Comisiwn Bevan Commission

# Bevan Commission

## Achieving Change Together

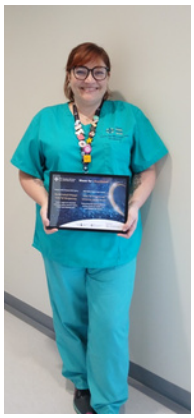
Bevan Exemplar Programme

Cohort 9 Compendium


www.bevancommission.org



> The support from the Bevan Commission has been instrumental throughout providing a dynamic platform to bring innovation to life and validate new approaches within healthcare. I would strongly encourage any emerging healthcare projects to consider applying to the Bevan Commission. It's an excellent opportunity to refine ideas, gain support, and drive meaningful change.
>
> *Bevan Exemplar, Cohort 9*




# WELCOME AND FOREWORD

The Bevan Exemplar programme was founded on a simple but powerful belief: that the people closest to delivering care are best placed to improve it, *transformation from within*. Over successive cohorts, that belief has been consistently proven. What began as an idea to support individual innovation projects has evolved into an internationally recognised approach to enabling frontline-led change; building the skills, confidence, and capability needed to translate ideas into tangible improvements in care, experience, outcomes, and efficiency.

This compendium brings together the achievements of Cohort 9: a group of innovators whose commitment, resilience, and leadership stand out in a system where meaningful change is rarely easy. Alongside demanding frontline roles, these Bevan Exemplars have identified real problems, chose to act, and persisted, often in highly pressurised environments, to deliver change that is practical, locally led, and grounded in real-world need.

Their work has delivered impact that is felt every day by patients, staff, and the wider system. Improvements in quality of care and experience sit alongside reductions in pressure on services, waiting lists, and demonstrable gains in efficiency, productivity, and staff wellbeing. Crucially, these outcomes have not been achieved through large-scale restructuring, but through focused, proportionate innovation led by those who understand the system best.

As the programme enters its tenth cohort, it does so at a time of unprecedented challenge for health and care services in Wales. Demand, workforce pressures, and financial constraints continue to intensify. Yet, the Bevan Exemplar programme has matured into a core part of Wales' innovation and improvement infrastructure, contributing to system-wide change, measurable savings, and improved outcomes for communities.

What distinguishes the programme is not only the quality of individual projects, but the lasting skills and capability that is embedding across the system. With each cohort, Wales strengthens its ability to turn ideas into action, to spread what works, and to sustain improvement. This is no longer a collection of isolated innovations, but a growing, system-wide movement for change.

The challenge ahead is clear: to ensure that the learning and impact demonstrated here are not confined to individual projects or places, but are adopted, spread, and embedded to deliver wider benefit across Wales. The Bevan Commission's Adopt, Spread and Embed programme provides a clear and practical mechanism to support this next step.

The evidence is here. The capability exists. The need is undeniable. What remains is the collective commitment to act at scale, working and learning together to deliver better health and care for all. The question we are left with is simple: if not now, when?

Professor Baroness Ilora Finlay
Chair, Bevan Commission

Dr Helen Howson
Director, Bevan Commission

# COHORT 9 IMPACT SNAPSHOT
# Delivering Transformation from Within

## At A Glance

- **42 projects** successfully delivered across Wales.
- **All NHS Health Boards represented**, alongside Trusts, Local Authorities and Third Sector.
- **5 national award winners**. Further **8 shortlisted** for national awards.

## Improving Care and Outcomes

- **1,000s of patients benefited** from new or redesigned services, pathways and interventions.
- **Earlier access to care and intervention**, reducing avoidable deterioration.
- **Improved patient safety**, including reduced medication-related harm.
- Consistently **positive patient feedback**.

## Reducing Pressure on the System

- **Significant reduction in hospital bed days** and **delayed transfers of care**.
- **100s of GP, outpatient and follow-up appointments avoided.**
- **Care shifted closer to home**, reducing escalation into acute services.
- **Improved flow** across pressured pathways, supporting system resilience.

## Driving Productivity, Operational Efficiency and Value

- **Significant cost reductions** and **cost avoidance**.
- **Reduced length of stay, avoided admissions** and **unnecessary follow-ups**.
- **Reduced medicines waste** and duplication.
- **Clinical and operational time released** for higher-value patient care.
- **Efficiency gains** achieved within existing resources.

## Empowering the Workforce and Supporting Wellbeing

- **100+ staff developed** as frontline innovators.
- **Increased confidence** and autonomy to challenge inefficiency and redesign care.
- **Reduced duplication** and frustration in day-to-day work.
- **Positive impact on staff wellbeing**, **motivation** and **professional satisfaction**.

## Building Capability and Capacity for the Future

- Innovations designed with **spread and sustainability** in mind.
- **Replicable models, pathways and tools** created for wider adoption.
- **Foundations laid for future scale, capacity and system resilience.**

**Min. 750 outpatient appointments saved**
OWLi: Orthopaedic Waiting List Initiative, SBUHB

**Ave. 40 ultrasound slots released back to radiology per week.**
The Introduction of One-Stop Diagnostic Gynaecology Services, HDUHB

**Waiting time reduced from 58 weeks to ave. 6 weeks.**
A Podiatry Led Community Vascular Screening Pathway, CAVUHB

**437 hours of discharge delays avoided over 4 months**
Embedding a Prescribing Pharmacist into the Cardiology MDT, SBUHB

**Multiple unnecessary emergency admissions avoided, saving £27k over 6 months**
Bringing Care Closer to Home, BCUHB

**Reduction in ave. length of stay to 16.5 days from 89.7 days**
Implementing a Dedicated Inpatient Podiatry Service for Acute Diabetic Foot Disease, CTMUHB

Driving Change in Health and Care in Wales

# CONTENTS



***Note:*** *Third Sector led projects are listed under the health board of the area in which the project is delivered. Partnership projects are listed under the lead health board.*

Driving Change in Health and Care in Wales

# INTRODUCTION
# The Bevan Exemplar Programme - Cohort 9

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, Regional Partnership Boards and the Third Sector.

The Bevan Exemplar programme call for Cohort 9, 'Achieving Change Together,' challenged applicants to develop prudent and innovative solutions to overcome issues facing the sustainable delivery of health and care services in Wales. Applications were encouraged around the following themes, aligned with Welsh Government and NHS Wales priorities:

- Supporting prevention, early diagnosis and treatment.
- Tackling issues related to mental health and women's health.
- Transforming care for those with long term conditions.
- Supporting older people, frailty and preventing falls.

Alongside the Bevan Commission's Foundations for the Future Model of Health and Care:

- Building resilient and resourceful people and communities.
- Reducing waste across health and social care.
- Integrating care and tackling inequalities.
- Using data and technology to support system change.

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

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

# Aneurin Bevan University Health Board

# Optimising Medicines, Enhancing Lives: The Role of Clinical Pharmacist Reviews in Improving Outcomes and Reducing Waste in Nursing Homes | ABUHB

Elizabeth Hallett & Kayleigh Poulsom, ABUHB | Contact: Elizabeth.Hallett@wales.nhs.uk

## Background:

ABUHB supports 1,800 beds across 43 care homes, caring for older, frailer residents with multiple conditions. Polypharmacy is common—over 80% of people aged 75+ take at least one medicine, and over a third take four or more—heightening risks of falls, cognitive decline, and hospital admission. With 6.5% of UK acute admissions linked to medicines and many residents missing timely reviews, this project aimed to evaluate the impact of a clinical review of care home patients by a dedicated care home pharmacist.

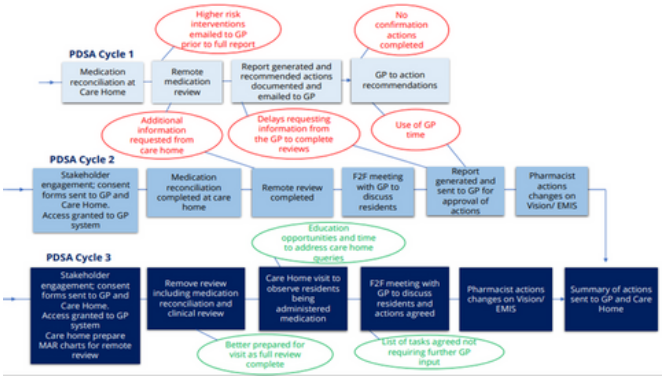
## Aims & Objectives:

Improve medication safety, patient outcomes, and reduce medicines waste in care homes through structured, pharmacist-led medication reviews.

### Objectives:

- Deliver detailed medication reviews for care home residents, focusing on high-risk medicines, dose optimisation, and deprescribing.
- Measure impact on patient safety.
- Optimise prescribing and reduce waste through in-depth polypharmacy reviews with appropriate and improved compliance.
- Assess impact on GP workload by reducing appointments and care home visits.
- Engage stakeholders to co-produce and evaluate the project for continuous improvement.
- Develop a standardised toolkit to support consistency and scalability across ABUHB and beyond.

## Methodology:




## Outcomes:

- **New Clinical Service:** Pharmacist-led medication reviews introduced for care home residents and Complex Care Team patients, delivering personalised pharmaceutical care closer to home.
- **Structured Toolkit:** A comprehensive implementation resource with guidance, templates, and training materials to support spread and scale.
- **Protocols & Policies:** Developed PRN and OTC medication guidance, with educational materials to promote safe, autonomous medicine use.

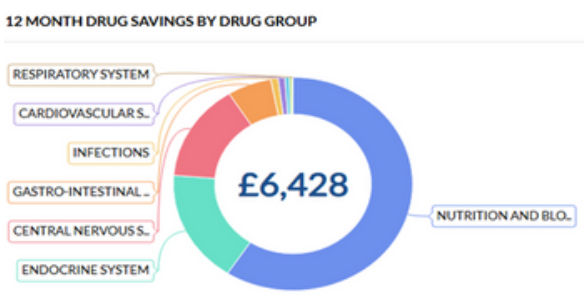
## Impact:

*(PDSA cycle 1,2 and 3)*

- Residents reviewed **341.**
- Potential ACB score reduction: 55 across residents contributing **falls reduction risk.**

*(PDSA cycle 2 and 3)*

- **40** Medicines stopped.
- **64** less administrations per day across 89 residents freeing up nursing time.
- **34%** residents aligned to 28 day cycle to reduce waste.
- **7** high risk drug interventions.
- **12%** formulation changes to aid compliance.
- **51** PPIs reviewed.
- ACB score reduction of **10** across residents reviewed.
- Stopping 40 medicines (≈ 0.5 kg $CO_2$ per box) saved 20 kg of $CO_2$**.**
- **267** GP appointments saved.
- Rectified doses, ordering of up to date monitoring and specialist advice for high risk medicines.
- Resident previously chewing all tablets – now **compliant** with medication in a suitable form.




> The Medication Review allowed an in depth review of residents on multiple items ensuring appropriate switches, deprescribing and initiation were identified and highlighted the GP for review. This method allowed the GP additional capacity.

## Key Conclusions:

- Safer, personalised medication for residents.
- GP time saved via pharmacist-led reviews.
- Empowered care home staff through education.
- Reduced medication waste and environmental impact.
- Enhanced patient safety.
- Care brought closer to home.
- Developed a replicable toolkit for medication reviews.

FINALIST Welsh Pharmacy Awards 2025

# Transforming Endoscopy Services in Aneurin Bevan University Health Board | ABUHB

Rhodri Davies, Kelly Milford, Dan Loder, Joanne Robbins & Matt Evans, ABUHB | Contact: rhodri.davies5@wales.nhs.uk

## Background:

This project aimed to develop digital resources to support endoscopy teams in ABUHB and improve the patient experience.

Two work streams were identified:

1. Develop internal webpages for HB staff to standardise work across our endoscopy units.
2. Develop a comprehensive patient-facing internet platform.

## Aims & Objectives:

**Develop intranet resources** including:

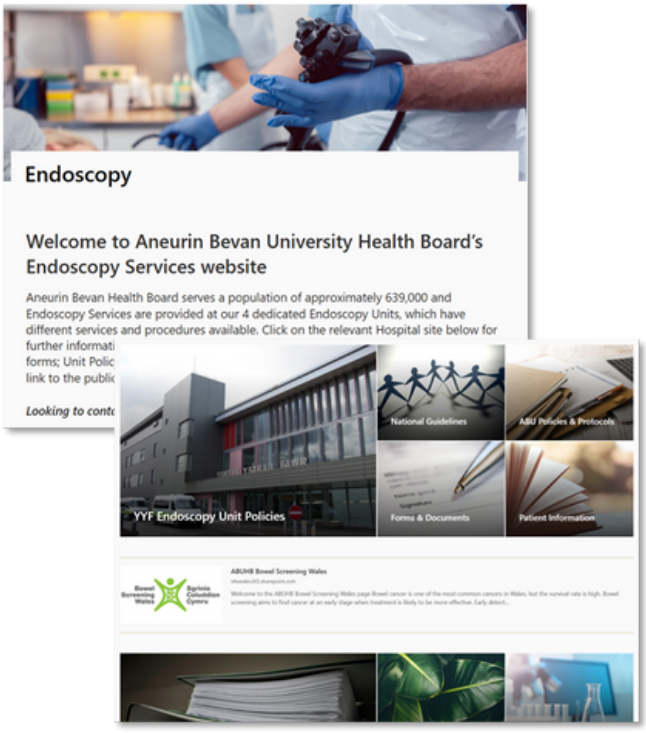
- Clinical policies.
- Governance and audit policies.
- SOPs for all aspects of endoscopy service work.

**Provide staff with links** to guidelines and information resources related to endoscopy.

**Develop patient-friendly resources** for the ABUHB internet pages.

## Methodology:

- A core group was established to develop intranet content with input from the wider team.
- The Clinical Psychology team were involved to develop easy-read and psychologically supportive patient information.
- Evaluation metrics included patient and staff feedback, web analytics, and achievement of Joint Advisory Group (JAG) accreditation: a nationally recognised standard of excellence in endoscopy.




## Outcomes:

- A unique and comprehensive Intranet resource was created, incorporating multiple content domains relevant to the endoscopy services in ABUHB.
- All policies, guidelines and SOPs were completed and submitted for approval in relevant forums.
- Work is still ongoing to develop content for the internet pages, including bilingual easy-read patient information and walk-through videos.

## Impact:

- **Ysbyty Ystrad Fawr was awarded JAG Accreditation in September 2025.**
- **The intranet platform is utilised regularly** according to analytics. JAG commended the platform.
- **Standardised working has had dramatic benefits** with improved endoscopy list efficiency.


## Key Conclusions:

This project developed new digital resources to support both endoscopy teams (via the hospital Intranet) and patients (via the Internet). These platforms provide accessible information, clinical standards, referral pathways, and patient guidance to improve quality and efficiency across services.

The approach was recognised nationally when Ysbyty Ystrad Fawr achieved JAG accreditation, with assessors citing the platforms as exemplars and inviting a paper for UK-wide sharing.

By improving access, quality, and efficiency, this work has the potential to strengthen Wales' endoscopy services, support cancer pathway targets, and underpin the Welsh Government's ambition for all Units to achieve JAG accreditation.

# Better Together: The True Value of Positive Ageing | Action for Elders

James Lewis, Action for Elders | Contact: info@actionforelders.org.uk

## Background:

The population in Wales is ageing, with more people now living beyond the age of 65 than children under the age of five. This demographic shift has significant implications for society and places increasing pressure on health and care services.

Despite this, opportunities for prevention and early intervention within community settings remain limited. Many older people experience delayed access to preventative support, while others remain in acute hospital environments or care homes without access to programmes that support resilience, recovery, or the continuation of preventative approaches.

This project responds to these challenges by proposing an early intervention model focused on supporting healthier ageing. It seeks to address current gaps in preventative provision and contribute to a longer-term shift towards enabling older people in Wales to live longer, healthier lives and remain active contributors within their communities.

## Aims & Objectives:

- Strengthen prevention by supporting older people to stay active, stable and connected.
- Reduce avoidable NHS demand by using evidence based discipline which prevent decline before it starts.
- Put the individual at the centre of service design and measurement.
- Improve mobility, resilience, wellbeing and social connection.

## Methodology:

- Weekly community Balanced Lives groups across Aneurin Bevan University Health Board region.
- Holistic model: movement, balance, breathing, social connection and mental wellbeing.

Evaluation includes:

- Self-reported wellbeing (EQ-5D, WEMWBS, Loneliness Scale).
- Physical measures (6-minute walk, balance, flexibility).
- Participant interviews capturing lived experience.
- Social value analysis to understand benefit to the individual, not only cost savings.

## Outcomes & Impact:

- Strengthens physical and emotional resilience.
- Reduces frailty, loneliness, falls risk and unplanned GP use.
- Helps people feel more confident, connected and purposeful - with greater control over ageing.
- Supports NHS goals for improved prevention and healthier ageing.

90% are more physically active.


Increased walking distance.

- **72% reduced frailty scores.** Participants showed measurable reductions in frailty, improving stability and daily confidence.
- **81% improved flexibility scores.** Participants gained strength, mobility and control.

**£2,381 social value** created per participants. Net value after deadweight and attribution.

> “Before joining, I felt myself slipping slower, lonelier and losing confidence. Now I feel stronger, steadier and part of something again. This programme hasn’t just helped my body, it’s helped my whole life.
>
> Balanced Lives Participant

## Key Conclusions:

- Prevention works: supporting strength, stability and connection reduces need for reactive care.
- Social value places older people’s lived experience at the centre of decision making.

**True innovation is changing attitudes to ageing - both personal and systemic.**

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

# Betsi Cadwaladr University Health Board

# Bringing Care Closer to Home | BCUHB

Meghan White, BCUHB | Contact: meghan.white@wales.nhs.uk

## Background:

The UK's health and social care system faces growing pressures as older adults' needs become more complex. One in seven people aged 85+ live in care homes, accounting for around 185,000 emergency admissions and 1.46 million bed days each year—up to 40% potentially avoidable (NHS Long-Term Plan, 2019).

In Wales, delayed discharge remains a challenge. A BCUHB review (June 2024) found 30% of care-home residents in acute beds needed enhanced therapy and 17% required higher support, suggesting earlier, indicating missed opportunities for early intervention.

At the same time, over 150,000 social care vacancies and 30% staff turnover, contribute to risk-averse escalation and inconsistent monitoring (Quality Care Group, 2025).

In response, a Welsh Government AHP Investment Fund funded and pilot tested an in-reach occupational therapy model in two Flintshire care homes. It delivered early, function-focused assessment to keep residents well and at home, aligned with prudent healthcare principles.

## Aims & Objectives:

Provide timely, specialist care in care homes to promote independence, reduce avoidable hospital admissions, and optimise use of NHS resources.

### Objectives:

- Prevent decline early through proactive intervention.
- Build staff skills to improve care quality.
- Strengthen communication between care homes, community services, and hospitals.
- Use resources wisely to avoid waste and duplication.
- Ensure fair access for all care home residents.

## Methodology:

The service model was co-designed with care home managers and staff, BCUHB occupational therapy leads, allied health professionals, representatives from the National AHP Lead for Primary and Community Care and Flintshire local authority partners. Local scoping data and national policy drivers informed the co-design.

The design focused on **embedding specialist occupational therapy in-reach provision** directly into care homes, enabling timely functional assessments, targeted interventions, and workforce upskilling to support prevention and early intervention.

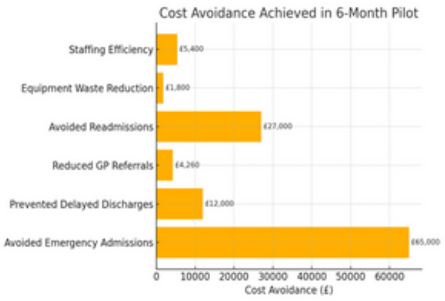



Figure 1: Cost Avoidance Achieved in 6-Month Pilot

## Outcomes:

The pilot established a new replicable model for delivering specialist occupational therapy directly in care homes, producing practical tools and processes for wider adoption.

