Anuerin Bevan University Health Board Public Board Meeting

Tue 26 November 2024, 09:30 - 12:30

Conference Centre, St Cadoc's Hospital

Agenda

1. Preliminary Matters

Board Consent Agenda 26th November 2024.pdf (3 pages)

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence for Noting

Verbal *Chair*

1.3. Declarations of Interest for Noting

Verbal *Chair*

2. Consent Agenda Items

Verbal *Chair*

The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion

3. Key Updates

3.1. Update from the Chair

Verbal *Chair*

3.2. Update from the Chief Executive

Verbal *Chief Executive*

4. Patient Experience and Public Engagement

4.1. Children's Rights - Enabling Children's Voice and the Best Start in Life

Presentation *Director of Nursing*

4.2. Report from Llais, Gwent Region

Attachment *Regional Director, Llais*

Agenda _Item _4.2_Llais Gwent Region - Report for Aneurin Bevan University Health Board - Public Board Meeting - November 2024.pdf (13 pages)

5. For Approval

5.1. Winter Plan 2024/25 - Responding to Seasonal Pressures

Attachment *Director of Strategy, Planning and Partnerships*

- Agenda_Item_5.1_Winter Resilience Plan.pdf (21 pages)
- Agenda_Item_5.1a_Appendix 1_Science Evidence Advice_winter modelling 2024 to 2025.pdf (68 pages)
- Agenda_Item_5.1b_Appendix 2_System assurance readiness template.pdf (11 pages)

5.2. Improving Waiting Times for Planned Care and Diagnostics 2024/25 - Allocation of additional funding

Attachment *Chief Operating Officer*

- Agenda_Item_5.2_Planned Care Funding Board Paper.pdf (9 pages)

5.3. RE:FIT Funding Opportunities

Attachment *Director of Finance and Procurement*

- Agenda_Item_5.3_REFIT.pdf (12 pages)

5.4. Quality Improvement Strategy

Attachment *Director of Nursing*

- Agenda_Item_5.4_Quality Improvement Capability Strategy.pdf (5 pages)
- Agenda_Item_5.4a_Appendix A_Quality Improvement Strategy.pdf (26 pages)

5.5. Compassionate Leadership Pledge

Attachment *Director of Workforce and OD*

- Agenda_Item_5.5_Compassionate Leadership Pledge.pdf (9 pages)
- Agenda_Item_5.5a_Appendix 1_Letter NHS Leadership Behaviours.pdf (2 pages)

5.6. Establishment of a Mental Health & Learning Disabilities Committee

Attachment *Director of Corporate Governance*

- Agenda_Item_5.6_Establishment of MH&LD Committee.pdf (4 pages)
- Agenda_Item_5.6a_Appendix A_Draft MHLD Committee ToR October 2024.pdf (10 pages)

6. Items for Discussion

6.1. Stroke Reconfiguration Update

Attachment *Chief Operating Officer*

- Agenda_Item_6.1_Stroke Reconfiguration Update.pdf (9 pages)
- Agenda_Item_6.1a_Appendix a_Patient Story Feedback.pdf (2 pages)

6.2. Management of General Medicine Patients at the Grange University Hospital

Attachment *Chief Operating Officer*

- Agenda_Item_6.2_Respiratory Gen Med Update.pdf (8 pages)

6.3. Focussed review of Children and Young People's Services and Performance

Attachment *Director of Nursing and Director of Public Health*

- Agenda_Item_6.3_Children and Young People Assurance Report.pdf (34 pages)

6.4. The Grange University Hospital and Hospital Network Model

Attachment *Director of Strategy, Planning and Partnerships*

- Agenda_Item_6.4_GUH System Report.pdf (6 pages)
- Agenda_Item_6.4a_Appendix A_Clinical Futures and Grange System Report.pdf (39 pages)

6.5. 2024/25 Performance Reporting

Attachment *Executive Leads*

a. Integrated Performance Report, Q2

b. Quality Outcomes and Performance Report, Q2

c. Financial Performance at Month 6

- Agenda_Item_6.5a_Quarter 2 Integrated Performance Report.pdf (5 pages)
- Agenda_Item_6.5ai_Appendic A_Quarter 2 Integrated Performance Report.pdf (46 pages)
- Agenda_Item_6.5b_Quality Performance Report - November 2024.pdf (6 pages)
- Agenda_Item_6.5bi_Quality Performance Report .pdf (57 pages)
- Agenda_Item_6.5c_Finance Report 24-25 M6.pdf (35 pages)
- Agenda_Item_6.5ci_Appendix A_Finance Report 24-25 M6_Additional Detail.pdf (35 pages)

6.6. Strategic Risk Report, November 2024

Attachment *Chief Executive*

- Agenda_Item_6.6 _Board Strategic Risk and Assurance Cover Report_Nov 2024.pdf (7 pages)
- Agenda_Item_6.6_Appendix A_Strategic Risk Dashboard and Assessments.pdf (42 pages)

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7. Consent Agenda

7.1. For Approval

7.1.1. Draft Minutes of the Health Board Meeting, held on 25th September 2024

Attachment *Chair*

- Agenda_Item_7.1.1_Minutes of Public Meeting Held On 25 September 2024.pdf (16 pages)

7.1.2. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

- Agenda_Item_7.1.2_Report on Sealed Documents and Chairs Actions.pdf (5 pages)

7.2. For Noting

7.2.1. Board Action Log with Updates

Attachment *Chair*

- Agenda_Item_7.2.1_Board Action Log_26 November 2024.pdf (3 pages)

7.2.2. Strategic Partnership Updates

Attachment *Director of Strategy, Planning & Partnerships and Director of Public Health*

a. Regional Partnership Board

b. Public Service Board

- Agenda_Item_7.2.2A_RPB Update.pdf (11 pages)
- Agenda_Item_7.2.2B_ PSB Update.pdf (4 pages)

7.2.3. Executive Committee Chair's Report

Attachment *Chief Executive*

- Agenda_Item_7.2.3_Executive Committee Chair's Report November.pdf (9 pages)

7.2.4. Key Matters from Committees of the Board

Attachment *Committee Chairs*

- Agenda_Item_7.2.4_Key Matters from Committees of the Board.pdf (20 pages)

7.2.5. An overview of Joint and Partnership Committee Activity

Attachment *Chief Executive*

a. Joint Commissioning Committee

b. NHS Wales Shared Services Partnership Committee

- Agenda_Item_7.2.5a JCC Update Report.pdf (5 pages)
- Agenda_Item_7.2.5ai_Appendix A_Highlight Report - JCC 17 Sept Final.pdf (6 pages)
- Agenda_Item_7.2.5b_Shared Services Partnership Committee Update Report.pdf (3 pages)
- Agenda_Item_7.2.5bi_Appendix A_SSPC Assurance Report 19 September 2024.pdf (5 pages)

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8. Other Matters

8.1. Any Other Business

8.2. Date of Next meeting

22nd January 2025

BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MEETING OF THE BOARD

AGENDA			
Date and Time	Tuesday 26th November 2024 at 9.30 am		
Venue	Conference Centre, Headquarters, St Cadoc's Hospital		
Item	**Title**	**Format**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence for Noting	Oral	Chair
1.3	Declarations of Interest for Noting	Oral	Chair
2	**CONSENT AGENDA BUSINESS**		
2.1	The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion		Chair
3	**KEY UPDATES**		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
4	**PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT**		
4.1	Children's Rights - Enabling Children's Voice and the Best Start in Life	Presentation	Director of Nursing
4.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
5	**FOR APPROVAL**		
5.1	Winter Plan 2024/25 - Responding to Seasonal Pressures	Attachment	Director of Strategy, Planning and Partnerships
5.2	Improving Waiting Times for Planned Care and Diagnostics 2024/25 – Allocation of additional funding	Attachment	Chief Operating Officer
5.3	RE:FIT Funding Opportunities	Attachment	Director of Finance and Procurement
5.4	Quality Improvement Strategy	Attachment	Director of Nursing
5.5	Compassionate Leadership Pledge	Attachment	Director of Workforce & OD

5.6	Establishment of a Mental Health & Learning Disabilities Committee	Attachment	Director of Corporate Governance
6	**ITEMS FOR DISCUSSION**		
6.1	Stroke Reconfiguration Update	Attachment	Chief Operating Officer
6.2	Management of General Medicine Patients at the Grange University Hospital	Attachment	Chief Operating Officer
6.3	Focussed review of Children and Young People's Services and Performance	Attachment	Director of Nursing & Director of Public Health
6.4	The Grange University Hospital and Hospital Network Model	Attachment	Director of Strategy, Planning and Partnerships
6.5	2024/25 Performance Reporting: a. Integrated Performance Report, Q2 b. Quality Outcomes and Performance Report, Q2 c. Financial Performance at Month 6	Attachment	Executive Leads
6.6	Strategic Risk Report, November 2024	Attachment	Chief Executive
7	**CONSENT AGENDA**		
7.1	**FOR APPROVAL**		
7.1.1	Draft Minutes of the Health Board Meeting, held on 25th September 2024	Attachment	Chair
7.1.2	Report on Sealed Documents and Chair's Actions	Attachment	Chair
7.2	**FOR NOTING**		
7.2.1	Board Action Log with Updates	Attachment	Chair
7.2.2	Strategic Partnership Updates: - a. Regional Partnership Board b. Public Service Board	 Attachment Attachment	Director of Strategy, Planning & Partnerships and Director of Public Health
7.2.3	Executive Committee Chair's report	Attachment	Chief Executive
7.2.4	Key Matters from Committees of the Board	Attachment	Committee Chairs
7.2.5	An overview of Joint and Partnership Committee Activity a. Joint Commissioning Committee	Attachment	Chief Executive

	b. NHS Wales Shared Services Partnership Committee		
8	**OTHER MATTERS**		
8.1	Any Other Business		
8.2	Date of the Next Meetings: • 22nd January 2025		
9.	**PRIVATE/IN COMMITTEE SESSION**		
	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*		

Llais Gwent Region – Report for Aneurin Bevan University Health Board, Public Board Meeting.

November 2024

To inform Aneurin Bevan University Health Board of current issues of concern, and positive observations, or public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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About Llais

We believe in a healthier Wales where people get the health and social care services, they need in a way that works best for them.

We are here to understand your views and experiences of health and social care, and to make sure decision-makers use your feedback to shape your services.

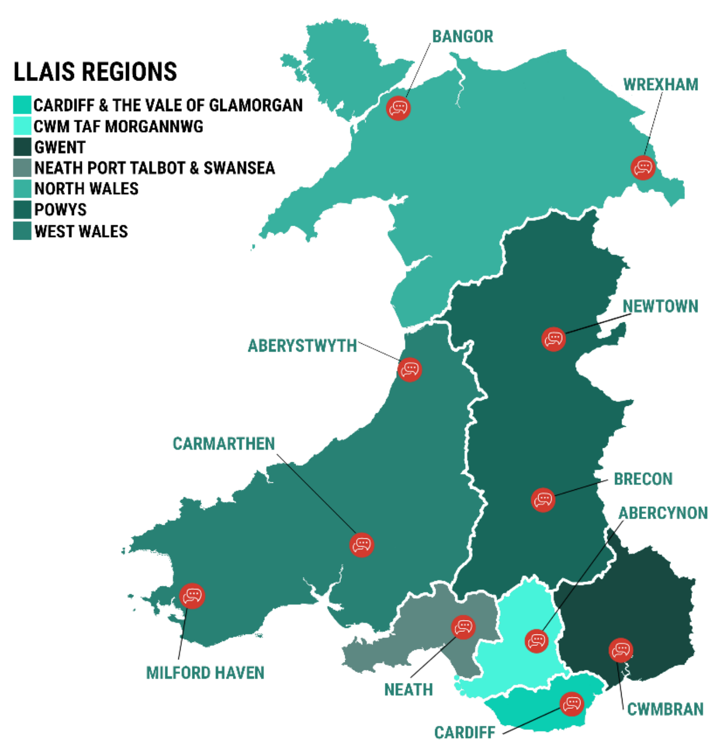
We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong, we support you to make complaints.

There are 7 Llais Regions in Wales. Each one represents the "patient and public" voice in different parts of Wales.



Introduction

The purpose of this report is to inform Aneurin Bevan University Health Board of current issues of concern and positive observations, and public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

Llais continues to work in respect of engaging with the population, scrutinising, and offering independent challenge to the NHS and social care, to monitor and consider routine and urgent service changes. We also continue to provide independent Complaints Advocacy Service.

A National Conversation: Llais strategic plan 2024-2027

We now have our first national strategic plan. This plan has been created using what we have been told by the people of Wales, by our staff and volunteers and other bodies and groups we work with.

When this plan was being created, we thought about our legal duties and responsibilities such as the Quality and Engagement Act 2020, Equality Act 2010, The Well-being of Future Generations Act 2015, The Welsh Language Standards 2016, The Socio-Economic Duty, the Public Sector Duty, and national plans and commitments such as the LGBTQ+ and the Anti-racist Wales Action Plan, as well as our remit letter.

Building on what we have learned in our first year, we have grouped things into five main priorities:[1]

1) Drive a national conversation about the future of health and social care services

2) Push for services that meet everyone's needs.

3) Work together better.

4) Help people and services to use technology in ways that work for them.

5) Grow and improve as an organisation.

[1] https://www.llaiswales.org/about-us/national-conversation-llais-strategic-plan-2024-2027

Llais Gwent Region

Local activities and feedback:

1. Public feedback from our Advocacy services

There were 85 contacts in September and October. 61 were concerns and 24 enquiries.

Of the 85 contacts, 18 have now been resolved and 67 are still active.

In particular there was an increase in concerns around Mental Health Services (reduction of care, long waits for treatment and threshold). We also received concerns about hospital care and treatment.

2. Representations that we have made or been involved in

We have a duty to make representations to health and social care services on behalf of our population when services may change or when we hear about health and social care performance matters that impact on people's experiences (positively or negatively). We might make these representations via formal letter, in emails or by attending planned service groups/meetings hosted by our health and social care partners.

Since September, we have been involved in or made **regional representations** about:

- Emergency Department handovers from ambulance crew and people's experiences of waiting in the Emergency Department.
    - Early insights: E-triage at Same Day Urgent Care Units. People have shared with us their struggles to use the new e-triage check-in system and in some instances no support by staff when needed. People who are digitally excluded report additional check-in difficulties. Llais have escalated to the health board for a response.
- ABUHB: Proposals for Respiratory Reconfiguration
    - Llais are awaiting updated information from the health board regarding reconfiguration at Nevill Hall Hospital. We

understand people are concerned about the future of services.

- ABUHB: Dental Access Portal
    - Llais has supported a soft launch of the Dental Access Portal which will launch on the 20th of November. This approach has been designed to manage public expectation, recognising that the launch itself does not create capacity.
- ABUHB: Sexual Safety by patients accessing health services
    - Llais were made aware of concerns in relation to sexual safety encountered by patients accessing health services. The Health Board informed us they have created a task and finish group, led by the Head of Safeguarding, tasking them with three specific responsibilities, these being:
        - Production of a Sexual Safety Policy
        - Production of a Dashboard
        - Development of an Action Plan

    Assurance can be sought that this concern is being monitored on an "All Wales" basis by the National Safeguarding Team which is hosted by Public Health Wales.

- Primary Care Services: Magor Branch Surgery, Senghenydd Surgery, Brynmawr Medical Practice, Pontypool Surgery & Bevan Health and Wellbeing Centre
    - Llais had conversations with the Primary Care Team about people's experiences, including access to services regarding the above practices.
- eLGH department/unit reconfiguration proposals
    - Presentation received by health board on the eLGH reconfiguration proposals, including early conversations of future service change in stroke services.
- ABUHB: Mental Health and Learning Disabilities 10-year strategy
    - Llais facilitated focus groups shaped to collaboratively develop MH and LD vision statement to feed into the refresh of the strategy.
- Torfaen County Borough Council: Arthur Jenkins Care Home
    - Concern has been raised by the local community regarding the potential closure of Arthur Jenkins Care Home. Llais is in communication with Torfaen Local Authority to ensure meaningful engagement is taking place.

Representation highlight:

In August, we made a representation to the health board sharing emerging concerns around maternity services, in particular early pregnancy loss.

In October, we received a response from the health board who have addressed our representation. They confirmed these concerns have also been identified through their own service user engagement forums.

The health board are taking steps relating to three areas of care: communication, information and informed choice. This is being addressed through their maternity improvement plan, and targeted training and education on civility, kindness, compassion, choice and consent.

3. Children and Young People

We have completed a full and thorough stakeholder mapping. This will ensure we connect with the right organisations with the right voice at the right time. To be noted, we will be moving forward a National Conversation and adopting the Gwent region as a pilot for our work with children and young people.

Llais met HIW in relation to their joint review with CIW and Estyn to explore how healthcare, education and children's services support the mental health needs of children and young people in Wales. Full report to be published November 2024.

During our engagement during September – October, young people told us that they struggled to access GP appointments and issues were raised about moving from child to adult mental health services. This will form part of our report following our transition from child to adult services in both health and social care survey.

4. Engagement in Gwent (September - October)

From September to October, we engaged with 457 individuals including 231 young people. We connected with people in community spaces, education settings, social care settings, and support groups.

We also completed visits to the following:

1) GP Exit Surveys at Ringland Health Centre:

61 people told us their experiences of accessing services at Ringland Health Centre. Using what people told us, we made representations to the Practice Manager to improve future services. People told us of their struggles to get through on the phone to make an appointment:

"Lovely staff, but appointment system is not the best. It has to be improved. Sometimes it is impossible to get through, so about my general concerns, I don't even try to contact. I try to sort myself out which sometimes leads to bigger issues"

5. Upcoming Activities

1) Llais Local: Blaenau Gwent

In November, we're planning focussed engagement in Blaenau Gwent. Our volunteers and staff will be in the community, speaking to people about Llais and gathering their insights on health and social care services. We will amplify the voices of Blaenau Gwent to inform the health board and local authorities, highlighting where improvements are needed to enhance future services.

2) Presentations

In November and December, we are receiving presentations on the following hot topics:

- WAST: Ambulance Service Performance and Activities
- Local Authority: Southeast Wales Emergency Out of Hours Social Services Support

3) Mental Health Services:

In response to what we have heard regarding Mental Health, in December 2024 we will launch a survey to find out people's experiences of accessing mental health services in Gwent. We will also speak to people at online sessions, one-to-one conversation and in group settings.

National Work:

1. Access to Dentistry in Wales

Llais are creating their policy position on access to dentistry to be announced November 2024. The position will be influenced considering our research combined with what we have been hearing and already know, and consideration of Welsh Government research and outcome from Senedd reviews.

2. Same Day Urgent Care Project

Across Wales Llais are concerned about people's experiences accessing Same Day Urgent Care:

1. People are experiencing long waits to receive emergency care.
2. People taken to hospital by ambulance are experiencing long waits for handover. This causes delays for those waiting for an ambulance in the community.
3. Waiting rooms are overcrowded and some people are having to stand, sit on the floor or wait in the car.
4. Some people are being put on beds in inappropriate areas (boarding).

Therefore, we wanted to understand people's experiences of accessing care in an Emergency Department, Acute Medical Unit and Minor Injury Units. We were present in these departments and held a national survey which was live from 30th September – 27th October. We held online and face-to-face patient experience sessions to maximise richness and understanding of impact. A report will be submitted to all health boards in Wales replaying what we heard.

3. Silly Rules – Breaking the rules for better care

In Collaboration with the Bevan Commission, we'll be launching the "Silly Rules" campaign. Silly Rules builds on the success of the 'Breaking the Rules for Better Care' campaign launched by the Institute for Healthcare Improvement in the United States in 2016. The campaign has since transformed how healthcare systems identify and address processes

that frustrate those who access care and professionals, ultimately improving outcomes, saving costs, and reducing waste.

We're launching the campaign across Wales, in both health and social care services. We want to hear from staff as well as the public, asking the question: "if you could break one rule for better care, what would it be?"

We'll be happy to answer any questions you may have about Silly Rules. When the results are gathered in January, after the survey closes, we will make any relevant representations based on trends and themes emerging from the feedback. We'll then look to communicate the outcome of the "Silly Rules" campaign with the public through working with you to identify where people's feedback has made a difference - and explaining why when rules can't be changed. This is an opportunity to pick up on rules, processes, systems and ways of working that aren't serving staff or people who access care and support, identifying where small changes can be made to make a positive impact and streamline services.

Thanks

We thank everyone who took the time to share their views and experiences with us about their health and social care services and also sharing their ideas with us.

Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Winter Resilience 2024/25**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Executive Director Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Chris Dawson-Morris, Deputy Director Strategy, Planning and Partnerships

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

This paper sets out how the Health Board, with partners, will respond to the challenges which will be faced by the health and care system over the coming months. Building system resilience is part of the core focus of the Health Board and activity in core programmes, such as the Six Goals for Urgent and Emergency Care, as well as work through the Regional Partnership Board all support meeting the additional challenges of the period. Therefore, this plan should not be considered in isolation of the wider work programme of the organisation set out in the Annual Plan. Partnership, whole system working, transparency and action will be essential in planning and meeting the tasks that lie ahead.

Cefndir / Background

The health and social care system continues to operate under sustained and significant pressure and continues to balance responding to urgent and emergency

care demand with recovery and tackling backlogs for treatment. Respiratory illness will again pose a threat this year with further anticipated waves of COVID-19, influenza and Respiratory Syncytial Virus peaking in December and early January.

Against the backdrop of increasing demand driven by an aging population and staffing challenges, services across the region will be required to meet the health and well-being needs of both staff and the population in evermore complex and pressured circumstances.

Within this context, this plan sets out the actions that will provide focus, enabling flow and considering best utilisation of capacity. In addition, it sets out work in partnership between health and social care through the Regional Partnership Board, to support the system and deliver preventative activity. Importantly, this plan builds upon local urgent and emergency care plans, delivered through the Health Board's Six Goals for Urgent Care programme, which focuses upon enhancing capacity within the community and providing alternatives to admission. Recognising the financial situation of the organisation this plan highlights the risks and opportunities in delivering winter actions to the financial plan.

It is frontline staff who will once again have to bear the challenge of meeting the needs of our citizens in pressured circumstances and this plan seeks to provide assurance to teams that we are doing all we can to support them in acting in the best interests of our citizens.

Context for Winter 2024/25

National Winter Scenario Modelling

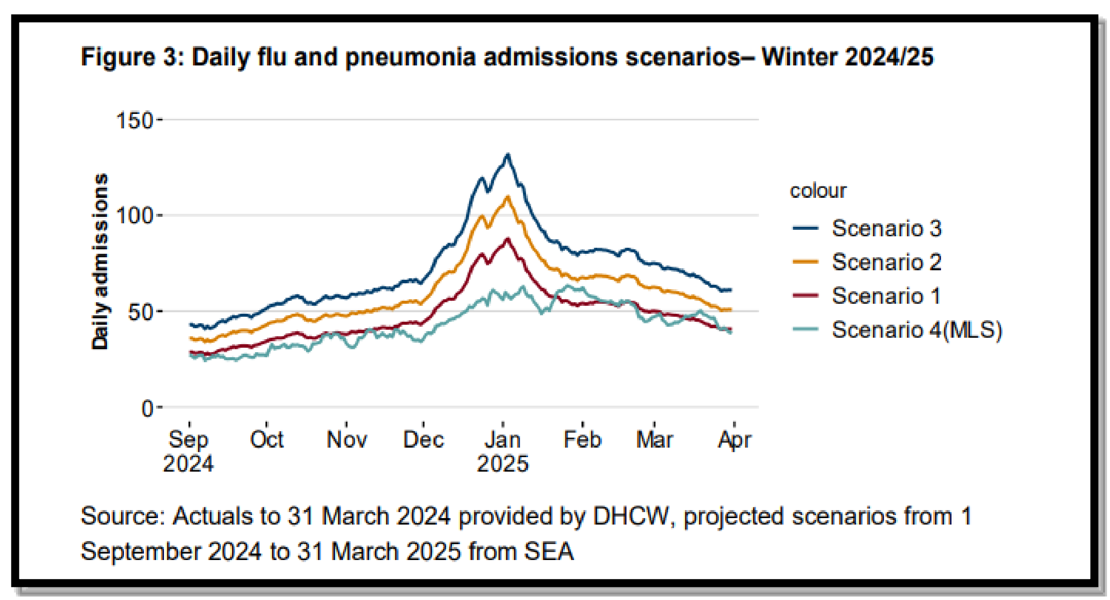
Winter respiratory viruses cause increased demand on the NHS in Wales each year. However, there is always uncertainty about how these viruses will impact the healthcare services and demand can vary depending on a variety of factors, for example if several viruses peak at the same time or how well a vaccination matches the virus in circulation.

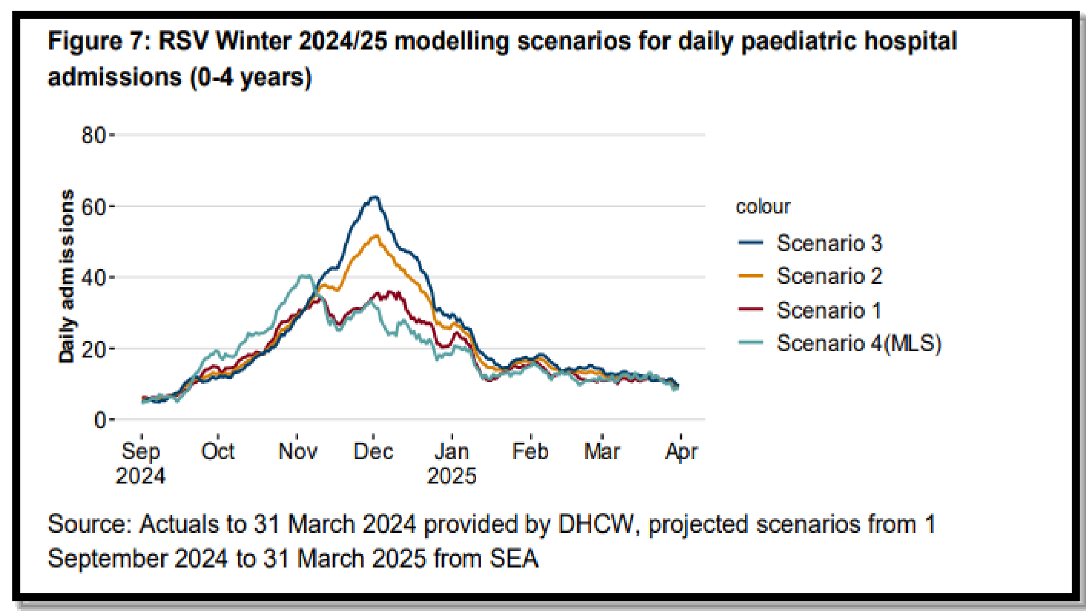
The modelled scenarios in this paper include analysis of historical data used to project forward and estimate the pressures that could be seen by an increase in respiratory viruses and other factors which are typically more prevalent in the winter months. National modelling (focusing on influenza (flu) and pneumonia, Respiratory Syncytial Virus (RSV) and COVID-19) has been used to feed into local data.

Key messages from national modelling:

- Flu and pneumonia modelling scenarios provided by Welsh Government have peak national admissions ranging from 63 to 132 daily admissions for winter 2024/25. The peak in the occupancy scenarios for patients admitted due to influenza ranges from 441 to 1,058 nationally.
- RSV paediatric admissions during the non-pandemic years peaked between 6th November and 2nd December.
- Four scenarios have been provided by Welsh Government for COVID-19 admissions.

- Combined scenarios assess the collective impact of flu and pneumonia, RSV and COVID-19. In the most likely combined scenario, flu admissions contribute more than 50% of total admissions after January 2025. The daily admissions most likely scenario is expected to peak at 126 admissions in the first week of January 2025 (3rd January 2025). The most likely hospital occupancy scenario peaks at 896 beds occupied (nationally) on 13th October 2024.
- The combined worst-case scenario estimates a peak of 262 daily admissions on 11th December 2024 and peak daily bed occupancy of 2,485 on 21st December 2024.
- The charts below summarise that national level modelling done against different scenarios for flu, RSV and covid





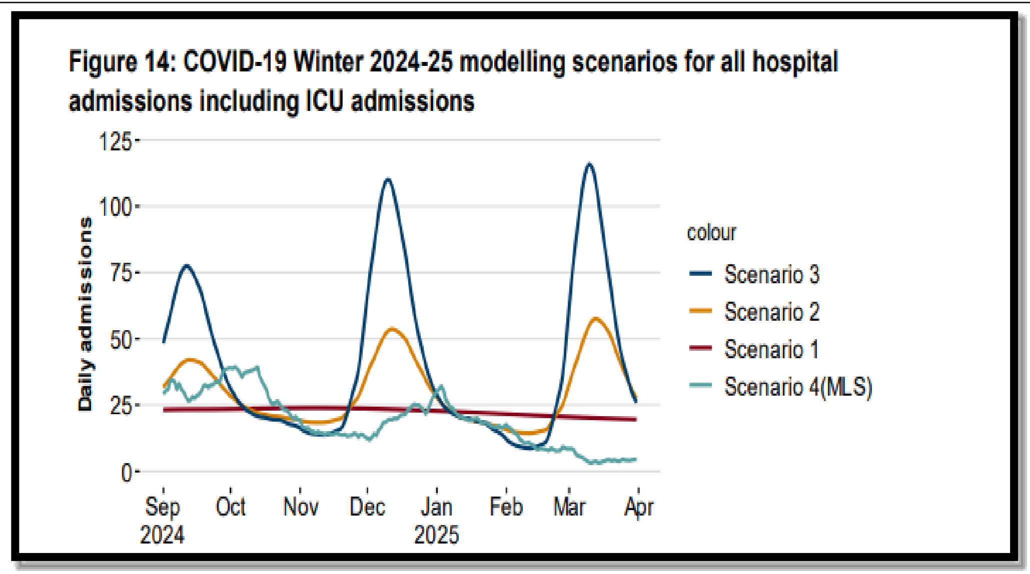


Figure 14: COVID-19 Winter 2024-25 modelling scenarios for all hospital admissions including ICU admissions

Source: [Science Evidence Advice: winter modelling 2024 to 2025 (gov.wales)]() **Appendix 1**

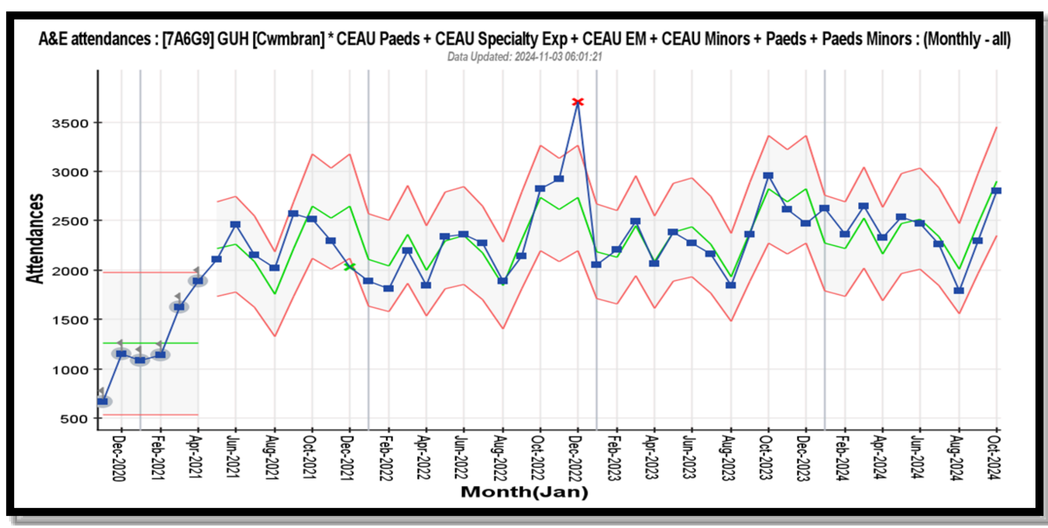
Current Status of Acute Respiratory Infection

The Heath Board services are beginning to see very small numbers of new influenza cases detected each week alongside high numbers of new RSV detected and the trend is increasing. COVID-19 had been circulating at higher levels but has been on a declining trend since the beginning of November 2024.

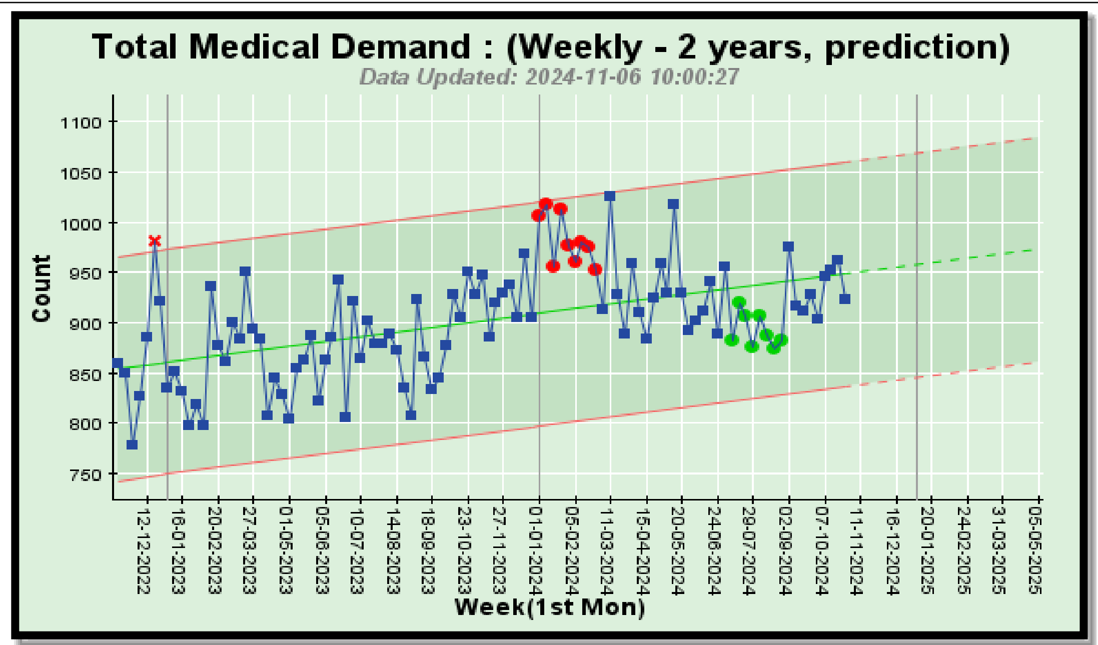
The national modelling provides an indication to support planning for Winter. It is also important to consider current service demand and pressures in order to fully assess the potential need this winter.

Current Service Demand

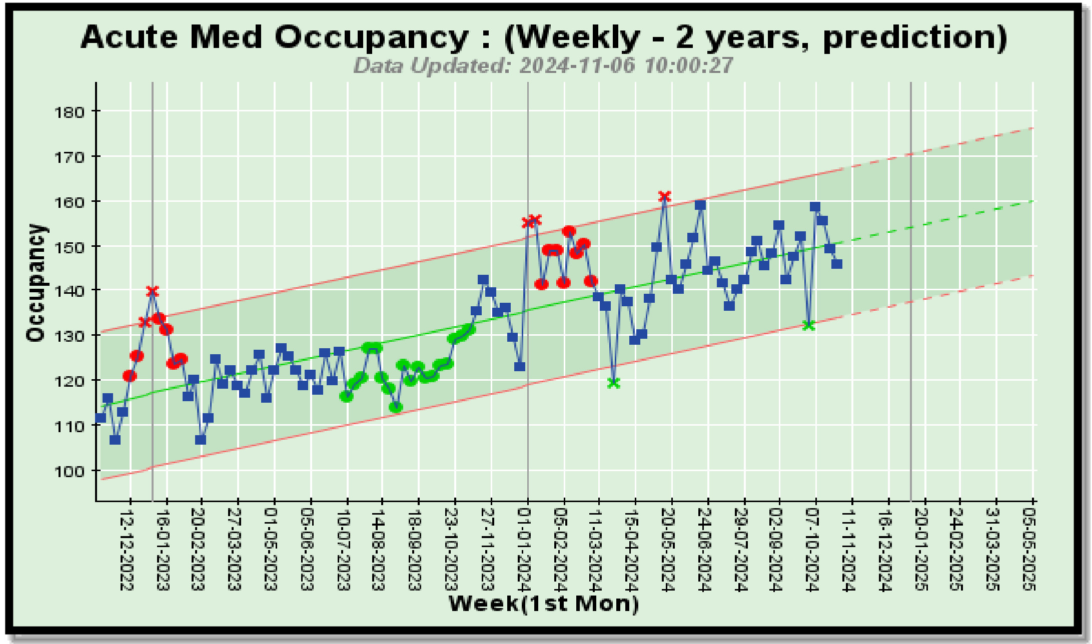
Children's Emergency Assessment Demand is broadly following predicted demand, however there are more notable fluctuations associated with summer and winter months. This aligns with forecasted models for RSV.



Acute Medical Demand is increasing at a rate of an additional 2.4 patients per week, locally settling at around 960 per week.



Acute Medical bed occupancy has stepped up this year from 120 to 150 beds per week. As can be anticipated with an aging population and the impact of worsening health inequality.



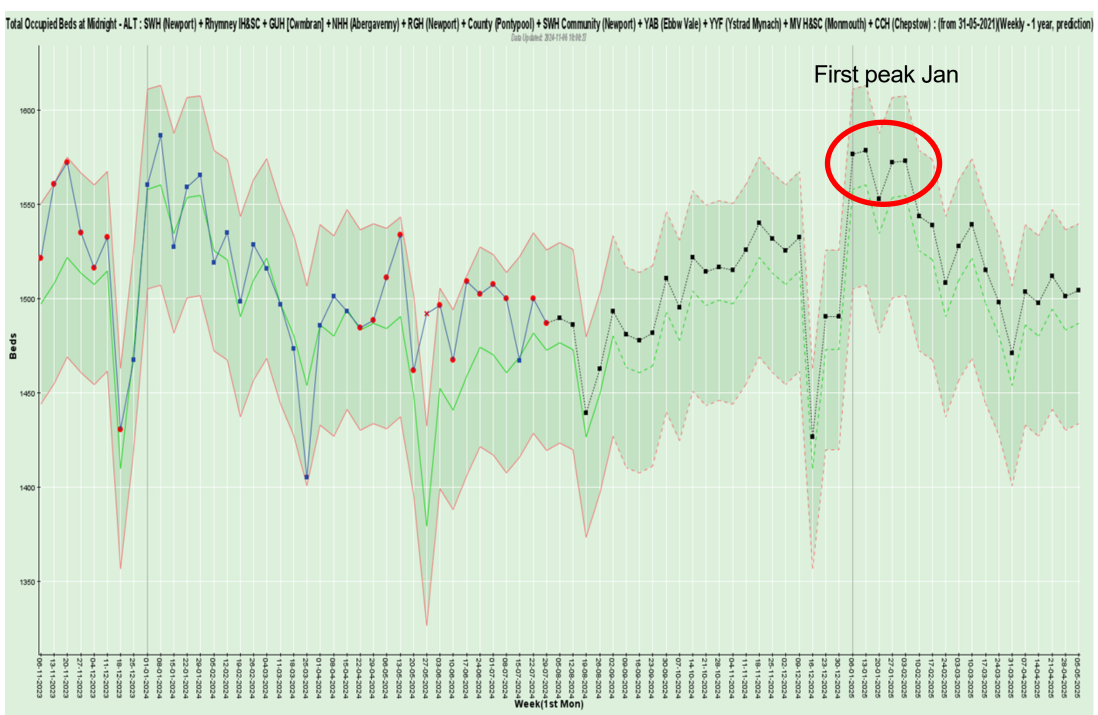
Forecasted Hospital Bed Demand

Combining the respiratory scenarios provided by Welsh Government and insight into the current system performance allows for the forecasting of potential bed requirements for the Winter period. This modelling has been tested via Executive team and the Winter Delivery Group.

The key messages for the Health Board modelling are:

- The Health Board bed base as of the 14th November is 1529 beds
- Bed occupancy is expected to peak during the second week in January 2025 at 1,579, with a range of 1,505 – 1,613,

- After a decrease in the third week of Jan (to 1,553), there is a second peak at the end of the month and the beginning of February to near identical levels of occupancy of 1,573 (range = 1,501-1,608).
- Occupancy then trends downwards through February to 1,508 (range = 1,437-1,544), before a spike through to the second week in March to 1,539 (range = 1,468-1,574).
- A further downward trend is projected through the remainder of March to 1,471 (range =1,401–1,507) at the end of the month, with occupancy stabilising at around 1,505 in April.
- The model shows a decrease in occupancy during the final 3 weeks of Dec before a sharp rise up to peak winter levels in the new year.



The challenge for this winter period is for the system to meet the demand equivalent to a range of between 85 and 130 beds hospital beds. The upper end of this forecasting accounts for the impact of potentially closed beds due to infection prevention control measures and limitations in the ability to utilise surgical beds for medical capacity due to emergency surgical demand and focussed work to meet planned care targets.

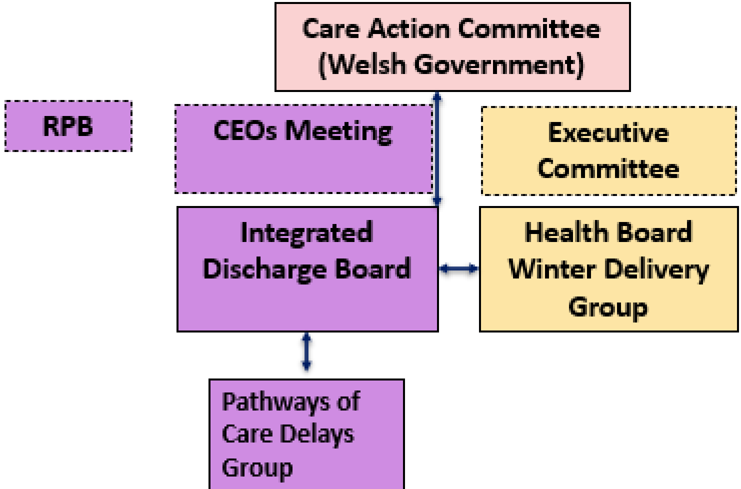
Asesiad / Assessment

Approach to Governance and Escalation

In order to meet the demands of the winter period it will be important the infrastructure to provide effective decision making, oversight and escalation are in place. Within the Health Board and across the system, mechanisms are being put in place to provide clarity of decision making and oversight.

Recognising the additional pressures of the period the Health Board has agreed to streamline its governance for the period into a Winter Delivery Group. Across the partnership space, the RPB has agreed to the Integrated Discharge Board providing the tactical system leadership for the period. Local Authority partners

have also agreed to a regular meeting of executives to provide a clear escalation point and enable rapid decision making.



<u>Winter Delivery Group (Health Board)</u>
The Winter Delivery Group will replace Six Goals Programme and eLGH/inpatient board meetings for the period. It will provide tactical coordination of winter actions within the health board.

This group will track progress against a core set of metrics

Measures
Vaccination rates – Public and Staff
Length of Stay
Bed Occupancy
Delayed Pathways of Care
ED Demand
Staff Absence

The Winter Delivery Group will also track demand against the model.

<u>Integrated Discharge Board</u>

The Integrated Discharge Board will oversee implementation of system actions across health and social care including the 50 day winter resilience action plan. The group will prioritise tactical response to system pressure and coordinate responses to the Care Action Committee. The Integrated Discharge Board will also be allocated resources from regional funding slippage as delegated from the Regional Partnership Board.

<u>Pathways of Care Review Group</u>

In line with Care Action Committee expectation, a Pathways of Care Review Group will be established to provide a weekly operational forum to review pathways of care delays. The group will also agree operational mitigation plans in relation to delays identified.

Actions to meet the challenge

The Winter plan is focused around:

1. Health Board actions – primary and community services and hospital system,
2. Partnership Actions - the 50 day challenge and RPB actions
3. Prevention actions – vaccination and communication
4. Resources – the focus of workforce and OD and financial implications

As set out, the challenge this winter is to mitigate the potential equivalent of between ***85 and 130*** hospital beds. The following section sets out the intended actions to support this mitigation.

Whilst some assessment has been made of the potential bed impact, realising this is dependent on many factors and fluctuations in demand. Maintaining flow through the system will be key to meeting demand this winter.

A summary key parts of plan is set out below:

Action Area	Potential Bed Equivalent
Health Board actions	
Primary and Community Care	15 (Expansion of Beds + Impact of admission avoidance and discharge activity)
Hospital System Actions	34 – 54 (Surge Capacity, impact of operational changes + increase as Discharge Lounge comes online)
Partnership Actions	20 to 50 (Target Delivery is 25% reduction in Delayed Pathways of Care which would be 58 based on September census)
Prevention Actions	Vaccination programme and communications

Actions against these headings are summarised below, the detail of which is pulled together in a detailed Gantt chart with milestones and leads. This, alongside the metrics will be tracked via the Winter Delivery Group.

1. HEALTH BOARD ACTIONS

Health Board actions include actions in Primary and Community care alongside hospital system actions. Increasing capacity in primary and community care in the winter period will enable individuals to maintain support within their community and prevent deterioration to a higher level of care. It should be noted that the health board community teams also contribute heavily to the partnership actions set out in a later section. Hospital based actions include enhancing models of care, actions to improve flow and safety and additional capacity.

The Health Board is also introducing new operational framework to improve flow management through the winter and there are bespoke surge plans required and in place for services such as paediatrics and critical care.

Action	Ambition	Anticipated Impact
PRIMARY AND COMMUNITY ACTIONS		
Resilient Community Resources - Rapid response capacity	Rapid response 8am-8pm model and consideration of weekend Consultant Community Resource Team support in line with GP demand. This is funded from Further Faster.	Increased number of referrals and reduced risk of admission to hospital later in day and on weekends
Resilient Community Resources - District Nursing Capacity	Increase District Nursing capacity and capability over the winter period to improve resilience, plans to appoint 10WTE B4 Health Care Support Worker to provide additional resilience. This is funded from Further Faster.	Increase weekend activity to 60% of core in order to support weekend discharge/admission avoidance Provide planned overtime at Bank Holiday periods to continue activity across all CRT teams
Urgent Primary Care	Robust mobile GP support available during out of hours period, with scoping of daytime hybrid model within	Additional home visiting capacity during daytime hours
Frailty Direct Access Beds	Increase in Direct Access Pathway (DAP) beds to support increase in number of people admitted through the community CRT referrals pathways. This is delivered from reconfiguration of existing resource-resource neutral	Pilot initially at YAB from November, reconfiguration of beds to flip 8 community beds to DAP beds to better match demand providing a reduction in unnecessary admissions to the Grange/eLGHs
Integrated pathway at The Grange front door	Improve operational alignment of Community Admission Avoidance Team, Home First and Acute Frailty Response teams. This is reconfiguration of existing resource.	Increased admission avoidance for older / frail population Increased capacity as a result of working to a single MDT model
Acute Frailty Response	Expansion of the service to 7 days in-reach to The Grange from 5 days - funded via Further Faster monies	Increased admission avoidance for older / frail population, in particular on weekends
HOSPITAL SYSTEM ACTIONS		
Action	**Ambition**	**Anticipated Impact**

Emergency Department Staffing Resilience	Recruitment of Six additional Emergency Department Consultants – funded via agreed business case	Ability to improve patient wait to be seen times –
Pilot of Medical SDEC first	During November 2024, test concept of Medical patients having initial assessment in SDEC first as opposed to Medical Assessment unit – resource neutral	Increase the number of medical patients seen in SDEC and increase assess-our rate
Discharge Lounge Capacity	Procurement and implementation of a discharge lounge at The Grange in line with approved Business case	Benefits of additional capacity at GUH to start being seen towards end of winter 24/25 – adding an extra 10 beds and 15 chairs
Ambulatory Surgical CEPOD (emergency theatre list)	Pilot of ambulatory day case pathway for patients requiring emergency surgery, allowing for prompt treatment, improved patient experience and overall system flow. – resource neutral	Increased number of cases operated on day of admission for selected treatments (abscesses, lap appendix) - reducing hospital length of stay.
Enhanced Respiratory Support to 999 / 111	Pilot enhanced support to respiratory patients in the out of hours and weekends by scheduling of patients into Respiratory Ambulatory Care - pilot resource neutral	It is anticipated that this could be beneficial to 1 – 2 patients per day avoiding ED / Assessment Unit Attendance
DVT Clinic Expansion	Review right sizing of demand to release Acute Medical unit Capacity, expand service hours to meet demand - resource neutral	Improved patient experience and additional medical assessment unit capacity
Additional capacity for Paediatric Emergency Assessment	Pilot increasing opening hours of 'Fox pod' Paediatric assessments for primary care expected patients -	An additional 3 hours capacity to 11pm . Improved patient experience and reduction wait to be seen
Additional Winter surge capacity	Increase winter surge bed capacity in line with modelling. Detailed work ongoing to identify capacity and workforce models – dependent on funding secured via RIF slippage	Up to 40 beds to come on line, in line with modelling from January 2025
Total Potential Bed Mitigation		49-69

Operational Framework

The Health Board's Operational Framework will be a key mechanism in the management of demand peaks and service escalations, it is designed to enhance

patient care quality and safety by addressing systemic challenges in patient flow and ambulance handover times. The framework aims to ensure timely patient handovers from ambulances to hospital services, particularly during periods of high demand and seasonal peaks by clearly setting out the expectations of all parts of the system.

The framework outlines necessary steps to ensure patient safety, minimise risks, and normalise operations post-escalation. It details the roles and responsibilities of staff across four key areas: Pre-Hospital, Acute Front End, Transport, and On-Call.

- **Pre-Hospital**: Focuses on optimising patient flow in community settings.
- **Acute Front End**: Aims to improve efficiency in emergency departments, medical assessment units, and surgical assessment units, emphasising timely patient reviews and discharges.
- **Transport**: Discusses services provided by the Welsh Ambulance Services NHS Trust, including emergency medical services, inter-site transfers, and non-emergency patient transport.
- **Effective Discharge Planning**: Involves clear communication with patients and families, timely preparation of medicines, and coordination with nursing and residential homes.
- **Planned Care Capacity:** Identifying times where escalated action is required and decisions may have to be made in relation to the balance of risk between urgent and planned services. To support this, the above Operational Framework escalation plans set out processes for decision making should this be needed.
- **Escalation process:** managing increased demand and operational pressures, ensuring patient safety and system efficiency

The framework is being tested throughout November across all sites with Executive leadership support.

In addition to the actions outlined above and in line with best practice there are specific contingency plans are in place for services such as Critical Care and Paediatrics as detailed below:

Department	Capacity Plan
Critical Care	Plans have been worked up within the Grange Hospital to expand up to a total of 84 ICU beds in the event of a full surge (60 patients in ICU footprint and the remainder across Cardiology and Theatres recovery)
Paediatrics	RSV Paeds surge plan created to enable expansion of capacity within Paediatrics at GUH In the event of a child needing to be taken to a PICU in UHW or Southmead, the child would be stabilised in the HDU space within the GUH before taken via WATCH ambulance to the relevant tertiary centre.

2. PARTNERSHIP ACTIONS

The challenges set out in the modelling will be reliant on effective working with partners across Gwent. The partnership plan is made up of actions already in train or planned via the well-established System Resilience Plan of the RPB plus new

commitments made more recently in response to the Care Action Committee's 50 Day Challenge. The RPB received the plans set out below in its meeting of 19th November.

The **System Resilience Plan** actions have traditionally been managed through the   Gwent Adult Strategic Partnership (GASP) which has delegated authority from RPB to manage this funding pot from RIF. Many of the schemes have been funded on an 18 month basis up to March 2025.

In addition to the above actions, Welsh Government has required Regional Partnership Boards to participate in the **50 Day Integrated Care Winter Challenge** with the aim of accelerating evidence based high impact actions that are proven to work but are not standardised across regions to further bolster system resilience in the lead up to the turn of the year.

Ten best practice interventions have been identified through gathering learning from across Wales as well as other parts of the UK. Some actions will accelerate or spread commitments already underway in the System Resilience Plan.

The ambition of Welsh Government is for a 25% reduction in the longest pathways or care delays by 31st December 2024. Based on the Delayed Pathways of Care Census data from September 24 this would be equivalent to a reduction in the number of delays by 58 for the Health Board.

The table below summaries the actions of the System Resilience Plan and the 50 day actions

Partnerships actions funded with through System Resilience monies of RIF		
Action / Project	**Ambition**	**Anticipated Impact**
Step Closer to Home (SCTH) - Ad Hoc Spot Purchasing	The SCTH aims to support patients who are waiting for 3-4 domiciliary care calls per day to enable discharge from the hospital.	• Sustained length of stay reduction. • Acute hospital bed capacity - reduction in medically optimised patients waiting for discharge.
Step Closer to Home - Hospital to Home (H2H)	The project facilitates early discharge and provides home-based care with a dedicated team of healthcare support. The project also assesses and provides support for people outside of the hospital environment, preferably in their own homes with personal care, mobility, meal preparation and medication prompting until longer-term support can be arranged.	• Sustained length of stay reduction. • Acute hospital bed capacity - reduction in medically optimised patients waiting for discharge. • Hospital admission prevention through home visit assessment and intervention.

GWICES	The project employs an additional member of the team - GWICES Equipment Technician - to improve assessment turnaround, equipment reuse and tracking resulting in speedier discharges.	• Suitable adaptation/equipment to improve the physical and mental health of people and their Carers. • Improved discharge times, fewer bed days, and more single-handed packages through effective equipment delivery and turnaround.
ED Well-being and Home Safe Service	The project (British Red Cross) enhances the ED experience and post-discharge transitions, offering emotional support, optimising patient flow, and connecting to community services.	• Improvements in patient flow, higher discharge rates, enhanced resource allocation, lower readmission rates, stronger community connections, and a focused commitment to patient-centred care. • Number of people supported target of 4000 individuals supported per month. This figure includes the support already available via core RIF funding.
Community Resource Team (CRT) Pharmacy Expansion	The project provides medicine reviews, medicine deprescribing, home visits and discharge planning. SRP support has allowed the service to expand to the whole of Gwent and develop the service to take on responsibility for providing pharmacy services on wards in County and Chepstow Hospital sites which will positively affect patient flow and discharge. The project also provides home visits to frail patients identified through HRAC criteria in collaboration with GP practices.	• Creating a Gwent-wide service - expanding delivery to Monmouthshire CRT and increasing support to the Blaenau Gwent CRT. • Expert linkage to the right services. • Improved discharge at County and Chepstow hospitals. • 1,000 Rapid Medical / Nursing / HRAC patients. • 100 Reablement patients per annum when operational.
Falls Response Service Expansion	The project includes an expansion of the Gwent WAST Falls	• Dedicated regional falls response service overnight.

	Response Service (FRS) in two ways: 1. An additional daytime vehicle to the current one operating across Gwent. (This is not currently operating). 2. The addition of night support, provided by St John Ambulance. Will link with action sin 50 day plan	• Reduced conveyance and hospital admission. • Timely referrals to local teams including Community Resource Teams (CRT) and Rapid Medical to continue supporting people at home and improving independence. • A reduction in long-lay deconditioning.
Hospital to Healthier Home (H2HH) Expansion	The project offers rapid home adaptations for patients leaving the hospital due to housing issues. The project expands support and secures flexible funding for complex cases, aiming to enhance patient independence and reduce readmissions.	• The H2HH project will support 50 individuals monthly, with a primary focus on expediting rapid adaptations for safe hospital discharge within 2-3 working days. • Follow-up calls conducted within 28 days post-case closure to reduce readmissions and foster long-term home independence. • Ongoing housing interventions address individual client needs, thereby creating safer living environments.
Balancing Rights and Responsibilities Training	The project delivers a training and mentorship programme to enable a cultural shift across health and social care, ensuring the right conversations are held by the right individuals, and barriers are removed.	• Removing barriers to support seamless working, ensuring the right individuals have the right conversation with individuals. • Enable a cultural shift across health and social care, ensuring the right conversations are held, and barriers removed.
YYF Trusted Assessor – Stroke Pathway	The project includes a Social Work Assistant who works with ward staff to screen and gather stroke pathway patient information for all the Gwent local authorities to facilitate discharge.	• Accurate sharing of information with all Gwent LAs to support timely discharge. • Compliance with stroke pathway.

50 Day Challenge Actions		
	High Impact Intervention	**Summary of key actions**
1	**Optimal Hospital Flow Framework**	• Optimal ward focus on 3 wards at RGH to embed flow framework • Operational framework pre-launch end of November multi-site approach • Senior nurse allocation to sites leading framework • Embedding of D2RA principles, deconditioning leads
2	**7 day working for Health & Social care**	• Additional 10 HCSW to increase weekend CRT capacity • Frailty weekend pilot • Discharge lounge & hub 7 day model • 7 day acute frailty response from Jan 25 • Urgent primary care HCSW weekend coverage • RIF funded
3	**Undertake Decision Support Tool in the Community**	• Additional hospital to home capacity – RIF funded • Fortnightly integrated discharge board to oversee goals 5, 6 and 50 day plan, • Develop covid-19 pandemic initiative for care home support for patients with complex needs
4	**Integrated Navigation Hubs**	• Develop plan for a single integrated navigation hub encompassing Urgent Care, Urgent Primary Care • Frailty and health protection • Expand discharge hub model
5	**Regional Health & Social care weekly review of long LOS Patients**	• Action orientated weekly Pathway of care delay reviews with local authorities • Agreed joint weekly action plans • CWS2 roll-out to improve data accuracy, routine monitoring aligned to integrated discharge board
6	**Proactive management of 0.5% population at Risk**	• MDT approaches in three NCN areas • Risk stratification exercise to align EFI and sfn generated risk scoring • Future care plans approach to care homes • Winter support for respirator • Fracture liaison service
7	**GP enhanced Service rollout for care homes and HRAC**	• Increasing the proportion of care home patients with active future care plans • Care home direct access to urgent primary care professional line
8	**Trusted Assessor Model for all care Settings**	• Review of best practice models for leveraging such as YYF stroke ward trusted assessor model on behalf of 5 local authorities
9	**Home First default for all clinically optimised patients**	• Balancing right and responsibilities training/education roll-out • GUH front door services review underway encompassing home first, Acute frailty and therapies teams for improved 'one team' working • Re-enforcing 'what matters' communication and practice

10	**7 day community falls response**	• Workshop held on 11th Nov, involving ABUHB and WAST colleagues to explore opportunities for reducing conveyance to hospital • Agreement to review current support to care homes, with a view to improving our offer, referencing past schemes such as I-stumble • Agreement to map all current falls response services and associated funded streams,

The Integrated Discharge Board is the agreed local delivery vehicle for the 50 Day Integrated Care Challenge which will be held on a fortnightly basis.

The full Gwent RPB submission is attached in **Appendix 2**

3. PREVENTION ACTIONS

Winter Respiratory Vaccination Programme

Children under the age of 5 years have the highest hospital admission rates for flu compared with other age groups. Not only does the flu vaccine protect the children themselves, it also reduces the spread of infection by helping to protect family members, particularly elderly relatives, and others in the local community.

The vulnerable populations most at risk of adverse outcomes resulting from influenza are those 65 years and over and those in at risk clinical groups. However, there are specific cohorts, particularly vulnerable people in enclosed settings such as residents in care homes or patients in hospital, where the impact of flu is greatest.

The Primary Care and Community teams deliver the flu vaccination programme to the public, and an outline of their plan for each cohort is included within the table below. Mop up sessions through the vaccination service will also be offered following the success of this the previous year where both pre planned appointments and walk ins were offered through the centres as the season progressed.

A summary of key elements of the plan is set out below:

Cohort	Plan
Influenza vaccination for 2 & 3 year olds	GP practices are focusing on influenza vaccinations from September in line with CMO advice. Blaenau Gwent and Caerphilly North NCNs have been offering flu vaccination in Flying Start childcare and nursery settings.
RSV	The Health Board has completed the RSV catch-up campaign for pregnant women who are over 28 weeks gestation achieving the highest uptake in Wales. GP practices are commissioned to work with community midwives to offer vaccination to pregnant women when they reach 28 weeks apart from pregnant women who are registered with the 10 practices that have opted out who will receive their offer through the Health Board. GP practices are also commissioned to offer RSV vaccinations to the rising 75 year olds and a catch up campaign for adults aged 75 to 79 years will be commissioned in early 2025.

Antivirals	The Health Board has transferred health protection functions, including antiviral treatment, into the Urgent Primary Care directorate. Urgent primary care will therefore be able to prescribe influenza antivirals both for general prescribing for the treatment of influenza, and for prophylactic treatment necessary for the management of outbreaks in residential care settings and will be providing COVID-19 antiviral treatments.

Flu Vaccination Campaign

The Gwent Flu Vaccination target is 75% for each of the following patient cohorts:

- Aged over 65
- Under 65 at risk groups
- 2 to 3 year olds

In winter 23/24 the uptake was 75.6%, 42.1% and 49.6% respectively. As at the end of November, vaccination rates for the same groups stand at 42.6%, 15.6% and 37.78%. Action is continuing to drive up rates through primary and community services.

Staff Vaccination Programme

Vaccination of health and social care staff will protect themselves and the people they care for. Vaccination coverage amongst staff will also help ensure business continuity over the Winter by reducing staff related illness. Protecting our staff is of vital importance.

Staff flu vaccines will also be offered via Flu champions, Occupational Health, and pop-up clinics at staff events. Uptake rates will be monitored weekly and outreach clinics will be targeted at low uptake areas and activity will be monitored weekly.

The Health Board has identified and trained 212 flu vaccination champions across the system which has increased by 62 compared to last year. Staff flu vaccinations with be recorded and monitored on the Welsh Immunisation System. The Health Board Vaccination Service will be offering flu vaccinations "on-site" in care home in addition to the Community Pharmacy scheme.

Winter Communications and Engagement

An important element of the winter plan will be the communications activities with our staff, communities, and partners.

The Health Board will continue to lead the way on the use of Digital Communications, as well as more traditional methods of sharing important messages, to ensure widespread coverage of the population we serve.

Our Winter Communications and Engagement campaign will align with the Six Goals for Urgent and Emergency Care and include a particular focus on accessing the right healthcare services and celebrating our staff. We will further inform and

engage people on the unique configuration of NHS health services in the Gwent, as well as promoting the national Help Us Help You campaign.

The activities of our Health Board's Communications and Engagement Team will include:

- Communications through Health Board channels and local media to raise awareness and promote our work to discharge patients from hospital as quickly as possible;
- Live update videos and social media broadcasts from clinicians; including use of the new Health Board podcast 'Gwent Health Matters'
- Increased face-to-face and digital engagement with local people;
- Improving the health and wellbeing of residents through our Population Health communications and engagement;
- Ensuring our staff are well informed and supported in their roles; and
- Responding to comments and concerns, helping and reassuring people throughout the winter period, which will then also be used as insight to inform communications activity
- Utilising the Gwent Communications Hub to maximise on sharing of messages on partner platforms across Gwent both online and offline

The Health Board will continue to hold engagement events around Gwent to enable us to speak directly to residents and seek their views. Any feedback given will be recorded by our Engagement Team and fed back directly to the Health Board through a reporting system. Details of our engagement events are published and shared beforehand to ensure local people in each area are given the opportunity to come along and speak with us face-to-face. This will help to build mutual understanding and relationships with the communities we serve.

RESOURCES

Workforce & Organisational Development

Despite some success with recruitment and retention campaigns this year due to local and national skills shortages we continue to experience challenges with vacancies and higher staff absence during the winter months. The Health Board will continue to expedite and prioritise the actions within the People Plan 2021-25 and support our partners in delivery of the Gwent Workforce Board programme of work.

Supporting employee wellbeing over the winter will continue to be a priority. The Employee Wellbeing Service and Organisational Development will continue to host evidence-based initiatives that contribute to improving and protecting staff biopsychosocial wellbeing across the Health Board.

The 12-month accumulative sickness absence rate of 6.25% (September 2024) was lower than last year at 6.29%. This equates to 808 WTE staff lost per month through sickness absence.

We predict higher levels of absence over the winter period with sickness absence forecasted to peak at 7% in January 2025. This is based on current sickness, previous trends and local intelligence. This will result in increased reliance on

temporary staffing solutions through bank and agency including block booking agency workers.

To continue to support reducing our reliance on agency staff we will mitigate this by undertaking the following actions which are supported by the Variable Pay Reduction Programme:

- Continuation of data management and governance
- Administration review
- Fair transparent pay for substantive hours
- Enhanced roster management
- Recruitment
- Retention and Flexible Working Approaches
- Optimised models of care, role, and team design/job descriptions
- Absence Management
- Establishment control and vacancy management
- Job Planning

Finances

As outlined above there are already resources aligned to support the delivery of the RPB System resilience plans via GASP of circa £2m. To date there has been no confirmation of any additional funding provided for winter from Welsh Government. The RPB have agreed that any slippage in Regional Integrated Funding can be utilised to support winter capacity and resilience, this funding has been allocated to the Integrated Discharge Board to coordinate, as at November this amounts to £513k, further slippage from the RPB infrastructure funding is anticipated. The Health Board is assuming any further costs associated with additional capacity will be covered from this unallocated resource as there is no resource allocated in the financial plan.

Summary

This winter, our services will face many complex challenges underpinned by significant uncertainty.

Through undertaking the actions set out in this plan the organisation will endeavour to meet the challenges of the winter. The organisation will target the areas of greatest challenge and provide the best opportunity to ensure people access care and support in the right place, first time, whilst optimising effective flow through our system.
The extent to which the demand materialises will be proactively tracked via the governance mechanisms set out.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the context with which the Health System is operating, the winter forecasts and potential impact upon the system; and
- **ENDORSE** the actions planned to mitigate.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
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	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	As set out within the paper
Rhestr Termau: Glossary of Terms:	ED Emergency Department GP General Practitioner UPC Urgent Primary Care IMTP Integrated Medium Term Plan GUH Grange University Hospital CRT Community Resource Team RGH Royal Gwent Hospital YYF Ysbyty Ystrad Fawr NHH Nevill Hall Hospital STW St Woolos Hospital ICU Intensive Care unit SDEC Same Day Emergency Care DVT Deep Vein Thrombosis IPC Infection, Prevention and Control

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

Winter Modelling 2024/25

September 2024

Science Evidence Advice (SEA)

gov.wales

Providing evidence and advice for Health and Social Services Group on behalf of the Chief Scientific Advisor for Health

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Headline Results

Winter 2024/25 modelling scenarios for respiratory illnesses in Wales:

- **Influenza ('flu') and pneumonia** modelling scenarios have peak daily hospital admissions ranging from 63 to 132 for winter 2024/25. Admissions scenarios 1-3 suggest a peak in the first week of January (03/01/2025). Scenario 4 (the most likely scenario) suggests a smaller peak of 63 in the third week of January (26/01/2025). The peak in the occupancy scenarios for patients admitted due to influenza ranges from 441 to 1,058 and is estimated to occur in the second week of January 2025.
- **Respiratory syncytial virus (RSV)** modelling scenarios for winter 2024/25 have peak daily hospital admissions for 0–4-year-olds ranging from 36 to 63. Scenario 1 suggests a peak during the first week of December (07/12/2024) and scenarios 2 and 3 suggest a peak a few days prior to this (02/12/2024). Scenario 4 suggests an early peak in the first week of November (06/11/2024). The daily peak in the number of beds occupied by RSV patients aged 0-4 ranges from around 40 to 70 estimated to occur between early November and the first week of December 2024.
- **COVID-19** admissions scenarios 2 and 3 indicate there could be three COVID-19 peaks throughout the winter however, scenario 4 suggests two peaks and scenario 1 indicates a stable series with no peaks. Across the scenarios with peaks these range from 24 to 116 daily admissions. ICU scenarios predict peaks between 1 to 7 daily admissions
- **COVID-19** occupancy scenarios estimate a varying number of peaks, with the maximum of these peaks between 391 and 1,549 daily beds. Scenario 4, the repeat of last year's data suggests a peak of 520 beds in second week of October after which occupancy decreases throughout winter.
- **Combined scenarios** assess the collective impact of the flu, RSV and COVID-19. In the most likely combined scenario, flu admissions contribute more than 50% of total admissions after January 2025. The daily admissions most likely scenario is expected to peak at 126 admissions in the first week of January 2025 (3rd January 2025). The most likely occupancy is likely to peak at 896 beds on 13th October 2024.The combined worst-case scenario estimates daily admissions of 262 to peak on 11th December 2024 and daily occupancy of 2,485 to peak on 21st December 2024.
- **Care home residents** are more likely to be admitted due to winter viruses and COVID-19 than those who do not reside in a care home. In 2023/24, 5.83% of care home residents and 1.2% of non-care home residents were admitted due to flu.
- By examining the **international** picture as a means to estimate what we may see in Wales, the flu season is likely to be similar to recent years but with the potential to see increased cases compared to 2023/24.

Additional winter 2024/25 modelling scenarios (for respiratory illnesses and all causes) in Wales:

- The modelling scenarios suggest there will be a peak of 261 to 511 **emergency department (ED) attendances due to respiratory problems** per day in Wales over the 2024/25 winter period. Scenarios 1-3 suggest daily peaks in ED attendances in the last week of December (30/12/2024) and Scenario 4 suggests peak daily attendances in the first week of January (01/01/2025).
- The percentage of ED attendances (from all causes) that met the 4-hour target decreased from 92% in October 2019 to 70% in April 2024.
- Modelled scenarios suggest **monthly ambulance calls due to all causes** coded as red calls are estimated to peak at 5,923, and amber calls are estimated to peak at 25,979, with both peaks occurring in December 2024.
- Scenarios 1-3 suggest that the **daily ambulance calls due to respiratory illness** are likely to peak in the first week of January 2025 with peak values of 216, 270 and 324 daily ambulance calls. Scenario 4, which is the repeat of last year's data, suggests a slightly smaller peak of 190 daily ambulance calls in the same week.
- **Red ambulance calls due to respiratory illness** are estimated to peak during third week of December (17/12/2024) with a peak value of 70 calls (upper limit=79, lower limit=60) while amber calls are expected to peak last week of December (29/12/2024) with a peak value of 100 calls (upper limit=124 and lower limit=76).
- Modelled scenarios suggest there will be a peak of 30 to 138 **GP consultations for influenza-like illness (ILI)** per day in Wales over the 2024/25 winter period (0.95 to 4.34 per 100,000 people). The smallest peak in the scenarios (30 daily consultations or 0.95 per 100,000) is a repeat of the 2023/24 data. The three scenarios with the highest peak suggest the peak will be during the first week of January 2025. The scenario with the lowest peak estimates the peak will arrive in the last week of January 2025.
- All modelling scenarios suggest that the **paediatric bed occupancy** is likely to peak in November 2024 with peak values of between 271 and 419 occupied beds per day.

Additional context of NHS demand throughout winter 2024/25:

- **Referrals for any cause from a GP or other medical practitioner to hospital** for treatment in the NHS in Wales with a wait time of above 36 weeks was the highest during August 2022 when it reached a maximum of 271,165 in the data included in this analysis between September 2011 and March 2024. However, the number of monthly referrals has been increasing since September 2023 and reached 271,872 in June 2024.

- During a 72-hour period of **industrial action** by junior doctors in January 2024, 41% (22,258) of outpatient appointments and 62% (1,467) of surgical cases were cancelled or postponed.
- **COVID-19 Vaccine uptake** of the population of Wales aged 65 and above who have taken a COVID-19 vaccination (at least 1 dose in 2020/21 and a booster in subsequent years) has decreased from 97% in 2020/21 to 75% in 2023/24.
- **Flu vaccine uptake rates** among those aged 65 and over in Wales have been above 70% in recent years although uptake among those at risk aged below 65 is substantially lower. For both groups, uptake increased during the pandemic compared with winter 2019/20, but decreased again during winter 2023/24. In the winter of 2023/24, the flu vaccine uptake was 72% among adults aged 65 and above, and 39% among 6 month-64-year-olds at risk respectively.
- A survey question regarding whether people would accept an RSV vaccine offer showed, 44% would accept the offer, 14% would not, and 40% would need more information in order to make their decision.
- **Absences of health care workers due to flu** as a percentage of absences due to all sickness between 2013/14 and 2022/23 seasons was 5.25%, 5.64%, and 6.78% of occurrences of sickness absence among nurses, medical staff, and allied health professions respectively. This increased to around 10% each winter during the peak of flu season.
- **Cost of living** is likely to contribute to issues relating to hunger, poor-quality diets and cold homes, which may lead to increased winter mortality and hospital admissions for respiratory conditions. The reallocation of resources to emergency care during winter may exacerbate existing healthcare delays, potentially influencing levels of workforce participation. The challenges in accessing GP services could also intensify winter health problems if individuals postpone seeking medical attention or resort to A&E. Patients and service users may need financial support and advice along with their medical care.

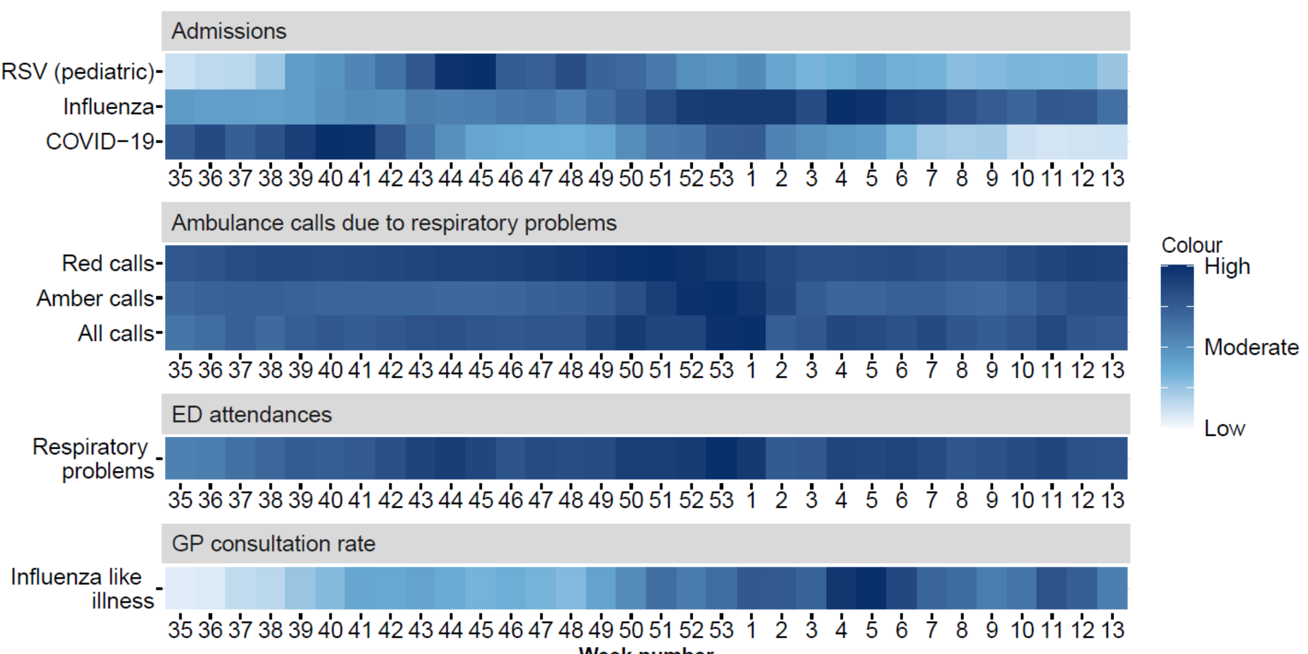
Definitions

- Note that we refer to the most likely scenario (MLS) throughout this report. This is the scenario, out of the provided modelling scenarios, that we consider most likely to occur during the 2024/25 winter in Wales.
- Unless stated otherwise, averages are referring to the mean.
- Admissions and occupancy refer to new admissions to hospital and hospital bed occupancy respectively. For admissions, this is where the relevant diagnosis code is the primary diagnosis for the first episode of the spell only (ie. The admitting episode). For more information, see NHS Wales data dictionary.
- Most analysis in this report focusses on the winter period (between 1st September and 31st March inclusive). Unless stated otherwise, analysis carried out is usually only over the winter period. However, there are parts of the report where the whole year is considered, such as the vaccine rollout as it is important to deduce vaccine uptake throughout the year.

2024/25 Winter Peaks

To convey winter pressures for different elements of the health care system (admissions, ambulance calls, ED attendances and GP consultations), we have created the following visual:

Figure 1: Most likely modelled scenario pressures due to admissions, ambulance calls, ED attendances and GP consultations between week 35 and 13 of Winter 2024/25 [Note 1]



Sources: Digital Health and Care Wales (DHCW), Welsh Ambulance Services University NHS Trust (WAST), and Public Health Wales

[Note 1]: The average value for each week was calculated from daily data. 'High', where the darkest blue is observed, refers to the estimated 2024/25 winter peak. All other colours are relative to the estimated peak.

The most likely modelled scenarios from our analysis estimates that: For admissions, peaks are likely to occur in week 45 2024, week 4 2025, and week 40 2024 for RSV, influenza and COVID-19 respectively. For ambulances calls coded red, amber and green, the peaks occur in weeks 51 2024, week 53 2024 and week 1 2025 respectively. ED attendances due to respiratory problems peaks in week 53 2024. GP consultation rates for influenza like illness peaks in week 5 2024.

For tables of the number of peak admissions, ambulance calls, ED attendances and GP consultation rates, see the Appendix.

Summary

Winter respiratory viruses cause increased demand on the NHS in Wales each year. However, there is always uncertainty about how these viruses will impact the healthcare services. The demand can vary depending on a variety of factors, for example if several viruses peak at the same time or how well a vaccination matches the virus in circulation.

The modelled scenarios in this paper include analysis of historical data used to project forward to estimate what we may see in winter 2024/25, contributing to winter planning for NHS Wales. We aim to estimate the pressures that could be seen by an increase in respiratory viruses and other factors which are typically more prevalent in the winter months than other times of the year. In this paper, there is a focus on influenza (flu) and pneumonia, Respiratory Syncytial Virus (RSV) and COVID-19. Although COVID-19 has not shown signs that it is solely a 'winter virus', the virus can cause compounding pressures if the peaks are combined with those of flu and RSV.

The paper also explores other areas of the care system that can be impacted by winter pressures beyond hospital admissions and occupancy. This includes Emergency Department attendances and ambulance calls, with modelled scenarios focusing on respiratory health. Outside of emergency and secondary care, we also explore historical data for GP consultations for influenza-like illnesses and acute respiratory infections, emphasising how winter pressures are over-arching across the whole NHS Wales system. This paper also provides estimates of vaccine uptake rates for flu and COVID-19 across different groups and considers the potential effect of the RSV vaccine due to be rolled out September 2024 to older adults and pregnant women.[1]

As with all modelling, the scenarios in this paper are not a prediction of what will happen but estimates of what could happen. We could also see similar peaks occurring at a different time in the season. The modelling uses past data to estimate future projections. Any changes to the NHS system, particularly in the past 12 months, may not have been taken into account in the modelling.

Looking at wider determinants of health, the paper explores socio-economic factors that can influence the pressures of winter not only on the healthcare system but population health too. This includes risks with regard to cold homes and inadequate nutrition due to financial difficulties experienced by many people.

This paper estimates the impact of known viruses and other determinants of health likely to increase the demand for healthcare in Wales across the 2024/25 winter period. It should be used as an indication of what we expect to see based on historical data, rather than what will happen. A similar modelling approach has been taken for the past 2 years (2022/23 and 2023/24) Please see the appendix to see how last year's 2023/24 winter modelling compared to the actual number of hospital admissions etc which occurred.

[1] National RSV vaccination programme announced - GOV.UK (www.gov.uk)

Winter Modelling 2024/25: Acute Respiratory Infections

Top Line Summary – Acute Respiratory Infections

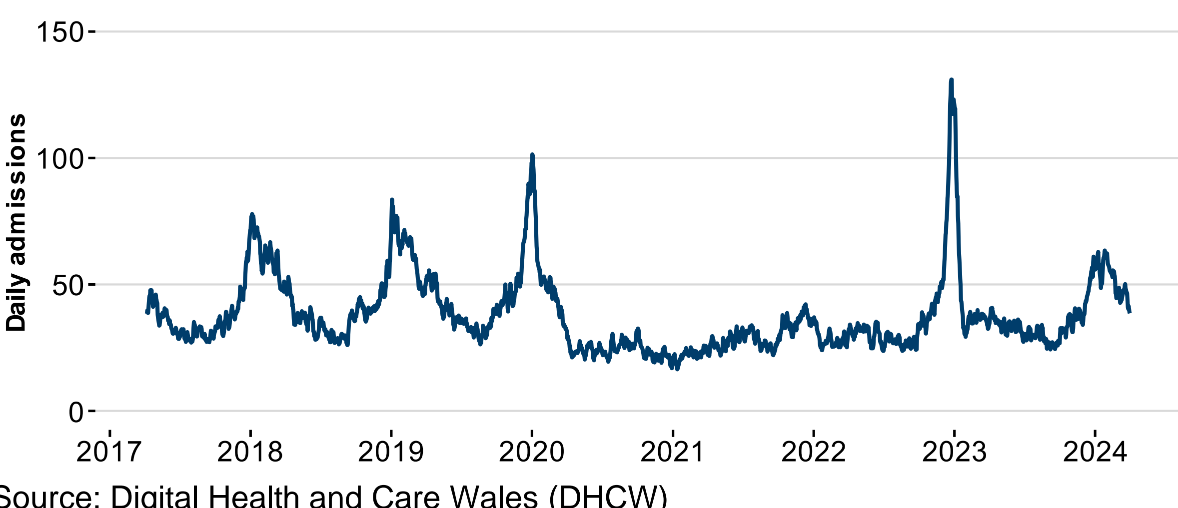
- Flu and pneumonia modelling scenarios have peak admissions ranging from 63 to 132 daily admissions for winter 2024/25. The peak in the occupancy scenarios for patients admitted due to influenza ranges from 441 to 1,058.
- Flu and pneumonia admissions during the non-pandemic years peaked between 24th December and 26th January.
- Respiratory syncytial virus (RSV) scenarios from winter 2024/25 have peak paediatric admissions ranging from 36 to 63 daily admissions. The daily peak in the number of beds occupied by RSV patients ranges from around 40 to 70.
- RSV paediatric admissions during the non-pandemic years peaked between 6th November and 2nd December.
- In 2023/24, admissions among children aged 0-4 accounted for 57% of the total RSV admissions while admissions among adults aged 65 and above amounted to 21% of the total RSV admissions.
- COVID-19 admissions scenarios 2 and 3 indicate there could be three COVID-19 peaks throughout the winter however, scenario 4 suggests two peaks and scenario 1 indicates a stable series with no peaks. Across the scenarios with peaks these range from 24 to 116 daily admissions. ICU scenarios predict peaks between 1 to 7 daily admissions.
- COVID-19 occupancy scenarios estimate a varying number of peaks, with the maximum of these peaks between 391 and 1,549 daily beds. Scenario 4, the repeat of last year's data suggests a peak of 520 beds in second week of October after which occupancy decreases throughout winter.
- Combined scenarios assess the collective impact of flu and pneumonia, RSV and COVID-19. In the most likely combined scenario, flu admissions contribute more than 50% of total admissions after January 2025. The daily admissions most likely scenario is expected to peak at 126 admissions in the first week of January 2025 (3rd January 2025). The most likely hospital occupancy scenario peaks at 896 beds occupied on 13th October 2024.
- The combined worst-case scenario estimates a peak of 262 daily admissions on 11th December 2024 and peak daily bed occupancy of 2,485 on 21st December 2024.
- There were 36 admissions due to whooping cough in Wales Between April 2023 and March 2024, although numbers remain low. This is more than double the number seen in the six previous years (2017/18 to 2022/23 range from below 5 to 17 admissions).

