IMTP 2019/20 – 2021/22 APPENDICES

APPENDIX 1: SUMMARY OF WELL-BEING ASSESSMENT

The following pages provide a summary of the Well-being and Population Needs Assessments which were originally undertaken in response to the development of the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014. The full analysis and list of sources can be found at https://en.powys.gov.uk/article/5794/Full-Well-being-assessment-analysis.

POWYS DEMOGRAPHICS

A Changing Population

The population in Powys is generally older in comparison to the rest of Wales.

The working age adult population is smaller in Powys compared to Wales.

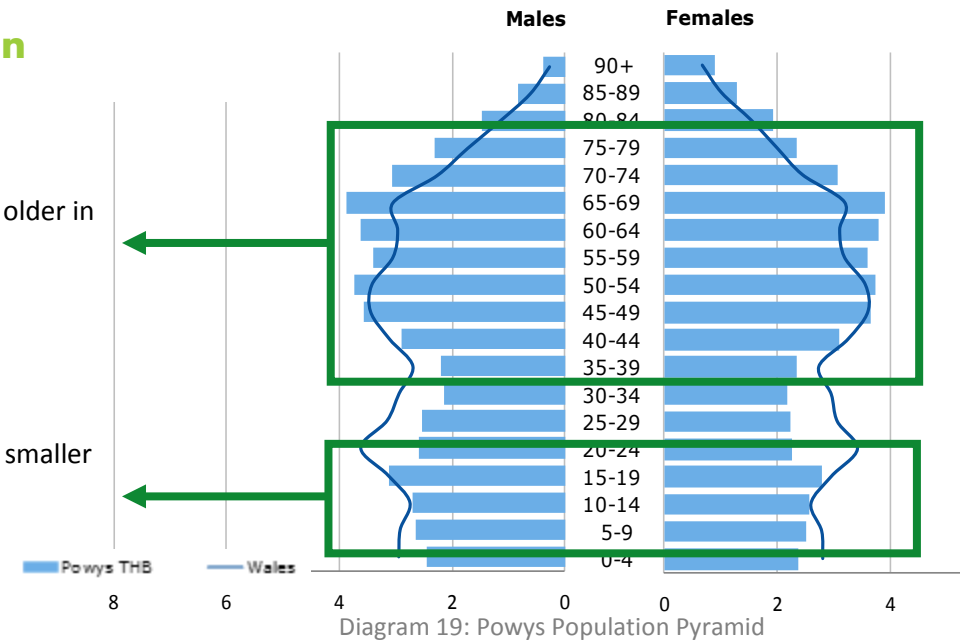


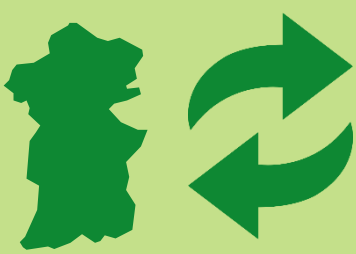
Diagram 19: Powys Population Pyramid

8% Projected overall decline in the Powys population by 2039.

15% Powys population aged 15 and under.

59% Powys population aged between 16 and 65.

26% Powys population aged 65 or over.



5,500 people migrated out of Powys in 2015

5,900 people migrated into Powys in 2015

The number of young people and those under 65 is predicted to decrease while the number of older adults in Powys is predicted to increase.

DETERMINANTS OF HEALTH

Economic Well-being and Poverty

Economic well-being is above the Welsh average but there is hidden poverty in Powys associated with rural communities.

On average, Powys residents earn consistently less than people in many other Welsh Local Authorities, ranking third lowest in Wales.

Unemployment rates are low but there is a high proportion of people in part time work and a low wage economy.

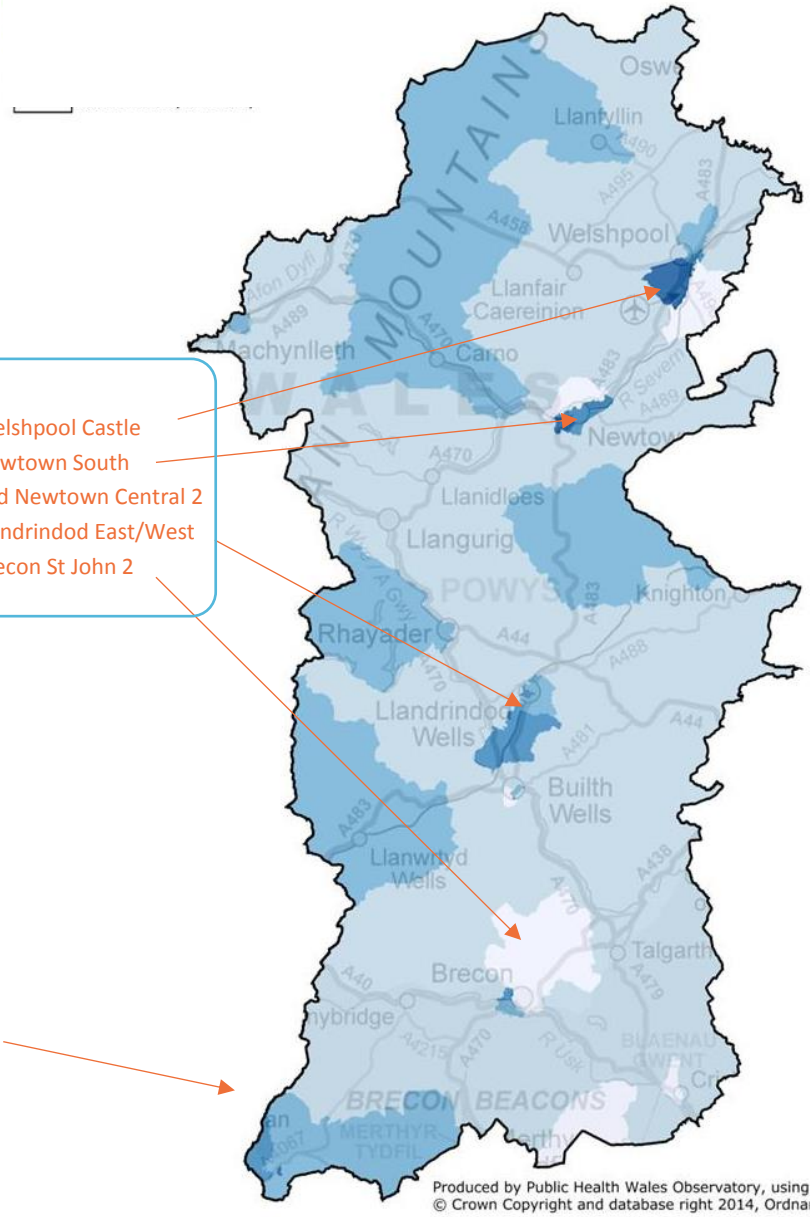
Five Local Authority Super Output Areas (LSOAs) in Powys are among the most deprived in Wales

- Welshpool Castle
- Newtown South and Newtown Central 2
- Llandrindod East/West
- Brecon St John 2

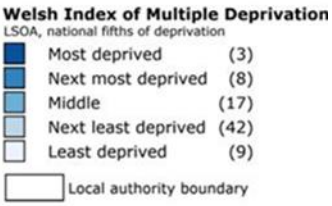
Five LSOAs in Powys as shown above are among the most deprived 30% in Wales while Ystradgynlais 1 is the most deprived area and is among the 10% most deprived LSOAs in Wales.

Powys has a disproportionately high number of small businesses, alongside a high proportion of self-employed workers. This needs to be seen in the context of 11.3% of men and 8.9% of women of working age in Powys having no formal qualifications.

Between 2004 and 2013, there was a reduction in the proportion of Year 11 leavers not in education, employment or training.



WIMD Map of Powys LSOAs



Community Well-being and Health Assets

83% Of Powys residents report that they feel they belong to their local area (Welsh average 76%).

Powys has a high prevalence of the assets required for resilient, self-reliant communities. This is almost universally the case, with good levels of provision relative to Wales, whether looking at people, community or structural assets. The only area where more attention may be required in some parts of Powys is in relation to education and training.

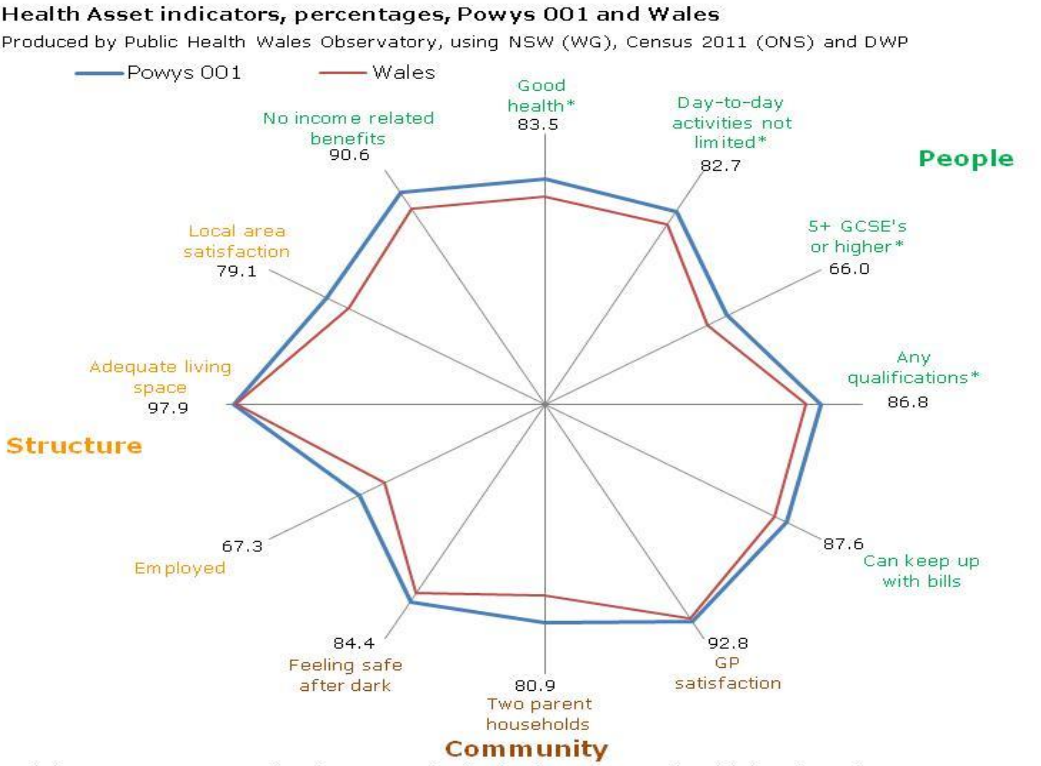


Diagram 21: Health Asset Indicators, Percentages Powys 2011

Public sector services in Powys include 98 schools, 17 branch libraries and 2 mobile libraries, 16 leisure centres, 9 hospitals, 1 Integrated Health and Care Centre, 18 fire stations and 14 police stations.

Powys is the second most expensive place to buy a house in Wales in relation to income rates (8.7 times the median annual gross pay for a full time job in Powys, 6.4 in Wales).

