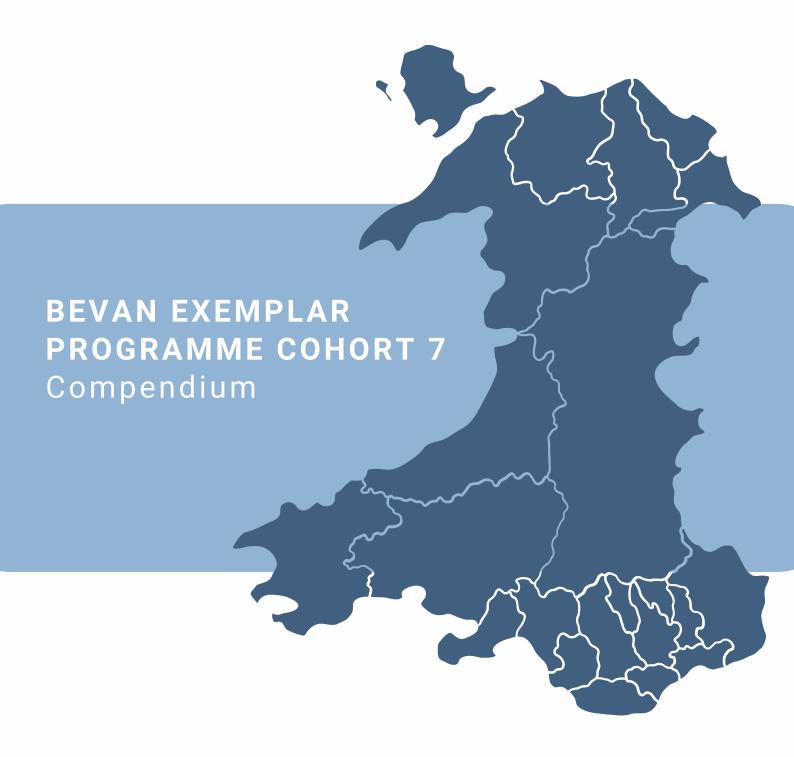
Comisiwn Bevan Commission



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The world will not be destroyed by those who do evil, but by those who watch them without doing anything.

Albert Einstein

FOREWORD

As Director of the Bevan Commission, it is with great pride, pleasure and admiration that I introduce this compendium of projects from our seventh cohort of Bevan Exemplars.

Each project highlights the creativity, commitment and courage of individuals working at the very heart of health and care in Wales.

The Bevan Exemplar programme continues to demonstrate the power of front-line innovation, providing a platform for professionals to develop and test ideas that improve services,



outcomes, and experiences for the people of Wales. This cohort, like those before it, has shown remarkable resilience in the face of ongoing pressures, finding new ways to deliver better, more sustainable care.

What makes this programme so unique is not just the diversity of the projects, but the collaborative spirit that underpins them. Our Exemplars have engaged with colleagues, patients, communities, and partners to co-create solutions that are grounded in real-world challenges and shaped by lived experience. In doing so, they are helping to transform not only what we do, but how we do it.

The work presented here is a testament to what can be achieved when we invest in people, support bold thinking, and nurture a culture of learning and improvement. I would like to thank each of our Exemplars, their teams, and supporters for their dedication, and for embodying the Bevan Commission's values of prudent, person-centred innovation.

I encourage friends and colleagues across health and care to engage with these projects, to champion their benefits and work together to adapt and embed these into everyday practice. By doing so, we can ensure that the work of Cohort 7 delivers enduing improvements in patient care and service efficiency.

In closing, I hope this compendium serves as both a celebration and an inspiration — a spark for future ideas and a reminder that meaningful change often begins with a single, passionate individual willing to try something new.

Helen Howson

Director

Bevan Commission

INTRODUCTION The Bevan Exemplar Programme Cohort 7

The Bevan Commission's Exemplar Programme supports health and care professionals from across Wales to take their innovative prudent health and care ideas and try out and test these in practice. The 12-month programme provides training and mentorship to inform thinking and develop skills so Exemplars can transform health and care services from within, having positive impacts on patient care, lived experiences, health outcomes and on service efficiency.

The Bevan Exemplar programme is open to anyone working in NHS Wales, Social Care Wales, Local Government or within Regional Partnership Boards.

The Bevan Exemplar Programme call for Cohort 7, 'Doing things differently for a prudent, sustainable recovery,' challenged applicants to develop prudent and innovative solutions to overcome issues facing health and care services in Wales. Applications were encouraged around the following themes, aligned with Welsh Government and NHS Wales priorities:

- Using digital and technological solutions to do things differently.
- Working in different ways and with different people.
- A different approach to reduce waste and achieve sustainable health and care without harm.
- Cutting bureaucracy, empowering people and managing shared risks.
- Developing innovative actions around shared priorities, such as connecting with hard to reach groups.
- Collaborating to make the most of all skills and resources and doing only what's needed.
- Priorities consistent within local organisations and collaborative working.

For further information on all our projects, including video testimonials and patient case studies, please visit https://bevancommission.org/programmes/bevan-exemplars/.





Aneurin Bevan University Health Board Bevan Exemplars

Mini MOVE: Collaborating Towards a Better Future for Children with Physical Disability | ABUHB and MOVE Europe

Jo Wood, Jennie Christie and Louise Leach - ABUHB; Charlotte Peck, Emma Dyer and Verity Sowden - MOVE Europe | Contact: Louise.leach@wales.nhs.uk / Charlotte.peck@moveeurope.org.uk

Project Background:

The MOVE Programme is currently used by over 130 UK ALN schools to support over 1,100 children to develop and maintain functional physical skills. 'Mini MOVE', an adapted MOVE Programme framework, would address provision inequity by providing early years and mainstream education settings with the knowledge and skills necessary to support children with physical disability, empowering both families and staff.

Project Objectives:

- Deliver an earlier and immediate response for children facing delays as a result of the Covid-19 backlog.
- Develop an adapted MOVE assessment framework and delivery model and pilot this on patients from 18 months – 5 years old across the ABUHB geography.
- Provide families with a proactive model to engage with education and health.



Project Methodology:

To achieve the objectives, the Paediatric Physiotherapy team from ABUHB and MOVE Europe co-produced a Mini MOVE assessment framework to trial with 14 children accessing mainstream early years provision within the ABUHB geography. Skill progress was tracked through GAS Goals and number of skills gained, and family engagement was evaluated through conversations with parents/carers.

Project Outcomes:

A Mini MOVE framework was developed for use in early years settings across the ABUHB geography to support children with physical disability to gain lifelong functional skills and improve their health outcomes.

"I was a bit nervous with him starting nursery because they never had experience with children like him, but they are a lot more confident after using Mini MOVE!" - Parent



Figure 1: Progress made towards shared goal

Project Impact:

14 children aged 18 months - 5 years accessing mainstream early years provision in the ABUHB geography were assessed using the Mini MOVE framework and began following programmes.

- 100% of the children either met or made progress towards their goal (see Figure 1), with 28% making significantly more goal attainment than expected (see Figure 2).
- Over the short 3-month pilot period, 100% of the pilot group gained 3 or more skills, with 2 children making significant progress, gaining 18 and 21 skills respectively (see Figure 3).
- Thematic analysis of family and education staff feedback showed that families and mainstream and early years provisions responded positively to Mini MOVE's "accessible" framework.

Project Conclusions:

The development of a holistic early intervention for children with physical disabilities can support them to develop lifelong functional skills resulting in improved health and wellbeing outcomes. This also has significant implications for Welsh Health Boards in regard to increasing capacity of Physiotherapists and reducing costs of specialist intervention, resources, and equipment.



Figure 2: Change in GAS goals
Skill Gains

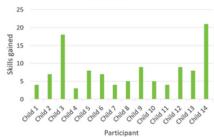


Figure 3: Number of skills gained per participant

Diagnostic Spirometry Hubs | ABUHB

Natalie Janes, Lloyd Hambridge, Angela Andrews and Lisa Morgan - ABUHB Contact: Natalie.Janes@wales.nhs.uk / lloyd.hambridge@wales.nhs.uk

Project Background:

90% of COPD and asthma patients are diagnosed within their GP practice. The provision of diagnostic spirometry across primary and community care was severely disrupted by the Covid-19 pandemic. Spirometry was suspended in these settings in line with national guidance and as a result, alternative methods to perform diagnostic spirometry were required. This project introduced diagnostic spirometry hubs across ABUHB to undertake spirometry and fractional exhaled nitric oxide (FENO) testing, interpretation, confirm diagnosis and where necessary determine appropriate treatment and management pathways. It also supported the educational and training requirements for health care professionals.

Project Objectives:

To address the backlog of patients awaiting diagnostic spirometry testing within primary and community care services to:

- Reduce waiting list/time to test.
- Improve treatment outcomes, ensuring prudent prescribing / appropriate medicines management.
- Reduce A&E attendance, OOH, GP, and secondary care service contacts.
- Provide services and care closer to home in line with 'A Healthier Wales'.
- Ensure primary and community health care professionals are appropriately trained, certified, and have the required competence to undertake spirometry.

Project Impact:

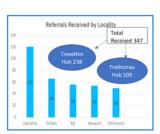
- Provision of a prudent healthcare model has enabled patients to access specialist advice and services within primary and community settings, providing a more efficient service/shorter patient pathway.
- Detailed assessment and management of respiratory conditions targeting those with greatest need and diagnosis within reduced timeframes.
- Enhancement of services that were previously available, providing future sustainability, and increasing capacity.
- Reduction in inappropriate referrals into specialist secondary care, reducing costs.

Project Methodology:

To ensure appropriate geographical coverage, two diagnostic hubs were set up in the north and south of ABUHB, operating 4 days a week. The consultations were carried out by ARTP trained RGN/HCSW which allowed for comprehensive assessment, diagnosis, treatment, and management services. Evaluation of the service was completed by collecting both quantitative and qualitative data. Patient satisfaction surveys allowed patients views of service and quality of care received to be collated, which supports continuous improvement methodology.

Project Outcomes:

The diagnostic hubs in both the north and south afforded patients the opportunity to receive a diagnostic spirometry test during Covid-19 restrictions, supporting earlier diagnosis and onward care where required.



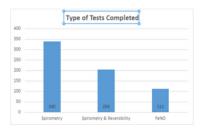


Fig. 1: No. of referrals received (Left). Type of tests completed (Right).

The model enabled improved capacity within secondary care, improving diagnosis, management, and treatment outcomes, which supported practices to focus efforts on tackling the backlog of annual asthma and COPD reviews built-up during the pandemic. 347 risk stratified patients were reviewed of which 136 patients had a change in referral diagnosis. These patients were having significant symptoms affecting QOL. 31 had an admission to hospital and 7 had admission to ITU in past 12 months. 104 patients had 2 more previous exacerbations in past 12 months.

Project Conclusions:

- The development of the diagnostic spirometry hubs enabled patients to receive a timely, holistic respiratory assessment with accurate diagnosis and ongoing treatment management.
- Patients with respiratory conditions have a significant impact on NHS care particularly during the winter period. Reduced
 waiting lists and improved access to services, therefore, reduce impact on hospital admissions by accurate early diagnosis
 and ongoing self management support.
- Implementation of innovative new models of prudent service delivery, allowing easy access to patients for specialist advice whilst empowering them to look after their own health and well being will improve quality of life of patients with respiratory conditions within the community.

Heart Failure Rehabilitation Closer to Home: A Community Hub

ABUHB

Linda Edmunds, Emma Davies, Hayley Rose, Nadine Eckford, Mark Harris, Rachael Prosser and Maria Davies - ABUHB Contact: karen.hazel@wales.nhs.uk

Project Background:

ABUHB were successful in securing funding for a fixed-term project to test a community model for rehabilitation and review of heart failure patients in the Caerphilly Borough. Caerphilly was chosen due to its:

- 1. High prevalence of heart failure (HF).
- 2. High readmission rate to secondary care in 30 days = 25% in Caerphilly compared to 11% across ABUHB.
- 3. Only 4% of patients accessed Cardiac Rehab in this area.

Project Aims and Objectives:

- To test a different model to reduce readmissions, increase cardiac rehabilitation uptake and improve quality of life and health outcomes.
- To place a greater emphasis on rehabilitation for delivering an evidence-based programme of care and optimizing HF patients on their medications.
- To free up cardiac specialist capacity for more HF complex patients in ABUHB.

Project Methodology:

The project ran over 3 sites – *Trethomas, Rhymney* and *YMCA Bargoed*, offering care closer to home for patients, where their Usual care arm would be secondary care.

- Placing greater emphasis on self management of Heart Failure.
- Developing shorter appointment times for HF patients in the community.
- Use of PROMS/HAD scores to track symptoms in real time throughout the project.
- 8 weeks CR and OT input +/- with optimization alongside using MDT approach.

Project Impact:

- **Improvements in exercise and QoL** reporting reduction in anxiety and depression score.
- Optimisation of medication was achieved on average 15 weeks compared to 28 weeks in usual care.
- Readmission rate 1.5% compared to the usual readmission rate 25%.
- **335 appointments were freed** in secondary care for more complex patients.

Project Outcome Measures:

- Use of PROMS to monitor symptoms.
- Improvement in patients to self manage LIKERT
- Decrease in optimization time 4 pillars therapy.
- Decrease in readmission in 30 days.
- · Improved QoL by end of programme.
- Increased no. of patients optimized during CR.

Patient Benefits:

- Reduced admission rates.
- Quicker treatment optimisation.
- Provision of care closer to home.
- Increased capacity in sicker patients.
- Completed cardiac rehabilitation.

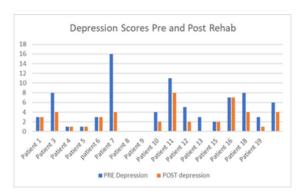


Figure 1: Comparison of Admissions and LoS pre and post

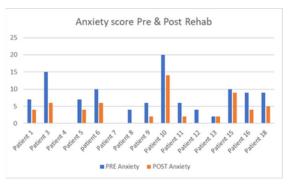


Figure 2: Comparison of anxiety scores pre and post rehab

Cardiac Rehab in my Pocket | ABUHB

Andrew Scard - ABUHB | Contact: andrew.scard@wales.nhs.uk

Project Background:

There has always been a percentage of eligible patients who do not take up Cardiac Rehab (CR) and reasons can vary across Wales. During Covid many teams were decimated by redeployment as well as not being allowed to see patients face-to-face. This led to teams being more inventive and the creation of virtual programs began.

