Annual General Meeting
Questions from Public

Question 1:

Cllr Kevin Etheridge	**Caerphilly.Gov.Uk** **Member of Social Services and Wellbeing Scrutiny Committee**

Hope to attend here is my question

I see the **Welsh Government has provided £42m in regard Mental Health Provision**;

1 What proportion has been allocated to the Aneurin Bevan Health Board?

2 How will it be prioritised e.g. resources, care in the community Mind, Local Authorities?

3 How will monitoring, targets and objectives to ensure it is effective to individuals and groups in each area within the trust including South Powys?

4 Have you a timescale and action plan which could be shared with the stakeholders?

A response was provided by Sandra Mason, Assistant Director Primary Care, Mental Health and Learning Disabilities

The Health Board has been advised of £4.99m new funds to recurrently invest in mental health in total for 2021/22. This funding is made up of the following:

	Funding £M
Core Mental health cost and Demand uplift	2.04
Service Improvement Funds	1.32
Crisis Care (all ages)	0.75
CAMHS	0.68
Foundation Tier/Tier 1 MH	0.20
Total	4.99

The funding has been prioritised by the team that submitted the bids, across a number of services, including core mental health services, child & adolescent, eating disorders and crisis care. The funding allocation is as follows:

Areas	Spending £M
Core Mental Health cost and demand uplift:	
Core Mental health pay cost first 1%	0.54
CAMHS improvement in crisis service	0.30
Single Point of Contact	0.61
Adult Inpatient review	0.59
Service Improvement Funds:	
Perinatal Mental Health Service	0.10
Early Intervention service	0.10
Eating Disorder service	0.44
Psychological Therapies	0.68
Crisis Care (all ages)	
Shared Lives extension	0.28
Sanctuary Provision	0.18
Older Adult Crisis Service	0.18
Single Point of Contact	0.11
Enhancement to specialist CAMHS pathway and increased capacity	0.68

Foundation Tier/Tier 1 Mental Health	0.20
Total	4.99

In order to access a significant proportion of the above monies the Health Board was required to submit funding requests to Welsh Government. Such submissions included key actions with timescales to be achieved following approval of funding, and a description of how the impact of each of the initiatives would be measured and monitored.

A range of monitoring methods will be used including systematic analysis of user and carer outcomes and experience, external independent evaluation, working with the Health Board's Value Based Healthcare team to consider evaluation through a value based healthcare lens and for those services the Health Board will commission regular quality monitoring reports submitted to the Health Board.

A number of the initiatives above form part of the Health Board's Mental Health and Learning Disabilities Strategic Partnership strategic priorities and their implementation will be monitored via the appropriate governance structures.

We can also confirm that mental health services for South Powys were transferred to Powys Teaching Health Board a number of years ago and Aneurin Bevan University Health Board is no longer responsible for either commissioning or providing mental health services to Powys residents.

Question 2:

Hilary Rees	Member of public / resident
I would like to put a question to the AGM: **Please can you publish (or simply tell me) what the plans are for the derelict flats at the Friars Rd end of the Royal Gwent site?**	
A response was provided by Chris Dawson Morris, Assistant Director of Planning	
As part of our Estates strategy plans for our Royal Gwent Hospital site form a part of the reconfiguration of services, including the opening of GUH. We are currently reflecting on those plans and how best we can use our estates. We recognise the changes that have taken place over the last year particularly in relation to how we work as an organisation. It is very likely those buildings will be used as enabler sites to support the wider reconfiguration of our estates. We cannot give a detailed answer right now while we undertake the review, but we will be looking at how we use those flats as part of our plans for the site. We have established a Reconfiguration Board for our enhanced local and general hospital sites and we are working through those plans at the moment. It is intended to develop those plans for those sites in the next few months.	

Question 3:

Julie Payton	**Patient**

My question is

How does ABUHB plan to improve diagnosis and care of those patients with rare genetic conditions?

A response was provided by Dr James Calvert, Medical Director

Mrs Payton is the second person to contact me about the rare condition and I have previously had the opportunity to do some research about resources available.

As people may or may not know, services for very rare conditions in Wales are, quite rightly, commissioned at a national level rather than at a Health Board level. Wales has a Rare Diseases Implementation Group that specifically advises the Welsh Government on the care required for people with rare conditions.

As a result of the contact from another person enquiring about the same condition, I contacted the Chair of the group who drew my attention to the fact that there is currently an open consultation for patients with rare musculoskeletal diseases and they are, in particular, considering care for patients with Mrs. Payton's condition.

