Appendix 1

Grant Thornton Executive Summary for the Clinical Services Strategy work

Executive summary

Cwm Taf Morgannwg University Health Board (CTMUHB) is developing an ambitious five-year strategy which will tackle the fundamental challenges and inequalities faced by its population. Bringing together population health and clinical service strategies is critical to create sustainable healthcare delivery and manage future demand. The Health Board commissioned Grant Thornton in August 2021 to provide research, data and challenge whilst partnering to conduct a series of clinical service planning workshops in conjunction with the Strategy Clinical leads.

CTMUHB provides primary, community, hospital and mental health services to the 450,000 people living in three County Boroughs: Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The 65 – 84 and 85+ age groups are projected to have the largest increase in population by 2036, when an estimated one in four people in Wales will be aged 65 and over. These projections will have significant implications for the way in which the Health Board designs and provide our increasingly integrated health and social care services, so that they can help the people living in local communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions. The Health Board is comprised of three Integrated Locality Groups (ILGs),

- Merthyr and Cynon
- Rhondda Taf Ely
- Bridgend

The challenge the Board's clinical strategy must address is the poor health status of the CTMUHB population whilst protecting future generations from avoidable disease. Life expectancy for both females and males is lower in all three authorities compared to the Welsh life expectancy. Bridgend has the best life expectancy out of the three areas and Merthyr Tydfil the worst. This along with the additional challenge arising from the impact of Covid and the backlog of "regular" NHS work e.g. in cancer and elective care has increased health inequalities. CTMUHB experienced the highest number of Covid-19 deaths of all Welsh Health Boards by March 2021.

The clinical strategy must be cognisant of the wider determinants of health, sensitive to health inequity and bring all parts of the system together to deliver different models of care rather than shunting activity around. The strategy needs to bring together public health and national strategies for wellbeing (as per A Healthier Wales) to set out a transformation journey in both health and social care. As part of the review it is important to factor digital development, science and technology into realistic change to pathways and service models. The approach must consider risk stratification, prevention and early detection of disease and life course management.

The establishment of a strategy steering group attended by the Clinical Strategy Leads provided a strong clinical input to the development of the pathway exemplars. The aim was to build on the sound developmental work already in train. The Strategy Steering Group and Clinical Strategy Leads were created in August 2021. This work has been codeveloped with the group to retain local context and ensure ownership to drive the ongoing development of the clinical strategy beyond this report. The Strategy Steering Group helped plan, run and lead the virtual workshops, set out the approach to co-development, including the design principles, and clarify the local context in terms of population health, public health strategy and challenge the local clinical performance data sets to inform discussions. This group has been pivotal to steering the development of the exemplars and will continue to drive the clinical strategy development following this report.

In preliminary work we explored the population based "life cycle" and disease-based pathway approaches to developing a clinical strategy. The group wanted to maximise the population and person-centred focus offered by the life cycle approach. The strategy steering group established the focus of the first wider stakeholder workshops to help define the pathway focus. Although originally the detailed exemplar development was to be on system pathways the focus was amended and refined to ensure a population, 'person' focus. This aligned to the partnership and system group work that the Clinical Strategy Leads had already started. The life stage approach was codeveloped to pick out key exemplar pathways that can inform an approach to an overall clinical strategy, based on impact and need. These pathways were selected to map onto the key life stages identified in CTM2030, and whilst some areas were more developed than others, the insights provided by the data and conversations with key staff helped identify actionable interventions for key sections of the population, alongside broader measures that can be rolled out further in the strategy process. The first series of workshops brought together a wide group of stakeholders from across the Board to consider local priorities within each life cycle stage. Attendees used a prioritisation matrix to select areas within each life cycle segment for further development. Selection was based around local need, impact, national policy and engagement across disciplines.

1) Born well – attachment and wellbeing
2) Growing well – healthy weight
3) Living well – colorectal cancer and lower limb musculoskeletal disorders
4) Aging well – frailty
5) Dying Well – last 12 months of life

By aligning population health management with clinical strategy, the wider determinants of health are considered, bringing sustainable health outcomes and reducing the demand curve for the future population. Given the health status variation within CTMUHB and the impact of deprivation on people living in the region, a population health management lens was deemed appropriate. The life stage approach mapped to the Health Board's core strategy and these chosen exemplars informed an approach to overall clinical strategy and life cycle issues. The interventions considered were discrete exemplar methods rather than whole pathway analyses.

