

**Appendix 2:
National Planning
Templates**

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Template 1

Delayed Transfers of Care – DTOC

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination.

	Priority area(s)
Key focus should be on delivering	As part of the Regional Partnership Board, we will continue developing a closer relationship with local government and wider partners in order to sustainably tackle the issue of delayed transfer of care (Pathway of Care Delays), improving outcomes for our population.
	Implement and embed Pathways of Care Reporting framework for delayed transfers of care (DTOCs) in 2023 and to monitor the progress of safe and timely discharge in real time. Learning from the work undertaken on increasing community capacity to inform future planning.
	Under Goal 6 of Unscheduled and Urgent care – implement and embed the revised D2RA Pathways (July 2023), Discharge Policy and reluctant discharge guidance (due for publication Spring 2023), and implementation of the Trusted Assessor Guidance (by September in line with WG requirements). As part of Goal 5 – implement and embed the Optimal Flow Framework which includes the principles of SAFER, Red to Green days, with the aim of preventing deconditioning.
	We will work together to strengthen community capacity by developing an integrated community care system in line with 'Further, Faster'.
	<p>Priority Areas have been identified as:-</p> <ol style="list-style-type: none"> 1. Assessment including Trusted Assessor (across all partner agencies) 2. Care Home related delays (across all partner agencies) 3. Packages of care (across all partner agencies) <p>In addition there will be a focus on lengths of stay, consistency of applying the new guidance and identifying good practice of where we have got it right. Identifying and prioritising service gaps for each of the 4 D2RA pathways.</p>
Baseline	Phase 2 (3 month pilot) of implementing the revised Delay Pathway of Care Codes and reinstating Census day has now concluded. April baseline:-

		April	
		No. Pts Delayed	No. of Days delayed
Anglesey		40	1001
Gwynedd		60	1519
Conwy		50	929
Denbighshire		44	956
Flintshire		53	2072
Wrexham		74	4142
Out of Area		5	157
Total		326	10845

Top 3 account for more than 80% of all delays
 Top 3 account for more than 75% of bed days lost



PoCDs - Action Plan
 - April 2023.xlsx

Quarter 1:

<ul style="list-style-type: none"> ▪ Milestones 	<p>Full compliance with updating the National Delayed Data-base weekly (validation of Pathway of Care Delays by LA will remain monthly).</p> <p>Commence the implementation of the revised D2RA Pathways in preparation of the HB launch on July 31st 2023.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Strengthen IHC governance arrangements for reporting to 6 Goals Programme Board.
	<ol style="list-style-type: none"> 2. Undertaken 'After the Event' review of the closure of 2 care homes (loss of 145 beds since January 1st 2023), develop action plan for implementation. Follow up held on 19th May 2023. Briefing Paper to be developed and shared with partners.
	<ol style="list-style-type: none"> 3. Further develop the Regional Pathway of Care Delays Action Plan. Develop Action Plans for the 3 IHCs and Mental Health. This will include targeted work on managing avoidable delays, with a focus on length of delays and three target areas: <ol style="list-style-type: none"> 1. Assessment – Health, Social Care, Joint 2. Care home related delays – availability, funding, choice 3. Packages of Care.
	<ol style="list-style-type: none"> 4. Care Home Workshop held on 24th April. Questionnaire to all care home providers on challenges, gaps and opportunities. Aim will be on improving outcomes, appropriate admission avoidance, reduction in ED attendances, and optimising timely transfer back to care homes. Detailed action plan will be developed with partners and stakeholders. 3 Task and Finish Groups will be established (End of Life Care, Multiagency Hub, Sharing information).

	5. Review of winter planning / increasing community capacity initiatives and commence plan for winter 2023 / 24 e.g. block purchasing of additional care home beds (surge capacity), Extra Care Housing – what has worked well, and what could we have done differently.
	6. Establish robust reporting and monitoring systems and share information across the HB and partners to inform priorities.
	7. Undertake scoping work for the introduction of Trusted Assessor and submit to Regional Partnership Board.
	8. Undertake scoping work on what services are available and gaps aligned to the 4 D2RA Pathways.
Quarter 2:	
▪ Milestones	D2RA implementation on 31st July 2023 (Detailed Action Plan with key project milestones available). Implementation of Trusted Assessor Roles by end of September 2023.
▪ Actions	1. Agree with each IHC what reduction in the number and length of time people are delayed. (This will be variable across North Wales, and % of reduction will be confirmed in Q1).
	2. Identify any additional initiative to manage delays for implementation in Q3 and Q4 as part of winter planning.
	3. Care home Task and Finish Groups to present their recommendations to the Care Home Steering Group by end of quarter.
	4. Scope and agree priority areas and opportunities across IHCs, Mental Health, LA's, Housing e.g. Trusted Assessor, Supported Living and specialist EMI care home beds.
	5. Full implementation of the New Discharge Guidance (subject to publication by WG in July 2023) with a focus on reluctant discharge.
	6. Report Monthly on progress of increasing number of Trusted Assessor Roles (Trajectory to be agreed).
Quarter 3:	
▪ Milestones	Achieve and maintain agreed reduction of in-patient DTOCs.
▪ Actions	1. Implement Regional Pathway Delays Action Plan.
	2. Implement any initiatives identified in Q2 to prevent increase in delays due to any sessional pressures.
	3. Implement recommendations from Care Home Task and Finish Groups.
Quarter4:	
▪ Milestones	Maintain the reductions achieved in Q's 1, 2 and 3.
▪ Actions	1. Implement Regional Pathway Delays Action Plan.
	2. Review / Audit D2RA implantation.
Risks	<ul style="list-style-type: none"> ▪ Inconsistent / robust data collection on type of delays (Feb, March and April data variable – difficult to agree an accurate baseline). <ul style="list-style-type: none"> ○ Share national and local data with partners.

- Deep dive into specific areas where there is significant variation across North Wales e.g. choice.

- Continued fragility of the independent sector to support timely discharge and maintain optimum flow, resulting in people remaining in hospital longer than clinical required and increasing the potential for harm.

Mitigation:

- Care home workshop arranged for April (follow up September)
- Establish care home steering group (3 Priority T&F Groups)
- local and national discussions on fee setting
- Development of Commissioning Strategy for Care Homes.

- Continued recruitment and retention issues of health and social care workforce to deliver safe and sustainable discharge and community services.

Mitigation:

- Regional Workshop Board under review
- Local initiatives in place to consider joint posts
- Robust training programme in place as part of the Care Provider Quality Assurance Framework

- Lack of capacity to release staff to ensure robust and consistent discharge education programme.

Mitigation:

- Range of training / awareness / education packages being developed e.g. ESR access, face to face, easy to read booklets etc.

- Failure to embed the new D2RA Pathways due to lack of integrated IT systems for recording and reporting, gaps in service provision to ensure people are assessed in the most appropriate setting i.e. not in a hospital setting.

Mitigation:

- scoping what services are available and gaps aligned to each of the 4 D2RA Pathways
- Work with IT to agree the longer term recording system and identify 'workarounds' in the interim.

- Inability of the Health Board to respond in a timely way to unscheduled and urgent care and planned care.

Mitigation:

- Improved Governance and support to the 6 Goal Programme Board
- Improved Governance at IHC level
- Clarity on requirements to meet the HBs objectives at each level

- Health is providing social care when it is not registered with CIW to do so. This activity is not picked up in the Pathways of Care Delayed reporting as people are not in a hospital bed.

	<p>Mitigation:</p> <ul style="list-style-type: none"> ○ Priority in each of the IHC action plans ○ Activity will be collected across North Wales as part of the monthly census and reported to HB and partners ○ HB registered with CIW to provide Domiciliary Care.
Outcomes	In-patients are safeguarded against deconditioning, ensuring better outcomes and experiences for people in hospital. People are assessed for care in the most appropriate place. Achieving Home First Principles for all discharges. Improved flow for both emergency and planned care.
Alignment with workforce plans	This will be linked to the Primary care, IHC and Mental Health workforce plans. Link with work of the Regional Partnership Board.
Alignment with Financial plans	Care provider fee setting for 2023 /24, interim rates for FNC and CHC have been agreed. Funding for schemes to support reducing delays is within IHCs, MH and RIF, Further Faster.
OPTIONAL	
Digital / Technology Opportunities	The need to ensure that Health Board and National systems are compatible i.e. need for improved interface between Health Board and National platforms is being taken forward. Requirements for recording D2RA pathways within 24 hours of admission and on discharge are still being worked through (STREAM) and request for support has been submitted. Access to training tools for D2RA, Trusted Assessor, information packages have been developed nationally but not yet available.

Template 2a

Primary Care Access to Services: GP & Community Services

	Priority area(s)
Key focus should be on delivering	Improved access to GP and Community Services
Baseline	<p>Access to Primary Care services is of significant priority to citizens, and plays an important bearing on levels of satisfaction amongst people using primary care services. As we move towards a period of recovery the need to refocus on access is therefore crucial. What is required is a primary care recovery plan for access that details the immediate tangible actions to those issues that are causing the greatest noise within the system, and that will, once in resolved, better enable primary care practitioners to deliver high quality care. In seeking to improve access to GP and community services, we need to consider a number of separate but interconnected elements:</p> <ol style="list-style-type: none"> 1. GMS Access Standards (Phases 1 and 2) 2. Escalation levels 3. Referrals for ambulatory sensitive conditions 4. Workforce initiatives – including the shift towards an MDT primary care workforce 5. Service initiatives – including the development of urgent primary care services <p>1. GMS Access Standards:</p> <p>A great deal of effort has been made during 2022/23 to improve access to GP and community services by opening up practices, and returning to offering face-to-face appointments alongside video-consultations. As a consequence, compliance with Phase 1 of the GMS Access Standards across north Wales, is high.</p> <p>The 2022/23 GMS Contract negotiations agreed that Phase 1 standards will now become part of the core contract from 1st April 2023. This means that they are no longer optional and will be mandatory for all practices. The contractual assurance framework to support this new measure has not yet been released, however, given that there were 2 practices within BCUHB that chose not to achieve previously, and 10 in total not achieving, then they will need to be supported to move into the new arrangement.</p> <p>At the end of Q4, all practices who submitted their achievement on the Primary care Information Portal (PCIP) at end of year achieved Phase 1. At Q2, 9 practices did not achieve Phase 1 and therefore were unable to progress onto Phase 2 to achieve financial achievement. 7 of these practices did achieve Phase 1 at Q4. There are currently only two practices in the East who are not achieving Phase 1.</p> <p>Phase 2 is described as the “Reflective Phase” and allows practices time to reflect, listen to patient experience and make improvements to access. Practices</p>

will be required to report quarterly and be prepared to supply evidence (which could include but is not limited to the practice's appointment system, patient experience survey outcomes and up to date infographics) via the PCIP Access Reporting Tool. WG has provided a template for practices to use for the reflective report and they are also expected to discuss the report at collaborative level.

89.5% of practices have achieved Phase 2 of the Access Standards. 90.6% of practices submitted a reflective report and EQIA.

2. Practice escalation levels:

Whilst achievement against the GMS Access Standards is a useful indicator for understanding whether access to GP services is improving, it is also useful to look at practice escalation levels.

Despite the ongoing pressures and backlog of work that has resulted from the pandemic, GP practices have remained available to those who need support. Whilst there had been some early signs of recovery, it should be noted that the current financial crisis is placing increased pressure on independent contractors and is adding significant strain to an already exhausted and somewhat depleted workforce. Despite these pressures, the number of GP practices at escalation level 4 has fallen between April (9) and June (2), although the number of practices at Level 3 remains fairly consistent (9 in April – 10 in June). However, it is likely that as the cost-of-living crisis and other pressures continue to take their toll, the number of GP practices at risk is likely to increase at least in the short-term.

3. Admission rates for ambulatory sensitive conditions:

Admission rates for ambulatory sensitive conditions and long-term conditions are each an indicator of a healthy and resilient primary care system.

There has been an overall increase in the number of GP referrals for ambulatory sensitive conditions being referred to secondary care from a low of 1,200 in July through to September, rising to 1,500 in November. Furthermore, the number of admissions where the primary diagnostic reason for admission is exacerbation of COPD or asthma has risen from 170 in July to 225 in November. Whilst a slight increase may be indicative of changes in weather, the increase may be explained in part by the challenges practices have faced in effectively reducing the planned care backlog for chronic disease reviews (see urgent primary care template for examples of how improvements will be delivered).

4. Workforce initiatives:

Central to the Health Board's vision for primary care is the widening of the primary care workforce to include a range of practitioners, and the ongoing development of an MDT workforce. Clusters have worked hard over the last 5-10 years with the help of the Primary Care Academy, to grow this workforce, which now includes:

- ANPs
- First Contact Physiotherapists
- Advanced Occupational Therapists
- Chronic Disease Nurses
- Dieticians

	<ul style="list-style-type: none"> ▪ Family Well-being practitioners <p>Each delivering care and support to people within the Cluster in order to ensure individuals are seen by the most appropriate professional for the presenting need, and freeing up GP time for more individuals with multiple and more complex needs.</p> <p>5. Service initiatives: The Health Board has introduced a number of initiatives to help improve access to GP services, including:</p> <ul style="list-style-type: none"> ▪ Urgent Primary Care Centres (see separate Ministerial template) for how the development of urgent same day care services will support the achievement of this objective) ▪ Tier 0/1 mental health services ▪ Social prescribing <p>Moreover, the accelerated development of Clusters, and the population health management approach that underpins it will, with time, help to ensure a greater focus on prevention and early intervention, as well as the promotion of self-care; all of which will have a demonstrable impact on demand and capacity within primary care.</p> <p>Our routine and transformational work will continue throughout 2023/24, and will be enhanced through the implementation of a strategy that sets the Health Board’s strategic direction of travel for primary and community care over the next 3-5 years. In delivering our strategy we transform the delivery of primary care in north Wales, through realising improvements in:</p> <ul style="list-style-type: none"> ▪ Sustainability and access ▪ Urgent same day care ▪ Estates ▪ IT and digital technology ▪ Population health management, incl. management of ‘high risk’ cohorts ▪ Health Board practices <p>The strategy places primary care front and centre of the management of urgent and same-day/ unscheduled care, including strategic and clinical leadership and oversight of the 6 Goals programme. This template should therefore be read alongside the template outlining our approach for the delivery of an urgent same day service.</p>
Quarter 1:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Primary Care Strategy (2023-28) together with ‘Sustainability Action Plan’ and ‘Primary Care Recovery Plan for Access’ signed-off by Executive Team and Health Board.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Engage with individuals/ Groups to understand issues and experiences re: access ▪ Primary Care Recovery Plan for Access – action plan developed based on survey findings.