Influenza (flu) and Pneumonia

Seasonal flu viruses can cause severe acute respiratory illness, leading to hospitalisations, especially among older adults and individuals with underlying risk factors. These infections result from established, circulating influenza viruses.[2] These viruses mutate rapidly over time, making them prone to immune escape allowing for the reinfection of previously infected or vaccinated individuals.[3]

To assess the impact of influenza (flu) on secondary care in Wales, daily hospital admissions related to flu and pneumonia were deduced using International Classification of Diseases, Version 10 (ICD-10) codes: J09-J18.[4] Subsequently, admissions data was smoothed by calculating the 7-day rolling averages. Following this, peaks and trends during each season were identified.

Figure 2: 7-day rolling average of daily influenza and pneumonia admissions, between April 2017 and March 2024 [Note 1]



Source: Digital Health and Care Wales (DHCW)

[Note 1]: Data includes diagnosis codes J09 to J18 (flu and pneumonia) from ICD-10

Within the financial year of 2023/24 [5], a total of 14,110 flu admissions were recorded, with only 3% of those admissions being to the Intensive Care Unit (ICU). Of all flu admissions, 64% were among patients aged 65 years and older, 26% among 20–64-year-olds, 4% among 5–19-year-olds and 6% among 0–4-year-olds. The daily admissions showed a smaller peak of 63 in 2023/24, around half the size of 2022/23 winter peak. The 2023/24 peak in admissions occurred during the last week of January 2024, which was 3-4 weeks later than in previous years.

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[3] The evolution of seasonal influenza viruses | Nature Reviews Microbiology

[4] This includes syndromic evaluation of the patient and does not necessarily always include testing for flu virus.

[5] which we took to be 1 April 2023 to 31 March 2024.

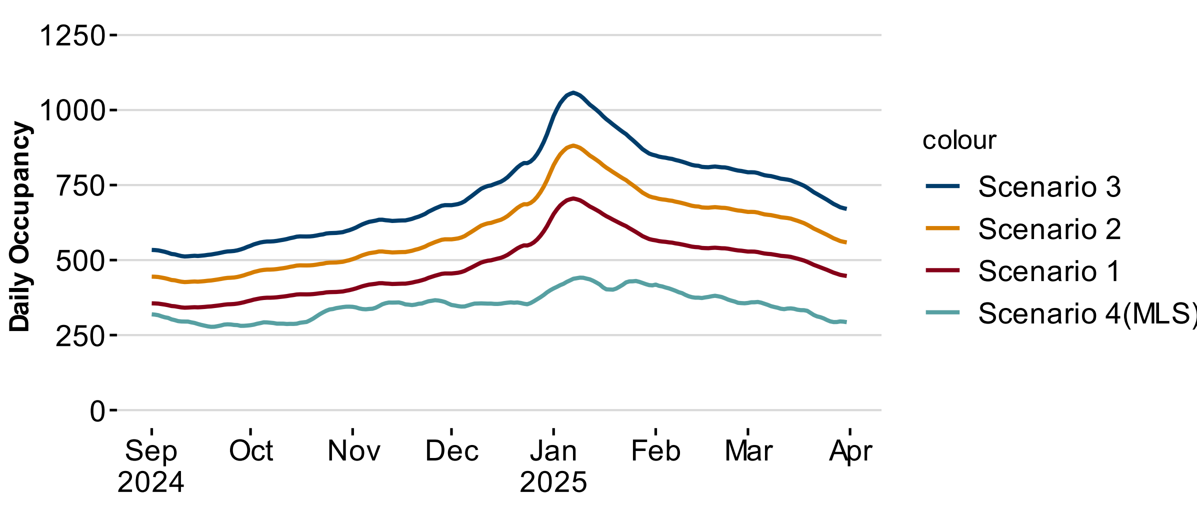
Based on the previous seven years of historical data,[6] the following scenarios were created for flu admissions and occupancy: Scenario 1 represents the average of non-pandemic years (2017/18, 2018/19, 2019/20, 2022/23 and 2023/24). Scenarios 2 and 3 are obtained by multiplying Scenario 1 by scalars 1.25 and 1.5. Finally, scenario 4, which repeats last year's admissions, is considered the most likely scenario (MLS).

Figure 3: Daily flu and pneumonia admissions scenarios– Winter 2024/25

Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Admissions scenarios 1 to 3 suggest a peak of 88, 110 and 132 admissions in the first week of January (03/01/2025). Scenario 4 suggests a small peak of 63 in the third week of January (26/01/2025). This is in line with the peaks in historical admissions during the non-pandemic years which peaked between 24th December 2024 and 26th January 2025.

Figure 4: Daily flu and pneumonia occupancy scenarios– Winter 2024/25



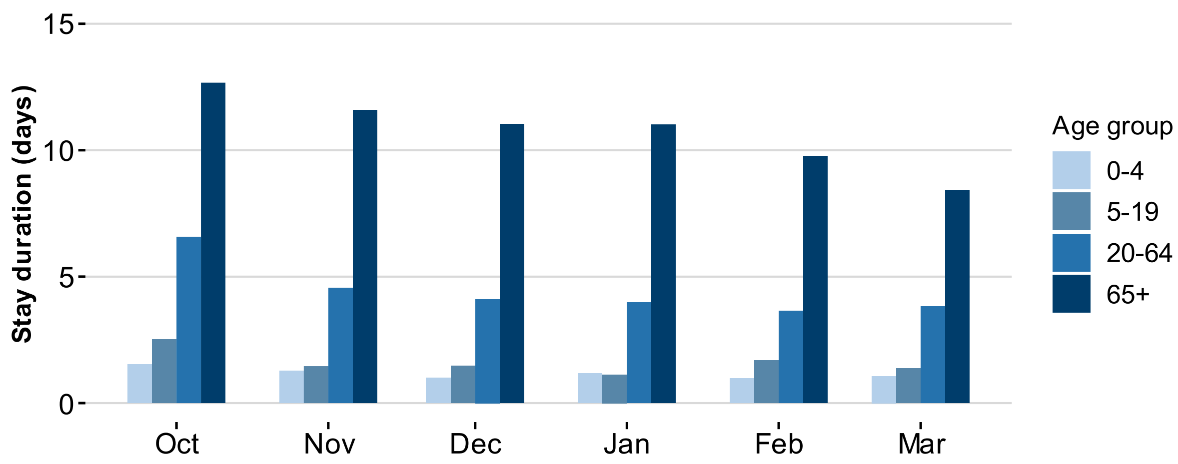
[6] Admissions during the pandemic years were not included in the scenarios due to very low numbers.

Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Occupancy scenarios 1-3 suggest peaks of 705, 882 and 1,058 patients occupying hospital beds due to flu, which is estimated to occur a few days behind the flu admissions peak (07/01/2025). The Scenario 4 peak suggests a maximum occupancy of 441 on 09/01/2025.

The average length of stay was calculated for patients admitted due to flu in the winter of 2023/24. However, due to incomplete clinical coding during that season, there's a possibility that we are underestimating the actual length of stay.[7] With these caveats in mind, the average length of stay for all age groups in October 2023 was 10.4 days but this decreased to 7.3 days in January 2024 and 5.9 days in March 2024.

Figure 5: Average length of stay in hospital due to flu and pneumonia during the winter of 2023/24, by month and age group



Source: DHCW and SEA calculations

Compared to other age groups, adults aged 65 and above had longer hospital stays due to flu with an average stay length ranging from 8.4 to 12.7 days across the months. Meanwhile, the 0-4 year old age group had an average stay length of 1.0 to 1.5 days, and the 20-64 year old age group had an average stay length between 3.6 and 6.6 days.

[7] For more details, please refer to the Appendix

Respiratory syncytial virus (RSV)

RSV Paediatric admissions

RSV is a common respiratory virus that usually causes mild, cold-like symptoms.[8] While most RSV infections usually cause mild illness, infants aged less than 6 months may develop conditions such as bronchiolitis and pneumonia, resulting in hospital admissions.[9] Over 90% of children have been infected by 2 years of age. Therefore, admissions for the 0–4-year-old age group were analysed between April 2017 and March 2024.

Figure 6: 7 day rolling average of daily RSV paediatric admissions (ages 0-4 years), April 2017 to March 2024 [Note 1]

Source: Digital Health and Care Wales (DHCW)

[Note 1] : Data includes diagnosis codes J21 to J22 from the ICD-10

RSV admissions among 0-4 year olds followed a consistent seasonal pattern before the pandemic, with peak rolling admissions exceeding slightly above 60 during the last week of November. Although admissions declined in the winter of 2020/21, they rebounded in the subsequent winters. However, both the peak and total number of admissions remained significantly smaller compared to pre-pandemic years.

During the 2023/24 financial year, there were a total of 5,168 RSV peadiatric (aged 0-4 years) admissions, with only 0.23% of those resulting in ICU admission. The 7-day rolling average peaked at 40 daily admissions on 6th November 2023, which was a month earlier than observed in the 2022/23 season. The peak height in 2023/24 was around two thirds the height of the pre-pandemic average. Based on the previous historical data, the following scenarios were created for RSV admissions and occupancy:

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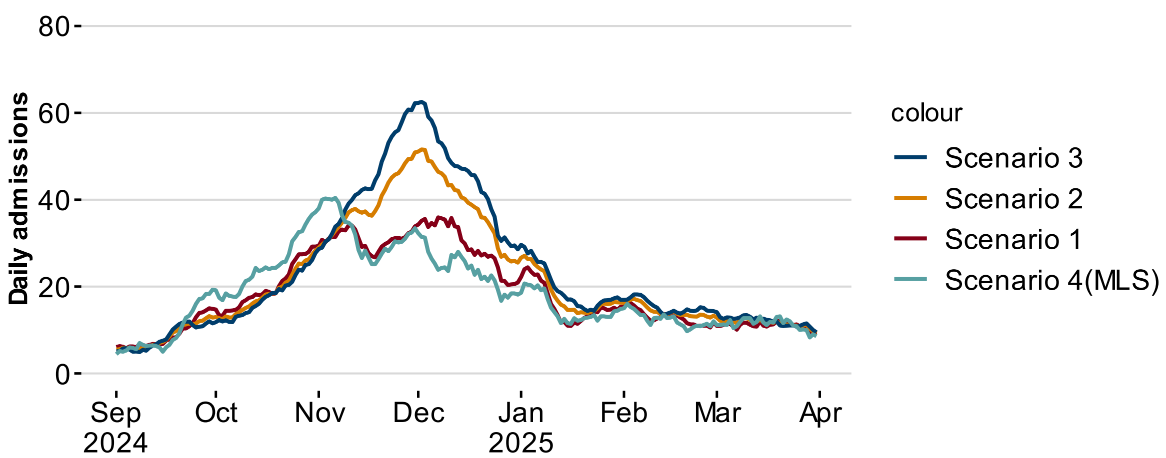
[8] Respiratory syncytial virus (RSV) immunisation programme for infants and older adults: JCVI full statement, 11 September 2023 - GOV.UK (www.gov.uk)

[9] Respiratory syncytial virus (RSV): symptoms, transmission, prevention, treatment - GOV.UK (www.gov.uk)

Scenario 1 reflects trends in the last two years. Scenario 3 assumes pre-pandemic patterns (from 2017/18, 2018/19 and 2019/20). Scenario 2 combines elements from both Scenario 1 and 3 (2017/18, 2018/19, 2019/20, 2022/23 and 2023/24). Scenario 4 is the repeat of the last year's data and the most likely scenario. The scenarios for RSV differ to the scenarios for other conditions due to the varying historical trends before, during and after the COVID-19 pandemic. These scenarios do not consider the impact of the new RSV vaccination programme, which will provide vaccines to older adults (aged 75 years and above) and pregnant women starting in September 2024.

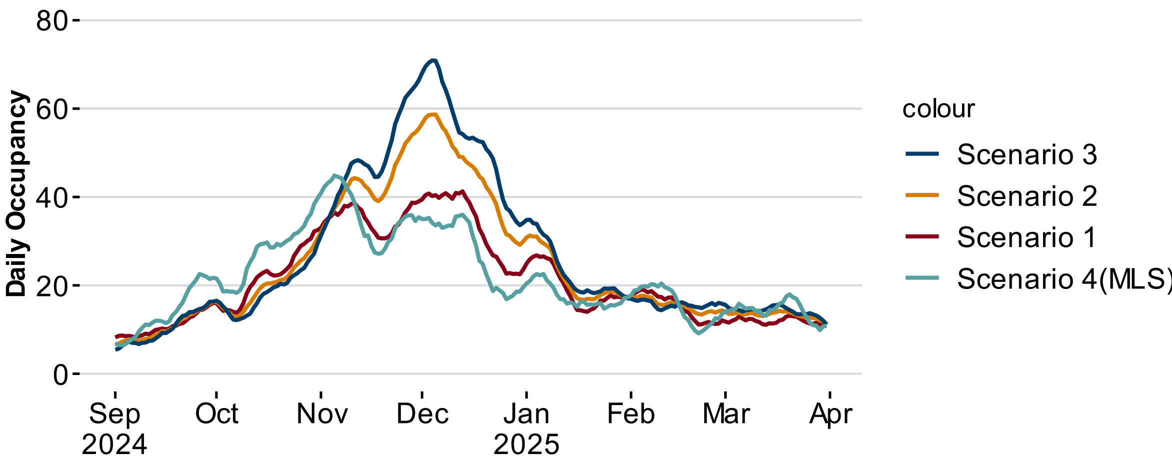
Figure 7: RSV Winter 2024/25 modelling scenarios for daily paediatric hospital admissions (0-4 years)



Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Scenario 1 suggests a peak of 36 daily admissions during the first week of December (07/12/2024). Scenarios 2 and 3 suggest a peak of 52 and 63 admissions few days before Scenario 1 (02/12/2024). Scenario 4 suggests an early peak of 40 admissions in the first week of November (06/11/2024). Historically, the peak of RSV admissions occurred between 6th November and 2nd December.

Figure 8: RSV Winter 2024-25 modelling scenarios for daily paediatric hospital occupancy.



Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Occupancy scenarios 2 and 3 suggest a peak of around 60-70 daily beds occupied by RSV patients in the first week of December while scenarios 1 and 4 suggest a maximum of around 40-45 beds occupied by RSV patients in hospitals per day.

RSV admissions across age groups

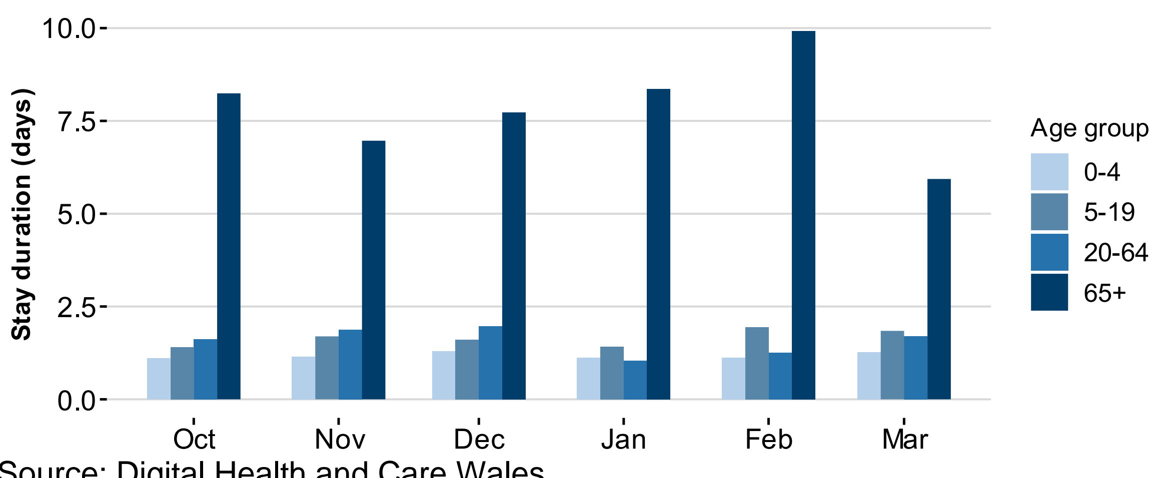
Table 1: Total number of RSV admissions and percentage, by age, in financial years between 2017/18 and 2023/24

financial year	0-4	5-19	20-64	65+	0-4 (%)	5-19 (%)	20-64 (%)	65+ (%)
2017/18	5,590	650	1,564	3,694	49%	6%	14%	32%
2018/19	6,342	621	1,554	3,249	54%	5%	13%	28%
2019/20	6,179	724	1,616	3,066	53%	6%	14%	26%
2020/21	661	159	516	1,109	27%	7%	21%	45%
2021/22	5,270	385	768	1,287	68%	5%	10%	17%
2022/23	5,636	442	1,085	1,652	64%	5%	12%	19%
2023/24	5,168	728	1,245	1,954	57%	8%	14%	21%

Source: Digital Health and Care Wales

Children aged 0-4 and adults aged 65 and above account for most of the RSV admissions each year. In 2023/24, admissions among children aged 0-4 accounted for 57% of the total RSV admissions while adults aged 65 and above accounted for 21% of the admissions. The number of admissions among adults aged 65 and above decreased from 3,694 in 2017/18 to 1,954 in 2023/24.

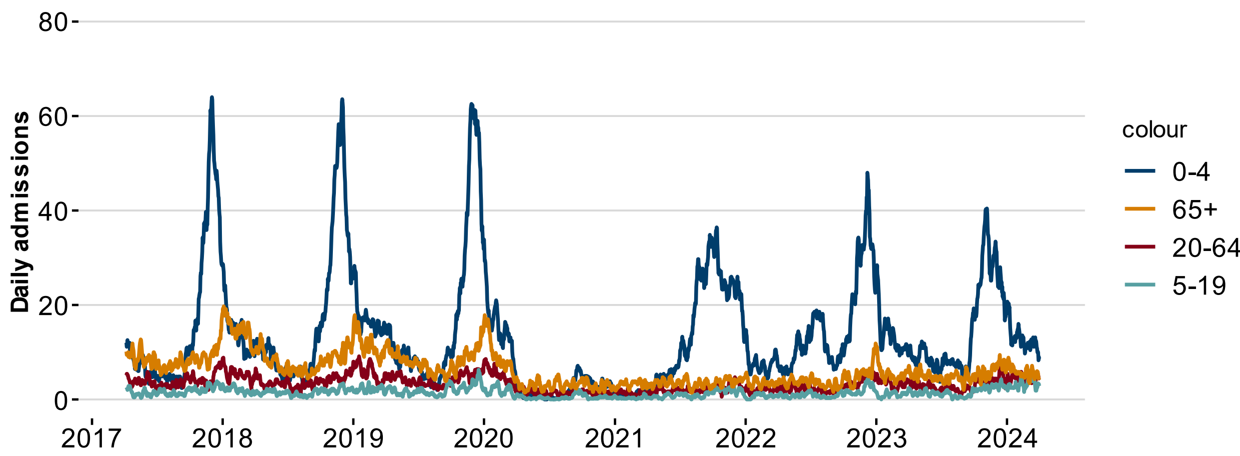
Figure 9: Average length of stay due to RSV, by age group, winter of 2023/24



Source: Digital Health and Care Wales

The duration of hospital stays resulting from RSV admissions varied across different age groups. Specifically, for children aged 0-4 years, the length of stay due to RSV ranged from 1.1 to 1.3 days between October 2023 and March 2024. Adults aged 65 and above experienced longer stays, lasting approximately between 5.9-9.9 days due to RSV.

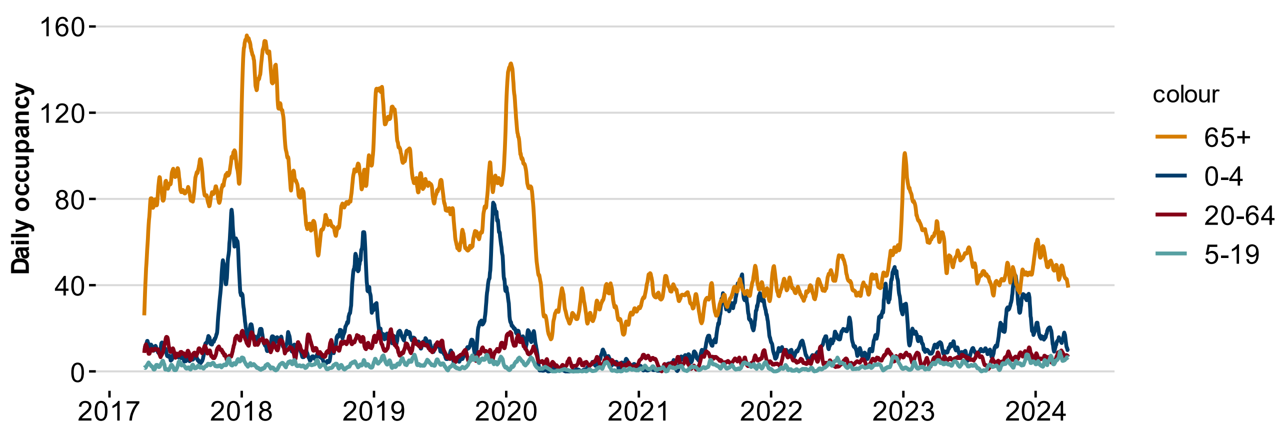
Figure 10: 7 day rolling average of RSV admissions, by age group, April 2017 to March 2024.



Source: Digital Health and Care Wales

Among adults aged 65 and above, there was a peak of under 20 RSV admissions in the first week of January in each of the three years before the pandemic (2017/18, 2018/19, and 2019/20). These annual peaks occurred roughly a month after the RSV admissions peaks observed in children aged 0-4. The peaks in RSV admissions in adults aged 65 and above decreased by half after the pandemic, reaching 12 and 9 admissions in winter of 2022/23 and 2023/24 respectively.

Figure 11: 7 day rolling average of RSV occupancy, by age group, April 2017 to March 2024



Source: Digital Health and Care Wales

As reflected in the stay length, admissions among 65 years and above resulted in a higher daily occupancy than admissions among 0-4-year-olds. The occupancy peaks were around 130-150 beds per day before the pandemic. After the pandemic, the peak daily beds occupied decreased to around 100 beds and 60 beds in the winters of 2022/23 and 2023/24 respectively. Hospital bed occupancy due to RSV in age groups 20-64 and 5-19 were under 20 beds per day.

Effects of RSV vaccination on hospital admissions

A number of vaccines have been developed to protect against RSV disease including: a bivalent RSV prefusion F vaccine (Abrysvo, Pfizer) and a long-acting monoclonal antibody (la-mAB, Nirsevimab, Sanofi).[10] [11] The vaccine Abrysvo given to adults aged 60 and older and pregnant women (24–36 weeks gestational age) has an efficacy against medically attended lower respiratory tract infections (LRTI) of 57.1% (99.5% CI, 14.7% to 79.8%) and 51.3% (99.5% CI, 29.4% to 66.8%) within 90 and 180 days after birth.[12] The la-mAB vaccine (Nirsevimab) has an efficacy against medically attended RSV-associated LRTI of 76.4% (95% CI, 62.3% to 85.2%). The new NHS Wales vaccination programmes against Respiratory Syncytial Virus will provide the RSV vaccine Abrysvo to pregnant mothers at gestational age 28 weeks and adults aged 75 and above from September 2024.

The introduction of a maternal vaccine for RSV coincides with winter 2024/25. This will result in a small reduction in RSV admissions amongst those aged 0 to 4. At the end of the winter period (the end of March 2025), all babies under the age of 6 months will have been born to mothers eligible for a maternal vaccine for RSV, at that time making

[10] Bivalent Prefusion F Vaccine in Pregnancy to Prevent RSV Illness in Infants | New England Journal of Medicine (nejm.org)
[11] Nirsevimab for Prevention of RSV in Healthy Late-Preterm and Term Infants | New England Journal of Medicine (nejm.org)
[12] Respiratory syncytial virus (RSV) immunisation programme for infants and older adults: JCVI full statement, 11 September 2023 - GOV.UK (www.gov.uk)

up around 10% of all those aged 0 to 4[13]. If 60% of eligible mothers take up the RSV vaccine offer, the babies of those mothers are estimated to receive around 50% protection from hospitalisation. At the very end of winter 2024-25, this would result in roughly 3% of RSV hospitalisations amongst those aged 0 to 4 being prevented at the end of winter, and even fewer before then. [14] Over the next few winters, the number of 0–4 year-olds whose mothers would have received the maternal vaccine will increase and the effect of the RSV vaccine will also increase. Therefore, each subsequent winter period will see others amongst those aged 0 to 4 with at least residual vaccine-caused immunity and so a cumulatively greater effect.

The effect of RSV vaccines on young children would be clearer to see if data allowed us to look at a smaller age bands for younger children (eg. 0-9 months) rather than assuming hospital admissions are equally distributed in 0-4 year olds. Since most hospitalisations of 0–4-year-olds occur in those under 1 year of age, there may be a large impact on preventing hospitalisations in this younger group following the RSV maternal vaccine rollout.

For older adults, assuming a vaccine uptake of 60 to 80% among adults aged 75 and above based on historical flu uptake data, and vaccine efficacy of 57% from the clinical trials, we would expect a reduction of hospitalisations of those aged 75 and above of 34% to 46% once vaccine uptake exceeds 60%.

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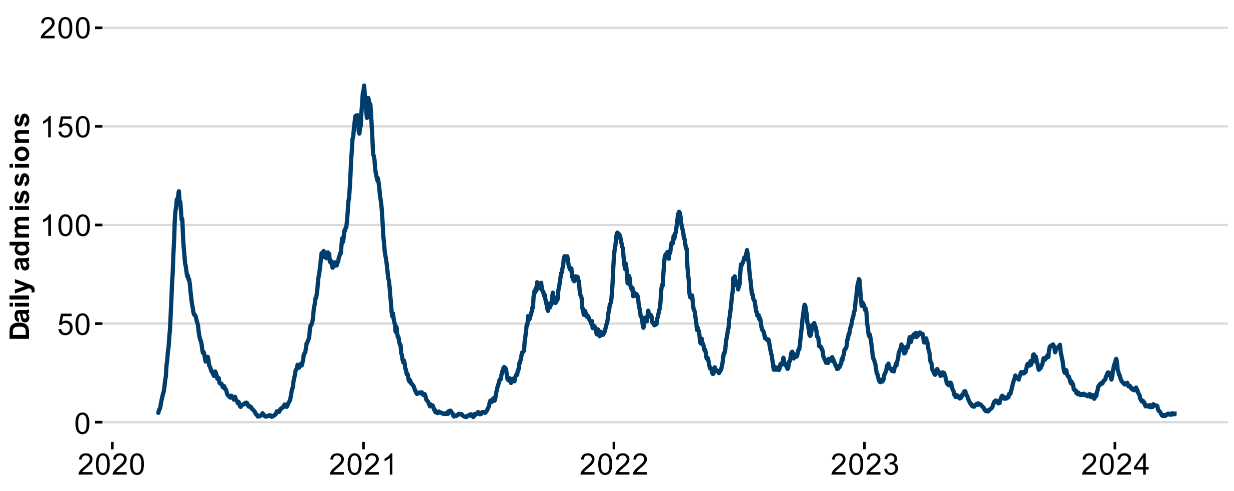
[13] Assuming the number of babies and children aged 0-4 years are uniformly distributed.
[14] The product of 10% of babies, 60% uptake rate, and 50% vaccine efficacy).

COVID-19

In May 2023, the World Health Organization (WHO) announced that COVID-19 is no longer classified as a global health emergency. However, the WHO also emphasised that the risk of virus evolution remains, with new variants emerging. Despite an overall downward trend, we should still anticipate the virus's impact on the population for some time to come.

Figure 12: 7 day rolling average of admissions due to COVID-19 (any mention), between March 2020 to March 2024 [Note 1]



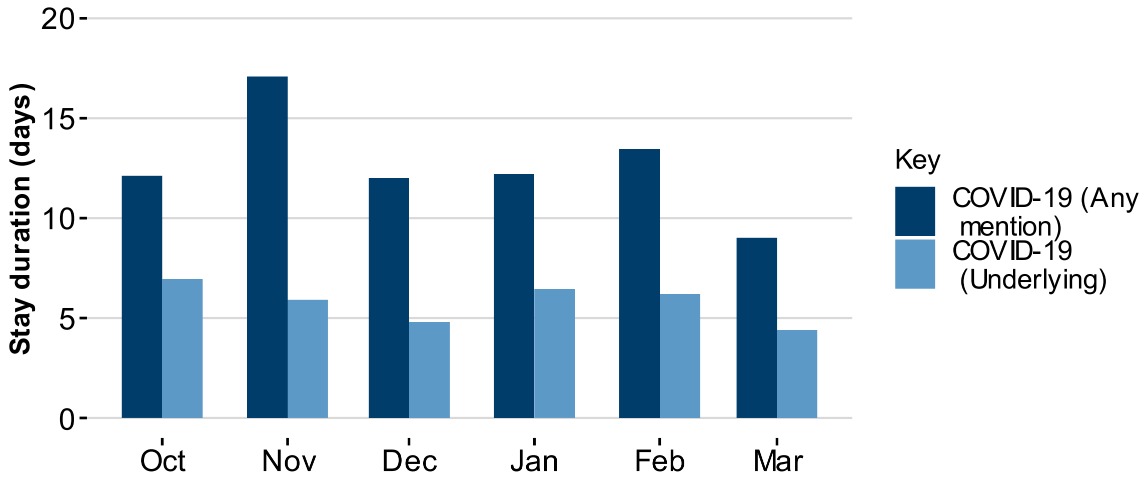
Source: Digital Health and Care Wales

[Note 1]: Includes ICD-10 codes U071, U072, U099, U109.

In Wales, admissions with any mention of COVID-19 showed a similar decreasing trend totalling 6,574 admissions in 2023/24, compared to 19,196 in 2020/21. Additionally, the daily admission peaks were significantly smaller, below 40 admissions per day. Only 3% of these admissions required intensive care unit (ICU) treatment compared to 7% in 2020/21. Adults aged 65 and above accounted for 61% of the total admissions, while 11% of the admissions were among children aged 0-4 years in 2023/24. By contrast, only 1% of the total admissions were among children aged 0-4 in 2020/21.

The average length of stay with admissions due to COVID-19 as an underlying condition ranged between 4.4 and 6.9 days across the months in the winter of 2023/24. Admissions with any mention of COVID-19 had a longer mean stay duration between 9.0 and 17.1 days possibly due to other co-morbidities or co-infections.

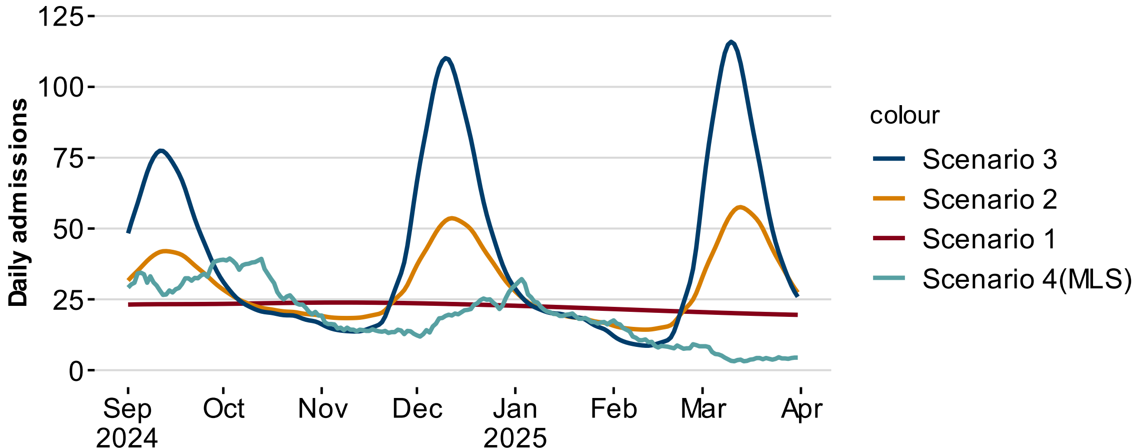
Figure 13: Average length of stay in hospital due to COVID-19 (any mention or underlying condition) in the winter of 2023/24



Source: Digital Health and Care Wales

COVID-19 admissions and occupancy scenarios were created by Swansea University where a new variant emerges gradually every 3 months. The degrees of immune evasion from the variant is given by the scalar value 1, 1.2 and 1.5 and represented as scenarios 1-3. Scenario 4 is the repeat of last year's data from Digital Health and Care Wales.

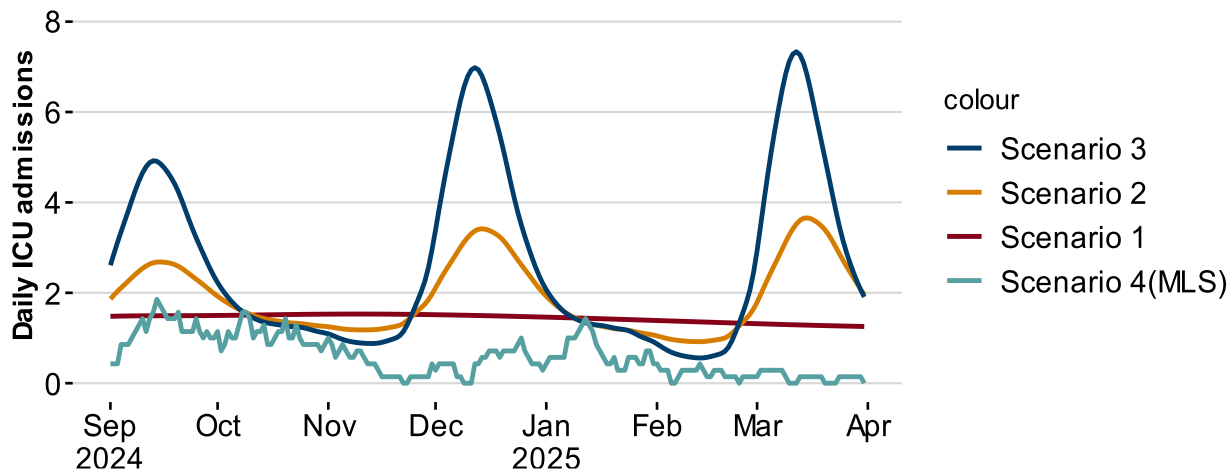
Figure 14: COVID-19 Winter 2024-25 modelling scenarios for all hospital admissions including ICU admissions



Source: Swansea University modelling (Scenarios 1, 2 3), actuals underlying the MLS to 31 March 2024 provided by DHCW, projected MLS scenarios from 1 September 2024 to 31 March 2025 from SEA

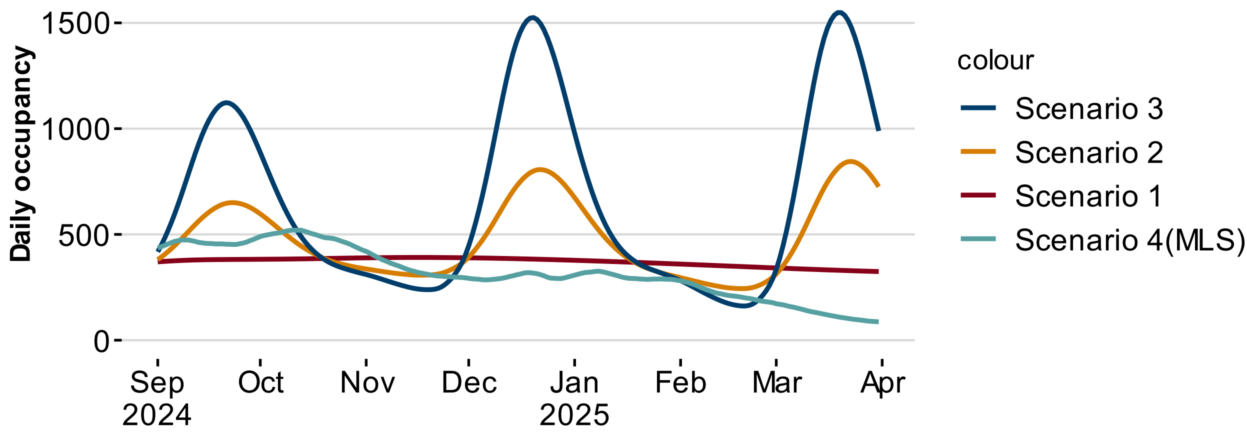
Scenario 1 indicates a flat time series with a maximum of 24 daily admissions. Scenarios 2 and 3 both suggest three peaks, occurring in the second weeks of September, December, and March. Scenario 2 projects smaller peaks of 42, 54, and 58 daily admissions respectively, while scenario 3 projects larger peaks of 77, 110, and 116 daily admissions respectively. Scenario 4, the repeat of last years' data suggests two peaks: 39 admissions in the first week of October and 32 admissions in the first week of January. ICU scenarios predict peaks between 1-7 daily admissions.

Figure 15: COVID-19 Winter 2024-25 modelling scenarios for ICU hospital admissions



Source: Swansea University modelling (Scenarios 1, 2 3), actuals underlying the MLS to 31 March 2024 provided by DHCW, projected MLS scenarios from 1 September 2024 to 31 March 2025 from SEA

Figure 16: COVID-19 Winter 2024-25 modelling scenarios for hospital occupancy



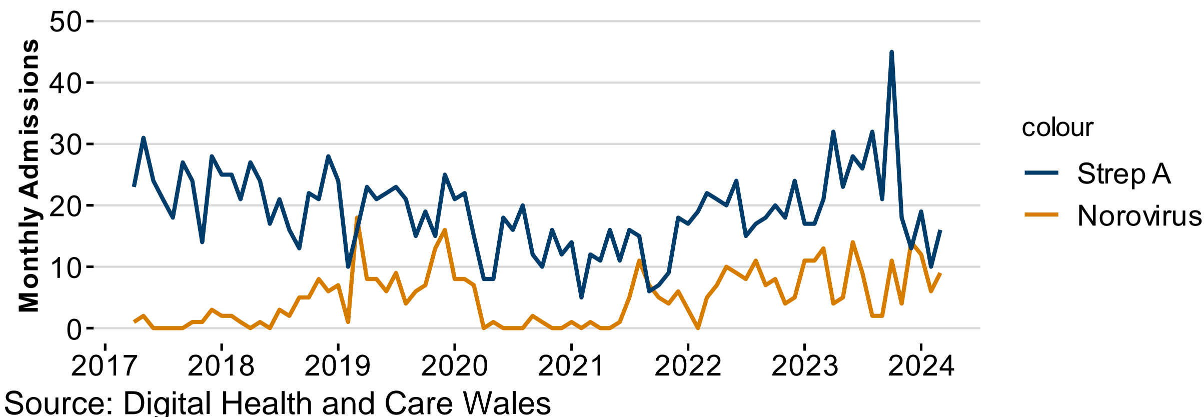
Source: Swansea University modelling (Scenarios 1, 2 3), actuals underlying the MLS to 31 March 2024 provided by DHCW, projected MLS scenarios from 1 September 2024 to 31 March 2025 from SEA

Occupancy scenario 1 suggests occupancy to lie between 325-391 daily beds. Scenarios 2 and 3 both suggest three peaks, occurring in the third weeks of September, December, and March, approximately a week after the admissions peaks. Scenario 2 projects smaller peaks of 650, 807, and 845 daily beds occupied respectively, while scenario 3 projects larger peaks of 1123, 1525, and 1549 daily beds being occupied. Scenario 4, the repeat of last year's data suggests a peak of 520 beds in second week of October after which occupancy decreases throughout winter.

Other Admissions

Admissions due to infectious diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010 were analysed monthly.[15]

Figure 17: Monthly admissions due to Strep A and Norovirus, April 2017 to March 2024



Source: Digital Health and Care Wales

Table 2: Total admissions due to Norovirus, Whooping cough, Mycoplasma and Strep A in Wales by financial years between 2017/18 and 2023/24 [Note 1]

Financial year	Norovirus	Whooping Cough	Mycoplasma	Strep A
2017/18	13	14	Below 5	281
2018/19	56	13	8	239
2019/20	100	17	6	242
2020/21	6	Below 5	Below 5	151
2021/22	47	Below 5	Below 5	167
2022/23	104	12	Below 5	232
2023/24	92	36	25	283

Source: Digital Health and Care Wales

[Note 1]: ICD-10 codes used: Norovirus (A081), Whooping Cough (A37), Mycoplasma (A493, B960) and Strep A (A389, A40, B95)

Admissions due to Streptococcus A (Strep A) increased from 232 in the financial year of 2022/23 to 283 in 2023/24. These include admissions due to Scarlet fever and IGAS (invasive Group A Streptococcal disease).[16] However, there were higher notifications due to Scarlet fever in 2022/23 winter than the 2023/24 winter.[17] Therefore, it is possible that while there are fewer Strep A admissions in 2022/23, the infected individuals might have accessed other avenues in the healthcare system (i.e GPs).There were 92 admissions due to Norovirus in 2023/24 and 36 admissions due to whooping cough.

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[15] Notifiable diseases and causative organisms: how to report - GOV.UK (www.gov.uk) Whooping cough and Mycoplasma have been supressed due to low numbers

[16] Streptococcus A (strep A), Scarlet Fever and iGAS - Public Health Wales (nhs.wales)

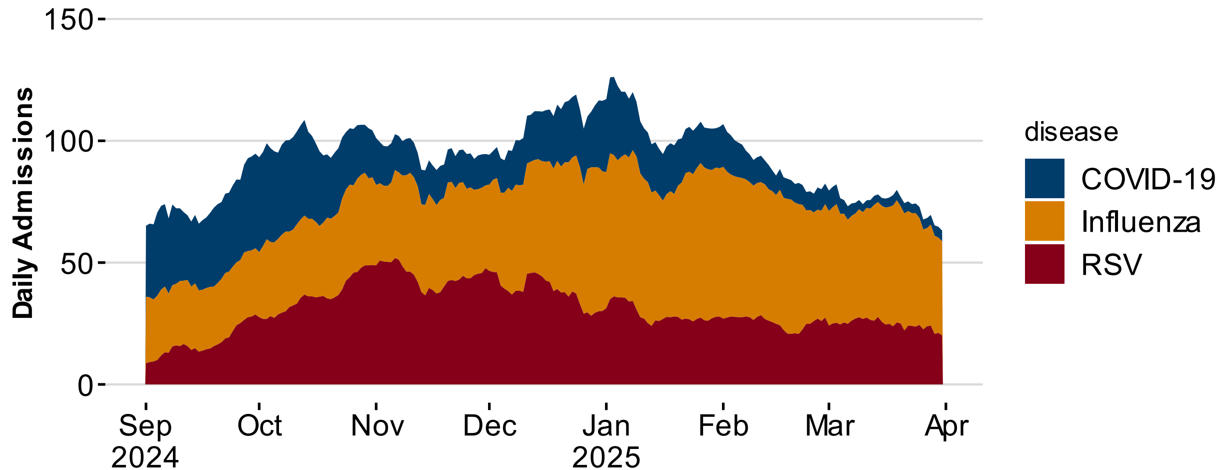
[17]https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/NotificationsofSCARLETFEVERinWales/Dashboard2

Combined scenarios

In order to assess the collective impact of the three winter viruses (flu, RSV and COVID-19), a most likely scenario and a reasonable worst-case scenario was selected for each, and then combined. The most likely scenario combines the following three scenarios from above:

- COVID-19 - "Scenario 4", which is a repeat of last year's actual data (2023/24)
- Influenza & pneumonia – "Scenario 4", which is a repeat of last year's actual data (2023/24)
- RSV – a repeat of last year's actual data for all age groups (2023/24)

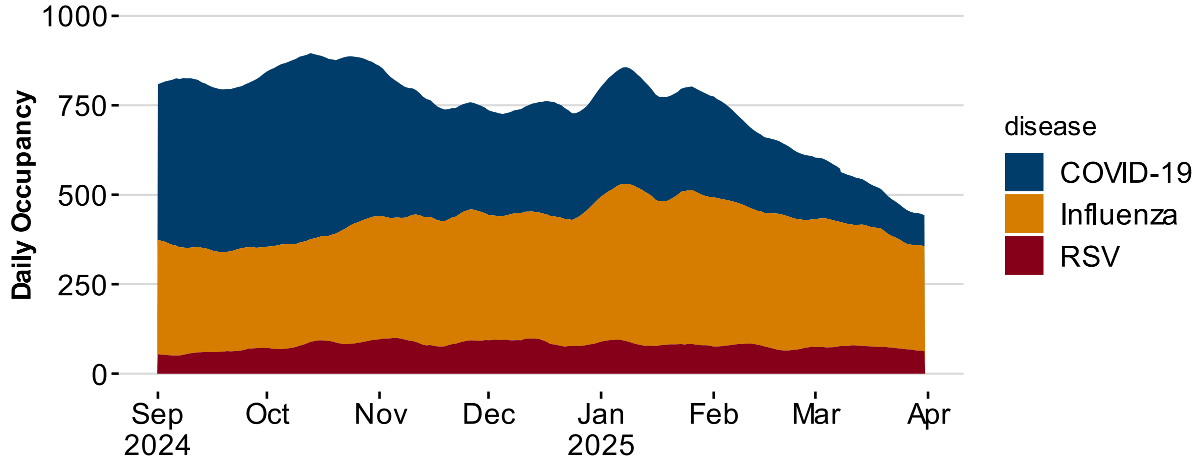
Figure 18: Combined most likely scenario – daily hospital admissions (including ICU admissions) for winter 2024/25



Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Flu admissions contribute mainly towards admissions compound pressure accounting for more than 50% of total admissions after January 2025. The daily admissions most likely scenario is expected to peak at 126 admissions in the first week of January 2025 (03/01/2025). The most likely occupancy is likely to peak at 896 beds on 13/10/2025.

Figure 19: Combined most likely scenario – daily hospital occupancy (including ICU occupancy) for winter 2024/25

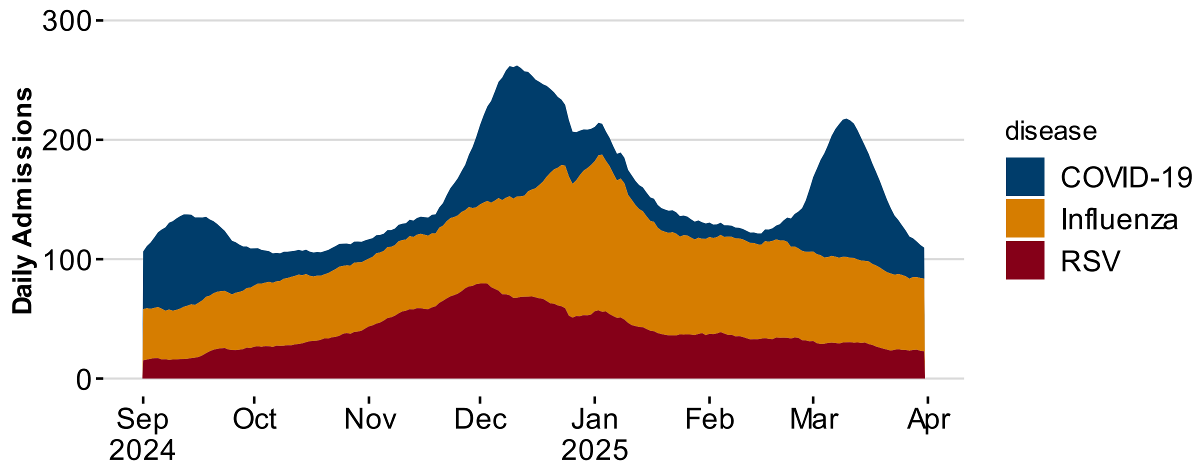


Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

The worst case combines the following three scenarios:

- COVID-19 - “Scenario 3”, which is the introduction of a new COVID-19 variant that becomes dominant every 3 months (cos wave) with a scalar of 1.5
- Influenza & pneumonia – “Scenario 3”, which is the average of the non-pandemic years (2017/18, 2018/19, 2019/20, 2022/23 and 2023/24) multiplied by 1.5
- RSV – “Scenario 3” which is the average of pre-pandemic years (2017/18, 2018/19 and 2019/20)

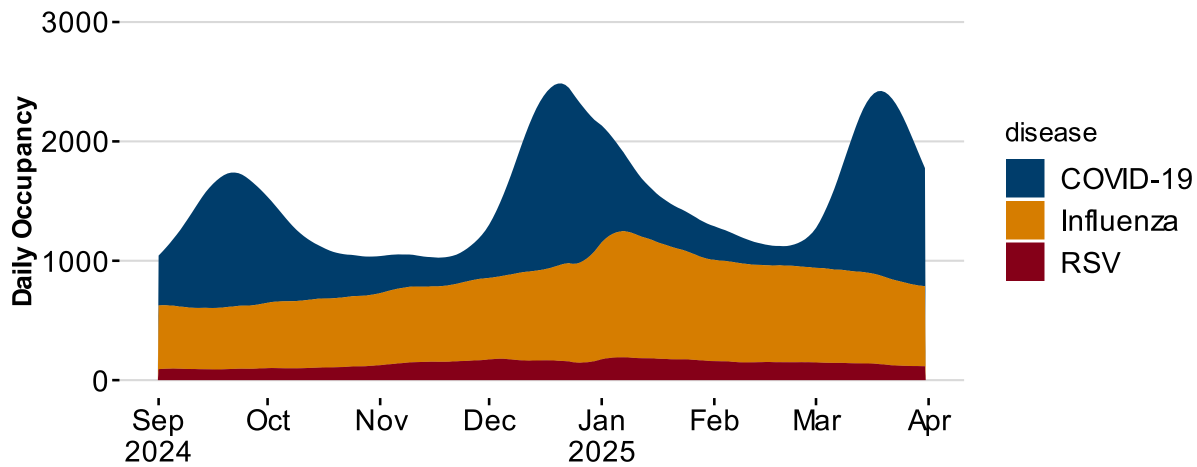
Figure 20: Combined worst case scenario – daily hospital admissions (including ICU admissions) for winter 2024/25



Source: Swansea University COVID-19 modelling, Influenza and RSV actuals to 31 March 2024 provided by DHCW, projected scenarios (for Influenza and RSV) from 1 September 2024 to 31 March 2025 from SEA

The worst-case scenario estimates daily admissions of 262 to peak on 11/12/2024 and daily occupancy of 2485 to peak on 21/12/2024 (more than 2 times the peak admissions height and around 3 times the peak occupancy height predicted by the most likely scenarios).

Figure 21: Combined worst case scenario – daily hospital occupancy (including ICU occupancy) for Winter 2024/25



Source: Swansea University COVID-19 modelling, Influenza and RSV actuals to 31 March 2024 provided by DHCW, projected scenarios (for Influenza and RSV) from 1 September 2024 to 31 March 2025 from SEA

International Winter Season

We looked to the southern hemisphere for an indication of how next winter may play out in Wales due to the different timing of the seasons between the northern and southern Hemispheres.

In Australia monitoring up to week 28 (week ending 14 July 2024) shows the percentage of FluTracking participants reporting new fever and cough symptoms are above the percentages seen in 2023 and tracking closely to the five-year mean (2017-2019 and 2022-2023).[18] It is too early in the winter season to say if the peak has passed. However, of the samples referred to the World Health Organization Collaborating Centre, most have been antigenically similar to the corresponding vaccine components, suggesting a good vaccine match to the circulating virus.

There is a similar story across other countries including Hong Kong where the ILI consultation rate in 2024 is similar to 2023.[19] In Singapore the polyclinic attendances for acute respiratory infection are similar to the attendances seen in 2023.[20]

Using the international picture to estimate what we may see in Wales, the flu season is likely to be similar to recent years but with the potential to see increases on figures seen in 2023/24.

[18] Australian Respiratory Surveillance Reports – 2024 | Australian Government Department of Health and Aged Care
[19] Centre for Health Protection - Sentinel Surveillance of Infectious Diseases among Chinese Medicine Practitioners (CMPs) (chp.gov.hk)
[20] MOH | Weekly Infectious Diseases Bulletin

Admissions from care home residents

All care home residents

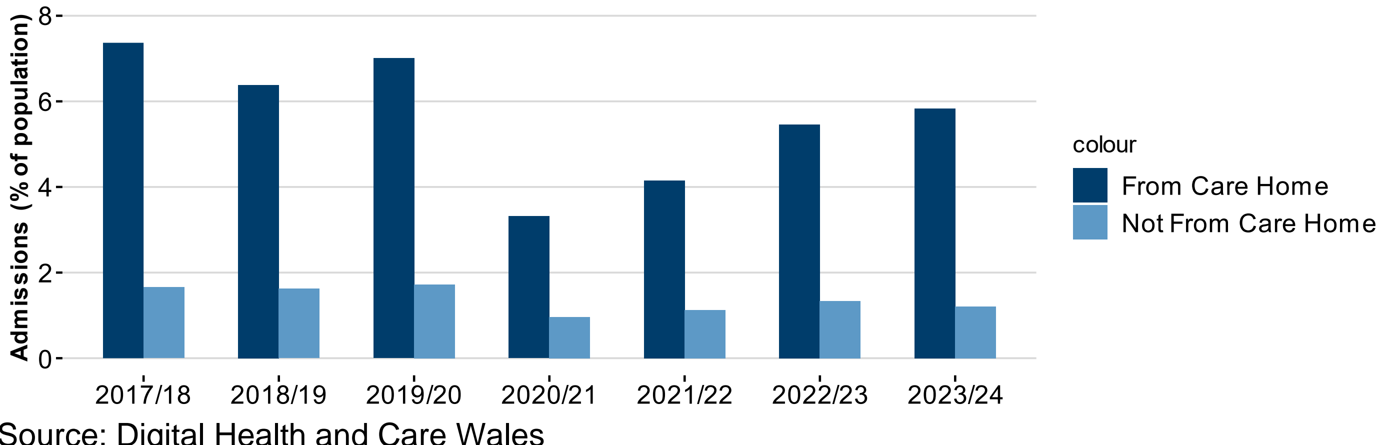
In 2023/24, there were 1,036 influenza and pneumonia admissions, 263 RSV admissions and 225 COVID-19 admissions were from people residing in care homes.

Care home residents aged 65 and over

To assess the impact of winter viruses and COVID-19 on care home residents, we analysed admission rates as a proportion of the population. We focused on adults aged 65 and above, who constituted 81% of the total care home population in Wales based on 2021 census data.[21] For non-census years, we extrapolated the resident population using the population of adults aged 65 and above in Wales.

Our analysis suggests that care home residents were more likely to be admitted due to winter viruses and COVID-19. Before the pandemic, an average of 6.9% of care home residents aged 65 and above were admitted annually due to flu. In contrast, only 1.67% of those who did not reside in a care home experienced flu admissions. Although these numbers declined during the pandemic (3.32% for care home residents and 0.96% for non-care home residents), they have been rising since. In 2023/24, 5.83% of care home residents and 1.2% of non-care home residents were admitted due to flu.

Figure 22: Admissions (% of population) due to flu and pneumonia, in adults aged 65 and above in Wales by financial years between 2017/18 and 2023/24.



Source: Digital Health and Care Wales

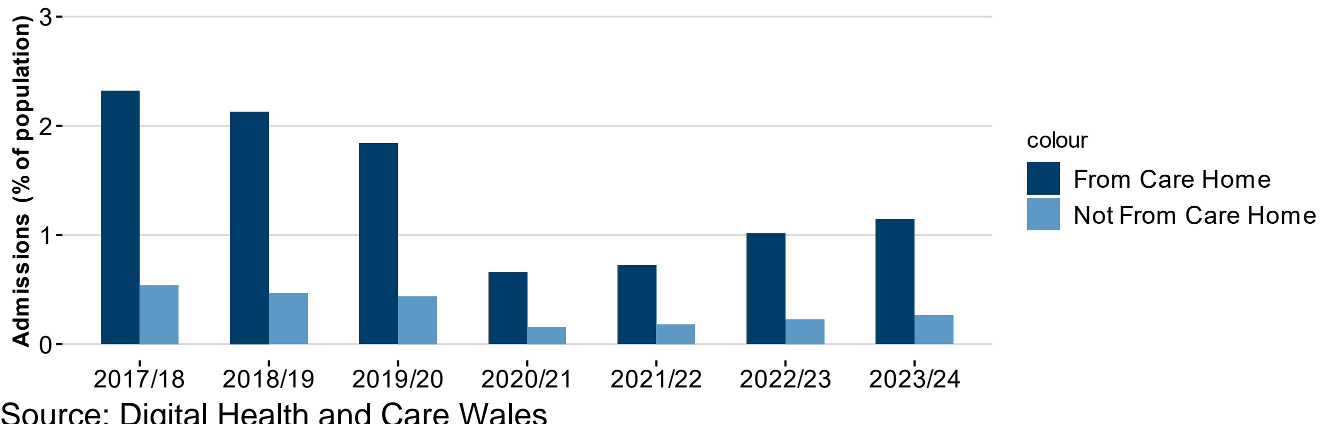
[21] Care home resident population, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk)

Table 3: Admissions (% of population) due to flu and pneumonia, in adults aged 65 and above, by care home status, by financial years, 2017/18 to 2023/24.

Financial year	From Care Home	Not From Care Home
2017/18	7.37%	1.66%
2018/19	6.38%	1.62%
2019/20	7.01%	1.72%
2020/21	3.32%	0.96%
2021/22	4.15%	1.13%
2022/23	5.46%	1.33%
2023/24	5.83%	1.20%

A similar trend is seen in RSV admissions where a greater percentage of RSV admissions occurred among care home residents compared to non-care home residents. In 2023/24, 1.15% of care home residents were admitted due to RSV while only 0.27% of non-care home residents were admitted due to RSV. Compared to flu admissions, a lower percentage of the care home population were admitted due to RSV.

Figure 23: Admissions (% of population) due to RSV, in adults aged 65 and above in Wales by financial years between 2017/18 and 2023/24.



Source: Digital Health and Care Wales

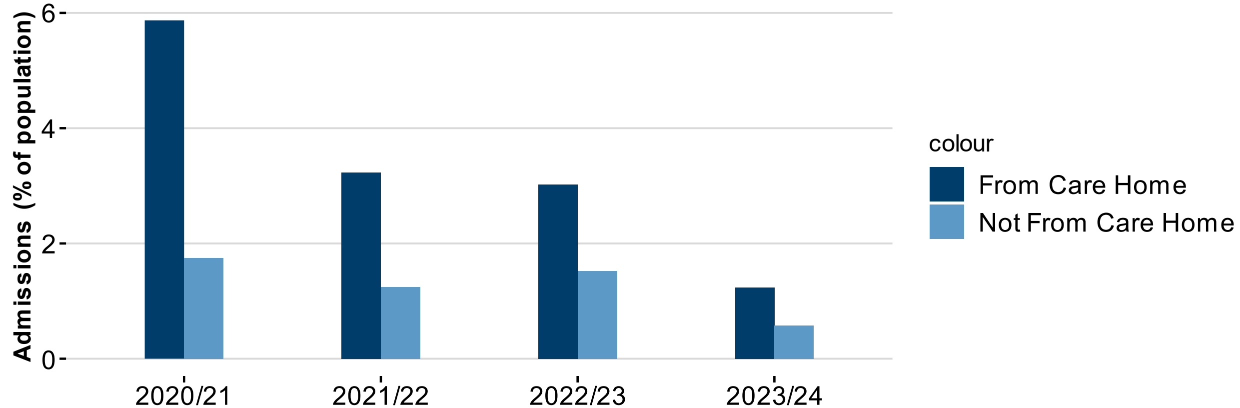
Table 4: Admissions (% of population) due to RSV, in adults aged 65 and above, by care home status, in Wales by financial years between 2017/18 and 2023/24.

Financial year	From Care Home	Not From Care Home
2017/18	2.32%	0.54%
2018/19	2.13%	0.47%
2019/20	1.84%	0.44%
2020/21	0.66%	0.16%
2021/22	0.72%	0.18%
2022/23	1.01%	0.23%
2023/24	1.15%	0.27%

Source: Digital Health and Care Wales

Percentage of care home residents being admitted due to any mention of COVID-19 decreased from 5.87% in 2020/21 to 1.23% in 2023/24 while percentage of non-care home residents admitted decreased from 1.75% to 0.58%.

Figure 24: Admissions (% of population) due to COVID-19 (any mention), in adults aged 65 and above by financial years between 2020/21 and 2023/24.



Source: Digital Health and Care Wales

Table 5: Admissions (% of population) due to COVID-19 (any mention), in adults aged 65 and above in Wales by financial years between 2020/21 and 2023/24.

Financial year	From Care Home	Not From Care Home
2020/21	5.87%	1.75%
2021/22	3.23%	1.24%
2022/23	3.02%	1.52%
2023/24	1.23%	0.58%

Source: Digital Health and Care Wales

Emergency Department (ED) attendances

Top Line Summary

- The scenarios suggest a peak of 261 to 511 ED attendances per day in Wales over the 2024/25 winter period.
- If the trend observed between October 2019 to April 2024 continues, the percentage of ED attendances estimated to meet the 4-hour target would decrease to from 70% in April 2024 to 67% in April 2025.

ED attendances due to respiratory problems

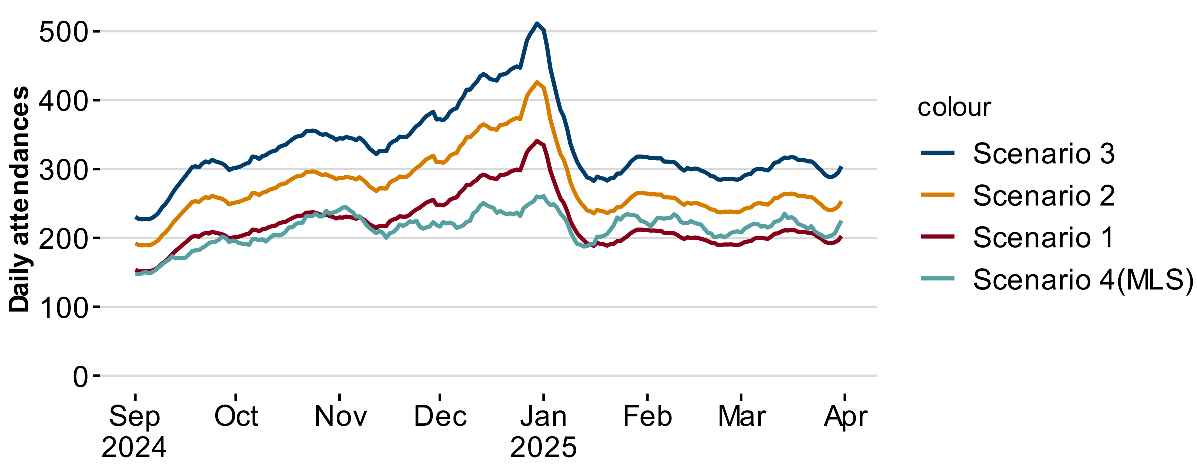
Figure 25: 7 day rolling average of daily ED attendances due to respiratory problems between January 2019 and March 2024

Source: Digital Health and Care Wales

ED attendances due to respiratory problems were analysed between January 2019 and March 2024. On average, there were 191 ED attendances per day due to respiratory issues. Additionally, small upticks were observed during the winters of 2019/20 and 2022/23 giving rise to daily peaks of 345 and 418 ED attendances. In line with these peaks, the following ED scenarios were created for the winter of 2024/25. Scenario 1 is the average of the non-pandemic years (2019/20, 2022/23 and 2023/24). Scenarios 2 and 3 are obtained by multiplying Scenario 1 by scalars 1.25 and 1.5. Scenario 4, which repeats last year's ED attendances, is considered the most likely scenario.

Scenarios 1-3 suggest daily peaks of 341, 426 and 511 ED attendances in the last week of December (30/12/2024). Scenario 4 suggests a smaller peak of 261 ED attendances per day on 01/01/2025 (first week of January).

Figure 26: ED attendances due to respiratory problems scenarios for winter 2024/25

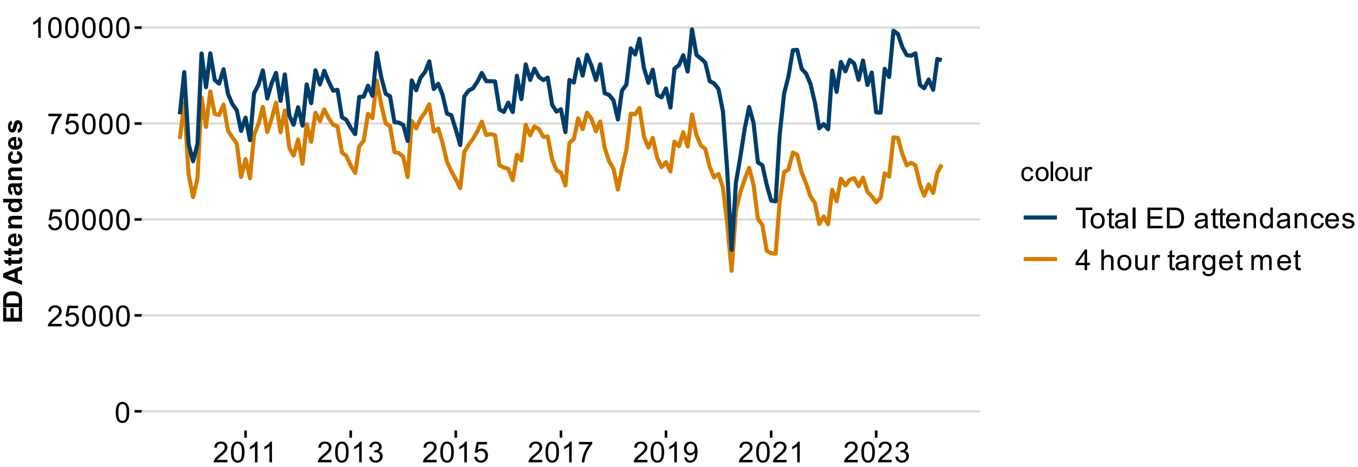


Source: Actuals to 31 March 2024 provided by DHCW, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Total ED attendances

There is a seasonal pattern to the ED attendances due to all causes, with maxima typically occurring in spring/early summer (May to July), and minima typically occurring in February. In 2023/24, Emergency Department (ED) attendances reached their highest in May with 99,193 attendances, and their lowest in February with 83,761 attendances

Figure 27: Monthly total ED attendances and performance against 4 hour waiting times target between October 2009 and April 2024



Source: Performance against 4 hour waiting times target, all emergency care facilities by local health board (gov.wales)

Ambulance calls

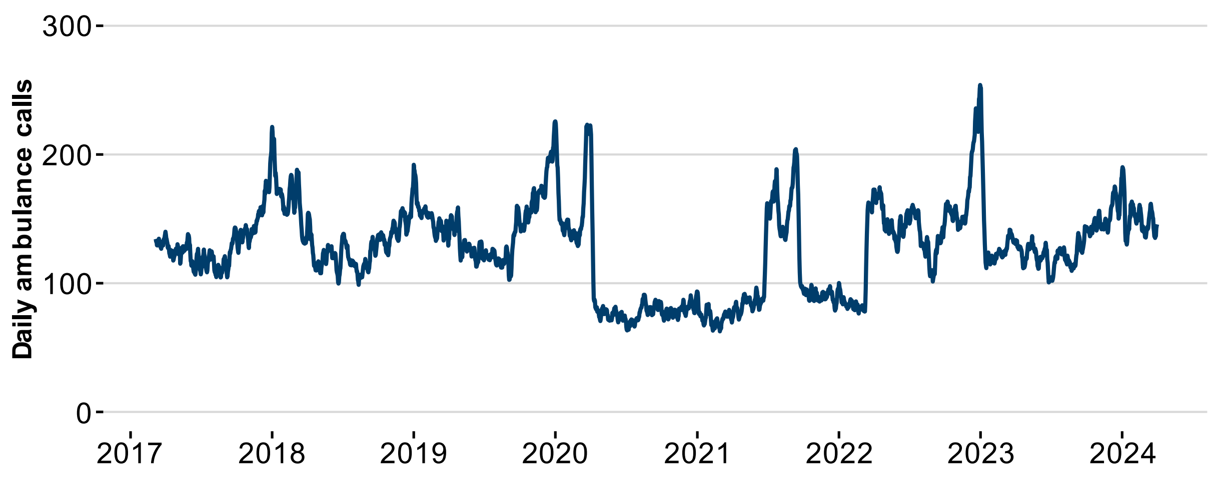
Top Line Summary

- Scenarios estimating the number of ambulance calls for respiratory problems (code 6) suggest a peak between 190 and 324 daily calls for the 2024/25 winter season.
- Modelled projections suggest red calls due to respiratory problems are likely to peak during third week of December with an estimated peak value of 70 daily calls while amber calls are expected to peak last week of December with an estimated peak value of daily 100 calls.

Ambulance calls due to respiratory problems

Emergency ambulance calls due to respiratory problems (code 6) were analysed between March 2017-2024. Calls due to pandemic flu (code 36) were excluded from the analysis due to low numbers after 2021. Total number of ambulance calls exhibited a seasonal pattern over the years, typically peaking during the first week of January (excluding pandemic years).

Figure 28: 7-day rolling average of daily ambulance calls due to respiratory problems between March 2017 and March 2024



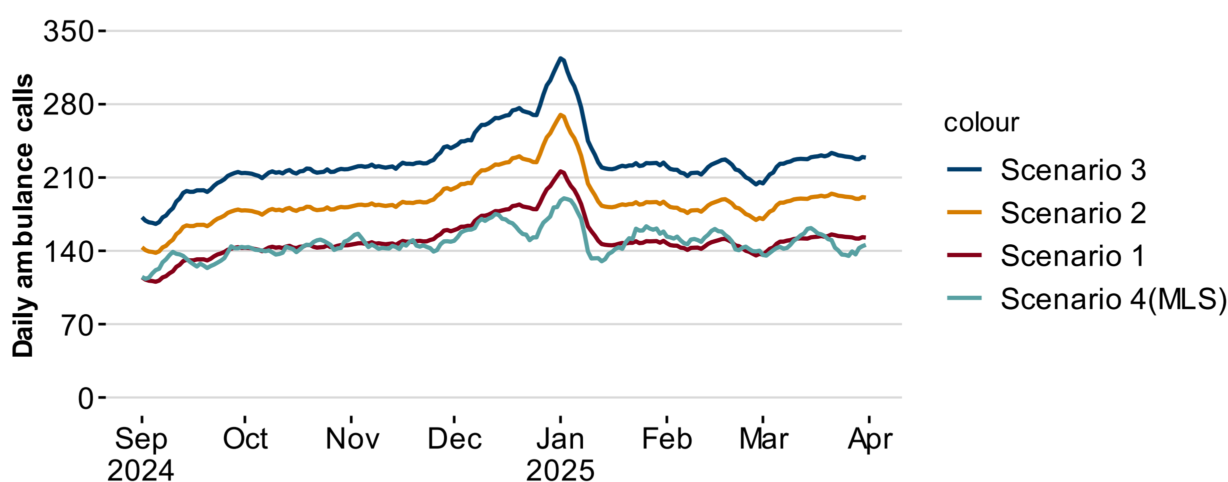
Source: Welsh Ambulance Services University NHS Trust (WAST)

During the winter of 2023/24, there was a smaller peak than the year prior of 190 daily emergency calls on 2nd January 2024, 75% times of the peak height during the winter of 2022/23 of 254 daily emergency calls on 31st December 2022. A similar trend was observed in the total number of ambulance calls, with the financial year 2023/24 experiencing fewer ambulance calls compared to 2022/23 (49,910 compared to 53,726 respectively).

As the total number of ambulance calls showed a seasonal trend, the following scenarios were created for the winter of 2024/25. Scenario 1 was the average of the non-pandemic years (2017/18, 2018/19, 2019/20, 2022/23 and 2023/24). Scenarios 2

and 3 are obtained by multiplying Scenario 1 by scalars 1.25 and 1.5. Scenario 4, which repeats last year's ambulance calls data, is considered the most likely scenario.

Figure 29: Ambulance calls due to respiratory problems scenarios for 2024/25 winter

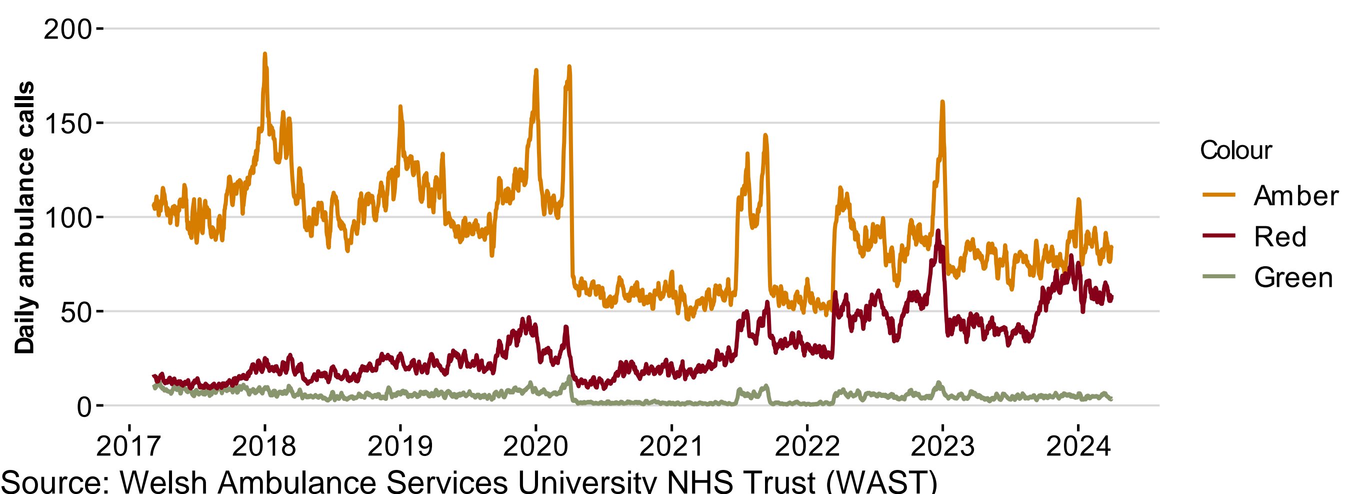


Source: Actuals to 31 March 2024 provided by Welsh Ambulance Services University NHS Trust (WAST), projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Scenarios 1-3 suggest that the daily ambulance calls are likely to peak in the first week of January 2025 with peak values of 216, 270 and 324 daily ambulance calls. Scenario 4, which is the repeat of last year's data, suggests a slightly smaller peak of 190 daily ambulance calls in the same week.

Ambulance calls are colour coded- red calls (immediately life-threatening situation), amber calls (life-threatening or serious) and green calls (not serious or life-threatening).[22]

Figure 30: 7-day rolling average of daily ambulance calls in Wales due to respiratory problems (code 6), by colour, March 2017 to March 2024.



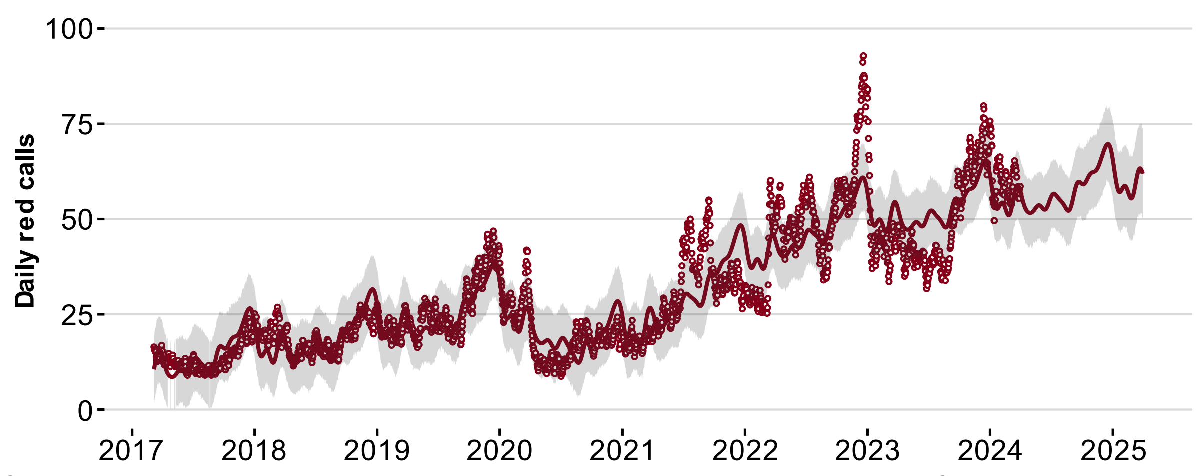
Source: Welsh Ambulance Services University NHS Trust (WAST)

[22] NHS 111 Wales

The total number of red calls due to respiratory problems (code 6) increased from 5,516 in 2017/18 to 19,015 in 2023/24. By contrast, the number of code 6 amber calls decreased from 42,599 in 2017/18 to 29,235 in 2023/24.

Given the increasing trend in red calls and the decreasing trend in amber calls over the years included in this analysis, along with a monthly seasonal pattern, the Prophet model was used to generate scenarios that combine both annual and seasonal trends. Prophet is a procedure implemented by Meta for forecasting time series data based on an additive model where non-linear trends are fit.[23] Scenarios were not created for green calls as the numbers were too low.

Figure 31: Ambulance red calls due to respiratory problems scenarios for 2024/25 winter [Note 1]

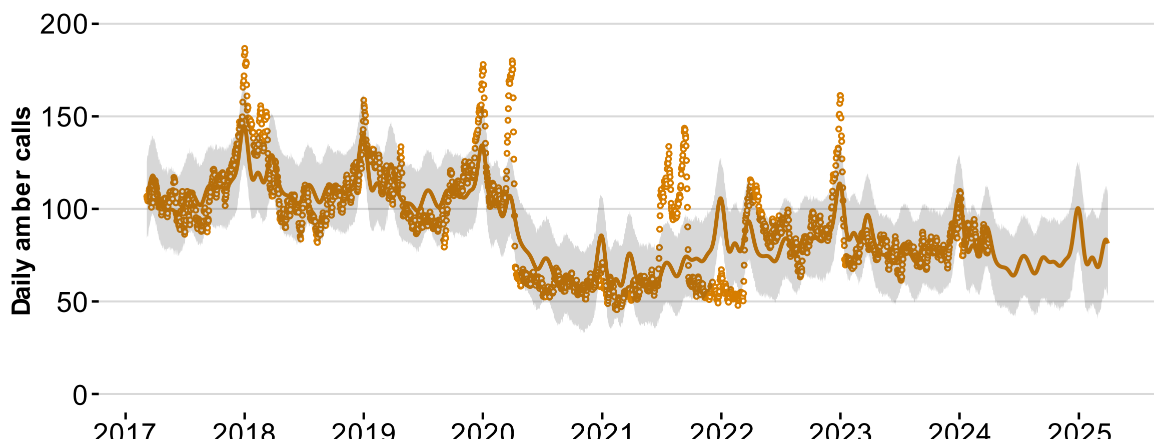


Source: Actuals to 31 March 2024 provided by Welsh Ambulance Services University NHS Trust (WAST), projected scenarios from 1 September 2024 to 31 March 2025 from SEA

[Note 1]: The red dots represent the historical data points, the red line depicts the model fit, and the grey ribbons indicate the confidence intervals.

[23] Prophet | Forecasting at scale. (facebook.github.io)

Figure 32: Ambulance amber calls due to respiratory problems scenarios for 2024/25 winter [Note 1]



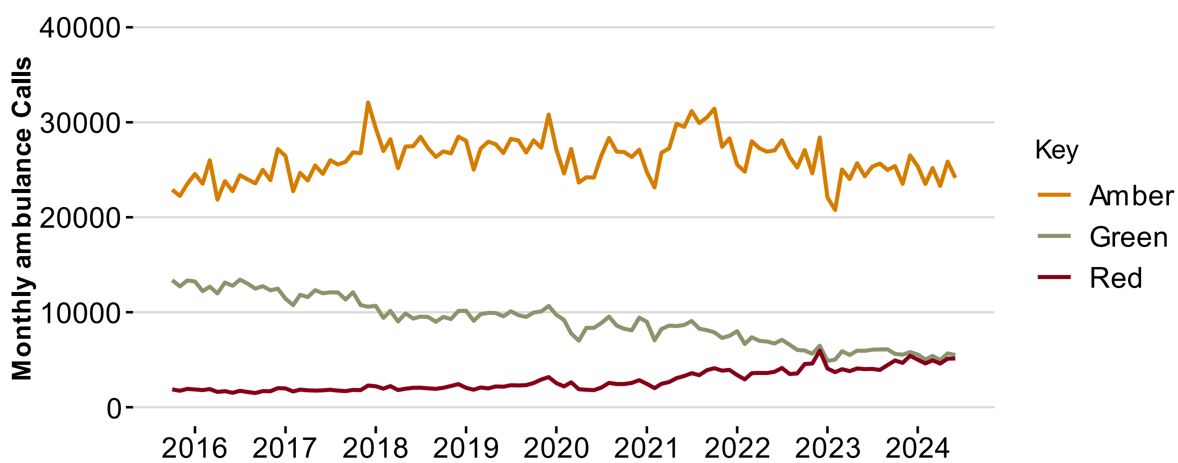
Source: Actuals to 31 March 2024 provided by Welsh Ambulance Services University NHS Trust (WAST), projected scenarios from 1 September 2024 to 31 March 2025 from SEA

[Note 1]: The amber dots represent the historical data points, the amber line depicts the model fit, and the grey ribbons indicate the confidence intervals.

