Agenda – Health and Social Care Committee

Meeting Venue:
Hybrid – Committee room 5 Tŷ Hywel and video conference via Zoom
Meeting date: 24 January 2024
Meeting time: 09.30

For further information contact:
Sarah Beasley
Committee Clerk
0300 200 6565
SeneddHealth@senedd.wales

Private pre-meeting (09:00 – 09:30)

1 Introductions, apologies, substitutions, and declarations of interest

(09.30)

2 Pre-appointment hearing for the role of Chair of Betsi Cadwaladr University Health Board: evidence session with the Welsh Government's preferred candidate

(09.30–10.15) (Pages 1 – 41)

Dyfed Edwards, Welsh Government's preferred candidate for the role of Chair of Betsi Cadwaladr University Health Board

Research brief
Paper 1 – Pre-appointment hearing questionnaire
Paper 2 – Personal statement and CV
Paper 3 – Welsh Government briefing
Paper 4 – Information for candidates

3 Motion under Standing Orders 17.42 (vi) and (ix) to resolve to exclude the public from items 4 and 7 of today's meeting and for the meeting on 1 February 2024

(10.15)

4 Pre-appointment hearing: consideration of evidence

(10.15-10.30) (Pages 42 - 46)

Paper 5 - draft report

Break (10.30 - 10.45)

5 Supporting people with chronic conditions: evidence session with Public Health Wales

(10.45-12.00) (Pages 47 - 88)

Professor Jim McManus, National Director for Health and Well-being - Public Health Wales

Zoe Wallace, Director of Primary Care - Public Health Wales

Research Brief

Paper 6 - Public Health Wales

Paper 7 - Public Health Wales (additional information)

6 Paper(s) to note

(12.00)

6.1 Letter from the Chair to the Minister for Health and Social Services, the Deputy Minister for Social Services and the Deputy Minister for Mental Health and Wellbeing with follow up questions from the general Ministerial scrutiny session of 8 November 2023

(Pages 89 - 92)

6.2 Response from the Minister for Health and Social Services, the Deputy Minister for Social Services and the Deputy Minister for Mental Health and Wellbeing to the Chair with follow up questions from the general Ministerial scrutiny session of 8 November 2023

(Pages 93 - 106)

7 Supporting people with chronic conditions: consideration of evidence

(12.00-12.15)

Agenda Item 2

Document is Restricted

Welsh Parliament
Health and Social Care Committee
HSC(6) 34-24 Paper 1

Pre-appointment hearing: Chair of Betsi Cadwaladr University Health Board

Pre-appointment questionnaire

January 2024

Background

You are being asked to complete this questionnaire because you are the Welsh Government's preferred candidate for the post of Chair of Betsi Cadwaladr University Health Board.

Your answers to this questionnaire will be published with the meeting papers for the pre-appointment hearing, and will be used to inform Members' preparation for the hearing. Your response to each question should be no more than around 250 words.

Providing Written Evidence

The Senedd has two official languages, Welsh and English.

In line with the Senedd's Official Languages Scheme the Committee requests that documents or written responses to consultations intended for publication or use in Senedd proceedings are submitted bilingually. When documents or written responses are not submitted bilingually, we will publish in the language submitted, stating that it has been received in that language only.

Please see guidance for those providing evidence for committee.

Disclosure of information

Please ensure that you have considered the Senedd's policy on disclosure of information before submitting information to the Committee

1. What motivated you to apply to be the Chair of Betsi Cadwaladr University Health Board?
I feel passionate about public services. Or, rather, about seeking to create excellent and forward-thinking public services that provide support, assistance and guidance to the people of Wales. For me, this is part of the agenda to create a Fairer Wales and a regime that will enable people to live their lives to their full potential. Health, and the health and care system, is an important cornerstone in this regard: it touches all our lives at different times and is a key part of the social fabric that sustains our communities across the north. I have lived and worked in the north my whole life. Family members have worked or continue to work for the health service locally. I have experience of the NHS first-hand literally from the cradle to the grave and have always felt grateful for the support. But now it is fair to say that Betsi Cadwaladr University Health Board is underperforming and falling short in terms of delivering world-class public services. Indeed, with the Board in special measures, the situation can be described as unacceptable and one where a new direction is needed. I am currently acting as interim Chair of the Board following action by the Welsh Government last February. This period has been very challenging, but also exciting at times! Things are changing: there is a different culture, important permanent appointments have taken place and we have an excellent team of Independent Members. I am keen to continue to be involved in shaping a new future for the Health Board. I believe I have a contribution to make as one of the leaders of the organisation. That contribution is not necessarily better, or worse, than the contribution others can make. But it is possibly a contribution that Betsi Cadwaladr University Health Board needs in the current context.
2. Why do you think you are well-suited for the role?
I have a background in Local Government, as former leader of Gwynedd Council and as a Member and spokesperson for the Welsh Local Government Association (WLGA). In addition, I have experience in education, both as a former small business owner and as a volunteer with third-sector bodies. These experiences, along with my time as a Non-

Executive Director on the boards of the Welsh Revenue Authority and Public Health Wales, have given me special opportunities to gain the appropriate leadership skills for this role. I have learned a lot, succeeded and failed at times, but I have benefitted from every experience. The various roles I have taken on over the years have meant that I have gained a broad understanding of what it means to lead a public body of a certain size, to create change, to connect with people and to create success.

And just as important, in my opinion, is that I understand north Wales and its people. I have lived and worked in the north-east and north-west, with a period in between as well! All of this means I have connections across the north and can relate to people in their diverse communities. As a user of health services myself I know that the people in these areas need and deserve the best possible Health Service.

I am a person who hopefully balances an ambitious attitude with the reality of certain situations. But I am a person who recognises weaknesses and the need to change. Perseverance and determination are undoubtedly needed if you want to succeed in this job. I am ready to continue to give everything I have to the job and to serve the Health Board, and Welsh Government, to the best of my ability.

3. What are the three main outcomes that you want to achieve during your tenure?

To lead a Health Board that believes in learning and continuing improvement

To lead a Health Board that understands quality and standards in all its activities

To lead a Health Board that is outward-facing, engages with the public and partners and is open and transparent

4. How will you work with NHS bodies, Welsh Government, local authorities and social care partners?

One of my priorities since being appointed to the position of interim Chair of the Health Board is strengthening engagement with partners. In this regard I have met all Local Authority leaders and the majority of Chief Executives. I have attended scrutiny committees and plenary meetings of the Council to provide an update on the Health Board's position and an opportunity for members to ask questions or raise any points. This relationship needs to be developed further and a focus is needed on that common ground of securing suitable support for the citizen. I intend to hold relevant and regular meetings to achieve this. I will continue to attend meetings of the Regional Partnership Board, submitting timely progress reports, and will attend meetings with Audit Wales and Health Education and Improvement Wales. Establishing a constructive relationship

with these two organisations has been very important and I will continue to maintain this relationship into the future.

As a Board in Special Measures, we are in close contact with the Minister for Health and Social Services and the Deputy Minister for Mental Health and Well-being. We have taken every opportunity to arrange visits with Ministers to demonstrate developments and share information. The First Minister has also held discussions with the Chief Executive and myself. Continuing these links is key, and the same is true for Government officials – both locally and nationally.

I am fully involved in the network of All-Wales Health Chairs and I intend to organise Board-to-Board meetings with Public Health Wales and Health Education and Improvement Wales into the future.

5. How will you work with community groups, patients, the third sector and other stakeholders?

I am keen to build on the work of listening to patients' voices/experiences in our activities. I believe that we need to consider the experiences of patients and their families as a resource that can be valuable to the Health Board on our journey towards improvement. In this regard I am keen for the Board to gain more knowledge about patient experiences more directly by collecting relevant data and information but also engaging in discussions with specific groups.

Local Partnership Forum meetings provide an opportunity to promote the collaboration agenda and discuss workforce needs. Direct meetings with representatives of local Trade Unions would also provide this. I am keen to build on this work so that frontline staff and the workforce can have an influence in shaping our services into the future.

I have worked with the Chief Executive and other officials to organise a programme of community meetings across the region. This is an opportunity to engage directly with people and community groups and the third sector. I hope this work will develop into an ongoing discussion so that we can learn about the concerns and hopes of our people. Specific committees within the Board such as the Strategic Stakeholder Group and the Partnerships Committee provide an opportunity to promote the third sector agenda as well, but I am keen to do more by identifying collaboration opportunities and ensuring better ownership of the collaboration agenda among community and third-sector groups, in seeking to realise the clear potential that exists.

