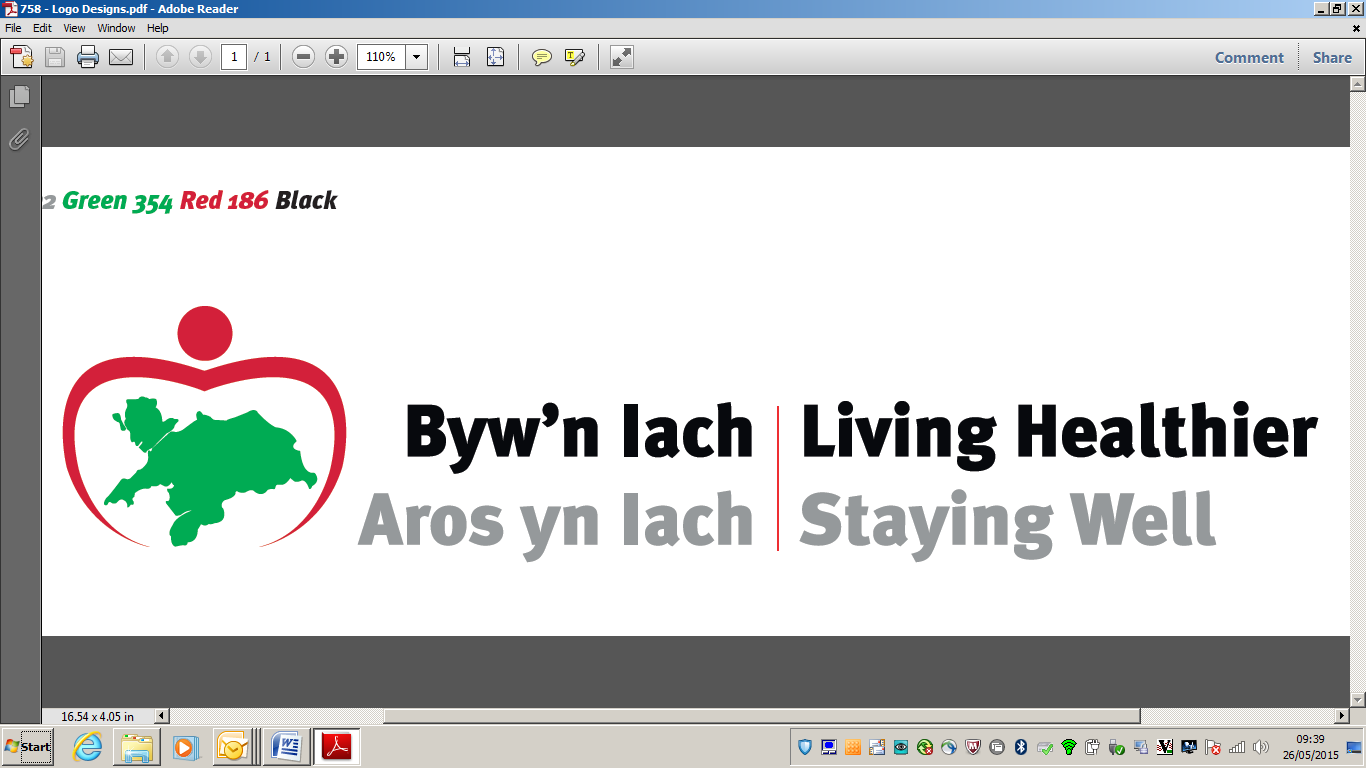
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**BASELINE ASSESSMENT**

**MARCH 2017**

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The description of a baseline position is an important part of the process agreed for the strategy development programme. It enables a clearer understanding of the needs and challenges and priorities of the population we serve and the context within which we are working.

The baseline document feeds into the overall strategy as part of the seven step approach we have adopted:

* ***Frame*** the strategic questions we are seeking to answer ✓
* ***Diagnose*** the current position ✓  
  *Establish baseline starting position - detailed summary of performance and drivers; evidence base and standards; commence modelling of health needs and population projections*
* ***Forecast*** – develop a clear view of the potential future
* ***Generate scenarios*** – ideas and options for change
* ***Prioritise*** ideas and build into an overall strategy
* ***Agree and implement*** the goals of the strategy
* ***Evolve –*** monitor the impact, refresh and recreate when necessary

For a graphic representation of the seven step approach and summary of each step, see Appendix 1.

1. **INTRODUCTION**

The Health Board has undertaken a significant amount of work in the recent past to engage clinicians, other staff, partners and stakeholders in the debate around improving the health of the population and ensuring efficient and effective health services when needed. The Board is now in a position to build on this work and take the opportunity to shape a coherent, system-wide strategy for health, well-being and healthcare.

The Health Board has defined a clear strategic vision statement:

* We will improve the health of our population, with particular focus upon the most vulnerable in our society
* We will do this by developing an integrated health service which provides excellent care delivered in partnerships with the public and other statutory and third sector organisations
* We will develop our workforce so that it has the right skills and operates in a research-rich learning culture

**The Health Board’s ambition is to lead the way on integrated care, supporting health improvement for the population now and in the future.** “Integrated care takes many different forms. In some circumstances, integration may focus on primary and secondary care, and it others it may involve health and social care.” (King’s Fund, 2011.) Integration may be real - where organisations merge their services - or virtual integration, in which providers work together through networks and alliances. There is a growing evidence base for different forms of integration, whether for whole population groups or for the individual.

The vision is further defined by the 7 Strategic Goals

1. Improve health and well-being for all and reduce health inequalities
2. Work in partnership to design and deliver more care closer to home
3. Improve the safety and outcomes of care to match the NHS’s best
4. Respect individuals and maintain dignity in care
5. Listen to and learn from the experiences of individuals
6. Use resources wisely, transforming services through innovation and research
7. Support, train and develop our staff to excel

In addition, from April 2016, the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 have come into effect.  Both Acts have major implications for the Health Board and the way that we carry out our business.

The Social Services and Well-being (Wales) Act focuses on the individual well-being of a sub-set of our population, namely those individuals who need care and support, and carers who need support. Its aim is to maximise each individual’s ability to feel good and function well by increasing their sense of control; strengthening their resilience and ability to access resources to cope when needed; and feeling included and being able to participate.

The Well-being of Future Generations (Wales) Act 2015 requires all public bodies to change the way they work in order to improve well-being for the *whole* population, by acting in accordance with the sustainable development principle, and meeting the 7 Well-being Goals.  Working in this way means we can better meet the needs of our present population without compromising the ability of future generations to meet their own needs. Sustainable development connects the environment in which we live, the economy in which we work, the society which we enjoy and the cultures that we shared to the people that we serve and their quality of life.

The implementation of both Acts will require a significant cultural and behavioural shift within the Health Board, especially in relation to the way we work with the public we serve and with our partners.   Both, however, represent a significant opportunity to create the conditions in which we can improve the well-being of both current and future generations in North Wales.

A new approach is needed to developing, defining and applying new ways of working with our communities, new models of care and new roles within the workforce:

* We need a strategic direction that will set out a clear and acceptable offer to our population
* Our strategy must be based on the achievement of better health outcomes for our population and clinical outcomes and standards for our services
* Engagement with our population and partners must be at the heart of the development of the strategy and continue throughout the work of all the component workstreams
* We must establish a safe, sustainable service for the medium to longer term future
* We must recognize and work to address constraints in our resources – financial and workforce - and take advantage of new opportunities
* We need to support our workforce to be fully engaged, involving people at all levels of the organization in driving forward the change we need
* We must demonstrate, and deliver upon, our shared commitment to the well-being duty set out in the Well-being of Future Generations Act.

One of the requirements of the Well-being of Future Generations Act is to set well-being objectives for the Health Board. These should be integrated within the corporate plans of the Board and should reflect the sustainable development principle in their development and delivery.

The seven current strategic goals were discussed with our Local Partnership Forum, Health Professionals Forum and Stakeholder Reference Group, all of whom support them as a framework to guide our actions moving forward. These goals also built on feedback from the population and partner organisations through the extensive listening exercise that was commenced during 2015 and continued into 2016/17.

We are proposing therefore to adopt our strategic goals as our initial well-being objectives on an interim basis. We will use the strategy development process to ensure the alignment of the strategy work programmes with the Heath Board’s strategic goals and their overall contribution to the seven Well-being Goals set out in the Act. Our initial assessment of the alignment is set out below.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Our strategic goals:**  **our well-being objectives** | | **Prosperous** | **Resilient** | **Healthier** | **More equal** | **Cohesive** | **Culture** | **Global** |
|  |  |  |  |  |  |  |  |  |
| 1 | Improve health & well-being for all and reduce health inequalities |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 2 | Work in partnership to design and deliver more care closer to home |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 3 | Improve the safety and outcomes of care to match the NHS’s best |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 4 | Respect individuals and maintain dignity in care |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 5 | Listen to and learn from the experiences of individuals |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 6 | Use resources wisely, transforming services through innovation & research |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| 7 | Support, train and develop our staff to excel |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

We will review the objectives further during the strategy development process and the subsequent IMTP development process to refine the approach.

**How the development of the strategy will be progressed**

There will be three overlapping major **programmes** within the overall portfolio:

* **Improving Health and Reducing Inequalities**
* **Care closer to home**
* **Acute hospital care**

Whilst there will be a specific programme to drive and deliver on the Health Board’s contribution to improving health and reducing inequalities, the focus on addressing inequalities will be a founding principle for *all* areas. Each programme will be required to demonstrate that improving health and well-being and reducing inequalities is the foundation. All programmes will need to have regard to improvement of health through the life course – understanding and addressing the needs of individuals at different stages of the life course, including the specific needs of those who share protected characteristics.

The Health Board has, in addition, prioritised the need to focus on developing effective strategies with our partners for two distinct life-course phases: **children & young people**, and **older people**. For each there will be a plan developed to ensure that there is consistent and appropriate focus on meeting the needs of the relevant group. This work will ensure strong links with existing partnership groups, but recognising that there will need to be capacity and resources committed by the Health Board to ensure appropriate direction and delivery of priorities for our strategy.

The development of a robust strategy for **mental health and well-being** is a key area for the Health Board and has a specific focus under the Special Measures performance and improvement framework. Development of the governance arrangements has already commenced, working through the Together for Mental Health Partnership and will be led by the Mental Health division but linking in to the overall strategy development programme.

All areas of work will be built upon an assessment of health need for the relevant area and will identify the outcomes which are to be achieved. These will include public health and well-being outcomes, and will also include service quality outcomes - clinical and patient experience – for specific service areas.

Academic and clinical leadership and contribution will be sought throughout the programme to ensure the strategy development is founded on robust evidence gathering, and includes appropriate research and evaluation to support the work.

The Programme will ensure links with strategic programmes in adjacent areas which will impact on our population, notably the work of the Mid Wales Healthcare Collaborative; the Future Fit Programme in Shropshire and Vanguard developments in Cheshire and Merseyside.