Housing quality in Powys is worse than across Wales, with 24 of the 75 Electoral Divisions among the worst 20% of areas for housing quality in the WIMD 2000.

A total of 859 people are supported by domiciliary care in Powys. As our elderly population increases, there will be more demand for suitable accommodation options.

LIFESTYLE AND HEALTH STATUS

Public Health Outcomes Framework

The Public Health Outcomes Framework[1] sets out a shared understanding of the health outcomes that are important to the people of Wales. The key messages and the position of Powys relative to the Wales average for each measure is shown below:

Powys is significantly better than the Wales average for nearly half the indicators published in the Public Health Outcomes Framework.
People in Powys live longer and spend more years in good health.

Adults eat more healthily and are more physically active in Powys.

The mortality rate from road traffic accidents is relatively high in the Powys population; however, there is some complexity in relation to this information.

Fewer people feel lonely and there is a greater sense of community in Powys.

Working age adults and older people are more satisfied with life.

Table 2: Public Health Outcomes Measures for Powys

Overarching Outcomes	
Outcome	**PTHB value**
Healthy life expectancy (females)	68.7yrs
Healthy life expectancy (males)	68.2yrs
Life expectancy (females)	83.5yrs
Life expectancy (males)	80.3yrs
Mental well-being among adults (ave score on Warwick-Edinburgh Mental Well-being Scale)	52.3
Gap in healthy life expectancy at birth between the most and least deprived fifth (females)	14.4yrs
Gap in healthy life expectancy at birth between the most and least deprived fifth (males)	10.4yrs
Gap in life expectancy at birth between the most and least deprived fifth (females)	5.2yrs
Gap in life expectancy at birth between the most and least deprived fifth (males)	5.2yrs

Living Conditions that Contribute to Health	
Outcome	**PTHB value**
People able to afford everyday goods and activities	87.91%
School leavers with skills & qualifications (level 2)	No data
Gap in employment rate for those with a long term health condition (i.e. difference in employment rate between general population and those with Long term health conditions)	13.1%
A sense of community	64.7%
People feeling lonely	13.1%
People who volunteer	37.5%
Quality of housing (% assessments free from cat 1 hazards)	51.7%
Quality of the air we breathe (ave NO_2 concentration)	5.1µg/m^3*

Ways of Living that Improve Health	
Outcome	**PTHB value**
Adolescents drinking sugary drinks once a day or more	13.6%
Adolescents using alcohol	7.2%
Adolescents who smoke	2.7%
Adults drinking above guidelines	17.8%
Adults eating 5 a day	29.7%
Adults meeting physical activity guidelines	65.9%
Adults who smoke	18.4%
Physical activity in adolescents	16.8%
Breastfeeding at 10 days	51.5%
Smoking in pregnancy	11.2%
Teenage pregnancies	14.9 per1,000
Vaccination rates at age 4yrs	86.2%

Health throughout The Life Course	
Outcome	**PTHB value**
Low birth weight	4.7%
Adolescents of healthy weight	76.7%
Children age 5yrs of healthy weight	72.6%
Tooth decay among 5yr olds (ave no. decayed, missing, filled teeth)	0.9
Life satisfaction among working age adults	85.6%
Working age adults free from limiting long term illness	75.3%
Working age adults in good health	79.3%
Working age adults of a healthy weight	44.7%
Hip fractures among older people	502.4 per 100,000
Life satisfaction among older people	87.8%
Older people free from limiting long term illness	50.8%
Older people in good health	60.9%
Deaths from injuries	41.9 per 100,000
Deaths from road traffic injuries	8.7 per 100,000
Premature deaths from key non-communicable diseases	261 per 100,000
Suicides	14.6 per 100,000

Source: Public Health Wales Observatory

Key:

- Significantly better than the Wales average
- Not significantly different to the Wales average
- Significantly worse than the Wales average
- ★ Significance to Wales average not measured

MENTAL HEALTH NEEDS

Importance of Mental Well-being

Improving mental health is a critical issue for people of all ages and its impact is cross cutting, affecting life chances; learning, home life, employment, safety, physical health, independence and life expectancy.

11 Years — The average lost years to life for males with mental health problems. Women with mental health problems on average lose 6 years this is the biggest health inequality.

1in4 — Number of people in the UK who will experience a mental health problem each year.

25% — GP consultations which are for people with mental health problems.

Depression and Anxiety

8% — Of the Powys population report being treated for depression or anxiety and it is one of the top three leading causes of disability.

One in four patients presenting to their GP live with depression with the average GP seeing at least one patient with depression during each surgery session. 80% of people identified as having depression, are managed entirely in a primary care setting. In the UK, 25% of older adults have depression requiring an intervention and over 40% of those in their 80s are affected by depression. This is significant given Powys' demography. It is also important to note that ddepression is the leading cause of suicides in England and Wales each year.

It has been estimated that between 10-15% of women suffer from post-natal depression. In Powys there are approximately 1000 births per year, which means around 100 women may suffer post-natal depression.

Dementia and Alzheimers

Dementia prevalence increases with age, roughly doubling every five years for people aged over 65 years. Dementia affects 20% of people over 80 years of age in the UK and one in 14 people over 65.

4,256 — Estimated number of people in Powys aged over 65 with dementia. At 44% Powys, along with Ceredigion, has the highest projected rise in the number of people with dementia in Wales.

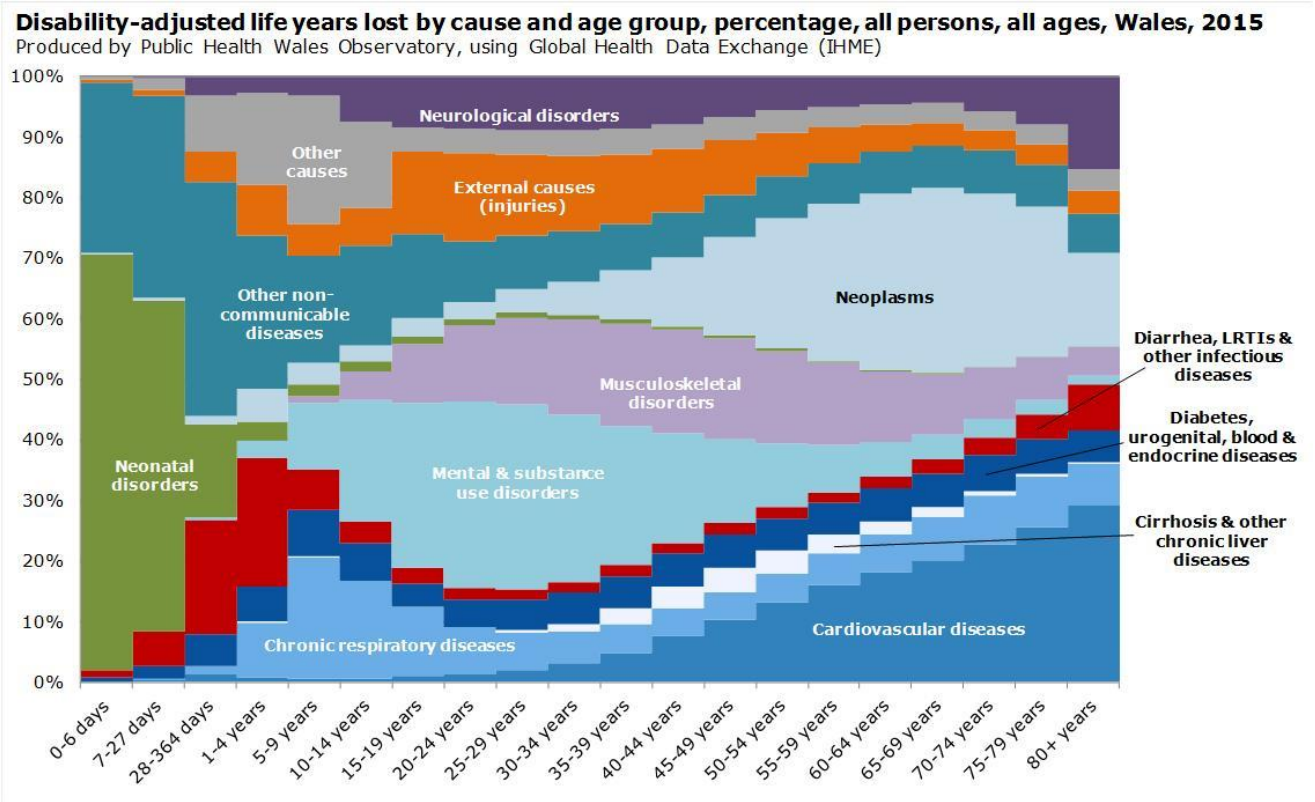
In Powys it is thought that only 39.6% of the projected number of people with dementia have a diagnosis.

Up to 70% of acute hospital beds are occupied by older people, approximately 40% of whom have dementia. However, patients who have dementia experience many more complications and stay longer in hospital than those without dementia. It is also estimated that 30% of people will die with dementia and many of these die in general hospital settings. The improvement in care for people with dementia in general hospitals is a component of the Powys Dementia Plan.

Link to Powys Dementia Plan

BURDEN OF DISEASE

The *Health and its determinants in Wales*[2] report provides an overview of the health and well-being of the population of Wales. It outlines the main areas of health need and presents the complex picture of health in Wales. Although information is shown on an all Wales basis, the picture it presents of disease and disability throughout the life course is equally likely to apply to Powys. Given the importance of maintaining health and well-being, it is useful to see the relative contribution made by different causes to ill health and disability across the life course. This is shown below using disability-adjusted life years as a measure of ill health.



Source: Public Health Wales

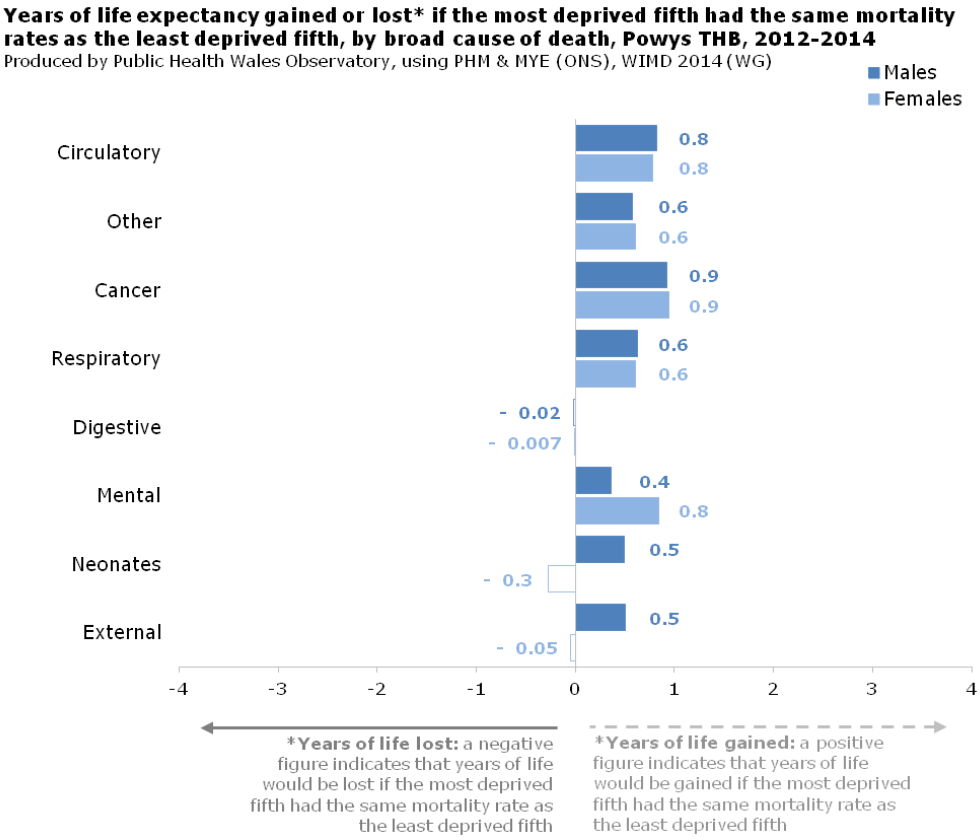
Diagram 22: Disability-adjusted Life Years Lost by Age Group, Wales 2015

This clearly illustrates the contribution made to ill health by different causes at different stages of the life course. Cancer (neoplasms), cardiovascular diseases, respiratory diseases, and mental health disorders all feature prominently from the early years onwards. *The Health and Care Strategy for Powys*[3] recognises the need to address these four causes, bringing them together under the heading "The Big 4".

