other mental health providers, particularly in terms of bed numbers, bed occupancy, admission rates, CMHT caseloads and rebalancing of financial investment between community and inpatient services.

The redesign of the mental health inpatient service model and associated construction of the new AMHU are key to taking forward improvements to mental health services and providing modern facilities which meet expectations for privacy, safety and dignity and also an improved patient experience through better recreational, social and therapeutic facilities. The associated benefits have been identified and these are captured in the Benefits Register within the Business Case. Some of the key benefits anticipated are described below.

Quantifiable benefits:-

- Reduced staff time escorting patients between the Llanfair Unit and PICU at Whitchurch – 486 hours of staff time based on average of 3-4 transfers each week;
- Reduction in staff vacancies within AMHU – annual rate to reduce by 10% to 1.34%;
- Reduction in staff sickness rates within adult MH inpatient services – annual sickness rate reduced by 1% to 4.48%;
- Overall length of stay to reduce by 20% to 41 days;
- Patients requiring intensive 1:1 nursing support to reduce by 25% per year to 87;
- Delayed transfers of care to reduce by 25% per year to 38;
- Reduction in current number of external packages of care by 50% to 6;
- Reduction of serious untoward incidents by 20% to 1,329;
- Reduction of physical assaults on staff by 20% to 106; and
- Reduction of aggressive/threatening behaviour incidents by 20% to 204.

#### **Description of the Schemes contained within the SCP**

During 2014/15 work will continue in relation to progressing the service strategy for adult mental health services and in particular the implementation of the new service models. This work will see bed reductions implemented in advance of the completion of the new AMHU beds, from 159 to 135 – a total of 24 less beds.

Priorities for the coming year for both inpatient and community services, will feature the following:-

- Embedding the redesigned inpatient model incorporating the crisis assessment and locality treatment wards, resulting in a bed reduction of 25;
- Expansion of psychiatric intensive care beds from 5 – 10;
- Embedding the new Supportive Recovery Service, which will result in a bed reduction of 4;
- Development of patient pathways for a range of community services including the eating disorders services, early intervention services for psychosis and primary mental health services;
- Repatriation of Western Vale provider responsibility for mental health from April 2014
- Working with other Clinical Boards and Local Authority partners to improve the quality and efficiency of services such as development of CHC step down and repatriation; development of mental health liaison services, medicines management;
- Clarifying commissioner intentions and service priorities in relation to neuropsychiatry, substance misuse, CAMHS and learning disabilities

Further details can be found in the Mental Health Clinical Board IMTP.

The capital development, which will continue to be progressed over the next 2 years, comprises three elements:-

- Construction of a new Unit which will accommodate 135 beds and associated services for crisis assessment and treatment, psychiatric intensive care, addiction, neuropsychiatry, male low secure, and supportive recovery
- Plaza providing café and retail facilities for all staff, patients and visitors to the site.
- A multi-level car park to replace the main car park. This opened in November 2013.

#### **Timescales and Milestones**

Construction of the new Unit began in November 2013 and is due to be completed at the end of 2015. Following a commissioning period, mental health services will transfer to the new Unit in the Spring of 2016.

Service remodelling work is being undertaken in parallel with the construction work, with the aim of introducing new inpatient service models prior to the opening of the new Unit and developing community based services to support service users to manage their mental health issues. This service development work will continue into 2016/17, with a continued focus on developing and enhancing specialist community services and CMHTs; and enhancing partnership arrangements to deliver a better range of integrated services

#### **Enablers – IT and Estates**

The development of the AMHU is consistent with the Estates Strategy, particularly in relation to reducing the number of inpatient sites across the UHB (Whitchurch Hospital will close) and the commitment to delivering services from modern purpose designed facilities.

#### **Activity projections**

New service models will be introduced in advance of the commissioning of the new AMHU, taking the bed numbers down from 159 to 135. While the impact of the new service models will see an improvement in performance, it should be noted that forecast figures include activity relating to the transfer of Western Vales services:-

<b>Activity</b>	<b>2012/13</b>	<b>2013/14 Forecast</b>	<b>2014/15 Forecast</b>	<b>Comments</b>
Inpatient Bed Days	56,002	56,876	44,795	Beds reduced by 21 by March 2014
CRHT Assessments	2,382	2,400	2,600	Demand expected to remain stable, but will increase following Western Vale transfer
Crisis Recovery Unit Attendances	2,219	2,840	2,840	Optimal attendance
New Outpatients	1,457	790	800	New ways of working and the MH Measure. Will enable increased focus on more complex patients
Follow-up Outpatients	11,467	8,126	7,500	Further reduction anticipated
CMHT Referrals	5,853	6,338	6,400	Anticipate increased GP awareness impacting on demand, despite Primary MH Support Service
CMHT Caseload	4,457	4,211	4,650	Western Vale transfer
CMHT Contacts	59,057	55,000	55,275	Western Vale transfer
Day Care	3,945	3,854	4,000	Western Vale transfer

#### **Finance Implications**

FBC and associated capital funding of £87.992m from the All Wales Capital Programme has been approved by WG for the construction of the new AMHU at UHL. The FBC is based on a predicted reduction in revenue as a result of reduced bed numbers and the remodelling of inpatient clinical and non-clinical services. The Clinical Board strategy to achieve the financial target set, focusing on high impact service redesign, will continue into 2014/15, and beyond. In addition to the anticipated savings from service redesign, a number of high impact schemes will be developed to realise planned savings, including CHC repatriation, step down and growth avoidance; Western Vale transfer; clinical administration review; medicines management; and nursing workforce efficiencies. Details are provided in the Clinical Board IMTP.

#### **Workforce Implications**

Current services redesign and cost improvement plans are anticipated to result in an overall reduction of established posts by March 2015. Work has been undertaken during 2013/14, through the service redesign process, to strengthen staff and improve skill mix to support the development of the new crisis assessment and locality treatment wards. This work will continue over the following 2 years within the Psychiatric Intensive Care Unit and the Supportive Recovery Unit, in preparation for the commissioning of the new AMHU.



Development of integrated mental health services in partnership with Local Authorities and the third sector will continue, with many roles being jointly developed and generically working with core mental health skills and specialty interests being developed

#### **Risks and Mitigation**

The Clinical Board has identified a number of key risks and mitigation actions in relation to the development and delivery of mental health services over the period 2014/15 – 2016/17. In relation to planned service change, engagement with clinicians will continue to provide a clinical focus and ensure appropriate governance arrangements

The development of the Business Case for the AMHU involved significant work to identify key risks and associated mitigating actions in relation to both the construction of the Unit and also the associated service redesign. These are included in the Risk Register appended to the Business Case and is monitored by the Project Board, the Project Team and Clinical Board and action taken as appropriate.

### **SCP NEONATAL SERVICES**

The Neonatal Unit (NNU) at the University Hospital of Wales (UHW) provides intensive care, high dependency and special care services for the local population of Cardiff and the Vale as well as a tertiary service for South Wales. It is the only Unit in Wales to provide neonatal surgery with approximately a quarter of its admissions coming from other units in Wales

#### **Health Needs**

Demand for neonatal services in the future is expected to increase. The main factors are:

- Over the last 4 years the birth rate in Cardiff and Vale has steadily increased, together with increased levels of prematurity and increased survival of premature infants;
- Strategic service developments; due to workforce pressures, work is currently underway to reconfigure Obstetrics, Neonatal and Paediatric services in South Wales as part of the SWP, which is likely to result in the provision of neonatal high dependency and special care on fewer sites.
- Deanery requirements in relation to training provision and junior/middle grade requirements
- Maternal transfers out of area due to unavailability of cots
- Downward changes in Medical staff numbers in Cwm Taf Health Board

#### **Actions**

The solution to provide a greater amount of space between each of the cots and to enable the provision of additional cots in relation to capacity issues will require the development of a business case, and as the capital cost has been estimated to be in excess of £5m, the route will be through the Strategic Outline Case, Outline Business Case and Full Business Case process. A number of options have been explored and these include the use of existing neonatal accommodation in conjunction with the 2<sup>nd</sup> floor of the Tertiary Tower block or utilisation of the existing neonatal accommodation in conjunction with ward C2 linked via a new build link which is the emerging preferred option.

#### **Key Strategic Drivers / Benefits**

**Capacity Issues** - The All Wales neonatal network has recently carried out a capacity review across Wales which shows that occupancy rates in the South Central region regularly operate at around 90-100%, which is well in excess of that recommended by the British Association of Perinatal Medicine of 70%. The pressure is greatest at high dependency and special care levels, with babies often occupying intensive care cots to receive high dependency care because of a shortage of high dependency cots. A review of neonatal capacity across South Wales covering the first six months of 2013 re-confirm the previous recommendations for an increase of 1 Intensive Care (IC), 3 High Dependency (HD) and 8 Special Care (SC) cots across the South Central (Cardiff and Vale and Cwm Taf) region. This would have the effect of increasing the number of cots in UHW to 40 split in the following configuration:

- 10 Intensive Care
- 15 High Dependency
- 15 Special Care

In addition the potential implications of the SWP 'best fit' option have been assessed, but will not be able to be confirmed until the consultation and decision process is concluded, and the following additional cots have been identified:

- 5 Intensive Care
- 1 High Dependency
- 4 Special Care

This would bring the total number of cots required to 50.

**Infection Rates** - This has previously been highlighted as a serious concern by the UHB and is identified as one of the UHBs major risks. There have been several outbreaks over the last year and whilst these are being managed through a number of mitigating actions, the age of the building and the physical capacity and space are known contributory factors.

**Storage** - There are inadequate storage facilities on the neonatal unit resulting in storage of large pieces of equipment in clinical spaces or in corridors creating risk and contributing to over-crowding.

**Family Facilities** - There is no waiting room or facility for parents to make themselves refreshments. In addition there is only one rooming-in room, which is in almost constant use for either bereavement care or to facilitate breast-feeding/family support prior to discharge home.

### **Timescales and Milestones**

The Strategic Outline Case is in the initial stages of development and it is anticipated that the completion of the business case process will be towards the end of 2015.

### **Enablers – IT and Estates**

The SCP is aligned to, and supported by, the UHB Estate Strategy particularly around the commitment to delivering services from modern purpose designed facilities. The strategy is based on the need to rationalise the estate, while ensuring that what is retained reflects clinical needs and ensures that engineering and building solutions do not place a constraint on progress but support it by providing appropriate and cost effective solutions.

### **Activity projections**

The activity projections in relation to current UHW activity and the SWP 'best fit' option have been identified as follows:

#### **Intensive Care**

Current UHW activity	2481	
Proposed UHW activity	3620	
Difference		+1139

#### **High Dependency**

Current UHW activity	3082	
Proposed UHW activity	3200	
Difference		+ 118

#### **Special Care**

Current UHW activity	3688	
Proposed UHW activity	4606	
Difference		+ 918

### **Finance projections**

The capital cost of the development has been estimated at around £6m. The revenue costs have not been assessed at this stage, although additional staffing will be required to staff the increase in the number of proposed cots which will need to be discussed and agreed with WHSSC.

### **Workforce implications**

There will be additional staffing requirements given the substantial increase in the proposed number of cots and this will be assessed in detail during the development of the business case.

### **Risks and Mitigation**

It is intended that upon completion of this development the following risks, identified in the UHBs Corporate Risk Register, will be mitigated:

- Patient safety and quality
- Governance, legal and regulatory frameworks external standards.