6. How will you work with Senedd Members and Senedd committees?
Since being appointed as interim Chair, I have worked to maintain constructive and open relationships with all Senedd Members in the region. I will continue to do this by holding meetings, whether as individuals or as a group. I understand the importance of correspondence from Members of the Senedd on behalf of their constituents and will continue to promote a regime that responds to this and to be available to assist Members directly as required. I also want to work with Members to offer them opportunities to visit new services or developments so that any changes can be seen first-hand in their constituencies. I will seek to promote a relationship that proactively informs Members of the Senedd of any developments or problems in their constituencies. I will be happy to work with Senedd committees to provide updates on the development of the Health Board in Special Measures and will be happy to work with committee chairs to identify opportunities for inquiries or visits to find relevant information. I will, of course, be very happy to present evidence to Senedd committees on any occasion.
7. Do you currently hold any other appointments that could give rise to any potential conflicts of interest or perceived conflicts of interest? If so, how do you propose to manage those conflicts or perceptions?
I surrendered my roles as Non-Executive Director of the Welsh Revenue Authority and as an Independent Member of Public Health Wales, on an interim basis, whilst taking up the post as acting Chair of the Health Board. If appointed to the position of Chair on a permanent basis, I would give up both of these positions.

Betsi Cadwaladr University Health Board

Personal Statement

We are in the midst of a period full of challenges: a percentage of the population is still suffering the consequences of the pandemic; the cost of living is driving more people into poverty; we are trying to meet the climate change challenge and more people than before are seeking access to health and wellbeing services. And this all while public funding is being significantly reduced. This context underlines the need for us to try to do things differently and this is an opportunity for us to engage with the workforce, service users and people in our communities. That is why, in my current role as a leader in health, I have consistently met with staff at the workplace and with service users as well. I recently met with families who had suffered from the serious shortcomings of one service; I have discussed the use of agency workers with union representatives and have changed the AGM from a short, formal meeting to a public event in a community centre, as a sign of the intention to turn the organisation from being a health board that looks inward to a board that looks outward.

I have had the opportunity to lead and influence strategies during my time as Chair, Non-Executive Director and Council Leader. Always common to these times is the emphasis on two things – the outcomes for the public and the need to adopt alternative approaches to reach people, to be bold and creative. In my former position as Council Leader, I worked with relevant officers and members to create a cautious approach to financial strategy. As a result, we took a mid/long term approach to budgets and a detailed regime of public consultation giving the public the opportunity to play a key role in prioritising. This was done by detailing all aspects of the Council's budget, detailing the work of services and departments and explaining the impact of any budget cut. This work has been carried out in bespoke workshops with the public, council members and key partners. This comprehensive regime recognised the public as a resource when making decisions by canvassing opinions. It also enabled the public and others to better understand the Council's activities and the difficult financial decisions we faced. My role involved reminding everyone of the need for us to set a budget and ensure there was a clear understanding of the impact of decisions taken. Having gone through this comprehensive process with the public and Council members, I was in a strong position to get the necessary support to set the council budget and level of taxation, and then put the services in place to prepare the savings over a period of time.

I have learnt a lot from my time as Chair, Council Leader and Non-Executive Director. One is undoubtedly the ability to step back from the heat of key decision making and weighing things up before coming to a conclusion about the way forward. Making a major decision and setting the direction is a better process having held comprehensive and purposeful discussions that include citizens and service users. None of us have a monopoly on the truth and creating the right conditions to ensure contribution from others outside the normal circle is key. I have had the opportunity over time to sharpen my skills working as part of a team, challenging and

supporting each other and engaging in discussions with bespoke research and statistics that ensure decisions are made in accordance with evidence.

My work as a Council Leader and as Spokesperson for the Welsh Local Government Association involved working in partnership with others and seeking to influence the strategic and policy direction – locally, regionally and nationally. I worked closely with some ministers and officials as part of the work and had an opportunity to hold discussions and try to put forward some policy possibilities: an example of which is the ability for local authorities to charge a premium on second homes and empty houses.

I believe that I have developed the skills necessary to negotiate with and persuade others, whether they are groups representing the voluntary sector locally or Welsh Government ministers and officials. I was used to working in a challenging political context in my job as Council Leader, without a clear majority, but at the same time managed to develop an agenda of changing and modernising services from education to care. I hope I have managed to strike that balance between making arguments with passion and conviction and having solid evidence and key facts at hand at the same time. There was a case of trying to change provision for adults with needs in one part of the county, creating a new provision that would better meet the needs of consumers and families. But there was strong local opposition. I persuaded some to arrange a visit to similar provision in England and as a result got support for the change and won advocates for the cause. And that's a fundamental principle for me in formulating any strategy, such as the need to show the new world – what's going to change and how things will be better. And that must be done positively and offer hope to people.

Good governance is the foundation of every institution. I am currently working within a context where governance has been historically weak. As a result I am trying, with others, to reset the expectations and culture: reminding everyone of the need to comply with the procedure for reporting to committees and not to promote a last-minute process. My experience as Chair of the Audit and Governance Committee of another organisation has been helpful to me in this regard. Also my years as Council Leader, and the strong emphasis on public accountability.

I hope I have the wide range of experiences and skills needed to contribute constructively to being Chair of Betsi Cadwaladr University Health Board during this challenging but exciting time. I am always enthusiastic and constructive in my approach and what drives me is the opportunity to make a difference working with others to create a fairer Wales and a healthier Wales.

CURRICULUM VITAE

Name: Dyfed Edwards

Personal Profile

- Experienced strategic leader and developer at local, regional and national levels
- Familiar with setting targets and implementing measures to ensure progress in line with objectives
- Experience managing significant budgets
- Able to make joint decisions working in a team
- Influential and able to convince others, with a history of perseverance
- Business background as founder of a music publishing company

Skills

- Experience of working across the public sector, locally, regionally and nationally
- Experienced Chair and Non-Executive Director of public bodies in Wales
- Experienced Vice Chairman and Committee Chair
- Skilled communicator – broad experience as a spokesperson and media liaison on local, regional and national issues as well as presenting evidence to Welsh Parliament committees
- Experienced and respected as a negotiator, working closely with Welsh Government Ministers and officials
- Fully bilingual in English and Welsh

Education and Qualifications

Recognised as Local Politician of the Year in 2009;

Graduate of the Improvement and Development Agency (IDeA) Leadership Academy 2008;

Certificate from the Institute of Financial Education and Training, Bangor University 1999;

B. Mus (Hons), University of Wales, Cardiff 1980;

Postgraduate Certificate in Education 1981;

2 'A' Levels Ysgol Rhiwabon, Wrexham 1977; 7 'O' Levels Ysgol Rhiwabon, Wrexham

Employment and Work Experience

2023 – Acting Chair of Betsi Cadwaladr University Health Board

2022 - Commissioner, North Wales Transport Commission

2021 – Member of the Welsh Language Partnership Council, Welsh Government

2017 - Non-Executive Director of the Welsh Finance Authority - Vice Chairman and Chair of the People Committee

2018 - Non-Executive Director of Public Health Wales - Chair of Audit and Corporate Governance Committee

2008 – 2017: Leader, Gwynedd Council

2011 – 2017: Spokesperson for Housing, Heritage and the Welsh Language of the Welsh Local Government Association

2011 – 2012: Environment, Sustainability and Waste Spokesperson for the Welsh Local Government Association

2008 – 2017: Member of the Welsh Government/Welsh Local Authorities Finance Sub-Group

2008 – 2017: Member of the North Wales Leadership Board

2008 – 2017: Gwynedd-Môn Local/Public Services Board Member (Former Chair)

2008 – 2017: Deputy President, Welsh Local Government Association

2016 – 2017: Member of Expert Group on Housing an Ageing Population, Welsh Government

2015 – 2017 Member of the Syria Refugee Task Force, sponsored by the Welsh Government

2012 – 2013: Member of Welsh Communities Task and Finish Group, Welsh Government

2008-2012: Spokesperson for Heritage, Welsh Language, Sport and the Arts for the Welsh Local Government Association

2007-2008: Gwynedd Council Education Portfolio Member

1992: CURIAD founded – a leading music publisher; resigned as director in 2012

1988 – 1992: Freelance work in music industry composing and working with a music publishing company

1986 – 1988: Head of Music at Ysgol y Gader, Dolgellau

1981 – 1986: Head of Music at Connah's Quay High School

Other interests

Community
- Former governor of Ysgol Dyffryn Nantlle and Ysgol Bro Lleu, Pen-y-groes (former Chair)
- Director of Antur Nantlle Ltd. (Economic Regeneration Agency)
- Volunteering with the Llond Bol scheme in Dyffryn Nantlle
- Founder and volunteer with IwthPen, a scheme for young people in Dyffryn Nantlle
- Former director of Ymddiriedolaeth Tir Cymunedol Dyffryn Nantlle
- Former member of the steering group for Codi'r To – 'El Sistema' project in Caernarfon and Bangor

Leisure

- sports
- arts
- reading

Recruitment of Chair– Betsi Cadwaladr University Health Board (BCUHB)

Background:

Betsi Cadwaladr University Health Board (the Health Board or Betsi Cadwaladr) is the local NHS organisation for North Wales.

