Finance and Performance Committee

Tue 17 June 2025, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

FPC 20250617 Agenda - Approved FINAL.pdf (2 pages)

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

1.3. Declarations of Interest

Chair

1.4. Draft Minutes of the last Meeting held on 17th February 2024

Chair

FPC 20250617 1.4 Draft Minutes FPC20250217.pdf (9 pages)

1.5. Committee Action Log

Chair

FPC 20250617 1.5 Action Log - Approved.pdf (6 pages)

09:30 - 09:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

09:30 - 09:30
0 min

3. ITEMS FOR DISCUSSION

COMMITTEE GOVERNANCE

3.1. Committee Risk Report

Director of Corporate Governance

20250617 3.1 Finance and Performance Committee Risk Report.pdf (7 pages)
20250617 3.1a Appendix 1 Finance and Procurement.pdf (13 pages)

3.2. Development of Committee Annual Programme of Business 2025/26

Director of Corporate Governance

FPC 20250617 3.2 Cover Paper Finance Performance Committee - Forward Work Plan 2025-26.pdf (4 pages)
FPC 20250617 3.2a Appendix 1 FPC Forward Work Plan 2025-2026.pdf (7 pages)

ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT

3.3. Performance Management & Escalation Report

Director of Strategy, Planning and Partnerships

- FPC 20250617 3.3 June 25 PMF update F and P.pdf (11 pages)

3.4. Integrated Performance Report

Director of Strategy, Planning and Partnerships

- FPC 20250617 3.4 Finance and Performance Committee - Performance Report Cover Paper 2025.06.17 FINAL.pdf (6 pages)
- FPC 20250617 3.4a Finance and Performance Committee - Performance Report 2025.06.17 FINAL.pdf (42 pages)

3.5. Stroke Improvement Plan Update Report

Director of Allied Health Professionals and Health Science

- FPC 20250617 3.5 Stroke Improvement Plan.pdf (11 pages)
- FPC 20250617 3.5a Appenidx 1 GIRFT Report.pdf (37 pages)
- FPC 20250617 3.5b Appendix 2 Therapy Review 2021.pdf (18 pages)
- FPC 20250617 3.5c HIW Patient Flow Review 2023.pdf (89 pages)
- FPC 20250617 3.5d Appendix 4 Welsh Government letter to NHS Wales Health Board Chief Executives - Improving Stroke Services in Wales.pdf (4 pages)
- FPC 20250617 3.5e Appendix 5 GIRFT Action Plan Tracker.pdf (1 pages)
- FPC 20250617 3.5f GIRFT Action Plan Tracker.pdf (1 pages)
- FPC 20250617 3.5g GIRFT Action Plan Tracker.pdf (2 pages)

3.6. Information Governance Report

Director of Digital

- FPC 20250617 3.6 IG Performance_Report_ June 2025.pdf (11 pages)
- FPC 20250617 3.6a Worksheet in C Users ga053678 AppData Local Microsoft Windows INetCache Content.Outlook 58U39KIS IG Performance_Report_ June 2025.pdf (1 pages)

3.7. Assurance Reports from the Digital, Data and Technology Group

Director of Digital

- FPC 20250617 3.7 Digital Delivery Update_2506.pdf (11 pages)

3.8. Corporate Information Report

Director of Corporate Governance

- FPC 20250617 3.8 Corporate Information Performance Report (Qs 3 4).pdf (4 pages)
- FPC 20250617 3.8a Corporate Information Performance report Quarter 3 & 4. Appendix 1.pdf (7 pages)

ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE

3.9. Monthly Finance Report and Monitoring Returns

Director of Finance, Procurement & VBHC

- FPC 20250617 3.9 Board Finance Report 25-25 M01vfinal FPC_25.06.17.pdf (23 pages)
- FPC 20250617 3.9a Board Finance Report appendices 25-26 M01 FINAL.F&PC25.05.17.pdf (23 pages)

3.10. Value and Sustainability Assurance Reporting

Director of Finance, Procurement & VBHC

- FPC 20250617 3.10 - FPC.3.11_Apr 25 - VSB update.pdf (16 pages)
- FPC 20250617 3.10a VSB Dashboard-March 24-25.pdf (6 pages)
- FPC 20250617 3.10b Appendix B.pdf (1 pages)
- FPC 20250617 3.10c Appendix C.pdf (1 pages)
- FPC 20250617 3.10d Appendix D.pdf (1 pages)

3.11. Opportunities identified through costing return analysis for ABUHB

Director of Finance, Procurement & VBHC

- FPC 20250617 3.11 PRESENTATION Costing Submission Data 2024.pdf (21 pages)

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0 min

4. Items for Information

4.1. External Audit Review of Cost Savings Arrangements

Director of Corporate Governance

- FPC 20250617 4.1 ABUHB Cost Savings Arrangements.pdf (24 pages)

4.2. NHS Wales Joint Commissioning Committee - Planning, Performance and Finance Sub-Committee Highlight Report

Director of Corporate Governance

- FPC 20250617 4.2 JCC Highlight Report April 2025 Final.pdf (5 pages)

4.3. Committee Annual Report 2024/25

Director of Corporate Governance

- FPP20250617 4.3 Finance and Performance Committee Annual Report 2024.25.pdf (43 pages)

4.4. Annual Review of Committee Terms of Reference

Director of Corporate Governance

- FPP20250617 4.4 ToR Finance & Performance Committee Approved May 2025 (1).pdf (12 pages)

4.5. Project Brief – Digital Transformation Review – Aneurin Bevan University Health Board

Director of Corporate Governance

- FPC 20250617 4.5 ABUHB Digital Transformation Review - Project Brief Final.pdf (26 pages)

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0 min

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

Chair

5.2. Any Other Urgent Business

Chair

5.3. Date of the Next Meeting: 31st July 2025

Chair

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
FINANCE AND PERFORMANCE COMMITEE

AGENDA	
Date and Time	17th June 2025, 09.30-12.30
Venue	Microsoft Teams

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 17th February 2024	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section		
3	**ITEMS FOR DISCUSSION**		
COMMITTEE GOVERNANCE			
3.1	Committee Risk Report	Attached	Director of Corporate Governance
3.2	Development of Committee Annual Programme of Business 2025/26	Attached	Director of Corporate Governance
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT			
3.3	Performance Management & Escalation Report	Attached	Director of Strategy, Planning and Partnerships
3.4	Integrated Performance Report	Attached	Director of Strategy, Planning and Partnerships
3.5	Stroke Improvement Plan Update Report	Attached	Director of Allied Health Professionals and Health Science
3.6	Information Governance Report	Attached	Director of Digital
3.7	Assurance Reports from the Digital, Data and Technology Group	Attached	Director of Digital
3.8	Corporate Information Report	Attached	Director of Corporate Governance
ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE			
3.9	Monthly Finance Report and Monitoring Returns	Attached	Director of Finance, Procurement & VBHC
3.10	Value and Sustainability Assurance Reporting	Attached	Director of Finance, Procurement & VBHC

3.11	Opportunities identified through costing return analysis for ABUHB	Presentation	Director of Finance, Procurement & VBHC
4	**ITEMS FOR INFORMATION**		
4.1	External Audit Review of Cost Savings Arrangements	Attached	Director of Corporate Governance
4.2	NHS Wales Joint Commissioning Committee - Planning, Performance and Finance Sub-Committee Highlight Report	Attached	Director of Corporate Governance
4.3	Committee Annual Report 2024/25	Attached	Director of Corporate Governance
4.4	Annual Review of Committee Terms of Reference	Attached	Director of Corporate Governance
4.5	Project Brief – Digital Transformation Review – Aneurin Bevan University Health Board	Attached	Director of Corporate Governance
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 31st July 2025		

Motion to Exclude Members of the Public and the Press
There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting: “Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”. *Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960*

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE

DATE OF MEETING	17th February 2025
VENUE	Microsoft Teams.

PRESENT	Richard Clark, Chair
	Iwan Jones, Vice Chair
	Neil Patrick, Independent Member
	Helen Sweetland, Independent Member.
IN ATTENDANCE	Robert Holcombe, Director of Finance, Procurement and VBHC.
	Hannah Evans, Director of Strategy, Planning and Partnerships.
	Paul Solloway, Director of Digital
	Nicola Prygodzics, Chief Executive Officer
	Tomos Jones, Audit Wales.
	Dan Davies, Chief Business Officer, to support with agenda item 3.4
APOLOGIES	Dafydd Vaughan, Independent Member
	Rani Dash, Director of Corporate Governance

FPC/1702/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
FPC/1702/02	**Apologies for Absence** Apologies for absence were **NOTED.**
FPC/1702/03	**Declarations of Interest** There were no declarations of interest raised to record.
FPC/1702/04	**Draft Minutes of the meeting held on 16th December 2024.** The minutes were **AGREED** as a true and accurate record.
FPC/1702/05	**Committee Action Log** The Committee received the action log and was content with the progress made in relation to completed actions and against any outstanding actions, as set out within the paper.

FPC/1702/06	**Emerging Annual Plan 2024/25, including Performance and Finance** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, outlined the Ministerial Priorities and enabling actions against which the plan would be measured. The Committee noted a high-level forecast for Health Board activity as at the end of March 2026. This included targets within secondary care activity, such as, referrals, follow ups and elective treatments. The Committee sought clarification on how susceptible the Health Board was to changes made within the assumptions underpinning delivery, and whether the actions highlighted as necessary in order to meet the listed assumptions would take priority over Ministerial priorities. HE highlighted that the HB was sensitive to changes, and that there was the ability to share with the Committee some sensitivity testing under taken to date. Robert Holcombe (RH), Director of Finance, Procurement and VBHC, highlighted to the Committee that the efficiency assumptions were a significant priority for service delivery. The Committee discussed the potential need for two-tier reporting in order to capture priorities based on direct and indirect service impact. The Committee noted an interest in a comparison between the costs and benefits of having senior doctors o the front of the Emergency department, especially the impact witnessed on reduced waiting times. Paul Solloway (PS), Director of Digital, highlighted that the Emergency Department digital data set was to be implemented this year which would aid the collection of data in regard to ED waiting times. HE highlighted target forecasts for ministerial priorities in 2025/26. It was noted that further tracking would be desired by the organisation on-top of ministerial criteria, such as, in regard to the number of ambulances waiting over 1 hour, how many hours were lost after the one hour cut off had elapsed.

The Committee noted that the speciality services Referral to Treatment waiting time remained at 104 weeks. Work would continue into improving the end of year position for the three worst affected areas, Orthopaedics, Ophthalmology and General Surgery.

Nicola Prygodzicz (NP), Chief Executive Officer, highlighted that there was potential money being released in order to enable the divisions to continue work on the reduction of waiting times into Quarter 1.

HE provided the Committee with an outline of some of the priority areas within Performance Ambitions 2025/26. It was noted that the slide pack would be circulated with Committee members outside of the meeting for further scrutiny.

ACTION: Director of Strategy, Planning and Partnerships.

Next steps were listed as:

- To note discussions with Welsh Government regarding Quarter 1 additionality.
- First draft of the Annual Plan to be shared with the Board for comments the week commencing 24th February.
- Final draft to be discussed at Board on 31st March 2025.

RH provided the Committee with updates regarding the financial forecast for 2025/26.

The Committee noted that the presentation had been distributed to Committee members following the Board Briefing Session on 12th February 2025.

RH highlighted that the financial settlement for the Health Board was 1.77% rather than the estimated 3%, as well as the HB receiving conditional funding of £40.5million.

The Committee noted the underlying position had changed from £7million to £19million. This was due to changes such as, high-cost recurrent drugs moved from recurrent for 24/25 to non-recurrent.

The Committee noted that the £2million set aside as built-in cost pressures, included £1million in risk budget, and incorporated a cost outlook for Harley Street operations.

	The Committee received an outline of local and national pressures, savings through services and directorates, and the development of route maps to increase efficiency and improvement. The Committee noted the need for lobbying to Welsh Government to continue to provide financial support for projects which were developed through 111, such as urgent primary care, to avoid these priority schemes being put at risk. RH concluded that in comparison to other organisations, Aneurin Bevan University Health Board's costs savings plan was an outlier in terms of being the most effective. Next steps were noted as to liaise with Executives into initiating more of the strategy to ensure efficient cost saving without influence upon quality care. The Committee raised the need for increased granularity into plan to deliver savings. It was noted that for the £8million saved to date, a slide pack with a further breakdown could be provided to the Committee outside of the meeting. **ACTION**: Director of Finance, Procurement and VBHC. The Committee **NOTED** the contents of the presentation.
FPC/1702/07	**Performance Report** Hannah Evans (HE), Director of Strategy, Planning and Partnerships provided an update to the Committee. Including: • Significant progress in Urgent and emergency Care, pathways of care delays. • Continued weekly escalation oversight. • Emergency department consultant growth. • Ahead of trajectory for 104 days targets. • Mental Health division processed backlog, although need to focus on psychology waiting lists. The Committee requested to receive an update in regards to consultants starting in the emergency Department. HE highlighted that the position within the Emergency Department was improved despite winter measures remaining in place after the instigation of critical incident. HE

	offered to share the timeline for trajectory of improvement with the Committee by the end of the week. **ACTION**: Director of Strategy, Planning and Partnerships. The Committee **NOTED** the report.
FPC/1702/08	**Update against Performance Management Framework & National Escalation** Hannah Evans (HE), Director of Strategy, Planning and Partnerships updated the Committee that the report would summarise the month 6 reviews. Assurance was given that whilst the month 6 reviews were not fully accurate due to winter pressures, the reviews looked at the most up-to-date information for both performance and finance out-turn. It was noted that escalation levels for the divisions remained the same, presented as within normal arrangements, with Mental Health and Urgent Care being in enhanced Monitoring. The Committee noted the main challenge faced within Urgent care was to sustain improvements made, which was being scrutinised as a national occurrence. Whereas, Mental Health had made great improvement in regard to performance targets. A conversation was held to discuss a review of Mental Health Performance, and to check that all improvements were successful embedded and in-line with overall patient quality and safety improvement plans. The Committee noted that the surgical division had challenged their worsening financial position. Conversations had been held into enhanced monitoring of the divisions financial position, with a special budget meeting to be held in regards to escalation within the financial domain. It was noted that national escalation levels remained unchanged in regard to targeted intervention. The next reviews were scheduled for February and August 2025. It was predicted that the national escalation levels would remain unchanged, subject to the Health Board meeting the current years financial plan, and the financial plan for the following year. The Committee noted that the next quarterly review meeting with Welsh Government was scheduled to be held on 5th March 2025.

	The Committee noted that management strategies, such as mitigations, opportunities and reserves had been instigated to manage divisional shortfalls in meeting financial targets. It was highlighted that some progression had already been made within divisions as a result of these measures, however, the Committee noted that some divisions would be unlikely to reach their targets. Deep dives had been commissioned into divisions that had been raised as being outside of the escalation process. The Committee **NOTED** the report.
FPC/1702/09	**Corporate Information Performance Report** Dan Davies (DD), Chief Business Officer provided assurance on Freedom of Information requests received under the Freedom of Information Act (2000), handled by the Corporate Information Team. The Committee noted that the report also satisfied the Information Commissioners requirement for the publication of the Health Boards performance when handling these requests. The Committee noted that in Quarter 1 and 2 of the 2024/25 financial year, 333 requests were received under the act, and 264 enquiries from Members of the Senedd and Parliament. It was highlighted that the Health Board aims to respond to enquiries from members of the Senedd or Parliament within 20 working days. It was highlighted that the highest number of enquiries related to waiting lists within the surgical division. The Committee noted that a report on Quarter 3 and 4 would be coming to the Committee in June 2025. The Committee raised the need for a comparison element, such as against a Wales average or Welsh Health Boards, to be included within the report, to provide further understanding of the health boards performance within this area. DD assured the Committee that the paper due to be presented at the June Committee meeting would include further detailed as it would include an annual summary. It

	was agreed that a comparison statistic would be included within the paper being presented at the June meeting. The Committee requested clarification on how the service responds to enquiries of a differing nature, such as individual patient or group enquires, such as, constituency group. The Committee noted that for individual patients, subject to identification criteria, information would be able to be tracked through the patient's journey, whereas information related to a group of constituents, would be more contextual in nature. The Committee **NOTED** the report.
FPC/1702/10	**Monthly Financial Performance Report** Rob Holcombe (RH), Director of Finance, Procurement and VBHC provided an update on the Health Board's financial position at the end of Month 9. It was highlighted that the HB had a year-to-date deficit of £7.285 million. The Committee noted receipt of the monetary returns content via email. The Committee noted that the underlying end-of-year financial deficit for 2024/25 was, £81.4 million. This was revised in November 2024, and adjusted to show an underlying deficit of £14.4 million. The Committee was assured that figures from GP practices had also been included with the findings. The Committee raised concern in regard to a stagnation in material improvement shown within the divisions. Assurance was provided that there were only two areas presenting issues, those being surgery and elective care. In elective care the shortfall had arouse from the demand witnessed by the Health Board over the winter months, and the need to increase internal solutions for these divisions. The Committee requested more information on a review into value and sustainability for enhanced care, due to a fluctuation in costs by the division. The Committee raised the potential need for a paper to be presented at a Patient Quality Safety and Outcomes Committee for increased assurance, due to a potential affect into patient care.

	Director of Corporate Governance to be consulted in regard to a potential presentation to be made to PQSO Committee. **ACTION**: Director of Corporate Governance. RH assured the Committee that he would circulate slides on the Month 10 position outside of the meeting, for the Committee to note. **ACTION:** Director of Finance, Procurement & VBHC. The Committee **NOTED** the report.
FPC/1702/11	**Value and Sustainability Assurance Reporting** Rob Holcombe (RH), Director of Finance, Procurement and VBHC presented to the Committee. The Committee noted key highlights of the report, such as; • Over performing on savings delivery, which had made it up to £44.2 million. • Ty Gwent Office move had been completed, with a projected saving of £0.5 million for 2025/26. • Life Time Allowance Arbitration with Cwm Taf Morgannwg University Health Board successfully achieved savings of £1.5 million above estimates. The Committee noted that next steps were to develop more saving at divisional level, and to optimise thematic Value and Sustainability Board group mechanisms. The Committee **NOTED** the report.
FPC/1702/12	**Review of Committee Programme of Business 2024/25** The Committee Programme of Business 2024/25 was provided to the committee for information. The Committee requested for the 2025/26 Forward Work Programme to be circulated at the earliest opportunity. **ACTION**: The Committee Secretariate. The Committee **NOTED** the report.
FPC/1702/13	**Items to be Brought to the Attention of the Board and Other Committees** None raised.
FPC/1702/14	**Any Other Urgent Business**

	None raised.
FPC/1702/15	**Date of the Next Meeting:** Tuesday 8th April 2025, 09.30-12.30.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING- FINANCE & PERFORMANCE COMMITTEE
ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
16/12/2024	**FPC/1612/09**	**Information Governance Report, including SIRO Update** Update to be shared via email, regarding progress from Digital Health and Care Wales and desktop patching.	**Director of Digital.**	**February 2025**	**Complete** May Update DHCW have implemented the required configuration changes to enable NHS Wales organisations to utilise Windows Update for Business to security patch devices over the internet and therefore removing the requirement to bring back to base or connect remotely. The

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					ABUHB team have completed all pre-requisites and are planning the roadmap to implementation with indicative timescales of 6 weeks to start the deployment. February update Awaiting System change from DHCW which is scheduled for February.
16/12/2024	**FPC/1612/10**	**Assurance Report from the Digital, Data and Technology Group** Item to be scheduled for update at next Committee meeting.	**Committee Secretariat**	**February 2025**	**Completed** May update Scheduled for presentation to the Committee at June 2025 meeting.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
17/02/2025	**FPC/1702/06**	**Emerging Annual Plan 2024/25, including Performance and Finance** Slide pack outlining performance ambitions 2025/26 to be circulated to Committee members	**Director of Strategy, Planning and Partnerships.**	**April 2025**	**COMPLETED** Email circulated
17/02/2025	**FPC/1702/06**	**Emerging Annual Plan 2024/25, including Performance and Finance** Slide pack detailing breakdown of savings to date to be circulated to the Committee.	**Director of Finance, Procurement and VBHC**	**April 2025**	**COMPLETED** Email circulated on 17th February 2025.
17/02/2025	**FPC/1702/07**	**Performance Report** Timeline for trajectory of improvement related to the Emergency Department to be shared with the Committee.	**Director of Strategy, Planning and Partnerships**	**April 2025**	**Completed** A paper on Urgent & Emergency Care Developments was presented to the May Public Board.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
17/02/2025	**FPC/1702/09**	**Corporate Information Performance Report** Comparison statistic to be included in the annual summary at June 2025 meeting.	**Chief Business Officer**	**June 2025**	**Complete** May update Corporate Information report will be included in the June agenda.
17/02/2025	**FPC/1702/10**	**Monthly Financial Performance Report** Update to be provided on whether the report should be presented to the Patient Quality and Safety Committee due to a potential impact upon patient care.	**Committee Secretariat**	**April 2025**	**COMPLETED** Director of Corporate Governance has confirmed that the business of the PQSO Committee is driven by a risk based approach and focusses on risks identified through the integrated risk management system and Quality Impact Assessment process. The

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					Financial Performance Report is not required to be presented to the PQSO Committee.
17/02/2025	**FPC/1702/10**	**Monthly Financial Performance Report** Slide pack detailing the Month 10 financial position to be circulated to the Committee.	**Director of Finance, Procurement and VBHC**	**April 2025**	**COMPLETED** February update Email circulated on 17th February 2025.
17/02/2025	**FPC/1702/12**	**Review of Committee Programme of Business 2024/25** 2025/26 Forward Work Programme to be circulated to the Committee once final approval has been received.	**Committee Secretariate**	**April 2025**	**Completed** May update 2025/26 FWP to be included on the agenda for June 2025

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION LOG

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.
Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2025
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The purpose of this report is to provide the Finance and Performance Committee (the Committee) with a detailed overview of the current strategic risks delegated to it by the Board, including an overview of their status, mitigating actions, and associated assurance mechanisms.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

Since the last report to the Committee in December 2024, the Board has approved the addition of a new overarching risk, outlined below, to the Strategic Risk Register (SRR), along with one associated sub-risk. Oversight of this risk has been delegated to the Finance and Performance Committee to enable enhanced focus and scrutiny.

Strategic Risk SRR 011	**Risk Rating and Score**
Risk Theme – Service Delivery **Risk Appetite –** Open (Score of 17 or below)	**Extreme** **15** (L5 x I3)
Overarching risk The Health Board is at risk of failing to meet the Welsh Government's Public Sector emissions reduction targets of 16% by 2025 and 34% by 2030.	
Sub-risk Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale.	

Decarbonisation is a key priority for the Health Board, serving as an enabler to enhance the sustainability of the healthcare system. By recognising the risks associated with this priority, appropriate governance and oversight mechanisms have been established to try to address these challenges.

Asesiad / Assessment

Committee Strategic Risk Register (SRR)

The current risk portfolio for the Committee, outlined in Table 1, contains three high-level strategic risks with six sub-risks.

In accordance with best practice, all strategic risks have been reviewed within the appropriate timeframe for their respective levels of risk. The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Where it has been determined that the existing controls are insufficient, additional controls have been documented, and actions are being taken to address these gaps. Similarly, the three lines of assurance are evaluated to ascertain the effectiveness and reliability of the controls in place. If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are implemented to close these gaps.

Table 1

Risk Details	High-Level Risk Description	Sub-Risk	Risk Level L x I	Within Appetite
SRR 001G Director of Finance & Procurement **Theme** Financial Sustainability **Appetite** Cautious Score 13 and below	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	**4 x 4=16** **Extreme**	**N**
SRR 001I Director of Strategy, Planning & Partnerships **Theme**		i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health	**3 x 4= 12** **Extreme**	**N**

Compliance & safety **Appetite** Minimal Score 8 and below		Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.		
SRR 006 A – C Director of Digital **Theme** Service Delivery **Appetite** Open Score 17 and below	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	a) Due to the full or partial failure of existing digital infrastructure and systems.	**3 x 4= 12 High**	**Y**
		b) Due to an adverse impact on service delivery in the implementation of new digital systems.	**3 x 4= 12 High**	**Y**
		c) Due to a failure to develop digital solutions that are sustainable and fit for the future	**3 x 4 = 12 High**	**Y**
SRR 011 Director of Finance & Procurement **Theme** Service Delivery **Appetite** Open Score 17 and below	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030.)	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.	**5 x 3 =15 Extreme**	**Y**

Risks Outside of Appetite

Risk ID	Sub Risk Description	Current Score	Management of the Risk
SRR 001G	Due to a failure to deliver a sustainable financial position and longer-term financial plan	**16**	**Treat** the risk, and **Take Opportunities** to unlock benefits but Prepare to **Tolerate** any residual risk outside of the Health Board's control.
SRR 001I	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management	**12**	**Treat** the residual risk, but also **Take the Opportunity** to redesign and strengthen services for long-term sustainability.

	Framework domains of Quality and Safety, Operational Delivery, and Finance.		

Management of the risks outside of appetite are explained in greater detail, below.

SRR 001G: Failure to deliver a sustainable financial position and longer-term financial plan

Since the Board's last meeting, the Director of Finance and Procurement has reviewed the strategic risk outlined above. In light of the improved year-end financial forecast and the Health Board entering the 2025/26 financial year on a stronger financial footing, the likelihood of this risk materialising has been revised from 'Almost Certain' (5) to 'Likely' (4), reducing the overall risk score from 20 to 16.

At the end of the 2024/25 financial year, the Health Board is reporting a year-end deficit of £7.2 million (subject to audit). This represents a significant improvement in the Board's financial position, largely attributable to the Welsh Government's allocation of £40.5 million in additional funding, confirmed in correspondence dated 02 December 2024. Of this, £9.5 million is recurrent funding to address operational pressures, and £31 million is also recurrent but conditional on the achievement of defined performance objectives.

While this improvement is encouraging, the Director of Finance and Procurement and the wider Executive Team fully acknowledge that the Integrated Medium-Term Plan (IMTP) 2025–28 and its associated annual plan continue to carry a considerable level of financial risk. As such, a comprehensive set of internal controls is being deployed to manage this risk effectively and ensure continued progress.

- **Preventative controls** have been strengthened to reduce the likelihood of adverse financial outcomes. These include rigorous budget-setting processes, enhanced financial governance frameworks, and proactive cost control measures designed to mitigate overspending before it occurs.

- **Detective controls** have been instrumental in identifying deviations from expected performance and triggering timely interventions. These mechanisms help detect risks that have already materialised, allowing for corrective actions to be taken swiftly.

- **Directive controls** are being enhanced to provide clear guidance and direction in financial decision-making. These include strategic leadership directives, mandatory financial training for budget holders, and alignment of financial incentives with organisational objectives. Such controls are crucial in shaping behaviours and ensuring accountability across all levels of the organisation.

Together, this integrated approach to risk management is enabling the Executive Team to respond with greater agility and assurance, not only to immediate financial pressures but also in planning for long-term financial sustainability. Continued

monitoring, regular review of controls, and adaptive planning will remain essential in managing this strategic risk over the coming year.

SRR 001I: Failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management and Accountability Framework domains of Quality and Safety, Operational Delivery, and Finance.

The Health Board’s performance risk is partially attributable to its financial position. Ongoing efforts to manage the deficit have increased scrutiny on spending, which, in turn, has affected service delivery in some areas. This pressure has, at times, led to misalignment between planned priorities and the actual trajectory of key objectives. However, financial constraints are not the sole contributing factor, wider resource limitations and external influences also continue to impact overall performance.

Audit Wales has acknowledged the Performance Management and Accountability Framework as an effective mechanism for identifying performance shortfalls and providing targeted support to promote improvement and maintain organisational stability.

While several areas remain under enhanced scrutiny, detective controls, such as performance monitoring reports or audit reviews, have been effective in providing the Executive with a reasonable level of assurance. These controls have helped detect where risks are materialising and take corrective action, thereby supporting continued progress.

However, there is a growing need to strengthen preventative controls, which are designed to reduce the likelihood of risks occurring in the first place. Such controls, include the implementation of Frameworks, staff training, or early-warning indicators that pre-empt and address emerging performance issues. Similarly, enhanced directive controls, those that guide and shape behaviours and actions toward desired outcomes, such as strategic planning, leadership directives, or defined service standards, will be essential in supporting more consistent delivery across the Health Board’s operations.

In the year ahead, focused monitoring of individual service areas will remain a priority. This ongoing surveillance, combined with strengthened control measures, will be essential in managing associated risks and ensuring alignment between resources, performance targets, and patient outcomes.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated Committee risks as detailed within the Strategic Risk Register, ensuring alignment with the Board's Strategic Objectives;
- **NOTE** the continued efforts to bring all risks to within the agreed threshold for the risk appetite;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR 001 G & I SRR 006 A, B & C
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Contained within the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

Reference				Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan					×					◊	●	
	Director of Public Health & Strategic Partnerships		l) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.					◊×			●				
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems					×			●		◊		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				×				●		◊		
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					×			●		◊		
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) . This is common to all Health Bodies across the country.	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected								×	●	◊		

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

Key		
	Current Score	●
	Target Score	×
	Appetite Threshold	◊
	Current to target	◂–

RISK THEME	FINANCIAL SUSTAINABILITY					
LINK TO IMTP	SECTION 4: ENABLER - FINANCE					
Strategic - SRR 001 G	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.				**Risk Appetite Threshold – Score 17 and Below** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**4 (**Likely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**4** (Major)		
Last Reviewed	01 May 2025	**Risk rating**	**= 16 (Extreme)**	***= 8*** **(Moderate)**		
Next Review (Monthly based on risk score)	01 June 2025					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance	None	• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	None	• 2025/26 – 27/28 IMTP plans focussed on 'living within' budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit • Annual Report • 2025/26 Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews **Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS	SECTION 4: ENABLERS – WORKFORCE & CULTURE		
Strategic Risk **SRR 001 I**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**		**Publication Status**	**Public**

Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact *(Consequences of the threat)*	**Patient** • Unintended Patient Harm. • Negative Public/Patient Experience.	**Staff** • Reduced Staff Morale leading to potential absence from work.	**Organisation** • Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee	Finance and Performance Committee.	**Likelihood**	3 (Possible) x	**2** (Unlikely x
Initial Date of Assessment	19 April 2024.	**Impact**	***4** (Major)*	**4** (Major)
Last Reviewed	01 April 2025	**Risk rating**	**= 12 (High)**	**= 8 (Moderate)**
Next Review (Quarterly based on risk score)	01 July 2025			

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive • Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates	• 12-month Performance Management Framework review in the Autumn	• Outcome if the review will determine if further action is required
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety • Committee • Established reporting to the Board • Routine reporting through the IQPD process	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan • Directorate Review - Mental Health and Learning Disabilities (Q2) • Divisional Governance Arrangements (Q2) • HIW Inspections • Llais for feedback	• Internal Audit 2024/25 Plan • Findings and recommendations from the Divisional Governance Arrangements (Q2) • Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	• Implementation of the management responses set out in the final Internal Audit Reports

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 A	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the full or partial failure of existing digital infrastructure and systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	01 April 2025	**Risk rating**	**= 12 (High)**	***= 8 (Moderate)***
Next Review (Quarterly based on risk score)	01 July 2025			

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. • Implement the recommendations from Templar report: • Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · • Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · • Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • ·Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	• Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Updated audit from Cyber Resilience Unit to be undertake in Q2 2025. • Internal Audit review on Shadow IT scheduled for 2025/2026. • Improvements in mandatory training compliance for Information Governance and Cyber Security.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.		• None	• N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report.		• None	• N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. • Oversight from NHS Wales Cyber Resilience Unit.	Internal Audit 2024/25	• None	• N/A

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 B	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

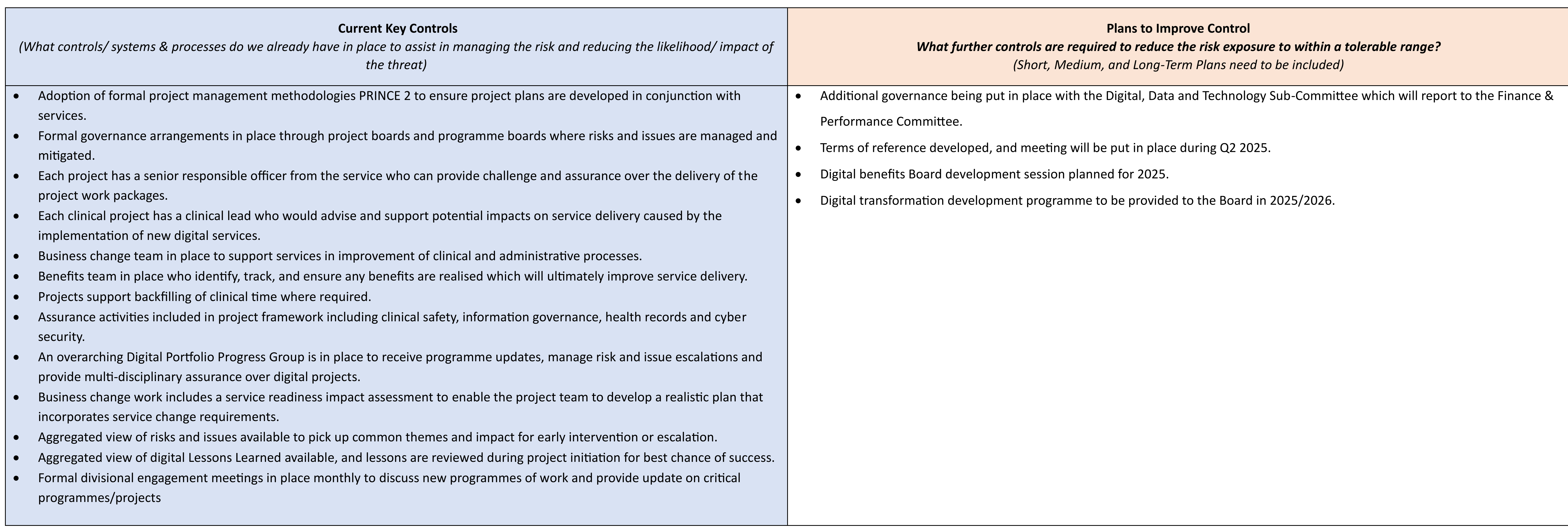
		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 April 2025	**Risk rating**	**= 12 (High)**	***= 6 (Moderate)***
Next Review (Quarterly based on risk score)	01 July 2025			

SRR 006 B

Risk Score: 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Legend: Current Risk Score; Target Risk Score; Appetite Threshold



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee. • Terms of reference developed, and meeting will be put in place during Q2 2025. • Digital benefits Board development session planned for 2025. • Digital transformation development programme to be provided to the Board in 2025/2026.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board's Risk Framework		• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Regular Reporting to the Finance & Performance Committee		• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance	**Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 C	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and fir for the future.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.	**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

Lead Director	Director of Digital	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** (Major)
Last Reviewed	01 April 2025	**Risk rating**	**= 12 (High)**	***= 8 (Moderate)***
Next Review (Quarterly based on risk score)	01 July 2025			

SRR 006 C

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score
Target Risk Score
Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • New Digital Request quarterly reporting to DDAT sub-committee • New governance structures to be put in place further to directorate restructuring • Development of product management approach to delivery of core software applications and extending use of agile processes to ICT • Development of digital strategies including Electronic Health & Care Record

Sources of Assurance	Gaps in Assurance	Actions to Address Gaps

(Evidence that the controls/ systems which we are placing reliance on are effective)	*(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	*(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Quarterly reporting to DDAT sub-committee	• If the NDSR process delivers anticipated improvements • The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution - planned for Q4	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	**SECTION 4: ENABLER – GREEN HEALTH**				
Strategic Risk **SRR 011**	**There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030)** *This is common to all Health Bodies across the country.*			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.** *(The effect of a failure to meet this target is on the wider environment.)*			**Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact *(Consequences of the threat)*	**Organisation** • Failure to meet the target set on Welsh Health bodies for reducing carbon output • Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. • Reputational damage and loss of public confidence. • Opportunity cost of reduced energy costs			**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small. **SUMMARY** The current risk level is **OUTSIDE** of target level and WITHIN the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Finance and Procurement	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	5 (Almost Certain) x	**4** (Likely) x
Initial Date of Assessment	30 October 2024	**Impact**	***3*** *(Moderate)*	***3*** *(Moderate)*
Last Reviewed	01 May 2025	**Risk rating**	**= 15** **(Extreme)**	***= 12*** ***(Moderate)***
Next Review (Monthly based on risk score)	01 June 2025			

SRR 011

Current Risk Score

Target Risk Score

Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Quarterly review of projects and workstreams at the Decarbonisation Programme Board • The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, • waste and facilities and estates • Regular reporting of financial data available • Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for • projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. • Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. • Annual net zero return submitted to Welsh Government • Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) • Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website • SUS Qi training • Met office training • Carbon literacy training HEIW • 4 modules on carbon reduction and net zero ESR • Spread & Scale academy training sessions	• Project structure regularly reviewed should action be needed. • Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Regular meetings of the subgroups to discuss position, monitor and new ideas • Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment.	• All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Six monthly updates to the Board • Executive Committee (Clinical Futures Board) updates – Quarterly • Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	• None	• The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. • Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Report in July 24. • Received "limited assurance" but not because of controls – the issues were largely around funding limitations. **External Audit Reports 2023 -24**Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	• Funding for a comprehensive ABUHB decarbonisation strategy is not available.	• As above - REFIT invest to Save capital opportunities being progressed.

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**NEGATIVE**

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 June 2025
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance and Performance Committee - Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2024/25 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

The Finance and Performance Committee supports the Board by providing assurance on the delivery of its aims and objectives, as set out in the Integrated Medium-Term Plan. In fulfilling this role, the Committee operates in accordance with the standards of good governance established for NHS Wales. In doing so, the Committee will seek assurance that:

- ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health

board's business, in line with the Board's Performance Management Framework;
- that arrangements for financial management and financial performance are sufficient, effective and robust;
- that services are improving efficiency and productivity and financial plans are being delivered;
- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

In line with good governance practice, a committee forward work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

Asesiad / Assessment

The Committee is requested to approve the Committee forward work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2025-26

Finance and Performance Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2024/25
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek assurance that there is: • ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework; • that arrangements for financial management and financial performance are sufficient, effective and robust; • that services are improving efficiency and productivity and financial plans are being delivered;

- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings					
			QTR 1 Apr to June		QTR 2 July to Sept		QTR 3 Oct to Dec	QTR 4 Jan to Mar
			8th April 2025	17th June 2025	31st July 2025	29th Sept 2025	15th Dec 2025	2nd Feb 2025
Preliminary Matters								
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓	✓	✓
Reflections of the meeting held	Chair	SI	✓	✓	✓	✓	✓	✓
Committee Governance								
Development of Committee Annual Programme of Business 2024/25	DoCG	AN	✓					
Review of Committee Programme of Business 2024/25	DoCG	SI	✓	✓	✓	✓	✓	✓
Committee Risk Report	DoCG	SI	✓	✓	✓	✓	✓	✓

Annual Review of Committee Terms of Reference	DoCG	AN	✓					
Annual Review of Committee Effectiveness 2024/25	DoCG	AN	✓				✓	
Outcome of annual Review of Committee Effectiveness 2024/25	DoCG	AN	✓					
Committee Annual Report 2024/25	DoCG	AN	✓					
Performance Management								
Annual Review of Performance Management Framework	DoSP&P	AN						✓
IMTP/Performance Ambitions for Future Years	DoF&P/DoSP&P	AN						✓
Performance Management Framework Report	DoSP&P	SI	✓	✓	✓	✓	✓	✓
NHS Wales Escalation and Intervention Framework Update	DoSP&P	SI	✓	✓	✓	✓	✓	✓
Integrated Performance Report, including performance against Ministerial Priorities	DoSP&P	SI	✓	✓	✓	✓	✓	✓
Reporting on Benefits Realisation Projects	DoF&P/DoSP&P						✓	
Financial Performance								
Monthly Finance Report and Monitoring Returns	DoF&P	SI	✓	✓	✓	✓	✓	✓
Financial Outlook for Future Financial Year, including	DoF&P	AN						✓

Revenue Budget Allocation letter								
Value and Sustainability Assurance Reporting	DoF&P	SI	✓	✓	✓	✓	✓	✓
Efficiency Opportunities and Update Report	DoF&P	SI	✓	✓	✓	✓	✓	✓
Commissioning Update Report to include: • Primary Care • CHC • Intra NHS Agreements • SLAs	DoF&P	AN						✓
Service Activity and Performance								
Welsh Government Performance Escalation Report (Targeted Intervention & Enhanced Monitoring)	DoSP&P	SI	✓	✓	✓	✓	✓	✓
Outpatient Transformation Programme Update	COO					✓		
Stroke Improvement Plan Update Report	DoT&HS		✓					
Theatres Utilisation Programme	COO						✓	
Information Management								
Information Governance Report, including SIRO Update	DoD	SI	✓	✓	✓	✓	✓	✓
Freedom of Information Act Report	DoCG	AN						✓

Digital and IM&T								
Assurance reports from the Digital, Data and Technology Group, including an update on the Delivery of Digital Programmes	DoD	SI	✓	✓	✓	✓	✓	✓
Capital, Estates and Facilities								
Estates Compliance including compliance with Health Technical Memorandums	COO	AN						✓

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 June 2025
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Escalation Levels and Performance Management Framework review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director Planning and Performance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to provide feedback to the Finance and Performance Committee regarding escalation levels and update on the progress of the Performance Management Framework (PMF) Review.

Specifically, the Finance and Performance Committee are asked to:

- **Note** the update on the current internal escalation status levels and intent to review these levels post the End of Year reviews which are running through to end of July,
- **Note** the update regarding the Health Board's national escalation
- **Note** the update on the progress of the PMF review and next steps.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In line with the Performance and Accountability Framework, End of Year reviews (EOY) take place between June – July for all Operational and Corporate Departments. These reviews are currently underway using a standard agenda and information pack. Escalation levels for Divisions and Departments will not be re-considered by the Executive Team until these reviews are complete. The focus of this update therefore is on actions and progress being made by those in internal escalation.

It should be noted the current escalation status of Divisions is aligned with the Welsh Government Oversight and Escalation Framework (Jan 24) the approach is set out to national escalation of NHS organisations.

The purpose of this report is to update on the status of each Division, and escalation levels as at June 2025 noting the ongoing EOY reviews, provide an update on national escalation status and the review of the Performance Management Framework.

Cefndir / Background

The PMF allows for consideration of escalation levels to occur at any time in line with triggers in the same section. However, as a minimum, a formal review of status should occur every 6 months.

Health Board Escalation

The current status of escalation levels prior to the 12 monthly reviews are as follows:

OPERATIONAL DIVISION	ESCALATION DOMAIN		
	Quality & Safety	Operational Delivery	Finance
Facilities & Estates	Normal Arrangements	Normal Arrangements	Normal Arrangements
Surgery Care	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Complex Care	Normal Arrangements	Normal Arrangements	Normal Arrangements
Urgent Care	Enhanced Monitoring	Enhanced Monitoring	Normal Arrangements
Medicine	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Primary Care	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Mental Health & Learning Disabilities	Enhanced Monitoring	Enhanced Monitoring	Enhanced Monitoring
Family & Therapies	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Clinical Support Services	Normal Arrangements	Normal Arrangements	Normal Arrangements

These escalation levels were formally communicated to Divisions in February 2025.

Urgent Care Division and Mental Health remain in enhanced monitoring across the two domains of Quality & Safety and Operational Delivery. The following Divisions were put into, or remain in enhanced monitoring for Finance:

- Medicine Division;
- Primary, Community and Complex Care Division;
- Family and Therapies Division;
- Clinical Support Services Division;
- Surgery Division.

The Health Board’s escalation levels are set by Welsh Government in line with the NHS Wales Oversight and Escalation Framework. The current escalation status of the Health Board remains unchanged since January 2024:

- Targeted Intervention Level 4 for Finance, Strategy and Planning;
- Enhanced Monitoring Level 3 for Performance and Outcomes related to Urgent and Emergency Care Pathways at The Grange University Hospital Emergency Department.

The de-escalation criteria have previously been shared with the Committee and are attached in **Appendix 1** for reference. Progress is tracked by Welsh Government via a number of mechanisms:

- Monthly Enhanced Monitoring for Grange ED meetings, following the monthly IQPDs;
- Monthly Planning Touchpoints with Welsh Government Lead;
- Monthly Financial meeting with Welsh Government and NHS Executive;
- Quarterly Escalation meeting with Director General of Health and Social Care Welsh Government and Welsh Government Executive Team and Health Board Executive Team.

Assessment

The End of Year Reviews are currently taking place through June and July. Table 1 sets out schedule of meetings:

Table 1 – Schedule of meetings

Date	**Area**	**Status**
Divisional Review Meetings		
12th May 2025	Facilities and Estates	Complete
19th May 2025	Mental Health & LD	Complete
12th June 2025	Urgent Care	Complete
18th June 2025	Clinical Support Services	Scheduled
19th June 2025	Therapies	Scheduled
23rd June 2025	Primary Care	Scheduled
2nd July 2025	Medicine	Scheduled
2nd July 2025	Family & Therapies	Scheduled
Corporate Review Meetings		
	Public Health	To be arranged
26th June 2025	Digital	Scheduled
30th June 2025	Workforce & Organisational Development	Scheduled
2nd July 2025	Planning	Scheduled
2nd July 2025	Nursing	Scheduled
9th July 2025	Allied Health Professionals & Health Scientists	Scheduled
16th July 2025	Finance & Procurement	Scheduled
17th July 2025	Corporate Governance	Scheduled

Actions in Response to Extant Escalation Levels

In line with the Performance Management Framework, when Divisions or Teams are in escalation a number of actions are agreed. In line with escalation triggers and response, for those in escalation for Finance, Special Budgetary Meetings are held. The purpose of these to ensure there is clarity, assurance and where required challenge on the opportunities and actions being taking to improve the financial position. A number of these meetings have taken place or are planned.

Date	Directorate	Status
9th April	Surgery	Complete
1st April	Medicine	Complete
13th May	Primary Care & Community - Prescribing	Complete
22nd July	Digital	Scheduled

These meeting were underpinned by detailed packs of management information detailed drivers for spend, opportunities and risks. Detailed notes and actions have been agreed via these meetings. These actions are being tracked through the monthly Divisional Assurance meetings.

Update on Divisional Escalation Progress and Actions

Urgent Care Division and Mental Health remain in enhanced monitoring across the two domains of quality & safety and operational delivery.

Urgent Care

The Health Board remains in Enhanced Monitoring at a national level for ED at GUH and whilst there have been areas of improvement, these have not been consistently achieved against the national escalation metrics, although it is recognised that there is a Cross Divisional contribution required to improvements.

There has been recent positive improved performance in two keys metrics:

- >12hr EDMIU was 1,089 which was below IMTP trajectory for month (1,266) and the best monthly performance since May 2021. Additionally, 12hr compliance under the EDMIU definition was 92.9% which is the highest since June '21.l
- Clinician Median Wait (WTBS definition) at GUH ED was 112 mins against and IMTP trajectory of 120 mins. This is the best performance since April 2022.;
- GUH ED >1hr ambulance performance remained static at 771 (Feb 771, Mar 774).

The highlights from the improvement programme of work include the Transfer Lounge opening. Typical utilisation is of 100-120 pts per week, one third from ED and two thirds from wards supporting timely discharge and supporting patients to get to the right place for their care. The Clinical Prioritisation Framework led by Medical Director draft has been completed. The upcoming ED extension works are entering the final phase with a focus on the interim arrangements required to ensure safety and flow for the period between two phases completing.

The urgent and emergency care improvements are overseen by a weekly COO led Safety Flow meeting. In recognition of both internal and external escalation status of this service, since April the Chief Executive now chairs the Safety Flow meeting once a month.

Progress is tracked externally via a monthly WG led meeting on the improvements in the Grange ED.

Mental Health

Mental Health have stabilised the significant improvements to a number of areas and are maintaining the excellent progress in delivery of the national performance standards. Looking to the future and service sustainability, workshops to develop models for Inpatient Services with focus on Models of Recovery, Rehab and Maintenance are underway. The development of these models is reflective of the new Welsh Government Mental Health Strategy.

The improvement Programme of Work based on the principles of Quality Improvement has been established with a clear programme of work which is on track to deliver in 25/26:

- Inpatient (QPS) reviews completed for all wards;
- Baseline data capture for Enhanced Services;
- Engagement in the National Patient Safety Programme;
- Nursing Establishment Reviews completed;
- Establishment of the QI-nnovation Hive in November;
- Divisional Strategy workshops completed, delayed until September due to release of Welsh Government Mental Health and Wellbeing Strategy.

The improvements in Mental Health are overseen and tracked via the monthly Divisional Assurance Reviews.

<u>Update on National Escalation Status</u>

Progress against the national escalation requirements is tracked via Quarterly Escalation meetings with WG. The most recent meetings were on 5 March and then as part of the Joint Executive Team (JET) on 3 June. Following the meeting of 5 March, the following progress and issues were noted:

- The challenges faced in the Emergency Department over the Winter period and of particular note the calling of a Critical Incident due to those pressures;
- Progress with implementing Civica SMS in ED and the improvement to food provision and volunteer provision;
- The plans in place to improve Urgent and Emergency Care were noted including the recruitment to ED Consultants, the Transfer Lounge Development and the expansion to the ED planned for Summer;
- The ambition to de-escalate at the end of Summer were noted.

Other points noted were:

- The improving financial position including savings of circa £45m and a clear expectation of year end delivery;
- Improvements in operational delivery with respect to Mental Health and Planned Care;
- Progress with plan development was discussed and noted.

At the recent JET meeting delivery against the measurables was again noted as well as delivery of key "products" linked to de-escalation such as:

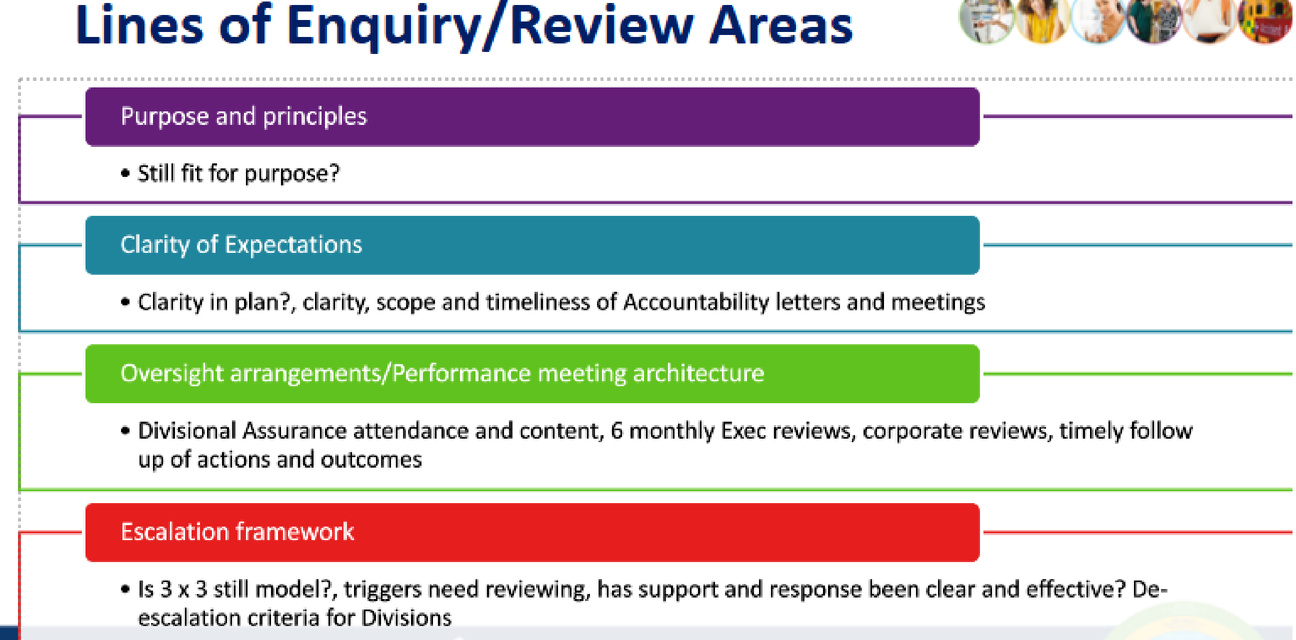
- Delivery of Three Year Route Map;
- Delivery of Hospital System/Grange report;
- Planning Maturity Matrix – exemplar across Wales;
- Delivery of a Board approved financially balanced plan;
- Strategy development and engagement work, again seen as an exemplar across Wales.

A letter post JET meeting has not yet been received. A national review of escalation levels is expected in the summer months.

PMF Review

The review of the PMF continues with a number of key "live" actions which are required to continue to the final update.

The review has focused on the following areas:



The review to date has been wide in scope to include a range of views and experiences of the first iteration of the Framework:

- A desk top review of evidence;
- Executive Time Out Session;
- Cross Divisional Time Out session;
- Time at Divisional Management Meetings.

A survey is currently live in the organisation seeking additional views a Workshop Session planned with Committee Members for the 17th June 2025. In addition, an Internal Audit into the PMF is close to being finalised.

Feedback on the work so far:

Desk Top review of Evidence

The Review of Actions has shown that the arrangements required to implement the Performance Management Framework have mostly been met in line with the expectations which included:

- Accountability letters for Executive Directors;
- Accountability letters for all Divisions, alongside the same model;
- The Planning Cycle to be more explicit about delivery expectations alongside clear milestones and clarity on delivery mechanisms.;
- In year review of the structured Quarterly Outcomes Report strengthened reporting and performance reviews;
- Review of Escalation Status at the 6-month Assurance Review;
- Desktop Review;
- Full assessment and mitigation of these risks will be assessed after the feedback review is completed.

There is corporate support for the implementation from the Planning Team, which has been further strengthened in 2024 by the development of the Performance function.

From the assessment to date, it is noted improvement is required in the following areas:

- Timeliness of the Accountability Letters;
- Assurance processes in place for Corporate Departments;
- A review of the length of Assurance meetings.;
- Assessment of the workload against the timeline of certain Executives to implement and agree the Accountability Conditions, notably the COO.

Executive Time Out Session

An Executive Time Out Session was held covering all aspects of implementing the Framework. The following recommendations were made as a result of the session:

- Quality Measures to be reviewed for assurance and escalation.
- Extra escalation domain to be added for Leadership and Governance;
- Triggers for escalation and de-escalation to be reviewed and updated;
- Clarity on roles and responsibilities at all levels to be reviewed;
- Quarterly reviews to be removed – Operational Divisional Assurance to be continued monthly with an escalation review in 6th month with Execs joining Divisional Assurance.

Cross Divisional Time Out Session and Time at Divisional Management Meetings

A further timeout session was held at Cross divisional and individual Team Management Meetings which resulted in the following recommendations:

- Emphasised the need for consistency, clarity, and support in its implementation, and the importance of addressing barriers to accountability;
- Support provided by Business Partners in Finance, Planning, and HR, highlighting the challenges of limited capacity and the need for better integration and support for Divisions;
- A need for clear criteria for escalation and de-escalation in the escalation framework, as well as sufficient support for divisions in understanding and managing the process;

- The QPS metrics are not clearly defined enough, the levels need to be defined clearly in terms of trigger points, current definitions make it difficult to have a consistent approach;
- Schemes approved that are not funded, Divisions should not fall into accountability with financial elements of the PMF and further flexibility is needed in this area;
- Many areas of reporting can support information flow for accountability but are parallel processes to Divisional accountability process e.g. Quality and the Health and Safety agenda these should look to be streamlined;
- It is helpful to have a structured approach. Performance is often concentrated on particular areas, and it is difficult to maintain approach across the board due to firefighting/ministerial priorities;
- Underperformance in some areas is related to shift of resources to other areas;
- Improving ownership and transparency of performance is essential and while offered in framework as "additional local measures", this could be incorporated into the accountability letters so a formal approach in the Directorate's response.

The feedback and opportunities identified to date in the review will be triangulated with feedback from the live survey, the Internal Audit report and the session with Committee Members and a draft brought back to the next Committee at the end of July.

Argymhelliad / Recommendation

The Finance and Performance Committee are asked to:

- **NOTE** the update on the current internal escalation status levels and intent to review these post the End of Year reviews which are running through to end of July;
- **NOTE** the update regarding the Health Board's national escalation;
- **NOTE** the update on the progress of the PMF review and next steps.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply All Health & Care Standards Apply Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Appendix 1 – De-escalation Criteria

DESCALATION CRITERIA - Planning
1. Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
2. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.
3. Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix.
4. Progress made with regional planning.
5. Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities.

DESCALATION CRITERIA – Finance
1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

DESCALATION CRITERIA - Urgent and Emergency Care (Grange University Hospital)
1. A three-month continuous reduction of at least 15% in each month from the Oct-Dec 2023 baseline) for ambulance handovers over an hour.
2. Continuous improvement towards no more than 5% of patients waiting over 12 hours at each individual site and across the health board.
3. 100% of patients to be assessed by senior clinical decision maker within 60 mins from arrival.
4. Consistent reduction in delayed pathways of care (target to be agreed).
5. Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to urgent and emergency care.
6. Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.
7. Evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.
8. The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 June 2025
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Performance Report – June 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant for Director Planning and Performance Paul Steynor, Head of System Planning & Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For AssuranceEr Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Finance and Performance Committee with an overview of operational performance against the 25/26 IMTP Key Performance Metrics. Performance Metrics have been updated to reflect the latest, validated position. Due to the differing nature of the frequency of reporting for each measure, some positions remain as of 24/25, whereas those where more timely, validated data is available are reporting against April or May. The full Performance Report details performance against the Ministerial Delivery Expectations, and IMTP measures across the five system change priorities, with the exception of the below:

Prevention & Pop Health

- % uptake of the COVID-19 vaccination for those eligible Spring Booster (due Q2);
- Percentage of adult smokers who make a quit attempt via smoking cessation services (due mid-June);
- Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks (due mid- June).

Primary & Community Care:

- Increase in capacity at the weekend of Community Nursing and Specialist Palliative Care Nursing to at least the required levels previously set for 2024/25 (due mid-June).

Planned Care & Cancer

- Deliver improvements in Day Surgery rates, achieving a BADS Day case rate (exploring whether this is reportable quarterly or annually).

The Committee is asked to:

- **NOTE** the performance of the Health Board, as of the latest reporting periods.

Cefndir / Background

The Q4 Performance Report was presented to the Board in May 2025, setting out progress against the 24/25 Annual Plan performance ambitions, including the Ministerial Delivery Expectations and updates against the key deliverables under each of the five priority areas:

1. Embedding Prevention and Population Health in all that we do;
2. Improving patient experience and timeliness of care in our Urgent and Emergency Care System, focusing on access and Discharge Pathways;
3. Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care;
4. Progressing our Place-Based Models of Care in Primary and Community Services;
5. Improving our Mental Health Services.

This report provides the 25/26 IMTP performance measures including the Ministerial Delivery Expectations, with data as of the latest, reportable positions against the system priority areas above.

Asesiad / Assessment

1. Ministerial Delivery Expectations

Of the 17 Cabinet Secretary priorities, 10 are meeting/exceeding agreed trajectories, 3 are borderline, and the remaining 4 are yet to be reportable/have reportable positions in 25/26. Full performance against trajectories is detailed in the main report, however updates of significance are:

- Pathway of Care Delays: An increase in the May census from the April position puts performance as borderline, but days delayed continues to decrease and the reduction over the past few months has been a success story.
- Urgent and Emergency Care (UEC) Metrics (>1hr ambulance handover and >12hrs in EDMIU): Very positive start to the year with both measures meeting their trajectories as of May and achieving recent historical lows.

- Planned Care (104 weeks): Following delivery of 288 position at year end, focus has turned to Q1 delivery following funding across ENT, T&O and Ophthalmology. The aim is to maintain position by the end of the quarter, with a risk of 345 breaches. As of April RTT submission, performance is on track to deliver against this Q1 risk position and is ahead of IMTP trajectory.
- Cancer & Diagnostics (SCP compliance and >8 week waits): SCP compliance ended the year strongly with two year high of 67.5%. April performance decreased slightly to 65.3%, marginally below a Q1 trajectory of 67% although continuing overall improvement trajectory observed since the beginning on 24/25 and the second highest performance in this period. Diagnostics also tracking marginally above IMTP trajectory which was a hold position of 1,077, at 1,225.
- Mental Health Parts 1A and 1B (Assessments and interventions) across both CAMHS and Adults: Significant improvement delivered and sustained, with both now meeting the national standard across all 4 measures.
- 24/25 outstanding Ministerial Expectations for Primary Care (GMS core standard and GDS contract value): confirmation received that 100% of practices have achieved core access standards. GDS contract was 62% at the end of Q2, final year end reporting will be available in July. GMS core access remains a Ministerial Delivery Expectation for 25/26 but GDS is no longer included.