Musculoskeletal disorders are also shown to be a significant cause of disability and ill health, especially in relation to working age adults. In the context of *The Health and Care Strategy for Powys*, the incidence of musculoskeletal disorders will be addressed through actions that fall within the "Focus on Well-being" (i.e. keeping adults healthy and active), and through "Early Help and Support" (i.e. ensuring prompt access to diagnosis and treatment). Musculoskeletal problems often arise in the workplace, and, as a significant employer, Powys Teaching Health Board will continue to prioritise the well-being of staff, taking a preventive approach and managing employee health rather than employee sickness. Actions to address the well-being of our staff are described elsewhere in the IMTP.

HEALTH INEQUALITIES

People who live in the most deprived parts of Powys live more years in poor health compared to people in the least deprived areas. A child born in the most deprived quintile can expect to live in good health for 14 years (female) or 10 years (male) less than in the most affluent. The graph shows the uneven distribution of the major causes of premature death in Powys:



A number of evidence-based high impact interventions have been shown to work in tackling health inequalities and reducing the life expectancy gap:

- Widespread, systematic adoption of increased prescribing of drugs to control blood pressure and cholesterol; increased smoking cessation services; increased anticoagulant therapy in atrial fibrillation; improved blood sugar control in diabetes.
- Targeted approaches to case finding to address late diagnosis, particularly in disadvantaged communities, in hypertension, Chronic Obstructive Pulmonary Disease (COPD), lung cancer, cardiovascular risk, diabetes and harmful drinking.
- Improving access to health care for vulnerable populations such as ensuring the homeless are able to register with a GP, and older people with cancer are given access to chemotherapy as determined by their functional status and not their age.
- Involving people and communities in designing services to meet health and care needs.
- Promoting the Making Every Contact Count initiative, which systematically puts prevention, protection and promotion of health and well-being into each contact.
- Investing in targeted and universal early years services and good maternal health for all.
- As an employer, reducing discrimination and nurturing and developing a workforce that is representative of the population it serves.

OTHER KEY FINDINGS

16,154	Carers in Powys, showing an increase of 14% from 2001.
576	The number of young carers known to Credu (the Powys organisation for carers) in 2016.

Carers

The increasing numbers of carers and young carers is of particular significance as unpaid carers, usually family members, contribute significantly to maintaining the well-being of individuals with complex needs due to long term physical or mental ill-health, disability or old age in the community. The health and well-being of carers is affected by their caring responsibilities, as many may experience ill health, poverty and problems accessing employment. In Powys, 65% of unpaid carers are over 50 and 39% are retired. Their health is typically below average, and some carers are now providing more than 50 hours of care each week.

Of those carers who took part in the citizen survey; 33% said they could do things which were important to them with 24% saying this applied only part of the time and 29% felt supported to continue in their caring role. People also said there are a lack of places to go for older people during the daytime and have stressed the importance of the existing day time services and the respite it provides to carers.

The number of young carers is increasing, with most providing up to 19 hours of care. Some young carers, due to their responsibilities, are missing out on school time. This can have an effect on their education and future prospects. Due to the increasing elderly population, more young people are finding themselves with caring responsibilities.

Violence Against Women, Domestic Abuse and Sexual Violence

In 2016, Powys has seen a 10% rise in the number of domestic violence incidents being reported, compared with 2015. In the north of Powys, BME (Black, Minority and Ethnic) and LGBT (Lesbian, Gay, Bisexual, Transgender) groups are also more likely to be affected. Many crimes are still not reported, and the number of incidents is expected to rise over the coming years. This rise continues an existing trend with an overall increase of 75% since 2010.

Vulnerable Children

The most common age group of vulnerable children is 10-15 years old, this makes it hard to find suitable foster parents as their needs are greater. More children are being placed on the child protection register, with neglect being the most common reason. The number of cases referred to the Youth Justice Service has fallen since 2010, along with the number of children in need. This is in the context of a statutory requirement for Powys County Council to improve children's services, following a review by CIW during 2017.

Children with Disabilities

Autistic spectrum disorders are the most common presentation of disability within children in Powys. In 2016, 155 open cases were referred to the team (a decrease of 13% since 2012). From caseloads, 52% of children with disabilities live in north Powys.

SUMMARY PLAN: CANCER

Local Priorities for 2017/18-19/20	Measures
Focus on Well-being • Assessment of population need • Programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy lifestyles **Early Help and Support** • Develop targeted and coordinated screening campaigns and activities, and review onward referrals. • Appropriate access to MRI & CT and timely receipt of scan reports to ensure appropriate and timely onward referral; Patient pathway to be identified to attend DGH urgent assessment unit. • Strengthen training and development plan for primary care engaging with the Macmillan Framework for Cancer Programme to support clinical leadership development for cancer services. • Improve information provision and awareness by ensuring resources are available and accessible. Working with partners to develop a "neighbour scheme" to take this to the workplace and the wider community. **Joined Up Care** • Robustly and effectively performance manage commissioned cancer services and change programmes. • Strengthen links between acute and primary care strengthening and improving whole pathway of care. • Improve access to and patient experience of systemic anti cancer therapy services. • Develop teleheath solutions where possible across the cancer pathway. • Develop Local Powys Improving Cancer Journey project with Macmillan and Third Sector partners. **Tacking the Big Four and Health Inequalities:** • Develop the information available to support performance improvement and development across whole pathway including patient experience, activity and access. • Ensure implementation of the Single Cancer Pathway. • Secure and deliver well coordinated palliative and end of life care as per the End of Life Delivery Plan. • Increase the funding diverted to Powys in relation to cancer research and pilot studies. • Ensure the appropriate targeting of cancer screening and other approaches supporting the early diagnosis of cancer. • Targeted approaches to cancer case finding. • Analysis of cancer pathways and outcomes to identify and address **health inequalities**.	• Cancer access targets • Hospital activity data • Population needs • Screening uptake • Training activity

Key Milestones			
2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
• Initiate project on developing an integrated ICJ model in Powys • Implement Single Cancer Pathway • Launch of Macmillan Cancer Quality Toolkit for Primary Care	• Commence scoping work for ICJ model • Roll out of use of Holistic Needs Assessments	• Delivery of training for clinical teams and across all staff groups in PTHB	• Undertake scoping exercise for patient pathways from primary into secondary care in Lung and Lower GI.

SUMMARY PLAN: STROKE

Local Priorities for 2019/20-22	Measures
Focus on Wellbeing: • Assessment of population need • Programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and promotion of healthy lifestyles **Early Help and Support:** • Improving detection and management of atrial fibrillation in primary care in Powys • Improve prevention, diagnostics, early intervention and access to stroke care and treatment as close to home as possible **Joined Up Care:** • Undertake review of staffing and MDT working on wards which admit stroke patients • Improving patients experience of transition of care from hospital to home by working more flexibly across hospital and community settings • Improving flow of patients through acute and inpatient rehabilitation units by improving community rehabilitation utilising funding made available by Welsh Government • Workforce planning to address patient flow throughout the whole stroke pathway, ensuring a prudent workforce model • Increasing intensity of therapy provided in the community • Improving communication and coordination of care to improve 6 month review rates utilising funding made available by Welsh Government • Improving emotional support and access to psychological therapies for stroke survivors enable them to self manage their own conditions • Developing and responding to patient experience and outcome measures **Tacking the Big Four and Health Inequalities:** • Engage in plans for thrombectomy services in line with the WHSSC led commissioning process to ensure appropriate rates for patients in Wales • Continue to participate in consultation and engagement in HASU implementation plans in neighbouring Health Boards • Conduct study for "Gait in young stroke survivors" • Update information available on website for stroke survivors including clear pathways for services and support both within the county and for specialist services out of county • Pilot the new Community Clinical Information System ensuring it supports the collection and inputting of stroke sentinel national audit data and it promotes interdisciplinary and interagency working • Continue to support the development of stroke research network in Wales	• Stroke treatment measures • SSNAP Data • Hospital activity • Primary Care Activity • Programme Plans • Study results • Patient experience • Workforce measures • Therapy / clinic activity

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1-Q2	2020/21 Q3 - Q4
Paper developed to review MDT working, role of blended support workers and nursing HCSWs	Continue to improve effectiveness and quality of community rehabilitation for stroke survivors	Continue to support and promote stroke prevention and awareness campaigns	Improve completion of 6 month reviews for stroke survivors	Annual review and planning cycle	

SUMMARY PLAN: DIABETES

The national diabetes implementation group decides its priority areas annually but three key strands are likely to be consistent: meeting national standards in primary and inpatient care; supporting people to manage their conditions through structured education programmes; and creating more integrated primary and specialist provision

Local Priorities for 2019/20-22	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles. **Early Help and Support:** • Develop campaigns with community pharmacies and Diabetes UK Cymru • Delivery of structured education programmes **Joined Up Care:** • Adopt the Referral Pathway for Children with Suspected Diabetes. • Demonstrate improvement against the 8 essential care processes for adults. **Tackling the Big Four and Health Inequalities:** • Promote the uptake of Diabetes Enhanced Services in primary care. • Participate in peer review of type 1 diabetes services.	• Public Health Outcome Framework • Emergency admissions for hypoglycaemia and Diabetic ketoacidosis • Insulin pump rates • Hospital length of stay • Medication errors • Compliance with the key care processes • Attendance at transition clinics. • Neonatal care admissions • Referral / attendance at structured education services • Attendance at structured education

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q2	2020/21 Q4	2022/22
• Deliver protected learning time workshops to GP's and link nurses	Review with secondary care providers transition from paediatric to adult services	• Support local influenza vaccination campaign & encourage patients who have diabetes to have vaccination	Diabetes Planning & Delivery Group review of priorities and performance and new key milestones identified	Annual review of the 8 essential care processes for adults	As per review	As per review