**Developing the Health Board’s strategy for health and healthcare**

The Programme will be supported by enabling workstreams which will work to identify how future models of care will be facilitated and supported.

**Health through the life course**

***Physical, emotional and mental health and well-being***

Feeding into the whole will be three frameworks – for mental health and well-being; for children and young people; and for older people.

1. **STRATEGIC QUESTIONS**

***- What are we seeking to achieve?***

It is important to be clear at the earliest stage what we are seeking to achieve. To support this, we have identified a series of strategic questions. The questions link back to our vision statement and the 7 strategic goals; they also reflect what people have told us is important to them in the general listening exercise undertaken in 2015/16.

The questions are shown below, together with the Strategic Goal to which they will contribute.

* How can we work with people to improve health and well-being for all ages – physical and mental health – both now and in the future?   
  Strategic Goal 1 *(improving health & well-being for all, reduce health inequalities*)
* What can we do to help reduce the differences in health and well-being in different parts of North Wales or different groups?  
  Strategic Goal 1*(improving health & well-being for all, reduce health inequalities*)
* How can we make sure our NHS always provides good, safe and effective care, and produces good results for all, to match the best?  
  Strategic Goal 3 *(improve safety and outcomes of care to match the NHS’s best*)
* How will we reduce how long people wait for health services, so that people can get the support they need, at the time they need it, in the right place?  
  Strategic Goal 6 *(use resources wisely, transforming services through innovation and research*)
* How can we make sure we use our staff, our budgets and our hospitals, clinics and other facilities well so we can provide better NHS services in the future?  
  Strategic Goals 6 *(use resources wisely, transforming services through innovation and research*) and 7 (*support, train and develop our staff to excel*)
* How will we use current and new technology to help improve how we connect with people and how others connect with us?  
  Strategic Goal 6 *(use resources wisely, transforming services through innovation and research*)
* How do we work better together with our staff and with others in addressing these issues?  
  Strategic Goal 2 (*work in partnership to design and deliver more care closer to home*)
* How do we make sure we continue to listen and to learn from feedback and from patients’ experiences in the future?  
  Strategic Goals 4 *(respect individuals, maintain dignity in care)* and 5 *(listen to and learn from experiences)*

These strategic questions are important in setting the scope for the overall strategy and guiding the work of the different programmes. Referring to these questions will ensure that all programme groups are working to achieve the same aims.

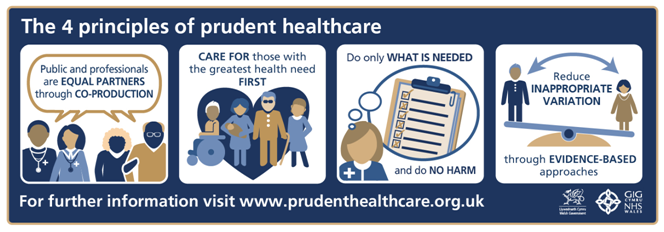
1. **ENABLING PRINCIPLES**

There are two sets of enabling principles which will underpin the development of the Living Healthier, Staying Well strategy.

The Well-being of Future Generations (Wales) Act 2015, referenced above, has the potential to influence the way we work to secure sustainable solutions for the present and future generations.

There are **five ways of working** which support the Sustainable Development Principle:

These are in part complemented by the four Prudent Healthcare Principles:



In the paper, Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales (Public Health Wales, 2016), these two sets of principles are

brought together with recommendations on how to embed the principles into practice.

**5. Involvement and “co-production”**

Ensure communities and people in Wales are given a voice, involved in decisions about their health and well-being and listened to through “knowledge forums” to facilitate the engagement of the public, professionals, policy makers and academic experts

**6. Minimise and mitigate harms to health**

Ensure impacts on health, well-being and equity are known and harms are minimised and mitigated through adopting a “Health in All Policies” approach across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, to improve population health and health equity

**7. Reduce variation and address the greatest population health need first**

Ensure a “Proportionate Universalism” approach, i.e. all decisions and interventions which benefit health and well-being are implemented for all people but delivered at scale proportionate to need.

1. **Prevention**

Invest in preventative interventions which are based on evidence and offer value for money.

1. **Long-term view**

Adopt a long-term investment and prioritisation framework to protect, improve and promote the health and well-being of people and communities in Wales

1. **Integration**

Utilise Health Impact Assessment… in order to consider the impact of any decision and intervention on health, well-being and inequalities, i.e. assessing the potential influences of policies, plans and projects in different non health sectors

1. **Collaboration and “systems working”**

Working in partnership and synergy across sectors on national and local level, including governmental, public, private and third sector organisations.

These enabling principles will be used to develop and scrutinize proposals coming forward within the developing strategy.

1. **OUTCOMES**

The backdrop for population health and well-being in Wales has recently been more clearly articulated through the publication of both the national indicators accompanying the Well-being of Future Generations Act, and the closely related Welsh Government Public Health Outcomes Framework.

The Figure below, taken from Measuring the health and well-being of a nation(Welsh Government and Public Health Wales, March 2016), illustrates the broad context and links between key Welsh Government strategic, policy and operational strands.



**Figure 1**

It is within this context that our strategy Living Healthier, Staying Well sits, and it is timely, therefore, that we begin to describe our current population health and well-being status through the indicators in the Government’s Public Health Outcomes Framework (Outcomes Framework). Many of these are also National Indicators included within the Wellbeing of Future Generations Act outcome indicators.

The NHS Wales Planning Framework 2017/20 confirms the requirement for every NHS organisation to have a long-term strategy which should be a separate document to the IMTP.

“*In essence, the strategy should set out the organisation’s strategic goals; outline the ‘roadmap’ which the organisation will follow; and describe how it will address any key strategic challenges or opportunities*.”

From 2017, the NHS Delivery Framework is changing. It will start to align more closely with the public-health framework, working towards the production of only one outcome framework. This means that there will be one health outcome framework using public health indicators, instead of the current two frameworks.

This change is intended to demonstrate how NHS delivery measures contribute to wider health gains (outcome indicators) and should support partnership working to deliver sustainable health and well-being outcomes. By using public health outcomes, linked to national Well-being of Future Generation indicators, public sector boards will work towards the same measures. Health boards, trusts and partnership organisations will be able to demonstrate how they are working together to meet the goals of the Well-being of Future Generations (Wales) Act.

It is timely and appropriate therefore that our strategy addresses how we will contribute to achieving public health outcomes.

Our contribution to the delivery of the Outcomes and the accompanying Indicators is described in a number of different functions in the Table below

|  |  |
| --- | --- |
| **OUTCOMES** | **OUR CONTRIBUTION** |
| **Overarching Outcomes**   * Years of life and years of health * Mental well-being * A fair chance for health | These highest level, longer term outcomes describe changes in overall population health status over time and are particularly important for assessing progress in reducing inequalities. |
| Three sets of Intermediate Outcomes follow which illustrate overall changes in behaviour, practice and environments. | |
| **Living conditions that support and contribute to health now and in the future**   * Children have the best opportunity for a healthy start * Families and Individuals have the resources to live fulfilled, healthy lives * Resilient, empowered communities * Natural and built environment that supports health and well-being | Although other public sector and government bodies have substantial responsibilities in respect of securing many of the elements included here, we also have a substantial opportunity to influence.  Being a key partner in a multitude of local and national bodies, a major employer in the region and a major contributor to the wider economy of North Wales, gives us not only a powerful voice in advocating for improvement in living conditions but also considerable opportunity to make changes through our own policies and actions.  Of particular importance here are education, skills and training, and the extent to which the way we plan and deliver our services enables and empowers people in local communities. |
| **Ways of living that improve health**   * Healthy actions * Healthy starts | In this aspect of the Framework, the work of the staff we employ and the contractors with whom we develop and implement primary care service is of fundamental importance. The potential reach into the population of the many thousands of staff we employ and contract with offers a golden opportunity for influencing, advising and supporting people to adopt the healthy actions evidence has shown to be beneficial.  We also have a crucial role in influencing and supporting partners from the earliest childcare settings right through the educational system to ensure that critical aspects which impact on future health and wellbeing are delivered.  As an employer we also have a duty not only to support our own staff in increasing the healthy actions they adopt, but also to use our influence and example with other employers across North Wales. |
| **Health throughout the lifecourse**   * Health in early years and childhood * Good health in working age * Healthy ageing * Minimising avoidable ill health | Our Strategy clearly recognises the importance of adapting our planning and delivery to the differing needs of people at each stage of life.  As a planner, provider and commissioner of services, we can prioritise and visibly advocate a shift in focus towards prevention and early intervention at each stage. |
| The Indicators included within each section of the Framework describe Short term Outcomes, demonstrating the impact and effectiveness of what we, our partners and the people we serve do to improve health and wellbeing. | |

* Many of the Indicators allow comparison with Wales as a whole, and depending on the specific indicator, with other Health Board areas.
* A number of indicators are also available at Local Authority level, which gives us greater insight into variation at a more local level within our geography.
* A smaller number of Indicators have also been analysed according to age, gender and disability.
* Some analysis is also included which describes rural and urban differences, using the Rural Urban Classification developed by the ONS. The classification defines areas as rural if they fall outside settlements with more than 10,000 residents.

Not all of the 49 indicators identified within the Outcomes Framework are as yet available. There are 40 Indicators currently accessible via the Public Health Wales Observatory Interim Reporting tools. The summary table attached as Appendix 2 sets out the baseline position for the indicators which are available. A fuller document is available which describes the baseline and what indicators mean for our population.

1. **EQUALITY AND HUMAN RIGHTS**

* **A more equal Wales**

**5.1 Background**

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

**5.2 Context**

**Is Wales Fairer?**

In the 2015 report, **Is Wales Fairer?**, the Equality and Human Rights Commission identify a number of key equality and human rights challenges for Wales. Evidence suggests that inequality damages the economy and society as a whole. Everyone is affected whether or not we experience discrimination in our daily lives. That’s why the review, and the detailed evidence on which it is based, is so relevant to all of us in the public, private and third sectors across Wales. In assessing whether Wales is fairer, the review found that compared to five years ago:

* There are a few improvements, for example, a reduction in hostility towards lesbian, gay and bisexual people.
* In areas of life such as education and employment significant inequalities remain between different groups of people.
* Young people are significantly worse off in many ways including income, employment, poverty, housing and access to mental health services.

The analysis identified key challenges that need to be addressed in Wales over the next five years which are major, entrenched inequalities and human rights abuses that will require substantial efforts of public, private and third-sector organisations and of individuals to reduce them.

In North Wales, we need to understand how the national experiences of inequalities and human rights abuses are reflected in our population. We have been working with representatives of groups of people who share protected characteristics to collect information to help inform this.

Sometimes the data is not available at all, and it is often impossible to undertake a more sophisticated assessment of key areas of disadvantage, for example, where people’s characteristics intersect. Some small groups of people such as those aged over the age of 80, transgender people, Gypsies and Travellers, children and young people affected by abuse and exploitation, are often invisible in the data.