	<ul style="list-style-type: none"> Sustainability action plan developed and process for driving forward agreed Analyse Urgent Care Services review and develop proposed model to inform development of urgent same-day service.
Quarter 2:	
<ul style="list-style-type: none"> Milestones 	<p>Robust primary care data in place to support identification and analysis of challenges/ issues across GMS and Health Board (managed) practices, in relation to access and other key domains</p> <ul style="list-style-type: none"> 100% (n=12) Health Board (managed) practices signed-up to Analyse-RX GMS practices provided with opportunity to sign-up to Analyse-RX Baseline data for number of people awaiting a chronic disease review, collated
<ul style="list-style-type: none"> Actions 	<ul style="list-style-type: none"> Agree plan to introduce Analyse-RX into Health Board (managed) practices Engage with GMS practices to determine wider interest in using Analyse-RX Evaluation of Cluster initiatives aimed at improving GMS access Evaluation of Cluster initiatives aimed at reducing planned care backlog Further development of Primary Care Dashboard to reflect breadth of data requirements Data collected via Analyse-RX to help map demand and capacity as well as identify pressure areas
Quarter 3:	
<ul style="list-style-type: none"> Milestones 	<p>Improvement plan for Health Board (managed) practices to commence implementation:</p> <ul style="list-style-type: none"> Improved access amongst Health Board (managed) practices Health Board (managed) practices to achieve 100% compliance with Access Standards, Clear route for practices to come in and out of Health Board management articulated and in place.
<ul style="list-style-type: none"> Actions 	<ul style="list-style-type: none"> Implementation of Health Board (managed) practice programme, including development of centralised support function for Health Board (managed) and GMS practices.
Quarter4:	
<ul style="list-style-type: none"> Milestones 	<p>Improvement plan for third sector partnerships in place</p> <ul style="list-style-type: none"> Third sector cluster commissioned services mapped Reduction in duplication across commissioned services and strengthened commission approach.
<ul style="list-style-type: none"> Actions 	<ul style="list-style-type: none"> Third sector cluster commissioned services mapped and aligned against corporate contracts register, Working with mental health, review Tier 0/1 cluster commissioned services, and other funded initiatives and develop forward (re)commissioning plan, Working with Public Health, review social prescribing commissioned services, and other funded initiatives and develop forward (re)commissioning plan.
Risks	<ul style="list-style-type: none"> There is a risk that the intended outcomes of the strategy will not be realised due to the significant pressures facing primary and GPs in particular

	<ul style="list-style-type: none"> There is a risk of further practice closures as a result of the increasing financial pressures on primary care. Work is being undertaken to build a primary care sustainability plan, which once in place will help to mitigate against this risk and its impact on the initiatives described within this plan.
<p>Outcomes</p>	<p>For the people of north Wales:</p> <ul style="list-style-type: none"> Improved access to primary care services Improved experience of primary care <p>For the workforce:</p> <ul style="list-style-type: none"> Greater job satisfaction Greater integration with secondary care <p>For the organisation:</p> <ul style="list-style-type: none"> Improvements in recruitment and retention of primary care workforce Improved resilience Increased capacity within primary and community care services A reduction in emergency admissions
<p>Alignment with workforce plans</p>	<p>Resources to deliver this plan have been identified within the corporate primary care team. However, it is important to note that the current fragility of the wider primary care workforce presents a risk to clusters and individual practices being able to move forward at pace, and implement the required changes.</p> <p>Health Board (managed) practices are currently holding 28.1fte vacancies. These posts have historically been difficult to recruit to and are filled by locums in the short-term, which represents a significant cost pressure to the Health Board.</p>
<p>Alignment with Financial plans</p>	<p>The annual GMS budget for 2022/ 23 is £144,132,000, with a forecast overspend of £0,616m. In addition, spend relating to Health Board (managed) practices is anticipated to yield a cost pressure for the Health Board, largely due to high locum costs.</p> <p>Financial pressures are increasingly being cited by GP practices as a significant sustainability concern – the Health Board will therefore need to consider the support available to practices at risk of hand-back as a result of financial pressures.</p> <p>The costs associated with the ongoing management of Health Board (managed) practices is higher than the GMS financial envelope. Work is being undertaken to confirm the exact costs, benchmarked against standards of practice. As the number of practices at risk increases, so too does the chance that they will come under health board management (at least temporarily).</p>
<p>OPTIONAL</p>	
<p>Digital / Technology Opportunities</p>	<p>We will continue to work with practices to support the use of video-consultations and digital technology as a way of supporting improved access to GP and community services. We will endeavour to work with community groups and local partners to support digital inclusion so as to increase uptake amongst all patient cohorts</p>

Template 2b

Primary Care Access to Services: Community Pharmacy

	Priority area(s)
Key focus should be on delivering	Improved use of Community Pharmacy
Baseline	<p>1. Supply of medicines</p> <p>The 147 pharmacies in BCUHB are dispensing approximately 1.3 million prescription items per month. A number of GP practices have taken steps to increase the periods of treatment issued on prescription, but despite this, there has been a growth of around 2% in the total number of items dispensing in the 12 months to November 2022, compared to the preceding 12 months.</p> <p>The End of Life Care Medicines Hubs Service is established in 11 pharmacies to give assurance on key end of life care (EoLC) medicines in the community. Since commissioning, the list of medicines held has been extended to include key treatments for clostridium difficile and influenza. A new service specification for an Urgent Medicines Service has recently been agreed and it is planned to use this in place of the EoLC Medicines Hub service, along with a review of the stock to be held by the hubs.</p> <p>2. Urgent Primary Care</p> <p>Of the 147 community pharmacies in BCUHB, 145 (99%) are commissioned to provide the Clinical Community Pharmacy Service (CCPS). The remaining two pharmacies are not anticipated to be able to meet the requirements for a consultation area by that point. In addition to this, around 60% of pharmacies are expected to be commissioned for the Sore Throat Test and Treat enhancement to the CCPS. In the 12 months of 2022, around 55,000 consultations were carried out under this service, almost double the level of consultations undertaken in 2021.</p> <p>The Pharmacist Independent Prescribing Service (PIPS) is currently available in 18% of the pharmacies in BCUHB. These pharmacies are typically offering 1,000 consultations per month, but in December 2022, around 1,800 consultations were completed under this service. All of these pharmacies manage a range of acute conditions, but one of them currently offers consultations for provision of contraception.</p> <p>3. Medicines Optimisation</p> <p>The Discharge Medicines Review Service is commissioned in 145 of the pharmacies in the Health Board. In the 12 months to end September 2022, 2,681 DMR consultations were provided, to reconcile medication on discharge and support patients to use these safely and effectively.</p> <p>The Inhaler Review Service is available in around 60% of community pharmacies, providing review and support with inhalers for patients with COPD and Asthma. From February 2022 to December 2022, 1,814 level 1, and 240 level 2, reviews have been carried out.</p>

	<p>The service specification for the Care Home Support Service has recently been revised, following a suspension in provision since the start of the COVID-19 pandemic. The service has recently been commissioned from 24 pharmacies (16%).</p> <p>The Adherence Support Service has been developed over 2022/23 and is currently commissioned in five pharmacies. This service is being rolled out using an agile methodology to allow ongoing review and refinement of the service specification and supporting materials, building on the learning from early site setup. Where commissioned, pharmacists or pharmacy technicians are reviewing the support provided to patients to ensure they can use their medicines safely and effectively, as well as providing advice, support, and tools to aid them in this.</p> <p>A Multidisciplinary Structured Medication Reviews in Care Homes Service has been developed and successfully piloted during 2022. This service supports general practice teams to ensure that patients in care homes are taking the most appropriate medicines to minimise the risk of harm and maximise the therapeutic benefits gained from the medication. This service is not currently offered in any pharmacies.</p> <p>4. Population Health</p> <p>The Help Me Quit @ Pharmacy Service is commissioned in 117 pharmacies. Over 2021 and 2022, around 100 clients have been supported through this service each month, with quit rates of around 24%.</p> <p>The Supervised Consumption of Oral Substitution Therapy Service is currently commissioned in 131 pharmacies and over 66,500 doses of methadone and 3,500 doses of buprenorphine were supervised under this service in 2022.</p> <p>The Needle and Syringe Programme Service is commissioned in 75 pharmacies. A new service specification has been developed to provide a multi-tiered service including Naloxone and it is being rolled out, along with a review of the providing pharmacies, during 2023/24.</p> <p>The Patient Sharps Service is commissioned in 143 pharmacies and provides the opportunity for patients to dispose of sharps and obtain sharps waste bins in their community pharmacy.</p>
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Quarter 1:

<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ▪ Expand the number of pharmacies offering the Pharmacist Independent Prescribing Service ▪ Expand the number of pharmacies offering contraception through the Pharmacist Independent Prescribing Service ▪ Expand the number of pharmacies offering the Inhaler Review Service ▪ Full coverage of the Care Home Support Service to provide access to expert support with medicines management for all care homes in North Wales ▪ Transfer all Needle and Syringe Programme to new service model and expand sites where needed, including specialist services
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<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Work with GP practices and other stakeholders to progress increased Periods of Treatment work to release capacity within community pharmacy for other services ▪ Support community pharmacists to access training for independent prescribing, including facilitating access to Designated Prescribing Practitioners, to enable further expansion of the Pharmacist Independent Prescribing Service in future years ▪ Support pharmacists who are annotated as prescribers to establish the Pharmacist Independent Prescribing Service in their pharmacy ▪ Work with pharmacy teams to support staff to complete training and sign up for the Inhaler Review Service ▪ Work with community pharmacy and care home providers to link every care home that wishes to access medicines management support with a names pharmacy commissioned to provide the Care Home Support Service ▪ Continue agile roll-out of Adherence Support Service within the initial cluster, including engagement with local stakeholders to ensure appropriate patient referral ▪ Refresh commissioning of Needle and Syringe Programme and begin to commission specialist services (Level 2 provision and naloxone provision and training), where needed.
<p>Quarter 2:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ▪ Live public-facing data on availability of community pharmacy services relevant to urgent primary care (Pharmacist Independent Prescribing Service and Clinical Community Pharmacy Service) ▪ Expand the number of patients appropriately accessing the Pharmacist Independent Prescribing Service
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Work with community pharmacy contractors and their staff to ensure that live data on service availability is routinely being shared through the new national tool ▪ Continue to work with community pharmacy owners to ensure that all eligible staff are able to access training for the Sore Throat Test and Treat (STTT) service ▪ Work with contractors and their teams to establish the Sore Throat Test and Treat Service in pharmacies that are not yet providing this service ▪ Develop integration mechanisms to link UPCC and General Practice with Community Pharmacy for efficient care pathways that incorporate the Pharmacist Independent Prescribing Service and Clinical Community Pharmacy Service ▪ Work with community pharmacy teams to promote the Inhaler Review Service to patients who may benefit from a consultation ▪ Recruitment of a Medicines Optimisation Lead for Community Pharmacy to support the existing team on delivering this plan ▪ Scope out potential to use automation to provide access to medicines in the South Meirionnydd Cluster, particularly in the evening/at weekends ▪ Scope out sites for Blood Borne Virus Screening Service to support work around elimination of Hepatitis C in Wales
<p>Quarter 3:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ▪ 100% of community pharmacies commissioned to provide the Clinical Community Pharmacy Service

	<ul style="list-style-type: none"> ▪ Implement the Urgent Medicines Service with updated stock list of medicines ▪ 80% of pharmacies providing the Sore Throat Test and Treat Service ▪ Expand the number of patients appropriately accessing the Clinical Community Pharmacy Service ▪ Medicines Optimisation Lead for Community Pharmacy begins in role ▪ Begin pilot of automated solution for access to medicines in South Meirionnydd Cluster ▪ Commission 10 pharmacies to undertake testing under the Blood Borne Virus Screening Service
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Review the End of Life Care Medicines Hubs stock list and update alongside transitioning to the Urgent Medicines Service ▪ Engagement with other healthcare providers and the public to promote CCPS and PIPS and when pharmacies are the most appropriate location to access care ▪ Continue agile roll-out of Adherence Support Service by cluster, including engagement with local stakeholders to ensure appropriate patient referral ▪ Support pilots of Electronic Prescription Service across the network ▪ Scope roll out of the national Medicines Administration Record Chart Service, including engagement with stakeholders
<p>Quarter 4:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ▪ Adherence Review Service established in 3 Clusters
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Begin commissioning and associated stakeholder work for the Medicines Administration Record Chart Service ▪ Continue agile roll-out of Adherence Support Service by cluster, including engagement with local stakeholders to ensure appropriate patient referral ▪ Scope the rollout of <i>Multidisciplinary Structured Medication Reviews in Care Homes Service</i> ▪ Support pilots of Electronic Prescription Service across the network
<p>Risks</p>	<ul style="list-style-type: none"> ▪ Workforce shortages within community pharmacy – including pharmacists, pharmacy technicians, and support staff are making recruitment challenging and resulting in over-reliance on locum workforce. ▪ Continued high demand for dispensing of prescriptions, support with self-care, and clinical services ▪ Burnout of staff – high pressure since the beginning of the COVID-19 pandemic is leading to pharmacists, pharmacy technicians, and support staff to leave Community Pharmacy for other sectors, or to leave Pharmacy altogether, further depleting the workforce available ▪ Challenges in accessing Designated Prescribing Practitioners is limited the opportunities for community pharmacists to access training as an independent prescriber and this will limit the rate of progress that is possible for rollout of the PIPS. ▪ Capacity within the health board’s community pharmacy team to support pharmacies to overcome barriers to rollout of new services, and increasing use of commissioned services <p>The risks identified above, particularly in relation to workforce/ recruitment, are national as well as local issues. The Community Pharmacy and Primary Care team proactively monitor and provide support to contractors, including</p>

	<p>monitoring of closures and pressures, and work closely with contractors to support mitigating actions to minimise impact of patients.</p>
Outcomes	<p>For the Citizen:</p> <ul style="list-style-type: none"> ▪ Increase in number of people with minor illnesses and contraception needs supported in the right place at the right time by the right person, ▪ Improve the safe and effective use of inhaled medicines in COPD and asthma, ▪ Provide access closer to home for patients who need urgent medicines ▪ Reduction in medicines related harm for residents of care homes, and those who live in their own home and have difficulties in using their medicines. ▪ Access closer to home to screening services for blood borne viruses to reduce harm <p>For the Organisation:</p> <ul style="list-style-type: none"> ▪ Increased use of community pharmacies for management of acute conditions (including through self-care) and to obtain contraception, ▪ Reduce demand on community pharmacies to dispense medicines by appropriately increasing the periods of treatment for prescribed medicines, ▪ Reduction in admissions to hospitals and improving speed of discharge through reduced demand for support with medicines taking, or ensuring that these needs can be easily met in the community, ▪ Improved management of medicines within care homes, including ordering, storage, use, and disposal
Alignment with workforce plans	<p>Workforce pressures within community pharmacy continue to be a challenge to delivery. Therefore, in order to continue to deliver this ambitious programme of work, on top of 'business as usual' demands there is a need to increase staffing within the Health Board's Community Pharmacy Team. Recruitment to a Medicines Optimisation Lead for Community Pharmacy is underway, with an aim to have a member of staff in post by Q3.</p> <p>Ongoing work with HEIW is improving access to training placements for community pharmacists to train as independent prescribers, staff to train as accuracy checking pharmacy technicians, and upskill staff at all grade to provide services and improve quality.</p>
Alignment with Financial plans	<p>Funding of existing and new services will fall within the ring fenced Community Pharmacy Clinical Services allocation.</p> <p>1.0wte Band 8b Medicines Optimisation for Community Pharmacy role is being recruited to and will be funded from the wider Community Pharmacy allocation</p>
OPTIONAL	
Digital / Technology Opportunities	<p>Use of robotics will enable access to medicines in remote locations, or at times where normal services are not available, to support care closer to home and improve access.</p>