As the largest health board in Wales, with a workforce of over **19,000**, it plans, organises and provides health services to more than 700,000 people.

The Health Board currently provide services across the six counties of north Wales:

- Anglesey
- Gwynedd
- Conwy
- Denbighshire
- Flintshire
- Wrexham

The Health Board is responsible for the provision of primary, community and mental health as well as acute hospital services. It operates three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd Hospital in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases.

The Health Board coordinates the work of 96 GP practices, and NHS services provided by 83 dental and orthodontic practices, 69 optometry practices and opticians and 147 pharmacies in North Wales.

Highly specialised services, such as some major trauma treatment, cardiac (heart) care, and complex burns, are organised through the national Welsh Health Specialised Services Committee. These services can be provided outside the boundaries of our area, for example in England, Swansea, or Cardiff.

Publicity summary:

The Welsh Government circulated details of the appointment through stakeholder lists held by the Public Bodies Unit (PBU) and posted the vacancy on the Welsh Government public appointments website.

The vacancy was promoted and advertised through the as set out below:

- Jobs Wales
- Golwg
- Diversity Jobs Network
- Safle Swyddi

Networks

- Betsi Cadwaladr University Health Board's (BCUHB) Black Asian and Minority Ethnic Advisory Group
- Organisations with an interest in these appointments BCUHB's Stakeholder Reference Group (SRG) who will be asked to share with their individual networks e.g., Third Sector/voluntary sector.
- Local Authority Groups.
- Talking health membership
- IM and Executive networks
- Local Authority Leaders and Llais, new citizens' voice body
- As part of the Welsh Government's commitment to increasing diversity in public appointments the advert will be sent to equality and other organisations who have expressed an interest.
- BCUHB's Equality & Diversity contacts – through the Welsh Government's Equality & Diversity lead

Recruitment process summary:

Advertised on the Welsh Government website between 27 September and 20 October 2023

Stakeholder Session – 28 November 2023. The stakeholder session members were representatives from the Health Board, their partners and stakeholders and Welsh Government. The candidates were asked to deliver a 15-minute presentation on the following:

"How do you change culture across a large area and multiple sites?"

Interview – 29 November 2023

Assessment advisory panel membership:

Judith Paget, Director General Health and Social Services, Welsh Government and NHS Wales Chief Executive (Chair)
Arun Midha, a Senior Independent Panel Member
Helen Arthur, Director of Workforce and Corporate Business, Health and Social Services Group, Welsh Government.

One application for the new role were received and the candidate was recommended for interview**.** Following interview, the Advisory Assessment Panel considered the candidate as **Appointable**.

Minister for Health and Social Service's preferred candidate – Dyfed Edwards

Conflict of Interest

None
Political Activity
None

HSC(6) 32 24 Paper 4

Chair of Betsi Cadwaladr University Health Board

Candidate Information Pack

Llywodraeth Cymru
Welsh Government

The Commissioner for Public Appointments

Contents

1.	Introduction	3
2.	About Betsi Cadwaladr University Health Board	4
3.	Our Health and Care Strategy	5
4.	Escalation Status	6-7
5.	Values and behaviours	8-9
6.	Working with our partners	10
7.	The role of the Board	11
8.	Chair role – key responsibilities	12-14
9.	Person specification	15-16
10.	Key facts about this post	17-23

1. Introduction

Message from Eluned Morgan, Minister for Health and Social Services, Senedd Cymru, Welsh Parliament

Thank you for showing an interest in the position of Chair of the Betsi Cadwaladr University Health Board.

Now more than ever, the contribution made by our public appointees is critical in ensuring an improved health board that supports all staff to achieve their full potential.

The successful candidate will have a critical role in taking forward the strategy and plans of the Health Board. There are many opportunities to improve the health of the population of North Wales, ensuring they receive the services they deserve. I particularly value the contribution made by Chairs and public appointees to our NHS boards, and I will look to the successful candidate to provide leadership to the Board to ensure the delivery of my priorities of:

- Developing a closer relationship with local government in order to tackle the issue of delayed transfers of care;
- Improving access to primary and community care;
- Urgent and emergency care;
- Planned care and recovery;
- Cancer services; and
- Mental health and child and adolescent mental health services.

They will also have an important role in driving forward quality, safety and good clinical outcomes whilst ensuring financial stability, robust governance and leadership of the organisation.

It has been a very challenging time for the board following the recent escalation to special measures and here is an exciting opportunity for you to be involved in shaping and leading the organisation in providing the quality services that you and the people of North Wales expect. If you are interested in this role and would like to know more about the important role of a Chair within NHS Wales please contact Judith Paget, Director General Health and Social Services/NHS Wales Chief Executive who will be very happy to discuss this role with you on my behalf.

2. About Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board (the Health Board or Betsi Cadwaladr) is the local NHS organisation for North Wales.

As the largest health board in Wales, with a workforce of over 19,000, we plan, organise and provide health services to more than 700,000 people.

We currently provide services across the six counties of north Wales:

- Anglesey
- Gwynedd
- Conwy
- Denbighshire
- Flintshire
- Wrexham

We are responsible for the provision of primary, community and mental health as well as acute hospital services. We operate three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd Hospital in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases.

We coordinate the work of 96 GP practices, and NHS services provided by 83 dental and orthodontic practices, 69 optometry practices and opticians and 147 pharmacies in North Wales

Highly specialised services, such as some major trauma treatment, cardiac (heart) care, and complex burns, are organised through the national Welsh Health Specialised Services Committee. These services can be provided outside the boundaries of our area, for example in England, Swansea, or Cardiff.

3. Our Living Healthier, Staying Well Strategy

The Health Board's purpose is to improve the lifelong health and well-being of the people of North Wales. As well as providing care, our role is to support people to look after their own health and well-being and to help make North Wales a healthy place to live.

Our long-term objectives are set out within our strategy, Living Healthier, Staying Well, which are to:

- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities
- Support children to have the best start in life
- Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being
- Improve the safety and quality of all services
- Respect people and their dignity
- Listen to people and learn from their experiences

4. Escalation status

On 8 June 2015, Betsi Cadwaladr University Local Health Board (the Health Board) was placed in special measures due to failings in service delivery, organisational effectiveness, and the quality and safety of care in a range of areas, including the provision of mental health services, maternity services and primary care including out-of-hours services.

A decision was made to de-escalate the health board from special measures to targeted intervention in November 2020. This decision was made in light of the progress in some of the areas that were previously of concern and recognising that the health board delivered a coherent and comprehensive response to the pandemic, demonstrating improved engagement with partners. The health board was placed in targeted intervention (TI) in November 2020 for the following areas:

- Mental Health (adult and children)
- Strategy, planning and performance
- Leadership (including governance, transformation and culture)
- Engagement (patients, public, staff and partners)

In May 2022, following patient safety, governance and assurance issues highlighted through a number of serious incidents and inspections, a decision was made to widen the targeted intervention status at Betsi Cadwaladr University Health Board to include:

- Ysbyty Glan Clwyd – patient safety, governance, leadership, operational oversight, clinical safety governance including record keeping, incident management, team working, reporting concerns, and consent
- Vascular Services
- Emergency Department at Ysbyty Glan Clwyd

The extension of TI measures in May 2022 saw an increased support package targeted at the health board with a particular focus on Ysbyty Glan Clwyd.

Since this decision as taken, a number of concerns have been raised encompassing board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management within the board. There was sufficient evidence to indicate that significant and timely improvement was not happening under TI and further escalation was considered necessary and appropriate. A major consideration was the unitary board's effectiveness to develop and implement change and make the necessary improvements.

On 27 February 2023, the health board was escalated to special measures. The escalation to special measures reflects serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management.

Special Measures

Special measures are the highest level of escalation in the NHS Wales escalation and intervention framework. There are a number of areas of concern that resulted in the special measures status of the organisation. These are set out in the special measures framework which has been agreed with the Health Board. Each of these will receive directed intervention, support and de-escalation planning. The intervention plan for each domain will report into the overarching special measures process, this will incorporate areas previously subject to the targeted intervention status.

5. Values and behaviours

Betsi Cadwaladr University Health Board has an important job to do. Our work matters because it is our job to care for our patients, enable, and empower our population to stay well. We all want to do this to the best of our abilities – but we know that good intentions are not always enough.