**SCP - NOAH'S ARK CHILDREN'S HOSPITAL FOR WALES – PHASE 2**

The second phase of the Noah's Ark Children's Hospital for Wales (NACHfW) will complete the development of a child focussed hospital providing high quality, responsive and integrated paediatric care. This phase will provide dedicated facilities to support surgical, diagnostic, outpatient and and critical care services fully integrated with the services established in the first phase..

This phase will integrate all paediatric inpatient and outpatient services into a single environment thereby reducing service boundaries and facilitating efficient patient pathways through both service and professional co-location. The services to be provided in Phase 2 are:

- Paediatric theatres to support the anticipated range of surgical procedures, from day/case ambulatory care to complex specialised surgery, this includes a dedicated dental theatre.
- A paediatric critical care service combining the paediatric intensive care unit and the paediatric high dependency unit, with the capacity to support the paediatric retrieval service.
- Inpatient accommodation for surgical beds and ambulatory care/overnight beds.
- Co-location of children's assessment unit and children's investigation unit.
- Inpatient accommodation for renal/cardiac beds.
- Dedicated paediatric outpatient department to enable integration of specialised outpatient clinics and enhance MDT working.
- Radiology department for basic imaging, ultrasound, MRI and fluoroscopy.
- Dedicated academic and teaching facilities for child health services.
- An age-appropriate environment across all services including enhanced play and educational facilities.

The Full Business Case (FBC) for Phase 2 of the Noah's Ark Children's Hospital for Wales was approved by Welsh Government on 12 December 2011.

**Key Strategic Drivers / Benefits**

The key drivers for change impacting on the provision of health care services and young people are summarised as follows:

- **Delivering specialised services**
- **Dedicated paediatric environment**
- **Integration of children's services**
- **Capacity**
- **Creating a sustainable workforce**

Quantitative benefits include:

- Efficiency opportunities through co-location of the Children's Assessment Unit (CAU) and Children's Investigation Unit (CIU)
- Efficiency opportunities in relation to the co-location of Paediatric Intensive Care Unit (PICU) and the High Dependency Unit (HDU)
- Improved access to a hydrotherapy pool which will improve efficiencies through not having to travel for hydrotherapy treatment

Qualitative benefits include:

- All children cared for in age appropriate environment
- Core NSF and CYPSSP standards met.
- Reduced clinical risk with particular reference to child protection and surgical MDT support.
- Sustainability of specialist elective surgery on children.
- Access to a sustainable emergency surgical service.
- Provides services in facilities that are able to meet the needs and preferences of children and their families.

- Service efficiencies from co-location of all hospital based paediatric services working apart of children's services network.
- Improved outpatient efficiency.
- Reducing the dislocation of services for children across the University Hospital of Wales site.
- More activity/better utilisation via expanded and dedicated ambulatory care / day care unit.
- Co-location of key services e.g. dental.
- Meets health and safety and environmental standards providing care in a modern, clean and therapeutic environment.

#### **Timescales and Milestones**

The FBC was approved by WG, on 12 December 2011 and construction of the building commenced in February 2012. The construction contract completion date is December 2014, however it is currently anticipated that the building work will be completed ahead of contract in November 2014, with a view to occupation in March 2015. The post main scheme works which encompass the development of the facilities on the ground floor of the existing Children's Hospital including the CAU, CIU and colposcopy facilities will start in 2015 once the commissioning of the new facility is complete.

#### **Enablers – IT and Estates**

The SCP is aligned to, and supported by the UHB Estate Strategy particularly around the commitment to delivering services from modern purpose designed facilities

#### **Workforce implications**

The disaggregation of paediatric and adult services will result in some dis-economies of scale as services move out of main theatres and outpatient settings into the new Children's Hospital. This will mean that new staff will be required to ensure correct levels of staffing and also that some existing staff will require further and enhanced training. This is currently being taken forward as part of the services redesign of children's services.

#### **Resource Implications**

The costs identified in the approved FBC are:

Capital Costs - £59,660,239  
 Service Revenue - £2,324,000  
 Capital Charges - £792,000

The capital investment is being funded by Welsh Government and the revenue will be funded as follows:

<b>Total WHSCC Activity and General Paediatric Activity Split by LHB</b>								<b>Total</b>
	Cardiff & Vale £	Abertawe Bro Morgannwg £	Aneurin Bevan £	Cwm Taf £	Hywel Dda £	Powys £	OTHER £	£
	<b>1,343,363</b>	<b>199,043</b>	<b>458,513</b>	<b>155,925</b>	<b>152,915</b>	<b>14,714</b>	<b>525</b>	<b>2,324,000</b>

#### **Risks and Mitigation**

The Project Risk Register identifies key risks and associated mitigating actions, including:- revenue cost assumptions underestimated. The revenue costs are currently in the process of being reviewed to assess whether they are still in line with the costs identified in the business case.

## IM&amp;T NATIONAL AND LOCAL PROJECT PLAN FOR 2014 /15

**1. Sustaining and refreshing an enormous IT Infrastructure and supporting in excess of 10,000 users.**

1. Upgrade to the 'Core' Data network at the UHW - Subject to Capital Funding
2. Cisco Project: - Subject to Capital Funding
3. Configure / Install requirements for NHS Wales Finance system into CRI Data Centre
4. Wireless Networking Expansion- Subject to Capital Funding
5. Replacement of 2000 PCs
6. Migration to Service Point helpdesk software
7. Implement SNOW (Software Licensing)
8. Review model for a sustainable Desktop
9. Windows 7 Upgrade within the UHB
10. WAO Implementation Plan
11. EOL Server Replacement (Virtualisation) Subject to Capital Funding
12. Email Upgrade and Archiving (Subject to Funding)
13. Strategic review of Data Centre environments & requirements: Full Aircon & power review, redeployment of equipment based on the review
14. SAN Infrastructure Install: NexSan, Veam & Eva
15. Data Warehouse Infrastructure
16. Backup Infrastructure CRI
17. Implementation of the DHR infrastructure
18. Cardiac Services Backup Redesign
19. Cardiac Services Hardware / Software Upgrade (subject to Capital funding)
20. Replacement of the Aastra Switchboard Servers EOL - Subject to Capital Funding
21. Switch Board UPS - Replacement of the batteries which supports the UHB Switchboard
22. Replacement of the PARIS Hardware platform - Subject to Capital Funding
23. Radis2
24. Upgrade Switchboard to Version 5
25. Tendering for the Maintenance Contract
26. Data Warehouse ongoing Support
27. Patient Level Costing - Support & Analysis
28. Business Intelligence System Support
29. Business Intelligence System - Development & Analysis
30. Business Intelligence – Training

**2. Delivery of the National IM&T Programme**

1. WCCG E-Referrals Phase 2
2. Hospital e-Referrals (HeRs) - Phase 1
3. HeRs2 in Welsh Clinical Portal
4. E-comms to Primary Care -WCCG Phase 2
5. Welsh Clinical Portal Medicines Transcribing & e- Discharge & Individual Health Record
6. Welsh Clinical Portal Results Reporting
7. Radis 2
8. Radis2 - Business Intelligence for Patient Level Costing and RTT
9. Enterprise Master Patient Index
10. Individual Health Record Out of Hours Service
11. TrakCare- New Laboratory Information Management System
12. GP Test Requesting
13. My Health On Line
14. Encryption
15. Child Health 2000 Replacement
16. Secure File Sharing Portal

### 3. Delivering Clinical Service Board IT and Information priority requirements.

1. Meet & Agree IT Work Packages for Clinical Boards 2014/15
2. Incorporate into IM&T Workplan
3. General PMS Developments - Agreed for Workplan
4. E-Referrals (HeRs 2)
5. Clinical Documents (Generic Letters and Results Reports)
6. Other E Comms Projects to Primary Care (Clinical Lettes - Shared Discharge Notifications)
7. Ward Clinical workstation integration with WCCG / Bed Management
8. Data Warehouse - New Requests
9. Gateway Services Integration with PMS/WCP
10. Clinical Information Repository (CIR)
11. PMS Development for 'tablet scoping'
12. PMS - CHFW Call System Development
13. Clinical Portal - ISEC Requirements
14. Integration between Community and Acute Scoping Project
15. Integration and Interfacing : Radis2, Med Phys, WCP, LIMS Ect,,
16. Support integration requirements for DHR
17. National CCIS (Health&Social Care) Procurement
18. MHCS/PMS EBI Interface (Support RTT) -( Dates TBC)
19. MHCS Mobile Working
20. Major Software Initiatives
21. Interface from PARIS to Other systems
22. Integrated (Health & Social) CMHTs - Appointment Booking
23. SMS appointment Texting for Addictions Services
24. Deliver Addictions 3rd Sector services to PARIS
25. Consent Recording across Services
26. Violence Markers delivery to uHB policy
27. Council based Flying Start services migration to PARIS
28. Support to TeleHealth Implementation
29. Additional Team Access to PARIS (EU/MEAU/CRRU etc..)
30. Group Recording facility for uHB and Council services
31. Community DIARY (i.e. scheduling)
32. Mental Health Crisis Wards
33. Podiatry Phase 3 - Clinical rollout
34. Interface WCCG into PARIS - Phase 2
35. New Mental Health Unit Design
36. CHFW Phase II Design
37. In Touch self Checking System
38. Dental Prodcution
39. Review Point of Care Treatment (POCT)
40. Review NWIS Secure Email Solution & Implement
41. Support eDatix Upgrade
42. Upgrade to Shire Database - Subject to Funding
43. Develop a dedicated HIV Database with PCIC
44. Provide support for Business Case to replace Pharmacy EDS System
45. Mental Health Services - Business Intelligence Suite
46. PLC & Albatross support and development
47. Support delivery of internal trading SLAs
48. Community Services - Business Intelligence Suite
49. Diagnostic & Therapy Services - Business Intelligence Suite
50. Clinical Dashboard additional indicators
51. Cognos Application & Web server replacement
52. Upgrade BIS to Cognos version 10
53. Assessment and redevelopment of IW feeds from PMS

54. Support improved management of the FU cycle including IW and BIS development for reporting
55. Develop and implement reconciliation scripts PMS:IW
56. Clinical Information Repository - new data feed & reports (unresourced)
57. Radis2 data feed and development in IW (including results)
58. LIMS data feed and development in IW (including results)
59. MTED data feed and development in IW
60. Euroking Maternity System data feed and development IW
61. Develop PMS PMI feed into IW including management of merges
62. Develop PMS Referral extract from into IW
63. Develop PMS OP Waiting List Removals extract into IW
64. Patient Experience Electronic Survery data feed and development in IW
65. E-Datix data feed and development in IW
66. Support rollout of Telehealth & Risk Stratification
67. Bed Bureau Module - new data feed & reporting
68. SALUD Dental System - new data feed
69. Review options for publishing BIS content on other media i.e. Intranet pages
70. Regular reporting & adhoc information provision
71. Rationalise adhoc service and increase self-service
72. Development of national data sets from IW & decommission old PMS extracts
73. Automate regular report production from BIS
74. Work to ensure compliance with WG mandated information governance requirements and optimise data quality
75. Development of PMS functionality to ensure that waiting times in defined scenarios are correctly accounted for. Explore potential for rationalising waiting list management through techniques such as autovalidation.
76. Co-ordinate submissions to NHS Benchmarking Network
77. Develop tools to support demand, capacity and activity analysis
78. Support use of CHKS to ensure that UHB systematically benchmarks its performance against comparable providers and responds accordingly
79. Developing and enhancing the reporting and management of cancelled admitted procedures
80. Implement HRGV4
81. Achieve 90% records coded within 10 working days and 98% within 3 months
82. Feasibility study for the exectronic coding of scanned patient records
83. Review implementation of ENT OP procedure coding
84. Establish coding audit function
85. Review EU coding of presenting complaint and initial diagnosis