Template 2c

Primary Care Access to Services: Optometry

	Primary Care
Key focus should be on delivering	Improved use of Optometry Services
Baseline	<p>The new Optometry contract, currently going through implementation, focusses on increased use of Optometry services. The contract obliges Optometrists to be a minimum of EHEW accredited, which will result in an increased access and range of acute emergency care and non-acute care in Optician practices, providing "Care Closer to Home". The contract also requires changes to be made to domiciliary provision to include EHEW care at home. This is currently practice-based only.</p> <p>Cluster working is new within Optometry, however, the implementation of the new contract and the requirement to work at this new local level will encourage local solutions to population need.</p> <p>Outside of contract reform, there are established Integrated pathways providing "Data Gathering" for Glaucoma and Diabetic patients in five Optometry practices across North Wales. Clinically-Led Integrated Eye Care Networks continually review current eye care effectiveness and identify new pathways. Optometrists are key members of the Networks and equal partners in reviewing, planning and monitoring eye care delivery.</p> <p>There has been some recent work on fixed-term pathways to support the increased use of Optometry services across BCUHB, including:</p> <ul style="list-style-type: none"> ▪ Intraocular measurement pathway ▪ Diabetic retinopathy pathway expansion ▪ Ocular hypertension/ glaucoma suspect SOS pathway <p>Discussions re: a paediatric pathways are in exploration phase with Primary and Secondary care (within clinically-led Networks)</p> <p>The higher level work of the new Optometry contract (WGOS 3/4/5) which enables better integrated working with secondary care and the transfer of a number of patients to primary care, requires the Optometrists to hold higher qualifications (independent prescribing, higher glaucoma, medical retina qualifications). We are reasonably prepared for independent prescribing and medical retina, but there is a notable shortage of higher glaucoma qualified Optometrists across BCUHB (only 1 currently). The higher qualifications required as a result of contract reform require clinical placements in Ophthalmology. It can be challenging to meet the need for placements for all these qualifications locally.</p>
Quarter 1:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Optometry Professional Collaboratives in place, with agreed ToR</p> <ul style="list-style-type: none"> ▪ 6x Optometry Professional Collaboratives in place (County footprint)

<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Engagement with Optometry practices ▪ Professional Collaborative leads undertake specialist induction training to support role development. ▪ Seek nominations for 6x Collaborative Leads and develop process for appointing (work with NWROC to support nominations) ▪ Inaugural meetings held and Professional Collaborative Leads invited to attend appropriate multi-profession Cluster meetings ▪ Alignment with BCUHB Digital programme: implementing National Digital Programme with Primary and Secondary care partners.
<p>Quarter 2:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Opportunities for inter and intra-collaborative working to meet patient needs and outcomes at a local population level, explored and proposals submitted as part of Health Board’s Plan priorities.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Review service provision and undertake gap analysis in order to understand the readiness of contractors to meet the requirements of the new contract, ▪ Make informed decisions around locally commissioned eye care services in cluster areas (this would require alignment with Eye Care Programme. Strategic alignment/governance for Eye care is within remit of Eye Care Collaborative.
<p>Quarter 3:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Teach and Treat Clinic for North Wales Project, underway Placements begin to be offered in Independent Prescribing, Higher Glaucoma and Medical Retina.</p> <ul style="list-style-type: none"> ▪ When fully operational, the initiative has the potential to treat c. 3000 people per year.
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Ongoing development of proposal ▪ Development of Business Case for additional investment to support scale-up in 2024/25
<p>Quarter 4:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Plan for improving access to optometry services amongst harder to reach communities.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Develop stakeholder mapping exercise, align this to your communication and engagement plan, ▪ Link with other initiatives already working with harder to reach communities e.g., Inverse Care Law, ▪ Work with public health to raise awareness of eye health and eye disease amongst harder-to-reach groups in order to improve access and encourage a proactive rather than symptom-led approach.
<p style="background-color: black; color: black;"> </p>	
<p>Risks</p>	<p>The ongoing uncertainty and timescales regarding the digitalisation programme (electronic patient record and electronic referral) presents a risk to the service. This is because many of the proposed pathways are hindered without a digital solution for the transfer of patient information. Risks will be managed via the Optometry Advisor, and Primary Care Contracting Team, with escalation up through to the primary Care Programme Board, where necessary.</p>

<p>Outcomes</p>	<p>For the people of north Wales:</p> <ul style="list-style-type: none"> ▪ Improved access to Optometry services (measured via new contract) ▪ Improved citizen confidence in accessing care (measured through complaints and compliments in short-term). <p>For the workforce:</p> <ul style="list-style-type: none"> ▪ Greater job satisfaction ▪ Greater integration with secondary care <p>For the organisation:</p> <ul style="list-style-type: none"> ▪ Improvements in recruitment and retention of Optometry workforce ▪ Improved resilience ▪ Increased capacity within Optometry services
<p>Alignment with workforce plans</p>	<p>The higher level work of the new Optometry contract (WGOS 3/4/5) which enables better integrated working with secondary care and the transfer of a number of patients to primary care, requires the Optometrists to hold higher qualifications (independent prescribing, higher glaucoma, medical retina qualifications). We are reasonably prepared for independent prescribing and medical retina, but there is a notable shortage of higher glaucoma qualified Optometrists across BCUHB (only 1 currently). Work will be undertaken during the course of this year to address this shortfall.</p>
<p>Alignment with Financial plans</p>	<p>The higher qualification described above required clinical placements in Ophthalmology. It can be challenging to meet the need for placements for all these qualifications locally. We are currently at advanced stages of discussion with the Health Board and WG re: a potential Teach and Treat Clinic for North Wales. This will be able to offer clinical placements in Independent Prescribing, Higher Glaucoma and Medical Retina. Furthermore, at capacity it could potentially offer appointments for c.3000 patients per year that may otherwise have been seen in Ophthalmology, this freeing up secondary care capacity. If the Teach and Treat Clinic for North Wales project is approved and successful, we are likely to have 2 years of revenue funding to run from September 2023. A business case for additional investment to support scale-up will be developed in Q3.</p>
<p>OPTIONAL</p>	
<p>Digital / Technology Opportunities</p>	<p>Q4 Milestone:</p> <ul style="list-style-type: none"> ▪ Business case for technologies and innovation to improve access to care and improve capacity for face-to-face consultants, developed. <p>Actions:</p> <ul style="list-style-type: none"> ▪ Scope range of opportunities for innovation and transformation of optometry services ▪ Explore opportunities for remote prescribing rather than visit a person’s GP.

Template 2d

Primary Care Access to Services: Dental Services

	Priority area(s)
Key focus should be on delivering	Increased access to dental services.
Baseline	The number of patients accessing a completed course of dental treatment in BCU HB during Q4 2022/23 and March 2023 will be used as a baseline for increased access. Figures for comparative all Wales data will be referenced.
Quarter 1:	<ul style="list-style-type: none"> ▪ Commence commissioning exercise for additional activity to replace lost activity from handed back/terminated contracts. The funding from these contracts remains in the GDS ring fenced budget and will be used for the recommissioning. <p>The commissioning will target underserved areas identified from the Oral Health Needs assessment, areas where contracts have been handed back and those traditionally under resourced areas. Looking for additional activity on current contracts or establishment of new practices.</p> <ul style="list-style-type: none"> ▪ Commence commissioning of Oral Surgery (OS) enhanced service and Tier 2 to commence Q4 2022/23 (dependent on HEIW rollout of T2 accreditation process). ▪ Support contract holders and review current contracted positions and activity levels.
▪ Milestones	<ul style="list-style-type: none"> ✓ Commence GDS commissioning exercise. ✓ Scope Oral Surgery commissioning exercise and commence governance process. ✓ Monthly and quarterly performance and activity reviews.
▪ Actions	<ol style="list-style-type: none"> 1. Oversee commissioning exercise, score and commence governance for contract award. 2. Paper through governance for award of OS contracts. 3. Engagement sessions with contract holders (group sessions and individual meetings).
Quarter 2:	<ul style="list-style-type: none"> ▪ Work with HEIW to discuss issues and blockers to overseas recruitment of dental staff. ▪ Complete scoring of commissioning exercise for additional GDS services. ▪ Finalise scope and funding for commissioning of Oral Surgery (OS) enhanced service and Tier 2 to commence Q4 2022/23 (dependent on HEIW rollout of T2 accreditation process). ▪ Review Urgent and non-urgent access sessions and commission additional sessions as required.

<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ✓ Complete discussion with HEIW on current challenges with overseas recruitment to add to the Dental Recruitment workstream and Train, Work, Live work. ✓ Write paper recommending variation and award of GDS contracts following scoring. ✓ Submit paper to governance process for award of GDS contracts. ✓ Complete paperwork for the OS commissioning exercise ✓ Hold engagement sessions with contract holders (group sessions and individual meetings).
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Paper into governance for award of GDS contracts. 2. Complete paperwork for the OS commissioning exercise and submit to governance for HB and WG approval 3. Engagement sessions with contract holders (group sessions and individual meetings).
<p>Quarter 3:</p>	<ul style="list-style-type: none"> ▪ Explore options for supportive model of contracting for salaried model of delivery.
<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ✓ Paper through HB governance outlining different methods of working with and supporting contractors to develop different models for managed, supported and salaried practices. ✓ Engagement sessions with contract holders (group sessions and individual meetings). ✓ Commence and score OS commissioning exercise
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Write paper on different methods of working/contract fulfilment. 2. Paper through governance for different methods of working. 3. Mid-Year Reviews with contract holders. 4. Commence and score OS commissioning exercise 5. Submit paper to governance process for award of OS contracts. 6. Engagement sessions with contract holders (group sessions and individual meetings).
<p>Quarter 4:</p>	<ul style="list-style-type: none"> ▪ Review current spend against budget and delivered activity levels. ▪ Review needs analysis across general and specialist services. ▪ Draw conclusions make plans and take action to rectify where funding within GDS budget allows. ▪ Review commissioning priorities and strategy against current delivery and issues.
<ul style="list-style-type: none"> ▪ Milestones 	<ul style="list-style-type: none"> ✓ Engagement sessions with contract holders (group sessions and individual meetings). ✓ Write paper recommending award of OS contracts. ✓ End of year position paper written and submitted to BCU Exec.
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Engagement sessions with contract holders (group sessions and individual meetings).

<p>Risks</p>	<ul style="list-style-type: none"> ▪ Commissioning exercise will take time to show benefits to population. If additional activity in an existing contract is awarded then this will require ramp up and recruitment time. If a new practice is commissioned it will need mobilisation time and support. Firmer risks around mobilisation timeframes arising from the commissioning exercise would be raised following award of contract. <p>Mitigation: Monitor access situation and use of urgent appointments in the under served areas. Where possible commission non recurrent flexible provision with local providers to the area.</p> <ul style="list-style-type: none"> ▪ There is the risk of handback of contracts with NHS provision ending and practices moving to private provision. This has been a long standing risk on the local risk register but its likelihood has increased due to the current uncertainty around contract reform and the future revised contract position. <p>Mitigation: Monitor the risk and work closely with contract holders to support and understand current issues within practices. Flexible and innovative commissioning of non-recurrent and recurrent services, as well as non-recurrent reduction of contract values.</p> <ul style="list-style-type: none"> ▪ There are issues around availability of dental workforce and attracting practitioners to the area can take time, limiting the ability to increase provision and improve access. This is a national issue and there is a generic risk on the HB risk register around primary care workforce. <p>Mitigation: We continue to review all roles and work in a whole system way to be able to offer blended Primary and Secondary care roles, as well as research and education opportunities. We are continuing to develop the offering of the North Wales Dental Academy as well as increasing links to Cardiff Dental School and the Welsh Oral and Dental Research Interest Network.</p> <ul style="list-style-type: none"> ▪ There is a risk to the wider dental services and pathways that an increase in access into GDS practices will bring an increase in referrals along pathways for Tier 2 and secondary care services. Concerns around Orthodontics, MaxFac and Restorative specialities that are already holding long waits and similar workforce issues. <p>Mitigation: Working in a coordinated way across the system to ensure that we are supporting delivery across all elements of the service in line with the system reform goals. This includes looking at Tier 2/Intermediate Tier and DWSI models.</p>
<p>Outcomes</p>	<ul style="list-style-type: none"> ▪ Increased access (measured against close of 2022/23 baseline as at December 2022 24 month rolling access around 40%). Historically we have provided approx. 49% 24 month rolling access in North Wales during the pandemic this fell to around 16%. We are aiming to increase to around 45% in 2023/24. ▪ Additional services commissioned (measured against close of 2022/23 baseline. As at 1/2/24 78 GDS contracts (19 UDA, 59 DCR at approx. £34m

	<p>committed spend). We have had 1 termination and 4 handbacks in 2022/23 (total value £1.26m) and we are expecting more requests for handbacks and some contract size reductions before the year end (potentially 4 known planned handbacks of up to £2m total).</p> <ul style="list-style-type: none"> ▪ New supportive models of working explored, documented and plans in place to roll out. ▪ Additional tier 2 services commissioned (measured against close of 2022/23 baseline number of contracts (currently 0))
<p>Alignment with workforce plans</p>	<p>Workforce issues around recruitment and retention are being looked at through a number of workstreams within dental. There is national work led by HEIW about dental workforce transformation and the recruitment of overseas staff.</p> <p>We are working with stakeholders through the North Wales Dental Academy to work on upskilling and training delivery in North Wales to retain staff in area.</p> <p>Courses for Dental Nurses and hygienists are running in North Wales, with plans for therapy training, further placement for under and post grad into North Wales from Cardiff Dental School.</p> <p>Investigating ways that we can support CDS and GDS practices in recruitment and attracting new staff, rather than churn of staff across practices within the area.</p>
<p>Alignment with Financial plans</p>	<p>All activity can be carried out within current funding, additional resourcing may be required in two forms in later stages of the plan:</p> <ol style="list-style-type: none"> 1. Additional funding to provide Primary Care dental activity to the population in GDS, PDS or Tier 2 contracts, to increase capacity above what the current funding allows (historically never given over 50% access in North Wales. Funds already set aside in the 2023/24 GDS budget plan for this activity. Additional funds will be added if additional contracts are handed back in year, or utilise underspend/clawback in year from ring fence budget. If additional funding is required this will be identified when reviewing outcomes against spend at quarterly Dental Contract Management meetings, or following discussion at dental contracting team meetings. 2. Access to capital funding to allow the HB Dental Team to explore the options around delivery of salaried services, to support the set-up of new practices on different models to attract practitioners to explore becoming practice owners in a supportive environment, to allow Health Board to purchase practices where current owners wish to retire and have tried and failed to sell to allow for managed/salaried practice options rather than loss of service in underserved areas.
<p>OPTIONAL</p>	
<p>Digital / Technology Opportunities</p>	<p>A replacement IT Patient Management Solution for CDS is required as our current system is a burning platform with a March 24 date for end of support by supplier. We will liaise with other Health Boards around CDS system</p>

	<p>provision, and work with Welsh Government Dental Directorate around the IHSC report into Dentistry recommendation that the feasibility of a single Patient Management System (PMS) be investigated for all Primary Care dental services.</p> <p>A system to deliver email/text confirmation and reminder of appointments for CDS is required and will be linked to the PMS scoping.</p> <p>An online repository for dual language (or multi language) Oral Health resources and information for patients that can be accessed by all patients and practices would be useful. We have asked Welsh Government Dental Directorate and Public Health Wales around a once for Wales repository but will investigate options for a local solution in the interim.</p>
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Template 3a