At Betsi Cadwaladr University Health Board, we have a set of values and behaviours that establish expectations for our people across the organisation. These values, developed with staff and stakeholders, provide the basis for our behavioural framework; appraisal and development.

Our Values are

- **Put patients first**
- **Work Together**
- **Value and respect each other**
- **Learn and innovate**
- **Communicate openly and honestly**

Our values set out how we are all expected to behave in our work roles. But they are more than just a set of words or a set of posters on the walls – they are a commitment we all make to "showing up" for those we care for and each other from a place of integrity, purpose and respect.

All of our people are expected to behave in accordance with our agreed values and are encouraged to challenge anyone in the organisation who appears not to be doing so.

Our Vision

The Health Board's vision is to create a healthier North Wales that maximises opportunities for everyone to realise their full potential, reducing health inequalities. This means that, over time, the people of North Wales should experience better quality and length of life.

It aims to provide excellent care, which means its focus for the next three years will be developing a network of high-quality services that deliver safe, compassionate and effective care based on what matters to our patients. In addition, the Health Board will ensure its work is closely aligned with Welsh Government's long-term vision for achieving a 'whole system approach to health and social care'.

To do this, we will:

- Improve population health and well-being through a focus on prevention;
- Improve the experience and quality of care for individuals and families;
- Enrich the well-being, capability and engagement of the health and social care workforce; and
- Increase the value achieved from health and care funding through improvement, innovation, use of best practice practices, and eliminating waste.

Organisational Culture Reset 2023

In 2022, Audit Wales undertook its review of board effectiveness. This identified serious issues around the way the Board operates as a unitary body. work has been started to support the health board in:

1. Defining the culture of the organisation
2. Reviewing our values
3. Defining and agreeing our behaviours.

6. Working with our partners

We recognise that we cannot address our current and future health and care challenges alone. To successfully deliver our strategy, we work closely with a broad range of partners that includes:

- Other health boards, trusts and special health authorities.
- Llais (the Citizen Voice Body for Health and Social Care Wales).
- Local and community councils – Conwy, Denbighshire, Isle of Anglesey, Flintshire, Gwynedd and Wrexham that are within the Betsi Cadwaladr region.
- Welsh Ambulance Services NHS Trust, North Wales Police, and North Wales Fire and Rescue Service.
- Community groups.
- Our local voluntary organisations, third sector and charities

To learn more about our work, and how we work with partners and communities you can access our latest Annual Report here or the full suite of papers from the Annual General meeting here.

7. The role of the Board

All Betsi Cadwaladr Board members share corporate responsibility for formulating strategy, overseeing accountability, monitoring performance, and shaping culture, together with ensuring that the Board operates as effectively as possible.

The Board comprises of the following members:

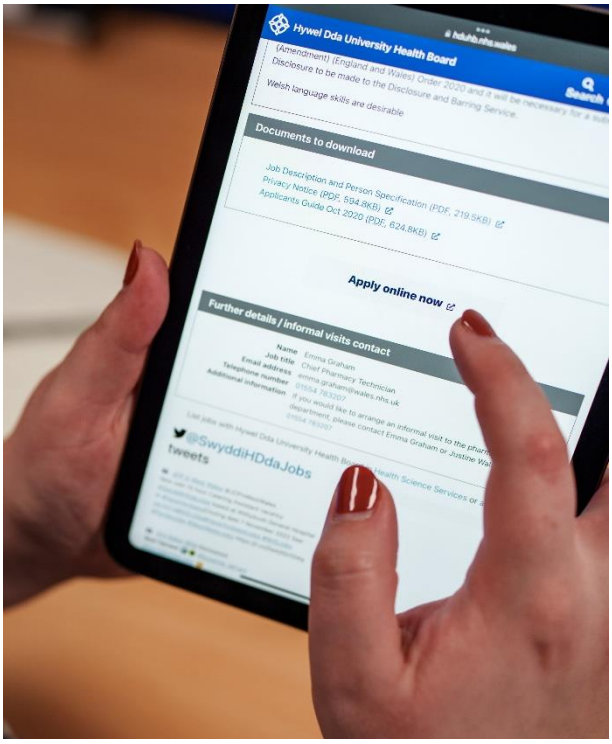
11 Independent Members
Including the Chair and Vice-Chair who are appointed by the Minister for Health and Social Services.

9 Officer Members
Executive Directors, including the Chief Executive.

3 Associate (non-voting) Members of the Board
Chair of the Healthcare Professionals Forum, Chair of the Stakeholder Reference Group, and a Director of Social Services Representative.

We are looking for an individual who understands the needs of the Health Board's population and the importance of ensuring diversity and inclusion and promotion of the Welsh Language.

Board Development
Led by the new Chair and Interim Chief Executive, the Health Board benefits from a continued commitment to personal, organisational and Board development. Development support is reflective of, and tailored to, the specific role accountabilities of each Executive and Independent Member of the Board, and furthermore on the dynamics and effectiveness of the Board as a whole.



8. Chair role – Key responsibilities

NHS Boards play a key role in shaping the strategy, vision, purpose and culture of an organisation. They hold the organisation to account for service delivery, quality and safety, performance, value for money and strategic development and implementation.

They are also responsible for ensuring that risks to the organisation, staff and the public are effectively mitigated. Led by an independent Chair and comprised of a mixture of both Executive and Independent Members (also known in some organisations as Non-Executive Directors), the Board has a collective responsibility for the performance of the organisation.

The Chair will be accountable to the Minister for Health and Social Services for the performance of the Board and its effective governance, upholding the values of the NHS, and promoting the confidence of the public and partners.

KEY RESPONSIBILITIES

The Chair will:

Strategy

- Lead the Board's development of a strategic vision for the organisation, identifying and realising the inherent potential and skills within the organisation to develop an innovative and world leading service.
- Provide independent judgement and advice on issues of quality, strategy, vision, performance, resources and standards of conduct.
- Constructively challenge, influence and work with the Executive Directors to develop proposals on such strategies.
- Support fellow Board members in providing leadership within a framework of prudent and effective controls to ensure the long term sustainability of the organisation.
- Ensure that risks to the delivery of the organisation's strategy are articulated and managed.

Planning

- Be accountable for the performance of the Board at community, regional and national levels through the agreement of a three year medium term plan (or annual delivery plan); and the annual evaluation of achievements against the plan.
- Ensure the Board provides effective scrutiny of the three year medium term (or annual) plan, ensuring that it establishes clear objectives to deliver the strategy; encompasses the necessary quality, workforce, operational and financial resources for the organisation to meet its objectives and regularly reviews performance against the plan.

Performance

- Receive, review and apply appropriate scrutiny to safety, quality, performance, workforce and financial data and information to compare achievements against targets and, where necessary, support the implementation of remedial action.
- Agree challenging objectives for the Chief Executive and the Board for improving performance; agree objectives for the Vice Chair and Independent Members/Non-Executive Directors and undertake annual appraisals.
- Ensure effective control and, where relevant, commissioning arrangements are in place to secure the financial viability of the organisation.

Governance

- Hold the Chief Executive to account across the breadth of their responsibilities.
- Provide strong, effective and visible leadership and communication across the breadth of the organisation's responsibilities, internally through the organisation and externally through their connections with a wide range of stakeholders and partners within and outside of the NHS at a national, community, and local authority level.
- Ensure the organisation's commitment to the highest standards of governance, such that it acts in the interests of the population and partners it serves and is seen to be accountable for the services provided and the resources used.
- Ensure the provision of accurate, timely and clear information to the Board and directors to meet statutory requirements.
- Seek assurance that internal controls and systems of risk management are robust and well governed.
- Analyse and interpret information provided to the Board, seeking clarification, further assurances and triangulation of information, wherever possible.
- Ensure the organisation complies with its Standing Orders, policies and relevant legislation and regulations.

Culture and Behaviour

- Demonstrate the Seven Principles of Public Life (also known as the Nolan Principles) of selflessness, integrity, objectivity, accountability, openness, honesty and leadership and ensure the principles are upheld by all Board members.
- Embrace and promote the importance of Welsh Language bilingualism and Welsh culture in all organisational activities.
- Instil a culture that encourages staff, patients, families, and the public to raise concerns that are then appropriately addressed.
- Embrace and promote equality, diversity, and inclusion for the organisation's population, patients, staff and stakeholders, reflecting and learning from own or the lived experiences of others.
- Ensure the highest standards of probity, integrity, and governance, and that the organisation's governance arrangements comply with best practice and statutory requirements.

- Provide visible compassionate leadership in supporting and promoting a healthy culture for the organisation and reflect this, and the values of the organisation, in their own behaviour.
- Bring past professional and lived experience, knowledge and influence to the work of the Board to promote innovation, curiosity, and to challenge norms.