Public Health Wales developed Equality Profiles for each of the six local authority areas in North Wales which provide a valuable summary of information regarding groups who share protected characteristics. These profiles are available as a resource.

**What have people already told us about equality issues in North Wales?**

For a number of years we have been working with individuals and groups who represent the interests of people with different protected characteristics and who have an interest in the way the health board carries out its functions to help determine our priorities. This includes:

* former, current and potential service users
* former and current staff, including staff equality groups
* trade unions
* third sector and equality organisations
* the wider community.

What these individuals and groups have told has helped shape our Strategic Equality Plan and will inform the strategy development.

The Equality Team has collated the key themes from engagement with different groups representing those who share the protected characteristics. The summary is available as a supporting paper for the strategy.

**The Strategic Equality and Human Rights Plan**

To meet the requirements of the Specific Equality Duties for public sector organisations, we have developed, following extensive involvement with as many interested parties as possible, our Strategic Equality and Human Rights Plan (2016-20) – Fairness, Rights and Responsibilities.

The key themes identified in the Strategic Plan are as follows, mapped to the relevant Strategic Goal of the Health Board:

**Strategic Equality Objective 1**

**Better health outcomes for all: to achieve better health outcomes for everyone, having regard for a person’s protected characteristics.**

*Maps to Strategic Goal 1*

* At Betsi Cadwaladr University Health Board (BCUHB) services are commissioned, procured, designed and delivered to meet the health needs of local communities
* Discrimination is challenged, equality and human rights are promoted and efforts are made to reduce health inequities through strategies, equality impact assessment, policies, practices, procurement and engagement
* The needs of individuals are recognised and addressed whatever their identity and background, and their human rights are upheld. Individual people’s health needs are assessed and met in appropriate and effective ways
* Transitions from one service to another are made smoothly with everyone well-informed
* When people use BCUHB services their safety is prioritised and care is free from mistakes, mistreatment and abuse

**Strategic Equality Objective 2**

**Improved patient access and experience: to improve access and experience for everyone, having regard for a person’s protected characteristics with a focus on dignity and respect.**

*Maps to Strategic Goals 3, 4, & 5*

* People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
* People’s experience of health care at BCUHB is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, spiritual needs and language
* People are informed and supported to be as involved as they wish to be in decisions about their care and feel that their involvement is valued
* People report positive experiences of BCUHB
* People’s complaints about services are handled respectfully and efficiently

**Strategic Equality Objective 3**

**Becoming an employer of choice: to be a fair and inclusive employer and build a workforce that is equipped to meet the diverse needs of our service users and colleagues, having regard for a person’s protected characteristics.**

*Maps to Strategic Goals 5 & 7*

* Recruitment and selection processes are fair and lead to a more representative workforce at all levels
* Staff are treated fairly at all stages of the employment cycle
* BCUHB is committed to equal pay for work of equal value and will fulfil our legal obligations
* Training and development opportunities are taken up and positively evaluated by all staff
* When at work, staff are free from abuse, harassment, bullying and violence from any source
* Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

**Strategic Equality Objective 4**

**Inclusive leadership at all levels: to provide the vision and motivation to advance equality at BCUHB and harness the energy and efforts of others to make improvements.**

*Maps to Strategic Goals 4, 5, 6 & 7*

* The Board and senior leaders routinely demonstrate their commitment to promoting equality within and beyond BCUHB
* Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
* Middle managers and other line managers act as role models and support their staff to work in culturally competent ways within a work environment free from discrimination
* The delivery of the SEP is embedded within Health Board Operational Plans and synchronised with normal business planning and performance management processes and delivered by the 3 Area Teams Mental Health and Learning Disabilities and Secondary Care teams

1. **PARTNERSHIPS AND COLLABORATION**

The two significant Acts which are referred to in the opening section above are bringing changes to the way in which we work in partnership, and new and refreshed duties for joint working.

**The Well-being of Future Generations (Wales) Act 2015**

The WFG Act brings specific corporate duties for the Health Board but also collective duties to work with partners to achieve the well-being goals. These collective duties are being taken forward through the newly established Public Service Boards for Gwynedd & Ynys Môn, Conwy & Denbighshire, Flintshire, and Wrexham.

The Health Board has taken a leading role in each of the PSBs, through the presence of Areas Directors, as Chairs or Vice Chairs and Executive Director input. This reflects the significance of this legislation and the Board’s commitment to actively contribute to cross sector working to deliver improvements for the population of North Wales.

We have collaborated on the preparation of 4 Well-being Assessments across North Wales. This work, along with the Board’s previously published strategic goals, will inform the development of our local well-being objectives and will shape our longer term strategy work. This new approach will support our ability to redesign services with our partners and our population, targeting preventative actions and prioritising those in greatest need first.

We will continue to work with partners during 2017/18 to develop action plans to address the priorities within the published Wellbeing Assessments.

**The Social Services and Well-being (Wales) Act 2014**

We have worked with colleagues in the Local Authorities to develop a single North Wales Population Assessment to inform the Social Services and Well-being Act implementation. This Population Assessment describes the care and support needs of specific groups within our population. We have established our Regional Partnership Board and will use this to drive improvement and greater collaboration in service design and delivery.

The Act places specific responsibilities upon the Board to develop greater integration of services, to be supported by pooled budgets from April 2018 and our Plan sets out actions to deliver this.

The Plans we develop in response to both of these Acts will ensure that the way we work builds upon a strong connection to the communities we serve. We will develop plans together which prioritise our attention to those with the greatest need and provide services in a manner which is carefully considered. We should not automatically intervene just because that is possible, rather we should understand what matters for individuals and what would bring the greatest benefit to them. We will ensure that our services are delivered consistently and in line with evidence and best practice. This will enable us to achieve the best possible outcomes for the people we serve. This approach to planning is consistent with the principles of prudent healthcare.

This way of planning will guide our thinking going forward and be central to the dialogue we have with staff, our population and partner organisations. Adopting these principles offers us:

* A challenge to our traditional assumptions and ways of doing things in favour of a new approach
* A requirement to consider what will bring about the best benefit in individual circumstances
* A clear focus upon prevention and early intervention, and on enabling people to maintain and improve their own health
* A clear shift of emphasis to primary and community-based support designed and delivered in partnership with individuals and communities to achieve the best possible outcomes from the resources available.

It is important to recognise that partnership working encompasses a wide range of partners. There are those with whom we share collective legal responsibilities, including Public Health Wales; other NHS organisations; the Community Health Council; Local Authorities; North Wales Police; the Police and Crime Commissioner; North Wales Fire and Rescue Service; Natural Resources Wales; the third sector and the independent sector. There are other partners including town and community councils, community groups, businesses and many others who also have an important role to play. We will seek to build on these relationships as we take forward the development of the strategy.

1. **OUR POPULATION HEALTH NEEDS**

* **A healthier Wales**

**7.1 North Wales Population Overview**

North Wales has a resident population of around 694,000 people, living across an area of approximately 2,500 square miles. Gwynedd UA in the west is the least densely populated area with 48.5 persons per square kilometre and Flintshire in the east is the most densely populated area, 352.2 persons per square kilometre.

The population of North Wales is expected to increase to 729,100 by 2030. The increasing population of North Wales can be accounted for by an increasing general fertility rate and a decreasing mortality rate, which has led to extended life expectancy (ref: Welsh Government, 2016. Local Authority Population Projections for Wales (2014-based): Principal projection. Available online

<http://gov.wales/docs/statistics/2016/160929-local-authority-population-projections-2014-based-en.pdf> [accessed 17.10.16]).

The population of most local authorities in Wales in projected to increase between 2014 and 2039. Wrexham is projected to have the second largest increase in Wales (10%); the populations of Gwynedd and Wrexham are projected to increase steadily; the Isle of Anglesey’s population is projected to decrease steadily; and the populations of Conwy, Denbighshire and Flintshire are projected to increase then decrease, but remain higher in 2039 than in 2014.

The 2.6% decrease in the Isle of Anglesey’s population (almost 2,000 people) is due to natural changes. Whilst the younger members of the population are projected to decline, the number of people aged 75 years and over is projected to increase by around 5,500.

Between 2014 and 2039, the population of Gwynedd is projected to grow by 8.4% (just over 10,000 people). Nearly all of the increase is in the population aged 75 years and over, with the population aged 85 years and over projected to increase by 122% (4,700 people). About 75% of the projected increase will be due to net migration (7,800).

The population of Conwy is projected to increase by 1.7% (almost 2,000 people) between 2014 and 2039. The County’s younger population is projected to fall, while the population aged 75 years and over is projected to increase by around 10,000. Net migration will account for an increase of 12,600 in the population, which will be driven by internal migration; natural change will be down 4,100.

Denbighshire’s population is projected to increase by 2.7% (around 2,500 people) between 2014 and 2039. The population aged 75 years and over is projected to increase by 7,500, while the population aged 18 to 74 years is projected to decrease by 4,800. Net migration will account for an increase of 6,600 in the population, driven by migration; natural change will be down by 4,100.

The population of Flintshire is projected to increase by 1.3% (around 2,100 people). Females aged under 59 years and males aged under 64 years are projected to decline; the population aged 75 years and over is projected to increase by 13,300. Net migration will account for a decrease of 1,000 in the population between 2014 and 2039 (driven by internal migration); national change will account for a further 3,000 increase.

Between 2014 and 2039, the population of Wrexham is predicted to increase by 9.7% (around 13,300 people). The youngest members of the population, aged 0-4 years and 5-10 years are projected to fall, with the largest increases in the older age groups. Net migration will account for an increase of 8,600 in the population, which will be driven by international migration; natural change will account for a further increase of 4,700.

Across North Wales, Gwynedd has the highest proportion of Welsh speakers, 65.4%, compared to 19% across Wales. The proportion of Welsh speakers in Flintshire (13.2%) and Wrexham (12.9%) is lower than the average for Wales. All UA areas across North Wales have experienced a decline in the proportion of Welsh speakers between the 2001 and 2011 Census, with the largest decline occurring in Gwynedd (-3.6%).

Twelve percent of the North Wales population live in the most deprived fifths in Wales compared to 19% across Wales; however, this masks considerable pockets of deprivation across the region, some of which are amongst the highest levels of deprivation in Wales, for example West Rhyl.

Educational outcomes have implications for social determinants such as income and living standards, which impact on physical and mental health. Across North Wales unitary authorities, the percentage of residents aged 16 to 74 years who have no academic or professional qualifications is lower than the average for Wales (25.9%), with the exception of Wrexham (26.7%). There is consideration variation at local level within counties.

(Ref: PHWO Snapshot of 2011 Census

http://howis.wales.nhs.uk/sitesplus/922/page/55162)

Unemployment is associated with financial problems, distress, anxiety, depression and poor health related behaviours. Just over 5% of working age residents in Wales have never worked or are long-term unemployed. Across North Wales, all six unitary authorities are below the average for Wales; however, there is considerable variation within counties.