Urgent and Emergency Care: Implementation of a 24/7 urgent care service

	Priority area(s)																				
Key focus should be on delivering	Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability																				
Baseline	<p>The impact of Covid, together with challenges with GMS recruitment and retention means that people increasingly struggle to access same day GP appointments for urgent care needs. Consequently, individuals often choose to attend ED in order to have their urgent need met.</p> <p>Urgent Primary Care Centres (UPCCs) have been established in each of the IHCs in order to target on-the-day urgent primary care presentations, in order to create capacity within primary care and reduce unnecessary ED attendances. There have been over 15,000 referrals into the UPCCs since they commenced. Whilst it is difficult at this stage to measure impact on ED performance, engagement with individuals from across each of the IHCs suggests that had the UPCC not been available, they would have sought help from ED (12% in East; 20% in Centre, and; 21% in West).</p> <p>The models of delivery vary across each IHC area in terms of design, referral and access criteria, workforce and funding, thereby creating inequity in the system. A recent Peer Review exercise identified a number of crucial improvement actions needed in order to strengthen the provision of urgent primary care across the Health Board’s footprint, including governance and leadership; estates; workforce; criteria and model. A series of actions are in place to deliver against these actions in the short-term. As well as there being variation in the models of delivery across each of the IHCs, there are a wide range of urgent same day initiatives operating in addition to the UPCCs (i.e., OOH, MIUs, UTCs, GP Streaming, Clinical Assessment, SICAT), which again all operate to a different set of criteria. The result is fragmentation and siloed working both within and across IHCs, limited capacity within each of the individual service elements and stretched resources, leading to poor patient experience and outcomes.</p> <p>The table below highlights some of the differences between the models for same day urgent care in operation across the IHCs:</p> <table border="1"> <thead> <tr> <th></th> <th>East IHC</th> <th>West IHC</th> <th>Centre IHC</th> </tr> </thead> <tbody> <tr> <td>Model</td> <td>Health Board Model – covering 39 GP practices</td> <td>Health Board Model – covering 28 GP practices</td> <td>Cluster Model – covering 6 GP practices</td> </tr> <tr> <td>Referrals</td> <td>GP practices, ED, SICAT, OOH, MIU</td> <td>GP practices, ED, SICAT, OOH, MIU</td> <td>GP practices</td> </tr> <tr> <td>Services covered</td> <td>Telephone consultation, F2F, video consultation</td> <td>Telephone consultation, F2F, video consultation</td> <td>Telephone consultation, F2F</td> </tr> <tr> <td>Operating times</td> <td>9am – 6pm Monday to Friday</td> <td>9am – 6pm Monday to Friday</td> <td>9am – 6pm Monday to Friday</td> </tr> </tbody> </table>		East IHC	West IHC	Centre IHC	Model	Health Board Model – covering 39 GP practices	Health Board Model – covering 28 GP practices	Cluster Model – covering 6 GP practices	Referrals	GP practices, ED, SICAT, OOH, MIU	GP practices, ED, SICAT, OOH, MIU	GP practices	Services covered	Telephone consultation, F2F, video consultation	Telephone consultation, F2F, video consultation	Telephone consultation, F2F	Operating times	9am – 6pm Monday to Friday	9am – 6pm Monday to Friday	9am – 6pm Monday to Friday
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Operating times	9am – 6pm Monday to Friday	9am – 6pm Monday to Friday	9am – 6pm Monday to Friday																		

	Planned monthly capacity	2688	1120	600
	Workforce	Therapist(B7) 2.54wte GP/ ANP 3.0wte ACP/APP 2.4wte NP (b7) 1.0wte	Therapist (B7) 2.0wte GP 1.0wte ANP (b8a) 3.5wte	AP/APP (b8a) 0.8wte NP (b7) 0.8wte GP 0.2wte Trainee ACP 1.0wte
<p>As a consequence of the above, we have identified the need to transform our approach to and delivery of urgent same day services across north Wales, and to develop an approach that is consistent, fully integrated within the wider system, has a clear identity, purpose and function, and that is seamless and accessible to the public. Limited funding and challenges with recruitment and workforce capacity means that in order to deliver transformational change at the level that is required, we need to look at how we use our existing resources differently in order to maximise our assets and reduce duplication and waste in the system. This model will need to be fully aligned to the 6 Goals Programme for Urgent and Emergency Care (and in particular Goal 2), and consistent with the Strategic Programme for Primary Care’s Framework for Urgent Primary Care.</p> <p>Work to consider what our model and approach to urgent same day care services needs to look like has already started, and a high-level plan on a page containing a series of principles has been shared with, and approved by IHC Directors, and will help underpin our approach to service development moving forward. Central to our approach is a need to consolidate a number of same-day urgent care within each IHC. We have identified the need to map each of the different services in terms of their SOP, interrogate the activity data, and agree which service elements to consolidate. In addition, we have identified the need to map the workforce available within each of the services in order to understand whether, once combined, we have a sufficiently sized workforce to support delivery of a single 24/7 same day urgent care service in each of the IHCs, and if not, what additional resources are required.</p> <p>Further work is therefore required over the course of this next year, to build a robust model for 24/7 same day urgent care that delivers positive outcomes for patients, supports GMS, and helps reduce inappropriate demand on ED.</p>				
Quarter 1:				
Milestones		Full system review of urgent same day services operating across the Health Board finalised, with clear recommendations for future delivery and approach		
Actions		<ul style="list-style-type: none"> ▪ Primary care team to undertake whole systems service review and map existing resources and assets, processes, systems, criteria, etc., across each site ▪ Instigate regular check points to ensure actioning of urgent issues is undertaken and not delayed by review process. 		
Quarter 2:				
Milestones		Pan-BCUHB model for same day urgent care co-designed, based on findings of review		
Actions		<ul style="list-style-type: none"> ▪ Model co-designed with IHCs and wider system partners, including SOP, access criteria and standardised pathways, 		

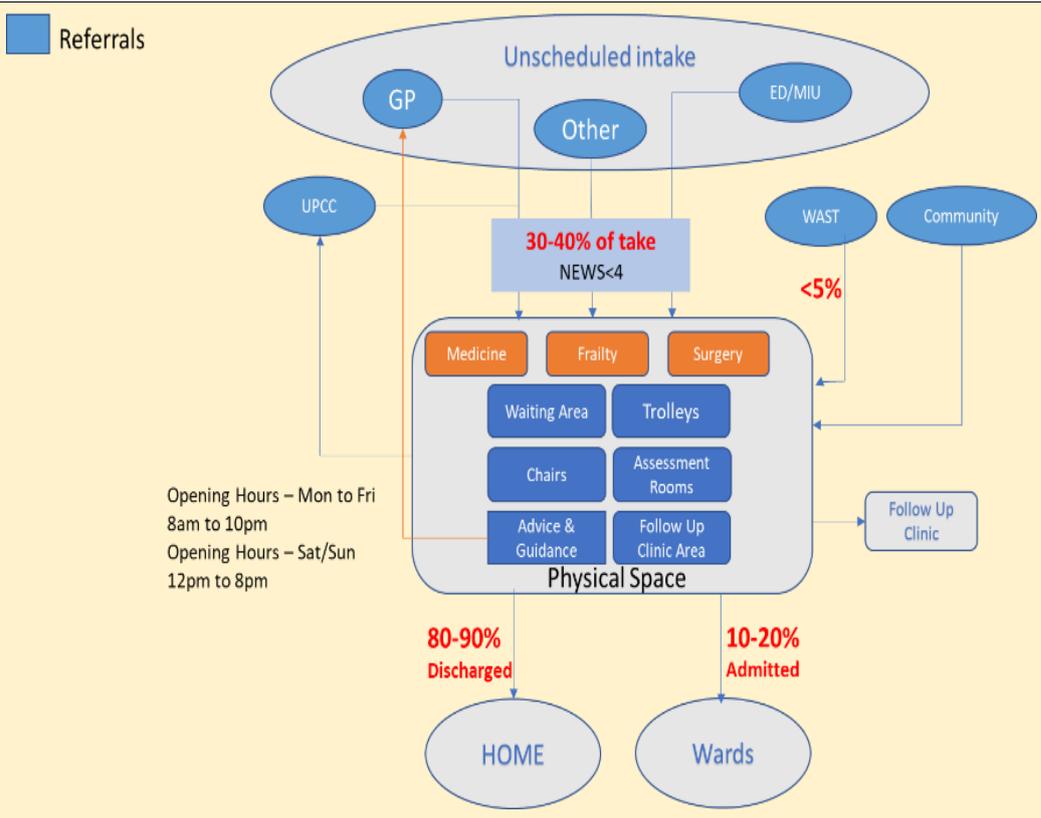
	<ul style="list-style-type: none"> ▪ Agree which urgent same day services to consolidate as part of new model, ▪ Map available workforce against proposed model to understand whether new approach can be delivered within existing resources, or whether additional investment is required, ▪ Options appraisal for new model drafted and shared with IHCs and HBLT, ▪ Final pan-BCUHB model and approach signed-off, ▪ Engage with WOD and Trade Unions to discuss approach and likely workforce implications, ▪ Commence staff consultation over proposed model and approach ▪ Commence consultation and engagement over proposed model with citizens and stakeholders. ▪ Implementation of 'quick wins' identified as part of the review work undertaken in Q1.
Quarter 3:	
▪ Milestones	Local IHC delivery plans developed, outlining how they will operationalise agreed model and approach for same-day urgent care
▪ Actions	<ul style="list-style-type: none"> ▪ IHCs to develop local delivery plans outlining how they will implement agree pan-BCU model, locally, and based on feedback received as part of workforce and public consultation, ▪ Develop performance framework to measure activity, success, impact and benefits, ▪ Determine Estates needs and scope opportunities for Capital investment, ▪ Implementation of 'quick wins' identified as part of the review work undertaken in Q1.
Quarter4:	
▪ Milestones	<p>Consistent SOP and access criteria for same day urgent care operating across each IHC</p> <ul style="list-style-type: none"> ▪ <i>Evidence of a shift towards re-balance between routine, urgent and emergency care</i>
▪ Actions	<ul style="list-style-type: none"> ▪ IHCs commence implementation of new model and approach.
Risks	<p>The proposed model represents a significant workforce change programme – there is a risk that issues with consolidating the workforce from across the range of services might create delays. In terms of mitigation, we will engage early with WOD teams and Trade Unions with regards our proposed plans and work collaboratively to identify a detailed workforce consultation and engagement plan. Risks will be monitored through the 6 Goals Programme Board and/ or Primary Care Programme Board, with escalation up to the BAF / Corporate Risk Register where required.</p>
Outcomes	<p>OUTPUTS & IMMEDIATE OUTCOMES;</p> <ul style="list-style-type: none"> ▪ Comprehensive understanding of services and resources available across the system ▪ Solid evidence-base upon which to make commissioning and/ or service development decisions ▪ Single approach/ set of principles for urgent same day care in place across the 3x IHCs ▪ Improved integrated working across primary, community and secondary care

	<ul style="list-style-type: none"> ▪ Reduction in siloed working and duplication of effort ▪ Maximisation of Health Board resources ▪ Standard set of performance indicators in place to measure activity, success and impact <p>LONGER-TERM OUTCOMES:</p> <p>For citizens:</p> <ul style="list-style-type: none"> ▪ Improved experienced for same day urgent care services ▪ Seamless integrated pathways ▪ Reduced duplication <p>For the workforce:</p> <ul style="list-style-type: none"> ▪ Development of opportunities for staff, making the best use of skills in our workforce to support sustainability ▪ Development of clear sense of identity ▪ Improved morale <p>For the organisation:</p> <ul style="list-style-type: none"> ▪ Increased capacity in primary care ▪ Improved GMS sustainability ▪ Improved recruitment and retention ▪ Reduction system waste/ more effective use of resources ▪ Greater system integration
<p>Alignment with workforce plans</p>	<p>As outlined in the milestones listed above, work will be undertaken in order to map the available workforce and skills mix etc. against the requirements of our new model. The expectation is that we already have sufficient staff within the system to support the delivery of this new way of working, albeit with some re-alignment. However, mapping work will enable us to confirm this, and / or plan for any additionality required</p>
<p>Alignment with Financial plans</p>	<p>The improvements will be achieved by consolidating the existing range of urgent same day initiatives into one consolidated service/ approach within each IHC. This will enable existing resource commitments to be maximised. Where the mapping work described above indicates a need for additional workforce to deliver the model, a Business Case will be developed to support further investment.</p>
<p>OPTIONAL</p>	
<p>Digital / Technology Opportunities</p>	<p>Develop proposals to support digital innovation and transformation within urgent same day care provision:</p> <ul style="list-style-type: none"> ▪ We have identified the value of front door screening to ensure people are appropriately signposted away from ED and to the correct community service (where appropriate). Whilst in some areas this front door screening may be undertaken by a GP, there is scope for the function to be undertaken digitally. We will work with our Digital Team, SBRI and industry leads to identify digital streaming options. ▪ The lack of interoperability between health board systems represents a significant challenge to integrated working. As part of this programme we will scope the development of a 'digital/ IT bridge' to enable inter-operability of range of primary care, community, and secondary care electronic systems Business cases will be developed in order to support digital innovation.

Template 3b

Urgent and Emergency Care: Same Day Emergency Care (SDEC)

	Priority area(s)
<p>Key focus should be on delivering</p>	<p>Implementation of Same Day Emergency Care service that complies with the following:</p> <ul style="list-style-type: none"> ▪ Open 5 days a week moving to 7 days a week 12 hours a day by end of Q2. ▪ Accessible at key times by emergency departments in line with the demand profile of each hospital site for the ambulatory patients that are managed in the waiting rooms or corridors. ▪ Direct access and bypasses Emergency departments for ambulatory patients. ▪ Delivers a service at minimal with medical and surgical specialities within same day care. ▪ Accessible to by WAST paramedics/nurses as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. <p>Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme</p> <hr/> <p>The current SDEC provision varies across the 3 acute sites in BCU, with respect to capacity, space and opening times.</p> <p>Funding was received by Welsh Government in 2021 to enhance the SDEC services and each acute site has recruited resources into their respective services in line with allocated funding.</p> <p>Bedding into trolley spaces remains a key challenge when sites face extreme pressure at the front door and especially when infectious conditions are at high levels. The following diagram illustrates the optimum SDEC model that BCU would wish to adopt.</p>



Each BCU site will deliver a planned programme to deliver a 7 day SDEC over the next 2 years. During 2023/24 the 3 DGH sites will focus on the following key enabling and improvement programmes:

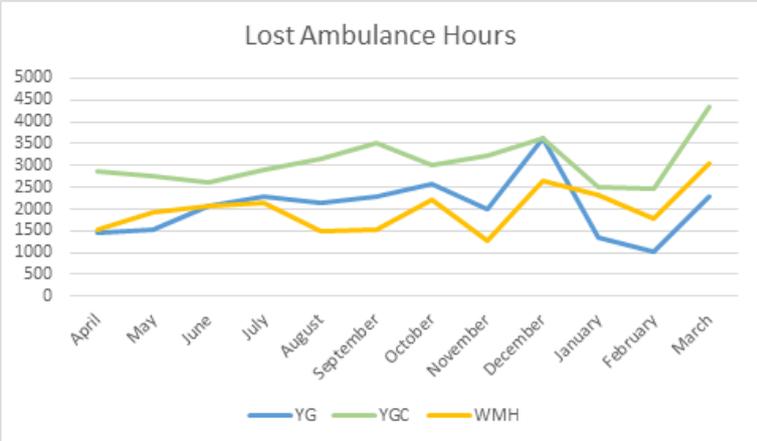
1. Focus on implementation of a data standard for all three units in line with the guidance from GIRFT and accurate performance reporting
2. Focus on local initiatives on all 3 sites to look at SDEC trolley protection and avoid bedding in key SDEC areas and develop process to capture 'bedding' in SDEC
3. Develop plan in conjunction with WAST to support WAST Paramedics/Nurses direct referrals to SDEC
4. Develop plans to review direct ED pathways to SDEC's
5. Develop evidence based pilots for extended opening hours in SDEC across North Wales.
6. Develop options appraisal on delivering SDEC services during weekends on all 3 sites and specialties
7. Develop plan to strengthen clinical leadership on all 3 sites by a monthly SDEC clinical/operational meeting that will allow clinicians to exchange information and ideas.

