Partnerships, Population Health & Planning Committee

Wed 16 November 2022, 09:30 - 12:00

Microsoft Teams

Agenda

09:30 - 09:45
15 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Committee Action Log- November 2022

Attachment *Chair*

1.4 PPHPC Action Log November 2022.pdf (5 pages)

1.5. Draft Minutes of the meeting held on 7th July 2022

Attachment *Chair*

1.5 Draft PPHPC Committee Minutes- 7th July 2022 (Chair approved).pdf (6 pages)

09:45 - 10:00
15 min

2. Committee Governance

2.1. To receive the Committee Workplan 2022/23

Attachment *Director of Corporate Governance*

2.1 DRAFT PPHPC_Committee Work Programme 2022-23.pdf (4 pages)

2.2. Committee Risk Report

Attachment *Director of Corporate Governance*

2.2 Planning Committee Cover Risk Report Nov2022 V1.pdf (7 pages)
2.2a Updated SAPlanning Committee Risks Nov 2022 (002).pdf (10 pages)

10:00 - 10:15
15 min

3. Strategic Partnerships

3.1. To discuss the Programme Plan for the Gwent Marmot Region

Attachment *Director of Public Health & Strategic Partnerships*

3.1 PPHP Committee_16Nov22_Marmot Programme Plan_v0.2.pdf (5 pages)

10:15 - 10:45
30 min

4. Strategic Planning and Developments

4.1. To receive and discuss an update on the delivery of the Clinical Futures Programme

Presentation- to follow *Director of Planning & Performance/Clinical Futures Programme Director*

4.2. To receive and discuss an update from the Redesigning Services for Older People Programme

Attachment *Medical Director/ Clinical Futures Programme Director*

4.2 PPHPC RSfOP Update Paper 16.11.22 v3(1).pdf (9 pages)

4.3. To receive and discuss an update on the 6 Goals for Urgent & Emergency Care Programme, including the evaluation of SDEC

Presentation- to follow *Director of Operations*

4.4. To receive an update on the Capital Programme 2021/22

Attachment *Director of Planning & Performance*

4.4 PPHPC Capital Programme FINAL (1).pdf (16 pages)

4.5. To receive an update in respect of Regional Planning

Attachment *Director of Planning & Performance*

4.5 Regional Planning Update PPHP Committee Nov 2022 (002).pdf (14 pages)

4.6. To discuss the Approach to developing the 2023/3 – 25/26 Integrated Medium Term Plan

Attachment *Director of Planning & Performance*

4.6 PPHPC IMTP paper final.pdf (7 pages)
4.6a Appendix 1 IMTP Approach 2023 to 26 planning cycle base v2.pdf (11 pages)

10:45 - 10:45
0 min

5. Items for Information

5.1. Health and Wellbeing Alliance report "Mind the gap: What's stopping change"

Attachment

5.1 Mind the gap - The rise in inequalities in Wales (2).pdf (16 pages)
5.1a Press release - Mind the gap report (bilingual) .pdf (6 pages)
5.1b Cofiwch y bwlch - Anghydraddoldeb cynyddol yng Nghymru.pdf (16 pages)

5.2. The Public Sector Readiness for Net Zero Carbon by 2030; Evidence report

Attachment

5.2 Public_Sector_Readiness_for_Net_Zero_Carbon_by_2030_Evidence_Report_English.pdf (40 pages)

5.3. Report regarding the Third Wales Wellbeing Survey

Attachment

5.3 NHS Report 10th July '22 (English).pdf (35 pages)

10:45 - 10:45
0 min

6. Other Matters

6.1. To confirm any key risks and issues for reporting/escalation to Board and/or other Committees

Verbal *Chair*

10:45 - 10:45
0 min

7. The next Committee meeting will be held in April 2023, finalised date to be confirmed

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Partnerships, Population Health & Planning Committee
2022/23 Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the PPHPC and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the PPHPC these actions will be taken off the rolling action sheet.)

Agreed Actions Key:

Overdue	Not yet due	Due	Transferred	Complete	In progress

Action Ref	Action Description	Due date	Lead	Progress	Status
PPHPC 2504/05.1 Overview of Work of the Gwent Public Service Board (PSB), including an update in respect of Developing a Marmot Region	The Communications plan to be included in the paper being presented to the PSB in June. Any papers presented at the PSB to come to future meetings for discussion.	**Nov 2022**	**Director of Public Health & Strategic Partnerships**	Gwent Marmot Region Communication and Engagement Strategy presented to the PSB on 30th June 2022. Included on the Agenda November 2022.	**Complete**

PPHPC 2504/06 Integrated Medium-Term Plan, 2022-2025	Paper on the Health Board's revised performance reporting, linking to the development of the Outcomes Framework, to be presented to the Committee in July.	**July 2022**	**Director of Planning & Performance**	Included as part of the Outcomes Report to the July Board.	**Complete**
PPHPC 2504/06.1 Integrated Medium-Term Plan, 2022-2025	An analysis of the 'first look' and implementation of the Outcomes Framework to come back to the Committee at the end of the first Quarter.	**July 2022**	**Director of Planning & Performance**	Included as part of the Outcomes Report to the July Board.	**Complete**
PPHPC 2504/06.2 Integrated Medium-Term Plan, 2022-2025	A report would be presented to the Committee each quarter, linked to the Board Assurance Framework (BAF), updating members on progress against each priority area. An example of the report was displayed to members.	**July 2022**	**Director of Planning & Performance**	Included as part of the Outcomes Report to the July Board.	**Complete**
PPHPC 2504/06.3 Integrated Medium-Term Plan, 2022-2025	Led by James Calvert, Medical Director, the previous COTE and Frailty programmes were being combined as one service for patient care in and out of hospital, aiming to deliver consistency of services across the Health Board area. **Action:** Further detail on the	**Nov 2022**	**Clinical Futures Programme Director/ Medical Director**	Included on the Agenda	**Complete**

	establishment of this programme of work to come back to the Committee.				
PPHPC 2504/06.5 Integrated Medium-Term Plan, 2022-2025	A report on SDEC and its associated assumptions to come back to the Committee.	**April 2023**	**Clinical Futures Programme Director**	Document circulated outside of the meeting providing an overview of the Implementation approach, timeline, Clinical model, layout and expected benefits to patient experience. Verbal update to be provided at the meeting in November 2022. Added to the Committee Forward Work Plan for April 2023.	**In progress**
PPHPC 0707/05 Committee Action Log	A report on the evaluation of Vascular Services, including governance and assurance, to be presented to a future meeting.	**April 2023**	**Director of Planning & Performance**	Report included in the Committee forward work programme.	**Not yet due**
PPHPC 0707/06 Committee Strategic Risk Report	The Chair queried whether or not the clinical futures model remained fit for purpose, and it was agreed that CRR007 would be reframed to better reflect the current position.	**Nov 2022**	**Head of Corporate Services, Risk and Assurance**	The reframing of risk CRR007 is reflected in the Committee Risk Report included on the Agenda.	**Complete**
PPHPC 0707/07 To Receive an Update in respect of Creating a Marmot Region	An update on community engagement to be reported to a future meeting.	**Nov 2022**	**Director of Public Health & Strategic Partnerships**	Included on the Agenda.	**Complete**

via the Public Services					
PPHPC 0707/08 To receive an update on the development and delivery of a Strategy for Mental Health Services in Gwent	Third All-Wales Wellbeing Survey report to be circulated with members once published.	**Nov 2022**	**Director of Primary Care, Community and Mental Health Services**	Item included on the agenda for information.	**Complete**
PPHPC 0707/08.1 To receive an update on the development and delivery of a Strategy for Mental Health Services in Gwent	A re-focus of the Estate's Strategy and a formal strategy for MHLD estates, including a timeline of action to be presented to the Committee.	**2023**	**Director of Primary Care, Community and Mental Health Services/ Director of Planning & Performance**	Due to current capacity issues the current focus is on completing the Outline Business Case for the Specialist In-Patient Services Unit. Welsh Government are currently evaluating the 10 years Together for Mental Health National Strategy and the outcome of the evaluation will need to inform any local service and associated estates strategy developed by the Health Board in 2023.	**In progress**
PPHPC 0707/08.2 To receive an update on the development and delivery of a Strategy for Mental Health	The Chair and Chris O'Connor would discuss Prison Mental Health Services outside of the meeting.	**Dec 2022**	**Director of Primary Care, Community and Mental Health Services/ Chair**	Meeting to be arranged.	**In progress**

Services in Gwent					
PPHPC 0707/09 To receive an update on the Key Clinical Futures Models of Care	A detailed review of the Clinical Futures models, aligning with the Health Board's IMTP priorities would be undertaken in Quarter 3 of 2022. Action: An update on the formal evaluation to come back to the Committee, alongside regular updates.	**Nov 2022**	**Director of Planning & Performance**	An item discussing the approach to developing the 2023/3 – 25/26 Integrated Medium Term Plan added to the agenda for discussion in November 2022.	**Complete**

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Partnerships, Population Health and Planning Committee held on Thursday 7th July 2022 at 9.30 am via Teams

Present:	
Ann Lloyd	Chair
Katija Dew	Independent Member (Vice-Chair)
Richard Clark	Independent Member
Phil Robson	Co-opted Member, Special Advisor
In attendance:	
Sarah Aitken	Director of Public Health & Strategic Partnerships
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT
Bryony Codd	Head of Corporate Governance
Chris O'Connor	Interim Director of Primary, Community and Mental Health Services
Sarah Simmonds	Director of Workforce & OD
Robert Holcombe	Interim Director of Finance, Procurement & Value Based Healthcare
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
Glyn Jones	Interim Chief Executive Officer
Laura Howells	Principal Auditor, NWSSP
Delyth Brushett	Audit Wales
Ian Thomas	General Manager, MHLD
Kathryn Walters	Interim Divisional Director, MHLD
Apologies:	
Rani Mallison	Director of Corporate Governance

	Preliminary Matters
PPHPC 0707/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PPHPC 0707/02	**Apologies for Absence** Apologies for absence were noted.
PPHPC 0707/03	**Declarations of Interest** There were no Declarations of Interest raised to record.
PPHPC 0707/04	**Minutes of the previous meeting** The minutes of the meeting held on the 25th of April 2022 were agreed as a true and accurate record.

PPHPC 0707/05	**Committee Action Log- July 2022** The Chair requested an update on the progress of Vascular Services, as discussed in the previous meeting, and assurance of the effectiveness of the evaluation framework underpinning implementation. Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, informed members that the 'go live' date of the 18th of July 2022 was on schedule. Members were informed that there would be a robust evaluation, with governance and assurance for Vascular Services to come back to future meetings. **Action:** A report on the evaluation of Vascular Services, including governance and assurance, to be presented to a future meeting. **Director of Planning, Performance, Digital and IT**
	Committee Governance
PPHPC 0707/06	**Committee Strategic Risk Report** Danielle O'Leary, Head of Corporate Services, Risk and Assurance presented the report to the Committee, providing assurance that the Committee's forward work plan would be determined by the organisational strategic risks linked to the Committee. Members were informed that divisions had received targeted support and intervention to review current risks and encourage tailored business meetings around emerging risk themes. The Chair queried whether or not the clinical futures model remained fit for purpose, and it was agreed that CRR007 would be reframed to better reflect the current position. **Action:** Risk to be reviewed and reframed **Head of Corporate Services, Risk and Assurance** The Committee; - • **RECEIVED** the report for **ASSURANCE** and compliance. • **ENDORSED** the approach to utilising the risk profiles for this Committee to inform the Committee work plan throughout the year, with the caveat that risks may change.
	Strategic Partnerships
PPHPC 0707/07	**To Receive an Update in respect of Creating a Marmot Region via the Public Services** Sarah Aitken, Director of Public Health & Strategic Partnerships, presented the report, providing an update on the Health Board's progress with the Gwent Marmot Region programme and in response to follow up actions recorded at the previous meeting of the Committee. Members were informed that the report had been presented to the PSB in June 2022 and that all recommendations outlined in the report had been agreed. Members discussed the follow up action of the alignment of the Marmot Programme with the Gwent Well-being Plan 2023-27 and noted further discussions would take place with members of the PSB in the following weeks.

	Members were informed of the establishment of the Gwent Marmot Region Leadership Programme Group, a subgroup of the PSB, with Health Board representation from Stuart Bourne, Consultant in Public Health, and Scott Wilson-Evans, Strategic Head of Communications and Population Health. Richard Clark, Independent Member, highlighted the importance of cascading the outlined initiative to all Local Authorities. Sarah Aitken informed members that critical next steps included a programme of engagement, to include community engagement. **Action:** An update on community engagement to be reported to a future meeting. **Director of Public Health & Strategic Partnerships** The Chair thanked Sarah Aitken and the teams for the work undertaken and highlighted the importance of active engagement between the Health Board and Local Authorities, working together to achieve the targets to improve outcomes for the population. The Committee **RECEIVED** the report, **NOTING** the contents.
	Strategic Planning and Developments
PPHPC 0707/08	**To receive an update on the development and delivery of a Strategy for Mental Health Services in Gwent** Chris O'Connor, Interim Director of Primary, Community and Mental Health Services supported by Ian Thomas, General Manager, MHLD, and Kathryn Walters, Interim Divisional Director, MHLD, presented the update to the Committee. The update focused on the Health Board's progress and future for the Mental Health Strategy within Gwent. Members were informed that the implementation of the Mental Health Transformation Programme was one of the key priorities for the IMPT for 2022/23. A Mental Health Transformation Board was in place to provide support and oversee delivery of the strategy for Mental Health. Members were informed that the Health Board's Mental Health and Learning Disability Division plan aimed to implement change through a 'whole pathway approach'. A Health Board focus was to provide support to the population by supporting good mental wellbeing, encompassing partnership working alongside statutory agencies and third sector partners. Members were informed that the Health Board worked alongside people with lived experience to help co-design strategies and support development of services. People with lived experience were involved in staff selection, staff training and were peer mentors within the division, helping transform services. Members were presented with early data from the third all Wales Wellbeing survey. Early data indicated that there had been a slight improvement in the wellbeing of the population surveyed, although still significantly lower than pre-pandemic. **Action:** Report to be circulated to members, once published. **Interim Director of Primary Care, Community and Mental Health Services**

	Members received an update on the current estate within Mental Health and Learning Disabilities and it was agreed that there needed to be a formal strategy to address the issues. **Action:** A re-focus of the Estate's Strategy and a formal strategy for MHLD estates, including a timeline of action to be presented to the Committee. **Interim Director of Primary, Community and Mental Health Services/Director of Planning, Performance, Digital and IT** The Chair requested further conversation around mental health services in prisons**. Action:** It was agreed that the Chair and Chris O'Connor would discuss Prison Mental Health Services outside of the meeting. **Interim Director of Primary, Community and Mental Health Services/Chair** Katija Dew, Independent Member, discussed reports of an increase in the UK Benefits Bill, attributed to a rise in claims for Personal Independence Payments (PIP). Members queried how this related to the demand seen on mental health services within the Health Board area. Members were informed of the multiple determinants impacting upon people's mental health and wellbeing, including recovering from the pandemic and food and fuel poverty. The Health Board had seen an increased demand throughout the MHLD pathway. The Health Board had previously put a proposal to the Department of Works and Pensions (DWP) to develop a service to help individuals with mental health problems to get back into work. Members were informed that a decision had not been made at the time; however, the DWP would be revisiting the proposal in the coming year. The Chair thanked the team for the presentation, noting the promising vision for provision of care. Members thanked the MHLD team for the progress made and work undertaken over the last two years, despite the challenging circumstances.
PPHPC 0707/09	**To receive an update on the Key Clinical Futures Models of Care** Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, provided an update on the priority Clinical Futures service models, and the revised Clinical Futures Programme Priorities. Members received an overview on the areas of remaining concern that were forming a core part of the Clinical Futures Programme in 2022/23. Members noted that full service-readiness assessments had taken place in March 2020 on 23 service areas, in line with the planned changes to hospital structures due to the opening of GUH. The report proposed that a detailed review of the Clinical Futures models be undertaken, aligning with the Health Board's IMTP priorities. This would be undertaken in Quarter 3 of 2022. **Action:** An update on the formal evaluation to come back to the Committee, alongside regular updates. **Director of Planning, Performance, Digital and IT**

	Specific service models were discussed, as outlined in the report. Under the Gastroenterology service model, it was noted that there had been recent approval for a new Endoscopy Unit at the Royal Gwent Hospital. Emergency pressures were noted as a key constraint for optimisation of the Clinical Futures model. Members were informed that demand, capacity and workforce continued to be a challenge across the eLGH and GUH sites. Further work was required around the utilisation of workforce and improvement of pathways. The Committee formally **ENDORSED** the review of the Clinical Futures service models, as outlined in the report, and **NOTED** the contents.
PPHPC 0707/10	**To receive an update on the development and delivery of a Strategy for Agile Working in ABUHB** Sarah Simmonds, Director of Workforce & OD, provided an update on the Health Board's approach to deliver and develop the strategy for agile working. The report outlined progress against key objectives, next steps and identified risks associated with the delivery of the strategic programme It was discussed that performance against agile working and its associated risks was overseen by the Agile Delivery Group. The group had recently refreshed its terms of reference, enabling integration of agile working and the estates strategy. In addition, the group was supported by four subgroups, workforce, ICT, Capital Planning and Works and Estates. Members were informed of plans for the Health Board to re-establish the Accommodation Group, linking the Agile Working agenda with best practice and changes in the Health Board footprint. The agile working area at the Grange University Hospital was operational, with workforce teams working alongside staff side representatives to address any issues raised. In addition, an Agile Working Framework had been developed by the Health Board to provide support to staff and managers. The Committee thanked the Director of Workforce & OD for the progress made and **NOTED** the update in relation to the Agile Working Strategy across the Health Board.
	Other Matters
PPHPC 0707/11	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** The Chair requested that the following be reported: • ***To Receive an Update on the Key Clinical Futures Models of Care***- The action in relation to the virtual review of the Clinical Futures models, estimated to take place in Quarter 3 of 2022. • ***To Receive an Update on the Development and Delivery of a Strategy for Mental Health Services in Gwent-*** A brief overview of the Mental Health Strategy and its progress.

	Date of Next Meeting
PPHPC 0707/12	The date of the next meeting was noted as: - Tuesday 8th November 2022, via Microsoft Teams.

PARTNERSHIPS, POPULATION HEALTH AND PLANNING COMMITTEE
PROGRAMME OF BUSINESS 2022/23

The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on the robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership; that plans and arrangements are adequate, effective, robust and achieving outcomes in relation to Joint Committee and partnership planning, engagement and communication and Civil contingencies and business continuity; that partnership governance and partnership working is effective and successful; and that the arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

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

- the Committee's Terms of Reference as agreed by the Board in March 2022;
- the Board's Assurance Framework (based on its Annual Objectives for 2021/22 and 2022/23);
- delivery of the IMTP 2022-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			25 April 2022	7 July 2022	16 Nov 2022	TBC April 2023			
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓			
Declarations of Interest		All Members	✓	✓	✓	✓			
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓			
Action Log and Matters Arising		Chair	✓	✓	✓	✓			
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG	✓						
Review of Committee Programme of Business	Standing Item	Chair	✓	✓	✓	✓			
Annual Review of Committee Terms of Reference 2022/23	Annually	Chair & Director of CG				✓			
Annual Review of Committee Effectiveness 2022/23	Annually	Chair & Director of CG				✓			
Committee Annual Report 2022/23	Annually	Chair & Director of CG				✓			
Strategic Partnerships									
Overview of work of the Gwent PSB, including an update in respect of Developing a Marmot Region	Standing Item	Director of Public Health	✓	✓		✓			
Update on the development and delivery of a Strategy for Mental Health Services in Gwent	Annually	Dir. PC,C&MHS		✓					
Gwent Marmot Region Communication and Engagement Strategy (as presented to the PSB on 30th June 2022)	Annually	Director of Public Health			✓				
Strategic Planning and Developments									
Approach to developing the Integrated Medium-Term Plan	Annually	Director of Planning & Performance			✓				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			25 April 2022	7 July 2022	16 Nov 2022	TBC April 2023			
Draft Integrated Medium-Term Plan	Annually	Director of Planning & Performance	✓			✓			
Regional Planning Update	Standing Item	Director of Planning & Performance	✓	✓	✓	✓			
A report on the evaluation of the Vascular Services Network	Annually	Director of Planning & Performance				✓			
Update on the Overarching Clinical Futures Programme	Standing Item	Director of Planning & Performance		✓	✓	✓			
To review the development of plans in respect of the key Clinical Future Priorities:									
1. Public Health Protection and Population Health Improvement	Annually	Director of Public Health				✓			
2. Accelerated Cluster Development	Annually	Dir. PC,C&MHS							
3. Redesigning Services for Older People	Annually	Medical Director			✓				
4. Mental Health Transformation	Annually	Dir. PC,C&MHS				✓			
5. Planned Care Recovery: *Outpatient Transformation & Pathway Optimisation*	Annually	Director of Operations							
6. Urgent and Emergency Care Improvement, to include an update on SDEC	Annually	Director of Operations			✓				
7. Enhanced Local General Hospital Network	Annually	Director of Operations							
8. Transforming Cancer Services	Annually	Medical Director							
9. Net Zero - Decarbonisation	Annually	Director of Planning & Performance	✓						
Enablers: Update on the development and delivery of an Agile Working Strategy	Annually	Director of Workforce & OD		✓					
Enablers: Capital Programme	Annually	Director of Operations			✓				
Enablers: Digital Strategy	Annually	Chief Executive							

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			25 April 2022	7 July 2022	16 Nov 2022	TBC April 2023			
Information on Regional Partnership Boards (RPB) funding plans and allocation- in relation to the Primary Care Evaluation Report- Action transferred from the People & Culture Committee- (2002/05)	tbc	Director of Partnership & Integration							

KEY	
D of CG	Director of Corporate Governance
Dir. PC,C&MHS	Director of Primary, Community and Mental Health Services

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Partnerships, Population Health and Planning Committee 16th November 2022 Agenda Item: 2.2

Aneurin Bevan University Health Board

Partnerships, Population Health and Planning Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of risks that are required to be reported to the Partnerships, Population Health and Planning Committee (PPHPC). The risks reflect the sustained challenges of service delivery and restart and recovery plans against a backdrop of a challenging financial position alongside continued disruption and delays caused by residual impact of the COVID pandemic.

The report also provides an update in respect of:

- Continued embedding of the Risk Management Strategy and associated delivery framework within operational, Divisional teams and at Executive level.
- Engagement with key partners across Gwent in respect of internally and externally identified risks.
- Identification of new risks pertinent to the PPHPC that are proposed to be added to the Corporate Risk Register.

The PPHPC is asked to note this report.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Director of Corporate Governance
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board:**	• **Partnerships, Population Health and Planning Committee**

Date of the Report: 7th November 2022

Supplementary Papers Attached:
Appendix 1 – Risk Assessments for Planning/Strategic Risks

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks related to the Partnerships, Population Health and Planning Committee (PPHPC), which also form strategic risk profiles for the Health Board and as such, feature within the Board Assurance Framework.

Background and Context

In conjunction with the Board Assurance Framework (BAF) and the Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the revised IMTP.

This report provides the Partnership Population Health and Planning Committee with an opportunity to review the organisational strategic risks pertinent to the Committee and which also form part of the risks featured within the Board Assurance Framework.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

Revised Risk Management Approach and Update on National OfW Risk Module

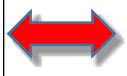
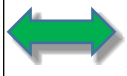
The organisational risk management approach remains in the embedding phase throughout the organisation. A plan for implementation and full realisation of the risk management strategy has been developed and is being actively monitored through the Audit, Risk and Assurance Committee. A review of the Health Board's Risk Management Strategy is currently being undertaken. The review will determine if the strategy continues to be fit for purpose and aligns to most recent, evidenced best practice in relation to risk management. A draft is anticipated to be shared with Audit, Risk and Assurance Committee at it's December 2022 meeting and will form part of a wider organisational consultation process prior to final Health Board endorsement.

Continued and targeted engagement throughout the organisation has taken place to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). This is being driven, informed and underpinned by the National work being undertaken by Once for Wales to develop a dedicated and specific Risk Management module. It is anticipated that the electronic risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification. Of note is the progress that has been made in relation to data cleansing of risks within the Scheduled Care Division. The data cleansing exercise means that this Division is the best possible position to optimally utilise the new RL DATIX risk management module, as soon as it becomes available. The approach taken by the Division has recently been shared with colleagues from across the Health Board at the risk management community of practice and colleagues were encouraged to adopt a similar approach in their respective Divisions/Directorates.

Current Status

There are currently **26** risks that form the Corporate Risk Register, **3** of which report to the PPHPC; **1** forms a Principal Risks within the remit of the Committee and the remaining **2** present moderate risk levels. The risks with a score 15> are also

considered to be principal risks to achievement of the Health Board IMTP. The following tables provide a breakdown of the risks, level of severity and risk appetite assessment:

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR007 ***(re-framed July 2022***) Current service delivery model does not take into consideration the evolving needs of the population at this time.	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services**
CRR012 ***(re-framed Dec 2021)*** Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impact's ability of achievement of strategic objectives.	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore,	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships and Board Secretary**

			risk appetite in this area is defined at a moderate level.		positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.			

Detailed risk profiles for which the Committee provides oversight (**3 profiles in total**), are appended to this report at ***Appendix 1***.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

Organisational risks that feature on the Corporate Risk Register and receive oversight from this Committee will be actively reviewed as part of the identification of the Committee's priorities and agenda setting process to ensure a risk focussed approach is taken to managing the business of the Committee. This will also strengthen assurance in relation to Committee priorities and ensure appropriate focus is placed on most significant areas.

Engagement with Key Partners and Horizon Scanning Risk Management

At a recent Gwent Local Resilience Forum (GLRF) meeting, the Winter Planning Risk Register for all partners in Gwent was presented. A discussion took place in relation to risk scoring, descriptors and impacts and as an outcome, a mutually agreed risk register was developed and endorsed. It is important to note that many of the risks highlighted through partners reflected the internal Health Board position and took into consideration the National Security Risk Assessment (NRSA) highlighted risks. The Committee is requested to acknowledge that risks are being discussed across key partner organisations to provide reassurance that the approach to Winter Planning and associated risk mitigation, has been executed collaboratively.

Following discussions across the organisation, a review of data available on DATIX, through various fora and through direct Executive Director escalation, the Executive Team has recently received a paper outlining a number of proposed new risks to be added to the Corporate Risk Register. All these risks will be highlighted within the Strategic Risk Report to the November Board meeting; however, members are requested to note that the following newly identified risk are pertinent to the Committee and subject to formal approval from the Board, will be reported to the Committee at each meeting:

External escalation of displaced people/migrants – Expected increase of displaced people in to the Gwent area under the Home Office commissioned [section 98] accommodation. This presents a potential risk of further compounded demand for services across areas of Gwent.	**Recommendation from HoRA[1] due to spiralling position of conflict in Europe and external environmental FIRM risk assessments.**	**Primary and Community Services continues to support the resettlement programme in Gwent, impacting on capacity in Primary Care and eventually will impact on Secondary Care services as numbers increase and patient demographic changes.**	**Low (averse to risk) Risk Appetite Level 2**	**4x4 = 16**
Cost of living crisis – impact on population of Gwent and staff – New Risk – Levels of staff absence may increase due to the costs associated with travelling to and from work, increased demand for services as population unable to heat their homes adequately, especially impacting the elderly population of Gwent.	Recommendation from the Chair, substantive item requested and confirmed for January 2023 People and Culture Committee.	Staff well-being and physical health compromised leading to an inability to staff shifts appropriately. Increased demand over Winter due to people not eating or heating themselves appropriately due to costs. Increased pressure on Primary Secondary Care services and potentially increased demand for Mental Health services.	Moderate (cautious risk taking) Risk Appetite Level 3	4x5 = 20

Recommendation & Conclusion

The Committee is asked to:

- **NOTE** the content of this report, recognising that there will be further iterative development work to embed the revised risk management approach across the organisation.

[1] Head of Risk and Assurance

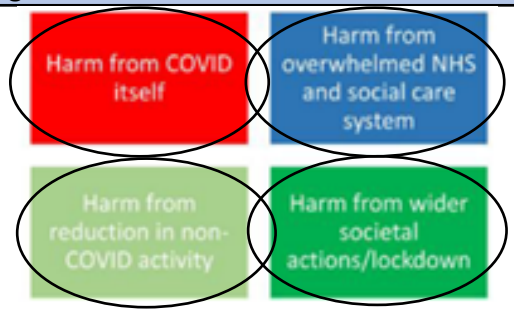
• **ACKNOWLEDGE** the updates that have been received and reflected in the appendices for the last reporting period. • **NOTE** the proposed new risks which, subject to endorsement at the Board, will be routinely monitored and reviewed by the Committee.	
Supporting Assessment & Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

<table>
<tr><th colspan="2">Applicable Strategic Priorities – IMTP</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">CRR007 – (re-framed July 2022)
Risk of: The Health Board is unable to meet the increasingly complex needs of its population
Due to: Current service delivery model does not take into consideration the evolving needs of the population at this time.

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Population health
Partnership
Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence</td><td>Risk Appetite</td><td colspan="2">Zero or low level of risk in terms of protecting patient safety and the quality of services in care homes; however, acknowledge that this is a transferable, shared risk and therefore the Health Board should understand its Partner's risk profile in relation to the care home sector and a dynamic risk appetite may be required.

When exploring innovative areas of providing enhanced services, the Health Board will be cognisant and acknowledge that some level of risk will need to be tolerated. Therefore, a higher level of risk appetite will be applied in this instance.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Partnerships, Population Health and Planning Committee</td><td>Section 33 Pooled budgets for Care Homes to support sustainability in place.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

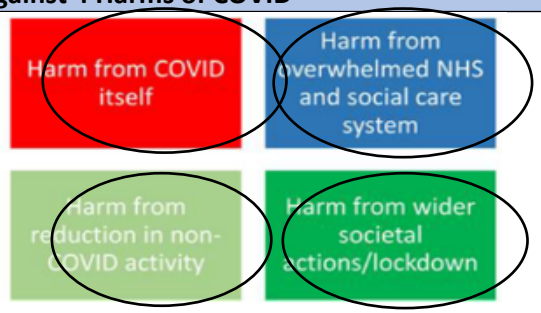
	• Continued training, equipment and staff support is provided to care homes. • Implementation of agreed joint contract. • Health Boards continue to work on an All-Wales basis to comply with requirements of the Supreme Court Judgement. • Risk assessment updated monthly and reported to Complex Care and Health Board Quality and Patient Safety meetings.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	4	4	3	4
Sustainability Funding Plan to be developed.	Mar-20	**16**		**16**		**12**	
Trend		**Executive Owner: Director of Primary Care, Community and Mental Health**					

Mapping Against 4 Harms of COVID	**Update**
	Nov 2022 : Since the onset of the COVID 19 pandemic we have seen a significant increase in the number of vacancies within the Older Adult Care Home sector and this has resulted in a significant change in the financial sustainability / fragility of the sector. A review is required based on the anticipated demand and capacity requirements of the local population and the type of care provision, which is required, working with the providers to ensure we have a sustainable and vibrant sector providing the quality of care determined by the commissioners and population. Redesign of older adult services has commenced on a multi-agency basis. The plan will be fully costed, with financial and workforce modelling as a core part of the delivery.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – IMTP</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">CRR012 (Nov-2021) – (Reframed)
Risk of: Increased dependency on Health Board services in the longer term.
Due to: Inability to address health inequalities across the population including adequate access to appropriate Health Board Services

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience
Public Confidence
Financial</td><td colspan="2">Risk Appetite</td><td>Low risk appetite in terms of patient safety and services. Moderate risk appetite with regard to innovation and developments in primary care and public health initiatives.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Partnerships, Population Health and Planning Committee</td><td>Sustainability Board established to monitor and report on all Primary Care GP Service sustainability.
New MDT model in place in a number of practices.
New model implemented in managed practices.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• Work continues on managed practices, supported mergers and manager redistribution continues. • Oversight at Senior Management Team Meetings within Primary Care and Community Services. • Neighbourhood Care Networks well established and plans in place and reviewed. • Continuous and regular monitoring of the implementation of 'A Healthier Gwent' at Committees, Executive Team and the Board.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	3	4	1	4
Additional sessions to be secured in GMS/GDS Practices. Individual actions plans to be developed for each NCN area/Practice and reviewed monthly.	Jan 2022 Jan-2022 Jan-2022	**16**		**12**		**4**	

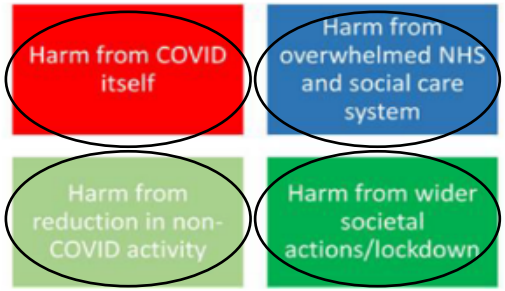
Additional dental recovery monies to secure additional activities. Health inequalities to be included as a priority in the Gwent PSB Well-being Plan 2023-27 to drive partnership action.	Sept-2022			
Trend		**Executive Owner: Director of Primary, Community and Mental Health Services and Director of Public Health and Partnerships**		
Mapping Against 4 Harms of COVID		**Update**		
		June 2022: **Primary Care – access to Health Services:** Despite significant pressures within the Primary Care system, the vast majority of services have been maintained through the pandemic period, with only a small number of branch practice closures on an intermittent basis. The Primary Care team have conducted a full survey of GMS access arrangements which have been reported through the Executive and Board to inform the current position Action plan has been developed to support those practices with difficulties in achieving the required access standards and individual practice plans are now being implemented to enable all areas to achieve the required minimum standards. Further financial support has been made available for the remainder of the year in those practices where additional capacity is required to meet the increase in demand and support further improvements in sessional availability- this money will be non-recurrent and is aimed at supporting the practices who have achieved the minimum standards but who have seen growth in demand Further work is underway in the NCN networks to develop the MDT model and now incorporates additional mental health foundation tier professionals who are deployed to support GP practices with high levels of mental health demand and provide additional staff to redirect patients to the most appropriate services Demand for GP appointments continues to grow and the further development of community and social care support services for the coming period will be essential if demand for services is to be met. Additional capacity has been secured within planned Dental services to deal with the treatment backlogs, alongside the investment in emergency dental appointments has resulted in an improvement in dental service access in many areas of the health board.		

	The continued development of the A C D is ongoing with the Gwent compliance framework being reviewed by Executive Directors. NCN development sessions are taking place throughout July August. Jun 2022: **Public Health – addressing health inequalities within communities:** Draft response analysis produced which provides a position statement and recommendations for addressing health inequalities for Gwent PSB. To be discussed and agreed at Gwent PSB meeting on 30/06/22 as part of PSB Well-being Plan development. Work continues with Institute of Health Equity and Gwent PSB to develop the Marmot Region approach in Gwent. Nov 2022 **Public Health – addressing health inequalities within communities:** Gwent Marmot Region leadership event held on 21st Oct. Gwent PSB draft Well-being Plan currently out for consultation. Creating a fair and equitable Gwent for all is one of three draft objectives in the plan. Consultation ends mid-Dec'22.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – IMTP</td><td colspan="2">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="2">CRR004 (Nov 2021) – (Reframed)
Risk of: Non-compliance with relevant Legislative requirements.
Due to: The Health Board does not meet its statutory duty under the Well-Being of Future Generations (Wales) Act 2015 or the Socio-Economic Duty.

TAKE OPPORTUNITIES TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience
Health Inequalities
Financial
Public Confidence</td><td>Risk Appetite</td><td>LOW/MODERATE - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="2">Risk Score</td></tr>
</table>

Partnerships, Population Health and Planning Committee	Programme Board in place to ensure the duties in the WBFA are applied across the organisation. Each Division has developed and agreed wellbeing objectives which have been signed off by Board and published. Organisational wellbeing objectives and PSB(s) wellbeing objectives reflected within the IMTP and Divisional Plans.		**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			3	4	1	4	1	4
WBFA management arrangements to be reviewed post pandemic. Programme Board operations and wellbeing objectives to be re-set during 2022-23 to reflect maturity of WBFA arrangements. Development work is underway to incorporate the statutory obligations of the Socio-economic Duty to the corporate reporting templates of the Health Board to emphasise the importance of the Duty across the organisation.		Mar-23 Dec-21	**12**		**4**		**4**	
Trend			**Executive Owner: Director of Public Health and Partnerships and Board Secretary**					
Mapping Against 4 Harms of COVID			**Update**					

	Jun 2022: Pre-pandemic management arrangements to support adherence to WBFA requirements will be reviewed and re-set during 2022/23. This will reflect the post-pandemic position, as well as the ongoing prominence of the legislation in Wales. This will result in a re-statement of wellbeing objectives in the Health Board and a re-set of management arrangements. The Marmot Region programme of work through Gwent PSB is a significant demonstration of the Health Board's commitment to compliance with the Socio-Economic Duty. Nov 2022: Inclusion of Gwent PSB's draft well-being objectives for the next five years to be taken forward as part of IMTP process.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Partnerships, Population Health & Planning Committee 16 November 2022 Agenda Item: 3.1

Aneurin Bevan University Health Board

Gwent Marmot Region Programme and Communication Plans

Executive Summary			
This paper provides a summary of the Marmot Region programme plan and communication plan(s).			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			**X**
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Dr Sarah Aitken, Director of Public Health			
Report Author(s): Consultant in Public Health, Gwent Marmot Region Programme Manager, Strategic Head of Communications, Population Health			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 31/10/2022			
Supplementary Papers Attached: N/A			

Purpose of the Report

To provide a briefing to Partnerships, Population Health and Planning Committee (PPHPC) on the Marmot Region programme and communication plans.

Background and Context

Gwent Public Services Board (PSB) has formally decided to apply the framework of the eight Marmot principles to shape the partnership response to inequity. In so doing, Gwent will become the first Marmot region in Wales, and will join parts of England including Greater Manchester, Coventry and Cheshire and Merseyside as a growing network of places using the Marmot principles to address inequity and the social determinants of health. The eight Marmot Principles are:

1. Give every child the best start in life;
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives;
3. Create fair employment and good work for all;
4. Ensure a healthy standard of living for all;

5. Create and develop healthy and sustainable places and communities;
6. Strengthen the role and impact of ill-health prevention;
7. Tackle racism, discrimination and their outcomes;
8. Pursue environmental sustainability and health equity together.

Gwent's response to the eight Marmot Principles will be set out in the Gwent PSB Well-being Plan when it is published in 2023. This will be a five-year plan.

Under the leadership of the Director of Public Health (DPH), Aneurin Bevan Gwent Public Health Team is coordinating the delivery of the Marmot Region programme in partnership with organisations in Gwent, and under the governance of Gwent PSB.

Assessment and Conclusion

Marmot Region Programme Plan

Within Aneurin Bevan Gwent Public Health Team (ABGPHT), a small Marmot programme team has been created to establish the Gwent Marmot Region programme over the next twelve months. This team consists of:

- Consultant in Public Health;
- Programme Manager;
- Senior Public Health Practitioner;
- Public Health Practitioner.

In addition, the Strategic Head of Communications (Population Health), and a specialist registrar (SpR), are also contributing to the programme.

An agreement is also in place with the University College London Institute of Health Equity (IHE) to support Gwent over the next twelve months.

The Marmot programme team reports to a Marmot Programme Leadership Group made up of leaders from Gwent PSB. Programme update reports are provided at each PSB meeting.

The Marmot programme team is responsible for updating the core programme management documents, including the timeline, communications and engagement plan, and risk register. The Marmot team will also engage with partners and key stakeholders to communicate the Gwent Marmot Region framework and support the PSB Well-being Plan development.

The Marmot programme team has just commenced work – starting in September 2022. A live programme plan has been created and is being implemented.

The timeline for the initial stages of the Marmot programme are closely aligned to the work underway in Gwent PSB to develop the 2023-28 Well-being Plan. This is to ensure that actions to address the eight Marmot Principles form the basis of Gwent PSB's response to objective one of the Well-being Plan, i.e. 'We want to create a fair and equitable Gwent for all'.

Key events between October to December 2022 include:

- Gwent Marmot Region leadership launch event (21st October 2022)

On 21st October 2022, leaders from across public sector organisations in Gwent came together for the Gwent Marmot Region launch at the Lysaght Institute in Newport.