- **Specialist AHP In-Reach Model:** Embedded an OT for rapid functional assessments, targeted interventions, and staff support.
- **Functional Outcome Measure:** Developed a care-home specific tool to assess function pre- and post-intervention.
- **Equipment Pathway:** Enabled same-day assessments and provision, reducing delays and duplication.
- **Training Framework:** Delivered real-time training in moving, handling, and behavioural support.
- **Improved Coordination:** Strengthened communication across health, social care and local partners.
- **Proof of Concept:** Demonstrated feasibility and alignment with national priorities for scale-up.

## Impact:

The pilot delivered clear benefits across residents, staff and the wider system:

- Residents achieved **functional gains** of 3–83% (median **44.5%**) through early, targeted in-reach OT, helping maintain independence.
- Timely therapy supported **faster, safer discharges,** reducing reliance on GP referrals.
- Real-time training and support built care-home capability and boosted confidence with mobility, behaviour and specialist equipment.
- Improved communication across sectors streamlined problem-solving and cut duplication.
- Financially, net of costs (£67,452), one clinician delivered **£81,734 cost avoidance in six months** (Fig. 1) —equating to >£1.14m annually if scaled across Wales.

> "Before, I needed two people to help me move. Now I can walk to the dining room myself. It's given me my life back."
>
> Care Home Resident

## Key Conclusions:

- Embedding AHPs directly in care homes prevents deterioration, avoids hospital admissions, and supports independence.
- Early, preventative care improves quality of care and delivers measurable cost savings and system efficiencies.
- Collaboration between all partners underpins success.
- Real-time, on-site training upskills staff and builds confidence.
- Combining quantitative data with lived-experience narratives strengthens the case for scaling.
- The model is scalable across Wales—enhancing integration, reducing waste, addressing health inequalities, and building community resilience.

# The Problem with PipTaz: Using Pharmaceutical Science to Provide Healthcare Solutions | BCUHB

Chris Goodwin & Rebecca Jones, BCUHB | Contact: Christopher.goodwin2@wales.nhs.uk

## Background:

In 2021, the Welsh Government published the Transforming Access to Medicines (TRAMs) plan aimed at transforming hospital services in Wales. It recognises that medicine preparation by nursing staff is resource intensive, taking valuable time away from clinical duties. By adopting automated batch preparation within Technical services, the NHS can improve accuracy, safety and efficiency. The preparation of Piperacillin/ Tazobactam (PipTaz) serves as an example of a product well-suited for this.

In 2024, 130,000 doses of PipTaz were prescribed within BCUHB with each dose taking approximately 15 minutes for a nurse to prepare. With average patient requires three doses per day, this represents a substantial time burden to already stretched nursing capacity.

## Aim & Objectives:

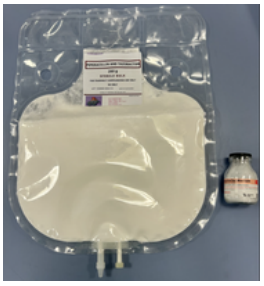
- Determine suitability of the PipTazSmartPak for the UK NHS market.
- Demonstrate value of multi-dose PipTaz bags by developing a semi automated manufacturing method to produce PipTaz doses safely, efficiently and sustainably.

## Methodology:

- Audit manufacturing site to determine acceptability.
- Conduct Quality Control testing to confirm product specifications.
- Develop and validate a semi-automated manufacturing method to enable sustainable manufacture.

## Outcomes:

- **81%** reduction in production time when compared to aseptic manufacture.
- **94%** reduction in production time when compared to ward manufacture.
- **74%** reduction in the number of aseptic manipulations when compared to vials.
- **21 days** chemical stability when stored at 5°C ± 3°C.
- Satisfactory audit and product suitable for UK.



## Impact:

Based on the average annual usage across BCUHB, we can estimate the potential savings in nursing hours if 10% of these doses were prepared in the aseptic unit using a semi-automatic method, compared to preparation by ward nurses below:

| Parameter | Before Project | After Project |
|---|---|---|
| Approximate annual usage | 13,000 | 13,000 |
| Preparation of 13,000 bags (hours) | 3,250 (nursing) | 199 (aseptic) |
| Annual nurse/operator time saved compared to slowest method (hours) | 0 | **3,051** |
| Ratio of nurse/operator time investment required per workday | 16.67 | 1 |

## Key Conclusions:

This project has successfully demonstrated that the Multidose PipTaz back can be used to provide a sustainable manufacturing service for this drug product with significant potential to support frontline services. Additionally this will mark the first time this product has been evaluated for use within the United Kingdom.

# CAPTURE: ChaAllenging Penicillin Allergy staTUs – a REview with patient | BCUHB

Clara Tam & Amber Hughes, BCUHB | Contact: clara.tam@wales.nhs.uk

## Background:

Penicillin allergies are amongst the most reported allergies in healthcare, with 5.6% of the population recorded as penicillin allergic. Patients with penicillin allergy labels have been linked to increased mortality, worse healthcare outcomes and higher healthcare costs. Up to 95% of people who reported penicillin allergic are not truly allergic to penicillin when formally tested.

Many people are prevented from accessing penicillins due to spurious penicillin allergy status. This causes harms and costs that could be avoided by correcting those false penicillin allergy labels.

## Aims & Objectives:

Develop an All Wales guideline and supporting tools for history based penicillin allergy de-labelling.

1. Review the evidence for history based penicillin allergy de-labelling.
2. Produce guidance and a one-page assessment for history based penicillin allergy review.
3. Include information on how to update or remove allergy to ensure it is recorded across all patient notes and systems.
4. Define the roles and responsibilities of various health care professionals in the implementation of history-based penicillin allergy de-labelling.
5. Identify methods or searches or system templates to aid with the implementation of history based penicillin allergy de-labelling.

## Methodology:

- A group of relevant stakeholders and experts in Wales co-designed the guideline and resources to support the delivery.
- Baseline data were collected to ensure the need of a new guideline.
- The project was delivered in two GP practices in BCUHB and PTHB between July and September 2025.
- Patient satisfaction survey, feedback and data from service providers were used to enable the group to finalise the process and materials.

## Baseline Data:

- Baseline 1 showed **92%** of people with penicillin allergy in BCUHB might not have a true allergy and suffering from harms unnecessarily.
- Baseline 2 with 122 people interviewed, showed **97%** said no one had discussed the risk of false penicillin allergy with them in the past.

## Outcomes:

- A guideline, assessment tools and resources have been developed and delivered in two GP practices.
- AWTTC has accepted this project proposal and aiming for submission in the next coming quarter.

## Impact:

In total, 55 patients were reviewed using the assessments tools between Powys Teaching and Betsi Cadwaladr University Health Boards.

- **46 patients (84%)** show zero scores based on the penicillin allergy risk stratification tool. This means there is <1% chance of having true penicillin allergy.
- Out of the 55 patients, **34 patients (62%)** have been successfully de-labelled based on the initial assessment criteria. Two patients did not consent for de-labelled despite criteria being met.

### Cost Avoidance (with 34 patients de-labelled):

| Spending | Cost Avoidance (£) |
|---|---|
| Hospital stay | £320,255 |
| Antibiotic spent | £3,496 |

### Impact on Individual Health Outcomes:

A penicillin record was associated with six in 1000 more deaths and one in 1000 more patients with MRSA (West et al 2019). Our initial pilot had 34 patients de-labelled, this has avoided:

- 204 deaths in 1000 patients.
- 34 patients with MRSA in 1000 patients.

### Impact on Public Health Outcomes:

Each delabelled patient is now 4 times less likely to receive non-access group antibiotic (Powell, West & Sandoe, 2021). This contributes to the national action plan for antimicrobial resistance 2024-2029.

### Patient Experience:

Six patients answered a satisfaction survey. 100% felt comfortable about taking penicillin in the future. 100% rated the highest level of overall experience.

## Key Conclusions:

By removing spurious penicillin allergy in the community, it prevents unnecessary deaths, improves health outcomes, reduces antimicrobial resistance and avoided unnecessary cost spent on excess bed days and additional antibiotic cost.

# How Can Advanced Nurse Practitioners in Primary Care Develop a Women's Service to Improve Health Outcomes and Reduce Inequalities? | BCUHB

Nia Boughton & Lucie Parry, BCUHB | Contact: nia.boughton@wales.nhs.uk & lucie.parry@wales.nhs.uk

## Background:

- The Women's Health Plan for Wales aims to better meet women's health needs and reduce inequalities.
- Many women delay seeking help until a crisis point or feel their concerns are not fully heard.
- Improving the quality of first contact is essential.
- Every woman should receive a comprehensive post-natal check after childbirth.
- Supporting timely health-seeking behaviour strengthens the wellbeing of women and their families.

> "It's not good talking as people judge you as a mother and think you cannot cope.

## Aims & Objectives:

- To develop a comprehensive biopsychosocial assessment process to transform the historic 6/52 week postnatal check into an opportunity to address the full health needs of women at a key point in their lives.
- To set up, test and evaluate the service.
- To establish a framework/toolkit for other practices/clusters to be able to initiate the women's health service themselves in the future.

## Methodology:

- Offered a post-natal check to all women following childbirth.
- Placed particular emphasis on engaging groups who are typically less likely to access services.
- Co-designed the clinic questionnaire with women to ensure relevance and clarity.
- Set up a multi-agency project group to guide and support delivery.
- Issued the questionnaire to all women before their clinic appointment.
- Provided follow-up after the clinic where required.

## Outcomes:

A new 6-week post-natal check service was established and delivered for all women attending with their baby, focusing on the needs of the woman, the infant, and the wider family.

### What Women Most Commonly Sought Support with:

- Low mood.
- Historic physical or mental health issues.
- Loneliness.
- Anxiety.
- Feelings of guilt.
- Poverty-related pressures.
- Sexual health.
- General women's health concerns.

## Impact:

### For Women

- **128** women attended the post-natal clinic.
- Health visitors arranged appointments with **12** difficult to contact women.
- The DNA rate was **0.**
- **65** women were contacted as follow up by phone or text.
- **42** women attended for face to face follow up appointment.

### For Nurses

- Increased role satisfaction.
- Training and development.

### For the Service

- Streamline processes.
- Awareness where to refer women.

### For the System

- Economic benefits.
- Supporting women to reach full potential.

> "I have never mentioned this in 10 years but I feel I can talk to you.

> "Thanks for listening and your help. I didn't know if I should just get on with it.

> "What? You can help with contraception and everything else?

## Key Conclusions:

- Targeted approaches led to more women attending and engaging with post-natal checks.
- Earlier identification of concerns ensured timely support and safer care.
- Streamlined pathways reduced duplication and avoided unnecessary appointments.
- Upskilling nurses delivered measurable cost benefits and improved service sustainability.
- Embedding evidence-based practice was central to achieving meaningful, lasting change.

# Developing a Holistic Stroke Survivors and Carers Programme for Secondary Stroke Prevention | BCUHB

Emma Davies, Holly Brislen & Nicola Vickers, BCUHB | Contact: BCU.StrokePreventionTeam@wales.nhs.uk

## Background:

- In the UK, around 100,000 strokes occur each year, with this number increasing year on year.
- In the UK, approximately 30% of people who have a stroke will experience another within five years (Figure 1).
- Around 80 - 90% of strokes are preventable with the early identification and effective management of stroke risk factors.
- Wales has the highest percentage of people with prevalent stroke risk factors. Many stroke survivors experience emotional distress and anxiety regarding risk of reoccurrence. They may struggle to manage risk factors due to perceived lack of support.

This project intends to:

- Increase satisfaction of stroke survivors.
- Empower stroke survivors and carers to manage stroke risk factors.
- Reduce incidence of second stroke.

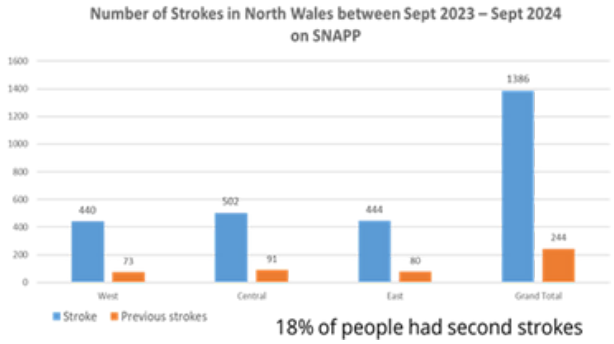



Figure 1: Incidence of second strokes

## Aims & Objectives:

**Aim:** Reduce the incidence of secondary stroke in North Wales and improve patient experience and support following their stroke.

1. Improve patient knowledge of stroke prevention and their experience of stroke prevention education.
2. Establish a clear referral pathway for high-risk patients for referrals from the stroke multidisciplinary team.
3. Strengthen the Stroke Prevention Team's capacity to deliver high-quality secondary prevention education for stroke survivors and carers across BCUHB.

> Meeting others with the same problem helps. I enjoyed your kind helpful meetings, it helps our partners understand what we are living through! It's a shocking shock to become a stroke survivor.
>
> Service user

> I've just spoken to a client who attended your sessions. She thought it was brilliant and enjoyed meeting the other people and has lots of numbers to contact people if needed.
>
> Referrer

## Methodology:

**Co-design of Programme:** Stroke survivors and carers provided qualitative and quantitative feedback on stroke-risk concerns, informing programme content and delivery. Engagement took place through North Wales stroke groups and MS Forms surveys, alongside input from partners across the stroke pathway. This evidence shaped the final programme design.

**Delivery:** Four weekly 1.5-hour sessions were delivered in June–July 2025 to seven participants (four patients and three carers). Each focused on a specific theme and was held in an accessible community venue. Participants were referred via the East Integrated Health Community stroke pathway.

**Evaluation:** A mixed-methods evaluation captured feedback from participants and referrers, alongside reflections from the Stroke Prevention Team on delivery and engagement.

## Outcomes:

The project extended the stroke pathway by offering additional support to stroke survivors and carers in North Wales. Implementation is planned across the region. The initiative ensured high-quality care and a holistic approach to secondary stroke prevention.

## Impact:

Seven participants took part in the programme.

- **100%** agreed the content and duration were appropriate and clearly presented.
- **75%** reported feeling equipped with the knowledge to reduce their future stroke risk, with timing judged appropriate post-stroke (Figure 2).
- **100%** valued the face-to-face format and found the venue suitable and accessible.

The average cost of a stroke patient from admission to discharge is estimated at £23,315. Preventing just two strokes annually through this programme could save the health board approximately **£46,630**, demonstrating both health and economic benefits.

## Key Conclusions:

- The project was well received by stroke survivors, referrers, and stakeholders, enhancing patient experience within the BCUHB stroke pathway and adding a valuable new element to local services with potential for wider roll-out across North Wales.
- With around 17,000 stroke survivors in BCUHB, targeting those at greatest risk of recurrence offers the greatest community benefit.
- Participant feedback identified new areas for development, including of sleep and stress management.
- The current programme template can be readily implemented across North Wales, and beyond, by stroke specialist nurses, supporting consistent and holistic secondary prevention.

# Clean Hands, Clear Water: Hand Rubbing for an Eco-Friendly Scrub | BCUHB

Stephanie Rees, Kenneth Igwe & John Glen, BCUHB | Contact: stephanie.rees236aca@wales.nhs.uk

## Background:

### Chlorhexidine (Status Quo)

- Harsh on skin - 27.8% report dermatitis related to chlorhexidine.[1]
- High use of clean water - >1 million litres of water per year in Glan Clwyd Hospital.
- Not removed in water treatment - persists into the oceans and water table.
- Toxic to aquatic life - affects fish behavior and primary producer numbers.[2]

### Alcohol-Based Hand Rubs (ABHRs)

- Use no clean water - if hands not visibly soiled and have been washed that day.
- 2 minutes for sterile hand preparation - Hand must remain wet for 2 minutes.
- Prolonged antimicrobial action - suppressed microbial growth within surgical gloves for up to 6 hours.[3]
- Recommended by the Royal College of Surgeons - in the 'Intercollegiate Green Theatre Checklist'.[4]
- Improved skin hydration - reduced cracking and fissuring.[5]

## Aims & Objectives:

- **Implementation:** Transition to ABHRs for all sterile procedures within 12 months.
- **Education:** Provide training for all clinicians, integrated into hospital inductions.
- **Monitoring:** Audit compliance and infection rates post-implementation.

## Methodology:

- Introduced ABHRs (Sterillium) to the Intensive Care Unit to evaluate feasibility in a controlled environment.
- Delivered drop-in sessions, bedside teaching, and visual "memory aids" to address technique changes.

## Outcomes:

The pilot was successfully established in ICU, though wider rollout faced cultural and logistical hurdles.

**References**:
1) Barnes S, Stuart R, Redley B. Health care worker sensitivity to chlorhexidine-based hand hygiene solutions: A cross-sectional survey. Am J Infect Control. 2019 Aug;47(8):933-937. doi: 10.1016/j.ajic.2019.01.006. Epub 2019 Feb 12. PMID: 30765146.
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3) Hennig TJ, Werner S, Naujox K, Arndt A. Chlorhexidine is not an essential component in alcohol-based surgical hand preparation: a comparative study of two handrubs based on a modified EN 12791 test protocol. Antimicrob Resist Infect Control 2017;6:96. https://doi.org/10.1186/S13756-017-0258-0.
4) https://www.rcseng.ac.uk/-/media/images/rcs/about-rcs/sustainability/greentheatrecompendiumofevidence.pdf
5) Lopes AER, Menegueti MG, Gaspar GG, Tartari E, da Silva Canini SRM, Pittet D, et al. Comparing surgeons' skin tolerance and acceptability to alcohol-based surgical hand preparation vs traditional surgical scrub: A matched quasi-experimental study. Am J Infect Control 2022;50:1091–7. https://doi.org/10.1016/J.AJIC.2022.01.028.

## Impact:

### Before ABHR (n=12)

- **50%** rated scrub stations outside of theatre as inadequate.
- **30%** reported skin irritation from chlorhexidine hand scrubs.
- **20%** were familiar with ABHRs or had used them previously.

**Do you have any concerns about the use of alcohol-based hand rubs?**

> Dry hands, skin peeling off.

> Does not feel as thorough. No good if visibly soiled. Not sure if it's effective for all pathogens.

> Need assurance comparable to standard scrub with water and chlorhexidene/betadine.

### After ABHR (n=13)

- **100%** reported ABHRs as easy to use.
- **93%** reported increased ease of adherence to hand hygiene practices for sterile procedures.
- **85%** reported no change or improved skin condition.
- **93%** were either 'satisfied' or 'very satisfied' with the introduction of ABHRs in ICU.

**What changes have you noticed in hand hygiene practices since the introduction of alcohol-based hand rubs?**

> Easier and less mess.

> Hand washing for aseptic technique is much easier, quicker and less messy (compared to soap and water). No need to worry about non-sterile towels to dry your hands. Gloves easier to put on as alcohol rub dries completely, whilst it can be difficult to dry hands completely after using soap and water.

**What could be done to improve the implementation of alcohol-based hand rubs in your department?**

> To consolidate and disseminate information about safety and efficacy.

> Continue to introduce across other areas of the hospital, including the ED.

## Key Conclusions:

- High satisfaction (93%) suggests that initial resistance can be overcome through education and evidence.
- Despite implementation hurdles, the ICU pilot proved ABHRs are a practical, cost-saving, and eco-friendly alternative.

# Collaborative Partnership Approaches of Community Engagement and Participation | BCUHB

Brian Laing, BCUHB | Contact: brian.laing@wales.nhs.uk

## Background & Context:

Wicked challenges require radical thinking. Our public services need to adapt and evolve to more relational & outcomes focussed models of planning and care delivery. And we need to do this alongside the communities we serve.

Despite various policy commitments, there is an evident lack of consistency and clarity regarding what constitutes effective community engagement and co-production, leading to fragmented approaches and limited scalability. This ambiguity often hampers the ability of stakeholders to evaluate impact and share learning across systems.

This research is intended to provide our communities voice & agency to take shared accountability for delivery and for evaluating shared outcomes.

