BCU Health Board Three Year Plan 2018/21

Draft

Version: 1.0

20th March 2018

Section 1 - Foreword

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Betsi Cadwaladr University Health Board is committed to working with others to improve the health of the population of North Wales and provide excellent healthcare to those who access our services. The experience of most people who access our services is one of high quality care and treatment and some of our services deliver results that are among the best in both Wales and the United Kingdom. There are, however areas where it is clear that we can and should do better.

The Health Board has faced a number of challenges in recent years and was placed in Special Measures by Welsh Government in 2015. Since that time significant work has been undertaken to bring about improvement. The most recent assessment of progress has recognised improvement, most notably in maternity services which have now been de-escalated from Special Measures. There are however further challenges with regard to finance and performance which have led to these being escalated to the Special Measures level. A new framework setting out the required improvements will soon be published by Welsh Government. This will provide a focus for our detailed one year plan for 2018/19 in order that we demonstrate the improvements necessary to move away from Special Measures. The Health Board must rightly focus upon delivering rapid improvement in the areas which remain in Special Measures, however it is crucial that the Health Board does not focus solely on short term issues.

We have a duty to plan for the future in a more structured way. The work we have been undertaking to develop and agree our long-term strategic direction through our Living Healthier, Staying Well programme has now completed its initial phase. This represents a major step forward for the Health Board in setting out a vision for our services and a clear aspiration of how we wish to work to improve health and well-being, reduce health inequalities and deliver excellent care. This work has allowed us to set out clearly what the Health Board, working with partners, seeks to deliver in the future.

A key part of this work has involved using feedback from our population, partners and staff, alongside an understanding of the health needs of our population to help us plan improvements in service design and delivery to meet these needs. Importantly, this work has also served to provide the framework, which sets out what we aim to deliver over the next 3 years. It is this work that sets the context for this plan.

This Plan identifies the priorities we wish to pursue over the coming three-year period. Some of this can start now, with the resources, we have available to us, and have an immediate impact. Other areas require further development and they will come to fruition during the lifetime of the Plan as resources become available. We will build upon this work during 2018/19 as we move towards the production of an Integrated Medium Term Plan to cover the period 2019-22.

The Health Board is aware of the need for an immediate focus in 2018/19 upon the urgent work that must be progressed to improve access to the services we currently deliver, enhance the quality and safety of those services and manage our resources more effectively. We will set out a detailed one-year delivery plan for 2018/19 which addresses these matters and provides clear measures to help track our progress, drawing upon the first year priorities set out in this Plan.

Section 2 – Summary of Priorities for 2018/21

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The narrative below identifies our key priorities for each area of our plan starting in 2018 through to 2021.

Improving Health and tackling Health Inequalities

During the period of our plan we will focus on three key areas, namely:

- Promoting health and well-being with a strong focus on improving mental health and well-being, reducing suicide and self-harm, supporting healthy weight and diet, alcohol awareness raising and immunisation.
- Tackling health inequalities through growing our Well North Wales Programme, developing health and well-being centres, mainstreaming social prescribing, tackling poverty and deprivation and providing services for the homeless.
- Staff health and Well-being –delivering workplace health, mental well-being and general well-being.

Care Closer to Home

During the period of our plan we will focus on five priority work streams, namely:

- Cluster development - support the development of clusters to enhance their role in designing and delivering primary and community services.
- Service Model - improve access to sustainable primary and community care services. We will expand the number of integrated multi-disciplinary community teams and develop our staff to engage with individuals to deliver support which reflects “what matters” to them.
- Primary care workforce - build on work done to date to introduce a broader range of health and social care professionals including Specialist Nurses, Pharmacists and Therapists into independent and managed GP practices.
- Health and Well-being Centres - in support of Care Closer to Home an estate strategy for primary care will be developed.
- Digital healthcare and Technology - improved access to digital technology in the community, IT equipment, telehealth, supported self-management.

Urgent and Emergency Care (Unscheduled Care)

Our plan is designed to ensure that more health service needs can be met outside hospitals by providing treatment alternatives to hospital admission and ensuring that patients who do require admission for specialist treatment can be safely discharged from hospital as soon as possible.
Key priorities for the period of our plan are to:-

- Work with the Welsh Ambulance Service to enhance the integrated clinical hub and roll out of 111 to allow patients to be treated nearer to home and avoid unnecessary admissions, supported by our Care Closer to Home work stream and developments.
- Review and develop standardised protocols for our Emergency Departments to ensure patients are streamed quickly and efficiently, that services are in place to treat patients, with an aim of no ambulance handover delays and all patients seen within four hours.
- We will focus on daily senior review of patients in hospital and planning for early discharge at the point of admission. Co-ordinating with Community, Social Services, the third sector and Independent sector we will strengthen support to patients within their own homes including evening and weekends.

Planned Care

Our plan recognises the importance to patients of improving access times. In providing services to patients we will ensure that people are treated in terms of their clinical priority. Key to delivery of the Health Boards Referral to Treatment (RTT) targets is targeted action in Orthopaedics and Ophthalmology.

During the period of our plan we will focus on the following key areas:

- We will maintain the reduction made in patients waiting over 36 weeks throughout the year, deliver 8 week target for diagnostic services and deliver upon cancer waiting times standards towards full delivery of national targets over the three year period of the plan.
- Maximise our efficiency and productivity through appropriate scheduling and resource utilisation within our theatres. We will also ensure that we treat patients of equal priority in turn, based on length of wait.
- We will deliver our eye care and orthopaedic plan.
- Implement a sustainable model for outpatients including the use of peer-to-peer triage, virtual clinics, Care Closer to Home, reducing the follow up backlog and targeting Hospital Initiated Cancellations (HICs) and DNAs.
- Implement Acute Hospital Configuration of services for Vascular.
- Conclude the review of Urology services linked to the development of Robotic Assisted Services.

Women's Services

During the period of our plan we will focus on four priority work streams, namely:

- Implement the Women's Quality and Health Improvement Priorities, including infant feeding, 10 steps to healthy weight, prevention of low birth weight babies, vaccination, perinatal mental health, reduce avoidable morbidity and mortality and reduction in caesarean sections.

- Developing and implementing the longer term service model identified in the strategy with seven areas for transformation: Gynaecology, Obstetrics, Midwifery, Estates, Workforce and OD, IM&T and Patient Experience.

- Co-develop a community model for Women's Services aligned to the development of Health and Well-being Centres within the community.
- Implementation of sustainability plans for Gynaecology and Women's Specialist Services.

Mental Health and Learning Disabilities

Throughout the period of our plan, we will work closely with our partners to focus on quality, safety, and sustainability of our services. With continued involvement of people with lived experience we will implement early priorities identified within our mental health strategy, namely:

- Promote the 5 ways to well-being, linked to preventative and primary & community services.
- Promote peer support and other services for people moving on from care.
- Step in sooner to support young people with eating disorders and give better support to young people who self-harm.
- Widen our range of responses for people experiencing mental health problems for the first time.
- Have better crisis services available 24/7.
- Work with our partners to develop a strategy for Learning Disabilities.

We will also continue to strengthen governance, quality and performance, specifically:

- Ensure that we build on progress in 2017/18 to strengthen governance and performance through strong leadership at all levels.
- Deliver improved performance and compliance with the standards set out in the Mental Health Measure for adult and children (refer to CAMHS services below).
- Continue our investment programme to develop the environment of care in inpatient settings.
- Review and remodelling of out of Area and Continuing Healthcare (CHC) Packages.

Children's and Young People's Services

The Children and Young People's Services plan is focused upon seven work streams:

- Improving outcomes in the 1st 1000 days.
- Promotion of healthy weight.
- Improving emotional health, mental well-being and resilience of children and their families.
- Crisis intervention services for children and young people who are experiencing an urgent perceived mental health crisis.
- Prevention and mitigation of adverse childhood experiences – delivering trauma informed services.
- Children with complex needs due to disability or illness.
- Sub Regional Neonatal Intensive Care Centre (SURNICC) based at Ysbyty Glan Clwyd hospital will be fully operational.

Older People

Our plans aim to ensure services are available which everyone can access, as well as providing more targeted services to support and help older people with particular needs.

During the period of our plan, we will:

- Make sure older people and carers have their rights respected and are involved in decisions.
- Base our plans and services on evidence of what works.
- Working with our partners in the third sector, explore ways to reduce isolation.
- Develop the role of people as health mentors in the community.
- Communicate better with older people who may have specific needs arising from sensory impairment or dementia.
- Make sure our plans work together with the Local Authorities' ageing well plans.

When people are facing the end of their lives we will:

- Encourage people to talk.
- Help them get the support they need.
- Have information and advice that is easy to find and understand.
- Develop guidance for staff giving people end of life care.
- Work in partnership with hospices to ensure people die in the place of their choice.

Improving Quality and Safety

The Quality Improvement Strategy (QIS) was launched in June 2017. This three-year organisational strategy sets out the clear intentions to keep patients health and wellbeing at the heart of all areas of improvement as follows:

- No Avoidable Deaths; Using crude mortality as an indicator we will identify any variation from normal and initiate investigation at case-note level to ascertain lessons to be learned.
- Safe; Continuously Seek Out and Reduce Patient Harm; with a focus upon: eradicating avoidable Hospital acquired thrombosis by 2020; Infection Prevention (Healthcare Acquired Infections); Hospital acquired Pressure ulcers and falls; Medication Safety; Identification and early treatment of Sepsis.
- Effective; Achieve the Highest Level of Reliability for Clinical Care; Achieving the best outcomes for patients requires us to provide care that is effective and we want to do this in a way that provides the best possible patient experience, e.g through strengthened clinical pathways and audits to ensure reliability against NICE guidance and standards etc.
- Caring; Deliver What Matters Most: Working in partnership with patients, carers and families to meet all their needs and actively improve their health. In line with our drive for an integrated approach to care we will support patients, carers and families to fully engage and understand the pathway of care they are following to receive seamlessly co-ordinated care.
- Building on the success of the previous year, we are committed to Rolling out the patient advice and support service and ensuring we provide timely investigation and resolution of Concerns (Complaints and incidents) in line with Putting Things Right (PTR).
- Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living linked to our Care Closer to home plan.

Workforce and Organisational Development

During the period of our plan, the Workforce plan will be focussed on the following key areas:

- Organisational Development.
  - Strengthening the future workforce and widening access.
  - Strengthening leadership capacity and capability.
  - Developing a highly engaged workforce.
  - Talent management and succession planning.
- A Healthy Workforce.
- Recruitment and Retention.
  - Attraction and retention.
  - Recruitment challenges.
  - Workforce transformation.
  - Medical Workforce.

Infrastructure Investment (Capital)

Capital Investment is a critical enabler to allow the Board to meet the health needs of the population we serve by providing assets to support the delivery of safe and sustainable services. The Board's capital programme and its associated investment proposals will be geared towards supporting the realisation of the goals set out in our strategy 'Living Healthier Staying Well'.

During the period of our plan, we will continue to implement our capital programme with the following schemes funding through All Wales capital resources:

- Ysbyty Glan Clwyd Redevelopment.
- Sub Regional Neonatal Intensive Care Centre (SURNICC) based at Ysbyty Glan Clwyd.
- Ysbyty Gwynedd Emergency Department.
- The Elms, Substance Misuse Services, Wrexham.
- Hybrid Theatres at Ysbyty Glan Clwyd.

We will also progress work on business cases to bring the following schemes to fruition during the period of our plan:

- North Denbighshire Hospital.
- Centre Denbighshire Primary Care.
- Waunfawr Surgery.
- Substance Misuse Services in Shotton and Holyhead.
- Delivering Sustainable Orthopaedic Services.
- Robotic Surgery.
- Linear Accelerator Replacement.

Digital Health

The plan and approach for 2018/21 will be to implement a range of technology solutions to maintain and improve our existing infrastructure and to embrace innovative technologies.

Our plan will be achieved through implementing a range of incremental projects to deliver the following objectives:

- Digital roadmap.
- Data driven decision making.

- Underpinning service transformation.
- Digital mobile workforce.
- Managing innovation and emerging technologies.
- Digital infrastructure.
- Workforce development, transparency, sustainability and standards.

Finance

The draft financial plan sets out the financial strategy of the Health Board to support service delivery over the three year period commencing 1st April 2018.

In addition, the Health Board is focused on improving it's in year financial position, reducing its accumulated underlying deficit and restoring in year and recurrent financial balance. This will provide the Health Board will a significant financial challenge over the period of the plan.

The three year plan aims to deliver improved levels of efficiency alongside improved and sustained delivery against performance standards.

To address the financial position will mean a combination of continued improved efficiency measures and transactional savings but more significantly the requirement for transformational plans to cope with the increased pressures and demands on the Health Service.

Section 3 - Strategic Overview

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Betsi Cadwaladr University Health Board's role is to improve health and provide healthcare services for the population of North Wales which is around 694,000 people. This number is increased by the large number of visitors whom we welcome into the area.

We are responsible for:

- Improving health and well-being for all and
- Providing healthcare in GP practices, dentists, pharmacists and optometrists (eye care); community health teams, health centres, hospitals; mental health services.

We work together with other organisations that provide healthcare; for example, ambulance services are provided by the Welsh Ambulance Services NHS Trust. We also work closely with other partners in public services, the third sector and community groups.

We provide services and support for some residents of other areas who use our healthcare services (such as some parts of Powys, Shropshire and Cheshire) and some North Wales residents use services outside North Wales, including Bronglais Hospital in Aberystwyth, the Countess of Chester Hospital and Robert Jones and Agnes Hunt in Gobowen.

We are living longer, and the good news is that many people stay in good health for much of their lives. However, we need to do more to help everyone to have an active and healthy happy life and to stay well as long as possible.

More people are living with one or more health needs or conditions such as diabetes or heart disease. More people are experiencing mental health needs. There are also more people living with dementia.

There are increasing demands on our health services, from GPs to hospital care. We cannot always see patients as quickly as we should and waiting times for some operations are too long.

As well as this, we have significant financial challenges. We need to make sure we work efficiently and spend wisely, making the best use of our resources to improve health.

In recent years, we have had some difficulties in dealing with our challenges and were placed in "Special Measures" by the Welsh Government. Since that time we have been working hard to improve and have made progress in many areas. However, there is more to do and we recognise it will take time.

We have developed our longer term 10 year strategy link here and co-produced this with many individuals and groups across North Wales. This details our organisational purpose, vision and values alongside our strategy for meeting our population's future needs.

Well-being of Future Generations Act

The Well-being of Future Generations Act is a new law that came into effect in 2016. The Act gives us an opportunity to change the way we plan and deliver services. We need to work together with other public services to think about the long term impact of the decisions we make.

One of our duties under the Well-being of Future Generations Act is to set well-being objectives for the Health Board. We think these should be our organisation's long-term strategic goals. When we talked to people about this strategy, we asked for their views about these. This has helped us refine our objectives. Our refreshed well-being objectives will be:

- To improve physical, emotional and mental health and well-being for all
- To target our resources to those with the greatest needs and reduce inequalities
- To support children to have the best start in life
- To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being
- To improve the safety and quality of all services
- To respect people and their dignity
- To listen to people and learn from their experiences

In achieving these objectives we will:

- Use resources wisely , transforming services through innovation and research
- Support, train and develop our staff to excel.

We believe that aiming towards these objectives will help us define and maximise our contribution to the seven national well-being goals. More detail on how this will work is described on our website.

We need to change the way we work, ensuring we adopt the sustainable development principle defined within the WFG Act – this means taking action to improve economic, social, environmental and cultural well-being, aimed at achieving the seven goals.

There are five ways of working which we need to think about when working towards this:

We have sought to follow the 5 ways of working in developing our strategy and within our plan we have included the symbols that show where there are examples of how the five ways have been followed.

Our Principles

In developing our strategy, we followed a number of key principles. These are set out below. We will continue to work with these principles as we implement the strategy.

In everything we do:

- We promote equality and **human rights**
- We will actively provide Welsh language services to address the needs of our Welsh speaking population, in line with the Welsh Language (Wales) Measure 2011

- We work together with local authorities, other services and organisations, including third sector
- We listen to what matters to people and involve them in decisions
- We will address the needs of individuals and their carers
- We use evidence of what works so we can improve health and learn
- We work to improve services
- We use our resources wisely (finances, buildings and staff)
- We will work with the principles of prudent healthcare

Human rights represent all the things that are essential to us as human beings, such as being able to choose how to live our life and being treated with respect and dignity.

It is our ambition to adopt a rights based approach which places human rights at the centre of our policies and practice, and the person at the centre of his or her own care. This approach is based on the values of Fairness, Respect, Empowerment, Dignity and Autonomy.
We need to ensure we consistently use this approach in all that we do.

Our challenges

We face a number of challenges in the coming years which will affect the way we need to provide services -

- People are living longer which is good
- Health needs are changing and we need to respond in a different way
- People need support to make informed choices about a healthy lifestyle
- More people have conditions like diabetes or heart disease
- More people are experiencing mental health issues
- More people are living with dementia
- Waiting times are too long and we need to see patients sooner
- Our workforce is changing and we face challenges in recruiting staff in a number of specialties and staff groups
- Public money is tight, so we need to be efficient and spend wisely

Integration

There are other challenges which are affecting all public services - such as poverty, inequalities, jobs and economic growth, and climate change. These make the context in which we are working more difficult, and make it more important that we understand the impact of our actions on other organisations as well as our population.

Environmental Well-being – we are the largest Health Board in Wales, and cover almost a third of the country's landmass. We can have a significant environmental impact which must be carefully managed. We are developing a more comprehensive sustainability plan which will support this. In our planning we will consider environmental infrastructure, how we can support a more resilient environment, and work to understand better and contribute positively to the natural environment.

Quality and Safety

Improving health and outcomes whilst providing excellent care is a responsibility BCUHB takes seriously. Our intention is to work collaboratively across the whole organisation as well as social partners, Local Authorities, Regional and Welsh Government and all stakeholders to continue to improve the quality and safety of care that BCUHB provides. As part of this commitment, we launched the Quality Improvement Strategy (QIS) in June 2017. This three-year organisational strategy sets out the clear intentions to keep patients health and wellbeing at the heart of all areas of improvement and further detail is set out within the quality improvement section of our plan.

Our Population's Health Needs

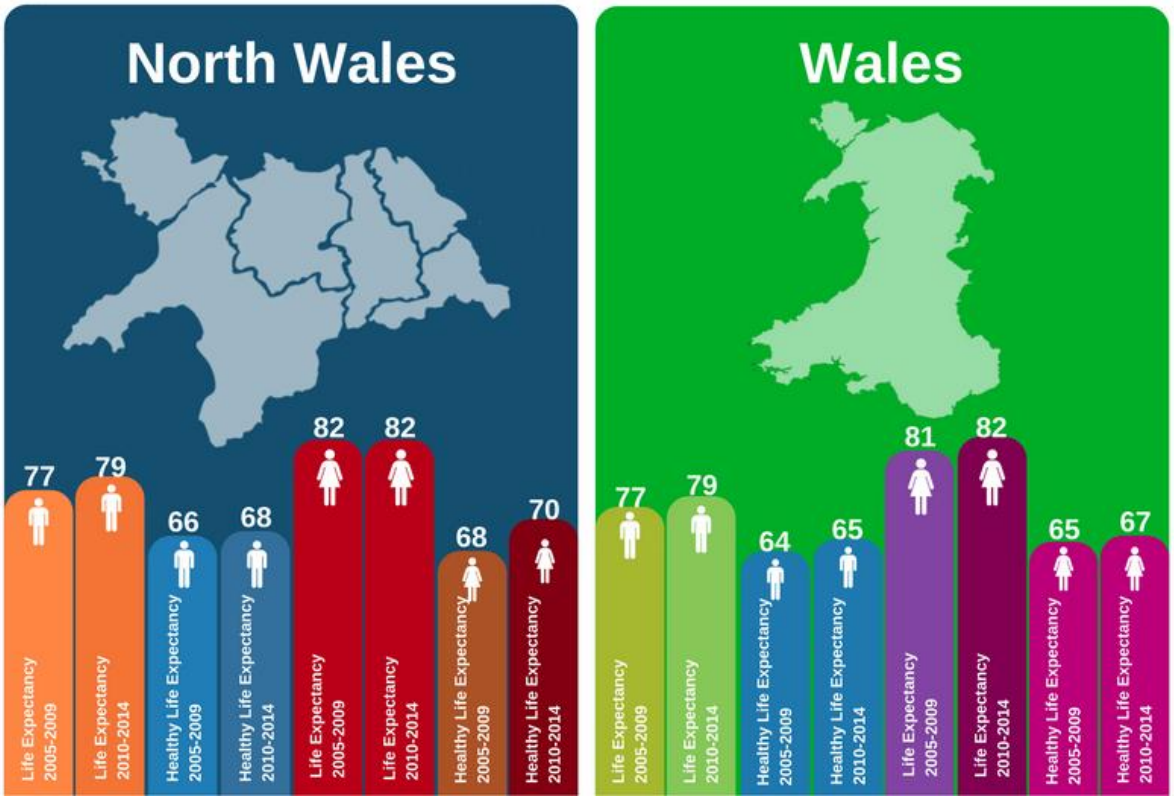
Our plan for 2018 – 21 reiterates our commitment to reducing health inequalities within the population we serve. Guided by the principles and practice envisaged within the Wellbeing of Future Generations Act, with our partners across the public and third sectors, we are reframing our focus to promote ways of working which prioritise prevention, promote good health and wellbeing and support and enable people and communities to look after their own health. This remains the most important challenge we face and our commitment to addressing it will guide and influence our redesign of the healthcare services we deliver in people's homes, in their communities, in our primary care settings and in our hospital facilities.

We know that the overall health status of our population compares favourably to other parts of Wales, and this gives us a strong basis on which to build. However, the benefits of this are not equally shared across the population, and comparison against other areas of the UK and Europe demonstrates that we could achieve even better health and wellbeing.

These projections are currently the most up to date for different age groups at Health Board level.

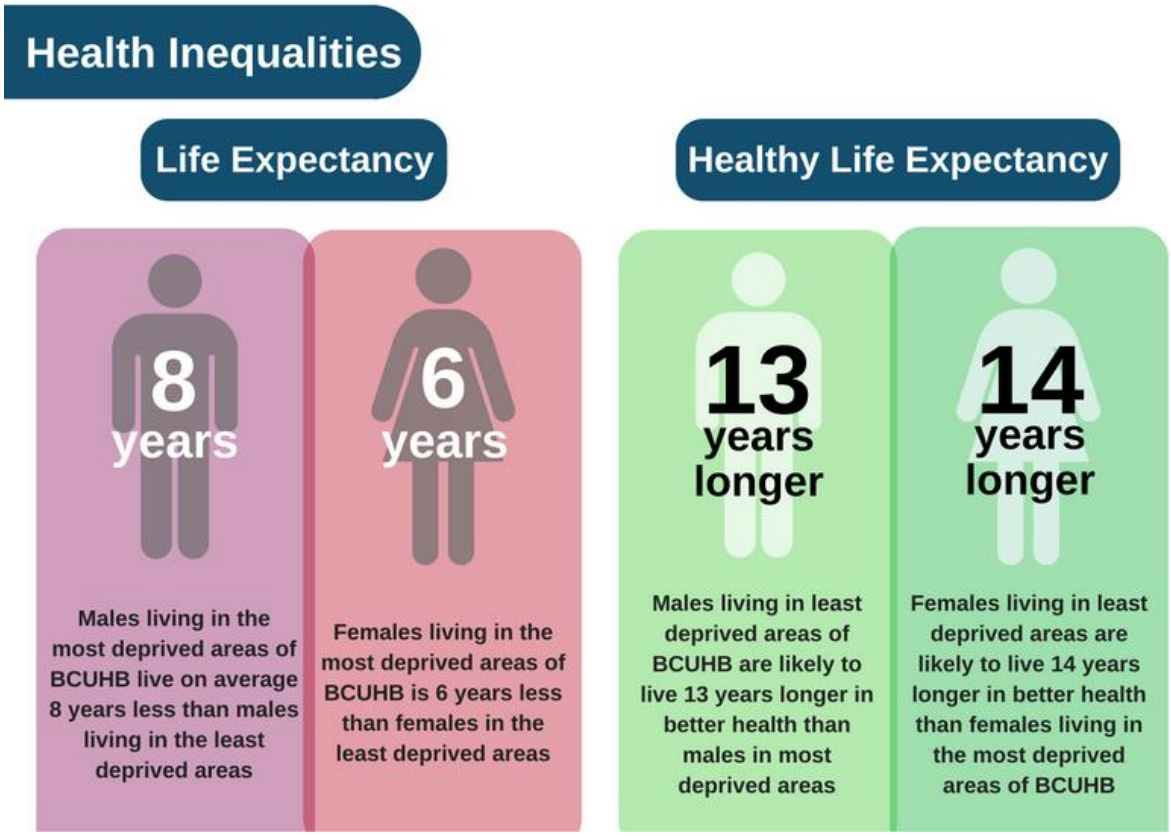
Years of life and years of health

The progress we are already making is shown by our overall Life Expectancy and Healthy Life Expectancy which compares the periods 2005 - 2009, and 2010 – 2014.



Source: Public Health Wales Observatory, 2016

There remains a considerable Inequality Gap in both of these indicators as demonstrated below



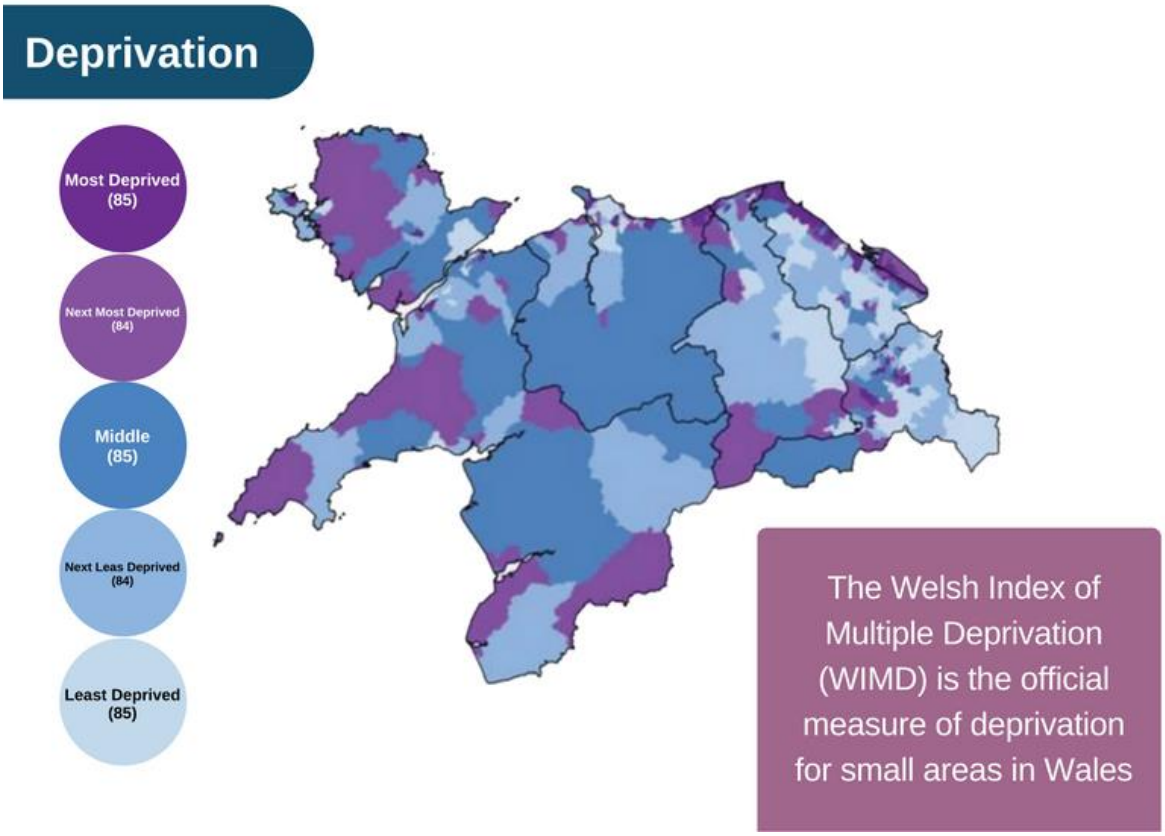
Source: Public Health Wales Observatory, 2016

The 'Inequality Gap' between the most and the least deprived has shown a slight decrease for both men and women in respect of healthy life expectancy over this period, but the gap in overall life expectancy as yet shows no sign of closing. This pattern is consistent with Wales as a whole.

At Local Authority level across North Wales the Inequality Gap can be even greater and this is described in further detail in the supporting needs assessment technical document.

Deprivation

We know that the much of the inequality is the result of social and economic disadvantage at both individual and community level. This is clearly seen in the 'social gradient' described by Wales' CMO in his 2015 Annual Report. The pattern of deprivation is clearly seen in the map below. Those areas with the highest disadvantage will have the greatest need, but also the greatest opportunities for improvement, and so are the areas in which we will concentrate our efforts to identify and build on assets, increase community resilience, and strengthen the planning and delivery of services tailored to need.



Source: Public Health Wales Observatory using WIMD 2014 (WG)

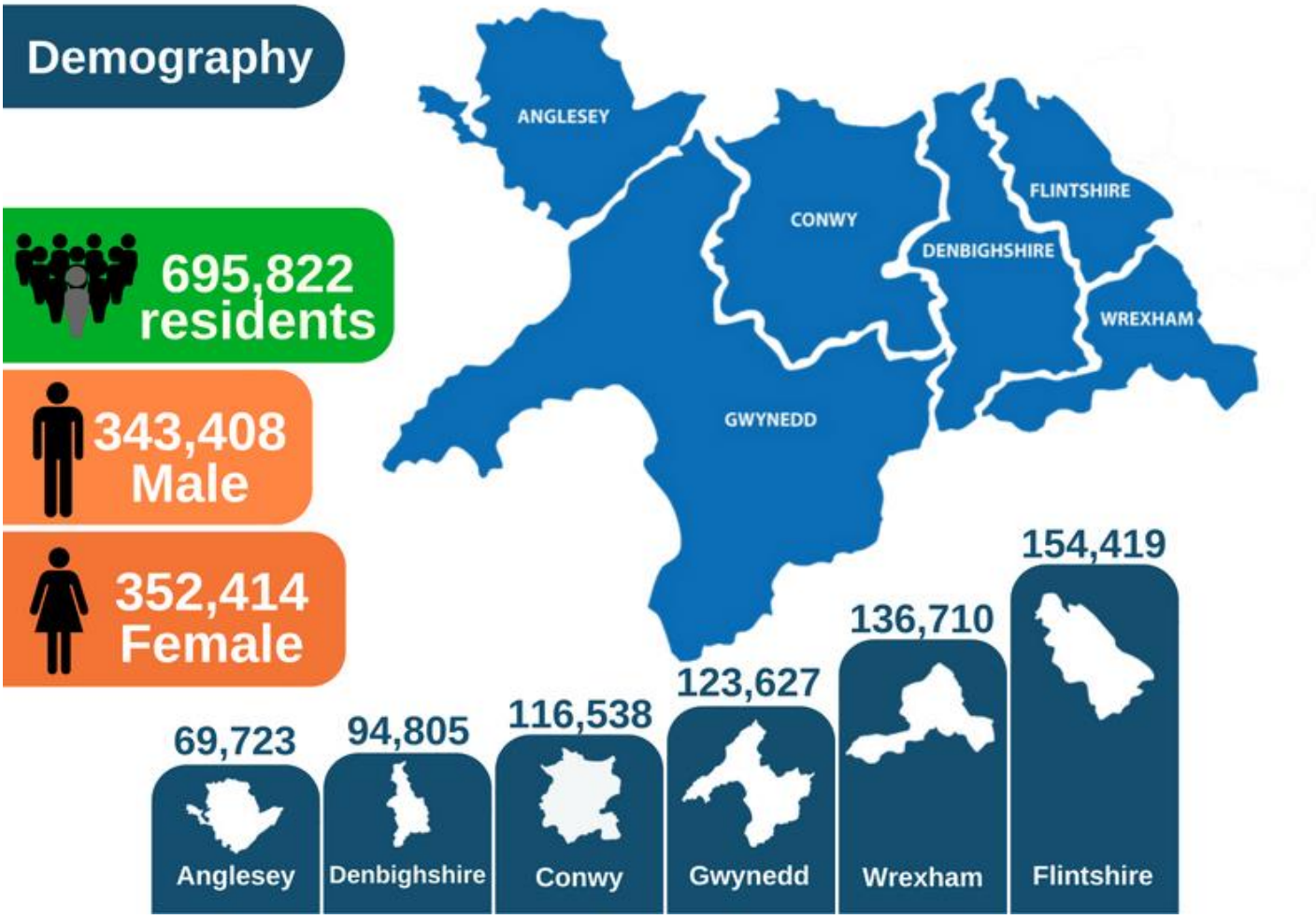
Population Change

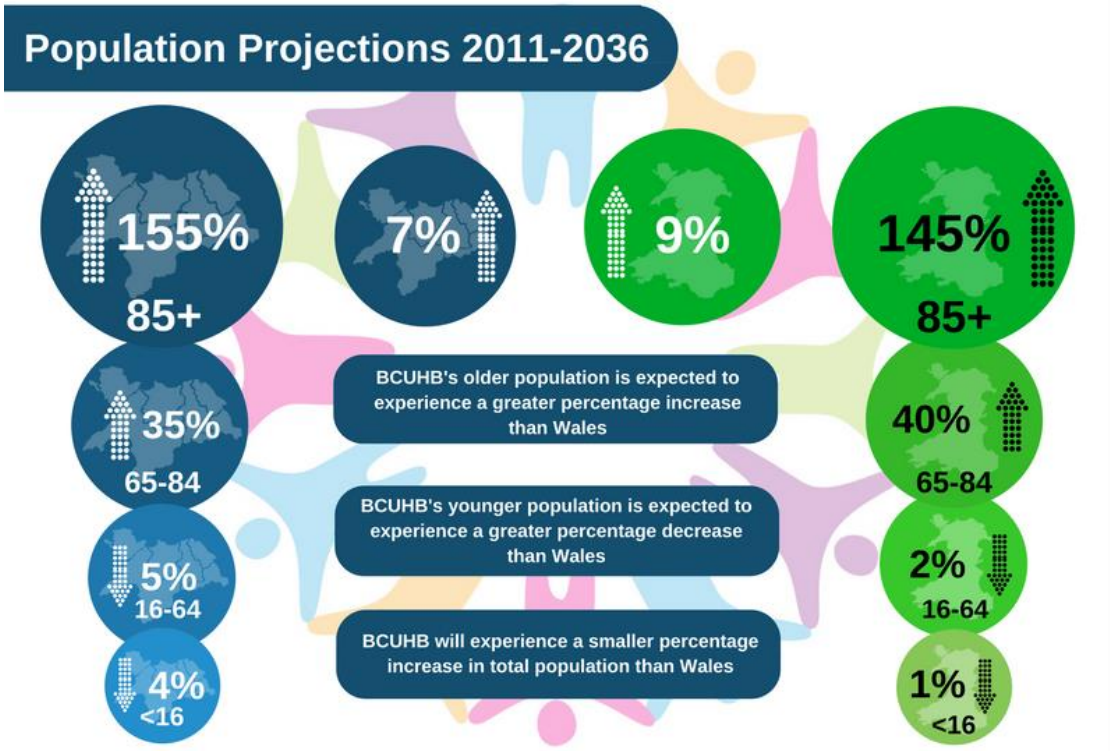
The make-up of our population heavily influences the services we need to deliver, and ongoing change, characterised by an ageing population and changing composition of our communities, will have considerable impact in the near future and the longer term.

Our resident population of around 694,000 is split between the 6 Local Authority areas as show below.

Source: Office for National Statistics, Mid-Year Estimates 2015

The latest projections suggest a 6.7% increase in the total population by 2036. It is expected that there will be a decrease in younger population groups (under 16 and 16 to 64), but large increase in the older age groups.





Source: Public Health Wales Observatory, using 2011-based population projections (WG)

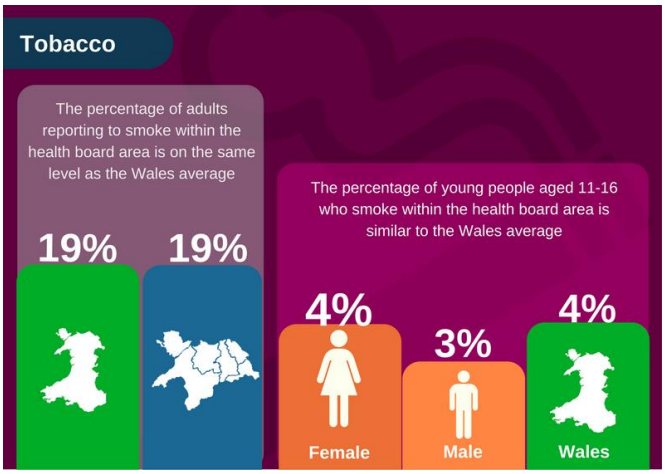
Prevention

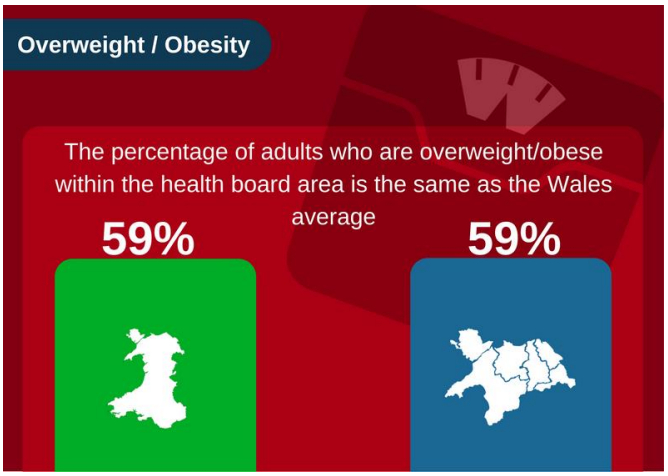
There is solid evidence to demonstrate the considerable impact of a small number of key health-risk behaviours – not smoking, maintaining a healthy weight, eating a healthy diet, keeping alcohol consumption within recommended limits and being more active. The infographics below show that there is still considerable opportunity to embed healthy behaviours across our population.

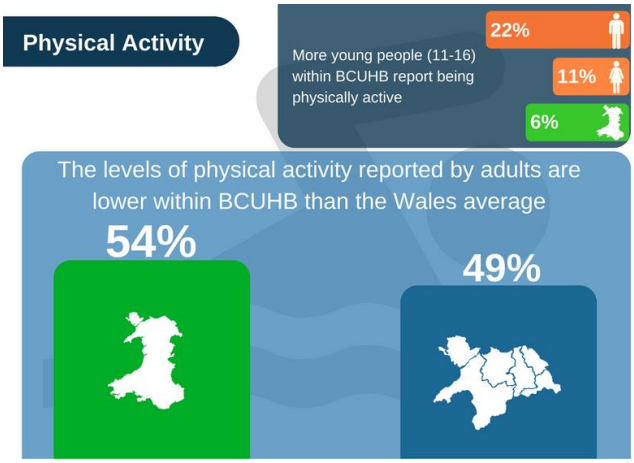
With our partners, we will be placing the strongest emphasis on maximising every child's experience in the First 1000 Days of life which covers the period from Conception to age 2, as we know that this time is crucial in giving the best start in life and helps to secure good health and wellbeing for the whole life course.

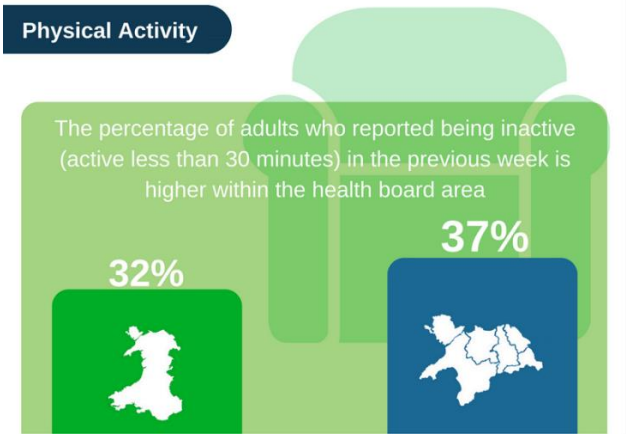
Chronic Conditions

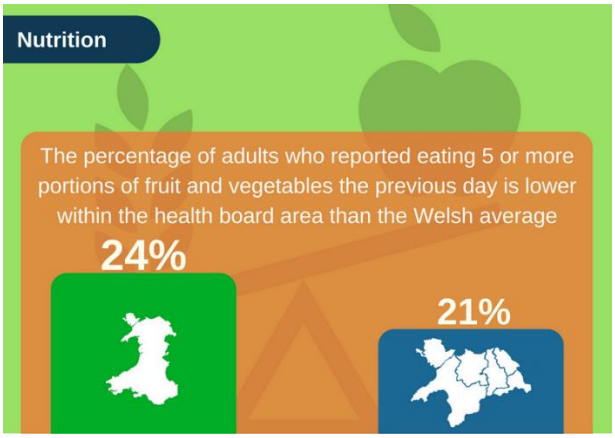
Increasing the number of people who adopt all 5 healthy behaviours will directly impact on the levels of chronic ill-health these behaviours often contribute to. In turn this reduction will bring measureable improvement in overall health, wellbeing and quality of life.





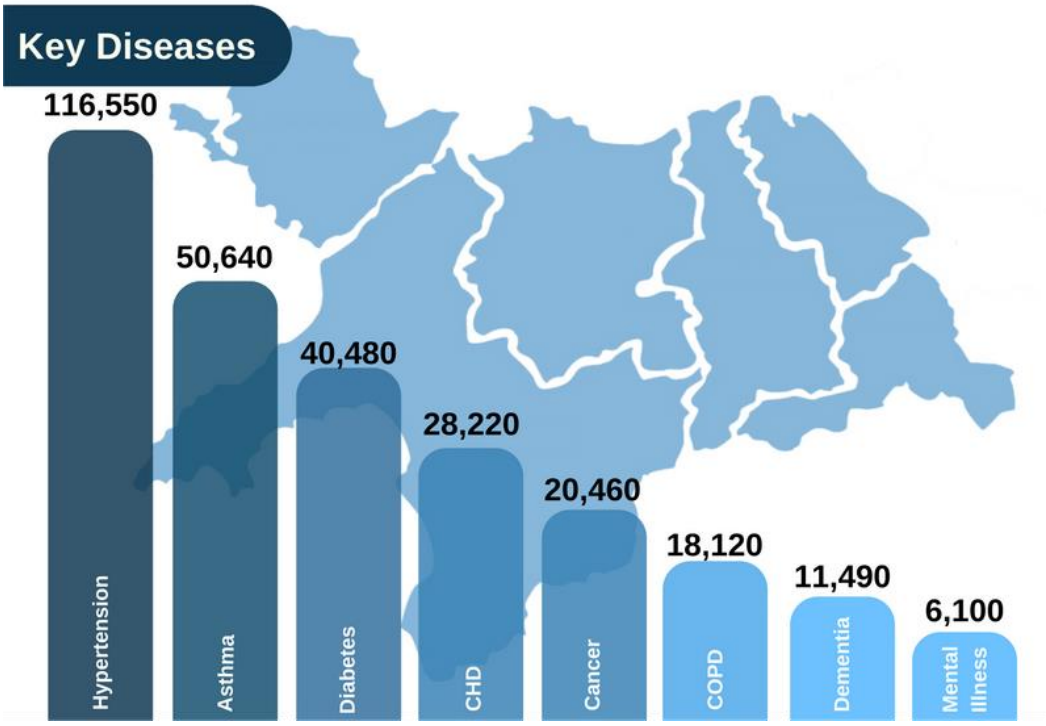




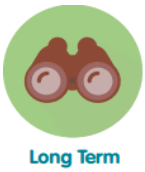


Source: National Survey for Wales, 2017 (WG)

The Infographic below illustrates the number of people recorded on GP practice registers with a confirmed diagnosis of each condition*.



Source: Public Health Wales Observatory using Audit+ (NWIS)
*Figures only report diagnosed cases of conditions. There will be a number of undiagnosed cases in all practice populations; therefore these numbers are more likely to underestimate the true prevalence of the condition.
For Mental Illness the diagnosed conditions included are Schizophrenia, Bipolar Affective Disorders and Other Psychoses.



Future trends

We have reviewed what we know about possible future trends in population and in health needs. We have also begun to model the impact on demand for our services as a Health Board.

The Future Trends Report, Welsh Government (May 2017) provides some key messages which we have taken into account:

- On current projections, there is no clear trend of reduction in the gap between the most and the least deprived populations
- There are mixed trends in common illnesses, which may or may not continue, such as:
  - Reduction in heart disease and arthritis
  - Increase in diabetes and mental illness
  - Little change in the occurrence of cancer in the population (although the numbers will increase due to population increases)
  - A marked increase in the numbers of people living with dementia is likely

- Mixed trends are predicted in healthy lifestyle behaviours
  - Smoking levels are likely to continue to reduce

- Obesity levels and the proportion of people eating less than the recommended volume of fruit and vegetables are likely to increase

We have undertaken detailed modelling of the potential impact of demographic change on demand and activity in health care services – assuming that we ***do nothing differently.*** This suggests that in ten years' time, if we take no further action, we could need around 260 more hospital beds in North Wales. This is clearly unsustainable and adds emphasis to the need to change how we support our population, placing more emphasis on prevention of ill health rather than simply relying on treatment when needs are more serious.

We are continuing to work on projections and to develop a detailed understanding of the impact of the priorities and actions within our strategy. This is a complex area as there are many factors which affect health and well-being, and consequently demand on healthcare. We will use the detailed work to support implementation plans and to review the impact of the early actions identified.

Section 4 - Our 10 Year Strategy for Future Health, Well-being and Healthcare – ‘Living Healthier, Staying Well’

Section 4 - Our 10 Year Strategy for Future Health, Well-being and Healthcare – 'Living Healthier, Staying Well'

We have talked to many people over the last year and their views have helped us to develop our ten-year strategy. It is about meeting the needs of people now and in the future. We have identified the actions we will prioritise over the next three years to begin delivering our strategy. These actions and summary delivery plans are set out within this 3 year plan for 2018/21.

Why do we need a ten-year strategy?

Having a clear and well thought out strategy will help achieve our objectives for the NHS in North Wales and contribute to sustaining safe, effective patient care. This will influence how our resources are allocated and how staff prioritise their time.

We have structured our strategy around three main programmes and through partnership working with people and organisations from across North Wales - partner organisations and other public services, the third sector, independent organisations. These are:

Health Improvement and Health Inequalities – focusing on the broader aspects of health improvement and prevention, and seeking to support those with the greatest health needs first. This sits alongside our contribution to the Well-being Plans being developed for the broader population by the Public Services Boards in North Wales.

We want to work in partnership to support people to make the right choices so they can have a long, healthy life. Reducing health inequalities is an important part of this plan. We want to support the communities that need it the most.

Poverty can affect people's well-being, health and life opportunities and can affect how long someone lives as well. As the largest employer in North Wales, we will take action to contribute to reducing poverty and the impact of poverty, as well as a service provider and commissioner.

We will also work with partners in the Public Services Boards to develop and deliver local Well-being Plans that address the broader aspects of well-being – economic, social, environmental and cultural.

These are the outcomes we want to achieve:

People are healthy, active and do things to keep themselves healthy

People have access to information and advice about services and opportunities that enable them to maximise their health & well-being

People are well supported in managing and protecting their physical, mental and social well-being

Inequalities that may prevent people from leading a healthy life are reduced through programmes tailored and designed to meet needs

Interventions to improve people's health are based on good quality and timely research and best practice

Through smoking prevention measures and smoking cessation, people have minimal risk of developing smoking related diseases

People are aware of the significance of tobacco and alcohol consumption, poor diet and lack of physical activity as risk factors for chronic conditions and cancers

People are supported to identify cancer at an early stage through screening, education and awareness programmes

Care Closer to Home - when people need support or health care to stay healthy, providing as much of this as close to people's homes as it is safe and effective to do so. This also recognises the broader factors that influence health. Care Closer to Home will work with people to prevent, detect early and manage physical and mental health needs. This sits alongside the partnership plans for provision of care and support to individuals and their carers – for example, veterans, and people with learning difficulties or disabilities - which are being developed with the Regional Partnership Board.

Care will be developed around local areas, which will form the building block of future planning. An equitable range of services will be provided for all, although the way they are delivered will be tailored to meet local circumstances or geography. Some services will cover more than one area.

We will expand the services of our community teams, with a single point of contact who will arrange access to the right team member or service for people. Services will be integrated, working closely with a wide range of partner organisations, and focusing on "what matters" to the person.

We will maximise use of technology using health videos and apps whilst preventing people having to travel for appointments, particularly when they have a long-term health condition. We know that not everyone uses technology, and we will support people who don't have easy access.

More help will be provided for carers, recognising their individual needs as well as those of the person they care for.

We will invest in more modern, purpose-built facilities to bring services together under one roof, working with other public sector and third sector partners. We will use our premises, partner organisations' or other community facilities to develop health and well-being centres in local areas. This will include our community hospitals as part of the network of resources available to local areas. We will work with local communities to assess local needs and determine the best use of resources in the area to meet those needs.

The outcomes we want to achieve

People can access the right information, when they need it, in the way that they want it and use this to improve their well-being

Health and care support is delivered at or as close to people's homes as possible

To ensure the best possible outcome, people will have their condition diagnosed early and treated in accordance with clinical need

People have easy and timely access to primary care services

People know and understand what care, support and opportunities are available and use these to help them achieve health and well-being

Interventions to improve people's health are based on good quality and timely research and best practice

Care for More Serious Health Needs - when health needs are more serious and people need hospital care, or care from more specialist teams working in the community. People want the safest and highest quality of care possible and a good experience. They will be treated by the right person, in the right place, at the right time and with the right facilities.

People have told us that they have to wait too long to access services, whether it is in the Emergency Department or for an operation.

We will improve our services to reduce these waits. We will ensure that we have the right capacity in our hospitals to achieve access standards and meet future demand. To help us do this we will develop and adopt new and innovative ways of working and continually review the way resources are deployed to improve patient and carer experience, efficiency and productivity. For example, changing the skill mix of the work force and redesigning and developing new ways to access and deliver services.

We know that improvements in efficiency and productivity alone will not be sufficient to reduce waiting times and we will implement the Care Closer to Home initiatives so that more people can have access to more services (where appropriate) out of the main hospital settings.

The outcomes we want to achieve

People have an accessible responsive and proactive health care system that supports them when they have a more serious health need

People have the best possible outcome, conditions are diagnosed early and treated in accordance with clinical need

People are safe and protected from harm through high quality care, treatment and support

People know and understand what care, support and opportunities are available and use these to facilitate self-care and help achieve health and well-being

People are supported to make the right choices so they have a long, healthy life

People will be cared for in the right place, at the right time, and by the most appropriate person

Standardised, accessible and comprehensive data and information on service delivery

Staff will always take time to understand ‘what matters’ and take account of individual needs when planning and delivering care

We recognise the importance of adapting our planning and delivery of services to the differing needs of people at different stages of life. There are two supporting frameworks which have been developed to reflect this:

- Children and young people – supporting the best start in life
- Ageing well – supporting people aged 50 and over to stay healthy and independent as long as possible

Together with a further strategic framework to reflect the importance of addressing holistic health needs:

- Mental health and well-being

All three of the supporting frameworks will be taken forward through partnership working, linked to the North Wales Regional Partnership Board.

Section 5 - Service Transformation – Three Year Plan 2018/21

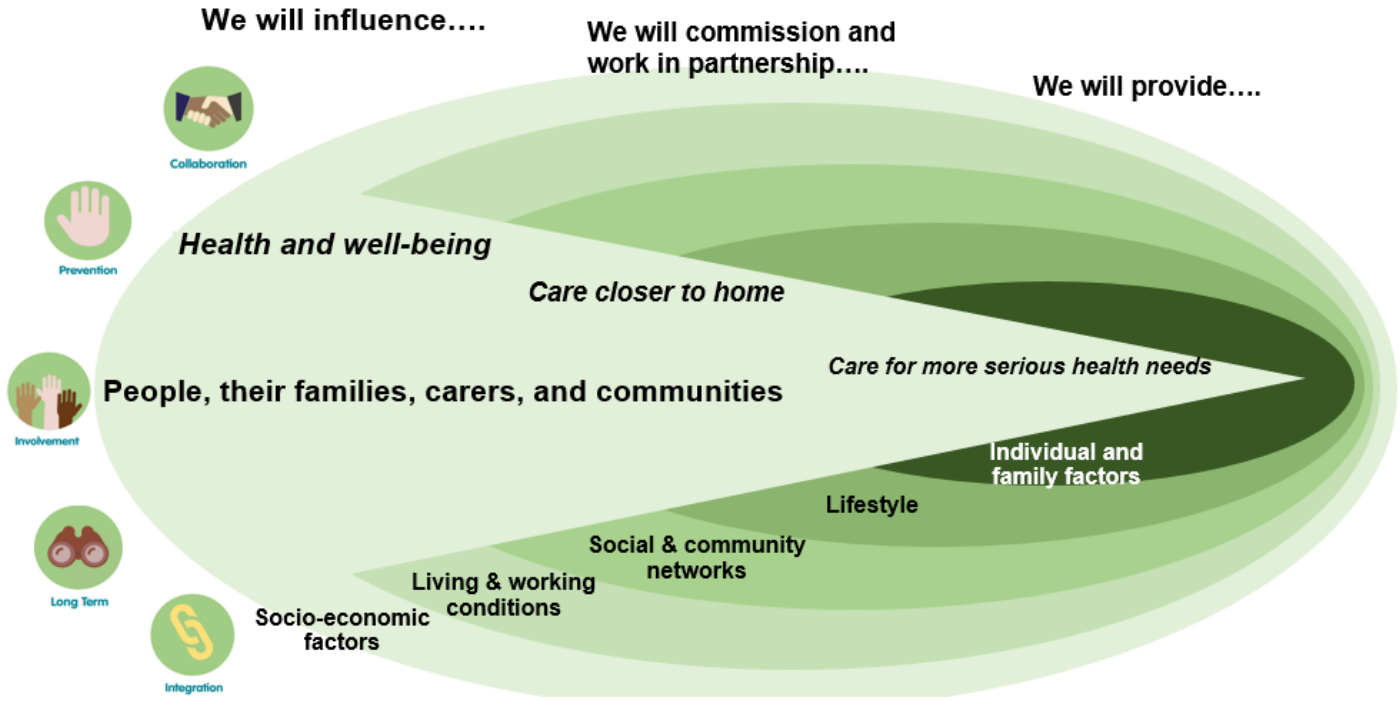
Section 5 - Service Transformation – Three Year Plan 2018/21

This section describes our service transformation plans for 2018/21.

We have to think about how the decisions we make now have an impact on the future. We must meet the needs of today without compromising the ability to meet the needs of future generations. We need to support the people of North Wales to achieve the best health outcomes in the longer term and start to put in place the actions that will achieve this.

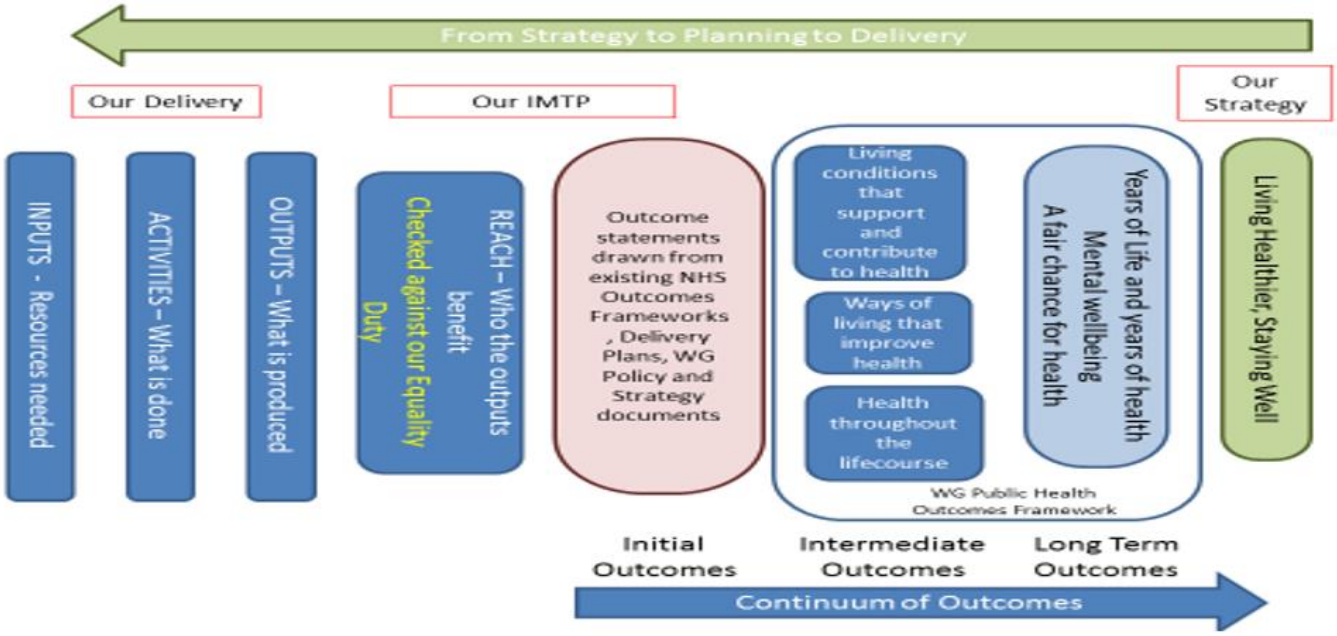
The proposals within our strategy are designed to help us deliver better outcomes for people - improvements in health and well-being. In the longer term, we will aim to see improvements in whole population health status. To deliver this, in the medium term, we will work to support changes in behaviour, practice and the environment.

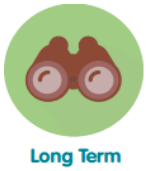
We cannot deliver these changes alone; we will need the contribution of many others to achieve the improvements we all want to see. There are many factors that influence our health and well-being. There are some areas that we can only influence indirectly; some areas where we can commission others or work in partnership to provide care and support; and some areas where we can directly provide services.



We have adapted A Logic Model approach to the development of our strategy and three year planning process which is a graphical representation summarising the key elements of the pathway towards defined Outcomes. This simply seeks to add clarity to what we do and how we communicate the complexity of what we are seeking to achieve across the organisation.

Through using the Logic Model we are therefore able to articulate and convey on a single page the underlying theory of change driving our thinking in key areas, and provide a high level summary of our prioritised actions. This is supported by the key Indicators we will use to measure progress.


From Strategy to Planning to Delivery
Our Delivery
Our IMTP
Our Strategy
INPUTS - Resources needed
ACTIVITIES – What is done
OUTPUTS – What is produced
REACH – Who the outputs benefit
Checked against our Equality Duty
Outcome statements drawn from existing NHS Outcomes Frameworks , Delivery Plans, WG Policy and Strategy documents
Living conditions that support and contribute to health
Ways of living that improve health
Health throughout the lifecourse
Years of Life and years of health
Mental wellbeing
A fair chance for health
WG Public Health Outcomes Framework
Living Healthier, Staying Well
Initial Outcomes
Intermediate Outcomes
Long Term Outcomes
Continuum of Outcomes



5.1 HEALTH IMPROVEMENT AND HEALTH INEQUALITIES

5.1 HEALTH IMPROVEMENT AND HEALTH INEQUALITIES

Our Vision for the Future

We want to work in partnership to support people to make the right choices so they can have a long, healthy life. Reducing health inequalities is an important part of this plan. We want to support the communities that need it the most.

- Poverty is not having enough money for food, clothes, heating and other basic needs. It can mean not having enough money to take part in activities that can support well-being. Poverty is one aspect of inequality and one of its effects.

Poverty can affect people's well-being, health and life opportunities and can affect how long someone lives as well. As the largest employer in North Wales, we will take action to contribute to reducing poverty and the impact of poverty, as well as a service provider and commissioner.

We will also work with partners in the Public Services Boards to develop and deliver local Well-being Plans that address the broader aspects of well-being – economic, social, environmental and cultural.

- People have also told us their concerns about the inequalities in health experienced by people from specific groups. This includes people from different black and minority ethnic groups; disabled people; LGBT+ people and people from different faith groups. Sometimes people experience poorer health outcomes. Sometimes information, appointments or actual care and treatment are not as accessible.

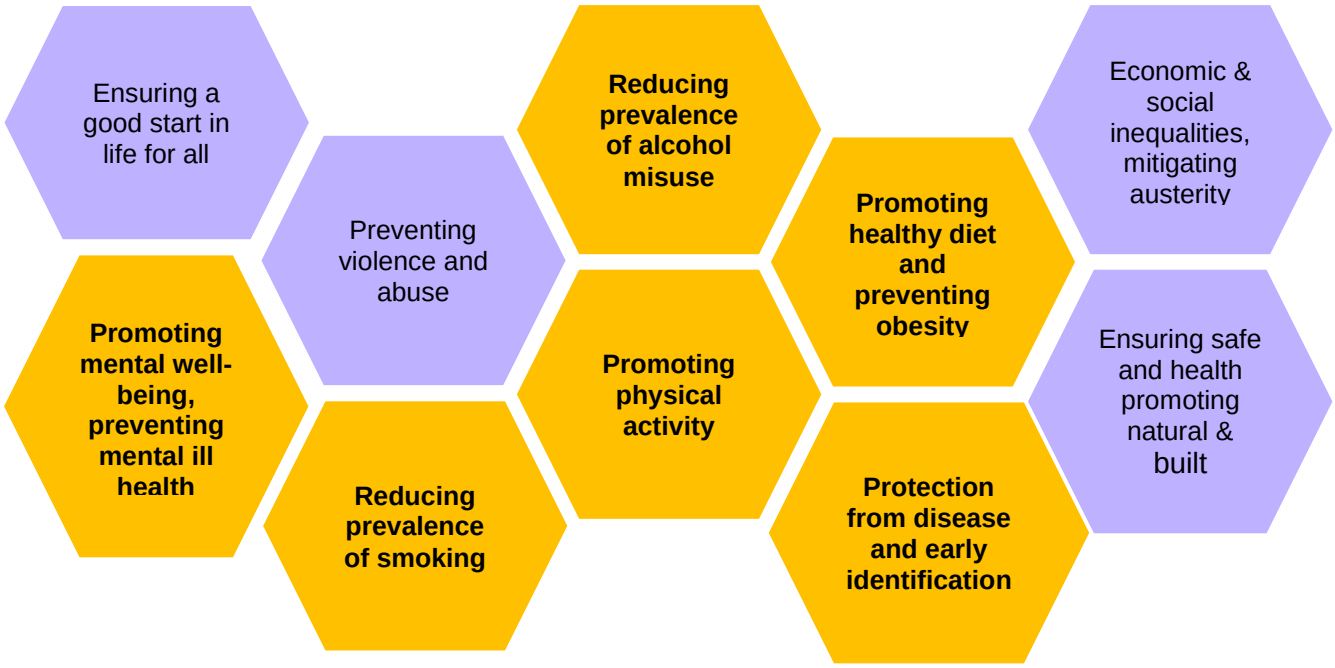
Addressing inequalities: the Health Board will respect United Nations Conventions and Principles including the **UN Convention for the Rights of Disabled Persons** is designed to promote and protect the human rights of disabled people and ensure full and equal enjoyment of those rights.

