<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>13:30</td>
<td>Chair’s Introduction.</td>
<td>Graham Shortland, Medical Director</td>
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<tr>
<td>13:35</td>
<td>Transformation in Cardiff and Vale: Introducing the Turning the Curve Programme.</td>
<td>Graham Shortland</td>
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<tr>
<td>13:50</td>
<td>Changing models of delivery of care in surgery.</td>
<td>Alun Tomkinson, Clinical Board Director, Surgical Services</td>
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<tr>
<td>14:10</td>
<td>Applying a “Whole Systems” model to planning care.</td>
<td>Clare Williams, Corporate Strategic Planning Lead / Rachel Rayment, Clinical Lead, Shaping Our Future Wellbeing Strategy</td>
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<td>14:20</td>
<td>Questions and Answers.</td>
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<tr>
<td>14:35</td>
<td>BREAK</td>
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<tr>
<td>14:50</td>
<td>Introduction to the proposed structure and function of the transformation boards:</td>
<td>Brendan Boylan, Locality Board; Jonathan Kell, Planned Care Board; Peter Durning, Unscheduled Care Board.</td>
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<tr>
<td>15:20</td>
<td>Questions and Answers</td>
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<td>15:35</td>
<td>Closing Remarks</td>
<td>Graham Shortland</td>
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<td>15:45</td>
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Turning The Curve to Transformation
(Quality, Finance and Activity)
Urgency and Pace in 2017/18
<table>
<thead>
<tr>
<th>01</th>
<th>Chair’s Introduction</th>
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<tbody>
<tr>
<td>02</td>
<td>Transformation in Cardiff and Vale: Introducing Turning the Curve</td>
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<td>04</td>
<td>Changing models of delivery of care in Surgery</td>
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<tr>
<td>05</td>
<td>Introduction to the Transformation Programme: Unscheduled Care, Locality and Planned Care</td>
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</table>
Chair’s Introduction
Transformation in Cardiff and Vale: Introducing Turning the Curve
Our Common Purpose

Delivering effective models of care and pathways for our citizens that balance quality, activity and resource.

Responding when any aspect of this triangle becomes or is at risk of becoming imbalanced.

Activity is rising. Resource is reducing. We need to act now, in the interests of our citizens, to address issues of harm, waste and variation and to develop new models of care on a system-wide basis to respond to this challenge and to deliver sustainable services.
Shaping Our Future Wellbeing to guide us:

Our Transformation Programme will be person-centred and will reflect the principles we agreed through Shaping our Future Wellbeing. Our values and behaviours will guide the way we work.
Transformation Principles

Our Transformation Programme will...

- Not compromise patient safety
- Deliver financial benefits
- Have clear measurable outcomes
- Clearly articulate expectations of staff
- Focus upon cultural & behavioural change

Our Transformation Programme is reliant upon...

- Clinical leadership
- Creating capacity in clinical boards
- Using the skills & experience of our own staff

Our Transformation Programme will have...

- Robust governance
- Clear comms
- A programme & project management approach
Governance: Accountability and Delivery at Pace

Turning the Curve senior leadership group

Management Executive

Transformation Board

Cost Reduction Board

Choices and Strategic Solutions

Unscheduled Care Board (BIG1)

Locality (BIG 2)

Planned Care Board (BIG 3)

Leaner & Fitter Workstreams

Good Management Grip and Control – Performance Review Meetings
A Project Approach

60 day cycles
- Projects that can be delivered at pace
- Small tests of change using PDSA cycles

Local Projects
- Local projects to change service models
- Partnership working
- Up-scaling 60 day cycles

National Priorities
- UHB projects to implement priorities established at the national Planned Care Board, Unscheduled Care Board and Primary Care Board
Clinical Leadership

“Put simply, organisations with more engaged clinicians and staff achieve better outcomes and experiences for the patients they serve.” (Chris Ham, Kings Fund, 2012)

- Chairing **Programme Boards** x3
  - Defining scope
  - Identifying leads
  - Monitoring progress

- **Transformation Team** (medical and non medical)
  - Supporting projects
  - Clinical engagement to accelerate and deliver change

- **Wider organisation**
  - Generation of ideas
  - Delivery of projects
Applying a “Whole Systems Model” to planning care
Turning the Citizen Model into a Service Model

In co-producing the *Shaping Our Future Wellbeing Strategy*, the UHB worked alongside over 400 people and organisations to describe a vision for health and wellbeing:

To enable the next steps, those that commission and provide services across health and social care need to have a common understanding of how their services fit together; what needs they are seeking to address, how a citizen, patient or service user accesses and moves through the services and where there are gaps in existing services. Taking a whole systems approach, this requires the development of a shared *whole system service model* based on the *citizen model*.
Independence and Wellbeing

Intensive and/or Enhanced

First Point of Contact Stable Non-Complex Care

Long Term, Stable Complex Care

Specialist

An Unscheduled Care Pathway

A Planned Care Pathway
But...in a Perfect Locality focused on "me, my home, my community" we have to think of the whole system.
Services promote prevention, health and wellbeing, independence and empowerment, recognising that a wide range of social and health needs may have an impact on a person's wellbeing.

- e.g. public health promotion, healthy communities, leisure and learning services, self help services, mental health promotion

Services provide a first point of contact, they screen and assess, providing early intervention and sign posting. Where a person's needs are stable and not complex, services provide routine ongoing support.

- e.g. contact centres, wellbeing co-ordinators, third sector, general medical, dental and optometry services, community pharmacy, flying start.

Services provide a flexible and coordinated response to a person's rising unstable need. They either provide an intensive re-ablement service or an ambulatory care intervention. Both prevent inappropriate long term care and avoid hospital admissions.

- e.g. community resource service/teams, community mental health, acute response team, domiciliary care, children's speech and language assessment, REACT.

Services provide for people whose needs are not necessarily low but are stable, additional support may be needed to meet daily living needs. Rising complexity can mean care planning by specialist multi-disciplinary teams to avoid unstable acute hospital or care home admission.

- e.g. district nursing, virtual diabetes clinics, community paediatric clinics, residential and nursing home services, end of life care, multi-condition service, community mental health teams.

Services provide for people whose needs are highly unstable and/or for highly specialist assessment and care. Integrated discharge planning supports timely discharge.

- e.g. accident and emergency, inpatient services, integrated discharge teams, children's centres, continuing health care packages, specialist mental health services, specialist outpatient / diagnostic.
Services promote prevention, health and wellbeing, independence and empowerment, recognising that a wide range of social and health needs may have an impact on a person's wellbeing.

- Public health/healthy communities
- Community networks/befriending
- Leisure and learning activities

Services provide a first point of contact, they screen and assess, providing early intervention and sign posting. Where a person's needs are stable and not complex, services provide routine ongoing support.

- Contact centres
- Equipment / aids
- Third sector
- Care and Repair
- GP and dental surgeries
- Sheltered housing

Services provide a flexible and coordinated response to a person's rising unstable need. They either provide, an intensive re-ablement service or an ambulatory care intervention. Both prevent inappropriate long term care and avoid hospital admissions.

- Community resource teams
- Step up/down accommodation
- Mental health teams
- OTs
- Telecare Plus
- Domiciliary care

Services provide for people whose needs are not necessarily low but are stable, additional support may be needed to meet daily living needs. Rising complexity can mean care planning by specialist multi-disciplinary teams to avoid unstable acute hospital admission.

- Extra care accommodation
- District nursing
- End of life Care
- Residential care homes
- Nursing care homes

Services provide for people whose needs are highly unstable and/or for highly specialist assessment and care. Integrated discharge planning supports timely discharge.

- Specialist assessment
- Inpatient services
- Integrated discharge team
Changing models of delivery of care in Surgery
Questions and Answers
Break

15 minutes
Introduction to the Transformation Programme: Planned Care, Locality and Unscheduled Care.
Transformation Programme

- Planned Care
- Clinical Boards
- Locality
- Unscheduled Care
Planned Care

What are the aims of the Planned Care Board?

The aim of the Planned Care Board is to work with Clinical Boards and other partners to:-
• Reduce hospital based outpatient appointments by 30%
• Improve theatre utilisation
• Address unwarranted harm, waste and variation

Who is involved in the Planned Care Board?

Jonathan Kell (Chair)
Mike Bond (Vice Chair)
Karen Pardy (Vice Chair)
Fiona Jenkins (Executive Link)

What projects will be progressed?