Red calls are estimated to peak during third week of December (17/12/2024) with a peak value of 70 calls (lower limit=60, upper limit=79) while amber calls are expected to peak last week of December (29/12/2024) with a peak value of 100 calls (lower limit=76, upper limit=124).

Ambulance calls due to all causes by month

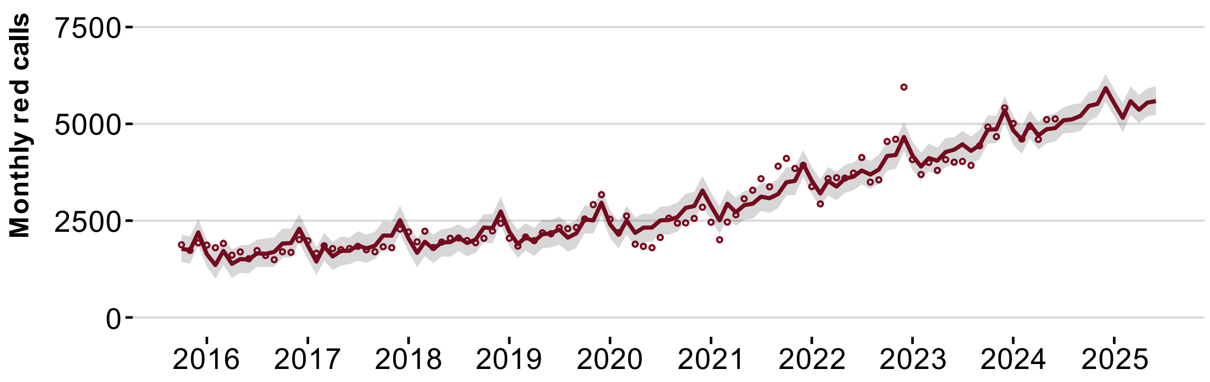
Figure 33: Monthly emergency ambulance calls due to all causes from October 2015 to June 2024



Source: Emergency ambulance calls and responses to red calls, by LHB and month (gov.wales) and SEA calculations

Monthly ambulance calls due to all causes were obtained from Stats Wales. Red calls showed an increasing trend, rising from 1,877 in October 2015 to 5,127 in June 2024. Green calls decreased from 13,337 in October 2015 to 5,487 in June 2024. Amber calls increased between 2015 and 2018, after which it plateaued. Red and amber calls typically peaked in December each winter, except during the pandemic years. Scenarios were created using Prophet, as mentioned previously.

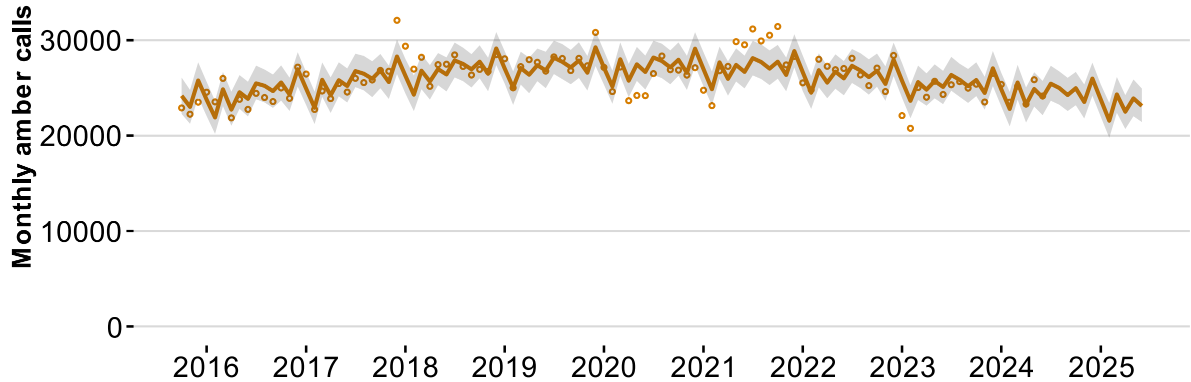
Figure 34: Monthly ambulance red calls due to all causes, scenarios for 2024/25 winter.



Source: Emergency ambulance calls and responses to red calls, , projected scenarios from 1 September 2024 to 31 March 2025 from SEA

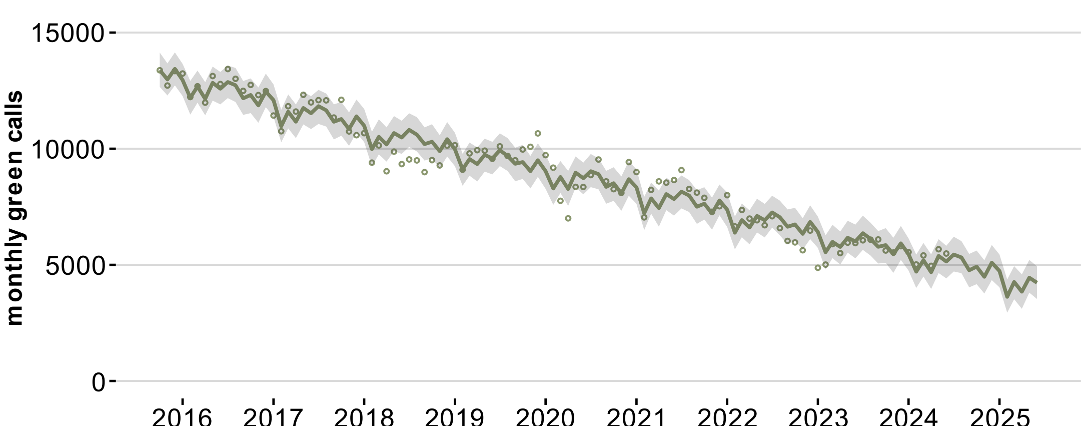
Red calls are estimated to peak at 5,923 and amber calls are estimated to peak at 25,979 with both peaks occurring in December 2024.

Figure 35: Monthly ambulance amber calls due to all causes, scenarios for 2024/25 winter.



Source: Emergency ambulance calls and responses to amber calls, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Figure 36: Monthly ambulance green calls due to all causes, scenarios for 2024/25 winter.



Source: Emergency ambulance calls and responses to green calls, projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Primary Care

Top Line Summary

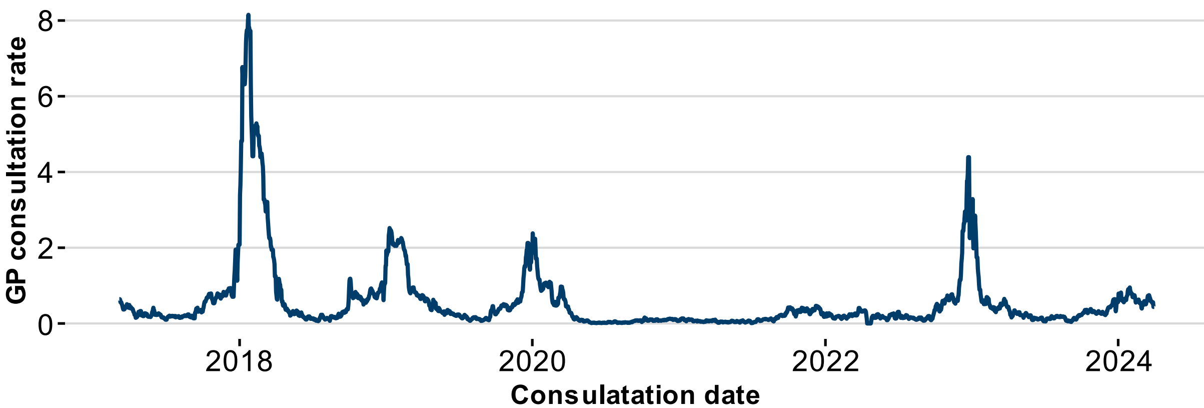
- The scenarios suggest there will be a peak of 30 to 138 GP consultations for influenza-like illness (ILI) per day in Wales over the 2024/25 winter period. The smallest peak in the scenarios (30 daily consultations) is a repeat of the 2023/24 data.
- The total acute respiratory infections (ARI) GP consultation rate dropped in 2023/24 with only 6,331.5 consultations per 100,000, compared to 8,706.1 in 2022/23.

GP consultations data related to infectious diseases (such as influenza and COVID-19) are derived from the GP Sentinel Surveillance of Infections Scheme in Wales. This program monitors a subset of GP practices within Wales. The diagnosis relies on syndromic evaluation of patients, without conducting specific pathological tests for confirmation. Therefore, it is likely that GP consultations might over/underestimate the incidence of infectious diseases. To standardise the data, consultation rates are normalised by the practice population, resulting in consultations per 100,000 population.

Influenza-like illness (ILI)

Daily sentinel GP consultation rate for influenza-like illness (ILI) was analysed between March 2017 and March 2024. Before the pandemic, an average of 333.2 consultations per 100,000 population was observed in Wales annually. The ILI consultation rates dipped during the COVID-19 pandemic years in line with the influenza and pneumonia admissions. ILI rates returned to nearly pre-pandemic levels (220.3 consultations per 100,000 population) in 2022/23 but decreased almost by 46% to 119.7 consultations per 100,000 population in 2023/24. Similarly, 2023/24 winter showed a significantly smaller daily peak ILI rate when compared to 2022/23 (1.0 vs 4.4 consultations per 100,000 population).

Figure 37: 7-day rolling average of daily Influenza like illness (ILI) GP consultation rate, March 2017 to March 2024

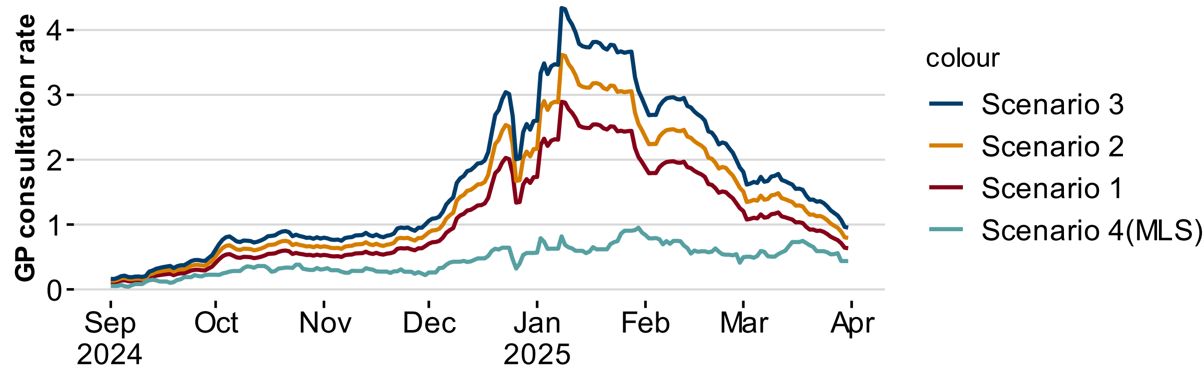


Source: Public Health Wales

Using the historical data, the following scenarios for ILI consultation rates were created. Scenario 1 was the average of the non-pandemic years (2017/18, 2018/19, 2019/20,2022/23 and 2023/24). Scenarios 2 and 3 are obtained by multiplying Scenario 1 by scalars 1.25 and 1.5. Scenario 4, which repeats last year's ILI rate, is considered the most likely scenario.

Scenarios 1-3 suggest that the daily ILI consultations are likely to peak in the first week of January 2025 with peak values of daily GP consultation rate 2.89, 3.62 and 4.34 per 100,000 population (or 92,115 and 138 consultations) respectively. Scenario 4, which is the repeat of last year's data, suggests a significantly smaller peak of 0.95 per 100,000 population daily GP consultation rate in the last week of January (40 consultations).

Figure 38: Daily Influenza like illness (ILI) GP consultation rate scenarios for 2024/25 winter.

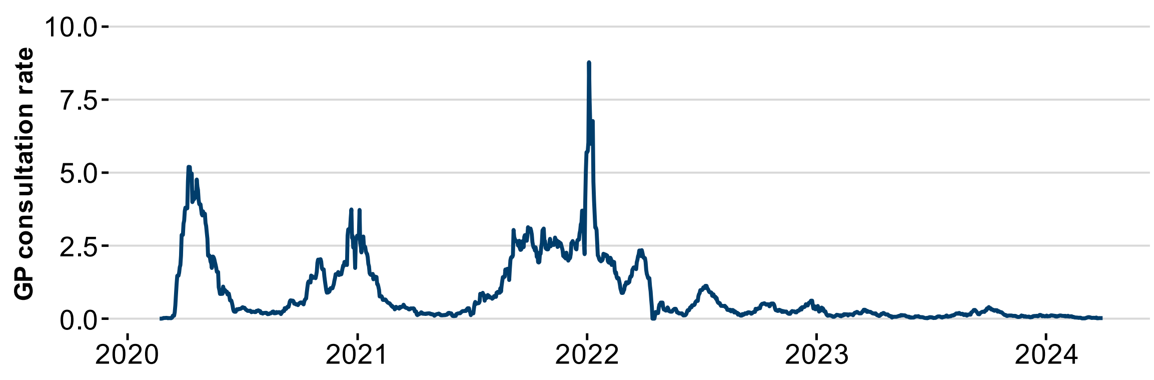


Source: Actuals to 31 March 2024 provided by Public Health Wales (PHW), projected scenarios from 1 September 2024 to 31 March 2025 from SEA

Suspected COVID-19

GP consultation rates due to suspected COVID-19 were high in 2020/21 and 2021/22 reaching 446.8 and 611.5 consultations per 100,000 population annually. This number dropped to around 38 consultations per 100,000 population in 2023/24 suggesting the impact of COVID-19 pandemic on the primary care system has reduced considerably.

Figure 39: 7-day rolling average of daily suspected COVID-19 GP consultation rate, March 2020 to March 2024

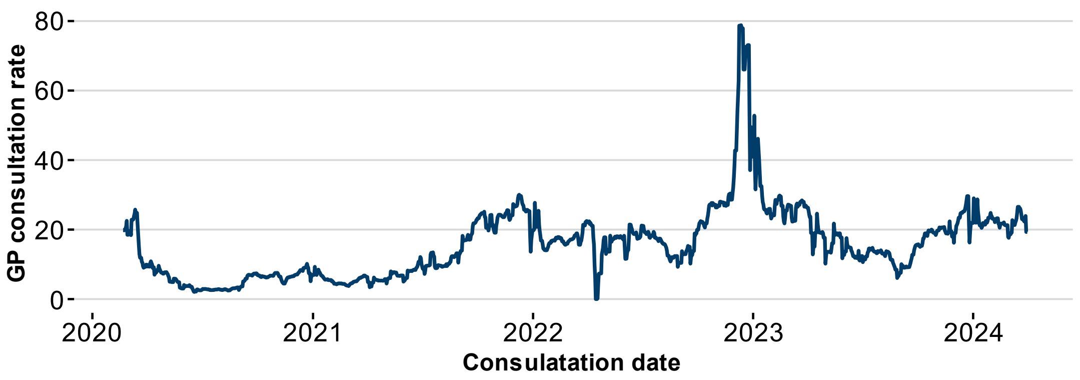


Source: Public Health Wales

Acute Respiratory Infections

UKHSA defines acute respiratory infections (ARI) as the acute onset of one or more of the respiratory symptoms listed at People with symptoms of a respiratory infection including COVID-19 and a clinician's judgement that the illness is due to a viral acute respiratory infection (for example COVID-19, flu, respiratory syncytial virus (RSV)).[24] During the winter of 2022/23, there was a peak of 78.8 acute respiratory infection (ARI) consultations per 100,000 population. In contrast, the winter of 2023/24 saw a smaller peak, with 29.6 consultations per 100,000. Total ARI GP rate dropped in 2023/24 with only 6,331.5 consultations per 100,000, compared to 8,706.1 per 100,000 population in 2022/23.

Figure 40: 7-day rolling average of daily Acute respiratory infections (ARI) GP consultation rate, March 2020 to March 2024



Source: Public Health Wales

[24] Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) - GOV.UK (www.gov.uk)

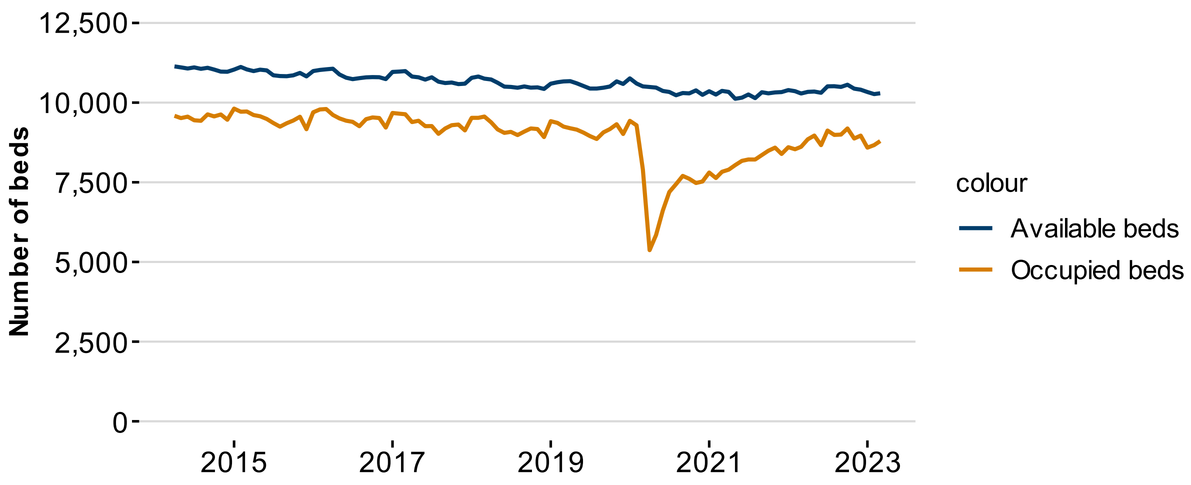
Capacity and Resilience

Top Line Summary

- All scenarios suggest that the paediatric bed occupancy is likely to peak in November 2024 with peak values between of 271 and 419 occupied beds per day.
- Overall, patients waiting to start treatment increased to 768,899 in March 2024, the maximum recorded figure since September 2011.
- Referrals with a wait time of above 36 weeks was the highest during August 2022 when it reached a maximum of 271,165. In 2023/24, this decreased to 251,287 in March 2024.

NHS Hospital Beds

Figure 41: Number of beds available and occupied, April 2014 to March 2023.



Source: Monthly NHS beds data by measure, site and specialty, March 2014 onwards (gov.wales)

Between April 2014 and March 2023, the number of beds occupied by patients in hospitals in Wales never exceeded the number of beds available. This is contrary to the pressures in demand observed in hospitals which is often publicised whereby patients are unable to obtain hospital beds. The difference between the number of hospital beds available and those occupied could be attributed to several factors such as:

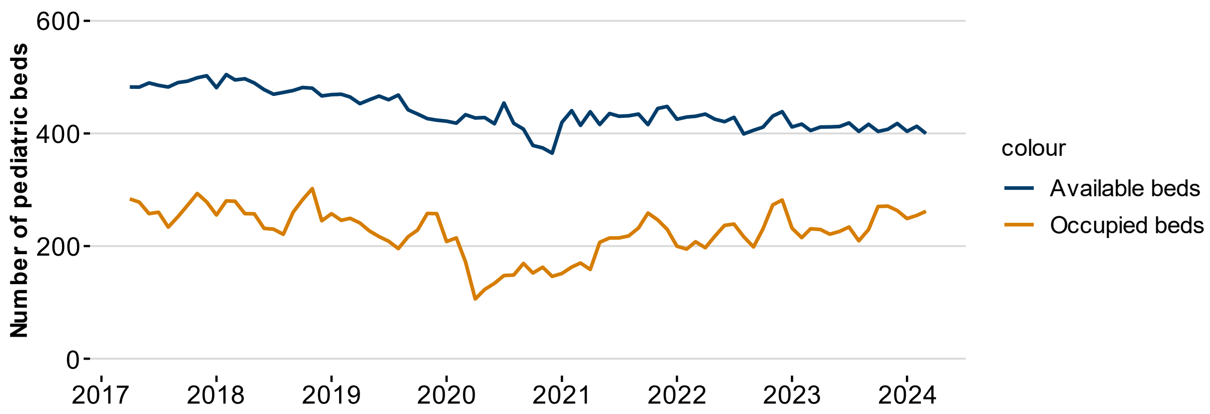
- Staffing issues where a shortage of health care staff may limit the hospital's ability to utilise their beds effectively,
- Specialised care requirements where some patients require care that is only available in certain types of beds (eg. ICU, cardiac care or paediatric beds)

- Emergency admissions where hospitals may face sudden surges leading to a temporary mismatch between bed availability and demand. During these peaks, patients may be placed in corridors until beds become available
- Hospital policies and procedures where some hospitals may mandate keeping a percentage of hospital beds free for emergency situations
- Logistical and administrative delays where cleaning and preparing beds could lead to delays in a bed becoming available again after a patient is discharged from it

NHS Paediatric Hospital Beds

Paediatric beds are defined here as beds designated for paediatric care, typically to those aged 0 to 18 years. The annual peak for the number of paediatric beds occupied in Wales was between 258 and 302 beds per day from 2017/18 to 2023/24, with the exception of 2020/21 when the peak was 170 beds occupied per day. The peak in 2023/24 equated to 67% of the available beds being occupied. This is the highest peak in percentage occupied across the timeseries analysed. Figure 42 shows that the number of beds occupied in Wales has remained below the beds available across the whole timeseries.

Figure 42: Number of paediatric beds available and occupied, April 2017 to March 2024



Source: Digital Health and Care Wales

Using the historical data, the following scenarios for number of paediatric beds occupied were created. Scenario 1 was the average of the non-pandemic years (2017/18, 2018/19, 2019/20,2022/23 and 2023/24). Scenarios 2 and 3 are obtained by multiplying Scenario 1 by scalars 1.25 and 1.5. Scenario 4, which repeats last year's paediatric beds data, is considered the most likely scenario.

Figure 43: Number of paediatric beds occupied scenarios for 2024/25 winter.

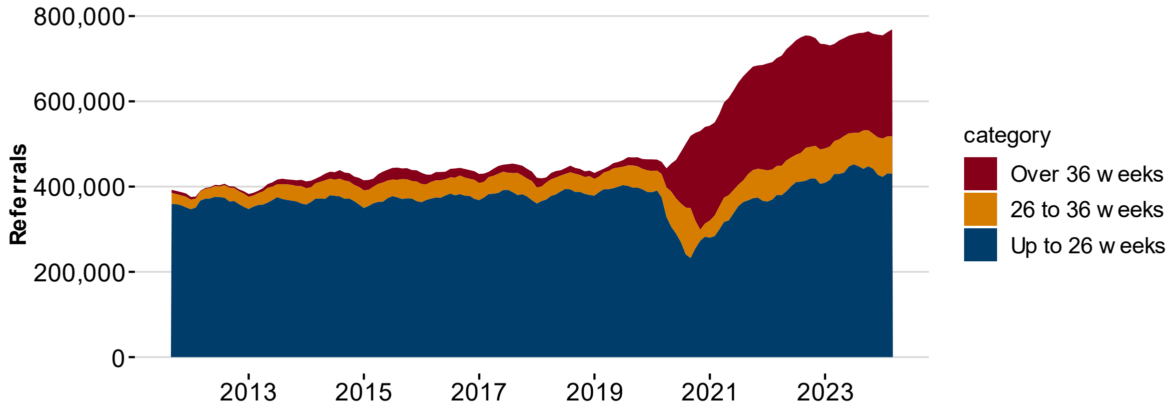
Number of occupied pediatric beds
500
400
300
200
100
0
Sep 2024 Oct Nov Dec Jan 2025 Feb Mar
Scenario 3
Scenario 1
Scenario 2
Scenario 3
Scenario 4(MLS)

Source: Actuals to 31 March 2024 provided by DHCW projected scenarios from 1 September 2024 to 31 March 2025 from SEA

All scenarios suggest that the paediatric bed occupancy is likely to peak in November 2024 with peak values of 280, 349, 419 and 271 occupied beds per day (scenario 1-4 respectively).

Referrals

Figure 44: Referral to treatment patient waiting times to start treatment, September 2011 to March 2024



Source: Patient pathways waiting to start treatment (StatsWales)

The patients receiving referrals from a GP or other medical practitioner to hospital for treatment in the NHS in Wales were categorised by the wait times: up to 26 weeks, 26-36 weeks and above 36 years.[25] Overall, patients waiting to start treatment increased in the month of April 2023 from 743,060 to 768,899 in March 2024. This increase is the maximum recorded figure since September 2011. Referrals with a wait time of above 36 weeks was the highest during August 2022 reaching a maximum of 271,165 during the period covered by the chart (September 2011 to March 2024).

[25] Referral to treatment (gov.wales)

However, the number of monthly referrals has been increasing since September 2023 and reached 271,872 in June 2024.

Industrial Action

Between 7am on Monday 15 January to 7am on Thursday 18 January 2024, industrial action by junior doctors took place. During this 72-hour period, data from self-assessments provided by Local Health Boards in Wales showed that 41% (22,258) of outpatient appointments and 62% (1,467) of surgical cases were cancelled or postponed. Knowing this should allow for more accurate modelling prior to future strikes. There are however other varying factors to consider for any potential future industrial action, including the increased amount of annual leave booked during a holiday (eg. Easter) by staff who could potentially cover the staff shortages.

In June 2024, the British Medical Association's (BMA's) consultants, junior doctors and SAS (specialist, associate specialist, and specialty doctors) committees in Wales have all accepted the Welsh Government's pay offers after members voted in favour of the deals, putting an end to the three separate pay disputes for doctors working in secondary care. The acceptance of the pay offers following the referendum officially puts an end to the current pay disputes. [26] A GP strike has been announced in England on 2 August 2024. It is unclear whether similar action will take place in Wales, but early planning may help mitigate any impacts of any future industrial action by health care workers.

[26] Doctors in Wales vote to accept pay offers - BMA media centre - BMA

Vaccine uptake

Top Line Summary

- Vaccine uptake for flu has remained fairly stable between 2020/21 and 2023/24. Vaccine uptake for COVID-19 (at least 1 dose in 2020/21 and a booster in subsequent years) has decreased from 97% in 2020/21 to 75% in 2023/24, meaning uptake rates are now similar to those for flu.
- Recent studies assessing vaccine uptake interventions report varying results. There is evidence to support the effectiveness of providing information on the benefits and risks of a vaccine from a trusted source, as well as for behaviourally informed reminders such as letters, phone calls and texts.
- 40% of respondents to a Public Health Wales survey said they would need more information before deciding whether or not to accept the new Respiratory Syncytial Virus (RSV) vaccine this winter, in addition to the 14% who said they would not accept it.

Evidence on vaccine uptake and interventions

Each winter, vaccinations are offered to certain groups within the Welsh population, including health and social care workers, children, and those with clinical vulnerabilities. High uptake for flu and COVID-19 vaccinations, as well as a new vaccine for RSV to be introduced in 2024, is critical for minimising pressures on the health service over winter by reducing incidence and severity of illness.

There is some concern that vaccine hesitancy is increasing globally following the COVID-19 pandemic, especially with social media as a tool for sharing anti-vaccine content to a wider audience[27,28]. Flu vaccine uptake rates among those aged 65 and over in Wales have been above 70% in recent years[29] although uptake among those at risk aged below 65 is substantially lower. For both groups, uptake increased during the pandemic compared with winter 2019/20, but decreased again during winter 2023/24. Uptake of COVID-19 vaccines has decreased over time but is now at similar levels to the flu vaccine. It is unclear whether there is a significant problem with vaccine hesitancy for winter vaccines in Wales.

Healthcare workers

Achieving high uptake of winter vaccines among healthcare workers is crucial as they may have higher levels of exposure to viruses and more opportunities to pass on viruses to vulnerable patients/service users if infected. In addition, high levels of sickness absence among healthcare workers over winter puts additional strain on a

[27] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00136-8/fulltext
[28] https://www.bmj.com/content/384/bmj-2023-076542
[29] The WHO target for those aged 65 and over is 75% uptake; this was exceeded in Wales for three consecutive winters between 2020/21 and 2022/23.

system which already experiences substantial pressure during this period. It has been previously shown that improving NHS flu vaccination rates can reduce staff sickness absence levels[30].

Public Health Wales "Time to talk" surveys

Public Health Wales have asked questions relating to vaccines in several iterations of their Time to Talk panel survey.[31] In December 2023, 80% of respondents who were offered a COVID-19 booster vaccine for winter 2023/24 said they had already had it or were planning to have it. For the flu vaccine, the equivalent figure was 81%.

In May 2024, survey respondents were asked questions about the vaccine for RSV, which will be offered for the first time in winter 2024/25. When asked if they would accept an RSV vaccine offer, 44% said that they would, 14% said they would not, and 40% said they would need more information in order to make their decision. 80% of the participants reported that they did not have difficulties getting an appointment for a vaccine. There was a spread of responses to the acceptable travelling distance for a vaccine appointment from up to 1 mile (10%), up to 3 miles (26%), Up to 5 miles (33%), up to 10 miles (21%) and over 10 miles (7%), reflecting a broad range of circumstances and or attitudes to travel. The most preferred appointment slots were in the morning on a Monday, Tuesday, Wednesday and Saturday, whilst evenings were least preferred across all the days amongst the respondents.

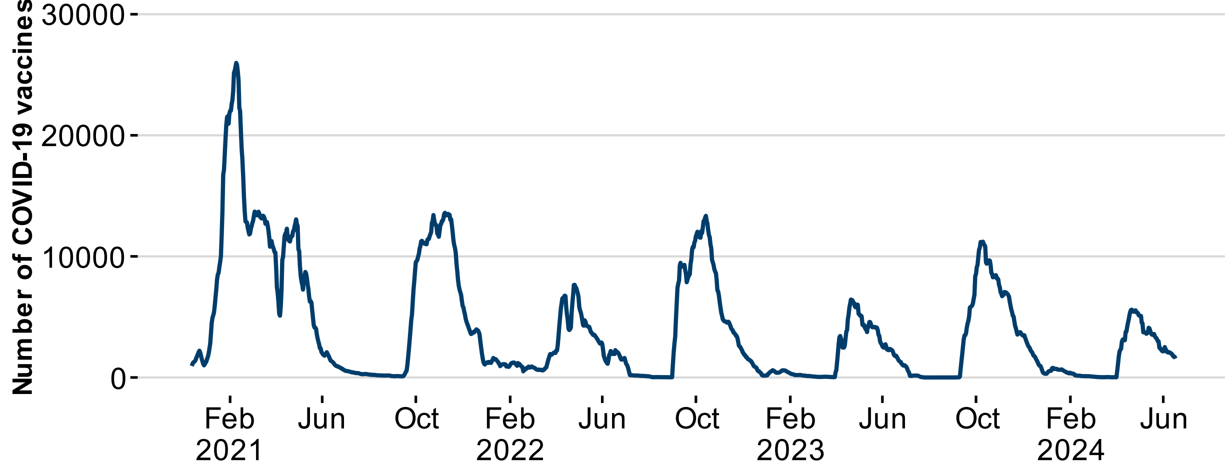
Vaccine uptake in Wales

COVID-19 Vaccinations

Since vaccination programmes (for COVID-19 and flu) are often rolled out in Autumn (and again the following spring for COVID-19), we have taken the vaccination years in our analysis to run from 1 September to 31 August. We have used the ONS population mid-year estimates to estimate the size of the population aged 65 and above in Wales. For example, the 2020/21 vaccine year would include vaccines administered in Wales between 1 September 2020 and 31 August 2021 and would use the mid-2021 population size to estimate the vaccine uptake levels. Note that, in the absence of population estimates beyond mid-2022, we have also used the mid-2022 population estimate for the 2022/23 and 2023/24 vaccine years.

[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297706/
[31] https://phw.nhs.wales/topics/time-to-talk-public-health-panel/time-to-talk-public-health-panel-publications/publications/time-to-talk-public-health-december-2023-panel-survey-findings/

Figure 45: Number of COVID-19 vaccines administered to health care workers per day, adults aged 65 and above and immunocompromised individuals (7 day rolling average), December 2020 to June 2024

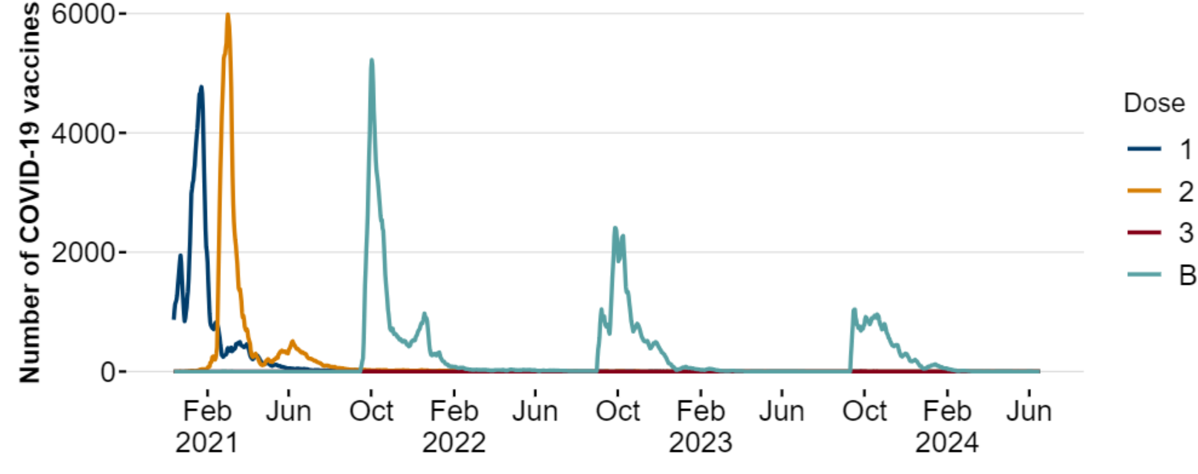


Source: Public Health Wales

The large peak of over 25,000 daily COVID-19 vaccines in early 2021 was due to the initial rollout of the COVID-19 vaccine to a large proportion of the population of Wales. Since then, booster COVID-19 vaccines have been offered to certain individuals (eg. health and social care workers, those aged over 65 and those immunocompromised). Booster programmes have been run twice a year, with an offer to certain individuals in Autumn and then another roll out to fewer individuals in spring for the past 3 years. This explains why the daily vaccines administered peaked at higher levels in Autumn (around 11,000 to 13,500) compared with spring (around 5,000 to 8,000).

Different populations meet different eligibility criteria for COVID-19 vaccine programmes so it may be more useful to look at the populations of those aged 65 and above in Wales, health and social care workers, and those who are immunocompromised separately.

Figure 46: COVID-19 vaccines administered daily to health and social care workers, by vaccine year, by dose, December 2020 to June 2024 [Note 1]

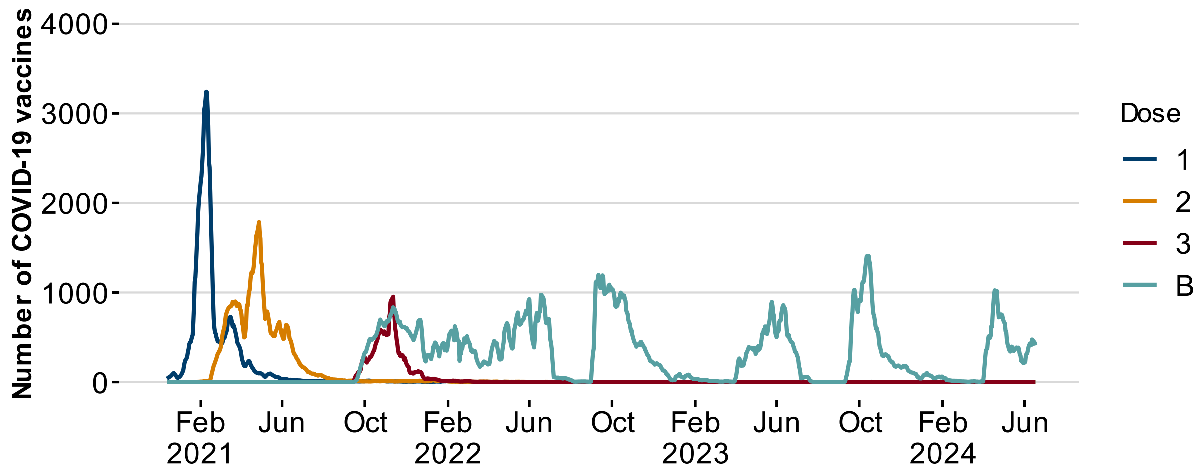


Source: Public Health Wales

[Note 1]: Dose B stands for the booster COVID-19 vaccination.

Though health and social care workers have been eligible for one COVID-19 booster vaccine each year for the past 3 years (2021/22, 2022/23 and 2023/24), the number of COVID-19 total vaccines being administered has decreased each year. Since 2020/21 where 172,000 first doses and 169,000 second doses were administered, the vaccines taken by health and social care workers has decreased from 156,000 vaccines in 2021/22 to 63,000 in 2023/24. Note that, the 2023/24 vaccine year is not complete yet but vaccine uptake tailed off after February 2024 so is unlikely to rise much above this figure.

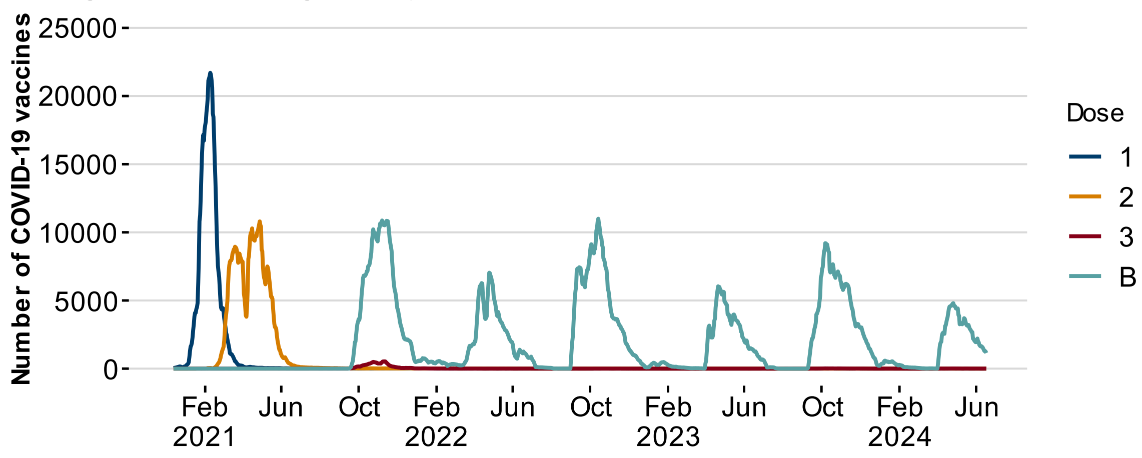
Figure 47: Number of COVID-19 vaccines administered per day (7 day rolling average) to immunocompromised individuals, December 2020 to June 2024



Source: Public Health Wales

The vaccines rolled out to immunocompromised individuals follow a slightly different pattern to other groups eligible for the COVID-19 vaccine. There were 2 clear spikes each year from 2021/22 indicating a separate autumn and spring vaccination programme for health and social care workers and adults aged 65+. This wasn't the case for immunocompromised individuals where numbers of vaccines administered per day did not fall to near zero between September 2020 and June 2021.

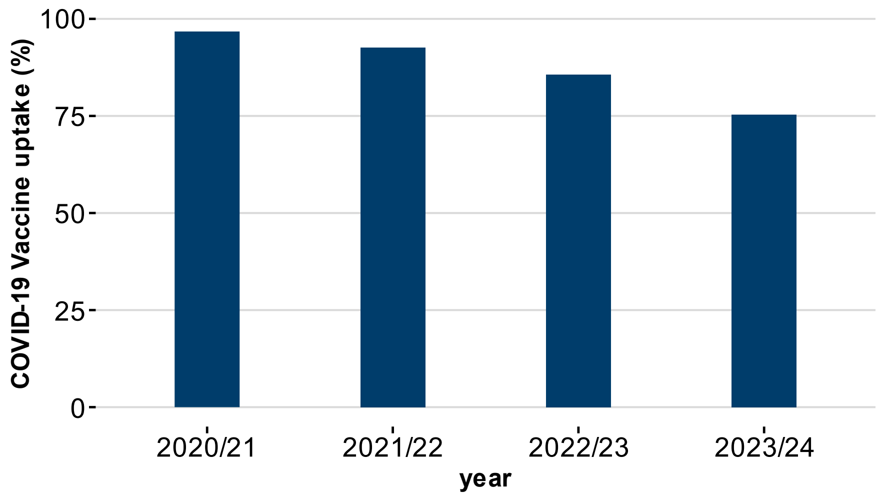
Figure 48: Number of COVID-19 vaccines administered per day (7 day rolling average) to adults aged 65 years and over, December 2020 to June 2024



Source: Public Health Wales

The first course of COVID-19 vaccines included 2 doses. Dose 1 was mainly rolled out between December 2020 and March 2021 and dose 2 between February 2021 and June 2021. A small proportion of the population had a third dose. Since then, boosters have been administered each year, usually with an Autumn vaccination programme followed by a spring vaccination programme. The 2 programme rollouts can be observed in Figure 35 (above), as there are 2 peaks throughout each vaccine year from 2021/22 onwards. Not all those that had the Autumn booster were eligible for the spring booster.[32] The second wave in each vaccination year from the spring vaccination programmes are smaller than the autumn vaccination programme waves, at around half the size (50% for 2021/22, 47% for 2022/23, 45% for 2023/24). These figures were used to determine the vaccine uptake of people aged 65 and over in Wales having at least one booster within the year. Note that, some of those who had the spring booster may not have had the previous Autumn booster which may affect the estimation, but these numbers should be small.

Figure 49: Estimated percentage of adults aged 65 and above vaccinated with a COVID-19 vaccine (with dose 1 in 2020/21, and booster in subsequent years), December 2020 to June 2024



Source: Public Health Wales, ONS mid year population estimates

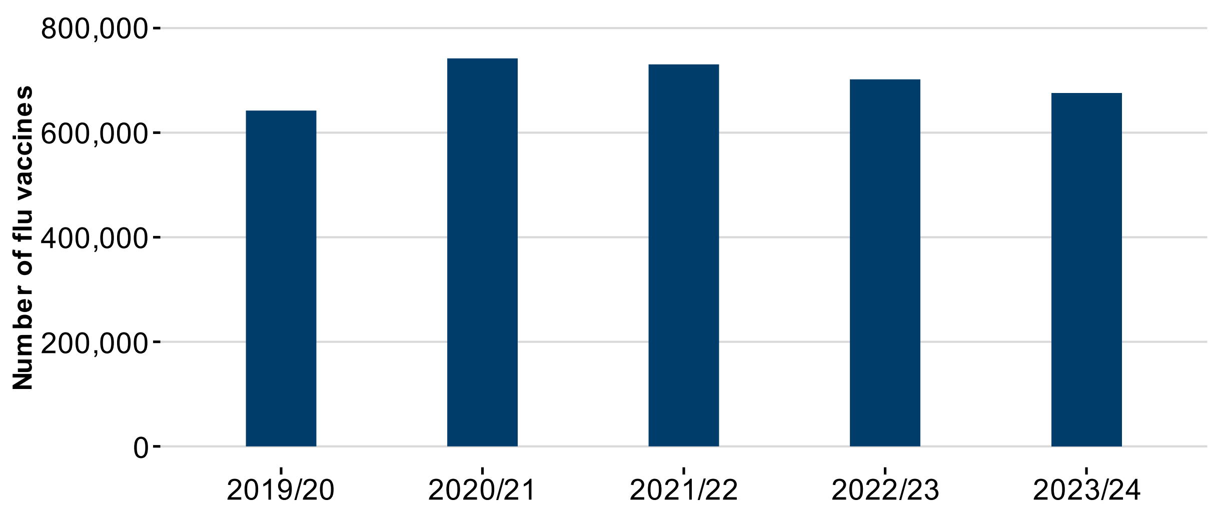
The vaccine uptake of the population of Wales aged 65 and above who have taken a COVID-19 vaccination (at least 1 dose in 2020/21 and a booster in subsequent years) has decreased from 97% in 2020/21 to 75% in 2023/24.

Influenza vaccinations

The vaccine programme offers one flu vaccine per vaccine year to eligible individuals. Therefore, the number of vaccines offered per year are like the same/similar to the number of people vaccinated for flu (which was not the case with COVID-19 where multiple vaccines could be administered within each vaccine year).

[32] COVID-19 vaccination programme | GOV.WALES

Figure 50: Total number of flu vaccines administered to adults aged 65 and above and individuals at risk (aged 6 months - 64 years) October 2019 to March 2024



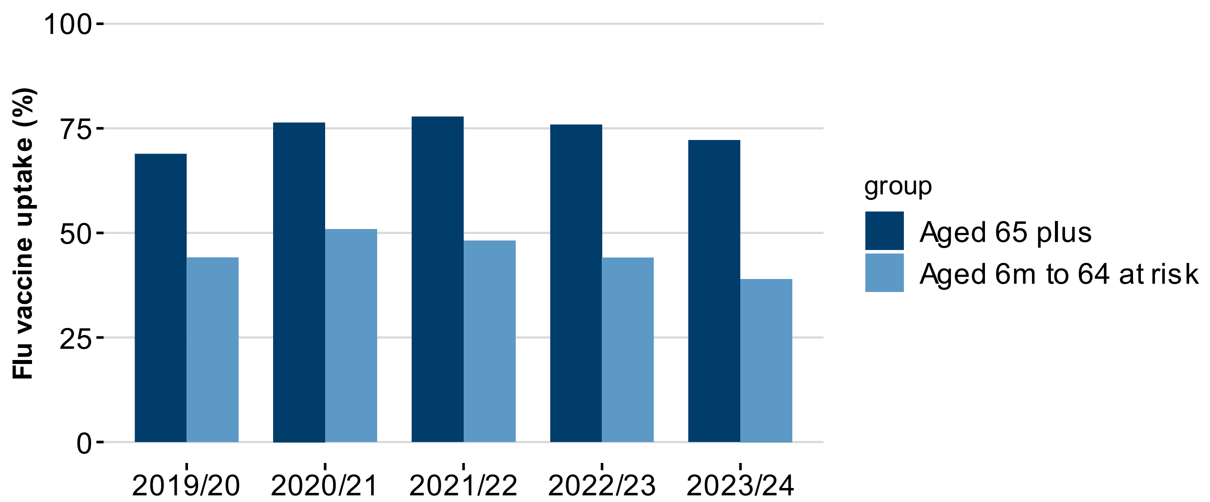
Source: Public Health Wales

Excluding the 2019/20 vaccine year where the flu vaccines administered were lower[33], the number of flu vaccines taken have decreased each year since 2020/21, closer to pre-pandemic levels. The total number of flu vaccines administered per year have decreased from 742,000 in 2020/21 to 676,000 in 2023/24. However, because the population eligible for the flu vaccine (provided by PHW) has also decreased, the vaccine uptake has remained fairly stable (between 67% and 70%).

However, it is useful to look at the different age groups (above 65 years and 6 months -64 year olds at risk). The target flu vaccine uptake for both age groups is 75%. Adults aged 65 and above had higher vaccine uptake than at-risk individuals aged 6 months - 64-years-old, meeting the threshold in the years 2020/21 – 2022/23. However, the at-risk individuals aged 6 months - 64 fell short of the 75% target, with vaccine uptake consistently around 50% or lower in previous years (2020/21 – 2022/23). In the winter of 2023/24, the vaccine uptake was 72% and 39% among adults aged 65 and above and at-risk individuals aged 6 months – 64 years respectively.

[33] Table (nhs.wales)

Figure 51: Estimated percentage of people vaccinated with the flu vaccine, October 2019 to March 2024

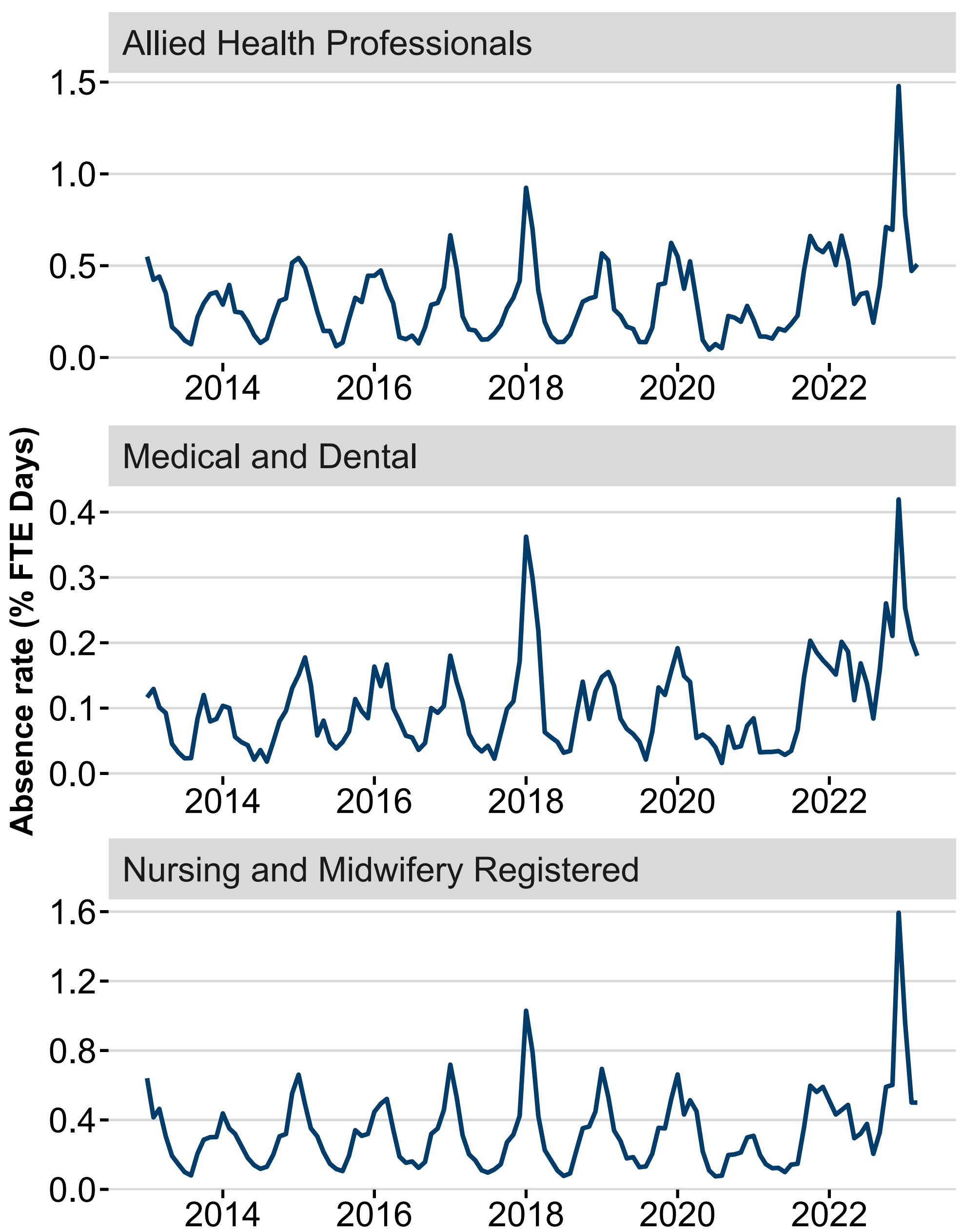


Source: Public Health Wales, ONS mid year population estimates

Absence rates of health care workers and the effect of flu vaccine uptake

Since health care workers are eligible for certain vaccines (flu, COVID-19 etc), we analysed whether there was a relationship between vaccine uptake and absence rates for each health care worker group (Allied health professionals, medical and dental, nursing and midwifery).

Figure 52: Monthly absence rate (% FTE days available) due to cold, cough or flu among different staff groups from 2013-2023.



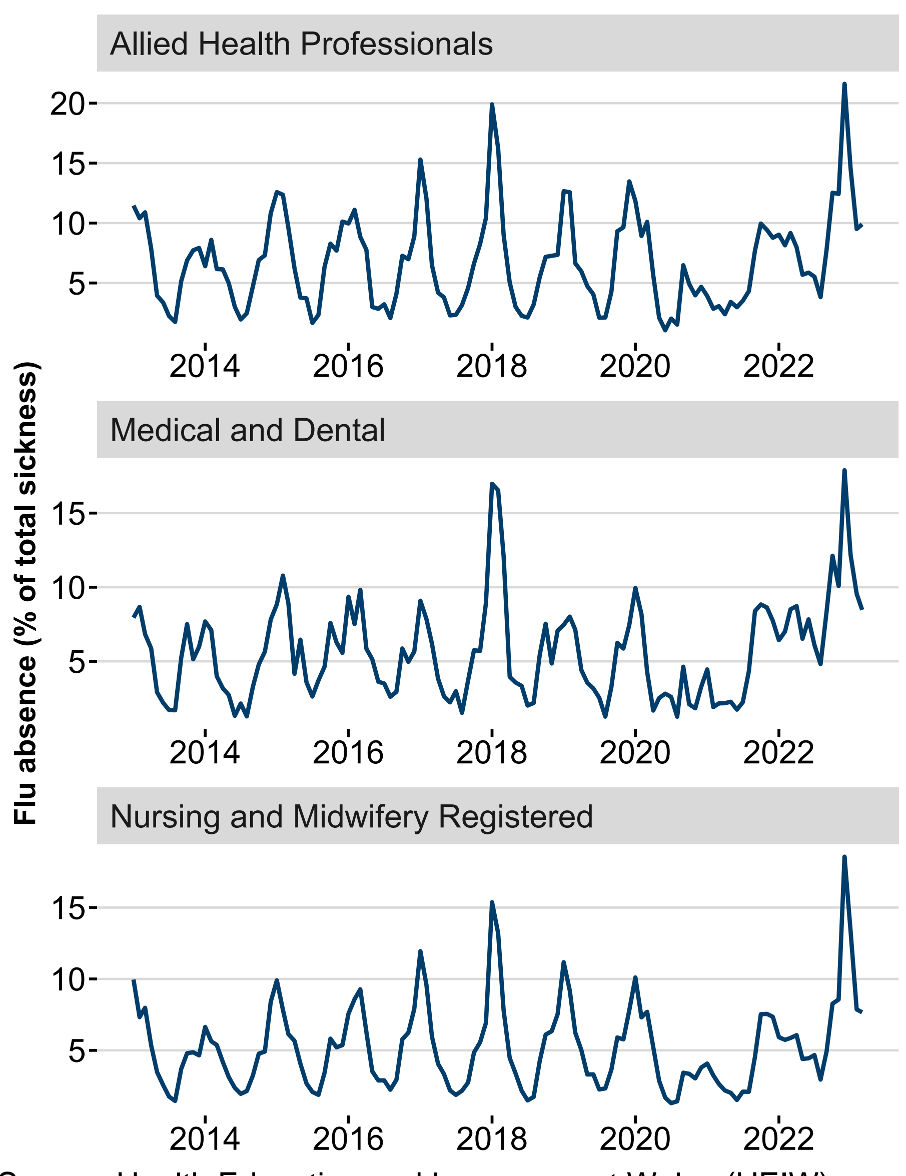
Source: Health Education and Improvement Wales (HEIW)

Between January 2013 and March 2023, the absence rate due to cold, cough or flu was lowest among medical and dental staff averaging to 0.10% within the given time frame. The average absence rate of nurses and allied health professionals was 0.33% and 0.31% respectively, around three times that of medical and dental staff resulting in 0.73 and 0.69 days per person lost due to flu each year.

Absence rate due to flu, cold and cough cycled periodically among health care workers (HCWs) in Wales, peaking each winter. Absence rates due to flu decreased in 2020-21 and 2021-22 flu seasons when compared to previous seasons before the COVID-19 pandemic. However, the 2022-2023 season saw a rise in absence rates in

comparison. Peak absence rates due to cough, cold and flu were 1.59% for nurses, 0.42% for medical staff, and 1.48% for Allied Health Professionals occurring in the month of December 2022.

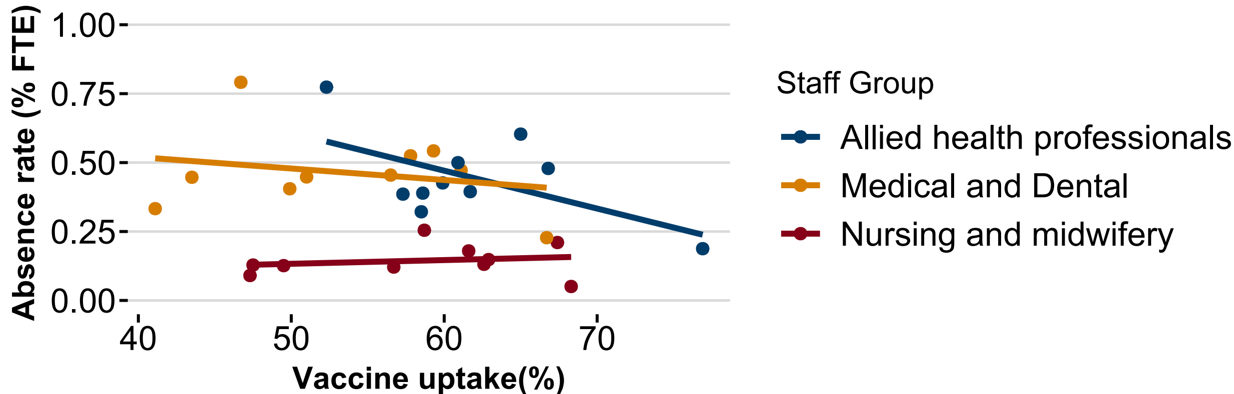
Figure 53: Monthly absences due to cold, cough or flu (% of total sickness) among different staff groups from 2013-2023.



Source: Health Education and Improvement Wales (HEIW)

Absences due to flu as a percentage of absences due to all sickness was plotted between 2013/14 and 2022/23 seasons. Flu on average accounted for 5.25%, 5.64%, and 6.78% of occurrences of sickness absence among nurses, medical staff, and allied health professions respectively. This increased to around 10% each winter during the peak of flu season. The 2022/23 season saw a high occurrence of absences due to flu reaching a maximum of 18.56% ,17.89%, and 21.61% among nurses, medical staff, and allied health professions respectively.

Figure 54: Linear regression using vaccine uptake and staff group type as predictor variables and average absence rate (% full time equivalent) due to flu each season as the response variable.



Source: Public Heath Wales and Health Education and Improvement Wales

To better understand if the vaccine uptake reduced absence rate, a fixed effects linear model was employed with vaccine uptake and staff group type as predictor variables. The model explains around 60% of the variation in absence rates (Adjusted R^2 =0.5981). The model predicts a weak negative relationship between vaccine uptake and absence rate in allied health professionals (β = –0.014, p<0.018). In other words, 10 percentage points increase in vaccine uptake is significantly associated with a reduction of 0.14 percentage points sickness absence rate in allied health professionals. However, there was no significant relationship found between vaccine uptake and absence rate in medical and dental staff and nurses (β = -0.004 and 0.001, p>0.05).

RSV vaccinations

In September 2024, the UK will become the first country in the world to offer a national vaccination programme that uses the same vaccine to protect both infants and older adults from RSV. [34] The new routine RSV vaccination programme will be offered year-round to older adults, as they turn 75 years old and pregnant women, who will be offered vaccination at 28 weeks gestation, with a catch-up programme for those already past 28 weeks gestation, but that have not yet given birth.[35]

Both the maternal and older adults programmes will commence on 1st September 2024. As explored more fully in the RSV section, it is likely that the reduction on the number of people contracting the virus will be more evident in older people than infants. For the older group vaccine uptake suffers from a lag but can be completed within this winter season. For infants the lag between the vaccination and birth date for the maternal vaccinations and the part of the 0 to 4 population affected this year leads to a smaller initial effect. We will continue to monitor both vaccine uptake and the RSV hospitalisations over the winter months compared to historical data.

[34] National RSV vaccination programme announced - GOV.UK (www.gov.uk)
[35] Introduction of RSV vaccination programme 2024 (WHC/2024/032) [HTML] | GOV.WALES

Socio-Economic Factors

Top Line Summary

- Impacts of the cost-of-living crisis are still being felt by households despite inflation returning to target levels.
- High food and energy prices relative to wages and benefits mean ongoing risks relating to hunger, poor-quality diets and cold homes. Fuel poverty is associated with winter mortality and hospital admissions for respiratory conditions. Malnutrition and obesity can increase risk of infections such as COVID-19 and flu, result in a slower recovery, and increase likelihood of hospital admission.
- Socio-economic deprivation is associated with higher hospital admissions in winter for both flu and COVID-19.
- The number of people out of work due to long-term sickness is at an historic high. Diversion of resources away from planned care over winter to cope with emergency pressures may exacerbate current backlogs and levels of economic inactivity.
- Some people in Wales struggle to get an appointment with their GP, which may add to winter pressures in emergency care if patients subsequently present at A&E, particularly if they have become more unwell in the meantime.
- Regardless of entry point to the healthcare system, patients and service users experiencing hardship due to the cost of living may benefit from signposting to appropriate financial support and advice in addition to their medical care and treatment.

Macroeconomic overview

Continued pressures on household costs are demonstrated in responses to the Opinions and Lifestyle Survey (OPN) during the combined survey period 10 May to 30 June 2024[36]. The cost of living was cited as one of the most important issues facing the UK by 87% of respondents.

Essential expenditure

Increased costs will disproportionately impact lower-income households, who typically spend a higher proportion of their income on essential expenditure. With energy costs remaining high, risks associated with living in a cold home are likely to be a persistent contributor to public ill-health over the winter period. The most common ailments seen as a result of poorly heated homes are circulatory diseases, respiratory problems, and mental ill-health. Other conditions which are influenced or exacerbated by cold

[36] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/publicopinionsandsocialtrendsgreatbritain/latest

housing include the common flu and cold, as well as arthritis and rheumatism. Analysis of official data by End Fuel Poverty Coalition estimates that cold housing contributes to a substantial number of excess deaths over winter[37]. A Public Health Wales report on winter health and well-being[38] states that fuel poverty[39] in particular has been linked to hospital admissions for respiratory conditions, and that fuel-poor households have a "significant risk" of winter morbidity. This has cost implications for the NHS and care services, with increased demand for GP appointments, A&E visits, hospital stays, and social care and support.

Given the cost of food remains high in relative terms, it is unlikely that food insecurity levels will lessen substantially over the coming winter period. Malnutrition can increase the risk of being infected with COVID-19 and result in a slower recovery from it[40]. Hunger can have immediate health risks such as decreased immunity, poorer mental and physical health, and can cause malnutrition, heart disease and fatigue[41]. The long-term impacts may also be seen in children's educational attainment, particularly during school holidays when free school meal provision is varied[42]. In times where budgets are stretched, it is also imperative to safeguard good quality healthy food in schools, since this also has an impact on educational attainment as well as authorised absences, which are usually linked to illness and health[43].

Over the long-term, poor diet and nutrition can cause high body mass index (BMI), high blood pressure, cardiac disease, diabetes, and malnutrition[44]. Obesity and living with excess weight, which can result from a poor-quality diet, also increases the risk of requiring hospitalisation for COVID-19[45]. In general, poor nutrition has been shown to increase the risk of bacterial, viral, and other infections.[46]

Socio-economic deprivation

Socio-economic deprivation is associated with higher likelihood of hospital admission due to flu and COVID-19. NHS England found that flu admission rates for people living in the most deprived areas were, on average, 2.6 times higher than the least deprived areas during the 2022/23 winter period and corresponding COVID-19 admission rates were 2.1 times higher. [47]

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[37] 4,950 excess winter deaths caused by cold homes last winter (endfuelpoverty.org.uk)
[38] https://phw.nhs.wales/news/winter-health-how-we-can-all-make-a-difference/report/
[39] Fuel poverty is defined in Wales as a household needing to spend more than 10% of net income on fuel to heat their home to an adequate standard of warmth.
[40] https://www.guysandstthomas.nhs.uk/health-information/coronavirus-covid-19-and-malnutrition#:~:text=Malnutrition%20can%20increase%20your%20risk,need%20to%20make%20some%20changes.
[41] Why preventing food insecurity will support the NHS and save lives | NHS Confederation
[42] On the interplay between educational attainment and nutrition: a spatially-aware perspective | EPJ Data Science
[43] Healthy school meals and educational outcomes - ScienceDirect
[44] NHS England » Food and nutrition
[45] https://nutrition.bmj.com/content/early/2022/01/18/bmjnph-2021-000375
[46] https://nutritionsource.hsph.harvard.edu/2020/04/01/ask-the-expert-the-role-of-diet-and-nutritional-supplements-during-covid-19/
[47] https://www.gov.uk/government/publications/covid-19-and-flu-inequalities-in-emergency-hospital-admission-rates/inequalities-in-emergency-hospital-admission-rates-for-influenza-and-covid-19-england-september-2022-to-february-2023#:~:text=influenza%20admission%20rates%20for%20people,than%20the%20least%20deprived%20areas

Economic Activity
The percentage of the population off work due to temporary sickness saw a peak during the COVID-19 pandemic and has since stabilised to pre-pandemic levels. However, the percentage of the population classed as "economically inactive" due to long-term sickness has been rising since mid-2021, accounting for 30.0% of economically inactive people in the three months to April 2024, compared with 24.9% in the same period in 2021. The number of people out of work due to ill-health is now at a historic high, following a long-term trend of decline despite population increases. Analysis by the ONS shows that for in the three months to March 2023 (the most recently available data), the most common cause of long-term sickness was "depression, bad nerves or anxiety", with 53% reporting this as their main or secondary health condition.[48].

The rise in economic inactivity due to long-term sickness may be caused by a number of factors, some of which are related to the COVID-19 pandemic. In addition to the health impacts of long-covid for some individuals, the pandemic response saw a reduction and subsequent backlog in elective care, diagnostic services and therapies in the NHS, and hospital waiting lists are now at extremely high levels[49]. Some individuals may be unable to work until they have undergone their procedure or treatment, notably those awaiting orthopaedic surgeries such as hip and knee replacements.[50]

It can be challenging for the NHS to maintain planned care over the winter period, as an increase in emergency care demand (such as in the event of high levels of respiratory illness) may necessitate a diversion of resources. If this occurs, it could exacerbate the problem of economic inactivity while waiting for planned care by keeping people out of work for longer, or adding to the number of people leaving the workforce as they wait for care.

Access to GPs
The National Survey for Wales (NSW) asked a series of questions about access to hospital and GP services for the period from April 2021 to March 2022[51]. Evidence from the Welsh Index of Multiple Deprivation shows that, in theory, those living in rural areas suffer higher levels of deprivation with regard to GP access as they typically have further to travel to their nearest surgery, particularly if they are reliant on public transport[52]. However, the NSW data demonstrates that it is those in urban areas who report greater difficulty in getting a convenient GP appointment in practice. Almost a quarter (24%) of respondents in the Cardiff & Vale University Health Board area said it was "very difficult" to get a convenient appointment compared with just 10% in Powys

[48] Rising ill-health and economic inactivity because of long-term sickness, UK - Office for National Statistics (ons.gov.uk)
[49] https://www.gov.wales/nhs-activity-and-performance-summary-may-and-june-2024-html
[50] https://www.health.org.uk/publications/long-reads/what-we-know-about-the-uk-s-working-age-health-challenge
[51] Hospital and GP services (National Survey for Wales): April 2021 to March 2022 | GOV.WALES and National Survey for Wales: results viewer | GOV.WALES
[52] Indicator data by Rural/Urban Settlement Classification - All Domains (gov.wales)

Teaching Health Board area. Geographic differences in GP access are likely to cause disparities by ethnicity, since those belonging to ethnic minority groups are concentrated in urban areas of Wales.

Those responding to the Commissioner's survey, who had been unable to get a suitable appointment with their GP in a timely manner, provided a variety of responses as to what course of action they took as a result. Many chose to keep trying or to accept an appointment at a later date, but some turned to pharmacies, A&E or the NHS 111 service. Others gave up entirely and opted to suffer or self-medicate. Those who find themselves unable to see a GP when they need to, or who have not experienced the care they expected, may subsequently seek help in other parts of the health service. This has the potential to add to pressures in emergency care if patients, who could have been treated by a GP, subsequently present at A&E or out-of-hours services, particularly if they have become more unwell as a result of delays to getting treatment.

In addition, GPs are accustomed to signposting patients to appropriate advice and support beyond their immediate medical care, such as debt support. They can also act as "social prescribing practitioners", recognising that addressing non-medical needs can improve health and wellbeing. Given the winter health risks associated with cold homes, poor diet/hunger and socio-economic deprivation, difficulty accessing support that helps people alleviate these issues could have knock-on effects for the health service.

Discussion

The upcoming 2024/25 winter season will likely see a rise in respiratory viruses as we see each year. The scenarios in this paper give an insight into how these viruses may impact the demand for healthcare in Wales across primary and secondary care.

Vaccination programs remain a first line of defence against an unprecedented rise in cases for the most vulnerable people in the population. With the rollout of the RSV vaccine which will be offered to older adults and pregnant women from 1 September 2024, there may be a reduction on hospital admissions, particularly in babies. The impact (eg. Potential reduction in hospital admissions due to RSV) may increase over the years as more children and older adults become protected by the RSV vaccine.

This paper outlines that it is not only the rise in winter viruses that could increase demand but social-economic factors too. With long-term sickness and unemployment at high levels, coupled with high energy and food prices, we could see a rise in cases from people struggling financially to protect themselves against winter illnesses.

There is also the potential for a rise in cases in a condition that is not expected, like the case of Strep A in winter 2022-23. Cases of Monkeypox (Mpox) have been spreading in parts of Africa and 2 cases of a new clade (Clade 1b) have been identified in Sweden and Thailand.[53] [54] Therefore, there is potential for Mpox to spread to the UK so this may need to be taken into account when planning for winter. Similarly, earlier in the year, avian flu spread in cattle across the USA.[55] The risk assessment for avian flu remains the same, but the response is being managed more pragmatically.

Over the winter months, there will be continued surveillance of acute respiratory viruses which will allow us to provide insight into what could happen on a shorter-term basis. This includes continuous production of modelled scenarios throughout the winter period to provide the health and care sector with scenarios to inform decision making.

[53] Mpox is spreading rapidly. Here are the questions researchers are racing to answer (nature.com)
[54] Thailand Confirms First Case of New, Deadlier Mpox Strain, Clade 1b - The New York Times (nytimes.com)
[55] CDC A(H5N1) Bird Flu Response Update August 16, 2024 | Bird Flu | CDC

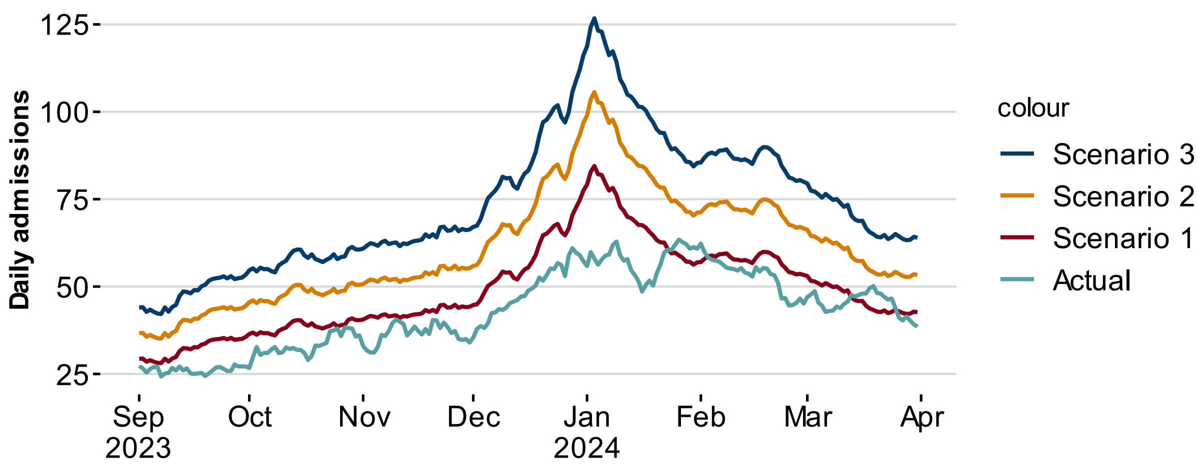
Appendix

Retrospective analysis of 2023/24 winter modelling

Top Line Summary

- Actual flu and pneumonia admissions data closely followed scenario 1 but did not exhibit the sharp peak estimated by scenario 1. Actual daily admissions showed a flatter peak and remained above 50 from the 3rd week of December to the 3rd week of February.
- Between September 2023 and March 2024 daily admissions for RSV peaked on November 6th, 25 days earlier than predicted by scenarios 1 and 2. The peak height reached 40 admissions, falling between the projections of scenario 1 and 2.
- The actual COVID-19 admissions tracked below the most-likely scenario throughout the 2023/24 winter. Actual admissions data revealed several peaks during the winter season, with 40 admissions recorded on 28th September 2023, and 35 admissions on 2nd January 2024.

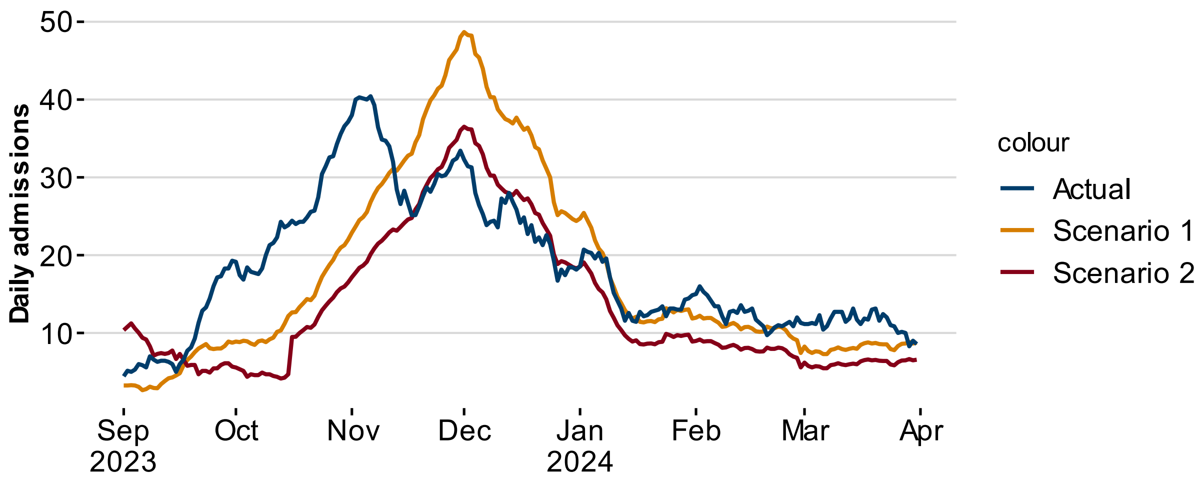
Figure A1: Comparison of flu and pneumonia daily admissions scenarios vs actuals in Wales between September 2023 and March 2024



Source: Digital Health and Care Wales and SEA calculations

Last year's scenarios for flu and pneumonia predicted daily admissions peaking between 85 (scenario 1) and 127(scenario 3) during the first week of January. While the actual admissions data closely followed scenario 1, it did not exhibit the sharp peak estimated by scenario 1. Actual daily admissions showed a flatter peak remained above 50 from the 3rd week of December to the 3rd week of February.

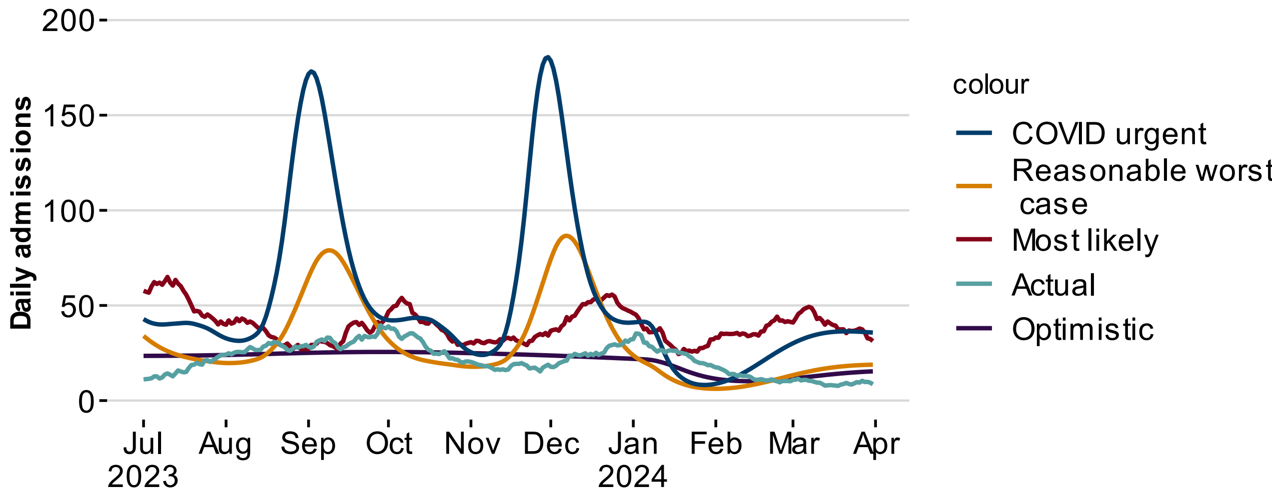
Figure A2: Comparison of RSV paediatric (ages 0-4) daily admissions scenarios vs actuals between September 2023 and March 2024



Source: Digital Health and Care Wales and SEA calculations

Scenarios 1 and 2 estimated daily RSV paediatric admissions to peak at 49 and 37 admissions in the first week of December. However, the actual daily admissions peaked on November 6th, 25 days earlier than estimated by scenarios 1 and 2. The peak height reached around 40 admissions, falling between the projections of scenario 1 and 2.

Figure A3: Comparison of COVID-19 daily admissions scenarios vs actuals between July 2023 and March 2024



Source: Public Health Wales and Swansea University modelling.

For the winter of 2023/24, COVID-19 daily admissions scenarios were created where a new variant that dominates every three months (cos wave) was introduced. The scenarios explored a range of natural immunity lengths, spanning from 100 to 300 days. Within these scenarios, cos waves were multiplied by

1, 1.2, and 1.5 to create optimistic, reasonable worst-case, and COVID-19-urgent scenarios, respectively. The most likely scenario was the repeat of 2022/23 winter. The analysis shows that the actual COVID-19 admissions tracked below the most-likely scenario throughout the 2023/24 winter. Actual admissions data revealed several peaks during the winter season, with 40 admissions recorded on 28th September 2023, and 35 admissions on 2nd January 2024. In summary, the actual admissions data for the 2023/24 winter were lower than the most likely scenarios estimated. These scenarios tended to overestimate admissions, which facilitated planning for extreme situations.

Peaks analysis for the 2024/25 winter

Table A1: Peaks in 7-day rolling averages of flu and pneumonia admissions between the financial years of 2017/2018 and 2023/24.

Financial year	Date	Peak admissions
2017/18	5 January 2018	78
2018/19	3 January 2019	84
2019/20	2 January 2020	101
2020/21	2 October 2020	33
2021/22	11 December 2021	42
2022/23	24 December and 25 December 2022	131
2023/24	26 January 2024	63

Source: Digital Health and Care Wales

Table A2: Peaks in 7-day rolling averages of RSV paediatric admissions between the financial years of 2017/2018 and 2023/24.

Financial year	Date	Peak admissions
2017/18	2 December 2017	64
2018/19	1 December 2018	64
2019/20	27 November 2019	63
2020/21	19 September 2020	7
2021/22	12 October 2021	36
2022/23	7 December 2022	48
2023/24	6 November 2023	40

Source: Digital Health and Care Wales

Table A3: Peaks in 7-day rolling averages of ED attendances due to respiratory problems between the financial years of 2019/2020 and 2023/24.

Financial year	Date	Peak admissions
2019/20	30 December 2019	345
2020/21	16 September 2020	202
2021/22	21 October 2021	272
2022/23	30 December 2022	418
2023/24	01 January 2024	261

Source: Digital Health and Care Wales

Table A4: Peaks in 7-day rolling averages of all ambulance calls between the financial years of 2017/2018 and 2023/24, code 6 calls only

Financial year	Date	Peak number of calls
2017/18	01 January 2017	221
2018/19	01 January 2018	192
2019/20	01 January 2020	226
2020/21	31 December 2020	94
2021/22	12 September 2021	204
2022/23	31 December 2022	254
2023/24	2 January 2024	190

Source: Welsh Ambulance Services University NHS Trust

Table A5: Peaks in 7-day rolling averages of red ambulance calls between the financial years of 2017/2018 and 2023/24, code 6 calls only

Financial year	Date	Peak number of calls
2017/18	10 March 2018	27
2018/19	1 January 2019	28
2019/20	13 December 2019	47
2020/21	17 December 2020	24
2021/22	18 March 2022	60
2022/23	20 December 2022	93
2023/24	13 December 2023	80

Source: Welsh Ambulance Services University NHS Trust

Table A6: Peaks in 7-day rolling averages of amber ambulance calls between the financial years of 2017/2018 and 2023/24, code 6 calls only

Financial year	Date	Peak number of calls
2017/18	1 January 2018	187
2018/19	1 January 2019	159
2019/20	31 March 2020	180
2020/21	2 January 2021	71
2021/22	10 September 2021	144
2022/23	31 December 2022	161
2023/24	2 January 2024	109

Source: Welsh Ambulance Services University NHS Trust

Table A7: Maximum of the average number of monthly paediatric beds occupied, between September and March (inclusive), 2017/18 to 2023/24

Financial year	Maximum number beds occupied	Maximum percentage of beds occupied
2017/18	293	59%
2018/19	302	63%
2019/20	258	61%
2020/21	170	43%
2021/22	259	62%
2022/23	282	64%
2023/24	271	67%

Source: Digital Health and Care Wales

Table A8: Peaks in 7-day rolling averages of ILI consultation rates between the financial years of 2017/2018 and 2023/24

Financial year	Date	Peak rate of consultations
2017/18	23 January 2018	8.2
2018/19	10 January 2019	2.5
2019/20	02 January 2020	2.4
2020/21	07 October 2020	0.2
2021/22	09 December 2021	0.5
2022/23	23, 24, 25 December 2022	4.4
2023/24	30 January 2024	1.0

Source: Public Health Wales

Table A9: Annual acute respiratory infections (ARI) consultation rate, in Wales, between the financial years of 2020/2021 and 2023/24.