We will work with seldom heard groups and people with different protected characteristics to make sure we can adapt to respond to their needs. There are some important areas of work already happening which will support this, including these examples:

- Developing support for carers, working in partnership with social services and the third sector, through the Regional Partnership Board
- Supporting the development of proposals to meet the needs of people with a learning disability better, also through the Regional Partnership Board
- Supporting accessible healthcare for people with sensory loss

There are many innovative ways of working being developed to support the health improvement and health inequalities programme. For example, we are working with the creative arts sector in North Wales to support people to participate in many different activities which, evidence increasingly

shows, have a positive effect on health and well-being. In the first years however there are improvements we must make in how we provide support to people to choose healthy lifestyles.[1]



What we will do in the first three years

We will:

- Promote well-being and support people to meet their own needs
- Step in early to stop problems happening or getting worse
- Enable people to make informed choices about healthy lifestyles – like stopping smoking
- Launch our plan to prevent suicide and self-harm
- Support people become more active and enjoy using green spaces
- Enable people to take part in activities that promote well-being, like arts projects
- Target resources to where they will make the most difference
- Look at ways to contribute to reducing food poverty using local projects
- Work with housing providers to support tenants and people who are homeless
- Ensure people are not treated differently because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation - and respond to their specific needs
- Support our staff's health and well-being and support the needs of people entering employment in the Health Board.

In keeping with Prosperity for All, our long term aim is to contribute to a Wales that is prosperous and secure, healthy and active, ambitious and learning, and united and connected.

This plan identifies BCUHB's commitments for 2018-21 for the population of North Wales, acknowledging the need to work as part of the wider Welsh public service. We understand that we have a significant role to play in each of the priority areas such as shaping the future of youngsters

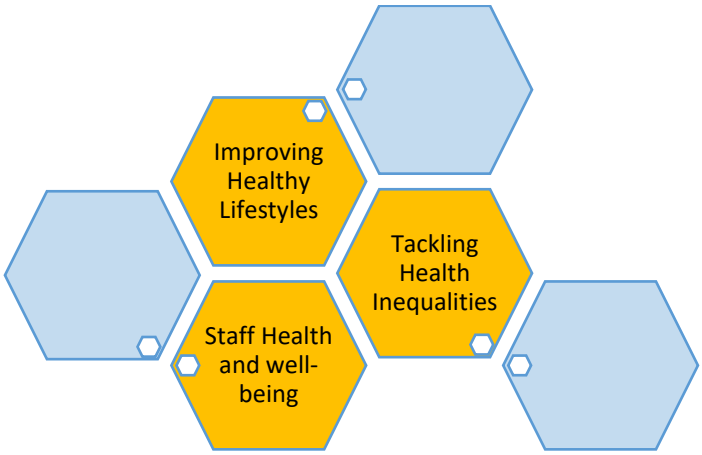
[1] Ten key public health issues, Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales, Public Health Wales, 2016

in order to lead a healthy and prosperous life; establishing awareness of mental health conditions with provision of the right treatments at the early stages and that as an organisation, we must influence and support the key priorities around housing in order to bring a wide range of benefits to individual's health and well-being.

Commencing from a strong base of existing activities in this area, BCUHB continues to build a picture of the health and subsequent needs of our communities. We have looked carefully at what the future holds for our local population, not over the three years that the plan spans, but over the coming 10 years. Whilst (overall) North Wales compares favourably to Wales in terms of general health and being limited by a health condition or impairment *(Jones et al., 2016),* the overall rates mask differences in health across the region. In some areas our population experience greater levels of deprivation and poorer health, or experience more barriers to accessing health care and support. We aim to reflect this in our planning and provision.

Our understanding of inequalities which arise as a consequence of socio-economic deprivation is reasonably well established, we know, for example, that there are significant differences in life expectancy and in the prevalence of limiting long-term illness, disability and poor health between different socio-economic groups (The Deprivation Profile of North Wales). We are not defined by any singular characteristic, social determinants such as ethnicity; gender, disability, and sexual orientation combine and intersect to affect health and wellbeing, often varying across the life-course. A narrow focus on one aspect of an individual's or a group's identity may therefore work to the detriment of understanding and responding to the reality of people's lives and experiences. We recognise that we have a significant amount of work to do with individuals, communities and other agencies to better understand the inequalities which arise as a consequence of differences including those identified as protected characteristics

The Improving Health and Tackling Health Inequalities plan for 2018-21 focuses upon three key priority work streams:



This plan will highlight specific schemes of work which will develop over the three-year period and contribute to specific outcomes and measures for the health of North Wales.

Delivery of this plan will create an impact on the overall health and well-being of the North Wales population. It will enable individuals, families and communities to make increasingly informed choices, adopt and recognise the value of healthier lifestyles and access high quality support, advice and resources.

The plan aims to tackle the root causes of ill health and wider health determinants and inequalities that exist in our population. We will work to support people to adopt healthy behaviours and over time aim to see a decrease in incidence of diseases such as:

- Cardiovascular diseases
- Cancer
- Respiratory disease

Integral themes to delivery of the plan will be:

- Transforming ways of working
- Collaborative working
- Engagement and evaluation
- Promoting equality and human rights in all that we do
- Embedding good practice
- Developing organisational learning

Outcomes we want to Achieve

The desired long-term outcomes we want to achieve are:

- Individuals are healthy, active and do things to keep themselves healthy and reduce their risk of developing chronic conditions.
- Access to information and advice about services and opportunities that enable individuals to maximise their health and well-being.
- Individuals are well supported in managing and protecting their physical, social and mental well-being.
- Interventions to improve health are based on good quality and timely research and best practice.
- Through smoking prevention measures and smoking cessation, individuals have minimal risk of developing smoking related diseases.
- Individuals are supported to identify cancer at an early stage through screening, awareness and education programmes.
- Health Board employees are well with better attendance, have a higher productivity and are better recruited, retained and engaged to keep themselves healthy and fit for work.

Key Outcome Indicators

We will use a range of indicators to measure our progress, key examples of which are set out below:

- Increase in proportion of the population adopting all recommended healthy behaviours.
- Decrease in incidence of diseases most commonly associated with unhealthy behaviours:
  Cardiovascular diseases
  Cancer
  Respiratory disease.

2018/21 Work Programme

During the next three years, we will focus on the following key areas:

- Promoting health and well-being with a strong focus on improving mental health and well-being, reducing suicide and self-harm, smoking cessation, supporting healthy weight and diet, alcohol awareness raising and immunisation.
- Tackling health inequalities through growing our Well North Wales Programme, developing health and well-being centres, mainstreaming social prescribing, tackling poverty and deprivation and providing services for the homeless.
- Staff health and Well-being –delivering workplace health, mental well-being and general well-being.

We are also preparing for the implications of the Public Health (Wales) Act 2017, given the range of topics included within the legislation and required Health Board actions.

The work streams to deliver our priorities are described in more detail below.

Work stream 1: Improving Healthy Lifestyles

BCUHB will continue to support people to make positive changes to their own health and well-being. The Healthy Lifestyles work stream will work to improve the health and resilience of the population of North Wales, and will work collaboratively with our local population, particularly those living with health issues and their carers. We will also work with primary, community and secondary care professionals and external partners to deliver services to impact the population level outcomes. This work supports the UHB preventative activity on the cross-cutting delivery plans, and detailed in the major health conditions of this report.

Health promotion 'Hubs' such as the award winning Dolgellau hub, offer a whole range of services and assistance within the heart of the community. The third sector collaboration with a rural outpatients' department has provided a fantastic resource which provides information on lifestyles, individual needs, health and well-being and provide screening. The hub has strong links with voluntary organisations and local educational and leisure providers, bringing a full complement of expertise, advice and support to the community. Learning from the success of this venture and others such as those found in Mold and Tywyn, BCUHB will seek to further develop aspects of this work in other key areas. We will identify and evaluate the measures of impact on the population.

The Healthy Lifestyles work stream includes the following key areas of work:

Developing Smoking Cessation Services

The rate of smoking in North Wales is higher than that of Wales overall with the areas of greatest deprivation reflecting the highest rates. Whilst overall death rates from smoking are falling it continues to be the largest single preventable cause of ill health and premature death. Not enough smokers are accessing the smoking cessation services. Our aim is to make our smoking cessation services more accessible to this group within our population.

We are progressing our key actions in response to the newly refreshed Tobacco Control Action Plan for Wales (2017-2020), which will be supported by the powers contained within the Public Health (Wales) Act 2017. Through this we will build on our established work to promote smoke-free living across North Wales.

By working with a range of partners including primary and secondary care we aim to improve the 'Help me Quit' service. We will introduce a service in secondary care and continue to create interest in the service through social media.

As part of the Help Me Quit programme, BCUHB will have a specific interest in fully implementing the 'Help me Quit for Baby' service. We aim to increase the number of women and partners taking up the service already offered by midwifery services. We will explore further ways to improve primary care smoking cessation services through the clusters.

Embedding the smoking cessation services into both internal and public facing campaigns BCUHB will aim to see a year on year increase in quit rates across North Wales including within our own workforce. Through further development of accessibility to services through the implementation of the Health and Well-being centres, social prescribing schemes and Ein Dyfodol, the longer term outcome aim is to see a reduction in demand on primary and secondary care services.

Through the identification of GP practices in cluster areas BCUHB will seek to increase the number of practice patients taking up smoking cessation services and quitting. Over the three-year period we will aim to not only increase the number of people quitting but also maintain smoke free lives.

National Delivery Framework Targets

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun	Sept	Dec	Mar-19	Mar-20	Mar-21
Quarterly	The percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual target	3.8%	1.0%	2.0%	3.0%	4.0%	5.0%	5.0%
	The percentage of those smokers who are co-validated as quit at 4 weeks	40% annual target	31.1%	8.0%	16.0%	24.0%	32.0%	35.0%	40.0%

Improving Mental Health and Well-being

As part of our Mental Health Strategy, there is an acknowledgement of the need to progress mental public health. During 2018-21 we will focus on:

Implementing the Suicide and Self-Harm Plan

In response to Welsh Government guidance, the BCUHB Mental Health Strategy and as part of the North Wales Together for Mental Health Partnership Board, BCUHB launched the North Wales Suicide and Self-Harm Prevention Strategic Plan in February 2018. The plan recognises a multi-sectoral approach across a range of settings and has consulted with a wide range of experts, organisations and stakeholders throughout its development.

Over the next three years, working collaboratively with Local Authorities, schools, North Wales Police, the third sector and other key organisations, BCUHB will actively include the following:

- Focusing on prevention of mental illness and early intervention
- Supporting people in their recovery from mental illness
- Reviewing the implementation of 'Time to Change'
- Developing workplace guidance
- Identifying and providing training to key members of the workforce.

Promoting the Creative Arts

The contribution of the arts to improving health and well-being is increasingly recognised. Our work will contribute to improving individual and community mental health and well-being and resilience. Arts and health interventions are an effective illustration of the collaborative approach promoted in the Well-being and Future Generations Act. The Arts Council has signed a memorandum of understanding with the Welsh NHS Confederation to support the development of the field. The Arts Council has undertaken a mapping of arts and health activity which has revealed a large number of initiatives, from the very small to bigger projects, and all funded in different ways. The challenge is to deliver the benefits of arts and health work at large scale and of the highest quality.

Creativity, empowerment, happiness, inclusivity and resilience have been identified as important elements. Our plan identified for the period 2018-2021 seeks to build on these elements to develop a concordat that partners can sign up to.

This Concordat will set out the commitments of partners, with the aim of creating an environment in which arts and health work can flourish. This will ensure arts and health has a solid, sustainable foundation within North Wales.

In addition to this new development, BCUHB Arts in Health and Well-being will progress the existing schemes identified within the 'Creative Well' strategy. The five key areas in the strategy are:

- Working with older people and people with chronic conditions
- Improving mental health and well-being for all ages
- Transforming healthcare environments
- Integrating the arts into education, training, professional development and staff well-being
- Capitalising on creative therapists' and artists' ability to act as catalysts for innovation

In collaboration with Wrexham Glyndwr University, BCUHB are already supporting the Graduate Teaching Assistant (PhD Student in Residence) Training and Development in Arts in Health. The purpose of the project is to enable BCUHB to guarantee that the delivery of arts activities within its 'Creative Well' programme has a positive impact on health, are of high quality, and sustainable for the future generations of people living in North Wales.

Promoting Five Ways to Well-being

Five Ways to Well-being forms an integral part of the Improving Health strategic plan. Launched in BCUHB during 2017 with a recognisable logo and 'brand', it has already been a focus of the 'Self Care Week' using evidence based messages to improve mental health and well-being.

The messages have been organised into five key actions, each offering examples of more specific behaviours that enhance well-being:

During 2018-2021 BCUHB will continue to develop the Five Ways to well-being website content and formulate a communications plan. A continual campaign of awareness, promotion and collaboration will support positive mental well-being across our population – including amongst our staff.

Scoping work directly with teams will identify how Five Ways to Well-being can be embedded within services and teams, starting with the community Mental Health Team in Hafod. Together with the development of toolkits and the website, staff and members of the public will find useful supportive resources and materials to help make improvements in their daily lives. Linking directly with the Staff Health and Well-being work stream, training workshops will enable staff to identify not only how the Five Ways to Well-being can help themselves but also the public they meet through the course of their work.

Making Every Contact Count (MECC)

MECC is an approach to behaviour change that utilises the millions of interactions between organisation and individuals, helping them to make changes which will have a positive impact on their health and well-being.

Over the three-year period BCUHB will build on its MECC foundations to ensure the biggest impact for the future. It will identify the key frontline staff and equip them with the knowledge, confidence and skills needed to 'make every contact count' – recognising the impact this can have on our key priority areas.

MECC will provide a lever to support health improvement activity within BCUHB and aid us in meeting our responsibilities towards the population of North Wales. We will look to utilise existing national MECC information and resources, and create an organisational MECC implementation plan, including a staff training programme which fully utilises the available e-learning product on ESR. We will also develop a suite of information and resources to support organisational learning including a toolkit in April 2018.

Supporting Healthy Weight and Diet

Our aim is to support people to make healthy choices, maintain a healthy weight and become more active. During 18/19 our focus will be on developing further our obesity service.

Unhealthy weight and diet represents a major public health challenge with major implications for health in both the short and long term. Across North Wales, the proportion of adults and children who are overweight and obese is increasing year on year, with data showing that currently 60% of adults and report being unable to maintain a healthy weight. This poses one of the most significant challenges for BCUHB.

Work to address overweight and obesity will focus on delivering the various aspects of the All Wales Obesity Pathway:
Level 1 – Community based prevention and early intervention services
Level 2 – Community and primary care weight management service
Level 3 – Specialist MDT weight Management Services
Level 4 – Specialist medical and surgical services

BCUHB aims to promote Level 1 activities and services that support adults to maintain a healthy weight and prevent rising levels of obesity. The Health Board plan to scope and redevelop Level 2 services across North Wales in order to ensure consistency through an evidence based approach. In addition, BCUHB will continue to develop, evaluate, and roll out the Level 3 service for patients with a BMI 40+ (35+with co morbidities)

We will work with a range of partners both locally and nationally to deliver the pathway. The BCUHB Children's Plan covers aims to address the dramatic rise in weight gain and obesity in children which presents a significant cause of chronic illness amongst the youngest age groups.

Reducing Sedentary Behaviour

Increasing physical activity can help reduce mortality and improve life expectancy by lowering the incidence and prevalence of conditions such as coronary heart disease and certain cancers.
Being more active can support people to maintain a healthy weight, increase mental well-being, reduce the risks of falls and reduce conditions that affect the muscles and bones.

BCUHB will continue to promote the reduction in sedentary behaviour with partners across North Wales and is the lead partner in the Get North Wales Moving project. Through the development of the Health and Well-being centres, social prescribing schemes, MECC and Care Closer to Home plan, BCUHB will identify further opportunities to increase opportunity for people to move more in their daily life.

Our aim is to be an integral part of both empowering individuals to become less sedentary, to improve their physical activity levels and support them to maintain or increase levels further. We will build on the large scale change approach 'Getting North Wales Moving' and enhance the collaborative approach in 2018/19 through the development of a network charter. There will be a launch of the rebranded network during 2018/19.

Alcohol Awareness Raising

Alcohol is a major contributory factor for premature death and a direct cause of 5% of all deaths in Wales and is associated with many chronic health problems. It is also linked with injuries and poisoning and social problems including crime and domestic violence. Alcohol also affects the poorest the most, with alcohol-related mortality in the most deprived areas much higher than in the least deprived.

Although alcohol consumption is gradually declining, we know that more than 40% of adults in North Wales self-report drinking above guidelines on at least one day in the past week. It remains a major cause of death and illness in North Wales.

BCUHB will support people across North Wales to drink responsibly or to give up by continuing to work with partner organisations to reduce alcohol misuse. Limiting the availability of alcohol in areas with high levels of alcohol related morbidity and mortality can see a reduction in the number of patients being treated for alcohol related diseases and conditions and will improve health outcomes. As part of its collaborative responsibilities, during 18/19 BCUHB will further its support to Local Authorities to assist in responses to licencing applications through provision of local data and information to inform licensing responses.

Key activities for the three-year period will be to raise awareness within the population of the national guidance around safe levels of alcohol consumption and the effects of alcohol on physical and mental health and wellbeing as well as families, home and work lives. BCUHB will produce a communication plan which both compliments and supports planned national campaigns through social media, promotional events and activities. This will be further supported through the development of the Health and Well-being Centres, Well North Wales and social prescribing programmes of work. Through the identification of GP practices in cluster areas BCUHB will work together with partners to increase the number of practice patients who are supported to manage and maintain safer drinking levels or give up alcohol completely as well as raising awareness.

Immunisation & Health Protection

BCUHB will continue to provide protection from preventable serious infectious diseases to the population of North Wales through increasing vaccination uptake rates annually, continuing our core work on protecting population health, and our established work on planning for emergencies/incidents/threats from infectious diseases/threats. We also continue to work with partners to also raise awareness and improve uptake rates for our Screening programmes, and given specific forthcoming changes to the national bowel, cervical and anti-natal programmes. The Health Board continues to work closely with its local Public Health Wales health protection team to ensure timely and appropriate community disease control actions are taken for our population.

Our immunisation plan will focus on developing knowledge both internally and for the public, allowing informed, positive choices regarding vaccination and prevention. There will be specific targeted campaigns continuing for pre-school children and teenagers. BCUHB will also continue to develop and strengthen the Influenza plan each year.

We will seek to expand access to all eligible groups including those who are less likely to attend routine immunisation services - including the homeless and travelling communities across the cluster groups whilst reducing variation.

We will also continue to work with partners, including Local Authorities on the wider health protection agenda. We have experience of working to raise awareness of environmental hazards, (eg air quality, radon etc) in partnership with key colleagues.

Following the recently published Review of Sexual Health in Wales 2017/18, we will continue to support national targeted prevention of sexually transmitted disease campaigns and locally through our own SEXtember campaign.

National Delivery Framework Targets

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun	Sept	Dec	Mar-19	Mar-20	Mar-21
	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	Percentage of children who received 2 doses of the MMR vaccine by age 5		91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%

Work stream 2: Tackling Health Inequalities

Evidence demonstrates the link between socio-economic deprivation and health inequalities. Within North Wales are several of the most deprived areas in Wales, where communities experience more years of poor health and are likely to have unhealthy lifestyles and behaviours. We will work with partners and through the cluster mechanism to progress this agenda.

The North Wales population assessment 2017 (*North Wales Social Care and Well-being services improvement Collaborative),* identified that for many people the feelings of loneliness, isolation, worthlessness, loss of employment, mobility and economic independence had a major bearing on people's health.

Growing Well North Wales

The continuation of work within the 'Well North Wales' programme will expand on our existing programmes, tackling health inequalities across our communities. It will look to develop further initiatives including social prescribing, health and well-being centres and actively contribute towards tackling homelessness and food poverty. The programme will have particular links to the Care Closer to Home strategic plan.

Well North Wales provides a framework for local communities and organisations to work together to improve health and well-being and to reduce inequalities through creating independent individuals, resilient families and stronger communities.

Focus for the projects within Well North Wales will support the four core objectives of prevention, integration, collaboration and involvement.

In 2018-2021 we will build on the existing foundations as described in the 'Well North Wales Annual Report 16/17'. The 'Ein Dyfodol' programme will be integral to the success of Well North Wales. We have made significant progress in terms of both identifying key communities and building partnerships. Focus will now turn to further developing the infrastructure through the full implementation of projects. The communities involved in each of the three geographic BCUHB

areas (West, Central, and East) are amongst the 20% most deprived in Wales. The communities have not formerly benefitted greatly from interventions as other target areas have.

Ein Dyfodol has been identified as an exemplar project by the Bevan commission and BCUHB seeks to build on this through the next phase of engagement. Together with local stakeholders from the various groups, BCUHB will identify funding sources for progressing Ein Dyfodol as part of the wider Well North Wales programme.

The continuation of our existing work will be further supported by research to ensure the maximum future impact of key projects on both health services and the health of the North Wales population. We recognise that currently there is no robust mechanism for capturing good practice and innovation across the wide geographic and service areas and during the next three years, we will seek to develop and embed an internal framework that supports this.

Developing Health & Well-being Centres

The development of Health and Well-being Centres in North Wales is a key feature of both this plan and the Care Closer to Home plan and an integral part of the overall delivery of our ambitions.

The Health and Well-being Centre Development project will establish a programme to engage and consult with stakeholders to develop and implement agreed proposals for the configuration of Health &Well-being Centres in North Wales. The Health and Well-being Centres will be within clusters, where a range of information, early intervention and services are available with co-location of other service provision such as GP practice services and enhanced care. Some of the centres will include minor injuries and illness services or step up and step down care beds.

Mainstreaming Social Prescribing "Made in North Wales"

This BCUHB programme of work has a broad scope and seeks to build a sustainable framework for social prescribing. Whilst long term the programme aims to reach the whole of North Wales, the immediate attention for delivery of local priorities will be through the primary care clusters where activities are co-ordinated.

The focus of work for 2018-21 is to roll out the model and the strong links which have already been developed with the voluntary and community sectors and will identify the existing provision of social prescribing activities underway across North Wales. Thereafter, agreement on monitoring and evaluation will be actioned. The outcomes of this initial work will feed into a strategic approach on future investment.

This programme of work aims to extend past the narrow definition of social prescribing and make provision for groups not usually associated with such schemes. These will include the homeless, people in care homes and individuals involved in anti-poverty programmes.

The importance of evaluation to inform evidence based initiatives seek to add to the evaluation including who is accessing, the identification of cost, the impact and how well it works.

The 2018-21 key examples of outputs include:

- Formation of a consistent, equitable and practical approach to facilitating social prescribing
- Identify and establish a system that can help monitor the impact and value of social prescribing within North Wales – focusing on both social and economic benefits

- Develop and educational framework and training to support the North Wales programme based on practitioner identified priorities
- Work towards establishing North Wales as a 'centre of excellence' through identifying opportunities for further research and evaluation

Tackling Poverty & Deprivation

With 12% of the North Wales population living in the most deprived communities in Wales BCUHB recognises the importance of its role in addressing poverty which in turn can affect people's well-being, health and opportunities. BCUHB will contribute to tackling food poverty and supporting communities and individuals to make healthy choices and access support.

As part of the Flint regeneration project. BCUHB has worked with local partners to identify ways that ensure that nutritious, healthy meals are made available to vulnerable individuals in society and providing an alternative to reliance on food banks. This will be continued and evaluated.

We acknowledge that as BCUHB is a significant provider of food to patients and staff we have the scope, ability and economic power to extend a traditional role.

In 2018-21, BCUHB focus will include:

- Supporting the introduction of a community food hub system to help provide sustainability around funding, infrastructure and resource
- Carry out a review of Health Board food outlets/dining facilities with the aim of introducing Food clubs and advertising for general public use.
- Continue support of local initiatives such as community gardens e.g. Eirias Park project
- Utilise the purchasing power of BCUHB to assist with community schemes aimed at tackling food poverty

As housing has such an important impact on health, in addition to tackling food poverty, BCUHB will contribute to local partnerships in order to influence key decisions regarding housing and accommodation - in order to support tenants and the homeless. We will contribute to work with the housing collaborative '2025'.

Providing services for Homeless People and Vulnerable People

BCUHB recognises that whilst early analysis of the impact of the Housing (Wales) Act 2014 shows progress regarding preventing homelessness, many individuals within the North Wales population lead complex lives and can challenge the traditional model of services. It will be necessary to build on our existing partnerships to reach those who are homeless and more exposed to poor physical and mental health to help them to connect with services. BCUHB will develop a robust Homelessness plan which links to multi agency/partner strategies to review access to services, transfer of care cases and demand on other health services (ambulance, A&E as examples).

In addition, BCUHB will seek to further support the Abbey Road facility (Bangor) through the Well North Wales programme of work, to provide access to a range of support including community health services. To complement the Food Poverty programme, BCUHB will work collaboratively with the Mental Health voluntary sector organisation at Abbey Road to form a community café which will be run by homeless individuals.

Work stream 3: Staff Health and Well-being

This work stream will look to develop our understanding of our staff needs and requirements, ensuring that we will have a health, supported and resilient workforce for years to come. As a result of the work, there will be plans in place to support staff health and well-being and also how we will support an increasingly aging workforce. This work stream will seek to help staff make positive changes in their lifestyles and promote mental well-being. It will also focus on developing best practice and support for staff in our employment, or people seeking employment with us, who may fall within the definition of 'protected characteristics' as set out in the Equality Act 2010.

Our guiding model will be based on delivering workplace health, mental well-being and general well-being.

2018-2020 key outputs include:

- Work with managers to conduct assessment of staff health needs and identify appropriate health surveillance for all staff groups and the older workforce.
- Develop a longer term occupational health and well-being strategy which meets the evolving needs of the organisation and attains the evidence required for platinum corporate health standard criteria and SEQOSH occupational standards.
- Engage staff and managers to embed the health and well-being agenda within teams to support conducive environments.
- Identify initiatives and pathways to supports aspects of lifestyle and well-being.
- Embedding a Five Ways to Well-being approach and time to change action plan through application of educational programmes and local level support for mental well-being.
- Review current engagement methods and initiatives for staff in relation to vaccination uptake.

Improving Health and Tackling Health Inequalities

We continue to work with a range of divisions across Public Health Wales to ensure our improving health and tackling health inequalities activity benefits from the work in the national Public Health Wales programmes, and we fully utilise the observatory data analysis reports. The Health Board holds regular Board to Board meetings with Public Health Wales and the Memorandum of Understanding is in place to support accountability and delivery aspects.

BCUB will continue to progress collaborative working for improving health and well-being together with Public Service Board partners, voluntary groups and the public, thus ensuring the promotion of positive health behaviours as a fundamental underpinning principle for all transformational change in North Wales.

In addition to the above primary areas of action which link to our strategy development, there is significant work in the following streams

- We will continue the core areas of health intelligence systematically getting evidence into practice as we maintain our transformation approach and develop our 'value' agenda.

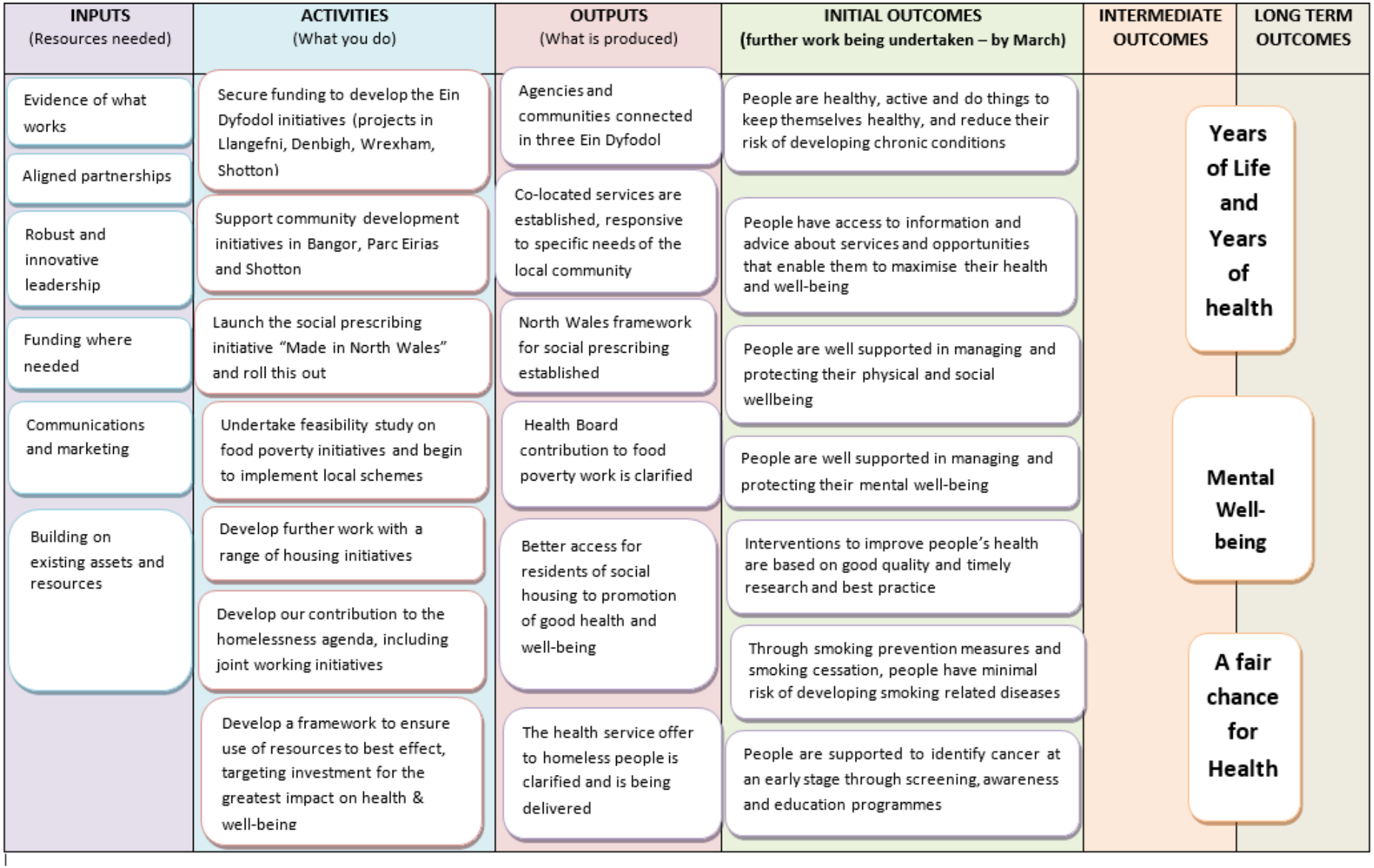
- The Green Health approach will be progressed as agreed under the Mid Wales Healthcare (MWHC) agenda. This links to our Mental Health and public awareness work and in an embedded partnership approach.
- Work with the Armed Forces in Health Sub Group to support the commitment the organisation has made is to the Armed Forces Covenant (including Veterans).
- Work with the Public Health Wales Screening Engagement Team to promote screening and increased uptake of screening programmes in populations where uptake is low.
- Support the Healthy Schools Programme across all six Counties to increase the proportion of accredited schools and pre-school settings.
- We are exploring opportunities to support the emerging public health issue of gambling as identified in the CMO Wales Annual Report (2018). We note potential links to our current work on Mental Health & Wellbeing, tackling alcohol awareness and also substance mis-use work with partners.
- We are refreshing our long-standing Oral Health Strategic Plan and constantly reviewing our work on the Designed to Smile agenda.
- We will refresh plans for Falls prevention and support the 18/19 Priority Falls work streams within our acute hospital sites.

The following logic models convey on a single page the underlying theory of change driving our thinking with Improving Health and Tackling Health Inequalities and provides a high level summary of our prioritised actions.

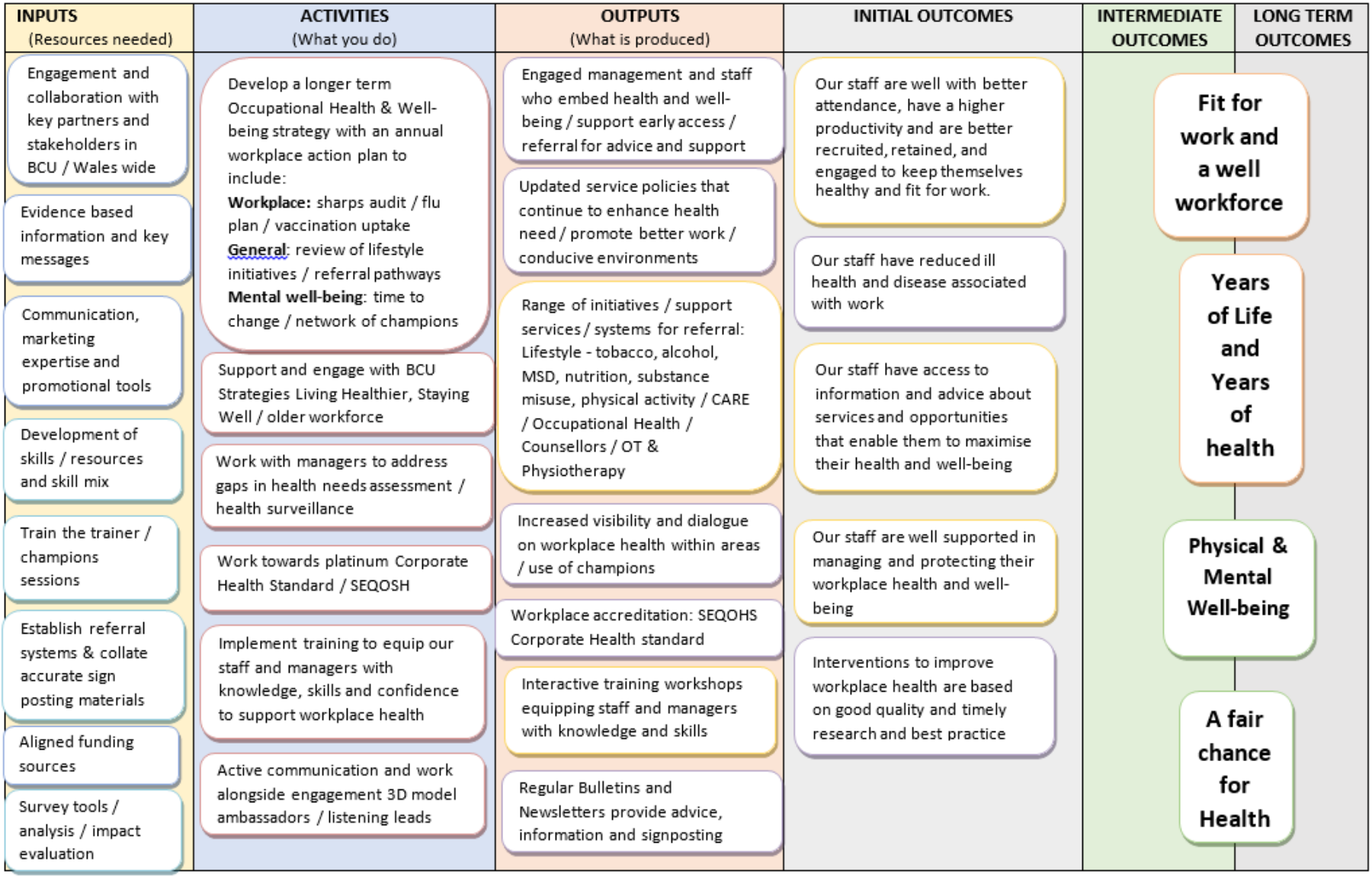
Improving Healthy Lifestyles Logic Diagram / Plan on a Page

INPUTS (Resources needed)	ACTIVITIES (What you do)	OUTPUTS (What is produced)	INITIAL OUTCOMES	INTERMEDIATE OUTCOMES	LONG TERM OUTCOMES
Evidence of what works	Implement Smoking cessation services in acute hospitals	Rapid access to smoking cessation support	People are healthy, active and do things to keep themselves healthy, and reduce their risk of developing chronic conditions		Years of Life and Years of health
Aligned partnerships	Develop and implement weight management pathway for children and adults	Preventative interventions aligned to all clinical and service pathways	People have access to information and advice about services and opportunities that enable them to maximise their health and wellbeing		
Short term resource to initiate skills development	Develop support for alcohol awareness and reducing alcohol use to safer levels	Consistent and clear messages about alcohol harms	People are well supported in managing and protecting their physical and social wellbeing		
Communication and Marketing expertise	Develop and implement action plan to support the 5 ways to wellbeing	Promotion and protection of mental wellbeing built into all service pathways.	People are well supported in managing and protecting their mental wellbeing		Mental Wellbeing
Training of Trainers to enable cascade of skills	Further develop the Get North Wales Moving programme	Confident and skilled staff delivering consistent advice on all aspects of lifestyle	Interventions to improve people's health are based on good quality and timely research and best practice		
Alignment to existing systems for signposting information (e.g. SPOA / DEWIS /NHS Direct)	Equip frontline staff with the knowledge, confidence and skills to Make Every Contact Count	Awareness & understanding of suicide and self harm risks and prevention amongst staff and the population	Through smoking prevention measures and smoking cessation, people have minimal risk of developing smoking related diseases		A fair chance for Health
Aligned funding sources	Develop creative arts framework and strategic plan with partners		People are supported to identify cancer at an early stage through screening, awareness and education programmes		
	Implement Suicide and self harm prevention strategy				

Tackling Health Inequalities Logic Diagram / Plan on a Page



Staff Health and Well-being Logic Diagram / Plan on a Page



Improving Health and Tackling Health Inequalities Three Year Plan 2018/21

Overview

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Improving Health														
Improving Health	Developing Learning - create an organisational repository for capture of best practice, information, contact information, progress reports in relation to improving Health													
	Embed - Create an overarching communication plan to include special interest events and acknowledge achievement													
	Transform - review Transformation Group Terms of reference and membership in line with the 3 year plan and establish reporting structures													
	Design and develop an evaluation plan which will contribute to measuring the success of the overall plan													
	Contribute - review attendance and participation in local and national groups/boards and identify where our input can make the biggest impact													
Smoking Cessation Services	Implementation of the Help me quit for baby service (HMQ)													
	Specialist service developed by Public Health Directorate and BCUHB during 17/18. Now operational and requires ongoing support to ensure high level of referrals and quits are recorded													
	Review handover arrangements between Public Health Directorate and BCUHB for embedding HMQ for Baby service into midwifery services													
	Review HMQ for Baby service documentation to include protocols, resource and manuals and updated as required to meet current recommendations													
	Undertake quarterly review of HMQ for baby service performance and escalate issues where required													
	Development of a single database system to capture smoking status throughout pregnancy													
	Help me Quit - Secondary care smoking cessation													
	Implementation of the secondary care smoking cessation service, funded by Respiratory Health Improvement Group until October													
	Undertake quarterly review of the service performance using outcome data from CO monitors and escalate issues													
	Evaluate the impact of the service													
	Secondary care smoking cessation service for full sites (inc MH)													
	Develop business case and agree BCUHB funding for continuation of service beyond Oct 2019													
	Cluster plan's to reflect smoking cessation as a priority and increase in referrals to smoking cessation services													
	Review prescribing practice within primary care for nicotine replacement therapy													
	review the outcome of the HMQ Primary Care pilot and agree next steps													
	Development of the primary care offer including agreement of funding requirements and targets via Cluster Leads													
	Quarterly benchmarking of quit rates against agreed standards by all specialist providers													
	Escalation of underperformance and remedial action where necessary													
	Health board occupational health services to record smoking status of all staff with whom they are in direct contact, and motivate, advise and record referral to smoking cessation services													
	Health board occupational health service to signpost to Help me Quit in any relevant communications activity													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Undertake review of progress against the requirements of the Tobacco Control Delivery Plan Wales 17-20													
	Continuation of smoking cessation schemes 17/18 - including in reach primary care programmes and integration of Quit Manager													
	Revisit Smoke Free Site activity given the Public Health (Wales) 2017 Act requirements													
	Review Local Enhanced Service through GP													
	Review current marketing,comms and media activity (Local/national) for raising awareness of the integrated smoking cessation													
	Actively participate and develop the Health Board role in the Tobacco control Strategic Board, advising on cross sector strategies and illicit/illegal tobacco use in North Wales													
	Review dental referrals to smoking cessation services by 2020, 2.5% adult smokers attending dental practices, target areas of greatest need.													
Mental Health and Well-being - Suicide & Self Harm	Identify staff in close proximity to those with history of self-harm and those with suicidal ideation													
	Utilise training programme – prioritising those who have been identified, rolling out to tertiary staff and services year on year													
	Review implementation programme of 'Time to Change' with regard to suicide and self-harm													
	Develop a local multi-agency suicide and self-harm communications plan with focus on recognised campaigns (Mental Health awareness week, World Suicide Prevention Day, World Mental Health Day													
	Raise understanding and awareness of helplines and target promotion accordingly													
	Develop workplace guidance													
	In partnership with other identified organisations, deliver the Mental Health Transformation Plan (Care Crisis models)													
	Early identification and treatment of depression													
	Identification and support of women with a possible mental disorder during pregnancy or the post-natal period													
	Develop a local multi-agency suicide and self-harm communications plan with focus on recognised campaigns (Mental Health awareness week, World Suicide Prevention Day, World Mental Health Day													
	Support implementation of NICE clinical practice guidelines													
	Develop North Wales Suicide and Self-harm Community Response Plan													
	Develop School and college based approaches to promote awareness among staff, pupils and parents and raise knowledge of referral routes and support													
	Regular assessment of ward areas to identify and remove potential risks													
	Produce annual data report to ensure that local relevant data is collected and shared between partners to inform and monitor trends and local activity													
	Assess the suitability of effective national suicide prevention interventions for local implementation													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mental Health & Well-being - Creative Arts	Engage with partner organisations in developing Concordat through facilitated workshop													
	BCUHB to attend follow up workshop to finalise Concordat and formulate action plan for delivery between partners on agreed themes													
	Formal sign off by partner organisations													
	Launch of Concordat and action plan in BCUHB													
	Delivery of Action plan													
	Recognition at wider level (Arts council, Welsh NHS Confederation)													
	Graduate Teaching Assistant (PhD Student in residence)													
	Identify whether and how arts activity improves the well-being of BCUHB service users													
	To assess, develop and mage the competence of BCUHB arts practitioners and the quality of their outputs													
	To grow its arts and health output within BCUHB in a financially and practicably sustainable manner													
Mental Health and Well-being - Five Ways to Well-being	Develop a local multi-agency communications plan with focus on recognised campaigns (Mental Health awareness week, Day, World Mental Health Day)													
	Develop website presence with stories, tools and links to key resources and support													
	Agree local leads													
	Review progress of pilot work with Hafod													
	Develop further teams to work with implementing a Five Ways package													
	Delivery of Training workshops to staff													
Making Every Contact Count (MECC)	Governing Group formed and plan approved													
	Engagement events													
	champions identified (Train the trainer)													
	resources identified and central repository created (intranet presence and website use)													
	MECC Framework for 19/20 agreed													
	Training programme established - MECC level 1													
	MECC level 2													
	Measure engagement and whether MECC embedded (survey and evidence)													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Obesity, reducing sedentary behaviours, healthy weight healthy diet	Healthy Weight - Establish a Tier 3 Obesity service for Adults		■											
	Commence service			■										
	Roll out service across North wales				■									
	Evaluate and refine service					■								
	Develop a Tier 2 Model for Adults - Tier 2 Business Case developed			■										
	Tier 2 programme Children - pilot delivered and evaluated	■	■											
	Child measurement Programme (CMP) system reviewed and new model developed			■										
	New information letters developed to support CMP		■											
	New model trialled				■									
	Communication s plan developed and delivered		■	■	■	■								
	Yr 2 Continue to improve and embed programmes to promote health weight and develop services to support obese adults, children and young people through various aspects of service, based on evidence, capacity and funding						■	■	■	■				
	Level 3 service for Children & Young Persons (dependent on funding)						■	■	■	■				
	Actively promote key healthy weight messages and programmes to maintain healthy weight in children and adults						■	■	■	■				
	Yr 3 - continuation of existing programmes of work and additionally Level 2 pathway (all ages) implemented across North Wales (depending on funding)										■	■	■	■
	Increasing physical activity & reducing sedentary behaviour - support the development of the GNWM (Get North Wales Moving) collaborative, agree and sign the formal Charter		■											
	Pledge activity against the key principals		■											
	Develop action plan to support delivery			■										
	Share and learn form good practice		■	■	■	■								
	Develop and implement Yr2 campaign focussing on moving more and sitting less - GNWM						■	■	■	■				
	Focus on working with partners to increase the access and use of green spaces to improve physical and mental heath						■	■	■	■				
	Work with organisations to promote physical activity and ensure the work environment is conducive to reducing sedentary behaviour						■	■	■	■	■	■	■	■

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Alcohol Reduction	Alcohol licensing - provide information to produce minimum dataset to inform licensing responses													
	review data to inform licensing responses at regular intervals													
	Utilise data to work with partners to inform current and new systems and highlight local needs													
	Adopt new framework to inform alcohol licensing responses													
	Alcohol Awareness - form delivery group													
	Identify priority groups for roll out of awareness raising campaign													
	identify the measures for success/monitoring													
	Produce communication plan for raising awareness													
	Identify leads in each area for supporting roll out of awareness raising campaign													
	Identify Cluster practices to work on specific targeted campaigns													
	Deliver Yr 1 campaign													
	evaluate effects - access of supportive services, attendance rates, information requests													
	Deliver Yr 2 Campaign - based on re-evaluated target groups													
	evaluate effects - access of supportive services, attendance rates, information requests													
	Deliver Yr 3 Campaign - based on re-evaluated target groups													
	evaluate effects - access of supportive services, attendance rates, information requests													
	3 Year delivery - evaluate overall success of campaign - effects on primary/secondary referrals, data from partner organisations (police, third sector etc.)													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Immunisation and Health Protection	Recruitment of area immunisation nurses													
	Increase knowledge by reviewing evidence base on effective strategies and best practice to meet the needs of hard to reach individuals that are under vaccinated													
	Increase knowledge about local existing pathways to vaccinate hard to reach groups													
	Deliver workshops with school nurses in each area prior to the start of the 2018-19 academic year to improve knowledge and raise awareness about responsibilities to their caseload.													
	Improve data accuracy by data cleansing Year 8 and Year 9 immunisation information on girls that attend schools out of the health board area before the end of the 2018-19 academic year													
	Improved data accuracy by data cleansing Year 10 and Year 11 immunisation information on all pupils that attend schools out of the health board area before the end of 2018-19 academic year													
	To identify children aged 3 years and 8 months that are under vaccinated and inform health personnel to liaise with the parent/guardian to facilitate vaccination													
	To increase knowledge for members of the public and develop factual information for BCUHB internet website													
	Influenza **:** Development of the Flu Plan (and subsequent reviews annually)													
	To commence implementation of the agreed action plan to ensure efforts are made to address issues prior to the commencement of the next influenza campaign commencing September 1st. Adjustments may need to be made during the campaign based on uptake data or vaccine supply issues.													
	To explore new opportunities with secondary care to vaccinate people with some at risk conditions													
	To implement a scheme to vaccinate the homeless													
	Update immunisation information on BCU internet website													
	Ensure clear pathways are in place to vaccinate young children if under vaccinated by 3 years and 8 months.													
	Immunisation training will continue to inform colleagues of best practice/initiatives to increase the uptake and report uptake													
	Review quarterly uptake for immunisations: 2nd MMR at 4 and 5 yrs; 4th dose of diphtheria, tetanus, pertussis, HIB at 4 and 5 yrs;													
	Annual review of immunisation uptake of: HPV at 14 yrs; teenage booster aged 16 yrs; number of immunisations given at home													
	Influenza campaign: Monitor weekly immunisation uptake and adjust plans if required to address issues during the flu campaign													
	Update immunisation information on BCU internet website													
	Ensure clear pathways are in place to vaccinate young children if under vaccinated by 3 years and 8 months.													
	Immunisation training will continue to inform colleagues of best practice/initiatives to increase the uptake and report uptake													
	Review quarterly uptake for immunisations: 2nd MMR at 4 and 5 yrs; 4th dose of diphtheria, tetanus, pertussis, HIB at 4 and 5 yrs;													
	Annual review of immunisation uptake of: HPV at 14 yrs; teenage booster aged 16 yrs; number of immunisations given at home													
	Influenza campaign: Monitor weekly immunisation uptake and adjust plans if required to address issues during the flu campaign													
	Maintain planning work for emergencies/incidents/threats from infectious diseases													
	Continue work with the Public Health Wales health protection team re community disease control													
	Maintain awareness raising for screening services and planning for changes to bowel, cervical and anti-natal programmes													
	Continue work with partners inc Local Authorities regarding the wider health protection agenda (eg environmental)													
	Promote improvement in Long Acting Reversible Contraceptive (LARC) prescribing by GPs by supporting clusters to address variation in working to national guidance													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Sexual Health	Promote improvement in Long Acting Reversible Contraceptive (LARC) prescribing by GPs by supporting clusters to address variation in working to national guidance													
	Promote and seek to strengthen the North Wales Condom C-card scheme by advocating for the work at strategic levels													
	Maintain links with the Sexual Assault Referral Centre (SARC), monitor quantitative and qualitative data from the centre and ensure this informs prevention services by linking with ACEs prevention work													
	Support local/national public health targeted prevention campaigns – continue this locally via our own SEXtember campaign													
Health and Well-being Centre Development	Complete gap analysis													
	Progress pipeline priority schemes													
	engage and agree with clusters and practices the priority areas for improvement grant investment													
	Engage with stakeholders													
	Commence work to identify resource implications													
	finalise and approve estates strategy													
	Develop implementation plan and business case as required													
	progress pipeline priority schemes													
	Engage with stakeholders													
	Information advice and assistance implemented													
	Complete priority schemes													
	commission training packages													
	Engage with stakeholders													
	Information advice and assistance implemented													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tackling Health Inequalities														
Made in North Wales' Social Prescribing Programme	Appoint project management support and establish steering group													
	identify current practitioners and create network													
	Map current activity													
	Roll out to 50% of participating clusters													
	Roll out to 100% of participating clusters													
	Produce evaluation report													
	Agree next phase, including funding													
Well North Wales 'Ein Dyfodol'	Formation of local group in Pen-y-cae, Upper Denbigh, Llangefni,													
	Scoping exercise and needs identification in Pen-y-cae, Upper Denbigh, Llangefni													
	Agreement across the three areas													
	Apply for funding to roll out programme and support existing work													
	Identify best method and forums for capturing relevant activity													
	Create central repository for sharing good practice, stories, events													
	Identify cross working themes with partnership organisations													
Tackling Food Poverty	Form local steering group (Flint) and agree BCU contribution													
	Discussion and agreement with trade union representatives re: contribution to the programme both within BCU and with external													
	Initial scoping and agreement on project content													
	Introduction of targeted interventions													
	Agreement reached on target area Central													
	Agreement reached on target area West													
	Introduce programme into Central and West													
	Evaluation of programme and recommendations for future													
	Contribute to local partnerships re Housing and accommodation													
Homelessness	Wrexham and Gwynedd profile developed													
	Conwy profile developed													
	Denbighshire and Anglesey profile developed													
	Flintshire profile developed													
	Delivery plan developed based on identification of needs and services													
	Strategy completed													
	Extend provision of services at Abbey Road													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Advancing Equalities & Human Rights														
Better Health Outcomes for All	Strengthen scrutiny of EqIA in regards to service change driven by implementation of Living Healthier Staying Well strategy													
	Work with Deputy Medical Director to prepare for and implement the interim GI pathway for NHS Wales. Establish T&F Group to oversee this work													
	Provide Equality and Human Rights advice to the Improving Health and Tackling Health Inequalities Programme Transformation Group													
	Maintain ongoing public engagement via Equality Stakeholder Group (ESG) Expand membership of ESG to reach out to more groups													
	Maintain ongoing scrutiny of EqiA via Strategy, Planning Equality Scrutiny Group													
	Equality Week promotion and targeted awareness raising campaigns													
	Equality and Human Rights promotion and campaigns													
	Work with Head of Patient Experience to implement the Standards for Accessible Information and Communication													
	Support teams to identify equality and human rights themes from concerns and incidents													
Improved Patient Access and Experience	Communicate requirements of Welsh Government Advancing Equality and Human Rights delivery framework and work with Transformation Groups to embed													
	Provide EqiA training													
	Communicate requirements of Welsh Government Advancing Equality and Human Rights delivery framework and work with Associate Director Nursing Quality Assurance to embed													
	Provide equalities advice to Transformation Groups													
	Identify equality and human rights themes from patient experience activity													
	Facilitate equality training for concerns teams													
Becoming an Employer of Choice	EqIA recruitment strategy													
	Strengthen visible commitment to diversity within train, work ,live website													
	Analyse annual employment reports by protected characteristics													
	Stonewall Workplace Equality Index action plan Disability Confident action plan Working Forward action plan Gender pay action plan													
	Implement training plan Target primary care													
	Promote Equality Week													
	Mandatory Training Evaluation													
	Promote dignity at work policy													
	Promote North Wales hate crime campaign in partnership													
	Evaluate victim support pilot													
	Publish guidance and resources													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Inclusive Leadership at all levels	Facilitate Board Development session with Equality and Human Rights Commission													
	Identify Independent Board Member Equality Champion													
	Promote key messages via organisational campaigns and communications													
	Communicate requirements of Welsh Government Advancing Equality and Human Rights delivery framework and work to embed with Board Secretary													
	Implement training plan													
	Communicate requirements of Welsh Government Advancing Equality and Human Rights delivery framework and work with Director of Strategy and Planning to embed													
	Review Strategic Equality Plan (SEP) 2016-2020. Gather evidence. Undertake engagement. Develop draft equality objects. Undertake consultation. Board approval. Publish revised SEP 2021-2025.													
	Implement revised SEP and objectives.													
Staff Health and Well-being														
	Completing platinum portfolio													
	External assessment of the corporate health standard													
	Scope Safe Effective Quality Occupational Health Service (SEQOHS) requirements													
	Complete SEQOHS portfolio													
	Design health needs assessment													
	Engage managers with service meetings regarding well-being agenda													
	Service areas completes health needs/health surveillance assessment													
	evaluate and form actions													
	Draft initial strategy based on needs assessment													
	consult and implement strategy													
	review current pathways in place													
	Implement an evaluate all Wales Health & Well-being tool													
	Support communications and initiatives for lifestyle, health and well-being													
	Range of educational programmes through the year													
	regular messages, updates and meetings with local mental well-being champions													
	Promote mental well-being through engagement and listening leads													
	support communications and initiatives for mental well-being													
	Undertake staff flu service for those who have not had the flu jab in season 17/18													
	Evaluate the survey and assess beliefs													
	Design initiatives address beliefs													
	Embed and evaluate the effectiveness of the well-being strategy with staff and managers													
	Equalities team to review and develop guidance/best practice for dissemination regarding supporting staff with protected													
	Awareness raising/promotion of the available resources and guidance regarding supporting staff with protected characteristics													

5.2 CARE CLOSER TO HOME

5.2 CARE CLOSER TO HOME

People tell us they want to stay independent for as long as possible. They also want their care and support close to home, supported by family and community networks where available. We will support this where it is safe and effective to do so.

Our Vison for the Future

Our ambition for Care Closer to Home is to deliver integrated primary and community-based healthcare services which support people to stay healthy and live independently for longer. Our ethos is to support citizens to self-care and to work in equal partnership with people who use all our services, including family Carers to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it.

We aim to deliver much more care in the community, either in patients' homes or close to where they live and work. For example, in local Primary Care practices, Health Centres or Community Hospitals. Improving community-based services will reduce the need for some people to have a stay in hospital. For those who do need hospital care, our plans will ensure there is more support available locally so they can return to their home as quickly as possible.

It is important to ensure that local health care professionals and members of the wider team can meet needs in the right way at the right time. This includes GPs, pharmacists, specialist nurses and other community support, including dentists and optometrists. There will be other new roles to support the team, including closer working with the third sector. People will see the team member who is best placed to meet individual needs.

New roles will be developed and implemented to further support the Primary Care model. Advanced Practice Paramedics will deliver the urgent home visiting service, Physician Associates supporting GPs and a team that will support and help sustain our Practice network. These professionals will further enhance the multi disciplinary team that currently exists within Primary Care, whilst other schemes transition into core delivery services.

We will work with people to prevent, detect early and manage any deterioration to patient's physical and mental health. When people need care and support, we will put them at the centre of all that we do, providing support and coordinating their care needs in order to keep them healthy and independent.

Care will be developed around clusters which are a group of GP's working with other health and care professionals to plan and provide services locally. These will form the building block of future planning. An equitable range of services will be provided for all, although the way they are delivered will be tailored to meet local circumstances or geography. Some services will cover more than one area.

We will expand the services of our community teams, with a single point of contact who will arrange access to the right team member or service for people. Services will be integrated, working closely with a wide range of partner organisations, and focusing on "what matters" to the person.

We will maximise use of technology using evidence-based health videos and apps whilst preventing people having to travel for appointments, particularly when they have a need to attend regularly for a long-term health condition. We know that not everyone uses technology, and we will support people who don't have easy access.

More help will be provided for carers, recognising their individual needs as well as those of the person they care for.

We will invest in more modern, purpose-built facilities to bring services together under one roof, working with other public sector and third sector partners. We will use our premises, partner organisations' or other community facilities to develop health and well-being centres in local areas. This will include our community hospitals as part of the network of resources available to local areas. We will work with local communities to assess local needs and determine the best use of resources in the area to meet those needs.

What we will do in the First Three Years to Further Develop and Transform our Services
We will:

- Deliver the "Made in North Wales" social prescribing framework in partnership with the third sector.
- Support local services to work together better using the "cluster" model.
- Build on the resources in local communities.
- Look at ways to use community hospitals and other places as health and well-being centres.
- Work with local people to make best use of resources and develop the right plans for their area.
- Support GP practices better, developing and using a toolkit to manage pressures.
- Work with other organisations closely to develop community services.
- Develop Community Resource Teams that work with specialists to support patients in their community.
- Provide more support for carers within Community Resource Teams.
- Use technology better including information and advice apps.
- Develop new ways to identify and support people who have higher risks to their health.
- Develop and implement new roles and models, such as the Urgent Home Visiting Service, Physician's Associate and the sustainability and innovation team.
- Ensure safe transition of successful models to becoming core delivery services, i.e. Physiotherapy, Audiology, Pharmacy, and some Advanced Practice Nursing.

Outcomes We Want To Achieve

Plans for Primary Care and Community Services have been developed under the umbrella of our Care Closer to Home strategy. The desired outcomes as described in high level Logic Model/Care Closer to Home are:

- Access to the right information, when it is needed, in the way that the person would want it and support improvement of wellbeing.
- Easy and timely access to primary care services.
- Health and care support delivered at or as close to the persons home as possible.
- Individual's will know and understand what care, support and opportunities are available and use these to help achieve health and wellbeing.

- To ensure the best possible outcome, condition is diagnosed early and treated in accordance with clinical need.
- Interventions to improve health are based on good quality and timely research and best practice.
- Individuals are safe and protected from harm through high quality care, treatment and support.
- Quality trained staff are fully engaged in delivering excellent care and support to individuals and their family.

Key Outcome Indicators

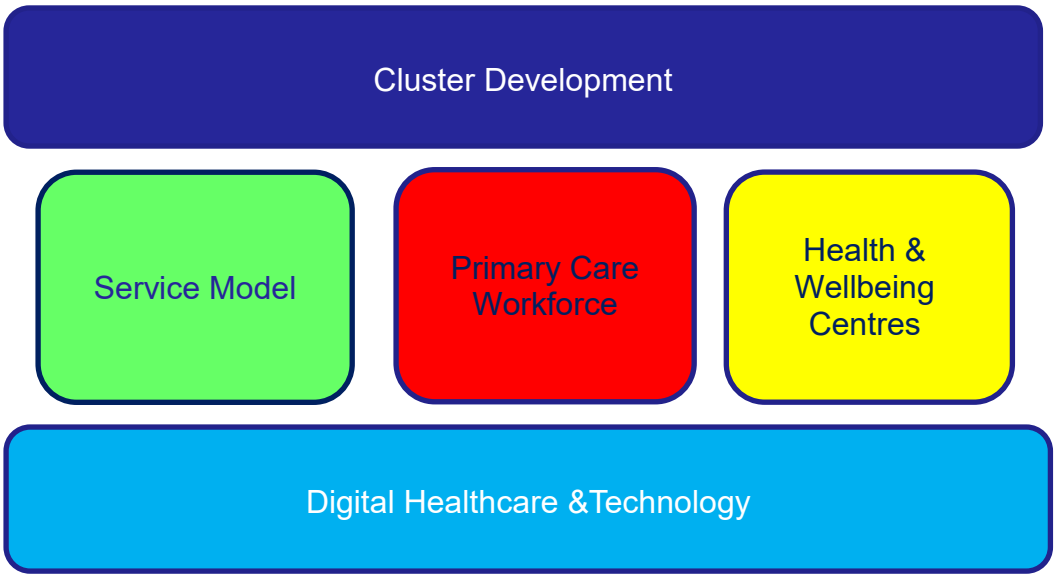
We will use a range of indicators to measure our progress, key examples of which are set out below:-

- Access to GP practices and opening hours
- Reduction in the percentage of people (age 16+) who find it difficult to make a convenient GP appointment
- Improved Community Resource Team Coverage
- Performance against selected Out of Hours service indicators
- Percentage of the heath board population accessing NHS primary dental care
- Improved access to Community Dental Services
- Increase in access to social prescribing activities.
- Increase in outpatient follow-up within a primary and community setting
- Reduction in patients being delayed as their care is transferred out of a hospital
- National prescribing indicator rate for antibacterial items, anti-depressants, painkillers
- Implementation of new roles and models into Primary Care to support sustainability, increase access to care in the community and shift services out of hospital Secondary Care settings.

2018/21 Work Programme

We have identified five priority work streams for the next three year's:

- Cluster development - support the development of clusters to enhance their role in designing and delivering primary and community services.
- Service Model - improve access to sustainable primary and community care services. We will expand the number of integrated multi-disciplinary community teams and develop our staff to engage with individuals to deliver support which reflects "what matters" to them.
- Primary care workforce - build on work done to date to introduce a broader range of health and social care professionals including Specialist Nurses, Pharmacists and Therapists into independent and managed GP practices. These will include new roles such as Paramedics, Physician Associates and a sustainability team.
- Health and Well-being Centres - in support of Care Closer to Home an estate strategy for primary care will be developed.
- Digital healthcare and Technology - improved access to digital technology in the community, IT equipment, telehealth, supported self-management.