Professor Sir Michael Marmot, Director of the IHE, presented information on health inequalities and what actions have worked both globally and in other Marmot regions in England. Keynote speakers sat on a Q&A panel and answered questions from delegates who were physically present and online.

The appetite for change in the room was evident, and the launch provided a clear call to action to work together to address inequity across Gwent. The Gwent Marmot programme team will be working closely with partners over the coming months to form a plan of action on what is achievable together.

- Gwent Well-being Plan stakeholder workshops

The Marmot programme team is working with the chair of the PSB's Engagement Group and the IHE to finalise plans for five local authority area workshops. These workshops are focused on leaders and managers of partnership organisations and are being held on the following dates:

- Monday 14th November, Greenmeadow Golf Club, Torfaen
- Wednesday 16th November, Bedwellty House, Blaenau Gwent
- Thursday 17th November, Lysaght Institute, Newport
- Thursday 24th November, Llancaiach Fawr, Caerphilly
- Wednesday 30th November, Cwrt Bleddyn, Monmouthshire

A further online only workshop is being organised for delegates unable to attend in person. All invitations are due to be sent by the end of October 2022. The Marmot programme team are also planning a series of community focused events in December/January facilitated via the Integrated Wellbeing Networks.

From January 2023 onwards, the Marmot programme team will be working closely with Gwent PSB officers to ensure the Well-being Plan reflects the eight Marmot principles, and that steps set out in the plan are consistent with the ambition and views of those being consulted. The PSB Well-being Plan will be approved by individual member organisations between February-March 2023, prior to approval collectively by Gwent PSB in April 2023.

A copy of the draft PSB Well-being Plan is available at:
https://www.gwentpsb.org/wp-content/uploads/2022/09/03-Appendix-1-Draft-WBP-for-consultation-Gwent-PSB-29-Sept-22.pdf

Gwent Marmot Region communications
The Gwent Marmot Region webpage was launched on 20th October 2022. The webpage includes information about what becoming a Marmot Region means for Gwent.

A press release and social media content was distributed following the 21st October leadership event. This is available to view via the PSB website:
https://www.gwentpsb.org/en/gwent-marmot-region/

Branding has been developed in collaboration with community groups and partners by an appointed creative agency. The branding is a vital part of the programme to raise the profile of the programme and engage partners and communities.

Four branding concepts were originally developed by the creative agency and were taken to focus groups with young people and the wider community to gather input and insight. Out of these focus groups both sessions preferred a less corporate option.

Following the feedback from these focus groups, two concepts were redesigned and put forward at the 21st October Marmot launch. Final feedback is being undertaken with the aim to launch the branding soon.

Communications strategy
The Marmot Region Communications and Engagement Plan has been developed by the ABUHB communications team and provides an overview of the communications and campaign plan over the next 12 months. The aim is to ensure there is widespread understanding and engagement in the Marmot Region programme in Gwent. This is a working document and is kept updated.

Conclusion and next steps
Between now and May 2023, the Gwent Marmot programme team will be supporting Gwent PSB in producing a final Well-being plan that meets the aspiration of the Gwent Marmot Region programme. In conjunction, additional support will be given to the IHE team to produce a Gwent Marmot Region report which will further make the case for addressing inequity in Gwent.

Recommendation
PPHP Committee members are asked to **DISCUSS** and **NOTE** the content of this paper.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The purpose of the Marmot principles Framework is to mitigate the risk of widening health inequalities, inequality and inequity
Financial Assessment, including Value for Money	The work programme is funded from existing budgets. Widening health inequalities is a financial risk to the Health Board which this work is intended to mitigate
Quality, Safety and Patient Experience Assessment	The programme of 'Marmot Region' workshops is being designed in a way to enable residents to participate, learning from the 2019 Building a Healthier Gwent programme
Equality and Diversity Impact Assessment	The work programme directly addresses health inequalities
Health and Care Standards	The work programme directly addresses providing access to health promotion services proportionate to population need
Link to Integrated Medium Term Plan	Links to the IMTP core strategic priority to reduce health inequalities
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The Marmot Principles Framework will be integrated into the Gwent Well-being plan and will cover a period of five years and will respond to issues related to health, well-being and social inequality

	Integration –The Gwent Marmot team are part of a wider partnership organisation and will look to align and integrate the response of partners and public to achieve accelerated action on social determinants of health at a regional level, including through the sharing of experiences and joint interventions.
	Involvement – A wide range of stakeholders are engaged in the work of Gwent PSB and Marmot Principles Framework.
	Collaboration – Both the Well-being Assessment, the Well-being Plan and the Marmot Region work will be subject to public engagement and collaboration.
	Prevention – The PSB and the Gwent Marmot Region team are working together to address some of the underlying structural issues at the root of health inequalities
Glossary of New Terms	N/A
Public Interest	Report written for public domain

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Partnerships, Population Health & Planning Committee Wednesday 16th November 2022 Agenda Item: 4.2

Aneurin Bevan University Health Board

Redesigning Services for Older People Programme Update

Executive Summary

The Redesigning Services for Older People (RSfOP) programme is one of the key ABUHB IMTP transformation programmes. A paper was taken to the Executive Team for discussion in August 2022 with a proposal for phase one delivery, specifically relating to Workstream 1: Early Intervention and Workstream 2: Ambulatory/Admission Avoidance Clinics. This paper provides an overview of the work streams and progress to date.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Dr James Calvert, Medical Director

Report Author: Ruby Punchard, Senior Programme Manager

Report Received consideration and supported by:

Executive Team		**Committee of the Board:** Partnerships, Population Health & Planning Committee	X

Date of the Report: 16/11/2022

Supplementary Papers Attached: None

Purpose of the Report

To provide an update on the Redesigning Services for Older People Programme to the Partnerships, Population Health & Planning Committee.

Background and Context

ABUHB recognised the need to review Care of the Elderly/Frailty pathways and service delivery models in the recently approved IMTP, focussing on ensuring that those who require hospital care receive it in a timely way and are not unnecessarily held up in our complex systems, and that our primary and community care services are resourced appropriately with applicable pathways to deliver place-based patient care. The

programme supports the fourth priority of the IMTP (*Older adults are supported to live well and independently*) as well as the overarching Clinical Futures strategy of the Health Board. There are also several key policy drivers that informed the strategic direction of travel for the programme, namely: *A Healthier Wales; D2RA and Care Closer to Home; Right Sizing Communities, and; 6 Goals for Urgent Care*.

At the design phase the programme was split into 4 key work streams which were identified as the key points of the pathway that were transformational, with opportunity for improvement and benefit (to patients and the wider health and social care system). These were:

- **WS1: Early intervention** – focussed on our GP and Frailty services, building on the integrated approach and interface with local authority and third sector partners to provide proactive and preventative care and services to support people to live well at home and to receive treatment wherever possible outside the hospital setting
- **WS2: Ambulatory/Admission Avoidance (Hot) Clinics** – develop a service that provides rapid assessment, diagnostics and treatment for ambulant patients with inpatient admission only occurring where there are clear further secondary care requirements
- **WS3: Community Hospitals and Step Up/Step Down** – Graduated care, developing the pathways, types of bed and associated staffing / resources required to meet the needs of patients admitted to our Community Hospitals. This workstream will also consider how community hospitals can be better utilised as a resource for reablement and admission avoidance closer to people homes, to avoid patients being referred to acute hospital services in situations where their care needs do not require that level of intervention.
- **WS4: Early Supported Discharge** – MDT approach to enable people to get home or closer to home as quickly as possible following an admission to hospital through establishment of better methods of communication and collaboration between hospital and community-based teams.

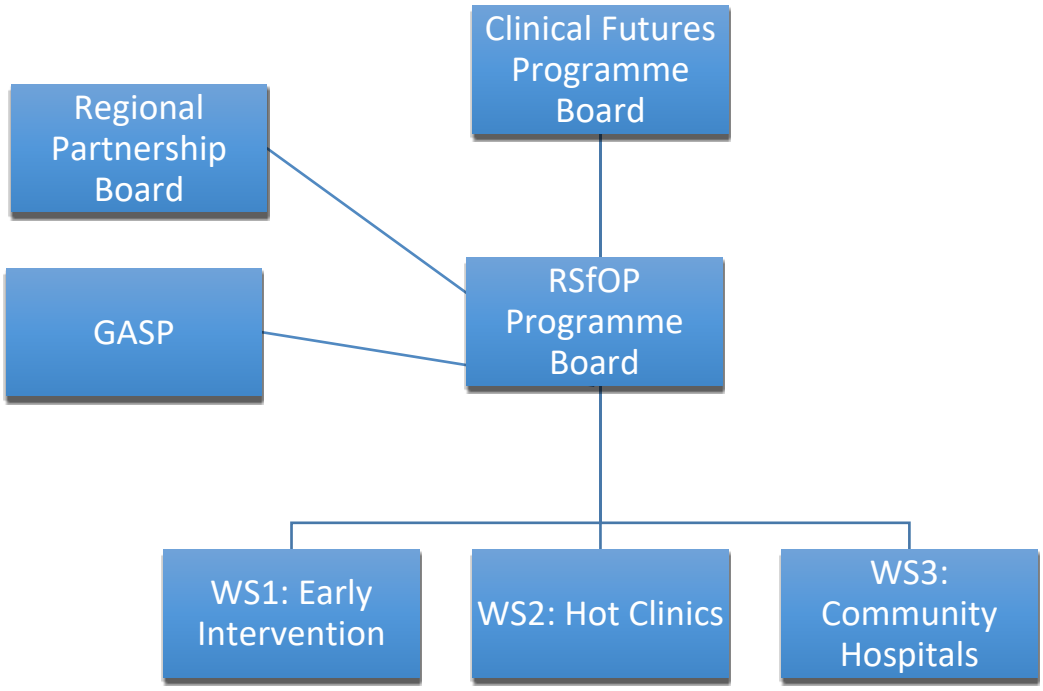
Working groups for each workstream were established with representation from all key stakeholder groups, including external partners (LA, WAST and 3rd sector), and it quickly became clear that WS1 & WS2 were synergistic.

The focus was to begin solution finding on the theme "working collectively as a health and social care system, how can we improve efficiency and effectiveness of support provided to frail, elderly people to enable them to stay at, or close to home, where it is safe to do so?". This engagement culminated in a workshop held on 22nd June for WS1 & WS2 to agree the priority ideas and solutions that are in support of the programme vision.

This was then developed into a proposal for phase 1 programme delivery over the 4 weeks that followed, again with extensive engagement of the key stakeholder groups to check thinking and incorporate feedback. A summary of the proposal was then presented to all members of the stakeholder group on 22nd July, and was positively received with agreement on the key elements of the proposal as well as the broader requirement for change.

Regarding WS4: Early Supported Discharge, it was proposed that this workstream was moved from the RSfOP programme. The work straddles Goal 5 (Optimal hospital care and discharge practice from the point of admission) and Goal 6 (Home first approach and reduce risk of readmission) of the 6 Goals for Urgent Care/Urgent Care Transformation programme. These two goals (and their respective leads) are working closely together, and thus, in the interests of ensuring a joined-up approach to discharge work, it was felt that it would make more sense for the frailty perspective to engage with this work rather than existing as a standalone workstream within RSfOP.

The programme structure is therefore as below:



Assessment and Conclusion

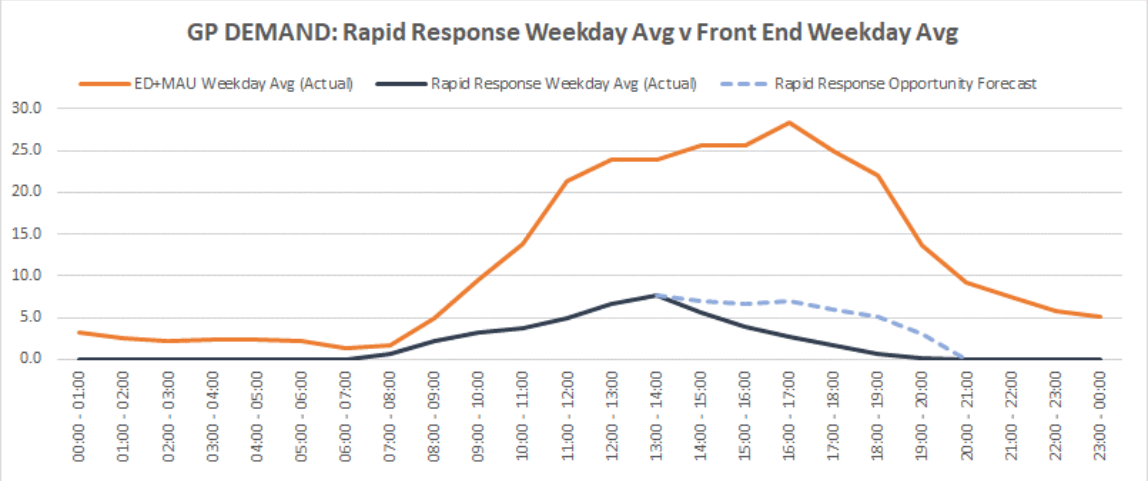
There were 3 key themes which arose from the workshop to take forward in phase 1 of programme delivery. A summary of the proposal is detailed below:

1. Extend core CRT rapid, senior led service hours from 8am-5pm to 8am-8pm seven days per week (and to consider whether service availability beyond 8pm was necessary in the future).
2. Provide Emergency Personal as well as Medical Care at Home and ensure it is also available out of hours across all areas.
3. Agree what is meant by 'hot clinic provision'; what it should be and reorganise the offer to make a more standardised, easily understood service across all boroughs with divisions working synergistically to support people to stay at or close to home.

1. Extend senior led Rapid Service hours of operation

Rapid Response Services currently close at the time of greatest demand arising from GP Practices (16:00 – 17:00). As a consequence, it is likely that demand appropriate for CRTs is directed by default to the hospital setting. From 08:00-14:00, Rapid Response accept 22.3% of all GP referrals to a combination of Rapid Response, Emergency

Departments and Assessment Units. This reduces to 13% from 14:00-17:00 and to just 4% from 17:00-20:00. Modelling indicates that, if 22.3% is taken as the average eligibility for Rapid Response Services and if demand from 14:00 onwards was forecast at this level for all GP referrals, then an average of an additional 19.7 patients could be directed to Rapid Response Services every weekday.



Identified enablers required to deliver the extended service are:

- Enhance borough level, single management tier across all teams to drive forward improvement and ensure excellent communication and engagement using quartet approach including Consultants, Senior Nurses, Head of Service and LA Head of Adult Services.
- Work with SAS doctors to agree how they could provide support to both Actual (hospital) and Virtual (home) beds to improve continuity of care and participant experience, considering appropriate arrangements for clinical supervision.
- Consider how the medical model is organised between and across divisions; The opportunity to work across boroughs to provide greater security of service provision will be considered as part of this.
- Build on existing models of care including the MDT and Virtual Ward approaches to further improve planning and communication across all disciplines.
- Finalise and deliver graduated care across all hospitals; commence by co-locating medical patients in one area on a ward to reduce safari ward rounds and build confidence in nursing teams to reduce reliance on doctors.
- Develop alignment between CRT, community, practice, and Long-Term Conditions nurses working in the community by reducing bureaucracy and improving opportunities for shared decision making.
- Develop confidence and access routes to increase GP referrals to CRT; working with Flow Centre to develop pathway management. Health Pathways will be an important enabler here.
- Create a workforce training and development strategy with a view to creating opportunities for career progression and to ensure staff feel valued and have the skills and resources necessary to do their jobs.
- Consider how the development of therapy and nursing clinical and managerial leadership roles (e.g. consultant level clinicians) could enable service development

2. Urgent Responsive Care at Home

Increasing clinical hours will go a long way to enabling extra capacity in Rapid Services to support people at home. This must also be complemented by support teams to provide Emergency Care at Home, including OOH, across all areas.

Identified enablers required to deliver are:

Map the existing provision of emergency social care, across each borough.

- Agree what an ideal service should look like; to include reduction in barriers to referral and better visibility of availability built into services to manage short notice requests.
- Give consideration to recruitment of HCSW working as part of health teams to provide care and support.
- Introduce flexibility in roles, increasing the opportunity for individuals to work across a range of skills.
- Identify opportunities in each SLA with third sector and maximise flexibility of provision.

3. Ambulatory care provision and admission avoidance

Evidence shows that 'Hot Clinics' provide an opportunity for rapid diagnostics, assessment and treatment without the need for an inpatient admission. ABUHB already has an offer for such clinics within COTE/Frailty, as well as other specialties. It was clear, however, from the programme work and engagement with NCNs that there is a lack of clarity and awareness from referrers about what the existing ABUHB offer is for these clinics, what the eligibility criteria are, and how they should be accessed. The workshop crystalized the need to develop a navigable pathway for HCPs to understand the Health Board offer for these clinics and how/when/where to refer. The next steps for this workstream are:

- Using evidence describe what a Hot Clinic response should look like.
- Engage with Value Based Health Care colleagues to work across divisions in order to map services to identify areas of good practice and share.
- Working with service users and HCP, identify a process across CRT and COTE, in the first instance, to establish a seamless process by which GP or other professionals can obtain a same or next day appointment with immediate feedback and a management plan.
- Improve confidence in directly accessing Hot Clinics to avoid referral to Flow Centre.
- Consider how established technology i.e., Consultant Connect or new algorithmic responses could support remote appointments.

This piece of work is of wider benefit than solely to this programme as it will be key to consider the broader ABUHB offering in relation to the pathway mapping. Once this is complete, we will be able to make a judgement on the opportunity and demand for any further hot clinic services for COTE/Frailty, whether they be based in the community and/or at other eLGH sites.

Another key, overarching piece of work that will support all 3 components will be agreeing with all stakeholders how best to manage a single point of access to ensure a rapid response from community teams.

Since August, we have also been successful in obtaining RIF Funding for the following proposals:

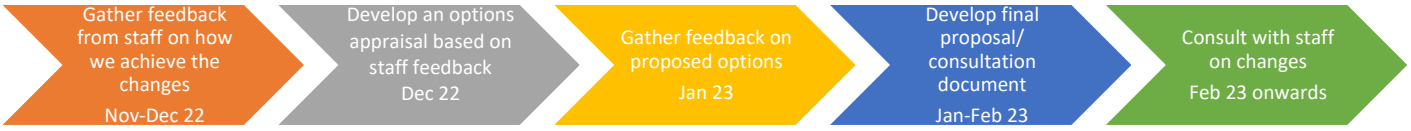
1. Additional staffing to support Rapid Services extension
2. Urgent Responsive Care – overnight Healthcare Support Workers
3. Proactive Frailty - identifying people before they worsen, via GP practices as a multiagency response

The focus has been on progressing the above proposals so that they can be operational for Winter.

In order to redesign the way care is delivered for older people, it is crucial that we engage with staff to listen to their views and feedback on how the community service can be improved. We are preparing to undertake a wide scale engagement exercise, supported by Workforce & OD colleagues. This will build on the success of the workshop held in June, allowing us to ask specific questions to ascertain how we achieve some of the change ideas that were proposed such as:

- Enabling referrals to be accepted up to 6.30pm and to providing face to face senior review on the same day.
- Increasing the percentage of people seen within 4 hours (and moving toward 2 hour All Wales target eventually).
- Increasing the number of people safely cared for at home without going to hospital.
- Providing a robust programme of ambulatory care clinics that professionals can reliably and easily refer into.

The overall plan is as follows:



We will be adopting a locality approach to the engagement exercise, with the Trade Unions, LMC and CHC starting week commencing 7th November.

	07/11	14/11	21/11	28/11	05/12	12/12	19/12	26/12	02/01	09/01
Unions/LMC/CHC										
Caerphilly										
OOO + UPC										
Newport										
Torfaen										
Monmouthshire										
Blaenau Gwent										
Mop up sessions on Teams for all staff										

Staff will have multiple opportunities to share their views and no changes will be made without formal consultation with those affected.

Recommendation

Next steps:

With regards to timescales, delivery is planned as per the following schedule:

- Short term: within three months
  - Set up mapping process with VHBC for Ambulatory Care.
  - Undertake wide scale engagement exercise with staff as a pre-cursor to consultation.
  - Define for each borough the alignment process for district and CRT nurses.
  - Establish quartet approach to service management, linked to NCN development.
- Medium term: within six months
  - Change hours of CRT operation to 8-8, Monday – Friday.
  - Establish formal hot clinic pathway across all boroughs/eLGH and make assessment on any additional demand.
  - Introduce graduated care model across/within all community hospitals wards in order to manage prudency of care.

Initial planning for Phase 2 of the programme is currently scoping the following:

- Continuation of existing workstreams
- Scope and plan the work to take place in WS3: Community Hospitals and Step Up/Step Down
- Understand the form and function of the varying pharmacy components and how these fit with and service the community model

- Development of proactive frailty – identifying people before they worsen, via GP practices as a multiagency response
- Review reablement provision and maximise opportunities to support people in their own home (D2RA)
- Develop a formal response to the risk of community falls

The Committee is asked to note this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Failure to complete the programme activities will result in potential harm to patients, increased demand on acute services, problems with system flow and difficulties in providing sustainable services.
Financial Assessment, including Value for Money	A finance-led resource group has been established for this programme to map the resources and activity of current service delivery, closely linked to value-based healthcare.
Quality, Safety and Patient Experience Assessment	The recommendations and actions outlined in the plan will improve access for patients thus improving patient quality, safety and experience.
Equality and Diversity Impact Assessment (including child impact assessment)	This programme of work will not have an adverse equality or diversity impact but will improve care provided for older people.
Health and Care Standards	The aim of the RSfOP programme is to provide older people with the right care, at the right time and in the right place, improving their experience and quality of care.
Link to Integrated Medium Term Plan/Corporate Objectives	The RSfOP programme is a key organisational priority for ABUHB and is one of the priority programmes within the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** This programme fits into the longer-term strategy for the Primary Care and Community division and is key to delivering the Health Board's key priorities.
	Integration – This programme ensures that there is a focus on the whole system approach in terms of patient pathways.
	Involvement – This programme recognises the importance of involving partners with an interest in achieving the objectives, and ensuring that those partners reflect the diversity of our population.
	Collaboration – This programme will take a collaborative approach to work with organisations and partners to meet its objectives.

	Prevention – This programme will encompass preventative activities to ensure people receive the care they need to ensure they stay well for longer.
Glossary of New Terms	N/A
Public Interest	N/A

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Partnerships, Population Health & Planning Committee Wednesday 16th November 2022 Agenda Item: 4.4

Aneurin Bevan University Health Board

Completed Capital Programme – 2021/2022

Executive Summary

Capital investment is a key enabler of the Clinical Futures Strategy and the priorities set out in the Health Board's Annual Plan for 2021/22. Investment and development of our estate is crucial to maintaining safety, having effective work environments, supporting our decarbonisation plans and enabling strategic change. The purpose of this paper is to present the successful delivery of the 2021/22 Capital Programme.

It will demonstrate the level of capital funding that has been supporting the delivery of patient services coupled with the challenges of managing the COVID-19 pandemic, patient care, statutory compliance, equipment replacement, Informatics, and backlog maintenance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	✓

Executive Sponsor: Christopher Dawson-Morris, Interim Director of Planning & Performance

Report Author: Michael Ellery, Head of Capital Planning

Report Received consideration and supported by :

Executive Team	✓	**Committee of the Board** Partnerships, Population Health & Planning Committee	

Date of the Report: 13.10.2022

Supplementary Papers Attached:

Purpose of the Report

The themes below will provide an opportunity to review the delivery of the Capital Programme 2021/22 as an enabler for the Clinical Futures Strategy and service sustainability. It identifies how the funding was allocated based on the Health Boards position in respect to strategic projects, current risks, equipment replacement programmes, compliance, infrastructure, and investment in the Estate.

Themes of Investment

The Table below identifies the capital expenditure against respective themes:

Theme Review	Funding Streams (£m)								
	DCP Funding	AWCP Funding							TOTAL
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Strategic Projects	0.218	15.908	3.101						19.227
Compliance/Health & Safety/Fire	0.919		0.009			0.726			1.654
Estates Infrastructure	1.330		0.021			1.466			2.818
Decarbonisation	0.000		0.000			2.245			2.245
Small Estates Schemes/Sustainabilty	1.712		1.516				0.488		3.716
Mental Health & LD	0.111		0.016	0.160		1.373			1.660
Imaging Programme	0.054		0.000		5.064				5.118
Informatics	3.392		0.056	1.368				2.111	6.927
Equipment Replacement	3.132		2.905	2.277				0.299	8.614
TOTAL Capital Programme Expenditure 2021-22	**10.867**	**15.908**	**7.625**	**3.805**	**5.064**	**5.811**	**0.488**	**2.410**	**51.979**
Previous years expenditure 2020-21	**14.840**	**75.053**	**18.261**	**1.043**	**1.362**	**0.000**	**0.323**	**0.960**	**111.842**

Strategic Investment

Strategic Projects are core enablers to the Clinical Futures Strategy, these areas represent developments which take care closer to home, consolidate our hospital model and provide the environments for partnership working.

Strategic Capital developments are normally funded from The All-Wales Capital Programme (AWCP) following Business Case Development and approval leading to financial award and delivery. Over the last 12 months the Health Board has been successful in securing over £19m of investment for major strategic projects including:

Grange University Hospital - Remaining expenditure (£4.086m) 2020-21 saw the completion and handover of the Health Board's Flagship Hospital, final outturn cost circa £366m. The expenditure in 2021/22 included final equipment purchases, WIFI and mobile telephony expenditure, the Admin and Well-being facilities works to Grange House and the purchase of sfn software licences via Lightfoot to maintain the predictive modelling approach.

Grange University Hospital SDEC (£2.274m) commenced with completion July 2022. This is a refinement of the original model and a key enabler to delivery of the Health Board's Urgent Care model, providing an effective clinical environment to see and treat patients without admission, in line with the six goals for urgent care principles.

Grange University ED Temp Main Wait Improvements (£0.592m) Additional temporary patient waiting area was completed to combat the additional through-put and patient pathways

subject to staffing availability. The permanent solution waiting area will be completed at the earliest opportunity and subject to capital availability.

Hospital Sterilisation and Decontamination Unit (HSDU) (£3.503m) – Was completed providing a JAG accredited modern up to date facility and is now operational meeting increased demand. The out-turn cost circa £16.6m.


Aerial View of HSDU Unit

Completed HSDU Unit

Tredegar Health & Wellbeing Centre Development. (£4.189m) - Construction commenced in September 2022. Phase 1 completion expected in July 2023.

NHH SRU Enabling Works (£934.0k) - Enabling Works for the Radio Therapy Unit commenced with completion 1st quarter 2022/23. These works involved the relocation of the existing Antenatal Unit as part of the larger NHH Satellite Radiotherapy Centre proposed development.


SRU Enabling Works

Business Case Development - Each year there are continued efforts to secure All Wales Capital Funding for future major projects that have substantial opportunities to enhance Patient Services aligned to the IMTP. The Business Case Process delivery can be long, normally stretching over two or more financial years and fees are secured to progress the various stages. Business Cases that have been further developed in financial year 2021-22 included:

RGH Endoscopy This Business Case for the proposed Endoscopy Unit at RGH was submitted to Welsh Government in March 2022. This has since been approved and work commenced 15th August 2022 with an anticipated completion date of October 2023. This case supports the

delivery of the recurrent capacity required to meet the Health Boards endoscopy demand, replacing the need for outsourcing and insourcing activity.

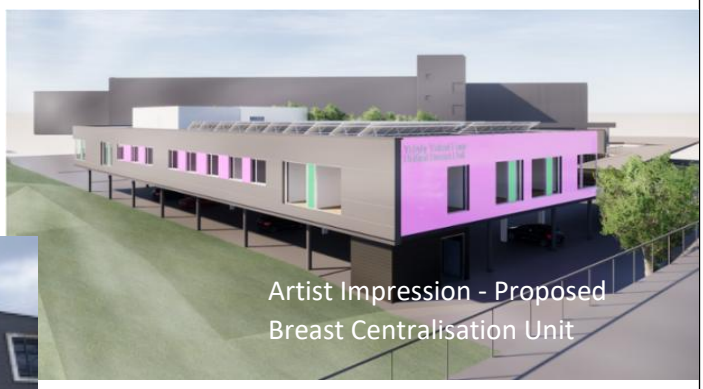
Specialist Inpatient Services Unit (SISU) – Development of OBC progressed with an anticipated submission to the Board in March 2023. Capital cost of preferred option circa £90 million.

NHH Satellite Radiotherapy Centre Development FBC was progressed and has subsequently been completed and submitted to Welsh Government for approval in June 2022.

Newport East Health & Wellbeing Centre Development – The FBC case was progressed and has subsequently (Financial Year 2022-23) been approved by WG. Start on site 4th July 2022. This will be a major element of delivering care closer to home and a community led approach in partnership with Newport Council.


Artist Impression - Newport Wellbeing Centre

YYF Breast Centralisation Unit FBC was submitted last quarter of 2020-21 financial year and was approved by Welsh Government in March 2022. Works commenced on site October 2022.


Artist Impression - Proposed Breast Centralisation Unit


Artist Impression- Proposed Breast Centralisation Unit

Compliance/Health & Safety/Fire

An integral part of the Discretionary Capital Programme (DCP) funding stream is to manage statutory obligations including Firecode, and Health & Safety. Each year there are risks identified under this theme which are managed against all other risks in the Health Board. This is one of the key areas of investment that enables the organisation to operate safely. Welsh Government introduced the new Estates Funding Advisory Board (EFAB), a Welsh Government initiative introduced to fund estate targeted improvements. Submitted bids for year (2021/22) was a success pulling in an additional award of circa £5.8 million to the capital programme, of which £726.0k was specific to this theme. The following table identifies the expenditure incurred to manage this area of commitment.

Theme Review	DCP Funding £m	AWCP Funding £m							TOTAL £m
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Compliance/Health & Safety/Fire	0.919		0.009			0.726			1.654

Discretionary Capital (£919.0k) projects included:
Statutory Compliance – Allocation of £535.0k was utilised across several areas of the Health Board including electrical testing to all sites (£55.0k), water system upgrades at YYF (£68.0k), water safety and tank cleaning HB wide (£101.0k), various small schemes including roof upgrades at County and NHH Xray Dept. (£154.0k), replacement of unsafe flooring YYF, RGH and NHH (£54.0), road & and path repairs at LGH, NHH, RGH and YYF. In addition, £202.0k was utilised for the management of Asbestos, the 2nd year of a 3-year programme. Assessment of Legionella Risk across various areas of the Estate (£40.0k), and Asbestos clearance (£44.0k).

EFAB - National Program for Targeted Improvements in The NHS Estate. (£726.0k).
Key areas targeted included upgrading the alarm system at NHH to L1 standard (£415.0k). In St Woolos and YAB hospitals, new fire alarm panels have replaced the old (£169.0k). RGH & NHH residences have also had the benefit of new compliant fire doors installed (£141.7k).

Estates Infrastructure

The Health Board has an Estate Strategy identifying backlog maintenance and condition of the estate. Using this document and identification of immediate infrastructure requirements high risk projects were allocated funding. These investments are essential to maintain the estate at a required standard paramount for staff safety, wellbeing, and patient experience.

The Table below shows that the discretionary programme invested £1.330 million towards these issues. The additional EFAB award of £1.466 million and Covid funding of £0.021m increased the total invested in the infrastructure of the estate to £2.818 million.

Theme Review	DCP Funding £m	AWCP Funding £m							TOTAL £m
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Estates Infrastructure	1.330		0.021			1.466			2.818

Several areas that have received DCP investment include:

Lift Replacement Programme RGH (£941.0k) Lifts within the RGH locations are past their manufacture's life expectancy. To ensure that Patient Services are not disrupted, further replacement works were carried out in line with the lift replacement programme.

Distribution Board Replacements (£134.0k) Several distribution boards were replaced at NHH, including wards, departments, and plant rooms, mitigating circuitry overloading and risk of failure.

Other Investments include CCTV for RGH (£36.0k), Upgrade of Security Measures RGH (£36.0k), Swipe access doors D5W RGH (£8.0k), North Lodge Upgrade Works (£ 60.0k), Serennu Water Ingress (£54.0k), and Glan Usk Roof / Drainage Works (£50.0k).

Covid Recovery funding (£21.0k) - Upgrade of ECT Dept air flow ventilation system at Maindiff Court

EFAB - National Program for Targeted Improvements in The NHS Estate. (£1.466 million).

Key areas targeted from this funding stream included acceleration of the backlog lift replacement work in RGH, replacing B Block Lifts. In addition, Building Management Systems were replaced/upgraded in various locations to maximise opportunities to efficiently manage building services through the use using automatic computerised components.

Informatics

Informatics have played a major role in managing the fight against the Pandemic. Without the opportunity to communicate and rely on sensitive patient systems in and out of the hospital environment the COVID impact would have been far greater. Progress also continues to be made in line with the digital strategy ensuring transformation through digital and ensuring resilient, safe, and secure infrastructure.

One area that has been forced to accelerate is 'Agile Working'. This has been accelerated by several years due to the Pandemic restrictions, without the supply and installation of personalised IT, and support from informatics staff, the impact on patient services would be far more extreme.

In addition, informatics cross over and support all services in the organisation, the Table below identifies areas of 'Informatics' funding that have contributed to managing these areas.

Theme Review	DCP Funding £m	AWCP Funding £m							TOTAL £m
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Informatics	3.392		0.056	1.368				2.111	6.927

DCP Funded Schemes included:
The Data Centre Move (£414.0k) The datacentre move has strengthened the resilience by relocating the new data centre and allows identification of end user applications and their owners. Numerous hardware components will now have resilience including recycled equipment into other areas.

ECR and CCR Room Improvements (£246.0) This area has been in need for updating for some time. Works to date have been focussed on patching and make do basis. Given the increasing dependence we have on digital to deliver patient care this room improvements have now brough the Health Board up to dictated industry standards.

Critical Server Refresh (£242.0k) The Health Board has several hardware platforms that are end of life – continuing to operate these would provide the Health Board with a significant risk. Microsoft identified that server 2008 will no longer be supported i.e. Microsoft will no longer issue security patches to these systems, which would be a cyber security issue. In many cases this has also meant that the hardware and applications that are being support by server 2008 have also required upgrading or mitigations put in place to eliminate the risk.

Telephone Handset Refresh Cisco YAB (£295.0k) The telephony equipment at YYF was end of life. This was now unsupported by the vendor and a replacement programme initiated to integrate with the telephony system installed at GUH and replace handsets at YYF.

Desktop / Laptop Replacements (£729.0k) The Health Board has a significant investment in ICT desktop PC's and Laptops to support the activities of the business. There is a requirement to replace aging computers that are no longer fit for purpose as technology has moved on. The current average age of desktop PC's is 4 years, and a yearly replacement programme is required

to ensure aged, unreliable and unsupported hardware is retired. Additionally, aging hardware is unable to run Windows 10 which leaves the organisation vulnerable to cyber-attack.

Careflow Licence Extension (Year 4) (£335.0k) An upgrade to CareFlow was being assessed by the team, by extending for a further year this allowed us to evaluate the new features and provide stability to end users.

Replacement Maternity System (£156.0k) The current digital patient record system came to the end of its life in May 2020. A replacement system is required to provide the data necessary for maternity services to offer assurance of the safety and wellbeing of mothers and babies within the Health Board. The implementation of the replacement system is still ongoing.

Wi-Fi replacements to Llanfrechfa, St Cadocs and Maindiff Court (£468k). The Wi-Fi network at these sites had past their end of life and there was a risk of a WLAN failure. The Health Board has now completed the replacement of the specific areas identified which will mitigate the risk at these sites.

Patient TV Replacements YYF & YAB (£128.0k) following continuous breakdown these units have now been replaced providing better patient environment.

Digital Priorities Investment Fund (DPIF) (£1.707 million)
This further funding was received from Welsh Government and was utilised on the following projects.

Data Centre (£304.0k) – relocation of Mamhilad data centre to the new GUH. This places one of the Health Board's primary data server locations in a Health Board owned location.


Informatics Mobile Cart

Mobile Carts (£309.0k) Refresh programme replacing old, outdated informatic portable trolleys with new.

Cisco License Upgrade (£268.0k) – Upgrading of licencing to SDA compliance aligned with and compatible with new technology installed in the GUH.

Netcall Refresh (£245.0k) Upgrade of back-end infrastructure for 'Lucy' communication system.

LINC Funding (£285.0k) – Pathology hardware upgrade.

Digital Eyecare Funding (£75.0k) - New Technology eyecare e-referral system and associated equipment, working with end users. using new technology with patients – Networks to local opticians will be available to view restricted levels of patient records.

Mental Health & Learning Disabilities

The Health Board is committed to deliver high quality, compassionate, person-centred mental health and learning disability services and has invested the total sum of £1.660m as identified in the table below.

Theme Review	DCP Funding £m	AWCP Funding £m							TOTAL £m
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Mental Health & LD	0.111		0.016	0.160		1.373			1.660

DCP / Covid / EOY Slippage (£287.0k) The Health Board is committed to investing in this service, Extensive areas of work have been achieved with primary commitments included:

- Overhead Hoist System Replacement Twyn Glas (£94.0k),
- Flooring upgrades to Park Square and South Lodge St Cadoc's hospital (£17.0k),
- Extension of the clinic room on Talygarn, an Infection Control recommendation which will be completed in financial year 2022/23 with an outturn cost of £20.0k,
- Reducing climbing risks in Adferiad Garden (£22.0k),
- Eating Disorders Reconfiguration of Maindiff Court Hospital Offices (£40.0k),
- Additional door sets on Anwylfan to create isolation area (£25.0k) and
- Monmouthshire Team relocation to Ty Bryn (£66.0k).

EFAB Additional Funding (£1.397m) was received from the Welsh Government. Projects consisted of Anti ligature schemes including:

- installing Anti ligature fire detectors on inpatient units (£39.83k),
- anti-Ligature Door Set Pilot (£30.1k),
- ligature works on various inpatient areas (£196.2k),

It also enabled other improvements particularly in security as listed below:

- Patient call and safety alarms systems (£958.0k)
- Talygarn Main Front Doors/airlock and ECA External Doors (£39.1k),
- Ty Cyfannol ECA/CAMHs Security Doors (£11.8k),
- Ty Skirrid Ward Windows and external doors, Maindiff Court (£80.9k), and
- Replacement Showers x 10 Anwylfan (£17.4k

Mental Health Specialist Inpatient Services Unit (SISU)
In strategic terms work commenced on the above business Case. The following bullet points provide some anticipated milestone dates:

- OBC planned to be submitted to March 2023 Board
- Revenue costs discussed at Executive Team August 2022
- OBC capital cost of preferred option circa £90 million.

Equipment Replacement

The hospital environment has an extensive reliance on equipment, not just for direct patient care but across all support services. The financial year saw circa £8.614 million committed to the purchase of new or replacement equipment.

The table below identifies various funding streams supporting this investment:

Theme Review	DCP Funding £m	AWCP Funding £m							TOTAL £m
		AWCP - Strategic Projects	Covid & Recovery	EOY Slippage	Imaging	EFAB	ICF	DPIF / LINC / Eyecare	
Equipment Replacement	3.132		2.905	2.277				0.299	8.614

Equipment is normally replaced following one or more of the following considerations:

- Emergency Breakdown.
- Performance and history of reliability, to ensure that the service continuity is as robust as possible to ensure minimum delays to patient care.
- Manufacturer support – reliability, cost and whether they are continuing with the support over time.
- Innovative and improved technology providing increase patient throughput with enhanced output typically reducing the need for repeat patient referrals or diagnostics.
- Equipment resilience to face new and existing and increased pressures of patient care.
- Statutory compliance, following new legislation.

