Cwm Taf University Health Board

Three Year Integrated Plan

2014/15 – 2016/17

Cwm Taf Cares

Final
(Following Board approval 2 April 2014)

2nd April 2014
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Chief Executive

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Foreword from the Chair and Chief Executive

Allison Williams  
Chief Executive

Dr Christopher Jones CBE  
Chairman

We are very pleased to introduce the Cwm Taf University Health Board three year integrated plan for the period 2014 - 2017. The plan both reflects and builds upon our achievements of the last year and outlines the opportunities and challenges ahead. We are confident that the work outlined in this document positions the University Health Board well to ensure local services are safe and effective and are organised to deliver the best possible outcomes for our patients.

We have made a strong commitment to quality and safety that continues to underpin our system of integrated planning. Within the context of a community that experiences significant challenges in terms of deprivation and the burden of ill-health, the focus is clearly on quality of delivery, improved patient experiences, ensuring optimal access to services, and equity of resources.

Our focus in the plan is on clinically led transformation such as delivering a strengthened primary care service, implementation of the South Wales Programme and an overarching focus on the reduction of health inequalities. We understand the significant challenges in delivering the transformative change set out in this plan. In particular, ensuring we respond effectively to the opportunity of more integrated care, that we reduce the variation in the quality of primary and community care, and that we remain well placed to adapt to an evolving, changing healthcare environment.

The University Health Board has embraced the ideals of co-production, which offers a whole-system approach to public service delivery.
This underlying philosophy values individuals, builds upon their own support systems and considers their place in the wider community. Equally important is our partnership working with service users, carers and the wider public to involve them meaningfully both in decisions about individual treatment and care as well as engagement and consultation about service changes.

The University Health Board’s workforce is clearly its most significant asset and we recognise that to meet the challenges in our Plan, we need to fully engage with our staff and Primary Care contractors to embrace the principles of Working Differently Working Together. We are committed to fully engaging our staff on the way that we will translate our Plan into action and will support our workforce through these changes, working closely together and in partnership with our staff representatives including our Working in Partnership Forum.

We face many challenges over the coming years with growth in our population need, increased costs and significant resource constraints. The next three years will be particularly challenging with further real terms reductions in resource allocations over this period. This will present the most significant challenge of this type that the University Health Board has faced to date. The achievement of a balanced financial plan over the three years of the plan assumes 100% achievement of a cash releasing saving requirement of £71m.

In order to meet such a challenge, while also best addressing the healthcare needs of our local population, the University Health Board understands and is committed to radically redesigning both systems and services in order to ensure that the best value is achieved from its resources. Systems will be better developed to understand the key drivers that affect financial performance and deliver change that secures safety, clinical and financial sustainability for the future.

We are determined that by implementing our transformation programme and by working closely with our partners that we will maximise the resources available to us to ensure that we can continue to deliver safe and effective services to the population of Merthyr Tydfil and Rhondda Cynon Taff. Working together has never been as important and is essential if we are to make our vision a reality.
1. EXECUTIVE SUMMARY

We are pleased to present our draft three year plan (hereafter known as ‘the Plan’) for Cwm Taf University Health Board, for the period 2014/15 to 2016/17. The Plan is an opportunity to both reflect upon the achievements of the last year and the opportunities and challenges ahead. The past twelve months have seen scrutiny and significant financial challenges in the NHS in Wales on an unprecedented scale.

The publication of the Francis Report was a bleak and difficult time for each and every one of us working in the NHS, regardless of which part of the service we work in. The challenge for us in leadership positions in the University Health Board is to create a culture and a plan which we can deliver for the benefit of our population, where compassionate care can flourish and where all staff feel cared for, no matter what challenges we face with budgets and targets.

As it is for all healthcare organisations across the UK, developing a three year plan which meets our objectives of maintaining and improving quality and safety, while achieving cost reductions of around 5.5% each year for the next three years is very challenging for our University Health Board. This is an ongoing challenge we have into the future and this Plan sets out to present a transformational change agenda in order to meet and deliver that challenge.

1.1 Vision & Strategy

Our vision as a University Health Board is to:

Prevent ill health, protect good health and promote better health by providing services as locally as possible and reducing the need for hospital inpatient care wherever possible

- We will prevent ill health, protect good health and promote better health.
- We will provide care as locally as possible wherever it is safe and sustainable.
- Our services will be of the best quality and delivered within efficient, affordable and effective models of care.
- More care will be delivered in primary and community based settings, reducing the need for hospital inpatient care wherever possible.
- We will develop joined-up health and social care services by working with the Local Authorities and Voluntary Sector.
• We will work with our staff, partners and communities themselves, building on strong local relationships and the solid foundations of the past.
• Paying due regard to equality will underpin everything we do.

1.2 Strategic Objectives

The University Health Board has the following five strategic objectives, derived principally from the Institute for Healthcare Improvement (IHI) Triple Aim, which provides a clear framework for our plan. These objectives are:

• To improve quality, safety and patient experience.
• To protect and improve population health.
• To ensure that the services are accessible and sustainable into the future.
• To improve governance and assurance.
• To reduce the per capita cost of care in line with the resources made available to the University Health Board.

As a University Health Board, our key priorities for 2014-15 are:-

• Reduce health inequity.
• Continue to improve patient experience throughout the University Health Board.
• Develop the Clinical Service Strategy, including the South Wales Programme and transitional arrangements.
• Continue to implement ‘Delivering Local Healthcare’.
• Continue to improve unscheduled patient care, patient care, & outpatients, patient flow and urgent care processes.
• Continue to focus attention on improving referral to treatment times.
• Continue work to meet the 62-day cancer target, particularly in urology.
• Improve data quality, including reporting, openness and transparency.
• Improve the health and wellbeing of the workforce and reduce sickness rates.
• Continue to develop our staff engagement and ensure that all staff participate in the appraisal process and have agreed job plans.
• Ensure compliance with legislation.
• Achieve financial balance.
2. HEALTH BOARD PROFILE

2.1 Introduction

Cwm Taf Local Health Board was established on 1 October 2009 and is led by its Chairman, Chief Executive and a Board of Executive Directors, Independent Members and Associate Members.

In July 2013, the Health Board was awarded University Health Board status by the Minister for Health and Social Services and we became Cwm Taf University Health Board (known hereafter as University Health Board or CTUHB). This was an important achievement in our development journey and is a source of pride for the Cwm Taf community. We are confident that this will help us in our ongoing drive to provide high quality, responsive care and services for our community.

2.2 Overview

The University Health Board is responsible for the provision of services to the 289,400 residents of Merthyr Tydfil and Rhondda Cynon Taf. Almost 81% of the population live in Rhondda Cynon Taf Local Authority and the remaining 19% in Merthyr Tydfil. The University Health Board’s catchment population increases to 330,000 when including patient flow from the Upper Rhymney Valley, South Powys, North Cardiff and the Western Vale.

Key Facts

<table>
<thead>
<tr>
<th></th>
<th>Cwm Taf</th>
<th>Wales</th>
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</thead>
<tbody>
<tr>
<td>Areas size</td>
<td>535 km²</td>
<td>20,779 km²</td>
</tr>
<tr>
<td>Total population</td>
<td>289,400</td>
<td>2,980,000</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- males</td>
<td>75.1</td>
<td>76.8</td>
</tr>
<tr>
<td>- females</td>
<td>79.9</td>
<td>81.2</td>
</tr>
<tr>
<td>Persons per km²</td>
<td>540.8</td>
<td>143.4</td>
</tr>
<tr>
<td>% population from ethnic minority background 2001</td>
<td>1.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total births</td>
<td>3,610</td>
<td>34,572</td>
</tr>
<tr>
<td>Total deaths</td>
<td>3,359</td>
<td>32,148</td>
</tr>
<tr>
<td>% lower super output area (LSOAs) in most deprived 5th of Wales</td>
<td>39%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: CTUHB Website

The University Health Board provides a full range of hospital and community based services to the residents of Rhondda Cynon Taf and Merthyr Tydfil. These include the provision of local primary care services; GP Practices, Dental Practices, Optometry Practices and Community
Pharmacy and the running of hospitals, health centres and community health teams. The University Health Board is also responsible for making arrangements for the residents of Rhondda Cynon Taf and Merthyr Tydfil to access health services where these are not provided within Cwm Taf.

Detailed information about the services we provide and our facilities can be found on our website in the section ‘Local Services’. This can be accessed from the home page, or via the following link Our Services.

Cwm Taf’s main hospital and community based sites are:

<table>
<thead>
<tr>
<th>Royal Glamorgan Hospital</th>
<th>Prince Charles Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ysbyty Cwm Cynon</td>
<td>Ysbyty Cwm Rhondda</td>
</tr>
<tr>
<td>Pontypridd &amp; District Cottage Hospital (Y Bwthyn)</td>
<td>Dewi Sant Hospital</td>
</tr>
<tr>
<td>Ysbyty George Thomas</td>
<td>Keir Hardie University Health Park</td>
</tr>
</tbody>
</table>

In the primary care sector, Merthyr Tydfil and Rhondda Cynon Taf has:

- 48 General Medical Practices
- 1 University Board managed GP Practice
- 38 Dental Practices
- 29 Optometrist Practices
- 77 Community Pharmacies

The University Health Board employs on average 6,976\(^1\) whole time equivalent (WTE) staff and has a total pay bill of circa £290M per annum. 6% staff turnover is amongst the lowest in Wales. The following graph highlights how our workforce is made up by staff groups. As the second largest employer in the area, a significant number of our workforce live and work within the communities that we serve.

Breakdown of WTEs by Staff Group

Source: SIPs, Nov 2013

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\(^1\) As at January 2014
The University Health Board’s estate covers a total land area of 74 hectares with buildings having a total gross internal floor area of 178,002m². The estimated value of our property is in the region of £300m, with equipment valued at a further £20m. As a result of the significant investment that has taken place over recent years, the University Health Board’s estate is now the most modern in Wales.

New Emergency Care Centre – Prince Charles Hospital

Ysbyty Cwm Cynon

Keir Hardie University Health Park

2.3 Services Provided

In terms of clinical activity, the University Health Board directly provides, or contracts for the following services each year:

- 807,244 GP Face to Face Contacts
  - 183,414 GP telephone contacts
  - 425,426 Nurse face to face contacts
  - 35,692 Nurse telephone contacts

- 132,783 District Nursing Community Contacts
  - 93% delivered in patients’ own home
  - 4% Residential Homes
  - 57% were for patients over the age of 75

- 923,678 Outpatients Appointments
247,020 new patient appointments
676,656 follow up appointments

- 116,690 Inpatients
  - 17,356 planned/elective
  - 99,334 emergency/non elective
- 39,542 Daycases
- 134,824 A&E Attendances
  - 123,392 new attendances
  - 11,432 follow up attendances

The following table provides a summary of our full year activity for 2012/2013 and activity this year to date.

### Outpatient Activity: Total Activity for 2012/13 & 2013/2014 Year to Date

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Speciality</th>
<th>New Outpatient 2012/13</th>
<th>Follow up 2012/13</th>
<th>Total 2012/13</th>
<th>New Outpatient 2013/14</th>
<th>Follow up 2013/14</th>
<th>Total 2013/14</th>
</tr>
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<tr>
<td>Surgical</td>
<td>General Surgery</td>
<td>9,555</td>
<td>14,187</td>
<td>23,742</td>
<td>4,632</td>
<td>8,139</td>
<td>12,771</td>
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<td></td>
<td>Urology</td>
<td>3,067</td>
<td>8,398</td>
<td>11,465</td>
<td>1,600</td>
<td>4,424</td>
<td>6,024</td>
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<td></td>
<td>Trauma &amp; Orthopaedics</td>
<td>14,544</td>
<td>33,507</td>
<td>48,051</td>
<td>7,954</td>
<td>18,245</td>
<td>26,219</td>
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<td>Sub Total</td>
<td>27,166</td>
<td>56,092</td>
<td>83,258</td>
<td>14,186</td>
<td>30,808</td>
<td>44,994</td>
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<td>Head and Neck</td>
<td>ENT</td>
<td>7,174</td>
<td>14,062</td>
<td>21,236</td>
<td>3,141</td>
<td>6,961</td>
<td>10,102</td>
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<td>Ophthalmology</td>
<td>7,398</td>
<td>29,882</td>
<td>37,280</td>
<td>4,889</td>
<td>13,989</td>
<td>18,878</td>
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<td>Oral Surgery</td>
<td>4,464</td>
<td>7,335</td>
<td>11,799</td>
<td>2,538</td>
<td>4,113</td>
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<td>Restorative Dentistry</td>
<td>298</td>
<td>1,053</td>
<td>1,351</td>
<td>79</td>
<td>396</td>
<td>475</td>
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<td>Orthodontics</td>
<td>594</td>
<td>6,401</td>
<td>6,995</td>
<td>330</td>
<td>1,131</td>
<td>1,461</td>
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<td>Sub Total</td>
<td>19,928</td>
<td>58,733</td>
<td>78,661</td>
<td>10,977</td>
<td>26,590</td>
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<td>600</td>
<td>1,036</td>
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<td>498</td>
<td>934</td>
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<tr>
<td></td>
<td>Sub Total</td>
<td>436</td>
<td>600</td>
<td>1,036</td>
<td>436</td>
<td>498</td>
<td>934</td>
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<td>Acute Medicine</td>
<td>General Medicine</td>
<td>17,841</td>
<td>17,207</td>
<td>35,048</td>
<td>7,228</td>
<td>8,611</td>
<td>15,839</td>
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<td>Gastroenterology</td>
<td>1,696</td>
<td>4,742</td>
<td>6,438</td>
<td>861</td>
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<td>2,425</td>
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<td>Dermatology</td>
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<td>13,043</td>
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<td>4,833</td>
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<td>Respiratory Medicine</td>
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<td>6,334</td>
<td>8,916</td>
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<td>Nephrology</td>
<td>418</td>
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<td>Neurology</td>
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<td>Rheumatology</td>
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<tr>
<td><strong>Care of the Elderly</strong></td>
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<td>0</td>
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<td><strong>7,132</strong></td>
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<td>80</td>
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<tr>
<td><strong>Sub Total</strong></td>
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<td><strong>587</strong></td>
<td><strong>744</strong></td>
<td><strong>80</strong></td>
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Source: Cwm Taf University Health Board Performance Data

**Inpatient Activity: Total Activity for 2012/13 & 2013/2014 Year to Date**
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<tr>
<td>Source: Cwm Taf University Health Board Performance Data</td>
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</table>
As well as delivering services to its local population, the University Health Board provides patient care services to the populations of other health boards. Aneurin Bevan University Health Board is the largest external commissioner of services from Cwm Taf and this reflects the patient flow from the Upper Rhymney Valley.

Where we are unable to provide services locally, usually for more specialist or tertiary services, the University Health Board makes arrangements with other health boards or trusts to provide these services on its behalf. In addition, the Welsh Health Specialised Services Committee (WHSSC) commissions highly specialised services on behalf of all the Welsh Health Boards. In summary for 2012/2013, the financial value of these ‘flows’ were as follows:

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<td>Powys</td>
<td>£0.980</td>
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<td><strong>Total</strong></td>
<td><strong>£35.894</strong></td>
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Source: Cwm Taf University Heath Board Commissioning Plan 2014 -2017

### 2.4 Quality & Patient Experience

**Safe Care, Compassionate Care** (2013), the National Governance Framework to enable high quality care in NHS Wales, has informed the development of the University Health Board’s Quality Strategy and Quality Delivery Plan. The **Triple Aim** is the foundation of our plans, ensuring that our services are:

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

We are committed to ensuring that we put patients and carers at the centre of all our work, engaging and listening to those who use our services to inform our quality improvement priorities and to address any concerns. ‘Cwm Taf Cares’ is our philosophy and the **Quality Strategy** and **Quality Delivery Plan** embrace this to ensure that we deliver services that are safe and effective, by staff that deliver care with compassion.

Putting the patient at the heart of all that we do is fundamental to our vision of ‘Cwm Taf Cares’. It is about the creation of a leadership culture
which nurtures compassionate care. The linkages between the delivery of safe, high quality, patient centred services and staff health and well being is well evidenced. Therefore, part of the ‘Cwm Taf Cares’ philosophy has a strong focus on our staff caring for themselves and each other. The essence of ‘Cwm Taf Cares’ threads through our Quality Strategy and is central to our workforce and organisational development approaches.

In his report, Sir Robert Francis QC, captured the learning against five key themes, underpinned by a fundamental quality improvement culture and the adoption of common values which are built into our Quality Strategy:

- Fundamental standards;
- Openness, transparency and candour;
- Compassionate, caring and committed staff;
- Strong, patient centred healthcare leadership;
- Accurate, useful and relevant information.

Our Plan reflects our drive to further improve quality, safety and efficiency and our approach over the next three years will build on current good practice to optimise these, focusing on the quality improvement priorities across NHS Wales including working closely with the 1000 Lives Improvement Service. This includes:

- Further and sustained improvements in patient flow;
- Inverse Care Law Programme;
- Improving Quality Together – Model for Improvement.
- Accurate, useful and relevant information.

Our Quality Delivery Plan identifies a number of key measures that are regularly reviewed by our Quality Steering Group to determine and support priorities and actions for quality improvement. Triangulation of information and measures, which include patient/carer feedback and review of our Integrated Performance Dashboard, has informed the following five local quality improvement priorities:

- Focus on improving patient flow (including frailty & stroke bundles).
- Improving the pathway for fractured neck of femur patients.
- Reduction of risk of in-hospital and community falls.
- Improving the experience of patients with cognitive impairment/dementia.
- Improving communication: consent, documentation, clinical coding, ‘handover’, discharge planning and creating a culture of care.
We also measure and publish the quality of our service delivery in our Integrated Performance Dashboard with key indicators published for:

- Patient experience/feedback
- Pressure damage
- Infection rates
- Hand hygiene
- Mortality Rates
- Immunisation Rates

Further indicators are also being developed to reflect patient outcomes.

### 2.5 University Health Board Status, Teaching, Research & Development

Securing University Health Board status in 2013 has been a major achievement for Cwm Taf, recognising and helping us build upon the strong relationships that have flourished over the years between ourselves, the University of South Wales and Cardiff University. Strong academic and service partnerships support the promotion of health and wellbeing and high quality, safe and effective patient care, by ensuring the workforce is well educated and trained, the community is well informed and empowered and research opportunities are maximised.

The recently formed Academic Partnership Board is responsible for strategic collaboration between the UHB, the University of South Wales and Cardiff University to deliver our shared strategic goals, to provide and strengthen quality, safety and health improvement, whilst gaining an international reputation for excellence, research and innovation. The Board and its Steering Group provide a formal mechanism whereby the strategic and operational benefits of partnership will be established and integrated across the UHB and local universities.

The University Health Board and our partner universities have a long standing history of collaborative working, with existing and expanding good practice in areas such as degree programme design, delivery and sponsorship. University Health Board status brings further opportunities for collaborative academic ventures and joint academic appointments, the development of new roles and outcome based practice, all of which will help enhance recruitment and retention in the partner organisations.

Cwm Taf University Health Board already has an extensive research and development portfolio, undertaking and supporting high quality collaborative research studies registered on the National Institute for Social Care and Health Research (NISCHR) Clinical Research Portfolio, or are “Pathway to Portfolio” projects. We also support non-commercial research projects in primary and secondary care and public health.
Through the appropriate distribution of the NHS R&D funding allocation CTUHB can provide financial resources where required in support of high quality research. The current portfolio of research includes Sepsis, Paediatrics, Vascular Disease, Mental Health, ENT, Midwifery, Primary Care, Diabetes, Cancer, plus other areas that fall within the research and development priorities identified by the NISCHR, Welsh Government and Cwm Taf University Health Board.

University Health Board status will bring a distinct advantage to the UHB in achieving its strategic aim of increasing the commercial research undertaken across the organisation. An increase in commercial research income would complement the funding received from NISCHR and any successful grant applications. The combined income can then be reinvested into developing the UHB’s research infra-structure, further developing the research activities of all health care professionals. Ensuring that research is integral to the roles and professional development of all health care professionals will be an important step in developing and maintaining a research culture across the organisation. It will also be important for the University Health Board to encourage and support the development of research leadership in addition to research activity, as both are critical in attracting additional research funding into the organisation.

A further exciting development are the plans we have prepared in conjunction with Cardiff University School of Medicine to set out the case for change for provision of an undergraduate medical education facility on the Merthyr Tydfil Health Park site. This is in response to Cardiff University School of Medicine’s proposal to establish a teaching and research base for undergraduate medical trainees at the Merthyr Tydfil Health Park as part of a wider network of community-based teaching hubs.

A Business Justification Case (BJC) was submitted to the Welsh Government in 2012 seeking £2.8m for the construction of a medical undergraduate facility on the Health Park site, to support the introduction and implementation of the C21 curriculum. This business case has been developed and agreed in conjunction with the Cardiff School of Medicine and has recently been approved by the Welsh Government. We are now starting on site with the Centre being completed in early 2015.

Through the continuous development of partnerships with academia and industry, we are at the forefront of research studies investigating priority areas such as Smoking Cessation and Knowledge Transfer. These are important regional level studies, supported financially by Cwm Taf, which aim to develop the evidence base that could change the processes used to reduce smoking in pregnancy and the translation of research findings into
clinical practice. A Research Delivery Group (RDG) has been established by the South East Wales Academic Health Science Partnership (SEWAHSP) with a view to developing a “Citizens Cohort” study called the Cwm Taf Valleys Project. This is a developing collaboration between the UHB, University of South Wales, Public Health and Cardiff University. The research partners may evolve to include bio-informatics and genomics using a population based cohort model.

Our strategic vision of developing Keir Hardie University Health Park as a centre for such research activity will be very attractive for all partners, in addition to helping form the link with the education and training of all health care professionals. The facility has been recently been re-named as the Keir Hardie University Health Park, with office accommodation secured for our researchers and academic partners, at the centre of the community. This will provide a visible and accessible interface with the population served, to encourage recruitment and participation in high quality research.

The success of obtaining University Health Board status will also provide additional opportunities for collaborative research, where combining the skills and resources of the NHS, academia and industry can only serve to raise the quality of the research being undertaken. This will also help with the quality and increase the likelihood of success of future funding applications. The relationships developed with academia and industry has already proved fruitful with success at the MediWales Innovation Awards in 2013, providing an excellent platform on which to develop the research portfolio and partnerships further.

The most important outcome of research activity is to provide the evidence base required to translate robust research findings into clinical practice for the health, clinical improvement and experience of our patients. However, the additional benefits that research and innovation can generate, to include a considerable contribution to the wealth and economic development and stability of the population, should not be underestimated.

During 2014/15 the Academic Partnership Board and Steering Group will develop a Business Plan, Teaching Strategy and joint Research and Development Strategy, formalising our shared priorities into a detailed implementation programme aimed at maximising the opportunities afforded by achieving University Health Board status.

2.6 Workforce

The Board has adopted an organisational development approach to the maturing University Health Board. The intention has been to build capacity and capability from within to enable staff to change, improve
quality of service delivery and continuously enhance performance, improvement and quality improvement trajectories.

Given the health challenges facing the Cwm Taf population and in the context of the Triple Aim philosophy, the priority has been to build leadership capacity and capability amongst key individuals, teams and staff groups, so that they are empowered to take responsibility to make the necessary change happen and so continue to improve our services for patients and the population.

There are a range of definitions in the literature describing ‘organisational development’; the one used which most closely reflects Cwm Taf approach is:

“A planned, holistic approach to improving organisational effectiveness – one that aligns strategy, people and processes”

As we move forward, in the context of ‘Together for Health’ and the agenda set out in ‘Working Differently Working Together’, the Welsh Government’s strategic approach to workforce development; continuing and extending our organisational development cycle and approach is a critical enabler for us to ensure delivery of the Plan.

Optimising the opportunities flowing from being an integrated University Health Board and translating these into tangible results and improvements for our patients and the population, is essential in this next three year cycle. This will only become possible when staff are fully engaged and there is credible clinical leadership distributed throughout the organisation, underpinned by robust management and visionary leadership at the top of the organisation working well with our partners and with a very definitive focus on the primary care setting and the whole patient experience pathway.

In this same cycle, the opportunities from attaining University Health Board status are there now to be reaped. This too will be underpinned by our organisational development approach and will help us achieve our Triple Aim intentions.

The University Health Board’s workforce is clearly its most significant asset and it is through the commitment, professionalism and dedication of our staff that we are able to deliver high quality services to our population. The UHB’s workforce plan is provided in detail in Chapter 7.

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2 The Tayside Centre for Organisational Effectiveness
2.7 Performance

During 2013-14, the University Health Board remained committed to improving services to patients and achieving key targets set locally and by the Welsh Government. Good progress has been made across the University Health Board in 2013/14 including, improved patient flow which has enabled better unscheduled care services, winter planning and capacity for scheduled care service delivery. Annex A1 provides a summary of our progress in 2013/2014.

The University Health Board reports regularly on its performance including the ‘Tier One’ targets set by Welsh Government. The key reporting mechanisms are through the Executive Board, the Board’s Quality and Safety Committee, Finance and Performance Committee and through the Health Board meetings.

The following provides a summary of current performance in a number of key performance and quality target areas, with a fuller snapshot available in our Integrated Performance Dashboard, the latest ‘At a Glance’ details of which are attached at Annex A2.

<table>
<thead>
<tr>
<th>Type of Target</th>
<th>Explanation of Target</th>
<th>How we are performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting the Direction (Primary and Community Care Delivery)</td>
<td>This relates to services provided outside of hospital.</td>
<td>Good progress in establishing locality models which included some surgical services, ENT services and outpatients.</td>
</tr>
<tr>
<td>Dignity in care</td>
<td>This relates to areas of patient experience and how we provide treatment in a dignified way.</td>
<td>Good progress continues to be made in addressing the actions in the Older Person’s Commissioner’s Report which includes enhanced training, communication and the introduction of dignity pledge.</td>
</tr>
<tr>
<td>Quality in Care</td>
<td>This relates to areas such as our infection and immunisation rates.</td>
<td>We are not currently achieving on all three Health Associated Infection indicators. We will continue to focus on reducing these in 2014-15 and throughout the life of our Plan.</td>
</tr>
<tr>
<td>Hospital Mortality Rates</td>
<td>This relates to our death rates for specific conditions compared to similar types of services.</td>
<td>Producing timely mortality information is reliant upon timely clinical coding of consultant episodes. This has previously been a challenging target for the Health Board but significant progress has been made this year. Due to the poor general health of our population as well as other factors, such as no</td>
</tr>
<tr>
<td><strong>Access Elective Referral to Treatment Times</strong></td>
<td>This relates to how long patients wait for planned procedures.</td>
<td>Unfortunately unprecedented winter pressures in 2012/2013 affected the Health Board’s ability to deliver its access targets for elective care. Good progress had been made since however in a number of areas, and we are currently delivering over and above the improvement trajectory we have set. The focus remains to maximise delivery where possible to minimise the number of patients experiencing lengthy waits for treatment.</td>
</tr>
<tr>
<td><strong>Unscheduled Care</strong></td>
<td>This relates to how long people wait to be treated in our Minor Injuries and Emergency departments. It also looks at how long ambulances remain at hospital while patient care is transferred.</td>
<td>Similar to our Elective Services, the unprecedented demand for unscheduled care in 2012/2013 had an adverse effect upon delivery of the A&amp;E access targets. Good progress has since been made however and recovery has been considerable in both the 4 hour target and the ambulance 15 minute handover target. The Health Board remains committed to making further sustainable improvements in all areas of unscheduled care access.</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>This relates to waiting times for those patients referred with either a non-urgent or an urgent suspected cancer.</td>
<td>Achievement of the 31 day target is generally consistent across the year. Delivery of the 62 day cancer target remains a continuing challenge for the Health Board, particularly within Urology and Lung tumour sites but we have seen recent improvement which we are committed to sustaining.</td>
</tr>
<tr>
<td><strong>Efficiency and Productivity</strong></td>
<td>This relates to how we deliver day surgery, when we admit patients for surgery, and how long patients stay in our hospital beds.</td>
<td>Continued improvement including admission on the day of surgery and average length of stay.</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td>This relates to how we treat patients with acute stroke.</td>
<td>Unfortunately there has been variable performance this year in our performance against the stroke care bundles, particularly during our busy times of the year when we have seen an increase in unscheduled care</td>
</tr>
</tbody>
</table>
activity. However most recently, following further local service improvement, including the ring-fencing of stroke beds, we have seen good progress in relation to our targets particularly relating to the acute care of stroke patients.

| Finance and HR Capacity Utilisation | This relates to whether the Health Board achieves financial balance and the achievement of annual local Sickness and Absence workforce targets. | Despite a significant financial challenge during the year, the Health Board met its statutory financial duty in 2012/2013. We have not met the sickness absence target consistently during the year. However, progress has been made with the specialist sickness team continuing to provide support and advice to directorates across the Health Board. By introducing designated HR support the Health Board has seen a noticeable decrease in the number of long term cases that are being supported. |

### 2.8 Financial Overview

CTUHB is forecasting a £3.9m deficit for 2013/2014. This is after factoring in the additional funds allocated by the Welsh Government in October 2013. This level of deficit is lower than planned by the Health Board (£8.1m after taking account of the additional allocation), but this improvement is due to non-recurring improvements. The underlying projected deficit the Health Board will take into the 3 year plan period is £9.0m.

The financial outlook resulting from this underlying deficit and the further real terms reduction in resource allocations over the plan period presents a significant challenge to the University Health Board. The achievement of a balanced financial plan over the three years of the plan assumes 100% achievement on a cash releasing saving requirement of £71m over the next three years. The scale of challenge is greater still if the planned savings from terms and conditions changes are not achieved at an all-Wales level. However, the Health Board has developed strong plans to meet that challenge. The medium term financial plan is shown in detail in Chapter 8 - Finance. This shows that the University Health Board plans to deliver a £2.8m net surplus over the three year period.
2.9 Partnership Working

The University Health Board has embraced the ideals of co-production, which offers a transformative, whole-system approach to public service delivery. This underlying philosophy values individuals, builds upon their own support systems and considers their place in the wider community. This approach requires us to move away from service-led or top-down approaches to one of genuine citizen empowerment, involving service users and their communities in the co-commissioning, co-design and co-evaluation of services. This radically different approach to the planning and provision of health care will need new skills and attitudes, along with health care systems that operate very differently to the way in which they currently work.

This will be challenging, however above all, we recognise that managing the increasing pressures on statutory sector services associated with demographic changes and the growth in health expenditure, needs a ‘transformational’ change. This can only be achieved by developing a genuine and reciprocal partnership between professionals, service-users and their communities with patient centred, inspirational leadership.

Single Integrated Plans

The University Health Board recognises the fundamental principles of working with partners to produce and implement collaborative strategies around Health, Social Care and Wellbeing, Children and Young People and Community Safety. The Local Service Boards (for Rhondda Cynon Taf, Merthyr Tydfil and a Regional Collaboration Board covering both areas) are at the heart of our multi agency planning, agreeing strategic priorities and driving improvements in service areas to tackle the most difficult problems facing our communities.

During 2012/13, each Local Service Board was required to develop a long term Single Integrated Plan (SIP) to replace a number of plans previously produced separately by Strategic Partnerships such as Health, Social Care and Wellbeing and a Children & Young People Framework Plan. The University Health Board is a joint signatory to both SIPs and they have been aligned to the University Health Board’s plans. This can be seen further in the Plan when we come to specific actions and deliverables.
3. LOCAL POPULATION HEALTH NEEDS AND CHALLENGES

All Health Boards have a two-fold role; to look after people when they are ill and also to work closely with their partners to improve the overall health of their local population. Like all Health Boards in Wales, Cwm Taf is facing significant challenges to manage changes in the population and the associated growth in health expenditure.

In this context, we recognise that demographic changes alone will compel us to reform health care. Keeping pace with this increasing demand and the rising costs of health care will require a very different approach. Cutting health care is unlikely to be the solution to this challenge because health ‘need’ will move from one setting to another, potentially costing more. We will need to take an approach that delivers ‘transformation through innovation’ and it is more important than ever that we understand the way our population is changing and that we renew the focus on improving population health overall. Working in partnership with Local Authorities, Third Sector partners and our local community and in particular, embracing the philosophy of co-production, will be a key tenant of our approach.

‘Together for Health’ sets out the tough challenges facing our healthcare system in Wales which it identifies to be – a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

It grouped these challenges into five main themes:-

- Health has improved but not for everyone and our population is ageing;
- Health care quality has improved but the NHS can do even better;
- Expectations are continually rising;
- Medical staffing is becoming a real limitation on our services;
- Funding is limited.

We recognise these as very real challenges reflected in our own local population and are challenges that must face, as we continue to deliver high quality services.

3.1 Population demography

The resident population of the University Health Board area is estimated to have been 294,497 in 2012, accounting for 10 per cent of the Welsh population. Cwm Taf is geographically the second smallest Health Board area in Wales, but also the second most densely populated area.
Compared to the Wales average there are over three times as many people per square km living in the University Health Board area. Within Cwm Taf, 20 per cent of the population live within the County Borough of Merthyr Tydfil with the remaining population living with Rhondda Cynon Taf.

Merthyr Tydfil contains the smallest population whilst Rhondda Cynon Taf has the second largest population of all local authorities in Wales. The catchment population served by the University Health Board increases when including the Upper Rhymney Valley, South Powys, North Cardiff and the Western Vale. Table 1 below illustrates the estimated population and gender numbers by locality (co-terminous with former Borough Councils) across the Cwm Taf University Health Board area, in 2010.

Table 1 – Cwm Taf Resident Population Distribution (2010)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynon Valley</td>
<td>30200</td>
<td>32300</td>
<td>62500</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>27200</td>
<td>28500</td>
<td>55700</td>
</tr>
<tr>
<td>Rhondda Valley</td>
<td>33800</td>
<td>35400</td>
<td>69200</td>
</tr>
<tr>
<td>Taff Ely</td>
<td>50400</td>
<td>52200</td>
<td>102600</td>
</tr>
<tr>
<td><strong>Cwm Taf HB</strong></td>
<td><strong>141600</strong></td>
<td><strong>148400</strong></td>
<td><strong>290000</strong></td>
</tr>
</tbody>
</table>

*rounded to the nearest 100 persons

The age profile of our population is similar to Wales but with slightly higher proportions of persons aged under 5 years and in the 20-44 year age group, and slightly higher proportions of persons aged 60 and over.

In 2012 there were approximately 303,700 individuals registered with Cwm Taf University Health Board general practices. This includes patients registered with practices located at the University Health Board boundary and who live in neighbouring Health Board areas.

Table 2 – Number of practices and total list size, GP clusters in Cwm Taf UHB, 2012

<table>
<thead>
<tr>
<th>GP cluster</th>
<th>No. of practices</th>
<th>Total list size*</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Cynon</td>
<td>6</td>
<td>39,760</td>
</tr>
<tr>
<td>North Merthyr Tydfil</td>
<td>5</td>
<td>31,780</td>
</tr>
<tr>
<td>North Rhondda</td>
<td>7</td>
<td>36,420</td>
</tr>
<tr>
<td>North Taf Ely</td>
<td>5</td>
<td>46,740</td>
</tr>
<tr>
<td>South Cynon</td>
<td>6</td>
<td>20,820</td>
</tr>
<tr>
<td>South Merthyr Tydfil</td>
<td>6</td>
<td>27,400</td>
</tr>
<tr>
<td>South Rhondda</td>
<td>8</td>
<td>44,080</td>
</tr>
<tr>
<td>South Taf Ely</td>
<td>5</td>
<td>56,600</td>
</tr>
<tr>
<td><strong>Health Board Wales</strong></td>
<td><strong>48</strong></td>
<td><strong>303,700</strong></td>
</tr>
</tbody>
</table>

Produced by Public Health Wales Observatory, using WDS (NHSWIS) *Rounded to nearest 10 for ease of reading

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3.2 Cwm Taf Population Projection

Current projections see a rise in the total resident population of Cwm Taf to 298,600 by the year 2033. This is primarily due to a rise in the older population. The number of residents age 75 years and over is projected to rise from 23,300 (7.9 per cent of total population) in 2013 to 37,100 (12.4 per cent of total population) in 2033. The number of persons aged 65 and over resident in Cwm Taf is projected to increase by 37% over the same period. Overall, our population is living longer and the increase in elderly population is likely to result in an increase in the prevalence of chronic conditions such as circulatory and respiratory diseases and cancers.

Meeting the needs of the growing elderly population will be a key challenge for the University Health Board. In the current economic climate, the relative (and absolute) increase in economically dependent and, in some cases, care-dependent populations will pose particular challenges to communities.

3.3 Deprivation

Overall the health of our population is improving however, within the University Health Board we have areas of significant deprivation and far too many people still experience poor health. Many of the causes of poor health are difficult to tackle. Cwm Taf is an economically deprived area, with low levels of employment and educational attainment. These factors,

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along with other aspects of the physical environment, impact on the lifestyles of people living in the Cwm Taf University Health Board area.

Within the University Health Board boundaries there are well recognised areas of deprivation, particularly in the post industrial areas such as in the Rhondda and Cynon Valleys and Merthyr Tydfil as illustrated in Figure 2. Within Cwm Taf, 34% of the resident population live in the most deprived areas of Wales as determined by the Welsh Index of Multiple Deprivation. The University Health Board has the highest proportion of LSOAs\(^5\) in the most deprived fifth in Wales\(^6\).

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**Figure 2 – Pattern of Deprivation, Cwm Taf University Health Board (WIMD 2011)**

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\(^5\) Following the 2001 Census the ONS derived a set of statistical geographies in England and Wales called super output areas to improve the reporting of small area statistics. Lower Super Output Areas (LSOAs) contain around 1,500 people; Middle Super Output Area (MSOA) have a mean population of 7,500. Upper Super Output Areas (USOA) have a mean population of 32,000.

\(^6\) Deprivation fifths for Wales have been produced by ranking all Lower Super Output Areas (LSOAs) and grouping them into five groups (fifths), based on the Welsh Index of Multiple Deprivation (2011).
3.4 Health Inequalities

There is a significant variation in people’s life expectancy across Wales, with those living in the most deprived communities living shorter lives than those in the least deprived areas.

The comprehensive review of health inequalities in England\(^7\) demonstrated the clear causal link between deprivation and poor health. Deprivation is a wider concept than poverty (lack of money) and refers to wider problems caused by a lack of resources and opportunities. The Welsh Index of Multiple Deprivation (WIMD) is constructed from eight different types of deprivation – income, housing, employment, access to service, education, health, community safety and physical environment. The deprivation-health link is demonstrated for Cwm Taf in the maps below, which show that areas of greatest deprivation generally also experience higher mortality in the under 75 age group.

\(^7\) Fair Society: Healthy Lives (The Marmot Review), University College London, 2010
The association between deprivation and health is clearly apparent with the differences in the mortality rates demonstrated between our most deprived communities and least deprived areas (Figure 4).

**Figure 4 - Mortality in males under 75 in Cwm Taf, European age standardised rates (EASR) per 100,000 population**

![Graph showing mortality rates](image)

Source: Public Health Wales Observatory

In excess of 40% of the populations of Rhondda and Cynon Valleys and Merthyr Tydfil live in the most deprived areas of Wales. The proportion is much lower in Taff Ely (19%) yet still represents 19,800 individuals (table 4).

**Table 3 – Population distribution, by deprivation (Cwm Taf Localities)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Least Deprived</th>
<th>Next Least Deprived</th>
<th>Median</th>
<th>Next Most Deprived</th>
<th>Most Deprived</th>
<th>% living in most deprived fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynon Valley</td>
<td>4,200</td>
<td>1,600</td>
<td>14,200</td>
<td>16,600</td>
<td>25,900</td>
<td>41.5</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>1,500</td>
<td>3,000</td>
<td>10,400</td>
<td>17,100</td>
<td>23,800</td>
<td>42.6</td>
</tr>
<tr>
<td>Rhondda Valley</td>
<td>1,400</td>
<td>1,600</td>
<td>8,800</td>
<td>27,700</td>
<td>29,700</td>
<td>42.9</td>
</tr>
<tr>
<td>Taff Ely</td>
<td>24,300</td>
<td>21,900</td>
<td>19,100</td>
<td>17,600</td>
<td>19,800</td>
<td>19.3</td>
</tr>
<tr>
<td>Cwm Taf HB</td>
<td>31,300</td>
<td>28,100</td>
<td>52,500</td>
<td>79,000</td>
<td>99,100</td>
<td>34.2</td>
</tr>
</tbody>
</table>

*Produced by Public Health Wales Observatory, using MYE (ONS) and WIMD 2011 (WG)
*Rounded to the nearest 100 persons

Deprivation not only limits life expectancy\(^8\), it also is a determinant of the age at which we lose our good health. Barnett et al (2012)\(^9\) found that this occurs 10-15 years earlier in those living in the most deprived circumstances compared with the most affluent. Individuals no longer living in ‘good health’ are also more likely to have multiple morbidities, and for mental health issues to be one of their diagnoses. The marked

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\(^8\) Life expectancy is the average number of years an individual of a given age (usually a new born) is expected (in a statistical sense) to live if current age-specific mortality rates continue to apply.

\(^9\) Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross-sectional study, The Lancet, 10.05.12, DOI:10.1016/S0140-6736(12)60240-2
difference in healthy life expectancy\(^\text{10}\) across Wales is shown in Figure 4. In Cwm Taf the healthy life expectancy for women is 60.6 years, the lowest in Wales and statistically significantly shorter than all other Health Board areas. For Cwm Taf males the equivalent is just 60 years, again the lowest in Wales and statistically significantly shorter than all other Health Board areas.

**Figure 5 - Life Expectancy & Healthy Life Expectancy**

**Females**

Life expectancy and healthy life expectancy at birth, ranked health boards, females, 2005-09

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Healthy Life Expectancy</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cwm Taf HB</td>
<td>66.6</td>
<td>78.0</td>
</tr>
<tr>
<td>Aneurin Bevan HB</td>
<td>63.4</td>
<td>79.1</td>
</tr>
<tr>
<td>ABM UHB</td>
<td>64.5</td>
<td>77.9</td>
</tr>
<tr>
<td>Hywel Dda HB</td>
<td>65.7</td>
<td>77.1</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>66.3</td>
<td>77.2</td>
</tr>
<tr>
<td>Powys THB</td>
<td>67.9</td>
<td>76.1</td>
</tr>
<tr>
<td>Betsi Cadwaladr UHB</td>
<td>81.2</td>
<td>81.1</td>
</tr>
</tbody>
</table>

**Males**

Life expectancy and healthy life expectancy at birth, ranked health boards, males, 2005-09

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Healthy Life Expectancy</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cwm Taf HB</td>
<td>66.0</td>
<td>76.4</td>
</tr>
<tr>
<td>Aneurin Bevan HB</td>
<td>61.7</td>
<td>76.5</td>
</tr>
<tr>
<td>ABM UHB</td>
<td>62.0</td>
<td>77.3</td>
</tr>
<tr>
<td>Hywel Dda HB</td>
<td>64.0</td>
<td>77.4</td>
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<td>Cardiff and Vale UHB</td>
<td>64.3</td>
<td>77.2</td>
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<tr>
<td>Powys THB</td>
<td>66.7</td>
<td>77.3</td>
</tr>
<tr>
<td>Betsi Cadwaladr UHB</td>
<td>81.0</td>
<td>81.1</td>
</tr>
</tbody>
</table>

Inequity in life expectancy is also evident within the Cwm Taf area, as illustrated in Figure 6. The difference in life expectancy between males in the most and least deprived areas of Cwm Taf is 8 years. In other words, a male born in the least deprived area of Cwm Taf can expect to live 8 years longer than a male born in the most deprived area. For females the equivalent difference in life expectancy is 6 years.

**Figure 6 – Life expectancy within Cwm Taf**

Life expectancy at birth by fifths of deprivation, Cwm Taf UHB, 2005-09

<table>
<thead>
<tr>
<th></th>
<th>Healthy Life Expectancy</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least deprived</td>
<td>66.8</td>
<td>78.0</td>
</tr>
<tr>
<td>Next least deprived</td>
<td>63.4</td>
<td>79.1</td>
</tr>
<tr>
<td>Middle</td>
<td>64.5</td>
<td>77.9</td>
</tr>
<tr>
<td>Next most deprived</td>
<td>65.7</td>
<td>77.1</td>
</tr>
<tr>
<td>Most deprived</td>
<td>67.9</td>
<td>76.1</td>
</tr>
</tbody>
</table>

**Axis truncated**

\(\text{Males, SII} = 8.0 (6.9; 9.1)\)

\(\text{Females, SII} = 6.0 (4.3; 7.8)\)

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\(^{10}\) Healthy Life Expectancy represents the number of years a person can expect to live in good health, and is often used as a measure of quality of life.
The life expectancy gap between the least and most deprived is widening. Stark differences are further highlighted for healthy life expectancy and disability free life expectancy\textsuperscript{11} within Cwm Taf.

Figure 7
Life expectancy, healthy and disability-free life expectancy at birth, males, Cwm Taf HB 2005-09
Produced by Public Health Wales Observatory, using ADDE/MYE (ONS), WHS/WIMD (WG)

The impact of living for longer in poor health on our health, social care and third sector services, and communities cannot be ignored. The University Health Board has a role in reducing health inequalities through ensuring appropriate access to services and in working with partners to tackle the wider determinants of health.

3.5 Cause of premature mortality

Cancers and circulatory disease were consistently the major causes of premature mortality in Cwm Taf between 1998 and 2008, as illustrated below. Most notable from this data is the significant difference between the two main causes of death in the under 75 year olds and all the other causes.

Cardiovascular (circulatory) disease was selected as the focus of Cwm Taf’s Inverse Care Law Programme as it was one of the major causes of premature mortality in Cwm Taf for which there are clinically and cost effective interventions.

\textsuperscript{11} Disability Free Life Expectancy represents the number of years a person can expect to live free of a chronic condition or Limiting Long Term Illness.
3.6 Lifestyle and Health

There are consistently higher proportions of people reporting key illnesses in Cwm Taf than across Wales. For many of the lifestyles and key illnesses included in the Welsh Health Survey and the GMS Quality and Outcomes Framework, Cwm Taf is statistically significantly worse than Wales.

**Figure 7 – Causes of Premature Death, Cwm Taf UHB**

Cause of Death (under 75) Cwm Taf Health Board 1998 to 2008

Data source: ONS

<table>
<thead>
<tr>
<th>Year</th>
<th>CHD (QOF)</th>
<th>Hypertension (QOF)</th>
<th>Stroke (QOF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2000</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2002</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2004</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2006</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2008</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Public Health Wales Observatory, Cardiovascular disease indicators (WHS & QOF indicators)
The Welsh Health Survey provides information about the health of people living in Wales, the way they use health services and their health related lifestyle. A report produced by the Cwm Taf Public Health Team, using six years of data from the Welsh Health Survey (2003/4-2009) at geographies below Local Authority level, has allowed more detailed analysis of the health of the population and highlights the differences across Cwm Taf\textsuperscript{13}.

The key messages are:

- There are consistently higher proportions of people reporting key illnesses in Cwm Taf than across Wales. The highest percentages of people reporting key illnesses are generally in the Upper Super Output Areas\textsuperscript{14} of Merthyr Tydfil, Rhondda Fach, Rhondda Fawr and South Cynon.

- People living in all areas of Cwm Taf consistently report poorer health and have lower SF-36 physical and mental component summary scores than the average scores across Wales. People living in Merthyr Tydfil, the Rhondda and South Cynon report poorer health status than people living in North Cynon and Taff Ely. The self-reported health status in these areas is statistically significantly poorer than the rest of Wales.

- Health related lifestyles are generally poor in Cwm Taf. Six of the nine USOAs have statistically significantly higher proportions of people with a Body Mass Index (BMI) classed as overweight or obese. With the exception of Merthyr Tydfil North, all USOAs report lower physical activity levels than the rest of Wales; the percentage of adults reporting smoking is higher than for Wales for all USOAs with the exception of North Cynon and South West of Taff Ely. Highest levels of smoking are seen in South Cynon and North Merthyr Tydfil.

- The use of GP and Hospital services varies among USOAs. A statistically significantly higher proportion of people in Rhondda Fach and Merthyr Tydfil North reported attending hospital because of accidents in the previous 3 months.

- The patterns exhibited for many of the indicators show associations between poor outcomes and area deprivation.

A summary of the health and lifestyles measures at sub Local Authority level is shown overleaf\textsuperscript{12}:

\textsuperscript{13} A profile of health and lifestyle in Cwm Taf. Cwm Taf Public Health Team. November 2013

\textsuperscript{14} Upper Super Output Area (USOA) is a statistical geography with a mean population of 32,000. There are nine USOAs in Cwm Taf.
The prevalence of chronic conditions in the Cwm Taf localities can be estimated from the Practice disease registers established as part of the GMS Contract Quality and Outcomes Framework as presented in a recent GP Cluster Report for Cwm Taf.\(^\text{15}\)

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\(^{15}\) GP Cluster Profile available at: [http://www.wales.nhs.uk/sitesplus/922/page/67885](http://www.wales.nhs.uk/sitesplus/922/page/67885)
The absolute numbers are shown below and are likely to be an underestimate of true prevalence.

3.7 Ageing Population and Dementia

Latest statistics predict an increasing proportion of people aged over 65 in the population. In particular, the rising costs of dementia (human, societal and economic) will be felt as our older population increases and the number of people becoming care dependant increases. This will have a significant impact on individuals, carers and health and social care services.
The strength of evidence around dementia prevention is currently limited\textsuperscript{16}. However, the evidence that is available suggests that the best current advice to prevent dementia includes advocating healthy lifestyles\textsuperscript{17,18,19} specifically:

- Stopping smoking
- Reducing alcohol intake
- Eating a healthy diet
- Participating in physical and social activity

It has been estimated that by promoting and adopting healthy lifestyles in middle age, an individual’s risk of developing dementia could be reduced by approximately 20\%\textsuperscript{20}.

### 3.8 Focus on Outcomes

The [NHS Wales Delivery Framework 2013-14 and Future Plans](http://howis.wales.nhs.uk/sitesplus/922/page/52072) provides clarity about the delivery priorities and the need to focus on prevention, standards and outcomes. For public health, the tier 1 targets are smoking and immunisation:


\textsuperscript{17} The Cochrane Collaboration (2011) Dementia and Cognitive Improvement Group. Review of ‘Prevention of Dementia’ Evidence Base. 8-11-2011


\textsuperscript{20} Russ T C, Starr J M. Clinical Evidence Editorial (2010) *Could early intervention be the key in preventing dementia?* BMJ Group
3.8.1 Smoking

Tier 1 Target Domain: Need and prevention

- Smoking
  - 5% of smokers make a quit attempt via smoking cessation services, with at least a 40% Carbon Monoxide (CO) validated quit rate at 4 weeks

The Welsh Health Survey 2011/12 indicates that 26% adults in Cwm Taf are smokers, which equates to approximately 62,000 individuals. To achieve the Tier 1 target, 3100 individuals in Cwm Taf, should make a quit attempt via smoking cessation services annually, and of these at least 40% would need to be carbon monoxide (CO) validated quitters at four weeks.

Within Cwm Taf, approximately 3.8% of the smoking population made a quit attempt in 2013/14, based on quarter 1-3 data. Support is provided through our specialist NHS services, which includes Community Pharmacy, Stop Smoking Wales and a new Maternity Smoking Cessation Support Service (MAMMS) being piloted in the Rhondda. Between 25% (MAMMS) and 40% (community Pharmacy) were validated as quitters at 4 weeks.

In addition to the above target, the Welsh Government has set an ambitious target to achieve a national smoking prevalence rate of 16% by 2020. To achieve this, approximately 7,200, or 11.5% of our smoking population would need to be referred each year to smoking cessation services.