#### **4. Embracing and exploiting new Technological opportunities**

1. Support Healthier Connections Project
2. Review Telehealth via Social Media
3. Implement Stroke Teleservices into Consultants Homes
4. Patient / Visitor Access to the Internet
5. Implement UAG onto UHB WiFi (staff access to systems)
6. Implement ISE onto UHB WiFi (staff access to systems)
7. Support access to DHR system including Mobile access
8. WiFi Connectivity to Vale of Glamorgan CC
9. Eduroam
10. NHS Wales LYNC Pilot - subject to Capital Funding
11. Test Windows 8x
12. Review of Patient Entertainment Solution
13. Implement Patient WiFi
14. Implement ISCE
15. Video Conferencing (desktops)
16. Review Mobile working solutions
17. Upgrade of Cardiology System (Subject to Capital Funding)



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	Criteria	Evidence	Assessment
<b>Criteria 1</b>	<b>A strong clinical and multi-professional focus which brings real added value</b>	<ul style="list-style-type: none"> <li>• Evidence of an understanding of population health</li> <li>• Evidence of service, clinical and health improvements demonstrating measurable impact</li> <li>• Capacity amongst staff to undertake improvement work</li> <li>• Evidence of spread of best practice and processes for spread</li> <li>• Results of staff feedback from national surveys and identified actions</li> <li>• External measurement of educational performance, research performance</li> </ul>	<ul style="list-style-type: none"> <li>• Examples of continuous service improvement, including spreading best practice</li> <li>• Examples of how service change responds to changing health needs</li> <li>• Outcomes of staff survey (included in performance review information) and actions to respond</li> <li>• Approach to staff engagement, including Trade Unions</li> <li>• Examples of research and development and approach to supporting this.</li> <li>• Staff representative in place</li> </ul>
<b>Criteria 2</b>	<b>Meaningful engagement with patients, carers and their communities</b>	<ul style="list-style-type: none"> <li>• Evidence of actions based on analysis of concerns and improving performance against targets</li> <li>• Evidence of measurement, learning and improvement from the four quadrants of the Patient Experience Framework</li> <li>• Evidence of cross-organisational partnership working</li> <li>• Evidence of active processes in place to identify and address equality issues</li> <li>• Evidence of assessment of population health needs and health inequalities</li> </ul>	<ul style="list-style-type: none"> <li>• Actions and plans to respond to concerns including complaints.</li> <li>• Plan to implement the Patient Experience Framework.</li> <li>• Examples of engagement with patients, carers and communities</li> <li>• Evidence of cross organisational working to be reviewed through Operational Plan</li> </ul>
<b>Criteria 3</b>	<b>Evidence of a commitment to and practice of the values and behaviours described in Organising for Excellence</b>	<ul style="list-style-type: none"> <li>• Evidence that values and behaviours form part of PADR discussion</li> <li>• Evidence of visible leadership and role modelling, recruitment and induction embed values and behaviours.</li> <li>• Evidence of written and verbal two way communication processes with all staff groups</li> <li>• Evidence of empowerment of appropriate decisions and responsibilities from Clinical Board to directorates</li> </ul>	<ul style="list-style-type: none"> <li>• CB self assessment of position against values and behaviours</li> <li>• Examples and/or plan of how they actively engage with and respond to front line staff</li> <li>• CB Development Programme (as previously)</li> </ul>

<b>Criteria 4</b>	<b>Clear and credible integrated plans which deliver services within financial and workforce resources</b>	<ul style="list-style-type: none"> <li>• Clinical Board Operational plan demonstrating delivery of agreed activity, service delivery, workforce plans; a balanced financial plan</li> <li>• Evidence of service planning and commissioning</li> <li>• Evidence of utilising the effectiveness and cost-effectiveness evidence base</li> <li>• Clinical Board change programme which supports delivery of the Operational Plan and Organising for Excellence.</li> <li>• Internal processes that review and manage performance (financial, activity, workforce, and quality and change delivery)</li> <li>• Evidence of collaboration with other clinical boards to ensure and assure patient centred care</li> </ul>	<ul style="list-style-type: none"> <li>• CB Operational Plan</li> <li>• Month 4 Finance report</li> <li>• Month 4 performance scorecard</li> <li>• Profiled financial forecast and recovery plan</li> <li>• CB Change Programme</li> <li>• Evidence of collaborative arrangements with other CBs</li> <li>• Performance management arrangements, including examples of recovery plans where key targets not being hit.</li> </ul>
<b>Criteria 5</b>	<b>Well defined management and governance arrangements, with the capacity and capability to deliver all their responsibilities</b>	<ul style="list-style-type: none"> <li>• Clear structures for assuring management, reporting and improvement of Quality and Safety</li> <li>• Effective reporting structures for performance management and change delivery.</li> <li>• Evidence of health needs assessment</li> <li>• Is able to demonstrate that the Standards for Health Services in Wales are being embedded across the Board area and being used routinely, assessed annually and help to inform improvement plans.</li> <li>• Compliance with all statutory requirements/licences</li> <li>• Awareness of key risks and risk reduction strategies in place</li> </ul>	<ul style="list-style-type: none"> <li>• Management arrangements and management structures, including Quality and Safety and Performance Management arrangements.</li> <li>• Copy of CB Risk Register.</li> <li>• Copy of actions against Standards for Health Services.</li> <li>• Examples of how health needs assessments have been used to support decision making</li> <li>• CB structure fully recruited to or adequate interim arrangements in place</li> </ul>

<b>Criteria 6</b>	<b>Collaborative arrangements for commissioning and delivering services with other Clinical Boards, the Executive and other partners e.g. Local Authorities and Third Sector</b>	<ul style="list-style-type: none"> <li>• Evidence of plans for effective working with the Clinical System and Institute Leads</li> <li>• Evidence that Clinical Board Operational Plans will not be detrimental to other Clinical Boards</li> <li>• Evidence of joint commissioning and delivery plans with Local Authorities and Third sector as appropriate</li> <li>• Evidence of effectiveness of pooled/aligned budgets where appropriate;</li> <li>• Evidence of effective citizen/patient pathways and referral management</li> <li>• Evidence of identification of opportunities for collaborative working</li> <li>• Evidence that plans are aligned to population health needs</li> <li>• Evidence that plans encompass the whole system from primary through to tertiary care</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of stakeholder mapping exercise if undertaken, or, how CB engages with others to achieve this and plan of how CB will undertake stakeholder mapping.</li> <li>• Examples of how CB engages with other CBs to plan and deliver integrated care.</li> <li>• Examples of collaborative working with other organisations.</li> <li>• Examples of care pathways and service specifications.</li> </ul>
<b>Criteria 7</b>	<b>Great leaders who, individually and collectively, can make a real difference</b>	<ul style="list-style-type: none"> <li>• PADR in place for every member of the Clinical Board and its Directorate management teams and evidence that the development plans are being delivered;</li> <li>• Clear delivery plans to address the “Good to Great” and delivering “Organising for Excellence” agendas</li> <li>• Clinical Board members and Directorate management teams to have completed or have plans to undertake a recognised service improvement programme and/or can evidence a service improvement project they have helped to deliver and its benefits</li> </ul>	<ul style="list-style-type: none"> <li>• PADR compliance rates for CB, and plans to improve where necessary.</li> <li>• CB Development Programme (as previously) to reflect Good to Great</li> <li>• Examples of service improvement programme completed including outcomes, and plans to spread across CB.</li> </ul>

	Level 1	Level 2	Level 3
<b>Freedom 1 Management</b>	Monthly performance review	Quarterly performance review	6 Monthly performance review
<b>Freedom 2 Financial</b>	Year end overall Clinical Board under spend to be carried forward against agreed non recurrent spend in following year	Year End Directorate under spend to be carried forward against agreed non recurrent spend in next year (even if Clinical Board has not under spent)	Under spend at year end to be carried forward by Clinical Board without Health Board scrutiny of plans for it.
<b>Freedom 3</b>	Clinical Board to operate according to former Divisional delegated limits	Delegated limits may be increased for some areas of the budget subject to agreement with Director of Finance	Delegated limits may be adjusted by CB if notified to Director of Finance.
<b>Freedom 4 Recruitment</b>	Apply to Health Systems Management Board to replace consultant medical staff vacancies	Replace medical consultant vacancies	Recruit to new and replacement consultant posts
<b>Freedom 5 Recruitment</b>	Replace vacant posts (excluding consultant medical staff) within agreed structure.	Recruit to and develop new roles and change skill-mix within overall staff resource. Develop overall CB structure for agreement	Recruit to & develop new roles and change skill-mix from total resource including non-staff. Develop and implement own CB Structure
<b>Freedom 6 Financial</b>	Manage fixed and variable pay, within UHB parameters, within overall agreed budget	Control variable pay to suit flexible service need within overall budget	Define and control variable pay/ design of flexible workforce around seasonal and capacity demand trends
<b>Freedom 7 Commissioning</b>	Unable to commission a service usually provided by the UHB from elsewhere e.g. third party unless appropriate planning and commissioning expertise can be demonstrated and approved by the Board Executive Directors	Unable to commission a service usually provided by the UHB from elsewhere e.g. third party unless appropriate planning and commissioning expertise can be demonstrated and approved by the Board Executive Directors	Able to commission a service usually provided by the UHB from elsewhere following proper contracting and procurement processes e.g. third party
<b>Freedom 8 Delivery</b>	Apply to Chief Operating Officer to open or close whole wards and individual beds within agreed Board framework.	Ability to open or close beds within agreed bed base	Ability to open or close wards if ward physical environment is available. This does not include the agreement of Capital Expenditure.
<b>Freedom 9 &amp; 10</b>	To be agreed following assessment to Level 1 to reflect clinical need/specialism within Board		
<b>Note</b>	A Clinical Board can not pursue its agenda to the detriment of another Clinical Board or the organisation as a whole		

	<b>ANNEX TITLE</b>
B.1	Tier 1 & Activity Profiles
B.2	Financial Plan Summary
B.3	Finance – Resource Planning Assumptions
B.4	Finance – Statement of Comprehensive Net Expenditure – 3 yrs
B.5	Finance – Statement of Comprehensive Net Expenditure – Profiles
B.6	Finance – Expected Revenue Resource Limit
B.7	Finance – Year 1 Savings Plan
B.8	Finance – Years 2 & 3 Savings Plan
B.9	Finance – Risks and Mitigating actions
B.10	Finance – Cash Flow
B.11	Workforce summary wte
B.12	Workforce summary £
B.13	Asset Investment Summary
B.14	Asset Investment Detail
B.15	Revenue Funded Infrastructure
B.16	Workforce - Recruitment Difficulties Summary
B.17	Workforce Changes Summary
B.18	Educational Commissioning information

Service Improvement Plan 2014/15	
Improvement in performance compared to March 2014 position:	
No change compared to March 2014 position:	
Decline in performance compared to March 2014 position:	

Cardiff and Vale University Health Board

Number of Tier 1 Measures (inc discretionary trigger)	53
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Area	Source	Deliverable	Target
Need & prevention	PHW	65 years and over	75%
		Uptake of influenza Vaccination among	
		Under 65 years in an at risk group	50%
		Pregnant women	
		Health care workers	
		5 in 1 age 1	95%
		MenC age 1	
		MMR1age 2	
		PCV age 2	
		Hib/MenCX booster age 2	
	PHW	5% of smokers make a quite attempt via smoking cessation services with at least a 40% CO validated quite rate at 4 weeks	Reduction