Work Stream One: Service Model

Utilising cluster and primary care funding a number of new ways of working and roles in primary and community services have been tested over the past three years. Alternative models of GP practice and workforce are developing in a number of health board managed and independent practices. The Healthy Prestatyn managed practice has developed a model of care which focuses on a "less medical, more social model"; with a focus on lifestyle and prevention and investing in a more integrated multi-disciplinary team. The team is still learning, and whilst there has been ongoing public engagement, a continuous change in culture and systems, as well as valuable leadership learning, there is more to do in delivering this model to its full potential. There is also a need to ensure the new workforce is available to effectively deliver this model going forward including the development of social prescribing across North Wales.

The Service Model Development work stream will also see the development of a primary care sustainability team to support GP practices and lead the roll out a new service model for patients in our clusters and practices in line with the Care Closer to Home strategic priorities with partners. Importantly, it will also encompass the role of health promotion and education.

Community Resource Team development plans will build on existing work to provide a multi-disciplinary 24/7 workforce who will provide advice, care and timely coordinated services and support for individuals and carers within their own homes, care homes and communities to keep people at home and enable faster discharge for others. Services for Children and Adults, mental and physical well-being, will be aligned within the CRT model.

A new contractual framework was introduced for community pharmacy in April 2005. It utilised the skills, expertise and experience of pharmacists and their staff and ease of access. Community Pharmacy has been identified by Welsh Government for service transformation and investment, with, £1m and £0.5m to support the implementation of a pharmacy quality programme and to support collaborative working between pharmacies and other primary care providers through our network of primary care clusters. WG intends further changes in the funding structure of Community Pharmacies to further increase the level of funding available to support national and local enhanced

service commissioning by at least a further £2m in 2018-19. Funding will also be made available from within the total community pharmacy contract funding to support community pharmacy workforce development.

Our Plan includes recommendations that we prioritise the following community pharmacy developments in this order and develop pace setter projects to support the development of the enhanced service frameworks:

1. Completion of the Choose Pharmacy roll out – common ailments and emergency supply service.
2. Further establish the role of community pharmacy to supporting vaccination programs within the community.
3. Roll out the National enhanced service for care homes to support the delivery of safe, efficient medicines management for residents.
4. Establish a Pace setter project (up to 15 community pharmacies in N Wales) of a community pharmacy enhanced service to support domiciliary care. This will support the fragile social care and domiciliary care / services in N Wales.
5. Develop Community Pharmacy Enhanced services that will support the framework for commissioning of independent prescribing clinics from community pharmacy to meet identified service need.

The Health Board has recently completed a tender process for additional dental activity that will commence in 2018/19 and will increase access rates across the Region in time. We will also commission additional recurrent and non-recurrent activity from unallocated funds available during the year Four contractors are taking part in the contract reform pilots and we will continue to support this work and seek other participants in phase 2 to improve access especially to people with greater oral health needs.

We will continue to progress the oral health plan.

Closer working relationships between eye health care professionals will be fostered to develop the concept of seamless MDT between primary and secondary care with a philosophy of ‘primary care first’. Agreement will be sought from optometry practices to share patients and to establish MDTs of medical and non-medical professionals grouped around clusters.

In 2018-19 we will;

- Establish pathway redesign groups for cataract glaucoma, AMD and OHT
- Post cataract surgery discharge to EHEW
- Develop pan Health Board consistent referral process
- Complete revision of pathway information to signpost patients to local services

In response to the WG Framework for Action on Hearing Loss 2017-20. we will pursue health board actions relating to the Welsh Government policy for integrated care and support for people with hearing loss, described in the Framework of Action for Wales 2017-2020.

The Supported Accommodation section of this work stream aims is to support people to live in the place of their choice. It is recognised that limitations in the market means that there is not the full

range of accommodation to meet the needs of our population. Working with our partners we will support people wherever they live, for example, extra care housing /supported accommodation and home or hospice care at end of life. This work stream supports our vision and service model of care closer to home, encompassing four key projects:

1. Working with partners to ensure people can receive access to minor repair, maintenance and adaptions – this will provide a structured, easy to access and responsive service for repair, adaptation and maintenance of housing to the population of North Wales. This project does not relate to any aspect of the Disabled Facilitates Grant (DFG) which is part of the function of the Local Authorities.
2. Community equipment project will undertake a review of community equipment services to the population of North Wales. Shared arrangements have been in place for 10 years for storage and delivery of equipment for use in people's homes. Arrangements vary across the region and there is an opportunity to streamline and share best practice across North Wales and potential to identify cost efficiencies in doing so.
3. Housing based solutions for admission prevention and discharge support will provide an increased number of housing based solutions to admission and step down care supported by the integrated working of each Community Resource Team. The aim is to reduce some admissions into hospital and reduce the number of patients who are placed in a longer term care environment.
4. Long term care sector support will provide a range of activities to support the long term care sector.

Work Stream Two: Primary Care Workforce

There is an urgent need to establish a robust system to keep up to date information about the primary care workforce including independent contractors. This will include the anticipated retirements and leavers, as well as the availability and retention of the multidisciplinary workforce, with improved planning to ensure future service sustainability. The learning from new ways of working and roles needs to be used to develop a plan for recruiting, training and retaining the necessary staff to maintain and develop services.

The Primary Care Workforce work stream will develop and support workforce planning, training, recruitment and retention across primary care services, inclusive of wider primary care professionals working with partner organisations.

Key examples from our plan include:

- Develop a Primary Care Academy to develop & support greater opportunities for more training placements and mentorship to ensure the delivery of the workforce model
- Develop a local bespoke training programme, acknowledging & supporting a 'grow your own' approach eg advanced practitioners, OTs, Team coordinators
- Recruitment and retention plans with supporting training plan
- Expand number of physiotherapists, pharmacist, ANPs, UCPs, community navigators in primary care.

Work Stream Three: Health and Well-being Centres

This represents a new and exciting work stream which will lead upon the development of Health and Well-being Centres within clusters working with community staff in line with the three levels identified within our Care Closer to Home Strategy as follows:

Level 1: **Health & Well-being Centre**
Medium to large local campus, building on existing or developing new Primary Care practices, Health Centres or Community Hospitals.

Level 2: **Health & well-being Hub**
Provision of access to health and well-being services to meet needs in primary care settings.

Level 3: **Well-being and Health Access Points**
Local points where health and well-being advice and information services are provided in community facilities.(see also health improvement section of the plan)

The Health and Wellbeing Centres will be within clusters, where a range of information, early intervention and services are available with co-location of other service providers such as GP practice services and enhanced care. Level one H&WB Centres will include minor injuries and illness services or step up and step down care beds. The Health and Wellbeing Centres have been developed into three levels of service provision as described in the Primacy Care section.

Facilities will be developed with our partners and aligned to the needs of the local population to ensure that there is equity of access to a range of information, early intervention and services across North Wales. This may include co-location of other service providers, inclusive of GP practice services and enhanced care, minor injuries and illness services or step up step down beds.

We have already undertaken significant work in assessing the condition of the primary care estate and identifying priorities for taking forward. Within the Programme, there will be a number of specific re-development projects, including:

- Development of services on Llandudno Hospital site
- North Denbighshire Community Hospital
- Central & South Denbighshire Hub
- Waunfawr development
- Development of health and Well-being precinct in Flint

Work Stream Four: Cluster Development

We will adopt the national cluster governance model. The 14 clusters are developing into effective groups to identify local issues and priorities and deliver agreed actions supported by cluster funding. There is a need to extend the membership, remit and delegated responsibilities of clusters over the coming three years, including consideration of them commissioning and managing primary, community and acute services.

The Cluster Development work stream encompasses the development and support to cluster level planning and delivery, inclusive of wider primary care professionals and other stakeholders.

Work Stream Five: Digital Healthcare and Technology

The main priority for this work stream is IT equipment for members of staff based in Community settings who spend significant amounts of time away from their hospital base. The Digital Healthcare and Technology work stream will focus upon improved access to digital technology to enable patients and members of the multi-disciplinary clinical team and secondary care colleagues to communicate at a cluster level. The technology will provide patients with quick and easy access to information about their conditions and/or treatments that could reduce the need for appointments, attendance at the Emergency Department and enable individuals to stay at home. The project encompasses three key elements:

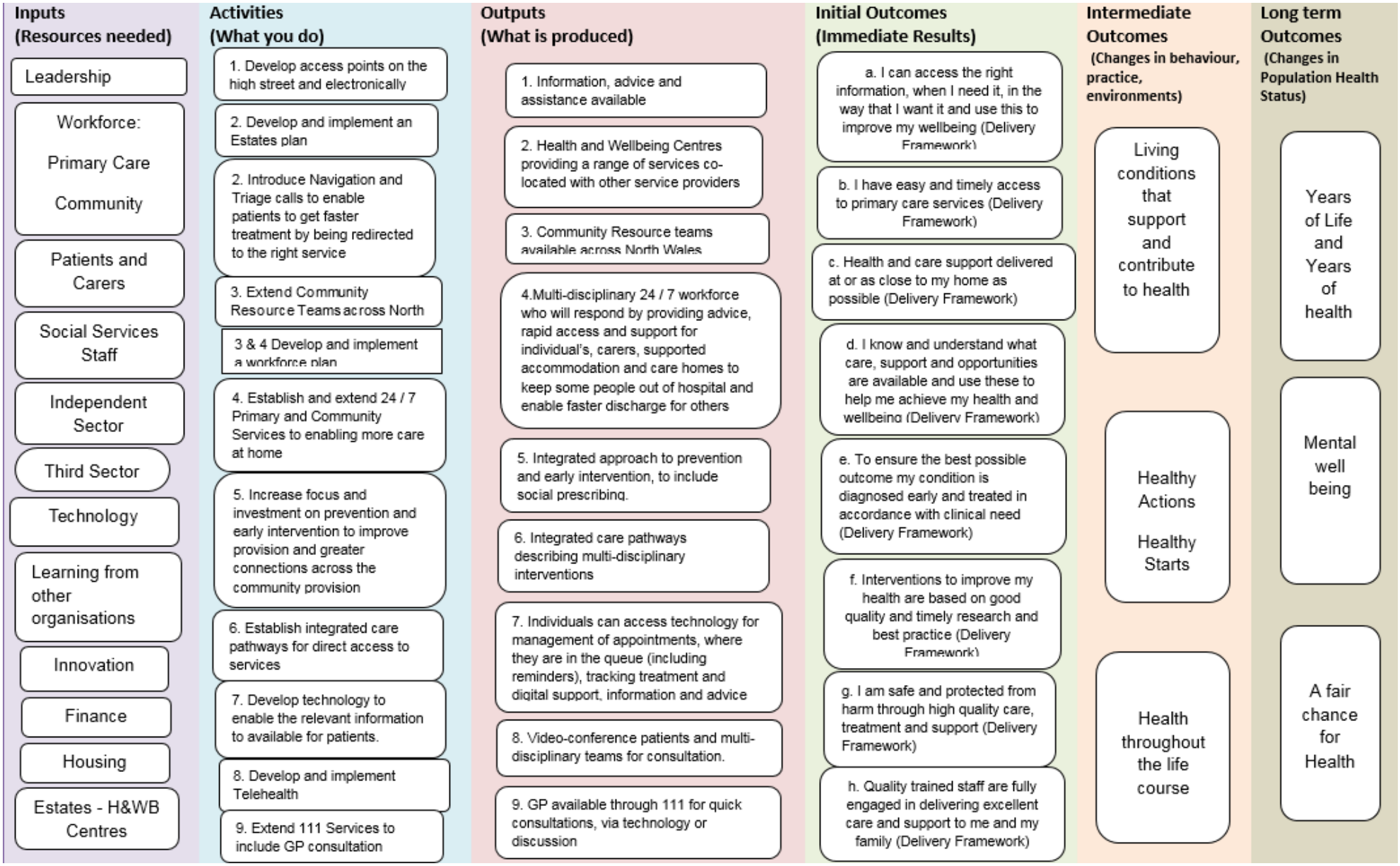
1. Telehealth
   a) the development of a system/process to provide clinics via telehealth technology enabling patients to attend appointments over video either from their own home or a location closer to their own home, recognising the variances in geography (e.g. rural, distance from a health facility) across North Wales.
   b) To explore use of telehealth technology within nursing homes with the aim to increase the number of people being supported within a nursing home setting.

2. Patient Administration System/Electronic Patient Records – this project will enable improved connectivity between primary, secondary, community care and social care giving clinicians a complete view of a patient's health. It will also increase patients access to information e.g. where they are on the waiting list. An example of this will be developing the functionality of Lillie for sexual health services to enable to direct booking for patients and electronic patient record. Having improved access to patient information including performance data whilst out in the community, will enable community teams to operate more efficiently and communication between primary care and community services will also be improved. The work stream is aligned to the National Plan for the development of WCCIS roll out and will require support both in terms of project management and capital investment in technology e.g. tablets and laptops. If WCCIS is delayed, alternatives need to be developed on an interim basis.

3. Supported Self-Management– the provision and promotion of use of health videos and apps in patients home to provide information on their specific condition and/or treatment. The roll out of this information will reduce the need to attend appointments in primary care as well as attendance at the Emergency Department and reduce hospital admissions. Importantly, the programme of roll out will take into account a proportion of the population who will not want to utilise technology in this way.

The following logic model conveys on a single page the underlying theory of change driving our thinking with Care Closer to Home and provides a high level summary of our prioritised actions.

Care Closer to Home Logic Diagram / Plan on a Page



Care Closer to Home Three Year Plan 2018/21

Overview

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Service Model	Develop models and governance and performance management arrangements of managed practices													
	Contract or equivalent in place for cluster procurement of workflow system support.													
	Extend GP practice sustainability teams to support practices facing difficulties and considering resigning contract. This will be led by the Bevan Exemplar as a new Primary Care funded scheme.													
	Working with CRTs maximise care co-ordination within Primary Care settings.													
	Review current range of support and inputs offered to care homes to identify gaps and duplication of provision. Identify priorities for future development.													
	Roll out social prescribing linked to urgent care and out of hours. This will be a new Primary Care funded scheme.													
	Med-Mgmt. - Develop training opportunities to enhance skill mix of community pharmacy													
	Med-Mgmt. - Support the development of All Wales Pharmaceutical Needs Assessment													
	Med-Mgmt. - Enhance pharmacy support for medicines management in community hospitals													
	Med-Mgmt. - Support development of CRTS and embed pharmacy support within MDTS													
	Undertake a review of pharmacy and medicines management services and staff, implement opportunities for re-design													
	Roll out risk stratification systems and processes to enable early identification and management of patients most at risk of being admitted.													
	Identify and implement measures to improve access to Primary Care by further developing existing and introducing new roles, models and services.													
	Develop and implement a commissioning plan for GMS Enhanced Services.													
	Dentistry - Additional tendered services to become available for patients													
	Dentistry - Commission additional recurrent and non-recurrent services from unallocated funds													
	Complete a review of Community Dental Services.													
	Continue dental reform project													
	Continue to implement actions from local oral health plan													
	Commence implementation of actions plans from 'Sustainable Eye Care Services for North Wales													
	Optometry - All referrals and scans electronic following an ocular coherence tomography OCT scan (to detect eye conditions)													
	Promote eye health and role of Eye Clinic Liaison Officers (ECLO) to provide information and advice on: Living with sight loss and remaining independent.													
	All referrals and scans electronic.													
	Optometry – review pathway changes and amend if necessary.													
	Continue with commissioning of all Wales enhanced services and dental services for 2021													
	Evaluate benefits of social prescribing services commissioned													
	Completion of the Choose Pharmacy roll out – common ailments and emergency supply service.													
	Further establish the role of community pharmacy to supporting vaccination programs within the community													
	Roll out the National enhanced service for care homes to support the delivery of safe, efficient medicines management for residents													
	Establish a Pace setter project of a community pharmacy enhanced service to support domiciliary care													
	Develop Community Pharmacy Enhanced services to support the framework for f independent prescribing clinics from community pharmacy to meet identified service need													
	Progress board actions relating to the Welsh Government policy for integrated care and support for people with hearing loss, described in the Framework of Action for Wales 2017-2020													
	Improve access to Mental Health services in primary care.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Care Home support fully implemented.													
	Continue roll out of social prescribing.													
	Commence roll out of risk stratification model and system													
	Commission all Wales enhanced services for 2019/20.													
	Finalise agreement of Model with Local Authority partners.													
	Support Primary Care in the delivery of risk stratification approach.													
	Gap analysis completed – baseline against plan established.													
	Workforce and training plan developed.													
	Continue to roll out Community Resource Team plan (integration of existing teams).													
	Evaluation – review Community Resource Team model and impact.													
	Identify further integration within teams and partner agencies.													
	Develop business case for further development to balance demand and capacity.													
	Report on impact of introduction of risk stratification.													
	Evaluate and monitor impact on primary and secondary care services.													
	Further refine model and agree opportunities for further alignment and integration of services.													
	Supported Accommodation Project 1: Access to minor repair, maintenance and adaptations													
	Establish the project group and agree the plan for the forthcoming year.													
	Identify the contracts, service specifications and performance monitoring currently in place.													
	Review existing contracts, service specifications and outcomes commissioned by BCU. These contracts are likely to be in partnership agreement.													
	Provide recommendations for the future commissioning of these services to inform year 2 plan													
	Establish a common North Wales service specification for the more minor repair, adaptation and maintenance of housing work, which can support health, illness and the wider determinants.													
	Commissioning plan for above services developed and aligned to review of existing contracts in the region. The plan will recognise the multiple providers within the local market place and local need													
	Implement commissioning plan across North Wales working towards the outcomes of the project. The commissioning plan will reflect longevity of existing contracts													
	Supported Accommodation Project 2: Review of community Equipment													
	Establish project group, governance arrangements and project plan for 2018/19													
	Develop position paper setting out existing services, contracts in place, service specifications and outcomes													
	Compare existing services and define future state based on standards, good practice models elsewhere, / current and future demand, market place ad new technologies													
	Recommendations to move towards a standard model of community equipment stores agreed across the region													
	Implementation plan established with delivery actions for 2019/20 implemented													
	Further implementation of the action plan and begin evaluation and impact monitoring against desired outcomes													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Supported Accommodation Project 3: Housing Based Solutions for admission prevention and discharge support													
	Establish project group, governance arrangements and project plan for 2018/19													
	Commence research project to examine opportunities and challenges in generating an alternative discharge pathway that moves form the community hospital setting to a housing support scheme or domiciliary care													
	Analysis of patient flow into each community hospital in North Wales completed to understand existing demand by postcode and cluster level													
	Improved access to existing housing based solutions through the use of a Housing Officer role within the 3 discharge teams in BCUHB													
	Provide an Area based pathway/commissioning plan for the utilisation of existing extra care housing / rehabilitation flats as an alternative to admission to hospital or as temporary home post discharge. This will link to the development of CRT and telehealth/ care.													
	Conclude an area based commissioning plan for the scope, scale, location and funding of housing based alternatives to admission and discharge													
	Implement commissioning plan across north Wales ensuring that all patients can access suitable housing based solutions to meet their needs.													
	Supported Accommodation Project 4: Long term care sector support													
	Each area team to work with partners to map / agree service provision and project plan													
	Evaluate success of current provision of a dedicated ANP/Nurse in clusters.													
	Explore systems to coordinate health input to care homes.													
	Implement systems for the co-ordination of care provision													
	Implement an evaluation framework to monitor the impact of co-ordinated health interventions													
	Review opportunities of pooled budgets for this sector													
	Monitor impact and refine systems													
	Work with care home sector in respect to workforce planning and explore opportunities for staff, particularly students working in the care home sector.													
	Work with the regional Workforce Group to identify opportunities to increase domiciliary care provision.													
	Undertake skills and training gap analysis in partnership with the independent sector.													
	Continue to monitor impact and refine systems in line with current and future guidance.													
Primary Care Workforce	Update primary care workforce plan alongside a recruitment and retention plan and training plan.													
	Develop a Primary Care Academy to develop & support greater opportunities for more training placements and mentorship to ensure the delivery of the workforce model													
	Develop a local bespoke training programme e.g. Advanced practitioners, OT's, Team Coordinators.													
	Develop and support training placements and mentorship to ensure delivery of workforce model.													
	Develop and agree costed workforce model in respond to implications of Wylfa Newydd development.													
	Maintain a robust primary care workforce plan.													
	Expand number pf pharmacists, physiotherapists, ANPS etc. working in primary care													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Health and Well-being Centres	Health and Well-being Centres: • Complete gap analysis. • Progress pipeline priority schemes. • Engage and agree with stakeholders and patients to identify opportunities. • Engage with stakeholders. • Commence work to identify resource implications. • Finalise and approve Estates Strategy.													
	Llandudno Hospital: • Undertake work to inform and complete the Llandudno Hospital Site Development Control Plan. • Continue development of business case for Llandudno Hospital Outpatient Service and facilities. • Commission emergency multi-disciplinary unit accommodation in Llandudno Hospital.													
	North Denbighshire Community Hospital: • Outline business case resubmitted to WG. • Commence work on full business case. • Development of full business case and submission to WG													
	Health and Well-being Centres: • Develop implementation plan and business case as required. • Progress pipeline priority schemes. • Engage with stakeholders. • Information, advice and assistance implemented.													
	Health and Well-being Centres: • Complete pipeline priority schemes. • Commission training packages. • Engage with stakeholders. • Information, advice and assistance implemented • North Denbighshire Community Hospital – commence construction.													
	Based on CCTH, agree the future strategy and configuration of Health and Well-being Centres and GP practices.													
	Progress Welsh Government Primary Care pipeline priority schemes: Waunfawr, Ruthin clinic/ hospital re-development.													
	Progress Primary Care improvement grant process.													
	Progress priority estate development projects: Penygroes, Kinmel Bay, Conwy/ Llandudno Junction H&WB Hub, Bangor H&WB hub and Llay Third Party Development, Queensferry, Cefn Mawr.													
	Commission Flint Health and Well-being Centre													
	Commence scheme to consider reconfiguration of primary care estate in Wrexham. Linking in with the development of the Wrexham Maelor campus.													
	Benefits realisation Blaenau Ffestiniog													
	Develop implementation plan for CCTH.													
	Establish project team for Bangor H&WB hub													
	Develop business case for Penygroes health and well-being hub													
	Benefits realisation Flint H&WB Centre													
	Complete construction of and commission new GP practice for Waunfawr.													
	Establish project team for Holyhead primary care development.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cluster Development	Develop an agreed Health Board vision, direction and implementation plan for primary care clusters.													
	Develop a programme of training and development for cluster members to support change and innovation.													
	Continue to develop the primary care dashboard and other sources of information to increase understanding of priorities of clusters and monitor impact of activity undertaken.													
	Support clusters to ensure that information and tools available to meet Information Governance requirements													
	Increase communication and engagement with the public, secondary care and others in relation to cluster developments.													
	Work to increase uptake of immunisations for children and adults.													
	Pilot and develop Cardiovascular Disease (CVD) Risk Assessment programme to target deprived populations through the management of risk factors													
	Implement Cardiovascular Disease (CVD) Risk Assessment programme to target deprived populations through the management of risk factors and undertake an evaluation of effectiveness													
	Explore potential for clusters to increase their role in service commissioning and delivery.													
	Review prescribing Local Enhanced Services to consider a level of local reinvestment or prescribing efficiencies.													
	Roll out of agreed cluster development programme.													
	Maturity assessment and progress review at the end of each year.													
	Maturity assessment and progress review at the end of each year.													
	Maturity assessment and progress review at the end of each year.													
Digital Healthcare and Technology	Agree service model/s for telehealth clinics and nursing homes across all areas and develop plan for procurement and support requirements.													
	Patient Administration System / Electronic Patient Record – confirm position and full engagement with WCCIS roll out on a national level. Record baseline of current resource in all areas.													
	Supported self-management – research availability of technology/software, engage with both staff and patients and develop business case accordingly.													
	Virtual Clinical Hub – develop with partners potential of developing a virtual clinical hub with 111, WAST and GP OOHs.													
	Evaluation and review of telehealth model and develop plan for longer term implementation.													
	Develop and implement interim (Patient Administration System) solution if required. Develop business case for procurement of technology to support roll out.													
	Business case for supported self-management agreed													
	Agree a virtual clinical hub model with partners.													
	Evaluate telehealth model and adapt as required.													
	Procure technology as required and implement plan for roll out with IM&T.													
	Supported self-management - Promote technology with public/patients and staff and provide support as required.													
	Virtual Clinical Hub (hub) – development of service.													

5.3 MORE SERIOUS HEALTH NEEDS

5.3 MORE SERIOUS HEALTH NEEDS

Our Vision for the Future

Our plan for care closer to home means that more care will be delivered outside hospital. When people have more serious health needs they want the safest and highest quality of care possible and a good experience. They want to be treated by the right person, in the right place, at the right time and with the right facilities.

It is important that the services provided are evidence based and sustainable so that we can be confident about safety, quality and outcomes for patients.

People have told us that they have to wait too long to access services, whether it is in the Emergency Department or for an operation.

We will improve our services to reduce these waits. We will ensure that we have the right capacity in our hospitals to achieve access standards and meet future demand. To help us do this we will develop and adopt new and innovative ways of working and continually review the way resources are deployed to improve patient and carer experience, efficiency and productivity. For example, changing the skill mix of the work force and redesigning and developing new ways to access and deliver services.

We know that improvements in efficiency and productivity alone will not be sufficient to reduce waiting times and we will implement the Care Closer to Home initiatives so that more people can have access to more services (where appropriate) out of the main hospital settings.

In order to deliver services to meet future needs we will ensure that our three main hospitals at Ysbyty Gwynedd in Bangor, Glan Clwyd Hospital in Bodelwyddan and Wrexham Maelor Hospital provide core services to meet the needs of the population.

Each hospital will continue to have:

- 24 / 7 emergency department
- Consultant-led maternity and children's services
- A wide range of medical and surgical care, both for planned care and emergencies
- Day case surgery, diagnostic tests and outpatient clinics

Where clinics (and some diagnostic services) do not need to be at one of the main hospital sites, we will increasingly provide them more locally in our communities.

When people need emergency care, they will be able to be assessed at any of our Emergency Departments and most will be treated at the hospital they go to. Some might need to be transferred to another hospital for more specialised care.

We know from the evidence that for some more specialist services people have better outcomes when treated in larger centres by highly specialist teams. Our aspiration is that we will widen the range of specialist care we provide in North Wales so that in ten years' time people will have to travel outside the area less frequently. This will also help attract, retain and develop the specialist staff needed to provide high quality and sustainable care in our hospitals. We are already working

to develop some services like this – such as the new Sub-regional Neonatal Intensive Care Centre, and robotic assisted surgery.

Sometimes people will still have to travel outside North Wales to get very specialised care which is better provided for a larger population - such as neurosurgery at the Walton Hospital, or specialised paediatric care at Alder Hey. We have strong partnerships with hospitals outside North Wales and we will continue to do so in the future.

What we will do in the first three years

We will:

- Make sure hospital services can meet increasing demand
- Improve care and response times in emergency departments
- Work with professionals to find ways to reduce waiting times
- Use hospital specialists better and make best use of resources
- Look at how we provide eye care and out of hours ENT (ear, nose and throat) services
- Do more orthopaedic work (e.g. hips and knees)
- Keep maternity units running safely, ensure women have a choice in where they give birth, and have a safe and comfortable environment
- Open the new Sub-Regional Neonatal Intensive Care Centre
- Look at urology services and explore robotic assisted surgery
- Open a centralised vascular service for major surgery (veins and arteries)
- Look at having one or two specialist centres to provide hospital care for people after a stroke
- Provide better support for people leaving hospital
- Support the work of the care Closer to Home programme, enabling more people to remain in their own homes
- Work towards improving hospital accommodation so that it is fit for purpose and addresses inclusive design principles.

Outcomes We Want to Achieve

Plans for Unscheduled Care and Planned Care have been developed under the umbrella of our Acute Hospital Care strategy. The desired outcomes as described in the high level Logic Model are:

- Residents of North Wales have accessible, responsive and proactive health care system that supports them when they have a more serious health need.
- To ensure the best possible outcome, conditions are diagnosed early and treated in accordance with clinical need.
- Individuals are safe and protected from harm through high quality care, treatment and support.
- Individuals know and understand what care, support and opportunities are available and use these to facilitate self-care and help achieve health and well-being.
- Staff will always take time to understand ‘what matters’ and take account of individual needs when planning and delivering care.
- Standardised, accessible and comprehensive data and information on service delivery.
- Individuals will be cared for in the right place, at the right time by the most appropriate person.
- Individuals are supported to make the right choices so they have a long, healthy life.

Key Outcome Indicators

We will use a range of indicators to measure our progress, key examples of which are set out below:

- Reduction in RTT Waiting times achieved in 2017/18 will be sustained throughout the year.
- Diagnostic tests will be provided within eight weeks.
- Improved waiting times for cancer diagnosis and treatment services.
- Reduction in outpatient follow-up appointments.
- Reduction in delayed transfers of care.
- Improved performance against national indicators for Stroke services.
- Increase the range of Patient Related Outcome Measures (PROMS).
- Increase the range of Patient Related Experience Measures (PREMS).
- Increase the range of secondary care services provided outside the three main hospitals.
- Improved waiting times in Emergency Departments, from ambulance handovers to assessment and treatment.
- Increase the rate of survival within 30 days of emergency admission for a hip fracture.
- Reduction in Healthcare associated infections.
- Increased discharge to normal place of residence.
- Reduced mortality rate.
- Reduced re-admission rates.

5.3.1. Unscheduled Care

Introduction

Current performance in our unscheduled care system is unacceptable and will be a key focus of improvement under the Special Measures framework going forward. This reflects the fact that in recent years we have experienced sustained pressures upon our urgent and unscheduled care services and as a result, patients in acute need seeking urgent care have experienced delays in receiving their treatment. This can lead to anxiety and distress and also have an impact on the recovery from the treatment provided. The Health Board is therefore fully committed to improving services such that all patients can obtain timely access to high quality urgent care and treatment

Access to urgent treatment can be through a variety of forms of service provision e.g. Primary Care, Community services and Secondary Hospital. Furthermore, urgent care services are provided with the support of partner agencies, such as the Local Authorities providing Social Work and domiciliary/care home provision for patients with continuing health requirements. Providing access to high quality Unscheduled Care (USC) Services therefore depends on all elements of the healthcare system operating effectively in a co-ordinated way. There is a need for a whole system change, working with primary and community services that will ensure we meet the changing needs of our population as set out within our population needs assessment.

Background

Whilst there have been some improvements in urgent care services over the past 18 months, access to urgent care in hospital, as measured by the 4 hour and 12 target in ED, is not at a level that reflects the ambition of the Health Board. The 4 hour performance represents a large number of individuals experiencing delays for diagnosis and treatment in ED and the performance on 12 hours indicates that a number of patients experience excessive delays.

There is a significant capacity challenge across the three acute hospital sites, with all sites operating levels of bed occupancy which are incompatible with ensuring that beds are always available for emergency admission. As a result, all hospitals regularly hold patients in ED waiting for admission. At times of extreme pressure patients are delayed handing over from ambulances.

A primary underlying objective running through this plan is therefore to address the system capacity issue. This requires both ensuring that patients are only admitted to hospital when it is absolutely essential and that when admission is required a bed is always available. There are a range of initiatives described in the plan, each with specific objective, but the overall theme of most of these changes is to resolve the capacity challenge.

Vision

The Health board vision for people who need to access unscheduled care services is to:

- Ensure patients are fully informed of the range of services available and how to access these services
- Ensure all patients are able to access high quality urgent care at all times of the day and night with minimal delay.

2018/21 Work Programme

The Health Board recognises that the vision set out above is ambitious and requires significant improvement from the current service offer. Therefore to support the plan, Price Waterhouse Cooper (PWC) have been commissioned to work with the Health Board in the further development and delivery of this plan. This contract represents a significant investment and commitment towards service improvement and also recognises that there is a shortfall in internal capacity in service planning and implementation.

BCU is also working closely with other Health Boards across Wales as part of the all Wales Unscheduled Care Board and Emergency Ambulance Services Collaborative Commissioning programme. A system wide solution is needed and therefore we are working closely in Unscheduled Care with the Community Transformation Board as well as the Primary Care Transformation Boards.

Our plan is designed to ensure that more health service needs can be met outside hospitals by providing treatment alternatives to hospital admission and ensuring that patients who do require admission for specialist treatment can be safely discharged from hospital as soon as possible.

We have identified four priority work streams for the next three years:

- Community – Prevent Attendances
- Community – Prevent Conveyances
- Stabilisation, Grip and Control
- Community / Hospital – Discharge from Hospital

Key priorities for the year ahead are to:-

- Work with the Welsh Ambulance Service to enhance the integrated clinical hub and roll out of 111 to allow patients to be treated nearer to home and avoid unnecessary admissions, supported by our Care Closer to Home work stream and developments.
- Implementing plans with our partners to manage frequent callers
- Falls prevention services

- Embedding alternative pathways e.g. mental health, MIU
- Review and develop standardised protocols for our Emergency Departments to ensure patients are streamed quickly and efficiently, that services are in place to treat patients, with an aim of no ambulance handover delays and all patients seen within four hours.
- We will focus on daily senior review of patients in hospital and planning for early discharge at the point of admission. E.g. SAFER model
- Co-ordinating with Community, Social Services, the third sector and Independent sector we will strengthen support to patients within their own homes including evening and weekends.
- Develop an integrated approach to the management of patients with frailty on admission to hospital- including the combined early planning of discharge between acute, community and Local Authority teams. This will include Discharge to Assess (D2A).

Rapid Improvement Plan

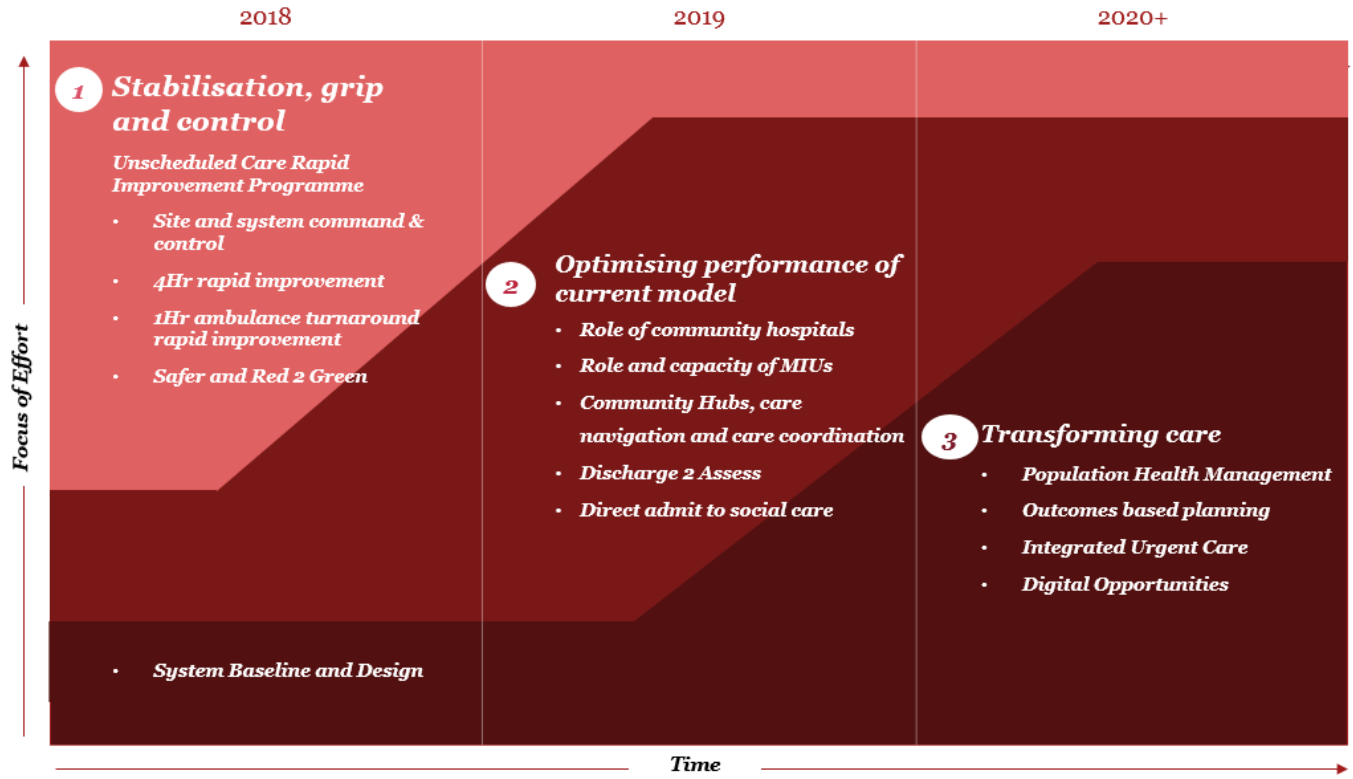
Working with PWC, our approach and priority areas of focus are set out below. We recognise that the journey to will be one of progression in which in year operational improvements will lead to an optimised model of care that is stable to support transformation. The diagram below outlines the key activities within our journey to transform services and describes how the focus of effort changes over the three year planning horizon.

PwC will support these priorities of work. In addition, a baseline of our current model of unscheduled care will be undertaken to identify further opportunities to drive improvements in the short, medium and long term. Most importantly this will produce a recommended future model of unscheduled care against which we can prepare our refreshed plans to deliver.

The following table summarises the approach we are already taking with PWC which will continue in years one, two and three of our plan to move from a focus on stabilisation, grip and control in year one, optimising performance of current model in year two and transforming care in year three.

Managing Performance Improvement and System Change

BCUHB priorities for 2018 and indicative plans for 2019 and 2020



The detailed actions are set out in the Unscheduled Care Gantt section of the plan which describes the improvement programme and timescales to deliver improved system performance.

Site and System Command and Control

The following steps are in the process of being implemented at Ysbyty Glan Clwyd and will be rolled out to Ysbyty Gwyned and Wrexham Maelor into year one.

Project	Intervention
1. Rapid Improvement in ED 4Hr Performance	Operational Planning and Grip in ED
	Effective Management of Capacity in EQ
	Streaming of Patients Away from ED
2. Rapid Improvement in Ambulance Turnaround	Deflection and Diversion of Inappropriate Ambulance Attendances
3. Operational Control and Coordination	Operational Planning and Grip at Site Level
4. Accelerating Implementation of Safer Bundle	Discharge Planning and Coordination

1. Rapid Improvement in ED 4 Hour Performance

Work stream initiative and key outcome	*Detail*
2 hourly huddles – Structured huddles every 2 hours to review ED performance and focus on action planning.	• Re-focussing the ED huddles on actions to drive flow by re-enforcing the rhythm of huddles and improving staff engagement at regular intervals of the day.
Escalation protocol – Provide a framework for Hospital Management to effectively escalate and deescalate.	• Support YGC management in drafting a effective and robust escalation protocol. Identify and risk stratify potential escalation areas, understand the patient groups suitable for each area and the key trigger and decision points.
Patient Streaming – Deflection of patients presenting to ED but who could be more efficiently treated at other care providers.	• Assess ED staffing model and develop ideas to resource the Streaming Nurse role at ED reception.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	**Target**	**Profile**						
		Projected end of March 2018 position	**Jun-18**	**Sep-18**	**Dec-18**	**Mar-19**	**Mar-20**	**Mar-21**
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%	80.0%	80.0%	88.0%	80.0%	90.0%	90.0%	95.0%
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	1,297	850	850	1,200	900	500	0

2. Rapid Improvement in Ambulance Turnaround

Work stream initiative and key outcome	*Detail*
Diversion of ambulance to other care settings • Working with WAST staff i.e. controller and paramedics.	• This intervention has been identified as medium to long term. • Scope project with key stakeholders to develop a project plan.
Queuing Out – Improve ambulance handover time.	• Stop holding patients in ambulance whilst space in ED becomes available, instead move patients out of ED's clinical space once they have completed all clinical interventions to create space for patients conveyed via ambulance.
Patient Streaming – Deflection of patients presenting to ED but who could be more efficiently treated at other care providers.	• Scope out/design project for directing patients who have been assessed (Triaged) to the more appropriate care setting.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	Target	Profile						
		Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	73.0%	80.5%	81.1%	74.0%	75.0%	80.0%	80.0%
Number of ambulance handovers over one hour	0	957	850	850	1,100	900	700	500

3. Operational Control and Coordination

Work stream initiative and key outcome	***Detail***
System Leader and C2 Hub in place • Site capacity management and flow plans developed before the 0830 Safety Huddle which will allow them to go into operation earlier. • Reduced in time spend in daily huddles / site management meetings. • Reduction in time spend proactively seeking information from across the site	• Role fully operation from 28/02/2018 • C2 Command Team roles defined and role holders in place • C2 Hub fitted out • Information flow managed into C2 Hub • Draft escalation and flow protocols developed and being tested

4. Accelerating Implementation of Safer Bundle

Work stream initiative and key outcome	***Detail***
'Collect' and 'Collate' inpatient information	Coach ward managers and teams to improve information capture to enable improved data quality.
'Report' information in appropriate forms	Develop improved outputs that collate tasks for team and site focus on a daily basis with minimal intervention.
'React' through accountable action owners	Provide focused workload lists for clinical support services to provide focused attention on morning discharges.

Transforming Care – System Baseline and Design

Alongside the rapid improvement programme set out above, work will commence to develop a system baseline and design plan for USC for completion by the 14th May 2018. The phases and activities to achieve this are described in further detail below.

Phase One – Develop an activity, provision, performance and cost baseline by April 2018.

Phase Two – Identify and validate opportunities to transform by May 2018.

Phase Three – Development of a future model of Unscheduled Care (USC) by May 2018.

Phase Four – Development of a case for change document by June 2018.
The final document will consist of the following:

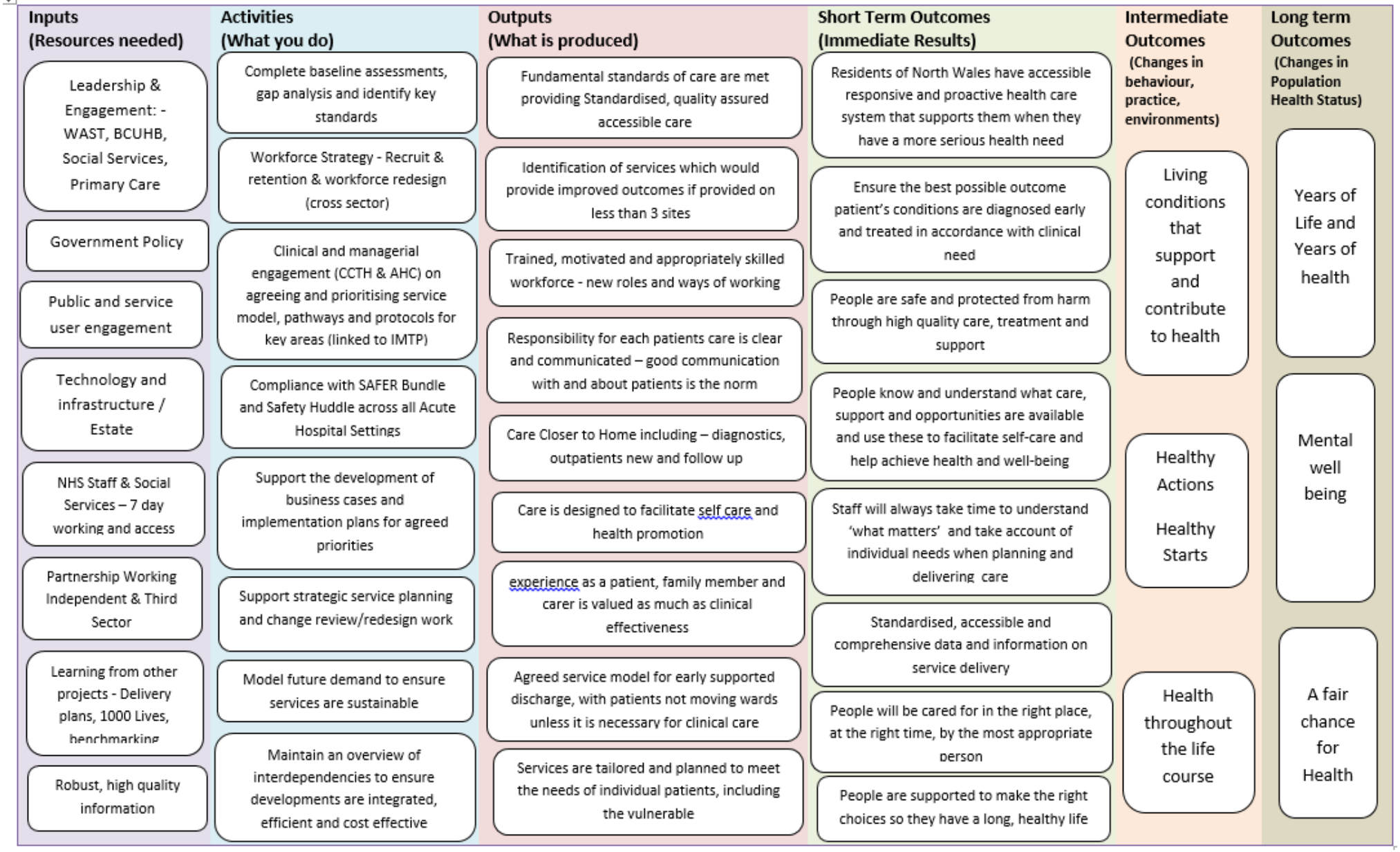
- The strategic case for change
- The Future Model of USC
- The quality and cost impacts of adopting the Future Model of USC
- The quality and cost impacts of adopting the Future Model of USC
- The investment and transitional architecture required to deliver the quality and cost impacts
- The impact on the new model on key enablers including workforce, estates and governance.
- Recommendations.

By the 14th May 2018 a Programme Plan will also be developed consisting of the following:

- Programme Initiation Document
- Programme Management Plan
- Benefits realisation Plan
- High level programme schedule.

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	Number of non-mental health HB DToCs	At least a 5% reduction on the 2017/18 position	78	74	77	77	74	70	66

Planned Care & Unscheduled Care Logic Diagram / Plan on a Page



Unscheduled Care Three Year Plan 2018/21

OVERVIEW

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stabilisation, Grip and Control	Site and system command and control													
	Four hour rapid improvement programme													
	One hour ambulance turnaround rapid improvement programme													
	Safer and Red 2 Green (see below for details)													
	ED Model: Evaluation of pilot work in Ysbyty Glan Clwyd working with Price Waterhouse Cooper													
	ED Model: Options appraisal on future configuration of Emergency Department's													
	ED Model: Business case to take forward future model													
	ED Model: Project plan approved and implementation commenced													
Community - Prevent Attendances	Integrated clinical hub **:** Stock take of current services, map overlaps, define scope of the project. Create working group with an agreed project brief													
	Integrated clinical hub : Options appraisal with business case with **e**xploration of the scope of the integrated clinical hub													
	Integrated clinical hub : Project plan approved for implementation of integrated clinical hub													
	111 Plus: Create project group across BCU to research lessons learnt and scope out 111 project													
	111 Plus: Options appraisal written for consideration for way forward to implement a 111 service, including the creation of a Directory of Service.													
	111 Plus: Project plan approved for implementing 111													
	Community Support to alternative pathways : Complete demand and capacity modelling to identify gaps in delivery of supporting more USC patients in the community													
	Community Support to alternative pathways : Options appraisal developed													
	Community Support to alternative pathways**:** Agreement to implement project plan													
	Frequent caller initiative: Project to be established at Ysbyty Glan Clwyd and Wrexham Maelor initially.													
	Frequent caller initiative : Evaluation of effectiveness of project													
	Care Homes: Undertake analysis of the work already collated on Care home activity (North Wales care home specific – ED attendance, Emergency Admission and Length of stay)													

Community - Prevent Attendances	Care Homes: Map out current Care Home support initiatives across North Wales (Macmillan, Primary Care, Medication Reviews, Conwy Care Home Response Team, Falls Teams etc.)														
	Care Homes: Establish links with care home providers and Care Forum Wales to ensure involvement and engagement														
	Care Homes: Review of the Evidence of what works, identifying areas for targeted intervention Consideration given to telehealth care (Airedale), education & training (Macmillan) and direct care (Community Resource Teams)														
	Care Homes: Review lessons learned by the Enhanced Care Home vanguards and highlight the components that have the highest impact														
	Care Homes: Write up proposed project plan for approval and establish steering group and governance arrangements including KPIs														
	Care Homes: Implement project plan														
	Falls: Review of 2017 gap analysis and current best practice across BCU														
	Falls: Project plan written to roll out best practice across BCU														
	Falls: Falls prevention services - Implementation of project plan across the three Area Falls groups														
	Falls: Review CAT team as a model for North Wales														
	Falls: Complete business case with WAST for a new model.														
	Falls: Submit business case for approval from BCUHB and WAST														
	Falls: Complete full North Wales coverage of the CAT model or Implement new model if approved.														
	Falls: Full impact evaluation and further development of the chosen model.														
	Mental Health Pathway: Map current activity and evaluate														
	Mental Health Pathway: Create business case to roll-out existing mental health pathways for ambulance staff, across BCU														
	Mental Health Pathway: Identify issues for police service regarding patients with mental health needs, create options appraisal for addressing needs														
	Mental Health Pathway: Implementation of Mental Health Pathway Projects														
	D&V: Map out current best practice activity across BCU														
	D&V: Options appraisal written for supporting patients across BCU														
	D&V: Implementation plan agreed														
	D&V: Project plan implementation commences														
	Breathlessness Pathway: Roll out of district nurse alternative pathway for breathlessness														
	MIU: Understand current utilisation of Minor Injury Unit's														
	MIU: Options paper written with optimisation plans for specific Minor Injury Unit's														
	MIU: Project plan implementation commenced														

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community/Hospital: Discharge from Hospital	Huddle: Identify the current gaps in delivering the safety huddles													
	Huddle: Project plan developed to address gaps													
	Huddle: Wards agree to deliver discharge profiles													
	Huddle: Each hospital management team to consider increasing ward discharge profiles													
	Huddle: BCU management to link safety huddle scores with business continuity plans													
	Huddle: IT solutions identified to support safety huddles													
	Huddle: IT solutions implemented to support safety huddles													
	SAFER: Establish Pan-BCU Safer Implementation Quarterly Assurance Group for embedding whole organisation lessons learned and variance reduction													
	SAFER: Full roll-out plans written for Ysbyty Glan Clwyd and Wrexham Maelor Hospital													
	SAFER: Establish mechanism for collecting data on senior reviews													
	SAFER: Engagement with staff regarding setting Estimated Date of Discharge and whole SAFER Bundle													
	SAFER: Engagement with Patient Experience for ongoing evaluation/appraisal of four key question feedback													
	SAFER: Evaluate national learning of SAFER Implementation/Sustaining skill-mix to inform option appraisal of sustainability skill-mix model/structure													
	SAFER: All patients are set an Estimated Date of Discharge													
	SAFER: Red 2 Green: Establish an IT mechanism for “live” ward-based input/Ward-level review of SR2G data (Touch screen/Computers on wheels)													
	SAFER: Red 2 Green: Evaluation of main pressure points in the discharge process.													
	SAFER: Red 2 Green: Option appraisal for issues/current gaps in delivery/sustaining identified in Tests of Change Wards													
	SAFER: Red 2 Green: Review of discharge processes between acute and community hospitals													
	SAFER: Golden Patient: Staff engagement on the benefits to patients of shorter lengths of stay. Identification of main barriers/issues with Golden Patients													
	SAFER: Golden Patient: Options appraisal for issues identified													
	SAFER: Golden Patient: Implementation of options													
	SAFER: Golden Patient: Evaluation of Golden Patient projects													
	SAFER: Criteria Led discharge: Roll out of criteria led discharge to all wards in community and acute													
	SAFER: Criteria Led Discharge: Evaluation of criteria led discharge													

5.3.2. Planned Care

The Planned Care plan for 2018/21 focusses on six key work streams:

- Capacity and Demand
- Bed model
- Theatres
- Cancer Delivery
- Acute Services Configuration
- Specialty Plans

Work stream 1: Capacity and Demand

On 1st March 2018, the Board reinforce the commitment to continue to sustain RTT performance throughout 2018/19. Activity plans by speciality are being refined working closely with WG and will be incorporated into our delivery plan for 2018/19.

The capacity and demand work stream focuses on seven key areas namely:

- Referral to Treatment - this work stream will bring patient waiting times in line with National Delivery Framework targets through a combination of efficiency savings, service transformation and investment in capacity to meet demand.

  The Health Board faces a current demand-capacity gap of circa 13,500 patient pathways per year and detailed plans sit beneath the three year plan which set out the options for reducing RTT waiting times, eliminating long waits and putting the Health Board into a long-term, sustainable position.

  This plan sets out proposals to maintain the reduction made in patients waiting over 36 weeks throughout the year, deliver 8 week target for diagnostic services and deliver upon cancer waiting times standards towards full delivery of national targets over the three year period of the plan.

  Key to delivery of the Health Board's RTT targets is targeted action in Orthopaedics and Ophthalmology and both of these specialties have strategic work programmes under development which will set out an ambitious, transformational service delivery model across North Wales. These delivery models challenge the way these services traditionally operate and look to further integrate primary, secondary and community care to ensure pathways are as effective, timely and sustainable as possible to meet current and future demand.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	The percentage of patients waiting less than 26 weeks for treatment	95%	82.0%	82.0%	84.0%	84.0%	87.0%	90.0%	95.0%
	The number of patients waiting more than 36 weeks for treatment	0	4,237	4,237	4,237	4,237	4,237	4,237	4,237

- Follow Up - this project will focus on provision of appropriate and safe clinical review outpatient management pathways for the reduction of the follow up outpatient review backlog with specific focus on ENT, Ophthalmology, Orthopaedics and Urology.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date	Reduction (12 month trend)	77,000	77,000	75,000	73,000	70,000	53,000	41,000

- Outpatients – the aim is to put in place a sustainable model for outpatient delivery across North Wales, through the use of peer-to-peer triage, virtual clinics, Care Closer to Home, reducing the follow up backlog and targeting Hospital Initiated Cancellations (HICs) and DNAs.

OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	The percentage of patients who did not attend a new outpatient appointment	Reduction (12 month trend)	6.5%	6.0%	5.5%	5.0%	5.0%	5.0%	5.0%
	The percentage of patients who did not attend a follow-up outpatient appointment		7.2%	7.0%	6.5%	6.0%	5.5%	5.0%	5.0%

- Surgical Patient Pathway Transformation Group – this project will evaluate end to end patient pathways for surgical specialities and provide a comprehensive framework for service improvement.

- Radiology – individual specialty plan to create a sustainable radiology service across North Wales to support the attainment of key national performance targets across both planned and unscheduled clinical specialties.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	The number of patients waiting more than 8 weeks for a specified diagnostic test	0	0	0	0	0	0	0	0

- Endoscopy – the service requires review to ensure service provision meets the necessary capacity to achieve and sustain the eight week RTT target and 2 week milestone for the National Cancer Target. Following completion of the JAG accreditation scheme and the

Acute Hospital redevelopments, a sustainable services modelling exercise will be completed to develop a sustainable service for the future.

- Pathology – despite significant modernisation and reconfiguration of pathology services there remains a significant financial and capacity gap within key service areas. This project will aim to address the capacity issues to ensure the service is able to maintain acceptable performance times for critical investigations.

The table below provides a summary of the waiting list position for Planned Care as follows:-

Table 1; shows the projected growth in our waiting list and specifically patients waiting over 36 weeks assuming activity remains at 2017/18 levels. This shows the number of patients waiting over 36 weeks is forecast to increase from 4,237 to 18,419 by end March 2019.

Table 2; sets out the additional activity required to maintain the number of patients waiting over 36 weeks at 4,237 throughout 2018/19 and into 2019/20 and 2020/21.

Table 3; sets out the additional activity required to deliver improved waiting times to achieve 36 weeks by March 2019 and reduce further to 26 weeks by 31st March 2020, thereafter maintaining 26 week performance into 2020/21.

Note for orthopaedics the activity relates to achieving 52 weeks by March 2019, 36 weeks at end March 2020 and 26 weeks at end of March 2021. Plans for orthopaedics and eyecare are being finalised for consideration by Board in April 2018.

SPECIALTY	Starting Position 01 Apr 18 (>36wks)	1. Forecast position (>36wks) at current core capacity		
		Mar-19	Mar-20	Mar-21
General Surgery	420	2,252	2,429	1,520
Urology	494	2,297	2,101	1,660
ENT	74	1,461	1,459	791
Ophthalmology	201	4,589	4,258	3,246
MFS	203	400	285	128
Pain Management	114	745	654	541
Gynaecology	-	415	533	387
Gastroenterology	64	35	12	3
Orthopaedics	2,746	4,196	4,515	4,243
ALL (excl. Ortho)	1,570	12,194	11,731	8,276
ALL (inc. Ortho)	4,316	16,390	16,246	12,519

Work stream 2: Bed Model

The bed model work stream encompasses the assessment of each acute hospitals bed capacity model and the identification of areas for improvement. Each hospital site has developed a model and plan, and this work stream will ensure that bed requirements for the strategic service changes

are coordinated; this will include critical care capacity, as well as the interrelationship with community sites for appropriate services.

Work stream 3: Theatres

The theatre project will review the configuration, capacity and resilience of all theatre facilities across North Wales. Key components of the project will include Orthopaedics, development of specialist vascular services and a robust Endoscopy plan.

Work stream 4: Cancer Delivery

To ensure the Health Board is able to achieve national cancer waiting time targets, including the proposed single cancer pathway, there are several significant areas of work that need to be completed. These include the service capacity for North Wales Urological cancer surgery, endoscopy capacity across North Wales and the development of new ways of working for the introduction of the colorectal straight to test pathway. Other key pieces of work include the service sustainability review and development of the UGI surgical centre and the increase of critical care beds for Head and Neck cancer patients.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	98%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
	The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral	95%	87%	88%	90%	90%	92%	95.0%	95.0%

Work stream 5: Acute Hospital Configuration

The Acute Services section of the plan focusses on specific detailed work on Breast, Vascular, Urology and Upper GI services and sets out the timeframes for the review of Breast Services, the establishment of specialist Vascular Services using a custom built hybrid theatre in Glan Clwyd Hospital and the business case for Robotic Assisted Surgery (RAS) for Urology, Gynaecology and Colorectal Services.

This work dovetails with the individual specialty plans for these services to provide the foundation for sustainability and putting in place capacity to meet growing demand.

Work stream 6: Specialty Plans

The individual specialty plans look at how the Health Board plans to deliver the National Planned Care Programme priorities, the All Wales Delivery Plans and provides the strategic framework for Secondary Care delivery in each of the these specialities. It also includes the transformational work on Orthopaedics and Ophthalmology services, the delivery plan for Urology and Critical Care services and the Health Board actions in response to the All Wales Liver Disease plan.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	For HBs with OOH services: Percentage of urgent calls that were logged & patients started their clinical definitive assessment within 20 mins of initial calls being answered For HBs with 111 services: Percentage of P1 calls that were logged & patient started their clinical definitive assessment within 20 mins of the initial calls being answered	98% (OOH) Improvement (12 month trend) (111)	70.0%	73.0%	75.0%	76.0%	80.0%	88.0%	98.0%
	For HBs with OOH services: Percentage of patients prioritised as very urgent and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage For HBs with 111 services: Percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage	90% (OOH) Improvement (12 month trend) (111)	72.0%	75.0%	78.0%	77.0%	80.0%	85.0%	90.0%

Acute Hospital Care Three Year Plan 2018/21

Overview

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Capacity and Demand	RTT: Reduce waste in secondary care through the delivery of efficient and productive services.													
	FU: Released resource capacity to enable appropriate follow up appointments.													
	FU: Safe clinical pathways for all specialities.													
	FU: Clinically agreed new:review model based upon clinical criteria.													
	FU: Full review of alternative models of service provision.													
	OP: Collect accurate Hospital Initiated Cancellation data across Secondary Care.													
	OP: Public engagement campaign to reduce DNA's.													
	OP: Initial review of new to follow up data.													
	OP: Virtual Gastroenterology clinic established in West.													
	OP: Review and prioritise key areas for reduction of Hospital Initiated Cancellation's.													
	OP: Completion of BCU Outpatient Department Dashboard.													
	OP: Carry out review of new ways of working, understand opportunities and evaluate.													
	OP: Complete roll out of electronic outcomes in Central.													
	OP: Rollout of virtual fracture clinics across BCU.													
	OP: Review and rollout virtual Gastroenterology clinics across BCU.													
	OP: All Wales work to interface with Non Emergency Patient Transport to reduce DNA rates through transport cancellation.													
	OP: Phase 1 of implementing new ways of working with All Wales Strategy / Vision.													
	OP: Phase 2 of implementing new ways of working for Primary Care.													
	SPPTG: A review of the pre-operative patient pathway.													
	SPPTG: Effective procurement and stock handling.													
	SPPTG: Ward reconfiguration to include ring fenced surgical beds.													
	SPPTG: Matching of job plans to current theatre scheduling.													
	SPPTG: Capital assets and capital bids.													
	RAD: Implementation of non-recurrent insourcing activity solution.													
	RAD: Capacity and demand modelling, financial monitoring and present a sustainable service model solution.													
	RAD: Establish integrated prioritised replacement equipment / systems inventory, including single RADIS and fixed PET CT service.													
	RAD: Establish additional equipment requirements to match capacity and demand analysis.													
	RAD: Develop business cases for identified major equipment replacement.													
	RAD: Submission of business cases in relation to site development plans.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	RAD: Identify key clinical pathways													
	RAD: Review identified pathways.													
	RAD: Analysis of identified pathways with respect to capacity and demand modelling.													
	RAD: Incorporation of redesigned pathways into service model.													
	ENDO: Delivery of 8 week waiting time target													
	ENDO: Establish sustainable workforce													
	ENDO: Develop sustainable model for Endoscopy service delivery													
	PATH: Capacity and demand modelling for all service areas including phlebotomy and coroners post-mortem service.													
	PATH: Pathology service review including workforce and financial modelling.													
	PATH: Presentation of sustainable service model solution.													
	PATH: Establish integrated prioritised equipment / systems / contracts inventory													
	PATH: Establish additional requirements to match capacity and demand analysis.													
	PATH: Develop business cases for identified equipment / systems / contracts replacement.													
	PATH: Submission of business cases to support sustainable service model.													
	PATH: Identify key clinical pathways.													
	PATH: Review identified pathways.													
	PATH: Analysis of identified pathways with respect to capacity and demand modelling.													
	PATH: Incorporation of redesigned pathways into service model.													
Bed Model	Wrexham Maelor bed model and required changes.													
	Ysbyty Glan Clwyd bed model.													
	Ysbyty Gwynedd bed model.													
	Critical Care capacity / model.													
	Development of a pan North Wales Secondary Care bed model.													
Theatres	Implement phases one and two of the Orthopaedic Plan.													
	Endoscopy – JAG plans and single endoscopy plan.													
	Develop North Wales theatre plan for secondary care.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer Delivery	Establish impact of single cancer pathway including the mechanisms and resource required to deliver.													
	Lead review of cancer pathways – three year funded project.													
	Secure additional endoscopy and urology surgery capacity to meet cancer targets.													
	Secure additional resources for single cancer pathway.													
	Establish requirements for single cancer pathway that will commence in 2019/20.													
	Support introduction of e-vetting of referrals.													
	Support individual specialty/service plans.													
	Colorectal - service redesign to support development of enabling GP's to refer directly to diagnostic endoscopy.													
	Head and Neck – increase of critical care capacity required.													
	UGI – a sustainability model for the surgical centre in Wrexham to be produced.													
	Implement Tracker 7 (All Wales cancer tracking software).													
	Continued monitoring of performance.													
	Implementation of the early diagnostic / straight to test process for colorectal and lung pathways.													
	Pathway modernisation – Macmillan funded project to support patient flow.													
	Establish resource required to ensure all cancer patients have key worker and Holistic Needs Assessment (HNA) completed.													
	Recruit skill mix required to deliver the Holistic Needs Assessment.													
	PATH: Electronic requesting.													
	PATH: Increased system automation.													
	PATH: Changes in staff skill mix.													
	PATH: Voice recognition instant reporting.													
	ONC: Seven day acute oncology service for improved patient flow.													
	ONC: Advance practice / skill mix review to ensure sustainability.													
	ONC: Consultant recruitment strategy.													
	ONC: Radiotherapy strategy and new techniques.													
	ONC: Strengthen relationships with Clatterbridge Cancer Centre.													
	ONC: Further roll out of agreed plan for regional services.													
	ONC: Oncology E-prescribing roll out.													
	HAEM: Develop 2-3 year plan for regional Haematology / Haemophilia service.													
	HAEM: Plan for upcoming retirements / succession planning.													
	HAEM: Continue with three site model.													
	HAEM: Further roll out of agreed plan for regional services.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acute Services Configuration	BREAST: Business case development.													
	BREAST: Submit business case to Exec's for approval.													
	BREAST: Further develop implementation plans.													
	BREAST: Substantive Breast Consultant posts to be appointed to.													
	BREAST: Presentation of sustainable Radiology service model solution.													
	VASC: Vascular implementation task and finish group will be exploring what vascular surgery can be undertaken at YGC.													
	VASC: Establishment of estate to support vascular surgery including hybrid theatre in YGC.													
	VASC: Appointment of Consultant Vascular Surgeons and supporting teams.													
	VASC: 'Go Live' of vascular services in YGC.													
	VASC: Full implementation of Vascular service configuration.													
	ROBOT: Agree service model for Urology Services in quarter one.													
	ROBOT: Completion of business case for robotic assisted surgery													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Specialty Plans	ORTHO: Establish an Orthopaedic Network													
	OPHTH: Establish pan BCU optometrist network.													
	OPHTH: Improved access to Optical Coherence Tomography scanners for primary care and community services.													
	OPHTH: Develop a robust communication framework between Primary and Secondary Care.													
	OPHTH: Centralised pooling of cataract waiting lists and development of pathway for 2nd eye cataracts.													
	OPHTH: Review of capacity and demand following pathway redesign.													
	OPHTH: Utilisation of treatment rooms for some procedures.													
	OPHTH: Pre-operative assessment to be carried out by qualified nurse practitioners.													
	OPHTH: Review of financial model for eye care service delivery.													
	OPHTH: Orthoptist led clinics in secondary care including refraction clinics.													
	OPHTH: BCU wide e-referral process for primary and community into secondary care.													
	OPHTH: Full connectivity / data sharing between clinical equipment in primary and secondary care.													
	UROL: Paper to be completed for submission to EMG and/or Board reflecting the Urology Service Delivery Plan.													
	UROL: Delivery of National Planned Care Programme priority actions for Urology, including measurement and reporting at sub-specialty level, single visit haematuria patients, cystoscopy surveillance and prostate cancer treatment pathways													
	UROL: If approved, two year programme for implementation will follow.													
	CRITICAL CARE: Maximise critical care capacity including reduction of Delayed Transfers of Care													
	CRITICAL CARE: Implement Critical Care Clinical Information System.													
	CRITICAL CARE: Implement agreed pathway for out of hospital cardiac arrest patients with return of spontaneous circulation.													
	CRITICAL CARE: Work to support deteriorating patients in hospital through Critical Care outreach and Acute Intervention Teams.													
	CRITICAL CARE: Reduce demand on Critical Care through effective processes of escalation including work with Primary Care and WAST.													
	LIVER: GP Liver Disease champion to be appointed.													
	LIVER: Recruitment and retention of secondary care alcohol care teams (alcohol liason nurses)													
	LIVER: Develop plan to expand to a six day service with evening service.													