2. Performance against System Change Themes

The full Performance Report metrics and analysis performance and narrative for all Annual Plan measures across the five system change themes. A summary is provided below:

Embedding Prevention and Population Health in all that we do

6 measures in reporting period: 1 reporting in year and meeting trajectory, 5 not yet reporting in year (latest performance would be 4 meeting trajectory and 1 off track).

The only measure reporting in period is the new Ministerial Delivery Expectation of patients with diabetes receiving all 8 NICE recommended care processes and is meeting IMTP trajectory as of April 25.

Progressing Place Based Models of Care and sustainability in Primary and Community Services

7 measures in reporting period: 3 reporting in year and meeting trajectory, 1 reporting in year and borderline, 1 reporting in year and off track, 2 not yet reporting in year (latest performance would be borderline and the other not measurable against IMTP with no data).

Ministerial Delivery Expectation of the number of 'Pharmacist Independent Prescribing Service' (PIPS) Consultations has started strongly indicating ability to meet Q1 trajectory. Common Ailment scheme claims and the proportion of over 65-year-old being referred to Rapid Response Services are also on track. Risk to highlight is the measure for the number of patients accessing urgent Emergency Dental Services which, based on M1 performance, is already challenged to meet Q1 trajectory.

Improving our Urgent and Emergency care System focusing on experience, access and discharge pathways

14 measures in reporting period: 7 reporting in year and on track, 4 reporting in year and borderline, 3 not yet reporting in year.

As already highlighted in the Ministerial Delivery Expectations, there has been encouraging improvement in the first two months of the year with 50% of measures on track and zero off track. All Ambulance and ED/EDMIU measures are either close to or exceeding their targets, with performance for certain measures having been the best for several years. The Stroke measures are due to be reported for Q4 24/25 by the end of the current quarter.

Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care

17 measures in reporting period: 10 reporting in year and on track, 4 reporting in year and borderline, 3 reporting in year and off track

104, diagnostics, and SCP update as per above in Ministerial Delivery Expectations. Cancer backlogs were significantly reduced through 24/25 and remain stable and as a target proportion of the PTL. 28-day decision to treat performance has been excellent and is meeting trajectory. Further work required to improve rates of SOS/PIFU, to begin to decrease the volume of patients waiting 100% past target for follow up, and to improve DNA rates. Enabling actions as part of Theatres work is ongoing.

Improving our Mental health services

9 measures in reporting period: 7 meeting trajectory, 2 off track.

Excellent performance across the majority of adult MHLD and CAHMS. ND assessment performance has increased following investment and now meeting the national standard and the only Health Board to do so. Parts 1a & 1b are all meeting the national standards across both adults and young people following successful delivery of substantial improvement. Divisional (MHLD) focus moves to improving performance for adult access to Psychological Therapies.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the performance of the Health Board as of the latest, validated reportable positions.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. All IMTP Priorities Apply
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staffImprove the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worseImprove patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability servicesImprove the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

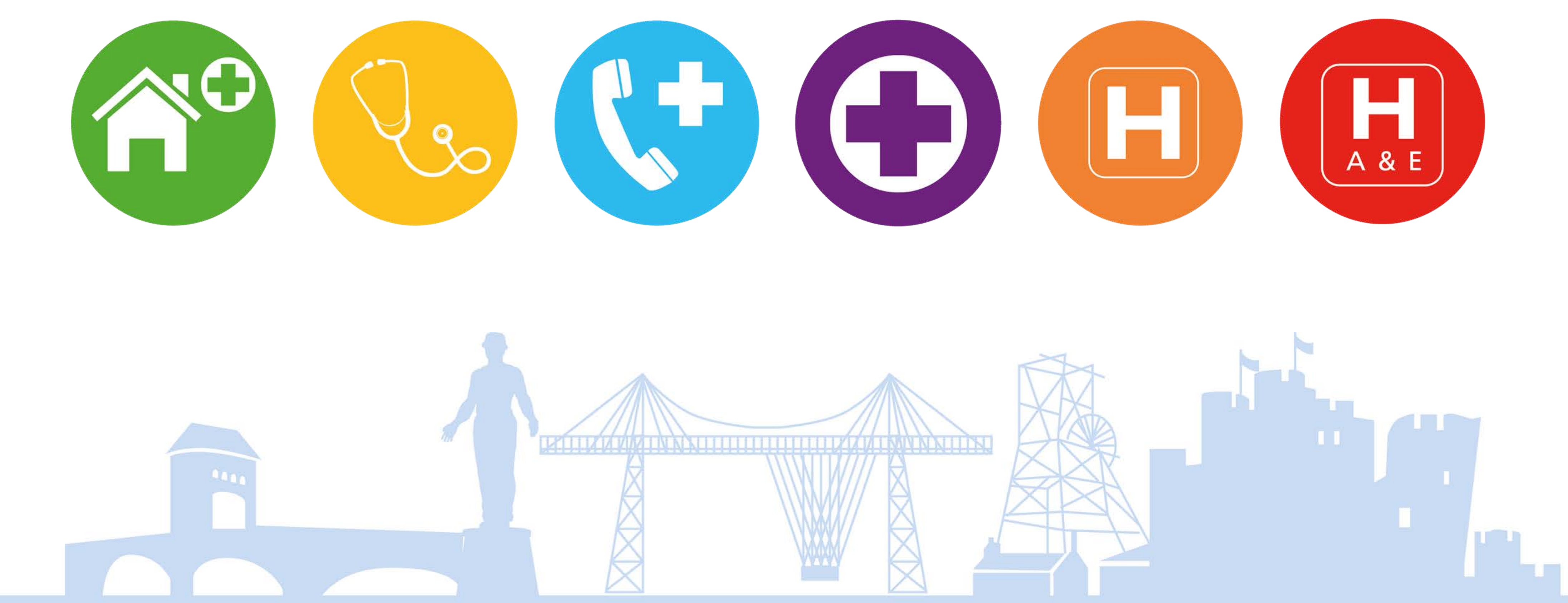
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)

Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirementsNo does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not ApplicableNot Applicable Choose an item.

Finance & Performance Committee: Performance Report

June 2025



CONTENTS

Performance Summary

Section 1: Ministerial Delivery Expectations

Section 2: Our Performance & System Change Delivery

PERFORMANCE SUMMARY

What went well this period?

- Urgent and Emergency care measures have started the year positively, with key performance measures linked to WG de-escalation criteria (>1hr ambulances, >12EDMIU, and Clinician median wait) all having reported recent historic lows.
- Performance across Ministerial Delivery Expectations for Mental Health (Parts 1a and 1b for both adults and CAMHS), having delivered significant improvement through the latter part of 24/25, continues to exceed the national standard. Neurodevelopmental assessments for people aged 0-18 has also seen a sharp increase in compliance and has now met the national standard of 80% for two consecutive months and is the only Health Board to achieve this.
- Delivery against Q1 104wk plans remains on track as of April RTT submission, working to a risk position of 345 at the end of the quarter.

What were the challenges this period?

- There has been an increase in the number of adults admitted as an emergency who remain in a bed for more than 21 days, which is impacting on system flow and is reflected in the increase in POCDs from April to May. However, POCDs by days delayed continues to reduce which is reflective of the work operationalised through the Integrated Discharge Board.
- In Mental Health, performance for the 26 week wait standard for psychological therapies has remained broadly static and someway short of the national standard. This will be the next area of improvement focus following delivery of improvements across Part 1.
- The M1 position for the number of patients accessing urgent and emergency dental position is significantly lower than forecast, presenting a risk to delivery of Q1 trajectory.

What actions are we taking to improve?

- Whole system safety flow meetings in place on a weekly basis to address continued front door pressures to support Urgent and Emergency Care performance improvements.
- Expanded Discharge Lounge opened at GUH and a Senior Nurse for Discharge appointed.
- Cross divisional planning underway for interim front door model to mitigate disruption caused by expansion work.
- F&T are undertaking comprehensive demand and capacity work across CAMHS and ND.
- Work is ongoing to improve diagnostics sustainability through increased capacity and regional opportunities.

What are our risks to delivery?

- Maintaining delivery to target for 104 week+ through Q1.
- Implications of emerging 26wk OP funding on other parts of the pathway (e.g. diagnostics and treatments) and the resources and capacity required to not simply shift the problem further down the line.
- Maintaining improvements in UEC metrics through the summer period with the impact of the ED Extension Project between two Phases.
- Tracking against additional, emerging, performance measures (e.g. enabling actions for 6 goals, MAG recommendations etc) that differ from performance framework and Ministerial Delivery Expectations that were planned against through IMTP process.

Section 1: Ministerial Delivery Expectations

The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Prevention and Population Health, with a focus on vaccinations and diabetes;
- Building Community Capacity, with a focus on reducing delayed pathways of care and improving access and shifting resources into Primary and Community Care;
- Timely Access to Care, with a focus on delivery of the 6 Goals Programme to make improvement in Urgent and Emergency Care, as well as delivering against key targets within Cancer & Planned Care;
- Mental Health, including CAMHS, with a focus on delivery of the national programme, and;
- Women's Health, by establishing a Women's Health Hub by the end of 25/26.

Further to these priority areas the Welsh Government and NHS Wales have identified 17 Key Performance Indicators across Primary and Community Services, Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas. For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Ministerial Delivery Expectations

Priority	Aim	ABUHB commitment	Ability to meet national standard?	In month performance against trajectory
Population Health & Prevention	**Measure:** % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes **National standard/ambition:** 12 month increasing trend **Reporting period:** Monthly	**44%** Jun-25 **47%** Mar-26	Yes	**44.1%** Apr-25 (Q1 Trajectory: 44%)
	Measure: Achievement of the 5 Vaccinations targets in the Performance Framework **National standard/ambition:** Various **Reporting period:** Quarterly/seasonally	**Yes** Mar-26	Yes	**First reported Q2**
Building Community Capacity	**Measure:** Number of Pathway of Care Delays **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	**190** Jun-25 **160** Mar-26	Yes	**208** May-25 (Trajectory: 200)
	Measure: General Medical Services (GMS) – Number of GP Practices achieving core access standards **National standard/ambition:** 100% **Reporting period:** Annual – in month position for information	**100%** Mar-26	Yes	**Reported Q4**
	Measure: Number of people accessing Pharmacist Independent Prescribing Service for Acute Minor conditions and routine Contraception Services, where the patient reports they would have otherwise visited their GP **National standard/ambition:** 12 month increasing trend **Reporting period:** Monthly	**4,820** Jun-25 **24,065** Mar-26	Yes	**2,550** Apr-25 (Q1 Trajectory: 4,820)
	Measure: Capacity at the weekend of Community Nursing and Specialist Palliative Care Nursing **National standard/ambition:** 12 month increasing trend **Reporting period:** Monthly	**31,217** Jun-25 **128,347** Mar-26	Yes	**Awaiting April data**
	Measure: Capacity of Enhanced Community Care **National standard/ambition:** 12 month increasing trend **Reporting period:** Monthly	**1,245** Jun-25		**393** Apr-25 (Q1 Trajectory: 1,245)

		5,277 Mar-26		
Timely Access to Care	**Measure:** Number of Ambulance patient handovers over 1 hour **National standard/ambition:** Zero **Reporting period:** Monthly	**621** Jun-25 **500** Mar-26	**No**	**664** May-25 (Trajectory: 716)
	Measure: Number of patients who spend 12 hours or more in all Major and Minor Emergency Care Facilities from arrival until admission, transfer or discharge **National standard/ambition:** 12 month ecreasing trend, building towards a target of zero **Reporting period:** Monthly	**1,101** Jun-25 **750** Mar-26	**Yes**	**1,124** May-25 (Trajectory: 1,301)
	Measure: Number of patients waiting more than 104 weeks for referral to treatment **National standard/ambition:** Zero **Reporting period:** Monthly	**966** Jun-25 **3,291** Mar-26	**No**	**326** Apr-25 (IMTP Trajectory: 450) (Q1 Trajectory: 340)
	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) **National standard/ambition:** 12 month improvement trend, building to 80% by March 2026 **Reporting period:** Monthly	**67%** Jun-25 **70%** Mar-26	**No**	**65.3%** Apr-25 (Q1 Trajectory: 67%)
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard ambition**: Zero **Reporting period:** Monthly	**1,077** Jun-25 **1,077** Mar-26	**No**	**1,225** Apr-25 (Trajectory: 1,077)
Mental Health, including CAMHS	**Measure:** CAMHS 1a: percentage of assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	**80%** Jun-25 **80%** Mar-26	**Yes**	**82.4%** Apr-25 (Trajectory: 80%)

	Measure: Adults 1a: percentage of assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	**80%** Jun-25 **80%** Mar-26	**Yes**	**92.6%** Apr-25 (Trajectory: 80%)
	Measure: CAMHS 1b: percentage of Therapeutic Interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years **National standard/ambition:** 80% **Reporting period:** Monthly	**80%** Jun-25 **80%** Mar-26	**Yes**	**82.7%** Apr-25 (Trajectory: 80%)
	Measure: Adults 1b: percentage of Therapeutic Interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over **National standard/ambition:** 80% **Reporting period:** Monthly	**80%** Jun-25 **80%** Mar-26	**Yes**	**84.5%** Apr-25 (Trajectory: 80%)
Women's Health	**Measure:** Establishment of one Women's Health Hub in each Health Board area by March 2026 (aligned to the Women's Health Plan) **National standard/ambition:** Establishment **Reporting period:** Annually	**Yes** Mar-25	**Yes**	**Reported Q4**

Section 2: Our Performance and System Change

The Performance Report section provides detail of Health Board performance across the 5 system change themes identified in the Integrated Medium-Term Plan 2025/26:

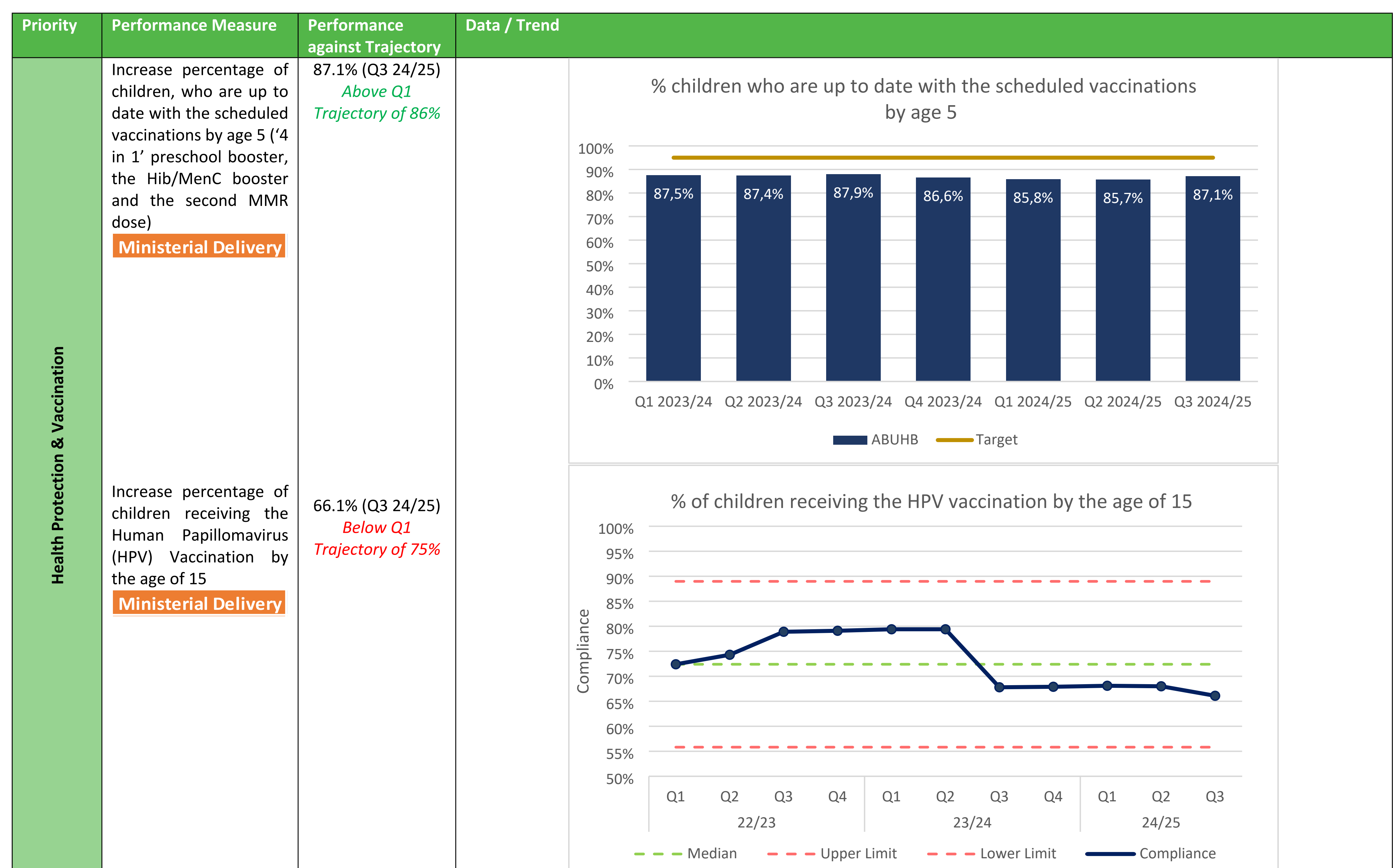
- Embedding **Prevention** and Population Health in all that we do;
- Progressing place based models of care and sustainability in **Primary and Community Services;**
- Improving our **Urgent and Emergency Care System** focusing on experience, access and discharge pathways;
- Continuing to prioritise **Cancer, Urgent and the longest waiting patients for Planned Care;**
- Improving our **Mental Health Services**;

A summary of performance is provided under each theme against the Health Board's priorities and corresponding performance ambitions, including detail of Annual Plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

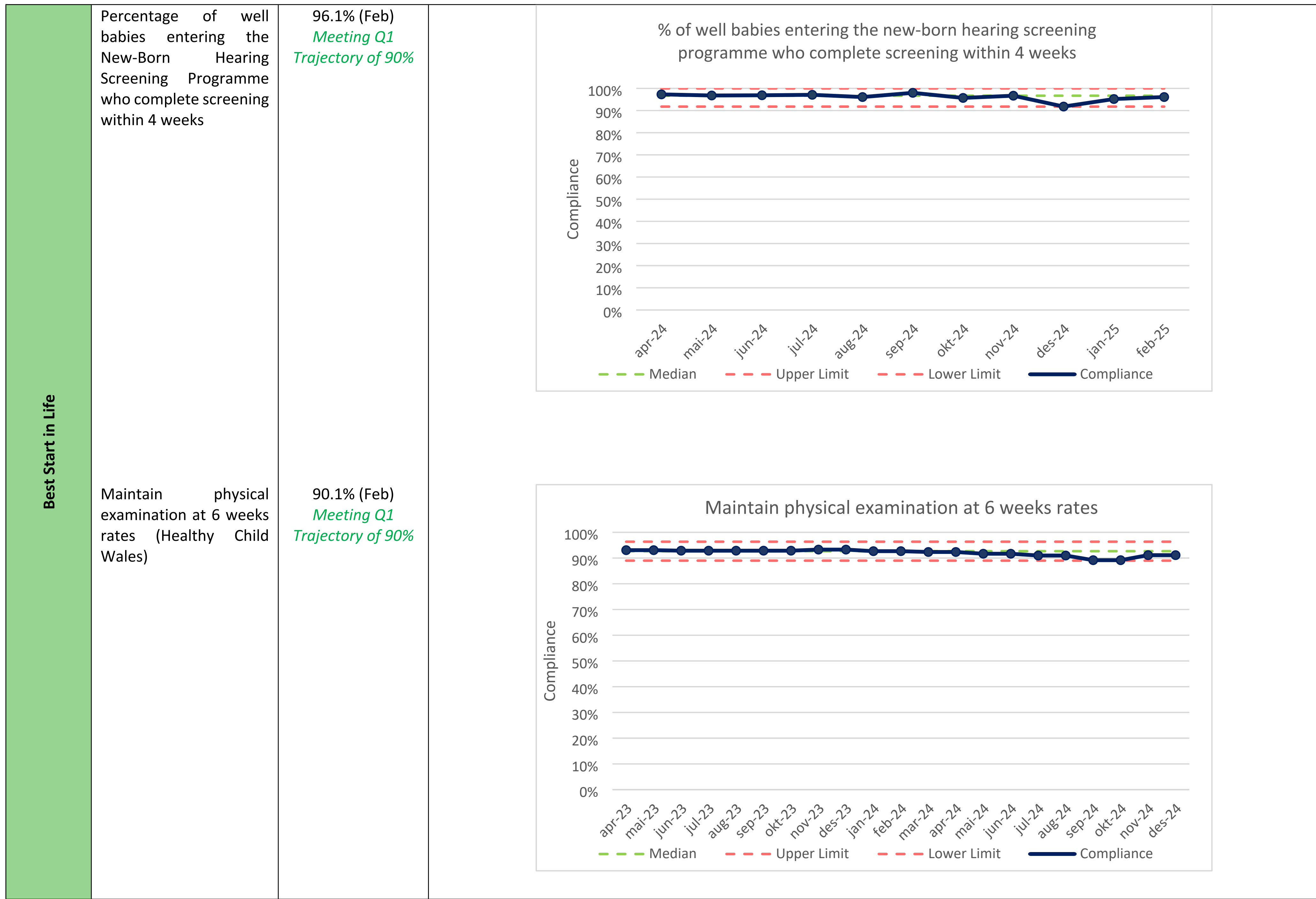
Quadruple Aim 1	Embedding **Prevention** and Population Health in all that we do

KEY MESSAGES & ACTIONS:

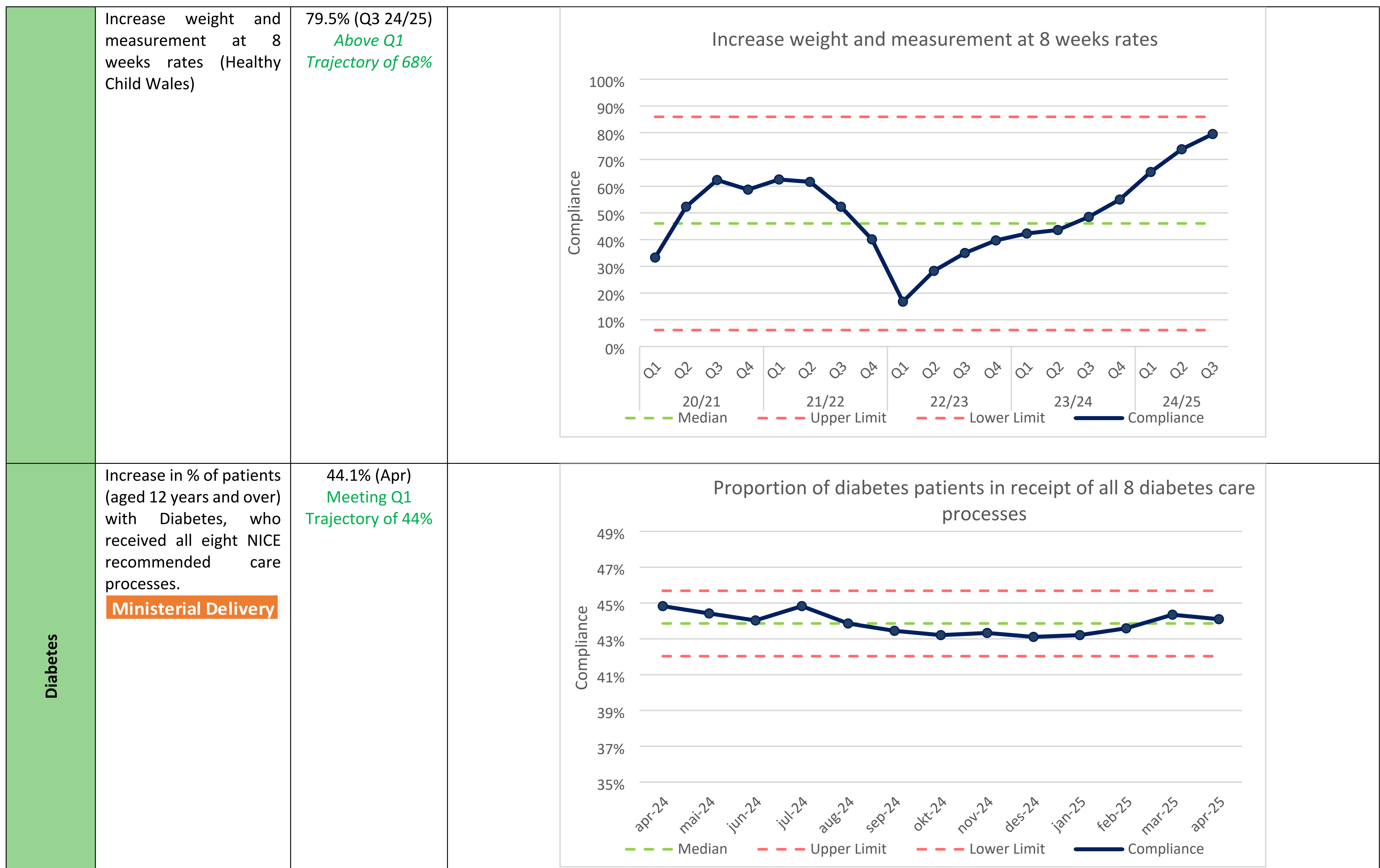
- The majority of performance measures within this theme are subject to a lag with reporting, and thus there are minimal updates from previously communicated positions. The annual report covering the two children and young people vaccinations (up-to-date by age 5, and HPV by 15) is due to be published at the end of Q1, with 25/26 reporting then being published quarterly in arrears. The other three vaccination targets which form part of the consolidated Ministerial Delivery Expectation are seasonal, with the spring COVID booster ongoing and reportable at the end of Q2, with the autumn COVID booster and winter influenza performance measures reported at the end of Q4.
- The Health Child Wales (HCW) measures for rates of physical examination at 6 weeks, and weight and measurements at 8 weeks are also still reporting against 24/25, however the latest position for the latter has improved again to 79.5% (Q3 24/25) which is a historical high and marginally below our 25/26 IMTP trajectory of 80%. An additional measure of the percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks is also included within our IMTP for 25/26, however we are yet to report against this for this in 25/26.
- A new measure within this theme and also a Ministerial Delivery Expectation is to deliver an increase in percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. Performance over the past 13 months has been within a relatively tight range (<2%) with an annual trajectory to increase by 3% through the course of the year from the current performance of 44%.
- There are several actions underway to support the delivery of the IMTP for this quarter. In relation to vaccinations, a plan has been developed for the seasonal respiratory vaccinations campaign including roll out for 2 & 3 year olds, Care Homes, pregnant women and older adults.
- The Public Health team are working in partnership with NCNs to identify eligible cohorts for Diabetes Prevention and establish a Hypertension Case Finding Service, and continue with 12-month follow up clinics to repeat the HbA1c test with people who received interventions in Blaenau Gwent and Caerphilly.



Priority	Performance Measure	Performance against Trajectory	Data / Trend
Health Protection & Vaccination	Increase percentage of children, who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose) **Ministerial Delivery**	87.1% (Q3 24/25) *Above Q1 Trajectory of 86%*	
	Increase percentage of children receiving the Human Papillomavirus (HPV) Vaccination by the age of 15 **Ministerial Delivery**	66.1% (Q3 24/25) *Below Q1 Trajectory of 75%*	



Best Start in Life	Percentage of well babies entering the New-Born Hearing Screening Programme who complete screening within 4 weeks	96.1% (Feb) *Meeting Q1 Trajectory of 90%*	
	Maintain physical examination at 6 weeks rates (Healthy Child Wales)	90.1% (Feb) *Meeting Q1 Trajectory of 90%*	

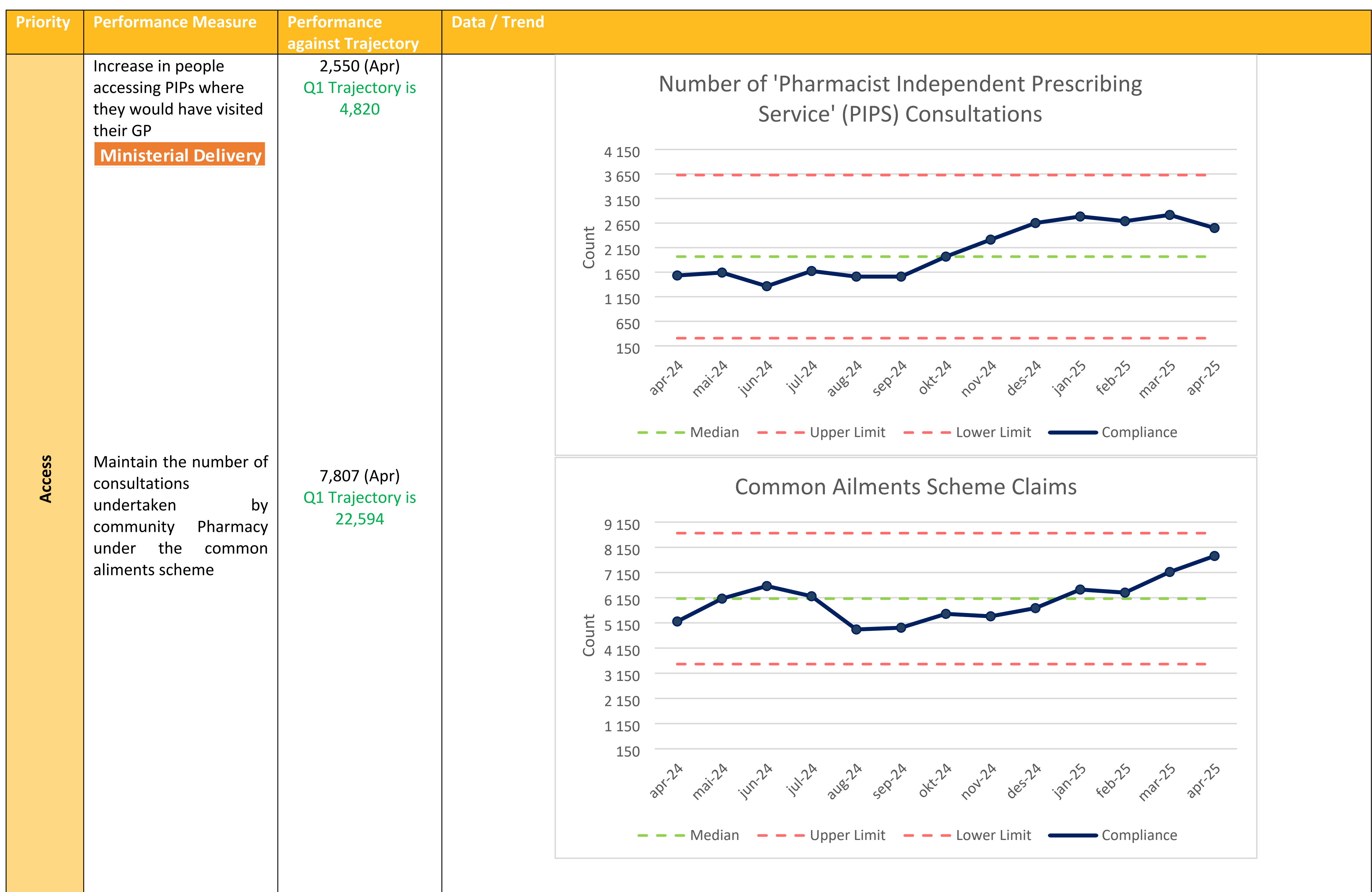


	Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	79.5% (Q3 24/25) *Above Q1 Trajectory of 68%*	
Diabetes	Increase in % of patients (aged 12 years and over) with Diabetes, who received all eight NICE recommended care processes. **Ministerial Delivery**	44.1% (Apr) Meeting Q1 Trajectory of 44%	

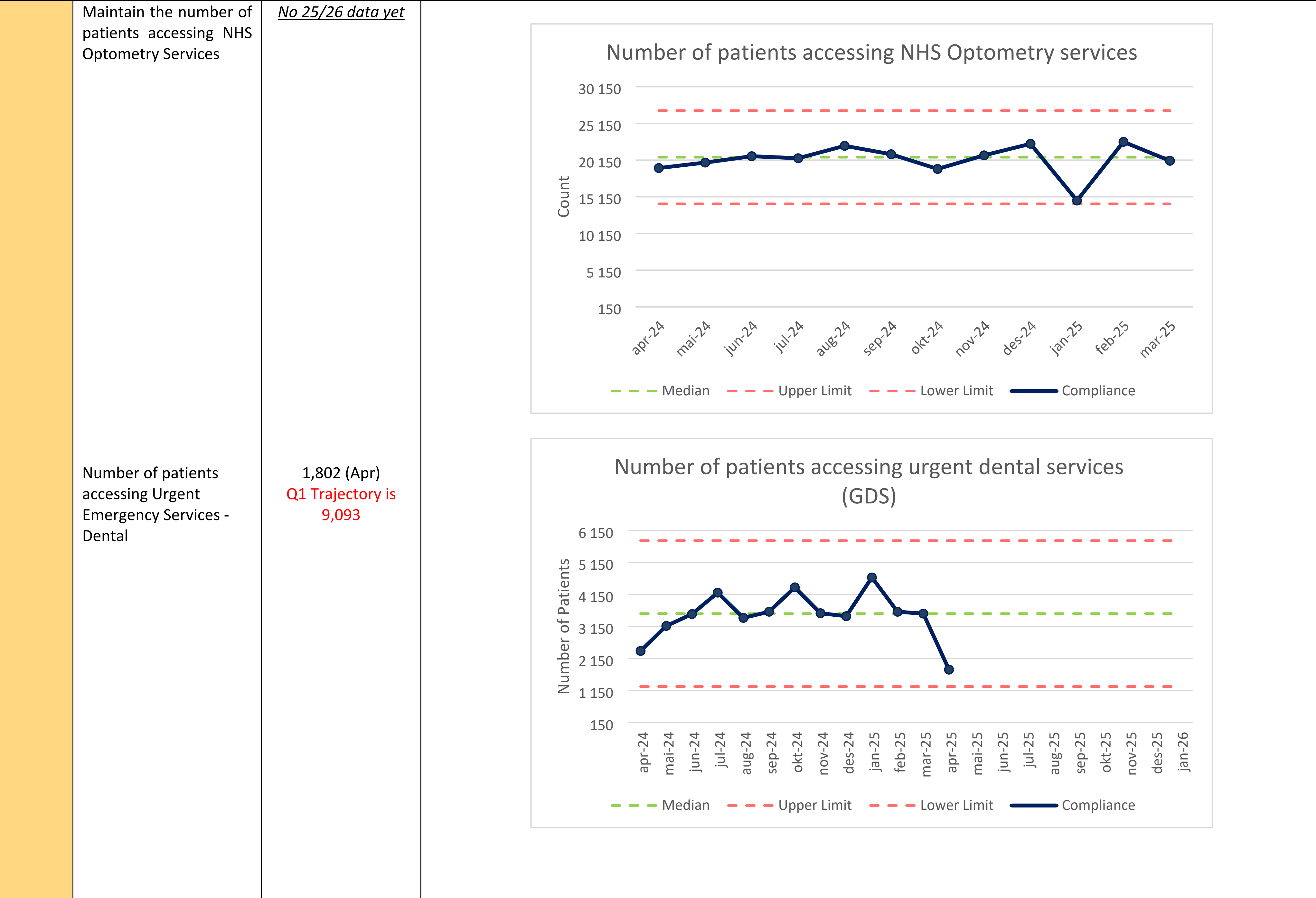
Quadruple Aim 2	Progressing place based models of care and sustainability in **primary and community services**

KEY MESSAGES & ACTIONS:

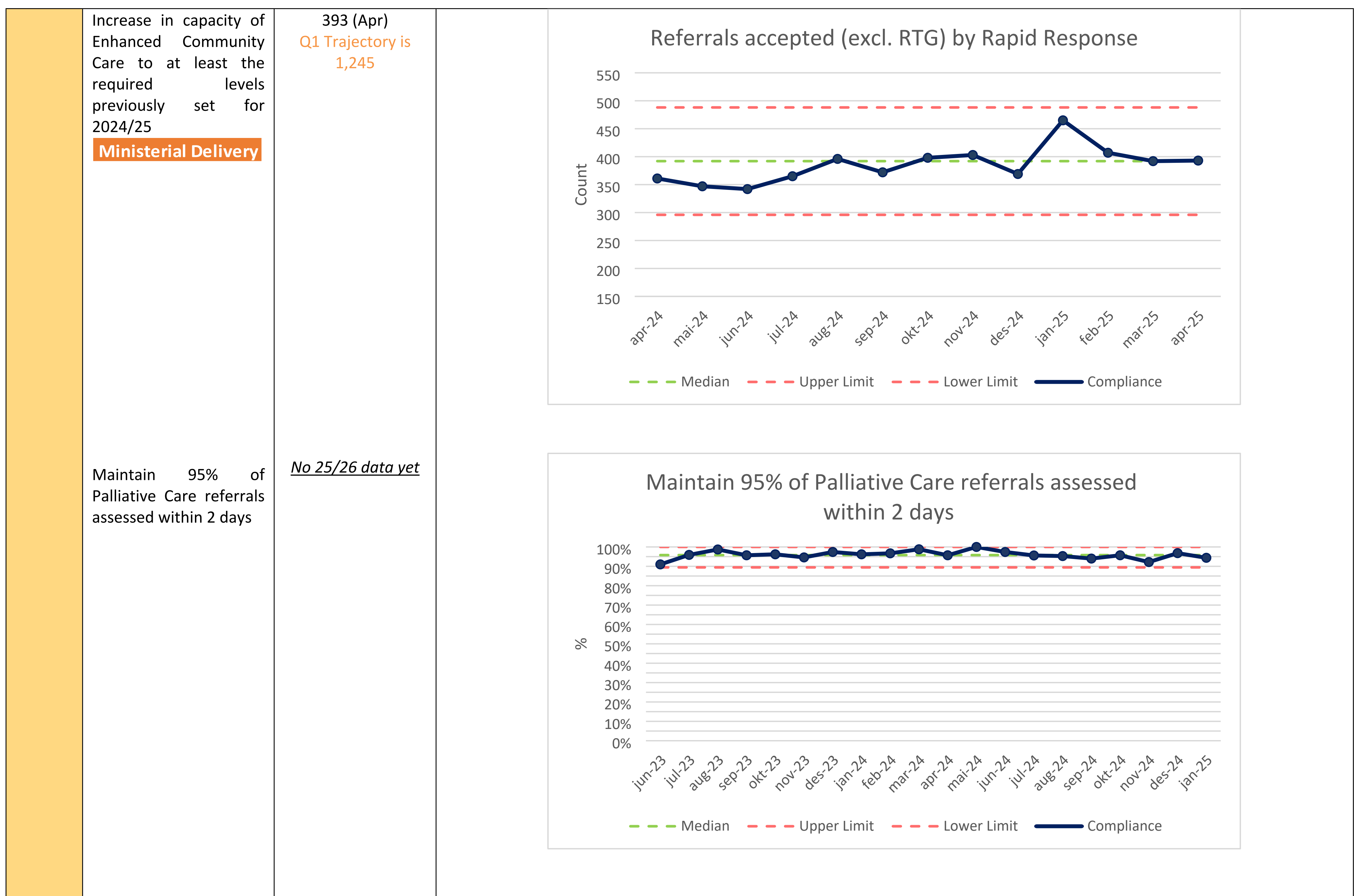
- 5 measures are currently reporting with updated data for 25/26. A new Ministerial Delivery Expectation within this theme is to increase the number of people accessing Pharmacy Independent Prescribing Service (PIPS) where they would otherwise have visited their GP, with good M1 performance leaving delivery on track to meet its Q1 ambition.
- Another new Ministerial Delivery Expectation is to increase capacity at the weekend of Community Nursing and Specialist Palliative Care Nursing to at least the required levels previously set for 2024/25, which the Health Board is reporting as referrals accepted by Rapid Response services at the weekend. M1 performance currently indicates on track to meet the Q1 ambition.
- The final Ministerial Delivery Expectation within this theme is to increase capacity at the weekend of Community Nursing and Specialist Palliative Care Nursing to at least the required levels previously set for 2024/25. A reportable position against this measure is expected in June.
- The number of patients accessing Urgent and Emergency Dental Services has reported a significantly low M1 figure which highlights a risk to delivery against trajectory, however the historical data shows a level of month-to-month fluctuation so the position may recover with normal seasonal variation.
- Actions underway under this theme in Q1 to support delivery, improvement and transformation include:
    - Confirmation of 24/25 Achievement of Access Standards
    - Investment into General Dental Services through Newport East Development
    - Support those with the necessary qualifications to deliver WGOS 4 and 5
    - Continue to embed the WG Optimal Hospital Flow Framework across all sites and a focus on the optimal hospital ward and assessment of implementation
    - Training on responsibilities of all parties and review of model aligned to integrated front door model



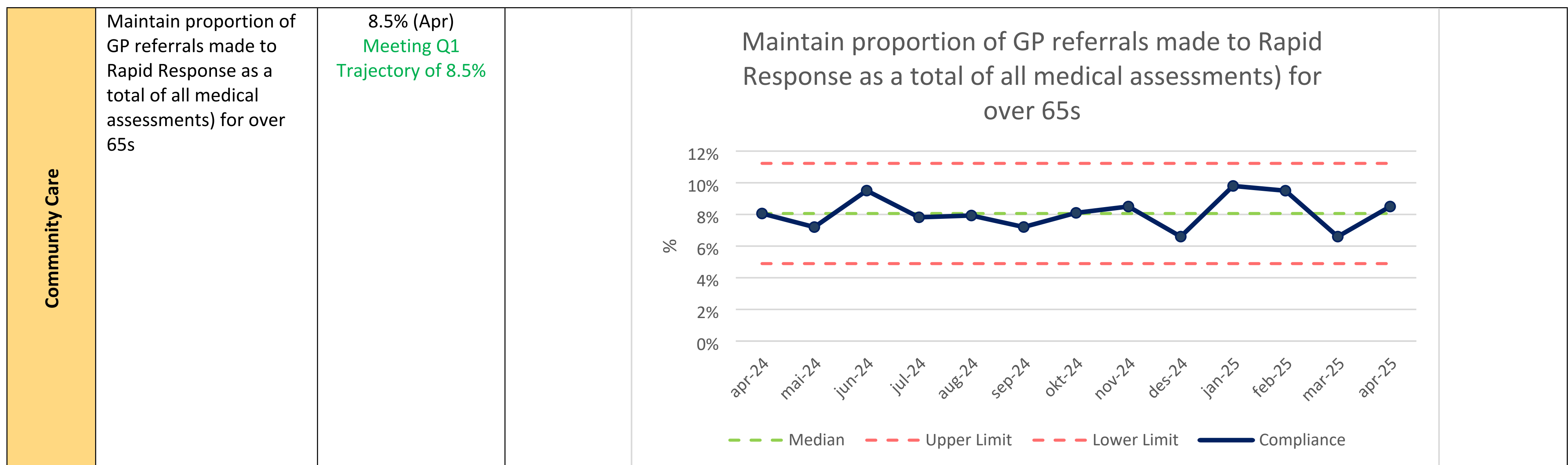
Priority	Performance Measure	Performance against Trajectory	Data / Trend
Access	Increase in people accessing PIPs where they would have visited their GP **Ministerial Delivery**	2,550 (Apr) Q1 Trajectory is 4,820	
	Maintain the number of consultations undertaken by community Pharmacy under the common aliments scheme	7,807 (Apr) Q1 Trajectory is 22,594	



	Measure	Data	Chart
	Maintain the number of patients accessing NHS Optometry Services	*No 25/26 data yet*	
	Number of patients accessing Urgent Emergency Services - Dental	1,802 (Apr) Q1 Trajectory is 9,093	



	Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25 **Ministerial Delivery**	393 (Apr) Q1 Trajectory is 1,245	
	Maintain 95% of Palliative Care referrals assessed within 2 days	*No 25/26 data yet*	

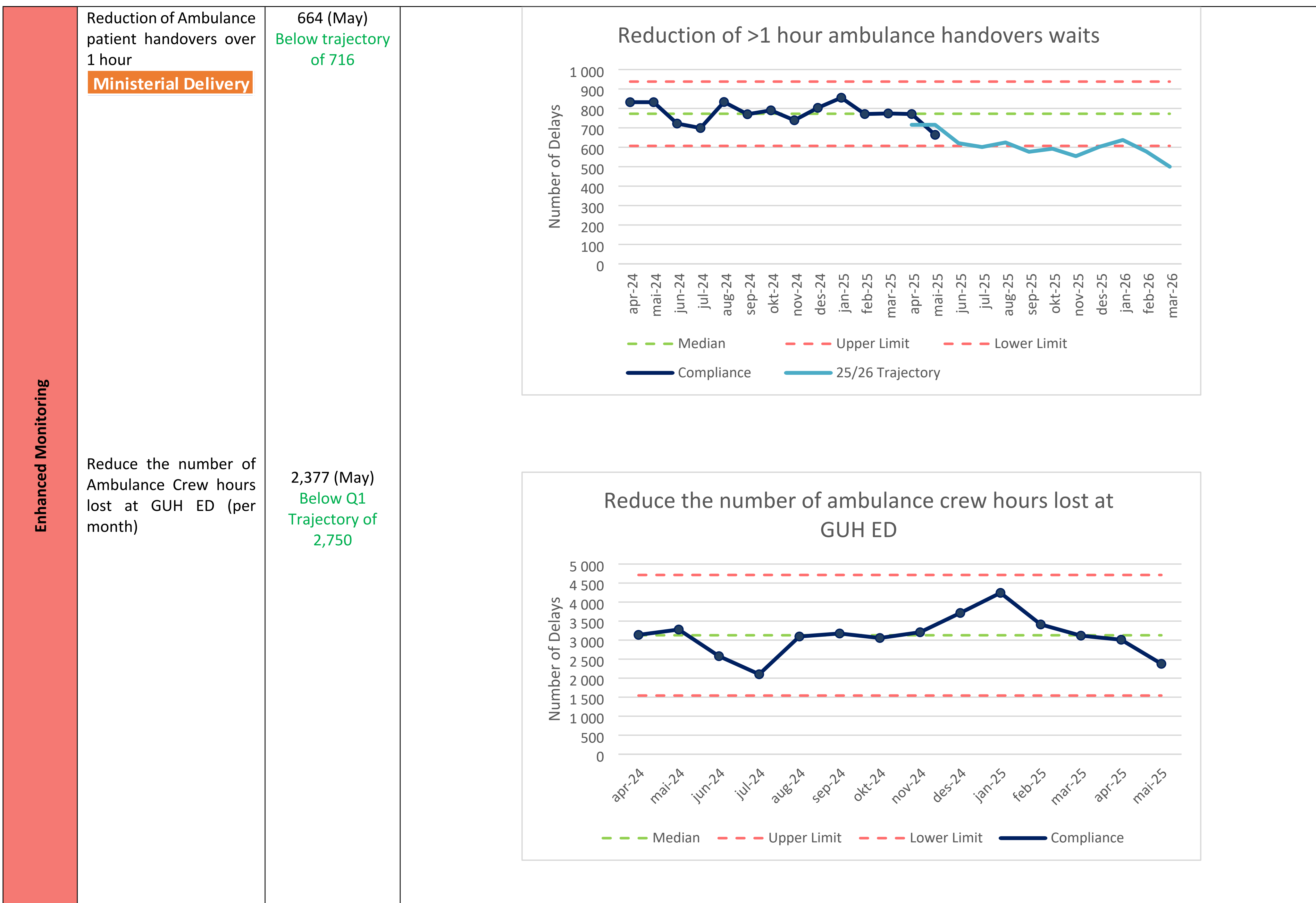
Community Care	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s	8.5% (Apr) Meeting Q1 Trajectory of 8.5%		

Quadruple Aim 2	Improving our **Urgent and Emergency care** system focusing on experience, access and discharge pathways

KEY MESSAGES & ACTIONS:

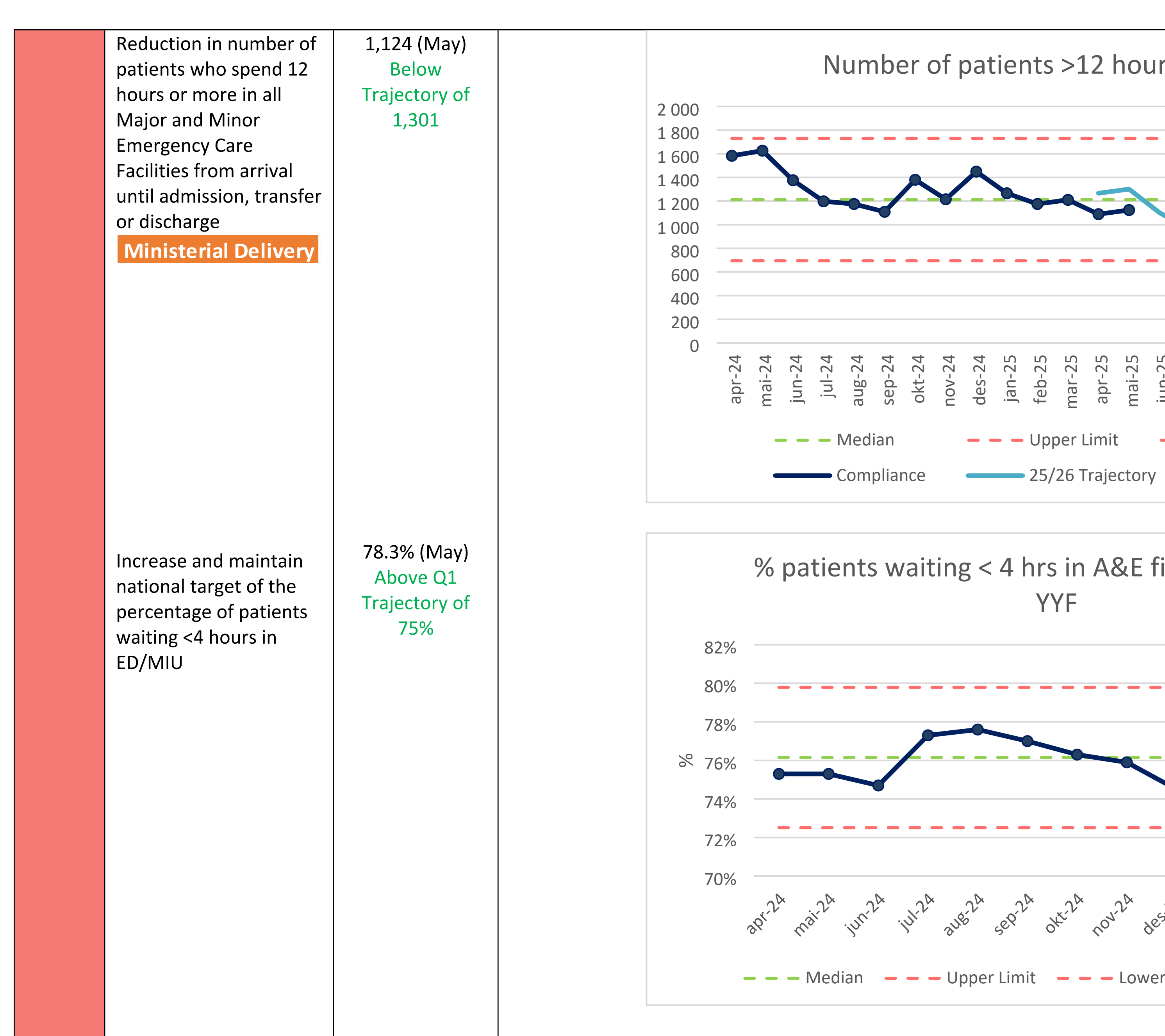
- 25/26 has begun with encouraging improvements seen within Urgent and Emergency Care, particularly in relation to the two key Ministerial Delivery Expectations of >1hr Ambulance delays at GUH ED and >12hr EDMIU breaches, and then additionally the median wait to Senior Clinical Decision Maker at GUH ED as these three form the main part of the Welsh Government de-escalation criteria.
- Having experienced a challenged winter period, we have seen improvement across all 3 measures over the first two months of 25/26. In May >1hr ambulance reduced to 664, which is the best performance since Feb 2021. The number of 12hr EDMIU breaches was 1,089 in April which is the lowest value recorded since May 2021 and in May, whilst total numbers increased slightly to 1,124, overall 12hr compliance was 93.2% under the EDMIU definition and 85.1% at GUH only; this is the best performance recorded since June 2021. Clinician Median Wait in April was 1h52m which was a also a recent record low, having not been bettered since April 2022. Performance for May broadly held, increasing by 3 mins.
- Pathway of Care Delays (POCDs) performance remains strong. Despite the increase seen from April (176) to May (208), we continue to observe the total number of days delayed reduce with current performance being almost half of that that we reported through Q2 and Q3 of last year.
- There are no updates to the three Stroke performance measures with Q4 24/25 due to be reported through SSNAP towards the end of Q1. Stroke Improvement Plan is in place bringing together the 53 recommendations from GIRFT, HIW and the Welsh Government, the workstreams include: imaging, staffing, rehab, prevention, patient flow, governance, education and training, community, acute stay, data capture and audit compliance.
- The Q1 actions underway within this theme include:
  - Monthly reviews of POCD across LA and HB, and bespoke, site-based meeting on a weekly basis;
  - Workshop defining the target operating model of a Navigation Hub;
  - Significant, cross divisional planning work in preparedness for phase 2 of the ED extension works which are being undertaken through the summer and will impact system operations, thus necessitating plans for an interim model.