A recent economic study by Swansea University estimates that smoking accounts for:

- 22% adult hospital admission costs
- 6% outpatients costs
- 13% GP consultations
- 12% practice nurse consultation costs
- 14% prescribing costs

The pattern of smoking across Cwm Taf is illustrated below:
At USOA level, 21 to 30 per cent adults reported smoking in Cwm Taf. Seven USOAs reported smoking above the Welsh average of 25 per cent. Smoking in one USOA (Taff Ely South West) was statistically significantly lower than the average for Wales. Two USOAs (Cynon South and Merthyr Tydfil North) were statistically significantly higher than the average for Wales. Chapter 5 outlines the actions we are taking to further reduce smoking prevalence in the Cwm Taf area.

3.8.2 Immunisation

Immunisation is a key public health intervention, preventing significant morbidity and mortality from a number of serious illnesses. High uptake rates are required to achieve "herd immunity". Once herd immunity is achieved little disease circulates in the community, with the effect that unvaccinated individuals are also protected.
**Tier 1 Target Domain: Need and prevention**

- **95% vaccination of all children to age 4 with all scheduled vaccines. (This is the best in Wales)**
- **Immunisation**
  - 75% uptake of influenza vaccination among:
    - 65 years and over
    - Under 65s in at risk groups
    - Pregnant women
  - 50% uptake of influenza vaccine among Health care workers

Immunisation uptake is increasing year on year in all our target groups.

Our level of flu immunisation for patients has increased, but much more work is needed to support all practices to achieve the 75% uptake in all target groups. This is detailed in action plans and will ensure that we continue to increase towards target levels. We have increased our staff immunisation rate from a very low base of 9% to being within reach of the 50% target for 2013/14. Further work will be undertaken for 2014/15 and onwards to achieve and exceed this target.

We achieve the 95% target rate for most of the individual childhood vaccines, but do not yet achieve the composite target. However with the collaborative multi-disciplinary working we have in place this is resulting in increasing rates each quarter. In addition, definitive areas each have their own action plans which are also contributing to increasing uptake.

**3.8.3 Obesity**

Although obesity isn’t currently a tier 1 target for Health Boards, the burden of ill health caused by being overweight and obese has rising health and cost consequences and implications.

Most recent data from the Welsh Health Survey shows that the levels of being overweight and obesity are increasing; 64% of adults in Rhondda Cynon Taff, and 65% in Merthyr Tydfil describe themselves as overweight or obese compared to the Wales average of 58% ([Welsh Health Survey 2011-12](https://www.gov.wales/publications/2011/07/welsh-health-survey-2011-12/)). This is the highest for all Health Boards in Wales and significantly higher than the Wales average of 58%.
A more detailed analysis of Welsh Health Survey data, for Cwm Taf, shows that Cwm Taf Health Board has the highest percentage of the most severely obese people (BMI 40+), compared with other Health Boards in Wales. The numbers of adults that this equates to is startling, with:

- 6,300 adults with a BMI of 40+
- Of these, 900 have a BMI of 50+.

The map, below, illustrates the extent of obesity, by USOA in Cwm Taf (2003/4-2009). Compared with the Wales average of 20%, all areas in Cwm Taf have levels of obesity above 20%.
Data from the All Wales, Child Measurement Programme shows that Cwm Taf has highest prevalence of overweight and obesity in this age group.

**Child Measurement Programme:** % children aged 4/5 who are overweight or obese (2013)

Source: Public Health Wales

Fruit and vegetable consumption for adults and children in Cwm Taf is below the Welsh average, as are physical activity rates.

Chapter 6 outlines the actions we are taking to tackle obesity in the Cwm Taf area.
3.8.4 Alcohol

Alcohol misuse is a major preventable cause of premature mortality, and the estimated annual NHS cost of dealing with alcohol in Wales is between £70-85 million. Alcohol related mortality shows a clear connection with health inequalities, in that whilst alcohol consumption is highest in the least deprived groups, alcohol attributable mortality rates are three times higher in the most deprived groups.

Alcohol consumption above guidelines is higher in Cwm Taf Health Board (45%) than Wales (43%). Binge drinking is statistically significantly higher in Cwm Taf Health Board (30%) than Wales (27%). Rhondda Cynon Taf (31%) has the highest proportion of people reporting binge drinking in Wales (WHS, 2011/12).

![Trend in binge drinking 2003-2012.](image)

Source: Produced by Cwm Taf Public Health Team, using Welsh Health Survey data

3.8.5 Conceptions

Despite a downward trend within Cwm Taf, rates of teenage conceptions have been consistently higher than the Welsh average for many years as illustrated in the graph below. The under 18 conception rate in Merthyr has come down from 54.1 in 2011 to 31.9 in 2012, and in RCT from 40.3 in 2011 to 35.5 in 2012. For comparison, the rate for Wales has reduced from 34.2 in 2011 to 30.8 in 2012.

![Rate of Teenage conceptions (under 18) per 1000 females in age group Cwm Taf (2006-12)](image)
Further analysis of data over a 6 year period (2005-2010) has allowed mapping of conception rates in females aged under 18 years, by electoral division to help inform targeting of services.

The darker shaded areas highlight the electoral wards with higher rates of conceptions for under 18s. Across Cwm Taf, the rates of 19 wards were statistically significantly higher compared to Wales. Action has been targeted to these areas.
Chapter 6 outlines the actions we are taking to reduce teenage conception and alcohol consumption in the Cwm Taf area

In summary, our key messages are:

- By 2033 the population growth in Cwm Taf is projected to result in a 59% increase in the number of residents over 75 years of age.
- The increase in elderly population is likely to result in an increase in prevalence of dementia, chronic conditions such as cardiovascular, respiratory diseases and cancers.
- Of all Health Boards, Cwm Taf UHB has the highest proportion (34%) of its population living in the most deprived areas of Wales; 61% live below the Wales median of deprivation; Deprivation is not confined to small geographical areas; indeed three of the four localities (Merthyr, Cynon and Rhondda Valleys) have in excess of 40% of their population living in areas classed as the most deprived in Wales. As few as 11% of the Cwm Taf population live in the least deprived.
- Residents of Cwm Taf experience the lowest life expectancy in Wales. A male born in Cwm Taf can expect to live 75.4 years (Wales average 77 years), of which only 60 years are in “good” health. Males living in the most deprived areas of Cwm Taf live 23 years, almost one third of their lives with a limiting long term illness or disability.
- Cardiovascular disease and cancers are the major causes of premature mortality (under 75 years) in Cwm Taf residents.
- There are consistently higher proportions of people reporting key illnesses and unhealthy lifestyles in Cwm Taf than across Wales (Welsh Health Survey). The prevalence of chronic conditions is higher in Cwm Taf than the Wales average (GMS Quality and Outcomes Framework) and this is likely to be an underestimate of the true prevalence in the population.
- Teenage conception rates are reducing yet remain among the highest in Wales.
4. STRATEGIC CONTEXT

4.1 Our Journey

The last few years have been very challenging for the University Health Board. It acknowledged its own position in 2011/12 as the start of a journey from ‘turnaround’ to ‘transformation’. The University Health Board is on this journey and is demonstrating the maturity necessary to move towards ‘transformation’ in the next three years, underpinned by a programme of strategic and organisational development.

We are moving further into a ‘developing’ state, with a focus on clinically led transformation such as delivering a strengthened primary and community care service, implementation of the South Wales Programme (SWP) and an over-arching focus on the reduction on health inequalities. Cwm Taf’s Inverse Care Programme is aimed at reducing health inequity through the development of innovative models of community orientated primary care, with targeted provision of highly integrated disease prevention, health promotion and chronic conditions management.

4.2 Priorities

As a University Health Board, our over-arching priorities for 2014-15 are:-

- Reduce health inequity.
- Continue to improve patient experience throughout the University Health Board.
- Develop clinical service strategy, including the South Wales Programme and transitional arrangements.
- Continue to implement ‘Delivering Local Healthcare’.
- Continue to improve unscheduled patient care, patient flow, outpatient and urgent care processes.
- Continue to focus attention on improving referral to treatment times.
- Continue work to meet the 62-day cancer target, particularly in urology.
- Improve data quality, including reporting, openness and transparency.
- Improve the health and well being of the workforce and reduce sickness rates.
- Continue to develop our staff engagement and ensure that all staff participate in the appraisal process and have agreed job plans.
- Ensure compliance with legislation.
- Achieve financial balance.

4.3 Key Messages
4.4 Clinical Strategy

As the basis for our clinical strategy, it is acknowledged that within the University Health Board, we face significant challenges in 2014/2015 and over the following years, particularly in terms of improving health outcomes for our communities, system performance and the financial health of the organisation.

The Future Generations (Wales) Bill looks to future-proof our communities to ensure that they are protected from pressures that threaten their viability and survival. This means that in meeting pressing short term needs, as a University Health Board, we must also make every effort to safeguard the long term interests of our local communities by addressing intergenerational challenges such as health inequalities, raising skills, and mitigating the impact of climate change.
Together for Health sets out the tough challenges facing our healthcare system in Wales which it identifies to be – a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate. It grouped these challenges into five main themes:-

- Health has improved but not for everyone and our population is ageing;
- Health care quality has improved but the NHS can do even better;
- Expectations are continually rising;
- Medical staffing is becoming a real limitation on our services;
- Funding is limited

The report also sets out that the period where rising demands and expectations being largely matched by increased funding are no longer sustainable and it set a challenge to the Health Boards and the people of Wales to recognise that whilst huge strides have been made in recent years, the status quo is no longer an option.

In late 2010, the University Health Board undertook a comprehensive, multi-disciplinary review of all its clinical services in order to assess the fitness of its services to meet its core objectives. This work, together with our own local needs assessment, has identified a range of challenges that were consistent with those identified in Together for Health.

Further work has also been undertaken on more specific local needs assessments, including in areas such as heart disease and critical care, to support the development of our service planning and redesign, and some of the key issues are described in Chapter 3 – Local Health Needs & Challenges. Our local Public Health Strategic Framework 2012-13 also provides further detailed commentary on the health of the communities that we serve and is in congruence with the Public Health Wales 3 Year Plan.

The University Health Board is developing plans for a long term programme based on the Inverse Care Law to increase healthy life expectancy by five years by 2023. The programme is designed to reduce health inequalities through the targeted provision of highly integrated disease preventing and health promoting primary care and community focussed services. Through this and wider work, the University Health Board and the Cwm Taf Public Health Team will continue to work with statutory and third sector partners in implementing local action plans targeted at:
Work is currently underway with our clinicians and partners to refresh our clinical service strategy and determine next steps in our local service planning and delivery, including a strengthened commissioning approach and improved demand management. This is informed by All Wales strategic documents such as ‘Together for Health’ and All Wales Service Delivery Plans, as well as work delivered as part of the South Wales Programme, which is now moving into its implementation phase.

The University Health Board is firmly committed to the need to further improve service integration both within its own clinical services and together in partnership with other Local Health Boards, Local Authorities, the Third Sector and local communities.

Further details can be found in Chapter 6 on our services initiatives and change plans and the Director of Public Health’s Annual Reports including the most recent Annual Reports for 2012 and 2013.

The University Health Board is implementing its whole-system, integrated healthcare strategy for the benefit of our patients and the populations we serve. This is our blueprint for creating healthier communities and ensuring that effective and high quality healthcare services lie at the heart of our service delivery and patient experience.

Primary Care must be the foundation of integrated care, where we support patients by building services around their needs. This requires us to continue to bring processes together both within our organisation and with partners; to bring our professionals further together in the spirit of much closer working and all with the aim of improving outcomes for patients and overall population through the delivery of integrated care. The pace of integration will be accelerated wherever possible and where service outcomes for the patients and populations are clear to see.

- Reducing smoking prevalence rates
- Reducing levels of obesity.
- Reducing teenage pregnancy rates.
- Improving mental health and wellbeing.
- Reducing the harm from alcohol and drugs.
- Increasing vaccination and immunisations rates.
- Reducing accident and injury rates.
The vision for improving health and well-being through improved service delivery across Cwm Taf draws upon a four level model and this is demonstrated below:

In terms of the financial plan, we are looking to build up to £6m investment in order to facilitate the implementation of new service models, excluding changes which may emanate from the South Wales Programme.

When developing our three year efficiency and re-design savings plans, we have been mindful of the requirement to phase in programmes of work to ensure a whole systems approach is being adopted and to target work on improvements where there is the biggest opportunity. To facilitate this, we have identified a number of cross-cutting themes which we have used to plan and prioritise the development of the overall plan.

The themes are organised into five overall strategic categories of change each are set out below:

**Whole Systems Re-design**

- Emergency care
- Frail elderly and rehabilitation care
- Planned care
- Reconfiguration and rationalisation of services
- Estate rationalisation
- Prudent medicine
Commissioning

Efficiency and Productivity

- Theatre productivity
- Outpatient productivity
- Patient care administration
- Diagnostics
- Medical staff productivity
- Nursing productivity
- General workforce productivity
- Back office

Non-pay Management

- Traditional non-pay
- Prescribing
- CHC

All Wales Measures

- Changes to staff terms and conditions

Chapter 6 – Service Change Plans and Initiatives sets out a summary of our service redesign priorities, many are transformational in nature, underpinned by detailed, supporting service delivery plans and linked to workforce and financial plans, as can be seen later within the Plan.

Annex A3 provides summary details of our underpinning service delivery plans across a range of areas including identification of Executive and Clinical Leads, together with planning and implementation groups taking this work forward.

4.5 Prudent Healthcare

The University Health Board is developing the commissioning agenda into the wider commissioning process. This is based on a commissioning cycle that uses evidence of clinical and cost effectiveness to:

- Ensure we are delivering the right services to the right patients.
- Ensure we not only improve services to patients but also to improve the outcomes for patients, improve the health of the population and reduce health inequalities.
- Developing a process to examine the services we provide and then look at the available evidence base for clinical and cost effectiveness. This will be based on the prioritisation work started in Welsh Health Specialised Services Committee (WHSCC).

This is summarised in the diagram below:
This work will continue to be underpinned by clinical engagement and further supported by public health. Our aspiration is to look at the needs of the population and what services are required to meet that need, this approach is linked with that recently announced by the Minister at the NHS Confederation Wales 2014 Conference on ‘prudent healthcare’

As part of this work, we will be willing and engaged partners in the forthcoming workshops to be facilitated by Public Health Wales, mounted by clinicians and working in close partnership with the BMA, to bring people around the table in a desktop exercise, starting with four different areas of treatment and conditions:

- Orthopaedics;
- Pain management;
- Prescribing;
- Ear, Nose and Throat services.

Our local focus will also be linked to work on:

- Clinical pathways for those people with chronic conditions and the frail elderly;
- Review of BMI thresholds (Body Mass Index) as part of clinical pathway development;
- Development and implementation of the podiatry taxonomy;
- Links with smoking cessation programmes.

More importantly the evidence base will not only outline what is clinically and cost effective, it will provide evidence of those groups of patients that have the best ability to receive the optimum benefit from any intervention. That is it allows the identification of criteria for access to services.

The work in WHSSC identified that this allows the prioritisation of resources to achieve best outcomes based on clinical evidence. Not all
patients with the same condition would necessarily see the same optimum outcome from treatment and, often, this requires drill down to identify clinical characteristics that have demonstrated an ability to achieve optimum outcomes.

Directorates/Localities are highlighting areas as part of their plans, where procedures/services we either provide or commission are of no, or limited clinical effectiveness in order to ensure that all of our services are both clinically and cost effective, representing good value for money.

4.6 Performance and Information

4.6.1 Integrated Quality and Performance Dashboard

The University Health Board has in place a comprehensive Integrated Performance Dashboard that is presented monthly at Executive Board and a number of sub-committees and bi-monthly at the University Health Board public meeting as part of our openness and transparency agenda with our public.

Since its inception in October 2012, the performance dashboard has evolved to encompass key performance indicators that cover:

- Need and Prevention
- Quality and Safety
- Experience and Access
- Use of Resources

The report is also segmented to highlight any areas which may be under formal escalation measures by the Welsh Government and is supported by a covering report that seeks to expand on these areas as well as to highlight areas of best practice within the UHB.

4.6.2 Importance of Data Quality

The key to ensuring the Board is kept abreast of any potential areas of concern is data quality and the UHB continually strives to ensure that its data and information is of the highest quality. The Performance and Information team works closely with Clinical Directorates to ensure that the recording of data is as real-time as is possible and that it mirrors the patient pathway.

To that effect, a Data Quality Group has been developed and approved by the Information Governance Group and the Corporate Risk Committee. The policy outlines the UHB’s approach to data quality and is explicit in the responsibilities held by individual staff members.
To ensure ownership of performance monitoring and data quality at an operational level, the Performance and Information Team has developed a Ward Dashboard. As an interactive business intelligence tool, the dashboard facilitates the local production of key performance indicators, with the ability to review changes in delivery over the last three years. Based on quantitative measures currently, the tool will be further developed to include qualitative measures linked to the national Nursing Dashboard.

A Data Quality Steering Group (DQSG) has been established, chaired by one of our consultant surgeons and with a membership consisting of Assistant Directors and Heads of Nursing from all operational areas. The DQSG has developed a Data Quality Audit Programme with an annual timetable covering issues within all areas, clinical and administrative. Findings from these audits inform programmes of work to improve the quality and timeliness of Cwm Taf’s data.

4.6.3 Health Records and Clinical Coding

The development, improvement of standards and completeness in our health records and clinical coding, including the digitisation of our Health Records, is a priority for the University Health Board. Ensuring we are maintaining appropriate health record standards, providing high quality and timely clinical coding information and moving to the latest technology to improve access to the health record for our clinicians is a key enabler as we look to transform our services.

An integral part of this agenda is continuing to improve both the timeliness and quality of our clinical coding. The service is currently provided across three sites, both acute hospitals and at Ysbyty Cwm Cynon. There has been considerable improvement in the timeliness and backlog removal of clinical coding since April 2012 and the department is now focussed on delivering the national targets set for this and next year.

A particular priority at present is the need to focus on further improvement in the quality of our coding and to enhance clinical engagement. Clinical Engagement in an essential component in ensuring that this is delivered consistently and the department has regular presentation slots at Junior Doctor Induction sessions and is scheduled to present at the Medical Leadership Forum in March. Senior consultant engagement has been secured within each specialty area to conduct clinical coding audits and there are plans to align individual coders with lead clinicians to ensure the opportunity for engagement and dialogue is constant.

The Health Records service has traditionally been managed in silos with each of the acute and community hospitals holding their own hospital
and/or specialty records. The result is that there is no full clinical history available to the treating clinician with an inherent clinical risk to the patient. There are also significant storage issues and a range of inherent clinical and operational risks across the Cwm Taf sites. The capacity to rationalise and address these will be created through a new medical records scanning service. Whilst we anticipate that there will be an upfront revenue impact on the UHB for staff to resource the scanning, which we have sought Invest to Save’ funding for, in the longer term, we expect major economies of scale providing benefit in terms of releasing and redeploying staffing resource.

This is a key enabler for the University Health Board to take the tactical step towards achieving a fully computerised electronic health record system in the future. The creation of this electronic health record would resolve storage issues, remove the need for manual handling, eradicate the scenario of un-tracked/misplaced notes, release secretarial time and allow for the disposal of CTUHB properties. The introduction of this technology would liberate the health record to General Practitioners, other health professionals and the patient themselves, being readily available in any Primary care, Community care and Secondary care facilities without the current constraints of geographical location or timeliness.

4.6.4 Profiled Performance

The following table outlines the profiled performance that we will be aiming for as University Health Board, as we strive for improvement in our service provision. The table shows that by the end of 2014/15, we aim to be achieving all the national targets:
### 4.6.5 Demand and Capacity Profiles

In order to ensure that our planning assumptions relating to our service redesign plans and bed reconfigurations, as can be seen later on in the Plan in Chapter 5, are realistic and achievable, a demand and capacity model has been developed. Summary details of this can be seen in Annex A4.

This has allowed operational colleagues, in conjunction with the Information Department to model through efficiencies expected to be gained from the service redesign and the improvements in which we are investing in over the coming months and years. The focus at present has been on the acute surgical and medical wards across the UHB together with Community Hospital rehabilitation and care of the elderly beds.

#### Table: Demand and Capacity Profiles

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<td>% of patients referred as non-urgent suspected cancer starting</td>
<td>Pre April 2013</td>
<td>98%</td>
<td>100%</td>
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<td>% of patients referred as urgent suspected cancer starting treatment within 62 days of referral</td>
<td>Post April 2013</td>
<td>95%</td>
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<td>78.0%</td>
<td>90%</td>
<td>93.3%</td>
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<td>5.7%</td>
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<td>Deaths in hospital with 30 days of Emergency Admission for Hip Fracture - Major Trauma (rolling 12 mths)</td>
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In terms of potential efficiencies the model factors in:

- Volume of admissions
- Length of stay
- Day case rates
- Day of surgery admission rates

The main service redesign solutions, as can be see later on in the plan and which have been factored into the modelling include:

- Implementation of thresholds around BMI and smoking
- Adherence to INNU guidance
- Potential repatriation of Cwm Taf residents from neighbouring Health Boards
- Changes to WAST pathways
- Increased input of acute physicians
- Improved Liaison Psychiatry services
- Close working with Local Authorities to improve response times
- Increased utilisation of the CIAS and @Home services both from Primary and Secondary Care to avoid admission or promote early discharge
- Improved MDT meetings
- Seven day therapy

The modelling shows that with appropriate demand management and closer working with our partners, there is the potential to reduce our bed capacity appropriately, without affecting patient safety and quality and in line with investment in alternative models of care. Based on the work done to date, this should allow for:

- Potential reduction in community hospital bed capacity (up to 2 wards) as a result of reduced length of stay.
- Reconfiguration of beds between Medicine and Surgery to remove the requirement for outliers.
- Potential closure of an acute ward at one of the DGH sites.
- The introduction of a “swing” ward on each acute site to allow increased admissions during times of high demand.

### 4.7 Integration and Partnership Working

The University Health Board is committed to the development of integrated services as part of its clinical strategy, this is underpinned by effective partnership working with a wide range of both public and private sector organisations including, Local Authorities, the Third Sector, our staff, independent contractors, independent sector, Universities, the Community Health Council, volunteers and of particular importance, service users, carers and our wider communities.
We also acknowledge that the publication of the Report of the Commission on Public Service Governance and Delivery as well as the future work of the Commission, will have implications on the current and future arrangements for partnership working and public sector governance and service delivery.

Better health for all is not just about what the NHS can do in isolation. We must tackle the roots of the poor health that blights many of the more deprived communities in Cwm Taf. We must also deliver joined up services across acute and primary care and across health and social care. To do this with the greatest impact, we must ensure our partnership working in the years ahead is more clearly focussed on shared priorities and delivering the best possible services within the resources available to all of the partners working to improve life for the residents of Rhondda Cynon Taf and Merthyr Tydfil.

To enable us to do this, the University Health Board will continue to make a key contribution to the various joint planning mechanisms across both Rhondda Cynon Taf and Merthyr Tydfil including the Local Service Boards, Strategic Partnerships and Compact arrangements with the Third Sector, building on the achievements to date and the positive working relationships developed at both a strategic and operational level. Equally important is our partnership working with service users, carers and the wider public to involve them meaningfully both in decisions about individual treatment and care as well as engagement and consultation about service changes.

The Local Service Boards (for Rhondda Cynon Taf, Merthyr Tydfil and the Regional Collaboration Board (RCB) covering both areas) are at the heart of multi agency planning, agreeing strategic priorities and driving improvements in service areas to tackle the most difficult problems facing our communities. The development in 2012/13 of the Single Integrated Plan (SIP) in both RCT and Merthyr Tydfil has facilitated a more coordinated and effective response, providing a shared set of priorities and actions.

4.7.1 Staff Engagement

The University Health Board’s workforce is clearly its most significant asset and we recognise that to meet the challenges in our Plan, we need to fully engage with our workforce to embrace the principles of “Working Differently Working Together”. We recognise that we will need to take a strategic approach to workforce development and this will include continuing and extending our organisational development cycle. We are committed to fully engaging our staff on the way that we will translate our Plan into service change and will support our workforce through these
changes, working closely together and in partnership with our staff representatives including our Working in Partnership Forum.

4.7.2 Citizen Engagement

The University Health Board is committed to creating a culture that welcomes and facilitates the involvement of patients, relatives and carers from all communities it serves in the development, improvement and monitoring of services and patient care. They can help us to develop and refine solutions to the challenges of providing high quality, sustainable services.

Our proactive work in relation to citizen engagement and patient experience includes:

- Development of the CTUHB’s Citizen Engagement and Patient Experience Plans, based on agreed principles.

- Regular meetings of the University Health Board Stakeholder Reference Group (SRG) are held. The SRG provides advice to the University Health Board, ensuring that a range of stakeholder views (including representatives from local authorities, third sector, community health council, community groups, independent sector, patients and carers) are heard and can influence the planning, design and delivery of services. The SRG also plays a pivotal role in determining the agenda, format and style of the four Locality Public Fora, as well as ensuring the information and feedback gathered at these public meetings is appropriately disseminated, reported and reviewed within the UHB.

- Regular meetings of the CTUHB’s four Locality Public Fora are used as part of our approach to ensure continuous engagement as well as undertaking any formal consultations. We can engage communities on a range of issues and ensure the public has a voice. Topics discussed during 2013-14 include the South Wales Programme, Quality and Patient Experience, Winter Health, Primary Care Services and estate refurbishment.

- Together with our partners in Merthyr Tydfil and Rhondda Cynon Taf Local Service Boards (LSB), delivery of the joint consultation and engagement project funded through the European Social Fund (ESF) which will enable a coordinated approach to consultation activity across and between the LSB partners. Across Cwm Taf, the LSB has developed an online ‘consultation hub’ for consulting with the wider public on local service developments. Partners are able to set projects up in the system, consider whether the work has already been undertaken in a library of best practice, reducing duplication and allowing for more joined up working. There are also tools to develop
questionnaires and analyse results. Linked to the hub is the development of a feedback mechanism to ensure that:

- Consultations are effective;
- Results are being used to improve services, feedback is provided to the public.

- A Citizens' Panel comprising of 1,600 people across Merthyr Tydfil and Rhondda Cynon Taf have signed up to give their views on consultation topics the LSB partners may have.

- Building on the extensive engagement and formal consultation undertaken in relation to the South Wales Programme - we will continue to work with neighbouring health boards on the next phase of the Programme. We will also work closely with the community health council to ensure that engagement is timely and meaningful so that people better understand the case for change and the options being considered. As a result of the extensive work that has been undertaken, we have been able to engage with a wide range of “hard to reach” groups and develop a more robust approach to equality impact assessments.

- Involving children and young people in the planning, delivery and evaluation of services is important, not just from the perspective of improving services, but also in terms of developing confident, engaged and responsible citizens. Some of the activities undertaken during 2013-2014 have been linked to the South Wales Programme consultation process, where specific events and forums were held across Cwm Taf. Representatives of the University Health Board attended youth settings and talked to the young people about our plans to seek and discuss their views and engage them in our work. We have also started working with young people linked to our Reduction in Suicide and Self Harm Strategy to develop appropriate training materials about the issues relating to self harm.

### 4.7.3 Merthyr Tydfil

The vision for the SIP is to strengthen Merthyr Tydfil’s position as the regional centre for the Heads of the Valleys, and be a place to be proud of where:

- People learn and develop skills to fulfil their ambitions
- People live, work, have a safe, healthy and fulfilled life
- People visit, enjoy and return
4.7.4 Rhondda Cynon Taf (RCT)

The vision for the SIP is that people in Rhondda Cynon Taf are safe, healthy and prosperous. The following diagram provides a survey of the partnership’s priorities.

The RCT SIP has also identified common themes running through the Plan:

- Early intervention- with the aim of either preventing things from worsening or, better still, occurring in the first instance.
- Inequalities- ensuring that we focus on our most deprived communities or vulnerable groups
• A culture change within each of the partner organisations ensuring a skilled and flexible workforce
• Better coordination- joining up of services and activities across partner organisations

As can be seen in the diagrams above, there is a significant overlap in the two plans in terms of priorities, particularly relating to healthy lifestyles (e.g. smoking, obesity and substance misuse), mental health and promoting independence (e.g. preventative/early intervention services and facilitating discharge). This is helpful when working collaboratively across the Cwm Taf footprint and in ensuring alignment with our Integrated Plan.

For example, a paper was presented to the RCB in August 2013 to consider whether SIP health priorities relating to smoking, obesity and mental health could be considered as regional partnership projects across Cwm Taf.

The RCB agreed to take forward two specific projects relating to outdoor smoke free places and active environments. In relation to the mental health priority, it was agreed to work together on a strategy to reduce suicide and promote positive emotional wellbeing.

4.7.5 Third Sector

County Voluntary Councils (CVCs)

The University Health Board has developed very positive working relationships with the two County Voluntary Councils (CVCs), i.e. Interlink and Voluntary Action Merthyr Tydfil (VAMT), as demonstrated by the established Merthyr Tydfil Compact Agreement and Rhondda Cynon Taff Compact Agreement and Codes of Practice that underpin them. The open and transparent approach already taken will continue to evolve and strengthen as new or redesigned services emerge.

Third Sector Providers

In terms of access to services closer to home, the University Health Board recognises that our Third Sector partners play an important role in delivering community based services that complement both health and social care provision. We commission a diverse range of services from over twenty organisations that are attuned and complementary to the services provided by the University Health Board. The University Health Board is also committed to engaging with the Third Sector as equal partners in designing and delivering better services together, with improved outcomes for service users and carers. During 2014/15 we will be:

• Agreeing a joint strategic framework for working with the third sector;
• Building on our commissioning arrangements by implementing the outcomes from a review of all Third Sector Service Level Agreements.

4.7.6 Cwm Taf Health and Social Care Economy

In February 2014 the Cwm Taf Health and Social Care Economy; a collaborative partnership of Cwm Taf University Health Board, Interlink (Rhondda Cynon Taf), Voluntary Action Merthyr Tydfil, Merthyr Tydfil County Borough Council and Rhondda Cynon Taf Council developed and submitted a proposal to be considered for funding from the 2014/15 Intermediate Care Fund. The proposal provided the partnership with the opportunity to consider how working together operating a ‘whole system approach’ will strengthen the foundations for further improving the outcomes for local people, providing better experiences for all people receiving services and delivering greater levels of effectiveness and efficiency. The partnership developed a number of local principles to underpin the proposal and this is part of the philosophy of care outlined in the @Home model which is described in section 6.15.6. Details of the funding proposal is outlined in Chapter 8, Finance.

4.7.7 Communities First

A Community Health Development Network (CHDN) has been established to bring together representatives of Communities First Cluster Groups, Cwm Taf University Health Board, Cwm Taf Public Health Team and other community organisations who have a vested interest in reducing health inequalities across Cwm Taf. Through multiagency planning the CHDN will work towards achieving the shared health outcomes within the SIPs and the new Communities First Programme.

4.7.8 Housing

A second multi agency event was co-hosted by the University Health Board in 2013 to consider the potential areas for collaboration between health and housing partners. The 2013 event served to build on the success of the work undertaken in 2012-13 and focussed on three topic areas:

• Asthma and Housing
• Mental Health and Housing
• Energy Efficiency/Fuel Poverty

An action plan is being developed to take forward the priority issues identified by all partners. Following the publication by the Welsh Government in 2013 of the revised Health and Homelessness Standards, the University Health Board with partners is reviewing its work in response to the standards and developing an action plan for 2014/15.
4.7.9 Carers

Working with partners across RCT and Merthyr Tydfil, including carers themselves, we developed the [Cwm Taf Carers Information and Consultation Strategy](#) as required by the [Carers Measure (CM)](#) introduced by Welsh Government. This places a new statutory duty on the UHB to ensure carers get the information and advice they need as well as being involved when decisions are made about the provision of services to the person cared for. Involving service users and carers in treatment decisions and self management where appropriate improves outcomes.

A six month report on progress in 2013/14 was submitted to Welsh Government highlighting a range of activity including:

- Identification of over 70 ‘Carers Champions’ in GP surgeries, hospitals and local authorities, including a ‘Carers Champion Information Sharing Event’ held in March 2014 to ensure networking amongst Carers Champions across health boards and local authorities share carer information with the champions.
- The development and procurement of an e-learning carer awareness training toolkit which is being rolled out across partner agencies. It has also been agreed with the University of South Wales that the toolkit will be used to train students on the nurse degree courses and also shortly to students on social worker courses.
- A Carers Event/Workshop was held in University of South Wales in February 2014 to promote Carer Awareness with university staff.
- Joint presentations with school nurses and welfare officers taking place across the Cwm Taf area to make the necessary connections for increased awareness of ‘Young Carers in Schools’ and therefore increased support to ‘Young Carers’.
- A joint [A-Z Guide for Carers](#) was produced and distributed widely across Cwm Taf.
- Increased awareness raising in GP Surgeries of the Carers Measure, with the Carers Measure Coordinator (CMC) making visits as appropriate to encourage surgeries to recruit Carers Champions.
- Training sessions commissioned from Carers Wales until April 2014 to train newly recruited Carers Champions.

The Carers Measure Steering Group will continue to monitor progress with the implementation of the Strategy and the annual Action plan for 2014/15 developed to support it.
4.7.10 Volunteers

The University Health Board recognises the unique and valuable contribution that volunteers make in complementing our services. Their contributions enrich and extend the range of support provided to service users by providing practical help and support to enhance the patient experience.

A robust process for the recruitment and management of volunteers has been in place since 2010 and volunteering guidelines have been developed for all staff across the organisation. All of our work is being driven forward through our Volunteering Steering Group.

A number of volunteering projects have been established within Cwm Taf:

- Hospital radio
- Meet & Greet Volunteers
- Breast feeding support group
- Chaplaincy volunteers
- Be-friending volunteers
- Volunteer drivers
- Audiology Volunteers
- Maternity Tour Guide volunteers

As highlighted above, we have made good progress to embed volunteering across the organisation, however there is an ongoing need to further development our volunteering programme. Expansion of volunteering services across the organisation is not without its challenges and our key challenges are, identifying funding to reimburse volunteers expenses and recruiting a co-ordinator to lead and manage service expansion.

We have developed strong links with our third sector partners, VAMT and Interlink and we continue to work in partnership to develop volunteering opportunities. We also work with our staff side’ leads to develop a consistent approach to volunteering that deliver benefits both to patients and volunteers themselves.

The University Health Board is currently developing a strategy for volunteering to outline the Health Board’s support for and encouragement of volunteers and voluntary organisations. The strategy will reflect the Rhondda Cynon Taff Compact and Merthyr Tydfil Compact and associated Codes of Practice in place between the Third Sector, Health Board and respective Local Authorities.

During 2014/15 we will be:

- Appointing a Volunteer Coordinator in partnership with the WRVS.
- Developing a Strategy for Volunteering to support the expansion of volunteering across the UHB.

4.7.11 Social Corporate Responsibility (CSR)

Corporate Social Responsibility (CSR) is about ensuring that the University Health Board makes a positive impact on society and aligns social and environmental responsibility to economic goals and value for money. It seeks to raise awareness of the impact that our work has on people and our environment, and the steps being taken to reduce any negative effects. It covers areas related to: -

- Employment
- Procurement
- Environmental Sustainability
- Global Health
- Health and Wellbeing

As a large employer providing public services and spending public money, our activities need to take place in the most sustainable way, and we want to lead by example and make a contribution to our local communities, acting as a catalyst to improve lives. This can only be achieved through:

- Seeking to deliver the best and most ethical healthcare through developing and promoting services and products that we buy that support a more sustainable way of life.
- Measuring and publicly report on our environmental impact and setting challenging targets to lower our impact on the environment.
- Seeking to foster strong positive relationships with our diverse local community and staff and meeting diverse need, promoting social mobility and tackling inequality.
- Teaming up with suppliers to minimise impacts: sourcing more sustainable and local products and services where possible, with particular emphasis on carbon emissions.
- Giving our employees information to increase their awareness of the impact of their actions on the planet both at work and at home.
- Working in partnership with our local and business communities in ways that meet their environmental, economic and social needs and has a positive effect on our business.
- Using our influence and resources to support international health development, and enrich our community through shared learning.
- Promoting healthy and sustainable lifestyles for our patients and staff and enabling them to take responsibility for their own health and well being.
We already have a number of initiatives and schemes being taken forward as part of CSR and examples of these include careers events, Job Growth Wales initiatives, volunteering programmes and the ‘Big Bite’ event. We believe that by working towards the aims of corporate social responsibility we will also:

- Ensure service excellence;
- Make the best use of resources;
- Provide a great place to work;
- Be responsive and accountable to our communities

### 4.7.12 Work Experience

**New Innovation - Merthyr Healthcare Academy**

In September 2013 the first cohort of A-level students commenced their academic programmes in The College, Merthyr Tydfil. The Head of Science at the college and key representatives from Cwm Taf University Health Board worked in partnership to create an innovative “Healthcare Academy”. The Healthcare Academy was designed to provide education, training and work experience opportunities for students, followed by university application guidance and support for those students aspiring to a career in healthcare. The Academy aims to promote local initiatives in South Wales, and facilitate career opportunities for the future workforce within the community. The programme is delivered at The College, Merthyr Tydfil and facilitated by a wide variety of professionals from Cwm Taf University Health Board.

### 4.8 Integrated Assessment Process

*Integrated Assessment, Planning and Review Arrangements for Older People* sets out a process for delivering integrated assessment processes and is a key part of implementing the *Framework for Older People with Complex Needs*. This guidance replaces the Unified Assessment Process (UAP) in its application to people agreed 65 years and over.

The University Health Board is working collaboratively with its partners, Merthyr Tydfil and Rhondda Cynon Taf Local Authority respectively, to implement the requirements for the Integrated Assessment Process as set out in the guidance. A formal joint planning and implementation process has been established and progress is reported to the Localities Partnership Board.

### 4.9 Equality and Diversity

The University Health Board is committed to the principles of equality and diversity and the importance of meeting the needs of the nine protected
groups under the Equality Act 2010. We are required to meet the general duty under the public sector equality duty which is to:

- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not;
- Eliminate unlawful discrimination, harassment and victimisation.

The University Health Board’s four specific objectives, as agreed in the strategic equality plan and which must be taken into account in the development of the Integrated Plan are:

- Better health outcomes for all.
- Improved patient access and experience.
- Empowered, engaged and included staff.
- Inclusive leadership at all levels.

A fifth ‘stand-alone’ objective is to identify gender pay difference which is being addressed as part of a national research project led by Cardiff University.

Finally, the equality impact assessment is fundamental to planning, whether in the development, change or withdrawal of services and this must be conducted in accordance with the Brown principles, with particular reference to paying ‘due regard’ to the needs of different groups within our workforce and our community. This will occur in detail in the development of our underpinning, specific service, directorate and locality plans.

### 4.10 Bilingual Skills Strategy

Welsh legislation saw the introduction of compulsory Welsh Language Schemes for public sector bodies within Wales. Health Boards implemented these Schemes and reported on progress against national and local targets each year.

Since the appointment of the Welsh Language Commissioner, a new set of Welsh Language Standards will be imposed upon public bodies within Wales as part of a rolling programme. As part of the University Health Board’s obligations to fulfilling the requirements and targets of its existing statutory Welsh Language Scheme, Health Boards within Wales have agreed to create and implement a Linguistic Bilingual Skills Strategy.

The strategy will look at how the University Health Board’s workforce can strategically deliver services through the medium of Welsh to the Welsh
speaking public within Cwm Taf. The strategy will focus on the completing the following:

- An audit of staff’s current Welsh language Skills – finding out where our existing Welsh speakers are based
- A Welsh Language Service Needs Assessment – analysing data to determine what Welsh service provision is needed to meet the needs of the local population
- Identifying current skills gaps - within specific departments and teams across the Health Board
- Bridging the skills gap – developing actions plans with team managers; using creative ways of working with current Welsh speaking staff; providing training for staff to learn Welsh; to recruit Welsh speakers.

A Welsh Language, Workforce and Organisational Development Sub-group was established within the University Health Board to develop and monitor Welsh language targets relating to Workforce and Organisational Development. This Group has undertaken the task of developing a suitable Linguistic Bilingual Skills Strategy for the University Health Board, using Hywel Dda Health Board’s approved strategy as a model. The Sub-group meets on a bi-monthly basis.

Our Linguistic Bilingual Skills Strategy is in the consultation process and will be submitted to relevant groups for comments over the coming months. It is anticipated that the strategy will be approved by the Board and will be ready for implementation in April 2014. The strategy has a 3 year Action Plan which must be implemented and monitored by the Sub-group. The Director of Workforce and OD provides Executive leadership for the strategy and will report information to the Board when required to do so.

4.11 Diagnostic Assessment and Support

When developing our Plan, we have been mindful of the requirement to ensure that we are looking at all opportunities to improve quality; where we can improve efficiency and where we can get better value for the NHS pound. It is also about identifying where we may need to invest to make savings. In order to support this, we have asked an external company, Newton, to work with us over the course of January, February and March 2014 as part of the development of our Three Year Plan.

During this time, Newton has been carrying out a detailed external review to support us in identifying, assessing, developing and refining the opportunities we have across the University Health Board for service and financial improvement and for further improving patient outcomes and experience over the course of the next three years. This takes account of
the considerable work that has already been carried out over the last few years to reshape services and to improve quality and efficiency. This work will also help us to prioritise and focus our future plans for improved service quality and financial performance for the years ahead.

The review is overseen by a co-ordinating group of Executive Directors and Assistant Directors and covers ten specific areas of service, each of which has a CTUHB lead and team, who work with Newton to co-ordinate the work in the relevant service area. The ten areas are as follows:

- District and community nursing
- Mental Health
- Theatres
- Endoscopy
- Outpatients
- Length of stay and patient flow
- Ward staffing
- A&E
- Diagnostics
- Procurement
5. QUALITY ASSURANCE AND IMPROVEMENT

5.1 Our Aim

Quality and the focus on it should be a thread that runs through all components of the Plan. This section provides the opportunity to highlight particular Quality Improvement approaches and includes:

- Establishing a baseline of Quality indicators (link to AQS);
- Projections of improvements;
- Identification of actions required to improve.

The University Health Board Quality Strategy embraces the CTUHB philosophy of “Cwm Taf Cares” and is supported by CTUHB Annual Quality Delivery Plan developed from triangulation of local and national data and patient/user/staff feedback and aligns with the requirements set out in Achieving Excellence (the Quality Delivery Plan for the NHS in Wales 2012 - 2016) and Safe Care, Compassionate Care, the National Governance Framework to enable high quality care in NHS Wales (2013).

CTUHB is committed to putting patients, service users and carers at the centre of everything we do, engaging and listening to those who use our services to inform quality improvement. Our Quality Strategy focuses on delivery of safe and effective care and achieving excellent patient/user/carer and staff experience and supports the implementation of the CTUHB 3 year Integrated Delivery Plan.

This requires effective leadership for improvement and this Integrated Delivery Plan supports the requirements set out in Delivering Safe Care Compassionate Care (2013) which requires leaders to put patients and patient safety central to all that they do promoting values and behaviours to ensure a culture of compassionate and caring staff. The University Health Board is committed to listening to service users, patients, carers and our staff and acting on what is heard and seen. We will use the triangulation of the data (complaints, incidents, inquests, claims, audit, mortality reviews and Executive Walk Rounds) to inform our quality improvement priorities.

CTUHB is committed to act in ways that build accountability for quality assurance and quality improvement by applying the NHS Wales core values:

- Putting quality and safety above all else
- Integrating improvement into everyday working
Focusing on prevention, health improvement and inequality
Working in true partnership
Investing in our staff

The Cwm Taf Quality Strategy has adopted Darzi’s (2008) definition of quality and our improvement measures focus on:

- The safety of treatment and care provided to patients
- The effectiveness of the treatment and care provided to patients
- The experience patients have of the treatment and care they receive

5.2 Quality Assurance

Quality assurance is provided through our improving compliance with the 26 Standards for Health Services in Wales (Doing Well, Doing Better 2011) informing our annual improvement priorities. Key quality indicators are monitored across the services provided by CTUHB with the quality and performance dashboard providing a framework for continuous monitoring and measurement.

To provide quality assurance we must consider:-

<table>
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<th>Safe Care</th>
<th>Are patients and patient safety central to our decision making?</th>
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<tbody>
<tr>
<td>Effective Care</td>
<td>Ensuring we are concerned about the quality of the care and not just the quality of the treatment</td>
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| Excellent patient/user/staff experience  | Are we asking “what matters to you?” rather than “what is the matter with you?”;
                                      | Are we actively listening to what the public, patients and our staff are telling us?;
                                      | Are we involving the public, patients and our staff in designing/improving our services?;
                                      | Is the individual person and carer at centre or all that we do? |

Our Quality Strategy is supported by an Assurance Framework developed from the learning from National Reports and reviews of the NHS in England and Wales during 2012/13 and is based on the themes identified in the Keogh Review (July 2013). Learning from National audits (NHS Wales National Clinical Audit and Outcome Review Plan 2013/14); Confidential Enquires; feedback from Welsh Government and Inspectors (HIW); stakeholders and partners (Community Health Council, other Public service partners) also inform this dynamic Assurance Framework.
Reports on complaints, incidents, claims and inquests are scrutinised in detail by a sub-committee of the Board and all serious incidents are reported to the full Board for discussion and consideration with learning from this being disseminated through the organisation. In addition, we provide performance reports and quality indicators at Board and Board-sub committees for scrutiny on outcomes for patients.

5.3 Patient Experience

This plan has been informed by listening and learning from our patients, services users and carers. Strengthening patient engagement to learn from their experiences is important to us, as evidenced in “Safe Care, Compassionate Care” “Together for Health – A Five Year Vision for the NHS”, also the recently published Improving Healthcare White Paper – “The Listening Organisation” which promotes patient engagement and person centred care. We are committed to listening to our patients/service users/carers to ensure that feedback on patient, user and carer experience is obtained, published and acted upon to harness the learning to inform quality improvements.

We are committed to creating a culture that welcomes and facilitates the involvement of patients, service users and carers from all the communities we serve in the development, improvement and monitoring of the patient care and services we deliver.

5.3.1 Our Commitment to Seek feedback From Patient Experiences:

We want our patients to know that we care about their experiences and interactions with all aspects of the University Health Board by:

- Listening to the concerns and experiences of our patients and learning from this is essential to inform our continuous quality improvement planning.
- Implementing the All-Wales Service User Experience Survey national approach to measuring and reporting user experience scheduled for implementation in March 2014.
- Improve people’s health and well-being through local partnership working.
- Directorates, Localities and Primary Care are building and embedding regular patient experience involvement within normal activities
- Empowering and involving the wider community
- Continuing to develop and strengthen the 1000 Lives Stories for Improvement work using patient stories to drive service change and improvement.
• Providing evidence of outcomes on decisions and developments as a result of capturing patient experience.
• Establishing a collective body to monitor and evaluate patient experience and engagement, i.e. Citizen Engagement/Patient Experience Steering Group.
• Continuing to strengthen the work of the Primary Care ‘Access Improvement Group’ by capturing the patient’s perspective via CHC representation on the group.

Our commitment and priorities to strengthen the UHB patient, service user, carer engagement, include:

• Develop Directorate/Locality Patient Experience Champions.
• Directorate/Localities to develop local patient experience plans and embed patient experience into integrated governance arrangements to inform planning and improvements.
• Provide quarterly patient experience reports to the Board.
• Integrate patient experience with clinical audit activities.
• Patient experience to be core part of staff development:
  o Corporate and local induction
  o F1 & F2 training programmes
  o Revalidation sessions
  o Dignity training days
  o Improving Quality Together IQT.
• Implement a structured approach to patient satisfaction from April 2014 using the All Wales User Satisfaction Survey and the Fundamentals of Care Patient Surveys.
• Develop stories for Improvement – capture patient and staff experiences.
• Involve patients, service users, carers in quality improvement projects.
• Provide quarterly performance reports to the Quality & Safety Committee on the quality indicators and publish quality information on our website.
• Develop further quality indicators to demonstrate outcomes for patients.
• Act on outcomes of the Fundamentals of Care Audit.
• Explore new and innovative ways to ensure patients are at the centre of care in relation to bereavement services.
• Strengthen links with the Chaplaincy Service to support patients, relatives and carers, memorials, end of life pathway.
• Improve and enhance priority treatment and experience of War Veterans and their families - establish a Veterans Forum.
• Continue to strengthen the work of the Primary Care ‘Access Improvement Group’ by capturing the patient’s perspective via CHC representation on the group.
• Work collaboratively with key external stakeholders to strengthen Patient Experience:
  o Communities First
  o Community Links Project
  o Consultation Hub
  o Community Health Council
  o Voluntary Sector

• Develop systems and processes for communicating to enable patients and service users to share their experiences with us.

• Further develop the role and contribution of Volunteers across the University Health Board:
  o Be-friending projects
  o Encouraging patients at meal times
  o Undertaking activities with patients
  o Supporting patients with Voluntary sector post discharge.

The Citizen Engagement/Patient Experience Steering Group will monitor activity across the University Health Board through updates from Directorates, Localities and Primary Care on progress against key indicators. Feedback will be shared with a range of our partnership groups, including the Stakeholder Reference Group, Quality Steering Group, and Quality & Safety Committee and with the wider public. Reporting of patient experience will also be reported to the Board on a regular basis.

5.4 Quality Improvement

The 1000 Lives Improvement Service and Health Board/Trusts across Wales have built national priorities for improvement into the three year integrated plans. For the University Health Board these are:-

- Improving Patient Flow
- Inverse Care Law
- Improving Quality Together – Model for Improvement

The Cwm Taf Annual Quality Delivery Plan is a dynamic improvement plan which identifies detailed priorities for improvement, determined from the triangulation of data, feedback from services users, patients, carers and staff and formulated from directorate and locality patient care and safety team looking at themes and trends from complaints, concerns and incidents. The quality delivery and improvement process is underpinned by a delivery structure to ensure this is progressed through the organisation. The Quality Steering Group monitors the implementation of the Annual Quality Delivery Plan and the model for improvement is applied to each improvement project through the application of Improving
Quality Together Bronze and Silver training to clearly determine improvement measures and outcomes for each project team.

5.5 Quality Indicators

The following key indicators are monitored by the Quality Steering Group to reduce harm whilst promoting an improvement culture and safe and effective care in practice by measuring:

5.5.1 Delivery of Safe Care – “Reducing Harm”

- Timely nutritional assessment (National indicator)
- Health Care Acquired Pressure Ulcers (National indicator)
- Health Care Acquired Infections (National indicator)
- Incident and near miss reporting clusters
- Incidence of falls and falls associated with harm
- Medication errors
- Mortality Review –trends/themes

5.5.2. Delivery of Effective Care – “Improving Outcomes”

- Incidence of Sepsis
- Incidence of VTE (compliance with risk assessment)
- NEWS compliance, escalation and response – failures to act on deteriorating patients
- Incidence of lack of timely key specialist medical input to individual patients
- Incidence of undertaking unauthorised clinical procedures
- Compliance with National clinical audits and Outcomes program to inform improvements
- Achievement against the Quality and Outcomes Framework
- Increase in the number of patients who are diagnosed with a chronic condition and whose care is optimally managed in the Primary Care setting.

We will continue to focus on primary and secondary prevention of health problems with Public Health in relation to smoking, obesity and alcohol associated problems.

5.5.3 Achieving Excellent Patient (user/carer) Experience

The CTUHB Patient Experience Plan provides the framework to measure patient/service user/carer feedback to inform improvement and involve patients/carers in quality improvement work. The plan applies the domains of the All Wales User Framework (2013) and supports the principles of The Listening Organisation 1000 Lives white paper as
listening and learning from patient/user/carer experiences us with quality assurance and identifies areas for improvement.