Engagement

- Build and maintain strong partnership relations between the organisation's partners and stakeholder groups to promote the effective operation of the organisation's activities.
- Provide leadership to support and encourage effective working with partners, in particular with Health Boards, NHS Trusts, Special Health Authorities, local authorities, the third sector and social care partners, to ensure the planning and delivery of safe, effective services.
- Attend Welsh Government, health body peer groups and other stakeholder meetings where required.
- Undertake an external ambassador role, delivering in the public spotlight and instilling public confidence.
- Be expected, with support, to understand the business of the organisation through active involvement.

Board Activities

- Plan Board meetings with the Chief Executive and Board Secretary and design a Board development programme to deliver high performance.
- Facilitate the effective contribution of Board Members and ensure constructive relations within the organisation and between Executive Directors and Independent Members.
- Chair the organisation's Board meetings and lead development sessions and other meetings of members as appropriate.
- Participate fully in the work of the Board and Committees, including pre- and post- meeting engagement and annual evaluations to support good governance.
- In conjunction with the other Board Members and where applicable, discharge their duties as Chair of the organisation's Charitable Fund, of which the Board acts as the corporate trustee.
- Undergo an annual personal performance appraisal, participating in any additional training and development highlighted as a result of the evaluation process to ensure personal objectives are delivered.

9. Person specification

To be considered, you must be able to demonstrate that you have the qualities and experience to meet all the essential criteria for this appointment. Some of these are more easily demonstrated at the application stage whilst others are better explored at interview (please see below). An opportunity will also be taken at interview to explore in more detail some of the criteria evidenced in your personal statement.

Section 9(a)

Essential criteria to be evidenced in personal statement.

Values

- Commitment to engaging with people who use our services, their carers and families, our staff and stakeholders.

Skills

- A track record of strategic, Board level leadership in a public sector, private or third sector organisation.
- Ability to instil vision and lead the development of defined strategies in the pursuit of achieving long, medium and short-term goals.
- Ability to understand and facilitate the understanding of complex issues.
- Strong interpersonal and influencing skills and ability to act as an effective advocate and ambassador.
- Ability to work collaboratively and as part of a team to meet common goals.
- Evidence of an understanding of effective governance.

Desirable criteria to be evidenced in personal statement where relevant.

Experience

- An understanding of risk management and systems of internal control and assurance.

Section 9(b)

Essential criteria to be evidenced at interview.

Values

- Commitment to adhering to the Seven Principles of Public Life (Nolan Principles) and the values of the organisation.

Skills

- Ability to provide, and encourage others to provide, independent challenge and scrutiny whilst maintaining constructive relationships.
- Ability to show an appreciation of bilingualism and culture, and a commitment to promoting and mainstreaming of the Welsh language.

- An understanding of and commitment to equality, diversity, and inclusion, including ability to reflect on and learn from your own lived experiences.
- Astute and able to grasp relevant issues and understand the relationships between interested parties demonstrating sound judgement, sensitivity and political awareness.
- Ability to motivate and develop the Board, to define roles and responsibilities, ensuring ownership and accountability.

Desirable criteria to be evidenced at interview where relevant.

Experience

- Demonstrable leadership and strategic change management experience including culture change.

Welsh language skills are desirable; however, all candidates will be expected to show commitment towards the language and culture and demonstrate leadership to strengthen and promote bilingual service provision within the NHS in Wales (see above essential skills and experience). We are looking for individuals who understand the importance of providing services in Welsh without people having to ask for it.

Welsh Government recognises the importance of developing and growing bilingual skills and encourages applications for the Welsh desirable members' roles from Welsh learners and applicants who may not feel confident speaking Welsh or do not speak Welsh.

Where a candidate wishes to demonstrate they meet the desirable criteria, they should provide an indication of their skills against the following level of skill:

Understanding	Can understand routine work-related conversations
Reading	Can read some basic words and phrases with understanding
Speaking	Can converse in some work-related conversations
Writing	Can write some basic messages on everyday topic

10. Key facts about the post

Location
Corporate Offices Block 5, Carlton Court St Asaph Business Park St Asaph, Denbighshire LL17 0JG.

It will also be necessary for the post holder to attend Health Board sites and attend Health Board, regional and national meetings. Whilst we are returning to face-to-face meetings, some continue to be held virtually as appropriate. There will also be the opportunity for some remote working.

Time Commitment
15 days per month.

Tenure of Office
Initial appointment of up to four (4) years.

Remuneration
£69,840 per annum plus reasonable expenses.

Making an application
To make an application please visit the Welsh Government public appointment website here https://cymru-wales.tal.net/vx/lang-en-GB/mobile-0/appcentre-3/brand-2/candidate/jobboard/vacancy/7/adv/.

To apply for this role, click on the Betsi Cadwaladr University Health Board vacancy and click on 'Apply' at the bottom left-hand corner. If this is the first time you have applied for a post, you will need to complete a registration form for the Welsh Government's online application system. You will only need to register once, and you will be able to keep yourself updated on the progress of your application, and any other applications you make, via your registered account.

Once you have registered, you will be able to access the application form.
To apply you will need to submit two supporting documents:

- A full Curriculum Vitae (CV)*; and
- A personal statement detailing how you meet the person specification (9a).

The two documents should be uploaded to the "Attach Supplementary Document(s)' section of the online application form. Failure to do so or follow the guidance below may lead to your application being rejected.

If you need adjustments to be put in place to enable you to make an application or any assistance or guidance, please contact the Public Appointments Team at PublicAppointments@gov.wales

Curriculum Vitae (CV)*

Please ensure your CV includes brief details of your current or most recent posts and the dates you occupied these roles. Please identify any past or present Ministerial appointments.

Your CV should be no more than three pages long.

Personal Statement

The personal statement is your opportunity to demonstrate how you meet some of the criteria set out in the person specification in this pack in **section 9 (a).**

Note: as mentioned above, you need not include all of your skills and experience in the personal statement. An opportunity will also be given to demonstrate the skills and experience in **section 9(b)** at interview.

The statement should include examples that show how your knowledge and experience matches each of the criteria. These examples should describe what your role was, the approach you took to achieving a specific result and how you would use this experience in the role you are applying for; you are welcome to use examples of both professional and lived experience.

How you choose to present the information is a personal choice; however, the appointment advisory panel will need to be able to assess how the examples provided relate to the criteria, and so we encourage you to avoid using statements, which simply reference the criteria without giving examples.

You should ensure you also follow the principles of 'name-free' recruitment in your personal statement, ensuring you do not inadvertently include any of the items highlighted above, for example, the name of an educational institution.

Please limit your personal statement to **1000 words**.

Your application may be rejected if you exceed requirements relating to the length of your CV or personal statement.

References

Please provide two referees who will be contacted for successful candidates only.

In order to preserve the highest standards of integrity and propriety, we are unable to accept Senedd Members or Welsh Government employees as referees for applications for membership of public bodies.

Selection Process

The Minister for Health and Social Services will appoint the Chair of Betsi Cadwaladr University Health Board.

The appointment will be a significant appointment by Welsh Ministers and is regulated under the Governance Code on Public Appointments.

The Minister for Health and Social Services will be assisted in their decision making by an Advisory Assessment Panel. This panel will be made up of the Director General Health and Social Services/NHS Wales Chief Executive; an Independent Panel Member; a Senior Independent Panel Member; and the Director of Workforce and Corporate Business, Health and Social Services Group, Welsh Government. In undertaking their assessment of candidates, the role of the Panel is to decide objectively who meets the published selection criteria for the role, in other words, who is appointable to the role. The Director General Health and Social Services/NHS Wales Chief Executive will chair the panel.

The panel will select for interview only the applicants who it feels have demonstrated that they best meet the criteria set out in Section 9(a) of the person specification. They will rely only on the information you provide in your CV and personal statement to assess whether you have the skills and experience required. However, if you have applied under the guaranteed interview scheme (see below) **and you meet the minimum essential criteria** for the post, then you will also be invited for interview.

There will also be a stakeholder session stage for shortlisted candidates, which will be made up of individuals from within the Health Board and partner organisations. Shortlisted candidates will be required to engage with stakeholders during the session on a relevant and critical topic, which will be agreed nearer the time. If you are unable to make the arranged stakeholder engagement session or interview date, we will endeavour to re-arrange it, but it might not be possible due to time constraints within the appointment timetable or availability of participants.

You will receive email communication from Welsh Government's application centre to let you know whether or not you have been invited to be interviewed. If invited to interview, the panel will question you about your skills and experience, including those referenced in Section 9(b) above, asking specific questions to assess whether you **meet the criteria** set out for the post.