Women's Services

Plans for Women's have been developed under the umbrella of our Acute Hospital Care Programme as part of the Health Boards Longer Term Strategy. It must be recognised that the successful delivery of many of the priorities is dependent upon other areas of transformational work including Care Closer to Home, Health Improvement- Health Inequalities, Children & Young People, Planned and unscheduled care, Older People and Mental Health.

Outcomes We Want to Achieve

The desired outcomes as described in the high level Logic model are:

- Placing the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect.
- Promoting healthy lifestyles for pregnant women which have a positive impact on them and their families health.
- Providing a range of safe high quality choices of care from midwife to consultant led services.
- All children have the best possible start in life which is enabled by giving parents and carers the support needed.
- Optimal outcomes from every pregnancy for mother and child – first 1000 days.
- ACE's are understood and mitigated against.
- Women of North Wales have an accessible, responsive and proactive urgent, emergency and planned care pathways that supports them when they are in need.
- Health and care support are delivered at or as close to home as possible.
- To ensure the best possible outcomes, conditions are diagnosed early and treated in accordance with clinical need.
- Individuals are safe and protected from harm through high quality care, treatment and support.
- Individuals know and understand what care, support and opportunities are available and use these to facilitate self-care and help to achieve optimum health and well-being.
- Individuals will be cared for in the right place, at the right time, by the most appropriate person.

We will use a range of indicators to measure our progress, key examples of which are set out below:

- Compliance with the patient safety reporting system.
- Serious incident and never event rates in all care settings.
- Enhanced Care for the Sick Mother fully embedded.
- Implementation of all wales standards for accessible communication and information for women and families with sensory loss.
- Full achievement of cancer waiting time targets and referral to treatment time targets.
- Reduction in patients being delayed as their care is transferred out of a hospital.
- Increase in outpatient follow up appointments within a primary and community setting.

The Women's plan for 2018/2021 is focused on four work streams:

- Developing and implementing the longer term service model identified in the strategy.
- Develop a community model for Women's Services aligned to the community centre strategic developments.
- Gynaecology and Women's specialist services.
- Implement the Women's quality and health improvement priorities.

Work stream 1: Developing and implementing the longer term service model identified in the strategy

The women's framework is part of the Health Board's overall strategy Living Healthier, Straying Well. The priorities identified reflect the outcome of extensive engagement with key stakeholders.
There are seven key areas for transformation and strategic development some being a local priority whilst others are regional:

1. Gynaecology
2. Obstetrics
3. Midwifery
4. Estates
5. Workforce Development
6. Information & Technology
7. Patient experience.

Work stream 2: Develop a community model for Women's Services aligned to the Community Centre Strategic developments

1. Community Midwifery
    - Community midwifery teams have a link consultant obstetrician and regular team meetings to discuss and improve models of care
    - Community midwives offer a range of services in the Level 1, Health & well-being Centres and where appropriate in the Level 2 Health & well-being hubs
    - Review workload of community midwives - caseload sizes to enable high quality care
    - Plan the use of level 1 and level 2 facilities to clearly communicate to women what NHS parenting education and support is available in their area, as close to home as possible.

2. Listen and Act
    - All women will see no more than two midwives for routine antenatal and post-natal care
    - Use of DATIX process to monitor when women are denied their chosen birth due to service acuity
    - Birth Choices information
    - Antenatal education.

3. Prudent Maternity Care
    - Continuity of Care - All women will see no more than two midwives for routine antenatal and post-natal care
    - Succession plan for all staff groups to enable professional development to reflect women's and service needs
    - Re-evaluate women's care plan at 36 weeks and again at the onset of labour to determine the most appropriate birth plan.

Work stream 3: Gynaecology and Women's Specialist Services

Develop and implement sustainability plans for gynaecology and Women's specialised services. There are two cross cutting activities to this priority area: -

1. Primary and Community care
    - Referral management
    - Primary care
    - Community care

2. Productivity, Efficiencies, New ways of working
    - Outpatients
    - Minor Operative Procedures (MOPS)
    - Day Case provision
    - In-patient provision
    - Emergency care
    - Theatre Utilisation
    - New roles
    - Staffing efficiencies

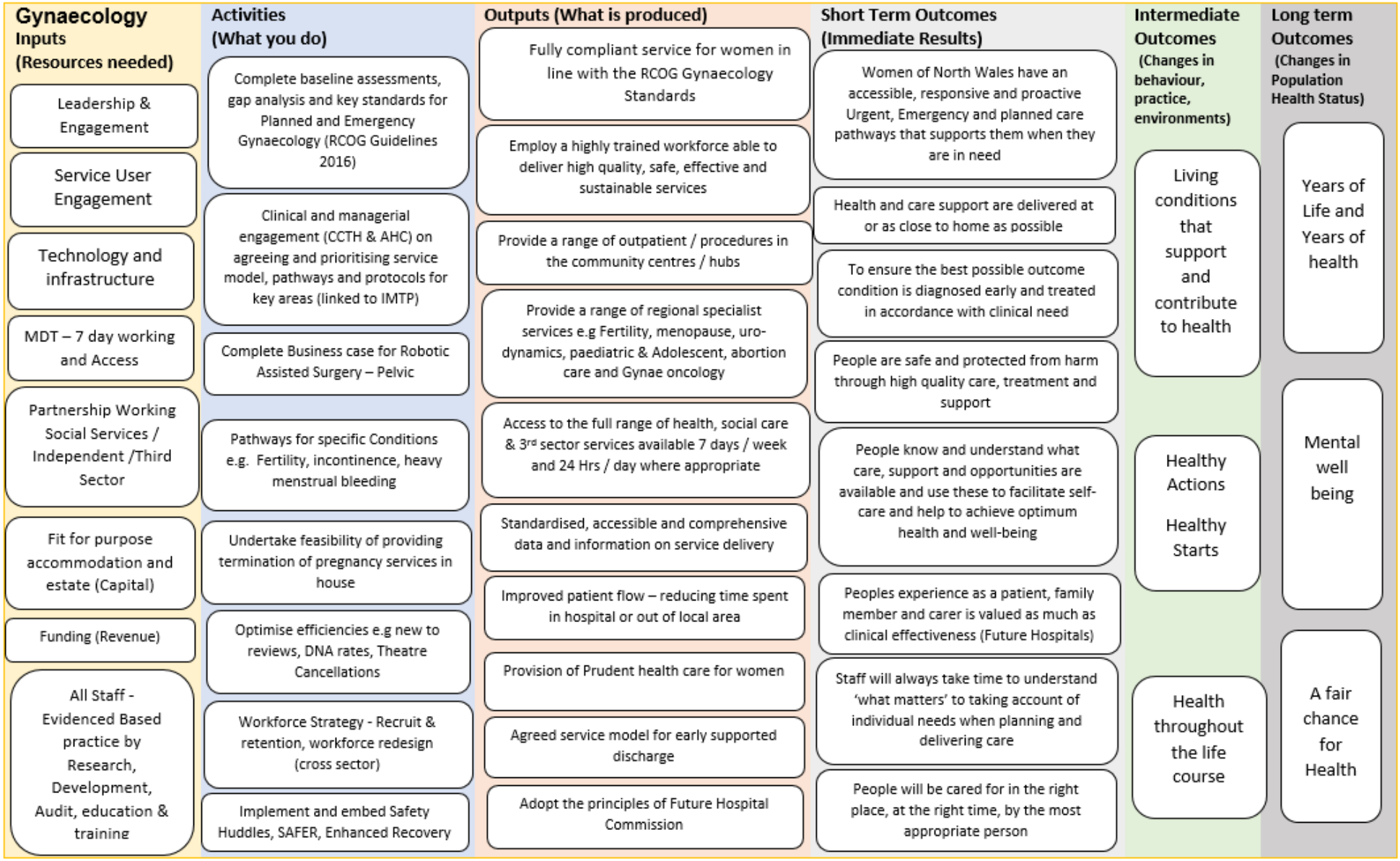
Work stream 4: Implement the Women's Quality and Health Improvement Priorities

This priority area outlines the current and future joint areas of work with the North Wales Public Health Directorate. It contributes to the well-being goals outlined in the Well-being of Future Generation (Wales) Act 2015. There are 7 key cross cutting activities to this priority area:-

1. To improve infant feeding and ensure support and information is consistent
2. Every Child – 10 steps to a healthy weight
3. Prevention of Low Birth Weight Babies
    - Tobacco Exposure
    - First 1000 days collaborative (inclusive of ACE's)
4. Vaccination of pregnant women
5. Perinatal Mental Health support
6. Reduce Avoidable morbidity and mortality by 2020
7. Reduction in Caesarean sections.

The following logic model conveys on a single page the underlying theory of change driving our thinking with Women's Services and provides a high level summary of our prioritised actions.

MATERNITY - Inputs (Resources needed)	Activities (What you do)	Outputs (What is produced)	Short Term Outcomes (Immediate Results)	Intermediate Outcomes (Changes in behaviour, practice, environments)	Long term Outcomes (Changes in Population Health Status & Well Being Status)
Leadership	Work in partnership with Childrens on the relevant priority areas:- Healthy weight, Reduction of ACEs, First 1000 davs	Promote normal birth and reduce unnecessary intervention with 40% of women commencing labour outside a consultant unit	Placing the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect	Ways of living that improve health – Healthy Starts	Mental Well Being
Partnership Working – Internal & External	Service users are effectively engaged in planning and developing services e.g. Maternity Voices & Listening events	New families are healthy and well supported and have the best start in life	Promoting healthy lifestyles for pregnant women which have a positive impact on them and their families health	Children have the best opportunity for a healthy start	
Robust data and information systems	Maternity Voices Focus on 'your birth we Care' Recommendations	Women have access to a range of high quality maternity services that meet their needs	Providing a range of safe high quality choices of care, from midwife to consultant led services	Health in Early Years & Childhood	A Fair Chance for Health
Engagement & involvement	Clear and consistent information e.g. Birth Choice leaflets available to all	Midwives are the first point of contact for the majority of women	All Children have the best possible start in life which is enabled by giving parents and carers the support needed	Minimising avoidable ill-health	
Learning from other projects, best evidence	As part of the IMPT identify how to implement the long term vision for maternity services	Employ a highly trained workforce able to deliver high quality, safe and effective services	Optimal outcome from every pregnancy for mother and child (First 1000 days)	Families and individuals have the resources to live fulfilled, healthy lives	Years of Life and Years of Health
Technology	Pathways for specific conditions	Families are supported to make long term health enhancing choices	ACEs are understood and mitigated against	Ways of living that improve health Healthy Actions	
Government Policy	Prioritise Prevention and Early Intervention evidence based practice	Maternal and family emotional health and resilience are positive		Resilient, empowered communities	
Research & Development	Continuity of antenatal and post natal care	Bonding and attachment supports positive parent child relationships resulting in secure emotional attachment for children			
Valued, Informed, trained and motivated workforce	Services are compliant with the Meeting the RCOG Standards	Women with, or at risk of PNMH problems are identified early and can cess services to support them throughout their pregnancy and the first year of their child's life			
Fit for purpose facilities and accommodation for women, partners & staff	Apply the principles of Prudent Maternity Care	Access to specialist Maternal Medicine			
	Promoting normality and midwifery led care				
	Improve Bereavement Support				


Gynaecology
Inputs
(Resources needed)
Leadership & Engagement
Service User Engagement
Technology and infrastructure
MDT – 7 day working and Access
Partnership Working Social Services / Independent /Third Sector
Fit for purpose accommodation and estate (Capital)
Funding (Revenue)
All Staff - Evidenced Based practice by Research, Development, Audit, education & training
Activities
(What you do)
Complete baseline assessments, gap analysis and key standards for Planned and Emergency Gynaecology (RCOG Guidelines 2016)
Clinical and managerial engagement (CCTH & AHC) on agreeing and prioritising service model, pathways and protocols for key areas (linked to IMTP)
Complete Business case for Robotic Assisted Surgery – Pelvic
Pathways for specific Conditions e.g. Fertility, incontinence, heavy menstrual bleeding
Undertake feasibility of providing termination of pregnancy services in house
Optimise efficiencies e.g new to reviews, DNA rates, Theatre Cancellations
Workforce Strategy - Recruit & retention, workforce redesign (cross sector)
Implement and embed Safety Huddles, SAFER, Enhanced Recovery
Outputs (What is produced)
Fully compliant service for women in line with the RCOG Gynaecology Standards
Employ a highly trained workforce able to deliver high quality, safe, effective and sustainable services
Provide a range of outpatient / procedures in the community centres / hubs
Provide a range of regional specialist services e.g Fertility, menopause, uro-dynamics, paediatric & Adolescent, abortion care and Gynae oncology
Access to the full range of health, social care & 3rd sector services available 7 days / week and 24 Hrs / day where appropriate
Standardised, accessible and comprehensive data and information on service delivery
Improved patient flow – reducing time spent in hospital or out of local area
Provision of Prudent health care for women
Agreed service model for early supported discharge
Adopt the principles of Future Hospital Commission
Short Term Outcomes
(Immediate Results)
Women of North Wales have an accessible, responsive and proactive Urgent, Emergency and planned care pathways that supports them when they are in need
Health and care support are delivered at or as close to home as possible
To ensure the best possible outcome condition is diagnosed early and treated in accordance with clinical need
People are safe and protected from harm through high quality care, treatment and support
People know and understand what care, support and opportunities are available and use these to facilitate self-care and help to achieve optimum health and well-being
Peoples experience as a patient, family member and carer is valued as much as clinical effectiveness (Future Hospitals)
Staff will always take time to understand 'what matters' to taking account of individual needs when planning and delivering care
People will be cared for in the right place, at the right time, by the most appropriate person
Intermediate Outcomes
(Changes in behaviour, practice, environments)
Living conditions that support and contribute to health
Healthy Actions
Healthy Starts
Health throughout the life course
Long term Outcomes
(Changes in Population Health Status)
Years of Life and Years of health
Mental well being
A fair chance for Health

Women's Services Three Year Plan 2018/21

Overview

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Long Term Service Model	Team working and the development of a positive working culture is to continue and to be embedded into day to day working													
	Continue to work with PH on the medium to longer term programmes to improve outcomes for maternal and child health													
	Implement the agreed priority areas within clusters as part of the Care Closer To Home Framework including the development of Health & Well Being Centres (e.g. Bangor), Level 1 and Level 2 centres for midwifery and gynaecology													
	Strategy Development / Transformation of Obstetric Services - Further development of local, regional and sub-regional specialities e.g. supporting the full implementation and further development of the SuRNICC, RCOG - Providing Quality Care for Women (Obstetric Standards), improving access and capacity to ultrasound, Free Standing Midwife Led Units													
	Strategic Development / Transformation of Gynaecology Services - Further development of local, regional and sub-regional specialities e.g. developing Robotic Assisted Surgery , Menopause Services, Endometriosis and provide quality care for women (gynaecology) as set out in the RCOG guidelines, improving access and capacity to ultrasound													
	Further develop the priority areas for role re-design and development including Advanced Practice Midwives, Advanced Practice Nurses, Associates Physicians and succession planning e.g. Colposcopy Service and increased capacity													
	Review the impact of the priorities for years 1, 2 and 3 on demand and activity and undertake a review of the workforce requirements													
	Scope and Identify the resources and actions required to enhance the Gynaecological Cancer Pathways including one stop service provision across the 3 sites													
	Identify the resources and actions required to meet the standards set out in 'Safe Provision of Early Pregnancy Services' and develop action plan for implementation													
	Implement the recommendations / requirements of the Revised All Wales Maternity Strategy													
	Continue to work on improving the accommodation / estate to ensure that it is fit for purpose in order to improve outcomes and provide an environment which is safe and comfortable for women and families e.g. MLUs, Centralised Antenatal Clinics, Active Birth Strategy , Colposcopy unit													
	Contribute to the development and implementation of the model for 'Abortion Care' in North Wales													
	Identify the opportunities for enhanced use of technology to improve the quality of care and service user experience													
	Identify and develop opportunity for social prescribing for women and families													
	Review and further develop additional new ways of engaging with women and families													
	Develop an annual work plan following feedback from the Listening Groups.													
	Welsh Audit Office Review of Maternity Services Across North Wales													
	Ensure that the service implements the 5 ways of working as part of the Future Generations Act is embedded in all we do													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Women's Services Community Model	Develop and agree guidance on how to run effective teams with community team leaders and consultants		■	■										
	Implement guidance and audit effectiveness and collate findings			■	■					■				
	Make changes based on audit findings					■	■							
	Review of caseload sizes and identify workforce issues			■										
	Implement recommendation of the caseload review and undertake bi-annual audit				■	■					■			
	Provide advice and support on managing early labour					■								
	Audit of midwifery skills		■	■										
	Develop guidance / flow charts for key pathways			■	■									
	Provide appropriate training				■	■								
	Implement and audit new guidance / pathways					■	■							
	Birth Choices information to all women in first trimester – implement and audit and re-audit.		■	■	■	■				■				■
	Develop and sign off comprehensive feeding strategy and action plan.		■											
	Implement infant feeding strategy.			■	■	■								
	Review the projected impacts of the actions, refine and implement required changes			■	■	■				■				■
	Continuity of Care - All women will see no more than 2 community midwives for routine antenatal and post-natal care		■	■	■	■				■				■
	Active Birth Classes rolled out across BCU with a focus on supporting women and their birth partners to prepare themselves for labour and birth		■	■	■	■				■				■
	Identify and develop condition Specific Pathways for maternity care		■	■						■				■
	Implement and review condition specific pathways				■	■				■				■
	Consider / Scope - including: point of discharge post-natal contraception and long activing reversible contraception from the unit of birth			■	■									
	Implement plans to increase the number of women that receive midwife led antenatal care by reviewing criteria for consultant led care.		■	■	■	■				■				■

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gynaecology and Women's Specialist Services	Develop an action and implementation plan for the 3 areas which are assessed as red (RCOG Benchmarking):- o Time slots for routine gynaecology Outpatient appointments o Unscheduled care - Providing verbal and written information o All emergency admissions seen by consultant with 14 hours.		■	■										
	Implement RCOG action plan				■	■	■	■			■			
	Complete and submit the Colposcopy Business Case for YGC and proposal for increasing clinical capacity and clinics in Wrexham		■	■	■	■					■			
	Establish clinical leads across primary and secondary care to identify procedures and key pathways which could be provided / commenced in a different care setting			■										
	Scope the potential impact of the identified initiatives				■									
	Agree requirements for implementation including training, engagement, communication, facilities, KPIs				■	■								
	Implement recommendations for pathways and alternative care settings					■	■	■			■			
	Implement the revised new to review time slots for RCOG				■									
	Identify and implement new ways of working to reduce number of reviews including telephone, apps etc.			■	■									
	Review impact of new initiatives - refine and refresh					■				■				■
	Identify procedures which could be carried out in an alternative hospital setting (in-patient, daycase, MOP)				■									
	Identify patterns across north wales and identify best practice				■									
	Implement best practice, review, refresh and refine					■				■				■
	Identify areas where there is avoidable variation across the three units		■	■						■				■
	Audit compliance with best practice / standards / targets across North Wales			■						■				■
	Develop a 'reducing variation 'action plan and implement, review, refine and refresh				■	■	■			■				■
	Establish a group to undertake review of waiting list management across the 3 sites		■											
	Undertake scoping exercise and make recommendations			■	■									
	Implement recommendations					■								
	Review of SAFER implementation across other clinical areas - lessons learned			■	■									
	Develop and implement action plan			■	■									
	identify opportunities for nurse / non medical led discharge			■										

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Quality and Health Improvement	Develop and sign off comprehensive infant feeding Strategy and action plan.													
	Implement agreed action plan and review impact													
	Establish flying start project group													
	Every child – 10 steps to a healthy weight to reduce levels of maternal and childhood obesity - Link work on maternal obesity to wider HB work on adult and child obesity services - promote healthy weight during pregnancy													
	Prevention of low birth weight by training the workforce - Recruit to remaining smoking cessation vacant posts													
	Work with PH Team to continually monitor and evaluate success of the Specialist Maternal smoking cessation													
	Work with PH team to undertake review of LBW rates , including trends - rates remain high in some areas													
	Continue the implementation of NICE guidance to smoke free hospitals													
	Continue to support ongoing partnership to improve outcomes in first 1000 days including ACE identification and prevention in pregnancy (Children's Priority Area)													
	Ensure staff trained and promoting benefits of vaccination to all pregnant women - monitor uptake													
	Work with Perinatal Mental Health Team to develop the service including education and training													
	Universal promotion of the importance of mental well-being in perinatal period (5 ways to well-being)													
	Monitor C-Section rates and trends													
	Audit compliance with C-Section Tool Kit													
	Increase referrals to Vaginal Birth After C-section Clinics / advise / support.													
	Reduction in Still birth - implementation of projects/ initiatives													
	Identify and implement actions identified in the MBRACE Report with a focus on Epilepsy and Diabetes													
	Scope provision of bereavement support services and identify best practice													
	Make recommendations for improving bereavement support - develop action plan for implementation													

5.4. MENTAL HEALTH AND WELL-BEING, LEARNING DISABILITIES & SUBSTANCE MISUSE

MENTAL HEALTH AND WELL-BEING, LEARNING DISABILITIES & SUBSTANCE MISUSE

Mental well-being is concerned with how people feel about their lives and whether their lives are worthwhile. It is not just the absence of mental health problems – it is broader than that. It is about how much control someone feels they have; resilience and support networks; participating and being included.

Anyone can experience mental health issues including depression and anxiety. These can affect work, life, relationships, health and well-being.

In 2017, we developed a new strategy for mental health and well-being in North Wales. This is an all-ages mental health strategy, which was co-produced with service users and staff. The strategy will ensure there is promotion of health and well-being for everyone; prevention of mental ill-health and early intervention when needed; and delivery of joined-up and recovery-focused care. The strategy is being taken forward through the North Wales Together for Mental Health partnership board. You can find the full strategy on our website at BCU HB April 2017 Mental Health Strategy.

We will provide high quality, person-centred care to people living with dementia and those affected by it, support the creation of dementia-friendly communities and listen and respond to people with dementia.

What we will do in the first three years

We will:

1. Implement the Together for Mental Health Strategy which will include:

    - Improving Crisis Care
    - Promote the 5 ways to well-being
    - Promote peer support and other services for people moving on from care
    - Step in sooner to support young people with eating disorders
    - Give better support to young people who self-harm
    - Implement the plan to reduce suicide and self-harm for all ages
    - Have more psychological therapies, including online services
    - Widen our range of treatments for people experiencing mental health problems for the first time
    - Have better community services available 24/7
    - Make mental health wards fit for purpose, safe and comfortable
    - Deliver local care when possible
    - Support people living with dementia and their carers

2. Implement the recommendations of external review reports relating to Tawel Fan.
3. Implement Thematic Quality Improvement Plan; Special Measures Framework
4. Review embed of our Governance & Reporting Systems
5. Develop Learning Disability Strategy
6. Refresh Substance Misuse and implement co-occurring framework

In all that we do, ensure individual needs are addressed – such as for people with co-occurring conditions, or people who are homeless. The Mental Health strategy, the developing Learning Disability strategy and the plan for co-occurring mental health and substance misuse have informed our three year plan. We have reflected on and continue to use intelligence from our engagement work, population needs assessments and national benchmarking information as well as our own extensive academic, clinical and operational knowledge and expertise to inform our service transformation. Throughout the ongoing and emerging transformation work, we will ensure that quality improvement is fundamental to all of the care we deliver to our patients at home, in the community and in acute settings. We will also ensure that our systems of governance support and reflect the delivery of high quality of care.

Making it Happen

Responsibility for implementing the strategy has therefore been delegated to four Local Implementation Teams (LITs) covering Anglesey & Gwynedd, Conwy & Denbighshire, Wrexham, and Flintshire. The LITs' membership includes representatives of BCUHB staff, patient and carer representatives, the third sector and partner organisations.

While all of the LITs are focusing on the first year priority of improving crisis care, they are also working to identify solutions to other local problems which have been identified by service users, healthcare professionals and our partner organisations.

For example, the Anglesey & Gwynedd LIT are working to ensure that there is appropriate support in place for people whose mental health may be affected by the imminent rollout of Universal Credit. To complement the work of the Local Implementation Teams we are also working to produce options for multi-disciplinary models of working that will enable us to deliver the ambitions set out in the strategy. This includes evaluating current service pathways, looking at workforce implications and agreeing the professional standards required for new models of working.

Outcomes we want to Achieve

The desired outcomes as described in the high level Logic Model are:

- Individuals are safe and protected from harm through high quality care, treatment and support.
- Individuals know and understand what care, support and opportunities are available and use these to help them achieve health and well-being.
- Health and Care support are delivered at or as close to home as possible.
- Individuals are treated with dignity and respect and treat others the same.
- Voices are heard and listened to.
- Individual circumstances are considered.
- Interventions to improve health are based on good quality and timely research and best practice.
- To ensure the best possible outcome, conditions are diagnosed early and treated in accordance with clinical need.
- Quality trained staff who are fully engaged in delivering excellent care and support to patients and their families.

Key Outcome Indicators

We will use a range of indicators to measure our progress, key examples of which are set out below:

- Increase in number of mental health assessments undertaken within 28 days from the date of receipt of referral.
- Increase in number of therapeutic interventions started within 28 days following assessment.
- Reduced number of frequent attenders in each Emergency Department.
- Increase in outpatient follow-up appointments within a primary and community setting.
- Percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients.
- Percentage of people agreeing that they belong to that area, that people from different backgrounds get on well together and that people treat each other with respect.
- Increase in number of dementia friends / communities in North Wales.
- Reduction in patients being delayed as their care is transferred out of a hospital.

2018/21 Work Programme

Our plan for 2018/21 reflects the ambition set within our strategy. The narrative below gives an overview of our plan for the next three years.

Improving Crisis Care

Our first year priority (to September 2018) is to ensure an effective urgent care system for people in an acute mental health crisis. This includes:

- Working to prevent mental health crises by focusing on early intervention and promoting emotional resilience
- Developing local alternatives to admission: crisis cafes, sanctuaries, strengthened home treatment services, step-down services
- Reviewing and improving the routine processes of bed management and patient flow
- Working with criminal justice services to divert demand arising from the police, via section 136 arrangements, street triage or control room-based mental health staff
- Working with voluntary and third sector agencies to review their role with people at risk of severe mental health crises
- Reviewing how CMHTs work with people at periodic risk of severe mental health crises.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80.0%	80.0%
	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80%	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80.0%	80.0%
Quarterly	Percentage of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	100%	100.0%					100.0%	100.0%

INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	90%	89.7%	89.9%	90.0%	90.2%	90.4%	90.0%	90.0%
	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	100%	100%	100%	100%	100%	100%	100.0%	100.0%

Promote the 5 ways to well-being

We are linking in with the Improving Health transformation group to develop a social prescribing plan that will ensure we promote access to education, exercise, personal and creative outlets for patients from across the community with specific focus on vulnerable groups. Evidence from the population needs assessment demonstrates the impact of loneliness and isolation on physical and mental health and association with primary and community colleagues will allow us to identify individuals or groups with need. We will be working with the cluster model development to embed good mental health promotion into primary care pathways. We are increasing access to psychological therapies for people with mild mental health and physical health problems. Our intent is to ensure the promotion of the 5 ways to well-being is used by and for our staff with the promotion of 'Manager Wellbeing Matters' to provide guidance to support managers' own wellbeing and the wellbeing of others.

Promote peer support and other services for people moving on from care

We will be using the skills and expertise of our rehabilitation service staff to develop pathways that will facilitate community based 'step down' services. We are developing and enhancing the provision of services within our Community Mental Health Teams that will facilitate greater opportunities for care closer to home. We will be reinforcing our relationships with and raising awareness of our third sector partner services to support people moving on from care.

Step in sooner to support young people with eating disorders and give better support to young people who self-harm

We will be working with our colleagues in Children's and Adolescent services to review and analyse current transition arrangements for young people with eating disorders and mental health issues and ensure our staff are appropriately skilled and trained to support younger adults as they move into our care.

Implement the plan to reduce suicide and self-harm for all ages

We will be developing and implementing elements of the suicide prevention strategic plan based on national guidance for Primary Care, with improved access to community based services with an integrated approach with physical health care services to the management of and prevention of self-harm. We will be raising awareness of the availability of the CALL helpline and improved access to psychological therapies. We will be rolling our an alert system that has been developed from our partnership with North Wales Police to allow our ED department staff and psychiatric liaison staff to quickly identify risk patients and ensure they are assessed in a safe environment as soon as possible.

Have more psychological therapies, including online services

We will undertake a whole system review of Psychological Therapy services to inform the service model. This will include increasing access to Psychological Therapies (PT) across both mental and physical health services and developing a strategy and integrated pathways including Early Intervention in Psychosis, trauma informed services, people with mild mental health problems and physical health conditions. We are introducing an electronic means to more effectively monitor waiting times in line with new reporting procedures and will focus on reducing waiting times and reducing variation in access across our services. We will also be strengthening the level of psychological therapy input into substance misuse service and identify opportunities for early psychological therapy intervention for those with chronic health conditions. We will also increase the availability of CBT interventions available across North Wales and intend to extend the provision of nudge training to our nursing staff.

Widen our range of treatments for people experiencing mental health problems for the first time

We will be improving our relationships with GPs and other primary and community colleagues to ensure our patients are appropriately referred and receive the right treatment, at the right time in the right place. We will also use our work to promote the 5 ways to well-being and other mental health awareness promotions and interventions to raise awareness of the availability of our services. We will be improving and enhancing our Mental Health and Learning Disabilities intranet pages to better inform patients of the availability of our services and signposting to our partners.

Have better community services available 24/7

We will increase awareness and use of CALL, Dementia and DAN helplines, through a continued marketing campaign commenced this year. We will be piloting street triage and crisis cafes and evaluate for effectiveness and potential roll out across North Wales. We will be strengthening the relationships between our psychiatric liaison services and unscheduled care services to ensure timely referrals into our care.

Make mental health wards fit for purpose, safe and comfortable

We are reviewing current environments in line with dementia friendly requirements and aligning estates plan to implement changes. We will implement solutions to support the redevelopment of isolated older people's wards. We will continue the improvements, upgrades and reconfiguration of environments to support health and safety and address backlog maintenance issues.

Deliver local care when possible

We will be remodelling and enhancing our inpatient and community services to provide care closer to home. This will be fundamental to our work in the first year of our 3 year plan through a whole system review focusing on pathway development for a multi-disciplinary model that improves people's outcomes. We will be using the national and local intelligence that we have gathered to establish the factors that influence cause, crisis management and recovery and rehabilitation and responding with appropriate pathways that support the development and improvement of our Community Mental Health Team provision, access to psychological therapies, Helplines, street triage, crisis cafes etc.

Our intent in year 2 is to define the pathways, realign and reinforce the partnership arrangements to facilitate effective and appropriate use of the services, facilitate the pathways with appropriate

systems and ensure our staff are trained appropriately in the delivery of care and deployed to the greatest effect.

In all that we do, we will ensure individual needs are addressed – such as for people with co-occurring conditions, or people who are homeless. Substance Misuse Services will be part of the whole system review and will focus on the requirement to provide treatment pathways for people with co-occurring mental health and substance misuse problems. This work will entail addressing the substance misuse implications for physical health and well-being and work with our Hepatology services to increase the testing and treatment for Hepatitis C and B.

Support people living with dementia and their carers

Our older people's services will be as part of the whole system review and we will be continuing the work undertaken so far to improve care for those with high dependency needs and addressing the priority areas identified from the Flynn-Eley review. This builds upon our work to becoming a more dementia friendly organisation. Key to the development of the older peoples services will be addressing key intelligence in the population needs assessment that shows the growing needs due to our ageing population and the increasing impact of loneliness on the over 65s. We will be raising awareness of our dementia helpline and will work with primary care clusters to develop clinical networks to support people with dementia and their families and promote the links between physical and mental health and well-being in older persons.

Learning Disabilities

Year 1 of the 2018/21 plan will see the production of a North Wales Learning Disabilities Strategy. This work has already commenced and is being co-produced with Local Authorities with support from Public Health Wales and the North Wales Social Care and Well-Being Services Improvement Collaborative. The Strategy will be a reflection of both our current practice and our intent for quality improvement, meeting the needs of service users and their families and the continuing and improving Health and social care agenda for North Wales citizens with Learning disabilities. Year 1 priority is to validate, review and assess all the information gathered through the engagement events, evidence gathering and service activity and combine this with best practice from health, education and social care expertise to finalise the strategy and submit to Partnership Board. Year 2 will see the implementation of the strategy and on-going evaluation.

The development of the strategy does not preclude the plans for delivery of Learning Disability services and in year we intend to ensure that all Learning disability services are subject to the same levels of support and scrutiny through the quality improvement agenda. Our estates plan includes the redesign of Mesen Fach and the upgrade and reconfiguring of a number of our wards and buildings to not only address the health, safety and maintenance requirements but to develop environments that are holistically supportive of care in our facilities.

Areas for Urgent Improvement

Quality Improvement, Safety & Assurance

Following the recent Special Measure update from Welsh Government We are developing a Quality Thematic Improvement plan which will continue to ensure that people with lived experience are at the heart of everything we do across the Mental Health and Learning Disability Division and we are committed to improving quality and achieving excellence for our patients, families and carers. We will do this by using population evidence to support and inform the citizens of North Wales to improve their health and well-being and to ensure our staff and services operate within a framework of assurance for quality, safety and within the resources available. This approach will allow us to

address the requirement in Special Measures to have a clear quality improvement and governance plan for mental health services

We are developing a culture of learning to support continuous quality improvement and we are growing this culture through engagement with our own staff and service users to utilise and build upon their knowledge, expertise and experiences. We will increase academic and peer engagement to support new and emerging clinical and technological evidenced based practices, methodologies and techniques.

We will deliver our plans through our strengthened leadership which is key to the development of an improvement culture and our ability to demonstrate improvements in standards and outcomes across all aspects of care. Our commitment and delivery to quality improvement will be critical in establishing a solid foundation for the division on which to build the ambition set out within our strategies.

Specific actions for Quality Improvement, Safety & Assurance for the next 3 years will see greater engagement with our colleagues in both clinical, operational and corporate areas to ensure we can drive the quality improvement agenda. Working closely with our partners we intend to jointly; act on feedback from staff and service user engagement; respond to actions and recommendations from external reviews; manage risks and improve compliance with targets; facilitate and progress the priority areas within our plan.

Our plan responds to addressing quality improvement, safety and assurance and runs throughout all that we do alongside delivering upon our commitment outlined in our Mental Health Strategy. These actions have been prioritised to take into consideration, alignment with need and to address the issues around managing timelines with our partners for co-produced projects.

- **Reduction in the number of Out of Area Placements**

  The requirement to reduce the number of Out of Area placements is a key expectation within Special Measures. We know from national intelligence that out of area placements is a pressure area across the UK, but more specifically we know from feedback from our service users and concerns from our staff that this is not the best choice for our patients. The cost implications for the division are great and those costs could be more appropriately deployed within the division with effective pathway redesign. Immediate steps have been taken to ensure there are rigorous processes in place for assessment and approval of any capacity issues that may result in an out of area placement and we are now addressing the fundamental causes of these capacity issues, one of which is DToC.

- **Reduction in Delayed Transfers of Care (DToC)**

  Whilst the numbers of mental health patients is relatively low the length of the delays are impacting on our patients and services. We have a small but significant number of patients within our DToC delays that require highly complex bespoke packages of care, not readily available to our patients. We are working with Local Authorities and other partners to address these needs, identify the need as early as possible in the patient's pathway and involve service users and families to find solutions.

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful								
Measure		Target	Profile					
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
	Number of mental health HB DToCs	At least a 10% reduction on the 2017/18 position	28	25	21	20	21	19	15

- **Ensure Safe Staffing Levels**

  Work undertaken in 2017/18 will continue throughout year 1 of our 2018/21 plan. Following our participation in the national data exercise for mental health safe staffing levels and a reliance upon bank and agency staff, a full review of nurse staffing levels has been undertaken by our academic and nursing leads. This review was informed by research and guidance outlined in the National Quality Board's guidance document; 'Safe, sustainable and productive staffing – An improvement resource or mental health' and through the triangulated analysis of key workforce, concerns, finance, benchmarking and activity data. Work is being progressed to establish appropriate staffing levels, revise the establishment, recruit to that establishment and ensure current staff are appropriately trained and supported.

- **Review and Remodelling of Continuing Healthcare (CHC) Packages**

  As part of the quality improvement agenda, we have an immediate focus on the demand for and appropriateness of our CHC care. Our population in North Wales are living longer and we will in our service planning, consider the implications for those citizens with lifelong or life limiting needs who are likely to need continuing healthcare for longer periods of time. Our immediate steps include the need to ensure care packages are reviewed more frequently and realigned to the revised need as soon as possible. We will be ensuring there is no backlog or delay to the review timelines. We will also be ensuring care packages are within appropriate environments as close to home as possible as we know from our service user feedback that this is better for our service users and families, and supports and improves continuity of care for patients..

- **Reinforce Leadership and Governance Arrangements**

  We understand the need for strong and effective leadership and clear lines of accountability that will drive the intent of the plan and ensure supportive and measured responses to areas of emerging need. Work has begun on substantive recruitment to the senior management structure including strengthening governance arrangements throughout the division. We are responding to staff feedback and acting on and addressing needs identified from patients, Carers and within our services.

Across our service redesign and practice our intent is to demonstrate the Mental Health Strategy six key principles that will be reflected in everything we do:

- We will treat people who use our services, and their carer's and families as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales
- We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care.
- We will work to ensure everyone feels valued and respected
- We will support and promote the best quality of life for everyone living with mental health problems
- We will promote local innovation and local evaluation in how we provide services

- We will continually measure our impact on outcomes, within both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services.

Enabling Plans

We know that delivering our quality improvement agenda and service redesign will need to be facilitated by well trained, enthusiastic and committed staff, supported by systems and processes that enable quality delivery of care, and provide assurance as to the delivery, that the care is delivered within environments that are fit for purpose and within resources available to us. To this end our plan is supported by the following key enabling plans;

Workforce and Organisational Development

Our Workforce and Organisational development plan builds upon the work already undertaken to date to agree and implement current and future safe staffing levels, role redesign and recruitment strategies. This work will support the reduction in use of agency staff, improvement in our ability to recruit new staff and keep our existing staff motivated and up to date in their training. This work will also take into consideration that as part of our population needs assessment and our own intelligence we need to factor in the ageing of our workforce. We intend from year 1 to use training, peer support, feedback and skills building to support staff and leaders in the execution of their role. Working with colleagues in workforce to appoint listening leads as part of our service level feedback and evaluation process. Engage with programmes such as 'step into work' which has the potential not only to support the division but provide opportunities for some of our service users.

Capital and Estates Plans

The ongoing implementation of our current estates plan will continue to be updated and in Year 1 will be extended to incorporate a longer term view aligned to support the delivery of the redesigned services. Our intent is to ensure we are addressing both the maintenance backlog and development and redesign of new environments working with the area planning board on current bids for Learning Disabilities estates, Ablett unit redesign and plans for our substance misuse service buildings.

Information Management and Technology

Year 1 of our plan will also see the development of a performance framework. Work has already begun on scoping out the current systems in use and the degree to which they are used across all the services. The intent is to ensure we have appropriate systems that will adequately support and reflect the services, enabling the staff to deliver the services, enable managers to evaluate the division, teams, and individuals on all areas of performance, support managers to effectively control budgets and allow the provision of useful and supportive information for families. Year 1 will see the development of WCCIS and Broadcare and ensure this is aligned to service redesign.

Implementation

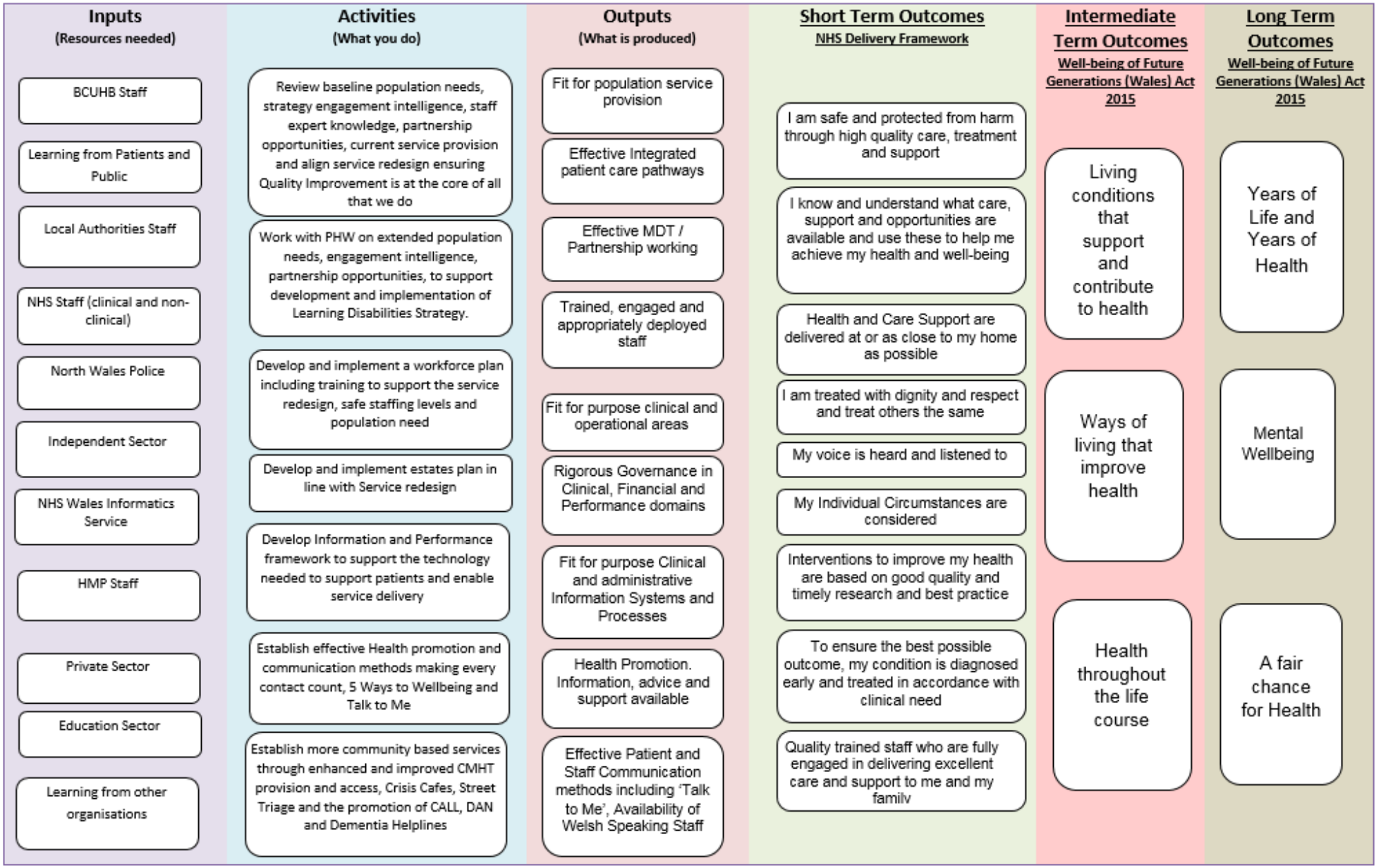
The approach to implementation will be as bottom-up as possible and in all that we do we will put the patient at the centre, and be rooted in the various communities across North Wales – with the default being local, rather than regional implementation structures. The reasons for this are:

- The strategy intends increasingly to prioritise actions to promote public mental health and wellbeing. Most of these will need to be planned and delivered at local level.
- There are numerous historic and current differences between the communities and resources

across the various parts of North Wales. It is essential that our work together reflects those differences, and builds on differing local strengths and assets.

- Most of our staff and services are based within local teams and services, rather than regional systems and structures. A locally-driven process will find it easier to engage staff, to facilitate closer working relationships, to build trust, and thereby to promote the cultural change we are aiming to achieve.
- For service users and their families likewise, engagement with processes of change will be much easier if this is primarily being handled at local level.

Mental Health Logic Diagram / Plan on a Page



Mental Health and Learning Disabilities Three Year Plan 2018/21

OVERVIEW

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
QUALITY IMPROVEMENT, SAFETY AND ASSURANCE	Embed the Health Board Risk Management strategy across all areas of the Division.													
	Embed the Quality Improvement Strategy across all areas of the Division.													
	Increase the evidence of patient / service user engagement and partnership involvement in all areas of service developments.													
	Respond positively to external reviews through the development of action plans to address recommendations and continuously drive improvements.													
	Sustain compliance with the Mental Health measure whilst driving continual improvements.													
	Sustain implementation of current estates plan and progress development of emerging fit for purpose estates plans that support service redesign													
	Develop an information and performance framework to support compliance with care delivery and provide assurance on quality of care and financial and performance management													
LEARNING DISABILITIES	Design and produce a strategy for Learning Disability services in partnership.													
	Baseline current provision investment and population needs. Engagement with primary, secondary, community and LA to identify integration opportunities and service priorities.													
	Undertake improvements to ward environments as required.													
	Approval of new strategy.													
	Develop future models of care. Commence a repatriation group, identify current patients out of area, develop business cases for schemes that aim to reduce repatriation barriers, develop a communication plan and integrated strategy.													
	Implement the new strategy.													
	Evaluation of new strategy.													
PRIMARY CARE & WELLBEING Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Promote peer support and other services for people moving on from care * Implement the plan to reduce suicide and self harm for all ages * Widen our range of treatments for people experiencing mental health problems for the first time * Have better community services available 24/7 * Deliver local care when possible	Review patient flow between primary and secondary care including the development of an agreed pathway between primary and secondary care.													
	Develop and roll out a plan to ensure women are offered a Mental Health assessment in the antenatal and postnatal period by appropriately trained health professionals.													
	Support the development and implementation of the suicide prevention strategic plan based on national guidelines.													

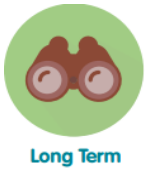
PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Promote peer support and other services for people moving on from care * Implement the plan to reduce suicide and self harm for all ages * Widen our range of treatments for people experiencing mental health problems for the first time * Have more psychological therapies, including online services * Have better community services available 24/7 * Make mental health wards fit for purpose, safe and comfortable * Deliver local care when possible	Emergency medical admissions. To include a scoping exercise with Primary Care, Psychiatric Liaison and Acute Physicians to consider the impact of Medically Unexplained Symptoms, identify best practice from other areas and implement new pathways.													
	Chronic Conditions. Scope opportunities for early intervention for those with chronic conditions. Identify best practice and identify areas for action and implementation of new pathways.													
	Further develop data-set to understand flow, capacity and pull/pushes in the system.													
	Undertake environmental improvements and develop a strategic estates plan for ensure all wards are fit for purpose, safe and humane.													
	Agree and implement a whole system model for acute and community care and a recovery focussed pathway development for a multi-disciplinary model that improves people's outcomes.													
	Develop medicines management and pharmacy requirements including role redesign during 2018/19 with implementation and evaluation in 2019/21.													
	Increase access to Psychological Therapies. Year one pathways and service profiles to be developed, year two implementation of integrated pathways and year three evaluation and outcome report.													
	A focus on perinatal mental health support will ensure clear clinical pathways in place and improved access to services.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
OLDER PEOPLE'S MENTAL HEALTH SERVICE Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Support people living with dementia and their carers * Promote peer support and other services for people moving on from care * Implement the plan to reduce suicide and self harm for all ages * Widen our range of treatments for people experiencing mental health problems for the first time * Have more psychological therapies, including online services * Have better community services available 24/7 * Make mental health wards fit for purpose, safe and comfortable	Agree service developments in line with HASCAS report and Okenden Older People's Mental Health Governance report.													
	Develop a vision for Older People's Mental Health services.													
	Working with Primary Care Clusters, develop clinical networks to support people with dementia and their families.													
	Make dementia friendly environments through developing and implementing a new national dementia plan.													
	Introduce the BCU approach to dementia care across Older People's Mental Health services which will include the memory services commencing assessment within 28 days of referral.													
	Undertake improvements, upgrades and reconfiguration of wards to address the backlog maintenance issues.													
	Explore models and solutions to support isolated Older People's Mental Health wards. To include reviewing existing isolated estate, agree plans and complete the programme of improvement.													
	Older People's Mental Health home treatment service and high dependency ward. To include development of a proposal for the service, proof of concept, implementation of home treatment service and evaluation.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
FORENSIC AND REHABILITATION SERVICES Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Promote peer support and other services for people moving on from care * Implement the plan to reduce suicide and self harm for all ages * Have more psychological therapies, including online services * Make mental health wards fit for purpose, safe and	Develop a fully costed plan to address workforce challenges with implementation to commence in Q4.													
	Agree a long term model for forensic and low secure supporting patient flow pathways. Pathways to be presented in 19/20 and implemented in 20/21.													
	Review the existing forensic/rehab wards and consider capital investment to redesign wards by Q4. Plans to be submitted in 19/20 and implementation in 20/21.													
	Submit plans for forensic/rehab redesign for approval in 19/20 and implementation in 20/21.													
	Submit joint agreed plans for rehab unit in 19/20 and implementation in 20/21.													
SUBSTANCE MISUSE Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Implement the plan to reduce suicide and self harm for all ages * Widen our range of treatments for people experiencing mental health problems for the first time * Have more psychological therapies, including online services * Have better community services available 24/7 * Deliver local care when possible	Strengthen existing psychological interventions available within substance misuse service.													
	Be actively involved in the Working Together to Reduce Harm review and implementation of the delivery plan.													
	Develop manualised programmes based on helping hands to grow in year two and increase CBT interventions in year three.													
	Develop and implement treatment pathways in line with framework for people with a co-occurring mental health and substance misuse problem.													
	Develop a training programme for all staff across in mental health and substance misuse to have training in co-occurring mental health and substance misuse problems. Implementation of the agreed pathways in year 2 and evaluate in year 3.													
	Develop a primary care service with clear governance arrangements. To include review of current model, development of business case for enhanced services, consult on proposed new model.													
	Consult and implement of new primary care service model throughout North Wales SMS in Year 2 and evaluate in year 3													
	Develop non-medical prescribers across North Wales to enhance current prescribing arrangements, Job descriptions to be agreed for NMP posts. Policy and formulary to be agreed and training undertaken.													
	Non-medical prescribers to be operational within SMS in year 2 and a thematic review of availability of and planning for prescribing arrangements in year 3.													
	Develop jointly between Hepatology, BBV and SMS service a robust testing and treatment plan in line with WHO targets.													
	Implement plan to ensure all patients are to be routinely offered BBV testing at assessment													
	Review and evaluate joint Hep, BBV and SMS service provision and governance arrangements													
	Ensure the principles of quality and safety underpin the service by completing a review, sharing of best practice and embedding audit in all areas of practice													
	Undertake thematic mortality review													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CAMHS **Facilitating strategy ambitions to; * Promote 5 ways to wellbeing * Step in sooner to support young people with eating disorders and give better support to young people who self harm * Implement the plan to reduce suicide and self harm for all**	Transition to adult services - work at all levels with LA's to develop a shared understanding and shared approach to working with young people transitioning to adult services.													
	Implement new transition model.													
	Evaluate new model.													
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	Continue with ongoing workforce planning to accurately forecast our future staffing requirements and review the structure and size of our establishment including role redesign.													
	Commence recruitment to those areas with agreed establishment levels and then continue recruitment in line with workforce planning to maintain levels to ensure safe staffing and address issues in relation to age profile of workforce e.g. development of apprenticeships, and paying regard to issues with relation to older workforce													
	Strengthen leadership, capability and engagement.													
	Support and develop staff to deliver expected standards of care and deal with performance that falls short of expectations.													
	Implement training programmes and evaluate.													

5.5. CHILDREN AND YOUNG PEOPLE



CHILDREN AND YOUNG PEOPLE

We want to work in partnership with our communities including children, young people and their families so that all have the best start in life.

Our Vision for the Future

We will put the United Nations Convention on the Rights of the Child (UNCRC) at the centre of everything we do. We will listen to children, young people and their families; we will include them in decisions and in the planning and design of our services for the future.

We will support the first 1,000 days of life (from conception to a child's second birthday) as we know this gives children the best opportunity for a healthy start and makes a real difference to the rest of their life. Getting it right can also reduce lifelong health problems like heart disease, diabetes, and cancer.

We want to reduce the impact of Adverse Childhood Experiences (ACEs), for example parental separation or divorce, substance misuse in the home, or emotional neglect. We know that, in Wales, children who suffer four or more adverse experiences in childhood are more than twice as likely to be diagnosed with chronic disease as adults, compared to those who do not have such experiences. Preventing ACEs can improve health across the whole life course, having far reaching impacts for our future generations.

What we will do in the first three years
We will:

- Keep putting children's, young people's and families' rights at the centre of our work.
- Improve support in the first 1,000 days of life.
- Find more ways to support children's emotional health, mental well-being and resilience.
- Focus on reducing childhood obesity and promoting healthy eating habits for future health and well-being.
- Look at the crisis services we have for children and young people who have mental health needs.
- Find ways to handle ACEs better and reduce the impact they have on lives.
- Improve how we bring services together to support children with complex needs.
- Improve how we listen to and engage with children and young people and their families.

Outcomes We Want To Achieve

The desired outcomes as described in the high level Logic Model are:

- All children have the best possible start in life.
- Children are prevented from ACE's.
- Children and Young People are more resilient and better able to tackle poor mental well-being.
- When experiencing mental health and physical problems / illnesses, access to services is timely and as close to home as possible.
- Children are listened to and services planned and provided based on what is important to them.
- All children in early years learn, develop, are and feel safe, cared for, supported and valued.
- All children in early years do not live in and are not disadvantaged by poverty.

Key Outcome Indicators

We will use a range of indicators to measure our progress, key examples of which are set out below:

- Breast feeding rates
- Children aged 4 / 5 years are of healthy weight
- Immunisation and vaccination rates
- Reduced rates of infant mortality
- Reduction in number of low birthweight babies
- Teenage pregnancy rates
- Increase the breadth and timeliness of services available to respond to children in crisis
- For those children in crisis, improve the multi-agency response and breadth of service available in order to reduce the use of the Mental Health Act
- Reduce the prevalence of suicide and self-harm
- Increase in the number of staff trained in ACE recognition and mitigation
- Reduce waiting times for Specialist Child and Adolescent Mental Health Services (CAMHS) assessment and treatment, Neurodevelopmental assessment and acute Paediatrics.
- Increase the community multi-agency provision to reduce inappropriate referrals to Emergency Departments and CAMHS
- Increased collaboration with partners (Education, Social Care, Third Sector, Housing) to improve outcomes for children, families and young carers
- Level of free school meals
- Young people not in education, employment or training (NEETS)
- Increase in outpatient follow up appointments within a primary and community setting.
- Compliance with referral to treatment time targets.
- Reduced length of wait when accessing treatment through Emergency Departments.
- Reduction in hospital acquired infections.
- Full compliance with the patient safety reporting system.

National Delivery Framework Targets

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun	Sept	Dec	Mar-19	Mar-20	Mar-21
	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	Percentage of children who received 2 doses of the MMR vaccine by age 5		91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%

2018/21 Work Programme

Plans for children and young people have been developed in partnership and following extensive engagement as part of the Children's Transformation Group. The identified priorities have been ratified by the Part 9 Board and form the priorities of the Health Boards Longer Term Strategy. It must be recognised that the successful delivery of the priorities is dependent upon co-design, planning and delivery with Partners. There are also critical interdependencies with other programmes of work including Care Closer to Home, Health Improvement, Women's, Mental Health, Planned and unscheduled care.

The Children's plan for 2018 / 2021 is focused upon six work streams:

- Promotion of healthy weight and prevention of childhood obesity
- Crisis intervention services for children and young people who are experiencing an urgent perceived mental health crisis
- Prevention and mitigation of adverse childhood experiences – delivering ACE informed services
- Improving emotional health, mental well-being and resilience of children and their families
- Improving outcomes in the 1st 1000 days
- Children with complex needs due to disability or illness

Principles

- That children, young people and their families are engaged with designing and planning services. Clear strategies are needed to ensure this engagement captures the views of young service users (and their carers) with respect to what it is that they value and need from services.
- That children and young people are Safeguarded from neglect and abuse.
- That our strategy and service plan is underpinned by the Children's Rights Approach grounded in the UNCRC.

Work stream one - Promotion of Healthy Weight and Prevention of Childhood Obesity

Co-produce / design services which promote and support children and young people and their families to maintain a healthy weight by evidence based:-
Tier 1 – Community based prevention and early intervention services
Tier 2 – Community and primary care weight management service
Tier 3 – Specialist MDT weight Management Services (Produce Business case for North Wales)
The Healthy Weight, reducing childhood obesity plan for North Wales will be aligned to the All Wales Obesity Pathway, and consider support and services which will include the first 1000 days to 18 years, including consideration to 18 – 25 years.
This project will also consider the importance and benefits of establishing positive eating habits and a healthy weight on the wider issues of eating disorders.
The work stream will work with all the other priority areas (Children with complex needs, Children in Crisis, First 1000 days, ACEs, Emotional Health & Well-being) with a greater focus on First 1000 days and Emotional Health & Well-being.
NB. Tier 4 specialist medical and surgical services is outside the scope of this work.

The focus for year one will be on the following:

- Infant Feeding Strategy
- 10 Steps to a Healthy Weight

- Child Measurement Programme
- Lifestyle Programme
- Healthy Schools, Pre-school, physical literacy
- Tier 3 Business Case
- Social Prescribing

Work stream two - Crisis Intervention Services for Children and Young People who are experiencing emotional and/or Urgent Mental Health Crisis

The number of Children and Young People in a level of distress and requiring a crisis response has been increasing over a number years however, it has hit a new threshold over recent years. Young People are being admitted to paediatric wards and to the s136 suite as a consequence of self-harming, high level of distress, suicidal ideation and complex challenging behaviour that is a consequence of psycho social factors.

Ultimately the sustainable solution is to ensure that the prevention and early intervention activity being delivered by the Health Services, Schools, Social Services, Primary Care is effective and continues to be invested in by Welsh Government and is a priority for partnerships.

However the impact will take time and while this work continues to progress there is an urgency to address the current service response to young people in acute mental distress.

Paediatric wards are orientated to caring for children and young people with physical ill health, the impact of having young people on the ward in distress has risks for the individual and potentially for other children and the staff on the ward, particularly when physical intervention is required.

As a consequence of the concerns expressed regarding the use of the s136 suites and the large increase in crisis presentations, a workshop was convened to explore these issues and to develop solutions.

Partnership working between Health, Local Authorities, Education, Emergency Departments, Paediatrics and Adult Mental Health is fundamental to delivery of care to these young people and their families, the solutions will need to be developed and delivered together.

This work stream will therefore gather evidence from young people and their families, identify options and develop a business case to improve crisis intervention services including S136, Crisis Care and Emergency Beds.