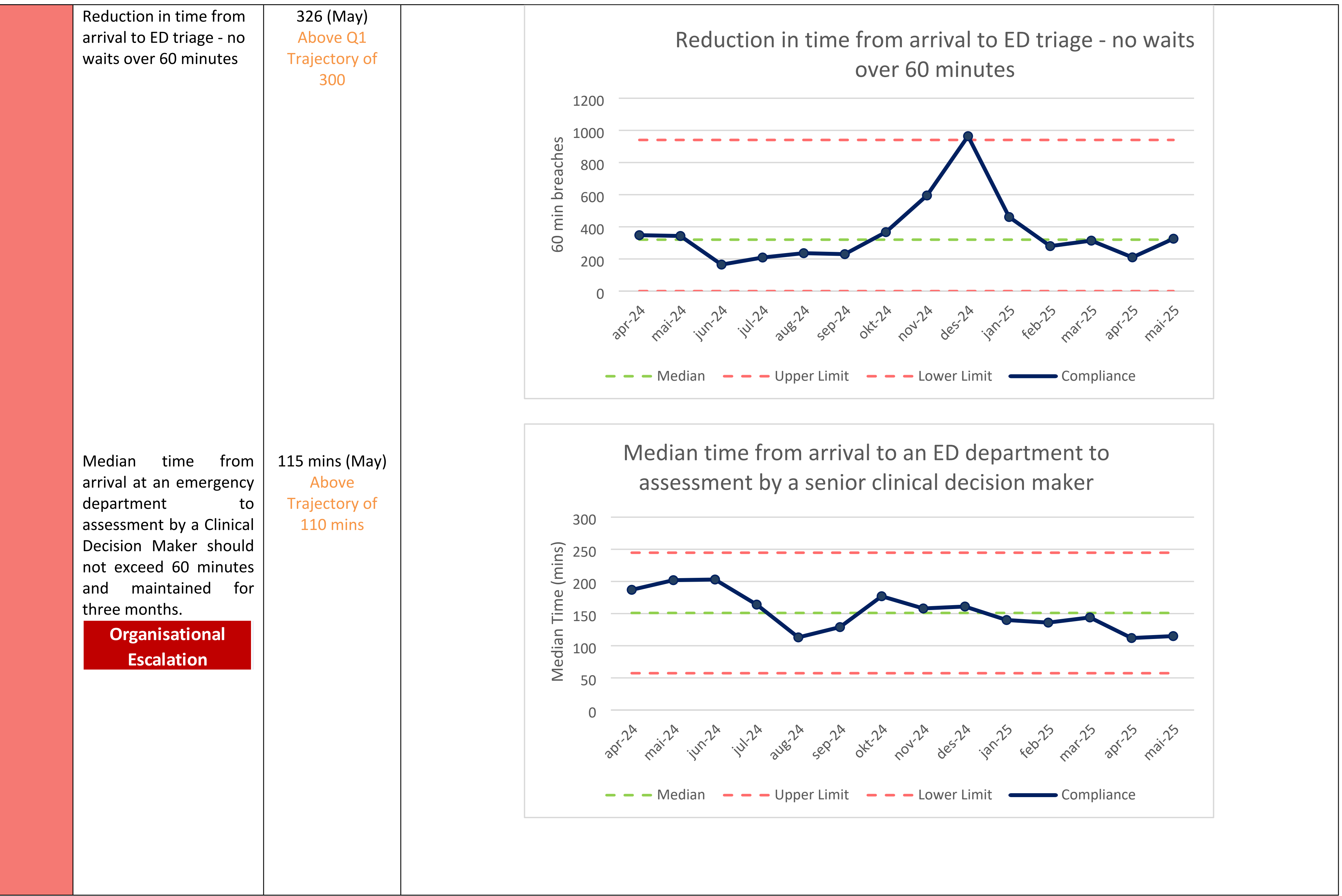
Priority	Performance Measure	Performance against Trajectory	Data / Trend
Urgent Primary Care	Maintain the number of Urgent Primary Care Contacts (inc. virtual)	8,512 (Apr) Q1 Trajectory is 22,923	Urgent Primary Care Cases - Total Contacts



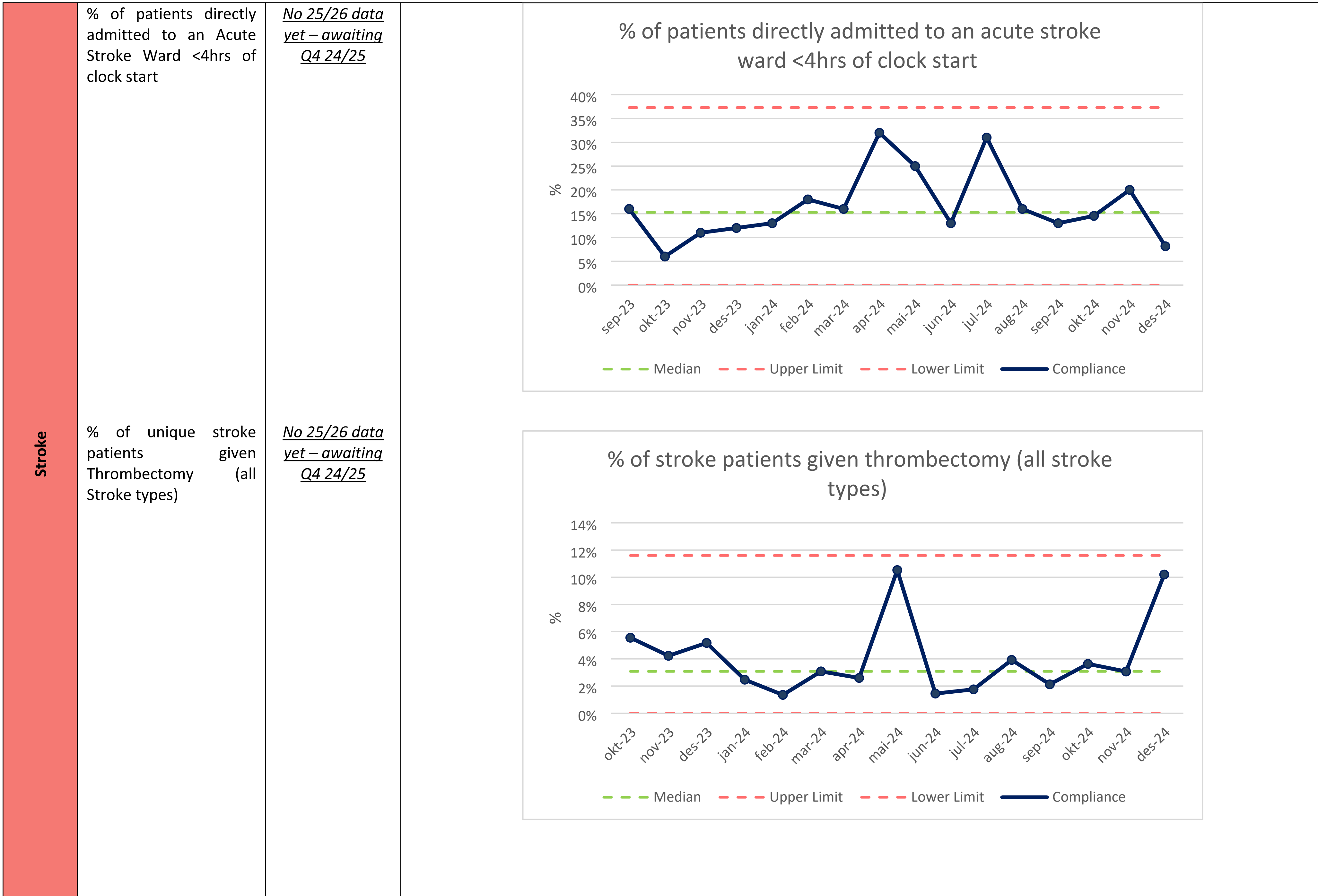
Enhanced Monitoring	Reduction of Ambulance patient handovers over 1 hour **Ministerial Delivery**	664 (May) Below trajectory of 716	Reduction of >1 hour ambulance handovers waits (chart)
	Reduce the number of Ambulance Crew hours lost at GUH ED (per month)	2,377 (May) Below Q1 Trajectory of 2,750	Reduce the number of ambulance crew hours lost at GUH ED (chart)

	Measure	Performance	
	Reduction in number of patients who spend 12 hours or more in all Major and Minor Emergency Care Facilities from arrival until admission, transfer or discharge **Ministerial Delivery**	1,124 (May) Below Trajectory of 1,301	
	Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU	78.3% (May) Above Q1 Trajectory of 75%	

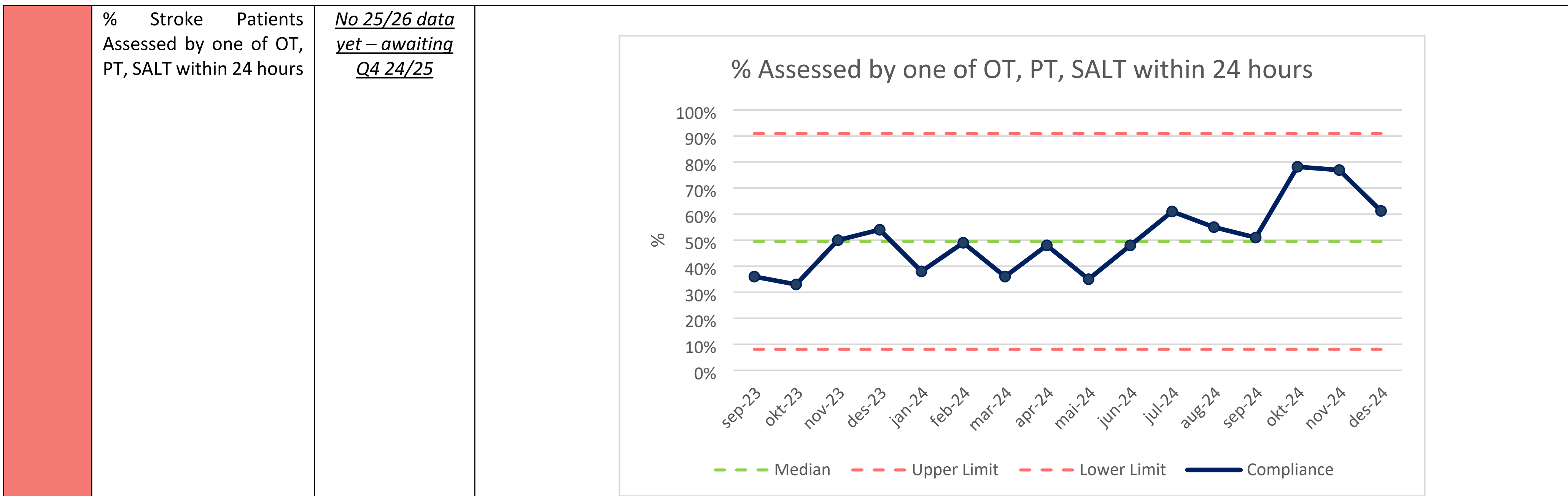


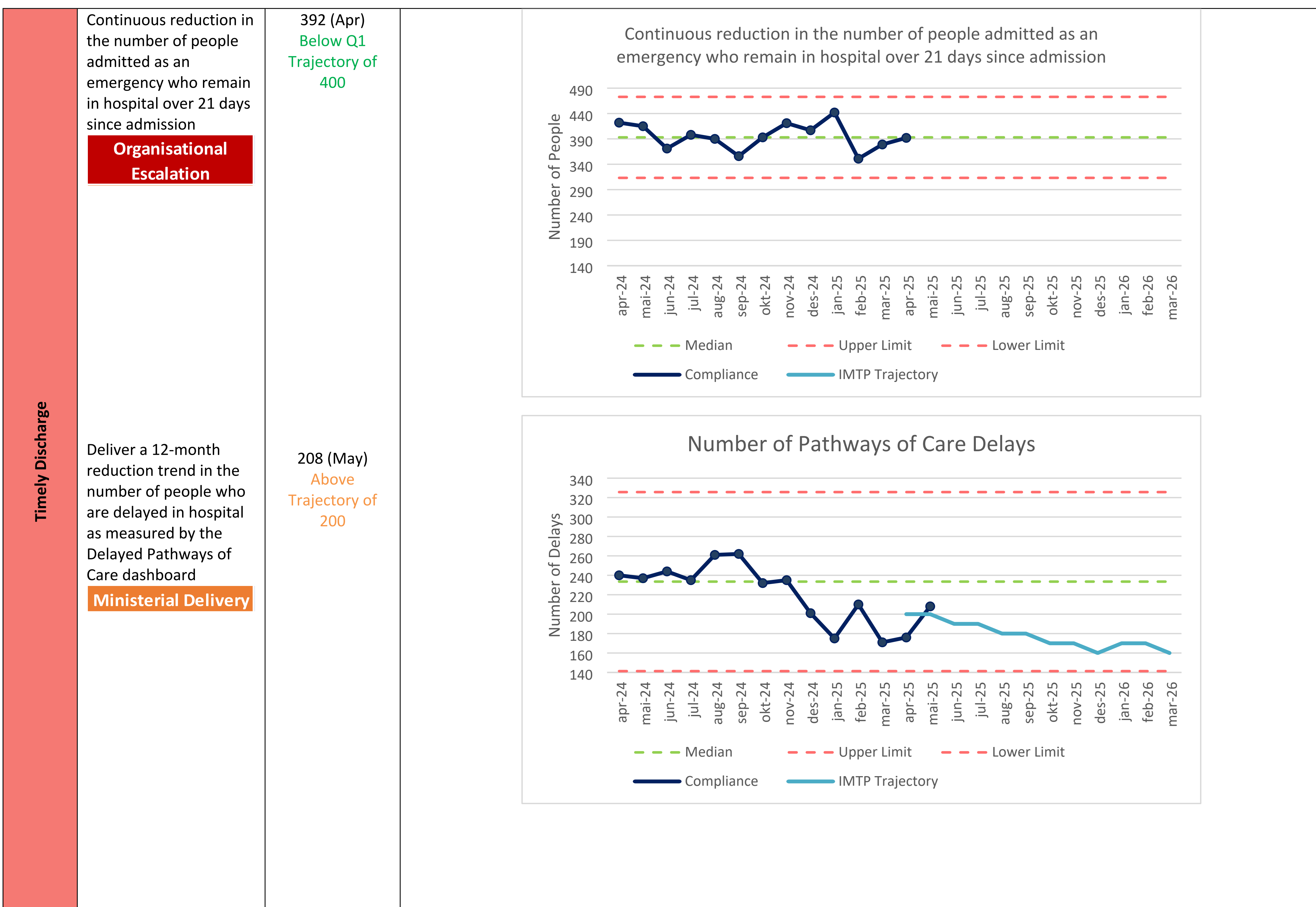


	Reduction in time from arrival to ED triage - no waits over 60 minutes	326 (May) Above Q1 Trajectory of 300	
	Median time from arrival at an emergency department to assessment by a Clinical Decision Maker should not exceed 60 minutes and maintained for three months. **Organisational Escalation**	115 mins (May) Above Trajectory of 110 mins	

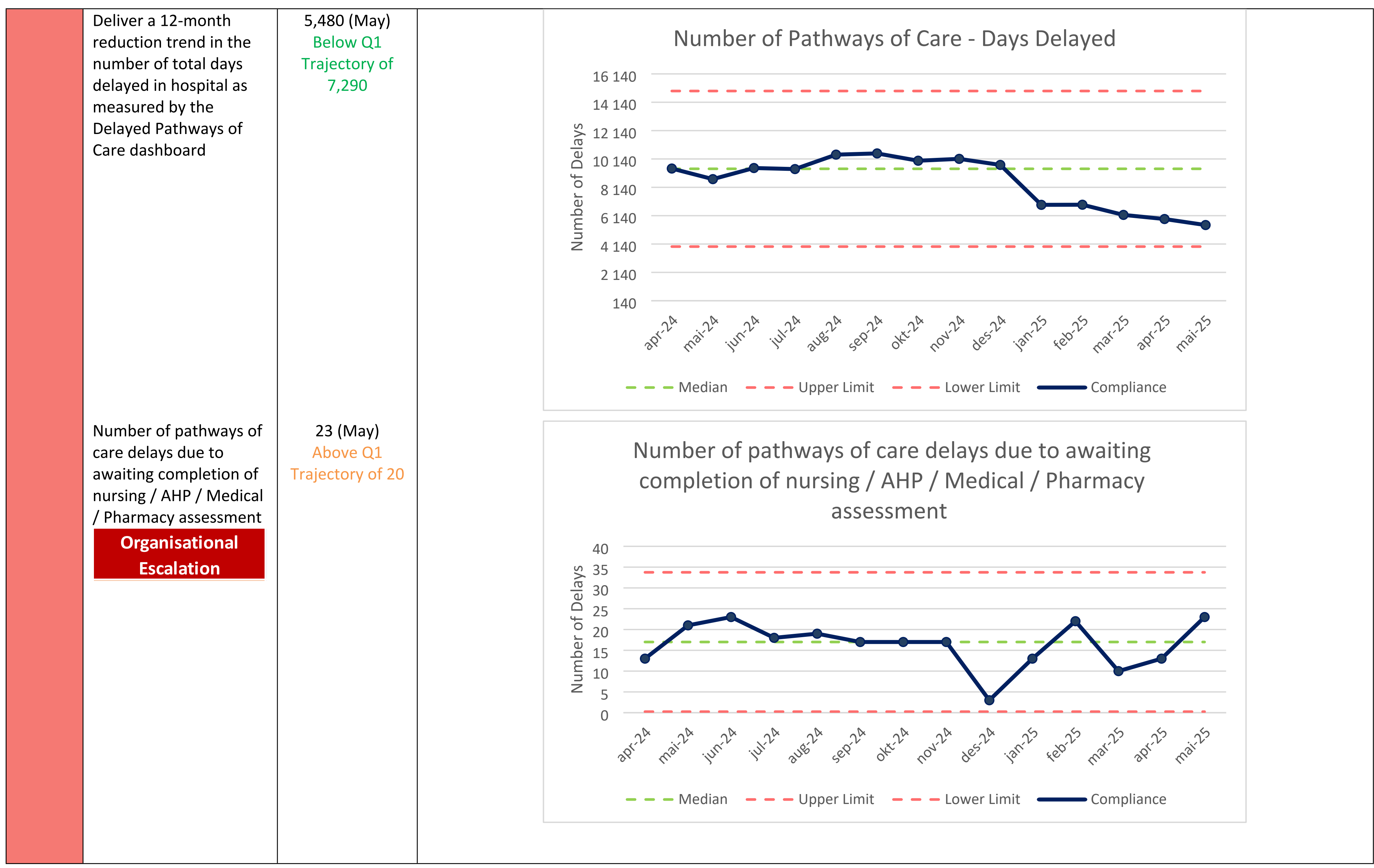


Stroke	% of patients directly admitted to an Acute Stroke Ward <4hrs of clock start	*No 25/26 data yet – awaiting Q4 24/25*
	% of unique stroke patients given Thrombectomy (all Stroke types)	*No 25/26 data yet – awaiting Q4 24/25*

	% Stroke Patients Assessed by one of OT, PT, SALT within 24 hours	***No 25/26 data yet – awaiting Q4 24/25***	



Timely Discharge	Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission **Organisational Escalation**	392 (Apr) Below Q1 Trajectory of 400	
	Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard **Ministerial Delivery**	208 (May) Above Trajectory of 200	



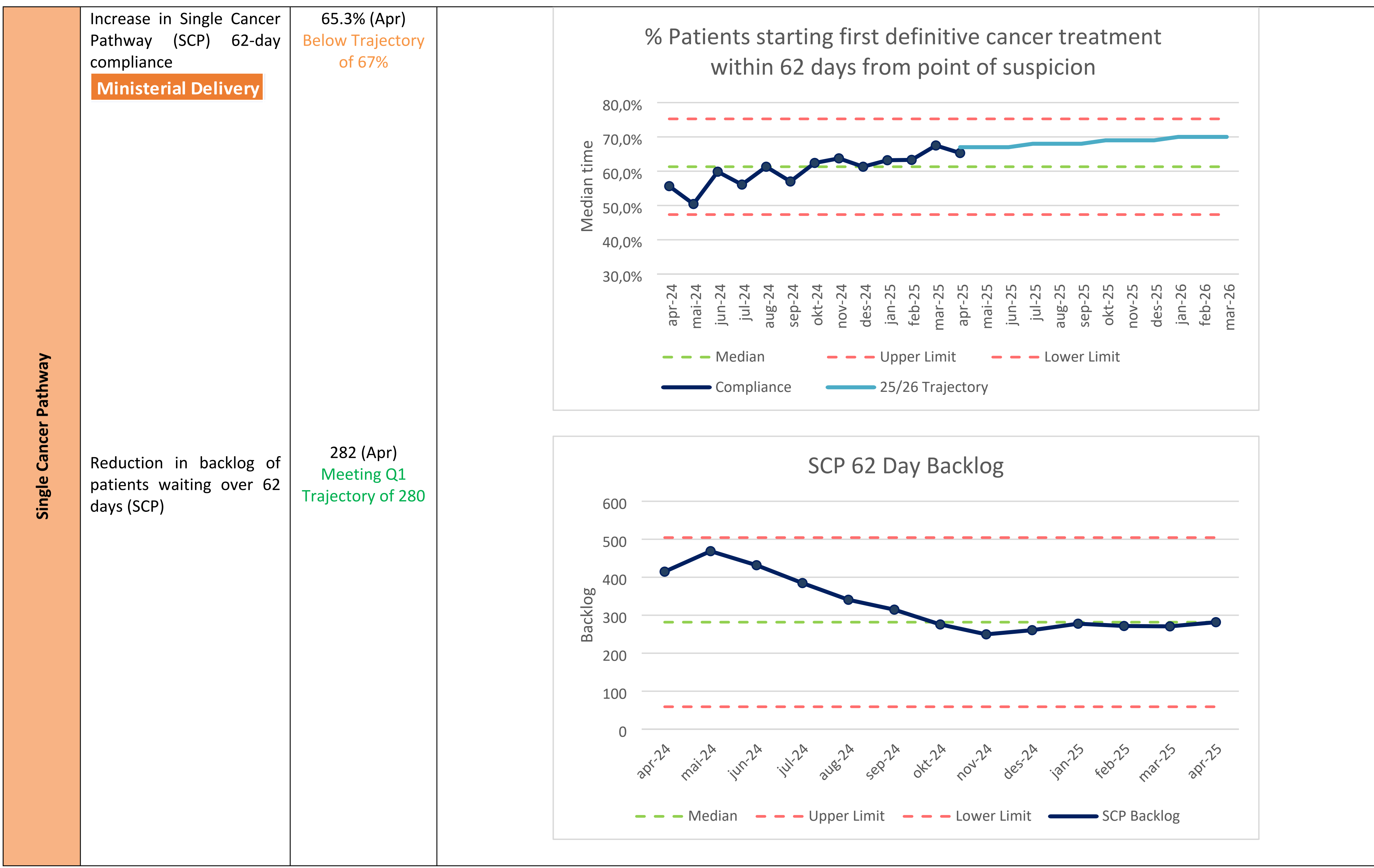
	Measure	Performance	Chart
	Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	5,480 (May) Below Q1 Trajectory of 7,290	
	Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment **Organisational Escalation**	23 (May) Above Q1 Trajectory of 20	

Quadruple Aim 2	Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**

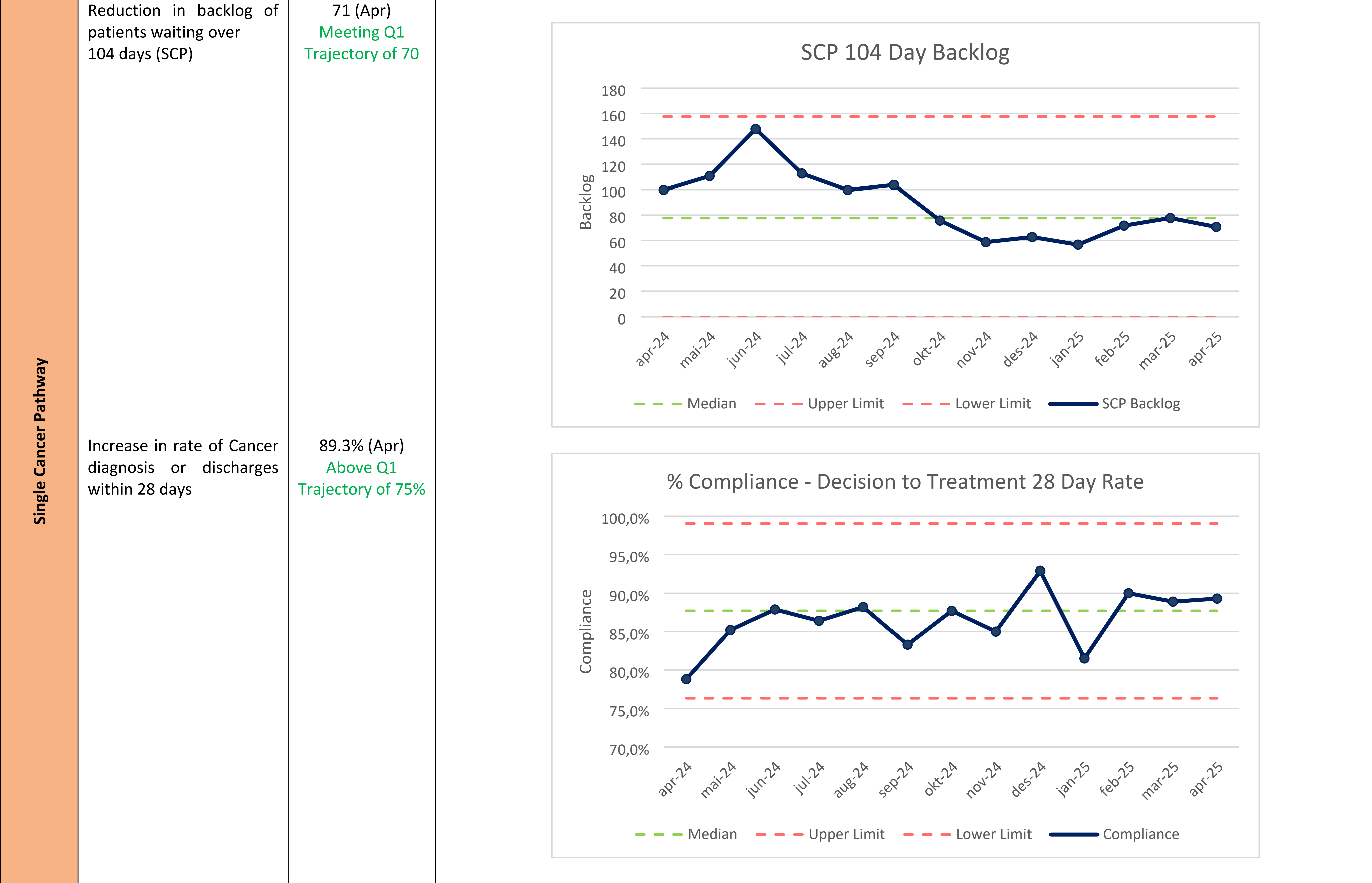
KEY MESSAGES & ACTIONS:

- Single Cancer Pathway (SCP) ended the year strongly, delivering 67.5%. Whilst not quite meeting the annual plan trajectory of 70%, there was less volatility in month to month performance through the second part of the year with more stable, improved performance. The 62 and 104 day backlog for the SCP through the course of 24/25, with the 62 day position remaining stable through Q4 and the 104 seeing only a small increase in the latest reporting period. April performance decreased slightly to 65.3%, marginally below a Q1 trajectory of 67% although continuing overall improvement trajectory observed since the beginning on 24/25 and the second highest performance in this period.
- Tumour site specific Task and Finish groups have been instrumental in delivering improvement in the backlog position, as has Divisional scrutiny to improve compliance and maintain attentive focus of management of patients going through the pathway.
- Within Planned Care, Q1 focus has been on maintaining the 104wk position that was delivered at the end of 24/25 of 288. Non recurrent funding for ENT, Ophthalmology (non cataract), and T&O was received for Q1 to deliver a zero position with a risk of 345, as well as whole year funding for Regional Ophthalmology which is now aiming to deliver against a 94wk position. As of April RTT submission we are on track to deliver against the Q1 risk position of 345. Our 52 week outpatient position is ahead of track as a net beneficiary of the focussed 104 work through the final part of 24/25. Our performance against the Ministerial Delivery Expectation pertaining to 8wk diagnostics is marginally ahead of where we expected to be, albeit only one month into the year.
- Another significant focus within Planned Care are the enabling actions relevant to this area. Four of these were included within our IMTP and related to DNA/CNA performance (target of 5%, April performance 6.4%) and Theatres, of which one is essentially three sub measures (early starts, late finishes and theatre utilisation), one relates to protecting elective theatre capacity, and the final one is BADS daycase rates (no 25/26 data yet so not included in this report).
- Q1 actions underway under this theme include:
    - Increased use of virtual clinics and identification of new pathways through scoping of opportunities in CIN and GIRFT recommendations
    - Theatres Service Model development to inform the planning of a Day Case Centre of Excellence as part of NHH Development Programme
    - Scale of Golden Patient process across further specialities
    - Develop implementation and communications plan for inbound calls to the Keeping Well Service
    - Full roll out of training programmes to the wider audience including both technical and contextual training (Planned Care Academy)

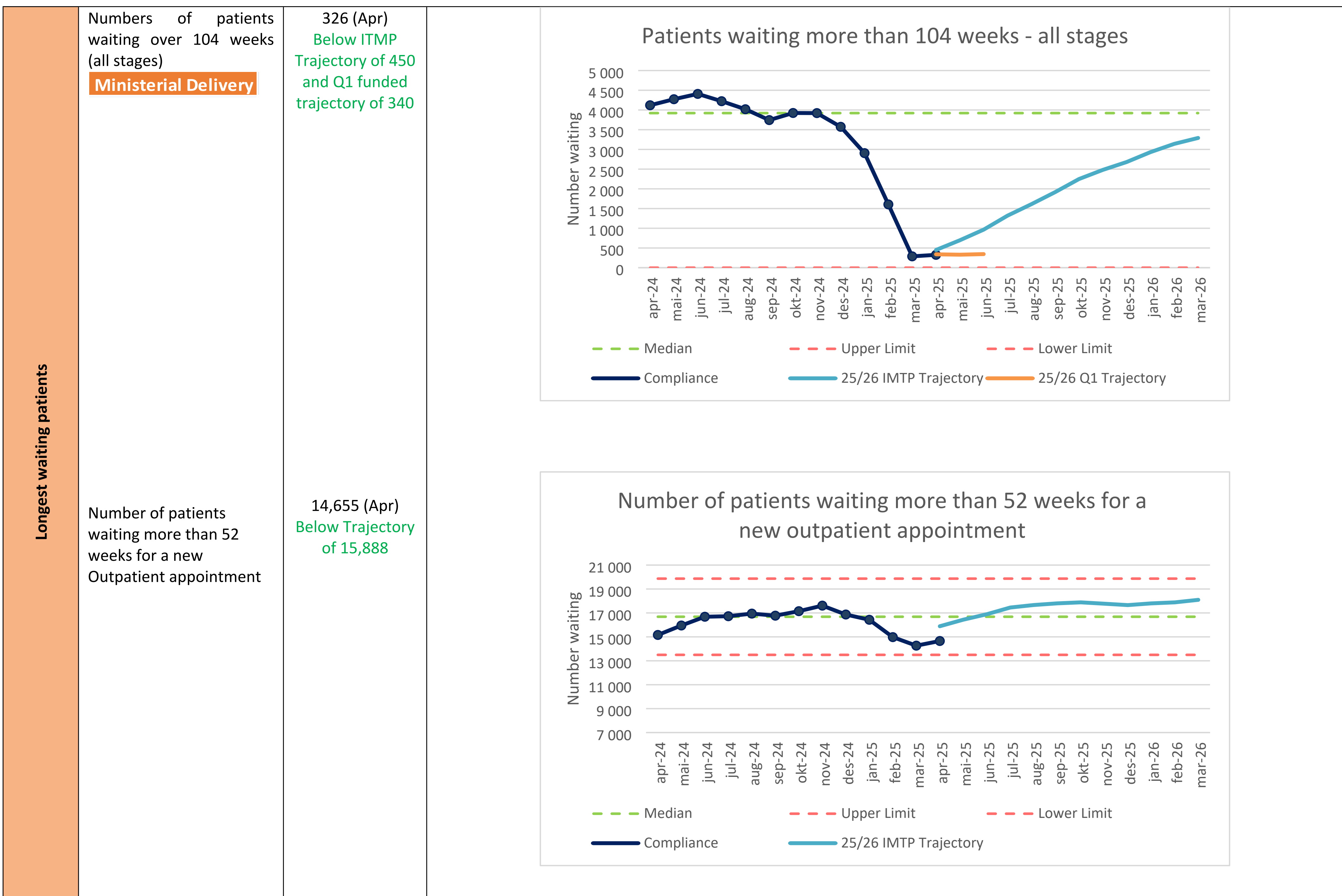
Priority	Performance Summary	Performance against Trajectory	Data



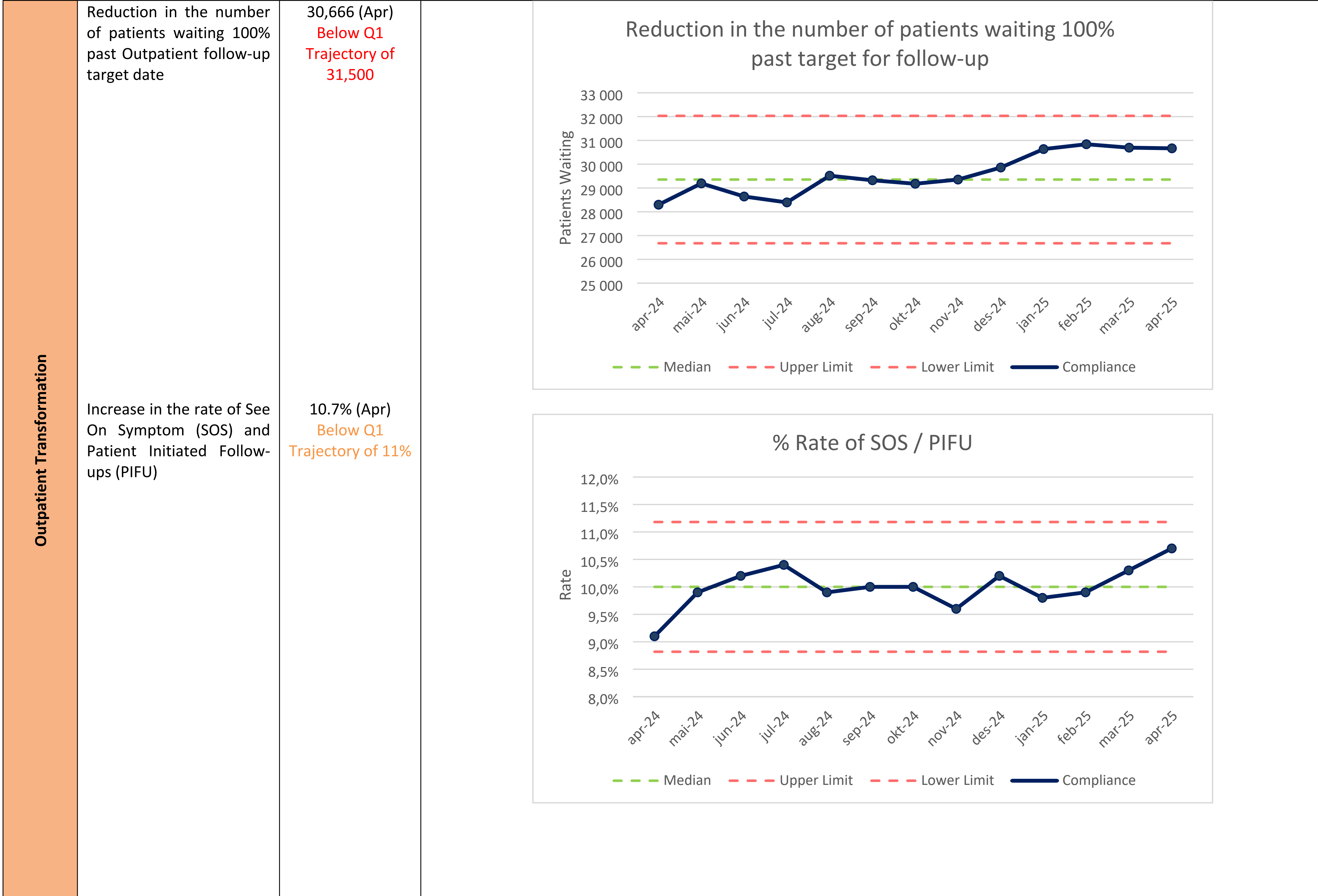
Single Cancer Pathway	Increase in Single Cancer Pathway (SCP) 62-day compliance **Ministerial Delivery**	65.3% (Apr) Below Trajectory of 67%	
	Reduction in backlog of patients waiting over 62 days (SCP)	282 (Apr) Meeting Q1 Trajectory of 280	



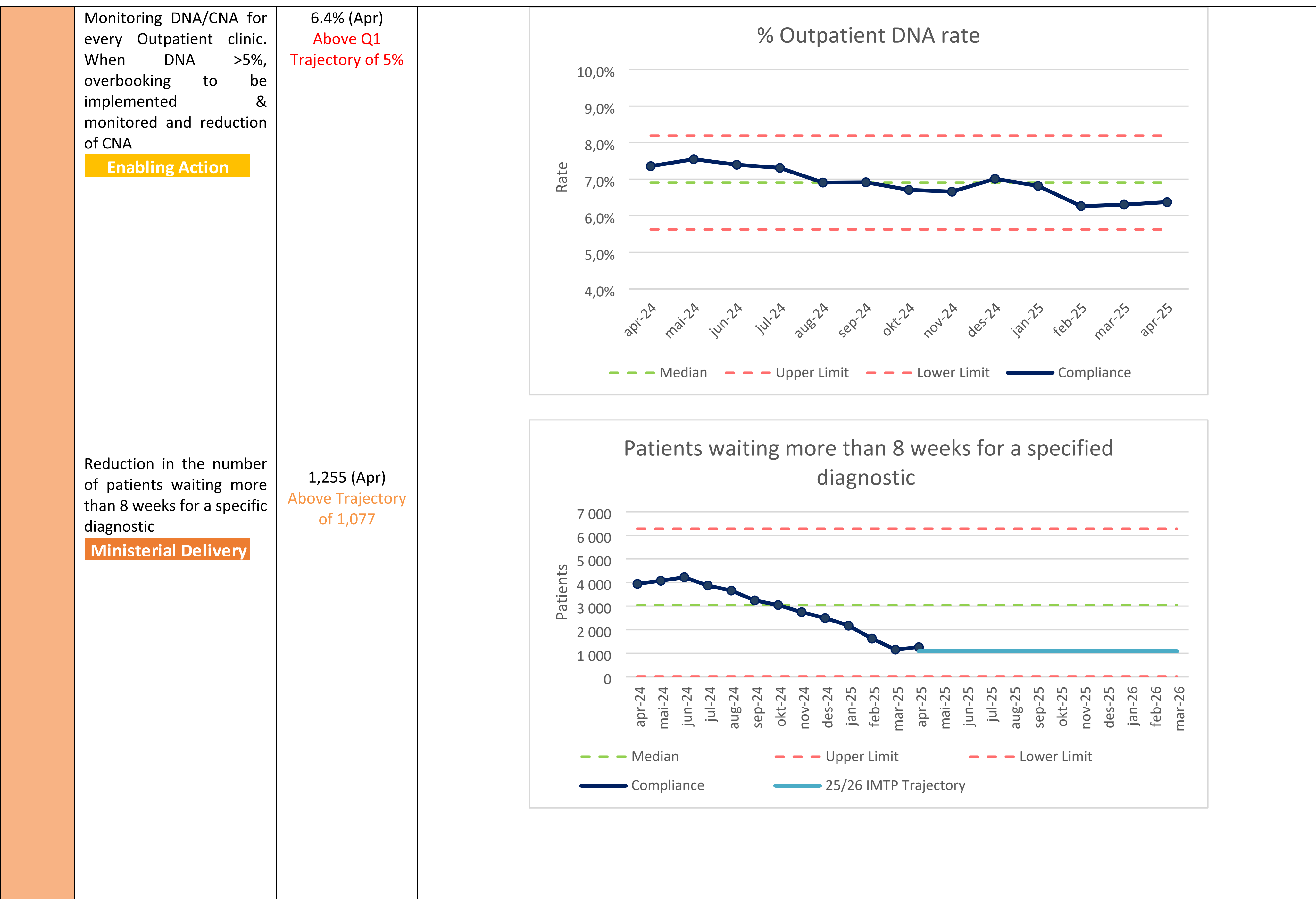
Single Cancer Pathway	Reduction in backlog of patients waiting over 104 days (SCP)	71 (Apr) Meeting Q1 Trajectory of 70	
	Increase in rate of Cancer diagnosis or discharges within 28 days	89.3% (Apr) Above Q1 Trajectory of 75%	



Longest waiting patients	Numbers of patients waiting over 104 weeks (all stages) **Ministerial Delivery**	326 (Apr) Below ITMP Trajectory of 450 and Q1 funded trajectory of 340	
	Number of patients waiting more than 52 weeks for a new Outpatient appointment	14,655 (Apr) Below Trajectory of 15,888	

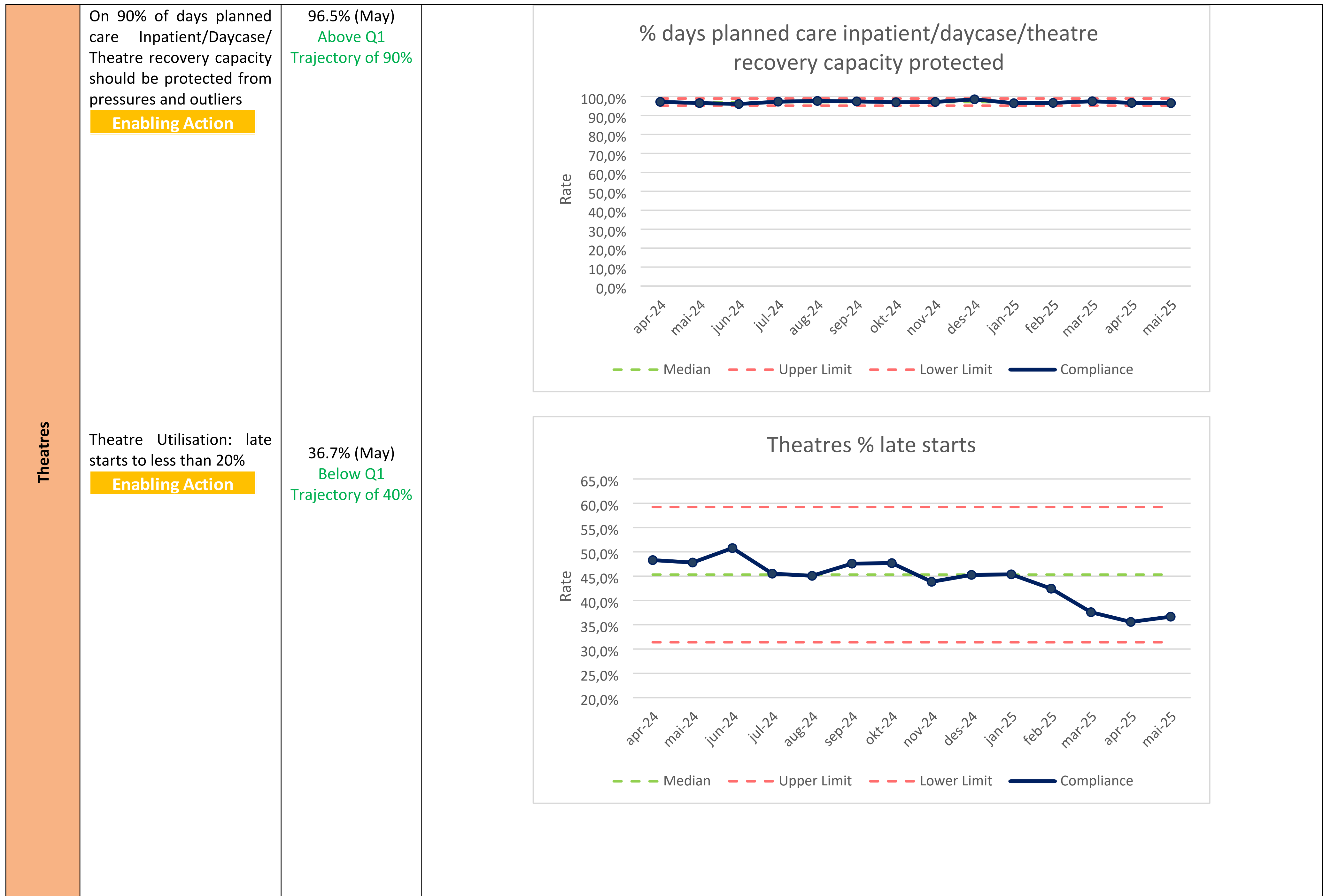


Outpatient Transformation	Reduction in the number of patients waiting 100% past Outpatient follow-up target date	30,666 (Apr) Below Q1 Trajectory of 31,500	
	Increase in the rate of See On Symptom (SOS) and Patient Initiated Follow-ups (PIFU)	10.7% (Apr) Below Q1 Trajectory of 11%	

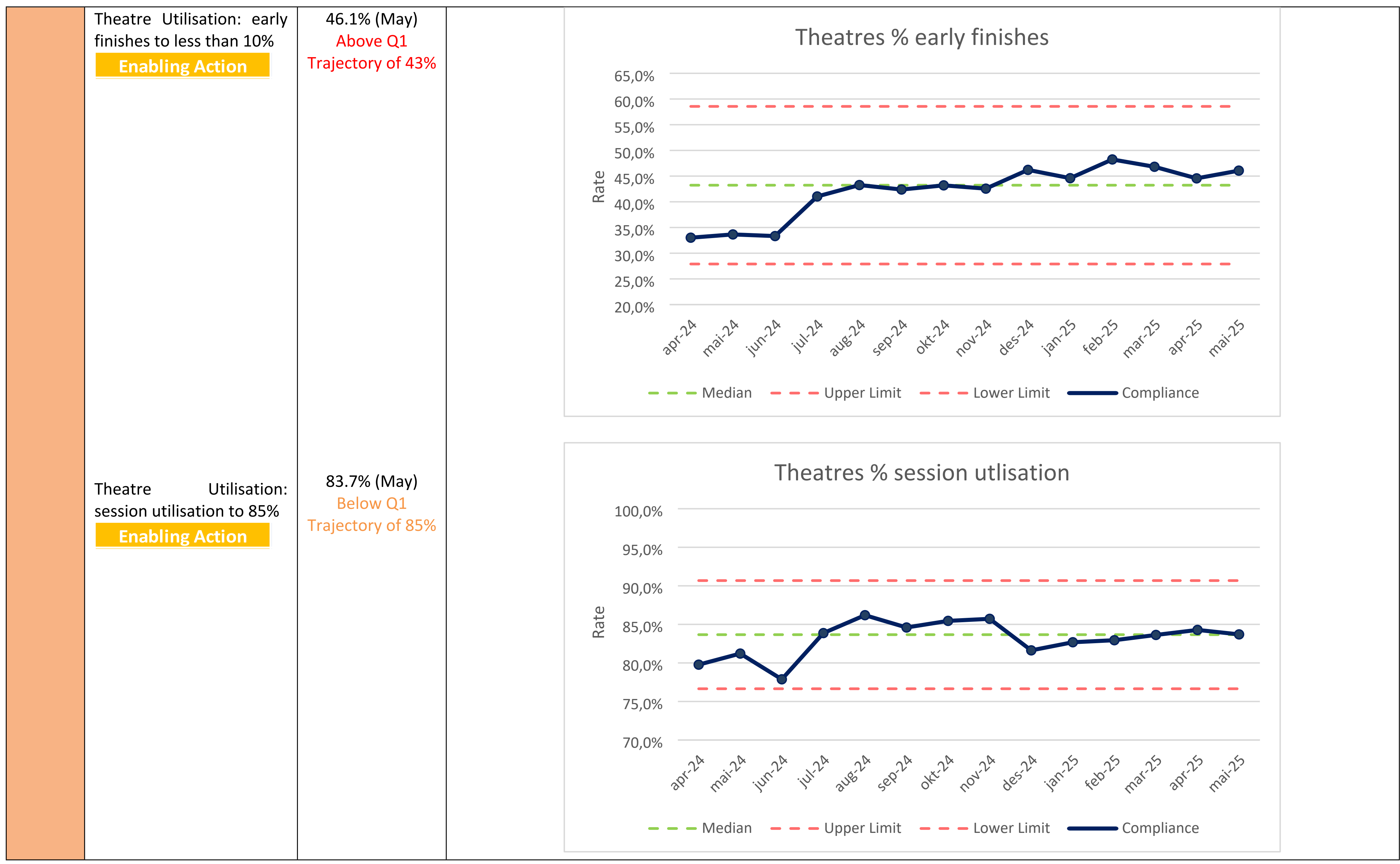


	Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA **Enabling Action**	6.4% (Apr) Above Q1 Trajectory of 5%	
	Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic **Ministerial Delivery**	1,255 (Apr) Above Trajectory of 1,077	

	No patient waiting more than 14 weeks for a Therapeutic Assessment	45 (Apr) Below Q1 Trajectory of 170	Patients waiting more than 14 weeks for a therapeutic assessment Backlog 800 700 600 500 400 300 200 100 0 apr-24 mai-24 jun-24 jul-24 aug-24 sep-24 okt-24 nov-24 des-24 jan-25 feb-25 mar-25 apr-25 Median Upper Limit Lower Limit Compliance
	Number of adults waiting more than 14 weeks for all Audiology Pathways	4,625 (Apr) Below Q1 Trajectory of 5,001	*Newly reportable pathways for 25/26 – no time series data yet*
	Number of children waiting more than 6 weeks for all Audiology Pathways	1,047 (Apr) Below Q1 Trajectory of 1,654	*Newly reportable pathways for 25/26 – no time series data yet*



Theatres			
	On 90% of days planned care Inpatient/Daycase/ Theatre recovery capacity should be protected from pressures and outliers **Enabling Action**	96.5% (May) Above Q1 Trajectory of 90%	
	Theatre Utilisation: late starts to less than 20% **Enabling Action**	36.7% (May) Below Q1 Trajectory of 40%	

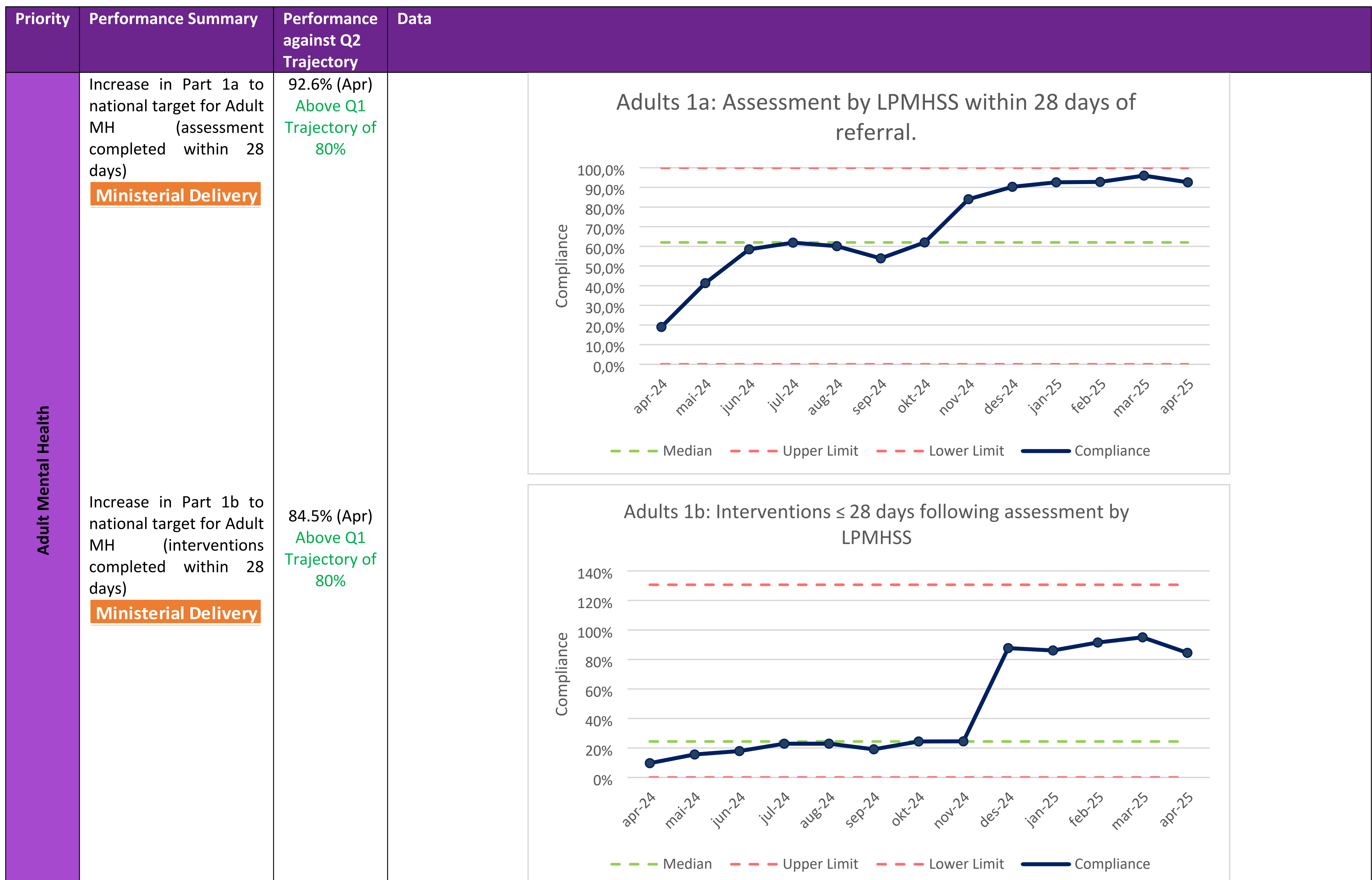


	Metric	Performance	Chart
	Theatre Utilisation: early finishes to less than 10% **Enabling Action**	46.1% (May) Above Q1 Trajectory of 43%	
	Theatre Utilisation: session utilisation to 85% **Enabling Action**	83.7% (May) Below Q1 Trajectory of 85%	

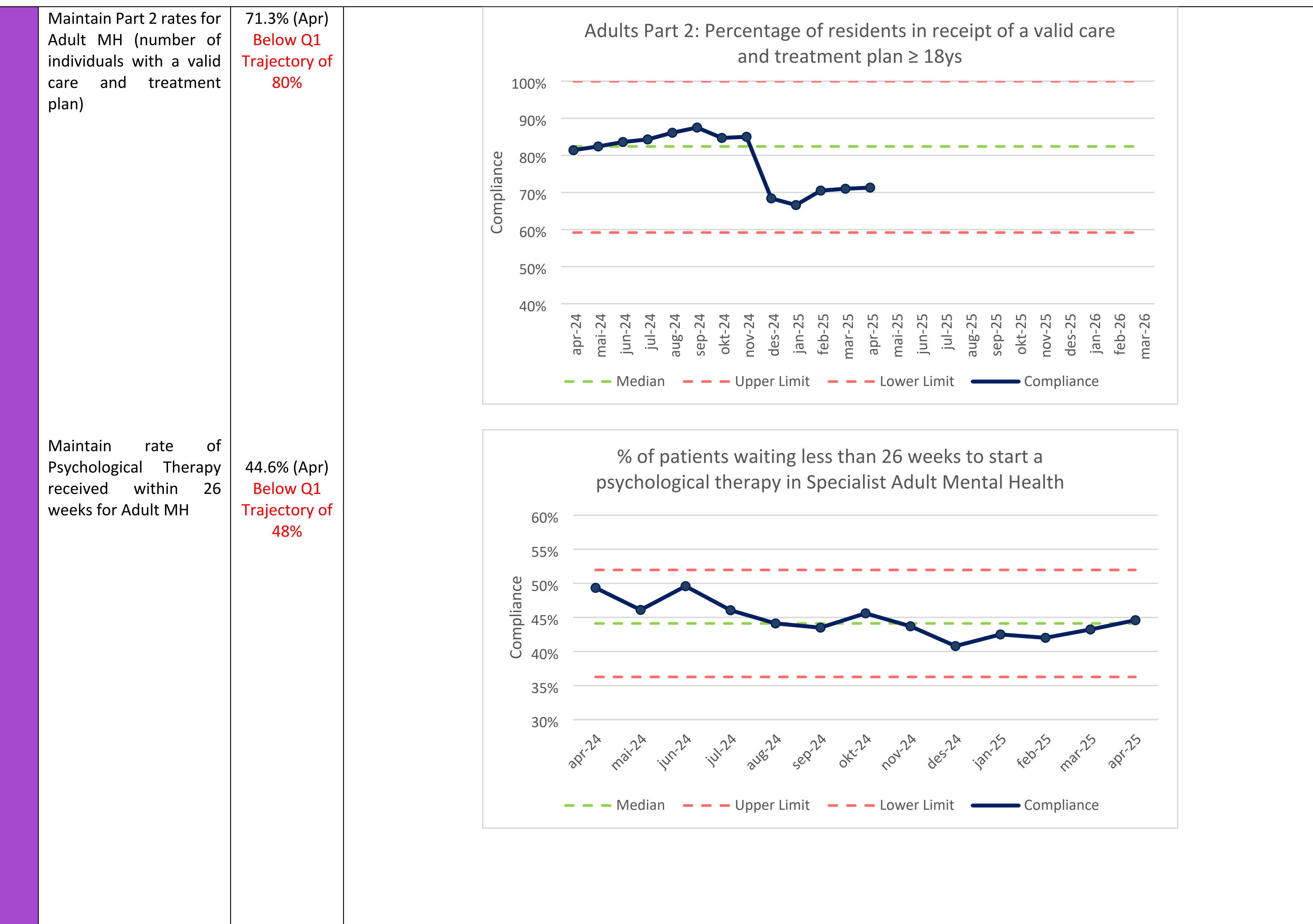
Quadruple Aim 2	Improving our Mental health services

KEY MESSAGES & ACTIONS:

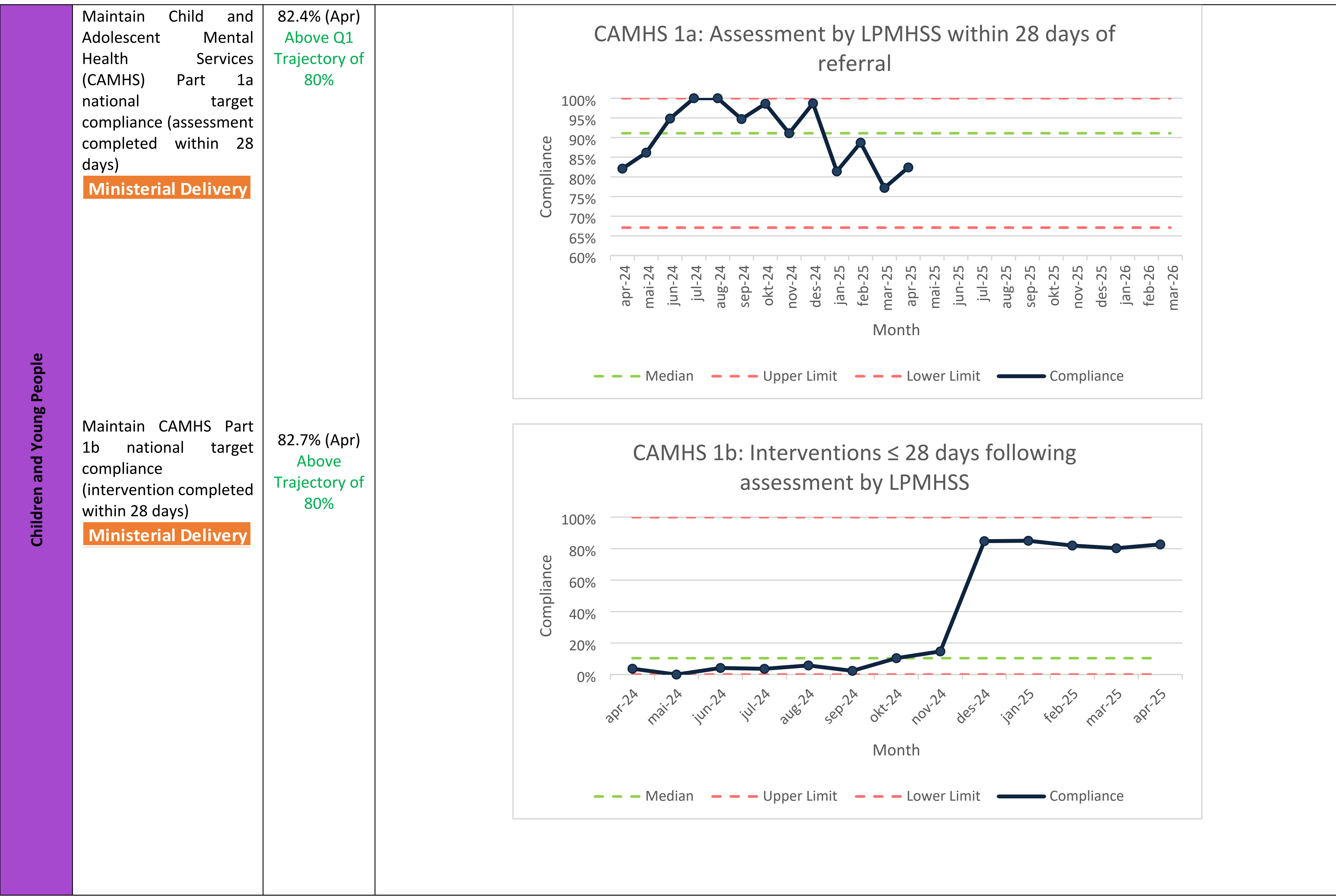
- Performance across Mental Health and Learning Disabilities was a key success story for the Health Board, having delivered against step improvement trajectories across Parts 1a and 1b for both adults and CAMHS. All 4 measures, all of which are Ministerial Delivery Expectations, remain above the national standard as of the latest reporting period.
- Part 2 within adults has seen a decrease in compliance to below the national standard of 90%, however the action plan is in development to ensure performance returns to the levels seen through the first parts of 24/25. Part 2 within CAMHS remains excellent.
- A key focus for 25/26 will be to improve performance for timely access to psychological therapies and increase compliance against the national standard of 26 weeks.
- Performance for Neurodevelopmental (ND) assessments for children and young people aged 0-18 years continues to deliver strongly. Facilitated via £94k at the end of Q3 24/25, additional capacity in clinical and administrative roles as well as the innovative approaches taken by the service delivered a significant improvement in performance through Q4 and has been maintained as of the latest reporting period (April), meeting the national standard of 80% for the second month in a row. AB is the only Health Board to have achieved this and there is a great deal of interest nationally in learning from the approach taken.
- Q1 actions underway within this theme include:
    - Define Single Neurodevelopmental pathway for Adults
    - Develop model for Adult inpatient, community and forensic services
    - Scope all crisis services and ensure they are delivering to capacity
    - Regular waiting list review and team communication to ensure fidelity to new service model and therapeutic offerings with CAMHS



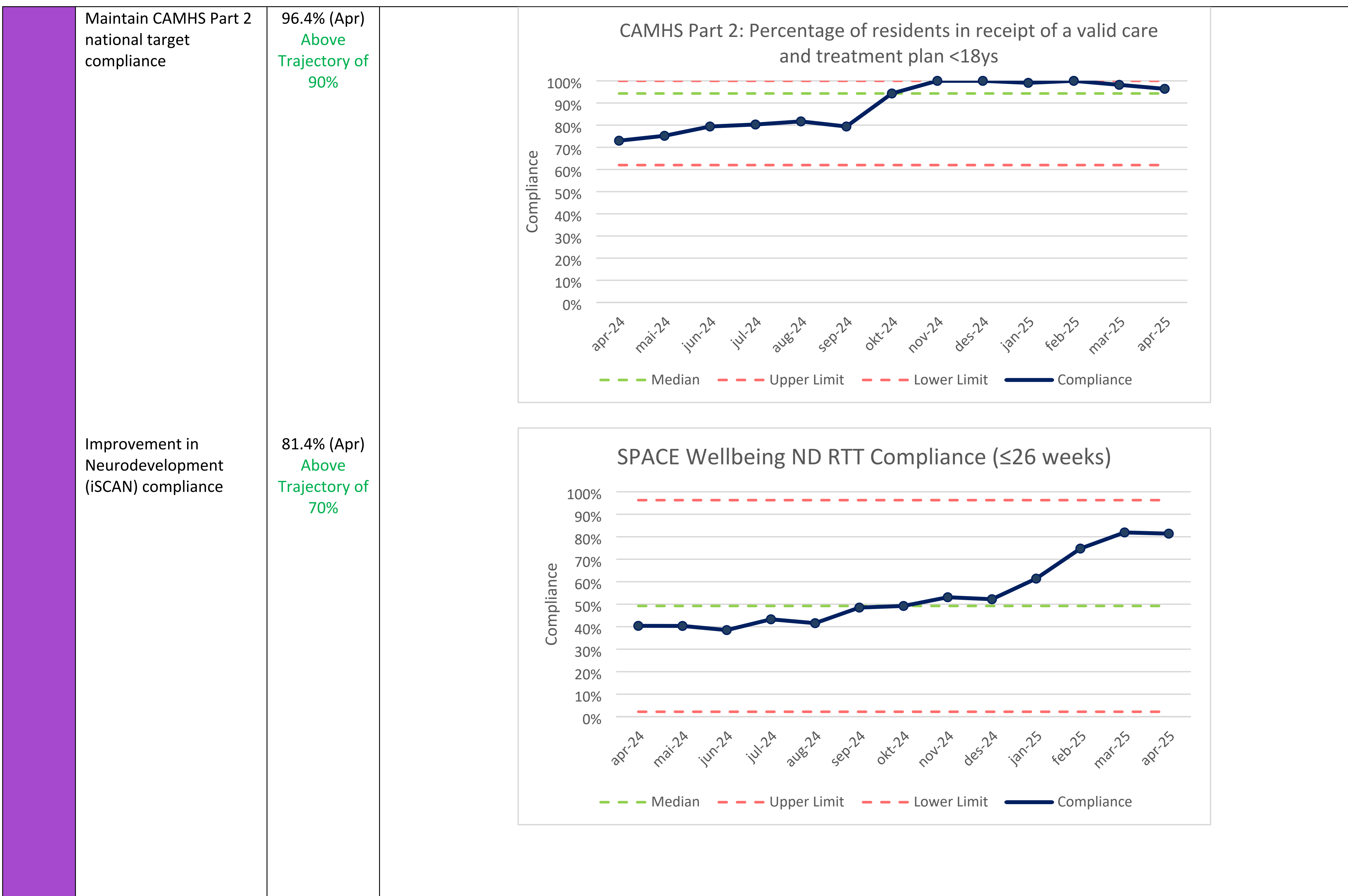
Priority	Performance Summary	Performance against Q2 Trajectory	Data
Adult Mental Health	Increase in Part 1a to national target for Adult MH (assessment completed within 28 days) **Ministerial Delivery**	92.6% (Apr) Above Q1 Trajectory of 80%	Adults 1a: Assessment by LPMHSS within 28 days of referral.
	Increase in Part 1b to national target for Adult MH (interventions completed within 28 days) **Ministerial Delivery**	84.5% (Apr) Above Q1 Trajectory of 80%	Adults 1b: Interventions ≤ 28 days following assessment by LPMHSS



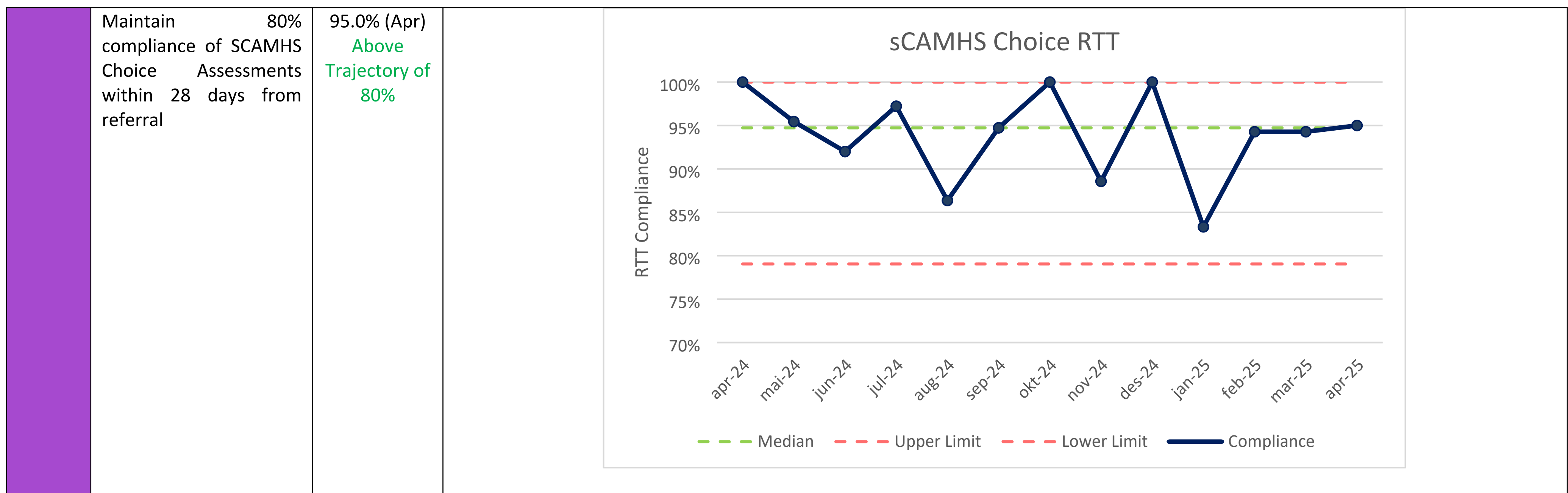
	Maintain Part 2 rates for Adult MH (number of individuals with a valid care and treatment plan)	71.3% (Apr) Below Q1 Trajectory of 80%	
	Maintain rate of Psychological Therapy received within 26 weeks for Adult MH	44.6% (Apr) Below Q1 Trajectory of 48%	



Children and Young People	Maintain Child and Adolescent Mental Health Services (CAMHS) Part 1a national target compliance (assessment completed within 28 days) **Ministerial Delivery**	82.4% (Apr) Above Q1 Trajectory of 80%	
	Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days) **Ministerial Delivery**	82.7% (Apr) Above Trajectory of 80%	



	Maintain CAMHS Part 2 national target compliance	96.4% (Apr) Above Trajectory of 90%	
	Improvement in Neurodevelopment (iSCAN) compliance	81.4% (Apr) Above Trajectory of 70%	

	Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	95.0% (Apr) Above Trajectory of 80%	

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 June 2025
CYFARFOD O: MEETING OF:	Finance and Performance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	GIRFT (Getting It Right First Time) Action Plan for Stroke Services Update & Ringfencing policy for Stroke beds
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr Executive Director of AHPs and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Rhys Monk/Alice Reed/Collette Kiernan

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper is being brought to the committee to provide an update on the progress of the Stroke Service Action Plan. The report also references other reviews that have been undertaken including, the 2021 Therapy Review, the 2023 HIW Patient Flow Review and the 2024 Welsh Government Recommendations on Improving Stroke Services in Wales and acts as a ABUHB Stroke Improvement Plan.