(Ref: PHWO Snapshot of 2011 Census

http://howis.wales.nhs.uk/sitesplus/922/page/55162)

Housing has an important effect on health, education, work, and the communities in which we live. Across Wales, 77% of people in owner occupied houses were very satisfied with their accommodation, compared with 52% of people in private rented accommodation and 48% of people in social housing.

The majority of people in Wales report having enough money to heat their home; however, there is a difference across tenure type with 96% of people in owner-occupied housing having enough money to heat their home compared to 89% of private rented tenants, and 87% of those in social housing.

(Ref: WG. National Survey for Wales 2014-15

<http://gov.wales/docs/statistics/2016/160608-national-survey-wales-2014-15-accommodation-energy-saving-measures-en.pdf>).

There has been a rapid rise in homelessness in Wales, with a 16%-25% increase between 2007 and 2012. This then presents an average in Wales of 39.0 households accepted as homeless per 10,000 households.

(Public Health Wales, 2016. Final Report of the Health Care Needs Assessment & Health Profile: Homeless People).

Heart disease, cancers and respiratory disease are the three leading causes of death and premature death in North Wales, which share common risk factors – tobacco, alcohol, physical inactivity and unhealthy diet. Health-related behaviours are strongly related to deprivation and there are variations across North Wales.

Rates of smoking vary considerably by area, in line with levels of deprivation and by socio-economic gradient. Twenty two percent of adults in North Wales report being a smoker, compared to 20% across Wales. The Isle of Anglesey and Denbighshire have the highest smoking prevalence, 24%.

Over half of the population of North Wales (58%) report being overweight or obese, which is just below the average for Wales, 59%. Across North Wales, Gwynedd has the lowest percentage of overweight and obese adults, 53% and Denbighshire has the highest, 61%.

Levels of overweight and obesity in children have also increased dramatically, and are a significant cause of chronic illness in childhood. Just under 28% of children aged four and five years in North Wales are overweight, compared to just over 26% across Wales. The Isle of Anglesey has the highest percentage of overweight four and five year olds in Wales, 32.4%.

There are some specific population groups on which the strategy will focus – summary data follow.

**7.2 Children and young people**

**Profile of children and young people in North Wales**

In 2015, there were around 124,000 children aged 0-15 in North Wales (mid-year population estimates.) There has been very little change in the number of children between 2011 and 2015 across North Wales or in each county as shown in the table below. This trend is likely to continue over the next 25 years as shown in figure [2](#Ref466382306) with an overall increase of around 1% (280 children).

There are some small differences within the counties. Denbighshire’s population of children aged 15 and under is projected to remain the same by 2039, while Anglesey, Conwy and Flintshire will see a decrease of around 6%. Gwynedd is the only county where the projections estimate an increase in the number of children of around 9% (1,800 children).

Number of children aged 0-15

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2011** | **2012** | **2013** | **2014** | **2015** |
| Anglesey | 12,000 | 12,000 | 12,000 | 12,000 | 12,000 |
| Gwynedd | 21,000 | 21,000 | 21,000 | 21,000 | 21,000 |
| Conwy | 19,000 | 19,000 | 19,000 | 19,000 | 19,000 |
| Denbighshire | 17,000 | 17,000 | 17,000 | 17,000 | 17,000 |
| Flintshire | 29,000 | 28,000 | 28,000 | 28,000 | 28,000 |
| Wrexham | 26,000 | 26,000 | 26,000 | 26,000 | 26,000 |
| North Wales | 123,000 | 124,000 | 124,000 | 124,000 | 124,000 |

*Numbers have been rounded so may not sum.*

Source: Welsh Government Mid-year-estimates, StatsWales

#### Figure 2

#### Population projections, children aged 15 and under (2014 based)

A more detailed analysis is included within the baseline for the Children’s framework being developed as part of the overall strategy programme.

**7.3 Older People**

**Profile of Older People in North Wales**

* Rising life expectancy means that there are increasing numbers of older people in North Wales. Those aged 65 years and above in North Wales are predicted to increase by 34% between 2015 and 2035; those aged 85 years and above will increase by 23% in the same period (North Wales Public Health Team 2016).
* The highest proportion of people aged 85+ live in Conwy and the lowest proportions live in North East Wales (Public Health Wales 2012).

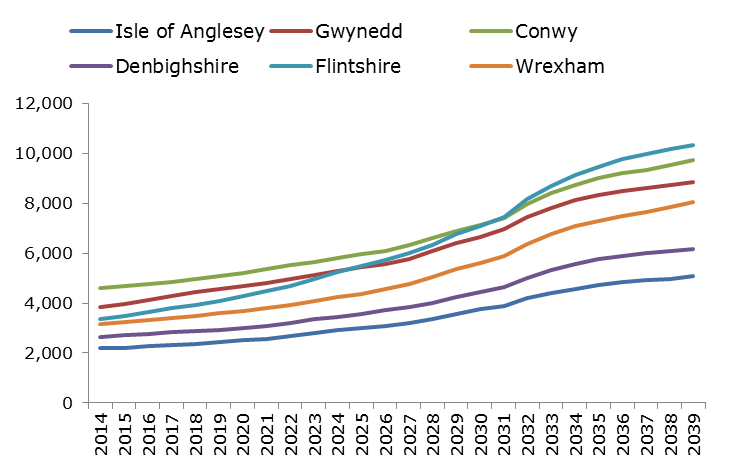
**Percentage of the population aged 85+**

Rising life expectancy means there are increasing numbers of older people in North Wales, and therefore, an increase in the number of oldest old people. Studies suggest that around 1 in 4 people aged 85+ are likely to experience frailty and require significant levels of support.

**Population projections, persons aged 85 years and over, Betsi Cadwaladr University Health Board and unitary authorities, 2015 to 2035**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2015** | **2020** | **2025** | **2030** | **2035** |
| BCU HB | 20,720 | 24,070 | 29,100 | 36,310 | 46,160 |
| Anglesey | 2,290 | 2,640 | 3,280 | 4,130 | 5,170 |
| Gwynedd | 3,870 | 4,420 | 5,030 | 6,150 | 7,560 |
| Conwy | 4,780 | 5,390 | 6,270 | 7,510 | 9,280 |
| Denbighshire | 2,800 | 3,230 | 3,930 | 4,920 | 6,330 |
| Flintshire | 3,670 | 4,460 | 5,810 | 7,440 | 9,840 |
| Wrexham | 3,310 | 3,920 | 4,780 | 6,170 | 7,980 |

(North Wales Public Health Team 2016)



**Figure 3**

**Population Projections, all persons aged 85 years and over,**

**Betsi Cadwaladr UHB unitary authorities, 2014 to 2039**

Data produced by Public Health Wales Observatory using ONS 2014 based population estimates

Further detail is available in the baseline assessment paper for older people.

**7.4 People with mental health needs**

**What do we know about the population?**

An estimated 1 in 4 people in the UK will experience a mental health problem each year (Mind, 2016). In the Welsh Health Survey 13% of respondents reported being treated for a mental illness, which is a slight increase since the survey started in 2003/4 (Welsh Government, 2015).

People in North Wales report slightly better mental health than in Wales as a whole although there has been a slight drop (worsening) in scores for mental wellbeing since 2009-10.

The number of people with mental health problems is likely to increase, with the highest rate being in Wrexham. Data from the Welsh Health Survey can be used to see how numbers change over time. From prevalence rates from the Welsh Health Survey and applied to population projections to 2035. It shows that the number of adults in North Wales with a common mental health problem is predicted to increase from 93,000 to around 99,000 by 2035.

The Quality and Outcomes Framework (QoF) can provide very rough estimates of the prevalence of some psychiatric disorders. This data is likely to underestimate the true prevalence because it relies on the patient presenting to a General Practitioner (GP) for treatment, receiving a diagnosis from the GP, and being entered onto a disease register. On the current recording rates the most common mental health conditions are anxiety and depression.

A more detailed analysis can be found in the interim Mental Health Strategy (BCUHB Board, November 2016.)

* 1. **Carers**

**What do we know about the population?**

Around 73,000 people provide unpaid care in North Wales according to the 2011 census, which is about 11% of the population. This is slightly lower than the all Wales figure of 12% and slightly higher than the England and Wales figure of 10%.

**The number of carers in North Wales is increasing, particularly in north-west Wales.**

There were 6,000 more carers in North Wales in 2011 than in the 2001 census, which is an 8% increase. Overall, more women provide unpaid care than men: 57% of carers in North Wales are women, and 42% are men, which is similar to the proportion across Wales and in each local council area. This difference has narrowed slightly since the 2001 census by one percentage point due to a greater increase in the numbers of men providing unpaid care.

Table 7.1 shows that Flintshire has the highest total number of carers in North Wales and Anglesey the lowest.

##### Number of carers in North Wales by local authority, 2001 and 2011

|  |  |  |  |
| --- | --- | --- | --- |
|  | **April 2001** | **April 2011** | **% increase** |
| Anglesey | 7,200 | 8,000 | 11 |
| Gwynedd | 11,000 | 12,000 | 11 |
| Conwy CB | 12,000 | 14,000 | 11 |
| Denbighshire | 11,000 | 12,000 | 9 |
| Flintshire | 16,000 | 18,000 | 7 |
| Wrexham | 15,000 | 15,000 | 2 |
| North Wales | 73,000 | 79,000 | 8 |

*Numbers have been rounded so may not sum*

Source: Census

**People aged 50 to 64 are the most likely to provide unpaid care**

In North Wales around 20% of people aged 50 to 64 provide unpaid care compared to 11% of the population in total. Generally speaking the proportion of people providing unpaid care increases with age until the 50-64 age group. In the 65 and over age group 14% of people provide unpaid care, which is the same proportion as in the 35 to 49 age group. These proportions follow a similar pattern in each local authority.

##### Number of carers in North Wales by age and local authority, 2011

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Age** | | | | | |
|  | **0 to 15** | **16 to 24** | **25 to 34** | **35 to 49** | **50 to 64** | **65 and over** |
| Anglesey | 140 | 360 | 520 | 1,800 | 3,000 | 2,200 |
| Gwynedd | 250 | 620 | 780 | 3,000 | 4,500 | 3,300 |
| Conwy CB | 260 | 550 | 750 | 3,200 | 4,800 | 4,100 |
| Denbighshire | 260 | 640 | 740 | 2,800 | 4,100 | 3,100 |
| Flintshire | 340 | 920 | 1,200 | 4,500 | 6,600 | 4,100 |
| Wrexham | 290 | 860 | 1,300 | 4,000 | 5,400 | 3,200 |
| North Wales | 1,500 | 4,000 | 5,300 | 19,000 | 28,000 | 20,000 |

*Numbers have been rounded so may not sum*

Source: Census

Further information is available in the North Wales Carers’ Strategy work.