Upon re-commencement of face-to-face services there was now a group who preferred virtual delivery. The question to solve is how best to serve these patients with a quality service that could compliment face-to-face delivery.

Project Aims and Objectives:

To deliver a system that will increase overall uptake of eligible patients into cardiac rehab, provide an efficient way to manage more virtual patients and deliver a product that ensures equitable service provision across Welsh Health boards.

Objectives:-

- Easy access to CR materials for more patients.
- Increase uptake of CR for eligible patients.
- Encourage better self-management of their condition.
- Menu based approach to care.
- Allow staff to manage the new virtual workload more efficiently.
- Manage majority of virtual patients at a glance.
- Reduce risk of re-admission from repeated events.
- Embrace modern technologies into our treatment plan.

Project Methodology:

After patient feedback in ABUHB about the virtual resources used during Covid, the idea of an app based resource was thought of. After discussions locally, a working group of cardiac rehab staff across Wales was created to discuss the idea of a Welsh CR app and what it could include. This group included members from the all specialties in the cardiac rehab MDT.

Background research was undertaken into what systems are already in use and initial talks with app creators and filming companies began to look at costing and timelines. After discussing and evaluating the options available, it was decided that creating a new product would be the most cost efficient and would also ensure that content and functionality would include everything CR requires.

While funding is being secured a simple prototype of the patient app was created and initial testing and feedback has been gathered from staff and patients about app content and functionality.

Project Outcome Measures:

Feedback from prototype app. 41 surveys collected. 36 patients responded, 5 staff.

- Navigation **88% positive use**, 10% passive in their response, 2% had a negative experience (1 person).
- Look of the app -100% positive feedback, in 2 cases it exceeded expectations.
- Locating required information 80% positive feedback, 14% were passive in their response, 6% were negative, perhaps due to some topics not currently covered.
- 70% people said the app contained everything they required, 20% were unsure of what they needed exactly and 10% felt more was needed (has already been planned for release).
- Everyone surveyed agreed an app was better than Facebook and YouTube for access to material. Also nobody thought having the resource to compliment F2F delivery was a negative.
- Only one patient did not think it would be useful if doing a solely virtual program (they do not have a smart phone).

The feedback from the initial prototype and discussions across the All Wales CR group, have been overwhelmingly positive and resulted in the project being pushed for funding to create a downloadable app and staff hub for full testing with patients and staff in ABUHB. If successful the app would go out to all health boards in Wales.

Project impact:

The impact will become clearer once a full prototype is available for patients to test and staff to utilise in the hub.

"I think everything was there that I personally would need. Sometimes it's difficult to access the exercises via Facebook, so to have this alternative would be great."

The potential impact across Wales would be that every Health Board will have a product that will enable all patients to receive an equitable standard of care as a minimum, whether they run face to face rehab or not.

Project Conclusions:

This project has highlighted that there is a need for a virtual service offer for patients and that currently there is not an efficient way to manage the patients who want to access this. The project has, therefore, shown that a package to help better manage patients, while minimising time for staff, is needed across Wales to ensure a professional virtual service is given to patients who want it.

TeleOphthalmology NHS Wales | ABUHB

Ebube Obi - ABUHB | Contact: ebube.obi@wales.nhs.uk

Project Background:

A significant number of patients cannot be cared for or monitored in the community, because not all optometrists have digitised slit lamps to send digital photos of the patient's problem for clinicians to review remotely and offer advice. There is also no mutually agreed (Ophthalmologist & Optometrist) information portal for management of patients in the community/primary care versus secondary care. The majority of patients referred for surgery/therapeutic management, with problems affecting the front of the eye, are referred to secondary care without photographs of the problem. As a result, the majority of these patients have to be seen directly in clinic. This results in huge waiting lists and longer wait times for patients as well as patients coming to harm while waiting.

Project Aims and Objectives:

- Enabling all optometrists who don't have digital slit lamps to be able to access and utilise digital solutions in order to capture digital photos of anterior segment pathology to accompany all referrals and enable appropriate clinician "signpost" triaging of these referrals.
- Provide mutually agreed health care information in the community for optometrists, GPs and Patients, on what can be safely monitored and treated in the community and what needs to be referred in to secondary care - via a new Tele-Ophthalmology website.
- Listing patients for surgery directly from the community following a review of digital photographs accompanying the referral as well as providing electronic patient information on the operation and digital consent forms.

Project Methodology:

1.Optometrists Digitalisation – A digital questionnaire sent to the Optometrists enquiring about their opinions and comments on digitalising their slit lamps. Funding applied for and granted for a limited number of optometry practices. Unfortunately the funds could not be used directly due to NHS policy restrictions. As a result, I used my personal funds to obtain the digitisation kits.

2.Digital health care information in the community for optometrists, GPs and Patients - via a new Tele-Ophthalmology website. Funding applied for but not granted.

3.A pilot study was set up and approved by R&D. Liaised with the Directorate manager, medical photographers, and another consultant ophthalmologist to run virtual cataract clinics first and later virtual anterior segment clinics.

Project Outcomes:

Optometrists digitalisation: All Optometrists who expressed an interest in the pilot study and digitalisation now have the digitalisation kit – slit lamp adaptors needed.

Digital health information in community for Optometrists, GPs and patients - via a new Tele-Ophthalmology website. Funding applied for but not granted - continuing to pursue.



Eyepiece Adapter

Listing patients for surgery directly from the community following a review of the digital photographs of the patients pathology - we now have pilot virtual cataract clinics running.

Project Impact:

All Optometrists in this study with slit lamp adaptors are able to send in anterior segment referrals with photography. Clinicians can now receive referrals with photographs and as a result will be able to offer advice for therapeutic management in the community, list patients directly for surgery.

We now have a R&D approved virtual cataract clinics running and a number of patients have been operated on from the virtual cataract clinics. We are able to review 50% more patients in the virtual cataract clinics than in face to face clinics. In addition to this we do not require a clinic room for virtual reviews, hence a clinic room is freed up to be used for another clinic. This has not only BEEN more efficient, but results in increased financial savings.

Project Conclusions:

Digitalisation of healthcare in ophthalmology as well as other specialties is an essential part (not an optional part) of the NHS and needs to be facilitated and incorporated in clinical practice.

An Online Clinical Quality Application: Testing the Concept and Acceptability for Clinicians | ABUHB

Clare Connor - ABUHB | Contact: clare.connor@wales.nhs.uk

Project Background:

Improvement behaviours should be integral to the daily work of all in healthcare. The clinical quality reporting structure for musculoskeletal (MSK) physiotherapy was based on 6-monthly notes audits. Results were not synthesised or translated into improvements. The audit did not encompass the spectrum of clinical quality that the service aspires to align with. Online clinical quality reporting has the potential to facilitate frequent reflection, evaluation and improvement.

Project Aims and Objectives:

Aims:

- Produce a user friendly clinical quality application (CQA) to support clinical reflection and quality reporting.
- Measure aspects of quality that matter to clinicians and patients.

Objectives:

- Develop measures that clinicians regard as representative of clinical quality.
- Test user experience of CQA in clinical settings.

Project Methodology:

· Engagement:

Engagement with MSK physiotherapists to gather views on existing audit and aspirational approaches to quality reflection, reporting and improvement.

· Implementation:

CQA was used for reflection after direct clinical contacts in MSK physiotherapy. Clinical quality ratings were entered as personal reflections and during mentored reviews.

• Evaluation:

Qualitative feedback about user experience of CQA and its contribution to clinical quality and improvement. Thematic analysis of responses.

Review of data and dashboards generated by CQA

Project Outcomes:

Clinician views on how to improve clinical quality evaluation were defined by 3 themes: A need to:

- 1. Simplify.
- 2. Incorporate into daily practice, personal reflection and mentoring.
- 3. Inform learning and improvement through evaluation.

The CQA was tested in 7 MSK Physiotherapy departments in ABUHB. It gathered data and generated personalised and service level aggregated quality dashboards.

Feedback was returned by 27 clinicians and 6 service managers and clinical leads.



Figure 1: CQA dashboard

Project Impact:

- 74% said a CQA entry took less than 4 minutes to complete.
- Ease of access was 'easy' or 'very easy' for 71% clinicians and 100% managers and clinical leads.
- Clinicians said that the CQA is quick and easy to use; feels meaningful and relevant; encourages reflection and organises data to inform development

Project Conclusions:

The CQA is valued by clinicians who have tested it. It supports clinical reflection and reporting as part of daily practice. It yields frequently updated quality information and can inform improvements for individuals and services.

It has potential for adaptation to other clinical areas to enable granular and widescale quality information to be accessed by individual clinicians and service leaders.

Sustaining and Protecting Spoke Sites Post Centralisation. South EAST Wales VASCULAR Network | ABUHB

Tracey Hutchings - ABUHB | Contact: tracey.hutchings@wales.nhs.uk

Project Background:

Vascular disease affects the circulatory systems which includes arteries, veins and lymphatics.

In July 2022, a major service change was initiated where 4 health boards amalgamated to form the South East Wales Vascular Model.

All patients requiring complex vascular care would be admitted to the Hub. When medically fit from a vascular perspective they would be discharged home or if there were ongoing medical needs they would be repatriated to spoke hospitals nearer home.

This would result in ABUHB having no vascular inpatient beds and non vascular wards receiving repatriated vascular patients with ongoing medical requirements.

Project Aims and Objectives:

- To deliver ongoing educational support mechanisms to ensure patient safety and support non vascular wards with educational tools to provide equity of care to these patients.
- To improve knowledge, skills and competencies to non vascular nursing staff to reduce rates of inappropriate referral or readmission to the Hub.
- To work within prudent healthcare principles an sustain a competent workforce.

Project Methodology:

Team meetings were conducted to inform staff and listen to their concerns. ABUHB has 10 spoke hospitals across a huge geographical area. The project focused on larger spoke hospitals and an intention to roll out to other spoke hospitals.

Key stakeholders identified potential problems around education, teaching packages, skills development and additional would management knowledge.

Project Outcomes:

Centralisation underwent several postponements and significant delays, with the model taking effect from 18th July 2022. Limited data is available currently.

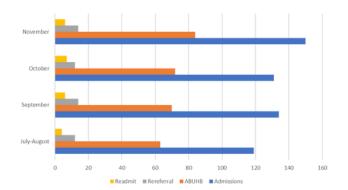
Digital education packages have been concentrated on 2 main spoke sites which have taken the majority of repatriated patients.

The vascular web page is accessible to all ABUHB sites and ongoing practical site training with complex wounds has developed staff competency to allow them to take these patients.

Feedback from staff is that they feel they have a safety net with these patients and as the vascular nursing team have remained accessible, many unnecessary readmissions have been avoided.

Project Impact:

Better collaborative working has developed across the vascular nursing team and spoke sites.



Project Conclusions:

It is hoped that with developing this new service delivery with digital education and teaching, the rates of referral will decrease and a sustainable knowledgeable workforce would continue.

By spoke staff competencies improving, it is hoped patient flow will continue and discharge of patients will be trouble free.

The scale of the project is significant and it would benefit from having a full time clinical role.



Exploring Virtual Reality Masks and Mindfulness Skills Training as a Psychological Intervention for Military Veterans on a NHS Waiting List for Psychological Therapy: A Pilot Study | ABUHB

Vanessa Bailey, Mike Mo, Martin Thorp and Damon Rees - ABUHB | Contact: 01873 735240

Project Background:

Virtual Reality (VR) has a growing evidence base for efficacy in treating mental health difficulties such as generalised anxiety disorder (Gorini et al., 2010, Valmaggia et al., 2016). VR is also being researched as a means to deliver mindfulness skills training for 10 minutes per day over a set time scale (Chandrasiri et al., 2020, Navarro-Haro et al., 2017). Patients who are on our psychological treatment waiting list at Veterans NHS Wales have mental health conditions which typically have anxiety as a core component. We became interested in the use of VR and wanted to understand if loaning Virtual Reality Masks (VRM) would be a beneficial intervention for our patients to use in the comfort of their own home whilst waiting for psychological treatment.

Project Aims and Objectives:

Aim: To establish the effectiveness, feasibility and acceptability of using a VRM as a treatment waiting list intervention for managing anxiety.

Objective: Participant to loan a VR mask and use daily at home over 2 weeks. Participant to select and watch one of the 4 preloaded 10 minute duration VR mindfulness clips.

Project Methodology:

Creation of VRM Mindfulness content: In collaboration with Digital Communities Wales and service user representatives, we created four immersive 360-degree 4k VR mindfulness clips. The 4 clips were areas of natural scenery in Wales with voice over of mindfulness skills training; Mindful Breathing, Mindful Seeing, Three Step Breathing Space and Body Scan.

Population: Military veterans with military service related mental health difficulties.

Participants recruitment: 15 participants on our waiting list consented to taking part in the pilot study. Participants were shown how to use Oculus Quest 2 VRM. The VR masks were used as prescribed for ten minutes per day over two weeks in the military veteran's own home. 2 participants were excluded as the VRM was not used as prescribed.

Outcome measures and data collected: GAD-7 and ReQol-10 clinical measures were completed on the day of VRM loan (pre) and two weeks later on return of VRM (post). A qualitative participant feedback form was devised with questions based on a 7 point Likert scale and this was completed on return of the VRM.

References:

Chandrasiri, A., Collett, J., Fassbender, E., & De Foe, A. (2020). A virtual reality approach to mindfulness skills training. Virtual Reality, 24(1), 143-149.

Gorini, A., Pallavicini, F., Algeri, D., Repetto, C., Gaggioli, A., & Riva, G. (2010). Virtual reality in the treatment of generalized anxiety disorders. Annual Review of Cybertherapy and Telemedicine 2010, 39-43.

Navarro-Haro, M. V., López-del-Hoyo, Y., Campos, D., Linehan, M. M., Hoffman, H. G., García-Palacios, A., ... & García-Campayo, J. (2017). Meditation experts try Virtual Reality, Mindfulness: A pilot study evaluation of the feasibility and acceptability of Virtual Reality to facilitate mindfulness practice in people attending a Mindfulness conference. PloS one, 12(11), e0187777.