Financial year	Number of annual ARI consultations per 100,000 population
2020/21	1,989.9
2021/22	5,675.5
2022/23	8,706.1
2023/24	6,331.5

Source: Public Health Wales

Totals analysis for the 2024/25 winter

Table A10: Total flu and pneumonia admissions, 2017/18 to 2023/24

Financial year	Influenza and pneumonia admissions
2017/18	15,593
2018/19	16,098
2019/20	16,690
2020/21	8,585
2021/22	10,803
2022/23	14,665
2023/24	14,110

Source: Digital Health and Care Wales

Table A11: Total number of RSV admissions in children aged 0-4, by financial years between 2017/18 and 2023/24.

Financial year	RSV admissions
2017/18	5,590
2018/19	6,342
2019/20	6,179
2020/21	661
2021/22	5,270
2022/23	5,636
2023/24	5,168

Source: Digital Health and Care Wales

Table A12: Total number of admissions due to COVID-19 (any mention), in Wales, in financial years between 2020/21 and 2023/24

Year	Admissions
2020/21	19,196
2021/22	16,221
2022/23	16,471
2023/24	6574

Source: Digital Health and Care Wales

Table A13: Total ED attendances due to respiratory problems, by financial years between 2019/20 and 2023/24.

Financial year	ED attendances
2019/20	74,897
2020/21	52,834
2021/22	72,368
2022/23	76,244
2023/24	70,516

Source: Digital Health and Care Wales

Table A14: Total number of ambulance calls due to respiratory problems (code 6), in Wales, between the financial years 2017/2018 and 2023/24.

financial year	Ambulance calls
2017/18	50,931
2018/19	48,696
2019/20	53,866
2020/21	28,196
2021/22	39,993
2022/23	53,726
2023/24	49,910

Source: Welsh Ambulance Services University NHS Trust (WAST)

Table A15: Total number of ambulance calls due to respiratory problems by call code colour, between the financial years 2017/2018 and 2023/24

Financial year	Amber	Green	Red
2017/18	42,599	2,816	5,516
2018/19	39,849	1,896	6,951
2019/20	41,137	2,490	10,239
2020/21	21,590	505	6,101
2021/22	26,649	964	12,380
2022/23	32,662	2,030	19,034
2023/24	29,235	1,660	19,015

Source: Welsh Ambulance Services University NHS Trust (WAST)

Table A16: Annual Influenza like illness (ILI) GP consultation rate, between the financial years of 2017/2018 and 2023/24.

Financial year	Total ILI consultation rate (consultations per 100,000 population)
2017/18	527.4
2018/19	261.0
2019/20	211.4
2020/21	26.2
2021/22	67.8
2022/23	220.3
2023/24	119.7

Source: Public Health Wales

Coding Completion

The ICD-10 coding is used to systematically record and analyse mortality and morbidity data in hospitals in the UK.[56] However, the completion of coding is often time-consuming and experiences delays of several months. For instance, the coding completion of hospital admissions decreases from 81.3% in October 2023 to 65.7% in April 2024 when the data was received from DHCW. Therefore, it is possible that the admissions calculated for the financial year 2023/2024 in this paper are likely an underestimate.

[56] NCCSICD2024[10.0]FINAL (classbrowser.nhs.uk)

Table A17: Coding completion of hospital admissions, by month, within Wales between January 2020 and April 2020

Month	Coding completion
Jan-20	92.4%
Feb-20	90.3%
Mar-20	86.3%
Apr-20	90.7%
May-20	92.1%
Jun-20	92.8%
Jul-20	92.0%
Aug-20	92.2%
Sep-20	91.7%
Oct-20	91.6%
Nov-20	93.9%
Dec-20	91.8%
Jan-21	92.2%
Feb-21	91.4%
Mar-21	88.6%
Apr-21	87.5%
May-21	88.7%
Jun-21	90.3%
Jul-21	92.6%
Aug-21	92.5%
Sep-21	92.3%
Oct-21	93.7%
Nov-21	91.6%
Dec-21	91.8%
Jan-22	91.6%
Feb-22	90.2%
Mar-22	87.9%
Apr-22	86.9%
May-22	87.9%
Jun-22	89.1%
Jul-22	87.9%
Aug-22	88.1%
Sep-22	88.2%
Oct-22	88.6%
Nov-22	85.0%
Dec-22	86.9%
Jan-23	83.3%

Feb-23	80.3%
Mar-23	77.3%
Apr-23	83.7%
May-23	82.4%
Jun-23	83.4%
Jul-23	83.2%
Aug-23	81.2%
Sep-23	82.5%
Oct-23	81.3%
Nov-23	74.8%
Dec-23	76.0%
Jan-24	74.0%
Feb-24	70.7%
Mar-24	69.4%
Apr-24	65.7%

Source: Digital Health and Care Wales

50 Day Integrated Care Winter Challenge

System assurance readiness template

Region	Gwent				
Regional Partnership Board Chair	Ann Lloyd				
10 best practice interventions					
Number	**Intervention**	**Planned additional action**	**Executive lead / sponsor**	**Link to existing plan (provide copy)**	**Key Impact Measures**
1	Refresh focus on embedding the Optimal Hospital Flow Framework to include a proactive emphasis on rehabilitation and	**Current Activity:** • Daily board rounds, including allocation of D2RA pathway, Red to Green and clinically optimised status • Distribution of patient pathway posters and online promotional tools to all wards to embed D2RA pathways across the Health Board	**Jennifer Winslade/Sarah Paxton**	*Linked to Goals 5&6 Return and Stay Well at Home*	• Pathways of Care Delays • Number of discharges • Length of Stay • D2RA Pathway • Red to Green

	reablement across the H&SC system *(Amanda Hale/Annie Lewis/LA & HB Heads of Service)*	• Optimal Hospital Flow intranet page developed as a resource for staff to share best practice and tools • Deconditioning leads confirmed to encourage and embrace patient's functional activity, pilot hospital acquired deconditioning tool for the NHS Executive • Education and training aligned to roll out of digital solution focusing on key themes such as SAFER • Patient discharge leaflet to reinforce 'what matters' conversation and discharge planning at point of admission • Roll out of new inpatient digital system CWS2 to support recording and extraction of discharge data, development of ward-based dashboards • Head of Discharge to utilise CWS2 to monitor compliance per ward regarding recording the Optimal Hospital Flow Framework principles • Focus on 'optimal ward', three wards an RGH to embed discharge principles and reinforce the risks of hospital acquired deconditioning, supported by senior staff, Senior Nurse for Discharge to lead at RGH **Additional Activity:** **Short Term** • Weekly POCD review of patients, detail to be confirmed with Local Authorities to review and take forward actions • Operational Framework Pre-launch, end of November to support sites and wards with the implementation of the Optimal Hospital Flow Framework, to improve patient flow and deliver timely pathways care, working in partnership with the five Local Authorities • Integrated pathway at GUH front door (Community Admission Avoidance Team, Home First, Acute Frailty Response), scope			

		current 'state' and provide recommendations on what a preferred model looks like and operations, implement changes • Targeted work with Care Homes, re admission avoidance, why did patients come in, what could be undertaken differently to prevent an admission **Medium Term** • Potential to support admission avoidance through Hospital to Home model aligned to Community Resource Team to provide additional capacity for admission avoidance • To develop an integrated discharge pathway, alignment of discharge teams and resource across Health and Social Care, to streamline the process and support the timely discharge of patients • OT Assessments, pull model to operate utilising Health Board funding to address recruitment challenges in YAB, consider roll out to other areas			
2	Apply 7-day H&SC working to enable discharge of patients during the weekend *(Lloyd Hambridge/Amanda Hale/Steve Bonser/Jo Lane/LA & HB Heads of Service)*	**UPC Current Activity** • Urgent Responsive Care team – Health care support worker team Saturday and Sunday 7am – 7pm supporting patient discharges from acute sites, Acute frailty response and supporting patients to stay at home when supporting Urgent Primary Care Service **UPC Additional Activity** **Short Term** • Expanded support across winter bank holidays, aligned with Urgent Primary Care Service, in addition to supporting discharges at the front door **Community – Current Activity** **Medium Term** • Additional 10 HCSW funding via Further Faster – to increase weekend activity to 60% of core	**Jennifer Winslade/LA Heads of Service**	*Linked to Goal 1 Redesigning Services for Older and Frail people* *Linked to Goals 5&6 Return and Stay Well at Home*	• No of weekend discharges • No of discharges earlier in the day • Pathways of Care Delays • No of patients supported by community nursing on weekend and overnight cover • No of patients supported by UPC on weekend and bank holidays • No of palliative patients supported in the

		in order to support weekend discharge/reduce admission • Further Faster Funding to palliative care to support provision of care at weekends • Additional B6 appointment via uplift to lead on palliative and complex care management which will support weekends • Frailty weekend pilot which will support discharge however primarily reduce admission **Discharge Lounges Current Activity** • RGH & NHH discharge lounges operational 7 days to enable discharge of patients during the weekend operating a pull model from wards • Relocation of RGH discharge lounge to alignment with Ready to Go Unit and Discharge Hub, cross working across areas **Discharge Lounges Additional Activity** **Medium Term** • Expansion of discharge lounge at GUH operating 7 days, increased capacity aligned with demand, appointment of B7 to provide leadership, proactive 'pull' of patients, supported by Pharmacy provision to enable patient to leave • Scoping potential discharge lounge at YYF to facilitate timely patient discharge **Discharge Hub at RGH** **Longer Term** • Integrated Discharge Hub at RGH operational 5 days a week, resourced by Health and Social Care to support timely discharge of patients at the RGH site, review potential for 7 days **Discharge Hub at NHH** **Short Term** • Under development led by Monmouthshire/Health Board **Discharge Transport** **Medium Term**			community on weekend • No of patients supported by AFR on weekend

		• Potential to increase discharge resource over the weekend, undertake demand and capacity analysis and work with WAST to scope the options and timescales **Acute Frailty Response** **Medium Term** • Currently operating an in-reach model at GUH front door 5 days, with plans to expend to 7 days in January 2024, potential to roll out to eLGH sites **Additional Activity:** **Short term** • RIF slippage to be reallocated to support increase capacity, existing staff undertaking additional hours to increase assessment 7 days across the Local Authorities • Review capacity in Home First potential for agency staff to increase assessment capacity or reallocate funding to Local Authorities **Medium Term** • Utilise criteria led discharge for suitable patients to be progressed via the Operational Framework Pre-Launch end of November • Senior Nurse for Discharge at the RGH to lead the 'optimal ward' workstream with a focus on three wards – medicine/surgery/community			
3	Undertake Decision Support Tool (DST)/CHC process in the community *(Lloyd Hambridge/Donna Wetter/LA & HB Heads of Service)*	**Current Activity:** • Hospital to Home provides additional capacity to discharge patients in a timely manner to facilitate assessment in a person's home or in another suitable community setting • Monthly Integrated Discharge Board to build integration between partner organisations, chaired by SRO for Goals 5&6, to oversee the 50-day action plan and co-ordinate response to Care Action Committee **Additional Activity:** **Short Term**	**Donna Wetter/ LA Heads of Service**	*Linked to Goals 5&6 Return and Stay Well at Home* *POCD Action Plan*	• No of patients discharged with support from Hospital to Home • Monthly Integrated Discharge Board • No of DST completed Care Homes by Complex Care Team

		• Introduce model utilised during the COVID-19 pandemic, Health Board to contract and fund people discharged to care homes who have nursing/EMI nursing needs and triggers for CHC. DST completed at Care Homes by Complex Care Team **Medium Term** • Potential expansion of Hospital to Home to support additional capacity in the community subject to confirmation of funding			
4	Regional collaboration to ensure that 'integrated navigation hubs' exist to facilitate discharge for acute hospital sites and admission avoidance in the community *(Lloyd Hambridge/Paul Underwood/Tracy Morgan/LA & HB Heads of Service)*	**Current Activity** • Access to the professional line support for WAST colleagues, DNs, Nursing Homes, Hospice and clinicians on scene **Additional Activity** **Medium Term** • Expansion of the professional line support for WAST colleagues to 24/7 into Urgent Primary Care, an extension from OOH periods • Explore the opportunity for residential care homes to have access to the professional line within UPC OOH, in addition to Nursing Homes • Work to redefine integrated navigation hub with merge to UPC, Single Point of Access (SPA) and Health Protection. Opportunities for work to be undertaken on pathways from the Flow Centre and closer integration/navigation opportunities • Work within VPH to align an Integrated Navigation Hub with the system wide approach, pre hospital streaming, UPC signposting and clinical review, Frailty SPA, DNs • Direct access to SDEC, all acute medicine patients to GUH to be streamed directly to SDEC, triaged by ANP then directed	**Lloyd Hambridge/Paul Underwood/Tracy Morgan**	*Linked to Goals 2 and 3, Signposting and Alternatives to Acute Admission*	• No of patients accessing SDEC • Time spent in SDEC • Percentage of patients assessed out of AMU • No of admission avoided, with support via the professional line • Reduction in nursing home admission/conveyances • Increase no of discharges from north Gwent (NHH Discharge Hub) • No of referrals to CRT made/accepted • No of admission avoided (through sign posting)

		appropriately, to be piloted, anticipated increase in patients turned around same day • Potential for an integrated discharge hub to be developed at NHH aligned to the RGH model			
5	Regional H&SC weekly review of LOS 21-28 days and 20 longest LOS patients with focused actions to progress discharge *(Annie Lewis/LA & HB Heads of Service)*	**Additional Activity:** **Short term** • Weekly POCD review of patients, detail to be confirmed with Local Authorities to review and take forward actions • Refocus to establish clear actions for those people to facilitate discharge or escalation as required • Robust joint weekly action plans to be implemented working in partnership across Health and Social Care • Monitoring via CWS2 reasons for delays, clear actions with accountability to support discharge of individual patients • Routine monitoring and oversight by Executive Director for Nursing • Review all joint POCD to understand the issues and take forward actions to support timely patient discharge	**Jennifer Winslade/Annie Lewis/ LA Heads of Service**	*POCD Action Plan*	• Pathways of Care Delays • Joint weekly action plans implemented
6	Proactive management of identified 0.5% high risk population group by clusters and multiprofessional community teams *(Lloyd Hambridge/Kelly Downes/LA & HB Heads of Service)*	**Current activity** • A Populations at Risk Group has been established which is implementing tests of change to support the recognition of this group and introduce appropriate processes. Exercise being undertaken to compare information gained from EFI and HRAC and better understand the risk stratification process • 3 clusters have established MDT processes which saw approximately 2500 patients in 23/24; • **Newport E&W –** MDT established in each NCN including lead and co-ordinator roles. GP's and other partners brought together weekly/fortnightly to present people with	**Jenny Winslade/Jo Williams**	*Linked to Goal 1 Redesigning Services for Older and Frail people*	• FCP initiative rolled out to care homes • No of high-risk population group patients reviewed by MDT • No of care home patients conveyed/admitted

		complexity and agree an MDT response to care • **Monmouthshire S** – SMART MDT recently introduced to identify, via EFI, those people at greater risk of deterioration and conveyance. Further algorithm utilised to select those who would further benefit from a medical review from which a plan is agreed and shared • HB wide FCP initiative is planned to roll out to care homes, many of home will form part of 0.5% **Additional activity** **Medium Term** • MDT - With additional resource an approach could be introduced to each of the other Boroughs/NCN areas to support the introduction such an initiative • To progress the review of ACP/FCP at greater pace, additional support would provide additional traction			
7	GP Enhanced Service rollout for care homes and Proactive Care / Urgent Care provision for 'High Risk Cohorts' *(Lloyd Hambridge/Steve Bonser/Kelly Downes/WAST)*	**Current activity** WS4 (Goal one) supports the care home agenda including; • Focus education to support care home staff to recognise deterioration early and escalate appropriately • Prevent and mitigate falls and fall risk • Increasing the number of appropriate FCP and educate staff in enabling residents who deteriorate, to stay at home, where this is appropriate • Plan to consider piloting a process to refer people who are deteriorating, to an alternative service, before calling 999 • HB support to care homes to develop additional FCP's as referenced in point six **Additional Activity** **Short Term**	**Lloyd Hambridge/Steve Bonser**	*Linked to Goals 2 and 3, Signposting and Alternatives to Acute Admission* *Linked to Goal 1 Redesigning Services for Older and Frail people*	• No of care home patients conveyed/admitted • No of falls patients conveyed/admitted • FCP initiative rolled out to care homes

		• Explore the opportunity for care homes to have access to the professional line within UPC OOH, in addition to Nursing Homes. Captures High Risk Adult Cohort, links to point 4 • HB/WAST discussion about community falls management – opportunity to consider if this can commence with care homes • Consider how the updated Care Home DES, when produced, is implemented and practice activity monitored against it **Medium Term** • Review Opportunities with WAST/ Primary Care for admission avoidance pathways for respiratory conditions			
8	Trusted Assessor model for all care settings *(Jenny Winslade/Alexis Williams /LA & HB of Heads of Service)*	**Current Activity:** • YYF Stroke wards, Social Worker undertake MCA assessments on behalf of the 5 LA's • CRT OT's to undertake assessment in YAB re pull model trusted assessor for discharge subject to confirmation of funding **Additional Activity:** • Review of Trusted Assessor Models within the region against exemplar areas within Wales with a view to adopting best practice	**Jenny Winslade/Jo Williams**	*Linked to Goal 1 Redesigning Services for Older and Frail people* *Linked to Goals 5&6 Return and Stay Well at Home*	• Review of Trusted Assessor model across the region
9	Home First default for all patients clinically optimised – Health and Social Care discharge planning begins on admission *(Amanda Hale/Jo Lane/LA & HB Heads of Service)*	**Current Activity:** • Education and training aligned to roll out of digital solution focusing on key themes such as SAFER • Patient discharge leaflet to reinforce 'what matters' conversation and discharge planning at point of admission • Optimal Hospital Flow intranet page developed as a resource for staff to share best practice and tools • Distribution of patient pathway posters and online promotional tools to all wards to embed D2RA pathways across the Health Board	**Jenny Winslade/Jo Williams**	*Linked to Goal 1 Redesigning Services for Older and Frail people* *Linked to Goals 5&6 Return and Stay Well at Home*	• Review of Trusted Assessor model across the region

		• Roll out of new inpatient digital system CWS2 to support recording and extraction of discharge data, development of ward-based dashboards • Home First team to support timely patient discharge, operating at the front door at GUH, RGH and remotely at NHH **Additional Activity:** **Short Term** • Integrated pathway at GUH front door (Community Admission Avoidance Team, Home First, Acute Frailty Response), scope current 'state' and provide recommendations on what a preferred model looks like and operations, implement changes • Reinforce the 'Home First' message through the Balancing Rights Responsibilities training, literature etc, planned training session with Health and Social Care staff on 12th November			
10	Integrated community services to focus on 7-day community-based falls response pathways *(Lloyd Hambridge/Paul Underwood/Collette Kiernan/Steve Bonser/LA & HB Heads of Service)*	**Additional Activity** • Understand community falls service and explore opportunities particularly with long lies, linked to Integrated Navigation Hub • Working as part of HB/WAST community falls management approach to recognising risks associated with falls mitigation and response • Expansion of CRT operating hours, rapid medical now 8-8 • Permanent recruitment to WAST for therapist for the falls response vehicle, to focus on prevention of admission • Communication campaign re trips slips and falls to be proactive • WAST Community Falls Responders are appropriately trained to level 1 and are adequately supported to attend level 2 falls following initial assessment	**Lloyd Hambridge/LA Heads of Service**	*Linked to Goals 2 and 3 Alternatives to Acute Admission*	• No of patients attended to via community falls response, supported stay at home outcome • No of falls patients conveyed/admitted on weekdays/weekends • No of falls patients redirected via Integrated Navigation Hub • No of fall patients support by CRT on weekdays/weekends

		• There is 24-hour level 1- and 8-hour level 2 response in ABUHB – modelling has been undertaken nationally to determine resource requirements for falls response • Six goals have been clear that the 2-hour Urgent Care response is for Health Boards to provide/commission - WAST has a service option to do so if required • Falls response service refers to community falls teams for multifunctional assessments with digital referrals now in place – WAST are putting in place monitoring to assess the level of acceptance to support future planning			

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Improving Waiting Times for Planned Care and Diagnostics 2024/25 – Additional Funding**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins – Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Richard Morgan-Evans – Deputy Chief Operating 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

Over the course of the 2024 there have been positive improvements in the trajectory of our planned care waiting lists for those patients waiting over 104 weeks as well as those waiting for a routine diagnostic over 8 weeks. This is as a result of additional focus and an internal prioritisation of funding since May 2024, in line with previous Ministerial expectations.

Additional Welsh Government funding has now been made available to support further reductions in our longest waiting lists, as outlined in the report.

Cefndir / Background

The Health Board's originally submitted annual plan for 2024/2025 showed a deteriorating planned care waiting list position, driven largely by key surgical specialties such as T&O, ENT and Ophthalmology. This was reflected in both the 52-week stage 1 (first new outpatient appointment) and 104 week all stages trajectories. These key surgical services do not have enough capacity to increase activity to the required levels to meet demand and therefore there has been a negative imbalance in demand and capacity leading to extended waiting times.

In May 2024, Welsh Government wrote to all Health Boards stating the annual plan submissions needed further improvement. Ministerial 'KPIs' (key performance

indicators) were announced which set revised targets for all areas of service delivery including planned care, urgent care, cancer and mental health services.

From a ABUHB Planned Care perspective, new trajectories were agreed and c.£1m of internal reserve funding was released to support stage 1 outpatient capacity options, targeted at the three most challenged specialties with the longest waits. New trajectories were then submitted.

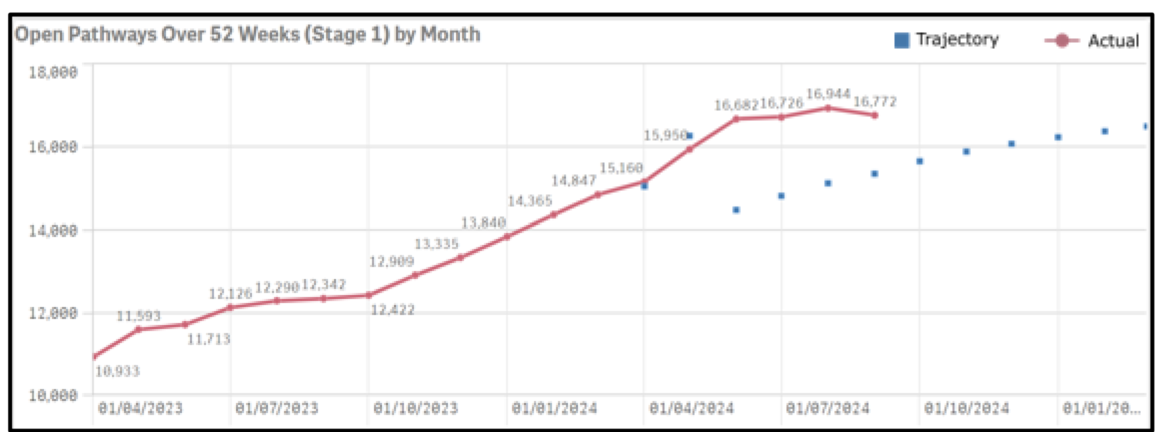
The table below shows the improvement in trajectory based on the revised 104-week submission in May 2024:

Specialty	Original Submission – Annual Plan – Mar 24	Revised 104 week Submission – May 24	Improvement
ENT	3,047	1,242	1,805
General Surgery	-	-	-
Gynaecology	-	-	-
Maxillo Facial	-	-	-
Ophthalmology	2,218	775	1,443
Orthopaedics	2,951	1,908	1,043
Urology	-	-	-
Total	**8,216**	**3,925**	**4,291**

Additionally, there was an improvement in the May trajectory for 52-week stage 1 which took the original end of year figure from 21,739 to 16,500.

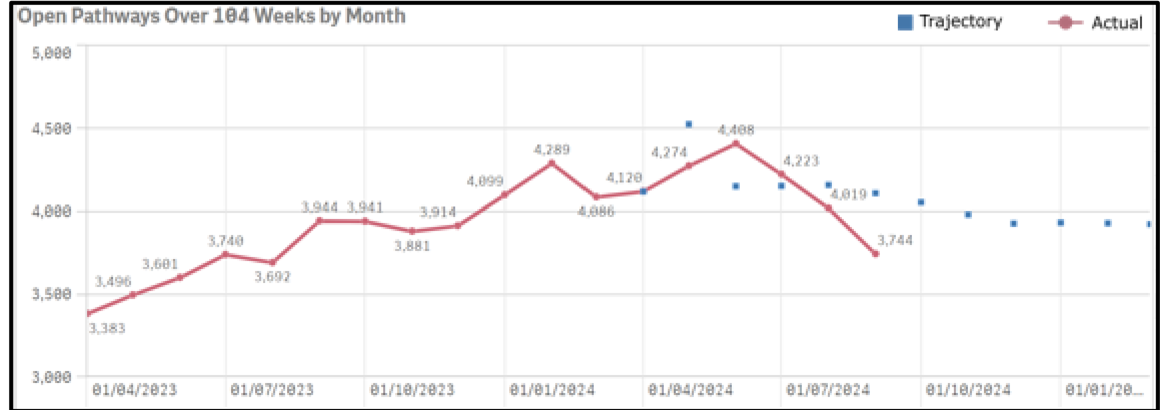
The graphs below show, as at the end of October 2024, how the Health Board is performing against the revised trajectories set in May.

52 weeks – Stage 1 Outpatients:



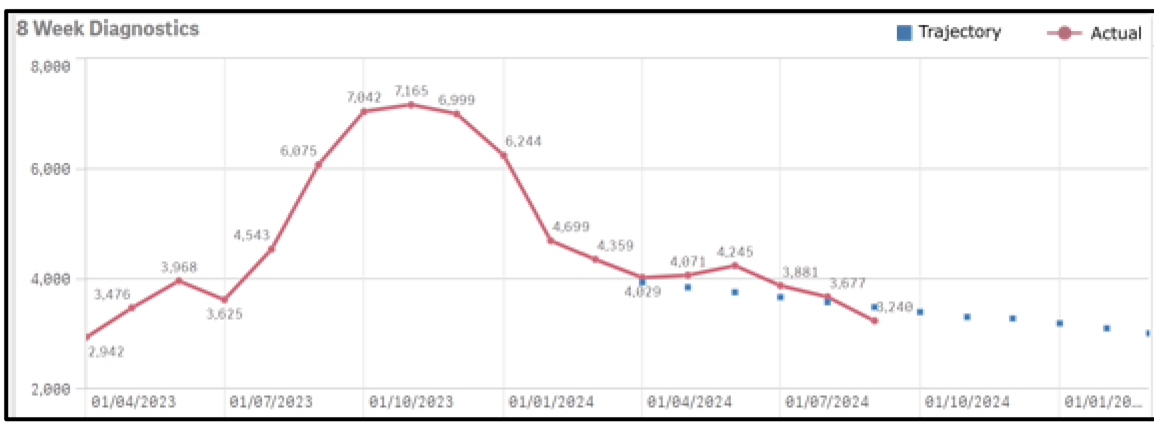
Revised trajectory showing the Health Board able to achieve 16,500 patients over 52 weeks at stage 1 outpatients at year end and on course to deliver this.

104 weeks – all stages:



Revised trajectory showing the Health Board able to reduce >104 weeks patients and we are currently ahead of schedule.

8 weeks – diagnostics:



Revised diagnostics trajectory showing we are just ahead of trajectory with Radiology already having achieved 95% of the waiting list under 8 weeks.

In August 2024, there was a further request to all Health Boards from Welsh Government to submit additional options to increase capacity further. This was with an intention to be able to deliver key targets by the end of the financial year. This included having no patients waiting more than 104 weeks for any first definitive treatment as well as having at least 95%+ of patients waiting under 8 weeks for a routine diagnostic.

It should be noted that for patients on an urgent suspected cancer pathway or urgent non-cancer pathway, these timelines are significantly shorter.

Asesiad / Assessment

In August 2024 the Health Board submitted potential costed options to increase activity to reduce both surgical and diagnostic waiting lists. This was completed using detailed modelling looking at all options to deliver required activity and considering the waiting list cohort sizes to the end of the year.

In mid-October Welsh Government confirmed the following funding in relation to ABUHB:

- £3.816m to address the outstanding 104 week wait gap for Orthopaedics
- £1.3m for the diagnostic schemes, to include Endoscopy, Neurophysiology and Cardiology to get to 95%+ under 8 weeks.
- ENT schemes were not supported at this stage but more information was requested.

Welsh Government also confirmed that the Southeast Region would also receive £3m for Ophthalmology, in a first phase of a further £7.4m potentially available, to meet the cataract treatment plan developed for the region. The first phase would deliver c.2100 treatments with a potential to increase if the additional capacity is available to do so is available.

The following section outlines the patient activity that will be generated from this funding:

Trauma & Orthopaedics

No.	Plan	Activity	Impact on Year End Position
1.	New Treatment activity	704 patients	Reduce to 500 (submitted forecast 1,908)
2.	Outpatient activity	1,210 New 1,044 FU	Currently under 104 wks. This will reduce OP waiting times to under 18 months / 65 weeks
3	Paediatric elective outpatient waiting list recovery	270 New	Reduce outpatient waiting times to **26** weeks for routine paediatric patients. Currently at 52ww Reduce outpatient waiting times to 8 week wait for urgent paediatric patients
4	Outsourcing treatments	c. 500 treatments	Zero x 104wks
	Total	**3,728**	***Aim to zero***

It should be noted that there is a risk of outsourcing activity for T&O due to a number of factors. These include the short funding timeline available as well as patient acuity levels, which will determine if more complex patients would be clinically appropriate to be treated in an independent sector setting away from hospital clinical support services.

Endoscopy

This funding will support the Health Board reducing >8 week waiting patients to zero from a current number of c.1600 patients waiting over 8 weeks. The revised delivery plan bid value submitted to Welsh Government for this additional support was £1.24m.

Cardiology

This funding will support the Health Board reducing >8 week waiting patients to zero from a current number of c.290 patients waiting over 8 weeks. The revised delivery plan bid value submitted to Welsh Government for this additional support was £32,870k.

Neurophysiology

This funding will support the Health Board reducing >8 week waiting patients to zero from a current number of c.910 patients waiting over 8 weeks. The revised delivery plan bid value submitted to Welsh Government for this additional support was £300k. Although there is a risk of having c.750 patients over 8 weeks at year end, all opportunities to improve this to zero are being explored.

After a quick turnaround, on the 25th October the Health Board completed and submitted delivery plans. These delivery plans have been submitted to Welsh Government in three categories:

1. *Schemes that received approval by Welsh Government* – This included T&O and specific diagnostics schemes (Endoscopy, Neurophysiology, Cardiology) with additional detail, risks and costings.

2. *Revised ENT schemes in order to seek approval* – this included insourcing options for outpatients and treatments, as well as internal Audiology schemes, additionally prioritising paediatric patients.

3. *Additional opportunities dependent on funding availability* – This included General Surgery options promoting high volume low complexity (HVLC) surgery as well as Ophthalmology schemes outside of the regional cataracts programme funding.

As at the 4th November the Health Board is waiting to receive feedback as to whether schemes submitted under points 2 and 3 above have been approved.

If point 2 schemes for ENT were approved we would have the opportunity yo deliver the follow level of activity:

No.	Plan	Activity	Impact on Year End Position
1.	Insourcing ENT Outpatients	1000 outpatients	Zero Outpatients > 104
2.	Insourcing ENT Treatments	500 Treatments	0 at treatment stage > 104 weeks
3.	Insourcing ENT Outpatients	5000 outpatients 12-week programme	Zero outpatients > 52 weeks by end March 2025
4.	Audiology - Direct access-hearing assessment and fitting-	DA = 58 pr wk Hearing aid fittings	Waiting time end of March 2025 = 48 weeks for RTT.

	current wait time = 61 wks	38 pr wk (fitting incorporated with DA appts) Total activity 58 x 18 weeks = 1044	Improving patient experience, and quality of life along with reducing risk of ear health deteriorating potentially requiring surgery
5.	Audiology - Direct access- unilateral tinnitus- current w/time = 58 weeks	10 patients per week for 18 weeks = 180 patients	Wait time end of March 2025 = 45 weeks Improving patient experience, and quality of life along with reducing risk of ear health deteriorating potentially requiring surgery
6.	Audiology - Paediatric assessments Current waiting time - 46 wks	Community new w/lists for >4 years w/time currently 46 weeks 36 appts pr wk x 18 weeks = 648 appts	Waiting list reduced from 46 weeks to 18 weeks. From April 2025 WG RTT Audiology Paediatric target will be 6 weeks Improving patient experience, and quality of life potentially impacting development. Additionally reducing risk of ear health deteriorating potentially requiring surgery

As a whole, there is a risk of non-delivery against targets due to:

- The timing of confirmed additional funding allocated. The Health Board is doing all it can internally to progress initiatives as far as possible ahead of receiving funding confirmation.

- Staff uptake – Many of these schemes require our clinical staff to perform additional work, including at evenings and weekends. This is in the context of heading into the Christmas period and what is predicted to be a difficult winter period.

- Potential market saturation or availability of providers for outsourced or insourced capacity.

If all additional funding was agreed without delay and all schemes delivered with full internal staff support then this would result in ending the financial year with zero patients waiting over 104 weeks at all stages. It would reduce waiting lists significantly, most notably in ENT which could see lists reduced to ensure no patients are waiting over 52 weeks for an outpatient appointment.

Welsh Government have made it clear that funding, as described in this paper, is conditional based on activity delivery and may be retracted if the Health Board cannot demonstrate waiting list reduction as per the submitted delivery plan.

Although unconfirmed, the Health Board is working with Welsh Government to understand the potential recurring planned care funding opportunities going into next financial year. If ongoing focussed financial support is achieved then the Health Board can build momentum in reducing waiting lists and start to make more substantive decisions to achieve service sustainability. This would also support submitting more ambitious planned care trajectories for the 2025/2026 annual plan.

Oversight of plan delivery

Monitoring of delivery of new trajectories will be via the fortnightly "RTT" meeting run by the Deputy COO, Divisional Assurance meetings and through to a refocused Ministerial Priorities Oversight Group which is being established for the Winter Period to support streamlining the meeting infrastructure. Performance reports from Q3 will be updated to reflect new trajectories so that tracking will be against these new commitments.

Argymhelliad / Recommendation

The Board are asked to NOTE and ENDORSE this report, providing the background and latest updates as to funding and planned care intentions to the end of the year.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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:	Executive Committee

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	Choose an item. Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**ReFit Energy Framework - Invest to Save Funding Update**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe, Executive Director of Finance, Procurement and Value (and SRO Decarbonisation)
SWYDDOG ADRODD: REPORTING OFFICER:	Jamie Marchant, Director Estates and Facilities Division

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

Ar Gyfer Trafodaeth/For Discussion

The Board is asked to discuss the contents of the report and note the onward process for the development of the Investment Grade Proposal (IGP) and request for invest to save funding to support decarbonisation of ABUHB estate.

ADRODDIAD SCAA
SBAR REPORT

This report details the progress of the work within the Health Board in developing proposals under the ReFit framework for invest to save capital funding to enhance ABUHB estate, reduce carbon emissions and reduce costs associated with energy. Following a tender process and award of contract partner, Health Board officers have worked with the appointed partner and developed a High-Level Assessment of potential for investment and the next stages including an IGP and formal submission for investment.

Cefndir / Background

ReFit is a UK-wide Official Journal of the European Union (OJEU)-procured framework which provides large-scale guaranteed savings Energy Performance Contracts (EPC) to public sector bodies, guaranteed and underwritten by the ReFit service provider/contractor. Savings are both financial and energy/carbon related.

ReFit Cymru is a Welsh Government promoted scheme that aims to accelerate the energy efficiency of public sector buildings. Support relating to the scheme is provided by the Welsh Government Energy Service (WGES) and a body entitled Local Partnerships.

The framework provides a guaranteed 100% of the energy saving or generation (kWh) via a contractual agreement for the payback period of the project, this key

feature is helping to remove risk of failure with new developments, plus protecting the client and their investment.

Additional benefits include improvements to buildings' operational performance and comfort levels for staff, reductions in building-related complaints and maintenance backlogs, a boost to local investment through local job creation, and important reductions in CO_2 emissions.

Local Partnerships is a public sector consultancy jointly owned by the Local Government Association, HM Treasury and Welsh Government. They work solely for central government departments, the Welsh Government, councils and combined authorities. Local Partnerships is established to support public bodies' financial challenges and specifically in the context of ReFit to offer expert advice, resources and programme delivery support to develop carbon reduction solutions through the framework.

Salix Finance works with the UK government and devolved administrations in Scotland and Wales to provide funding schemes with the aim of supporting public bodies to boost their energy efficiency, reduce their impact on the environment and save money. Within Wales they operate the 'Wales Funding Programme' on behalf of Welsh Government which provides loan funding for energy efficiency and decarbonisation for public sector bodies registered in Wales. The 'Invest to Save' funding is a specific scheme within the 'Wales Funding Programme' available for public sector bodies who do not have borrowing powers, such as Health Boards. The funding via 'Invest to Save' is provided interest free with the funds being awarded and administered by Welsh Government.

The NHS in Wales has a carbon footprint of circa 1 million tonnes CO2 (baselined 18/19) with Aneurin Bevan University Health Board accounting for 14% of these total emissions. Carbon emissions from buildings alone equate to 21% of the NHS Wales total, therefore providing a significant opportunity for investment in decarbonising technologies.

The Health Board is currently challenged by the Welsh Governments target for Net Zero emissions by 2030 and the initiatives and objectives prescribed in the NHS Wales Decarbonisation Strategic Delivery Plan. Interim emissions reduction targets of 16% by 2025 and 34% by 2030 mean the Health Board faces a significant challenge. The ReFit Programme provides a mechanism to design, install and deliver large scale estate-wide decarbonisation schemes demonstrating commitment to meeting these challenges.

An initial business case to proceed with the ReFit Programme was approved by the Board in 2021 and was based on the identification of a suite of over 90 energy conservation measures across the hospital and clinic portfolio. These estate-wide surveys that were conducted in 2018/19 identified significant investment opportunities, to the scale of circa £7m with an anticipated annual revenue saving of over £800,000 (as at 2021 prices). At that time there was an associated carbon saving of 3,547 tonnes CO2, that would now equate to approximately 15% of the emissions from building energy use.

During 2022 and 2023, officers from the Estates and Facilities Division, assisted by NHS Wales Shared Services Partnership (NWSSP) Legal & Risk and NWSSP

Procurement Services prepared the tender specification, Invitation to Tender (ITT) and various other framework contract documents to tender the opportunity to partner with Aneurin Bevan University Health Board to deliver energy and carbon saving projects. The tender went live on E-TenderWales on 1st June 2023, open to all 16 ReFit Framework providers.

Nevill Hall Hospital (NHH) was used as the test site for bidders to demonstrate their technical abilities and several "Bidders Days" were hosted at NHH whereby potential bidders were given the opportunity to survey and audit the hospital.

Of the 5 tenders returned, Vital Energi Utilities Ltd (hereafter referred to as Vital Energi) were the successful bidder. Vital Energi, had already won ReFit tenders with other NHS Wales Health Boards and other national organisations and are well placed to partner with the Health Board to deliver successful programmes of work. Vital Energi is an award-winning energy company specialising in renewable and sustainable energy solutions across all sectors[1]. Vital have evolved a suite of products and services to offer a complete energy solution and they have proven themselves as market leaders in energy conservation measures.

As part of their service, Vital have offered Energy Performance Contracts to clients, where appropriate, guaranteeing £300m of energy savings to the NHS alone, as well as delivering across multiple frameworks to assist with the UK Government's target of net zero carbon by 2050.

Following internal and Welsh Government approvals the Call Off Contract was signed by both parties on 30th January 2024. Fortnightly meetings of a Project Team have taken place with Vital Energi led by the Director of the Estates & Facilities Division, members of the estates function, Finance, Contract teams as well as Vital Energi. There has also been regular attendance from Local Partnerships to offer counsel and challenge as well as separate interactions with Welsh Government Energy Service (WGES) who offer expert advice on the energy and decarbonisation matters across Wales and are asked by Welsh Government to offer specific advice and scrutiny on any ReFit proposals.

There are a number of stages in ultimately developing a case for invest to save funding to Salix Finance (and thus Welsh Government). This starts with a High Level Assessment (HLA), onto an Investment Grade Proposal and finally a formal application for funding. Upon appointment of Vital Energi as the preferred partner in this work, the scope of the HLA was discussed using knowledge and experience of hospital and energy issues by HB officers along with the experience of Vital Energi. In developing the outline of the HLA, it is necessary to be cognisant of the payback criteria set by the funding. The invest to save funding criteria have recently been relaxed to make more projects and technologies eligible and the main eligibility criteria is now increased to 10yrs payback and £350/tonne CO_2.

Experience shows that a balanced HLA needs to be developed which blends 'quick returns' but also some proposals which require significant capital which by themselves would not meet the payback period. Over the last 15 years ABUHB has benefitted from significant investment in estate, notably in the form of Ysbyty Aneurin Bevan (YAB), Ysbyty Ystrad Fawr (YYF) and Grange University Hospital (GUH). This means that those sites offer less potential for marked gain in

[1] CHP | Heat Pumps | District Heating | Vital Energi

investment, and this affected the sites and solutions which would be considered for the HLA.

Based upon detailed interactions with Vital Energi and knowledge and assessments by officers of ABUHB estate and existing technologies, the HLA was completed by Vital Energi for a first phase of schemes. It is beneficial to note that there is not a limit to the number of phases a Health Board can apply for funding and the only limit is the national availability of the fund but at this stage the focus is on a prompt development of a range of schemes which can be delivered in 2025/26 and 2026/27 which is referred to as Phase One.

The selection of schemes within the HLA represents opportunities for traditional energy conservation measures (ECMs) and feasibility for renewable energy installations. Traditional ECMs would include LED lighting, insulation, upgrades to ventilation, Building Management Systems upgrades and building fabric improvements.

The HLA identifies a suite of ECMs across the six premises these are identified in the matrix below:

ECM	Nevill Hall Hospital	Grange University Hospital	Royal Gwent Hospital	Serennu Children's Centre	St Woolos Hospital	Chepstow Community Hospital
Building Fabric						
Glazing Upgrades						
Draughtproofing	✓		✓			
Pipework Insulation	✓		✓			
BEMS Optimisation & Distribution Improvements	✓					
Cooling Distribution Improvements						
Cooling System Improvements						
Chiller EC Fan Replacements	✓		✓			
AHU EC Fan Replacements	✓		✓			
Ventilation Improvements						
LED Lighting Replacements	✓		✓			✓
Solar PV Ground						
Solar PV Roof			✓	✓	✓	✓
Solar PV Car Port		✓				

Assessment

The HLA Report was received on programme in July 2024. Subsequent review over the following 6 to 8 weeks was undertaken initially by the HB Project Team and then by Local Partnerships (LP) and Welsh Government Energy Service (WGES). Following this process, approval was given by the Director of Estates and Facilities

Division to move onto the Investment Grade Proposal (IGP) stage. The HLA and supporting appendices is provided to the Board under confidential cover due to commercial sensitivities.

The HLA identifies anticipated annual revenue savings of £730k per annum, and an associated 995 tonnes emissions reduction. This equates to a significant energy saving providing a 6.6% carbon emissions savings based on the baseline data and collectively a 10.2 year simple payback. These HLA performance parameters are slightly outside of the current funding criteria associated with the invest to save funding, but this will be refined throughout the IGP Phase including active discussions with Local Partnerships and Welsh Government Energy Service.

Parameter	Target	HLA Value
Maximum Project Capital Sum	£7,000,000	£7,447,531
Maximum Project Payback	10 Years	10.2 Years
Maximum Carbon Cost	£350/tCO_2	£362/tCO_2

Expected savings by site and ECM type have been provided in the HLA and are summarised below to provide an overview on where and at what scale savings will be made:

Draughtproofing	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Nevill Hall Hospital	15	83,490	£6,236
Royal Gwent Hospital	28	155,225	£11,594
Total	43	238,715	£17,830

Pipework Insulation	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Nevill Hall Hospital	19	101,613	£7,589
Royal Gwent Hospital	113	615,012	£45,935
Total	131	716,625	£53,525

BMS Optimisation and Distribution Improvements	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Nevill Hall Hospital	159	837,847	£76,553
Total	**159**	**837,847**	**£76,553**

Chiller EC Fan Replacement	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Nevill Hall Hospital	19	83,031	£16,901
Royal Gwent Hospital	19	84,099	£17,118
Total	**38**	**167,130**	**£34,019**

AHU EC Fan Replacements	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Nevill Hall Hospital	63	273,983	£55,769
Royal Gwent Hospital	90	390,037	£79,392
Total	**153**	**664,020**	**£135,161**

LED Lighting Replacement	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	TCO2	kWh	£
Nevill Hall Hospital	33	143,171	£29,142
Royal Gwent Hospital	129	557,585	£113,497
Chepstow Community Hospital	24	104,446	£21,260
Total	**186**	**805,202**	**£163,899**

Rooftop Solar PV	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Royal Gwent Hospital	16	69,479	£14,143
Serennu Children's Centre	18	77,667	£15,809
St Woolos Hospital	11	48,024	£9,775
Chepstow Community Centre	19	82,464	£16,786
Total	**64**	**277,634**	**£56,513**

Solar Carports	ANNUAL SAVINGS		
	Total Annual CO_2 Saving	Total Annual Energy Saving	Energy Cost Savings
	tCO_2	kWh	£
Gwent University Hospital	219	948,167	£192,999
Total	**219**	**948,167**	**£192,999**

Site	Annual Savings (kWh)	Annual Savings (%)	Annual Cost Savings (£)	Simple Payback (Years)	Emissions Reduction (tCO2)	Emissions Reduction (%)
Nevill Hall Hospital	1,523,135	33%	£192,191	7.4	308	31%
Grange University Hospital	948,167	20%	£192,999	15.5	219	22%
Royal Gwent Hospital	1,871,438	40%	£281,678	9.0	396	40%
Serennu Children's Centre	77,667	2%	£15,809	5.9	18	2%
St Woolos Hospital	48,024	1%	£9,775	6.8	11	1%
Chepstow Community Hospital	186,910	4%	£38,045	9.1	43	4%
Total	**4,655,340**	**6%**	**£730,499**	**10.2**	**995**	**6.6%**

With ReFit providing an energy performance guarantee associated with any measures, the health board are guaranteed any repayments necessary as the energy cost savings will be equal or greater than the repayments. This will be underwritten by Vital Energi, as arranged within the Call-off Contract.

As part of the aforementioned external review by Local Partnerships and also Welsh Government Energy Service a number of observations were received. Some of these comments informed and benefitted the final HLA but the majority of the observations were aimed at informing the detail of the Investment Grade Proposal and have been shared with Vital Energi.

There are three specific topics within the observations which were noted at this stage prior to IGP. They relate to the issues of client-side costs, VAT treatment and modern slavery.

The capital sum in the HLA does not include any client-side costs. These are costs that the Health Board would incur to ensure the Health Board can act as an informed client when the capital work is happening on site and in addition to the HLA value stated above they have been estimated as approximately 3% of capital costs which would add £223k to the capital cost. Funding for this element will be considered and confirmed at the appropriate IGP stage and it is hoped these costs will be submitted as part of the funding proposal.

In terms of VAT treatment, the HLA value did not include any VAT on the capital costs. Guidance from WGES is that Health Boards should not claim VAT in the capital costs for items where the HB will ultimately be able to reclaim the VAT and therefore at this stage VAT has not been added against capital costs but also has been excluded against the utilities costs also. The IGP will include a formal assessment and calculation of VAT treatment for all capital costs and also the utilities as the latter will also be key in assessing the annual savings.

The HLA includes a wide range of solar photovoltaic (PV) panels. Solar has become a fundamental solution globally in reducing carbon however WGES noted the recent issues relating to 'modern slavery' in procurement chains relating to solar panels. ABUHB has therefore sought clarity on the position from Vital Energi who have provided their response to this issue. This topic will be revisited throughout the IGP with Vital Energi and any assurance will be re-provided in that stage.

Upon the advice of WGES, the Health Board has submitted an Expression of Interest (EOI) to the Wales Funding Programme (otherwise referred to as Salix Funding) for £7.44m, phased over 2 financial years of investment as Phase One progresses.

The subsequential IGP will form the business case upon which the Health Board will form its bid to the Invest-2-Save Wales Funding Programme. Vital Energi will undertake further site visits to clarify specifications and quantities, so more accurate capital costs will be drawn up. By ensuring the recommendations presented by LP and WGES are taken into account – accurate payback and carbon savings can be calculated, and the suite of ECMs can be flexed to ensure compliance with the Invest-2-Save eligibility criteria. The IGP will also identify the level of guaranteed savings to be expected annually in Phase One.

The IGP process will also include a period of time liaising with National Grid and Local Planning Authorities to ensure any planned solar PV developments can be installed. A draft IGP document is expected from Vital Energi in mid-December which will reviewed and discussed internally by the Project Team and include informal discussions with Local Partnerships and WGES. A final proposal will then be developed by mid-January 2025 for formal consideration within the Health Board as well as Local Partnerships and WGES. Whilst an expression of interest for funding has been made, which seeks to help Salix and WGES manage the competing interests for the pot, there is no guarantee of funding hence the need for expeditious actions by Vital Energi and ABUHB to develop and finalise the IGP and funding proposal as soon as is practicable.

The timeline for the IGP development and subsequent steps is outlined below:

Task	Start	Finish	Duration
HLA Stage Sign-off	**20 Sep 24**	**20 Sep 24**	
IGP Pre-start Meeting	23 Sep 24	27 Sep 24	1w
Early Design Activities (Solar)	**30 Sep 24**	**13 Feb 25**	**17w 4d**
RIBA Stage 3 Design (Solar)	30 Sep 24	31 Oct 24	4w 4d
G99 / G100 Applications	**18 Oct 24**	**13 Feb 25**	**15w**
Liaise with DNO (Solar)	18 Oct 24	31 Oct 24	2w
Submit G99 Application (Solar)	01 Nov 24	07 Nov 24	1w
Anticipated G99 Approval Period	08 Nov 24	13 Feb 25	12w
G99 Approval (Anticipated)	13 Feb 25	13 Feb 25	
Planning Applications	**18 Oct 24**	**13 Feb 25**	**15w**
Prepare Planning Information (Solar)	18 Oct 24	31 Oct 24	2w
Submit Planning Application (Solar)	01 Nov 24	07 Nov 24	1w
Anticipated Approval Period (Solar)	08 Nov 24	13 Feb 25	12w
Planning Approval (Anticipated)	13 Feb 25	13 Feb 25	
Investment Grade Proposal Stage (IGP)	**30 Sep 24**	**17 Jan 25**	**14w**
Mobilisation Period (Supply Chain)	30 Sep 24	04 Oct 24	1w
IGP Site Surveys	**07 Oct 24**	**18 Oct 24**	**2w**
Supply Chain Update Quotes	21 Oct 24	01 Nov 24	2w
Cost Development (Solar)	04 Nov 24	22 Nov 24	3w
ECM Model Updates	25 Nov 24	29 Nov 24	1w
Draft IGP Report Production	02 Dec 24	13 Dec 24	2w
Submission of Draft IGP Report	**13 Dec 24**	**13 Dec 24**	
Draft IGP Report Review Period	16 Dec 24	10 Jan 25	2w
Final IGP Report Production	16 Dec 24	17 Jan 25	3w
Submission of investment grade proposal	**17 Jan 25**	**17 Jan 25**	
IGP Review / Approval	**20 Jan 25**	**28 Feb 25**	**6w**
IGP Report Review - ABUHB	20 Jan 25	31 Jan 25	2w
IGP Report Review – Local Partnerships	03 Feb 25	07 Feb 25	1w
IGP Report Review – WGES	10 Feb 25	14 Feb 25	1w
IGP Report Final Submission	17 Feb 25	21 Feb 25	1w
IGP Report Approval	24 Feb 25	28 Feb 25	1w
IGP Stage Sign-off	28 Feb 25	28 Feb 25	
Finalise WOS Agreement	**20 Jan 25**	**07 Mar 25**	**7w**
Finalise WOS Agreement	20 Jan 25	07 Mar 25	7w
Works/Optimisation Services Agreement in place	07 Mar 25	07 Mar 25	

The current programme seeks to conclude the scrutiny and approval 6 weeks after receipt of the IGP (i.e. end February 2025).

Parallel to the approval within the Health Board of the IGP a formal submission for funding will need to be submitted to Salix based on the financial and carbon details within the HLA. In support of the aforementioned desire to move expeditiously,

discussions will be ongoing with Salix during the scrutiny process so that Salix is aware of the value of the impending submission. Detailed discussions will take place with all the aforementioned external bodies relating to the items in the funding proposal beyond the capital works including VAT, client side fees (ie project, legal fees and framework fees).

Subsequent to formal support of funding by Salix this will then need to be formally considered by WGES and will subsequently require Welsh Government approval by three Ministerial Cabinet Secretaries covering Finance, Health & Social Care and Climate Change.

Following this final approval, a Work Optimisation Services (WOS) Agreement is developed and signed between the Health Board and Vital Energi which commits to the work within the approved IGP in line with the funding envelope and programme. At this stage a fee of 0.75% of the capital expenditure funded (to a cap of £45k) is payable by the Health Board to Local Partnerships for the framework use and support. The development of the WOS will require support from NWSSP Legal & Risk Services.

The invest to save funding 'pot' is aimed to be self-sustaining in that monies paid back each year by organisations with approved financing, will 'top up' the capital pot for incoming organisations. There is however a risk at some point in the future that funding may not be available. Following advice from WGES as well as NWSSP Procurement and NWSSP Legal and Risk there is a need to add an amendment to the existing Call Off Contract which would allow the Health Board to seek alternative routes to invest to save financing outside of the Salix route. This could be for example through funding streams available to Vital Energi. NWSSP Legal and Risk are working with Browne Jacobson LLP on behalf of a number of HBs who are developing IGPs to add this amendment and mechanism, and the work is ongoing. At this stage there is no formal suggestion of a lack of Salix funding so this step is simply a necessary precaution. Should the scenario arise where funding is not provided the Health Board will wish to take full and careful consideration of the options available.

Recommendation & Conclusions:

The Board is asked to DISCUSS the report and note the positive progress to date, and the programme of work planned for the year leading to IGP submission and funding request.

The Board is asked to APPROVE the request for the Executive Committee to consider and approve, as appropriate, the IGP in January 2025 for prompt submission alongside the formal request for invest to save funding.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 1.1 Health Promotion, Protection and Improvement Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Enabling Estate
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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)**	
	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. **Long Term –** Improving the energy efficiency of the Health Boards premises and reducing carbon emissions will contribute towards the "resilient Wales" goal and reduce negative environmental impact. Decarbonisation ambitions of the ReFit programme will contribute towards the national net-zero carbon target. **Integration** – The Health Boards carbon reduction activities will compliment and make progress towards objectives shared by other local partners e.g. local authorities and PSB and supporting to deliver some well-being objectives focussed on the environment. **Involvement** – Through work decarbonise our building stock, we will engage and consult where necessary with relevant local organisations, staff, local authorities and Welsh Government. **Collaboration** – This will be demonstrated by working with Vital Energi Utilities Ltd and other local partner organisations to leverage best practice and deliver energy efficiency projects. **Prevention –** Continuing to maintain and enhance our natural environment and air quality by reducing carbon emissions to help mitigate the effects of climate change.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Improvement Capability Strategy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Trask, ABUHB Quality Improvement Lead Jonathan Clarke, Assistant Medical Director for Quality Improvement

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 Aneurin Bevan University Health Board's Quality Strategy, published in 2023, is a three-year strategy that serves as a blueprint for putting quality and safety at the forefront of all we do. It sets out a vision where Quality is embedded in our culture, where we are committed to continually improving the care that we provide. The three-year Quality Improvement Capability Strategy is key to delivering elements of the Quality Strategy and describes initial plans to embed Quality Improvement into everything we do.

Quality Improvement (QI) is an effective methodology that may be applied to some of the challenges that the Health Board currently faces. Board level leadership is crucial to developing a culture of learning and improvement.

Developing an organisational approach to Quality Improvement was discussed at a recent Board Development session in October 2024. This strategy follows on from that discussion and will describe how we will embed Quality Improvement by building Organisational Capability for continuous Quality Improvement.

Cefndir / Background

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- A Healthier Wales

With our aims to continuously improve and learn, new legislative requirements support the development of our strategy. The Health and Social Care (Quality and Engagement) (Wales) Act 2020, places more responsibility on health and care organisations in Wales. The Duty of Quality sets out a requirement to develop a system-wide way of working to continuously, reliably and sustainably meet the needs of the population that we serve. Amongst the six enablers described, is a requirement for the healthcare system to create the conditions and capacity for an organisation and system-wide approach to continuous learning, Quality Improvement and Innovation.

Quality Improvement is a specific evidence-based methodology where teams work together using the consistent application of quality improvement principles to understand their system, set aims, measure, test changes, learn and continuously improve.

The Health Board has a small central Quality Improvement Unit, ABCi (Aneurin Bevan Continuous Improvement), which has been in place since 2013. The ABCi Unit support teams in their improvement work, train staff and have run programmes of QI work.

Benefits of using Quality Improvement methodology have been demonstrated recently through the national Safe Care Partnership/Collaborative and within local QI projects. QI has impacted on patient outcomes and derived finance benefits and include:

- Reducing avoidable cardiac arrests by 80%
- Reducing paediatric waiting lists from 26 to 15 weeks
- Theatre Never Events – 1 every 93 days to over 330 days between events
- Decision to treat times for patients with cancer reduced by 20%

Asesiad / Assessment

The Duty of Quality requires the NHS to establish Quality Management Systems that focus on learning and are driven by their boards. Quality Improvement works at its best when operating alongside systems for Quality Control, Quality Planning and Quality Assurance. The Health Board is working with the national Safe Care Partnership to scope out and develop our own organisational Quality Management System.

Quality Improvement within the Health Board has not operated within a wider QMS system and despite training staff and running programmes of work, QI is not

embedded into the services. A recent NHS IMPACT self-assessment carried out within the Health Board indicated that only 4% of staff felt that QI was embedded, and in a recent survey 50% found that quality improvement is not easy to carry out within teams. In the past QI has been seen as a 'niche' activity for enthusiasts rather than a mainstream activity for everybody.

Aneurin Bevan University Health Board faces current challenges around Quality and Safety, Performance, Staff Wellbeing and Finances. Embedding Quality Improvement into everything we do is one solution to help with these challenges and has benefits for service users, the workforce and the Health Board.

Our vision for the next three years is that:

Aneurin Bevan University Health Board is a learning organisation where clinical & non-clinical staff share ownership over the services they provide, have the agency to improve them and an environment that enables them to do so.

The evidence base and learning from best practice in other organisations indicates that to embed continuous quality improvement we need to be intentional and systematic around developing organisational Capability for QI. Building on direction set by the national improvement hub within the NHS Executive we plan to *support individual QI Capacity by building systemwide QI Capability*.

To build organisational QI Capability we will need to develop:

- QI Capacity – building knowledge and skills for QI
- QI Conditions – systemwide enablers for QI
- QI Connections – teams and partnerships sharing learning and good practice

To truly embed Quality Improvement into everything we do will take many years. However, the Aneurin Bevan University Health Board Quality Improvement Capability Strategy outlines a vision for the next three years and builds upon the good work already undertaken across the Health Board. The strategy articulates this direction via a QI capability driver diagram, delivery plan and specific objectives to be achieved over the next three years.

Argymhelliad / Recommendation

The Board is asked to **APPROVE** the Quality Improvement Capability Strategy.

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):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care

	3.3 Quality Improvement, Research and Innovation 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently QI Strategy has implications for all IMTP priorities
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Research, Innovation, Improvement, Value
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve 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 worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	**Quality Improvement** - Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement. **Improvement Capability** - The organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance
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	**Yes not yet available** 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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

Quality Improvement Capability Strategy:

Embedding Quality Improvement into everything we do

2025-2028

Introduction – Quality Improvement Capability Strategy

The Aneurin Bevan University Health Board's Quality Strategy, published in 2023, is a three-year strategy that serves as a blueprint for putting quality and safety at the forefront of all we do. It sets out a vision where Quality is embedded in our culture, and how we are committed to continually improving the Safety, Timeliness, Equity, Efficiency, Effectiveness and Person Centredness of care we provide. Specific commitments made are:

- Aneurin Bevan University Health Board endeavours to become a learning organisation where staff members work towards delivering high quality clinical care every day.

- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.

Quality Improvement Capability Strategy

This three-year *Quality Improvement Strategy* is key to delivering elements of the *Quality Strategy* and describes initial plans to embed Quality Improvement (QI) into everything we do.

Quality Improvement is an effective methodology that may be applied to some of the challenges that the Health Board currently faces so that we can deliver better care for patients and give better outcomes for communities. The vision of this QI Strategy is:

Aneurin Bevan University Health Board is a learning organisation where clinical & non-clinical staff share ownership over the services they provide, have the agency to improve them, and an environment that enables them to do so.

This strategy will describe how we will achieve this by building organisational *Capability* for continuous Quality Improvement.

Quality Improvement [QI] – what is it?

Implicit in the commitment to put Quality at the heart of everything we do, is the role of continuous quality improvement. 'Quality Improvement' is not the same as 'improving quality'. There are different methods that all healthcare providers employ to improve quality which may include planning, assurance mechanisms, continuous monitoring or even research.

"Quality Improvement" is not the same as "improving quality" [Care Quality Commission]

However, Quality Improvement is a specific evidence-based methodology where teams work together using the consistent application of quality improvement principles to understand their system, set aims, measure, test changes, learn and continuously improve.

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement." [The Health Foundation]

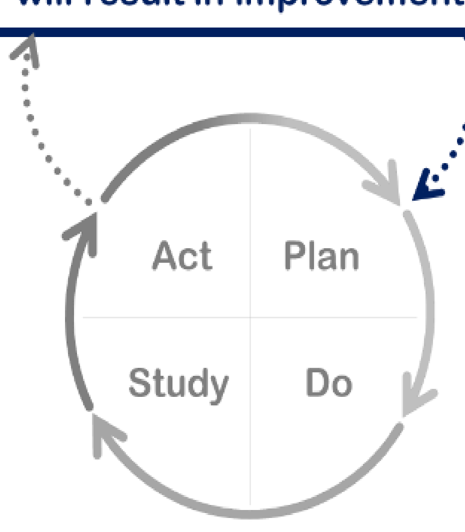
Quality Improvement is fundamentally about learning. It involves using an evidence-based methodology that draws upon what is useful and practical from different spheres of science such as engineering and statistics. It helps staff delivering care to understand the problems they are encountering, build knowledge of what works and what doesn't and to reduce variation in good practice. However, most importantly, Quality Improvement in Healthcare is acknowledged to be 20% technical and 80% human, it is a 'team sport'. QI science also draws from the world of Psychology to enable staff to use their creativity, professional expertise and experience within psychologically safe teams to improve what matters to them and their patients.

At its best QI is a 'bottom up' approach of organic learning and adapting embedded into everyday work. However, where wider improvement needs to take place there are different collaboration-based approaches that may be employed that are designed to enable participants to learn directly from each other.

'Improvement in healthcare is 20% technical and 80% human' [M Godfrey]

Improvement Collaboratives are one such methodology and, in their purest form, are based on the IHI Breakthrough Series Model which sets out a structure for those involved to learn from each other and from recognised experts in topic areas where improvements are being made. An output from improvement collaborations is not just improvement, but also increased staff capability to make further improvements in practice.

At present the predominant model for Quality Improvement used in Wales and in the Health Board is the 'Model for Improvement' (see figure), however there are other models such as Lean/Six Sigma that may be equally useful.



The Health Board Quality Strategy sets out core objectives around Quality Improvement that contributes to building a culture of continuous quality improvement, in particular to:

- Embed Improvement into daily work throughout the organisation
- Accelerate the development of learning and improvement skills for staff, service users and carers
- Align improvement work across the organisation

Key to this is building **Organisational Quality Improvement *Capability*** by developing organisational *capacity*, *conditions* and *connections* to enable staff to improve services and spread learning.

Strategic Context for Quality Improvement

Legislative

The purpose of the legislation outlining the **Duty of Quality, as part of (Quality and Engagement) (Wales) Act (2020),** is to ensure that NHS bodies secure improvements in the quality of services they provide.

Quality is more than just meeting service standards. It needs to be a system-wide way of working to continuously, reliably and sustainably meet the needs of the population that we serve. A culture of learning and improvement is crucial.

Amongst the six enablers described is a requirement for the healthcare system to create the conditions and capacity for an organisation and system-wide approach to continuous learning, Quality Improvement and Innovation.

Strategy & Policy

The Welsh Government Quality and Safety, and National Clinical Frameworks, published in 2021, outline how Quality Improvement works at its best when operating within a wider Quality Management System (QMS).

The Quality and Safety Framework outlines the need for an organisational approach to quality improvement. Without board-level leadership action and support, system improvement will fail. It is critical to create the conditions for quality improvement at all levels within an organisation.

'There needs to be an organisational approach to quality improvement. Without board-level leadership, system improvement will fail.'
[Quality and Safety Framework]

Values

A Healthier Wales (2018) outlines core values for NHS Wales. These are:

- Putting quality and safety above all else
- Integrating improvement
- Focusing on prevention, health improvement and inequality
- Working in true partnerships
- Investing in our staff

The Health Board Core Values as set out in the Aneurin Bevan University Health Board Values and Behaviours Framework are:

This strategy will show that continuous Quality Improvement culture and practice set out in this strategy aligns with these values.

Quality Improvement: Learning from Best Practice

There are numerous healthcare organisations who have become world leaders by embedding Quality Improvement into their culture and practice. The Care Quality Commission have learnt through inspections that:

'Organisations with a mature quality improvement approach have, among other things, prioritised improvement at board level, put in place a plan for building improvement skills at all levels of the organisation, and developed structures to oversee QI work and ensure it is aligned with the organisation's strategic objectives.'

'Improvement is Mainstream Business' [Health Foundation]

High-quality organisations delivering outstanding care have embedded systematic improvement cultures [CQC]

To enable Improvement to become mainstream business, evidence shows that we need to transform how we operate. The most effective approach is based on the belief that sustained improvement across a broad range of key delivery priorities relies on the presence of a positive, learning workplace culture, long-term investment in organisation-wide improvement capability, strong data management and analysis systems, mechanisms for planning and prioritising improvement work and effective governance arrangements. The development of an organisational Quality Management System would encompass these components.

Quality Improvement: Learning from Best Practice

NHS organisations within the UK such as East London Foundation Trust and others are embedding continuous quality improvement into their everyday practices. They understand that the benefits of Quality Improvement alone may be limited if not set within a wider QMS. The key components of a QMS are:

Quality Assurance

Leadership at different levels of the organisation need to know that the level of quality in services is being maintained. Data is shared with leadership at regular intervals, for them to understand where problems are occurring so that they can support staff in their improvement efforts. For instance, directorate leads have dashboards of safety or activity data. Boards will receive regular reports outlining quality and safety information.

Quality Improvement

This is about teams coming together using QI methods to solve problems that the service encounters. Data collected over time is used to enable staff see how their improvement work is progressing. For instance, in response to an increase in Never Events around retained swabs in theatres, a team gets together to test and measure the effects of a new process 'Quiet for the Count'. Or at an organisational level cardiac arrest rates are increasing so teams come together using QI methods as part of a wider improvement collaborative based on learning of what works and what doesn't.

Continuous Quality Improvement works best in the context of a wider Quality Management System

These together act as a Quality Management system where meaningful data is key.
(QS&I NHS Executive, 2024)

Quality Planning (Planning for Quality)

This is where a team, directorate, division or organisation decides what is important for them to focus their improvement work on and plans how this might work in practice. Data is used to help staff understand where the problems are to plan improvement. For example, a ward manager may realise that their falls are increasing and plans how the team might tackle this. Perhaps a directorate might want to focus on its outpatient delays, or at an organisational level the decision is made to focus on patient deterioration and plans to start with a couple of teams and create a spread plan to share learning with the rest of the organisation.

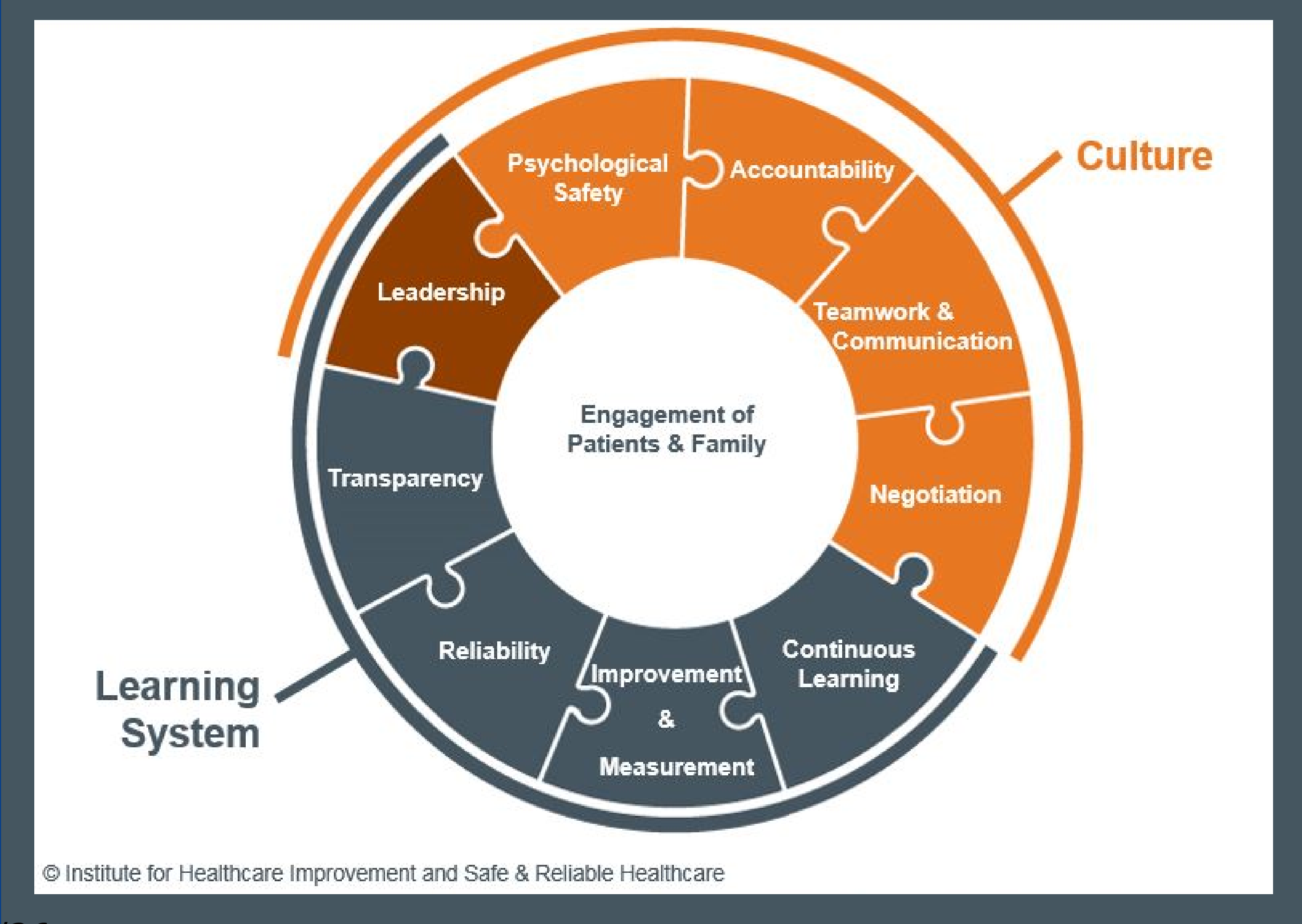
Quality Control (Maintaining Quality)

This is about maintaining quality in real time and is best done by staff at the point where service is delivered. Data collected over time is used to enable staff to know how they are doing in real-time. For instance, a ward manager has up to date data to check the safety incidents within their ward e,g. infections, falls etc. They are then able to act on what they learn, potentially to initiate some QI work, to keep these incidents low.

Quality Improvement: Learning from Best Practice

IHI Framework for Safe Reliable and Effective Care

Provides clarity and direction to healthcare organisations on the key strategic, clinical and operational components needed to achieve operational excellence. It's two foundational domains, culture and a learning system work with strong leadership to enable safe, reliable and effective care. Improvement and measurement are key enablers to achieve this.



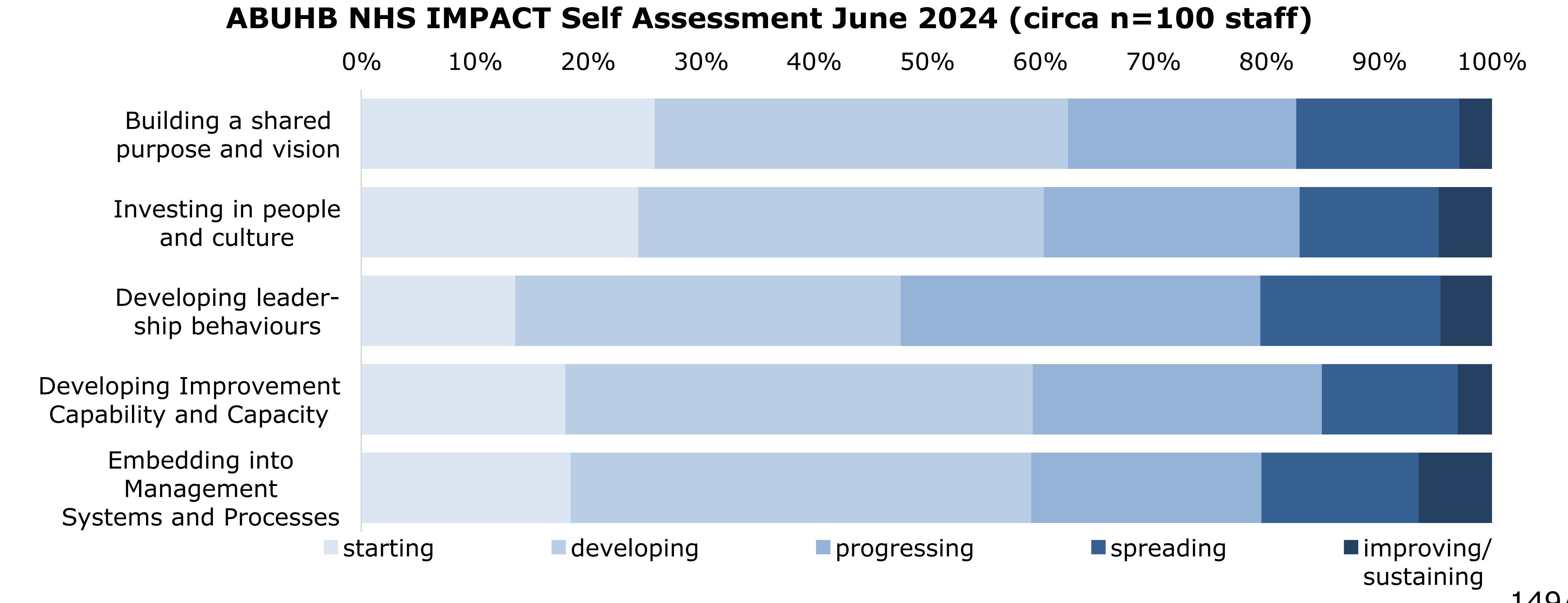
NHS Impact

NHS Impact is a shared NHS Improvement approach to support NHS organisations to have the skills and techniques to deliver continuous improvement. There are five components that underpin this systematic approach:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

At developing/progressing stage toward a system of continuous improvement

All are key to embedding quality improvement into everyday practice and achieving this within the Health Board would represent long-term strategy. An initial NHS IMPACT self-assessment survey carried out within the Health Board indicated most staff feel we are at the early stages of developing a system for continuous improvement (see figure).



The Benefits of Quality Improvement

The benefits of embedding Quality Improvement into practice are manifold as the methodology can be applied to all components of Quality. The recent QI work outlined below are examples where clinical teams in the Health Board have worked together with ABCi Quality Improvement Coaches:

Ward C0 reduced Cardiac Arrests by over 80%

- Avoidable cardiac arrests on ward C0 reduced by over 80% in the last 18 months. The days between cardiac arrests previously averaged at 1 every 41 days. At time of writing there have been over 300 days and counting since the last arrest. This represents a potential saving of almost £130k in hospital costs

Legal and Care costs reduced by delivering safer care

- Using QI methodology, the average wait for children to have their first paediatric appointment has reduced from around 26 weeks to15 weeks. According to a recent Royal College of Paediatrics report, only two health boards in Wales have achieved this improvement.

- Aneurin Bevan University Health Board was reported to have the highest number of Never Events over the past three years, on average these were occurring every 93 days. Following on from a Theatre Safety Programme there have been no Never Events in theatres for over 330 days. This equates to potential savings from avoided Never Events of around £268k in legal and hospital costs.

- Decision to treat colorectal cancer patients reduced from 60 to 46 days.

- Decision to treat head and neck cancer patients reduced from 58 to 47 days.

Decision to treat times for cancer patients reduced by 20%

Embedding quality improvement into the fabric of the Health Board will also place less reliance on top-down solutions to improve performance but more importantly it will build a network of improvers to call upon for directorate, divisional or organisational level priorities for improvement

There is also evidence to show that Quality Improvement activity can have benefits beyond the improvement work itself. For instance, the:

- **Workforce** – by bringing teams together there can be a positive impact on workplace culture and connectedness. Giving teams time, space, tools and permission to implement solutions gives staff more job control and higher satisfaction. Also, participation in improvement endeavours can develop an array of leadership, management, learning and technical skills which are well suited to today's healthcare landscape.

Quality Improvement benefits the workforce and may used to reduce staff harm

Quality Improvement may also be used directly to improve staff experience. For instance, a Health Board project which won an NHS Wales Award in 2023 aimed to reduce staff harm by improving the employee investigation process. The number of investigations was reduced by 67% and projected figures estimated that a reduction in employee investigations represented a cost aversion average to be around £792k.

- **Patients, service users, society** – application of improvement methods can improve access to appointments and services in addition to smoothing the flow between services as illustrated in the examples above. It can improve patient safety and outcomes through reliable adoption of best practice and improve service user experience through shared decision making and co-production.

- **Organisation** – the central organisational benefit from the deployment of improvement approaches at scale is the delivery of safe, high-quality care due to a reduction in patient harm and variations in care delivery. Training staff in improvement approaches can lead to significant organisational benefits, if staff are given opportunities to put their skills into practice. It can also support the effective use of scarce resources, efficiency gains and sustainability through the removal of waste, delay and duplication within care pathways.

Quality as a Business Strategy

Whilst continuous quality improvement activities are not about saving money, Quality can be at the core of healthcare business strategy. There are opportunities to both improve quality and reduce costs through reducing harm, waste or speeding up processes. For instance, Intermountain Health in the USA have saved $2 billion over five years (New York Times, 2019), whilst providing high-quality care. Leeds Teaching Hospitals NHS Trust as part of an NHS partnership with Virginia Mason Institute, identified a financial benefit of over £14.2 million from waste reduction in 2019/20 as a result of training staff in the Leeds Improvement Method (The Health Foundation, 2023).

Quality Improvement at Aneurin Bevan University Health Board - where are we now?

History of Quality Improvement at the Health Board

The Health Board has a small central Quality Improvement Unit, **ABCi (Aneurin Bevan Continuous Improvement)**, which has been in place since 2013. Originally set up in response to international learning around Quality Improvement Hubs e.g. The Qulturum in Jönköping County in Sweden, the initial ABCi team was one of the first QI teams in Wales. Initially, it also included a team providing Leadership training (now sits within Organisational Development) and a Mathematical Modelling team (now sits within Planning). In 2024 the Quality Improvement Unit retained the ABCi branding and moved into the Nursing Directorate. ABCi is currently comprised of 3 whole time equivalent permanent staff and 1 full-time secondee working with Theatres. An Assistant Medical Director for Quality Improvement was employed in June 2023 also works within ABCi. There is a wealth of expertise, skills and experience held within the ABCi team that is recognised beyond the Health Board.

In response to the Welsh Government Achieving Excellence: Quality Delivery Plan published in 2012, 25% of the Health Board workforce received a basic level online QI training. ABCi has continued to train staff in Quality Improvement Skills and at present has completed training for over 700 staff. ABCi have also supported staff across the Health Board with their improvement work, have coordinated programmes of QI work and supported national Quality Improvement Collaboratives. The most recent of which is the IHI/Improvement Cymru Safe Care Partnership and Safe Care Collaborative, the next stage of which is being co-designed.

However, despite training staff and running numerous programmes, Quality Improvement is *not* embedded into the service. The NHS IMPACT self-assessment tells us that we are predominantly at the developing stages of this work and that we have to build wider conditions to enable quality improvement in practice. In a recent survey of those within the Health Board who are interested or trained in Quality Improvement, around 50% said they did not find it easy to carry out improvements within their team or workplace.