**7.6 Health Inequalities**

* **A Wales of cohesive communities**

Recent research has reinforced earlier evidence of the link between socio-economic deprivation and health inequalities. We know, for example, that there are significant differences on life expectancy and in the prevalence of limiting long-term illness, disability and poor health between different socio-economic groups. (Deprivation Profile of North Wales, PHW, 2016)

People living in the most deprived communities experience more years of poor health and are more likely to have unhealthy lifestyles and behaviours than people in the least deprived communities. As a result, the most deprived communities experience higher levels of disability, illness, loss of years of life, productivity losses and higher welfare dependency (Public Health Wales, 2016).

Twelve percent of the North Wales population live in the most deprived fifths in Wales compared to 19% across Wales; however, this masks considerable pockets of deprivation across the region, some of which are amongst the highest levels of deprivation in Wales. Rhyl West 2 (Denbighshire) and Queensway 1 (Wrexham) are the second and third most deprived areas in Wales. Three further LSOAs in Rhyl (Rhyl West 1, Rhyl West 3 and Rhyl South) are in the top twenty most deprived areas in Wales (Welsh Government, 2015).

People living in the most deprived areas live on average shorter lives than those living in the least deprived areas. Gwynedd has the lowest inequality gap in the whole of Wales for males (3.4 years); Denbighshire has the fourth highest in Wales (11 years) (Public Health Wales, 2016).

Male residents in the most deprived areas of Denbighshire live, on average, 11 years less than those in the least deprived areas on the same county. The difference for females is also largest in Denbighshire, where female residents in the most deprived areas of the county live, on average, 8.4 years less than those in the least deprived areas of Denbighshire (Public Health Wales, 2016). Whilst our understanding of inequalities which arise as a consequence of socio-economic deprivation is reasonably well established, we recognise that we have significant work to do with individuals, communities and other agencies to understand better the inequalities which arise as a consequence of other differences including those identified as Protected Characteristics.

**7.7 Poverty and health**

* **A prosperous Wales**

The Welsh Government’s **Tackling Poverty Plan,** sets out actions to build resilient communities and to help prevent and reduce poverty in Wales. There are a number of key actions where our services, particularly primary, community and mental health services can play a direct role:

* Identifying and taking action to address inequities within the Health Board area, improving healthy life expectancy and closing gaps between social groups
* Extra effort to bring families into contact with primary care services and extending hours, strengthening the population focus through the work of clusters and localities
* Delivery of the Designed to Smile service to target inequalities in oral health and linking with the oral health action plan
* Increasing uptake of immunization
* Aiming to reduce accidents and injuries in the home and on our roads
* Reducing teenage pregnancy rates, often associated with poor health and social outcomes for mother and baby, and an increased likelihood of postnatal depression
* Early support at all ages, and strengthening of community services and improved links with specialist services through the mental health measure

These examples are amongst those areas where we can contribute to the anti-poverty agenda. There are many broader areas where we can contribute to this agenda – such as employment opportunities, use of local businesses, support to enable children and young people to benefit from good education – and we will need to consider these aspects in all that we do.

**7.8 Other significant issues in population growth**

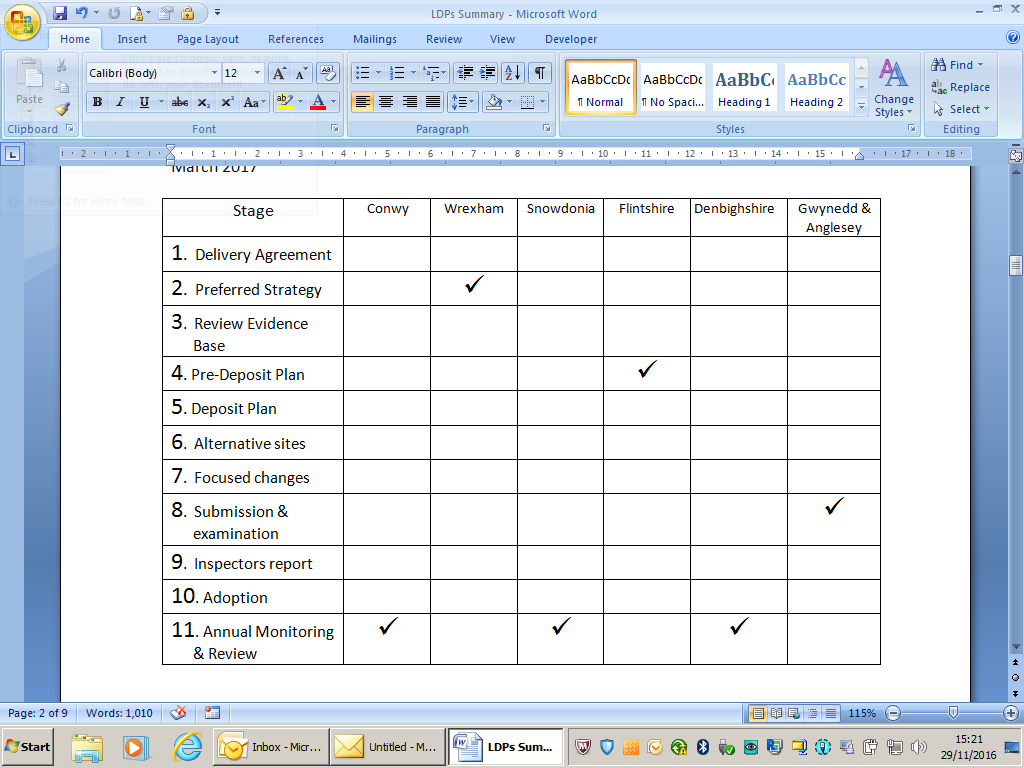
**Local Development Plans**

The Health Board is engaging with the local planning authorities in North Wales in order to ensure good communication and involvement in the development of plans and planning proposals, and to understand, assess and respond to the potential impact of these.

The Local Development Plan is a statutory plan required for each local planning authority area in Wales under Part 6 of the Planning and Compulsory Purchase Act 2004. It should include a vision; strategy; area-wide policies for development types, land allocations and where necessary policies and proposals for key areas of change and protection.

For North Wales, there are seven local planning authority areas: Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, Wrexham and Snowdonia National Park.

The authorities in North Wales are at different stages in the LDP process.



The Health Board is engaging with the local planning authorities to understand the implications of the spatial and growth development proposals and liaise over the implications for population health needs and demand for health care services.

It is important to understand the potential impact of projected growth and development of housing across North Wales. The modelling undertaken for the LDP proposals may be based on assumptions regarding economic growth and inward migration which may differ from the population and demographic projections routinely used to assess future demand for healthcare.

A summary of the LDP proposals is attached as Appendix 3.

1. **CULTURE AND WELSH LANGUAGE**

* **A Wales of vibrant culture and thriving Welsh language**

One of the seven well-being goals of the WFG Act is to achieve a vibrant culture and a thriving Welsh language. The aim of this is to deliver a society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.

**8.1 Vibrant culture**

Engaging with creative activity can have a positive impact on health and well-being. There are several perspectives to this positive impact.

“Creativity, culture and the arts can help raise aspiration, confidence, a sense of community and cohesion, and individual and community well-being. They can contribute to improved public health… creative activity can promote healthy living and lifestyles, positive messages around public health issues.

“….[Creative activity] can also improve the mental, emotional and physical status of Health Service users, improve health and social care environments for staff and service users, and help medical staff, carers, patients and families to communicate more effectively with each other.”

(Light Springs Through the Dark: A Vision for Culture in Wales, Welsh Government, December 2016.)

In the Health Board, the Creative Well programme for the Arts in Health and Well-being aims to deliver an inspirational programme that is of the highest possible quality, providing value-for-money creative services, contributing to improving health and providing excellent care. The programme aims to improve experience of the Health Board’s services through the delivery of high calibre participatory arts activity, enhanced environments and a focus on access by all as an inspiration.

The programme is building on partnership working with Arts Council of Wales, the Local Authorities, third sector, cultural organisations / establishments, social enterprises and charities.

The programme is focusing on five key areas:

* **Working with older people and chronic conditions**  
    
  The arts can make a powerful contribution to increasing the health and well-being of older people and those living with chronic conditions, through strengthening social networks and physical and creative activity
* **Improving mental health and well-being for all ages**  
    
  Arts Therapists play an important role in secondary care mental health settings (such as adult acute mental health, CAMHS, Adult Forensics), with focus on mental illness assessment and providing creative psychological intervention. Pathways may be developed to support young people and adults further in their recovery and staying well via a creativity-based model
* **Transforming healthcare environments**  
    
  Art can create more intimate, calming and uplifting environments, contributing to improved health and well-being outcomes and bringing real benefits to patients, staff and visitors. The programme encourages innovative developments in the built environment
* **Integrating the arts into education, training, professional development and staff well-being**  
    
  The programme supports the development of innovative art-based methods of training for healthcare students and professionals. Arts can make a distinctive contribution to education and training, for example in building crucial communication and analytical skills; so, too, participating in the arts to improve well-being and morale.
* **Capitalising on creative therapists’ and artists’ ability to act as catalysts for innovation**  
    
  Creative therapists and artists can contribute to the pursuit of innovation, stimulate thinking and problem solving, and motivate and inspire healthcare teams.

The approach can contribute to innovation, co-production and prudent healthcare. Further work on the potential impact of developing and extending the programme will need to be taken forward as part of the strategy development. A North Wales Arts in Health and Well-being Forum is being established which will help facilitate a better understanding of the extent of the arts’ contribution to health and well-being in North Wales, in respect of both general population health and the more therapeutic interventions for service users and carers.

**8.2 A Thriving Welsh Language**

The Welsh Language Act 1993 established the statutory principle that – in the conduct of public business in Wales – the Welsh and English languages should be treated ‘on the basis of equality’.

In order to achieve this, public bodies were obliged to draw up Welsh Language Schemes, which are documents that provide an outline of an individual organisation’s specific arrangements in relation to providing services bilingually.

The Welsh Language (Wales) Measure 2011 gave the Welsh language official status in Wales and placed the language in a new legal context. Along with reinforcing the principle that Welsh should not be treated less favourably than English in Wales, the 2011 Measure also created a new legislative framework for placing specific legal duties on public bodies in relation to the Welsh language.

Public institutions and organisations will now have to operate in accordance with a series of fixed statutory Standards: a number of specific benchmarks which will formalize the nature and provision of Welsh-medium public services for the future.

These new Welsh Language Standards will become applicable to BCUHB during 2016 (and a number of the related provisions that were originally created by the passing of the Welsh Language Act 1993 will consequently be updated, or become obsolete).

The implementation of the new Standards will also result in a greater consistency in relation to the standard of the services that are provided through the medium of Welsh by various bodies.

Research has identified the link between language and care and refers to examples which imply that the quality of care to vulnerable users may be compromised by the failure to communicate in their first language. Some examples are given in research undertaken by IAITH - the Welsh Centre for Language Planning for the Department for Health, Social Services and Children, Welsh Government and the Care Council for Wales (2012) which informed the first “More than just words” framework.