5.5.4 Achieving Excellent Staff Experience

Staff satisfaction and commitment predict patient satisfaction. A key role of our leaders is consulting staff and learning from them. NHS staff survey results 2013 have informed an improvement plan being led by the Director of Workforce and Organisational Development. Our Fundamentals of care audits (autumn 2013) also inform the Quality Delivery Plan.

CTUHB commits to weekly Executive Walk Rounds by Executive Directors and Independent Members to visit clinical areas, speak with staff and patients, observe good practice and agree areas for improvement.

5.5.5 Measuring Improvement

i. The national indicators are monitored via the Fundamentals of Care system for pressure ulcers, nutritional risk assessments and hand hygiene compliance. The Cwm Taf University Health Board Integrated Performance Dashboard will continue to be developed to present the key quality indicators over time to identify good practice and to focus on areas for improvement.

ii. General Medical Services (GMS); achievement against the Quality and Outcomes Framework (QOF) is one measure used to monitor the performance of General Practitioners. An All-Wales comparison of achievement within Cwm Taf UHB and externally against other Welsh LHBs areas is available on an annual basis. Further more detailed local analysis is undertaken annually and individual Cwm Taf practice QOF achievement is compared to identify low achievement and significant variance. This process also informs priority areas for the QOF programme of visits. Where significant variance is identified the individual GP(s) are visited by the Head of Primary Care and the Locality Clinical Director to discuss the low achievement and plans for service improvement. Our data shows that where areas have been identified through this process and practices have been visited improvements are made in the following year and not repeated. Overall QOF achievement has been improving year on year.

iii. Opening Hours and Appointment System within GP Surgeries; GP Practices within Cwm Taf Localities are working hard to improve opening times and access to appointments. The annual statistical release has demonstrated year on year improvement. Where concerns are raised through patient complaints, practices are visited and action plans for improvement are agreed and implemented.
iv. General Dental Services; regular monitoring of claim trends and achievement of activity against agreed UDA (Units of Dental Activity) is undertaken. Dental Practitioner’s are advised if the practice has a percentage of claims above the average and advice is sought from the Dental Advisor in Public Health Wales. When clinical concerns or inappropriate claiming is suspected a detailed review of the clinical records is undertaken by the Clinical Policy Advisor from the NHS Business Services Authority Dental Division.

v. Optometrists; a rolling programme of Post Payment Verification visits is undertaken by NHS Wales Shared Services Partnership. Where appropriate recoveries are made and performance issues identified.

A Performance Dashboard for Primary Care has been developed and will be available shortly. Further work to encouraging practice audit, peer review and qualitative research is ongoing through the professional representative bodies and development groups.

5.6 Quality Triggers

Quality Triggers and questions are applied when triangulating the information from a variety of sources to consider the dimensions of quality to demonstrate that we are actively listening and learning:

- Are we providing safe care?
- Are we meeting required standards of effective care?
- Are we improving user experience?
- Are we providing efficient services within our resources?
- Are we engaging with the workforce?
- Are we providing accessible and equitable services?
- Are we improving population health?

A number of key measures are regularly reviewed and triangulated by the UHB Quality Steering Group to determine and support actions for improvement within the Quality Delivery Plan. These include:

- Mortality Review
- Healthcare Associated Infections
- 1000 Lives work streams
- Patient/User feedback
- Staff feedback
- Executive Walk Rounds actions for improvement
- Clinical Audits – National/local
The regular analysis and review of data from these quality triggers to inform the priorities for service improvement is an iterative process.

As part of the development of the UHB Quality Delivery Plan, data identified from the quality triggers was reviewed and analysed, with further triangulation and interpretation of information from a range of other sources. This work formed the basis of the quality improvement priorities identified in the Quality Delivery Plan and these are described in section 5.6. The following section summarises how these priorities were developed.

5.6.1 Mortality Review

For the period November 2012 – October 2013 Cwm Taf University Health Board’s Risk Adjusted Mortality Index (RAMI) demonstrated an improving downward trajectory, whilst remaining above the All Wales average. During this period mortality reviews were undertaken on 600 patient deaths, with 219 being referred to stage 2. The review process identified the following messages:

- Communication between members of multi-disciplinary teams;
- Delays for investigations/interventions on weekends/bank holiday;
- Poor standards of documentation
- Anticoagulation related trends

We have developed a robust process for undertaking mortality reviews that relate to our 2 acute District General Hospitals and we will be shortly rolling this out to our community hospitals. This process also includes General Practitioners in additional to the hospital teams. Our challenge is to ensure the same robust process applies in our community hospitals and we will be focusing on this improvement.

Our commitment is to continuously improve our RAMI each year and over the next 3-years our planned improvement trajectory is shown in the table below:-

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>102</td>
<td>100</td>
<td>95</td>
</tr>
</tbody>
</table>
5.6.2 Learning from Coroners Inquest

The main trends from Coroners Inquests relate to the prevention and management of fall and the standards of documentation.

5.6.3 Healthcare Associated Infections (HAI)

The national targets for the reduction of clostridium difficile infection were surpassed in 2011/2012 and we have achieved the lowest rate in Wales in 2012/2013. Our current performance shows a continuation of this improving downward trajectory.

![Graph showing the reduction in MRSA rates](image)

During 2014 we achieved a 470% reduction in MRSA rates from the previous year. We are reflecting a generally static trend, noting a spike in cases toward the end of 2013 that is also reflected in numbers reported at an All Wales level.

![Graph showing the reduction in C-Difficile in IP's > 65 years](image)

The upward trend for MSSA bacteraemia across Wales and the following graph shows this trend in CTUHB.
Focused improvement work remains ongoing across the University Health Board to continue to improve Healthcare Associated Infection Rates. Our aim is to reduce our HIA rates in clostridium difficile, MRSA and MSSA over the next 3-years on a trajectory as shown in the table below:

<table>
<thead>
<tr>
<th>Year</th>
<th>2014/2015</th>
<th>2015/2016</th>
<th>2016/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further reduction in C-difficile (aged &gt;65 yrs)</td>
<td>33</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>Further reduction in MRSA</td>
<td>12</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Further reduction in MSSA</td>
<td>40</td>
<td>32</td>
<td>26</td>
</tr>
</tbody>
</table>

**5.6.4 Reported Patient Safety Incidents**

Analysis of these incidents shows that the highest category of patient related safety incidents relate to slips/trips and falls with other significant themes relating to:

- Admission/transfer/discharge;
- Pressure damage; and
- Delays

Historically incident reporting from primary care has been extremely low, but following a closer joint working with the Patient Safety and Primary Care teams the number of incidents being reported is improving month on month. A mechanism for feeding back learning from incidents has been introduced via the development of a Primary Care Newsletter.

The highest number of these incidents relate to the quality and timeliness of the documentation shared between primary, community and secondary care. A number of actions are in place to address the issues, these include:

- Encouraging all GP practices to report incidents involving poor communication or sharing of documentation;
- Encourage all hospital doctors/nurses to report incidents involving poor communication or sharing of documentation;
• Introduction of Discharge Advice Letters;
• Regular audit of the quality and communication of discharge advice letters;
• Specific training for new hospital doctors incorporated into induction programme;
• Challenging of individuals when incidents are raised;
• Improving communication between community hospitals and GP practices when patients are transferred for rehabilitation or complex discharge.

In summary, the following key messages were triangulated from this analysis:

- Improving patient flow and care of patients with frailty
- Reduction of risk in hospital and community falls
- Improving the timeliness and quality of documentation exchange between primary, community and hospital services.

### 5.6.5 Formal Complaints

The range and volume of services provided by CTUHB is outlined in section 2.3, services provided, for example this includes, over 900,000 outpatient appointments, over 116,000 inpatients procedures and over 800,000 face to face GP consultations.

Between January 2013 and December 2014, 630 complaints were received from patients. An analysis\(^\text{21}\) of these complaints showed that the majority related to:

- Patients being unhappy with their treatment (clinical practice and diagnosis);
- Delays/cancellation of appointments;
- Waiting times and concerns attributed to failures in communications standards.

There is a correlation between formal complaints and clinical negligence claims. The main trends identified from this analysis can be summarised into the following themes:

- Failure to diagnose/delay in diagnosis;
- Failure to recognise complications;
- Inappropriate treatment;
- Failure/delay in treatment.

\(^{21}\) As per the categories recorded on Datix
An extremely small proportion of these formal complaints and clinical negligence claims relate to Primary Care Professions. This work was triangulated into the following key messages:

- The focus on patient flow and the care of patients with frailty.
- Improving the pathway for patients with fractured neck of femur.
- Improving the experience of patients with cognitive impairment/dementia.
- Improving communication: consent, documentation, handover, culture of care.

### 5.6.6 Patient Experience Feedback

An analysis from patient experience and other sources of patient feedback identified the following themes:

- The way in which staff communicate with patients, relatives and carers;
- Lack of involvement of carers in the care planning and discharge process;
- Service users reporting wanting to be more involved in the planning and design of services; and
- Lack of feedback to service users when they were involved in this process;
- Difficulties with waiting times, in particular waiting in A&E, for first appointments and for their surgery;
- Concerns with delays/cancellations relating to lack of beds

### 5.7 Priorities

These emerging themes informed the Year 1 priority high level improvement projects outlined in the 2014/2015 Annual Quality Delivery Plan, including the top five quality improvement projects that are outlined below:

- Improving patient flow and develop transformational models of care of patients with frailty.
- Improving the pathway for fractured neck of femur.
- Reduction of risk of in hospital and community falls.
- Improving the experience of patients with Cognitive Impairment/dementia.
- Improving Communication: consent, documentation, communication, handover and culture of care
- Improve the range and quality of General Medical Services delivered within each cluster area of GPs.
- Encourage GPs to work collaboratively in cluster groups to provide more specialised services for the total population.
- Improve the number of patients being optimally managed by their GPs.
- Reduce the gap in life expectancy between the most and least deprived areas.
As outlined above the Cwm Taf Annual Quality Delivery Plan is a dynamic plan, responsive to patient, public and staff feedback and reflecting triangulation of data and emerging trends which will continually inform priorities for improvement and deliver sustainable change.

5.8 Openness and Transparency

The University Health Board is committed to being open and transparent with the public, patients and service users with the quality of the services we provide, sharing good practice, achievements and identifying areas for improvement via:

- Cwm Taf University Health Board internet site: Quality & Performance reports, Board and Committee papers
- Annual Quality Statement
- My Local Health Service – NHS Wales, quality data and performance
- Public Forum events across Cwm Taf Localities

The University Health Board Annual Quality Statement provides our public with clarity about our commitment to Quality Improvement and confirms our performance, what we have done well and not so well and what our public, patients, service users and carers are telling us we need to improve on to inform our Annual Quality Delivery Plan.

____________________________________
6. SERVICE CHANGE PLANS AND INITIATIVES

In line with our Clinical Strategy, the following chapter sets out our specific service change plans and initiatives set against both disease and condition based plans, as well as cross cutting developments we wish to make in our primary, community, secondary and tertiary care services.

This continues the theme of our pathway based approach in the figure below and a useful framework for presentation of our service plans and priorities below, the latter which are highlighted in blue boxes. The section below presents our plans moving across the pathway, from left to right, commencing with prevention, moving all the way through to specialised services.

In particular, we have three linked areas of change as follows:

- Building on the successful improvements in patient flow over the last three to four months, to extend the flow work and add additional improvements to systems and pathways of care to further reduce the requirement for acute and community beds. These additional improvements include increasing the acute physician service, introducing a Liaison Psychiatry Service, and using the current Newton review to help us to focus our actions on improving flow, subject to success with invest to save funding to pump prime these developments. This should enable the incremental release of bed capacity in the next financial year.

- Development of Older Persons Mental Health Services, increasing the provision of community services and reducing and rationalising bed numbers. This should enable the closure of the Mental Health ward on the Dewi Sant site and changes to the current service at
Thomastown House in response to changes being made by Merthyr Tydfil Local Authority.

- These two changes above should enable rationalisation of facilities and estates services on the Dewi Sant site, as the site would then no longer be taking inpatients.

In addition, we are then looking to relocate the Palliative Care Service on an interim basis, pending a longer term solution, and this enables the closure of the Y Bwthyn site.

There are then a range of initiatives around prudent healthcare which we plan to pull together into a coherent programme over the first two quarters of the financial year, for implementation incrementally through the rest of the financial year.

In terms of the South Wales Programme, we are now moving towards an implementation phase with a number of key, associated developments agreed by the Health Board which will be delivered either primarily by the Health Board or where required by new ‘alliances’ of networked hospitals.

These new systems of care which network hospitals and their services more firmly together must be developed to strengthen the delivery of services across the whole of South Wales and South Powys. This will allow all the skills, expertise and facilities within that network to be maximised for the benefit of all patients. The Welsh Ambulance Services NHS Trust will be an important partner in the development and success of the new arrangements, particularly in delivering pre-hospital assessment and care and ensuring that when patients require hospital care, they are conveyed to the most appropriate facility.

Three such networks or alliances are being established for the wider South Wales area (including Hywel Dda) based around three “major acute” centres at Morriston Hospital, University Hospital of Wales (University Hospital Wales) and the Specialist and Critical Care Centre (SCCC) (when built).

These alliances will need to develop new systems of governance to ensure that clinical and financial accountabilities are appropriately ascribed and that clinical services are safely delivered. It is recognised that there will need to be continuing engagement with stakeholders as these alliances develop.

In terms of developments relating to the South Central Alliance in particular, of which our hospitals – the Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) are a key part, section 6.16 below outlines the main components of the work programme.
The following offers further detail in these and a range of other service change plans and initiatives.

## 6.1 Prevention

### Key Strategic Drivers

The Welsh Government has published a range of condition-specific delivery plans to support its [Programme for Government](#) and its [NHS Five Year Plan](#) with the aim that:

- Health will be better for everyone.
- Access to care and patient experience will be better.
- Better service safety and quality will improve health outcomes.

Prevention of ill health and the promotion of good health feature as the first theme across all these delivery plans. Action to address modifiable lifestyle risk factors such as smoking, obesity, alcohol consumption above recommended guidelines and lack of physical exercise is fundamental to reducing the prevalence of ill-health.

Our local delivery plans will:

- Highlight the key risk factors relevant to that condition, the relationship to the Rhondda Cynon Taf and Merthyr Tydfil Single Integrated Plans and the role of the University Health Board as a key partner in supporting this work.
- Acknowledge the contribution of national organisations (e.g. Diabetes UK) and partner organisations (e.g. National Exercise Referral in local authorities) in tackling health inequalities, their collaborative relationship and affect.
- Describe the interface between primary, community and secondary care, and impact on risk factor management.

### Priorities:

#### i. Smoking

To make a difference in the number of people smoking in our population requires action at all levels, and is dependent on good partnership working and strong leadership. Further detail is contained within the Smoke Free Cwm Taf Strategic Action plan.

We recognise that sustained work is needed to maximise the population impact of tobacco control actions, to increase the number of smokers who
connect with smoking cessation services and ultimately to change social norms and the inequalities that exist within our communities.

There has been a decline in the numbers of individuals being supported to quit via the established services during 2013-14 (illustrated below). This may be a consequence of the increasing popularity and heavy promotion of electronic cigarettes locally and nationally. This is being investigated and will be addressed as an emerging issue under the Smoke free Cwm Taf Strategic Action plan, but is likely to require a national solution.

The University Health Board will continue to work closely with Public Health Wales (PHW) to ensure that the PHW Stop Smoking service is designed and delivered around the needs of the Cwm Taf population.

Policy Statement & Making Every Contact Count: In September 2013, Cwm Taf adopted a policy statement on reducing smoking prevalence, building on Smoke Free, Cwm Taf University Health Board’s Strategy established in 2012.. This statement reaffirms and clearly communicates the Board’s determination to tackle this challenge and also lays a key foundation for specific action to address inequity:

Smoking cessation is a key treatment for all smokers. Health care professionals should take every opportunity to:

- Ask patients about their smoking habits, and
- Advise patients to stop smoking, and
- Act by providing information and signposting to smoking cessation support services.
Maximising the potential of this policy statement will involve ensuring that health care professionals systematically identify individuals who wish to stop smoking and signpost or refer them to appropriate local services. This approach reduces the impact of morbidity and mortality rates resulting from smoking as well as financial costs associated with accessing unscheduled care and increased length of stay.

We have been working with Cardiology, Stroke, and Respiratory leads to improve and shorten the referral pathway to smoking cessation services, and have plans to systematically work with other clinical leads during 2014/15- 2016/17.

**Smoking in Pregnancy**

In May 2013, our MAMSS (Models for Access to Maternal Smoking Cessation Support) research project, sponsored by Cwm Taf R&D, commenced. The aim was to determine if alternate models of behavioural support established as part of maternal care increase the uptake of behavioural support and improves quit rates amongst pregnant women.

On the basis of the results of the pilot, funding has been secured from “Families First” to provide this service to the Rhondda, Cynon and Taff Ely localities during 2014-15. Based on experience during the pilot, this could result in an additional 150 pregnant mothers being supported to quit per annum, with 1 in 3 being smoke free.

**Working with primary care:**

- Our Community Pharmacy Level 3 Smoking Cessation Service is well established in Cwm Taf and in January 2014 an additional 10 pharmacies joined the scheme increasing the number of participating pharmacies to 39 out of 77. This could increase the number of people accessing cessation support via the scheme by 25% during 2014/15 and beyond.

- Together for Chronic Obstructive Pulmonary Disease (COPD) is a non promotional joint working project between Cwm Taf University Health Board and GlaxoSmithKline to optimise the management of COPD patients. This project has a particular focus on smoking, and all the participating GP practices (32) have received training on the impact of smoking on the disease pathway, the importance of cessation support to improve the quit attempt, and the locally available services and referral method.

- As part of our work to tackle health inequalities (Inverse Care Law programme) we are prioritising smoking cessation in patients on chronic disease registers as one of our interventions.
Working with our communities:

- A Smoke Free Homes project has been developed in Cwm Taf. A number of our Communities First Clusters and Registered Social Landlords have received comprehensive training and resources, and further Clusters and Registered Social Landlords are scheduled for involvement.

- In October 2013, the Regional Collaboration Board agreed Smoke Free Public Places as a priority, committing partners to work together in delivering the Smoke Free Cwm Taf Action Plan 2011/15.

Our Local Performance Indicators

- Percentage of adult smokers making a quit attempt via smoking cessation service (target 5%).
- Percentage of treated adults smokers who successfully quit smoking at 4 weeks (CO verified) (target 40%).
- Percentage of pregnant smokers making a quit attempt via MAMSS.
- Percentage of pregnant women who successfully quit smoking at 4 weeks (CO verified).
- Number of households signed up to ‘smoke free homes’ initiative.
- Percentage of smoke free playgrounds, parks, sports grounds, council grounds.

Population Outcome Measures

- % Adult smoking who report smoking
- % of women smoking during pregnancy
- % of 11-16 year olds smoking weekly

What will we achieve over the next three years?

- A reduction in adult smoking prevalence rates through increased use of smoking cessation services (5% of smokers making a quit attempt, with at least a 40% CO validated quit rate at 4 weeks).
- A reduction in % of women smoking during pregnancy resulting in a reduction in the proportion of babies born with a low birth weight by increasing the number of women receiving smoking cessation support through MAMSS.
- A Reduction in % of 11-16 year olds smoking weekly
- An increase in the percentage of smokers on chronic disease registers who stop smoking as part of the Health Inequalities (Inverse Care Law programme) work.
- A reduction in the exposure to second hand smoke in homes.
ii. Immunisation

Immunisation uptake is increasing year on year in all our target groups.

a) Influenza vaccination

Our level of flu immunisation for patients has increased, but more work is needed to support all practices to achieve the 75% uptake in all target groups. This is detailed in action plans and will ensure that we continue to increase towards target levels. Planned action includes vaccination by midwives and Health Care Support Workers.

We have increased our staff immunisation rate from a very low base of 9% to 43% (within reach of the 50% target for 2013/14). Plans for 2014/15 and onwards to achieve and exceed this target include:

- Consolidate and build on the successful actions and initiatives implemented to date
- To secure a slot in the corporate induction programme to talk about workplace vaccinations focusing on Flu, Hep B and MMR

b) Childhood Immunisations

Cwm Taf exceeds or is close to achieving the individual targets for most of the childhood immunisations and is progressing with the new challenging composite target. The composite target is more difficult as different children will miss different immunisations. Achievement of these % targets is more difficult in a small population as one child missing their immunisation has a disproportionate impact on the % result.

All involved with providing immunisation are prioritising this work, and it can be seen that rates are continuously improving. We anticipate exceeding 90% by quarter four of 2013-14.

What will we achieve over the next three years?

- Achieve and maintain 95% uptake of routine childhood immunisations.
- Achieve and maintain target uptake rates for flu immunisation in eligible groups including the new flu immunisation programme for children and young people.

iii. Obesity

Cwm Taf Healthy Weight, Healthy Valleys Strategy identifies and coordinates the partnership approach to improving nutrition and physical activity and maintaining a healthy weight in Cwm Taf through:

- Clear leadership and co-ordination of action
• Improving the wider environment to encourage healthy eating and an increase in physical activity
• Improving healthy eating and physical activity levels
• Supporting overweight people to reduce weight and increase physical activity.

The strategy and action plan have been adopted by the Single Integrated Plans of Merthyr Tydfil and Rhondda Cynon Taf areas. The multi-agency action required to slow down, and eventually halt, the increasing trend in overweight and obesity includes:

• The development and implementation of a weight management resource and support toolkit which offers those leading self-help community weight management groups with further guidance and practical ideas on how to incorporate these recommendations into local programme delivery. Eleven community weight management groups have been established to date, with training for further groups planned working with the Community First Clusters.
• The public health team has facilitated a multi agency learning set on behalf of the Families First Consortium, looking at child and family overweight and obesity. The outcomes of this learning set will be used to inform the development of a childhood obesity pathway.
• Work with Midwifery to address overweight and obesity in pregnancy.
• National Exercise Referral Scheme (NERS) – Referral from primary and secondary care into the local authority run NERS.

These contribute to the Levels 1 and 2 of the All Wales Obesity Pathway. The different levels of the obesity pathway can be summarised as:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Community based prevention and early intervention</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Community and primary care weight management services</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Specialist multidisciplinary team weight management services run in community, primary or secondary care settings.</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Specialist medical and surgical services (including bariatric surgery)</td>
</tr>
</tbody>
</table>

Cwm Taf is contributing to the development of criteria for All Wales Level 3 obesity services. The aim of a Level 3 service is to improve the health and wellbeing of adults with severe and complex obesity (BMI > 35 with co-morbidities or BMI > 40 without co-morbidities). Currently, there is little provision across Wales of specialist weight management services focusing on a multi component, holistic approach to treating obesity as recommended in NICE guidance. However, the figures given in Chapter 3 showing the high number of adults with BMI ≥ 40 demonstrate the need for future service development in Cwm Taf.
Joint Care Programme

Following a successful pilot run in Cwm Taf in 2013, the Health Board is considering introducing a care pathway for obese patients who may be heading towards elective orthopaedic surgery, where their weight is a significant risk factor in their condition. It is anticipated that there will be 280 clinical referrals to the community weight management programme in 2014/15 increasing to 420 per annum in 2015/16 and 2016/17. This is projected, as a conservative estimate, to result in the avoidance of 21 operations per annum with improved outcomes for many more.

Maternity Services

The introduction of the ‘Monday Clinic’ model for obese pregnant women in the Rhondda, Cynon and Merthyr localities, supported by Families First.

Our Local Performance Indicators

- Development and implementation of family weight management programme for obese children.
- Development and implementation of targeted adult weight management programmes.

Population Outcomes Measures

- % of adults reporting meeting the physical activity guidelines of 5 x 30 minutes in the past week.
- % of adults reporting eating five or more portions fruit/vegetables the previous day.
- % of children and young people meeting weekly recommendation of 60 minutes each day of moderate intensity physical activity.
- % of adults reported as being overweight or obese.
- % of children aged 4-5 who are overweight or obese.

What Will We Achieve Over The Next Three Years?

Halt the rising levels of overweight and obesity in the Cwm Taf population through:

- Development and implementation of a childhood obesity pathway.
- Development and implementation of a weight management resource and support toolkit.
- Increased number of referrals to the Exercise Referral programme, particularly in the ‘Inverse Care Law’ programme areas.
- Increased numbers of community weight management groups.
- Implementation of a programme to address overweight and obesity in pregnancy leading to a reduction in low birth weight babies.
- Introduction of a Joint Care Programme to reduce the need for orthopaedic surgery and or improve outcomes surgical outcomes.
iv. Alcohol – priorities described in section 6.5

v. Reducing Teenage Pregnancy

The Cwm Taf Sexual Health Advisory Board (SHAB) provide a multiagency, strategic lead for sexual health work, in the Cwm Taf area. The group provides a structured mechanism to allow improved communication, sharing of good practice and resources and the development of performance management and reporting structures amongst all partners working on the sexual health agenda.

A variety of work is incorporated into the sexual health action plan including the development of community profiles to target services. Ward-level data for conception rates in females aged under 18 years illustrated that across Cwm Taf, the rates of 19 wards were statistically significantly higher compared to Wales. Across the University Health Board area, five wards have been identified with the highest rates of conceptions in females aged under 18 years: Gurnos, Tylerstown, Penywaun, Maerdy and Cwmbach. Work has been established with partners to increase provision and access to services, such as expanding the c-card scheme to more outlets, enhancing the provision of emergency hormonal contraception in community pharmacies and promoting young people’s clinics, in an attempt to reach our most vulnerable young people and reduce future conception rates.

As part of this work, a 6 month pilot will be undertaken in 2014 with a number of community pharmacies to provide information and signposting/referral to methods of long-acting reversible contraception (LARC) and the c-card scheme for those accessing the NHS Emergency Hormonal Contraception (EHC) Service.

Cwm Taf Condom Card (c-card) Scheme: The scheme works in partnership with health, schools and youth and community services to increase the availability of condoms and sexual health advice and support to young people aged 14-25 years, in Cwm Taf.

Across Cwm Taf, the scheme is operated in over 70 outlets and provision has increased with the inclusion of many secondary schools, pupil referral units and additional nurse-led services. The scheme is strongly supported by the Sexual Health Outreach team and provides a valuable access point into mainstream services.

To support this work the Public Health Team will continue to deliver the Sexual Health Foundation Course on a quarterly basis, offering training to a variety of professionals who engage with young people around sex and relationships.

Supporting the ‘Empower to Choose campaign’ – the University Health
Board is participating in the national programme managed by Public Health Wales to reduce repeat teenage conceptions by encouraging the uptake of long acting reversible contraception (LARC). Additional work to train community based staff and improve access to services is being progressed.

Work is currently underway to promote the update of Long Acting Reversal Contraception (LARC) in young people who abuse substances. This is considered a particularly vulnerable sub-set of young people due to the impact of pregnancy on those young people, their babies and services to support vulnerable families.

**Population Outcome Measures**
- Conception rate of young women under the age of 18.
- Rate of low birth weight babies

**Our Local Performance Indicators**
- Number and usage of Condom Card Scheme sites, including school and higher education venues
- Increase in number of venues offering EHC and LARC, particularly in target areas
- Increase in uptake of LARC (Data development area)
- Numbers of staff who have undertaken sexual health foundation course, particularly those working with target groups
- Number of schools delivering a consistent agreed SRE programme

**What Will We Achieve Over The Next Three Years?**
- Continue to reduce teenage conception rates through accessible LARC and emergency contraception services.

**Performance**

A number of preventative performance indicators are included in the Integrated Dashboard including:
- Immunisation uptake rates
- Smoking cessation rates

**Financial Plan**

Provision of at least £2.0m per annum has been made in the University Health Board’s financial plan for each of the three years. This is currently being prioritised for service change with areas of investment being planned for 2014/15 and into 2015/16 to include investment of £0.1m per annum in weight management services to help tackle rising levels of obesity and provide alternatives to surgery where appropriate.
6.2 Chronic Conditions

Key Strategic Drivers
The University Health Board has some of the highest levels of incidence of chronic disease in Wales, as well as an increasingly elderly and frail population. There have been historically high hospital admission rates for respiratory related admissions to hospital. With the support of our partners, CTUHB aims to address some of the cultural, as well as systemic issues, in order to transform these services.

The Wales Audit Office report on Transforming Unscheduled Care and Chronic Conditions Management (2012) in the University Health Board found the following:

- The University Health Board has made good progress in strengthening the way in which it seeks to support people in the community and prevent unnecessary use of hospitals.
- The University Health Board is beginning to test new ways to identify individuals at risk of unplanned admissions and support them in the community.
- Service redesign and investment is helping to shift the location of care from hospital to community.
- The University Health Board is now making more use of primary care contracts to support patients with chronic conditions and unscheduled care needs.
- Reliance on the acute sector to manage chronic conditions is reducing with Cwm Taf having made more progress than most other Health Boards, but multiple admission rates and lengths of stay for some chronic conditions remain above target.
- The University Health Board has revised its governance arrangements for chronic conditions management and unscheduled care and is now better placed to deliver planned service changes.

Priorities
The challenge for the University Health Board going forward is to develop integrated care pathways for key chronic disease areas which ensure where possible that individuals with a chronic condition have access to a range of services that support them in managing their condition. The following offers a snapshot of work underway and future priorities in:

- Self-care
- Pain management
- Diabetes
- Heart disease
- Respiratory disease.
### 6.2.1. Self Care

#### Key Strategic Drivers

Evidence tells us that self care or self management programmes for chronic disease improve health outcomes and reduce hospital use, particularly those managing well defined conditions with clear methodology (e.g. those developed in Stanford such as the Chronic Disease Self Management Programme) and that many individuals feel more satisfied with their care and achieve a better sense of control and self efficacy through supporting self care interventions.

The diagram below indicates that support for self care is needed at all stages of a patient journey, and that this includes services designed to promote healthy lifestyle choices, as well as support for helping people manage a health problem.

#### Self Care as a component of Chronic Condition Management

![Diagram of self care and chronic condition management]

**Priorities**

Mechanisms are needed to co-ordinate all this activity and to assist health practitioners to make appropriate referrals for their patients. In addition, there are gaps in service provision, particularly in relation to disease specific support classes for patients, and these should be addressed. Our priorities include:

- **Signposting**: healthcare professionals need to know how to refer patients to existing programmes, and robust mechanisms for ensuring that this information is to hand and up-to-date should be explored.

- **Similarly healthcare waiting areas are appropriate venues for advertising the value of such programmes to patients, and the ways in**
which this can be used to the full should be developed. Links to telephony services should also be explored. Our Local Public Health team will work with primary and secondary care to develop centrally coordinated information systems that can be kept up to date.

- Motivational Behaviour Change: the evidence indicates that more success is achieved if health care practitioners are skilled in Motivational Behaviour Change and Brief Interventions, and use these techniques in general consultations. These techniques will be offered to healthcare professionals in primary and secondary care.

- The National Exercise on Referral programme for people with chronic conditions is similarly available in all areas, and is receiving large numbers of referrals.

- Health and Wellbeing Checks for Over 50s – Add to Your Life: roll out from April 2014 of the WG over 50s Health checks programme to support and empower older people to have greater control over their own health and wellbeing.

- Referral to Stop Smoking Wales and Community Pharmacy Services to be embedded across pathways.

The Education Programme for Patients (EPP) Cymru is an NHS based self-management course for people living with any long term condition. It helps people improve their quality of life by learning different skills to better manage their condition on a daily basis. A comparison of ‘before and after’ measures showed that 4-6 months after completing the course:

- GP consultations decreased by 7%
- Outpatients visits decreased by 10%
- A&E attendances decreased by 16%
- Pharmacy visits increased by 18%

The University Health Board will continue its skills training for patients; a number of generic programmes are available for patients with any chronic condition. This work will continue in 2014/15, focussed on:

- Recruiting and training sufficient volunteers to run the courses,
- Increasing the number of referrals to the programme
- The results of an evaluation/outcome pilot the CTUHB has undertaken with NLIAH to provide outcome measures on patient experience and the benefits from the programme.

6.2.2 Pain Management

Key Strategic Drivers

Chronic non-malignant pain (CNMP) is a common pain disorder causing
physical and psychological distress to patients and can occur due to conditions involving inflammatory and neurological pathways. An increasing number of patients are seeking help for chronic pain - it’s not always easy for them to get the help they need and it can place pressure on the NHS.

In recent years the treatment options for chronic pain have increased, resulting in inappropriate medication usage. This has resulted in an increase in adverse events and rising costs resulting from adherence, monitoring and inappropriate therapies. Our aim has been to develop new, more accurate ways of assessing and treating types of chronic non-malignant pain and provide guidance about when patients should be referred to the chronic pain service. This will allow patients in both primary care and hospital services to be referred to the most appropriate specialists for their needs. This should ultimately mean they are treated more effectively and quickly within Cwm Taf.

**Priorities**

- Cwm Taf’s chronic pain service, in conjunction with pharmacy, has developed an evidence-based guideline to direct primary and secondary care clinicians in correct assessment of chronic pain, selection of cost-effective therapies and appropriate referral to the chronic pain service.
- Adherence to the guidelines will result in improved medication management of chronic pain conditions and has the potential for significant cost-savings across the University Health Board. The guidelines are available on SharePoint and should be referred to by all non specialist clinicians managing chronic pain conditions.
- Further, new guidelines are also being introduced in the University Health Board to improve services, with a group led by specialist pain clinicians and the pharmacy’s pain lead. This has been set up to develop further advice which will ensure patients are getting consistent and effective treatment. The work has recently been recognised by the Royal Pharmaceutical Society, which awarded the group the Award for Innovations in Healthcare at the national RPS conference in Birmingham.
- A further priority is the need to ensure we maintain our non-malignant chronic pain service referral to treatment waiting times within 26 weeks. This will involve consideration of further chronic pain specialism amongst our clinical workforce and there will also be a requirement to further strengthen our links with our GPs in this respect. A full service workforce review and redesign programme will need to be undertaken to assess the workforce implications and actions needed to deliver the service changes specified.
6.2.3 Diabetes

Key Strategic Drivers

The prevalence of Diabetes is increasing year on year. Within Cwm Taf 4.2% of the population (age-standardised prevalence) have diabetes compared to the all Wales figure of 3.9%. Spend on diabetes care across the UK accounts for 10% of all NHS expenditure, in Wales this equated to £500 million in 2009-10. Diabetes among adults in Wales is predicted to rise to 10.3% in 2020 and 11.5% by 2030.

Together for Health - A Diabetes Delivery Plan was published in September 2013. In response to this, the Health Board’s Diabetes Planning and Delivery Group has developed a local Diabetes Delivery Plan which sets out the vision and required action for the organisation and its partners over the next 3 years.

Priorities

The University Health Board’s Diabetes Planning and Delivery Group have decided to prioritise 5 key areas for focus in the first year of implementation of the plan. The priorities are aligned to those identified at a Wales level as follows:

i. Reducing pre-diabetic risk

The University Health Board will target the high risk population - those that the pre-diabetes stage through:

- General Practice
- Diabetes UK road shows
- Community Pharmacy

Specifically the University Health Board will:

- Explore opportunities to build on the annual Diabetes UK and Community Pharmacy Wales (CPW) campaigns, through the community pharmacy contract.
- Work in collaboration with Diabetes UK to run local campaigns signposting individuals to the range of lifestyle management information, advice and support.
- Via the Inverse Care Law Programme, target cardiovascular risk reduction (specifically working with General Practice to identify opportunities to signpost individuals to lifestyle management support).

ii. Improved education for all diagnosed diabetics

The University Health Board will focus on improving access to structured education which is provided in line with the relevant NICE guidance to ensure individuals with diabetes have the necessary information, tools and techniques to manage their condition.
Specifically the University Health Board will:

- Develop, agree and implement a model for delivering education to patients within primary care which complements existing structured education programmes which ensures equity of access across Cwm Taf e.g. X-Pert, DAFNE etc.
- Increase the number of patients referred to the Education Programme for Patients (EPP).

iii. Improved education for all young diabetics

The University Health Board will prioritise the following actions within Paediatrics services:

Specifically the University Health Board will:

- Review current provision of education for children, young people and their families with a view to improving access both in traditional NHS venues and in the community and schools.
- Identify opportunities to educate staff within schools.

iv. Improved integration across the pathway

Further integration of diabetes services across the patient pathway is a key priority for the University Health Board.

Specifically the University Health Board will:

- Identify the most appropriate model for providing greater access to secondary care support for primary care.
- Review its model of outpatient services to ensure patients have timely access to specialist teams when required and reduce duplication of annual reviews.
- Seek to optimise treatment and outcomes for patients by ensuring its Diabetes Clinical Planning Group has access to the range of data and information available e.g. prescribing patterns, admission rates etc.

v. Improving foot management for all inpatients

The University Health Board will prioritise foot management with the longer term aim of reducing amputation rates

Specifically the University Health Board will:

- Promote 'Putting Feet First Integrated Care Pathway across all disciplines.
- Standardise foot screening by promoting an alternative method of accessing training which is resource neutral, for example FRAME e-learning foot screening module.
- Development of a robust nursing assessment tool, with diabetes foot risk added to the Waterlow Pressure Ulcer Prevention Chart.
The University Health Board will review its delivery plan annually to identify the subsequent priorities for 2015 and 2016. Prioritising these areas will provide focus and pace to our efforts to integrate diabetes services across the pathway so that patients receive seamless care and we make maximum use of the resources we have invested in diabetes.

**Performance**

The Diabetes Planning and Delivery Group will be responsible for overseeing delivery, reporting progress to the Executive Board and producing an Annual Report for the Health Board which must then be published on our website.

### 6.2.4 Heart Disease

**Key Strategic Drivers**

Following the launch of the Welsh Government’s [Heart Disease Delivery Plan](#), the University Health Board has developed a local [Heart Disease Delivery Plan](#) aimed at helping to prevent avoidable heart disease and deliver well-coordinated services, where specialised care is well connected to local services, providing better patient experience and outcomes.

As part of this work, the University Health Board:

- Carried out a local population needs assessment;
- Analysed the gap between current provision and the standard of service described in the NSF and in [Together for Health – a Heart Disease Delivery plan](#);
- Developed a plan to take action to close that gap;
- and are demonstrating through regular reporting, improved outcomes for patients, with an emphasis on reducing health inequalities.

A key element of the plan is the health needs assessment which has been undertaken by Public Health and is included with the plan. This recognises the high level of morbidity and mortality from cardiovascular disease in the Cwm Taf area. The key messages are:

- Deaths from cardiovascular disease (all ages) are higher than the rest of Wales.
- Death rates from cardiovascular disease are highest in the most deprived populations. Thirty six percent of the resident population live in areas which are among the most deprived 20% (fifth) in Wales (WIMD 2011). Whilst the rates overall have decreased since 2001, the inequality gap has widened.
- Rates of premature mortality (under 75 years of age) from cardiovascular disease are the highest in Wales; death rates are
highest in the most deprived areas and twice as high in males than females.
- Premature mortality from coronary heart disease is the highest in Wales.
- The General Practice prevalence of hypertension and coronary heart disease (QoF 2012) is highest in the University Health Board (12.9% and 2.9% respectively). This is statistically significantly higher than the Wales prevalence for hypertension and CHD (11.1% and 2.6%)

Priorities

The Delivery Plan sets out the following:

i. **Delivery Theme 1: Promotion of Healthy Hearts**
   Aim: to ensure people are aware of and supported in minimising their risk of premature heart disease through healthy lifestyle choices and medication where appropriate.

ii. **Delivery Theme 2: Timely detection of heart disease**
   Aim: To ensure risk is managed and heart disease is detected quickly when it does occur, allowing timely progress to treatment.

iii. **Delivery theme 3: Fast and Effective care**
   Aim: People with heart disease receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life.

iv. **Delivery Theme 4: Living with Heart Disease**
    Aim: that whether in the community or in hospital, people are placed at the centre of heart care and their individual needs identified and met so they feel well supported and informed and able to manage the effects of heart disease.

v. **Delivery Theme 5: Improving Information**
   Aim: Ensure information systems support high quality care and performance, clinical audit and review information to drive service improvement.

vi. **Delivery Theme 6: Targeting Research**
   Aim: Ensure a commitment to research, delivering improved prevention and treatment options and outcome.

Currently undergoing peer review, our plan identifies the significant challenge that this brings and recognises the importance of developing a comprehensive prevention agenda. It is expected there will be a long lead time in seeing the planned outcomes from this work and in the interim, we also need to address increasing demands and challenges this places on services, as the number of patients requiring treatment rise across the pathway from primary to tertiary care.
Many of the underlying determinants of heart disease are also the same for other disease groups such as stroke and diabetes and the University Health Board is planning to address many of these in a single work programme linked to reversing the Inverse Care Law that will underpin all three delivery plans, as can be seen above. The initial focus of this work will be cardiovascular disease, which is a key driver for theme 1 of the action plan, promoting healthy hearts.

In terms of our secondary and tertiary care, our priorities include:

- Delivery of our Referral to Treatment targets including outpatients and diagnostics.
- Investment in a greater diagnostic unit capacity to accommodate ‘one stop assessment’ and allow services such as physiologist led treadmill testing, physiologist led pacing and defibrillator clinics to run parallel to consultant clinics.
- Development of Pacing Service at Prince Charles Hospital.
- Repatriation of Cardiology activity from Cardiff and Vale ULHB.
- Expansion of our catheter laboratory capacity.

Links to Workforce Plan

From the work done to date, it is likely that the plan will identify a shortfall in consultants, specialised cardiac nurses and physiologists, as well as a shortfall in equipment to meet the delivery requirements set by Welsh Government. The full extent of this is being developed in the next stages of our action and workforce plans and will require service redesign and prioritisation.

Links to Financial Plan

The challenges in meeting increasing demand for services, reducing waiting times and improving timely access to diagnostics and consultant services cannot be underestimated. Whilst clinicians have identified the need to expand certain services, especially one stop clinics and nurse led clinics, and investment to meet appropriate increases in demand has been built into the financial plan it is recognised that service and workforce redesign may not always be sufficient to meet the demands of the service within the timescales set.

A service and workforce review and redesign will be undertaken, resulting in a clear plan of what can be achieved within existing resources and what cannot, with the additional resource required identified and clearly evidenced. This will be aligned with the Directorate’s 3 Year Integrated Plan and will also be affected by the South Wales Programme as the implications of the outcome are worked through for other acute services.
We have identified that any work where a resource is identified, will need a robust business case prepared and submitted to the Executive Board for consideration. The plan clearly highlights the challenging financial context over the next three years within which the plan needs to be delivered.

**Performance**

The Cardiac Planning Group will be responsible for overseeing delivery, reporting progress to the Executive Board and producing an Annual Report for the Health Board which must then be published on our website. There will also be an increase in the number of heart disease related indicators that we will be reporting as part of our Integrated Quality and Performance Dashboard over the coming months to ensure greater visibility at Board level.

### 6.2.5. Respiratory Disease

**Key Strategic Drivers**

For respiratory care, the University Health Board has recognised that there is a high prevalence of respiratory disease in the population it serves. The Health Board has sought to address this in a number of different ways that include, providing education and support to primary care professionals to ensure timely diagnosis and treatment; increasing access to Pulmonary Rehabilitation; providing Home Oxygen services; and facilitating closer working between primary and secondary care health professionals.

**Priorities**

Chronic Obstructive Pulmonary Disease (COPD) is a particular focus for the University Health Board with approximately 8,000 patients registered as having the condition in Cwm Taf. This is clearly a significant health condition within Cwm Taf and is a legacy of the historical heavy industry, the socio-economic status and the prevalence of smoking. In 2012/13, there were 11,862 emergency admissions for COPD.

In order to support patients in managing this condition, the University Health Board is working with Glaxo Smithkline (GSK) and General Practices to optimise the management of COPD in primary care. The collaborative project involves training and education of healthcare professionals, optimising medicines use and increasing patients and carers awareness and understanding.

Other priorities for the University Health Board include:
Increasing referrals and provision of Smoking Cessation services;
Working collaboratively with Housing partners to educate the public and professionals on the relationship between housing conditions and respiratory health;
Delivery of an inhaler technique programme to primary and secondary care clinicians and community pharmacies; and
Development of referral pathways with Welsh Ambulance service to ensure patients with respiratory conditions are directed to the most appropriate service.

The University Health Board will reflect its next step priorities for respiratory services and also the requirements emerging from the national Respiratory Health Delivery Plan when it is published in 2014. It is anticipated that this will set out the Welsh Government’s vision for the delivery of respiratory services from 2014 onwards, which we will reflect also in our local plan.

6.3 Adult Mental Health

Key Strategic Drivers

During the early part of 2013 the Health Board reviewed its Strategic Framework and Local Action Plan to align it with the recently published Together for Mental Health – A Strategy for Mental Health and Well-Being in Wales. This work builds upon the considerable improvements made to mental health service provision in Rhondda Cynon Taf and Merthyr Tydfil over the past decade and to progress phase two of the Five Year Strategic Framework to address any remaining inequities, service gaps and modernisation needs.

Priorities

The Strategic Framework for Mental Health in Cwm Taf (2011 – 2016) presents a number of objectives for improving the lives of people with mental health problems and has three phases.

The first phase, adults of working age, was reviewed, planned and implemented this year and we are now in phase two examining older persons’ services. A key aspect of the strategy was not to treat components of mental health as separate as we aim to develop an ageless service which is supported within the new all-Wales Strategy. However, to ensure we can manage the strategic intention appropriately, it has to be phased. Linking key components of our service into a seamless pathway is essential to success.
Phase 2 of implementing the recovery model for older people involves significant service and workforce redesign. A paper was submitted to the Health Board in January 2014, giving approval to proceed to an engagement phase with patients/service users, staff, Community Health Council, statutory partners and other stakeholders on the newly proposed service redesign.

Over the next 3 years we will redesign older person’s mental health services, shifting the focus of treatment and care from in-patient settings to the community and improve the quality of patient care. Our aim is for patients to have high quality treatment and care in the right place, at the right time, without delays, with a high level of expertise. In particular, we expect in-patient assessment to be progressive, continual assessment to be consistent and liaison services to be enhanced.

In 2014/2015 we will focus upon in-patient care and building a sustainable model, in 2015/2016 we will ensure we have robust community and liaison services and 2016/2017 will see better outcomes overall compared to our current baseline across a range of key performance indicators.

A reconfiguration of in-patient services is only one part of the redesign programme. We would also aim to improve liaison services to reduce the length of stay in the general hospital wards and improve primary care liaison services. As the population ages, the demographic nature of general ward populations is changing. A snapshot survey of Cwm Taf beds (excluding Obstetrics, Paediatrics and Palliative Care) in September 2012 revealed that almost 3 in 4 general hospital beds in Cwm Taf were occupied by patients over 65, 1 in 4 beds occupied by someone identified as suffering from dementia and 1 in 12 by someone identified as suffering from a solely mental health problem. The combination of reconfigured in-patient mental health services for the elderly, enhanced liaison services and reinvestment from increased productivity will provide better outcomes for patients and the community.

On the basis of change we predict;

- Shorter in-patient stays for assessment.
- Reduced lengths of stay in continuous assessment beds.
- Safe high quality patient environments.
- Reduced delays in acute general settings.
- Early identification of preventable illness.
- Improved community service provision.

Over the next three years our wider priorities including the above include:

- Build on the ‘Recovery Model’ redesign, examine the development of locality based services and revised medical model working alongside GP Clusters.
• Develop proposals for addressing service gaps in Liaison Psychiatry, introducing a new service to deal with increasing mental health problems in acute hospital services. This is a key area identified in our 5 Year Strategic Plan for Mental Health.
• Develop a local strategy for psychology services and plan to rationalise the prescribing of anti-psychotics and to examine the further use of ‘talking therapies’/‘psycho education’ in partnership, to reduce the use of prescribing of anti-depressants.
• Shift to more community based services and work jointly with QUERY
• The development of a ‘Spend to Save’ Scheme for First Episode Psychosis.
• Develop a plan to manage the gap in the Court Diversion Service following withdrawal of provision from Abertawe Bro Morgannwg University (ABMU) Health Board in 2013 /2014.
• Support the roll out of the Rhondda Cynon Taf Reduction of Suicide and Self Harm Strategy and Multi Agency Immediate Response to Critical Incident Protocol into Merthyr Tydfil.
• Review needle exchange and supervised consumption schemes and revise current specifications to reflect best practice. In relation to needle exchange, this may involve the procurement of supplies and services from alternative providers.
• Continue to improve performance against the Mental Health Act Measures.
• Potential use of Intermediate Care Fund in partnership for EMI

Links to Workforce Plan

• The reduction of inpatient of capacity could release up to 23 WTE who will be redeployed into the assessment service and community services. In addition, recruitment to healthcare assistant (HCA) posts has been restricted to enable the redeployment of the HCAs into the acute medical wards.
• Following a review of the new model, further inpatient capacity could be released which following investment in community services may result in the need to release or redeploy up to 32 WTE.

Links to Financial Plan

Provision of at least £2.0m per annum has been made in each of the three years. Areas of investment being considered for 2014/15 and into 2015/16 include:-
• Liaison Psychiatry Services
• Community Mental Health Services

In terms of links to the savings plan and some reinvestment contributory schemes include:
• Older Person Recovery Model
• Potential closure of Y Bwthyn
• Potential closure of Tonteg

**Estate/Capital Implications**

• Potential transfer of a CMHT and OPMH service from Y Bwthyn
• Potential redesign of ward 35 at PCH to support new service model

**Performance**

The Mental Health Directorate has its own Performance Dashboard in addition to a number of indicators presented as part of the Corporate Integrated Quality and Performance Dashboard. These indicators include performance against the Mental Health Act Measure. The service redesign outlined above should lead to the following improvements in quality and performance:

• Improved health outcomes through early identification and treatment.
• Reduced acute length of stay.
• Increased admission avoidance.
• Reduction in the number of bed days

### 6.4 Child and Adolescent Mental Health

**Key Strategic Drivers**

The University Health Board provides Child and Adolescent Mental Health Services (CAMHS) to its own resident population together with the populations also of Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards.

CAMHS are undergoing a number of changes to develop services and minimise risks at all tiers of service. Work has commenced to review our core business within a limited funding stream, in line with the requirements of the Mental Health Measure and the recently released guidance on definitions to be used, the 'National Service Guidance for Planners'. In that respect, it is a specialist service dealing with significant mental health problems and complex co-morbid mental health. This work demands a strategic approach and a longer-term strategy in close partnership with all sectors in both Cardiff and Vale and ABM University Health Boards.

**Priorities**

• To assist operational delivery and performance, we will build upon the locality model and review the structure around the management and
administrative teams to support the localities and improve communication.

- As a CAMHS service we have commenced work to examine what our core business is within a limited funding stream, in line with the requirements of the Mental Health Measure and the recently released guidance on definitions to be used, the National Service Guidance for Planners. In that respect it is a specialist service dealing with significant mental health problems and complex co-morbid mental health.
- A significant element of CAMHS, particularly Tier 4 services, is commissioned by Welsh Health Specialised Services Committee (WHSSC). Working with WHSSC and the other Health Boards in South Wales, we will assist commissioners in developing the Community Intensive Treatment Team model further so that it is equitably provided throughout South Wales. In addition, work with WHSSC to formally commission the five additional beds in Ty Llidiard and repatriate patients from high cost placements at a cost neutral basis.
- The Tier 4 Inpatient Service is commencing work through implementation of STEAM (System to Escalate and Monitor). STEAM was designed to track in-patient acuity through accurately measuring it. It is being piloted in response to WG plans to identify and develop an occupancy level target between providers and WHSSC that could be reflected in the performance monitoring and contracting process.
- CAMHS are aiming to implement a care and partnership approach (CAPA) into our service. CAPA is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management. CAPA improves services to clients by:
  - Focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning;
  - Improving access by ensuring timely appointments that are fully booked, i.e. no waiting lists;
  - Ensuring service users are seen by a clinician with the right skills.
- Use of Outcome measures.
- Facilitates commissioning and provision of services by transparency of capacity and care packages.