If Mrs Payton would like to get in touch with me separately I am happy to put her in contact with the Chair of the Group, so that she could contribute her very relevant observations to them.

When I received Mrs. Payton letter I did look at the UK website supporting patients with her condition because she had made on observation that services in Wales are deficient compared to England. Unfortunately, my interpretation of the patient group website is that provision generally, across the whole of the UK is poor and the only specialist services I could see set up in a way I would consider comprehensive are in a couple of teaching hospitals in London.

I look forward to receiving the report of the Rare Diseases Implementation Group and their advice on services for patients with musculoskeletal diseases.

I would be happy to enter into direct correspondence with the patient to see what I could do to help.

Question 4:

Melanie Blethyn	Member of public

I would like to ask the Board what plans there are to tackle issues with accessing primary care appointments in general practice. Patients are not able to access new urgent Primary care centres directly due to GMS contract and they often cannot get same day appointments at their own GP surgery. This leaves pressure on the Grange and other hospitals and patient's needs not met.

Thanks in advance

A response was provided by Sandra Mason, Assistant Director Primary Care, Mental Health and Learning Disabilities

The Health Board is responsible for providing General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.

There are 72 General Practices that are responsible for providing care to patients between 8.00 am and 6.30 pm Monday to Friday. Outside of these "core hours", access to medical care is provided by the Health Board's Out of Hours Service, which operates between 6.30 pm and 8.00 am each week day evening and throughout weekends and Bank Holidays.

Outside of the period the Urgent Primary Care Service provides clinical assessment including face to face consultation in urgent care centres in Newport, Abergavenny and Ystrad Mynach and also home visits where a patient is medically unfit to attend one of the centres.

Patients are initially assessed by the 111 service which is provided by the Welsh Ambulance Service Trust.

More recently we have established an in-hours urgent care service in Newport and Abergavenny for patients who have been diverted by the 111 service, or by the Accident & Emergency Unit at the Grange University Hospital or by the Minor Injury Units in Abergavenny, Newport, Ebbw Vale or Ystrad Mynach.

Approximately 90% of all patient interventions take place in the primary care setting.

At the start of the pandemic, increasing pressures were placed upon health care services and Welsh Government announced a range of measures to be undertaken to ensure that GP practices were able to continue to provide urgent and essential care, support to the most vulnerable people in our communities and deliver care to the expected increase in the number of confirmed cases of COVID-19.

One of the first measures was that GP practices were asked to implement the 'telephone-first' model. This meant that all patient contacts were triaged, clinically assessed and offered a face to face examination, when required, subject to clinical judgment and patient needs.

These measures have been taken to protect patients and staff, however this undoubtedly has placed added pressure on the telephone system. To support this, various platforms are available to facilitate and support remote consultations; *Attend Anywhere*, *AccuRX* and *E-consult* are the leading examples.

Many GP practices will have a multi-disciplinary practice team, which includes extended roles such as Advanced Nurse Practitioners, Pharmacists, Physiotherapist, Paramedics, Mental Health Practitioners and Occupational Therapists. Patients do not always need to see a GP and the practice will have systems in place to navigate patients to the appropriate health care professional or service best placed to treat them.

General Practice has had to adapt very quickly to new ways of working in response to the pandemic. However, as restrictions begin to ease and services resume, the Health Board acknowledges the need for these new ways of working to be reviewed and ensure patients have appropriate, safe and timely access to their GP services, whilst adhering to national guidance. We are working closely with practices and other partners including Gwent Local Medical Committee and Aneurin Bevan Community Health Council and a review of access arrangements has commenced.

With the emphasis still on telephone first, practices have adopted a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate. The number of face to face appointments is increasing, however, there remain challenges with this, especially in relation to managing social distancing and throughput of patients.

Question 5:

Matthew Crowley	Member of public

Question 1 - Pandemic Preparation and Learnings

In the 2017 UK National Risk Strategy, it was predicted that a Pandemic was the country's most significant risk and highly likely to occur within the next 5 years. This was reflected in turn on the ABUHB Risk Register as at Dec 2019, scored as 16 out of 25 (and lower than several other risks), with a major aim being able to maintain Health Services for the whole population in the face of such a Pandemic. Notwithstanding the actual emergency response, it became quickly evident that the UK and AHBUHB were not adequately prepared for any Pandemic that may occur across many levels which resulted in the majority of Health Services having to be suspended over 2 extended periods. Given these circumstances:

A. Why was Pandemic Risk scored relatively low in Dec 2019 and why was ABUHB so poorly prepared for the Pandemic that then followed?