SUMMARY PLAN: HEART DISEASE

Local Priorities for 2019/20-22	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles **Early Help and Support:** • Information about signposting to local support services is included in MECC training • Implement All Wales pathways to improve access, treatment times and outcomes for acute coronary syndrome, atrial fibrillation and heart failure • Rollout of International Consortium for Health Outcomes Measurement pilot across Powys and analysis of data collection; **Joined Up Care**: • Develop a community cardiology one stop shop • Improve detection and management of atrial fibrillation in Primary Care • Introduce a Cardio Vascular Disease risk assessment programme in deprived areas of Powys • Provide GPs with timely access to diagnostic testing and procedures for heart disease, increasing direct access to testing at the point of care or from a central laboratory as well as timely access to specialist cardiology advice **Tackling the Big Four and Health Inequalities:** • Map community service utilisation and effectiveness of pathways of care • Improve accountability and reporting arrangements in liaison with WHSSC • Explore funding opportunities for cardiovascular research and pilot studies • Participate in National cardiac rehabilitation audit	• Public health outcome framework • Referral for structured education programme • Reduction in attendances and admissions to secondary care providers • PROM data

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1-2	2020/21 Q3 -4	2022/22
• Approval of Community Cardiology Services development • Develop Workforce plan • MECC Rolled out		Implementation of Community Cardiology subject to agreement Cardio vascular disease risk assessment in place		Annual review and planning cycle		

APPENDIX 2: SUMMARY PLANS (National Delivery Plan Areas)

Local Priorities for 2019/20-22	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles • Continue to raise awareness with the public of how to live healthy with active lifestyles to maintain respiratory health. • Strengthen the work undertaken as part of invest in your health. **Early Help and Support** • Improve access to the pulmonary rehabilitation services for those patients who live in more rural areas. • Increase the funding linked with Spirometry to provide training throughout Powys for Respiratory nurses, HCAs and other health professionals. • Deliver efficient self management plans to all of our patients diagnosed with COPD. • Ensure people receive prompt, effective treatment and care for their respiratory condition whether adult or child so that they have the best chance of optimising their quality of life. • Reduce unnecessary variation in oxygen prescribing by sharing best practice **Joined Up Care** • Ensure crisis management packs are available to the whole of Powys. • Develop initiatives to promote the management of acute respiratory conditions in the patient's home and in intermediate care settings. • Strengthen links between acute and primary care; strengthening and improving the whole pathway of care. • Continue to work with GP Practices to undertake peer review of emergency respiratory admissions. • Ensure that service users of oxygen have a positive experience of care • Improve the provision of specialist sleep service • Improve the efficiency of the patient pathway from RTT **The Big Four/Addressing Health Inequalities** • Targeted approaches to case finding and active management of chronic obstructive pulmonary disease and lung cancer. • Consider the local impact of, and response to, occupationally associated disease.	• Increased referrals for pulmonary rehab • Increase in smoking cessation referrals • Reduction in admissions for COPD • Oxygen variation minimised

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q2	2020/21 Q4	2022/22
• Agree local programme of activity relating to respiratory services and prioritise initial work • Improve referral rates to, and uptake of PR programmes	• Work with existing GP to support development through appropriate skills, capacity and training	• Review performance against national standards • Support ongoing provision of NERs programme	Annual review and planning cycle			

SUMMARY PLAN: NEUROLOGICAL CONDITIONS

Local Priorities for 2019/20-22	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles **Early Help and Support:** • Implement a co-productive approach to raising awareness of neurological conditions through continuing to work with Third Sector partners and local patient groups to raise awareness **Joined Up Care:** • Implement a co-productive approach to service development through using patient stories to evaluate and inform service developments and developing a service user forum to support the Steering Group • Developing clear pathways and models of care based on best practice and research evidence by working with specialist services in England and Wales to refine and improve patient pathways in line with national guidance • Raise the profile of the support and rehabilitation available in Powys to service users and professionals working in and out of Powys • Reduce unplanned admissions through better coordination of care in the community • Develop further capacity to provide appropriate intensity and level of therapy in the community through use of blended therapy assistants and telehealth • Enhance links with the Third Sector to maximise opportunities to support self-management • Ensure training programmes are in place for all levels of staff working with people with these conditions to improve access to emotional support • Support the development of clinical leadership skills in the field of stroke and neurological rehabilitation • Implement use of PREM and PROM in service evaluation and development • Powys subgroup of the National Steering group will pilot the Cerebral Palsy register using WCCIS and host the first stakeholder participatory events organised by part time research physiotherapist and Lead Paediatric Physiotherapist	CNS engagement with awareness raising event across Powys Service User Forum in place Evidence based service specifications in place for commissioned services PADRs 2 clinicians on the Stroke leadership Programme Reduced admission, greater uptake of services Number of neuro cafés in place National PREM and PROM tested locally and rolled out

Key Milestones					
2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q2	2020/21 Q4
Clinical Leadership workshop for B7 stroke and neurological Conditions Clinical Leads	Pilot PROM and PREM as part of national project Additional Neuro café's up and running in mid locality	2 PTHB Community Neuro Service Clinical Leads on the Stroke Clinical Leadership Development Programme New Specialist MS pathway in place in south locality	Roll out PREM and PROM for community neuro clinics	Service User Forum to meet	2 further neuro café's running across Powys

SUMMARY PLAN: END OF LIFE

Local Priorities for 2019/20-22	Measures

Supporting Living and Dying Well • Roll out the Powys My Life My Wishes to support advance care planning. • Ensure training is available for clinical teams to enable the use of My Life My Wishes and facilitate conversations about advance care planning • Work with Byw Nawr to raise public awareness about the importance of advance care planning and being more open about death, dying and bereavement. **Detecting and Identifying Patients Early** • Through the Macmillan GP End of Life facilitators ensure that primary care are able to identify patients early, maintain palliative care registers and have regular MDTs to support Advance Care Planning. • Through Macmillan Lead Nurses for End of Life Care Planning deliver the 6 steps programme in Powys care homes which will provide education and receive the support necessary to ensure the provision of good end of life care. **Delivering Fast, Effective Care** • Ensure that infants, children and young people approaching end of life have access to specialist paediatric palliative care team • Agree a model of End of Life care and scope current access to care provision for patients at end of life who wish to be cared for at home to ensure that there are accessible, equitable, quality services available to provide care to patients at end of life. **Reducing the distress of terminal illness for patients and their families** • Ensure transition arrangements are in place from child to adult palliative care services • Continue to provide support and guidance for clinical teams on the care decisions guidance, anticipatory prescribing and just in case boxes. • Scope the feasibility of supporting lay carers to administer sub cutaneous injections • Scope the provision and feasibility of providing intravenous bisphosphonates for malignant hypercalcaemia in community hospitals • Scope the current bereavement information and support in place for people who die in Powys **Education** • Deliver the 6 steps education programme to all Powys care homes • Develop a fundamentals in palliative care study day which will be available to all clinical staff • Deliver the palliative care module in Powys bi annually	• Staff feel they have the skills and knowledge to support advance care planning. • A programme of public events to support Byw Nawr will be in place • Appropriate Palliative care registers are in place and patients are reviewed through MDTs • Increase in the number of people with an Advance Care Plan • Appropriate care is available for people who wish to be cared for at home • Reduced inappropriate admissions at end of life from care homes. • The degree module and fundamentals study day will be delivered.

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q2	2020/21 Q4	2022/22
Delivery of annual training programme/ events/ education/ care home support; My Life MY Wishes launch Q1 Education to support ACP Q1				Review / annual planning process		

SUMMARY PLAN: LIVER DISEASE

Areas of focus in the national plan include lifestyle risks and variation in outcomes, reducing average length of time spent in hospital, reducing emergency admissions, reducing alcohol related admissions and reducing the increasing incidence of liver cancer. There is also a need to progress actions to improve outcomes in relation to lifestyle factors including obesity and alcohol.

Local Priorities for 2019/20-20/22	Measures
Focus on Wellbeing: • Whole system approach including assessment of population need; programmes for smoking cessation, substance and alcohol misuse, healthy weights, physical activity and immunisation; promotion of healthy active lifestyles **Early Help and Support:** • Improve awareness and understanding of liver disease within primary and community care and with partners to help detect early liver disease and make appropriate referrals • Ensure appropriate primary care management of those with liver disease including uptake of appropriate vaccinations • Further development of opportunistic assessment of alcohol in different settings and secondary care responses **Joined Up Care:** • Delivery of the Health and Care strategy model of care which has a focus on prevention based outcomes, lifestyle factors and reduction of the burden of the disease, which will support work to tackle liver disease, provide care closer to home and reduce admissions • Commissioning plans to ensure onward pathways are clear, specialist services are available and access to diagnostic testing and treatments are in place • Strengthen clinical leadership and review of services and pathways • Work with Third Sector substance misuse services to implement strategies in order to continue to reduce risk behaviour and substance misuse as part of the implementation of the Substance Misuse Strategy • Taking forward the implementation of WHC 048 2017 "Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health • Improve the provision of assessment and testing of those at highest risk of liver disease	• Proportion of population who are obese • Promotion of healthy lifestyle factors • Proportion of adults self-reporting drinking more than recommended guidelines • Reduction in alcohol related admission rates • Rates of new diagnosis or cirrhosis • Liver disease mortality figures • Rate of hospital admission for liver disease

Key Milestones

2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q2	2020/21 Q4	2021/22
• Strengthen clinical leadership and review	• Ongoing oversight with strengthened clinical input to review services and pathways, aligned to Powys model of care			Review and confirm in annual planning		

SUMMARY PLAN: CRITICALLY ILL

PTHB commissions critical care services from relevant NHS provider organisations through its Long Term Agreements (LTA) in both England and Wales. The Welsh Health Specialised Services Committee (WHSSC) is delegated to commission specialised services for the population of Wales. This includes paediatric intensive care and the critical care episodes which form part of a specialised admission for adults.

Local Priorities for 2019/20-22	Measures

Focus on Wellbeing/ Early Help and Support:
• PTHB has a role in relation to minimizing avoidable critical illness and admissions and the PTHB Health and Care Strategy promotes a way of working that improves the management of conditions and diseases through joined up support and care co-ordination, which is known to help prevent avoidable exacerbations and admissions.
 	