Position at: Mar-14	2014/15 PROFILED PERFORMANCE - CARDIFF AND VALE UNIVERSITY HEALTH BOARD												
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	
67.8%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	
48.8%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	
42.4%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%	43%	
40.4%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	41%	
84.3%	84.3%			84.3%			84.3%			84.4%			
0.2%	0.4%	0.6%	0.7%	0.9%	1.0%	1.2%	1.3%	1.5%	1.6%	1.8%	1.9%	2%	

				Position at:	2014/15 PROFILED PERFORMANCE - CARDIFF AND VALE UNIVERSITY HEALTH BOARD													
Area	Source	Deliverable	Target	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		
Experience and Access	NWIS	% of patients waiting less than 26 weeks for treatment – all specialties	95%	84%													further work reqd	
		Number of 36 week breaches – all specialties	0	2470	2306	2142	1978	1813	1649	1485	1321	1157	993	828	664	500		
		% of procedures cancelled on more than one occasion by the hospital with less than eight days notice that are subsequently carried out within 14 days of at the patients earliest convenience	100%	19%	30%	30%	30%	60%	60%	60%	80%	80%	80%	90%	90%	90%		
		% of new patients spend no longer than 4 hours in an Emergency Department	95%	88%	94%	94%	94%	95%	95%	95%	95%	95%	95%	90%	90%	90%		
		Eradication of over 12 hour waits within all hospital emergency care facilities	0	144	20	10	0	0	0	0	0	0	0	0	0	0		
		Deliver the 65% Cat A response times	65%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%		
	MH data return	Part 1:80% of assessments by LPMHSS undertaken within 28 days from date of referral	80%	3.9%	0.0%	0.0%	0.0%	16%	29%	42%	55%	68%	80%	80%	80%	80%		
		Part 2: 90% of LHB residents (all ages) to have a valid CTP completed at the end of each month	90%	85%	86%	88%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
		Part 3: Individuals are assessed in a timely manner	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		Part4: 100% of hospitals within each LHB to have arrangements in place to ensure advocacy is available to qualifying patients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Quality and Safety	Cancer Health Stats	Cancer Mortality rate under 75 years per 100,000	Improve	197.2 (for 2011)	197.2	197.2	197.2	197.2	197.2	197.2	197.1	197.1	197.1	197.1	197.1	197.1		
		% of patients referred as non-urgent suspected cancer seen within 31 days	98%	98%	98.0%			98.0%			98.0%			98.0%				
		% of patients referred as urgent suspected cancer seen within 62 days	95%	88%	95.0%			95.0%			95.0%			95.0%				
	Stroke Delivery Unit	Reduction in circulatory disease mortality rate under 75 years per 100,000	Improve	62 (2009 to 2011)	62	62	62	62	62	62	62	61	61	61	61	61		
		1 - First hours bundle	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
		2 - First days bundle	95%	52%	63%	74%	85%	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
		3 - First 3 days bundle	95%	83%	86%	89%	92%	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
		4 - First 7 days bundle	95%	92%	93%	94%	95%	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		



Quality and Safety	PHW	Eradication of Healthcare Acquired Infections	0%															BY March2015 we aim to reduce the avg number of HCAls per
	PHW	Reduction in C Difficile	Improve	210	209	208	206	203	200	195	190	185	179	172	164	155		
	PHW	Reduction Staphylococcus Aureus Bacteraemia (MRSA & MSSA)	Improve	170	169	168	167	164	162	158	154	150	145	139	133	126		
	Nursing dashboard	Reduction in the number of Healthcare acquired pressure ulcers	Improve	585	583	579	573	566	556	544	530	515	497	478	456	432		
		% compliance with Hand Hygiene	Improve	92%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
	CHKS	Demonstrate reduction in the mortality rate of stroke 30 days post event	Improve	15.7%	15.7%			15.7%			15.7%			15.6%				
		Demonstrate reduction in the mortality rate of heart attack 30 days post event	Improve	2.8%	2.8%			2.8%			2.8%			2.7%				
		Demonstrate reduction in the mortality rate of fractured neck of femur 30 days post event	Improve	8.4%	8.4%			8.4%			8.4%			8.3%				
		Reduce Crude & Risk adjusted scores together with mortality reviews	Improve	Crude MA(12): 3.45%	3.45%			3.45%			3.45%			3.45%				
	NWIS	Ensure that the data completeness standards are adhered to within 3 months of discharge	95%	87.5%	90%	90%	90%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
	NWIS	Reduction in the number of emergency hospital admissions for the basket of Chronic conditions	Improve	6946	579	1158	1736	2315	2894	3473	4051	4630	5209	5788	6366	6945		
	NWIS	Reduction in the number emergency hospital readmissions with a year for basket of chronic conditions	Improve	1043	87	174	261	347	434	521	608	695	782	868	955	1042.0		
		Improvement in DTOC delivery per 100,000 of local Authority population MH all ages	Improve	0.54524	0.54	0.54	0.54	0.54	0.54	0.54	0.54	0.54	0.54	0.54	0.54	0.54		
	KAS	Improvement in DTOC delivery per 100,000 of local Authority population non mental Health 75 years and over	Improve	15.3	15.30	15.30	15.30	15.30	15.30	15.30	15.30	15.30	15.30	15.30	15.30	15.29		
		Percentage of GP practices offering appointments between 17:00 and 18:30 on a least two nights per week	Improve	96%	96%			96%			96%			96%				
	ESR	Percentage of GP Practices open during daily core hours or within one hour of daily core hours	Improve	100%	100%			100%			100%			100%				
		% GP practices offering appointments after 5pm	Improve	96%	96%			96%			96%			96%				
		Percentage of staff (excluding medical) undertaking PADR	Improve	61.1%	60%			70%			80%			85%				
		Medical Staff- percentage of staff undertaking Performance Appraisal	Improve	35.1%	40%			50%			60%			70%				
	Finance returns	% of staff completing staff survey in the organisation	Improve	19%	19%			19%			19%			19%				
Overall measure for organisational; climate		Improve	51%															
Achieve annual local Sickness and Absence workforce target <sup>4</sup>		Improve	5.54%	3.6%			3.6%			5.5%			5.1%			average for year = 4.49%		
Financial Balance		Improve	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
	Remain within resource limits	Improve	-19320000	-£1,291,667	-£2,583,333	-£3,875,000	-£5,166,667	-£6,458,333	-£7,750,000	-£9,041,667	-£10,333,333	-£11,625,000	-£12,916,667	-£14,208,333	-£15,500,000			

Notes

Data is on a monthly basis unless specified.

<sup>1</sup> This data shows performance up to the most recent period available. **It does not** take into account the 3 month coding delay, hence data is subject to revisions as coding completeness improves.

<sup>2</sup> This data takes into account the 3 month coding delay and data quality is reliant on coding completeness.

<sup>3</sup> Rolling 12 month data.

<b>LHB MEDIUM TERM FINANCIAL PLANS</b>
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	2014/15	2015/16	2016/17
	£m	£m	£m
<b>1. High Level Summary</b>			
<b>RRL</b>	<b>-758.3</b>	<b>-761.6</b>	<b>-770.3</b>
<b>Other Income</b>	<b>-379.2</b>	<b>-383.3</b>	<b>-385.3</b>
<b>Total Revenue</b>	<b>-1137.5</b>	<b>-1144.9</b>	<b>-1155.6</b>
<b>Comparator - see note below</b>	<b>-808.7</b>	<b>-808.7</b>	<b>-808.7</b>
<b>2 Underlying deficits and cost pressures b/f</b>	<b>-0.9</b>	<b>3.0</b>	<b>-8.2</b>
<b>3 New WG allocations</b>	<b>0.0</b>	<b>-14.2</b>	<b>-8.9</b>
<b>4 New Cost Pressures</b>			
<b>Cost Growth</b>			
Pay Inflation	6.7	6.7	6.7
Pensions Costs	0.0	14.2	8.9
Non pay Inflation	3.8	2.5	2.5
Travel Allowance Changes	0.0	0.0	0.0
Statutory Compliance and National Policy	1.1	0.8	0.8
Continuing Health Care	1.5	0.3	0.3
Funded Nursing Care	0.4	0.1	0.1
Prescribing	0.0	0.0	0.0
<b>Total Inflationary costs</b>	<b>13.5</b>	<b>24.6</b>	<b>19.3</b>
<b>Demand / Service Growth</b>			
NICE and New High Cost Drugs	4.2	2.5	2.5
Continuing Health Care	2.3	1.5	1.5
Funded Nursing Care	0.2	0.1	0.1
Prescribing	5.5	2.5	3.5
Specialist Services	3.8	1.4	1.4
Demographic / Demand on Acute Services	5.0	3.5	3.5
<b>Demand / Growth</b>	<b>21.0</b>	<b>11.5</b>	<b>12.5</b>
<b>Local Service/Cost Pressures</b>			
Unfunded 2014/15 Clinical Board cost pressures	3.2	0.0	0.0
Revenue costs of approved capital schemes	0.2	1.0	0.0
Nursing establishments	2.4	0.0	0.0
GMS	0.4	0.0	0.0
Pharmacy Contract	0.4	0.5	0.5
R&D, SIFT and HCA income reductions	3.0	0.7	0.0
Re-provision of 13/14 non recurrent opportunities	8.8	0.0	0.0
Planned investment	3.7	4.0	7.5
Welsh Risk pool	0.7	0.7	0.7
Strategic Change / Contingency Reserve	7.0	5.0	5.0
<b>Local Cost Base Change</b>	<b>29.8</b>	<b>11.9</b>	<b>13.7</b>
<b>Savings Plans/Cost Avoidance</b>			
Pay & Employee Benefit Expenses	-22.1	-30.3	-35.7
Non Pay	-14.2	-8.4	-8.8
Primary Care Contractor	-0.4	-0.5	-0.5
Medicine Management	-4.1	-3.0	-2.0
Continuing Care and Funded Nursing Care	-3.0	-3.0	-1.0
Commissioned Services	0.0	0.0	0.0
Income	-4.1	-4.8	-2.0
<b>Total Savings Plans</b>	<b>-47.9</b>	<b>-50.0</b>	<b>-50.0</b>
<b>Forecast Outturn</b>	<b>15.50</b>	<b>-13.20</b>	<b>-21.60</b>

Comparator based on H&CHS expenditure - note 3.3 of 2012/13 accounts adjusted as follows

- less Depreciation and Impairments (note 3.3 of the accounts)
- less Hosted Services
- plus Prescribing (note 3.1 of the accounts)
- plus Continuing Health Care (note 3.2 of the accounts)
- plus Funded Nursing Care (note 3.2 of the accounts)