50% staff surveyed don't find QI easy in their team or workplace

In the past Quality Improvement has often been seen as a 'niche' activity for enthusiasts who carry it out *despite* organisational conditions, rather than a mainstream activity that is carried out by everyone *because of* organisational conditions.

This Quality Improvement Strategy will outline how we can enable staff to improve the services they provide by building capacity, conditions and connections, thus building organisational Quality Improvement Capability.

Our Ambition for Quality Improvement at ABUHB

Our vision for the next three years is that:

Aneurin Bevan University Health Board is a learning organisation where clinical & non-clinical staff share ownership over the services they provide, have the agency to improve them and an environment that enables them to do so.

Learning from other organisations who have been on this 'improvement journey' tells us that it can take several years to fully embed continuous improvement and that it needs consistent leadership support during this time. However, recent feedback from staff is demonstrating an enthusiasm to embed quality improvement into their practice. This coupled with national policy direction, strong leadership within the Health Board and a need to find ways to meet the challenges that we currently face, leads us to believe that the time is right for the Health Board to work towards embedding Quality Improvement.

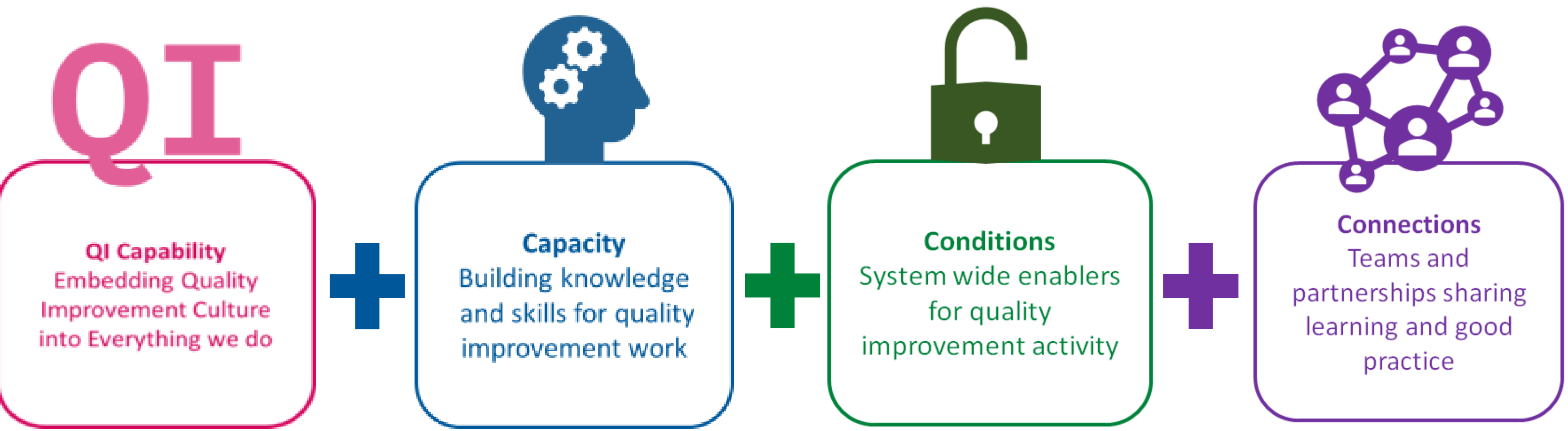
Building Organisational QI Capability to enable our staff

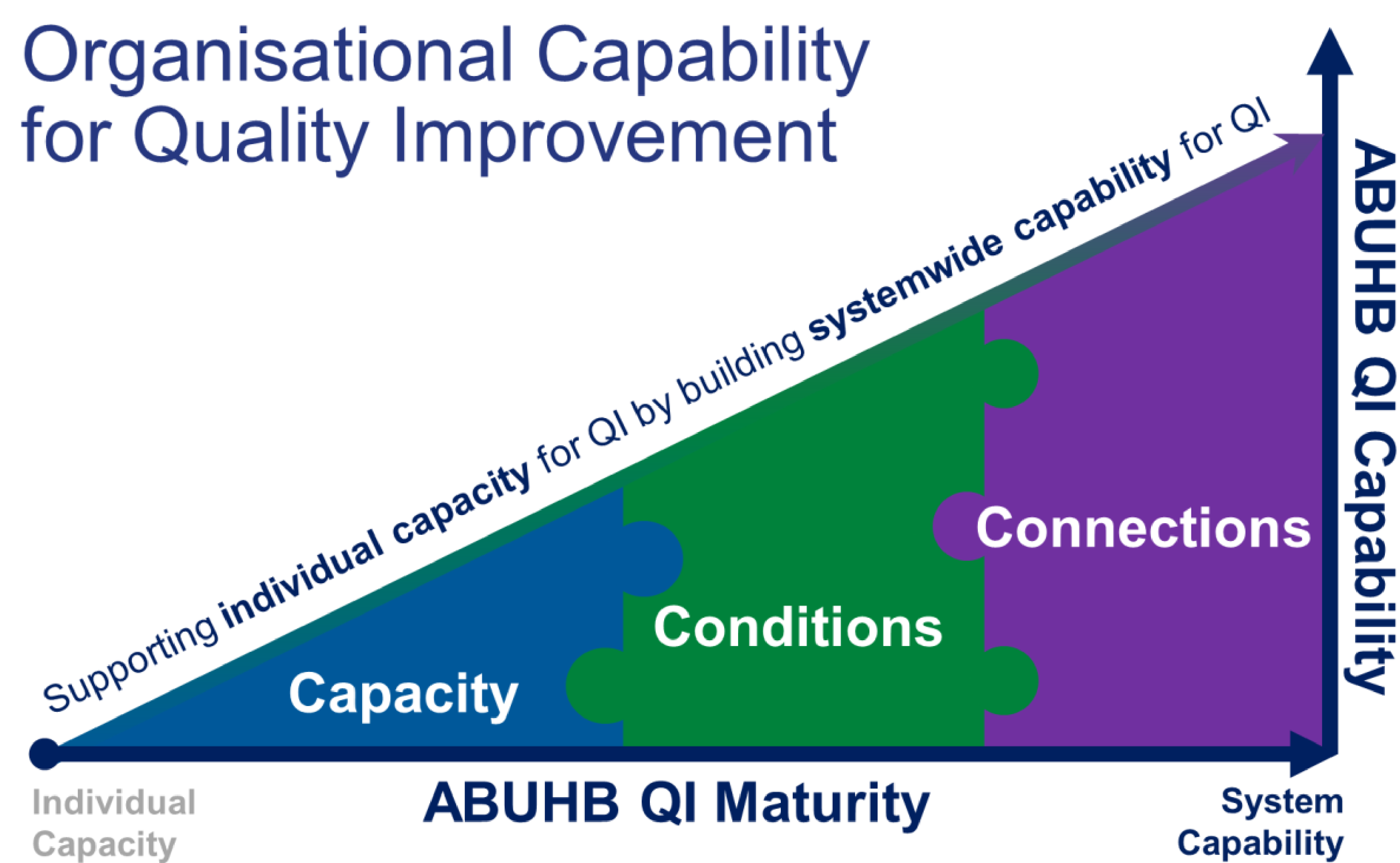
We will achieve this by building organisational *Capability* for Quality Improvement across the length and breadth of the Health Board. Improvement *Capability* has been defined as:

"The organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance".

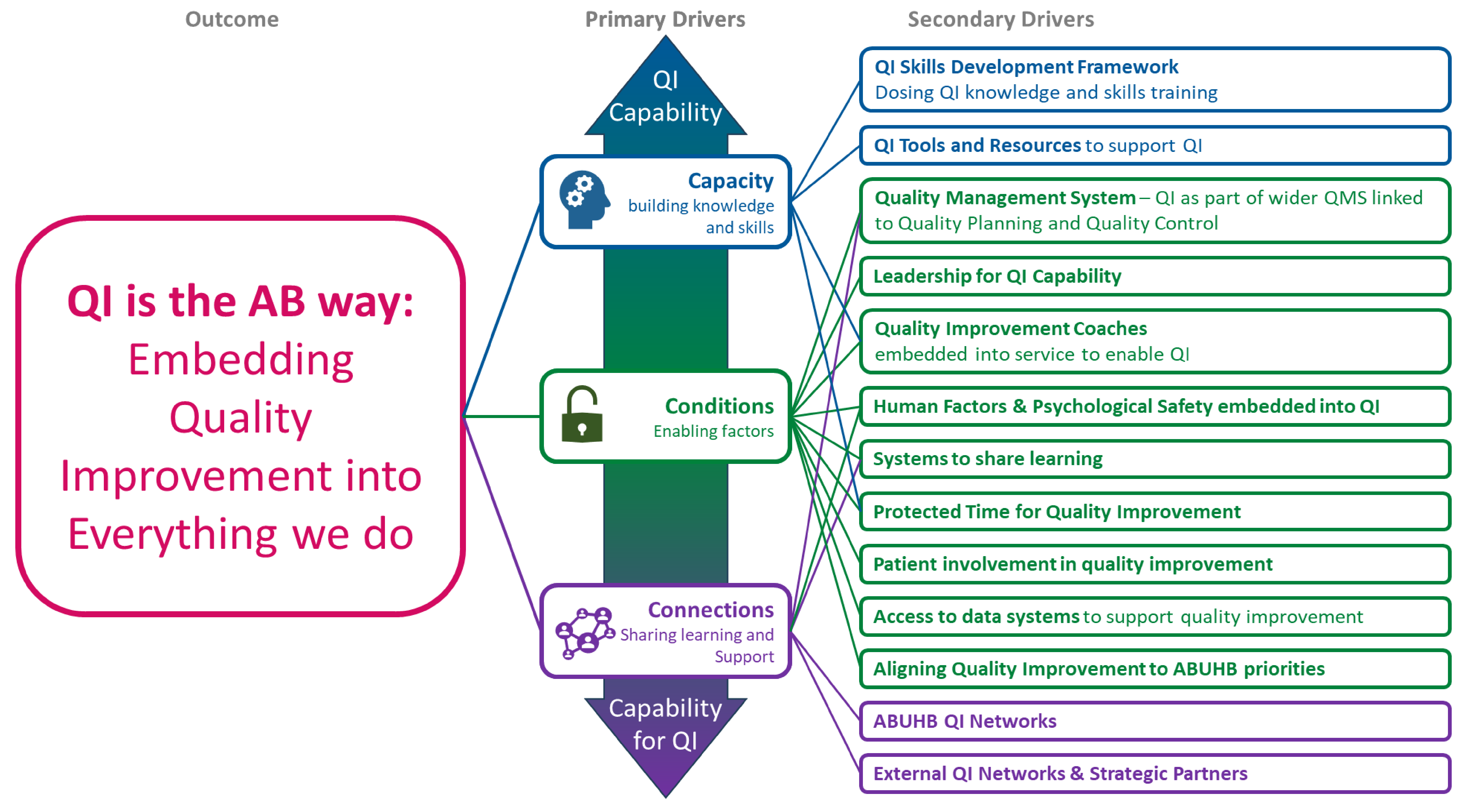
Building on direction set by the national improvement hub in Wales 'Improvement Cymru', which now forms part of the Quality Safety and Improvement Directorate within the NHS Executive, we have split building Quality Improvement Capability into three areas.

QI Capability = Capacity + Conditions + Connections





Strategy to Embed Quality Improvement into everything we do



This Aneurin Bevan University Health Board Strategy to embed Quality Improvement into everything we do is built upon developing organisational QI Capability. It has been developed based on the evidence around building infrastructures for Quality Improvement, through speaking to colleagues across the Health Board and external partners, plus the experience and expertise of Quality Improvers within the Health Board. This strategy focusses on the first three years of this work but it is acknowledged that to fully embed continuous improvement into everyday practice can take as long as 10 years. This Driver Diagram illustrates the main workstreams to achieve this, with the full Driver Diagram included in the Appendices.

Capacity – Building Knowledge and Skills

Capacity

Building knowledge and skills for quality improvement work

Developing upon the ideas set out in the NHS Dosing Strategy of 2017 we have come to define our local QI Capacity as meaning *Building Skills, Knowledge and Experience of our staff and population*. Capacity is about building our workforce with the skills, time and resources necessary to improve their services.

The QI Skills Development Framework (see appendices) – is a programme of QI training which is grounded on 'Dosing' principles which are fundamentally about, who needs to know what about Quality Improvement in order for them to support QI, whatever their role? The development of QI knowledge and skills are specifically targeted as *'not everyone in the organization needs the same depth of knowledge of QI concepts, methods and tools, and differing skill levels should be established'.*

The framework is grounded in experiential learning and the application of concepts, tools and methods in daily work, utilizing both classroom and virtual learning as part of design principles. The Framework includes both internal and external QI Training opportunities. The ABCi team currently provide:

Building skills, knowledge and experience of our staff

- **PocEd QI** – two half day virtual training in basic QI principles
- **PocEd Measurement** – half day virtual training in the use of time series data
- **Quality Coach Programme** – to develop QI Coaches embedded into Health Board services

QI Tools and Resources – ABCi continue to develop tools and resources to support clinical teams to improve their services. These include the use of Padlet, used to make and share content, which includes the 'Problems to Solutions' tool. Also accessing easy to use time series graphing such as ABCi Charts or FreeSPC and also a QI project/ programme platform such as Life QI or HIVE that enables staff to record the progress of their QI work.

Conditions – Enabling Factors

Conditions

System wide enablers for quality improvement activity

Health Board staff continue to strive to deliver high quality services. Key to enabling staff to use their quality improvement skills are conditions to support them to learn, prioritise improvement, and achieve what matters to them and their patients. The Conditions primary driver in particular needs organisational leadership and support.

Quality Management System (QMS) - The Health Board is working towards building a system to manage quality. This work will be supported by the Leadership worksteam which forms part of the next phase of All Wales Safe Care Partnership between health boards and Improvement Cymru within the NHS Executive. QMS structures should function at different levels within the organisation. A small project within the Paediatrics directorate will be exploring how a QMS might work at the clinical level with a potential to spread to the wider division.

Leadership for QI Capability – Leadership is key to creating consistency of purpose in order to develop systems for continuous quality improvement, and this includes leadership from the Board, Executive Team and embedded throughout the organisation. A QI Faculty supported by ABCi will be developed that will act as a tactical arm that sits between executive level strategy and operational services. The QI Faculty will support the development of organisational conditions for quality improvement activity. It will be key to Quality Planning for QI around organisational priorities whilst also support the Health Board's response to national improvement initiatives.

In response to conversations with differing clinical professional leaders, there was a suggestion to build local QI Leads within each directorate. QI Leads would support the development of local conditions for continuous Quality Improvement, align QI work to local priorities and provide leadership for other staff working to improve services.

Conditions – Enabling Factors

Quality Improvement Coaches – NHS Staff are *striving* to deliver the high quality of care their patients deserve, but sometimes the system *stifles* their ability to improve what matters to them and their patients. Quality Improvement Coaches are skilled in the human side of change, in addition to the use of QI tools and measurement for improvement and can coach teams achieve their aims. In any healthcare organisation working to embed quality improvement practice, 5% of staff are trained coaches with protected time to support clinical teams in their improvement work. This would equate to around 750 Quality Improvement Coaches over the next 10 years within the Health Board.

We aim to *unleash* **a million minutes of quality improvement coaching** to enable our people to improve their services over the next 4 years. To do this we are running a Q Community Quality Improvement Coach programme. We aim to develop 75 Quality Improvement Coaches across 3 cohorts of Quality Improvement Coach Programme each year.

Human Factors – Human Factors is about making it easy for staff to do the right thing and is closely aligned with Quality Improvement methodology.

A system-wide adoption of Human Factors concepts offers a unique opportunity to support cultural change and empower the NHS to put patient safety and clinical excellence at its heart. The World Health Organisation (WHO) defines human factors as

'the relationship between human beings and the systems with which they interact, and focuses on improving efficiency, productivity, creativity and job satisfaction, with the goal of minimizing errors.'

A programme of Human Factors training has been initiated from within the Department of Medical Education, initially as an innovation to address concerns within Theatres in relation to never events. Developed with a multidisciplinary approach, the programme promotes a culture of patient safety, team working and staff wellbeing through Simulation & Debrief sessions in a protected and safe environment.

This approach enables staff to identify and discuss factors impacting on clinical situations and develop sustainable solutions and is being expanded across the organisation

The human factors approach at Aneurin Bevan University Health Board can be neatly summarised by the slogan **"explore, empower, evolve"**. This allows for an easier understanding of how to apply human factors principles to different contexts (see Appendices for more details)

- **Explore** - Explore allows for a deeper understanding of the current state, highlighting the critical interactions between people and systems that impact care delivery.
- **Empower** - Empowering healthcare professionals by giving them the tools and autonomy to act on this understanding, making changes that reduce errors, enhance safety, and improve efficiency.
- **Evolve** - Evolve ensures that organisations continuously grow and adapt, keeping pace with new challenges, technologies, and best practices, resulting in a resilient and proactive approach to safety and wellbeing.

Conditions – Enabling Factors

Psychological Safety *is the belief that people will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes'.* Psychological Safety has been identified as the most powerful predictor of team performance.

Psychological Safety has been shown to be the leading factor team effectiveness

Building psychological safety within our local teams and embedding Human Factors into continuous improvement will bring the 'Human' element to continuous improvement.

Systems to share learning – Systems are being developed within the Health Board to share learning such as the Patient Safety Learning and Improvement Forum and other professional fora. To optimise learning, discussions around quality improvement should be incorporated into the wider quality management systems and management structures.

Protected Time for Quality Improvement – Sponsors for Quality Improvement Coaches completing training allow coaches half a day per month for QI coaching activity. The new Procedure for Consultant Job Planning includes core SPA time for consultant staff to carry out QI work or an extra SPA session for consultant staff to act as QI Leads. Further discussion with professional groups such as Nursing, Therapies and Health Sciences and Divisional teams will take place in order to explore options to allow protected time for quality improvement activity.

Patient Involvement in Quality Improvement – The Aneurin Bevan University Health Board Patient Experience and Involvement Strategy 2023 outlines a key principle *to use people's feedback proactively to identify quality improvement opportunities*. Involving service users in quality improvement is key to achieving meaningful change that takes account of their perspectives and improves experience. We also know that involving patients increases the likelihood of quality improvement work achieving its aims. There are great examples where patients are involved in quality improvement activities. We need to learn from these and areas of good practice so that we can build co-productive reciprocal relationships as part of continuous improvement work. This strategy outlines an aim to better understand how to work with patients in a meaningful way to involve them in improving services.

Access to data systems – Links are being forged with the Digital, Data and Technology team around systems such as Qlik and Google Cloud to visualise data in time series in support of quality improvement activity. PocEd Measurement training is in place to help staff understand how to interpret their data in real-time. Tools such as ABCi Charts and FreeSPC are being developed to help staff plot their own data as part of local QI work.

Aligning Quality Improvement to Health Board priorities – The aim is for the QI Faculty to support the prioritisation of QI work across the Health Board as part of the Quality Planning QMS structure. At a local level QI Leads will support directorates to align QI work to priorities.

Connections – Sharing, Learning and Support

Connections
Teams and partnerships sharing learning and good practice

Aneurin Bevan University Health Board Networks

The Health Board will develop a network of QI training alumni and those interested in quality improvement which will include a QI Coaching network. This network will act as a place where Health Board staff can connect and gain support from colleagues. Quality Improvement Programmes or Collaboratives at a local or national level also act as networks to enable staff to share learning.

External QI Networks and Strategic Partnerships

The Q Community is a community of around 6000 people across the UK and Ireland, collaborating to improve the safety and quality of health and care. Q offers connection, resources and funding for members who are working to improve services. We will work to increase Health Board membership of Q to enable staff to learn, share and collaborate with others. Aneurin Bevan University Health Board will continue to work in partnership with external bodies such as Improvement Cymru within the Quality Safety and Improvement arm of the NHS Executive, other healthcare organisations and external expertise.

Embedding the Strategy – Delivery Plan

Improvement is 80% human and 20% technical. This strategy is fundamentally about people. It is about building a partnership between our staff and patients, listening to and trusting our staff and co-production with service users. It outlines an approach for the first three years to embed continuous Quality Improvement into everything we do. The strategy is based on evidence, expertise and experience and builds on where we are now as a Health Board. The strategy will evolve over time as the Health Board engages with this new approach. To truly embed QI will take a constancy of purpose and strong leadership support. The driver diagram outlines our theory to build organisational capability for QI and specific objectives for the next three years are both outlined in the Appendices. The QI Capability Strategy will be put into practice via the following delivery mechanisms:

- Quality Improvement Programmes, Collaboratives and Projects
- Ward Accreditation – integrating quality improvement
- Aneurin Bevan University Health Board Quality Management System

Quality Improvement Programmes, Collaboratives & Projects

Alignment of QI activities to organisational priorities is key to delivery of the QI Capability Strategy and may be achieved through development and delivery of Quality Improvement programmes, collaboratives or projects. Such work serves two purposes and whilst the main goal is to deliver improvements in quality, a secondary, but equally important, purpose is to build residual QI knowledge, skills and experience for those staff taking part. QI Programmes will be informed by a Quality Planning process which highlights the key organisational quality improvement priorities. This enables staff to continue to maintain improvements once the programme, collaborative of project has ended. Organisational QI Programmes/Collaboratives that will be initiated or carried forward into 2025 include involvement in national and health board priorities such as:

Safe Care Partnership - with the NHS Executive and Health Boards across Wales

- Acute Deterioration including Call 4 Concern
- Deconditioning linked with the Six Goals
- Leadership – Developing Quality Management System

Aneurin Bevan University Health Board priorities:

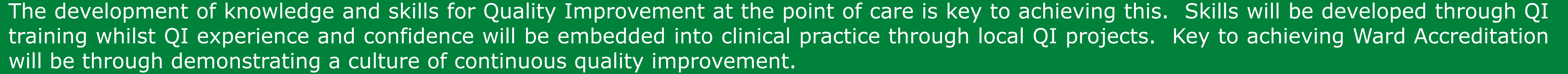
- Infection Prevention & Control
- Sepsis
- Pressure Ulcers
- Falls

Quality Improvement Coaches will focus their support for both divisional and organisational priority programmes, collaboratives or projects where appropriate.

Embedding the Strategy – Delivery Plan

Ward Accreditation – Integrating QI

The Health Board has launched an accreditation pathway for all wards and teams. Accreditation creates a platform for continuous improvement in patient care and safety. It can be used as a tool to encourage ownership of continuous quality improvement locally, reducing variation and increasing staff pride and team working within clinical areas. Ward Accreditation enables teams to work over a two year period to gain Bronze, Silver, Gold and ultimately Platinum Accreditation where teams have been able to achieve 85% compliance with standards for a year.



The development of knowledge and skills for Quality Improvement at the point of care is key to achieving this. Skills will be developed through QI training whilst QI experience and confidence will be embedded into clinical practice through local QI projects. Key to achieving Ward Accreditation will be through demonstrating a culture of continuous quality improvement.

Quality Management System

Both QI programmes, collaboratives and projects plus links with Ward Accreditation will support the development of a Health Board Quality Management System as each will need to employ Quality Planning, Quality Control and Quality Improvement activities which will ultimately provide Quality Assurance for clinicians and health board leaders.

Conclusion

The Aneurin Bevan University Health Board Quality Improvement Strategy is about putting quality and safety at the core of the services we provide. It is about building capability into the system that enables our staff to improve what matters to them and their patients. It is about giving our workforce the skills, resources, time and conditions to improve services where they need to, whilst developing connections with others to enable learning to be shared.

APPENDICES

QI is the AB way: Embedding QI into everything we do – Driver Diagram

Outcome

QI is the AB way: Embedding Quality Improvement Culture into Everything we do

Primary Drivers

QI Capability

- **Capacity** building knowledge and skills
- **Conditions** Enabling factors
- **Connections** Sharing learning and Support

Capability for QI

Secondary Drivers

- **QI Skills Development Framework** – Workforce development QI skills
- **QI Tools and Resources** to support QI
- **Quality Management System** – QI as part of wider QMS linked to Quality Planning and Quality Control
- **Leadership for QI Capability**
- **Quality Improvement Coaches** embedded into service to enable QI
- **Human Factors & Psychological Safety embedded into QI**
- **Systems to share learning**
- **Protected Time for Quality Improvement**
- **Patient involvement in quality improvement**
- **Access to data systems** to support quality improvement
- **Aligning Quality Improvement to ABUHB priorities**
- **ABUHB QI Networks**
- **External QI Networks & Strategic Partners**

Changes

- **QI Skills Development Programme**
  QI Leaders programme | QI Coach Programme | QI Advisor Cymru Prog. | PocEd QI | PocEd Measurement | Human Factors
- **Spread and Scale** – 1 million minutes of QI Coaching over next 4 years
- **Online platform to log QI Projects/Programmes** e.g. Life QI / HIVE
  ABCi/FreeSPC charts | Padlet noticeboards
- **Human Factors Simulation and debriefing sessions**
- **Developing Quality Improvement, the ABUHB way**
- **Quality Improvement as part of management structure/meetings**
- **ABUHB QI Faculty –** building organisational conditions for QI
- **ABCi - Internal Quality Improvement Experts -** developing team structure
- **QI Leads** embedded within directorates building local conditions for QI
- **Patient Quality & Safety Learning & Improvement Forums** sharing learning
- **Quality Improvement as part of consultant job planning** SPA sessions
- **Explore how to build protected time for QI for professional groups**
- **ABUHB data systems for QI** such as Qlik, Civica, PROMS.PREMS, Survey tools
- **Data visualised in Time Series** to monitor quality improvement work
- **Data Literacy -** building understanding/interpretation of time series data
- **ABUHB QI Networks:**
  QI Trained staff | QI Coaches/Leads | Junior Doctor QI Forum
- **Improvement Collaboratives/Programmes –**
  ABUHB Programmes/Collaboratives | National Collaboratives
- **ABUHB Quality Improvement Awards –** celebrating and sharing learning
- **Q Community – increase membership** access to funding, resources, network
- **Collaboration with Strategic QI partners:**
  Improvement Cymru | Q Community | IHI | National/International Expertise | Other UK healthcare orgs.

Aneurin Bevan University Health Board
QI Skills Development Framework 2024-2025

Foundations in Improvement (ESR – NHS Wales) - Brief introduction to Quality Improvement principles and how to get involved (1 hour)

PocEd QI (ABCi) - Overview of QI principles & useful tools (2 half days - virtual)

PocEd Measurement (ABCi) – Overview utilising & interpreting time series data (half day - virtual)

***As capacity for Quality Improvement Coaches increases – aim to provide QI coaching support for project leads**

Quality Improvement Coach Development Programme* – **(ABCi)** Develop coaching skills to support others in their improvement work. Aim to develop QI Coaches embedded within directorates (4 Days – face to face with time to coach)

Leading QI (ABCi) – Develop medical, nursing, therapy & health science QI Leads embedded within directorates/divisions who evolve local conditions for QI, in addition to acting as coach/mentor for clinical colleagues

Quality Improvement Advisor Programme (Improvement Cymru) – Develop expert skills within central QI Unit and QI experts within each division (10 months)

Leadership for Quality – Series of board development sessions for ABUHB board and senior leadership within ABUHB

Human Factors - Model

The Human Factors approach can be neatly summarised by the slogan **"explore, empower, evolve"**. This allows for an easier understanding of how to apply human factors principles to different contexts.

EXPLORE - allows for a deeper understanding of the current state, highlighting the critical interactions between people and systems that impact care delivery.

Encouraging healthcare staff to explore using a human factors approach involves creating an environment that 'listens to learn' - fostering curiosity, collaboration, and continuous learning, while highlighting the direct benefits for patient safety, job satisfaction, and efficiency.

Creating a culture of safety and openness within teams using mechanisms such as debriefs, huddles or team meetings as protected listening spaces with a continuous feedback loop.

Incorporate regular human factors workshops or simulation sessions where staff can explore new workflows, test new tools, and learn about the impact of human factors in a risk-free environment.

EMPOWER - Empowering healthcare professionals by giving them the tools and autonomy to act on this understanding, making changes that reduce errors, enhance safety, and improve efficiency.

Human Factors Training - Introduction & Advanced levels available. The training is inclusive – all grades / roles welcome.
Local leadership - Assigning local leaders at all grades/roles to set the example and embed human factors principles within their areas of work. Encourage using existing spaces or structures.
Tools for Change – Accessible tools to support improvement. Psychological Safety and Safety Culture surveys. QI Coaches.

EVOLVE - ensures that organisations continuously grow and adapt, keeping pace with new challenges, technologies, and best practices, resulting in a resilient and proactive approach to safety and wellbeing.

This is on the understanding that culture constantly evolves, and that teams and organisations should have systems for regular measurement of culture. This would enable teams and organisations to reassure that their decisions, actions and behaviours are always aligned with the values and beliefs. This would also indicate the organisation's ability and capacity to deal with external pressures and adapt accordingly.

QI Capability Delivery Objectives

CAPACITY

Objective	Action	Year 1	Year 2	Year 3
QI Skills Development Framework	Ongoing programme of PocEd QI, PocEd Measurement training			
	3 cohorts of Quality Improvement Coach Training			
	3 Health Board staff to attend the National Quality Improvement Advisor Cymru Programme every year			
	Initial scoping of Quality Improvement Leaders Programme			
	QI data included in Quality Outcomes Framework			
	Link QI training to other Health Board development programmes eg. Primary Care Academy, Nursing Academy, OD prospectus, Ward Accreditation			
	Review dosing strategy around targeting QI training each year			
	Central ABCi team trained in further continuous methodology, eg Lean			
	Where needed, provide specialist QI sessions around specific topic eg. measurement for improvement			
	Work with Divisions to identify QI Leaders within each directorate/division			
	Test initial cohort of QI Leads Programme – 5-10 QI leaders trained			
	Spread the QI Leads Programme – 20 QI leaders trained			
	Review and update the QI Knowledge and Skills Framework			
	10 QI Advisor/experts trained as either IHI Improvement Advisors (IA), Scottish Improvement Leaders (ScIL) or Quality Improvement Advisor Cymru (QIAC)			
Quality Improvement Coaches	Develop 75 Quality Improvement Coaches each year			
	Support the national Safe Care Partnership work			
	150 Coaches completed Quality Improvement Coach Programme			
	Incorporate Human Factors into QI Coach Programme			
	1,000,000 minutes of Quality Coaching achieved by the end of 2028			
	225 Coaches completed Quality Improvement Coach Programme			
QI Tools and resources	Develop online QI platform for teams to record their QI work – aim to have 5 QI projects on platform. Eg HIVE or Life QI			
	Develop further tools and resources eg. Padlet, FreeSPC tool			
	Develop resource to support teams running Quality Improvement Programmes within the Health Board			
	15 QI projects on online QI platform			
	Online QI platform available to all – desktop app			

QI Capability Delivery Objectives

CONDITIONS

Objective	Action	Year 1	Year 2	Year 3
Quality Management System	Establishing links between Quality Planning, Quality Control, Quality Improvement and Quality Assurance			
	Test how a Quality Management System might be developed within one directorate			
Leadership for QI Capability	QI Faculty to support the development of organisational conditions for QI			
	QI Leads within each division			
	Assistant Medical Director for Quality Improvement in post			
	ABCi Central expertise for Quality Improvement in place			
Human Factors & Psychological Safety	Institute introductory Human Factors sessions for all Health Board Staff			
	Develop programme of advanced Human Factors sessions for the full year, including following up with teams around how they are progressing			
	Evaluation of the impact of the Human Factors programme including impact on Safety Culture – use to improve programme and report to divisional team			
	Embed Human Factors into QI Coaching Programme			
	Human Factors embedded into Leading People Programme			
	Building Human Factors into QI the AB way			
Systems to share learning	Incorporate QI stories into Patient Quality & Safety Learning and Improvement Forum and other meetings			
	Develop template and support staff to write up and share their improvement work			
Protected time for quality improvement	Include QI in job planning for consultants			
	Exploring how to build protected time with divisions and professional groups eg. Nursing , Therapies and Health Sciences			
	Engaging sponsorship for QI coaches protected time (half a day per month)			
	Engage with Medical Education to support Junior Doctor Quality Improvement			
	Explore QI portfolio roles – protected time for QI as part of clinical roles			
Patient involvement in quality improvement	Engagement with Patient Engagement team			
	Further use of Civica in QI work			
	Further use of PROMS/PREMS in QI work			
	Exploring best practice to actively involve patients in QI work			
	Engagement with third sector			
Access to data systems	Qlik data visualisation automatically phasing time series charts to make charts easier to interpret for staff			
	Qlik data dashboards developed along pathways			
	Qlik data dashboards at ward/department level			
	Google cloud displaying phased time series charts to make charts easier to interpret			
	Staff have easy access to use Qlik and other data systems			
Aligning Quality Improvement to priorities	Governance and Permission structure around Quality Planning for QI work at directorate, divisional and organisational level			
	QI Faculty aligning organisational level QI work			
	QI leads within directorates and divisions aligning QI work			

QI Capability Delivery Objectives

CONNECTIONS

Objective	Action	Year 1	Year 2	Year 3
QI Networks	Develop QI Alumni and QI Coach network within the Health Board			
	Connect with professional and other forums to discuss how to embed Quality Improvement			
	Set up Annual Quality Improvement Award: project to feed into NHS Wales Awards			
	Align Quality Improvement priorities to health board programmes/collaboratives			
External QI Networks & Strategic Partners	Ongoing collaboration with national QI body, Improvement Cymru NHS Executive – QI Programmes Collaboratives			
	Connect with Annual Quality Improvement Week			
	Work to increase Health Board membership of the UK Q Community			

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- Human Factors in Healthcare: A Concordat from the National Quality Board
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	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Compassionate Leadership Pledge**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Simmonds, Executive Director of Workforce and Organisational Development
SWYDDOG ADRODD: **REPORTING OFFICER:**	Dr Peter Brown: Assistant Director of Workforce and Organisational Development; Dr Adrian Neal: Head of Employee Wellbeing

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

NHS Wales has committed to the Compassionate Leadership Framework which aims to promote a positive working environment for all staff.

In July 2024 Judith Paget wrote to all NHS Wales Health Board and Trust CEOs acknowledging the continuous pressures and challenges faced by our staff and reinforced the need to provide a caring environment where psychological and physical wellbeing is positively maintained. In addition, the letter **Appendix A**, reaffirmed the all-Wales commitment to develop and maintain compassionate working cultures underpinned by a desire for prosocial (i.e., positive, constructive, considered and supportive or as commonly known in NHS Wales: compassionate) beliefs and behaviours.

The HEIW Compassionate Leadership Pledge (see Figure 3) sets out an example of the principles of how organisations, teams and individuals may work towards creating an NHS Wales workplace that optimises the chance of a positive experience of work and greater opportunities for staff to thrive.

All Chief Executives and Chairs agreed that organisations would create local versions of the compassionate leadership pledge and by doing so commit to the pledge's core principles.

By tailoring the HEIW pledge to better fit local contexts, Health Boards are being asked to commit to develop, model and maintain compassionate leadership type behaviours at all levels so that we work towards compassionate and inclusive cultures within the organisation.

The Board is asked to discuss the pledge and provide a decision to use the modified pledge created for the Health Board.

Cefndir / Background

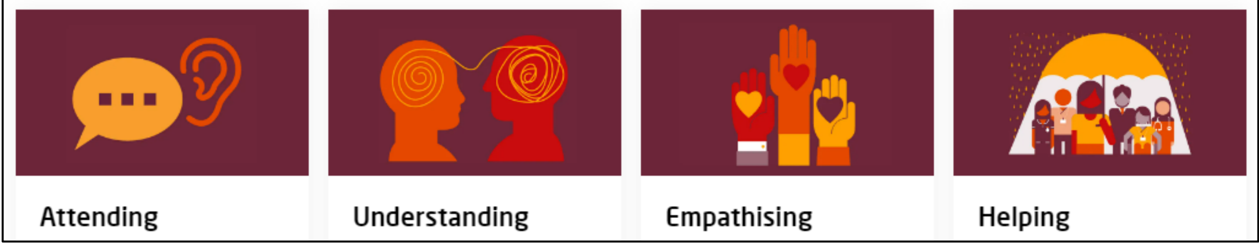
Compassion can be defined as 'a sensitivity to suffering within self and others with a commitment to (intentionally) alleviate and or prevent it' (Gilbert 2013, *The Compassionate Mind*). Compassion is fundamental to effective relationships, across all societies and cultures. Compassion takes several forms: compassion for others, compassion from others and compassion to self. Compassion, therefore, is an essential ingredient in establishing and building belonging, trust, understanding, social support and, by definition, inclusion (West 2021, *Compassionate Leadership*).

Compassionate leadership focuses on two domains: *domain 1*, how leaders behave (and how others experience their behaviour) which is described by 4 behaviours (see Figure 1) and *domain 2,* how leaders understand, shape and respond to the core (psychosocial) needs of staff (Figure 2). Both of these domains are described below.

Domain one: leadership behaviours:
Compassionate leadership involves a focus on relationships through 4 behaviours (see Figure 1). In essence a conversational and coaching model adapted for health and social care, this approach ultimately aims to foster a supportive work environment where staff feel valued, respected, and listened to. The 4 behaviours which can be observed in one to one or team interactions include:

- *Attending*: active listening with curiosity, without judgement and bias
- *Understanding*: exploring the individual's context and situation to create a shared understanding
- *Empathising*: mirroring and acknowledging the feelings of colleagues
- *Helping*: supporting and enabling the individual to move to action so that they feel respected and cared for, do their best work and reach their potential

Figure 1. Four behaviours of compassionate leadership



There is evidence that these (and other) compassionate behaviours result in more engaged and motivated staff. Other recorded benefits of behaviours which are described as compassionate include lower levels of stress and greater job satisfaction which can also improve performance. Patients who experience greater

levels of compassion from staff describe higher levels of care and greater satisfaction. In comparison, the absence of compassionate-like behaviours has the opposite effect, and can harm individuals, the systems we operate within and over time the organisation itself.

Domain two: core needs of staff:
Meeting peoples core needs at work is important in supporting their wellbeing and motivation and leaders strive to understand and meet the core needs of the people they work with. Recent work with doctors, nurses, midwives and trainees have shown that the wellbeing and engagement of health and care staff is affected by eight key factors that can be organised into three core needs: autonomy, belonging and contribution (the ABC of compassionate leadership).

These core needs are not new or exclusive to compassionate leadership. They are based upon research into human motivation known as self-determination theory (Deci and Ryan, 1985, *Intrinsic motivation and self-determination in human behaviour*). Self-determination theory demonstrates that humans require the fulfilment of three basic innate, human psychosocial needs (autonomy, competence, and relatedness) for optimal human functioning. The core needs of health and social care staff using the model of compassionate leadership are shown below in Figure 2. Importantly, the Health Board's Employee Experience Framework (The 6 pillars) developed in 2020 is based in part on self-determination theory, and as such is congruent with many of the pledge's compassionate principles.

Figure 2. The core needs of health and social care staff adapted from the original research of Deci and Ryan (1981).

Compassionate leadership pledge:
The compassionate leadership pledge provides a series of principles which individuals, teams and the Health Board can work towards, creating an NHS Wales workplace that optimises a positive experience of work and greater opportunities for staff to thrive. The 'pledge' stage of the commitment is important, but there are a range of additional stages to the successful embedding of the required culture as described above.

HEIW suggest that the pledge will help organisations to embed compassionate leadership. The pledge more accurately reflects an opportunity to promote a compassionate, inclusive and high functioning organisation by aspiring to work

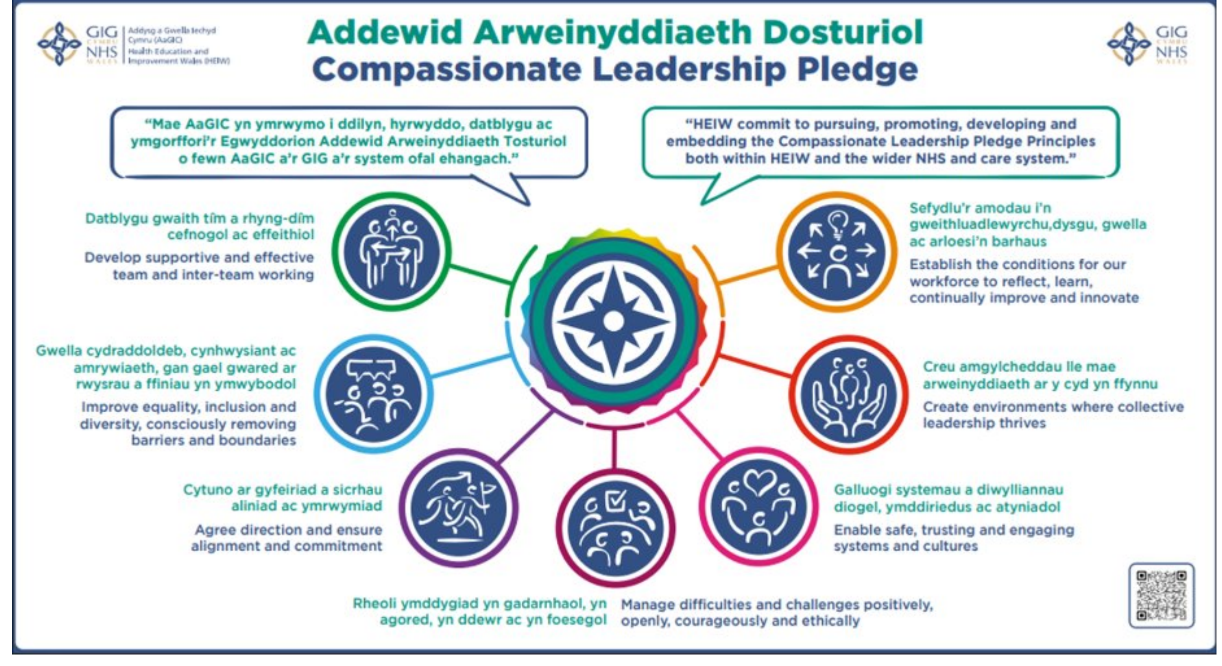
towards each of the principles described. For the Health Board context, the modified compassionate leadership pledge (see Figure 4) represents the culmination work undertaken across the organisation to promote compassionate, inclusive and high performing individuals, teams and organisations.

The template for the compassionate leadership pledge provided by HEIW is shown below in Figure 3 and includes 7 focus areas. These principles broadly describe sensible ambitions for any organisation to consider in order to have a working environment which promotes engaged, motivated and supported staff. Notwithstanding this, compassionate leadership is not the only factor which will affect the employee experience of work and the workplace; many other factors are also incredibly important such as workload, pay, the physical environment, employment terms and conditions etc which are not represented in this pledge. Therefore the ambition should not be considered in isolation as the solution to workplace staff challenges.

The 7 areas of focus from the HEIW pledge include:

- Develop supportive and effective team and inter-team working.
- Improve equality and diversity by consciously removing barriers and boundaries.
- Agree on direction and ensure alignment and commitment.
- Manage difficulties and challenges positively, openly, courageously, and ethically.
- Enable safe, trusting, and engaging systems and cultures.
- Establish the conditions for our workforce to reflect, learn, continually improve, and innovate.
- Create environments where collective leadership thrives.

Figure 3. HEIW template for the compassionate leadership pledge.

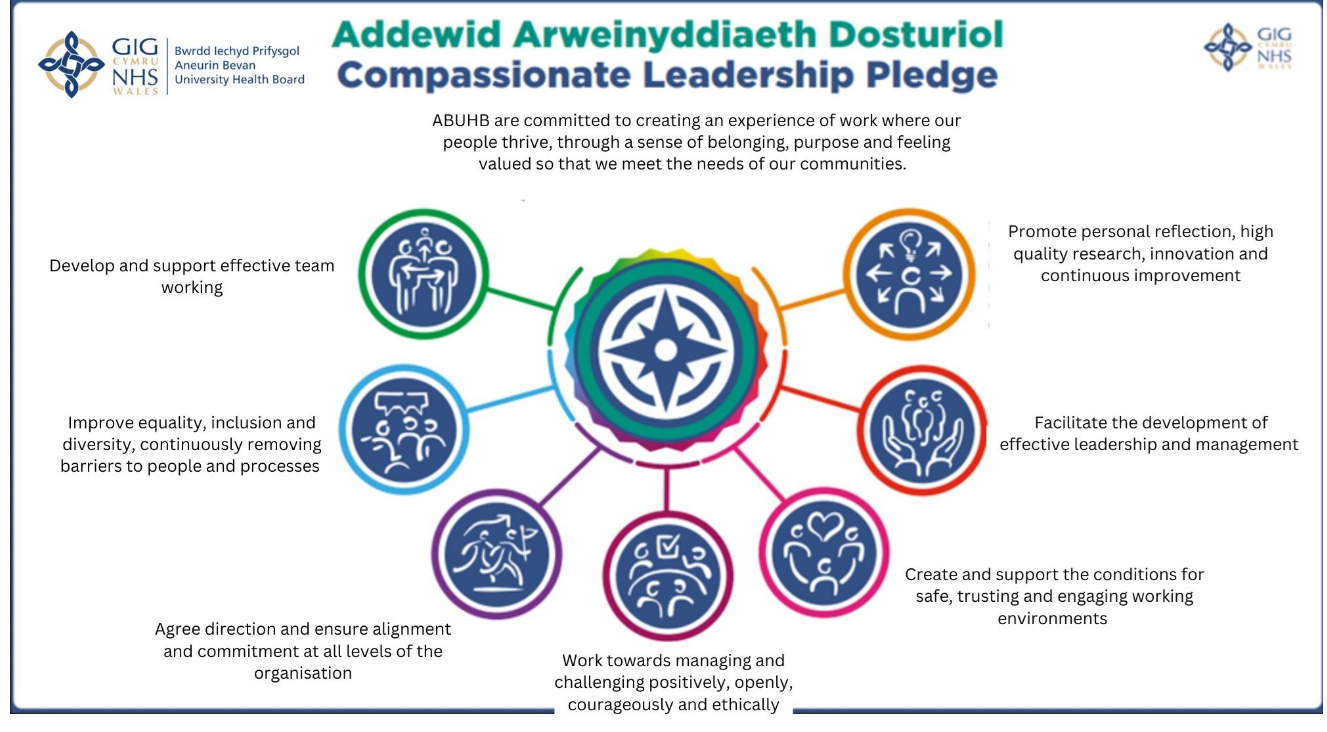


The Health Board's modified compassionate leadership pledge:
Upon review of the HEIW compassionate leadership pledge template, a modified version has been created which is more appropriate for the context of this Health Board and aligns to our ambitions to focus upon the long-term experience of work for our staff (see Figure 4). The modified pledge also aligns more closely to both domains of compassionate leadership described above (see Figures 1 and 2).

These include:

- Promote personal reflection, high quality research, innovation and continuous improvement.
- Facilitate the development of effective leadership and management.
- Create and support the conditions for safe, trusting and engaging working environments.
- Work towards managing and challenging positively, openly, courageously and ethically.
- Agree and ensure alignment and commitment at all levels of the organisation to the long-term ambitions of the Health Board.
- Improve equality, inclusion and diversity, continuously removing barriers to people and processes.
- Develop and support effective team working.

Figure 4. The Health Board's modified compassionate leadership pledge. The final version will be bi-lingual.



Asesiad / Assessment

The Health Board is committed to fostering a culture of compassion and inclusivity and this modified pledge is one mechanism by which this can be visually demonstrated to our staff, patients, service users and stakeholders. Largely

symbolic in nature and with low financial, reputational and organisational risk, it continues the internal and public focus upon and the culmination of our commitment and moral imperative to our organisational values and valuing our people. The pledge also aligns more broadly with our Organisational focus upon optimising the long-term experience of work for staff.

Bringing the pledge to life:
The Health Board has a wealth of compassion focused stories, a great collection of these were demonstrated at the recent staff recognition awards. Below is a selection of narratives within each of the Health Board's Compassionate Leadership Pledge principles which bring it to life. The pledge presents the intent of compassionate leadership, the narrative below provides an indication of the how; the practical actions to enable compassionate leadership. Observing the opposite of these will not enable people to have a positive experience of work and will impair psychological safety and collaboration.

1. **Promote personal reflection, high quality research, innovation and continuous improvement**

    - The streamlined PADR process enables leaders to focus on the experience of work for the employee and their career progression.
    - Leaders enable staff to engage in research projects big or small which will enhance their experience or the experience and outcomes of patients.
    - Putting staff at the heart of our processes such as the avoidable employee harm within employee investigations.
    - Leaders enable staff to reflect, decompress and learn such as team away days, Swartz rounds and compassion practices.

2. **Facilitate the development of effective leadership and management**

    - The Health Board support leadership and management development across a variety of levels. This includes entry level leaders (Leadership Development Programme), Clinical Directors (CDx), Directorate Managers (DMx), Senior Nursing and Midwifery Academy, Multi-disciplinary clinical teams (Leading People).
    - This also includes Health Board-wide masterclass programmes on key management themes and core management training.
    - The Health Board has launched its talent management and succession planning tools enabling staff to describe their career aspirations and the critical roles which need to be managed.

3. **Create and support the conditions for safe, trusting and engaging working environments**

    - Leaders enable the conditions for staff to thrive by acknowledging their core needs of autonomy, belonging and contribution.
    - Leaders providing the space and time for staff to raise concerns and where this isn't possible the organisation support staff to anonymously raise concerns using the Health Board's Speaking up Safely service.

- Enable staff to raise their thoughts without the fear of being reprimanded.
- The Health Board's Employee Experience survey (formally Wellbeing survey) provides granular data describing the staff experience of work with rapid tangible actions for divisional teams to action.

4. Work towards managing and challenging positively, openly, courageously and ethically

- An essential skill for effective teamwork is the ability to have difficult conversations, hold contrarian points of view and hear the voices of those who challenge our assumptions.
- Leaders will enable their teams to make decisions closest to the problems avoiding unnecessary escalation and delay.
- Support is provided for staff who wish to have difficult conversations.

5. Agree and ensure alignment and commitment at all levels of the organisation to the long-term ambitions of the Health Board

- Visibility of senior staff is critical. This is shown through Executive drop-in sessions, all-staff Chief Executive calls and leaders engaging with their teams to help understand experiences of staff at all levels.

6. Improve equality, inclusion and diversity, continuously removing barriers to people and processes

- Diversity of thought, perspectives and lived experiences are critical to the Health Board.
- We support and encourage our staff networks from a variety of protected characteristics to connect, build relationships and provide a strategic advantage.
- The Health Board support staff networks, visual impairment training, reverse mentorship.

7. Develop and support effective team working

- Collectively workforce, organisational development and Employee Wellbeing services support effective team working across a vast array of teams using many best in class methods and approaches. In the past 12 months Workforce & Organisational Development have assisted 45 directorate and divisional senior leadership teams.

- Leaders will take time to listen and address the needs of staff, understand the constraints, empathise and help using a coaching and conversational approach.

Signing the pledge:
Once agreed, HEIW will print a large and robust version of the pledge, deliver and mount for display at a suitable location for the Health Board to sign. There are 3 ways in which the pledge can be signed:

1. Organisational: Board members within organisations can physically sign the pledge on behalf of their organisation, committing to creating compassionate

workplaces and modelling compassionate leadership behaviours in all interactions, promoting and addressing the core needs of staff. This will also represent a useful publicity opportunity.

2. As a Team/Department: Teams or departments can agree in collaboration how they may model and experience each principle within their respective areas.
3. As an individual: Staff members can reflect on how they embed each of the principles within their work.

Using the pledge:
There are several ways in which the pledge can be used:

- Embedding the pledge into leadership development/team development programmes.
- Use within development reviews and appraisals.
- The pledge logo can be added to recruitment materials, marketing etc.
- Departments can sign and use the pledge demonstrating the Health Board is a compassionate employer and these are the behaviours and culture towards which we are working.

Argymhelliad / Recommendation

The Health Board is committed to creating and maintaining a compassionate and inclusive environment for staff, patients and service users and demonstrate to all that we are committed to living the values of the Health Board and regarded as an employer of choice.

The Board is asked to approve the compassionate leadership pledge, commit to sign the pledge and its use across the Health Board as appropriate.

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 Board's assurance framework.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 7. Staff and Resources Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Information provided by HEIW https://nhswalesleadershipportal.heiw.wales/pledge
Rhestr Termau: Glossary of Terms:	CEMT – Chief Executive Management Team CEO – Chief Executive Officer HEIW – Health Education and Improvement Wales
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

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**	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/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

To: NHS Wales Chief Executives
Managing Director, NWSSP
Interim Chief Commissioner, JCC

Our Ref: JP/LR/SB

26 July 2024

Dear Colleagues

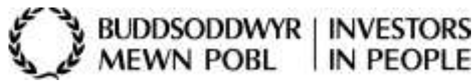
NHS Leadership Behaviours

Our roles within public service come with high expectations of how we behave and support our colleagues and their wellbeing. How we create safe workplaces demonstrate empathy and work with others across the NHS system and beyond needs to be at the centre of our thinking.

Recognising that the pressure on our colleagues is not reducing and the challenges for all our people, it is essential that we provide a caring environment where mental and physical wellbeing is positively maintained and colleagues are confident and able to speak up. As leaders, we need to understand the underlying emotions impacting on our teams and how we react to and support is critical to the team success.

Over recent years we have focused on, and continue to work within, the framework of compassionate leadership and the four key behaviours of attending, understanding, empathising and helping. We should not lose sight of this.

There have been a range of very recent reports which individually give clear messages but collectively have an even more powerful voice. The recent WRES reporting, shared with colleagues by Anton Emmanuel and team alongside the work across your organisations on speaking up safety, the research and work on avoidable employee harm, the outcomes of the GMC 2024 national training survey and the recent upsetting NMC report demonstrates the need to listen with understanding and empathy, be inclusive recognising individual needs and lived experience, engage with colleagues and recognise personal and work related challenges.



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As senior leaders, we must understand the impact of our own behaviours on others and take positive action in this space, setting an example to all colleagues, modelling the behaviours we expect others to demonstrate.

HEIW have recently written to Chief Executives to share the NHS Wales Success Profile for current and aspiring CEOs. There is also a self-assessment tool which can be used for self-reflection and to identify areas of development. I particularly note the behaviours focused on nurturing kindness and inclusion, modelling self-leadership and building trust and collaboration which all reflect the way in which we should present ourselves in work settings.

A link to the framework can be found through Gwella Welcome! - Gwella HEIW Leadership Portal for Wales or by directly accessing the link below.

CEO - Full Success Profile.pdf (heiw.wales)

We are approaching another opportunity via the 2024 staff survey to hear about how our colleagues are feeling and what employee experience looks like across Health. Therefore, we should take time to reflect on what has changed and what we as organisation leaders can and need to do to set the example to others to fundamentally improve our colleagues' working lives.

Yours Sincerely

Judith Paget

Judith Paget CBE

cc: Senior Leadership Team NHS Wales Executive

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Establishment of a Mental Health & Learning Disabilities Committee**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As previously reported to the Board, concerns were raised in July 2023 about the assurance of safety and quality of services within the Mental Health and Learning Disability Division. As a result, the Executive Team, supported by the Chief Executive and Chair, implemented additional governance and oversight.

The additional scrutiny led to the identification of several improvement actions which were organised into a structured 30, 60 and 90 day improvement plan.

The Mental Health and Learning Disability Division has been reporting on the progress of quality, safety and governance to the fortnightly Divisional Assurance meetings and various committees to include the Executive Committee, Patient Safety and Outcomes Committee, the Board and Integrated Quality, Performance and Delivery meetings.

In line with the new governance and escalation procedures, the Executive Committee supported reducing the Division's escalation level within the internal governance and performance framework to enhanced monitoring due to improved assurance around quality, safety and governance.

In order to support better oversight across the Division, it is proposed that the Terms of Reference for the Mental Health Act Monitoring Committee be reviewed to incorporate a broader Mental Health and Learning Disability Committee.

Asesiad / Assessment

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board has established a Mental Health Act Monitoring Committee. The purpose of this Committee is to advise and assure the Board and the Accountable Officer by critically monitoring and reviewing the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983.

The Terms of Reference for this Committee have been reviewed and revised (Attachment One) to enable a broader focus on all aspects of the Health Board's activities in relation to mental health, learning disabilities and child and adolescent mental health services.

These Terms of Reference are largely based on the Terms of Reference for a previous Mental Health and Learning Disabilities Committee which was in place until 2019. Following consideration and review, the Mental Capacity Act and National Dementia Standards have also been included in the revised Terms of Reference.

The revised purpose of the Committee is to:

Advise *the Board to assist it in discharging its functions and meeting its responsibilities with regard to mental health and learning disabilities issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 and associated legislative and statutory frameworks.*

Hold to account and provide assurance *to the Board that in relation to the LHB's arrangements for responding to the above legislation that this is being undertaken appropriately in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales. In undertaking this work the Committee will have close liaison with other committees of the Board, especially the Quality and Patient Safety Committee.*

Hold to account and provide assurance *to the Board that the National Dementia Standards are being implemented, with oversight being delegated to the Regional Dementia Board.*

Argymhelliad / Recommendation

The Board is asked to **APPROVE** the revised Terms of Reference for the Mental Health and Learning Disabilities Committee.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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. Enabler
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. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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. Not applicable to this report

Mental Health and Learning Disabilities Committee Terms of Reference

Version: Draft

Date: October 2024

Document Title:	Mental Health and Learning Disabilities Committee Terms of Reference
Date of Document:	October 2024
Current version:	Draft
Previous version:	N/A
Approved by:	Board
Review date:	March 2025

1. Introduction

1.1 The Health Board's Standing Orders provide that:-

"The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with Standing Orders (and the Board's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health and Learning Disabilities Committee**. This Committee will focus on all aspects of the Health Board's activities to contribute to the agreement of a strategic direction for mental health, learning disabilities and child and adolescent mental health services (CAMHS) in the areas of Gwent.

1.3 It will monitor the effectiveness and efficiency of service delivery for mental health, learning disabilities and CAMHS services and identify areas for improvement; and will also monitor the appropriate delivery of the functions of Hospital Managers in response to Chapter 11 of the Mental Health Act 1983 (co-ordinated on behalf of the Committee by the Mental Health Act Managers Group).

The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are provdied below.

2. Purpose of the Committee

The purpose of the Mental Health and Learning Disabilities Committee, "the Committee" is to:

- **Advise** the Board to assist it in discharging its functions and meeting its responsibilities with regard to mental health, learning disabilities and CAMHS issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks.

- **Hold to account and provide assurance** to the Board that in relation to the health board's arrangements for responding to the above legislation that this is being undertaken appropriately in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales. In undertaking this work the Committee will have close liaison with other committees of the Board, especially the Patient Quality, Safety and Outcomes Committee.

- **Hold to account and provide assurance** to the Board that the National Dementia Standards are being implemented within the health board.

3. Delegated Powers and Authority

3.1 Committee will, in respect of its provision of advice and assurance to the Board:

(a) Advise on the development and delivery of high quality and safe mental health and learning disabilities services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

(b) consider the implications for mental health and learning disabilities care, this will include the implications for the Mental Capacity Act and Dementia Standards, arising from the development of the Board's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board and statutory partnerships;

3.2 The Committee will, in respect of its assurance role, seek assurances that governance arrangements (including risk management and integration of the Equality Act and Accessibility Standards) are appropriately designed and operating effectively to ensure the provision of high quality, safe and accessible mental and learning disabilities health care and services across the whole of the Board's activities including those services provided for the Board by third sector providers and service provision made by the independent sector.

3.3 To achieve this, the Committee will continually monitor, and seek assurance that the Health Board is complying with legislation to ensure that in relation to all aspects of mental health and learning disabilities provision:

(a) there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

(b) that the Health Board, at all levels (strategic, directorate/division/clinical) has a citizen centred approach, putting patients, patient safety, well-being and safeguarding above all other considerations;

(c) that the care planned or provided across the breadth of the organisation's functions (including directorate/division/ clinical and partnership steams and those provided by the independent or third sector) are consistently applied, based on sound evidence, are clinically effective and meet agreed standards and legal frameworks;

(d) that the Health Board, at all levels (directorate/division/clinical/partnership teams) has the right systems and processes in place to deliver, from a patients perspective - efficient, effective, timely and safe services;

(e) there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;

(f) there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;

(g) risks are actively identified and robustly managed at all levels of the organisation and that key risks are escalated appropriately to the Committee and included on a Committee risk register;

(h) decisions are based upon valid, accurate, complete and timely data and information;

(i) there is continuous improvement in the standard of quality and safety of mental health and learning disabilities care across the whole organisation and that these are continually monitored;

(j) all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of mental health and learning disabilities care provided;

(k) Sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver and support mental health and learning disabilities services;

(l) Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and

(m) Lessons are learned from patient safety incidents, complaints, concerns and claims and that these, together with good practice are shared across and out with the organisation; the impact of learning should be measured.

3.4 The Committee will advise the Board of key indicators of mental health and learning disabilities provision against which the Board's performance will be regularly assessed and reported on through Annual Reports.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Board and primary care practitioners relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee or Group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from external agencies with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Chair of the Mental Health and Learning Disabilities Committee shall have reasonable access to Executive Directors and all other relevant staff, any other Committees, and Groups deemed appropriate by the Committee, and to primary care practitioners.

Sub Groups

3.8 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

In this respect a ***Power of Discharge Sub-Committee*** will be created. The Health Board, as Hospital Managers, may arrange for their functions under the Mental Health Act to be performed on a day-to-day basis by an Officer or Lay Member on their behalf. These individuals appointed by the Health Board will be known as Associate Hospital Managers and will form the membership of the Power of Discharge Sub-Committee.

The Sub-Committee will report routinely to the Committee for assurance and developmental purposes.

4. Membership

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4.1. Members

The Committee shall comprise a minimum of four (4) members:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board
Members	At least 2 other independent members of the Board.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

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4.2. Attendees

In attendance

Chief Operating Officer

Executive Director of Nursing or Nominated Representative

Medical Director or Nominated Representative

Director of Public Health or Nominated Representative

Divisional Director, Mental Health and Learning Disabilities

Divisional Nurse, Mental Health and Learning Disabilities

General Manager, Mental Health and Learning Disabilities

Clinical Director, CAMHS

General Manager, Families and Therapies Division

Divisional Director, Families and Therapies Division

Head of Nursing Person Centred Care

Others by invitation

The Committee Chair may invite any other Health Board officials and / or any others from within or outside the organisation to attend all or

part of a meeting to assist it with its discussions on any particular matter.

4.3. Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair and Director of Corporate Governance (Board Secretary), taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

5. Support

5.1. Secretariat

Secretariat arrangements will be determined and arranged by the Director of Corporate Governance.

5.2. Advice and Member Support

The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for the committee itself and committee members.

6. Committee Meetings

6.1. Quorum

At least three of the selected members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

6.2. Frequency of Meetings

Meetings will be held quarterly per annum and otherwise as the Chair of the Committee deems necessary consistent with the Health Boards plan of Board business.

6.3. **In Committee and withdrawal of individuals in attendance**
The Committee Chair may ask any or all of those who normally attend but who are not members of the Committee to withdraw to receive information which may include matters of a sensitive and/or confidential nature.

6.4. **Record of the Committee Meeting**
A record of the meeting will be presented as notes and action points.

6.5. **Public Meetings**
The Committee will be open to the public.

7. Relationship and Accountabilities with the Board and its Committees

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

8. Reporting and Assurance Arrangements

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Accountability Report and the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

The Board may require the Committee Chair to report upon the Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Governance, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

9. Applicability of Standing Orders to Committee Business

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

10. Review

These terms of reference shall be reviewed annually by the Committee with reference to the Board.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Stroke Service Reconfiguration – Evaluation**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Tracy Morgan, General Manager, Medicine Kate Fitzgerald, Clinical Futures Assistant Programme Director

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

This paper outlines:

- An update on the outcome of the temporary Stroke reconfiguration and the consolidation of services across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF) in November 2023 following board approval last year.
- A request to support the extension of the current service provision for 12 months aligned to the Health Boards wider long-term strategy and public engagement and consultation to support further assessment.

Cefndir / Background

The Stroke service has continued to experienced significant workforce challenges for a prolonged period of time across a number of workforce disciplines. This position deteriorated further recently with increased workforce challenges experienced across the medical workforce resulting in a lack of stability in the core clinical provision for the Stroke pathway. In the long term it is acknowledged that a safe, sustainable and efficient workforce model will be key to ensuring the delivery of optimal patient outcomes and quality patient care for the population of Gwent.

The proposal and subsequent reconfiguration were aligned with the recommendations of the Getting It Right First Time (GIRFT) review (September

2022), the temporary service consolidation was approved by the Executive Committee and Public Board in July 2023 and implemented in November 2023.

A formal consultation was undertaken through the Organisational Change Process (OCP) framework on Monday 31st July 2023. The changes detailed within the OCP documentation did not alter the remit of staff roles and responsibilities. However, it was accepted that as a result of the change there would be a temporary requirement for some staff to work from an alternative ward within the existing site or alternative sites and change their contractual base. Where possible individual staff preferences were accommodated in terms of location and speciality, ensuring alignment with the service and staff requirements.

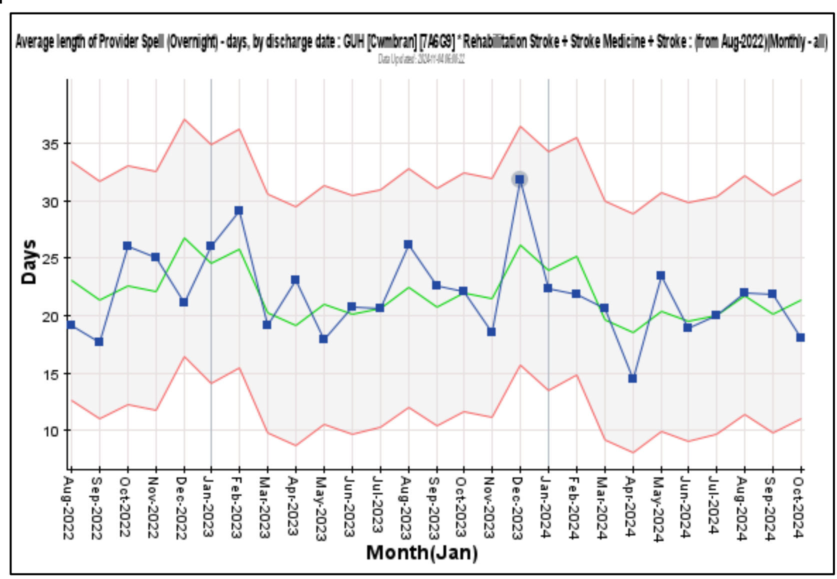
The reconfiguration was undertaken as planned in November 2023 with an agreement for one year's service review to support a wider long-term proposal.

Asesiad / Assessment

It was considered that the proposed Stroke reconfiguration would deliver and realise a number of benefits and provide opportunities, challenges and new ways of working for patients along the stroke pathway.

Impact and Changes

With reference to the average Length Of Stay (LOS) for patients with a subspecialty of Stroke/Stroke Rehab at any one time on a ward during their whole spell, this has been improving since late 2022, with further improvements since January 2024 noting particular improvements in April 2024 and a sustained improvement over recent months:



The Sentinel Stroke National Audit Programme (SSNAP) reporting for April – June 2024 highlights a significant improvement from previous reporting periods, with the Health Board awarded a 'C' from a position of an 'D' with improvements in scanning, and discharge processes:

SSNAP Scoring Summary:	*Team type*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*
	ISDN	Wales	Wales	Wales	Wales
	Trust	Aneurin Bevan University Health Board	Aneurin Bevan University Health Board	Aneurin Bevan University Health Board	Aneurin Bevan University Health Board

	Team	Grange University Hospital	Grange University Hospital	Grange University Hospital	Grange University Hospital
	Time period	Jul-Sep 2023	Oct-Dec 2023	Jan to Mar 2024	Apr-Jun 2024
	SSNAP level	D	D	D	C
	SSNAP score	58.5	55.1	46.0	62.0
	Case ascertainment band	A	A	A	A
	Audit compliance band	C	B	A	A
	Combined Total Key Indicator level	C	D	D	C
	Combined Total Key Indicator score	65.0	58.0	46.0	62.0
Number of records completed:	*Team-centred post-72h all teams cohort*	*186*	*186*	*235*	*215*
Patient-centred KI levels:					
Patient-centred Domain levels:	1) Scanning	A	B	B	A
	2) Stroke unit	E	E	E	E
	3) Thrombolysis	D	D	D	C
	4) Specialist Assessments	C	C	D	B
	5) Occupational therapy	C	B	C	B
	6) Physiotherapy	C	C	D	C
	7) Speech and Language therapy	C	C	C	C
	8) MDT working	E	D	E	E
	9) Standards by discharge	A	B	C	B
	10) Discharge processes	A	E	C	A
Patient-centred KI level	Patient-centred Total KI level	C	D	D	C
	Patient-centred Total KI score	62.0	54.0	48.0	66.0
Patient-centred SSNAP level	Patient-centred SSNAP level (after adjustments)	D	D	D	C
	Patient-centred SSNAP score	55.8	51.3	48.0	66.0

The SSNAP is a major national healthcare quality improvement programme, measuring how well Stroke care is being delivered in the NHS in England, Wales and Northern Ireland. The clinical audits measure the processes of care provided to Stroke patients in inpatient and community settings.

Benefits

As a demonstration of impact as a result of this temporary change a number of benefits were identified as follows:

Benefit	**Delivered**	**Outcome**
Reduction in LOS for Stroke Patients at eLGH site	√ LOS has remained stable since the consolidation	• LOS on average 30 days, this is reflective of the Stroke rehab pathway, average of 6 weeks • LOS has been impacted, increase in Acquired Brain Injury (ABI) and neurology patients centralised at YYF which was not part of the original proposal
Reduction in LOS for Stroke patients at HASU	√ Reduced LOS	• Reduction in LOS by 0.8 days
Improved Patient Flow	√ Improved flow through HASU	• Increase of 4 patients per week through the HASU • Development of both a daily 10am call and Stroke Watch List have ensured timely and clear communication across teams

Patient experience and outcomes – Patient story (appendix 1)	√ Reduced LOS, sustainable staffing model, increased frequency of specialty review and treatment	• Patients reviewed by relevant therapies ANPs same day/next day • Therapy representation at MDTs • Social Worker/Social Worker Assistants aligned to each ward, parallel discharge • Trusted Assessor model, commenced and embedded well • CNRS in-reach model • Improvement integrated working

SWOT Analysis

In addition to the benefits outlined above each of the stakeholders involved in service provision undertook a SWOT analysis of their service following the service change.

This analysis identified a number of generic and specific themes which are articulated below: -

Strengths	Weaknesses
• Improved flow and LOS on HASU • Better co-ordination between Rehabilitation and HASU • All patients receive the same intervention, one pathway • Enhanced therapy intervention, on wards daily • Volunteer in-reach, sustained on one site • Staff support, supervision, mentorship, skills mix and learning • Enhanced MDT approach, joint working • Single site, easier for smaller professions to cover • Senior experienced staff available to support conversations re complex care e.g., Tube feeding • Modern, calm, private environment supports stressed staff • Introduction of Trusted Assessor Model • Introduction of Stroke Co-Ordinator role	• Challenges to identify and transfer Stroke patients admitted to NHH/RGH to YYF • Lack of formalised inpatient Neurorehabilitation/ABI pathway • Limited Neurology input in YYF compared with RGH due to proximity to clinics • Boarding of medical patients, unable to use the dayroom for therapy • Trusted Assessor model working well, although some limitations • Ongoing low staffing in some professions (SLT/Dietetics) • Inadequate therapy space, challenging on a daily basis • Displacement of staff, unsettling • Therapy staffing (ward based) remains 50% below national guidance, as per the 2022 therapy review commissioned by the Health Board • Public transport links for visiting relatives

Opportunities	Threats
• Recruitment of Specialist Doctor(s) to backfill vacant Consultant posts • Better integration with Therapies • Ringfencing of Rehabilitation beds • Further upskilling and training, scope for Stroke CNS to support with training and Stroke support • Daily Stroke call improves communication with the ward team • More opportunities to meet GIRFT recommendations • Simplified in-reach opportunities • Enhanced MDT working across Stroke pathway • Service development and working towards a Centre of Excellence • Pooled therapy resources	• Returning to the previous model • Recruitment to Medical posts • Limited stroke surge capacity • Reliance on Locum • No defined ABI Pathway, no non-stroke/neuro pathway/beds, not included in the reconfiguration • As a result of the reconfiguration, Caerphilly patients have been displaced to other sites, lower number than anticipated • Sustained increase in referrals to CNRS, average of 30% increase in demand per month (appendix 2) • Two wards, still have separate processes, difficulties experienced, less efficient for staff working across the wards • High use of agency staffing affects patient experience, safety including knowledge of safe feeding

Financial Update

The financial assessment in the business case was estimated to be circa £600k saving per annum. It has been difficult to assess this impact due to the wider work undertaken on the reconfiguration of inpatient beds on the RGH site.

However, the centralisation of the Stroke Rehab beds onto one site, YYF, has enabled the full benefit to be realised within the Medicine Division of £1.6m for a full year, this is a combined saving achieved as a result of both the Stroke and RGH configuration. The financial savings of £1.6m has been realised from April 2024, for the Division. The saving has materialised from the reduction in nurse variable pay and the reduction in medical locums.

Communication and Engagement

The extension of the current service provision for a further 12 months has been communicated to staff through local communication methods aligned to workforce specialities i.e., therapies, nursing and included focused communication with staff through team meetings, 1-1s and Divisional communication.

In addition, Llais have been engaged regarding the extension of the current temporary and permanent service change, noting that the permanent service change is subject to public engagement and consultation and this will be in accordance with the Welsh Government guidance and will require an 8-week public engagement followed by a further 12-week consultation period.

The formal engagement and consultation for the permanent service model will be aligned with the Health Board's wider engagement and communication plan. This

will ensure a consistent and joined up approach across all service change programmes across the Health Board for example the NHH Clinical Service Model and the development of the long-term strategy for the Health Board.

Risk Assessment (As outlined in the original proposal)

Risk	Outcome	Mitigation
Community hospital pull model at YYF following completion of stroke pathway for appropriate patients	Increase in the number of Caerphilly patients at YAB and County Hospital, around 10 Caerphilly patients displaced across Community Hospitals	Monitor the allocation of community hospital beds to YYF, alignment with bed allocation workstream
Therapy space at YYF	Therapy space is challenging, cubicles limited for treatment, can only treat one patient at a time	Undertake an audit to monitor the usage, explore other areas on the site, investment in appropriate therapy space
Boarding of patients in day rooms	Poor patient outcomes and experience	Lack of appropriate space for patients to socialise and practice communication skills
Alignment with Clinical Futures Strategy, care close to home model	Number of COTE Caerphilly patients displaced to Community, RGH & NHH lower than anticipated	Consolidation of the services, sustained staffing, centre of excellence, patients received better quality care, start rehab at home sooner
Relocation of staff from RGH and NHH to other sites as per the proposed consolidated model	No loss of speciality Stroke staff, sustained staffing levels across sites, aligned with pre consolidation	Through OCP staff offered opportunity to work at YYF on a Stroke rehabilitation ward or to remain at their current work base working within a different specialty, majority of staff remained at their current site
Public opinion and interest in the proposed reconfiguration	No complaints received from members of the public following the reconfiguration	Promote key messaging, care close to home where possible, delivery of quality services, service reconfiguration recommendation from external review

Staff Feedback
The following comments were noted from staff:

- 'We now have a better understanding of each other's roles'
- 'The move has enabled closer MDT working'
- 'There are now better links with families, better communication and patient goals are discussed'
- 'Working closer with the medical staff'
- 'Therapy staff are on the wards every day'
- 'Change has been positive overall, however more to be done around discharge planning'
- 'Easier for volunteers to in-reach into the wards'
- 'Whole system improvement, one rehab unit'
- 'Improved experience for patients'
- 'Good communication with staff across all disciplines'
- 'Introduction of the 10am Stroke call, flag support for families'
- 'Positive move for therapy staff however investment needed in appropriate rehab space for the long-term permanent model'
- 'I think it's really made the pathway cleaner and more efficient'

Extension of the Temporary Consolidation
An extension of the current service provision for 12 months is requested whilst the long-term strategy is agreed, supporting clear communication with staff groups.

The next steps for the longer-term sustainability of the service provision will be in line with the Health Boards strategy and will need to include:

- Public engagement/consultation in accordance with the Welsh Government guidance
- Review of the CNRS model, aligned to wider Divisional improvement and delivery of care closer to home
- Permanently address the issues in therapy space at YYF

Argymhelliad / Recommendation
The Board are asked to: -

- **Note** the update on the outcome of the temporary Stroke reconfiguration and the consolidation of services across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF).
- **Support** the extension of the current service provision for 12 months whilst the long-term strategy is agreed, accompanied by a thorough review of patient outcomes.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently Choose an item.
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 the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As within paper
Rhestr Termau: Glossary of Terms:	CF – Clinical Futures HASU – Hyper Acute Stroke Unit YYF - Ysbyty Ystrad Fawr GIRFT – Getting It Right First Time eLGH – Enhanced Local General Hospital GUH – Grange University Hospital RGH – Royal Gwent Hospital NHH – Nevill Hall Hospital OCP – Organisational Change Process CNRS - Community Neuro Rehabilitation Service COTE – Care of the Elderly YYF – Ysbyty Ystrad Fawr SWH – St Woolos Hospital LOS – Length of Stay SWOT – Strengths, Weaknesses, Opportunities, Threats SLT – Speech, Language, Therapy

	MDT – Multi-Disciplinary Team SSNAP - Sentinel Stroke National Audit Programme
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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	**Yes not yet available EIA** 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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs 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

Feedback from a service user on her experiences with ABUHB Stroke Services whilst an inpatient and following discharge from Hospital.

The patient spoke with a member of staff from the Health Board on 17.07.2024 and gave permission for her feedback to be used in any appropriate way including where relevant direct feedback to individuals and their line managers.

When I arrived in YYF I had not had a good experience in leaving the Grange. I was told at 1 o'clock that I would be moving and my locker was emptied but then it took hours for it to happen. I arrived at YYF at around 7:30-8 in the evening and 2 members of staff took me into a room and they did a body check. It made me feel like I was entering a prison. I was a bit scared and it would have been beneficial for me to have it explained – I understand why it was done now.

On the ward I was put in a room but half an hour later was told it had been allocated to someone else by the powers above so I was put in a day room amongst tables and chairs. I was given a call bell but no one came at first and I was afraid I would wet the bed. Someone did come after a while.

I was there for 24 hours and then went into a room. Everything changed, it was wonderful, the staff were attentive, checking I was ok and the food was good. I was very happy in that room. The staff gave me the confidence to use the bathroom.

I met an OT Technician What I loved about him was he very soon got on my wavelength, he worked out my needs and would talk to me. He took me to the kitchen to see my abilities. He was amazing, absolutely amazing. He would always pop his head in when he passed my door. He came to see me on the Friday when the Dr said I could go home and advised that it would be better for me to stay in over the weekend and that made a difference. He visited me on the Monday morning and thought about everything, very caring, thoughtful and still very professional.

A nurse encouraged me to try showering and it gave me the confidence to try it and it's such a feeling when you achieve something yourself. From the time I go into my own room they all did such a wonderful job. Everyone of them deserves a pat on the back. And since going home I have had several more appointments and check ups and a visit to Ophthalmology for my eyes.

On going home [with Supported stroke discharge] From the beginning the communication was excellent, empathetic and lots of information, verbally and

in literature. I found the staff were always punctual and communicated about appointments, they were friendly and professional – quite an achievement. Very good listeners, really important, always ensured I had contact details.

The Therapy Assistant Practitioners always checked on how I had been doing and what I had been doing checking if I had had any challenges or frustrations and then would help me problem solve my challenges like cleaning the house or doing the garden. He instilled self confidence and "have a go at a thing". He set exercises and explained how I would benefit from it. Always encouraging and I found that very positive and it enabled me to set my goals. Exercises were set at the right level.

The Stroke Dietitian provided lots of information in words and literature. My weight had reduced prior to my stroke and she made sure I understood how supplementary drinks could help and the importance of fitting snacks in and fortifying food. She checks my weight and I've started gaining a bit.

Overall, from CNRS I am very satisfied with the help they gave me on this journey.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Update on the Respiratory Reconfiguration and the General Medicine model at GUH**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Tracy Morgan, General Manager Medicine Kate Fitzgerald, Clinical Futures Assistant Programme Director

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to update the Board on the implementation of a General Internal Medical (GIM) model of care at the Grange University Hospital (GUH) and the Respiratory Medicine reconfiguration which included:

- Realignment of medical staff from Nevil Hall Hospital (NHH) to GUH to further support our Respiratory team
- Clear clinical accountability for 16 General Internal Medicine beds at GUH

Cefndir / Background

Clinical Futures Model

In order to support the delivery of the new clinical model and the reconfiguration of services following the opening of the Grange University Hospital in November 2020, the Health Board continues to take forward an improvement programme aligned to the Health Board's Clinical Futures Strategy, with the overall aim of reducing health inequality, improving population health and right sizing the bed base and community service provision.

Four years into the implementation of the new clinical model, taking on board lessons learned and increasing pressure across the system, further opportunities have been identified to refine the model to ensure the Health Board delivers safe and sustainable services through new ways of working to better meet the needs of its population.

To ensure we continue to deliver the best possible care and outcomes for our patients, an opportunity was identified to centralise the Respiratory inpatient team from NHH to GUH to further support the Respiratory Medicine at GUH.

General Internal Medicine
Since the opening of GUH in 2020, the model of care designed and subsequently delivered at GUH has been based on speciality-based beds with General Medical patients being supported at the eLGH sites. The Health Board has not operated a General Internal Medical model at GUH for the last four years which, based on experience, impacts on speciality patients accessing appropriate beds whilst negatively impacting on the timeliness of care delivered to patients requiring general medical support. This predominantly affects our elderly and frail population.