* The evidence provided in relation to domiciliary care services and residential care facilities for older people suggests the need to pay attention to language-appropriate provision in service procurement arrangements, through third party contractual agreements
* Mental health service users provide evidence which conveys the importance of providing language-appropriate therapeutic and psychiatric services. For many, their use of English to access their inner, emotional world does not enable them to make the best use of the service being provided
* The importance of language-appropriate assessment is raised with particular reference to dementia and children’s services – speech and language therapy; eye and hearing tests, and health visitor assessments. Other examples also highlight the vital role of language as a diagnostic tool
* Issues regarding the accuracy of assessment via translation are raised by several respondents

The provision of Welsh language services is therefore a matter of quality in care and better outcomes, not choice alone.

One of the key principles of in care provisionis the Active offer. An Active Offer simply means providing a service in Welsh without someone having to ask for it. “It means creating a change of culture that takes the responsibility away from the individual and places the responsibility on service providers and not making the assumption that all Welsh speakers speak English anyway.” (Welsh Government, 2016)

**What do we know about our Welsh speaking communities?**

In North Wales, Gwynedd has the highest proportion of Welsh speakers, 65%, although this can be higher in some areas of the county. Elsewhere in North Wales, 57% of residents on the Isle of Anglesey speak Welsh, 27% in Conwy and 25% in Denbighshire. The proportion of Welsh speakers in Flintshire (13.2%) and Wrexham (12.9%) is lower than the average for Wales. All local council areas across North Wales have experienced a decline in the proportion of Welsh speakers between the 2001 and 2011 Census, with the largest decline occurring in Gwynedd (-3.6%).

Just over half (53%) of Welsh speakers in North Wales are fluent in the language and 63% speak Welsh on a daily basis; in Gwynedd, 78% of Welsh speaking residents are fluent and 85% speak Welsh every day.

The Health Board operates a statutory Welsh Language Scheme (WLS) in accordance with the Welsh Language Act 1993. The Scheme outlines the Health Board’s aim to deliver services bilingually:

*“Our aim is to enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal choice and to encourage other users and providers to use and promote the Welsh language in the health sector.” (WLS April 2010)*.

The level of Welsh speaking, particularly in the north west of the region, influences the number of people choosing to access services in Welsh. In Gwynedd, 37% of people attempt to use the Welsh language at all times when contacting public services.

In primary care, 1.8 GPs per 100,000 population in North Wales can speak Welsh; at local council level, Gwynedd has the highest rate, 4 GPs per 100,000 population that can speak Welsh and Flintshire has the lowest, 0.5 per 100,000 population. Among other health professionals in North Wales, speech and language therapists have the highest percentage of Welsh speakers (46%), followed by paramedics (44%); just over 30% of nurses working in the region can speak Welsh (Public Health Wales, 2016c).

The Welsh Language Standards will introduce a requirement to undertake an assessment of impact on Welsh language for policies and procedures. This will be built into the impact assessment process for the development of our strategy.

1. **SUSTAINABILITY**

* **A resilient Wales**
* **A globally responsible Wales**

The Health Board is the largest LHB in Wales, covering almost a third of the country’s landmass. Our size and the nature of the services we provide mean we have an environmental impact which must be carefully managed to avoid significant financial and environmental consequence. As part of our corporate commitment towards reducing these effects we maintain a formal Environmental Management System (EMS) designed to achieve the following:

* Sustainable development.
* Compliance with relevant legal and government requirements.
* Prevention of pollution.
* Mitigation against the impact of climate change.
* A culture of continuous improvement.

Effective environmental management is achieved through:

* Promotion of the environmental policy to all relevant stake holders.
* Identification of all significant environmental aspects and associated legal requirements, including those resulting from service change and new legislation.
* Establishing and monitoring objectives and targets aimed at reducing environmental and financial impacts, in line with those issued by the Welsh Government.
* Provision of appropriate training to all relevant personnel.
* Regular internal and external audits.
* Regular review of the effectiveness of the EMS by the Environmental Steering Group.
* Working with local, regional and national partners to achieve a consistent public sector approach to environmental management and ensure best practice procedures are identified and implemented.

Our performance is measured using a number of tools and through our involvement with a number of partnership bodies:

* BS EN ISO 14001 Environmental Management System.
* Carbon Reduction Commitment Annual Reporting.
* Annual Energy and Facilities Performance Monitoring System.
* NHS in Wales Low Carbon Strategy.
* Carbon Trust Management Review.
* Flintshire Carbon Reduction and Adaptation Group.(CRAG)
* NHS Wales Shared Services Partnership-Facilities Services.
* In-house, real-time utility consumption monitoring systems.

These arrangements ensure that effective environmental management is conducted to current best practice standards and that continuous improvement is embedded in the culture of the organisation.

A statement of current performance against the environmental targets is attached as Appendix 4.

Natural Resources Wales have produced summary environmental information for each county to support the Public Service Boards in their development of well-being assessments. These provide a useful picture of the issues facing our region. We will work with colleagues through Public Service Boards to identify and contribute towards addressing environmental needs.

1. **THE FINANCIAL POSITION**

**Background**

The Health Board’s cumulative overspend to 31 March 2017 is forecast to be £76.1m, which will increase to £102.1m by 31 March 2018 following the Interim Plan approved by the Board on 16 March 2017. Likewise the Health Board’s position against the 3 year cumulative breakeven duty is expected to be £76.1m at 31 March 2017, and £75.5m at 31 March 2018.

This overspend will need to be reduced over the medium term, and there is an expectation from Welsh Government that the cumulative deficit incurred will need to be repaid over the longer term.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Figure 4: Health Board cumulative deficit and position against three-year duty** | | | | |
|  | **2014/15** | **2015/16** | **2016/17** | **2017/18** |
|  | **£’m** | **£’m** | **£’m** | **£’m** |
| Planned Annual deficit | 0.0 | 14.2 | 30.0 | 26.0 |
| Forecast/Actual Annual deficit | 26.6 | 19.5 | 30.0 |  |
| **Annual variance** | **26.6** | **5.3** | **0.0** |  |
| **Total cumulative overspend** | **26.6** | **46.1** | **76.1** | **102.1** |
| **3 year rolling overspend** |  |  | **76.1** | **75.5** |

Much of this overspend arises from service inefficiencies which are based on known service issues. These relate to longstanding issues which are recognised in many areas across the Health Board, and the challenge in addressing some of these was a key driver to the Special Measures Improvement Framework. It has also been widely recognised that there are other potential financial opportunities and gains around infrastructure costs and use of technology.

The Health Board relative service inefficiency, based on 2015/16 data, has been determined based on benchmarking across similar services elsewhere in Wales.

|  |  |
| --- | --- |
| **Figure 5: Health Board inefficiency by key service lines** | |
|  | **£’m** |
| Mental Health and Learning Disabilities | 9.1 |
| Obstetric services | 5.8 |
| General surgery | 2.7 |
| Trauma and Orthopaedics | 2.0 |
| Urology | 1.9 |
| Gastroenterology | 1.6 |
| Cardiology | 1.5 |
| Endocrinology | 1.4 |
| Ophthalmology | 1.4 |
| ENT | 1.3 |
| Cancer | 1.3 |
|  | **30.0** |

**2017/18 Interim Financial Plan**

The Board approved the Interim Financial Plan set out below on 16 March 2017. This is noted as an Interim Plan given the Health Board is spending in excess of its allocation. The plan includes a challenging requirement to deliver £35.4m savings.

|  |  |  |
| --- | --- | --- |
| **Figure 6: Health Board budget, 2017/18** | | |
|  | **£’m** | **£’m** |
| **Discretionary income uplift** |  | **(19.3)** |
| **Opening financial challenge** |  |  |
| Health board inefficiency brought forward | 30.0 |  |
| Financial risk brought forward | 5.0 |  |
| **Total Health Board inefficiency** |  | **35.0** |
| Unavoidable cost pressures | 19.7 |  |
| Expected cost pressures | 17.5 |  |
| Board pre-commitments and corporate compliance | 6.5 |  |
| Operational commitments from 2016/17 | 2.0 |  |
| **Total cost pressures** |  | **45.7** |
| **Discretionary savings requirement** |  |  |
| Cash releasing | (30.4) |  |
| Cost avoidance | (5.0) |  |
| **Total discretionary savings** |  | **(35.4)** |
| **Net deficit budget** |  | **26.0** |

**Medium Term outlook**

The NHS faces a significant financial challenge over the next 3 years, with the published spending plans for the UK between 2016/17 and 2019/20 showing a real term budget reduction of 3.2% for Welsh Government.

Whilst it is assumed that the NHS budget in Wales will remain protected, it is estimated that the budget for the NHS in Wales will increase on average by only 0.7% a year between 2015/16 and 2019/20. This is substantially less than the longer term growth required of 2.2% identified by the Health Foundation.

**Long term outlook**

In setting out the challenges facing the Health Service in Wales over the coming 15 years, the Health Foundation[[1]](#footnote-1) has outlined two key drivers: a growing ageing population alongside a growth in chronic conditions.

The impact of age on the costs of healthcare is clear. The average population of the six counties of North Wales is expected to grow by 6.1% between 2011 and 2031; but the population over 65 is expected to grow by 30.8% over the same period[[2]](#footnote-2). The multiplier effect of a growth in the population cohort which is linked with requiring higher cost healthcare paints a stark picture of the demand on the service over the medium to long term.

The growth in demand is clearly linked to a number of chronic conditions, which are responsible for a significant proportion of Health Board spending. In addition to demographic and health pressures, inflationary pressures contribute to the overall funding requirement on the Health Board.

This will represent a very significant challenge for the Health Board as it reduces its annual operating deficit. Addressing this will require both efficiencies within service models; and the transformation of service models.

**Other Factors**

The Health Board currently receives in excess of its ‘fair share’ allocation from Welsh Government based on the ‘Townsend Formula’, which adjusts population shares to reflect age, deprivation and disease prevalence.

While there are no plans by Welsh Government to realign core resource allocations, the Health Board’s allocation is over target by c£70m (based on 2012/13 data). Against this backdrop, ongoing discussions over increased funding for the Health Board are challenging.

In addition none of the growth assumption in both the long term and the short to medium term assessments take account of the impact of the pressures on social care from reduced funding.

It is estimated that pressures on social care will rise by around 4.1% a year between 2015 and 2030/31, which will require the budget for social care to almost double to £2.3bn by 2030/31 to match demand.

**Opportunities**

A recent OECD report[[3]](#footnote-3) outlined that up to 20% of health spending could be channelled to better use. They argued that there was significant waste within health services across the OECD, both in wasteful clinical care (both over and under treatment); and in operational waste (mainly productivity and reducing input costs).

They outlined significant examples, including:

* Unwarranted variation in admissions;
* Overuse of antimicrobial prescriptions;
* Inappropriate use of emergency departments;
* Adverse events occurring in 10% of admissions in the NHS in England, of which half may be avoidable;
* Hospital acquired infections;
* Delays in transferring patients from hospital to more appropriate care settings; and
* Overuse of C-sections above the World Health Organisation accepted rates of up to 15% of births.