## Research Methodology:

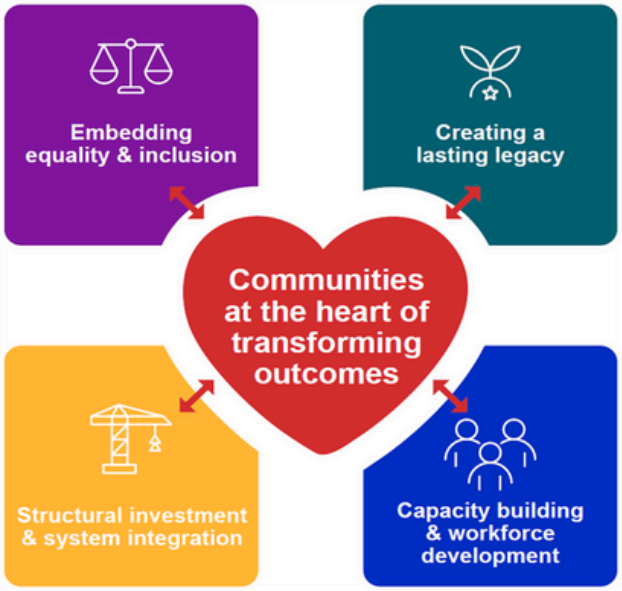
Following a double diamond methodology, stakeholders were engaged and participative in the process throughout in order to collectively define the challenge, and to develop solutions.

The research consists of:

- A comprehensive literature and evidence review to identify effective community engagement and co-production methods and to evidence the impacts these can have on health & wellbeing outcomes.
- A series of stakeholder workshops to gather practical insights at the hyper-local level.

The insights are used to develop a practical framework which could be applied at various system levels.

## Key Insights:




| System Level | Owner | Co-Production |
|---|---|---|
| Local | Town & Community Councils | Place Plans |
| Regional | Regional Partnership Boards / PSBs | Wellbeing Plans |
| National | Bevan Commission / Welsh Government | To influence scale & spread across Wales |

## A Practical Framework for Application at Local, Regional and National Levels:

**1. Structural Investment and Systems Integration**
Firstly, a sustained structural investment is required to move beyond short-term, project based models. Embedding co-production and community participation within commissioning and regulatory frameworks, and allocating core funding to support community infrastructure and leadership development, are all considered essential steps towards embedding and institutionalising these practices.

**2. Capacity Building and Workforce Development**
Secondly, capacity building must be prioritised across both professional and community domains. The health and care workforce requires capacity and support for training in facultative, relational, and power sharing practices while communities, particularly those which have been historically marginsalised, must be supported to develop leadership, organisational capacity, and participatory confidence.

**3. Embedding Equity and Inclusion**
Equity must be embedded as a guiding principle across all stages of design, implementation, and evaluation. This includes prioritising engagement in high-need communities, adopting intersectional approaches to understand differential impacts and ensuring that power is re-balances and shared meaningfully with those most affected by health inequalities. This shift represents not only a strategic imperaitive but a moral one: to ensure that health systems are shaped with, not merely for, the populations they serve.

**4. Creating a Lasting Legacy**
Finally, these approaches must be adopted as a means to create a lasting legacy through evaluation., learning and accountability. In order to re-build and maintain trust, shared ownership and accountability, organisations should come together in partnership alongside empowered communities.

# In My Place: Combined Hospital Avoidance and Future Care Planning Service | The Rainbow Foundation

Susan Ikin & Caroline Tudor-James, The Rainbow Foundation | Contact: info@therainbowfoundation.org.uk

## Background:

**System Pressure on Acute Services:** Nationally falls in people over 65 lead to over 220,000 emergency admissions and four million bed days each year. In Wrexham, older adults account for 8,053 A&E attendances and 8,456 bed days (2024).

**Impact of Falls and Long Lie:** Frail older people often face long waits for an ambulance after a fall. This increases risks such as dehydration, hypothermia and pressure damage. A "long lie" of over an hour is associated with 50% mortality within six months.

**End-of-Life Care Gaps:** Many people in their last year of life are admitted to hospital, contributing to bed pressures and over-medicalised care. Most prefer to die at home, yet over half die in hospital.

**Population Trends and Future Demand:** Wrexham's over-85 population is expected to double by 2030 (to 6,000), with palliative care demand rising by 42% by 2040. Growing dementia prevalence means more people will experience severe dementia in the final months of life.

## Aims & Objectives:

- Decrease non-elected admissions to hospital.
- Decrease number of bed days in hospital and over-medicalisation during end stages of life.
- Promote a move from resistance to acceptance and dignity at end of life.
- Increase the number of people who die well in a place of their choice.
- Increase patients and carers understanding of end-of-life stages and choices at end-of-life.
- Reduce repeat hospital readmissions in the last 2 years of life.

## Innovative Funding Model:

In My Place was offered full investment through a Social Impact Bond, providing an Invest-to-Save model where costs are repaid only if agreed outcomes — such as reduced unplanned bed days — are fully achieved. Support from Social Finance included data analytics, operational expertise and dashboard development, creating a risk-free way to test the model while aligning incentives with measurable improvements.

Although the original 2022 offer was not progressed in time and funding was later redirected to another health board, strong clinical leadership and clear repayment mechanisms remain. Partners are now revisiting the opportunity to bring this proven model of care to Wrexham.

## Integrated Model of Care:

'In My Place' addresses the lack of Future Care Planning (FCP) across Wrexham, and supports behaviour change. Making FCP a routine part of care, like birth planning, reduces stigma, helps professionals to honour end-of-life wishes, and builds on best practice.

**In My Place Model:** Tailoring healthcare to individual patient needs, preferences, and values. Noting FCP is essential to prevent repeated, unnecessary transfers to A&E during the last years of life.

**Rainbow Response (Hospital Avoidance) Service:** A proactive community team preventing unnecessary hospital admissions.

- Nurse prescriber-led team, 7 days/week, 7am to 10pm, with a 2-hour response time.
- Supports 2,347 call-outs/year.
- Integrated with the Wrexham-wide hospital avoidance scheme and Palliative Care Team.
- Responds to uninjured falls, deterioration, infections and end-of-life needs.
- For people over 65, living with frailty and/or dementia, at home or in residential care.


**Future Care Planning (FCP) Service:** Engages patients and communities in future care discussions to align treatment to long term goals.

- Referrals from Rainbow Response Team and the community.
- Five days/week, 9am to 5pm.
- Led by enhanced social prescribers linked to all GP practices.
- Supports individuals to make informed decisions about their end-of-life wishes.
- Provides training for carers and guidance on the natural stages of dying, helping more people to die well at home.

## Impact Assumptions & Benefit Analysis:

The target population is 1,261 end-of-life patients per year. The service is expected to support 50% annually. The median number of admissions in the last year of life is 2.3 non-elective admissions with an average length of stay of 16.7 days. This service aims to reduce admissions by 435 non-elective patients per year.

**System value over three years = £6.54m (system savings to the NHS), with £4.49m retained by the health board.**

## Key Insights & Learning:

**Billy's Story – a small step in the right direction**
When Billy had a fall he experienced a long lie of 20 hours, before being admitted to hospital. The Red Bag (and Future Care Plan) ensured that Billy's medical information and care preferences were immediately available. Billy experienced a smooth transition to his chosen place of care where his dying wishes were treated with dignity and respect.

**Future Care Planning Alone has Shown:**

- Improved patient agency.
- Reduced hospitalisation.
- Better carer confidence and system coordination.

The Rainbow Foundation

# The Effectiveness and Benefits of the Active Futures/Fit Futures Programme | The Rainbow Foundation

Susan Ikin, Caroline Tudor-James & Ian Pope, The Rainbow Foundation | Contact: info@therainbowfoundation.org.uk

## Background:

Most people over 65 with musculoskeletal (MSK) conditions are managed in primary care, with 25% of a GP caseload MSK in origin. In Wrexham, one in five people are over 65, many living with complex health and mobility issues. Sarcopenia (age-related loss of muscle mass and strength) contributes to reduced mobility and increased risk of falls and frailty. Falls and frailty are key factors in a sudden decline in health. Fragility fractures cost the NHS £1.1 billion in hospital stays every year.

## Aims & Objectives:

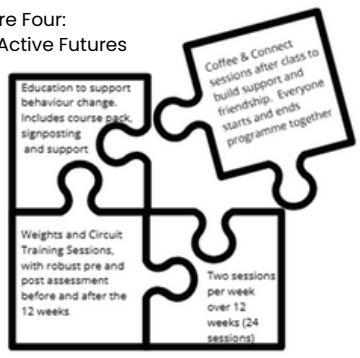
- Reduce risk factors associated with surgery and the need for surgery.
- Increase knowledge and self-management of long-term conditions.
- Effectively reverse and reduce frailty.
- Reduce pain.
- Help improve MSK conditions, and reduce falls.
- Reduce risk of Dementia (through regular exercise).

## Methodology:

Active Futures builds strength and confidence, and tackles falls, frailty and mental health; it also addresses wider determinants of ill health and uses peer support to drive positive behaviour change and encourage attendance.

Active Futures supports older people with MSK conditions, living with frailty, or at risk of falls through a three-step approach Participants (56% with a history of falls in the last 12 months) attend a twice-weekly, physiotherapist-led circuit classes held in accessible community venues with transport provided. Each 12-week programme began with a functional fitness MOT and mental health assessment to set baselines. Outreach support is offered to address wider determinants of ill health which may impact on engagement with the programme. Each session is followed by an opportunity to connect socially, building peer support and promoting sustained attendance, positive behaviour changes and healthy habits. This COM-B framework was used to understand and influence behaviour change.

The Core Four:
What Makes Active Futures




## Funding Model:

The funding model is a cross-subsidy funding approach. "Fit Futures" subsidises "Active Futures" ensuring inclusivity and sustainability.

## Outcomes & Impact:

### Julia's Story:

Julia began the Active Futures classes to maintain independence and rely less on her family. She had had a hip operation and was listed for the other hip too. She is in her early 70s. Her left arm has been 70% contracted since a severe burn in her childhood years. She says:

> "One is shorter than the other and I was in pain. […] I have far more flexibility. After 40 years, the left arm is now the same length as the right."

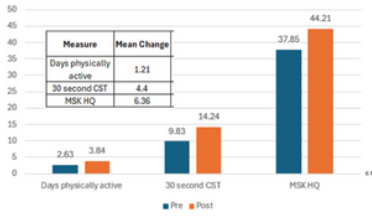
**Results from Active Futures showed Julia has improved:**

- Increased flexibility in Sit and Reach test by 9cm and by 13 cm in Back Scratch test.
- Able to complete 24 chair stands in 30 seconds at follow up compared to 9 at baseline.
- Increased her 6-minute timed walk by 60% to 200m and no more walking sticks!
- Self-reported weight loss of 1.5 stone and is motivated to eat better and do a lot more.

### Clinical Outcomes:

Following the Active Support programme:

- **90%** are more physically active.
- **79%** increase in wellbeing scores.
- **72%** decrease in frailty scores.
- **70%** felt more connected to people.
- **80%** continue their progress in Fit Futures.





### System Impact:

Long term health benefits result in:

- Fewer GP and hospital visits.
- Decrease in ambulance call outs.
- Reduced A & E attendance due to falls. At pre-assessment, 30% had experienced an A & E admission due to falls. There were no admissions two years on.

**System Saving: £2,7514** of Social Value created for every person.

### Social Return on Investment:

For every £1 spent, **£14.02** in social value is generated, based on improvement in patients' physical health and overall wellbeing.

The Rainbow Foundation

# Young People's Wellbeing Space | GISDA

Sian Tomos and Lyndsey Thomas, GISDA | Contact: gisda@gisda.co.uk

## Background:

The number of anxiety cases has increased among children and young people in Wales. Statistics show that 46% of children and young people (compared to 12% in 2015–16), who received counselling in Wales in 2022–23 had anxiety as their problem.
(Welsh Government. (2024c) Counselling for children and young people: September 2022 to August 2023).

50% of mental health problems are established by age 14 and 75% by age 24.
(https://www.mentalhealth.org.uk/explore-mental-health/statistics/children-young-people-statistics)

On average, our Housing Support project, which supports 32 individuals in accommodation, visits emergency departments once a month due to self-harm, suicide attempts, or young people who need urgent attention and are unable to keep themselves safe.
(GISDA Statistics 24-25)

## Aim:

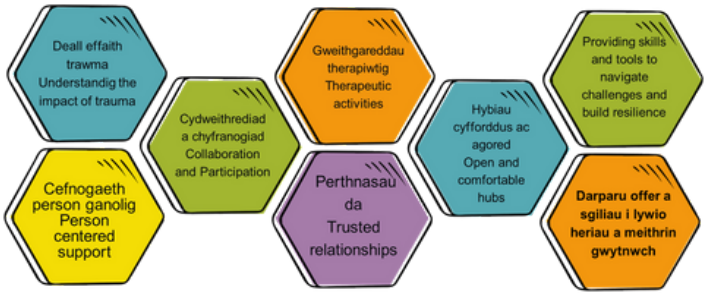
To address the growing need for accessible mental health support for young people, by developing a young people's wellbeing space. This innovative approach improves access to services, simplifies support pathways, and improves outcomes by bringing specialist agencies into a safe, youth-focused space. The project is intended to support statutory mental health services.

## Methodology:

- Original Plan: Buy a property (a house in Bangor) for a dedicated "Alternative to Admission" centre.
- Challenges: Lack of capital funding to buy and adapt a new building and the timetable to achieve this.
- Offer: Use the Bangor cafe to run a pilot.

**Six Month Pilot:**
Provide mental health services in four areas in Gwynedd offering support to young people aged 12-18.

**Model Fi - A way of working to give the best results for young people:**




**Available at the hubs:**


## Outcomes:

- Providing support around the young person.
- Reducing waiting times.
- Improving access to support.
- Improving early intervention.
- Simplifying multi-agency support – health, social services, education, and the third sector.
- Empowering young people.
- Supporting families and carers.
- Raising awareness and reducing stigma.
- Promoting wellbeing and resilience.

## ICAN Project:

Funded by BCUHB.

ICAN provides easy-to-access early support to people struggling with their mental health and wellbeing, reducing the need for referral to specialist NHS services.

- 166 service referrals in 23/24.
- 100% with mental health needs.
- 69% with a mental health diagnosis.
- 56% risk of self-harm / suicide.
- 86% visited a GP about their mental health.
- 34% visited emergency departments with urgent mental health needs.

Following support:

- **70%** noted an **improvement in their mental health and wellbeing**.
- 59% noted that they can now cope better with difficult situations.
- **77%** noted an **increase in awareness of the support available.**

Comisiwn Bevan Commission

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

# Cardiff and Vale University Health Board

# A Podiatry Led Community Vascular Screening Pathway, Improving Peripheral Arterial Disease Diagnosis and Treatment Planning within Cardiff and Vale UHB | CAVUHB

Samantha Waters, Adam Fox & Rosie Bacon, CAVUHB | Contact: samantha.waters@wales.nhs.uk

## Background:

Peripheral arterial disease (PAD) is present in around 20% of people over the age of 60 years (1). PAD accounts for 83.22 deaths per 1000 person years (2). As our population grows older chronic diseases, and peripheral arterial disease will have the potential to be a financial and resource burden on the health service early detection is key (3).

## Aims & Objectives:

- To look at reducing the waiting times of non-urgent peripheral arterial disease patients to have an expert assessment and treatment plan.

This has two major benefits. It reduces the long-term burden of this potential chronic disease , hence hopefully future proofing a deterioration of symptoms and also reducing waits for severely urgent patients to have a vascular surgeon opinion on potential limb and lifesaving surgical interventions.

## Methodology:

This project proposed that the Vascular Consultants have the ability at triage to re-direct referrals triaged as 'routine' lower limb PAD patients to the podiatry team.

**Design:** Development of a new clinical pathway.
**Delivery:** New clinical pathway implemented at point of referral from primary care to secondary care vascular consultants. Referrals were triaged by the consultants using the I.T referral system.
**Evaluation:** Mixed methods approach used.

## Outcomes:

A new clinical pathway was developed and implemented to deliver timely, efficient vascular assessments for peripheral arterial disease. It has:

- Reduced waiting times and improved access.
- Ensured patients are seen by the right professional.
- Positioned podiatry as the first point of care.
- Delivered high-quality care closer to home, within community settings.
- Aligned with NHS Wales' transformation agenda.

> This has allowed the diversion of a significant number of patients referred with likely non-vascular origin symptoms to be assessed and managed appropriately in a more timely fashion than the vascular department is currently able to manage. It also manages the risk of a inadequately structured referral leading to triaging into non-urgent category and patient sustaining harm. […].
> I fully support this initiative and hope this important work is able to continue.
>
> Vascular Consultant

## Impact:

- 43 patients referred, triaged and assessed through the new pathway.
- **Average wait time of 6.22 weeks**, compared to **58 week** wait to see a vascular consultant. This avoids a total of 2,226 weeks wait for this cohort.
- **66%** required **no vascular review**, avoiding unnecessary appointments.
- Those with signs of and symptoms of PAD received a faster treatment plan.
- Only **1 urgent referral** made to vascular consultants.
- Patients reported feeling reassured, informed and supported.
- Estimated **annual saving of £22,800** for Cardiff and Vale UHB.



> Great, clarified what was wrong. Nothing was left open ended. It made a lot of sense and with circulation ruled out that was a big thing. It made me feel better. I would recommend the project.
>
> Patient

## Key Conclusions:

The project and data showed that Podiatry as a profession is very well placed and trained to receive, assess and treatment plan for this group of patients, bringing care closer to home and improving the patient journey and outcomes.

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1) NICE CG147 (2020) Peripheral arterial disease diagnosis and management
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Podiatry Podiatreg
Promoting Foot Health Hyrwyddo Iechyd Traed
South East Wales Vascular Network
Rhwydwaith Fasgwlaidd De Ddwyrain Cymru

# Embedding Sustainability in Wales' Sole Dental Hospital and School - Crafting the Narrative for Change | CAVUHB & Cardiff Dental School

Nagham Katif, Cardiff University & Sheelagh Rogers, CAVUHB | Contact: KatifN@cardiff.ac.uk & Sheelagh.rogers@wales.nhs.uk

## Background:

Healthcare is a significant contributor to carbon emissions. NHS Dentistry accounts for approximately 3% of the NHS's total carbon footprint. Despite growing interest in sustainability across both Dental School and Dental Hospital, collaborative leadership and strategic direction was required. Recognising the urgency of the climate crisis, the need for systemic change, and alignment with national policies, both institutions appointed sustainability leads to collaborate on this urgent agenda.

## Aims & Objectives:

- Establish a Joint Sustainability Working Group.
- Support and promote projects aimed at reducing waste and driving sustainable change.
- Identify cost savings and reduction in carbon emissions associated with change.
- Embed sustainability across all levels of dental education.
- Raise awareness-build a culture of sustainable behaviour.

## Methodology:

Using core sustainability principles in conjunction with the Bevan Commission's WASTES typology (Figure 1), the Joint Sustainability Working Group mapped and planned projects in areas of waste and process inefficiencies. Students, NHS dental trainees, clinical and non-clinical staff undertook these projects.

Sustainability was introduced as a core educational theme in the new dental curriculum, enabling introduction at undergraduate level.

Raising awareness and engagement withplanned projects- outcomes were disseminated through the inaugural Sustainability in Dentistry (SID) talks.

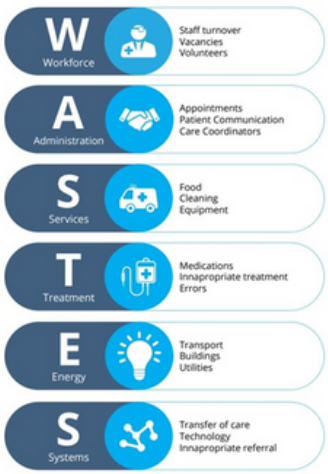



Figure 1: Bevan Commission WASTES Typology.