Proposals were developed to deliver a General Internal Medical model at GUH alongside the reconfiguration of the Respiratory Medicine service which included:

- Closure of the Medicine inpatient beds on ward 4/3 at NHH
- Delivery of a phased Respiratory in reach model at NHH and YYF
- Clear clinical accountability for 16 General Internal Medicine beds at GUH

Assessment

The proposal included:

- Reconfiguration of current medical beds and relocation of Respiratory High Care Unit to result in the General Internal Medicine capacity on the GUH site being provided across Wards **C4 and B4**
- **Respiratory High Care Unit** on C4 to relocate to C2
- **A3 beds** (currently utilised for outlying General Medical patients) allocated to Surgery
- First floor General Medical patients continue to be managed by the **Acute Medical team**, as per previous model
- Closure of a medical ward at which equated to **22 Respiratory and 6 Diabetes beds**, (Diabetes beds to be absorbed into existing footprint), a total reduction of 28 beds. This is enabled by maintaining the surge capacity currently operating on the wards at NHH.
- Clear clinical accountability (Respiratory) for **16 General Medical** beds at GUH

The **overall bed reduction**:

Overall Bed Reduction	
Medicine	
NHH	
22 Resp & 6 Diab, Diab beds to be absorbed into NHH footprint	-28
GUH	
A3 Gastro beds	-8
C2 (machen)	6
Total	**-30**
Surgery	
GUH	
C2 (machen)	-6
A3 additional	8
Ambo CEPOD	2
Total	4
Bed Reduction	**-26**

Nevill Hall Hospital
Although the Respiratory team have vacated ward 4/4 at NHH, this ward has been reconfigured and will remain open to ensure that the Sleep service and the labs continue to operate to support patients. Ward 4/3 was the closed. The Orthogeriatric ward 4/2 has not been impacted by this change and remains open. This bed reduction at NHH is aligned to the Health Board's planned bed model for the site and formed part of the previous consultation on the original Clinical Futures model. Half of the beds were reduced in the summer as part of the surge reduction plan; the remaining were closed in the days leading up to the implementation of the change.

Workforce Analysis
The following is noted:

- All staff identified were supported aligned to the all-Wales organisational change policy
- Engagement undertaken with Trade Union Partners
- Staff preferences were supported through the change process; all staff attained their option 1 or 2 preference
- All staff attended 1-1 meetings with senior management and workforce
- The Ward Manager and Deputy Ward Manager on ward 4/3 through mutual agreement were absorbed into vacancies on the NHH site in the Acute Medical Unit
- Divisional engagement sessions were held with the ward staff with representatives from all staff groups
- An Executive drop-in session was held at NHH with the Chief Operating Officer and Executive Director for Nursing to provide reassurance to the staff and respond to any concerns
- 8.9 wte medical staff agreed to relocate from NHH to GUH
- There was a guarantee that all nursing and support staff from wards 4/3 and 4/4 could remain working at NHH
- Some nursing staff requested and were supported to change to alternative hospitals during this process to support their own development or personal circumstances
- All agreed annual leave, flexible working and rosters were honoured in the new areas of work

Finance Analysis
The following table outlines the additional staffing required to support the Respiratory reconfiguration, noting that this is an invest to save model that will deliver a number of benefits over time:

Grade	1 WTE Salary (Gross)	WTE	Annual Cost
Consultant	£158,747	2.00	£317,494
PA – Band 7 Weekends only	£92,978	0.40	£37,191
Registered Nurse – Band 6 Days	£54,407	0.6	£32,644
HCSW – Band 2 Full Rotational	£37,934	5.69	£215,844
Total			**£603,173**

This table outlines the net savings to be realised over a three-year period across the Health Board noting the reduction in savings for the Division of Medicine in 2026/27 due to the appointment of the second Consultant:

Division	2024/25	2025/26	2026/27
Medicine	-729,874	-1,617,527	-1,458,780
Surgery	-157,000	-471,000	-471,000
Estates & Facilities	-73,605	-220,815	-220,815
Total Net Savings	**-960,479**	**-2,309,342**	**-2,150,595**

It is noted that the model of care required at the GUH is different from that of an eLGH site due to the high acuity of the patients; therefore there is a requirement for additional workforce to support the GIM proposal to ensure the delivery of safe, sustainable and efficient care with the anticipated benefits of reducing hospital LOS, facilitating timely patient discharge and wider system impacts e.g., a reduction in General Medicine step-downs, ambulance hand overs times. This also aligns to the financial plan assumptions around bed capacity for 2024/25.

Benefits:
It is anticipated that the following benefits will be realised as a result of this change:

- Clear clinical accountability for 16 GIM beds at GUH, improved patient experience and outcomes
- Clarity of patient pathways and definitions at GUH, improved flow and reduced LOS at for GIM and speciality patients at GUH
- Respiratory medical staff aligned to speciality demand, caring for the right patients in the right place in the system
- Medical model of care at NHH aligned with demand, accommodating multi-morbid care of the elderly patients with complex discharge requirements, care delivered close to home
- Right sizing the bed base aligned to the Clinical Futures model, delivering safe, sustainable and efficient patient care

- Consistent Respiratory in reach model of care delivered across the eLGH sites, single site Respiratory inpatient bed base

Mitigation

The following key actions and improvements support the reconfiguration in terms of mitigating the impact of a net reduction in beds and enable closer alignment to the clinical futures bed plan and delivery of improved outcomes:

Action	Comment
• Implementation of new governance arrangements	• Weekly meeting to oversee the changes and trouble shoot • Weekly GUH medical meeting to discuss and deal with any key issues
• Clear clinical accountability of GIM patients at GUH	• Reduced LOS for GIM patients at GUH • Respiratory ward at NHH LOS 4 days less compared to Gen Med wards • Increased no. discharges • Reduction in no. of step-down patients
• Clarity on patient pathway/definition	• Improved patient flow • Improved LOS for GIM and specialty patients
• Recruitment of six additional Emergency Department Consultants	• Ability to improve patient wait to be seen times
• Ambulatory Surgical CEPOD	• Increased number of cases operated on day of admission for selected treatments (abscesses, lap appendix) - reducing hospital length of stay
• Discharge Transfer Lounge at GUH to open beginning of February 2025	• Additional capacity, 10 beds, 15 chairs • Improved patient flow
• Integrated Front Door at GUH	• Optimising use of front door resources, improved admission avoidance
• Operating Framework	• Improvements in LOS, increased discharges • Baseline to be tracked before and after • Potential to create significant improvements
• SDEC, all medical patients to be streamed to SDEC for initial assessment	• Increase the number of medical patients seen in SDEC • Increased assessed out rate
• Improvement in CRT / community capacity	• Increase in DAP beds to support number of people admitted through community CRT referral

	• Increase in district nursing capacity to improve resilience • Hospital to Home, additional capacity • CRT rapid medical, 08:00 – 20:00, aligned to GP demand, increase number of referrals, reduced risk of hospital admission

Monitoring and Evaluation
A weekly meeting will be held to oversee the change and discuss any issues aligned to the Inpatient Reconfiguration Programme. The Chief Operating Officer will chair the weekly meetings, reporting progress directly to the Executive Committee

An evaluation of the above change will be undertaken to monitor and track the benefits, the methodology for the evaluation will be aligned to the recent Stroke reconfiguration and will include:

- A SWOT analysis to be undertaken by all workforce groups
- Tracking of anticipated workforce and financial benefits
- Reviewing the communication and engagement approach with staff, the public and wider partners, overall management of the change process
- Feedback from all staffing groups nursing/medical at various sites
- Feedback from patients to include patient stories
- Metrics to be tracked as an indicator of success e.g., LOS
- Gather lessons learned to inform future Health Board service change/redesign

The reconfiguration of Respiratory medicine and the implementation of a General Internal Medical model of care at GUH, which is consistent with the Clinical Futures model, took place over the week commencing 11th November 2024 noting the phased decommissioning of beds at NHH to support the change prior to this date.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the realignment of medical staff from NHH to GUH to further support our Respiratory team and the clear clinical accountability for 16 General Internal Medicine (GIM) beds at GUH.
- **Note** the improved model of care at GUH for elderly and frail patients.
- **Note** the system wider mitigating actions aligned to the overall bed reduction.
- **Note** the benefits to be tracked and realised over time.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Strategic Risk Register

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As within the paper
Rhestr Termau: Glossary of Terms:	GIM General Internal Medicine GUH Grange University Hospital NHH Nevill Hall Hospital YYF Ysbyty Ystrad Fawr eLGH Enhanced Local General Hospital LOS Length of Stay SDEC Same Day Energy Care DAP Direct Admission Bed CRT Community Resource Team

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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Children and Young People Assurance Report**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Chard, Assistant General Manager, Family and Therapies Division

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

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an overview of existing and planned arrangements for services for children and young people in Gwent. The report describes the strategic drivers and the underpinning public health model as well as outlining the demand for key services delivering care to children and young people. It outlines the work completed to date within Aneurin Bevan University Health Board and through partnership working and proposes a way forward that would strengthen both the mandate and commitment from Local Authorities to work collaboratively to deliver services to this cohort of the population.

The Board are asked to consider the information within this report and support the direction of travel.

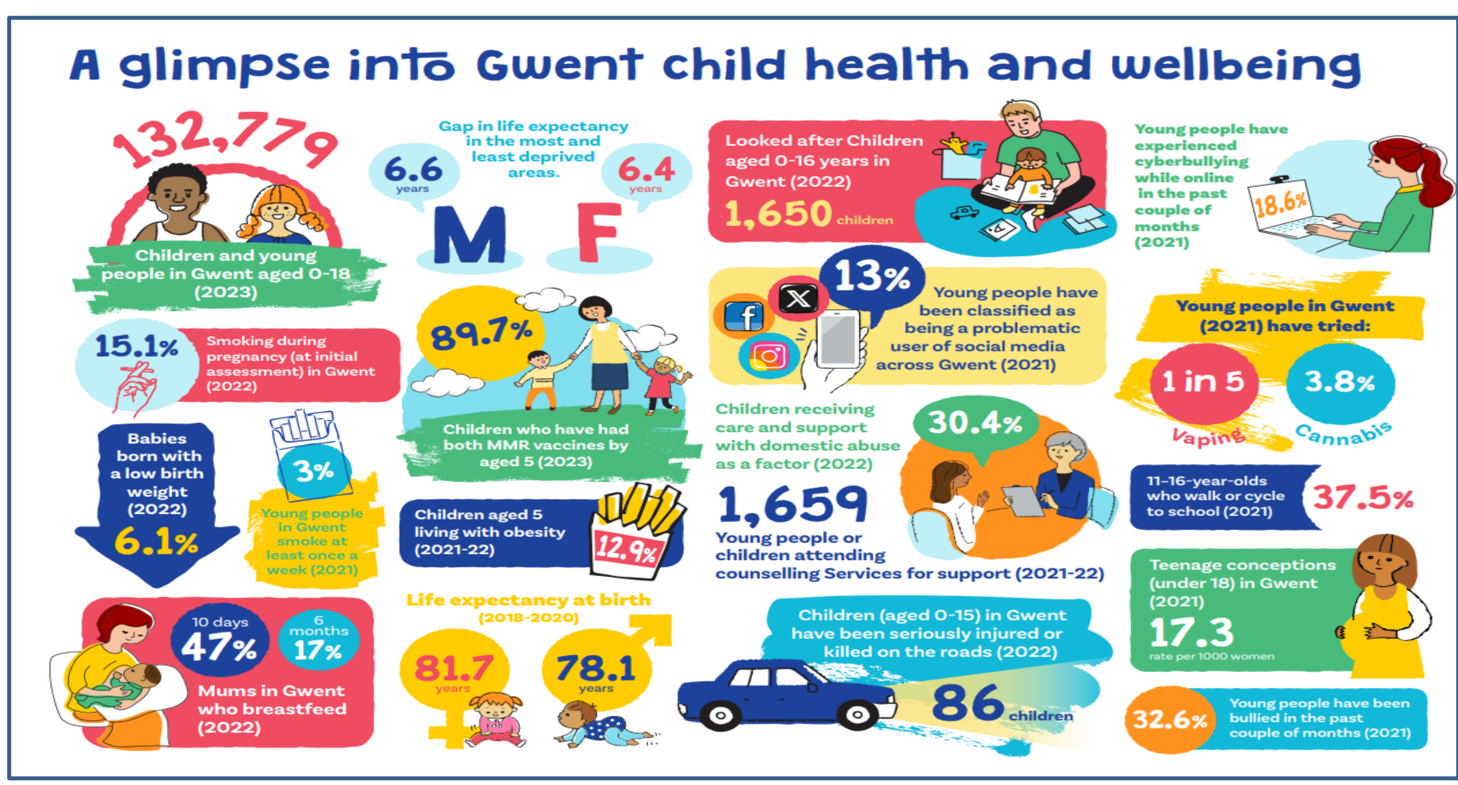
Cefndir / Background

Ensuring children have positive early experiences (access to quality healthcare, nutrition, education and a nurturing and safe social environment) profoundly shapes their life trajectory. The factors that influence this can range from the obvious such as the health and wellbeing of the mother, poverty, housing, parental mental health to determinants that influence how parents think and feel in terms of what they are able to do.

The UK is also on the facing a cost-of-living crisis and children are one of the population groups whose health and wellbeing are most affected both directly and indirectly[1]. Figure 1 shows both direct and indirect impacts of the cost-of-living crisis on children. Direct impacts of the cost-of-living crisis on children's health include a higher risk of asthma and other health conditions associated with living in a cold home, and a greater risk of obesity associated with missing out on nutritious food.

Indirect impacts include being at a higher risk of exposure to abuse and neglect, increased risk of chronic illnesses in adulthood and poorer employment prospects due to lower educational attainment. There is an established understanding of Adverse Childhood Experiences (ACEs) which refer to traumatic events or circumstances which happen in childhood and can lead to poorer outcomes across the life course. ACEs include child maltreatment (physical and emotional abuse and neglect) and wider experiences of household dysfunction (domestic violence, parental separation, substance misuse, mental illness or parental incarceration). The impact varies depending on the age of the child ranging from higher levels of crying and poor sleeping patterns in babies, bed wetting or, sleep disturbances in pre-school children, to underperformance in education, self-harm and engagement in antisocial behaviour in older children. Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential.

The needs of children in Gwent are currently in the process of being mapped through a Joint Strategic Need Assessment; however as outlined in the table below, we already understand some of the impact of direct and indirect influences on outcomes for children and young people.



This demonstrates that a whole system approach is required between the Health Board and the Gwent Local Authorities to optimise our chances of improving outcomes for children and young people in Gwent.

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[1] PHW-Children-and-cost-of-living-report-ENG.pdf (phwwhocc.co.uk)

A Public Health approach and the wider NHS strategic context

The Public Health Model of Parenting Support describes how parents, communities and wider society can work together to give children in Wales the best start in life.

The model builds on the routes of influence framework by drawing on research and the views and experiences of parents and professionals to identify the specific structural, community and individual building blocks that enable parents to thrive in their parenting role. It helps explain why information and advice is often insufficient on its own to change behaviour and why some families are more able to benefit from support than others.

Figure 1

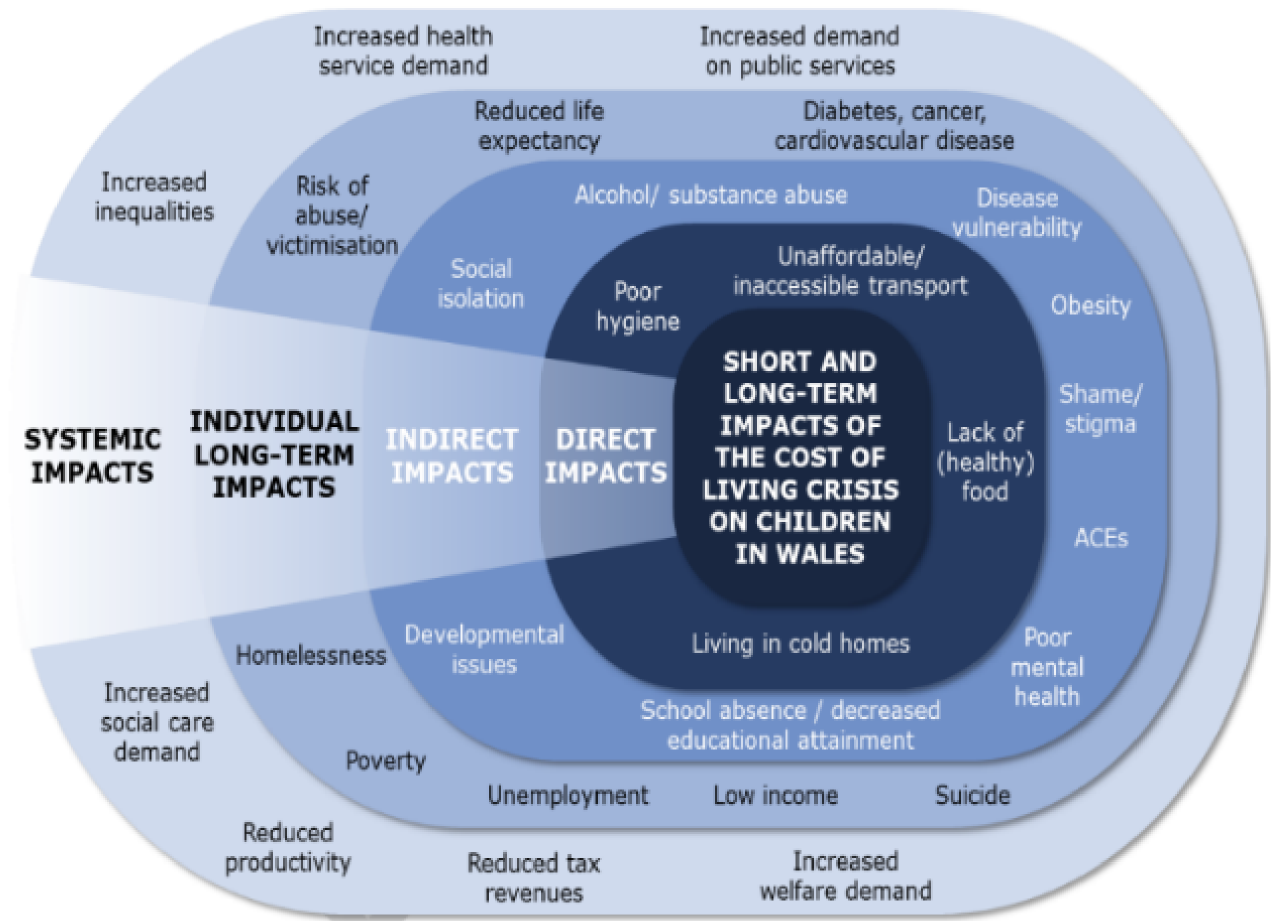
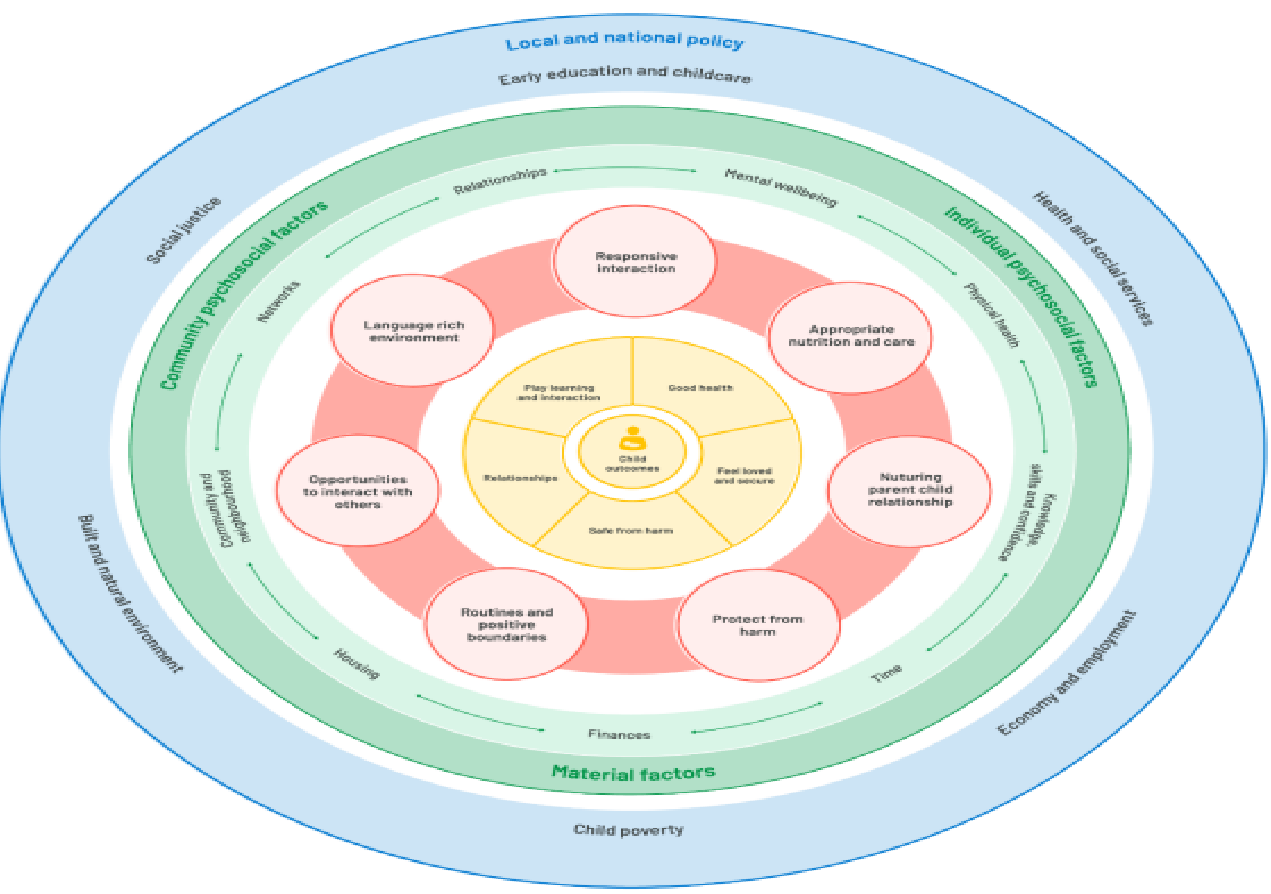


Figure 1. Conceptualisation of the public health impacts of the cost of living crisis on children in Wales.

The model (Figure 2) highlights the importance of creating a whole system that supports parents. Action at local and national policy level, in the places where parents live, work and access services is needed to create the conditions for families to thrive.

Figure 2



A Public Health Approach to Supporting Parents 5

These underpinning principles form the basis of the Marmot Review undertaken in 2010 and Building a Fairer Gwent: improving health equity and the social determinants in 2023 which set out recommendations for both Health and Social Care that includes giving children the best start in life, enabling children and young people to maximise their capabilities and have control over their lives, ensuring a healthy standard of living supported by healthy and sustainable places and communities and to strengthen the role and impact of ill health. Other key legislation and strategic frameworks that support women and children are outlined in Appendix 1 and have been a key enabler for driving change within services.

Asesiad / Assessment

Through a combination of key strategic frameworks and targeted but time limited funding such as the Public Health's Whole School Approach to Mental and Emotional Wellbeing Grant, Regional Integration Fund and Early Years Integration Fund, the Health Board has been afforded an opportunity to demonstrate some initiative in re-designing services and working collaboratively with Local Authorities and Services. An overview of service demand and some of the initiatives in Gwent is outlined below. These are presented against several themes: Antenatal to the first 1000 days, School Age and Transition, Vulnerable Children and finally non age specific children's services such as CAMHS and Planned Care.

1. Best Start in Life: Antenatal to First 1000 Dates

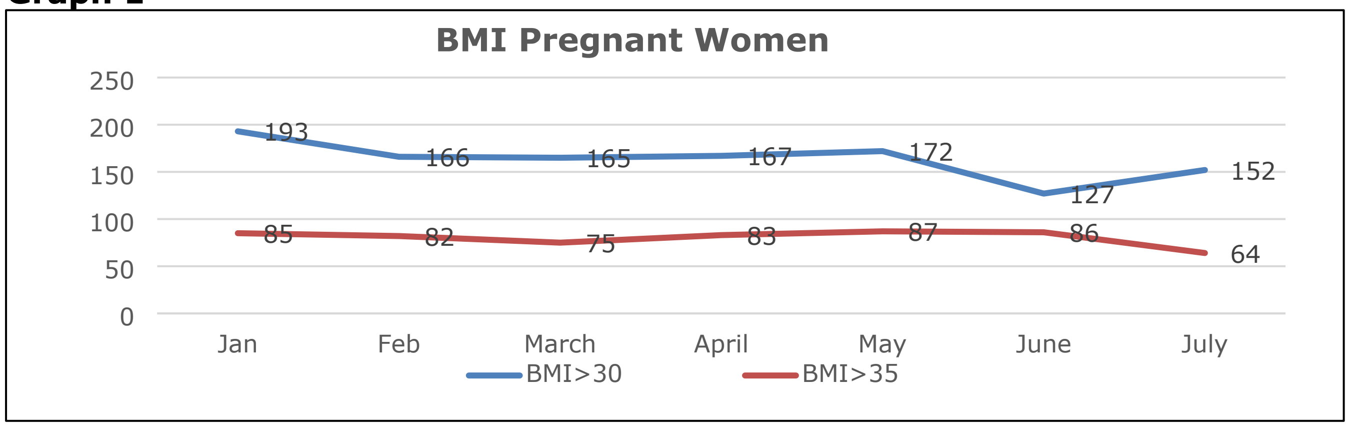
The "best start in life" refers to providing optimal conditions and support during the critical initial stages of a child's development, from preconception through early childhood (up to age 4). It involves ensuring access to high-quality healthcare, nutrition, nurturing relationships, safe environments, and early learning opportunities.

There were 1748 referrals accepted to the Healthy Pregnancy Team between 09/08/22 and 29/02/24. The number of eligible people (living in ABUHB with BMI 30+, BMI27.5+ for BAME groups) being referred is estimated to be 67%.

Graph 1 shows the BMI of pregnant women from January to July of 2024. Those with a BMI>30 show a decrease of 41 over that period, with 33% of women in July with a BMI>30. Those with a BMI>35 show a decrease of 21, with 20.5% of women in July with a BMI>35.

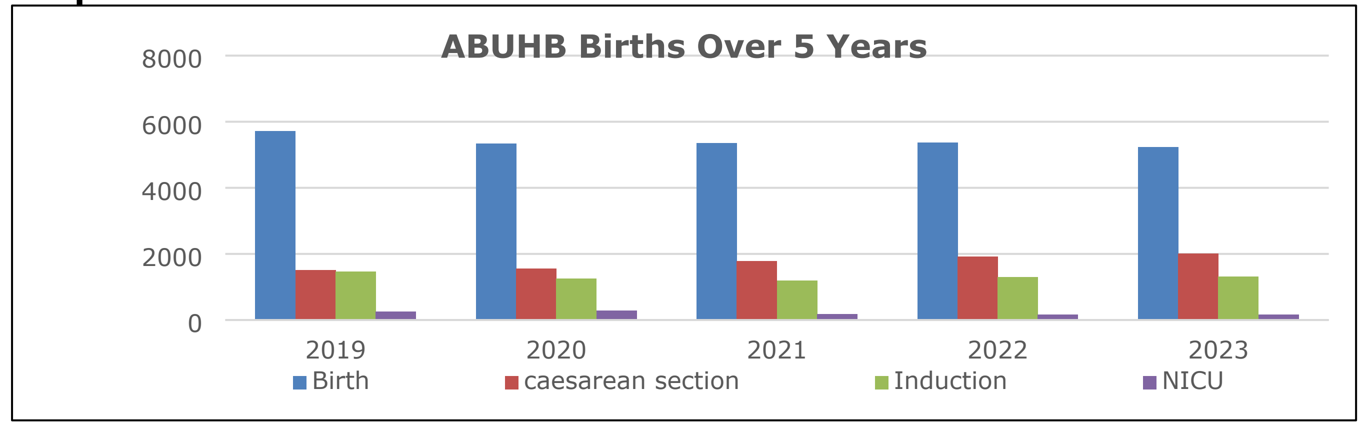
Previous data to this time period has lacked consistency and reliability due to limitations in data collection methods. Earlier records were maintained on paper and in an outdated digital system, both of which had inconsistencies in data capture. Graph 1 presents information sourced from the newly implemented digital system, Badgernet, which offers more precise and dependable data collection capabilities.

Graph 1



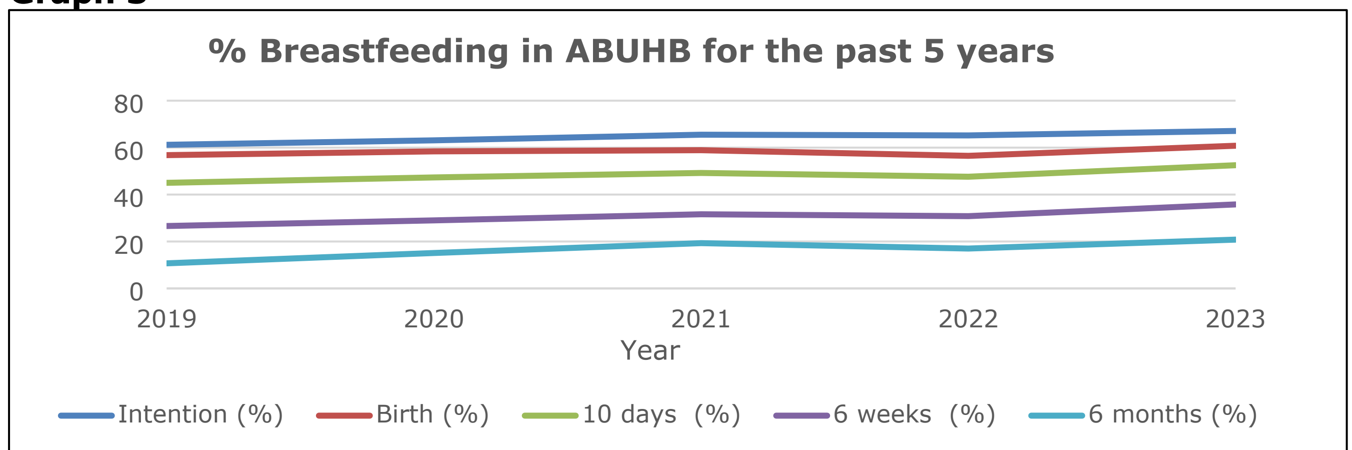
Graph 2 shows Health Board birth rates over the last 5 years. Whilst the number of births remain static, the complexity of births is increasing with current caesarean rates being 40%. The contributory factors relate not only to maternal choice but the overall health of the mother specifically in respect of weight and associated morbidity factors.

Graph 2



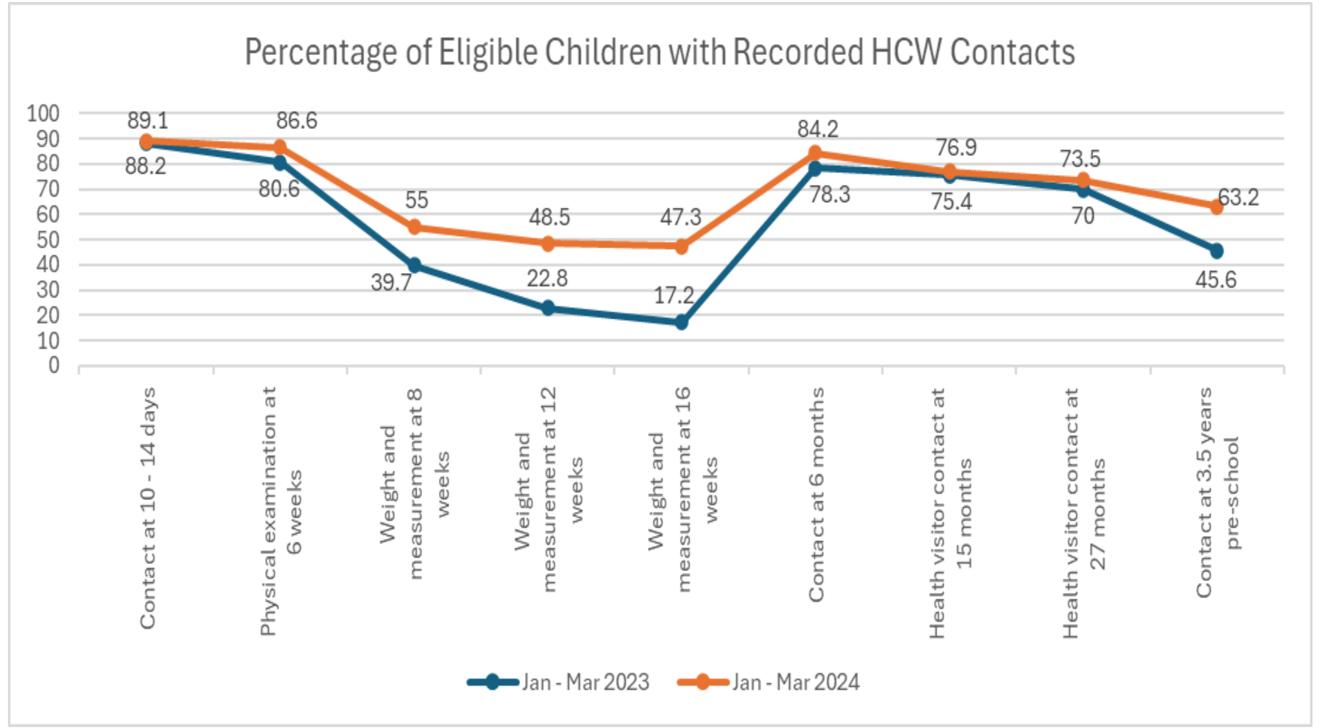
Graph 3 shows the Breastfeeding rates within the Health Board for the last five years, comparing the percentage of intention up to 6 months. At birth, the Health Board rates increased from 56.5% to 60.8%, with an additional increase from 17.0% to 20.8% at 6 months, more than doubling the rate at 6 months compared with 2019.

Graph 3



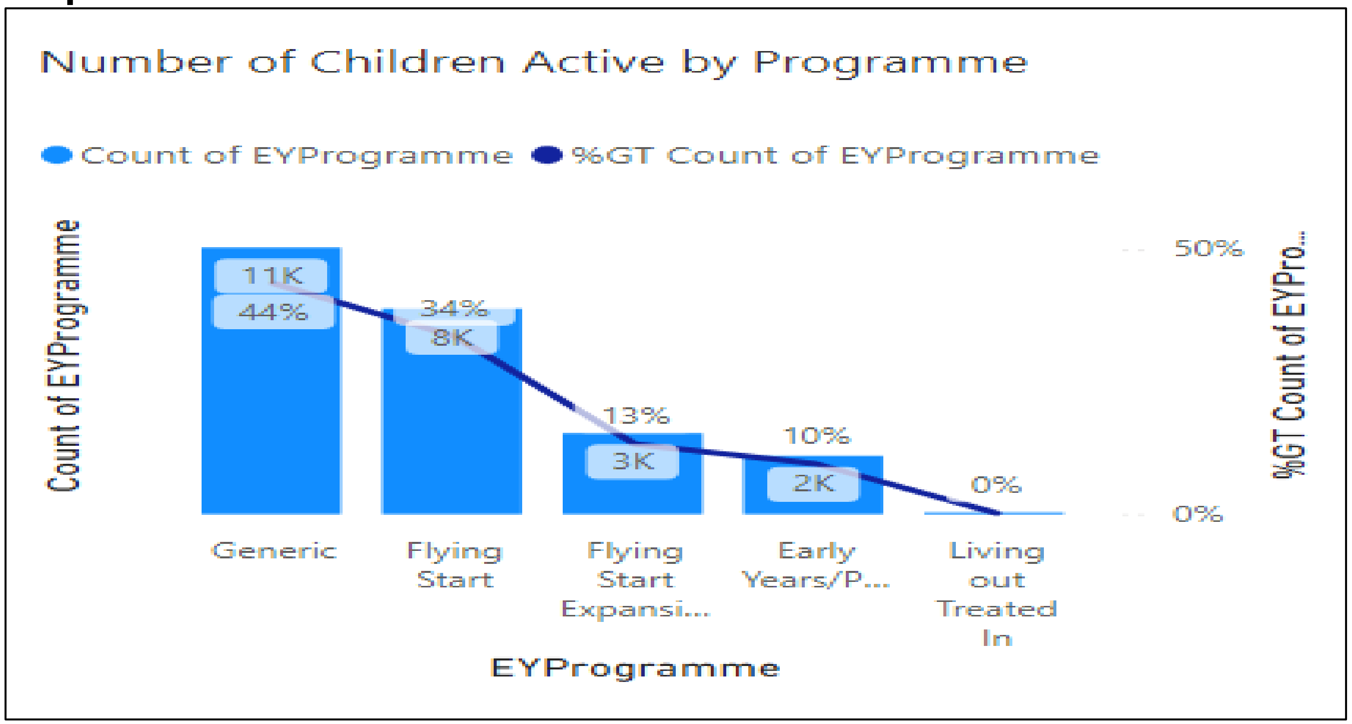
Graphs 4 shows the percentage compliance for the last year of Healthy Child Wales Performance (HCWP) from the 8 weeks to 3.5-year contact completed by a Health Professional within the Health Visiting team. This validated information is drawn from Stats Wales and is validated and compares Jan – March 2024 to Jan – March 2023 (this is the most up to date picture provided nationally with the next quarter expected to be shared at the end of November 2024). There have been some significant gains in part due to a major re-engineering of the service and enhanced recruitment because of the Health Visiting Sustainability Programme particularly in relation to the clinic model which has put more focus on parents bringing children to the clinic rather than visiting them at home creating more capacity and delivery within clinics. The full impact will not be known until Stats Wales provides data for November 2024. Improvement has been seen around the 8, 12 and 16 weeks check which has more than doubled in some instances.

Graph 4



Graph 5 shows the number of children currently within the Health Visiting service by programme. These are all children supported by the health visiting service including those supported by enhanced health visiting such as Flying Start and Flying Start expansion (Phase 1 includes the full Flying Start offer and Phase 2A and 2B is childcare only). Enhanced Health Visiting should involve more visits with a focus on entrance into childcare. Further work is needed to understand the availability of resources to deliver the full Flying Start offer.

Graph 5



1.1. Initiatives put in place to support antenatal to 1st 1000 days

The Maternity-Neonatal Programme which launched in January 2022, was developed to improve safety, experience, and outcomes for maternity and neonatal care and to ensure that a sustained culture of improvements was embedded. As part of the programme national and clinical leads were appointed and local safety champions were funded in each Health Board to begin the discovery phase of the programme. This culminated in the release of the report 'Improving Together for Wales' encompassing themes of culture, learning, workforce and clinical outcome measures for mothers and babies for which there were 124 recommendations. The Health Board has an improvement plan in place which has a risk-based focus on the recommendations within the report

A core foundation for building a healthier and more equitable future for Wales, **Best Start in Life** is a priority for tackling inequalities as well as giving children the best outcomes in life. Keeping the family unit together is a key part of supporting the best start in life to not only promote parent infant bonding but also infant breast feeding.

The Best Start in Life Making Every Contact Count (MECC) training package has been completed by approximately 250 maternity staff on subjects such as

immunisations, smoking, mental health, healthy start, infant feeding, perinatal mental health and physical activity/healthy eating and alcohol and substance misuse.

ABUHB has performed well against these targets with specific achievements for 2024 including:

- Civility training and cultural competencies accreditation focused on health inequalities
- Improved risk management and communication with regular safety huddles in place
- Enhanced cord clamping, implementation of actions to reduce the impact of brain injury and mortality rates
- SBAR presented on the need for a transitional care unit which was presented to the Pre-Investment Panel in November 2024

Healthy Pregnancy Team introduced a pathway for pregnant women, living within the Health Board footprint, with a BMI > 30+kg/m^2 (BMI27.5+ kg/m^2 for BAME groups). Between August 2022 and February 2024 there were 1748 weight management referrals of which 73% (1274 women) had a brief intervention to offer dietary changes and options for physical activity of which 83% met their target weight. There was a 20% increase in breastfeeding, an 11% reduction in induction of labour and a small reduction in birth and pregnancy complications such as gestational diabetes, still birth, emergency C-sections.

Weight Management in Pregnancy - Approval has been given by the Executive Director for Public Health and Strategic Partnerships that Healthy Weight Health Wales funding can be utilised to re-establish a healthy weight in pregnancy service. Recruitment for staff required to deliver the service will be led by the weight management service (Dietetics) and will begin in December 2024

Smoking Cessation in pregnancy programme - Carbon monoxide (CO) monitoring at onset of pregnancy was completed for 57% of community booking appointments (early pregnancy) (April 2023-March 2024). This has increased to 73.5% for Quarter 1 (April – June 2024). The variation of CO monitoring by locality is reducing.

CO monitoring at the end of pregnancy (at birth/36-weeks) has been completed for 40.6% of women and birthing people (March – July 2024) and there is variation in completion by locality. Smoking status and CO monitoring at this point requires further attention to enable accurate reporting on outcomes.

Substance Misuse - Substance misuse was the focus of a Bitesize MECC session delivered in June 2024. It was delivered jointly between public health and ABSDAS (Aneurin Bevan Specialist Drug & Alcohol Service) and provided information on how to "ask, advise and act" in relation to drugs and alcohol, alongside Fetal Alcohol Spectrum Disorder. This is a new initiative, and further work is required to embed this training fully amongst staff. The development of a pathway for substance exposed pregnancies is ongoing. The next step is to engage wider partners outside the Health Board and commissioned services, such as social services and safeguarding.

Neonatal Peri-premature Initiatives – PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) was launched in Wales in 2023. It is a unique, perinatal care pathway of 10 evidence-based interventions to reduce preterm mortality and

brain injury. The neonatal service was already meeting many of the interventions prior to the launch but these have been strengthened. These include breastfeeding advisors on the unit, administering probiotics earlier, showing an improvement in practice from 32% in 2023 to 49% in 2024. Another intervention that has shown improvement from 66% in 2023 to 75% to date in 2024 is optimal cord management using a portable resuscitaire which allows the team to resuscitate babies safely while still attached to the umbilical cord. Regular PERIprem team meetings occur involving both maternity and neonatal team members where data is discussed and also any improvements that can be implemented. The team is always seeking to improve outcomes.

Gwent Peri Infant Mental Health Service (G-PIMHS) has reached its 5th year as a multidisciplinary early intervention and prevention service that provides therapeutic support to groups and individuals as well as training to professionals. Sitting within Public Health Nursing, last year referrals increased by 64% and this level of referrals has been maintained over this year (total 343).

Early Years Integration Programme aims to develop a seamless cohesive system for children and families from antenatal to 7 years.

The model which was initially funded by Welsh Government was developed on a regional Gwent footprint and covers maternity, health visiting, school nursing and Early Years Services in Local Authorities. Progress includes: -

- Workforce training
- Development of an Information Sharing Protocol (ISP) to share family information between organisations
- Completion of a midwifery and early years core programme that maps all service contact / provision across midwifery, health visiting, school nursing, therapies, and Local Authority early years services
- Co-location of teams and integrated funding in some areas

Health Visiting Sustainability Programme led by the Executive Director of Nursing is an extensive programme of work that was initiated in 2023. The programme makes far reaching reforms that cover recruitment and retention, service efficiency, health and wellbeing of staff and improved governance and processes so that children can receive the very best of care. The programme has already achieved many of its objectives and is now moving into the areas of reviewing the scope of service provided to children to ensure it aligns fully with the Best Start in Life Programme. Key achievements include:

- A leadership restructure and appointment of a Band 8B clinical lead,
- A successful enhanced recruitment programme, appointment of 16.5 WTE staff (of which 10.5 were health visitors) over the last 6 months
- Development of a service guide and new protocols for record management reducing the write up of notes from over 1 hour to 15 minutes
- Reconfiguration of staff numbers across the borough according to need and case mix
- Stabilisation of Newport and Monmouthshire which were RAG rated as red in terms of clinical risk
- Enhanced work in relation to communication and engagement involving the health and wellbeing team and a strengthened business function around communication

Additional initiatives include:

Toileting Team - an early intervention toileting service that ensures children are continent before going to school. Since January 2023, over 468 children have been seen and discharged, with a further 163 waiting or in active treatment.

The Responsive Feeding Team which supports mothers in the first 72 hours in relation to breast feeding support and attachment.

Delivery of **Talk with Me -** A strategy to enhance children's speech and communication and ensure early identification of speech disorders for children between 0 to 4years and 11 months.

2. School Age

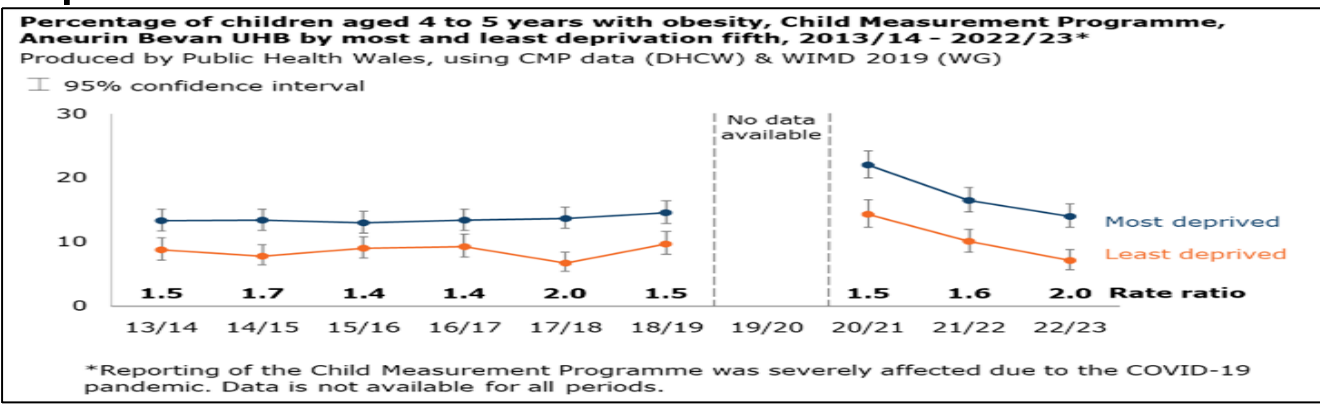
The services provided to school age children are extensive ranging from core assessment and support delivered through the school nursing service to more targeted services for vulnerable children.

The **Healthy Child Wales Programme for school aged children** is a new unified operating model for school nursing services which provides a programme of planned universal health contacts for all compulsory school aged children (aged 5 to 16 years) in Wales, regardless of setting. Welsh Government have given the Health Board two years to implement the programme from September 2024-26.

Part of the new programme requires School Nursing to compile a health needs assessment for each school cluster to gain a more in-depth understanding of their population with the goal of enabling more effective planning, prioritisation, and subsequent delivery of services to improve outcomes for children and young people. High impact areas can include health behaviours and lifestyle, smoking and vaping, sexual health, building resilience, reducing risky behaviours, and supporting children with complex needs.

The School Entry Review is an opportunity to assess a child's health, needs and to promote public health and wellbeing. This includes checking immunisation status, height, weight, and vision screening. Graph 6 shows the Health Board percentage of children aged 4 to 5 from 13/14 to 22/23 with obesity reported by the most and least deprivation fifth.

Graph 6

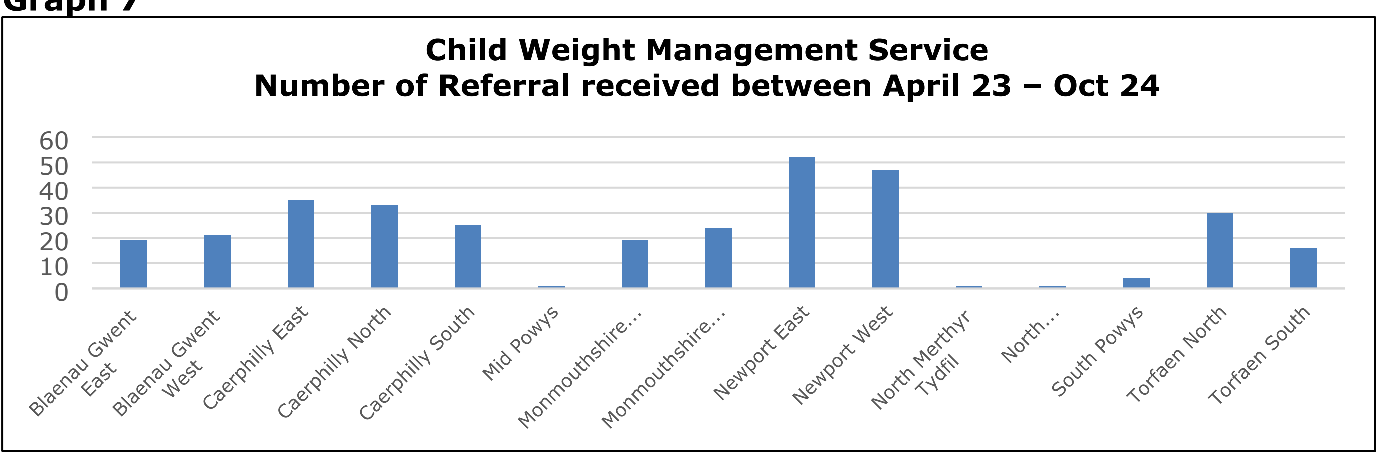


Note: No official statistics were produced for 2019/20 and 2020/21 academic years due to children being home schooled during the Covid-19 pandemic).

The data evidences the increase in BMI in the most deprived areas.

Graph 7 illustrates the number of referrals received by the Child Weight Management Service for April 23 – October 24. The data shows Newport having the most referrals throughout the service.

Graph 7



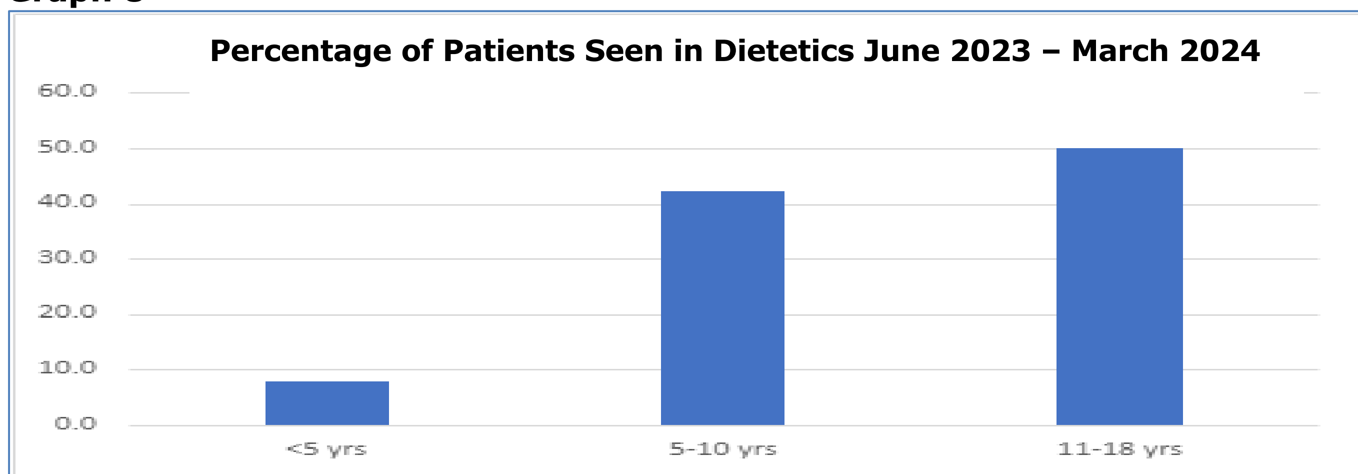
ABUHB also provides a range of other interventions including:

- Structured education from the Public Health Team
- Nutrition skills for life, early years training
- Dietetic led health visitor training on childhood obesity as well as responding to queries and providing advice
- Weaning groups
- In November the service has recruited further to the maternal weight management service which will also influence Childrens eating habits in the longer term

Early years intervention has however decreased following the loss of funding earlier this year reducing the availability of resources to deliver this agenda fully.

Graph 8 illustrates the percentage of patients seen in Dietetics from June 23 to March 24. The data shows those in the age range 11-18 years have the highest percentage.

Graph 8



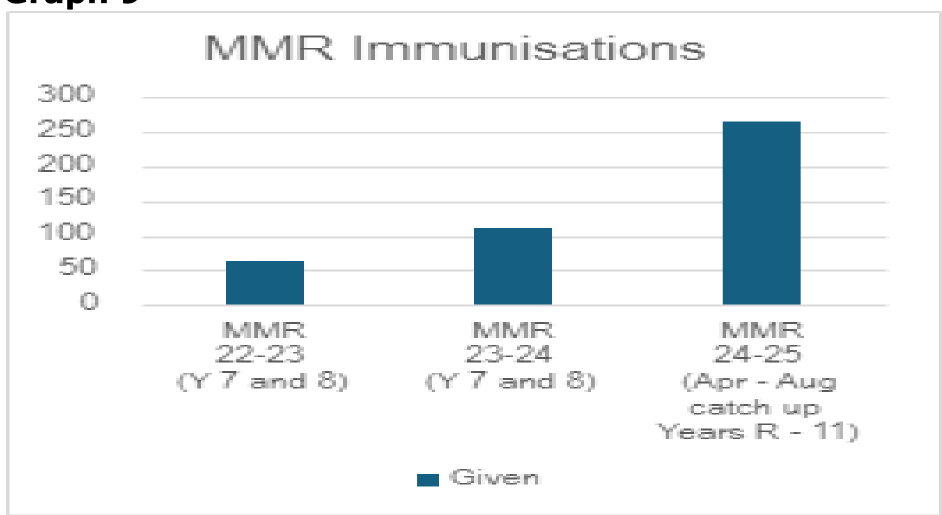
A key element of the HCW school age programme is the childhood immunisation programme for school age children. Ensuring children are offered and receive vaccinations is a fundamental aspect of public health. It helps to promote individual wellbeing and community resilience against preventable diseases.

The Public Health team work closely with school nursing to ensure children are offered vaccination in line with the routine schedule. There is also close partnership working when dealing with infection disease outbreaks and catch-up programmes. Recent examples of work include the Welsh Health Circular to promote full Measles Mumps Rubella (MMR) vaccination (2 doses) uptake to 90% in all schools; and the tailoring of ongoing catch-up campaigns geographically in response to a measles outbreak.

Graph 9 shows the comparison from 22/23 to 24/25 for MMR immunisations.

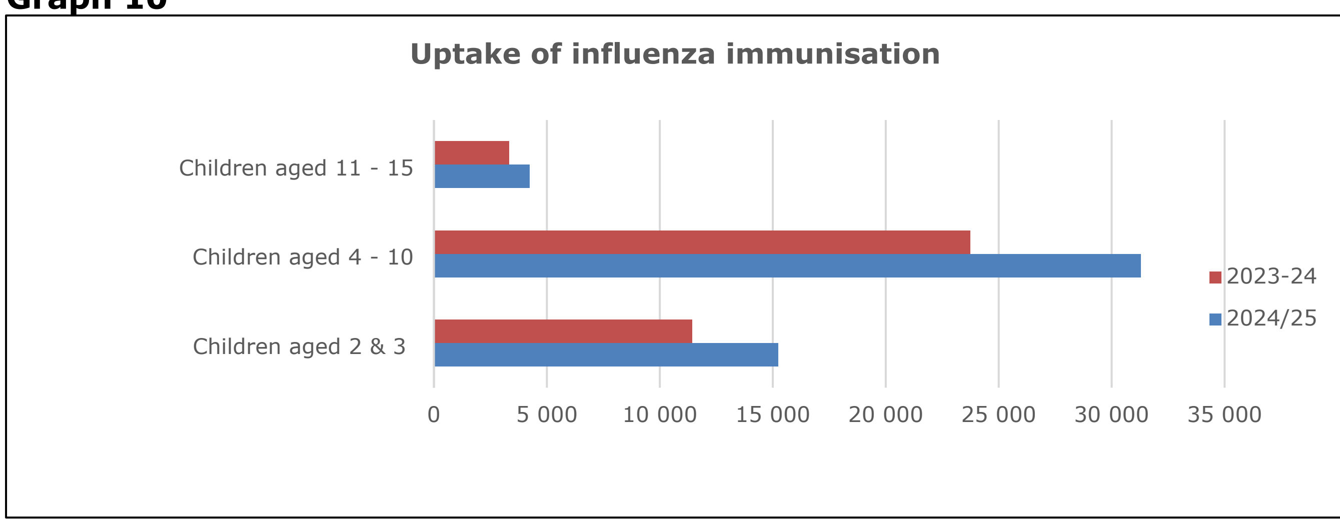
There has been a significant increase of 203 additional children being administered the vaccine from 22/23 to 24/25.

Graph 9



Graph 10 shows the uptake on influenza immunisation until 22/10/2024. The data evidence an increase in children being immunised for all ages when comparing 2023-24 with 24/25. With ages 4-10 increasing by 7,559.

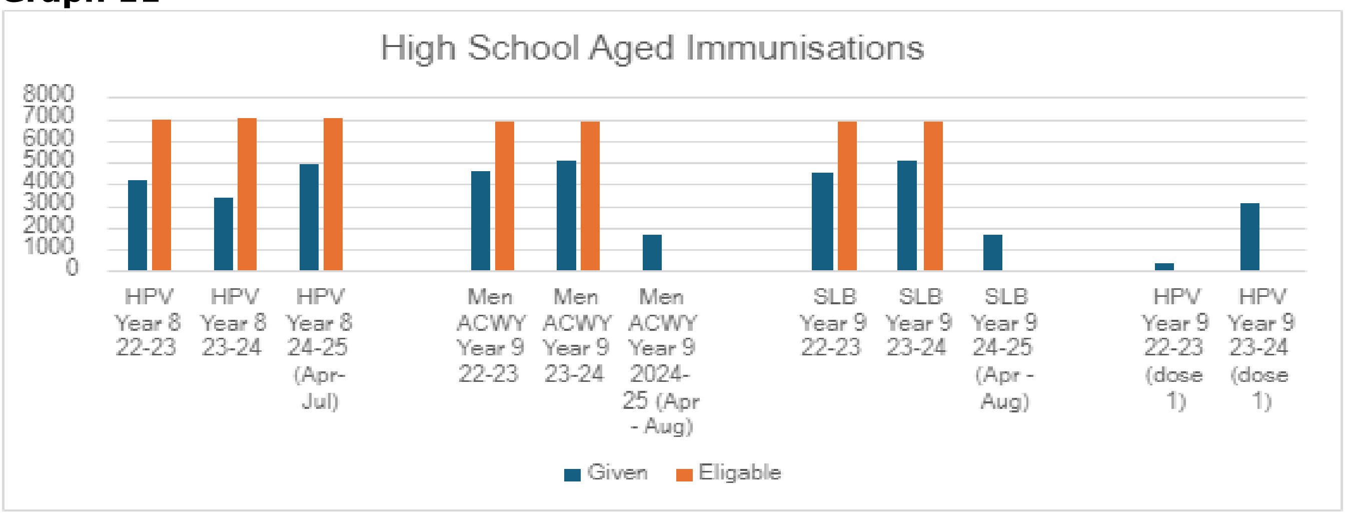
Graph 10



Graph 11 shows the comparison from 22/23 and 24/25 for high school aged immunisations. In 23/24 an additional 1554 Human Papilloma Virus (HPV) Immunisations were administrated.

An additional 1013 school leavers were administered with Meningitis (MenACWY) vaccines; for 24/25 this programme of vaccination remains ongoing.

Graph 11

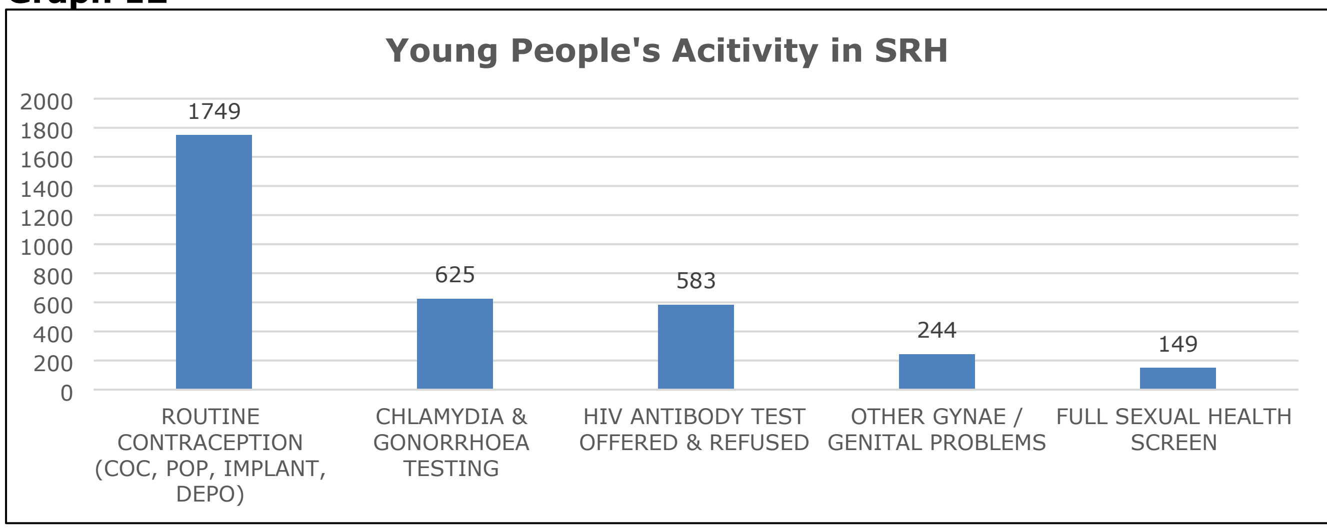


Sexual Health

Relationship and sexuality education is crucial for all children and young people to ensuring children and young people are empowered to make informed, healthy, respectful, and responsible choices about their sexual health, relationships, and wellbeing. An overview of the services accessed in the Sexual Reproductive Health Service (SRH) is outlined below.

Graph 12 provides a snapshot of young people's (18 and under) activity in Sexual and Reproductive Health, from October 2023 to October 2024. The data shows the highest area of activity is Routine Contraception with 1749 children accessing the service.

Graph 12

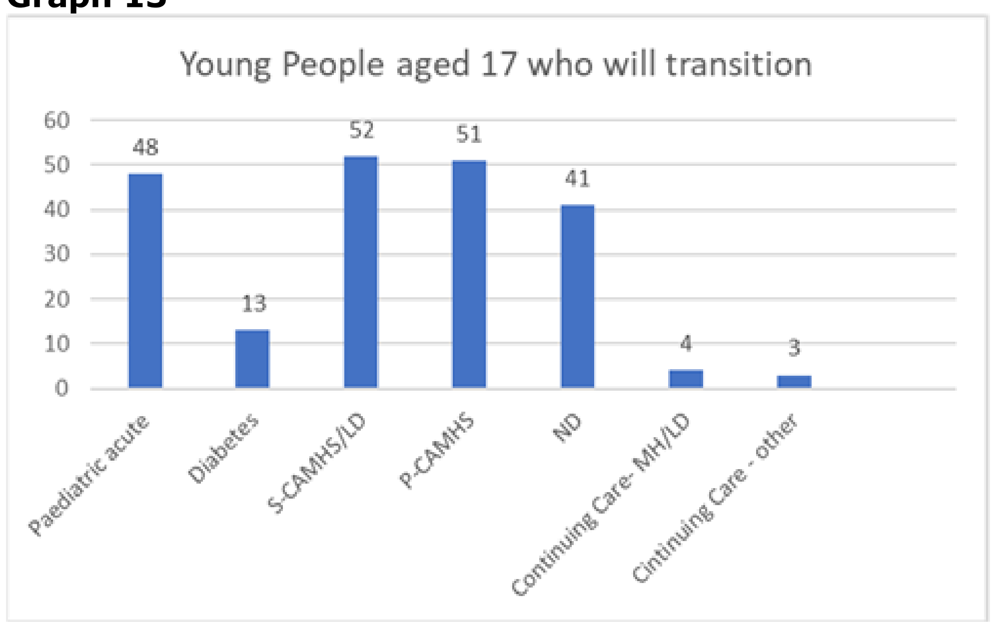


Transition

The handover of care and accountability from children to adult services has been highlighted as a key priority for improvement (i.e., WG transition guidance 2022) The 2016 NICE guidance on transition should be used by all health services.

Graph 13 shows the number of young people aged 17 expected to transition across key services. The Family and Therapies Division will be taking forward a programme of work around transition led by its Partnership Manager and Assistant Head of Nursing over the next 12 months. This programme of work will ensure transition will adhere to the 5 key principles of the children's rights approach as outlined by the Welsh Government.

Graph 13



2.1. Range of initiatives put in place to support children of school age and transition

The school nursing service launched **Chat Health** in July 2023 offering school age children a confidential point of contact to discuss concerns. There has been a total of 127 complete conversations plus drop-in sessions. Currently, the top themes are Immunisation queries and concerns, Self-Harm and Anxiety.

Public Health in collaboration with sexual health provides training to school nursing staff on the **C-Card Scheme** which is operating in several schools across Gwent. The C-Card Scheme is aimed at young people between 13 to 24 years old who can register to receive free condoms, information and advice.

Community Psychology is currently offering schools **Circle of Security** classroom programs to help teachers relate to children and young people in an attachment and trauma informed way.

Cynefin is a team of highly skilled Clinical and Educational Psychologists who have developed a series of training offers for schools based on the 5 elements of wellbeing. They have also developed expertise in inquiry-based models to support schools in creating cultural change.

3. Safeguarding Vulnerable Children

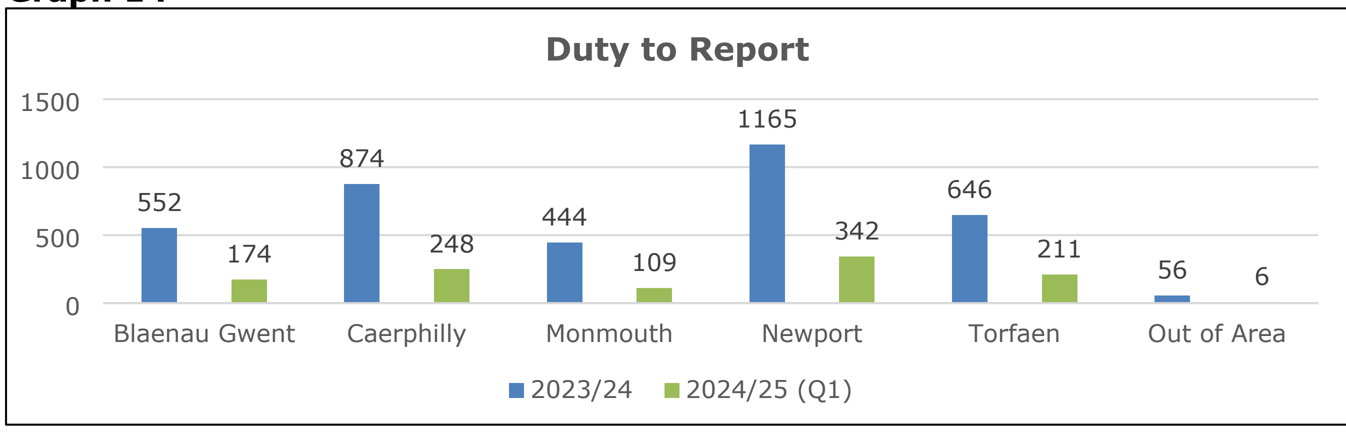
A vulnerable child is one who has been identified as being at greater risk of experiencing physical or emotional harm or one who is at risk of achieving poor outcomes. The Health Board works closely with its Local Authority partners to ensure this cohort of the population are protected and provided with the right support.

Older children are more likely to show the effects of disruption in their lives through under performance at school, poorly developed social networks, self-harm, running away and engagement in anti-social behaviour.

The graphs 14 to 19 present, where possible, a breakdown of safeguarding activity for the year 2023/24, alongside Q1 of 2024/25. Comparisons with 2022/23 reveal a rise of over 65% in referrals and strategy meetings, with Q1 data indicating that this upward trend in activity is continuing. Alongside the increase in activity, there is a marked increase in the complexity of these cases, which follows a national picture.

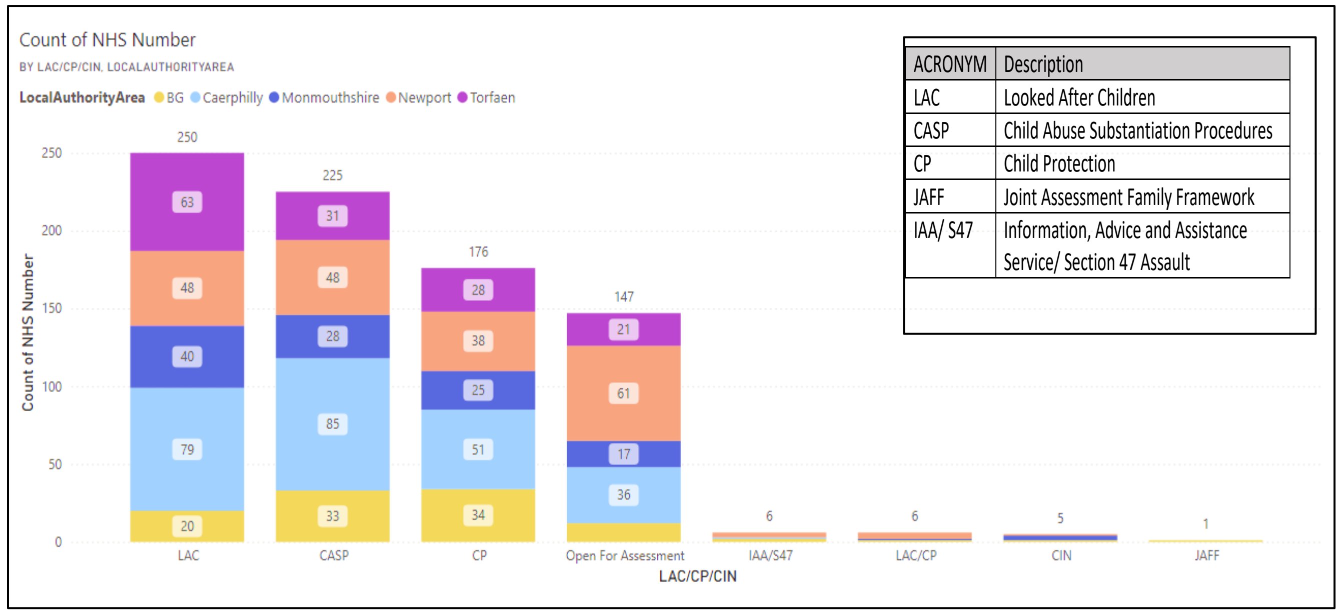
Graph 14 provides an overview of the numbers of referrals made professionally by the Health Board to Local Authorities in relation to safeguarding concerns. The highest levels of referrals are in the more deprived areas of Gwent.

Graph 14



Graph 15 shows the current Child Protection status of children broken down into Local Authority areas within Health Visiting. The data shows there is only 25 more Looked after children (LAC) compared with those with a Care and Support Protection Plan (CASP).

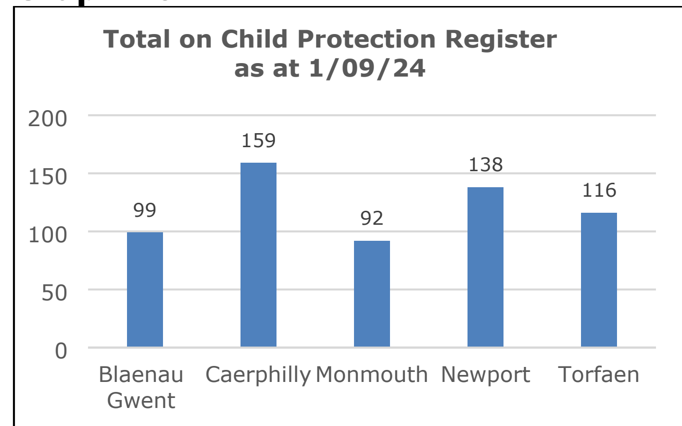
Graph 15



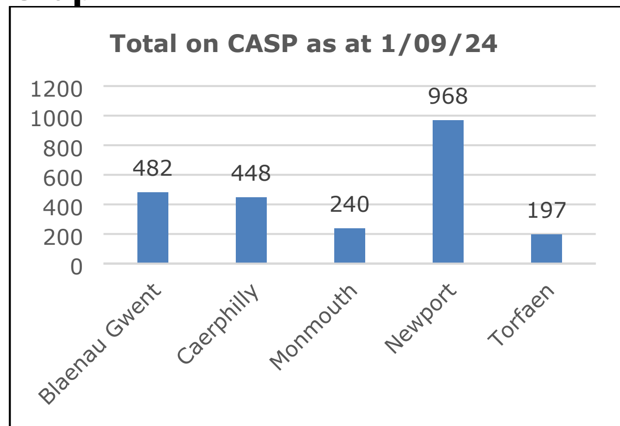
ACRONYM	Description
LAC	Looked After Children
CASP	Child Abuse Substantiation Procedures
CP	Child Protection
JAFF	Joint Assessment Family Framework
IAA/ S47	Information, Advice and Assistance Service/ Section 47 Assault

Graphs 16 and 17 show the data relating to those children on the Child Protection Register and on support plans. The provided data evidences the high number of children managed by professionals.

Graph 16

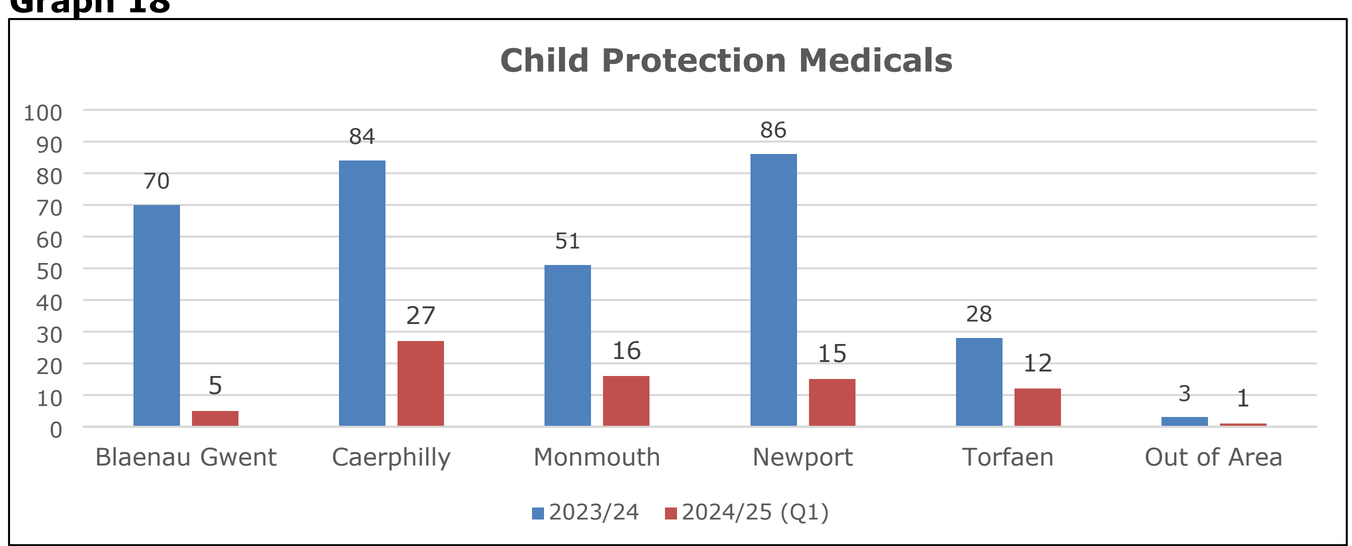


Graph 17

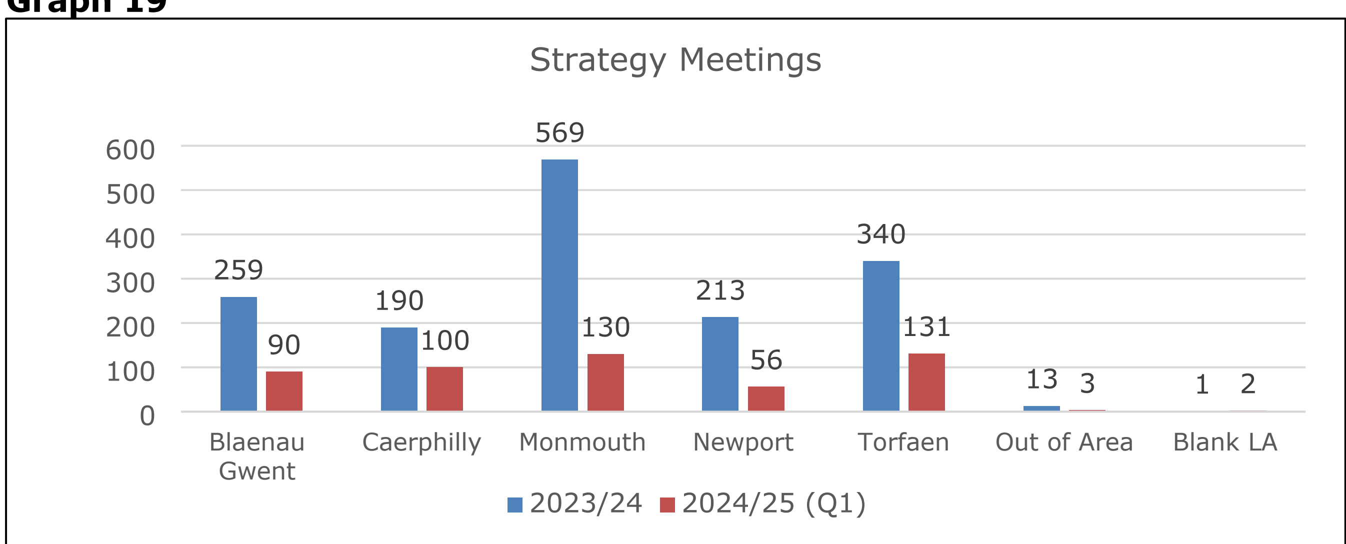


Graph 18 shows the number of child protection medicals undertaken to look for signs of a child being neglected or abused.

Graph 18



Graph 19



It is difficult to quantify the reasons for increased referral activity and the increase in strategy meetings, as in part this will be due to increased awareness of safeguarding.

However, it is unlikely that this would be the sole reason for the increased activity, with matters relating to the financial pressures on families and the increase in safeguarding concerns away from the family home (contextual safeguarding) relating to exploitation and substance misuse.

Review of 2023/24 data has highlighted that the fastest growing area of children's safeguarding is in relation to criminal exploitation.

The number of children believed to be engaged actively by organised crime groups within the Gwent area is rapidly approaching one hundred. In these cases, multi-agency work is key both in the detection and management of these cases, with regular multi-agency meetings now in place for each of the five boroughs.

Further areas of concern are in relation to the use of vapes "spiked" with Delta-9-tetrahydrocannabinol (THC) and the use of Lean (a mix of codeine, cough syrup and fizzy pop). Both substances, used by young people, have led to attendances in urgent care. Education has been provided to urgent care to ensure that any attendances of these type are recorded as a safeguarding concern and a Duty to Report raised. In addition, the safeguarding team is now pulling together a monthly report highlighting the volume of these incidents, which is shared with Public Health.

Looked After Children (LAC)

Looked after children services deliver more specialist services to children in care for either a short while or, in some cases, until they reach the age of 18 and beyond. They provide an initial health assessment which is reviewed regularly and provide onward referral to other professionals as well as general support around a range of issues such as safe sex, healthy eating, relationships etc

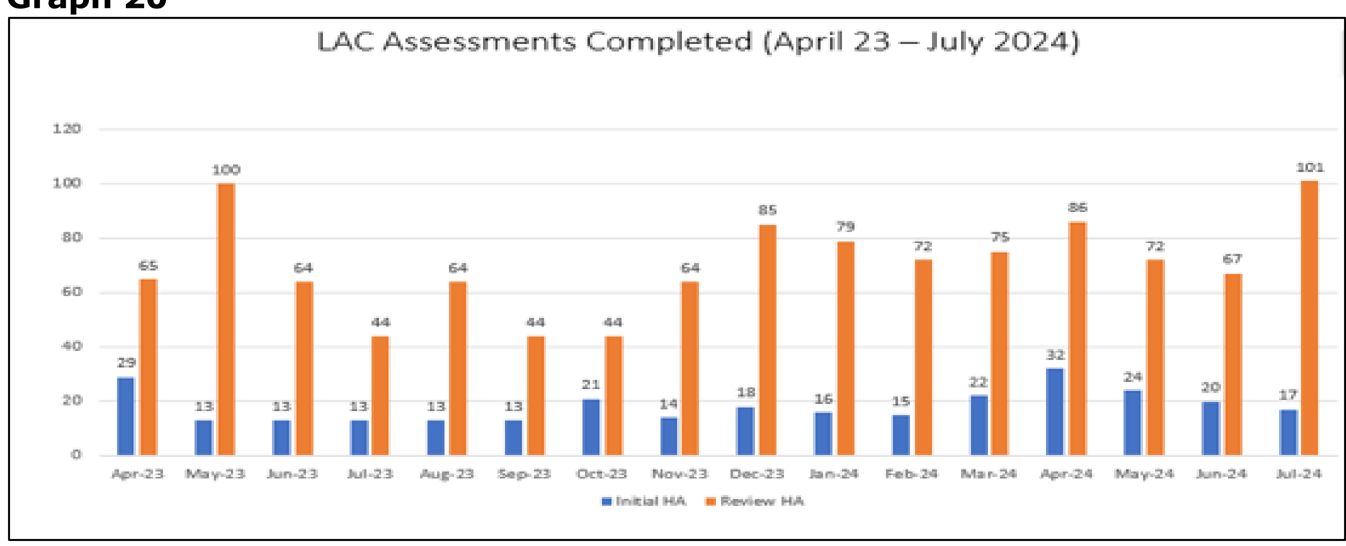
However, research provides an insight into how these children's experiences before and during care makes them a particularly vulnerable group of young people. Many

children who enter care have been abused, neglected, or experienced other forms of trauma.