Joined Up Care
• A Key local priority is the interface between secondary and tertiary service with regard to intensive care for adults, managed though the WHSSC Integrated Commissioning Plan and interface with Powys
• Work is underway in Wales with the overall aim of developing a national model of care for those who are critically ill. The review is considering ways of working which could improve capacity and the impact of changing flows of some services e.g. vascular, out of hospital cardiac arrests and major trauma. PTHB is seeking to ensure that cross-border reconfiguration issues and patient flows are taken into account, e.g. Changes to the configuration of vascular services in England.
• Delivering Appropriate Effective Ward Based Care – PTHB has a role as a commissioner in relation to critical care providers to ensure:
  • Patients be cared for in the correct facility with highly qualified specialists
  • Patients and carers are as involved in their care as they feel appropriate
  • Patients receive care that is clinically effective
  • Effective Critical Care Provision and Utilisation - Welsh Health Boards caring for patients from Powys are expected to be compliant with the standards set out in the critical care delivery plan for Wales. English providers are also provided with links to the Welsh condition specific plans to ensure the compatibility of essential requirements.
• To respond to finding of the National Care Survey in Critical Care as appropriate.
• A key local priority for Powys is to work with the WHSSC to ensure there is clarity about the interface between secondary and tertiary service commissioning with regard to intensive care for adults. Through the WHSSC Integrated Commissioning Plan and the interface group with Powys, PTHB is seeking more detailed information about Welsh residents receiving services in **Timely Discharge from Critical Care**
• Patients have timely access to (where appropriate for their condition and needs) and discharge from critical care
• Procure and Commission the Clinical Information System for Wales
• (Psychiatric Intensive Care is covered through the arrangements for mental health services.)
	• National Outcomes
	• Commissioning Assurance Framework

APPENDIX 3: TABLE OF LONG TERM AGREEMENTS (LTAs)

English NHS Providers	LTA Value 18/19 £'000's	Commissioning Intentions 2019/2020
Shrewsbury and Telford Hospital NHS Trust	£25.3m	• Escalated arrangements in response to regulator action • Implementation of the outcome of the public consultation on Future Fit • Address High Cost Drugs • Ensure DToC arrangements are working smoothly • Ensure sustainable arrangements for neurology • Clarify and strengthen shared care arrangements • Review any fragile in-reach arrangements
Wye Valley NHS Trust	£14m	• Review the impact of additional funding to address referral to treatment times • Review the orthopaedic pathway • Review the outcome of work to reduce: Delayed Transfers of Care; Emergency Activity; Waiting times breaches; Costs. • Consider the impact of the development of the Accountable Care Organisation; the Foundation Group arrangements with South Warwickshire; and strategic change within the Herefordshire and Worcestershire STP area (including stroke and vascular services). • Review any fragile in-reach arrangements • Clarify and strengthen shared care arrangements • Review Rheumatology Business case • Respond to potential change to stroke services • Seek access for paediatric dental GAs
Robert Jones & Agnes Hunt Orthopaedic Hospital	£9.1m	• Seek to develop pre-referral advice and support • Review alternative orthopaedic pathway • Ensure satisfactory alternative arrangements are in place for pain management
Gloucester NHS Foundation Trust	£1.5m	• Explore new ways of working including pre-referral advice and the modernisation of follow-up. • Monitor progress addressing financial special measures and mortality rates • Assess impact of changes to specific tariffs
Midlands Partnership	£1.1	• Ensure appropriate access to CAMHS, including vulnerable children placed out of county
Worcester	£0.522m	• Increase access to cardiac MRI • Review the impact of changes to stroke and vascular services in the Hereford and Worcestershire STP area. • Monitor progress addressing special measures. • Review access to cardiac MRI
Wolverhampton	£0.193m	• Seek to maintain additional neurology support until sustainable services closer to home secured
Sandwell	£41k	N/A
Shropshire Community Health Care NHS Trust	TBC	• Clarify commissioning responsibility for services transferred to local authorities

APPENDIX 3: TABLE OF LONG TERM AGREEMENTS (LTAs)

Welsh NHS Providers	LTA Value £'000's	Key Issues
Aneurin Bevan UHB	£11.8m	• Clarify the provision of paediatric and obstetric services; Review patient pathways in response to Nevill Hall service model.
Hywel Dda UHB	£7m	• Seek further collaboration with Hywel Dda and BCUHB to develop services closer to home and address current gaps, including clinical in-reach services for diagnostics • Seek access for paediatric dental GAs
ABMUHB	£7.9m	• Work with ABMUHB to modernise clinical in-reach services to ensure sustainability • Work through the implications of the Bridgend transfer of services
Betsi Cadwaladr UHB	£2.1m	• Work with BCUHB on the implications of potential changes to Upper GI and vascular in England • Seek further collaboration with Hywel Dda and BCUHB to develop services closer to home and address current service gaps, including clinical in-reach services for diagnostics • Seek progress in relation to special measures.
Cwm Taff UHB	£1.1m	• Seek further collaboration with Cwm Taf as a key partner for South Powys to enable repatriation of services to Wales where possible; and to secure sustainable in-reach services within Powys. • Explore stroke, ToP and Vasectomy services • Work through the implications of the Bridgend transfer of services • Increase access to cardiac MRI
Cardiff & Vale UHB	£1.3m	• Work with CVUHB on any changes to pathways arising from the South Wales Programme • Ensure provision of Powys specific incident information
Velindre	£1m	• Participate in collaborative commissioning arrangements to deliver the next phase of the Cancer Strategy.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Annual Plan 2019/20

Our Vision: A Healthy, Caring Powys

Core Well-being Objective 1

FOCUS ON WELLBEING

PRIORITIES

- Wider Determinants of Health
- Health improvement & Disease Prevention and Population Screening
- Information, Advice and Assistance

Core Well-being Objective 2

PROVIDE EARY HELP AND SUPPORT

PRIORITIES

- Primary and Community Care
- Cluster Working
- Connecting Communities

Core Well-being Objective 3

TACKLE THE BIG FOUR

PRIORITIES

- Mental Health
- Cancer
- Respiratory Conditions
- Circulatory Conditions

Core Well-being Objective 4

ENABLE JOINED UP CARE

PRIORITIES

- Care Coordination and Urgent Care
- Planned Care
- Specialised Care
- Quality and Citizen Experience

Enabling Well-being Objective 1

DEVELOP WORKFORCE FUTURES

PRIORITIES

- Well-being and Engagement
- Recruitment and Retention
- Workforce Design, Efficiency and Excellence
- Skills and Development

Enabling Well-being Objective 2

PROMOTE INNOVATIVE ENVIRONMENTS

PRIORITIES

- Capital, Estates and Facilities
- Research, Development and Innovation
- Rural Health & Care Alliance

Enabling Well-being Objective 3

PUT DIGITAL FIRST

PRIORITIES

- Digital Care – Telehealth/ care
- Digital Access – National ICT Programme
- Digital Infrastructure & Intelligence

Enabling Well-being Objective 4

TRANSFORMING IN PARTNERSHIP

PRIORITIES

- Good Governance
- Financial Management
- Planning, Performance and Commissioning
- Partnership Working

APPENDIX 4: PTHB Annual Plan 2019 - 2020

Organisational Priority		Ref.	Organisational Delivery Objective	Lead
Well-being Objective	Wider Determinants of Health	1.1	Implement the Powys Wellbeing Plan as a partner of the Public Service Board	DPH
	Health Improvement and Disease Prevention	1.2	**Implement the health improvement and disease prevention programme** Including improving access to smoking cessation, increasing physical activity, healthy weights, immunisation and deliver substance misuse strategy. Increase local participation in the national population screening programmes and address local inequalities in uptake	DPH
	Information, Advice and Assistance	1.4	**Improve the offer of information, advice and assistance** Including roll out of making every contact count (MECC), work with the third sector on Info Engine and Dewis, advice for wellbeing and signposting for those most vulnerable	DPCCCMH
	Primary and Community Care	2.1	**Implement the development programme for primary and community care** Including general practice, dental services, eye care and pharmacy support services	DPCCCMH
	Cluster Development	2.2	**Continually improve Cluster working arrangements** Including integrated team working across sectors to meet community needs	DPCCCMH
	Connecting Communities	2.3	**Connect communities to develop and strengthen community assets** Work with the Regional Partnership Board on community development; carers plan, awareness of Adverse Childhood Experiences and enhancing volunteering opportunities	DoN
	Mental Health	3.1	**Improve access across primary, community and secondary mental health care** Including implementing options to integrate mental health care; new approaches to psychological therapies; the Powys Dementia Plan and strengthening CAMHS services, reducing health inequalities, improving access and outcomes	DPCCCMH
	Cancer	3.2	**Implement the Powys Improving Cancer Journey Programme** Improve co-ordinated care, addressing health inequalities in outcomes, improving access to treatment and outcomes; the single cancer pathway and end of life plan, with third sector partners	MD
	Respiratory Conditions	3.3	**Implement a Powys Respiratory Plan** Improve access to respiratory health care and treatment, with a focus on prevention, reducing health inequalities and outcomes.	DoN
	Circulatory Disease	3.4	**Improve access to circulatory disease care and treatment** Focus on prevention and reducing health inequalities in the treatment of diabetes, heart disease and stroke, improve access to care and treatment and outcomes.	DPH

APPENDIX 4: PTHB Annual Plan 2019 - 2020

Organisational Priority			Ref.	Organisational Delivery Objective	Lead
Well-being Objective		Care Co-ordination and Urgent Care	4.1	**Deliver a Powys Urgent Care Programme** Including Community Resource Teams/Discharge to Assess; Home First; Patient flow co-ordination; Seasonal Planning; collaborative working with WAST and EASC	DPCCCMH
			4.2	**Deliver the Violence Against Women, Domestic Abuse and Sexual Violence Strategy and Sexual Assault Referral Centre pathway**	DoN
		Planned Care	4.3	**Deliver the Planned Care Programme** Including theatre modernisation, Outpatient (OPD) and diagnostics transformation and actions to meet key trajectories including Diagnostics, Referral to Treatment and OPD Follow Ups; implementation of the neighbourhood nursing model	DPCCCMH
			4.4	**Develop voluntary and non emergency patient transport schemes**	DWOD
		Specialised Care	4.5	**Deliver the WHSSC Integrated Commissioning Plan (PTHB contribution)** Including agreement and management of Financial Assumptions for 2019-2020	DPP
		Quality and Citizen Experience	4.6	**Deliver the Annual Quality Statement and Quality Priorities** Including sepsis bundle, Health Care Acquired Infection control, pressure ulcers scrutiny panel, medical devices management, improvement and innovation, Serious Incidents management, Concerns and Complaints, Quality assurance, Welsh Language and equality and diversity plan	DoN
		Well-being and engagement	5.1	**Implement programme of Well-being and Engagement activity** Including Chat2Change; Staff Survey actions; review of stress related absence; managing attendance, national well-being campaign rollout, Health and Safety Audit & Inspection	DWOD
		Recruitment and Retention	5.2	**Implement annual action plan for Attraction, Recruitment and Retention** Including use of apprenticeships and volunteers; undertake temporary staffing review	DWOD
		Workforce Design, Efficiency and Excellence	5.3	**Implement Organisational Change Process (OCP)** To realign to Health and Care Strategy, establish a Joint Workforce Planning approach; including introducing band 4 Health Care Support Worker role	DWOD
			5.4	**Strengthen monitoring of Staffing Act compliance across commissioned services and within PTHB provided services**	DoN
		Skills and Development	5.5	**Deliver annual skills and development action plan** Including review of clinical and non clinical training; management induction and training; HCSW induction review; Rural Academy of Learning development	DWOD