Advert Closing date	20 October 2023
Sift	31 October 2023
Stakeholder session (in person)	w/c 20 November 2023
Interviews	29 November 2023
Pre-appointments hearing (provisional)	24 January 2024
Appointment confirmed	February 2024
Appointment start	1 March 2024

Candidates, who the panel believe are 'appointable', will be recommended to the Minister who will make the final decision. The Minister may choose to meet with

appointable candidates before making a decision. If they do, they will meet all candidates and in the presence of the panel chair or their nominated representative. There will be a time gap between interview and a final appointment decision being made. Candidates who have been interviewed will be kept informed of progress.

In addition to the stakeholder session and interview, the Minister's preferred candidate will be required to attend a pre-appointment hearing, conducted by the Senedd's Health and Social Care Committee. The Committee will take evidence from the preferred candidate before the appointment is confirmed, but after the selection process has taken place. Provisional date for the hearing is 24 January 2024.

Diversity Statement

The Welsh Government believes that public bodies should have board members who reflect Welsh society - people from all walks of life - to help them understand people's needs and make better decisions. This is why the Welsh Government is encouraging a wide and diverse range of individuals to apply for appointments to public bodies.

Applications are particularly welcome from all under-represented groups, including women, people under 30 years of age, black, Asian and minority ethnic people, disabled people, and lesbian, gay, bisexual and transgender people.

Disability Confident

The Welsh Government accepts the social definition of disability, in which it is recognised that barriers in society act to disable people who have impairments or health conditions or who use British Sign Language. We are committed to removing barriers so that all staff can perform at their best. The Equality Act 2010 uses the medical definition of disability ("a physical or mental impairment which has a substantial and long-term impact on a person's ability to carry out normal day to day activities").

We guarantee to interview anyone who is disabled whose application meets the minimum criteria for the post. By 'minimum criteria' we mean that you must provide us with evidence in your application which demonstrates that you generally meet the level of competence for the role and any qualifications, skills or experience defined as essential.

If you would like a guaranteed interview, please contact the Public Appointments Unit at publicappointments@gov.wales to let them know.

If you have an impairment or health condition, or use British Sign Language and need to discuss reasonable adjustments for any part of this recruitment process, please contact the Public Appointments Unit as above as soon as possible and a member of the team will contact you to discuss your requirements and any questions you may have.

Personal Development and Performance Review

Welsh Government values the contribution made by public appointees and wishes to ensure, in association with Betsi Cadwaladr University Health Board that post holders are able to access a range of personal development opportunities. On appointment, a personal development plan and objectives will be agreed with the Minister. Successful candidates will also be required to attend an induction programme. Academi Wales deliver a range of leadership development programmes across the public service in Wales and opportunities to access these and other programmes will be explored on appointment.

Eligibility

A person shall be disqualified from appointment if he/she:

a. has within the preceding five (5) years been convicted in the UK, Channel Islands or the Isle of Man of any offence and has had passed on him/her a sentence of imprisonment (whether suspended or not) for a period of not less than three (3) months.
b. has been adjudged bankrupt or has made a composition or arrangement with her/his creditors.
c. has been dismissed, otherwise than by reason of redundancy, or non-renewal of a fixed term contract, from any paid employment with a health service body, and;
d. are a person whose tenure of office as the chairman, member or director of a health service body has been terminated because his/her appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of pecuniary interest.
e. has within the preceding year been in the paid employment of Velindre University NHS Trust or the Welsh Ambulance Services NHS Trust.

Whilst employment with other NHS bodies in Wales does not, at present mean a person is disqualified from appointment it will be necessary to consider any potential conflicts of interest which may arise (see below).

An individual shall also not normally serve concurrently as a Non-Officer Member (Chair, Vice-Chair or Independent Member) on the Board of more than one NHS body in Wales.

If candidates require any further clarification regarding the above eligibility criteria they should contact PublicAppointments@gov.wales providing the question to which they require a response.

Applicants should also note that membership of a Health Board is a disqualifying post for membership of the Welsh Parliament under the Senedd Cymru (Disqualification) Order 2020.

Conflicts of Interest

When applying you will be asked to declare any private interests, which may, or may be perceived to conflict with the role and responsibilities as Chair of Betsi Cadwaladr

University Health Board, including any business interests and positions of authority outside of the role in Betsi Cadwaladr University Health Board.

Any conflicts of interest will be explored at interview. If appointed, you will also be required to declare these interests on a register, which is available to the public.

Due Diligence

The Welsh Government's Public Bodies Unit will undertake due diligence checks on all candidates successfully sifted to interview. This will include, but not necessarily be limited to, social media and Internet searches. As a result, you may be asked questions at interview in relation to any due diligence findings.

Standards in public life

You will be expected to demonstrate high standards of corporate and personal conduct. All successful candidates will be asked to subscribe to the Code of Conduct for Board Members of Public Bodies and the Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006. You can access these documents at:

https://www.gov.uk/government/publications/code-of-conduct-for-board-members-of-public-bodies, and

NATIONAL ASSEMBLY FOR WALES (gov.wales)

Making an appointment

If you are successful, you will receive a letter from the Minister for Health and Social Services appointing you as Chair to Betsi Cadwaladr University Health Board, which will confirm the terms on which the appointment is offered. Your appointment will be subject to a reference check undertaken by the Welsh Government's Public Bodies Unit and to pre-appointment checks, including a DBS check undertaken by the NHS Wales Shared Services Partnership.

Contacts

For further information regarding the selection process or applying for the role, please contact: Public Appointments Team, Public Bodies Unit, and Email: PublicAppointments@gov.wales

For further information regarding the role of Chair of Betsi Cadwaladr University Health Board, please contact:

- Judith Paget, Director General Health and Social Services/NHS Wales Chief Executive, Welsh Government; email: pstodgforhsscenhswales@gov.wales
- Phil Meakin, Director of Corporate Governance and Board Secretary, Betsi Cadwaladr University Health Board; email Phil.Meakin@wales.nhs.uk

For further information about Public Appointments in Wales, please visit www.gov.wales/publicappointments

If you are not completely satisfied

Welsh Government will aim to process all applications as quickly as possible and to treat all applicants with courtesy. If you have any complaints about the way your application has been handled, please contact publicappointments@gov.wales .

Additionally, you can write to Office of the Commissioner for Public Appointments G/08, 1 Horse Guards Road, London SW1A 2HQ.

Agenda Item 4

Document is Restricted

Document is Restricted

Health and Social Care Committee
Supporting people with chronic conditions

Public Health Wales written response

June 2023

Chronic or long-term conditions are experienced by 46% of adults in Wales, with 19% experiencing two or more long-term conditions. Musculoskeletal conditions were the most frequently reported at 16%, followed by heart and circulatory problems (11%) and mental health problems (10%).

These conditions are all characterised by their long-term nature and by the potential for prevention either by detecting risk factors and acting before the disease develops or by effective management of risk once the disease has been diagnosed to prevent exacerbation and recurrence of acute episodes.

NHS and social care services

- The readiness of local NHS and social care services to treat people with chronic conditions within the community.
- Access to essential services and ongoing treatment, and any barriers faced by certain groups, including women, people from ethnic minority backgrounds and disabled people.
- Support available to enable effective self-management where appropriate, including mental health support.

As previously mentioned, a considerable proportion of the burden of disease and ill-health in Wales is preventable through identifying and addressing behavioural and clinical risk factors to prevent disease development and progression. Therefore, these primary and secondary prevention measures are integral to the delivery of local NHS and social care services, which support people with chronic conditions in the community.

There are many examples of prevention in NHS and social care settings, some of which are delivered systematically, such as immunisation and screening programmes. These programmes are successful, not just because the interventions are evidence-based, effective, and deliver value, but because they are underpinned by a whole systems approach. This

includes central policies regarding the target population, clear eligibility criteria, delivery by staff groups who are adequately trained and resourced, and data collection systems to monitor uptake, with equity of uptake routinely analysed and reported.

However, much of the prevention activity which aims to reduce the risk of clinical and behavioural risk factors is opportunistic in nature, implementation may vary in effectiveness and quality, and alignment to clinical guidance and the 'offer' may be inequitable.