Equipment that was replaced includes:

Site Wide:

- Replacement Ovens x 5 (£86.0k) – NHH/RGH/STW/YAB/YYF
- Cleaning Equipment (HPV/ UV/Ecobot) (£712.0k) – GUH, County Hospital, SWH, NHH, YAB
- Hysteroscope Kits (£147.0k) – HB Wide

RGH:

- Excelsior Processors AS modules x2 (£80.0k)
- Operating Table Replacements x 3 (£112.0k)
- Replacement Microscopes x 5 (£200.0k)
- Laser system with Colposcope attachment – RGH theatres (£126.0k)
- New Theatre Lights DSU RGH (£70.0k), Replacement of existing lights which were constantly failing
- Neptune urology equipment x 2 (£164.0k)
- Replacement Microbiology MALDI-Tof Machine (£192.0k)
- Ophthalmology Widefield Scanners and Slit Lamps (£1.04m)
- Pathology Seal Safe (£173.0k)
- Endoscopic Surgery Sets (£141.0k)

NHH:

- Operating Table Replacements x 3 (£112.0k)
- Replacement Stacks, Scopes, and Drying machines (£865.0k)
- Replacement Microscopes x 4 (£200.0k)
- Laparoscopic Simulator (£139.0k)
- Maternity Resusitaires (£113.0k)
- CTG machines x 14 (£109.0k)
- Birthing Beds x 3 (£34.0k)

YYF:

- Replacement Stacks, Scopes, and Drying machines (£865.0k)
- Decontamination Equipment (£180.0k)

National Imaging Equipment Programme

ABUHB Radiology Directorate Capital Equipment replacement programme identifies requirements of Imaging equipment replacement/refurbishment in timely manner. All imaging Kit including CT, MR, X-ray and US life span varies from 7-10 years and there are other contributing factors warranting earlier replacements such as unreliable equipment, technology advancements etc. There is little debate relating to new versus maintaining old equipment as Imaging is being revolutionised with technology leading to more efficient, and increased patient through put with the added benefit of early and precise diagnostics without extensive lead in times or numerous attendances/referrals. It is important to have a fully functional, reliable, and technologically fit Radiology Department to ensure timely access for our patients for the diagnostic investigations

This funding is for timely replacement of manufacturers of out-of-date imaging equipment with the latest high end advanced technology. These replacements included:

CT Scanner at YYF (£1.27m), 3 General X-Ray Room replacements SWH, RGH and Chepstow (£1.16m). In addition, a two-year programme was secured with WAG providing a further 2 new CT Machines at RGH and NHH (£4.24m), and 3 General X-Ray Rooms at NHH, YYF & YAB (£1.29m) to be delivered across the financial years 2021-22 and 2023-24.

Other imaging equipment within this programme of work include Ultrasound machines (£1.48m), replacement Dental Imaging Equipment - NHH / YYF / RGH (£0.342m) and various other equipment amounting to £0.039m.

Decarbonisation

Aligned to the Well-being of Futures Generation Act 2015 the Health Board will ensure that the climate is considered at an everyday decision-making level. The purpose of this funding initiative is to reduce the organisation's Carbon Footprint. This is being achieved through introduction of modern equipment/systems and components ensuring maximum efficiency, whilst reducing energy. A large element of funding has been used to replace current internal and external lighting components to LED, a far more resilient and efficient lighting system. Several EV vehicle electrical charging points have been installed across various sites to support the internal electrical vehicle fleet and to encourage the use of electrical vehicles generally. Building Management Systems have been installed in YYF and SWH hospitals to maximise opportunities to efficiently manage energy using automatic computerise components.

Through the Welsh Government EFAB initiative the Health Board was awarded £2.3 million to assist in the NHS decarbonation plan. Investments included:

- **LED Lighting Upgrades/Replacement** of energy efficient lighting, longer lifespan and enhance environmental performance assisting in the reduction of the HB Carbon footprint. Projects included lighting retrofit YAB (£774.0k), New and upgrading of Street, external and internal lighting RGH (£204.0k), lighting upgrades to education centres, E Block RGH and Cwmbran Clinic and St Woolos (£303.0k).

- **Building Management System (BMS) upgrades** YYF, SCH (£667.4k), providing modern efficient automotive management use of estate energy.

- **Staff/Public EV charging** infrastructure SCH, NHH, YAB, YYF (£228.0k), Providing and supporting Patient/Staff in using clean energy in the commute to and from hospital environments.

Sustainable Schemes/Projects

The Health Board strive to ensure that Patient Services are provided and maintained at the highest efficiency level and within a conducive environment for patients, staff, and visitors.

This theme identifies those investments whether in the early assessment through feasibility appraisals or as a direct consequence of modernisation requirements to ensure that 21st Century efficient care is provided to patients. It will also identify those schemes/projects that will assist in delivering the UBUHB service strategies aligned to the IMTP.

Refurbishment of Ward 3/3 NHH (£672.0k), Phase 2 – Complete refurbishment and re - configuration of the Ward bringing the environment up to 21st century standards.

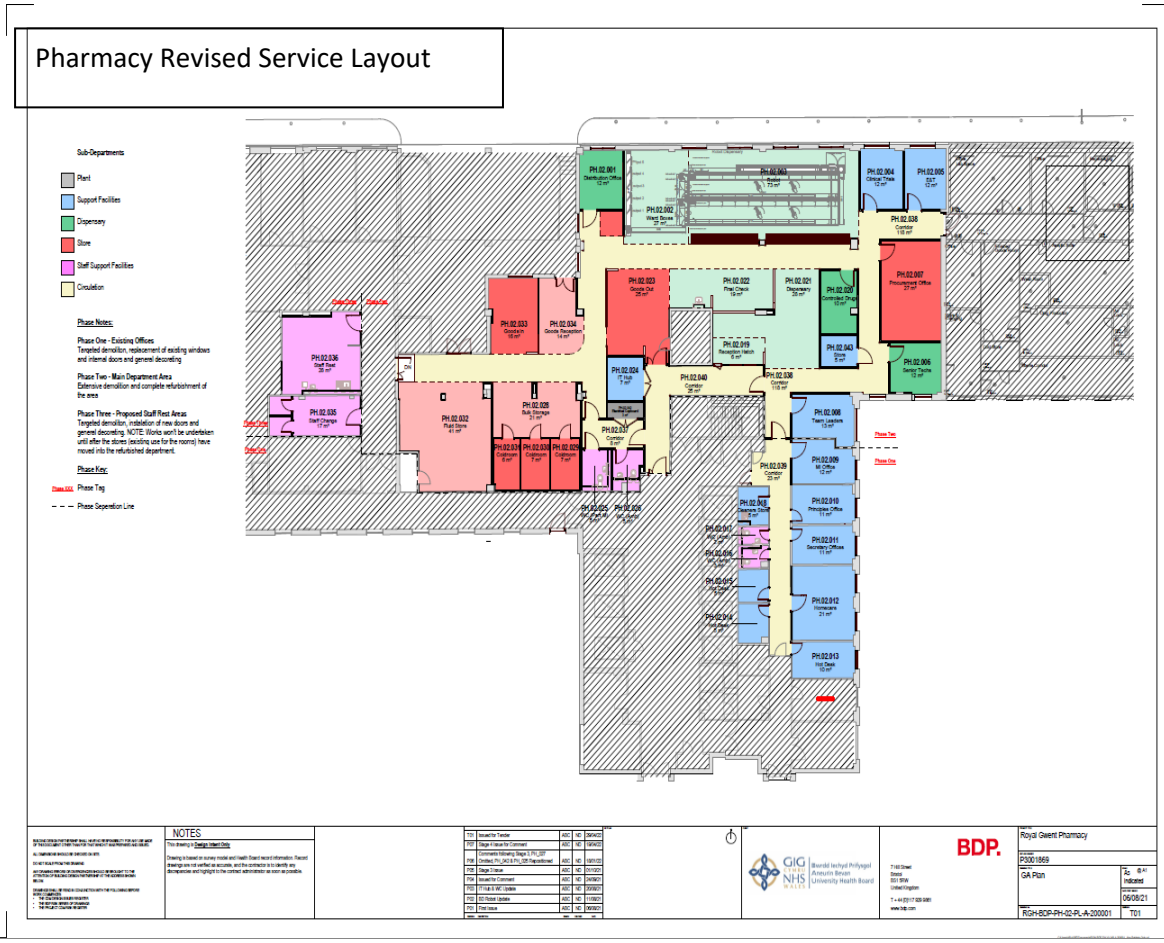
Additional Car Parking RGH (£204.0k) To help ease issues relating to car parking 65 additional spaces were created.

Pathology Rest and Break Room (£117.0k) Works carried out to increase distancing coupled with compliance of HSE recommendations. This has

provided a far better environment to promote Wellbeing, which was complimented by an additional Porta Cabin space.

Pharmacy Refurbishment and replacement Robot Feasibility (£155.0k)
Full feasibility to review more efficient and safe ways of working, providing a better staff environment in what is a restricted area. This work also includes the planned replacement of the existing Pharmaceutical Robot.

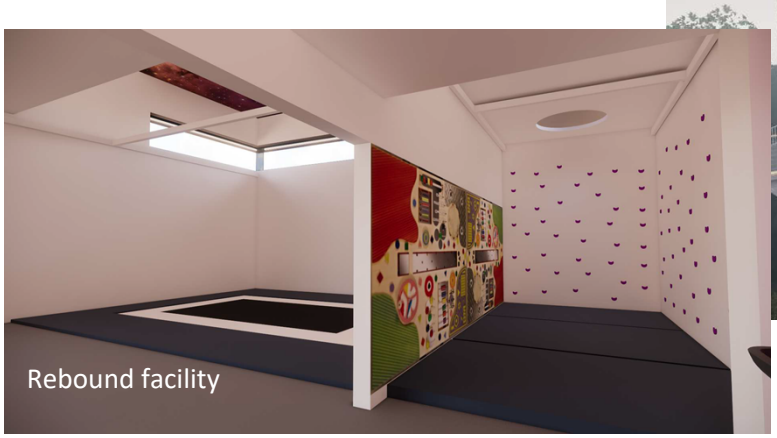
Pharmacy Revised Service Layout



RGH Main/Belle Vue Front Door Upgrade (£236.0k) Creation of a 'visible' main entrance to the Royal Gwent hospital providing bright, confident and a modern environment creating the wellbeing feel for patients, visitors, and staff. To further assist this wellbeing approach general fabric upgrading was also carried out.

Creating an environment for staff to feel proud to work for the Health Board

Serennu Children's Centre: A further area which received investment under the funding stream of Integrated Care Funding (ICF) is the Serennu Children's Centre.


Rebound facility

This has had the benefit of an extension comprising of a **'Rebound Centre'** (outturn cost of £818.0k), which commenced in financial year 2020/21 and completed 2021/22. This centre assists in the delivery of Integrated Children's Health and Social Services across Gwent.

Primary Care & Community using ICF Funding commenced feasibility Studies on **Trethomas** (£55.0k) and **Pontllanfraith** (£65.0k) **Health Care Centres** and will be focused on reconfiguration and refurbishment to sustain the increasing needs of the service. Completion expected financial year 2022-23.

Covid Recovery Funding (£7.62 million) funding was introduced by WAG to assist in preparations to combat the COVID 19 Pandemic. This included areas for patient inoculation, interim transition of hospital space, new/replacement equipment, agile working, acceleration, upgrading of patient environmental standards (ventilation, infection control modifications etc). In addition, the Health Board presented the opportunity to increase funding for the Grange acceleration to provide additional

capacity yet reducing abortive costs by using the funding on permanent accommodation not typically field hospitals. The Covid-19 pandemic has also challenged the Health Board to review the plans for eLGH sites to ensure they meet the needs of our population and enable us to respond to the treatment backlog. A range of projects responding to these needs that fall under the small schemes/ sustainability category are identified as follows:

Refurbishment of D6 E (£357.0k) Conversion of Paediatric Ward to Full Adult Ward including all Sanitary areas. This is now used as decant/surge/covid 19 ward for the Gwent.

Refurb B7E/W RGH Infrastructure feasibility carried out in readiness for reconfiguration to support recovery for 2 theatres (£6.0k)

Refurbishment of Cath Lab 2 for Outpatients Treatment Unit RGH (£293.0k) Development of a new Outpatient Treatment Unit creating opportunities to reduce backlog following the COVID Pandemic. The Health Board vision for this Outpatients Department focusses on patient and prudent health care principles:

- Advice and Guidance
- Complex/Treatment Clinics
- Face to face clinics
- Non face to face i.e telephone, video etc.

This benefits patients by providing a one-stop complex/outpatient service providing patients with all the services needed in a single visit, therefore:

- Less appointments for patients – increased accessibility
- Reduces the complexity of the system in terms of communication and uncertainty for the next steps in their care/investigation
- Enables patients to receive prompt diagnosis
- Reduces the delays in patients' waiting times
- One appointment reduces issues such as less travelling, finding parking spaces, time off work for child/relative care. Although the time on the day may be slightly longer, these benefits are significantly outweighed by preventing several appointments

Further benefits to the Health Board include:

- Optimising workforce – medical/nursing and administrative
- Increasing skills of outpatient staff
- Releases capacity within day surgery facilities

- Where procedures such as infusions may be undertaken in OPD – again releases space for other clinics
- Releases clinic space in terms of less new outpatient and follow-up appointments – in areas which are now overcrowded (acerbated due to social distancing requirements for Covid 19)
- Releases capacity from the pre-assessment service
- Decreased financial costs with reduced steps in the pathway
- Effective use of accommodation
- Patients are not brought back to appointments that do not add value
- Reduced administrative functions

Refurb of Cordell for General PAC & B6 for Sexual Health (£186.0k) This work has commenced and will be completed in financial year 2022-23. Relocation of sexual health to B6 will provide an improved patient environment. This solution also provides standardisation of pre assessment clinics in Cordell.

Convert Rooms on D5E For Stoma Nurses, CNS & IP Therapies RGH (£86.0k) creating a co-location of stoma clinics from NHH and Gwent.

Allway HC Refurbishment (£147.0k) – Received extensive 'fit for purpose' reconfiguration and upgrade which was much needed to improve patient care and experience.

Conclusion and Recommendation

The Health Board has had significant success in securing additional capital investment into the organisation in 2021/22. As set out in this paper this investment has made a significant difference across many areas, taking forward our strategic ambition, ensuring safe working environments, supporting the decarbonisation action plan, enabling the response to the pandemic, and improving patient experience.

The financial year had many constraints resulting from the COVID-19 Pandemic and BREXIT, both creating issues, including shortage of equipment, materials, delays in international deliveries and staff shortages across all disciplines internal and external, all having a material effect on efficient planning and delivery of projects/equipment.

However, notwithstanding the above constraints the Capital Programme was successfully delivered.

The Partnership, Population Health & Planning Committee is asked to note the content of this paper and the significant demands and successful delivery of the Capital Programme for 2021/22.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk has been managed throughout the delivery of this capital programme of work.
Financial Assessment, including Value for Money	The financial implications and delivery of the Health Board's Capital Programme are fully described within the paper.
Quality, Safety and Patient Experience Assessment	Quality, safety, and patient experience are key elements of the risk-based assessments undertaken with Divisions and across the organisation.
Equality and Diversity Impact Assessment (including child impact assessment)	It is not considered that there are equality and diversity impacts of the Capital Programme.

Health and Care Standards	These standards have been adopted throughout the delivery of the capital programmer relevant to each specific service
Link to Integrated Medium Term Plan/Corporate Objectives	The paper links to Section 5 of the Board's approved Integrated Medium-Term Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The paper demonstrated an integrated approach to working across the Health Board and combines both short- and long-term goals.
	Integration –
	Involvement –
	Collaboration –
	Prevention –
Glossary of New Terms	None
Public Interest	None

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Partnerships, Population Health & Planning Committee Wednesday 16th November 2022 Agenda Item: 4.5

Aneurin Bevan University Health Board

REGIONAL SERVICES PLANNING UPDATE

Executive Summary

This report provides an update of progress in respect of a number of ongoing regional and south Wales service planning programmes. Particularly noted is the recent establishment of strengthened governance arrangements for regional planning, including a new Chief-Executive led Portfolio Oversight Board. Committee members are asked to note the updates and the attached Memorandum of Understanding (MOU) that has been developed by the respective Health Boards and endorsed by the Oversight Board as the basis for regional planning and collaboration going forward.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	x

Executive Sponsor: Chris Dawson-Morris, Interim Director of Planning and Performance

Report Author:

Report Received consideration and supported by :

Executive Team		**Committee of the Board- Partnerships, Population Health & Planning Committee**	**X**

Date of the Report: 3rd November 2022

Supplementary Papers Attached: None

Purpose of the Report

This purpose of this report is to provide the Committee with an update of progress in respect of regional service planning programmes of work being undertaken in collaboration with health board colleagues across south and south east Wales.

Background and Context

Health Boards in south Wales remain committed on an ongoing basis to active collaboration where this delivers added value to clinical service delivery. Health Board planning teams continue to meet on a regular basis to agree common approaches to

strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

Collaborative programmes include recently-formalised arrangements for prescribed services within the south east and wider review and reconfiguration of specialist services across south Wales where ABUHB are stakeholders.

An overview of current programmes is set out below.

Assessment and Conclusion

Revised Regional Portfolio Oversight Board

Revised oversight arrangements for regional planning within the south east have recently been agreed, including co-ordination by a new Programme Director and a formalised Chief Executive led Regional Portfolio Oversight Board receiving regular progress update reports for key collaborative programmes across the region. Each Health Board is leading a programme with ABUHB overseeing ophthalmology, C&VUHB overseeing orthopaedics and CTMUHB overseeing diagnostics. The latter two are still at a relatively early stage, with programme details currently being finalised. Very recently, it has been agreed that regional stroke services development will also be brought within the remit of the Board.

A memorandum of understanding has been developed and agreed between the respective Directors of Planning to formalise the basis of future collaboration. This document has now been approved by the Portfolio Oversight Board and a copy is attached as an appendix for information.

The regional ophthalmology programme as led by ABUHB has made good progress, overseen by a Regional Ophthalmology Programme Board and dedicated programme manager. Three principal work streams have now been set out within the programme as follows:-

Cataract Recovery – this is addressing existing post-COVID backlogs / waiting times for treatment and involves two key stages; firstly comprising 'insourcing' of C&V / CTM Health Board patients at the University Hospital of Wales, running until March 2023; secondly preparing a business case for Welsh Government consideration and funding from April 2023 to maximise existing physical assets for 12-18 months. This will involve the use of additional 'hub' capacity in the south and north (potentially on the Nevill Hall Hospital site) of the region, supplemented by outsourcing of other activity as required to reduce treatment backlogs.

Ophthalmology Regional strategy – a proposed longer term strategy for ophthalmology services across the region has been developed following clinical workshops and wide discussion within the service. This work stream aims to raise awareness of the Regional Ophthalmology Strategy and to allow sufficient space and opportunity for stakeholders and partners to contribute their views, thereby gaining agreement and momentum for the priorities in the strategy and to set the future direction of the service in the region. The strategy is currently subject to stakeholder engagement and is intended to be ratified across the region by December 2022.

Regional Cataract and Vitreo-retinal Service – this work stream is reviewing the specific longer-term requirements for two sub-specialty areas, with the aim of developing sustainable clinical / staffing models and referral pathways for cataract and vitreo-retinal surgery, together with the associated infrastructure and costing implications. This is a longer-term work stream, with subsequent business cases for revised models likely to be developed from late 2023.

Ophthalmology Electronic Patient Record - this is a separate national programme hosted by Cardiff and Vale UHB to deliver a comprehensive electronic patient record for ophthalmology. The programme has experienced a number of technical issues that have delayed implementation and operational go-live planning. A number of these relate to national dependencies and are now to be subject to external review. The feasibility of programme management and oversight being transferred to Digital Health Care Wales is currently being actively considered as part of the plan to address the current acknowledged challenges to progress. A local ABUHB EPR Board continues to meet and has agreed that whilst the new system will be of considerable value once fully in place, target dates for local go-live will not be set until the wider national / strategic issues have been resolved and finalised.

Cancer Services

Progress continues in respect of implementation planning for a new comprehensive clinical model of acute oncology services across South East Wales. Within ABUHB, new clinical posts to facilitate the first phase of the plan have been recruited and a new Partnership Board is being established with Velindre NHS Trust to ensure aligned planning for the next phase (which will include additional clinic capacity and administrative support for the team) over the coming months.

Welsh Government approval of the final business case for the new satellite radiotherapy centre at Nevill Hall Hospital is anticipated shortly, with construction start from December and operational commissioning by November 2024. This will provide radiotherapy services fully aligned with the satellite specification issued by Velindre NHS Trust and will provide additional capacity to deliver a range of patient benefits.

Plans are also progressing in parallel for the development of a complementary cancer centre on the Nevill Hall site, which would provide a centre of excellence for research, innovation and collaborative working with Velindre to deliver haematology and acute / non-acute oncology services. The business justification case for this development is currently being progressed; if final Welsh Government approval is confirmed by summer 2023, it is envisaged that the new facility could be operational before the end of 2024 in broad alignment with the satellite radiotherapy centre.

Vascular Services

Following an extended period of detailed planning, operational implementation of the new south east Wales regional vascular network took place in July of this year. This encompasses a hub and spoke model, with acute / inpatient services and theatre activity undertaken in Cardiff, supported by routine, outpatient and rehabilitation provision on spoke sites across all health boards. A series of regular reviews have

been scheduled to assess progress and benefits realisation (with the first planned for early December), but operational experience to date has indicated that the network is generally working well with no major issues arising.

Sexual Assault Referral Centre (SARC) Service

Health Boards, police forces, Police and Crime Commissioners and third sector partners continue to work closely to implement and deliver the new service model for sexual assault referral services in South Wales, Dyfed Powys and Gwent. This involves an enhanced hub for acute services at Cardiff Royal Infirmary (CRI), supported by spoke facilities in Risca and Merthyr. The model will provide a more integrated service that is driven by the needs of victims and patients and supports the provision of services that meet clinical, forensic, quality and safety standards and guidance (including new ISO accreditation standards that are required to be in place by October 2023), and ensures robust governance arrangements. Key ongoing work streams include the following:-

- The arrangements for compliant interim facilities for the hub service at CRI are progressing well and are on target to be operational by the ISO deadline.

- The outline business case for a new capital development on the hub site has been submitted to Welsh Government and a decision is expected imminently

- Commissioning meetings are being arranged with each spoke Health Board to clarify and agree any financial and commissioning implications and the first of these was held with the ABUHB team during September

- Operational plans are progressing, with acute patients able to begin transferring to the revised CRI facilities from January 2023, supported by an active recruitment plan

- The importance of timely and comprehensive communications has been emphasised, with revised plans in place to ensure all stakeholders are familiar with the future service configuration, pathways and accommodation plans. Regular briefings are also held with community health councils as required.

ABUHB clinical, managerial and planning representatives remain fully engaged with the programme

Thoracic Surgery

The strategic outline case (SOC) for the centralisation of thoracic surgery services for South Wales in new facilities in Morriston Hospital in Swansea has been approved by Welsh Government, and work is now progressing to complete the outline business case as the next phase of the proposed capital development.

The key aims and benefits of the programme include:-

- Provision of additional surgical capacity, now expected to deliver a total of 1,500 cases per annum by the time of opening, as a result of increasing demand and the impact of the proposed future lung cancer screening programme
- Provision of a best practice dedicated thoracic surgery hybrid theatre that supports improved health outcomes for patients
- Improved equity of care across Wales for, e.g. resection rates, surgical procedures and access
- Creation of a more sustainable medical and nursing staffing model
- New ability to address current unmet service need, especially for benign work and supporting MDTs and in anticipation of the future rollout of a lung cancer screening programme

More detailed service planning work is currently ongoing to finalise the agreed service specification and to assess the workforce implications of this at all parts of the whole patient pathway. Workshops have been arranged with each of the 'spoke' Health Boards to progress this, and the first of these was held with the ABUHB service team in September. A separate option appraisal workshop to inform the outline / final business case for the new centre took place in October, with a preferred option selected as the basis for the outline business case which is now being progressed.

ABUHB remain fully engaged with regular clinical, planning and financial / commissioning input and a local group meets regularly to review the latest developments, ensure a common understanding of programme progress / decisions and to facilitate timely responses to any requests from the programme for information, decision feedback etc. The potential revenue cost pressures have been raised as a future issue, and it is anticipated that further discussions will be required to agree the affordability and equity of the final business case over the coming months.

Hepato-Biliary and Pancreatic Surgery

A programme has recently been established (managed jointly between Cardiff & Vale / Swansea Bay UHBs) with terms of reference to develop proposals for improving current service provision for hepato-biliary and pancreatic surgery.

Across the UK, it is accepted practice for liver and pancreatic surgery to be based together as part of a comprehensive hepato-pancreato-biliary service. Typically, these centres will provide specialist care for patients with benign and malignant diseases of the liver, biliary system and pancreas. In south Wales, these services are currently split (with liver surgery undertaken at the University Hospital of Wales and pancreatic surgery undertaken at Morriston Hospital)

A Programme Board (alternately chaired by the Medical Directors of Cardiff & Vale / Swansea Bay UHBs) is now meeting regularly, with representation from all stakeholder Health Boards in south Wales. The Board is reviewing all aspects of the service with a view to making recommendations for a safe, effective and sustainable future service model. It is intended that proposals for the future service model should be finalised by January 2023.

Although the programme is at a relatively early stage, ABUHB are fully engaged with clinical / planning input currently and feed back to the service as required to ensure a common understanding of programme progress / decisions and to facilitate timely responses to any requests from the programme for information, decision feedback etc

Stroke Services

A National Stroke Programme Board - sitting under the NHS Wales Health Collaborative – has been established to support health boards in taking forward a national piece of work to re-design stroke services across Wales into a Hyper Acute Stroke Model. This will involve the setting up of regional stroke centres and significant collaboration between health boards e.g. new regional networks for C&V / CTM and for SB / HD. The national programme will support regional programme teams by co-developing nationally agreed guidance and recommendations around areas such as service specifications, pathways, workforce, as well as support with consistent key messaging etc. for public engagement and consultation. Wherever possible this will take a 'once for Wales' approach but recognising that models will be different for each region e.g. taking into account challenges of rurality. The national Chief Executive lead for stroke (Mark Hackett) has been invited to provide a progress briefing for the Executive Team later in November.

ABUHB will be established as a single health board region, with self-contained services for all but specialist tertiary interventions such as thrombectomy. Full engagement with the national programme will however remain important to ensure local population needs get optimal benefit from the new arrangements and any central resource opportunities. This is particularly relevant for the implementation of the recommendations coming from the recent Getting It Right First Time (GIRFT) review of services, which was commissioned for the service earlier this year. Funding has been confirmed for programme manager support, and a bid for this is currently being expedited.

Recommendation

The Partnerships, Population Health and Planning Committee is asked to:-

1. Note the update report for information.
2. Note the attached memorandum of understanding as the basis for future regional collaboration

Further updates will be provided to future meetings.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Many of the regional work streams are informed by risk assessment and have been established to address and mitigate system risks
Financial Assessment, including Value for Money	Regional planning and collaboration is evidenced as providing enhanced potential for greater efficiencies in service provision and value for money across the wider health economy
Quality, Safety and Patient Experience Assessment	All regional programmes place a high priority on enhancing quality standards and the patient experience, and this forms a key part of evaluation and benefits realisation
Equality and Diversity Impact Assessment (including child impact assessment)	It is intended that the improvements in the service generated by regional collaboration will give real quality benefits to patients, regardless of background and protected characteristics, and will in many cases improve equity of access across south Wales
Health and Care Standards	Many of the regional programmes e.g. stroke services align closely with a number of the Health and Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	Regional planning and collaboration constitute a clear Ministerial priority and form a core element of the Health Board's IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** addressing the long term needs of the population and organisation by providing enhanced and more effective services to meet future demand.
	Integration – providing improved and integrated service configurations in response to concerns such as service consistency, sustainability and access.
	Involvement & Collaboration – programmes have been developed in collaboration with all key stakeholders across the service and are endorsed through comprehensive communication and engagement strategies as appropriate
	Prevention – implementation of the agreed regional programmes will support the prevention of future challenges of key service access and delivery and hence improve population health.
Glossary of New Terms	New terms are explained within the body of the document

Public Interest	Regional plans are made widely available to all stakeholders and health boards as part of public interest sharing of best practice and lessons learned

APPENDIX

DATED

MEMORANDUM OF UNDERSTANDING

IN RELATION TO

SOUTH EAST WALES REGIONAL PLANNING

between

ANEURAN BEVAN UNIVERSITY HEALTH BOARD
And

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
And

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

THIS AGREEMENT is dated

Parties

Aneurin Bevan University Health Board of St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ **(ABUHB)**

Cardiff and Vale University Health Board of Woodland House, Maes y Coed Road, Llanishen, Cardiff, CF14 4TT (**CVUHB**).

Cwm Taf Morgannwg University Health Board of Ynyfmeurig House Unit 3 Navigation Park, Mountain Ash CF45 4SN **(CTMUHB**)

Background

ABUHB, CVUHB and CTMUHB have agreed to work together on the portfolio of regional opportunities that will initially include Orthopaedics, Ophthalmology, and Diagnostics.

The parties wish to record the basis on which they will collaborate with each other on the portfolio. This Memorandum of Understanding (**MoU**) sets out the:

- Key objectives of the portfolio;
- Governance structures the parties will put in place and agree to adhere to; and
- Respective roles and responsibilities the parties will have in delivery of the portfolio.

Key objectives for the Portfolio

The parties shall enter into the portfolio to achieve the following objectives;

a) To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
b) To improve resilience.
c) To make effective use of capacity and capability in whichever organisation it sits.
d) To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that my not reside in every organisation.
e) Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
f) To enable clinical leaders, and others, to work together, lead together and learn together.

Governance

A Regional Portfolio oversight board (RPOB) shall be established to oversee the portfolio (as per its terms of reference). Each Health Board shall be represented on this forum via its Chief Executive, Director of Planning and Chief Operating Officer

Each Health shall ‘host’ a programme of work on behalf of the RPOB. This shall be as follows;

- Ophthalmology - *Aneurin Bevan University Health Board*
- Diagnostics - *Cwm Taf Morgannwg University Health Board*
- Orthopaedics – *Cardiff and Vale University Health Board*

Where additional programmes of work are bought into the portfolio at any point in the future the programme(s) hosting arrangements must be determined at the outset.

This MOU recognises that programmes do not always have to be a three-way programme if one particular organisation does not have a need to join. Specific partnerships/programmes may exist within this MOU where there are only two interested parties.

The RPOB must establish robust mechanisms for ensuring a clear line of site to any other regional programme, partnership, collaboration etc which are outside the scope of its terms of reference but could be depended on the delivery of work of the RPOB. Or vis versa.

Roles and responsibilities the parties

Hosting a programme shall not mean that the end clinical solution is to be found within the respective hosts Health Board boundary. Rather hosting shall mean a commitment to;

- Adequately resource a programme of work from both a manager and clinical perspective.
- Ensure the programme is fit for purpose in both its approach, governance
- Ensure a programme is representative of the region it is operating on behalf including a model of distributed leadership where, for example, the SRO maybe from organisation A, clinical lead from organisation B
- Ensure a programme robustly reports into the regional governance structures described in this ToR (annex A)

Escalation

If any party has any issues, concerns or complaints about the portfolio, or any matter in this MoU, that party shall notify the other party and the parties shall then seek to resolve the issue by a process of consultation. If the issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the RPOB, which shall decide on the appropriate course of action to take.

If any party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the portfolio, the matter shall be promptly referred to the RPOB (or its nominated representatives). No action shall be taken in response to any such inquiry, complaint, claim or action, to the extent that such response would adversely affect the portfolio, without the prior approval of the RPOB (or its nominated representatives).

Term and termination

This MoU shall commence on the date of signature by all three parties, and shall expire on receipt of formal notice from a partner that it wishes to withdraw from the portfolio.

Variation

This MoU, including the Annexes, may only be varied by written agreement of the RPOB.

Charges and liabilities

Except as otherwise provided, all parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU.

All parties shall remain liable for any losses or liabilities incurred due to their own or their employee's actions and neither party intends that the other party shall be liable for any loss it suffers as a result of this MoU.

Status

This MoU is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from this MoU. The parties enter into the MoU intending to honour all their obligations.

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the parties, constitute either party as the agent of the other party, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

Signed for and on behalf of **ANEURAN BEVAN UNIVERSITY HEALTH BOARD**

Signature: .....
Name: .....
Position: .....
Date: .....

Signed for and on behalf of **CARDIFF AND VALE UNIVESITY HEALTH BOARD**

Signature: .....
Name: .....
Position: .....
Date: .....

Signed for and on behalf of **CWM TAF MORGANNWG UNIVESITY HEALTH BOARD**

Signature: .....

Name: .....

Position: .....

Date: .....

Regional Portfolio oversight board (RPOB) - Terms of Reference

1. Purpose

The RPOB is a joint forum consisting of ABUHB, CAVUHB and CTMUHB. Its purpose shall be to;

- On behalf of each organisation be assured on progress being made across the portfolio in developing and implementing sustainable and high quality regional services into the future.
- To take a shared view in identifying and initiating further regional opportunities.
- Ensure that a collaborative relationship between the three Health Boards is maintained to deliver the best quality and outcomes of care possible to patients.
- Ensure collaboration is pursued with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

Initially the focus of the Portfolio shall include - *Orthopaedics, Ophthalmology and Diagnostics.* This may be amended at any point via a formal decision on the RPOB.

2. Membership

The forum will be made up of a core membership which includes the following from each of the three organisations–

- CEO
- Executive Directors of Strategy/Planning
- Chief Operating Officers

In addition the Regional Planning Programme Director shall be a core member.

Other Executives being invited to attend the meetings where appropriate. As to may Senior clinical and operational leaders from the appropriate services.

3. Portfolio scope

The RPOB will work on behalf of all three Health Boards. It will provide assurance to ABUHB, CVUHB, CTMUHB chairs, Boards and other relevant Board sub committees that both the key objectives of the Portfolio and programme specific outputs and outcomes are being met and that the portfolio is performing within the boundaries set.

The RPOB shall have the authority to endorse outputs / outcomes of programmes. Where required it shall recommend sign-off / support to individual organisation Boards and Committees but this will be handled by local organisation governance processes.

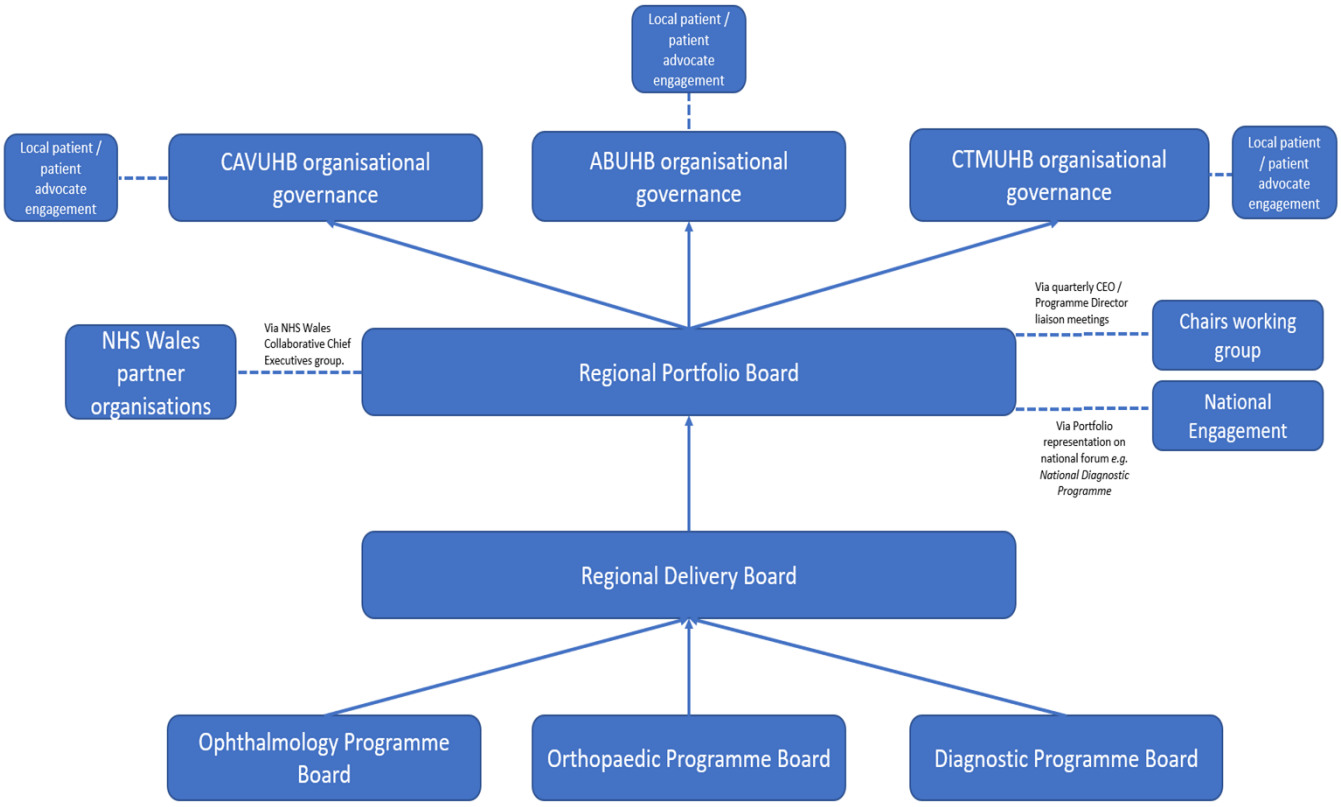
The RPOB shall have no delegated financial authority from any partner organisation.

4. Governance and Reporting

Where required Chief Executives will engage with Chief Executives of other Health Boards and Trusts on matters / decisions pertaining to the Portfolio that may impact on wider NHS Wales service delivery through the NHS Wales Collaborative Chief Executives group.

A Regional Delivery Board (RDB) shall report into the RPOB and work on its behalf to ensure effective design, delivery and implementation of the programmes of work within the scope of the Portfolio.

The RPOB will ensure there exist robust arrangements in place for ensuring ongoing assurance to Health Board Chairs, Welsh Government, Community Health Councils and other interested stakeholders.



The RPOB shall record current and feature contributions made to the Portfolio (financial and otherwise) by respective partners to ensure and risk is being appropriately shared.

5. Meeting Arrangements

- The forum will meet on a monthly.
- Meetings will be held on MS Teams.
- The chair will be held on a three month rotational basis by each of the respective Chief Executives.
- The secretariat function will be provided by the Regional Planning Programme Director.
- The meeting shall be quorate if each organisation is represented by a ‘core’ member

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Partnerships, Population Health & Planning Committee Wednesday 16th November 2022 Agenda Item: 4.6

Aneurin Bevan University Health Board

Approach to Developing the 2023/4 – 2025/26 Integrated Medium Term Plan (IMTP)

Executive Summary

The report presents the approach that is being adopted for the preparation of the Health Board's IMTP.

The Partnership, Population Health and Planning Committee is asked to note and endorse the approach that is being proposed for the development of the IMTP 2023/24 – 2025/6.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Christopher Dawson Morris, Interim Director of Planning

Report Author: Eithne Hunter

Report Received consideration and supported by :

Executive Team	✓	**Committee of the Board-** Partnerships, Population Health & Planning Committee	

Date of the Report: November 2022

Supplementary Papers Attached: Appendix 1

Purpose of the Report

The purpose of this report is to provide the Population, Population Health and Planning Committee with the approach that is being adopted for the preparation of the Health Board's IMTP for 2023/25.

Background and Context

The NHS Wales Finance Act (2006) requires the Health Board to annually submit an Integrated Medium-Term Plan (IMTP) to Welsh Government for approval.

The putative submission date for a Board approved Plan was originally set at 31st January 2023, however in the last week Welsh Government, in recognition of the volatility of the

current environment, has now confirmed the date for submission of approved IMTPs as 31st March 2023.

Each year Welsh Government issues an NHS Wales Planning Framework that sets out the requirements from the IMTP including the national policy context, ministerial priorities and statutory obligations with Minimum Data Sets (MDS) adopted as the mechanism that provides assurance on delivery of core services. The framework requires us to look ahead to the next three years to deliver a sustainable system for patients and improve population health.

This year the minister will focus NHS Wales Planning Guidance on a discrete number of priorities. There is a strong indication that Health Board's will be required to submit additional templates to provide assurance for these priority areas as part of the IMTP. NHS Wales Planning Guidance will be issued in mid-November 2022.

The context within which the Health Board continues to operate post Covid-19 pandemic is characterised by a renewed focus on sustainable recovery, characterised by a fundamental shift encompassing the wider role of Health and Social Care in reducing health inequalities, delivering the foundational economy and protecting the environment for future generations with the ambition of Net Zero by 2030.