Baseline	<p>The baseline from April 2023 will use current SDEC dashboards with plan to include bedding days and an emphasis on follow up data. There will be an increased focus on correcting reporting and use of either a modified WPAS or Symphony based solution to support standards based approach across the 3 SDEC sites.</p> <p>There will be national benchmarking KPI's to support SDEC once modelling has been agreed by Q2 2023/204 that are likely to be inclusive of:</p> <ol style="list-style-type: none"> 1) 95% KPI for Triage within 15 minutes of arrival 2) 95% KPI time to clinician assessment < 60minutes. 3) 80% Discharge rate profile. 4) 75% of patients with a News score <4 accepted directly to SDEC (Pending clinical presentation. 5) 10% of ambulances arrivals direct to SDEC.
Quarter 1:	
▪ Milestones	Improve SDEC performance reporting and strengthen leadership
▪ Actions	<ol style="list-style-type: none"> 1. Develop robust process for accurately recording 'bedding' within SDEC facilities on all sites. 2. Work with Command and Control to develop process for SDEC protection, with full support for Hospital Full Capacity protocols. This will require all sites to raise an incident when trolley spaces are used for beds and will require development of DATIX dashboard. 3. Set up SDEC pan BCU workshop with clinicians and operations to discuss SDEC leadership development and actions plans to support 7 day SDEC. 4. Develop an SDEC leadership group inclusive of Clinical/Nursing/Operational and AHP staff. 5. Plans for each site to ensure data inputting and coding reflects referrals, discharges and follow-ups for all specialities on an electronic system.
Quarter 2:	
▪ Milestones	<p>Pilot extended working in SDEC with full tracking on performance to create evidence for ongoing business case development. Review workforce models to support SDEC sustainability. (KPI's to be agreed via Benchmarking and Goal 2 July 2023)</p>
▪ Actions	<ol style="list-style-type: none"> 1. Monitor operating hours for SDEC for Monday to Friday for a pilot period and capture all evidence re impact and outcome measures. 2. Implement a pilot of using Symphony EPR solution on one site – progress IT mandate. 3. Review WAST based referrals and develop in-conjunction with WAST a plan to introduce direct WAST/Paramedic referrals. Work with SDEC leads and WAST leads to create high level plan per site. This will require trolley space protection.

	<ol style="list-style-type: none"> 4. Review of job planning with speciality consultant and junior doctor workforce to evaluate potential of covering additional. 5. Visit other effective SDECs to review processes and workforce models.
Quarter 3:	
▪ Milestones	Evidence based tracking for weekend working in SDEC
▪ Actions	<ol style="list-style-type: none"> 1. Pilot of Saturday working with clear performance information on specialties. 2. Pilot of Sunday working with clear performance information on specialties. 3. Develop plans for direct ED based referrals to SDEC on all sites. 4. Develop plans for direct GPOOH referrals to SDEC.
Quarter4:	
▪ Milestones	Review of 7 Day SDEC business case and plan for 2024/25
▪ Actions	<ol style="list-style-type: none"> 1. Review all evidence from pilots for extended working in week. 2. Review all evidence from pilots for extended working on weekends. 3. Review and agree workforce models.
Risks	<p>A review of budgets will be required to support a 7-day service.</p> <p>Mitigation: review pilot of extended working hours in week and weekend and review impact on performance. Evidence to be used to support a further business case if required. Review of Job planning to ensure accurate planning for demand.</p> <p>Trolleys are 'bedded' in cases of extreme pressure and high infection rates resulting in reduced impact of SDEC and resulting drop in performance and potential admissions</p> <p>Mitigation: develop a planned reduction in SDEC space but with enough capacity to maintain SDEC services. Hospital full protocols to be amended to remove/reduce the usage in periods of extremis.</p> <p>A shortage of Acute Medical consultants and Junior Doctors nationally.</p> <p>Mitigation: review workforce models in line with using Advanced Nurse Practitioners, Advanced Care Practitioners and Physician Associates with senior consultant oversight</p>
Outcomes	<p>Evidence relating to attendance increases and discharge increases through extended opening hours in SDEC.</p> <p>Less admissions as a result of securing SDEC spaces when sites in extreme pressures Initial focus on 10% reduction increasing to 15% by Q4</p> <p>Ambulance handover delays reduced due to direct WAST referrals to SDEC – 5%</p> <p>SDEC follow up's accurately recorded and reported correctly.</p> <p>Improved patient experience.</p>

Alignment with workforce plans	Irrespective of funding there are challenges with regards to consultant availability and current additional costs aligned with Nursing.
Alignment with Financial plans	<p>Funding of £1.6M was provided to BCU in 2021 to support SDEC development.</p> <p>The original request was for £3.108M for 7 day SDEC, this leaving a £1.5M gap for a seven day service.</p> <p>To deliver the optimal model the level of funding will exceed £1.5M based on current assessments.</p>
OPTIONAL	
Digital Technology Opportunities	<p>/</p> <p>Symphony to be used as a single EPR system with ED which will provide improved reporting and efficiencies between SDEC and ED</p> <p>Consultant Connect could be used to support Advice and Guidance for referrals into SDEC – GP’s, Paramedics, WAST.</p>

Template 3c Urgent and Emergency Care: Handover Waits

<p>Key focus should be on delivering</p>	<p>Priority area(s) Health boards must honour commitments that have been made to reduce handover waits</p>																																																																																												
<p>Baseline</p>	<p>The baseline reduction from 2023 onwards is 20% reduction in lost hours per quarter, with Zero tolerance to delays >4hrs by March 2024.</p> <div style="text-align: center;">  <p>Lost Ambulance Hours</p> <table border="1"> <caption>Estimated data for Lost Ambulance Hours</caption> <thead> <tr> <th>Month</th> <th>YG</th> <th>YGC</th> <th>WMH</th> </tr> </thead> <tbody> <tr><td>April</td><td>1500</td><td>2800</td><td>1500</td></tr> <tr><td>May</td><td>1500</td><td>2500</td><td>1800</td></tr> <tr><td>June</td><td>2000</td><td>2800</td><td>2000</td></tr> <tr><td>July</td><td>2200</td><td>3000</td><td>2000</td></tr> <tr><td>August</td><td>2000</td><td>3200</td><td>1500</td></tr> <tr><td>September</td><td>2200</td><td>3500</td><td>1500</td></tr> <tr><td>October</td><td>2500</td><td>3000</td><td>2000</td></tr> <tr><td>November</td><td>2000</td><td>3200</td><td>1200</td></tr> <tr><td>December</td><td>3500</td><td>3500</td><td>2500</td></tr> <tr><td>January</td><td>1200</td><td>2500</td><td>2000</td></tr> <tr><td>February</td><td>1000</td><td>2500</td><td>1800</td></tr> <tr><td>March</td><td>2200</td><td>4200</td><td>3000</td></tr> </tbody> </table> </div> <div style="text-align: center; margin-top: 20px;">  <p>4 hour handover delays</p> <table border="1"> <caption>Estimated data for 4 hour handover delays</caption> <thead> <tr> <th>Month</th> <th>YG</th> <th>YGC</th> <th>WMH</th> </tr> </thead> <tbody> <tr><td>Aug 2022</td><td>200</td><td>500</td><td>650</td></tr> <tr><td>Sept 2022</td><td>220</td><td>600</td><td>750</td></tr> <tr><td>Oct 2022</td><td>300</td><td>600</td><td>800</td></tr> <tr><td>Nov 2022</td><td>200</td><td>550</td><td>650</td></tr> <tr><td>Dec 2022</td><td>400</td><td>800</td><td>1050</td></tr> <tr><td>Jan 2023</td><td>100</td><td>350</td><td>550</td></tr> <tr><td>Feb 2023</td><td>100</td><td>300</td><td>500</td></tr> <tr><td>Mar 2023</td><td>250</td><td>750</td><td>1050</td></tr> <tr><td>Apr 2023</td><td>150</td><td>500</td><td>800</td></tr> </tbody> </table> </div>	Month	YG	YGC	WMH	April	1500	2800	1500	May	1500	2500	1800	June	2000	2800	2000	July	2200	3000	2000	August	2000	3200	1500	September	2200	3500	1500	October	2500	3000	2000	November	2000	3200	1200	December	3500	3500	2500	January	1200	2500	2000	February	1000	2500	1800	March	2200	4200	3000	Month	YG	YGC	WMH	Aug 2022	200	500	650	Sept 2022	220	600	750	Oct 2022	300	600	800	Nov 2022	200	550	650	Dec 2022	400	800	1050	Jan 2023	100	350	550	Feb 2023	100	300	500	Mar 2023	250	750	1050	Apr 2023	150	500	800
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<p>Quarter 1:</p>																																																																																													
<p>▪ Milestones</p>	<p>Embedding of the Integrated Commissioning action plan (ICAP) plan in conjunction with National Collaborative Commissioning Unit (NCCU)</p>																																																																																												
<p>▪ Actions</p>	<ul style="list-style-type: none"> ▪ Developing an electronic dashboard to support key actions in line with ongoing national developments led by the Delivery Unit (DU). ▪ Ensuring all Emergency Departments are completing agreed actions for escalation in a timely fashion. (ED Full protocols) 																																																																																												

	<ul style="list-style-type: none"> ▪ 20% reduction in lost hours for Quarter 3 by utilising agreed actions that account for over 30% of total lost hours via the motion time study completed in 2021 ie: forecasting of arrivals and developing flow with a minimal of 2 moves/hr (minimal) ▪ Ensuring all IHC's are sighted on the special measures journey as agreed in IQPD for Urgent and Emergency care for local planning consideration.
Quarter 2:	
▪ Milestones	Zero tolerance to delays >4hrs to offload.
▪ Actions	<ul style="list-style-type: none"> ▪ ED Full protocols go live across all three Emergency departments. ▪ Hospital full protocols go live across all three acute sites that have clear actions for the integrated health communities and social care providers to support de-escalation in a timely fashion. ▪ Direct access to Same Day Emergency Care (SDEC) Acute Medical units for Welsh Ambulance Emergency service staff at point of referral for ambulatory patients. ▪ Further 20% reduction in lost hours by the end of Quarter 2.Utilising alternative pathways i.e. SDEC for ambulatory arrivals. ▪ Embedding Fit to Sit criteria for those low acuity patients post review by ED staff.
Quarter 3:	
▪ Milestones	Physician Triage and Assessment System (PTAS) utilisation in all 3 Health economies by Single Integrated Clinician Assessment Team (SICAT)
▪ Actions	<ul style="list-style-type: none"> ▪ Reduction in Care home / Nursing Home conveyances for chronic complaints. ▪ 10% Reduction in ambulance attendances to Care Home / Nursing homes approximately 300 / Month across BCUHB ▪ Reduction in conveyances owing to social concerns. ▪ 5% reduction in Ambulance conveyances and attendances to home address owing to the ability to screen the calls prior to an ambulance being sent. ▪ Roll out of Immedicare across North Wales to support the care home demand during OOH and Weekends for clinical support
▪ Milestones	Development of a 24/7 call hub with SICAT to support Six goals for urgent and emergency care by Quarter 3
▪ Actions	<ul style="list-style-type: none"> ▪ Business case development to support a 24/7 hub that has access to all pathways and IHC services to reduce ambulance conveyances as part of the system wide review of additional services to support unscheduled care with managing care closer to home. ▪ Service model to have access to senior Clinician along with Specialist nursing in reach for advice.

	<ul style="list-style-type: none"> Service provision would reduce a further 10% of arrivals to the Emergency department by Quarter 4.
Risks	<p>As part of the special measures review it has been agreed for BCUHB to focus on Zero tolerance to ambulance delays >4hr by March 2024. This is being monitored via the special measures framework that is shared with executives and national external stakeholders.</p> <p><u>BAF 1.2</u> Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users.</p> <p>Current mitigation is being developed through the six goals programme for urgent and emergency care to support "Right patient, Right place approach.</p> <p><u>BAF 1.3</u> Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience</p> <p>Current mitigation is being managed with support from the national delivery unit as part of the performance accountability reviews to ensure respective Integrated health communities are sighted on the their red flag with demand and ensuring clear ability to support de-escalation as an example – Hospital full protocols that demonstrate a rising tide approach but would actively support de-escalation.</p> <p><u>Risk 4613</u> - Extended corridor nursing due to demand of arrivals and lack of flow through the Emergency department.</p> <p>Current mitigation, additional funding has been received to support increasing staffing within the emergency departments to ensure safe staffing.</p> <p><u>Risk 3873</u> – Timely care, due to ongoing delays there will be periods were relevant investigations/assessments may be delayed.</p> <p>Current mitigation is that in line with Royal College of Emergency Medicine (RCEM) statement that senior clinicians can assess and commence interventions whilst awaiting capacity within the Emergency departments to reduce the risk of delays.</p> <p><u>Risk 2968</u> – Gridlocked Emergency departments due to lack of flow.</p> <p>Current mitigation through the Six goals for urgent and emergency care goal 3 is the development of an ED full protocols alongside hospital full protocols to ensure on going flow out of the ED's to support demand.</p>
Outcomes	<p>20% reduction in lost hours per Quarter aligned with ICAP planning for BCUHB.</p> <p>Improved red response to support vehicle utilisation links with WAST as part of the ICAP.</p>

	<p>75% Reduction in delays for intra hospital transfers for live saving/ life changing emergencies.</p> <p>10% reduction in conveyances that could be managed closer to home or utilizing alternative pathways in the community.</p> <p>Outcomes are monitored via IQPD/ICAP and NHS Executive meetings along with internal access meetings.</p>
<p>Alignment with workforce plans</p>	<p>Irrespective of funding there are challenges with regards to staffing availability post COVID pandemic and during the current social care crisis which is resulting in vacancies across North Wales.</p> <p>Additional funding has been allocated to Unscheduled care across North Wales to increase Emergency department staffing (Clinical/Nursing/AHP' and Admin) for which majority of posts have been recruited into with current gaps due to service leavers.</p> <p>National funding to support Same day emergency care capacity is non-reoccurring therefore; the ability to recruit into a sustainable workforce is difficult unless the IHC's are prepared to go at risk in the current financial climate.</p>
<p>Alignment with Financial plans</p>	<p>Emergency department business case funding has been released to ensure ability to provide a nurse to support ambulance off loading and triage for all three Emergency departments and assurances from all IHC's that positions have been recruited to.</p> <p>The ability to signpost patients to the correct area does not carry any financial gain in the first instance but over a period of time will reduce the cost aligned to Bed days lost, care packages being ceased and recommenced.</p> <p>There will be a financial improvement to support WAST with the reduction in delays shift over runs/missed meal breaks costs will reduce.</p>
<p>OPTIONAL</p>	
<p>Digital / Technology Opportunities</p>	<p>Utilization of national ODU dashboard to support identifying demand prior to arrival with ETA's to support flow.</p> <p>Electronic Patient Report Form (EPRF) access to allow case review prior to arrival to support alternative pathways as per Goal 2.</p> <p>Consultant connect is already instigated for direct access for ambulance crews and being increased with new pathways.</p> <p>Symphony utilisation as means of communication with Site managers and ED nurse in charge to allow reduction in time lost for notifying of bed availability.</p>