Valmaggia, L. R., Latif, L., Kempton, M. J., & Rus-Calafell, M. (2016). Virtual reality in the psychological treatment for mental health problems: An systematic review of recent evidence. Psychiatry research 236: 188-198

Project Outcomes:

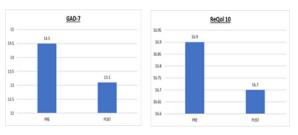


Figure 1: pre and post GAD-7 scores (left) and pre and post ReOol10 scores (right)

Post outcome measures indicated a slight decrease in the participants anxiety (GAD-7) and a slight increase in the quality of life (ReQol-10), however the results were not statistically significant.

Qualitative feedback was variable on the effectiveness of using VR and learning mindfulness skills as an intervention for anxiety. VRM was generally found to be feasible and acceptable to use at home.

Project Impact:

- 62% participants reported their anxiety reduced while using the VRM, and the same reported reduced anxiety after use.
- 6% reported learning new mindfulness skills during the pilot, with 67% reporting that they would continue to use these skills.
- 62% suggested that 2 weeks was not long enough to learn mindfulness skills.
- 62% felt that the intervention was easy to fit into their day.
- 4% suggested that this had been a helpful intervention whilst waiting for treatment.
- 77% would recommend VRM as an intervention to others waiting for psychological treatment.
- 69% reported that overall, they benefitted from the experience.

Project Conclusions:

- The VRM pilot suggests this is generally an acceptable and feasible intervention that can be used for patients on our NHS psychological treatment waiting list.
- This is not an intervention that suits all on our psychological treatment waiting list however it is effective for some to learn mindfulness skills and managing anxiety.
- Despite no statistically significant change in anxiety, pre and post quantitative measures indicated stability of mental health during VRM use.

Compassionate Care in Challenging Times: Growing a Peer Support Network for Healthcare Colleagues with Healthcare Staff | ABUHB

Avril Jones - ABUHB | Contact: Avril.Jones@wales.nhs.uk

Project Background:

The project focus is on staff wellbeing to maintain a preventative/proactive health promotion service. Evidence is growing that our NHS Covid-19 response will have had huge collateral damaging effects upon our population health, especially infants, children and young adults. By supporting our care-giving staff, (initially health visiting service and extending to other disciplines), we can protect the delivery of our healthcare service for all families in Aneurin Bevan UHB.

Practitioner peer support and reflection are recognized as a necessity by practitioners working at the `caring face' as evidenced in the Kings' Fund Report. `ABC Needs of Nurses and Midwives. Courage of Compassionate care` 2020

Project Aims and Objectives:

- · Access voices of staff
- · Access voices of service users
- Act on themes captured:
- 1. Staff to be valued, heard and trusted (AUTONOMY)
- 2. Support the support (Peer-to-peer) (BELONGING)
- 3. Compassionate responsive management model
- 4. Communication and celebration/feedback (CONTRIBUTIONS)

Project Methodology:

The project uses the Solihull Approach, motivational interviewing and leadership concepts, among others, to support professionals working with complex families. The emphasis of the model is on the resilience of the professional, improving their own health and wellbeing.

Volunteer colleagues will then be trained to become active in a network of 'Reflective/Restorative Supervisors.

Project Impact:

A different and new focus on staff self-care around emotional wellbeing.

"RS has been extremely useful to me during a difficult year in management. It has been a support network where I felt listened to-it is invaluable- I wish more staff could take it" - Middle manager



Project Outcomes:

- The continued functioning of peer-to-peer care via facilitation of reflective safe space and time. Virtual and face-to-face.
- Upskill colleagues, co-ordination of network. Availability of regular reflective supervision sessions for all staff.
- Annual professional review discussion to prioritize wellbeing.
- Delivered online monthly sessions to middle managers.
- Recognition that a cultural change is needed to support compassionate care to fellow healthcare professionals.
- The need to support all staff to practise their focus upon own wellbeing in a workplace that is learning to be compassionate and recognise that `avoidable harm` to staff is a necessity.
- The introduction of a new senior professional role to support staff wellbeing throughout our service. Facilitation of:
- 1. Staff to be valued, heard and trusted (AUTONOMY)
- 2. Support the support (Peer-to-peer) (BELONGING)
- 3. Compassionate responsive management model
- 4. Communication and celebration/feedback (CONTRIBUTIONS)

Project Conclusions:

"This work is supporting a cultural change in healthcare. They need to be learning organisations with leaders accessible, listen more than they talk, and respond to concerns. Internal communications must exist in organizations that link leaders' responses to frontline provider concerns, in essence ensuring that staff feel their voices are heard."

A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017





Betsi Cadwaladr University Health Board Bevan Exemplars

PLGF Point of Care Test for Decision-Making in Pre-Eclampsia

BCUHB | Ashwin Ahuja and Lynda Verghese - BCUHB | Contact: dr.ashwin.ahuja@gmail.com

Project Background:

Ambiguities arising out of the complexities in conventional risk stratification of women with suspected pre-eclampsia inevitably lead to repeated hospital attendances, increased use of resources, considerable anxiety for women and often missed at-risk cases. In order to reduce unnecessary admissions and visits to the hospital, to optimize patient outcomes, this evidence-based pilot study was conceived.

Project Aims and Objectives:

- Accurately risk stratify the patients with suspected preeclampsia.
- Reduce number of repeat outpatient attendances and unnecessary hospital admissions in patients with suspected pre-eclampsia.
- Avoid missing at-risk patients slipping through gaps.
- Preventing iatrogenic preterm births and potentially Special Care Baby Unit (SCBU) admissions.
- Allay the anxiety and mental health issues for the patient and their families associated with hospitalisation.
- Optimise the use of NHS resources including the burden on the pathology laboratories, health care staff, emergency departments and maternity day assessment units – thereby making tremendous positive managerial and financial impact.

Project Outcomes:

Cohort of 34 women, all 6 cases in the red group were admitted, developed severe preeclampsia (2 of which developed HELLP) within the same week, were stabilized, given prophylactic steroids in view of prematurity and were delivered. The amber group was managed with increased outpatient surveillance until a max. of 37 - 38 weeks.

The patients in the green group were cared for on an outpatient basis to prolong the pregnancy without inpatient admission till term. 68% of the cases in our cohort of 34 women were cared for with outpatient surveillance alone. There were no stillbirths or unnecessary iatrogenic preterm deliveries.

Project Impact:

- PLGF Triage testing proved to be of excellent diagnostic value in the local cohort of patients with suspected preeclampsia.
- Prevented maternal complications like eclampsia / stroke / DIC / death.
- Prevented foetal complications: stillbirths, prevented iatrogenic preterm deliveries.
- Provided reassurance for outpatient surveillance and alleviated maternal anxiety allowing patients in this subgroup to safely go home.
- Impact on midwifery/HCA staffing and turnover in labour ward ensuring smooth transition of patient from induction bay to the labour ward.
- SCBU cost/day saved about £1,118 day to look after iatrogenic preterm in intensive care.

Project Methodology:

- Collaborate with Biochemistry department to decide on which type of PLGF analyzer.
- Write a business case to BCUHB to get approval.
- Set out the strict inclusion criteria.
- Determine the duration of the project.
- Train the doctors and midwives to use the machine and run QC tests weekly.
- Regularly audit uptakes.
- Meet with the staff to ensure motivation to engage with the project.
- Collect relevant data in an approved Excel database.
- Do a descriptive analysis to derive inferences.

Project Impact (Continued):

- Total net bed cost savings of the outpatient management of the 68% of the cases identified in the study period saved the hospital about £ 34,304 in 6 months alone.
- Saved medicolegal costs in terms of litigation for stillbirth/eclampsia/stroke.
- Each patient that avoids hospitalization due to the PLGF triage test reduces the greenhouse gas emissions equating to 35T of CO2 making the project's entire footprint to be near carbon neutral and in fact be greatly beneficial to the environment.

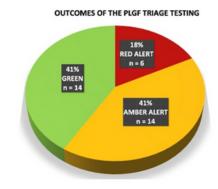


Figure 1: Outcomes of PLGF triage testing

Project Conclusions:

"The PLGF Test is an evidence based, cost-effective, bedside, environmentally beneficial, triage test that enhances maternal and foetal safety, improves outcomes, benefits the patient and the NHS financially and safeguards the national health service and the patients from potential litigation."

Realigning Secondary Care Community Occupational Therapy Services across the East Integrated Health Community with Primary Care Services | BCUHB

Heather McNaught, Vicky Warburton, Louise Barker, Melanie James, Lucy Jones, Martyna Muchowska, Amber Jenkins, Kim Sutton, Gwawr Williams and Deb Rowlands - BCUHB | Contact: Vicky.Warburton@wales.nhs.uk

Project Background:

Historically, patients would be triaged and wait up to 14 weeks on the Occupational Therapy waiting list. The Covid-19 pandemic and the temporary cessation of routine community assessments allowed for a strategic change of the community OT provision to become aligned with primary care services and colleagues. The team would realign with the multi-disciplinary teams (MDT) within the GP clusters to further enhance their understanding of OT. This would provide earlier access to OT for patients, therefore improving stakeholder and system-level outcomes.

Project Aims and Objectives:

- Facilitation of direct health to health referrals, received electronically to a shared email inbox.
- Existing secondary care community OT service to be aligned within primary care teams. Allowing for a physical presence of an OT within the setting, ensuring referrals are generated earlier, before patients functionally decline or crisis ensues.
- The realignment will in turn allow the MDT access to OT services earlier and vice versa, meaning that crisis can be avoided and promotion of health and well-being needs can be instigated sooner.

Project Outcomes and Impact:

- Waiting times have reduced by an average 9 weeks, with longest wait being 4 weeks.
- RTT is now on average 1.5 days, an improvement on 10 days from mid 2019.
- Assessment to discharge time is now on average
 9 weeks from a previous 17 weeks.
- Urgent referral rates have reduced to on average 2.5 weekly from 6.5 a week.

Project Methodology:

Attending GP Cluster meetings across 6 cluster areas in Wrexham and Flintshire via TEAMS. Of those that requested further information or to be an early implementer surgery, contact was then made with the GP practice manager. This enabled a more bespoke discussion regarding their GP surgery population health needs, priorities and opportunity to engage with the OT service. This involved identifying resources available from both the OT service and GP surgery to enable an OT to be based at the surgery each week. This included access to GP health record systems, referral routes and ensuring governance arrangements were in place prior to alignment with each surgery.

Project Conclusions:

The cohesion that now exists between patient, OT, primary care and third sector agents reflects the benefits suggested in political drivers alongside the delivery of a greater provision of services, early interventions and greater co-production. Our realignment project in Occupational Therapy has enabled us to be at the heart of achieving this transformation, making the necessary transition in service redevelopment.

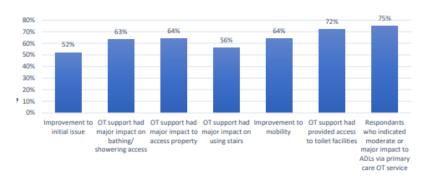


Figure 1: Project outcomes for patients

"We cannot let this opportunity pass without thanking our OT for her most helpful advice and exemplary caring professionalism in the duty of her profession. There was very little time from the need for OT being identified, to the arrival of the advice and action by our OT. The service was provided swiftly, which ensured our issues didn't impede daily life. She was an outstanding representative for a most helpful team." - Patient

A Quality Improvement Project Reducing Carbon Footprint in Carpal Tunnel Surgery | BCUHB

Preetham Kodumuri and Prash Jesudason - BCUHB | Contact: Preetham.Kodumuri@wales.nhs.uk

Project Background:

Specific information on estimation of carbon footprint of a routinely performed surgical procedure such as CTR is lacking. This study set out to not only estimate the carbon footprint of CTR, but also to demonstrate the environmental, financial and social impact of introducing changes and applying sustainable healthcare principles in Betsi Cadwaladr University Health Board.

Project Objectives:

- To define the carbon footprint of CTR operation as performed under standard patient pathway.
- To reduce the carbon footprint of CTR by changing to a "lean and green theatre set up" by:
- 1. Using smaller trays with fewer surgical instruments & smaller drapes;
- 2. Reducing use of single-use items.
- To assess the financial costs of traditional and 'lean and green' pathways for CTR.

Project Methodology:

- · Carbon mapping of hotspots activities.
- Calculation of clinical waste per case.
- Calculation of traditional carbon footprint.
- Assessment of savings made by "lean and green" theatre set up and "Green pathways".

Project Outcomes:

- A total of 43 patients were seen from June Dec 2021.
- Demonstrated an 80% reduction in carbon footprint.
- Evidenced a reduction in Co2 per case by 22.14 kg.
- Demonstrates a 2/3 equivalent economic savings.
- Intervention proved cheaper by £34.72 per CTR.
- No complications were recorded throughout project.

Project Impact:

Lean and Green theatre set up alone would create annual UK savings of:

- Environmental impact 12 tonnes of Co2.
- Financial impact £1.33 millions.
- Social impact less time spent in hospital.
- · Indirect savings through less buildings energy.

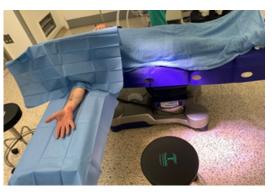
Project Conclusions:

- "Lean and green" theatre setup and an environmentally friendly patient pathway can deliver a safe, efficient, costeffective and sustainable service for CTR.
- It would be possible to consider a similar exercise for a variety of other hand surgery procedures.









The Community Wellness CIC - Reaching the Hard to Reach

BCUHB | Karen Sankey - Community Wellness CIC; Jane Bellis - Art and Soul Tribe | Contact: Karen@Kswellness.co.uk

Project Background:

We are exploring and uncovering the conditions, support, tools and skills that we need, not just to survive in our challenging, hierarchical and unjust society, but to flourish and thrive. We have developed a radical new model that blends the knowledge, skills, and resources, from the public sector, with the passion and local expertise of third sector.