In 2021/22, the Health Board adopted a life course approach focusing on delivering outcomes that over time improve the health status of the population. The approach was strengthened in last year's IMTP planning cycle where a scenario-based approach was adopted, tested with clinical teams alongside workforce and finance partners to understand profiles for delivery, key risks, constraints and priorities for all clinical areas. This understanding of the Health Board's system highlighted areas of high risk and/or opportunities to enable delivery of sustainable recovery. The Clinical Futures/PMO Priority programmes was refocused on these key areas and plays an important role in driving the system change, at scale and pace, that has been identified through the planning process.

The proposed approach for the 2023/26 planning cycle is a natural progression from our approved IMTP (2022/25). It builds on the life course, Clinical Futures Programme Management Office (CF/PMO) and dynamic planning approaches adopted last year, whilst recognising the increasingly challenging financial context for the public sector, the current operational demands and being able to focus on realistic, sustainable recovery.

The Health Board, for the first time since its inception in 2009, has declared an overspend year end position of £37 million. This is in the context of recovery from the harms of Covid-19 most notably in the delivery of planned care, together with growing demand for acute and emergency physical and mental health care. This has also had significant impacts on social care, leading to additional capacity, with longer lengths of stay and high occupancy rates, which drives inefficiency and volatile staffing. The response has required higher temporary workforce and medicine costs and compromised many of the savings plans identified in the IMTP coming to fruition. This is hitting all parts of our system, from primary contractor services, through community and hospital-based care.

The Health Board has a responsibility to delivery financial balance over the 3-year planning cycle, and to deliver a balanced profile of services that meet competing demands across our system, whilst maintaining and improving quality of care and patient experience. The ominous economic climate, with the likely constriction on public sector funding, cost of living increases, fuel costs, procurement and potential industrial action means that this IMTP cycle will be the most challenging to date.

The IMTP will be further strengthened by the Pan-Cluster 3-year strategic plans (locally known as the Integrated Service Partnership Board (**ISPB** plans). These plans, based on Population Needs Assessment, and Neighbourhood Care Network Plans identify what services are needed making prudent use of all funding, workforce, and other resources to address the health, care and wellbeing needs of the local population. The IMTP and the Regional Partnership Board Area Plan will both reflect and align with these pan-cluster plans.

The IMTP will remain purposefully short. It will aim to provide a coherent story of the organisation's ambitions and priorities. It will seek to demonstrate an understanding of the system, specific opportunities for change that will materially improve how the system operates and improve the health and wellbeing of the population.

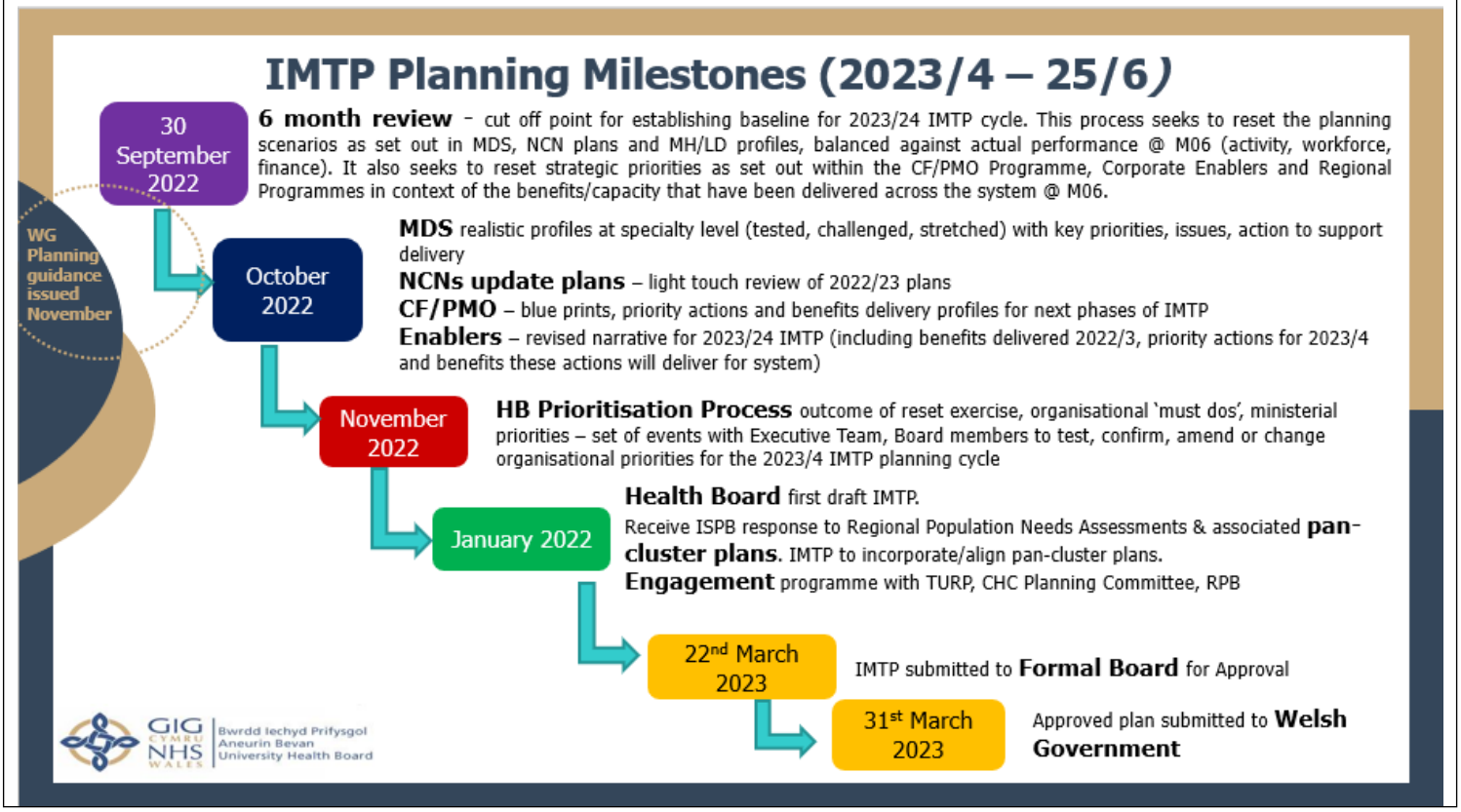
Proposed Approach

The phases to developing the IMTP together with the proposed timeline (based on a submission of an approved IMTP to Welsh Government on 31st March 2023) is shown in Figure 1, with further details on the proposed approach attached in Appendix 1.

It broadly follows the approach that has been adopted over the past two years, and differs only in respect of:

- The timeline for production of the plan has been moved forward, allowing for the main body of work to be completed by the end of October/November
- Strengthening the process to reset baselines to inform MDS profiles, NCN plans, organisational priority milestones
- Consideration and alignment of Pan-Cluster plans to inform final version of the Health Board's IMTP.

Figure 1IMTP planning process and milestones 2023 - 25



Setting the baseline is central to understanding what the system can realistically deliver. It forms the foundation of this plan and is the backdrop against which our response to Ministerial and Welsh Government policy priorities can be determined and ultimately assists the Health Board to confirm, adapt and/or change organisational priorities.

The IMTP planning process for 2023/4 – 2025/6 seeks to strengthen dynamic planning, triangulating demand/capacity profiles with activity outturn, stretching what can be delivered in the context of public sector finance, workforce and other constraints facing our system in 2023 and beyond. The recent confirmation of the revised timeline for submission of the IMTP, will allow more time in to be invested in the triangulation of workforce, finance, operations and enabling functions to strengthen delivery assumptions and to ensure that activity can be aligned with the templates that support ministerial priorities for this planning cycle.

1. Reset baselines and delivery profiles for 2023/24 (MDS/NCN)

a) Minimum Data Sets

The Dynamic Planning Approach adopted last year used demand/capacity data sets at specialty level, tested and worked up through clinical teams (specialty) alongside workforce and finance partners to understand delivery profiles, interdependencies, key risks, constraints and priorities for each clinical area. This will be strengthened to include:

- Workforce data sets by specialty
- Finance data sets by specialty
- Activity data sets by specialty
- CF/PMO delivery profiles by specialty (where relevant)

These data sets will be tested by and worked up with clinical teams to set realistic delivery profiles for 23/24 in the context of operational pressures, activity/performance delivered in year and known constraints.

Triangulation of these data sets with workforce, finance and enabler functions will be undertaken to further test and validate delivery profiles within and across specialties.

b) Neighbourhood Care Network (Cluster) Plans

In 2022/23 NCN (Cluster) Plans were based on an agreed national guidance template that sat outside of the IMPT Planning Framework and Guidance. Health Boards were required to submit these plans with their IMTP. Our Health Board embedded the 11 NCN plans within the IMTP document. The level of integration of NCN plans within the IMTP was hampered by timescales, capacity and operational pressures consequently plans were developed in parallel. Notwithstanding this, there was clear line of sight between organisational priorities and NCN plans, not limited to but exemplified by 'Accelerated Cluster Development' being one of the CF/PMO priorities.

This year the role of NCN plans in informing the Health Board's IMPT, together with the Integrated Service Partnership Boards (ISPBs) Pan-Cluster Plans and the Regional Partnership Plan is being strengthened. Welsh Government have confirmed that 2023/24 will be a year of transition in respect of Pan-Cluster Plans.

To ensure that NCN plans visibly inform and are informed by the Health Board's IMTP it is proposed that the approved 2022/23 NCN plans provide a baseline that will be reviewed, tested and reset to set out realistic programmes of work to improve the health and wellbeing of their populations.

ISPB plans will be available by December 2022, confirmation that the date for submission of the IMTP has shifted to March 2023 will enable the Health Board to be fully cognisant of and incorporate/align each ISPB priorities within the Health Boards plan.

c) Clinical Futures programmes for 2023/24 – 2025/26)

The Health Board reinvigorated the Clinical Futures (PMO) team over the past 12 months to support the establishment of Transformation programmes. These are encapsulated in the Health Board's top priorities which set out the system changes that are central to delivering sustainable recovery. The Clinical Futures function is designed to ensure that the Health Board take forward these programmes at pace and deliver measurable benefits to the system.

In 2022/23 the Clinical Futures Programmes were at varying levels of maturity, some spanning long established priorities (urgent and emergency care, planned care, cancer care) others relatively new as a consequence of new opportunities following the opening of the Grange University Hospital or new challenges in the context of learning from the experience of the Covid-19 pandemic (eLGH network, accelerated cluster development, health protection, net zero).

The focus for 2022/23:

- to establish robust formal Programme Management arrangements for each organisational priority, and
- to deliver the system improvements set out in the IMTP

In addition to setting out what each of the programmes has delivered over the past 12 months, this year programmes will seek to articulate the transformation changes that will be delivered in the short (year), medium (3 years) and longer term. Together with a benefits profile and timescales for delivery.

d) Enablers

The process that has been adopted in previous planning cycles will be maintained with an added focus on the benefits that have been delivered to the system against the actions set that were set out in the 2022/23 IMTP.

e) Timetable

The timetable for resetting the baseline at specialty and NCN level has been brought forward, and will be undertaken between 1 October – 30th November. This recognises:

- the substantial body of work required by corporate teams and clinical teams to set realistic demand/capacity profiles for 2023/24
- the need to complete this work before the challenges of winter pressures impact further on operational pressures

- the need to build sufficient time into the process for Executives and Independent Members to confirm and set organisational priorities
- the additional requirements of mandated templates to support ministerial priorities as part of the IMTP

2. Health Board Prioritisation Process

The output from resetting the baselines will be used to support the Executive Directors and Independent Members to revisit the organisational priorities set out in our approved IMTP and to ensure that they are addressing what matters most to the organisation now and over the next three years.

The prioritisation process will confirm the programmes and projects that are the most strategic and in the best interest of the organisation as a whole. Their contribution to improving the safety of our system, the interventions we provide and patient care will be paramount in determining organisational priorities.

The framework for delivering organisational priorities will be supported through the CF/PMO function with alignment between corporate strategic objectives and those within divisions, departments and services.

The prioritisation process will be scheduled for fourth week of November 2022 with the Executive Team, and with the Board members in mid-December.

3. Engagement

There are no changes proposed to the approach adopted in previous years, with ongoing dialogue on the process, outcome of dynamic planning and emerging themes through established fora including Aneurin Bevan Community Health Council Planning Committee, the Trade Union Partnership, sub-committees of the Board and regular meetings with WG Planning Team.

4. Narrative Plan

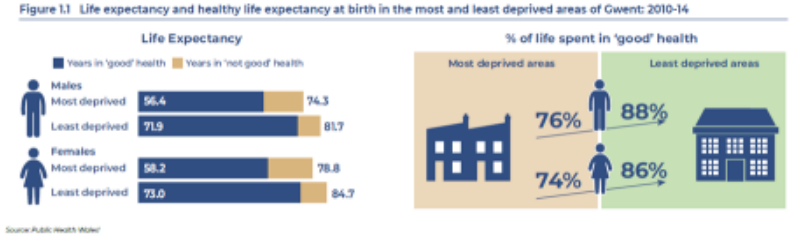
A draft IMTP will be available by 31st March 2023.

The final version of IMTP and all associated documents including the Minimum Data Set, and mandated templates will be submitted to the March 2023 Board for formal approval. Submission to Welsh Government on or before 31 March 2023.

Recommendation
The Partnership, Population Health and Planning Committee is asked to note and approve the approach that is being proposed for the development of the IMTP 2023/24 – 2025/6.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	Sets out the financial framework with key opportunities and risks. Areas of opportunities for improved efficiency and value for money are identified throughout the Plan.
Quality, Safety and Patient Experience Assessment	Quality, Patient Safety and Patient Experience underpins the whole Draft IMTP and runs as a theme throughout the plan. An enabling section on Quality and Patient Safety sets out the key headlines.
Equality and Diversity Impact Assessment (including child impact assessment)	Key issues are reflected within the Plan.
Health and Care Standards	The Health and Care Standards underpin the Draft IMTP.
Link to Integrated Medium Term Plan/Corporate Objectives	This is the Draft IMTP and sets out the key organisational priorities informed by our detailed understanding of how our system operates.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The Plan demonstrates an integrated approach to working across the Health Board and with partners and combines both short and long term goals
Glossary of New Terms	Any new terms are explained as they occur within the document.
Public Interest	This report has been written for the public domain.

IMTP 23/26 Approach



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What's the point of an IMTP?

- Set organisational direction
- Identify priorities
- Provide Assurance on delivery
- Align performance, service plans, finance, workforce and wider corporate teams
- **The One Plan**

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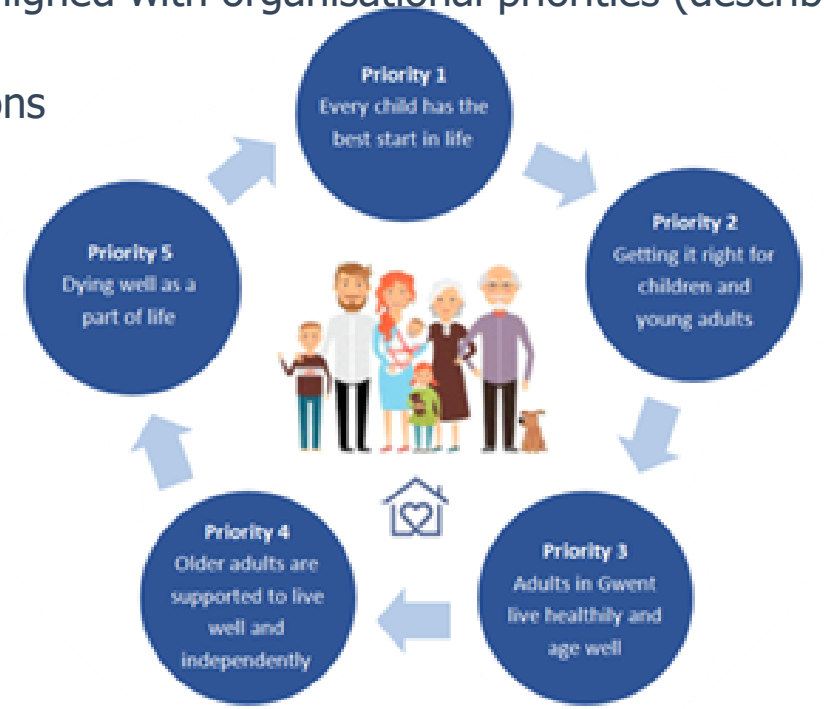
Output –
A Board Approved 3 year IMTP by 31st March 2023

- Three Year Integrated Medium Term Plan 2023/2026 builds on the IMTP 2022/25
- Process light, intelligence driven and reducing any burden on overstretched operational and corporate teams
- Clarity of purpose and function aligned with organisational priorities (described in context of life course outcome measures) and
- Delivering our statutory obligations

The Health Board's Mission is to reduce health inequalities experienced by our communities through improving population health. A life course approach with five overarching priorities sets out how the Health Board seeks to deliver its ambition.



We will do this by adopting:
- Pathways approach (starting in community) focused on system interventions
- High Value Interventions
- Intelligence Driven, always on, real time data to inform decision making
- A Trust culture, and
- Partnership first approach

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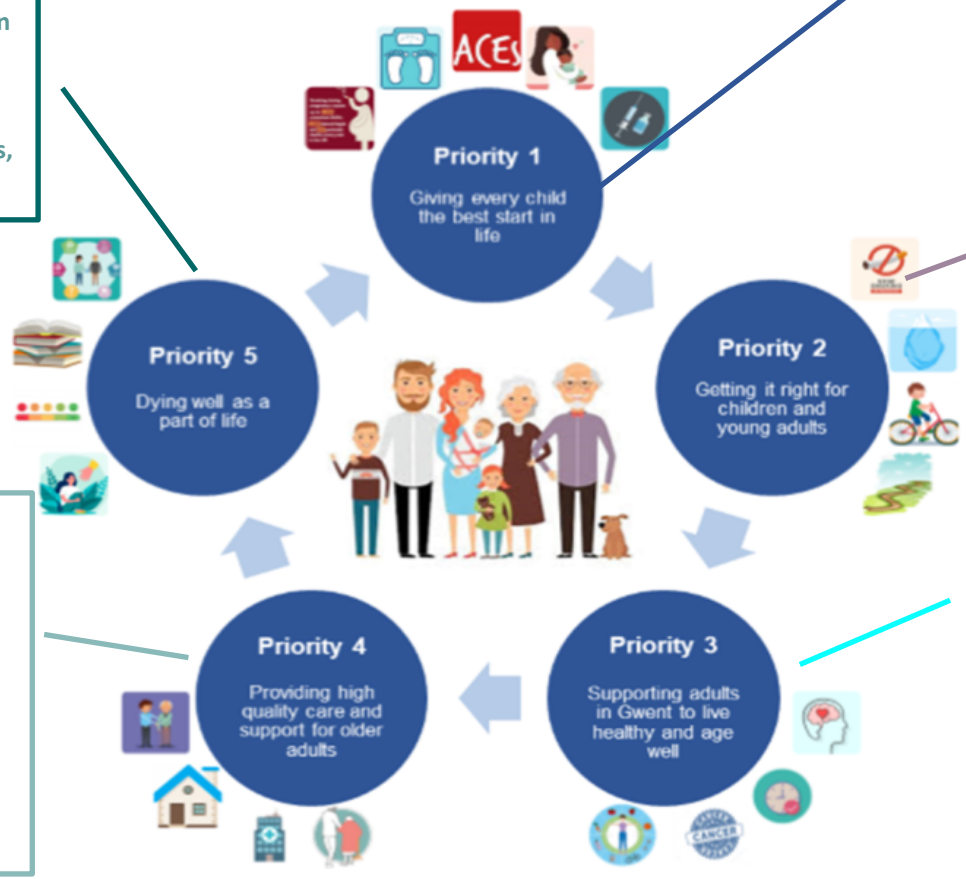
Outcomes (and measures being employed against life course)

- **Improve care at end of life** (↓ % of people with hospital as place of death, ↑ compliance issuing death certificates within 5 days)
- **Improve planning and provision of care at end of life** (↑ proportion of urgent palliative care referrals assessed ≤ 48 hours, ↑ ACPs with escalation treatment plans)



- **Improving good health in pregnancy** (↓ low birth rates, stillbirths and smoking rates in pregnant women)
- **Optimising a child's long term potential** (↑ breastfeeding, 8 week checks and contact @3.5 years)
- **Increasing Immunisation & Vaccinations, outbreak prevention** (uptake 6-in-1 @ 12 months and 2 MMR doses @ 5

- **Improving MH & resilience in children and young adults** (mean mental health wellbeing score, ↓4 week CAMHS waits, neurodevelopmental waiting lists)
- **Smoke free environments** (smoking and vaping rates)
- **Support being a healthy weight** (↑adolescents of healthy weight, % 2-7 year olds who are active for ≥ 1 hour/day, % children who eat vegetables each day

- **Prevention and keeping people well** (social Prescribing, early diagnosis of dementia, Falls, ACP, support for carers – indicators to be developed)
- **Proactive care and support @ home** (↑ rapid response ≤ 4 hours, number of short stay patients, average time spent on care load)
- **Hospital/Care Homes** (↑ admission avoidance, ↓ LoS ≥ 21 days (from 65 to 55 %)

- **Maximising individual time** (↓ number waiting ≥ 36 weeks for treatment, number waiting for follow up OP, ↑ primary care consultations, Think 111 calls, ↓ handovers ≥60 mins, never waits in ED ≥ 16 hrs, time to be seen by clinician and time for bed allocation)
- **Adults living healthily and ageing well** (↑ adults active for ≥ 150/week, working aged adults in good or very good health, uptake of national screening programmes ↓ % smokers, number of adults with BMI ≥ 25)
- **Improving mental health** (↑MH & wellbeing score, % of residents in receipt of Secondary care services with valid care and treatment plans)
- **Maximising cancer outcomes** (↑ compliance with single (suspected) cancer pathway, 5 year survival rate)

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Integrated Medium Term Plan **3 Year Health Board Plan** (process and timeline)

Phase 1 - reset (1st Oct – 30-th Nov)

MDS Reset and Operational Priorities (Specialty/service)	NCN Delivery Plans & Priorities (PC&C)	HB Strategic Priorities (CF/PMO)	Enablers Strategic Priorities (Corporate Depts & Regional Programmes)
Baseline reset for 2023/24 with assumptions & priorities to achieve modelled activity profiles		Benefits realised by each programme, status and anticipated benefits Y2	Reset, benefits/actions delivered Y1 and focus with anticipated benefits Y2

Phase 2 – external ask (Mid October to mid November)

RPB/ISPB Priorities (drawn from population health needs assessment by Borough)	Ministerial priorities (drawn from NHS Wales Planning Framework)	Policy lead priorities
Available by 31 December for consideration and alignment with IMTP January 2022, RIF priorities known now	NHS Planning Framework (issued 9th November in 2021)	Implementation Groups, Networks and Programmes

Diabetes ▪ EoL Care ▪ Liver Disease ▪ Neurological conditions ▪ Stroke ▪ Respiratory ▪ Women's Health ▪ Rare Diseases

Mental Health ▪ Maternity/ Neonates ▪ Cardiac ▪ Critical Care ▪ Cancer

Endoscopy ▪ National Pathology Programme ▪ Lab Information ▪ National Imaging ▪ Radiology Informatics ▪ Welsh sexual assault service

Health Board Prioritisation Process	Engagement	Draft IMTP	Cluster Plans published	Approve IMTP	Submit to Welsh Government 31 March 23
(Executives, Independent members, Clinical Futures Board (HSLG) events scheduled for weeks 2 & 3 January	TURP, CHC Planning Committee, RPB, Cluster Planning Groups, Sub committees January	February Board		March Board	

Our Current Position

MDS (profiles and operational priorities)

- Covers all surgical, medical and acute family and therapy; theatres and diagnostics and bed plan
- Primary care and community confirming data sources in inform profiles for this planning cycle 23/24
- Mental Health, Learning Disabilities and therapies – to confirm data sources to inform profiles

Reset Task

= @ M06 what was profiled activity (MDS 22/23), delivered activity (performance), gap, reason for gap (workforce, capacity (physical space, technology), finance, data/intelligence)
= assumptions, interdependencies, priorities/actions to support delivery
= reset profiles for 23/26

Team and timescales

- Planning/modelling, workforce, finance as introduced in 2022/23 with added rigour and challenge to test and optimise capacity profiles in the context of known constraints (e.g. finance, workforce)
- Performance to be included in individual directorate/specialty sessions to triangulate profiles, performance and to progress data/intelligence/monitoring/delivery assurance mechanisms
- CF/PMO to be included in individual directorate/specialty sessions where that service area contributes to the delivery of a PMO programme
- Complete reset of demand/capacity profiles no later than second week in November

Our Current Position

Neighbourhood Care Networks (NCNs)

- NCNs are long established in Gwent. Based on a 'cluster' geographical footprint, the 11 NCNs widen the membership from a traditional 'GP' cluster to a multi-disciplinary team including professionals working within social services, community teams and third sector agencies.
- NCNs have developed plans over a number of years, including development of **Integrated Medium Term Plans** in 2018, 2019, 2022 and annual delivery plans in 2021, in line with WG requirements.
- NCN plans for 2022 are shown as Appendix a

Reset Task

= @ M06 review of each of the 11 NCN plans what has/is being delivered, impacts, gaps, challenges
= assumptions, interdependencies, priorities/actions for 2023/26
= align/assess in context of Pan- Cluster Plans mandated by Welsh Government (due for submission December 2022)

Team and timescales

- PC&C have set out their timetable for 2023/26
- Divisional Plan will cover contractor services
- NCN plans will feed pan-cluster plans
- Pan-cluster plans will feed corporate IMTP and Gwent Area Plan

What	Start	Complete
Population Needs Assessment	19-Aug-22	**30-Sep-22**
Workforce Analysis	26-Aug-22	**30-Sep-22**
Financial Analysis	30-Sep-22	**30-Nov-22**
Planning Templates to support Reset of NCN plans	19-Aug-22	**16-Sep-22**
Divisional IMTP Priority Setting	02-Sep-22	**30-Nov-22**
Plan Submission		
Professional Collaborative SWOT Analysis	19-Aug-22	**30-Sep-22**
NCN Annual Plan reset (first draft)	16-Sep-22	**31-Oct-22**
ISPB (pan-cluster) IMTP	30-Sep-22	**30-Nov-22**
Divisional IMTP	02-Sep-22	**31-Dec-22**
Gwent Area Plan	31-Dec-22	**31-Mar-23**

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IMTP Planning Milestones (2023/4 – 25/6)

WG Planning guidance issued November

30 September 2022

6 month review - cut off point for establishing baseline for 2023/24 IMTP cycle. This process seeks to reset the planning scenarios as set out in MDS, NCN plans and MH/LD profiles, balanced against actual performance @ M06 (activity, workforce, finance). It also seeks to reset strategic priorities as set out within the CF/PMO Programme, Corporate Enablers and Regional Programmes in context of the benefits/capacity that have been delivered across the system @ M06.

October 2022

MDS realistic profiles at specialty level (tested, challenged, stretched) with key priorities, issues, action to support delivery

NCNs update plans – light touch review of 2022/23 plans

CF/PMO – blue prints, priority actions and benefits delivery profiles for next phases of IMTP

Enablers – revised narrative for 2023/24 IMTP (including benefits delivered 2022/3, priority actions for 2023/4 and benefits these actions will deliver for system)

November 2022

HB Prioritisation Process outcome of reset exercise, organisational 'must dos', ministerial priorities – set of events with Executive Team, Board members to test, confirm, amend or change organisational priorities for the 2023/4 IMTP planning cycle

January 2022

Health Board first draft IMTP.

Receive ISPB response to Regional Population Needs Assessments & associated **pan-cluster plans**. IMTP to incorporate/align pan-cluster plans.

Engagement programme with TURP, CHC Planning Committee, RPB

22nd March 2023

IMTP submitted to **Formal Board** for Approval

31st March 2023

Approved plan submitted to **Welsh Government**

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Cross Divisional Impacts

- eLGH reconfiguration - review of estates across the eLGH sites including the interface with relevant Primary and Community Care services and the Grange University Hospital.
- Planned Care - key transformation programme, three workstreams, focusing reducing long waits and maximising core capacity. Theatres, and therapies, dietetics B4 proof of concept (winter plan)
- Planned Care recovery programme - Welsh Government programme, delivery of the goals through collaboration and partnership, optimising patient and staff experience, achieving clinical outcomes and value.
- SDEC and theatre at RGH
- CSS establishment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our Current Position

Clinical Futures/Organisational Priorities (PMO)

- 9 programmes established, most with PMO support, varying degrees of maturity and clarity, some are focused operationalising national plans (6 goals for urgent care; planned care recovery) and/or transforming models to create capacity to deliver those plans. On the face of it programmes lack transparency in respect of profiles for benefits realisation, or realisable benefits that inform/underpin their respective work plans and actions
- Monthly highlight reports provide high level overview of status of programmes and outline the actions for the next month, narrative only lot of focus on set-up/governance

Reset Task

= @ M06 6 month review benefits delivered v benefits anticipated from the programme, confirm if programme on plan/off plan and reasons for variance.

= assumptions for next phase, interdependencies, priorities/actions and deliverables for 2023/26

Team and timescales

- Blueprint for each CF Programme that defines the scope of what is going to change once all the projects in the programme are complete
- Clarity on what benefits will be delivered in 2023/24, 2024/25 and in 2025/26 against the blue print (depending on the planned life of the transformation programme)

1. Public Health Protection and Population Health Improvement
2. Accelerated Cluster Development (ACD)
3. Redesigning Services for Older People
4. Mental Health Transformation
5. Planned Care Recovery
6. Transforming Cancer Services
7. Urgent Care Transformation
8. Enhanced local General Hospital Network
9. Net Zero – Decarbonisation

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Our Current Position

Enablers

- Most of the enablers report through sub-committees of the Board
- Each enabler has set out priority areas, actions and/or mechanisms that are being progressed to support the organisation to deliver its statutory obligations and organisational priorities.
- It is not clear whether existing governance arrangements hold these corporate functions to account specifically on the areas set out in the IMTP

Reset Task

= @ M06 month review benefits delivered v benefits anticipated for areas specified in the 2022/23 – 25/26 plan

= confirm whether they are on plan/off plan against what they are delivering and reasons for variance.

= assumptions for next phase, interdependencies, priorities/actions and deliverables for 2023/26

Team and timescales

- Enabler leads to be commissioned to undertaken reset in September to feed into MDS and NCN exercise.
- Revised/refreshed narrative sections to be completed by end of January 2022

ENABLER

1. Experience, Quality and Safety
2. Partnership First (RPB links with CF# Pan cluster planning ACD)
3. RIIV (change to Research & Development and Value (? Innovation – do we have this function now), Improvement ? Sit with modelling/planning) (future of AB Connect in new world)
4. Workforce and OD – (people plan, shaping the workforce)
5. Transformation through Digital
6. Enabling estate (link with CF# eLGH)
7. Finance
8. Regional Solutions (link with CF# planned care, cancer)

REPORTING ARRANGEMENTS

1. **Patient Quality, Safety & Outcomes Committee**
2. **Partnerships, Population Health and Planning Committee**
3. R&D via **Patient Quality, Safety & Outcomes Committee**: Value via The **Finance & Performance Committee**, ABCi via? Innovation via?
4. The **People and Culture Committee**
5. **Executive Team** via the Digital Delivery Oversight Board
6. **Executive Team** Enabling estate via **Strategic Estates Group**
7. The **Finance & Performance Committee**
8. Regional Solutions via **Partnerships, Population Health and Planning Committee**

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Welsh NHS Confederation
Health and Wellbeing Alliance

In partnership with

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Mind the gap: what's stopping change?

The cost-of-living crisis and the rise in inequalities in Wales

July 2022

The cost-of-living crisis is a health crisis

Poverty causes ill-health and illness.

At a glance

- 60% of people in Wales say the rising cost-of-living has had a negative impact on their wellbeing (RCP)
- Health inequalities cost the Welsh NHS £322 million every year (Public Health Wales).
- Wales now has the worst child poverty rate of all the UK nations at 31% (End Child Poverty).
- One in ten Welsh households live in insecure housing (Bevan Foundation).
- People in Wales face a higher risk of dying in poverty than any other UK nation (Marie Curie).
- Almost 60% of adults in Wales are living with overweight or obesity (Public Health Wales).
- The full social cost of obesity to Wales is around £3 billion a year (Frontier Economics).
- 12% of Welsh households are at least one month behind on a bill (Bevan Foundation).
- Child poverty has increased in 20 of 22 local authorities over the past 5 years (End Child Poverty).

The COVID-19 pandemic has widened existing inequalities and highlighted the link between poverty and poor health outcomes in Wales. Indeed, the Future Generations Commissioner and Public Health Wales have found that those who were already living in poor health, poverty or in marginalised communities in Wales have been the hardest hit by the pandemic.

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Over the coming months, as the everyday cost-of-living continues to rise faster than people's income, this is likely to lead to a drop in living standards for many people. The rising cost of groceries and energy, combined with staff shortages in some sectors and supply chain disruptions, have driven up inflation. This is likely to exacerbate inequalities in the coming years.

> "Many people have had to make impossible choices – between buying food, paying household bills, or staying connected with loved ones. This has impacted on people's mental health and overall wellbeing, leaving some to feel as though they are unable to cope and recover from the COVID-19 crisis."
>
> British Red Cross

> "Those struggling with poor health face loss of earnings through employment and indeed may be unable to work, leading them to interact with the benefit system. As well as impacts on wellbeing, those in poor health may also have increased living costs and children suffering with poor health will see an impact on their education."
>
> Joseph Rowntree Foundation

Evidence suggests that at most, only 20% of a nation's health and wellbeing is dependent on healthcare services. The NHS alone does not have the levers to reduce inequalities: this is why we need to shift the focus from public health initiatives delivered through the NHS and local authorities to addressing factors such as poor housing, transport and food quality. Addressing the factors that cause ill-health in the first place should be a central focus for the Welsh Government.

> **The Welsh Government should produce a cross-government plan for reducing poverty and inequalities in adults and children.** This should outline the action being taken across all government departments, setting out how success will be measured and evaluated through shared performance measures and outcomes for all public bodies in Wales, accompanied by guidance on how individual organisations should collaborate to reduce inequalities and tackle the cost-of-living crisis.

Key recommendations

The Welsh Government should:

- prioritise closing the implementation gap on health and wellbeing for adults and children
- provide more detailed guidance on implementation to local delivery bodies
- map out existing activity on public health, inequalities, poverty reduction and social security
- introduce health impact assessment regulations as a priority
- consolidate commitments on inequality in one delivery plan to improve accountability
- develop a shared set of performance measures focused on reducing inequalities
- ensure that funding encourages collaboration and is linked to tackling inequalities
- improve access to prevention programmes based in primary and community care, especially for those living in poverty
- invest in innovative prevention including screening programmes, vaccines and wearable technology
- improve access to high-quality, robust data to measure any change in inequalities
- require regional partnership boards (RPBs) and public service boards (PSBs) to tackle inequalities.

> "For too long, we have looked to the health service to address these challenges in isolation. Health inequality is the result of many and varied factors and meaningful progress will require coherent efforts across all sectors to close the gap."
>
> Welsh NHS Confederation

> "Evidence shows that a comprehensive approach to tackling health inequalities can make a difference. Concerted, systematic action is needed across multiple fronts to address the causes of health inequalities."
>
> The King's Fund

Why do we need a cross-government approach?

While the Welsh Government has committed to tackling inequalities through its programme for government, there is no overarching explanation of how this work will be joined up across different government strategies, how outcomes will be measured and how ministers will be held accountable for delivering these commitments on a collaborative basis.

> A cross-government plan could set existing commitments in context, provide some clarity around shared outcomes and provide transparency in how performance will be measured (see Table 2).

Good health plays a fundamental role in the prosperity of our nation – a healthy workforce has a direct effect on economic productivity – as well as our overall wellbeing and happiness. There is a strong link between work and health: for work to have a positive impact on health, it must be 'good work' which provides stable employment, pays a living wage, and offers fair working conditions, work-life balance and career progression.

Table 1: Wider social determinants of health

The wider social determinants of health include:

- income and financial security (health and wealth)
- the availability of good, fulfilling and fair work
- education and skills
- access to healthy food and drink
- discrimination, especially on the grounds of a protected characteristic
- access to the arts and cultural activities
- social connections (family and friends)
- access to sports and physical activity
- access to transport and travel
- the quality and security of housing and the open space around us (space and place).

> "The relationship between health and income is long established. Better health generally improves your quality of life; it allows improved employment opportunities and reduces the extra costs ill-health can bring. Living in poverty means extra stresses on day-to-day decisions and can lock people out of health-promoting services or assets such as better housing."
>
> Joseph Rowntree Foundation

> "Deprived areas have on average nine times less access to green space, higher concentrations of fast-food outlets and more limited availability of affordable healthy food."
>
> The King's Fund

Table 2: What might a cross-government plan look like?

At a Welsh Government level, it should:
• have an agreed definition of health equality: what does success look like? • include clear, measurable targets and outcomes with a defined timescale • highlight regular milestones along the way, underpinned by the necessary funding • be owned by the whole cabinet, led by the first minister • include annual reporting on progress, drawing on action taken by all departments and partners • share performance measures across government departments • bring together existing work on inequalities from across government departments.
At a regional or local level, it should:
• have a named lead for tackling inequalities for every public sector organisation • include guidance on how organisations should collaborate regionally within established structures • involve transparent data collection that allows for meaningful and independent scrutiny.
Communication and engagement principles:
• clear communication and engagement with external stakeholders and the public • development in genuine partnership with people and organisations in Wales.

What's stopping change?

Delivery is the biggest issue facing us. In many cases, smaller bodies simply do not have the capacity, expertise, resource or focus to deliver the national vision set out in ambitious legislation and policy documents. We need a system-wide transformation in behaviour: a large-scale shift to the prevention of ill-health by all public bodies, led by the Welsh Government.

We must drive prevention upstream, so that interventions take place at the earliest possible point. For example, current work to end homelessness focuses on primary, secondary and even tertiary prevention levels instead of acute spending (see table 3).

Community organisations should be supported with the capacity and resource to ensure change takes place from the grassroots. Collaborations need to be more widely encouraged.

Table 3: What are prevention levels?

Prevention levels	
Primary prevention	Preventing or minimising the risk of problems arising through universal policies, eg education, health promotion, good housing management and tenancy support.
Secondary prevention	Targeting individuals or groups at high risk or showing early signs of a particular problem to try to stop it occurring, eg early referral to family or youth support services.
Tertiary prevention	Intervening once there is a problem to stop it getting worse and to redress the situation, eg writing off rent arrears to avoid eviction.
Acute spending	Spending to manage the impact of a strongly negative situation – this does little or nothing to prevent problems recurring in future, eg cost of temporary housing when made homeless, long-term cost of supporting children who have suffered adverse childhood experiences (ACEs) as a result of loss of home.

We also need to map where national and local government are working with partners to reduce inequalities across all government departments and sectors, evaluate whether programmes are working and identify the lessons learned, while sharing good practice on a much larger scale.

Reducing inequalities and improving wellbeing should be central to every strategy that comes out of every government department: an intersectional approach is crucial.

Closing the implementation gap

Over the past decade, the Welsh Government has passed the Wellbeing of Future Generations Act, the Public Health Act (including health impact assessments which have not yet been introduced) and has enabled the Equality Act's socio-economic duty. This is a complex and ever-changing landscape with hundreds of targets and performance measures. The Welsh Government has published national wellbeing indicators and is in the process of developing national milestones, but it is doubtful that many people outside of policymaking circles will be aware of this work. Better communication and engagement with external stakeholders, community organisations and the public is essential.

Change proposed at a national level is not necessarily taking place at a local level. Significant barriers to change include the prioritisation of short-term issues and targets, workforce pressures and increasing demand for services. While we recognise that the pandemic has put a huge strain on public services, the Welsh Government must now show national political leadership in driving change. This means providing more detailed guidance for smaller, local organisations to implement changes required by national legislation.

> "Political leadership is essential to ensure that population health is a key priority for the health and care system and across government. This should include setting ambitious and binding national goals to improve health outcomes and developing a new cross-government strategy to reduce health inequalities."
>
> The King's Fund

The Public Health (Wales) Act 2017 received Royal Assent in July 2017, but almost five years later, regulations about the carrying out of health impact assessments by public bodies have still not been laid. It took more than a decade to lay the Equality Act 2010 regulations that brought the socio-economic duty into force in March 2021. This issue needs transformational, system-wide change in behaviour.