APPENDIX 4: PTHB Annual Plan 2019 - 2020

Organisational Priority			Ref.	Organisational Delivery Objective	Lead
Well-being Objective		Capital, Estates and Facilities	6.1	**Develop and implement Long Term Estates Strategy** Including the capital programme priorities: Llandrindod Wells, Machynlleth and Ystradgynlais Community Hospital improvements; Llanfair Caereinion Medical Practice	DPP
			6.2	**Schedule estates maintenance to comply with health and safety standards and deliver ISO14001 to improve environment and sustainability standards**	DPP
			6.3	**Deliver modernisation programme to deliver facilities improvements** Including review of waste and recycling; catering, and transport	DWOD
		Research, Development and Innovation	6.4	**Establish the Research & Development infrastructure** Introduce the Research and Innovation Hub; Rural Health and Care Alliance; strengthen patient reported outcome and experience measures (PROMS and PREMS)	MD
		Digital Care (Telehealth & Telecare, virtual outpatients)	7.1	**Improve access to information about wellbeing and use of digital technologies** including developing online/text or app based support, virtual in reach/outreach and roll out of and access to online Cognitive Behavioural Therapy and e approaches to care	DoF
		Digital Access (ICT National Programme)	7.2	**Implement the systems to improve digital access to support care co-ordination, referral and diagnostics** WCCIS rollout, mobile application and introduction of E record in community hospitals	DoF
		Digital Infrastructure and Intelligence	7.3	**Improve ICT infrastructure and business intelligence** Including information storage, hosting, security and recovery, back up and archiving, connectivity and professional / user skill development for digital transformation	DoF
		Good Governance	8.1	**Deliver Annual Governance programme** Board and Committee Governance, Board Assurance Framework, Information Governance, Business Continuity including Brexit.	BS
		Financial Management	8.2	**Deliver the Financial Strategy in line with Efficiency Framework** Including approval of balanced IMTP 2019-2022 and delivery of financial balance in year	DoF
		Planning, Performance and Commissioning	8.3	**Deliver a strengthened approach to planning, performance and commissioning** Including delivery of the Improving Performance Framework; Strategic Planning and Commissioning in line with organisational realignment to Health and Care Strategy	DPP
		Partnership Working	8.4	**Robust management of Strategic Change and delivery of the PTHB Health and Care Strategy actions within key Partner plans** Including the Regional Partnership Board (RPB), Public Service Board (PSB) and Mid Wales Joint Committee (MWJC); strategic change programmes	DPP
			8.5	**Deliver the the North Powys Rural Regional Centre**	DPP

Principles of Delivery

Do What Matters
We will focus on 'what matters' to people. We will work together to plan personalised care and support focusing on the outcomes that matter to the individual.

Do What Works
We will provide care and support that is focused on 'what works' based on evidence, evaluation and feedback. We will have honest conversations about how we use resources.

Focus on Greatest Need
We will focus resources on those with greatest need for help and support, in a way that looks ahead to future generations.

Offer Fair Access
We will ensure that people have fair access to specialist care and to new treatments and technologies, helping to deliver a more equal Powys and recognising rural challenges.

Be Prudent
We will use public resources wisely so that health and care services only do those things that only they can and should do. Supporting people to be equal partners and take more responsibility for their health and care.

Work with People and Communities
We will work with individuals and communities to use all their strengths in a way that maximises and included the health and care of everyone, focusing on every stage of life – Start Well, Live Well and Age Well

6

Self Assessment against key points in the Welsh Government IMTP Guidance

	IMTP Guidance	Section in IMTP
	Quality and Safety	
1	Outline the Quality Improvement approach adopted in the organisation	- Strategic Overview p.4-11 - Joined Up Care Quality Section p.57 - Transforming in Partnership – Good Governance section p. 86-88 - Templates - Wellbeing Assessment – Appendix 1
2	Describe the organisation's plans for a whole systems approach to quality	
3	Clearly outline the intended measurable quality improvements, including (but not limited to) those in 'A Healthier Wales' NHS Outcomes & Delivery Framework and the Health & Care Standards;	
4	Articulate how improvement will be delivered, including priority performance	
5	Clearly link the quality and equality priorities to the population needs assessment findings, the risk register, and the challenges and improvement priorities set out in the Annual Quality Statement	
6	Explain how quality throughout the whole organisation will be monitored by the Board	
7	Demonstrate specific plans to address patient user experience and concerns	
	Prudent Healthcare	
8	Provide clear evidence of how all board members and staff are involved in taking up the opportunities presented by prudent healthcare	- Transforming in Partnership – Finance section P. 89-94 - Transforming in Partnership – Governance section p.86-88 - Joined Up Care p 54-63 - Templates - Front pages / narrative in delivery sections
9	Show the practical steps being taken to implement the actions emerging from national programmes and activities that will support the prudent healthcare principles to be followed, including national planned, unscheduled and primary care programmes.	
10	Show that prudent healthcare underpins all parts of the plan, with clear implementation milestones and impact measures	
	Integration	-
11	Reflect the shared priorities that have been agreed with public service partners through the Public Service Boards, Local Service Boards and partner agencies	- Strategic Overview p. 4-11 - PSB 12 Steps added to Focus on Wellbeing p.23 - Transforming in Partnership p. 85-99 - Hyperlink RPB Area Plan and PSB Well-being Plan
12	Reflect partnership priorities and progress in other key areas, e.g. Mental Health partnership programmes	- Strategic Overview and throughout
13	Show how integration is underpinning the other programmes described within this framework, notably the work on primary care, planned, urgent and emergency care	- Strategic Overview and throughout - Big Four (MH) p. 41-46

	IMTP Guidance	Section in IMTP
14	Demonstrate how priority performance indicators of reducing delayed transfers of care will be achieved	- Joined Up Care p. 54-63 - Templates
	Addressing Health Inequalities	
15	Demonstrate a commitment to improved analysis and reporting of health inequalities in health promotion, primary and secondary care;	- Focus on Wellbeing p. 22-27 - Early Help and Support p. 28-39 - Big Four p. 40-53 - Joined Up Care p. 54-63 - Digital First p. 80 - 84 - North Powys RRC p.21 - Transforming in Partnership p. 85-99 - Hyperlinks - Health Inequalities Plan
16	Demonstrate tackling health inequalities is understood and the responsibility of the whole organisation and all who work in it	
17	Have clear measurable objectives for reducing health inequalities aligned to the equality priorities set out in the Strategic Equality Plan	
18	Have specific, identifiable actions for reducing health inequalities, comprising both stand-alone actions and targeted actions embedded into different functions and services	
19	Have clear actions to counter the inverse care law in primary and secondary care, and how resources will be reallocated to reflect need	
20	Demonstrate integrated working with relevant initiatives such as Flying Start, Families First, Healthy Child Wales Programme, Valleys Taskforce to secure the greatest reduction in health inequalities, particularly through strengthening links with primary and community care services; and	
21	Identify local poverty goals and demonstrate how they will achieve these and the goals in the national tackling poverty programme	
	Governance	
22	Plans must be fully completed, financially balanced and include: ○ performance, workforce and finance profiles; ○ fully populated mandatory templates; and ○ identify any area of issue or risk by exception.	- Templates - Full Plan - Cover Letter
23	Demonstrate that: ○ the plan has been developed in line with the five ways of working and sustainable development principle as required by WBFG Act; ○ the plan has been developed and agreed following meaningful engagement with public, staff and stakeholders;	- Strategic Overview p. 4-11
24	account has been taken of the Welsh Language Standards and the need to comply with the compliance notice from May, 2019; and	- Transforming in Partnership – Governance p. 86-88
25	findings previously identified during Internal Audit, Wales Audit Office and external reviews are responded to;	- Transforming in Partnership – Governance p. 86-88

	IMTP Guidance	Section in IMTP
26	The plan has been subject to the appropriate level of board and committee review, challenge and scrutiny throughout its development, and to be approved by the organisation's board for final submission in January	- Cover letter
27	Be aligned to, and consistent with, outcomes of the joint assessments and requirements of the Local Well-being Plans and Area Plans developed with PSBs and RPBs	- Strategic Overview / throughout - Hyperlinks - RPB PSB Plans
28	Demonstrate how the plan has captured the provisions of *A Healthier Wales*, including the potential impact and opportunities provided by the Transformation Programme;	- Strategic Overview p. 4-11 - *Cover Letter*
29	Demonstrate the appropriate involvement and engagement of the clinical and operational teams, executives and board members throughout its development;	- Strategic Overview p. 4-11 - *Cover Letter*
30	Confirm that the required agreements have been reached in terms of collaborative and inter-organisational arrangements to deliver the plan;	- Strategic Overview p. 4-11; North Powys p.21 - Hyperlinks - RPB PSB Plans
31	Confirm, and be able to demonstrate, that all relevant impact assessments (e.g. equality, health, privacy etc.) have been undertaken and their findings responded to;	- Transforming in Partnership – Governance p. 86-88
32	Describe the approach to risk management and assurance, the risks identified and arrangements for their mitigation	- Transforming in Partnership– Governance p. 86-88
33	Provide assurance that planned actions are real, sustainable and deliverable;	- Summary Plans (throughout)
34	Have clear management arrangements to ensure delivery of the plan, including reporting and performance management arrangements with clear accountability throughout the organisation	- Strategic Overview p. 4-11 - Delivery arrangements p.12-15 - Summary Plans (throughout)
	Finance	
35	Include an affordable balanced medium term financial plan (MTFP) that plans to meet the first financial duty, as part of a viable and sustainable IMTP to meet the second financial duty;	- Transforming in Partnership p. 85-99 - Finance p. 89-94 - Templates
36	Place the balanced financial plan within the resource allocation and planning parameters set out in the LHB Revenue Allocation Letter, NHS Planning Framework; and prioritised in line with Ministerial and Board priorities;	
37	Focus on value and totality of resources applied, across the whole range of services and communities, rather than focus on the marginal changes, pressures and opportunities;	
38	Fully integrate the MTFP with clinical, service, workforce and other elements of the IMTP	
39	Have clear cross-referencing, integration and alignment with clinical, service & workforce plans	
40	Demonstrate the rebalancing of the healthcare system, underpinned by a value based healthcare approach through a prudent lens, through the strengthening of care delivered in primary and community settings, including the resource shift / investment towards prevention	
	Maternal and Child Health	
41	Demonstrate how improved outcomes for health improvement strategies targeted at maternal health, children and young people will be achieved, including maternal and childhood immunisation;	- Focus on Wellbeing p. 22-27 - Early Help and Support p. 28-39

