GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM 2030

Ein Hiechyd Ein Dyfodol

DATBLYGU CYMUNEDAU IACHACH GYDA'N GILYDD

CTM 2030

Our Health Our Future

BUILDING HEALTHIER COMMUNITIES TOGETHER

March 2022 Update

Our Vision

STARTING WELL | GROWING WELL | LIVING WELL | AGEING WELL | DYING WELL

We will build healthier communities together by:

1. *Creating Health*

2. *Improving Care*

3. *Inspiring People*

4. *Sustaining our Future*

5. *Living our values*

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WE LISTEN, LEARN AND IMPROVE | WE TREAT EVERYONE WITH RESPECT | WE ALL WORK TOGETHER AS ONE TEAM

Contents





- Population segmentation
- The approach of the strategy work
- Strategy development – vision statements
- Our workforce
- The Net Zero challenge
- Engagement with our population
- Next steps and how we will manage change

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CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

STARTING WELL

GROWING WELL

LIVING WELL

AGEING WELL

DYING WELL

Reducing health inequalities
Equal focus on mental and physical health
Supporting our communities
Being a healthy organisation

CREATING HEALTH

Our Strategic Goals

IMPROVING CARE

Delivering safe and compassionate care
Developing new models of care
Digital transformation for patients and staff
Ensuring timely access to care

Becoming a green organisation
Ensuring our services financial sustainability
Embedding value based healthcare
Ensuring our estate is fit for the future

SUSTAINING OUR FUTURE

INSPIRING PEOPLE

Visible and inspiring leadership
Promoting diversity and inclusion
Embedding our values and behaviours
Encouraging local employment

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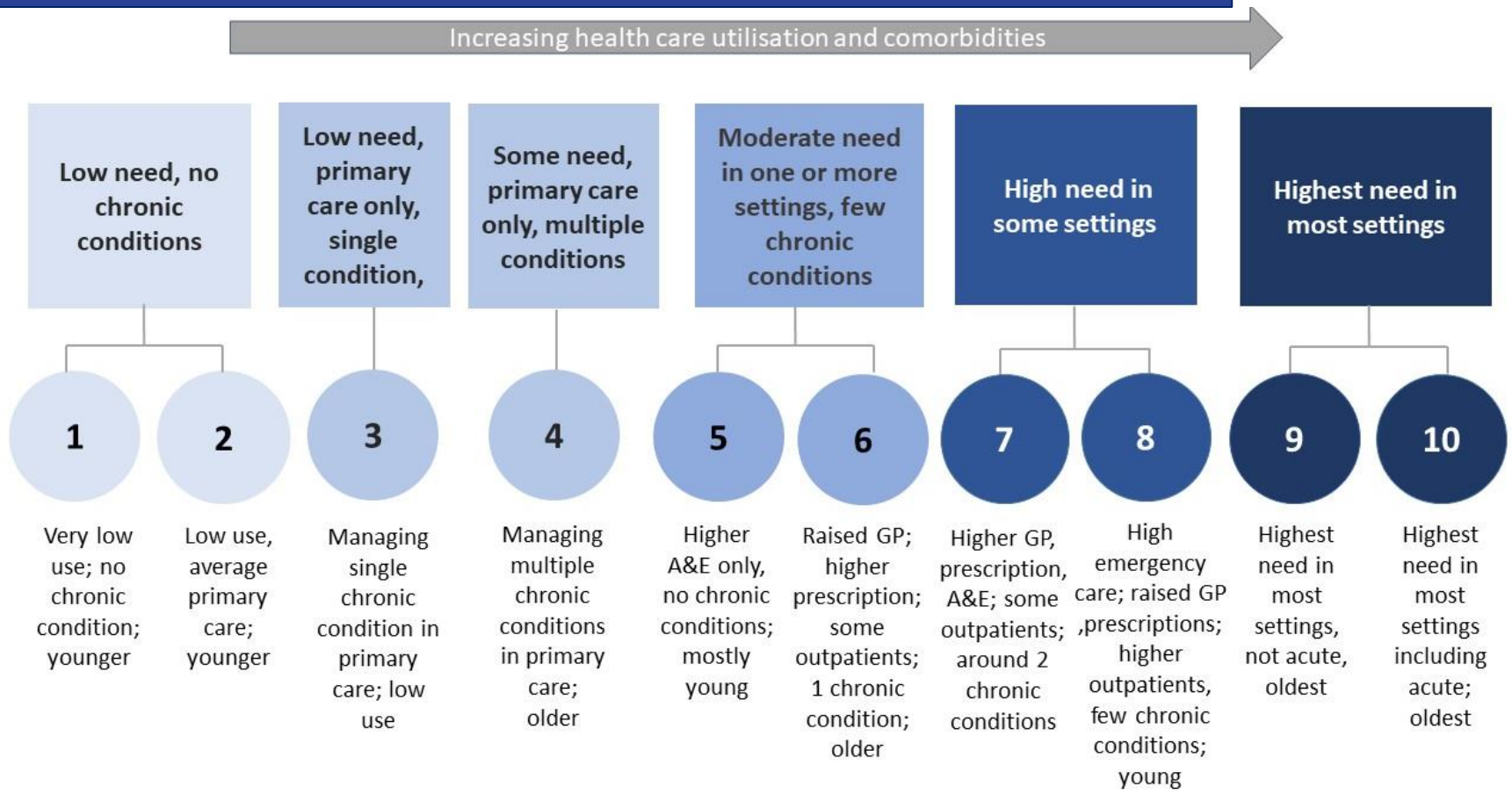
CTM UHB data-driven segments, 10 point scale