> "Health is a complex system involving a large range of relevant actors and potentially long timescales for change. Small-scale or half-hearted interventions will see the healthy life expectancy mission missed by a long distance, or worse, see continued falls in healthy life expectancy. If we are to take this mission seriously, it must be a mission for the whole of government."
>
> Health Foundation

PSBs and RPBs have not done enough to build awareness and understanding of what they do. They should become more visible and accountable, and engage more effectively with the communities they serve, and place more of an emphasis on reducing inequalities.

> "Concurrent action is needed at multiple levels: an enduring national mission to tackle inequality; a new local and national partnership to create the conditions for system success; and local leadership to nurture the disruption needed to sustain success."
>
> The King's Fund

Measuring success

Performance measures drive the way services are delivered: shared outcomes across public bodies could ensure that priorities and resource allocations are focused on long-term health and wellbeing and behaviour change. Outcome measures should be co-produced with patients and patient-led advocacy organisations.

> "The system in place is extremely complex. If all the performance measures, across the different plans, are combined, there are over 350 measures that health services have to report on. This generates vast amounts of waste in time and resources to collate and analyse this information."
>
> Bevan Commission

Usually when a government talks about what it has achieved, it talks about the investment it has made into a particular programme or area of work. More rarely does it demonstrate through the evaluation of outcome measures that things have improved.

Delivery bodies in Wales can still find it difficult to work together on the things that determine our chances of living well – and part of this is driven by competing performance measures and targets. A genuinely cross-government approach should ensure that outcomes measures apply across all sectors and include those working in the gaps between sectors. Any framework should not be used as a tool to measure health board performance alone, but to drive a focus on reducing inequalities across all public bodies. RPBs and PSBs should be measured by how effectively they are reducing inequalities through their population needs and wellbeing assessments and plans.

Understanding the system

To avoid duplication of work, the Welsh Government should work with public bodies, delivery partners and the voluntary and community sector to review and map out existing outcomes frameworks, targets and indicators into one piece of work. This would show where existing measures and published indicators already contribute to shared action on inequalities and could be the precursor to an effective cross-government plan.

> The Public Health Wales Observatory has published a Public Health Outcomes Framework and the Welsh Health Equity Solutions Platform is being developed as a way of accessing data and evidence on reducing health inequalities.

But the system is still complex. The jigsaw puzzle of funding for public health, inequalities, prevention, poverty reduction and social security makes it almost impossible for anyone outside government to know what is happening, let alone whether it is making a real difference. A more comprehensive and consolidated plan for reducing poverty and inequalities would make everything much clearer and help the voluntary and community sector to work in partnership with public bodies to deliver Welsh Government ambitions to tackle inequality and ill-health.

The role of the UK government

It is important to remember that many of the levers for change (social scrutiny, universal credit, the benefits system, immigration and free movement, and welfare to work programmes) remain outside of Welsh Government control: indeed, the Bevan Foundation recently made the case for the devolution of power over housing benefit and the housing element of Universal Credit.

The UK Government's white paper on levelling up should be considered as part of this work; however, this should not stop Welsh public bodies doing everything within their power to improve health and wellbeing where they can. The pilot universal basic income scheme is a good example of where Welsh Government is using its existing powers to improve the benefits system.

> "It's clear that levelling up will require a long-term approach to tackle entrenched inequalities between and within places across Wales and the UK. The extent to which the UK Government's approach will successfully address the challenges many people and communities across Wales face, and how it will interact with Welsh Government policy in devolved areas, remains to be seen."
>
> Senedd Research

> "The importance of Wales-specific social security measures should not be underestimated. Although the UK social security system plays an important role in solving poverty, Welsh support schemes also play a vital role. It is therefore even more important that the Welsh Government establishes a clear, effective and fair benefits system, which complements the social security system that already exists in the UK. Retaining the temporary uplift of universal credit and working tax credit allowances, as well as extending this to legacy benefits is key. For instance, of the 180,000 children in poverty, 140,000 live in families that receive income-related benefits."
>
> Joseph Rowntree Foundation

The Co-operation agreement: 2021 sets out Welsh Government and Plaid Cymru support for the devolution of the administration of social security. They have committed to exploring how this would work in practice and building the necessary infrastructure.

The Child Poverty Action Group has recommended that the Welsh Government review the discretionary assistance fund (DAF) and using administrative data, explore the reasons for successful and unsuccessful claims (with a full breakdown of all protected characteristics, family status and local authority area, and whether applicants were signposted to further sources of support) as well as developing a staged roadmap that moves towards a simpler and more inclusive eligibility criteria for the DAF, and an evaluation framework.

Table 4: Selected impacts of wider determinants of health – The King's Fund

Sector	Examples
Income	Income determines people's ability to buy health-improving goods, from food to gym memberships. Managing on a low income is a source of stress, and emerging neurological evidence suggests that being on a low income affects the way people make choices concerning health-affecting behaviours. Children from households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those in the highest fifth.
Housing	Poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. As external temperature falls, death rates rise much faster for those in the coldest homes. Households from minority ethnic groups are more likely than White households to live in overcrowded homes and to experience fuel poverty.
Environment	Access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Levels of access are likely to be worse for people in deprived areas, and for areas with higher proportions of minority ethnic groups. Exposure to air pollutants is estimated to cut short 28–36,000 lives a year in the United Kingdom. Exposure has been linked to both deprivation and ethnicity. For example, within the most deprived areas of London, people from non-White groups have been found to be more exposed to high concentrations of nitrogen dioxide, one of the main pollutants associated with traffic fumes.
Transport	Those living in the most deprived areas have a 50% greater risk of dying in a road accident compared with those in the least deprived areas. Children in deprived areas are four times more likely to be killed or injured on the road than those in wealthier areas. The cost of transport can also be a barrier with inconsistent coverage of concessionary travel schemes and a lack of affordable transport options, particularly in rural areas.
Education	On average, among 26 Organisation for Economic Co-operation and Development (OECD) countries, people with a university degree or an equivalent level of education at age 30 can expect to live more than five years longer than people with lower levels of education. In Wales, 12% of adults (216,000 people) lack basic literacy skills. This means they are locked out of the job market and struggle to support their children's learning.
Work	Unemployment is associated with lower life expectancy and poorer physical and mental health, both for individuals who are unemployed and for their households. The quality of work, including exposure to hazards, job security and whether it promotes a sense of belonging, affects the impact it has on both physical and mental health. Non-White groups experience higher levels of work stress, controlling for other demographic factors.

This document is endorsed by:

This document was finalised on 8 June 2022.

About the Welsh NHS Confederation Health and Wellbeing Alliance

Health is not a standalone issue.

We all need to play our part in developing a health service that is fit for the future. The Welsh NHS Confederation Health and Wellbeing Alliance consists of over 70 health and care organisations from royal colleges, third sector organisations and social care organisations, and was established in 2015.

Convened by the Welsh NHS Confederation, and previously known as the Policy Forum, we developed recommendations in the run-up to the 2016 and 2021 Senedd elections. In April 2021, we published Making the difference, which called on the next Welsh Government to:

- publish an ambitious cross-government strategy to tackle inequalities
- invest in long-term prevention across all sectors
- work in partnership with people and communities to change lives for the better.

This paper followed an open letter to the First Minister and Senedd opposition party leaders in February 2021, calling for a cross-government strategy on health inequalities.

@WelshConfed

www.nhsconfed.org/wales/health-and-wellbeing-alliance

@RCPWales

www.rcp.ac.uk/wales

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Registered charity no. 1090329

60 per cent of people in Wales say their health has worsened due to rising cost of living

50 organisations in Wales come together to call for renewed cross-government action to tackle inequalities and ill-health.

Embargoed until 00.01 on Friday 15 July 2022

Poverty causes ill-health and illness, which is why 50 organisations across health, housing, and social care, including royal colleges and patient advocacy groups, have come together today (Friday 15 July) to launch *Mind the gap: What's stopping change? – The cost-of-living crisis and the rise in inequalities in Wales* (link goes live on 15 July, report attached).

A new paper from the Welsh NHS Confederation Health and Wellbeing Alliance, in partnership with the Royal College of Physicians (RCP), is calling on the Welsh Government to produce a cross-government plan to reduce poverty and tackle inequalities.

Over the coming months, as the everyday cost-of-living continues to rise, an increase in poverty and inequality will lead to greater strain on people's health and the NHS. We urgently need coordinated cross-government action to improve people's lives and protect health and care services.

The Alliance is also calling on Welsh Government to make a real difference to local communities by providing more hands-on support and detailed guidance for smaller organisations on how to tackle inequalities as well as simplifying a complex and ever-changing landscape with hundreds of targets and performance measures.

This report comes as research finds that 60 per cent of people in Wales feel their health has been negatively affected by the rising cost of living, according to a YouGov poll commissioned by the RCP. 90 per cent said it was due to increased heating costs, over three quarters (76 per cent) said it was a result of the rising cost of food and almost half (45 per cent) said it was down to increased transport costs. 72 per cent said that other fixed bills (council tax, water etc) were also having a negative impact on their mental or physical health.

Health inequalities – unfair and avoidable differences in health and access to healthcare across the population, and between different groups within society – have long been an issue, but the COVID-19 pandemic and the rising cost of living has exacerbated them.

Respiratory conditions such as asthma and COPD are often made worse by air pollution or exposure to mould in poor quality housing. Recently, a debt counselling charity warned that the proportion of people in arrears with their energy bills in Wales is worse than any other part of the UK, which is pushing people into mental health crisis.

That is why the Welsh NHS Confederation Health and Wellbeing Alliance is calling for cross-government action to reduce inequalities and tackle poor housing, food quality, community safety, low incomes, fuel poverty, racism and discrimination, poor transport links and air pollution, many of which are outside the remit of health and social care services.

Inequalities at a glance

- Health inequalities cost the Welsh NHS £322 million every year (Public Health Wales).
- Wales now has the worst child poverty rate of all the UK nations at 31% (End Child Poverty).
- One in ten Welsh households live in insecure housing (Bevan Foundation).
- People in Wales face a higher risk of dying in poverty than any other UK nation (Marie Curie)
- Almost 60% of adults in Wales are living with overweight or obesity (Public Health Wales).
- The full social cost of obesity to Wales is around £3 billion a year (Frontier Economics).
- 12% of Welsh households are at least one month behind on a bill (Bevan Foundation).
- Child poverty has increased in 20 of 22 local authorities over the past 5 years (End Child Poverty).
- Half of all children in lone-parent families in the UK are now living in relative poverty (IFS).

Nesta Lloyd-Jones, assistant director of the Welsh NHS Confederation and chair of the Health and Wellbeing Alliance, said:

“The COVID-19 pandemic has exposed the extent of the country’s inequalities - we know those living in more deprived areas have been disproportionately affected by the impacts of the pandemic. Data shows the stark difference in life expectancy between different parts of Wales and health leaders are deeply worried about the impact the rising cost of living is having, and will continue to have, on patients in their local communities.

“Tackling inequalities needs concerted and holistic action across Welsh Government departments and all sectors. There is clear evidence of the impact that poor quality housing, air pollution, food poverty and access to transport, sport and the arts has on people’s health. It is now vital that the government details how it will address the health divide and tackle the issue head on.”

Dr Olwen Williams, vice president for Wales, Royal College of Physicians said:

“We know that poverty causes illness and poor health. In fact, everything affects health. The cost of living crisis is likely to have a significant impact on the NHS and social care in the coming months as more people become ill and join growing waiting lists for healthcare.

“People in poverty die younger. Inequalities in life expectancy in Wales are getting wider, partly due to the pandemic, which has highlighted how economic conditions can cut lives short. People should be able to afford healthy food and warm homes without worrying so much that it negatively impacts their mental and physical health.

“Concerted cross-government action to reduce health inequalities would help keep people contributing to the economy, their local communities, and wider society and reduce avoidable illness, and in the long-run, avoidable pressure on the NHS.”

Clarissa Corbisiero, deputy chief executive, Community Housing Cymru said:

"Society's responsibility for health and wellbeing goes beyond simply healthcare. All public services have a part to play – not just the NHS. This report reinforces the fact that not everyone in Wales has access to the things they need to stay healthy and well – such as adequate housing, fair employment, quality food, access to green space and more.

"Housing associations in Wales are supporting the shift to prevention across the multiple issues and areas affecting these inequalities, including poverty, homelessness and social care. By working together, and with a cohesive plan, we can close the health inequality gap for good."

#EverythingAffectsHealth

Notes to editors

The Welsh NHS Confederation Health and Wellbeing Alliance consists of over 70 health and care organisations from Royal Colleges, third sector organisations and social care organisations, and was established in 2015 to discuss key priorities and policy areas. The sub-group on health inequalities is chaired by the Royal College of Physicians and Community Housing Cymru.

Welsh NHS Confederation
Health and Wellbeing Alliance

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Mae 60 y cant o bobl yng Nghymru yn dweud bod eu hiechyd wedi gwaethygu oherwydd costau byw cynyddol

Daw 50 o sefydliadau yng Nghymru at ei gilydd i alw am gamau o'r newydd ar draws y llywodraeth i fynd i'r afael ag anghydraddoldebau a salwch.

Embargo tan 00.01 ddydd Gwener 15 Gorffennaf 2022

Mae tlodi yn achosi afiechydon a salwch. Dyma pam mae 50 o sefydliadau ar draws meysydd iechyd, tai a gofal cymdeithasol, gan gynnwys colegau brenhinol a grwpiau eiriolaeth cleifion, wedi dod at ei gilydd heddiw (dydd Gwener 15 Gorffennaf) i lansio *Cofiwch y bwlch: Beth sy'n atal newid? – Yr argyfwng costau byw a'r anghydraddoldeb cynyddol yng Nghymru* (yn fyw ar 15 Gorffennaf, adroddiad wedi'i atodi).

Mae papur newydd gan Gynghrair Iechyd a Lles Conffederasiwn GIG Cymru, mewn partneriaeth â Choleg Brenhinol y Meddygon, yn galw ar Lywodraeth Cymru i lunio cynllun trawslywodraethol i leihau tlodi a mynd i'r afael ag anghydraddoldebau.

Dros y misoedd nesaf, wrth i gostau byw bob dydd barhau i gynyddu, bydd cynnydd mewn tlodi ac anghydraddoldeb yn arwain at fwy o straen ar iechyd pobl ac ar y GIG. Mae angen gweithredu cydlynol ar frys ar draws y llywodraeth i wella bywydau pobl ac i amddiffyn y system iechyd a gofal.

Mae'r Gynghrair hefyd yn galw ar Lywodraeth Cymru i wneud gwahaniaeth go iawn i gymunedau lleol drwy ddarparu mwy o gymorth ymarferol ac arweiniad manwl i sefydliadau llai ar sut i fynd i'r afael ag anghydraddoldebau yn ogystal â symleiddio system gymhleth sy'n newid o hyd gyda channoedd o dargedau a mesurau perfformiad.

Daw'r adroddiad hwn wrth i ymchwil ganfod bod 60 y cant o bobl yng Nghymru yn teimlo bod costau byw cynyddol wedi effeithio'n negyddol ar eu hiechyd, yn ôl arolwg YouGov a gomisiynwyd gan Goleg Brenhinol y Meddygon. Dywedodd 90 y cant mai'r rheswm dros hyn oedd costau gwresogi uwch, gyda thros dri chwarter (76 y cant) yn dweud ei fod o ganlyniad i'r cynnydd yng nghostau bwyd, a bron i hanner (45 y cant) yn dweud mai cynnydd mewn costau trafnidiaeth oedd yn gyfrifol am hyn. Dywedodd 72 y cant fod biliau sefydlog eraill (treth gyngor, dŵr ac ati) hefyd yn cael effaith negyddol ar eu hiechyd meddwl neu iechyd corfforol.

Mae anghydraddoldebau iechyd – gwahaniaethau annheg mae modd eu hosgoi mewn iechyd a mynediad at ofal iechyd ar draws y boblogaeth, a rhwng gwahanol grwpiau mewn cymdeithas – wedi bod yn broblem ers tro byd, ond mae pandemig COVID-19 a chostau byw cynyddol wedi gwaethygu'r sefyllfa.

Mae llygredd aer neu ddod i gysylltiad â llwydni mewn tai o ansawdd gwael yn aml yn gwaethygu cyflyrau resbiradol fel asthma a COPD. Yn ddiweddar, rhybuddiodd elusen cynghori ynghylch dyledion fod cyfran y bobl sydd ag ôl-ddyledion gyda'u biliau ynni yng

Nghymru yn waeth nag unrhyw ran arall o'r DU, ac mae hyn yn gwthio pobl i wynebu argyfwng iechyd meddwl.

Dyna pam mae Cynghrair Iechyd a Lles Conffederasiwn GIG Cymru yn galw am weithredu ar draws y llywodraeth i leihau anghydraddoldebau a mynd i'r afael â thai o ansawdd gwael, ansawdd bwyd, diogelwch cymunedol, incwm isel, tlodi tanwydd, hiliaeth a gwahaniaethu, cysylltiadau trafnidiaeth gwael a llygredd aer, llawer ohonynt y tu allan i gylch gwaith gwasanaethau iechyd a gofal cymdeithasol.

Cipolwg ar anghydraddoldebau

- Mae anghydraddoldebau iechyd yn costio £322 miliwn i GIG Cymru bob blwyddyn (Iechyd Cyhoeddus Cymru).
- blith holl wledydd y DU, Cymru sydd â'r gyfradd waethaf o ran tlodi plant erbyn hyn, ar 31% (Rhoi Terfyn ar Dlodi Plant).
- Mae un o bob deg aelwyd yng Nghymru yn byw mewn tai ansicr (Sefydliad Bevan).
- Mae pobl yng Nghymru mewn mwy o berygl o farw mewn tlodi nag unrhyw wlad arall yn y DU (Marie Curie)
- Mae bron i 60% o oedolion yng Nghymru dros eu pwysau neu'n ordew (Iechyd Cyhoeddus Cymru).
- Mae cost gymdeithasol lawn gordewdra yng Nghymru oddeutu £3 biliwn y flwyddyn (Frontier Economics).
- Mae 12% o aelwydydd Cymru o leiaf fis ar ei hôl hi gyda thalu bil (Sefydliad Bevan).
- Mae tlodi plant wedi cynyddu mewn 20 o'r 22 awdurdod lleol dros y 5 mlynedd diwethaf (Rhoi Terfyn ar Dlodi Plant).
- Mae hanner yr holl blant mewn teuluoedd un rhiant yn y DU yn byw mewn tlodi cymharol erbyn hyn (IFS).

Dywedodd Nesta Lloyd-Jones, cyfarwyddwr cynorthwyol Conffederasiwn GIG Cymru a chadeirydd y Gynghrair Iechyd a Lles:

"Mae pandemig COVID-19 wedi amlygu faint o anghydraddoldebau sydd yn y wlad – rydyn ni'n gwybod bod effeithiau'r pandemig wedi effeithio'n anghymesur ar y rheini sy'n byw mewn ardaloedd mwy difreintiedig. Mae data'n dangos y gwahaniaeth amlwg mewn disgwyliad oes rhwng gwahanol rannau o Gymru, ac mae arweinwyr iechyd yn poeni'n arw am yr effaith y mae costau byw cynyddol yn ei chael, ac y bydd yn parhau i'w chael, ar gleifion yn eu cymunedau lleol.

"Mae angen gweithredu holistaidd ar y cyd ar draws adrannau Llywodraeth Cymru a phob sector er mwyn mynd i'r afael ag anghydraddoldebau. Mae tystiolaeth glir o'r effaith y mae tai o ansawdd gwael, llygredd aer, tlodi bwyd a mynediad at drafnidiaeth, chwaraeon a'r celfyddydau yn ei chael ar iechyd pobl. Mae'n hanfodol yn awr bod y llywodraeth yn nodi sut y bydd yn mynd i'r afael â'r bwlch iechyd ac yn delio â'r mater yn uniongyrchol."

Dywedodd Dr Olwen Williams, is-lywydd Cymru, Coleg Brenhinol y Meddygon:

"Rydyn ni'n gwybod bod tlodi'n achosi salwch ac iechyd gwael. Yn wir, mae popeth yn effeithio ar iechyd. Mae'r argyfwng costau byw yn debygol o gael effaith sylweddol ar y GIG a gofal cymdeithasol dros y misoedd nesaf wrth i fwy o bobl fynd yn sâl ac ymuno â rhestrau aros cynyddol ar gyfer gofal iechyd.

"Mae pobl sy'n byw mewn tlodi yn marw'n iau. Mae anghydraddoldeb o ran disgwyliad oes yng Nghymru yn mynd yn fwy, yn rhannol oherwydd y pandemig, sydd wedi tynnu sylw at sut

y gall amodau economaidd achosi marwolaethau cynnar. Dylai pobl allu fforddio bwyd iach a chartrefi cynnes heb boeni cymaint nes ei fod yn effeithio'n negyddol ar eu hiechyd meddwl a chorfforol.

"Byddai cymryd camau trawslywodraethol ar y cyd i leihau anghydraddoldebau iechyd yn helpu i sicrhau bod pobl yn gallu cyfrannu at yr economi, eu cymunedau lleol, a'r gymdeithas ehangach, a lleihau salwch mae modd ei osgoi ac, yn y hirdymor, pwysau mae modd ei osgoi ar y GIG."

Dywedodd Clarissa Corbisiero, dirprwy brif weithredwr, Cartrefi Cymunedol Cymru:

"Mae cyfrifoldeb cymdeithas dros iechyd a lles yn fwy na dim ond gofal iechyd. Mae gan bob gwasanaeth cyhoeddus ran i'w chwarae – nid dim ond y GIG. Mae'r adroddiad hwn yn atgyfnerthu'r ffaith nad oes gan bawb yng Nghymru fynediad at y pethau sydd eu hangen arnynt i gadw'n iach – fel tai digonol, cyflogaeth deg, bwyd o safon, mynediad at fannau gwyrdd a mwy.

"Mae cymdeithasau tai yng Nghymru yn cefnogi'r symudiad i atal ar draws y llu o faterion a meysydd sy'n effeithio ar yr anghydraddoldebau hyn, gan gynnwys tlodi, digartrefedd a gofal cymdeithasol. Drwy gydweithio, a gyda chynllun cydlynol, gallwn gau'r bwlch anghydraddoldeb iechyd am byth."

Nodiadau i olygyddion

Mae Cynghrair Iechyd a Lles Conffederasiwn GIG Cymru yn cynnwys dros 70 o sefydliadau iechyd a gofal o'r Colegau Brenhinol, sefydliadau'r trydydd sector a sefydliadau gofal cymdeithasol, ac fe'i sefydlwyd yn 2015 i drafod blaenoriaethau allweddol a meysydd polisi. Mae'r is-grŵp ar anghydraddoldebau iechyd yn cael ei gadeirio gan Goleg Brenhinol y Meddygon a Chartrefi Cymunedol Cymru.

Contact

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Conffederasiwn GIG Cymru
Cynghrair Iechyd a Lles

Mewn partneriaeth â'r
Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Cofiwch y bwlch: beth sy'n atal newid?

Yr argyfwng costau byw a'r anghydraddoldeb cynyddol yng Nghymru

Gorffennaf 2022

Mae'r argyfwng costau byw yn argyfwng iechyd

Mae tlodi yn achosi salwch.

Yn gryno

- Mae 60% o bobl yng Nghymru yn dweud bod y costau byw cynyddol wedi cael effaith negyddol ar eu llesiant (RCP).
- Mae anghydraddoldebau iechyd yn costio £322 miliwn y flwyddyn i GIG Cymru (Iechyd Cyhoeddus Cymru).
- Erbyn hyn mae gan Gymru y gyfradd tlodi plant waethaf o blith holl wledydd y DU ar 31% (Dileu Tlodi Plant).
- Mae un o bob deg aelwyd yng Nghymru yn byw mewn tai anniogel (Sefydliad Bevan).
- Mae pobl yng Nghymru yn wynebu risg uwch o farw mewn tlodi nac unrhyw wlad arall yn y DU (Marie Curie).
- Mae bron 60% o oedolion yng Nghymru dros eu pwysau neu'n ordew (Iechyd Cyhoeddus Cymru).
- Mae cost gymdeithasol lawn gordewdra i Gymru tua £3 biliwn y flwyddyn (Frontier Economics).
- Mae gan 12% o aelwydydd o leiaf 1 mis o ôl-ddyledion ar fil (Sefydliad Bevan).
- Mae tlodi plant wedi cynyddu mewn 20 o'r 22 awdurdod lleol yn y 5 mlynedd diwethaf (Dileu Tlodi Plant).

Mae pandemig COVID-19 wedi ehangu'r anghydraddoldebau presennol ac wedi amlygu'r risg rhwng tlodi a chanlyniadau iechyd gwael yng Nghymru. Yn wir, mae comisiynydd cenedlaethau'r dyfodol ac Iechyd Cyhoeddus Cymru wedi canfod mai'r bobl sydd eisoes yn byw gydag iechyd gwael, tlodi neu mewn cymunedau ymylol yng Nghymru sydd wedi dioddef fwyaf yn sgil y pandemig.

Mae anghydraddoldebau iechyd yn annheg, mae modd eu hosgoi ac mae gwahaniaethau systematig yn iechyd grwpiau gwahanol o bobl. Yn ystod y misoedd nesaf, wrth i gostau byw o ddydd i ddydd barhau i gynyddu'n gyflymach nag incwm pobl, mae hyn yn debygol o arwain at ostyngiad yn safonau byw llawer o bobl. Mae cost gynyddol bwyd ac ynni, yn ogystal â phrinder staff mewn rhai sectorau ac amhariadau o ran y gadwyn gyflenwi, wedi achosi cynnydd mewn chwyddiant. Mae hyn yn debygol o ddwysáu anghydraddoldeb yn y blynyddoedd i ddod.

> "Mae llawer o bobl wedi gorfod gwneud dewisiadau amhosibl – rhwng prynu bwyd, talu biliau'r cartref neu gadw mewn cysylltiad ag anwyliaid. Mae hyn wedi effeithio ar iechyd meddwl pobl a'u llesiant yn gyffredinol, gan wneud i rai deimlo na allent ymdopi a chael adferiad yn dilyn argyfwng COVID-19."
>
> Y Groes Goch Brydeinig

> "Mae'n bosibl y bydd y rhai sy'n cael anhawster gydag iechyd gwael yn wynebu colli enillion trwy gyflogaeth ac yn wir, efallai na fyddant yn gallu gweithio, sy'n golygu y bydd angen iddynt gysylltu â'r system fudd-daliadau. Yn ogystal ag effeithiau ar lesiant, efallai fydd gan y rhai ag iechyd gwael gostau byw uwch a bydd plant sy'n dioddef iechyd gwael yn gweld eu haddysg yn cael ei effeithio."
>
> Sefydliad Joseph Rowntree

Mae tystiolaeth yn awgrymu, ar y mwyaf mai dim ond 20% o iechyd a llesiant poblogaeth sy'n ddibynnol ar wasanaethau gofal iechyd. Nid oes gan y GIG ei hun y pŵer i leihau anghydraddoldeb: dyna pam y mae angen i ni newid y ffocws o'r mentrau iechyd y cyhoedd sy'n cael eu darparu trwy'r GIG ac awdurdodau lleol a mynd i'r afael â ffactorau sy'n cynnwys tai gwael, trafnidiaeth ac ansawdd bwyd. Mae angen i lywodraeth Cymru roi blaenoriaeth i fynd i'r afael â'r ffactorau sy'n achosi salwch yn y lle cyntaf.

> **Dylai llywodraeth Cymru greu cynllun traws-lywodraethol i leihau tlodi ac anghydraddoldebau ymysg oedolion a phlant.** Dylai hyn amlinellu'r camau gweithredol sy'n cael eu cyflawni ar draws holl adrannau'r llywodraeth, gan esbonio sut bydd llwyddiant yn cael ei fesur a'i werthuso trwy fesurau a chanlyniadau perfformiad a rennir ar gyfer pob corff cyhoeddus yng Nghymru, yn ogystal â chanllawiau ar sut y dylai sefydliadau unigol gydweithio i leihau anghydraddoldebau a mynd i'r afael â'r argyfwng costau byw.

Prif argymhellion

Dylai Llywodraeth Cymru:

- roi blaenoriaeth i'r ymdrech i leihau'r bwlch gweithredu ar iechyd a llesiant ar gyfer oedolion a phlant
- darparu canllawiau mwy manwl ar weithredu i gyrff cyflawni lleol
- mapio gweithgaredd presennol ar iechyd y cyhoedd, anghydraddoldebau, lleihau tlodi a nawdd cymdeithasol
- cyflwyno rheoliadau asesu'r effaith ar iechyd fel blaenoriaeth
- cydgrynhoi'r ymrwymiadau ar anghydraddoldebau mewn un cynllun cyflawni er mwyn gwella atebolrwydd
- datblygu cyfres o fesurau perfformiad sy'n canolbwyntio ar leihau anghydraddoldebau
- sicrhau bod cyllid yn annog cydweithredu a bod hyn yn cysylltu â'r ymdrechion i fynd i'r afael ag anghydraddoldebau
- gwella'r mynediad at raglenni ataliaeth mewn gofal sylfaenol a chymunedol, yn arbennig ar gyfer y rhai sy'n byw mewn tlodi
- buddsoddi mewn dulliau atal arloesol yn cynnwys rhaglenni sgrinio, brechlynnau a thechnoleg gwisgadwy
- gwella'r mynediad at ddata cadarn o safon uchel i fesur unrhyw newid mewn anghydraddoldebau
- ei gwneud yn ofynnol i fyrddau partneriaeth rhanbarthol a byrddau gwasanaethau cyhoeddus fynd i'r afael ag anghydraddoldebau.

> "Ers gormod o amser, rydym wedi disgwyl i'r gwasanaeth iechyd fynd i'r afael â'r heriau hyn ei hun. Mae ffactorau niferus ac amrywiol yn achosi anghydraddoldeb iechyd a bydd angen ymdrechion cydlynol ar draws pob sector er mwyn sicrhau cynnydd ystyrlon i gau'r bwlch."
>
> Conffederasiwn GIG Cymru

> "Mae tystiolaeth yn dangos y gall dull gweithredu cynhwysfawr ar gyfer mynd i'r afael ag anghydraddoldebau iechyd wneud gwahaniaeth. Mae angen camau gweithredu systematig, ar y cyd ar draws sawl maes er mwyn mynd i'r afael ag achosion o anghydraddoldebau iechyd."
>
> Cronfa'r Brenin

Pam fod angen dull gweithredu traws-lywodraethol arnom?

Er bod llywodraeth Cymru wedi ymrwymo i fynd i'r afael ag anghydraddoldebau trwy ei rhaglen lywodraethu, nid oes esboniad trosfwaol o sut bydd y gwaith hwn yn cael ei gydgysylltu ar draws strategaethau gwahanol y llywodraeth, sut y mesurir canlyniadau a sut bydd gweinidogion yn cael eu dwyn i gyfrif am gyflawni'r ymrwymiadau hyn ar sail gydweithredol.

> Gallai cynllun traws-lywodraethol sefydlu ymrwymiadau presennol yn eu cyd-destun, darparu rhywfaint o eglurder ynghylch canlyniadau a rennir a darparu tryloywder o ran sut y mesurir perfformiad (gweler tabl 2).

Mae gan iechyd da rôl sylfaenol yn ffyniant ein gwlad – mae gweithlu iach yn cael effaith uniongyrchol ar gynhyrchiant economaidd – yn ogystal ag ar ein llesiant a'n hapusrwydd cyffredinol. Mae cyswllt cryf rhwng gwaith ac iechyd: er mwyn i waith gael effaith gadarnhaol ar iechyd, mae'n rhaid iddo fod yn 'waith da' sy'n darparu cyflogaeth sefydlog, sy'n talu cyflog byw ac sy'n cynnig amodau gwaith teg, cydbwysedd rhwng bywyd a gwaith a datblygiad gyrfa.

Tabl 1: Mae penderfynyddion ehangach iechyd

Mae penderfynyddion ehangach iechyd yn cynnwys:
• incwm a diogelwch ariannol (iechyd a chyfoeth) • argaeledd gwaith da, boddhaus a theg • addysg a sgiliau • mynediad at fwyd a diod iach • gwahaniaethu, yn arbennig ar sail nodweddion gwarchodedig • mynediad at y celfyddydau a gweithgareddau diwylliannol • cysylltiadau cymdeithasol (teulu a ffrindiau) • mynediad at chwaraeon a gweithgaredd corfforol • mynediad at drafnidiaeth a theithio • ansawdd a diogelwch tai a'r mannau agored o'n hamgylch (gofod a lle).

> "Mae'r berthynas rhwng iechyd ac incwm wedi ei sefydlu ers amser. Mae iechyd gwell yn gyffredinol yn gwella ansawdd eich bywyd; mae'n galluogi cyfleoedd cyflogaeth gwell ac mae'n lleihau'r costau ychwanegol y gall salwch eu hachosi. Mae byw mewn tlodi yn golygu straen ychwanegol ar benderfyniadau o ddydd i ddydd a gall gloi pobl allan o wasanaethau sy'n hybu iechyd neu asedau eraill megis tai gwell."
>
> Sefydliad Joseph Rowntree

> "Mae gan ardaloedd difreintiedig naw gwaith yn llai o fynediad at fannau gwyrdd ar gyfartaledd, mwy o siopau bwyd brys a dewis mwy cyfyngedig o fwyd iach, fforddiadwy."
>
> Cronfa'r Brenin

Tabl 2: Beth allai cynllun traws-lywodraethol ei gynnwys?

Ar lefel Llywodraeth Cymru, dylai:
• gynnwys diffiniad cytûn o gydraddoldeb iechyd: beth sy'n cynrychioli llwyddiant? • cynnwys targedau a chanlyniadau clir, mesuradwy gydag amserlen wedi ei diffinio • pwysleisio cerrig milltir rheolaidd ar hyd y ffordd, wedi'u hategu gan y cyllid angenrheidiol • y cabinet cyfan i fod yn berchen arno, o dan arweiniad y prif weinidog • cynnwys adroddiadau blynyddol ar gynnydd, gan ddefnyddio'r camau gweithredu a gyflawnwyd gan bob adran a phartner • rhannu mesurau perfformiad ar draws adrannau'r llywodraeth • uno gwaith presennol ar anghydraddoldebau ar draws holl adrannau'r llywodraeth.
Ar lefel ranbarthol, dylai:
• benodi arweinydd enwebedig ar gyfer mynd i'r afael ag anghydraddoldebau ar gyfer pob sefydliad y sector cyhoeddus • cynnwys canllawiau ar sut y dylai sefydliadau gydweithio ar lefel ranbarthol o fewn strwythurau wedi eu sefydlu • cynnwys data tryloyw a gasglwyd sy'n galluogi proses graffu ystyrlon ac annibynnol.
Egwyddorion cyfathrebu ac ymgysylltu:
• dulliau cyfathrebu ac ymgysylltu clir gyda rhanddeiliaid allanol a'r cyhoedd • datblygu partneriaeth wirioneddol gyda phobl a sefydliadau yng Nghymru.

Beth sy'n atal newid?

Cyflawni yw'r broblem fwyaf sy'n ein hwynebu. Mewn llawer o achosion, yn syml nid oes gan gyrff llai y gallu, yr arbenigedd, yr adnoddau na'r ffocws i gyflawni'r weledigaeth genedlaethol a gyflwynir mewn deddfwriaeth a dogfennau polisi uchelgeisiol. Mae angen trawsnewid arferion ar draws y system gyfan: newid ar raddfa fawr gan bob corff cyhoeddus er mwyn atal salwch, o dan arweiniad llywodraeth Cymru.

Mae'n rhaid i ni sbarduno dulliau atal ymhellach i fyny'r gadwyn gyflenwi, er mwyn i ymyriadau gael eu gweithredu mor fuan â phosibl. Er enghraifft, mae gwaith presennol i roi diwedd ar ddigartrefedd yn canolbwyntio'n bennaf ar lefelau atal sylfaenol, eilaidd a hyd yn oed trydyddol, yn hytrach nag ar wariant acíwt (gweler tabl 3).

Dylai sefydliadau cymunedol dderbyn cefnogaeth gyda gallu ac adnoddau i sicrhau bod newid yn digwydd ar lawr gwlad. Mae angen rhoi mwy o anogaeth i gydweithrediadau.

Tabl 3: Beth yw lefelau atal?

Lefelau atal	
Atal sylfaenol	Atal neu leihau'r risg y bydd problemau'n codi, a hynny fel arfer trwy bolisïau cyffredinol, e.e. addysg; hybu iechyd; gwaith rheoli tai da a chymorth tenantiaeth.
Atal eilaidd	Targedu unigolion neu grwpiau sy'n wynebu risg uchel neu'n dangos arwyddion cynnar o broblem benodol er mwyn ceisio ei hatal rhag digwydd, e.e. atgyfeirio'n gynnar at wasanaethau cymorth i deuluoedd neu gymorth ieuenctid.
Atal trydyddol	Ymyrryd pan fydd problem wedi codi er mwyn ei hatal rhag gwaethygu ac unioni'r sefyllfa, e.e. dileu ôl-ddyledion rhent er mwyn osgoi achos o droi allan.
Gwario acíwt	Gwario arian er mwyn rheoli effaith sefyllfa negyddol iawn – prin y mae hyn yn gwneud unrhyw beth, os o gwbl, i atal problemau rhag codi eto yn y dyfodol, e.e. cost tai dros dro pan fydd pobl yn cael eu gwneud yn ddigartref; cost hirdymor cefnogi plant sydd wedi dioddef Profiadau Niweidiol yn ystod Plentyndod o ganlyniad i golli cartref.

Hefyd mae angen i ni fapio lle mae llywodraeth genedlaethol a lleol yn gweithio gyda phartneriaid i leihau anghydraddoldebau ar draws holl adrannau a sectorau'r llywodraeth, gwerthuso a yw'r rhaglenni yn gweithio a nodi'r gwersi a ddysgwyd, wrth rannu arfer da ar raddfa fwy o lawer.

Dylai lleihau anghydraddoldebau a gwella llesiant fod yn ganolog ym mhob strategaeth sy'n deillio o bob un o adrannau'r llywodraeth: mae dull gweithredu croestoriadol yn hollbwysig.

Cau'r bwlch gweithredu

Yn ystod y degawd diwethaf, mae llywodraeth Cymru wedi pasio Deddf Llesiant Cenedlaethau'r Dyfodol, y Ddeddf Iechyd y Cyhoedd (yn cynnwys asesiadau asesu'r effaith ar iechyd nad ydynt wedi'u cyflwyno hyd yma) ac wedi galluogi dyletswydd economaidd-gymdeithasol y Ddeddf Cydraddoldeb. Mae'r tirlun hwn yn gymhleth ac yn newid yn gyson, gyda channoedd o dargedau a mesurau perfformiad. Mae llywodraeth Cymru wedi cyhoeddi dangosyddion llesiant cenedlaethol ac mae wrthi'n datblygu cerrig milltir cenedlaethol, ond mae'n annhebygol y bydd llawer o bobl y tu hwnt i gylchoedd llunio polisïau yn ymwybodol o'r gwaith hwn. Mae dulliau cyfathrebu ac ymgysylltu gwell gyda rhanddeiliaid allanol, sefydliadau cymunedol a'r cyhoedd yn hollbwysig.

Nid yw'r newidiadau a gynigir ar lefel genedlaethol o reidrwydd yn cael eu cyflawni ar lefel leol. Mae rhwystrau sylweddol o ran newid yn cynnwys blaenoriaethu materion a thargedau tymor byr, pwysau ar y gweithlu a galw cynyddol am wasanaethau. Er ein bod yn cydnabod bod y pandemig wedi rhoi straen aruthrol ar y gwasanaethau cyhoeddus, mae'n rhaid i lywodraeth Cymru ddangos arweinyddiaeth wleidyddol genedlaethol yn awr i sbarduno newid. Mae hyn yn golygu darparu canllawiau manylach er mwyn i sefydliadau lleol, llai weithredu'r newidiadau sy'n ofynnol yn ôl deddfwriaethau cenedlaethol.