	IMTP Guidance	Section in IMTP
42	Demonstrate how health care will be delivered to all children, including implementation of the requirements of the Additional Learning Needs and Education Tribunal Act 2018 and appointment of a Designated Education Clinical Lead Officer (DECLO);	- Focus on Wellbeing p. 22-27 - Early Help and Support p. 28-39
43	Plan to deliver substantial improvement in maternal smoking rates;	
44	Demonstrate an implementation schedule for increasing breast feeding rates, reducing caesarean section rates, reducing term admissions to neonatal units, and improving data capture;	
45	Demonstrate how the Healthy Child Wales Programme is being fully implemented through additional recruitment and skill mix, given that full implementation is required by October 2018;	
46	Demonstrate how the organisation is working in a joined-up and collaborative way with Flying Start and Families First, drawing on effective practice, to ensure improved outcomes for children, young people and their families;	
47	Demonstrate how the organisation will integrate with the national CAMHS service change programme 'Together for Children and Young People'(T4CYP) and deliver the Neurodevelopmental (ND) plan;	
48	Demonstrate how the organisation will evidence and monitor compliance with statutory safeguarding requirements for staff recruitment and conduct, and workforce support for roles and responsibilities;	
49	Demonstrate how the organisation will support the workforce to ensure staff understand their role and responsibilities in maternity and child patient safety to ensure safe practice and effective governance;	
50	Demonstrate compliance with current All Wales Neonatal Standards, including a plan to achieve full neonatal workforce compliance by 2021;	
51	Evidence the steps taken to overcome any identified barriers to effective joint working, including children and young people transferring into adult services	
52	Demonstrate plans to implement and improve health board delivered screening programmes for newborn and infant physical examination, school age vision and hearing screening; and	
53	Programmes in place to quality assure delivery of health board child screening programmes for newborn and infant physical examination, school age vision and hearing screening	
	Workforce and OD	
54	Priority actions for workforce redesign and innovation, restructuring, and new ways of working to facilitate service change;	- Workforce Futures p. 63-69 - Templates
55	Have key milestones for delivery;	
56	Demonstrate a clear read across from workforce to financial information;	
57	Identify areas of workforce that pose a risk to delivery and actions to manage this	

	IMTP Guidance	Section in IMTP
58	Identify centrally funded education and training requirement	- Joined Up Care p.59 (nurse staffing)
59	Demonstrate clearly how they will implement the requirements of the Nurse Staffing Levels (Wales) Act 2016, including the statutory guidance to calculate and maintain nurse staffing levels commencing on 6 April 2018	
60	Reflect any programme of OD work required to deliver other elements of the IMTP; and	
61	Demonstrate how organisations will ensure increased staff engagement, reduced sickness absence, reduced medical and dental agency and locum spend and increased appraisal completion rates.	
	Research and Development	
62	[Leadership] Identify the Executive level lead and the R&D Director responsible for research activity and engagement with Welsh Government	- Innovative Environments – Research, Development and Innovation section p.76-78
63	[Culture] Describe how the organisation will actively promote the value of research, engage staff with the research strategy and build capacity and capability;	
64	[Organisational alignment] Describe how the organisation intends to align its approach to research and activity with existing innovation and improvement structures;	
65	[Strategy] Have a web-link to the R&D strategy to demonstrate equity of access for the population to participate in a range of research studies/activities;	
66	[Delivery] Highlight key milestones from the annual R&D plan (which links to the Health and Care Research Wales R&D performance indicators);	
67	[Partners] Describe how the organisation will engage with external partners; universities, industry partners, and with Health and Care Research Wales initiatives; and	
68	[Sharing/Adopting good practice] Describe arrangements that ensure research feeds into the mechanisms for uptake of best practice, innovation and service change, and that service changes are then evaluated.	
	Infrastructure Investment	
69	Ensure that Capital and Revenue infrastructure investment is clearly prioritised in line with Board and Ministerial priorities, defined and linked to the plan;	- Innovative Environments 70-79 - Transforming in Partnership p. 85-99 - Templates
70	Align infrastructure investment with the service and other elements of the IMTP;	
71	Provide infrastructure investment plans that are affordable and drive out maximum efficiencies	
72	Demonstrate clear improvements in the patient quality and safety environment across the NHS in Wales;	
73	Articulate the impact on other planning areas including performance, quality, workforce as well as revenue affordability;	
74	Have clearly defined benefits and benefits realisation plans to demonstrate the impact of investment and service change, particularly regarding patient outcomes;	

	IMTP Guidance	Section in IMTP
75	Include the impact of monitored Estate Key Performance Indicators such as backlog maintenance, space utilisation and out of date equipment, including primary & community care;	
76	Demonstrate year-on-year growth in investment in information technology and digitally enabled models in line with the principles and vision set out in the Digital Health and Care Strategy.	- Digital First p. 80-84
	Innovation	
77	[Leadership] Have an Executive level innovation 'champion' for the organisation, to lead innovation activity & engagement with Welsh Government innovation leads;	- Innovative Environments – Innovation, Research and Development section p.76-78
78	[Strategy] Have a clear innovation strategy or approach, including a robust assessment of the organisation's current position, with appropriately ambitious future objectives;	
79	[Organisational alignment] Describe how the organisation intends to align its innovation approach and activity with existing research and improvement structures;	
80	[Culture] Demonstrate how the organisation will build an innovation culture, encourage ideation, engage staff around innovation and create innovation skillsets;	
81	[Delivery] Describe how a strategy will be delivered and a culture created, with credible milestones, resources and accountable leadership;	
82	[Partners] Demonstrate how the organisation will engage with external partners; Regional Partnership Boards, clusters, universities, industry and all-Wales innovation initiatives; and	
83	[Sharing / Adopting good practice] Describe how the organisation will identify, adopt and share innovative practice with other NHS Wales organisations.	
	Digital Health and Care	
84	Demonstrate what action will be taken by the organisation to support and help accelerate Digital Inclusion for its patients, service-users and staff;	- Digital First p. 80-84
85	Be clear on how clinical care, quality improvement and service plans will be increasingly data driven and how informatics will support this	
86	Ensure digital health and care developments are fully aligned and integrated with the service and workforce change priorities	
87	Demonstrate how the organisation is embracing the opportunities that digital technologies, including telehealth, can bring to transforming service models and supporting our ambitions;	
88	Identify the highest priorities within the approved strategic outline programme (SOP) and how and when these will be implemented, along with the workforce, revenue and capital resource requirements	
89	Have a clear resource plan for informatics to support service transformation	
90	Be clear what benefits informatics improvements will deliver and how they will enable the delivery of the wider organisational objectives; and	
91	Demonstrate how organisations are working collaboratively to deliver digital change.	

	IMTP Guidance	Section in IMTP
	Welsh Language	
92	Demonstrate that the organisation meets the statutory requirements set out in the Welsh Language (Wales) Measure 2011 and the Welsh language standards;	- Transforming in Partnership – Governance p.86-88
93	Demonstrate that services are planned and delivered in line with the strategic framework for health and social care in Wales, "More than just words" and the Welsh Government's response to the Welsh Language Commissioner's Primary Care Inquiry Report;	
94	Promote the use of Welsh language in the primary care sector, including working with independent primary care contractors	
95	Recognise that patients receiving care in their first language is a key patient experience and quality issue	
96	Demonstrate an increase in completion rate of the Welsh language skills competency in ESR;	
97	Show that in delivering services and the development of service change and improvement plans there is due regard to the need to actively offer services through the medium of Welsh;	
98	Show that health needs assessments identify issues of language and that the population assessment is undertaken in line with the Social Services and Well-being (Wales) Act 2014;	
99	Demonstrate how assessing the needs of the population including developments in recording patient language preference is influencing and supporting future planning of services; and	
100	Demonstrate the organisation uses ESR, population assessment and demand for Welsh language services data to support the development and delivery of a Welsh Language Bilingual Skills Strategy which is monitored through appropriate governance mechanisms – this should include a measurable plan to develop the Welsh language skills of the workforce	
	Primary Care Model for Wales	
110	Embrace co-production and reflect the action to achieve the Welsh Government's delivery milestones for the Primary Care Model for Wales;	- Early Help and support p. 28-39 - Digital First p. 80-84 - Transforming in Partnership – finance section 89-94
111	Evidence how good practice from the National Pacesetter Programme is being adopted and justify where it is not;	
112	Set actions to develop and support cluster level planning and delivery;	
113	Evidence how they are directly informed by primary care cluster-level needs assessments and three year service, workforce and facilities/estate development plans;	
114	Set actions to: achieve service sustainability; improve access; specify services to be accessible closer to home and delivery of this.	
115	Actions to develop more preventative services, including systematising access to non-clinical care and support;	
116	Identify how modern technology will be used to best effect; and Identify action to improve quality, including identifying baseline and planned	

	IMTP Guidance	Section in IMTP
117	level of improvement of performance against the phase 2A national primary care quality and delivery measures.	
	Urgent and Emergency Care	
118	Plans to help citizens choose the best service for their needs e.g. considering areas such as social referral models; choose well campaign (marketing); technology; mental health call line; choose pharmacy; 111; patient navigation from ED; Making every contact count	- Joined Up Care p. 54-63 - Early Help and Support p. 28-39 - Big Four p. 40-53 - Workforce Futures p. 63-69
119	Demonstrate how citizens with long term conditions, and other vulnerabilities, will be empowered to manage their own health helping them to live – and die – well at home, preventing unnecessary hospital;	
120	Admissions e.g. considering areas such as advance care and end of life care planning; reducing harm for people who substance misuse; collaborating with fire and rescue / third sector on home safety checks or reparation; working with housing sector to improve home quality / warmth; frequent attenders network; supporting children through flying start and families first initiative; loneliness and isolation	
121	Demonstrate how citizens with complex or urgent care needs will be assessed and monitored but enabled to stay well at home, preventing unnecessary hospital admissions e.g. through risk stratification; comprehensive geriatric and frailty assessment; community resource teams; ambulatory emergency care; collaborating with social care and third sector on intermediate care; discharge to assess; mental health crisis response; GP emergency appointments; primary care out of hours; emergency dental; 111 and WAST clinical support desk;	
122	Demonstrate how citizens with acute care needs will be provided the right response, first time and treated in the right place to optimise their outcome e.g. EMRTS; collaborating with WAST, fire and rescue and volunteers on emergency medical responses; major trauma network; critical care; direct admission to specialist units (acute oncology, stroke, STEMI, #NOF); health care professional referrals by ambulance to hospital; alignment to ED Quality & Delivery Framework;	
123	Demonstrate how citizens who are admitted to hospital as an emergency will receive optimal hospital care for only as long as it benefits them before returning home e.g. SAFER patient flow bundle; placing the individual at the centre of a truly integrated discharge planning process; 'what matters to me' conversations; #ENDPJPARALYSIS; e-discharge; choice; trusted assessor; focusing on medically fit lists;	
124	Plans to empower citizens to return to living well at home following an emergency admission to a hospital e.g. recovery; rehabilitation; re-ablement; family fostering; discharge to assess models; collaboration with third sector; home care package;	