## Resource Planning Assumptions

	All Wales Resource Planning Assumptions			Local Resource Planning Assumptions Used			Commentary on local material difference/update/refinement on All Wales assumptions
	2014/15 % Cost	2015/16 % Cost	2016/17 % Cost	2014/15 % Cost	2015/16 % Cost	2016/17 % Cost	
<b>Inflationary Pressure</b>							<p>Local assessed cost of incremental drift is lower than Welsh average Due to higher proportion of spend on non pay, the local costs are below Welsh average</p> <p>Lower than average forecast inflationary costs</p> <p>2014/15 forecast pressures in HIV and medicine and catch up of pressures from 2013/14</p> <p>2014/15 higher than average due to catch up of pressures from 2013/14 Higher in 2014/15 due to pressures in HCA with WHSSC. Based upon additional costs for RTT, winter pressures, unscheduled care and ICU.</p>
<b>Cost Growth</b>							
Pay Inflation	1.14%	1.11%	1.06%	0.83%	0.83%	0.83%	
Pensions Costs	0.00%	1.84%	1.33%	0.00%	1.76%	1.10%	
Non pay Inflation	0.35%	0.32%	0.38%	0.47%	0.31%	0.31%	
Travel Allowance Changes	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	
Statutory Compliance and National Policy	0.12%	0.12%	0.12%	0.14%	0.10%	0.10%	
Continuing Heath Care	0.29%	0.19%	0.20%	0.19%	0.04%	0.04%	
Funded Nursing Care	0.06%	0.02%	0.02%	0.05%	0.01%	0.01%	
Prescribing	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
<b>Total Cost Growth</b>	<b>1.98%</b>	<b>3.60%</b>	<b>3.11%</b>	<b>1.67%</b>	<b>3.04%</b>	<b>2.39%</b>	
<b>Demand / Service Growth</b>							
NICE and New High Cost Drugs	0.31%	0.29%	0.29%	0.52%	0.31%	0.31%	
Continuing Heath Care	0.29%	0.24%	0.25%	0.28%	0.19%	0.19%	
Funded Nursing Care	0.01%	0.01%	0.02%	0.02%	0.01%	0.01%	
Prescribing	0.30%	0.42%	0.58%	0.68%	0.31%	0.43%	
Specialist Services	0.28%	0.28%	0.26%	0.47%	0.17%	0.17%	
Demographic / Demand on Acute Services	0.64%	0.64%	0.64%	0.62%	0.43%	0.43%	
<b>Total Demand / Service Growth</b>	<b>1.83%</b>	<b>1.88%</b>	<b>2.04%</b>	<b>2.60%</b>	<b>1.42%</b>	<b>1.55%</b>	
<b>Total</b>	<b>3.81%</b>	<b>5.48%</b>	<b>5.15%</b>	<b>4.27%</b>	<b>4.46%</b>	<b>3.93%</b>	

	Assumptions Used		
	2014/15 £'000	2015/16 £'000	2016/17 £'000
<b>Inflationary Pressure</b>			
<b>Cost Growth</b>			
Pay Inflation	6,700	6,700	6,700
Pensions Costs	-	14,200	8,900
Non pay Inflation	3,800	2,500	2,500
Travel Allowance Changes	-	-	-
Statutory Compliance and National Policy	1,100	800	800
Continuing Heath Care	1,500	300	300
Funded Nursing Care	400	100	100
Prescribing	-	-	-
<b>Total Cost Growth</b>	<b>13,500</b>	<b>24,600</b>	<b>19,300</b>
<b>Demand / Service Growth</b>			
NICE and New High Cost Drugs	4,200	2,500	2,500
Continuing Heath Care	2,300	1,500	1,500
Funded Nursing Care	200	100	100
Prescribing	5,500	2,500	3,500
Specialist Services	3,800	1,400	1,400
Demographic / Demand on Acute Services	5,000	3,500	3,500
<b>Total Demand / Service Growth</b>	<b>21,000</b>	<b>11,500</b>	<b>12,500</b>
<b>Total</b>	<b>34,500</b>	<b>36,100</b>	<b>31,800</b>

## STATEMENT OF COMPREHENSIVE NET EXPENDITURE

## REVENUE - ALL SERVICES

	Annual Plan 2014/15	Annual Plan 2015/16	Annual Plan 2016/17
Revenue	£'000	£'000	£'000
1 Revenue resource limit - HCHS	(648,964)	(652,281)	(661,006)
2 Revenue resource limit - Brokerage	0	0	0
3 Revenue Resource Limit - Non recurrent Support	0	0	0
4 Revenue resource limit - Contractor services	(109,331)	(109,331)	(109,331)
5 WHSSC income	(178,863)	(178,863)	(178,863)
6 Income from other Welsh NHS bodies	(82,088)	(82,972)	(83,638)
7 Education, training and research	(48,882)	(50,465)	(51,132)
8 Other income	(49,312)	(50,895)	(51,562)
9 Non cash limited income	(20,064)	(20,064)	(20,064)
<b>10 Total Revenue</b>	<b>(1,137,504)</b>	<b>(1,144,871)</b>	<b>(1,155,596)</b>
<b>Operating Expenses</b>			
11 Pay & Employee Benefit Expenses	517,763	509,513	493,563
12 Non Pay	156,632	141,132	153,042
13 Primary Care Contractor	114,655	114,655	114,655
14 Medicine Management	131,442	133,442	137,442
15 Continuing Care and Funded Nursing Care	45,884	44,884	45,884
16 Commissioned Services	164,779	166,179	167,579
17 Depreciation	21,829	21,829	21,829
<b>18 Total Operating Expenses</b>	<b>1,152,984</b>	<b>1,131,634</b>	<b>1,133,994</b>
<b>19 Forecast (Surplus)/Deficit</b>	<b>15,480</b>	<b>(13,237)</b>	<b>(21,602)</b>

## Note : Services Commissioned From Other NHS Bodies

	Annual Plan 2014/15	Annual Plan 2015/16	Annual Plan 2016/17
Services Commissioned From Other NHS Bodies	£'000	£'000	£'000
20 Abertawe Bro Morgannwg	12,976	12,976	12,976
21 Aneurin Bevan	3,228	3,228	3,228
22 Betsi Cadwaladr	689	689	689
23 Cardiff & Vale	0	0	0
24 Cwm Taf	8,577	8,577	8,577
25 Hywel Dda	712	712	712
26 Powys	30	30	30
27 Welsh Ambulance Service	4,946	4,946	4,946
28 Velindre	17,200	17,200	17,200
29 Public Health Wales	4,883	4,883	4,883
30 WHSSC	107,167	108,567	109,967
31 England	4,371	4,371	4,371
32 Other NHS providers	0	0	0
33 Other NHS providers	0	0	0
<b>34 Total Services Commissioned From Other NHS Bodies</b>	<b>164,779</b>	<b>166,179</b>	<b>167,579</b>

Year 1 Forecasts - 2014/15					
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
<b>Revenue</b>					
1 Revenue resource limit - HCHS	(163,746)	(161,931)	(161,711)	(161,576)	(648,964)
2 Revenue resource limit - Brokerage	0	0	0		0
3 Revenue Resource Limit - Non recurrent Support	0	0	0		0
4 Revenue resource limit - Contractor services	(27,332)	(27,333)	(27,333)	(27,333)	(109,331)
5 WHSSC income	(44,716)	(44,716)	(44,716)	(44,715)	(178,863)
6 Income from other Welsh NHS bodies	(20,522)	(20,522)	(20,522)	(20,522)	(82,088)
7 Education, training and research	(12,220)	(12,221)	(12,220)	(12,221)	(48,882)
8 Other income	(12,328)	(12,328)	(12,328)	(12,328)	(49,312)
9 Non cash limited income	(5,016)	(5,016)	(5,016)	(5,016)	(20,064)
<b>10 Total Revenue</b>	<b>(285,880)</b>	<b>(284,067)</b>	<b>(283,846)</b>	<b>(283,711)</b>	<b>(1,137,504)</b>
<b>Operating Expenses</b>					0
11 Pay & Employee Benefit Expenses	130,637	129,108	129,018	129,001	517,763
12 Non Pay	39,230	39,145	39,130	39,127	156,632
13 Primary Care Contractor	28,664	28,664	28,664	28,664	114,655
14 Medicine Management	32,923	32,840	32,840	32,840	131,442
15 Continuing Care and Funded Nursing Care	11,645	11,529	11,413	11,298	45,884
16 Commissioned Services	41,195	41,195	41,195	41,195	164,779
17 Depreciation	5,457	5,457	5,457	5,457	21,829
<b>18 Total Operating Expenses</b>	<b>289,750</b>	<b>287,937</b>	<b>287,716</b>	<b>287,581</b>	<b>1,152,984</b>
<b>19 Forecast (Surplus)/Deficit</b>	<b>3,870</b>	<b>3,870</b>	<b>3,870</b>	<b>3,870</b>	<b>15,480</b>

Year 2 Forecasts - 2015/16						Year 3 Forecasts - 2016/17				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
<b>Revenue</b>										
1 Revenue resource limit - HCHS	(163,070)	(163,070)	(163,070)	(163,070)	(652,281)	(165,252)	(165,252)	(165,252)	(165,252)	(661,006)
2 Revenue resource limit - Brokerage	0	0	0	0	0	0	0	0	0	0
3 Revenue Resource Limit - Non recurrent Support	0	0	0	0	0	0	0	0	0	0
4 Revenue resource limit - Contractor services	(27,333)	(27,333)	(27,333)	(27,333)	(109,331)	(27,333)	(27,333)	(27,333)	(27,333)	(109,331)
5 WHSSC income	(44,716)	(44,716)	(44,716)	(44,716)	(178,863)	(44,716)	(44,716)	(44,716)	(44,716)	(178,863)
6 Income from other Welsh NHS bodies	(20,743)	(20,743)	(20,743)	(20,743)	(82,972)	(20,910)	(20,910)	(20,910)	(20,910)	(83,638)
7 Education, training and research	(12,616)	(12,616)	(12,616)	(12,616)	(50,465)	(12,783)	(12,783)	(12,783)	(12,783)	(51,132)
8 Other income	(12,724)	(12,724)	(12,724)	(12,724)	(50,895)	(12,891)	(12,891)	(12,891)	(12,891)	(51,562)
9 Non cash limited income	(5,016)	(5,016)	(5,016)	(5,016)	(20,064)	(5,016)	(5,016)	(5,016)	(5,016)	(20,064)
<b>10 Total Revenue</b>	<b>(286,218)</b>	<b>(286,218)</b>	<b>(286,218)</b>	<b>(286,218)</b>	<b>(1,144,871)</b>	<b>(288,899)</b>	<b>(288,899)</b>	<b>(288,899)</b>	<b>(288,899)</b>	<b>(1,155,596)</b>
<b>Operating Expenses</b>					0					0
11 Pay & Employee Benefit Expenses	127,378	127,378	127,378	127,378	509,513	123,391	123,391	123,391	123,391	493,563
12 Non Pay	35,283	35,283	35,283	35,283	141,132	38,261	38,261	38,261	38,261	153,042
13 Primary Care Contractor	28,664	28,664	28,664	28,664	114,655	28,664	28,664	28,664	28,664	114,655
14 Medicine Management	33,361	33,361	33,361	33,361	133,442	34,361	34,361	34,361	34,361	137,442
15 Continuing Care and Funded Nursing Care	11,221	11,221	11,221	11,221	44,884	11,471	11,471	11,471	11,471	45,884
16 Commissioned Services	41,545	41,545	41,545	41,545	166,179	41,895	41,895	41,895	41,895	167,579
17 Depreciation	5,457	5,457	5,457	5,457	21,829	5,457	5,457	5,457	5,457	21,829
<b>18 Total Operating Expenses</b>	<b>282,909</b>	<b>282,909</b>	<b>282,909</b>	<b>282,909</b>	<b>1,131,634</b>	<b>283,499</b>	<b>283,499</b>	<b>283,499</b>	<b>283,499</b>	<b>1,133,994</b>
<b>19 Forecast (Surplus)/Deficit</b>	<b>(3,309)</b>	<b>(3,309)</b>	<b>(3,309)</b>	<b>(3,309)</b>	<b>(13,237)</b>	<b>(5,401)</b>	<b>(5,401)</b>	<b>(5,401)</b>	<b>(5,401)</b>	<b>(21,602)</b>

NOTE : Requirement to submit Monthly Profile will be met as part of Monitoring Returns Submissions