In 2019, The Faculty of Public Health report What the NHS thinks about prevention identified barriers, which included "lack of integration of prevention into core services, systems capacity issues, prevention not being seen as the remit of the delivery organisation and staff workload". Whilst there was limited input from leaders in Wales to this work, these barriers were mirrored in engagement work by the Primary Care Division of Public Health Wales (PHW) in 2019, which asked healthcare professionals about perceived barriers to the delivery of prevention in clinical settings. Key barriers identified related to:

1. *Capability (of the workforce)*: for example, lack of confidence to raise the topic of a risk factor such as weight, for fear of harming their relationship with a person, and lack of knowledge about both the services into which they can refer patients for support with behaviour change, as well as the effectiveness of prevention interventions.
2. *Opportunity*: examples included lack of time and lack of remuneration for undertaking prevention interventions.
3. *Motivation*: in particular, that prevention was not considered part of their professional role.

The task 'as a wider system' to create the conditions to enable prevention and early intervention as part of routine care therefore remains, enabling local NHS and social care services to treat people with chronic conditions within their community. This is a strategic priority for Public Health Wales, which is committed to supporting and developing a sustainable health and care system in Wales, focused on prevention and early intervention.

It is well recognised that there are widespread challenges in accessing services, with barriers often being experienced by certain groups. PHW, through our leadership in the development and implementation of the All Wales Diabetes Prevention Programme (AWDPP), has tried to proactively consider and address equity of access and uptake to the Programme. Firstly, during the 'design' phase of the Programme in 2021, we completed

an Equality Impact Assessment, which identified a number of groups that may face barriers to access. This included people from specific minority ethnic groups, who are both at increased risk of developing type 2 diabetes due to their ethnicity, but also less likely to access and therefore benefit from AWDPP services if invited to them, due to a range of factors.

In response to this, we ensured that the development of a minimum dataset, which is being collected by the AWDPP frontline staff, included demographic parameters to allow equitable access to be monitored. These data are now feeding through to the development of an 'Audit Plus' module to enable practices, clusters and health boards to understand their own data. Once the module is live, we plan to publish an 'AWDPP Equity Toolkit' to use alongside this, to support local service providers to gain insight into barriers to access and uptake and to guide appropriate actions in response. It is hoped that this approach will enable barriers to access for certain groups to be identified and effectively addressed to improve the equity of the Programme, with potential learning for other programmes.

Whilst a number of behavioural and clinical risk factors for the development and progression of chronic conditions can be addressed through effective self-management, it is also recognised that there are inequalities and wider determinants affecting the ability of people to self-manage these risk factors. Access to health and care services, the quality of those services and the way they are experienced by people, are determinants of health and may contribute to health inequalities. Health inequalities are differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable. Reducing health inequalities is a strategic aspiration in Wales and is core principle that underpins the work of Public Health Wales, running through the Integrated Medium Term Plan (IMTP).

Supported self-management is important to both reduce inequalities and to improve the effectiveness of self-management. The NHS and social care services have a key role within supported self-management, whether through signposting and referral to well-being activities/services, or additional capacity in the community through social prescribing and other routes. However, enabling these approaches to deliver supported self-management requires a whole system approach to mainstream prevention, as described above.

Multiple conditions

- The ability of NHS and social care providers to respond to individuals with multi-morbidity rather than focusing on single conditions in isolation.
- The interaction between mental health conditions and long-term physical health conditions.

Health and care services, which focus on a single condition alone, are often not person-centred, leading to multiple interactions with healthcare professionals, and an inability to consider a person's needs in a holistic way where the individual is experiencing multi-morbidities/ multiple risk factors. The Primary Care Model for Wales recognises the need for a model of care which addresses individuals' social as well as medical needs, and which allows for a more sustainable, holistic approach.

The interaction between mental health and long-term physical health is complex.

Survey results suggest that 19% of adults in Wales experience two or more long-term conditions. Specific groups in the population are at increased risk of poor mental health and well-being. This can be due to structural factors, such as the conditions in which they live and work; the impacts of factors such as discrimination and stigmatisation; or other health issues, such as living with chronic pain. There can also be inequalities in physical health outcomes for people living with poor mental health i.e. their physical health needs can be overshadowed by their mental health presentations ("diagnostic over-shadowing"), and/or their medication can put them at increased risk of poor physical health.

PHW's work on supporting obesity prevention through primary care has included undertaking a healthcare needs assessment (HCNA) looking at the primary care needs of people living with obesity in Wales. This highlighted the interactions between mental well-being and obesity, a long-term condition, and the impact the two conditions can have on each other. In particular, the HCNA identified a number of factors that are associated with poorer outcomes for those experiencing obesity, including: low self-esteem, societal stigma, self-stigma and perceived judgement. Furthermore, it identified that the opinion of healthcare professionals can have either a negative or a positive impact on motivation and engagement. The HCNA concluded with recommendations including the need for sensitivity in raising weight in consultations, ensuring that people's needs

are met holistically, and considering obesity in the context of a person's physical, mental and social needs, in a non-judgemental way.

In Wales, social prescribing is defined as 'connecting citizens to community support, to better manage their health and well-being'. PHW's Social Prescribing Interfaces report (2022) recognises the interaction between mental health and well-being, social well-being, and long-term physical health and well-being. It also recognises how social prescribing can be used to help individuals manage both mental health and long-term physical health conditions, as either an additional or alternative support to medical treatment.

Social prescribing involves a deliberate, individualised process that connects individuals to non-clinical services and activities, typically provided by the voluntary and community sectors. The Social Prescribing Interfaces report describes the synergies and distinctions between: (1) physical and mental health services; (2) well-being activities and community assets; and (3) social prescribing. Five recommendations have been identified within the report, of which two relate to embedding person-centred approaches and improving the understanding of referrers of the purpose of social prescribing. To support these two recommendations, PHW are developing a suite of resources on 'Meeting health and wellbeing needs through social prescribing' to demonstrate how a broad range of mental, physical and social health and well-being needs can be addressed through social prescribing.

Impact of additional factors

- The impact of the pandemic on quality of care across chronic conditions.
- The impact of the rising cost of living on people with chronic conditions in terms of their health and well-being.
- The extent to which services will have the capacity to meet future demand with an ageing population.

People living with chronic conditions were already more likely to be in poverty before the cost-of-living crisis. The cost-of-living crisis is a public health emergency and will therefore hit people with chronic conditions harder. The National Survey for Wales results (2021-22) indicate that 19% of those living with a long-term condition experience material deprivation compared to 7% of those without a long-term condition.

Long-term conditions also impact on an individual's ability to gain or maintain employment, which has a direct impact on household income. There is strong evidence that high quality, fair work has a positive impact on employee health and well-being, whereas unemployment undermines good health. Factors such as impairments and long-term health conditions act as barriers to people getting and being able to stay in work, exacerbating health inequalities. In Wales only 46.9% of the working aged disabled population are in employment (compared to 79.7% of non-disabled working aged people, amounting to a 33% gap) and we have the highest sickness absence rate of any UK region (2.8% in Wales vs a UK average of 2.2%).

The greatest burden of disease in working age adults in Wales is attributed to mental health (including substance misuse) and musculoskeletal disorders, which is widely reflected in studies looking at the most common reasons for sickness absence. The burden of disease changes with age, with rising levels of cancers (neoplasms), cardiovascular disease, neurological disorders (including dementia), other chronic conditions (such as diabetes) and infectious diseases as people age.

Since the COVID-19 pandemic, the number of working age adults across the UK on long-term sickness absence has risen by over a third of a million, contributing to over half of the rising rates of economic inactivity. This is due to a rise in mental illness and nervous disorders (up 22%), musculoskeletal disorders (up 31%) as well as 'other' which includes a range of conditions including long COVID (up 41%).

Whilst all age groups have seen increases in economic inactivity due to ill-health since 2019, over half (55%) of those now out of the labour market are older workers aged 50-64 years. The lowest paid occupations and sectors less adaptable to hybrid and home working, such as retail, wholesale, transport, health, social care and construction, have higher rates of former workers who became economically inactive due to ill-health.

The role of employers in relation to staff health and well-being is wide-ranging but crucially includes being able to proactively support individuals with chronic conditions to come back to work after periods of absence due to ill-health and to stay in work for the longer term. How well employers and line managers deliver effective and supportive sickness absence management is crucial to achieving this, as is a supportive return to work incorporating phasing and adaptations (for example, phased working hours, the ability to work flexibly, and adaptations to the job role and/or the

working environment) as required. Employers also have an important role in taking a proactive approach to recruiting (as well as retaining) disabled people and those with impairments to help address the current 33% gap in employment outlined above and in recognition that being in work is overall better for an individual's health than not being in work.

Employers therefore play a key role in contributing to the health and well-being of their workforce and consequently, the health and well-being of the population as a whole.

The Healthy Working Wales (HWW) programme delivered by PHW supports employers to create healthy working environments, take action to improve the health and well-being of their staff, manage sickness absence well and engage with employees effectively.