Prevalence of chronic conditions by segment

- Higher than average prevalence in highest need segments, but also high prevalence in segment 4 and 7

Average number and prevalence of selected chronic conditions by CTM data-driven segments, November 2021

	1	2	3	4	5	6	7	8	9	10	All segments
Average number of:											
Chronic conditions	0.09	0.48	1.13	3.37	0.29	1.67	2.23	0.88	5.08	4.82	**1.42**
Prevalence (%):											
Asthma	0.0%	0.5%	31.3%	26.6%	0.4%	21.4%	28.8%	7.4%	29.4%	25.4%	**12.7%**
Anxiety/Depression	0.3%	2.0%	32.8%	43.9%	1.2%	35.1%	45.8%	12.1%	47.3%	43.0%	**20.0%**
CHD	0.0%	0.0%	0.7%	8.9%	0.0%	1.2%	3.1%	0.6%	20.4%	18.8%	**3.1%**
COPD	0.0%	0.0%	0.7%	8.1%	0.0%	1.3%	2.9%	0.8%	15.4%	16.1%	**2.7%**
Dementia	0.0%	0.2%	0.2%	2.7%	0.1%	0.8%	1.9%	1.0%	6.5%	10.1%	**1.3%**
Diabetes	0.0%	0.0%	2.2%	24.4%	0.0%	3.6%	7.9%	1.8%	36.1%	30.9%	**7.0%**
Heart failure	0.0%	0.0%	0.1%	2.3%	0.0%	0.2%	0.6%	0.2%	8.1%	9.3%	**1.0%**
Hypertension	0.0%	0.1%	14.2%	55.0%	0.0%	17.7%	21.5%	4.7%	64.4%	57.0%	**16.8%**
Mental illness	0.0%	0.0%	0.6%	3.1%	0.0%	0.7%	1.9%	0.5%	3.9%	4.7%	**1.0%**

Note: Chronic conditions based on coded diagnosis in primary and secondary care data between 2001 and Nov 2021 using Johns Hopkins ACG system (results similar to QOF coding) and record-linked data from the SAIL databank; Segments based on health care utilisation and comorbidities; Colouring is based on intervals within the range of values to highlight variation. Based on 45 of 49 CTM GP practices.

Approach to Clinical Services

- **Reduce complexity** and unwarranted variation
- Focus on **supporting independence** and self care
- **Prioritise those who need us** the most
- Align with **net-zero strategies**
- **Address complete patient pathways**, not just organisational slices
- Be supported by data and insight using a '**single version of the truth approach**'
- Driven by digital **technology and innovation**
- **Adopted at scale** where appropriate
- Be **supported by rather than driven by estate** considerations
- Have the **best and most sustainable use of resources**, including how staff work

The Care Model

The overall care model includes the following key elements to guide the strategy:

- Supported prevention and self care
- Integrated Primary and community & social care – home first
- High quality Acute / hospital services
- Specialised services in centres outside of CTM

Clinical Services Strategy workshop outputs - 1

Workshop outputs showing 'what good would look like' in the future:

Born well – Attachment and wellbeing:

Parenting services are joined up and consistent across the region and working closely with Local Authority partners, harnessing the third sector opportunities and utilising community groups available. Staff are upskilled to better support parents enhanced by better data systems and improved communication and signposting.