Over the past 26 months, the Health Board's Stroke Service has encountered numerous opportunities, faced significant challenges, and achieved meaningful progress.

In 2022, the Medicine Division invited the national GIRFT (Getting It Right First Time) team to assess its stroke services, resulting in 20 key recommendations (see Appendix A: GIRFT Report).

Since then, the service has undergone considerable change and disruption, exposing its underlying fragility. Key events included the retirement of the Nevill

Hall Consultant, ongoing difficulties in recruiting both Consultants and Allied Health Professionals (AHPs), and the temporary loss of several Clinical Nurse Specialists (CNSs) due to maternity leave. These factors placed additional strain on an already overstretched workforce.

The Stroke Directorate continues to face significant challenges in medical recruitment. However, to help address this, specialist grade doctors have been appointed to provide senior-level cover at the rehabilitation unit at Ysbyty Ystrad Fawr (YYF). In parallel, a comprehensive deep dive assessment of the entire stroke pathway is currently underway to identify further opportunities for improvement and service optimisation.

Concerns about the sustainability of the service led to the approval of an interim "urgent service collapse" plan in November 2023. As a result, stroke rehabilitation services were consolidated onto a single site at YYF. While this transition was challenging, it has helped to stabilise the service by concentrating available resources and has strengthened the overall stroke care pathway.
Despite these pressures, the team has continued to make steady progress in addressing the GIRFT recommendations.

In addition to the GIRFT report, several other reviews have informed the development of a comprehensive improvement plan. These include the 2021 Therapy Review (Appendix B), the 2023 Healthcare Inspectorate Wales (HIW) Patient Flow Review (Appendix C), and the 2024 Welsh Government letter to NHS Wales Health Board Chief Executives on improving stroke services (Appendix D). These documents have been carefully integrated into a unified Stroke Improvement Plan for Aneurin Bevan University Health Board (ABUHB).

In February 2025, Cwm Taf Morgannwg (CTM) Health Board also experienced an urgent collapse of its stroke service. Anticipating increased demand from CTM patients, ABUHB secured Executive approval to ring-fence the entire stroke pathway—from the Hyper Acute Stroke Unit (HASU) to rehabilitation wards. This proactive measure aimed to protect the existing service and accommodate any additional patient flow from neighbouring areas.

Asesiad / Assessment

The final report from the GIRFT team was received in September 2022 and is attached as Appendix a. The report included a total of 20 short- and medium-term recommendations, from which the key priorities are seen to be as follows:

- Provide supernumerary specialist stroke nurse presence at GUH (Grange University Hospital) on a 24/7 basis to ensure ownership and direction of the stroke patient pathway
- Enhance pre-hospital notification arrangements to ensure elimination of avoidable delays at the front door
- Increase thrombolysis rates to be consistently within agreed national norms
- Raise organisational priority for patients gaining access to the acute stroke unit within four hours
- Widen range of workforce options / competence to ensure 24/7 ability to perform swallow assessments
- Review rehabilitation / early supported discharge pathway, with emphasis on seven-day access to therapies, (this being considered likely to involve utilising fewer rehabilitation sites in the Health Board)
- Ensure robust arrangements for patient review six months post-discharge
- Support development of clinical leadership for the service

A complete update of the status of each recommendation is referenced in the attached document: (appendix e. GIRFT Action Plan Tracker)

To summarise the contents of the referenced appendices, of the 20 recommendations, nine of these have been completed and are now within specified ranges for deliverables. These are:

(Please note that since November 2024, data dashboards have been unavailable due to underlying SSNAP dataset changes. These are being updated by NHS Executive in Wales. The following data references rely on manual calculations and may be slightly different to data published when the dashboards are operational again).

Ongoing implementation, requires additional support & intervention

Action	**Progress**
Action 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.	This metric continues to be rated E by SSNAP. There has been a 2% increase in access to stroke unit within 4 hours since last reporting period (May 2024). Since stroke service collapsed in Prince Charles Hospital, Cwm Taf Morgannwg University Health Board (CTMUHB) on 8 January 2025, it has been agreed to ring fence the whole of the stroke pathway in ABUHB including 15 bedded HASU unit at GUH as well as 55 rehabilitation beds at YYF. Teams have been notified of potential increase by 2 patients per week from CTMUHB (referenced by WAST). The data is being monitored to evaluate the impact of recent service collapse in CTMUHB.

	The Chief Operating Officer has convened a meeting on 25th March to commence a deep dive of the operating framework and related escalation / surge options required to ensure timely flow for the hyper-acute part of the stroke pathway. **Current performance is approx. 17% of patients reaching the HASU in less than four hours.** **A process is being undertaken by Stroke DM to embed on the ward to identify and unblock delays in the pathway.**
Action 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.	Current staffing levels allow for 07:00 – 19:00 cover. Further investment will be required to run a full 24/7 service.
Action 13: Ensure 7-day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.	The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day. This will not just be delivered by Therapists but will have an overall contribution from all ward staff on a ward with an enabling rehabilitation ethos. Physiotherapy currently do not have sufficient resources to provide a 7-day service. Additional funding and resources would be required. Physiotherapy are not consistently delivering 45 minutes of therapy across HASU or YYF rehab. Timetabling and group work has been implemented in YYF to help support delivering 45 mins daily physiotherapy. In order to address the recommendations related to actions 13, 14, and 19, the Exec Director of AHPs and HS has commissioned an update of the 2021 therapy stroke inpatient workforce review, to be extended to consider psychological services, to understand therapy capacity across the entire stroke pathway. This updated review will quantify the gaps of current provision in achieving the GIRFT recommendations, with some options to be considered by the Health Board. The completed review and options paper will be presented to the Executive Committee in July 2025.
Action 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT (Speech and Language Therapy), embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.	The current Therapies commissioned inpatient staffing for stroke across all professions is on average 51% below minimum National Standards. Therefore, delivery of a 5-day service is extremely challenging and without significant financial investment 7-day service provision remains unachievable. A Therapies Staffing review was undertaken in 2021 but there has been no change in the commissioned

	stroke staffing since that review except some within service movement as a result of colocation of services at YYF. A workforce review along the whole pathway has been commissioned to assess current staffing levels and provide an update on gaps and risks and this will include HASU staffing as part of that pathway workforce review. The workforce review will be considered along the new standards that specify the requirement for 7 day service provision. All Therapies services continue to be commissioned to work 5 days a week, Mon- Fri service and therefore the 24-hour therapy target remains challenging to achieve. MDT goal setting is an ongoing piece of work in YYF. Weekly electronic MDT meeting forms have been designed and are now being used by the MDT and placed in the patient records each week.
Action 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT (Multi-Disciplinary Team) goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5-day rota.	A 5-day service provision will be unchanged without significant financial investment to be able to increase to a 7-day service which will continue to impact on the ability to achieve some of the goals around seeing patients within 72 hours. Ward reconfiguration and the co-location of rehabilitation services to a single site now provides the opportunity to standardise the approach for MDT (Multi-Disciplinary Team) goal setting etc this remains a key focus of ongoing pathway reconfiguration work. This has also enabled cross cover within the team for any absence or staff vacancy and has enhanced staff supervision and learning.

This summary clearly shows that work is still ongoing to implement all of the GIRFT recommendations, with the reconfiguration plans playing a significant part in progressing the recommendations. Progress updates continue to be a standing agenda item for the ABUHB Stroke Regional Network Board, chaired by the Executive Director of AHPs and Health Science.

The metrics are taken from the latest published SSNAP audit (July – September 2024). Please note, following the publication of the National Clinical Guidelines (NCG) and updated NICE guidelines for Stroke in 2023 the SSNAP dataset has been updated from 1st October 2024. This recent change has brought many challenges to the teams including impact on therapy data recording, performance metrics and technical considerations with the new web tool. SSNAP has acknowledged ongoing issues and extended the period for locking records for the October – December 2024 quarter. Due to these changes SSNAP has not publicly specified the exact duration for which health boards will receive official scores due to the implementation of the new web tool; however, health boards were reassured that sufficient time will be provided to allow adapt to new processes.

Update on Stroke Bed Ring-Fencing at GUH

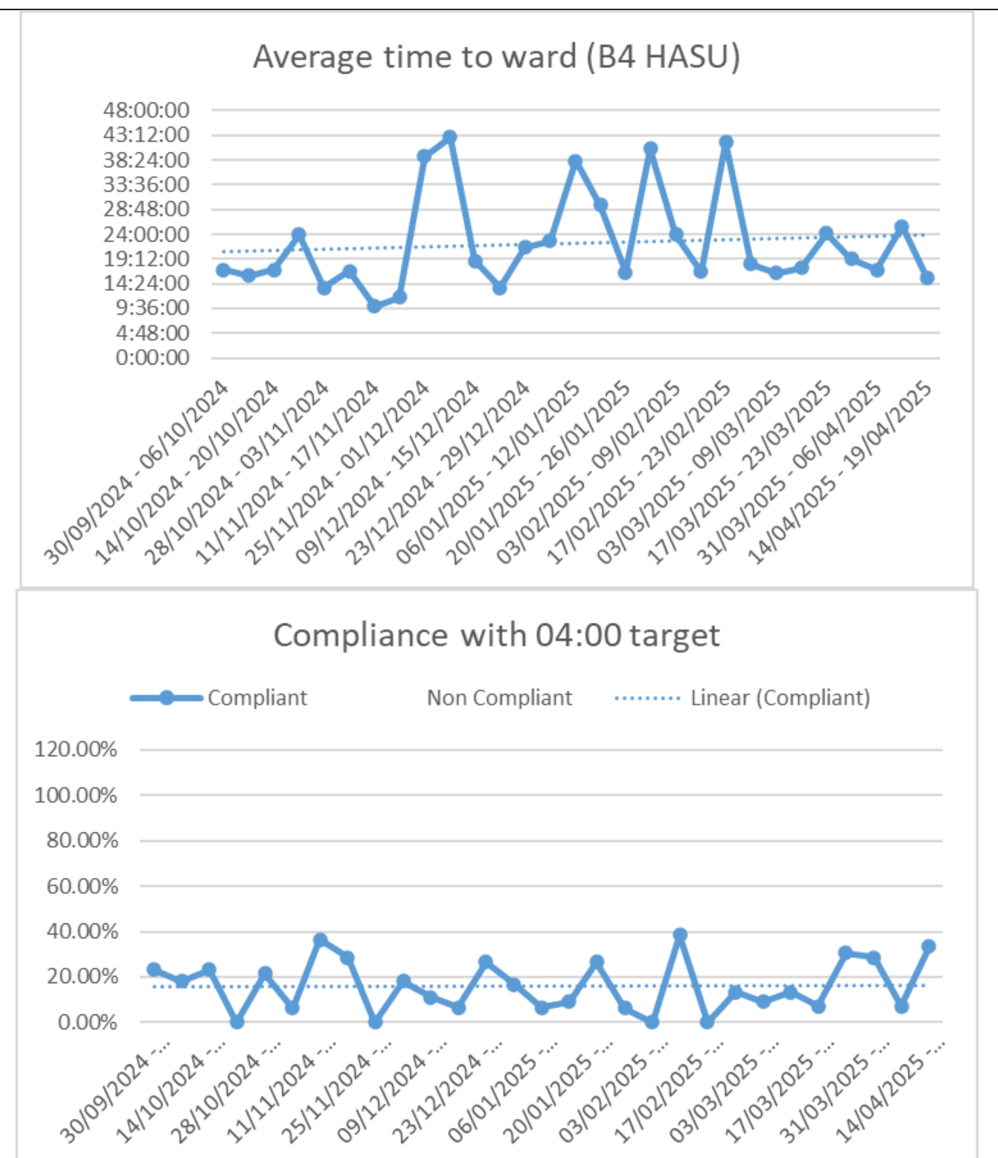
Although stroke beds are officially designated as ringfenced, this policy is not consistently followed when stroke admissions are low, and beds remain unoccupied. The recent reallocation of 8 stroke beds to General Medicine (GENMED) limits the system's ability to scale up during periods of increased stroke demand and this is significantly affecting the ability of the service to manage spikes in demand.

As noted in the summary section, a piece of work is ongoing with the Directorate Manager to manage the minutia of the process between patients being assessed in ED and arriving on the HASU.

Key issues identified include:

- General Medicine patients being placed in stroke beds, leading to prolonged lengths of stay
  - Instances of GENMED patients being placed on the HASU when Stroke patients were waiting in ED.
  - GENMED patients being placed on HASU with the team being told that they would have a short LOS, however patients remain on HASU for longer than expected
- Delays in transferring patients who are no longer on the stroke pathway to alternative accommodations
  - Patients who can step-down to community beds straight from HASU that require additional care needs
- Delays in obtaining MRI scans
  - Individual calls between senior managers yield rapid processing of scans, however unless escalated patients will wait up to 24h for scans.
- Inefficiencies in portering and cleaning services
  - Ward staff are resorting to going down to ED themselves to bring patients up to the wards as well as cleaning the cubicles to facilitate rapid changeover
- Lack of support from transfer lounge
  - Noting that stroke patients can be more complex to care for compared to other patients, there have been several instances where stroke patients have been refused access when waiting for transfer elsewhere

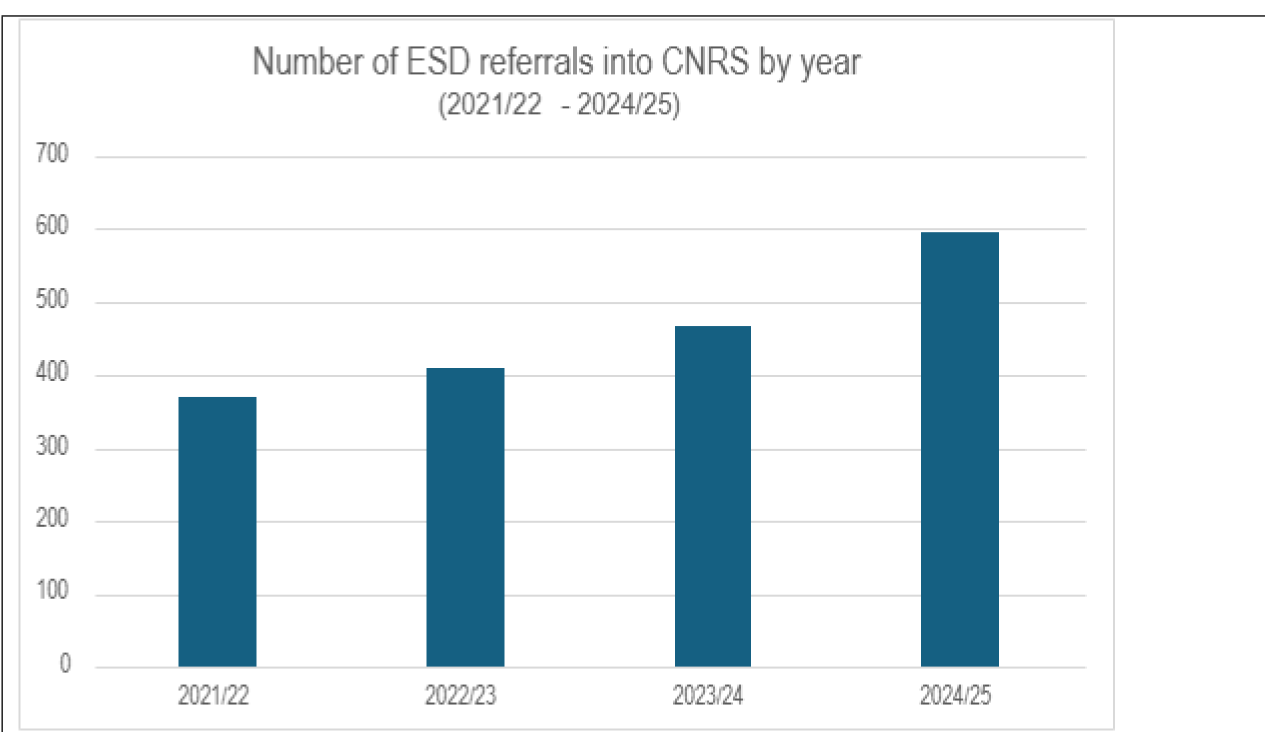
Some of these challenges could be mitigated by revisiting and reinforcing the criteria for breaching the stroke ward, in line with the agreed protocol. Additionally, prioritising stroke-related requests over routine tasks for all investigations and discharge dependent reviews would help maintain the integrity and responsiveness of the stroke pathway.



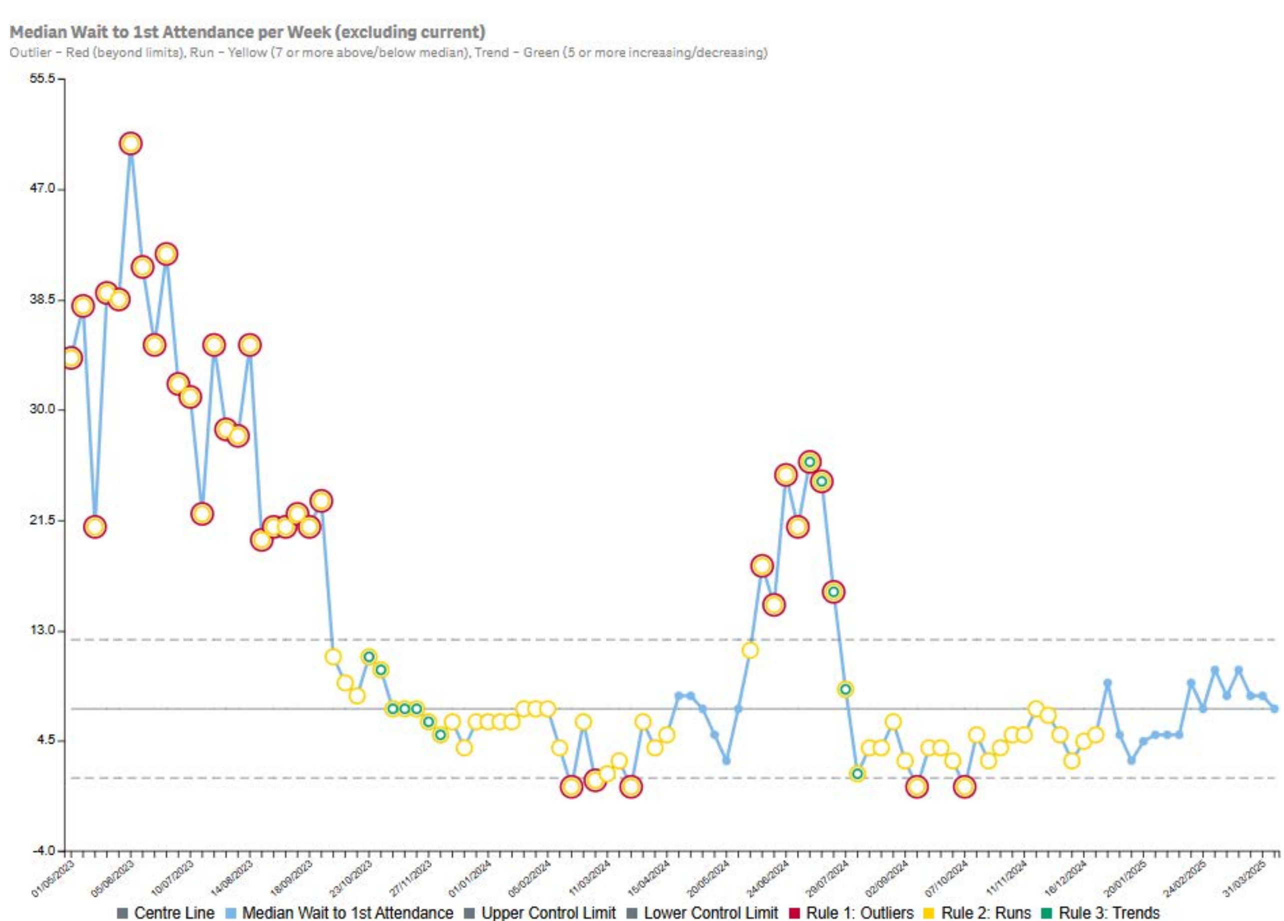
The above graph provides a snapshot of audit compliance and the weeks that met the 4-hour target to for HASU admissions From November 2024 to April 2025 there is a slight deterioration in performance with a compliance rate of 16.1%.

While this report focuses on the acute inpatient pathway, it would be remiss not to note the challenges and opportunities that exist within the community, rehab and outpatient services; both TIA and Stroke Follow-up.

Since 2021 the demand for ESD services has increased by 56%. This increase could be due to a number of factors but this timeframe overlaps the colocation of wards in 2023.



The out-patient service has recently implemented an eReferral service for TIA patients being referred from GPs, this has streamlined the process and is ensuring that the process is much more transparent. Current waits are approx. 3-4 days



Follow-up waiting lists are also being clerically validated for the first time (1,225 significantly passed target). A number of pathways are being closed due to inaccuracies in the pathways. It transpires that this waiting list is not routinely

validated by central validation teams, and this work is being undertaken within the directorate.

Additional follow-up capacity is being brought online in the form of specialty doctors who are now empowered to manage their own templates alongside consultants to increase capacity and build their experience.

Appendix a.

GIRFT Report.

RNOH_GIRFT_ABUHB Stroke Report_Fin.

Appendix b.

2021 Therapy Review

Review%20of%20Therapy%20Stroke%20

Appendix c.

2023 HIW Patient Flow Review

31082023 - Patient flow - Final brandec

Appendix d

Welsh Government letter to NHS Wales Health Board Chief Executives - Improving Stroke Services in Wales

Welsh Government letter to NHS Wales

Appendix e.

GIRFT Action Plan Tracker

Stroke Action Plan Tracker.xlsx

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to

- Note the assurance from this paper that progress and focus is still very much on the GIRFT recommendations, and that actions that have been taken to

implement specific recommendations have shown improvements in many key performance indicators indicative of good Stroke care across the pathway.

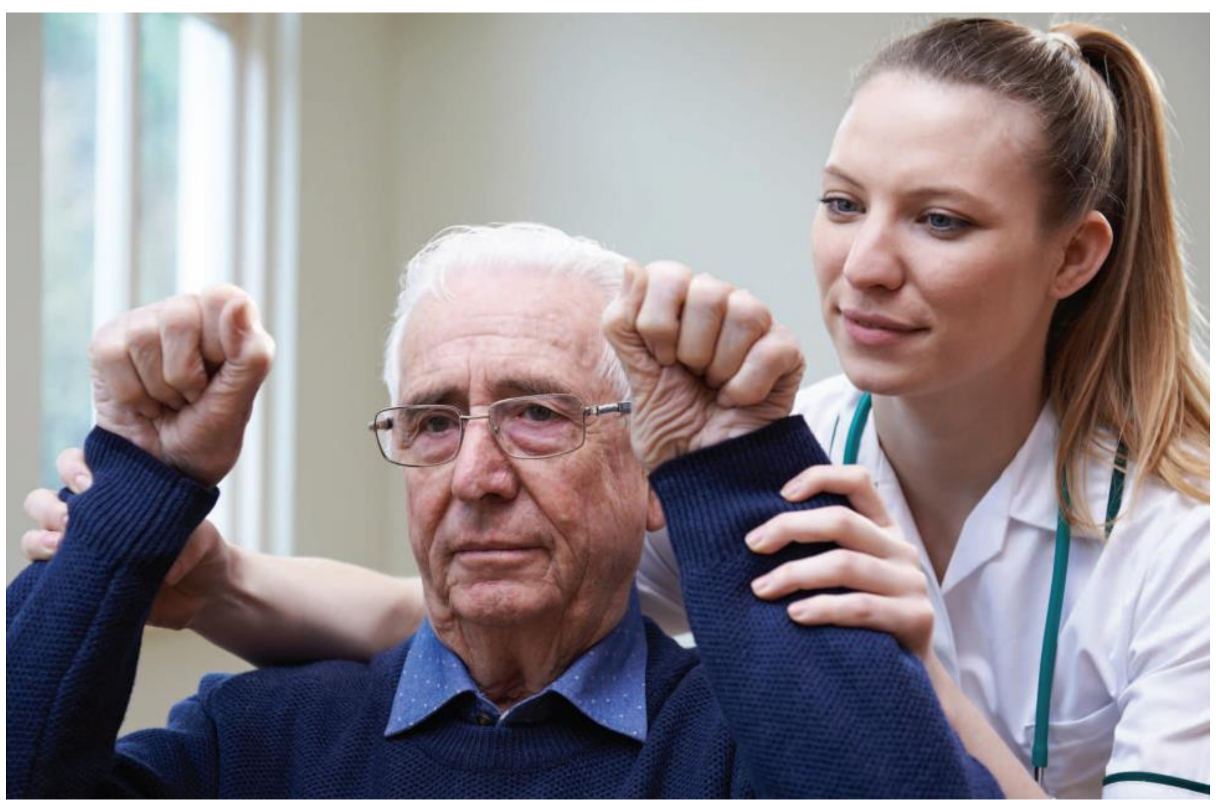
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3.1 Safe and Clinically Effective Care Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)

	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

GETTING IT RIGHT FIRST TIME
Stroke Medicine Review Report
Aneurin Bevan University Health Board
September 2022



This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the Wales Planned Care Board team. It aims to identify improvements in stroke services at ABUHB to help them ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

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1. Introduction

Getting It Right First Time (GIRFT) is a national programme designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The ambition of the programme in Aneurin Bevan UHB is to identify examples of innovative, high quality and efficient service delivery as well as identifying areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. RNOH/GIRFT worked closely with the National Clinical Lead for Stroke in Wales, Dr Shakeel Ahmad, to ensure that this project is aligned with the Wales Stroke Strategy.

2. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Aneurin Bevan University Health Board (ABUHB), to conduct a review of their Stroke services using the GIRFT methodology, with the aim to support the Health Board with effective delivery, structure and performance of their stroke services.

This Programme of work is split into three phrases:

1) RNOH/GIRFT delivered a summit meeting on Thursday 27th January 2022 to provide colleagues from ABUHB with an overview of the GIRFT Programme and the GIRFT stroke workstream in England and to explain the principles and approach of the stroke programme planned for ABUHB.

2) The RNOH/GIRFT team visited all four stroke units in ABUHB on 11th May 2022; Nevill Hall Hospital (NHH), Ysbyty Ystrad Fawr (YYF), Royal Gwent Hospital (RGH) and The Grange University Hospital (GUH). A deep dive review and feedback meeting was conducted at GUH with key stroke staff attending either in person or joining virtually from the other three sites that had been visited earlier in the day.

3) Once this report has been delivered and the recommended actions made clear, the GIRFT Stroke Clinical Leads will hold a series of virtual monthly implementation support meetings. The purpose of these meetings will be to support and challenge the ABUHB clinical, operational and analytical teams to implement the recommendations from this report and to leave a legacy of sustainable quality improvement.

This document captures the key findings and recommendations arising from the visit to ABUHB by Dr David Hargroves and Deb Lowe on the 11th, May 2022. We are extremely grateful to all those who attended our visit and gave such open and honest feedback.

This report is a companion document to the Health Board Provider Level SSNAP Datapack. Many of the process markers of performance used in the GIRFT stroke analysis come from The Sentinel Stroke National Audit Programme (SSNAP). This is a major national healthcare quality improvement programme based formerly at the Royal College of Physicians (RCP) in

London, now housed within the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is a single source of stroke data in England, Wales, and Northern Ireland. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

3. Aneurin Bevan University Health Board

The Aneurin Bevan University Health Board (ABUHB), which was established on the 1st October 2009, covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys and services a population of 600,000 and has approximately 850 stroke admissions per year. It employs over 14,000 staff, two thirds of whom are involved in direct patient care. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

ABUHB has a new specialist and critical care centre, the Grange University Hospital (GUH), which opened in November 2020, has 560 beds and features a 24-hour Acute Assessment Unit, Emergency Department and Helicopter Pad. It provides a 24/7 Emergency Service for patients that need specialist and critical care. Upon opening, GUH became the only Hyper Acute Stroke Unit in ABUHB, taking over this role from the Royal Gwent Hospital (RGH), based in Newport. RGH is one of three enhanced Local General Hospitals operating in ABUHB, the others being Nevill Hall Hospital (NHH), in Abergavenny, and Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. Each of the Local General Hospitals provides therapy and rehab services for stroke patients. Most patients are admitted via the Flow Centre to GUH for their acute phase of care. Any self-presenters at the ELGhs or patients who have had a stroke whilst on an ELGH site are assessed and depending on clinical presentation are almost always “dripped and shipped” to GUH.

There are also Community Hospitals and facilities which were not included in this review but may care for some patients once they have completed their stroke pathway and awaiting discharge as a step-down facility. These are:

1) St Woolos Hospital (Newport) ‘Ruperra’ ward and formally dedicated to Stroke Rehabilitation. However, when GUH opened this ward moved to the ELGH and is now a community ward.
2) County Hospital (Pontypool) this hospital receives patients who normally reside in Torfaen, from both the Royal Gwent and Neville Hall Hospitals for rehabilitation after stroke,
3) , provide some community based inpatient stroke rehabilitation services.
4) Monnow Vale, (Monmouth) provides community based inpatient rehabilitation, not specifically for stroke patients
5) Ysbyty Aneurin Bevan (Ebbw Vale) provides community based inpatient rehabilitation, not specifically for stroke patients
6) County Hospital (Pontypool) community based inpatient rehabilitation, not specifically for stroke patients

3.1. ABUHB and Its People

The strength of a National Health Service is in its people. The power of an organisation is so often in the loyalty, dedication, shared purpose and clear vison of its staff to deliver the best care they can and to always put the patient at the centre of everything they do. We were impressed by the culture and leadership at all the hospitals, which became evident within a few minutes of meeting the multi-disciplinary teams.

We also witnessed frustration and fatigue; to be expected at the end of a two-year pandemic, but this ran deeper and relates to a longer duration than the pandemic as it was clear that many felt unable to influence change within their organisation, yet still were willing and able to speak up and express their desire to drive the necessary changes forward.

We were told that the workforce challenges throughout NHS Wales are significant across medical, nursing and therapy teams, but are particularly marked in some of the ABUHB hospitals. BASP-Stroke-Medicine-Workforce-Requirements-Report and the https://www.hee.nhs.uk/our-work/hee-star are useful bench marking tools which the ABUHB stroke team may wish to use to address these workforce challenges.

There is good evidence for working within networks and we were very pleased to hear that the Welsh Stroke Strategy looks to support the development of stroke networks across Wales, to share knowledge, information, facilitate inter-organisational collaboration and learning and manage change. This will require excellent leadership, and we were impressed to see so many natural leaders across the professions whose skills need to be harnessed to support delivery of high-quality care.

4. Service Overview

The following Service Overview was provided by ABUHB prior to the meeting and discussed during the deep dive session. Additional information was gathered in the pre-visit virtual meeting and in the meetings with staff on the day.

SERVICE OVERVIEW – Aneurin Bevan University Health Board					
1	**Population served**	Total Number: 600,000 in ABUHB			
2	**Hospital beds in total in individual hospitals**	Where based and Total Number: 1217 RGH 218 NHH 212 YYF 227 GUH 560			
3	**Stroke beds**	Number of beds Stroke Rehab RGH 24 Stroke Rehab NHH 22 Stroke Rehab YYF 15 Hyper Acute Stroke GUH 12+ 3 general medicine	Base and No. of Hasu=1 HASU GUH HASU 12 beds specifically for HASU the ward is 15 bedded with the additional 3 beds used for GM patients		
4	**Stroke Consultants**	Number per site RGH- 1 Consultant NHH – 1 consultant YYF – 1 consultant GUH – 4 consultants	Number On-Cal 8 Stroke-only	Further detail: i.e. 5/7 or 7/7 service 1:8	

		Total DCC's:45,	Consultants on-call:	
5	**Stroke Nurses**	WTE Number 4	Hours of Cover 7am -5pm	Plans in discussion for 12 hour cover when vacancies filled and staff trained.
6	**Stroke Ward Staffing**	Registered Nurses: 3 day 3 night Health Care support: 3 day 3 night Nursing Bands: Band 6 x2 Band 5 Band 3 Band 2	Therapists: SLT 0.7WTE dedicated SLT for HASU 1WTE SLTA FOR HASU (No other sites have stroke specific staff. Only able to provide 4 day dysphagia cover. Occupational Therapists: GUH 0.8WTE BAND 7, 0.6 BAND 6 RGH= 1 WTE BAND 7, 1WTE BAND 6, 1WTE B5, 1WTE BAND4 1 WTE B3 NHH: 0.8 WTE BAND 6, 1WTE BAND 5, 0.8 WTE BAND 4 YYF: 1WTE BAND 6, 1WTE BAND5 1WTE BAND 3 AND 0.8 WTE BAND 8A FLOATING Physiotherapist: GUH 2 WTE YYF 2.5 WTE RGH 3.6WTE NHH 3.3 WTE	Extra Detail: 1 ward manager, supernumerary to numbers by day (M-F)
7	**Psychology**	1 WTE Psychologist for Stroke 1 WTE Assistant		Based in Community Neuro rehab service but in reach to wards and

		psychologist for Stroke 1 WTE Consultant psychologist for Stroke and Neurological conditions		provide life after stroke psychology service through 1:1 interventions and group based psychoeducational modules
8	**ESD and community stroke rehab Service**	5 days Cover 0800-1700	Speech Therapy 1.2 WTE OT 3.2 WTE Physio 2.8 WTE Dietitian 0.4 WTE Therapy Assistant Practitioner: 5.6 WTE Life after Stroke Wellbeing practitioners: 1.8 WTE	Extra detail: 1 physio is also Team Lead so has 0.3 WTE dedicated to managerial role. All patients can access the service based Niwrostiwt Neuro Recovery College which delivers education on common stroke issues and opportunities for personal recovery.
9	**6/52 and 6/12 Review Process**	6 weeks follow up consultants 6/12 is completed by CNS		
10 11.	**Stroke imaging** **Relationship with IAT Centre & Hours of Service:**	Access to CTA: hours / per day 24 hours a day Access to CTP: hours / per day 0 Hours a day Access to AI: Y/N Not available But funding been approved the Welsh Government recently **Access to MRI first line for acute stroke and TIA patients?: There are no dedicated slots for stroke and TIA but this is available daily.** **Current waiting for TIA imaging. MRI two weeks, CT one week, Carotid doppler one week.** **Inpatient CT 10 min to 1 hour, MRI 2 to 24 hours (same day 60%, next day 40 %), MRI Scans requested after 3 pm mostly done next day.** Modality used for carotid imaging? Carotid Doppler Please describe: Bristol South meads 8am to 6 Pm 7 days a week		

Most of this report focuses on the performance and data we have for ABUHB's hyper-acute stroke service, as the GIRFT methodology relies heavily on the use of data to drive improvement. This, however, is only one part of the complex pathway of stroke care within this hospital group. It was important to the visiting team to understand the flow, the facilities, and the people within the three surrounding stroke units to enable a rounded discussion at the deep dive meeting held at GUH and to support the development of strategic and quality improvement recommendations.

4.1. Nevill Hall Hospital

The NHH Rehab Team

Nevill Hall Hospital (NHH) in Abergavenny has 213 inpatient beds and a wide range of services including a 24/7 nurse led minor injuries unit and a medical assessment unit.

The stroke ward at NHH had 28 beds when we visited, 24 beds were funded and 21 of these were stroke beds; the remaining were general care of the elderly beds. The team informed us that on average, 20% of the beds were occupied by acute stroke admissions; these patients don't get entered in to SSNAP as this hospital is not classed as a routinely admitting stroke unit. The model in ABUHB is that all patients should come through the Flow Centre for admission at the GUH not ELGHs. There is access to thrombolysis 24/7 and a 'drip and ship' model is employed with some but not all patients moving to The Grange for their hyper-acute stroke care. The length of stay was reported to be 42 days. As the ward is mixed, this figure also included patients classed as "General Medicine and Care of the Elderly".

There are two medical consultants that support the unit, one substantive and one locum consultant that is going through the Certificate of Eligibility for Specialist Registration (CESR) route. The medical lead at this ward is very clearly a highly valued member of the team and there was a positive inclusive culture felt on the ward. The ward has two foundation doctors and one CMT doctor during the week. There had been two experienced Clinical Nurse Specialists supporting the ward on a pro-rata basis that had moved to the Grange when the HASU was centralised in 2021. These posts have not been backfilled on the ELGH sites. We were pleased to hear that ABUHB had recruited two new Nurse Consultants in other areas so there could be scope to develop similar roles in Stroke

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was a very high level of neuro-rehabilitation expertise within the group of senior therapists that we were able to meet. Of note there was only 0.6 WTE dysphagia trained Speech and Language Therapy provision. At the time of the review, it was reported that there was no psychology support but in theory there is usually 4 hours

per week of support for inpatients. The role of rehabilitation assistants was recognised and their ability to support 7 day working with the correct supervision was supported.

Access to Early Supported Discharge (ESD) and Community Rehabilitation Teams (CRT) was variable. There was usually at least a 1 week wait to access 'ESD' and there was no enablement/domiciliary care included within the commissioned service. The ESD responds to received referrals within 1 day of discharge Monday – Friday. Contact is via telephone triage – if same day assessment is indicated, it is available (staffing challenges may sometimes affect this). If same day assessment is not indicated, we target the right profession to complete the assessment – this approach is based on the Malcolmess Care Aims intended outcomes framework and aims to get the right person out to assess at the right time. This allows stroke survivors to settle at home and explore their new functional status so that when we assess they are able to identify hopes and goals in a more meaningful way than they can on the first day home from hospital when they are often very tired and just needing time. The pathway was commissioned for 3 months, but this could be extended based on patient need. If a patient was discharged to a nursing home, there appeared to be less access to specialist stroke rehabilitation. The ESD team works with people for up to 3 months (average 8 weeks). If ongoing support is required, this is arranged through outpatient physio/SLT services. The clinical psychology team support over a longer time frame up to and over one year.

Social work support is locality based and can be variable with significant delays for packages of care. It is not unusual to wait 4 weeks for a larger package of care and even longer delays for nursing home placements.

There had previously been a commissioned Stroke Association Family and Carer support worker service across ABUHB, but this service had been decommissioned. Following the end of the commissioned stroke association service, Life-After Stroke support is provided through 2 Life after Stroke wellbeing practitioners who are embedded in the Community Neuro Rehab Service. The recently appointed2 practitioners will support anyone who has had a stroke in the past year and provides face to face, telephone and virtual support as appropriate. The service sends a letter and leaflet contact for people to request support. The service will also in reach to the stroke units if in reach support is requested by the ward staff.

The estates at Nevill Hall were sub-optimal for delivery of effective rehabilitation. There was inadequate therapy space and no quiet space for speech and cognitive assessments. Toilet facilities were mixed sex, and you could not enable patients requiring a hoist for transfer to use the bathrooms. Some of the environmental constraints within this ward could be addressed by returning the ward to 24 funded beds and utilising the released space to address the above concerns.

4.2. Ysbyty Ystrad Fawr

The YYF Rehab Team

Ysbyty Ystrad Fawr (YYF) in Hengoed has 164 inpatient beds and has a Minor Injuries Unit, medical assessment unit included within its services. It has 30 rehabilitation beds, 15 of which are usually occupied by stroke patients. It was reported that the length of stay is approximately 42 days on this ward. At times the stroke ward may be occupied with more General Medical or Care of the Elderly patients so the length of stay will be affected by this. It was also reported that it was unusual for acute stroke patients to present to this hospital and only a handful of patients had been transferred to The Grange by 'drip and ship'. This is because all patients are managed through the flow centre and directed to the GUH. Stroke patients are referred from the HASU at GUH into this unit for rehabilitation. This makes flow management and discharge planning difficult, as the ward works with multiple locality social work teams and different commissioned community CRT services and one ESD team. There seemed to be a lack of a commissioned pathway for complex neurological rehabilitation.

There is a single-handed consultant who is job planned to deliver 6 PAs to support the service and there has been a Stroke Consultant vacancy at this site for almost 5 years. There are additional ward rounds by a Care of the Elderly Consultant but when the Stroke Consultant is away, there is usually only one ward round per week. Junior doctor support can be variable but on average there are 5 junior doctors including F2's, GPVTS and two registrars. There was an excellent culture of training and education within the unit and supported places to attend the Welsh Stroke Conference each year. There was good support from ward-based pharmacists for safe prescribing.

There was excellent nursing leadership, as with all the hospitals we visited, but there are significant nursing recruitment challenges at YYF with a 50% nursing vacancy rate despite attempts at international recruitment. Band 4 nurses had recently been appointed using band 5 funding.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1.2 WTE SLT for the entire hospital; of this, only 0.6 WTE is dysphagia trained SLT. The remaining 0.6 WTE is for communication only. At the time of the review, it was reported that there was no psychology support but in theory there is usually support for inpatients from an in-reach on referral model. There is a very limited spasticity service offered at this hospital with ad hoc support available. The senior physiotherapist was also being trained to administer Botox therapy which is to be commended.

There is good social work support and a discharge coordinator role but still major delays in accessing packages of care and nursing home places.

Follow up post discharge is delivered at 6 weeks by the Stroke Consultant, but there is no routine 6 month follow up.

The ward was made up entirely of single rooms. Whilst this has some advantages for privacy and infection control, there is evidence that stroke patients in the rehabilitation phase get a lot of benefit from the socialisation of communal bay accommodation and therapy spaces. The toilet facilities could not accommodate patients that needed to be hoisted. The rehabilitation therapy space was not based on the rehabilitation ward and was not exclusively reserved for the rehabilitation ward.

4.3. Royal Gwent Hospital

The RGH Rehab Team

Royal Gwent Hospital in Newport has approximately 370 inpatient beds and again a 24/7 Minor Injuries Unit and Medical Assessment Unit amongst its services. There are 24 stroke rehabilitation beds, and these are usually exclusively occupied by stroke patients with the occasional complex neurological rehabilitation patient. The average length of stay is

approximately 44 days. There are some self-presenting stroke patients making up around 10-15% of all admissions; these patients are rarely moved to The Grange.

The Medical Consultant cover is currently being provided by a Consultant from The Grange who carries out a twice weekly ward round. The ward is also supported with daily specialty doctor cover; this is clearly not a sustainable model and new consultant appointments were being explored to support the medical workforce. There are 4 junior doctors that support this ward, one foundation doctor and three middle grade speciality doctors.

There were significant challenges across nursing recruitment with 5 RN vacancies and 4 CSW vacancies at the time of our visit. It was clear to see that there was strong nursing leadership as this unit has previously been a nurse led rehabilitation unit, but frustration was expressed with the ongoing recruitment difficulties. There was a good working relationship between the therapy and nursing teams with key interventions to support nursing workload.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1 WTE band 6 SLT for the entire hospital. There was a reported delay of 3-4 weeks for PEG insertion. There is psychology support from an in-reach on referral model.

There were similar challenges to NHH and YYF with access to ESD and CRT, with a perception of a delay in availability onto ESD. NHH ESD responds to received referrals via a telephone call the day after discharge from hospital. Assessment is undertaken on the same day when required. Delays in packages of care, which sit within Social Services / Community Resource Team (CRT) is still a concern and may delay access. Only patients that were fit for transfer could be discharged for home therapy, with only one patient able to do so. Neuro-rehabilitation out-patient services were only available for Physiotherapy.

There are significant delays to access packages of care and nursing home placements. Stroke patients are moved to other ward areas to support flow due to discharge delays if they are no longer receiving active rehabilitation. It was reported that on average 15% of patients were medically optimised for discharge.

There were two large therapy areas on the ward but no quiet room for speech and cognitive assessments. There was one bathroom accessible for hoist transfer patients. Group rehabilitation was offered, and Occupational Therapists had changed working patterns recently to support morning Personal Activities of Daily Living (PADL) assessment and to support the nursing staff.

4.4. The Grange University Hospital

The GUH Rehab Team

As described earlier, this new hospital has 560 beds and provides all Specialist and Critical Care services for Gwent. It is also a major Trauma Centre for the region as well as being ABUHB's Acute Stroke Centre. It has 15 stroke beds, 12 of which are funded Hyper-Acute Stroke Unit beds, with an average length of stay of 6 days. It is difficult to meet the 4 hour target for admission as beds are not ring-fenced and frustration was expressed about the inability to manage their own beds.

There are 7 side rooms, two bays with 4 monitored beds in each and one therapy room on the ward (which at times of high demand in the hospital overnight was being used as a General Medical patient bed, although this has now been removed from the site escalation plans)

There are 4 stroke consultants that support the acute stroke pathway. There are 6 Neurologists that are employed by this Health Board and are based at the Royal Gwent Hospital, but only one works within the stroke team. A total of 8 consultants support the on-call rota from the four ABUHB hospitals. There is remote PACS radiology access to support remote review of brain scans

There were reported to be excellent nursing levels and no issues with recruitment. There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was 0.8 WTE SLT in post but 1.4WTE funded Speech and Language Therapy. There was no dietician support for the stroke unit with psychology support being offered as an in-reach service to the ELGH rehab site.

The acute care pathway was reviewed during our discussions with the team, and we had the opportunity to 'walk' the stroke pathway from A&E to radiology and up to the ward. Pre-alerts do occur directly to the stroke nurses but there is often limited information, which does not

enable pre-registration. Stroke Specialist Nurses are available Monday to Friday, 8am to 5pm and outside these times the Medical Registrar supports acute stroke assessments in A&E. An A&E sister commented during the visit, that she couldn't understand why the stroke review team would visit the resuscitation /high intensity A&E area as "stroke patients should never be assessed here". This was concerning, as acute stroke patients are some of the most acutely unstable patients in the emergency department. We accept that this may have been the opinion of an individual, but parity of esteem for stroke patients and support for the stroke team in A&E is essential to a successful stroke pathway.

Following initial review, suspected stroke patients go directly to CT +/- CT Angiogram. This pathway is less streamlined out of hours. Artificial Intelligence decision support software is not used, nor is Commuted Topography Perfusion (CTP), to support recanalization referrals and decisions. Thrombolysis is given in A&E. MRI is available 0730 to 2000 7 days a week for investigating minor strokes and stroke mimics and CT provision is available 24/7.

Thrombectomy services are delivered at Bristol South Mead Neuroscience Centre, 8am to 6pm, 7-days a week. There are good relationships between the referring hospital and the Neuroscience centre, although Thrombectomy rates remain well below a potential target of 8-10% of all stroke patients.

There are no specific TIA and Minor Stroke out-patient clinics delivered at GUH as the model for GUH does not include an outpatient footprint. These are all provided by the three other hospitals. Patients wait between 5 and 6 days to be seen and there is no provision for 'one stop assessment'. There is no access to first line MRI imaging, as per NICE guidelines, and patients often wait up to a week for brain and carotid imaging. Vascular surgery centralised in SE Wales on 18th July 2022 and is performed at the Regional Vascular Unit at the University Hospital of Wales in Cardiff. Intracerebral Haemorrhage Patients requiring Neurosurgical Intervention are also managed here.

5. SSNAP Data Performance Metrics: Findings and Recommendations

The recommendations that we have made in the report have been based upon the data accessible to us at the time of the visit to ABUHB and within the SSNAP published annual portfolio reports. It is also based on information from Trust Executives, Clinical Leads and Operations Managers on the pre-visit meeting and at the site visits. These are not exhaustive but are key areas that if focused on will reduce unwarranted variation and improve delivery of services along the stroke pathway.

During the deep dive visit on 11th May 2022, RNOH/GIRFT presented performance data for SSNAP registered routinely admitting stroke services in Wales, benchmarked against all stroke units in Wales and against the English national average. GUH is represented as the single routinely admitting stroke service in ABUHB; however, it is recognised that there are patients directly admitted to ELGHs and may not transfer to GUH (and therefore not included in SSNAP data). This included data from the most recent published SSNAP data available for the period October 2021-December 2021. Although this represents only a short period in time, having reviewed annual data in preparation for this visit, the Clinical Leads are confident that this quarterly data is representative of the performance out with this timeframe, and that recommendations are all relevant for future quality improvement.

5.1 Stroke Activity and Performance

Figure1

Routinely Admitting Team	Admissions (Oct 21 - Dec 21)	SSNAP level	SSNAP score	*Case ascertainment band*	*Audit compliance band*	Combined Total Key Indicator level
Grange University Hospital	186	D	48.4	A	B	D
Glan Clwyd District General Hospital	95	D	59	A	A	D
Maelor Hospital	92	D	42.5	C	A	D
Ysbyty Gwynedd	88	D	44	A	A	D
University Hospital of Wales	178	C	64	A	A	C
Prince Charles Hospital	135	C	65	A	A	C
Princess Of Wales Hospital	70	D	45.6	B	A	D
Bronglais Hospital	28	B	71.7	A	A	B
Prince Philip Hospital	40	B	72	A	A	B
West Wales General	44	C	63.2	B	B	B
Withybush General Hospital	45	A	81.7	A	B	A
Morriston Hospital	153	D	59	A	A	D

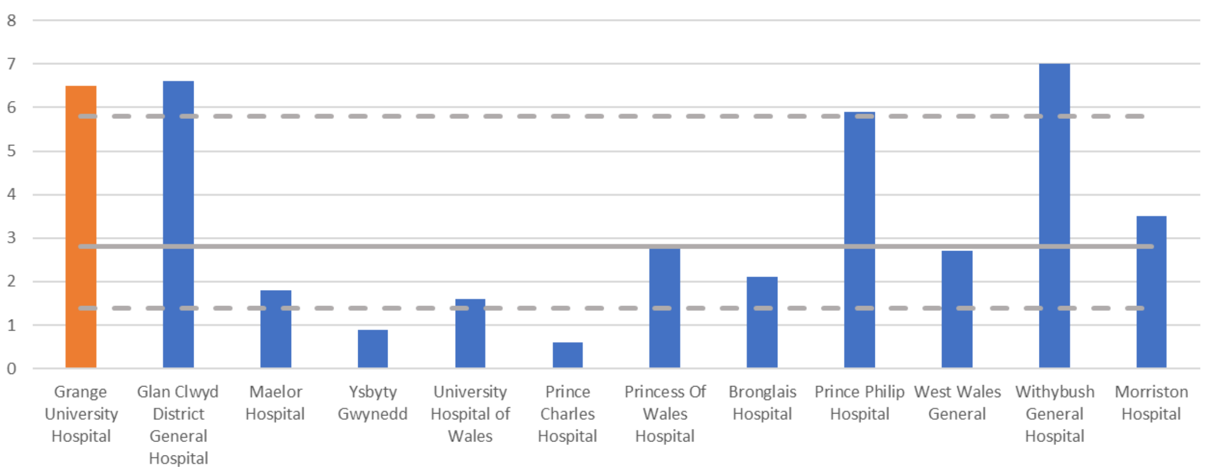
5.2 SSNAP Patient-Centred Data (routinely admitting teams)

Figure2

	Patient Centred Data										
Routinely admitting teams	Scan	SU	Throm	Spec Asst	OT	PT	SALT	MDT	Std Disch	Disch Proc	PC KI
Grange University Hospital	A	E	D	D	B	B	D	E	D	C	D
Glan Clwyd District General Hospital	B	E	D	D	C	C	B	C	A	C	C
Maelor Hospital	B	E	B	D	D	D	D	B	C	D	D
Ysbyty Gwynedd	C	E	E	D	E	D	D	C	A	D	D
University Hospital of Wales	B	E	E	E	B	A	C	B	B	A	C
Prince Charles Hospital	A	E	C	E	A	B	C	D	B	B	C
Princess Of Wales Hospital	B	E	C	E	C	D	E	E	A	C	D
Bronglais Hospital	A	C	B	B	C	B	C	C	A	E	B
Prince Philip Hospital	A	D	E	A	C	B	B	B	A	C	B
West Wales General	A	E	C	B	C	B	C	B	A	C	B
Withybush General Hospital	A	B	B	A	B	A	C	B	B	A	A
Morriston Hospital	C	E	D	B	C	B	C	D	B	C	D

5.3 Admission to record start

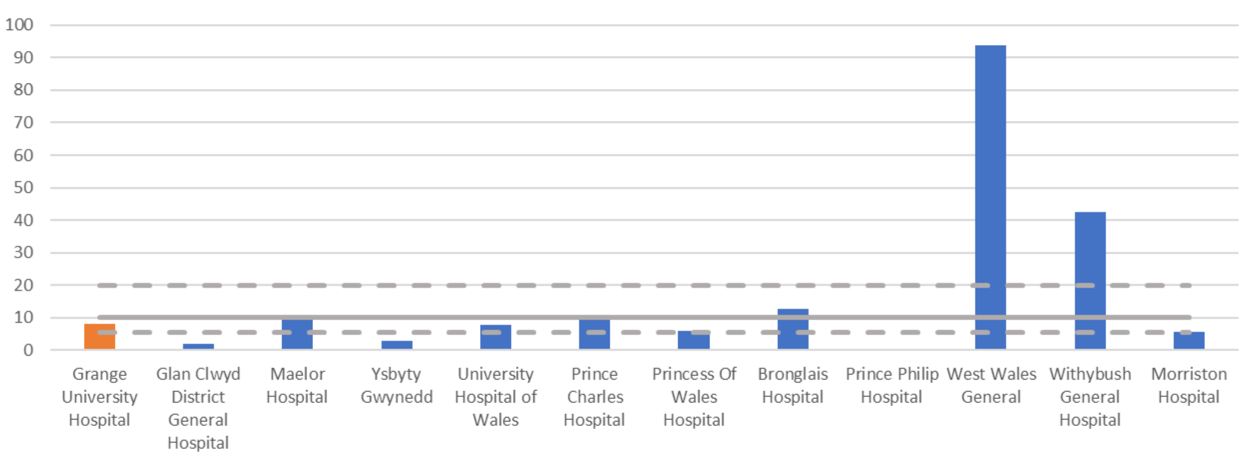
Figure3



Number of days from when patient is admitted/onset to when the record is started – 6.5 days

5.4 Delay (days) between clock start and date of starting electronic SSNAP record

Figure 4



Number of days from patient transferred to next team to when the record is transferred on the webtool – 7.9 days

Analysis from the most recent SSNAP process markers (fig 1 and 2) at the time of this review demonstrated:

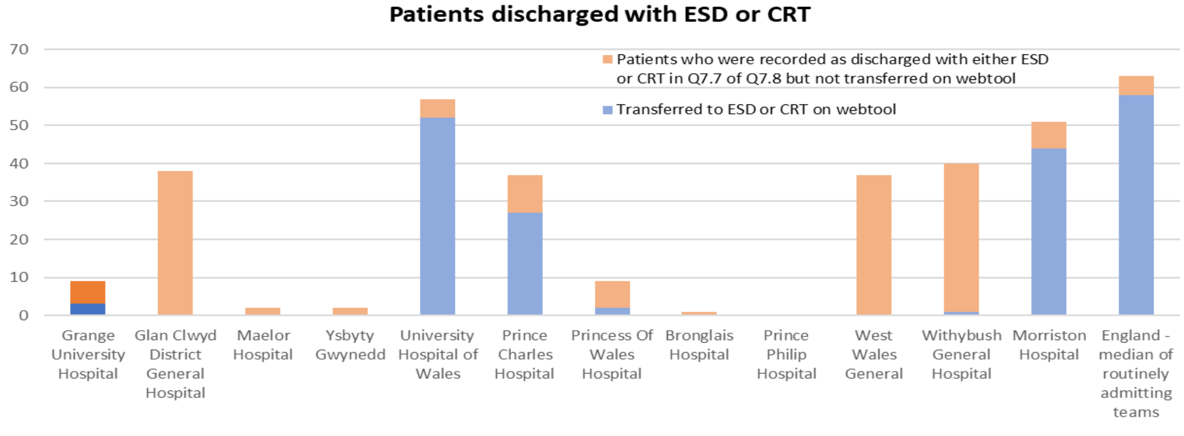
- A good level of case ascertainment band
- Excellent data submission for time to first scan
- There is significant opportunity for improvement in the timely access to the stroke beds at GUH with specialist assessments (particularly SLT) and access to mechanical thrombectomy
- Improvement is required in audit compliance, with significant delays of 6.5 days from admission to records starting respectively (fig 3)
- MDT working and discharge processes are lacking in the SSNAP record

SSNAP collects data on the whole care pathway from initial arrival at hospital, through all inpatient settings, across ESD and community rehabilitation and up to a six-month follow-up appointment. Use of SSNAP is an imperative to drive quality improvement. Recognising that the overall aim of SSNAP (fig 4) is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients is vitally important. SSNAP operates through manual provider level data entry. Acknowledging that SSNAP is only as good as the data submitted is paramount; all efforts should be made to ensure data is entered as accurately possible

Recommendation 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.