Template 4a

Planned Care, Recovery, Diagnostics and Pathways of Care

Priority 1: Delivery of Milestones for Outpatient Assessment and Planned Care Waits

Planned Care Priority 1	Priority area(s)
Key focus should be on delivering	52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024 for New Outpatient Appointments
Baseline	<i>Forecasts will be populated against the volume of patients waiting over 52 weeks for Stage 1 and number of patients waiting over 104 weeks for any stage of their pathway.</i>
Quarter 1:	
<ul style="list-style-type: none"> Milestones 	<p><i>Target - No patients waiting over 52 weeks for Stage 1 and no patients waiting over 104 weeks for any stage of their pathway.</i></p> <p>We forecast that at Q1 we will have 9,972 people waiting over 52 weeks and 8,616 waiting over 104 weeks</p>
<ul style="list-style-type: none"> Actions 	<ol style="list-style-type: none"> We will monitor by specialty and target actions at those specialties with the highest numbers of patients overdue for stage 1. We will undertake routine administrative and clinical validation so that the only people on a waiting list are the people who need to be on one
Quarter 2:	
<ul style="list-style-type: none"> Milestones 	<p><i>Internal target - No patients waiting over 46 weeks for Stage 1 and no patients waiting over 94 weeks for any stage of their pathway.</i></p> <p>We forecast that we will have removed 2,000 patients from this cohort by the end of Q2 with 9,122 patients still waiting.</p>
<ul style="list-style-type: none"> Actions 	<ol style="list-style-type: none"> We will continue to monitor performance against these priorities via the Planned Care Business Intelligence (BI) dashboard at weekly Health Board 'Access' meetings. Continued clinical prioritisation of those waiting longest and/or at greatest risk from deterioration. We will be making significant headway implementing 'Getting it Right First Time' (GiRFT) recommendations, which will in turn, assist with delivery that is more efficient.
Quarter 3:	
<ul style="list-style-type: none"> Milestones 	<p><i>Internal target- No patients waiting over 41 weeks for Stage 1 and no patients waiting over 84 weeks for any stage of their pathway.</i></p>

Planned Care Priority 1	Priority area(s)
	<p>We know that every year, winter pressures cause us major delivery issues with access to beds for inpatient procedures. Because of this, and recognising that not every patient is suitable for day case procedure, we will still have not met the target and we have revised our forecast accordingly to take account of seasonal variation.</p> <p>However, we will be making progress in the right direction, although not as fast as we would like. To that end, by Q3, we forecast that we will have:</p> <ul style="list-style-type: none"> ▪ Removed over 15,858 follow ups from the waiting list, ▪ Seen 3,700 waiters for diagnostic tests, ▪ 1,620 fewer people waiting more than 2 years for treatment, ▪ 5,000 fewer people waiting more than 36 weeks for a new outpatient appointment.
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Performance against these 2 priorities continue to be monitored via a BI dashboard at a weekly performance meeting. 2. Seek to increase rates of day case surgery to mitigate the known pressure on beds. 3. Ensure GiRFT recommendations are being implemented.
<p>Quarter 4:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p><i>Target - No patients waiting over 36 weeks for Stage 1 and no patients waiting over 75 weeks for any stage of their pathway.</i></p> <p>We forecast that we will have removed approximately 5,000 people from this cohort, but will still have 17,000 patients waiting more than 36 weeks for a first appointment and a further 10,000 who will have been waiting more than 52 weeks.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Performance against these priorities are monitored via a BI dashboard at weekly performance meeting. 2. Patients prioritised on the basis of clinical risk. 3. Ongoing validation activity.
<p>Risks</p>	<p>Staffing – Being able to recruit to vacancies* * <i>see workforce section</i></p> <p>Reduced Funding – Limited funding available to deliver additional capacity above core i.e. limitations on the extent to which the service can utilise additional capacity via outsourcing/insourcing.</p> <p>Capacity – Core capacity is not protected from seasonal variation but we will develop robust winter plans over the summer to increase and protect activity levels (conversion to day case, provision of more community follow up activity)</p> <p>We are seeking to implement a system for electronic referral, booking and scheduling. This will ensure that we can:</p> <ul style="list-style-type: none"> - Better manage referrals and only have people on lists who need to be on there.

Planned Care Priority 1	Priority area(s)
	<ul style="list-style-type: none"> - Ensure that our booking and scheduling is to available capacity (i.e. not based on historic activity levels, which do not reflect our true capacity).
Outcomes	<p>Waiting list and waiting times will decrease but we will not achieve any Ministerial targets in this year. What remains of key importance is reduction year on year, and that the reduction is sustainable.</p> <p>However:</p> <p>Our cancer performance will continue to improve and we expect that by the end of this financial year, we will be seeing 70% of cancer referrals starting their first definitive treatment within 62 days of referral (regardless of the referral route).</p> <p><i>See also Ministerial Template for Cancer priority 1.</i></p>
Alignment with workforce plans	<p>Our demand and capacity plans align with current vacancies.</p> <p>We continue to develop alternative roles to backfill specialist vacancies (e.g. clinical endoscopists instead of consultant gastroenterologists) and the use of more advanced practitioner roles in therapies to reduce the burden of follow up activity and remove this from consultant surgeons (e.g. using specialist practitioners in physiotherapy to look after orthopaedic follow up activity).</p>
Alignment with Financial plans	<p>Our demand and capacity plans align with financial plans and the cost to deliver these plans.</p>

Template 4b

Planned Care, Recovery, Diagnostics and Pathways of Care

Priority 2: Address Capacity Gaps in Specific Specialties

Planned Care Priority 2	Priority area(s)
Key focus should be on delivering	Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity
Baseline	<i>We have identified the capacity required to prevent further growth in waiting list volumes within each speciality and by point of delivery.</i>
Quarter 1:	
▪ Milestones	Demand and capacity modelling completed for 2023/24.
▪ Actions	<ul style="list-style-type: none"> ▪ Phase 1 completed before April 1st 2023 (Demand and capacity modelling by site, speciality and at Health Board Level). ▪ Phase 2 completed before April 1st 2023 (Forecasts to meet Priority 1 populated and uploaded into the BI dashboard for performance management throughout the year). ▪ Action plans agreed with solutions to mitigate gaps including reports/recommendations i.e. GiRFT, Royal College of Surgeon (RCS), the Pyott review, Audit Commission inter alia. ▪ Action plans monitored against to deliver key deliverables.
Quarter 2:	
▪ Milestones	Planned Care BI Dashboard to reflect all Key Performance Indicators (KPI's) linked with the Performance Team to facilitate management against KPI's.
▪ Actions	<ul style="list-style-type: none"> ▪ Planned Care Access meeting to be revised to reflect delivery of KPI's. ▪ KPI's agreed, to include priority 1, reduction of long waiting patients across all stages and reduction of follow up waiting list with increase in the number of patients being discharged, or placed on an SOS/PIFU pathway ▪ Upload forecasts into BI dashboard of See on Symptoms (SOS)/Patient Initiated Follow Up (PIFU).
Quarter 3:	
▪ Milestones	<p><i>Target - reduce follow up by 25% against 2019/20 levels by October 2023 and repurpose that capacity</i></p> <p>We will not reduce follow up levels by 25% across all specialties but are working towards achievement for dermatology, gynaecology and orthopaedics with follow up activity being converted to treatment capacity for stage 4 waits.</p>
▪ Actions	<ul style="list-style-type: none"> ▪ Monitor reduction of follow up waiting list with increase in the number of patients being discharged, or placed on an SOS/PIFU pathway and track quarterly count of patients being discharged to SOS/PIFU. ▪ Use Q3 position to facilitate demand and capacity modelling for 2024/25.

Planned Care Priority 2	Priority area(s)
Quarter 4:	
<ul style="list-style-type: none"> ▪ Milestones 	Continue actions identified to reduce gaps identified and increase the number of patients placed on an SOS/PIFU pathway.
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Include the outstanding gaps within the 2024/25 demand and capacity planning. ▪ Use the % of patients placed on an SOS/PIFU pathway as a starting point for 2024/25 to increase this further.
OPTIONAL	
Risks	See comments for Priority 1, additionally: Staffing – Being able to recruit to vacancies, Funding – To deliver capacity above core capacity, Capacity – Core capacity is not protected from the impact of operational pressures (e.g. strike action), Referral rate – Increased number of referrals.
Outcomes	Number of patients placed on an SOS/PIFU pathway will increase. Reduced outpatient follow up will release time for procedures and first appointment activity.
Alignment with workforce plans	See comments for Priority 1, additionally: Our demand and capacity plans align with current vacancies, long-term absence. We have identified areas of national staffing shortage.
Alignment with Financial plans	See comments for Priority 1, additionally: Our demand and capacity plans align with financial plans and the cost to deliver these plans.
OPTIONAL	
Digital / Technology Opportunities	See comments for Priority 1, additionally: Business Intelligence dashboards created to facilitate waiting list management and performance monitoring. Demand and capacity planning models linked to PTL management opportunities. AI opportunities to facilitate validation, waiting list and PTL management, automated booking and text correspondence. AI automation of follow up waiting list linked to SOS/PIFU.

Template 4c

Planned Care, Recovery, Diagnostics and Pathways of Care

Priority 3: Implementation of Regional Diagnostic Hubs

Planned Care Priority 3	Priority area(s)
Key focus should be on delivering	<p>Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024</p> <p>Our vision for diagnostic services includes providing ambulatory diagnostics off acute hospital sites that are organised and delivered on a regional footprint.</p> <p>The focus on delivering this key ambition is to ensure that services that can be organised in this way, on a regional footprint, are being planned in that way. Achieving sustainability for diagnostics will also reduce secondary care waiting times and meet waiting time ambition over the medium term.</p>
Baseline	<i>Forecasts will be populated against the volume of patients waiting over 8 weeks for a diagnostic procedure.</i>
Quarter 1:	
▪ Milestones	Develop a plan for which diagnostic services can be organised regionally and delivered away from acute hospital sites.
▪ Actions	1. Performance and development against this priority is monitored via the planned care programme
Quarter 2:	
▪ Milestones	Prioritisation of the tests and pathways that we could redesign within the existing resources will be undertaken by end Q2.
▪ Actions	Clinical engagement exercises to be undertaken to determine consensus on the type of tests in a prioritised order (e.g. biggest waits vs most fragile pathways).
Quarter 3:	
▪ Milestones	Costed plans to change service model.
▪ Actions	1. Completion of business case supporting change.
Quarter 4:	
▪ Milestones	Commence implementation of revised model.
▪ Actions	1. Engagement completed and implementation plan signed off.
Risks	<p>Diagnostic capacity - Additional demand created from various sources, inclusive of core, WLI's and Insourcing. Gap to meet demand is unfunded on a recurrent basis.</p> <p>Physical capacity – Scanners, age and capital expense, this relates mainly to MRI, CT and ultrasound (in that order).</p>

Planned Care Priority 3	Priority area(s)
	<p>Staffing – Ability to recruit to vacancies/recruit in a timely manner.</p> <p>Funding – Gap to meet demand unfunded recurrently. To deliver capacity above core capacity.</p> <p>Referral rate – Increased number of referrals are seen due to protracted waiting times and complexity of the request. Vetting of most complex referrals will be undertaken to ensure optimal use of resources.</p>
Outcomes	Waiting list and waiting times will decrease. We will provide forecast trajectories for best, worst and most likely end of year position, updated monthly.
Alignment with workforce plans	<p>Our demand and capacity plans align with current vacancies and take account of long-term absence.</p> <p>We have identified areas of national staffing shortage. Work will continue to develop new posts to mitigate long-standing recruitment challenges.</p>
Alignment with Financial plans	We have submitted a bid to the NHSE for continued support with clinical leadership to enable this work to go forwards.
OPTIONAL	
Digital / Technology Opportunities	<p>BI dashboards created to facilitate waiting list management and performance monitoring.</p> <p>Demand and capacity planning models linked to waiting list management opportunities</p>

Template 4d

Planned Care, Recovery, Diagnostics and Pathways of Care

Priority 4: Implement Pathway Redesign

Planned Care Priority 4	Priority area(s)
Key focus should be on delivering	Implement Pathway Redesign – adopting ‘straight to test (STT) model’ and onward referral as necessary.
Baseline	<i>A review of services against straight to test model undertaken using demand and capacity modelling 2023/24.</i>
Quarter 1:	
▪ Milestones	Prepare services for Straight to test (prostate) and model for Teledermoscopy.
▪ Actions	▪ Develop and submit business cases to the NHSE Cancer Network.
Quarter 2:	
▪ Milestones	Initiate new Straight to Test Pathways.
▪ Actions	▪ Robust implementation plans that continue through the year into business as usual.
Quarter 3:	
▪ Milestones	Reporting delivery against plan.
▪ Actions	▪ Routine monthly monitoring reports
Quarter 4:	
▪ Milestones	Produce evaluation report and ongoing plans for service to be incorporated / business as usual.
▪ Actions	▪ Production of evaluation draft report to go for consideration through planned care programme and executive team.
Risks	<p>Staffing resource to be able to engage and implement actions</p> <p>Clinical engagement – ability to engage and implement actions will need to work across primary and secondary care</p> <p>Staffing – Being able to recruit to any vacancies identified</p> <p>Funding – identify gaps in funding or ability to deliver service model within existing envelope.</p>
Outcomes	Successful proof of concept of more efficient service model, using technology to improve diagnostic waiting times.

Planned Care Priority 4	Priority area(s)
Alignment with workforce plans	Plans will need to identify any gaps within workforce (linked to the demand and capacity plans 2023/24) and 'new'/innovative ways of working and be included within action plans.
Alignment with Financial plans	We will undertake a value based analysis of the implemented pathways to ensure alignment with our financial plans.
OPTIONAL	
Digital / Technology Opportunities	BI dashboards created to facilitate monitoring of data identified to demonstrate benefits of implementing straight to test models. AI opportunities to support delivery of straight to test models

Template 5a

Cancer Services: Reduction in backlog over 62 days

	Priority area(s)
Key focus should be on delivering	Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Baseline	Actual backlog at end of March 2023 was 869 patients waiting over 62 days.
Quarter 1:	
▪ Milestones	15% reduction in backlog
▪ Actions	<ul style="list-style-type: none"> ▪ Adjust clinic templates to ensure 1st outpatient appointment capacity meets 80th/95th percentile demand, in line with Health Board capacity and demand work ▪ Appoint to Breast Services Network Manager post to oversee maximum utilisation of rapid access breast clinic capacity across the region (if funded). ▪ Increase tracking resource to ensure accurate data reporting and reduce backlog through timely escalation (if funded). ▪ Maximise opportunities within endoscopy to increase capacity including 3 session days as per endoscopy business case.
Quarter 2:	
▪ Milestones	Further 15% reduction in backlog
▪ Actions	<ul style="list-style-type: none"> ▪ Ensure sufficient prostate biopsy capacity in place across Health Board to provide an average of 7 procedures per week per site ▪ Commence new prostate pathway to facilitate straight to test and pre-booking of biopsies (pathway agreed as part of NOP work and funding secured for co-ordinators for 12 months) ▪ Restore full clinical oncology capacity (9wte) through recruitment and retention initiatives.
Quarter 3:	
▪ Milestones	Further 15% reduction in backlog
▪ Actions	<ul style="list-style-type: none"> ▪ Continue to rebalance capacity to ensure sufficient capacity for patients with suspected cancer.
Quarter4:	
▪ Milestones	Further 15% reduction in backlog
▪ Actions	<ul style="list-style-type: none"> ▪ Continue to rebalance capacity to ensure sufficient capacity for patients with suspected cancer.
Risks	Continued increase in GP urgent suspected cancer referrals Initiatives above not funded – ongoing discussion through Annual Plan development process.