There will be an initial presentation in January 2014 with clinicians to consider if CAPA is appropriate to take forward in CAMHS and identify a team to pilot it.

**Performance**

Over 2013 the management team in CAMHS have developed a performance dashboard and it currently includes the following data:

- Activity/Waiting List
• MHM Part 2 Information
• In-patient bed days/acuity
• Sickness
• Concerns/compliments
• Incidents/Sentinel events
• Finance

The dashboard is presented and discussed in the Clinical Business Meetings within the University Health Board regularly and is utilized by local clinical teams to check variances and improve performance. Our current hot spots for improvement are:

• DNAs
• Mental Health measures
• PDRs
• Medical Appraisals

**Estate/Capital Requirements**

• Potential reduction in number of CAMHS bases – possibility of single site option e.g. relocate Tonteg to RGH and look to reduce the number of CAMHS sites.

**Links to Workforce Plan**

• Consider findings of CNO Mental Health Nursing workforce standards.
• Administration review - likely to release resources if Tonteg move is supported.
• Evaluating impact of workforce changes in light of increased turnover.

**Links to Financial Plan**

• In process of agreeing a plan with both C & V and ABM UHBs to close the funding gaps over a 18 month period.

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**6.5 Drug and Alcohol Services**

**Key Strategic Drivers**

Established in 2010, the Cwm Taf Area Planning Board supports the planning, commissioning and performance management of substance misuse services.

**Priorities**

A broad range of integrated substance misuse services are in place and together with key stakeholders such as the Local Authorities and Third Sector organisations, with a number of developments underway including:
• A Drug and Alcohol Single Point of Access (DASPA) was expanded during 2013 to include children and young people. DASPA now assists people of all ages in seeking help for a drug and alcohol problem to ensure they get the support they need by the most appropriate agency.

• Alcohol Brief Intervention (ABI) is a brief, evidence based, structured conversation about alcohol consumption with patients/clients to motivate and support the individual to think about reducing their alcohol consumption. Public Health Wales has developed a training model for all Allied Health and Social Care and other professionals/workers to ensure a population approach to ABI. To date, over 300 individuals have been trained to deliver ABI across Cwm Taf with plans to roll out the train the trainer model in order to reach a greater proportion of the population.

• All schools and youth clubs have been issued with guidelines around the reporting of substance misuse incidents on their premises.

6.6 Learning Disabilities

Key Strategic Drivers

Services for Learning Disability are provided by Abertawe Bro Morgannwg University Health Board (ABMU) in partnership with the University Health Board, local authorities and partner agencies. CTUHB attend a strategic group led by ABMU to ensure there is delivery of key objectives.

‘Forward Together: Strategy for the South Wales Learning Disability Collaborative (Adult Services) provides an action plan for future development of learning disability services which we support and will implement as we strengthen our commissioning arrangements together with our partners.

Priorities

This Strategy set out to achieve, through incremental steps, the following:

• Creation of (managed) health teams leading to integrated health and social care teams.
• Development of services on the ‘Tiered Approach’
• Fully integrated services and formal partnerships utilising mechanisms as Section 33.

As most people with a learning disability will access health care through a variety of different means, it is important that all health care staff are aware and trained to deal with their needs. Training is available to all staff and for 2014 we will be implementing the new revised LD Care Bundle as
recommended by Welsh Government, with the aim of improving the patient and care journey when in general health care.

6.7 Oral Health

Key Strategic Drivers

The National Oral Health Plan (NOHP) for Wales outlines a series of actions for improving oral health and reducing oral health inequalities in Wales over the next five years and beyond. The Plan fits in well with the Welsh Government’s vision for the NHS in Wales outlined in ‘Together for Health’.

Cwm Taf University Health Board has developed its local Oral Health Delivery Plan to respond to each of the actions identified in the NOHP in order to address the oral health needs of the residents of Merthyr Tydfil and Rhondda Cynon Taf.

Over the last few months the members of the Cwm Taf Oral Health Advisory Group, which includes representation from the following areas, have developed the draft plan: -

- Community Dental Service
- Dental Public Health Team
- Local Dental Committee
- Head & Neck Directorate
- Hospital Consultants
- Primary Care Team

There remain sharp differences between individuals with the best and worst oral health in Wales and in Cwm Taf and our performance lags behind similar areas in some important aspects. Prevention is at the core of the plan and reducing the risk factors that lead to oral disease is only possible if the delivery of dental services and oral health improvement programmes are oriented towards primary health care and prevention.

Priorities

One of our major goals must be to help people take responsibility for ensuring their own good oral health. By working together, we believe we can make a real and sustainable difference to the oral health of our population. The University Health Board aims to deliver the actions outlined in the plan within five years and full implementation of the actions will lead to an improved provision of dental services and signs of improvement in the oral health of the population of Merthyr Tydfil and
Rhondda Cynon Taf.

This Strategy set out to achieve, through incremental steps and while all the actions outlined in the plan are important, we have prioritised 17 actions to be taken forward during 2013/14. The immediate priorities for identified in section 5.15.3 General Dental Services.

**Links to Workforce Plan**

Workforce issues identified in local plans include:

- An establishment review has recently been undertaken of the Nursing Staff which need to be considered.
- The Directorate will need to come to a decision about the way ahead for the Dental Laboratory Service. The Manager has retired and been replaced and there are plans being made for the possibility of generating further income and developing the service.
- Within Orthodontics, there are issues about the supply of SpR staff – the supply from the University is uneven year on year at present. There is a plan to smooth out this supply of staff and hence of patient flow but this may have financial consequences.
- The Orthodontic Department are currently considering options for replacing medical staff, including in restorative dentistry.

**Links to Financial Plan**

The **Oral Health Plan** highlights that the majority of the actions will be taken forward by making the best use of the current resource whether that is a staff, facility or financial resource. Where a financial implication has been identified it is accepted that the area will need to be included in the Cwm Taf three year strategic plan and prioritised against other areas in respect of the best use of resources within Cwm Taf. However, there is an expectation from the Welsh Government that General Dental Services (GDS) funding is utilised to its maximum and therefore any initiatives supported from the GDS allocation should be prioritised.

**Performance**

The Plan and the associated actions will form the work programme for the OHAG for the next 5 years and progress will be monitored through the quarterly meetings of the Group with reports presented to the Executive Board as appropriate.
6.8 Family Services

Key Strategic Drivers

Building on our achievements of planning and delivering services in partnership, we are working with our staff across the partnership to increase their skills and abilities to maximise every opportunity they are presented with to make a positive difference to children and families. We are working to support the needs of the whole family as well as the problems of the child or young person.

This in turn will empower families and raise awareness amongst parents on how best to meet the needs of their children, enabling effective engagement with the family earlier in line with programmes such as Flying Start and Families First which aim to reduce the numbers of family related problems escalating and requiring more specialist support.

Linked in with this work, maintaining safe and sustainable maternity and newborn care is a priority for the University Health Board and remains a challenge. Paediatric and Maternity services continue to develop, linked with the South Wales Programme, local paediatric service plans and our Maternity Services Delivery Plan. For neonatal care this challenge is shared across the South Wales area.

Priorities

- Continue to implement the plan to achieve standards outlined in the Welsh Government document, ‘Delivering a Strategic Vision for Maternity Services in Wales.’
- Work with partners to full implement the Continuing Care Framework for Children and Young People.
- Ensure mechanisms are in place to meet the new requirements for Adoption & Fostering Medical Services.
- Enhance community paediatric services including the development of Community Paediatric Nursing to prevent admissions or readmissions and deliver care closer to home when appropriate.
- For obstetrics and neonatal services all opportunities for innovative and new models will be pursued within the alliance to retain as much care locally as possible on the RGH site.
- Consideration of an innovative model for a potential Paediatric Assessment service and short stay observation beds at the “front door”,...
• to enable children who are unwell and their families to be supported and observed without the necessity of being formerly admitted to a children’s ward.
• Redesign of Community Midwife Service.
• Redesign the Hysteroscopy service to improve access and efficiency.
• Over the past few years, the Sexual Health service has undergone modernisation. The service has also had the benefit of new Health Park and Community Hospital premises in order to allow further developments to take place. As a result of modernising, which has also included restructure and development of the Operational workforce, the service is in a position to propose further changes that will enhance services for clients as well be cost effective.
• Increase access to home termination and early medical termination services.

Links to Workforce Plan

• Redesign of Community Midwife Service linked with the SWP implementation work.
• The development of Advanced Neonatal Nurse Practitioner roles has the potential to provide a stable workforce capable of delivering neonatal care traditionally provided by junior doctors in neonatal units.
• Timing dependant upon impact of changes to Paediatric rota in September 2014.
• The development of Advanced Neonatal Nurse Practitioner roles has the potential to provide a stable workforce capable of delivering neonatal care traditionally provided by junior doctors in neonatal units.
• Timing dependant upon impact of changes to Paediatric rota in September 2014.

Links to Financial Plan

A service and workforce review and redesign will be undertaken, resulting in a clear plan of what can be achieved within existing resources and what cannot, with the additional resource required identified and clearly evidenced. This will be aligned with the Directorate’s 3 year Integrated Plan and will also be affected by the South Wales Programme as the implications of the outcome are worked through for services.

Estates/Capital Requirements

Dependant on the South Wales Programme, capital may be required to facilitate single site working and/or transition planning.
Performance

A range of performance information exists in order to support the development of family services including the development of maternity dashboard.

6.9 Frail Elderly

Key Strategic Drivers

In recent years, health and social care partners in Cwm Taf have sought to strengthen the services provided to the frail elderly population by seeking to work collaboratively and increasing the range of services provided in communities. Particular successes include:

- Development of @Home services including:
  - CIAS
  - Community IV Service
  - Community Ward
  - Reablement & Intermediate Care
- Mental Health service developments

Despite the progress made above, our current system does not function as effectively as we would like and services do not always offer the right quality. We want to deliver services that are:

- Person centred;
- Dignified;
- Flexible
- Co-ordinated/joined up;
- Integrated between health and social care.

To address these issues the University Health Board established a Frail Elderly and Rehabilitation Project Board involving key partners to provide direction and energy for the continued development of services for this population group.

Following a review of current practice, the work of NHS Sussex and Birmingham and Solihull Frail Elderly Programme was highlighted by colleagues as resonating with the vision for services in Cwm Taf.
The diagram below sets out the principles that will govern the development and delivery of our services in Cwm Taf in the future (adapted from Birmingham and Solihull).

**Priorities**

- Review of current service models for chronic disease management to ensure patients are proactively managed in the community
  - Acute management of frail elderly patients in inpatient settings: where individuals do require admission to hospital we must ensure that frail patients are assessed in a timely manner by the appropriate multi-disciplinary team. The time spent in an inpatient setting will be minimised due to proactive management and discharge planning.
  - Key areas for development include: Explore opportunities for a single point of access to all assessment service for frail elderly patients (acute and community based).
- Development of a frail team/assessment model at the front door.
- Implement an in-reach model for complex discharge planning.
- Implementation of integrated assessment.
• Work with local authority and the independent sector providers to ensure the implementation of the National Outcome Focused Framework and robust funding arrangements.
• Work with Partners to fully establish the local Adult Safeguarding Board, contributing to the work plan priorities.
• Increase the breadth of support available in the community and provide additional population will be delivered through an integrated enhanced @Home service the name for our core and enhanced community services.

Key characteristics will include:
• Proactively identify and care for frail elderly at every stage of the pathway.
• Integrated health and social care team with one single point of access.
• Wrap care around the patient through care co-ordination;
• Care Coordinator role is a key function and must be performed by the right team member with the ability to advocate and influence.
• Care planning is owned by the patient and their carer.
• Ability to provide an acute response to those patients with short transient medical issues whose care/treatment could be provided in a community/home setting.
• Support patients to be safely ‘discharged’ from acute hospital;
• Early identification of frail elderly patients in primary care.

Links to Workforce Plan

• Further potential enhancement of @home service through the implementation of an ‘Initial Response’ team with a view to involving therapies and Local Authority partners in development of service model.
• Further development of community ward model.

Links to Financial Plan
Provision of at least £2.0m per annum has been made in each of the three years. This is currently being prioritised, with reinvestment required in a number of primary and community services to support the strategic direction articulated above.

Estates/Capital Requirements
Potential reconfiguration of Dewi Sant site to facilitate the conversion of inpatient accommodation for other uses, linked with the development of a South Cwm Taf Health Park.
Performance

The increase in the breadth of support available in the community and provision of additional robust alternatives to acute admission and support people coming out to assist patients coming out of hospital and being maintained in their own home or alternative non hospital setting will contribute towards at least:

- 5% reduction in non elective admissions
- 2% reduction on elective admissions
- 5% improvement in outpatient activity
- Further reduction in hospital admission avoidance where appropriate
- Assist with 5% reduction of non elective admissions and readmissions

6.10 Unscheduled Care

Key Strategic Drivers

Since January 2013, the University Health Board has faced high levels of emergency pressure which have severely affected the its ability to carry out elective activity and the number of cases cancelled due to lack of available beds continues to impact significantly on the core capacity delivered.

CTUHB submitted its Unscheduled Care Delivery Plan to Welsh Government in June 2013 and its Winter Plan in September 2013. Delivering sustainable unscheduled care services remains a top priority and key challenge for the Health Board.

Together with its key partners in Merthyr Tydfil County Borough Council and Rhondda Cynon Taf County Council, the University Health Board has been making a concerted effort to implement its plans and tackle the gridlock situation that had resulted in high levels of escalation within the University Health Board and across Wales for a sustained period of time. This is resulting in some significant improvements which can be seen for example in some of our tier 1 targets as outlined below.

Work has been focused on understanding the components of the pathway and their relationships and interdependencies. The plan is targeting improvements predominately in the length of stay, bed days released, impact on occupancy and emergency department performance with a collective focus on patient flow across its five main hospital sites by incorporating the ‘Improving Quality Together’ model with quality improvement coaches and a buddy system for adult inpatient wards. The aim is to reduce lengths of stay and enhance patient safety, effectiveness and the patient experience across all services.
There is a review and further development underway of parts of the @Home service (Community Integrated Assessment Service, Community Ward and Reablement services) to prevent inappropriate admissions and provide support for patients following discharge. The University Health Board’s response to Delivering Local Health Care sets out the range of actions required to further develop locality networks, support individuals with chronic conditions, ensuring our service model for frail elderly addresses the needs of this group of patients and address health inequalities via the Inverse Care Law Programme. Implementation of this work locally will be undertaken in collaboration with Primary Care, Local Authorities and Third Sector.

Further work remains ongoing to identify the key factors affecting the provision of our unscheduled care. The University Health Board continues to drive forward, across a range of areas, focusing on specific condition pathways identified in the point prevalence study as well as the more general process issues.

In light of the unscheduled care pressures, the University Health Board has invested in Advanced Emergency Practitioners in A&E, an additional Consultant in A & E; additional Middle grade Doctors in A&E and additional acute Physicians to support front-door activity in response to escalating risk in the management of emergency care.

**Priorities**

We will continue to develop this programme as part of a suite of measures used to drive forward a system that ensures patients access to services that are proportionate to their need. Going forward, the focus of work includes:-

- Provision of sustainable Accident and Emergency service at both PCH and an innovative acute medicine model at the RGH.
  - Appointment of extended hours acute physicians at the ‘front door’.
  - Communications campaign re minor injuries service.
  - Rollout the ‘Phone First’ model for minor injuries.
  - Redesigned Out of Hours service.
- The development of a sustainable service model for acute surgery.
- Proactively manage patient flow:
  - Daily multidisciplinary ward rounds.
- Anticipated Day of Discharge Model on all sites.
- Strengthening of the existing therapies assessment team.
- Criteria led discharge across all sites
- Establishment of Discharge Lounges on DGH sites.
Implementation of a live bed management system & improvements to operational bed management systems.

- Surge capacity area identified on each DGH site.
- Reduce demand on GP Out of Hours Services.
- Influencing the way the public access services.
- Promoting clinical engagement across the healthcare system.
- Evaluate the impact of the agreed work programmes on outcomes that reflect patient experience, patient care and quality.

**Links to Workforce Plan**

- Recruitment and reconfiguration of Acute Physician consultant rota to provide a structured commitment to include cover of Acute intake and Medical Day unit. Two Acute Physicians has been appointed and recruitment of two more is underway.
- A redesigned Out of Hours service will look to new and innovative roles to support the new model.

**Links to Financial Plan**

- A service and workforce review and redesign has been undertaken as part of the development of the Unscheduled Care plan and Winter Plan.
- This and further work underway is resulting in a clear plan of what can be achieved within existing resources and what cannot, with the additional resource required identified and clearly evidenced. This will be aligned with the Directorate’s 3 year Integrated Plan and will also be affected by the South Wales Programme as the implications of the outcome are worked through for services.
- Provision of at least £2.0m per annum has been made in each of the three years. Areas of investment for 2014/15 and into 2015/16 include:
  - Acute Physicians
  - Liaison Psychiatry Service
  - Acute therapy services
  - Discharge lounges

**Estates/Capital Requirements**

Capital is required to redesign all of the acute medicine services at the RGH site as this will significantly enhance the quality of patient care and productivity and will support the outcome of the South Wales programme.

**Performance**

We have made good progress on improving patient flow through our unscheduled care services, particularly over recent months. As the graphs
show below, our ambulance handover performance is amongst the best in Wales as we work hard to achieve the target; and our 4, 8 and 12 hour performance has improved significantly over the last couple of months as we have implemented our patient flow work.

The graphs below show recent performance against our improvement trajectories submitted to Welsh Government.

The following sets out the anticipated performance impact from the further planned actions detailed above which form part of internal performance monitoring arrangements and our demand/capacity planning outlined in Chapter 4. We aim to look for:

- Reduction in overall non-elective length of stay from the 2012/13 level by at least 10% through:-
o Greater turnaround on day 1 in CDU/MAUs (extended medical cover, bed reconfiguration at RGH).

o Increased ward round and ‘board’ round frequency from physician medical time released by improved CDU turnaround, including increased weekend ward rounds.

o Realignment of beds between medicine and surgery, and re-allocation within medicine.

o Reduced/avoided outliers and multiple patient moves.

o Improved discharge practice on wards (EDD compliance, nurse led discharge, cultural change etc – dependency on nursing productivity project)

o Increased speed of access to social care packages (choice policy review, performance management, engagement with LAs etc)

o Earlier discharge to community hospitals via reductions in community hospital length of stay (dependency on frail elderly project)

o Better management of patient flow from moving to real time bed state recording and reporting, and use of information from periodic point prevalence studies.

o Improved case management of trauma including earlier trauma surgery due to trauma co-ordinator.

o Reduced admissions to residential and nursing homes from hospital.

• A 5% reduction in non-elective admissions from 2012/13 outturn (including re-admissions) from :-
  o Improved/more integrated CIAS, front door therapy assessment and in reach reablement teams and models
  o Extended therapy assessment team at PCH
  o Improvements to primary care decision making (e.g. COPD training packages).

• Non-elective bedday reductions from the above enabling :-
  o Priority 1: reduction in average occupancy to 85% occupancy, thus avoiding medical outliers and enabling planned care to work optimally (and so reduce RTT costs in the first instance), and enabling improvement in A&E 4 hour performance.
  o Priority 2: possible reduction in capacity if the above target could be exceeded, but not to be a core target deliverable in 2013/14.

• A&E :-
  o Avoiding A&E attendances through more admissions direct to CDU/MAU
  o Greater turnaround on day 1 in CDU/MAUs (extended medical cover, bed reconfiguration at RGH).
Increased ward round and “board” round frequency from physician medical time released by improved CDU turnaround, including increased weekend ward rounds
- Re-alignment of beds between medicine and surgery, and re-allocation within medicine. Avoiding A&E attendances through maximising use of MIUs (phone first etc)
- Avoiding A&E attendances through improved WAST protocols and practice
- Avoiding A&E attendance through better use of CIAS/review of CIAS model
- An overall resulting reduction in attendances through the PCH and RGH A&Es of 5%.

- Frail Elderly & Rehabilitation :-
  - Optimise and integrate CIAS, therapy assessment teams and in reach re-ablement to provide the maximum contribution to reducing acute and community hospital bed-days.
  - Reduction in length of stay in community hospitals

### 6.11 Cancer Services

**Key Strategic Drivers**

In summer 2012, the Welsh Government published a national Five Year Cancer Delivery Plan. In October 2012, the University Health Board developed a local Cancer Delivery Plan which established our action to improve outcomes in the following key areas between now and 2016 and the specific actions that would be undertaken in year 1 (2013 /2014).

A Cancer Access Delivery Plan was also developed and submitted in June 2013 focused on delivery of the 31 and 62 day cancer access targets and improvements required. The Plan outlined the strategies that it will employ within Cancer Services to bring the Urgent Suspected Cancer (USC) targets back into line and maintain performance.

**Priorities**

Delivering high quality cancer services that result in good clinical outcomes and improved survival rates is a key priority for us. In addition to delivering the priorities identified within our Local Cancer Delivery Plan, during 2013 /2014 we are focusing on:

- Continuing to sustain and improve compliance for All Wales Cancer Standards;
• Treating patients as efficiently and effectively as possible, in particular striving towards achieving cancer waiting times targets.
• Responding to the outcomes of Peer Review processes undertaken during the year.
• Delivering on the priorities identified within our Local Cancer Delivery Plan 2013/2014; and
• The production of our Annual Report for Cancer Services in line with Welsh Government requirements;
• Responding to the recent patient experience findings.

Performance

The University Health Board has given a commitment to Welsh Government that every complex urgent suspected cancer (USC) referral for which the complete investigation and treatment pathway is delivered within Cwm Taf, will be treated within its target date. Similarly the University Health Board expects that all non urgent suspected cancer (NUSC) referrals will be treated within 31 days of a decision to treat, although this also depends on delivery within the timescales in tertiary centres.

A copy of our most recent performance against our improvement trajectory is shown below:

In terms of our 31 and 62 day access performance, whilst the major focus of the work has been in urology and the need to arrive at a decision to treat within 31 days, all directorates have been asked to focus on ensuring that a decision to treat is reached as soon as possible. A robust
approach to performance management has been taken and cancer patients are "tracked" by the cancer service teams and an escalation process for patients outside their target dates has been implemented.

As a commissioning University Health Board, we will ensure that referrals are made to partner LHBs/Trusts following a decision to treat/diagnosis within the first 31 days of the pathway. However, it must be appreciated that the diagnostic pathway for some cancer patients can be complex, involving a number of investigations, and on these occasions obtaining a decision to treat within the first 31 days is not always possible. This is particularly true of lung cancer patients who have multiple investigations before a definitive treatment pathway is agreed.

We will continue to manage the interface with our tertiary providers and receive a weekly report on progress with the tertiary element of the pathway, with an agreed escalation process of Medical Director to Medical Director.

6.12 Stroke Services

Key Strategic Drivers

Our Stroke Delivery Plan builds upon the considerable improvements made to stroke service provision in Rhondda Cynon Taf and Merthyr Tydfil in recent years, by continuing to progress the development and redesign of stroke services.

Aligning with the National Stroke Delivery Plan, our local plan focuses on the whole pathway of care from stroke prevention, to detecting stroke quickly, delivering fast, effective treatment and care, and supporting life after stroke. This is underpinned by improving information and targeting research.

Priorities

Following extensive stakeholder engagement during 2012/13 and 2013/14, proposals to redesign stroke services in Cwm Taf incorporating the centralisation of the acute and rehabilitation stroke units and creation of an Early Supported Discharge service are being further developed. This proposed redesign is driven by the need to meet ever more challenging quality standards and to make best use of specialist stroke resource.

The key features of our proposed new model for stroke care are:
Consideration is being given to incremental implementation of the new model, whilst decisions are being made as part of the South Wales Programme, which will enable some of the more pressing performance issues relating to resilience on single-handed stroke specialists to be addressed and to enable performance against the stroke care targets to be optimised and service quality to be improved for patients.

We therefore propose to introduce this redesign incrementally during 2014/15, starting with the centralisation of stroke rehabilitation beds, followed by centralisation of our acute stroke beds onto one of our acute hospital sites.

Meanwhile it can be seen from the performance information below that our performance has been variable, although there have been significant improvements over recent weeks, particularly in care bundles 2 and 3 as a result of further improvement work we have put into place including:

- Designated fast-track stroke trolley in resuscitation;
- Ring-fenced stroke bed on both stroke wards to enable direct admission following confirmation of stroke diagnosis;
- Weekly monitoring and reporting of performance at present.
- To overcome the recurrent problem of delayed swallow and nutritional screening, both sites are now ensuring there is a designated nurse 24/7 to take responsibility for stroke care in line with the bundles.

### Links to Workforce Plan

- Through our Stroke Services Redesign project we are proposing to use our specialist stroke resources differently in a reconfigured model of stroke care, by bringing the specialists who are currently spread out across various hospital sites into stroke centres of excellence, and to create multidisciplinary teams to support patients to return to their home and family life as soon as possible.
- Centralising our stroke specialist resources will enable us to provide more equitable access to stroke specialists, particularly consultants and therapists, several of whom currently work single-handedly and cannot be covered when on leave.
- For the rehabilitation service the impact on staff is minimal. However, this will require therapies staff to either rotate, or relocate, to different sites.

- Centralisation of acute and early rehabilitation stroke services into one dedicated stroke unit on an acute hospital site;
- Centralisation of longer term stroke rehabilitation services on one community hospital site;
- Creation of a community based stroke Early Supported Discharge service.
sites. In respect of the acute service, again therapies staff will be required to rotate or relocate to different sites. In respect of nursing the current staffing levels do not meet the guidelines set out in caring for acute stroke patients which will require investment.

- Further detailed work needs to be undertaken to ensure that the workforce plan enables appropriate staffing levels on both an interim basis and in respect of the longer term plan to meet the Stroke guidelines.

**Estate/Capital Requirements**

The stroke service redesign will require capital to facilitate the required moves. At present £0.5m is built into our capital programme in 2014/2015.

**Performance**

The following tables set out our performance this year against the stroke bundles set as part of the tier 1 targets by the Welsh Government.

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### Bundle 3

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### 6.13 End of Life Care

#### Key Strategic Drivers

A [Strategy for Palliative and End of Life Care Services](#) was developed by a clinically led multi-disciplinary team and has formed the basis of the [Cwm Taf local End of Life Care Delivery Plan](#) published in September 2013.

**Priorities**

- The redesign of palliative care services in Cwm Taf focuses on the development of a locality wide model which addresses both the estates provision and improving the quality and co ordination of palliative care services in Cwm Taf.
• A key element of this work is being developed through stakeholder engagement on the future provision of specialist palliative care services currently provided at Y Bwthyn, with a view to relocating the service onto a purpose designed facility such as on the Royal Glamorgan Hospital site.
• This will enable improved access to acute interventions for palliative care patients, whilst also offering a suitable environment for end of life care.
• The model identifies a range of health and social care services already delivered within the community and wishes to strengthen the @Home model for palliative care aligning this with the @Home service.
• The model also provides the opportunity to integrate teams, develop new pathways, work with the Third Sector providers and reduce duplication to achieve better outcomes for patients and service users.

**Links to Workforce Plan**

• Maintenance of robust District Nursing Service to provide community based palliative care.
• MacMillan CNS posts been agreed.
• A full service workforce review and redesign programme will be undertaken to assess the workforce implications and actions needed to deliver the service changes specified.

**Links to Financial Plan**

Potential release of Y Bwthyn

**Estates/Capital Requirements**

• Capital funding will be required to support this development.
• MacMillan Cancer Support has indicated that they may be willing to help support this development financially.
• Following a move of service Y Bwthyn would become free for potential disposal, assuming other co-located services are also relocated.

**Performance**

An outcome framework to accompany Welsh Government’s [Together for Health - Delivering End of Life Care](https://www.gov.wales) will provide the main mechanism for annual performance reporting.
6.14 Accessible Healthcare

Key Strategic Drivers

The recently launched Welsh Government standards focus on the needs of people with sensory loss. This includes people who are deaf, deafened or hard of hearing; blind or partially sighted; or deafblind whose combined sight and hearing impairment cause problems with communication, access to information and mobility.

Priorities

Our work as a University Health Board will look to encompass actions to ensure that:

- All frequently used information leaflets and documents intended for patients and the public should be available in accessible formats for patients with sensory loss;
- All public and patients areas should be accessed in order and understand their needs and this process must involve and engage with people with sensory loss and ensure that their views are reflected in any proposals to design, develop or change a service. Capital funding will be required to support this development.

We have established a project group with Executive leadership to develop an agreed action plan with clear timescales and actions for delivery. This will include the review or development of appropriate policies, procedures and protocols in order to effect the changes required to deliver the standards. There will also be a significant training agenda. Progress on the delivery of the plan will be monitored and reported formally to the Board.

6.15 Primary and Community Care

The design and provision of our primary and community care services are aimed at:

‘Supporting people to live independent, healthy and fulfilled lives’

The following sections describe the priorities for our primary and community services:
6.15.1 General Practice

The Health Board’s annual spend on GMS services is £43,274,808 with a range of services commissioned from its Practices via the GMS contract in addition to the essential and additional services which all Practices provide.

The Quality and Outcomes Framework is a voluntary incentive scheme which rewards Practices for the quality of care they deliver. QOF achievement is reviewed annually by the Board; the 2012/13 data identified that achievement in Cwm Taf was comparable to all Wales figures.

Particular issues within Cwm Taf include the number of small single-handed practices which affects the range of services available within those Practices and the number of deprived communities which contributed to the high workload within General Practice.

A key priority for the Localities Management Team has been to ensure appropriate and equitable access to primary care services. Working collaboratively with GP Practices significant improvements have been realised as follows:

- 83% of practices in Cwm Taf are open for 95% or more of weekly total hours compared to 21% in 2011.
- 2% of practices in Cwm Taf are open for less than 80% of weekly total hours compared to 13% in 2011.
- 60% of practices are open for daily core hours or within one hour of daily core hours compared to just 33% in 2011.
- 98% of practices offer appointments between 17.00 and 18.30 at least 2 week days.

6.15.2 Out of Hours

Work has progressed with regard to the remodelling of Out Of Hours (OOHs) and the UHB has engaged with stakeholders as part of the change management process. It is envisaged that the new model will be based on ‘integrated emergency care’ centres at the acute sites. Timescales for implementation of the remodelled service are currently being developed.
Links to Workforce Plan

The new model will require collaborative working between A&E staff and OOHs staff. The impact of this will result in the need to relocate the elements of the service not currently operating out of the acute sites.

6.15.3 General Dental Services

There are currently 36 General Dental Practices and 2 Community Dental Services (CDS) Practices providing general dental services in Cwm Taf. The number of practices in each locality is shown in the table below:

<table>
<thead>
<tr>
<th>Taf Ely</th>
<th>Cynon</th>
<th>Merthyr Tydfil</th>
<th>Rhondda</th>
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<td>8</td>
<td>9</td>
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The University Health Board is also responsible for the provision of emergency dental services for those patients who require immediate access to dental treatment. Within Cwm Taf we do not have any specialist orthodontist practices, so the majority of patients are referred to specialist practices in Cardiff.

The University Health Board also has a Dental Teaching Unit which is collaboration with Cardiff University Dental Postgraduate Department and was the first of its kind in Wales. The majority of patients who attend the Unit require extensive treatment as many patients have not been in receipt of regular dental treatment.

The University Health Board also provides oral health sessions, along with an extensive dental health promotion programme delivered in primary schools with further targeted support in schools in Communities First areas.

In response to the National Oral Health Plan (NOHP) for Wales the CTUHB has developed a local oral health plan, through the Health Board’s Oral Health Advisory Group. This sets out our priorities over the next 3 years.

- In total 17 areas have been identified for action during 2014 and these focus on prevention, access in primary dental care and the provision of specialist services in secondary care. Amongst these immediate priorities are:-
  - Increased delivery of fluoride based prevention and fissure sealant to patients attending dental practices.
  - General Anaesthetic service provision for special care dentistry.
- Provision of restorative dentistry services.
- Commissioning a referral based dental conscious sedation service in the primary/community setting.
- Reviewing and developing a care pathway for domiciliary care.
- Commissioning additional GDS/PDS services in Merthyr Tydfil

### 6.15.4 Optometry

There are 29 Optometry Practices in Cwm Taf and they provide a wide range of services including sight tests and eye examinations, fitting of contact lenses and dispensing of spectacles. This work is either delivered under the General Ophthalmic Service or privately. Ophthalmic expenditure in primary care which includes sight tests, optical vouchers, repair and replacement claims is currently non resource limited.

The University Health Board has continued to work with Community Optometrists to provide alternative pathways to the Hospital Eye Service and has introduced visual fields and intraocular pressures refinement pathway. This allows accredited optometrists to repeat diagnostic tests to confirm the risk of glaucoma and also improves the accuracy of referrals and deflects unnecessary referrals into the secondary care service. 25 Optometrist Practices are currently participating in the pathway.

Over the next 12-months the University Health Board will focus on improving access for patients and the delivery of the Eye Care Plan. This includes:

- Establishing an Ophthalmic Diagnostic and Treatment Centre to service the populations of Merthyr Tydfil and the Cynon Valley.
- Expanding the catchment area of the current ODTC in the Rhondda to include patients from the Taf Ely area.

### 6.15.5 Community Pharmacy

Cwm Taf has 77 Community Pharmacies and on average each pharmacy in Cwm Taf will dispense over 400 prescription items every day. Community pharmacists have on average greater contact with patients on a daily basis than any other health care professional and they provide accessible healthcare at the heart of the community. Community Pharmacies are making an increasingly important contribution to the health and well-being of everybody living across Cwm Taf.

The University Health Board is committed to developing integrated community based services that improve access to health care. [Together for Health: a Five Year Vision for the NHS in Wales](#) reinforces the
opportunities for using community pharmacies to deliver services to the community. We will continue to explore new and innovative ways of working that draws upon the skills and expertise available through community pharmacies, this will not only enhance the role they play in meeting the needs of our community, but it will also allow increased access to health care services.

The Cwm Taf University Health Board 3 year Community Pharmacy Strategy outlines 5 key themes where community pharmacy services can be developed:

- Health Promotion and Public Health
- Workforce Integration
- Chronic Conditions Management
- Medicines Management
- Finance & Resources

Our key priorities for developing community pharmacy services over the next three years are: The key developments for the next 3 years are:

i. Public Health

- Develop the community pharmacy substance misuse and needle exchange services.
- Develop community pharmacy based vaccination and immunisation services.
- Review and develop existing sexual health and emergency contraception service provision.
- Review and develop the provision of smoking cessation services via community pharmacy.

ii. Integrated Workforce

- Develop the role of a portfolio pharmacist.
- Develop the concept of joint appointments with community pharmacy employers.
- Develop resource packs to support community pharmacist to provide targeted MUR’s & DMR’s.
- Review and develop the role of community pharmacists in providing anticoagulant services.
- Review and develop the role of community pharmacists in the provision of palliative care medicines.

iii. Medicines management

- Review and develop the role of community pharmacists in the provision of pharmacy led support to care homes.
- Develop the pathfinder minor ailments service in community pharmacy in line with Welsh Government directions.
- Review and develop the role of community pharmacists in the HMAS service.

**iv. Finance & Resources**

- Review and develop community pharmacy Waste Reduction Scheme.
- Develop the Repeat Dispensing Service (RDS).
- Delivery of the Your Medicines Your Health programme

**6.15.6 Community Services**

The ‘Delivering Local Health Care’ plan builds on progress made in implementing ‘Setting the Direction’ and aims to accelerate the pace of change. A key feature of the plan is to continue to build on the development of locality networks along with improved integration and co-ordination of services, care and support between health and social care. In this context the plan sits alongside the Health Board’s response to the consultation document “A Framework for Delivering Integrated Health and Social Care”.

‘Delivering Local Health Care’ provides a framework for action for Health Boards, Local Authorities and the Third Sector, to respond to current challenges and to provide high quality, equitable services to meet the needs of people across Wales. The purpose of the Delivering Local Health Care Plan is to increase the pace and scale of change in the way services, care and support are planned, organised and delivered, to better meet the needs of people in local communities across Wales. The key themes are:

- Improving health and wellbeing.
- Improving access to local care.
- Supporting people with long term conditions.
- Improving care for older people.

The development of locality networks along with improved integration and co-ordination of services, care and support between health and social care will be crucial to ensuring successful delivery.

The University Health Board aims to achieve our vision referred to above by providing health and social care services that are:

- Integrated, joined up and seamless;
- Focused on prevention, self-management and reablement;
- Responsive and locally delivered in the right place, at the right time and by the right person; and
- Safe, sustainable and cost effective.
Which will:

- Promote healthy lifestyles and prevent ill health;
- Promote independence and protect the vulnerable; and
- Improve services and joint working.

By:

- Investing in the development of short term services such as Reablement and Community Integrated Assessment Service (CIAS);
- Formalising information sharing and integration between health and social care staff; and
- Locating services in the community where they are needed.

A significant amount of work has already been undertaken to redesign the community services infrastructure and this has facilitated some reduction in capacity within the acute settings. In April 2012 an ‘Invest to Save’ (I2S) application was submitted to the Welsh Government to support the further development of community services which was successfully approved. The funding is based on the premise that investment in these services (known as @Home) will support the shift in resources required to reduce reliance on acute services. The @Home service is the overarching name for a range of services provided in the Community which include the existing core services of:

- District nursing services
- Primary Care GP services
- Reablement services
- JETT
- Palliative Care
- Community Mental Health
- Community Stroke services
- Parkinsons and other chronic disease services

The ‘invest to save’ funding enabled the University Health Board to develop new services and enhanced existing services to complement core service provision. These are listed below:

- The Community Integrated Assessment Service (CIAS)
- Community Ward
- Community IV Service
- Reablement

The @Home model was launched on 29 October 2013 (Reablement and Community IV service were already in place however invest to save funding was provided to Reablement to increase access). An evaluation of the impact of the services in the first year is currently being
undertaken. Initial findings highlighted a number of issues which the Health Board is currently pursuing.

These include:

- Developing a single point of access across health and social care to streamline the pathway for frail elderly patients and provide primary care colleagues with a more robust and timely response.
- The current CIAS model will be reviewed to identify opportunities to increase the number of admissions avoided. This could be achieved by implementing a risk stratification tool in primary care, thereby targeting the resource at those patients at greatest risk of admission.
- There is further potential to provide additional support to Care Homes using the CIAS outreach model maintaining complex patients within this environment where traditionally care may have been delivered in hospital.
- An assessment of the potential benefits of using the current resource to deliver an Initial Response service and associated implications of refocusing the resource in this way (this will allow the team to manage acute short term conditions e.g. COPD exacerbation).
- The function of the Community Resource Team needs clarification and the Health Board is currently exploring how this resource could be used to more effectively manage more complex cases in the community.
- There is potential to increase the capacity of the Community IV Antibiotic service and a need for a 7 day service.
- Reablement services have yet to realise full capacity and therefore greater impact could be achieved with a full complement of staff.

The above will inform the next stage of development of our @Home services ensuring that we further strengthen our community infrastructure and develop the model to meet the growing demands on these services.

### 6.15.7 Locality Development

The University Health Board’s Locality model has been developed in conjunction with local authority partners who have restructured their social services functions to develop a “total operating model” which aligns to Localities. The model is outlined below:-

- Universal Services – Information and advice
  - Communications Hub
- Targeted Interventions – Short Term Services
  - Direct Discharge Referrals
  - Multi Disciplinary Discharge Liaison Meetings
  - Reablement
- Reablement in Day Centres
- Care and Support – Long Term Services
  - Home Medication Administration Scheme
  - Supply – Commissioning Integrated Community Equipment (Vision Products)

Delivering services on a Locality basis as close to peoples’ homes as possible will lead to benefits for service users in terms of quality of care, access and timeliness. By providing a visible seamless and reliable community and primary care structure, co-ordinated across health and social care, our citizens will have increased confidence in local public services.

Primary and community services within Cwm Taf are managed on a Locality basis by two Locality Management Teams:

- Rhondda and Taff Ely
- Merthyr Tydfil and Cynon

Within each of the four Localities there are two GP clusters consisting of a number of GP Practices. It is the University Health Board’s intention to further develop the cluster model and introduce the concept of “federated” practices which will support the provision of localised services which may have traditionally been provided in a hospital setting. The development of primary care services is led by our Locality Clinical Directors, one for each Locality. The Locality Clinical Directors facilitate regular Locality meetings with General Practices in their Locality, providing a mechanism for two-way communication on key service developments/issues. Services currently provided on a Locality basis include:

- District Nursing
- Health Visiting
- School Nursing

**6.15.8 Inverse Care Law Programme**

The Inverse Care Law Programme is central to the University Health Board’s commitment to driving up standards through service remodelling based on the needs of the population and the best available evidence of clinical and cost effectiveness. A comprehensive programme focused on disease prevention and early intervention through primary care and community services will realise benefits across the whole pathway.
The programme recognises the importance of a ‘whole of society approach’ to promote healthier, happier and fairer lives.

An implementation plan is being developed for Cwm Taf, which is focussing initially on cardiovascular disease. The plan will detail specific interventions to be undertaken in primary care to assess vascular risk and ensure optimal treatment of patients. It is proposed that investment upstream in primary care and the community will in time realise reduced demand on services in secondary and tertiary care.

Reducing the burden of cardiovascular disease in Cwm Taf will increase the number of years lived in good health, free of disability and limiting long term illness. This will enable the working age population to remain economically active and improve outcomes for families and the community. There will also be benefits to the health and social system realised through the reduced burden of ill health and disability.

The programme has a number of priority commitments as follows:

- To focus on premature mortality from cardiovascular disease (approx 40 fewer deaths per annum in adults under 75 yrs across Cwm Taf);
- To be implemented across Cwm Taf University Health Board targeting the Localities (six GP Cluster areas with the highest level of deprivation). The approach will be determined by the needs and maturity of the locality;
- To prioritise actions that should be able to demonstrate outcomes within 5 years;
- To focus on systematic and population scale implementation of evidence-based interventions;
• In the initial phase, the programme will focus on the determinants of inequalities in health that are within the control and influence of primary care and the wider locality networks.

6.15.9 Integrating Health and Social Care

A Localities Leadership Group for Cwm Taf was established in 2013 to bring together public service officers across the Cwm Taf region to focus on the integration of health and social services (specifically Adult services) both in terms of management arrangements and also operation delivery.

The key objectives of the Locality Leadership Group are:

• To support the integration of service delivery and management arrangements in four Localities across Cwm Taf.
• To implement a joint performance management framework.
• To identify the opportunities for more collaborative use of resources both in terms of workforce and finances.
• To implement joint commissioning arrangements.
• To identify any opportunities for information sharing protocols and use of IT systems.
• Support the implementation of an Integrated Assessment.

The importance of this agenda locally has already been recognised by the Cwm Taf Regional Collaboration Committee. Integrated Localities is one of the six local delivery projects agreed as part of the work programme of the Cwm Taf RCB. The project is part of the plans to implement 'Setting the Direction' and "Sustainable Social Services for Wales – A Framework for Action", driving forward integrated health and social care, focusing on the provision of services on a locality basis as close to people’s homes as possible.

Working through the four Localities of Rhondda, Cynon, Taff Ely and Merthyr Tydfil, the vision of partners is to support people to live independent, healthy and fulfilled lives.

As part of the workstream, a European Social Fund (ESF) bid was submitted to WG for project management support to provide additional momentum and capacity to tackle the organisational and cultural barriers to progress and deliver the change we need more quickly. In particular the project was to address the need for:-

• integrated service delivery and management arrangements including governance;
• a joint performance management framework;
• more collaborative use of resources in terms of workforce and finance;
• joint commissioning arrangements;
• information sharing protocols and use of IT systems;
• collaboration with a wider range of stakeholders at locality level including the Third Sector and Communities First.

This bid was approved and a project manager took up post on 9th September 2013. Alongside this, the Institute of Public Care have been working with partners to review current arrangements supporting health and social care integration and provide a steer for the actions which will be taken forward through the ESF project and Delivering Local Health Care.

6.15.10 Community Resource Team

The University Health Board’s Community Resource Team consists of a range of professionals who provide community based services which are more specialist in nature or, where critical mass suggests that this service should be provided on a Cwm Taf wide basis. Such services delivered by the Community Resource Team include, Tissue Viability, Lymphoedema, and support to Care Homes and Parkinson’s services. The Community Resource Team support wider community based services in maintaining patients within the community and providing those services which can be delivered outside of the acute hospital setting.

The Community Resource Team also provides support to General Practice in the provision of GMS services where Practices have short term staffing issues or where the Health Board takes on a Practice as a Managed Practice for a period of time.

6.15.11 Community Hospitals

Community Hospitals are key to the Health Board’s vision for Setting the Direction and the provision of care closer to home. Reviewing the role of community hospitals will ensure that they play a more dynamic role within the local community, it being considered vital that the services available in key community hospitals are improved to support a greater shift of care from acute hospitals with the potential for more medical, specialist, therapy and diagnostic services available closer to patient’s homes.

The completion of Ysbyty Cwm Cynon, in the Spring of 2012 provides us with an exciting opportunity to deliver a comprehensive range of high quality rehabilitation and intermediate care services from one modern,
purpose built facility. It will be a centre of excellence and hub for community rehabilitation services serving the patients of both Cynon and Merthyr Tydfil.

As well as Ysbyty Cwm Cynon the Health Board opened Merthyr Health Park in September 2012. The Health Park supports integrated delivery of care by providing a multi-agency base for a range of professionals working within the Merthyr Locality. The Health Park will remove boundaries between organisations and support new ways of working and the development of integrated teams.

**Priorities for primary and community care include:**

- Further and more rapid development of primary and community care services, in line with the Welsh Government’s drive to develop a wider system of integrated service delivery and further integration with social care
- Improving ‘patient flow’ by implementing ‘pull’ systems that minimise the number and length of hospital admissions and support admission avoidance. The specific focus will be on the @Home model.
- Development and implementation of a Frailty model for Cwm Taf. Continuing to improve access to GP services, including new models for GP ‘Out of Hours’.
- Developing a single point of access to direct patients to the most appropriate service to meet their clinical need. This will also involve developing alternative referral pathways in collaboration with the Welsh Ambulance Service Trust (WAST).
- Development of a frailty model for Cwm Taf which sets out the Health Board’s vision for the future provision of services for this patient group.
- Redesign of Community Hospital services including review of current service provision linked with reducing average length of stay.
- Further development of Locality Networks, led by the Locality Leadership Group; based on the needs of the local population.
- To achieve the objectives of the Localities Leadership Group as outlined above. Focus on addressing inequalities in health care via the Inverse Care Law project.
- Development of key chronic conditions pathways which the strengthen availability of services within the primary and community setting and are delivered by integrated teams.
- Exploring options to utilise technology to provide individuals with a chronic disease with an individual care plan.

**Links to Workforce Plan**

- Reliant on workforce to work in different models of care.
- Requires engagement and sign up of secondary care, primary care and partner colleagues.
- Medical productivity.
Nursing productivity.
Further investment of resources, redirected from elsewhere in UHB into this service.

Links to Financial Plan

Building on the successful improvements in patient flow over the last three to four months, to extend the flow work and add additional improvements to systems and pathways of care to further reduce the requirement for acute and community beds. These additional improvements include increasing the acute physician service, introducing a Liaison Psychiatry Service, and using the current Newton review to help us to focus our actions on improving flow, subject to success with invest to save funding to pump prime these developments. This should enable the incremental release of bed capacity in the next financial year and further investment in primary and community care services.

Estates/Capital Requirements

• Review of Primary & Community service provision across the various estates in an effort to improve the quality of services via relocation, centralisation and/or release of sites for alternative use or disposal
• Aberdare Health Centre – potential relocation of GP practice and community staff.
• Capital may be required to support the modernisation of a number of GP premises which remain under the management of the University Health Board.

Performance

A number of primary and community care indicators are included in the Integrated Performance Dashboard including:

• GP all day opening
• GP appointments availability between 5.00pm and 8.00pm
• Enhanced service provision
• Immunisation rates
• Condition of premises

5.15.12 Medicines Management

Key Strategic Drivers

Medicines use by patients is the most common and frequently occurring healthcare intervention in the developed world. Pharmaceutical Care is the responsible provision of drug therapy for the purpose of achieving
definite outcomes that improve a patient’s quality of life. Ensuring that patients have the best outcomes from their medicines through excellent pharmaceutical care is a key challenge and an opportunity for the UHB and its Medicines Management Team.

The health benefits for both our patients and economic opportunities for our healthcare system that can be derived from effective pharmaceutical care are significant. As part of this approach, pharmaceutical care already works alongside the principles of prudent healthcare, where we aim to avoid waste and harm, apply the minimum intervention, maximise the benefit of interventions and encourage co-production and self reliance with patients. This will translate into a whole system culture change with respect to the way medicines are used and is the basis for the Cwm Taf project “Your Medicines Your Health”.

A particular challenge for pharmaceutical care is the public health and demographic changes linked to an aging population and the associated increase in need in terms of chronic condition management identified in chapter 3. The “over 65” age group constitutes 12% of the population but consumes 40% of the primary care medicines expenditure. 36% of people over 60yrs take 4 or more medicines compared to 7% below 60yrs. The “over 65” age group is growing in Cwm Taf

We believe that maximising the benefits from medicines, whilst minimising the potential harm, can deliver the most benefit to the frail and vulnerable in society.

Another important driver is the work to reduce antimicrobial resistance as part of the UK Antimicrobial Resistance (AMR) Strategy. This will be another key challenge for all Health Boards and Trusts in the UK and will involve a multidisciplinary and cross sector approach.
The development primary and community care aimed at ‘supporting people to live independent, healthy and fulfilled lives’ is outlined in section 6.15. This reinforces the necessary shift of both focus and support to the Primary care sector and identifies the added value that can be achieved in this model using a range of healthcare professionals including the increased role of community pharmacy in primary healthcare delivery.

Priorities
Promoting medicines safety, improving quality and ensuring cost effectiveness will continue to be the cornerstone of the work of our medicines management team.

In 2014/2015 our priorities will include:

- The implementation of the medicines transcribing and electronic discharge system (MTeD) across secondary care and ensure access by pharmacy staff into IHR via the Welsh Clinical portal.
- To fully develop and extend the Your Medicines Your Health programme as a large scale intervention that will change the culture of patients and the wider public with respect to the use of medicines.
- To implement the Antimicrobial Stewardship Programme as a multidisciplinary, cross sector programme of initiatives to ensure the best clinical outcome for treatment or prevention of infection, to minimise unintended consequences of antimicrobial use, including antimicrobial resistance and to minimise healthcare costs without compromising quality of care.
- To review and extend access to the Home Medication Administration Scheme (HMAS) for all Cwm Taf localities.
- To implement the next phase of the Community Pharmacy Strategy ensuring best use of this primary care resource to deliver the UHB objectives. This will include the public health agenda of smoking cessation and flu vaccination services and extending the Choose Well Scheme.
- To implement the Frail and vulnerable Pharmaceutical care Strategy, which will include provision of community based poly-pharmacy medicines reviews, reducing antipsychotic use in dementia patients, implementing falls prevention medicine reviews and using post discharge medicine use reviews in supported discharge processes.
- To deliver the financial challenges of the prescribing expenditure saving targets through schemes at the local, UHB and Welsh Government levels.
- To respond to and support clinical services by reviewing and realigning pharmacy services to clinical speciality changes, by implementing technology such as ward based automated storage units and leading on new models of managing medicines such as electronic prescribing in secondary care.
**Capital requirements**

- MTeD equipment and implementation will require capital investment to deliver patient flow and quality benefits.
- The replacement of existing medicines management technology is required to sustain and improve services; these include replacing the pharmacy computer system (EDS), replacing the automated pharmacy system in RGH and updating the aseptic unit equipment.
- Investments in modernising the management of medicines will include more ward based automated storage units and developing electronic prescribing for secondary care.