5.5 Patents discharged with ESD or CRT

Figure 5



Total number of patients discharged with ESD or CRT: 9x patients

- ***Transferred to ESD or CRT on webtool – 3x patients***
- ***Patients who were recorded as discharged with either ESD or CRT in Q7.7 of Q7.8 but not transferred on webtool – 6x patients***

Local intelligence suggests the number of patients supported with ESD during this timeframe was 31 referrals accepted from GUH during Q3 of 2021 (total number of referrals received from all sites including Cardiff and England was 85).

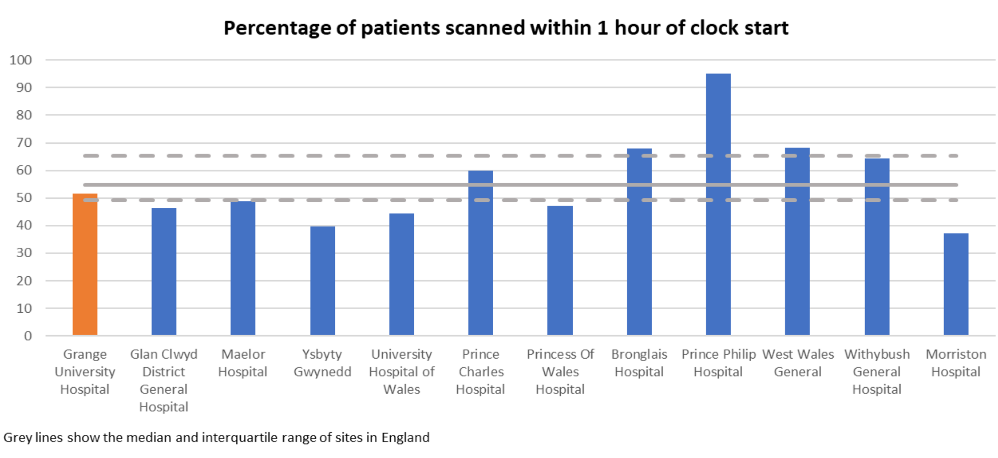
There was wide variation in the access to ESD as recorded on SSNAP. At GUH, the rate of patients discharged with ESD or CRT is significantly lower than the England median. Continued rehab may be delivered at ELGH sites.

Recommendation 2: Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) **that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.**

6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics

6.1 Percentage of patients scanned within 1 hour of clock start

Figure 6



Percentage of patients scanned within 1 hour of clock start – 51.6%

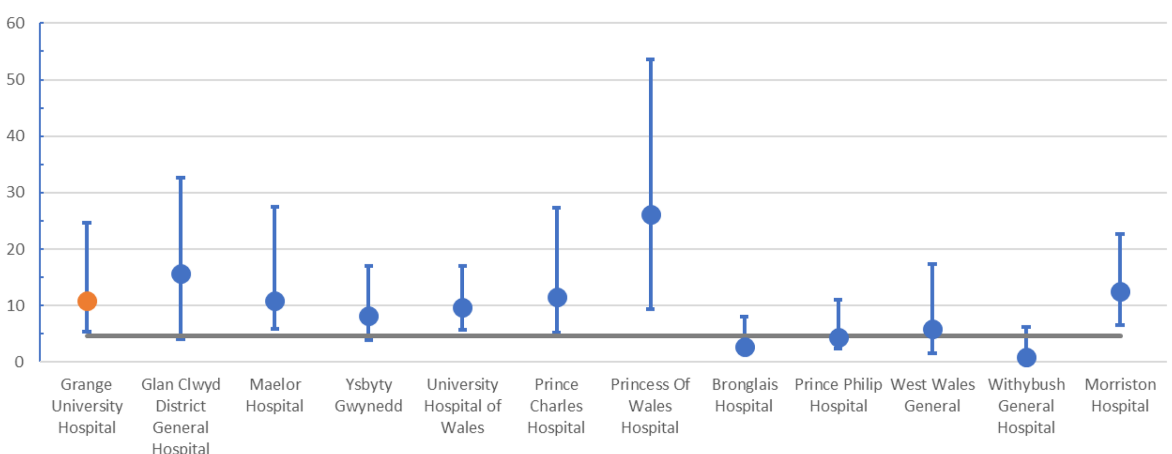
GUH's percentage of patients scanned within 1 hour of clock start was slightly lower than the national average.

Pre-hospital identification of suspected stroke patients could reduce delays to scanning and delivery of emergency treatment and stroke unit admission.

Recommendation 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 National-stroke-service-model-integrated-stroke-delivery-networks**.**

6.2 Clock start to stroke time

Figure 7



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient centred results at team level for Key Indicator 2.2A

Source: SSNAP Oct 2021-Dec 2021

Time between clock start and arrival on stroke unit (hours) – 10.85

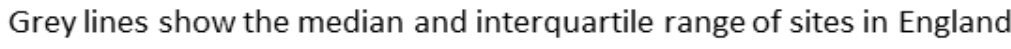
Timely admission to a Stroke Unit is considered a vital aspect of hyper acute care. GUH rates are on a par with the Welsh average, but are however, below the England average rates. There is inadequate bed capacity at GUH to enable all stroke patients to have an admission within 4 hours of presentation to hospital and enable equitable access to evidence-based stroke unit care for all.

Recommendation 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.

6.3 Stay on stroke unit

Figure 8

Percentage of patients who spent at least 90% of their stay on stroke unit



Patient-centred results at team level for Key Indicator 2.3A

Source: SSNAP Oct 2021-Dec 2021

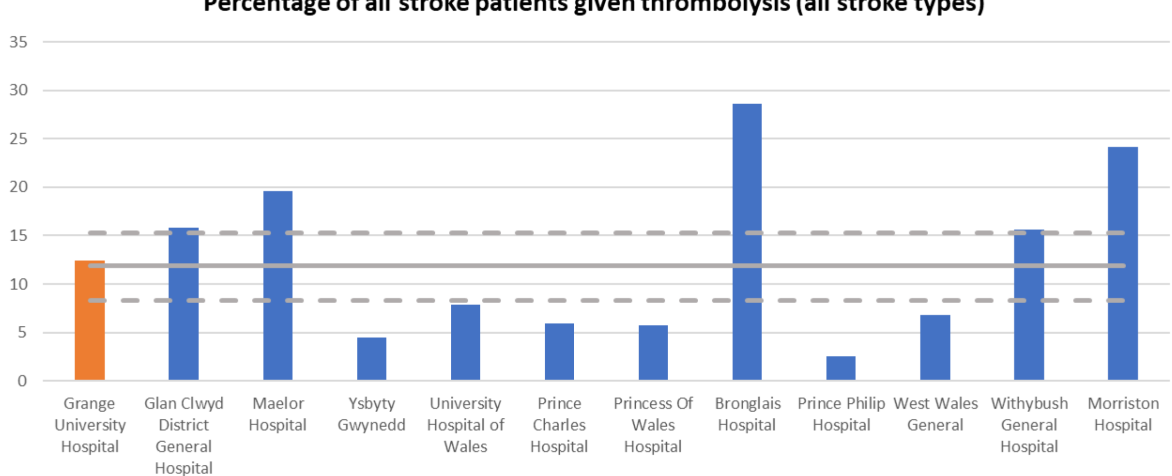
Percentage of patients who spent at least 90% of their stay on stroke unit – 63.9%

The GUH rates for accommodating patients for 90% of their in-patient stay on a stroke unit is lower than the England median. Patients that spend greater than 90% of their time on a stroke unit have fewer severe complications compared to those spending less than 90% of their inpatient stay on stroke units. The RGH reported moving stroke patients to other wards when they were medically optimised, to release beds. This will also have a positive impact on the 90% stay target.

Recommendation 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging (see fig 7 and 8) should help to release bed capacity and increase access.

6.4 Thrombolysis rate (all stroke)

Figure 9



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 3.1A

Source: SSNAP Oct 2021-Dec 2021

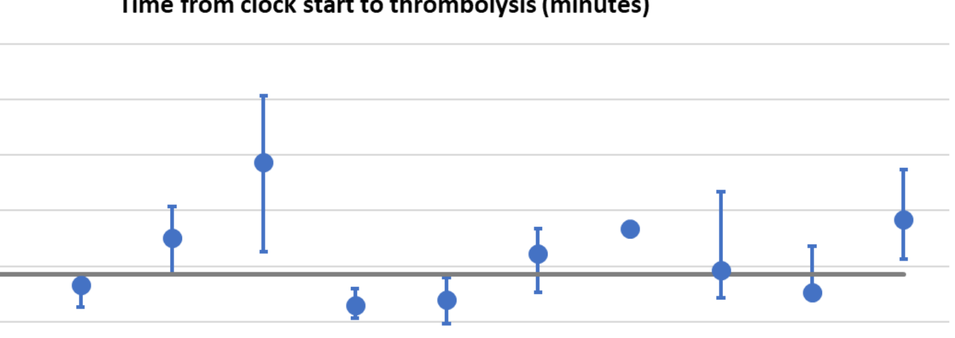
Thrombolysis rate – 12.4%

The thrombolysis rates are slightly above the England national average of 12%.

Recommendation 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.

6.5 Clock start to thrombolysis

Figure10



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 3.5A

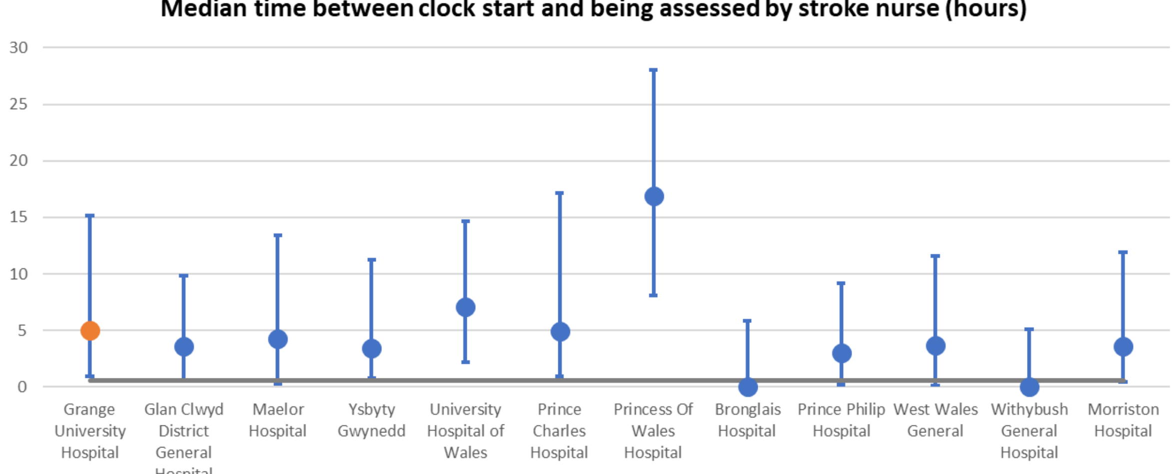
Source: SSNAP Oct 2021-Dec 2021

Time from clock start to thrombolysis (minutes) – 57mins

The GUH is providing timely access to thrombolysis from admission. Rates are in line with the median of sites in England. Aiming for a target closer to 30 minutes is gold standard and is being achieved in many highly performing stroke units in England, aided mostly by pre-registration of patients, immediate review by the stroke team and going straight to CT scanning.

6.6 Median time between clock start and being assessed by stroke nurse

Figure 11



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.4A

Source: SSNAP Oct 2021-Dec 2021

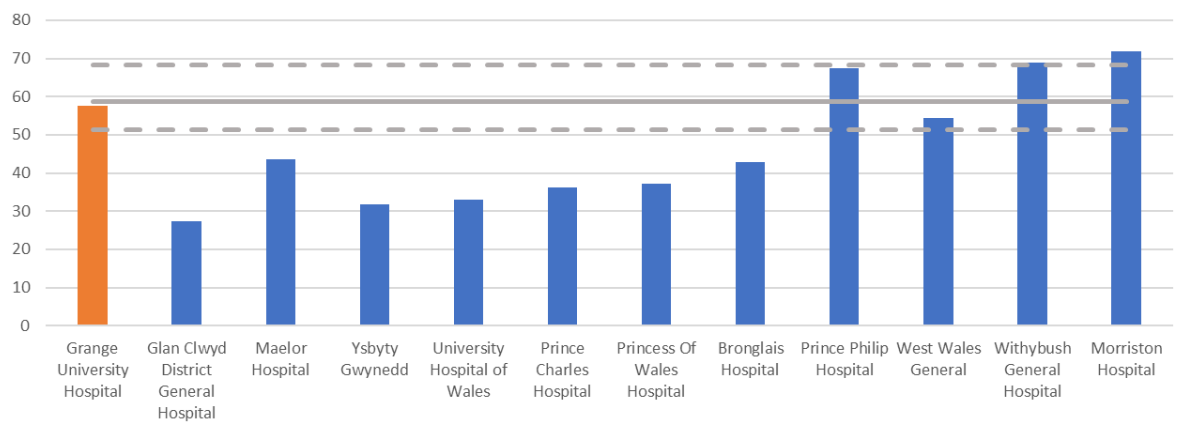
Median time between clock start and being assessed by stroke nurse – 4.95hr

GUH's median time between clock start and being assessed by a stroke nurse is 4.95 hours. There is variation due to GUH's inability to deliver a Stroke Specialist Nurse Assessment out-of-hours (outside of Monday-Friday 8am to-5pm).

Recommendation 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.

6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs

Figure 12



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Item Reference G9.19

Source: SSNAP Oct 2021-Dec 2021

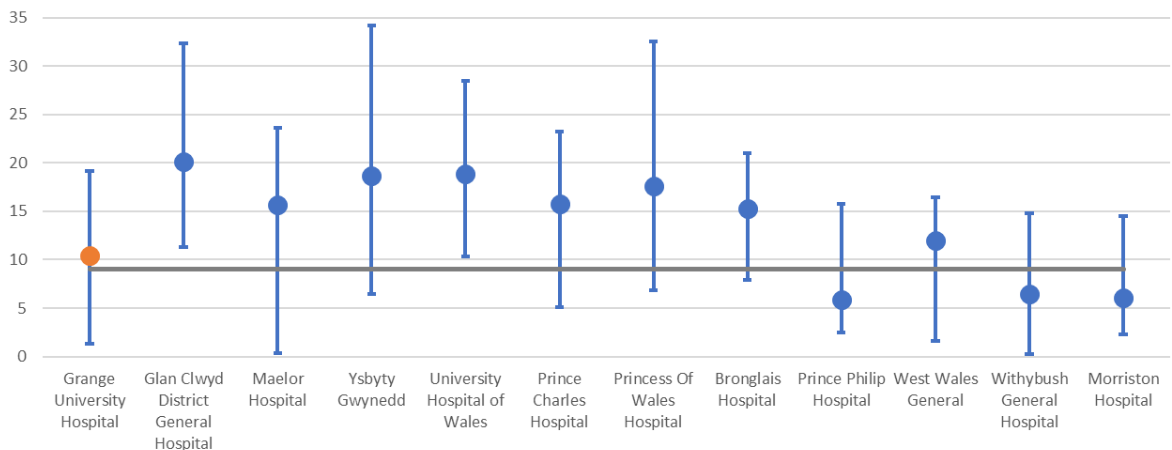
% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start – 57.5%

Good practice identified: The percentage of patients assessed by a stroke specialist consultant physician within 14hrs of clock start is in line with the English national average.

6.8 Specialist consultant assessment – Time between clock start and being assessed

Figure 13

Median time between clock start and being assessed by stroke consultant (hours)



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.2A

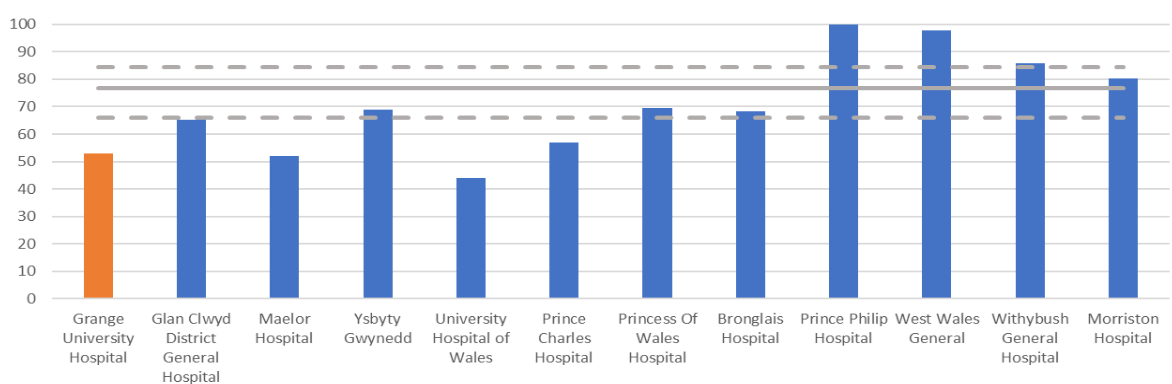
Source: SSNAP Oct 2021-Dec 2021

Median time between clock start and being assessed by stroke consultant (hours) – 10.37hrs

GUH are in line with the national average for the median time taken for first consultant review.

6.9 Swallow screen within 4 hours

Figure14



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.5A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – 52.8%

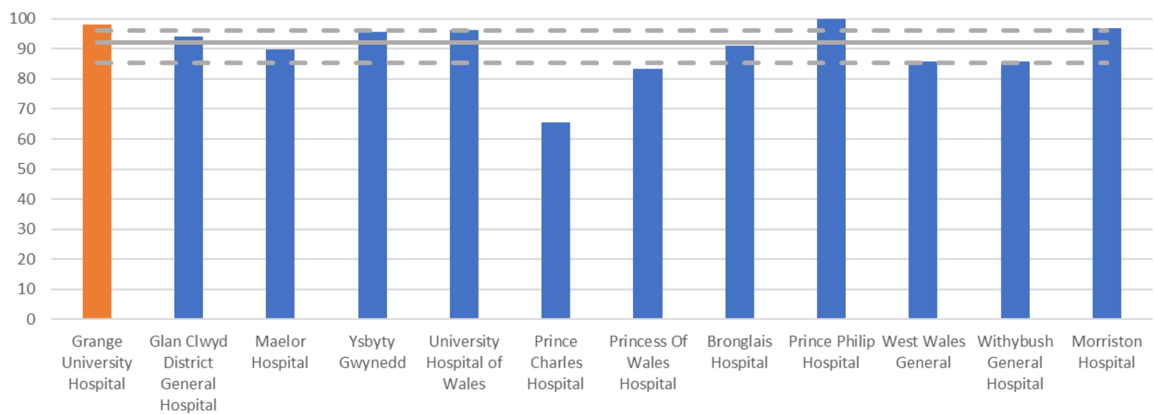
Only 52.8% of patients accessed a swallow screen within 4 hours, this is significantly lower than the national average.

Recommendation 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.

6.10 Swallow Screen within 72hrs of clock start

Figure15

Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.6A

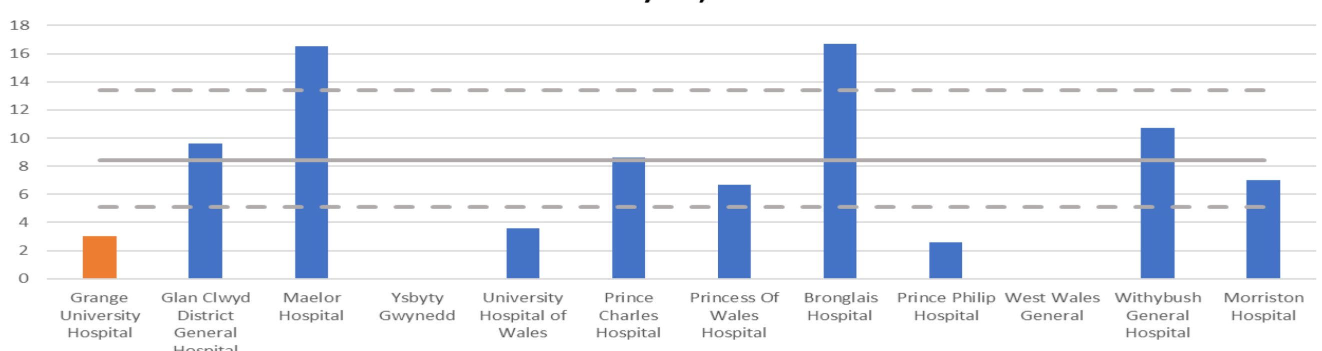
Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start - 98.2%

Good practice identified: 98.2% of GUH's patients accessed a formal swallow assessment by a Speech and Language Therapist within 72 hours of clock start. This is in the top quartile when compared with NHS Trusts in England.

6.11 Antibiotics for newly acquired pneumonia

Figure16



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Post72h Indicator J26.3

Source: SSNAP Oct 2021-Dec 2021

Antibiotics for newly acquired pneumonia in the first 7 days from clock start – 3 cases

Good practice identified: The data shows a low use of antibiotics for presumed pneumonia within the first 7 days of admission. This may be due to good processes being in place regarding swallow screening.

6. MDT Working

There is good evidence of early supported discharge and the delivery of therapy in people's homes.

There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

There is significant room for improvement in discharge processes and services i.e. social, packages of care and availability of care homes. Offering a stepdown for these patients to encourage flow across GUH and the rehab sites should be a priority. A goal should be to maximise support for patients who are most impaired and dependant following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

Recommendation 9: ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.

The community discharge pathway demonstrated a time based model, the current commissioned pathway is for 3 months. The Stroke Association carers support pathway has not been fully embeded in all units, with significant gaps in two thirds of the units. Currently,

patients in a residential or nursing home in this region do not have access to rehabilitation, other than ESD to people who meet the ESD criteria. People with more significant impairment requiring additional staffing to undertake effective rehab do not fit the criteria. The ESD rehab programme is time limited but there is a Neuro recovery college model which provides a range of educational modules covering fatigue management, living well with stroke, GRASP upper limb rehab, rebuilding your life after stroke, community exercise. These modules are open for people to attend and provide support for much longer than 3 months for ESD. The Life After Stroke wellbeing practitioners also support on a longer term basis as do the clinical psychology team. We also informed that there is also a pathway to which works in partnership with the DWP to support people back into employment and or voluntary roles.

The psychology team routinely provide life after stroke support. The Acquired Brain Injury (ABI) team have also stepped in to provide longer term rehab on a number of occasions. Both the ABI and psychology resources are small and we have worked hard to prioritise people who are most in need of ongoing support. The basis of our prioritisation is risk to wellbeing and ability of people who are already proximal to manage this risk.

The Niwrostiwt Recovery College was developed by the ABI and psychology teams to support us in our commitment to doing the most good for the most people, whilst minimising harm and maximising autonomy. Whilst led by the ABI team the Niworstiwt is a collaboration between CNRS ABI & Stroke teams, people with lived experience of stroke and brain injury, Headway and the Stroke Association. The latter organisations contribute to the Stiwt's steering group.

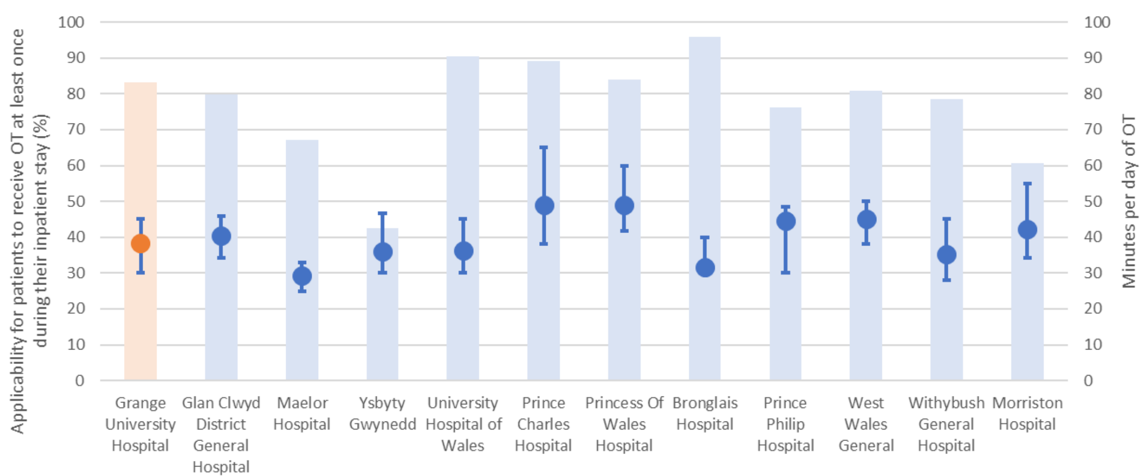
Recommendation 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).

Recommendation 11: Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.

Recommendation: 12: Embed the National Stroke Service Model in ABUHB
https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf

7.1 Applicability and minutes of OT

Figure17



Bars show the % of patients applicable to receive physiotherapy at least once during their inpatient stay (England median is 87%). Dots show the median minutes receiverd per day (and interquartile range)

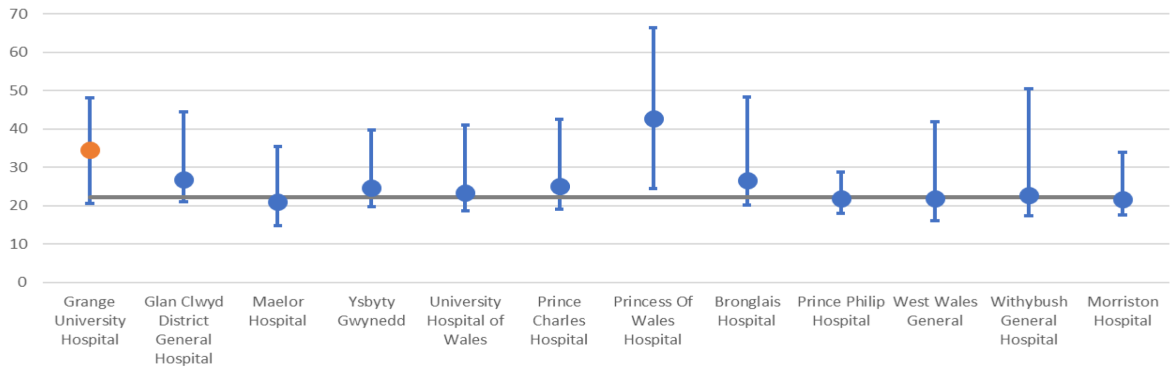
Patient -centred results at team level for Key Indicators 5.1A and 5.2A

Source: SSNAP Oct 2021-Dec 2021

Applicability and minutes per day of OT – 38.38%, in line with Wales's average

7.2 Clock start to OT assessment time

Figure18



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

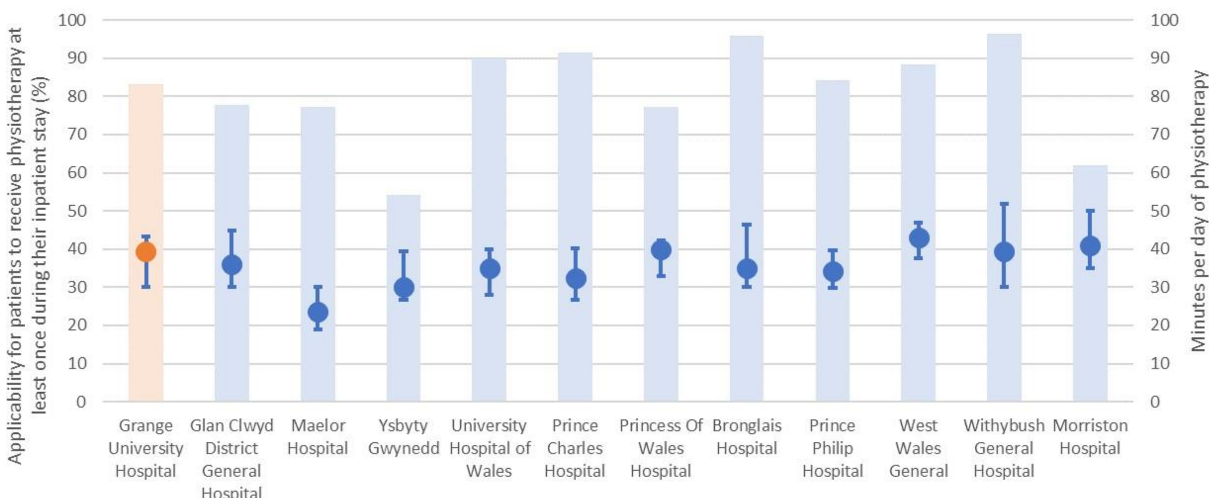
Patient-centred results at team level for Key Indicator 8.2A

Source: SSNAP Oct 2021-Dec 2021

Time from clock start to occupational therapy assessment – 34.35 hours

7.3 Applicability and minutes of physiotherapy

Figure
19

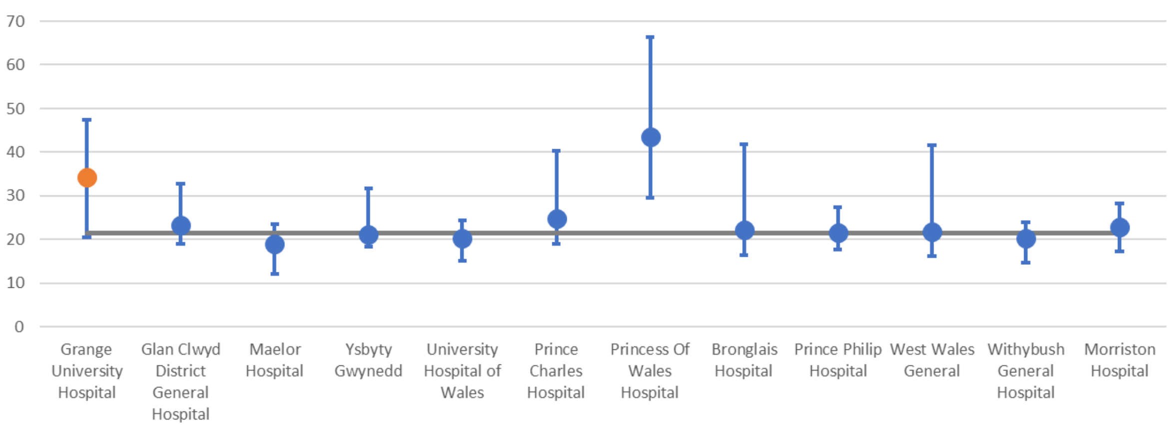


Applicability and minutes per day of physiotherapy – 39.2% in line with Wales's average

7.4 Clock start to physiotherapy assessment time

Figure20

Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start)



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.4A

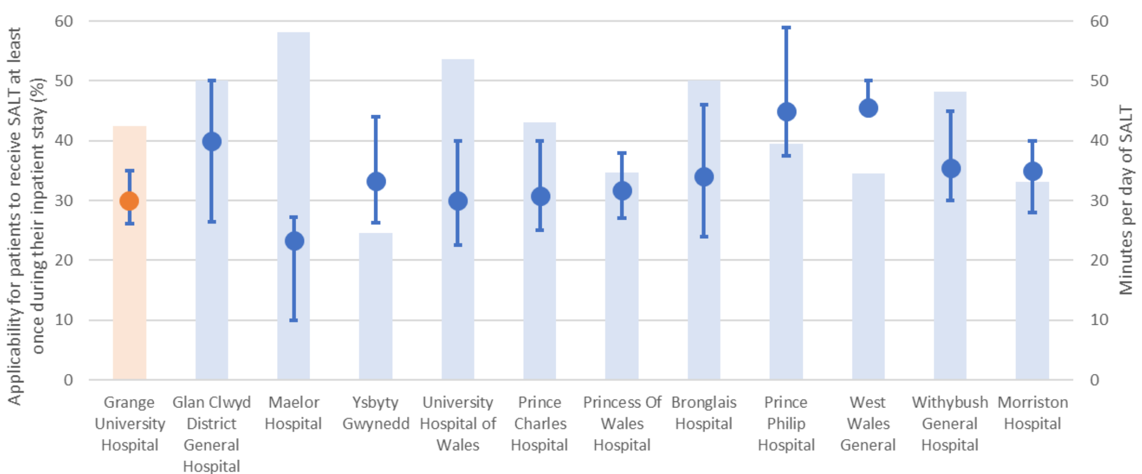
Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start) – 34.17%

Recommendation 13: Ensure 7 day access to physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients

7.5 Applicability and minutes of SALT

Figure21



Bars show the % of patients applicable to receive speech and language therapy at least once during their inpatient stay (England median is 54.4%). Dots show the median minutes receiverd per day (and interquartile range)

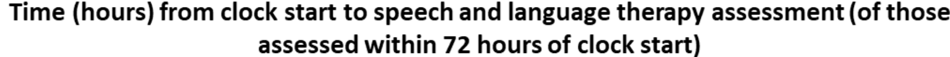
Patient -centred results at team level for Key Indicators 7.1A and 7.2A

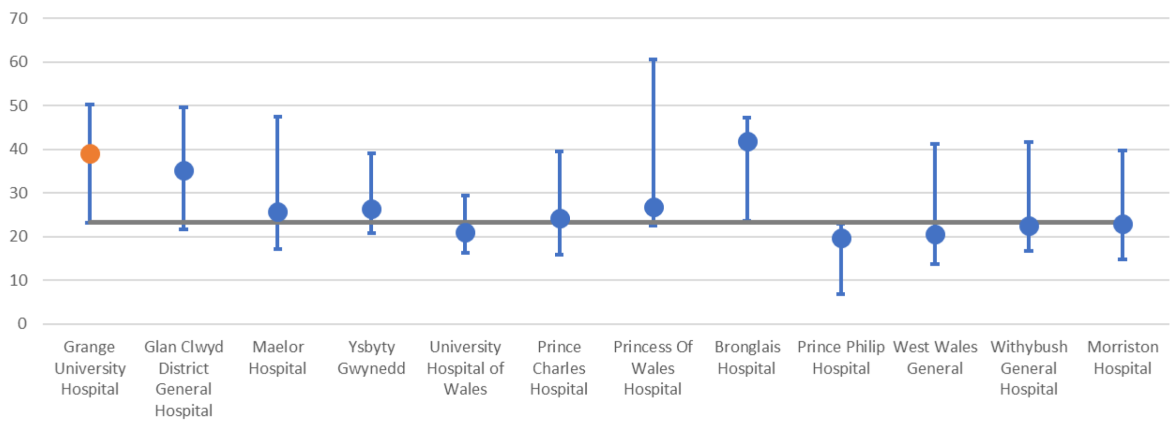
Source: SSNAP Oct 2021-Dec 2021

Number of minutes per day on which SALT is actually received – 30%, below Wales's average.

7.6 Clock start to SALT assessment time

Figure22





Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.6A

Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to speech and language therapy (SLT) assessment (of those assessed within 72 hours of clock start) – 39.05hrs

There is variation in the timely access to speech and language therapy services (see fig 21 and 22), as well as to physiotherapy and occupational therapy. The HASU currently provides a 5-day service for speech and language therapy. There are significant challenges in this pathway. The SSNAP standard is that sites should have at least two of the therapies shown available seven days a week. In most units, this is physiotherapy and occupational therapy.

Recommendation 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.

Currently not meeting the SSNAP 5 day standards for intensity of therapy, so it is clear that a review of rehabilitation staffing is required to meet 5 days before expansion to days can be considered. Expanded use of rehabilitation assistants and group therapy sessions to be considered. It may be worth exploring a virtual liaison tele-swallow service given the extreme staffing pressure within speech and language therapy.

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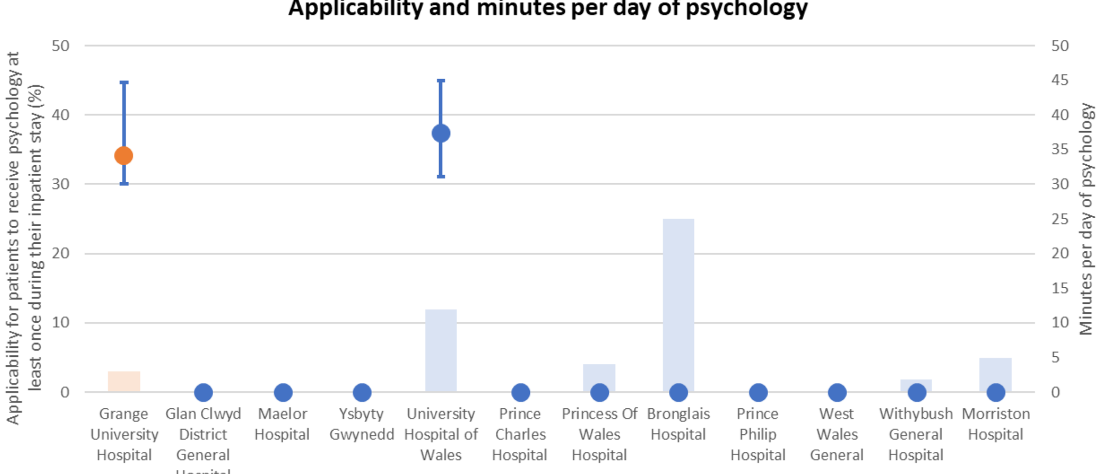
7.7 Applicability and minutes per day of psychology

Figure23



Bars show the % of patients applicable to receive psychology at least once during their inpatient stay (England median is 3.2%). Dots show the median minutes receiverd per day (and interquartile range)

Patient-centred results at team level for Item Reference J7.3-J7.7

Source: SSNAP Oct 2021-Dec 2021

% of the patient's days at in hospital (out of period patient requires psychology across all teams) on which it is received by the patient – 34.2%

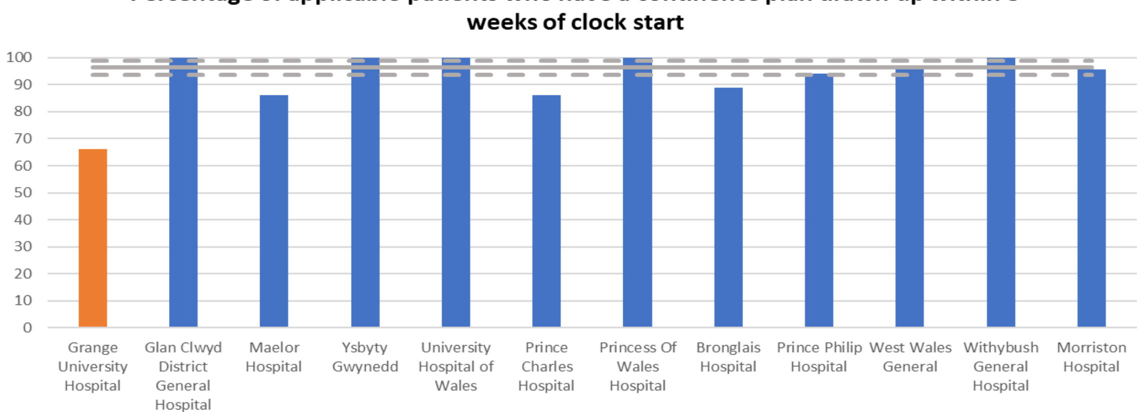
Assess to neuropsychology is variable across the region. A high proportion of patients (1 in 3) may require psychological support post-event. The current psychology model is 1 session of in reach per week for each ELGH based stroke unit. However, at the time of the GIRFT visit the psychology resource was significantly depleted by absences. We are told this has improved now, although there have not been any applicants to cover fixed term appointments, through secondments or agency staff. The psychology service provides support across the whole pathway and takes referrals from medics, primary care and healthcare professionals.

The ABUHB CNRS psychology team work across the width and along the full length of the stroke pathway. In practical terms this involves responding to requests for assistance from the HASU, the three sub-acute rehabilitation wards, the three Early Supported Discharge Teams, the ABUHB Living Well-After Stroke Service, and colleagues working in community services supporting stroke survivors. The CNRS psychology team have also been instrumental in the establishment of the Neurological Conditions Recovery College.

Recommendation 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.

7.7 Continence plans

Figure 24



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.2A

Source: SSNAP Oct 2021-Dec 2021

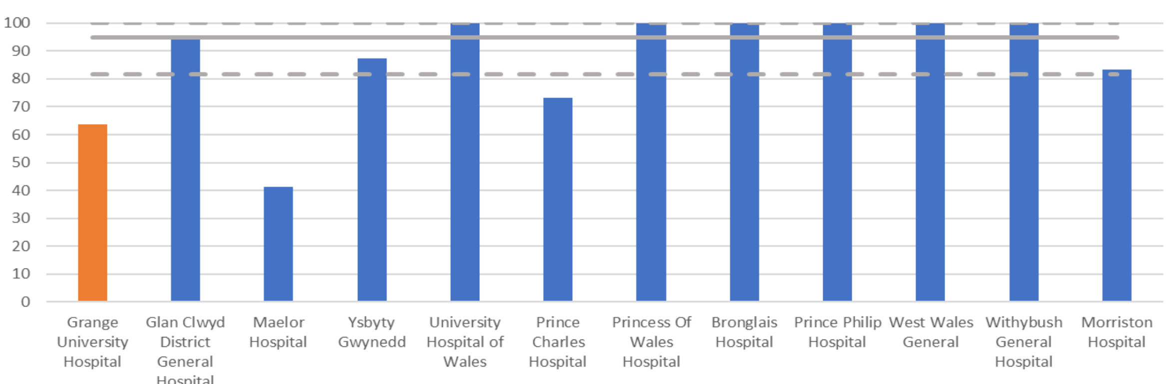
Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start – 66.1%

The data showing the percentage of patients who have continence planning within 3 weeks of admission is low in comparison to the national average. This is likely to be an issue with documentation in medical notes and hence data reporting.

Recommendation 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.

7.8 Nutrition screening and seen by dietician at discharge

Figure25



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key indicator 9.1A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care) – 63.6%, below Wales average

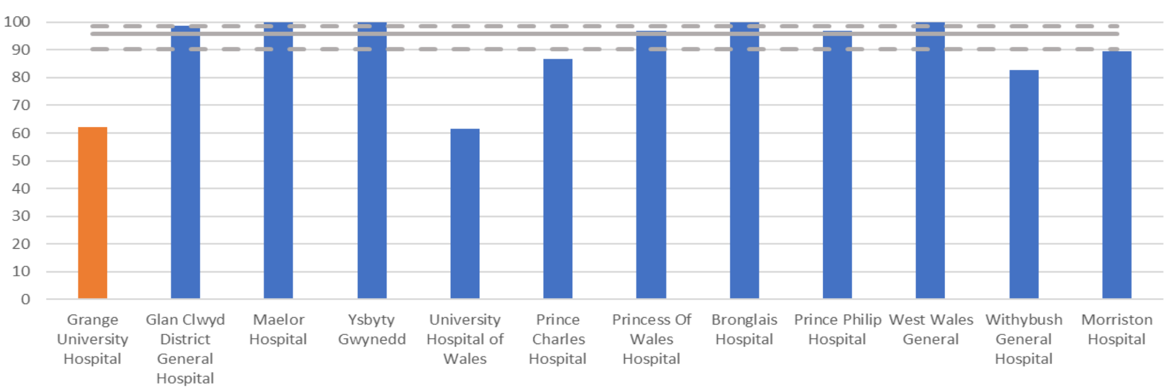
The data showing the percentage of patients who have been screened for nutrition and been seen by a dietitian by discharge is low in comparison to both the English and Welsh national averages. This is likely to be due to an issue with documentation and hence data reporting. We were informed that all patients assessed by ESD teams have a nutritional screen completed.

Recommendation 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.

7.9 Mood and cognition screening by discharge

Figure26

Percentage of applicable patients who have mood and cognition screening by discharge



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.3A

Source: SSNAP Oct 2021-Dec 2021

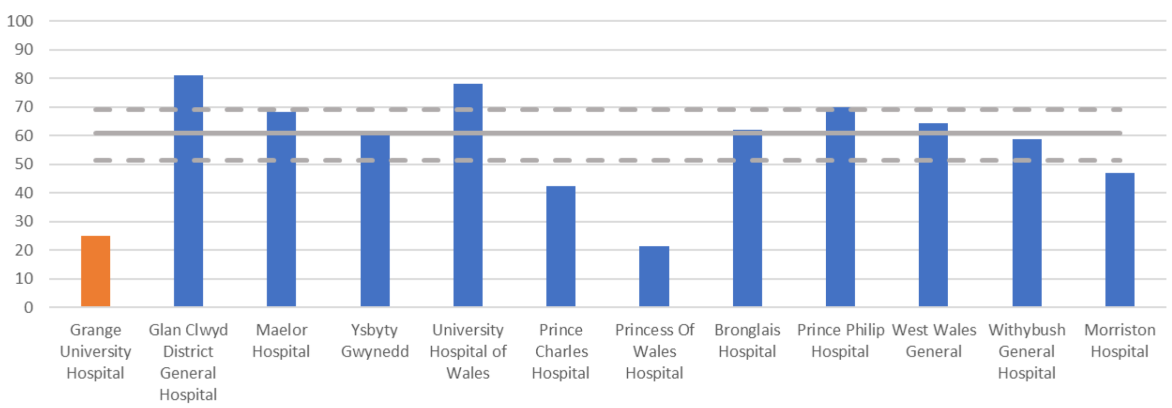
Percentage of applicable patients who have mood and cognition screening by discharge – 62.1% which is below the Wales average.

It was evident there is focus on mood and cognition assessment. The data showing the percentage of patients who have mood and cognition screening by discharge is low in comparison to the national average. This is likely to be an issue with documentation and hence data reporting.

Recommendation 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.

7.10 Nursing therapy and rehab goals

Figure27



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 8.8A

Source: SSNAP Oct 2021-Dec 2021

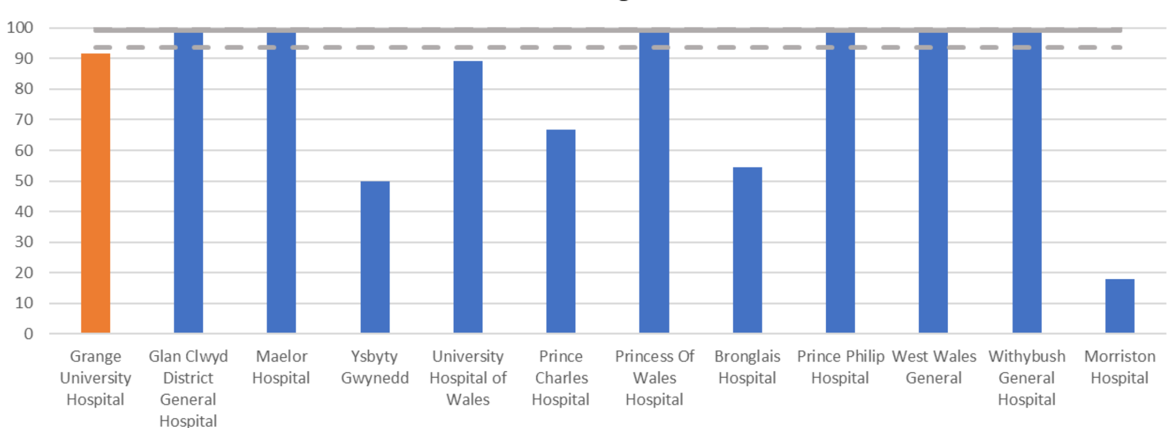
Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days – 25%

This performance measure (see fig 27) may be related to poor documentation, which makes it difficult for a data clerk to record that this target has been met. Although goals are often set, this may not be clearly documented following MDT discussions.

Recommendation 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.

7.11 Joint health and social care plan by discharge

Figure28



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.1A

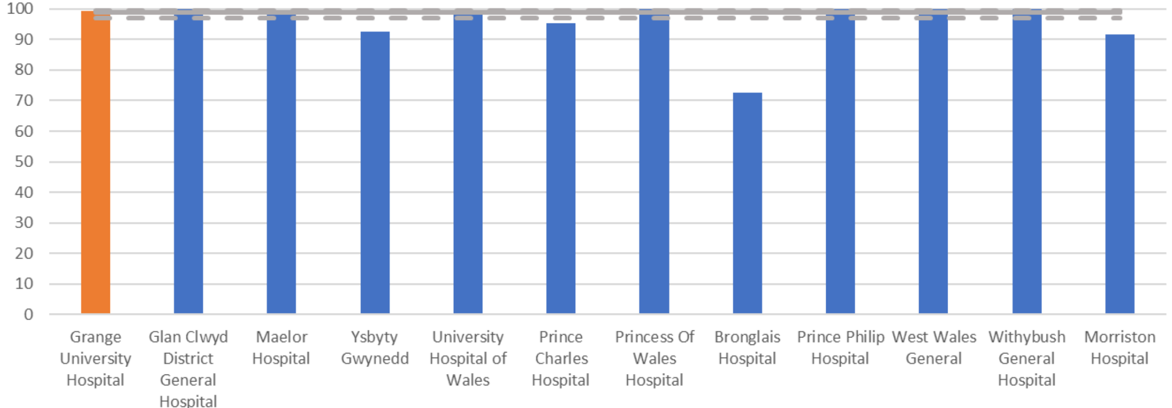
Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients receiving a joint health and social care plan on discharge – 91.7%

Joint health and social care planning by discharge is delivered and documented in over 90% of patients, this is below the English national average.

7.12 Discharged with a named contact

Figure29



Grey lines show the median and interquartile range of sites in England

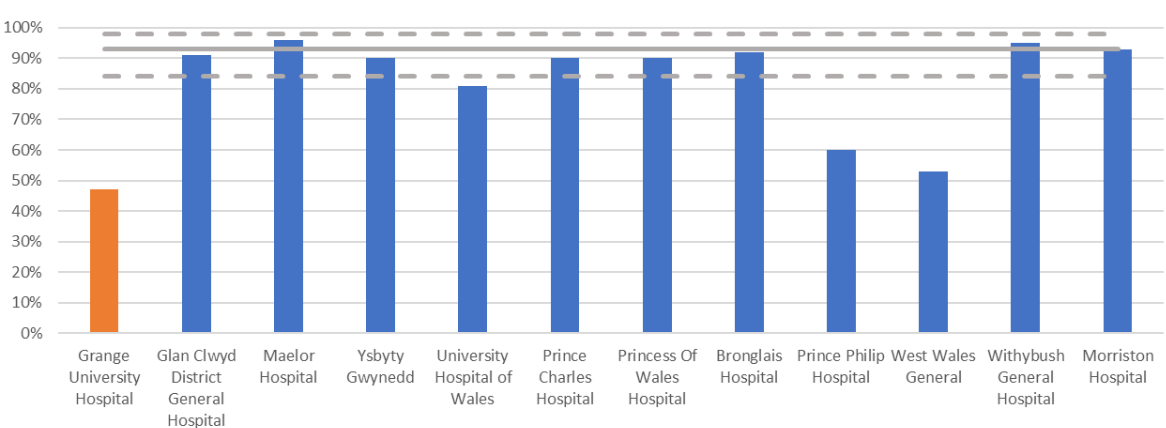
Patient-centred results at team level for Key Indicator 10.4A

Source: SSNAP Oct 2021-Dec 2021

Percentage of those patients who are discharged alive who are given a named person to contact after discharge – 99.3%

7.13 Patients applicable for a 6-month assessment

Figure 30



Grey lines show the median and interquartile range of sites in England

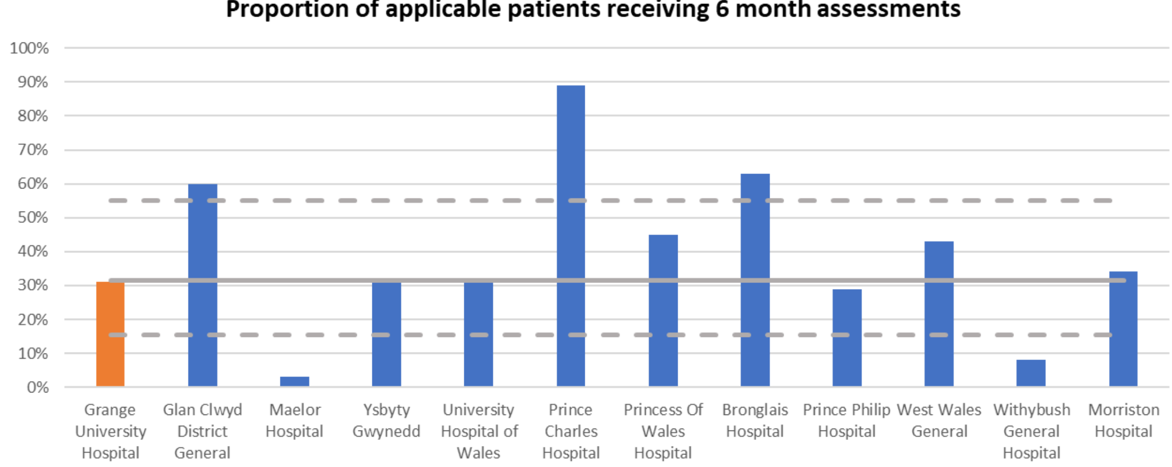
Team-centred results at team level for Item Reference B12.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of patients alive who are considered applicable to be assessed at 6 months – 47%, below Wales's average.

7.14 Applicable patients receiving 6-month assessments

Figure31



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B13.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of applicable patients receiving 6-month assessments – 60%

There is unwarranted variation in the proportion of patients who receive a 6-month assessment.

Delivering an adequate review post discharge is essential to ensure that patients have completed all the necessary investigations to identify the aetiology of stroke, have had access to appropriate post discharge rehabilitation, are taking appropriate secondary prevention and are having their risk factors for recurrent stroke adequately managed. This

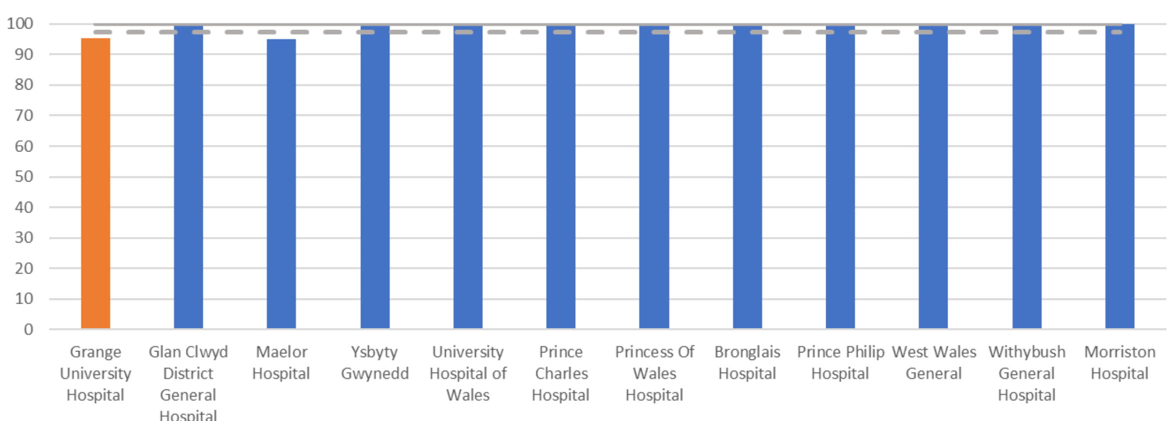
does not need to be delivered by a secondary care stroke physician and is often more effectively delivered by community stroke nurses who deliver a more holistic approach

Recommendation 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.

8 Secondary prevention

8.1 If in atrial fibrillation, discharged on anticoagulants

Figure32



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.3A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation – 95.2%

9 Summary of Recommendations

The table below summarises the recommendations made in the body of this report and is intended to serve as a useful tool for action planning.

Table of Recommendations

#	Recommendation
1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
2	Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.
3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.
4	ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.
5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for

	imaging should help to release bed capacity and increase access.
6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.
8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.
9	ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.
10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).
11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.
12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf
13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.
14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.
15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.
16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.
17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.
18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.
20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool:https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf

Review of Therapies in Stroke Services

Aneurin Bevan University Health Board (July 2021)

Authors:

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Madelaine Najjar, Dietetic Operational Lead – Bridgend, Cwm Taf Morgannwg University Health Board

Background

In February 2017, Welsh Government published its Stroke Delivery Plan 2017-2020 (Welsh Government, 2017) to continue to improve stroke services in Wales. It provided a framework for action by Heath Boards setting out expectations of stroke care which included workforce. Allied Health Professionals form an integral and part of this critical workforce in giving patients 'an excellent chance of surviving and returning to independence as quickly as possible'.

All Health Boards in Wales participate in the Sentinel Stroke National Audit programme (SSNAP) (Kings College London, 2021) which includes regular review of performance against set standards.

In a recent review by the NHS Wales Delivery Unit (Appendix A), stroke services at ABUHB were reported for targets associated with therapies as B, C, C and D to St. Woolos, Royal Gwent (RGH), Neville Hall (NHH) Hospitals and Ysbyty Ystrad Fawr (YYF) respectively. This report was against October to December 2019 performance. The report also stated there continues to be minimal change in performance overall. Several observations and subsequent recommendations were made. Many improvements have already been scoped and some initiated to date by the stroke therapy team with plans to implement others over time. This in itself will result in some efficiencies.

Whilst treatment of stroke patients remained a priority service during 2020, it was undoubtedly affected by the urgent need to address the impact of COVID19. From discussions with the therapy team staff worked flexibly over this period to support stroke patients and wider priority patients during the pandemic.

A significant impact for ABUHB was the opening of the Grange University Hospital (GUH) ahead of schedule to increase bed capacity during the pandemic. Originally, plans proposed to move HASU stroke beds to GUH. This was completed without immediate closure of stroke beds on other sites and therefore without additional stroke specialist therapy workforce. The current specialist workforce stretched to cover these additional beds.

Purpose

The aim of this report is to analyse the current status of specialist therapy workforce for stroke services in ABUHB against recommended standards. This includes services to patients in commissioned stroke beds as well as those receiving specialist care from the Early Supported Discharge (ESD) community service which in Aneurin Bevan University Health Board is via the Community Neuro-rehabilitation Service (CNRS).

*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

The purpose is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The report objectives are set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for ESD
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

Criteria

Professions included in this analysis include;

- Physiotherapists
- Occupational therapists
- Speech & Language therapists
- Dietitians

The therapy workforce that is included are those who are classed as stroke specialist. This includes those that are deemed competent in the clinical area of stroke through training, achievement of professional competencies or through experience. Some therapy staff at band 5 level are included that may not be classed as stroke specialist however work under the direct supervision of a senior stroke specialist therapist and has dedicated time to commissioned stroke beds.

Senior staff time to operationally lead teams or strategically develop stroke services have been omitted from the workforce numbers. Generalist therapy staff who provide ad hoc cover are not included in the workforce analysis.

All therapy workforce included in this report have a mix of WTE from defined stroke financial resources and some dedicated from core professional services budget. Therapy Service Managers have prioritised WTE from core service budgets to stroke services in combination with dedicated stroke financial investment as services developed.

Stroke services within ABUHB covered within this report:

- Grange University Hospital (GUH) – 15 beds;12 hyper-acute, 3 GM/TIA
- Ysbyty Ystrad Fawr (YYF) – 17 beds; 3 acute, 14 rehabilitation
- Royal Gwent Hospital (RGH) – 24 beds; 6 acute,18 rehabilitation
- Neville Hall Hospital (NHH) – 21 beds; 5 acute, 16 rehabilitation
- Early Supported Discharge (ESD) via CNRS* – average 348 patients per year

Data was provided by therapy services on current workforce. Skill mix of workforce and split over multiple units was obtained. General subjective assessment of working within settings was also discussed with the senior staff within each of the therapy professions.