	2014/15 £000s	2015/16 £000s	2016/17 £000s
RRL used in SCNE profiled analysis	-758,295	-761,612	-770,337
Made up of:-			
<b>Allocation Letter/ Resource Planning Figure</b>	-741841	-741841	-741841
<b>Plus the following additional anticipated allocations:-</b>			
<b>DEL</b>			
Substance Misuse	-2153	-2153	-2153
Clinical Excellence/Distinction Awards	-4176	-4176	-4176
Orthopaedics	0	0	0
Provisions Funding	0	0	0
Immunisations (Vaccine & GMS fees) & HPV	-416	-416	-416
SpR Allocation	-687	-687	-687
Palliative Care Funding	-270	-270	-270
Palliative Care Funding - addnal 48k	-48	-48	-48
NHS Redress costs Q1 and Q2	-73	-73	-73
NHS Redress costs Q3 and Q4	-73	-73	-73
Supporting the Carers Strategy (Wales) Measures	-136	-136	-136
Community Pharmacy - Pre Reg trainees	-212	-212	-212
GMS - IM & T Refresh	-1110	-1110	-1110
GMS - Vaccination Programme	-51	-51	-51
Dental - Vocational Trainees	-1626	-1626	-1626
Dental - Dental Foundation Training	-29	-29	-29
Ambulance Radio Replacement and St John's Ambulance Funding	-336	-336	-336
I2S Repayments	942	5825	0
New I2S VERS Funding	-6000	0	6000
Pensions funding	0	-14200	-23100
Depreciation and impairments	TBC	TBC	TBC
<b>AME</b>			
Impairments	TBC	TBC	TBC
Dontaed assets and Government Grant Depreciation	TBC	TBC	TBC
<b>Total RRL used in SCNE profiled analysis</b>	<b>-758295</b>	<b>-761612</b>	<b>-770337</b>
<i>Check total</i>	0	0	0

**Savings Plans:-**

	Year 1 - 2014/15				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
Pay & Employee Benefit Expenses	2,663	4,192	4,282	4,299	15,436
Non Pay	3,483	3,568	3,583	3,586	14,220
Primary Care Contractor	100	100	100	100	400
Medicine Management	958	1,040	1,040	1,040	4,078
Continuing Care and Funded Nursing Care	574	690	806	921	2,991
Commissioned Services	0	0	0	0	0
Income	894	940	990	1,292	4,116
<b>Total</b>	<b>8,672</b>	<b>10,530</b>	<b>10,801</b>	<b>11,238</b>	<b>41,241</b>

**Cost Avoidance / Containment Plans:-**

	Year 1 - 2014/15				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
Pay & Employee Benefit Expenses	1,675	1,675	1,675	1,675	6,700
Non Pay					0
Primary Care Contractor					0
Medicine Management					0
Continuing Care and Funded Nursing Care					0
Commissioned Services					0
Income					0
<b>Total</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>6,700</b>

<b>Total Savings &amp; Cost Containment</b>	<b>10,347</b>	<b>12,205</b>	<b>12,476</b>	<b>12,913</b>	<b>47,941</b>
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**NOTE : Requirement to submit Monthly Profile will be met as part of Monitoring Returns Submissions**

## Health Board

## Cardiff and Vale University Health Board

### Savings Plans:-

	Year 2 - 2015/16					Year 3 - 2016/17				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
Pay & Employee Benefit Expenses	5,913	5,913	5,913	5,913	23,650	7,250	7,250	7,250	7,250	29,000
Non Pay	2,100	2,100	2,100	2,100	8,400	2,200	2,200	2,200	2,200	8,800
Primary Care Contractor	125	125	125	125	500	125	125	125	125	500
Medicine Management	750	750	750	750	3,000	500	500	500	500	2,000
Continuing Care and Funded Nursing Care	750	750	750	750	3,000	250	250	250	250	1,000
Commissioned Services	0	0	0	0	0	0	0	0	0	0
Income	1,188	1,188	1,188	1,188	4,750	500	500	500	500	2,000
<b>Total</b>	<b>10,825</b>	<b>10,825</b>	<b>10,825</b>	<b>10,825</b>	<b>43,300</b>	<b>10,825</b>	<b>10,825</b>	<b>10,825</b>	<b>10,825</b>	<b>43,300</b>

### Cost Avoidance / Containment Plans:-

	Year 2 - 2015/16					Year 3 - 2016/17				
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	Total £'000
Pay & Employee Benefit Expenses	1,675	1,675	1,675	1,675	6,700	1,675	1,675	1,675	1,675	6,700
Non Pay					0					0
Primary Care Contractor					0					0
Medicine Management					0					0
Continuing Care and Funded Nursing Care					0					0
Commissioned Services					0					0
Income					0					0
<b>Total</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>6,700</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>1,675</b>	<b>6,700</b>

<b>Total Savings &amp; Cost Containment</b>	<b>12,500</b>	<b>12,500</b>	<b>12,500</b>	<b>12,500</b>	<b>50,000</b>	<b>12,500</b>	<b>12,500</b>	<b>12,500</b>	<b>12,500</b>	<b>50,000</b>
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## Overview Of Key Upside &amp; Downside Risks

		Financial Challenge 2014/15			Financial Challenge	
		Worse Case	Most Likely	Best Case	2015/16	2016/17
		£'000	£'000	£'000	£'000	£'000
1	Financial Challenge	66,400	63,400	63,400	36,800	28,400
2	Savings plans identified at 31 Jan 14	(47,900)	(47,900)	(47,900)	(50,000)	(50,000)
3	Risk of savings plan delivery	9,580	5,000	5,000		
4	Use of reserves	(4,000)	(5,000)	(5,000)		
5	VERS funding	6,000				
6	Discretionary capital funding not available to support savings delivery	5,000				
7	Welsh Risk Pool	3,000				
8	SIFT redistribution	3,000				
9	Commissioner risks	2,000				
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20		(23,320)	(47,900)	(47,900)	(50,000)	(50,000)
21		43,080	15,500	15,500	(13,200)	(21,600)

## Actions to Mitigate Risks

		2014/15	2015/16	2016/17
		£'000	£'000	£'000
1	Further savings plans being developed	tbc		
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20		0	0	0

## Cash flows 2013/14 to 2016/17

	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
<b>Receipts:</b>				
WG Revenue Funding	758021	736466	739783	720628
WG Capital Funding	63162	92170	33097	7806
Other (incl Non Cash limited)	519435	492650	496700	498700
<b>Total Receipts</b>	<b>1,340,618</b>	<b>1,321,286</b>	<b>1,269,580</b>	<b>1,227,134</b>
<b>Payments:</b>				
Revenue	1157795	1131155	1107806	1105665
Capital	69806	92170	33097	7806
Other	113441	113441	113441	113441
<b>Total Payments</b>	<b>1,341,042</b>	<b>1,336,766</b>	<b>1,254,344</b>	<b>1,226,912</b>
<b>Bank &amp; Cash B/F</b>	961	537	- 14,943	293
<b>Bank &amp; Cash C/F</b>	537	- 14,943	293	515

**NOTE : Requirement to submit Monthly Profile will be met as part of Monitoring Returns Submissions**

## Health Board

## Cardiff and Vale University Health Board

### Workforce Plans - WTE

	Workforce @ 01/04/2014 WTE	2014/15 Profiled Workforce at end of each Quarter				Workforce at end of	
		30/06/2014 WTE	30/09/2014 WTE	31/12/2014 WTE	31/03/2015 WTE	31/03/2016 WTE	31/03/2017 WTE
Core workforce:-							
Board Members	22	22	22	22	22	22	22
Medical & Dental	1245	1243	1243	1241	1241	1195	1145
Nursing & Midwifery Registered	3587	3575	3534	3532	3532	3401	3256
Additional Professional, Scientific and Technical	714	706	706	706	706	655	599
Healthcare Scientists	394	394	394	394	394	387	380
Allied Health Professionals	709	712	712	712	712	683	651
Additional Clinical Services	2496	2436	2433	2433	2432	2367	2296
Administrative and Clerical (inc Senior Managers)	1856	1843	1829	1810	1803	1736	1661
Estates and Ancillary	1145	1103	1103	1103	1103	1068	1030
Students	21	21	21	21	21	21	21
<b>Sub total</b>	<b>12189</b>	<b>12055</b>	<b>11997</b>	<b>11974</b>	<b>11966</b>	<b>11535</b>	<b>11061</b>
Agency/Locum/Bank/Overtime: -							
Board Members							
Medical & Dental							
Nursing & Midwifery Registered							
Additional Professional, Scientific and Technical							
Healthcare Scientists							
Allied Health Professionals							
Additional Clinical Services							
Administrative and Clerical (inc Senior Managers)							
Estates and Ancillary							
Students							
<b>Sub total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total workforce plans</b>	<b>12189</b>	<b>12055</b>	<b>11997</b>	<b>11974</b>	<b>11966</b>	<b>11535</b>	<b>11061</b>

### NOTE

Workforce Plan numbers to be based on Funded Establishment/Budgetted WTE

## Health Board

## Cardiff and Vale University Health Board

### Workforce Plans - £'000

	2014/15 Workforce Quarterly Profile				Workforce Annual	
	Qtr 1 £'000	Qtr 2 £'000	Qtr 3 £'000	Qtr 4 £'000	2015/16 £'000	2016/17 £'000
Core workforce:-						
Board Members	542	542	542	542	2204	2223
Medical & Dental	32670	32670	32620	32620	128119	124082
Nursing & Midwifery Registered	40965	40168	40126	40137	158736	153750
Additional Professional, Scientific and Technical	6287	6188	6394	6270	24626	23850
Healthcare Scientists	5641	5641	5641	5641	22153	21455
Allied Health Professionals	7837	7837	7837	7866	30894	29920
Additional Clinical Services	17366	16832	16846	16854	67964	65822
Administrative and Clerical (inc Senior Managers)	13958	13859	13731	13700	53706	52014
Estates and Ancillary	5250	5250	5250	5250	20620	19971
Students	121	121	121	121	491	476
<b>Sub total</b>	<b>130637</b>	<b>129108</b>	<b>129108</b>	<b>129001</b>	<b>509513</b>	<b>493563</b>
Agency/Locum/Bank/Overtime: -						
Board Members						
Medical & Dental						
Nursing & Midwifery Registered						
Additional Professional, Scientific and Technical						
Healthcare Scientists						
Allied Health Professionals						
Additional Clinical Services						
Administrative and Clerical (inc Senior Managers)						
Estates and Ancillary						
Students						
<b>Sub total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total workforce plans</b>	<b>130637</b>	<b>129108</b>	<b>129108</b>	<b>129001</b>	<b>509513</b>	<b>493563</b>

### NOTE

Workforce Plan numbers to be based on Funded Establishment/Budgets £'000

## Property &amp; Asset Investment

## Summary

	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
<b>Gross Capital Expenditure (approved and unapproved)</b>	<b>93419</b>	<b>41141</b>	<b>7806</b>	<b>7806</b>	<b>7806</b>
less: Receipts	-1249				
<b>Net Capital Expenditure</b>	<b>92170</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
<b>Welsh Government Funding</b>					
Discretionary	18806	7806	7806	7806	7806
Approved Schemes	73364	25291	0	0	0
<b>WG Funding Required</b>	<b>92170</b>	<b>33097</b>	<b>7806</b>	<b>7806</b>	<b>7806</b>

## Key Performance Indicators

	2012-13 as per EFPMS	2018-19 Forecast
	£m	£m
High Risk Backlog Maintenance	0.963	0
	%	%
Physical Condition: % in Category B or above	85	92
Statutory, Safety & Compliance: % in Category B or above	91	96
Functional Suitability: % in Category B or above	81	86
Space Utilisation: % in Category F or above	87	88
Energy Performance: % with Energy B or better	87	90