Project Aims and Objectives:

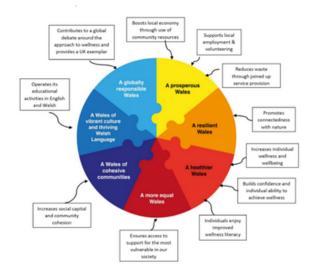
At Community Wellness we are striving to reimagine the way communities, organisations and our society at large view, engage and support those with most need. We are seeking to do this by changing the narrative around:

- The people who experience homelessness, addiction or complex mental health issues and those who are excluded from school.
- The negative impact that adversity, prolonged stress and trauma has on the minds, bodies and souls of humans and ultimately their lives and their potential.
- The human experience and what makes us truly well emotionally, psychologically, socially and spiritually.

Project Methodology:

Two pilot projects were undertaken in Flintshire, at Shotton and Glanrafon, from December 2021 – May 2022. The key components focus on:

- Engagement
- Discovery
- · Community Inclusion and Connection
- Enrichment
- Growth
- · Story Telling



Project Outcomes:

For participants

- Promotion of inclusion, and consequent reduction of loneliness and isolation.
- Active engagement of beneficiaries.
- Co-production of project activities, and strengths-based working.
- Realisation of opportunities for personal progression and skills development.
- Improved physical, emotional and psychological health & wellbeing;

For the community:

- Greater community resilience, and a growing culture of inter-dependency, based on recognising community strengths.
- More safe and supportive community spaces

Project Impact:

- 75% of participants say that they are now more satisfied with their lives.
- 88% feel that the things that they do are more worthwhile.
- 100% say that they feel happier now.
- 38% have reported a reduction in their anxiety.
- 3 Participants have been supported into housing.
- 2 Participants supported into paid work.
- 6 Participants supported into volunteer work.

All participants have expressed an interest in continuing their journey with Community Wellness.

Project Conclusions:

We have dispelled the myth that some groups are "hard to reach" and it is a matter of engaging with them in the right way. In line with recent work by Joanna Moncrieff, we have demonstrated the lack of evidence for the current mental health model, which links chemical imbalance to mental illness. We have also demonstrated the Human Givens approach which shows that when emotional and psychological needs are met, we will not suffer from mental illness or addiction.

Cancer-related fatigue(CRF): New Road Map for Patients and Health Care Professionals (HCPs) | BCUHB

Jackie Pottle, Lisa Heaton -Brown, Jeanne Dore and Ellen Grier - BCUHB | Contact: Jacqueline.pottle @wales.nhs.uk

Project Background:

CRF: "distressing, persistent, subjective sense of tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and interferes with usual functioning." (National Comprehensive Cancer Network, 2018) Rated as most distressing symptom by patients for all tumour sites & at any stage. (Macmillan holistic needs assessment review (2018-2020).

HCP's survey identified lack of knowledge / confidence / need to access evidence-based information quickly. No service for patients or HCPs prior to 2020.

Charity funds for OT/ psychology collaboration for 1 day / week for year.

Project Aims and Objectives:

- To develop an effective patient-centred service to support patients and HCPs with CRF and implement long term coping strategies.
- To develop easy access to evidence based resources for HCPs and patients.
- To provide stratified CRF levels of support to patients.
- To upskill HCPs to support stratified levels of CRF.
- To share skills across Wales and UK.
- To secure funds to sustain service for long-term support of patients & HCPs.

Project Methodology:

- Collaboration between OT & Psychology has resulted in innovative layered patient & HCPs' support.
- · Development of
- 1. SharePoint site
- 2. HCPs' education sessions
- 3. Range of patient centred support
- An iterative collaborative approach with cancer patient forum has resulted in creation of self referral forms and person centred care remaining at heart of the service.
- Service was guided by HCP's survey and ongoing patient feedback to ensure continued service refinement.

Project Outcomes:

- A new innovative CRF service was developed to support patients and upskill HCPs across primary and secondary care.
- Innovative introduction of remote video group clinics to support wider range of patients.
- Sustained funding to continue service for another year.
- Sharing of knowledge via Welsh Cancer Network conferences/ newsletter / publication (BMJ blog); UK wide mesothelioma support group / Lead nurse/AHP conference.
- BCUHB, Macmillan Excellence and Moonlight Cancer Charity innovation awards.

Project Impact:

90 patients supported in 12 month

PROM showed:-

85% reduction in concerns 85% increase in wellbeing

120 HCPs - education sessions

Over 800 visits to SharePoint site

Described by patients as a "road
map" to controlling CRF and
"essential" to HCPs.

"One other huge benefit of these sessions is that you feel, as a patient, that skilled NHS staff are taking time to listen. ... a feeling of being on a treatment conveyor belt..... This programme online devotes time and thought, excellent."

- VGC patient



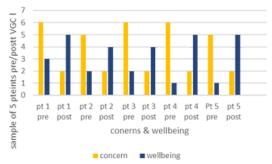


Figure 1: CRF PROM concerns and wellbeing

Project Conclusions:

- The development of a new CRF service to support patients and HCPs can have a positive effect on CRF symptom reduction and increase wellbeing.
- The upskilling of HCPs will ensure sustainability of supporting as many patients as possible.
- This also has significant implications for healthcare providers in Wales in terms of reduced costs in follow ups for CNS and supports greater oncology & GP capacity.



Digital Patient Passport: Improving Decision Making for Patients with Complex Health Conditions and Rare Diseases | BCUHB

Lowri Smith | Contact: lowrismith88@gmail.com

Project Background:

- · Complex health conditions are common.
- Lived experience: repeated emergency admissions!
- Crisis: inflexible pathway in EDs.
- Literature review: patient passports for safety critical information?

Project Aims and Objectives:

- 1.Improve care pathways through emergency departments for patients with complex health conditions/rare diseases.
- 2. Simplify care for clinical staff.
- 3. Fast-track pathways to specialist.
- 4.Improve communication between teams for cross-border care.
- 5. Ability to upload medical documentation to app to assist with continuity of care.

Project Methodology:

- · Literature review.
- Focus groups with patients and clinicians prior to development.
- App development with Welsh SME.
- Beta-testing with patients.

Focus Groups

- · Clinicians and Patients.
- · Preference for digital solution.
- Advice: Don't bypass the triage system. A clinical assessment is an important part of the process.
- Important that the record is regularly updated.
- · Concerns that other issues would be missed.
- Include advice/signpost on where to seek specialist advice.

Project Outcomes:

Ready-to-use patient owned mobile application.

Now: beta testing with a small group of patients with complex health conditions and rare diseases at BCUHB.





Project Impact:

- · Improve decision making.
- Better communication.
- Eliminate the need for paper notes.



Project Conclusions:

Patients with complex health issues often don't require the traditional ED pathway, but require to be seen by a specific specialty in a timely manner.

The use of a patient owned passport will enable better communication and better informed decision making by clinicians.



The introduction of Rehabilitation Champions within a Community Hospital setting | BCUHB

Rebecca McConnell, Fiona Moss and Nicola Powell - BCUHB | Contact: Rebecca.McConnell@wales.nhs.uk

Project Background:

A review was undertaken in relation to current delays of provision of rehabilitation services for our community hospital inpatients; along with a patient evaluation questionnaire which highlighted lack of patient understanding around their admission and what they were waiting for before they could be discharged.

The aim of the project is to provide a seamless rehabilitation service for patients transferring from the acute setting to the community hospital and reduce the delay between a purposeful therapy contact by introducing 'Rehab Champions' onto the ward. The Rehab Champion will support the patient by adopting a 24 hour approach to their rehabilitation plan, utilising a therapy care plan which sets out each individuals rehab needs.

Project Aims and Objectives:

- To upskill current Health Care Support Workers (HCSW) to reduce delays.
- To improve patient understanding and engagement with their rehab journey.
- To reduce length of stay and reduce hospital acquired deconditioning and decline.
- To empower the ward MDT way of working to facilitate a 24/7 approach to rehabilitation and discharge planning.

Project Methodology:

Inspired by 'Last 1000 days' and 'End PJ Paralysis' together with likeminded conversations with colleagues, the concept was discussed and plans commenced for the project. The initial team was made up of Ward Manager, Occupational Therapists, Physiotherapist and support from the Quality Improvement team within BCUHB. Regular meetings were held where it was decided on a pilot on one ward within a community hospital, with a view to rolling out further if there was a positive outcome following evaluation. It was necessary to use the resources we had at ward level in order to work together as a successful multi-disciplinary team to promote success of the project. A training programme was created to deliver to staff. Therapy care plans were designed to inform each individual patients' rehab need. The care plan is then communicated to the wider team and owned by the patient to promote self ownership of rehab.

6 Health Care Support Workers and 1 Registered Nurse were identified and trained on the ethos of rehabilitation, the role of the Occupational Therapist and Physiotherapist together with training on items of equipment regularly issued to patients by therapists, which would not necessarily be used on the ward.

Data collection – both quantitative (length of stay, falls, care requirements) and qualitative (case studies and patient, staff, family feedback) are being collated throughout the pilot.

Project Outcomes:

- Patients discharged with lower packages of care than anticipated.
- Patients discharged with reduced manual handling equipment needs.
- · Reduced length of stay and dependency on staff.
- Increased knowledge and skills of existing HCSW's resulting in increased confidence with rehab.

Project Impact:

Although in its infancy, the anticipated impact of the project will be seen in key areas such as reduced length of stay and re-admission and a reduction in care packages and intervention from community services. It is hoped that the patient experience will improve with patients taking more ownership of their rehabilitation journey. Potentially a reduction in falls and collectively a cost saving identified in many areas. With regard to staff we would expect an increase in morale, greater job retention and enhanced future aspirations.

Project Conclusions:

The introduction of the Rehab Champions has been welcomed within the whole team involved and positive patient feedback has already been gained. If rolled out both locally and pan-BCUHB, the potential benefits could be significant from both a patient and staff experience point of view along with cost saving for the health board.



Living with Long COVID | BCUHB and Mental Health Foundation

Michelle Rigby - BCUHB; Josh Elton - Mental Health Foundation | Contact: Michelle.Rigby@wales.nhs.uk

Project Background:

It is reported that 2 million people in the UK may be living with long covid symptoms, and requiring support for that. The knowledge and understanding of the mechanics of post covid syndrome and the effective treatments are increasing as time and research goes on, but the impact on the psychology of the individual remains the same.

The rationale for the project was to provide a general structured self-management education programme and follow up peer support to individuals who are still experiencing symptoms 12 weeks post-infection. Providing this education at this point encourages self-management of symptoms, supporting individuals to navigate and access services in the most appropriate manner. The subsequent access to the ongoing peer support (via the Mental Health Foundation (MHF)) will enable community capacity to be developed; emotional support from their peers and a forum to utilise their self-management skills going forward.

Project Aims and Objectives:

- Integration of the lay led structured education into the Long Covid Service in BCU as it emerges.
- Embed peer support into our communities, supported by robust information (validated by the HCP).
- Activate the individuals who take part in structured education to be empowered and enabled. Skilled to actively engaging as partners in their care and treatment.

Project Methodology:

- The project utilised a broadly PDSA approach to deliver each section outlined above.
- By listening to feedback and responding, the service has grown and developed, continually over the year.
- The service has developed in response to feedback from patients and health and care professionals.

Project Outcomes:

- Activated patients working as partners in their own care and taking responsibility for the day to day management of their condition.
- A long Covid Self management programme has been developed and is routinely available across the BCU area, available to staff and patients.
- The Self Management Education is now routinely referred to from primary care at three months of symptoms.
- Ongoing peer support is available in BCU for groups of patients experiencing Long Covid and Chronic Pain.

Project Impact:

This Bevan Project has included 8 cohorts – with 147 Registered to attend the EPP Long Covid Selfmanagement programme (LCSMP), 76 completing the LCSMP, 36 individuals continuing to attend a session with Mental Health Foundation (MHF).

Project Conclusions:

Key Insights from EPP qualitative data

- 1. Figure 1 below demonstrates that the majority of subthemes relate to a positive experience of the course on long covid itself.
- 2. Even sub-themes relating to negative emotions or aspects of care such as 'Feeling Safe' and 'Pain' are reported in a positive manner and can be interpreted in terms of the an increase in efficacy as a result of the programme.

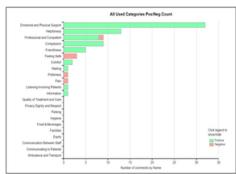


Figure 1: Experience of Course

The key insights from the quantitative feedback

The initial findings show that the EPP Cymru Long Covid Selfmanagement Programme shows improvement in EQ5D, and in the Universal Loneliness Score when comparing Precourse (n=105) to post course (n=77) and three-month post course (n=25) data.

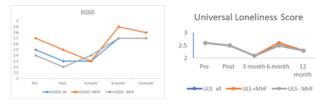


Figure 2: Universal Loneliness Score (Right). ESQD (Left)

This perceived health score demonstrates that an individual's perception of their health improves by attendance at the LCSMP and is supported for continued improvement by accessing peer support.



Figure 3: Overall Health Score)

Patients who 'Walk With Purpose': Developing Clinical Guidance

BCUHB

Sophia Keene, Hayley Tapping, Reena Cartmell, Gaynor Hughes, Tracey Williamson, Amy Kerti and Lucy Francis - BCUHB | Contact: Sophia.keene@wales.nhs.uk

Project Background:

The Safe Clean Care campaign during the Covid-19 pandemic within Betsi Cadwaladr University Health Board (BCUHB) identified that patients who walk with purpose (WWP) could be increasing the spread of infection across acute inpatient wards as well as community hospitals and Mental Health and Learning Disability (MHLD) wards.

Patients who walk with purpose may have dementia, delirium, alcohol withdrawal or a learning disability. They therefore may move around the environment more and not be as aware of social distancing and use of PPE.

Clinical conversations were planned with staff across the health board using the COM-B methodology which is a psychological approach to behaviour change. This was used to identify what was needed to support staff, patients and carers to reduce infection risk and improve patient centred care as well as support staff through escalation.

Project Aims and Objectives:

- Clinical conversations using the COM-B methodology with staff in the East area of BCUHB, Central, West and MHLD including inpatient staff and community hospital staff of all grades.
- Identify themes across the areas and wards and invite all who took part to a task and finish group.
- Use themes and guidance already in place to develop a specific document to support patients, staff, unpaid carers and also reduce infection spread.
- Analyse what behaviour changes are needed in order to carry out any guidance.

Project Methodology:

A group of various expertise and invited staff from each area of the health board was formed to discuss four key topics:

- 1. Safe Infection Prevention Control (IPC) environment.
- 2.MDT support and pathway utilisation.
- 3. Appropriate placing of patients and reducing unnecessary moves
- 4. Escalating situations when required.