B. What lessons have been learned specifically by ABUHB (in conjunction with other local agencies) to prepare for another Pandemic, and other significant risks as identified on the latest 2020 UK National Risk Register?

A response was provided by Chris Dawson Morris, Assistant Director of Planning

The Health Board has a statutory duty to prepare for emergencies under the Civil Contingencies Act. The Health Board had a Pandemic Response plan in place plus a joint plan developed through the Local Resilience Forum. The Health Board undertook exercises alongside the Local Resilience Forum to plan for pandemic scenarios. The learning from these exercise, for example in relation to Ebola, informed the initial response of the organisation in relation to how potentially infectious patients were managed and treated. There were care pathways in place developed from the plans for SARS, Ebola and MERS which were adapted with clinicians, alongside surge plans for intensive care, to respond to the early days of the pandemic.

The developments of the Covid-19 pandemic were unprecedented and the Health Board developed and adapted its plans in response to the course of the pandemic. There is of course significant learning from the experiences of the last 18 months. The underpinning principles of Emergency Response, including command structures and reporting arrangements supported the organisation in its ability to adapt to the situation. The appropriate zoning of healthcare services enabled essential healthcare services to be delivered throughout the last 18 months.

Learning from the Covid-19 pandemic has been a process of applying this learning to the lived experience as the organisation has dealt with the situation. Zoning of sites, use of PPE, staff guidance and working with partner organisations have all developed with each

wave of the pandemic alongside national guidance. The organisation has also revised its pandemic plan to take account of the learning.

Matthew Crowley	Member of public

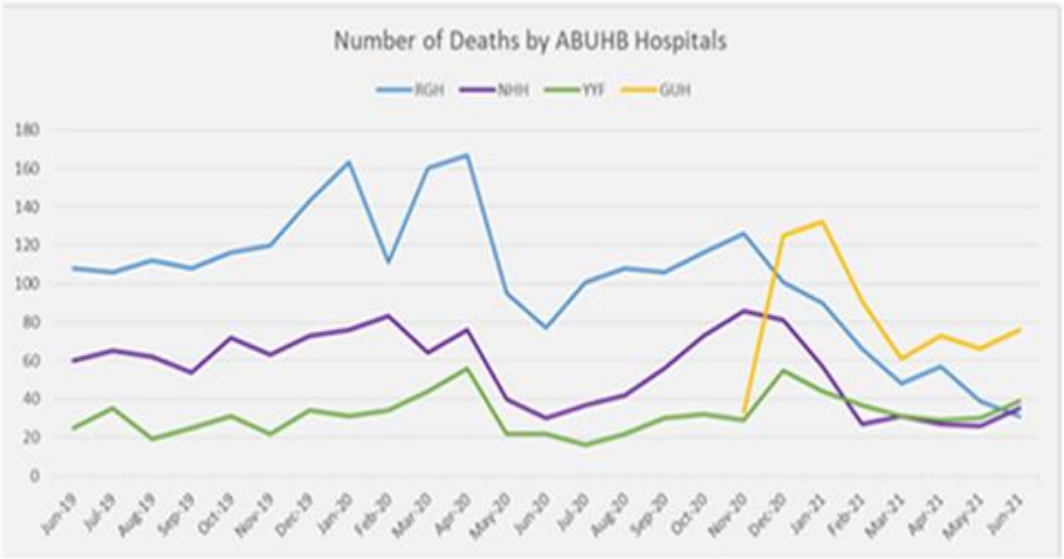
Question 2 - Grange University Hospital Crude Mortality Rates

Given the warnings made by Dr. Deborah Wales ahead of the opening of the Grange University Hospital in November 2020 and subsequent skilled staff shortages, problems with hospital acquired infections, and reports off patients being held in ambulances for up to 24 hours outside the hospital, what are the established reasons for the Grange University Hospital having a crude mortality rate at nearly 3 times the rate of the average for Welsh Hospitals and other ABUHB hospitals? Given the massive expenditure on GUH, how can this possibly be the case and what is being done to investigate and resolve these highly concerning figures?

A response was provided by Dr James Calvert, Medical Director

Crude Mortality is very difficult to understand and its use in Welsh hospitals was studied in some depth by Professor Palmer in 2014. He wrote an interesting report that demonstrates that it is very easy for them to be misleading and there is a danger of them being particularly misleading in a Health Board where the structure of services is very comprehensive but unusual.