**Invest To Save**

- The Antimicrobial stewardship programme requires an investment in additional pharmacist resources to enable the programme to be fully implemented and sustained across the whole of the UHB including engagement with the public. The savings have been identified in the prescribing of antimicrobials and the patient and quality benefits fully support this in the business case.
- Extending and sustaining HMAS across the UHB localities requires investment in resources. The qualitative and financial benefits of avoided hospital admissions or care home admissions have been identified.

**Links to workforce plan**

- Service redesign to support the S. Wales programme changes and the shifting focus to primary care.
- Implementation and use of MTeD.
- Implementation and development of the Antimicrobial Stewardship Programme.
- Implementation of the Frail and Elderly Pharmaceutical Care Strategy.
- Increased use of ward based automated storage systems.
- Increased use of independent prescribing pharmacists.
- The development of Consultant Pharmacist posts and Advanced Practitioners.

**Links to financial plan**

- Acute and primary care prescribing savings plans delivery.
- NICE and AWMSG approved medicines planning and control.
- Community pharmacy contract becoming a cost pressure to support the public health agenda of smoking cessation, flu vaccinations etc.

**Estates/Capital Requirements**

- Capital funding for MTeD is required and had been identified and in addition it has been included as a bid to the Health Technologies Fund.
Performance

There is a well developed medicines management Key Performance Indicators (KPI) dashboard which includes financial and patient quality and medicines safety indicators. This also links to the C-Difficile rates and Anti Microbial Stewardship (AMS), patient flow indicators and discharge communication (MTeD).

6.16 Secondary Care

Clearly the South Wales Programme has a significant impact on the development of the University Health Board’s clinical service strategy as we move forward. The Programme was set up by the Health Boards in South Wales - Cwm Taf, Aneurin Bevan, Cardiff & Vale and Abertawe Bro Morgannwg and Powys Local Health Boards, working in partnership with the Welsh Ambulance Services Trust, in order to develop options for the reconfiguration of some specialist, acute hospital service in line with the requirements of Together for Health.

The drive to meet and maintain core clinical standards supported by a sustainable clinical workforce has required hospitals across the UK, including Wales, to review how some key hospital services can be safely staffed to provide safe and appropriate hospital care. The main specialties under pressure and the focus of the South Wales Programme include:

- Accident and Emergency, also described as Emergency Medicine
- Paediatrics and Neonatal services
- Maternity services and consultant obstetrics units in particular.

In order to ensure that the optimal range of configuration options could be considered, the Health Boards agreed to assess possible scenarios that would take account of wider population needs rather than focus solely on local service solutions within individual health board boundaries.

For the services identified, the Health Boards completed a Public Engagement and Consultation exercise which took place between September and July 2013 on possible scenarios to reorganise consultant led Emergency Medicine, Obstetrics and Inpatient Paediatric services.
The scenarios all assumed that University Hospital of Wales in Cardiff, Morriston Hospital in Swansea and the proposed Specialist and Critical Care Centre in Llanfrechfa in Aneurin Bevan will comprise three of the ‘specialist’ hospital sites.

In February 2014, the South Wales Programme Board made a number of recommendations to its constituent Health Boards and in March 2014, agreement was reached on the next phase of work to develop the detail of the future models of care and implementation plans that will provide sustainable solutions across the new alliances of networked hospitals.

For the Health Board, as part of the South Central Alliance, the following outlines the key elements of further detailed and implementation work now underway, either within the Health Board or as part of the Alliance as required:

- The South Wales Programme consultation confirmed the strategic importance of Prince Charles Hospital (PCH) in preserving access to services for the residents of South Powys and the wider heads of the valleys communities. Recognising some of the critical mass challenges this hospital faces, Cwm Taf in association with other Health Boards will accelerate the network arrangements requiring support from both the South Central and South East Alliances in delivering services in Prince Charles Hospital in the medium and long-term.

- The developing role of the University Hospital of Wales (UHW) as a major trauma centre will become increasingly important to the population of Cwm Taf in the future. In this context, it is recognised that the most seriously ill patients and injured patients will not receive their care in Royal Glamorgan Hospital in the future.

- This will mean that 24 hour consultant-led A&E services will not be delivered from the Royal Glamorgan Hospital (RGH) site in the future but implementation will require the proposed new model for a local Accident and Emergency service and acute medicine (aligned to an appropriate surgical and critical care system) to be in place before or at the same time as the changes take place. It has been agreed that RGH will be a ‘beacon site’ for developing a new and innovative model of acute medicine that maximises the opportunity of delivering the widest range of medical care in a local hospital setting.

- These changes will require a significant improvement in the local emergency ambulance response together with the development of a robust retrieval and transfer system to mitigate risk. Recognising its own responsibility for commissioning of ambulance services, Cwm Taf will work closely with partners including the Welsh Ambulance Service to develop a retrieval and transfer system that will function within the to safely manage patient flow.
• Inpatient Paediatric services will not be delivered from the RGH site in the future but implementation will be dependant upon a new local assessment model being in place, before, or at the same time as the changes take place, to ensure that the majority of children continue to have their care delivered locally.

• The Royal Glamorgan Hospital will also develop a significant role in diagnostics and ambulatory care supporting the wider network of hospitals within a South Wales Central Alliance

• For Obstetric and Neonatal services all opportunities for innovative new models will be pursued within the Alliance, to retain as much care locally as possible on the RGH site.

Our staff will be fully involved in developing the new models of care which will have to be in place before or at the same time as the traditional models change. We are now progressing swiftly with getting our key staff together to do the detailed planning, with work already going with clinicians around acute medicine; creating a new front-door model that fulfils the consultation commitment to keeping the vast majority of work locally and working with Cardiff and Vale UHB on obstetric and neonatal service development. We are also establishing next step discussions with our clinicians on developing a model for an acute paediatric assessment unit at RGH.

The new Alliance arrangements give us the opportunity to be at the forefront of a new and exciting model of acute service delivery that so our patients get the best care and our staff get the very best opportunities to be part of the delivery system across hospital boundaries.

### 6.16.1 Scheduled Care

#### Key Strategic Drivers

The University Health Board (UHB) submitted its [Scheduled Care Delivery Plan](#) to Welsh Government in June 2013. This described our plans to bring Referral to Treatment (RTT) targets back to agreed trajectories for each speciality. The plan acknowledged that achieving and sustaining the required RTT position in all specialities will continue to be a major challenge for us.

The Board recognise the benefit of early assessment and treatment on health outcomes and place a high priority on achieving the national access targets. We have taken positive steps to improve our performance, including implementing a range of ‘enabling’ measures that are contributing to the development of a sustainable service model. We
remain committed to our journey of continuous improvement necessary to develop a sustainable service model for scheduled care.

**Priorities**

Our expectation remains that there will be no 52 week breaches at the end of March 2014 and we are confident that we will deliver a year end figure for 36 week waits below our original trajectory of 1,071 outlined in our Scheduled Care Plan. We remain committed to deliver March 2014 position for 36 week waits that shows an improvement on the March 2013 RTT position where we had 824 patients waiting over 36 weeks.

With regard to demonstrating continuous improvement for planned care from April 1st onwards, detailed below is the UHB’s estimated trajectory based on the end of year target being achieved.

<table>
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This straight line trajectory is not speciality specific and there are particular challenges to achieving a zero 36 week position by the end of November 2014 in orthopaedics, ophthalmology and most significant oral surgery. Achieving the target in these specialities will necessitate additional activity in the first eight months of 2014/15 and this will incur additional cost.

We are undertaking focused work in specific areas this includes demand and capacity exercise for oral surgery with a view to identifying alternative treatment pathways for patients. We have also commissioned external capacity for MRI as the first step to improving diagnostic waiting times in radiology and similar strategies will be employed for other radiological modalities where necessary.

As part of our improvement work, we will continue to maintain a particular focus on improving efficiency and patient flow. This includes improving admission rates for day of surgery, building on the Enhanced Recovery after Surgery (ERAS) model which is already in place for a small number of consultants in some specialties. Key enablers are also expansion of overnight stay capacity, improved treat in turn rates, and pre-operative assessment. The new Theatre Productivity Tool, along with the thematic project to look at theatre productivity, has recently been introduced to support surgical teams to improve theatre utilisation.

In relation to outpatients, the waiting time for a first outpatient appointment has grown to an unacceptable level in some specialities over recent months. This is due in part to long standing capacity issues in some areas, in particular the Head and Neck specialties and consultant
absences in Gastroenterology, Cardiology services and Restorative Dentistry. Whilst every effort has been made to replace key posts this has not always been possible within the necessary timescales and it has resulted in a backlog in activity. We are continually reviewing the situation and looking at ways of developing services in primary care, identifying alternatives pathways, improving efficiency and maximising capacity in outpatients.

The Musculo Skeletal (MSK) Triage service within orthopaedics has reduced demand for outpatient consultation by 50%, with patients being seen more appropriately within therapy services. Within oral surgery, the development of a community based minor oral surgery service is also beginning to reduce demand for consultant led services. We will continue to look for opportunities to manage demand via alternative sources in other areas.

There has been some progress in moving appropriate outpatient activity back in to primary care, particularly in diabetes, cardiology, oral surgery and ophthalmology. This will need to be integrated with the referral management project, supported with improved referral criteria and referral management systems to improve demand management.

Our Theatre Quality Improvement Group was set up to improve overall theatre efficiency, safety and productivity. The membership includes all the surgical clinical directors, with the Clinical Director for Anaesthetics chairing the group. Under the cross-cutting theme of theatre productivity, a figure of 1.5 million has been identified as a savings target. This is based on the fact that the utilisation rates are assumed to be 78%. Since April 2013, the utilisation rate has improved. The average theatre utilisation rate at present is now 83% for CTUHB as a whole.

With the improvements we are seeing in unscheduled care and patient flow, we are seeing far fewer operations cancelled improved utilisation and higher productivity. We are also seeking to increase our current day case and short stay surgical rates, thus reducing the need for patients to stay in hospital for less than a day 23.59. There is also a focus on theatre start times trying to ensure lists start on time to include the pre-lists briefing times.

During 2014/2015 the focus of work will include the following, including systems to manage referrals and to direct people to the most appropriate setting:

- Reducing unnecessary overnight stays, maximising the use of the Overnight Surgical Stay Units and the throughput of elective cases on a day case basis.
- Increasing theatre productivity and efficiency, and developing measures and processes to monitor improvements.
• Optimising core outpatient and inpatient capacity and improving patient flow.
• Reducing bed days and length of stay using evidence based models such as ADD, Enhanced Recovery after Surgery (ERAS) and a standardised Health Board wide Pre-operative Assessment Screening Service.

Performance

The University Health Board’s current performance against the RTT access targets is as follows:

![36 Week Census Profile - All specialties](chart)

The reported position for December showed there were 47 patients waiting in excess of 52 weeks. The majority of the breaches were for patients requiring general surgical, ophthalmology and orthopaedic procedures. The reported position for December is 1458 patients waiting over 36 weeks and a 86.44% performance against the 26 week target.

Links to Workforce Plan

• Therapies are introducing demand led working across 7 days with the aim of:
  o Reduced LOS
  o Increased admission avoidance
  o Improved patient flow

• This is requiring redesign and enhancement of the workforce to deliver services across seven days.

Links to Financial Plan

The financial plan highlights a total of £1.3m fixed and up to £0.6m of variable costs that will be invested in achieving our referral to treatment targets for next year.
Performance

- There are a range of indicators related to scheduled care in the Integrated Performance Dashboard including:
  - Referral to treatment time
  - Theatre efficiency
  - Average length of stay
  - Delayed transfers of care
  - Surgical site infection rates

6.16.2 Critical Care

Key Strategic Drivers

Critical care provision is very expensive with the major recurring costs relating to medical and nurse staffing, and drugs. An analysis of the Critical Care use in Wales undertaken by the Public Health Wales Observatory in March 2012 estimated that:

- Level 3 (ventilated or 3 or more organ failure) care cost in the region of £1500 to £2000 per bed day.
- High Dependency care (1 or 2 organ failure not including ventilated care) cost in the region of £500 to £1000 per bed day.

NHS Wales has a limited number of critical care beds with an average of 3.2 (intensive care) beds per 100,000 people. This is lower than the number of beds provided for the population in the rest of the UK. Such a low level of beds makes it all the more important that they are used to maximum efficiency and effectiveness by minimising avoidable or unnecessary admission and ensuring timely discharge.

Value for money is expected in all areas of healthcare and we know much can be done to improve the efficiency of critical care. However, efficiencies alone will not be enough to cater for the increasing demand and the national plan recognises that further investment to increase critical care capacity is necessary. The extent of this shortfall requires further modelling to fully understand the total unmet need.

This plan will play a pivotal role in helping NHS Wales understand this unmet need and will also support the service reconfiguration aligned to the Welsh Government’s Together for Health – Delivery plan for the Critically Ill.

Priorities

Our Delivery Plan for the Critically Ill is divided into 5 themes as follows:
The University Health Board acknowledges the challenges it faces in implementing the Delivery Plan for the critically ill 2013 – 2016. In themes 1, 4 and 5 we are either partially or fully meeting the standards, where there is partial compliance there is an action plan in place to achieve full compliance.

**Links to Workforce Plan**

- In themes 2 and 3 investment is required in medical staffing to achieve full compliance. Both Prince Charles and Royal Glamorgan hospitals currently provide Tier 3 care services. However we do not meet the required Medical Staffing standard, in particular in relation to intensivist cover.
- There may be difficulty recruiting middle grade Anaesthetic doctors in the future, which will need to be closely monitored.
- There maybe opportunities to train Anaesthetic Critical Care Practitioners such as Band 7 Nurses or ODP staff to take on some of these responsibilities which will be further investigated.

**Links to Financial Plan**

- To meet the standards, further investment will be required in a junior tier of medical staff in Prince Charles Hospital (depending on the review of the South Wales Programme) and an increase in the number of Consultants specialising in Intensive Care Medicine.
- This investment will enable the University Health Board to meet the Tier 3 standard and will need to align with the Directorate’s 3 year Integrated plan and is also likely to be affected by the South Wales Programme as the implications of the outcome are worked through for other acute services.
- A service and workforce review and redesign will be undertaken, resulting in a clear plan of what can be achieved within existing resources and what cannot, with the additional resource required identified and clearly evidenced.
- This will be aligned with the Directorate’s 3 year Integrated Plan and will also be affected by the South Wales Programme as the implications of the outcome are worked through for services.

**Performance**

The University Health Board will receive Annual Reports detailing progress against the Delivery Plan for the Critically Ill. The Integrated Performance Dashboard also includes critical care delayed transfers of care and theatre cancellations.
6.16.3 Clinical and Non-Clinical Support Services

Key Strategic Drivers

We continue to maximise opportunities to utilise clinical and non-clinical support services to support service re-design, develop new ways of working and to maximise capacity within the healthcare system.

These services include:

- Pathology
- Diagnostics
- Medical Records, Clinical Coding & Patient Care Administration
- Outpatients
- Facilities
- Patient care administration
- Procurement
- Corporate services

Priorities

i. Pathology

**Introduction of Blood Science department:** currently Biochemistry, Haematology, Immunology and Transfusion are separate departments with individual management and staffing skill mix structures; plan is to amalgamate the services into one department.

**Regionalisation of Microbiology & Histopathology Services:** potential redesign of CTULHB microbiology & Histopathology testing service into Public Health Wales. The intention is to regionalise the testing but leave consultants in situ to maintain the clinical link. This could lead to a single microbiology and Histopathology service in South East Wales region and Wales and is dependant upon further redesign work and agreement.

**Clinical Haematology service redesign:** utilising new technologies

**Electronic referrals:** building on the introduction of LIMs, development of electronic test requesting and results reporting.

**Repatriation of haematology/chemotherapy** from Cardiff.

**Point of care expansion** - Introduction of POCT INR service. This service is part way complete. As part of the change to better INR service provision, we will introduce self testing service. This plan is to provide point of care testing in the community with the aim of reducing admissions. Screening patients prior to symptoms has already been proven.
• **Autopsy service** - The impending change to the Coroner’s Act will herald the introduction of Medical Examiners. All deaths will involve the ME which will likely increase the number of autopsies. Whilst currently this service is provided for the Coroner by HB consultants in below the line job plan activity the increase will impact on the current staffing ability to manage. A plan to provide this service has been produced and is to be discussed with the Medical Director, HM Coroner and Local Authority.

**Diagnostics**

**Development of a diagnostic hub** concept, building on increased direct access, increased capacity required and as a linked part of implementing the South Wales Programme.

**Radiology service redesign**: further role redesign and skill mix work is being developed in conjunction with the workforce plan. Single site for breast radiology is a preferred option.

• **Radiology capacity** / geography is dependent on the clinical support required for each CTUHB site and will also be dependant in part on the outcome of the South Wales Programme.

• **Rolling programme for replacement equipment** - facilitate the IT infrastructure and equipment replacement programmes that underpin diagnostic provision.

• Review equipment decontamination arrangements for community services.

• **MRI capacity** will also need to be increased as figures are based on the present, with increased staffed time. Increased demands with technological advance (e.g. all prostate cancers imaged with MRI and an increased need for stroke management etc). This will require further MRI capacity. CT Colonography is projected to require additional time and is a clinical cancer requirement.

• **Additional CT capacity** will be required to address increasing capacity requirements and also help address difficulties with acute on call imaging associated with breakdown, equipment service and eliminates patient transfer. Further high end CT Scanner capacity will also permit development of Cardiac CT which is another necessary clinical development.

**Medical Records, Clinical Coding and Patient Care Administration**

• Roll out of partial booking within Medical Records: all patients should receive a letter six weeks before their outpatient appointment which confirms the time and date. The patient then rings the call centre to confirm that they are available and happy with the appointment. This is also sometimes called patient focussed booking and is recommended as part of guide to good practice. As the roll out of partial booking to the remaining follow up specialties is progressed,
the work of the admissions office will reduce due to the introduction of the live bed management to the wards
• Engage with management, staff and staff side about possible job redesign at an early stage in planning.
• Live bed management rolled out fully to all the wards in RGH.
• Move some of the admissions office staff to Ty Elai to increase partial booking.
• Review of Health Records standards, linked in with the Royal College of Physicians standards.
• Health Records Digitisation Project
• Focus on improved clinical coding data quality
• Improved clinical engagement in clinical coding
• Implement longer term, sustainable workforce plan for clinical coding, linked in with succession planning.

Outpatients
• As part of our outpatient redesign, we need to invest in information technology systems within outpatients to communicate with our patients.
• One area is to invest in text remind service reminding patients about their new or follow up outpatient appointment the day before.
• The other is to invest in self serve patient check in system. Patients can book themselves into an outpatient clinic without having to go through a receptionist. This has £300k savings identified for outpatients.

Facilities
• Implementation of income generation opportunities.
• Facilities services re-design including:
  o Housekeeping: review of cleaning standards for low risk areas as outlined in the Cleanliness Standard and audited by Credits for Cleaning Audit Tool;
  o Catering: review of restaurant services;
  o Portering/security: service review

Procurement
• Procurement savings review to continue linked with cross cutting theme.

Corporate Services
• Complete corporate services review
• Identifying opportunities for support services to improve process efficiency and quality of care.
• Identifying opportunities for support services to improve process efficiency and quality of care.

**Capital Requirements**

• Pathology reorganisation: there will need to be some capital money available to redesign departments, yet to be estimated.
• Radiology rolling programme for replacement equipment - facilitate the IT infrastructure and equipment replacement programmes that underpin diagnostic provision.
• Income generation opportunities within facilities may require capital expenditure as an enabler
• The developing plan for the digitisation of patient health records will require significant capital investment but will avoid premises costs, and support the move over time to a digital health record, significantly reducing medical records staff costs.
• The creation of a diagnostic hub at RGH would improve patient flow (and hence reduce bed requirements) at Cwm Taf by reducing A&E and inpatient waits for diagnostics, while providing additional capacity for scans across South Wales to provide cheaper alternatives to the current use of premium rate capacity.

**Links to Workforce Plan**

**Pathology & Radiology**

• Following the introduction of the All Wales On-call agreement both Pathology and Radiology have introduced a 24/7 shift system to cover out of hours work. This was not achievable within the current establishment and required additional investment into qualified posts. Both services are within a period of transition and recruitment will be complete by the end of 2014/15.

**Pathology**

• Potentially a significant number of staff will not wish to relocate and will therefore need to be redeployed or released. Work is ongoing in modernising laboratory careers through skill mix redesign.
• Development of alternative roles for POCT e.g. HCAs undertaking some phlebotomy duties
• Potential introduction of more nurse led clinics to increase the capacity of consultants.
• Recruitment to a new consultant for the autopsy service. However this is an area where there are recruitment difficulties.

**Radiology**

• Service redesign and additional MRI and CT capacity requirements all have implications for further investment in radiographers.
Medical Records, Clinical Coding & Patient Care Administration

- The Health Records Digitisation Project includes a staff investment of 10 temporary WTE’s in quarter 1 (Q1) 2015/2016, with an eventual release of up to 50 administration posts.
- Further detailed work is required to understand the potential benefits of increased use of technology on administration systems.

Links to Financial Plan

There are a number of links to the financial plan including the following:
- A number of the themes above are cross-cutting themes

Performance

- There are a range of indicators related to clinical and non-clinical support services in the Integrated Performance Dashboard and local dashboards. For example:
  - Clinical Coding
  - Diagnostic and Therapy waiting lists
  - Outpatient activity and clinic cancellations

6.17 Commissioning

Commissioning is the means by which the University Health Board aims to secure the best value for local citizens and taxpayers i.e. the best possible health and wellbeing outcomes, within the resources available. It is an on-going process within the Health Board that applies to all services, whether they are provided internally, by other Health Boards, Trusts, Local Authorities, other public agencies, or by the independent sector.

The Commissioning and Contracting delegated budget manages both the outflow of monies to other providers to deliver a range of services for Cwm Taf residents and the inflow of monies from other LHBs for Cwm Taf to provide services for other LHBs residents. These flows of monies are supported by Contracts/Long Term Agreements (LTAs). In summary, for the full year 2012/13, these flows were as follows:
To put this into context, the entire University Health Board delegated budget excluding contracting and commissioning is £480m so the contracting flows are very significant for the organisation.

The University Health Board has developed a commissioning strategy and our local commissioning intentions are underpinned by ten key principles that are outlined in our commissioning framework. These are:

- Applying the NHS Core Values.
- Patient Centred.
- Inclusive Stakeholder Engagement.
- Needs based.
- Whole System.
- Services should be provided as locally as possible.
- Services will be evidence based using best practice and fostering innovation wherever possible.
- Achieving Value for Money.
- Performance Managed to ensure services deliver high quality care efficiently, effectively and in a timely manner.
- Commissioning decisions are based on ‘good decision making’ guidance.

A key focus for commissioning has been on understanding the patient flows between LHBs and the impact on the historical contracts that underpinned these flows. Our ambition for this work has been to ensure that patients who need care outside Cwm Taf receive appropriate and timely services which represent good quality and value for money. This has enabled Cwm Taf to improve its contracting arrangements. Through clinical engagement in the commissioning process, it has also led to a range of improvements, which include developing appropriate services that are closer to home for patients.

We aim to build on this work and in this context we will:

- Ensure the services provided to our residents are evidence based for clinical and cost effectiveness, ensuring best practice and innovation are fostered.
- Provide services, whenever clinically appropriate and cost effective, locally within Cwm Taf. Where services are provided within Cwm Taf, they will be provided, as far as clinically appropriate, within a range of improvements, which include developing appropriate services that are closer to home for patients.

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<td>4.559</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>4.171</td>
<td>19.165</td>
</tr>
<tr>
<td>WHSSC</td>
<td>5.938</td>
<td>52.928</td>
</tr>
<tr>
<td>Velindre</td>
<td>-</td>
<td>5.848</td>
</tr>
<tr>
<td>Powys</td>
<td>0.980</td>
<td>-</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>0.186</td>
<td>0.279</td>
</tr>
<tr>
<td>NCA/IPFR</td>
<td>0.408</td>
<td>0.734</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35.894</strong></td>
<td><strong>84.321</strong></td>
</tr>
</tbody>
</table>
community/ out of hospital setting and as close as possible to peoples homes.

- Commission services we cannot provide within Cwm Taf from neighbouring LHBs to reduce travelling times for patients, recognising that a small number of patients requiring more specialised treatment may be required to travel to a UK specialist centre in England.
- Maximise value/mitigate risks in our external contracts; including to avoid/reduce additional Referral to Treatment spend

### 6.17.1 Specialist Services

Specialised and tertiary services are those provided by a relatively small number of specialist centres, to populations greater than 1 million people. These services are typically high cost and low volume. The Welsh Health Specialised Services Committee (WHSSC) is a Joint Committee of the seven health boards in Wales, and is responsible for the planning of specialised and tertiary services on their behalf.

The [Commissioning Plan for Specialised Services for Wales 2014/2015](#) sets out an integrated commissioning plan for specialised and tertiary services for the population of Wales for this financial year. On behalf of LHBs including Cwm Taf, the aim of WHSSC is to ensure that these services are planned and secured from providers that have the appropriate experience and expertise; are able to provide a robust and sustainable service; are safe for patients and are cost effective for NHS Wales.

The seven Health Boards in Wales have agreed a three year commissioning strategy in order to:

> “Ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales.”

The strategy also aims to raise awareness and understanding of specialised services and to ensure that specialised services help meet the Institute for Healthcare Improvement ‘Triple Aim’ to:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

The key priorities for the six programme areas are set out in the following work programmes:
• Mental Health
• Cancer and Blood
• Cardiothoracic
• Neurosciences and Complex Conditions
• Renal
• Women and Children

During 2014/15, Cwm Taf University Health Board will continue to work with WHSSC to look at further opportunities to improve the management of pathways between secondary care and tertiary services.

In particular, one of the key issues for Cwm Taf in 2014/15 will be the repatriation of ICD work from Cardiff & Vale University Health Board to Cwm Taf University Health Board. This will expand the range of interventional cardiology services within Cwm Taf and improve access for patients.

The Commissioning Plan for Specialised Services for Wales 2014/2015 is being discussed at the Joint Committee on 25 March 2014 but was not approved. The Plan set out a forecast deficit of £13.861m, of which risk share attributable to the University Health Board was £1.730m, broadly made up to two elements:

• A forecast deficit of £0.758m in 2013/14 to carry forward,
• Net additional costs pressures of £0.972m, covering full year effects of 2013/14 pressures, adjustments for non-recurrent 2013/14 items and new cost/demand pressures, net of savings schemes.

The Cwm Taf UHB financial plan (see section 8 below) includes, as a working assumption, that the forecast deficit of £0.758m will roll forward but net pressures of a further £0.600m will arise (made up of £1.2m gross pressures net of a £0.600m internal savings target). The WHSSC Plan discussed at the Joint Committee therefore anticipates a cost which is £0.372m more than that provided for in the Cwm Taf University Health Board 3-Year Plan. However, it is assumed that all health boards will continue to work closely with WHSSC to reduce the projected costs by ensuring that service growth is appropriately managed, savings opportunities are maximised and value for money is provided for in WHSSC contracts, based on sound evidence and due process.

6.17.2 Clinical Transport Service

Ambulance response targets remain challenging across the Cwm Taf locality. There are a number of contributory factors for this including:

• Geography/topography.
• Increased activity.
• The increased acuity of calls.
• Flow of ambulances out of the area.
• Resource levels to meet demand.

In spite of this, there have been a number of positive improvements across the area, all of which contribute to a wider, more sustainable unscheduled care system. These include:

• Significantly reduced levels of hospital delays
• Team based working and a new management structure
• Development of additional care pathways
  o Use of Community First responders for 2013 April to November, Cwm Taf has the highest contribution to 8 minute performance from Community First Responders across Wales at 6.3 %.

All of these improvements have been put in place during the last 12 months and therefore need time to come to fruition. In conjunction with resource levels which meet demand, there is evidence to support improved ambulance response times and a subsequent improvement in patient outcomes.

Performance against the 8 minute standard (Red/Category A) within Cwm Taf locality for the year to date 2013/14 (April/December) is at 54.7% against the 65% standard. Performance against the 8 minute standard for Merthyr Tydfil UA is 58.4% Year to December. Performance against the 8 minute standard for Rhondda Cynon Taf UA is 53.8% Year to December.

The following factors are key influences to current performance achieved:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Life threatening calls have risen by 17% (an additional 2,408 incidents in January-December 2013 compared to January-December 2011).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Green call volume has increased by 8% (an additional 1,626 incidents January-December 2013 compared to January-December 2011).</td>
</tr>
<tr>
<td>Acuity</td>
<td>999 calls shows a 2% increase in life threatening calls (January-December 2013 compared to January to December 2011).</td>
</tr>
<tr>
<td>Flow</td>
<td>There is a significant net flow of ambulance resources out of Cwm Taf, particularly into the Aneurin Bevan area.</td>
</tr>
</tbody>
</table>
When comparing 2012/13 to 2010/11 (2 years prior), there has been 17% increase in Red / Category A demand (verified incidents).

![Cwm Taf Cat A Verified Incs 2011 vs 2013](image)

In addition, Green call volume (i.e. those calls not immediately life threatening) has increased by 8% (an additional 1,626 incidents January-December 2011 compared to January-December 2013).

![Cwm Taf - Top 5 Chief Complaints 2012/13](image)

During 2012/13 the top 5 chief complaints alone accounted for 40% of all emergency (AS1) activity. Health Care Professional (Card 35) accounted for 19% of all AS1 activity. Both Chest Pains and Breathing Problems accounted for 10% each of all emergency (AS1) activity.

Activity within the Rhondda Cynon Taff locality of Cwm Taf has the third highest level of demand within Wales, behind Cardiff and Swansea:
Acuity, or the total of immediately life threatening calls as a percentage of all 999 calls received shows a 2% increase in life threatening calls (January-December 2011 compared to January to December 2013). In 2011, 40.1% of 999 calls received were categorised as immediately life threatening. In 2013, this has increased to 42.1% of 999 calls. This means that more patients are in need of a response within the 8 minute performance target.

The graph below demonstrates that Cwm Taf has the second highest level of life threatening calls in Wales (January to April 2013). This is reflective of the demography of the population of Cwm Taf.

The conveyance rate in Cwm Taf is consistently the highest across Wales. The current work programme on alternative pathways of care (see below) should reduce the conveyance rate further and ensure that patient care is delivered in the right place at the right time by the right person. However the ratio of Category A / Red calls to the overall workload within Cwm Taf is reflective of the demographic profile and subsequent health needs of the population of the area.

Good working relationships between the University Health Board and WAST are already in place and will be the foundation to support an improving unscheduled care system moving forward.
One of the key priorities for the University Health Board is to ensure the implementation of the Welsh Government’s requirements following the McClelland Review including the establishment of new commissioning arrangements for ambulance services and the provision of non emergency transport. This could include for example identification of further locally enhanced transport developments where required to support local service developments.

A public consultation on the future of Welsh Ambulance services is currently taking place and the outcome of this will feature prominently in our March 2014 submission.

6.17.3 Priorities

In terms of the overall commissioning agenda, for the next three years, the priorities below reflect the above objectives and our direction of travel for a more mature approach to commissioning, including appropriate prioritisation.

It should be stressed that the plan identifies significant opportunities to repatriate activity from existing contracts, based on initial assessments that such repatriation would be both clinically appropriate and cost effective.

In each case, work is continuing with the relevant directorate/locality to firm up these opportunities. Each will require a detailed business case to confirm the costs/benefits associated with the revised patient flows supported by a detailed implementation plan, in particular covering communication and engagement with all relevant parties. This work will need to build on the detailed demand and capacity work undertaken in the directorates.

Also, this plan and priorities will be impacted by the on-going work for the South Wales Programme – no provision has yet been made in the plan for any potential changes in patient flow/costs. The following outlines our priorities:

- Repatriation – based on detailed analysis with the directorates/localities regarding demand, capacity and costs/benefits, the drive to provide services locally where clinically appropriate and costs effective. Projects will be prioritised based on clinical impact, potential savings and deliverability including:
  - Cardiff & Vale orthopaedics – the repatriation of non complex, non paediatric orthopaedic activity, currently charged at 100% full cost per case under CAVOC,
o Over-performing services under the Cardiff & Vale LTA – in particular Haematology, Addiction, Cardiology and Rheumatology.
o Repatriating below current LTA levels – in particular, a number of non-specialist areas currently serviced by ABMU.

- This will be under-pinned by the implementation of the Referral Management System as a key enabler to allow the commissioning and contracting process to function effectively. This will support patient flows in and out of Cwm Taf, in line with agreed service specifications, referral criteria and contract agreements.
- Referral Criteria and Service Specifications - the development of these are a key priority for 2014/15 to ensure each patient is seen and treated by the right clinician and in the right place.
- Continued review of patient flows on a whole system basis and developing plans to bring services closer to patients. The priority services include:
  - Trauma and Orthopaedics.
  - Rheumatology.
  - Dermatology.
  - Cardiology.

- Working with partner LHBs, to review current service provision and service development opportunities in areas such as CAMHS and outreach services to Powys LHB.
- Re-investment in population health – ensuring improvement in service needs is accompanied by general/targeted re-investment in population health, for the longer term sustainability of services and the health and well-being of the population.
- WHSSC and the commissioning of specialised services – continuing to work with WHSSC to ensure clinically and cost effective services are delivered within available resources (supported by the prioritisation process and the collaborative commissioning work between WHSSC and Cwm Taf)
o Improving value in existing contracts – focusing particularly on: Our commissioner contract with ABMU – after years of under-performing, Cwm Taf is looking to reduce the contract to reflect activity being delivered rather than historic, unattainable levels,
o Our provider contract with ABHB – an agreed process in 2013/14 is set to provide a ‘fit-for purpose’ contract going into 2014/15 after Ysbyty Ystrad Fawr (YYF) repatriation and the resolution of detailed, disputed issues. This needs to be accompanied by an agreed set of contract rules but also will require very close monitoring for any remaining impact of repatriation, including to YYF, and the alternative use/removal of capacity at PCH.

Collaborative Commissioning - the University Health Board has committed to developing its commissioning agenda in partnership with other LHBs and WHSSC, to share its work and learning with other LHBs as
appropriate. It intends to play a key role in the emerging All Wales Commissioning Collaborative, building on the ‘prioritisation’ workstream of WHSSC, ensuring services are developed across Wales on a consistent basis and where, using the available evidence base they are deemed to be both clinically and cost effective.
7. WORKFORCE AND ORGANISATIONAL DEVELOPMENT

7.1 Workforce Profile

Together for Health, supported by Working Differently, Working Together, the All Wales Workforce and Organisation Development strategy, recognise that all staff have a vital role in creating safe and effective care for the people of Wales and in shaping the future of our services. Specifically, it identifies the importance of working in true partnership with staff and partner organisations, investing in our workforce through training and development, thereby enabling them to influence decisions, and providing them with the tools, systems and environment to work safely and effectively.

The University Health Board’s workforce is clearly its most significant asset and it is through the commitment, professionalism and dedication of our staff that we are able to deliver high quality services to our population. The way in which the University Health Board plans, recruits, supports and develops, deploys and utilises its staff, are vital to its ability to meet the increasing service and financial challenges it faces.

Our average WTE is 7,000 and the average number of contracted staff in post is 8,166. The total pay-bill is circa £294M per annum which represents approximately 66% of ‘controllable’ budget. Variable pay accounts for circa £20m of this, the majority of which is attributed to agency, locum and bank costs. In this context, the importance of developing integrated workforce plans which are aligned to service and financial delivery plans and which are focussed on ensuring service quality and workforce engagement is a major challenge. The pie chart below shows our current workforce profile by profession.
We are the second largest employer within the area and a large proportion of our workforce will be our patients and be in receipt of our services. Chapter 3 provides a detailed commentary on the health profile of our population. This shows that there are areas of significant social deprivation within the catchment areas of the University Health Board (UHB) and that healthy life expectancy for both males and females in the area is the lowest of any of the Health Boards in Wales. Health risk behaviour indicators in Cwm Taf are generally worse than, or at best, similar to the Wales average. Therefore we can expect that an element of our workforce, the majority of who live locally, will be included in this group. This fact is likely to be a contributing factor to the high average sickness percentages of our workforce. Whilst sickness rates remain a challenge for the University Health Board, the rolling average sickness percentage for 2012/2013 is 5.5% (as at December 2013). Whilst the level of reduction has not been sufficient to meet the Welsh Governments targets, there has been a steady downward trend over the past two years.

The University Health Board has a high age profile of groups of staff aged 51 and over within our total workforce. The top three staff groups with a high proportion of staff aged 51 and over are Nursing & Midwifery, Estates and Ancillary and Administration and Clerical. We will be addressing this through a range of succession planning and service redesign opportunities.

The pie chart below shows the age profiles within the UHB by profession.

![Cwm Taf Staff Group by Age Profile 51 years and over 31 Dec 2013](image)

The University Health Board employs 683 doctors and dentists, on average this is represented by 577 full-time and 105 part-time posts.
59% of this workforce is currently male and 41% are female. There are particular challenges with this staff group which relate to recruitment and retention; some of which are national challenges and some of which reflect local changes in the Deanery training posts. This means that we are heavily reliant on locum cover to manage some of our services.

The chart below shows the breakdown of staff by pay band/medical grade.

The University Health Board is committed to improving the current rate of consultants with a ‘signed off job plan’ from its current rate of 56.07%. Currently over 80% of our consultants have undertaken a job plan review as described later as part of our workforce efficiency our plans are to achieve agreed job plans to support appraisal and revalidation with 85% achieved by April 2014 and 100% by the end of April 2015.

### 7.2 Key Workforce Assumptions

The key workforce assumptions for the University Health Board for the next three years are as follows:

- A 1% pay award in each year.
- Agenda for Change incremental drift of £1.2 in 2014/15 reducing to £1.0m and £0.80m for subsequent years.
- Incremental drift for medical staff is projected at £0.5m in each year.
- Commitment awards for consultants are projected at £0.2m in each year.
• We estimate that the rate of staff turnover will remain at 4.75% in 2013-14. This is a key factor in delivering planned reductions in pay spend. Theoretically with turnover at this level, in a full year the maximum that can be saved from head count reduction if no leavers were replaced would be 2.4% in year, and 4.75% in a full year. As most leavers will be in areas where replacement is needed (such as certain front line services), the realistic potential for incremental reductions is around 1.5% to 2%. Each 1% of turnover is around 70 WTE.
• Changes to national terms and conditions for all staff will deliver pay bill reduction which equates to £6 Million for the UHB.

7.3 Key Workforce Challenges

As described in more detail in chapter 10, the approach to planning incorporates directorate and locality plans together with cross cutting themes. The workforce implications have been developed as an integrated part of these local plans and the key implications have been identified throughout the plan. One of the cross cutting themes is general workforce efficiency and incorporates Medical Staff Productivity; Nursing Productivity; General Workforce and back office Productivity.

At this stage, the workforce plan does not take account of the South Wales Plan. With the programme of work now moving to implementation stage, agreement has been reached between the participating Health Boards and Welsh Ambulance Trust on the mechanisms for developing integrated workforce plans associated with the development of new service models within the Acute Care Alliances. In the meantime, there are significant pressures in maintaining a viable medical workforce to support the some of these ‘fragile’ services and local contingency measures continue to be developed and implemented in liaison with the Wales Deanery.

Therefore the key challenges facing the UHB in the lifetime of the plan are as follows:

• The sustainability in junior doctor rotas which has been exacerbated by the reduction of training places provided by the Deanery. In addition to specific challenges faced in the four specialties under consideration as part of the South Wales programme, the UHB has found recruitment to the Trauma and Orthopaedics and Surgery rotas challenging and has had to rely on locum doctors to cover these slots.
• The fragility of the GP ‘Out of Hours’ Service, plans are currently being developed to re-model the service.
• The need for service change and new models of working, e.g. 24/7 working, more care provision in the community and in patients’
homes, consolidation of services to fewer sites and the proposed closure of inpatient beds associated with new service models. The implications of these developments for our workforce are that staff will need to adapt to different working patterns, in different locations and in different roles. Given that over 80% of our current workforce is also our future workforce, this will require significant change management programmes and effective staff engagement and partnership working.

- Implementing the Chief Nursing Officer’s nursing workforce recommendations will involve the rebalancing of the nursing workforce across our wards and hospitals and an associated reduction in bank and agency usage.
- The digitisation of some clinical services.
- Balancing the need to ensure safe staffing levels are sustained to enable the provision of high quality care, with the need for a significant reduction in the pay bill.
- The low turnover of staff currently running at 4.75%.
- The high sickness rates (as above, linked to the poor health of the local community).
- As shown, the age profile of the workforce within the Health Board highlights that there are several areas where an aging workforce could present a problem to the sustainability of the service provision. In particular, in respect of community nursing with 38% of the nursing workforce over 51; Mental Health and in Obstetrics and Gynaecology where 25% and 31% respectively of the Nursing staff are over 51; Estates with 50% of the over 56; and Pathology with 15% of the Medical Workforce over 56. A particular concern is Haematology where one of our two remaining consultants is due to retire in the near future and the other is over 56. Additionally this is a recognised area of recruitment challenge.
- Balancing the need to drive workforce modernisation and efficiency at the same time as widening access to employment and protecting jobs for the community.

### 7.4 Workforce Savings

As noted above, given our turnover is running at 4.75% per annum, the maximum reduction that could be made in any one year is estimated at between 1.5% - 2%. This is because some posts will need to be replaced.

Therefore reductions through turnover and vacancy control will need to be supplemented by initiatives such as the use of interim or temporary staff, the release of staff through other mechanisms such as redeployment out of the organisation and/ or exit strategies such as VER programmes. As a last resort redundancy would need to be considered as an option.
7.4.1 Projected changes over the three years 2014 – 2017

Based on our further modelling and benchmarking work, a total paybill reduction from the local plans is projected at circa 867 paid WTE over 3 years. This reduction is offset by an increase of 302 paid WTE, following the introduction of new service delivery models and other quality and safety investments. The overall reduction of 565 paid WTE of current workforce is shown in table below:-

Table 1

<table>
<thead>
<tr>
<th>Workforce Plan 2014-15 to 2016-17</th>
<th>Savings Plans</th>
<th>Cost Pressures &amp; Investments</th>
<th>Net Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>-340</td>
<td>93</td>
<td>-247</td>
</tr>
<tr>
<td>2015/16</td>
<td>-223</td>
<td>83</td>
<td>-140</td>
</tr>
<tr>
<td>2016/17</td>
<td>-304</td>
<td>126</td>
<td>-178</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-867</strong></td>
<td><strong>302</strong></td>
<td><strong>-565</strong></td>
</tr>
</tbody>
</table>

Further details of year 1 impact by staff group and the expected model of workforce reduction is shown in the following two tables. Table 2 reinforces the importance of our VER Programme to achieve our planned workforce reduction. The tables below reflect this position for both financial and workforce plan movements:-

Table 2

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Group</td>
<td>Baseline</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>264.0</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>1,337.4</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1,212.2</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>401.1</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>858.9</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>151.5</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>626.0</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2,322.9</td>
</tr>
<tr>
<td>Students</td>
<td>19.1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>7,193.1</strong></td>
</tr>
</tbody>
</table>
Table 3

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Baseline</th>
<th>Turnover</th>
<th>VER</th>
<th>Non Contracted</th>
<th>31/03/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>264.0</td>
<td>0.44</td>
<td>0</td>
<td>0</td>
<td>263.6</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>1,337.4</td>
<td>26.44</td>
<td>-22</td>
<td>-19</td>
<td>1,270.0</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1,212.2</td>
<td>17.22</td>
<td>-17</td>
<td>0</td>
<td>1,177.9</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>401.1</td>
<td>2.81</td>
<td>0</td>
<td>-2</td>
<td>401.9</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
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<td>31.82</td>
<td>-32</td>
<td>-15</td>
<td>780.1</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>151.5</td>
<td>3.44</td>
<td>-3</td>
<td>0</td>
<td>145.0</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>626.0</td>
<td>11.29</td>
<td>0</td>
<td>0</td>
<td>637.3</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2,322.9</td>
<td>44.12</td>
<td>0</td>
<td>-28</td>
<td>2,250.8</td>
</tr>
<tr>
<td>Students</td>
<td>19.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>19.1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>7,193.1</td>
<td>109.39</td>
<td>74.0</td>
<td>64.00</td>
<td>6,945.7</td>
</tr>
</tbody>
</table>

7.5 Rebalancing the Workforce; the UHB’s approach to workforce change.

As above, we recognise that the current configuration of the workforce is not sustainable in terms of ensuring that we have the right people and skills in place to deliver the service changes we are planning. Additionally the difficult financial context means that at the same time as we need to invest in new roles and new service models, there is a need to maximise the efficiency of our current workforce and deliver significant savings through control of the pay bill. Given the context of our local labour market and our social responsibility a key driver is where possible to protect the low paid and to save jobs and we will be seeking to re-skill and redeploy staff wherever possible in order to avoid redundancies.

The proposed changes to the workforce in 2014/15, both investments in new posts and reductions in workforce numbers, have been identified by service scheme/change programme and plotted in terms of when the scheme is likely to deliver the changes. This is explained in more detail in chapter 8, Finance. Detailed workforce change plans have been developed for the major change areas and further work is ongoing with individual directorates to finalise their detailed plans. The plans are fully integrated and incorporate the change management processes to be utilised including use of turnover and retirement, redeployment, investment and growth and finally use of voluntary exit mechanisms. Compulsory redundancy will only be considered should these fail to deliver the changes planned.
The methodology has been developed between service, finance and workforce and is represented graphically for the facilities directorate in the following two flow charts.

**Baseline Opportunities – Plan Development**

**Baseline Opportunities – Workforce Plan**

The UHB’s approach to rebalancing the workforce is based on 3 complementary strategies all of which will need to be utilised. These are:
The following section provides further detail on the planned initiatives and change programmes associated with each of these work streams.

### 7.5.1 Workforce redesign to support service change

The service change plans in section 6 identify a range of schemes which have implications for the workforce design. A summary of the significant workforce changes is provided below.

#### i. Service Design and Site Rationalisation

Proposed service redesign and where appropriate site rationalisation will necessitate the physical movement of staff across the organisation. We are assuming the phased reduction of beds/wards will release capacity equivalent to 118 paid WTE qualified and unqualified nursing staff and 20 WTE facilities staff.

The realignment of nursing workforce across sites and the reduction of the workforce resulting from these closures will remain within the parameters of the CNO standards (see below).

#### ii. Development of new/extended roles

The UHB has submitted an Invest to Save bid to support the development of 15 additional Advanced Nurse Practitioner (ANP/AEP) posts by 2015 to improve the quality and safety of care as a consequence of increased continuity of staffing. Currently due to shortages in the supply of junior doctors a substantial proportion of junior doctors are short term agency staff, with inherent problems with staffing resilience and continuity. The aim is to train and develop 10 existing registered nurses to be Advanced Nurse Practitioners ANPs and to directly recruit 5 ANPs who are already able to operate at ANP level. The period of formal training is generally 2 years, which would need to be followed by 1 year of developing competence in the roles before being able to fully undertake the ANP roles. By year 4, 15 agency junior doctors could be replaced by the trained ANPs. The key clinical specialties where this would be introduced would be paediatrics, neonates, A&E, surgery and mental health.

The Director of Nursing has recently established a task and finish group to progress the development of the HCSWs workforce to identify where these can be utilised to greater effect to support qualified staff.
group is currently scoping the potential service areas for development of these roles and will then determine the competencies, training and development required. The working definition of the HCSW group of staff has been categorised by those who provide care and those who support the provision of care. This will ensure that the development of the wider HCSW is addressed. A key challenge for this work programme will be motivating HCSWs to access the development opportunities as this has proved challenging in the past.

The service modernisation plan for maternity services includes the introduction of a Maternity Support Worker (MSW) role to rebalance the skill mix and to allow qualified midwives the time to dedicate to caring for pregnant mothers. The introduction of MSWs will also allow the release of qualified midwives to undergo additional training in order to undertake the examination of new born babies which is currently done by junior doctors thus in part helping to reduce the pressure on junior doctor rotas. It is proposed that 5 MSW are recruited and trained initially and then the workforce increased on a phased basis as the qualified midwifery workforce is rebalanced.

### iii. Mental Health Service Redesign

An Invest to Save bid has been submitted for the development of a DGH mental health acute liaison service to enable improved assessment of mental health patients who also have with physical health problems. This service would provide an initial assessment of patients and would provide cover to A&E during office hours seven days per week on both DGH sites. The development of this service would require the recruitment of a small multidisciplinary team including consultant psychiatrists and junior doctor support, specialist nurses, nurse therapy and administrative support.

The Older People’s Mental Health redesign (the recovery model phase 2) for mental health services is dependent on the opportunity of closing further inpatient beds in one of our DGH’s and the closure of a ward in one of our community hospitals which will result in the movement of some mental health staff between sites, the development of community roles and a small reduction in the qualified nursing workforce. The consultation and engagement process has commenced and a detailed workforce plan will be informed by and finalised after this process has concluded.

### iv. Acute Medicine

Following identification of the Royal Glamorgan Hospital as a beacon site for the development of a new acute medicine service model, a programme of work has commenced within the UHB to determine the service model. As part of the development, the workforce implications will
be considered and planned on an integrated basis and where appropriate within an agreed Acute Care Alliance framework.

Additionally a further Invest to Save bid has been submitted to support the investment in 3.7 WTE additional Acute Physicians to improve the flow of patients through unscheduled care systems and to facilitate increased capacity for ward rounds.

v. Facilities service redesign

The facilities directorate has undertaken a comprehensive review of portering, housekeeping and laundry and catering services and has utilised benchmarking data to assess the scope for modernisation and driving efficiency. An ambitious programme of service reconfiguration has been developed which will result in balancing the workforce across the UHB’s sites, resizing the workforce to be in line with the national benchmarking and investment in new models of service which in years two and three will require investment largely self-funded through income generation.

Additionally, as the impact of the anticipated reduction in inpatient beds is clarified, there will be further assessment of the facilities workforce to determine the impact.

The net impact on the workforce over the three years will be a small reduction in the workforce. However, in years one and two of the plan, there is a need for significant relocation and potentially change of roles for many staff and will release capacity in 2014/15 equivalent to 52 paid WTE staff.

7.5.2 Maximising Workforce Efficiency

Maximising the efficiency and productive contribution of the workforce is a key component of our workforce plan. The priorities range from ensuring our operational and management systems and process are robust and facilitate the effective management and deployment of our staff, to the utilisation of e-employment systems to minimise waste. This requires the UHB to ensure that it develops best practice employment policy and practice, benchmarked with comparable organisations. The UHB will utilise the resources being developed through the Working Differently Working Together programme to ensure that it maximises the flexibilities afforded in the range of employment contracts and terms and conditions.

i. Workforce Productivity Programme

One of the cross cutting themes identified to support the delivery of the UHB’s plan, the workforce productivity programme incorporates three
core areas of activity: general workforce productivity, medical workforce productivity and nursing workforce productivity. The programme is led by the Director of Workforce and OD, with the Director of Nursing and Medical Director providing executive leadership to their respective work streams.

ii. General Workforce Productivity

A number of cross cutting themes relating to workforce productivity have been progressed via task and finish groups within the UHB in order to maximise workforce efficiency. In year savings have been delivered through this work and will continue in 2014/15.