We then completed a thematic analysis across the areas and wards and used the COM-B Methodology to review which aspect of people's behaviour needed to change. Existing documentation and guidance was used to support a new clinical guidance for patients who WWP.

Project Outcomes:

A clinical guidance was developed (Figure 1). This provides prompts for staff to utilise in supporting patients but also in involving families and carers, knowing who to involve and when, and when to escalate. The guidance was made available with hyperlinks to the intranet for the most up to date referrals to specialists and also to important documents such as the Mental Capacity Act and policy on alcohol withdrawal.



Figure 1: Final clinical guidance for patients who WWP

Project Impact:

The guidance was trialled on eight wards (two in each area) and a feedback questionnaire was developed using the COM-B headings as sections. There were 25 questions in total. This was sent to the wards for them to complete as a group (one per ward or area).

Project Conclusions:

The feedback was qualitative data which was thematically analysed using the COM-B Methodology (Figure 2). Wards had been displaying the guidance in a paper format and found this more useful however they had disseminated it electronically via email or WhatsApp groups for their ward staff. Discussion of the guidance was being used at safety briefs and ward rounds, managing WWP as an MDT approach. Bank and agency staff were using the guidance and found it particularly helpful. The interactive links were good and wards felt they had good links with IPC and Psychiatric liaison already.

Most wards found that the guidance was very busy and 'wordy' and they had not had enough time to fully utilise the guidance. Some areas found it difficult with competing demands of the ward and felt the guidance may fit better in a ward with less patients who WWP. Care of the elderly wards and dementia wards for example felt they were already doing everything from the guidance.



Figure 2: Clinical guidance feedback thematic analysis

Virtual Drop-in Support Clinic for Hearing Aid Patients | BCUHB

Susannah Goggins - BCUHB | Contact: susannah.goggins@wales.nhs.uk

Project Background:

Within the Audiology service, there is a need for timely access to support for hearing aid patients due to patient reliance on hearing devices. For some, conversing over the telephone can be difficult, so we offer a variety of ways patients can contact us. As a service, we have been using the Attend Anywhere video call platform for some scheduled care appointments (booked in advance), but not as a method for patients to access support when needed.

Project Aims and Objectives:

To investigate the use of an Attend Anywhere Waiting Room for a 'drop-in' virtual clinic, attended by a clinician, during advertised opening times.

- Allow access to a clinician via video for those with hearing aid issues.
- Ability to see the patient on screen, potentially helping with fault finding and practical elements such as correct ear mould insertion and re-tubing.
- Encouraging self-management of hearing aids, providing timely support, and preventing some patients from needing to attend the hospital or converse on the telephone.

Project Methodology:

- Engaged with service leads and clinicians to plan 'drop-in' video clinics.
- Patients shown letter, information /instructions for informal feedback.
- · Training pack devised for staff.
- 300 patients contacted by letter over 4 month period (sent in batches of 100) advising of new clinic/way of accessing service.
- Clinics held from May to end of Aug 22 at advertised times.

Project Outcomes:

- 300 patients contacted with instructions about the video 'drop-in' repair/support clinic
- 0 patients used the service in the 4 month time period

Average age of those contacted: 73.9 years old (range 18-93).

The first 100 patients who were contacted by letter were looked at in more detail:

 34 of these accessed the service for support in the time period that the video 'drop-in clinics were running. These attended the service for the reasons identified in figure 1.

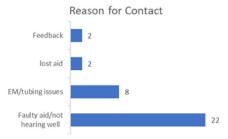


Figure 1: Reason for Contact

- A further 22 contacted the service to request more batteries or tubing
- The remaining 44 had no contact with the service during that time period.

The outcomes of the appointment for support were collated (figure 2).

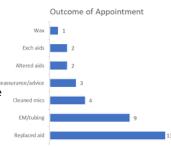


Figure 2: Outcome of Appointment

Of the 34 that accessed the service for support during the 4 month time period, a group of 20 were contacted to complete a questionnaire.

- All reported their preferred method of contact with the service was by phone.
- 70% were aware they could contact the service by email.
- 60% were aware the service had a website with information and instructions for patients
- All reported they received the video drop-in clinic letter.
- All reported they did not try the service and they prefer to see someone in person.
- All patients reported they were hoping the open access repair/support clinic (face-to-face) would reopen soon
- 20% also stated they were hoping the volunteer dropin community clinics would re-open soon (both closed during Covid-19 pandemic)

Project Conclusions:

Results indicated that this hearing aid patient group did not benefit from a video 'drop-in' hearing aid support clinic.

Patients chose not to contact the department this way and reported to prefer face-to-face support.

This would suggest it would not be worthwhile offering this service as a means of accessing support for Audiology hearing aid patients.





Cardiff and Vale University Health Board Bevan Exemplars

The Sustainable Value of Analgesics within the NHS: Could Adoption of Oral Pre-Operative Analgesia Reduce the Need for IV Analgesics? | CAVUHB

Siena Hayes - CAVUHB/Cardiff University | Contact: hayessi@cardiff.ac.uk

Project Background:

Climate change has been defined by the WHO as the most substantial threat to human health in the 21st century. Currently the NHS accounts for 25% of public sector carbon dioxide emissions in the UK and is coming under increasing pressure to reduce its environmental impact. The current NHS carbon footprint is 24.9 million tonnes CO2e per year. The main contributors being medical equipment and pharmaceuticals and thus scrutinisation of these areas to help deliver a net-zero NHS by 2050 has been of particular interest. Anesthetics specialty has the highest overall Greenhouse Gas (GHG) emissions in secondary care. The use of preoperative oral analgesia is being practiced more over recent years, however the traditional intraoperative IV analgesia is still the most popular method. Paracetamol is widely accepted as an effective analgesic worldwide based on its well established efficacy and tolerability, with recommendations for its use as first line analgesia established globally. As pharmaceuticals are the largest GHG emitter within the NHS, and with paracetamol being the most clinically used analgesic, it represents an ideal target to determine the magnitude of GHG emission attributable to its different delivery formats.

Project Objectives:

Calculate per 1g paracetamol:

- Carbon footprint
- Cost
- Clinical efficacy

To enable the study to evaluate the 'sustainable value' of each preparation. Once results attained, see if this clinical change can be discussed and integrated into clinical practice within NHS preoperative wards across Cardiff and nationally.

Project Methodology:

A Life-cycle Assessment (LCA) was calculated from 'cradle to grave', applying the Inventory of Carbon & Energy database to attain the embodied carbon factor to enable a total kgCo2e for each preparation. Once data was attained, pre-operative teams were given a self reporting questionnaire. Likert scales were used to assess knowledge of this practice and also thought on the proposed change of oral use. Discussion groups were organised to assess barriers to clinical change, and how we could address them to enable a smooth transition.

Project Impact:

To instigate a clinical change from IV to oral paracetamol preoperatively, through creating the 'IMPROVE' project at Noah's ark – 'Improving Paracetamol use with Routine Oral over Venous administration'. Guidelines have been formatted for doctors and nurses involved in pre-operative patients care.

Project Outcomes:

The IV preparation had the highest price per 1g of paracetamol at £1.20. Of significance was the substantial cost of suppositories at £11.04 per 1g, being the most expensive. Overall this equated to **1g of IV paracetamol being x48 more expensive than oral.**

IV preparation has a significantly higher total kgCo2 at 9.23, oral suspension at 2.79, suppositories 0.71, effervescence at 0.39 and oral at 0.084 kgCo2 per 1g of preparation. **This equated to IV having x110 increase in KgCo2 in comparison to the oral tablet.** Extrapolation of these result for the use of oral over IV paracetamol peri-operatively for the current Wales/ England yearly surgical total could **yield a reduction of 42.8 million kgCO2e per year.** The government would have to plant 2.7 million trees to have the same effect (Kendall 2012), so over 4 years that's the same number as all the trees in Wales!

Clinical efficiency between all preparations were equivalent. 90% of anaesthetists were concerned about the impact of their clinical practice on the environment and already actively take measures to try and reduce this. Further the vast majority (85%) administer paracetamol IV intraoperatively but most (86%) would also consider changing practice to prescribing oral paracetamol preoperatively.

Project Conclusions:

With a substantial GHG emission and price difference in IV paracetamol over oral, the question surrounding the need for this preparation needs to be considered with lack of clinical superiority over its concurrent oral use. With the NHS striving for 'Net-Zero' GHG emissions, this contribution could bring this ambitious target a step closer, whilst reducing the NHS economic burden that pharmaceuticals confer.

The pre-operative team are open minded to this change however did highlight challenges. This allowed us to develop solutions to these issues raised, which has lead to the IMPROVE project, being integrated into the pre-op proforma in Cardiff.

Automating Dose Badge Distribution Tracking: To Save Time, Money and Accurately Track Doses | CAVUHB

George Morris - CAVUHB | Contact: George.morris@wales.nhs.uk

Project Background:

By law any individual working with/around ionising radiation must wear a Thermoluminescent Dosimeter (TLD). These TLDs once processed show how much radiation an individual has been exposed to over a period of time. On average these TLDs are changed bi-monthly and sent off to be processed. If one of these TLDs are not returned within the specified time period, the department responsible for returning the TLD is fined £31.80. In large departments it is possible that a significant number of these TLDs are not returned by individuals, resulting in a large fine to be paid by the department. To counter this, a system whereby the exchanging of these TLDs could be monitored, was needed.

Project Aims:

- Reduce the number of unreturned TLDs by radiographers.
- Reduce the time spent by radiographers sorting TLDs
- Accurately track timings of returns to aid dose breach investigations.

Project Methodology:

Over a 14 month period, the spreadsheet was used to track the exchange of TLDs by individuals working in the University Hospital of Wales Radiology department. This study included a cohort of 92 radiologists, 93 radiographers and 41 radiology department practitioners (RDAs). At the end of the study the data from the spreadsheet was compared against the official return statistics provided by RPS Velindre to assess whether the number of TLDs scanned into the spreadsheet impacted the total number of TLDs returned.



Figure 1: Example of TLD

Project Outcomes:

The data shows that the percentage of unreturned badges is closely linked to the number of TLDs not scanned into the spreadsheet. The greater the percentage of TLDs scanned the higher the percentage of returns.

On the other hand the data suggests that this system has not improved the overall return rate of TLDs within the department.

When analysing the fine reports from RPS Velindre the fines to the department for radiographer TLDs has dropped by nearly £400.

	30/04/2021	30/06/2021	31/08/2021	31/10/2021	31/12/2021	28/02/2022	30/04/2022	30/06/2022
NOT SCANNED	8	4	15	17	17	5	8	14
NOT RETURNED	0	0	4	0	4	2	2	1
RETURNED	67	71	70	67	67	81	74	58
TOTAL EXPECTED	75	75	85	84	84	86	82	72

Figure 2: TLD Returns/Scanned

Project Impact:

The overall impact of this project has been a decrease in fines paid by the department, a decrease in radiographer time taken to arrange and log the TLDs and increased awareness of the importance of returning TLDs on time.



Figure 3: Graph of Percentage TLD Returns/Scanned

Project Conclusions:

Logging TLD exchanges has shown to positively impact the rate of TLD exchange. However, the lack of interaction with the spreadsheet has meant that the rate of TLDs returned has fluctuated throughout the monitored period.

Despite the fluctuations, the **6 monthly fines have dropped from a maximum of £733 to a low of £237**. If this trend continues along with an increased interaction with the system then there is potential for these fines to reduce even further.

Psychoeducation Programmes for Bipolar Disorder | CAVUHB

and National Centre for Mental Health

John Tredget - National Centre for Mental Health | Contact: tredgetj@cardiff.ac.uk

Project Background:

Bipolar disorder is thought to directly affect approximately 5% of the population, the equivalent to 3.4 million people in the UK. It can be a serious and enduring mental health condition with high morbidity and mortality.

Presentations include symptoms consistent with depressed or elevated mood but can vary hugely between people, although there can also be many similarities.

The burden of bipolar disorder can be significant, impacting on personal, family, social and employment activities with a UK economic cost estimated at £6.4 billion annually through lost productivity, informal care and health and social care (Costs of bipolar disorder in the UK, Simon et al, 2021).

Psychoeducation is recognised by NICE and SIGN guidelines as being beneficial for bipolar disorder through reduction of symptoms, reduced number of relapses, increased periods of remission and improved wellbeing. However, implementation appears to be low and geographically variable.

Project Aims:

We wanted to build on our success of the Bipolar Education Programme Cymru (BEPC) and develop similar psychoeducation interventions virtually as well as establishing training programmes for clinical staff further afield to provide our psychoeducation programmes.

Project Methodology:

As a result of the Covid pandemic we re-tooled our existing psychoeducation interventions, offering virtual programmes, including:

- "Booster" sessions to previous BEPC course graduates.
- "Bitesize BEPC" webinars developed and provided with Bipolar UK, the leading UK charity for supporting those affected by bipolar disorder.
- **eBEPC courses**, similar to the face-to-face groups but in a virtual setting.
- Developed and produced training programmes in conjunction with Virtual College for clinicians to provide the face to face BEPC.















Project Impact:

- 86% of eBEPC respondents (n=42) stated they had learned new information and better ways to manage bipolar disorder
- 95% stated they were satisfied or highly satisfied with the programme
- 100% would recommend the programme to others with bipolar disorder

"I have learned much more about bipolar disorder and how to continue living a fulfilling life."

"Sharing with others in a supportive environment"

"Knowing I wasn't alone – I had never spoken to anyone else with bipolar before!"

Project Outcomes:

- Booster sessions attended by 76 participants.
- Five "Bitesize" BEPC webinars attended by **350 people** and subsequently viewed **3,300** times online.
- 11 eBEPC courses delivered with **53 participants.**
- Two 45 minute training programmes for clinicians to deliver the BEPC and eBEPC programmes completed in conjunction with Virtual College. These are now due to be uploaded on the NHS ESR platform.

Project Conclusions:

Group psychoeducation interventions for bipolar disorder have been clinically proven to be effective in reducing relapse, increasing periods of remission and improving wellbeing. Despite this, there appears to be no widespread use of such interventions and they should be firmly embedded in routine mental health care.