To aid the development of the exemplars in line with the newly formed Health Board a set of deign principles were codeveloped with the Strategy Clinical Leads and endorsed by the Strategy Steering group. These principles will underpin a future clinical strategy model:

- ✓ **Reduce complexity and unwarranted variation or duplication**
- ✓ **Focus on supporting independence and self-care**
- ✓ **Prioritise those with the highest needs**
- ✓ **Align with Zero Net Carbon strategies**
- ✓ **Address complete patient pathways, not just organisational slices**
- ✓ **Driven by data and insight using a 'single version of the truth' approach**
- ✓ **Be supported by digital technology and innovation**
- ✓ **Be adopted at scale where appropriate**
- ✓ **Be supported by rather than driven by estate considerations**
- ✓ **Have the best and most sustainable use of resources**

A second stage of six virtual workshops, defined by the workshop series one output, considered six pathways for each population group. In advance of the workshops we worked with the clinical strategy group leads to develop a set of pre read-materials that would inform the stakeholders at the workshop to ensure a focused and useful discussion:

- ✓ **Review the current pathway and challenges**
- ✓ **Understand the current and emerging evidence base**
- ✓ **Consider the impact of the workforce, technology and estate**
- ✓ **Review exemplar materials**
- ✓ **Engage and gather input from local patients to inform discussions**
- ✓ **Conduct supporting modelling work around demand and capacity analysis for the future system position taking account for predictive future data, capacity available within the Health Board (Theatres etc), productivity analysis.**

The output of the second series of workshops led to a series of interventions being identified by pathway. However, many were generic and could be applied across the health board, others were pathway specific. The next steps were to understand the impact of the identified interventions and how these can be applied to the specific pathway. These have been pursued in the series two workshops or as a more generic change to be made across the Health Board.

The generic actions which emerged when considering the six specific pathways in detail covered:

- Facilitate **better risk stratification of patients** to aid the right channeling and most appropriate use of hospital and community resources consistent with national and local policy. Technologies to support stratification and decision making will become increasingly important.
- **Join up and map the NHS services** delivering the solution alongside public health activities – too many pathways demonstrated multiple pilots running, a crossover of services provided or a disjointed patient experience because the services were not effectively interfaced.
- **Join up and map the services with the local authority and the third sector** – many of the pathways identified better ways of working with the third sector and identified this as an area for partnership development.
- **Standardise referrals and ways of working across the ILGs** to ensure equity of treatment – referrals and entry points into the NHS differed by ILG and the services provided were also dependent on the workforce model e.g. access to language therapy differed by ILG.
- **Develop a joined up digital strategy across ILGs** addressing community, primary and secondary care – this was a continuous theme throughout either gathering data for analysis or having access as a clinician. There are different systems and access to meaningful joined up data was a challenge.

The implications of addressing the generic actions listed above would have implications on the following areas. These will all need to be addressed in the wider vision of the Health Board as part of the development of the clinical strategy:

1. Forming **a comprehensive workforce strategy** to impact the robustness of the workforce, including considering new roles.
2. **Making the best use of the estate**, including looking at the services offered on the acute sites (eg. Trauma and Orthopaedics) to make best use of the facilities /deployment of services to meet future demand.
3. Developing **a digital strategy and sufficient digital maturity** to support a modern, forward-looking digital infrastructure. Including developing a workforce to create strong capability in data management and analysis, and clinical decision making to the top of its licence across all three ILGs
4. Working with education providers to ensure the **education, training and continuing professional development** meets the needs of the staff so they are equipped with the skills to contribute fully to a digitally enabled health board
5. Addressing **governance, monitoring, and reporting** across the organisation to improve communication and delivery of services. In particular, the relationship between the framework and standards developed by the Health Board and the local delivery role of the ILGs needs to be properly articulated.

Each pathway also had a detailed set of interventions that could be applied in the short, medium or long term. These are considered in turn in each table below setting out the action, implications and the next steps required to monitor and review progress.

Born well: attachment and wellbeing

Actions	Implications	Monitoring and review
• Join up services across the ILGS that impact on perinatal wellbeing and early years parental attachment • Work with local authority partners to broaden and focus resources and harness the use of the third sector • Map the health and social care services and handovers in place • Link with infant feeding specialists where there are breastfeeding challenges • Improve service monitoring and develop robust reporting mechanisms • Review and standardise the rigid and limited referral criteria • Define the Born Well strategy • Improve communication and signposting of services to families • Create public health messages for parents	• Define a multi-disciplinary workforce and training plan to upskill existing staff • Improved information sharing and processes for transition between services • Improved partnership working with local government, third sector and community groups	• Harness the recent CTMUHB regional attachment project • Implement consistent Health Board wide criteria for referrals • Implement an integrated data capture and reporting system