Work stream three - Prevention and Mitigation of Adverse Childhood Experiences – Delivering Trauma Informed Services

This work stream will focus on preventing exposure to ACEs through:

- Awareness raising / training – frontline staff
- Early pregnancy intervention
- Prioritise parents for support and interventions e.g. mental health, substance misuse, domestic abuse

Implement evidenced based best practice to ensure that early recognition of risk and early intervention in the following priority areas:

- Routine Enquiry in pregnancy and early childhood
- Behaviour management and support to schools
- Looked After Children – mitigating pre care ACE IMPACT
- CAMHS / Police / Youth Offending Services

Provision of treatment and care, specifically:

- Access to continuous trusted adult support for every child
- Early intervention for abuse, mental illness, substance use, offending and violence
- Trauma Informed services, tackling root causes not symptoms

Work stream four - Improving Emotional Health, Mental Well-being and Resilience of Children and their Families

This work stream outlines planned work within BCUHB and partner agencies in improving the emotional health wellbeing and resilience of children, young people and families. This project should be read in conjunction with all other plans for children and young people as outlined above.

CAMHS has experienced one of the fastest growing increases in demand when compared with all other health services, a trend which is consistent across the UK. Evidence shows that early intervention is effective, especially when early in the life of a problem, a child, or both. Over the last five years specialist services in North Wales have been increasingly moving towards a more upstream position despite year on year increases in demand and the introduction of targets under the mental health measure that focus mainly on waiting times.

This work stream seeks to work in partnership with young people, schools, public health teams and professionals from all agencies in developing a joined up multiagency approach to promoting good mental health, wellbeing and resilience in all children, young people and families; and ensuring that those who need help know what to do and where to go.

Work stream five - First 1000 Days

This work stream describes the planned activities of BCU HB's children and young people services and the BCH HB public health team to improve outcomes in the first 1000 days of life (conception to age 2). This plan should be read in conjunction with the Women's Health Improvement plan which describes the actions to be taken by maternity services. It should also be considered alongside the other CYP plans for healthy weight, ACE and emotional health/mental well-being and the HB plans for immunisation and tobacco. Evidence shows this period of the life course is a crucial window of time in which to intervene in order to improve health and well-being across the whole life course. Evidence based interventions should be prioritised in the F1000D in order to align activities with brain development and maximise population health and return on investment for families, communities, public services and society. The key aims of this plan are:

- Implementation of HB's infant feeding strategy and action plan
- Reduce childhood obesity to ensure children start school a healthy weight
- Implement Healthy Child Programme – with a strong focus on preventative approaches in relation to infant feeding, healthy weight, exposure to tobacco, SIDS prevention, mental health and well-being (Cross reference plan on HCP implementation)
- Describe Health Board contribution to First 1000 days Collaborative and other relevant partnership approaches
- Ensure 95% 2 year olds are up to date with Immunisations and targeted support for pre-school children with the second MMR immunisation.
- Early identification and timely support to parents in relation to mental health and well-being and early parenting.

Work stream six - Children with Complex Needs due to Disability or Illness

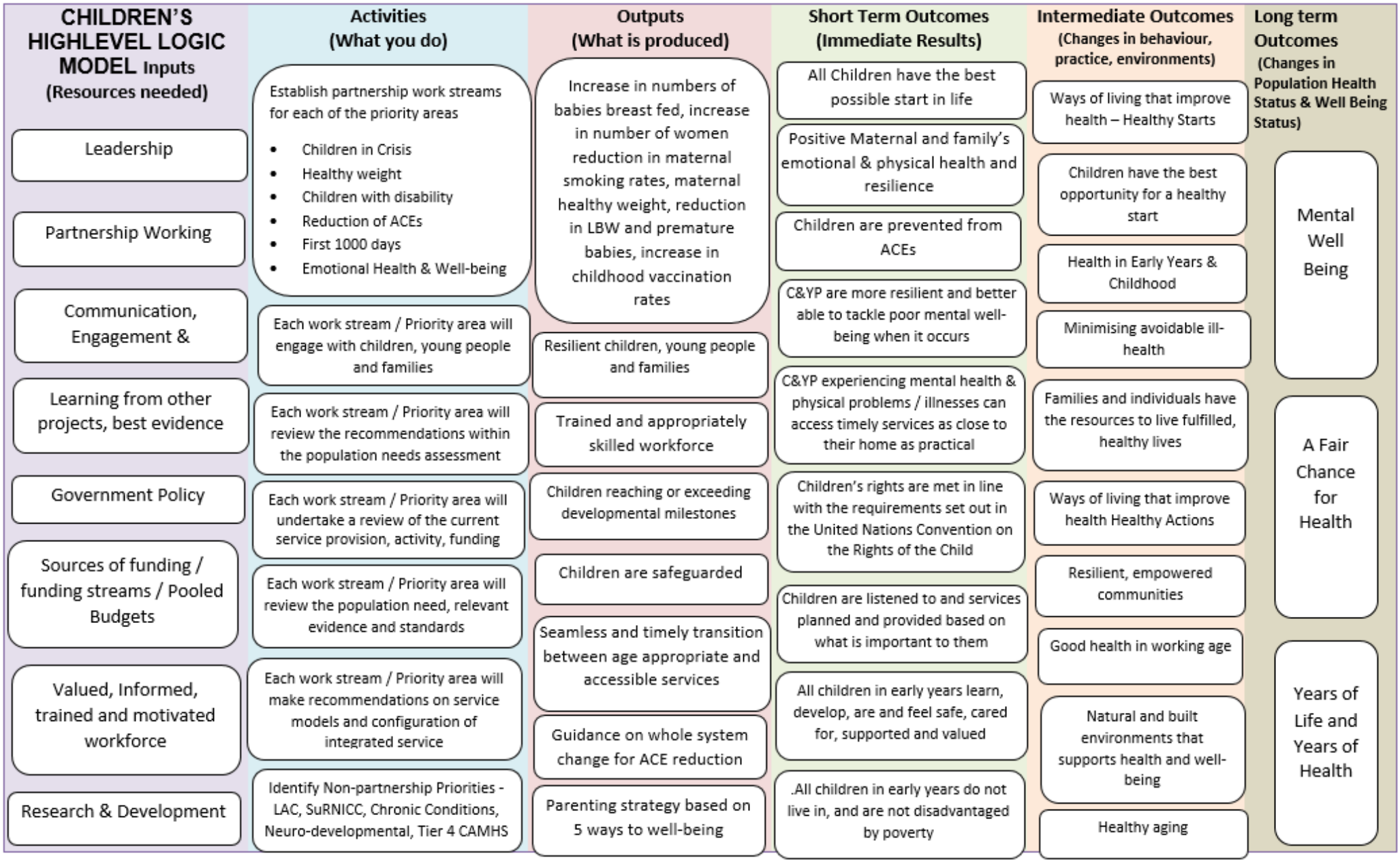
Children and young people with complex needs is a board term that can mean different things to different groups. It is therefore important that we establish an agreed set of definition between all parties to enable us to work together. Having established the baseline from the key agencies involved and the voice of the users we will establish a risk assessment to identify the priority areas.

Following identification of priorities pathways will be reviewed using a lean methodology to improve the effectiveness, safety and quality of them. This will include roles, responsibilities and escalation process within those pathways.

Whilst undertaking this strategic partnership approach to children and young people with complex needs, the current service provision already being delivered and developments in progress from 2017-18 need to continue:

- Looked after Children: To prioritise Looked after Children within the service – for medicals/ LAC health assessments and reviews.
- Children have multi-disciplinary neuro development assessments (Autism/ADHD).
- Children with Disabilities - improved access to children and their families to early assessment and support.
- Children and young people with chronic conditions are able to access timely evidenced based care as per NICE guidance: Diabetes, Epilepsy, and Respiratory.
- Children with palliative care needs and their families are supported, with seamless care delivered at home and in hospital.
- Neonatal Care - SuRNICC. Phase 3 final cot configuration all Babies 27+0 to 31+6 cared for at YGC.
- Paediatric Unscheduled Care – Consultant Paediatrician and Paediatric Nursing with the Emergency Dept., ensuring that assessment of children and young people with acute medical needs is timely by skilled clinicians, that children are not subjected to clinical investigations or admitted unnecessarily.

The following logic model conveys on a single page the underlying theory of change driving our thinking with Children's and Young People's Services and provides a high level summary of our prioritised actions.


CHILDREN'S HIGHLEVEL LOGIC MODEL Inputs (Resources needed)
Leadership
Partnership Working
Communication, Engagement &
Learning from other projects, best evidence
Government Policy
Sources of funding / funding streams / Pooled Budgets
Valued, Informed, trained and motivated workforce
Research & Development
Activities (What you do)
Establish partnership work streams for each of the priority areas
Children in Crisis
Healthy weight
Children with disability
Reduction of ACEs
First 1000 days
Emotional Health & Well-being
Each work stream / Priority area will engage with children, young people and families
Each work stream / Priority area will review the recommendations within the population needs assessment
Each work stream / Priority area will undertake a review of the current service provision, activity, funding
Each work stream / Priority area will review the population need, relevant evidence and standards
Each work stream / Priority area will make recommendations on service models and configuration of integrated service
Identify Non-partnership Priorities - LAC, SuRNICC, Chronic Conditions, Neuro-developmental, Tier 4 CAMHS
Outputs (What is produced)
Increase in numbers of babies breast fed, increase in number of women reduction in maternal smoking rates, maternal healthy weight, reduction in LBW and premature babies, increase in childhood vaccination rates
Resilient children, young people and families
Trained and appropriately skilled workforce
Children reaching or exceeding developmental milestones
Children are safeguarded
Seamless and timely transition between age appropriate and accessible services
Guidance on whole system change for ACE reduction
Parenting strategy based on 5 ways to well-being
Short Term Outcomes (Immediate Results)
All Children have the best possible start in life
Positive Maternal and family's emotional & physical health and resilience
Children are prevented from ACEs
C&YP are more resilient and better able to tackle poor mental well-being when it occurs
C&YP experiencing mental health & physical problems / illnesses can access timely services as close to their home as practical
Children's rights are met in line with the requirements set out in the United Nations Convention on the Rights of the Child
Children are listened to and services planned and provided based on what is important to them
All children in early years learn, develop, are and feel safe, cared for, supported and valued
.All children in early years do not live in, and are not disadvantaged by poverty
Intermediate Outcomes (Changes in behaviour, practice, environments)
Ways of living that improve health – Healthy Starts
Children have the best opportunity for a healthy start
Health in Early Years & Childhood
Minimising avoidable ill-health
Families and individuals have the resources to live fulfilled, healthy lives
Ways of living that improve health Healthy Actions
Resilient, empowered communities
Good health in working age
Natural and built environments that supports health and well-being
Healthy aging
Long term Outcomes (Changes in Population Health Status & Well Being Status)
Mental Well Being
A Fair Chance for Health
Years of Life and Years of Health

Children's and Young People's Services Three Year Plan

OVERVIEW

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Promotion of Healthly Weight and Prevention of Childhood Obesity	Develop and sign off comprehensive infant feeding Strategy and action plan.													
	Implement agreed action plan and review impact													
	Review evidence base on effective weight management services for children and young people, and for pregnant women who are obese. Scope pathways.													
	Review current documentation and processes for Child Measurement Programme.													
	Make recommendations for change of CMP to Transformation Group and secure resources													
	Develop action plan and implement new CMP and undertake annual review of impact													
	Review current provision of services and priority areas across North Wales, review best practice from other areas and shared priority areas for healthy schools, pre-school and physical literacy.													
	Implement recommendations and monitor impact													
	Review current provision of services and referral mechanisms across North Wales for Lifestyle Programmes, review referrals for the cohort aged 16-25 years (numbers and reasons).													
	Implement recommendations and monitor impact													
	Undertake review of current service provision for levels 1, 2 and 3. Draft business case, sign off and submission.													
	Secure Resources and implement service with mid year and annual review													
	Link work on children's and maternal obesity to wider HB work on developing business cases for adult and child obesity services.													
	Scope opportunities for social prescribing with implementation in yrs. 2 and 3													
Crisis Intervention for Urgent Mental Health Crisis	Listening to children, young people and their families – gather patient stories and capture the views of young people who have been admitted under Section 136 over the last 1-2 years.													
	Collective table top review of S136 attendances, benchmark against other HBs and English Trusts.													
	Roll-out of integrated self-harm pathway with Education.													
	Based on views of young people who have been admitted under Section 136 over the last 1-2 years – inform the design and planning of improving services. Final report and dissemination.													
	Implement changes to the Police & Crime Act.													
	Produce option appraisal, cost options, assess quality and equality impact, agree preferred option and develop business case (S136, Crisis Care, Emergency Beds).													
	Sustain seven day CAMHS service supporting Paediatric wards and Emergency Department.													
	Improve transition between CAMHS and Adult Mental Health.													
Prevention and Mitigation of Adverse Childhood Experiences	Establish a working / virtual group to prioritise the work of ACEs for the Health Board - Terms of Reference & scope													
	Develop action plan, implement and monitor emerging evidence for each of the priority areas													
	For each of the other 5 priority areas - agree specific actions in increase ACE awareness, reduction and mitigation													
	Identify and scope the work currently underway across North Wales e.g. Anglesey Project , PSB priorities													
	Identify partnership collective commitment and contribution to raising awareness, changing the responses to children and adults who have experienced ACEs													
	Work with ACE Support Hub in creating an environment for change, support individuals, communities to create an ACE aware society - sharing best practice, emerging projects, what works													
	Produce appropriate information on incidence of ACEs and possible impact for Health Board staff.													
	Identify the cross cutting themes with the other children's priority areas, mental health and women's and feed into the priority setting for Q3													
	Consider the feasibility of rolling out the work of Angelesy Health Visitors on 'Routine Enquiry' (North Wales HV and Midwives)													
	Develop action plan for yr. 2 and 3 and implement													
	Review to ensure that the organisation has raised awareness, impact on adult mental and physical health													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Improving Emotional Health, Mental Well-being and Resilience of Children	ADTRAC – recruit to posts.													
	Consult with young people, families and referrers about their experiences and views on service improvement.													
	ADTRAC – deliver.													
	Report and dissemination following consultation with young people, families and referrers – service improvement.													
	Establish a joined up multi-agency work plan on early and preventative approaches to emotional health, wellbeing and resilience across North Wales.													
	Deliver CAMHS-Schools In-Reach project.													
	Implementation of the Mental Health Measure													
Improving Outcomes in the 1st 1000 days	Develop and sign off comprehensive Infant Feeding Strategy and action plan.													
	Scope need for regional First 1000 days programme and how would link to existing partnership approaches.													
	Implementation of Healthy Child Programme.													
	CYP staff to continue to support emerging work on 1000 days.													
	Support Public Health team in their delivery of communication plan to disseminate evidence and key measures from Every Child: 10 Steps national campaign.													
	Implementation of agreed action plan for infant feeding.													
	Support development of HB strategy for immunisation.													
	Universal promotion of importance of mental well-being in peri / postnatal period and ways to improve (5 Ways) from staff to families as part of routine care.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Children with Complex Needs due to Disability or Illness	Identification of key stakeholders.													
	Group work common types of complex care: E.g.: Health, Social, Educational or Physical, Emotional and mixed.													
	Engage with Children and Young People.													
	Establish Risk scoring criteria amongst team to use on agreed language and then prioritise them.													
	Share output and identify highest risk pathway.													
	Baseline current pathway for highest risk theme.													
	New pathway developed, including training and roll out plan.													
	Deliver new pathway, carryout next pathway development.													
	Operational Delivery of service provision: • Looked After Children have timely assessments and reviews. To prioritise Looked after Children within the service – for medicals/ LAC health assessments and reviews • Children with disabilities & development needs are able to access early assessment and support. Children with Disabilities- improved access to children and their families to early assessment and support. • Children have multi-disciplinary neuro development assessments (Autism/ADHD) - within 26 week target. • Children and young people with chronic conditions are able to access timely evidenced based care as per NICE guidance: Diabetes, Epilepsy, Respiratory. • Paediatric Unscheduled Care – Consultant Paediatrician and Paediatric Nursing with the Emergency Dept., ensuring that assessment of children and young people with acute medical needs is timely by skilled clinicians, that children are not subjected to clinical investigations or admitted unnecessarily.													
	North Wales Neonatal Care - SuRNICC Phase 3 final cot configuration all Babies 27+0 to 30+6 cared for at YGC													
	Paediatric Unscheduled Care: (with reference to the Unscheduled Care plan) • Consultant Paediatrician and Paediatric Nursing within the Emergency Dept., ensuring that assessment of children and young people with acute medical needs is timely by skilled clinicians, that children are not subjected to clinical investigations or admitted unnecessarily. • Paediatric Assessment Units • Link Paediatricians for GPs													

5.6. AGEING WELL

AGEING WELL

Collaboration

Involvement

The Older People's Commissioner for Wales recognises that people's rights can diminish as they get older. We want to ensure that older people's rights have parity with other age groups. By older people we mean people aged 50+. Many people within this age range will be in paid employment or in the early years of retirement. The age at which support needs may emerge will vary.

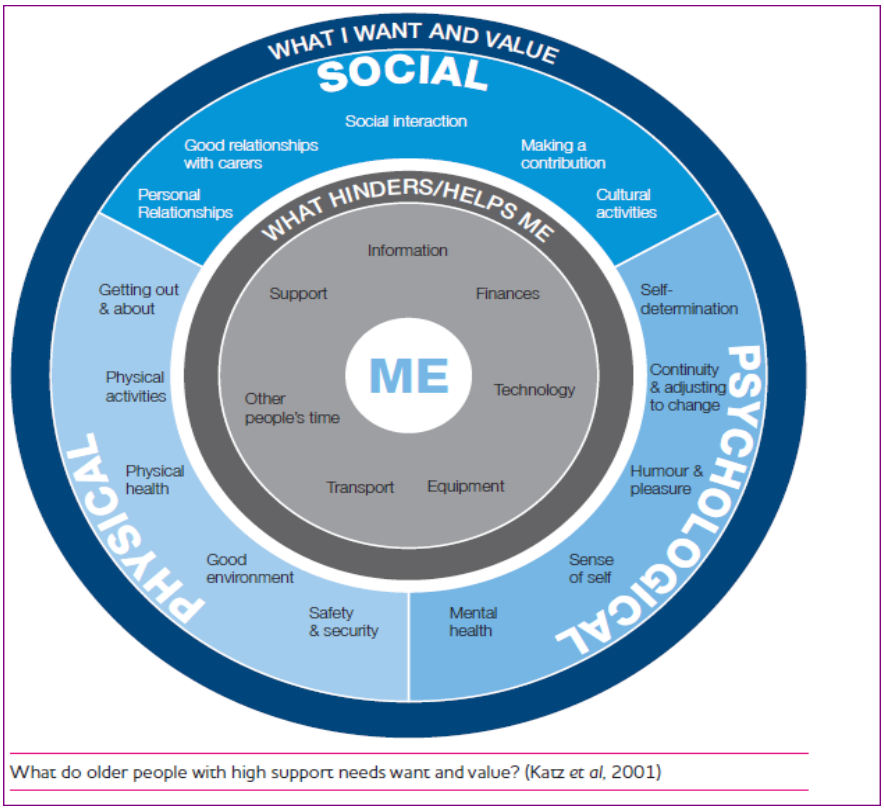
Our Vision for the Future

The United Nations Principles for Older Persons set out 18 principles under five themes – independence, participation, care, self-fulfilment and dignity. We will work to ensure we fulfil these principles.

Older people say they want to stay as independent as possible, for as long as possible. They also want control over the support they get and decisions that affect them. We want people to benefit from health improvement activities throughout their lives so that they have fewer risks for the long term conditions when they reach older age. Older people say they want access to a range of activities and networks that help counteract loneliness and enable them to make a positive contribution to community life. When possible, we help people stay out of hospital or care homes.

We recognise the important role of carers - both those people who care for an older person, and those many older people who are themselves carers, who need support to enable them to continue in this valued role.

It is our ambition that the people of North Wales should have first class healthcare that provides the best possible outcomes; that is joined up with social care and other agencies; that is available as close to home as possible and which will make North Wales a great place to grow old.



What do older people with high support needs want and value? (Katz *et al*, 2001)

Health care services in North Wales provide a wide range of high quality care that improves the quality of life for many older people. However these services are under considerable strain as resources are squeezed and demographic changes increase. We also know that the present arrangements in North Wales can sometimes fail to provide the service experience that people are looking for.

The Framework for Delivery for Older People provides a long term and strategic approach to delivering change. It informs the BCUHB system wide strategy, 'Living Healthier Staying Well', and is a key driver in achieving the 'ambition' of the Health Board. It also supports the delivery of other strategies, such as the Dementia Strategy and the Mental Health and Well-being Strategy. Together these long term plans build a comprehensive approach to meeting the care and support needs of older people.

From a service and commissioning perspective, older people are typically defined in terms of those aged 65+ years. The Framework for Older People however includes everyone aged 50+ years. This is because action needs to start much earlier when working to prevent poor outcomes later in life. In addition, for people from more socially and economically deprived groups, the process of ageing can begin much sooner.

The Framework for Older People includes therefore:

- Those aged 50+ years (many of whom will be in paid employment).
- Those in their early years of retirement.

- Those in their later years of retirement and who may find it more difficult to continue with the life that they enjoyed pre-retirement.
- 'Oldest' old people who may require longer term care and / or may be experiencing a marked impact on the quality of their lives.
- End of life care.

The proportion of older people in the North Wales population has been steadily rising over the past 25 years and will continue to rise in the future. Whilst ageing does not necessarily mean care and support are required, as the population gets older the potential for additional demands for health and care resources has to be allowed for over a longer period.

We have undertaken a significant amount of work in the recent past to engage clinicians, other staff, partners and stakeholders in the debate around improving the health of the population. The Older People's Programme Group has continued to build on this work by undertaking a comprehensive programme of engagement. We will continue to engage on our approach with the local population.

The key over-arching messages below have shaped the development of the Framework for Delivery for Older People:

Key Messages

Older people make an important contribution – demographic change creates a challenge but can also offer a potential solution in that older people provide far more care than they receive. By working together and supporting communities we can achieve better outcomes and better value.

A shift in philosophy and approach – we need to move away from measuring success by how much we do to how many, and towards measuring success by how many older people are enabled to stay living independently at home.

Adding healthy years to life – from a service planning and commissioning perspective we need to re-think our concept of older age, with a focus on ' individual needs as opposed to chronological age. We need to ensure that people have benefited from health improvement activities throughout their lives so that they have fewer risks for long term conditions.

Supporting and caring for older people – we all have a role to play (not just health and social services): families, neighbours and communities; providers of services like housing, transport, leisure, community safety, education and arts; and also shops and banks. The approach to achieving our vision must be 'whole system' recognising that many people make an important contribution in this respect.

Services will be outcome focussed – services will be focussed on working with individuals and their families to deliver what matters to them and will be designed to encourage people to lead meaningful lives in a place of their choice.

Informed decision-making – a well-informed older person can actively participate in the decision-making about their care and better understand the likely or potential outcomes of their treatment. Fundamental to informed decision making is a two way dialogue between an older person and their health practitioners that reflects the ethical principle that the person has the right to decide what is appropriate for them, taking into account their personal circumstances, beliefs and priorities. This includes the right to accept or to decline the offer of certain healthcare and to change that decision. In order for a patient to exercise this right to decide, we must ensure that they have the information that is relevant to them and the capacity to make a decision about the specific issue at the specific time.

Partnership resources are aligned to achieve outcomes – there is considerable pressure on all public sector budgets - which makes it important that all resources spent on services for older people are used to optimal effect

What we will do in the first three years

We will:

- Make sure older people and carers have their rights respected and are involved in decisions.
- Base our plans and services on evidence of what works.
- Reduction in number of older people who feel socially isolated.
- Look at having people as health mentors in the community.
- Communicate better with older people who may have specific needs arising from sensory impairment or dementia.
- Make sure our plans work together with the Local Authorities' ageing well plans.

When people are facing the end of their lives we will:

- Encourage people to talk.
- Help them get the support they need.
- Have information and advice that's easy to find and understand.

● Develop guidance for staff giving people end of life care.
● Work well with hospices.

Outcomes We Want To Achieve

The desired outcomes for people aged 50+ as described in the high level Logic Model are:

- Access to information and advice about services and opportunities that enable them to maximise their health and well-being.
- Individuals live in environments that are sensitive to their needs, support healthy ageing and enable them to be socially connected.
- Appropriate access to high quality primary and community services within the local area.
- Access to proactive community based clinical or social care interventions which avoid unnecessary admission to hospital.
- Access to integrated services to enable them to manage long term conditions, dementia, mental well-being and complex needs.
- Individuals are proactively supported to regain their motivation following an adverse life event / period of poor health / admission to hospital.
- Quality of end of life care is optimised for people aged 50+ and later in life.

Key Outcome Indicators

Examples of the indicators used to measure progress are set out below – some of which will be taken forward in conjunction with partners:

- Self-reported life satisfaction among older people.
- More older people accessing appropriate health screening and immunisation opportunities.
- Older people feeling lonely.
- More older people have access to a health promoting diet.
- More older people self-report being physically active.
- Older people have a home appropriate to their needs.
- Reduction in number of Neck of Femur fractures and attendances at Emergency Departments.
- Reduction in fractured neck of femur.
- Percentage of population who have access to social prescribing activities.
- Increase in outpatient follow-up appointments within a primary and community setting.

Reduction in patients being delayed as their care is transferred out of a hospital.

2018/21 Work Programme

The framework for delivery for Older People is split into four work streams:

- Promoting Health, Independence and Well-being
- Pro-active Support
- Caring for People in the right place at the right time
- End of Life / Palliative Care

Promoting Health, Independence and Well-being

Health Mentor Roles

Health mentors will be an important addition to services. They will support people to develop skills in order that they can respond to change, self-manage their own health and well-being, maintain resilience and identify assets for health.

A multi-disciplinary group will be formed with the aim of developing health mentor roles / health volunteers within community settings (or the work environment). The Health Mentors will be recruited from local communities with a good understanding of local issues and can offer tailored advice, motivation and practical support to individuals who want to increase their well-being.

Health Promotion Interventions

Health promotion supports older people to increase control over, and to improve, their own health. This is of importance to everyone including those with long-term conditions in order to maximise their well-being

A multi-disciplinary group will be formed with the aim of developing evidence based interventions that promote and encourage healthy lifestyle choices.

Assistive Technology

The Care Closer to Home programme has recognised the importance of the development and implementation of telehealth across the Health Board as well as the use of technology such as apps to support people to live as independently as possible in their own homes and communities.

Technology Enabled Care and Support (TECS) is the use of technology by professionals, older people and carers that supports the promotion, self-administration, monitoring and delivery of care, support, safety, security and well-being. TECS offer great potential to transform the way people engage with and control their own healthcare. Fully embracing this technology has the potential to support older people to have ownership and manage their own care (in a way that is right for them) and empowering those people who can take a more active role in managing their own health.

Pro-active Support

Primary Care – Targeted Case Finding

Targeted case finding is used for identifying high risk patients who are likely to be high service users in the future and who may benefit from pro-active management and preventative services and / or immediate and early intervention. The case finding model to be adopted will be one component of a wider approach to managing patients with chronic illness.

This programme of work will be overseen by the BCUHB Primary Care Transformation Group responsible for taking forward elements of the Care Closer to Home work-stream.

Caring for People in the Right Place at the Right Time

A key principle in the care of older people is that of timely help through joined up care. Older people should experience the care and support they receive as if it were from a single source, or managed through a single source. This is fundamental to the development of the Community Resource Teams and the single point of access which seeks to ensure that older people only have to tell their story once to those who are helping them, rather than repeating it to each person involved in their care; and that professionals have access to all the information they need to provide support and care.

Primary Care – Access

Improving access to primary care services is a top priority for older people and carers. Changes to the way primary care services work will mean more timely and convenient access to care, a stronger focus on population health and prevention, a wider range of practice staff (including therapists, advanced practitioners and mental health), and better integration with community / preventative services and hospital specialists. Improvements will include the provision of navigation and triage systems that signpost patients – helping them to move more smoothly through the health (and social care) system. This programme of work will be overseen by the BCUHB Primary Care Transformation Group responsible for taking forward elements of the Care Closer to Home work stream.

Community Resource Teams

Comprehensive Assessments are a multi-disciplinary assessment of medical, functional, psychological and social capability that ensures problems are identified, quantified and managed appropriately. Using this well recognised diagnostic tool, we plan to have dedicated units with staff trained in using comprehensive assessments which will ensure the needs of older people who require acute hospital level care are met. This approach will ensure that management plans are agreed with patients and their family/carers and implemented in order to support the patient to return and remain in their usual place of residence. BCUHB plans to have specialist units to support those older people who would benefit from this type of assessment.

Joint Priorities – Part 9 Regional Partnership Board (RPB)

Part 9 of the Social Services and Well-being (Wales) Act 2014 prioritises older people with complex needs and long term conditions, including dementia as priority areas for the Regional Partnership Board (RPB). A Sub Group of the RPB will review the BCUHB Framework for Delivery for Older People to identify which elements can be taken forward from a partnership perspective.

End of Life / Palliative Care

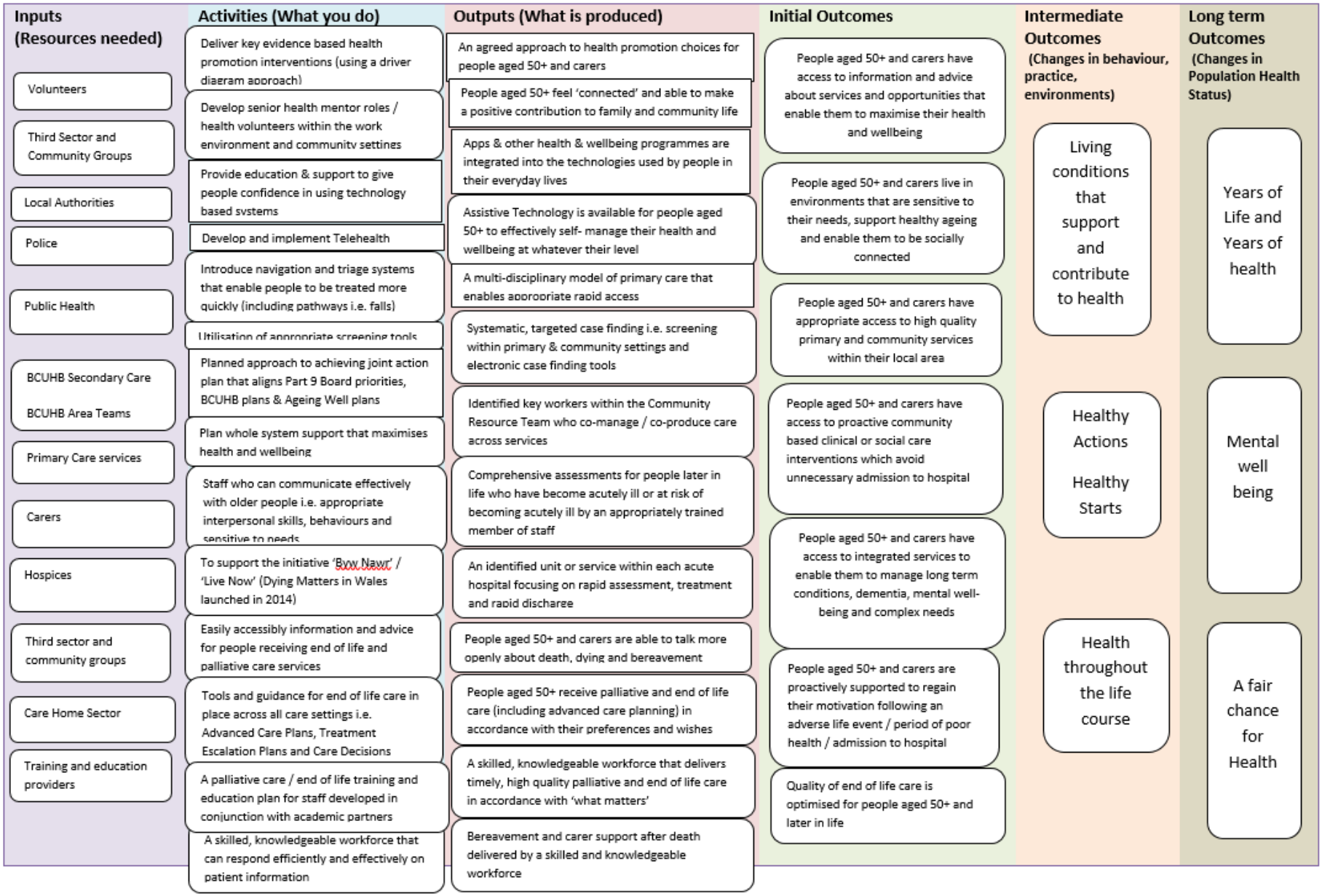
End of Life Care

It is important that patients, carers and their families have the care and support they need during the end of life. End of life care is not just an issue for older people and it is important that the needs of children, families and adults are also recognised and responded to.

In March 2017, Welsh Government published and refreshed the 'Palliative and End of Life Care Delivery Plan' which outlines specific priorities and actions required to improve patient experience and outcomes. The Delivery Plan plays an important role in improving the quality and consistency of palliative and end of life care across Wales, including North Wales. The most recent annual report published by Welsh Government in 2016, outlines where the NHS is doing well and where it needs to improve care. A number of challenges remain which require priority and focus throughout Wales, and by BCUHB, through 2020 and beyond.

Key actions for the following three years include:

- Increase public awareness of death and dying (e.g. Bwy Nawr or other organisations). Continue roll out / evaluation of advance care planning within BCUHB.
- Ensure equitable and timely access to palliative care services in all care settings.
- Working with third parties as appropriate, explore options for improved bereavement support.
- Establish BCUHB strategic group to help co-ordinate above activities.
- Active promotion of initiatives to encourage discussion about the end of life that helps to promote and support for dying well.
- Implementation of Advance Care Planning (SCP) across all care settings to support that support receive palliative and end of life care in accordance with their wishes and preferences. Implementation of other tools / guidance to improve End of Life Care, namely TEPs and All Wales Care Decisions for the Last Days of Life.
- A skilled, knowledgeable workforce that delivers timely, high quality palliative and end of life care in accordance with what matters.


Inputs (Resources needed)
Volunteers
Third Sector and Community Groups
Local Authorities
Police
Public Health
BCUHB Secondary Care
BCUHB Area Teams
Primary Care services
Carers
Hospices
Third sector and community groups
Care Home Sector
Training and education providers
Activities (What you do)
Deliver key evidence based health promotion interventions (using a driver diagram approach)
Develop senior health mentor roles / health volunteers within the work environment and community settings
Provide education & support to give people confidence in using technology based systems
Develop and implement Telehealth
Introduce navigation and triage systems that enable people to be treated more quickly (including pathways i.e. falls)
Utilisation of appropriate screening tools
Planned approach to achieving joint action plan that aligns Part 9 Board priorities, BCUHB plans & Ageing Well plans
Plan whole system support that maximises health and wellbeing
Staff who can communicate effectively with older people i.e. appropriate interpersonal skills, behaviours and sensitive to needs
To support the initiative 'Byw Nawr' / 'Live Now' (Dying Matters in Wales launched in 2014)
Easily accessibly information and advice for people receiving end of life and palliative care services
Tools and guidance for end of life care in place across all care settings i.e. Advanced Care Plans, Treatment Escalation Plans and Care Decisions
A palliative care / end of life training and education plan for staff developed in conjunction with academic partners
A skilled, knowledgeable workforce that can respond efficiently and effectively on patient information
Outputs (What is produced)
An agreed approach to health promotion choices for people aged 50+ and carers
People aged 50+ feel 'connected' and able to make a positive contribution to family and community life
Apps & other health & wellbeing programmes are integrated into the technologies used by people in their everyday lives
Assistive Technology is available for people aged 50+ to effectively self- manage their health and wellbeing at whatever their level
A multi-disciplinary model of primary care that enables appropriate rapid access
Systematic, targeted case finding i.e. screening within primary & community settings and electronic case finding tools
Identified key workers within the Community Resource Team who co-manage / co-produce care across services
Comprehensive assessments for people later in life who have become acutely ill or at risk of becoming acutely ill by an appropriately trained member of staff
An identified unit or service within each acute hospital focusing on rapid assessment, treatment and rapid discharge
People aged 50+ and carers are able to talk more openly about death, dying and bereavement
People aged 50+ receive palliative and end of life care (including advanced care planning) in accordance with their preferences and wishes
A skilled, knowledgeable workforce that delivers timely, high quality palliative and end of life care in accordance with 'what matters'
Bereavement and carer support after death delivered by a skilled and knowledgeable workforce
Initial Outcomes
People aged 50+ and carers have access to information and advice about services and opportunities that enable them to maximise their health and wellbeing
People aged 50+ and carers live in environments that are sensitive to their needs, support healthy ageing and enable them to be socially connected
People aged 50+ and carers have appropriate access to high quality primary and community services within their local area
People aged 50+ and carers have access to proactive community based clinical or social care interventions which avoid unnecessary admission to hospital
People aged 50+ and carers have access to integrated services to enable them to manage long term conditions, dementia, mental well-being and complex needs
People aged 50+ and carers are proactively supported to regain their motivation following an adverse life event / period of poor health / admission to hospital
Quality of end of life care is optimised for people aged 50+ and later in life
Intermediate Outcomes (Changes in behaviour, practice, environments)
Living conditions that support and contribute to health
Healthy Actions
Healthy Starts
Health throughout the life course
Long term Outcomes (Changes in Population Health Status)
Years of Life and Years of health
Mental well being
A fair chance for Health

Older People Three Year Plan 2018/21
OVERVIEW

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Health Mentor Roles	Develop senior health mentor roles / health volunteers within the work environment and community settings.													
Health Promotion Interventions	Deliver key evidence based health promotion interventions using a driver diagram approach.													
Assistive Technology	Develop and implement Telehealth.													
	Provide education and support to give people confidence in using technology based systems.													
Primary Care - Targeted Case Funding	Utilisation of appropriate case finding tools.													
Primary Care - Access	Introduce navigation and triage systems that enable people to be treated more quickly (including pathways i.e. falls).													
	Support Primary Care in the delivery of risk stratification to support people to maintain their health.													
	Report on impact of introduction of risk stratification.													
Community Resource Teams	Staff who can communicate effectively with older people i.e. appropriate interpersonal skills, behaviours and sensitive to needs.													
	Plan whole system support that maximises health and well-being.													
Joint Priorities - Part 9 Regional Partnership Board	Planned approach to achieving joint action plan that aligns Part 9 Board priorities, BCUHB plans and Ageing Well plans.													
End of Life / Palliative Care	People aged 50+ are able to talk more openly about death, dying and bereavement. Dying matters in Wales.													
	Tools and guidance for end of life care in place across all care settings i.e. Advanced Care Plans, Treatment Escalation Plans and Care Decisions.													
	A palliative and end of life care training plan for staff developed in conjunction with academic partners.													
	A skilled and knowledgeable workforce that can respond efficiently and effectively on patient information.													

5.7 Major Health Conditions

5.7 Major Health Conditions

The National Implementation Groups for the nine Major Health Conditions set out specific areas for improvement in the prevention, diagnosis and management of these conditions. They provide oversight of the work with clear expectations that the Health Board will demonstrate progress in key areas. The following sections summarise the national priorities for 2018/19 and the areas we will focus on during 2018/19 utilising our existing staff and resources to best effect.

Major Health Conditions		
Plan	**National Priorities for 2018/19**	**BCU Priorities for 2018/19**
Cancer	• Prevention opportunities in secondary care and screening uptake. • Diagnosing cancers earlier supported by Detecting Cancer Early and Framework for Cancer programmes. • Meeting cancer waiting times and developing the single cancer pathway. • Delivering and responding to cancer peer review. • The sustainability of Acute Oncology Services • E-prescribing, the replacement of CaNISC and the development of the cancer performance framework • The regional planning of services.	• Management of increase in USC demand • Develop business case to address physical capacity challenges - Shooting Star Oncology Day Unit, Wrexham. • Early diagnostics • Straight to test for endoscopy • Cancer pathway modernisation - Lung, Urology and Breast • Skill mix review - Oncology and Haematology • Work with WCN and WHSCC to ensure equity of access • Continued participation in national clinical audit and peer review • Introduce 7 day Acute Oncology Service at the 3 DGH sites • Adoption of SNOMED clinical terms • Look to adopt Tracker 7 to monitor component waits and support pathway improvement • Continued promotion of R&D - provide platform for staff to engage • Look at re-establishing Cancer Bank service within BCU • Business case for additional CNS capacity.
Heart Disease	• To build on the development of clinical consensus on all Wales clinical pathways to work across HB's to implement and deliver more prudent pathways to improve access and treatment times for ACS, AF and HF • To improve access to , and develop, cardiac diagnostics • To Implement the OHCA Plan for Wales • To develop and Implement a Cardiac Performance Framework for Wales • To develop and Implement a programme of Cardiac Peer Review for Wales • To develop and Implement a cardiac informatics roadmap.	• Sustain a robust 24/7 PPCI service and agree operational plan for the management of ROSC (return of spontaneous circulation) for patients suffering a cardiac arrest. • Improve waiting times for patients referred to outpatient cardiology; new and follow ups • As part of the community cardiology programme, implement the comprehensive community angina service supported by the Consultant Cardiologists with diagnostic services, CTCA and Stress Echo. • Improve the optimisation of anticoagulation therapy in high risk patients to reduce the risk of strokes from AF

		• Meet the cardiac RTT waiting time targets by providing timely access to imaging across NW; development of CT Coronary Angiography; development of stress echo and the expansion of Cardiac MRI as well as improve the provision of echocardiography and the clinical workforce to train and undertake diagnostic tests. • Sustain Integrated Heart Failure service model for management of heart failure patients across primary, community and secondary care. • Enhance the Arrhythmia and Brady & Complex Device Implantation service and workforce. Business case in development for additional clinical staff to provide pre-assessment care and post implant care. • Develop a CVD Risk Assessment programme to target deprived populations through the management of risk factors. The CVD inequalities project in Ynys Mon will focus on CVD risk factors, for example, smoking cessation, BP management and statins for cholesterol in high risk populations. The above are not mutually exclusive as part of a range of cardiac pathways, focusing on prevention and where appropriate managing patients in the community setting and when patients are referred to hospital, timely referral, timely and most clinically effective diagnostic imaging and treatment is available. • Provision of post nurse registration cardiac education for cardiac nurses across BCU.
Diabetes	• To increase completion of NICE recommended eight care processes and attainment of three treatment targets as measured in the National Diabetes Audit; for paediatrics the seven NICE recommended care measured in the National Paediatric Diabetes Audit. • Support better self-management by promoting the free Pocket Medic film series to people with diabetes. • Promote the free e-learning modules that have been developed covering pre-conception care, diabetes for HCSWs and care homes, preventing diabetes, managing type 2 diabetes, insulin safety, and Think Check Act for inpatient settings.	• To develop the components of a fully integrated diabetes service vision for BCUHB. • Sustain & further develop the Locality based nurse led diabetes MDT's. • Review and agree strategy to implement the Negotiated Enhanced Service specifications (to enable majority of diabetes care to take place in General Practice). • Review and agree implementation of the acute diabetes team 'Super six' activity. • Support the agreed business case for adult clinical psychology for diabetes.

	• Ensure diabetes transition services meet the new Standards for Transition of Diabetes Care from Paediatric to Adult Services in Wales. • Hospitals to have an agreed foot-screening tool implemented for all inpatients with diabetes and review the National Diabetes Inpatient Audit data to create an action plan.	
End of Life Care	• Continue to build the Hospice at Home provision. • Advance Care Planning. • Reducing admissions to Acute Hospitals at the end of life and supporting patients to remain in their place of residence. • Measuring success through better engagement with patients and by developing outcome measures that more accurately reflect the experience of the patient. • Improving access to Bereavement care and appropriate facilities. • Extending the Reach through Education by facilitating 'Serious Illness' conversations and providing training to professionals on how best to support patients around decision making on behalf of those that who lack mental capacity. • Better utilising digital technology to ensure that end of life care information is captured in a way that supports the delivery of better care. • Using research and audit to effect change and enable Palliative Care in Wales.	• Increase public awareness of death and dying (e.g. Bwy Nawr or other organisations). Continue roll out / evaluation of advance care planning within BCUHB. • Ensure equitable and timely access to palliative care services in all care settings. • Working with third parties as appropriate, explore options for improved bereavement support. • Establish BCUHB strategic group to help co-ordinate above activities. • Active promotion of initiatives to encourage discussion about the end of life that helps to promote and support for dying well. • Implementation of Advance Care Planning (SCP) across all care settings to support that support receive palliative and end of life care in accordance with their wishes and preferences. Implementation of other tools / guidance to improve End of Life Care, namely TEPs and All Wales Care Decisions for the Last Days of Life. • A skilled, knowledgeable workforce that delivers timely, high quality palliative and end of life care in accordance with what matters.
Critically ill	• Optimise and maximise use of critical care capacity, including reducing delayed transfers from critical care by 10% per quarter and producing clear plans to address capacity shortfalls. • Advance the programme to implement a Critical Care Clinical Information System in 2018. • Implement the agreed pathway for patients who have out of hospital cardiac arrest with return of spontaneous circulation as part of the National Out of Hospital Cardiac Arrest Plan. • Support care of deteriorating patients in hospital by developing	• Respond to service developments including vascular centralisation and care of patients following cardiac arrest. • Evaluate potential benefit of Post-Anaesthetic Care Unit (PACU) beds to preserve Critical Care capacity and provide unmet needs for surgical patients at intermediate risk. • Finalise pathways for patients who have out of hospital cardiac arrest according to local geographic variation and pre-hospital medical input (Out of Hospital Cardiac Arrest with ROSC – BCU). • Further development of Advanced Critical Care and Acute Intervention Team Practitioners.

	and extending critical care outreach/acute intervention. • Reduce inappropriate demand on critical care by focusing on promoting discussions about ceilings of treatment and advanced care planning.	
Stroke	• The identification of individuals with atrial fibrillation (AF) • Reconfiguration of stroke services in Wales including the development of Hyper-Acute Services in Wales (HASU) • Community rehabilitation • Development of a stroke research infrastructure/network for stroke in Wales • Developing and responding to patient experience and outcome measures • The management of childhood stroke. • Thrombectomy for stroke.	BCUHB is considering proposals for the development of Hyper Acute Stroke co-located with Acute Stroke services as part of the overall service model for stroke care in North Wales. Taking a comprehensive stroke pathway approach would require the Health Board to redesign and develop community based early support rehabilitation services that facilitate in-patient bed based care and that are managed through an integrated specialist multi-disciplinary team. There will also be a focus on opportunities to improve lifestyle through public education as well as the identification and management of AF, pulse and blood pressure management. The Health Board's strategic proposals for stroke services will be presented to BCU Board for consideration. The delivery plan will be developed in line with feedback received. The following key immediate areas of improvement will be progressed through 2018/19: • Continuous improvement in line with Peer Review recommendations for clinical governance to improve patient experience and outcomes • Increased prevention work jointly with Cardiology and Pharmacy on AF, May Measurement Week for Blood Pressure awareness and identification, link to Stop Stroke and 1000Lives plus programme • New clinical lead for stroke to be recruited as BCU stroke collaborative clinical lead and lead on SIG • Thrombectomy 24/7 contract for 2018-19 to be finalised • Revisit technological advances and access to adequate home broadband width for supporting Consultants out of normal working hours

		• Complete recruitment to therapy vacancies to provide continuity of service across 3 sites over 7 days • April workshops developing criteria for ESD/Community rehabilitation hubs and assessing present locations against these • Programme Manager (SIG funded) for pre-consultation, consultation and implementation of comprehensive stroke service model • Stroke service model and plan to Board in June.
Respiratory	• Responding to the recommendations NCEPOD report on acute non-invasive ventilation, including staffing and resource implications. • Long-term support for secondary care smoking cessation officers and sufficient provision across sites. • Supporting sufficient provision for TB screening, specifically with regard to university students and contact tracing.	• Embed the Acute Smoking Cessation service across the Health Board • ILD - strengthen process and links with Aintree. • Fully establish the pulmonary rehab service to support early discharge from hospital. • Support the delivery of COPD pathway development ensuring patients are cared for nearer to home. • Supporting people living with lung disease and ensure access to pulmonary rehabilitation service to support early discharge from hospital. • Review of palliative care for patients with progressive chronic lung disease.
Neurological Conditions	Raising awareness of neurological conditions: • Wales Neurological Alliance to lead on scoping current awareness raising activities across the statutory and third sectors and make recommendations for ongoing awareness. • Health Boards to establish Neurological Service User Forms in partnership with people living with neurological conditions to inform awareness raising needs and service improvements, which meet their needs. Fast, effective, safe care and rehabilitation: • Health Boards to develop and implement PROMs and PREMs for patients with neurological conditions and act on findings to continually improve services. Living with a neurological condition: • Health Boards will continue to develop their neuro-rehabilitation services, including psychological	• Implement a co-productive approach to raising awareness of neurological conditions. • Implement a co-productive approach to service development. • Developing clear pathways and models of care for the population of Wales based on research and best practice.

	support and consider opportunities for self-referral for people living with a confirmed neurological condition. Timely diagnosis of neurological conditions: • Health Boards to provide GPs with timely access to specialist advice through structured telephone and email contact, speeding diagnosis for people who may not need referral to a clinic. Targeting Research: • Health Boards work with the Health and Care Research Wales speciality lead researchers to increase the number of neurological condition research studies undertaken in Wales.	
Liver	• Further develop the opportunistic assessment of alcohol in different settings and develop secondary care-based alcohol care teams to provide timely interventions as appropriate • Raising public and healthcare professionals' awareness of the risk factors contributing to preventable liver disease and help support individuals already living with liver disease • Taking forward the legacy of the Blood Borne Viral Hepatitis Action Plan in all relevant settings and continue the effort to eradicate viral hepatitis with improvements in access to testing, treatment and harm reduction services • Improve the provision of assessment and testing of those at highest risk of developing liver disease • Health Board liver disease units to work with WAGE to meet common standards and meet regularly to share best practice and assess performance against standards • Improve information and data available related to liver disease and its risk factors.	• GP Liver Disease champion to be appointed. • Recruitment and retention of the secondary care alcohol care teams. Posts will be advertised to fill the vacant posts but as there has been additional funding from LDIG for expansion of these positions, planning needs to take place to establish the increase of posts. • Planning for a provision of a six day service with the inclusion of an evening service to be explored. • HCC plans. • Liver ward. • Extra fibroscan capacity. • ALT primary care.
Rare Diseases (Rare Disease Implementation Group)	• Identify and improve the pathway for patients with unknown or delayed diagnosis; • Ensure better use of patient feedback, best practice and evidence to improve pathways for primary, secondary and specialist services;	• Identify support for local (BCU) group. • Progress development of BCU Rare Diseases group to facilitate implementation of national priorities. • Explore generic "rare disease" coding to facilitate learning from concerns • Work with coding, IT, and Primary Care to facilitate data review.

	• Improve reporting of rare disease information including epidemiology, significant event analysis and shared learning.	• Ensure RnD team are linked to group.
Dental Services		• Full roll out across North Wales of the refocussed Designed to Smile (D2S) Oral Health Improvement Programme. • Roll out of Gwen am Byth programme to all care home across North Wales in line with WG strategy. • Develop and implement Community Dental Services strategies which will address services, estate and workforce issues. • Re-establish and develop Restorative Dentistry service. • Develop and implement the dental care pathways.

Section 6 - Resourcing and Enabling Plans

6.1 Improving Quality and Safety

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6.1 Improving Quality and Safety

Improving health and outcomes whilst providing excellent care is a responsibility BCUHB takes seriously. Our intention is to work collaboratively across the whole organisation and with Local Authorities, Regional and Welsh Government and all stakeholders to continue to improve the quality and safety of care that BCUHB provides. Improving quality and safety is a fundamental principal across areas of BCUHB, below is how we will support quality and safety in the coming years.

As part of this commitment, we launched the Quality Improvement Strategy (QIS) in June 2017. This three-year global organisational strategy sets out the clear intentions to keep patients health and wellbeing at the heart of all areas of improvement as follows:

- **Aim 1 – No Avoidable Deaths;**
- **Aim 2 – Safe; Continuously Seek Out and Reduce Patient Harm;**
- **Aim 3 – Effective; Achieve the Highest Level of Reliability for Clinical Care;**
- **Aim 4 – Caring; Deliver What Matters Most: Work in partnership with patients, carers and families to meet all their needs and actively improve their health;**
- **Aim 5 - Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living.**

The Quality Improvement Strategy can be accessed through the following link:
http://howis.wales.nhs.uk/sitesplus/documents/861/QIS%20Final.pdf

We aim to deliver safe, effective and compassionate care and to do no harm. The revised QIS will support and strengthen our Clinical leadership teams across all of BCUHB as it provides an accountability framework with clear measures and patient outcomes with agreed priorities.

The Quality Improvement strategy is underpinned by ensuring staff are confident in using improvement methodology locally. This will be embedded in leadership development and facilitated by those in the organisation who are trained in the approach.

This will support a Quality Collaborative of ‘champions’ who will facilitate and provide the catalysts for change at a level which is closest to the service and patient. This will require a shift of emphasis to ensure we are measuring for success, but this has already commenced within our quality dashboard and the collaborative 90 day plan approach recently introduced, alongside the PDSA cycle.

Key ambitions will be monitored at a Board level, but the principles will support local improvements in response to incidents, patient and staff feedback and transformation.

The local ownership of the quality improvement dashboard is already seeing local leaders use their own intelligence to improve care locally and seek support where necessary. A full quality accreditation programme will be developed over the next two years across the HB to establish where support is most needed and to facilitate improvement and staff development. The scoping element for this work has been established, alongside and environmental risk assessment so we

can prioritise the areas for implementation. This will work alongside and include the training for QI.

The launch of the Harm's dashboard (please see figure 1) in October 2017 provides real time information for all wards in BCUHB and has provided the opportunity for board to ward review and triangulate patient outcomes against key workforce data areas. This enables identification of areas of best practice as well as those that need improvement; currently the dashboard provides information in relation to four core areas of harm:

- Hospital Acquired Pressure Ulcers
- Inpatient falls
- Medicine management
- Infection Prevention

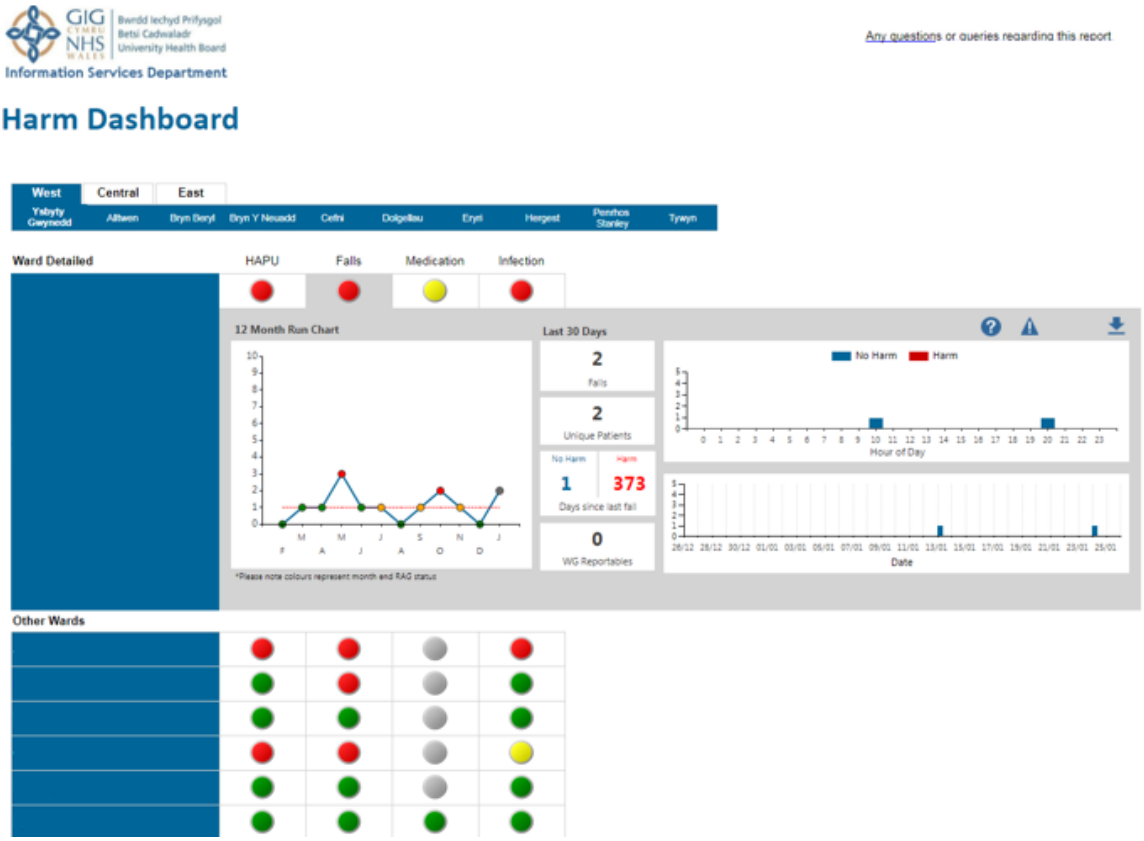


Figure 1

We intend to build our intelligence systems and grow leadership and improvement capabilities across our workforce and for the period 2018/19 Health Board wide developments will include:

- Addition into the dashboard of further key quality indicators some of which will be speciality specific in order to achieve spread of our improvement work across the organisation.
- Strengthen the programme of training on improvement methodologies in order to grow capacity within clinical teams and enable them to effectively use data and information to build sustainable change.
- Develop our Nursing Documentation: national work is underway to establish standardised sets of nursing data and documentation to underpin the development of electronic nursing documentation.
- Make transparent information about Nurse staffing levels. The Nurse Staffing Levels (Wales) Act became law March 2016. Under the act, the Health Board is required to make provision

for appropriate nurse staffing levels on our Adult acute wards. The Health Board will be required to report against the implementation of the Act and to provide evidence of harm with agreed quality indicators where staffing levels did not meet the required levels.

- Continue to raise the profile of recruitment across the Health Board.
- Review and refresh the Clinical Leadership programme for Senior Nursing colleagues.
- Review, value and celebrate the contribution our volunteers make within the Health Board.

Corporate Safeguarding: People at Risk of Harm

The Social Services and Well-being (Wales) Act 2014 forms the basis for a new statutory safeguarding framework in Wales. The regulations and guidance both strengthen existing arrangements for children and introduces new statutory arrangements for adults at risk.

As an NHS organisation, BCUHB is recognised as a relevant partner and is one of the 'partner agencies' in which this legislation applies. The Act sets out what must be done and should be done to safeguard children and adults. In relation to children, a duty to report is introduced and in relation to adults, a duty is introduced where a partner agency has reasonable cause to suspect that an adult is an adult at risk. The introduction of Adult Protection Support Orders, the strengthening of statutory arrangements of the multi-agency Safeguarding Boards and the establishment of the National Independent Safeguarding Board will strengthen and build upon existing arrangements and good practice, and multi-agency partnership working. The Act sits alongside and enhances existing Safeguarding Legislation which targets the 'harm' agenda for example; Domestic Abuse, Modern Slavery, Prevent & Sexual Exploitation.

Our aim is to fully engage and participate in the development of National and Regional Strategic guidance based upon the Act. To review, develop and improve our governance arrangements to establish a robust Corporate Safeguarding Strategic and Operational Function to safeguard service users and their families and establish preventative pathways to reduce risk and harm.

BCUHB has refreshed the Safeguarding structure to provide local specialist support and focus on priority areas. The plan for the next twelve months is to build on the re-structure to deliver the following:

1. Resource realignment and agreed collaboration with the informatics department to develop and implement integrated analytical programmes and systems to support automated alerts, trends and improve governance and reporting mechanisms, within the organisation and with partner agencies.
2. Development and revision of the Quality Assurance Framework, Communication Strategy and a Reporting Framework which will include a total update of the web page and all multi-agency activity.
3. Continue and improve engagement with Secondary Care and Area Teams, implementation of ward/unit champions with recognised role and responsibilities. Development and implementation of revised strategies for engagement.
4. Revision and implementation of a reporting framework to enhance performance at the point of Adult/child referral/enquiry, attendance at strategy meetings / Case conferences and quality reporting

5. Annual audit and review of secure storage of Adult at Risk / Child Protection strategy minutes from strategy meetings and outcomes of referrals incorporating legislative guidance from Information governance
6. Training needs analysis for Level 3 training programmes to inform the revision of all training packages, with the development of bespoke Level 3 packages for key areas and key subject matters.
7. Full implementation of the Corporate Safeguarding Structure; evaluate outcomes relating to new posts for example; Training, Data analyst and Dementia.
8. Proactively engage with CHC teams and Area Teams to increase engagement and to provide support in a preventative capacity within Care Home settings.
9. Implementation of the governance and reporting mechanisms into and from Adult MHLD for the provision of a Young People's bed.
10. Identify work streams to engage and review SLAs, commissioning contracts, Multi-agency information sharing agreements in line with updated Data protection legislation coming into force 2018
11. Review of BCUHB Policies and Procedures ensuring full engagement and implementation of revised and updated National and Regional multi-agency policies and procedures
12. For the Corporate Safeguarding to drive the Domestic Abuse agenda forward within BCUHB and ensure full compliance with the VAWDASV Act. Full review of the Domestic Abuse screening activity and implementation from the MARAC review, incorporating Safe Lives DASH RIC assessments, Ask and Act, and the use of Alerts, With engagement form Welsh Women's Aid and Domestic Abuse Helpline.
13. Engage with Welsh Women`s aid for a joint venture of supporting an independent domestic violence advocate working within either ED or with the HV teams to pick up incidents of Domestic Abuse from preventative perspective with the objectives of the VAWDASV agenda
14. Based upon NICE guidance. IG framework to Review, implement, develop and audit a robust flagging system that will support clinical identification and enable staff within the safeguarding team to track repeat admissions within Emergency Departments for victims of domestic violence, incorporating lower threshold cases
15. Full engage in all MAPPA activities ensuring full participation in the MAPPA reporting framework which include sub groups and key initiatives.
16. Update, Review and the Development of KPIs and Standard Operating Procedures (SOPS) to progress and continue to encourage staff members to be active within APR/CPR/DHR process (ranging from panel members/reviewers/chair), with triangulation of concerns, incidents and Regulation 28 Coroner Cases.
17. Continue to implement the APR/CPR/DHR BCUHB review group. Revisit the TOR to incorporate all safeguarding reviews, ensuring clear accountability and ownership to support the implementation of actions/lessons learnt within BCUHB.
18. Identify and disseminate themes of serious incidents (including Mental Health cases) are shared with partners within APR/CPR/DHR to enable complete transparency within the safeguarding process. Captured within the revised reporting framework.
19. Identify an Audit work plan based upon themes, issues and evaluation of learning from critical incidents and reviews.
20. Develop and update DoLs Policy, Procedures and Guidance in consultation with other partners in Wales; Health Boards, Local Authorities, Healthcare Inspectorate Wales and Welsh Government to identify priority changes, plans and actions. 21. Implement in consultation with the Professional Advisory Group recently devised draft "Gold Standard" DoLS Application Form, to improve quality and practice within all clinical areas.