	IMTP Guidance	Section in IMTP
125	Plans to improve alignment of the right capacity with the right demand; Clear trajectories and measures for improvement – both from a Delivery Framework (target) perspective and a patient quality and safety perspective;	
126	Better management of interfaces, and handover of patients, between professionals;	
127	The right workforce to provide the right response in the right place; and	
128	Quantification of the impact of actions/programmes in terms of outcomes for patients, with milestones for delivery (or provide a link to local unscheduled care action plans with this detail).	
	Planned Care	
129	Provide trajectories to outline quantifiable annual improvements; this must be supported by the identified investment you have committed in your financial forecasted outturn;	- Joined Up Care p. 54-63 - Big Four p. 40-53 - Early Help and Support p. 28-39
130	Evidence how the published implementation plans of the Planned Care Programme Board are being progressed and used to address service delivery challenges;	
131	Demonstrate how the required actions to reduce follow up are being implemented, including virtual clinics, PROMS, self management of prostate patients and the redesign of glaucoma services to ensure appropriate follow up in the correct settings;	
132	Demonstrate how priority performance indicators of RTT (26 & 36 weeks), 'follow ups', new ophthalmology measures, diagnostic waits (8 weeks) Therapies (14 weeks) and cancer standards while rolling out and reporting shadow single cancer pathway will be achieved	
133	Demonstrate the additional diagnostic activity and pathway redesign required to implement the single cancer pathway;	
134	Highlight the actions taken to achieve a sustainable ophthalmology service whilst implementing the new eye care measure;	
135	Reflect the organisation's response to the planned care programme work areas; in particular follow-up action plan progress, including service redesign regional and local;	
136	Demonstrate how demand and capacity will be brought into balance within the organisation; as well as addressing backlog reduction- to include both local and regional work;	
137	Demonstrate how planned care fits into the overall capacity plan of the organisation, in particular primary and community care clusters, and with urgent /unscheduled care;	
138	Reflect how core stages of service delivery will be managed, maximising opportunities through the implementation of agreed pathways for: o outpatients (new and follow-up) o diagnostics (one stop clinics) theatres- (maximising day surgery, theatre productivity, and reduced cancelations) o beds (including critical care, management of flow with unscheduled care);	
139	Identify & plan services to be delivered out of hospital, ensuring integration of services with primary care;	
140	Recognise seasonal challenges, in particular winter plans and bed management	

	IMTP Guidance	Section in IMTP
	Delivery Plans	
141	Include reference to delivery plans and how they contribute to the organisation's strategic approach to transforming care	- Big Four p. 40-53 - Summary Plans for NDPs appended
142	Build in a proportionate level of detail, at appropriate points within the plan, on the areas of priority identified by the implementation groups	
143	Ensure delivery plan priorities are taken forward as part of core service delivery	
	Mental Health	
144	Demonstrate an understanding of the mental health and mental well-being needs of the population across the life-course;	- Big Four p. 40-53
145	Include a capacity and demand analysis which also demonstrates how the organisation is actioning the areas for improvement;	
146	Define service models to meet population needs supported by workforce plans;	
147	Demonstrate progress against the actions in the 3 year delivery plan that underpins T4MH	
148	Have clear actions, measureable milestones for implementation, analysis of risks to delivery, and measures of success;	
149	Evidence the quality of service provision and the involvement of service users and families at all levels of care;	
150	Clearly articulate the priorities for improvements in mental health provision covering CAMHS;	
151	Show expenditure over the previous year against the mental health ring-fenced allocation and the future spending plans against that budget.	
	Care for people with a learning disability	
152	Evidence a person and community-centred approach to assess and meet the population needs with a view to supporting independence within the home environment;	- Big Four p. 40-53
153	Demonstrate how organisations will assess and meet the needs of people with learning disabilities within their population, including how they will avoid unnecessary hospital admissions;	
154	Demonstrate how strategies and services to prevent or delay the escalation of care and support needs help people to improve their wellbeing and personal outcomes; demonstrate evidence that population health assessments have been undertaken;	
155	Set out plans for the development of integrated children's services across health, social care and education clearly demonstrating partnership working with local authorities;	
156	Clearly demonstrate integration and partnership working via the Regional Partnership Board;	
157	Demonstrate how they will reconfigure NHS residential services for people with learning disabilities to achieve the best outcome; Have clear plans to implement the refreshed autism strategy;	

	IMTP Guidance	Section in IMTP
158	Describe plans for patients to be repatriated through the development of pathways and services for people with dual diagnoses (mental health and learning disabilities) and forensic need;	
159	Clearly demonstrate how people accessing acute services will be identified and supported through their care journey, including discharge; and	
160	Demonstrate how they will develop plans to improve access to primary care and improve the uptake of annual health checks	
	Care for Older People	
161	Evidence a person and community-centred approach to assess and meet the population needs with a view to supporting independence within the home environment;	- Strategic Overview ; North Powys p. 4-11 - Joined Up Care p. 54-63
162	Evidence a whole system approach to seamless care, led by primary and community care;	- Strategic Overview p. 4-11 - Joined Up Care p. 54-63 - Big Four p. 40-53 - Early Help and Support p. 28-39
163	Have efficient and effective discharge processes;	- Joined Up Care p. 54-63
164	Use anticipatory care planning to support those living with long term or palliative care needs;	- Joined Up Care p. 54-63 - Big Four p. 40-53
165	Clearly demonstrate integration and partnership working via the Regional Partnership Board;	- Strategic Overview p. 4-11
166	Demonstrate how population assessment inform the IMTP, demonstrate clear links to delivery plans and dementia care;	- Strategic Overview p. 4-11 - Delivery Section Front pages - Big Four p. 40-53 - Appendices NDPs
167	Demonstrate how strategies and services to prevent or delay the escalation of care and support needs help people to improve their well-being and personal outcomes;	- Strategic Overview, North Powys p. 4-11 - Early Help and Support p. 28-39 - Joined Up Care p. 54-63
168	Demonstrate how assistive technologies are being used to support care of and maintain independent living	- Digital First p. 80-84
169	Demonstrate workforce skills in adult safeguarding to meet legislative requirements	- Joined Up Care – Quality p. 57
170	Provide evidence of the actions taken/planned to respond to the Fall and Fragility Fracture Audit Programme, Dementia and Breast Cancer in Older Patients audits;	- Joined Up Care p. 54-63 - Big Four p. 40-53
171	Demonstrate a comprehensive approach to falls prevention in the community (including care homes) and inpatient settings; and	- Joined Up Care p. 54-63
172	Identify improvement resource to work with 1000 lives Patient Safety and Quality Improvement Programme for Care Homes.	- Early Help and Support p. 28-39

	IMTP Guidance	Section in IMTP
	Carers	
173	Clearly demonstrate integration and partnership working in relation to carers via the RPB	- Early help and support p. 28-39 - Appended RPB and PSB Plans
174	Demonstrate how the needs of carers will be assessed and met, re: Population Assessment;	
175	Demonstrate how the Integrated Care Fund will be used to support carers and deliver against the priority areas for action set out in the Strategic Plan for Carers in Wales;	
176	Clear plans to deliver the 3 priority areas for action identified in the national priorities for carers	
177	Clearly demonstrate how carers will be identified and recognised as partners in the delivery of care for the person they care for; and	
178	Demonstrate an integrated approach to deliver flexible respite care which puts the individual and their needs at the centre of the provision and is responsive to individual outcomes.	
	Prevention and Health Improvement	
179	Demonstrate that prevention and health improvement is understood to be the responsibility of the whole organisation and all those who work in it;	- Strategic Overview p. 4-11 - Focus on Wellbeing p. 22-27 - Delivery sections - Hyperlinks RPB and PSB Plans
180	Show an understanding of needs and assets at community level;	
181	Demonstrate that prevention and early intervention are included in all pathways and service change: with emphasis on early years, children, parenting, family and wider environmental interventions to ensure positive childhood experiences	
182	Demonstrate understanding of local performance against national and international benchmarks, and how resources are being redeployed to tackle deficiencies;	
183	Evidence a whole system approach to integrated planning;	
184	Make clear the health board leadership and contributions to delivery of performance indicators;	
185	Demonstrate how the health and well-being of an organisations own workforce is prioritised;	
186	Demonstrate a whole system approach to addressing all lifestyle risk behaviours; and	
187	Demonstrate how public health promotion will take account of known barriers to access.	
	Well-being and Future Generations Act	
188	Be built on robust well-being assessments (not just health needs assessments, but also taking a 'place based' concept of well-being which encompasses environmental, social, economic, and cultural well-being into consideration; with implications for health from a range of partner organisations such as housing, local authority, education);	- Strategic Overview p. 4-11 - All Delivery sections particularly Focus on Well Being; Early Help and Support; Joined up Care, Workforce Futures, Transforming in Partnership - Hyperlinks RPB and PSB Plans
189	Demonstrate clearly how organisations will work together with partner organisations through the Public Service Boards to collectively plan and deliver the well-being goals set out in the Act;	
190	Demonstrate clearly how they will meet all the duties under the Act, including those associated with Welsh language, human rights, equality and CHCs; and	
191	Show how the emerging well-being objectives are designed to contribute to the seven well-being goals in the Act, and that delivery takes into account the five key ways of working.	

Glossary of Terms

For a useful Glossary of Terms and Acronyms relating to the health board, click on the link below:

http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/pthb%20sos%20-%20glossary%20of%20terms%20-%20june%202014.pdf

Useful Links to Further Information

Powys and Mid Wales	
Powys Teaching Health Board	http://www.powysthb.wales.nhs.uk/ and separate hyperlinks to PTHB Annual Report; PTHB Annual Quality Plan; PTHB Health Inequalities Plan
Powys Regional Partnership Board Area Plan	https://en.powys.gov.uk/article/1741/Powys-Regional-Partnership-Board
Powys Regional Partnership Board Health & Care Strategy	http://www.powysthb.wales.nhs.uk/health-and-care-strategy
Powys Public Service Board Well-being Plan	https://en.powys.gov.uk/article/5789/Towards-2040---the-Powys-Well-being-Plan
Powys Well-being Assessment	https://en.powys.gov.uk/article/5794/Full-Well-being-assessment-analysis
Hearts and Minds: Together for Mental Health	http://www.powysthb.wales.nhs.uk/hearts-and-minds
Powys / Mid and West Wales Safeguarding Framework	http://www.powysthb.wales.nhs.uk/safeguarding http://cysur.wales/home/regional-policies-procedures/
Other Joint Plans and Commissioning Strategies:	https://en.powys.gov.uk/article/1742/Powys-RPB-Documents
- Powys Assistive Technology Strategy Joint Commissioning Strategy: Substance Misuse - Joint Commissioning Strategy: Learning Disabilities - Joint Commissioning Strategy: Domestic Abuse - Dementia Care Plan - Powys Ageing Well Plan - Joint Commissioning Strategy for Carers - Joint Commissioning Strategy and Plan for Older People	
Powys Community Health Council (CHC)	http://www.wales.nhs.uk/sitesplus/1144/home
Powys County Council	http://www.powys.gov.uk/
Powys Association of Voluntary Organisations (PAVO)	http://www.pavo.org.uk/home.html
Mid Wales Joint Committee	http://www.midwalescollaborative.wales.nhs.uk/

APPENDIX 6: USEFUL LINKS

All Wales	
Rural Health and Care Wales	https://ruralhealthandcare.wales
Welsh Ambulance Services NHS Trust	http://www.was-tr.wales.nhs.uk/
Welsh Health Specialised Services Committee	http://www.whssc.wales.nhs.uk/home
Emergency Ambulance Services Committee	http://www.wales.nhs.uk/easc/about-us
Welsh Government	https://gov.wales/?lang=en
Health Education and Improvement Wales (HEIW)	https://heiw.nhs.wales/
Public Health Wales	http://www.publichealthwales.wales.nhs.uk/
NHS Wales Informatics Service (NWIS)	http://www.wales.nhs.uk/sitesplus/956/home
NHS Wales Shared Services Partnership (NWSSP)	http://www.nwssp.wales.nhs.uk/home