> "Mae arweinyddiaeth wleidyddol yn hanfodol er mwyn sicrhau bod iechyd y boblogaeth yn flaenoriaeth allweddol i'r system iechyd a gofal ar draws y llywodraeth. Dylai hyn gynnwys pennu nodau cenedlaethol uchelgeisiol a gorfodol er mwyn gwella canlyniadau a datblygu strategaeth draws-lywodraethol newydd i leihau anghydraddoldebau iechyd."
>
> Cronfa'r Brenin

Derbyniodd Deddf Iechyd y Cyhoedd (Cymru) 2017 Gydsyniad Brenhinol ym mis Gorffennaf 2017, ond bron i bum mlynedd yn ddiweddarach, nid yw rheoliadau ynghylch cynnal asesiadau o'r effaith ar iechyd gan gyrff cyhoeddus wedi'u gosod. Cymerodd ddegawd a mwy i osod rheoliadau Deddf Cydraddoldeb 2010 a ddaeth â'r ddyletswydd economaidd-gymdeithasol i rym ym mis Mawrth 2021. Mae'r mater hwn yn galw am newid trawsnewidiol i ymddygiad, ar draws y system gyfan.

> "Mae iechyd yn system gymhleth sy'n cynnwys ystod eang o gyfranogwyr perthnasol ac amserlenni hir o bosibl ar gyfer newid. Bydd ymyriadau bach neu lugoer yn golygu y byddwn ymhell o gyflawni'r genhadaeth disgwyliad, neu'n waeth, yn gweld disgwyliad oes iach yn gostwng yn barhaus. Er mwyn cymryd y genhadaeth hon o ddifrif, mae'n rhaid iddi fod yn genhadaeth ar gyfer y llywodraeth gyfan."
>
> Sefydliad Iechyd

Nid yw BGCau a BPRhau wedi gwneud digon i ddatblygu ymwybyddiaeth a dealltwriaeth o'r hyn maent yn ei wneud. Dylent fod yn fwy gweladwy ac atebol, ac yn ymgysylltu'n fwy effeithiol gyda'r cymunedau a wasanaethir ganddynt, ac yn rhoi mwy o bwyslais ar leihau anghydraddoldebau.

> "Mae angen gweithredu cydamserol ar sawl lefel: cenhadaeth genedlaethol barhaus er mwyn mynd i'r afael ag anghydraddoldebau; partneriaeth leol a chenedlaethol newydd er mwyn creu'r amodau ar gyfer llwyddiant y system; ac arweinyddiaeth leol i ddatblygu'r aflonyddwch sydd ei angen i sicrhau llwyddiant."
>
> Cronfa'r Brenin

Mesur llwyddiant

Mae mesurau perfformiad yn llywio'r ffordd y mae gwasanaethau'n cael eu cyflawni: gallai canlyniadau a rennir ar draws cyrff cyhoeddus sicrhau bod blaenoriaethau a dyraniad adnoddau yn canolbwyntio ar newidiadau hirdymor i iechyd a llesiant ac ymddygiad. Dylid cynhyrchu mesurau canlyniad ar y cyd gyda chleifion a sefydliadau eiriolaeth a arweinir gan gleifion.

> "Mae'r system sydd ar waith yn gymhleth iawn. Pe byddai pob un o'r mesurau perfformiad, ar draws y gwahanol gynlluniau, yn cael eu cyfuno, mae yna 350 a mwy o fesurau y mae'n rhaid i'r gwasanaethau iechyd adrodd arnynt. Mae hyn yn golygu gwastraff amser ac adnoddau aruthrol i gydgrynhoi a dadansoddi'r wybodaeth hon."
>
> Comisiwn Bevan

Fel arfer, pan fydd llywodraeth yn trafod beth mae wedi ei gyflawni, mae'n trafod y buddsoddiad mae wedi ei wneud mewn rhaglen neu faes gwaith penodol. Anaml y bydd yn dangos, trwy werthuso mesurau canlyniad, bod pethau wedi gwella.

Mae cyrff cyflawni yng Nghymru yn parhau i gael anhawster yn cydweithio ar y pethau sy'n llywio ein rhagolygon o fyw'n dda – ac mae rhan o hyn yn cael ei ysgogi gan fesurau a thargedau perfformiad sy'n cystadlu â'i gilydd. Dylai dull gweithredu gwirioneddol traws-lywodraethol sicrhau

bod mesurau canlyniad yn berthnasol ar draws pob sector a'u bod yn cynnwys y rhai sy'n gweithio yn y bylchau rhwng sectorau. Ni ddylid defnyddio unrhyw fframwaith fel dull o fesur perfformiad bwrdd iechyd yn unig, ond yn hytrach dylai ysgogi ffocws ar leihau anghydraddoldebau ar draws pob corff cyhoeddus. Dylid mesur BPRhau a BGCau yn ôl pa mor effeithiol y maent yn lleihau anghydraddoldebau trwy eu hasesiadau a'u cynlluniau o anghenion a llesiant eu poblogaeth.

Deall y system

Er mwyn osgoi dyblygu gwaith, dylai llywodraeth Cymru weithio gyda chyrff cyhoeddus, partneriaid cyflwyno a'r sector gwirfoddol a chymunedol i adolygu a mapio fframweithiau canlyniadau, targedau a dangosyddion presennol mewn un darn o waith. Byddai hyn yn dangos lle mae mesurau presennol a dangosyddion sydd wedi eu cyhoeddi eisoes yn cyfrannu at gamau gweithredu a rennir ar anghydraddoldebau a gallai hyn arwain at gynllun effeithiol ar draws y llywodraeth.

> Mae Arsyllfa Iechyd Cyhoeddus Cymru wedi cyhoeddi Fframwaith Canlyniadau Iechyd y Cyhoedd ac mae Llwyfan Atebion Tegwch Iechyd Cymru yn cael ei ddatblygu fel ffordd o gael mynediad at ddata a thystiolaeth ar leihau anghydraddoldebau iechyd.

Ond mae'r system yn parhau i fod yn un gymhleth. Mae'r jig-so cyllid ar gyfer iechyd y cyhoedd, anghydraddoldebau, ataliaeth, lleihau tlodi a nawdd cymdeithasol yn ei wneud yn amhosibl bron i unrhyw un y tu allan i'r llywodraeth wybod beth sy'n digwydd, heb sôn am wybod a yw'n gwneud gwahaniaeth gwirioneddol. Byddai cynllun mwy cynhwysfawr a chyfunol ar gyfer lleihau tlodi ac anghydraddoldebau yn gwneud popeth yn fwy clir a byddai'n helpu'r sectorau gwirfoddol a chymunedol i weithio mewn partneriaeth gyda chyrff cyhoeddus i gyflawni uchelgeisiau llywodraeth Cymru i fynd i'r afael ag anghydraddoldebau a salwch.

Rôl llywodraeth y DU

Mae'n bwysig cofio bod llawer o'r ysgogwyr newid (craffu cymdeithasol, credyd cynhwysol, y system fudd-daliadau, mewnfudo a symudiad rhydd a rhaglenni o fudd-dal i waith) yn parhau y tu hwnt i reolaeth llywodraeth Cymru: yn wir, cyflwynodd Sefydliad Bevan yr achos yn ddiweddar dros ddatganoli'r pŵer dros y budd-dal tai ac elfen dai y Credyd Cynhwysol.

Dylid ystyried papur gwyn llywodraeth y DU ar godi'r gwastad fel rhan o'r gwaith hwn; fodd bynnag, ni ddylai hyn atal cyrff cyhoeddus yng Nghymru rhag gwneud popeth o fewn eu gallu i wella iechyd a llesiant lle bynnag y gallant. Mae'r cynllun peilot incwm sylfaenol cyffredinol yn enghraifft dda o lywodraeth Cymru'n defnyddio ei phwerau presennol i wella'r system fudd-daliadau.

> "Mae'n amlwg y bydd codi'r gwastad yn galw am ddull gweithredu hirdymor ar gyfer mynd i'r afael ag anghydraddoldebau hirsefydlog rhwng ac o fewn lleoedd ar draws Cymru a'r DU. Nid yw'r graddau y bydd dull gweithredu llywodraeth y DU yn llwyddo i fynd i'r afael â'r heriau y mae llawer o bobl a chymunedau'n eu hwynebu ledled Cymru, a sut bydd yn rhyngweithio gyda pholisïau llywodraeth Cymru mewn meysydd datganoledig, yn hysbys hyd yma."
>
> Ymchwil y Senedd

> "Ni ddylid diystyru pwysigrwydd mesurau nawdd cymdeithasol penodol i Gymru. Er bod gan system nawdd cymdeithasol y DU rôl bwysig yn datrys tlodi, mae gan gynlluniau cymorth Cymru rôl bwysig hefyd. Mae'n bwysicach fyth felly bod llywodraeth Cymru yn sefydlu system fudd-daliadau glir, effeithiol a theg, sy'n ategu'r system nawdd cymdeithasol sydd eisoes yn bodoli yn y DU. Mae cynnal y cynnydd dros dro i'r credyd cynhwysol a'r lwfansau credyd treth gweithio, yn ogystal ag ymestyn hyn i fudd-daliadau etifeddiaeth, yn hollbwysig. Er enghraifft, o'r 180,000 o blant mewn tlodi, mae 140,000 yn byw mewn teuluoedd sy'n derbyn budd-daliadau sy'n gysylltiedig ag incwm."
>
> Sefydliad Joseph Rowntree

Mae'r *Cytundeb cydweithio: 2021* yn cyflwyno cefnogaeth llywodraeth Cymru a Phlaid Cymru i ddatganoli gweinyddiaeth nawdd cymdeithasol. Maent wedi ymrwymo i archwilio sut gallai hyn weithio'n ymarferol a chreu'r seilwaith angenrheidiol.

Mae'r Grŵp Gweithredu ar Dlodi Plant wedi argymell y dylai llywodraeth Cymru adolygu'r gronfa cymorth dewisol a defnyddio data gweinyddol, archwilio'r rhesymau dros hawliadau llwyddiannus ac aflwyddiannus (gyda dadansoddiad llawn o'r holl nodweddion gwarchodedig, statws teulu ac ardal awdurdod lleol ac a gafodd ymgeiswyr eu hatgyfeirio at ffynonellau cymorth pellach ai peidio), yn ogystal â datblygu map trywydd fesul cam sy'n symud tuag at feini prawf cymhwysedd mwy syml a chynhwysol ar gyfer y gronfa cymorth dewisol, a fframwaith gwerthuso.

Tabl 4: Effeithiau dethol penderfynyddion ehangach iechyd – Cronfa'r Brenin

Sector	Enghreifftiau
Incwm	Mae incwm yn dylanwadu ar allu pobl i brynu nwyddau sy'n gwella iechyd, o fwyd i aelodaeth gyda champfa. Mae byw ar incwm isel yn ffynhonnell straen, ac mae tystiolaeth niwrolegol ddiweddar yn awgrymu bod bod ar incwm isel yn effeithio ar y ffordd mae pobl yn gwneud dewisiadau ynghylch ymddygiad sy'n effeithio ar iechyd. Mae plant o aelwydydd ym mhumed isaf y dosbarthiad incwm dros bedair gwaith yn fwy tebygol o brofi problemau iechyd meddwl difrifol o gymharu â'r rhai yn y pumed uchaf.
Tai	Mae tai o safon gwael ac amodau tai gorlawn yn gysylltiedig â risg uwch o glefydau cardiofasgwlaidd, clefydau anadlol, iselder a gorbryder. Wrth i dymheredd allanol ostwng, mae cyfraddau marwolaeth yn cynyddu'n gyflymach o lawer i'r rhai yn y cartrefi oeraf. Mae aelwydydd o grwpiau lleiafrifoedd ethnig yn fwy tebygol nag aelwydydd Gwyn i fyw mewn cartrefi gorlawn a phrofi tlodi tanwydd.
Amgylchedd	Mae cysylltiad rhwng mynediad at fannau gwyrdd o safon uchel a gwelliannau i iechyd corfforol a meddyliol, a lefelau is o ordewdra. Mae lefelau mynediad yn debygol o fod yn waeth i bobl mewn ardaloedd difreintiedig, ac i ardaloedd â chyfrannau uwch o grwpiau lleiafrifoedd ethnig. Amcangyfrifir bod cyswllt â llygrwyr aer yn byrhau 28-36,000 o fywydau y flwyddyn yn y Deyrnas Unedig. Canfuwyd cysylltiad rhwng cyswllt ag amddifadedd ac ethnigrwydd. Er enghraifft, yn ardaloedd mwyaf difreintiedig Llundain, canfuwyd bod pobl o grwpiau nad ydynt yn Wyn yn cael cyswllt â chrynodiadau uwch o nitrogen deuocsid, un o'r prif lygrwyr sy'n gysylltiedig â mygdarth traffig.
Trafnidiaeth	Mae gan y rhai sy'n byw yn yr ardaloedd mwyafrif difreintiedig 50% yn fwy o risg o farw mewn damwain car o gymharu â'r rhai yn yr ardaloedd lleiaf difreintiedig. Mae plant mewn ardaloedd difreintiedig bedair gwaith yn fwy tebygol o gael eu lladd neu eu hanafu ar y ffordd o gymharu â'r rhai mewn ardaloedd cyfoethocach. Gall cost trafnidiaeth fod yn rhwystr hefyd, gydag argaeledd anghyson cynlluniau teithio rhatach a diffyg opsiynau trafnidiaeth fforddiadwy, yn arbennig mewn ardaloedd gwledig.
Addysg	Ar gyfartaledd, ymhlith y 26 o wledydd Y Sefydliad ar gyfer Cydweithrediad a Datblygiad Economaidd (OECD), gall pobl â gradd prifysgol neu lefel gyfwerth o addysg yn 30 oed ddisgwyl byw 5 mlynedd yn hwy na phobl â'r lefelau isaf o addysg. Yng Nghymru, nid oes gan 12% o oedolion (216,000 o bobl) sgiliau llythrennedd sylfaenol. Mae hyn yn golygu eu bod wedi eu cloi allan o'r farchnad swyddi ac yn cael anhawster yn cynorthwyo addysg eu plant.
Gwaith	Mae cysylltiad rhwng diweithdra a disgwyliad oes is ac iechyd corfforol a meddyliol gwaeth, i unigolion sy'n ddi-waith ac i'w haelwydydd. Mae ansawdd gwaith, yn cynnwys cyswllt â pheryglon, diogelwch swyddi ac a yw'n hyrwyddo ymdeimlad o berthyn yn effeithio ar iechyd corfforol ac iechyd meddwl. Mae grwpiau nad ydynt yn Wyn yn profi lefelau uwch o straen gwaith, sy'n rheoli ffactorau demograffig eraill.

Cymeradwyir y ddogfen hon gan:

Cwblhawyd y ddogfen hon ar 8 Mehefin 2022.

Ynglŷn â Chynghrair Iechyd a Lles Conffederasiwn GIG Cymru

Nid yw iechyd yn fater annibynnol.

Mae angen i ni gyd chwarae ein rhan yn datblygu gwasanaeth iechyd sy'n addas ar gyfer y dyfodol. Mae Cynghrair Iechyd a Lles Conffederasiwn GIG Cymru yn cynnwys 70 a mwy o sefydliadau iechyd a gofal o golegau brenhinol, sefydliadau'r trydydd sector a sefydliadau gofal cymdeithasol, a chafodd ei sefydlu yn 2015.

Cafodd ei ymgynnull gan Gonffederasiwn GIG Cymru, a'i alw'n Fforwm Polisi yn flaenorol. Datblygwyd argymhellion wrth baratoi ar gyfer etholiad 2016 ac etholiadau'r Senedd yn 2021. Ym mis Ebrill 2021, fe wnaethom gyhoeddi *Gwneud y gwahaniaeth*, oedd yn galw ar lywodraeth nesaf Cymru i:

- gyhoeddi strategaeth draws-lywodraethol uchelgeisiol i fynd i'r afael ag anghydraddoldebau
- buddsoddi mewn ataliaeth hirdymor ar draws pob sector
- gweithio mewn partneriaeth â phobl a chymunedau i newid bywydau er gwell.

Roedd y papur hwn yn dilyn llythyr agored i brif weinidog Cymru ac arweinwyr y gwrthbleidiau yn y Senedd ym mis Chwefror 2021, yn galw am strategaeth draws-lywodraethol ar anghydraddoldebau iechyd.

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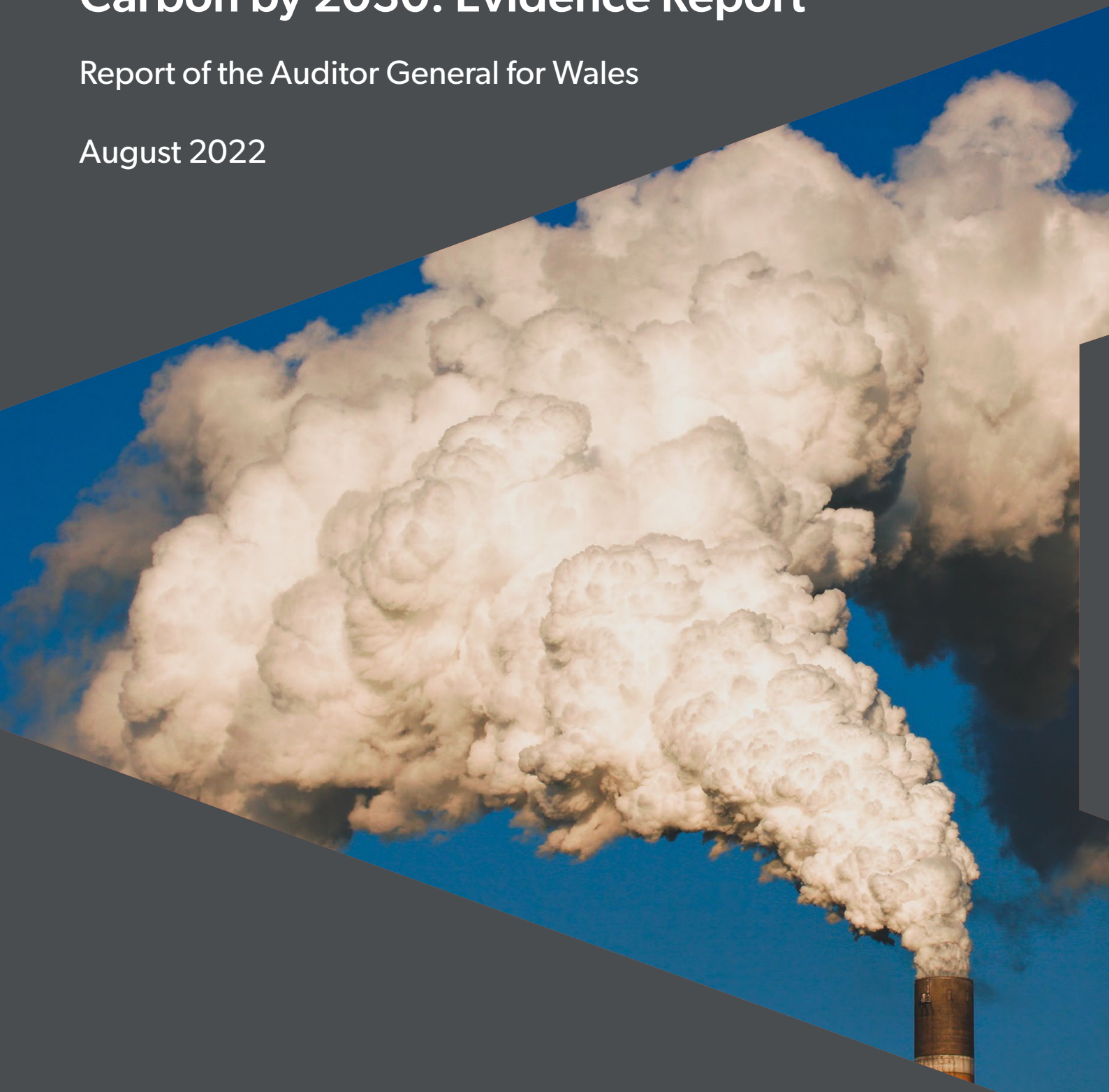
Rhif elusen gofrestredig 1090329

Archwilio Cymru
Audit Wales

Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report

Report of the Auditor General for Wales

August 2022



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Detailed report

Background

1 Climate change is one of the world's defining challenges and it requires immediate action from everyone. A landmark report by the United Nations in August 2021 said that human activity is changing our climate in unprecedented ways and that drastic reductions in carbon emissions are necessary.

2 The latest climate projections for Wales show an increased chance of milder, wetter winters and hotter, drier summers, rising sea levels and an increase in the frequency and intensity of extreme weather events. The implications are clearly stark.

3 A crucial way to mitigate the further impacts of climate change is to reduce carbon emissions. In March 2021, following advice from the Climate Change Committee[1] in December 2020, the Welsh Government set targets for a 63% carbon reduction by 2030, an 89% reduction by 2040, and a 100% reduction by 2050[2]. In addition, the Welsh Government set out a more challenging collective ambition for the Welsh public sector[3] to be net zero carbon by 2030 (the 2030 collective ambition).

4 In June 2021, the Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government. The Programme for Government also makes a series of commitments to embed a response to climate change in everything the Welsh Government does.

1 The Climate Change Committee (CCC) is an independent, statutory body established under the Climate Change Act 2008. Its role is to advise the UK governments on emissions targets and to report on progress made in reducing greenhouse gas emissions and preparing for and adapting to the impacts of climate change.

2 Net zero does not mean eliminating greenhouse gas emissions but balancing the greenhouse gas emissions with the amount of gas being removed from the atmosphere.

3 The Welsh Government's definition of the 'public sector' in this case covers 65 bodies as set out in Appendix 2 of the Welsh Government, Public sector net zero data: baseline and recommendations, June 2022.

5 The Welsh Government has also published Net zero carbon status by 2030: A route map for decarbonisation across the Welsh public sector (the public sector route map) to support the Welsh public sector in achieving the collective ambition. Alongside the public sector route map the Welsh Government has published the net zero reporting guide and associated spreadsheet to allow the public sector to capture and report emissions on a consistent basis. Our separate key findings report provides further detail on the national strategic direction for decarbonisation and its underpinning policy and legislative framework.

6 The Auditor General has committed to carrying out a long-term programme of work on climate change. Our first piece of work is a baseline review that asks: '**How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?**'. To inform the baseline review, 48 public bodies, including the Welsh Government, completed a call for evidence. **Appendix 1** explains our audit approach and methods.

7 We have published two reports to share our findings:

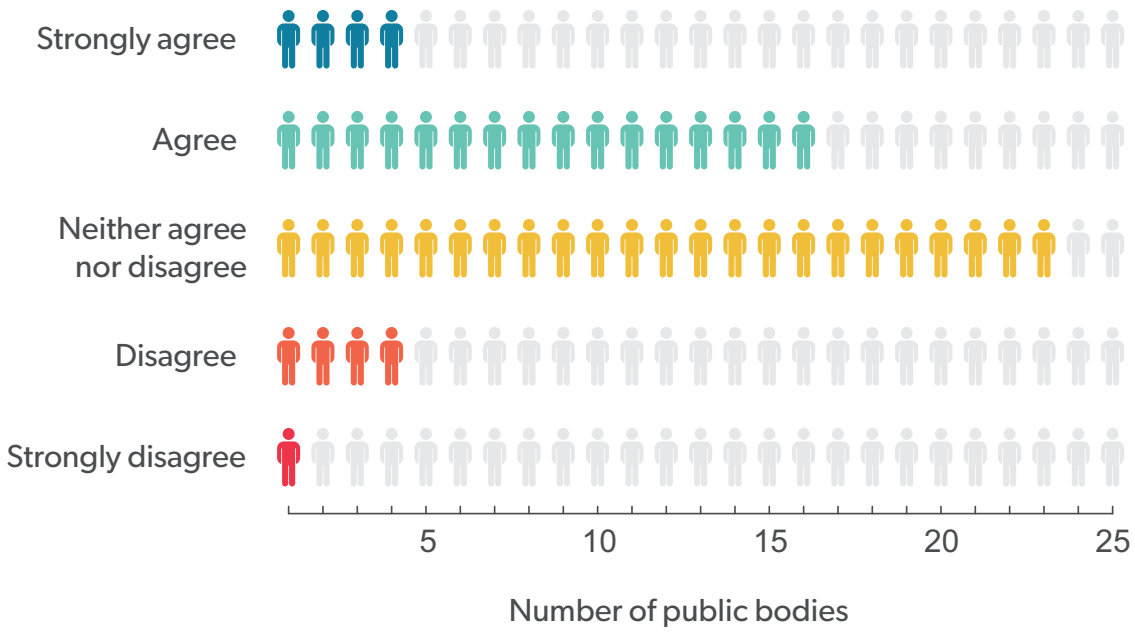
a **key findings report**: a summary report, published in July 2022, that targets senior leaders and those with scrutiny roles in public bodies, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. In that report, we set out the overall conclusion from our work and five calls for action for organisations to tackle the common barriers to decarbonisation in the public sector. The key findings report also notes that application of the sustainable development principle and the frameworks provided by the Well-being of Future Generations (Wales) Act 2015 can be used to help organisations to decarbonise.

b **this evidence report**: supplementing the key findings report by providing more detailed findings and data from the call for evidence and our wider work.

Confidence in meeting the 2030 collective ambition

8 We found considerable uncertainty (and clear doubt from some) about whether the collective ambition for a net zero public sector will be achieved by 2030. **Exhibit 1** shows that in our call for evidence, 20 out of 48 bodies agreed or strongly agreed they were confident that their organisation would meet the 2030 collective ambition, whereas 23 said they neither agreed nor disagreed and five disagreed or strongly disagreed.

Exhibit 1: public bodies' responses to the statement, 'Our organisation is confident that it will meet the 2030 target to have net zero carbon emissions'



Source: Audit Wales call for evidence

9 For NHS bodies, the NHS Wales Decarbonisation Strategic Delivery Plan (the NHS plan) includes a target to deliver a 34% reduction in carbon emissions by 2030. This target is based on a calculation about the reduction in emissions that can be realistically expected from the 46 initiatives set out in the plan. Our evidence from NHS bodies indicates considerable uncertainty about meeting this target (as well as the more challenging net zero ambition). **Paragraph 50** provides further consideration of the barriers to achieving the 2030 collective ambition.

10 The evidence suggests there is a need for greater clarity on how the 34% target fits within the wider context of the 2030 collective ambition. The Welsh Government has deliberately set a stretching collective ambition to stimulate action, although it is not a statutory target. At the same time, the NHS has set itself a less stretching target of a 34% reduction by 2030, while other parts of the public sector do not have separate targets. The health sector accounts for around a third of the public sector carbon emissions in Wales[4]. If the NHS was to achieve only a 34% reduction in emissions, it would make it significantly more difficult to achieve an overall net zero position across the public sector.

11 **Exhibit 2** provides examples of what public bodies told us in relation to the 2030 collective ambition and the likelihood of it being achieved.

4 As set out in Public Sector Net Zero: data and recommendations, health boards and trusts produced 1,134,000 tonnes of CO2 against a total of 3,279,000 tonnes produced by the public sector as a whole in 2020-21.

Exhibit 2: some comments from public bodies about the 2030 collective ambition

- ‘We recognise the enormity of the challenge we face.’
- ‘We are committed to contributing to the Welsh Government’s ambition for the public sector to be net zero by 2030 and will endeavour to deliver on or exceed the targets it sets.’
- ‘Not yet sufficiently clear what it will mean in practice.’
- ‘We do not have complete confidence that we will be able to measure the results of our actions.’
- ‘It will involve decarbonisation action in areas that we have yet to develop decarbonisation expertise, for example, in procurement and local area energy planning.’
- ‘If our entire supply chains are not zero carbon, then we cannot be either.’
- ‘The council is committed to achieving its net zero ambitions, notwithstanding the challenges.’
- ‘The level of financial investment will be a driver in whether or not we achieve our ambition and how quickly we’re able to act.’

Source: Audit Wales call for evidence

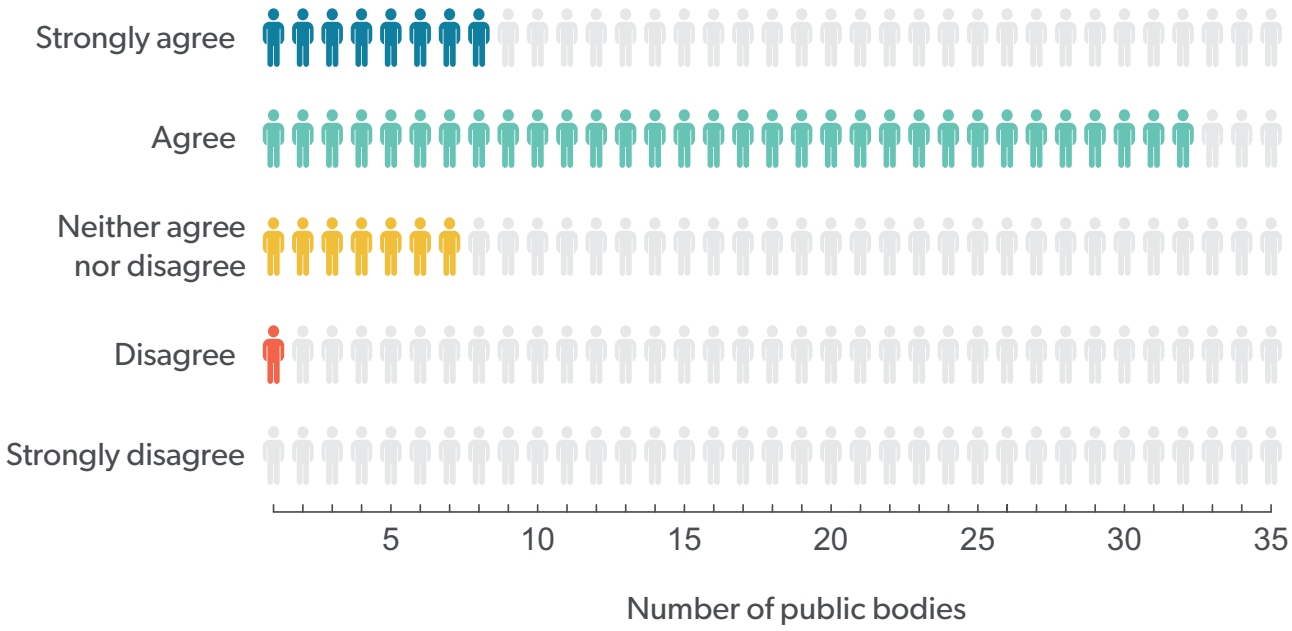
“We recognise the enormity of the challenge we face”

Strategic direction and action planning for decarbonisation

National strategic direction

12 **Exhibit 3** shows that public bodies were generally positive about the Welsh Government's strategic direction on decarbonisation. Public bodies were also largely positive about the way in which the Welsh Government had engaged with them through various channels over the approach to achieving net zero.

Exhibit 3: public bodies' responses to the statement, 'The Welsh Government has set a clear strategic direction for public bodies in Wales to support the achievement of their 2030 carbon reduction targets'



Source: Audit Wales call for evidence

13 **Exhibit 4** provides examples of what public bodies told us in relation to the national strategic direction.

Exhibit 4: some comments from public bodies about the national strategic direction

- 'Welsh Government have set a clear strategic direction in terms of ambition and there is a clear and consistent message in terms of where we need to get to.'
- 'We have used the strategic direction and guidance as a framework to develop an organisational climate change plan.'
- 'The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities, and the support we receive is not clear.'
- 'I believe that the government could be offering more support ensuring that the guidance provided is consistent for everyone.'
- 'Further work is required by (Welsh Government) to publicise the wider strategic narrative and tools available.'
- 'The National (NHS Wales) Strategic Decarbonisation Plan provides a clear direction of travel for Wales and robust evidence base for the priorities within (our area).
- 'The NHS Wales Decarbonisation Strategic Delivery Plan sets out a number of actions with clear timelines.'

Source: Audit Wales call for evidence

> **"The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities…is not clear"**

14 The public sector route map is a key part of the national strategic direction. Some public bodies told us they view the public sector route map as a high-level thematic and strategic framework. They told us it sets the overall direction, and is an accessible, well-presented and user-friendly document. Several bodies made comments about the usefulness of the route map as a tool for explaining, identifying, developing and delivering actions. Some also told us that the route map was a valuable aid for explaining responsibilities and requirements to senior management, members and board members.

15 Nevertheless, several non-NHS bodies said they wanted more help to translate the strategy into local, day-to-day operations, through their action plans. These organisations told us that while the public sector route map provides a high-level template, they need more clarity, support and guidance on how to decarbonise. The Welsh Government told us that it deliberately designed the route map to be a high-level framework to assist public bodies in developing local solutions based on individual circumstances, rather than a one-size-fits-all approach. In addition, the Welsh Government does provide other sources of support to public bodies through the Welsh Government Energy Service and through the Wales Funding Programme, as set out in **paragraph 22**.

16 **Exhibit 5** provides a summary of some concerns public bodies expressed about the public sector route map. **Exhibit 18** expands on some of these concerns as part of a discussion about wider barriers to decarbonisation.

Exhibit 5: summary of concerns from public bodies about the public sector route map

- **Timeliness**: Overall, public bodies felt there was consistency between the direction set by the Welsh Government and their individual approaches. However, due to the timing of the route map's publication[5], some bodies had already started developing their own strategies and action plans so there is not always complete read across to the route map. There is an opportunity to fully align when strategies and action plans are refreshed.
- **Detail**: the public sector route map needs additional clarity, support and guidance on how to decarbonise.
- **Targets**: some of the targets and the timeframes to achieve them are very challenging.
- **Funding**: there is a lack of planned, long-term, external investment from the Welsh Government to support delivery.
- **Inconsistency**: potential for inconsistent interpretation of the guidance and the reporting requirements.
- **Calculations**: further detail and clarity are needed in the carbon calculator, specifically in relation to the procurement and land use themes.

Source: Audit Wales call for evidence

5 The Welsh Government chose to delay publication of the route map during the COVID-19 pandemic because it did not want to overburden public bodies at such a difficult time.

Sector-specific strategies and support for decarbonisation

17 In the health and care sector, the Welsh Government has convened the Climate Change and Decarbonisation Programme Board for Health and Social Care, to help lead, support and give strategic oversight to decarbonisation work. Guidance on decarbonisation is available to NHS bodies through the NHS plan which was published alongside the public sector route map in May 2021. The Carbon Trust and the NHS Wales Shared Services Partnership developed the NHS plan, which sets out 46 initiatives for decarbonisation that will be assessed and reviewed in 2025 and 2030.

18 The NHS plan aligns with the public sector route map, provides more detail and allocates responsibility for initiatives and actions to different parts of NHS Wales. The NHS plan focuses on traditional areas of decarbonisation, such as buildings and transport. While these remain important areas of focus, the Welsh Government has acknowledged that the section on decarbonising healthcare[6] is less detailed, reflecting the developing practice in this area.

19 Our call for evidence responses from NHS bodies demonstrated a focus on and commitment to delivering the actions set out in the NHS plan. And while there appears to be support in the health sector for the NHS plan, the Welsh Government recognises there is scope to strengthen its co-ordination and leadership.

20 In local government, the Welsh Local Government Association is developing tailored support and guidance for councils on decarbonisation. The Welsh Government funds the Welsh Local Government Association transition and recovery support programme. Focussing on the key themes of the public sector route map, the programme provides a range of support including toolkits, commissioned research on interventions to achieve net zero, training to build knowledge and expertise, and events to facilitate sharing of best practice. The Welsh Government is also part of the Local Government Climate Strategy Panel which supports and gives strategic overview to decarbonisation work in local government.

21 The Welsh Government does not currently plan to produce specific decarbonisation plans for other sectors covered by the public sector route map. However, it acknowledges that more support and guidance may be needed for bodies outside of the NHS and local government.

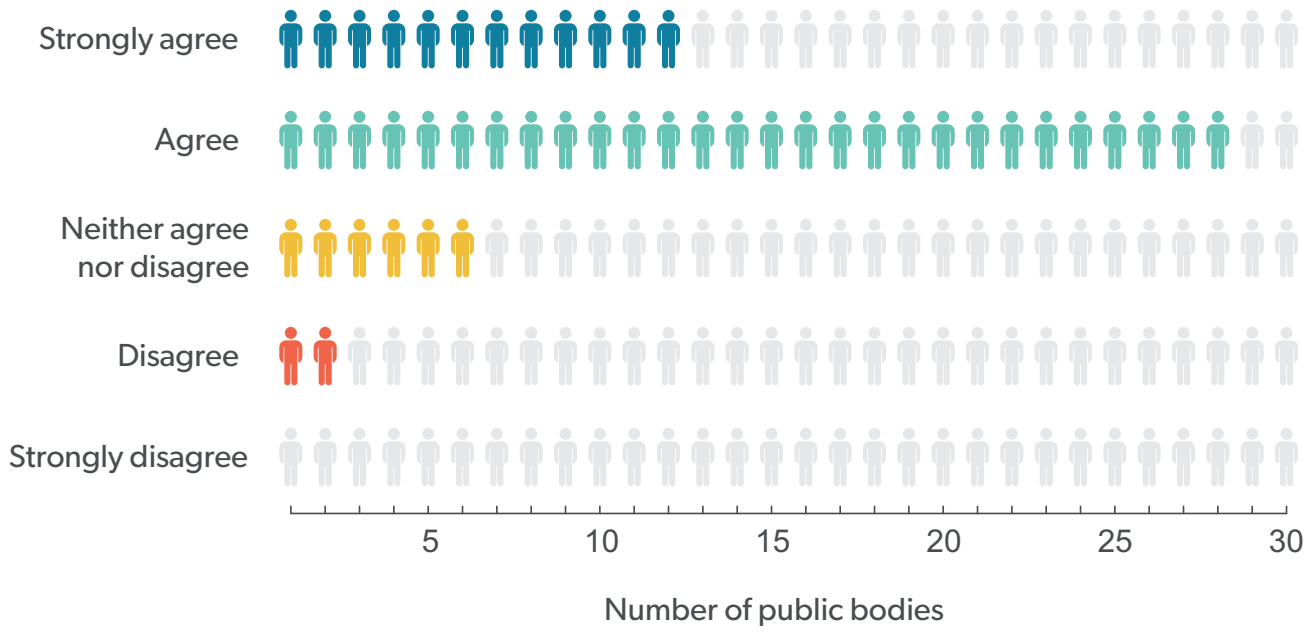
6 Decarbonising healthcare refers to reducing carbon emissions in health services rather than decarbonising the physical infrastructure surrounding healthcare. Examples include the use of medical gases and inhalers that involve greenhouse gases.

22 The Welsh Government is providing other central assistance on decarbonisation, including support through the Welsh Government Energy Service (WGES) and grant funding for various programmes. The WGES provides technical advice and other support to public sector bodies and community enterprises on energy efficiency, renewable energy projects and fleet improvements. The WGES annual report provides further information about the support it provides. The Welsh Government has made funding available for public sector decarbonisation projects through the Wales Funding Programme, which aims to make buildings and assets more energy efficient.

Local strategic direction

23 **Exhibit 6** shows that most public bodies were confident their organisation had set a clear, local strategic direction to deliver the 2030 collective ambition.