Addressing this would be a transformative change, ensuring that value is at the core of health. If waste is defined as services and processes which are harmful or do not deliver benefits; and excess costs which could be avoided by replacing them with cheaper alternatives with the same benefits: then the value framework offers a powerful approach to address such issues.

The value framework offers a suitable approach through linking the allocation of resources; productivity and outcomes into a coherent approach which enables a common understanding across the Health Board. Inherently, the quality and safety of care is therefore closely aligned with finance. The challenge for the Health Board is to provide safe care of a high quality which minimises waste and maximises value.

The Health Board has implemented a Programme Management Office approach to support the delivery of service change and to provide an assurance mechanism over delivery. The remit of the PMO is wider than savings delivery, and encompasses the delivery of productivity and quality improvements. Consequently, the Health Board will monitor its efficiency against the delivery of productivity; cost avoidance and cash releasing savings.

A complex concept in its widest sense, the value framework is outlined below based on the work of NHS Rightcare[[4]](#footnote-4), which broadly splits as follows:

1. Allocative value: determined by how resources are distributed to groups within the local population
2. Technical value: how well resources are utilised
3. Personalised value: how well the decisions relate to the values of each individual

The Health Board is developing its approach to value, and this is expected to encompass four workstreams, as follows:

1. Allocation of resources (Allocative value)
2. Service usage (Allocative value)
3. Secondary care productivity (Technical value)
4. Outcomes (Personalised value)

It is expected that this will result in the development of cases for value-based change. These will then be implemented through the existing Programme Management Office framework.

|  |
| --- |
| **Figure 7: Implementing value-based change** |

**Summary**

Clearly the Health Board faces significant challenges over the medium term to achieve financial sustainability by addressing the £30m service inefficiency; alongside the pressures from delivering productivity gains significantly higher than the historic average in order to keep pace with demand. All of which do not take into account of the impact on health from social care pressures, and the impact on new monies when the distance from our ‘fair share’ allocation is taken into account. Financial discipline will need to be seen as of equal importance as providing a safe service of high quality to our population.

Nonetheless, there are significant opportunities for the Health Board to become more efficient, but these need to be pursued decisively and with pace. The challenge will be for the organisation to improve quality and performance and at the same time safely reduce operating costs, thereby delivering value to our population.

1. **INFORMATICS**

# Informatics Driven Transformation

***Underlying Premise***

In order to deliver the long term vision for health and health services it must be recognised that Informatics is integral to its success, put simply the service will be required to evolve from an ‘enabler’ to a ‘driving change agent’ providing vision, expertise and leadership to bring about change. The Informatics Department will lead Technology or Information driven transformational programmes and ensure staff and patients have access to timely and accurate information to make informed decisions about their care. The programme of work will be defined via out Informatics Strategic Outline Plan which will articulate the schemes and investment required to provide digital services for staff and patients.

Working in partnership with NHS Wales Informatics Service and other Health Boards in the co-production of both national ICT products and targeted local interim technical solutions, for areas which are not yet covered by the national informatics plans and developments.

***Potential Investment Benefits***

The draft forecast investment gap for delivering major digital transformation in the organisation over the next three years stands at over £20m capital and £16m for revenue. Whilst these figures will be validated further as part of the BCU planning and engagement process it is unlikely that we will need less funding than has been outlined. This funding gap is hard to fathom in the context of current level of capital investment in Informatics which generally stands as £2m to £3m every year depending on discretionary allocation and funding made available due to slippage in other schemes.

Therefore the fundamental questions are

* Why is there such a gap?
* And how can we justify such a massive increase in investment?

Firstly the gap is exacerbated by the historic limited investment. For example, most health boards have typically received around half the required capital for computer replacement. BCU in particular requires in excess of £2m a year to maintain a rolling programme of good equipment and significant investment is required to simply maintain a decent level of acceptable computers. Therefore BCU requires an additional £5m capital over three years for decent modern computers and the requisite resource to rollout that equipment. More people need mobile equipment and we are seeing a dramatic increase in demand from staff for laptops, tablets devices and a mobile phones which automatically changes the investment level required. In addition, as we move to more reliance on clinical IT on wards etc. the demand for equipment is also bound to increase as well.

We need to be ambitious at a time of special measures and large underlying budget deficit and identify schemes which will have significant cash releasing benefits in as well as the softer quality benefits. Each scheme in our Strategic Outline Plan will have to be subject of detailed analysis and business cases and the benefit vision will need to show how informatics schemes could release significant cash savings. Examples of schemes which evidence better quality service and deliver significant savings include;

* Technology Enhanced Care – using technology to monitor patients remotely e.g. video links to nursing homes or video clinics which avoid patients long journeys.
* Patient Flow- a system wide change in technology and processes that avoids patients being admitted to hospital unnecessarily and makes it easy to see where the constraints are in the system and allow the service to pull patients through the system safely and efficiently.
* Electronic Prescribing – all medicines are prescribed and tracked electronically – providing decision support for clinicians and ensuring medicines are managed appropriately.
* Digital Dictation and Speech recognition – allows clinicians to capture information and produce letters more efficiently and generates digital content for the electronic patient record. This improves the quality of communications between all health sectors.
* Digital clinical and nursing notes – building on the successful Welsh Government Innovation funding which has developed a nursing application in North Wales which has demonstrated it can release 23% of nursing time to focus on direct patient care.
* Patient portal – allowing patients secure access to all their health and care information and allow them to communicate electronically with the services e.g. book appointments and order prescriptions online. This could even allow direct voice or video links with clinicians and carers.

The above are just a few examples of potential schemes. However, very few organisations have been able to implement multiple schemes of this nature in parallel. Organisations often seem to specialise in one or two areas and our challenge in BCU is to understand how we set the organisation up to adopt these technologies and changes in working practice on a system wide basis.

We are fortunate in BCU to be already on a course to rationalise core systems which will naturally present opportunities for significant benefit realisation. Not only will the Welsh Patient Administration System standardise our booking, outpatient and many other processes for the first time since the inception of BCU, it will also augment our imminent new IP Telephony technology system and allow us to look at modernising switchboard and booking centre models and provide lower cost, more patient friendly access contact centres.

In addition the Welsh Community Clinical Information System will allow social care, community and mental health care to be integrated across North Wales. Our greatest challenge will not be the technology itself but the workforce engagement and change management process to drive better quality more efficient services on the back of the technology.

Each of any proposed schemes in isolation could provide a high level of benefit. However, the real power of the schemes are the combined effect: The combination of administration, clinical and logistics systems create a tipping point in year 4 a 5 which changes into an organisation relying on digital services with very limited paper based processes. This shift will in-turn eliminate major administration and management overheads.

Further evolution of this document through the BCU planning process will refine and verify these benefits and timescale in more detail. Each scheme will be prioritised and worked up into detailed business cases for consideration.

1. **WORKFORCE PROFILE**

BCU HB is a major employer in the region, employing a large number of staff across a range of professional groups and occupations. Currently the organisation employs just over 17,000 staff.

Low turnover, an increased number of staff over the age of 50 and low numbers of staff under the age of 20, present workforce challenges for the Health Board. A local Working Longer Review Group has been set up to assess the implications of the age profile of our current workforce and identify strategies to support the workforce effectively.

**Recruitment and Retention**

In April 2016 the board approved a Recruitment and Retention Strategy which outlined plans to attract and retain a workforce fit to deliver healthcare in the 21st century. In order to implement this strategy effectively recruitment processes and activities will be required. There are some major challenges in the short term to maintain services as they currently operate. The department will support a shift of focus from secondary care to primary and community care and prevention. There are substantial areas of shortage and risk within a number of staff groups which is a significant challenge for the Health Board and across NHS Wales. The department will work with NWSSP and with manager to improve and speed up processes.

The Health Board has commenced work on its Recruitment attraction strategy and outlined a range of initiatives that the Health Board is taking forward in achieving its aim of attracting, recruiting and retaining a workforce with the requisite skills. Development of a bespoke Recruitment website and supporting marketing materials will provide the focus for this attraction strategy along with selling and marketing of our new brand Train Work Live – North Wales. The Web site will be a key focus on the BCU internet as well as the ‘Working for us’ section on the internet.

The age profile across BCU similar to other NHS organisations is skewed towards staff over the age of 45 and therefore expecting to retire within the next 10 to 15 years. A working longer review group has been established within BCU to review the outputs from the ‘UK Working Longer Group’ and ‘The Working Longer Steering Group Wales’ to formulate and develop strategies across BCULHB to meet the needs of an ageing workforce and the challenges that this might pose for BCULHB.

**Recruitment Challenges**

The Health Board has significant recruitment challenges in a number of specialties and staff groups. Areas with particular challenges are listed below:

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

Recruitment difficulties are a key driver for skill mix changes, but there will also be significant focus on improving recruitment.

A summary of key workforce data is attached as Appendix 5.

1. **ESTATES AND INFRASTRUCTURE**

**13.1 Headline description of existing Estate**

In common with the rest of the NHS in Wales, the Board’s estate requires an increasing level of capital investment to ensure that existing assets are compliant with regulations, fit for purpose and support the development of safe and sustainable clinical services.

As a result the Board has pursued an active policy of focusing and rationalising its estates assets in support of the delivery of the service and business needs of the organisation. This has resulted in the sale, or termination of lease, of 43 properties over the last few years. A profile of the current health board’s premises is as follows:

Acute general hospital (including Acute Mental Health) 3

Sub-acute hospitals 2

Mental Health and Learning Disabilities 6

Community hospitals 15

Community facilities (incorporating direct patient care) 90

Other support facilities (no patient care) 10

T**otal 126**

Primary Care services are delivered from 173 properties in North Wales. Some of these are owned by the Health Board and included in the “Community facilities” figure above. The remainder are a mixture of property owned by the GP practices and property owned by third party developers and leased back to the GPs.

In addition the Health Board delivers services from a range of properties in North Wales which are owned by other organisations, such as the Eirias Park Precinct and the new prison, HMP Berwyn, in Wrexham. It also hosts staff and services from other agencies, including local government and the third sector, in its buildings.

**13.2 Estates Performance**

Welsh Government has established six national performance indicators for the condition and performance of the NHS Estate in Wales, as follows:

|  |  |
| --- | --- |
| **Indicator** | **Target** |
| Physical condition | 90% of the estate to be in condition B or better |
| Statutory compliance |
| Fire safety compliance |
| Functional suitability |
| Space utilisation |
| Energy performance | Energy consumption to be < 410 kWh/m2 |

The latest national performance information (2015/16), prepared by NWSSP – Specialist Estates Services indicates the Board’s performance is:

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Target** | **Performance** |
| Physical condition | 90% | 75% |
| Statutory compliance | 90% | 78% |
| Fire safety compliance | 90% | 80% |
| Functional suitability | 90% | 84% |
| Space utilisation | 90% | 88% |
| Energy performance | <410 kWh/m2 | 395 kWh/m2 |

Based upon the indicated condition and performance of our Estate, NWSSP assessment of the cost of our backlog maintenance was as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **2015/16 BCUHB** | **High risk backlog cost** | **Significant risk backlog cost** | **Moderate risk backlog cost** | **Low risk backlog cost** | **Risk adjusted backlog cost** |
|  | **(£)** | **(£)** | **(£)** | **(£)** | **(£)** |
|  | 20,749,982 | 16,144,996 | 32,416,185 | 62,105,900 | 41,556,218 |

Of the Health Boards which contain major acute hospitals, BCU’s performance is the poorest. In terms of high risk backlog maintenance the Health Board’s cost of circa £21 million is higher than all of the other Health Boards combined. BCUHB is also the only Health Board that achieves just one green indicator (for energy performance) with the remainder either orange or red.