60 day cycles
One stop poly clinics
DNAs
Home Treatment
MSK CMATs
Eye Care
High Cost Devices

Local Projects
Locality

- **What are the aims of the Locality Board?**
  - The aim of the Locality Board is to work with Clinical Boards and other partners to:
    - deliver a plan for sustainability in primary care
    - support the development of new models of care using a whole systems approach

- **Who is involved in the Locality Board?**
  - Brendan Boylan (Chair)
  - Alun Morgan (Vice Chair)
  - TBC (Vice Chair) Vale LA
  - Fiona Kinghorn (Executive Link)
  - Chris Darling (PCIC)
  - Sarah McGill (Cardiff LA)
  - Carolyne Palmer (Cardiff LA)
  - Rachel Jones (Integrated Care)

- **What projects will be progressed?**
  - 60 day cycles
  - Psychological service in 1 care
  - Local Projects
  - GP Sustainability
  - Models of care (older people)
  - Prevention & Wellbeing
  - Technology as an enabler
  - Infrastructure developments
  - Me, my home & my community
Local Jigsaw

By working together on all the pieces of the puzzle to ensure that the whole is better than the sum of its parts:

<table>
<thead>
<tr>
<th>Co-design</th>
<th>Co-production</th>
<th>Co-ownership</th>
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<tbody>
<tr>
<td>Develop whole system models (that matter to citizens and patients)</td>
<td>Improve patient pathways across primary &amp; secondary care</td>
<td>Sustain primary care particularly general practice</td>
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<tr>
<td>Agreeing a new care model and joint commissioning arrangements based on a</td>
<td>Provide the interface, services to support clinical theme and specialties based</td>
<td>By working at:</td>
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<tr>
<td>home first approach (initially focused on older people)</td>
<td>GP/consultant, virtual Directorate</td>
<td>• National level</td>
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<td>For the interface, services to support clinical theme and specialties based</td>
<td>• Cluster level; including the identification and functional integration of</td>
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<td>GP/consultant, virtual Directorate</td>
<td>UHB, Local Authority and Third Sector resources</td>
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<td>Provide the business cases for major physical infrastructure required to</td>
<td>• Individual Practice level</td>
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<td>support improved access to community services and assets</td>
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<td>Develop Health &amp; Wellbeing Centres &amp; Hubs</td>
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<td>Focus on Wellbeing</td>
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<td>To systemise wellbeing and prevent ill-health, we will work with partner</td>
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<td>organisations on actions that:</td>
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<td></td>
<td>• Create supportive environments</td>
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<td>• Strengthen community action</td>
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<td></td>
<td>• Reorient our services to focus on prevention</td>
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<td>• Build healthy public policy across our organisation</td>
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<td>• Develop personal skills of staff and citizens</td>
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<td></td>
<td>By working at:</td>
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<td></td>
<td>• Individual Practice level</td>
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<td>Facilitate technology solutions</td>
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<td>Ensure that digital solutions are explored further to promote health &amp;</td>
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<td>wellbeing, and assist in the management of long term conditions</td>
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Health literacy | Empowerment | Self-care
Primary / Secondary integration

**What we did**

- established and embedded HERS2 into the directorate. It has enabled advice from consultants, a dyspepsia service and more straight to test where indicated for upper/lower GI endoscopy.
- agreed pathways for several of the common GI presentations (dyspepsia, liver and IDA). Others (IBS, constipation and diarrhoea) are being finalised.
- joint educational sessions with primary care.
- enhanced our primary care information on our Clinical Portal pages.

It has been a **great step** having S in this position. We now have a named person to link into primary care (this should be happening an awful lot more throughout every specialty given the philosophy of a 'Health Board' versus Hospital Trusts and PCTs over the border).

We absolutely want S and his role to continue. I think there are other areas we can develop and improve in the interface between primary and secondary care (pathways for other presentations,)

...............one important aspect is to build this relationship with Steve and to incorporate him in our directorate meetings etc.

It is **fantastic working with S** & has had a really **positive impact on the service & in driving things forward**. I regularly see evidence of use of the liver function pathway in particular. It has also been **beneficial in terms of governance issues** in helping to understand & provide solutions to scenarios that arise.
Unscheduled Care

Who is involved in the Unscheduled Care Board?
- Peter Durning (Chair)
- Sue Morgan (Vice Chair)
- Jason Roberts (Vice Chair)
- Steve Curry (Executive Link)
- Lee Davies (Operations)

What are the aims of the Unscheduled Care Board?
The aim of the Unscheduled Care Board is to work with Clinical Boards and other partners to:
- reduce length of stay
- reduce unnecessary hospital admissions

What projects will be progressed?
- 60 day cycles
- Preventing decline
- Local Projects
- Pre Hospital
- In Hospital
- Non acute patients
- TBC

Pre Hospital
In Hospital
Non acute patients
Questions and Answers
Closing Remarks