*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

The therapy workforce has recommended standards of staffing levels per beds or number of beds from several sources. For this report, clinical recommended standards for therapy workforce were used as follows:

- Hyper-acute and acute services
    - RCP National Clinical Guideline for Stroke (Royal College of Physicians, 2016)
- Rehabilitation in-patient services
    - Specialised Neuro-rehabilitation Service Standards (updated May 2019) (British Society of Rehabilitation Medicine, 2019)
    - As mid-point level 2a to 2b (pp. 5)
- CNRS (ESD) Services
    - 'A Consensus on Stroke: Early Supported Discharge' (Fisher et al, 2011)

Within the standards for ESD services there were no recommended workforce levels for dietitians. These standards are now in effect 10 years old and although reference need for access to dietetics, several articles state dietitians must be part of the multi-disciplinary team. As a result this report was unable to determine recommended dietetic workforce needs in the ESD service.

All workforce figures are based on services for 5 days a week for both stroke beds and CNRS service. Where Saturday services have been trialled, this did not include additional workforce but stretched the working week.

Findings – Commissioned Stroke beds

Total workforce for each of the therapy professions for all HB commissioned beds can be seen in table below 'Therapy Workforce Analysis in total; 77 stroke beds in ABUHB'. All professions have a gap in workforce against the relevant recommended standards for bed type (i.e. hyper-acute, acute or rehabilitation). The percentage gap can be seen for each profession ranging from 36 to 51% over all sites.

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Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Therapy Workforce Analysis for total; 77 (29 acute, 48 rehabilitation), Stroke bed in ABUHB				
Physiotherapy	17.7	11.4	-6.4	-36
Occupational Therapy	17.5	8.8	-8.7	-50
Speech & Language Therapy	6.9	3.4	-3.5	-51
Dietetics	2.7	1.6	-1.1	-40

As the commissioned stroke beds are split across 4 hospital sites within the Health Board. The next table 'Therapy Workforce Analysis per site' shows the breakdown of each professions workforce at each site. Against each of the professions relevant standards per bed type (i.e. hyper-acute, acute or rehabilitation) some sites are better staffed than others. Only 1 site, GUH has the sufficient staffing levels for only 1 profession, occupational therapy, but this is not consistent with the other professions. Generally physiotherapy appears to be the most adequately staffed over all sites but is still in all areas below recommendations.

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Therapy Workforce Analysis per site

Site	Bed numbers	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce
			WTE				WTE				WTE				WTE		
GUH	15	PHYSIOTHERAPY	2.2	2.0	-0.2	OCCUPATIONAL THERAPY	2.0	2.0	0.0	SPEECH & LANGUAGE THERAPY	1.0	0.7	-0.3	DIETETICS	0.5	0.2	-0.3
YYF	17		4.4	2.5	-1.9		4.3	2.0	-2.3		1.6	0.9	-0.7		0.6	0.0	-0.6
RGH	24		6.0	3.6	-2.4		5.9	2.8	-3.1		2.3	0.8	-1.5		0.8	1.0	0.2
NHH	21		5.2	3.3	-1.9		5.2	2.0	-3.2		2.0	1.0	-1.0		0.8	0.4	-0.4

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The following 4 tables below show the breakdown of therapy staffing per site including percentage gap of each profession. The best staffed site from a therapy perspective is GUH (as seen in table 'GUH Therapy Workforce Analysis'). Although the gap varies greatly between each profession, for example, with no gap if staffing for occupational therapy to 60% staffing gap in Dietetics.

GUH Therapy Workforce Analysis (15 acute beds)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	2.2	2.0	-0.2	-9
Occupational Therapy	2.0	2.0	0.0	0
Speech & Language Therapy	1.0	0.7	-0.3	-30
Dietetics	0.5	0.2	-0.3	-60

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YYF Therapy Workforce Analysis
(17 beds; 3 acute, 14 rehab)

Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	4.4	2.5	-1.9	-43
Occupational Therapy	4.3	2.0	-2.3	-53
Speech & Language Therapy	1.6	0.9	-0.7	-44
Dietetics	0.6	0.0	-0.6	-100

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RGH Therapy Workforce Analysis
(24 beds; 6 acute, 18 beds)

Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	6.0	3.6	-2.4	-40
Occupational Therapy	5.9	2.8	-3.1	-53
Speech & Language Therapy	2.3	0.8	-1.5	-65
Dietetics	0.8	1.0	0.2	25

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NHH Therapy Workforce Analysis (21 beds; 5 acute, 16 rehab)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	5.2	3.3	-1.9	-37
Occupational Therapy	5.2	2.0	-3.2	-62
Speech & Language Therapy	2.0	1.0	-1.0	-50
Dietetics	0.8	0.4	-0.4	-50

YYF, RGH and NHH were similar in their inadequacy of staffing. YYF featured a slightly worse in the gap average over the professions. This site had no specialist stroke dietetic cover so a 100% gap in the specialist dietetic profession recommended workforce. Interestingly, YYF was the site with the poorest SSNAP scores overall (score D). Other than GUH all other sites were at 50% gap in therapy workforce on average or higher.

Summary of Findings - Commissioned stroke beds:

- There is insufficient specialist therapy workforce to commissioned stroke beds
- Gaps in therapy workforce vary between professions and between sites
- GUH is the best staffed site overall but still carries significant gaps in therapy workforce
- 1 site has no specialist stroke dietetic workforce
- Only 1 site, GUH overall has sufficient staffing for only 1 profession, OT
- Site will lowest gap in therapy staffing performed better in SNNAP targets (see table below)

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Percentage gap in therapy staffing mapped to stroke target score for each stroke site		
Stroke Site	**Therapy staffing gap**	**SSNAP score**
St. Woolos (beds transferred to GUH)	14%	B
YYF	50%	D
RGH	45%	C
NHH	49%	C

To safely staff commissioned stroke beds without enhancement in the existing therapy workforce then the current bed capacity would need to be reduced. This is not a recommendation of this report as this should be set according to population needs for stroke incidents. The table below theoretically represents the beds numbers each profession in therapies could safely staff in line with recommended workforce levels. Current bed numbers total 77 across the health board. The number of sites would also impact on the ability to logistically work well. The geographical area would also dictate this in reality. Whilst collocating could bring efficiencies in current staffing levels it still would not solve the deficient in therapy workforce staffing. Efficiencies are possibly use of better skill mix of workforce, cover during leave and reduction in travel of staff who cover multiple sites

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Number of stroke beds safely staffed from existing therapy workforce		
Profession	Existing Workforce (WTE)	Beds safely staffed from existing workforce*
Physiotherapy	11.4	49
Occupational Therapy	8.8	39
Speech & Language Therapy	3.4	38
Dietetics	1.6	46

*assuming the current hyper-acute, acute, rehabilitation bed type ratio is the same

Findings – CNRS Service

Analysis of workforce against recommended clinical standards in the CNRS can be seen in the table below. Overall, physiotherapy, occupational therapy and speech and language therapy workforce are insufficiently staffed to patient's numbers. As discussed earlier there are no recommendations for dietetic workforce. The Therapy assistant practitioner workforce appears to be staffed above recommended standards.

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Therapy Workforce Analysis for ESD Service in ABUHB; based on average 385 patients per year				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	3.9	2.5	-1.4	-36
Occupational Therapy	3.9	3.0	-0.9	-23
Speech & Language Therapy	1.5	1.2	-0.3	20
Dietetics	no std	0.4	no std	no std
Unregistered	1.0	5.4	4.4	440

The patients per year data was based on an average of the last 2 years. However, the patient numbers have grown year on year and so the workforce is likely to be increasingly insufficient as the year's progress and the gaps underestimated with current year to date.

CNRS Service:

- All qualified therapy staff, where standards of workforce exist, are insufficient
- Gaps in workforce per patient numbers per year are likely to be underestimated and as demand grows this gap will worsen and impact on service capacity

With current workforce levels the table below shows per profession how many patients can be safely managed in the CNRS. On average this equates to 283 patients per year which is

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much lower than the current average of 385 which has already been suggested as below current year forecast of 409.

Number of ESD patients per year safely staffed from existing therapy workforce		
Profession	Existing Workforce (WTE)	Patient numbers/year safely staffed from existing workforce
Physiotherapy	2.5	250
Occupational Therapy	3.0	300
Speech & Language Therapy	1.2	300
Dietetics	0.4	unknown

Discussion

Commissioned beds

Overall, all sites where there are commissioned stroke beds are understaffed for therapy workforce.

Only 1 site met only 1 professions standards and that was Occupational Therapy services at GUH. Without an MDT there is limitations in each profession to support patients to achieve their overall expected outcomes of recovery from stroke and prolonged hospital stay.

With multiple sites to staff across the therapy professions, this adds its own inefficiencies. Any potential efficiencies identified may not be possible even if staffed appropriately and further detrimental with staff levels low due to the multiple site model. The multiple sites, whilst also

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needing to be suitable for the population needs and accessibility adds further concerns to the ability to treat patients following a stroke for several reasons suggested below:

- With staff covering more than 1 site, daily targets for therapy are not met as the majority of therapy professions do not have the staffing requirements to cover all sites 5 days a week. This was identified in delivery unit review 2019 (Appendix A).
- Not all professions able to attend MDT depending on day they visit site. Recommendation in SSNAP (2021).
- Travel between sites is inevitable and therefore a loss of clinical time. Mostly staff coordinate their week to minimise travel during the day, adhering to one site per day however this means patient referrals, assessments or follow-ups will have to wait until the therapist next visits. Alternatively telephone support or more generalist staff support can be sought but is not in line with standards of clinical treatment in stroke for therapies and can impact of patient's stroke recovery and potential outcomes.

Where hyper-acute, acute and rehabilitation are not delivered in the same site, therein results in the need to transfer patients. This again can result in inefficiencies in therapy staffing provision. Concern was also raised by the therapy staff for a need to improve the patient pathway for stroke. Points were raised and discussed by staff as follows:

- With no rehabilitation beds at the site of the HASU this means transfer to other site impacting on services for transfer and therefore flow within site rather than between sites for stroke patients.
- Frequently prior to COVID stroke patients were not on the designated stroke beds but on other wards (outliers).
- Stroke patients, cared for in non-stroke beds were not in the most appropriate environment to enable stroke specialist care due to space, equipment available causing restrictions to rehabilitation that could be achieved.
- Stroke beds often would have general medical patients (particularly in NHH and YYF) and so therapy team would pick up non stroke work as well as seeing outliers in non-stroke beds.
- Often OT stroke staff would keep patients requiring complex discharge planning support in stroke beds and covered by these staff. It aids reducing 'hand-offs' and minimising length of stay but is not accounted for in staffing requirements for stroke services.
- Self-presenting patients were not always transferred to the correct site for the stroke pathway treatment needed

The staffing figures in this report are based on the 5 days service only for both stroke beds and CNRS service. The SSNAP target recommend 7 day services to improve patient outcomes. Where the therapy services are already under staffed across 5 days, to stretch to a 7 day service to meet SSNAP targets would dilute the week day service without extra investment therefore further impacting patient outcomes.

Whilst work has been trialled to deliver a 6 day service, which included Saturdays, this showed the Occupational therapy, Physiotherapy and Speech and language therapy staff spread thinly as no additional resource was added to support the increase in cover. Therefore this diminished the therapy services overall. The Therapy Stroke team also, over a period of 12 weeks, monitored a period of no weekend working, which showed limited impact on stroke patients overall compared to the 6 day/week pilot.

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All of the four therapy professions provide band 5 rotation programmes through the specialist stroke service. This is accepted as staffing resource in the standards reviewed given they are supervised by a stroke specialist. Whilst this has benefit training staff and increasing recruitment of specialists in future it also adds an extra pressure into the need for specialist stroke therapists to train. The rotations can vary in length but are generally 12 month in duration. The re-training of staff takes significant time and likely to impact on the time to deliver clinical care. This impact is significant in Speech and language therapy were it takes a minimum of 6 months to achieve specialist level dysphagia competencies, a key skillset for stroke intervention.

Most of the therapy professionals have part of their senior specialist work as team/strategic lead in addition to their highly skilled clinical work. Whilst this is imperative to service improvements, ensuring staff are appropriately trained and supported and evaluating excellent care to patient it does take up time from multiple staff. DU suggested a multi-professional lead similar to ESD. This would have more benefits to replicating team leads across each therapy and therefore diluting remaining time in work for clinical. It may also show efficiencies for inter-disciplinary working as basic as structuring the day, hand overs, replicating paperwork and QIM reporting.

Whilst there are no specialist stroke recommendations for therapy support worker staff, they remain a vital part of the specialist stroke therapy workforce. Most professions utilise therapy support worker hours either solely for the clinical area or as part of a wider generic caseload. Whilst in the stroke units, supervision by specialist therapists would be in place. By utilising support workers in addition to the qualified therapy workforce this provides an effective workforce skill mix but support workers should not replace only compliment qualified therapists.

Other discussion points raised for the teams DU report in 2019 includes use of clinical staff for clerical tasks. Many of the qualified therapist carry out clinical administrative tasks but also considerable amount of non-clinical administrative tasks. This was identified in the DU report and a regular frustration of staff. To quantify efficiencies with adequate administrative support is difficult to determine. However, currently utilising qualified staff for admin duties diminishes clinical time and will continue to do so if not addressed.

Lastly for commissioned stroke beds, the DU report also noted that focus should be made on increasing the intensity of therapy not simply the quantity. With a staffing level below recommended this will difficult to achieve with the deficit in demand already.

CNRS

Within the CNRS there is a deficit across all professions in comparison to the Fisher 2011 consensus, although Dietetics cannot be mapped to this. The current service is above the recommendations for unregistered staff, with these staff likely to be supporting some but not all of the gaps in qualified therapists. Psychology has not been included in the review although is recommended with the ESD standards.

The original service was set up using the staffing establishment suggested by Fisher 2011. This consensus statement is limited in that it is ten years old and so may not take into account relevant recent research into ESD services and neither does it include all relevant professions i.e. Dietetics. However, there is not a more recent consensus in the evidence base to use. SSNAP also reference access to dietetics as a recommendation. It is thought that further

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research and publication will include dietetics as a recommended need of the ESD MDT with many NHS services already including a dietitian as part of their local ESD teams. CNRS within ABUHB does have dedicated dietetic supported within the team. It is be determined locally if this is effective and sufficient for the population needs.

For the purposes of this staffing review the average number of accepted referrals into the service over the last 2 years was included. It should be noted that the service is growing year on year with a predicted 14% increase between 2019-2020 and the projection for 2020-2021. For 2020-2021 only the first 9 months was included and so the year total was estimated based on a forecast from the first 9 months. This does not take into account any capacity needed around those referrals not accepted i.e. with triage and in reach.

During the pandemic in-reach services have been replaced with a trusted assessor model. On review by the team, there has been no significant impact of using this change in model and may be able to be continued longer-term to improve team efficiencies.

The CNRS has increased its scope to accepting more severe strokes in to the service. On discussion with staff, when they have reviewed this, they found little improvement in patient outcomes for this cohort. Accepting these patients impacts the service for the mild to moderate patients due to the greater demands on therapy time from the more server strokes.

Similar recommendations were made by the DU (2019) report releasing more time for clinical task by considering better reporting systems to streamline therapists work. Introducing nursing establishment as per the ESD service standard recommendations may also release therapist's time for therapy interventions.

All of the above posts with the exception of 2.0 WTE band 4 Therapy Assistant Practitioner and the Clinical Psychologist have been funded via the ICF route ending in 2022. Although this staffing resource has been appointed to permanently this is now a financial risk for the organisation.

As in commissioned stroke bed discussion. The staffing resource of CNRS is based on a 5 day service. Whilst there are recommendations for this is work as a 7 day service this too would require additional investment so not to dilute the week day service.

Conclusion

The report objectives were set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for CNRS
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

Objectives 1- 4 have been addressed as part of the findings of this report. The current therapy workforce is significantly below the recommended standards for hyper-acute, acute,

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rehabilitation and CNRS overall. In addition to the low workforce provision a number of factors compound the limited resources available including multiple sites providing specialist stroke care, need for a clear stroke pathway for patients, rotational therapy staff, need for 7 day services as per recommendations and clinical time used for non-clinical administrative tasks.

Whilst investment appears to be needed to improve the Therapy workforce to meet standards there are several other opportunities to improve the efficiency of the therapy workforce and would be remiss to not further explore whether these are feasible to improve care for stroke patients.

Recommendations

The purpose of this report is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The last objective; Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services, is addressed in the recommendations below. Ultimately, investment of Therapy resources is the most urgent and clear need but there are also opportunities to improve efficiencies. This would improve efficiencies in, not only the current workforce clinical time, but also even if further invested, enabling a more effective therapy workforce:

Commissioned beds

- Investment into increasing therapy staff levels to recommendations as set out in this report per commissioned stroke bed
- Explore the current need for administrative support for the 4 sites to release clinical time
- Review of stroke bed sites available both from the case of multiple sites but also multi stroke treatment need (i.e. hyper-acute, acute, rehabilitation) thus reducing transfer of patient between sites
- A clear stroke pathway for stroke patient's i.e. ring-fencing beds for stroke care so not used by general medical and reducing outliers of stroke patients on other wards.
- Consideration of increasing therapy workforce above recommendations were rotational staff form a large percentage of the allocated specialist workforce including identification of most effective skill mix to enable continuity of patient care and training of staff to increase future workforce.
- With time deducted from several professions for 'team lead' or service development needs consideration of multi-professional leads similar to CNRS. Explore the benefits from inter-disciplinary working not only for staff efficiencies but better patient experience and outcomes.
- Consideration of inter-disciplinary therapy assessments to enable regular therapy monitoring or intervention and efficiencies for blended therapy approach and supervision particularly around reporting to MDT's if not all qualified staff available daily

CNRS

- Investment into increasing therapy staff levels to recommendations as set out in this report as per service demand.

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- Permanent financial investment in CNRS with scope to increase based on service demand to reduce impact on hospital beds, delays to discharge and potential readmissions
- Mapping of local population need to dietetic services for CNRS. To internally identify the current need and whether provision meets this. To identify any gaps in demand and capacity with CNRS for dietetic support.
- Maintain the 'trusted assessor' model rather than physical in reach into services. This has been implemented during COVID with positive feedback from staff and no reported negative impact on flow.
- Consideration of the introduction of nurse provision into CNRS establishment to release therapist time
- Review of reporting systems and ability to streamline and release therapy time back to clinical
- Review the current practice of accepting more severe stroke patients. Currently accepting patients with higher needs with no obvious improvement for those patients and causing a reduction in intensity of therapy for the rest of the caseload.

These recommendations outlined not only would improve therapy provision but likely to have a positive impact on other professions ensuring no impact on ability to meet patient outcomes for stroke survival.

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National Review of Patient Flow

a journey through the stroke pathway

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Foreword

I am pleased to be publishing this report which presents the findings from our National Review of Patient Flow: a journey through the stroke pathway. The focus of this work was to understand the risks and challenges associated with inefficient patient flow, and what impact this has on patients.

We know from our programme of assurance work that poor patient flow can have a hugely negative impact on the quality of services being provided. This has been a common factor in our inspections of Emergency Departments, and our previous review looking at ambulance handover delays to hospitals.[1] Poor flow can have a detrimental impact on the ability of staff to deliver safe and consistent standards of care and affects the experience and outcomes for patients.

It is fair to say that examples of poor patient flow are well known, and not just cited in the work of HIW. Every one of us is likely to know someone who works in a healthcare service; has been a patient who has encountered this during a hospital stay; or indeed, works in a service area where patient flow is a daily challenge.

What our review has done, however, is to highlight what these challenges mean in reality, to patients and to staff at various points on a journey from hospital admission through to discharge.

The impact of poor patient flow is ultimately felt by patients, who are not always receiving the care and treatment they need in the most timely manner. Delays in treatment can substantially impact the likelihood of developing further complications. This was particularly evident in stroke patients whom we considered as our case study. What is crucial now, is that all aspects of the health and social care system work together as effectively as possible to address poor flow and achieve better outcomes for patients in Wales.

As healthcare services continue to face unprecedented demands, and staff work tirelessly to provide safe and effective care to patients, it is clear that renewed efforts are required from the health and social care sectors, alongside Welsh Government, to tackle the issue of poor patient flow.

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[1] Review of patient safety, privacy, dignity and experience whist waiting in ambulances during delayed handover

I am pleased that our work has enabled us to identify areas for improvement, and to highlight areas of good practice. Not just in relation to the stroke pathway, but also for all patients.

I want to take this opportunity to thank staff working within both health and social care sectors who endeavour to provide safe and effective care to people on a daily basis. Their dedication and commitment provide a strong and positive basis upon which to improve.

Alun Jones
Chief Executive

Healthcare Inspectorate Wales

Summary

This report sets out the findings from our National Review of Patient Flow: a journey through the stroke pathway.

The review explored the experiences of people accessing care and treatment for stroke at each stage, from calling an ambulance, transfer to hospital, assessment, inpatient treatment, through to discharge.

Patient flow is the movement of patients through a healthcare system, from the point of admission to the point of discharge. When patient flow is impeded or is inefficient, it has significant repercussions on the quality and safety of patient care.

Our review has highlighted that across Wales, there are significant challenges which are having a negative impact on the efficiency of patient flow, and this means patients are not always receiving the care they need in a timely and appropriate manner. These challenges are wide ranging; the high demand for inpatient hospital beds combined with the complexities with discharging medically fit patients from hospital, leads to the inpatient healthcare system across Wales operating under extreme pressure. This impacts on the delivery of safe and timely care.

Whilst we found a range of initiatives, different models of care, and approaches being taken within health and social care to tackle the problems arising from poor patient flow, these have not sufficiently tackled the problem. Although there is no single solution, our review identifies opportunities for the health and social care systems to make improvements across each stage of the patient pathway, which may help lessen the impact of poor patient flow. The positive initiatives and approaches identified by our review, should be considered across Wales as services attempt to tackle their challenges with poor patient flow.

We specifically examined the journey of patients through the stroke pathway. This was to understand what is being done to mitigate any harm to those awaiting care, as well as to understand how the quality and safety of care is being maintained throughout the stroke pathway.

Demand is exceeding supply in relation to the healthcare system, and during our fieldwork almost all hospitals we visited were under level four 'extreme pressure', as highlighted in the National Emergency Pressures Escalation and De-escalation Action Plan[2]. The demand was having a knock-on impact on Welsh Ambulance Services NHS Trust (WAST) and its timely response to emergency calls.

[2] National Emergency Pressures Escalation and De-escalation Action Plan

Despite hospital patient flow teams across Wales working tirelessly 24 hours a day seeking to manage patient flow, we found that patient flow issues were negatively impacting on every stage of stroke care. This was from the point of needing to access healthcare at home, through to discharge from hospital.

A key area requiring improvement identified by our work, relates to the need for healthcare services to engage with people, to better understand the barriers to them accessing or choosing from the range of healthcare services available in Wales. The range of healthcare services includes pharmacies, Minor Injury Units, mental health helplines, online NHS consultations, and the NHS 111 Wales service. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

There were prolonged patient handover delays from ambulances to ED at all hospital sites we visited. These delays were significantly impacting on the ability of WAST to respond to emergency calls in the community and increase the risk to patients requiring emergency treatment and transportation into hospital.

It was positive to find that patients suspected as having had a stroke, were prioritised for ambulance handover, and transferred into ED promptly in line with the stroke pathway. However, we found that achievement of the Welsh Government 15-minute target for handover of stroke patients was challenging. This target aims to ensure that time critical investigations and treatment are undertaken promptly to ensure the best outcome for patients.

Challenges with the demand on EDs meant that some patients waited longer than expected for triage and ongoing assessment or treatment. This is a particular risk for those patients who self-present at an ED and have not had any clinical input prior to their arrival.

We found that the recognition of stroke and its prevention is a key area that needs attention across Wales. More needs to be done by NHS healthcare providers and Public Health Wales (PHW) to educate people about this debilitating condition, to help minimise their risk of developing a stroke, and to seek immediate help if symptoms arise. This is of relevance to certain population groups who are at a greater risk of having a stroke, such as those who smoke, have high blood pressure, high cholesterol, diabetes, are obese, or who excessively consume alcohol[3].

Evidence also suggest that Black and Asian people are at a higher risk of developing a stroke. Health boards and PHW should therefore work closely with these communities to understand the specific issues they face and ensure ongoing engagement with them, in support of better health outcomes.

It was disappointing to find that in 2022, the performance of most acute hospitals in Wales which provide stroke services had deteriorated since 2019.

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[3] Causes of Stroke

As highlighted within the UK's Sentinel Stroke National Audit Programme (SSNAP) data, there was an increase from three, to 11 out of 14 acute hospitals who were performing poorly and were categorised as either a D or an E grade (lowest).

However, it is important to note that this period coincided with the global Covid-19 pandemic, and there was an unprecedented demand on hospital beds nationally, which was significantly impacting on patient flow in general, and throughout the stroke pathway.

As highlighted earlier, during our fieldwork almost all hospitals were under level four 'extreme pressure'. To help manage the pressure and patient flow through hospital systems, patient flow meetings were held regularly in all hospitals. They were well attended by the key staff responsible for a patient's journey through hospital. In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the handover delays and plans for longest wait patient handovers. We found this to have a positive impact in managing the issues associated with delayed patient handovers from ambulance crew to ED staff.

Overall, we found that patient flow teams appeared to manage meetings well, and we concluded that they had a strong understanding about which patients needed beds or moves to other wards. This included the oversight of patient specialty outliers in other service groups, such as medical patients cared for in surgical beds and vice versa.

Due to pressure on bed availability, hospitals were not always able to admit patients to the right bed or ward for their treatment. These patient outliers, as they are known, were a consistent finding across Wales. This meant that it was not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment. It was concerning to find that because of poor patient flow, patients are regularly being treated on a ward that would not usually care for that condition.

Patients who are not allocated to the right bed or ward, can at times experience an increased length of stay. This may lead to other complications, creating additional challenges for care teams and adding to the issue of poor flow. A stroke patient who has been admitted to hospital is likely to have a much better outcome if they are treated on a stroke ward.

During our work, it was positive to find that Improvement Cymru[4], was undertaking a pilot within three acute hospitals supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity methodology to focus on the flow process. This focuses on discharge and improving flow in small increments.

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[4] Improvement Cymru website

Whilst it does not assist with the existing flow issues which relate to social care, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. We noted that this pilot was making a positive difference to the flow process and overall management of beds, and it is an approach that should be considered nationally.

We found that in all cases, staff endeavour to achieve a brain scan for a symptomatic stroke patient within an hour of arrival at hospital. However, although infrequent, it was concerning to find in our clinical records review, that some patients were not receiving a brain scan within the one-hour target. In addition, the SSNAP data we reviewed for the period of April to June during 2019, 2021 and 2022, showed that performance had reduced in nine out of 12 sites, with an increased number of patients suspected as having a stroke waiting more than one hour for a brain scan.

Following assessment and a subsequent stroke diagnosis, it was positive to find that overall, the treatment (called thrombolysis) to help dissolve the clot in the brain, was commenced promptly in ED if there were no beds available to administer this on the acute stroke ward. Thrombolysis is used for certain categories of ischaemic stroke diagnosis and must usually be undertaken within 4.5 hours of the known onset times of stroke symptoms. However, within the updated *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[5], this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion imaging[6]. Therefore, it is important that WAST works with health boards and Welsh Government to consider the protocol when sending an ambulance to stroke patients, and the increased treatment window.

An alternative procedure to thrombolysis therapy, is surgery to remove a blood clot which is known as a thrombectomy. Thrombectomy can be effective up to 24 hours from onset time of stroke symptoms and can significantly reduce the severity of disability a stroke can cause. This can result in better patient outcomes than those treated with thrombolysis. The only health board in Wales which provides a thrombectomy service is Cardiff and Vale University Health Board. This service operates Monday to Friday from 9am to 5pm, when expert interventional neuroradiology staff and radiology facilities are available to undertake this treatment.

All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust, where the service is available to patients from Wales daily between 8am and midnight, or to the Walton Centre NHS Foundation Trust in Liverpool, which offers a 24/7 service. Given the geographical challenges and the availability of ambulances across Wales due to handover delays, this can have a negative effect on the timely provision of a thrombectomy and is of particular concern when thrombolysis is not clinically appropriate.

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[5] National Clinical Guideline for Stroke for UK and Ireland

[6] CT Perfusion – The Walton Centre NHS Foundation Trust

Treating stroke patients with thrombectomy can have better long-term outcomes for people. According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[7].

It is concerning to find that in Wales, only 13 patients received a thrombectomy at the University Hospital of Wales, just 16 patients from other health boards received treatment in North Bristol and only four at the Walton Centre. More needs to be done to provide equitable access to thrombectomy treatment across Wales.

To give a patient the best possible chance of recovery, specialised stroke unit care must be initiated as soon as possible after the onset of stroke symptoms. Due to the range of specialist treatment they provide, acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs. It was, therefore, disappointing to find several delayed admissions to acute stroke wards from ED. This was often due to a lack of available beds owing to delayed transfers to rehabilitation wards, or delayed discharges out of hospital impacted by the inability of social care providers to deliver timely social care.

To help mitigate this issue and maintain flow for stroke patients, most stroke wards aim to ring-fence a stroke beds. However, we found these beds are repeatedly used for non-stroke patients across Wales, due to the persistent issues with the demands on ED services. This is a concern since some stroke patients may not receive the most appropriate and timely care for their condition, including timely ongoing treatment needed to help with their recovery.

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh. We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS 'Gwaith Iaith' badge.

Across Wales, we found inconsistencies with the provision of rehabilitation to people following their stroke. Overall, we found that the health boards with stroke rehabilitation wards provided an environment that facilitated specific multidisciplinary stroke rehabilitation care, although in some hospitals both acute and rehabilitation care were undertaken in the same environment. We also found inconsistencies across Wales in the provision of the 45-minute daily target for physiotherapy, occupational therapy and speech and language therapy. This was attributed to the challenge with recruiting staff into key therapies posts, and the ability to provide timely services on wards that manage both acute and rehabilitation care to stroke patients.

HIW found good collaborative working between the stroke multidisciplinary teams

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[7] Annual thrombectomy April 2020 to March 2021

in relation to patient discharge preparation.

However, a key issue which significantly impacts on patient flow and overall patient progress, is the delayed transfer of care and discharge for patients who are medically fit to leave acute care. This can be due to the availability of care home beds or social care and rehabilitation therapies provided within the home.

Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections, deconditioning or deterioration whilst awaiting discharge, all of which further impact on flow. The bottleneck at the point of discharge has a knock-on impact on EDs, WAST response times, inpatient care, primary care, planned admissions and overall staff wellbeing.

It is therefore essential that Welsh Government, health boards and social care providers redouble their efforts and work collaboratively to help improve the persistent issues with discharging people from hospital.

To support us with the social care aspects of our review, we utilised the help of Care Inspectorate Wales (CIW)[8]. Through collaboration with CIW and its peer reviewer, we found several factors aligned to social care which also contributed to discharge delays. One issue was frequent delays with social worker allocation causing unnecessary discharge delays for patients who are medically fit to go home. This was identified as an issue in most health boards. Another challenge impacting timely discharge is the ability to provide timely or appropriate domiciliary care packages to people in the community, or the availability of beds in care homes. We found the most significant issue was the recruitment and retention of domiciliary carers, who are needed to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. This in turn, increases the flow bottleneck at the hospital 'back door'.

Adding to the complexity of organising packages of care, some hospitals discharge patients to numerous local authorities within their own health board boundary, to local authorities within the boundaries of another health board, or even across the border to England. Sometimes the process in each can be different, adding to the existing challenges, which may include different referral processes or different IT systems. This makes the processes difficult to navigate and more challenging, therefore causing further unnecessary discharge delays and impacting on patient care.

It is evident that staff working within patient flow and stroke services are dedicated to helping patients move through hospital systems. However, our review indicates that health and social care services are not operating as efficiently as they could be. This inefficiency increases the risk of complications arising from delayed discharge and has a significant impact on the overall health and care system in Wales.

In our report, we have identified various areas that require improvement, and have

[8] Care Inspectorate Wales website

made recommendations for action to address these issues. We firmly believe that more can and should be done to tackle the problems highlighted by our review.

Context

In our Operational Plan for 2021-22, we committed to a programme of national reviews which considered the risks and challenges facing health services as they continue their response to, and recovery from, the pandemic.

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. This is caused by severe congestion within our hospital systems. There are ongoing pressures on the ability of healthcare systems to manage patients effectively and with minimal delays, as they move through each stage of care through to discharge or moved onto an appropriate care pathway.

Poor patient flow leads to congestion and overcrowding within our EDs, with patients waiting for admission into bed on the wards. Consequently, this also impacts on delays with patient handover from ambulances into EDs. This is consistent within several findings during previous HIW inspections of EDs across Wales, including Ysbyty Glan Clwyd[9], University Hospital of Wales[10] and Glangwili General Hospital[11] which were undertaken during 2022. In addition, patients in the community must often wait unacceptable lengths of time for an emergency response from WAST and transportation into hospital. This results in increased risks to those patients, as they have not yet been clinically assessed. Poor patient flow frequently impacts negatively on the whole of a patient's journey through the healthcare system.

Our most recent WAST review[12] highlighted how patient handover delays are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care systems. The impact of inadequate bed/trolley availability in EDs is that there are occasions where multiple ambulances are waiting together outside EDs for prolonged periods of time to handover their patients.

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[9] HIW Hospital Inspection Report - (Unannounced) - ED, Ysbyty Glan Clwyd - Betsi Cadwaladr University Health - 03, 04 & 05 May 2022

[10] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff, and Vale University Health Board - Inspection date: 20, 21 and 22 June 2022

[11] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff and Vale University Health Board, Inspection date: 20, 21 and 22 June 2022

[12] HIW WAST review: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances

The consequences of poor patient flow are well known nationally and can include:

- Delayed ambulance response times to calls
- Delayed ambulance handover
- Overcrowding in EDs
- Patients admitted as 'outliers' to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes
- Ambulatory care services, clinical decision units, even catheter labs and recovery units may be used with patients waiting for ward admission
- Inpatients are also often moved between different wards to accommodate new patients
- Staff are overstretched, and routine activities slow down dramatically
- Clinical outcomes can be measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds.

We recognise there are pressures through the stroke pathway to deliver effective person-centred stroke care, which relate to:

- Timely access to effective care, including transfer to hospital, assessment, key diagnostic interventions, thrombolysis[13] and/or thrombectomy
- Timely admission to an acute stroke ward/unit[14] (or other relevant ward), and other acute care requirements
- Timely therapeutic assessments and treatment
- Stroke rehabilitation and preparation for life after stroke
- Discharge with social care pressures, access to required therapies and ensuring the right support.

As a result of these issues, and our intelligence and other data sources, media reports, and the issues identified through our previous ED inspections, and within both our WAST reviews in 2019-20[15] and in 2020-21[16], we decided to undertake a review of patient flow with a focus on the stroke pathway. This is because stroke is a complex condition, and timely assessment, treatment, rehabilitation, and

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[13] Thrombolysis is a procedure to disperse a blood clot and return the blood supply to the brain. Some people with ischaemic stroke are eligible for thrombolysis which, for most people, needs to be given within 4 ½ hours of stroke symptoms starting.

[14] An acute stroke ward/unit is an area in the hospital that is staffed by a specialist stroke. multidisciplinary team.

[15] HIW local review report of WAST - Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centres

[16] HIW review report of Welsh Ambulance Services Trust - Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during delayed handovers

recovery for patients affected by a stroke, requires support from a range of health and social care professionals, with specialist knowledge and skill.

What We Did

Focus of Review

The focus of our patient flow review was to consider the patient journey through the stroke pathway from the point of requesting an ambulance or people self-presenting at ED, through to discharge from hospital or transfer of care to other services.

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, our retrospective review of clinical records considered the time-period from March 2020, through to the time of our fieldwork between March and August 2022.

Throughout our review we explored the experiences of people accessing care and treatment for stroke at each stage of care, from calling for an ambulance, to assessment, inpatient treatment, and through to discharge.

Throughout, we considered the following key questions:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps healthcare services are taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

When planning our review, we were aware work was (and still is) ongoing to tackle the issue of patient flow, with various approaches and initiatives in progress at a national level.

Scope and methodology

To review the areas detailed above, we requested relevant documents and key information from health boards in Wales and WAST. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the processes in place for patient flow on the quality and safety of stroke patients awaiting assessment and treatment. It also helped us to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

We also considered local and national performance data and statistics. The Sentinel Stroke National Audit Programme[17] (SSNAP) aims to improve the quality of

[17] The Sentinel Stroke National Audit Programme

stroke care by measuring both the structure and processes of stroke care against evidence-based standards. The SSNAP targets are informed by the *National Clinical Guideline for Stroke for the United Kingdom and Ireland*, and national and local benchmarks. The SSNAP clinical audit collects a minimum dataset for stroke patients in England, Wales, and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six-month assessment. All patients with a stroke admitted to hospital in Wales are included on the SSNAP database, which is used to monitor and audit stroke treatment and outcomes.

Over the course of our review, we undertook interviews with a variety of health board staff across Wales. We developed and shared several staff surveys and a survey of stroke patients, or their family members or carers.

We also completed fieldwork focusing on retrospective case studies and current cases of people travelling through the stroke pathway, which included the period of the Covid-19 pandemic.

Professional staff surveys

We developed and launched a staff questionnaire to obtain views from health board staff involved throughout the stroke pathway and their patient flow within the pathway.

In addition, we designed and distributed a questionnaire to obtain views from staff at WAST to gain their opinion of the flow of stroke patients to and from hospitals.

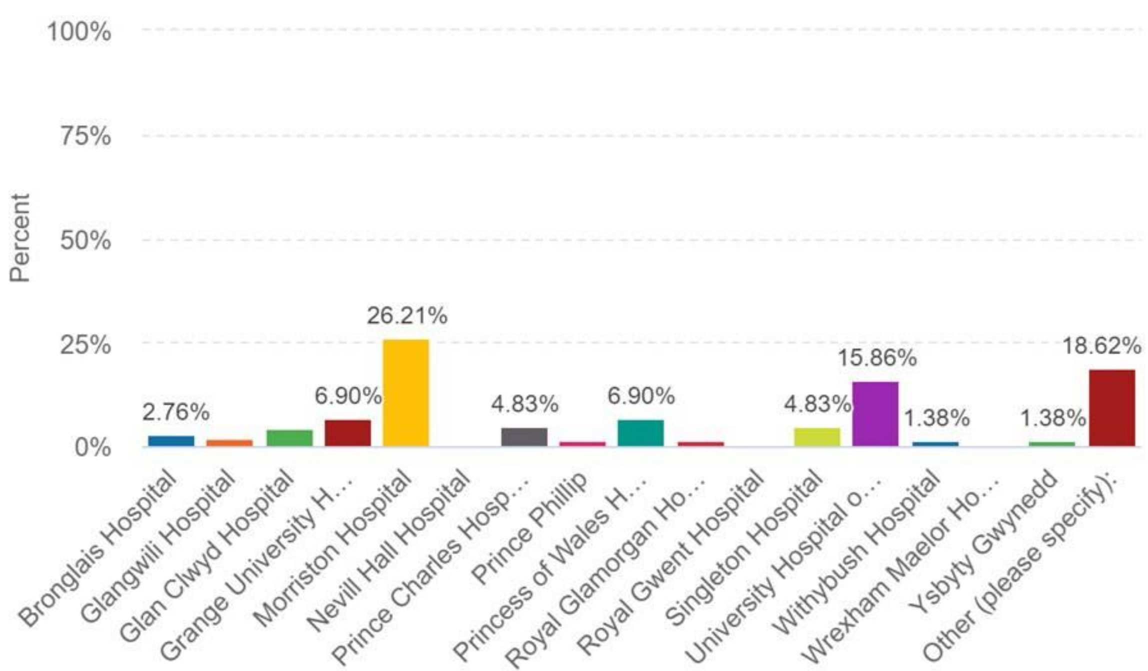
In conjunction with the Care Inspectorate Wales (CIW) we also developed and distributed two additional questionnaires. These were to obtain the views of staff working in social care and local authority staff on their opinion of the challenges faced in effective discharge of patients from hospital.

Health board staff survey

We had a total of 146 respondents who fully completed the health board staff survey.

Our survey found 75 respondents worked directly within stroke services, 20 worked within Patient Flow, 32 worked for emergency departments, 13 were senior management, 16 were site/bed management, 6 were discharge staff and the remainder were made up of various other roles.

The respondents worked within the hospitals highlighted in the chart below:



Social Care providers and Local Authority staff surveys

Both Social Services staff and Local Authority staff surveys were emailed to staff for completion in May to July 2022.

We had 26 staff respond to our social care provider survey from 16 of the 22 local authorities in Wales, which includes:

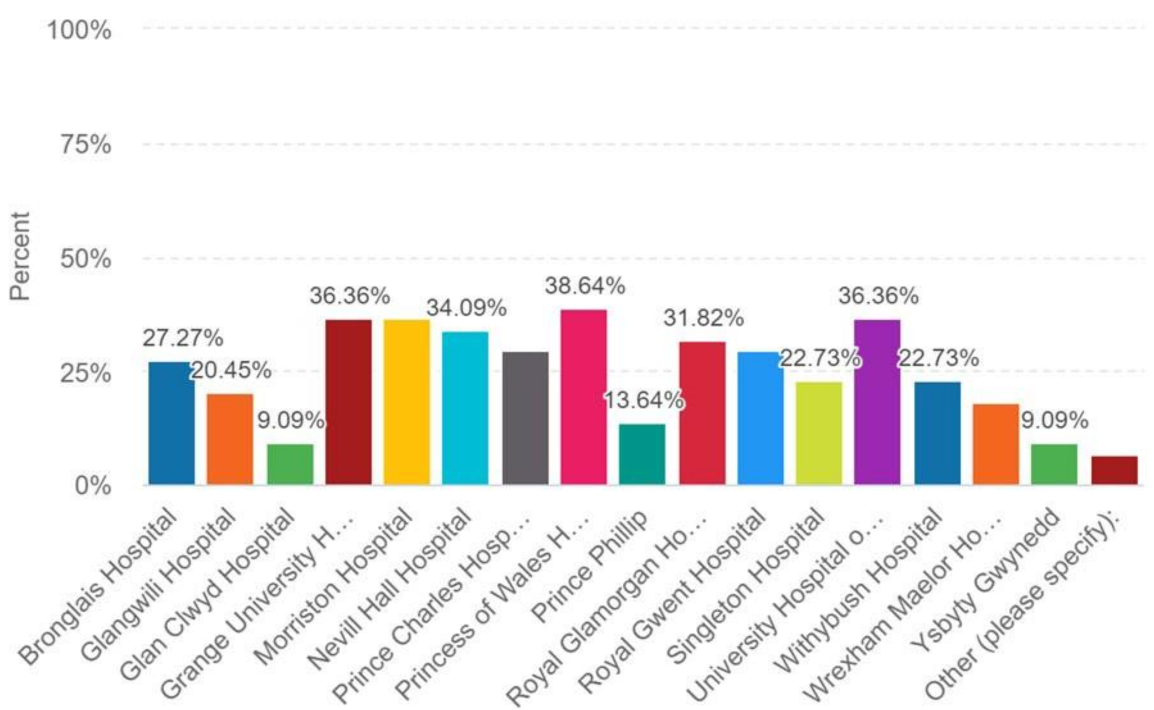
- 7 Registered Managers
- 7 Service Managers
- 6 Care Home Managers
- 3 Responsible Individuals
- 3 Other

Due to the limited number of responses, we have not undertaken a quantitative analysis, however, where applicable, we have considered comments from our qualitative analysis within the report.

WAST staff survey

The survey was emailed to staff for completion in May to October 2022.

We had 44 staff respond to our survey who worked with the following hospitals:



Public survey

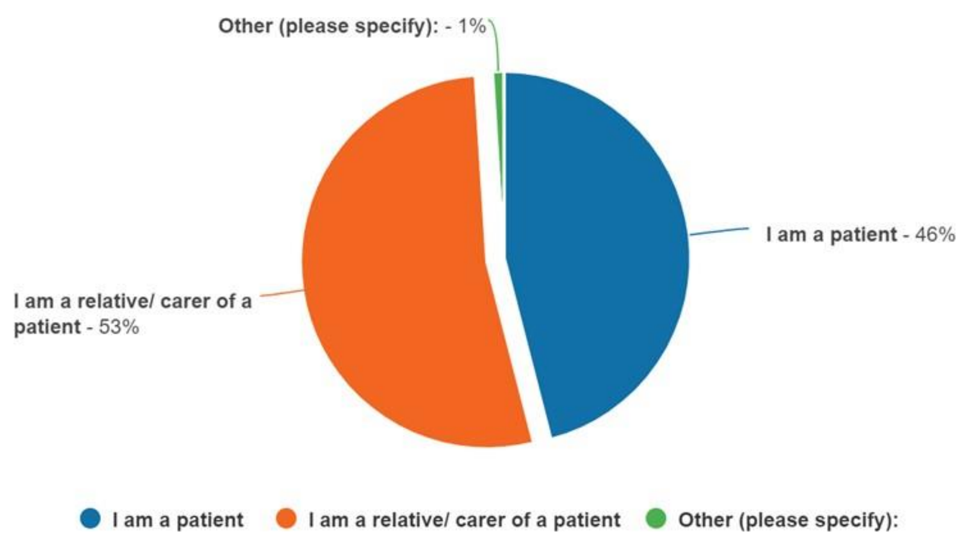
We conducted a survey to capture the views of stroke patients who had used healthcare services, or the views of their family members or carers. The patient questionnaire was designed and distributed by HIW, with the input of the Stroke Association, to obtain views from patients on the quality and safety of care throughout the stroke pathway.

The survey was promoted for completion from May to September 2022.

We received a total of 106 responses to our survey. Some partially completed or skipped some questions, but all 106 responses have been considered as part of this analysis. When asked of their gender identity, 52.5% said they identified as female, 42.5% as male and the remaining preferred not to say.

Only 81 respondents answered our multiple-choice question relating to ethnicity. 61 answered ‘white’, 29 answered ‘Welsh/English/Scottish/Northern Irish/British’, and one person answered ‘Irish’. There were zero responses to all other available options, for example, black, Asian, mixed ethnicity, gypsy/Irish travellers, or other ethnic groups.

The 106 responses were received from patients, carers or relatives, or other:



The ‘other’ response was a friend of a stroke patient. All respondents were asked to respond to questions on behalf of the patient. There was a good distribution of responses across Wales.

Fieldwork

Currently 12 hospitals across six of the seven health boards provides emergency services for stroke patients. Powys Teaching health board does not provide acute stroke services but accesses services from NHS England and Welsh health boards. All 12 sites listed below provide acute stroke services including thrombolysis treatment for patients with an acute, ischaemic stroke.

- The Grange University Hospital, Cwmbran
- Prince Charles Hospital, Merthyr
- University Hospital of Wales, Cardiff
- Princess of Wales Hospital, Bridgend
- Morriston Hospital, Swansea
- Prince Philip Hospital, Llanelli
- Withybush Hospital, Haverfordwest
- Glangwili Hospital, Carmarthen
- Bronglais Hospital, Aberystwyth
- Ysbyty Gwynedd, Bangor
- Glan Clwyd Hospital, Rhyl
- Wrexham Maelor Hospital, Wrexham

As highlighted above, we attended one acute site within every health board area during the period from March to August 2022. Most of our onsite visits were conducted over three days. Our approach to the fieldwork conducted within Powys Teaching Health Board was reduced to a two-day visit to a rehabilitation ward, given the absence of an acute stroke ward.

Our fieldwork included face to face interviews with ED staff, stroke services staff and patient flow/discharge managers. We were unable to visit all the acute sites providing stroke services within Wales; however, to understand the challenges faced with patient flow through the stroke pathway at every site, interviews were held via Microsoft Teams. We held in the region of 250 interviews with health board staff across Wales.

During our onsite visits, we also attended board rounds, multidisciplinary team meetings (MDT) or equivalent for stroke patients, bed or site management meetings and patient discharge meetings. Where we were unable to attend in person, and for sites we did not carry out fieldwork, these meetings were attended via Microsoft Teams.

Our focus during our fieldwork was on reviewing patient records and key documents within each health board, both on a retrospective review of patient clinical records from 2020 onwards, and the records of patients in hospital travelling through the stroke pathway at the time of our site visits.

The inspection team for each onsite visit consisted of:

- HIW Senior Healthcare Inspector (review lead)
- HIW Healthcare inspector (review support)
- Up to three clinical peer reviewers
- CIW peer reviewer (to interview key staff involved with the discharge of stroke patients from hospitals across Wales).

It was positive to note that during our onsite fieldwork site visits we did not identify any areas of immediate concern for patient safety, and we therefore did not need to implement our immediate assurance process.

In November 2022, we wrote to all health board Chief Executives with a summary of the initial key general findings to date. We did not require any specific action to be taken in response to these findings at that time.

Relevant guidance for patient flow and the stroke pathway

In considering the effectiveness of patient discharge, we looked at whether hospital wards follow the Welsh Government principles of 'SAFER Patient Flow

Guidance'[18]. This guidance provides good practice to promote safe and timely discharge, improve patient flow and prevent unnecessary waiting for patients.

Throughout this report, we often refer to the NICE guideline *'Stroke and transient ischaemic attack in over 16s: diagnosis and initial management' (NG128)*[19]. In addition, the *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[20]. We also refer to the NICE *Stroke Rehabilitation in Adults* clinical guideline (CG162)[21]. This relates to stroke rehabilitation for adults and young people aged 16 and over who have had a stroke with continuing impairment, activity limitation or participation restriction.

Welsh language 'active offer'

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh.

We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS 'Gwaith Iaith' badge.

Within our staff survey, 22 people said their first language was Welsh, although every questionnaire was completed in English, despite the choice available to complete this in Welsh. Our patient survey identified that eight people speak Welsh, with just one who said they were offered the opportunity to speak Welsh.

In most cases during our clinical records review, we found no evidence or reference to a patient's language choice. However, in one hospital, it was recorded that patients were English speaking only within the records reviewed. We also saw in one patient record, that a patient was asked for their preferred language, as part of the Occupational Therapy cognition test.

What We Found

Patient flow: a journey through the stroke pathway

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. It is caused by severe congestion within our hospitals, and there are ongoing pressures within health and social care services to manage patient journeys effectively. The challenge within both systems can impact on timely hospital discharges, and often, people do not always receive the right care, at the right time, in the right place, which may impact on their safety.

To explore the complexities of patient flow through the healthcare system, we focussed on a patient journey through the stroke pathway. It is therefore important to highlight the significance of stroke and its prevention first.

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[18] Welsh Government SAFER patient flow Guidance
[19] NICE guidance stroke-and-transient-ischaemic-attack-in-over-16s
[20] National Clinical Guideline for Stroke for the UK and Ireland
[21] NICE Stroke rehabilitation in adult's Clinical guideline

What is a stroke?

Stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors. The Stroke Association[22] suggests that currently, there are around 69,000 stroke survivors living in Wales, and NICE[23] suggest around 8,000 people in Wales experience a stroke each year.

As highlighted above, NICE highlights that stroke is a leading cause of death and disability, causing around 38,000 deaths each year in the UK, and in addition, in the UK there are approximately 1.3 million stroke survivors. The number of hospital admissions per year due to stroke is approximately:

- 126,000 in England
- 9900 in Scotland
- 8000 in Wales
- 5000 in Northern Ireland.

There are three different types of strokes, these include:

- **Ischaemic stroke** - caused by a blockage, such as a blood clot, cutting off the blood supply to a part of the brain
- **Haemorrhagic stroke** - caused by bleeding in or around the brain
- **Transient Ischaemic Attack (TIA)** - also known as a mini-stroke – brief blockage in supply of blood to parts of the brain.

It is critical that people know how to spot the signs and symptoms of stroke, and they should call 999 immediately, due to the time critical nature for the treatment.

The signs of stroke are highlighted below and are represented as the acronym

'FAST':

Face	Has their face fallen on one side? Can they smile?
Arms	Can they raise both their arms and keep them there?
Speech	Is their speech slurred?
Time	Time to call 999!

Stroke prevention

In its 2018 report, *A Healthier Wales: our Plan for Health and Social Care*[24], Welsh Government set out a long-term future vision of a 'whole system approach to health and social care'. It places a greater emphasis on preventing illness, by supporting people to manage their own health and wellbeing, and to enable people

[22] Stroke Association
[23] NICE - What is the prevalence of stroke and TIA in the UK?
[24] A Healthier Wales (gov.wales)

to live independently for as long as possible, supported by new technologies and by integrated health and social care services.

As part of our review, we considered what information is available to advise the people of Wales on the risks associated with having a stroke, and its prevention. The Royal College of Physicians[25] estimate that up to 70% of all strokes could be avoided if the risk factors were treated and people adopted healthier lifestyles.

The role of Public Health Wales in stroke awareness and prevention

Public Health Wales NHS Trust (PHW)[26] is the national public health agency in Wales. Through its work, the aim is to protect and improve the health and wellbeing of people and reduce health inequalities across Wales. As highlighted earlier, our review considered patient flow through the stroke pathway. It is, therefore, important to understand what PHW is doing to help prevent people in Wales having a stroke.

We considered how PHW were engaging with people to raise their awareness of the risk factors associated with a stroke, and their understanding of stroke symptoms. Additionally, what the Trust is doing locally or nationally to target certain groups of people who may be at the highest risk of sustaining a stroke. This may include Black and Asian people, and those living with high blood pressure, high cholesterol, diabetes, excessive alcohol intake, smokers, and those with Atrial Fibrillation (AF).

AF is a heart rhythm problem and increases the risk of a stroke due to a risk of blood clots forming in the vascular system (blood stream), which may travel to the brain causing a stroke. The Stroke Association[27] highlights that AF can happen to anyone, including people who are otherwise fit and well. It usually affects adults, and the risk increases with age, but also for people with conditions, such as heart disease, diabetes, obesity, high blood pressure, and in smokers.

In our survey, when we asked respondents about their ethnicity, there were zero responses indicating people were from Black, Asian, or other ethnic groups.

According to the Stroke Association and Different Strokes organisation[28], strokes may happen more often in people who are black or from Asian families. In addition, it is suggested that within these groups, people may need to get checked at an earlier age for diabetes, particularly if they have any risk factors, such as being overweight[29].

In 2021, Different Strokes Organisation launched a national outreach program, to raise awareness of stroke risk amongst Black and Asian communities, and to develop a longer-term plan, to break down barriers preventing Black and Asian stroke survivors from accessing its support services. Through the outreach programme, the organisation found there was lack of awareness of the risk of

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[25] The Royal College of Physicians
[26] Home - Public Health Wales (nhs.wales)
[27] Stroke Association - Atrial Fibrillation
[28] Different Strokes
[29] Stroke Association - What is stroke, are you at risk of stroke

stroke at all ages, and Black and Asian people were not aware of their increased risk of stroke. They also found limited information available regarding stroke for people from Black or Asian communities, or for people whose first language is not English. Additionally, they found in UK-wide NHS campaigns, there was a limited representation for these communities, such as a lack of images of Black and Asian people, meaning that when they were looking at stroke campaigns, they would not see themselves in the images or the stories shared.

The Different Strokes Organisation has developed an engagement strategy to tackle the issues highlighted above, which plans to support and raise awareness of younger stroke amongst Black and Asian communities in the UK. The equality and diversity statics in Wales for 2018-2020 indicate that 95% of the population described their ethnic group as White, and 5% described themselves as Asian, Black, or as being from mixed or multiple ethnic groups or from another ethnic group[30]. The Different Strokes Organisation alone cannot raise the profile of stroke in Black, Asian and ethnic communities, therefore, health boards, Welsh Government and PHW must make a concerted effort with reaching out to people within these communities through stroke awareness education and campaigns.

Stroke and health inequality

Socio-economic factors also impact on the risk of stroke. Health inequalities disproportionately affect certain communities and socio-economic deprivation is linked to worse health outcomes[31]. Strokes occur more commonly in areas of deprivation, therefore, highlights the inequalities in people's health status[31]. It is therefore important that when engaging with the public on stroke awareness and stroke prevention, health boards, Welsh Government and PHW should ensure they reaches out to people affected negatively by socio-economic factors.

[30] https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html
[31] https://phw.nhs.wales/services-and-teams/local-public-health1/cwm-taf-morgannwg-public-health-team/cwm-taf-morgannwg-public-health-documents/cwm-taf-annual-report-of-the-director-of-public-health-2018-a-public-health-approach-pdf/

Recommendation 1:

Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning between themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.

Recommendation 2:

Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.

Recommendation 3:

Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.

Stroke management performance in NHS Wales

To demonstrate their performance in managing stroke services, hospital sites in Wales (and the UK), are graded in line with SSNAP data. Each hospital which manages stroke patients is required to regularly submit their performance data to SSNAP. The grade for performance is categorised from A (highest) to E (lowest).

In 2019, just three out of 16 hospitals in Wales who manage stroke patients, received a D or E grade. In 2022, the data reflects an increase to 11 of 14 hospitals who received a D or E score. This is concerning, not only as each hospital is graded in the lower categories, but it also highlights hospital performance has declined significantly across Wales in the past three years. However, it is important to note that this period did coincide with the COVID-19 pandemic.

The extreme and unprecedented demand for hospital beds during the pandemic had a significant impact on flow through healthcare systems, to the extent that field hospitals were implemented to cope with the overwhelming demand for beds. Health and care staff across all roles and services showed huge resilience in the face of unprecedented demands and pressures and adapted quickly with different ways of working to keep themselves and people safe. Staff worked in extremely difficult circumstances to care for people not only with COVID-19, but for others with other healthcare needs.

Despite their best efforts to protect people, tragically, many of those they cared

for died, and some staff also had to deal with the loss of colleagues.

What is Patient Flow?

Patient flow is the movement of patients through a healthcare system. It involves the clinical care, physical resources, and the internal processes and systems needed to move patients from the point of admission to the point of discharge.

Within its *Programme for Government 2021-2026*[32], Welsh Government committed to the provision of urgent and emergency care services in the right place, first time. It developed the *Six Goals for Urgent and Emergency Care*[33], which supports the health and social care system in the delivery of the programme for government commitments.

Improvement Cymru[34] is the improvement service for NHS Wales. Its aim is to support the establishment of the best quality health and care system for Wales, so that everyone has access to safe, effective, and efficient care in the right place and at the right time. During our onsite fieldwork, we found that Improvement Cymru was undertaking a pilot in three hospital sites and was supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity (RTDC) methodology to focus on the process, using improvement methodology. This will be highlighted further, later in the report.

Managing people through the stroke pathway

In 2021, Welsh Government published its 5-year plan[35] to improve the quality of stroke services and outcomes. The new quality statement for stroke, sets out the future vision for stroke services in Wales and was developed with Wales' Stroke Implementation Group.

The Stroke Implementation Group provides guidance to the government and advice to key stakeholders and is developing a delivery plan[36] which is overseen by the National Clinical Lead for stroke in Wales. The plan will outline how services must improve the quality of stroke care and reduce variations in care across Wales. The group will also be supporting health boards to develop a network of comprehensive regional stroke centres, supported by regional operational delivery networks that work across boundaries to improve care, from acute treatment to rehabilitation.

However, to successfully achieve the above, effectively managing patient flow is pivotal.

The Senedd Health and Social Care Committee, undertook an inquiry into hospital discharge and its impact on patient flow through hospitals.

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[32] Welsh Government Programme for government: update | GOV.WALES
[33] Welsh Government - Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026
[34] Improvement Cymru website
[35] New plan for Stroke care announced for Wales | GOV.WALES
[36] This a Service Specification which is being developed by a sub-group of the Stroke Implementation Group, led by the Clinical Lead for Stroke in Wales and comprises clinical, third sector and academic partners

The report[37] was published in June 2022, and highlights several challenges facing the health and social care sectors. The inquiry identified the need to take radical steps to reform health and social care systems and made 22 recommendations for improvement to Welsh Government.

We found that several of the recommendations align with the improvements needed identified as part of our review. Our review highlights that whilst work is ongoing nationally to tackle patient flow, it is not clear how effective these work streams have been to date since the complex issues with patient flow remain unchanged.

How do health boards manage patient flow?

To manage the demand for beds across Welsh hospitals, designated teams within each health board hold regular meetings to address the issues with hospital admissions and discharges.

These meetings are held several times a day, 365 days a year. They are commonly referred to as patient flow, bed management or site management meetings. In addition to these, further regular meetings take place internally with members of the executive team such as the Chief Operating Officer, to consider the movement of patients across hospital sites within health boards. In addition, external meetings are held with other health boards and WAST. These consider the wider impact on flow across health board boundaries and the impact this may have on WAST providing services to people in the community. This will be highlighted later in the report.