The general workforce productivity group is overseeing a programme of work associated with reducing back office and corporate paybill costs including the targeted 29 WTE reduction; maximising the opportunities available from introducing flexible benefits including piloting a salary sacrifice lease car scheme; reducing travel and subsistence costs; overseeing the use of Voluntary Early Release programmes; securing increased efficiencies through NWSSP; and securing efficiencies through demand management and VAT efficient contracting of locums. Other components will be identified as the work progresses.

iii. Medical Workforce Productivity

Our medical workforce productivity group is focussing on a range of activities in order to maximise the deployment and utilisation of our medical workforce. Key actions in year one include ensuring that all consultants and SAS doctors have an agreed job plan to support appraisal and revalidation with 85% achieved by April 2014 and 100% by the end of April 2015. The current rate of completed job plans is 56% of consultants. However to date over 80% of our consultants now have taken part in job planning meetings.

To support this work the UHB is piloting the ESR job planning record module and an ‘Invest to Save’ bid to produce an electronic job planning and clinical activity management system that has been shortlisted by WG. The latter would enable more efficient rota management including the management of annual leave, study leave, and sickness which are core priorities for the group.

iv. Nursing productivity - acute and community hospital wards

A review of the acute and community ward nursing establishments (excluding mental health) was completed at the end of last year particularly to address the key issues identified in the Francis Review and in the context of the Chief Nursing Officer for Wales’ guidance on minimum standards. The UHB is currently implementing the agreed
changes to establishments which will result in a rebalancing of staff between our hospital sites. The overall staff numbers are consistent with CNO staff ratios of 1:7 during the day. However, in some areas, the nurse:patient ratios are higher than the CNO guidance due to the bed numbers on some wards not being at a multiple of 7. Consequently, these staffing changes incorporate provision for the ward sister role to be 50% supernumerary and comply as far as possible with an overall ratio of 60% RGNs to 40% HCAs in acute wards and a 50:50 ratio in community wards.

Ward nursing establishments will be based on the above principles with an additional 26.9% cover for absence incorporated. This absence cover provision will require a combination of substantive staff and a flexible bank allowance the relative proportions of each to be agreed as part of the implementation plan but for planning purposes assumed at 95% established and 5% bank.

Further impact on ward establishments will result from any reduction in in-patient beds and the rationalisation of some services as outlined in 7.5.1(i) above. Detailed workforce plans are being developed by ward, however mapping the changes and their impact across the organisation is informing our approach and will maximise choice and opportunity for the staff affected. The work is complex and incorporates utilisation of turnover and retirements, redeployment and relocation, reducing bank and agency usage, supplemented by access to VERs should the former fail to facilitate sufficient workforce change and cost reduction. The current levels of sickness absence on some of these wards will need to be reduced significantly to enable the targeted bank utilisation to be achieved and these areas are being targeted for increased intervention and support.

A summary of the proposed changes resulting from the changes to meet the CNO standards and the reduction of inpatient beds is illustrated in the table and commentary below:
The above table shows an overall target establishment of 1029 wte. As at month 11 the total substantive wte in post was 957 plus a total bank wte of 137. The difference between target establishment and substantive staff of 72 wte (RGNs 7wte and HCAs 64wte) was therefore more than covered by bank usage of 137wte.

However, as noted above, for planning purposes our target establishment of 1029wte comprises 95% substantive staff and 5% bank. The difference between our 95% target for substantive staff and actual staff in post as at Month 11 is summarised in table 5 below:
Table 5

<table>
<thead>
<tr>
<th></th>
<th>Target establishment based on 95% substantive staff – pre ward closures</th>
<th>Actual substantive staff in post as at Month 11</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wte</td>
<td>Wte</td>
<td>Wte</td>
</tr>
<tr>
<td>RGNs</td>
<td>550</td>
<td>572</td>
<td>22</td>
</tr>
<tr>
<td>HCAs</td>
<td>426</td>
<td>384</td>
<td>(42)</td>
</tr>
<tr>
<td>Total</td>
<td>976</td>
<td>956</td>
<td>(20)</td>
</tr>
</tbody>
</table>

To achieve our target establishment of 95% substantive staff and 5% bank would therefore need an overall reduction in substantive RGNs of 22 WTE and an increase in substantive HCAs of 42WTEs.

However, after allowing for the planned reductions in inpatient bed capacity in 2014/15 the target establishment reduces by circa 94wtes (RGNs 50 and HCAs 44) as follows:

Table 6

<table>
<thead>
<tr>
<th></th>
<th>Target establishment based on 95% substantive staff – post planned ward closures</th>
<th>Actual substantive staff in post as at Month 11</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wte</td>
<td>Wte</td>
<td>Wte</td>
</tr>
<tr>
<td>RGNs</td>
<td>500</td>
<td>572</td>
<td>72</td>
</tr>
<tr>
<td>HCAs</td>
<td>382</td>
<td>384</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>882</td>
<td>956</td>
<td>74</td>
</tr>
</tbody>
</table>

It is important to note that the above difference of 74wte is prior to any investment in community provision and new service models.

Alongside the introduction of the new ward establishments, the UHB is also implementing a programme of change to standard shift patterns of 12 or 6 hour shifts through a consultation and engagement process and reviewing nursing establishments in community hospitals.
v. Effective management practice

A range of actions will continue to be improved to ensure that all staff are effectively and fairly performance managed, throughout their employment. Key priorities in respect of developing management capacity and capability include the management of training and development, managing employee health and wellbeing, managing attendance across all domains of leave and performance management including undertaking regular development reviews.

The current rate of PDRs undertaken within a rolling 12 months is 57.85% against a target of 85%. Following a decline over several months, the rate is now improving and is monitored via the monthly clinical and corporate business meetings. An action plan has been developed to improve the incidence which includes improved recording and reporting mechanisms. Achievement of the target will be a core objective for line managers.

An associated area for priority is the active management of gateway increments and where appropriate ensuring that staff on protection are managed effectively and deliver value for money in respect of the scope of their duties.

vi. Health and wellbeing and reducing absence attributed to sickness.

Maximising attendance at work is a key priority for the UHB. Current sickness absence levels, whilst seeing a steady downward trend over the past 2 years, are still too high at a rolling 5.5%. The UHB’s existing target (as set by the WG) is 5.2%. The Minister for Health has recently written to NHS Wales to express his expectation that a 1% reduction in sickness absence is achieved by 2015. The UHB has set itself a challenging target of reducing sickness by 1% by the end of the financial year to March 2015. A further 1% reduction is profiled for the remaining 2 years.

A Health and Wellbeing action plan has been developed and recently submitted to the WG. This identifies a range of activity focussed on improving the health and wellbeing of the workforce through the five themes:

- Health and wellbeing initiatives via the corporate health standard work – we are seeking to achieve platinum by the end of the 2014/15
- Improved reporting and recording of sickness and data quality and analysis. This is associated with the roll out of ESR self service below.
• Ensuring managers actively and appropriately manage all episodes of sickness absence utilising the policy
• Improving our Occupational health Service through the development of KPIs, improved processes and stabilising our clinical workforce. A newly appointed senior nurse manager will commence on 1 March and through joint working with ABMU HB, we are securing a stable medical commitment from an experienced consultant OH physician and newly appointed consultant.

vii. E- Employment systems

The UHB is currently reviewing the impact of its local Wfis programme and has engaged additional support to refresh the project plan to accelerate the implementation of the suite of ESR associated programmes to support the effective management and deployment of staff. The UHB is piloting the e job planning module, and the bi-directional interface with the Occupational health system, COHORT on behalf of NHS Wales. Whilst nearly 70% of our Supervisors have been trained in SSS and 70% of our line managers have been trained in MSS, utilisation of the functionality is comparatively low. The revised project plans will address this to meet the 80% utilisation national target by April 2015.

The roll out of ESR Manager Self Service is another use of technology that is enabling us to maximise the efficiency of staff and to ensure that managers are taking the necessary accountability and responsibility for the staff they manage. The roll our of e-rostering within Cwm Taf UHB is a key way of maximising the efficiency of the Workforce and ensuring that wards are covered safely and within budget by the introduction of the e rostering system to manage the rotas electronically. A key element of the roll out programme is to raise awareness and the use of the Business Intelligence elements of ESR to enable line managers to access comparative management data and reports from their desktops.

The rollout plan for e-Rostering within Cwm Taf has identified 2935 staff as potential users. Currently, the programme has been rolled out to 30% (898) of these potential users. The plan for 2014, is to rollout to an additional 1204 staff, this will achieve 72% of the identified target. Completion of target is the end of July 2015. However, a further 667 potential users have been identified if roll out is extended to Facilities, Pathology and Radiology. Bringing these areas on board would extend the project to June 2016.
The UHB has targeted the roll out of e expenses over the past few months and has increased the submission of expenses electronically from a rate of 25% in November 2013 to 63% in February 2014.

viii. Other measures

The UHB has reinvigorated its vacancy control mechanisms managed to ensure that vacant position are properly scrutinised and alternatives to direct like for like replacements are considered routinely. The Vacancy Control Panel meets to discuss all vacancies on a fortnightly basis.

The UHB will continue to participate and contribute to the discussions regarding national changes to terms and conditions of employment

7.5.3 Reducing the Workforce

Detailed alignment of service, workforce and financial plans has been undertaken and the scale of the workforce challenge identified requires a net reduction in 2014/2015 of the workforce of 247 paid WTEs. Further work is underway with the directorates to model the impact of the longer term changes and will be complete by the end of April.

Delivering the scale of workforce change identified will be more challenging than anything we have previously achieved and will require a co-ordinated and staged change programme. The components of the approach the UHB proposes to utilise and has modelled is as follows:

- Actively planning a reduction in the workforce through the use of turnover from natural wastage and retirement and the non-replacement of leavers
- Restricting bank and other non-contractual work such as overtime and additional hours to limit the need for actual reductions in substantive posts.
- Cease and/or restrict recruitment based on required reduction of staff groups (All recruitment is processed via the Vacancy control panel)
- Redeployment of staff to suitable alternative posts via the OCP process
- Termination of fixed term contracts where appropriate
- Utilisation of VERS (see below)
- Seeking voluntary redundancies
- Make compulsory redundancies where services/posts have become redundant.
There is a risk in employing some of these strategies in terms of loss of essential skills and the impact on patient care but a robust risk assessment process will be employed in order to minimise any risks, e.g. compulsory redundancies would be a last resort and would require robust consultation and engagement.

i. Turnover

The low turnover of staff within the Health Board currently running at 4.75% is a challenge and we cannot rely on natural wastage to achieve the identified workforce reductions. The age profile of the organisation has been mapped by staff group and service, and assumptions have been made that a significant proportion (but not all) of staff who reach the age of 65 will retire. Given the assumption that 50 – 66% of all leavers will need to be replaced (given that they occupy front line posts) and factoring in the distribution of turnover across the 12 months of the year, it is assumed that the realistic projected turnover will deliver a 95 WTE reduction in year.

ii. Reducing variable pay costs

Excluding temporary workers, agency work, additional sessions and on call which has recently been reviewed as part of the national changes, the current variable element of the paybill is around 8%. As a result of the changes to the nursing establishment, it is assumed that there can be a proportionate reduction in the use of bank working as detailed above.

In addition, the reconfiguration of the facilities workforce to align with national benchmarking will enable a reduction in the overtime levels equating to approximately 15 WTE.

iii. Controls on recruitment and replacement of staff

The UHB introduced robust vacancy control processes in 2013, chaired by the Director of Finance/ Director of Workforce and Organisational Development, or their Assistant Directors. The panel meets fortnightly and considers all requests for replacement or new position against strict criteria including clinical service delivery and quality, the impact on the rest of the team, the robustness of the business case and the financial position of the requesting directorate/service.

The panel will utilise the outputs from the integrated planning process to inform decisions about vacancy requests and will track the progress against the delivery of the plans to support decision making. A methodology for tracking these changes has been developed in
conjunction with service managers and can be demonstrated through the following charts relating to the facilities directorate workforce plan.

The panel will need to consider whether there needs to any restriction on all or some recruitment when service changes are planned, or to enable appointments to proceed on the basis of temporary or interim appointments. For example, the impact of a proposed inpatient bed reduction in quarter 1 would result in releasing capacity in the ward nursing establishment of approximately 32 paid WTEs, both HCSWs and qualified nurses. Implementing a restriction on permanent appointment to HCSW and nursing posts in the previous quarter would result in a number of potential redeployment posts for displaced staff once the ward closed.

iv. Invoking the OCP and seeking redeployment options

Where possible, staff who may be displaced and wish to remain in employment, will be offered redeployment into suitable alternative posts. An active redeployment register is managed by the WOD department and will continue to be routinely referenced by the vacancy control panel prior to any appointment being approved for advertisement.

All vacancies will continue to be advertised internally first unless there are exceptional circumstances where it is clear that the required skills are not available within the organisation. Staff who do not accept suitable alternative posts will be managed in accordance with the provisions of the
policy. Additionally, displaced staff will be afforded the option to apply for VER.

v. Proposed Utilisation of Future VER processes

To support the ongoing need for the University Health Board to change the way we deliver our services over the next few years, and to ensure that the VER scheme is used as an enabling tool to support this flexibility to address service re-design, it is proposed that the Voluntary Early Release (VER) scheme is open for individuals to submit applications on an ongoing basis and for the Health Board to invite groups of staff associated with specific change programmes to apply for VER.

The UHB will continue to seek support via Invest to Save monies to maximise its capacity to utilise VERs and is reliant upon securing the funding within its current bid to enable it to deliver its projected workforce reductions in 2014/15.

The operational impact of this would be:

- Staff can submit a VERs application at any time to their line manager or the HR team.
- It is made clear that staff who submit applications do so in full understanding that there is no ‘right’ to VERs nor a guarantee that where a line manager supports an application, it will be approved or the funding available.
- The UHB may decide to run a targeted or general campaign to promote and invite applications as part of a corporate intention to reduce headcount.
- Staff will be asked to consider VERs in support of a specific organisational change process as a routine first step prior to commencing any slotting in and selection process under the all Wales Organisational Change Procedure.
- Remuneration Committee will be provisionally booked to coincide with all Board and Board development meetings and will proceed if and when there are fully supported business cases for employees who apply for VER.
- Remuneration Committee will be asked to support cases in principle on the basis that when and if the financial position allows, the approved applications will be released. This will allow staff to be released quickly when funding becomes available.
- Clear messaging via sharepoint, staffside and other communications will be reinforced to indicate that VERs is not a right and staff must not assume or plan on the basis that an application will be successful. The application form will be amended to reinforce these messages.
• Confirmation that the application has been approved will only be communicated to the employee at the point in which funding becomes available.

The anticipated contribution from VERs to workforce reduction is 74 WTE in 2014/15. A significant majority of these are assumed to be facilities and administrative staff, but given the level of reduction required this is likely to include some frontline staff. This is based on a number of factors including:

• The current cohort of applications which are predominantly from these groups
• The scale of savings required from these two groups of staff associated with the facilities service redesign and the back office review of corporate department
• The capacity to release staff from support functions without the need to backfill or replace is greater than for front line staff.

However, should the assumptions about turnover or the level of reductions in variable pay not materialise, or be delayed in taking effect, there may be a need to increase the number of staff who are approved for VERs.

The recent scheme attracted applications from 208 staff and given both the age profile and scale of change and physical relocation/movement required over the next three years, we anticipate that the number of applications for VERs will exceed the UHBs capacity to release staff.

vi. Voluntary or compulsory redundancy

In the event that it has not been possible to redeploy any displaced staff and that there is little prospect of any suitable employment arising in the near future, as stated, individuals will be asked to consider applying for VER. However, VER is by its nature a voluntary scheme and an individual cannot be compelled to access the scheme.

In these circumstance, in accordance with the provisions of the OCP, the UHB would need to consider offering voluntary redundancy and as a last resort compulsory redundancy. Before embarking on such a course of action, clear change management principles and engagement with staff side colleagues would be of paramount importance.


The projected workforce change and modernisation implications of the UHB service and financial plan 2015 – 2017 will require ongoing detailed
analysis and modelling. A summary of the headline changes is shown in table 1 of the workforce savings section.

viii. Investments in workforce change

There is a continued balance between planned investment in new service models and workforce change resulting in reductions to headcount. Investment is predicted to require the appointment of 83 and 126 new posts in 2015 and 2016 respectively. The main projected areas of growth include community staff associated with the management of chronic conditions, community mental health services, and investment in diagnostics and therapies.

ix. Projected reductions in workforce

A net reduction of a further 318 paid WTE staff is anticipated over the two years. The principle movement of staff in these years will be:

- Reductions in the nursing and HCSW workforce associated with any further reduction in the inpatient beds.
- Further site rationalisation
- Continued efficiency from the back office and patient care administration work.
- Efficiency savings resulting from improved electronic employment management systems including ESR self service and electronic rostering and job planning.
- Skill mix change will also be progressed through a systemic job banding review.
- Digitisation of services.
- Further change resulting from the modernisation and reconfiguration of facilities.
- Further improvement in our sickness absence levels.

x. Delivery

The strategies to deliver these changes will continue as in year one. However, our capacity to drive further efficiency from our variable pay bill particularly in respect of overtime and bank will be limited as a result of our actions in year 2014/15.

With lower projections of age retirements and an assumption of continued turnover at around 4.75 – 5%, the need for accessing voluntary or compulsory exit processes is likely to be greater.
xi. The Key Risks/limitations to Service Change

In order for the successful transformation of services to become a reality all of the above strategies and implications on the Workforce should be considered and carefully evaluated. Any service change would need to be implemented with the total buy in of the organisation and within legal and best practice frameworks.

The main risks/limitations to the transformation of services being delivered is as follows:

- Lower staff turnover levels than predicted will reduce our capacity to deliver pay savings
- Delays in delivering the service and workforce change in the earlier part of the year will necessitate greater levels of workforce savings in the latter part and may require blunter measures to be utilised, e.g. vacancy freeze, etc
- Our ability to manage the proposed reductions are dependent on rebalancing the nursing and facilities workforce and effective management of all leave including containing sickness absence
- Risk of not achieving the changes in service provision and workforce modernisation to enable safe and sustainable services to be provided.
- Breakdown in partnership working
- Fragility of medical workforce
- Management capacity and capability to deliver.
- Impact of the South Wales Programme is still unknown and it is difficult for managers to plan in this context
- Risk that staff who had planned to retire will delay their retirement plans and wait for an option to take VER.

xii. Communication and Engagement with Staff

A range of mechanisms have been developed to support our communication with our staff and their representatives and to engage them in shaping the service changes.

A draft communications strategy has been developed which will be finalised and published in 2014. The communications team has a page on SharePoint which is accessible to all staff and explains how the team works and how it can help the organisation.

xiii. Partnership Working

We have active engagement with our staff side colleagues via the formal partnership arrangements at the monthly meeting of the Joint Advisory
Group (JAG) and Working in Partnership Forum (WIPF). These meetings are attended by the Chief Executive, Directors, service managers and WOD. Major service changes, e.g. the SWP are shared on the agenda with our staff side colleagues.

However in order to support the level of change outlined in the three year plan for the UHB; these partnership arrangements are being reviewed and will need to be refreshed in order to ensure that the level of change needed is delivered in partnership.

There are also a number of other informal and formal fora for joint working within the UHB where staff side play a key role and which will ensure that service change is delivered, e.g. the Director of Workforce and OD has commissioned the chair of staff side to work part time over the next six months with Workforce and OD in order to undertake a review of partnership working within the UHB.

xiv. Staff Survey

Following the staff survey a working group of managers, staff side and W&OD has been set up to take forward the key concerns raised by staff in the survey, in order to address their concerns and to make improvements. They include:

- An improvement in senior managers involving front line staff in the plans for change and listening to their views
- An improvement in the top down/bottom up communication with staff
- Making sure that lessons are learned from incidents and that staff are a part of the communication loop for this learning
- An improvement to the management of organisational change as front line staff felt that this was not well managed – a toolkit for managers on ‘How to Manage Organisational Change’ has been developed based on the CIPD model and the principles learned from the management of the change during the closure of St Tydfil’s hospital. The toolkit is currently being piloted and tested within the UHB
- The reintroduction of team briefing
- The setting up of working groups to take PULSE surveys from staff. These groups are meeting to take this work forward in partnership
- Direct work with individual teams which link into other initiatives e.g. t Health and Well Being
- Utilising the initiatives of the national work on WTDT

xv. Capturing ideas from staff

The majority of ideas from staff for improvement and for change will be captured within the team structure and at ward/department level –
these will be taken forward, as appropriate, within individual departments.

However, there are many ways in which staff are able to share ideas for improvement across the Health Board. These include the Grapevine. This was set up in February 2012 to allow staff to anonymously ask questions and check rumours; however it has also become a place where staff can post ideas.

Staff are also able to post comments on the Chief Executive’s weekly blog and a new Quality in Care blog, written by the nursing and medical directors has just been launched, which also encourages staff to comment on its content and share ideas for improvement and change.

The intranet site features a news section which is updated daily with items from the communications team and from staff – this includes news about staff achievements.

The internal staff e-magazine The Courier was launched in 2013 – it is published every two months and features bilingual news and features about Cwm Taf staff, by staff and for staff. It actively encourages staff to contribute to the magazine.

In April 2013, Cwm Taf University Health Board launched a new monthly e-newsletter called Your Healthcare, which is a round-up of news about service change across Merthyr Tydfil and Rhondda Cynon Taf and is available via the Cwm Taf website and emailed directly to subscribers (people are able to sign up via the website). Your Healthcare currently has more than 500 subscribers, including staff members and local stakeholders and the audience continues to grow.

7.6 Organisational Development

The NHS Leadership Academy in the 2012 publication ‘Help us shape our plans for developing outstanding leadership in health’ outlined the case for change, the evidence for change and the direct link to leadership.

‘If the NHS is to meet the challenges of the coming years, we need to be more coaching and facilitative in our approach, supporting NHS leaders and their organisations to take risks, innovate on an industrial scale and completely transform many of our services. Building relationships with all parts of the health and social care system will be key to making this happen.

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22 The Tayside Centre for Organisational Effectiveness
Tweaking around the edge won’t deliver what’s needed. We need to transform the whole system, supporting each other to take risks and innovate and engaging our staff and the public in difficult conversations. The fundamental difference between success and failure will be the calibre of our leadership.’

This evidence takes on an even higher profile in the post Francis context and highlights the importance of leadership in the creation of a culture of clinical compassionate care.

High level priorities for the organisational development approach over the next three years involve:

- Building leadership capacity and capability
- Engaging our workforce in service change
- Change-ability and performance enhancement

<table>
<thead>
<tr>
<th>High Level Priorities for the organisational development approach over the next three years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Building Leadership Capacity and Capability</strong></td>
</tr>
<tr>
<td>1. Development programmes for clinical directors, assistant directors, directorate support managers and for heads of nursing;</td>
</tr>
<tr>
<td>2. Senior manager programme for staff in operational and corporate roles;</td>
</tr>
<tr>
<td>3. Internal secondments and development for key players to broaden their skills and experiences in different service and organisational areas;</td>
</tr>
<tr>
<td>4. Coaching network across the UHB to support effective engagement in service change and delivery;</td>
</tr>
<tr>
<td>5. New leadership programmes for newly appointed consultants and GPs, nurses and therapists and health scientists;</td>
</tr>
<tr>
<td>6. Working in partnership with Academi Wales to access programmes and resources to enhance leadership capability.</td>
</tr>
<tr>
<td><strong>Engaging Our Workforce in Service Change</strong></td>
</tr>
<tr>
<td>1. Implementation of a staff engagement framework;</td>
</tr>
<tr>
<td>2. Specific nursing workforce engagement programme;</td>
</tr>
<tr>
<td>3. Building the momentum around medical engagement (following on from the Doctors Debating Series; Medical Leadership Forum; medical and leadership development programmes and succession planning; implementation of the medical engagement scale;</td>
</tr>
<tr>
<td>4. Building momentum and connection within the Cwm Taf leadership community through a series of ‘Buzz events’ hosted for specific staff groupings e.g. senior leadership; nurses; therapists and health sciences; medical and multidisciplinary;</td>
</tr>
</tbody>
</table>
| Change-Ability and Performance Enhancement | 1. Series of development centres to access talent and potential to feed a succession planning pipeline;  
2. Implement the all Wales NHS Manager competency framework;  
3. Regular review of the organisation’s structure; management arrangements and process to ensure fitness for purpose;  
4. Re-shaping the Workforce and OD functions;  
5. Roll out IQT (Improving Quality Together) as the service improvement framework;  
6. Continuing to seek our best OD practice and using evidence to address complex service and workforce challenges;  
7. Robust commissioning framework for all OD workstreams to ensure executive sponsorship for each one; and alignment with corporate priorities.  
8. OD Team’s internal consultancy approach and provision to support quality improvement and service change.  
9. Utilisation of impact assessment tools and techniques to evaluate outcomes from OD commissions  
10. Appropriate participation; learning and sharing at 1,000 Lives+ events  
1. Bringing together clinical education; learning and development departments to offer a cohesive one stop shop development service which meets development needs which have been identified as corporate priorities. |

| | 5. A multi disciplinary conversation series around service innovations which create a culture of clinical compassionate care;  
6. Awareness of leaders impact in culture creation, including these themes in our monthly business meeting discussions;  
7. Reflective practices in quality improvement through the use of critical incident learning; appreciative inquiry; story circles and Schwartz centre rounds |
8. FINANCE

8.1 Context

i. Quality and Safety

As part of the 2013/14 planning process, the Board underlined its commitment to quality, safety and patient experience in adopting the IHI Triple Aim approach to service delivery. One consequence of this is that the mechanisms for service, workforce and financial planning have been grounded in a system of risk assessment against known quality indicators.

The Board is committed to continuously reflect on the context of the triple-aim requirements as the service and financial plan for 2014/15 – 2016/17 is developed and assessed.

These principles have been used in the development and implementation of cost improvement plans where triangulation of quality, performance and cost has meant that informed decisions have been made to manage risk as well as deliver cost reductions.

ii. Comparison of resources and expenditure within NHS Wales

An assessment has been made of where the University Health Board stands in relation to its expenditure levels and productivity, relative to other LHBs in Wales, and relative to English Primary Care Trusts (PCTs) with comparable population characteristics.

There is no clear overall measure of weighted population we can use to compare the health needs of Cwm Taf with that of other LHBs. When for example the Townsend formula is applied, it assesses a health need per head of population that is 12% higher than the Wales average. As identified in Chapter 3, Cwm Taf residents have shorter life expectancy and will on average, live for 15 – 20 years with chronic disease before they die.

When comparing the 2011/12 expenditure per head for each LHB relative to Cwm Taf, Cwm Taf is clearly the highest at £1,913 per head. This is 8% above the Welsh average; however this takes no account of the health needs variance referred to above.
iii. Comparison with English expenditure per head

Cwm’s Taf’s expenditure per head has also been compared with that of English PCTs which fall into the same Office for Population Studies category as Cwm Taf (Former Industrial Hinterlands Category A). Both 2010/11 programme spend (from programme budgeting returns) and total 2011/12 expenditure from the accounts has been compared. The results show Cwm Taf net spending on average is 5% less than the average, and is around the bottom quartile of the comparable PCTs.

There are technical differences between England and Wales reported expenditure figures, in that some costs are met by PCTs in England but are not charged to LHBs in Wales; the principal of these being clinical negligence, blood and blood products and capital charge dividends. These however account for less than 5% of the expenditure, and so even after adjusting for these technical differences, the spend per head figures for 2010/11 and 2011/12 are still higher for the comparable English PCTs. The 2013/14 funding differential against the English PCTs is likely to be greater than that outlined above for 2011/12 and 2010/11, as the different funding regimes are widening the gap year on year.

The National Audit Office report comparing expenditure on health in Wales with England, Northern Ireland and Scotland also shows that there is a widening gap between Wales and the other countries, as Wales has been operating on a flat cash basis.

The Welsh Government has moved away from flat cash during 2013/14 and for future years, but only to some extent. The recurring growth in allocations in 2013/14 has been around 2.5%, with a further 0.5% in 2014/15 and 1% in 2015/16. This compares to growth in allocations in England of 2.6% in 2012/13, 2.7% in 2013/14, and 2.9% in 2014/15. In summary:

<table>
<thead>
<tr>
<th>Year</th>
<th>Wales % growth</th>
<th>England % growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>0</td>
<td>2.6</td>
</tr>
<tr>
<td>2013/14</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>2014/15</td>
<td>0.5</td>
<td>2.9</td>
</tr>
</tbody>
</table>

iv. Allocation of resources

As our work develops it will be refined to reflect differences in spending per head of population and activity levels per head of population for particular services. This will then be taken into account in the development of the University Health Board’s medium term plan.
The National Audit Office in 2012/13 undertook a comprehensive comparative review of the financial positions of the home nations in which particular attention was drawn to the specific challenges faced by NHS Wales. This, together with the evidence recently provided by the Auditor General to the Finance Committee of the Welsh Government relating to the financial outlook for NHS Wales and the constraints associated with a financial regime that requires year-on-year financial balance underlines the scale of the challenge for all LHBs within Wales.

The key conclusion is that taking account of the population health, Cwm Taf Health University Board starts with a level of resource and expenditure which is lower than that of comparable organisations and means that the scale of the challenge is comparatively larger. This needs to be considered in the context of the risk that the Inverse Care Law predicts for this community. These key issues must be addressed within potential changes to the financial regime over the lifetime of this plan.

This fact, together with the output of the Francis Review serves to underline the need for the Board to continue to hold true to the Triple Aim principles in service and financial planning. This means that quality and safety need to be maintained whilst driving efficiency and productivity improvement, and also ensuring health care interventions provide best value for patients in line with the principles of prudent medicine.

8.2 Update on Financial Plan for 2013/14

The University Health Board submitted an updated financial plan to Welsh Government at the end of September 2013. This identified a planned in year deficit of £20.8m.

The Welsh Government subsequently confirmed an additional £16.86m funding for 2013/14 as follows:

<table>
<thead>
<tr>
<th>Table 2 Welsh Government additional funding 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£m</strong></td>
</tr>
<tr>
<td>Unscheduled care</td>
</tr>
<tr>
<td>Nurse staffing</td>
</tr>
<tr>
<td>Immunisation programme</td>
</tr>
<tr>
<td>VER funding</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The additional funding for nurse staffing, immunisations and VER had already been assumed within our financial plan for 2013/14. Of the £13.42m funding for unscheduled care, we have assumed a provisional amount of £0.7m for ambulance pressures which leaves £12.72m of uncommitted funding. This amount reduced the residual gap for 2013/14 from £20.8m to £8.1m.
As at month 11, the University Health Board is forecasting a deficit of £3.9m for 2013/14. It is important to note that the forecast improvements from the planned residual gap of £8.1m have primarily been achieved through non recurring measures. The University Health Board has also received the 2014/15 Allocation Letter which confirmed that the all of the £16.86m funding provided in 2013/14 will be made recurrent from 2014/15, with the exception of the VER funding.

The underlying deficit at the end of 2013/14 is projected to be £9m. This is the starting point for our medium term financial plan for the three year period 2014/15 to 2016/17.

8.3 Overview of Financial Plan For 2014/15 to 2016/17

The key assumptions driving our financial plan for the next three years are summarised below:

- An underlying deficit at the end of 2013/14 of £9.0m.
- Repayment of the forecast in year deficit for 2013/14 of £3.9m in 2016/17.
- An additional recurring allocation of £6.0m in 2015/16 and also a further £6.0m in 2016/17.
- An additional allocation of £3.0m from national contingency/flexibility resources which are currently being held centrally by the Welsh Government for 2014/15. We have assumed that this funding will be provided on a non recurring basis in 2014/15 and 2015/16 prior to being made recurring in 2016/17.
- An additional £5.0m of ‘flexibility funding’ in 2014/15 which would be repayable in 2015/16.
- Provision for recurring inflation, cost and service pressures of £18.8m (4.3%) in 2014/15, £16.6m (3.8%) in 2015/16 and £24.3m (5.5%) in 2016/17. This includes pay increases from 2014/15 at 1% per annum plus incremental drift and non-pay increases from 2014/15 in line with projected inflation. On the advice of the Welsh Government, the significant costs resulting from increased employer pension contributions from 2015/16 and from the end of “contracting out” from 2016/17 have been excluded. This is on the basis that the Welsh Government would be able to secure “consequential” funding from the UK Government, given that these are circular financial flows that reduce wider public expenditure outside devolved budgets.
- Recurring investment in new service and delivery models of £2.2m in 2014/15 and then £2.0m per annum for each of the two subsequent years.
• A non recurring investment in change fund of £3.7m for 2014/15 and £2m in each of 2015/16 and 2016/17.

• New invest to save income of £2.7m in 2014/15, to contribute to the above non-recurring costs, followed by full repayment in 2016/17, or later where agreed with the Welsh Government. This invest to save income is critical to the plan, as without the Board would be unable to fund the essential upfront investment needed in 2014/15 to drive financial and service improvements in 2014/15 and beyond.

• Availability of Welsh Government strategic capital funding to support the capital costs of the key changes included in the plan. Our 3 year capital plan includes a number of schemes in 2014/15 which are critical to deliver savings (Section 8.6). Without this funding, the relevant revenue savings within our plan could not be fully achieved.

• £53.2m of re-design and efficiency savings over 3 years (12.2% of controllable expenditure).

• £18.0m of savings from all Wales changes to terms and conditions, in line with advice from the Welsh Government.

• It is assumed that the depreciation costs of all future capital schemes are fully funded by the Welsh Government, in line with current policy. These additional costs and consequent non-cash backed allocation changes are not included in the financial schedules pending clarity on approvals.

• No direct account has yet been taken of the South Wales Plan itself, as the outcome, cost and timing is uncertain at this stage.

The medium term plan is shown in the table below, with costs and deficits shown as positive numbers and income and surpluses as negative numbers. Based on the assumptions outlined above, this which would deliver a £2.8m net surplus over the three year period.
The elements of the plan are described in further detail below.

### 8.4 Underlying 2013/14 deficit carried forward to 2014/15

As noted above the forecast underlying deficit going into 2014/15 is £9.0m. The table below sets out the differences between the assumed 2013/14 deficit of £3.9m and the recurring deficit of £9.0m.

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R £m</td>
<td>NR £m</td>
<td>Total £m</td>
<td>R £m</td>
</tr>
<tr>
<td><strong>Brought forward recurring deficit/-surplus</strong></td>
<td>9.0</td>
<td>9.0</td>
<td>6.8</td>
<td>6.8</td>
</tr>
<tr>
<td>LHB allocation changes</td>
<td>0.0</td>
<td>0.0</td>
<td>-6.0</td>
<td>-6.0</td>
</tr>
<tr>
<td>Share of further 2014/15 growth</td>
<td>-3.0</td>
<td>-3.0</td>
<td>-3.0</td>
<td>-3.0</td>
</tr>
<tr>
<td>Draw down/repayment of flexibility</td>
<td>-5.0</td>
<td>-5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Allocation of original 14/15 growth share</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Existing invest to save repayments</td>
<td>0.2</td>
<td>0.2</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>New invest to save and repayment</td>
<td>-2.7</td>
<td>-2.7</td>
<td>0.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Repayment of 2013/14 deficit</td>
<td>0.0</td>
<td>0.0</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Income changes</strong></td>
<td>0.0</td>
<td>-10.5</td>
<td>-6.0</td>
<td>-6.6</td>
</tr>
<tr>
<td>Inflation, cost pressures &amp; investment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflation</td>
<td>8.2</td>
<td>8.2</td>
<td>7.4</td>
<td>7.4</td>
</tr>
<tr>
<td>Service development</td>
<td>3.5</td>
<td>3.5</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Service and demand pressures - national and local</td>
<td>7.1</td>
<td>7.1</td>
<td>6.2</td>
<td>6.2</td>
</tr>
<tr>
<td>Recurring investment in new service and delivery models</td>
<td>2.2</td>
<td>2.2</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Non-recurring investment in change</td>
<td>3.7</td>
<td>3.7</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td>21.0</td>
<td>3.7</td>
<td>24.7</td>
<td>18.6</td>
</tr>
<tr>
<td>Efficiency and re-design savings</td>
<td>-17.2</td>
<td>-17.2</td>
<td>-18.0</td>
<td>-2.5</td>
</tr>
<tr>
<td>All Wales terms &amp; conditions/pay changes</td>
<td>-6.0</td>
<td>-6.0</td>
<td>-6.0</td>
<td>-6.0</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td>-23.2</td>
<td>0.0</td>
<td>-23.2</td>
<td>-24.0</td>
</tr>
<tr>
<td>Total change on previous year</td>
<td>-2.2</td>
<td>-6.8</td>
<td>-9.0</td>
<td>-11.4</td>
</tr>
<tr>
<td>Revised surplus/deficit</td>
<td>6.8</td>
<td>-6.8</td>
<td>0.0</td>
<td>-4.6</td>
</tr>
<tr>
<td>Description</td>
<td>£’000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forecast overspend for 2013/14</td>
<td>3,900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add non recurring benefits/(charges) in 2013/14:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repayment of 12/13 brokerage</td>
<td>350</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non recurring Orthopaedic funding</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slippage on VER allocation</td>
<td>900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance sheet &amp; provisions review</td>
<td>3,700</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repayment of I2S funding to WG</td>
<td>(3,000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non recurring PACS benefit</td>
<td>300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWSSP surplus</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full year effect of 2013/14 Cost pressures:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E medical staffing</td>
<td>800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIMS</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology On call</td>
<td>300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income stream reductions</td>
<td>600</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Forecast underlying deficit going into 2014/15</strong></td>
<td><strong>9,000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 8.5 Allocation changes and other income changes

A summary of our assumed allocation changes for 2015/16 and 2016/17 are shown in the table overleaf.
The key points to highlight are as follows:

ii. Welsh Government additional recurring allocations

The Financial plan assumes that a further recurring allocation of £6m will be received in both 2015/16 and 2016/17. The assumed movement in our recurring allocation from Welsh Government over the three year period is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014/15 over 2013/14 £000</th>
<th>2015/16 over 2014/15 £000</th>
<th>2016/17 over 2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring allocation</td>
<td>0</td>
<td>6,000</td>
<td>6,000</td>
</tr>
<tr>
<td>WG additional recurring allocation</td>
<td>0</td>
<td>6,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Share of 2014/15 £30m recurring growth</td>
<td>0</td>
<td>0</td>
<td>3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td><strong>6,000</strong></td>
<td><strong>9,000</strong></td>
</tr>
<tr>
<td>Non recurring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repayment of 2013/14 deficit</td>
<td>0</td>
<td>0</td>
<td>-3,900</td>
</tr>
<tr>
<td>Share of 2014/15 £30m Flexibility Fund</td>
<td>3,000</td>
<td>3,000</td>
<td></td>
</tr>
<tr>
<td>Draw down and repayment of additional flexibility funding</td>
<td>5,000</td>
<td>-5,000</td>
<td>0</td>
</tr>
<tr>
<td>Existing Invest to Save repayments</td>
<td>-240</td>
<td>-3,130</td>
<td>0</td>
</tr>
<tr>
<td>New Invest to save funding &amp; repayment</td>
<td>2,700</td>
<td>0</td>
<td>-2,700</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,460</strong></td>
<td><strong>-5,130</strong></td>
<td><strong>-6,600</strong></td>
</tr>
</tbody>
</table>

Recurring allocation as per 2014/15 Revenue Allocation Letter: £543.3

Additional recurring allocation in 2015/16: £6.0

Additional recurring allocation in 2016/17: £6.0

Share of 2014/15 £30m Flexibility received in 2016/17: £3.0

Recurring allocation at end of 2016/17: £558.3
iii. Share of 2014/15 £30m Flexibility Fund

The University Health Board is assuming that its £8.0m planned deficit for 2014/15 will be matched by its assumed share of a “flexibility fund” of £3m plus a further drawdown of flexibility funding of £5.0m, with the latter £5.0m being repayable in 2015/16.

From 2016/17 onwards we have assumed that our assumed share of the 2014/15 Flexibility fund will form part of our recurring allocation.

This is shown in the table below:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>NR</td>
<td>Total</td>
<td>R</td>
</tr>
<tr>
<td>Surplus/deficit (Pre flexibility funding)</td>
<td>6.8</td>
<td>1.2</td>
<td>8.0</td>
<td>-4.6</td>
</tr>
<tr>
<td>Use of NHS Wales flexibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share of 2014/15 Flexibility Fund</td>
<td>0.0</td>
<td>-3.0</td>
<td>-3.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Draw down/repayment of flexibility</td>
<td>0.0</td>
<td>-5.0</td>
<td>-5.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Net draw down/repayment</td>
<td>0.0</td>
<td>-8.0</td>
<td>-8.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

iv. New invest to save funding and repayment

The University Health Board is actively pursuing additional funding streams and has submitted a number of Invest to Save bids to the Welsh Government. The Financial plan assumes that an additional £2.7m will be received in 2014/15 and repaid in 2016/17, or later where agreed. This is based on the schemes below being approved, all of which have been favourably received.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Gross bid</th>
<th>Assumed funded</th>
<th>Assumed funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>%</td>
<td>£000</td>
</tr>
<tr>
<td>Voluntary Early release</td>
<td>1,700</td>
<td>100</td>
<td>1,700</td>
</tr>
<tr>
<td>Investment in Acute physicians</td>
<td>460</td>
<td>75</td>
<td>345</td>
</tr>
<tr>
<td>Investment in Liaison Psychiatry services</td>
<td>690</td>
<td>75</td>
<td>517</td>
</tr>
<tr>
<td>E rostering for medical staff</td>
<td>175</td>
<td>75</td>
<td>131</td>
</tr>
<tr>
<td>Total</td>
<td>3,025</td>
<td></td>
<td>2,693</td>
</tr>
</tbody>
</table>
This investment to save income is critical to the plan, as without the University Board would be unable to fund the essential upfront investment needed in 2014/15 to drive financial and service improvements in 2014/15 and beyond.

8.6 Inflationary and Service Demand and Cost Pressures

The table below shows the projected inflationary, demand and other cost pressures for the next three years.

<table>
<thead>
<tr>
<th>Table 1 - Recurring</th>
<th>2014/15 £’000</th>
<th>2015/16 £’000</th>
<th>2016/17 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay inflation and incremental drift</td>
<td>4,600</td>
<td>4,400</td>
<td>4,200</td>
</tr>
<tr>
<td>Non pay Inflation</td>
<td>1,500</td>
<td>1,500</td>
<td>1,500</td>
</tr>
<tr>
<td>Travel Allowance Changes</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuing Heath Care</td>
<td>1,000</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory compliance &amp; national policy</td>
<td>500</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>Sub Total</td>
<td>8,200</td>
<td>7,450</td>
<td>7,250</td>
</tr>
<tr>
<td>Service Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE and new high cost drugs</td>
<td>2,300</td>
<td>1,800</td>
<td>2,600</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>1,200</td>
<td>1,200</td>
<td>1,100</td>
</tr>
<tr>
<td>Sub Total</td>
<td>3,500</td>
<td>3,000</td>
<td>3,700</td>
</tr>
<tr>
<td>Service Demand &amp; Cost Pressures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Heath Care</td>
<td>1,000</td>
<td>400</td>
<td>1,100</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Primary care prescribing</td>
<td>1,300</td>
<td>1,500</td>
<td>2,500</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>300</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>Local cost, demand and service pressures plus investment in quality &amp; safety improvement</td>
<td>4,300</td>
<td>3,800</td>
<td>9,300</td>
</tr>
<tr>
<td>Sub Total</td>
<td>7,100</td>
<td>6,200</td>
<td>13,400</td>
</tr>
<tr>
<td>Total</td>
<td>18,800</td>
<td>16,650</td>
<td>24,350</td>
</tr>
</tbody>
</table>
The basis for the above estimates is outlined below.

i. **Pay cost inflation**

Pay cost pressures have been assessed to include

- An assumed overall 1% wage award in each year.
- Agenda for Change incremental drift which has been evidenced to still be impacting upon and increasing the cost of the workforce. The increases in recent years have been slowing down - £3.0m in 2010, £2.4m in 2011, £1.9m in 2012. £1.4m has been assumed for 2013/14 and £1.2m, £1.0m, £0.8m for subsequent years.
- Incremental drift for medical staff is projected at £0.5m in each year.
- Commitment awards for consultants are projected at £0.2m in each year.

There are two further potential cost pressures which could have an impact on Local Health Boards in 2015/16 and 2016/17. These are described below, but have been excluded from our three year financial plan pending further information on likelihood, quantum and the funding position of Welsh Government:

ii. **Employers Pension Contribution increases**

HM Treasury has published the final valuation and employer cost cap regulations and directions for the NHS Pension Scheme. This valuation measures the full cost of paying pension benefits and will inform the future employer contributions to be paid into the scheme. These results indicate a 0.3% increase of the employer contribution rate from 14% to 14.3% effective from 1 April 2015. This would equate to a potential cost pressure of circa £0.7m for Cwm Taf University Health Board.

iii. **Changes to Employers National Insurance Contributions**

The introduction of the Single Tier State Pension in April 2016 will coincide with the end of contracting out arrangements for salary related pension schemes. This change will result in the removal of the National insurance rebate for both employees and employers. NHS employers estimate that the impact of this change could be a rise in costs in excess of 2% of the pensionable payroll increase. This would equate to a potential cost pressure of circa £6m for Cwm Taf University Health Board.

iv. **Non Pay inflation**

Following the approach taken in previous years, a matrix largely based upon the Health Services Cost Index (HSCI) has been developed and applied to 2012/13 accounts expenditure heads to derive an assessment
of non pay inflation. To provide a more accurate assessment, colleagues from Welsh Health Supplies have provided estimates of inflation on medical and surgical consumables, provisions and external general service contracts.

v. NICE and new high cost drugs

The cost of NICE technical appraisals and nationally adopted high cost drugs has been a significant cost pressure in recent years. We have assumed annual increases of £2.3m, £1.8m and £2.6m for the next three years. It is important to note that these estimates include the anticipated growth in NICE costs at Velindre Trust and other Health Boards for Cwm Taf residents (2014/15 estimate= £0.6m). The net growth assumed for the provider function in 2014/15 is therefore £1.7m which represents an increase of £1.0m compared to a forecast increase in actual costs of £0.7m in 2013/14.

vi. Specialist services

Actual expenditure growth in specialist services is expected to be 1.7% in 2013/14 and projections from WHSSC indicate growth in the cost of specialist services of circa 2% pa for each of the next 3 years. This equates to a an estimated cost pressure for Cwm Taf University Health Board of £1.2m in each year, prior to factoring in savings plans.

vii. Continuing health care (CHC) and funded nursing care (FNC)

We currently spend circa £27m per annum on external CHC placements. The anticipated cost increases in continuing health care have been assessed on the basis of price inflation (circa 3.5%) and volume growth.

viii. Primary care prescribing

The anticipated cost pressures for Primary care prescribing have been based upon an assumed growth of £1.8m (2.5%) in gross prescribing costs for each of the next 2 years. For 2014/15 this has been reduced to £1.3m to reflect the anticipated full year effect of the CAT M price reductions made in 2013/14. We have assumed that growth in gross costs will be £1.5m in 2015/16 and increase to £2.5m (3.5%) in 2016/17.

ix. Local cost, demand and service pressures plus investment in quality & safety

Provision of £4.3m, £3.8m and £4.3m has been made over the next three years, plus a further £5.0m in 2016/17.
The key pressures driving a requirement for these increases are as follows:

- Demand increases in certain services requiring increased capacity (e.g. diagnostics)
- Increased junior medical agency costs as a consequence of the withdrawal of training posts by the Deanery
- Increased consultant agency costs as a result of Deanery requirements
- Growth in acute prescribing
- Withdrawal of patient flows to CTUHB from LHBs seeking to repatriate services
- Non-pay demand pressures
- Introduction of carbon credit charges
- Recruitment to vacant posts where critical for service performance and quality, or to ensure cost effective use of resources

A costed plan has been developed responding to these pressures in 2014/15, and outline plans for 2015/16 and 2016/17.

The cost of clinical negligence and other claims currently met by the Welsh Risk Pool will fall to be met by LHBs in 2014/15. It has been agreed that the each LHB will receive an additional budget reflecting its share of the current £70m Welsh Risk Pool budget. Actual costs in 2013/14 are projected to be £68m, but claims are on a rising annual growth trend of around 10% per annum. It has been agreed that a risk sharing arrangement will be put in place for 2014/15 such that all costs are shared between LHBs proportionate to their shares of the devolved budget, and the Welsh Government will cover the first £5m of any overspend. There is therefore total cover of £7m over the 2013/14 outturn across Wales before any additional cost would fall to LHBs. In light of this, no provision for cost pressures over and above the newly devolved budget has been provided for in the plan.

**x. Additional investment in improvement of £5.0m in 2016/17**

Pressures to improve the quality, sustainability and compliance with standards of a number of clinical services are currently being contained and this is likely to continue, unless critical, into 2014/15 and 2015/16, due to affordability constraints. Provided the Health Board delivers its overall plan, and particularly the savings plans, it has then built in financial headroom in 2016/17 to make some of these improvements. A provision for this of £5m has been made, equating to approximately 1% of the budget.
8.7 Investment in Change and New Service and Delivery Models

The following table sets out the planned recurring and non recurring investments in change for the three year period:

<table>
<thead>
<tr>
<th>Investment in Change and New service &amp; Delivery models</th>
<th>2014/15 £'000</th>
<th>2015/16 £'000</th>
<th>2016/17 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non recurring costs of enabling change</td>
<td>3,700</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Recurring investment in new service &amp; delivery models</td>
<td>2,200</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Total</td>
<td>5,900</td>
<td>4,000</td>
<td>4,000</td>
</tr>
</tbody>
</table>

Non-recurring investment in change

Provision of £3.7m has been made in 2014/15 and £2.0m in each of 2015/16 and 2016/17 for the non-recurring costs of the change programme and to meet non-recurring cost pressures. The main uses of this funding in 2014/15 include the following schemes:

<table>
<thead>
<tr>
<th></th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Early Release - the scale of the reduction in staff employed assumed in the plan is greater than can be achieved through natural wastage</td>
<td>1,700</td>
</tr>
<tr>
<td>Investment in clinical and management capacity to plan and manage change.</td>
<td>1000</td>
</tr>
<tr>
<td>Investment in digitisation of records</td>
<td>250</td>
</tr>
<tr>
<td>Set up costs of E job planning and E rostering</td>
<td>80</td>
</tr>
<tr>
<td>Non-pay costs of additional activity to eradicate over 36 week waiters</td>
<td>500</td>
</tr>
<tr>
<td>Other</td>
<td>170</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,700</td>
</tr>
</tbody>
</table>

This investment plan is partly funded through assumed Invest to Save allocations from the Welsh Government. It does not provide for investment in non recurring backfill and training costs to support future workforce models (ANPs replacing junior doctors), as the initial indications from Welsh Government is that this may not be funded through Invest to Save allocations.

The investment plan will be reviewed once the Welsh Government has decided which of these schemes will be funded and the level of funding.
Recurring investment in new service & delivery models

Provision of £2.2m per annum investment is included in the plan for 2014/15, and £2.0m in each of the subsequent two years. The main areas of investment in 2014/15 are summarised below. In some cases the levels of investment are approximate pending further work.