There are currently 1645 children and young people looked after by local authorities in Gwent. The Looked After Children`s Nurses complete initial reviews and undertake holistic health assessments in line with statutory requirements. The goal is to identify unmet health needs and provide enhanced interventions and signpost to services. Outstanding assessments that built up during COVID have continued to decrease by 72% since 2023.

Graph 20 shows the number of LAC assessments completed by the School Nursing team from April 23 – July 24.

Graph 20



3.1. Initiatives in Place to Support Vulnerable/Looked After Children

Lead Nurses for Vulnerability (LNV) provide enhanced additional support to staff working with a high intensity of vulnerable and complex families within Deprived Flying Start areas, this is provided through school nursing and health visiting with vulnerable leads identified in each locality in Gwent. All work closely with their equivalent leads in Local Authorities. They support teams with supervision, protection procedures, referrals, court appearances as well as training.

Specialist Health Visitor for the Intensive Support Team - The role sits within the intensive support team of Caerphilly Children's Services. It was developed to meet the Welsh government's objective of reducing the number of children becoming looked after and babies being born into care.

Homeless/ Refugee – A Specialist health visitor is in place to support homeless and refugee families making sure health needs are met.

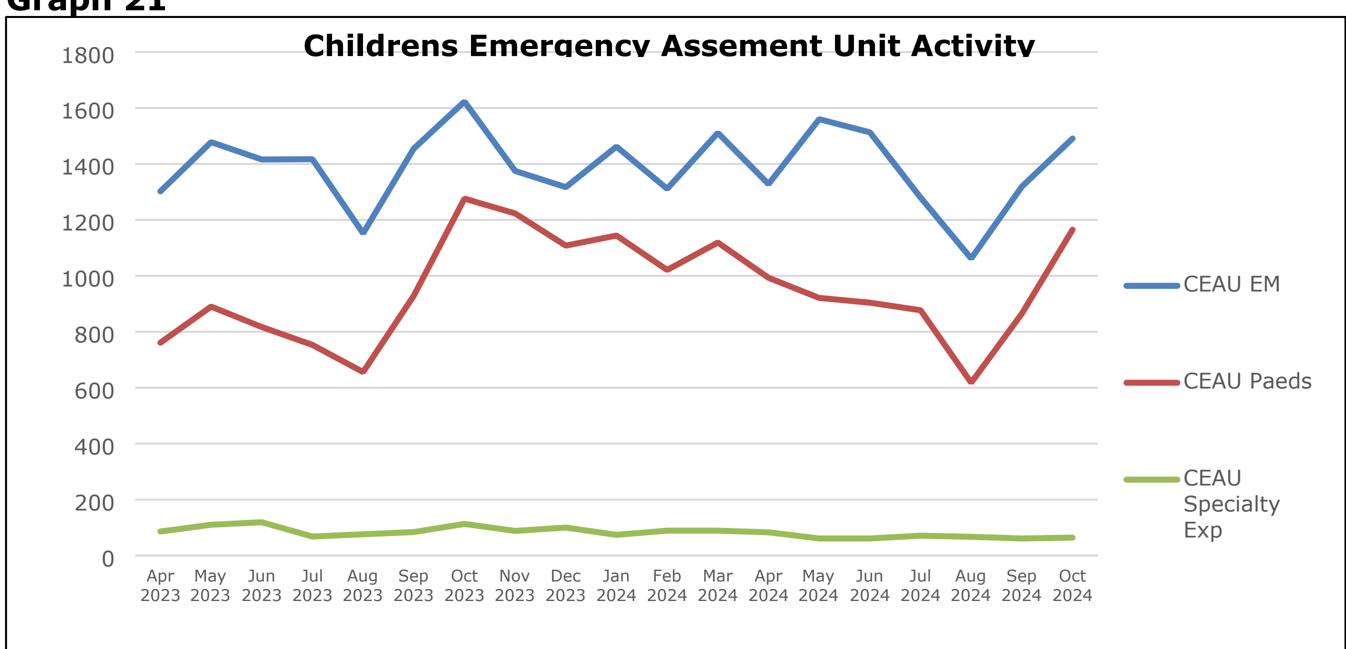
Roma Travellers Specialist – A health visitor has been appointed for Newport to meet the health needs of Roma Traveller families.

4. Children's Waits

Health Board Waits

Graph 21 shows the paediatric activity through Children's Emergency Assessment Unit (CEAU). There is a clear seasonal flow with most activity relating to bronchiolitis, asthma, viral infections and tonsilitis. The service capacity has improved following the introduction of GPs having the option to speak to a paediatrician rather than refer to CEAU which results in out of hospital management of children being put on an outpatient list.

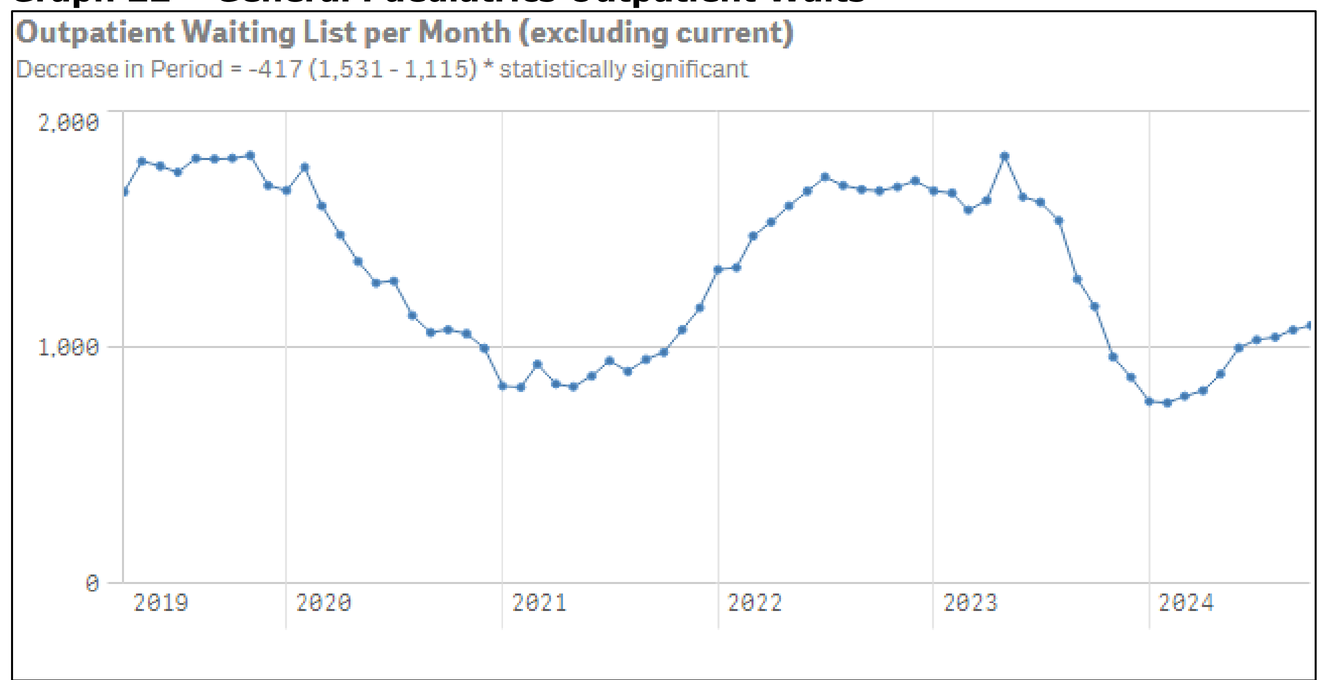
Graph 21



New outpatient waits have dropped significantly over the last year resulting in the service meeting its 26-week RTT target (currently 17 weeks). This is due to referral clinical triage (only a third of referrals convert to an outpatient appointment) and the use of Consultant Connect for the provision of advice rather than onward referral.

Graph 22 shows the outpatient waiting list. Follow up outpatient activity isn't coded however, from a clinic perspective, follow up activity falls mainly within asthma/allergy, cardiology SPIN (Special Interest) and Tertiary:- Cystic fibrosis, endocrinology, thyroid, inherited metabolic, nephrology, diabetes, epilepsy, gastroenterology, neurology, neonates and neonatal murmur.

Graph 22 – General Paediatrics Outpatient Waits



Further work is required to improve waits for follow up outpatient appointments. Overall, the longest wait is 120 weeks not booked and 79 weeks booked. Follow up outpatient activity isn't coded however from a clinic perspective, activity falls into the following areas and the longest waits are normally for very complex physical needs sometimes because of premature birth, behavioural difficulties, and neurodevelopmental needs. It is also dependent on the waits for specific consultants and their caseload.

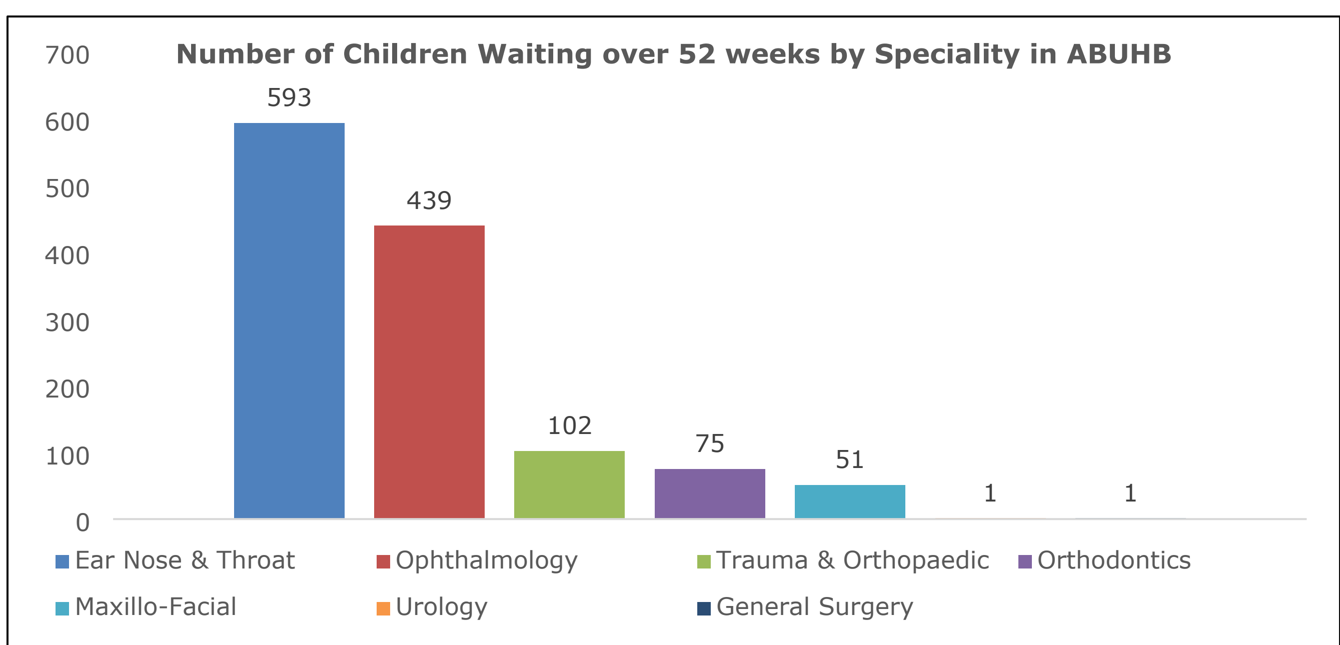
Graphs 23 and 24 show the Health Board inpatient waits for paediatrics. In relation to the specialties with the longer waiting times these are:

- Ear Nose and Throat (ENT) services: ENT are introducing an additional 1000 slots by the end of December 2024 which will reduce the number of children waiting over 52 weeks (142 children) in outpatients. From an inpatient perspective ENT has 44 children waiting over 104 weeks for treatment. The pressure points relate to theatre capacity, criteria for listing, and with access to appropriate facilities to recover children in the Royal Gwent Hospital. These will be a key priority to clear by March 2025.

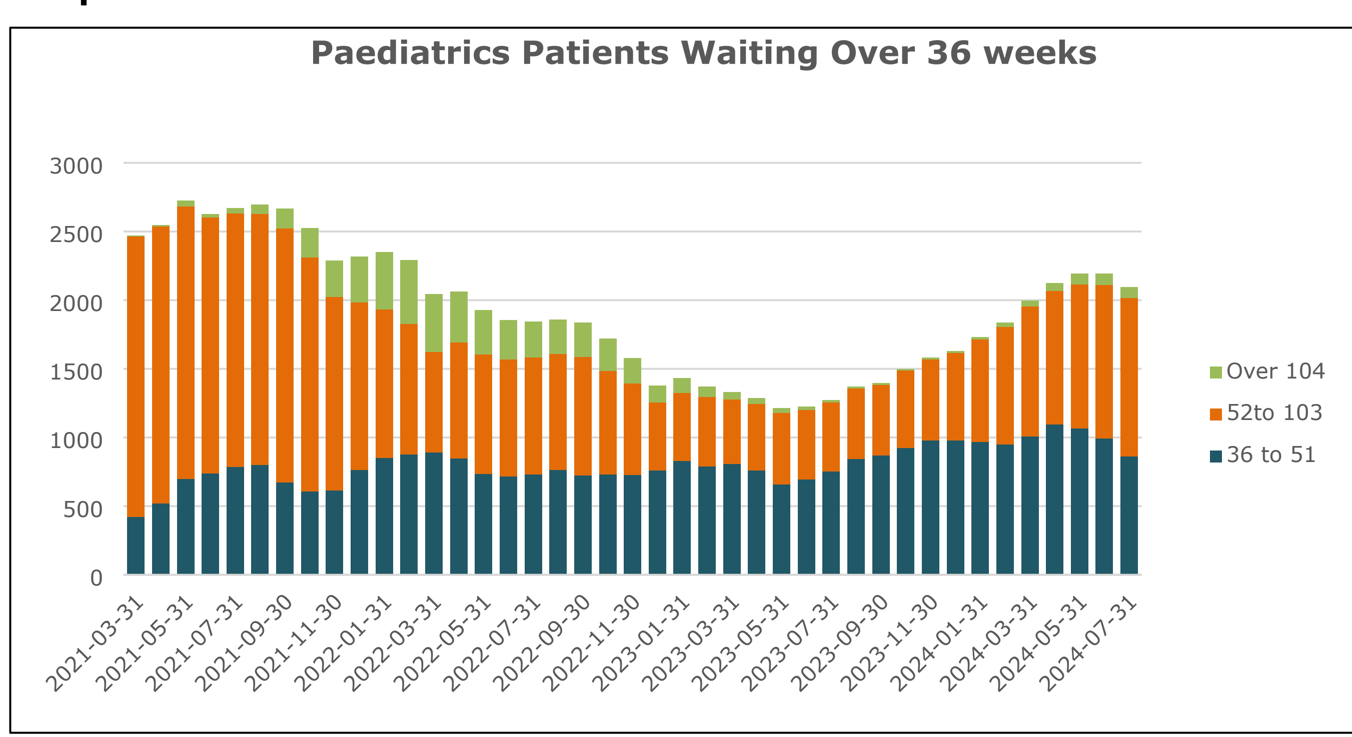
- Ophthalmology: this service currently has 1 WTE Paediatric Consultant vacancy but is using Orthoptists, Optometrists and Registrars to meet some of the demand. The service has also increased its Paediatric theatre capacity and is working with its consultants to create all day theatre lists.

- Trauma and Orthopaedics (T&O): T&O services are utilising Welsh Government recovery funding to run additional clinics. This will enable the team to bring the waiting list for routine appointments down to 26 weeks and urgent appointments down to 6 weeks. Orthopaedic Paediatric theatre capacity is challenged by constraints at the Grange University Hospital, including adult trauma cases taking precedence over paediatric elective lists. Anaesthetics, Paediatrics, Theatres and Orthopaedics services work collaboratively to ensure the theatre capacity is fully utilised.

Graph 23

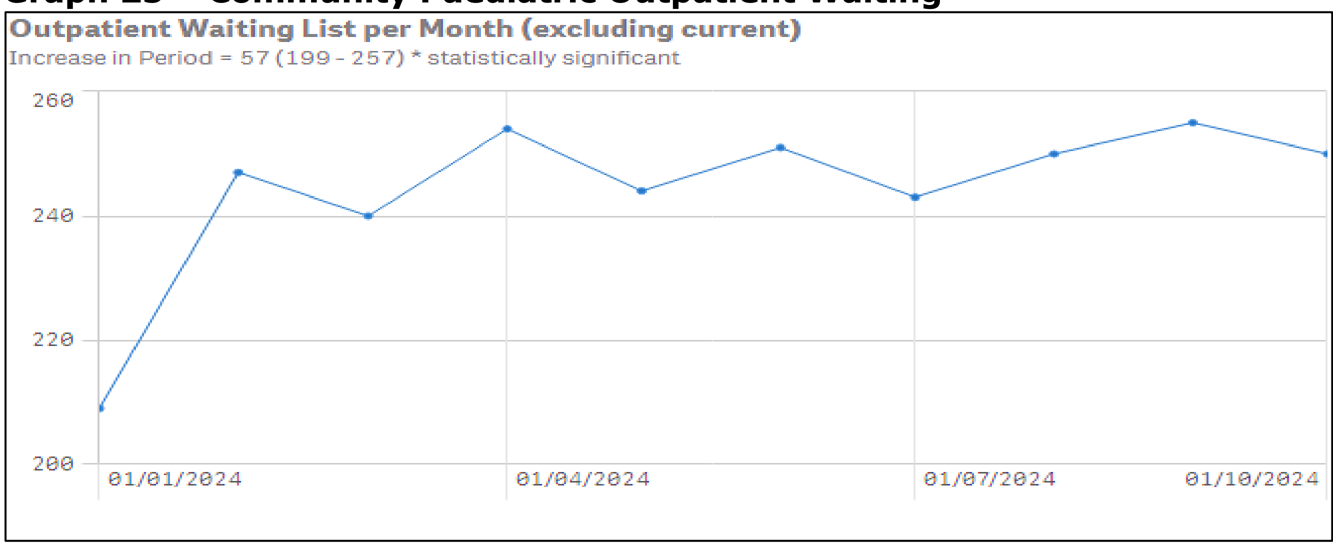


Graph 24



Graph 25 shows outpatient waits for community paediatrics. This remains a considerable pressure point for the Division because of the demand for adoption/ fostering medicals, under 5 neuro diversity assessment and general waits. Overall, the longest wait for a new outpatient is 54 weeks and 86 weeks for follow up. The waits across the localities are long and inequitable and is a key priority area of focus. A detailed plan is being developed to review the waiting times and see how they can be reduced through a number of measures including the development of a case for additional Community Paediatricians (this requires benchmarking with other organisations) and to identify if any of the work currently undertaken by Community Paediatricians can be undertaken by General Paediatricians.

Graph 25 – Community Paediatric Outpatient Waiting



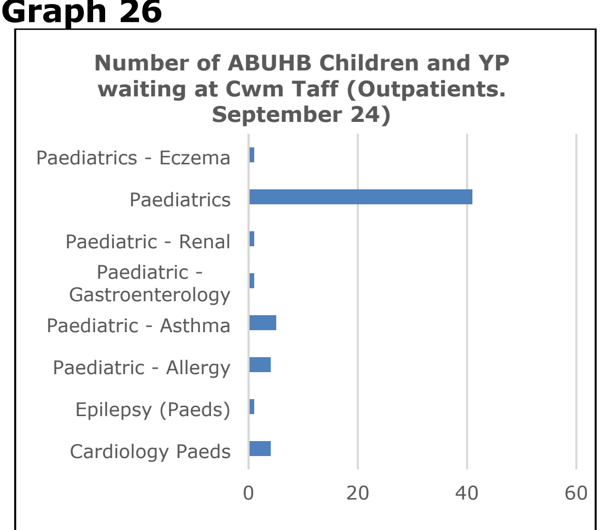
External Commissioned Services

Graphs 26 and 27 show the number of children waiting for the Health Board's two main commissioned services. Whilst Health Board clinical teams are not actively involved in the commissioning process, any key issues are discussed through contract meetings. Currently, there is a lack of information on wait times for children accessing external services, despite efforts to obtain this data. The Health Board operates without a dedicated commissioning function, relying solely on contracting. Implementing a more structured commissioning approach for external contracts would offer several benefits:

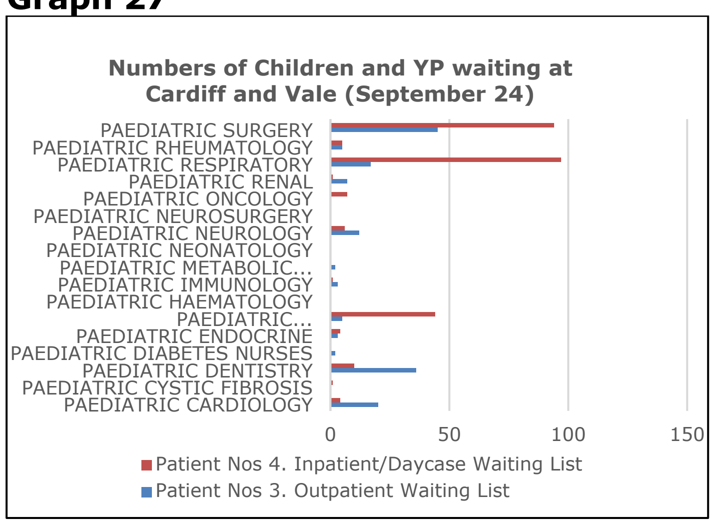
- Enhanced accountability for service providers
- Increased clinical involvement in evaluating services procured outside of the Health Board
- Improved scrutiny and challenge of existing contracts
- Better understanding of opportunities to repatriate services and expand our internal service provision

A formalised commissioning process would strengthen the Health Boards ability to manage and optimise external healthcare services and to improve quality and safety and this is being followed up as part of the new quality for commissioning approach.

Graph 26



Graph 27



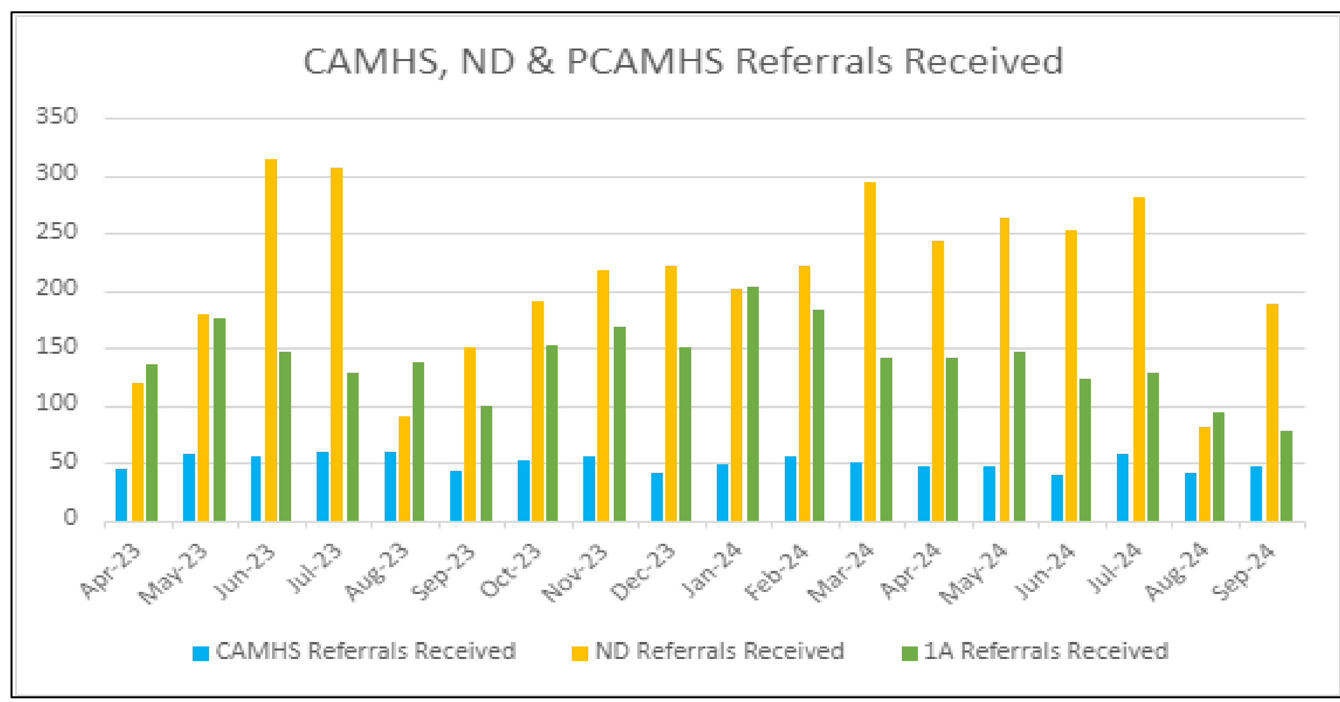
CAMHS (Children and Adolescents Mental Health Service)

A public health approach can support the work of CAMHS given that the strengths and issues for children and adolescents are based upon interactions between their internal genetic/biological predispositions, as well as their family, community, school, and societal environments.

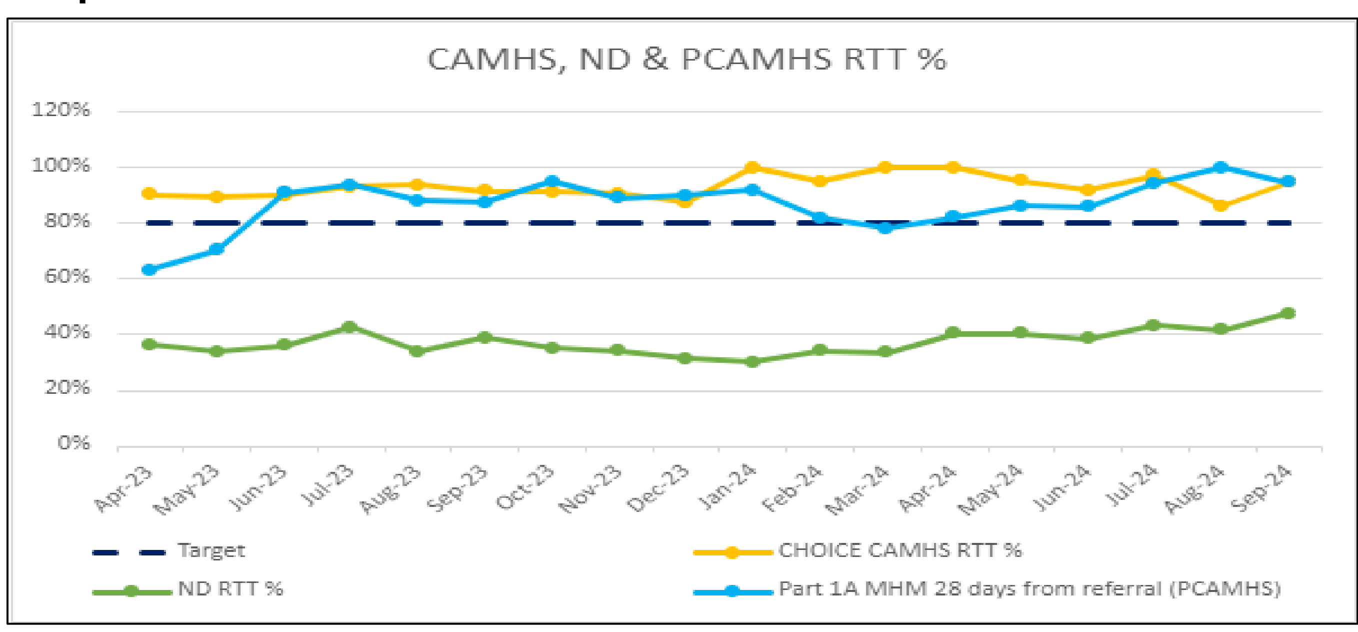
The Health Board offers a fully integrated CAMHS approach in Gwent that ensures that children and young people with mental health difficulties receive comprehensive, coordinated care. Facilitated through the single point of access - SPACE Wellbeing - this integrated model enables seamless collaboration among professionals leading to improved outcomes, including reduced hospital admissions, increased mental health and emotional well-being support, and better school attendance for children and young people. However, the service has been under sustained pressure and has struggled to meet Welsh Government targets for some of its services, primarily Primary CAMHS (PCAMHS) and Neurodevelopment (ND) services for under 5-year-olds. This is demonstrated in the graphs below.

CAMHS Waits: October 23 to September 24

Graph 28



Graph 29



Referrals to CAMHS via SPACE Wellbeing must be allocated within 28 days, while PCAMHS appointments should be completed within the same time frame to meet the 80% referral to treatment (RTT) target. The CAMHS Choice RTT includes patients still waiting for allocation or with upcoming appointments, whereas the PCAMHS 1A RTT covers appointments completed within 28 days of referral. The measure for ND RTT is to see an improvement in compliance, from April 2023, compliance has increased to 47%.

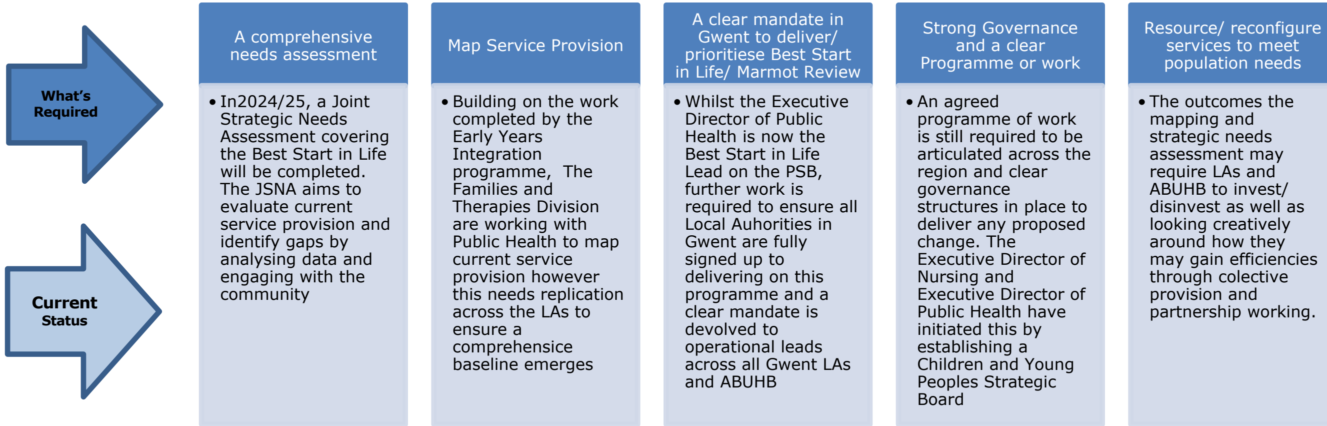
The CAMHS service has responded to the increased demand in a number of ways over the last 3 months including commissioning an external provider to deliver services (40 referrals a month), dispersing the demand to other services (150 cases), implementing a new clinical model for PCAMHS and screening referrals for children over 5-years-old waiting for ND services to increase access. There continues to be limited capacity in the under 5-year-olds ND service which is an identified risk for the Families and Therapies Division. However, it is anticipated that the 80% target will be delivered by March 2025 for over 5 year olds, with further solutions being considered for under 5 years.

5. Developing an approach to service planning for children and young people

The analysis around key service areas for children and young peoples outlined in this report highlights areas of good practice and initiatives that extol the principles of the Marmot review i.e., sustainable, integrated and meets the needs of families at the right time, right place by the right person. The Early Years Integration Programme whose funding ended in March 2024 made significant gains in mapping service provision in conjunction with Local Authorities. The Health Board will strive to continue to build on this good work; however the need to balance quality and safety, priorities, and funding investment in many of these services can be challenging.

Further work has been identified including:

- A mandate and strong governance with a programme managed approach to ensure Local Authorities and Health Boards work collaboratively on the commissioning and provision of children and young people's services. The flow chart below highlights what is needed at a high level and what the current status is.
- Focus around key areas such as waiting times, transition, workforce sustainability.
- Effective planning, commissioning and delivery across health and social care and education for LAC and vulnerable children to prevent escalation of complexity.



The newly formed Children & Young People Strategic Board (C&YPSB) which met in September 2024 sets out to provide the infrastructure and governance to take this agenda forward. Working across all levels of care from the promotion of health & wellbeing through to referral for specialist care, the C&YPSB will oversee the development of children and young people services ensuring they are fit for purpose now and for the future, clearly aligned with the Health Board's CYP Strategy as well as ensuring the Health Board's commitments for CYP in the Public Services Board Wellbeing Plans are monitored and delivered. The C&YPSB will formally report through to the Executive Committee and to the Patient Quality and Safety Outcomes Committee for assurance. A copy of the Terms of Reference is outlined in Appendix 2.

Argymhelliad / Recommendation

The Board is further asked to **NOTE** the progress in relation to the improvements within children and young people's services and the next steps and the establishment of the Children & Young People's Strategic Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 2. Safe Care 3.1 Safe and Clinically Effective Care 5.1 Timely Access

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Getting it right first time for children and young people
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:	Acronyms detailed in body of report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Family and Therapies Divisional Management Team.

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**	Yes, outlined within the paper
• **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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Appendix 1
Supporting strategies

Children's Health and Wellbeing

Building a Brighter Future

- Maternity Services
- Promote Healthy Choices and Lifestyles
- Improving the quality of care provided by health services
- Integration of Services

Current Policies/Strategies/Legislation/Guidance

- A Healthier Wales
- Breastfeeding Five Year Action Plan
- Children and Young People's Plan
- Designed to Smile
- Digital Maternity Cymru Programme
- Early Childhood, Play, Learning and Care (ECPLC)
- Early Years Integration Transformation Programme
- Families First
- Flying Start
- Healthy Child Wales Programme
- Healthy Eating in Schools
- Healthy Weight: Healthy Wales
- Legislation to ban smoking in vehicles/playgrounds
- Maternity Care in Wales - A Five Year Vision for the Future
- Mental Health and Wellbeing Strategy 2024-2034 consultation
- National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges
- Nyth-Nest Framework
- The Right Way Principles
- Trauma Informed Wales Framework
- Wales: A Play Friendly Country
- Whole-school approach to emotional and mental well-being

Supporting Families and Children

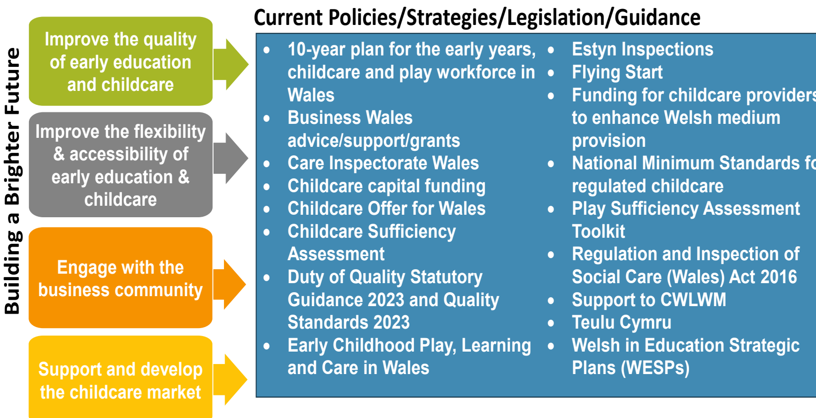
Building a Brighter Future

- Strong, supportive families and communities
- Helping parents engage in their child's learning
- Keeping Chilren Safe

Current Policies/Strategies/Legislation/Guidance

- Adult Learning in Wales
- Child Poverty Strategy
- Childcare Offer for Wales
- Community Focused Schools
- Education of disadvantaged children
- Ending Physical Punishment to Children legislation
- English for speakers of other languages
- FaCE the challenge together: engagement toolkit
- Families First
- Family Information Service
- Flying Start
- Healthy Child Wales Programme
- Housing Wales Act 2014
- Keeping Learners Safe Guidance
- National Independent Safeguarding Board
- Welsh language transmission and use in families
- Parenting give it time
- Raising the ambitions and educational attainment of children who are looked after
- Renting Homes Wales Act 2016
- Social Services & Well-being Act
- Social services national outcomes framework
- SLC: guidance for practitioners
- Talk with Me
- Teulu Cymru
- Welsh Housing Quality Standard

High-quality early education & childcare



Raising Standards

Llywodraeth Cymru
Welsh Government

Building a Brighter Future

- Strengthening regulation and inspection
- Developing the workforce
- Measuring progress

Current Policies/Strategies/Legislation/Guidance

10-year plan for the early years, childcare and play workforce in Wales
Childcare Act
Childcare sufficiency Assessments
Digital Maternity Cymru
Early Childhood, Play, Learning and Care (ECPLC)
Education Regulations
Estyn inspections
Flying Start
FRAIT
Healthy Child Wales Programme
Maternity Care in Wales: A Five Year Vision for the Future
National Minimum Standards for Regulated Childcare (NMS)
Qualification requirements for learning support workers in schools
NHS A Healthier Wales: Workforce Strategy for Health and Social Care
Schedule of Growing Skills (SoGS)
Schools causing concern - Statutory guidance
Speech, Language and Communication (SLC) Delivery Plan
Taking Oral Health Improvement and Dental Services Forward Framework
The Early Years Outcomes Framework
WASPI
WellComm

Appendix 2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD (ABU HB)

CHILDREN AND YOUNG PEOPLE STRATEGIC BOARD (C&YPSB)

TERMS OF REFERENCE

1. INTRODUCTION

The Welsh Government expects Local Authorities, Local Health Boards and their partners, including third sector, to focus on outcomes for children and young people and to ensure that all their partnership working is safe, effective and person centred for children and young people. Children and Young People's (CYP) agencies/partners are accountable to one another for the delivery of all services for children and young people in their area and are expected to hold each other to account collectively as a partnership as well as individually as organisations.

The purpose of the Health Board Children & Young People's Strategy Board is to ensure the delivery of safe, effective, and person-centred care for children and young people. This will be across all levels of care from the promotion of health & wellbeing through to referral for specialist care. Services will be developed for children and young people that are fit for purpose now and for the future, clearly aligned with the Health Board's CYP Strategy and ensuring the Health Board's commitments for CYP in the Public Services Board Wellbeing Plans are monitored and delivered.

2. STATUTORY RESPONSIBILITIES

2.1 Remit

The Children & Young People's strategy board is the Aneurin Bevan Health Board strategic board for the planning and oversight of the delivery of the Children and Young People's services. Specific remit includes:

- Overseeing CYP risks, ensure appropriate escalation and prioritised actions;
- Ensuring an effective audit and review plan with clear reporting and escalation processes;
- taking forward the Health Board's commitments for CYP in the Gwent Regional Partnership Board Area Plan and Wellbeing Plans;
    - ensuring the delivery of a highly engaged approach which involves citizens, partner organisations and clinicians, to deliver health improvement and inequalities agenda to improve the health and wellbeing of Children and Young People;
    - To develop, and monitor compliance against a clear set of HB and multi-agency performance indicators in relation to CYP feeing into the Regional Children & Families Board;
- Contribute to effective planning on CYP services that align to IMTP / Annual planning priorities;
- Provide assurance on the Quality and Performance of Health Board provided and commissioned services
- Oversee the CYP elements of the HBs Annual Quality Statement;
- Ensure the involvement of children and young people and their families in the development and implementation of the plan.

2.2 Responsibilities

- To monitor the delivery of the early years transformation plan
- To ensure a safe and effective system that will support the strategic direction of developing rights-based health and social care in keeping with the United Nations (UN) Convention on the Rights of a Child across all relevant HB services.
- To share and debate developments, whether corporate or locally led, specifically related to the rights of the child to improve outcomes for children and young people and their families/carers and to improve access to services.
- To lead on the development of a Health Board implementation plan for the CYP commitments contained within the Public Services Boards Wellbeing Plans and RPB Children's Area plan.
- To monitor the implementation of the Child & Adolescent Mental Health Services Delivery Plan and related action plans from the Emotional Health and Wellbeing Planning Group.
- To monitor the quality and safety of care within commissioned and provided services for children and young people
- To produce timely high-quality plans for inclusion in the IMTP which directly address population needs, inequalities in health, local issues of clinical safety and quality.

- The Board may form subgroups to identify priorities, measures and alignment into all IMTP.
- Contribute to the IMTP Planning group to include representative from CYP Strategy group to ensure CYP focus.
- To make recommendations for approval by the Board on changes to systems/pathways which deliver prudent healthcare principals and support the health board to deliver effective & efficient services.
- Ensure Youth feedback is incorporated into core functioning of Health Board
- Provide oversight of the transition to Adult Services for Children and Young People.

2.3 Legislative Requirements

- To ensure that the Health Board complies with the statutory requirements of the Children Act 2004 Sections 25(8), 26(5) and 27(4) of the Act deal with local co-operation and leadership of change.
- To ensure that any safeguarding issues are submitted to the Safeguarding Committee for discussion and resolution to comply with Section 28 of the Children Act 2004.
- Looked after children – Corporate Parenting Charter

2.4 Partnerships

To lead the development of a robust, system wide implementation plan to support the overall CYP Strategy and to progress priority setting through horizon scanning & Planning with partners.

3. MEMBERSHIP

Joint Chairman: Executive Lead for Children and Young People (Director of Nursing)
Executive Lead for Public Health (Director of Public Health)

Vice Chair:

Members: DECLO
Deputy Director of Nursing
Director of Strategy (Planning and Partnerships)

General Manager, Family & Therapies
Divisional Nurse Family & Therapies x 2

Divisional Director Family & Therapies
Head of Maternity Services
Head of Safeguarding services
Lead Consultant Paediatrician for Acute Services

Lead Consultant Paediatrician for Community Services
Head of Paediatric Speech and Language Therapy
Head of Paediatric Occupational Therapy
Head of Paediatric Physiotherapy
Head of Nutrition & Dietetics
Lead Nurse for School Health Nursing and LAC
Lead Nurse for Health Visiting
Consultant Psychologist in Child Health
Youth representative
Head of Children's services Newport, Torfaen, Caerphilly, Blaenau Gwent, Monmouthshire Local Authority's
Representative from Cardiff University & Cardiff University
Third Sector representative
Education Representative

In the event of a member being unable to attend a representative must be identified to attend who must be fully briefed and able to act under full delegated authority.

Co-option - Other attendees may be invited by the chair in order to meet the core deliverables of the group or respond to particular areas of risk or development.

Secretary: Director of Nursing Executive Assistant

Quorate - There should be at least six in attendance including: the Chairman / Vice Chairman; at least four Units; one therapist; and one partner in attendance for a meeting to be quorate.

Frequency - Meetings shall be held not less than quarterly and otherwise as the Chairman of the Group deems necessary.

6. MEETING ARRANGEMENTS

Notes will be circulated for accuracy within 7 days of a meeting being held.

Agenda Items and papers are to be sent to the secretary 10 days before the meeting.

All meeting papers are to be circulated 7 days before each meeting.

7. REPORTING

The Aneurin Bevan Children & Young People Strategic Board will formally report through to the Executive Committee and to the Patient Quality and Safety Oversight Committee for assurance.

Version:

Date Agreed:

Review Date:

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 November 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Clinical Futures Programme: The Grange University Hospital and Hospital Network Model**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Hannah Evans, Director of Strategy, Planning and Partnerships

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to provide a comprehensive overview of the system, patient and staff benefits realised since from the opening of the Grange University Hospital (GUH) and the operationalisation of the new hospital network in 2020.

The Board is asked to:

- **Note** The Grange University Hospital and Hospital Network Model report, and
- **Note** its onward submission to Welsh Government as part of the Health Board's Targeted Intervention requirements.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Following the opening of the Grange University Hospital (GUH) in November 2020, a "One year on" reflections report was presented to the Board in March 2022. This report set out progress and achievement during the first 12 months of operation of the Grange.

In February 2024, the Health Board was escalated to Targeted Intervention for Finance and Planning in line with the NHS Wales National Oversight and Escalation Framework. Through discussions with Welsh Government colleagues, a key deliverable within this escalation process was identified as an updated version of

this report, setting out the investments made into, and cost drivers associated with the new model and identifying any associated benefits arising from the reconfiguration.

The attached report has been developed in response to this ask, using the original "One Year on" report as a framework.

Cefndir / Background

The Investment Objectives for the Grange were confirmed in the Full Business Case (FBC). These are detailed below and form the framing of the report, with measures and narrative against each section which set out the extent to which these objectives have been realised.

1. Deliver access targets for both planned and unscheduled patient care in line with national targets for 2015 and beyond.
2. To achieve and exceed where possible minimum quality standards for health care service as outlined in National Service Delivery Frameworks, NICE and Standards for Healthcare for Wales to improve outcomes for patients
3. Improve the local provision of services and minimise travel times for access to health services and in particular, hospital and specialist services.
4. To deliver a fit for purpose environment for patients and staff which is NEAT and AEDET complaint
5. Support a workforce model that is sustainable and complies with the European Working Time Directive and Deanery requirements
6. To improve and expand provision of community-based alternatives to hospital services
7. To achieve and exceed where possible upper quartile performance on key performance indicators across all levels.

A robust process of investment considerations associated with the Grange and new hospital network was put in place and the investment decisions are summarised in the report.

Assessment

The Grange University Hospital opened in November 2020, four months ahead of schedule and within budget and was critical to the Health Board's response to meeting the population needs for the winter of 2020/21 in the context of the ongoing challenges of the Covid-19 pandemic.

The opening of the GUH also heralded new roles for the Enhanced Local General Hospitals (eLGHs) and the system of health care that connects them to each other, the community and the new Specialist and Critical Care services at the GUH.

Progress against the benefits associated with each Investment objective can be summarised as follows with more detail in the report:

Investment Objective 1: Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond

- System control managed through the flow centre – just 13% of calls through the flow centre result in ED attendance

- Majority of urgent care managed closer to home- MIUs respond to 51% of all urgent care demand and one of the best system wide 4hr performance of any Health Board with an ED in Wales
- Development of ambulatory care models- SDEC models delivered with an average length of stay through these units of fewer than 4 hours
- Separation of emergency and planned care flows- significant reduction in cancelled operations since reconfiguration and the lowest total numbers of patients waiting for treatment by population size
- Increased diagnostic capacity – nearly doubling CT/MR activity compared to pre-Grange

Investment Objectives 2 & 3: To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients and to achieve and exceed, where possible, upper quartile performance on key performance indicators across all levels.

- Improved clinical outcomes for the most seriously unwell patients – Improved Risk Adjusted Mortality and outperforming peers in key areas such as the Emergency Department and Stroke services
- Improved sustainability, quality and staffing in core services such as stroke, maternity and critical care
- Improved performance in clinical audit, outperforming peers in hip fracture performance, improvements in stroke, critical care and laparotomy
- Better than peer morality rates across MBRACE audit

Investment Objectives 4 & 5: To improve the local provision of services and minimize travel times for access to health services, and in particular, hospital and specialist services and to improve and expand provision of community-based alternatives to hospital services

- Navigation role of flow centre ensuring that only patients who need to come to GUH are directed there with just 13% of monthly calls directed to the Emergency Department at the Grange and 58% directed to sites or services other than the Grange and in local communities, eg MIUs, eLGHs or primary care
- MIUs supporting the local offer of the urgent and emergency care system though management of over 51% of all urgent care demand
- Development of eLGH services including: Development of Post Operative Care Unit in RGH, Breast Centre delivered at YYF, providing a one stop shop for Breast Cancer patients, and Satellite Radiotherapy Unit at Nevill Hall in partnership with Velindre NHS Trust

Investment Objective 6: To deliver a fit for purpose environment for patients and staff, which is NEAT and AEDET compliant

- The Health Board continues to have one of the lowest hospital acquired infection rates for Covid 19 and wider respiratory infections as demonstrated in the Public Health Surveillance data
- Since 2020 the Health Board has had lower or equivalent levels of infection with fewer spikes of outbreaks.
- Consistently lower infections as a rate per 1000 admissions at the Grange when compared with the other two large hospitals in Wales

Investment Objective 7: Support a workforce model that is sustainable, and complies with the European Time Directive and Deanery requirements

- Sustainability and improved safety achieved for staffing for Paediatrics and Obstetrics.
- Improved workforce resilience for Critical Care and ability to meet Covid demand within its own footprint.
- Improved workforce resilience through centralisation of additional investment in staff for Emergency Department, Respiratory, Gastroenterology, and within Emergency Surgery for many specialist consultant posts.
- Success in recruitment to hard to recruit roles such as cardiology and Interventional Radiology.
- New simulation facilities providing state of the art training alongside enhanced education facilities in the Grange.
- Turnover in the Grange is lower than all other sites, highlighting the benefits of enhanced facilities on retention

Financials
The report provides the detail on the financial assumptions and investments made and describes the changes or challenges to those assumptions throughout and post the pandemic including bed assumptions, variable pay assumptions and those relating to facilities.

There has undoubtably been progress in meeting the ambitions set out in the 2014 clinical futures business case;

- Service and workforce sustainability
- Service improvement and enhanced quality of care
- Modern functional estate and
- Wider system opportunities.

Staffing in core services such as critical care, the emergency department maternity and children's services are now more sustainable.
The Health Board is delivering improved outcomes as evidenced in clinical audit for the most seriously unwell patients.

There is greater resilience in services with flexibility and modern estates to meet the increasing demand and acuity of patient need.
There is also improved ability to innovate in the system to deliver new models of care closer to communities.

Whilst there is always more to do to drive further improvement and optimise the system there is significant progress in achieving the clinical futures ambition.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** The Grange University Hospital and Hospital Network Model report, and
- **Note** its onward submission to Welsh Government as part of the Health Board's Targeted Intervention requirements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk Register 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	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 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:	Data sets used and referenced throughout document

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:	Executive Committee
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

Clinical Futures Programme

The Grange University Hospital and Hospital Network Model

1. Introduction and Context

The Health Board's Clinical Futures Strategy has remained resilient and relevant for over a decade, and the opening of the new Grange University Hospital as part of a new network of hospitals was a fundamental milestone in the delivery of the broader strategy, and a key focus of the Health Board's agenda since its final approval in 2016.

This report provides an overview of how the system is operating over three years on from the opening of the Grange University Hospital (the Grange) and the implementation of the new hospital network, highlighting the benefits, challenges and financial implications of the Grange and the wider hospital system network.

2. The Case for Change Pre and Post Pandemic

The Grange had an approved final business case (FBC) in 2016 (original case 2014). The case was one of service and workforce sustainability with expected improvements in performance and clinical outcomes. The case required a significant capital investment of circa £350m and was assumed to be cost neutral on a revenue basis in the context of a 10-year financial outlook with assumptions around annual growth and saving requirements.

The objectives set out in the business case, reflect a case for change based in the following key system benefits:

- Service improvement and enhanced quality of care
- Service and workforce sustainability
- Modern functional estate and
- Wider system opportunities.

More detailed investment objectives were set out in the Business Case and included at Annex 1, these objectives fall under the following headings:

1. Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond
2. To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients
3. Improve the local provision of services and minimize travel times for access to health services, and in particular, hospital and specialist services
4. To deliver a fit for purpose environment for patients and staff, which is NEAT and AEDET compliant

5. Support a workforce model that is sustainable, and complies with the European Time Directive and Deanery requirements
6. To improve and expand provision of community-based alternatives to hospital services
7. To achieve and exceed, where possible, upper quartile performance on key performance indicators across all levels.

There have been significant achievements since the reconfiguration in 2020 against these objectives:

- ✓ Improved outcomes for the most seriously unwell
- ✓ Improved quality and safety
- ✓ Greater staffing sustainability in core services such as critical care and maternity
- ✓ Separation of planned and emergency activity
- ✓ Improved staffing and recruitment for essential specialties
- ✓ Greater resilience in services
- ✓ Ability to innovate within the system model

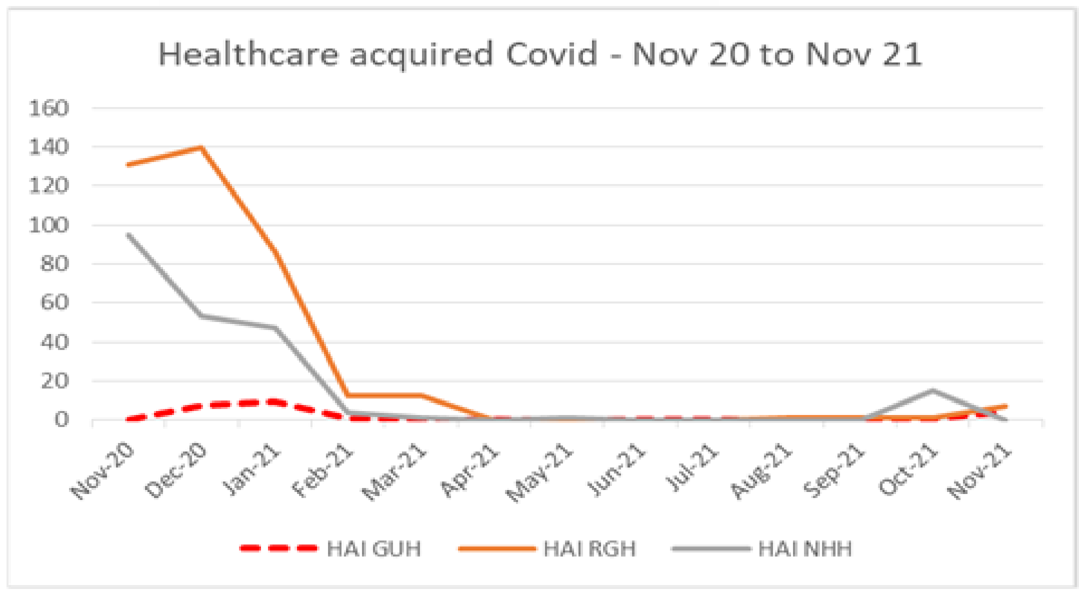
The report will explore these areas in more detail.

Pandemic Response

Intended to open in March 2021 after significant planning, the hospital was required to be opened four months ahead of schedule in November 2020 as part of the Health Board's response to the Covid-19 pandemic and the second wave that hit in the Winter of 2020/21 with the intent of achieving the following additional benefits:

- Enhanced service sustainability particularly for Women and Children's services which were facing significant risks,
- A new large critical care unit that provided the workforce benefits of centralisation and improved capacity plans ahead of winter and any further Covid-19 surges,
- Having an extra site with 75% single rooms would supplement the Health Board's winter response and infection control benefits,
- Significant additional oxygen capacity to ventilate patients in either a full critical care environment or using CPAP,
- Maximizing the transformation capability within the organisation,
- The opportunity to centralise several services to better utilise resource, creating economies of scale including the Emergency Department, Critical Care, Theatres and Women and Children's services,

The early opening of the Grange provided necessary resilience for the pandemic response. The 75% single room occupancy enabled significant improvement in hospital acquired Covid-19 rates, critical care capacity was enabled to respond to the demands of the pandemic and the Health Board did not require any field hospitals.



Whilst the new hospital and system model offered significant opportunities in the Health Board's response to the pandemic, the impact of early opening, the Covid-19 pandemic and the recovery challenges have had a significant impact on the ability to deliver and measure the benefits originally anticipated and within the financial envelope. Some key areas worth highlighting include:

3. System Demand and Context

The Full Business case for the GUH was based on a set of demand assumptions using 2015 as a baseline. Annual demand since 2015 had been above predicted levels with significant pressures across the health and social care system. New modelling had been undertaken as part of the refreshed planning post FBC approval. The impact of the pandemic further compromised the modelling assumptions which have seen unpredictable patterns of demand as we have moved through the different phases of the pandemic.

In 2024/25 there continues to be annual increases in the demand across most services including primary care and community services, urgent and emergency care, planned care, cancer services, Mental Health Services, Children services, women and children services and diagnostics. The challenges that this presents is significant at a time when we are trying to address the backlog of waiting lists, increasing acuity and public expectations.

- Increased demand in ED presentations to GUH and MIUs. Weekly attendances to ED and MIU was 2,300-2,900 pre GUH which is now well exceeded by weekly demand of 3,000-4,000.
- Increased demand of self-presenting patients particularly at GUH beyond those planned creating significant pressure on the Emergency Department. Self-presenter demand for the GUH via ED was predicted to average 167 attendances per day (pre-covid) the actual has ranged from 88-281 with periods regularly seeing 220 self presenters a day.
- Higher than predicted MIU activity at the eLGHs.

- Increased paediatric attendances and GP referrals above pre pandemic levels. Paediatrics have also rolled out Healthier Together, a tailored website for the public and professionals to understand pathways and appropriate access. With time, as these changes bed in, positive trends are now beginning to show.
- Increased demand and acuity for a number of key specialties such as Cardiology and Emergency Surgery
- All 3 eLGHs have seen a step change increase in MAU activity since April 2021, with a corresponding decrease in GUH MAU activity. This again indicates the system is moving closer in line as to what was originally designed as a decentralised medical assessment and admissions service away from the main ED. However the medical workforce challenges associated with a four site acute take model continues to present sustainability challenges.
- Beds occupied by patients over 21 days across the Health Board have been steadily increasing since March 2021 and currently sits at 650 and AVLOS is at its highest level since June 2016.
- Pathway of Care Delay (POCD) levels before the Grange opened were in the region of 150-200 and are now typically above 300.

It is also well reported that the Covid 19 pandemic worsened health inequality. The impact of this worsening health inequality can be seen in the demand on the Grange as noted in the recent GIRFT review of the Emergency Department. The review noted Emergency Department attendances were in the highest quintile of deprivation at 50.2% with an average age of admitted patient of 44 years, which is another indicator of high levels of socio-economic deprivation.

The Health Board is actively working to improve flow through its delivery programmes to optimise the performance and safety of the system.

4. Progress against Key Investment Objectives

This section outlines a more detailed assessment of delivery against the 7 Key Investment Objectives outlined in the Full Business Case (FBC). Concluding findings for each benefit are provided.

4.1 Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond

The opening of the hospital transitioned the Health Board to a new hospital system model focused on the Grange as a Specialist Critical Care Centre and Enhanced Local General Hospital Sites.

This model allows for development to happen across the system which derives benefit across the planned and urgent & emergency systems of care.

Urgent and Emergency Care

When the FBC for the Grange and systemwide change was developed there were key areas the Health board sought to improve against in the context of urgent and emergency care, The opening of the Grange and service model change coincided with broader demand changes across all healthcare systems and services due to the pandemic and the legacy of access issues that followed which has impacted on the organisation’s ability to fully realise the benefits.

The “new” model for urgent and emergency care centres around a flow centre model with around 4000 calls per month. Of those calls, just 13% are directed to the Emergency Department at the Grange and 58% are directed to sites or services other than the Grange. The remaining 29% are direct to appropriate departments in the Grange bypassing ED, such as Surgical Assessment Unit, Medical Assessment Unit and SDEC.

Minor Injury Units (MIUs) accommodate around half of all urgent care demand (51.2% so far in 2024) which reduces pressure on Grange and brings services closer to home. An additional investment of c.£0.8m was made directly to improve MIU performance post Grange opening and whilst there has been some service reconfiguration in the last 12 months, the MIUs are an important offer in the suite of urgent and emergency care services including a 24/7 service at RGH.

The MIUs support a strong systemwide 4-hour performance (with 97.8% four hour compliance as an average across the MIUs in October 2024 and 76.4% systemwide compliance in the same time period) – with the best systemwide 4-hour performance of any health board in Wales with an ED month on month (up to October 24).

This means that the Grange is focussed on the most acutely unwell patients. Recent audit work identified the vast majority of patients attending the Grange were in the appropriate place. The most recent on the day audit (carried out as part of the "GP at the front door pilot") identified just 2% of patients were "inappropriately" attending the Grange.

A recent GIRFT review of the emergency department noted a 22.5% attendance to admission conversion rate which demonstrates that there is not over-admission, particularly when the acuity score of the Grange is much higher than any other UK department due to the nature of separation of minor injury units. This demonstrates that from a signposting perspective, patients are going to the "right" place in the context of current service provision.

The GIRFT review also noted annual admissions per WTE ED consultants is 345 for the Grange against an average UK of 280. The GIRFT team also commented on the Grange environment noting it as one of the best in the UK in terms of facilities.

The new Clinical Futures model included c.£3.6m of additional urgent & emergency care investments to deal with, pre-assessment streaming, patient flow and discharge management. It should be noted that this list is not exhaustive given the nature of the services and inter-linkages across services.

Whilst there remains much to do to improve the efficiency and safety of the urgent and emergency care system, most notably under the auspices of the Enhanced Monitoring status, the environmental, control and separation of flows is having benefit to the urgent care system. The counterfactual (what would a system in 2024 in the pre grange configuration be delivering) is hard to quantify from a performance, safety and cost perspective. It is our view though that the increased levels of attendance and acuity could not have been met in the historic hospital footprint without the critical infrastructure and core staffing model. This is especially relevant when considering Resus demand and capacity. The Grange has 9 resus beds which is 50% increase on the previously combined Resus capacity with many occasions when Resus demand is close to exceeding capacity.

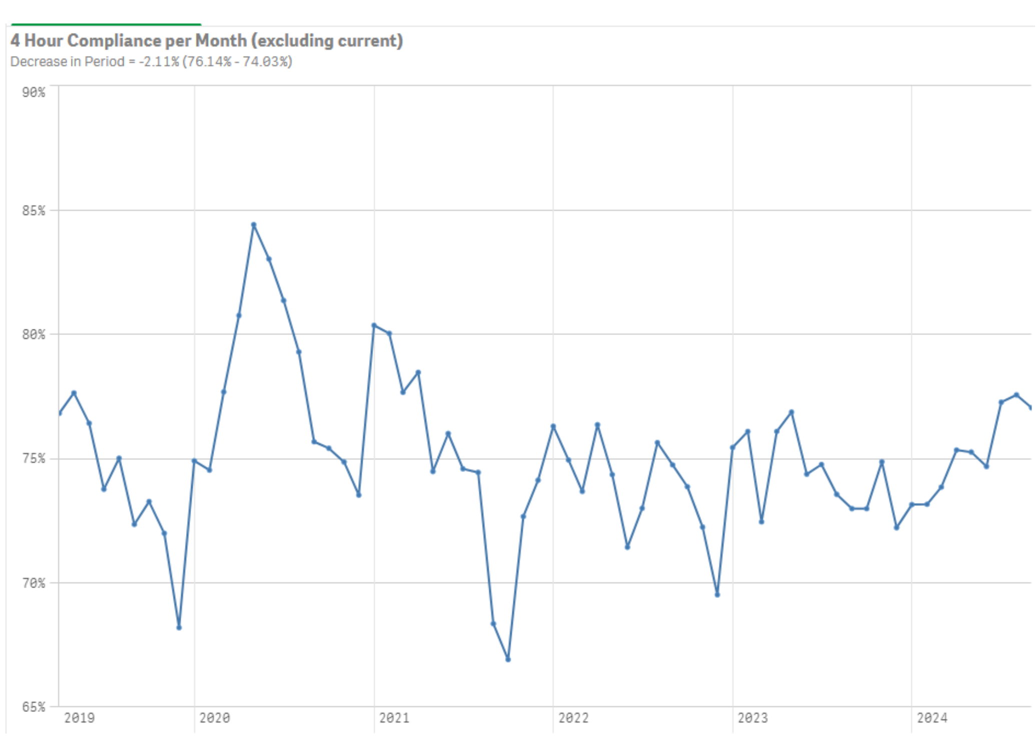
Notwithstanding the current escalation levels, the Health Board does perform comparatively and consistently well on 4 hour performance as demonstrated by the excerpt from national reports, currently the highest performing LHB (excluding Powys)

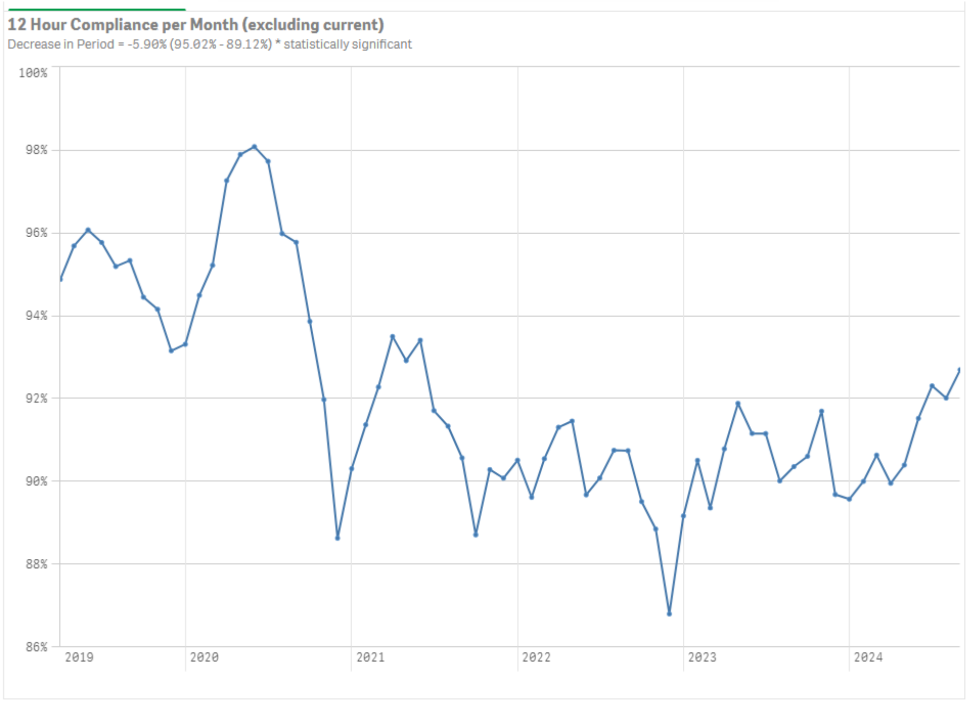
Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge															
LHB	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Target compliance	Rank
Wales	68.7%	69.5%	66.7%	68.3%	67.9%	67.8%	70.2%	69.7%	68.9%	69.3%	69.3%	68.4%	68.0%		-
AB	73.1%	75.0%	72.3%	73.2%	73.3%	73.9%	75.4%	75.3%	74.9%	77.4%	77.7%	77.2%	76.4%		2nd out of 7 health boards
BCU	67.3%	67.2%	63.7%	65.6%	65.3%	63.2%	69.9%	69.8%	67.3%	66.0%	67.1%	62.1%	61.4%		6th out of 7 health boards
C&V	66.8%	66.5%	63.9%	63.5%	64.4%	64.5%	64.7%	63.7%	62.6%	61.7%	60.0%	60.7%	61.3%		7th out of 7 health boards
CTM	62.4%	64.6%	60.7%	65.7%	63.7%	64.5%	66.1%	65.1%	64.7%	65.1%	66.6%	66.9%	67.0%		4th out of 7 health boards
HDda	65.9%	67.6%	65.7%	65.2%	66.2%	65.1%	65.7%	64.1%	64.9%	66.0%	66.2%	64.8%	65.8%		5th out of 7 health boards
Powys	99.9%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%		1st out of 7 health boards
SB	76.6%	75.3%	74.8%	76.6%	74.3%	75.8%	77.5%	78.1%	77.6%	79.1%	76.6%	78.7%	75.8%		3rd out of 7 health boards

Similarly in respect of 12 hour waits the Health board is performing relatively well:

Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge															
LHB	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Target compliance	Rank
Wales	9,933	8,623	9,632	9,939	9,590	10,304	9,650	10,514	9,987	10,163	9,471	9,726	10,159	🔴	-
AB	1,526	1,203	1,491	1,567	1,398	1,475	1,583	1,626	1,374	1,198	1,175	1,109	1,380	🟢	4th out of 7 health boards
BCU	2,999	2,928	3,201	3,093	2,888	3,338	2,943	3,058	3,136	3,507	3,151	3,354	3,253	🔴	7th out of 7 health boards
C&V	852	545	695	875	810	831	847	916	933	895	910	979	1,117	🔴	2nd out of 7 health boards
CTM	1,965	1,712	1,949	1,837	1,831	1,856	1,745	2,015	1,913	1,927	1,569	1,610	1,642	🟢	6th out of 7 health boards
HDda	1,362	1,235	1,285	1,583	1,446	1,655	1,521	1,745	1,623	1,592	1,466	1,546	1,532	🔴	5th out of 7 health boards
Powys	0	0	0	0	0	0	0	0	0	0	0	0	0	🟢	1st out of 7 health boards
SB	1,229	1,000	1,011	984	1,217	1,149	1,011	1,154	1,008	1,044	1,200	1,128	1,235	🔴	3rd out of 7 health boards

The timeseries charts below show the position from pre Grange to post Grange





There is still much to be done to improve the safety and performance on the urgency and emergency care system in a sustainable way.

Since opening of the Grange, the models for urgent and emergency care have continued to develop in line with the national 6 Goals Programme. An example within Aneurin Bevan is the development of Same Day Emergency Care (SDEC) services

SDEC models have developed across the hospital network and a Same Day Emergency unit was opened in the Grange in 2023 which was enabled due to the flexibility offered within the footprint of the Grange.

This has had significant benefits for patients and system flow.

GUH Gen Surgery	GUH Medicine	YYF Medicine
77% of SDEC Throughput	23% of SDEC Throughput	SDEC patients have an AVG **3.5 hours LOS**
SDEC patients have an AVG **4 Hours LOS**	SDEC patients have an AVG **4 hours LOS**	
Same Day patients within SAU have an AVG **7 hours LOS**	Same Day patients within MAU have an AVG **11 hours LOS**	Same Day patients within MAU have an AVG **8 hours LOS**
If SDEC did not exist, there would be an additional **21**	If SDEC did not exist, there would be an additional **7**	If SDEC did not exist, there would be an additional **10**

admissions to SAU each day Which would require an additional **10 beds / chairs** (with peaks up to 25)	**admissions** to MAU each day Which would require an additional **3 beds / chairs** (with peaks up to 10)	**admissions** to MAU each day Which would require an additional **5 beds / chairs** (with peaks more than 10)

To note that SDEC costs are not included in the cost assessment since this was funded directly via Welsh Government through 6 goals funding.

The Health Board continues to prioritise improvement in the urgent and emergency care model through the local Six Goals Programme and the focused sub set of actions explicitly linked to escalation status. It remains a focus of the Board and Executive teams.

Planned Care

The impact of the pandemic on elective waiting lists has been significant with just over 96,000 patients currently waiting for a first outpatient appointment compared with 74,000 pre pandemic.

The table below summarises the position over time:

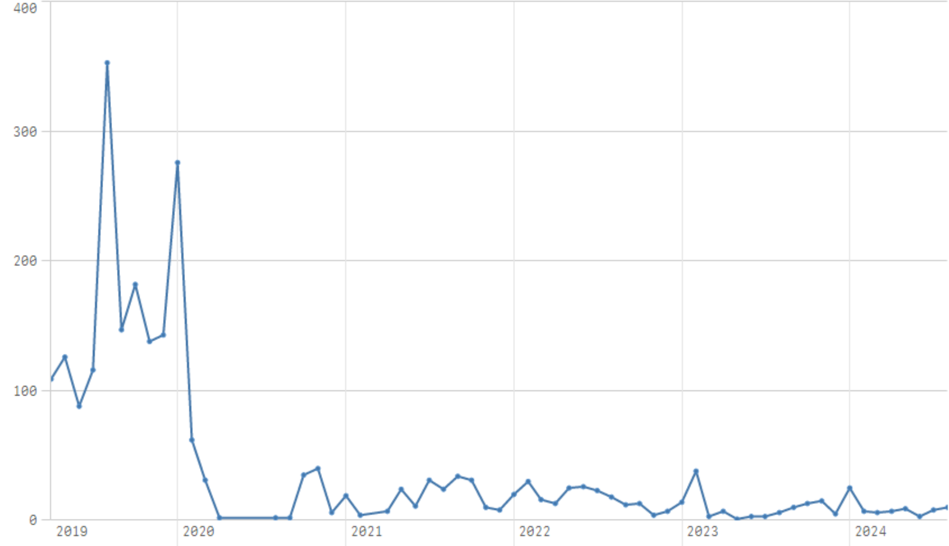
	March 20	**March 22**	**August 24**
New OP waiting list (RTT)	51,561	74,658	96,099
Total waiting list (RTT)	76,016	111,324	131,871
Diagnostics RTT and Non reportable	15,952	10,897	13,885

The planned care challenge is significant and continues to be a focus for the organisation with an explicit focus on the longest waiting patients (over 156 weeks). Good progress has been made on targeting this cohort, with a reduction from over 600 patients waiting over 3 years 12 months ago to 1 patient at the end of October 24.

The building blocks for planned care recovery have been established through the new hospital reconfiguration. The separation of flows afforded by the new hospital system model has enabled the organisation to maintain planned care activity throughout periods of high operational pressure. This has resulted in significantly fewer cancellations due to lost beds or trauma cases displacing planned activity as demonstrated in the graph below. The sustained reduction in cancelled operations is significant which is a key measure in respect of maximising elective capacity.

Cancelled Operations per Month (excluding current)

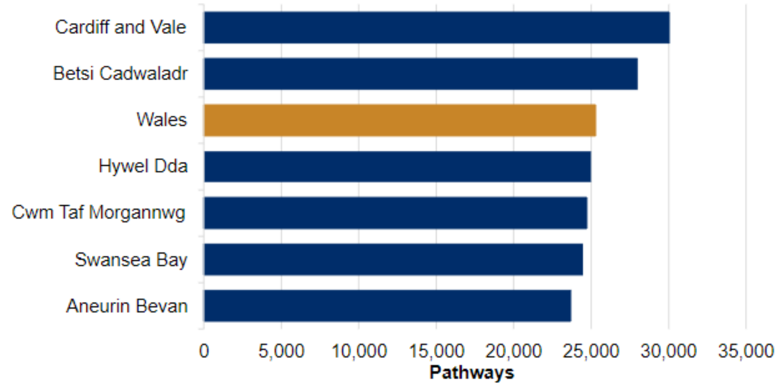
Decrease in Period = -137 (111 - -26) * statistically significant



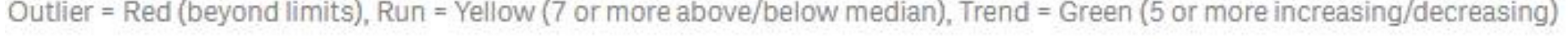
One of the opportunities of the new planned care model has been the development of a six bedded post-operative care unit (POCU) at the Royal Gwent Hospital (RGH), providing an alternative option to critical care for higher risk elective surgical patients. This is reducing planned care demand into the Grange whilst ensuring appropriate levels of safety and cover for higher risks surgical patients. This has proved successful in reducing cancellations of high-risk cancer and other surgeries and is increasingly being adopted as a model across units in Wales. The investment for POCU was approximately £1.8m on a recurrent basis including additional anaesthetics costs. In terms of outcomes, the mortality rate of the POCU unit is 0.5% against an expected rate of 1.4% with a low overall transfer rate to critical care of 2.7%. Due to its success, the potential expansion of this service to a 6 or 7 day service is being explored.

The additional capacity afforded by the Grange (+9 theatres) alongside the separation provided by the hospital system model means that the Health Board has the lowest number of people waiting by population size for treatments as at June 24 as demonstrated in the graph below.

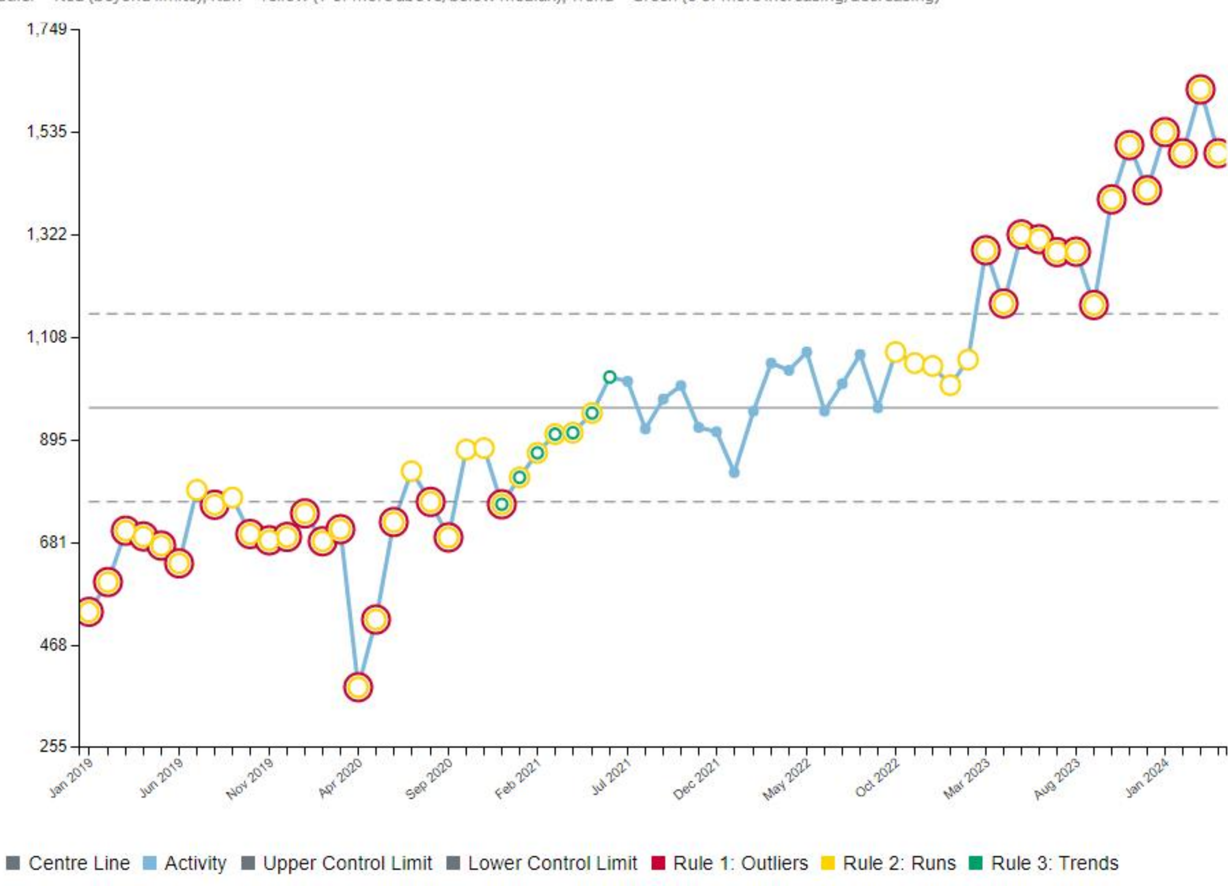
Figure 17: Patient pathways waiting to start treatment, per 100,000 population, by Local Health Board, June 2024 (total waiting) [Note 1]



Diagnostics



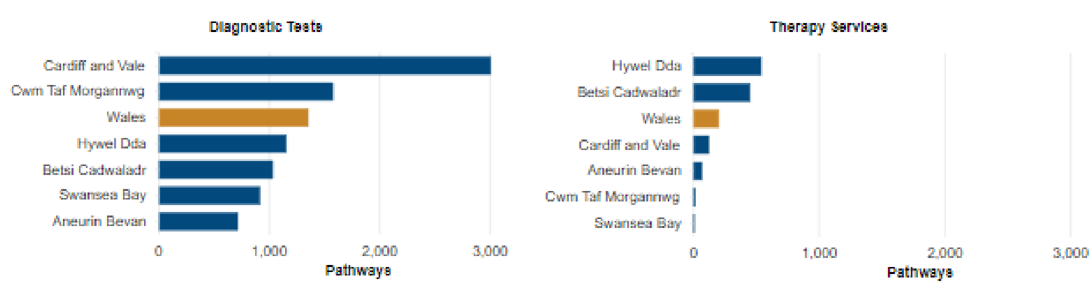
Diagnostic capacity was increased across the system by virtue of the new model and a corresponding investment was made into radiology services to deliver 7 day working to support planned care and unscheduled care pathways. The graph below demonstrates the increase in activity per month for radiology associated with this investment. Most notably there has been a 25% increase in CT/MR activity in 23/24 compared to 22/23 and activity levels have almost doubled compared to pre-Grange levels.



The new hospital model has increased the total number of radiology and endoscopy facilities with the introduction at the Grange of (2 IR (hybrid) rooms, 4 DR, 2 CT and 1MRI) equipped with the latest technology. A key driver for the increase above has been the maximisation of these additional assets as diagnostic facilities on other sites were maintained.

The figure below (source stats Wales) demonstrates the relatively fewer number of patients per 100k of population are waiting in Gwent (June 24) as compared to other Health Boards

Figure 15: Patient pathways (per 100k of the population) waiting over the target time for diagnostic tests and therapy services by Local Health Board, June 2024 [Note 1]



Progress in planned care has been impacted over the last 12-18 months due to the organisation's financial pressures and choices regrading variable spend in planned care (WLI, backfilling etc). However, the advent of the Grange and Clinical Futures model has led to the infrastructure (theatres), operating models (separation of flows, POCU, day surgery, Outpatients treatment centre) and focus on efficiency within core services to be firmly established for any future planned care investment opportunities.

The Planned Care programme is in place to steer the transformation agenda for planned care, with a big focus on scale up of HealthPathways, supporting patients whilst they are waiting via our developing "Keeping Well" programme, Outpatient Transformation and Theatres maximisation. The theatres programme includes the next step change of maximising the current configuration in terms of development of surgical high care, Day surgery centre of excellence and maximisation of Outpatient treatment Unit, all enabled via the new planned care model.

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Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond Highlights:

- System control managed through the flow centre – just 13% of calls through the flow centre result in ED attendance
- Majority of urgent care managed closer to home- MIUs respond to 51% of all urgent care demand and the best system wide 4hr performance of any Health Board with an ED in Wales
- Development of ambulatory care models- SDEC models delivered with an average length of stay through these units off fewer than 4 hours
- Separation of emergency and planned care flows- significant reduction in cancelled operations since reconfiguration and the lowest numbers waiting for treatment by population size
- Increased diagnostic capacity – nearly doubling CT/MR activity compared to pre Grange

4.2 To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients

4.3. To achieve and exceed, where possible, upper quartile performance on key performance indicators across all levels.

Patient & Clinical Outcomes

The Health Board undertakes a number of audits regarding clinical outcomes and standards of care that are peer or national body reviewed and published on an annual basis. These indicators of clinical quality and outcomes are condition specific but, in aggregate, can provide a high-level insight into achievements of the clinical model in the reconfigured health system.