Therefore, considering the mortality rate of GUH on its own isn't a valid comparison with other hospitals. The Health Boards care system channels our very sickest patients from our community to GUH and directs our unwell patients to our eLGHS sites. So, in considering mortality rates we have to consider the mortality rate in the Health Board as a whole. Having said that, I still think our crude mortality slides are really quite reassuring.



Using the Site Specific Mortality Graph June 2019-June 2021, the blue line represents RGH, purple line represents NHH, the green line YYF and the yellow line GUH. The period of Dec 2019-May 2020 shows the first wave of the pandemic where Gwent was hit much harder than any other part of the country.

Prior to the pandemic it can be seen that the Health Boards mortality rate was good but shows an increase as a result of the number of COVID-19 patients; those with a new condition that we were learning to treat that came into hospitals.

I should add that our COVID outcomes were among the best in the country.

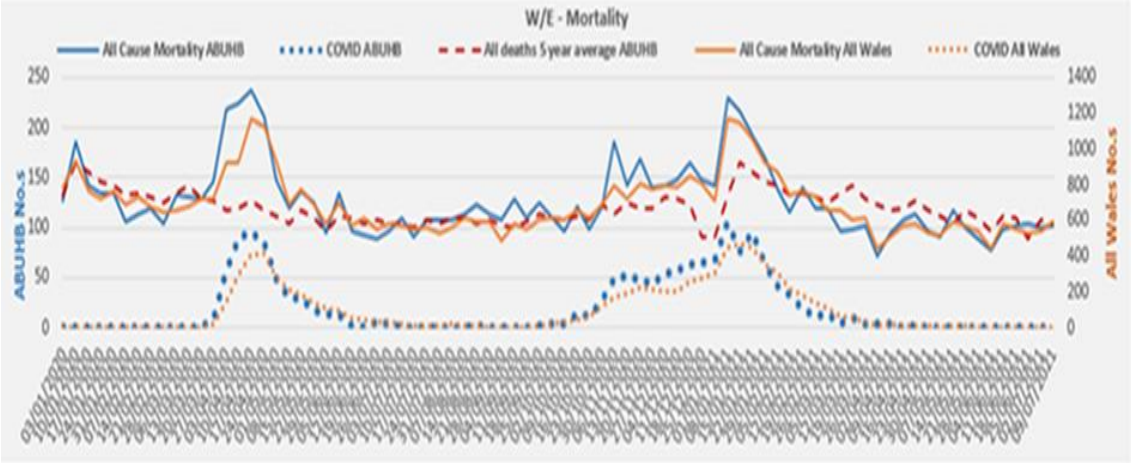
Moving to November 2020, when GUH opened, as you would expect from what I have said that we have seen a significant and rapid drop off in mortality at RGH, NHH and YYF and that is because patients there are less unwell. Now this change occurred during the second wave of the pandemic when mortality was even higher than in the first wave and again, you can see how excellent the outcomes from the Health Board are, because, despite, as you would expect, our highest level of deaths being in GUH, they do not match the levels in the first wave, demonstrating the resilience of our Health Board and the excellent work of our staff.

Throughout the pandemic period, the 'All-Cause Mortality' in our Health Board has tracked that in Wales as a whole. 'All-cause mortality' is regarded as being the most reliable way of looking at the likelihood of dying during the pandemic period because many people, unfortunately, who have suffered most as a result of COVID were those with existing medical conditions that COVID had a negative impact on.

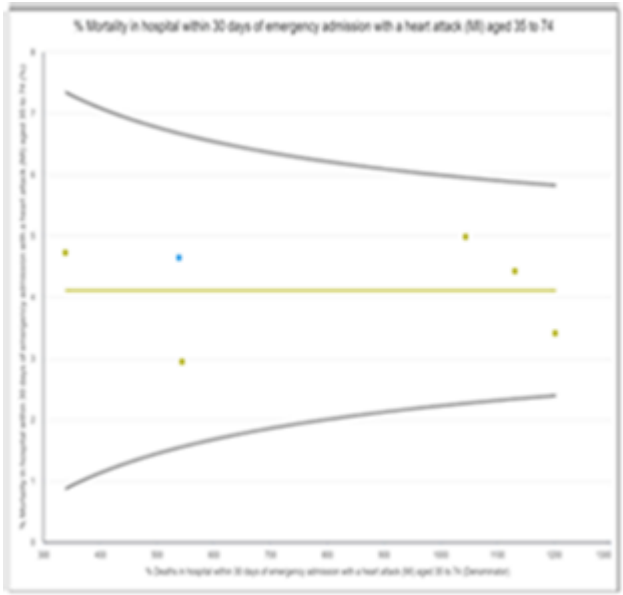
In the following graph the solid blue line is 'All-cause Mortality' for ABUHB and the solid orange line is 'All cause Mortality' for Wales. You can see that there are two significant peaks there, corresponding to the peaks in transmission in our communities.