<table>
<thead>
<tr>
<th>Description</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional acute physicians to improve the effectiveness unscheduled care</td>
<td>460</td>
</tr>
<tr>
<td>Investment to improve the Fractured NoF pathway – improved quality with reduced length of stay</td>
<td>50</td>
</tr>
<tr>
<td>Additional elective capacity in Ward 6 at PCH (expanding short stay surgery)</td>
<td>120</td>
</tr>
<tr>
<td>Liaison Psychiatry service to provide improved care for acute medical patients with mental health problems, while reducing bed use</td>
<td>520</td>
</tr>
<tr>
<td>Re-investment in community mental health services</td>
<td>300</td>
</tr>
<tr>
<td>Weight management services to provide an alternative to surgery for appropriate high BMI patients</td>
<td>100</td>
</tr>
<tr>
<td>E job planning and E rostering for medical staff to improve efficiency and effectiveness</td>
<td>85</td>
</tr>
<tr>
<td>Investment in community services (including CHC) to facilitate community hospital ward closures</td>
<td>250</td>
</tr>
<tr>
<td>Improved rheumatology services for Powys while enabling Cwm Taf to meet all of its own rheumatology demand internally</td>
<td>150</td>
</tr>
<tr>
<td>Investment in therapies over the rollover budget</td>
<td>500</td>
</tr>
<tr>
<td>Referral management centre (for referrals outside CT)</td>
<td>60</td>
</tr>
<tr>
<td>Move towards new imaging models (cardiac CT &amp; CT colons)</td>
<td>100</td>
</tr>
<tr>
<td>MEDACS managed service for agency medical staff</td>
<td>100</td>
</tr>
</tbody>
</table>

Firm decisions have already been made to invest in acute physicians, rheumatology services, referral management and the MEDACS managed service. As the total cost of making all the investments shown is around £2.9m in comparison with the £2.2m provided for in the budget, review of the levels of investment, prioritisation and phasing decisions will need to be made early in the financial year.

The principal areas of investment planned for 2015/16 and 2016/17 are in the following areas:-

- Improved management of chronic diseases in primary and community care, releasing further secondary care resources.
- Improved community mental health services, enabling further reductions to inpatient beds.
• Working with local authority partners to improve the access to high quality nursing home and community placements, and reduce inappropriate delays in secondary care.

• Investment in diagnostics and therapies to ensure prompt access to those services and minimising patient delays and unnecessary hospital beddays.

• Investment in technology to improve the effectiveness and efficiency of care.

**Investment from the Intermediate Care Fund**

A joint bid has been submitted to the Welsh Government by Merthyr Tydfil, RCT and Cwm Taf, which is expected to be approved. The elements of the proposals in the bid which would be delivered by Cwm Taf are shown below, matched by income from Welsh Government received through our local authority partners.

It is important to note that the Intermediate Care Fund is currently non-recurrent for 2014/15 only. This will potentially limit its effectiveness, and there will be further discussion with Welsh Government about this issue.

<table>
<thead>
<tr>
<th>Investment in community health services (CIAS etc.)</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for an integrated (Health &amp; LA) @ Home service</td>
<td>150</td>
</tr>
<tr>
<td>Interim nursing home placements</td>
<td>180</td>
</tr>
<tr>
<td>Improve quality of care provided to older people with demantia</td>
<td>100</td>
</tr>
<tr>
<td>Joint LHB/LA commissioning strategy</td>
<td>47</td>
</tr>
<tr>
<td>Other</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1900</strong></td>
</tr>
</tbody>
</table>

**8.8 Medium Term Savings Plan 2014/15 to 2016/17**

<table>
<thead>
<tr>
<th>Summary</th>
<th>2014/15 £'m</th>
<th>2015/16 £'m</th>
<th>2016/17 £'m</th>
<th>Total £'m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency and redesign savings</td>
<td>17.2</td>
<td>18.0</td>
<td>18.0</td>
<td>53.2</td>
</tr>
<tr>
<td>All Wales terms and conditions changes</td>
<td>6.0</td>
<td>6.0</td>
<td>6.0</td>
<td>18.0</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td><strong>23.2</strong></td>
<td><strong>24.0</strong></td>
<td><strong>24.0</strong></td>
<td><strong>71.2</strong></td>
</tr>
</tbody>
</table>

It is important to note that the savings of £71.2m over three years significantly exceeds the level of savings that have been achieved in previous years. It is a reduction of around 16.5% of the University Health
Board’s controllable expenditure (excluding capital charges and primary care contracts), around 5.5% per annum. 12.4% comes from reductions from efficiency and re-design savings (4.1% per annum of controllable spend). The balance results from all Wales changes to terms and conditions equating to 1% of the total budget per annum (3% over the three years). The Welsh Government has advised LHBs to plan for this level of saving.

When developing our three year efficiency and re-design savings plans, we have been mindful of the requirement to phase in programmes of work to ensure a whole systems approach is being adopted and to target work on improvements where there is the biggest opportunity. To facilitate this, we have identified a number of cross-cutting themes which we have used to plan and prioritise the development of the overall plan. This work is being informed by the benchmarking and other data referred to earlier in the Plan.

The themes are organised into 5 overall strategic categories of change. The strategic categories and the themes associated with each are set out below:

<table>
<thead>
<tr>
<th>Strategic Category</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Systems Re-design</td>
<td>Emergency care, Frail elderly and rehabilitation care, Planned care, Reconfiguration and rationalisation of services, Estate rationalisation, Prudent medicine</td>
</tr>
<tr>
<td>Commissioning</td>
<td></td>
</tr>
<tr>
<td>Efficiency and Productivity</td>
<td>Theatre productivity, Outpatient productivity, Patient care administration, Diagnostics, Medical staff productivity, Nursing productivity, General workforce productivity, Back office</td>
</tr>
<tr>
<td>Non-pay Management</td>
<td>Traditional non-pay, Prescribing, CHC</td>
</tr>
<tr>
<td>All Wales Measures</td>
<td></td>
</tr>
</tbody>
</table>
Changes to staff terms and conditions

Our medium term savings plans are summarised in the following two tables which show the firstly the savings by overarching category and theme for each of the three years, and secondly by the estimated impact on pay, non-pay and income and workforce.

### Medium Term Savings Plan (3 years from 2014/15 to 2016/17)

<table>
<thead>
<tr>
<th>THEME</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Urgent care</td>
<td>-</td>
<td>500</td>
<td>1,500</td>
<td>2,000</td>
</tr>
<tr>
<td>Planned care</td>
<td>-</td>
<td>270</td>
<td>370</td>
<td>640</td>
</tr>
<tr>
<td>Outpatients</td>
<td>-</td>
<td>372</td>
<td>572</td>
<td>944</td>
</tr>
<tr>
<td>Acute reconfiguration (rationalising to fewer centres)</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>1,500</td>
</tr>
<tr>
<td>Mental health admissions &amp; length of stay</td>
<td>300</td>
<td>789</td>
<td>789</td>
<td>1,879</td>
</tr>
<tr>
<td>Community hospital length of stay</td>
<td>1,548</td>
<td>965</td>
<td>965</td>
<td>3,477</td>
</tr>
<tr>
<td>Acute patient flow/length of stay</td>
<td>500</td>
<td>1,049</td>
<td>1,049</td>
<td>2,597</td>
</tr>
<tr>
<td>Premises rationalisation</td>
<td>385</td>
<td>558</td>
<td>558</td>
<td>1,500</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>3,233</td>
<td>5,002</td>
<td>6,302</td>
<td>14,537</td>
</tr>
<tr>
<td>Commissioning from other LHBs</td>
<td>1,541</td>
<td>930</td>
<td>930</td>
<td>3,400</td>
</tr>
<tr>
<td>General acute ward nursing</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Theatre productivity</td>
<td>918</td>
<td>299</td>
<td>299</td>
<td>1,516</td>
</tr>
<tr>
<td>Outpatients</td>
<td>135</td>
<td>83</td>
<td>83</td>
<td>300</td>
</tr>
<tr>
<td>Patient care admin</td>
<td>243</td>
<td>631</td>
<td>631</td>
<td>1,505</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>602</td>
<td>492</td>
<td>492</td>
<td>1,586</td>
</tr>
<tr>
<td>Community service productivity</td>
<td>300</td>
<td>339</td>
<td>339</td>
<td>979</td>
</tr>
<tr>
<td>Mental health &amp; CAMHS community productivity</td>
<td>785</td>
<td>429</td>
<td>429</td>
<td>1,644</td>
</tr>
<tr>
<td>Non-clinical income generation</td>
<td>325</td>
<td>238</td>
<td>238</td>
<td>800</td>
</tr>
<tr>
<td>Clinical directorate management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Facilities &amp; hotel services</td>
<td>1,770</td>
<td>769</td>
<td>769</td>
<td>3,308</td>
</tr>
<tr>
<td>Estates</td>
<td>155</td>
<td>111</td>
<td>111</td>
<td>377</td>
</tr>
<tr>
<td>Back office/corporate services</td>
<td>1,250</td>
<td>752</td>
<td>752</td>
<td>2,753</td>
</tr>
<tr>
<td>Skill mix, sickness management</td>
<td>554</td>
<td>473</td>
<td>473</td>
<td>1,500</td>
</tr>
<tr>
<td>Medical staff productivity</td>
<td>670</td>
<td>881</td>
<td>881</td>
<td>2,432</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>115</td>
<td>90</td>
<td>90</td>
<td>295</td>
</tr>
<tr>
<td>Nursing workforce (outside general wards, theatres &amp; community)</td>
<td>350</td>
<td>780</td>
<td>780</td>
<td>1,911</td>
</tr>
<tr>
<td>Therapy workforce</td>
<td>170</td>
<td>227</td>
<td>227</td>
<td>625</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>8,342</td>
<td>6,594</td>
<td>6,594</td>
<td>21,530</td>
</tr>
<tr>
<td>Non-pay management</td>
<td>1,733</td>
<td>1,134</td>
<td>1,134</td>
<td>4,000</td>
</tr>
<tr>
<td>Acute prescribing</td>
<td>250</td>
<td>336</td>
<td>336</td>
<td>922</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td>450</td>
</tr>
<tr>
<td>Primary care prescribing</td>
<td>1,200</td>
<td>1,300</td>
<td>1,300</td>
<td>3,800</td>
</tr>
<tr>
<td>CHC/FNC/Out of area placements</td>
<td>1,164</td>
<td>949</td>
<td>949</td>
<td>3,062</td>
</tr>
<tr>
<td>Energy efficiency</td>
<td>100</td>
<td>600</td>
<td>600</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>4,597</td>
<td>4,468</td>
<td>4,168</td>
<td>13,234</td>
</tr>
<tr>
<td>Total savings</td>
<td>23,213</td>
<td>23,994</td>
<td>23,994</td>
<td>71,200</td>
</tr>
</tbody>
</table>
Efficiency and redesign savings 2014/15

The detailed savings plans for 2014/15 are shown below in each of the strategic categories described above:

- Whole systems re-design
- Commissioning
- Efficiency and productivity
- Non-pay management
- All Wales measures

Whole systems re-design

These service rationale and aims behind these schemes are described further in Section 6 of the plan.

There are three linked areas of change as follows:

- Building on the successful improvements in patient flow over the last three to four months, to extend the flow work and add additional improvements to systems and pathways of care to further reduce the requirement for acute and community beds. These additional improvements include increasing the acute physician service, introducing a Liaison Psychiatry Service, and using the current Newton review to help us to focus our actions on improving flow, subject to success with invest to save funding to pump prime these developments. This will enable the incremental closure of two community wards and one acute ward over the first 6 months of the financial year.

- Development of Older Persons Mental Health Services, increasing the provision of community services and reducing and rationalising bed numbers. This enables the closure of the Mental Health ward on the Dewi Sant site, and changes to the current service at
Thomastown House in response to changes being made by Merthyr Tydfil Local Authority.

- The two changes above then enable rationalisation of facilities and estates services on the Dewi Sant site, as the site would then no longer be taking inpatients.

In addition, we are then looking to relocate the Palliative Care Service on an interim basis, pending a longer term solution, and this enables the closure of the Y Bythyn site.

There are then a range of initiatives around prudent healthcare which we plan to pull together into a coherent programme over the first two quarters of the financial, for implementation incrementally through the rest of the financial year.

The individual schemes are set out in the table below.

### 1. Directorate savings plans

<table>
<thead>
<tr>
<th>Start month</th>
<th>Pay</th>
<th>Pay</th>
<th>Non Pay</th>
<th>Income</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Whole System Redesign</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closure of community Hospital Ward</td>
<td>July</td>
<td>32</td>
<td>929</td>
<td>-</td>
<td>929</td>
</tr>
<tr>
<td>Closure of community Hospital Ward</td>
<td>October</td>
<td>32</td>
<td>619</td>
<td>-</td>
<td>619</td>
</tr>
<tr>
<td>Closure of Acute Hospital Ward</td>
<td>October</td>
<td>26</td>
<td>500</td>
<td>-</td>
<td>500</td>
</tr>
<tr>
<td>Closure of Older Persons Mental Health ward</td>
<td>October</td>
<td>16</td>
<td>300</td>
<td>-</td>
<td>300</td>
</tr>
<tr>
<td>Site rationalisation of Dewi Sant Hospital</td>
<td>October</td>
<td>6</td>
<td>80</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>Site rationalisation of Y Bwthyn Hospital</td>
<td>October</td>
<td>6</td>
<td>80</td>
<td>125</td>
<td>-</td>
</tr>
<tr>
<td>Maximising patient value from healthcare - prudent medicine</td>
<td>October</td>
<td>28</td>
<td>400</td>
<td>100</td>
<td>-</td>
</tr>
</tbody>
</table>

| | | | | | 146 | 2,908 | 325 | - | 3,233 |

### iii. Commissioning

The changes planned are shown in the table below.
iv. Efficiency and productivity

A wide range of schemes for achieving savings through improvements in efficiency and productivity has been developed, which are set out in the table below.

<table>
<thead>
<tr>
<th>1. Directorate savings plans</th>
<th>Start month</th>
<th>Pay WTE</th>
<th>Pay £k</th>
<th>Non Pay £k</th>
<th>Income £k</th>
<th>Total £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Securing Additional Income for CAMHS Network</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>WHSSC prioritisation and business case review of specialist service demand and developments</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>Repatriation of elements of interventional cardiology from C&amp;V.</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Repatriation of non specialist orthopaedic activity from C&amp;V.</td>
<td>October</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Repatriation of minor spine activity from C&amp;V.</td>
<td>October</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Repatriation of chemotherapy services from C&amp;V.</td>
<td>October</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Management of addiction service referrals to C&amp;V from 3rd sector organisations.</td>
<td>October</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Rheumatology service development enabling income from Powys and repatriation of Cwm taf Patients from C&amp;V.</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>LTA negotiations with ABMU.</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>Further repatriation and demand management opportunities.</td>
<td>April</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>250</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
<td>1,251.00</td>
<td>290.00</td>
<td>1,541.00</td>
</tr>
</tbody>
</table>
The Newton diagnostic review covered the following areas:

- Inpatients (acute and community)
- A&E
- Theatres
- Outpatients
- Endoscopy
- Mental Health
- Community nursing

### 1. Directorate savings plans

<table>
<thead>
<tr>
<th>Start month</th>
<th>Pay WTE £k</th>
<th>Pay £k</th>
<th>Non Pay £k</th>
<th>Income £k</th>
<th>Total £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Productivity &amp; Efficiency Schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Person Mental Health ward nursing levels/skill mix</td>
<td>April</td>
<td>5 185</td>
<td>-</td>
<td>-</td>
<td>185</td>
</tr>
<tr>
<td>Older Person Mental Health ward nursing levels/skill mix</td>
<td>April</td>
<td>6 185</td>
<td>-</td>
<td>-</td>
<td>185</td>
</tr>
<tr>
<td>Paediatric Nursing Workforce</td>
<td>April</td>
<td>3 141</td>
<td>-</td>
<td>-</td>
<td>141</td>
</tr>
<tr>
<td>Bed Management and Hospital @ Night Team</td>
<td>October</td>
<td>5 100</td>
<td>-</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Therapies skill mix and redesign</td>
<td>April</td>
<td>4 170</td>
<td>-</td>
<td>-</td>
<td>170</td>
</tr>
<tr>
<td>Outpatient productivity and staffing review.</td>
<td>April</td>
<td>3 135</td>
<td>-</td>
<td>-</td>
<td>135</td>
</tr>
<tr>
<td>Theatre productivity and staffing review.</td>
<td>April</td>
<td>2 63</td>
<td>-</td>
<td>-</td>
<td>63</td>
</tr>
<tr>
<td>ACT sickness management</td>
<td>April</td>
<td>3 105</td>
<td>-</td>
<td>-</td>
<td>105</td>
</tr>
<tr>
<td>Mental Health reduction in medical staff agency</td>
<td>October</td>
<td>- 5 215</td>
<td>-</td>
<td>-</td>
<td>215</td>
</tr>
<tr>
<td>Community Nursing Productivity</td>
<td>April</td>
<td>1 38</td>
<td>-</td>
<td>-</td>
<td>38</td>
</tr>
<tr>
<td>Localities medical staff review</td>
<td>April</td>
<td>- 10</td>
<td>-</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Localities patient care administration review</td>
<td>April</td>
<td>2 43</td>
<td>-</td>
<td>-</td>
<td>43</td>
</tr>
<tr>
<td>Pathology workforce redesign and productivity</td>
<td>April</td>
<td>9 362</td>
<td>90</td>
<td>-</td>
<td>452</td>
</tr>
<tr>
<td>Estates VERs</td>
<td>April</td>
<td>3 155</td>
<td>-</td>
<td>-</td>
<td>155</td>
</tr>
<tr>
<td>Facilities workforce redesign, commercial opportunities and productivity</td>
<td>April</td>
<td>52 716</td>
<td>584</td>
<td>270</td>
<td>1,570</td>
</tr>
<tr>
<td>Head &amp; Neck workforce redesign and income generation</td>
<td>April</td>
<td>2 75</td>
<td>-</td>
<td>75</td>
<td>150</td>
</tr>
<tr>
<td>Obstetrics and gynaecology workforce redesign and productivity</td>
<td>April</td>
<td>5 250</td>
<td>-</td>
<td>-</td>
<td>250</td>
</tr>
<tr>
<td>CYP workforce redesign and productivity</td>
<td>April</td>
<td>1 50</td>
<td>-</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>Radiology workforce redesign and productivity</td>
<td>April</td>
<td>4 150</td>
<td>-</td>
<td>-</td>
<td>150</td>
</tr>
<tr>
<td>Pharmacy workforce redesign and productivity</td>
<td>April</td>
<td>2 115</td>
<td>-</td>
<td>-</td>
<td>115</td>
</tr>
<tr>
<td>Endoscopy opportunities</td>
<td>April</td>
<td>2 100</td>
<td>-</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>MH Community Services Productivity</td>
<td>October</td>
<td>10 200</td>
<td>-</td>
<td>-</td>
<td>200</td>
</tr>
<tr>
<td>Facilities savings from proposed ward closures</td>
<td>January</td>
<td>20 120</td>
<td>80</td>
<td>-</td>
<td>200</td>
</tr>
<tr>
<td>NWSSP Income</td>
<td>March</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>Flexible benefits - cars</td>
<td>April</td>
<td>- 150</td>
<td>-</td>
<td>-</td>
<td>150</td>
</tr>
<tr>
<td>Flexible benefits - more schemes</td>
<td>October</td>
<td>- 50</td>
<td>-</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>MEDACs- VAT</td>
<td>April</td>
<td>- 360</td>
<td>-</td>
<td>-</td>
<td>360</td>
</tr>
<tr>
<td>Corporate back office</td>
<td>July</td>
<td>29 1,000</td>
<td>125</td>
<td>125</td>
<td>1,250</td>
</tr>
<tr>
<td>Reduction in RTT WLI costs</td>
<td>April</td>
<td>- 600</td>
<td>-</td>
<td>-</td>
<td>600</td>
</tr>
<tr>
<td>Patient Care administration - Cross cutting theme</td>
<td>October</td>
<td>14 200</td>
<td>-</td>
<td>-</td>
<td>200</td>
</tr>
<tr>
<td>Medical Staff productivity - Cross cutting theme</td>
<td>April</td>
<td>- 300</td>
<td>-</td>
<td>-</td>
<td>300</td>
</tr>
<tr>
<td>Community Nursing - Cross cutting theme</td>
<td>July</td>
<td>10 300</td>
<td>-</td>
<td>-</td>
<td>300</td>
</tr>
<tr>
<td>Specialist nurses and other non ward nurses - Cross cutting theme</td>
<td>October</td>
<td>7 150</td>
<td>-</td>
<td>-</td>
<td>150</td>
</tr>
<tr>
<td>Theatre productivity - Cross cutting theme</td>
<td>July</td>
<td>5 150</td>
<td>-</td>
<td>-</td>
<td>150</td>
</tr>
</tbody>
</table>

204 6,943 879 520 8,342
- Ward nursing
- Non-pay management and logistics
- Diagnostics

The final report from the Newton work will be received shortly. It broadly corroborates the areas of opportunity for efficiency savings which we have already identified, but does indicate potential for further efficiency opportunities in district nursing, radiology, mental health and endoscopy. An element of these additional opportunities has been reflected in additional savings targets for 2014/15. Further consideration will be given to this, and to later years, when the final report is received.

VER and potentially redundancy in certain cases will also be important to converting productivity improvements into workforce reductions and cash releasing savings. The Health Board has therefore also put in an ‘Invest to Save’ bid for VER funding.

In laundry and catering services, the University Health Board is proposing to use productivity improvement and its established delivery and quality record to provide these services for other Health Boards at lower cost than they are currently incurring. These proposals are being discussed with Welsh Government, and they also avoid the need for capital expenditure in the relevant Health Boards which would otherwise be necessary.

v. Management of non pay

The University Health Board has an established record of delivering non-pay savings across the range of traditional non-pay, prescribing and Continuing Health Care. This will continue into 2014/15 and through the three year plan period, but will be enhanced by new initiatives in the following areas:

- Improved management of travel claims
- Review and prioritisation of contracts and grants to voluntary bodies
- Energy efficiency improvements. The energy efficiency improvements require capital investment which cannot be funded from the Health Board’s discretionary capital allocation, and so a bid has been made against strategic capital to fund the capital investment needed in 2014/15 and later years.

The individual schemes are shown in the table overleaf:
vi. All Wales measures

On the advice of the Welsh Government, the University Health Board is assuming a 1% saving per annum (£6m) from changes to staff terms and conditions. This is obviously subject to discussion with unions across Wales and decisions by the Welsh Government.

vii. Efficiency and re-design savings in 2015/16 and 2016/17

While detailed plans have focussed on 2014/15, plans are also being developed for the latter two years. The key schemes in each of the overarching categories of change are as follows. These are reflected in the three year financial savings plan set out above.

Whole systems re-design

- Further improvement in patient flow and systems of care, enabling closure of one additional acute ward on each of the PCH and RGH sites in each year
- Development of the role of outpatient consultations within patient pathways
- Further development of the Older Persons Mental Health model, improving community and liaison services, enabling reductions in continuing assessment beds
- Rationalisation of some services on to a single site, linked to the outcome of the South Wales Plan. Examples would include stroke
services and also Pathology Regionalisation where the principal
would extend outside the Health Board boundary.

- Using the changes above to enable further estate rationalisation
  (e.g. Dewi Sant, Tonteg, Ynysmeurig House). In some cases this is
  subject to new capital investment (e.g. Pontypridd Health Park).

Commissioning

- Further development of prioritisation and development of models of
care for specialist services, including pathways and care models
- Looking at the opportunity to concentrate specialist services on
  single sites where appropriate
- Further repatriation of services provided for Cwm Taf patients by
  other Health Boards where appropriate (but limited)
- Ensuring the cost of CAMHS network services is fully covered by
  income from the commissioning LHBs.

Efficiency and productivity

- Further development of productive working across a wide range of
  settings - including in particular inpatients, theatres, outpatients,
  endoscopy, diagnostics, facilities and community services. This will
  require appropriate management capacity and technology as
  outlined previously
- Development of back office improvements, including salary sacrifice
  schemes (bringing the provision of salary sacrifice schemes within
  Shared Services), improved use of ESR and E rostering for a wide
  range of staff groups,
- Development towards an electronic medical record and increased
  use of electronic systems for referrals, order requesting and results
  reporting, enabling improved clinical information and reduced
  administrative staff costs.
- Systematic review of the banding of posts and the harmonisation of
  banding across the Health Board
- Further development of commercial activities for other health
  boards
- Further improvements in energy efficiency, subject to securing the
  necessary capital investment.

Non-pay management

- Ongoing work on procurement, non-pay management, prescribing
  and management of continuing health care placements.

All Wales measures

- Continuing to work with the Welsh Government to take forward
  further changes in terms and conditions, and other all Wales
  measures.
• Consideration of introduction of car parking charges if permitted by Welsh Government

No recurring savings in 2015/16
Our financial plan assumes that the successful outcome of ongoing legal claims will yield savings in the region of £2.5m in 2015/16.

8.9 Capital Expenditure Plans

Capital expenditure plans are included in Section 9.3.1. It is important to stress the criticality of capital investment to deliver the plan as a whole, but in particular to the delivery of efficiency and re-design savings. The areas where capital investment is key to enable change and savings are as follows:

• £6m over 3 years for an energy Invest to Save, including £2m, in 2014/15, including urgent initial funding early in 2014/15
• Reconfiguration of the Dewi Sant site to facilitate the conversion of inpatient accommodation to create a health park on the site, including initial transitional funding for interim moves
• Capital investment in tools and technology to support productivity improvement would significantly increase the rate of improvement and hence savings.
• Moving palliative care services currently at Y Bwthyn to an alternative site and close the Y Bwthyn site, including initial transitional funding for interim moves
• Bringing the Acute Assessment Unit and Medical Day Unit on the RGH site adjacent to A&E. This significantly improves the contribution acute physicians are able to make to improving patient flow, and thus is a significant enabler for savings from bed reductions.

The incremental savings assumed within the 3 year plan which is dependant upon capital funding is shown below:

<table>
<thead>
<tr>
<th>Incremental revenue savings</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital investment</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>South Health Park on Dewi</td>
<td>180</td>
<td>180</td>
<td>180</td>
<td>540</td>
</tr>
<tr>
<td>Stroke services remodelling</td>
<td>0</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Acute remodelling RGH</td>
<td>0</td>
<td>500</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Palliative Care Y Bwthyn</td>
<td>180</td>
<td>180</td>
<td></td>
<td>360</td>
</tr>
<tr>
<td>Energy management</td>
<td>129</td>
<td>600</td>
<td>300</td>
<td>1029</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>489</strong></td>
<td><strong>1510</strong></td>
<td><strong>480</strong></td>
<td><strong>2479</strong></td>
</tr>
</tbody>
</table>
In addition to the above areas requiring capital investment, the Health Board has also submitted a number of Health Technology Capital bids. The incremental savings associated within these bids are as follows:

<table>
<thead>
<tr>
<th>Health technology bids:</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimising treatment of patients and professionals</td>
<td>115</td>
<td>115</td>
<td>0</td>
<td>230</td>
</tr>
<tr>
<td>MTED</td>
<td>90</td>
<td>180</td>
<td>90</td>
<td>360</td>
</tr>
<tr>
<td>Technology assisted Long term conditions</td>
<td>127</td>
<td>275</td>
<td>167</td>
<td>569</td>
</tr>
<tr>
<td>Mobilising the workforce</td>
<td>213</td>
<td>213</td>
<td>213</td>
<td>639</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>COPD</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Electronic digitise record</td>
<td>42</td>
<td>14</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>605</td>
<td>797</td>
<td>537</td>
<td>1939</td>
</tr>
</tbody>
</table>

8.10 Balance Sheet and Cash Flow

The projected deficit for 2013/14 has resulted in a cash pressure, for which the Health Board received £900k cash assistance from Welsh Government. It is understood that this will be repayable in 2014/15. This has enabled the Health Board to pay its creditors without undue delay, thus maintaining its PSPP compliance target of 95% into 2014/15.

The Health Board’s plan for 2014/15 projects break-even subject to the receipt of £8m flexibility funding from the Welsh Government. If this funding was provided, and it was cash backed, then the balance sheet for 2014/15 would only be affected by the £0.9m repayment of cash assistance, with minimal impact on the associated PSPP performance.

However, if £8m flexibility funding was not provided, or it was provided but not cash backed, then the resulting additional £8m cash deficit in 2014/15 would cumulatively result in a £8.9m pressure in March 2015. This would result in serious delays of over a month in paying non-NHS creditors and/or NHS creditors. This will impact on PSPP in 2015/16 and, given the volume of invoices likely to have been delayed, will result in compliance falling significantly below the 95% target.

Surpluses generated in 2015/16 and beyond should result in improved PSPP from 2016/17, but challenges in meeting PSPP compliance are likely to remain until sufficient cash is generated in-year to reduce the cumulative deficit.
The projected working capital balances over the next three years are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Inventories</th>
<th>Receivables</th>
<th>Payables</th>
<th>Provisions</th>
<th>Cash</th>
<th>Total</th>
<th>Delay in paying non-NHS invoices at year-end (£m/wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>£3.6m</td>
<td>£54.3m</td>
<td>(£62.0m)</td>
<td>(£49.5m)</td>
<td>0.2m</td>
<td>(£53.4m)</td>
<td>£8.9m/4.5 wks</td>
</tr>
<tr>
<td>2014-15</td>
<td>£3.6m</td>
<td>£54.3m</td>
<td>(£70.9m)</td>
<td>(£49.5m)</td>
<td>0.2m</td>
<td>(£62.3m)</td>
<td>£6.9m/3.5 wks</td>
</tr>
<tr>
<td>2015-16</td>
<td>£3.6m</td>
<td>£54.3m</td>
<td>(£68.9m)</td>
<td>(£49.5m)</td>
<td>0.2m</td>
<td>(£60.3m)</td>
<td>£6m/3 wks</td>
</tr>
<tr>
<td>2016-17</td>
<td>£3.6m</td>
<td>£54.3m</td>
<td>(£68.0m)</td>
<td>(£49.5m)</td>
<td>0.2m</td>
<td>(£59.4m)</td>
<td></td>
</tr>
</tbody>
</table>

The above projections assume that any movements in working balances not associated with the deficit will be funded via cash assistance from Welsh Government. It also assumes that there will not be a material change in payment patterns of other Health Boards to Cwm Taf. Clearly, this is a risk given cash pressures also experienced by other Health Boards.

8.11 Key Risks to the Three Year Financial Plan

The following outlines the key risks to the financial plan:

**Risks to be managed by the University Health Board:**

- Not achieving the changes in service provision required to deliver £17.2m of savings in 2014/15 and £18.0m for 2015/16 and 2016/17, whilst continuing to provide safe and sustainable services.

- Low staff turnover levels limiting pay savings after delivering the required service changes results in a risk of not achieving the workforce reductions and associated pay savings. This risk can be mitigated to some extent if our Invest to Save bid for VER funding is successful.
  - Management capacity and capability to deliver.
  - Impact of the South Wales Programme.
  - Contracting and commissioning assumptions and delivery in relation to WHSSC and other Health Boards and the ability to develop more appropriate long-term agreements.

**Risks that require further discussion with Welsh Government:**

- Not achieving the All Wales terms and conditions savings of £6m per annum.
• Failure to secure £8.0m flexibility funding in 2014/15 from the Welsh Government.
• Failure to secure £2.7m Invest to Save funding in 2014/15 from the Welsh Government.
• Failure to secure additional recurring allocations of £6m per annum in both 2015/16 and 2016/17.
• Impact on savings plans due to failure to secure assumed capital funding from Welsh Government (see Section 8.9 above).
• Not achieving the £1m savings from car parking charges assumed in 2015/16.
• Welsh Government is unable to secure “consequential” funding from the UK Government to meet the cost of increased employer pension contributions from 2015/16 and cost of the end of “contracting out” from 2016/17

Financial Risk Management Plans for 2014/15

A phasing plan for investment and savings has been developed which will as far as possible:-

• Defer additional investments funded by savings until the necessary savings have been identified. This would include discretionary investments, including where agreed, costs such as the implementation of new NICE guidelines. It would also include deferring investment in improved nursing ratios in areas under target until expenditure is seen to reduce in areas which are over target.

• No investment to be made in invest to save schemes until clarity has been achieved on the expected service and financial impact of the investments, these are committed to by the relevant directorates, and the Executive Board has signed off their achievability.
9. ENABLERS

9.1 Information and Communications Technology

Cwm Taf University Health Board IM&T Strategy and 3 Year Workplan was approved by the Board in 2012. The strategy builds upon the strengths of the existing infrastructure and systems as enablers to our service redesign and improvement programmes.

The strategy describes how IM&T can be utilised to support the challenge of delivering new ways of working to provide safe and effective care, streamline management processes, cut across traditional boundaries and support integration between Health Services, other Public Sector bodies and the third sector. The University Health Board recognises the real benefits of IM&T in terms delivering efficiencies and/or return on investment opportunities.

The IM&T Strategy is based on the following 9 principles:

- Achieving system rationalisation and consolidation;
- Ensuring best use of resources;
- Delivering innovation;
- Effective partnership working;
- Effective risk management;
- Obtaining financial sustainability;
- Demonstrating Value for Money and Quality;
- Effective governance;
- Improving data quality and performance measurement

During the first 18 months of the workplan we concentrated on improving the infrastructure; allowing planned new systems to be established more easily.

As we move forward, a significant resource has been devoted to network improvements, including the consolidation of all Wide Area links onto the national Public Sector Broadband Aggregation Service and the development of Wi-Fi which allows the deployment of Welsh Clinical Portal (WCP) to the patient. Older hardware workstations have been replaced and work has been undertaken to develop and strengthen secure access; this has included increased use of both Citrix and IGel Thins client workstations across the organisation.

System Rationalisation has included implementation of the Welsh Clinical Portal as the sole access point for Pathology and Radiology results and this allows us to fast-track new. This includes:
• Individual Health Record (IHR)
• HERs2 (for Pilot)
• Alerts and Notifications.
• Medicines Transcription and Electronic Discharge (MTED)
• Clinical documentation

In early 2014 we will provide free, secure public internet access using the existing Wi-Fi hardware. This will enable patients, students and staff access to personal devices, including PCs, smart phones and tablets, whilst maintaining a secure partition between NHS and private use.

The University Health Board will continue to use this structured approach to the development of our core infrastructure to lever the maximum benefits from existing equipment, as well as allowing us to build capability and support the delivery of new systems that ultimately improve patient care and safety.

Over the life of CTUHB’s 3 Year plan, we will continue to explore and use technological opportunities, such as automated clinic ‘booking in’ processes and the development and digitisation of our Health Records. We will continue to utilise specific funding such as the Health Technologies Fund, our Capital Programme and an ‘Integration Fund’ that is being established to facilitate service redesign and service change.

9.2 Capital & Estates

9.2.1 Estates

The estate is one of the University Health Board’s largest assets and consists of a range of facilities and services which support all the Health Board’s activities in the delivery of healthcare for its catchment population. CTUHB’s Estates Strategy describes the University Health Board’s existing estate and broadly outlines known and potential changes proposed to it over the next five years, written in the context of this plan.

The diagram below compares the age profile of the University Health Board’s estate in 2012/13 with 2001/02. It can be seen that CTUHB’s modernisation programme over the last 12 years has resulted in a reduction in ‘pre 1948’ facilities from 26% to 9% and an increase in ‘post 1995’ facilities from 30% to 57%.
The major modernisation programme, which has been largely concentrated on improvements in the Merthyr and Cynon Valleys, has included the following:

- The ward refurbishment programme at Prince Charles Hospital which was completed in January 2013.
- The opening of a new Emergency Care Centre and Day Surgery Unit at Prince Charles Hospital.
- The opening of the new Ysbyty Cwm Cynon in Mountain Ash.
- The opening of the new Kier Hardie Health Park in Merthyr Tydfil.
- The disposal of Mountain Ash and St Tydfil’s hospitals and the Hollies and Seymour Berry Health Centres, with plans progressing for the disposal of the Aberdare hospital site.

Over the coming three years, the strategic objectives for our estate are to ensure that:

- The estate is developed to meet emerging service models.
- All statutory and safety obligations are achieved.
- Backlog maintenance levels are reduced year on year to a nominal amount by 2017/18.
- Performance against the 6 national targets is improved, with the 90% target achieved by 2015/16.
- The cost per square metre is decreased year on year, with a target to be set following the outcome of the current benchmarking work, taking account of the safety of the service.
In terms of energy management, the University Health Board recognises that the consumption of energy and water is necessary for the provision of healthcare services but that it also has a responsibility to be energy and resource efficient by minimising unnecessary energy usage. The reduction of energy usage will deliver benefits of:

- Minimising cost which will allow investment back into healthcare.
- Minimising the impact on the environment.

CTUHB has already invested in various low or zero carbon technologies which will help drive the University Health Board to a zero carbon emitting organisation. However, a national review of health organisations in Wales by the Carbon Trust has highlighted that, in order to avoid any additional energy costs due to price rises, organisations would need to reduce energy consumption by 7% year on year.

For CTUHB, under a ‘business as usual’ scenario, the energy price rises could see costs rising from £4.7m to £6.2m. The University Health Board has therefore agreed an Energy Management Plan which commits the organisation to a 7% reduction in consumption year on year. This will be reviewed each year to determine whether the target has been achieved and whether there are opportunities to extend the target further.

### 9.2.2 Capital

The University Health Board recognises the importance of ensuring that strategic links are made between significant service change proposals and capital investment. The capital programme is therefore fully aligned to the service and estate priorities set out in this plan.

The Health Board have recently received approval of the Outline Business Case for the major capital scheme to refurbish the Ground and First Floors at Prince Charles Hospital. This scheme is fundamentally designed to ensure that the organisation can meet its strategic aim to deliver statutory and safety compliance, and will meet the requirements of the outstanding Fire Enforcement Notice in that area.

However, the scheme also provides the opportunity to redesign patient flows, deliver service efficiencies and transform the patient experience.

Major capital investment will be required to implement many elements of this three year plan. The University Health Board has submitted to the Welsh Government a draft capital investment programme for the coming years, with schemes that enable service model changes, facilitate performance and efficiency improvements and maintain the Health Board’s assets (estate and equipment) to a high standard.
Specific schemes include:

- Prince Charles Hospital Ground and First Floor refurbishment.
- Medical Education facility at Keir Hardie University Health Park.

Schemes to enable service model changes:
  - Palliative care remodelling to facilitate the move of palliative care services currently at Y Bwthyn to an alternative site and close the Y Bwthyn site, including urgent transitional arrangements.
  - Stroke services redesign.
  - Acute medicine redesign at Royal Glamorgan Hospital.
  - Reconfiguration of the Dewi Sant site to facilitate the conversion of inpatient accommodation for other uses, including urgent transitional arrangements.
  - South Wales Programme, including development of a diagnostic hub.

Schemes to facilitate improvements in performance and efficiency:
  - Energy management improvements.
  - Digitisation of patient health records*.
  - Mobilising the workforce*.
  - Cardiopulmonary hub*.
  - Medicines Transcribing and Electronic Discharge system*.
  - Chronic Obstructive Pulmonary Disease improvements*.
  - Technology assisted long term conditions management*.
  - Optimising treatment of patients and professionals*.

- Major radiology and catheter laboratory modernisation programme.
- Primary care developments.
- Discretionary Capital Programme.

To note, the schemes marked with an asterisk refer to bids also submitted to the Health Technology Fund.

A number of these proposed schemes relate specifically to the organisation’s financial plan. Capital funding is urgently required in the first few months of 2014/15 to facilitate the changes in service models that will lead to achievement of cost reduction plans. Work is on-going to ensure that the appropriate business cases are developed and submitted.
Elements of this investment plan are already acknowledged by the Welsh Government and included in the future all Wales capital programme, including the refurbishment of the ground and first floor at PCH and the medical education facility on the Kier Hardie Health Park site.

Discussions will continue with the Welsh Government on the All Wales Capital Programme to determine what additional resources can be secured to support the remainder of the programme.

The University Health Board will seek to take advantage of any other funding opportunities or routes which become available, such as the Health Technology Fund, ‘Invest to Save’ and Integration Funds.

The University Health Board’s Capital Plan assumes a constant level of discretionary funding over the next three years. The primary use of discretionary funding will be to replace equipment and maintain the estate to ensure future sustainability of service. There will however be an element that will be used as an enabler to support other aspects of the Estates Strategy, including the energy management plan, and smaller service/estate improvement plans.

In summary, the following reflect the specific priorities for the coming year outlined in the Capital Plan and the Estates Plan:-
• Following the outcome of the South Wales Programme, develop a detailed programme of capital and accommodation works required to ensure that the estate supports the new service models, developing business cases as necessary.

• Complete the service and estate review of primary care and community premises, determining the priorities for redesign, developing business cases for development as required or seeking to utilise other funding mechanisms where appropriate. This is likely to include the development of proposals to rationalise the number of community premises.

• Develop and submit the Full Business Case for the refurbishment of the ground and first floor at Prince Charles Hospital;

• Dependent on the approval of capital, commence construction on the enabling works for this scheme;

• Commence construction on the medical education facility at Kier Hardie University Health Park, dependent on final approval from Welsh Government;

• Develop a range of business cases to support the full range of proposed capital schemes which enable the delivery of the organisations three year plan;

• Develop a programme for plant / equipment replacement to ensure that RGH remains at physical condition and statutory compliance category B;

• Continue to progress Mountain Ash and Aberdare primary care schemes;

• Undertake detailed benchmarking analysis, comparing with both Welsh and English organisation, to determine areas for further work in relation to efficiency and cost;

• Ensure a proactive approach remains in place for the management of Health & Safety;

• Complete the review of opportunities for the relocation of CAMHS services from Tonteg Hospital, with a view to being able to sell the land to the GP practice to expand their branch surgery;

• Review of office accommodation usage and development of an agile working policy across the organisation, to ensure office and non clinical accommodation usage is maximised;

• Review priorities for the Discretionary Capital Programme, taking into account the needs of the organisations 3 year plan;

• Undertake a range of actions as outlined in the energy management plan, including in particular continuing to seek capital funding for the major schemes required to reduce consumption;

• Continue with plans to dispose of the Aberdare General Hospital site.
10. DELIVERY, STEWARDSHIP & GOVERNANCE

10.1 Planning Approach

The planning approach that the University Health Board has used to prepare its Plan marks a significant change from the approach used in previous years. This approach recognises that the UHB has three main areas of focus in planning and monitoring improvements over time:

- Developing clear long term strategic objectives for the University Health Board which will frame the development of short term and medium term service improvement plans.
- A clear (and rolling) set of priorities for improvement over the next three years.
- A clear understanding of the steps which are required in the short to medium term (1-3 years), to underpin the successful delivery of the University Health Board’s longer term objectives and priorities.

The planning approach for the development of our Plan was designed as a two-fold process; developing directorate/locality ‘bottom up’ and owned plans within a local Integrated Planning Framework (IPF) and in parallel, developing plans based on cross cutting themes & other organisation wide plans. The building blocks of our local Integrated Planning Framework (IPF) involved the development of organisation wide ‘opportunities’ using benchmarking and closer integration between service, quality, workforce and financial plans.

Our directorate/locality integrated business planning followed a three stage process. It was designed as an iterative process that involves directorates and localities developing their own local integrated business plans using a template based approach, with supporting guidance contained in the Integrated Planning Framework. The UHB Directorate/Locality 3-year Integrated Plans are in their final stage of completion and once signed this will complete our planning and delivery cycle.

Our intention is to further strengthen our planning and delivery approach as part of our journey of clinically led transformation. Chapter 6; Service Change Plans and Initiatives demonstrates how we have developed this planning model using our pathways based approach, providing the structure for the presentation of our service plans and deliverables.

The development of the Plan has been an iterative process underpinned by a comprehensive formal and informal engagement process led by Executive Director’s, predicated on open and honest discussions which reflect the challenging environment in which we are operating. As an iterative process, we have developed our plan using this formal and informal feedback. An Engagement Plan has been developed and it is
attached at Annex A5. We will continue to use this to underpin our communication, engagement and consultation processes.

The University Health Board is committed to principles of genuine citizen and staff empowerment and we will continue to work with our partners to develop and strengthen the planning and prioritisation process.

In addition to the Engagement Plan, the process is also supported by an agreed formal approvals process which is described in the table below:

<table>
<thead>
<tr>
<th>Key Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} Submission of Directorate/Locality Plans</td>
<td>22 November</td>
</tr>
<tr>
<td>Directorate Managers planning session</td>
<td>27 November</td>
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<tr>
<td>2\textsuperscript{nd} Submission of Directorate/Locality Plans</td>
<td>13 December</td>
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<tr>
<td>1\textsuperscript{st} Draft of UHB Plan</td>
<td>13 December</td>
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<tr>
<td>Draft UHB Plan discussed with UHB Board</td>
<td>15 January</td>
</tr>
<tr>
<td>Draft UHB Plan discussed with UHB Executive Board</td>
<td>23 October 18 December 22 January 23 April</td>
</tr>
<tr>
<td>Draft Plan discussed with Finance &amp; Performance Committee</td>
<td>23 January 27 February 27 March</td>
</tr>
<tr>
<td>Submission of draft UHB Plan to Welsh Government.</td>
<td>31 January</td>
</tr>
<tr>
<td>FINAL Directorate/Locality Plans</td>
<td>30 April</td>
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<tr>
<td>FINAL Approval - UHB Board</td>
<td>April 2</td>
</tr>
<tr>
<td>FINAL BOARD-APPROVED PLAN submitted to Welsh Government</td>
<td>March 31</td>
</tr>
<tr>
<td>FINAL BOARD-RATIFIED PLAN</td>
<td>May 7</td>
</tr>
</tbody>
</table>

10.2 Delivery Model

The University Health Board has a very strong delivery focus; which has developed year on year since the original turnaround programme. The turnaround approach was highly intensive, but principally financially focused, which has limitations in an NHS setting. Over the last two financial years we have developed our governance in relation to delivery and we now have a more blended approach to quality, performance and finance, which retains the intensity, pace and focus of our initial recovery.
Over the last year the University Health Board has also sharpened its focus on a number of key priorities. This means that CTUHB’s significant investment in day to day governance is being properly utilised to gain maximum return for the communities we serve.

This year we are looking to take our approach to delivery a step further by developing:

- More sophisticated benchmarking data;
- Clarity on the further opportunities that each directorate has for improvement;
- Cross cutting activities that can be pursued with executive led projects;
- A matrix/programme management model that tracks directorate and locality performance against their plans, as well as cross cutting activities undertaken by several directorates;
- A reinforced approach to managing these activities with solid governance and performance management; and
- A delivery framework that supports delivery through our directorates and localities, underpinned by specialist advice and a programme infrastructure.

10.2.1. Benchmarking

We will maintain our focus on benchmarking as a business intelligence tool and we intend to:

- Develop clear information on the comparative spend per head of population on the services (commissioned and provided) by the University Health Board and key drivers for that comparative spend in terms of both activity levels (relative access rates) and unit costs (relative productivity).

The comparative cost per head would ideally be based on cost per head of population weighted for age and deprivation. However, there is not currently an agreed basis of defining weighted population for each Health Board in Wales this way and certainly not one that would allow comparisons across the UK. We are therefore comparing our spend per ‘un-weighted’ head of population for each service with those of identified Primary Care Trusts (PCTs) in England with comparable population characteristics – Durham, Middlesborough and Sefton.

The volume and productivity drivers for variations in overall cost are planned to be developed as follows:

- Volume in terms of activity per head of population for each service will be compared with the average for the three PCTs
above. This is currently being undertaken for the University Health Board by CHKS. We have asked for this to be broken down, for example, by specialty, patient type, Healthcare Resource Group (HRG).

- Productivity at an overall specialty/service level will be assessed initially by comparison of Cwm Taf reference costs and unit costs with those of other LHBs. However, we will then go on to consider how to compare reference costs with those in England, including what adjustments are necessary to achieve this.

The aim of this process is to build a picture of the relative spend on each specialty or service and the extent to which variances against comparable organisations are driven by volume as against productivity.

**10.2.2 Opportunities for Improvement**

We will continue to develop an “opportunities register” which will be populated with comparative (performance, quality, workload and cost) statistics covering all of the University Health Board’s clinical and support services. The aim is to use this as a framework for developing benchmarks, savings opportunities and plans at the detailed level; and to build momentum for ongoing improvement in the organisation. This will also support the University Health Board to strengthen its business intelligence.

**10.2.3 Cross Cutting Themes**

Directorate and Locality Plans on their own are likely to achieve less if they are drawn up and delivered without integration with the rest of the organisation and with partners. We are therefore committing ourselves to a further year of cross cutting plans.

There are two particular ways in which cross cutting plans can add value:

- Economies of scale and expertise in looking at difficult problems being faced by some or all directorates and localities (e.g. outpatient productivity improvement).
- Avoidance of ‘silo’ working which is sub-optimal for the organisation as a whole.

We recognise that cross-cutting plans that are not grounded in directorates and localities can be theoretical plans that do not get delivered; either because they are not practical or they are, but directorates and localities have not been adequately engaged to deliver them. However, there is also a major benefit in running cross-cutting programmes as enablers for directorates and localities (and specialties
and teams within directorates) to meet their financial, quality and performance objectives.

Our cross-cutting themes are organised into 5 overall strategic categories of change. The strategic categories and the themes associated with each are set out below:

<table>
<thead>
<tr>
<th>Strategic Category</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Systems Re-design</td>
<td>Emergency care, Frail elderly and rehabilitation care, Planned care, Reconfiguration and rationalisation of services, Estate rationalisation, Prudent medicine</td>
</tr>
<tr>
<td>Commissioning</td>
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<tr>
<td>Efficiency and Productivity</td>
<td>Theatre productivity, Outpatient productivity, Patient care administration, Diagnostics, Medical staff productivity, Nursing productivity, General workforce productivity, Back office</td>
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<tr>
<td>Non-pay Management</td>
<td>Traditional non-pay, Prescribing, CHC</td>
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<tr>
<td>All Wales Measures</td>
<td>Changes to staff terms and conditions</td>
</tr>
</tbody>
</table>

Whilst each directorate, locality and cross-cutting project will have clear plans and outcomes identified, we expect it to take up to three years for these arrangements to mature because there is a need to improve the reliability, completeness and timeliness of patient related information in the Health Board. It will also require the Health Board to strengthen the capacity and capability of its business intelligence function.

**10.2.4 Matrix/Programme Management**

The “matrix” is a programme management approach and is essentially the way in which we create a linkage between the directorates and
localities service change plans and the cross cutting themes; and keep track of quality and finance and performance targets to support delivery.

The form of the matrix is shown immediately below:

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<tr>
<th>Directorates</th>
<th>ACT</th>
<th>Acute Medicine</th>
<th>Surgery</th>
<th>Head &amp; Neck</th>
<th>Obs &amp; Gynae</th>
<th>Paeds</th>
<th>Therapies</th>
<th>Mental health</th>
<th>CAMHS</th>
<th>Locality teams</th>
<th>Primary care (incl prescribing)</th>
<th>Clinical support</th>
<th>Facilities &amp; Estates</th>
<th>Other corporate directorates</th>
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**Key**
- **Directly relevant**
- **Indirectly relevant**
- **Largely irrelevant**

This model is designed to ensure that we utilise a ‘whole system’ approach to the delivery of our three year efficiency and re-design savings plans. It recognises that we will need to phase in programmes of work, as well as targeting work on improvements where there is the biggest opportunity. This includes the importance assessing the impact on quality and patient experience using our Quality Impact Assessment Tool.

As outlined above, this ‘programme planning and delivery approach’ is a key part of our local planning and delivery cycle which will prioritise deliverables and establish a clear delivery framework with performance management arrangements. This has already identified:

- Directorate and Locality ‘just do it’ deliverables;
- Cross-cutting themes that are underpinned by clear programme management and project implementation plans;
• Model of Continuous Improvement e.g. using business intelligence; reflecting benchmarking and work from ‘Newton’;
• Continued process of communication, engagement, consultation and approvals.