Property & Asset Investment

Capital Expenditure					
	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
Approved Schemes					
Scheme 1 - CRI Development	120				
Scheme 2 - CRI Remedial Works	1271				
Scheme 3 - Childrens Hospital	12765	406			
Scheme 4 - Specialist Rehab	15244				
Scheme 5 - Adult Acute Mental Health	38539	24049			
Scheme 6 - Neurosciences	2510	508			
Sub Total Approved Schemes Total	70449	24963	0	0	0
Prioritised Schemes					
Scheme 1 - Pendine CMHT	2561	238			
Scheme 2					
Scheme 3					
Sub Total Prioritised Schemes	2561	238	0	0	0
Discretionary					
IT	2140	1500	1500	1500	1500
Equipment	825	1500	1500	1500	1500
Statutory Compliance	1100	806	806	806	806
Estates	14866	4000	4000	4000	4000
Other	1124				
Sub Total Discretionary	20055	7806	7806	7806	7806
Other Capital Expenditure:					
Donated Assets Additions	0	0	0	0	0
Capital Grants	0	0	0	0	0
Other - Rookwoodworks (WG funded)	354	0	0	0	0
Sub Total Other Capital Expenditure	354	0	0	0	0
Gross Capital Expenditure	93419	33007	7806	7806	7806
Receipts					
Land & Property Disposals (list individually)	1249	0	0	0	0
Capital Grants Received					
Donations					
Other					
Sub Total Receipts	1249	0	0	0	0
Net Capital Expenditure	92170	33007	7806	7806	7806

	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
Land and Property Disposals					
Trowbridge Health Centre	250				
Carville House	147				
UHL surplus land (garage)	150				
Radyr Health Centre	120				
Carville Land	582				
Scheme 6					
Scheme 7					
Scheme 8					
Scheme 9					
Scheme 10					
etc					
Total	1249	0	0	0	0

Revenue Implications (Incremental consequences)					
	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
Approved Schemes					
Scheme 1 - Non Cash - DEL	168	168	168	168	168
Scheme 1 - Non Cash - AME					
Scheme 1 - Other Revenue Costs	112	112	112	112	112
Scheme 1 - Revenue Savings					
Scheme 1 - Net Revenue	280	280	280	280	280
Scheme 2 - Non Cash - DEL	0	0	0	0	0
Scheme 2 - Non Cash - AME	3575				
Scheme 2 - Other Revenue Costs					
Scheme 2 - Revenue Savings					
Scheme 2 - Net Revenue	3575	0	0	0	0
Scheme 3 - Non Cash - DEL	166	864	792	792	792
Scheme 3 - Non Cash - AME		19676			
Scheme 3 - Other Revenue Costs	112	1343	1343	1343	1343
Scheme 3 - Revenue Savings					
Scheme 3 - Net Revenue	278	21883	2135	2135	2135
Scheme 4 - Non Cash - DEL	699	809	585	83	83
Scheme 4 - Non Cash - AME		8910			
Scheme 4 - Other Revenue Costs					
Scheme 4 - Revenue Savings					
Scheme 4 - Net Revenue					
Scheme 5 - Non Cash - DEL	109	112	959	959	959
Scheme 5 - Non Cash - AME		30309			
Scheme 5 - Other Revenue Costs					
Scheme 5 - Revenue Savings		-264	-434	-434	-434
Scheme 5 - Net Revenue	109	30157	525	525	525
Scheme 6 - Non Cash - DEL	233	233	233	233	233
Scheme 6 - Non Cash - AME					
Scheme 6 - Other Revenue Costs					
Scheme 6 - Revenue Savings					
Scheme 6 - Net Revenue	233	233	233	233	233
Prioritised Schemes					
Scheme 1 - Non Cash - DEL	0	0	0	0	0
Scheme 1 - Non Cash - AME	0	0	0	0	0
Scheme 1 - Other Revenue Costs:					
Scheme 1 - Revenue Savings					
Scheme 1 - Net Revenue					
Scheme 2 - Non Cash - DEL					
Scheme 2 - Non Cash - AME					
Scheme 2 - Other Revenue Costs					
Scheme 2 - Revenue Savings					
Scheme 2 - Net Revenue					
Scheme 3 - Non Cash - DEL					
Scheme 3 - Non Cash - AME					
Scheme 3 - Other Revenue Costs					
Scheme 3 - Revenue Savings					
Scheme 3 - Net Revenue					
Scheme 4 - Non Cash - DEL					
Scheme 4 - Non Cash - AME					
Scheme 4 - Other Revenue Costs:					
Scheme 4 - Revenue Savings					
Scheme 4 - Net Revenue					
Discretionary Non Cash Costs					
Discretionary Other Revenue Costs					
Discretionary Revenue Savings					
Discretionary Net Revenue					
Other Capital Expenditure:					
Non Cash Costs	945	1890	1890	1890	1890
Other Revenue Costs					
Revenue Savings					
Net Other Capital Expenditure					

**Revenue Funded Infrastructure (including Primary Care and innovative /  
third party funded investments)**

	Scheme Capital Value	Annual Revenue Repayment				
		2014-15	2015-16	2016-17	2017-18	2018-19
<b>Prioritised Schemes (to be named individually)</b>	£m	£m	£m	£m	£m	£m
2014/15 Llanedeyrn refurb option	0.60					
2015/16 Llanedeyrn new build option	3.00					
2015/16 Lansdowne Surgery	0.30					
2015/16 North Cardiff LHTC	4.50					
2015/16 Ely Bridge Surgery	0.30					
2015/16 St Isan Road Surgery	0.25					
2015/16 Other developments	0.20					
2016/17 Ravenscourt	3.00					
2016/17 Other developments	0.10					
<b>Total</b>	<b>12.25</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

No funding source has yet been secured for these developments

## Integrated Planning Framework - Recruitment Difficulties Summary

*This pro forma links to Planning Stage 1*

Professional Group	Role /Specialty	Band / Grade	Reason / impact
Additional Clinical Services	Clinical Psychologist	Band 7-8d	Due to the expensive nature of these roles they tend to be advertised as sessions and not WTE which can cause recruitment issues
	Speech & Language Therapy Assistant posts are not being released from Clearing because of the possibility of displaced staff within the organisation being able to fill these posts.	Bands 3 and 4	This has major impact on the number of children seen. Group therapy numbers in SLT are reduced from 6 to 3 so a reduction of 50%. Band 6 and 7 staff are spending more time photocopying, making resources, sending out letters and having to manage equipment under MDA guidance.
Additional Professional, Scientific & Technical	Perfusionist - Cardiac Surgery	7-8c	Perfusion is recognised nationally as a shortage profession and so recruiting to vacancies can be problematic. Eight staff are employed within the UHB and any vacancies have an impact on the on-call rota of 1 in 4 and can also impact of cardiac surgery activity. The UHB tends to recruit at Trainee level and develops and promotes the staff internally to address this problem however the training period is generally 3 years.
Allied Health Professionals	Physio/OT	Band 5 and 6	These roles are pivotal for Mental Health service user rehabilitation and home and activity assessment however occasionally the roles will be advertised and close with no one applying.
	Clinical neurophysiologist		
	Sonographer		
	Bioinformatician		There is a WG sponsored trainee role in the UHB in response to a national strategic imperative to support genetic/genomic medicine
Estates & Ancillary			
Health Care Scientists			
Medical & Dental	Psychiatry	Generalist and specialty post	This can be problematic to attract people, who can be specialist but also where required cover other services.
	Paediatrics	Specialist Registrar	Recruitment difficulties arising as a result of a shortage of Specialist Registrars arising from gaps left in Roster where Deanery has been unable to allocate a suitable trainee.
	Emergency Medicine (4 posts)	All at middle-grade level (Specialty Trainee & Clinical Fellow)	Emergency Medicine is a problem area nationally. As there are multiple gaps, impact is significant and relies on ad hoc locum & agency cover to plug the shortfall.
	Paediatrics (4 posts)	All at middle-grade level (Specialty Trainee & Clinical Fellow)	Paediatric specialties is a widespread problem and gaps relate to Neonates (2 posts), General Paeds and Paed Surgery. As there are multiple gaps, impact is significant and relies on ad hoc locum & agency cover to plug the shortfall.
Nursing & Midwifery	Healthcare Support Workers for Mental Health Services for Older people	Band 2	Often recruitment might not be a problem retention is a bigger issue and ensuring we have the right people for this sort of care delivery is crucial.



## Integrated Planning Framework – Workforce Changes Summary

This pro forma links to Planning Stage 4

Professional Group	Workforce Change including new / extended roles	In Place / Planned	Band	Identified Benefits
Additional Clinical Services	Training and Development post	Planned	Band 6	This role will support and develop our admin and clerical staff to develop skills and flexibly manage and cover services.
	Increase in band 4 roles decrease of band 5 as part of Play Service modernisation and development of an extended service for weekends.	Planned	Bands 5 and 4	New focused service with clear roles and functions to deliver therapeutic and universal play for the new Children's Hospital
	Introduction of Rehabilitation Support Assistants	Planned	Band 4	This role will be generic and undertake both nursing and therapy duties in support of the qualified staff.
Additional Professional Scientific & Technical	Recruitment to LD psychology post and planned service review	Planned		New service criteria defined
Allied Health Professionals	Special School review	Planned		Equitable provision of Therapy Services to pupils attending Special schools across the UHB. Collaborative working with the LEAs
	Ongoing review of Paediatric Therapy Skill Mix	Ongoing		Safe and sustainable delivery of service across all therapies.
	Additional funding for joint models and external income	Ongoing		Integrated models of working across education and social care
	South Wales Programme impact including the neonatal standards	Planned		MDT rehab business case completed and presented to WHISC. Neonatal pathways in place and audit of staffing being undertaken.
	Children's Hospital	Planned		Relocation of Specialist Services e.g. T&O, into the CHfW will require integration of staff from the adult therapy teams into paediatric services.
	Development of Advanced Practitioners	Ongoing	Band 7	This is being discussed on an all Wales basis so that there is clear progression and competencies required.
	Requirement for specialist grade staff to respond to the impact of increasing incidence of ASD and complex medical conditions	Ongoing	Band 6/7/8	Efficient, safe effective delivery of care. Compliance with the NICE guidelines around diagnosis of ASD and waiting times.
Estates & Ancillary				
Healthcare Scientists				
Medical & Dental	Replacement exiting Neonatal Unit and compliance with Local & Regional requirements and Neonatal standards	Planned		Business Case under development and to be presented to WHISC. Neonatal pathways in place and audit of staffing being undertaken.
	2nd Phase Children's hospital	Planned		Relocation of Specialist Services e.g. T&O, into the CHfW will require integration of staff from the adult therapy teams into paediatric services.
	Development of a single point of access for Paediatric Emergency Admissions			

Nursing & Midwifery Registered	Mental Health Project Manager post for Step down CHC patients. Previously called the Move on team.	To be advertised 2014	Band 8a	This role will need to have project management skills and operate in a senior position to manage the commissioning of services in Mental Health for CHC patients that are currently placed in various settings throughout the UK. This role involves clinical skills and senior management skills also.
	Peer Support Worker roles	To be advertised 2014	Band 2-3	This role is a pivotal appointment following the MHCB winning the NHS prize in 2013 for the initiative. Where peer support workers help service users and support them in the rehabilitation model.
	Senior Mental Health Nursing roles		7-8b	Deliver specific clinical and management skills and provide expertise in interpretation of commissioning agreements.
	Replacement exiting Neonatal Unit and compliance with Local & Regional requirements and Neonatal standards	Planned		Business Case under development and to be presented to WHISC. Neo natal pathways in place and audit of staffing being undertaken.
	2nd Phase Children's hospital	Planned		Relocation of Specialist Services e.g. T&O, into the CHFw will require integration of staff from the adult therapy teams into paediatric services.
	Development of a single point of access for Paediatric Emergency Admissions			
	Development of Community Based Transitional Care Unit			
	Ongoing review of Skill Mix	Ongoing		Safe and sustainable delivery of service across all therapies.
	Review of Community , School Nursing & Health Visiting and Nursing Services			
	Introduction of 'Advanced Critical Care Practitioners'	Planned - currently in training	7/8a	Supports the medical rota and provides better continuity and consistency for patients.
	Introduction of 'Advanced Cardiac Intensive Care Practitioners'	Planned - currently in training	7/8a	Supports the medical rota and provides better continuity and consistency for patients.
	The above roles are also likely to be developed over the next 2-3 years within neurology and cardiology.			