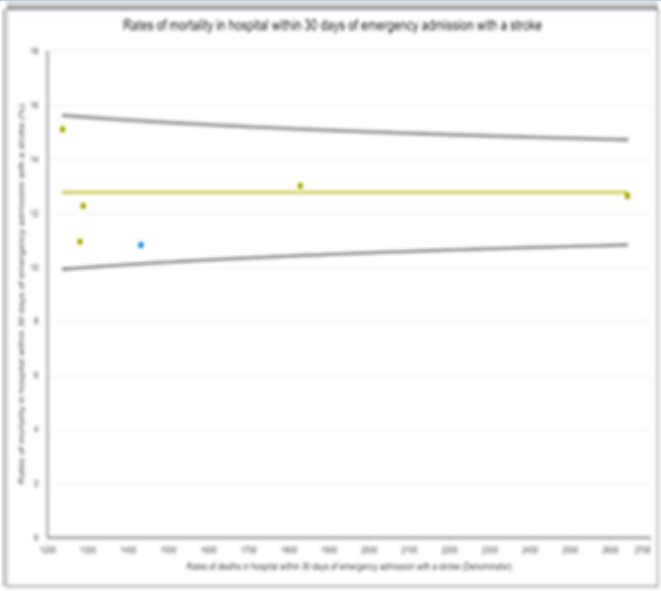
You can see that on the first occasion the Health Boards realised a peak in COVID patients before the rest of the country. Our population suffered at much the same time in the second wave, but our mortality has tracked the all Wales mortality rate.

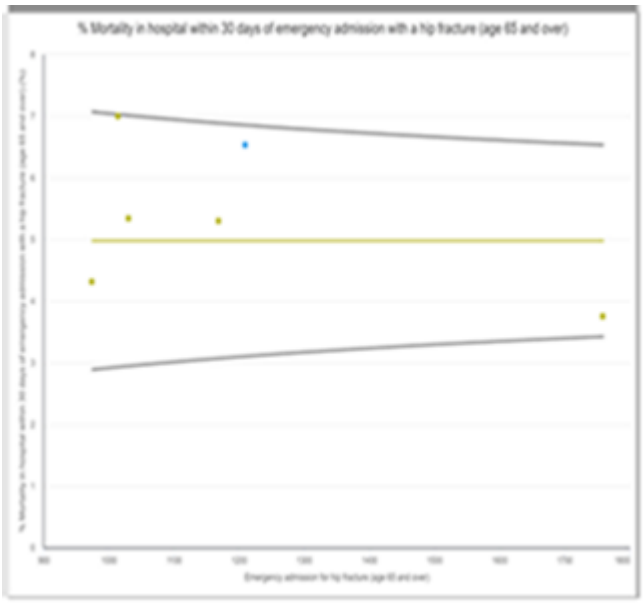
The Palmer report 2014 suggested that this was a more reliable way in reassuring ourselves that our services were safe.



Of importance is to present data in a way where we could understand differences between hospitals, These are carried out using charts similar to the following ggrpahs which display the 'Condition Specific' mortality rates.