## Outcomes:

- Established a Joint Sustainability Roadmap.
- Completed 15 projects- improving service delivery, patient care, reduction of waste whilst meeting students' and trainees' educational requirements.
- Introduced Sustainability through undergraduate and staff activities.
- Raised awareness through completed projects, local activities and forums

## Impact:

- Evaluation of dental theatres focused on training dental nurses as scrub nurses. In one year, this change is expected to prevent **75 patient cancellations**, saving **56 hours** of theatre time and **£43,290** in costs.
- The decontamination team (DSDU) improved protocol by eliminating a layer of paper wrapping, resulting in annual cost savings of **£1,670.50** and a reduction in carbon emissions of **1,761.17 kg $CO_2$** (Figure 2).
- SID talks drew an audience of 30 attendees, with positive feedback:

> "Presentations were very relevant and informative."


Figure 2: Results of the DSDU Team project.

## Key Conclusions:

- Co-leadership and engagement with stakeholders are crucial for implementing this agenda in both clinical services and dental education.
- The Bevan Commission WASTES typology provides an excellent foundational framework for identifying areas of change.
- Not all projects yield the same cost savings or carbon emissions but contribute to integrating quality improvement practice into dental education.
- Sustainable healthcare is firmly on the map within the Dental Hospital.

# Clozapine Constipation Prophylaxis: Developing a National Movement | CAVUHB

Katie Evans & Lee Griffiths, CAVUHB | Contact: katie.evans@wales.nhs.uk

## Background:

Clozapine, the gold standard for treatment-resistant schizophrenia, carries significant risks. Clozapine-Induced Gastrointestinal Hypomotility (CIGH) affects up to 75% of patients, ranging from mild symptoms (e.g., reflux) to severe, potentially fatal complications (e.g., ileus, obstruction, perforation). Severity relates to clozapine's pharmacology and patient risk factors.

Screening relies on patient-reported outcomes but lacks detection sensitivity. Given CIGH's prevalence and detection challenges, prophylactic laxatives have been recommended. A New Zealand protocol reduced serious CIGH cases from 8.2 to 1.1 per 100 person-years (RR 0.13; 95% CI 0.403–0.043).

In 2020/21, CAVUHB implemented a Clozapine Laxative Prophylaxis Pathway (CLPP) for all clozapine patients. This project evaluates CLPP and explores an all-Wales protocol.

## Objectives & Methodology:

**1.Evaluate CLPP Uptake**
Audit laxative prescribing in CAV clozapine outpatients.

**2. Gather Feedback**
Survey patients, prescribers & clinic staff on CIGH awareness and CLPP.

**3. Assess Impact & Value**
Review CIGH-related A&E visits/admissions (2006–2025) and cost-benefit of prophylaxis.

**4. Map Wales Practices**
Identify CIGH prevention approaches & clozapine patient numbers across health boards.

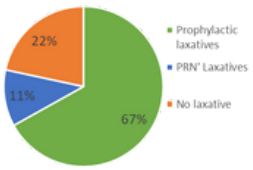
## Outcomes:

### 1. CLPP Uptake:

Audited 245 clozapine patients:

- 67% prescribed prophylactic laxatives.
- Most regimens appropriate.
- 15% involved inappropriate polypharmacy.
- 1% (n=2) included harmful laxatives.

Fig 1. Prophylactic Laxatives Uptake




### 2a. Patient & Carer Feedback:

- **43%** participated; 50% experienced clozapine-induced constipation.
- **93% recognised CIGH as serious** and supported prophylactic laxatives. Most seek help via clozapine clinic; others turn to family or GPs. Embarrassment commonly limits discussion in clinic.

> "I don't want to talk about my bowel habit, it makes me uncomfortable."

> "It is embarrassing for me to talk about my poo."

### 2b. General Staff Knowledge & Feedback:

- 89 prescribers responded.
- **52%** knew of CIGH; 59% of these knew CLPP → greater confidence in CIGH management.
- **0% opposed prophylactic laxatives**; 49% had reservations or felt it extended beyond their role remit.
- Support for CLPP higher among those aware of detection challenges; 50% of uncertain respondents cited outdated "cathartic colon" concerns.

> "I don't prescribe clozapine - I don't see patients regarding mental health issues."
> General Practice Prescriber

### 2c. Specialist Staff Knowledge & Feedback:

- 13 clozapine clinic staff responded.
- **100% aware of the CLPP**; Reliance on medic prescribing highlighted as timely treatment barrier.
- **70% unaware of detection sensitivity & silent nature of CIGH.** 61% wanted training to boost confidence in identification & management.

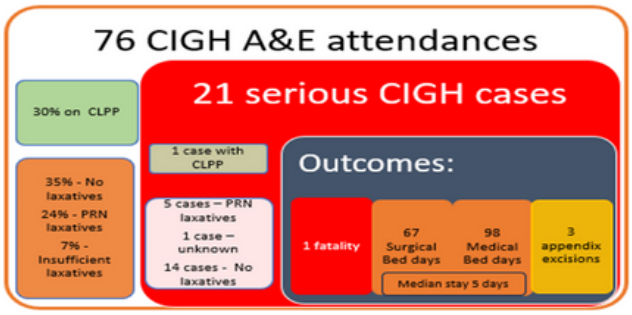



Fig 2. CIGH Cases Characteristics

### 3. Assessing Impact & Value:

2103 A&E attendances (355 patients) were screened for serious CIGH – Fig 2.

**Cost benefit model assumptions:**

- Serious CIGH prevalence (literature).
- Current CAV clozapine population.
- Maximal CLPP costs.
- A&E attendance + 5-day admission (median) + initial investigations.
- Acute interventions excluded.

**23 vs 3 Serious CIGH cases p.a.**
**CAV Gross Cost Avoidance p.a:**
**£97,492 - £152,492**
**CAV Net Cost Avoidance p.a:** (max CLPP cost deducted)
**£19,198 - £74,241**
Range attributes to difference in medical Vs surgical bed costs

### 4. Practices Across Wales:

- 1,685 NHS Wales clozapine patients.
- CIGH prevention practices are variable, with inconsistent approaches to laxative prophylaxis.
- Laxative prophylaxis could reduce serious CIGH episodes from 138 to 19 per annum.

## Key Conclusion:

CLPP can reduce serious CIGH cases and associated healthcare costs.

# Supporting Seamless Unscheduled Dementia Care in Partnership | CAVUHB & WAST

Versha Sood, Cardiff & Vale Regional Dementia Partnership
Alison Johnstone, WAST
Contact: versha.sood@wales.nhs.uk & alison.johnstone@wales.nhs.uk

## Background:

On average, people with undiagnosed dementia are three times more likely to attend hospital.

People with severe dementia will stay in hospital four times longer than people without (Alzheimer's Society Report 2024).

**35% increase** in people living with dementia regionally by 2035.

**One in two of us** will be affected by dementia in our lifetime (either through caring, developing the condition, or both).

## Aims & Objectives:

- Adaptations to emergency environments to reduce distress and overstimulation.
- Mapping the handover process to support smoother transitions between staff.
- Increasing awareness and use of biographical tools, such as the Read About Me document in Cardiff & Vale.
- Delivering targeted training opportunities to build staff confidence and capability in dementia care.

## Methodology:

- The project used a co-production approach to map challenges and improve the experience of people with dementia during emergency admission. Stakeholders included people affected by dementia, carers, health and care professionals, and partners across Cardiff & Vale UHB and WAST.
- Initial workshops identified key issues such as inconsistent dementia flagging, environmental overstimulation, communication gaps, and limited dementia-specific training. These findings informed a programme of targeted interventions delivered between September 2024 and September 2025.
- Activities included staff and patient surveys, dementia care mapping, ambulance and ward environment adaptations, and roll-out of the Read About Me biographical tool. Training was co-delivered with the Dementia Education Team, engaging over 500 staff across settings.
- Evaluation used a mixed-methods approach combining qualitative feedback, staff reflections, and observational data. Insights were reinforced through engagement with over 140 people living with dementia and their carers, and collaboration with local dementia networks and the Regional Partnership Board.

## Outcomes:

- Improved understanding of patient experience.
- Staff surveys revealed strong support for the biographical.
- Environmental improvements in ambulance and ward settings.
- Expansion of training opportunities.
- Process mapping and collaborative Learning.
- Identifying key issues like environmental stressors.
- Clarity on project infrastructure and governance.

## Impact:

- **200** 'Read about Me' distributed.
- **5** ambulance environment changes.
- **2** ward environment changes.
- **18** Staff training sessions delivered to WAST.
- **9** Staff training sessions delivered within the Emergency Department.
- **135** Sway presentation video views.
- **22** Engagement sessions including lived experience.

- Better understanding of patient experience
- Increased staff education
- Improved service efficiency
- Development of tools and resources

## Key Conclusions:

- Better WAST–ED relationships enable clearer, timely handovers.
- Biographical tools help staff provide person-centred care.
- Training empowers staff to spot signs of confusion.
- ED confirms cognitive issues are addressed and patients moved to dementia-friendly areas.

# Falling Off a Cliff: A Digital Carabiner for Rare Disease Young People and Their Families Transitioning to Adult Care | CAVUHB

Jamie Duckers, Zoe Morrison, Darcie Williams, Rhiannon Edwards on behalf of the Wales Rare Care Centre Leadership group & Laura MacDonald (Carecircle) | Contact: Jamie.Duckers@wales.nhs.uk

## Background:

**Rare diseases affect one in 17 people globally**, including around 180,000 in Wales, many facing life-limiting and complex conditions with limited treatment options or care pathways.

Individuals and families often experience isolation, delayed diagnoses, and fragmented support. The "diagnostic odyssey" can take years, with patients repeatedly explaining their history to different professionals.

Even after diagnosis, they face ongoing challenges coordinating health, education, and welfare needs with little support.

This lack of integration fuels health inequalities, limits access to research and NHS services, and contributes to declining mental, physical, and social wellbeing, increasing reliance on care resources.


## Aims:

- Develop a Wales Digital Rare Care Centre (WDRCC).
- Pilot peer support content and horizon scan for technology.
- Understand the impact of online service provision to NHS Wales.
- Develop peer clinical support and share opportunities across rare disease clinical services.

## Methodology:

1. Industry partner developed the rare disease platform.
2. Clinicians and lived experience groups defined priorities.
3. Governance, cybersecurity, and partnerships with NHS and charities followed.
4. Stakeholder engagement, PPIE groups, and shared learning shaped progress.
5. Combined resources improved access and equality.
6. Ongoing development invites community input into the Wales Digital Rare Care Centre vision.

## Results:

The Wales Digital Rare Care Centre is already highlighted as an example of good practice. The NICE Rare Disease Quality Standards and other UK rare disease framework guidance documents are currently being developed, focusing on public requirements for a one point of access digital platform to improve awareness of rare diseases and to share resources and peer support.

## Impact:




The development of a rare disease MDT peer support group will have benefits further than the boundaries of this project and help the clinical team members involved in rare disease care to share learning and gain valuable support from each other.

One access point, currently links to three separate, but interlinked hubs. 48 spaces (rooms) have been requested and developed by stakeholders and accessible in five languages (including Welsh). 186 documents have been uploaded, including videos. 64 clinicians and non-clinicians are using the site.

# Making the Invisible Visible: A Strategic Framework for Nursing Older People | CAVUHB

Ruth Cann, CAVUHB | Contact: ruth.cann@wales.nhs.uk

## Background:

- Wales faces a major demographic shift: the population aged 75+ will rise from 9.9% (2021) to 13.8% (2041), with two-thirds of adults over 65 living with multiple conditions by 2035.
- Nursing roles for older people with frailty or complex needs are undervalued and fragmented, with no national framework guiding education or career progression.
- This creates inconsistent care standards, workforce instability, and limits integrated, person-centred care.

## Aims & Objectives:

To develop a national framework that:

- Recognises and strengthens nursing roles in older people's care.
- Improves recruitment, retention, and professional development.
- Promotes older person care as a rewarding career.
- Co-produces an education and development framework for nurses.
- Validates and celebrates nurses' skills.
- Embeds "What Matters" principles in care delivery.

## Methodology:

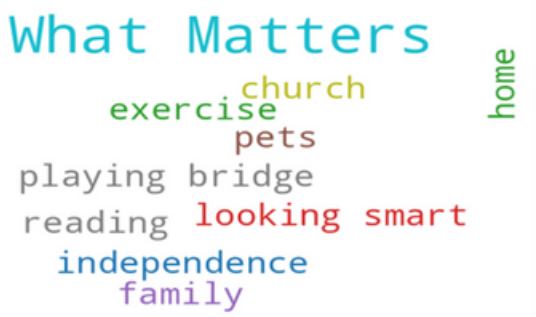
**Quantitative**: Staff survey (60% response) revealed gaps in dementia care, frailty education, future care planning, and advanced skills (e.g., CGA, prescribing).

**Qualitative**:

- Community of Enquiry explored person-centred care using DEEP methodology.
- Interviews highlighted emotional labour, system navigation, and advocacy roles.
- Unpaid carers reported mixed experiences, often feeling invisible.
- 'What matters' conversations revealed priorities like independence, home life, and personal routines.

> How do we see every colour of a Person's Rainbow within the constraints of our systems?
>
> DEEP Community of Enquiry

> I prioritise supporting people to live well on their own terms as we can never completely eliminate risk.
>
> GP Cluster Frailty Nurse






## Outcomes:

- Elevated voices of nurses, carers, and older people.
- Identified gaps in education and career progression.
- Proposed a values-based framework centred on:

Values: Person- and relationship-centred care, collaboration, empowerment.

Themes (Strategic Pillars): Education, relational skills, clinical expertise, MDT collaboration.

Initiated an All-Wales Steering Group to lead co-production of the framework.

## Impact:

- Positioned older person care as a strategic priority.
- Provided insights for workforce planning and policy alignment.
- Created momentum for national adoption.

## Key Conclusions:

Nursing older people living with frailty and complex needs requires advanced skills, emotional resilience, and system navigation. This project has made the "Invisible Visible", highlighting gaps in education and career progression while proposing a values-based national framework to strengthen professional identity, improve outcomes, and embed person- and relationship-centred care across Wales.

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# Cwm Taf Morgannwg University Health Board

# Implementing a Dedicated Inpatient Podiatry Service for Acute Diabetic Foot Disease | CTMUHB

Jess Rees & Gaynor Slocombe, CTM UHB | Contact: jessica.rees@wales.nhs.uk & gaynor.slocombe@wales.nhs.uk

## Background:

Active foot problems in people living with diabetes have a huge financial impact on the NHS across inpatient, outpatient and primary care settings.

- **Cost:** Diabetic foot ulcers (DFU) and amputations cost between £837 million and £962 million in England in 2014-15 (Kerr et al., 2019).
- **Impact:** Over 80% of amputations (NICE 2019) and 80% of deaths within five years are linked to DFUs (Kerr 2012).
- **Hospital Stay:** People with DFUs stay an average of eight days longer in hospital than someone with diabetes, but without ulcers (NDFA, NADIA).

Evidence suggests that one third of these patients with active foot ulceration at the time of admission have a foot examination within 24 hours of admission (NHS Digital 2017).

In CTMUHB, the absence of a dedicated inpatient podiatry service meant delays in assessment and treatment, limited ward staff education, and no immediate support for acute diabetic foot presentations in emergency or same day care departments.

## Aims & Objectives:

This project aimed to improve care for patients with diabetic foot ulcers by establishing a dedicated inpatient podiatry service.

### Objectives:

- Provide timely podiatry care for diabetic foot ulcers seeing all referrals within 1 working day (NICE NG19).
- Coordinate multidisciplinary management.
- Educate staff on diabetic foot risk assessment and management.

## Methodology:

- In 2021, funding was secured through Value-Based Healthcare Welsh Government funding for 1-year fixed term for acute inpatient podiatrists (3 WTE Band 7 posts) across the three district general hospitals.
- Due to recruitment challenges, the project was delivered via secondment of a Band 7 Podiatrist at RGH for one year from April 2023, subsequently extended to March 2025.
- Strong stakeholder engagement with diabetes, ED/SDEC, and nursing teams supported the launch of the service, development of referral pathways, and delivery of staff training.
- Ongoing data collection to measure impact, including PREMs, planned PROMs, and patient stories to enable to evaluation of access, experience, and outcomes.

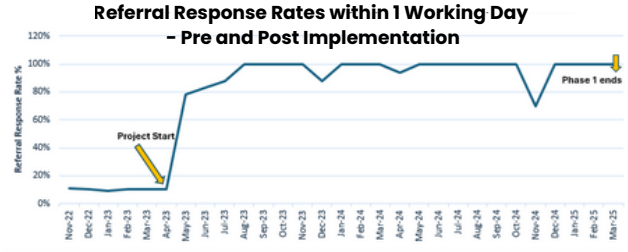
## Outcomes:

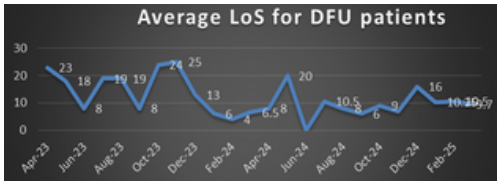
New service model implemented at Royal Glamorgan Hospital with aim to respond to 80% all inpatient referrals for acute diabetic foot disease by March 2025 including provision of on call service at emergency department/same day emergency care department.

## Impact:

- Reduction in length of stay (LoS) for patients admitted with DFU.
- Reduction in avoidable admissions for DFU.
- Improvement in time take for DFU patients to be reviewed (as per NICE NG19 within 24 hours).
- Reduction in re-admission following inpatient stay (30 days) for DFU.
- Reduction in hospital acquired DFUs.
- Improved patient reported experiences.
- Improved experience of wider MDT managing DFU.
- Increased awareness of diabetic foot risk and management amongst inpatient teams.

| | Baseline pre-project (Oct 22 - Mar 23) | Phase 1 project (Apr 23 - Mar 25) |
|---|---|---|
| Reduction in LoS for DFU | Av 89.7 days | Av. 16.5 days |
| Reduction in avoidable admissions | No baseline (no service) | Av. 0.88 per month |
| Responses rates within 1 working day | 63% | 96.90% |
| Reduction in readmission rates for DFU within 30 days | No baseline data | 62.5% of months no recorded readmission for DFU |
| Reduction in Hospital Acquired DFUs | Av. 1 per month | Av. 0.65 per month (35% reduction) |
| Improved patient reported experiences | No data collection | Majority positive responses over 80% |
| Improved experience of wider MDT managing DFU | | Positive testimonies from inpatient teams |




## Key Conclusions:

- Timely and efficient treatment and planning.
- Improved MDT working.
- 'Getting it right first time'.
- Avoidable admissions.
- Reduction in bed days.
- Improved patient experiences and outcomes.

# Development of a Health Visiting Cancer Framework: Targeting our inequalities 'Bringing 5 C's into everyday conversations' | CTMUHB

Health Visiting Service, CTM UHB | Contact: andrea.bevan2@wales.nhs.uk

## Background:

Cancer rates in Merthyr Tydfil are 20% higher than the national average (Cancer Research UK), and cancers are more common in deprived communities (Public Health Wales). Lung cancer is the leading cause of cancer death in Wales, responsible for 1,759 deaths in 2024, almost twice as many as the next most common cause.

Despite this burden, there is currently no UK-wide cancer framework for health visiting. Health visitors, as Specialist Community Public Health Nurses (SCPHN) with universal access to families with children under five, are well placed to promote early detection and prevention. Building on existing advice around breast, cervical and testicular cancer, this project introduces a comprehensive framework covering breast, bowel, lung, testicular and cervical cancer. By shifting from reactive conversations to proactive education, the framework aims to strengthen awareness, support timely screening, and improve outcomes for families and communities.

## Aims & Objectives:

**Aim:** Develop a Health Visiting Cancer Framework to expand current practice by promoting awareness of five key cancers.

**Objectives:**

1. Universal Reach: Integrate cancer awareness into Healthy Child Wales Programme (HCWP) contacts, focusing on five key cancers.
2. Signposting: Direct families to relevant information on cancer identification and screening.

## Methodology:

### Design

- The project was piloted using Patient Reported Experience Measures (PREMs), and staff focus groups. PREM data were collected via the CIVICA system, with eight service users completing the questionnaire.
- Training on cancer screening was provided by Cancer Research UK and CTM trainers (not directly involved in project delivery). An action plan with agreed timelines guided implementation.
- A designated health visiting team, supported by their line manager, identified eligible service users from their caseloads between April and August 2025.