## Integrated Planning Framework – Multi-Professional Education Commissioning

For Academic intake 2015/16				
Course Title	Course duration	Year of output	Band	Commission Requests in Full Time Equivalent (FTE)
Ambulance Paramedics	2 years	2017		
Ambulance Paramedics	1 year	2016		
<b>DENTAL</b>				
Diploma in Dental Hygiene	2 years	2017		11
Degree in Dental Hygiene & Therapy	3 years	2018		10
<b>NURSING &amp; MIDWIFERY</b>				
Bachelor of Nursing (B.N.) Adult	3 years	2018		120
Bachelor of Nursing (B.N.) Child	3 years	2018		20
Bachelor of Nursing (B.N.) Mental Health	3 years	2018		70
Bachelor of Nursing (B.N.) Learning Disability	3 years	2018		
Return To Practice	6 months	2016		
B.Sc. Midwifery	3 years	2018		20
B.Sc. Midwifery	18 months	2017		5
<b>COMMUNITY HEALTH STUDIES</b>				
District Nursing (Part-time)	2 years	2017		
District Nursing Modules (in modules)	1 year	2016		25
Health Visiting (Full-time)	1 year	2016		12
Health Nursing (Part-time)	2 years	2017		3
School Nursing (Full-time)	1 year	2016		1
School Nursing (Part-time)	2 years	2017		2
School Nursing Modules (in modules)	1 year	2016		
Practice Nursing (Part-time)	2 years	2017		
Practice Nursing Modules (in modules)	1 year	2016		3
Community Paediatric Nursing (Part-time)	2 years	2017		3
Community Paediatric Nursing Modules (in modules)	1 year	2016		
CPN (Part-time)	2 years	2017		
CPN Modules (in modules)	1 year	2016		12
CLDN (Part-time)	2 years	2017		
CLDN Modules (in modules)	1 year	2016		
Modules to enable individuals who completed previous module(s) to undertake additional module(s)	1 year	2016		
<b>PHARMACY</b>				
Pharmacy Technician	2 years	2017		2
<b>HEALTHCARE SCIENTIST</b>				
<b>Physiological Science - PTP</b>				
B.Sc. (Hons) Healthcare Science - Cardiac Physiology	3 years	2018		3
B.Sc. (Hons) Healthcare Science - Audiology	3 years	2018		2

Course Title	Course duration	Year of output	Band	Commission Requests in Full Time Equivalent (FTE)
B.Sc. (Hons) Healthcare Science - Respiratory and Sleep Science	3 years	2018		1
B.Sc. (Hons) Healthcare Science - Neurophysiology	3 years	2018		3
Physical and Biomedical Engineering - PTP				
B.Sc. Clinical Engineering in Rehab	3 years	2018		1
B.Sc. (Hons) Healthcare Science - Nuclear Medicine & Radiotherapy Physics	3 years	2018		1
Life Science - PTP				
B.Sc. (Hons) Healthcare Science - Biomedical Science - Blood, Infection, Cellular and Genetics	3 years	2018		3
Clinical Scientist - STP				
M.Sc. in Blood Sciences - Clinical Biochemistry	3 years	2018		1
M.Sc. in Blood Sciences - Genetics	3 years	2018		1
M.Sc. in Clinical Science - Medical Physics	3 years	2018		1
M.Sc. in Clinical Engineering	3 years	2018		1
M.Sc. in cellular Sciences - Reproductive Sciences - Clinical Embryology and Andrology	3 years	2018		
M.Sc. in Infection Science - Clinical Microbiology	3 years	2018		
M.Sc. in Blood Sciences - Clinical Immunology, with a variation to support Histocompatibility & Immunogenetics	3 years	2018		
M.Sc. Clinical Science in Neurosensory Sciences - Audiology	3 years	2018		1
RADIOGRAPHY				
B.Sc. Diagnostic Radiography	3 years	2018		3
B.Sc. Therapy Radiography	3 years	2018		
Assistant Practitioners Radiography - Diagnostic	1 year	2016		1
Assistant Practitioners Radiography - Therapy	1 year	2016		
ALLIED HEALTH PROFESSIONALS				
B.Sc. Human Nutrition - Dietician	3 years	2018		7
PG Diploma Medical Illustration	2 years	2017		2
B.Sc. Occupational Therapy	3 years	2018		7
Diploma in ODP	2 years	2017		10
B.Sc. Physiotherapy	3 years	2018		24
B.Sc. Podiatry	3 years	2018		3
Orthoptist	3 years	2018		1
PhD Clinical Psychology Doctorate	3 years	2018		5
B.Sc. Speech & Language Therapy	4 years	2019		5
B.Sc. Speech & Language Therapy - Welsh Language	4 years	2019		
NON MEDICAL PRESCRIBING				
Full Independent Prescribing	1 year	2016		13
Supplementary Prescribing	1 year	2016		
Limited Independent Prescribing	1 year	2016		

For Academic intake 2016/17				
Course Title	Course duration	Year of output	Band	Commission Requests in Full Time Equivalent (FTE)
Pre Reg Pharmacy	1 year	2017		4
Pharmacy Diploma	2 years	2018		4

#### Additional / new education requirements

Please complete the table below with details of any additional / new education requirements to consider  
– Please note that these entries will not automatically collate when joining different tools together.

Course Title	Course duration	Numbers Required/Comments
BSc (Hons) Healthcare Science - Clinical Engineering (Medical Engineering specialism)	3 years	1 FTE place requested. This course has been approved by HETAG and funding has been confirmed with the Director of WEDS.
MSc Cardiac Science	3 years	2

## Information to inform education commissioning of Medical & Dental Staff

Information on organisations' anticipated future requirement for medical and dental staff is needed to inform education commissioning decisions. In addition to the information on Practice Nurses and Dental Care Practitioners requested in the previous pages, please complete the tables overleaf.

### Please note:

- In each of the tables, please record what you organisation anticipates will be the net change of its medical/dental workforce during the next three years.
- "Net change" means the anticipated increase/decrease in the size of that workforce (in Full Time Equivalent) compared to the previous years.
  - In other words, if an organisation anticipates that it will simply replace all retirees / leavers on a "one for one" basis (i.e. with a new doctor/dentist of the same grade/specialty), then the "net change" would be zero.
  - However, if the organisation anticipates that it will replace all retirees/leavers on a "one for one" basis and also recruit an additional doctor (1.0FTE) in a particular specialty, then the "net change" for that specialty would be +1.0FTE.
- The following should be excluded from the tables on the next few pages:
  - Training grade doctors entering/leaving an organisation as a normal part of their rotation.
  - Doctors moving organisations under TUPE arrangements.
- Please record all figures as Full Time Equivalent (FTE)

### 1) Medical/Dental Consultants (FTE)

Group	Specialty	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)		
		2014	2015	2016
Medicine	Acute Medicine			
	Allergy			
	Audiological Medicine			
	Cardiology			
	Clinical Cytogenetics & Molecular Genetics			
	Clinical Genetics			
	Clinical Neurophysiology			
	Clinical Pharmacology & Therapeutics			
	Dermatology			
	Endocrinology & Diabetes			
	Gastroenterology			
	General (Internal) Medicine			
	Genito-Urinary Medicine			
	Geriatric Medicine			
	Infectious Diseases (& Tropical Medicine)			
	Medical Oncology			
	Neurology			
	Occupational Medicine			
	Palliative Medicine			
	Rehabilitation Medicine			
	Renal Medicine			
	Respiratory Medicine			
	Rheumatology			
	Sport & Exercise Medicine			
Pathology	Chemical Pathology			
	Haematology			
	Histopathology (includes Neuropathology)			
	Immunology			
	Medical Microbiology			
Paeds	Paediatrics			
	Paediatric Cardiology			
	Paediatric Neurology			
Psychiatry	Child & Adolescent Psychiatry			
	Forensic Psychiatry			
	General Psychiatry			
	Old Age Psychiatry			
	Psychiatry of Learning Disability			
	Psychotherapy			
Radiology	Clinical Oncology			
	Clinical Radiology			
	Nuclear Medicine			
Surgery	Cardiothoracic Surgery			
	General Surgery			
	Neurosurgery			
	Maxillofacial Surgery			
	Otolaryngology (ENT)			

**2) Medical/Dental Consultants (FTE) (continued)**

Group	Specialty	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)		
		2014	2015	2016
Surgery (cont'd)	Paediatric Surgery			
	Plastic Surgery			
	Trauma & Orthopaedic Surgery			
	Urology			
Other medical specialties	Anaesthetics			
	Intensive Care medicine			
	Emergency Medicine			
	Obstetrics & Gynaecology			
	Ophthalmology / Medical Ophthalmology			
	Public Health (excluding Dental)			
Dental specialties	Dental Public Health			
	Dental & Maxillofacial Radiology			
	Endodontics			
	Oral Surgery			
	Oral & Maxillofacial Pathology			
	Oral Medicine			
	Oral Microbiology			
	Orthodontics			
	Paediatric Dentistry			
	Periodontics			
	Prosthodontics			
	Restorative Dentistry			
	Special Care Dentistry			
<b>TOTAL CONSULTANT WORKFORCE</b>				

**2) GPs and Dentists (excluding Consultants) (FTE)**

These figures should include all GPs and Dentists, including those working in independent GP/dental practices and those directly employed by the Health Board/Trust (including locums).

- The only exception is for Consultants working in the Hospital Dental Service (HDS), who should be recorded in the table above.
- Commissioning requirement for Dental Care Practitioners and Practice Nurses should be recorded on pages 1-2 of this document.

Type of doctor/dentist	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Total change (2014-2016)
	2014	2015	2016	
General Practitioners (GP)				
General Dental Service (GDS) Dentists				
Community Dental Service (CDS) Dentists				
Other Dentists (excluding HDS Consultants)				

**3) Non-Consultant doctors (FTE) (all specialties combined)**

Please give a broad overview of how your organisation's overall non-consultant medical workforce is likely to change in size during the next three years. It is recognised that the size of an organisation's training grade workforce is not entirely within its control; the forecasts provided by organisations will therefore be triangulated against information from the Wales Deanery.

While specialty-specific information has not been requested below, please feel free to provide additional information (e.g. if the bulk of the forecasted increases/decreases are anticipated to be in specific specialties)

Type of doctor	Anticipated net change in the size of the workforce during each year (Full Time Equivalent)			Total (2014-2016)
	2014	2015	2016	
Non-Consultant Career Grade doctors				
Training Grades: Foundation Grades				
Training Grades: Core level (ST1-ST2)				
Training Grades: Higher level (ST3+)				