Growing well: healthy weight in children

Actions	Implications	Monitoring and review
• Join up existing NHS services and improve links with third sector and national bodies • Clarify mechanisms to identify, predict and risk-stratify children • Ensure a system wide and community owned approach • Develop a CTMUHB wide approach that can target interventions to the most deprived communities	• Consider universal and specialised workforce training programmes • Workforce training in making every contact count • Improved partnership working with local government, third sector and community groups to develop integrated planning and provision • Review and reallocate resources towards interventions with best evidence base • Develop a consolidated register of interventions for staff signposting	• Explore and invest in new initiatives as part of one governance structure • Measure success via increased breastfeeding rates, positive public, patient and staff feedback, and increased public engagement with healthy living messaging on social media

Living well: colorectal cancer

Actions	Implications	Monitoring and review
• Consolidate services across the 3 ILGs to provide one single, joined up offering • Define a clear referral process from Primary Care through to post surgical care, with a single point of access, to ensure patients are treated appropriately and efficiently • Invest in diagnostic resource to relieve the bottleneck which currently impacts Colorectal Cancer and other pathways across CTMUHB • Invest in administrative support to relieve pressure on clinical time	• Consolidation of two patient systems and investment in wider digital infrastructure • Further investment required in the workforce both in cancer but also diagnostic clinical support services • Recruitment of AHPs and other posts may need to be prioritised from other pathways if resourcing is limited • Estates may need to be reprofiled to allow for consolidated services or single centre of excellence	• Using this roadmap as a basis, develop a monitoring framework to track progress on clinical strategy implementation • Develop integrated data systems that enable intelligent use of data to intervene earlier to prevent conditions from developing or manage them in non-acute settings • Use techniques such as statistical process control to monitor the colorectal pathway and to identify and manage unwarranted variation • Develop CTMUHB as a learning organisation with a culture of using data to evaluate and continuously improve the effectiveness of interventions

Living well: lower limb musculoskeletal disorders

Actions	Implications	Monitoring and review
• Explore implementation of an elective hub or a green site to prioritise elective activity • Conduct theatre modelling to understand capacity and utilisation • Invest in parallel services, such as Pain Management, and third party organisations to relieve pressure on secondary care services • Shift to a prevention led model targeting highest areas of deprivation which analysis shows will be more likely to high a higher incidence of MSK issues.	• Estates may need to be reprofiled to increase theatre capacity • Investment in workforce may be required to deliver additional capacity, either out of hours or at weekends • Capacity in some parts of CTMUHB may be reduced to pool resource and reduce elective backlog	• Using this roadmap as a basis, develop a monitoring framework to track progress on clinical strategy implementation • Develop integrated data systems that enable intelligent use of data to intervene earlier to prevent conditions from developing or manage them in non-acute settings • Use techniques such as statistical process control to monitor the msk pathway and to identify and manage unwarranted variation • Develop CTMUHB as a learning organisation with a culture of using data to evaluate and continuously improve the effectiveness of interventions

Ageing well: frailty

Actions	Implications	Monitoring and review
• Join up existing NHS services and improve links with third sector and national bodies • Standardise existing frailty services to reduce unwarranted variation • Implement an electronic frailty index (eFI) to provide a standardised assessment mechanism and risk stratify the ageing population • Standardise Advanced Care Planning including ceiling of care and last days of life • Consider equality of treatment and unwarranted variation for strokes • Establish a single point of entry via community hubs in each ILG	• Workforce training is required to ensure all staff can identify needs and signpost appropriately • Review the workforce plan needed for a standardised frailty service, optimising use of the non-medical workforce • Establish a single patient record for all clinicians • Increased integrated working with third sector partners • Investment needed in preventative interventions and orthopaedic geriatric and perioperative services • Extension of multi-disciplinary frailty hubs and frailty nurse roles	• Establish a shared digital vision across all tiers and ILGs • Agree a common definition of frailty and establish an integrated reporting system • Measure success via reduce prevalence of frailty per head and reduced inequality between areas

Dying well: last 12 months of life

Actions	Implications	Monitoring and review
• Join up existing NHS services and improve links with third sector and national bodies • Build on six steps of life and introduce Advanced Care Planning • Implement standardised end of life care offer • Reduce unnecessary interventions in line with national policies	• Workforce training required on core principles of last year, months and days of life • Wider communication needed with public and staff to understand services available • Review workforce plans across health and social care • Consider investing in Hospice at Home and third sector services	• Improve data capture across ILGs and establish a shared digital vision across tiers and services • Undertake a review of access to end of life services to ensure diversity and inclusion for all • Measure success by increased proportion of patients given the opportunity to discuss their preference and proportion of patients dying in their place of choice