10.2.5 Governance for Delivery

The University Health Board has four important set pieces that will ensure the activities outlined above are appropriately managed, these are:

• **Clinical Business Meetings** – where a small core of Executives meet on a monthly business with the clinical and managerial leads of each directorate to provide oversight and performance management of the entire operation;
• **Corporate Business Meetings** – where a small core of Executives meet on a bimonthly basis with the managerial leads for each major corporate function to provide oversight and performance management;
• **Operations Board** – where the Chief Operating Officer oversees his cluster of cross cutting themes and associated activities to achieve medium to long term improvement trajectories;
• **Executive Programme Board** – where all the Executives meet on a monthly basis to give oversight and coordinate all of the performance and improvement activities in the organisation.

Our performance management arrangements outlined in the table below provide further synergy to this delivery model:-

<table>
<thead>
<tr>
<th>Forum</th>
<th>Performance Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Board</td>
<td>- Integrated Performance Dashboard</td>
</tr>
<tr>
<td></td>
<td>- Quality and Finance Reports</td>
</tr>
<tr>
<td></td>
<td>- Annual Service Delivery Reports</td>
</tr>
<tr>
<td></td>
<td>- 3 Yr Plan Progress Report</td>
</tr>
<tr>
<td></td>
<td>- Sub-Committee Reports</td>
</tr>
<tr>
<td></td>
<td>- External Audits and Reviews</td>
</tr>
<tr>
<td>Integrated Governance</td>
<td>- Sub-Committee Reports</td>
</tr>
<tr>
<td>Committee</td>
<td>- External Audits and Reviews</td>
</tr>
<tr>
<td>Board Sub-Committees</td>
<td>- Integrated Performance Dashboard</td>
</tr>
<tr>
<td></td>
<td>- Quality and Finance Reports</td>
</tr>
<tr>
<td></td>
<td>- External and Internal Audits and Reviews</td>
</tr>
<tr>
<td>Executive Board</td>
<td>- Integrated Performance Dashboard</td>
</tr>
<tr>
<td></td>
<td>- Quality and Finance Reports</td>
</tr>
<tr>
<td></td>
<td>- Annual Service Delivery Reports</td>
</tr>
<tr>
<td></td>
<td>- 3 Yr Plan Progress Report</td>
</tr>
<tr>
<td></td>
<td>- Business Case Approval</td>
</tr>
</tbody>
</table>
To further support delivery, we intend to provide the necessary specialist advice and programme infrastructure to directorates and localities; enabling clinical engagement and encouraging clinical leadership is a key tenant of this approach. The principles of this are outlined in more detail in the figure below:

- Prime support to be provided to Directorates and Localities via nominated leads for planning, information, PC&S, workforce and financial support.

- Where additional support or local expertise is required, provide from temporary backfill or redeployment e.g. certain numbers of clinical sessions for specific purpose/project

- Internal support made available from a small programme management office/central delivery support unit (PMO/DSU) providing the opportunity to build up and develop specialist local expertise on improvement and change management

- External support by exception e.g. where specific expertise is required and not available internally or if there are capacity problems.

The following diagram summarises the totality of our delivery model:
Delivery Model

The University Health Board has in place maturing governance and assurance arrangements, which has received support from the Wales Audit Office, following their initial structured assessment process. Indeed these arrangements have been developed and strengthened further during the last year and been further recognised within their 2013 assessment. Our delivery, governance and assurance arrangements are built on an organisational culture that is based on listening and learning which directs its role in determining policy and setting strategic direction and also ensures that there are effective internal control mechanisms for the University Health Board that demonstrate high standards of governance and behaviour. This is of course, set against a back drop of the University Health Board ensuring that it remains responsive to the needs of its communities.

The system of internal control is informed by the work of Internal Auditors and the Directors within the organisation who have responsibility for the development and maintenance of risk assurance and internal control frameworks comments on this are made by External Auditors in their Annual Audit Report and other reports. In addition the work of Healthcare Inspectorate Wales in both their planned and unplanned work and other regulators is utilised.

10.3 Corporate Governance
To ensure appropriate assurance arrangements are in place the Board is supported by a number of sub committees, namely, the Integrated Governance Committee; the Audit Committee; the Quality and Safety Committee; the Corporate Risk Committee; Remuneration and Terms of Service Committee; Mental Health Act Monitoring Committee and the Finance & Performance Committee. These key Committees of the Board scrutinise Executive Director delivery of the Board’s strategic priorities and will closely monitor and scrutinise the delivery of the integrated 3 year plan, along with the Board who are actively engaged in its ongoing development.

Patients and the public have an important role to play in proactively participating in their care and it is important that the organisation addresses this requirement in its governance arrangements. The University Heath Board has recognised that work is needed to introduce a more co-ordinated approach to ensure the patient voice is proactively informing service delivery and more importantly to ensure that information captured is readily available for reporting to Board on ‘lessons learned’ and implementing changes to working practices.

A new Quality Delivery Strategy (aligned with the Board’s ‘Cwm Taf Cares’ philosophy) has been developed and will be in place from 2014, which clearly articulates the key actions that will ensure this happens in a more coordinated and structured way. Indeed Wales Audit Office recognised the strength of the Board’s patient, public and engagement work in its recent structured assessment process.

This work will be further informed by the important lessons that the Board has learnt from Francis and the joint review that was undertaken by Healthcare Inspectorate Wales and the Wales Audit Office into the governance arrangements at Betsi Cadwaladr University Health Board (BCUHB). The joint report issued in June 2013, made many recommendations for the BCUHB and the wider NHS with regards to governance arrangements, including a recommendation that the wider NHS in Wales “should reflect and learn from the issues raised in the report”. The report had recommendations for individual Health Boards and NHS Wales. It is acknowledged that many of the issues could occur in the University Health Board.

During 2013/14 we have made good progress in completing a review of our clinical governance arrangements and making changes to those arrangements which have been captured within our new Strategy for Quality. This not only articulates the important lessons learnt from Francis and Keogh along with other relevant Inquiries, but importantly important messages from listening to our patients.
To facilitate this we have had our own HIW review into governance arrangements published in spring 2012 and developed a comprehensive action plan in response. During this year we have also reviewed the significant progress we have made against the agreed actions and ensured the few outstanding actions were captured in our action plan in response to the main recommendations from the BCUHB review. The University Health Board’s Integrated Governance Committee has reviewed and endorsed the revised action plan and routinely monitors related progress.

Over the last 2 and a half years there has been a significant amount of work undertaken to strengthen the governance and accountability arrangements supporting the delivery of the quality, performance and financial targets within the organisation and this progress has also been recognised by Wales Audit Office within its 2012 and 2013 Structured assessments. The organisation through its established clinical business meeting model has strengthened its arrangements for reviewing delivery and holding directorates to account to reflect the move to integrated planning and delivery.

The Wales Audit Office Structured Assessment 2012 concluded that the University Health Board had substantially strengthened its governance arrangements by clarifying and maturing the roles of the Board’s sub committees. The governance and internal control environment has been substantially changed and is maturing to support more effective Board assurance. This coupled with significant development of management information has assisted greatly. Encouragingly progress has been maintained and developed further during 2013.

As outlined above we are also developing the current arrangements for reviewing delivery and holding directorates to account to reflect the move to integrated planning and delivery.

The significant progress made on the University Health Board’s governance and assurance mechanisms as reflected in the 2012 and 2013 Wales Audit Office Structures Assessment reports will continue to be built on as we move forward on our journey of improvement from being an organisation that has matured its governance and assurance arrangements from ‘developing’ to consistently ‘practicing’.

The University Health Board’s governance and assurance arrangements also have a strong focus on performance and delivery. Whilst challenges remain going forward, good progress is being made in this area of our work and notable improvements in performance have featured during 2013/14. Robust scrutiny through the Board’s Finance & Performance Committee will remain the focus going forward.
The University Health Board will ultimately approve and oversee implementation and delivery of the 3 year plan. Central to implementation and delivery of Cwm Taf’s plan, is robust local scrutiny and assurance arrangements endorsed by the University Health Board that provide assurance in relation to contractor services, directly provided services and commissioned services.

In support of this, the Board will rely on its existing Governance and Assurance arrangements with Executive Board; Executive Programme Board and Clinical Business meetings being utilised to monitor operational delivery of key elements of the plan.

The key sub-committees of the Board involved in monitoring and scrutinising delivery of the plan will include, but not be limited to; the Finance & Performance Committee and the Quality and Safety Committee, but with regular updates provided to the Board on progress.

**Cwm Taf’s Integrated Assurance & Monitoring System**

Other Board Sub Committees also scrutinise delivery as appropriate.
10.4 Principal Risks to Delivery & Mitigating Actions

The University Health Board has an approved strategy for risk management and a related action plan that clearly outlines the organisation’s risk appetite and process for ensuring the Board’s plans are built on a foundation of risk assessment that informs mitigating actions. To support this, the University Health Board has an organisational Risk Register, which is published quarterly and considered by the Integrated Governance Committee, the Audit Committee and the Corporate Risk Committee. Further supported with the direction of the Executive, it ensures key risks aligned to delivery are considered and scrutinised by the relevant Sub-Committee of the Board. E.g. statutory and Tier 1 finance and performance targets are scrutinised routinely at the Finance & Performance Committee.

The University Health Board approach to risk management ensures that risks are identified, assessed and prioritised, ensuring appropriate mitigating actions are taken. Progress against these actions is reported to the appropriate business meetings in place across the organisation and as outlined above organisational risks are considered at Executive Board and scrutinised by the appropriate Sub-Committee of the Board.

Arrangements at a Directorate level have been strengthened to ensure that health and safety issues are properly considered and managed in line with the Board’s Strategy and related policy. Regular audits are undertaken on prioritised areas and this information is then used to ensure necessary improvements are introduced and implemented. A training programme is in place and related resource issues are being addressed to ensure improved compliance and uptake of training.

Staff awareness of the need to manage risks is encouraged through regular communication and the incident reporting system and the ‘datix’ risk module is being rolled out across the University Health Board to better capture assessed risks and the actions being taken to mitigate them.

Case studies and patient stories are presented to the Board’s Sub-Committees and scrutiny panels, in order that lessons can be disseminated and shared. The Wales Audit Office has recognised as part of its 2012 and 2013 structured assessment that the organisation has a positive open and listening culture focused on learning and improvement.

The organisation’s commitment to risk management, a bedrock of its governance and assurance processes, means that work will continue to ensure that:
• Risks related to the delivery of the organisations plans will be subject to regular assessment, review and scrutiny via the appropriate sub-committee of the Board.
• There is compliance with legislative requirements where non compliance would pose a serious risk.
• Evidence based guidance and best practice is utilised in order to support the highest standard of clinical practice.
• All sources and consequences of risk are identified and these risks are assessed and either eliminated or minimised.
• Information concerning organisational risk is shared with staff across the University Health Board and where appropriate partner organisations.
• Damage and injuries are minimised and people’s health and well being is optimised.
• Resources diverted away from patient care to fund risk reduction are minimised.
• Lessons are learnt from a variety of Board processes including; compliments, incidents and claims in order to share best practice and reduce the likelihood of recurrence.

The University Health Board manages risk through its Directorate structures. Annex A6 sets out a summary of key risks together with mitigating actions that will be monitored routinely through Board processes that are considered to impact on some elements of the Plan. Going forward, the organisational risk register is being reviewed and where appropriate updated on a bi-monthly basis by the Executive Board.

Further work is currently being undertaken to review and strengthen the Board’s governance arrangements and the processes and the structure of the Risk Register will be improved and aligned with the Board Assurance Framework, which is being developed by the Board Secretary/Director of Corporate Services.
SUMMARY OF PROGRESS MADE ACROSS THE UNIVERSITY HEALTH BOARD
2013/2014 TO DATE

Protecting and Improving our Public’s Health

- Reducing Smoking in Cwm Taf
  - Smoking rates decreased from 31% to 24% over three years in Merthyr Tydfil and in Rhondda Cynon Taf by 2%.
  - Increased the number of community pharmacists that offer specialist support for those wishing to quit smoking.
  - Developed ‘Smoke Free Homes pilot’ in partnership with Communities First and Registered Social Landlords.
  - Undertook research on smoking cessation support for pregnant women during pregnancy in collaboration with Public Health, Maternity Services and academic colleagues.

- Immunisation in Cwm Taf
  - Primary Childhood immunisation rates at overall the best in Wales with an uptake of 97.1%
  - Introduction of a pertussis vaccination to pregnant women
  - Ongoing programme of staff vaccinations for seasonal flu for frontline staff with improving update rates.

- Teenage pregnancy rates decreased to 44 per 1000 in Merthyr Tydfil.

- Training of Prescribing Advisors underway so prevention messages are embedded in their work.

- Speech & Language Therapy now key elements in the Flying Start Programmes in RCT and Merthyr Tydfil Local Authorities.

Patient Experience, Safety and Quality

- Development of patients stories through the Stories for Improvement Programme have driving service change and improvements, examples of this are:
  - ‘Transition’ planning into adult services for children with special needs.
  - Introduction of ‘This is Me’ booklet across wards for people with dementia
  - Development of the pathway for children with Autism.

- Improvements to environment to improve the patient experience, examples of this include,
  - Medical Admissions Unit - provision of televisions in each bay and cubicles providing entertainment for patients
awaiting transfer.
  
  - Introduction of ward ‘trolley’ service and small retail outlet in Ysbyty Cwm Cynon & Ysbyty George Thomas.

- Twice yearly memorial services in Prince Charles and Royal Glamorgan Hospital to support bereaved relatives.

- Resource Book developed by the Chaplaincy service to help people with dementia to trigger memories.

- National targets for the reduction of clostridium difficile infection were surpassed in 2011/2012 & we have achieved the lowest rate in Wales in 2011/2012 at a rate of 2.77/1000.

- Ongoing strengthening of our quality systems and processes which embed our ‘Cwm Taf Cares’ systems.

- MRSA bacteraemia was reduced by a further 20% in 2011/2012.

- Significant improvement in Tier 1 targets including admission on day of surgery and average length of stay.

- Planned & delivered the ‘23:59’ service.

- Significantly reducing cancellations due to lack of bed availability.

- Cancer: achieving NUSC target generally throughout the year and making improvements in USC.

- Solid progress to ‘pull’ services across from hospital bases into being locality based with a start to the process of rebalancing services. For example, some surgical services, ENT services and outpatient.

- Reduced demand in Orthopaedics by 50% through the provision of alternative pathways for patient with joint pain, improving Musculo-skeletal triage, extending the role and scope of a number of therapy practitioners.

- Achieved the highest overall score in Wales for the structure of its stroke service in the Sentinel Stroke National Audit Programme.

- Further refurbishment work undertaken, including on Seren Ward in the Royal Glamorgan Hospital.

- Engagement and consultation on the South Wales Programme completed with local communities and partners.

- Opened Hirwaun Medical Centre.

- Remodelled Ashgrove Surgery in Pontypridd.
# Access to Patient Centred Services

- **General Practice**
  - Cwm Taf practices made the most significant improvements to GP access compared to the rest of Wales
  - Implementing an electronic GP Referral System

- Established a local Chronic Pain Service meaning that people living in Merthyr Tydfil and the Cynon Valley no longer have to travel to Cardiff to access the Chronic Pain Service.

- Developing our @Home Services to support people to maintain their health and wellbeing in the community instead of hospital
  - Successfully developing the Community Integrated Assessment Service (CIAS) launched in 2012.
  - Extended access to Reablement services and enhanced service embedded to facilitate an earlier discharge for people with mild to moderate cognitive impairment.
  - Development of ‘Community Wards’
  - Development of Community IV Service

- Following patient engagement session the Head and Neck cancer SLT and CNS set up Patient support group and established website: [www.cwmtafuhb.wales.nhs.uk/hugs-support-group](http://www.cwmtafuhb.wales.nhs.uk/hugs-support-group)

- Phone First for the Minor Injuries Service at Ysbyty Cwm Rhondda implemented as part of the sustainable model for our Minor Injuries Units in Cwm Taf.

- Ophthalmic Diagnostic & Treatment Centre established in Ysbyty Cwm Rhondda.

- Primary Care Dental Extraction Service was established in the Dental Teaching Unit.

- Working with the Welsh Ambulance Services NHS Trust (WAST) to introduce a range of positive improvements across the scheduled care system, including:
  - Three new pathways to enable to avoid admission to hospital and remain in their own homes
  - Use of Community First Responders
  - Team based worked and a new management structure

- Development of a clinically led Palliative and End of Life Care Strategy focused on the development of a locality wide model which addresses both the estates provision and improving the quality and co-ordination of palliative care services in Cwm Taf.
Mental Health
  o Development of a mental health service in GP practices across Cwm Taf.
  o Enhanced Transport System for access to Mental Health Services.

Cancer Services – we have continued to develop our local Cancer Delivery Plan and our achievements include:
  o A number of successful bids with Macmillan.
  o Establishment of a Community Cancer Awareness Network.
  o Establishment of Nurse Led Prostate Specific Antigen (PSA) clinics across Cwm Taf.
  o Embedding the concept of the key worker within Cwm Taf
  o Colorectal Multi Disciplinary Team at Prince Charles Hospital awarded speciality status by the Association of Coloproctology of Great Britain and Ireland.

Working Differently, Working Together

Achieving University Health Board status and the development of Kier Hardie Health Park as a centre for research activity.

Implementation of the Calderdale competencies for unregistered staff across Health and Social Care, developing necessary skills within the workforce to support a cultural change from ‘caring for’ to enabling.

The ‘Resolve’ Mediation Service was shortlisted in the Award for Innovation in Dispute Resolution category of the Personal Today awards.

Development of a range of local conditions and service delivery plans in response to the national ‘Together for Health’ Delivery Plans.

Working Differently, Working Together

Stable and reliable forecasting

Turnaround processes and structures have been mainstreamed

A range of improvements to IM&T infrastructure, systems and processes.
Cwm Taf UHB at a Glance

### EXPERIENCE AND ACCESS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current Month Data</th>
<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Seen in 4 hours</td>
<td>February</td>
<td>95%</td>
<td>85.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>A&amp;E seen in 12 hours</td>
<td>February</td>
<td>100%</td>
<td>98.6%</td>
<td>98.8%</td>
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<td>Ambulance Call in 8 mins</td>
<td>February</td>
<td>65%</td>
<td>42.9%</td>
<td>53.3%</td>
</tr>
<tr>
<td>A&amp;E Handover within 15 mins</td>
<td>February</td>
<td>95%</td>
<td>85.3%</td>
<td>81.6%</td>
</tr>
<tr>
<td>A&amp;E Handover within 60 mins</td>
<td>February</td>
<td>95%</td>
<td>98.0%</td>
<td>98.8%</td>
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<tr>
<td>RITT No Patient &gt; 36 Weeks</td>
<td>February</td>
<td>zero</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>RITT ≤ 26 Weeks - Total</td>
<td>February</td>
<td>95%</td>
<td>89.5%</td>
<td>N/A</td>
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### Cancer Target

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<thead>
<tr>
<th>Standard</th>
<th>Current Month Data</th>
<th>Month Actual</th>
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<th>Forecast next month</th>
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</thead>
<tbody>
<tr>
<td>USC Treated ≤ 62 days</td>
<td>January</td>
<td>95%</td>
<td>95%</td>
<td>84.5%</td>
</tr>
<tr>
<td>NSC Treated ≤ 31 days</td>
<td>January</td>
<td>95%</td>
<td>99.1%</td>
<td>98.4%</td>
</tr>
<tr>
<td>USC Treated ≤ 31 days</td>
<td>January</td>
<td>95%</td>
<td>99.1%</td>
<td>98.4%</td>
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</table>

### MDOF

<table>
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<tr>
<th>Standard</th>
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<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractured Neck of Femur (MDOF) - 2 hr</td>
<td>January</td>
<td>improvement</td>
<td>50%</td>
<td>18%</td>
</tr>
<tr>
<td>Fractured Neck of Femur (MDOF) - 24 hr</td>
<td>January</td>
<td>57%</td>
<td>57%</td>
<td>62%</td>
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</table>

### Efficiency & Utilisation

<table>
<thead>
<tr>
<th>Standard</th>
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<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
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<tbody>
<tr>
<td>Theatre Productivity:</td>
<td>February</td>
<td>6879</td>
<td>6879</td>
<td>6879</td>
</tr>
<tr>
<td>Theatre Efficiency - hospital cancellations</td>
<td>February</td>
<td>16%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Outpatients DNA Rates - New</td>
<td>February</td>
<td>5%</td>
<td>7.9%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Outpatients DNA Rates - FJP</td>
<td>February</td>
<td>10%</td>
<td>9.3%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Outpatient Clinic Cancellations ≤ 6 Weeks</td>
<td>January</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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<tr>
<td>Emergency Ave LOS - Acute Medicine</td>
<td>February</td>
<td>6.3</td>
<td>6.3</td>
<td>6.3</td>
</tr>
<tr>
<td>Emergency Ave LOS - Orthopaedics</td>
<td>October</td>
<td>7.9</td>
<td>7.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Emergency Ave LOS - General Surgery</td>
<td>February</td>
<td>5.1</td>
<td>5.1</td>
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</tr>
<tr>
<td>Admission on Day of Surgery - General Surgery</td>
<td>November</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Admission on Day of Surgery - Urology</td>
<td>November</td>
<td>75%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Admission on Day of Surgery - Orthopaedics</td>
<td>November</td>
<td>12%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Admission on Day of Surgery - ENT</td>
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<td>81%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Admission on Day of Surgery - Gynaecology</td>
<td>November</td>
<td>79%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Admission on Day of Surgery - Ophthalmology</td>
<td>November</td>
<td>45%</td>
<td>56%</td>
<td>55%</td>
</tr>
<tr>
<td>Elective Ave LOS - General Surgery</td>
<td>March</td>
<td>3.3</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Elective Ave LOS - Orthopaedics</td>
<td>March</td>
<td>3.6</td>
<td>4.4</td>
<td>4.1</td>
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### Need & Prevention

<table>
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<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation Uptake Rates (Quarterly)</td>
<td>Qtr 3</td>
<td>95%</td>
<td>89.9%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Smoking Cessation (Quarterly)</td>
<td>Qtr 3</td>
<td>5%</td>
<td>3.17%</td>
<td>3.17%</td>
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### QUALITY AND SAFETY

#### Patient Safety

<table>
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<tr>
<th>Standard</th>
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<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAW - C. Diff in IP &gt; 65 years</td>
<td>February</td>
<td>0%</td>
<td>-5%</td>
<td>R</td>
</tr>
<tr>
<td>HAW - MMSA</td>
<td>February</td>
<td>0%</td>
<td>-58%</td>
<td>G</td>
</tr>
<tr>
<td>HAW - MSSA</td>
<td>February</td>
<td>0%</td>
<td>8%</td>
<td>G</td>
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### Finance

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current Month Data</th>
<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>I&amp;E surplus (actual versus plan)</td>
<td>February</td>
<td>&lt; 1%</td>
<td>over plan</td>
<td>February</td>
</tr>
<tr>
<td>Pay expenditure (actual versus plan)</td>
<td>February</td>
<td>&lt; 0.5%</td>
<td>over plan</td>
<td>February</td>
</tr>
<tr>
<td>Non-pay expenditure (actual versus plan)</td>
<td>February</td>
<td>&lt; 1%</td>
<td>over plan</td>
<td>February</td>
</tr>
<tr>
<td>Efficiency savings (actual versus plan)</td>
<td>February</td>
<td>&lt; 5%</td>
<td>over plan</td>
<td>February</td>
</tr>
<tr>
<td>Capital expenditure (actual versus plan)</td>
<td>February</td>
<td>&lt; 5%</td>
<td>of plan</td>
<td>February</td>
</tr>
<tr>
<td>Invoices paid within 30 days</td>
<td>February</td>
<td>95%</td>
<td>of total</td>
<td>February</td>
</tr>
</tbody>
</table>

### Workforce - Sickness Absence Rates

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current Month Data</th>
<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>December</td>
<td>5.20%</td>
<td>December</td>
<td>5.50%</td>
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</tbody>
</table>

### Use of Resource

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current Month Data</th>
<th>Month Actual</th>
<th>YTD (April to March)</th>
<th>Forecast next month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDR Compliance</td>
<td>January</td>
<td>100%</td>
<td>January</td>
<td>75.9%</td>
</tr>
<tr>
<td>Consultant Appraisal</td>
<td>January</td>
<td>100%</td>
<td>January</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Key:

- R: Red
- G: Green

### Update on Data Quality

- New Data Quality
- Under Development

### TBC

- To Be Completed

---

**Annex A2**

**256 | Page**
## OUR SERVICE DELIVERY PLANS INCLUDE:

<table>
<thead>
<tr>
<th>Product</th>
<th>Prescribed Format/Template issued</th>
<th>Final Published Date</th>
<th>Local Delivery Plan</th>
<th>Exec Lead</th>
<th>Current Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Together for Health - Cancer Delivery Plan</td>
<td>Published</td>
<td>October 2012</td>
<td>Cwm Taf Cancer Delivery Plan</td>
<td>MD</td>
<td>Local Plan developed &amp; approved by Board and is available on our Website. Annual Report produced &amp; signed off at Board level November 2013 and is available on our Website. Updated Local Delivery Plan required by 30th April 2014</td>
</tr>
<tr>
<td>Together for Health – a Heart Disease Delivery Plan</td>
<td>Published</td>
<td>May 2013</td>
<td>Cwm Taf Maternity Services Delivery Plan</td>
<td>DoPP</td>
<td>Local Delivery Plan Currently under development.</td>
</tr>
<tr>
<td>A Strategic Vision for Maternity Services in Wales</td>
<td>Published</td>
<td>February 2013</td>
<td>Cwm Taf Maternity Services Delivery Plan</td>
<td>DoN</td>
<td>Draft plan submitted to Welsh Government via Executive Nurse Director Maternity Dashboard developed.</td>
</tr>
<tr>
<td>Together for Health – Delivering End of Life Care</td>
<td>Published</td>
<td>April 2013</td>
<td>Local Delivery Plan</td>
<td>DPCMH</td>
<td>Local Delivery Plan developed and approved by Board Nov 2013 and is available on our Website. Updated Delivery Plan to be submitted to WG by end of March 2014.</td>
</tr>
<tr>
<td>Together for Health - Stroke Delivery Plan: Our Vision</td>
<td>Published</td>
<td>December 2012</td>
<td>Local Delivery Plan</td>
<td>DoPP</td>
<td>Local Delivery Plan developed and approved by Board in July 2013 and is available on our Website. Updated Delivery Plan to be submitted to WG by 30 April 2014.</td>
</tr>
<tr>
<td>Together for Mental Health Delivery Plan</td>
<td>Published</td>
<td>February 2013</td>
<td>Local Delivery Plan</td>
<td>DPCMH</td>
<td>Local Delivery Plan produced</td>
</tr>
<tr>
<td>Together for Health – A Diabetes Delivery Plan</td>
<td>Final document published September 2013</td>
<td>March 2013</td>
<td>Diabetes Delivery Plan</td>
<td>DPH</td>
<td>The UHB has prepared a local Diabetes Delivery plan which sets out its plans for delivering diabetes services within Cwm Taf. This was signed off by Exec Board in December and submitted to Welsh Government thereafter.</td>
</tr>
<tr>
<td>Delivering Local Health Care – Accelerating the Pace of Change</td>
<td>Published</td>
<td>June 2013</td>
<td>Delivering Local Healthcare Action Plan</td>
<td>DPCMH</td>
<td>Action Plan agreed which outlines the UHB &amp; its Partners initial response to the key actions. Given the close links to the Integrating Health and Social Care for Complex Older People document the Health Board and its Local Authority partners are preparing a joint delivery plan for both documents.</td>
</tr>
<tr>
<td>Eye Health Care Plan for Wales</td>
<td>Final Guidance</td>
<td>September 2013</td>
<td>Delivery Plan for the Critically Ill</td>
<td>COO</td>
<td>UHB Delivery Plan developed for Executive Board approval 23rd October and submission to Welsh Government at the end of October 2013. Plan approved by Board and is available on our Website.</td>
</tr>
<tr>
<td>Together for Health: Delivery Plan for the Critically Ill</td>
<td>Final</td>
<td></td>
<td>Delivery Plan for the Critically Ill</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td>Together for Health: Respiratory</td>
<td>Consultation open to January 2014</td>
<td></td>
<td></td>
<td></td>
<td>Consultation response will be prepared and submitted to Welsh Government by 9 January 2014.</td>
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<tr>
<td>Product</td>
<td>Prescribed Format/Template issued</td>
<td>Final Published Date</td>
<td>Local Delivery Plan</td>
<td>Exec Lead</td>
<td>Current Progress</td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Delivery Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unscheduled Care Delivery Plan</td>
<td>Various guidance issued</td>
<td>Togethers for Health – Urgent and Emergency Care</td>
<td>Developing Sustainable Unscheduled Care services: Delivery Plan</td>
<td>COO</td>
<td>UHB Plan developed and submitted to Welsh Government.</td>
</tr>
<tr>
<td>Scheduled Care Delivery Plan</td>
<td>Various guidance issued</td>
<td></td>
<td>Scheduled Care Delivery Plan</td>
<td>COO</td>
<td>UHB Plan developed and developed and submitted to Welsh Government.</td>
</tr>
<tr>
<td>Our Healthy Future</td>
<td><a href="http://wales.gov.uk/docs/phhs/publications/100521healthfutureen.pdf">http://wales.gov.uk/docs/phhs/publications/100521healthfutureen.pdf</a></td>
<td></td>
<td>DPH</td>
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<tr>
<td>Fairer Outcomes for All</td>
<td><a href="http://wales.gov.uk/docs/phhs/publications/110329workingtogetheren.pdf">http://wales.gov.uk/docs/phhs/publications/110329workingtogetheren.pdf</a></td>
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<td>DPH</td>
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<td>Creating an Active Wales</td>
<td><a href="http://www.wales.nhs.uk/documents/100121activewalesen.pdf">http://www.wales.nhs.uk/documents/100121activewalesen.pdf</a></td>
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<td>All Wales Obesity Pathway</td>
<td><a href="http://wales.gov.uk/topics/health/improvement/index/pathway/?lang=en">http://wales.gov.uk/topics/health/improvement/index/pathway/?lang=en</a></td>
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<td>DPH</td>
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<td>Rural Health Plan</td>
<td><a href="http://wales.gov.uk/docs/dhss/publications/100218ruralhealthplanen.pdf">http://wales.gov.uk/docs/dhss/publications/100218ruralhealthplanen.pdf</a></td>
<td></td>
<td>DPH</td>
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</tbody>
</table>
Annex A4
Royal Glamorgan Hospital – Bed Supply and Demand Modelling
Bed Supply (as of 24/01/2014)
Grouped
Specialty
Anaesthetics
Anaesthetics
Medicine
Cardiology
Medicine
Care of the Elderly
Surgical
ENT Surgery
Medicine
Gastroenterology
Medicine
General Medicine
Surgical
General Surgery
Surgical
Gynaecology
Medicine
Haem (Clinical)
Paediatrics
Midwife Episode
Obstetrics (I/P)
Obstetrics (I/P)
Surgical
Ophthalmology
Orthopaedics
Orthopaedics
Paediatrics
Paediatrics
Medicine
Respiratory Medicine
Medicine
Rheumatology
Surgical
Urology
Total

Current Bed
Configuration
Contingency
Anaesthetics
Medicine
Surgical
Obstetrics (I/P)
Orthopaedics
Paediatrics
Total
Total minus Obs &
Paeds & ITU/HDU

Demand
Admissions
0.00

New Adm
0

LOS
0.00

402.67

403

3.93

3.93

10578.23
3172.67
868.00
113.33
2338.67
934.67
80.67
1425.00
4258.67

10578
3173
868
113
2339
935
81
1425
4259

4.60
4.98
1.26
9.64
1.33
1.73
4.66
6.07
1.32

347.67
24520

348
24520

Any
Total demand adjustment
from
for
modelling
seasonality/
peaks

10
172
132
28
50
44
436

0
161
89
5
37
28
322

364

288

0

RGH HDU
4

RGH ICU
6

New LOS Req'd Beds
0.00
0.00

Total
Beds
0.42

New Beds
0.42

85.00%

8.86

8.86

0.15
8.09
0.19

85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%

85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%
85.00%

157.52
61.52
7.02
3.52
9.99
5.22
1.39
37.37
18.29

157.52
61.52
7.02
3.52
9.99
5.22
1.39
37.37
18.29

2.49

85.00%

85.00%

10.56

10.56

New Beds
0.00

Admissions
134

DC %
70.78%

Inpatient
39

New IP
39

LOS
3.30

New LOS
3.30

Beds
0.35

4.34

4.34

1123

47.98%

584

584

2.00

2.00

3.20

3.20

85.00%

4.60
4.98
1.26
9.64
1.33
1.73
4.66
6.07
1.32

133.36
43.26
2.99
2.99
8.49
4.44
1.03
23.68
15.35

133.36
43.26
2.99
2.99
8.49
4.44
1.03
23.68
15.35

2938
3235
1694

97.85%
60.65%
75.43%

63
1273
416

63
1273
416

3.09
2.59
2.61

3.09
2.59
2.61

0.54
9.04
2.97

2003
2037
171

97.31%
56.14%
75.64%

54
893
42

54
893
42

1.03
3.30
1.67

1.03
3.30
1.67

0.54
9.04
2.97
0.00
0.00
0.00
0.15
8.09
0.19

6.81

6.81

6.49
246

6.49
246

2608

82.01%

469

469

1.94

1.94

2.49

Total
demand

Surplus or
(shortfall)

New Bed
Configuration

Total
demand

Surplus or
(shortfall)

0
161
89
5
37
28
322

10
11
43
23
13
16
114

0
10
196
108
28
50
44
436

30
0
189
89
5
37
28
350

-30
10
7
19
23
13
16
56

288

66

364

316

8

RGH
Labour
Ward

RGH
Neonatal
HDU

Any
Total
adjustment
demand
for
Contingency
from
seasonality
modelling
/peaks
30
0
161
28
89
5
37
28
322
28
30
288

28

30

New Beds Occupancy New Occ
0.35
85.00%
85.00%

Currently Available Bed Configuration

RGH CCU
Anaesthetics
General Medicine
Surgical
Obstetrics (I/P)
Orthopaedics
Paediatrics

RGH
Neonatal
ICU

RGH SCBU

RGH Ward RGH Ward
RGH Ward RGH Ward RGH Ward
1
2
RGH Ward 3
4
5
6
RGH Ward 7
8
10
11
12
14
15
17
18
19
20

Total
Total minus Obs, Paeds

Total
10
172
132
28
50
44
436
364

RGH Ward RGH Ward
RGH Ward RGH Ward RGH Ward
1
2
RGH Ward 3
4
5
6
RGH Ward 7
8
10
11
12
14
15
17
18
19
20
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
24
0
0
0
0
25
0
0
0
0
28
28
28
0
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28
28
4
28
0
28
21
0
0
27
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0
0
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0
0
0
0
0
0
0
0
0
23
0
0
0
0
0
0
0
0
0
0
28
0
0
0
22
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
0
19
7
0
0
Total
Total minus Obs, Paeds

Total
10
196
108
28
50
44
436
364

7

25
28

28

28

28

21

23
6

6

6

28

28

28

27

5
28

28

0

22
19

7

Revised Bed Configuration

Anaesthetics
Medicine
Surgical
Obstetrics (I/P)
Orthopaedics
Paediatrics

RGH CCU
0
7
0
0
0
0

RGH HDU
4
0
0
0
0
0

RGH ICU
6
0
0
0
0
0

RGH
Labour
Ward
0
0
0
5
0
0

RGH
Neonatal
HDU
0
0
0
0
0
6

RGH
Neonatal
ICU
0
0
0
0
0
6

RGH SCBU
0
0
0
0
0
6

259 | P a g e


### Prince Charles Hospital – Bed Supply and Demand Modelling

**Bed Supply (as of 24/01/2014)**

<table>
<thead>
<tr>
<th>Grouped Specialty</th>
<th>Demand</th>
<th>Bed</th>
<th>New Beds</th>
<th>Admissions</th>
<th>DC %</th>
<th>Treatment</th>
<th>New IP</th>
<th>LOS</th>
<th>New LOS</th>
<th>Beds</th>
<th>New Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicine</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>28</td>
<td>26</td>
<td>24</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Surgical</td>
<td>38</td>
<td>5</td>
<td>36</td>
<td>160</td>
<td>100</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Obstetrics (SP)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Orthopaedics</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>30</td>
<td>20</td>
<td>20</td>
<td>80</td>
<td>100</td>
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<td>100</td>
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<td>100</td>
<td>100</td>
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<td>40</td>
<td>160</td>
<td>100</td>
<td>0</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Surgical</td>
<td>48</td>
<td>40</td>
<td>40</td>
<td>160</td>
<td>100</td>
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<td>100</td>
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</tbody>
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### Currently Available Bed Configuration

<table>
<thead>
<tr>
<th>PCH CDU</th>
<th>PCH CDU</th>
<th>PCH ITU</th>
<th>PCH Midwifery led Unit (Ward 21)</th>
<th>PCH Midwifery led Unit (Ward 31)</th>
<th>PCH Midwifery led Unit (Ward 32)</th>
<th>PCH Ward 1</th>
<th>PCH Ward 3</th>
<th>PCH Ward 5</th>
<th>PCH Ward 7</th>
<th>PCH Ward 9</th>
<th>PCH Ward 11</th>
<th>PCH Ward 13</th>
<th>PCH Ward 15</th>
<th>PCH Ward 17</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Obstetrics (SP)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>Orthopaedics</td>
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</tr>
<tr>
<td>Paediatrics</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

### Revised Bed Configuration

<table>
<thead>
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<th>PCH CDU</th>
<th>PCH ITU</th>
<th>PCH Midwifery led Unit (Ward 21)</th>
<th>PCH Midwifery led Unit (Ward 31)</th>
<th>PCH Midwifery led Unit (Ward 32)</th>
<th>PCH Ward 1</th>
<th>PCH Ward 3</th>
<th>PCH Ward 5</th>
<th>PCH Ward 7</th>
<th>PCH Ward 9</th>
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### Summary

- Total minus Obs, Paeds and MH: 162
- Total minus Obs, Paeds and MH: 162
### Royal Glamorgan Hospital - 2014/15 Bed Modelling

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Desired Occ % 85%

Total

Non Elective

Elective

Original Model

Revised Model

2014/15
### Prince Charles Hospital - 2014/15 Bed Modelling

#### Original Model

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### Elective Activity Plan 2014/15 - Royal Glamorgan

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<th>Projected 31/3/15 &gt; 36 week waiting list</th>
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## Elective Activity Plan 2014/15 - Prince Charles Hospital

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### Projected Changes in 2014/15

- **Implementation of Thresholds for BMI and Smoking**
- **Repatriation or Loss of Flows to other LHBs**
- **INNUs**
- **Primary Care Demand Mgmt**
- **Non-recurring waiting list reduction (includes growth at stages 1-3)**
## Non-Elective Activity Plan 2014/15 - Royal Glamorgan

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<th>Specialty</th>
<th>2011/12 outturn</th>
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## Non-Elective Activity Plan - Prince Charles Hospital

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### Elective Length of Stay Plans 2014/15 - Royal Glamorgan

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### Daycase rates

| Specialty     | CHKS benchmark - mean LOS | CHKS benchmark - UQ LOS | 2011/12 daycase rate | 2012/13 daycase rate | 2013/14 projected daycase rate | Projected changes in 2014/15 | Projected 2014/15 daycase rate | Projected Change (%) |
|---------------|---------------------------|-------------------------|----------------------|----------------------|**********************************|-------------------------------|-------------------------------|----------------------|
|               | Application of new daycase policy |                      |                      |                      | Total |                      |                      |                        |                      |
| Anaesthetics  | 88%                       | 89%                     | 71%                  | 0%                   | 71%   | 0%                    | 71%                   | 0%                    |
| Cardiology    | 75.70%                    | 89.90%                  | 99%                  | 98%                  | 97%   | 97%                   | 97%                   | 97%                   |
| ENT Surgery   | 61.60%                    | 72.60%                  | 41%                  | 44%                  | 43%   | 5%                    | 5%                    | 48%                   |
| General Medicine | 74.70%               | 93.10%                  | 94%                  | 95%                  | 98%   | 0%                    | 98%                   | 0%                    |
| General Surgery | 67.20%                 | 76.10%                  | 54%                  | 58%                  | 58%   | 3%                    | 3%                    | 61%                   |
| Gynaecology   | 66.70%                    | 73.70%                  | 74%                  | 75%                  | 70%   | 5%                    | 5%                    | 75%                   |
| Ophthalmology | 96.10%                    | 99.20%                  | 97%                  | 97%                  | 97%   | 0%                    | 97%                   | 0%                    |
| Orthopaedics  | 55.10%                    | 60%                     | 50%                  | 55%                  | 51%   | 5%                    | 5%                    | 56%                   |
| Paediatrics   | 64.70%                    | 85%                     | 60%                  | 74%                  | 76%   | 0%                    | 76%                   | 0%                    |
| Urology       | 76.20%                    | 82.50%                  | 81%                  | 78%                  | 80%   | 2%                    | 2%                    | 82%                   | 2%                    |
### Elective Length of Stay Plan 2014/15 - Prince Charles Hospital

#### Elective length of stay

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### Non-Elective Length of Stay Plan 2014/15 - Prince Charles Hospital

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**Further flow improvement**

Liaison Psychiatry

Acute physicians at front end

Increased board and ward rounds

Use of Discharge Lounge

Therapy and Nursing Establishment Increase

SAU

LA Improved Response

Total

**Projected changes in 2014/15**

**Projected 2014/15 LOS**

**Projected Change**
## 2014-15 activity change plan - Community Hospitals

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<td></td>
</tr>
<tr>
<td>Y Bythyn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>0.0</td>
<td>0.0</td>
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</tr>
</tbody>
</table>
### Community hospital beds required

<table>
<thead>
<tr>
<th>From RGH</th>
<th>From PCH</th>
<th>From home</th>
<th>From other source</th>
<th>Total</th>
<th>LOS</th>
<th>Bed days</th>
<th>Beds required @ 95% occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
<td>EL NEL</td>
</tr>
</tbody>
</table>

#### YCC

- **General Medicine**
  - Baseline: 0 0 0 0 0 1 0 0 0 1
  - Proposed: 0 187 0 -72 0 -50 0 0 0 0 65

- **Old Age Psychiatry**
  - Baseline: 0 0 0 0 0 4 0 4
  - Proposed: 0 0 0 0 0 0 0 4 0 4

- **Palliative Medicine**
  - Baseline: 0 9 0 39 0 64 0 16 0 128
  - Proposed: 0 9 0 39 0 64 0 16 0 128

- **Rehabilitation**
  - Baseline: 0 33 0 584 0 7 0 36 0 660
  - Proposed: 0 33 0 584 0 7 0 36 0 660

### YCR

- **Care of the Elderly**
  - Baseline: 0 648 0 3 52 7 0 40 52 697
  - Proposed: 0 905 0 -33 52 -68 0 40 52 843

- **General Medicine**
  - Baseline: 0 0 0 0 0 0 0 0 0 0
  - Proposed: 0 0 0 0 0 0 0 0 0 0

- **GP Other**
  - Baseline: 0 0 0 0 0 0 0 0
  - Proposed: 0 0 0 0 0 0 0 0

- **Rehabilitation**
  - Baseline: 0 0 0 0 0 0 0 0 0 0
  - Proposed: 0 0 0 0 0 0 0 0 0 0

### Dewi Sant

- **Care of the Elderly**
  - Baseline: 0 8 0 0 0 0 0 1 0 9
  - Proposed: 0 41.0 382.7 1

- **Old Age Psychiatry**
  - Baseline: 0 0 0 1 17 0 8 1 25
  - Proposed: 0 41.0 1038.7 3

- **Palliative Medicine**
  - Baseline: 0 0 0 0 0 0 0 0 0 0
  - Proposed: 0 0 0 0 0 0 0 0 0 0

- **Rehabilitation**
  - Baseline: 0 471 0 7 0 4 0 39 0 520
  - Proposed: 0 41.0 21320.0 61

### Overall total

- Baseline: 0 1169 0 632 53 100 0 144 53 2045
- Proposed: 0 615 0 517 52 -47 0 96 52 1181
# ENGAGEMENT PLAN 2013 - 2014

<table>
<thead>
<tr>
<th>Group</th>
<th>Lead</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Planning Group</td>
<td>Director of Planning &amp; Performance</td>
<td>Monthly – ongoing</td>
</tr>
<tr>
<td>Cwm Taf University Health Board</td>
<td>Director of Planning &amp; Performance</td>
<td>15 January 2014, 5 February 2014, 2 April 2014, 7 May 2014</td>
</tr>
<tr>
<td>Executive Board</td>
<td>Director of Finance, Director of Planning &amp; Performance &amp; Director of Workforce &amp; Organisational Development.</td>
<td>Ongoing via Executive ‘catch up’ Agenda: 18 September 2013, 23 October 2013, 18 December 2013, 22 January 2014, 19 March 2014</td>
</tr>
<tr>
<td>Executive Team Workshop</td>
<td>Director of Finance, Director of Planning &amp; Performance &amp; Director of Workforce &amp; Organisational Development.</td>
<td>30 September 2013, 9 October 2013</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
<td>Director of Finance/ Director of Planning &amp; Performance</td>
<td>23 January 2014, Monthly – ongoing</td>
</tr>
<tr>
<td>Clinical Business Meetings</td>
<td>Head of Strategy</td>
<td>Monthly – ongoing</td>
</tr>
<tr>
<td>Medical Leadership Forum</td>
<td>Director of Finance, Director of Planning &amp;</td>
<td>30 October 2013, 27 November 2013</td>
</tr>
<tr>
<td>Meeting</td>
<td>Chairperson</td>
<td>Date(s)</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>Performance &amp; Director of Workforce &amp; Organisational Development</td>
<td>29 January 2014</td>
<td></td>
</tr>
<tr>
<td>LNC</td>
<td>Director of Finance, Director of Planning &amp; Performance &amp; Director of Workforce &amp; Organisational Development</td>
<td>13 March 2014</td>
</tr>
<tr>
<td>Grand Round</td>
<td>Director of Finance, Director of Planning &amp; Performance &amp; Director of Workforce &amp; Organisational Development</td>
<td>16 January 2014</td>
</tr>
<tr>
<td>CHC Service Planning</td>
<td>Director of Planning &amp; Performance</td>
<td>15 November 2013, 17 January 2014</td>
</tr>
<tr>
<td>CHC Full Council</td>
<td>Director of Planning &amp; Performance</td>
<td>29 November 2013, 31 January 2014</td>
</tr>
<tr>
<td>Stakeholder Reference Group</td>
<td>Director of Planning &amp; Performance</td>
<td>15 October 2013, 19 December 2013, 4 February 2014, 8 April 2014</td>
</tr>
<tr>
<td>Health Professional Forum</td>
<td>Director of Planning &amp; Performance</td>
<td>26 September 2013, 20 February 2014</td>
</tr>
<tr>
<td>Regional Collaborative Board</td>
<td>Director of Planning &amp; Performance</td>
<td>6th February 2014</td>
</tr>
<tr>
<td>Hospital Medical Committee</td>
<td>Director of Planning &amp; Performance/ Director of Workforce &amp; Organisational Development</td>
<td>20 March 2014</td>
</tr>
<tr>
<td>Heads of Therapies meeting</td>
<td>Directorate of Planning &amp; Performance</td>
<td>29 January 2014</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Level</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Statutory Duty / Finance</strong></td>
<td>Delivering a break even financial position and breaching the Board’s statutory duty. Short and medium term risk.</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Business Objectives / Projects</strong></td>
<td>Delivering a level of performance that ensures delivery with Tier 1 and other key patient safety related targets.</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral to treatment times</td>
<td>High</td>
</tr>
<tr>
<td><strong>Statutory Duty / Inspections</strong></td>
<td>Fire Safety Management risks associated with the original design of Prince Charles Hospital, Merthyr Tydfil.</td>
<td>High</td>
</tr>
<tr>
<td>Management of asbestos</td>
<td>High</td>
<td>Updated Asbestos Management Plan in place – progress monitored via Corporate Risk Committee. Good progress noted following all Wales audit. Associated risks controlled and reducing.</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Significant backlog in provision and staff compliance with mandatory training.</td>
<td>High</td>
<td>Related plans in place, although partly compromised by staff absence and ability to maintain safe staffing levels whilst also releasing staff to attend various mandatory training programmes. Training programme in place, along with monitoring aligned with Personal Development compliance, with reports presented to Finance &amp; Performance Committee where elements of this mitigating action are monitored.</td>
</tr>
<tr>
<td>Finance</td>
<td>Risk of not be able to release staff costs, due to the lack of enabling processes (some of which relate to all Wales work on terms &amp; conditions), compounded by low levels of staff turnover.</td>
<td>High</td>
</tr>
<tr>
<td>Delivery of Major &amp; Discretionary Capital programmes</td>
<td>High</td>
<td>A Capital Programme Board is in place that routinely reviews schemes and related progress with Major and Discretionary capital schemes, including close liaison with Welsh Government.</td>
</tr>
<tr>
<td>Human Resource</td>
<td>Management of Absence, with staff sickness levels above the NHS Wales average.</td>
<td>High</td>
</tr>
<tr>
<td>Impact on Safety</td>
<td>Recruitment of Medical and Dental Staff</td>
<td>High</td>
</tr>
<tr>
<td>Risk Area</td>
<td>Risk Level</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Department is running a full service on both sites although there are fewer middle grade vacancies than in previous years. Completion of a full review of medical and specialist nursing provision for orthopaedic services to include independent prescribing training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Wales Programme (SWP) and other unrelated service redesign requirements</td>
<td>High</td>
<td>A dedicated risk register with associated mitigating actions are in place specific to the South Wales Programme. Active arrangements are in place overseen by the Board that consider, review and assess risks as the programme develops. In addition interim arrangements are under constant review to consider any urgent actions that may be necessary pending a decision and implementation of any SWP proposal.</td>
</tr>
<tr>
<td>Inappropriate placement of patients</td>
<td>High</td>
<td>A significant amount of work and related actions are in place that can demonstrate improvement in patient flow and mitigate the risks of inappropriate placement of patients. In addition, introduction of arrangements to monitor Effective Bed Management Policies to ensure safe and appropriate allocation of acute beds to all patients.</td>
</tr>
<tr>
<td>Achievement of 15 minute Ambulance target</td>
<td>High</td>
<td>Aligned with the Board’s action plan on unscheduled care and improved emergency patient flow, these actions also help to influence positively the target and identified risk.</td>
</tr>
<tr>
<td>Reduction in training posts within various specialities &amp; capacity to meet workload demands</td>
<td>High</td>
<td>Related actions are in place which include regular dialogue with the Deanery, related recruitment activities, plans to redesign services when required. Risks are mitigated through the introduction of Directorate Action Plans which are monitored by the Education Lead for Quality &amp; Standards and reviewed routinely in Clinical Business meetings as required.</td>
</tr>
<tr>
<td>Failure to sustain services as currently configured to meet waiting lists and cancer targets</td>
<td>High</td>
<td>Actions in place that focus attention on the treatment of all 52 week day case patients. Additional action plan for removing this 52 week cohort of inpatients, with exception of upper limb surgery. Continued and exerted action to reduce outpatient waits to below 26 weeks; with interim actions currently covering all specialities except: Ophthalmology</td>
</tr>
<tr>
<td>Business Continuity</td>
<td>Discharge delays from acute hospitals</td>
<td>High</td>
</tr>
</tbody>
</table>