	<p>Workforce gaps in particular in specialties where there are national shortages e.g. clinical oncology and dermatology. Cross-site working and locum recruitment used to bridge gap</p> <p>Capacity rebalanced leading to delays for non-urgent suspected cancer patients – inability to meet other targets.</p>
Outcomes	<p>Improve SCP performance to achieve 70% of patients treated within 62 days of suspicion of cancer (local projection of delivery against 75% target)</p>
Alignment with workforce plans	<p>Link to Oncology Task and Finish Group and Planned Care Recovery (dermatology recruitment)</p>
Alignment with Financial plans	<p>Above includes plans submitted for funding as part of Annual Planning process.</p>
OPTIONAL	
Digital / Technology Opportunities	<p>Remote monitoring software systems provide significant opportunities to ensure cancer patients are followed up in a safe and effective way whilst reducing the need for outpatient appointments and so releasing capacity to see new patients.</p>

Template 5b

Cancer Services: National cancer pathways

	Priority area(s)
Key focus should be on delivering	Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026
Baseline	Actual performance at end of March 2023 was 63.1% patients treated within 62 days of suspicion of cancer
Quarter 1:	
▪ Milestones	Cancer pathway work programme signed off by Cancer Partnership Board (CPB).
▪ Actions	<ul style="list-style-type: none"> ▪ Secure ongoing funding for Cancer Partnership Board, including key pathway clinical leads (submitted as part of Annual Plan planning round). Seek short term slippage funding if Annual Plan submission not funded ▪ Complete colorectal and prostate cancer pathways.
Quarter 2:	
▪ Milestones	Sign off 1 st two cancer pathways
▪ Actions	<ul style="list-style-type: none"> ▪ Sign off colorectal and prostate cancer pathways and commence implementation dependent upon financial and workforce resources (see below); this will include new referral guidance and straight to test pathways. ▪ Develop business case for GI triage referral hub and self-directed aftercare on colorectal pathway ▪ Commence work on next pathways – breast and gynaecology.
Quarter 3:	
▪ Milestones	Sign off 3 rd cancer pathway
▪ Actions	<ul style="list-style-type: none"> ▪ Complete internal consultation and sign off third cancer pathway ▪ Progress work on 4th cancer pathway ▪ Submit business cases for GI triage referral hub and self-directed aftercare on colorectal pathway
Quarter4:	
▪ Milestones	Sign off 4 th cancer pathway
▪ Actions	<ul style="list-style-type: none"> ▪ Complete internal consultation and sign off fourth cancer pathway
Risks	<p>Funding for Cancer Partnership Board. Seek short term slippage funding if Annual Plan submission not funded – discussions ongoing linked to financial plan.</p> <p>Long term funding for prostate co-ordinators – short term funding secured from Wales Cancer Network</p>
Outcomes	Improve SCP performance to achieve 70% of patients treated within 62 days of suspicion of cancer.

Alignment with workforce plans	Recruit to new pathway co-ordinator roles for prostate pathway – role agreed and out to recruitment.
Alignment with Financial plans	Above includes plan submitted for funding as part of Annual Plan bids re Cancer Partnership Board and ongoing funding for prostate co-ordinator roles (currently funded short term via Wales Cancer Network funding)
OPTIONAL	
Digital / Technology Opportunities	Remote monitoring software systems provide significant opportunities to ensure cancer patients are followed up in a safe and effective way whilst reducing the need for outpatient appointments and so releasing capacity to see new patients. This is already incorporated in the prostate pathway and will be considered for other cancer pathways

Template 6a

Mental health and CAMHS

CAMHS - Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS

	Priority area(s)
Key focus should be on delivering	CAMHS recovery of waiting times for access for Assessment and intervention under Part 1a and Part 1b of the MHM.
Baseline	Reduction in number of patients who had waited for assessment and therapy by CAMHS (LPMHSS) to achieve compliance against the 80% target of patients waiting under 28 calendar days for MHM Part 1a and 1b.
Quarter 1:	
<ul style="list-style-type: none"> Milestones 	<p>Recovery plan with trajectories for all areas across BCUHB to achieve full compliance with MHM Part 1a assessment target by the end of Qtr 4 2022/23 and sustain compliance throughout 2023/24.</p> <p>Sustain MHM Part 1b performance delivery at 25%</p>
<ul style="list-style-type: none"> Actions 	<ul style="list-style-type: none"> Qtr 4 delivery forecast reliant on successful recruitment into vacancies and external provider capacity. Currently Regional 20% vacancy factor across all CAMHS services. 30% vacancy factor in East Area – targeted recruitment campaign in place. Rebasing of 23/24 Qtr 1 performance projections and sustainability based on year end performance delivery in Qtr 4 2022/23 and recruitment Refresh of CAMHS Recovery Plan specifically to relation to MHM Part 1b <p>Additional supporting actions:</p> <ul style="list-style-type: none"> Ongoing focused attraction strategies to support recruitment in place across Region <ul style="list-style-type: none"> Validation – regular monitoring and oversight of waiting lists and demand and capacity, MDT caseload reviews Additional support and scrutiny – fortnightly meetings arranged with the Delivery Unit Compliance with waiting list management standard operating procedure across teams
Quarter 2:	
<ul style="list-style-type: none"> Milestones 	<p>Sustain MHM Part 1a compliance if trajectory achieved or rebase recovery plan trajectories if not achieved.</p> <p>Improvement in compliance with MHM Part 1b intervention target to 40%</p>
<ul style="list-style-type: none"> Actions 	<ul style="list-style-type: none"> If submission of 2023/24 WG MH SIF funding approved to sustain service delivery if further backlog reduction required for external provision or internal staffing to meet any increase in demand plan will be put in place for additional recruitment or commissioning required on release of funding in Q3

	<ul style="list-style-type: none"> ▪ If SIF funding not approved process to extend the private provider provision will be considered. ▪ Rebasing of 23/24 Qtr 2 performance projections and sustainability based on year end performance delivery in Qtr 1 and vacancy factor/ recruitment issues ▪ Continue supporting actions as in Qtr 1 ▪ Implementation of refreshed Recovery Plan
Quarter 3:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Sustain MHM Part 1a compliance if trajectory achieved or rebase recovery plan trajectories if not achieved.</p> <p>Further improvement in compliance with MHM Part 1b target to 45%</p>
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Robust monitoring of demand and capacity in line with CAPA modelling if trajectory on track for full and improved compliance of MHM Part 1a and MHM Part 1b ▪ Rebasing of 23/24 Qtr 3 performance projections and sustainability based performance delivery Qtr 2 report on vacancy factor/ recruitment issues ▪ Continue supporting actions as in Qtr 1
Quarter 4:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Sustain MHM Part 1a compliance if achieved into 2024/25 or rebase recovery plan trajectory if not achieved.</p> <p>Delivery of 56% compliance in relation to MHM Part 1b target or further improvement as per refreshed Recovery Plan actions.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ul style="list-style-type: none"> ▪ Review 2023/24 performance - analysis of capacity and demand and factors that support either further improvement if required or sustainability of service delivery for continued compliance with MHM ▪ Plan for forecast 2024/25 CAMHS performance against MHM ▪ Continue supporting actions as in Qtr 1
Risks	<p>Recruitment remains the most significant risk. This is both in terms of delivering the service and in the capacity needed to support improvement and transformational change.</p> <p>Further increased demand for mental health assessments 8% increase during 2022/23 when compared to pre-pandemic levels with just over 50% of assessments requiring ongoing therapy/intervention. In addition, teams are experiencing a change in the presentation of referrals with acuity and complexity levels have increased due to systemic complications.</p> <p>Further Industrial Action reducing capacity – Nursing</p> <p>This has resulted in a significant increase in the length of time that children and young people are open to CAMHS services with the average number of therapy sessions required increasing from 7 to 10. Rebasing capacity to adjust to the higher acuity levels could potentially impact on sustaining level of achieved compliance with MHM</p>

Outcomes	<p>Compliance with MHM measure Improved access routes for C&YP to MH services Reduced waiting times Improved quality of care for service users Improved pathways</p>
Alignment with workforce plans	<p>CAMHS workforce mapping/ profiling currently underway, including skills and training needs analysis. Development of a Strategic CAMHS Workforce plan by mid-year 2023/24 to support sustainable CAMHS provision recognising National shortages of mental health professionals.</p> <p>Introducing more development roles, student streamlining opportunities, associate CAMHS practitioners. Potential joint LA commissioning opportunities and third sector roles to support early intervention and prevention.</p> <p>Recruitment and in particular retention of staff for the current and future workforce, and the potential supply combined with the capacity and capability</p>
Alignment with Financial plans	<p>Aim is to reduce reliance on bank, agency staff and private provision outsourcing for MHM assessments and interventions, reduce vacancy factor and maximise service improvement funding to grow and develop a sustainable workforce for the future.</p>
Digital / Technology Opportunities	<p>Services have had to adopt digital mental health provision in a piecemeal way to best meet the needs of services with the systems available to us, our IT systems are heavily reliant on SharePoint and WPAS neither of which allow for sharing of information across agencies and between services. There is a need for better developed integrated care IT system that address gaps in provision. WCCIS may provide this opportunity in the future but this has been at project planning/initiation stage for many years.</p> <p>In addition the challenges faced across the system include the number of digital health offers currently available and the absence of a commonly understood system for identifying the safest and most efficacious digital treatments for mental health services.</p> <p>CAMHS are using Attend Anywhere along with AMH possibility of joint clinician working for services transitioning from CAMHS to adult services.</p>

Template 6b

Mental health and CAMHS

Implement 111 press 2 on a 24/7 basis for urgent mental health issues

	Priority area(s)
Key focus should be on delivering	Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Baseline	<p>Our intention is for the 111 press 2 service to cover all 6 Local Authority areas 24 hours a day, 7 days a week. This will be a phased introduction with Phase 1, operational from 17th January 2023, operating across North Wales from 08:30 am – 11:00 pm 7 days a week moving to a 24/7 service from 20th March 2023.</p> <p>Baseline for service initiation is based on established services in Wales. Hywel Dda Health Board has a call rate of 1500 calls per month, using population figures we have a call rate of 1.9 compared to 1 for Hywel Dda. Activity will be monitored for call volumes, call type and any times of day where there are peaks in calls. It will take a number of months of active service delivery for definitive demand patterns to be evident in the available data. In addition to evaluating the data of the service we will also be looking at any wider impact on other Mental Health services, such as referrals into LPMHSS Services. We will also look to other health boards for comparison in data and service delivery performance.</p> <ul style="list-style-type: none"> • BCU has 22% of the population of Wales • BCU will have 1.9 callers to a rate of 1 for Hywel Da Health Board (1500 calls a month estimated)
Quarter 1:	
<ul style="list-style-type: none"> ▪ Milestones 	3-month evaluation to ensure service is operating effectively. This will be to understand any emerging trends or issues and to begin building a baseline position. We do not envisage taking any significant actions to change the service model at this early stage.
<ul style="list-style-type: none"> ▪ Actions 	<p>Review call volumes into 111/2 service including review for evidence of patterns of peak call times against the baseline estimations. No definitive service changes to be made at this point as this is initial monitoring phase</p> <p>Review of calls in terms of clinical nature. Outputs of review to be discussed as part of ongoing staff support and training.</p> <p>Obtain and review feedback from staff on effectiveness of telephony and IT systems. Any general technical issues to be resolved as they occur. General issues to be fed back to project group for consideration of changes to system where possible and appropriate and where benefit can be achieved.</p> <p>Obtain and review feedback from staff on effectiveness of SOPs. Outputs to be fed back to project group for consideration as part of ongoing staff support and training.</p> <p>Review of demand impact on MHM referrals and waiting times for MHM assessments. No definitive service changes to be made at this point as this is initial monitoring phase</p>
Quarter 2:	

<ul style="list-style-type: none"> ▪ Milestones 	<p>6-month evaluation of service to ensure service is operating effectively</p>
<ul style="list-style-type: none"> ▪ Actions 	<p>Review call volumes into 111/2 including review for evidence of patterns of peak call times. At Qtr. 2 milestone consideration will be given to any emerging concerns that may require changes to staffing levels in order to address demand and timescales.</p> <p>Review of calls in terms of clinical nature with focus on frequent callers to support building a baseline of call types.</p> <p>Obtain and review feedback from staff on effectiveness of telephony and IT systems. At Qtr. 2 milestone, consideration will be given to any changes / improvements that need to be considered to ensure staff are enabled in their role. These will be discussed within the project group.</p> <p>Review of demand impact on MHM referrals and waiting list times for MHM assessments. At Qtr. 2 milestone consideration to be given to any emerging data patterns/themes that may need further analysis to establish cause and/or correlation with implementation of 111/2 services. This will be discussed at project group and with service leads to understand whether there is enough evidence to demonstrate causation.</p> <p>Review of any changes in demand to CALL / DAN and Dementia helplines to support establishment of knowledge base for effectiveness of service implementation.</p> <p>Undertake a service user satisfaction survey</p> <p>Analysis of Subjective User Distress Scale (SUD's) to establish a benchmark for future analysis and comparison.</p>
<p>Quarter 3:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>9-month evaluation to ensure service is operating effectively.</p>
<ul style="list-style-type: none"> ▪ Actions 	<p>Continuation of monitoring of Qtr. 2 actions building on evidence to understand impact.</p>
<p>Quarter4:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Annual review</p>
<ul style="list-style-type: none"> ▪ Actions 	<p>Analysis of outcomes to ensure callers have better Subjective User Distress Scale (SUD's) at the end of the call.</p> <p>Complete service user and staff satisfaction surveys.</p> <p>Assess impact on LPMHSS and GP practices.</p> <p>Review SOP and clinical pathways where necessary to ensure they remain current and effective and where appropriate respond to feedback established through surveys and review</p> <p>Consider actions for LMPHSS services that the evaluation of demand and waiting times has had due to implementation of 111/2 services.</p>
<p>Risks</p>	
<p>Risks</p>	<p>Demand is based on established services in South Wales, however, these are very newly established services and therefore demand projected may be vary. Staff modelling is based on this demand. Demand and staffing requirements</p>