### Delivery

- The framework was delivered through routine health-visiting contacts at a health centre in Merthyr Tydfil, with families identified during key Healthy Child Wales appointments.
- Health visitors, who already discussed cervical, testicular and breast cancers, received additional training to support accurate, evidence-based conversations on all five cancers. PREM questions were co-developed with the team, and service users completed them during their usual visits.
- A staff focus group was recorded for thematic analysis.

## Impact:

- **Health**: The project involved nine health visitors in Merthyr, with eight service users (75% aged 25-34) completing PREMs. All reported increased confidence in seeking support after cancer-related conversations.
- **Wellbeing**: 100% felt comfortable discussing cancer signs and symptoms with others. Conversations led to awareness of early screening options, especially with family history.
- **Service User Experience**: Feedback was positive. Users recalled specific cancer messages., especially around testicular cancer, showing strong message retention.
- **Service Efficacy**: Using existing HCWP visits and MECC principles proved effective. Early cancer discussions with younger families support prevention and align with public health goals. Cancer remails the leading cause of avoidable death in Wales.
- **Cost Savings**: Cancer cost the NHS in Wales £719m in 2022/23. Prevention and early detection could reduce long-term health care and economic burdens.
- **Staff & Education**: Health visitors debated optimal HCWP visit timing for cancer conversations. Expanding from three to five cancers added time to visits, however, it was seen as valuable. Staff suggested prompt cards to aid conversations.
- **System-wide Approach**: Staff advocated for broader involvement across the services – school nursing, sexual health, midwifery and pharmacy- to support cancer prevention.

## Key Conclusions:

- **Health Visitor (HV) Engagement:** Enabled HV's to explore adding five cancers topics into routine HCWP conversations.
- **Strengthened HV's role** in delivering public health messages.
- **Service User**: Positive feedback, high recall of key cancer messages.
- **Public Health Value**: Promoted prevention, early intervention, and detection.
- **Efficiently** using the HCWP programme contact to deliver conversations.

# The Feasibility of a Virtual Reality Mindfulness Intervention for Depression and Anxiety in Wales | New Horizons & Tend VR

Kim Bevan, Tend VR, Janet Whiteman, New Horizons & Lisa Wills, Arts Factory | Contact: kim@tend-vr.com

## Background:

There is a wealth of evidence for the efficacy and effectiveness of Mindfulness Based Cognitive Therapy (MBCT) as an effective treatment for depression and anxiety and for the potential of VR as a delivery tool.

Offering a mindfulness-based intervention (MBI) using the key elements of MBCT via immersive virtual reality (VR-MBI) provides a potential solution for people who normally struggle to access mental health services. This is something we wanted to explore in Wales.

We knew that if this pilot project demonstrated similar feasibility, acceptability and efficacy results as shown in our previous VR-MBI studies then we will have a truly scalable, accessible and affordable solution to tackling access issues that lead to long NHS Wales waitlists for mental health interventions, which can lead to poor outcomes for service users.

## Aims & Objectives:

Our overall aim was to explore the feasibility, acceptability, accessibility and impactful of the Tend VR-MBI programme when delivered at a place of the individual's choosing, to people who struggle to access traditional mental health services. Our objectiveS were:

1. To evaluate the feasibility, acceptability, accessibility and levels of engagement with Tend VR-MBI and explore its feasibility as a potential solution to waiting list and accessibility in mental health services in Wales.
2. To evaluate signs of the clinical efficacy of the VR-MBI programme.
3. To evaluate the engagement, sustainability, experiences and retention levels of participants.

## Methodology:

- All participants completed an online Expression of Interest (EoI) screening form.
- Eligible participants who wished to participate after an introduction to VR were asked where they wanted the programme - all chose either New Horizons or Arts Factory (not home) and completed consent forms.
- We used a mixed methods approach combining quantitative outcome scales (PHQ-9, GAD-7 & WSAS) to measure impact (baseline and end of study) with qualitative interviews at the end of the programme to review participants' engagement and overall experience with the VR-MBI programme.

## Outcomes:

We developed a new version of an existing mental health product, VR-MBI, adjusted to make it deliverable in a local venue as well as at home. The results from our project suggests that Tend VR-MBI is a feasible and acceptable approach to improving the mental health of people with mild learning difficulties and those for whom accessing traditional mental health services has proven challenging. We found that, for participants with learning difficulties, a small amount of additional support was required but their outcomes and feedback was very positive. This project has enabled us to develop a feasible, acceptable, comprehensive approach to supporting the mental health of underserved individuals in Welsh communities.

## Impact:

Although the sample size for the pilot was relatively small (n=12), the interventions demonstrated statistically significant improvements in mental health (Table 1), with self-reported improvements in depression and anxiety symptoms and in functioning.

Table 1: Pre and post intervention outcomes measures (mean)

| Psychometric Test | Pre-intervention | Post-intervention | Improvement |
|---|---|---|---|
| PHQ-9 (Depression) | 12.25 | 4.73 | **61%** |
| GAD-7 (Anxiety) | 11.25 | 4.18 | **63%** |
| WSAS (Work & Social Adjustment Scale) | 18.58 | 8.64 | **53%** |

### Participant Experience:

- Overall experience: Mean score **4.73 / 5.**
- Likelihood to recommend: Mean score **4.64 / 5.**

Participants reported consistently positive experiences with the programme and indicated that they would be highly likely to recommend Tend VR-MBI to friends and family.

> It really helps reduce my anxiety and helps me relax. The narrator's voice is very soothing.

## Key Conclusions:

> Looking at the future now, I've got life-changing skills that I can't lose in terms of just managing, you know, everything that goes on in my head and stuff and, you know, learning that I'm going under a lot of stress and that's okay. But I've got the tools to deal with it now and I'm going to get through it.

NEW HORIZONS MENTAL HEALTH
Patrons, Boyd Clack & Delia Powell

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Digital Health and Care Wales

# Digital Health and Care Wales

# Health Literacy and Mental Health in Older Adults | DHCW

Alexander Shaw, DHCW | Contact: alexander.shaw2@wales.nhs.uk

## Background:

Population ageing is accelerating globally, creating major challenges for health systems as mental health disorders among older adults remain underdiagnosed. Health literacy - particularly self-efficacy - is increasingly recognised as a key determinant of health equity, shaping outcomes across all populations, including older adults.

## Aims:

To identify health literacy factors associated with self-reported mental health and examine demographic determinants of self-efficacy.

## Methodology:

This study analysed Welsh data from the OECD Population Health Survey, which collected patient-reported outcomes across 199 randomly selected general practices. Participants aged 46+ were invited; this analysis focused on 13,704 respondents aged 65+. Data was collected July–October 2023 via paper, online, and telephone, with Welsh-language options. Mental health was assessed using PROMIS Global Health v1.2 (T-scores: 21.2–67.6). Health literacy was assessed using adapted, validated items. Four self-efficacy items formed a composite Health Confidence Index (0–3).

Responses were linked to deprivation quintiles using WIMD 2019. Covariates included age group, gender, education, chronic conditions, and medication count. Analyses were conducted in R Studio (v4.4.3), using linear regression and non-proportional odds models, with AIC and BIC guiding model selection.

## Results 1. Self-Efficacy and Mental Health

Linear regression explained 33.8% of the variance in mental health scores ($R^2$ = 0.338), confirming a strong association between self-efficacy and mental health. Confidence managing own health and wellbeing was the most influential predictor (β = 2.61, 95% CI [2.36, 2.86], p < 0.001), with each one-unit increase linked to a 2.61-point improvement on the PROMIS mental health scale. Other confidence dimensions - following care instructions (β = 1.15), identifying medical care needs (β = 0.87), and following lifestyle guidance (β = 0.66) - also showed significant positive effects. A composite Health Confidence Index (HCI) amplified this relationship, with each unit increase associated with a 5.18-point improvement.

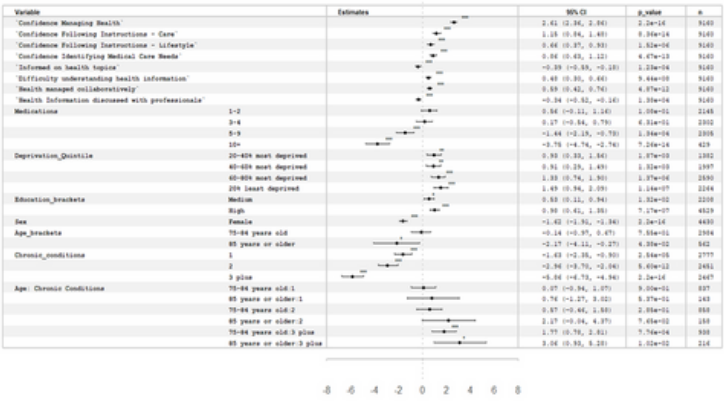

Figure 1. Linear Regression: Health Literacy and Demographics against Mental Health Score

## Results 2. Drivers of Self-Efficacy

Non-proportional odds modelling identified key demographic drivers of low confidence. Across all confidence domains, individuals with three or more chronic conditions had the highest odds of low self-efficacy (OR up to 6.10). Older age (≥85 years) and lower educational attainment were also significant predictors, while deprivation strongly influenced confidence in following care instructions. Sex reported as Male emerged as an additional factor for lifestyle-related confidence. These findings highlight multimorbidity, advanced age, and socioeconomic disadvantage as critical barriers to self-efficacy. Targeting these groups through tailored interventions offers the greatest potential for improving health confidence and, by extension, mental health outcomes.

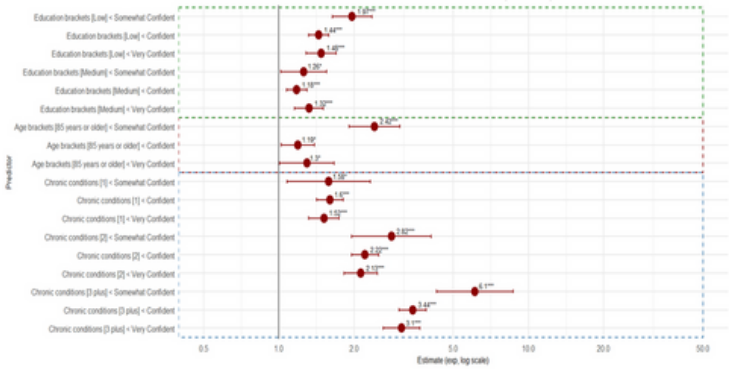

Figure 2. Non-Proportional Odds Model: Odds Ratio Estimates for Demographics and Confidence Managing Own Health and Wellbeing

## Key Conclusions:

This study demonstrates that self-efficacy is a critical determinant of mental health among older adults in Wales. Confidence in managing health and following care instructions showed the strongest positive associations with mental health scores, while multimorbidity and medication burden were significant negative predictors. Demographic factors such as advanced age, low education, and deprivation further influenced confidence levels, identifying priority groups for intervention. Enhancing health confidence through targeted strategies could yield meaningful improvements in mental health and help reduce health inequalities. These findings support scalable, evidence-informed approaches to strengthen self-efficacy in ageing populations.

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Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

# Health Education and Improvement Wales

# ‘What’s Your Score?’ | HEIW

Geraint Jones, HEIW | Contact: Geraint.Jones4@wales.nhs.uk

## Background:

Cardiovascular disease remains a leading cause of preventable ill health in Wales, with an **estimated 220,000 people living with undiagnosed high blood pressure**. Opportunities for early detection are often missed. By delivering simple health checks in everyday community environments, this may help reach those who may not routinely monitor their blood pressure, reduces stigma and normalises preventative behaviours. **‘What’s Your Score?’ aimed to bring opportunistic blood pressure checks into trusted, familiar spaces, supporting early awareness, prevention, and public empowerment.**

## Aims & Objectives:

The project aimed to pilot community-based blood pressure checks in football clubs and shared communal spaces, exploring public awareness, acceptance, and perceived barriers to non-clinical monitoring.

- Provide accessible blood pressure checks in community settings.
- Gather behavioural insight on awareness, engagement, and barriers.
- Raise public understanding of prevention and self-monitoring.
- Assess feasibility for wider scale-up across Wales.

## Methodology:

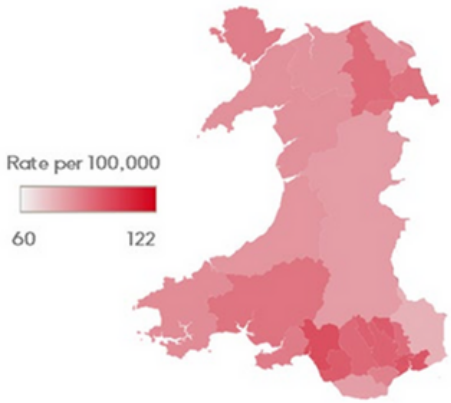
Using a mixed-methods evaluation, the project combined:

- 39 participants accessed blood pressure readings at a PureGym in South Wales.
- 300+ public survey responses captured attitudes, confidence, and likelihood of future monitoring.
- Stakeholder conversations (Football Association of Wales (FAW), British Heart Foundation (BHF) Cymru, Swansea City AFC Foundation) and public interaction informed feasibility and acceptability.

## Outcomes:

- **12.8%** of pilot participants identified with abnormal readings and were signposted and advised for a follow-up with a healthcare professional.
- **92%** agreed that gyms, football clubs and community venues are suitable for checks.
- **71%** believed that offering blood pressure checks in public places could reduce pressure on NHS services in the longer-term.
- **95%** felt confident they could self-monitor with simple instructions.
- **98%** agreed that this approach could help reach people who may not visit their GP regularly.
- **77%** planned to talk to their GP or another health professional as a result of this intervention.

Premature heart & circulatory disease (CVD) death rate by local authority 2020-22




British Heart Foundation Cymru, 2025)

## Key Conclusions:

- ‘What’s Your Score?’ shows that preventative health checks can be delivered safely, effectively and with high public acceptance in community environments.
- This enables earlier identification of risk, meaningful health conversations, and improved self-monitoring behaviours.
- Strongly aligns with Welsh prevention priorities and demonstrates clear opportunity for wider adoption across Wales.
- A scalable, low-cost model has been established, with strong cross-sector enthusiasm and clear potential to embed community-based prevention into everyday life.

## Recommendations:

- Scale delivery into additional community environments such as workplaces, sports clubs and high-footfall public spaces to reach broader population groups.
- Develop a ‘train-the-trainer’ framework so football clubs, workplaces and community organisations can deliver checks independently using standardised, evidence-based tools.
- Strengthen clinical evidence, including cost–benefit analysis, and longer-term behavioural tracking.
- Formalise partnerships with organisations such as BHF Cymru, FAW, local Health Boards, and community foundations to embed opportunistic checks within existing wellbeing programmes.
- Secure funding and commissioning support to create a sustainable, scalable national prevention model.

**Supported by:**

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Hywel Dda University Health Board

# Pioneering an Accessible, Effective and Efficient Women's Health Psychology Service | HDUHB

Bethan Lloyd, HDUHB | Contact: bethan.lloyd@wales.nhs.uk

## Background:

There is a high prevalence of psychological and emotional distress within women's health pathways which severely impacts wellbeing, mental health, social, relationships and occupational functioning. For example:

- Studies have shown up to 86% with endometriosis suffer with depression.
- 25% women with menopausal symptoms experience depression, anxiety and cognitive difficulties.

Psychology within women's healthcare in Wales is absent, however the NHS Wales Women's Health Plan calls for improvements in psychological care.

## Aims & Objectives:

- Pilot an innovative model of care to reduce psychological distress within women's health.
- Strengthen access to psychological support in line with the NHS Wales Women's Health Plan.
- Increase understanding of the prevalence and nature of mental health difficulties in this group.
- Evaluate the effectiveness of psychological approaches within women's health pathways.
- Assess the acceptability of a digital delivery model to help reduce health inequalities.
- Demonstrate value-based outcomes and inform future service design and workforce planning.

## Methodology:

- A two year funded collaboration between between Hywel Dda UHB Clinical Health Psychology and three GP Clusters designed, implemented, and evaluated a novel psychology pathway.
- Referrals were accepted across all tiers of care, including self-referrals, for those experiencing psychological difficulties related to gynaecological conditions or menopause-related symptoms.
- Tailored individual and group interventions for menopause and pelvic pain were developed and delivered.

> "When I was feeling at my lowest the guidance and support I had from [staff name] helped change my life around. I now feel I have a purpose [...]. Highly recommend this service."
>
> Patient

## Outcomes & Impact:

- **163** referrals were accepted across gynaecological and menopause-related conditions (ages 20 - 74 years). The highest referral rates were for menopause, pelvic pain, and endometriosis, highlighting significant unmet psychological need (Figure 1).
- At assessment, mental health difficulties were significant (Figure 2). **53%** met the clinical threshold for depression and **81%** for anxiety, demonstrating the service's reach and relevance for individuals with complex presentations.

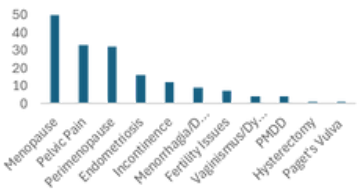



Figure 1: Distribution of referrals

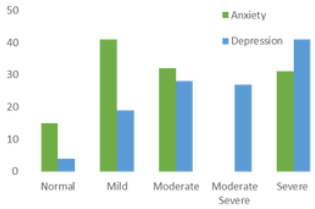



Figure 2: Severity categories of anxiety and depression at initial assessment

### Clinical Outcomes: PROMS

Psychological interventions delivered through the pilot led to clinically significant improvements in mental health (Figure 3), with significant changes in measurements of depression and anxiety.

| Psychometric Test | Pre-intervention | Post-intervention | Improvement |
|---|---|---|---|
| PHQ-9 (Depression) | 13.88 | 7.97 | **42.6%** |
| GAD-7 (Anxiety) | 12.39 | 7.48 | **39.6%** |
| EQ VAS (Self-rating of Overall Health) | 51.73 | 66.17 | **27.9%** |
| PSEQ (Pain Self-management) | 30.11 | 41.20 | **36.8%** |
| EQ-5D-L (Quality of Life) | 11.75 | 9.72 | **17.3%** |

Figure 3: Measured impact: Ave. Pre v Ave. Post

### Value-Based Healthcare:

The service released resources by reducing demand on gynaecology, pain, mental health, and unscheduled care services. Notably, three frequent A&E attendees did not return after engaging with the service, showing positive behaviour change in managing pelvic pain.

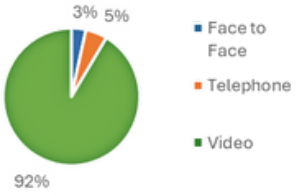



Figure 4: Appointment Modality: Digital Model Enhancing Accessibility and Reducing Health Inequalities

### Patient Experience:

100% of respondents to the Family and Friends test said they would recommend the service.

## Key Conclusions:

- The Women's Health Psychology Service pilot demonstrated clinical effectiveness in improving mental health, pain management, and overall quality of life.
- The service delivered resource-releasing benefits across gynaecology, mental health, pain services, and A&E.
- With 92% of psychological input delivered via video platform, the pilot showcased a strong digital model that enhances accessibility and helps reduce health inequalities.
- The pathway offers an efficient, scalable solution to address unmet needs in women's health by integrating holistic psychological care into existing services.

# Improving Cancer Waiting Times: The Introduction of One-Stop Diagnostic Gynaecology Services in Hywel Dda | HDUHB

Lauren Davies & Aimee Bowen, HDUHB | Contact: lauren.davies13@wales.nhs.uk & aimee.bowen@wales.nhs.uk

## Background:

Patients should be seen and treated on the Urgent Suspected Cancer Pathway within 62 days of referral.

This was not happening in the gynaecology department in Hywel Dda for patients on a post-menopausal bleeding pathway.

Average hysteroscopy wait: 75 days.

### Key causes of delay:

- Radiology staff shortages – limited access to ultrasound.
- Increased demand for ultrasound services.
- Delays in histology reporting.
- Limited access to pre-assessment (GA conversion).