22. To review the role, responsibilities and functions of the signatories within the Supervisory Body to ensure it is fully compliant to governance expectations and continues to be fit for purpose.
23. To review the current arrangements for recording DoLS data so it is more streamlined and fit for purpose in monitoring and reporting annually to HIW.

Raising the bar on Quality and Safety at BCUHB

Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivered within BCUHB and not only monitor the clinical outcomes but also a range of service user experience feedback methods developed as a framework of best practice in caring for patients.

What changes can we make that will result in improvement?

In order to accomplish our ambitious aims we will need a far-reaching plan to engage with staff on finding solutions right across the Health Board. The following Driver Diagram (figure 2) summarises the areas of work we will tackle in the next three years while the following pages examine each primary driver and what projects will be need for each.

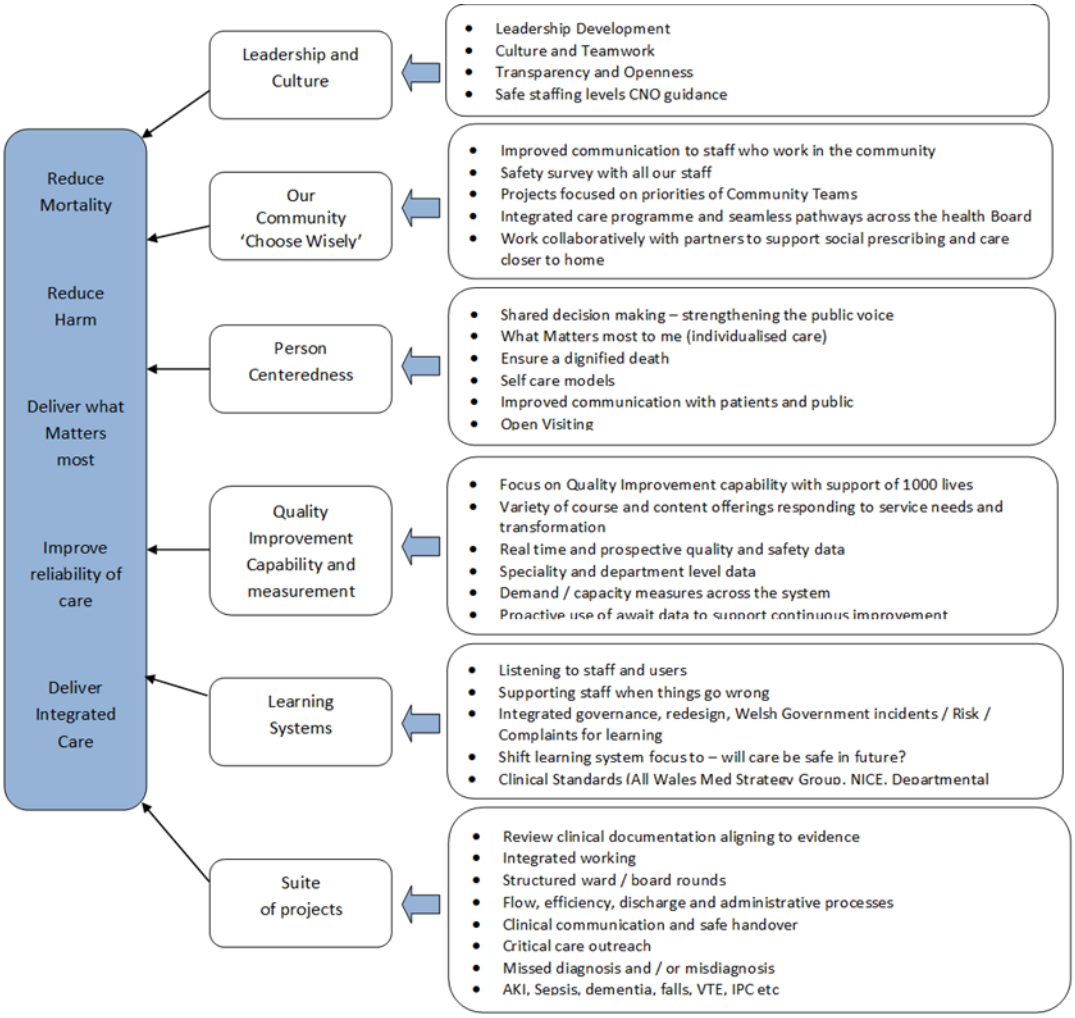


Figure 2

Our key Priorities and actions:

The engagement process and review of data across the Health Board has resulted in the following areas being adopted as the Health Board ambitions for improvement under the headings of *Safe, Effective and Caring*:

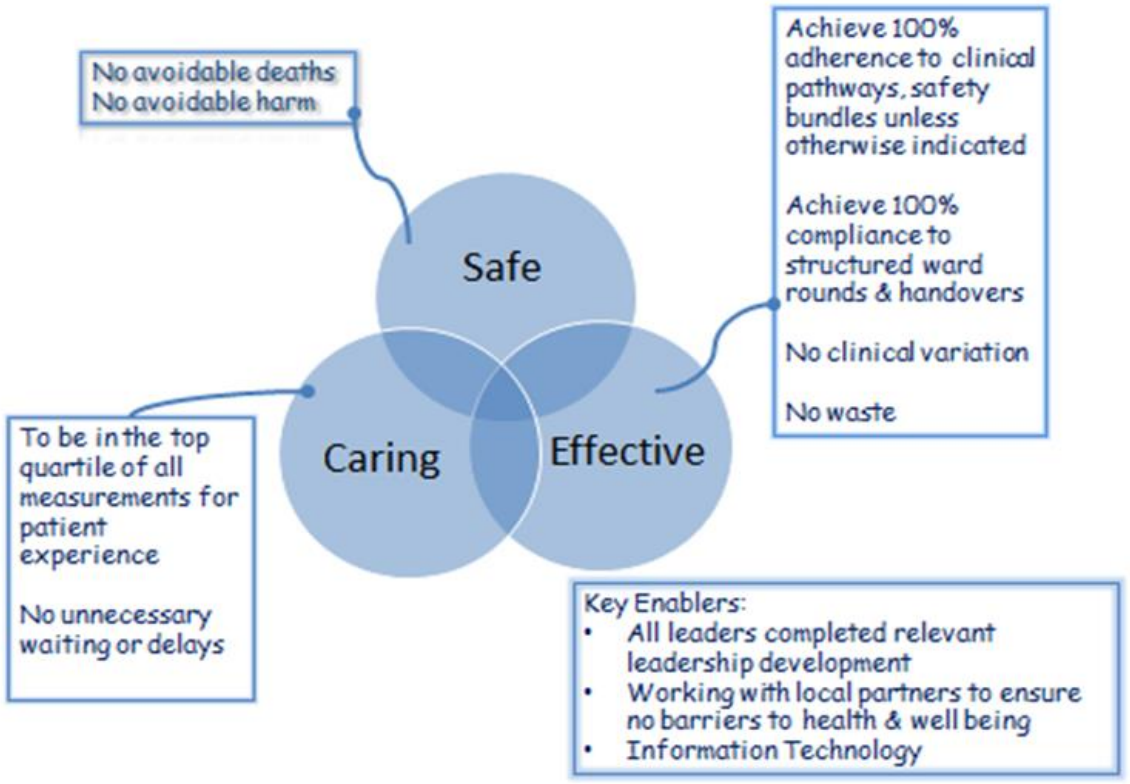


Figure 3

No Avoidable Deaths:

Safe	**We will prevent deaths when possible and ensure those dying are able to do so in a dignified manner**
Measures	**Using crude mortality as an indicator we will identify any variation from normal and initiate investigation at case-note level to ascertain lessons to be learned** **Serious untoward incidents that resulted in patient death** **Incidence of still births** **Number of patients able to die in their place of choice** **Reduction in mental health suicides**

Safe; Continuously Seek Out and Reduce Patient Harm:

The Health Board has prioritised Harm Free Care as a priority. This will focus on a reduction in the following:

VTE (Venous thromboembolism)

To eradicate avoidable Hospital acquired thrombosis by 2020. Site clinical leads attend Bi-monthly steering board meetings to discuss progress against actions and the OMD are working with clinical leads to develop plans to complete actions set in driver diagram.

Primary Drivers to achieve this goal.

1. Making appropriate resource available where needed.
2. Monitoring, reporting and driving progress
3. Improvements and raising awareness

Infection Prevention (Healthcare Acquired Infections)

Following the review of previous improvements an external review was completed in the autumn of 2017 and following on from this the Health Board will launch its Infection Prevention awareness campaign 'Safe, Clean Care'. This aims to generate a social movement amongst Health Board staff in terms of infection prevention to ensure they understand their contribution to patient safety. The launch date for campaign is Monday 29th January 2018 and focuses on:

- Clean hands
- Bare below the elbows
- Clean, clutter free spaces
- Rapid isolation
- Safe prescribing
- Device care

The organisation has completely reviewed the approach it takes to infection prevention, building on an improvement collaborative, rewriting standards and empowering staff to 'make a difference'. This has been launched across the organisation, with weekly accountability 'check points' to ensure progress is maintained, and adjust our direction as required.

The principles of a ward/community/patient to Board underpin these principles and are monitored via our *real time* dashboards

The Board trajectories for reduction are to meet and beat the targets set by Welsh Government, with an ambition for a zero tolerance of HCA MRSA bacteraemia and a further reduction of CDI of 5%, beyond the national objective.

Response to the Deteriorating Patient and adherence to Early Warning Scores

The NHS Early Warning Score helps staff to recognise at a very early stage when acutely ill patients are starting to deteriorate. It provides a system for interpreting blood pressure, speed of breathing and heart rate and other vital signs. Patients who trigger a NEWS-Score will then be discussed by

Consultant staff and Intensive Care doctors quickly, so that the patient can receive life-saving treatments.

A drive to support all arears in achieving a 100% target of all inpatients to have a NHS Early Warning Scores (NEWS) score calculated in a timely, effective assessment and care delivered as guided by appropriate application of the escalation algorithms.

Develop reporting metric that pulls together RRAILS interventions which will be monitored through triangulation of a range of data to include Acute Intervention Team continuous audit; Routine Retrospective Case Record Mortality Review, Cardiac Arrest Rates and Hospital level mortality metrics.

BCUHB has comprised a plan for Response to the Deteriorating Patient 2018/19 our plan for this can be seen in the appendix of this document.

Hospital acquired Pressure ulcers and falls

We continue to monitor all incidents of Hospital acquired Pressure ulcers and falls across BCUHB. Hospital acquired Pressure ulcers are now monitored via the HARM dashboard for all our acute, community, Mental Health and Learning Disabilities Wards. This has provided the opportunity from board to ward to review and triangulate patient outcomes against key workforce data areas. This enables identification of areas of best practice as well as those that need improvement; currently the dashboard provides information in relation to four core areas of harm. We aim to show a reduction in the number of HAPU's and fall's moving forward across BCUHB and use the information provided from the reporting of these events to raise our standards and improve outcomes.

Medication Safety

Our aim for Medication Safety over the next 3 years is to improve medicines optimisation through better prescribing and administration of medicines (please see appendices for further detail). This will be monitored by the Safe Medication Steering group who were established to monitor and review medication management.

Identification and early treatment of Sepsis

Sepsis is a major cause of hospital mortality, accounting for almost 40% of deaths on ITU. It is a complex condition to manage as there is not a common presentation and in 60% of cases, an infective organism is never identified. Sepsis management is a heavy resource user as 15% of ITU patients are septic but they utilise 30% of our resources. In the UK, sepsis costs us almost £300 million a year but the costs to individuals and their families is intangible and has a far greater impact.

An underpinning aim to support this will be to deliver care, 'in the right place, by the right member of staff, at the right time'. This will place an emphasis on our users receiving care in the right environment, including their own homes.

BCUHB has an extensive plan for Identification and early treatment of Sepsis 2018/19 our plan for this can

be seen in the appendix of this document.

Safety	We will not harm anyone in our care
Measures	Unexpected admissions to critical care environment Number of Cardiac arrest calls in a non-critical environment Reduction in incidents reported with harm specifically: ❖ Reduction in pressure ulcers ❖ Reduction in falls ❖ Never Events ❖ Infection rates Quality Audit performance, including safety thermometer, maternity dashboard & accreditation frameworks Medication errors - Safety Thermometer

Effective; Achieve the Highest Level of Reliability for Clinical Care:

Achieving the best outcomes for patients requires us to provide care that is effective and we want to do this in a way that provides the best possible patient experience.

Effective	Achieve the Highest level of reliability in Clinical Care
Measures	Results of national audits Strengthen our clinical pathways to ensure reliability against NICE, NCEPOD, WHO checklists etc. Performance against the new *accreditation programme for wards, departments and community* Adherence to the GROW programme recommendations Adherence with Sepsis Six

Caring, Deliver What Matters Most: Work in partnership with patients, carers and families to meet all their needs and actively improve their health.

In line with our drive for an integrated approach to care we will support patients, carers and families to fully engage and understand the pathway of care they are following to receive seamlessly co-ordinated care.

Caring	**We will provide services that patients rate as better than the national average** **We will have minimal waiting or delays**
Measures	Performance in national patient surveys Results of real time patient feedback The number of local resolutions managed by the introduction of the PALs team Number of serious complaints Number of service changes involving patients National waiting time standards (e.g., A&E waiting times) Hospital appointment cancellations The introduction of an *Open Visiting* policy across BCUHB to completely embed **'John's campaign'** Full implementation of the Dementia strategy Performance in staff feedback surveys

Putting Things Right:

Building on the success of the previous year, we are committed to ensuring we provide timely investigation and resolution of Concerns (Complaints and incidents) in line with Putting Things Right (PTR).

- Putting Things Right - achieve throughout the year 98% of all concerns acknowledged within 2 working days.
- To sustain the percentage of complaints closed within 30 working days at no less than 55%
- Achieve throughout the year 98% of complaints closed within 6 calendar months
- To sustain the percentage of incidents closed within 30 working days at no less than 65%
- Increase percentage of WG reports concluded with 60 working days to 45%
- Implement a systematic training programme for PTR
- Implement a robust and consistent approach to the management of Concerns and Incidents across BCUHB.

The Health Board is committed to establishing a duty of candour with our public and aligning where appropriate a single point of contact to ensure that full communication is maintained and a true two way conversation is in place. This will enable us to meet the needs of the individuals in our response and maximise learning.

Key areas for focus over the next three years include:

Year 1 2018/19	Year 2 2019/20	Year 3 2020/21
To reduce the backlog of complaints and incidents and establish real-time working	Embed the real-time complaints and incidents system across BCUHB	Ensure sustainability of complaints and incidents processes
To develop the model for organisational learning	Implement organisational learning model with an emphasis on vulnerable client groups	Undertake organisational cultural assessment in relation to learning
Establish the system for real-time patient feedback using triangulated themes from patient complaints and incidents	Develop thematic programmes of patient experience work to look to reduce enduring themes. Consider alternate approaches to complaint reduction e.g. experienced based design	Work with other sectors to share learning and develop expert patient groups to support organisational development
Conduct a training needs analysis in order to support the development of an effective training programme	Implement a training programme including elements of customer care and improving communication strategies	Evaluate and sustain education programmes
To rollout the PASS across the remaining secondary care sites	Evaluate effectivity of PASS and produce annual report	Undertake review of the complaints service model
To implement a process to ensure senior clinical oversite for all claims	Consider programmes of work using claims themes to drive down overall numbers	Continue to deliver programmes of work to address the identified themes of claims
To launch an online complaint and compliments submission system for the public	Develop 'you said we did' across BCUHB	Undertake review of the service model
To further embed Being open and the principles of duty of candour	To test patient satisfaction in relation to our BCUHB openness and transparency	Undertake organisational cultural assessment in relation to being open

Safe Care: Reduce Patient Harm:

We have prioritised Harm Free Care and we will continue to build on previous improvements with a focus on the following.

Compassionate Care:

We will provide services that focus on the needs of the individual and deliver what matters most to them; we want to ensure patient's rate their care as better than the national average.

Service user's feedback

Service users will:-

- Feel able to provide feedback, using the method that best suits their needs. We support the collection of anonymous feedback using Viewpoint ® Real Time Feedback system which is being implemented across the Health Board
- Be able to access the postal survey which is issued to a sample of 1000 patients discharged from hospital each quarter
- Be able to see what developments we have undertaken following service user feedback

Staff will:-

- Encourage service users to give feedback
- Learn lessons from service user feedback
- Share good practice
- Initiate and monitor change based on service user feedback

Comprehensive Listening and Learning from Experience report to be provided to the Quality, Safety & Experience sub-committee (6 monthly).

Measuring our development:

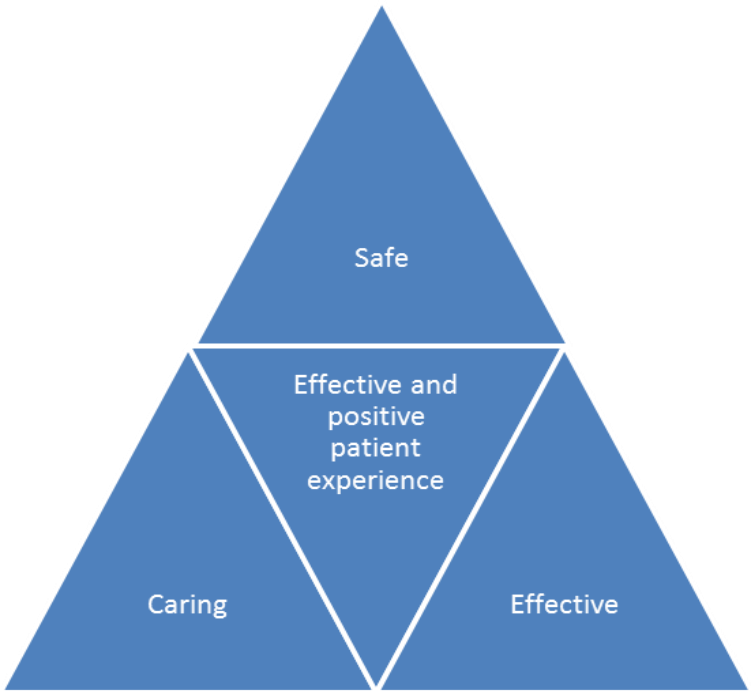
It is important that we evaluate our systems and processes to ensure that we continue to improve our standards locally, regionally and nationally.

Implementation and Monitoring

The quality strategy will be driven by the transparent and open reporting of achievements against agreed standards providing the golden thread of communication and assurance from ward, department and community to Board.

The Health Board has undertaken a baseline of harm information, which will be used to provide individual reduction trajectories, which will be monitored via the quality dashboard. This will be aligned with key metrics to provide the Board with assurances on progress.

Triangulate information:



The newly developed dashboard will enable local teams to review their own information, engage in local improvement plans, and seek assistance, alongside sharing good practice. Incorporating safe staffing and roster management, incidents, harm and audit outcomes, this will provide intelligence to teams to support early intervention and the introduction of real time patient acuity allowing staff to be safely allocated.

The measurement against individual department profiles for improvement will be monitored via the dashboard. Whilst initially focussing on harm, this will evolve to incorporate patient feedback, staffing levels and patient acuity. Each department will have access to their own dashboard information, with visibility from 'Service to Board'. An escalation framework will provide timely access to resources to help support improvement.

Information technology is a key enabler to delivering and measuring the impact of our refreshed Quality Strategy. The Health Board already proactively engages with IT solutions to help our staff to deliver timely and effective care in many areas, and, this will be further strengthened to enable us to deliver our ambitions.

National Delivery Framework Targets

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful									
Measure		**Target**	**Profile**						
			Projected end of March 2018 position	**Jun-18**	**Sep-18**	**Dec-18**	**Mar-19**	**Mar-20**	**Mar-21**
Monthly	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	95%	93.0%	93.0%	93.0%	93.0%	95.0%	95.0%	95.0%
Quarterly	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	100%	100.0%					100.0%	100.0%

SAFE CARE - I am protected from harm & protect myself from known harm									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The rate of laboratory confirmed C.difficile cases per 100,000 population	Performance against 18/19 local target	39	45.0	50.0	43.0	38.0	30.0	25.0
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population		29	27.0	26.0	24.0	22.0	20.0	18.0
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population		77	73.0	72.0	71.0	69.0	65.0	60.0
	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales (assuming this is the 6month timescale as target increased to 90%	90%	81.0%	83.0%	84.0%	86.0%	90.0%	90.0%	90.0%
	Number of new Never Events	0	0	0	0	0	0	0	0
	Number of grade 3, 4 and unstageable healthcare acquired (both hospital and community) pressure ulcers reported as serious incidents	Reduction (12 month trend)	40	37	35	36	35	33	30
	Number of administration, dispensing and prescribing medication errors reported as serious incidents		0	0	0	0	0	0	0
	Number of patient falls reported as serious incidents - In patient falls only		15	15	14	14	12	10	8
Quarterly	Fluoroquinolone, cephalosporin, clindamycin and co-amoxiclav items as a percentage of total antibacterial items prescribed	Reduction (4 quarter trend)	9.4%					8.0%	7.0%
	Non steroid anti-inflammatory drug (NSAID) average daily quantity per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)		1,400					1,100	1,050
	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)		325					320	320

DIGNIFIED CARE - I am treated with dignity & respect & treat others the same									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Bi-annual	Percentage of NHS employed staff who come into contact with the public who are trained in an appropriate level of dementia care	85%	85%					85%	
Quarterly	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Reduction (4 quarter trend)	tbc - awaiting comfirmation of base with new methodology						
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	75%	37.7%					65.0%	75.0%

6.2 Workforce and Organisational Development (including Equality and Human Rights)

6.2 Workforce and Organisational Development (including Equality and Human Rights)

The success of the Board and its primary care contractors in recruiting, retaining and developing the workforce is fundamental to the delivery of our Plan, it is recognised that the Health Board faces significant challenges, and key challenge is in relation to attracting and developing individuals with the right skills to transform delivery of care. Our ambition to adopt new models of working, new roles and innovative approaches to service delivery will require changes within the workforce. This section sets out the key activities and interventions which will support this and how the workforce will need to change to align with new ways of delivering services in the future.

The senior leadership team at the Board recognises the importance of good human resources management and are cognisant of the challenges faced by an employer with over 17,000 staff based in a large number of locations, spread over a wide geographical area. A key aspect of the organisational development agenda therefore must include line manager development aimed at honing skills to use the tools provided in the form of the All Wales HR policies, to achieve the best from staff and ensure that staff are managed within a framework of an accepted and understood code of conduct.

In 2017 a workforce planning tool was developed to support managers with future workforce modelling and this has been utilised to improve local plans. There remains however the need for a more strategic and holistic approach to workforce planning and this will commence in 2018 with the creation of an agreed establishment control on the Electronic Staff Record (ESR) that mirrors the budget planning process.

Workforce Profile

The current breakdown of the Health Board by staff is reflected in the table below: The projected changes are included in the attached templates.

MONTHLY BCU WORKFORCE DATA

Staff in Post as at 31-December-2017	FTE Contracted	Assignment Count	Headcount	Turnover	Turnover (exc M&D Training)	Sickness (cumulative 12 months)
BCUHB Total	15190.34	18170	17670	8.42%	7.58%	4.90%
Medical & Dental Staff Group in Post as at 31-December-2017	**FTE Contracted**	**Assignment Count**	**Headcount**	**Turnover**	**Turnover (exc M&D Training)**	**Sickness (cumulative 12 months)**
Total	1264.25	1367	1343	19.96%	11.02%	1.42%
Other Staff Groups in Post as at 31-December-2017	**FTE Contracted**	**Assignment Count**	**Headcount**	**Turnover**	**Turnover (exc M&D Training)**	**Sickness (cumulative 12 months)**
Additional Professional Scientific & Technical	695.14	819	799	6.05%	6.05%	3.44%
Additional Clinical Services	2965.04	3578	3509	7.79%	7.79%	6.94%
Administration & Clerical	2856.08	3493	3373	6.84%	6.84%	4.13%
Allied Health Professions	878.51	1082	1035	5.90%	5.90%	3.47%
Estates & Ancillary	1248.72	1635	1583	8.18%	8.18%	6.67%
Healthcare Scientists	277.73	300	298	5.82%	5.82%	3.67%
Nursing & Midwifery Registered	4988.89	5880	5714	7.79%	7.79%	5.05%
Students	15.99	16	16	0.00%	0.00%	0.22%

Data excludes assignments without contracted hours (i.e. bank and locum).
Turnover rate (FTE) for the period 01/11/2016 to 31/12/2017
Sickness rate (FTE) for the period 01/11/2016 to 31/12/2017

The Workforce composition across all pay bands continues to be predominantly female at 14,322 (81%) headcount versus the male headcount at 3,416 (19%). 52% of females work part time compared with 17% of males, which is been fairly typical over recent years.

The forecasted change in the workforce based on a three year trend analysis demonstrates an increase in registered nurse staffing. Given the work that is underway on attraction, this should result in a reduced requirement for agency staff. Clearly there is significant work to do around new ways of working, skill mix and workforce transformation over the period of the plan. These projections and assumptions will therefore need to be revised annually.

Staff turnover has decreased slightly over the last 2 years from March 2016 8.67% to Feb 2018 7.66%. It is difficult to estimate at present whether this trend will continue. The turnover data above excludes M&D Training grades.

Over the next 5 years we will develop a more flexible, sustainable and skilled workforce who will support the delivery of transformational change both within the area teams and wider unscheduled care divisions. We will develop rewarding and fulfilling career pathways for our workforce and aim to further improve recruitment, retention, training and engagement of our staff. There will be a move towards more generic, interchangeable professional roles which reflect the demand for more efficient and effective, patient-centred clinical care pathways, which are underpinned by the 'Prudent Healthcare' principles.

The following are key workforce themes identified by the Service Areas in their 2018/19 Plans.

- Efficiencies in bank, agency, locum us
- Skill mix changes
- Shifting of the workforce from acute to community
- Reducing sickness
- Focus on Consultant productivity
- Development of localities – new models of delivery and employment models being developed
- Centralisation of fragile services and pathway redesign
- Efficiency – "Prudent Healthcare"
- Medical workforce recruitment risk
- Development of Advanced Practitioners to support the Medical workforce shortages
- Introduction of the Physician Assistant role
- Primary Care team development
- Diagnostics – Imaging, Pathology – service redesign and modernisation
- Administration & Clerical – Digitisation and new ways of working

Recruitment and Retention

Attraction and Recruitment

BCUHB has a high reliance on an agency & locum workforce, and recruitment is one of our key risks. Organisational recruitment priorities for the coming 3 years include being able to meet and maintain safer staffing standards and reduce the financial burden of using agency and locum staff. Approximately 35% of the workforce are over age 50 so recruitment will be a significant challenge over the period.

Positive achievements

BCUHB has commenced implementation of the Health Board's Recruitment Attraction Strategy with new ways of attracting, recruiting and retaining staff already underway.

Collaborative working between all agencies, including nursing, the Universities, NHS Wales Shared Services Partnership (NWSSP) and workforce is proving successful. Over the next 3 years, we will continue to further build upon the work and achievements in 2017/18:

- Our new employer brand Train, Work Live – North Wales launched September 2017 with our own suite of marketing materials
- New BCUHB Recruitment Website
- Development of digital marketing through social media to take the brand to more potential applicants, to establish BCUHB as the employer of choice not just in North Wales but nationally
- Introduction of "volume" nurse recruitment days.
- Student nurse Recruitment days
- Overseas recruitment
- Nurse Bank recruitment
- Promotion of the Return to Practice course at Bangor and Glyndwr Universities.
- Raising the profile of BCUHB through marketing via attendance at Careers Fairs & Open Days across UK

Key priorities:

- BCUHB videos supporting all professions
- BCU Corporate Recruitment Strategy group to lead on the implementation of the Attraction Recruitment and Retention Strategy
- Recruitment sub groups in all professions, as well as a recruitment process sub group and a digital marketing subgroup.
- Work with Bangor University to maximise clinical learning placements and opportunities and identify additional clinical placement areas for students.
- Consistent Preceptorship which will be finalised by April 2018
- Targeted recruitment for band 5 nurses and creation of centralised team to support
- Meet All Wales time to hire target of 71 days by September 2018

- Reduce nursing vacancies by 50%
- Reduce time to hire for Band 5 nurses to 40 working days

Recruitment challenges

Significant recruitment challenges remain not only in nursing but also in a number of specialties and staff groups. Areas with particular challenges are listed below:

- Medical and Dental, in particular consultants in mental health, diabetes, radiology, pathology specialties, orthogeriatrics, dermatology, and Specialty and associate specialist (SAS) doctors in Care of the Elderly (COTE), general medicine, emergency medicine, mental health specialties, obstetrics and gynaecology and anaesthetics.
- Trainee doctors in obstetrics and gynaecology, general medicine, general surgery, orthopaedics
- Band 5 adult, mental health, CAMHS nursing and Health Visitors
- General practitioners
- Pharmacists
- Psychologists
- Radiographers
- Some allied health professionals including specialist posts, physiotherapy, Welsh speaking speech and language therapists.

Priorities for BCUHB 2018-2021

Over the next three years we need to develop a more flexible, sustainable and skilled workforce both within the area teams and wider unscheduled care divisions. An example of this is the development of Physicians Assistants and Community Resource Teams.

Work will be undertaken to strengthen strategic and recruitment support across the organisation.

It is planned to have recruitment support on each site to ensure that recruitment solutions are tailored to particular needs.

Key priorities:

- Efficiencies in bank, agency and locum use
- Skill mix changes
- Shifting of the workforce from acute to community
- Development of Community Resource Teams - new models of delivery and employment models being developed, working in collaboration with partner agencies and organisations
- Centralisation of fragile services and pathway redesign
- Development of Advanced Practitioners to support the Medical workforce shortages
- Introduction of the Physician Assistant role
- Primary Care team development
- Administrative & Clerical – Digitisation and new ways of working
- Collaboration and partnership working with local authorities, the third and private sectors

- Focus on consultant productivity

Workforce Transformation

There are a number of projects which will require workforce transformation to provide a more patient focused service. These include roll out of 7 day working and new generic roles at support worker level. There are also plans to recruit Physicians assistants and introduce community resource teams.

The primary care workforce project will develop and support workforce planning, training and recruitment and retention across primary care services. This includes redesign of services to include a wider range of health care professionals and require OD interventions to support development.

Key priorities:

- A workforce transformation group will be set up in 2018/19 to support and drive forward these objectives.
- Support development of community resource teams
- Support development of primary care workforce

Primary Care

The Health Board is witnessing a number of GMS practices handing back their contacts due to staffing and financial pressures. The supply of General Practitioners is far outstripped by demand. Over the past decade the supply of GPs has become increasingly feminised and part time. These practitioners are looking to practice their medical skills in an environment that offers an improved work life balance, they are less inclined to take on partnerships and instead seek part time work as a salaried GP.

In response the Health Board is seeking to develop a career progression for salaried GPs. This will allow the medical practitioners to take on additional duties that may be developing medical specialities, clinical leadership or managerial. Newly qualified staff will be offered a Health Board contract and for a 2 year period will be given the opportunity to work in health board managed practices, GMS practices, community and acute services. This will develop their skills and aid them to determine a career path for the future. A recent recruitment event indicated that this is the type of offer that newly qualified GPs are seeking. Over the next 2 years this programme will be developed and refined. Along with a career structure consideration will be given to how the pay structure will reward career development.

Where GMS Practices are unable to recruit GPs they are increasingly attempting to plug the skill gap with Advanced Nurse Practitioners (ANPs), of which there is a shortage. This includes paying salaries over and above the A4C rates. Recent experience of recruiting ANPs trained and experienced in secondary care has produced mixed results as the job demands and skills required in primary care can be very different. Work is currently being undertaken to recruit and train primary care specific ANPs. Practical work based education and training is being combined with academic studies. Discussions are ongoing with education providers to provide education options that focus on community and primary care.

HCSW development is also being considered in line with the work that is being undertaken at an All Wales Level to provide support to other primary care health care professionals.

A variety of other health care roles are also being developed in the primary care setting. These include therapists, pharmacists and advanced ambulance practitioners. The population demographics, levels of deprivation and the rurality of the practice all affect the level of demand for the various health care professionals. A suite of primary care job descriptions and training packages will therefore be developed for use as demand and supply requires. Discussions are ongoing with the local and national job evaluation teams as many of the A4C job profiles have not kept pace with changing roles.

Clusters are being encouraged to use funds available to share the appointment of new roles for example Occupational Therapists. Discussions are currently ongoing, as to whether such roles could be appointed to Health Board contracts, and seconded on a locum arrangement to GMS practices. This could potentially make the roles more attractive to staff and provide greater assistance to GMS contractors who may have flexible requirements for such roles.

Administrative and clerical staff in the traditional receptionist and practice managers roles are being encouraged to expand their roles into the fields of key team co-ordinators and navigators. Building upon their current knowledge training and experience, their skills will be developed and harnessed providing a career development pathway. In addition, staff are being encouraged to gain formal educational qualifications and participate in Health Board management programmes such as the 'A Step Into Management Programme'.

Additional management support is being provided to Primary Care. A workforce team has been established to provide guidance and support to the Primary Care community, both those who are GMS practices and Health Board managed practices. This will include assistance with workforce planning, training and advice on general HR issues. A recent recruitment event for GPs was recently delivered in partnership for both the Health Board and GMS practitioners, and further events are being planned.

The provision of GP training places is also under discussion. There is a recognition that practices that currently train GPs will require support and also that managed practices have a responsibility to participate in the training. Longer periods of placement in North Wales will also extend the number of options and experiences that can be offered to the trainees. Physicians Assistants roles are also being evaluated to assess their value within the primary care environment. A number of students at Bangor University have undertaken placements in Health Board Managed Practices.

Key priorities:

- Develop career pathway for GPs (year 2-3)
- Recruit and train primary care ANPs
- Support extension of roles in primary care
- Embed role of Physicians Assistant in primary care
- Recruitment of GPs
- Development of HR consultancy service to GMS practices

Medical Workforce

BCUHB works with partners as members of the North Wales Workforce Board and is committee to having a cohesive approach to the workforce challenges and opportunities across the sector.

There is commitment to having a joined up approach that supports workforce training and development across the sector. The regional workforce strategy and associated work plan has identified 3 key strategic priorities:

1. Stabilising the workforce
2. Hearing and development
3. Workforce intelligence and planning

Medical and Dental staff are a critical group in the workforce, and there are a number of challenges in relation to recruitment, retention and engagement.

Key Priorities for Medical, Consultant and Dental Workforce

- Development of BCU Medical and Dental staff retention strategy
- Embed our Values and Behaviours Framework within the Medical and Dental staff groups, especially with regards to recruitment and selection expected behaviours
- Develop the core skills of our clinical managers
- Ensure we enhance management and leadership skills for senior clinicians
- Develop organisation actions to address outcomes of Medical Engagement scale, NHS Wales Staff Survey and SAS Doctors and Dentists WG Listening Exercise
- Create opportunities for our staff to share/ learn from others in different sectors
- Ensure all medical staff have up to date job plans
- Evaluation of/Implementation of Lord Carter recommendations and maximise new opportunities to achieve the 'model hospital'
- Embed the integrated workforce and finance dashboard for the medical and dental employee group by:
    - Creation of single data team
    - Ensure that we maximise delegation and prudent workforce principles in all our services
    - Ensure that job planning and appraisals for medical and dental employees are carried out to a high standard and that outcomes are shared to develop clinical area level training need analysis.

How this will be achieved

- Develop innovative approaches to attracting Medical and Dental roles
- Development of new roles to support service sustainability (e.g. Physician Associates)
- Development of holistic skills mixes within directorates to reflect the overall Plan themes

- Continue to support job planning arrangements through supported training programmes for staff so that a framework can be developed to support job planning activity on a speciality by speciality basis. The components will focus on
  - activity
  - cost
  - performance against local and national targets
  - quality and safety issues
  - workforce measures
  - plans for service modernisation and reconfiguration
- Improve collaborative planning and working with other Health Boards and partners to share experience, expertise and opportunities
- Promote the “the North Wales offer” for medical staff.
- Work to revise the funding of doctors training posts
- Strengthen our connection with schools, colleges and universities

There continue to be number of significant challenges in terms of increasing demand, recruitment shortages, maximising efficiency/productivity opportunities and compliance with deanery standards:

- UK wide Skills shortages, recruitment challenges in a number of medical specialties.
- An ageing workforce profile
- Deanery rota compliance and training standards requirements for 2018 and beyond
- A competitive climate, both internally and externally, for salaries particularly in certain specialist areas and the impact this has on both recruitment and retention.
- Reduction in the availability of locums combined with pressures to increase rates to sustain services.
- Educational commissioning numbers across Wales will not meet medical and dental demand
- An increase in educational trainees, coupled with our existing vacancies, has created difficulties in capacity to train the trainees.
- Workforce planning across care pathways, which includes other parts of the health care system and realignment of workforce.
- In addition to the impacts of some rotas driving up junior doctor workforce demand, there are a number of specialities at immediate risk including Obstetrics, Emergency Medicine, COTE and Mental Health. The long lead in time for training, the ability to release resources for training and associated backfill costs, all present further challenges.

Investments and Cost Pressures

As well as the additional resources required to ensure medical workforce sustainability, each division has also identified a range of changes to service delivery that require investment in the years 2018/2021 and these include:

- Meeting RTT demands requires an associated increase in core medical staffing and reduced reliance on variable pay resource e.g. T&O, Dermatology and Anaesthetics.
- Ongoing service changes
- Additional Junior Doctors and Advanced Practitioners to meet deanery rota compliance in a number of surgical specialities, following removal of deanery training. This will result in a significant number of additional junior doctors and cost pressure to the organisation.

Workforce savings opportunities include:

- Workforce efficiencies through improved service efficient models including PICU and ED.
- Improved control of variable pay through the reduction in waiting list initiatives payments, some of which will be supported by increases in core staffing previously identified in investments.
- Changes in service models and skill mix in GP OOHs will reduce the need for GP locums.
- Tighter controls over vacancy scrutiny.

To underpin our work on resourcing, starting internally with medical recruitment we will map our processes to ensure that we have no lost or wasted time for medical staff recruitment. Together with NWSSP, we will continue to invest in our Improvement Group, which collaboratively is assessing our performance data and processes and investigating why it is taking longer for us to recruit compared to some neighbouring Health Boards.

Partnership Working

The Local Partnership Forum (LPF) and Local Negotiating Committee (LNC) provide the formal method for negotiation and consultation between staff and the organisation, although there are other local fora to engage with staff. Key themes from a workshop on the operational plan included development of a more sustainable workforce plan in rural areas, further improving engagement with staff, and using staff experience to inform development of future services.

Bilingual Skills

The organisation aims to ensure that Bilingual Skills are embedded into workforce planning through the organisation's Bilingual Skills Strategy. All policies and the commissioning and contracting of services reflect Welsh language considerations, ensuring clarity in terms of the commitment and engagement required. Welsh language will be rooted in operational planning and service delivery providing reassurance that language needs and choices influence the planning, commissioning and contracting of services.

Organisational Development

The organisational development function will focus on supporting the organisation to continuously improve, learn and deliver its vision. There will be a clear mechanism for engaging and developing staff and leaders to enable the culture changes required to deliver the strategic objectives, and ensure the values are at the heart of what we do. Key organisational strategies will be supported by:

- Enabling culture change
- Enhancing change capacity and capabilities
- Developing a sustainable and innovative workforce
- Building confidence in leadership

Organisational Development functions in the space between culture, performance, engagement & effectiveness. Together we help teams and services align their vision to the organisational values, deliver purpose through practice, and transformation through staff engagement, participation, dialogue and taking adaptive action. We deliver an approach to organisational transformation underpinned by inquiry-based practice, systems thinking, strengths-based working and an understanding of how internal culture and external context set the conditions for the organisation going forward. This contributes to our cultural ambition to promote and enhance the well-being of future generations through delivering effective, efficient and excellent services for those in need in our communities across North Wales.

The Organisational Development function will focus on the following key areas:

Strengthening Leadership Capacity and Capability

Key actions

- Leaders role model the behaviours developed within the Proud to Lead Framework (P2L)
- Embedding an engaging style of leadership throughout the organisation
- Innovation through the development and implementation of Senior Leadership Action Learning Sets with cross organisational and public sector boundaries.
- Development of a breadth of bespoke leadership development opportunities both internally and externally to the organisation.
- Creating opportunities for senior leaders to learn together across boundaries and disciplines through enhanced partnership working
- Delivering a robust process of coaching, mentoring and supervision for leaders at all levels
- Develop a clear pathway for leadership development which also enables robust talent management and succession planning
- Enable promotion and access to external programmes and resources provided by Academi Wales
- Establish a strong culture of coaching and mentoring through development of a Coaching Strategy

Our challenges

- Lack of engagement and buy-in into the P2L framework
- Lack of perceived benefit
- Lack of leadership behaviour accountability
- Lack of capacity within the system to release leaders for development
- Creating an environment of psychological safety to encourage full engagement in the process
- Lack of a formal and robust process for coaching and mentoring
- Lack of a formal and robust process for talent management

How will this be achieved?

- Re-fresh the behavioural statements within the P2L Framework
- Promotion and re-launch of the P2L framework i.e. social media, marketing plan
- Align exemplar leaders to the P2L Framework and use as Champions of best practice
- Develop Case studies to demonstrate benefits of using the Framework
- Encourage leadership nominations for Seren Betsi
- Identify the training and development needs of line managers at all levels through a comprehensive training needs analysis
- Establish a Task and Finish group with Further Education partners and other key stakeholders.
- Accelerate roll out of the Generation 2015 Ward Manager Development Programme
- Ensure newly appointed managers deploy a full range of people management skills, through attending ‘A Step into Management’ programme – to be mandatory for all new management appointments

- Continue to work with Academi Wales to establish effective programmes of leadership development, e.g. Cluster lead development, medical leadership development
- Identify key leaders and develop a framework with key partners implement a programme of action learning sets.
- Promote the benefits and outcomes of cross-functional sharing and learning
- Support the progression of the All Wales Coaching Collaborative
- Establish a Task and Finish group to develop a coaching strategy
- Participate in the All Wales Talent Management group
- Update and refresh the Leadership and Management Development Strategy
- Embedded coaching in all leadership programmes

Develop a Highly Engaged Workforce

Key actions

- Continued achievement of the Implementation Plan as set out in the Staff Engagement Strategy
- Developing and implementing planned actions to address the results of the 2016 Staff Survey
- Continue to support the establishment of local Proud of Working groups, increasing the spread to Areas and Mental Health units
- Continue to support the very successful Gwobr Seren Betsi Star Award to recognise and celebrate staff achievements and dedication
- Continue to grow and develop the network of Listening Leads across the organisation
- Embed Values Based Recruitment methods to ensure we recruit staff who align to our values and therefore understand, promote and live to our values
- Continue to spread the 3D *Discover, Debate, Deliver staff* engagement process
- Continued roll-out of Aston Team Based Working, supporting staff throughout the Health Board in order to develop high performing teams in all services and locations
- Promote the use of OD consulting and interventions to support team performance
- Actions to further embed a culture that supports staff to raise concerns and to learn from errors, incidents and concerns
- Develop and use a set of robust metrics to measure and analyse workplace data to inform OD interventions and support leaders and managers
- Commission a Culture Diagnostic Survey Tool to support the organisation with its transformation agenda

Our challenges

- Lack of engagement and understanding of the Engagement strategy and its various strands
- Lack of awareness of the Values Based Recruitment process
- Lack of engagement and ownership at local level

How will this be achieved?

- Promote the Staff Engagement Strategy widely utilising a variety of communication methods
- Encourage ownership of the strategy at local level
- Demonstrate the benefits of staff engagement through use of key performance metrics
- Refresh and re-launch the strategy, emphasising key achievements to date
- Connect with Staff Survey working groups in local areas to support implementation and monitoring of action plans
- Integrate Team Based Working principles within all leadership programmes
- Contract and use OD consulting models at all OD interventions
- Promote safe haven processes

Talent Management and Succession Planning

Key priorities

- Improved PADR rates to 85% supported by targeted training where necessary
- Develop a Talent Management and Succession Planning Strategy

Our challenges

- Staff not utilising ESR effectively and incorrect hierarchies held
- Lack of accountability and adherence to PADR policy
- No formal process in place for talent management and succession planning

How will this be achieved?

- Robust compliance reporting and accurate ESR data
- Sharing best practice and learning across divisions
- Partnership working with the Workforce Systems team
- Regular PADR audits across the divisions
- Monitoring exception reports and identification of 'non-compliance hotspots'
- Participate in the All Wales Talent Management group
- Establish a Task and Finish group for talent management strategy development and succession planning

Learning and Development

Key priorities

- Maintain relationships with local colleges and commission programmes to support the needs of the workforce in:-
    - Essential skills
    - Apprenticeship
    - Other staff development opportunities as identified over time e.g. short courses, workshops, accredited programmes

- Access a range of funding opportunities I.e. WULF to support learning and development across the organisation
- Develop a robust process for evaluating the impact of learning and development programmes
- Development and promotion of online toolkits and web based resources for learning

Our challenges

- Understanding and keeping up to date with funding opportunities and changes to qualifications
- Identifying internal resources to support delivery of programmes
- Identifying needs across the organisation
- Promoting the opportunities across the organisation
- Using measures that are statistically robust
- Keeping toolkits updated
- Technology limitations

How will this be achieved?

- Regular partnership and progress meetings
- Working with the Trade Unions, Further Education partners and other stakeholders
- Liaise with internal experts i.e. communication team, informatics

Shaping the Future Workforce and Widening Access

Further Education Students

A joint project with Coleg Llandrillo Menai and BCUHB has resulted in a programme where students undertaking their level 3 and 4 health and social care qualifications undertake a 100 hour volunteer work placement within BCUHB. The students will all receive rotations in Llandudno Hospital. Future programmes hope to incorporate a rotation in to local Nursing and Care homes. This Health and Social care rotation provides valuable experience across the sector and helps to break down barriers to the integration of the workforce, by ensuring that students value the importance of working within both sectors. This group completes the standard clearance processes for all Step into Work opportunities.

Adult Volunteer Programme

Welsh Government targets for BCUHB for LIFT (those who come from households where no one is in employment) are 125 opportunities to the end of December 2017. The adult volunteer work placement programme in BCUHB incorporates LIFT and initiatives from other groups who are furthest away from the job market.

Before the volunteers are supported in to the work place they are all required to be all 100% compliant with statutory & mandatory training, attend BCUHB orientation, and be DBS and Occupational Health cleared. They then complete a 6 week volunteer placement at a minimum of

16 hours per week. If posts become available in the organization, the volunteers are guaranteed interviews if they meet the essential requirement of the role. The programme has facilitated a process that eases difficulties in relation to large employment gaps so they can be supported into work.

27 individuals have secured an apprenticeship/permanent role in the organisation as a result of this initiative.

Project SEARCH

The Project SEARCH programme is a school-to-work internship for disabled students fully funded by the Welsh Government Big Lottery Fund. Ten interns commenced in Ysbyty Gwynedd in September 2017 and will spend an academic year in the hospital. The interns are supported by a full time teacher and job coach. During the year they undertake classroom instruction, career exploration, and on-the-job training and support. The goal for each student is competitive employment in the community using the skills they have acquired at BCUHB. The group of interns will be completing rotations in porter, domestic, catering, pathology, pharmacy, radiology, administration, maintenance, IT and sterile services.

The project team will also be engaging with local business employers to link the interns in to work opportunities in the areas that they live.

One intern has already secured substantive full time employment in BCUHB.

Apprenticeships

In order to support BCUHB in addressing recruitment challenges as well as supporting young adults in the community in to work, work is ongoing to increase apprenticeship uptake in BCUHB.

Working in partnership with Coleg Cambria and Coleg Llandrillo Menai existing substantive staff are undertaking apprenticeship framework as part of their development in work. Currently there are 167 staff members undergoing an apprenticeship framework in a variety of subjects including administration, management, customer service, project management, support services, innovation and growth and engineering as examples.

Key priorities

- Develop a work plan that supports continued development of the Step into Work programme in a more consistent manner
- Implement the new BCUHB HR Protocol/Process for recruiting Adult Volunteer Participants into Bank Roles, Fixed Term Roles and Apprenticeships. Creating a Talent Pool of Volunteers who are cleared and hold a passport to working in the NHS
- Continue to work with service areas to increase the apprentice provision in BCUHB
- Work with Project SEARCH interns to secure positions at the end of their academic year in BCUHB or local businesses with a Business Advisory Committee
- Establish NEETS apprentice programme

- Continue to develop the BCUHB Careers network increasing membership in all disciplines in the organisation. Support careers events in local education providers
- Facilitate apprentice roadshows for existing substantive staff to upskill and attain qualifications
- Continue with the inclusion of new Adtrac and Opus groups into the programme
- Work with cluster leads to explore possibilities of working in partnership with the independent health sector to create opportunities in difficult to recruit areas
- Consider if credit rated qualifications/ units can be offered to those undertaking placements in the organisation.

Workforce Development and Role Redesign

To support the workforce challenges area teams are developing new models of working that include expanding the breadth and depth of roles in order to develop sustainable services.

Key Priorities

- Support area teams as required to identify the skills required by the workforce
- Support teams to develop competency packages that develop the profile of their workforce
- Ensure that education packages are appropriate and available to support workforce development requirements
- Work across Wales to influence the WEDS agenda in developing the workforce.

Regional Workforce Strategy

The Regional Workforce strategy sets out the strategic commitment as a North Wales Regional Workforce Partnership for the social care and community health sector, confirming our priorities over the next 3 years. The North Wales Workforce Strategy (NWWS) has been developed by the North Wales Workforce Board (NWWB) and is the commitment to having a joined up approach to the workforce challenges and opportunities across the sector. The Strategy supports embedding the principles within the Social Services and Well-being (Wales) Act 2014 and is aligned to the North Wales Regional Partnership Board Priorities. The Strategy has been produced jointly with partners and discussions with partner organisations.

The regional workforce strategy and associated work plan has identified 3 key strategic priorities where partners will be concentrating their energies in the first phase of the work.

Strategic priority 1 – Stabilising the workforce

Strategic Priority 2 – Learning and Development

Strategic Priority 3 – Workforce Intelligence and Planning

Key Priorities

- The development of a joint training framework
- The development of a regional career framework for the Health and social care workforce

Job Evaluation

The Job Evaluation (JE) processes are set out in the NHS Job Evaluation Handbook and all organisations should deliver in line with that guidance. In the longer term, the JE Team will work with local staff representatives to ensure that local job evaluation practices are robust and in line with the national agreement, as well as providing the confidence that our JE processes are protecting the Health Board against equal value pay claims. Job Descriptions were reviewed and updated in 2004 as part of assimilation, but these should be reviewed regularly to ensure relevance to current service need. BCUHB needs to ensure that there will be enough trained and experienced job evaluation practitioners to enable matching, analysis and evaluation to continue.

Key Priorities

- Ensure that equitable, fair and consistent job evaluation processes are applied to the banding of all new, existing, and modernised posts
- Maintain the integrity of the NHS Job Evaluation scheme (hereafter referred to as “the scheme”) and ensure it remains fit for purpose
- Ensure and promote effective maintenance and application of the scheme at local level
- Ensure compliance of Job Evaluation with the Equality Act

Our Challenges

- Continued release of job matchers against significant demand with impact on recruitment processes/ Late cancellation of planned panels
- Delay in appointing to posts
- Financial implications of delayed re-banding outcomes
- Indicative/ un-banded jobs being advertised on NHS jobs
- Engagement from recruiting managers
- Poorly written job descriptions

How will this be achieved

- Routinely schedule in block release matching panels quarterly for the year. Regular updates on matcher release and cancelled panels to continue to be raised at Local Partnership Forum
- Continue to provide localised job matching training to ensure that a large pool of staff within BCU is available
- Prioritise clinical posts with clinical risk.
- Improve collaborative planning and working with other health boards within Wales and JE partners to share experience, expertise and opportunities
- Consider new ways of engaging with recruiting managers on the Job Evaluation process.
- Regular audit of TRAC/ NHS Jobs to avoid use of Indicative/ un-banded job descriptions
- Encourage the use of tolerance levels to outline any backlog delays
- Promote job description training
- Ensure the Health Board is aware of the Track Change procedure and the benefits

- Ensure JE is resourced and prepared for an estimated increased demand for job evaluation panels for 2018 – 2019
- Succession plan to retain strategic knowledge of Job Evaluation

A Healthy Workforce

Improving staff health and wellbeing remains a key priority for the Health Board and is a key aspect of staff engagement. A Health and Wellbeing group including managers, Trade Unions and representatives from across the organisation meets on a bi-monthly basis and has developed an action plan to enhance the way in which the Board encourages and supports staff to maintain their health and wellbeing. This is reflected in our commitment to the Corporate Health Standard. Gold level standard was achieved in 2016 and we are now working towards Platinum level by May 2018.

In May 2017, we held the annual Workforce and Organisational Development conference on Time to Change, Wellbeing and Equality for Everyone.

At the conference the 'Time to Change Wales' pledge was signed on behalf of the Health Board to tackle the stigma and discrimination surrounding mental health by lending its support to a national campaign to change attitudes in Wales. This was supported by a roadshow with the mental wellbeing and counselling team visiting 22 venues across BCUHB.

As part of the Time to Change Wales action plan over 120 local champions have enrolled to help reduce the stigma around mental health in the workplace and promote mental wellbeing initiatives.

Following the staff survey in 2016, the mental wellbeing lead will take forward a number of actions to support the staff survey action plan on mental wellbeing; including introduction of workshops on anxiety, depression and five ways to wellbeing. The service has also employed a health intervention co-coordinator whose remit is to focus on staff health and wellbeing and staff flu.

Whilst we are committed to supporting staff to stay healthy, staff sickness can be a challenge. A Sickness Absence Task and Finish Group provides a strategic approach to improving staff health and wellbeing and managing sickness absence across BCU, and an action plan has been developed to support the improvement..

Absence levels for the period April to September 2017 was recorded at 4.74% which is above the Welsh Government target of 4.55%. However, this has sustained the improvement achieved in 2016 due to a concerted effort across the Health Board to address the causes of sickness absence and to manage staff who are off work due to sickness.

The action plan will continue to be monitored in partnership at the Sickness Absence Task and Finish Group. This focusses on the ten fundamental standards that were developed in partnership by the NHS Wales Health and Wellbeing Group. This includes a strong focus on workplace mental health and wellbeing issues.

The remit of the group includes reviewing the nature and extent of sickness absence across BCU and the actions being taken to address this issue. During the past year the group has endorsed the roll out of a case management approach to sickness management for the most complex cases. A Working Longer Review Group has been established to consider the issues of an older workforce and to make recommendations for maintaining their health and wellbeing. Products delivered so far include access to an intranet site and the provision of a training package for staff and managers, these resources will continue to be developed in order to support staff to remain in work. This will

include promotion of flexible working where possible to support retention, including wider use of home working and other forms of flexible working where appropriate.

Changes to the pension scheme in 2015 accompanied by changes to the state retirement age now mean that staff will be required to work longer. Within BCU we are able to demonstrate a clear link between age and absence levels. This link is particularly noticeable for staff aged 46 – 50 and above. The increase in absence levels for older workers is amplified for staff aged 61 and above. In future it is anticipated that staff will have to remain in work due to financial necessity not through personal choice, and therefore there is increased emphasis on supporting staff with working longer.

Over the past 12 months, a focus has been on promoting the CARE early intervention process and the training of managers. The training packages have been reformatted to increase the focus on employee health and wellbeing through partnership working and early intervention. This is combined with the roll out of Five Ways to Wellbeing training and a Working Longer Staying Well package, in addition to pre-retirement courses that are already available.

Key priorities:

- Achieve Platinum Corporate Health Standard in 2018/19
- Roll out 5 ways to well being programme
- Roll out working longer staying well programme
- Continued development of support materials for staff

Conflict Resolution

The Workforce Department deals with conflict resolution on a regular basis and has a pool of approximately thirty trained mediators. A mediation working group was set up for two years in 2015 and will be re-established in 2018 to address any issues identified through mediation.

In an attempt to reduce the length of time it takes to arrange a mediation session the mediation process has been streamlined. A mediation SharePoint has been set up which all trained mediators have access to, this SharePoint includes a range of useful tips and resources on the mediation process.

Mediation is playing a central role in handling conflict in the workplace and early intervention is crucial in achieving a successful outcome and can also have significant financial benefits especially if an individual is off sick as a result of the issue,

Members of the Workforce and Organisational Development Team have been delivering Dignity at work training over the previous two years and will continue to do so during 2018. This training actively promotes the use of mediators to resolve conflict.
The Organisation has also devised guidance on what is considered to be acceptable behaviour. It is accepted that having a definition for what constitutes acceptable behaviour is a positive step in avoiding conflict.

Key priorities:

- Continue to roll out Dignity at Work training

Equality and Human Rights

To meet the requirements of the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 BCUHB must consider how the Health Board positively contributes to a fairer society through advancing equality & good relations in day-to-day activities.

This includes:

- Planning & Performance Management
- Governance
- Quality and safety
- Employment

We are required to promote knowledge and understanding of the equality duties amongst our employees and assess the impact of policies and procedures on equality, often called Equality Impact Assessment (EqIA) when deciding on proposed policies and practices.

Equality is at the heart of the Health Boards Living Healthier Staying Well strategy for health and health care in North Wales. It is the Health Boards ambition to adopt a rights based approach which places human rights at the centre of our policies and practice, and the person at the centre of his or her own care. This approach is based on the values of Fairness, Respect, Equality, Dignity and Autonomy.

Key priorities:

- We need to ensure we consistently use this approach in all that we do, our priority is to drive forward this message. Strengthening the Governance and Performance Management of this work is a priority**.**

There is a strong link between equality and socio-economic disadvantage and as evidence shows people with certain protected characteristics are more likely to be living in poverty. Income and work are two of the most important determinants of health and wellbeing.
Our Specific Equality Duties provide the momentum for driving equality and inclusion forward as set out in our Strategic Equality Plan, http://www.wales.nhs.uk/sitesplus/documents/861/BCU%20HB%20SEP%20March%202016%20Final%20Version%20following%20SPP%20approval.pdf
Equality Objective 3 'Becoming an employer of choice: to be a fair and inclusive employer and build a workforce that is equipped to meet the diverse needs of our service users and colleagues, having regard for a person's protected characteristics'

- **Increasing Employment Opportunities for People from Protected Characteristic Groups**

As a major employer in North Wales we have the opportunity to build upon the work done to date to target recruitment initiatives and employment opportunities with seldom heard and disadvantaged groups to support people from protected characteristic groups into employment. We will do this by encouraging people with protected characteristics into roles where they are under-represented and

helping reduce the number of people classed as NEET, a key social justice priority for Welsh Government. (Step into work programme, Project SEARCH)

- **Supporting People from Protected Characteristic Groups in Work**

We wish to create a fair and inclusive environment, where everyone has the opportunity to be themselves work and fulfil their potential. We will build upon best practice initiatives that support wellbeing and enable people from protected characteristic groups to remain in work.

Priority Actions

Stonewall Diversity Champion

Stonewall diversity champion scheme is an employers' programme that ensures all lesbian, gay, bi and trans staff are accepted without exception in the workplace. The Workplace Equality Index (WEI) is the benchmarking tool which measures progress on lesbian, gay, bi and trans inclusion in the workplace.

Disability Confident Scheme

The Disability Confident Scheme is a scheme that is designed to help recruit and retain disabled people and people with health conditions for their skills and talent. The heath board has attained Disability Confident Employer status and as such is recognised as going the extra mile to make sure disabled people get a fair chance. Progress is measured annually via external assessment.

Gender Pay

Whilst both equal pay and the gender gap deal with the disparity of pay women receive in the workplace, they are two different issues: equal pay means that men and women in the same employment performing equal work must receive equal pay, as set out in the Equality Act 2010.The gender pay gap is a measure of the difference between men's and women's average earnings across the organisation. We are working with our staff to better understand pay differences between men and women identified within our employment reports.

Working Forward Pledge

The EHRC Working Forward Campaign is about making our workplaces the best they can be for new parents. The Health Board has pledged support and joined the campaign.

Staff Networks

Employee networks have great potential to shape the culture and behaviours of organisations. They can also help to create a trusted space for discussing issues of concern that may be hard to raise elsewhere. Celtic Pride staff network at BCU HB is an established network for LGBT+ staff. We will continue to support the development of Celtic Pride and explore opportunities for other staff networks e.g. women's network.

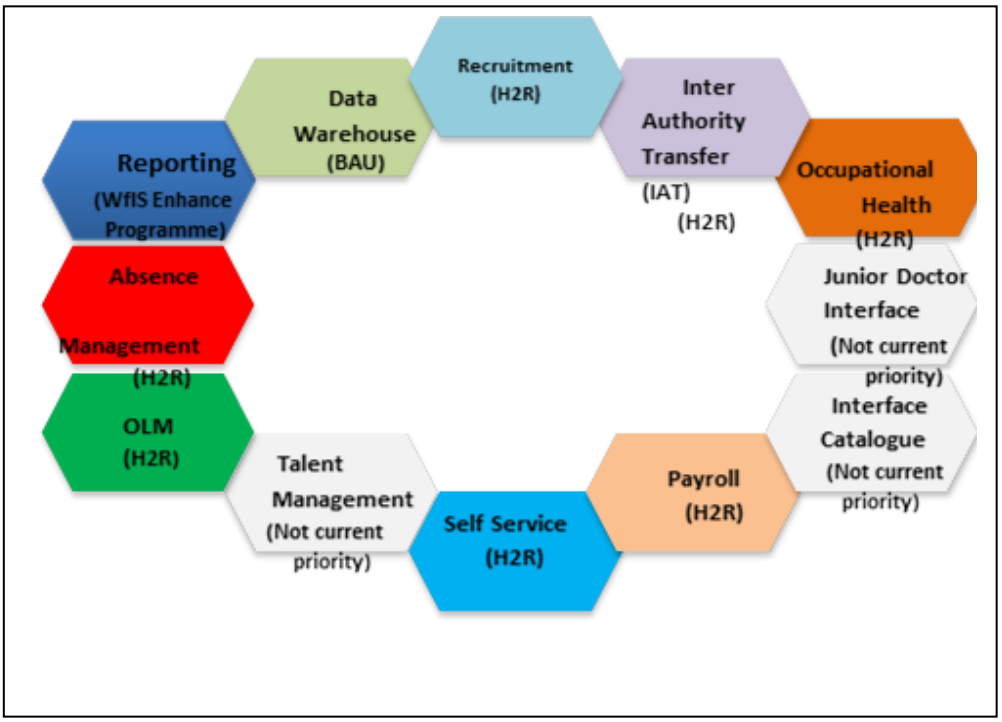
Outcome Measures

We will publish on an annual basis the number of people employed by protected characteristics. Progress is measured via the Strategic Equality Plan SEP and annual report, Staff Survey, Stonewall Workplace Equality Index annual score and Disability Confident Scheme annual assessment.