For ease, throughout this report, we will refer to the meetings above as 'patient flow' meetings.

Patient flow meetings

During our fieldwork, we attended several patient flow meetings across Wales, and considered how effective they were in managing flow to provide timely, safe, and effective care to patients.

Patient flow meetings were held regularly, at least three times each day across the sites visited as part of our review. They were well attended by the key staff responsible for a patient's journey through hospital, such as patient flow managers, department managers, different MDT members, senior managers, and discharge co-ordinators. The meetings enable everyone to have a collective understanding and a joint ownership of patient risk and safety across the whole hospital site.

In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the ambulance handover delays and plans for longest wait patient handovers.

Actions and plans were also discussed on how to off-load certain patients into ED,

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[37] Welsh Parliament Health and Social Care Committee, into hospital discharge and its impact on patient flow through hospitals

to release an ambulance from the hospital. In the absence of a HALO, this input was provided by staff from ED.

Ambulance Immediate Release Protocol

To help manage the constant issue found across Wales with ambulance handover delays, in June 2022, WAST in conjunction with NHS Wales, developed its first draft of the *All-Wales Immediate Release Protocol*[38].

When a person calls 999, there is a triage process which is completed by a call handler who enters data into the Medical Priority Dispatch System (MPDS)[39]. The response provided by the caller and data entered in the MPDS, generates a WAST priority code to determine the clinical response required for the patient. The system prioritises the most urgent patients, who are categorised as Red, Amber (1 and 2), and Green. Details of call categories are highlighted on the WAST website[40].

The immediate release protocol outlines the principles and processes for managing the immediate release of ambulances when new calls are categorised as 'Red or Amber 1'. This aims to minimise safety risk for people awaiting an ambulance response in the communities. This is usually invoked when ambulance capacity is reduced, when the time for patient handover at EDs is prolonged. The handover standard is 15 minutes and is considered extended beyond 30 minutes.

Data provided by WAST for the period 1 July 2022 to 5 September 2022, reflects a high volume of Immediate Release Directions (IRDs) being made. The data reflects the pressures that EDs across Wales are experiencing, which results in patient handover delays and patients in the community experiencing long waits for an ambulance response. During this period, a total of 1,900 IRDs were made. Around 30% of these related to 'Red' priority calls and 70% for 'Amber 1'. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, only 35.5% of the directions between April 2021 to June 2022, received this decision within the 8-minute response target for 'Red' calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 IRDs, despite the new protocol stating that they must not occur.

Recommendation 4:

Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.

Patient flow dashboard

[38] NHS Wales Immediate Release Protocol

[39] MPDS is a unified system used to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.

[40] How WAST Responds to Emergency 999 Calls

Each acute hospital site had a patient flow dashboard (commonly known as the 'SitRep' (Situation Report)) displayed within the patient flow meeting rooms. It presents all key details for patient flow throughout the hospital, which was reviewed systematically and was referred to appropriately throughout the meetings. They were used to visualise the key areas requiring discussion, and to help plan timely management of all patients from ambulance handover, the ED and through to the wards (and operating theatres), to patient discharge.

During the patient flow meetings, we found the Chair would consider all aspects of flow systematically through the SitRep. This was from the ED ('the front door'), to discharge or transfer from hospital ('the back door'). In addition, consideration was given to the workforce requirements, such as staffing on the wards or in ED. The escalation status of the hospital was determined within the flow meetings, based on the availability of the beds available, ambulance waits, ED capacity and ability to admit people for key treatment or surgery.

Hospital escalation Status

To establish a hospital escalation status consistently across Wales, Welsh Government, health boards and WAST, jointly approved a National Emergency Pressures Escalation and De-escalation Action Plan[41]. The action plan defines the four main escalation status levels for health boards and WAST. These levels and the triggers are used to determine the appropriate response to escalating and de-escalating emergency pressures, and the actions necessary to protect core services. This is to help provide the best possible level of service with the resources available.

Levels of Escalation

The table below defines the four main escalation status levels for health boards and WAST.

Level 1 **Level 2** **Level 3**	**Steady State** **Moderate Pressure** **Severe Pressure**	Ensure all standard operating processes are functioning as efficiently as possible to maintain flow. Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. Escalate when applicable. Prioritise available capacity to meet immediate pressures.

[41] National Emergency Pressures Escalation and De-escalation Action Plan

		Put contingencies into action to bring pressures back within organisational control. De-escalate when applicable.
Level 4	**Extreme Pressure**	Ensure all contingencies are fully operational to recover the situation. Executive command and control of the situation. De-escalate when applicable.

Throughout our onsite fieldwork, almost all hospitals were at a level four escalation at some point during our visit, which represents extreme pressure on the hospital system overall.

Focus of flow across departments

Overall, we found that patient flow teams appeared to manage meetings well. We witnessed discussions about each ward systematically, which included bed capacity and staffing of each ward and specialty of patients within the ward beds. Concerns were highlighted and discussed appropriately during all meetings we attended, with effective communication regarding the challenges with flow through the hospital system.

Updates were given from each area which includes the following examples:

- Patient handover delays from ambulances including the longest wait and number of ambulances waiting outside ED, and plans for the handover
- Demands and risk within ED, including the number of patients awaiting admission to a ward bed
- Numbers of patients on each ward, such as medical, surgery, paediatric, critical care
- Situation on ringfenced beds, including stroke
- Department staffing and resources
- Infection prevention and control issues
- Number of patients requiring surgery that day
- Total number of patients awaiting discharge or repatriation
- Action required on patients awaiting discharge and repatriation.

Overall, we saw that patient flow teams had a good understanding of which patients needed beds or needed moves to other wards. In addition, they had knowledge of the patients requiring transfer or repatriation to other hospitals or

community settings, and discussions took place on transport requirements. This included stroke patients who were deemed appropriate for transfer from acute settings to community rehabilitation wards. It is positive to note that 87% of stroke services staff who responded to our survey said, patient flow staff were involved with the stroke patient's journey throughout their care.

Patient outliers on different specialty wards

We found adequate oversight of patient specialty outliers in other service groups or hospital areas, such as medical patients being cared for in surgical beds and vice versa. Patient outliers was a consistent finding across Wales, due to pressure on the system and the high demand for beds. It was also an issue prior to our review and is frequently evident through HIWs annual inspection process.

It was clearly not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment due to bed availability. Whilst this is a common occurrence across Wales, it is concerning since patients are regularly being treated on a ward that would not usually care for that specialty. Whilst it was not always possible to place people on the correct ward, staff and flow teams risk assessed the most suitable patient to place to a different specialty ward. Effective management at patient flow meetings can help to ensure this happens effectively.

When considering the stroke pathway, some healthcare staff explained issues with demand and capacity in stroke services, as there were more acute stroke beds available than rehabilitation beds. Consequently, this can have a negative impact on patient flow through stroke services because patients were waiting in acute beds longer than necessary, before being moved to a rehabilitation ward.

We also found in some health boards, wards cared for both acute stroke patients and those in their rehabilitation stage on the same ward. Within one health board, we found patients were placed in an area of a ward which was previously a rehabilitation gym. Whilst this enabled stroke care in the right ward, losing the gym area was impacting on the prompt rehabilitation of all patients. Like this finding, a staff member commented in our survey as below:

'*Currently even with good MDT working and effective discharge planning, there is no step-down from acute to help flow. Patients that are no longer having active treatment then increases bed pressures in other areas of the hospital and often these patients still require input from a discharge planning point of view and reduce time spent with acute / rehab patients receiving active treatment. This then means there is increased pressures on staff and reduced available time to meet stroke guidelines and directly having a knock-on effect to patient progression and the time it takes to reach a safe level of discharge with increase length of stay and inhibits flow.*'

Bed capacity pressure

We interviewed patient flow staff across Wales, who told us that pressures on the hospital patient flow system had been exacerbated by the pandemic, and the pressure continues to rise. We were told that 'winter pressures' have become an

all-year-round issue, with hospitals finding it difficult to recover during the spring and summer months due to demands on the ED and ward beds.

During the winter period, many health conditions, including respiratory diseases such as asthma, can be caused or worsened by cold weather. Those issues along with higher incidences of so-called 'seasonal illnesses, such as flu and norovirus, can mean the NHS often faces much greater pressure during winter, due to demand on healthcare services. This not only impact on hospitals, but also within community services, such as GPs, community nursing teams and pharmacy services.

During our staff interviews, we found other reasons which can affect ED capacity, therefore impacting on patient flow. This includes:

- Difficulties in people accessing primary health care, such as GP appointments, means more people are self-presenting to EDs when they do not require emergency care
- An increased demand on ED services from people needing mental health support, as adequate community support is not available when needed.

Our interviews with patient flow staff, also found consistent problems with the timely discharge of patients. This was an issue across Wales, from both acute and rehabilitation wards, and was negatively impacting on patient flow and overcrowding in ED. This includes:

- Difficulties in admitting patients to a Ward from ED, due to a lack of available ward beds, as wards cannot discharge medically fit people due to social care capacity
- Insufficient capacity for patients who require rehabilitation or intermediate care after their acute phase.

Patient flow - discharge discussions

During the patient flow meetings, the number of patients medically fit for discharge were discussed in all hospitals we visited. Staff told us that on average, approximately one third of patients on a hospital site were fit for discharge.

However, they either had no social worker allocation, set plan or date for a social care package to commence at home, or there was a lack of beds available within nursing or residential homes, if they were unable to return to their previous residence.

We found in some but not all hospitals, that when a patient was likely to be discharged on a given day, an action plan would be developed and discussed at the patient flow meetings with a view to ensure the discharge is fulfilled as planned.

This may include completing timely blood tests, ensuring take home medication was prepared in advance of discharge, and hospital non-emergency patient transport was arranged in a timely manner.

These actions would sometimes be followed up at the next meeting and addressed in subsequent meetings if incomplete. We found examples where such actions were expedited effectively and saw progress had been made by the next meeting, or the patient had been discharged or placed within the hospital's discharge lounge awaiting transport. However, there were some occasions when actions had not been delegated appropriately, which impacted on the timely discharge process.

Recommendation 5:

Health boards must communicate with each other to establish the good practices taking place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.

Further details relating to the challenges faced for effective discharge of patients, are highlighted later in the report.

Improving flow with Improvement Cymru

As highlighted earlier, during our onsite fieldwork we noted that an Improvement Cymru team was undertaking a pilot to support three acute hospital sites to help manage their patient flow. This was done using a Real Time Demand Capacity (RTDC) methodology. We engaged with the Improvement Cymru team, to gain an understanding of their work and any progress made since the onset of the pilot.

The goal of the RTDC tool is to improve patient flow processes by developing a situational awareness amongst staff teams within hospitals. This is to ensure staff fully understand the demand and capacity, and to establish an appropriate awareness and understanding of the bottlenecks and constraints impacting on flow. This would help structure the planning process to improve flow and to pre-empt or predict demand and capacity, and to manage flow more effectively.

The RTDC methodology focuses on discharge and improving flow in small increments, particularly in the earlier part of the day. Whilst this does not assist with the existing flow issues which relate to social care challenges impacting on discharge, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. This can result in earlier availability of ward beds, which allows for a timelier transfer of patients from ED to the wards or minimise delays with theatre list start times. This in turn, impacts positively on the timeliness of patient handovers from ambulances to ED, hence releasing ambulance crews to attend emergency calls within the community, or to repatriate or transfer patients home from hospital when applicable.

The Improvement Cymru team highlighted to us some themes found which contribute to delays in patient discharge. This included transport delays and the timely management of take-home medication. They found that often, take-home medication was not being prescribed and sent to pharmacy until the same morning that the patient is due to be discharged, which adds to unnecessary delays. This is consistent with our findings in our review of *Patient Discharge from Hospital to*

General Practice[42].

During the first week of the RTDC project at one hospital, the Improvement Cymru team found significant delays in the undertaking of blood tests and obtaining the results for these in a timely manner. An immediate action to improve this was for the health board to allocate ten priority slots with phlebotomy services to ensure patient blood tests were completed early in a timely manner, for those being discharged that day. This had a positive impact on preventing some delays with discharge.

Recommendation 6:

Health boards must review and consider processes for prescribing take home medication so that these can be obtained from pharmacy more promptly in order to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).

Recommendation 7:

Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timely discharge.

We spoke with several staff from the three pilot sites about their engagement with the Improvement Cymru team. This was to establish what impact the RTDC methodology was having on their patient flow processes. One person said that one of the challenges they identified was the Ward Manager engagement with the RTDC process, and for them to understand how this would benefit their ward flow.

We were told by several patient flow managers that the flow processes currently in place in their hospitals had remained the same for many years, and to help change the process was a significant challenge. This would require strong leadership at both department and flow team level. The flow teams told us that to support the process, templates were developed to capture key information, and they would attend the wards in person to engage with ward managers, to support them in identifying solutions themselves, to help resolve delays in flow issues at a local level.

It was also explained to us that the RTDC methodology allows all departments across hospital sites to take ownership of the safety and risk associated with patient flow, and staff are now more engaged to share resources to help mitigate and balance the risk and safety of flow barriers across the whole hospital site.

As a result of the RTDC pilots, we also observed some positive processes implemented for improving flow discussions and the overall management of beds,

[42] HIW - Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018.

which included analysis of bottlenecks and challenges with patient discharge. We heard from staff in one hospital that work was in progress to analyse data of the key flow issues. This was to support predicted planning arrangements to improve the overall flow processes. An example of this includes data analysis of ambulance attendances at the ED, both daily and weekly, to understand and predict potential patterns for demand on the service with the aim to help reduce capacity issues.

We found some disparities across Wales with directorate clinical oversight of patient flow at more senior levels, such as Senior Nurses or Lead Nurses. In some hospitals, senior nurses would be placed on a daily directorate rota for effective senior clinical oversight of patient flow for their directorate, such as one for medicine and one for surgery. They would attend the daily flow meetings, and visit the relevant wards across their directorate frequently, to ensure staff teams were making timely progress to discharge patients, consult with senior nurses from other directorates (rostered to manage flow), challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding patient needs. They would also establish a plan for proposed discharges for the following or subsequent days. However, in some hospitals there was no daily senior nurse/ clinical oversight. We found that where a senior nurse oversight for flow was part of the daily process, the daily ward discharge process and planning for subsequent days was more effective. Any actions and discharges appeared to progress timelier, than hospitals without clinical flow oversight.

Recommendation 8:

Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timely patient flow.

Recommendation 9:

Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

Recommendation 10:

Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. This could also support early planning for patient discharge.

Non-emergency clinical care in the community

To help understand how people can access the most appropriate clinical support, if they have urgent, but not emergency healthcare needs, we considered what supportive measures were in place within the community.

Reducing the burden on GPs and EDs

Signposting people to other resources can help improve patient flow by reducing the burden and pressure on GPs or local EDs. Using other community services where appropriate, may reduce the overcrowding that occurs in EDs, and ensure people are getting the right care, in the right place, first time.

Welsh Government is currently promoting the '*Help Us to Help You*' campaign. This highlights to people that better health starts with them, and educates people on how to access relevant advice, support, or care for their health concern, with any new or existing condition.

The campaign and information on the *'Better Health Starts with You'* webpage[43], highlights the many ways to access healthcare in Wales. This includes using pharmacies, Minor Injury Units (MIUs) and mental health helplines, or using other online NHS consultations, to reduce the need for people to attend their GP surgery, or attending ED when their health concern is not an emergency.

Key messages relating to this campaign include advice on using the *NHS 111 Wales service*[44], which starts as a symptom checker and advises people of what steps to take prior to attending the GP or ED. There is also guidance available on accessing other local services and MIUs, and signposts support for mental health needs. We were told by Welsh Government that the reach and impact of this campaign is being measured at regular intervals; however, no data was provided to us to support this.

WAST also launched its campaign around awareness for the NHS 111 Wales service on their website[45]. It supports the *Help us to Help You* campaign by highlighting the 111-symptom checker. If a person feels their health concern is urgent, they can call 111 and speak with highly trained call handlers who will provide advice over the telephone and can arrange a call back from a clinician if needed. Using NHS 111 Wales first, can reduce pressure on the emergency 999 service and EDs.

The NHS 111 Wales service has now implemented further support for people needing help with their mental health, where they call the usual 111 number and press OPTION 2[46]. The service is available for everyone, 24 hours a day, 7 days a week to ensure those in need of mental health support can access it quickly when they need it most. The number is free to call from a landline or mobile, even to those with no credit on their phone.

When considering the *Help Us to Help You* measures in place across Wales, we explored whether it was having a positive impact on WAST and its ability to manage emergency calls in a more timely and effective way. We interviewed a senior manager within WAST who informed us that despite the promotion of the NHS 111 campaigns in Wales, the Trust continues to have multiple 999 calls for non-life-threatening emergencies. We were also told that the winter of 2022/2023

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[43] Better Health Starts with You
[44] NHS 111 Wales
[45] NHS 111 Wales: Healthcare advice you can trust - Welsh Ambulance Services NHS Trust
[46] https://www.gov.wales/nhs-111-press-2

had been particularly challenging for the service, with a high number of calls, and particularly from patients with respiratory issues. WAST regularly manages the data relating to calls and categories of need.

A key area requiring improvement is for healthcare services to engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

Recommendation 11:

Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.

Recommendation 12:

Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.

Impact of flow on WAST

WAST patient pathway

We considered the stroke patient's journey through WAST services as the primary frontline service for emergency transport into hospitals across Wales.

In 2015, WAST introduced a framework which replaced the time-based targets for measuring response times of ambulances. The framework is a five step Ambulance Care Pathway, which focuses on the patient journey and is more aligned to the patient outcomes and experiences.

Using the Ambulance Care Pathway framework, we sought to understand how a potential stroke patient is managed from the time of calling 999 for an ambulance, the outcomes they might expect, and the impact of poor flow on WAST's ability to respond to emergency calls.

These include:

Help me to choose

We have already discussed the benefits of people in choosing the most appropriate service for their health concern through NHS 111 Wales. This is to help prevent the need to use the resource of the GP or attend ED. However, when a stroke patient

feels it necessary to call 999 for an ambulance, the data available from Stats Wales[47] shows on average, around 1400 stroke related calls can be received by WAST each month.

Answer my call

As highlighted earlier, when a person calls 999, a call handler completes a triage process and enters data into the MPDS. This allows the MPDS to generate a priority code to determine the clinical response required for the patient, as either Red, Amber, or Green.

If a caller is suggesting symptoms of a stroke, the MPDS will prompt the call handler to undertake the 'Act FAST' test. If the patient is conscious and breathing with positive stroke symptoms, and the onset of symptoms are known to be less than five hours, the call is prioritised as 'Amber 1'. If the symptom onset time is over five hours, the call will be prioritised as an 'Amber 2'. This is because the time to treat a clot in the brain must commence within four hours of known onset of symptoms, and to be considered for thrombectomy for symptoms in less than six hours.

Results from our staff survey reflected seven views on call categorisation, and a feeling that stroke callers should be categorised as 'Red' and not 'Amber', if they are to meet the therapeutic timescales for treatment. This is to help ensure a better patient outcome. One comment included:

'From a WAST perspective, strokes are categorised as an Amber 2, when they should be a red, as the quicker we can attend and recognise, the sooner we can get them to hospital'.

In HIWs previous review of WAST[48], the findings recommended that work was required to consider stroke patients as an emergency who need a 'Red' response. This is due to the time critical nature for treatment. WAST, as a commissioned service cannot make this decision to change alone; it is dependent on guidance from NHS Wales, commissioners, and Welsh Government. Discussions and votes at Senedd Cymru on 26 October 2022[49],[50] , confirmed that stroke patients will remain within the 'Amber' category.

When a patient is waiting for an ambulance, there is a process in place to monitor a patient's clinical status if necessary. If a call handler has concerns for a patient's well-being, they would 'flag' the call on the MPDS to notify the WAST clinical team that a telephone review is required. Whilst this process is in place, it was concerning to find that over the Christmas period in 2022, there were occasions when over 200 callers awaiting a WAST vehicle response, who needed clinical team's intervention.

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[47] StatsWales is the Welsh Government's free-to-use online repository for detailed statistical data for Wales.
[48] Local Review of the Patient Management Arrangements within the Welsh Ambulance Service Trust
[49] Y Senedd - Votes and Proceedings Plenary - 26 October 2022
[50] Y Senedd TV - Plenary 26 October 2022

Come to see me

The ability of WAST to send a response to a caller is dependent on the resources available at the time. This is often impacted by the number of ambulances waiting outside EDs to handover their patients. We found this was a consistent issue across Wales because of poor flow within hospital sites. WAST call handlers or the clinical team are usually aware of prolonged waits for an ambulance to attend callers in the community. Therefore, guidance with a script is available which staff use to recommend the caller makes their own way to hospital, if it is safe to do so, as opposed to losing time whilst waiting for an ambulance to arrive.

Give me treatment

When WAST staff attend a patient suffering with a stroke, they will undertake a further assessment at the scene, which follows the *Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines*[51]. The guidelines identify stroke as a 'time critical' medical emergency and references the time dependency for thrombolysis (clot dissolving treatment). The guidance also states that patients must be transferred to an appropriate hospital as quickly as possible, to commence treatment once the stroke diagnosis is suspected.

Take me to hospital

There are arrangements in place for ambulance crews across Wales to provide pre-alert calls to ED. WAST has guidance in place for clinicians to follow when a stroke has been confirmed during assessment. We were informed that it is the decision of the clinician at the scene of the incident to determine which is the most appropriate hospital to transport a patient, according to their condition (including stroke). On occasion, this may be a hospital across the border, such as for patients living within Powys.

We considered how patients in rural areas would access timely treatment for stroke. We were told that there are challenges with this, and during our fieldwork, we found that work was ongoing in some areas of North Wales and Powys to try to improve transfer arrangements. WAST has been working with healthcare services across the border in England to ensure that arrangements are in place to review and treat stroke patients promptly when required.

Within our staff survey, it was positive to find a good response from WAST staff who felt well equipped to undertake their role with managing a stroke patient.

Almost 85% of staff told us in the survey they had received training to support and manage stroke patients, however, only 77% of respondents said they understood the WAST stroke pathway. In addition, we found that only 49% of WAST respondents said they always allocate or take a stroke patient to a specialist stroke unit.

We recognise the challenges faced by WAST in its ability to deliver a timely response to life-threatening emergencies. This is due to increased pressures on the

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[51] JRCALC Clinical Practice Guidelines - aace.org.uk

healthcare system overall, with prolonged ambulance handover delays to EDs all over Wales. It is, however, a concern that patients in the community have prolonged waits for ambulance resource, which places them at increased risk of deterioration and harm. This was also found in our two previous WAST reviews.

The impact of this is significant for stroke patients, due to the time critical nature of the investigations and treatment which are required to manage a stroke patient. Any delays to treatment will likely have life-long consequences for people.

We were told of a pilot project which is due to take place within one health board to evaluate a Pre-hospital Video Triage (PVT), which has been successful in several Trusts in England. A structured pre-hospital assessment will take place with WAST and the health board's stroke team while the patient is at home. If it is assessed that the patient is likely to have had a stroke, they will be immediately transferred to hospital and taken directly for a CT scan on arrival, bypassing the ED. In addition, when there is a pre-alert call from WAST to the ED, patients will be pre-registered within the department, which will reduce delays to thrombolysis and thrombectomy. This pilot is due to commence in August 2023.

Recommendation 13:

WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.

WAST initiatives to manage patients in the community instead of hospital

During our WAST interviews, we found that the Trust is exploring a new process with the aim of reducing the number of ambulances being sent to patients by 50%. This, however, will require increased establishments of staff within the clinical desk, advanced paramedic practitioner teams, ambulance paramedics, nurses, midwives, and mental health practitioners.

The response to calls via the clinical desks will be a Multidisciplinary Team (MDT) approach, which will determine how best to respond to patients instead of inappropriately sending an ambulance. The proposed timescales to fully implement this model is three years which will need additional Welsh Government funding.

However, we were informed that funding had not yet been approved for this.

Evidence has been collated which reflects the benefits of having people treated at home via advanced paramedic practitioners.

We were provided with data which outlines the number of patients who have been managed at home or referred to other services, as well as those who are taken to hospital. It reflects that on the occasions where advanced paramedic practitioners have been sent to see patients, as opposed to ambulance paramedics, in the region of 65-70% have been treated at home without the need to go to hospital. Advanced Paramedic Practitioners can administer a greater range of medication than an ambulance paramedic, which means that more patients can be treated at home, and can be referred to ongoing services, such as their GP practice, physiotherapy

services, or healthcare clinics, such as for TIA where appropriate.

We were told that the service will need to develop and implement different types of resource to operate, such as an increased number of Advanced Paramedic Practitioners. To implement this type of service, staff need to be supported to develop their skills and knowledge, to enable them to work in these roles.

Early implementation of the new WAST model should have a positive impact on the pressures on our hospital system across Wales by reducing the number of patients being transported to EDs by ambulance. A reduction in the first bottleneck of patient flow at 'the front door' of Welsh hospitals, could lead to a reduction in pressure across the whole hospital system and an improvement in patient flow.

Recommendation 14:

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.

Patient transfer to hospital

We explored the ways in which a patient can arrive at the ED seeking treatment, and this is highlighted below.

Patient arrival at ED

Patients can arrive at EDs in several ways, such as by ambulance, by GP or clinicians through the 111 service, or by referral from other healthcare practitioners, such as district nurses, or by people self-presenting. In our interviews with ED staff across Wales, we were told that people frequently attend ED who do not require emergency care.

There are many occasions where ED staff could redirect patients to alternative care pathways following initial clinical assessment, which would lessen the burden on ED, but also reduce waiting times at ED. The examples provided to us highlighted that people are often turned away from ED to use the services of their MIU, GP, community services, dentistry, and paediatric assessment units. However, some staff said that at times, there is a reluctance by ED staff to re-direct patients elsewhere and away from EDs, as they are risk averse and are not always confident to do so.

Stroke pre-alert calls

The stroke pre-alert call is used to notify ED staff of inbound patients that require immediate attention and is a key component in the stroke care pathway. The call enables the receiving hospital to have the specialist staff available upon the patient's arrival and aims to improve the timeliness of the treatment a patient receives.

We were informed by WAST that they have developed, in partnership with the

relevant stroke units across Wales, a standardised pathway to enable the conveyance of a patient to the appropriate hospital first time. The WAST clinician, upon suspecting a diagnosis of stroke, will pre-alert the ED of a hospital with a stroke unit capable of undertaking a scan, and when appropriate undertake thrombolysis treatment.

WAST staff told us that despite the effectiveness of the pre-alert call, issues can arise when hospital services are under extreme pressures due to poor patient flow. This can result in patients being assessed on the ambulance, then receiving their initial investigations and brain scan, and then returned to the ambulance due to pressures on ED services. This was supported by results from our WAST staff survey, which confirmed that a stroke patient is normally pre-alerted to the hospital, but often EDs are full and are unable to accept patients into the department.

During our onsite fieldwork, we found that some patients who were pre alerted or not, still showed signs of being FAST positive on arrival to ED. Some ambulance crew had documented on arrival at ED, that these patients were then a query Transient ischaemic attack (TIA)[52] as opposed to stroke, however, not all symptoms had resolved.

To support the stroke assessment process, NICE guidance for stroke, states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER (Recognition of Stroke in the Emergency Room). The aim of the ROSIER assessment tool is to enable medical and nursing staff to differentiate patients with stroke and stroke mimics, such as TIA.

Since the use of ROSIER is a recommended tool within NICE guidelines to differentiate Stroke from TIAs, it may be beneficial for WAST to train its paramedic staff in the use of the ROSIER assessment tool, alongside the FAST assessment.

The ROSIER assessment tool is discussed later in the report.

Recommendation 15:

WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.

It is positive to note that 94% of ED staff who responded to our survey said they were informed by a pre-alert call from ambulance services if it was a FAST positive patient. This was also supported by our interviews with ED and stroke services staff across Wales.

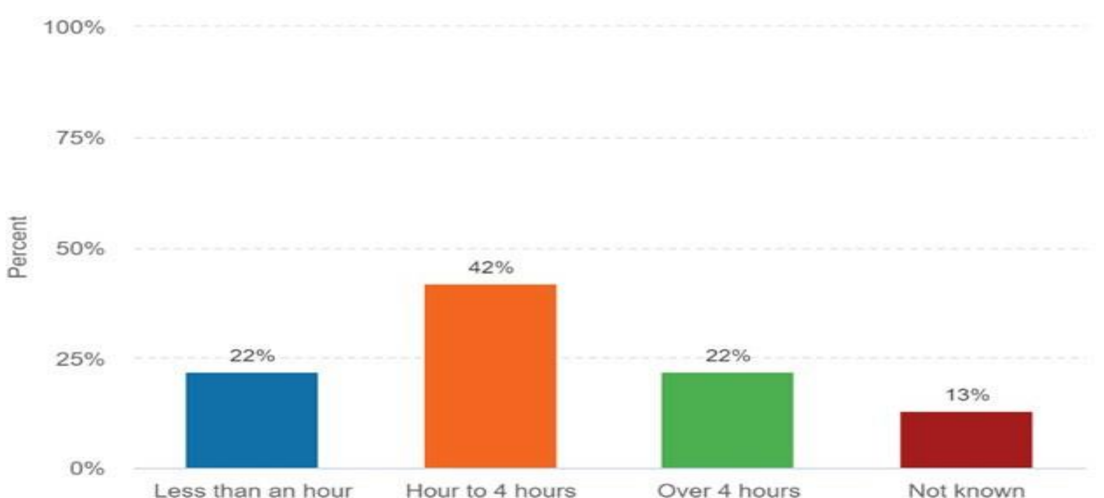
As highlighted above, we established that stroke patients arrive at EDs in different

[52] A TIA is a warning sign that you're at increased risk of having a full stroke in the near future. See: Transient ischaemic attack (TIA) - Treatment - NHS (www.nhs.uk)

ways, such as by ambulance, GP referral, or patients who self-present at EDs.

Therefore, there is a risk to some patients of missing their therapeutic window for thrombolysis treatment if there are delays in transfer or receiving timely assessments.

We asked people in our survey how long before arriving at hospital did their stroke symptoms start. The chart below highlights the times reported to us:



The above chart reflects that 64% of patients arrived at hospital within the time critical thrombolysis window.

People self-presenting at hospital

We were told by some patients and staff that due to the timely availability of an ambulance, some people self-present to ED. We were told that this can present risks to a patient if they did not clearly raise their stroke symptoms to the receptionist on arrival to ED, which consequently may impact on their triage and assessment time.

In addition, if a patient self-presents at a hospital that does not treat stroke patients, such as a MIU instead of ED, this may also present a risk for timely treatment.

This is because they may need to be transferred to a hospital that can appropriately scan and treat patients with a stroke. This in turn, may delay the time they have in the therapeutic treatment window of four and a half hours.

We considered the training provided to reception staff to help identify red flag

Recommendation 16:

Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation processes are in place if a receptionist is or is not sure a patient may be suffering with a stroke.

symptoms[53] of stroke, and to prioritise and escalate triage for patients if symptoms are present. We found that in general, most (but not all) reception staff had received training for this. Despite being non-clinical, they still have a vital role to play in the potential identification of stroke patients.

Impact of delayed ambulance handovers for stroke patients

We considered whether ambulance handover delays were having a negative impact on patients along the stroke pathway. In our staff survey, most ED staff said they were familiar with the hospital's handover policy to stroke services, and that the policy was easy to follow and was achievable. Whilst this finding is positive, delays in the ability of ambulance crews to hand over patients to ED staff are frequent and common.

Throughout our onsite fieldwork, we saw ambulances waiting outside EDs across Wales, waiting to handover and offload patients to the departments. Despite this, it was positive to find that patients suspected of having a stroke (and others with life threatening conditions), were prioritised and transferred into the ED promptly in line with the stroke pathway.

Timely assessment and treatment in ED for stroke patients

We observed stroke patients being assessed, investigations were undertaken, and treatment was commenced in a timely manner. We saw staff consider the risks and appropriately mobilise other lower acuity patients throughout the department, to accommodate those confirmed as stroke positive. This was to ensure timely assessment and treatment promptly.

Through our discussions with ED staff, we were told that in the event of no trolley space being available in ED to offload a stroke patient, assessment would take place onboard the ambulance if the appropriate ED staff suspected stroke.

We were told that whilst stroke patients would always be prioritised for transfer into the departments, there are occasions when this was not possible. In such instances, staff explained that investigations, such as blood tests and a CT scan would still be undertaken, although the patient may return to the ambulance until a decision on commencing treatment is made. This was to help maintain a timely response to the patient's needs. In response to our staff survey, one person said:

'At some hospitals there may be delays with handover, but assessment, and interventions are completed despite trolley or bed availability.'

In contrast to this, it was concerning to find that most respondents to our WAST survey said that ambulance offload delays are negatively impacting stroke patients. Several comments were received which included concerns with delayed

[53] Red flag symptoms of stroke may include complete paralysis of 1 side of the body, sudden loss or blurring of vision, being or feeling sick, dizziness, confusion, difficulty understanding what others are saying, problems with balance and co-ordination, difficulty swallowing (dysphagia), a sudden and very severe headache resulting in a blinding pain unlike anything experienced before, loss of consciousness.

response to those waiting in the community, timely offloading of patients to ED, and delayed patient assessment due to the bottlenecks within ED. One comment included:

'There doesn't appear to be any urgency when we pre alert a still FAST+ patient into ED. Or we are asked to take patient back onto vehicle. Not really appropriate when symptoms of a stroke have a good chance of being reversed if treatment is given promptly'.

The findings in our clinical records review were overall positive. Most FAST positive patients were taken into ED within the 15-minute Welsh Government handover target time. However, we did find instances of delays in handover and no investigations had been instigated by ED staff. This is a concern, particularly when stroke treatment is time critical, and delays may have life-long consequences.

Recommendation 17:

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.

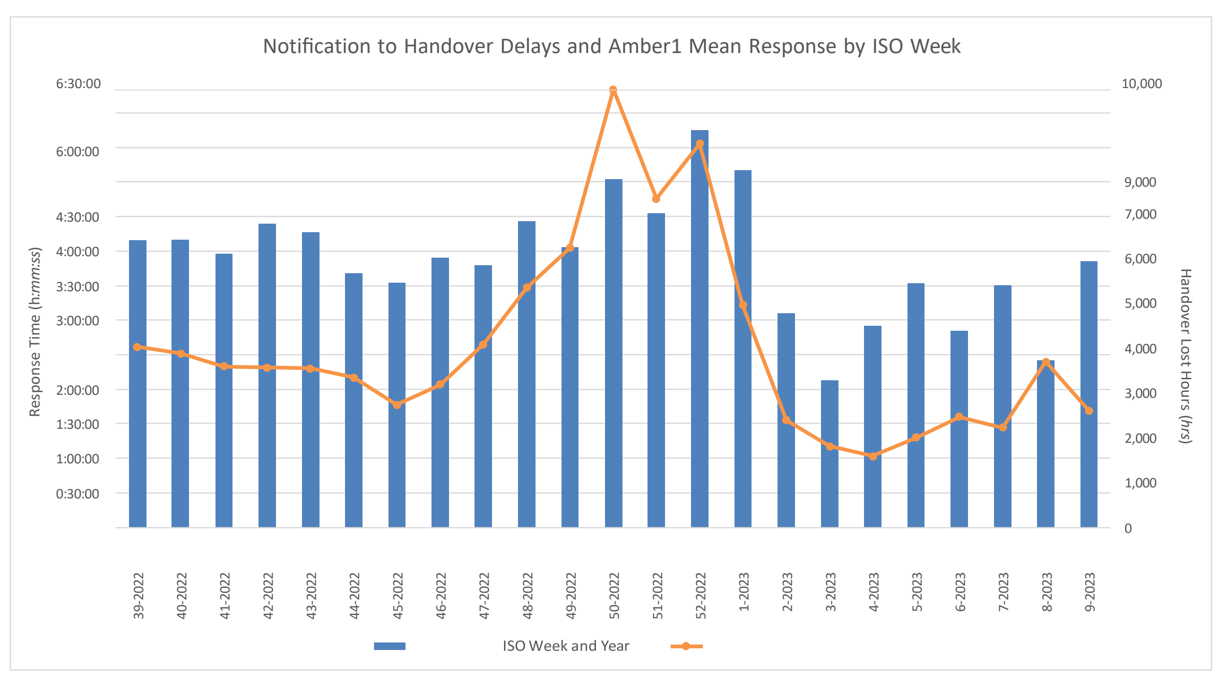
During our staff interviews, we were consistently told about the unprecedented increase in emergency care demand, impacting further on the ability to offload and handover patients from ambulances. Handover delays have been a challenge for WAST for a prolonged period, because of poor flow in hospitals. This has led to the service to re-evaluate its service delivery model, to help improve services, as highlighted earlier in the report, relating to the use of advanced paramedics in the community.

In our report, *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover,* it is highlighted that in December 2020, 11,542 hours of ambulance crew resource was lost due to delays experienced with hospital handover.

We also found the data for this in September 2022 was significantly worse, with around 25,166 lost hours due to handover delays.

This increase is concerning and is attributed to poor patient flow. The flow is impacted further by the ability of hospitals to discharge patients in a timely manner, because of the delays with social worker allocation, availability of social care packages or placements available in care homes.

Data provided by WAST in the chart below, highlights a clear correlation between lost hours due to handover delays, and the Amber 1 response times over a six-month period.



The chart reflects that in week 52 of 2022, 8,835 hours were lost due to handover delays, and the mean time of an Amber 1 category call response (which includes most stroke calls), for that week was 5.33 hours. Given the time critical nature of potential treatment for stroke patients, the delays in the ability of WAST resources to attend patients in the community is of particular concern.

We are aware of the ongoing work nationally to improve handover delays; however, despite this, our review has found that the challenges remain. To address these issues, is not something WAST or a health board can do alone, and collaborative work is required between Welsh Government and key stakeholders in health and social care systems, to analyse the issues in order to make improvements.

Recommendation 18:

Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving

Impact of flow on stroke assessment and admission to hospital

Stroke pathways

We considered whether health boards had a clear process in place for managing patients in ED with a stroke in line with NICE guidance. Overall, we found there are clear stroke pathways in place across Wales which focus on timely assessment, investigation, and ongoing treatment. All health boards follow a similar but not

identical pathway when stroke patients are admitted through ED. In general, the pathways include assessment, diagnosis, and treatment for thrombotic or haemorrhagic stroke, and for those where treatment is not a viable option, due to the extent of their stroke.

Timely assessment on arrival at hospital

We highlighted earlier that the incidences of people self-presenting at EDs with a suspected stroke is increasing. This is due to delays with the availability of ambulance resources in the community. This can prove challenging, since EDs are not pre-alerted to the arrival people self-presenting, which may present a risk in the timely assessment or diagnosis of stroke for some people.

During our onsite fieldwork, we found the challenges with the demand on ED, impacted by poor hospital flow, meant that some patients waited longer than expected for triage and ongoing assessment or treatment. Whilst this may not have impacted on FAST positive stroke patients, such delays may pose a risk to self-presenting patients who do not display easily identifiable stroke symptoms.

Stroke team assessment

When FAST positive patients are pre-alerted and arrive at hospital (and within the thrombolysis or thrombectomy treatment window), the relevant stroke team is alerted by an emergency stroke bleep of the imminent arrival of a patient. We found that all acute sites who provide stroke services have the stroke bleep system in place.

We considered the effectiveness of the relevant team response to the emergency stroke bleep. Our staff interviews found that the response to the bleep varied across Wales, according to the time and day, and who is on-call to respond.

Through the health board self-assessment responses and our interviews with staff, we found that when there is a Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP) for stroke available in acute sites across Wales, and their response is generally rapid. They will also facilitate prompt investigations and diagnosis, and the required treatment and plans for patients within the stroke pathway.

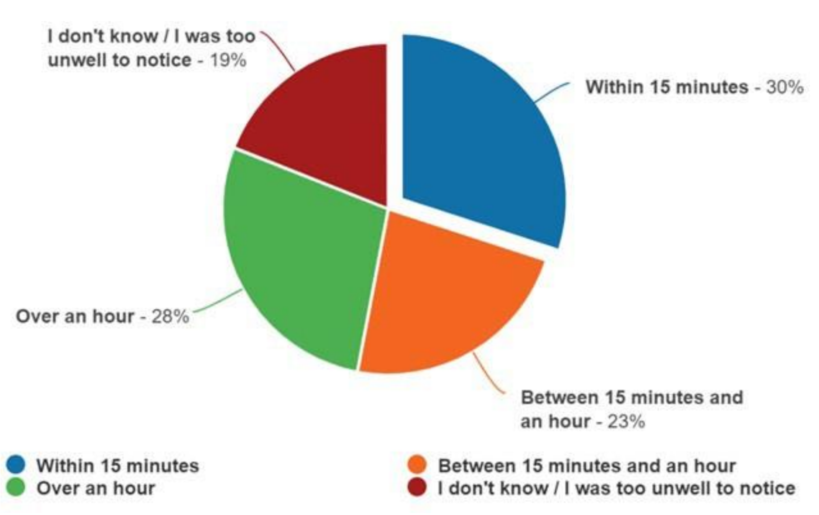
We found that during out of hours periods (such as nights or weekends), or in the absence of a Stroke CNS, ED staff and medical teams are alerted by the stroke bleep and arrange investigations and treatment for stroke patients. The medical team responders would also have access to an on-call stroke consultant.

We considered the process for those who self-present at hospital, and we found that the process was the same.

Through our clinical records review, we found positive responses from a designated on-site stroke team for attending ED. However, the timeliness of the bleep response was not always adequate. Some clinical records highlighted that triage and assessments were not always conducted in a timely manner, which may negatively impact on the ability to promptly assess and treat patients. Whilst we could not always identify the reason for this inconsistency, often the medical

teams were dealing with other in-hospital medical urgencies and emergencies on the wards.

We asked patients in our public survey how soon they were reviewed by a nurse or doctor following arrival at hospital. It was disappointing to find that over half the patients were not seen within 15 minutes, and 28% of those waited over one hour for assessment. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode. Our survey findings are highlighted in the chart below:



Within our staff survey, we also found that just 28% of ED staff felt patients were assessed within 15 minutes, 60% said sometimes, and 12% said patients are not assessed in a timely manner. This again is a concern due to the time critical window for stroke patients receiving treatment.

Recommendation 19:

Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.

Recommendation 20:

Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a tertiary referral centre is relatively close to the ED.

The CNS and ANP for stroke care

It is evident that prompt stroke care is essential for better patient outcomes, and the role of the CNS and ANP is beneficial in facilitating prompt progress through the stroke pathway.

We explored the CNS and ANP role further and found that it not only includes rapid assessment of patients for possible thrombolysis, but CNSs and ANPs also coordinate post-thrombolysis monitoring and acute stroke care. Their role was found to be significant in liaising between ED staff and acute stroke wards to facilitate prompt flow of stroke patients to an appropriate bed on a stroke ward, in line with national targets.

During our interviews, ED staff highlighted the benefits of the Stroke CNS and ANP to attend patients in ED. Staff reported that their presence assisted greatly in providing a prompt expert clinical opinion, and with ensuring stroke patients moved efficiently through the stroke pathway to the acute stroke ward. This also took pressure off the ED nurses and allowed them to focus on other patients requiring urgent clinical attention.

Across Wales, we interviewed staff within EDs and stroke services, and found consistently, that a key barrier to effective and timely stroke care, is the absence of a CNS or ANP for stroke service 24/7. Whilst medical teams have the appropriate knowledge and skills to manage stroke patients, there are occasions when their attendance at ED is delayed whilst they deal with other emergencies across the hospital. Such instances may negatively impact on stroke patients and their ability to be reviewed and treated in a timely manner.

Our interviews found that all hospitals aspire to have a 24/7 CNS for stroke services. However, we found inconsistencies across Wales in the provision of the CNS/ ANP service. The absence of a CNS/ ANP out of hours, such as nights and weekends, may impact negatively on patients due to the commitment of medical teams dealing with issues elsewhere across the hospital.

We found that issues with funding for the posts, or challenges in the recruitment for these key roles did not always enable a 24/7 service. Through our communication with the National Allied Health Professionals Lead for Stroke in Wales, it was highlighted that CNS or ANP for Stroke should be resourced to cover as much of the peak periods of stroke presentations to EDs as is possible, particularly during thrombectomy referral and the service availability time periods. It is therefore important that health boards regularly audit their stroke presentation and demand times on the service.

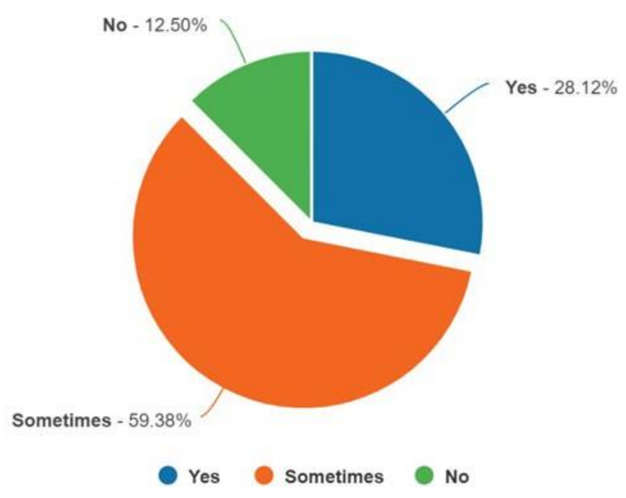
In the absence of a CNS/ ANP, we considered whether stroke patients were reviewed promptly by other stroke team members or medical teams. In our clinical records review, we found that most stroke patients arriving at EDs by ambulance were prioritised appropriately. We also saw evidence of patients who had self-presented at EDs receiving timely and appropriate assessments and investigations. However, we found that patients were not always assessed as promptly and did not

progress through the stroke pathway as effectively, in the absence of a Stroke CNS.

Recommendation 21:

Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.

In our survey, we asked staff whether they could assess stroke patients in a timely manner. Their response is highlighted in the chart below:



It is concerning that only 28% said they were able to assess people in a timely manner, and whilst 12.5% said no, the majority (60%) said they sometimes could.

The reasons highlighted to us as barriers to achieving a timely assessment include:

- Staffing issues or staff capacity
- High volume of patients to assess
- Lack of space or trolley bays in ED
- Increase of patients self-presenting at hospital

In response to our staff survey, we received the following comment which highlights the risk with people self-presenting with a stroke:

'Accident and Emergency unit staff need to be trained to pinpoint stroke pathway. Sometimes when patients have been admitted to hospital, they are not able to access the stroke pathway as efficiently as a patient attending the hospital in an Ambulance, this issue needs to be addressed. If all staff received training, it would benefit patients.'

Recommendation 22:

Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.

Stroke assessment tools

As highlighted earlier, to support the stroke assessment process, NICE guidance for stroke states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER. This will ensure the prompt diagnosis prior to scan of a potential stroke or TIA.

A key example of the benefits for using the ROSIER tool is; if the stroke call is put out by ED staff to alert the medical team of an imminent arrival, and a triage and ROSIER assessment is undertaken by the ED staff promptly, then a CT scan can be booked by the medical team and the patient can be taken directly to the scanner. This is to help ensure no time is lost in diagnosis, particularly when the ED is full, and ambulances are waiting outside to offload patients. Patients could then be moved directly into a space in ED to receive treatment, or placed back on board the ambulance if thrombolysis or thrombectomy is not indicated, to await the next available space in ED, if admission is needed.

The example above further questions if there is a need for WAST paramedics to be trained in ROSIER assessment as highlighted earlier in the report. This assessment could be undertaken at the scene in the community when a patient is displaying stroke symptoms, which may help with the timeliness of assessment, imaging, diagnosis, and treatment at the receiving hospital.

We found that stroke assessments and interventions were being undertaken by clinicians with appropriate expertise in neurological disability, and nursing and medical staff had the appropriate knowledge, skills, and experience to recognise and manage stroke patients. However, we considered whether an assessment tool, such as ROSIER tool was being used in EDs in all health boards.

Whilst the ROSIER tool was in use across Wales, during our fieldwork, this was not always consistent. Our clinical records review and our staff interviews found inconsistencies in the tools used across Wales. Overall, we found good examples of assessment and the use of appropriate tools, however, in some records we did not find evidence that a tool had been used to support diagnosis or treatment plan.

Recommendation 23:

Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.

Recommendation 24:

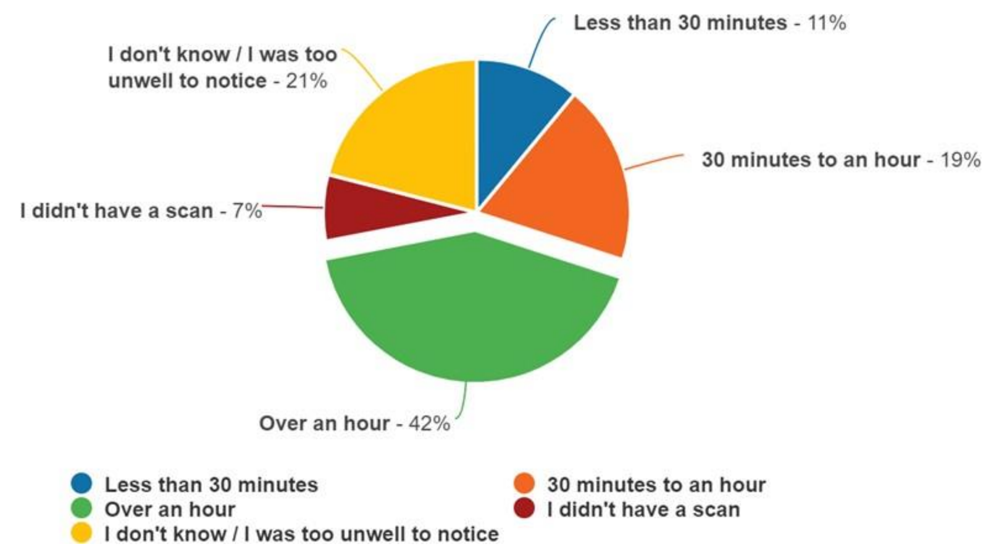
Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.

Timely imaging

We considered whether patient flow issues through departments impact on timely brain scans. The NICE guidelines for stroke state that specific categories of suspected stroke need to receive a CT scan immediately. That is defined in the guidelines as, ideally the next slot and definitely within 1 hour of arrival at hospital, whichever is sooner. The CT scan will diagnose whether the stroke is due to a clot or a bleed on in the brain and will help determine the required treatment promptly.

In our public survey, we asked peoplehow long they waited before receiving a brain scan after they arrived at hospital. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode.

Our survey findings are highlighted in the chart below:



On analysis of the survey results, it is concerning to find that 42% of patients felt that they waited over an hour for a scan after they arrived at hospital, which is beyond the recommendations within NICE guidance.

We explored this further through our interviews with staff. We found that staff

endeavour to achieve a brain scan for a patient within an hour. We found good working relationships existed between ED and stroke or medical staff and the radiology teams, which supported timely imaging for stroke diagnosis. We also found that scans are reviewed and reported on promptly by relevant radiology staff. In some health board areas, an after-hours radiology service[54] is utilised to provide interpretations of scans and ensure specialist expertise and round-the-clock support. This means that scans are sent electronically to a radiologist to obtain a rapid report of the scan.

We found a positive initiative within one acute site, where the stroke pathway facilitates symptomatic FAST positive patients (identified by ambulance paramedics), by-passing the ED, and being transported directly to the CT scanning department. This is to help mitigate against any delays with handover at ED and enables prompt diagnosis and subsequent treatment as appropriate.

We were told that the advance imaging can be supported by Artificial Intelligence (AI) for stroke imaging. The all-Wales procurement of AI stroke imaging was completed in Dec 21, and it is now in the implementation phase. This will have a positive impact on the prompt identification of patients for thrombectomy and thrombolysis through stroke imaging. Therefore, patients can access the treatment they need in a timely manner.

Recommendation 25:

All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.

As highlighted earlier, to support the diagnosis of stroke, consideration should be given to WAST paramedics training in the use of the ROSIER assessment tool for stroke patients. Health boards across Wales in conjunction with WAST, may wish to explore the benefits of direct admission by paramedic to CT scan for FAST positive stroke patients where appropriate.

Through our clinical records review, it was concerning to find that some patients were not consistently receiving a CT scan within the one-hour target. Whilst reasonable explanations were documented in the records for some patients, such as patients not presenting with typical stroke symptoms, other records provided no explanation for the delay.

We also considered SSNAP data of patients scanned within one hour of arrival at hospital. The data reviewed considered the period of April to June 2019, 2021 and 2022. Of the 12 acute sites who now deliver stroke services within Wales, the performance of nine sites dropped between 2019 and 2022 signifying that an increased number of patients waited more than one hour for a brain scan. As highlighted earlier in the report, consideration to the timing of the pandemic must be given when reviewing this data.

[54] Everlight Radiology provide immediate access to radiologists 24/7 and are often replied upon for out of hours service.

Recommendation 26:

Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.

Swallow assessment

In line with NICE guidelines, patients with acute stroke should have their swallow screened by an appropriately trained healthcare professional, such as a speech and language therapist or other competently trained healthcare professional on admission or within four hours. If the screen shows signs of difficulty, the swallow should be assessed within 24-72 hours and before the person is given any oral food, fluid, or medication. We considered whether patients received a swallow screen and/or assessment within the timeframe, particularly in the event of a delay in them being transferred from ED to the stroke ward.

During our interviews with ED staff, we were told that rosters aim to ensure there are sufficient staff on duty to complete timely swallow screen and/or assessments within ED, however, this was not always possible due to high turnover of staff at some acute sites, and a high number of bank or agency staff on duty.

Staff in one health board told us that training had recently been completed for ED staff, to help further identify stroke patients and the importance of swallow assessments, which is in line with within the NICE guidance. They told us that this positive action had benefitted patients with timely assessments and demonstrated improvements in their SSNAP data.

Through our clinical records review, it was positive to find that in general, most patients had received a swallow assessment within the four-hour target as recommended by NICE. This included patients who remained in ED awaiting an inpatient bed, and for those who had been transferred to an acute stroke ward.

Impact of flow on prompt stroke treatment

Thrombolysis

People who are diagnosed with an ischaemic stroke and who are eligible for thrombolysis, should usually receive treatment within 4.5 hours of the known onset time of stroke symptoms. However, within the new *National Clinical Guideline for Stroke*, this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion[55]. Therefore, in line with national guidance, treatment can be started between 4.5 and nine hours of known onset of symptoms, or within nine hours of the midpoint of sleep, when they have woken with symptoms[56].

We considered whether issues with flow prevented patients receiving thrombolysis

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[55] Perfusion CT is an X ray examination that looks at blood flow and the amount of blood within the brain.
[56] National Clinical Guideline for Stroke for the United Kingdom and Ireland

treatment in a timely manner. Our clinical records review found that decision for thrombolysis was done on an individual patient basis, and is influenced by factors, such as pre-existing conditions and the timing of the onset of symptoms. We found the rationale for decisions were recorded in all relevant notes we reviewed, and treatment commenced in an appropriate time.

We found in some records that thrombolysis was not clinically appropriate, and the rationale for this was documented appropriately. However, it was concerning to find that some reasons for this included a delay in obtaining a CT scan, and delays in patients seeking medical assistance following onset of symptoms. Evidence in one of the records reviewed reflected that one patient who lived in a rural area had been significantly disadvantaged due to their travel time to hospital, which resulted in them missing the four-hour thrombolysis window.

We also considered which staff were trained in thrombolysis administration outside of the stroke or medical teams. Across Wales several appropriately trained ED nurses can administer thrombolysis where required, this therefore meant delays for thrombolysis treatment was minimised.

When staff were asked whether they felt they have had appropriate training to undertake their role, the majority (72%), agreed they had. For those who disagreed, the following reasons were provided:

'I have had no additional stroke training since starting my role, I have learnt on the job.'

'I have been given the opportunity to take part in training however, due to operational pressures I often do the work in my own time.'

'This is very much caseload dependent and staffing dependent. We have significant staffing issues currently therefore our priorities are mainly clinical.'

When reviewing SSNAP data, we found inconsistencies across Wales in the timeliness of thrombolysis treatment. This is not conducive to equitable treatment to people across Wales.

Recommendation 27:

Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.

Recommendation 28:

Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.

Recommendation 29:

Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.

Thrombectomy

An alternative procedure to thrombolysis therapy is surgery to remove a blood clot, which is known as a thrombectomy. In the Stroke Association's publication, *What we think about: Thrombectomy*[57], it highlights evidence demonstrating that thrombectomy treatment can significantly reduce the severity of disability a stroke can cause, therefore can result in better patient outcomes.

When clinically appropriate, the NICE guidance states that a thrombectomy should be offered for people with acute ischaemic stroke as soon as possible, and within six hours of symptom onset.

We considered the provision of thrombectomy treatment across Wales. Only Cardiff and Vale University Health Board provides a thrombectomy service.

The service is available Monday to Friday from 09:00am to 5:00pm, and only when expert interventional neuroradiology staff, and the appropriate radiology facilities are available. The service is provided mainly to people who live within the health board boundary. All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust where the service is available to patients in Wales daily 8am-midnight, or to the Walton Centre NHS Foundation Trust which offers a 24/7 thrombectomy service. Given the geographical challenges and the impact of ambulance delays across Wales due to handover delays, this impacts negatively on the ability of some people receiving thrombectomy in a timely manner, particularly when thrombolysis may not be clinically appropriate for them.

According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[58].

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[57] https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_thrombectomy.pdf
[58] Annual thrombectomy April 2020 to March 2021

It is concerning to find that in Wales, just 13 patients received a thrombectomy at the University Hospital of Wales (for those living in the locality), just 16 patients received treatment in North Bristol and only four patients at the Walton Centre.

This does not appear to be conducive to equitable access to thrombectomy treatment across Wales, and those living within the Cardiff and Vale locality are at an advantage of receiving this type of treatment for stroke to those living in other health boards across Wales.

Our clinical records review found that where appropriate, stroke teams considered thrombectomy treatment for patients, although just one patient was deemed appropriate for the procedure. Whilst it was noted clearly in some records that the patients were not considered suitable for thrombectomy treatment, in several other records there was no evidence to suggest this had even been considered when it is part of the decision-making process for treatment.

Our interviews with stroke clinicians found that there was often consideration of patients who are suitable for thrombectomy, and where referrals have been accepted, there were often challenges with timely ambulance transfers to meet the treatment window target time. This was particularly challenging for cross border transfers, despite inter-hospital transfers for thrombectomy categorised as a 'Red' response by WAST. This may be due to the geographical location of a person, or the availability of an ambulance to transfer the patient in a timely manner.

We recognise that one of the aims within the quality statement for stroke services in Wales as highlighted earlier, is to improve opportunities for patients in Wales to receive thrombectomy treatment and to develop Comprehensive Stroke Centres within a network delivering thrombectomy locally. This is a significant challenge in Wales due to resources across the country and the number of suitably trained people to undertake the procedure. Work to consider this is currently ongoing nationally.

Recommendation 30:

Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.

Recommendation 31:

Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.

Recommendation 32:

WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.

Patient flow to acute stroke wards

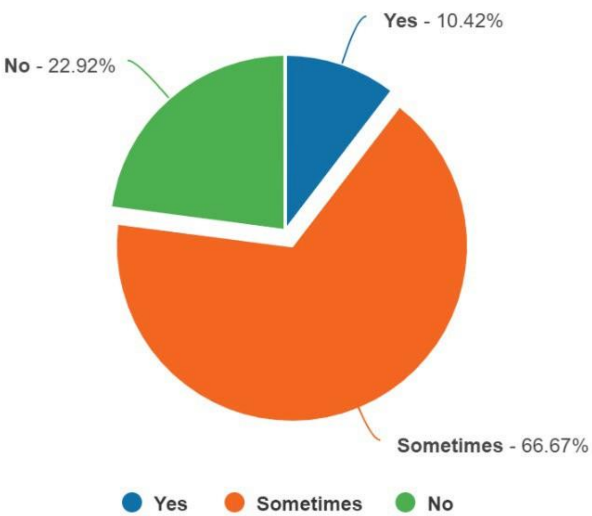
During our review, we considered whether people are admitted to an acute stroke ward in a timely manner. NICE Guidance (NG 128)[59] states that hospitals should admit everyone with suspected stroke directly to a specialist acute stroke unit after initial assessment, from either the community, the ED, or outpatient clinics. Acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs due to the range of specialist treatments they provide. They are staffed by a specialist stroke multidisciplinary team and should have access to equipment for monitoring and rehabilitating stroke patients.