### Impact:

- Caused significant bottlenecks in the pathway.
- Variation across the three acute hospital sites.
- Inequity of access that created inconsistent patient experience.
- Extended waiting times for patients.

## Aims & Objectives:

- Reduction of stress and anxiety for patients.
- Improve access to diagnostic investigations.
- Reduce overall waiting times within the Urgent Suspected Cancer pathway.
- Provide patients with same-day outpatient consultant, ultrasound scan and biopsy/hysteroscopy (where indicated).

## Methodology:

- Establishment of an Improvement Group.
- Standardisation and redesign of the pathway through the development of a One Stop Clinic model. This model brought together key diagnostic tests including OPA, ultrasound, biopsy, and hysteroscopy if needed on the same day.
- Pilot of new model in Bronglais General Hospital in May 2024. This demonstrated a reduction in waiting times and improved efficiency in the pathway.
- Model spread and scaled to Glangwili General Hospital and Withybush General Hospital in Summer 2025.

## Outcomes:

New pathway with a One Stop Clinic model implemented at three acute sites in Hywel Dda for patients on a post-menopausal bleeding pathway.

## Impact:

Since implementation, significant improvements have been observed:

- Average waiting times reduced from **178 days to 29 days** (Fig. 1).
- A streamlined, patient-centred pathway providing timely access to diagnostics and treatment.
- Improved patient experience with reduced anxiety and faster reassurance.
- Increased efficiency of discharge, limiting unnecessary referrals to diagnostic hysteroscopy.
- Progression towards achieving the national standard of 62 day first definitive treatment target.
- Establishment of five One Stop Clinics, running weekly across the three acute sites.
- **Release of approximately 40 ultrasound slots per week** back to radiology services across the health board.
- **Creation of 18 ring-fenced hysteroscopy appointments** dedicated to One Stop Clinic patients.

## Key Conclusions:

The introduction of the One Stop Clinic model has delivered a measurable and sustainable improvement to the post-menopausal bleeding pathway within HDUHB.

The model has:

- Significantly reduced waiting times.
- Standardised care provision across sites.
- Released diagnostic capacity within radiology.
- Enhanced the skills and flexibility of the workforce
- Improved patient experience through faster, more efficient pathways.

The One Stop model demonstrates a scalable and effective model which shows service transformation as well as supporting both patient outcomes and system resilience.

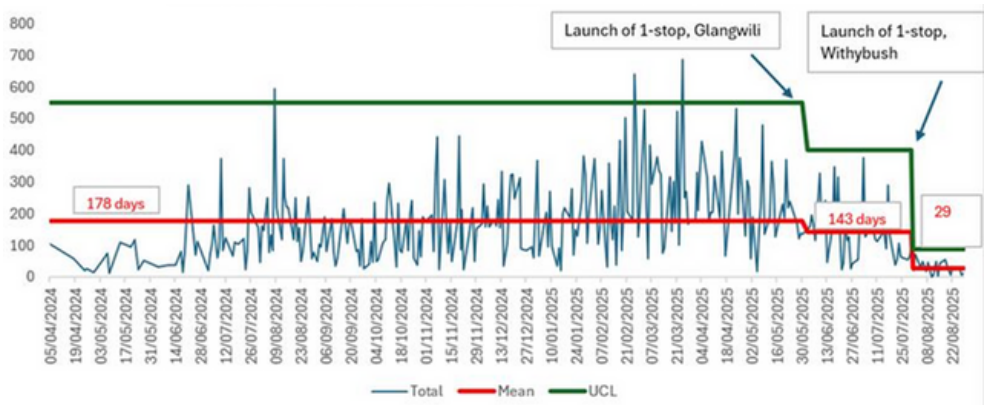



Fig. 1: Days between point of suspicion and diagnostic: HDUHB Gyneacology

# UPLIFT – Upper Limb Intensive Functional Therapy: A Hybrid Model in a Rural Health Board | HDUHB

Tanya O'Sullivan and Renee Groenevelt, HDUHB | Contact: Tanya.Osullivan2@wales.nhs.uk & Renee.Groenevelt@wales.nhs.uk

## Background:

Upper limb deficits are common in people with neurological conditions and significantly impact independence. Although evidence supports high-intensity, multidisciplinary rehabilitation, this is not routinely available in HDUHB or across Wales.

### Key Barriers in this Rural Setting:

- Large geography (travel time/cost).
- Shortage of suitable outpatient neurorehabilitation settings.
- Limited staff resource, knowledge, and access to intervention tools.

## Aims & Objectives:

To develop, deliver, and evaluate a hybrid high-intensity upper limb rehabilitation programme for people with neurological conditions within a rural health board context, demonstrating that evidence-based, high-intensity programs are achievable and effective.

### Key Objectives:

**Service Delivery:** Co-design and deliver the 3-week intensive hybrid model.

**Knowledge & Skill:** Train and upskill staff in evidence-based assessments and interventions.

**Self-management**: Foster a long-term self-management approach using digital tools for remote monitoring.

**Evaluation**: Assess patient outcomes, self-efficacy, service efficiency, and potential for scale-up.

## Methodology:

**Co-design**: Informed by a clinician questionnaire (47 responses) and three patient and carer focus groups.

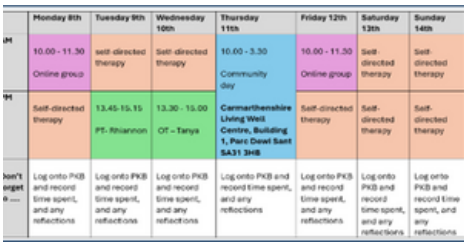
**The UPLIFT Hybrid Model** (3-Week Intensive): Combines structured, high-intensity therapy through:

- One 6-hour in-person group session per week.
- Two remote video-based therapy sessions per week.
- One in-person home session per week with occupational therapy (OT) and physiotherapy (PT).

**Digital Platforms to enable self management:**

- Patient Knows Best (PKB) as the the digital hub for educational resources, communication, and personalised weekly intervention plans to self manage at home.
- Virtual Reality (VR): Using six free-loaned NeuroVirt headsets for home practice and progress tracking.

Face to face therapy



| Monday 8th | Tuesday 9th | Wednesday 10th | Thursday 11th | Friday 12th | Saturday 13th | Sunday 14th |
|---|---|---|---|---|---|---|
| 10.00 - 11.30 Online group | self-directed therapy | Self-directed therapy | 10.00 - 3.30 Community day | 10.00 - 11.30 Online group | Self-directed therapy | Self-directed therapy |
| Self-directed therapy | 13.45-15.15 PT- Rhiannon | 13.30 - 15.00 OT – Tanya | Carmarthenshire Living Well Centre, Building 1, Parc Dewi Sant SA31 3HB | Self-directed therapy | Self-directed therapy | Self-directed therapy |
| Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections | Log onto PKB and record time spent, and any reflections |

Example of timetable

## Outcomes:

- **Therapy Intensity:** The hybrid model increased upper limb intervention time by 1025%, delivering a minimum of 22.5 hours/week of intervention.
- **Functional Gains (GAS):** Two of five measured participants exceeded expectations on the Goal Attainment Scale (GAS +2 score).
- **Physical Gains:** Average grip strength increase of 4.52 kg in three weeks.
- **Quality of Life:** Three participants reported improved quality of life.
- **Staff Development:** All staff reported improved morale, teamwork and confidence in delivering evidence-based interventions.

## Impact:

| Method | Standard Service Delivery | UPLIFT Programme | Minutes Increase |
|---|---|---|---|
| Face to face group | 0 | 360 mins | **360 mins** |
| Virtual group | 0 | 180 mins | **180 mins** |
| Face to face at home | 90 mins | 180 mins | **90 mins** |
| Guided self-management exercises at home | 30 mins | 630 mins | **600 mins** |
| TOTAL | 120 mins (2 hrs) | 1,350 mins (22.5 hrs) | **1,230 mins (20.5 hr increase)** |

- **Financial Efficiency:** Achieved a cost saving of **£13,194.00** for six patients compared to a traditional face-to-face service delivery model.
- **Patient Experience:** Patients reported positive experiences, highlighting peer support and feeling "given the skills and tools to continue" their rehabilitation.
- **Holistic Recovery:** Significant improvements noted in independence, overall quality of life, and in cognitive function (reduced fatigue, better concentration).

> Seen huge changes to my affected limb, my wrist and hand is more useable and overall, more use. Improved mental health too.

> Increasing ability to use affected arm in day-to-day activities. Feels like there is light at the end of the tunnel and a pathway back to a more "normal" version of me (even if the speed of progress often seems frustratingly slow).

## Key Conclusions:

The hybrid intensive upper limb programme proved feasible and effective in a rural setting, delivering meaningful functional gains, improved quality of life, and high patient and staff satisfaction. Technology enhanced access and efficiency while maintaining therapeutic intensity, in line with Prudent Healthcare principles.

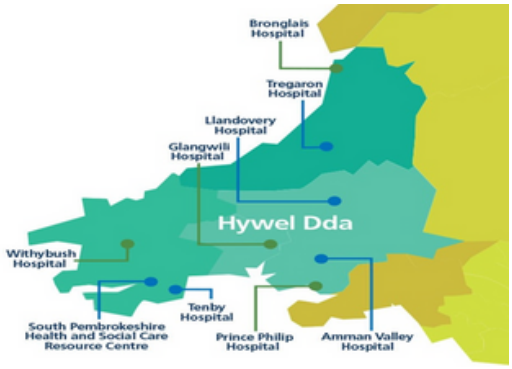
# Development and Implementation of a Dashboard to Facilitate the Caseload of a New Fracture Liaison Service | HDUHB

Will Backen & Tracy George, HDUHB | Contact: Will.Backen@wales.nhs.uk & Tracy.george2@wales.nhs.uk

## Background:

The Fracture Liaison Service (FLS) was established in September 2024 as a new, health-board-wide service operating across four acute sites. The model aims to deliver high-quality, timely and seamless care through a single, integrated team working flexibly across sites.

To support this, the service requires a coordinated, virtual approach to managing workloads across the team. This will enable effective internal cross-cover and support timely patient assessment and intervention, regardless of site. Establishing this approach is particularly important given the anticipated annual caseload of approximately 3,800 patients.




## Aims & Objectives:

**Aim**: To create a FLS dashboard within SharePoint, encompassing the functions that the team require to deliver safe standards of care across the whole health board.

**Objective:** To utilise applications already available to us to minimise costs, such as MS List, MS Teams, and skills from our internal software developers.

## Methodology:

To achieve the programme's aims and objectives, the team collaborated closely with digital and software development leads, meeting fortnightly to co-produce the required programme. This was subsequently presented to Information Governance colleagues to ensure appropriate approval and compliance.

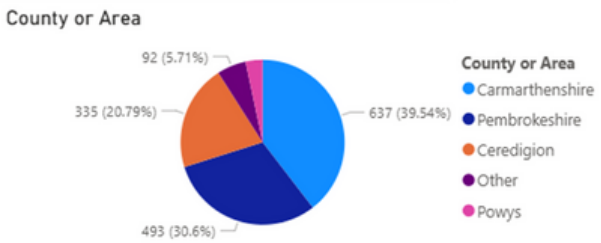
The tool was evaluated using questionnaires designed to assess functionality, usability and overall usefulness. These were distributed to the internal team, management, and a wider stakeholder group to inform learning and refinement.

## Outcomes:

**PADDINGTON** was developed:
**P**atient **A**nd **D**iagnostic **D**ashboard **I**ncorporating **N**otification **G**eneration & **T**racking **O**f **N**etwork

### The key benefits:

- It allows admin staff to highlight upcoming activity such as organising blood tests or appointments.
- Facilitates the safe distribution of caseloads across all sites, ensuring no inequality. It allows for more equitable distribution in areas with higher demand or where there is sickness or leave.




- The platform includes electronic referral functionality, digital assessment proformas that feed into Power BI, and a central repository for key documents with PDF export capability. It also integrates a range of clinical tools, including Promptly, FRAX and calcium calculators.

### Team Feedback

- Early evaluation demonstrated strong usability and anticipated frequent use, with the majority of team members reporting they would use the system several times each day.
- **81%** felt it would support and improve collaborative working.
- **63%** would recommend it to other FLS teams.
- **100%** of practitioners reported that it would save time in managing caseloads while enhancing the quality of their work.

### Management Team Feedback

- **100%** thought Paddington would make the patient experience of the service better.

## Impact:

Introducing PADDINGTON into the FLS has:

- Placed the patient journey at the centre of the FLS pathway.
- Enabled workload to be shared easily across a virtual team working in a rural setting.
- Provided live visibility of key performance indicators to support team oversight and decision-making.
- Supported quality improvement activity in real time, with reduced resource requirements.

Early indications also suggest reduced variation across the FLS pathway.

## Key Conclusions:

A digitally enabled, low-cost dashboard can support safe, efficient, multi-site FLS delivery in a rural health board. Using existing platforms can improve coordination, visibility of workload, and patient experience without additional system investment. The approach is transferable and offers a practical route to reducing variation and supporting scale across Wales.

# Meeting the Communication and Information Needs of People with a Sensory Loss when Accessing our Healthcare Services | HDUHB

Beverly Davies, Jane Deans, Ann Marie Kennard & Kate Tamilia, HDUHB | Contact: Beverly.Davies@wales.nhs.uk

## Background:

Around 15,671 people living in West Wales have a visual impairment and around 85,864 people have a hearing impairment.

All health boards are required to ensure that the communication and information needs of people with sensory loss are met when accessing healthcare service.

## Aims & Objectives:

To **co-produce** a user-friendly Sensory Loss Aware Self-Assessment Checklist to empower staff to meet the All-Wales Standards for Accessible Communication and Information for People with Sensory Loss.

### Objectives:

- Improve patient experience when attending hospital settings.
- Empower staff to assess their working environment for accessibility and where identified, confidently introduce changes to meet the needs of people with sensory loss.
- Increase staff awareness and confidence on how to support people with sensory loss.
- Improve the recording of the communication needs of patients.

## Methodology:

- Collaborative
- Evaluative
- Evidence base,
- Outcome focused
- Staff/user friendly
- Sustainable

## Outcome:

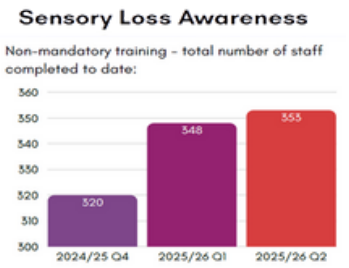
The development and testing of the Sensory Loss Aware Self-Assessment Checklist. The Checklist is a self-managed, practical tool for health professionals that helps them meet the communication and information needs of people with sensory loss when accessing our services.

Clutter-free signage and waiting areas in OPD

## Impact:

### Increased Training and Staff Awareness

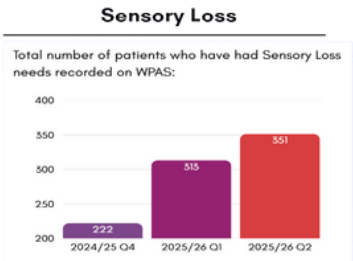
- **10.31%** increase in the number of health board staff completing the sensory loss e-learning module during Bevan Exemplar programme.
- **100%** of staff participating in the pilot completed the non-mandatory NHS sensory loss e-learning module.
- **100%** of staff participating in the pilot reported increased awareness of the sensory loss identifier on patient medical records.




Training in Outpatients, WGH

### Improved Identification and Recording of Patient Information

The introduction of guidance information for staff on how to record information in WPAS. **129** patients identified and recorded with sensory loss during the Bevan Exemplar programme. In 2023, a total of seven patients had sensory loss needs recorded.




> The fact that I was offered my operation information in large print was fantastic. It's just a pity that the appointment letters are not in big print too.
>
> Patient

> After using it a second time, I felt more confident, and it made the patient interaction smooth and professional. I even demonstrated the Insight App to colleagues who hadn't used it before to help build familiarity.
>
> Staff Member

## Key Conclusions:

The Checklist is a transformative tool for patient areas and aids health professionals meet the communication and information needs of people with sensory loss. They feel better equipped and supported to embed an inclusive culture as part of everyday service delivery.

# Early Doors - “It’s never too early to set up the home you need for the future you deserve” | Carmarthenshire County Council

Lucy Brown, Jo Edwards, Diane Harrott & Alun Morgan, Carmarthenshire County Council | Contact: Joedwards@carmarthenshire.gov.uk

## Background:

Housing-related support in Carmarthenshire had become largely reactive, focused on crisis response rather than prevention. Rising living costs, a shortage of suitable housing, and increasing homelessness highlighted the urgent need to shift resources upstream. Early Doors was developed as part of a new Community Preventative Services model to provide early, barrier-free access to housing support, working alongside health, wellbeing and financial services. The project builds on strong collaboration between the local authority, third-sector partners and communities. By reaching citizens earlier, improving service visibility, and empowering people to make informed choices, Early Doors helps to reduce crisis demand, promote stability, and improve long-term wellbeing.

## Aims & Objectives:

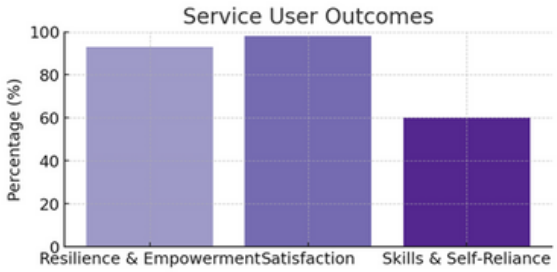
- Increase early access to housing-related support.
- Improve awareness and service visibility.
- Build citizen resilience, preparation, and empowerment.
- Foster collaboration across services and challenge barriers.

## Methodology:

- Co-produced with citizens, housing providers, and wider stakeholders to ensure inclusive and person-centred design.
- Community outreach: 402 engagement activities across schools, hospitals, Hwbs, town centres, and rural communities.
- Central referral ‘gateway’ introduced for streamlined access to support.
- Integrated pathways with health, financial wellbeing, and Community Home Support Services to address linked needs.
- Tailored local campaigns and accessible resources to improve awareness and uptake.
- Pilot of early relationship support to address one of the main drivers of homelessness before it escalates into crisis.

## Outcomes:


- 91–95% report improved resilience & empowerment.
- 98% satisfaction.
- Increased self-reliance & skills (≈60%).




## Impact:

- **74%** year-on-year increase in early access referrals (Apr–Sept 2025).
- **1,527 people engaged** through community events and drop-ins (157% increase), including significant outreach in rural areas.
- Strengthened collaboration across housing, wellbeing and financial support services, reducing crisis presentations and improving long-term stability.

> “Even friends have started to notice a difference in me.”

> “I feel thankful for the help that you have given me and find it reassuring that I have someone that I can contact I am worried about anything or just need some advice.”

## Key Conclusions:

Prevention works.

- Early intervention reduces crisis demand and improves wellbeing.
- Barrier-free, person-centred access empowers citizens to take control of their housing and wellbeing needs.
- Collaboration across housing, health, and wellbeing services delivers better outcomes for individuals and communities.
- Partnership working and co-production create trust, shared learning, and lasting change.
- The Early Doors model is scalable and replicable, offering a sustainable approach for other areas across Wales.

# Delivering Lifestyle Medicine in Practice | HDUHB

Sarah Tamplin, Lisa Davies & Jan Bower, HDUHB | Contact: Sarah.Tamplin2@wales.nhs.uk

## Background:

Lifestyle Medicine is an emerging medical discipline dedicated to the prevention and treatment of chronic diseases through evidence-based lifestyle interventions. It highlights the critical role of behavioural changes in areas such as nutrition, physical activity, sleep, stress management, social connections, and the avoidance of harmful substances. With the increasing prevalence of conditions like diabetes, heart disease, and obesity—often linked to lifestyle factors—Lifestyle Medicine has gained significant momentum.