**13.3 Condition Appraisal – Primary Care**

In terms of Primary Care, an inspection was undertaken in 2016. It identifies a similar range of issues, with performance against key indicators as follows:

* Based on an inspection of 173 Primary Care facilities in 2016
* Some duplication in the BCUHB data, where BCUHB are the landlord

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator** | **Excellent** | **Good** | **Poor/ Unacceptable** |
| Physical condition | 16% | 39% | 45% |
| Functional suitability | 16% | 25% | 59% |

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator** | **Fully Used** | **Under Used** | **Overcrowded** |
| Space Utilisation | 59% | 10% | 31% |

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator** | **Full/Near Full** | **Non-Compliance** | **High Level of Non-Compliance** |
| Disability Discrimination Act Compliance (DDA) | 13% | 30% | 57% |

The backlog maintenance cost is estimated at £4.5million.

**13.4 Key issues for the Estate in supporting the strategy:**

There are key challenges for the Estate which are directly relevant to supporting the clinical strategy for North Wales.

In terms of Primary Care, the survey in 2016 particularly highlighted non-compliance with the Equality Act (in relation to disability access) and a lack of space to deliver existing services and/or expand to provide a wider range of services locally.

For the Health Board-owned properties, a fundamental issue is the age and condition of the Estate, as indicated in the analysis above. Much of the mechanical and electrical infrastructure of the buildings is in urgent need of replacement, and is starting to fail with a direct impact on clinical services. There will need to be a substantial investment in the Estate simply to continue functioning.

The Health Board is in a situation where it needs to modernise its clinical services and supporting infrastructure. Much of the Health Board’s accommodation falls below current Health Building Note (HBN)/Health Technical Memorandum (HTM) and infection prevention guidance.

The poor resilience and unreliability of current mechanical and engineering systems, combined with aging and non-compliant/inflexible clinical environments, result in patient dissatisfaction and limited expansion capacity.

We will develop an Estates strategy for the organisation to support the overall strategy. This will include an investment strategy to achieve Condition B for the majority of the Estate, and to explore opportunities for joint developments with partners.

1. **ACTIVITY AND CAPACITY**

BCUHB provides a full range of primary, community, mental health and acute hospital services for the population of North Wales. The Health Board also commissions services for North Wales residents from other providers, mainly from hospitals in the North West of England. In the latest 12 months, 35,300 spells and 39,200 outpatient attendances were undertaken in hospitals outside North Wales.

A high-level and aggregated summary of the current activity levels in North Wales is outlined below. This is supported by more detailed data in Appendix 6.

Across the three main acute hospitals in North Wales, there are 1,376 funded inpatient beds (495 at Wrexham Maelor Hospital, 456 at Ysbyty Glan Clwyd and 425 at Ysbyty Gwynedd) alongside a further 24 beds at Abergele Hospital. On an annual basis, there are around 177,000 emergency department attendances and in the last 12 month period there have been over 176,000 spells and 458,000 occupied bed days (OBDs) across these four hospital sites.

Overview of secondary care

|  |  |
| --- | --- |
| Indicator | Value |
| Average number of emergency department attendances per day | 484 attendances |
| Average number of admissions per day | 483 admissions |
| Average number of occupied bed days (OBDs) per day | 1,255 OBDs |
| Average length of stay (Inpatients) | 3.6 days |
| Average number of outpatient attendances per day | 463 attendances |
| Average Did Not Attend Rate | 6.8% |
| Total number of patients waiting up to 25 weeks | 83,175 patients |
| Total number of patients waiting 26 weeks and over (26->52) | 14,130 patients |
| Number of inpatient beds | 1,400 funded  1,458 physical |

The system is under considerable pressure. For example approximately 75% of patients were admitted transferred or discharged from an Emergency Department or Minor Injuries Unit within 4 hours of presentation in December 2016, against a target of at least 95%. In terms of elective care over 6,000 people had been waiting over 36 weeks from referral to treatment at the end of December 2016. Bed occupancy levels are routinely higher than the 85% average level required to minimise delays in admitting patients, and delayed transfers of care are running at 208 patients per 10,000 population, compared to a national target of 129.5.

In terms of Community Services across North Wales, there are 15 community hospitals[[5]](#footnote-5), each of which range in the scope of services provided. In total there are 528 funded community inpatient beds. Minor Injury Units are provided from six of the community hospitals[[6]](#footnote-6), undertaking around 35,000 attendances and with Llandudno General Hospital seeing over 50% of these patients. In the last 12 month period there have been just over 13,700 spells and 164,600 Occupied Bed Days in community hospitals.

**Overview of community hospital care**

|  |  |
| --- | --- |
| Indicator | Value |
| Average OBDs per day at community hospitals | 451 OBDs |
| Average length of stay at community hospitals | 28 days |
| Inpatient beds | 528 (funded)  540 (physical) |
| Average outpatient attendances per day at community hospitals | 94 attendances |
| Average outpatient new to follow up ratio at community hospitals | 1.9 attendances |
| Average Did Not Attend Rate | 8.3% |
| Average MIU attendances per day | 152 attendances |

Across North Wales, the local population are also supported by a range of community area teams. These include community nursing teams which include district nursing, enhanced care at home, as well as other targeted services such as the Conwy intermediate care service and the Caia Park health team whose focus is improving health and wellbeing. Complete and consistent data on community services across the six counties is not readily available. Where important to the strategic modelling, work will be undertaken with service leads to build this baseline, understanding key metrics such as number and source of referrals, caseload, and average caseload per FTE, as well as understanding what a typical case may comprise in terms of contacts and resources.

In terms of primary care, the 109 GP practices across the health board area have on average a list size per practice of 6,489 patients. As with information on Community Services, work will be undertaken to agree which elements of primary care activity need to be modelled as part of the development of the strategy.

A separate in depth analysis is currently being undertaken on mental health and learning disability services provided across North Wales and therefore the baseline profile of these services will be considered separately from this report. This analysis will be available in May 2017.

1. **IMPACT ASSESSMENT**

Embedding equality, diversity and human rights into everything we do will enable the

Health Board to enhance individual and business performance, improving service delivery and developing a creative, innovative culture whilst attracting the best candidates, and retaining and developing our employees.

The Equality Act 2010 provides protection from unfair treatment for people who have ‘protected characteristics’, these are: race/ethnicity, sex, gender reassignment, disability, sexual orientation, religion or belief, age, marriage and civil partnership and pregnancy and maternity. Regulations made under this legislation require BCUHB and all public sector organisations in Wales to assess the likely impact of proposed new or revised policies and practices on our ability to comply with the general equality duty.

The Human Rights Act 1998 helps to define the relationship between the citizen and the state (public sector) and how public sector organisations like the NHS are required to observe and deliver basic human values. These also featured strongly in the organisational Values that were developed within BCUHB by staff and other stakeholders, and will help us to define and develop our organisational culture. We have therefore included Human Rights in our assessment processes.

Understanding any potential impact upon Welsh language has always formed part of our Equality Impact Assessment and The Welsh Language Standards make this requirement more explicit by requiring us to ensure our processes identify what effects, if any, any policy decision would have on:

(a) Opportunities for persons to use the Welsh language: or

(b) Treating the Welsh language no less favourably than the English language

Additional to these considerations, there is an increasing range of requirements and expectations - statutory, mandatory and good practice – relating to impact assessment. Health Impact Assessment (HIA), for example, has long been acknowledged as a means by which

*“a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.”*

(WHO Europe 1999, The Gothenburg Consensus)

HIA encompasses mental and emotional health and well-being as well as physical and social. A more focused assessment of impact on mental well-being may also be undertaken.

There is clearly overlap between some impact assessments, leading to duplication of effort for those undertaking the assessment, but more importantly potential duplication for people – service users, carers, members of the public, staff, other groups and organisations.

We have been looking for ways of streamlining impact assessment processes to ensure thorough and robust analysis of the potential impacts of policies, service changes or developments and other initiatives. This must be set in the context of the Well-being of Future Generations Act and the need to consider how everything that we do relates to people’s well-being. How does what we are doing contribute positively to people’s sense of control; resilience or access to coping resources; and feelings of being included or able to participate?

We have been discussing the potential approach with our leads on different impact assessments and also with our expert advisory group, the Equality & Human Rights Scrutiny Group. It has been recognised that there are some impact assessment tools that are focused on people; and some that are more technical. The approach we are proposing is that we bring together the early stages of impact assessment work particularly in relation to the people-focused assessments:

* data and evidence gathering – what do we know about the proposed policy or service change proposal?
* identifying who might be affected – a test of the relevance of the policy or proposal to different groups in our population
* involving people who might be affected in identifying the potential impacts and any mitigation.

The process will consider the potential impacts on all groups. We will then be able to filter the information gathered to help address the individual assessment areas, support decision-making and identify actions.

The diagram attached at Appendix 7 shows how the assessment work can link together, and provides a series of prompt questions to enable the thinking

This is work in progress and will be tested as part of the impact assessment work for our Living Healthier, Staying Well strategy development programme.

1. The path to sustainability, Health Foundation, October 2016 [↑](#footnote-ref-1)
2. Source: Demography 2016, Public Health Wales [↑](#footnote-ref-2)
3. Tackling wasteful spending on health, OECD, January 2017 [↑](#footnote-ref-3)
4. Chief Finance and Value Officers and Directors of Finance and Value: A think piece, Gray and Cripps, NHS RightCare, 2016 [↑](#footnote-ref-4)
5. Ysbyty Alltwen, Tremadog; Ysbyty Bryn Beryl, Pwllheli; Ysbyty Cefni, Llangefni; Chirk Community Hospital; Colwyn Bay Community Hospital; Deeside Community Hospital; Denbigh Community Hospital; Ysbyty Dolgellau; Ysbyty Eryri, Caernarfon; Holywell Community Hospital; Mold Community Hospital; Ysbyty Penrhos Stanley, Holyhead; Royal Alexandra Hospital, Rhyl; Ruthin Community Hospital and Ysbyty Tywyn [↑](#footnote-ref-5)
6. Llandudno General Hospital, Ysbyty Penrhos Stanley, Ysbyty Alltwen, Ysbyty Bryn Beryl, Ysbyty Dolgellau and Ysbyty Tywyn [↑](#footnote-ref-6)