Acute specialist stroke units are associated with improved patient outcomes. Admission targets to these units should be within four hours of arrival at ED, so specialist treatment can begin as quickly as possible, in line with NICE guidance (NG 128). We found in all stroke pathways across Wales, that admission to a specialist stroke ward/unit, must be within four hours of arrival at ED.

We considered whether issues with poor hospital flow, impacted on the timely admission of people to acute stroke unit in line with NICE guidance. It is concerning to find that just 10% of those who responded to our staff survey said it was possible to transfer patients to a stroke ward when needed, and 23% said no.

This is highlighted in the chart below:

[59] NICE guideline [NG128] Published: 01 May 2019 Last updated: 13 April 2022



This finding was consistent with responses in our staff interviews across Wales, who suggested that poor patient flow within their hospitals prevent patients being transferred to an acute stroke ward in a timely manner.

Our interviews with ED and stroke service staff found, that every effort is made to transfer patients to the acute stroke ward within the four-hour timeframe.

However, they are consistently faced with several challenges in achieving this, which were attributed to patient flow issues.

During our fieldwork, every acute stroke ward across Wales was at full capacity. This resulted in stroke patients either remaining in ED to receive treatment and post treatment care, until a bed became available, or they were being placed as an outlier in another ward.

In our public survey, people told us of delays in their transfer to an acute stroke ward. Comments included:

‘Day and a half in A&E before being admitted to ward.’

‘Admission to stroke ward not possible, still waiting 13 days after admission when writing this’.

We attended patient flow meetings across Wales and witnessed discussions on how teams tried to accommodate stroke patients on the acute stroke ward. However, due to the system wide flow issues, this was not always possible. We also found in some wards that staff were proactively attempting to receive stroke patients from ED at the earliest opportunity when they had a bed available.

We explored the reason for delays entering the acute stroke ward. Several reasons were provided to us in the staff survey.

These included a lack of bed availability with delayed discharges due to social care issues and outliers of other specialties placed in stroke beds, due to flow issues

elsewhere in the hospital. We were also informed that stroke patients who required transfer to a stroke rehabilitation ward cannot be transferred due to capacity there.

Some comments in our survey from staff included:

‘Often due to poor discharge flow from patients awaiting care packages and placements beds are not always readily available when a stroke patient has been identified for the pathway.’

‘Bed availability on acute and rehab ward becoming an increasing problem due to the inability to step down patients from the ward and into the community. Bed availability is also taken up on stroke units by non-stroke (medical) patients/admissions.’

‘Unfortunately, stroke patients are not always prioritised according to the stroke pathway, and when beds are available the decision on who fills stroke beds is not made by the stroke team.’

In our staff survey, we also asked people to comment on how the NHS could improve the service it provides to stroke patients, one respondent commented:

‘Immediate availability of access to stroke ward and the specialist patient care this would provide.’

When beds were not available on the acute stroke wards, we considered whether patients were managed safely and effectively in ED. In our clinical records review, we did not find any evidence to suggest delays in transfer to a stroke ward negatively impacted on the safe and effective care to patients.

Ring-fenced stroke beds

We found that each acute site we visited had a policy to ‘ring-fence[60]’ stroke beds. Whilst policies are in place to ring-fence beds, this is frequently breached due to the high escalation status of the hospital site and due to overall lack of bed availability in other areas.

Staff within stroke services told us they always aim to ring-fence a stroke bed, but it is frequently not possible due to patient flow issues within the whole system, and they are made to use the bed for a different specialty patient. This frequently results in medical outliers (non-stroke patients), being placed in the ringfenced stroke bed, and stroke patients frequently being placed as outliers on other wards.

This is concerning since this may result in stroke patients not receiving the most appropriate and timely treatment for their condition, and likewise for other

[60] A ring fence bed is a method of protecting an acute bed on a stroke ward from use by patients who are not stroke patients.

specialty patients.

Our staff interviews found that ring-fencing a stroke bed was essential to maintain flow in the stroke pathway. In addition, we asked staff in our survey if they had comments on what could be improved with the flow of patients along the stroke pathway. The most common theme in the feedback related to the need to ring-fence stroke beds for stroke patients. We received 22 comments suggesting the need to maintain a ring-fenced bed.

One comment included:

'We had a ring-fenced bed for a while, but hospital pressures have meant that this is rarely available and so patients need to be moved about to get an appropriate bed on the stroke ward, that can cause delay.'

Delays in accessing stroke beds

We explored the issues around outlying patients on different wards in relation to stroke. The aim was always to transfer patients to a stroke ward as soon as a bed was available. We also found examples that at times, patients may be swapped from other wards to allow for stroke patients to be in the best environment to manage their needs.

Our clinical records review found that patients remained in ED for prolonged periods of time. Some records found overnight delays and instances where patients had remained in ED over 24 hours, prior to their admission to the stroke ward.

Whilst this is not acceptable in the appropriate management of a person within the stroke pathway, it is positive to note that evidence demonstrated that patients received the required care from other specialties, such as therapies staff, in a timely manner.

Despite the continual issues with patient flow to the stroke wards, we found some positive patient experiences for timely transfer. Several clinical records showed that patients had been transferred to the acute stroke ward within the four-hour timeframe. One record highlighted that a patient remained in ED until their condition had stabilised and were transferred to the acute stroke ward within the four-hour timeframe. Other records demonstrated that a bed on the stroke ward was ring fenced for a patient and was not used whilst they received urgent care in ED. Whilst overall, the clinical records were clear and legible, in some records it was not always clear to establish times and dates of transfer of some to the stroke ward.

It is evident from exploring the timely transfer of patient flow to the stroke wards, that there is significant pressure on the whole of the system. Patient flow is a problem across all specialties, and for stroke patients, they are not always placed in right bed in the right place at the right time, due to the high demand on beds.

Recommendation 33:

Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.

Recommendation 34:

Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

Impact of flow on stroke rehabilitation

NICE guidance (NG128), states that stroke rehabilitation is essential for better patient outcomes. Ideally, this should be provided within a dedicated stroke inpatient unit, and by a specialist stroke team within the community if required.

Across Wales, we found clear inconsistencies for the provision of rehabilitation to people following their stroke. Some hospitals provide rehabilitation within the acute stroke ward since there is no separate ward available to provide this elsewhere. Other health boards have a dedicated rehabilitation ward within the same hospital site, or stroke rehabilitation may be provided within a different hospital site, such as community hospitals.

Early Supported Discharge

Early Supported Discharge (ESD) is an intervention for adults following a stroke which allows their care to be transferred from an inpatient to a community setting[61]. ESD enables people to continue their rehabilitation therapy at home, with the same intensity that they would receive in hospital. However, this may not always be suitable for everyone following a stroke, or in all circumstances, and the decision to offer ESD is made by the stroke MDT, after discussion with the person and their family or carer if applicable.

The stroke MDT will assess whether ESD is suitable for adults who have had a stroke.

The assessment will consider the person's functional, cognitive, and social circumstances, such as the person's ability to transfer from bed to chair independently or with assistance, and whether a safe and secure environment can be provided at home.

When considering the provision of ESD for people following a stroke, we found inconsistencies with the service available across Wales. Not all health boards provide this service and for those that do, there is no standardised format in the

[61] Early Supported Discharge - NICE

provision of ESD. Access to the service across Wales is varied and there is a lot of variation in the service provided in terms of frequency of home visits and intensity of rehabilitation provision).

Our interviews with ESD staff highlighted the significant benefits and positive outcomes for patients who have received ESD. The risks associated with remaining in hospital are minimised, and the psychological impact on patients improves with the ability to be discharged from hospital. We also found that where the service was available, staff reported improvement in patient flow due to savings on patient bed days.

Despite the benefits of ESD, it was disappointing to find inconsistencies across Wales with its provision. When speaking with staff about this, it appears there is a lack of resource or funding available to provide ESD services in some health board areas. This therefore highlights the inconsistencies with equitable access to ESD for people who may benefit from this.

Recommendation 35:

Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to hospitals, with earlier discharge improving flow through the stroke pathway.

Stroke rehabilitation wards

Overall, we found that hospitals with stroke rehabilitation wards provide an environment which facilitates multidisciplinary stroke care, such as nursing, medical and therapies treatment. For hospitals that do not have separate rehabilitation wards, our staff survey highlighted several comments which suggested the need for a step down or rehabilitation ward for treatment to assist with the flow of patients from acute stroke wards. One member of staff commented:

'a dedicated rehabilitation area that would allow for proper dignified assessment and rehabilitation to progress people.'

In one health board, the process was ongoing to separate the stroke ward into acute and rehabilitation wards, and it was also introducing the provision of ESD.

The rehabilitation ward was re-located to community hospital sites which were also in the process of introducing ESD for all three sites. The aim is to facilitate the provision of a seven-day therapies service on the rehabilitation ward, with plans to progress to a seven-day therapies provision at the acute site. The purpose is to improve flow for stroke patients from the acute setting to the rehabilitation ward, and to facilitate earlier discharge to the community with the support of ESD.

Another health board was providing a full therapies service over seven days. Whilst this was positive in enabling earlier discharge of patients, staff told us it was having a negative impact on the weekday provision of care, due to the thin spread

of stroke speciality staff to cover seven days. Our interviews with Senior Managers found that they were considering the options of increasing the staff establishment; however, recruitment to the site was a challenge, due to complexity with discharge planning. Therefore, a high reliance on regular agency and bank staff was necessary.

We received several comments from therapies staff in our survey in relation to this issue, which included:

'Occupational therapy are involved with patients they are able to assist patients to improve ability with increased level of rehabilitation for each patient however this service is very limited. Services need to be seven-day services.'

Physiotherapy stroke service

We held discussions with staff across Wales regarding the provision of physiotherapy services. It was highlighted that it was not always possible to provide the NICE recommendation for 45-minute daily treatment, which was subsequently highlighted in SSNAP data we reviewed. This was due to the high volume of stroke patients and insufficient capacity within physiotherapy teams.

Our clinical records review found inconsistencies in the provision of the 45-minute daily physiotherapy and occupational therapy across Wales. Our staff interviews found this was attributed to the challenge with recruiting staff and several sites we visited were carrying vacancies within their therapy establishments.

We considered the physiotherapy needs of patients during our clinical records review. In some records, we found evidence of patients being assessed in a timely manner and receiving regular physiotherapy as appropriate. However, in some records the physiotherapy notes were not filed within the clinical records and were kept elsewhere. This prevented us from making a judgement on the provision of the service provided to some patients. When considering other records, some demonstrated delays in referral for physiotherapy assessment, or no evidence of physiotherapy intervention despite referral. We also found examples of stroke patients placed as outliers on other wards with no physiotherapy assessments documented. This highlights the importance of stroke patients being placed on the appropriate stroke wards to prevent any issues with not receiving the required treatment.

We received some comments in our public survey relating to physiotherapy services, which support our records review findings, these included:

'The hospital was short of physiotherapists would have liked physiotherapy on a daily basis but this was not possible. The nurses on the ward were not even allowed to help with simple arm and leg exercises.'

'No physio available cos it was a weekend.'

'Treatment/physio was not frequent enough in hospital which had an effect on recovery as the first few weeks/months are critical. No physio sessions on weekends very frustrating.'

'I was prepared to attend physio gym every day but sadly, the facilities were unavailable on weekends, which makes for a very long day with no activity.'

Occupational therapy for stroke services

When considering the records for occupational therapy input, we found similar issues to that within physiotherapy. We found inconsistencies in the patient records, with some areas demonstrating positive evidence of timely treatment, whilst several records had no documentation completed at all.

Issues were also found at times following discharge, for example, when patients were repatriated to other health boards. Patients are sometimes repatriated from acute care, and the receiving health board has not been informed of the need for referral to other services, such as occupational therapy or physiotherapy.

Therefore, delays in the provision of care are inevitable. This is clearly not appropriate for patients who are reliant on additional timely therapies services.

The issue of insufficient provision of therapies for patients was also reflected by respondents to our patient survey when asked what the NHS could do to improve the service it provides for stroke patients. One comment included:

'More physio and speech and language help [is needed] and for a much longer period.'

Speech and Language Therapy (SALT)

As highlighted earlier, a swallow screen must be completed within four hours of admission to hospital for strike patients. If the assessment identifies that a patient has problems with swallowing safely, they should receive a specialist swallow assessment. This should be undertaken within 24 hours of admission, but no longer that 72 hours, as highlighted within NICE guidelines.

Our review of clinical records reflected that most patients had passed the initial swallow screen. Where patients required a referral to SALT, this had been done within the 72 hours. In addition, there was evidence to support that a plan of care had been prescribed to support the SALT assessment.

We also considered whether patients who were unable to take oral nutrition, fluids or medication received other means of nutrition, such as tube feeding with a nasogastric tube (a small tube inserted through the nostril to the stomach), within 24 hours of admission, unless contraindicated following thrombolysis, in line with NICE guidelines.

It was positive to find that for those who may be compromised nutritionally, relevant patients had been referred to Dietetics and Nutrition teams for a nutritional assessment and were prescribed individualised feeding regimes. In addition, oral medication was reviewed to amend either the formulation or the route of administration.

When reviewing SSNAP data we considered the therapy services across Wales and found variances in the provision of therapies within stroke services for patients. Inadequate therapy services have a negative impact on patient recovery from stroke and also impact on discharge planning and patient flow within stroke services. Therefore, health boards must ensure all therapy services for stroke patients are reviewed to consider how each is meeting the needs of patients in line with national guidelines.

Recommendation 36:

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.

Psychology support in stroke services

Patients with stroke may suffer psychologically because of their stroke due to the significant impact it may have on their mental and physical well-being. This may include anger, frustration, depression, and anxiety. In addition, to maintain psychological wellbeing, patients should be able to speak in the language of their choice. It is important that health and social care providers maintain the Welsh language active offer for people in Wales, as highlighted earlier in the report. In addition, providers must maintain the ability to provide a translation service for people in other languages, such as Spanish, Polish, Urdu or Chinese. We found that access to a translation service was available in all health boards.

In line with NICE guidance (NG128), people who have had a stroke should have access to a clinical psychologist with expertise in stroke rehabilitation, and who is part of the core multidisciplinary stroke rehabilitation team.

Soon after a stroke, and where appropriate, patients should receive a psychological assessment to assess whether they are experiencing any early emotional problems which may have a lasting impact.

Their psychological needs may fluctuate along the stroke pathway as they recover from the acute stroke, and the reality of any disabilities may become overwhelming. The psychological support alongside physical rehabilitation, can increase a patient's opportunities to engage with rehabilitation and help maximise the outcomes.

We considered the psychological support provided to stroke survivors across Wales and found this to be inconsistent, as not all health boards provide support in this area. Our review of clinical records highlighted the lack of psychological support to patients within several health boards. This was also highlighted through our interviews with staff. We found that one health board within Wales had recently appointed three psychologists. One for each of its rehabilitation sites, along with three assistants. In addition, the staff discussed the positive work in progress, which offers education and training around the psychological needs of the patient, to all MDT members involved with the patients journey through the stroke

pathway.

We interviewed a GP who undertakes weekly ward rounds on a stroke rehabilitation ward in one health board area, which is attended by the MDT members to discuss the progress and needs of stroke patients. They supported the need for psychology input and suggested this service would be beneficial for patients. They highlighted that for stroke patients there may be a need to prescribe anti-depressants to help with their mental well-being, and that complemented by psychology support could improve the rehabilitation process for patients. In addition, having a family member with a stroke can be challenging for families or carers to deal with, and participation in the psychologically and support could also be beneficial for them.

Recommendation 37:

Health boards must consider the need for psychological support for people with stroke, and ensure that adequately trained staff are providing this support to help effectively manage patient recovery.

Overall, we found that therapy services play a key role in the patient's journey through the stroke pathway, and when preparing people for discharge. We found good collaborative working between therapy teams and others within the stroke MDT, however, as highlighted above, further investment may be required in some therapy teams for patient progress, recovery, and overall wellbeing.

In line with the inconsistencies found across Wales, not all stroke services can provide the required timely therapy services to patients. This was for several reasons, such as staff vacancies, the impact of patient flow resulting in different specialty outliers using stroke beds and vice versa and demand exceeding capacity. In addition, the overall environment to conduct therapies on the wards was problematic, relating to facilities and space for timely rehabilitation services.

A holistic approach to therapies is required across Wales, to provide patients with both physical and mental support. This approach would also benefit flow within our hospital system by enabling patients to be discharged timelier and over seven days a week.

Recommendation 38:

Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.

Recommendation 39:

Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.

The impact of delayed discharge on patient flow

Discharge delays for medically fit patients

As highlighted earlier, in June 2022, the Senedd Health and Social Care Committee published its *Hospital discharge and its impact on patient flow through hospitals inquiry* report[62]. The report highlights that in February 2022, there were 1,081 patients who remained in hospital who were medically fit for discharge.

During our fieldwork, staff told us that around a third of all patients in their health board area were medically fit for discharge. Some patients had remained in hospital for months until an appropriate placement or package of care was available to facilitate a safe discharge. Health boards regularly provide up-to-date numbers to Welsh Government of the medically fit people waiting in hospital beds, for a package of care, to enable them to go home, or a care home placement.

Impact of delayed discharge or Delayed Transfer of Care (DTOC) flow

To support our review in relation to patient discharge, our team included a peer reviewer from Care Inspectorate Wales (CIW), who supported our work through interviewing key staff relating to social care and those involved in the discharge planning process. This assisted our team to gain a sound understanding of the challenges related to the provision of social care.

Our report has already highlighted the challenges with the bottlenecks at the 'back door' of the healthcare system with delayed discharge, which impacts on patient flow throughout a hospital. This is felt at the 'front door' where EDs are unable to admit patients from ambulances in a timely manner.

The conclusion to the Senedd's Health and Social Care Committee's inquiry highlights the lack of social care capacity is the biggest contributor to delayed discharges and restricted patient flow through hospitals.

Unnecessary stays in hospital due to delayed discharge of care (or DTOC), can place patients at risk of hospital acquired infections and deconditioning, which can lead to further ongoing care needs following discharge. The bottleneck at the point of discharge can affect Eds, WAST, inpatient care, primary care, planned admissions and staff wellbeing.

To help support the more complex discharges, across Wales, we found teams of staff in post, who had the responsibility for the discharge of patients with complex needs and who, therefore, need detailed planning to implement ongoing support following discharge. This includes patients following a stroke. We will discuss the complexities throughout this section of the report.

Discharging stroke patients

Our review found that most stroke patients have a range of complex needs both

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[62] Hospital discharge and its impact on patient flow through hospitals

physical and cognitive. This may include paralysis of limbs affecting mobility, issues with speech or swallow and cognitive impairment. Therefore, they are more likely to need ongoing packages of care at home, which are often complex to arrange. The resource is not always readily available, which may further delay a patient's discharge.

Our interviews with staff consistently found reports that discharge delays and DTOC can lead to worsening outcomes for patients and can also mean that some revert into an acute bed, and also impacts on their long-term care needs. Our staff survey also found similar, and one comment relating to this included:

'It is not good for patients' wellbeing for them to remain in hospital when they are ready to leave.'

Planning for discharge

We considered how the MDTs across Wales planned and prepared for patient discharges from hospital.

Board rounds

We attended stroke board rounds where discharge planning was central to the discussions that took place. They were led by a dedicated member of staff, and had an MDT approach, highlighting key information about each stroke patient, including diagnosis, admission date, care management plan and expected date of discharge. These meetings were consistent across Wales.

We found in most instances, a summary was made at the end of each patient discussion with the aim to highlight any daily tasks required, and the delegated person and task completion date to help ensure patient progress their journey through the stroke pathway to discharge. This also allowed for the opportunity to discuss any patients who were delayed in their discharge or DTOC.

Overall, we found board rounds were dynamic, constructive, and led to clear actions. However, some lacked effective leadership, direction, and decision-making, which in turn increased a risk to timely flow through the pathway, and out of hospital.

Recommendation 40:

Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.

SAFER patient flow guidance[63].

The *SAFER Patient Flow Guidance* was published by Welsh Government, and acts as a key enabler for an overarching good practice guide to improving patient flow.

[63] SAFER patient flow guidance

The guide identifies ten areas of focus to support flow across the unscheduled care patient pathway, and *SAFER* fits into one of these ten areas, relating to transfers of care.

SAFER consists of five elements of best practice which are summarised as:

- **S** – **Senior review** of all patients before midday, informed by a multidisciplinary assessment
- **A** – **All patients** and their families involved in the setting of an Expected Discharge Date (EDD)
- **F** – **Flow of patients** at the earliest opportunity from assessment units to inpatient wards
- **E** – **Early discharge** with at least a third of patients discharged from inpatient wards by midday on their day of discharge
- **R** – **Review** of patients involving MDT, the patients, and their families for those with extended lengths of stay.

We considered whether the sites we visited used any tools to help manage flow at a ward level. During our staff interviews, we were told that wards use the principles of *SAFER Patient Flow*, however, our findings from clinical records did not fully support this. We found inconsistencies in the recording of an EDD, or the rationale of why a date had not been considered, and there were also inconsistencies in the evidence recorded relating to the use of 'Red' and 'Green' days[64]. Our attendance at stroke board rounds also found that the use of the *SAFER principles* was not consistent across Wales.

It is evident that treating patients promptly with the appropriate care in the right place at the right time, can enable a person to be supported back to their own home in a timely manner. It is pivotal that all staff work together to manage the issues that may arise through a patient's journey, to be effective. Early planning for discharge is essential, and the individual, their family, and healthcare and social care professionals must work together, to achieve a smooth and timely discharge. This, in turn will help facilitate better patient flow through healthcare systems.

Recommendation 41:

Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.

Multidisciplinary meetings

We considered how well teams work together to support the discharge process for

[64] The Red and Green Days approach is an example of using simple rules to help reduce delays for patients by making 'non-value' adding days (from a patient perspective) visible, and a daily topic of conversation for clinical and managerial staff. It works particularly well when it is used across inpatient wards where patients often experience significant periods of time waiting for things to happen in their plan of care.

patients. During our fieldwork, we attended several MDT meetings to observe the discharge planning process within the relevant teams. We found the discharge teams help manage the support required for stroke patients, such as arranging and referring patients to appropriate post-discharge services. The teams also consult with services to manage their discharge home from hospital, including packages of social care or transfer of care to other services.

To plan for the discharge of stroke patients from hospital, we found an MDT approach for the continuity of patient care is taken by all health boards. A patient discharge plan is developed on an individualised basis, and includes all patients' needs for their continued rehabilitation and care at home, any community services required to support them, and any equipment or other aids they will need to maintain their care and safety following discharge.

We saw effective communication through all therapy disciplines to manage the flow of a patient through to discharge. In our staff survey, 81% said that there was an effective working relationship between all Allied Health Professions. We found good examples of early planning for discharge, and for ongoing care to facilitate rehabilitation and discharge from hospital. However, there were several prolonged delays in the allocation of social workers to patients, social care packages, and delays in obtaining nursing or residential home placements. This was consistent across Wales.

In line with NICE guidelines, we observed the core multidisciplinary stroke rehabilitation teams discussing individual patients to set and follow-up on goals. The rehabilitation teams consisted of:

- Consultant physicians
- Nurses
- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Rehabilitation assistants
- Pharmacy.

At some MDT meetings clinical psychologists and social workers were also in attendance, however, this varied across Wales. Through discussions with staff, we identified that prior to the COVID-19 pandemic, social workers were present at most MDT meetings to discuss and arrange the social care requirements for stroke patients who were close to the end of their rehabilitation phase and would soon be ready for discharge. Their involvement was described to us as a positive step in enabling a timely discharge. However, during our fieldwork, at most MDT meetings we attended, social workers were not present which added to the challenges of timely discharges.

Within our staff survey, all stroke services healthcare staff who responded, said

there are often delays in the discharge process, and 78% said the delays were frequent. We also received comments in our survey from local authority staff, which included:

'Poor communication between ward staff and social care staff appears to be one of the main reason for inadequate /ineffective discharge planning.

'Social Care is often inappropriately blamed as being the cause of delays when in actual fact the delays are frequently as a result of an internal issue on the ward.'

'One of the fundamental things that would see a marked improvement in discharge planning and make it a positive discharge for the patient would be evidence that a person centred/strengths based/outcome focused conversation has actually taken place with the patients themselves and health and social care staff are clear what matters to that individual. This would then help inform discharge planning and make sure we get it right.'

Communication with social care providers

When considering the perspective of staff who work within the social care system, their response to our survey highlighted issues with the communication with hospital teams. This included inaccurate or insufficient information being provided in the referral process. Only five of 17 respondents said they were given the right information about the patient to assist with discharge. Some comments included:

'*Very little information provided, inaccurate most of the time.'*

'Not always given correct information in terms of functional ability and rehabilitation / recovery plans.'

'We rarely get any information unless we go looking for it. We spend hours trying to contact the hospital wards and then are told different information depending on who you speak to. Its patchy and unreliable.

The staff nurses are unaware of their own discharge policy as the LA which health forms they need to complete. They ask the SW to take the lead in most meetings as they are just unsure of the process.'

'Agency nurses used to complete referrals are a massive setback as they do not know the patients well enough.'

The findings in our survey clearly highlight issues with communication between healthcare and social care teams. We also found that the view of local authority and social care staff were generally quite negative in relation to the health board's discharge policy. Just over half the respondents said that the health board had not shared their discharge policy with their teams. Ten of the 16 respondents said the health board policy was not easy to understand, and almost all said the policy wasn't followed in practice. In addition, very few said they had sight of the health board policy.

Social care providers also made comments regarding poor discharge documentation, along with the communication for patient discharge plans. These included:

‘Hospital discharges are sent out without paperwork and guidelines.’

‘Communication between the hospital staff and the home has been lacking at times and the information received from discharge has been wrong.’

‘More effective communications between hospital and us on discharge as at times it’s very difficult to get the information required until after they are home.’

In addition, nine of the 17 respondents to our local authority survey said it was not clear what was required from them, to meet the needs on discharge. The comments included:

‘As information is often limited, we can only work with the information we are given. When information is missing, we do not see the full scope of needs on discharge. Following admission, we often see a higher level of need, and these are addressed when they are realised.’

These comments were supported by information received as part of our social services provider survey, with one staff member commenting:

‘Better information and planning for discharge and more communication both verbal and written, from the ward.’

Our staff survey also found that health board staff reflected similar opinions, with around 50% agreeing that patients are discharged with a written and detailed discharge plan, but with insufficient information available to inform the social care teams to support the discharge process. Staff also suggested that the most common reasons for discharge delays, were challenges from family or carers and community support. Supporting the later comment, in our patient survey, only 55% said they had been included in the discharge planning process.

One respondent told us:

‘There were obviously insufficient staff, my mother was left on her own feeling very confused with no one to ask about her treatment. As her next of kin, I was given no information about her post discharge care.’

The findings above, in addition to others throughout this report, highlight the need for collaborative work between health and social care services, to improve working relationships and develop a clear understanding across service teams, as to what each sector is doing to progress a discharge and improve outcomes for patients.

Recommendation 42:

Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.

Allocation of social workers

When patients are medically fit for discharge but have ongoing complex needs, they are referred by healthcare staff to Social Services for social worker allocation. Social workers are required for numerous patients, and their role in discharge is to assess individuals to determine the social needs, and to help achieve a safe discharge plan that is considered the best outcome for the patient. They take into consideration patient views and wishes, and often need to balance complex family dynamics.

When exploring the access to social workers, our interviews with healthcare staff highlighted frequent delays with patient social worker allocation and the required assessments. We were told that social worker vacancies across Wales are negatively impacting on timely allocation to patients. Supporting their reflections, nearly all local authority staff who responded to our survey said they were unable to meet the demands on their time at work, and there aren't enough staff to do their job properly.

To help mitigate against staffing issues, some social care teams use agency staff to bolster the service, particularly in areas where recruitment of social workers is a challenge. However, we were told that the use of social worker agency staff can result in some inconsistencies in the service provided. One local authority staff commented:

'Agency [social worker] staff have no understanding of geography or rurality.'

Through our interview process, some healthcare staff shared their frustrations around the delays in the discharge process. They explained that in some localities, the allocation of a social worker was taking up to three weeks. Once a social worker is allocated, further delays are common with their ability to attend the

hospital to undertake patient assessments.

In addition, once the assessments have been completed, and care plans developed there are challenges in obtaining the social care package in a timely manner. This prolonged process is causing unnecessary discharge delays for several patients and is consistent across most health boards.

Other examples provided to us during interviews noted that once referred to social worker teams, staff would not come to assess the patient until a full referral had been completed. The nursing staff often notify the ward or hospital based social worker that a patient will need some assistance on discharge. However, the nurses were often informed that until the referral is received by fax, they would not commence the process of allocating a social worker.

It is evident through our work, that nursing staff do not always have time to sit and complete a full referral when a patient is ready for assessment, since they have several other patients to care for during their shift, as well as arrange discharges and admissions from ED. Sometimes, the referral cannot be completed until the end of a 12-hour shift, and if this were a Friday, then it would be several days before the social worker team would receive the fax and commence the process

from their department. This would unnecessarily prolong the potential discharge of a patient.

In our staff survey, healthcare staff highlighted the challenges they face with the allocation of social workers and eight people made comments in relation to this. One included:

‘Long waits for social services and packages of care and inadequate rehabilitation staffing means we can't optimise patients for their best recovery.’

We did, however, find a positive example of good engagement and cross team working with social work teams in one health board area. This was because of excellent relationships between health and social care workers. This enables timely allocation, and assessment of patients to be carried out in some localities, minimising delays with the discharge process for patients.

As highlighted earlier, delayed discharges for patients who are medically fit to leave hospital can impact on some patient’s well-being. If they acquire an infection or become deconditioned whilst they are waiting to leave hospital, they may need new or additional treatment. If this does occur, we found that the process for social worker allocation and assessment is stopped if the patient is no longer medically fit for discharge. Consequently, once the patient recovers, the process of allocation and assessment must re-commence, delaying discharge further.

Recommendation 43:

Health Boards and social worker teams must work together to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.

Recommendation 44:

Welsh Government must consider the process in place for social worker teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.

Patient Best Interest Meetings

For patients with more complex needs, and who require a Best Interest Meeting[65] in line with the Mental Capacity Act[66], we considered whether there were delays in arranging these meetings. Consistently across Wales, we found delays in holding a timely meeting on several occasions. This was due to coordinating attendance for all required attendees, which could include MDT members, family members or

[65] Best Interest Meetings take place where a patient lacks mental capacity to make significant decisions for themselves and need others to make those decisions on their behalf.
[66] The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

carers and social work or care home managers. This was also highlighted in our staff interviews, and within our staff survey. One person commented:

'If a patient requires a Best Interest Meeting once clinically optimised, there are delays and difficulties in arranging the meetings to ensure all relevant stakeholders are in attendance.'

Recommendation 45:

Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.

Whole system approach to health and social care

We considered how healthcare and social care teams are working to achieve Welsh Government's long-term future vision of a 'whole system approach to health and social care', as published in its updated plan, *A Healthier Wales: Our plan for health and social care*[67]. The vision outlines a shift over time from the reliance on traditional hospital services providing care to people, to a seamless approach of integrated care, which includes health, local authority and third sector services.

Through our staff interviews across Wales, it is positive to find that several key areas of work are effective in progressing the process of safe patient discharges, which includes stroke patients. As part of this work, some healthcare, social care and third sector teams have been developing new partnerships and implementing new models of 'Home First' and 'Hospital to Home' services in Wales, which is highlighted in the *Home First: The Discharge to Recover then Assess Model (Wales)*[68].

The model highlights the care and support offered to patients, to leave hospital and to receive ongoing assessment and recovery at home, and to limit unnecessary time in hospital settings. Since 2018 the development of Home First and Hospital to Home services and its implementation has been supported by the NHS Wales Delivery Unit, now known as NHS Wales Executive[69].

We found that Home First teams are dedicated in promoting faster discharge from hospital and provide ongoing support to people and can arrange the required packages of care for people who are medically fit for discharge. Welsh Government's long-term objective is for health and social care providers to implement and scale services from a local and regional level to a national level.

Overall, it was positive to hear from staff where the Home First model is effective, and patient discharge can happen more quickly, which in turn assists with the flow of patients through hospital. Our review has identified the benefits of Home First

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[67] A Healthier Wales: Our plan for health and social care
[68] Home First: The Discharge to Recover then Assess model (Wales)
[69] NHS Wales Executive

teams, which are making the required difference in line with the set ambition of *A Healthier Wales*. It is therefore important that health and social care teams develop this service to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

Recommendation 46:

Health boards must develop and strengthen Home First services across Wales to benefit the people who need this, and to help manage the issues with patient flow through health and social care systems.

Domiciliary care

During our interviews with discharge teams, across Wales we were told that domiciliary care-packages are difficult to obtain in most health board areas. The most significant issue highlighted, was the recruitment and retention of care workers to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. Therefore, increasing the size of the hospital's 'back door' bottleneck.

We found that social care providers have ongoing pressures heightened since the pandemic which includes, staff sickness, low morale, and exhaustion, which impacts on recruitment and retention. It also important to highlight that the complexity of some individuals who are very frail and need higher levels of social care support, often with two carers, has placed additional pressures on social care agencies in their ability to provide care to new patients leaving hospital.

We found that healthcare staff are fully aware of the demands for domiciliary care agencies and their ability to meet demand and are always in frequent contact with them. We were told that in some health board areas, some families are encouraged to seek private domiciliary care where local authority care provision is not yet available. However, this is not always affordable to some, therefore people remain in hospital unnecessarily, which is contributing to the issues with patient flow.

Within our staff survey, most social care staff said that there were challenges of people accessing services to enable appropriate discharge. The comments included:

'Lack of care providers to meet assessed care and support needs. Lack of carers.'

'Care sector is under huge pressures for staff capacity and poor discharges are a growing issue.'

'Lack of stroke rehab services locally both in patient and community.'

Recommendation 47:

Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.

Care home placements

Many patients who have sustained a stroke and others who need ongoing long-term care may need to move in to a nursing or residential home following their discharge from hospital.

Our staff interviews found that some health board staff are required to have difficult conversations with patients and their carers or families, around their care home choices. This can also include their finances and potentially paying for long term care placements. We also heard examples where due to the unavailability of domiciliary care services, patients have no choice but to move into a care home for interim periods.

We were told by healthcare staff that patients are often reluctant to enter care homes, as they want to go to their usual residence and often decline a bed when offered.

Many also decline admission to an interim bed placement for reablement, as they are worried of deteriorating and not being able to go home, or they may be faced with the need to pay high charges when their funded placement ends. In addition, for patients who require long term care home placement, many homes are long distances from their usual home and their family, and they often do not wish to move to these homes. We were told that having these conversations is challenging and can be quite upsetting at times, and most do not have experience or training for managing these difficult conversations.

We found that when people need admission to a care home in Wales, the funding process can be complex. In most cases, the person is financially means tested, and in many instances people in Wales are required to self-fund their bed if they haven more £50,000 in capital and assets. If capital and assets are less than this, then a person will likely be eligible for local authority funding. In addition, when some individuals are assessed as having long-term health needs, they may be eligible for NHS continuing healthcare funding. However, if a person does not qualify for this funding, sometimes they may be eligible for NHS funded nursing care, where the NHS will partially fund the placement, for the nursing element of the fees[70].

In our staff survey, people working within social care or local authorities shared comments with us around care home placements, with one comment including:

We have a long waiting list for both domiciliary care and residential and nursing

[70] Care Home Funding in Wales 2023.

placements.'

Reablement services

As part of its Deliver Home First[71] model, Welsh Government suggests that the process of discharge from hospital is a key factor for rehabilitation, and that the lack of support an individual receives leading up to discharge and post-discharge will impact the likelihood of them requiring care in the future.

Reablement services provided support to help people regain their independence after illness or disability, and it is usually provided for a relatively short time, such as weeks rather than months. This may include some stroke patients.

We found that the Continuing NHS Healthcare (CHC)[72] teams and complex care teams work well in their aim is to return people home quickly, however, we were told that where reablement care is needed, there have been waits for this service in some health board localities.

Variations in reablement services

There are variations to reablement services across Wales. Some health boards reported having Home First services available from all their sites.

We heard examples from staff, who said the availability of Home First for 10 days rehabilitation had a positive impact on discharging patients home promptly, and the health board approved funding to allow an extension of the daily working hours.

In other health board areas, we found waiting lists for patients to be discharged through the Hospital to Home schemes[73]; however, transition beds are available for up to six weeks, with funding agreed for up to three times a day.

We found that interim placements in care homes were available in some health boards, and patients were encouraged to utilise these when they were fit for discharge, until their home care was ready to start. These beds are funded by the health boards and at no cost to the patient but had a maximum stay of up to six weeks. Patients or their family/ carers were sometimes reluctant to utilise these beds, as they felt it would hinder their ability to return home, and if it they were not able to leave the home after the set period, they would need to pay for them after that time.

During our interviews, staff told us that the provision of interim or reablement beds in the community is often difficult to obtain. Whilst health boards can fund these beds for up to six weeks, they are associated with very high costs. During one interview, we were told that all care home beds were full within their health board and increased significant pressure on the wards to manage patient flow.

Overall, the provision of early supported discharge is inconsistent across Wales

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[71] Delivering Home First. Hospital to Home Community of practice: key learning and practice examples

[72] Any adult who has complex needs and as a result might be eligible for Continuing NHS Healthcare. Continuing NHS Healthcare information booklet for individuals, families, and carers | GOV.WALES

[73] Delivering Home First - Hospital to Home Community of Practice: key learning and practice examples

with peaks and troughs being reported in these services.

Patient home equipment needs

When patients need equipment or small adjustments made at home to support their discharge, we were informed by staff across Wales that this service generally works well. This was a consistent finding across Wales. These teams, based in the community, aim to provide and install home equipment or make minor adjustments quickly to support patient discharges. Overall, we were told the waiting times for equipment assessments, delivery and/or installation was quite low. However, longer waits were reported for home adaptation which required more complex structural alterations.

Whilst health board staff were positive with this in our interviews, several comments within our staff survey of social care providers were not so positive. These included:

‘Users are sent home without the necessary equipment in place and the responsibility and stress then falls on the provider to source this and ensure the safety of the users.’

‘The industry is under a lot of pressure but when people are discharged unsafely without equipment, and they end up going back to hospital.’

‘People are discharged without assessing the environment they are returning to. This means that in some instances people return to hospital as they are unable to live independently as they do not have access to the right equipment and services.’

It is concerning to hear the disparities in staff opinions regarding the availability of equipment. Particularly if healthcare staff suggest the service is working well, yet when social care staff attend people’s homes, the required equipment is allegedly not in place. We did not visit people’s homes as part of our review; therefore, we cannot establish whether the appropriate equipment was provided in line with assessment pre-discharge and whether the needs changed after a patient was home.

Positive aspects in preparing for discharge

Despite the challenges faced by health board staff across Wales for the safe and effective discharge of patients, our staff interviews highlighted several positive findings. These included the following:

- Occupational therapists and physiotherapists are available at all acute sites and as part of community reablement teams. This means that rehabilitation happens quickly and continues at home or in the community, where possible
- Where discharge coordinator posts exist in hospitals, complex discharges are managed effectively
- Partnership working at all levels is particularly good. Senior managers in both health and social care services are well informed of the issues and challenges with discharge and patient flow. Meetings occur daily and weekly

which focus on delayed discharges

- Where there is agreement for trusted assessors, assessments and care plans are carried out quickly but there is still a delay in obtaining the necessary service provision
- One health board reported operating an effective Discharge to Recover then Assess model with the aim to assess people in their own environments
- Specialist stroke rehabilitation units, with sufficient beds, and appropriate clinical support, allows people to be discharged from acute settings where appropriate
- Step-down beds are available throughout the county at the 10 Community Hospitals
- Integrated teams work well together with all professionals and the third sector playing a key part. The intermediate care teams in the community aim to keep people at home alleviating the pressure on admissions. The health board has invested in intermediate care to support people to remain at home, virtual wards, use of community hospitals for rehabilitation and GP's operate systems of case management
- There is a strong social work team in some parts of the health board, supported by students and agency staff are used where necessary
- Allocation and assessment of cases is therefore carried out speedily in those areas
- The health board has invested in Discharge Liaison Nurses who are part of the multi-disciplinary team.

Overall, we found that when patients were deemed medically fit for discharge, there were frequent lengthy delays in obtaining packages of care for patients across Wales as a whole, with minimal knowledge in some cases of when these packages could commence.

Where a patient was awaiting a placement in a nursing or residential home, we found dates were often set for transfer out, or plans were in place to cover the interim period elsewhere in reablement beds, before the placement was available, however, this was not consistent across Wales due to bed availability.

Discharge or repatriation to several localities

An additional challenge faced by several health boards is the need to discharge to several local authority areas, and the requirements in each can be different.

Whilst overall, relationships with different local authorities were described as good, we were told there are different referral routes, processes, and IT systems in place, which can make the processes difficult to navigate and more complex at times, delaying the discharge process unnecessarily. We were also informed some local authorities receive people to their homes from NHS Trusts in England, or from other health boards, where discharge processes may be different again from the usual discharging health board. This often makes discharge communication more

complex and challenging.

The day of discharge

To help facilitate daily discharges, we considered whether the hospitals we visited had a discharge lounge. A discharge lounge can help improve flow on a daily basis, as patients who are due to be discharged that day can be moved to the lounge to await transport home, or to await medication from pharmacy to take home. This can free up ward beds earlier in the day, which will help with flow across the hospital.

We found that most sites had a discharge lounge. Some lounges had flexible spaces which could be adapted according to demand and patient requirements, such as for a chair or bed. Access to the discharge lounge also varied across Wales, with some open from 8am to 6pm or 8pm, Monday to Friday with no weekend provision.

Our clinical record review found that some discharges took place late afternoon or in the evening. However, in some records reviewed, it was not clear what time of day the patient left the ward, or whether they went to a discharge lounge or other means. Therefore, it was not clear whether the wards had formally completed the timing of discharge process on the electronic patient system, therefore making them appear that they were still in the ward bed. This would make it difficult for patient flow managers to know when the bed is available (or not), which is important particularly when EDs are full, and beds are needed.

We recognise that use of the discharge lounge and accelerated discharge processes may not be clinically appropriate for all stroke patients, particularly those with complex needs, such as physical or cognitive impairments. Staff told us that some stroke wards use their day room for patients to wait for their discharge to help improve the flow through stroke services.

Recommendation 48:

Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.

Recommendation 49:

Health boards must identify the hospital sites that do not have a discharge lounge service and consider the positive benefits on patient flow of implementing this service.

Recommendation 50:

Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

Conclusion

It is clear from our findings that the healthcare system across Wales is frequently operating under extreme pressure, with hospitals regularly operating at the highest level of escalation. Poor patient flow is a fundamental issue causing this pressure, and our review has brought to the surface the negative impact this can, and is, having on all patients, not just those on the stroke pathway.

Whilst we have reflected in our review an intention and ambition to tackle this problem, as well as examples of good practice that have made a positive impact in alleviating flow problems, more needs to be done. It is clear that no single solution exists to solve poor flow, rather a range of approaches are required in combination to release the pressures on the health and social care system.

These solutions range from doing more to help inform and educate the public about the choices they make when accessing healthcare services, spreading the positive learning that exists from flow management initiatives within acute hospital settings, and strengthening collaboration and processes around discharge from hospitals between the health and social care sector in particular.

This review used stroke to understand the impact and dynamic nature of flow, and overall, our view is that the stroke pathway is operating effectively to some extent. People receive timely assessment, imaging, and thrombolysis treatment where appropriate. However, access to thrombectomy and the ability to progress people through their recovery and rehabilitation phase, following their stroke, is inconsistent across Wales and needs attention.

Poor patient flow is undoubtedly having a detrimental impact on aspects of the stroke pathway. We have seen the lack of timely packages of domiciliary care, and the availability of community hospital beds or care home beds, resulting in patients remaining in hospital much longer than is necessary. This can lead to patients become deconditioned with a risk that they are no longer medically fit for discharge and require further treatment.

Blockages in the discharge process can cause challenges and pressures across hospital beds, and lead to overcrowded EDs, causing significant issues in the ability of WAST to respond to patients who need emergency care in the community in a timely manner.

It is clear there is an unprecedented pressure across the whole of the health and social care systems in Wales, which has been intensified by the Covid-19 pandemic, however, this pressure is continuing to prevail. Staff are working tirelessly to help manage the flow through hospitals and out to the community. However, despite their best efforts, for a variety of reasons outlined in this report, including demand and system weaknesses this is not leading to a significant improvement in the overall position. Tackling the issue of flow is a multi-faceted challenge that needs the health and social care system, along with Welsh Government, to come together and ensure all is being done to address the issues highlighted by our review.

What Next?

We expect the health boards, Welsh Government, WAST, PHW and Local Authorities to carefully consider the findings from this review and act upon the 48 recommendations set out within the report and listed within Appendix A.

We hope this review will be used to help health boards to improve flow, by encouraging health board teams to collaborate with each other in relation to good practice and innovative practice. In addition, that this work can be a catalyst for improved relationships between health and social care teams.

All relevant stakeholders highlighted within this report are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

The findings highlighted in our report, and the responses that we receive, will support HIW in considering whether to undertake further, local or national work.

Appendix A

Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

	Recommendations
1	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.
2	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.
3	Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.
4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.
5	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.
6	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).
7	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.
8	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.
9	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

10	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.
11	Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.
12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.
13	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.
14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.
15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.
16	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.
17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.
18	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.
19	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.
20	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.

21	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.
22	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.
23	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.
24	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.
25	All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.
26	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.
27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.
28	Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.
29	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.
30	Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.
31	Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.
32	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms
33	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.
34	Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards

	must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.
35	Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.
36	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.
37	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.
38	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.
39	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.
40	Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.
41	Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.
42	Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.
43	Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.
44	Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.
45	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.
46	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

47	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.
48	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.
49	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.
50	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Mae’r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Dirprwy Brif Weithredwr, GIG Cymru

Health, Social Care and Early Years Group
Deputy Chief Executive, NHS Wales

To: Chief Executives - NHS Wales Health Boards

Our Ref: NW/JG

14 August 2024

Dear Colleague,

Re: Improving Stroke Services in Wales

I write following the paper and presentation to Leadership Board in May that gave an overview of the current challenges across Wales for stroke. Given these challenges, urgent action is required to improve the quality and performance in stroke services in Wales. An update was requested as stroke is a significant health concern in Wales, ranking as the fourth leading cause of death and the primary cause of disability, with significant cost to both NHS Wales and the Welsh economy.

As was highlighted in the paper (attachment 1), there is a need for NHS Wales to review its service provision, quality, and outcomes for people with stroke across the whole clinical pathway – from prevention and awareness raising, hyperacute care to specialist recovery and rehabilitation including integrated community stroke services and long-term life after stroke support.

The paper also identified several issues currently being faced and the priorities for stroke care, including:

- low and declining performance on the stroke bundle standards,
- the data capture and validation problems,
- the workforce shortages and fragility,
- the lack of prioritisation and governance,
- regional variation,
- the need to increase thrombolysis and thrombectomy rates and access.

There were six recommendations presented to Leadership Board for Health Boards assisted by the NHS Executive to take forward over the next few months. These recommendations along with the accompanying impacts and measures are outlined in the table in attachment 2.

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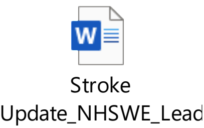
There will be an update requested from Health Boards against these recommendations in September.

If you would like any further information on this please contact **Joanna.Williams@wales.nhs.uk**

Yours sincerely

Nick Wood
Deputy Chief Executive NHS Wales

Attachment 1: Leadership Board Stroke Update Paper



Attachment 2: Table of recommendations for Health Boards

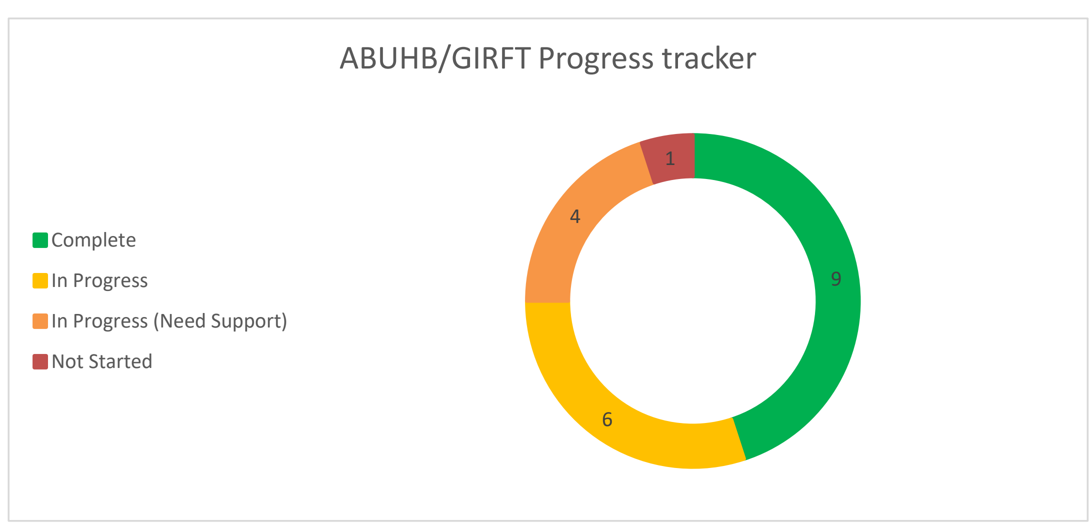
Recommendation	Impact	Measure
1. **Health Boards** to prioritise the implementation of new National Clinical Guidelines a particular focus on stroke imaging and deliver on the aims of the Quality statement to ensure timely, standardised and evidence-based stroke care delivery supported by the **NHS Executive**.	New national guidelines will extend the opportunity for treatment of strokes (up to 9 hours) which will increase thrombolysis rates and the success this treatment has. It will reduce the burden of disability; the new guidelines offer the opportunity for system resilience with reduced length of stay and patient flow with less disease effect. CT Profusion (CTP) will support increased opportunity for mechanical thrombectomy alongside AI.	Improvement in the Monthly performance information with reports including information on the entire pathway: - Prevention - Pre-hospital - Front door - Rehabilitation Aiming for increased number of strokes treated and rehabilitation, reviewed by the HB and NHS Executive Performance & Assurance team. Gap analysis to identify the areas for improvement between current practice and 2023 stroke guidelines. CTP offered 24/7 in all sites.
2. **Health Boards** to ensure robust and accurate data capture and monitoring systems to measure performance, outcomes and plan to capture annual patient experiences effectively.	Data capture is essential to support improvement, the resilience in HB's needs to be improved to ensure timely data capture and input into the SSNAP data set. Health Board's (HB) are recommended to ensure they do not have a 'single point of failure' in the data input and validation process. The SSNAP auditors groups will support the All Wales process	No tolerance for missing data uploaded to SSNAP, resilience plans to cover sickness and leave. The NHS executive are supporting improvement from tertiary centres. HB are asked to identify opportunities for electronic data capture to improve stroke efficiency
3. Health Boards ensure there is a robust governance structure for stroke with a regular Health Board wide meeting that focuses on performance and quality	Health boards are required to have good governance structures in place which amounts to: Stroke steering/management group including executive level support. Monthly operational	Rolling 12 months of calendar invites to both steering group and operational meetings. Cancelled meetings to be re scheduled ToR for each group describing the minimum quorate.

improvement.	meetings at site level. The NHS executive P&A team will be part of these groups	
4. **Health Boards** to support the development of a Regional Working Partnership Framework with a focus on national agreements to provide solutions for workforce, information governance, and a 'Once for Wales' approach to service redesign and innovation implementation.	To implement the National guidelines and the quality statement regional working will be imperative to improving stroke care in Wales. There is a benefit to the principle 'Once for Wales' to adopt new service improvement	Cooperation in regional working will be a focus in all aspects of NHS strategy, stroke service improvement will be part of this bigger picture.
5. **Health Boards** to prioritise stroke services within the Integrated Medium-Term Plan to address workforce shortages and improve patient access and outcomes.	To ensure stroke care remains high in the Health board agenda it is essential that it is highlighted in the IMTP, this will help HB focus on the requirements of workforce and equitable access	All IMTP should include the HB plan for stroke improvement.
6. **NHS Wales** to continue to support a multi-lingual, multi-cultural, FAST/NESA campaign to raise awareness about stroke symptoms and prevention strategies.	Patient understanding of stroke is essential to quick recognition 'time is brain'. In Wales we fall behind on public messaging and local application of the major campaigns due to unclear funding principles	The ask is to have annual FAST campaigns supported by Public Health Wales, with local HB /regional campaigns where the service is impacted for example AB reconfiguration of services HB are asked to update their Web sites and social media to reflect the 2023 stroke guidelines and local pathways

Reference	Reccomendation	Progress	Responsibility	Current Metric (if applicable)	Further notes
HEIW - PFR 50	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Complete	**Stroke Directorate (Incl. Nursing)**		Use of Stroke Hospital Internal Transfer Watchlist to map demand through ED and HASU
HEIW - PFR 20	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED	Complete	**Stroke Directorate**	Percentage of patients who were assessed by a nurse trained in Stroke Management within 24h: 63%	Data referenced: SSNAP Quarterly Report April - Jun '23 Bleep carried by Stroke CNS Front End Team and is covered Mon-Fri 07:00 to 19:00 Expansion of hours planned after maternity leave ends for significant proportion of the workforce after summer 2024
HEIW - PFR 48	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Complete	**Stroke Directorate** **Patient Flow**		Patients awaiting transfer to YYF Rehab routinely use the Discharge lounge Need clarification as to whether this constitutes as still on the pathway as reccomended by GIRFT 5
HEIW - PFR 31	Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records	Complete	**Stroke Directorate**	2.50%	Good links with Bristol SMH, expect to see further increase with BRAINOMIX
GiRFT 5	Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.	Complete	**Stroke Directorate**		Daily board rounds at 09:00 and 14:00 (pre and post ward round). Updates recorded on watchlist and patients cohorted into categories: Home, Stepdown, Investigations, Not MFFD/T etc.
HEIW - PFR 25	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	In Progress	**Stroke Directorate** **ED** **(?) Capture Stroke**		No bespoke solution available. Currently use Stroke Bleep & Watchlist combination which is helping. Consider use of Capture Stroke if funding can be identified
HEIW - PFR 39	All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.	In Progress	**Stroke Directorate**		Requires completion of Hazard log then implement toward end of Feb 2024 Implementation confirmed for Feb 2024
HEIW - PFR 26	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	In Progress	**Stroke Directorate** **Therapies**		Ongoing review of temporary move to YYF for Rehabilitation, as service is settled then opportunities for further development will be explored.
GiRFT 14	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance	In Progress		55.60%	Data referenced: SSNAP Quarterly Report Oct-Dec 2023 Weekly Audit in place
HEIW - PFR 1	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	Complete	**Stroke Directorate**		Appointment of a Program manager March/April 2024 Continued collab with National Network

Reference	Reccomendation	Responsibility	May 2024 Progress Update		February 2025 Progress Update		Notes
GIRFT 1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.	**Stroke Directorate**	**Complete**	Case Ascertainment: A Audit Compliance: C	**Complete**	Case Ascertainment: A Audit Compliance: A	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GIRFT 2	Commission an ESD pathway process flow map, it is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB. Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.	**Therapies - CNRS**	**Complete**	NA	**Complete**	NA	**May 2024:** A process map of the current pathway has been written and shared, this will now be reinforced with relevant demand and capacity data alongside a second version of the pathway that reflects the developments required to meet the Integrated Community Stroke Service model standards. **Feb 2025:** As above.
GiRFT 3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.	**Stroke Directorate Radiology**	**Complete**	SSNAP Rating : B	**Complete**	SSNAP Rating : B	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GIRFT 4	**ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation. Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome. Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.**	Stroke Directorate Patient Flow	**In Progress**	**SSNAP Rating : E 17.6%**	**In Progress**	**SSNAP Rating : E 19.6%**	**May 2024: Data referenced: SSNAP Quarterly Report Jul - Sep 2023. Needs organisational support as high priority** **Jan 2025 Stroke Pathway ringfenced as a result of CTM service collapse. Ongoing monitoring of patient flow direct to HASU from ED or AMU. Feb 2025: Data referenced: SSNAP Quarterly Report Jul-Sep 2024 (Increase by 2% since last reporting period)**
GiRFT 5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging should help to release bed capacity and increase access.	**Stroke Directorate Patient Flow**	**In Progress**	69.70%	**In Progress**	70%	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis. Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023. Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	**Stroke Directorate**	**Complete**	17.3% (75% of eligible patients)	**Complete**	10.1% (93.3% of eligible patients)	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 GUH Emergency Department & eLGH MIUs - GUH In_Hours_Thrombectomy_Pathway August 2023 (GUH).pdf - All Documents (sharepoint.com) GUH Emergency Department & eLGH MIUs - GUH OOH Thrombectomy_Pathway August 2023 (GUH).pdf - All Documents (sharepoint.com) **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke. Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	**Stroke Directorate**	**In Progress**	5/5 Recruited to cover 12 Hour service (note next steps challenges)	**In Progress**	5/5 Recruited to cover 12 Hour service	**May 2024:** 12 hour cover in place 7 days per week. Remaining nurses to return from Mat leave in Sept. **Feb 2025:** 12 hour cover in place 7 days per week. Maternity leave chalenges are still present with one CNS currently on Mat leave (coming back in June 2025) and another CNS starting Mat leave in April 2025.
GiRFT 8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.	**Emergency Department Therapies**	**In Progress**	81.00%	**In Progress**	82.9%	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 9	ABUHB to put a cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.	**ABUHB Corporate**	**Not Started**	NA	**Not Started**	NA	Course no longer exists
GIRFT 10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).	**Therapies - CNRS**	**In Progress**	NA	**In Progress**	NA	**May 2024:** Current community based stroke services will be mapped against the Integrated Community Stroke Service model identified in the GIRFT report and the 2023 Stroke Guidance with gaps and opportunities identified **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.	**Therapies CNRS**	**In Progress**	NA	**In Progress**	NA	**May 2024:** Requires completion & settlement of rehabilitation reconfiguration then Engage with Carers program manager **Feb 2025:**
GiRFT 12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf	**Stroke Directorate**	**In Progress**	NA	**In Progress**	NA	**May 2024 & Feb 2025:** Urgent Care: Improved technology & training ✓ ✓ Urgent Care: Increased availability of thrombectomy & thrombolysis ✓ ✓ Acute Care: Clear transfer pathways ✓ Acute Care: Seven day nursing & therapy services ✓ ✗ Rehabilitation: Comprehensive ESD & needs based community stroke rehab ✓ ✓ Rehabilitation: Seven day services ✗ Long Term: Comprehensive rehab and personalised care & support for as long as the person needs it ✓
GiRFT 13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients. Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance. Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	**Therapies CNRS**	**In Progress**	64.10%	**In Progress**	51.7%	**May 2024:** Data referenced: SSNAP Quarterly Report Jul - Sep 2023 The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day. **Feb 2025:**
GiRFT 14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.	**Therapies**	**In Progress**	NA	**In Progress**	NA	The current Therapies commissioned staffing for stroke across all professions is 51% below minimum National Standards.
GiRFT 15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach. Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	**Therapies CNRS Psychology**	**Complete**	NA	**Complete**	NA	**May 2024:** Very robust & long term service in place to offer support, both directly led by Psychology and patient led options depending on the individual needs. Update with Daryl Harris on 07/12/2023 that service does meet 'adequate' description as outlined in the GIRFT reccomendation and is infact an exemplar in Wales. **Feb 2025:** As above.
GiRFT 16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.	**Stroke Directorate**	**Complete**	92.10%	**Complete**	92.7%	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.	**Therapies**	**Complete**	76.90%	**Complete**	71.0%	**May 2024**: Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.	**Therapies Psychology**	**Complete**	96.40%	**Complete**	86.1%	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024
GiRFT 19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.	**Therapies**	**In Progress (Need Support)**	Link to Metrics	**In Progress (Need Support)**	Link to Metrics	
GiRFT 20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.	**Stroke Directorate**	**Complete**	Data TBC, reviews started in March 2024. Expect updated figures in next SSNAP publication.	**Complete**	35%	**May 2024:** Data referenced: SSNAP Quarterly Report Oct-Dec 2023 **Feb 2025:** Data referenced: SSNAP Quarterly Report Jul-Sep 2024

Row Labels	Count of Reference
Complete	9
In Progress	6
In Progress (Need Support)	4
Not Started	1
Grand Total	20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