	<p>will be better determined as the service embeds and matures across North Wales. Recruitment to date has been completed but there have been challenges, with some changes to the original workforce plan due national shortage of Band 6 staff. Job descriptions and bandings have been reviewed and alternate solutions recruited to including offer of additional hours/overtime to existing staff and bank staff utilisation.</p> <ul style="list-style-type: none"> • We will review demand as part of our routine monitoring to establish a baseline, but take into consideration demand is likely to increase as awareness of the service increase. Routine monitoring of the service will take into consideration any immediate or emerging staffing shortfalls or surplus. <p>Staff retention will be risk for the service given the recruitment issues across the organisation and any variance in demand noted above may factor into staff retention</p> <ul style="list-style-type: none"> • We will encourage feedback and review of staffing in terms of both capacity and capability in providing service. All 111/2 staff will as with other MHLD staff have access to support from Wellness, work and Us team. <p>Availability of Welsh speaking staff is a risk for this frontline service.</p> <ul style="list-style-type: none"> • We are using the language line as a support at present. • Remote working is being considered for staff and this may be a positive factor in recruiting to Welsh Speakers based on geographical working possibilities. <p>Our service is heavily reliant on IT and telephony systems.</p> <ul style="list-style-type: none"> • We have completed contingency plans mitigate disruption to service either due to system issues or environment issues. This includes provision for remote log in via laptop to allow for continuation of service from alternative location. All actions and risks are closely monitored through comprehensive project monitoring documentation with dedicated project group that feeds into our improvement governance process. <p>The decommissioning of the current software Adatastra is in process and the commissioning of a new system, will place risks on the service in terms of training, service continuity and revision of documentation.</p> <ul style="list-style-type: none"> • We remain in contact with the national teams as part of our service development and monitoring to ensure we are informed on the rollout of the new system and its, operational and training implications.
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<p>Outcomes</p>	<ul style="list-style-type: none"> • Universal approach to urgent calls i.e., we deal with all urgent calls regardless of age and mental health service area • Improve the caller’s experience • Improve the callers’ outcomes • Provide early intervention for well-being and mental ill health issues • Provide information and options for self-care and support • Provide navigation to appropriate services/non statutory support for welfare issues • Reduce the demand on A&E/GP/Police/WAST/MH crisis services • Make seamless referrals to MH teams across the Directorate service areas (when required) • Provide advice for other agencies such as WAST/Police/GP’s/Local Authorities through a dedicated Professional Line • Ensure a preventative approach to meeting the well-being and mental health needs of individuals of all ages • Ensure that service provision is in line with local and national strategy and best practice <p>We will achieve the outcomes above by:</p> <ul style="list-style-type: none"> • Using UK standard mental health triage tool to assess urgent mental health requests for help • Liaising with mental health teams for those who require an urgent mental health assessment or intervention • Arranging connections to a range of mental health services depending on assessed need • Support professional partners to manage and assess well-being and mental health needs of individuals of all ages more effectively • Referring to a range of services which can support an individual’s needs such as Third Sectors, debt advice, housing services, drug, and alcohol services etc • Having a positive impact on the caller’s resilience to assist them to manage more effectively and develop problem solving skills through a range of brief interventions • Promote health and well-being to those who access the Service • Considering all aspects of diversity, culture, spirituality, gender identity and sexual preference, which is important to the individual <p>A minimum established data set has been agreed nationally for 111/2 services. At present this is to establish a baseline for the services in Wales. We anticipate that targets and trajectories will be identified once the services across Wales are established.</p> <p>A national peer review for all 111/2 services in Wales is being undertaken and at present expectation is that BCUHB will take part in this in July 2023</p>
<p>Alignment with workforce plans</p>	<p>The agreed workforce model will be reviewed in line with the milestone reviews of service demand as noted in the risks above.</p>

<p>Alignment with Financial plans</p>	<p>The current service model is fully funded recurrently. Any changes to the service model may have financial impact and this will be monitored as outline in the milestones above.</p>
<p>Digital / Technology Opportunities</p>	<p>We are engaged with the DDaT WCCIS Project team and are taking part in the Pilot starting in March. The hope for the division is that WCCIS is fit for purpose and that DDaT will enable us to rollout WCCIS across all our services. This will enable 111P2 calls to be answered and with patient consent, their current record to be viewed and added to, enabling the Practitioner to give more informed advice and accessing up to date information.</p> <p>This would also enable us to identify if the caller is known to us as an existing patient. Currently many data sources such as SharePoint are reviewed to confirm this, a potentially inaccurate and time-consuming process. With CAMHS also engaging in this pilot, the same process can be followed for callers of all ages.</p> <p>111/2s Current system (Adastra) is due for decommissioning in 2023. This risk is broader than MHL D as Adastra supports GP out of hour's service across BCUHB. Risks and opportunities around replacement system as yet unknown but information is being pursued. The hope is that this system will be developed on a platform that allows for integration into in-house systems but this will be dependent on roll out of WCCIS.</p> <p>Investigating opportunity for offering video consultation to better facilitate effective consultations.</p>

Template 6c

Mental health and CAMHS

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.

Priority area(s)	
Baseline	<p>We currently deliver LPMHSS across North Wales but acknowledge that at present we are not compliant with all parts of the Mental Health Measure. We have regional variation in terms of delivery and practice and experience challenge in meeting the demand. We know from recent engagement events both local and regional that access to services can be perceived as prohibitive to timely care. We know that varying IHC primary care and third sector Mental Health provision both commissioned and non-commissioned are a factor on the demand that LPMHSS services face. We intend to strengthen our delivery by utilising our internal and external resources to create “no wrong door” approach to accessing Tier 0/1 services. This is a significant change to the way services are currently delivered and will take considerable resource to scope, agree model and implement.</p> <p>Stakeholder engagement will be key to the success as will a robust change management process. Therefore, this will be a phased approach with some interim measures introduced to support existing LPMHSS as longer-term solutions are developed. Interim arrangements will include shared and realigned utilisation of existing resources to support levelling of regional variation across all areas and implementation of new assessment documentation.</p> <p>Any early impact on LPMHSS due to implementation of 111/2 service will be considered as part of the improvement work and we will closely align the project work to key areas such as Crisis Care to ensure a whole system approach.</p> <p>2022/23 Waiting list @ March 31st = 1483 under part 1a of the measure and 360 under Part 1b. Focus will be on the reduction of the waiting list to ensure timely and equitable access to expert Mental Health care.</p>
Quarter 1:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Review of Quarter 1 position against targets and initial assessment of 111/2 impact.</p> <p>Reduction of assessment waiting list and delivery of 62% against Part 1a of the Mental Health Measure.</p> <p>Reduction in therapeutic intervention waiting list and delivery of 60% against Part1 b of the measure.</p> <p>Establishment of the Adult Community Pathway Transformation Project Group.</p>
<ul style="list-style-type: none"> ▪ Actions 	<p>1. Review of the Qtr. 1 impact of the interdependent 111/2 service. This will be an early review to understand if there is any impact on LPMHSS services that can be evidenced as defined cause rather than coincidence.</p>

	<ol style="list-style-type: none"> 2. Establishment of a project group with defined clinical lead and project support staff. 3. Monitoring of Mental Health Measure including its contributory factors against the trajectories outlined in the Planning Minimum Data Set to establish if interim arrangements are having any impact and to monitor all improving or worsening trends. Performance monitoring will be part of project group as well as existing governance arrangements. 4. Review of recruitment or issues with recruitment for existing and interim roles. Any long-term vacancies or newly created vacancies to be reviewed for alternative approach and / or highlighted through recruitment campaign. 5. Commencement of EqIA to support transformation project with a view to maximising engagement with key stakeholders and full integration with cluster work. Work to be underpinned by support from BCU Equalities team. 6. Completion of application for Welsh Government SIF monies to support development of the project. 7. Rebasing of 23/24 performance projections based on performance in Qtr1
<p>Quarter 2:</p>	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Review of Quarter 2 position against targets alongside evaluation and impact of 111/2.</p> <p>Reduction of assessment waiting list and delivery of 66% against Part 1a of the Mental Health Measure.</p> <p>Reduction in therapeutic intervention waiting list and delivery of 69% against Part1 b of the measure.</p>
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Review of the Qtr. 1 impact of the interdependent 111/2 service. This will be an early review to understand if there is any impact on LPMHSS services that can be evidenced as defined cause rather than coincidence. 2. Review of recruitment or issues with recruitment for existing and interim roles. Any long-term vacancies or newly created vacancies to be reviewed for alternative approach and / or highlighted through recruitment campaign. 3. Review of effectiveness of revised documentation implementation and make changes where appropriate based on feedback. 4. If SIF funding approved, transformation project document to be finalised to ensure key project areas can commence on release of funding in Qtr. 3 with appropriate resource allocated. Project areas will be supported by evidence from EqIA, Stakeholder engagement and existing and emerging performance data.

	<p>5. If SIF funding not approved or not to the level required, phased implementation of transformational areas within existing financial envelope to be agreed. Project areas will be supported by evidence from EqIA, Stakeholder engagement and existing and emerging performance data.</p> <p>6. Rebasing of 23/24 performance projections based on performance in Qtr2</p>
Quarter 3:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Implementation of defined actions in line with approved programme of works. Reduction of assessment waiting list and delivery of 75% against Part 1a of the Mental Health Measure.</p> <p>Reduction in therapeutic intervention waiting list and delivery of 80% against Part1 b of the measure</p>
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Commencement of transformation project in line with identified funding/phasing with appropriate project support in place. 2. Inclusion of project delivery within internal governance framework to ensure accountability is evident for delivery of project actions. 3. Continued monitoring of performance within LPMHSS services and the ongoing monitoring of impact of delivery of 111/2 service. 4. Rebasing of 23/24 performance projections based on performance in Qtr3
Quarter4:	
<ul style="list-style-type: none"> ▪ Milestones 	<p>Full year review of position against targets</p> <p>6-month review of progress against transformational plans</p> <p>Reduction of assessment waiting list and delivery of 83% against Part 1a of the Mental Health Measure.</p> <p>Reduction in therapeutic intervention waiting list and delivery of 90% against Part1 b of the measure</p>
<ul style="list-style-type: none"> ▪ Actions 	<ol style="list-style-type: none"> 1. Rebasing of transformational project in line with identified benefits, risks and lessons learned from in first months if appropriate. 2. Definition of projections for 24/25 performance
Risks	<p>Recruitment and retention remains the most significant risk. Within the current budget establishment we have had our resource reduced due to a vacancy rate of 23% as at year end 2022/23. This rate varies across the teams. Vacancies and recruitment to this workforce co-hort is an issue nationally. Work being undertaken to address this includes:</p> <ul style="list-style-type: none"> • Interim arrangements are being explored with additional hours, new posts and sharing workforce resource to mitigate risks.

	<ul style="list-style-type: none"> • The Just R recruitment project is working across the division to support recruitment marketing across varied platforms, streamline recruitment processes and maximise opportunities with newly qualified people. • We are considering as part of the transformation project the risk to the division when staff move between our services rather than new staff coming into the existing workforce. • We are exploring revision of contracted and third sector provision to support and enhance delivery of assessments and interventions and maximise potential within this valuable resource <p>Workforce modelling will form part of the transformation work being undertaken by The Adult Community Pathway Transformation group Any newly identified workforce requirements established as part of the transformation work may bring pressure on existing budgets.</p> <p>A lack of digital enablement across the division is a risk to our ability to comprehensive record patient data, manage services effectively, respond to mandated and ad hoc performance reports, undertake in-depth analysis to support routine and transformational working, respond to FOIs and support staff in their daily working. Lack of digital provision also impacts our ability to attract and retain staffing. There has been a lack of investment in digital solutions for Mental Health and Learning disabilities, which means we are largely reliant on paper based or ageing stand-alone electronic systems. In order to address some of the issues we will:</p> <ul style="list-style-type: none"> • Work with Welsh Government and the NHS Executive as part of the national Mental Health Outcomes and Measure – Technical Data Group, to establish a baseline data set and understand barriers and variation in system provision across LHBs • Pilot WCCIS in year, but note will be a small-scale development and not a full digitisation of the division. The pilot itself will pose risks as this will mean significant input from staff who will need to run the service and manage dual systems (existing and WCCIS) whilst the pilot is in process. • Review MHLDD digital scoping exercise to explore options to agree priority areas for improvement. • Progress roll out of Wi-Fi across Mental Health and Learning Disabilities sites. Lack of Wi-Fi provision for our division has been highlighted as a priority in the capital plan.
<p>Outcomes</p>	<p>Improved access routes to services for service users demonstrated by reduced waiting times</p> <ul style="list-style-type: none"> • Part 1a reduction from 1483 to 1000 • Part 1b reduction from 610 to 360 <p>Compliance with MHM measure achieving 80% Target for Parts 1a and 1b.</p>

	<p>Better integration between services and improved working methods and job satisfaction for staff - to be monitored through the project group.</p> <p>Further outcome measures will be defined by the project group.</p>
<p>Alignment with workforce plans</p>	<p>Initial capacity modelling for existing staff is done and resulted in the identified need in the short term for bank staff and sharing of resource across the CMHTs. Workforce planning is part of the transformational development work for Tier 0/1 looking at Banding, alignment of services, utilisation of third sector partners and job descriptions. Work will be undertaken to consider recruitment difficulties to date, recruitment successes via the Just R campaign and the intelligence that this work has given us in terms of availability of workforce and the alternative solutions that have proved successful in other services.</p>
<p>Alignment with Financial plans</p>	<p>Aim is to reduce reliance on bank and agency staff, reduce sickness rates and maximise service improvement funding and commissioning potential. As noted within risks, any delays in the interim funding may impact on delivery. Longer-term work may result in workforce redesign and changes to commissioned services. Short term solutions will need to retain some reliance on temporary staffing, to support waiting list reduction and stabilise services whilst recruitment to established posts is progressed.</p>
<p>Digital / Technology Opportunities</p>	<p>We hold significant risk, as the service is supported by SharePoint, which is neither a clinical nor patient administration system. WCCIS (Welsh Community Care Information System) commissioned in 2015 is the proposed solution but has not been ready for us in BCU to date. Pilots in community health in BCU are ongoing and the most recent health board to go live with WCCIS is Aneurin Bevan. WCCIS implementation is key for MHM data capture in BCU, enabling us to move away from SharePoint.</p> <p>The MHM team are involved in the WCCIS pilot being undertaken in BCU via the Digital, Data and Technology (DDaT) WCCIS Project team, this is planned for commencement in March 2023. As most of our patient activity falls under the MHM, it is essential that the MHM data can be collected and monitored correctly, for MHLD to move forward with WCCIS implementation across all services.</p> <p>CITO is a document archive system, implemented for health record archival by BCU DDaT - We have engaged with the CITO project team to support management of our 300,000 health records. Costings are being sought and engagement with the CITO project team is ongoing, with a site visit planned.</p> <p>We are exploring the expansion of the national Video Consultation program, Attend Anywhere, working with Business Support Managers to facilitate administrative resource needed. The division holds a strong desire to offer this to support care closer to home and alignment with clinical strategy. We are exploring potential for dual diagnosis appointments supporting effective care and maximizing resource. Possibility of joint clinician working for services transitioning from CAMHS to adult services.</p> <p>Fundamental to the above will be the modernisation of existing and implementation of new digital hardware & infrastructure with improved and expanded Wi-Fi availability across all MHLD sites. Several MHLD sites are</p>

	<p>without Wi-Fi, to resolve this a capital business case has been submitted and in addition, a priority list of sites, citing clinical justification has been sent to the BCU DDaT team.</p> <p>Early discussions to consider utilisation of WIFI spark to enable patients to have access to defined online sites and services. We have put together a senior staff group together to engage with DDaT on this, to help shape the plans to suit our patient groups.</p> <p>We hold a significant risk as the service is supported by SharePoint, which is neither a clinical nor patient administration system. WCCIS commissioned in 2015 is the proposed solution but not ready for use in BCU. Pilots in community health in BCU and mental health in Aneurin Bevan will be key to the success of future implementation for MHM data capture in BCU.</p> <p>We are engaged in discussions with CITO project team to support management of 300,000 health records.</p> <p>We are exploring the expansion of the use of attend anywhere, working with Business Support Managers to facilitate administrative resource needed. Strong desire to offer this to support care closer to home and alignment with clinical strategy. We are exploring potential for dual diagnosis appointments supporting effective care and maximizing resource. Possibility of joint clinician working for services transitioning from CAMHS to adult services.</p> <p>Fundamental to the above will be the resourcing of digital infrastructure with improved and expanded Wi-Fi availability across all MHL D sites.</p> <p>Early discussions to consider utilisation of WIFI spark to enable patients to have access to defined online sites and services.</p>
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