- Nutrition
- Physical activity
- Restorative sleep
- Stress management
- Avoidance of risky substances
- Positive social connections

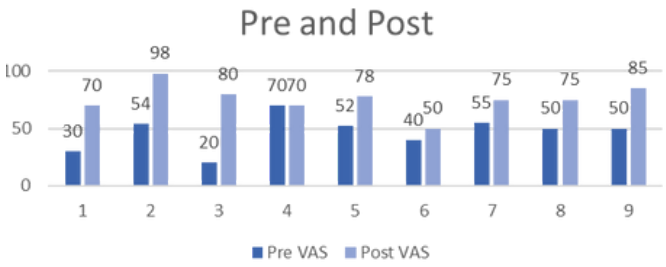
## Aims & Objectives:

- Encourage healthier lifestyle choices.
- Empower participants with knowledge and confidence.
- Promote peer support and problem-solving.
- Prevent worsening of chronic conditions.
- Foster sustainable change and motivation.

## Methodology:

The 9-week programme offers six themed sessions focusing on Sleep, Emotional Wellbeing, Food, Substances, Movement, and Relationships. Participants benefit from initial and follow-up one-to-one consultations, group health coaching, and interactive workshops. The programme also includes free and discounted leisure memberships, alongside ongoing support from a Community Connector to help guide and encourage engagement throughout.

## Outcomes:




- VAS (Visual Analogue Score) scores improved for 8 out of 9 participants.
- Blood pressure improved for 4 out of 6 participants.
- Average weight loss of 1.43kg.
- Boditrax scores and metabolic age improved.
- Strong participant satisfaction and recommendations.

## Impact:

- Increased physical activity and social engagement.
- Improved mental wellbeing and confidence.
- Formation of peer support networks.
- Enhanced understanding of lifestyle factors.
- Positive feedback and continued participant engagement post-programme.

> The course was the springboard I needed to get my health back on track. My life has changed immeasurably! I'm even looking at volunteering or retraining to help others.
>
> Participant

> Great news all. I still go to my 3 classes a week and am getting a watch to step count too.
>
> Participant

> Keep it up. Rich and I are still going to yoga, pilates and the gym. It is hard some days to keep motivated, but we keep moving forward.
>
> Participant

## Key Conclusions:

- Programme successfully motivated lifestyle changes.
- Peer support and community connection were critical.
- Participants continued healthy habits post-programme.
- High demand for future cohorts.

# A Novel Approach to Acute Kidney Injury (AKI) Management in a District General Hospital | HDUHB

Paula Davies & Vandse Aithal, HDUHB | Contact: Paula.davies8@wales.nhs.uk & Vandse.s.aithal@wales.nhs.uk

## Background:

Acute kidney injury (AKI) is a term covering a spectrum of injury to the kidneys, which can result from a number of causes. AKI is common, expensive to manage, prolongs hospitalisation and is associated with increased mortality.

A 2016 study by Sawhney in 'KDIGO- reported high morbidity and mortality for AKI patients, with 30-day mortality at 24.2%, with severe cases at 36.1%, and a third developing Chronic Kidney Disease (CKD) within 90 days.

The incidence of AKI is estimated at 150 episodes per 10,000 population per annum. The total population of the health board (HB) is estimated at 385,600 and is predicted to rise to 425,000 by 2033. This would equate to 5,775 episodes of AKI per year.

## Aims & Objectives:

To optimise the treatment of patients with acute kidney injury (AKI) at GGH through the establishment of a dedicated AKI team.

As a Wales-first initiative, the introduction of an AKI Specialist Nurse would deliver an education-focused, outreach clinical model aimed at preventing avoidable harm associated with AKI. The service would standardise and streamline AKI management, reducing incidence and severity, limiting progression, and decreasing the need for acute haemodialysis and ICU admission for single-organ failure at GGH.

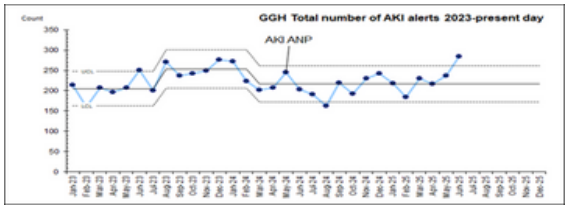
This approach aligns with NICE Acute Kidney Injury guidance (NG148) and quality standards (QS76).

## Methodology:

The service was implemented through a multidisciplinary team approach. **Four** fundamental elements being identified:

- Robust patient referral system.
- Favorable education Programme.
- Timely Central Venous Catheter (CVC) insertion and initiation of acute dialysis preventing single organ CVVHF failure in ICU.
- Dedicated Follow up clinic for patients on discharge following an AKI.

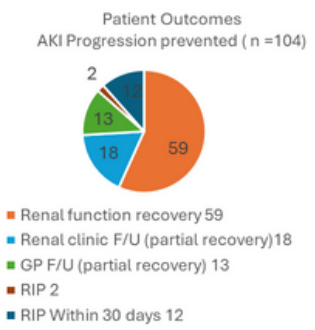
A mixed method approach was used to evaluate the impact of the four key components of the service. Data was then thematically analysed to draw accurate conclusions.

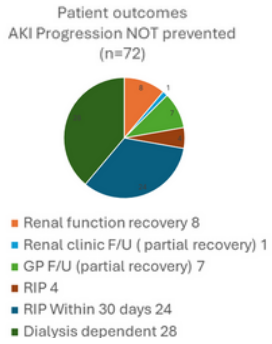



Work Generated though Daily AKI Alerts

## Outcomes:

Over its first 14 months, the AKI service demonstrated early positive impact. Improved recognition and timely management of AKI supported safer patient care and reduced the risk of AKI-related complications.




## Impact:

- Thirty-day mortality is a recognised indicator of risk in patients with AKI and is consistently higher than in patients without AKI, increasing with severity. Preventing AKI progression was associated with higher recovery rates (57% vs 11%) and lower mortality (13.5% vs 39%).
- Education delivered by the AKI Specialist Nurse improved clinical practice, achieving **60%** adherence to AKI core principles.
- During the 10-month period when acute patients were not accepted for haemodialysis (HD) in the renal dialysis unit (RDU) in GGH, 11 (39%) patients were transferred to the tertiary renal unit in SBUHB. Three (27%) of these patients were suitable for Intermittent HD treatment in the RDU in GGH.
- AKI specialist nurse follow-up clinics improved patient health and wellbeing, and supported continuity of care, with 90% of patients reporting a better experience.
- Compliance with NICE AKI guidance (NG148) and quality standards (QS76) increased from 0% to 78% following service implementation.

> “Doctor and AKI nurse were amazing, they were thorough, respectful and understanding. Felt I was listened too. They deserve a medal for the work they do.

> “AKI nurse was excellent. Efficient, understanding and informative.

## Key Conclusions:

This unique Wales first AKI Service provides a platform to structure a service-wide programme, ensuring the basics of AKI management are implemented as standard, focussing on prompt recognition and early intervention for those at highest risk of poor outcomes.

Exemplifying multi-disciplinary and collaborative team working. It addressed deficiencies highlighted in AKI care, follow-up and provided a more streamlined communication between renal and hospital teams.

# Worn To Protect - Empowering Frail Lives with Wearable Tech | HDUHB, PTHB, CTMUHB

Emma Dobson, HDUHB, Erin Hugo, PTHB & Sophie Bassett, CTMUHB | Contact: Erin.Hugo@wales.nhs.uk; Emma.Dobson@wales.nhs.uk & Sophie.Bassett2@wales.nhs.uk

## Background:

As frailty and dementia rise among older adults (Fig. 1), staying safe at home becomes more challenging. Traditional care can't always provide real-time support—potentially leading to increased risks and reduced quality of life.

Personal alarm watches can offer a smart solution:

- Continuous monitoring.
- Instant emergency alerts.
- Peace of mind for users and caregivers.

## Aims & Objectives:

Enhance safety, promote independence, and improve quality of life for vulnerable populations—particularly people living with dementia in Wales—through wearable technology.

### Objectives:

1. Assess Acceptability: Understand how the watches are received by participants, caregivers, and professionals.
2. Evaluate Usability: Assess ease, reliability, and practicality in daily life.
3. Measure Impact: Measure effects on safety, independence, and overall quality of life.
4. Establish Viability: Provide evidence to support integration into health and care systems.

## Methodology:

### Project Design & Delivery

- 12-month co-evaluation of personal alarm watches for people living with frailty and dementia.
- Explored acceptability and usability of wearable tech across urban and rural settings.
- Engaged patients, carers and professionals to ensure real-world insight.
- Partnership between Hywel Dda, Cwm Taf Morgannwg University Health boards, and Powys Teaching Health Board.
- Delivered by experienced clinicians, ensuring practical, patient-centred implementation.

### Key Challenges

- Technical issues (signal loss, setup, battery life, chargers).
- Cognitive decline affected consistent use and charging.
- Limited volume for hearing-impaired users.
- Some device returns due to anxiety or assisted-living moves.
- Families needed more training to use all features.

### Evaluation Approach

- Mixed methods combining data and lived experience.
- Quantitative: Questionnaires (safety, independence, usability, CORE-10 PROM).
- Qualitative: Interviews and case studies capturing real-world feedback.

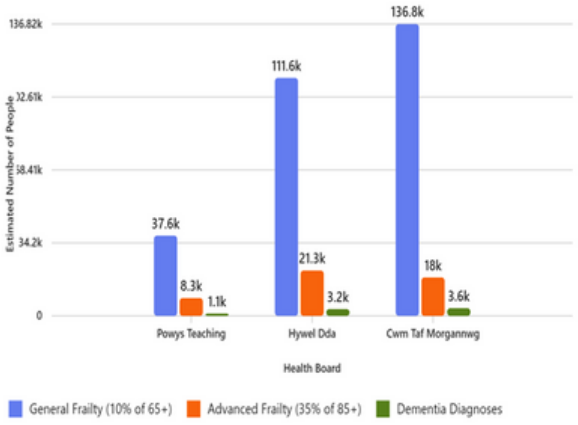



Fig 1. Frailty and dementia in older adults

## Impact:

- Enhanced safety and independence through real-time tracking and fall detection, while maintaining autonomy and confidence.
- Improved family reassurance, especially for those living or working remotely.
- Easy-to-use features: SOS alerts, geo-fencing, Wi-Fi boundaries, pedometer, and reminders.
- Clinical Outcomes: The CORE-10 assessment for the CTM UHB cohort showed a decrease in clinical score from eight to six over eight days, indicating a positive shift in mental health status, with reduced anxiety and distress, though sleep difficulties and suicidal ideation remained concerns.


## Key Conclusions:

- Involving patients, carers, and community representatives throughout ensured the solution addressed real needs and preferences.
- Technology acceptance varied, influenced by cognitive ability, anxiety, and support systems—highlighting the need for tailored education and setup support.
- Reliable connectivity and simple device setup are essential, especially in rural areas and for users with cognitive challenges.
- Ongoing involvement from carers and clinicians underpins successful adoption and sustained use.

Comisiwn Bevan Commission

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement

# NHS Wales Performance and Improvement

# EPP Cymru National Peer Support Service - Building Resilient and Resourceful Communities | NHS Wales Performance and Improvement

Christine Roach & Jules Godden, EPP Cymru, NHS Wales Performance and Improvement | Contact: christine.roach@wales.nhs.uk

## Background:

EPP Cymru has delivered self-management education for 20 years, empowering people with chronic conditions to live healthier lives and reduce NHS pressures.

With 48% of adults in Wales living with long-standing illness, there is an urgent need for sustainable, community-based support.

Peer support offers emotional, practical, and social benefits, aligning with Welsh Government priorities for prevention and person-centred care.

## Aims & Objectives:

To establish a national EPP Peer Support Service that complements self-management education, builds resilient communities, and improves health outcomes.

Objectives include creating accessible peer networks, reducing isolation, promoting behaviour change, and supporting NHS sustainability through prevention and reduced service demand.

## Methodology:

A phased plan:

- **Consultation (Late 2024):** Engaged patients, health boards, and stakeholders via surveys and design workshops.
- **Development (Early 2025):** Created online and in-person models, engaged health care professionals and developed evaluation criteria.
- **Delivery (Mid 2025):** Three pilots delivered with immediate reviews and continuous improvement (PDSA cycles).

## Outcomes:

**For patients:** Increased confidence in managing conditions, reduced loneliness, stronger coping skills, and improved self-care.

**For the NHS:** Early signs of fewer unnecessary appointments, proactive health monitoring, and potential cost savings through prevention.

Notably, volunteering opportunities have emerged as participants who benefited from peer support are now stepping forward to help lead and sustain future groups - creating a foundation for long-term community involvement.

> What does peer support personally mean to me? Quite simply, it's been a lifeline.
>
> Patient

> It's a place where you can talk freely and be amongst friends.
>
> Patient

> Life is challenging on so many levels. To have access to this brilliant service, is marvellous.
>
> Patient

> These initiatives save clinicians valuable time.
>
> Clinician

## Impact:

The first three peer support sessions are already driving change. Participants report feeling more connected and empowered, while health boards note improved engagement and early intervention behaviours.

These developments mark the beginning of a shift toward sustainable, community-driven support that enhances wellbeing, strengthens social networks, and aligns with Welsh Government priorities for prevention and resilience.


**of patients found peer support highly effective**

**Lymphoedema** (Online) **16 patients**
Swansea | Shropshire/Wrexham | Gwent | Merthyr

**Diabetes** (Online) **23 patients**
Shropshire | Pembrokeshire | Conwy | Gwent | Powys | West Glam | Carmarthenshire

**Osteoporosis** (Face-to-Face) **19 patients**
Gwent (incl. 1 homebound) | Swansea | Carmarthenshire

## Key Conclusions:

Peer support is proving to be a practical, cost-effective complement to clinical care. Early results confirm its potential to empower individuals, reduce NHS pressures, and foster resilient communities. Success depends on continued collaboration across health boards, voluntary partners, and local networks to scale and embed this model nationally.

# Seek Help Now - Ceisio Cymorth Nawr | NHS Wales Performance and Improvement

Tamsin Speight & Rhys Watkins, NHS Wales Performance and Improvement | Contact: Tamsin.Speight2@wales.nhs.uk

## Background:

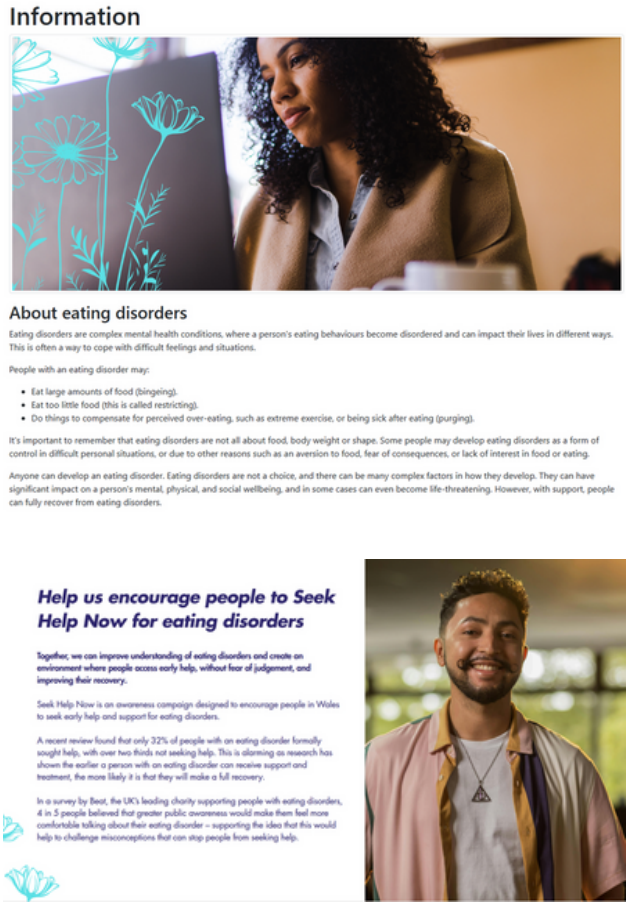
Eating disorders are serious mental health conditions that affect people of all ages. A recent review found that only 32% of individuals with an eating disorder formally sought help. Early intervention is critical to improving recovery outcomes and reducing long-term harm.

## Aims & Objectives:

- Encourage early help-seeking for eating disorders in Wales.
- Raise public awareness and reduce stigma.
- Provide accessible, high-level information and self-help resources.
- Support individuals, families, carers, and professionals.

## Methodology:

- Developed by the NHS Wales Eating Disorders Network.
- Co-produced with clinical experts, people with lived experience, and third sector partners.
- Delivered as part of the Bevan Commission's Exemplar Programme.
- Designed to simplify access to reliable information and support.




## Outcomes:

- Increased awareness and understanding of eating disorders.
- Improved access to early support and treatment.
- Empowered individuals to seek help sooner.
- Strengthened collaboration across sectors.

## Impact:

- Faster recovery and reduced severity of symptoms.
- More informed and compassionate communities.
- Enhanced service delivery and navigation.
- Greater confidence among professionals and carers.

> It was easy to navigate and had helpful advice.

> The information was well researched, professional and trustworthy.

> Brilliant, I wish something like this had been around when I was younger! This will help so many people.

## Key Conclusions:

- Early help leads to better outcomes.
- Public awareness is essential to reduce stigma.
- Co-production ensures relevance and effectiveness of resources.



https://www.nhs.wales/sa/eating-disorders/

Comisiwn Bevan Commission

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Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

# Swansea Bay University Health Board

# Orthopaedic Waiting List initiative (OWLi): Using a Digital Platform to Monitor Health and Support Patients Waiting for Planned Surgery | SBUHB

Christian Lambert & Dr Catherine Cromey, SBUHB | Contact: Chris.lambert@wales.nhs.uk & Catherine.Cromey@wales.nhs.uk

## Background:

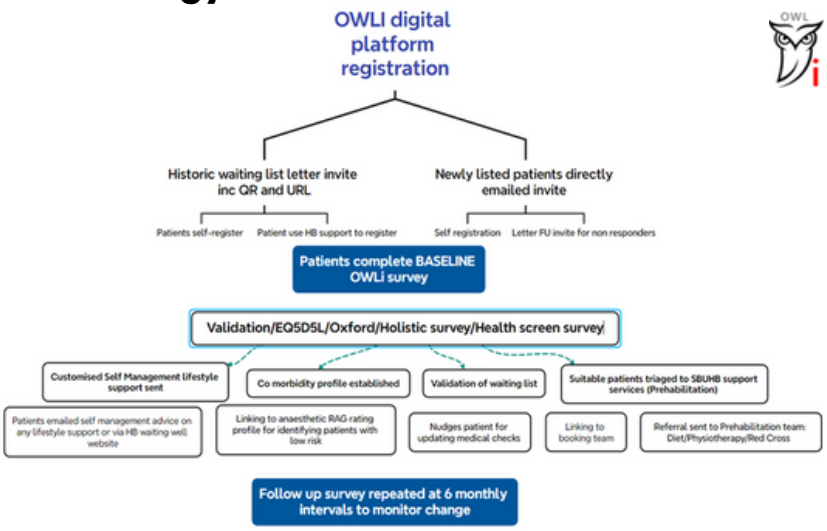
Following the COVID pandemic, elective surgical waiting lists in Wales have increased dramatically. Managing, supporting and optimising patients whilst they wait has never been more important. This project demonstrates the impact and utility of a new interactive digital platform to monitor patient health and provide customised health support and optimisation.

## Aims & Objectives:

Working in collaboration with Pro-Mapp Limited, Swansea Bay co-created a customised digital platform allowing patients to self-report their health and well being symptoms whilst they wait for hip and knee replacement surgery.The interactive platform uses intelligent technology to offer customised lifestyle support. It validates the waiting list and triages and prioritises patients with higher health needs to align with Therapy services. It highlights patients who report underlying health conditions requiring optimisation and signposts to appropriate support services. It can also health profile patients to stratify their risk for surgery.