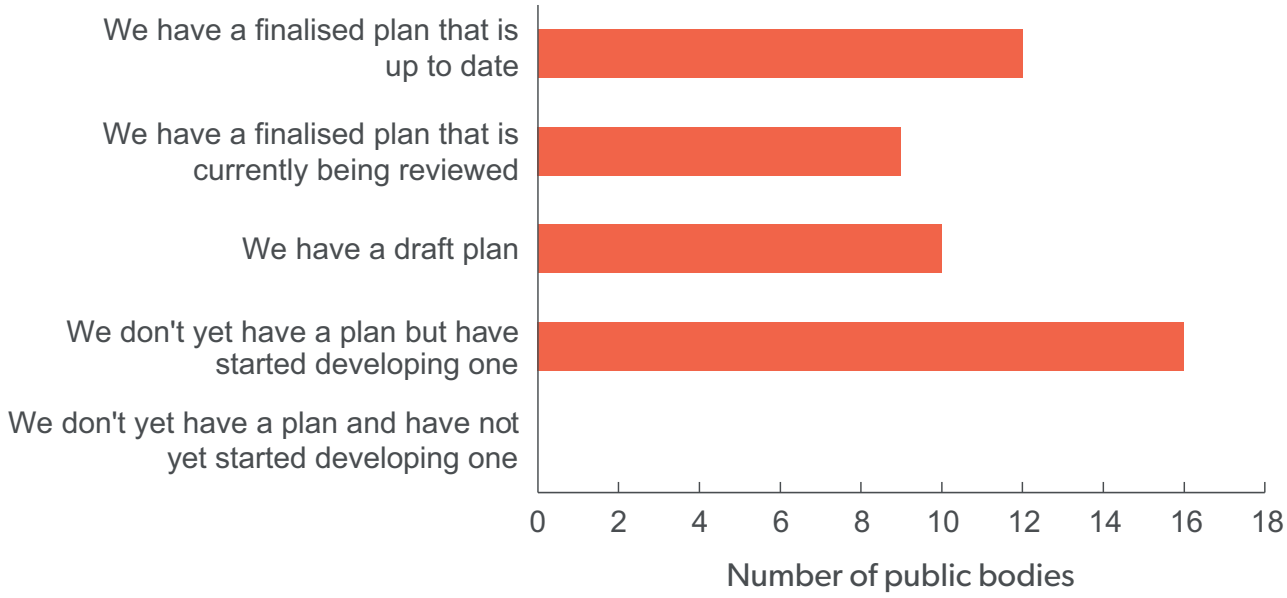
Exhibit 6: public bodies' responses to the statement, 'Our organisation has set a clear strategic direction to support the achievement of the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

24 However, **Exhibit 7** shows that public bodies are at very different stages in setting out their action plans for decarbonisation. Within these responses, NHS bodies appeared to be a bit further behind local government.

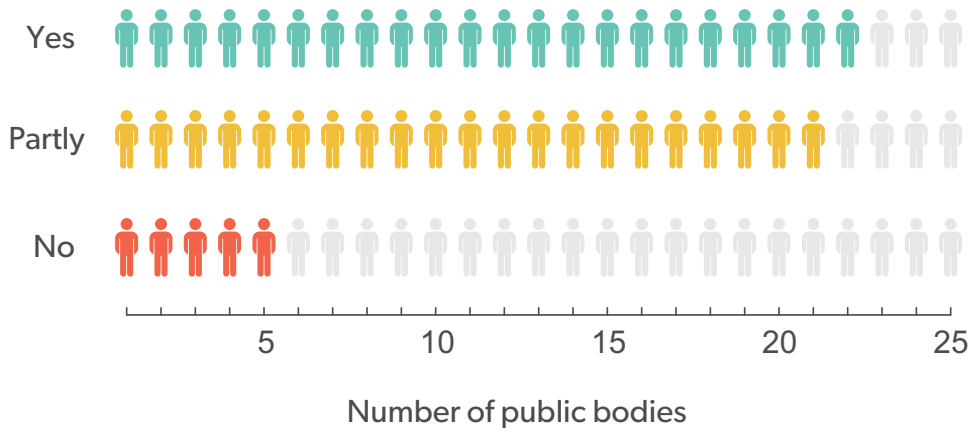
Exhibit 7: status of public bodies' action plans



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

25 **Exhibit 8** shows variation in the extent to which public bodies are using the public sector route map to guide their own strategic approach, with five responding to say that they are not using it at all.

Exhibit 8: public bodies' responses to the question, 'Is your organisation using the Welsh Government's public sector route map to guide its approach to reducing carbon emissions?'



Source: Audit Wales call for evidence

Governance and leadership arrangements for decarbonisation

26 It is important that public bodies have effective internal governance and leadership arrangements to drive decarbonisation. Public bodies described various existing and new structures, including boards and dedicated senior staff groups. For example, all NHS bodies have an identified director or executive director to oversee decarbonisation. Responses to the call for evidence also acknowledged that clear structures are essential and need to be regularly reviewed to ensure they remain fit for purpose.

27 Public bodies recognised the importance of engaging all staff in the critical issue of decarbonisation, but they acknowledged that more needs to be done. Upskilling of staff through training was identified as key to supporting the delivery of the 2030 collective ambition. However, more needs to be done to ensure upskilling covers the whole staff base and not just senior leaders or those charged with governance.

28 **Exhibit 9** provides examples of what public bodies told us in relation to their governance and leadership arrangements for decarbonisation.

Exhibit 9: some comments from public bodies about their governance and leadership arrangements for decarbonisation

- ‘A climate and nature emergency officer group has been established to lead, facilitate and support the delivery of the action plan.’
- ‘The health board has established a sustainability and decarbonisation programme board led by the Executive Director Finance.’
- ‘The council has just appointed … a Climate Change Manager.’
- ‘We are building decarbonisation into the clinical model which will be operating in new hospital infrastructure going through business case stages.’
- ‘Some early adopter clinical departments are creating their own sustainability action plans.’
- ‘[We] will appoint a board director as decarbonisation lead (and senior responsible officer) and establish a steering group to oversee our decarbonisation programme.’
- ‘The Sustainable Group is chaired by the Executive Director of Strategy and attended by staff from across the health board, including clinicians and those networked into a wide range of partner forums.’
- ‘The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. The Working Group was supported by a team of officers.’

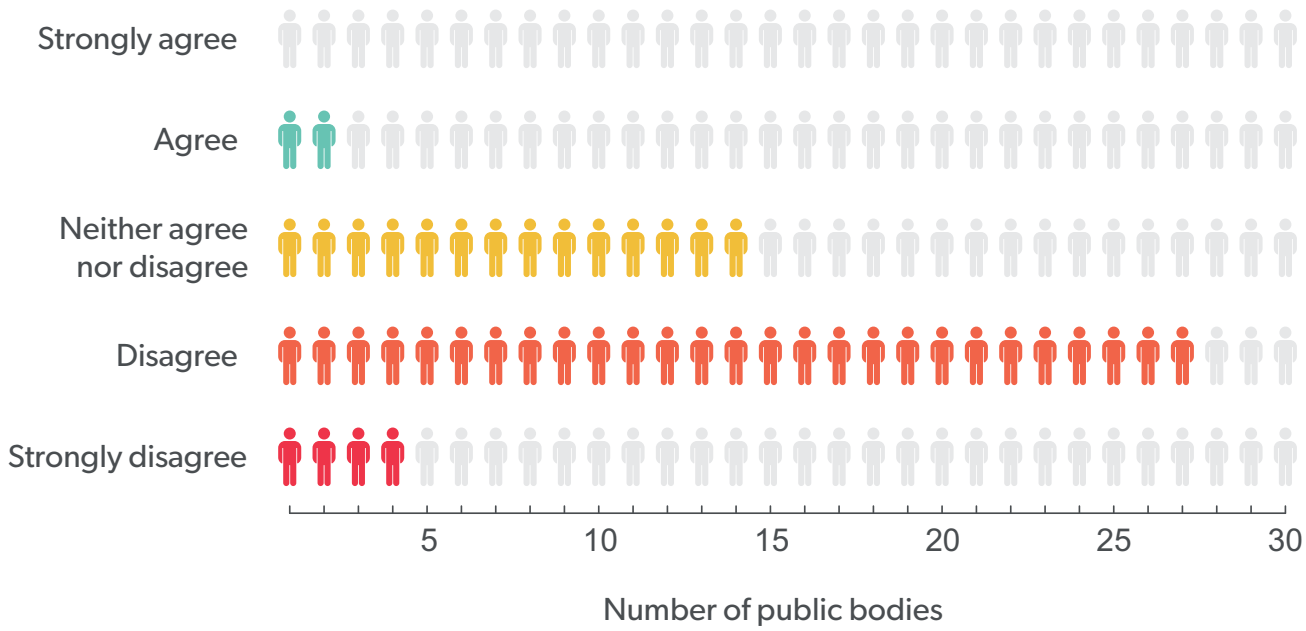
Source: Audit Wales call for evidence

“We are building decarbonisation into the clinical model”

Financial implications of decarbonisation

29 **Exhibit 10** shows that most public bodies have not fully assessed the financial implications of meeting the 2030 collective ambition. A few responses to the call for evidence included costings of specific recent or imminent projects but we did not see evidence of fully costed, long-term decarbonisation programmes. We are aware that some public bodies have since developed more detailed estimates for short to medium-term expenditure.

Exhibit 10: public bodies' responses to the statement, 'Our organisation has fully assessed the financial implications of meeting the 2030 carbon reduction targets'



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

30 In some cases, public bodies told us that they have not assessed the financial implications because they have not yet set out a clear set of actions and activities to achieve net zero. However, they were aware of the urgency and the need to increase the pace of implementing actions. Public bodies were very clear that decarbonisation at scale will require significant additional financial resources and that the absence of these funds will be a significant barrier to progress.

31 Public bodies need to plan their finances in such a way that they can deliver their decarbonisation strategies and action plans. This will require long-term planning because decarbonisation will need investment for many years. It will also require immediate expenditure because if the 2030 collective ambition is to be met, urgent action is essential. Public bodies told us significant long-term investment will be needed, particularly in relation to making their infrastructure fit for purpose to enable the decarbonisation of operations. However, public bodies expressed uncertainty over what additional funding would be available from the Welsh Government. They also pointed to the short-term nature of public sector funding and budget cycles making their longer-term financial planning more difficult.

32 The Welsh Government told us they are providing targeted funding for public bodies in certain areas but they also said they are unable to fund all activity required. The Welsh Government acknowledges that there will be additional costs in some areas and that funding will be provided to bridge some of those gaps, when moving to low carbon alternatives, for example, the increased cost of purchasing electric fleet rather than those powered by traditional fossil fuels. However, the Welsh Government said that as decarbonisation becomes increasingly mainstreamed into routine thinking, public bodies should not be focussed on additional funding, and they should move to a position where decarbonisation is funded through their existing budgets as a result of a strong business case.

33 **Exhibit 11** provides further examples of what public bodies told us in relation to the financial implications of decarbonisation.

Exhibit 11: some comments from public bodies about the financial implications of decarbonisation

- ‘The financial implications of decarbonisation have not been fully considered.’
- ‘We recognise that we have further work to do on this front.’
- ‘The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term.’
- ‘Until the council formulates a detailed fully costed 2030 net zero delivery plan the council is unable to accurately assess the financial implications.’
- ‘It should be acknowledged that funding will be required to deliver the aim of net zero by 2030.’
- ‘There are no cost estimates for medium-term levels of expenditure.’
- ‘The cost of decarbonising our clinical operations has not been estimated.’

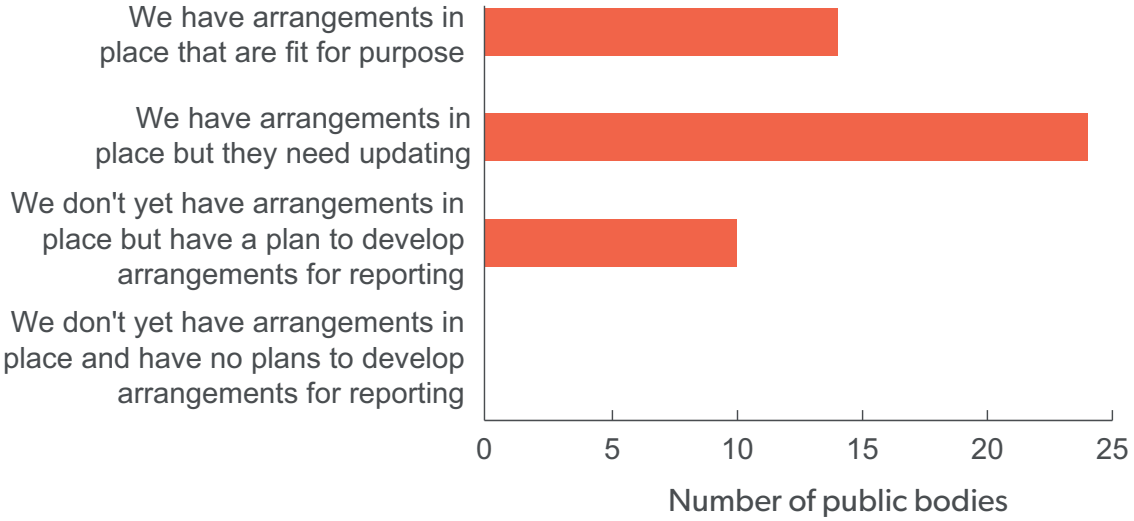
Source: Audit Wales call for evidence

“The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term”

Reporting progress on decarbonisation

34 Public bodies need to understand where their emissions are coming from so they can check if they are making progress and prioritise their actions. We found that data issues are a major barrier to having a shared understanding of the problem and to taking strategic decisions about the solutions. **Exhibit 12** shows that 14 bodies indicated they had reporting arrangements that they felt were fit for purpose, 10 did not have arrangements in place, and 24 had arrangements that needed updating.

Exhibit 12: public bodies' responses to the question, 'Which of the following options best describes your organisation's arrangements for reporting on progress towards net zero carbon emissions?'



Source: Audit Wales call for evidence

35 Current monitoring and reporting tend to be done through reports or dashboards to cabinet, council, board, scrutiny committee or other groups. Some bodies report on decarbonisation as part of reporting progress on their corporate plans or wellbeing objectives. Some responses pointed to dedicated climate groups and other arrangements that have been set up specifically to monitor and report on decarbonisation activity.

36 Overall, the evidence suggests there is scope for improved reporting on decarbonisation. This finding aligns with a blog we published in February 2022 that called for clearer information on climate change actions to be included in public bodies' financial statements, to ensure greater transparency and accountability.

37 The Welsh Government has published a common reporting methodology (see **paragraph 5**) for public bodies to report their emissions through the Welsh Public Sector Net Zero Reporting Guide and net zero reporting spreadsheet. The Welsh Government asked public bodies to submit the first data by October 2021 for the 2020-21 financial year.

38 In responses to our call for evidence, public bodies generally recognised the usefulness of having a common reporting methodology but found aspects of the submission challenging and highlighted problems with the data collection in October 2021. Some responses pointed to concerns over calculation methods, particularly regarding supply chain. In relation to supply chain emissions, public bodies pointed to the fact that the calculation is based on the cost of the contract rather than the actual emissions generated by the product or service procured. Public bodies also called for further clarity of definitions to ensure consistent interpretation and reporting. Some responses also noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive.

39 Public bodies pointed to some other concerns about the common reporting methodology. Some respondents said the way in which emissions from land use is reported is too simplistic.

40 NHS bodies also raised concerns about duplication with already established reporting on carbon emissions such those required by the Estates and Facilities Performance Management System[7]. This created confusion in the first reporting year. NHS bodies wanted further clarity to avoid duplication between these reporting requirements.

7 The Estates and Facilities Performance Management System is a comprehensive set of estates and facilities data. The Welsh Government set up the system in 2002 to improve the management of the NHS estate. It allows NHS bodies to compare performance against other NHS bodies in Wales and England.

41 The Welsh Government recognises improvements are required in the existing reporting approach and has committed to learning from feedback and improving methods and systems where required. The Welsh Government commissioned consultants, to review the first submission of data from public bodies and, in June 2022, the Welsh Government published the consultancy report, Welsh Public Sector Net Zero: Baseline and recommendations in full. The report states that the figures include significant uncertainty, particularly in relation to supply chain emissions, which it said represented 87% of public sector emissions. Plus, the data has not been thoroughly audited. The figures also suggest emissions across Wales for the public sector reduced by 5% between 2019-20 and 2020-21.

42 As this is the first year of the reporting guide, it is a period of learning, and the calculation for reporting emissions will be further developed where required. Following feedback from public bodies, and the review of the data submissions from an external consultant, the Welsh Government published a revised reporting guide and tool in July 2022.

43 **Exhibit 13** provides examples of what public bodies told us in relation to the monitoring and reporting on decarbonisation.

Exhibit 13: some comments from public bodies about monitoring and reporting on decarbonisation

- 'We followed the emissions reporting guidance as closely as possible.'
- 'Two distinct areas need to be strengthened/clarified which are waste and supply chain.'
- 'We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress.'
- 'The supply chain emissions reporting method needs significant refinement in order to be considered accurate.'
- 'Current data gathering and reporting functions require updating.'
- 'We are developing the necessary reporting tools to meet the requirements of the Net Zero Carbon Reporting Guidance.'

Source: Audit Wales call for evidence

> **"We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress"**

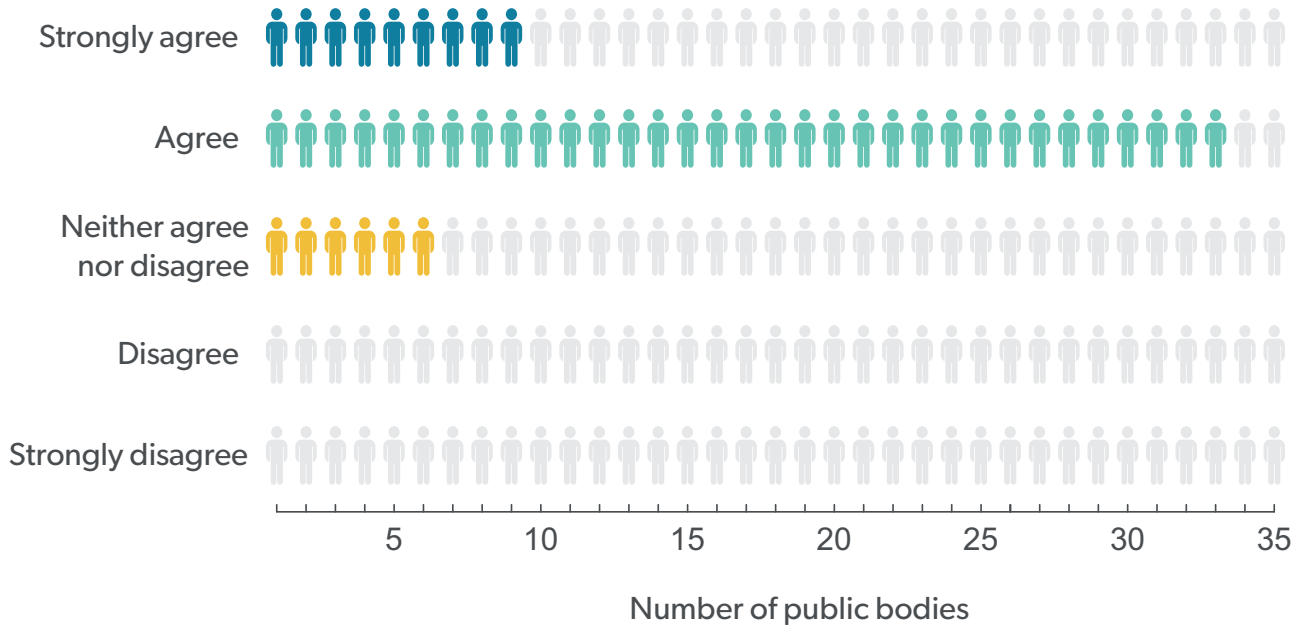
Collaboration and engagement with other bodies, staff, and citizens

44 To support collaboration and engagement at a national level, the Welsh Government published Climate Change: Welsh Government Engagement Approach 2022-26 in June 2021. The document refers to a Team Wales approach, where everyone in Wales plays a role in collective action on climate change. The engagement approach has two key objectives:

- to generate timely and effective engagement of stakeholders on matters of climate change; and
- to strengthen and grow the coalition of Team Wales to tackle the climate emergency.

45 **Exhibit 14** shows that public bodies feel they are working well with other organisations on decarbonisation. And **Exhibit 15** sets out comments made by public bodies about their collaborative efforts to date and aspirations for the future.

Exhibit 14: public bodies' responses to the statement, 'Our organisation is effectively collaborating with other bodies to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 15: some comments from public bodies about collaboration

- ‘Through the public services board (PSB) we have established a Climate Emergency Board which comprises existing PSB members, but also additional organisations including utility providers and our local university.’
- ‘As part of our Well-being Plan work, we are currently working collaboratively with our partners and are in the early stages of developing a Climate Strategy for the city.’
- ‘We are working closely with public sector partners through the North Wales Regional Leadership Board. We participate in the North Wales Decarbonisation Advisory Group.’
- ‘We have completed an informal analysis of who we need to work with, but we have not yet completed a formal analysis of partners.’
- ‘Collaboration between NHS organisations has been low, though is changing through Welsh Government setting up a Climate Change Programme Board.’
- ‘We have multiple representatives on the Decarbonisation Action Plan: Community of Experts. This will share learning and good practice across the health boards in Wales.’
- ‘We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges faced by serving communities covered by multiple local authority agencies.’

Source: Audit Wales call for evidence

“We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges”

46 Some bodies have set up their own local collaborative arrangements for decarbonisation, whereas other bodies are collaborating through Welsh Government or Welsh Local Government Association convened arrangements or through statutory fora such as public services boards. A significant proportion of bodies had also involved external experts in their decarbonisation efforts, such as the Carbon Trust.

47 Smaller bodies, such as the national parks and Welsh Government sponsored bodies, told us they have been collaborating well with each other. They said that due to their size, they are somewhat reliant on external expertise and advice in relation to decarbonisation.

48 Some public bodies acknowledged that their focus to date had been on establishing internal structures, rather than on external collaboration. And notwithstanding the responses shown in **Exhibit 14**, many public bodies agreed that collaboration and engagement needed to be strengthened.

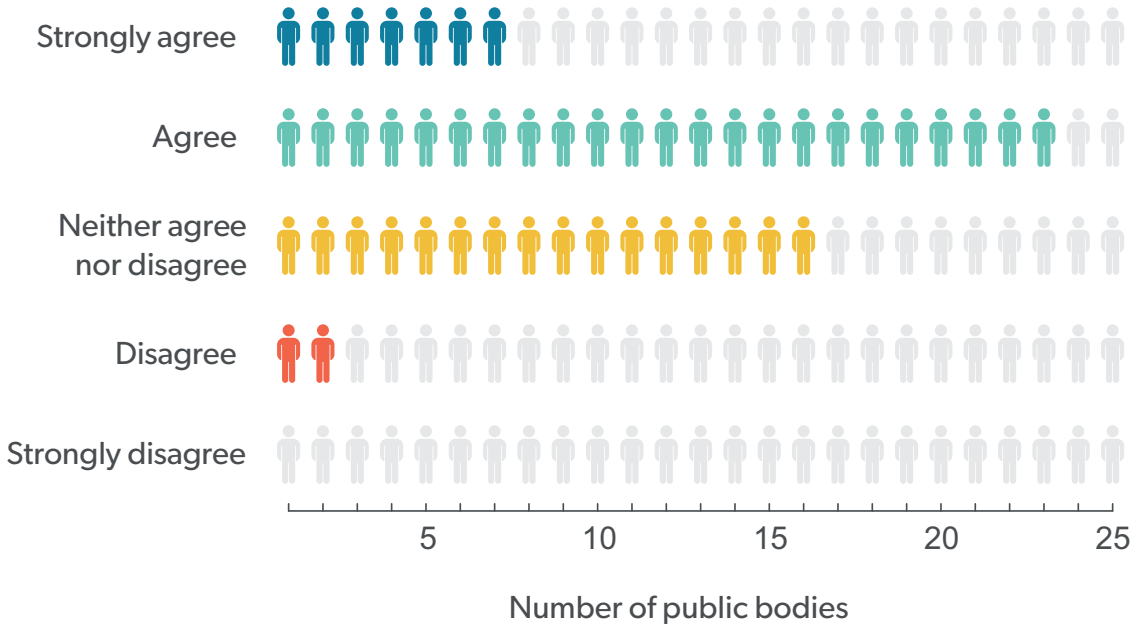
49 There is scope for stronger engagement and involvement with staff and the public. **Exhibit 16** shows mixed views from public bodies about the extent to which they are engaging and involving their staff. And **Exhibit 17** shows that only 15 of the 48 public bodies we contacted were confident that they were effectively engaging with the full diversity of the population. Some public bodies told us about engagement with the public through mechanisms such as online surveys, social media channels and community groups but they generally acknowledged that this engagement needs to improve. This is significant as both our 2019 report on fuel poverty[8] and the Decarbonisation of Homes in Wales Advisory Group[9] found there are some difficult trade-offs between social justice and carbon reduction goals. Engagement with the full diversity of the population should help public bodies in their efforts to make a just transition[10] towards net zero carbon emissions.

8 Auditor General for Wales, Fuel Poverty, October 2019

9 Decarbonising Homes in Wales Advisory Group, Better Homes, Better Wales, Better World: Decarbonising existing homes in Wales, July 2019

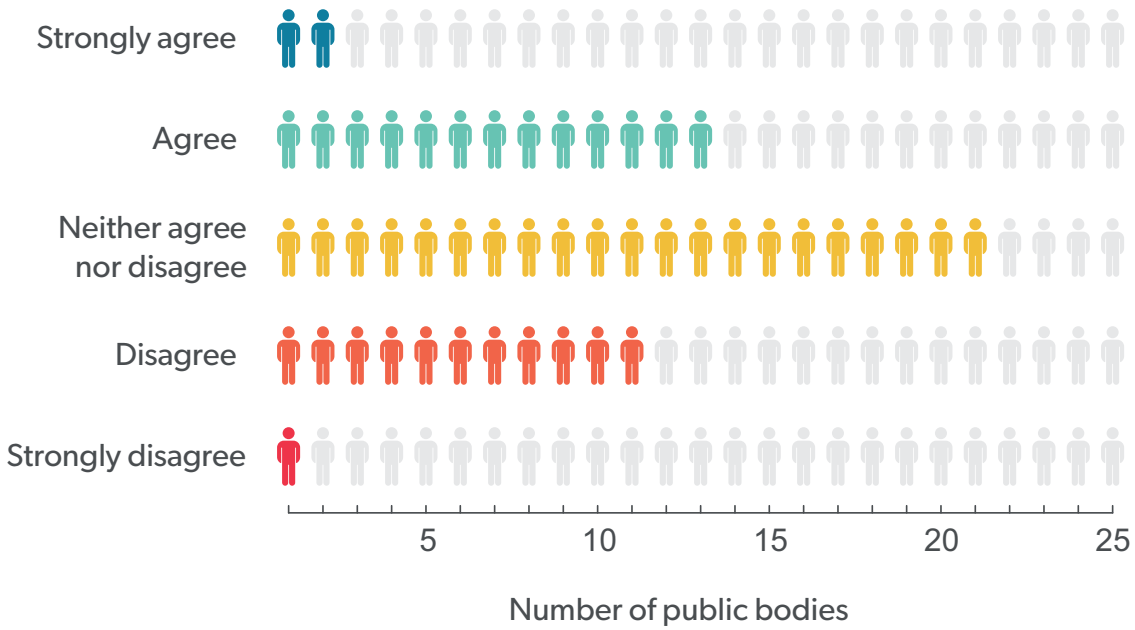
10 A 'just transition' means taking action on climate change and greening the economy in a way that is as fair and inclusive as possible to everyone concerned. Policy 1 in Net Zero Wales Carbon Budget 2 (2021-2025) sets out the Welsh Government's views on a just transition.

Exhibit 16: public bodies' responses to the statement, 'Our organisation is effectively engaging with and involving staff to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 17: public bodies' responses to the statement, 'Our organisation is effectively engaging with the full diversity of our population to achieve the 2030 carbon reduction targets'

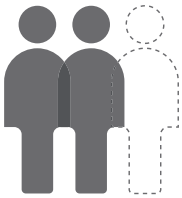


Source: Audit Wales call for evidence

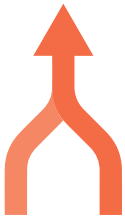
Barriers, opportunities and interesting practices on decarbonisation

50 We asked public bodies about the barriers to achieving the 2030 collective ambition. **Exhibit 18** summarises the barriers they told us about that were largely common across the public sector, many of which are explored earlier in the report. One common theme was that decarbonisation is complex, requiring significant investment and that many of the easy wins had been achieved. However, public bodies were aware that the pace of activity needs to increase and there are reputational risks of not doing so.

Exhibit 18: summary of public bodies' views about barriers to meeting the 2030 collective ambition

Barriers	
Finance 	This was the most commonly mentioned barrier. Bodies pointed to the need for significant and sustained revenue and capital investment in the short and long term. They said there was a particular need for investment in improving infrastructure, estates, appliances and equipment that are not fit for carbon reduction. These matters are discussed further in **paragraphs 29 to 33**.
Staff capacity and skills gaps 	Public bodies told us existing staff capacity is stretched delivering public services. Decarbonisation is a complex area and public bodies feel they do not have the skills and expertise in this area. There is considerable competition for people with specialist expertise and knowledge. Financial constraints make it difficult for some bodies to bring in additional staff. In addition, as the private sector can offer higher salaries, public bodies are at a disadvantage in attracting staff.

Understanding the activities required 	Public bodies are still building an understanding of the specific activities that are needed to decarbonise and how these should be prioritised. Public bodies feel that they need additional support and guidance on how to translate the strategic approach into action.
Culture, education and training 	Embedding decarbonisation in day-to-day activities can represent a significant cultural shift. Some public bodies told us that decarbonising is complex and it may be difficult to change longstanding approaches to delivery. Some bodies said there is the potential for staff apathy to having to undertake additional decarbonisation activities on top of the day job. Significant communication with staff will be required to obtain buy in and extensive training will also be needed to upskill staff to deliver.
Technology and infrastructure 	Many new technologies are expensive and public bodies are cautious about investing due the risks of the technology not being effective or becoming obsolete. In other areas, such as the development of electric-powered ambulances and fire appliances, public bodies told us the technologies were not developing quickly enough and in some cases were prohibitively expensive. There were also concerns about a lack of electric charging points and insufficient grid capacity to cope with the growing reliance on electricity. Supply and demand issues are also a problem in relation to some new technologies, where technologies are sought-after but are limited in supply.

Data 	Public bodies recognised the usefulness of having a common methodology for reporting carbon emissions. However, some responses pointed to concerns over calculation methods, particularly regarding supply chain and land use, and called for further clarity of definitions to ensure consistency. Some responses noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive. NHS bodies raised concerns about duplication with existing reporting arrangements on emissions.
Joined-up approach 	Some respondents told us that a wholesale change of thinking is required, with a more co-ordinated and joined-up approach across the public sector, driven by the Welsh Government. One example given related to the assessment of new and emerging technologies. Public bodies were concerned about investing in technologies that were quickly superseded or were not best practice, so a single public sector-wide decision over what is best would help mitigate this risk.
Third parties 	Third parties have a role to play in helping public bodies move towards the 2030 collective ambition. For example, emissions from partners in the procurement chain, and the high demand for limited specialist resources and newer technologies such as electric vehicles meaning they are often not available. The Office of the Future Generations Commissioner for Wales has recommended previously that public bodies should set out clearly how they have considered the carbon impact of their procurement decisions[11].

Source: Audit Wales call for evidence

11 Office of the Future Generations Commissioner, Procuring well-being in Wales, February 2021.

51 While public bodies identified a range of barriers to achieving the 2030 collective ambition, they also see some opportunities associated with decarbonisation (**Exhibit 19**) and shared with us some examples of interesting practices that they felt other bodies could potentially learn from (**Exhibit 20**).

Exhibit 19: some opportunities that public bodies told us about in relation to decarbonisation

Public bodies highlighted opportunities to:

- build on the profile of climate change from COP26 to take advantage of the raised public awareness and build relationships with local communities and other stakeholders;
- increase collaboration with other organisations, to share best practice in working towards decarbonisation and to develop local procurement approaches;
- increase the use of new and developing technologies, realise cost savings from renewable energies and consider the economic and job creation possibilities arising from new green industries;
- increase awareness of the urgency of decarbonisation with staff, executives, boards and members, and to revise governance and leadership arrangements to ensure decarbonisation is incorporated into everyday business and decision making; and
- build on flexible working practices that arose during the COVID-19 pandemic to further exploit digital technologies in service delivery and everyday working.

Source: Audit Wales call for evidence

Exhibit 20: some examples of interesting practices that other bodies could learn from

Cardiff and Vale University Health Board

The health board is involved in an initiative called Green Health Wales to build a community of healthcare professionals who can share experience with their colleagues across the country. Green Health Wales aims to empower the health and social care sector with the tools and knowledge to address the climate crisis.

The health board has not estimated the cost of net zero building infrastructure on the current estate configuration, however, specialists in 2021 estimated that in a new-build scenario of the University Hospital of Wales and the University Hospital Llandough, the cost of net zero building infrastructure could be between £89 million and £266 million.

Denbighshire County Council

The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. A key recommendation from the working group was to amend the council's constitution to include the need to have 'regard to tackle climate and ecological change' in the principles of decision making. The council has now formally committed to consider climate and ecological change when making all council decisions.

Swansea Bay University Health Board

The health board is developing a trajectory tool to measure the impact of different scenarios of financial input into decarbonisation measures. It will use the tool to monitor the efficacy of its decarbonisation measures.

A solar farm is directly connected to Morriston Hospital which supplies 30% of its electricity.

Blaenau Gwent County Borough Council

The council has been involved in establishing a mitigation steering group through the Blaenau Gwent Local Well-being Partnership, and residents' priorities have informed the group's work through the recommendations of the Blaenau Gwent Climate Assembly. The council, in its decarbonisation plan, has identified a number of transition pathways to follow in order to achieve net zero. Each transition pathway represents a coherent area of action with distinct, low carbon technologies, business models and infrastructure. These pathways have been developed to allow each to proceed at their own appropriate pace. Achievement of the pathways is supported by best practice readiness assessments adapted from tools developed by Place-Based Climate Action Network for Leeds Climate Commission.

Rhondda Cynon Taf County Borough Council

The council has established a 'Let's Talk' engagement website where members of the public can leave comments and ideas about a range of climate change matters.

Natural Resources Wales (NRW)

NRW's Carbon Positive Project, part funded by the Welsh Government to show leadership in how the public sector can measure and reduce its carbon impact, has informed the development of both the public sector route map and the net zero reporting guide. As part of the project, NRW is taking steps to not just reduce carbon emissions but enhance and protect carbon stored on the land it manages and share its experiences to encourage further decarbonisation in Wales.

Neath Port Talbot Council

The council is collaborating with a private company that specialises in the re-use of waste gases from industrial processes to enable conversion into biofuels. The plan is to deliver a pilot project within Neath Port Talbot which will utilise waste gases from the steel industry. It is anticipated that once fully operational, the plant will generate 30 million gallons of biofuels for use in the aviation industry each year.

The council's Lost Peatlands Project seeks to restore more than 540 hectares of historic landscape and habitat, including peat bogs and pools, heathland, grassland and native woodland.

Numerous public bodies

Several organisations gave us examples of:

- using the new construction or redevelopment of facilities to significantly improve their carbon footprint;
- procurement of low emission vehicles;
- installation of electric vehicle charging points;
- renewable energy generation on site;
- development of operational staff networks; and
- installation of energy efficient heating and lighting systems.

Source: Audit Wales call for evidence

Appendices

1 Audit approach and methods

1 Audit approach and methods

In November 2021, we issued a call for evidence to 48 public bodies, asking questions about their baseline position in achieving the 2030 collective ambition. Most public bodies responded in the period December 2021 to January 2022. We sent the call for evidence to the bodies covered by the Well-being of Future Generations (Wales) Act 2015 at the time. This included all principal councils, fire and rescue authorities, national park authorities, health boards and NHS trusts, and the larger Welsh Government sponsored bodies.

We also sent the call for evidence to the Welsh Ambulance Services NHS Trust, Digital Health and Care Wales, and Health Education and Improvement Wales to ensure we had a more complete picture across the NHS. We also sent the call for evidence to NHS Wales Shared Services Partnership (NWSSP), which is an independent mutual organisation, owned and directed by NHS Wales, that delivers a range of services for and on behalf of NHS Wales. NWSSP is hosted by and operates under the legal framework of Velindre University NHS Trust, which is itself covered by the Well-being of Future Generations (Wales) Act 2015.

We received responses from all bodies that were sent the call for evidence although in a small number of instances not all questions were answered. Where questions were not answered by all public bodies, this is set out in a note to each relevant graph.

To inform our work we held discussions with relevant stakeholders including the Welsh Government, the Office of the Future Generations Commissioner for Wales, representatives of NHS Wales and the Welsh Local Government Association. We also reviewed key documents, including policies and guidance, and other relevant information provided to us by the Welsh Government and other stakeholders.

We did not undertake a detailed review at each of the public bodies. While we have largely relied on what they reported through their call for evidence responses and any supporting documentation, we have also sought to triangulate our findings through discussions with stakeholders and evidence from our wider document and data review. We also shared and discussed our emerging findings at a public webinar held in May 2022. 109 people from outside Audit Wales attended the webinar, representing a range of public, private and third sector organisations.

As stated earlier in this report, the Auditor General has committed to a long-term programme of work on climate change. We have already reported on the decarbonisation efforts of fire and rescue authorities, we have begun to review council decarbonisation action plans and we are preparing a report on flood risk management. Following a recent consultation on our future work programme, we are considering our next steps in relation to auditing actions to decarbonise and to adapt to the changes already happening to our climate.

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Wales Wellbeing COVID-19 Research: 2021 - 2022

THE INFLUENCE OF THE COVID-19 PANDEMIC ON MENTAL WELL-BEING AND PSYCHOLOGICAL DISTRESS: ANALYSIS OF WAVE 3 DATA (OCTOBER – NOVEMBER 2021)

10th July 2022

Authored by: Chris O'Connor, Nicola S. Gray, James Knowles, Jennifer Pink, Nicola Simkiss, Stuart Williams & Robert J. Snowden

Contents

Executive Summary

This report details the results of the third survey of levels of psychological wellbeing and mental distress in the population of Wales associated with the Covid pandemic. Research monitoring the mental health and wellbeing of the population is essential in providing the understanding necessary to plan for a successful recovery process.

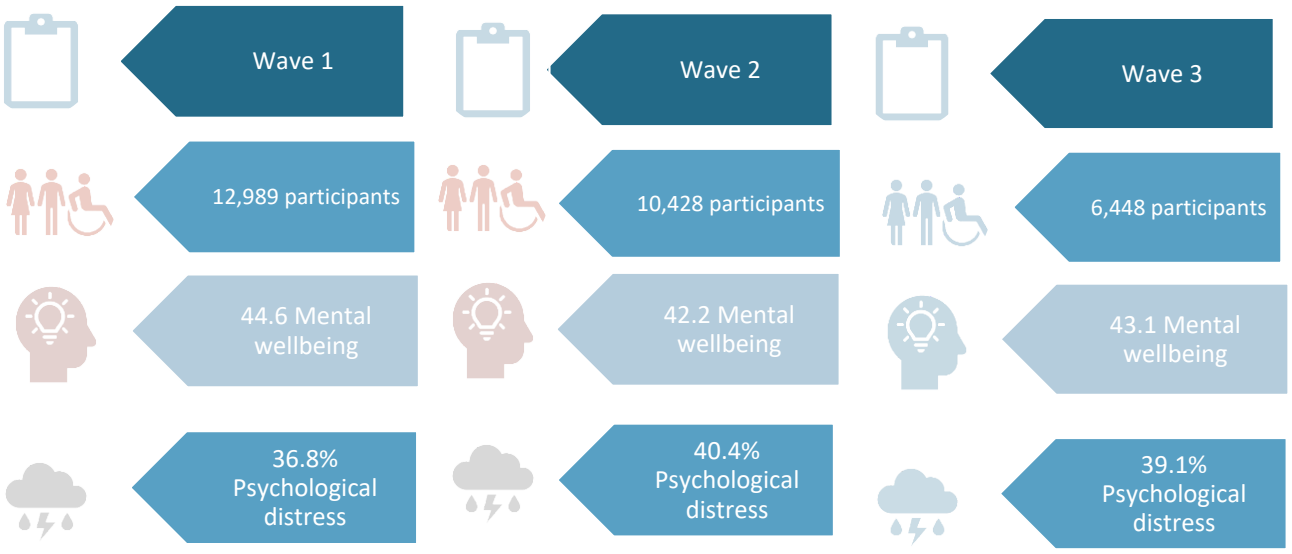
This research aims to administer a series of online surveys to the Welsh population to examine levels of psychological wellbeing and the prevalence of clinically significant psychological distress in the Welsh population as the COVID-19 crisis continues. The first survey took place between the 9thJune 2020 to the 13th July 2020 (11-16 weeks into the Welsh lockdown) and the second survey took place between the 18th January 2021 to the 7th March 2021 (4-11 weeks into the second Welsh lockdown). The present report examines data taken in the period of 4th October to 14th November 2021, just prior to the wave of infections caused by the variant Omicron which reached its peak in January 2022.