Promoting A Healthier Community | CAVUHB and The Mentor

Ring | Sujatha Thaladi - The Mentor Ring | Contact: Sujatha.thaladi@MentorRing.org.uk

Project Background:

A year long project that will provide three online 'chatroom' sessions with a minimum of three healthcare experts to deliver information, facilitate a discussion and answer questions on a topic chosen by the community itself.

We have held sessions like this within the community before focusing on Covid-19 and the misinformation surrounding protection protocol and vaccines. These have been very successful throughout the community.

We have also held sessions on mental health and diabetes and would love to be able to extend this further covering health topics that the community itself deems important.

Project Aims:

Promoting a healthy community' aims to address the misinformation that the community has received on a number of health issues. Many members of the community receive their information on healthcare through word of mouth or from many conflicting sources.

- We aim to tackle the abundance of misinformation in the community through using medical specialists to provide educational and information sessions. These sessions will empower the community members to make informed decisions on their health.
- We aim to address the emotional attachment that many members of the community have with these misconceptions.
- To deliver these sessions online so as to reach the highest number of vulnerable people and to make it as accessible as possible.
- To provide opportunities for the community to relay what healthcare advice they feel they need and then tailor the sessions to meet this demand.
- To provide opportunities for discussion and to ask questions to healthcare professionals.
- To provide workshops and 1-1 follow up sessions.

Project Methodology:

We held four information online sessions led by health experts: Milind Girish, Dr. Raj Madula, Dr. Sasha Ang, and Girishankar, Rupesh Kumar Polani.

Topics covered for the online sessions:

- Covid misinformation.
- Misinformation regarding Women's Health.
- MonkeyPox: information and misinformation on Monkey Pox and other communicable diseases.

ITopics for the in-person sessions included:

- Diabetes awareness session.
- Use of Pocket Medic.
- Self management of foot care for those with Type 2 diabetes.

We came across individuals who found it difficult to access the information. We held additional 1-1 mentoring sessions with those who requested help.

Project Outcomes:

Although our original proposal was to conduct 3 information sessions, we found that there was an increase in interest from the community to have more sessions.

This led to an increased number of peer support sessions.

Many members felt more informed as the information came from health experts and they were able to refer back.

Outstanding lessons

- · Wonderful networking.
- · Amazing training opportunities.
- Raising the profile and credibility of the charity The Mentor Ring.'

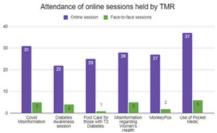


Figure 1: Attendance at online sessions

Project Impact:

- A total of 170 people viewed online sessions.
- 23 wanted face to face sessions (including, importantly those who were not able to communicate in English).
- An increased awareness of health and wellbeing issues and approach appropriate health experts for their concerns.

Work presentation

- TMR attended Welsh Government cross party meetings where TMR shared about their work.
- TMR is also publicised the information sessions via Welsh Assembly's Newsletter as well as Public Health Wales.
- Presented to Board Members of TMR.
- Social Media and local communities.
- TMR has a YouTube channel where recorded sessions are available for the public.

Project Conclusions:

- There is an abundance of misinformation in the community.
- Absolute necessity to better inform the public.
- Vulnerable people are most affected with misinformation.





Cwm Taf Morgannwg University Health Board Bevan Exemplar

A Novel Collaborative Approach to Swallowing, Nutrition and Medication Management using Digital Technology | CTMUHB

Sheiladen Aquino, Tom Sauter, Amber McCollum, Lucy Marland and Jodie Miller - CTMUHB Contact: Sheiladen.Aquino2@wales.nhs.uk

Project Background:

Difficulties with swallowing, known to precipitate malnutrition and affect compliance with medication, significantly affect residents in care homes. Currently, Speech and Language Therapists, Dietitians and Pharmacists provide separate home visits. Residents need to be referred to all three professionals, be on three different waitlists, and attend three separate appointments. While waiting, residents continue to deteriorate, resulting in poor outcomes and experiences. This causes more stress to care home staff who need to make decisions about their care without support. As the residents' health further deteriorates, they need to be taken to the hospital for admission, which is costly and causes further bed blockage in an already over stretched hospital system.

Project Objectives:

The project used quintuple aims to ensure that the proposed service improvement is based on the latest internationally recognised health and care improvement framework.

Aim 1: To improve individual care experiences by reducing waiting times and receiving seamless, integrated care from multiple professionals.

Aim 2: To improve clinical outcomes using standardized therapy outcome measures.

Aim 3: To evaluate costs reduction or cost-neutral opportunities in using the novel intervention.

Aim 4: To report workforce wellbeing from interviews and workforce-reported outcome measures when using this new model.

Aim 5: To assess equity of care to elderly residents in care homes with complex and chronic health issues when using digital technology.

Project Outcomes and Impact:

- Improved residents' experience as waiting times reduced by 75%.
- Improved patient Quality of Life outcomes.
- Potential savings of £48,645.37 pa.
- 85% of referrals completed care using telehealth
- Improved experience and clinical outcomes for care home residents.
- Increased NHS capacity: In a year, additional 66 hospital bed days are released and community staff can see 50 more clients.
- Greener planet: saved 1.12T of Co2.
- Improved workforce confidence and wellbeing with potential implications for recruitment and retention.
- Provided a model on how to use technology to provide equitable patient centred care.

Project Methodology:

A three phase approach was used in four care homes between three disciplines:

- 1.Collaboration phase 4 months
- 2. Training Phase 2 months
- 3. Pilot and Evaluation Phase 6 months

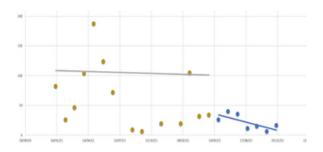


Figure 1: Significant reductions in waiting times pre and post intervention

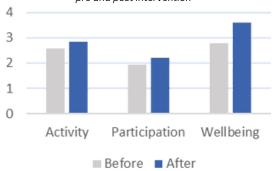


Figure 2: Improved Quality of Life Outcomes

Project Conclusions:

A remote integrated model of services to care home residents has shown positive patient experience, improved clinical outcomes, potential cost reduction, increased workforce confidence, and can provide equitable care for vulnerable patients in the community.





Hywel Dda University Health Board Bevan Exemplars

HDUHB Community Pharmacy UTI PGD Service | HDUHB

Rachel James, Kelly White and Zoe Kennerley - HDUHB | Contact: rachel.james10@wales.nhs.uk

Project Background:

There is a national drive to provide care closer to home and for community pharmacy to provide a greater range of clinical services. A community pharmacy based Urinary Tract Infection (UTI) service will build on services currently available and reduce pressures on other parts of the NHS including general practice and urgent and emergency care by providing a means of referral to participating pharmacies for females aged 16 to 64 years presenting with symptoms of uncomplicated lower UTI.

Project Aims and Objectives:

- To ensure that patients have access to timely, consistent and appropriate management of uncomplicated lower UTI in non-pregnant female patients aged 16 to 64 years.
- To reinforce the Pharmacy First messaging and to encourage self-care and educate patients on prevention of UTI as well as demonstrate antimicrobial stewardship.
- To be the **first** point of contact for **all** non-pregnant females aged 16 to 64 years presenting with symptoms of lower UTI, providing an alternative pathway.
- To utilise the skills and knowledge of Community Pharmacists and support the model of prudent healthcare.
- To allow for greater integration of community pharmacies into the primary care network.

Project Methodology:

The HB secured funding via the Urgent Primary Care fund for two years to start the service. The team developed a service specification and PGD as well as a detailed consultation form. A training package was then developed which accompanied with a HEIW webinar attributed to accreditation for the service. Information about the service was shared with GP practices, 111, GP OOH, local MIUs. a referral guide to aid with referring appropriate patients was also developed. Posters, leaflets and social media resources were produced to promote the service.

Project Conclusions:

Project Outcomes and Impact:

Up to the end of August 2022:

- 1,152 patients accessed the service which demonstrates significant savings with regards to appointments and related costs in other settings.
- Based on patient survey results, 71% stated that they
 would have attended a GP practice had they not had
 access to the UTI PGD service (Fig 1), this would suggest a
 projected cost saving within GMS alone of £31,902 over
 an 11-month period.
- 71% patients treated with an antibiotic.
- 160 pharmacists trained to provide the service.
- 71% pharmacies (HDUHB) now offering the service.
- Community Pharmacists have developed new clinical and diagnostic skills.
- 2. There is now an alternative referral pathway for the management of lower UTI in eligible patients.
- 3. Patient education around the 'Choose well' message and promotion of self-care and prevention of UTI.

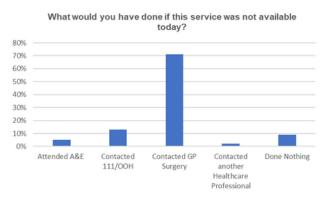


Figure 1: Patient survey findIngs

- Community pharmacy has the potential to provide a consistent and efficient service treating uncomplicated lower UTIs. It has demonstrated the ability to become a first point of contact for these patients, reducing the number of consultations carried out in GPOOH/A&E/111.
- Community Pharmacists have the skills and knowledge to deliver the service and this has provided the majority with professional satisfaction.
- Patients have shown confidence in the service with 98% saying they would use the service again.

Remote Clinical Pharmacist Rapid Medication Reconciliation

HDUHB | Ruth James - HDUHB | Contact: Margaret.james@wales.nhs.uk

Project Background:

Time in General Practice identified wide variability in how practices import DALs, allocate meds rec to staff; and the time taken to action DALs (24 hours v 2-3 weeks).

Project Aims and Objectives:

Aim:

 Streamline medication reconciliation, working across care settings to rapidly and safely act on information shared to release capacity for clinicians in practice.

Objectives:

- Reduce variability between staff in practice who undertake medication reconciliation work.
- Reduce time GPs spend on medication reconciliation.
- Improve communication of medication changes to Community Pharmacy for patients who require compliance aids to support medication administration.

Project Methodology:

Use remote access to WCP and GP clinical systems to:

- Identify patients discharged from WGH in preceding 24 hours.
- Update repeat prescriptions.
- Identify and arrange monitoring and raise queries relating to changes with secondary care / specialist teams as necessary.

Project Outcomes:

- Identification of critical prescribing errors in secondary care, and prevention of repetition in general practice.
- Reduction in number of patients accessing medication that has not been updated following changes in secondary care
- Release clinician time in practice.
- Identification of common themes that may contribute to medication errors when patients move between care-settings.

Project Impact:

- 6 DATIX forms completed.
- · 2 Yellow Cards.
- 11 errors in medication reconciliations undertaken in practice.

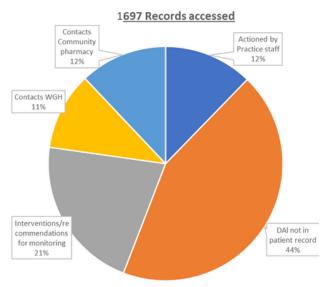


Figure 1: Outcomes of medication reconciliation

"A great resource in Community Pharmacy"

"Saves a lot of time and mistakes by GPs"

Project Conclusions:

Timely communication between HCP and care settings can be challenging, with the result that changes that have been effected may fall at one of multiple hurdles.

Timely, remote medication reconciliation by a clinical pharmacist benefits patients and HCP in different settings.

Community Pharmacy Mental Health and Wellbeing Project

HDUHB | Laura Lloyd Davies - HDUHB | Contact: lauralloyddavies@wales.nhs.uk

Project Background:

The mental health and wellbeing of the local population has been significantly affected following Covid-19. Llanelli Cluster has consistently witnessed the highest rates in Hywel Dda University Health Board, experiencing a local lockdown in September 2020 which has contributed to an increase in the local population accessing mental health and wellbeing services. This project will enable an opportunity for the cluster to offer additional support to our community and develop a new service for Community Pharmacy.

Project Aims and Objectives:

- It is hoped that it will result in increased opportunities for patients to access professional support and advice in the locality.
- The patient journey from GP to pharmacy to accessing services in the community will be strengthened and will benefit all, both staff and patient.
- The project will link cluster and community services such as Mind Llanelli, social prescribers, third sector groups enabling better communication and opportunities for the population.
- This will be a new role for Community Pharmacy and a development opportunity for the way that Community Pharmacy engages with the cluster and the local population.

Project Methodology:

The project will be a service offered to all adults in the Llanelli Cluster who have been newly prescribed a Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant by their GP. Community Pharmacy dispensers and technicians will deliver the service when patients attend the Pharmacy to collect their medication.

Project Outcomes and Impact:

The project commenced in September 2021 with all seventeen of the Community Pharmacies in the Llanelli Cluster engaging in Mental Health First Aid training delivered by a local team Mental Health Connected. At least one person from each practice received the training to enable them to deliver this service.

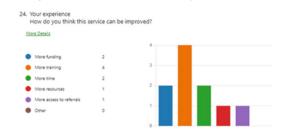
- **3** Community Pharmacies have engaged.
- 31 patients have had initial consultations.
- 9 patients have had their final consultation.

Health Professional Feedback:

Project evaluation was sent to all seventeen community pharmacies in the Llanelli Cluster. Six responses were received.



Figures 1 (above) & 2 (below): Survey responses



"I really enjoy providing this service so people are aware that there are other places available to help advise and listen which a lot of people are unaware of."

Project Conclusions:

Community Pharmacy are keen to engage with patients and change the more traditional roles carried out. Primary care and clusters must nurture and develop this movement as much as possible. With Accelerated Cluster Development (ACD) beginning to pick up speed, the interaction with primary care and community colleagues is key to progression.

To conclude, not everyone will be in a position to engage with this service but those that are, and those that are keen to have an impact with patients, should be supported and encouraged to do so. The future of primary care must be collaboration, patient co-production, skilled workforce and accessible services.

Developing an Interdisciplinary One Health Education Package

HDUHB and PHW | Marc Davies - HDUHB | Contact: marc.davies@wales.nhs.uk

Project Background:

"One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems. The approach mobilizes multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems." (WHO)

There is an opportunity for One Health approaches to promote interdisciplinary teaching and professional development on system-wide issues that cross the human-animal-environmental interface, integrating multiple disciplines across the system and bringing together partners to work on issues that intersect these domains.

Project Aims and Objectives:

Aim:

To embed One Health approaches in Wales, creating new partnerships on system-wide issues that cross the human-animal-environmental interface.