## Impact:

## Methodology:




## Outcomes:

The OWLi digital platform was launched in March 2023. **Over 5000 patients have been on-boarded and benefitted from universal preoperative advice and support**. Over 300 patients with a significantly raised body mass index (BMI) have been referred to specialist Prehabilitation weight management services. 200 smokers have been signposted to cessation support. Over 500 patients with pre-existing health conditions have been signposted to engage with their primary and secondary care providers to ensure their comorbidities are optimised and any overdue surveillance blood tests or reviews arranged. Without the platform interaction, these patients would not have sought review or optimisation and would have attended their pre-operative assessment without these comorbidities addressed. **65% of patients were identified as Green** and the majority of these were successfully streamed to high volume low complexity sites including private providers.

| Total Patients on Platform | Patient Compliance with Platform | High BMI Patients Identified for Specialist Assessment | Physiotherapy Patients Identified & Referred to Prehabilitation | Patients Leaving Waiting List | Haemoglobin | HbA1c |
|---|---|---|---|---|---|---|
| 3564 | 71% | 310 | 1176+ | 404 (8%) | 192 | 276 |

| Kidney Function | TFTs | OA Exercise & Education Self Management | Help Me Quit Smoking Cessation Advice | NHS Weight Management (BMI 30-35) | British Red Cross Waiting Well Support |
|---|---|---|---|---|---|
| 218 | 20 | 2183 | 475 | 1801 | 125 |

## Key Conclusions:

Using a digital platform to monitor and support the health needs of patients waiting for surgery has huge potential benefits for planned care pathways in Wales. A digital platform with in-built intelligence to customise support according to need is a highly innovative technology asset. The platform has the ability to engage patients at the point of being listed for their procedure, to start preparing and optimising their health in readiness for their surgery. The pathway team has used health data to streamline pathways and improve the efficient use of resource. OWLi has supported patients to “Wait Well”, actively preparing and becoming engaged in managing and improving their health status in readiness for their procedure.

# Embedding a Prescribing Pharmacist into the Cardiology MDT to Improve Safety, Efficiency, and Patient Care | SBUHB

Gareth Chapple & Joshua Lau, SBUHB | Contact: Gareth.Chapple@wales.nhs.uk

## Background:

Previously, the cardiac centre's ward-based pharmacy model focused on medicines reconciliation, safety checks and counselling, but pharmacists were not part of the MDT. This created delays, with medication queries taking ~7.5 hours to resolve, a 22% discharge prescription error wait, and missed opportunities for optimisation—impacting costs and patient satisfaction.

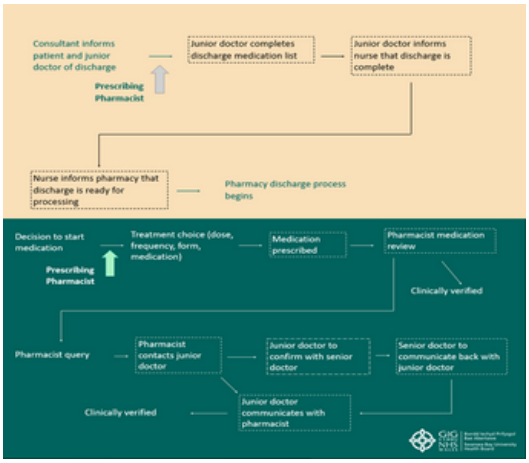
## Aims & Objectives:

### Overarching Aim

- Embed an advanced pharmacist prescriber within the cardiology MDT.

### Objectives

- Safety: Reduce prescribing errors, and ensure guide-line based accurate discharge prescriptions.
- Efficiency: streamline discharge processes and resolve medication queries in real time.
- Optimise medicines: Using evidence, initiate, deprescribe and reduce polypharmacy.
- Value: Minimise high-cost drug use and support cost effective choices.
- Patient and staff experience: Timely medicines access, clear communication, and reduced pressure on doctors.
- Alignment: Support NHS Wales priorities on medicines waste and align with the Duty of Quality.




## Methodology:

**Design:** Quality improvement approach to target earlier prescribing, guideline adherence, and discharge delays. Refined through iterative PDSA cycles.

**Delivery:** Advanced pharmacist prescriber embedded in the cardiology MDT, leading real-time prescribing, optimisation, deprescribing, and discharge management. Delivered collaboratively and supported by specialty boards and the NICE High Cost Drugs Group.

**A Mixed-Methods Evaluation:**
**Quantitative:** Resolution time for prescribing queries, discharge error rates, medicine optimisation, drug expenditure savings, and discharge delays avoided.
**Qualitative:** Patient and MDT staff feedback.

## Outcomes:

A new service model embedded an advanced pharmacist prescriber within the cardiology MDT at Morriston Hospital.

**Key outcomes included:**

- **New role:** A senior pharmacist with independent prescribing responsibilities integrated into the MDT, supporting patients from admission to discharge.
- **Streamlined discharges:** Pharmacist-led discharge prescribing reduced delays and improved accuracy.
- **Medicines optimisation:** Introduced for evidence-based initiation, deprescribing, and adherence to national guidance (e.g. antiplatelet use).
- **Cost-effective:** Reviewed high-cost drugs, switching to preferred alternatives and achieving savings.
- **Improved communication:** Clearer handover to GPs and community pharmacists, improving continuity of care.

## Impact:

Integrating a prescribing pharmacist into the cardiology MDT improved safety, patient experience, efficiency, costs, and sustainability.

- **Safety:** Discharge prescription errors reduced **from 22%** (junior doctors) **to 1.4%** (pharmacist prescribers).
- **Efficiency:** Time to resolve prescribing queries fell from **7.48 hours to <5 minutes**; **437 hours** of discharge delays avoided over 4 months.
- **Medicines: 8810** new medicines initiated in line with guidelines; **567** medicines deprescribed.
- **Cost savings: £71k** projected annual primary care savings (£31.7k confirmed). Secondary care savings of **£14,467**.
- **Sustainability**: Less waste, supporting NHS Wales decarbonisation goals. If each medication stopped is equated to one less box of medication supplied this would equate to **284 Kg of $CO_2$** production avoided.
- **Spread:** Model has influenced wider pharmacy leadership, with potential replication in other specialties.

## Key Conclusions:

Embedding an advanced pharmacist prescriber within the cardiology MDT has proven feasible, effective, and highly impactful. Shifting from a traditional ward-based model to a fully integrated prescribing role has improved safety, efficiency and patient experience while delivering cost and environmental benefits.

Patients and staff reported benefits including better education and involvement, smoother workflows and reduced pressure.

This project demonstrates a scalable model of clinical pharmacy leadership that can be replicated across specialties, supporting NHS Wales priorities for safe, effective, timely, person-centred, and sustainable care.

# Beyond the Beam: Piloting a Radiographer Led Late Radiotherapy Effects Service | SBUHB

Rebecca Lloyd, Sheena Lam & Maudon Phan, SBUHB | Contact: Rebecca.lloyd@wales.nhs.uk

## Background:

Radiotherapy is used to treat over half of all cancers. Yet even with advanced techniques, healthy tissues can't be fully spared leading to toxicities. Late effects, which may emerge months or years after treatment, impact over 500,000 people living with and beyond cancer in the UK, posing a significant and often under-recognised burden.

Currently there is no dedicated service in Wales to manage patients with long-term side effects of radiotherapy. Patients often present multiple times to various health professionals with symptoms and time to effective treatment can take many months to years.

## Aims & Objectives:

- **Develop a radiographer-led late radiotherapy effects service,** reviewing patients six plus months after prostate pelvic radiotherapy.
- **Identify late effects early** and increase awareness of late effects and support options.
- **Reduce pressure** on oncology and primary care teams through timely, specialist-led follow-up and scope out care pathways.
- **Improve efficiency -** minimise unnecessary appointments and investigations.
- **Improve Quality of Life** through treatment, referrals, and self-management strategies.
- **Increase awareness** of late effects and referral routes across the wider healthcare team.

## Methodology:

- A weekly clinic with flexible access via face-to-face or telephone consultations.
- Patients equipped with self-management techniques, resources and initial treatment started when necessary.
- Referrals to relevant specialties for treatment or investigation.
- PROMS was used to collect data and provide quality of life at baseline and at six months.

## Key Conclusions:

- A radiographer-led late effects service is feasible and effective, and addresses a key gap in survivorship care.
- It reduces time to specialist intervention, improves symptom control, and enhances quality of life.
- The model delivers cost savings and eases pressure on oncology, primary care and secondary care teams.
- Patient testimonials highlight significant emotional and practical benefits.
- The service shows strong potential for scaling and integration into routine follow-up pathways.

## Outcomes & Impact:

A pilot late radiotherapy side effects service was established, and 24 patients were seen between March 2025 - September 2025.

### Patient Experience & Impact:

- 62% reported improvement in symptoms following tailored support and intervention.
- 70% reported improved quality of life.
- 87.5% found service beneficial.
- Time to access specialist care reduced to ¼ of previous timelines.

> "Thank you so much for listening to me, for over a year I knew something was wrong, even when doctors told me it was normal after cancer treatment."

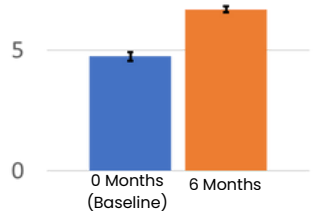



Fig. 1: Ave. improvement in quality of life score since being seen by the late radiotherapy effects – demonstrating a highly significant increase

### Impact on Service:

- Reducing appointments with GPs and secondary care specialists. Removed the need for initial GP appointment and follow up via self-referral pathway, cost avoidance of £90 per patient.
- Streamlined referral pathways, consistent follow-up and earlier intervention for all patients. Reduced the number of unnecessary tests and secondary care specialist appointments.

### Cost Avoidance:

Examples given below represent the management pathways taken of two patients who both developed long term rectal bleeding as a result of radiotherapy. Patient A had multiple appointments and tests, it took >1.5 years for correct treatment; under the pilot, similar cases were referred and treated within two months. Estimated cost avoidance of **up to £900 per patient** compared to traditional management pathways.

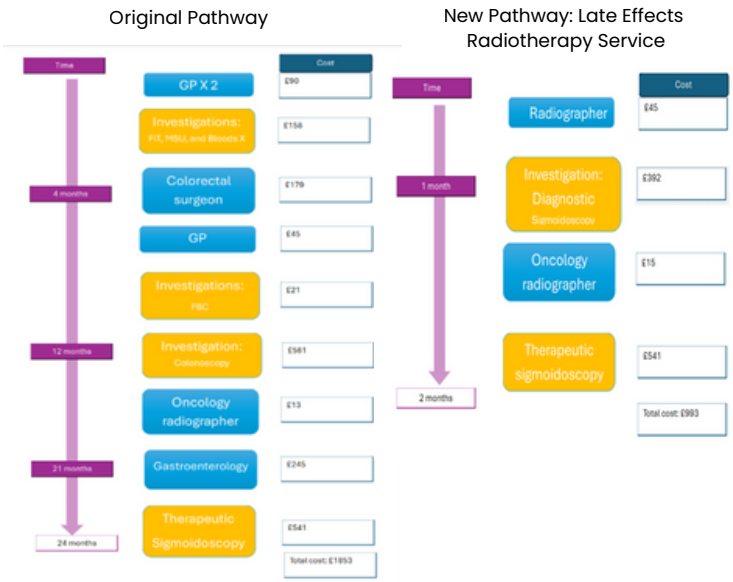



Fig 2: Process mapping with time and cost analysis for 2 patients presenting with rectal bleeding from radiotherapy. Left representing patient pathway prior to late radiotherapy effects service and above representing patient pathway when managed through the late radiotherapy effects service.

# 360 Degree Live Stream Cameras in Transfer Medicine and Remote Care | SBUHB

Prateek Verma, SBUHB | Contact: prateek.verma@wales.nhs.uk

## Background:

Up to 700 transfers per year between hospitals where there is a requirement for intensive care support.

Remote support presents unique challenges, especially for nurses and non-consultant doctors.

Audio only has limitations.

## Aims & Objectives:

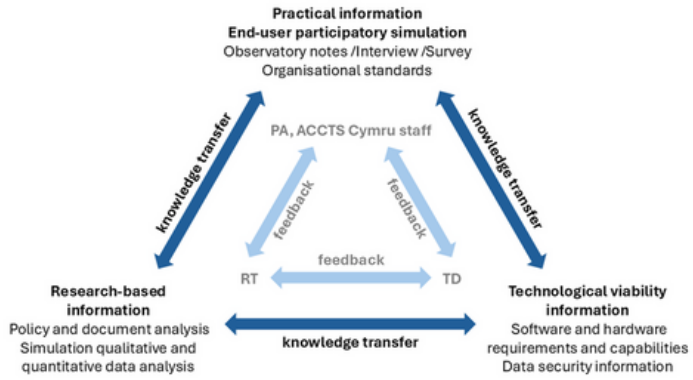
- To identify suitable 360-degree cameras, MR headsets and software to live stream directly from the 360 camera to MR headset.
- To trial remote support with this system in the clinical environment.
- To evaluate remote facilitation for simulations.
- To integrate the whole system within the secure NHS IT infrastructure within accepted cyber security and information governance requirements.

## Methodology:

- Technology – industry and academic input.
- Policy – Evidence integration triangle.
- Testing – extensive bench and simulation testing.

## Impact:

- Training resource and policy for Wales.
- Viable research programme.
- 20 simulation events using system.
- Investment in technology across the service.
- Public information videos and materials developed.




## Outcomes:

- Unique industry, academic and public sector partnership that has delivered a working product to enable remote interactive 360 video streaming from an ambulance, or trolley anywhere in the UK.
- Proof of concept of mixed reality headset use.
- Training package.
- National policy framework.
- Policy funding and resource secured.

## Key Conclusions:

Solid foundations to take a concept through to a working deployable system, which will not only benefit the service, but the wider health and social care sector.

Unique multi-disciplinary team also ensures that all elements including technical, feasibility, governance, and policy are covered off and that the solution is scalable.

# Building Wellbeing Across Wales: Scaling Evidence-Based Wellbeing Interventions | SBUHB & Swansea University

Zoe Fisher, Kelly Davies & Andrew Kemp, SBUHB & Swansea University
Suzanna Charles, SBUHB | Contact: Suzanna.L.Charles@wales.nhs.uk

## Background:

Chronic conditions and mental health needs now dominate the health landscape, yet services often remain reactive and focused on symptom management rather than prevention and resilience-building. This project brings wellbeing science into practice by creating and scaling evidence-based interventions across healthcare and higher education settings in Wales. The initiative targets two main groups, people living with acquired brain injury (ABI) and university students, demonstrating flexible application and systems-level learning.

## Aims & Objectives:

### Aim:

To embed wellbeing science into practice by developing sustainable, co-produced interventions that empower people to live well with chronic conditions, improve student wellbeing, and support system-wide change towards resilience and prevention.

### Objectives:

1. Promote holistic wellbeing in people living with Acquired Brain Injury.
2. Promote holistic wellbeing in undergraduate psychology students.
3. Scale wellbeing interventions.
4. Disseminate digital and written resources to enhance significance and reach.

## Methodology:

- Trained teams of clinicians to deliver wellbeing programmes using the GENIAL meta-framework.
- Adapted and delivered wellbeing modules within university curricula, combining lectures, workshops, and experiential practices.
- Piloted interventions with diverse groups (students from healthcare, science, biosciences, history; people with other chronic conditions).
- Co-produced written resources, a commissioned book, and digital tools (videos, app) for independent practice.
- Evaluation through surveys, focus groups, feedback, and validated scales (e.g., WEMWBS).

## The Wellbeing Intervention:


## Outcomes:

**Acquired Brain Injury:** Ongoing delivery established across three additional Health Boards. Participants reported skill, knowledge and motivation gains.

**Students:** 256 psychology students experienced significant wellbeing improvements, now embedded into curriculum with plans for expansion.

**Scaling:** Pilots proved adaptability to chronic conditions and integrating across academic disciplines engaging students across multiple disciplines and new clinical teams.

**Resources:** Development of clinician/patient manuals for publication, co-produced digital media with people with lived experience and Snakes & Ladders wellbeing app.

## Impact:

> The group has been like the Japanese art form of kintsugi, this is where they patch up and repair broken pottery using gold. Instead of hiding the cracks they make it more beautiful, stronger and just as useful.

> Embedding wellbeing as a routine part of study and care gives people tools for resilience in life transitions.

> What stood out for me … was really the mind body connection and how that makes a lot of sense particularly with people with fibromyalgia but for all the conditions that we work with.

## Key Conclusions:

- Evidence-based positive psychology intervention can be scaled to help more people with brain injury build wellbeing.
- Wellbeing science improves student outcomes when embedded in curricula.
- Adaptability across contexts is supported.
- Resources strengthen sustainability and reach.
- Co-production enhances effectiveness and authenticity.
- System-wide wellbeing-improvements are achievable.

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# Velindre University NHS Trust

# Specialist Neuro-Oncology Community Therapy Services: Addressing Inequalities and Gaps in Service Provision | Velindre University NHS Trust

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## Background:

Brain tumours are a relatively rare form of cancer, accounting for 3% of cancer diagnosis within the UK. However, these tumours represent a disproportionately high burden of disease due to low survival rates and significant impact on quality of life. Both diagnosis and treatment can result in multiple complex supportive care needs with disease progression being rapid and unpredictable.

It is widely recognised that multidisciplinary assessment is necessary to support this cohort of patients.

## Aims & Objectives:

- To carry out a pilot occupational therapy (OT) and physiotherapy (PT) outreach service which establish the quality, safety and financial value of having direct and timely intervention.
- To map existing services in communities and establish the unmet needs of these patients.

## Methodology:

The project completed a mapping exercise of the current service provision for patients in both local health boards and local authorities across the area. This involved gaining an understanding of their inclusion and exclusion criteria, waiting times and skills set within their teams.

The project engaged existing patients with a neuro oncology diagnosis to understand their needs and their experience of community services.

A pilot was designed to trial a service and following feedback and review from patients and professionals this was further adapted and carried out over a four week period.

> “I found the experience to be quite emotional in how well I was supported.

> “Really useful in own environment as [patient] can put on a bit of a show when in hospital.

> “You must carry on with it.

## Outcomes:

A range of outcome measures were completed to demonstrate the impact of the pilot service:

- Quality of Life (EQ5D5L)
- Clinical Function (AusTOMs)
- Patient Experience

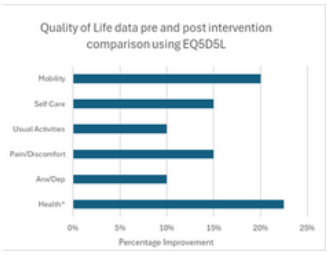


Figure 1: Average % improvement based on pre and post intervention scores for 4 individuals. (*2/4 individuals for health)

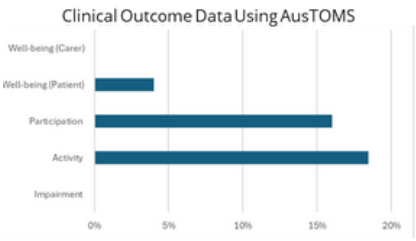


Figure 2: Average % improvement based on pre and post intervention scores for 5 individuals.

The Timed Up and Go Assessment both standard and Dual Task Load, demonstrated that all patients exceeded the normal score for their age range. This indicates a high risk of falls in this patient group.

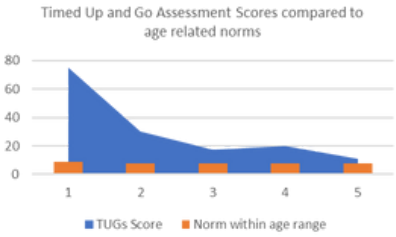


Figure 3: Scores for 5 individuals

## Impact:

The data from EQ5D5L completed both pre and post intervention demonstrated overall improvements for patients in mobility, self-care and anxiety/depressions domains.

Clinical outcomes identified that all patients required intervention related to their mobility thus demonstrating the high risk of falls within this cohort. Interventions to improve transfers and carry out self-care were required in 50% of patients. All patients improved their score in either Activity Limitation or Participation domains.

A patient questionnaire reflected that 100% of patients scored the maximum level of satisfaction when considering the pilots’ usefulness, relevance and their overall experience.

## Key Conclusions:

- Majority of referrals were needed at a later stage of disease than anticipated indicating the need for a review of current service provision.
- Clear evidence of risks of falls and the impact of dual tasking.
- All patients within pilot had unmet allied health professional needs, including speech and language therapy and dietetics.
- All patients required onward referrals for equipment and services that would otherwise have been missed.

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