This section outlines a number of the key indicators and outcomes of care eg Risk Adjusted mortality (RAMI), and condition specific outcomes such as national frailty score, stroke and emergency surgery (NELA audit).

For a number of the measures, they are Health Board wide as it is important to consider outcomes of care as a whole.

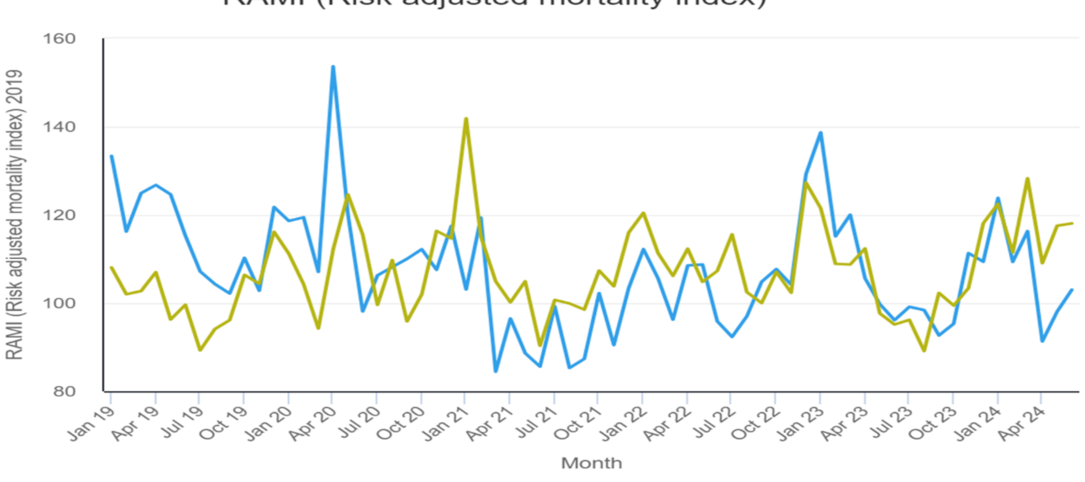
Risk Adjusted Mortality Index (RAMI)

Mortality data provides an indicator for the organisation in understanding the safety of the system. Learning from deaths is a key element of the Health Board approach to patient quality and safety. A learning form deaths report (October 22 – December 23) was presented to the Patient Quality, Safety and Outcomes Committee in line with the Learning from Death framework.

As illustrated in the graph below (Jan 2019 – August 2024), the Health Board's value for RAMI was higher than the average compared to the All-Wales peer until Q4 2020/21. When the Grange opened in Q3 2-20/21, the RAMI has remained consistently lower that the peer average. This increased in Q4 2022/23 above the peer average. RAMI has shown gradual improvement and has outperformed the All-Wales peers since February 2024. Quarter 2 average for RAMI is 101.

Tier One Mortality Indicators

Blue - ABUHB
Yellow – PEERS (All Wales)



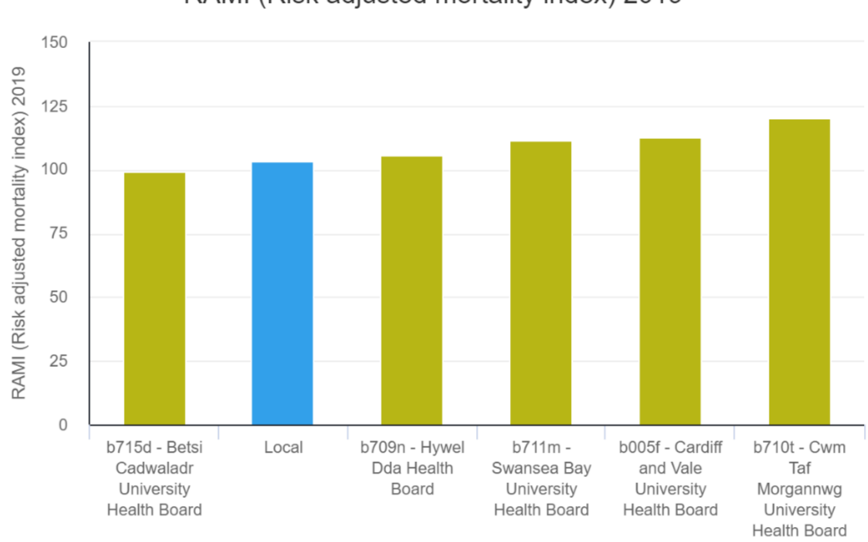
The two bar charts below demonstrate the improvement in the Health Board's RAMI in relation to other LHBs. It shows that pre Grange the RAMI (first bar chart) for the health board was the second highest which then improved to 2nd lowest in the period post the Grange (2nd bar chart).

/RAMI – (January 2019: November 2020) – Pre GUH

RAMI (Risk adjusted mortality index) 2019

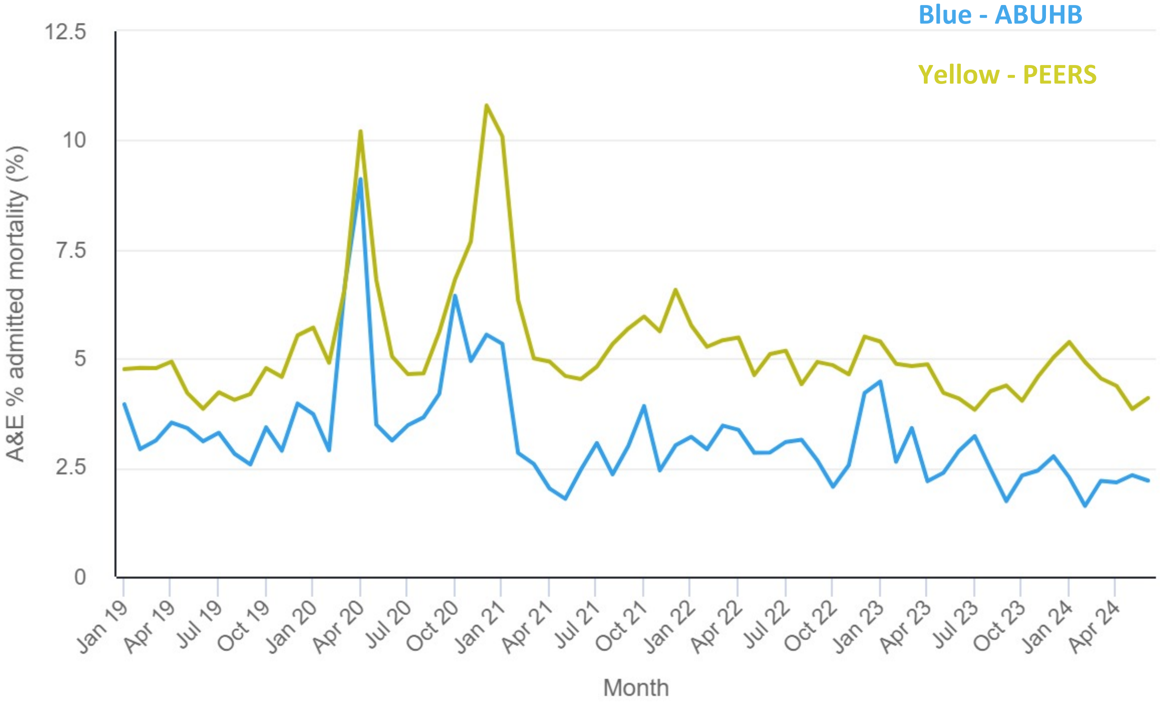
RAMI (Risk adjusted mortality index) 2019
150
125
100
75
50
25
0
b005f - Cardiff and Vale University Health Board
b715d - Betsi Cadwaladr University Health Board
b709n - Hywel Dda Health Board
b711m - Swansea Bay University Health Board
Local
b710t - Cwm Taf Morgannwg University Health Board

RAMI – (November 2020: Sept 2024) – Post GUH



Emergency Department admitted Mortality

In spite of the higher than planned number of attendances into the Grange ED, the graph below (up to August 24) sets out the Health Board's Emergency Department admitted Mortality, demonstrating this it is better than peer comparators and also lower than pre Grange.

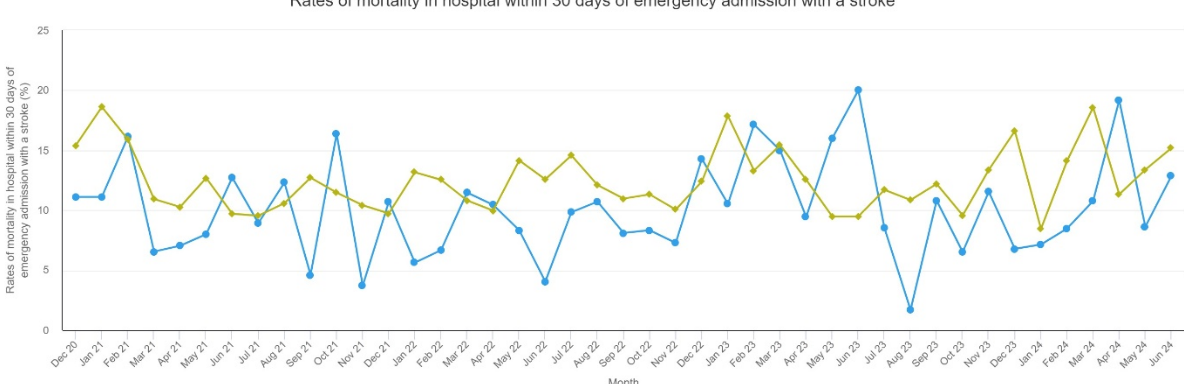


Stroke

Consolidation of acute stroke services and the delivery of the Hyper Acute Stroke Unit was achieved ahead of GUH at RGH but with the service transferred to the new hospital. Stroke input costs were part of the overall nursing workforce investment alongside acute medicine posts. Additionally, establishments increased linked to safer staffing reviews undertaken post Grange opening. The estimated investment in this specialty is c.£0.5m - £1m noting that this was indirectly part of Acute Medicine and overall nursing investments.

Whilst there is more improvement work required, there are positive indicators highlighted in the SNAPP audit. The graph below outlines the mortality for stroke. The 30 day inpatient stroke mortality has been variable over time noting that most recent mortality is at 10.1% and is lower than the All- Wales peer value of 13.1% and is the lowest in Wales.

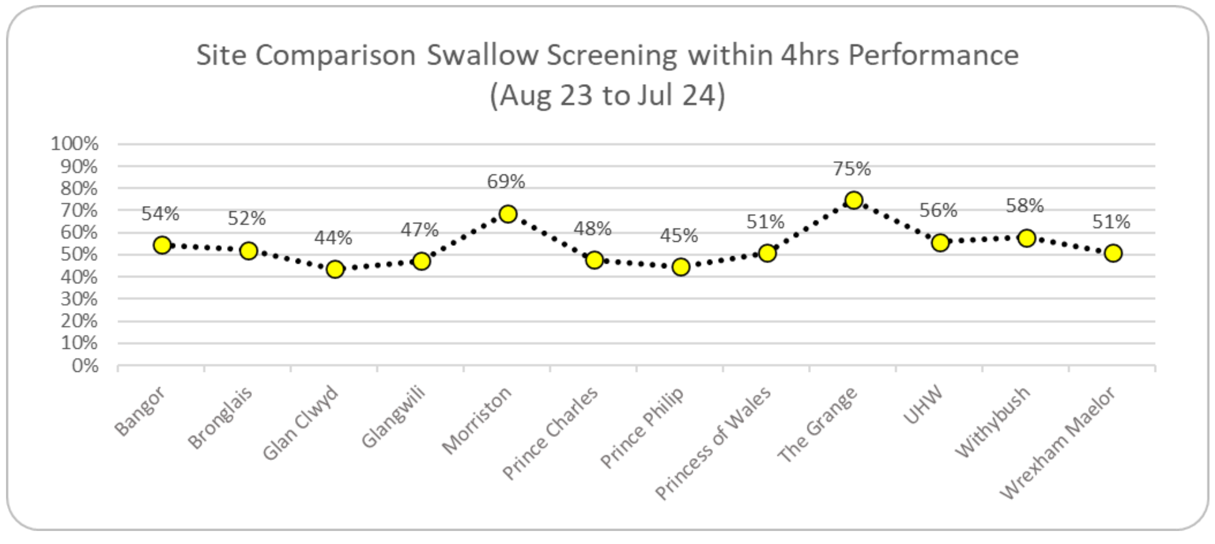
Blue - ABUHB
Yellow – PEERS (All Wales)



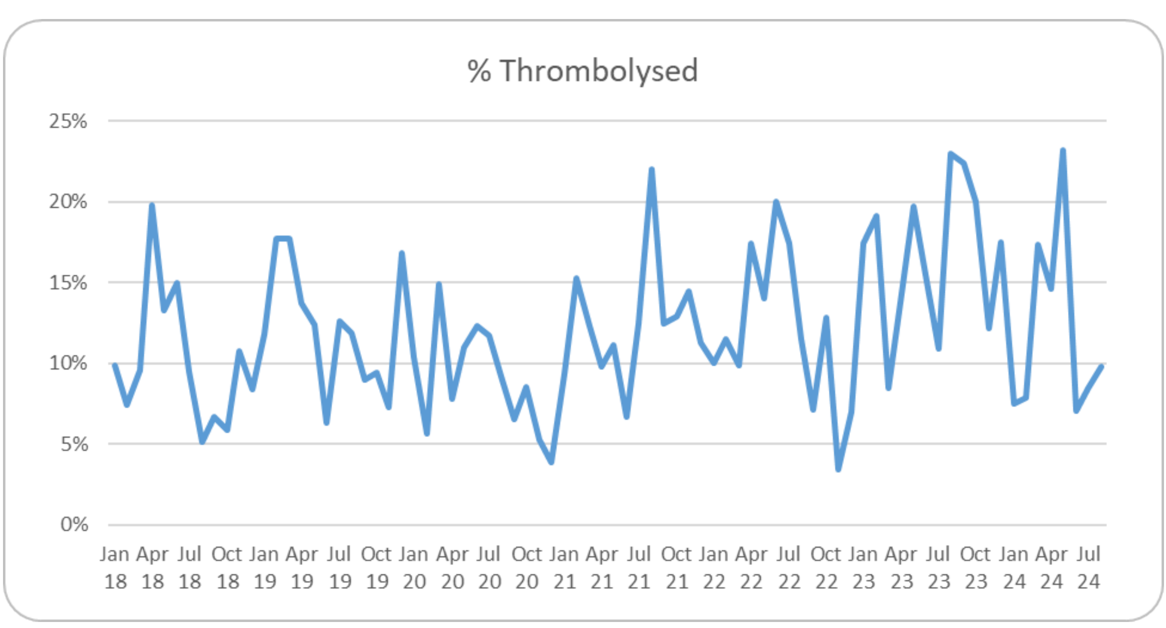
The SSNAP (National Stroke Audit) metrics cover;

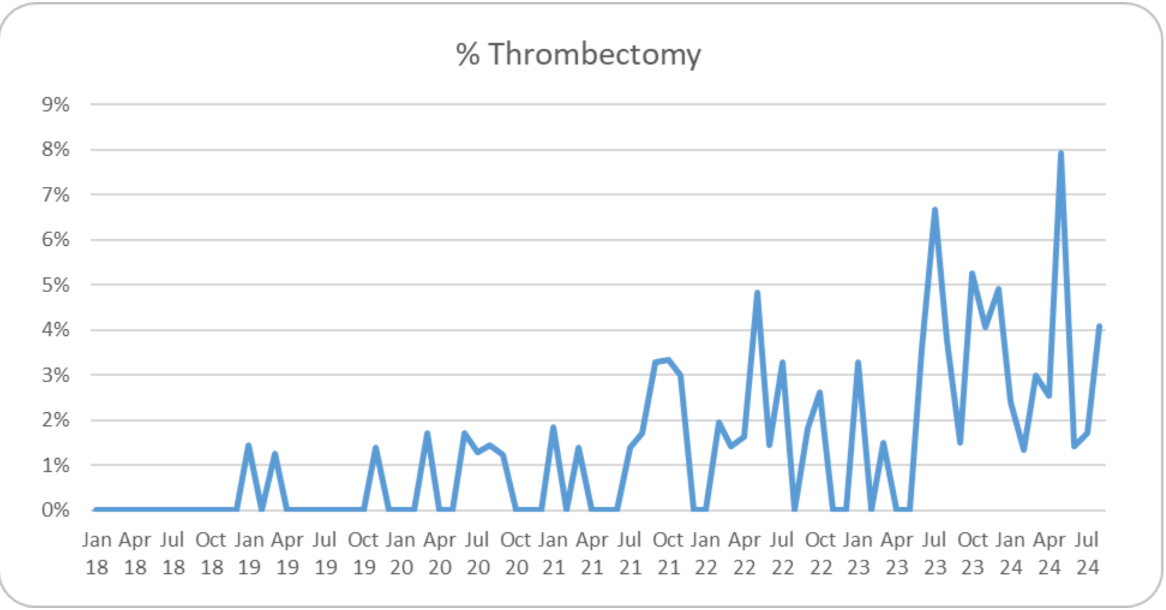
- CT scanning within one hour
- Direct admission to a stroke bed
- 90% of stay in a stroke bed
- % of patients thrombolysed
- Assessed by specialist stroke clinician within 24 hours
- Formal swallow assessment within 72 hours

Across all these metrics the Health Board has now progressed to above the national average, for example the swallow screening within 4 hours performance over a 12 month period is set out below: showing the Grange as the highest performing unit against this metric.



The graphs below show the changes in rate for % patients thrombolysed and % patients receiving thrombectomy with some improvement seen, although noting the need for further sustained improvements.



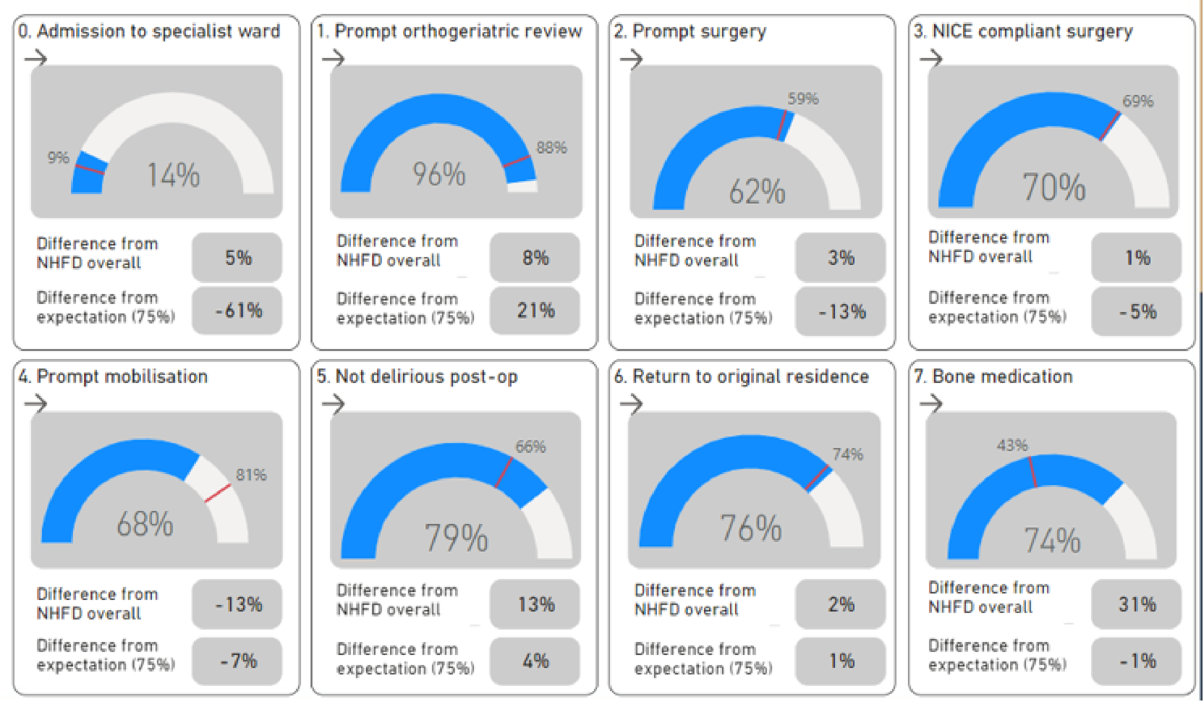


There remains a focus on improving performance against stroke bundles and the Health Board is driving further improvements in stroke enabled by the system model through greater protection of stroke beds in the Grange and consolidation of stroke rehabilitation in YYF.

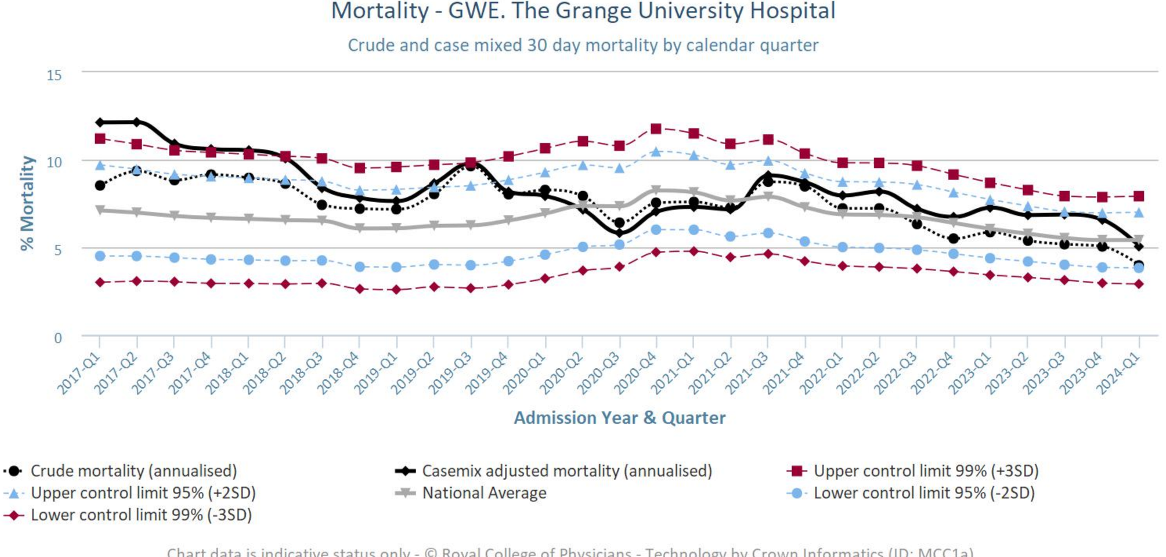
Hip Fracture (NHFD)

The National Hip Fracture Database (NHFD) is a peer reviewed, publicly available database of outcomes for patients who experience hip fractures.,

The new system (depicted by the blue shading), enabled via the Grange now outperforms the national average (the red line) all key indicators in all bar one measure as illustrated in the NHFD summary below.



This has seen a corresponding downward trend in mortality from hip fracture:



The investment for Trauma & Orthopaedics involved an additional medical (Ortho-geriatrician) consultant alongside nursing costs for the surgical wards in Grange.

National Emergency Laparotomy Audit

As with Hip Fracture, similar improvements have been seen in other clinical audits in relation to the co-location of clinical skills and increased access to diagnostics. Most

emergency laparotomy patients (91.8%) who underwent emergency laparotomy (emergency bowel surgery) now benefit from preoperative computerised tomography (CT) scanning. Prior to the Grange opening, the Health Board's audit showed this figure at 63.2%.

The table below charts the Adjusted mortality rates over the years of the NELA audit.

NELA Audit years	Y2 2014-2015	Y3 2015-2016	Y4 2016-17	Y5 2017-18	Y6 2018-2019	Y7 2019-2020	Y8 2020-2021
NHH	13.5	15	14.6	13.2	13.7	8.5	
RGH	14.7	14.2	13	12.2	12.3	14.1	
GUH						14.4	9.6

It shows a significant improvement in the most recent audit with services fully consolidated at the Grange. We recognise that there is more to do in improvements in this area to bring into line with peers. Since the opening of the Grange, there are now multi professional Morbidity and Mortality reviews that take place promptly after death and immediate learning is cycled back into practice. The expectation is that this will lead to ongoing improvements in future NELA audits.

Critical Care

Eliminating the fragility of critical care was another key driver for the Clinical Futures hospital system model. There are significant benefits from the consolidation in the Grange. The environment meets quality standards and has meant the department has alleviated staffing challenges with a waiting list for nurses wanting to work in the department.

The investment of c.£1.2m recognised the additional nursing costs required to support the single-room layout of the environment in Grange. In addition, one area of Critical Care is being used for both Cancer and Critical Care requiring additional staffing support. The use of one critical care pod in this way is providing ringfenced protection for patients needing complex cancer surgery.

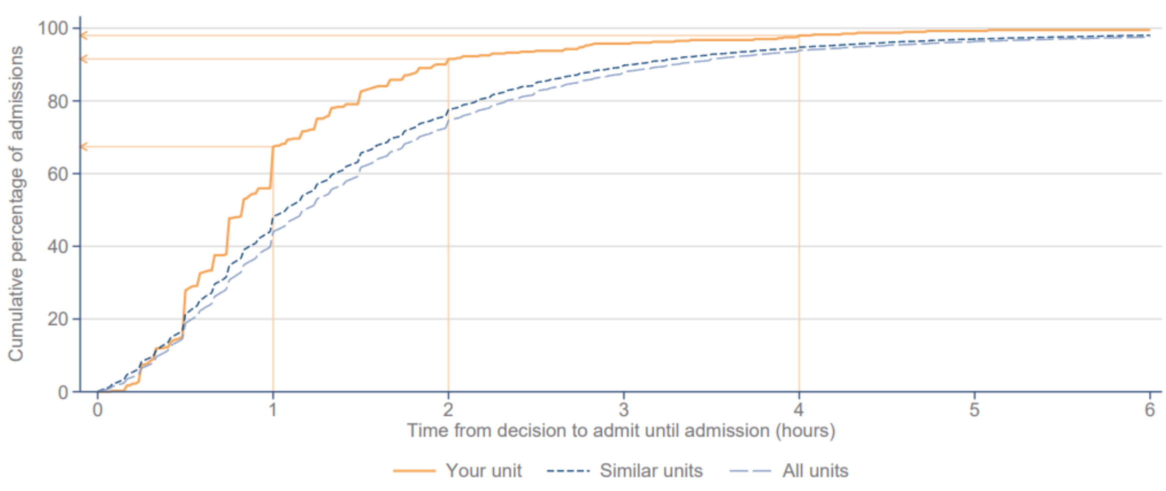
Since the opening of the Grange, no patients have had to be transferred to network partners due to capacity issues.

The average occupancy rate in critical care is 21.6 patients (90%) which is operationally efficient as planned.

The current configuration and capacity of 30 individual rooms is also underpinned by a surge capacity plan to deal with any future peaks in demand for critical care which clearly defines a progression of up to 60 beds (double occupancy) within the unit moving up to a potential of 83 spaces utilising capacity outside of the unit.

Time to admit is a core indicator in ICNARC (the audit of critical care services), where the Grange outperforms peer units. The graph below demonstrates that in Gwent, 90% of patients requiring critical care are admitted within 2 hours against a national average of just under 80%.

Cumulative distribution of time from decision to admit until admission



The critical care model is also inclusive of an outreach service across the eLGHs which includes follow up of all ICU discharges, rib fracture follow ups and Trachy support to general wards.

The new model has also enabled the development of other higher-level support including high care respiratory services.

Women and Children's Services

The consolidation of maternity and paediatric services has made a significant improvement in resolving previously unsustainable services models. The original financial assumptions included a financial benefit given centralisation of paediatrics as well as other Women and Children services (£2.5m saving in FBC, revised to £1.3m saving). This however has been negated by increased operational pressures within maternity services and gynaecology relating to vacant medical and nursing posts.

The opening of the Grange University Hospital (GUH) saw the centralisation of obstetric births supported by an Alongside Midwife Led Unit (AMU). In addition, Midwife led care births, close to home, was supported across four sites: Royal Gwent Hospital (RGH), Nevill Hall Hospital (NHH), Ysbyty Aneurin Bevan (YAB) and Ysbyty Ystrad Fawr (YYF).

Previously women in RGH had the opportunity to remain in maternity if required on level 2 care but NHH did not have the opportunity for a maternity high dependency care and would require transfer to ITU/general HDU if level 2 care. On moving to the

Grange, the Health Board now complies with both of these recommendations and have a separate elective team and theatre team ensuring there is separate oversight of emergency and planned work.

MBRRACE conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK and set out key recommendations for improvement. In the national clinical audit 2023 some of the key messages for the Health Board include:

→ A stabilised and adjusted still birth rate of 3.67 per 1000 total births, which is **average** for similar Trusts and Health Boards
→ A stabilised and adjusted neonatal mortality rate of 1.45 per 1000 live births, which is **15% lower** than the average for similar Trusts and Health Boards
→ A stabilised and adjusted extended perinatal mortality rate of 5.13 per 1000 total births, which is **lower** than the average for similar Trusts and Health Boards

A number of assumptions underpinning the Grange FBC have been challenged. The clinical futures model for maternity services was based on 6000 births per annum with an expected caesarean section rate of 25% and induction rate of 22%. Obstetric led births at GUH are slightly lower than was projected. However, high levels of acuity, complexities of obstetric led births, requirements for baby observations and antibiotic medication have increased overall care requirements and length of stay. The table below shows the changes in these rates from 2019 to 2022.

	C-section rates	**Induction Rates:**
2019	26.3%	26.2%
2020	29%	23.3%
2021	33.2%	22.2%
2022	34%	23.3%

The Health Board has retained a focus on the efficacy of the maternity services since the new model was introduced with a detailed review undertaken in 22/23. The review concluded that there was a need to rebalance midwifery workforce to strengthen sustainability of model. Following some temporary changes this led to an agreement to close the MLUs in RGH and NHH and the re-purposing on the YYF service to birthing pod model. This change has not impacted women's ability to chose their birthing option will all 4 options being maintained

In terms of neonatology, prior to centralisation the Health Board were running two neonatal units, with a lot of transfer of infants between the two, which negatively impacts on the family experience.

Before the move, less neonatal support was available for difficult deliveries in Nevill Hall. Now one team, maintains nursing and medical team skills, babies are born in the right place.

Efficiencies in staffing are much improved, as previously the service model required two qualified nurses covering the small neonatal unit in Nevill Hall, when often only SCBU babies in the unit.

The new NICU has vastly improved space and facilities:

- Much improved family facilities, with parents able to spend time with their infant at the cot-side, pods for parents to sleep in the room with their baby, parent sitting room/food area, large seminar/waiting room for parent teaching.
- Environment supportive of family integrated care
- Larger cot spaces in intensive care, better privacy for families
- Isolation rooms improved, very useful during the pandemic
- Parent houses on site, enables parents to remain near their baby

Patient/Parent feedback: *'I felt super lucky to be given the chance to use one of the parent rooms on the unit when my twins was in the nicu! This is going to help so many parents at such a stressful time!'* On the Parent accommodation at Mitchell Close: *'This is so amazing, like beyond amazing. How settling and reassuring for parents to know they don't have to be far from their babies'*

Benefits of centralisation of acute paediatrics have been significant as there is now in place pooled resources and therefore better staffed rotas. There is higher consultant presence at the front door and this has led to decrease in admissions despite increases in assessments. A large proportion of children need cubicles due to their age and the fact that they have viral respiratory illnesses, and in the Grange there is a much higher proportion of cubicles and therefore the system does not "run out" of cubicles.

Centralisation at the Grange has meant that the Paediatric service is more productive with a secure rota that is at low/no risk of collapse, better training, safe Out of Hours, less congestion, smaller more efficient bed base. The design is also great for Paeds with co-dependencies.

To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients:

- Improved clinical outcomes for the most seriously unwell patients – Improved Risk Adjusted Mortality and outperforming peers in key areas such as the Emergency Department and Stroke services
- Improved sustainability, quality and staffing in core services such as stroke, maternity and critical care
- Improved performance in clinical audit, outperforming peers in hip fracture performance, improvements in stroke, critical care and laparotomy
- Better than peer morality rates across MBRACE audit

4.3 Improve the local provision of services and minimize travel times for access to health services, and in particular, hospital and specialist services

4.4 To improve and expand provision of community-based alternatives to hospital services

One of the key focuses for the Clinical Futures model following commissioning of Grange has been to support the transition of enhanced Local General Hospitals (eLGH) sites to enable delivery of the agreed services and maximise care closer to home where possible.

Despite the challenges there has been growth in the breadth of services available at our eLGH sites, offering a wider range of urgent and planned services closer to home.

Importantly the development of our eLGH sites has enabled service recovery as set out above the ability to offer green elective capacity in the Royal Gwent Hospital and effective streaming of care through Nevill Hall and the YYF, reducing cancellations and supporting care closer to home.

Better Access to Urgent Care Close to Home

As highlighted in relation to system performance the Health Board operates a flow centre model with around 4000 calls per month to the flow centre. Of those calls, just 13% are directed to the Emergency Department at the Grange and 58% are directed to sites or services other than the Grange.

Minor Injury Units (MIUs) accommodate around half of all urgent care demand (51.2% so far in 2024) which reduces pressure on Grange and brings services closer to home. An additional investment of c.£0.8m was made directly to improve MIU performance post Grange opening and whilst there has been some service reconfiguration in the last 12 months, the MIUs are an important offer in the suite of urgent and emergency cares services.

The MIUs support a strong systemwide 4-hour performance (with 97.8% four hour compliance as an average across the MIUs.

In addition, the new model has led to development of Urgent Primary care Centre models (UPCC) in NHH and RGH which provide a multi disciplinary service 24/7 via a contact system.

The maintenance of acute medical takes on the 3 eLGHs was a key component of the urgent and emergency care model. Ensuring that there was local provision of medical assessment services was a key commitment to patients and communities. In spite of the investment earmarked for Acute Care Physicians and Clinical Fellows to support this model, recruitment has been challenging with a resultant reliance on locums to maintain the takes. The sustainability of this model is being reviewed and options considered as part of the Health Board's 2024/5 plan and will form part of our Routemap to Sustainability considerations

eLGH System Role

The system hospital model affords the opportunity to explore new models of care and right size the system to meet the needs of the population in the longer term. The opening of the Grange levered the opportunities for further improvement and service and estate development on the other eLGH sites. This work is being driven through our Enhanced Local General Hospital Programme. The Health Board has already delivered work to deliver centres of excellence closer to home and will continue to build on this model, for example;

- Development of Post Operative Care Unit in RGH as referenced in earlier section, enabling a higher acuity of surgery to be performed on this site,
- Breast Centre delivered at YYF, providing a one stop shop for Breast Cancer patients,
- Satellite Radiotherapy Unit at Nevill Hall in partnership with Velindre NHS Trust bring cancer care closer to communities in South East Wales,
- Development of a regional cataract centre at Nevill Hall,
- Day surgery centre of excellence development at Nevill Hall with tests of change informing future plans for centre for HVLC, HIT lists and high performing (GIRFT accredited) day surgery facility.
- Rationalisation of St Woolos in line with Estate Strategy, using bed reconfigurations and liberated capacity in RGH to enable to rationalisation,

- The use of liberated space in RGH to create a centre of excellence for sexual health, a new Endoscopy suite and a Respiratory Ambulatory Care Unit,
- Development of a Research and Development Centre in vacated space in B block in RGH, moving the service into more appropriate accommodate to support the organisation's ambitions around development in R&D and trials,
- Use of liberated space in NHH to improve haematology day facilities, de-congesting the "Windsor Suite" which was overcrowded and insufficient for SACT outreach and haematology day services.

The hospital system model has therefore provided a platform for reform of services, consolidation essential acute services to provide sustainability and improved clinical outcomes whilst developing centres of excellence close to communities.

Through the NHH development project (triggered through the RAAC situation) models of care for NHH in particular and eLGHs more broadly will be tested and challenged in line with any learning from the current system, new risks and opportunities and learning from best practice from other systems.

4.5. To deliver a fit for purpose environment for patients and staff, which is NEAT and AEDET compliant

The opening of the Grange introduced an additional 55,000 sq metres of estate into the Health Board's portfolio. Its design was carefully considered to provide the highest standards of air and space segregation, with a significantly higher proportion of single roomed accommodation than any other hospital in Wales. The provision of an additional site into the system required significant recurrent investment from a facilities perspective. This was not only to provide the necessary utilities and facilities management but this also includes an additional HSDU, IT support costs and the necessary recurrent equipment maintenance costs associated with achieving environmental and clinical standards.

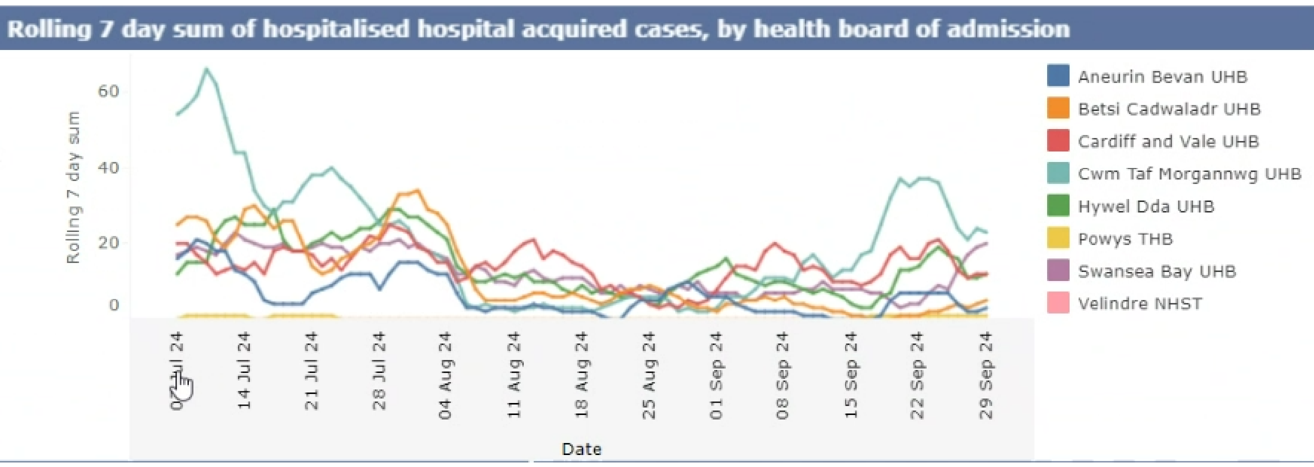
This investment has resulted in an enhanced quality of digital estate including network capacity, mobile telephony infrastructure with comprehensive wifi coverage within the Grange, all of which leading to greater levels of cyber security when compared with other sites.

Infection Prevention

The 75% single room model in the Grange has a benefit to patients not only reducing the risk of onward hospital transmission of infection but also for patients' dignity and privacy. Single rooms in the Grange (of which there are 24 of the 32 beds on each standard ward) have ensuite and bays have shared ensuite facilities. This significantly reduces the risk of infections such as C difficile and gram negative bacteraemia, where

patients carry the bacteria within their normal gut flora. The good estates are another contributing factor to risk reduction for patients, as the environment is easy to clean and maintain. Within the Grange there is ventilation that meets national standards, again reducing the risk of onwards airborne/respiratory infection. The number of single rooms allows patients to be isolated quickly which further prevents onward hospital transmission.

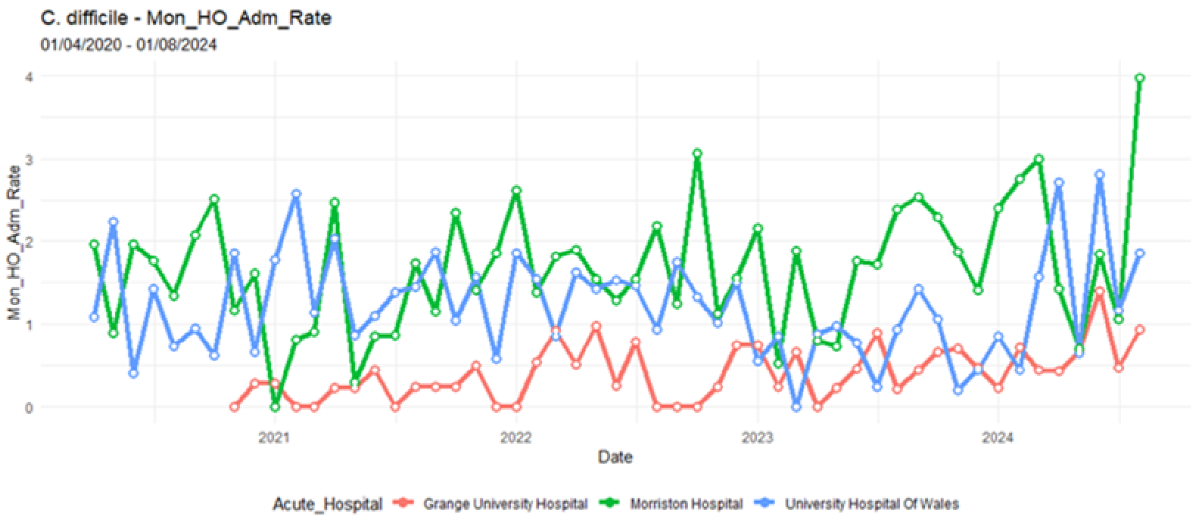
Since opening the Health Board continues to have one of the lowest hospital acquired infection rates for Covid 19 and wider respiratory infections as demonstrated in the Public Health Surveillance data below:



Comparisons and analysis of infection rates are impacted by the high acuity rates in the Grange meaning patients are more susceptible to infection. However, since 2020 the Health Board has had lower or equivalent levels of infection with fewer spikes of outbreaks.

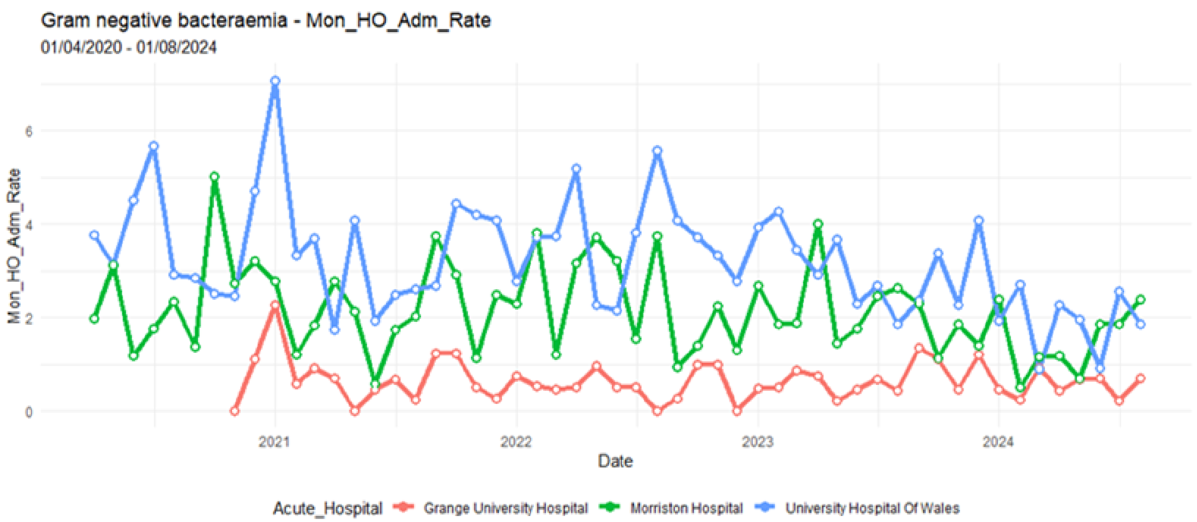
C Difficile

The chart below compares c-difficile infections as a rate per 1000 admissions at the Grange with the other two large hospitals in Wales and demonstrates consistently lower rates.



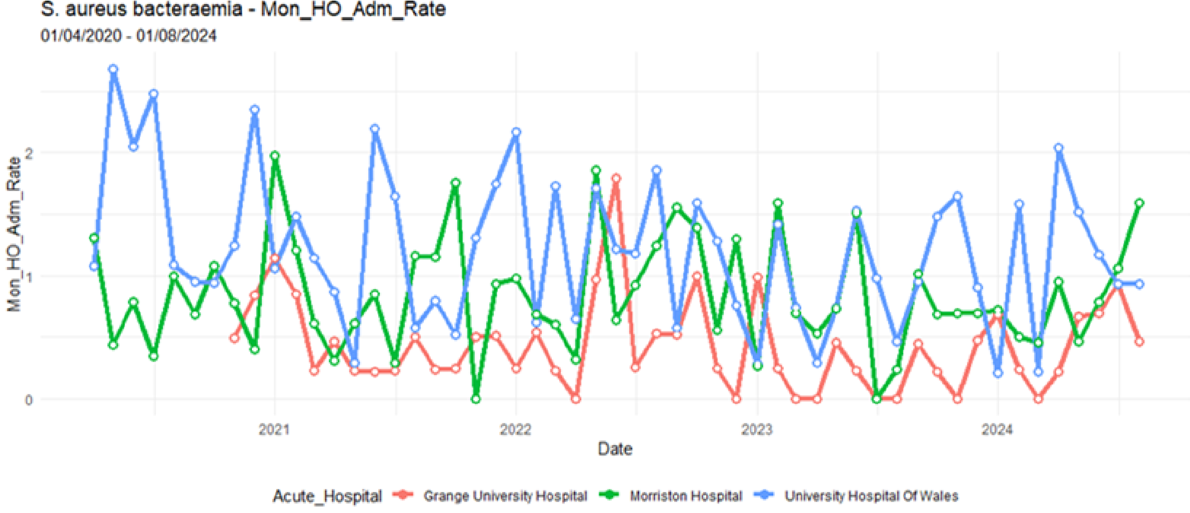
Gram Negative Bacteraemia

The chart below compares gram-negative infections as a rate per 1000 admissions at the Grange with the other two large hospitals in Wales and demonstrates consistently lower rates.



S Aureus

The graphs below compare infection rates at the Grange with comparable large hospitals in Wales (UHW and Morriston)
The chart below compares S Aureus infections as a rate per 1000 admissions at the Grange with the other two large hospitals in Wales and demonstrates consistently lower rates.



4.6 Support a workforce model that is sustainable, and complies with the European Time Directive and Deanery requirements

In opening the Grange early and commencing roll out of the system wide model, the benefits of centralisation of some services provided the intended workforce resilience and sustainability. These include:

- Sustainability and improved safety achieved for Paediatrics and Obstetrics. Both services were under significant pressures running a two site model pre-pandemic which escalated following the first wave with a real risk of collapse in the winter 2020/21 without centralisation.
- Improved workforce resilience for Critical Care and ability to meet Covid demand within its own footprint.
- Improved workforce resilience through centralisation or additional investment in staff for Emergency Department, Respiratory, Gastroenterology, and within Emergency Surgery for many specialist consultant posts.
- Improved nurse recruitment at GUH with low numbers of registered nurse vacancies.
- Ability to offer new roles in new services e.g. POCU.
- Success in recruitment to hard to recruit roles such as cardiology and Interventional Radiology with feedback indicating that the Grange and Clinical Futures model of care was the attraction to our new recruits. This extends beyond acute services provided at the Grange with new COTE consultants confirming the “pull” of the new system.

There were significant additional staffing requirements of the hospital system with the opening of additional estate, as set out in the table below

Pay type	**Recurrent additional WTE**
Medical and Dental - Consultants	32.84
Medical and Dental - Junior Doctors and other grades	19.50
Registered Nursing (inc. variable pay off-set)	59.58
Additional Clinical Services	163.51
Allied Health Professionals	25.74
Prof, Scientific and Technical	21.24
Administration and Clerical	40.70
Estates and Ancillary	94.31
Total pay related GUH/CF cost assessment	**457.42**

Recruiting to these additional levels represents a significant achievement given national and international recruitment challenges.

Recruitment and Retention

The new system model has provided the Health Board with an attractive new offer to recruit staff with the Grange becoming a beacon site in Wales. Previously difficult to sustain services now have sustainable rotas

- Within Critical Care there is now a waiting list for nurses wanting to work in the department.

- Within midwifery service the vacancy rate has reduced significantly. As at August 24, the vacancy rate was low with only 0.36 wte at band 7 and 14.3 wte at Band 6 but with just over 28wte coming online in October 24 through student streamlining and a turnover rate of only 6.55%.
- The Health Board's Emergency Nurse Practitioner (ENP) Competency Framework is well recognised and respected across Wales for its rigour, with ENPs trained across all competency areas – by contrast, other health boards cannot always train their ENPs in all domains, particularly eye-care. In order to minimise inappropriate redirections, the Urgent Care Division is expanding the ENP scope of practice to keep more injuries within the MIU footprint.
- The GMC trainee survey has shown strong improvements for ED trainees, with several domains in the top quartile in the UK, including Reporting Systems, Handover, Adequate Experience (as the model allows trainees to experience ED, MIUs via manipulation clinics and pre-hospital work via PRU), Educational Governance, Regional Teaching and Rota Design
- New simulation facilities are providing state of the art training alongside enhanced education facilities in the Grange.
- Turnover in the Grange is lower than all other sites, highlighting the benefits of enhanced facilities on retention

5. Financial Overview

The final FBC showed a net cost of £0.744m after a range of assumptions around investments and saving opportunities recognising the case was a sustainability case. The table below presents the investments made alongside the savings associated with the system model. It should be noted that this may not represent all costs but those than can be drawn out specifically in relation to the Grange and the implementation of the Clinical Futures System model. The table also highlights investments as part of the original Clinical Futures model as well as further investments made following the opening of Grange as well as subsequent operational pressures. Some of these costs would have been required regardless of system model change in order to meet increasing population demand and need.

Category	Recurrent assessment (£'000)		Difference (£'000)
	FBC	Oct-24	
Service improvement and enhanced quality of care			
Medical staffing and related investments	2,122	6,588	4,466
ED Centralisation	(816)	(510)	306
Women & Children's Centralisation	(2,452)	(1,286)	1,166
Diagnostics & Therapies	460	3,070	2,610
Sub-total Service improvement and enhanced quality of care	**(686)**	**7,862**	**8,548**
Service and Workforce sustainability			
Ward nursing	0	2,061	2,061
POCU - nurse staffing	0	728	728
WAST inter-site transport	500	4,538	4,038
Flow Centre and site related models	0	2,209	2,209
Sub-total Service and Workforce sustainability	**500**	**9,536**	**9,036**
Modern functional estate			
Estates and facilities - investments	3,497	5,791	2,294
Estates and facilities - savings	(510)	(438)	72
HSDU	0	941	941
Supporting Services - investment	797	3,084	2,287
Theatre support services - savings	(579)	(419)	160
Other non-staff	649	1,081	432
Sub-total Modern functional estate	**3,854**	**10,040**	**6,186**
Wider system opportunities			
Patient flow activity impact		3,000	3,000
Bed reductions	(2,924)	-	2,924
Sub-total wider system opportunities	**(2,924)**	**3,000**	**5,924**
Total GUH / CF cost assessment	**744**	**30,438**	**29,694**
Additional investments			
Beds / Urgent Care / Safer Staffing and other workforce		2,237	2,237
Anaesthetics and Transfer Practitioners		555	555
Machen POD		438	438
Respiratory RACU		240	240
Operational pressures / savings			
ED MIU additional staffing		800	800
Estates and Facilities Covid legacy and Provisions		3,438	3,438
Family & Therapies - (SaLT Cancer service & Midwifery operational pressures)		1,574	1,574
Inter-site Transport savings (21/22)		(295)	(295)
GUH Car Parking saving (23/24)		(57)	(57)
Medicine operational pressures		500	500
Total GUH assessment post-opening	**744**	**39,868**	**39,124**

In comparison to the FBC, the largest differences relate to the following areas which have been referenced throughout the report:-

- Estates and facilities investment to operate the additional urgent / emergency care site (including HSDU). The additional floor area of GUH is approximately 55,000m^2 with a reduction across eLGH sites of approximately 15,000m^2 therefore a net increase in estate of c.40,000m^2.
- Bed reduction savings have been challenging given the operational context however the last 6 months has seen progress in reducing the bed base to support the service, workforce and finance plans.
- Service model changes / Medical staffing particularly in relation to the acute medical take issue and ability to deliver and sustain a 4-site model.
- Additional nursing to support the critical care refined model and maximisation of the POCU at RGH to protect surgical activity.
- Investment in radiology staff to maximise the opportunity of the additional diagnostic capacity to meet the increasing demand.
- Investment required into a comprehensive reliable inter-site patient transport
- Urgent Care system pressures
- Patient flow activity impact which relates to changes in patient flows for Powys residents
- Planned investments post GUH opening were approved by the Executive Committee and/or Board as further developments to provide the benefits listed in previous sections these include: -
    - Safer staffing level increases for both nursing and medical staff
    - Theatres and A&C staffing within the Surgery / Clinical Support Services Divisions
    - Additional staffing for the ‘Machen’ (Cancer) POD
    - Respiratory Ambulatory Care Unit staffing at RGH to support ambulatory care model and reduce respiratory presentations at GUH
    - Transfer Practitioners to run 24-hour transfer service alongside further Anaesthetic variable pay costs
    - ED High Risk adult costs
    - SaLT 7-day GUH cancer service
- Further staffing operational pressures post-GUH opening listed include:
    - ED MIU additional staffing

- Estates and Facilities Covid legacy and additional provisions costs (some of which are ABUHB wide)
- Operational pressures for both medical and nursing staff within the Family & Therapies Division. This includes increased sickness, enhanced care and specifically premium costs to cover vacancies mainly for maternity / midwifery services.

It should be noted that ABUHB is currently reporting a £55m underlying deficit position carrying forward into the 2025/26 financial year. The breakdown of general reasons have been reported on a monthly basis both internally and externally. The alignment of GUH/CF pressures against the underlying deficit categories is presented below. This describes that broadly 50% of the current underlying deficit relates to GUH/CF related issues with the remaining 50% across other operational pressures (e.g. CHC/Prescribing).

		Underlying deficit breakdown		
Underlying deficit c/f 2024/25	ABUHB assessment £m	FBC assessment £m	GUH / Clinical Futures assessment and post -opening costs £m	All other ULD cost pressures £m
WG 2023/24 non-recurrent funding utilised to support workforce cost growth	14	0	13	1
Medical staffing cost increases due to operational acuity including ED safer staffing	7		6	0
Nursing pressures - due to nurse staffing act, additional capacity resulting from DTOCs, Acuity and Urgent Care	7		5	2
CHC	6			6
Medicines management (prescribing and acute drug costs)	11			11
Covid legacy (estates & facilities)	3		3	
WHSSC / EASC (service growth in excess of funded levels)	5			5
Cancer additional activity delivery through WLI and additional diagnostics	3			3
GUH service models, estate, patient flow and inter-site transport		1		(1)
Total	**55**	**1**	**27**	**27**

Savings

The full business case assumed savings across a number of areas including ED Centralisation, Women & Children's centralisation, Theatres efficiencies and facilities savings. The largest saving included in the FBC relates to bed reductions given expected reduced length of stay and consolidation of services. The revised Grange / Clinical Futures cost assessment assumed savings for the following areas: -

- ED Centralisation (c.£0.5m) linked to workforce re-design, development of ENPs and rationalisation of rotas
- Women & Children's savings (c.£1.3m) due to reduced variable pay from the centralisation of services

- Estates & Facilities provisions and facilities costs linked to the reduction in beds across the system (c.£0.4m)
- Theatres support savings (c.£0.4m) – efficiencies and rationalisation of rotas due reduce workforce establishments

Whilst there have been a range of specific savings plans that are ABUHB wide and therefore predominantly impact GUH, there are a small number of additional GUH specific schemes including reducing Inter-site Transport costs (c.£0.3m) and GUH Car parking savings through Electric charging points (c.£0.1m).

The original ambition to reduce bed costs through rationalisation and right-sizing of bed capacity will now be progressed as part of the 3-year route map to recovery. The opportunities presented by splitting 'hot' and 'cold' sites will also be progressed as part of this plan including optimisation of day case expansion.

Bed reductions

The FBC assumed there would be a range of bed reductions across both Acute and Community hospital beds. Length of Stay assumptions for the Grange in the FBC was assumed at 3 days (excluding) critical care and consolidation of some services informed the assumption that 86 beds could be saved once the model was fully operational and the new system embedded. The original Clinical Futures Programme business case assumed a system wide opportunity to reduce beds by 230. The GUH FBC assumed 86 of these beds could be delivered by the new hospital model based on LOS efficiencies and consolidation of some services in a smaller bed footprint and informed the £2.9m bed reduction saving.

This was refined further to assume a potential opportunity of up to 95 bed reductions prior to the advent of the pandemic.

	Clinical Futures - pre - GUH opening		
Site	Baseline (pre-Covid)	Revised bed plan post implementation	Difference
GUH	0	470	470
RGH	695	383	(312)
NHH	401	208	(193)
YYF	171	164	(7)
Community	306	253	(53)
Total	**1,573**	**1,478**	**(95)**

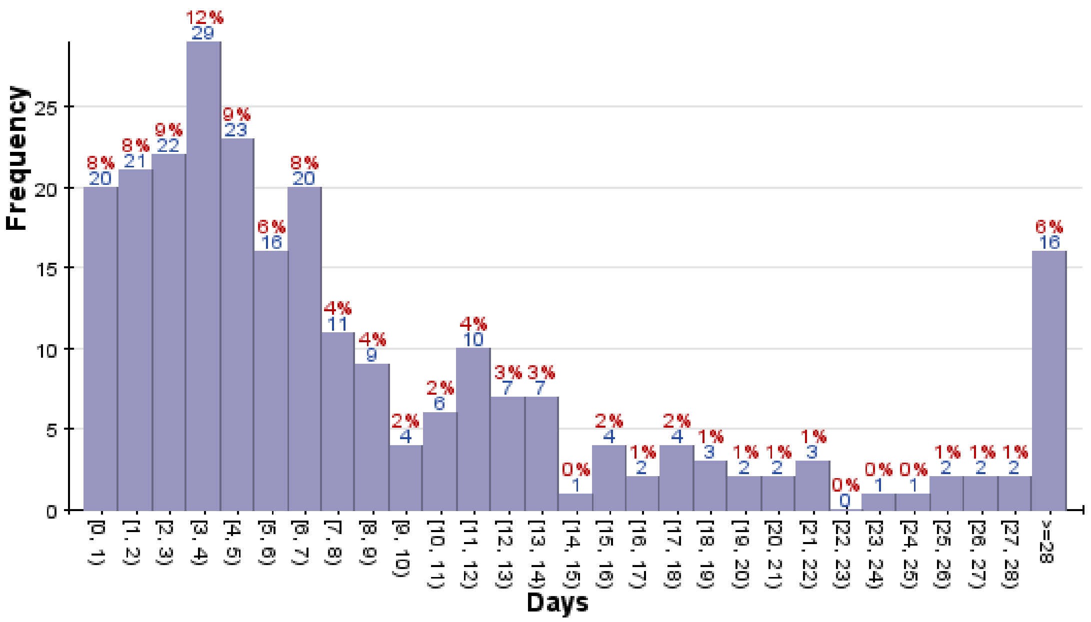
The table below sets out the Clinical Futures bed plan against current bed capacity which demonstrates we still have not achieved the Clinical Futures reduced bed base albeit recent progress is moving closer to the plan and is a key focus of the three year route map of sustainability.

	2024/25 Bed Base	Clinical Futures Bed Plan	Difference
Urgent Care*	0	66	**-66**
Medicine	669	507	**162**

Scheduled Care	413	386	27
Family & Therapies	185	184	1
Community	275	335	**-60**
Total	**1542**	**1478**	**64**

There are a number of factors that have influenced the ability to reduce bed capacity primarily driven by system pressures articulated throughout the report driven by increasing demand and increased challenges in discharging patients from hospital.

The graph below sets out the current LOS distribution for the Grange (excluding critical care, paeds and maternity)



Only 25% of patients currently have a length of less than 3 days, whilst the majority of patients have a stay between 3 and 4 days there are a number of longer waits.

The distribution of LOS above gives a median of 5 days. It should be noted that the patients with extreme stays of over 28 days are skewing the averages and will include some data errors that require validation.

Historically, Delayed Transfer of Care (DTOC) levels before Grange opening were in the region of 150 – 200. The levels of DTOC have significantly increased and are now at around 300. The table below charts the gradual increase of these numbers indicating the pressure put on the wider system.

Financial year	Average DTOC (at Census date)	Minimum	Maximum	Increase / (decrease) of Average DTOC from 19/20
2019/20	167	90	218	
2020/21	135	72	173	(32)
2021/22	212	149	261	45
2022/23	309	259	336	141
2023/24	294	261	336	127
2024/25	297	255	320	130

Only 25% of patients currently have a length of less than 3 days, whilst the majority of patients have a stay between 3 and 4 days there are a number of longer waits.

The distribution of LOS above gives a median of 5 days. It should be noted that the patients with extreme stays of over 28 days are skewing the averages and will include some data errors that require validation.

Historically, Delayed Transfer of Care (DTOC) levels before Grange opening were in the region of 150 – 200. The levels of DTOC have significantly increased and are now at around 300. The table below charts the gradual increase of these numbers indicating the pressure put on the wider system.

A number of the Grange service models alongside the additional estate, patient flow and inter-site transport costs were internally funded as part of previous years IMTPs and therefore do not make up the overall Health Board assessment.

It should be noted that the other underlying deficit categories listed will inevitably have overlap and impact with the Grange and Clinical Futures system. As a result, whilst those categories are shown as being separate to the Grange, the overall underlying financial pressure to the organisation is interlinked and can be considered in this way.

6. Summary and Conclusions

There has undoubtably been progress in meeting the ambitions set out in the 2014 clinical futures business case;

- Service and workforce sustainability
- Service improvement and enhanced quality of care
- Modern functional estate and
- Wider system opportunities.

Staffing in in core services such as critical care, the emergency department maternity and children's services are now more sustainable.

The Health Board is delivering improved outcomes as evidenced in clinical audit for the most seriously unwell patients.

There is greater resilience in services with flexibility and modern estates to meet the increasing demand and acuity of patient need.

There is also improved ability to innovate in the system to deliver new models of care closer to communities.

Whilst there is always more to do to drive further improvement and optimise the system there is significant progress in achieving the clinical futures ambition.

Appendix 1 Overview of Investment Objectives & Associated Benefits

Investment Objectives	Benefits
Deliver access targets for both planned and unscheduled patient care in line with national targets for 2015 and beyond.	better outcomes for patients through having more timely access to services
	more timely access to services with reduced waiting times
	better staff morale by being able to deliver services in a timely way
	less disruption to planned services through having the appropriate capacity in place to deal with the targets
	ability to deal with fluctuations in activity by having the appropriate capacity in place
	improved productivity in delivery of services
	sustainability of health services
To achieve and exceed where possible minimum quality standards for health care service as outlined in National Service Delivery Frameworks, NICE and Standards for Healthcare for Wales to improve outcomes for patients	better outcomes for patients by providing recognised standards
	opportunity for skills development
	enhances recruitment and retention by being able to offer good quality care
	improved integration of services across all levels through implementation of clinical pathways
	opportunity to further develop services / specialisation
	safer services for patients
	better staff morale
	less duplication of services and effort
	reduced number of complaints and litigation claims
	more sustainable services for Gwent
	improved staff morale by being able to deliver quality services
	increased opportunities for further clinical specialisation
Improve the local provision of services and minimise travel times for access to health services and in particular, hospital and specialist services.	reduce non-attendances of appointments
	more care available closer to home
	reduce length of stay
	more convenient for patients
	reduce avoidable admissions
	improve integration between services at local level
	more continuity of care for patients
	reduce travel times and transport requirements
	reduce delayed transfers of care and delays in the patient pathway
	develop services that are responsive to local need
	reduce flows of patients out of Wales
	help to reduce inequalities in health
	support local regeneration initiatives
To deliver a fit for purpose environment for patients and staff which is NEAT and AEDET complaint	improve outcomes for patients by providing care in therapeutic environments
	reduce length of stay by facilitating recovery
	reduce infection rate by providing facilities that are easier to clean
	increase staff productivity by arranging facilities in logical patterns
	improved safety by developing buildings that are easier to maintain and arranged logically
	improvements in privacy and dignity through modern design
	improve staff recruitment and retention by providing attractive working environments
	reduce disruption to services through developing facilities which are easier to maintain and based on more reliable technology

Investment Objectives	Benefits
	reduce stress for visitors and carers by providing appropriate therapeutic environments
	promote sustainable development through the design and construction of new buildings
	promote sustainable development in terms of the ongoing operation of new buildings
	improved training and development environments for clinical staff and achievement of royal college guidelines
Support a workforce model that is sustainable and complies with the European Working Time Directive and Deanery requirements	Robust and reliable services based on robust and reliable staffing patterns
	Meet requirements of Deanery for junior doctor training
	Safe services based on safe working hours for staff
	Improve outcomes for patients by ensuring that the right care is delivered by the right person
	Improve training opportunities for staff
	Improve recruitment and retention
To improve and expand provision of community based alternatives to hospital services	Increased local access to services
	reduced number of hospital admissions
	less time spent in hospital
	shorter lengths of stay
To achieve and exceed where possible upper quartile performance on key performance indicators across all levels	reduced variation in performance within health community
	increased productivity through increased patient throughput from reduced LOS
	shorter lengths of stay
	more timely access to services through reduced waiting times
	more patients treated as day case procedures instead of inpatient
	reduced number of queues and bottlenecks in system
	reduced number of cancelled operations due to patients being unfit
	more effective pre-admission processes
	better use of resources

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 November 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Quarter 2 Integrated Performance Report – November 2024**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships Sarah Simmonds, Director for Workforce and OD, Jennifer Winslade, Director of Nursing Robert Holcombe, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk Assistant for Director Planning and Performance Marie- Clare Griffiths Head of Strategic Planning Paul Steynor Head of Systems Planning and Performance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Board with an integrated overview of performance against the key Health Board and Ministerial Priorities at the end of Quarter 2 of 2024/25.

The Board is asked to:

- **Note** the progress achieved in Q2,
- **Note** the planned Actions.

Cefndir / Background

This report focusses on specific performance against the organisation's key priorities in line with the National Performance Framework, Ministerial and Cabinet priorities.

Asesiad / Assessment

This report is structured across sections as follows:

- Performance Summary
- Section 1: Cabinet Secretary Priorities
- Section 2: Our Performance & System Change Delivery, which include the System Change Priorities
    - 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 & 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
- Quality & Patient Safety
- Workforce
- Finance

This report is in the quarterly format and will cover the commitments in the Annual Plan, bringing together the wider reporting on system change priorities, value and sustainability and our enablers on a quarterly basis.

The have been a number of key highlights in Quarter 2.

- The 2024/25 reported forecast is a £47.856m deficit which is a £1m improvement on the previous position. The focus on maintaining our forecast position remains through Divisional Assurance, Value and Sustainability and Executive oversite. In line with national escalation requirement, a Three-Year Route Map to sustainability was developed during and approved by Board in Quarter 2.
- Good progress in delivery of Planned Care improvements as set out below, in line with or ahead of trajectories, which has fostered confidence and credibility in respect of support for additional Planned Care monies,
- Some improvement in Urgent and Emergency Care. >12hr ED attendances has trended downwards over the quarter from 1,376 to 1,109 and is ahead of trajectory.
- The performance rate for Cancer diagnosis or discharges within 28 days has been strong and remains above trajectory at the end of the quarter (81.5%).
- Mental Health Part 1a compliance is ahead of trajectory for both adults (50.3%) and children (95%).
- The increased oversight for Enhanced Monitoring remains in place and further actions within the Health Board and with Partners is included in the 2024/25 Winter plan.

There have been several improvements made against the Planned Care priorities. The position for patients waiting more than 104 weeks across all stages has improved, from 4,408 at the end of Q1 to 3,744 at the end of Q2; ahead of revised

trajectory and patients waiting more than 8 weeks for a specified diagnostic has improved, from 4,221 at the end of Q1 to 3,241 at the end of Q2; ahead of revised trajectory. 156+ week waits have reduced from 47 at the end of Q1 to 14 at the end of Q2 and are expected to be cleared over the coming quarter. Additional investment for Planned Care has been received from Welsh Government and with that additional investment will be the expectation of further progress and ambition in delivery. Future reports will include revised trajectories to reflect this investment. Further service improvements for Planned Care include the launch of the Waiting Well Service and development of a number of "HIT" (High Intensity Treatment) lists in NHH.

The performance rate for Cancer diagnosis or discharges within 28 days has been strong and remains above trajectory at the end of the quarter (81.5%).

There are several key areas which remained a challenge in Quarter 2.

- Sustaining improvements in the Urgent and Emergency Care System has been challenging, with some observed variability in performance across days and weeks.
- Single Cancer pathway compliance over the quarter has been mixed, with performance at 57% at the end of Q2 against a trajectory of 64%.
- Performance against Mental Health Part 1b compliance remains challenging, with performance at 19.1% at the end of Q2 against a trajectory of 41%, whilst focus is on bringing down the tail of the waiting list.
- Sickness Absence in Sept 24 was 6.06%, which has increased from 5.96% as reported end of March 24.

Looking forward to delivery over the next two quarters there are a number of areas that will improve the current position.

- In Primary Care, Community School Health Nurses are currently undertaking a robust Vaccination Plan coupled with dedicated MMR Catch Up Clinics in Vaccination Centres and pop-up clinics to improve the Q1 reported position of 85.8%, against a target of 92.1% of children with up-to-date scheduled vaccinations by the age of 5.
- Recruitment of additional Emergency Department Consultants has been undertaken and expected to be in post by April 2025.
- Development of Winter Resilience plan with a focus on LHB and Partnership actions – including response to 50-Day Challenge.
- Maximising opportunities of additional end-of-year Capital to support risk management.
- Additional Planned Care monies from Welsh Government allocated to improve Planned Care delivery

The following are of focus in Q3 and Q4 in order to maintain the position and prevent deterioration.

- ENT, Maxillofacial and T&O to reduce 104-week Outpatient position through continuation of additional work and improved attention to scheduling and booking. This will further be supported by implementation of ENT GIRFT recommendations, including reviewing day case rates and efficiency schemes.

- Performance has been varied across the three Enhanced Monitoring measures for Urgent Care and did not improvement sufficiently to meet the improvement trajectories. The Health Board has however achieved the 20% reduction in the number of patients who spend 12 hours or more in all Major and Minor Emergency Care Facilities from arrival until admission, transfer or discharge in Q2, with performance at 1,109 (ahead of the trajectory of 1,181).
- Further reviews of Cancer performance with actions to meet the 67% single Cancer pathway compliance by December 2024; current compliance is 57%.
- Continued reduction of backlog for Mental Health Part 1b compliance for adults to achieve 80% by end of Q4 and, through a supported recovery programme for neurodevelopmental adapted pathways for under 5s, enable Paediatric capacity to undertake assessments and MD.

Argymhelliad / Recommendation

Board is asked to **Note** the progress achieved at the end of September 2024.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The report highlights key risks for delivery against the IMTP
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. This is interim report against the Integrated Medium-Term Plan and the key organisational priorities informed by our detailed understanding of how our system operates.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve 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 worse 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:	Executive Committee

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.

Quarterly Integrated Performance Report

Quarter 2

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

CONTENTS

Performance Summary

Section 1: Cabinet Secretary Priorities

Section 2: Our Performance & System Change Delivery

PERFORMANCE SUMMARY

What went well this Quarter?

- The 2024/25 reported forecast is a £47.856m deficit which is a £1m improvement, supported by Three Year Route Map in line with escalation requirements
- There has been an increase in patient experience survey feedback for Q2 (1942) compared to Q1 (1733), with July being the highest month to date (759).
- Good progress in planned care improvements, patients waiting 104 weeks+ reduced, from 4,408 (Q1) to 3,744(Q2); and 156+ week waits reduced from 47 (Q1) to 14 (Q2) and expected to be cleared over Q3
- Patients waiting 8 weeks+ for a specified diagnostic improved 4,221 (Q1) to 3,241(Q2).
- Some improvement in urgent and emergency care. >12hr ED attendances has trended downwards over the quarter 1,376 to 1,109.
- The performance rate for cancer diagnosis or discharges within 28 days has been strong and remains above trajectory at the end of the quarter (81.5%).
- Mental Health Part 1a compliance is ahead of trajectory for both adults (50.3%) and children (95%).

What were the challenges this Quarter?

- Sustaining improvements in the urgent and emergency care system has been challenging with some observed variability in performance across days and weeks
- Single cancer pathway compliance over the quarter has been mixed, with performance at 57% at the end of Q2 against a trajectory of 64%.
- Performance against Mental Health Part 1b compliance remains challenged, with performance at 19.1% at the end of Q2 against a trajectory of 41% whilst focus is on bringing down the tail of the waiting list.
- Sickness Absence in Sept 24 was 6.06% which has increased from 5.96 % as reported end of March 24.
- Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over is below trajectory at 19.1%

What actions are we taking to improve?

- Reframe and refocus of approach to organisational priorities and planning and delivery infrastructure during Winter period
- Recruitment of additional Emergency Department consultants undertaken and expected to be in post by April
- Maximising opportunities of additional end of year capital to support risk management
- Development of Winter Resilience plan with a focus on LHB and partnership actions – including response to 50-Day Challenge
- Additional planned care monies from WG allocated to improve Planned care delivery
- Three wards identified at Royal Gwent Hospital to be Optimal Wards with learning being embedded from neighbouring Health Board
- As part of Winter plan, increasing focus on vaccination programme to support community resilience and staffing sickness levels.

What are our risks to delivery?

- Impact of operational pressures on capacity of teams and system
- Winter pressures and potential impact on workforce capacity and resilience
- Impact of medicine pricing changes on financial forecast
- Mobilisation of planned care plans (additional monies) linked to capacity in private sector market – eg outsourcing and insourcing opportunities
- Any unquantified risks to services affected by changes to National Insurance etc contributions, eg GP practices, pharmacies, Care homes
- Demand and acuity increases

Section 1: Cabinet Secretary Priorities

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:

- Enhanced Care in the Community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into Primary and Community Care
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme
- Planned Care and Cancer, with a focus on reducing the longest waits
- Mental Health, including CAMHS, with a focus on delivery of the national programme

Further to these priority areas the Welsh Government and NHS Wales have identified 8 Key Performance Indicators across 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.

Cabinet Secretary Priorities

Priority	Aim	ABUHB Commitment	Ability to meet national standard?	In Month Performance against trajectory	Link in Performance Report
Enhanced Care in the Community	**Measure:** Number of delayed transfers of care. **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	250 Mar-25	Yes	262 Sep-24 (Trajectory: 258)	Hyperlink to section
Primary and Community Care	**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%	Yes	100% Sep-24 (Trajectory: 100%)	Hyperlink to section
	Measure: General Dental Services (GDS) - % of contract value fulfilled **National standard:** 30% of contract value by end Q2, 100% Q4 **Reporting period:** Six Monthly	30% Sep-24 100% Mar-25	Yes	62% Sep-24 (Trajectory: 30%)	Hyperlink to section
Urgent and Emergency Care	**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:** 20% reduction by September 2024, further 20% reduction by March 2025 **Reporting period:** Monthly	1,063 Dec-24 945 Mar-25	Yes	1,109 Sep-24 (Trajectory: 1,181)	Hyperlink to section
	Measure: Number of ambulance patient handovers over 1 hour **National standard/ambition:** 30% reduction by December 2024 **Reporting period:** Monthly	705 Dec-24	Yes	770 Sep-24 (Trajectory: 772)	Hyperlink to section
Planned Care and Cancer	**Measure:** Number of patients waiting more than 52 weeks for a new outpatient appointment **National standard/ambition:** 40% reduction by end of September 2024, 0 by end of March 2025 **Reporting period:** Monthly	16,077 Dec-24 16,500 Mar-25	No	16,772 Sep-24 (Trajectory: 15,352)	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for referral to treatment **National standard/ambition:** 0 by end of December 2024 **Reporting period:** Monthly	3,929 Dec-24 3,925 Mar-25	No	3,744 Sep-24 (Trajectory: 4,110)	Hyperlink to section

	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) **National standard/ambition:** 60% by end of December 2024, 70% by end of March 2025 **Reporting period:** Monthly	**67%** Dec-24 **70%** Mar-25	**Yes**	**57%** Sep-24 (Trajectory: 64%)	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard/ambition**: 95% of patients waiting less than 8 weeks by end of December 2024 **Reporting period:** Monthly	**3286 (79.7%)** Dec-24	**No**	**3,241** Sep-24 (Trajectory: 3,492)	Hyperlink to section
Mental Health, including CAMHS	**Measure:** Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years **National standard/ambition:** 80% by end of December 2024 **Reporting period:** Monthly	**87%** Dec-24	**Yes**	**2.4%** Sep-24 (Trajectory: 0%)	Hyperlink to section
	Measure: 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% by end of December 2024 **Reporting period:** Monthly	**92%** Dec-24	**Yes**	**19.1%** Sep-24 (Trajectory: 41%)	Hyperlink to section

Section 2: Our Performance and System Change

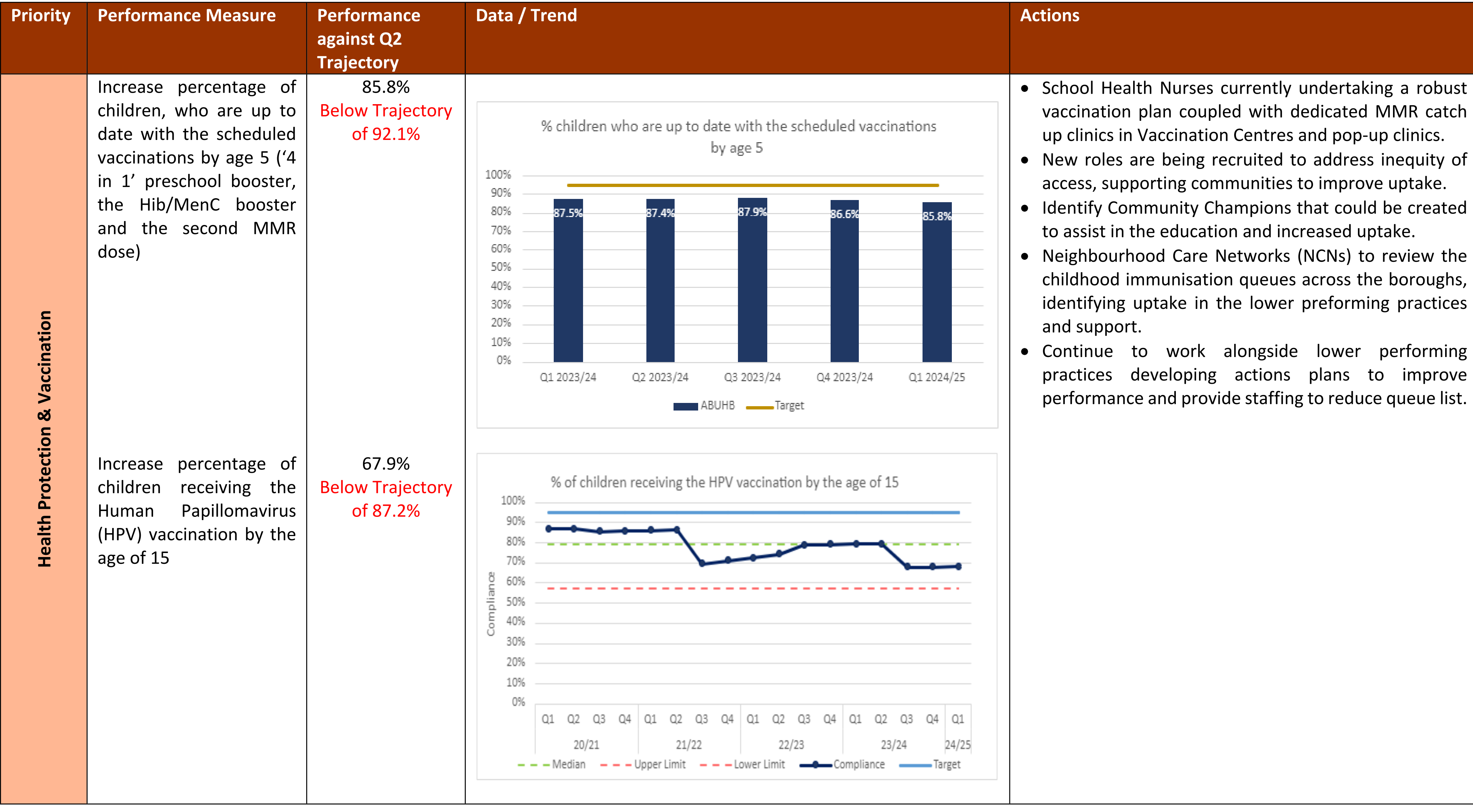
The Performance Report section provides detail of Health Board performance across the quadruple aims and the system change themes identified in the Annual Plan 2024/25.

Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided under each aim 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		Health Board's System Change Theme and Integrated Report
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	• Embedding **Prevention** and Population Health in all that we do
Aim 2	People in Wales have better quality and more accessible Health and Social Care Services, enabled by digital and supported by engagement	• 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
Aim 3	The Health and Social Care workforce in Wales is motivated and sustainable	Workforce and Culture
Aim 4	Wales has a higher value Health and Social Care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

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



Priority	Performance Measure	Performance against Q2 Trajectory	Data / Trend	Actions
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)	85.8% Below Trajectory of 92.1%	% children who are up to date with the scheduled vaccinations by age 5	• School Health Nurses currently undertaking a robust vaccination plan coupled with dedicated MMR catch up clinics in Vaccination Centres and pop-up clinics. • New roles are being recruited to address inequity of access, supporting communities to improve uptake. • Identify Community Champions that could be created to assist in the education and increased uptake. • Neighbourhood Care Networks (NCNs) to review the childhood immunisation queues across the boroughs, identifying uptake in the lower preforming practices and support. • Continue to work alongside lower performing practices developing actions plans to improve performance and provide staffing to reduce queue list.
	Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	67.9% Below Trajectory of 87.2%	% of children receiving the HPV vaccination by the age of 15	