Workforce Systems and Information

The Workforce Information Systems (WfIS) Team focuses on supporting the organisation to deliver on a programme of work aimed at improving workforce information data availability and quality through the deployment of electronic systems. Its aim is to streamline processes and develop a strategy to continuously improve the current ways of working. This is done through focusing on ensuring all Electronic Staff Record (ESR) functionality is appropriately utilised and managers and employees have access to ESR including Self Service, Business Intelligence Reporting and Oracle Learning Management (OLM) to fully utilise all functionality.

There has been a clear programme of work identified by the all Wales Hire to Retire Programme as per diagram below shows:



The ESR Hire to Retire Programme is a priority objective of the NHS Wales Workforce & OD Directors and aligned to the Finance Director's 'Driving Excellence' work stream to streamline processes and systems, embrace technology and informatics and provide work class services.

The **5 strategic objectives** of the Hire to Retire work programme:

- Reduce Recruitment Timescales through the full deployment of ESR functionality and related interfaces and well developed processes
- Support the reduction of Sickness Absence Levels through improved reporting and timeliness of data
- Fully Deploy ESR Self Service
- Payroll Paper Free Systems
- Full Transition to ESR Learning Management System

The Hire to Retire Programme Governance is made up of the following project groups and include representatives from each Trust and Health Board across Wales:

- HR/Recruitment
- Self Service
- Learning & OD
- Data Quality Reporting & Capacity
- Occupational Health Bi-Directional Interface
- Payroll
- Benefits & Controls

The Workforce Information System Team ensures BCUHB delivers on a number of strategic objectives commissioned by either the Health Board or the Hire to Retire Programme this includes:

ESR Self Service

Key priorities

- To implement the On-Line Payslip initiative by the 31st March 2018 to support the all Wales Hire to Retire and Director of Workforce strategic objective.
- Support new employees with accessing ESR from Day 1 of orientation to assist with the wider Learning & OD strategy of ensuring compliance with Core Skills Training Framework (CSTF).
- Ensure 100% deployment of ESR Self Service for managers.
- Support new managers with using ESR through delivering training on a number of BCU new manager programmes ie ASiM, which assists with supporting wider OD initiatives such as PADR rates in ESR to be above 85%.
- Continued implementation of ESR Self Service as set out in the BCU Change Impact Assessment and the all Wales Hire to Retire Programme, focusing on reducing paper based processes and transitioning to electronic for example New Starters and Terminations via ESR.
- Maximise the use of ESR Self Service through developing staff awareness of the functionality available and the benefits of recording information electronically.

- Maximise the use of ESR Self Service outside of the workplace, through enabling access to ESR for managers and through the promotion of ESR mobile/tablet accessibility for employees and managers.
- Fully utilise all of the ESR capabilities ie: Learning Paths and Talent Management.
- Enhance the data transfer links between E-Rostering and ESR to reduce duplicate data entry and improve accuracy of data in both systems.

Our challenges

- Moving Nurse Bank staff over to on-line payslips is challenging due to other work pressures and IT Challenges that are being faced by the Nurse Bank Team.
- Maintaining 100% deployment of ESR Self Service due to structural and management changes.
- Embedding the use of ESR into daily life in BCU.
- Improving the IT literacy of staff to use a computer and navigate ESR.
- Communicating the benefits of using ESR with employees.
- Data transfer barriers between E-rostering and ESR.
- Incompatible IT Hardware and Software.

How will this be achieved?

- Support the Nurse Bank Team with a different process to enable Nurse Bank staff to access ESR.
- Promote the importance of maintaining ESR hierarchies and ensuring management changes are reflected in ESR.
- Ensure we support and develop the ESR skills of managers through the delivery of ESR training.
- Promote the functionality of ESR and the benefits of using ESR through developing new approaches to communicating ESR related changes such as the ESR Portal, Superusers, Twitter feeds, ESR App.
- Continue to promote and drive the transition from paper to electronic, communicate and utilise all the functionality available in ESR.
- Promote the access and availability of ESR outside the workplace
- Work with managers to develop the IT literacy of staff through signposting and raising awareness of the work our OD colleagues are completing with the essential skills programme.
- Continue to work collaboratively with the E-Rostering team to look for ways to ensure improved data transfer between E-Rostering and ESR ie: ESR Go
- Continue to suggest and raise improvements and developments to ESR to enhance functions available and the user experience.

Data Quality / Completeness

Data quality encompasses all themes across the Hire to Retire Programme, incorporating accuracy, completeness and consistency of ESR data. Improvements to ESR data are driven through implementation of data standards, minimum data sets and utilisation of tools to help define the data and identify priority areas for action.

Key priorities

- Educating the workforce about the importance of data quality and completeness in ESR to enable reliable workforce reporting, and raising awareness of how ESR data affects operational and transactional processes.
- Undertake specific data cleanse exercise in respect of key ESR data fields which have been prioritised and which support the roll out / implementation of of Self-Service functionality, as well as to meet legislative requirements. Currently the priority data fields are in relation to: Nationality of staff, ESR Supervisor / ESR Supervisor Hierarchy, recording e-mail addresses in ESR and updating Welsh Language Competency levels.
- Nursing & Midwifery Council (NMC) and General Medical Council (GMC) monthly interface reports highlighting data inconsistencies and data errors; taking appropriate action to rectify data issues.
- WoVEN data quality reports – monthly review and monitoring of error counts; taking appropriate agreed action to rectify data errors and issues.
- Implementation of all Data Quality Improvement work inlcuing, GP Practices & Clusters Data Standards, HPCP Registrations in ESR, Consistency of Position Titles (eg HCA/HCSW).
- Set up and the maintenance of ESR 'Workstructures' which consist of the Organisations, Locations and Positions in ESR. The ESR structure must mirror as closely as possible with the Finance General Ledger as well as the actual organisational management structures.
- ESR position creation and continued maintenance of positions in line with requirements of posts e.g. DBS check levels, Professional Registrations and Memberships.
- Utilisation of tools to support data accuracy and validity i.e. NHS Workforce Information Verifier, BI Data Quality Dashboard, National Workforce Data Sets, NHS Occupation Code Manual.
- Commence pilots and scoping work to implement ESR Establishment Control which is the formal process for matching information on funded posts to the details of the staff currently employed in those posts. The aim is to enable accurate reporting on establishment in ESR and enable improved financial control around establishments, both staff in post and vacancies.

Our challenges

- Embedding the use of ESR into daily life in BCU providing staff with the knowledge around why their data is important.
- Improving IT literacy amongst staff and ensuring staff are able to access electronic workforce systems
- Engaging and securing commitment to the data quality agenda from other teams e.g. NWSSP, Medical Workforce where priorities may differ.
- Educating the workforce to understand data and make it interesting
- The availability of resources when priorities change may hinder successful implementation e.g. ESR Self-Service requires a help-desk facility for user support so if this is not resourced adequately there is a risk of disengagement and a downturn in data quality.

How this will be achieved?

- Continue regular communications with the workforce to enable new ways of working and support them to make the transition.
- Build and maintain good relationships with other teams including Finance, Medical Workforce and NWSSP Employment Services to secure commitment and understanding of the importance of data quality.
- Monitor progress of data cleansing exercises to ascertain % increases / decreases of specific data items. Regular update reports are produced to monitor performance.
- Develop smooth and accurate processes to ensure ongoing maintenance of ESR workstructures / position data.
- Implementation of Data Standards – planned for Health Care Support Worker Workforce, Psychology Workforce and Dental Workforce.
- Continue with preparatory work to populate HCPC registration details of BCU-registered staff into ESR. HCPC Interface will be implemented during 2018.
- Interfaces for General Dental Council (GDC) and General Pharmaceutical Council (GPhC) also planned to be introduced in 2018.
- Review the usage and monitor data quality against the Employee Relations Data Standard / Best Practice Document.

ESR Business Intelligence (BI)

Key priorities

- 2018 will see the decommissioning of Discoverer Reporting Solution, beginning with the removal of Discoverer Standard Reports where an ESR BI equivalent exists. It is essential all core users are adequately trained and that they have access to all required reports.
- Continued promotion of ESR BI reporting capabilities to manager self service users and management teams across the organisation.
- Ongoing development of ESR BI including the development of new local reports within the WP&I team to fulfil local requirements and testing of new functionality/standard dashboards deployed by the NHS Central Team.
- Provide training to managers / Core users to use core data.
- Further developments of the Employee Relations reports will be facilitated by developments to the Employee Relations URP e.g. recording of date of suspension.

Our challenges

- There is anecdotal evidence that some core users still hold a preference for Discoverer Reports despite promotion of ESR BI to core teams.
- Development requests can be slow to be deployed where the request is deemed low priority. eg. there is a delay in roll out to core users within OMD who are unable to access ESR BI through their current system access.

How this will be achieved

- Information relating to the imminent withdrawal of Discoverer reports will be communicated to core users to encourage use of ESR BI.
- We will continue to work closely with core users to test new reports and ensure provision is developed to fulfil local requirements.
- We will continue to develop a comprehensive library of ESR BI User Guides and Resources on the Intranet and Workforce Intelligence Library Sharepoint.

Oracle Learning Management (OLM)

There are a number of Hire to Retire programme objectives that impact on OLM usage including the full Transition to ESR Learning Management System objective; being led by the Hire to Retire Learning & OD project group; as well as maximising ESR Appraisal functionality & OLM.

Key priorities

- Maximise the use of OLM for recording all learning activity in BCU.
- Fully utilise the use of OLM functionality, including the new and recently enhanced functionality.
- Continue to modernise and improve the use of and benefits to using OLM.
- Encourage all training providers in BCU to utilise OLM for the administration of learning activity and the benefits of doing so.
- The full deployment of all e-learning into ESR and its effective use.
- Continue to creating Learning Paths as an alternative approach for other suitable workshops.
- Implement the use of credits for relevant courses in ESR, particularly to encourage use for revalidation purpose.
- Ensure a blended approach to OLM usage is maintained for the benefit of all.
- Change the culture in BCU of Training providers so as to ensure they own their class data in order to shift this away from administrative staff.
- Improve effectiveness to OLM to ensure that the removal of a central booking service for all training in BCU, and embedding the process of individuals booking training through Self Service.
- Agree upon and provide training to identified expert OLM administrators and continue to support their increased knowledge and skills base.
- Continue to train new users of OLM and support the current users of the Class and Learning Administration URP and in doing so maximise the effective and efficient use of it.
- Implement a process for BCU employees having access to ESR on day one of employment.
- Monitor and maintain the integrity of data within OLM by continually checking data entry for accuracy and consistency; ensuring the data is accurate and timely.
- Full compliance with the Core Skills Training Framework (CSTF) minimum requirements for all BCU staff and look at utilising ESR for use of other statutory mandatory training requirements eg Health Care Support Framework.

Our challenges

- The IM&T infrastructure and its ability to support the increased usage of OLM.
- The lack of suitable internet software on users PCs/Laptops due to the low hardware specifications of some machines.
- The acknowledged delay when users request a password re-set.
- The lack of PC access for staff wishing to book training through OLM, in particular, those roles where regular access to a PC is not a requirement.
- Cultural changes needed to bring training providers in line with the agreed view that they own their class data, not WOD and Workforce Systems team.
- Minimising any reluctance to the use of self service for learning.

How this will be achieved

- Investigate and test the ability to manage Competencies in OLM using a blended approach of Role/ staff group and position number.
- Write Local Competencies for the areas where specific targeted training is provided, ie Berwyn Prison and attached these to the relevant staff using.
- Train and maintain the skills set of expert OLM users within WOD and the Workforce Systems team.
- Continue to promote the benefits of OLM use for both the recording of training and completion of e-learning.
- Continue to provide training requests for new and existing Class and Learning URP users.
- Modernise the way in which class data is recorded and in doing so improve the efficient and timely recording of data in OLM.
- Continue to provide up to date and accurate guides on the usage of OLM functionality and the benefits of doing so.
- Continue to identify any perceived issues or errors regarding functionality and to escalate these to the Core IBM team using a service request (SR).
- Continue to work collaboratively with the central OD Administration team in order to maintain current compliance recording in OLM and any changes or updates to the minimum requirements of CSTF.

National Delivery Framework Targets

OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them									
Measure		**Target**	**Profile**						
			Projected end of March 2018 position	**Jun-18**	**Sep-18**	**Dec-18**	**Mar-19**	**Mar-20**	**Mar-21**
Monthly	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training). BCU note: The profile given in the template reflects PADR compliance. Medical appraisal rates are recorded as a separate indicator and links to revalidation. These figures are not included in this template	85%	64.0%	67.0%	70.0%	74.0%	80.0%	85.0%	85.0%
	Percentage compliance for all completed Level 1 competency with the Core Skills and Training Framework		83.0%	84.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Workforce and Organisational Development Three Year Plan 2018/21

OVERVIEW

PRIORITY AREA	PROJECT	2018-19				2019-20				2020-21			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Organisational Development													
Strengthening Leadership Capacity and Capability	Establish a small task and finish group to develop the L&MD Strategy												
	Marketing and roll out of the Proud to Lead Framework through a variety of methods												
	Develop and implement a leadership and management career development pathway												
	Enhance the current leadership development framework to provide a more integrated approach to succession and talent management												
	Establish effective partnership working with Academi Wales to enable access to their programmes and resources												
	Identify the training and development needs of line managers at all levels, particularly in relation to people management and ensure needs are met.												
	Accelerate the roll out of the Generation 2015 Ward Manager programme to ensure that all ward managers have the management and leadership skills and competencies to be effective in their roles as clinical leaders.												
	Ensure newly appointed managers deploy a full range of people management skills and competences. This will be made mandatory for all new management appointments.												
	Establish a test Senior Leadership Action Learning Set												
	Evaluate, modify and roll out to the wider cohort of senior leaders												
	Establish a small task and finish group to develop a Coaching Strategy												
	Continue to work in partnership with Academi Wales to establish an effective programme of leadership development for Cluster Leads												
Develop a Highly Engaged Workforce	Continue to achieve all elements of the Staff Engagement Strategy and Implementation plan												
	Review and refresh the Staff Engagement Strategy												
	Implement and monitor progress against the NHS Wales 2016 Staff Survey organisational and divisional action plans												
	Monitor PADR rates on a monthly basis ensuring the agreed trajectories are being met within divisions												
	Monitor compliance rates on a monthly basis ensuring the agreed trajectories are being met within divisions												
Talent Management and Succession Planning	Establish a small task and finish group to develop the TM&SP Strategy												
	Establish a partnership working group to look at the possibilities of a framework												
Shaping the Future Workforce and Widening Access	To develop a work plan that clearly identifies the numbers that can be sustained by the organisation. To work in partnership with corporate induction to ensure capacity can be managed. To work with service areas to develop and sustain good quality placements												
	To work with managers to raise the profile of the STEP programme, to encourage them to explore the possibility of recruiting a STEP adult volunteer in to vacant posts												
	Develop a business liaison committee with external business leaders to develop a partnership between the Project SEARCH interns and the wider business community, in order to develop opportunities for employment.												
	Work with managers in BCUHB to ensure that project SEARCH interns are able to be considered through a competitive approach for suitable work												
	Facilitate apprentice roadshows for existing substantive staff to upskill and attain qualifications												
	Encourage managers to consider apprenticeship routes for new starters. To skills mix and have a rotational apprenticeship possibilities												
	Use social media and internal communication sources to target managers												

Healthly Workforce													
Incorporating Working Longer and Management of Sickness Absence	Produce workforce age profiles and monitor changes in the workforce.												
	Data analysis of age profiles compared with sickness statistics for analysis by both the Working Longer and Sickness Absence Task and Finish Group.												
	Data analysis of retirement trends for consideration by the working longer review group												
	Working Longer review group to evaluate the working longer action plan to ensure that it addresses the trends identified by the data analysis												
	Working Longer – Staying Well seminar to be rolled out across the organisation as a result of the evaluation of the pilot sessions												
	Promotion of the 5 Ways to Physical and Mental Wellbeing Programme to staff												
	Work in partnership with trade unions to develop and implement policies and training to support staff to remain in work longer.												
	Promote and develop apprenticeship schemes for school and college leavers to address the low number of staff currently in the under 21 age bracket												
	Through workforce planning consider role redesign and modular training packages for succession planning.												
	Develop step down into retirement work contracts to encourage staff to adapt their working life in preparation for retirement.												
	Monitor levels of absence through the sickness absence task and finish group analysing outcomes to detect trends.												
	Continue to promote CARE for staff who are off work to sign post staff to NHS and third sector organisation who may provide assistance.												
	Consider the use and role of social prescribing in improving the health and wellbeing of our staff working alongside partners in local government and third sector organisations.												
	Continue to develop the Case Conference approach to managing the most complex cases.												
	Consider how treatment of staff can be accelerated to allow them to return to treating patients quicker												
	Training of managers to be more flexible in their approach to the management of staff.												
	Further develop workforce policies and protocols that work across the generations e.g. annual leave purchase for school holidays / caring responsibilities / additional holidays for those who wish to travel												
	Workforce conference in 2019 to focus on building and maintaining an age diverse culture.												
Conflict Resolution	Develop one hour mediation workshops to inform staff of the benefits of mediation.												
	Deliver one hour Dignity at Work training sessions highlighting the use of mediation.												
	Develop further conflict resolution training as part of 'Step into Management' Programme.												
	Develop one hour sessions on 'initial assessments' promoting the use of informal processes to manage potential conflict.												
	Deliver modules												
	Establish a small working group to examine cases where mediation hasn't worked and ascertain the issues and recommend any required changes.												
	Develop a questionnaire and undertake 12 one hour interviews with mediators to get 'their side' of the process.												
	Establish a joint working group of managers, WOD and Trade Union representatives to develop a 'Conflict Resolution' Toolkit to increase knowledge and skills												

Recruitment and Retention		
Recruitment and Retention Strategy	Digital media group in place , annual plan for delivery	
	Digital Media rep in Comms will have has part of annual plan	
	Generic email produced with IT with admin supporting emails	
	Digital marketing report produced quarterly	
	Auto response produced to ensure customer service provided	
	EMG SPPH receives quarterly update on items of significance	
	Consultation of draft preceptorship programme	
	Final document published Communication to senior nurses and wider through comms team	
	Evaluation of Nurse Recruitment day	
	Trend analysis on vacancies filled in line with activity	
	Bangor University lead/Glyndwr university to join BCU Recruitment strategy group as invites quarterly basis	
	Plan to have available workforce data on one dashboard (Qtly Director of WOD report)	
Recruitment & Retention	Improved R&S practices / investment in systems. Develop innovative approaches to attracting Medical and Dental roles. Promote the "North Wales offer" for medical and dental staff. Broaden the ways that young people can learn more about becoming a doctor or dentist in North Wales.	
	Development of new roles to support service sustainability. Work to revise the funding of doctors training posts. Improved partnership and collaboration with local social and health and third sector parties.	
	Full introduction of Exit interview Policy and Process	
	Engagement Strategy – Overall Engagement Score improvement	
	Develop strategy to ensure the retention of welsh trained doctors and increase the undergraduate and postgraduate translating into junior doctor and consultant roles in North Wales	
	An engaged workforce Clinical Leadership and management Development to support engagement of workforce	
	Accountability and performance management	
	Improve collaborative planning and working with other health boards and partners to share experience, expertise and opportunities (such as strategic secondments etc.)	
	Technological advancements Evaluation of Model Hospital and exemplar patient flow management and good practice to provide guide workforce requirements Improved and varied job planning with opportunities for improved work/life balance	
	Understand the changes to service delivery to be able to effectively utilise additional Junior Doctors and Advanced Practitioners to meet deanery rota compliance in a number of surgical specialities, following removal of deanery training.	
	Provision of a supportive approach to sickness absence in line with the All Wales Sickness Absence Policy Address the common acceptance within NHS Wales Health Boards, that Medical and Dental Employee sickness absence is generally under-reported and plan for improvement	
	Review of the use of Waiting List Initiatives, additional sessions, other supplements Reduce the use of Agency Locums	
	Improving Rates for Mandatory	
	Training for Medical and Dental employees	
	An integrated part of the IMTP ensuring collaboration and partnership working with commissioning bodies such as WEDS/HIEW	

6.3 Research, Development and Innovation

6.3 Research, Development and Innovation

Leadership

The executive lead for research and development (R&D) in Betsi Cadwaladr University Health Board (BCUHB) is Dr Evan Moore, Executive Medical Director. He is supported by Dr Melanie Maxwell, Senior Associate Medical Director and an R&D Director.

The R&D Team shares and is fully engaged with Health and Care Research Wales in supporting and developing excellent research in Wales which has a positive impact on the health, wellbeing and prosperity of the population.

Strategy

Our 3 year Research and Development Strategy was approved by the Board in 2016 and an update of the strategy was presented to the Board in January 2018. A commitment was made to review and refresh the strategy. We will do this in partnership with our academic partners, aligning our strategic goals both locally and nationally to ensure the greatest benefit to our population and researchers. Following strategy review and refresh we will develop an implementation plan to achieve our strategic aims.

One priority area to enhance strategic development is identifying and accessing additional research funding streams to augment the national research funding allocations from Welsh Government. We will continue to develop existing and new partnerships with industry to grow our commercial research portfolio and work with academic partners to support our developing research leaders to generate increased successful grant applications. The combined research income will then be reinvested into developing BCUHB's research infrastructure, and further developing the research activities of all health care professionals.

We aim to build a skilled workforce capable of advancing high quality multidisciplinary research as part of core service by, for example, ensuring research is recognised in job plans and job descriptions, and developing multi professional clinical academic pathways with our academic partners. Increasing the number of joint appointments and clinical/research posts are seen as key to being able to recruit and retain high quality health professionals who will provide high quality care to our population and increase our research capacity and capability.

The R&D team, in conjunction with Health and Care Research Wales, will continue to promote and support GP practice submission of applications to the PICRiS scheme to help develop the research culture in primary care. We have recently had Health Board approval to work with all our managed practices to achieve PiCRIS affiliation and support these practices to become research active; this work will commence in 2018.

Culture

During the last 12 months we have increased our R&D presence across the Health Board with regular awareness sessions in public areas (Science Slams), and presentations at Grand Rounds and local and national events, where opportunity is taken to promote the value of research and to

engage staff with the R&D strategy. A revitalised R&D website and Twitter account also continue to raise awareness and promote the value of research both within and external to the Health Board. These communication mechanisms enable us to promote the high quality work being undertaken across BCUHB supported by each of the regional research and innovation groups who also disseminate in their local areas.

The development and provision of a well-equipped, designated Clinical Research Facility is key in our strategy and will enable our clinicians and patients to have access to an environment that supports the increased provision of high quality research. Over the last two years a urology research laboratory has been developed by one of our research active clinicians supported by the R&D Department and local Hospital Directors. This is now being expanded as part of the strategic plan to develop a world class clinical research facility in North Wales -- the North Wales Clinical Research Centre (NWCRC).

The NWCRC is a BCUHB Research & Development initiative, working in collaboration with Glyndwr University, Bangor University, Celtic Advanced Life Science Innovation Network (CALIN), and the Life Sciences Hub Wales. This will provide an exciting opportunity for BCUHB staff to collaborate with academia and industry, bringing together expertise and centralising resources. Clinical areas currently developing an interest in this facility include obstetrics & gynaecology, urology, oncology, ENT, endocrinology, cardiovascular disease, audiology and pain management. Biological pathways, basic science, novel biomarkers and clinical outcome measures are also being developed. There are currently 5 PhD students working in the NWCRC and this is expected to increase over the next 3 years.

Partnerships

We have collaborative Partnership Boards with our two local universities, and further development of a close working relationship is a priority with strategic and operational investment to achieve this. Joint appointments/clinical academic appointments with academic partners are being developed. Two honorary visiting professor positions have recently been appointed with one of our local academic partners and plans are progressing to appoint a clinical cancer Chair. We plan over the next three years to increase the number of joint appointment and clinical academic posts, working with our university partners through our collaborative Boards.

The R&D team continues to signpost its research active professionals to other research resources such as the Research Design and Conduct Service (RDCS) and the North Wales Clinical Trials Unit, in order to develop high quality Welsh led research studies and funding applications. Regular communications between the teams, regular RDCS clinics and RDCS membership and attendance on our R&I Boards ensures that the valuable resources and expertise available are continually communicated. This work will continue and be further developed to ensure we are able to increase the number of Welsh led funding applications and studies in the future.

Work will continue to develop shared policies, procedures and guidance with our academic partners, to support joint work with shared Standing Operating Procedures and Intellectual Property principles.

We are continuing to develop close working relationships with MediWales, Menai Science Park, Health Innovation Cymru Wales, CALIN, and proactively holding industry networking events is providing additional opportunities to engage with the relevant commercial companies across Wales and the UK. This area of partnership working is progressing and will continue to develop.

Delivery

Research activity influences our Welsh Government R&D annual funding allocation and our recruitment in 2017 was reduced. This, along with changes in the funding formula, at the same time as the national delivery workforce were transferred into the Health Board, has significantly influenced our allocation. This has led to challenges that need to be addressed over the next three years but these challenges also present opportunities to review our structure, taking into account changes in UK research governance processes and structures. This reinforces our desire to identify additional revenue sources such as commercial studies and grant capture. Key to this is an excellent financial management infrastructure ensuring that all there is provision of financial and costings support for researchers, and appropriate research costs are recovered and attributed appropriately. We have implemented the NHS Wales Research Finance Policy and will continue to monitor full implementation in collaboration with Health and Care Research Wales over the next 12 months.

Patients currently have the opportunity to be involved in almost 400 studies in a range of areas and specialities, in our hospitals, clinics and GP surgeries. Research shapes future care so it is really important that we continue to be active in all research areas offering as many of our patients the opportunity to take part in research as possible. We are reviewing our research portfolio to ensure that studies we run reflect the health priorities of the local population as well as our areas of expertise. This will be done in partnership with our university partners, ensuring that we are working together to provide increased opportunities for our local population to take part in high quality research.

Welsh Government research funding is used in line with Health and Care Research Wales requirements on use of local support and delivery funding to support the delivery of high quality research by ensuring there is a research infrastructure to support researchers. It is also used to increase the research capacity of BCUHB's research active professionals, through the funding of Pathway to Portfolio studies, dedicated research time and additional support. The R&D team are also committed to developing research leaders in BCUHB by increasing the number of Chief Investigators (CIs), leading high quality, externally funded studies registered on the UK **Clinical Research** Network **Portfolio** of studies.

Sharing and adopting good practice

A Quality Improvement Hub is being co-produced with all Health Board staff and this will see a synergy between research, quality improvement and innovation, reducing artificial barriers between different strands of work which all has the overarching aim to improve the health and wellbeing of our population. The translation into practice and mobilisation of research findings needs to be improved further with knowledge mobilisation a key factor within our developing strategies.

We are working closely with our librarians to capture and disseminate research publications and this work continues. We are about to launch a repository which will hold all BCUHB related research

publications Our researchers regularly present their studies and findings both within the Health Board at, for example, Grand Rounds, Science Slams, local conferences and meetings, and via the R&D website and Twitter, as well as externally, one example being the 35th World Congress of Endourology & SWL in Vancouver, Canada, where four abstracts were accepted as podium presentations.

The R&D Department will continue to actively contribute to, and implement the proposed national changes in the research governance process and systems for commercial and non-commercial research through continued partnership working and communication with Health Care Research Wales.

Innovation

The executive lead for innovation in the Health Board is Adrian Thomas, Executive Director of Therapies. Innovation has many facets, including research, quality improvement, service development and transformation, that fully exploit the potential value of new products, processes and technologies to apply new and better ways of delivering health and care services. Over the next 12 months we will pull together these facets to assess our current position to underpin the development of an innovation strategy for BCUHB.

There are many innovations and innovative practices happening across the Health Board, and over the last 12 months examples include:

- Working with collaborators, particularly industry and academia, we have held two successful industry networking events and participated in the Conwy Business week, leading a day entitled 'Bringing Innovation to Life'.
- Developed opportunities for our staff to engage with innovation through innovation events and a number of 'Dragons Dens' events held where staff are invited to present their innovation idea. We have also held a clinical unmet needs event where staff were invited to identify their clinical unmet needs and these have been shared with industry partners at an Innovation event co-hosted by MediWales.
- "Game of Stools" was announced as the overall winner FAB NHS Stuff Awards at the O2 in London chosen by the academy as being the best of their 52 weekly winners in 2017.
- Clinician working with a global commercial partner to improve clinical outcomes for deteriorating patients
- Development and implementation of a clinical dashboard
- A number of Bevan exemplars in a range of areas, including multi disciplinary team working in primary care, ophthalmology, orthopaedics.

Innovation is recognised as a key enabler across a wide range of service in the Health Board and this is reflected in our plan. Examples include:

- BCUHB Arts in Health and Well-being 'Creative Well' strategy: Working with older people and chronic conditions ……Capitalising on creative therapists' and artists' ability to act as catalysts for innovation
- Growing Well North Wales: Develop and embed an internal framework that supports the capture of innovation and good practice.

- Care Closer to Home: New roles will be developed and implemented to further support the Primary Care model. Advanced Practice Paramedics will deliver the urgent home visiting service, Physician Associates supporting GPs and a team that will support and help sustain our Practice network. Develop and implement new roles and models, such as the Urgent Home Visiting Service, Physician's Associate and the sustainability and innovation team.
- Strengthening Leadership Capacity and Capability**:** Innovation through the development and implementation of Senior Leadership Action Learning Sets with cross organisational and public sector boundaries

Priorities for 2018/21

We are aware that we now need to develop a formal infrastructure to drive forward innovation. The infrastructure will develop and support:

- Clear pathways for staff who have innovative ideas or have identified clinical unmet needs.
- Uptake of new and innovative practices, processes and technologies.
- The sharing and spread of good practice, both across and outside the Health Board.

We need to engage with our staff to encourage innovation and build innovation skills and confidence in order to develop a culture that truly embraces and engages with innovation in all its forms, and is recognised as a key enabler within all services and departments.

During the next 12 months BCUHB, led by the executive lead for innovation, will start to develop an innovation infrastructure and culture to drive forward innovation along all parts of the innovation spectrum. The infrastructure will include management and clinical champions and will capture innovation in all areas, linking with quality and service improvement colleagues, education and research and development. The Innovation Strategy will be in place within 12 months, with the infrastructure in place within 3 years.

We need to ensure we have a process in place that enables the sharing and spread of innovation, both within and outside the Health Board. It would be supported by an all Wales infrastructure to ensure that Health Boards have the ability to share and spread across NHS Wales in a coordinated way.

Research and Development Three Year Plan 2018/21 Overview

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Research	Meet 90% of Key Performance Indicators													
	Launch North Wales Clinical Research Centre													
	Increase commercial research income by 20%.													
	Increase external grant capture by 10%.													
	Map high quality research studies against local health board health priorities to ensure priority is given to these studies and develop a system to clearly demonstrate this.													
	Review the R&D Strategy to ensure it is fit for purpose and delivering against key aims and objectives.													
	Ensure clear links between research strategy and priorities and BCU Health Board long-term strategy through the Living Healthier, Staying Well programme, Health and Care Research Wales Strategic Plan 2015-2020 and Prosperity for All.													
	Actively contribute to the development of the BCUHB Quality Improvement Hub which will integrate quality improvement, innovation and research.													
	Develop a clear, functioning, fit for purpose knowledge mobilisation strategy to disseminate research findings and adopt evidence based practice.													
	Benchmark proportionate funding ratio of national funding: commercial income: grant capture.													
	Develop a clinical academic pathway with adademic partners and increase the number of joint appointment posts.													
	Develop with academic partners a Shared Research Strategic Board.													
	Fully implement the NHS R&D Finance Policy.													
	Meet 95% of Key Performance Indicators.													
	Maintain increasing commercial and grant capture activity trajectory.													
	Fully functioning shared research Strategic Board.													
	Review NWCRC activity and sustainability, further widen clinical interest.													
	Review and adjust knowledge mobilisation strategy.													
	Work towards proportionate funding ratio of 70% Welsh Government funding : 30% commercial income and grant capture.													
	Meet 100% of Key Performance Indicators.													
	Work towards proportionate funding ratio of 70% Welsh Government funding : 30% commercial income and grant capture.													
	Review Strategy and progress.													

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Innovation	Carry out a robust assessment of BCUHB's current position using the innovation spectrum as a framework.													
	Develop and launch a robust strategy for innovation in BCUHB with clear deliverables, which compliments key principles in Innovation Wales.													
	Develop an innovation infrastructure and Quality and Innovation Hub, with named management and operational champions. The Hub will provide leadership, strategic direction, coordinated support and learning/sharing of good practice. The Hub will encourage closer integration between research, quality improvement, education and innovation activities.													
	Actively engage with academic partners e.g. Bangor University Health and Social Care Improvement Hub													
	Further develop relationships with academic and commercial partners.													
	Develop clear, robust metrics to measure the impact of innovation projects.													
	Develop a systematic approach to identifying, evaluating and adopting good practice both within and outside the organisation.													
	Build on the successful industry networking event and clinical unmet needs event held in 2017.													
	Develop a systematic approach to the sharing and spread of best practice													
	Progress infrastructure development. Identify dedicated resources and clear processes to accelerate selected innovation projects.													
	Implement a structured approach to developing and managing external partnerships.													
	Develop an approach to identify and address unwarranted variation.													
	Review approach to sharing and spread of best practice.													
	Review impact metrics and further develop as necessary.													
	Innovation infrastructure in place.													
	Review Innovation strategy.													

6.4 Infrastructure Investment (Capital)

6.4 Infrastructure Investment (Capital)

Capital investment is a critical enabler to allow the Board to meet the health needs of the population we serve by providing assets to support the delivery of safe and sustainable services. The Board's capital programme and its associated investment proposals will be geared towards supporting the realisation of the goals set out in our strategy "Living Healthier, Staying Well".

Developing our Estates Strategy

Our strategy for health and health services requires the provision of fit for purpose estate across North Wales. We will develop an estates strategy during 2018/19 which sets out how our estate will be developed to meet future service need.

Our programme to deliver improved primary and community care will drive the need for a major investment programme to ensure that we have the right facilities available across north wales to deliver more Care Closer to Home. Our strategy sets out a need for facilities to deliver health and wellbeing services at three levels in the community. We will engage with staff, communities and stakeholders at a Cluster level to determine the future estate needs and reflect these within our estate strategy. We have undertaken a survey of the condition of our primary care and community premises to inform this work and will use this to prioritise areas for future investment. As part of this work we will seek opportunities for collaborative approaches to asset utilisation with partner organisations, which will improve service delivery as well as delivering optimal value for money from investment in the estate.

Within hospital services we have set out our strategy to maintain our three main hospitals as the key delivery points for hospital care across North Wales. We have also indicated that we will provide more specialist services in key locations to ensure that we deliver the best possible outcomes for people who access these services. During 2018/19 we will model the impact of our service plans upon the capacity required at each hospital site in order to inform our estate strategy.

The redevelopment of Ysbyty Glan Clwyd has addressed many of the backlog issues on that site, however we will ensure that our estate strategy addresses those areas of the hospital which are not covered by the current programme. We have commenced work to set out an investment programme for the Wrexham Maelor Hospital to address known risks with the infrastructure as well as ensuring that the hospital is configured to deliver the services required for the future in Wrexham, in an efficient and effective manner. We are working on a Learning Disabilities strategy and will review health implications. A similar programme of work will be required in Ysbyty Gwynedd.

Within mental health services we have undertaken work in recent years to address immediate risks in our inpatient environments, however we recognise that we currently deliver care in some environments which are not fit for purpose. Our mental health strategy sets out our ambition for services in the future and we require a fit for purpose estate to deliver high quality services in the future. We have significant investment needs in the Ablett and Hergest Units and we will develop a programme business case as part of our estates strategy to address these requirements.

Our estates strategy will also cover clinical support services and our non clinical estate. We will bring forward a business case for the reprovision of laundry services in North Wales as part of the all Wales programme. We will undertake an appraisal of options for the future provision of residential

accommodation across the Health Board to address the current deficiencies in the condition of our estate, including potential collaboration with external partners.

Through this estates strategy we will also ensure that the risks associated with backlog maintenance will be reduced for the future.

As our strategy develops we will liaise with Welsh Government to ensure that it is aligned with national expectations. This discussion will also include exploration of potential sources of finance in addition to traditional NHS capital resources.

Our Current Major Capital Programme

We will continue to implement our capital programme, with the following schemes funded through All Wales capital resources –

- YGC Redevelopment
- SuRNICC
- YG Emergency Department
- The Elms, Substance Misuse Services, Wrexham
- Hybrid Theatre at YGC

We will progress work on business cases to bring the following specific schemes to fruition during the period of our plan -

- North Denbighshire Hospital
- Central Denbighshire primary care
- Waunfawr Surgery
- Substance Misuse Services – Shotton and Holyhead
- Delivering sustainable Orthopaedic Services
- Robotic Surgery
- Major imaging equipment replacement programme
- Linear Accelerator Replacement

Work will continue in year one to finalise the FBC for North Wales Laundry and Linen Service in line with the agreed All Wales model. Progress will also be made in year one to complete a Full Business case for the future delivery of Health Board Residential Accommodation following completion and support of the agreed Options Appraisal outcomes.

Discretionary Capital Programme

The Board has a discretionary capital Programme of £14.4m allocated by Welsh Government. This programme is principally designed to enable maintenance of essential infrastructure and replacement of equipment. The Board faces significant challenges in terms of backlog maintenance, urgent repairs and equipment replacement, both medical and Information technology.

In order to prioritise investment from the discretionary allocation the Board will assess potential investments against the following criteria:

- Ensure statutory compliance.

- Reduce risk.
- Support service continuity.
- Support service transformation.
- Deliver financial benefits.

The Board has sought to ensure a balanced programme which primarily focuses on management of risk whilst addressing key developmental areas. Taking these factors into account, alongside the contractual commitments already made, the following draft programme has been identified for the year ahead:

Scheme	£	£
East Area		
WMH additional “side rooms”	345,000	
WMH daycase and endoscopy	961,000	
WMH minimum works to endoscopy 2	200,000	
Paediatric ward	180,000	
Sub-total	1,686,000	1,686,000
Central area		
Corwen Health Centre	1,200,000	
YGC discretionary support	1,200,000	
YGC medical records risk mitigation	500,000	
Mobile devices – community pilot	72,000	
Sub-total	2,972,000	2,972,000
West Area		
Bala health centre discretionary support	68,000	
YG relocation of clinical prep	428,000	
YG Pathology – phase 1 reconfiguration	90,000	
Bryn Beryl hospital	496,000	
Sub-total	1,082,000	1,082,000

Mental Health		
Ablett Unit Tegid ward additional environment works	270,000	
Personal alarms (Hergest and Ablett)	28,000	
Reconfigure Bryn-y-Neuadd	100,000	
Sub-total	398,000	398,000
Estates		
High risk backlog maintenance - East	600,000	
WMH Fire alarms	150,000	
High risk backlog maintenance – Centre	800,000	
High risk backlog maintenance - West	800,000	
Removal of high risk ACMs	150,000	
Fire precaution works	200,000	
Ward environment	300,000	
Critical facilities equipment replacement	670,000	
Sub-total	3,670,000	3,670,000
Safe Clean Care		1,000,000
Medical Devices		2,750,000
Informatics		3,000,000
	TOTAL	**16,558,000**

Medical Equipment and Devices

In support of the development of clinical services outlined above, the capital programme will provide for the replacement and development of medical equipment and devices. The programme is developed annually reflecting clinical priorities identified, balancing innovation, risk and statutory compliance. Much of the equipment in the Health Board is beyond its recommended life span and in year emergency repairs, rental and replacements are becoming more common to ensure service continuity.

In addition to that which is financed through the discretionary programme, there are significant assets that will require support from the All Wales Capital programme including major diagnostic equipment. We will set out our priorities for investment in major diagnostic equipment in order to secure funding from Welsh Government's National Programme.

Informatics and Information

Investments to maintain and develop our information infrastructure are identified throughout this Plan and summarised in the section which follows.

Capital Infrastucture Three Year Plan 2018/21
OVERVIEW

PRIORITY AREA	PROJECT	Existing Scheme	2018-19				2019-20				2020-21			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
YGC Redevelopment	Asbestos removal complete													
	Re-furbishment and contract completion													
SuNICC	SuRNICC complete													
	Alterations to paediatric and maternity wards													
	New chapel													
YG Emergency Department	Refurbishment and contract completion													
The Elms, Substance Misuse Services, Wrexham	Decant													
	Refurbish and extend the Elms													
Hybrid Theatre, YGC	Business case													
	Procure and install													
Wrexham Maelor Strategic Review	Wrexham Maelor strategic review programme													
Business Case Development	North Denbighshire Hospital													
	Central Denbighshire Primary Care													
	Waunfawr Surgery													
	Substance Misuse Services - Shotton and Holyhead													
	Delivering Sustainable Orthopaedic Services													
	Robotic Surgery													
	Linear Accelerator Replacement													

6.5 Digital Health (Informatics and Information)

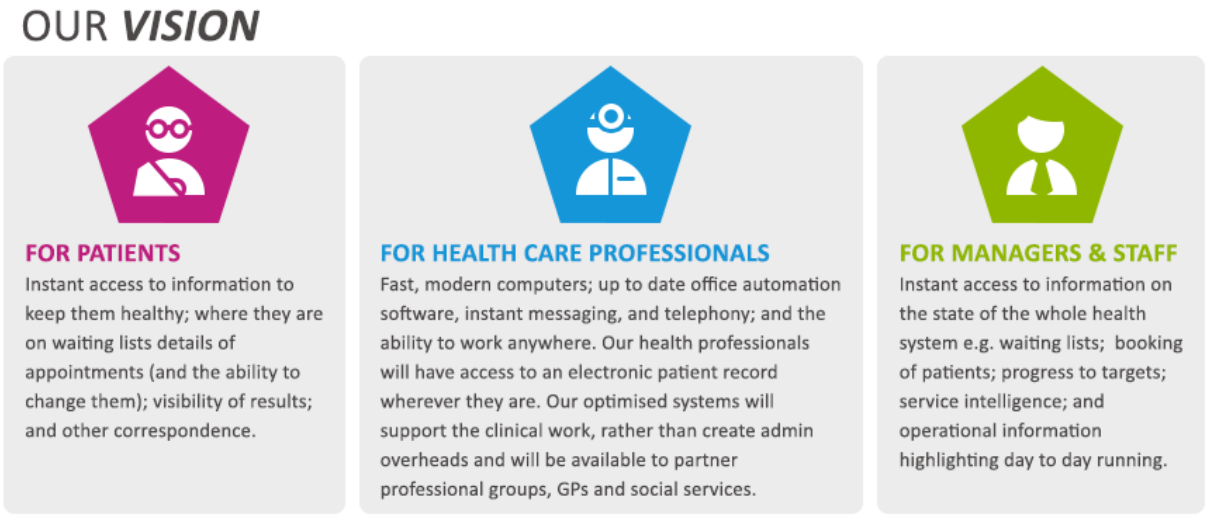
6.5 Digital Health (Informatics and Information)

The plan and approach for 2018/21 will be to implement a range of technology solutions to maintain and improve our existing infrastructure and systems, to support service transformation, grow our capacity and capability and to embrace innovative technologies.

The 'enabling' plan has been developed in response to Board's commissioning intentions. The plan will underpin service needs and support the delivery of a number of strategic developments in Digital Records, Analytics, Information Management and Information Communications Technology, that are detailed within the Strategic Outline Programme (SOP) for Informatics Services.

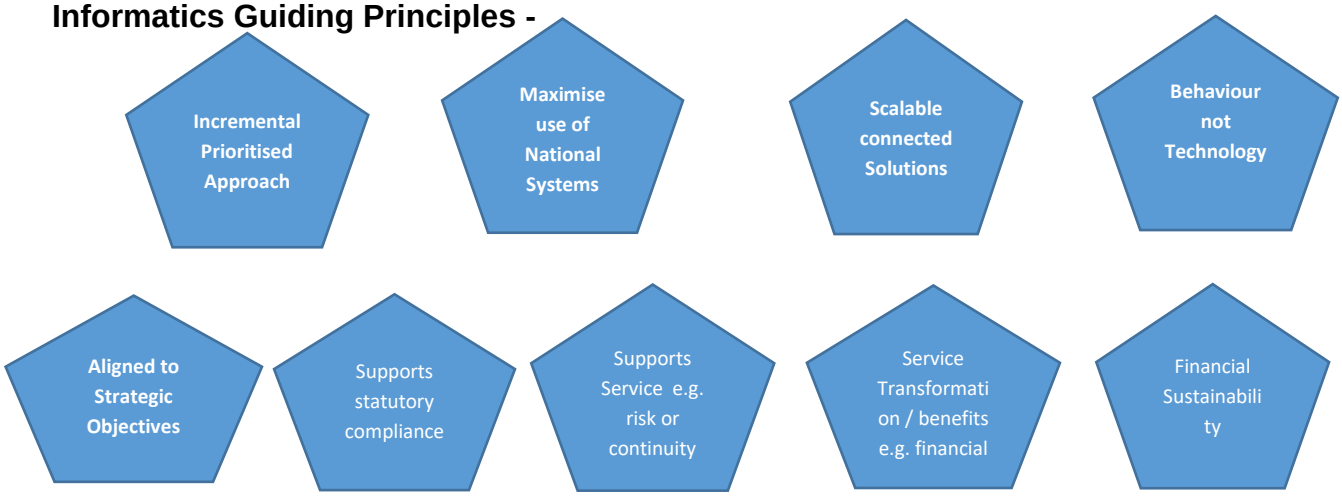
This SOP outlines the digital service vision and a potential programme of strategic investment in Informatics services that will be required to enable it to implement a range of technology and to support the delivery of national and local strategic objectives whilst complying with legislative requirements.

These investments are required to deliver a digital future that will transform healthcare. They must be in place to deliver the vision that Informatics driven work will produce:-

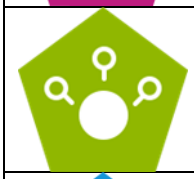
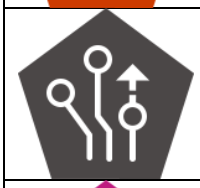
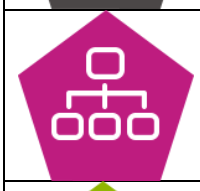
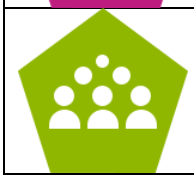


Our approach to delivering the vision will be influenced by "guiding principles" that will be taken into account when making planning and operational decisions. The principles which are detailed below have been adopted as they are considered to be essential to success.

Informatics Guiding Principles -



Our plan will be achieved through implementing a range of incremental projects to deliver the following objectives:-.

	**Digital Roadmap;** Adopting a digital by default principal, capturing data once and reusing it, minimising the use of paper and working towards "paper free at the point of care". The building blocks of a single patient view which can be accessed by those receiving, providing or supporting patient care.
	**Data Driven Decision Making;** providing tools to put data from a variety of sources at the heart of decision making in a timely and user friendly manner. Providing insights to inform effective decisions through synthesising information from a variety of sources
	**Underpinning service transformation;** Supporting services to combine technological opportunities with new business processes, that enable us to meet our Local and National responsibilities
	**Digital Mobile Workforce;** providing digital tools to support staff to undertake duties, work together and communicate effectively from a variety of locations. Reducing overheads, supporting strategies and enabling "time to care"
	**Managing Innovation and emerging technologies**; Learning and Innovating by providing accelerators of digital transformation. Collaborating with innovators and entrepreneurs and suppliers to encourage innovation
	**Digital Infrastructure**; Providing, developing and maintaining a secure, flexible and robust infrastructure to enable a digital future. Getting the "basics right" and building an Infrastructure to support transformation
	**Workforce Development, Transparency, Sustainability and Standards**; Nurturing a digital culture throughout the organisation. Supporting staff to develop and provide services that meet the efficiency, quality and sustainability challenges that we face.

The plan for 2018/21 has been designed to ensure that the services that we deliver are safe, effective and sustainable. To achieve safe services this will require 2018 2019 projects to include the replacement of the Health Records Library in Ysbyty Glan Clwyd and the provision of a new clinic preparation area in the Ysbyty Gwynedd. This is essential to minimise risk and protect staff and patients through the safe management of the patient record.

To deliver sustainable services 2018 2019 projects will include those required to achieve our cost improvement targets and those which will support both effective and sustainable service delivery. These include working with innovative partners to deliver automated coding for ‘simple’ episodes of care. This will release staff time to focus on coding more complex cases.

In line with the guiding principles previously mentioned an incremental and prioritised approach to implementing the projects that will deliver the aforementioned objectives has been adopted. This is depicted in the high level three year plan which is shown in Figure 1.

As shown a number of our initial projects is focused on “getting the basics right” and ensuring that our Digital Infrastructure is safe, secure and robust enough to enable a digital future. As such this is the primary focus of Informatics Capital expenditure.

Projects to support the delivery of the digital infrastructure include upgrades or enhancements to core infrastructure and the migration of our telephone infrastructure from an “end of life” solution to one which is fully supported and capable of underpinning service change once fully implemented. These projects have been prioritised to minimise risk to service and business continuity.

The prioritisation of the plan has been based upon commissioning intentions, risks, service priorities, available resources / products and a real understanding that it is better to get digitisation right than to do it quickly (1).

This is an essential code for us to adopt as evidence shows that digitising large scale organisations like BCU which work with substantial complexity and nuance, will be extremely difficult, requiring adaptive change at the highest order (1).

Delivery of the plan requires an extensive programme of National and Local Informatics Developments and another essential code which we are committed to is utilising National Systems which are built through partnership and designed to reduce transactional overheads.

We will work closely with National Informatics services (NWIS) and other bodies e.g. local authorities to leverage the benefits of a “once for Wales” approach and ensure that our infrastructure is capable of managing mobile devices in line with strategic principles that will be defined on an all Wales basis in quarter two of 2018 2019. This will support a mobile workforce of the future. In the interim we will require a tactical approach to mobile technology to support WCCIS and CHAI.

As shown in Figure 1 a number of national products which are essential components of our digital roadmap will continue to be incrementally implemented over the next few years thus building upon the work of previous years and introducing enhanced functionality.

A significant amount of Informatics resource will remain focused on the continued implementation of the Welsh Patient Administration system. Standardised process required to introduce a single patient administration system will require significant resource allocation throughout the health board. This will be essential to minimise implementation risks and deliver benefits for patient management and economies of scale.

As indicated in figure 1 other priories include an integrated Health and Social Care system (Welsh Community Care Information System). This will help Health and Social Care professionals to work together to provide care closer to people’s homes. It will do this by allowing access to relevant information on the care provided to show where a patient is with their treatment.

We will also learn from others through the National evaluation of Technology Enhanced Care pilot projects which are due to be completed in 2018 2019. We will use data from this evaluation to inform the delivery of a telehealth Business case which will support and underpin service transformation within BCU.

Where National solutions are not available to serve local priorities these will be designed in partnership with our stakeholders and innovators to be scalable, with the ability to be connected to

systems to reduce risk, reduce transaction overheads and improve data quality. They will be focused on behaviour not technology, and support our mantra of digital first.

When agreeing to resource local developments, we will agree and prioritise those which are aligned to our essential codes and which are aligned to Strategic Objectives, support our ability to reach or maintain statutory compliance, supports service need e.g. by reducing risk or enhancing continuity, delivers transformational/ financial benefits. They must also be delivered within the resource available to ensure financial sustainability.

Informatics Operational Plan 2018

OVERVIEW

[L] = Local Solution

STRATEGIC PRINCIPLE / OBJECTIVE		PROJECT	Existing Scheme	2018-19 Q1	2018-19 Q2	2018-19 Q3	2018-19 Q4	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3	2020-21 Q4
DIGITAL ROADMAP Adopting a digital by default principal, capturing data once and reusing it, minimising the use of paper and working towards "paper free at the point of care". The building blocks of a single patient view which can be accessed by those receiving, providing or supporting patient care.	Acute Electronic Patient Record	**[L] Paediatric Mobile Nursing Application (Chai) (Replacing Paper Nursing Documentation)**	✓												
		[L] Improving Assurance of Results Management (i.e. electronic ping to help stop printing Pathology results)	✓												
		[L] Local Document Repository/Digital Forms (Exploration to Accelerate the Journey to the EPR)	✓												
		Welsh Care Record Service Programme (National Repository for Information & Information Sharing Across Wales)	✓												
		Welsh Clinical Portal (National Portal to Record and View Patient Information)	✓												
		Welsh Results Reports Service (WRRS - National Repository for Results Reporting & Sharing Across Wales)	✓												
		Welsh E-Documents Reporting (National E-docs from within the WCP) - Diabetes (WISDM)													
		Welsh E-Documents Reporting (National E-docs from within the WCP) - Hep-C													
		[L] Digital Dictation Business Case development and approval.													
	MH, Community	Welsh Community Care Information System (WCCIS) (National Integrated Health and Social Care System)	✓												
	Core Systems	Welsh Hospital Electronic Prescribing and Medicines Administration System (WHEPMA)													
		Medicines Transcribing Electronic Discharge (MTED) - Recording medicines and adding them to a discharge letter													
		Welsh Patient Administration System (WPAS) East (National PAS Implementation and Standardisation) Phase 2													
		Welsh Patient Administration System (WPAS) West (National PAS Implementation and Standardisation) Phase 3													
		BCU Welsh Patient Administration System (WPAS) Data Migration for Integration of sites (National PAS Implementation and Standardisation) Phase 4													
		Welsh Emergency Department System (WEDS) (National ED System - Yr. 1 - Local Yr. 2 - National) / Symphony upgrade	✓												
		Welsh Radiology Information System (WRIS) (National Radiology System Across Wales) - Upgrade to 2.3/2.4													
		Patient Flow (an electronic system to enable staff to identify what actions are required to support the patient's progress, resolve any delay in the patient's hospital stay, aiding efficient and effective discharge planning)													
		Neopost Implementation. Supporting an estates project for more efficient ways to send mail and digital communications.	✓												
		[L] Legacy Systems Archive													
DATA DRIVEN DECISION MAKING Providing tools to put data from a variety of sources at the heart of decision making in a timely and user friendly manner. Providing insights to inform effective decisions through synthesising information from a variety of sources.		**[L] Local Data Warehouse expansion (New build\Infrastructure refresh yr1 and further data acquisition yr. 2-5)**	✓												
		Live Admit Discharge and Transfer - mainstreaming real time dashboards (requires real time data input)													
		Mobile dashboard to enable real time Business Intelligence (yr. 1 – 2 NWIS Dependent)													
		Improved Demand and capacity modelling capability using latest technology and learning													
		[L] Patient Management Status Boards (e.g. including bed management)													
		Incorporate Infection Prevention and control data into the BCU dashboard and support data collection	✓												

UNDERPINNING SERVICE TRANSFORMATION Supporting services to combine technological opportunities with new business processes, that enable us to meet our Local and National responsibilities.	Detailed Informatics architecture review and development of a technology roadmap Inc. business cases	
	[L] Expand on technology to track assets, patients, pharmaceuticals and resources	
	Leverage the value of national systems via intelligent integration/stapling/context sharing i.e. data sharing.	
	Portal to PAS stapling i.e. data sharing to view data in one place to drive clinical work/efficiencies.	
	General Data Protection Regulations - Supporting BCU in meeting the requirements	✓
	Information Governance Toolkit - Supporting BCU in meeting the requirements	
	BCU Standardisation to support the introduction of a single instance of WPAS	
	Telehealth Business Case	✓
DIGITAL MOBILE WORKFORCE Providing digital tools to support staff to undertake duties, work together and communicate effectively from a variety of locations - reducing overheads, supporting strategies and enabling "time to care".	**[L] Mobile Device Management Strategy,(Dependent on Publication of National Mobile Strategy Dev - Summer 18**	
	Further Rollout of Skype for Business,	✓
	Single sign on roll out including context sharing (computer session linked to individual not desktop/laptop)	
	Information Technology Self-Service web portal strategy and business case	
	Review available technology to support Infection Prevention Control Management and extend to include mobile app for use in clinical environments	
MANAGING INNOVATION & EMERGING TECH Learning and Innovating by providing accelerators of digital transformation. Collaborating with innovators and entrepreneurs and suppliers to encourage innovation.	Innovation management and delivery via technology funds (yrs. 1 – 5) (possible Cyber security yr. 1 - 2)	✓
	Future Proofing Coding for a Digital Health System (Coding SBRI) - Automating Clinical Coding for Simple episodes of care.	✓
	Host a Centre for Health Innovation Challenges in BCU. In collaboration with Welsh Government and Industry.	
DIGITAL INFRASTRUCTURE Providing, developing and maintaining a secure, flexible and robust infrastructure to enable a digital future. Getting the "basics right" and building an Infrastructure to support transformation.	Datacentre expansion and consolidation Wxm (Qtr. 2 YR 1), YG (YR 2 estate dependent)	
	Provision of support for Health Board wide estates reconfiguration schemes e.g. YGC Redevelopment	✓
	Development of ICT infrastructure monitoring and reporting systems (SCOM/ORION)	
	Leveraging the benefits of licencing (Microsoft Products)	
	Wide Area Network Transformation (PSBA) " spend to save"	✓
	Cyber security gap analysis and improvements for threat mitigation	✓
	Core Infrastructure upgrades/expansion/refresh	✓
	IP Telephony Programme continuation. Migration of users to telephony system Yr. 2 to Yr. 4 of a 5 year project.	✓
	Switchboard and paging system rationalisation	✓
	Replacement of obsolete server operating systems (2003 / 2007)	✓
	Strategy and Scope for Office 365	
	Migration towards cloud based hosting solutions (Microsoft and NWIS) (BI and Azure)	
WORKFORCE DEVELOPMENT, TRANSPARENCY, SUSTAINABILITY AND STANDARDS Nurturing a digital culture throughout the organisation. Supporting staff to develop and provide services that meet the efficiency, quality and sustainability	Workforce learning and development (e.g. HWB, Mentoring Programme, Increased compliance)	✓
	Sound Financial Management (e.g. CIP projects)	✓
	General Data Protection Regulations	
	Safe Environment - New Ysbyty Glan Clwyd File Library (Protecting staff and patients through the safe management of the	✓
	Safe Environment - New Ysbyty Gwynedd Preparation Office (Protecting staff and patients through the safe management of the	✓
	Safe Environment - Replacement / Installation of new flooring / track and mobile records within Wrexham Maelor Hospital	

6.6 Finance

6.6 Finance

Overview

The draft financial plan submitted as part of the three year plan focuses on the financial period 2018/19 to 2020/21.

To date, the Health Board has not been in a position to produce a financially balanced three year plan. The Health Board has worked with Welsh Government to develop a series of one-year operational delivery plans in the meantime. While this plan does not demonstrate a balanced plan over three years, it does work toward achieving financial balance over the medium term.

The financial environment in which the public sector generally within the UK, and consequentially on the NHS in Wales has been extremely challenging for a number of years. The Health Board has had to make significant efficiencies to offset inflationary and other service pressures. However, these savings have been delivered through transactional approaches to date, as shown below.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Transformation path

Stabilise	Improve	Sustain

• Special Measures
• FRG
• Management grip
• Central control
• Stabilising workforce
  • Agency
  • Rostering
  • Establishment control
  • Recruitment
• Quick impact savings
• Asset disposals
• Turnaround leadership
	• Efficiency & productivity
	• Workforce transformation
	• Corporate Service review
	• Clinical Service reviews
	• Standardisation
	• Rationalisation
	• Estates redesign and rationalisation
	• Technology
	• Contracting, Procurement and Medicines Management
		• Clinical transformation
		• Estate reconfiguration
		• Collaboration / partnership development
		• Commissioning and de-commissioning

The Health Board's Special Measures status has had an impact on the organisation's ability to deliver transformational change of its services, but such change will be critical in order to deliver the savings necessary to deliver medium term financial sustainability. Opportunities for savings have been identified, refreshing the work undertaken by Deloitte on whole-system technical efficiency undertaken in 2013. This work has determined c£180m of opportunities which are available to the Health Board.

Value

The Health Board has committed to incorporating Value as a key driver to service planning and change. Delivering value requires a focus, not only the more traditional concepts of productivity and efficiency, but also on outcomes.

The nature of the scale of the requirements over the medium term within the Health Board, covering quality, performance and productivity, demands that the approach taken is different to that utilised historically. This will require the culture of the organisation, at and across all levels, to be one that challenges all aspects of service delivery.

There are significant opportunities to deliver greater value, through a focus on the three key principles of value; through a focus on reducing waste; through embedding the principles of Prudent Healthcare; and the Wellbeing of Future Generations Act.

Value is focused on the individual patient, as it is inherently related to their outcomes from the treatment they receive. It therefore brings in the concepts of quality, safety and outcomes within its remit. This is a fundamental shift from a managerially-focused response to delivering efficiency and productivity.

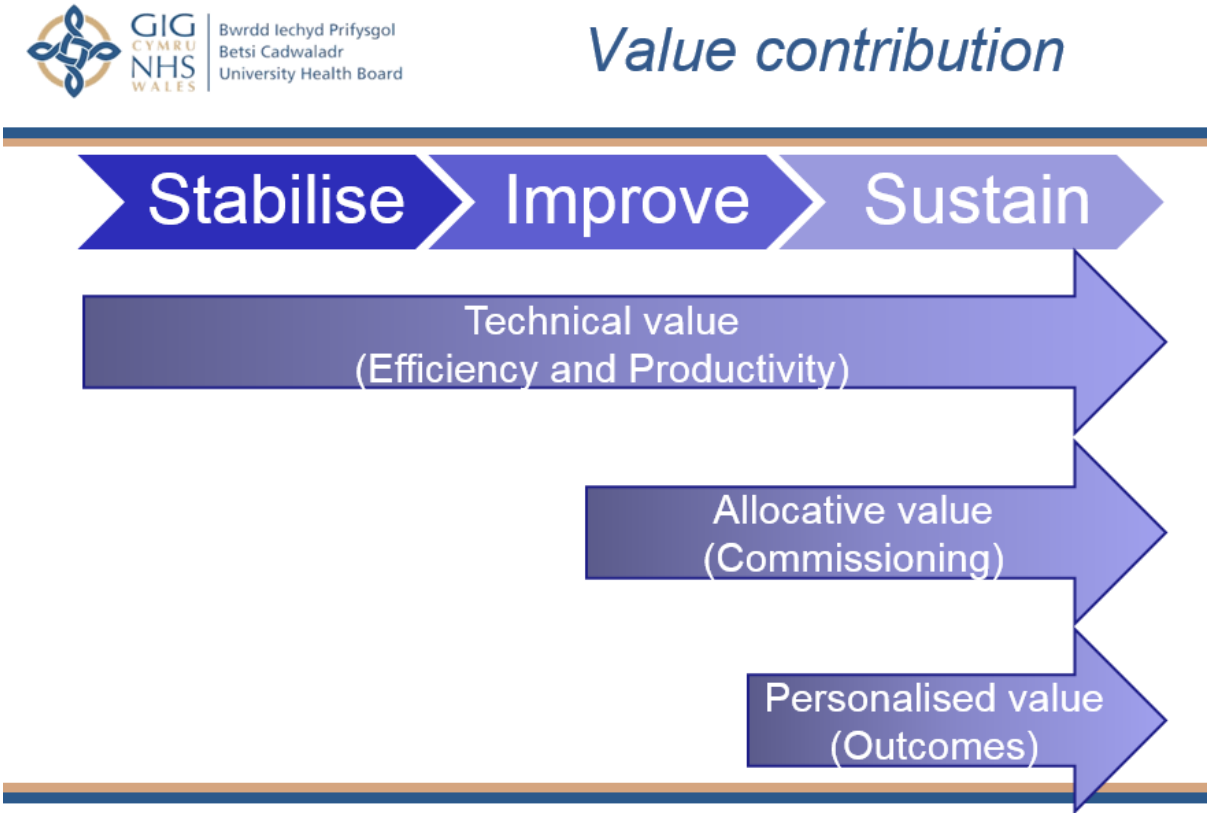
Operating across an integrated planning healthcare system, Welsh health boards are uniquely placed to address the challenge of addressing the three elements of value as a combined whole.