Objective:

To develop, deliver and evaluate a One Health education package aimed at introducing and embedding One Health concepts.

Project Methodology:

This project applied the One Health approach to the education setting, integrating a range of specialties and disciplines where possible. This involved establishing links with existing and new partnerships in order to develop, deliver and evaluate the education package and then develop a set of recommendations for the next steps. Different teaching methods were applied and evaluated to continuously develop and improve the approach.

Project Outcomes:

- Presented a One Health Webinar to a multidisciplinary audience hosted by Public Health Network Cymru.
- Delivered a One Health workshop at the Green Health Wales conference.
- Presented on One Health at a Swansea University Medical School Faculty Development Session.
- Delivered a One Health workshop to an audience brough together by the Bevan Commission and Learned Society of Wales.
- Funding has been secured for a One Health practitioner in Hywel Dda UHB, the first in Wales.



Project Impact:

Feedback from the Public Health Network Cymru Webinar



Why did you give this score? "A good overview of some of the

- issues an work that is going on."

 "Really informative, covering many aspects which does highlight the importance of communication between all stakeholders."
- "Information was relevant and all participants spoke very well."
- "Great selection of presenters, fascinating presentations."

Project Conclusions:

Connections

One Health highlights the importance of the connecting and coming together of multiple disciplines to share different challenges and perspectives. There was some discussion around the benefits of a coordinating function that promotes this collaboration and where the testing of these challenges and perspectives against One Health principles could be promoted.

Complexity

One Health as an approach can help us to work with the uncertainty and complexity of issues that intersect the human-animal-environmental interface, incorporating data, knowledge and skills from a range of disciplines and lenses. There was some discussion on how this complexity and uncertainty could be then applied within networks and statutory bodies in Wales, e.g. Public Service Boards under the Well-being of Future Generations Act.

Competencies

A One Health education package could be used to help test our challenges and experiences from our own disciplines against One Health principles. This could help us to address gaps in our knowledge and skills (e.g. zoonotic diseases and its relation to human health) as well as identifying opportunities to strengthen existing areas of work and promote cohesion in our approaches (e.g. using One Health as part of interprofessional education).

Building Bridges between Housing and Health | HDUHB

Gareth Morgan - HDUHB | Contact: Gareth.P.Morgan@wales.nhs.uk

Project Background:

There is an extensive and compelling evidence base that housing and health are linked. There are multiple relationships that are bi-directional and impact on both mental and physical health. Housing is also a major determinant of NHS pressures. A cold home can exacerbate chronic illness. It is also a major element of hospital discharge, especially in situations where patient mobility has changed. Yet there is no systematic framework to convert the evidence into practice across Wales.

In recognition of this, this project has set out to build bridges between housing and health with a view to better linkages.

Project Aims and Objectives:

Aims:

The overall aim of the project was to set down a foundation for a long-term housing and health programme across Wales. The aim of such a programme would be to improve health and reduce NHS pressures by converting the evidence into practice.

Objectives:

- Develop a housing and health good practice guide.
- Convene an all-Wales Community of Practice.
- Test the good practice guide in at least one Health Board.
- Raise awareness on the guide and the evidence-base.

Project Methodology:



Project Outcomes:

- Community of Practice brought together different partners, with the potential for future collaboration beyond the project.
- Good practice guide on health and housing delivered in a short and long version. A service user group was involved in the development of this guide.
- The good practice guide has been piloted in one health board.
- Awareness raised on the evidence based and guide.

Project Impact:

Impacts can be defined into 2 parts.

- 1.Indirect impacts in terms of discussions with other colleagues, including presentations at meetings.
- 2. Direct impacts are to be realised and given the current cost of living pressures, this project could help ease & mitigate these.

Project Conclusions:

This project has shown that housing and health partners can work collaboratively to develop practice solutions. The key product of the good practice guide is now ready for implementation.







On your Bike! | HDUHB

Anna L. Prytherch - HDUHB | Contact: anna.prytherch@wales.nhs.uk

Project Background:

- Obesity is a significant problem worldwide that has tripled since 1975 (WHO, 2018).
- 80% of obese adolescents will still be obese in adulthood (M. Simmonds et al, 2016).
- Welsh Government and Public Health Wales predict that by 2050, the NHS will spend £465M/yr caring for obese people (Healthy Weight; Healthy Wales, 2019).
- Lack of physical activity is a contributing factor to obesity, with only 14-17% of 11-16 year olds being active for more than 60 minutes a day (WG, 2019).
- Lack of physical activity has a detrimental effect on mental health, with more than 10% of Ceredigion's children experiencing stress, anxiety and depression (Ceredigion PSB, 2017), with these figures exacerbated as a result of the Covid-19 pandemic.
- "On your Bike" targets young people (14-25yrs old), encouraging them to use static bikes to charge their mobile devices whilst raising key messages on obesity, physical and outdoor activity and environmental issues.

Project Aims and Objectives:

- Increased awareness of the importance of outdoor activity for young people, evidenced through:
- 1. min. 150 completed questionnaires;
- 2. attendance by 60 young at 4 consultation and engagement events.
- Installation of static "human powered" bikes at 3 locations in Ceredigion.
- Data collection evidencing use (frequency / time) and energy created by 20 project volunteers.
- Changes in wellbeing of 20 project volunteers over project duration.
- Press / media coverage of project, with a minimum of 4 articles published.
- Research results published in an end of project report.
- Research results presented in poster or paper format at a minimum of 2 conferences.

Project Methodology:

PHASE 1:

- Consultation surveys to confirm preferred sites and facilities; consultation with identified communities.
- Installation of bikes (inc. necessary consents / compliance etc.).
- Awareness raising of provision, including wellbeing and health benefits of physical activity and outdoor recreation.

PHASE 2:

- 1. Research on use and benefits derived.
- 2. Final report on outcomes and benefits / any lessons learnt etc.

Project Outcomes:

- Over 300 young people engaged with (309 completed questionnaires).
- **9 focus groups** were held, with a total of 172 attendees.
- Over 500 young people engaged with via schools / youth clubs and other youth organisations (target was 150).

- **76** young people volunteered to participate in active research phase (target was 20).
- 143 out of the 309 (46%) participants were female
- 129 out of 309 (42%) participants spoke Welsh.
- 9 bikes installed in three sites (Cardigan, Lampeter and Aberaeron) in October 2022.
- Bikes launched in November 2022 January 2023.
- Active research scheduled for January June 2023.

Project Impact:

- So far, despite delays in siting the bikes and launching the active research phase, a significant number of young people have been involved and the public health messages have been successfully debated at schools and in youth groups.
- There has been a lot of interest in the project across Wales, particularly in light of the increasing prominence of climate change, the increase in cost of electricity / power and sustainable power generation.
- The potential for other areas across Wales to install these bikes as a means to encourage outdoor physical activity is immense.
- Young people have been very keen to get involved and enthusiastic to participate.
- The health and wellbeing impact of undertaking outdoor physical activity needs further promoting, particularly to young people.

Project Conclusions:

- Two reports produced on the consultation phase (engagement with young people & communities).
- Additional time is required to monitor active use and impact on health and wellbeing.
- Unforeseen delays, due to Covid and external factors, impacted the timing of the active research phase.
- Lessons learnt:
- 1. Factor in sufficient slack time, everything takes longer than vou think!
- 2. Don't give up when you hit a problem, revisit the project plan and adjust, but keep going.
- 3. Don't lose sight of the end goal.
- 4. Share your learning with others and absorb what you learn form others, formally / informally.

Connecting Realities | HDUHB

Sarah Beauclerk and Michelle Copeman - HDUHB | Contact: connectingrealities@gmail.com

Project Background:

Multiple aspects of the Covid-19 pandemic meant that people were unable to physically participate in the events and activities that previously connected them socially*, leading to new digital catalysts in which traditional face-to-face services moved online. Whilst the revolution of digital inclusivity has been found to help people at risk of isolation remain socially connected with others, virtual-only inter-household contact has also been negatively associated with mental well-being in older adults**, perhaps even exacerbating loneliness.

The project explored:

- What kinds of virtual experience create the most positive impacts on health and wellbeing, particularly within groups at the highest risk of isolation?.
- Can virtual technology be used in a way that will support a safe restoration of physical access and mobility?

Project Aims:

To develop digital solutions that provide meaningful wellbeing benefits and improved outcomes and quality of life for people at risk of isolation. The project hopes to create a new blueprint for integrating VR as a valuable community resource.

Project Methodology:

- A steering group was established and a variety of potential routes to development were explored.
- The areas with most clearly registered demand and potential were developed further and tested small scale. Service users were involved in the co-production of experiences.
- The toolkit was created. Systems were put in place. The project was rolled out on a larger scale using a method that supports constant research and development.

Project Outcomes:

The creation of a **Connecting Realities Toolkit** to empower the creation and sustained delivery of digital and immersive solutions.

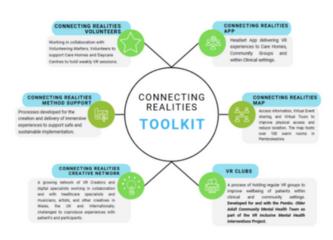


Figure 1: Connecting Realities Toolkit

Project Impact:

- 50 + VR Sessions supported over 200 VR Experiences.
- The project is working with 4 x Care Homes and 3 x Daycare Centres.
- 3 x team members are employed part-time to support and create VR sessions.
- 2 x support events occur weekly, each event reaching approx. 10 individuals at risk of isolation.
- 6 x Virtual Reality Tours and 10 x access information profiles are developed, with more in development.
- Project developed with the Pembrokeshire Hwb maps and shares over 100 warm rooms in Pembrokeshire.
- A Creative Network linking VR innovation with Healthcare is in development.
- 100% of Care Homes supported to hold a VR session requested more sessions.
- Feedback forms suggested that 78% of care home participants, many who are living with advanced dementia, showed an improvement in mood after a Virtual Reality Experience, with 0% reduction in mood observed.
- **100%** of health and social care professionals involved in the delivery of VR sessions found them a positive experience for their service -users.

"Excellent experience for the residents, they enjoyed it very much, a great way to show them something different." Care Home Feedback "Extremely immersive. I felt as if I was truly within the surroundings. Crystal clear images. Superb." Experience participant

Project Conclusions:

Of the routes explored, the following areas registered the highest demand and opportunity for continued development.

- To create and support the delivery of VR and XR material as a virtual wellbeing experience when physical access is not possible.
- Providing digital information to support people at risk of isolation to successfully access physical locations and experiences.
- Establish innovative new material by bringing together creative, computer, and healthcare specialists.

** COVID-19, Inter-household Contact and Mental Well-Being Among Older Adults in the US and the UK', Frontiers in Sociology, July 2021

VR Mental Health Interventions | HDUHB

Katherine Lewis and Sarah Beauclerk - HDUHB | Contact: Katherine.Lewis5@Wales.nhs.uk / connectingrealities@gmail.com

Project Background:

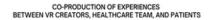
The pandemic has exacerbated pre-existing health and access inequalities and many older adult patient groups in the community are experiencing reduced mobility, increased weakness and pain, and consistently low feelings. One in five older adults is experiencing a deterioration of memory since lockdown, with reduction of mental stimulation leading to forgetfulness and confusion. These factors, along with a reduction in physical activity, loss of social routine, and continued uncertainty, have meant that social anxiety and feelings of isolation and low mood are at an all-time high. The Pembs OACMHT continue to see a higher rate of referrals for older people experiencing low mood and suicidal thoughts or intent. The OACMHT wanted to embrace technology and opportunities to improve on patient outcomes.

Project Aims:

- Reduce anxiety and depression, and decrease levels of distress in patients.
- Improved access to services for at risk groups.
- Increase evidence based practice utilising up to date technology and approaches.

Project Methodology:

The project group utilised a responsive and flexible approach to delivering the VR interventions by evaluating and updating experiences at each VR session. A referral form was developed that provided inclusion and exclusion criteria and the opportunity to gather information from patients that would shape the VR experience. A VR group was held twice a month facilitated by a CPN, HCSW and a VR practitioner. Limited availability of equipment impacted the project delivery and resulted in a shared experience in a group setting.





Project Outcomes:

VR mental health interventions were provided to older people experiencing low mood and suicidal thoughts, to elevate mood and provide positive treatment outcomes.



Project Impact:

VR mental health intervention was consistently provided to 6 patients over a 6 month period. Other patients joined on an ad hoc basis. All had previously reported either suicidal thoughts, plans, intent; or had made an attempt in the 6 months prior to starting VR interventions. Some had received care and treatment as an inpatient at the start or prior to joining the VR group. All patients that participated consistently self reported positive outcomes, none required referral to crisis and home treatment, none required readmission to manage mental health risks and all remained free from intrusive suicidal thoughts.

"Feeling emotional but in a good way."

Patient comment





Project Conclusions:

- The development of mental health interventions to support older people with significant low mood by embracing technology that improves health care outcomes for patients.
- VR interventions have a positive effect on the management of depression and isolation for older people.
- Staff satisfaction is improved by increasing resources and interventions available.
- Reduced patient relapse and/or crisis.
- Improved health care outcomes by utilising skills within the team already available together with evidence based VR experiences.
- Improved impact of VR experiences by involving patients in their selection and development.
- Potential to develop new VR and non-VR resources, such as using Al for mood analysis.

Creating Practice Learning Environments (PLE) within Care Homes: Increasing Student Nurse Placements | HDUHB & HEIW

Sarah Kingdom-Mills - HEIW | Contact: sarah.kingdom-mills@wales.nhs.uk

Project Background:

- There are approximately 25,088 beds within social care and 10,288 beds within health care.
- We have 2,290 student nurses enrolled on pre-registration programmes, all of whom require 50% of their nursing programmes to be in a Practice Learning Environment/clinical placements.
- Annual projected increase in student numbers.
- · Increased PLE/clinical placements required.
- Minimal numbers of students accessing a social care placement, whilst health care (NHS) placements regularly over capacity.
- The project will look at interprofessional clinical placements; starting with student nurses to see how these can be provided within care homes, linked to the Care Home Education Facilitator (CHEF) role.

Project Objectives:

The project will focus on developing the care homes in-line with the Nursing and Midwifery Council (NMC 2018) Education Standards and the Once for Wales 2020 arrangements.