The results of the wave 3 survey indicate that there has been a small increase in mental wellbeing, and a concomitant small improvement in psychological distress, in the Welsh population since Wave 2 of data collection (January-March, 2021). Most notably, this increase in wellbeing appears to be driven by strong increases in wellbeing in young adults.

Key points:

- Population mental wellbeing scores improved slightly from an average of 42.2 points (out of 70) in the wave 2 survey, to 43.1 points in the wave 3 survey.

- Rates of clinically significant psychological distress also improved slightly and were found in 39.1% of the wave 3 sample compared to 40.4% of the wave 2 sample.



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Background

Purpose and Aims

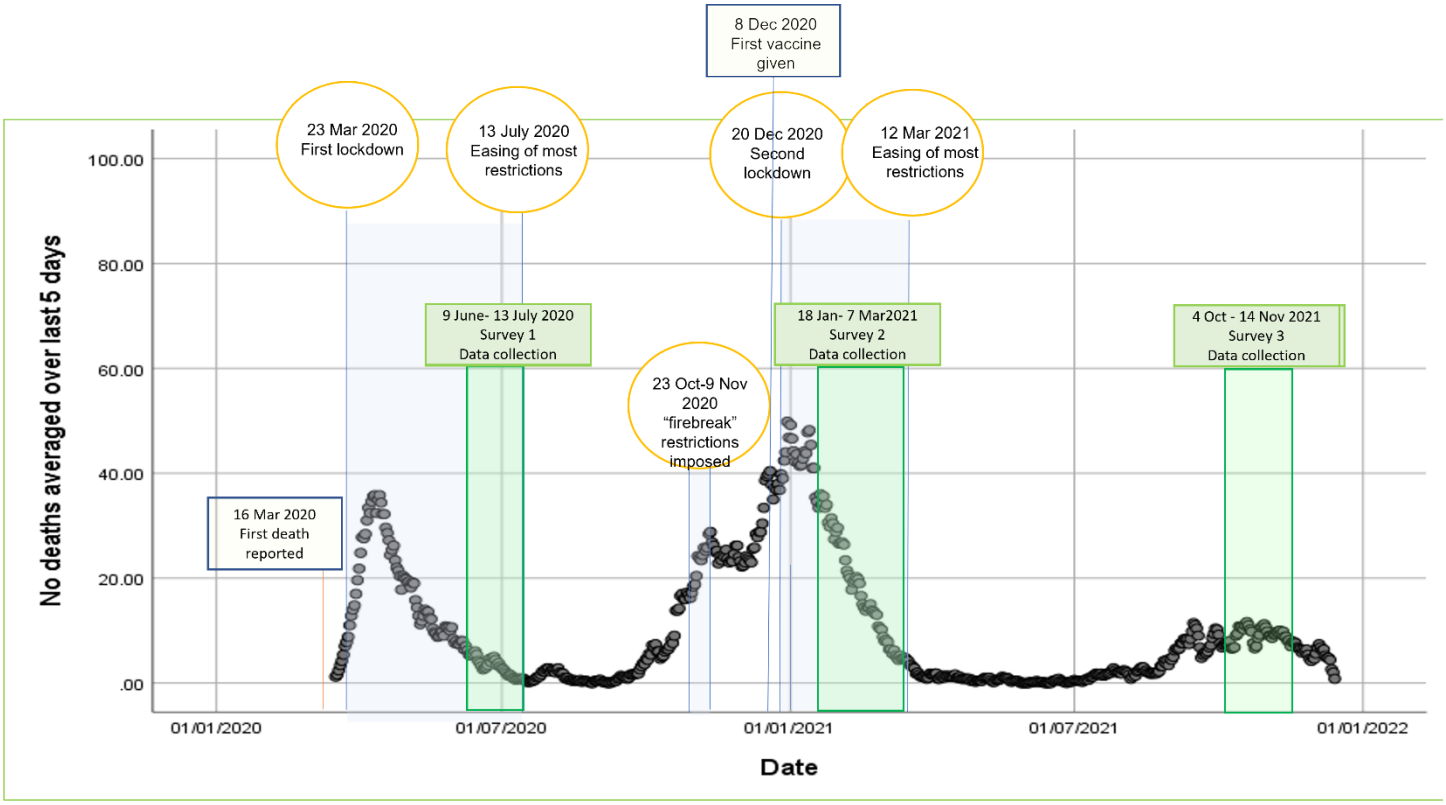
The COVID-19 pandemic has caused profound social and economic changes across the world. It has caused a wide range of problems ranging from fear for one's own safety, the loss of loved ones, economic uncertainty, and the challenging effects of physical and social isolation, all of which are likely to negatively impact the mental health and wellbeing of populations worldwide. The crisis is unique in being both continuous, and yet intermittent, in terms of the numbers of people being affected as new variants emerge and spread throughout the population, causing negative impact on health and the economy. These characteristics of the pandemic of both chronicity and intermittent severity have not yet been empirically tested in terms of the impact on the wellbeing and resilience of people in the population of Wales (and other nations). However, it seems likely that this intermittent severity, and the belief that the crisis was resolving, only to return once more, is likely to lead to feelings of helplessness and subsequent negative impact on mental wellbeing. It is therefore essential that the mental health of the nation is monitored so that services are at least armed with the knowledge of what to expect, and who among the population are most likely to be affected. A comprehensive understanding of the wellbeing needs of the population, and how this is changing overtime, facilitates the development of effective interventions and recovery strategies (Kings Fund, 2020).

This report presents the data on a third survey of the mental wellbeing of Wales.

The COVID-19 pandemic in Wales

Figure 1 illustrates some of the features of the time course of the COVID pandemic with respect to Wales.

Figure 1 – the number of deaths over time in relation to survey dates and periods of lock-down in Wales. Green shading corresponds to the dates of the survey. Blue shading corresponds to periods of national lock-down in Wales.



Following the onset of COVID in early March 2020, and the subsequent national lockdown (23rd March 2020) we aimed to sample the mental health of the nation via an on-line survey technique. This first survey took place in June-July 2020 during which the population was under the first national lockdown. The results of this survey were compared to data collected

by the National Survey for Wales (ONS, 2019) over the period of April 2018-March 2019 gathered by the National Survey for Wales (ONS, 2019) which were taken before the onset of the COVID pandemic. Details of this are reported in O'Connor et al. (2020) and in Gray et al. (2020). In summary, this first survey reported a substantial decrease in the mental wellbeing of the Welsh population with an estimated 36.8% of people reporting significant psychological distress levels compared to the expected levels of 5-10%. The survey also found that levels of distress were far higher in those of a younger age (rising to 56.9% for those age 16-24) and were somewhat higher in women than in men. Such a pattern of results has now also been reported across the UK, and across many parts of the world.

The second survey took place in January-March 2021, approximately six months after the first survey (see Figure 1). At this time Wales had entered a second period of lockdown. The results of the survey echoed that of the first survey. However, it was found that the levels of psychological distress had increased yet further (40.4 %), and, again the most affected were those of a younger age (66.3%).

The third survey, the focus of this present report, took place in October-November 2021, approximately six months after the second survey (see Figure 1). At this time Wales had been without severe restrictions for around 10 months, and the successful roll-out of the vaccination programme (Wales was the first UK nation to vaccine 50% of its population on the 25th June 2021) meant that around 75% of the population had received at least one dose of vaccine, and 70% had received two doses. Hence, it might be expected that the mental health of the nation might be improving despite the figures for infections from the virus remaining stubbornly high (between 2250 and 3000 per day during the period of this data collection).

Present Study

Monitoring the Mental Health and Wellbeing of the Population

Previous research has focused primarily on mental health difficulties experienced in populations throughout the COVID-19 pandemic. However, there is a growing emphasis in the mental health literature that mental wellbeing is not simply the absence of mental illness (Suldo & Shaffer, 2008). Mental health difficulties can be defined as "a pattern of behaving, thinking, and feeling that causes a person significant distress or impairment of functioning", whereas mental wellbeing is a construct that represents happiness and a sense of purpose which can remain even in the presence of distress or suffering (Weich et al., 2011). This research acknowledges the importance of both decreasing mental health difficulties and promoting positive mental wellbeing in the population. Therefore, this project places focus on measuring both mental health difficulties or psychological distress, and mental wellbeing.

Study Measures

This study chose to use two well-established measures relating to mental health and wellbeing:

- The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007). The WEMWBS is a measure of psychological wellbeing rather than mental distress. The two concepts are correlated, but distinct (Keyes, 2005). The construct of wellbeing recognizes that mental health is more than simply the absence of mental illness and aims to cover the whole spectrum of optimal psychological functioning and feeling. Whilst the concepts of mental distress and mental wellbeing are correlated (Keyes, 2005), they are not merely the inverse of each other, as feelings of happiness, fulfilment, and purpose can persist even in the presence of severe psychological distress (Weich et al., 2011).

- The Kessler Psychological Distress Scale (K10) (Kessler, 2002) is based on questions about anxiety and depression and is known to be closely associated with actual diagnoses of mental illness. The K10 is a well-established and validated measure for screening of mental illness and psychological distress used across the world (Goldberg et al., 1997).

Research Methods

Ethics

The study was approved by the Research Ethics Committee at the College of Health and Human Sciences, Swansea University. The project is registered with ISRCTN ref: 21598625. The study protocol is published at: http://psy.swansea.ac.uk/staff/gray/Protocol_Impact_of_COVID19_on_Mental_Health_July2020.pdf

Participants

Participants were recruited via three online surveys. The first survey took place in between June and July 2020, the second survey took place between January and March 2021. The third survey, and the focus of this report took place from the 4th October 2021 to the 14th November 2021 – see Figure 1.

Surveys

Participants were recruited via online snowball sampling. The survey was advertised via a programme of social media advertisements and emails designed to cover the population of Wales. This included emails and tweets being sent to organisations across Wales asking them to publicise the existence of the survey giving the URL of the survey website for participants to be able to access the survey. Many organisations agreed to support the research and to advertise and disseminate the survey. This included all seven Health Boards in Wales; the four police forces in Wales; the Welsh Ambulance Service Trust; the three Fire & Rescue services in Wales; many large employers across Wales, including large government organisations; care homes; homelessness organisations; GPs; the Welsh Farmers' Union; sporting organisations and third sector organisations (e.g., charitable organisations supporting specific sectors of the

community). The survey was also advertised via Facebook, newspapers, radio programmes, and celebrity tweets.

To make sure the survey recruited individuals from all areas across Wales, we attempted to gather a minimum number of participants (n = 250) from each of the 22 Local Authorities across Wales. This also ensured good coverage of all seven Health Boards across Wales. In total, 15469 logged on to the first survey (Wave 1), 13283 the second survey (Wave 2), and 8363 the third survey (Wave 3). We were successful in meeting the minimum target for all Local Authorities (LAs) for Wave 1, were successful in this for Wave 2 save for the LAs of Merthyr Tydfil (n = 176) and Wrexham (n = 180). For the third wave, we were successful in this with the exceptions of Blaenau Gwent (n = 162), Ise of Anglesey (n = 173), Merthyr Tydfil (n = 128) and Wrexham (n = 208).

For each of the surveys we then removed participants who: 1) did not complete at least 50% of the survey; 2) whose completion time was deemed too fast (< 4 min); and 3) participants who reported that they did not currently live in Wales. After these exclusions the final sample totals were, Wave 1 = 12989, Wave 2 = 10428, and Wave 3 = 6448

Measures

The survey was administered online (Qualtrics software, Version June 2020, Provo, UT, USA, Copyright © 2020 Version) for the vast majority of participants (> 99%) and was available in both English and Welsh language versions. We also had a dedicated telephone line for requesting a paper version of the survey that was widely advertised. This allowed hard to reach sectors of the population without access to the internet or without electronic devices to request a paper-based survey (with stamped addressed envelope) enabling these individuals to engage with the survey. The survey was designed to take around 10 minutes to complete.

The three surveys were largely the same. All measures described below appeared in both surveys, unless otherwise stated. The first section contained an information sheet and a consent form. The second section asked for demographic information that included questions on participants' age, gender, ethnicity and postcode (used to calculate the deprivation index). The third section included questions related to levels of wellbeing and psychological distress. The fourth section asked about COVID-19 related worries and stressors that participants were experiencing, and the final section enquired about participants' levels of hope for the future, psychological resilience, social connectedness, stress immunity and reality acceptance.

In accordance with recent ethical considerations for mental health research during the COVID-19 pandemic (Townsend et al., 2020), participants were informed that the study would ask questions about their emotional wellbeing before they were asked to provide fully informed consent. There was also a mood restoration section at the end of the survey that attempted to mitigate any distress caused by the survey. At the end of the study, participants were also provided with a debrief form that thanked them for their role in the research and signposted them to three separate services available across Wales that offered free 24/7 confidential listening and support services via telephone, SMS messaging, or e-mail. Participants were encouraged to contact these services if they were experiencing any current emotional difficulties.

Wellbeing

Current mental wellbeing (over the past two weeks) was assessed via the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007). The WEMWBS contained 14 items

covering issues such as positive affect, level of functioning, and relationships over the past two weeks. Items are answered on a five-point Likert scale with respect to frequency (from “none of the time” to “all of the time”) to give a score ranging from 14 to 70, with greater scores indicating greater wellbeing.

Psychological Distress

Current level of psychological distress was assessed by the Kessler Distress Scale (K10; Kessler, et al., 2002). The standard K10 asks people to rate distress over the past 30 days. However, we chose to amend this to over the past two weeks to match the time period of the WEMWBS. The K10 contains 10 items measuring current psychological distress and, in particular, symptoms of anxiety and depression. Items are rated on a five-point Likert scale with respect to frequency (from “none of the time” to “all of the time”) to give a score from 10 to 50, with greater scores indicating greater levels of psychological distress.

Welsh Index of Multiple Deprivation

The Welsh Index of Multiple Deprivation (WIMD) is produced by the Welsh Government (2019) and is a measure of relative deprivation for 1,909 areas of Wales (1 = most deprived, 1909 = least deprived), with each area containing an average of 1,600 people. It defines deprivation as “the lack of access to opportunities and resources which we might expect in our society” (p 14). Participants’ WIMD rank was calculated using their postcode information.

Research Findings

Demographics

Demographics from the surveys are displayed in Table 1. Relative to the demographics of the population of Wales the current sample underrepresented men, young individuals (aged 16-24) and older adults (aged 75+). Therefore, all statistical analyses were stratified by gender and by age, so that any differences in wellbeing or psychological distress due to gender or age would not affect the results reported.

Wave 3 Survey

An examination of the data from the Wave 3 survey showed a similar pattern of results to the previous surveys (see Table 2). Levels of mental wellbeing were lower in women, younger people, and in those from more deprived areas (all *p*s < .001). Levels of psychological distress (see Table 3) were also greatest in women, younger people, and those from more deprived areas (all *p*s < .001).

Wellbeing

Figure 2 compares the mean scores on the wellbeing measure (WEMWBS) for the three waves of data, it also includes national wellbeing data from the 2018-2019 National Survey for Wales (ONS, 2019) for comparison purposes. Descriptive statistics are also displayed in Table 2. Overall, the data showed a small increase in wellbeing for the Wave 3 data (October-November 2021) in comparison to Wave 2 (January-March 2021), $t(16864) = 5.42$, $p < .001$, representing a 0.9 increase in WEMWBS score or an effect size of $d = 0.09$.

Table 1. Demographic characteristics for the three waves and ONS data for mid 2020.

	Welsh Population Statistics (mid 2020)	Wave 1 (%)	Wave 2 (%)	Wave 3 (%)

Total		3,169,586 (100.0)	12,989 (100.0)	10,428 (100.0)	6, 448 (100.0)
Gender	**Male**	1,563,524 (49.3)	2,490 (19.2)	1,460 (14.0)	962 (14.9)
	Female	1,606,062 (50.7)	10,391 (80.0)	7,893 (75.7)	4, 825 (74.8)
	Other	-	25 (0.2)	17 (0.2)	25 (0.4)
	Prefer not to say/no response	-	83 (0.6)	1,058 (10.1)	636 (9.8)
Age	**16-24**	345,604 (10.9)	703 (5.4)	506 (4.9)	112 (1.7)
	25-34	404,786 (12.8)	1,870 (14.4)	1,359 (13.0)	428 (6.6)
	35-44	358,803 (11.3)	2,647 (20.4)	2,055 (19.7)	841 (13.0)
	45-54	409,425 (12.9)	3,254 (25.1)	2,498 (24.0)	1,531 (23.7)
	55-64	419,648 (13.2)	2,761 (21.3)	2,381 (22.8)	1,893 (29.4)
	65-74	361,841 (11.4)	1,356 (10.4)	1,302 (12.5)	1,295 (20.0)
	75+	306,749 (9.7)	398 (3.1)	327 (3.1)	348 (5.4)
Ethnicity	**White - any**	96.4	96.6	97.3	97.4
	Asian - any	1.7	1.0	0.6	0.4
	Black - any	0.5	0.1	0.2	0.1
	Mixed - any	0.5	0.8	0.8	0.7
	Other	0.8	0.6	0.6	0.6
	Prefer not to say/no response	0.1	0.8	0.7	1.2
Relationship status	**Single**	28.4	14.2	13.8	13.7
	Married/civil partner	45.2	54.7	56.0	55.5
	Co-habiting	-	14.5	13.6	10.6
	Partner non-cohabit	-	14.2	5.2	4.3
	Separated	2.4	1.5	1.7	2.0
	Divorced	11.8	5.0	5.1	7.3
	Widowed	12.2	3.1	3.3	5.3
	Other	-	0.5	0.6	0.3
	Prefer not to say/no response	0.1	0.6	0.7	1.0

Employment	**Paid employment**	46.3	65.7	58.6	50.7
	Self-employed		3.9	4.2	5.8
	Student	3.7	3.7	4.9	2.9
	Apprentice	-	0.2	0.1	<0.1
	Unemployed	2.1	1.1	1.0	1.2
	Long term sick/disability	5.5	3.2	3.8	7.0
	Retired	36.6	15.0	18.7	28.6
	Furloughed	-	4.4	2.9	-
	Stay at home parent	4.7	1.8	2.1	1.5
	Full time carer		0.3	1.6	2.2
	Other	0.8	0.0	2.9	3.5
	Prefer not to say/no response	0.0	0.7	0.4	0.4

Gender

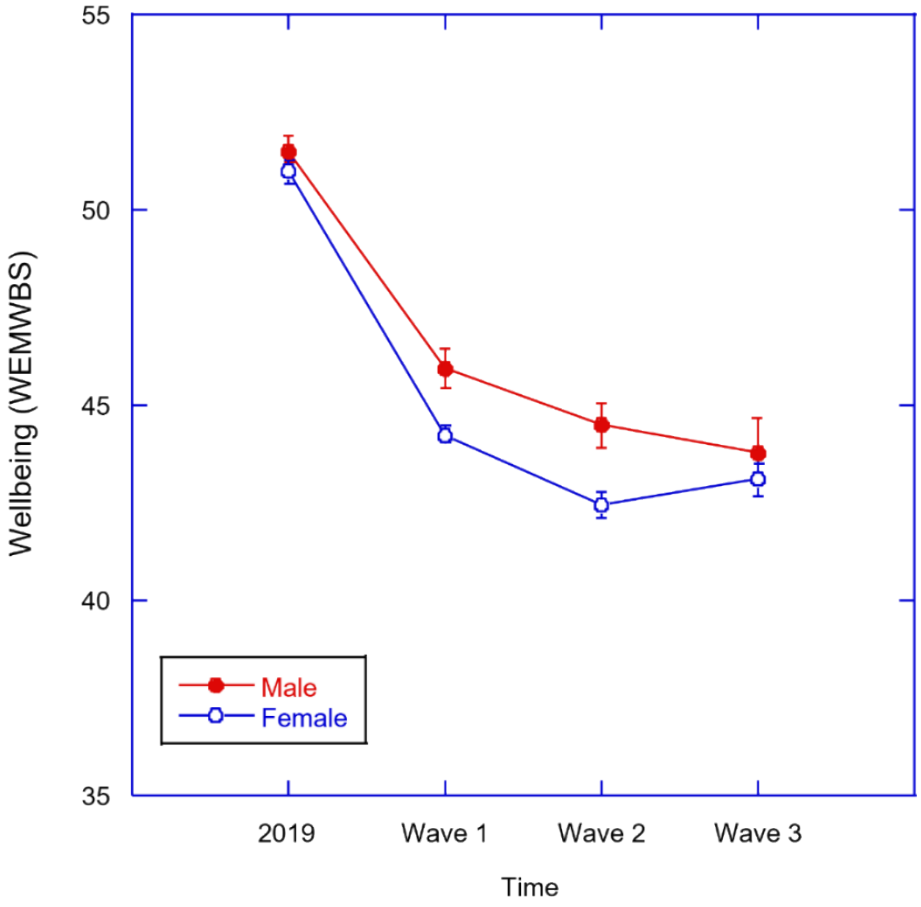
Compared to Wave 2 there was a significant increase in wellbeing for women, +1.1 points, $t(12710) = 5.96$, $p < .001$, $d = 0.09$, whilst there was no significant change for men, – 0.3 points, $t(2420) = 0.65$, $p = .53$. Indeed, while the previous surveys showed the wellbeing scores were significantly greater for men, the difference in wellbeing scores between genders was not significant in Wave 3, +0.8 points, $t(5781) = 1.87$, $p = .06$, $d = 0.09$.

Table 2. Mean scores on the WEMWBS (wellbeing measure) for the three waves.

Sample	**Wave 1 [95% CI]**	**Wave 2 [95% CI]**	**Wave 3 [95% CI]**	**Change wave 2 to 3**

All		44.6 [44.4 – 44.8]	42.2 [42.0 – 42.4]	43.1 [42.8 – 43.4]	0.9
Gender	**Male**	46.0 [45.5 – 46.4]	44.0 [43.4 – 44.6]	43.7 [42.9– 44.4]	-0.3
	Female	44.2 [44.0 – 44.4]	41.9 [41.6 – 42.1]	43.0 [42.6 – 43.3]	1.1
Age	**16-24**	41.3 [40.6 – 42.0]	37.8 [37.0 – 38.6]	42.5 [40.6 – 44.4]	4.7
	25-34	41.4 [41.0 – 41.8]	38.3 [37.8 – 38.8]	41.1 [40.2 – 42.1]	2.8
	35-44	43.2 [42.9 – 43.6]	40.2 [39.8 – 40.6]	40.9 [40.2 – 41.5]	0.7
	45-54	44.9 [44.6 – 45.3]	42.1 [41.8 – 42.5]	41.6 [41.0 – 42.1]	-0.5
	55-64	45.7 [45.3 – 46.1]	43.6 [43.2 – 44.0]	43.2 [42.7 – 43.7]	-0.4
	65-74	48.6 [48.1 – 49.1]	46.9 [46.3 – 47.5]	45.7 [45.0 -46.3]	-1.2
	75+	49.9 [49.0– 50.9]	49.6 [48.4 – 50.8]	48.0 [46.8 – 49.2]	-1.6
WIMD Rank	**1 (most deprived)**	43.5 [43.0 – 43.9]	40.7 [40.2 – 41.2]	41.5 [40.8 – 42.2]	0.8
	2	44.7 [44.2 – 45.1]	42.5 [42.0 – 43.0]	42.9 [42.2 – 43.6]	0.4
	3	45.2 [44.8 – 45.7]	43.4 [42.9 – 43.9]	44.1 {43.4 – 44.8]	0.7
	4	45.4 [45.0 – 45.9]	43.3 [42.8 – 43.8]	44.1 [43.4 – 44.8]	0.8
	5 (least deprived)	46.3 [45.9 – 46.7]	44.2 [43.7 – 44.7]	45.2 [44.6 – 45.9]	1.0

Figure 2. Mean wellbeing scores for men and women on the WEMWBS for the three surveys.



Age

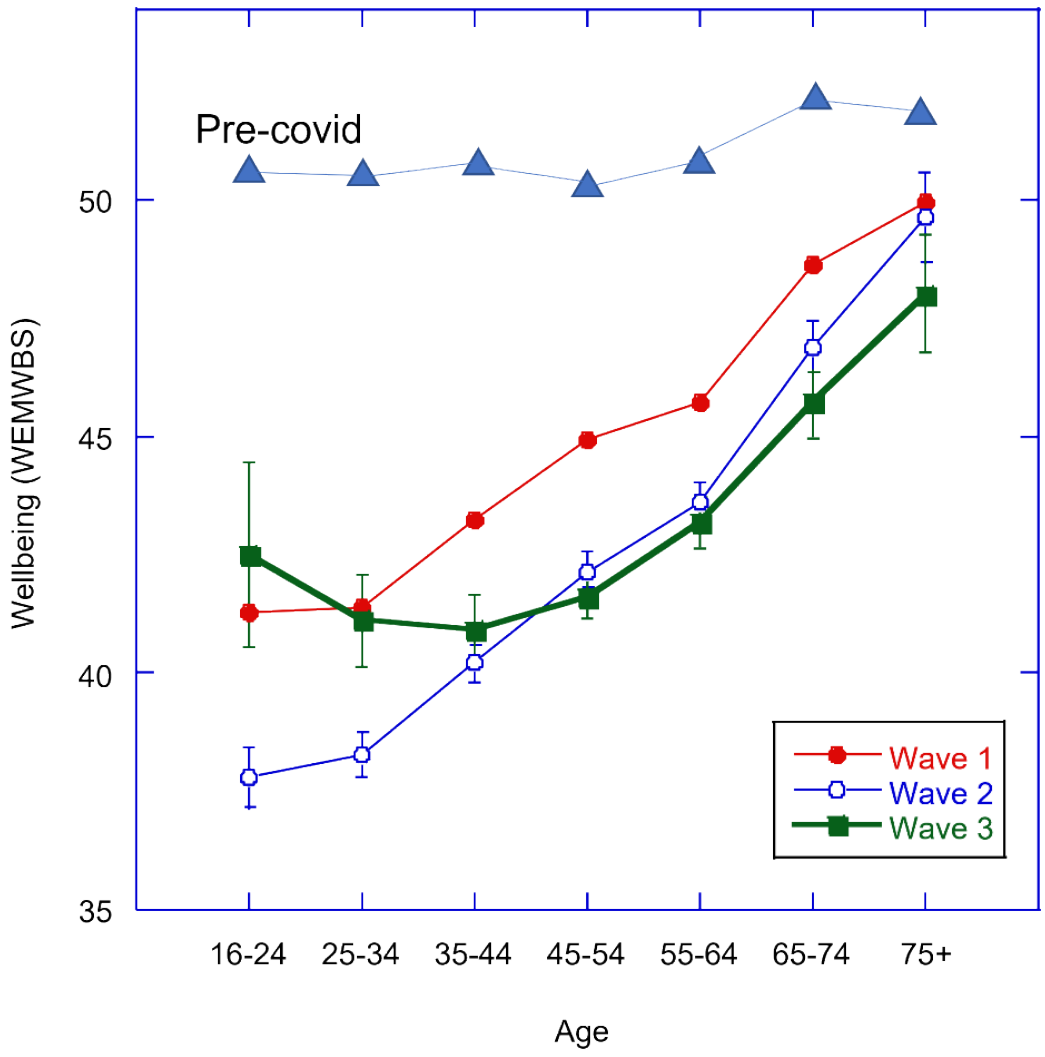
As in the previous waves of data, there was a strong influence of age, $F(1, 6) = 40.86$, $p < .001$, $\eta p^2 = .04$, with those in the youngest age groups showing the lowest levels of mental wellbeing (see Figure 3).

In comparison to the data from Wave 2, we found that wellbeing was differentially affected by age, $F(6, 16852) = 9.78$, $p < .001$, $\eta p^2 = .023$. This interaction was explored by a series of t-tests for each age category. The two youngest age groups (16-24, 25-34) both showed significant increases in wellbeing from Wave 2 to Wave 3 (*p*s < .001), the middle range age groups (35-44, 45-54, 55-64) did not show any significant changes, while the two oldest groups (65-74, 75+) showed a small, but significant decrease in wellbeing (*p*s < .05).

Socioeconomic Deprivation

As in the previous waves of data, there was a significant effect of level of deprivation upon mental wellbeing, $F(4, 4743) = 16.58$, $p < .001$, $\eta p^2 = .014$, with the most deprived group having a score of 41.5 compared to the least deprived score of 45.2. However, there was no interaction between level of deprivation and the time of the survey (wave1, wave 2, wave 3). Hence, the small improvement in mental wellbeing was fairly evenly distributed across areas with different levels of deprivation.

Figure 3. Mean scores for wellbeing for each age group on the WEMWBS for the three surveys



Conclusion: Levels of wellbeing have increased by a small amount between Waves 2 (January-February 2021) and Wave 3 (October-November 2021). These improvements have mainly been seen in those that were most previously hard-hit, namely those in the younger age groups, and in women.

Psychological Distress

The K10 was included in this study because of its well-established ability to categorise people in terms of clinically significant levels of mental distress. The K10 can be used to classify people as “psychologically well (0-19)”, “mild mental distress (20-24)”, “moderate mental distress (25-29)”, and “severe mental distress (30+)”. For the purposes of analysing levels of distress in the population, we used the cut-off of 25 or more to define people who had a “moderate or severe level of mental distress”. Past research has demonstrated that individuals scoring above 25 on the K10 have a 69.4% chance of meeting the criteria for a DSM-IV mental disorder in the past year (Andrews & Slade, 2001).

Overall, 39.1% of the sample were suffering from moderate to severe distress in the Wave 3 sample, compared to 40.4 % in the Wave 2 sample, a decrease of 1.3 percentage points representing a 3.2% decrease in prevalence. However, this did not constitute a significantly different change, $\chi 2(1) = 2.44$, $p = .12$.

To understand if this improvement in rates of psychological distress was influenced by gender, age, or socioeconomic deprivation, a series of logistic regressions examined which demographic factors influenced improvements in rates of psychological distress. Table 3 displays the rates of moderate to severe psychological distress for each demographic group during the Wave 2 and Wave 3 surveys.

Gender

In terms of change in psychological distress from Wave 2 to Wave 3, it appears that rates distress for men increased slightly from Wave 2 to Wave 3 (2.0 percentage points) while rates

Table 3. Prevalence of Psychological Distress

		Wave 1		Wave 2		Wave 3		Wave 2 to 3 change
		K10 ≥ 25 (%)	Odds ratio	K10 ≥ 25 (%)	Odds ratio	K10 ≥ 25 (%)	Odds ratio	
Overall		36.8	-	40.4	-	39.1		-1.3
Gender	Male	29.9	1.00	34.8	1.00	36.8	1.00	+2.0
	Female	38.5	1.47	41.5	1.33	39.7	1.13	-1.8
Age	16-24	56.9	6.67	66.3	10.00	50.4	3.68	-15.9
	25-34	52.2	5.52	57.2	6.76	46.8	3.18	-10.4
	35-44	40.1	3.38	46.1	4.33	45.4	3.00	-0.7
	45-54	33.9	2.59	40.1	3.38	45.1	2.97	+5.0
	55-64	32.0	2.38	32.6	2.44	39.1	2.32	+6.5
	65-74	21.8	1.41	24.5	1.64	28.9	1.47	+4.4
	75+	16.4	1.00	16.7	1.00	21.7	1.00	+5.0
WIMD	1 (most deprived)	40.8	1.63	48.0	2.18	46.2	2.00	-1.8
	2	35.8	1.32	39.9	1.56	39.2	1.50	-0.7
	3	35.6	1.30	35.6	1.30	35.4	1.28	-0.2
	4	34.8	1.25	34.2	1.22	34.6	1.23	+0.4
	5 (least deprived)	27.9	1.00	32.2	1.00	30.0	1.00	-2.2

of distress for women decreased (by 1.8 percentage points). However, these differences were not statistically significant, $\chi 2(2) = 2.19$, $p = .14$.

Age

As in both Wave 1 and Wave 2, rates of psychological distress were greater in the younger age groups than in the older age groups, β = -0.21, SE = 0.02, Wald = 122.74, p < .001, Exp(B) = 0.808. However, the magnitude of this age imbalance in distress has decreased considerably. Whereas the younger age group had an odds-ratio of 10.00 in comparison to the oldest group for Wave 2 (meaning that rates of distress were 10 times greater for the younger group), this had now shrunk to 3.68 for Wave 3. Notably, rates of distress have decreased for the youngest age groups (< 34 years), while rates have increased for the older age groups (> 45).

Socioeconomic Deprivation

As in the previous two waves of study, there was a significant effect of socioeconomic deprivation. β = -0.16, SE = 0.02, Wald = 54.18, *p* < .001, Exp(B) = 0.852, with the most deprived areas showing the greater levels of psychological distress. However, this pattern was unchanged from Wave 2.

Conclusion: Rates of moderate to severe psychological distress have decreased slightly from the Wave 2 to the Wave 3 survey. However, this change was not evenly distributed across the demographic groups. Notably, there were quite large improvements in rates of distress among the younger age groups, with increased distress being noted for the older age groups.

Health Boards

Comparing rates of psychological distress across Health Boards for the Wave 3 survey showed that Powys Teaching Health Board had the greatest levels of distress (43.4% meeting the criteria for moderate to severe psychological distress) which resulted from a sharp and statistically significant rise in prevalence in comparison to Wave 2 (31.1%). However, we note the sample size for this Health Board. The only other statistically significant change from Wave 2 to Wave 3 was for Aneurin Bevan University Health Board which showed a 20.4% improvement in the prevalence of distress.

Table 6. Percentage of participants experiencing moderate to severe psychological distress (K10) for each of the seven Health Boards across the three study waves.

Health Board	Number of Participants	Percentage experiencing moderate to severe psychological distress	Percent change

		Wave 1	Wave 2	Wave 3	
Aneurin Bevan University Health Board	**Wave1: 2470** **Wave2: 3486** **Wave3: 1121**	**34.4%**	**44.7**	**35.6**	**- 20.4***
Betsi Cadwaladr University Health Board	**Wave1: 2464** **Wave2: 1817** **Wave3: 1549**	**44.2**	**39.1**	**41.1**	**+ 5.1**
Cardiff & Vale University Health Board	**Wave1: 1625** **Wave2: 1187** **Wave3: 857**	**32.6**	**41.4**	**39.8**	**- 3.9**
Cwm Taf Morgannwg Health Board	**Wave1: 903** **Wave2: 777** **Wave3: 702**	**33.9**	**39.1**	**40.0**	**+ 2.3**
Hywel Dda Health Board	**Wave1: 2937** **Wave2: 1523** **Wave3: 1116**	**35.4**	**36.1**	**37.5**	**+ 3.9**
Powys Teaching Health Board	**Wave1: 312** **Wave2: 249** **Wave3: 297**	**31.5**	**32.1**	**43.4**	**+ 35.2***
Swansea Bay University Health Board	**Wave1: 1881** **Wave2: 1194** **Wave3: 754**	**38.0**	**36.3**	**41.8**	**+ 15.2**

* difference in rates between Wave 2 and Wave 3 significant *at p* <.01

Protective factors

This analysis aims to look at the factors that protect against the negative impact of the pandemic. To examine the extent to which each of these factors 'protected' against poor wellbeing, we conducted a series of correlations that looked at the relationship between

wellbeing scores and scores on each of the protective factors (hope, resilience, stress immunity, and reality acceptance). If the factor protected against poor wellbeing, we would expect to see a positive relationship between the protective factors and wellbeing.

To examine the extent to which each factor 'protected' against the development of moderate to severe psychological distress, we split participants into two groups based on their score on each protective factor (for details see Table 7). For example, when we examined the protective factor of hope, participants who reported high hope (scores of 3 or 4) were put into the 'high hope' group and participants who reported low hope (scores of 0 or 1) were put in the 'low hope' group. We then examined whether the 'low hope' group experienced more moderate to severe psychological distress compared to the 'high hope' group. We then calculated the odds ratios for this (described previously). This analysis was completed for each protective factor in turn. Table 7 describes how each protective factor was related to participants' wellbeing along with the degree to which that factor protected individuals from experiencing psychological distress.

Conclusion: All protective factors were positively associated with wellbeing levels and were linked to smaller rates of psychological distress. Levels of hope and resilience appeared to be the most powerful factors for maintaining good mental health and wellbeing during the COVID-19 pandemic.

Table 3. Protective factors relationships with wellbeing and psychological distress in the third survey.

Protective Factor	Relationship with Wellbeing	Adjusted Odds Ratio for Psychological Distress (95% CI)	What it Means

	(Correlation Coefficient: *r*)		
Hope	.68*	16.0 (13.3 – 19.2)*	The more hope someone had, the higher their wellbeing. People with low levels of hope (scores 0 or 1) were 16.0 times more likely to experience moderate to severe psychological distress than someone with high hope (scores of 3 or 4).
Resilience	.60*	8.3 (7.1 – 9.8)*	The more resilience someone had, the higher their wellbeing. People with low levels of resilience (scores of 0 -17) were 8.3 times more likely to experience moderate to severe psychological distress than someone with high resilience (scores of 19 - 30).
Stress immunity	.42*	3.4 (2.9 – 4.0)*	The higher a person's stress immunity, the higher their wellbeing. People with low levels of stress immunity (scores of 6 -14) were 3.4 times more likely to experience moderate to severe psychological distress than those with high scores (16-24).
Reality acceptance	.21*	2.3 (2.0 – 2.6)*	The more accepting of reality someone was, the higher their wellbeing. People with low levels of reality acceptance (scores of 0-22) were 2.3 times more likely to experience moderate to severe psychological distress than those with high scores (24-30).

* $p < .01$

Limitations

It is noticeable that the sample sizes across the waves of data collection are becoming smaller, with the size of Wave 3 being around a half that of Wave 1 despite using the same methods of data collection. The reduction in numbers was most notable in the younger age groups. This reduction would most readily be accounted for by a "Covid fatigue" effect and a waning in interest in the pandemic (Skulmowski & Standl, 2021) and in completing research questionnaires and surveys (Patel, Webster, Greenberg, Weston, & Brooks, 2020). If the Welsh-Wellbeing survey is to continue to produce high quality data for the NHS then it needs to consider methods to maintain or increase the uptake of the survey, with particular emphasis on how to increase participation in those in the younger age groups.

Participants in all three waves of the study were recruited using online convenience sampling methods. Whilst this method facilitated the recruitment of many participants across all regions of Wales, this sampling method often attracts volunteers who are already engaged with, and interested in, the topic and excludes those who have difficulty accessing the internet (despite our strong efforts to overcome this with telephone access and paper-based surveys). This may means that the sample cannot be considered to be fully representative of the Welsh population (Pierce et al., 2020). Relative to the demographics of the population of Wales the current sample underrepresented men, young individuals (aged 16-24) and older individuals (aged 75+). However, these characteristics were present in all three samples. Thus, the findings of a further decline in mental wellbeing (and the moderating effects of age), alongside an improvement in psychological distress cannot be attributed to the sampling method used. However, more detailed statistical analysis of the Wave 1 and Wave 2 data that attempted to correct[††] the estimate of wellbeing based on the sample taken relative to the general population of Wales did not find any change in the pattern of results produced (Knowles, Gray, John, O'Connor, Pink, Simkiss, & Snowden, *Advances in Mental Health*, 2022). Hence, there is no evidence that our sampling techniques has produced a bias in the results.

[††] For instance, our sample contained a smaller percentage of men than the general population of Wales, so the data for men are given greater "weight" in this correction process to make up for their poorer representation in the sample collected. This process was done for age, gender, and Local Authority.

Conclusion

The present data (Wave 3: October-November 2021) indicate that there has been a small increase in mental wellbeing, and a concomitant small improvement in psychological distress, in the Welsh population since Wave 2 of data collection (January-March, 2021). Most notably, this increase in wellbeing appears driven by strong increases in wellbeing in young adults. Taken with our earlier findings that this group of young adults was the most affected by the COVID pandemic, it would seem logical to conclude that the measures designed to limit the spread of COVID infection (e.g., lockdown, a lack of social interaction) affected younger people the most, and that the easing of these restrictions has therefore had the greatest beneficial effect in these groups.

Following the completion of the third survey Wales once again faced a period of uncertainty due to the influence of the Omicron variant and the significant increase in Covid infection rates. The continued monitoring of the mental wellbeing of the nation, and of specific sub-groups within it, is therefore needed for services to be warned, and therefore ready, to respond to the needs of our community.

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