At its simplest, delivering value requires us to deliver better outcomes for less resources.

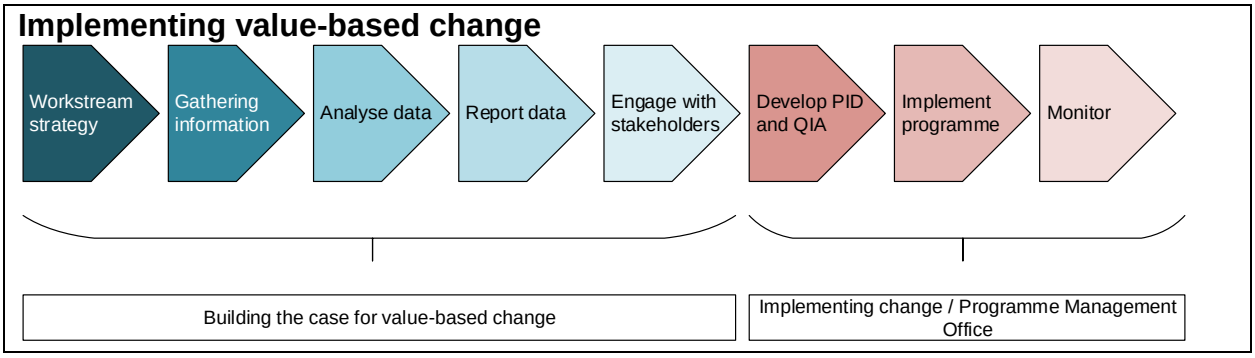
However, delivering this challenge is complex, and the Health Board will need to focus on the three key elements of value:

1. Allocative value / Value for the population: An assessment of how best value can be provided to the population through identifying overuse and underuse of resources;
2. Technical value / Value for the taxpayer: An assessment of how cost per unit is reduced;
3. Personalised value / Value for the individual: An assessment of the outcomes of care for individuals.

Given the Health Board's current position on the transformation path, the main focus is currently on driving technical value. Over the duration of the three year planning cycle, further progress needs to be made on allocative and personalised value.



It is expected that this will result in the development of cases for value-based change. These will then be implemented through the existing Programme Management Office framework.



As part of this work, the key service lines which are inefficient for the Health Board will be reviewed, and plans developed to address these will be incorporated into the IMTP, when this is developed.

The Health Board will also continue to work with the International Consortium for Health Outcomes Measurement (ICHOM), the initial focus being around Respiratory and Ophthalmology

Overview of the Financial Plan

The draft financial plan sets out the financial strategy of the Health Board to support service delivery over the three year period commencing 1 April 2018.

In addition, the Health Board is focused on improving its in year financial position, reducing its accumulated underlying deficit and restoring in year and recurrent financial balance. This will provide the Health Board with a significant financial challenge over the period of the plan.

The three year plan aims to deliver improved levels of efficiency alongside improved and sustained delivery against performance standards. In line with the approach for previous years, the Health Board will be provided with a number of savings options to determine its risk appetite, and appetite to delivering transformational change over the medium term.

However, to achieve operational target delivery, in particular in achieving sustainable improvements in the Health Board's unscheduled and planned care, further resources will be sought from Welsh Government. The financial quantum of these developments is currently being determined and they are therefore excluded from this plan.

The draft financial plan currently makes the following critical assumptions:

1. The Health Board will not have to repay its' historic deficit over the duration of the three-year cycle;
2. The planned deficit will be covered in cash terms by Welsh Government funding;
3. Planned decisions agreed on an all-Wales basis will not have an adverse impact on the Health Board's financial position;
4. Risks emanating within-year from NHS Wales-hosted organisations will be managed within those organisations (such as WHSSC, WRP, NWIS and NWSSP).

To address the financial position will mean a combination of continued improved efficiency measures and transactional savings but more significantly the requirement for transformational plans to cope with the increased pressures and demands on the Health Service.

The financial plan to date identifies the projected financial challenges faced by the Health Board together with an indicative assessment of the implication of the three year plan. Further work is being undertaken to fully review in preparation for the final submission in March. The plan also identifies the benchmarking opportunities the Health Board has to support the transformational groups.

Financial Gap Assessment

A longer term plan has been prepared over three and six years to understand the longer term sustainability of the Health Board. However, at a high level, the following assessment provides for a planning assumption of a deficit of £35m over the coming financial year.

This assessment is predicated on delivering cost containment measures of £23m and cash releasing savings of £22m over the year.

£'m	No choice	Limited choice	Option to withdraw	Total	(Total cost containment and savings)
Budget Deficit Brought Forward	36.0			36.0	
Net non-recurrent savings and mitigating actions	6.8			6.8	
Underlying Deficit Assessment	6.3			6.3	
Underlying Deficit	**49.1**			**49.1**	
Discretionary Uplift @ 2%	(19.6)			(19.6)	
MHLD uplift	(2.8)			(2.8)	
MHLD investment fund	(1.5)			(1.5)	
Less: Top Sliced Investment	7.1			7.1	
Net Uplift	**(16.8)**			**(16.8)**	
New Cost Growth	18.3	10.5		28.8	
Cost containment	(10.7)	(5.0)		(15.7)	(15.7)
Cost pressures	**7.6**	**5.5**		**13.1**	
Net before investments and saving	**39.9**	**5.5**		**45.4**	
Corporate pre-commitments	11.9	1.3		13.2	
Divisional pre-commitments		0.9	4.8	5.7	
Total pre-commitments	**11.9**	**2.2**	**4.8**	**18.9**	
Other cost containment	(7.5)			(7.5)	(7.5)
Cash releasing savings	(21.8)			(21.8)	(21.8)
Total	**22.5**	**7.7**	**4.8**	**35.0**	**(45.0)**

The position carries forward the budget deficit of £26m from 2016/17, and reflects costs pressures which have built up within the forecast deficit of £36m during 2017/18 to deliver an underlying deficit carried forward of £49.1m.

The main technical planning assumptions within these are as follows:

- Pay award cost pressure is capped at 1%
- Welsh Government provide additional funding for any award above the pay cap
- Living wage at £8.75 per hour

- Non pay inflation at 2% per treasury forecast
- NICE and HCDs growth 5.67% (treatment fund is non recurrent and is for new treatments only)
- Packages of care – inflation at 3.5%, growth at 7%
- Prescribing growth at 2%
- GMS pressures at 2% (assumes WG fund inflation uplift for ring-fence)
- MHLDS (includes CAMHS) investments will be funded from the £1.488m innovation and transformation fund held centrally by WG
- RTT funding will be available to support delivery of targets

Savings Requirement and Opportunities

The implications of the financial pressures together with the indicative investment priorities means the level of savings over the three year plan equates to a requirement to deliver between 4.5% and 5% over the duration of the plan.

Based on a comprehensive re-basing exercise of the savings opportunities available to the Health Board (based on a reworked approach to the Deloitte benchmarking exercise in 2013), opportunities of between £111.9m and £181.1m are available to the Health Board over the medium term.

Achieving these savings would allow the Health Board to deliver a balanced plan over the medium term. However, it is critical that the Health Board addresses the capacity and capability issues in change management which were highlighted by Deloitte in their recent review to maximise the delivery of the opportunities.

2017/18	Savings Opportunities by Source				
Area	Opportunity	Deloitte Benchmarking 2013		BCUHB Benchmarking 2017	
		£m Low	£m High	£m Low	£m High
In Hospital Total		**26.2**	**45.9**	**19.4**	**44.8**
(excluding workforce)	Theatres	14.4	30.6	13.3	30.5
	Inpatients - planned care	0.3	0.6	0.7	2.5
	Inpatients - emergency care	10.0	12.5	5.3	11.7
	Outpatients	1.5	2.2	0.0	0.0
Out of Hospital Total		**30.3**	**43.9**	**43.6**	**74.1**
(excluding workforce)	Improving Health	0.0	0.0	5.3	7.4
	Community/ District Nursing	2.4	2.8	3.2	4.2
	Community Hospitals	3.4	5.2	3.5	5.4
	Community Hospital Outpatients	0.8	0.8	0.0	0.0
	Community - Other	0.0	0.0	3.4	8.5
	Mental Health & Learning Disabilities	1.1	7.0	13.3	24.7
	Continuing HealthCare	15.6	15.6	9.0	12.0
	New care models/ service redesign	0.0	0.0	0.0	0.0
	Primary Care Referrals	1.8	6.9	2.3	6.0
	A&E Non Emergency Attends	5.2	5.2	2.7	3.5
	Out of Hours	0.0	0.4	0.0	0.0
	Primary Care - Other	0.0	0.0	0.8	2.4
Corporate Total		**29.0**	**35.5**	**48.9**	**62.2**
(including workforce)	Workforce	14.9	18.4	17.2	19.7
	Medicines management	2.0	5.0	19.7	27.5
	Procurement	10.0	10.0	10.0	10.0
	Contracting	0.0	0.0	0.0	0.0
	Other (incl Estates)	2.1	2.1	2.0	5.0
Total All Sources		**85.5**	**125.3**	**111.9**	**181.1**

2017/18	Savings Opportunities by Transformation Board				
Area	Opportunity	Deloitte Benchmarking 2013		BCUHB Benchmarking 2017	
		£m Low	£m High	£m Low	£m High
Transformation Boards		**56.5**	**89.8**	**63.0**	**118.9**
(excluding workforce)	Improving Health	0.0	0.0	5.3	7.4
	Primary Care	22.6	28.1	14.8	24.0
	Community Care	6.6	8.8	10.2	18.0
	Mental Health & Learning Disabilities	1.1	7.0	13.3	24.7
	Childrens & Young People				
	Unscheduled Care	10.0	12.5	5.3	11.7
	Planned Care	16.2	33.4	14.1	33.0
Enablers		**33.0**	**35.5**	**48.9**	**62.2**
(including workforce)	Outcomes	0.0	0.0	0.0	0.0
	Workforce	14.9	18.4	17.2	19.7
	Medicines Management	2.0	5.0	19.7	27.5
	Procurement	10.0	10.0	10.0	10.0
	Estates & Facilities	2.1	2.1	2.0	5.0
	Contracting	4.0	0.0	0.0	0.0
	Technology	0.0	0.0	0.0	0.0
Corporate		**0.0**	**0.0**	**0.0**	**0.0**
	Other				
Total All Sources		**89.5**	**125.3**	**111.9**	**181.1**

The savings focus for the coming financial year will be a continuation of the focus of previous years, with specific focus on technical efficiency, reducing input costs and improved utilisation of resources.

It is critical as a result of this challenging requirement, that the Health Board prioritise the appointments to a turnaround team to facilitate and support the delivery of these savings.

Cost containment is defined as being the mitigation or reduction of unchecked cost growth and inflationary assessments. Cash releasing is defined as the reduction of expenditure below brought forward expenditure levels.

The savings requirement alongside lead Executive Directors is outlined below:

Cost containment and cash releasing savings				
	Cost containment	**Cash releasing**	**Total**	**Executive Lead**
	£'m	**£'m**	**£'m**	
1% transactional	**5.0**	**5.0**	**10.0**	Director of Finance
Reducing input costs				
Medicines Management	2.9	3.1	**6.0**	Director of Strategy
Procurement	4.0		**4.0**	Director of Therapies
	6.9	**3.1**	**10.0**	
Improved deployment of resources				
Workforce	3.8	1.2	**5.0**	Director of Workforce and OD
	3.8	**1.2**	**5.0**	
Improved utilisation of resources				
Theatre efficiency		1.0	**1.0**	Director of Therapies
Acute Length of Stay		1.0	**1.0**	Chief Operating Officer
Community hospitals		2.0	**2.0**	
Outpatients		2.0	**2.0**	Director of Public Health
Clinical variation: Primary Care		2.0	**2.0**	Medical Director
Clinical variation: Secondary Care		2.0	**2.0**	
		10.0	**10.0**	
Service transformation				
CHC	5.0		**5.0**	Director of Nursing
MHLD	1.5	2.5	**4.0**	Director of Mental Health and Learning Disabilities
Estates	1.0		**1.0**	Director of Strategy
	7.5	**2.5**	**10.0**	
Total	**23.2**	**21.8**	**45.0**	

Risks

At this stage, an initial risk assessment suggests that there will be significant risks which will need to be managed over the first year of the three-year period. These are outlined below:

Figure 28: Financial risks associated with the 2018/19 budget		
Risk	**Potential Value £'m**	**Rating**
Risk items		
Savings may not be delivered in full, impact of achieving 80% of these.	9.0	
Impact of HRG4+ if applied going forward	4.0	
The consequences of not delivering performance targets in 2017/18 may result in a clawback of RTT funding.	3.0	
Demand growth and complexity in WHSSC commissioned services may exceed the budget allocated to WHSSC.	2.0	
Drug approvals exceed the Welsh Government Treatment Fund allocation. Impact of 25% excess in costs.	0.9	
Operational and seasonal pressures may mean that budget managers are unable to contain costs within available budgets. Impact of 0.5% overspending.	7.0	
Additional impact of HRG4+ if applied retrospectively	4.0	
Compliance with CNO nurse staffing requirements	1.0	
There is a risk that further resources may be required in the Welsh Risk Pool to meet the costs of rising litigation.	0.5	
Stress-tested budget	**31.4**	

These risks require further work to identify mitigating actions to minimise their impact over the period.

Financial risks will inevitably arise during the year and they will be carefully managed. Appropriate mitigating actions will need to be identified and delivered by the relevant Budget Managers. Material financial risks, and action plans, will be brought to the attention of the Finance and Performance Committee through monthly financial reporting.

The Risk Register will be updated as and when required.

Longer term financial outlook

The longer term financial outlook for the Health Board continues to be challenging and is grounded in issues facing all NHS bodies across the UK. For the coming 6 year period there will be requirement to deliver total savings (both cost avoidance and cash releasing) of £45m per annum for the coming 4 years to reach a sustainable financial position. Following this, and assuming successful delivery, the savings requirement could reduce to £33m on an ongoing basis.

Figure 11: Longer term financial outlook

	2018/19 Plan £ms	2019/20 Plan £ms	2020/21 Plan £ms	2021/22 Plan £ms	2022/23 Plan £ms	2023/24 Plan £ms
Net Allocation Uplift	**(15.2)**	**(22.3)**	**(22.3)**	**(22.3)**	**(22.3)**	**(22.3)**
MHLD investment fund	**(1.5)**					
New Cost Growth:						
Pay related	11.1	18.2	20.0	20.0	20.0	20.0
Non pay pressures	4.0	6.3	7.5	7.5	7.5	7.5
Drugs & Prescribing	2.9	6.9	6.9	6.9	6.9	6.9
Packages of Care	10.9	13.5	13.5	13.5	13.5	13.5
Other net local pressures/(net income)	(0.3)	7.5	8.5	8.5	8.5	8.5
New Cost Growth	**28.6**	**52.4**	**56.4**	**56.4**	**56.4**	**56.4**
Cost avoidance activity	**(23.0)**	**(23.0)**	**(23.0)**	**(23.0)**	**(23.0)**	**(23.0)**
Uplift less net Cost Growth	**(11.1)**	**7.1**	**11.1**	**11.1**	**11.1**	**11.1**
Pre-commitments & Investment Decisions	**19.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total in Year Position (before savings)	**7.9**	**7.1**	**11.1**	**11.1**	**11.1**	**11.1**
Cash releasing savings	**(22.0)**	**(22.0)**	**(22.0)**	**(22.0)**	**(10.0)**	**(10.0)**
Underlying Deficit	**49.1**	**35.0**	**20.1**	**9.2**	**(1.8)**	**(0.7)**
Net In Year Position - (Surplus)/Deficit	(14.1)	(14.9)	(10.9)	(10.9)	1.1	1.1
Cumulative Position - (Surplus)/Deficit	**35.0**	**20.1**	**9.2**	**(1.7)**	**(0.6)**	**0.5**

- Planning information to 2018/19 based on Health Board budget calculation
- Planning information to 2019/20 onwards based on known pressures (eg NHS Pensions scheme superannuation discount factor application) or general growth assessment based on NHS Improvement inflation assessments. Allocation uplift assumed at 2% per annum.

Conclusion

The Health Board's financial outlook over the coming three years is very challenging. While the Health Board has broadly contained costs within the allocation and savings over the past three years; it has not been able to deliver transformational improvements or reduce its underlying position. It is recognised that strategic transformation is required to improve productivity and integrate pathways to realise the benefits of an integrated health organisation

The coming three year plan will require a step change in change management within the Health Board. The appointment of a Turnaround Director and Transformational Director will be critical to achieving this although further change management additional capacity will be required elsewhere in the organisation. It is important to note that the opportunities to make savings exist in the organisation, and achieving them would allow the Health Board to deliver a balanced in-year position by year 3.

At this stage, further work is required to identify the profile of investments and savings in order to achieve year 3 balance, and a sustainable balanced plan in the years which follow.

6.7 Commissioning (External & Specialist Services)

6.7 Commissioning (External & Specialist Services)

The overriding aims of the Health Board are to deliver financial sustainability; to deliver national Welsh Government requirements such as referral to treatment timescales; and to deliver improved quality, through improving safety, effectiveness and patient experience of internally provided services.

However, there are a range of healthcare services that the Health Board either does not or cannot deliver directly and as such must commission from external providers and therefore there is an obligation to ensure that the Health Board achieves maximum value from all external provision. Where the Health Board is reliant upon external providers to treat or care for patients on its behalf, there are robust contractual arrangements in place to ensure quality and safety, to protect patients, to deliver positive outcomes and to demonstrate the value offered by external providers.

The Health Board commissions and contracts with a range of providers and currently hold 573 external contracts for the provision of care across a range of healthcare services, as shown in the table below:

Contracts by care type:

Type of care	**Number**
Ambulance / transport	8
Community Care	75
Diagnostic/testing	16
Domiciliary Care	57
General Healthcare	7
General support / signposting	38
Learning Disability	6
Mental Health	85
Nursing Home	138
Product & Nursing Care / Other	11
Residential Home	34
Secondary Care (Acute)	17
Secure Hospital / Wards	22
Specialist Hospital / Tertiary Care	59
Total	**573**

The Health Board contracts with a variety of providers including English NHS Trusts, Welsh Health Boards, Private, Local Authority and Voluntary Sector providers and holds providers to account through formal contracts. These contract focus on ensuring delivery of quality services, high levels of performance and a clear view of financial impacts, allowing corrective action to be taken prospectively to protect patients and the Health Board.

To enable that the Health Board to commission high quality services during a time of significant financial challenge, over the next 12-24 months the Health Board intends to further increase the focus on the commissioning arrangements for externally provided care to ensure they deliver best value. This focus on commissioning for value is intended to identify priority programmes which offer the best opportunities to improve healthcare and improve the value that patients and the Health

Board receive from externally provided healthcare One particular area of focus will be Continuing Health Care (CHC) which has emerged as a key area of growing spend.

The Health Board is seeking to implement a new approach to Commissioning CHC which will involve a specific focus on the management of Learning Disability, Mental Health and CAMHS patients, in addition to traditional CHC placements for care of the elderly. The anticipated benefits of future commissioning arrangements will be: a clear picture of 'what good looks like', a clear market position strategy, a focussed review of appropriate care for patients including a review of step up / step down support to support patients remaining in their own homes and a clear understanding of financial impacts.

National Strategic Commissioning across Health and Social Care

We will collaborate with other Health Boards across Wales to review opportunities for cost efficiencies and benefits to gain greater value for money and savings across Health and Social Care.

Emergency Ambulance Services Collaborative

BCU works closely at both a national and local level as part of the all Wales Emergency Ambulance Services Collaborative (EASC) to further develop national and local actions in collaboration with WAST. Our local joint priorities for action are set out within the unscheduled care section.

The chief ambulance services commissioner and EASC act on behalf of health boards, holding WAST as the provider of emergency ambulance services to account. WAST is required to meet a series of care standards, core financial requirements, outcome measures and indicators under each step of the five step ambulance patient care pathway.

Underpinned by the principles of prudent healthcare, EASC's expectations for how the ambulance services in partnership with Local Health Boards should provide services for our population are set out on a patient pathway basis as follows:-

- Helping people choose the service most appropriate to their needs
- Ensuring people receive timely and appropriate advice on the telephone which results in the delivery of the most clinically appropriate response to their need
- Ensuring the right care is provided as quickly as possible if a persons clinical need requires an ambulance response
- Ensuring the care provided by the pre-hospital clinicians adhere to best practice guidelines. If a patient does not require a afce to face assessment, they should be referred to the right service or individual the first time
- Ensuring that a patient is only taken to hospital or a specialist acre unit if they have clinical need and that all ambulance resources are available to respond to the next patient without delay.

The scope of services covered include: responses to emergency calls via 999; urgent hospital admission requests from general practitioners; high-dependency and into hospital transfers; major incident responses and urgent patient triage by telephone; NHS Direct Wales services; Non-

emergency Patient Transport Services (NEPTs); Emergency Medical Retrieval and Transfer Services (EMRTS).

Non- Emergency Patients Transport Services (NEPTS)

During 2018/19 we plan to expedite the recommendations contained with the ministerial approved NEPTS Business Case (2015).

In summary, these are:

- Introduce a plurality model for NEPTS in Wales. The overall intent of the Plurality Model is for the total resource envelop (contracted and ad-hoc services) to be utilised efficiently and effectively by the Welsh Ambulance Service Trust (WAST) to create the savings required to:
  - Extend the hours of operation between 0600hrs and 2000hrs
  - Improved discharge and transfer service – supporting the Health Boards unscheduled care agenda
  - Enhanced service for oncology, renal and end of life care
  - Single Point of Contact (SPOC) for all transport needs
  - Management and coordination of NEPTS, including the introduction of an auditable brokerage service.
- Provide dedicated management capacity and capability to represent and ensure the Health Board patient transport current and future interests are catered for within the NEPTS Delivery Assurance Group.
- Prepare BCUHB in readiness for the transition to the new national Collaborative Assurance Framework for NEPTS in Wales.
- Agree with WAST baseline activity and associated costs (new financial envelope) in preparation for novation to new Collaborative Assurance Framework for NEPTS.
- Funding of core NEPTS WAST provided services will be rolled forward from 2017/18 with a 2% uplift

Welsh Ambulance Service are working alongside the Health Board in developing plans for services including Vascular, Ophthalmology, Orthopaedics, Urology and Stroke.

Specialist Services

Specialist services (the majority of tertiary level care) in Wales are commissioned through Welsh Health Specialist Services Committee (WHSSC) and contracted to appropriate providers. For North Wales, these are provided in North West England as our local providers of very specialist services. Working closely with WHSSC, we monitor and review these arrangements in 2018/19, ensuring that, where it is clinically safe and appropriate to do so, services are developed in North Wales.

We also provide in-reach services where Consultants from tertiary centres provide outpatient clinics within North Wales (e.g. visiting neurologists from The Walton Centre in Liverpool). This will ensure that we have a joined up pathway from primary, secondary through to specialist tertiary services for areas which are key priorities in 2018/19 on both a national and regional level e.g. cardiology-cardiac surgery pathways, inherited bleeding disorders, etc.

As a supporting organisation WHSSC also develops the Integrated Commissioning Plan for Specialised Services for Wales (ICP). The ICP is commissioner-led and the process for developing it is designed to ensure that there is continuity with previous ICPs, as well as full alignment between the ICP and the Local Health Board Integrated Medium Term Plans, both at a financial and service level. The lessons learned from the previous three years of the ICP cycle are built into the process. These include:

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

The Integrated Commissioning Plan for Specialised Services for Wales 2018/19 highlights the key priorities for specialised services for Welsh patients. Specific priorities for BCU Health Board in 2018/19 are:-

- Augmentative alternative communication aids – maintaining access to AAC service for North Wales patients;
- Posture and mobility – improving access to wheelchairs (including replacement programme for obsolete equipment), and prosthetics for war veterans;
- Cardiac – delivery against the cardiac pathways action plan, development of commissioning policies and strategies for implantable devices, transition arrangements for the management of adult congenital heart disease;
- Cancer – access to additional indications for PET-CT, genetic testing, improving thoracic surgery resection rates, review of inherited bleeding disorders services;
- Mental Health – Gender Identity services project, Tier 4 Perinatal Mental Health task and finish group;
- Neurosciences – delivery of the first phase of the WHSSC Neurosciences Commissioning Strategy, supporting WHSSC in the development of collective commissioning arrangements for thrombectomy;
- Review resource allocation across Surgery (ENT) and Audiology to ensure delivery of adult cochlear implant service to meet contractual requirements of specialist services commissioners (WHSSC and England).

Mid Wales Health Collaborative

The Mid Wales Healthcare Collaborative (MWHC) comprises the four healthcare organisations that cover Mid Wales – Betsi Cadwaladr University Health Board (BCUHB), Hywel Dda University Health Board (HDUHB), Powys Teaching Health Board (PTHB) and the Welsh Ambulance Services NHS Trust (WAST) and was formally launched on 12th March 2015 by the Minister for Health and Social Services at the Rural Healthcare Conference. The MWHC was initially established for a period of two years and then extended by Welsh Government for a further 12 month period.

As from March 2018 the MWHC will be succeeded by the Mid Wales Joint Committee for Health & Social Care (MWJC) which will have a greater focus on joint planning and implementation. The key purpose of the Joint Committee, as outlined in its Terms of Reference, will be as follows:

i. Identify annual / three year key priorities for service development for the relevant population into a Joint Committee Work Plan; articulating these as a clear and core part of organisations Integrated Medium Term Plan / Annual Plan.
ii. Work collectively to implement agreed key service developments; ensuring clear, robust mechanisms for delivery, including performance management mechanisms, via the Joint Committee to individual Boards.
iii. Develop and implement clear mechanisms for engagement and consultation, and communication with the relevant population, and community / stakeholder groups; ensuring that plans, priorities for service development and evaluation of services are co-produced.
iv. Ensure mechanisms are developed that enable close working with and engagement of other key vehicles for improving health and well-being and delivering integrated services; specifically but not exclusively Regional Partnership Boards, Public Service Boards and other NHS Joint Committees/equivalents.

The following delivery priorities for inclusion in the Mid Wales work programme for 2018/19 have been identified as follows:

SERVICE OBJECTIVES

Ophthalmology
Develop an integrated community focused ophthalmic service across Mid Wales with coordinated services across primary care, community and hospital care services which will include enhancing the provision of community outpatient clinics.

Respiratory
Develop an integrated community focused respiratory service across Mid Wales with coordinated services across primary care, community and hospital care services in order to ensure early diagnosis of respiratory conditions and improved provision of chronic disease management through enhanced support from specialists within the community to optimize treatment and support for patients.

Dementia
Develop an integrated multi agency dementia care service across Mid Wales through joint working across health, social care, the voluntary sector and other agencies in order to improve identification and awareness/understanding of dementia and improve the support provided to those with dementia and their family/carers.

MAJOR CONDITIONS

Oncology
Review the existing oncology pathway for Mid Wales in order to improve access to community based oncology services.

Colorectal
Review the current colorectal pathway for Mid Wales in response to the recent reintroduction of elective colorectal surgery at Bronglais General Hospital.

ENABLERS
Key enablers to support the delivery of those priorities identified for Service Objectives and Major Conditions were as follows:

Telemedicine
Implement the Telemedicine Strategy and Implementation Plan (3 year Strategy and Plan) which will facilitate the development of accessible and appropriate telemedicine services available across Mid Wales and supports the delivery of care as close to a patient's own home as possible. The Strategy's key aims are:

- Development of specialist consultant in-reach services to Bronglais General Hospital from patient to clinician and clinician to clinician.
- Development of clinician outreach into rural communities.
- Supporting Primary and Secondary care joint working.
- Establishing Mid Wales as an exemplar for the deployment of telemedicine.

Workforce
Develop and extend new/enhanced workforce roles, including Physician Associates, Associate Nurses, Nurse Specialists and Consultants Nurses, which will support integrated working across primary, community and hospital care services.

Bro Ddyfi Integrated Health and Care Centre
Develop the Bro Ddyfi Integrated Health and Care facility in order to improve access to health and social care, well-being, prevention and health promotion services.

6.8 Corporate Governance

6.8 Corporate Governance

Good governance is essential in addressing the significant financial and operational challenges faced by the Health Board. The members of the Health Board have a unique leadership role in overseeing all aspects of the Board's business, setting the tone for the organisation through their own conduct and behaviour, giving clear direction, and assuring themselves of the quality and safety of services through systems of assurance and clear lines of accountability. Special Measures have highlighted areas where the performance of the Board must improve.

Board Members are committed to strengthening and improving all aspects of the Health Board's governance arrangements. In 2018/19 we will continue to build on the actions already underway and will target our actions to meet the requirements of the new Special Measures Improvement Framework (due to be issued in Spring 2018), the Wales Audit Office Structured Assessment 2017, the Follow-Up Joint Governance Review undertaken by Healthcare Inspectorate Wales and Wales Audit Office during 2017, and the Deloitte Financial Governance Review 2017. The expectations set out in the February 2018 statement by the Cabinet Secretary for Health and Social Services will also be incorporated into special measures governance arrangements for 2018/19 and beyond.

The Special Measures Improvement Framework Task & Finish Group will maintain its oversight of progress against expectations and the Office of the Board Secretary will continue to support the operation of this Group, including the production of reports as required by Welsh Government during 2018/19. The terms of reference of the Task & Finish Group will be reviewed during the first quarter of 2018, to ensure fitness for purpose as the organisation progresses through process of embedding change, sustaining improvement and achieving transformation.

Within the special measures framework, the key themes for planned corporate governance actions during 2018/19 are as follows:

1. **To have a stable senior leadership team in place**

This will involve concluding the appointment process for the Chair, Vice-Chair and 5 Independent Members by June 2018, reviewing and re-balancing Executive portfolios and introducing the new Director roles of Director of Turnaround and Executive Director of Primary & Community Care.

2. **To review the current organisational structure**

The introduction of new Director roles will necessitate consideration of the organisational and accountability structure, to ensure that arrangements are aligned to the regulatory framework and are conducive to delivering integrated care.

3. **To build the capacity and effectiveness of the Board**

The Board development programme will continue throughout the year, informed by the work undertaken in 2017/18 but also taking into account the needs of Board Members following recruitment or re-appointment to the Independent Member vacancies on the Board. The Board Development programme will be designed to improve the balance and quality of support and challenge provided by Board members to drive improvement. It will also include opportunities to reflect on the performance and effectiveness of the Board, taking into account information from self-assessments, internal and external feedback. As new Board members are appointed, an induction process will be rolled out to ensure that all new members have the appropriate skills sets and

knowledge to exercise good governance. This will be aided by the production of an online induction handbook. Training will include visits to observe high-performing Boards, financial turnaround & recovery, effective scrutiny, team-building, statutory & mandatory training sessions as well as governance training & development tailored to the needs of the individual. There will be a team-based Development Programme run specifically for Executives, facilitated by Academi Wales. Development opportunities will also be provided for prospective Board members in year.

4. **To build capacity and capability across the wider organisation**

During Quarter 1, a modernisation plan to strengthen the strategic, planning and transformational effectiveness of the Finance Department will be developed and implemented. Enablers such as informatics investment and change management expertise will be considered as part of this. The status of accountability meetings will be raised, to drive progress against plans. There will be a focus on clinical engagement and culture; steps will be taken to ensure the involvement of clinical leaders in service developments. Joint working with partners on shaping new roles will enhance tactical recruitment and the business skills of middle and senior managers will be bolstered through a series of masterclasses. This approach will also contribute to succession planning.

5. **To embed the approach to the management of risk**

The Risk Management Strategy and Corporate Risk & Assurance Framework are in place. The agreed approach to risk management has been rolled out across the organisation and the extent to which the approach is embedded has been assessed by Internal Audit. The conclusion was that there was only limited assurance that Divisions had fully adopted the approach. The focus over the coming year will be to work with the Divisions to improve on this position.

6. **To embed patient safety and quality assurance arrangements**

The focus will be on continuing to enhance the functionality of the Quality Dashboard to safeguard patient safety and ensure that there remains no disconnect between ward and Board. Patient safety huddles have been implemented and recently evaluated by the Delivery Unit. The findings of that evaluation will inform the steps to be taken over the coming year. The appointment of a Director of Quality Assurance will support the plan to embed quality assurance arrangements into the revised organisational structure by June 2018. Specifically in relation to Mental Health services, a Mental Health Quality and Governance Improvement Plan will be submitted for Board approval in May 2018. A new clinical audit programme will be devised by May 2018, with a renewed focus on alignment with quality strategy priorities & risks and patient & quality outcomes.

7. **To ensure the effective running of Board and Committee meetings**

The Health Board will retain oversight of the effectiveness of the committee structure. All committees will meet in public to ensure transparency of Board business. The Committee Business Management Group (CBMG) established in 2016 will continue to operate to support coordination of agenda setting across committees and ensure that all business is effectively covered by the appropriate committees.

The Board will continue to embed the approved business standards for Board and Committee meetings. The Office of the Board Secretary will continue to utilise the agreed electronic/ paperless meetings system to manage Board and Committee meetings thereby reducing costs, bureaucracy

and contributing to the Board's commitment to sustainability as part of the Well-being of Future Generations Act.

The Office of the Board Secretary will continue to ensure that where plans, as opposed to strategies, are presented to the Board these include costed options where applicable, and contain sufficient information to indicate to the Board that they are affordable in the short, medium and long-term.

The Office of the Board Secretary will also continue to ensure that cycles of business continue to be updated to reflect the organisation's risks and key decision, ensuring that these are reviewed by both the lead and Chair of the respective Committee and monitored on a quarterly basis by the Committee Business Management Group. All terms of reference will also be reviewed, in particular those of the Finance & Performance Committee and Financial Recovery Group (by April 2018), to ensure fitness for purpose in addressing the Health Board's challenging financial position. The committee governance arrangements in place will ensure that expectations within each of the special measures themes –covering leadership, governance, strategic & service planning, engagement, mental health, primary care plus finance and performance – are overseen appropriately in accordance with the principles of good governance.

Governance and the Global Agenda

During 2017, responsibility for overseeing international health issues at corporate level transferred to the Office of the Board Secretary. Ensuring good governance through membership of national groups, supporting the International Health Group and overseeing associated activities will continue in 2018/19. Learning events in North Wales will be facilitated in early 2018. This will contribute to the Health Board's strategic aim of improving health and well-being for all and reducing health inequalities, and in turn maps to the 'global' objective of the Well-being of Future Generations Act; international health partnerships are considered to be mutually beneficial to Wales and partner countries.

Information Governance

Information Governance is used to describe how organisations manage the way information is handled. It covers the requirements and standards that Betsi Cadwaladr University Health Board (BCUHB) needs to achieve to fulfil its obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust.

Information Governance applies the balance between privacy and sharing of personal confidential data and is therefore fundamental to the health care system, both providing the necessary safeguards to protect personal information and an effective framework to guide those working in health to decide when to share, or not to share.

The General Data Protection Regulations (GDPR) was adopted on the 27th April 2016 and will become UK law after a two year transition period on the 25th May 2018. The principles set out in the GDPR are similar to those in the Data Protection Act with the added requirement for accountability. The GDPR now requires organisations to show how they comply with the principles by documenting decisions and publishing details about processing activity. Therefore whilst work commenced during 2017/18 to implement these new and enhanced requirements, further work will continue into 2018/19 to ensure the Health Board becomes fully compliant with this new legislation.

Key Activities for Information Governance 2018/2019

GDPR readiness and full implementation Objective for 2018/19 is to fully embed the new and enhanced requirements under this new legislation. A programme of work is underway in line with the guidance issued by the Information Commissioners Office with further guidance expected in line with release of the UK Data Protection Bill. This is regularly being monitored via the Information Governance Group with exception reports provided to the Finance and Performance Committee.

Training Objective for 2018/2019 is to increase the level of mandatory training compliance, which will be monitored via the IPQR, as well as via quarterly and annual reports submitted to the Finance and Performance Committee.

Q1 84%	**Q2** 85%	**Q3** 86%	**Q4** 88%

FOI Compliance Objective for 2018/19 is to improve compliance with the 20 working day response times to requests for information, which will be monitored via the IPQR as well as via quarterly and annual reports submitted to the Finance and Performance Committee.

Q1 85%	**Q2** 87%	**Q3** 88%	**Q4** 90%

Subject Access Request Compliance (non-clinical information) Objective for 2018/19 is to improve compliance response times to requests for information within the required one month time frame, which will be monitored via the quarterly and annual reports submitted to the Finance and Performance Committee.

Q1 88%	**Q2** 90%	**Q3** 91%	**Q4** 92%

Risk Management and Assurance

The Health Board is committed to ensuring the safety and well-being of its patients, staff and visitors by developing a culture that promotes openness and honesty, and that focuses on improving practice and creating a safer environment. Integrated risk management promotes a continuous, proactive and systematic process to identify, understand, manage and communicate risk in a cohesive and consistent manner.

Significant work on embedding risk management processes has already been undertaken in line with the Risk Management Strategy, however further actions are required to ensure this is effective and in place across all areas of the Health Board.

Key Activities for Risk & Assurance 2018/2019

Training – ***Risk & Assurance*** training plan approved and in place. Objective for 2018/2019 is to underpin the plan with a robust and deliverable training schedule to encompass the following key elements:

- Principles of Risk Management
- Legislative Obligations
- Datix System Modules
- Development and use of Risk Registers
- Team Mate

Delivery of training will be through either e-learning or tutor led workshop style sessions available in all Regions.

Risk Management Systems Audit

2018/2019 will see the roll out of the risk management systems audit tool, developed to establish a baseline of how the requirements of RM01 Risk Management Strategy have been embedded in the BCUHB Divisions/Corporate Functions.

Risk Register Development

All services within the BCUHB have access to the Datix system risk register module and the RM02 Risk Register Procedure and Guide has been developed to support the production of risk registers. The task for 2018/2019 is to critically examine the developed registers from a qualitative viewpoint, with the aim being to ensure consistency of approach, risks reflective of activity and that they benefit from ownership, review and oversight.

Risk Management Procedures

All services are required to have in place suitable arrangements for risk management. This includes risk management procedures that detail the local arrangements for risk management and the associated roles and responsibilities within individual Divisions and Corporate Services. In support of the development of these arrangements, RM03 Model Risk Management Procedure has been produced. Support for the development of Risk Management Procedures within Divisions and Corporate Services will feature in the plan of work for 2018/2019

Risk Management Forum

2018/2019 will see the introduction of a Risk Management forum. This forum will be facilitated by the Corporate Risk & Assurance Department and will provide all Services with the opportunity to discuss risk management issues across a broad range of associated topics.

Effective risk management will monitored via the Risk and Assurance workplan which will be tested by Internal Audit and reported to the Audit Committee. Specific actions will be also be addressed and monitored as part of the Special Measures phased reporting and key requirements.

6.9 Key Corporate Priorities

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Welsh Language

Ensuring the safety, dignity and respect of Welsh speakers is integral to the provision of health services in Wales. The Welsh Language Standards under the Welsh Language (Wales) Measure 2011 established the legislative requirements for the Health Board. Whilst complying with legal requirements, we will also set a greater level of ambition that will be driven by the desire to improve the quality of care provided for patients in their first language.

The Health Board's Welsh Language Strategic Plan ensures that changes in the legislative landscape are reflected in our approach to planning high quality, language appropriate care. The Welsh Language Standards and the 'More than just words' Framework provide the foundation on which we continue to build and improve upon the following outcomes:-

- Outcome 1: Delivering the Welsh Language Standards across the organisation under the Welsh Language (Wales) Measure 2011
- Outcome 2: Workforce planning through the implementation of the Bilingual Skills Strategy
- Outcome 3: Promote and implement the "Active Offer" principle established within Welsh Government's follow-on Strategic Framework for Welsh Language Services in Health, Social Services and Social Care 2016-2019
- Outcome 4: Develop and strengthen bilingual primary care services
- Outcome 5: Provide a comprehensive Translation Service for the whole of the organisation.

Outcome 1: Delivering the Welsh Language Standards across the organisation under the Welsh Language (Wales) Measure 2011						
Ref.	**Output**	**Activities / Key Performance Indicators (Year 1)**				**Lead**
		Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	
1.1	Ensure organisation wide ownership of the delivery of the Welsh Language Standards via implementation of the Welsh Language Standards Work Programme	Meet with all nominated senior leads individually and outline requirements within their areas	Work with individual areas to develop local action plans - tailor Welsh Language Standards Work Programme and activities to meet their service needs Ensure understanding of reporting methods		Commence implementation of the action plans on operational level	Head of Welsh Language Services (HWL)/ Welsh Language Standards Compliacne Officer (WLSCO)
1.2	Implement specific activities that will lead to compliance with legislative framework and improve Welsh medium provision for patients and the public	Focus on front line provision in line with Service Delivery Standards to identify gaps Use this information as baseline for recruitment ad training activities	Utilise the Sharepoint dashboard scoring system to develop tables of compliance for each service area Identify challenges and work with services to determine actions required to address areas of concern		End of year governance report to demonstrate overall compliance and measure impact	HWL / WLSCO
1.3	Ensure that the measuring performance and governance arrangements that have been established to monitor compliance are fit for purpose	Review arrangements following initial discussions with senior leads to ensure arrangements are fit for purpose	Monitor data inputted via reporting methods to develop a continuous measuring tool Provide regular reports to the Welsh Language Strategic Forum to update on compliance			WLSCO

Outcome 2: Workforce planning through the implementation of the Bilingual Skills Strategy						
Ref.	**Output**	**Activities / Key Performance Indicators (Year 1)**				**Lead**
		Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	
2.1	Ensure Welsh language skills data is collated on the Electronic Staff Record (ESR) across the organisation to inform recruitment and training purposes	Continue to progress ESR data collection to increase compliance by 2% per quarter Reminder messages to be placed on Corporate Noticeboard and incorporate into ESR Roadshows Breakdown of compliance to be provided to individual services to identify gaps Data Completion Compliance Reports to be provided To the Finance and Performance Committee and as part of the Integrated Quality Performance Report			Annual report and overall compliance review	Workforce Systems Manager (WSM)
2.2	Increase capacity within the workforce to deliver service bilingually via recruitment process by designating posts as Welsh Essential For all other posts, utilise population needs assessment as a measuring tool via the Recruitment Flowchart to determine level of Welsh required for all other posts	Vacancy Control to continue to monitor designated Welsh Essential posts (Switchboard /Call centres / Patient Booking Centres / Receptionists) Ensure baseline data is collected for future monitoring purposes		Increase the number of posts designated as Welsh Essential and provide recommendations for enhancements Review Bilingual Skills Strategy to reflect developing recruitment processes Work with Trac and NHS Jobs to incorporate enhancements at application stage – Level 0-5 to be migrated into ESR		HWL / WSM

2.3	Support current staff to develop their Welsh language skills via Welsh language training programme in order to increase workforce capacity to meet the needs of bilingual patients	Launch 'Gaining Confidence' course and provide taster sessions across BCUHB	Identify candidates for Eisteddfod learners programme and support staff to submit applications Provide support to staff who have previously attended training to ensure continuous progress in the workplace	Explore development of professional course for elderly mentally infirm via partnership working with Alzheimer's Society`	Welsh Language Tutor

Outcome 3: Promote and implement the "Active Offer" principle established within Welsh Government's follow-on Strategic Framework for Welsh Language Services in Health, Social Services and Social Care 2016-2019						
Ref.	**Output**	**Activities / Key Performance Indicators (Year 1)**				**Lead**
		Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	
3.1	Identifying language choice of patients via implementation of 'Language Choice Scheme'	Roll out the implementation of the Scheme across all three acute sites		Conduct case study to gain staff and patient feedback on effect of the Scheme on workforce planning and patient satisfaction Review feedback to see whether current approach meets the needs of the service		HWL / WLO (Welsh Language Officer)
3.2	Raise awareness of the "Active Offer" as part of cultural and behavioural change across the organisation	Enhance Welsh language awareness orientation programme with session being presented by Welsh Language Team members Measure the impact of the orientation programme on behaviours of attendees and whether work based practice will change as a result		Explore proposal of mandating language awareness to all staff utilising data gathered from orientation session	Evaluate success of corporate orientation programme and awareness events and develop / amend accordingly for following year	HWL

		Work with NWSSP to improve Welsh language awareness e-learning package			
3.3	Increase the use of Welsh spoken by staff via 'Use your Welsh' campaign	Continuous roll out of the campaign by holding stalls, visiting staff on wards, utilisation of social media platform, creating visual aids, visiting wards with Welsh Language Mascot, circulating information via internal communication channels	Evaluate success of campaign to see whether more staff are willing to use Welsh at work	Evaluate data to identify whether campaign approach was successful and incorporate any improvement if required	WLO / Digital Media Assistant
3.4	Gather patient feedback on standard of Welsh language services offered and use findings to identify gaps in provision	Conduct patient experience surveys in outpatient departments across all three acute sites focusing on face to face provision, written correspondence, bilingual environment and consultations	Collate data and analyse according to themes and sites	Develop action plan to address gaps identified in service provision	HWL / WLO

Outcome 4: Develop and strengthen bilingual primary care services

Ref.	Output	Activities / Key Performance Indicators (Year 1)				Lead
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	
4.1	Ensure strategic approach is taken to progressing Welsh language services within primary care	Work with Area West Team to ensure delivery of the Primary Care Plan incorporates Welsh language requirements at cluster level Develop a series of achievable 'pledges' for adoption by primary care providers outlining support available from the Health Board		Work with the National Professional Lead for Primary Care in NHS Wales as part of a working group established to improve bilingual services and develop a specific toolkit for providers		HWL / Area Director for West
4.2	Work with community groups to engage and advise the primary care sector of the advantages of delivering bilingual services	Work with Hunaniaith, Gwynedd Council, to target individual	Target individual practices identified as lacking in Welsh language services to offer guidance and support		Review requirements following proposed introduction of specific Welsh	HWL

		providers offering joint support		Language Standards for primary care providers under the Welsh Language (Wales) Measure 2011	

Strategic Outcome 5: Provide a comprehensive Translation Service for the whole of the organisation						
Ref.	**Output**	**Activities / Key Performance Indicators (Year 1)**				**Lead**
		Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	
5.1	Explore machine translation to increase service productivity	Pilot accessibility of software via individual case study	Evaluate efficiency of software and contribution to current system		Roll out of software across the service	Desktop Engineer / Senior Translator (ST)
5.2	Mainstream internal Welsh language translation activities via implementation of 'Policy on Using Welsh Internally' in line with the Operational Welsh Language Standards	Establish new translation requirements (written and simultaneous) in partnership with key internal stakeholders	Review impact of policy implementation on service workload	Review organisation wide impact of policy implementation	Monitoring of organisation wide compliance with key internal stakeholders	ST
5.3	Develop capacity within the service to provide simultaneous translation across the organisation	Arrange and commence tailored training courses for translation team	Initiate practice across the organisation		Review uptake and success of implementation. Agree whether further training support is required.	ST

Year 2

Key Priorities

Welsh Language Standards

- Following Year 1 review, identify areas of concern and / or service areas that has found the delivery challenging
- Tailor support to address underlying barriers to avoid legislative non-compliance
- Utilise this information to set performance trajectories for Year 3 and work with service areas to identify resolving actions

Bilingual Skills Strategy

- Review overall compliance report on posts advertised as 'Welsh Essential'
- Increase the number of services that have access to tailored Welsh language training programmes
- Continued roll out of 'Use your Welsh' campaign and related 'Gaining Confidence' course

The "Active Offer"

- Continue to identify language choice of patients via the 'Language Choice Scheme' across all acute sites

Translation Service

- Undertake an audit to measure increased productivity following introduction of machine translation system and use findings to determine whether the current system is fit for purpose
- Continue internal roll out of simultaneous translation service

Primary Care Service

- Review success of Year 1 actions and whether services have progressed despite lack of legislative framework

Identifiable Actions and Plans

- Examine how models of success can be adapted to other service areas
- Continue to measure impact of training programme on patient care and experience to inform future development of programme
- Monitor impact of language choice scheme on workforce planning on the wards and on patient satisfaction
- Undertake a review of translation demand in line with the anticipated increase following approval and implementation of the Policy on Using Welsh Internally

Performance trajectories and Governance (including risks and mitigation plans)

- Assess risks and barriers following governance report on Welsh Language Standards delivery
- Utilise Welsh Language Scoring Matrix to identify risk areas and implement mitigation controls
- Undertake case studies across all three acute sites to measure impact of the 'Language Choice scheme'
- Use translation service data to support legislative compliance findings

Year 3

Outline of plans and performance

- Continued progress of Welsh Language Standards Work Programme and ensure developments are highlighted and reviewed
- Continue to raise awareness of the Welsh medium services provided and encourage patients and the public to make use of those services
- Review progress of Bilingual Skills Strategy and identify barriers to full delivery
- Ensure all staff on the Welsh language learning pathway have access to appropriate training via production of courses at all levels (Levels 1-5)
- Ensure organisation is complying with translation requirements set out within national legislative framework and internal governance policies

Performance trajectories and Governance

- Undertake a comprehensive review of previous three annual reports to identify services that have seen the highest increase in successful implementation of the Welsh Language Standards and the “Active Offer”
- Identify areas that have seen the lowest success rate and focus support accordingly
- Assess risk matrix and Welsh Language Risk Register to inform future development plan
- Review national legislative framework and proposed development within the primary care sector and update internal work programme and plans to reflect outcomes

Carers

During 2017 we have continued to focus on the transition from the Carers Strategies (Wales) Measure 2010 to the Social Services and Well-being Act (2014) which came in to force on 6th April 2016.

The Regional Partnership Board and the Regional Leadership Group has been established. Carers have been identified as a priority in Part 9 of the act for integration and pooled budgets. This is being taken forward by the Regional Leadership Group; the area director (West) is the lead for this aspect of the Act.

The service mapping has proven more difficult than anticipated; a draft document has been produced and workshops held with carers and all partners. It has been agreed to extend the deadline of the mapping exercise by 3 months (until March 2018).

Key priorities 2018/19

- Continue transition from Carers Strategies (Wales) Measure 2010 to the Social Services and Well-being Act 2014
- In association with Local Authority and Third Sector Partners complete the mapping of service provision for carers across North Wales and identify gaps
- Work with partners to address gaps identified in service mapping
- Develop local action plan in response to the 3 priorities national priorities identified for carers by Minister for Children and Social Care and the Population Needs Assessment
- Review staffing structure and funding streams within BCUHB to support delivery of the local action plan

Accessible Healthcare

All Wales Standards for Accessible Communication and Information for People with Sensory Loss were introduced in May 2013 and became operational by Autumn 2013. There is a steering group within BCUHB that monitors implementation of the standards and a reference group consisting of third sector providers, BCUHB staff and service users.

Priorities for 2018/19

- Continue with awareness raising sessions and promotion of e-learning package
- In partnership with third sector colleagues, seek funding for pilot study for remote access to BSL interpretation
- Repeat audit of compliance with standards in secondary care
- Explore accountability systems and processes within BCUHB with a view to including audit of standards within these systems to ensure ownership within Divisions
- Continue engagement with people with sensory loss; utilising feedback to inform service development
- Work with All Wales Sensory loss group to advise and support development of national approach to identification and recording of communication needs (Phase 2 of pilot study)

Emergency Planning, Resilience Assurance and Governance

In 2018/19 our actions to ensure Civil Contingencies preparedness will include:

Duty to Assess the Risks within local community

- To review the National Risk and Threat Assessment along with the local Community Risk Register in order to identify specific gaps within our preparedness or capability.
- To develop appropriate arrangements to mitigate identified risks in line with the updated Community Risk Register and the pre-determined LRF workload priorities,

Duty to perform emergency planning activities

- Address identified gaps within the Internal Audit Report relating to Civil Contingencies and revise the Civil Contingencies risk register,
- Provide adequate training opportunities for staff who have identified roles within emergency plans.
- Further to the review and refresh of the hospital major incident plans and the development of area team major incident plans there is a need to test the major incident planning arrangements by delivering at least 1 live play major incident exercise, 2 table top exercises and 2 communications cascade exercises.
- Develop robust “Lockdown” arrangements for each acute, community and mental health hospital/facility.
- Review MERIT team co-ordination and activation procedures.
- Contribute to the pan Wales work on mass casualty management and reflect these within local arrangements.
- Develop a plan which supports the health board in the event of a national fuel disruption – this action will be dependent on the publication of the UK Government national Emergency Plan – Fuel.

Duty to have in place Business Continuity arrangements

- Address identified gaps within the Internal Audit Report relating to business continuity.
- To facilitate 2017/18 exercises to test Business Continuity Plans across very high and high risk services.
- Perform Business Impact Analysis workshops across remaining areas within the Health Board.
- Develop Business Continuity Plans across remaining areas within the Health Board.

Duty to cooperate with our civil contingencies partners

- Cooperate with the Local Resilience Forum and its substructures.

Duty to share information

- Work with the corporate communications team in order to develop a single integrated communications plan, linked to the Local Resilience forum arrangements for communicating with the public.

- To further develop capabilities to provide information relating to vulnerable persons affected by an emergency.

Duty to warn and inform the public in the event of an emergency

- Develop capabilities to warn and inform the public affected during a major emergency.

Section 7 – Monitoring Performance and Delivery

Section 7 – Monitoring Performance and Delivery

Performance against this Plan will be monitored through the Board's accountability arrangements as set out in the Board's Performance and Accountability Framework.

Monthly accountability meetings will be held between Executive Directors and the Board's Operational Divisions, i.e. Area Teams, Secondary Care Division, Mental Health and Learning Disability Division, Estates and Facilities. In these meetings monthly performance and delivery metrics will be reviewed to ensure achievement of the priorities set out in the Plan, with remedial action plans implemented in areas where performance is not in line with profile.

Formal quarterly Performance Review meetings will be held with each of the Operational Divisions above and also with each Corporate Function. These reviews will examine delivery against the broad range of priorities in the Plan in addition to the detailed performance metrics considered on a monthly basis.

Reporting of Performance will take place monthly through the Integrated Quality and Performance Report which is considered by the full Board on a monthly basis. Detailed scrutiny of performance will take place on a monthly basis through the Finance and Performance Committee and the Quality, Safety and Experience Committee.

Quarterly reporting of progress against the overall plan will be scrutinised through the Board's Strategy, Partnership and Public Health Committee and subsequently reported to the Board.

Through these arrangements there will be regular, detailed reporting of performance and delivery which is transparent and conducted through the Board and Committee meetings which are held in public.

Key Performance Milestones

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun	Sept	Dec	Mar-19	Mar-20	Mar-21
Quarterly	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	Percentage of children who received 2 doses of the MMR vaccine by age 5		91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%
	The percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual target	3.8%	1.0%	2.0%	3.0%	4.0%	5.0%	5.0%
	The percentage of those smokers who are co-validated as quit at 4 weeks	40% annual target	31.1%	8.0%	16.0%	24.0%	32.0%	35.0%	40.0%

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care										
Measure			Target	Profile						
				Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The percentage of patients waiting less than 26 weeks for treatment		95%	82.0%	82.0%	84.0%	84.0%	87.0%	90.0%	95.0%
	The number of patients waiting more than 36 weeks for treatment		0	4,237	4,237	4,237	4,237	4,237	4,237	4,237
	The number of patients waiting more than 8 weeks for a specified diagnostic test		0	0	0	0	0	0	0	0
	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date		Reduction (12 month trend)	77,000	77,000	75,000	73,000	70,000	53,000	41,000
	% compliance with stroke QIMs:	Direct admission to Acute Stroke Unit (<4 hrs)	The most recent SSNAP UK National quarterly average	36.7%	42.0%	45.0%	40.0%	45.0%	53.0%	60.0%
		CT Scan (<1 hrs)		35.0%	40.0%	48.0%	43.0%	50.0%	60.0%	70.0%
		Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)		83.0%	83.0%	83.0%	83.0%	83.0%	95.0%	95.0%
		Thrombolysis door to needle <= 45 mins		15.0%	25.0%	30.0%	27.0%	30.0%	50.0%	90.0%
	The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge		95%	80.0%	80.0%	88.0%	80.0%	90.0%	90.0%	95.0%
	The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge		0	1,297	850	850	1,200	900	500	0
	The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes		65%	73.0%	80.5%	81.1%	74.0%	75.0%	80.0%	80.0%
	Number of ambulance handovers over one hour		0	957	850	850	1,100	900	700	500
	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)		98%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
	The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral		95%	87%	88%	90%	90%	92%	95.0%	95.0%
	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral		80%	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80.0%	80.0%
	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS		80%	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80% (Adult & Camhs)	80.0%	80.0%
	For HBs with OOH services: Percentage of urgent calls that were logged & patients started their clinical definitive assessment within 20 mins of initial calls being answered For HBs with 111 services: Percentage of P1 calls that were logged & patient started their clinical definitive assessment within 20 mins of the initial calls being answered		98% (OOH) Improvement (12 month trend) (111)	70.0%	73.0%	75.0%	76.0%	80.0%	88.0%	98.0%
	For HBs with OOH services: Percentage of patients prioritised as very urgent and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage For HBs with 111 services: Percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 mins following their clinical assessment / face to face triage		90% (OOH) Improvement (12 month trend) (111)	72.0%	75.0%	78.0%	77.0%	80.0%	85.0%	90.0%
Quarterly	Percentage of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA		100%	100.0%					100.0%	100.0%

INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	90%	89.7%	89.9%	90.0%	90.2%	90.4%	90.0%	90.0%
	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	100%	100%	100%	100%	100%	100%	100.0%	100.0%

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	95%	93.0%	93.0%	93.0%	93.0%	95.0%	95.0%	95.0%
Quarterly	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	100%	100.0%					100.0%	100.0%

SAFE CARE - I am protected from harm & protect myself from known harm									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The rate of laboratory confirmed C.difficile cases per 100,000 population	Performance against 18/19 local target	39	45.0	50.0	43.0	38.0	30.0	25.0
	The rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population		29	27.0	26.0	24.0	22.0	20.0	18.0
	The rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population		77	73.0	72.0	71.0	69.0	65.0	60.0
	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales (assuming this is the 6month timescale as target increased to 90%	90%	81.0%	83.0%	84.0%	86.0%	90.0%	90.0%	90.0%
	Number of new Never Events	0	0	0	0	0	0	0	0
	Number of grade 3, 4 and unstageable healthcare acquired (both hospital and community) pressure ulcers reported as serious incidents	Reduction (12 month trend)	40	37	35	36	35	33	30
	Number of administration, dispensing and prescribing medication errors reported as serious incidents		0	0	0	0	0	0	0
	Number of patient falls reported as serious incidents - In patient falls only		15	15	14	14	12	10	8
Quarterly	Fluoroquinolone, cephalosporin, clindamycin and co-amoxiclav items as a percentage of total antibacterial items prescribed	Reduction (4 quarter trend)	9.4%					8.0%	7.0%
	Non steroid anti-inflammatory drug (NSAID) average daily quantity per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)		1,400					1,100	1,050
	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)		325					320	320

DIGNIFIED CARE - I am treated with dignity & respect & treat others the same									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Bi-annual	Percentage of NHS employed staff who come into contact with the public who are trained in an appropriate level of dementia care	85%	85%					85%	
Quarterly	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Reduction (4 quarter trend)	tbc - awaiting comfirmation of base with new methodology						
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	75%	37.7%					65.0%	75.0%

OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them									
Measure		Target	Profile						
			Projected end of March 2018 position	Jun-18	Sep-18	Dec-18	Mar-19	Mar-20	Mar-21
Monthly	The percentage of patients who did not attend a new outpatient appointment	Reduction (12 month trend)	6.5%	6.0%	5.5%	5.0%	5.0%	5.0%	5.0%
	The percentage of patients who did not attend a follow-up outpatient appointment		7.2%	7.0%	6.5%	6.0%	5.5%	5.0%	5.0%
	Number of procedures that do not comply with selected NICE 'Do Not Do' guidance for procedure of limited effectiveness (selected from a list agreed by the Planned Care Board)	0	0	0	0	0	0	0	0
	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training). BCU note: The profile given in the template reflects PADR compliance. Medical appraisal rates are recorded as a separate indicator and links to revalidation. These figures are not included in this template	85%	64.0%	67.0%	70.0%	74.0%	80.0%	85.0%	85.0%
	Percentage compliance for all completed Level 1 competency with the Core Skills and Training Framework		83.0%	84.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Quarterly	Biosimilar medicines prescribed as percentage of total 'reference' product plus biosimilar	quarter on quarter improvement	85.0%					85.0%	85.0%

Section 7 – Glossary of Terms

ACEs
The term Adverse Childhood Experiences (ACEs) is used to describe a wide range of stressful or traumatic experiences that children can be exposed to whilst growing up. ACEs range from experiences that directly harm a child (such as suffering physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which a child grows up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration).

Cluster
A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. GPs in the Clusters play a key role in supporting the ongoing work of a Locality Network. Locality Network is a term used to describe this collaborative approach.

Continuing Healthcare
NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.

CRT
Community Resource Teams aim to provide a multi-disciplinary 24 / 7 workforce that will provide advice, care and timely and coordinated services and support for individuals and carers within their own homes, care homes and communities to keep people at home and enable faster discharge for others.

John's Campaign
John's Campaign is named after Dr John Gerrard, who died in November 2014 after a catastrophic stay in hospital. Shocked at how much damage disconnection can wreak on people with dementia, his daughter Nicci Gerrard and her friend Julia Jones co-founded the campaign with a single, simple principle: We should not enforce disconnection between carers and those who need care. When someone with dementia is hospitalized, the medical staff should do all within their power to make access easy for family carers and utilise their expert knowledge and their love. The principles of John's Campaign are applicable everywhere when a person with dementia cannot live in their own home. Whether someone with dementia is living in a mental health unit, a nursing home, a rehabilitation unit, supported housing or a care home, their families must be welcome to support them as often as they are able. Families are more than "visitors" to a person with dementia; they are an integral part of that persons life and identity and often their last, best means of connection with the world.

Looked after Children
A Looked After Child (sometimes referred to as 'LAC') is a child who is accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

MECC
Making Every Contact Count
The MECC approach aims to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.
This recognition extends not only to their interaction with clients/patients, but also to their own health and wellbeing and that of their friends, families and colleagues. To be successful MECC must not be seen as a separate public health initiative, but a part of what we all do.

RTT
Referral to Treatment
This is the total time from referral by a GP or other medical practitioner for hospital treatment and includes the time spent waiting for outpatient appointments, diagnostic tests, therapy services and inpatient or day-case admissions.

Telehealth
Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services.