- Showcase the role of the CHEF as a key stakeholder in developing care homes as practice learning environments.
- Work with local authorities and independent providers to advise and train the staff teams in the roles and responsibilities of Practice Supervisors/Practice Assessors (PS/PA).
- Support the educational audits and development of student information packs.
- Introduce the concept of social care placements to the students as they embark on their programmes.

Project Methodology:

- Operational CHEF role spanning whole student journey including: selection and recruitment, facilitation of placement, delivery of PS/PA training, monitoring quality and quantity of placements; supporting staff and their students with action plans as required through to the point of registration. Create PLE's.
- Develop governance processes.
- Strategic responsibilities of the CHEF role are to influence, promote and embed opportunities, through collaboration with key stakeholders.
- Establishment of a National CHEF Steering group.



Figure 1: Process for creating a Practice Learning Environment

Project Outcomes:

- CHEF role integral to the development of practice education across care homes.
- Work strategically and operationally enhancing placement quality and availability.
- Develop positive, effective relationships with care home managers and other key stakeholders.
- Promote new placement opportunities across Wales.
- Increase student nurse placements in care homes.

Project Impact:



- Increased student nurse placements.
- Skilled knowledgeable health and social care staff.
- Evidence based compassionate person centred care.

"I have always had positive engagement with the CHEF and they are always great at supporting and helping during placement" - Student

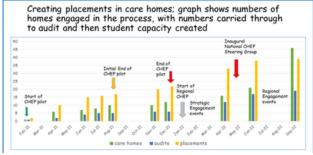


Figure 2: Care home engagement

Project Conclusions:

The CHEF's are ideally placed to link health and social care systems of work, ensuring social care are actively involved in developing our future workforce, not just in nursing but across healthcare in general.

People requiring services can be afforded the best possible care in the best possible place, with skilled staff to support and continuously assess and respond to their care needs.

Visioning a Different Care Workforce in Pembrokeshire

Pembrokeshire County Council

Rachel Gibby - Pembrokeshire County Council | Contact: rachel.gibby@pembrokeshire.gov.uk

Project Background:

In Pembrokeshire we have a growing retirement and older person's population, and like most of the UK, challenging times for recruitment and retention of staff into the care sector all contributing to growing waiting lists.

In a recent survey by West Wales Care Partnership asking staff in care what are their top motivating factors for applying for a job in care, whilst the highest was pay and benefits, the other top reasons were rewarding and varied work; increased job satisfaction; and promotion and progression.

The commissioning team within Pembrokeshire County Council have also anecdotally been informed that lone working and the feeling of isolation of people working in domiciliary care services is a barrier both within recruitment and retention of staff and sometimes a contributor.

Project Aims and Objectives:

Through developing a different model of care delivery for Pembrokeshire, across the three sectors of domiciliary care, day opportunities and care homes. Creating more flexible care roles where people are trained and offered the opportunity to work across the three sectors. Staff will be offered the opportunity to work across the sector in a given week and working in a more locality based method reducing travel time and lone working.

A second part of the project will be looking at the development of 'Place Based Care'. To create a locality care model where care can be provided within a certain mileage of a care home, bringing together people living in a care home and people receiving support in the community together.

Project Methodology:

- To achieve the aims of this project we are working with internal Local Authority teams and managers, with Social Care Wales and Care Inspectorate Wales and commissioned providers to discover flexible working over various services.
- Engagement with staff in all services, ensuring we listen to the experiences of redeployment through COVID-19 pandemic.
- Working with human resource teams looking at new job descriptions and agreements between departments.

Project Outcomes:

We were anticipating outcome for the project to be:

- 1. Enhanced skills development for staff
- 2. Improvement on 'do only what is needed no more, no less- and do no harm' staff undertaking role equivalent to their roles.
- 3. Reductions in travel time.
- 4. Improvements on the resident's experience of care.
- 5. Improvement on well-being of staff.
- 6. Reduction in waiting list.

Project Impact:

This project is still ongoing.

The impact so far is the opportunity for team managers and staff to explore different approaches to delivering care and how we can support staff differently, working with Social Care Wales and Care Inspectorate Wales.

Development of recruitment marketing and promotion tools.

Using the learning from Covid-19 pandemic redeployment programme.





Project Conclusions:

- This project has many layers and elements to it, each requiring dedicated time to develop.
- The project needs longer than 12 months to undertake.
- Covid-19 is still present and does have an impact on the development of this project as it involves working with staff involved in other front line roles.
- There is an enthusiasm for considering opportunities of other avenues of delivering services and supporting staff development.
- Engagement with staff presented additional considerations not previously considered.
- Need for a recruitment campaign.
- Consideration of additional training provision.
- Agreements between teams for ways of staff working jointly between services.
- New job description and development of a new role.





Public Health Wales Bevan Exemplar

Greener Primary Care Wales Framework and Award Scheme

PHW

Victoria Hannah, Angharad Wooldridge, Sian Evans and Huw Williams - PHW | contact: greenerprimarycare@wales.nhs.uk

Project Background:

In April 2019 the Welsh Government declared a climate emergency and committed to achieving a carbon neutral public sector by 2030. In March 2021 the NHS Wales Decarbonisation Strategic Delivery Plan was published. A scoping exercise was undertaken by the Primary Care Division, Public Health Wales to review the resources available to support primary care take action on environmental sustainability. Nothing suitable for all primary care contractors was identified. As a result, the development of a bespoke framework and award scheme that could be used by all 4 contractors was approved by the Strategic Programme for Primary Care.

Project Aims and Objectives:

To test the implementation of a national environmental sustainability Framework and Award Scheme which enables primary care contractors in Wales to take collective action at a practice level.

5% (Approx. 100) of professional contractors across Wales register to the Greener Primary Care Framework and Award Scheme, in the first year.

Increase capability and capacity of the primary care workforce in Wales in responding to the climate emergency.

Project Methodology:

An initial draft of the framework was co-produced with stakeholders via an Expert Group.

A pilot of the digital framework was conducted between December '21 and April '22.

A soft launch was held in May '22, followed by a national launch in June '22.

Ongoing engagement with the primary care frontline workforce continues to inform the development of the framework.

Project Outcomes:

- CHEF role integral to the development of practice education across care homes.
- Work strategically and operationally enhancing placement quality and availability.
- Develop positive, effective relationships with care home managers and other key stakeholders.
- Promote new placement opportunities across Wales.
- Increase student nurse placements in care homes.

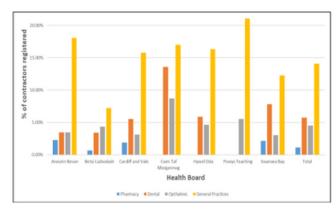


Figure 1: Percentage of contractors registered

Project Impact:

Capability and competency building within the primary care workforce and its strategic stakeholders via awareness raising sessions, education and implementation.

Wider impact: Influencing legislation relating to GP improvement grants, allowing grant money to be used towards climate mitigation.

National recognition from the Head of Ophthalmic Services in Northern Ireland congratulating Wales on "leading the way" following the publication of the Optometry Today article.

Pharmacy: Delivering A Healthier Wales 2025 Goals includes action for community pharmacy to sign up to scheme.

Project Conclusions:

Overwhelming support for the agenda has been shown at a strategic and frontline level. Co-production and an already developed framework has ensured good engagement within busy primary care settings.







Swansea Bay University Health Board Bevan Exemplars

Breath of Fresh Air! Paediatric Respiratory Physiotherapy Outreach Rapid-Response Service | SBUHB

Samantha Davies, Mari Powell and Briony Guerin - SBUHB | Contact: Sam.davies@wales.nhs.uk

Project Background:

Children and young people (CYP) with complex Cerebral Palsy (GMFCS IV and V) have abnormal muscle tone and postural deformities, which restrict lung function. These CYP are susceptible to recurrent respiratory infections. Relaxation of Covid-19 measures in 2021 prompted a global, non-seasonal surge in Respiratory Syncytial Virus (RSV), a common childhood lower respiratory tract infection. RSV causes bronchiolitis or pneumonia, often hospitalising children. To protect these vulnerable CYP, a proposal was made to pilot an outreach-in reach, rapid response service.

Project Objectives:

Based upon population health strategies, the project aimed to deliver cost-effective, prudent, innovative, sustainable healthcare to the CYP of Swansea Bay University Health Board (SBUHB) area. The objectives were to:

- Reduce A&E/PAU/hospital admissions.
- Reduce length of stay with early supported discharge.
- Educate parents/carers to self-manage the CYP.
- Improve quality of life (QoL) for the CYP and family.

Project Methodology:

- This is the first paediatric outreach respiratory service in Wales for CYP with complex disability.
- Services were benchmarked across the UK and a Nottingham-based model was adapted for our local population.
- A collaborative approach was taken, engaging parents, Allied Health Professionals and medics to create a new service delivery plan.
- Questionnaires were issued to parents to establish baseline data and pathways were streamlined in an iterative approach to feedback.

Project Conclusions:

Introducing a paediatric respiratory physiotherapy outreach-in reach rapid-response service would have a significant impact on social benefit to CYP and their families as well as to health staff and educational providers. All reported feeling more empowered to manage respiratory symptoms autonomously and to escalate concerns to the right person appropriately. Parents feel empowered to safely care for their CYP at home and feel "the service is invaluable."

Project Outcomes:

- 16 admissions prevented, plus an additional 55 bed days saved compared to 2021 data.
- 6 admissions prevented; 5 bed days saved compared to 2019 data.
- Average of 14 bed days saved per annum for assess-only admissions lasting 1-2 days each.
- Cost benefit over 8-months = a minimum of £28,350.

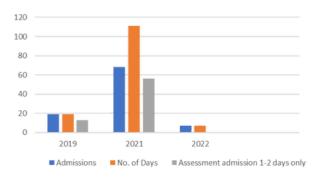


Figure 1: Comparison of Admissions and LoS pre and post intervention

Project Impact:

- Significant improvement in QoL measures for whole family.
- Improved patient-centred care/MDT working.
- Reduced parental anxiety.
- Improved sleep.
- Improved voice projection.
- Increased alertness.
- Improved ability to chew and swallow food effectively.

"Last year we had over 10 ambulance admissions...Since having access to the team, we have had no hospital admissions."

A National Occupational Health Service for Primary Care in

Wales | SBUHB | Shanti Karupiah - SBUHB | Contact: shanti.karupiah@wales.nhs.uk

Project Background:

The Covi-19 pandemic has been one of the most challenging healthcare crises since the inception of NHS. Though the pandemic affected most people, it disproportionately impacted ethnic minority groups, people with lower incomes and our frontline health and care workers across the UK. Many of these groups are still struggling with the effects of Covid-19.

Primary Care teams in Wales were struggling with their mental and physical wellbeing even before the Covid-19 Pandemic as a result of workload and exhaustion. This could also in part be due to the lack of a dedicated and independent National Occupational Health Service to oversee health, wellbeing and safety at work.

Project Aims and Objectives:

- To understand the availability and uptake of Occupational Health service for Primary Care Teams across Wales.
- To understand the need for a dedicated and independent National Primary Care Occupational Health service and what this might potentially look like.
- To design and test the viability of a potential new model of an Occupational Health Service for Primary Care in Wales.

Project Methodology:

Alongside drawing insight from observations of activities in Primary Care during the Covid-19 pandemic, the following steps were taken:

- Baseline Data Collection: from five Welsh Health Boards related to how many Primary Care staff accessed Occupational Health Services set up by Health Boards.
- Primary Care Workforce Health and Safety Survey for Wales: distributed to the All-Wales Primary Care Workforce team (clinical and non-clinical teams) to gain further understanding from frontline clinicians.
- **Discussions and interviews with occupational health experts**: on the current Occupational Health service provisions, their experiences as service providers and their vision for the future.
- Data analysis, design and testing of new Occupational Health service model for Primary Care in Wales.
- Evaluation of new model: Focus groups and questionnaires to gain stakeholder views on the proposed model.

Project Conclusions:

The project has highlighted that the lack of National Occupational Health Service for Primary Care had potentially impacted staff health and wellbeing including their safety at work.

The development of this service could significantly improve the health and wellbeing of our Primary Care workforce in Wales. This independent and self-funding service could support with retention and recruitment of the workforce by ensuring that priority is given to their wellbeing, ensuring that they are fit and able to look after our nation. This service could also help reduce the financial cost of hiring a locum workforce during sickness absence.

Project Outcomes:

Findings from data collection (Figure 1 & 2) demonstrated both low awareness and uptake of Occupational Health Services by Primary Care staff in Wales using data collected from health boards and surveys.

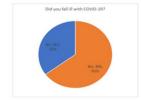
Number of Primary Care staff who had accessed Occupational Health Services in fiv NHS Wales Health Boards				
	Pre-Pandemic	Number:	During and Post Pandemic	Number:
SBUHB	01/03/2018 29/02/2020	1	01/03/2020 23/07/2021	- 5
ABUHB	01/03/2018 29/03/201	29	01/03/2020 31/12/2021	33
HOUHB	No data was provided		From 2021 - 2022	147
CAVUHB			From 2020 - June 2022	25
СТМИНВ			From 2020 -	,

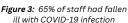
Seeal Health Services in five sealing the sealing

Figure 1: Uptake of Occupational Health services by Primary Care staff across five NHS Wales Health Boards.

Figure 2: 63% of staff working in Primary Care did not know that HB made available Occupational Health Service from 1 Nov 2020.

Findings from the survey also demonstrated a significant need for more effective occupational health services to support Primary Care staff in Wales (see Figure 3 & 4).





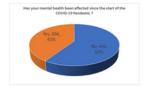


Figure 4: 41% of staff (304) are struggling with their mental wellbeing since the start of Pandemic.

Drawing insight from survey and interview data as well as the project lead's personal experience of delivering frontline care as a GP, a new model for a National Primary Care Occupational Health Service in Wales was designed and tested (Figure 5).

Suggested roles of the potential new service integrated into the model include amongst others: health assessments, surveillance and mental health support. The service would be run independently and would be self funding.

Project Impact:

Responses to questionnaires distributed to expert focus group members showed that **91%** of people who answered agreed that there is a need for a National Occupational Health Service for Primary Care in Wales. They also felt that the proposed service would have a positive impact on the health and wellbeing of the Primary Care staff.

Figure 5 (right): new model for a National Primary Care Occupational Health Service in Wales.