Growing well – Healthy weight in children

A whole family approach that is based on early identification and a system-wide effort, underpinned by psychological support. Opportunities for children will range from free cooking lessons, access to exercise and digital engagement resources. Universal and specialised staff training programmes will ensure that every contact counts and success will be clearly understood in a number of measurable ways.

Clinical Services Strategy workshop outputs - 2

Workshop outputs showing '<u>what good would look like</u>' in the future:

Living well - MSK – lower limb:

The service will provide fast and effective surgery with the shortest possible length of stay. An elective hub will offer a level of protection to ensuring the continuity of surgical activity. The pathway will focus on prehab to rehab, obesity reduction, promoting exercise, social prescribing, fracture liaison, ortho-geriatrics as well as a consistent falls prevention service. There will be a single point of contact standardising all referrals, advice and onward pathways incl. alternative care pathways and signposting to third sector.

Living well - Colorectal Cancer:

There will be a consolidated and joined up service offering across CTM aiming to optimise screening and offer a single point of contact for advice and referral to onward pathways. Regional and community hubs will enhance diagnostic capacity, and therapeutic pathways will be supported by prehabilitation and multi-disciplinary rehabilitation services to deliver high quality outcomes and reduce length of hospital stay. The latest digitisation and AI technologies will be utilised.

Clinical Services Strategy workshop outputs - 3

Workshop outputs showing '<u>what good would look like</u>' in the future:

Aging well - Frailty:

There will be a joined up and aligned service offering across CTM providing multidisciplinary team-based Frailty hubs as the single point of contact. An electronic frailty index will provide a standardised assessment mechanism, risk stratifying the ageing population. COTE specialists are provided across all pathways benefiting from the single patient record – monitored through wearables / apps for patients, allowing for self-care. A focus at all times on preventative interventions.

Dying well - Last 12 months:

This will join up existing NHS services and improve links with third sector and national bodies. A wider communications campaign will build awareness of services leading to a consistency of access and a better fast-tracked service. This will be underpinned by enhanced case identification and co-ordination systems. Advance care planning will ensure a high quality and standardised end of life care offer, reducing unnecessary interventions.

Workforce

Our workforce is key to bring CTM2030 to life:

- Our workforce are our effectors for strategic change
- Clinical staff are already engaged in delivering local exemplars. The workshops highlighted some of the 'good' that needs to be rolled out more widely.
- Staff across clinical pathways know the service and understand how improvements can be made
- If we know what population health outcomes we want to deliver our staff should be empowered to suggest the best ways to achieve this and would therefore be more invested in making change happen.
- We have new programmes to develop clinical leaders and should advertise these widely.

Net Zero 2030

STARTING WELL | GROWING WELL | LIVING WELL | AGEING WELL | DYING WELL

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CTM 2030 Our Health Our Future — BUILDING HEALTHIER COMMUNITIES TOGETHER

THEMATIC MAP

CREATING HEALTH | IMPROVING CARE | INSPIRING PEOPLE | SUSTAINING OUR FUTURE

COMMUNITY

CONNECTIONS
- Group / Peer Support
- Resilience
- Social cohesion
- Belonging

SPACES
- Local Services / Facilities
- Green Spaces
- Transport / Travel
- Safety and Accessibility

LONG TERM ILLNESS

SELF-MANAGEMENT
- Pain
- Medication
- Mobility
- Quality of Life

PATIENT EXPERIENCE
- Pathways
- Referrals
- Values and Behaviours
- Waiting lists

AGEING

PREVENTION
- Independence
- Skills and Knowledge

WORRY
- Intergenerational burdens
- Loss of abilities
- Reliability of service

HEALTHY BEHAVIOURS

MOTIVATION
- Automatic
- Reflective

CAPABILITY
- Psychological
- Physical

OPPORTUNITY
- Social
- Physical

PATIENT EXPERIENCE

ACCESS
- Closer to home
- GP surgeries
- Structure

COLLABORATION
- Local Networks
- Patient voice

IMPROVEMENT
- Prevention
- Change and ideas
- Communication

WORK / LIFE BALANCE

LIFE/ WORK SATISFACTION
- Work/Life balance
- Work as a barrier
- Stress

WELLBEING AT WORK
- Physical activity
- Mental wellbeing

Next steps

Focus areas looking forward:

- Community health and social care integration – primary care cluster development
- Working with hospital clinical staff around individual services including future urgent and elective configurations

When we change how services are delivered we will:

- Work with patients and the public to agree what needs to change and why
- Jointly Identify new Options
- Formally Consult On Options
- Be transparent about the decisions

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