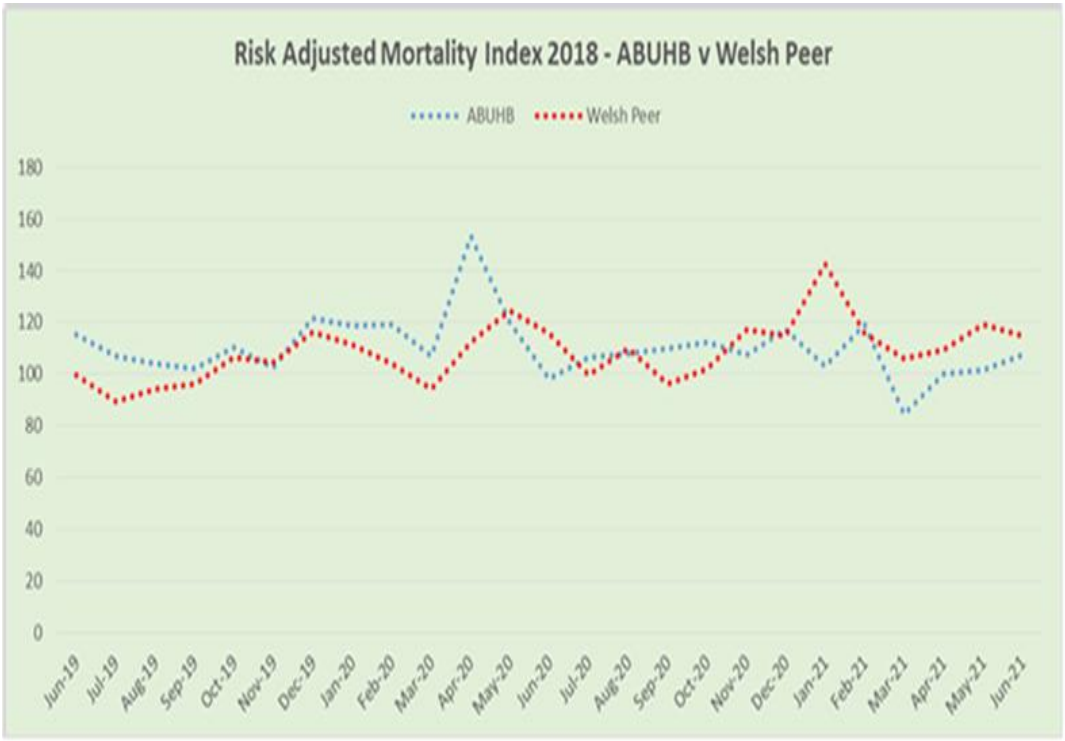






For our outcomes for stroke, myocardial infarction (MI) and hip fracture, the green (centre) line represents the median value in the hospitals studied, the grey line at the top is the upper limit and the grey line at the bottom is the lower control limit. What we want to see is the number representing mortality in our Health Board to sit in the middle, because that means that our performance is going to be where it is expected to be compared with other organisations. In fact, for stroke and MI you can see that our line falls down towards the lower limit which actually suggests that our mortality is much lower than expected when adjusted for the particular circumstances of our population. Hip fracture figures are nearer the upper control limit but within the range

that we would expect and I can provide assurance that our hip fracture mortality has, in fact, fallen recently.



The final graph looks at risk adjusted mortality. This is a more nuanced metric than the crude mortality rates raised in the question. This looks at the likelihood of dying once we have considered underlying health conditions and other factors.

It isn't a metric used regularly and the red line is mortality for other Health Boards in Wales.

You can see the peak where our mortality is above our Welsh peers during the first wave due to our early COVID mortality.

Since the opening of GUH our risk adjusted mortality for the Health Board has been tracking at a lower level than before and at a lower level than our Welsh peers.

I want to provide strong reassurance to our local population that our services are safe, and that they can rely on them and we have a number of routes in place that monitor mortality regularly.

We have an external review of our deaths by the Welsh Medical Examiners Service which examines in detail every death in the Health Board hospitals. It then feeds back

advice to us if they believe that there is something that could have been done better This advice is reviewed on a regular basis in our Mortality Group.

Matthew Crowley	**Member of public**

Question 3 - Masks

A. Even though masks were being widely utilised by the population in countries around the world (particularly across East Asia), ABUHB did not insist on masks being required for all persons in hospital and care settings (unless medically exempt), earlier then when it became mandatory by Welsh Government in Nov 2020, this being well after mask were being recommended under the precautionary principle and widely available across all of society.

B. Following the recent study from Adensbrook Hospital, concerning the use of higher quality masks for all hospital and care settings in both reducing hospital acquired infections and protecting staff and patients, what is ABUHB doing to ensure higher quality masks are being used across all these settings (for all medical staff, patients and other employees)? If you are not into introducing your own standards in this regard, why not?

A response was provided by Rhiannon Jones, Nurse Director

The use of masks is not a decision we make independently as a Health Board. ABUHB has at all times followed the Welsh Government Guidance and UK Guidance on the use of Personal Protective Equipment. The Welsh Government and the Department of Health, in turn, take advice from experts, such as, NERVTAG (The New & Emerging Respiratory Virus Threats Advisory Group). Its advice is based on evidence obtained as part of its studies and research. We will continue to follow the advice provided by the Welsh Government.