The new HWW delivery model is in the process of being transformed to being delivered virtually to groups of employers rather than the previous one-to-one support offered, in order to reach more employers in Wales at some level and make best use of limited resources. This includes the development of online needs assessment tools for employers to identify priority areas for development and enable virtual capacity building via workshops and webinars to help employers develop their skills and increase their confidence in dealing with health and well-being issues. We are also strengthening guidance and developing toolkits for employers on all aspects of health and well-being, including supporting employees with healthy ageing and health impairments, sickness absence management, equality, diversity and inclusion, and all aspects of fair work.

Until recently, PHW was leading a parallel programme, the Employee Health Management Partnership, in collaboration with partner agencies (including primary care, occupational health, allied health professionals, Department of Work and Pensions [DWP], trade unions and employers) to develop joint approaches to preventing people from falling out of work due to ill-health through better sickness absence management and workplace strategies to support employees with ill-health.

The Partnership agreed the following objectives and has undertaken some work towards them; however the programme is currently in abeyance due to capacity challenges:

- Develop a shared narrative and disseminate key messages about the value and ways of supporting people to stay in work and the importance of good sickness absence management;

- Engender greater understanding of the relationship between health and work among health professionals;
- Develop mutual understanding and action between key agencies working on this agenda at a local level e.g. DWP and NHS/primary care;
- Map and consider mechanisms for better integration of relevant services and initiatives to make best use of limited resources;
- Raise awareness of and address the needs of specific groups in the workforce e.g. older workers, disabled individuals;
- Develop joint resources where gaps are identified e.g. effective absence management and supportive conversations in the workplace;
- Embed workplace health in relevant training, policies and practices e.g. training of health professionals;
- Facilitate more proactive use of the 'fit note' by health professionals.

The 'fit note' allows health professionals to advise an employee 'may be fit for work', taking into account the advice given on the note to encourage people back to work if reasonable adjustments can be made by their employer (e.g., phased return, amended duties, altered hours, work environment/equipment adaptations). By law employers must make reasonable adjustments for disabled employees where needed. Data for England (not currently available for Wales) indicate that only 5.7% of the 8 million fit notes issued by general practices during 2022/23 contained 'maybe fit for work' advice. There is enormous scope to use fit notes more proactively as a supportive tool to ensure individuals with chronic conditions return to work in an adapted way that meets their needs and by so doing preventing them from falling out of work altogether.

To inform a programme of work, the Partnership undertook qualitative research with economically inactive individuals on benefits, DWP work coaches, GPs and employers on barriers and enablers to more proactive use of the fit note.

The costs of energy use within the home will be a significant challenge for those with chronic health conditions or who are terminally ill, particularly those reliant on home medical devices requiring electricity.

Those living in deprived areas are more likely to have pre-existing illnesses that may be exacerbated in winter months. We know that approximately 1 in 3 excess deaths during winter are linked to either living in cold homes or fuel poverty. Significant increases in the costs of energy have increased

the proportion of people in Wales living in fuel poverty, increasing the risk to life posed by cold homes, particularly in winter. At the same time, financial strain from debt, housing instability, unemployment and low income is a primary risk factor for anxiety, depression and even suicide. Furthermore, as is often the case, those who are already struggling will be the hardest hit: this includes people with chronic conditions. Taken together, the outlook for health and well-being across the population in Wales is worrying.

Research partly funded by the NIHR investigated the potential future impact of multi-morbidity among older adults. The study ran a computer model using data on over 300,000 people from three UK population surveys to predict changes in multi-morbidity between 2015 and 2035. It found that by 2035, two-thirds of adults aged over 65 are expected to be living with multiple health conditions. Seventeen percent would be living with four or more diseases, double the number in 2015. One-third of these people would have a mental illness like dementia or depression. Increased life expectancy by around three years for both men and women means people will spend longer living with multi-morbidity.

The estimates have limitations, including self-reporting of conditions and assumptions made around changes in health status. But analyses taking account of such factors gave consistent findings.

The projected increase in multi-morbidity will place greater demand on all areas of health and social care and highlights the need for commissioners to ensure adequate provision of services. It also supports the on-going public health focus on health awareness and disease prevention.

Prevention and lifestyle

- Effectiveness of current measures to tackle lifestyle/behavioural factors (obesity, smoking etc); and to address inequalities and barriers faced by certain groups.
- Action to improve prevention and early intervention (to stop people's health and well-being deteriorating).

PHW's primary focus is on the prevention of ill-health and the reduction of health inequalities. We provide national leadership, co-ordination and support for action to reduce the impact of long-term conditions through

tackling risk factors such as smoking and obesity and by strengthening protective factors such as physical activity and mental well-being.

Investment in health and well-being has wider implications for society and how it operates. A 2016 systematic review of the return on investment of public health interventions demonstrated that on average for every £1 invested in public health, £14 is returned to health services or the wider system. Investing in prevention and early intervention is the right thing to do – it saves lives and money and brings multiple benefits to people's health and well-being.

Public Health Wales' report Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales, provides evidence for the 'best buys' for healthy behaviours. A society that is fully orientated towards enabling health and well-being would be one that also prioritises well-being in its economic decisions – an 'Economy of Well-being'.

A life-course approach can provide a framework for understanding and addressing the root causes of inequalities with prevention and early intervention. Action is needed across the life-course, encompassing early years, children and young people, adults and older adults. Within this, there is a consensus that giving every child the best possible start in life, including through support for parents, is fundamental to stopping health and well-being deteriorating.

Effective action at scale to prevent long-term conditions requires action across the whole of society but also action by governments to mitigate the impact of the commercial determinants of health.[1] There is a need to redress the balance between the public/consumer and industry which spends large sums of money persuading and incentivising people to adopt unhealthy behaviours.

The action taken to curb the impact of tobacco on population health provides an insight into action required to address other behaviours.

Smoking remains the leading risk factor for poor health outcomes, partly because for some diseases the risk remains for several years even after someone has stopped smoking, particularly if they smoked for a long time and because of the wide range of conditions that smoking causes including heart and circulatory disease, dementia, cancers and lung disease.

[1] Commercial determinants of health refer to private/for-profit sector activities impacting public health, including the availability of unhealthy commodities such as tobacco, alcohol, or foods high in fat, salt and/or sugar.

However, smoking rates have reduced significantly over recent decades, with the most recent figures suggesting that around 13% of adults in Wales currently smoke. The Welsh Government launched 'A smoke-free Wales' in 2022 with the goal of reducing smoking rates to below 5% by 2030.

However, dietary factors and overweight and obesity far exceed the impact of tobacco, and whereas rates of smoking are falling, rates of overweight and particularly obesity are still increasing. In 2022, most of the adult population of Wales (62%) were either living with overweight or obesity, and 25% were living with obesity, meaning their weight is at a level where it is likely to affect their health. Rates of obesity are higher in those from more disadvantaged backgrounds.

Our diet (including consumption of alcohol), and whether we are active are the leading behavioural causes of overweight and obesity. Just over a half of adults (56%) reach the level of physical activity recommended by the UK Chief Medical Officers of 150 minutes of moderate or vigorous activity a week. We know that the greatest health gains are to be made from helping the 30% of Welsh adults who are currently inactive (active for less than 30 minutes a week) to become more active.

In 2019 the Faculty of Public Health (FPH) undertook a policy development and research project examining the role of the NHS in the prevention of ill-health. They found current NHS priorities for prevention are predominantly risk factor and single-issue based, e.g. screening programmes or interventions to address smoking or harmful alcohol use. However, NHS leaders were most likely to say that the NHS should be prioritising a systems approach to prevention, followed by embedding prevention into routine practice and clinical pathways.

Achieving a 'systematic, holistic and coordinated approach to prevention' in health and care settings is a strategic aspiration, underpinned in Wales by favourable legislation, policy, and extensive NICE guidance. Converting this aspiration into practice, however, remains challenging due to the scale of the task, complexity of the delivery landscape and competing demands. In 2018/19, PHW's Primary Care Hub began developing a conceptual framework for prevention in clinical settings, which deconstructed the elements of a systematic approach to delivering cost effective prevention activities, at a scale that would result in positive health gain at the population level. After being interrupted by the pandemic, this work has resumed and the PHW IMTP 2023/24 objectives include the translation of the conceptual model into a coordinated approach to prevention, to

facilitate delivery of evidence-based, cost-effective prevention interventions, at scale, in health and care settings. The approach aims to:

1) Strengthen prevention interventions with robust, equitable identification of those at risk and aims to recognise the need for high-quality interventions, adopting 'criteria for prevention' to determine what activities should be delivered to whom, to achieve population level health gain.
2) Support the health and care workforce, recognising their key role as a vehicle to deliver prevention interventions, through addressing their capability, opportunities and motivation to fulfil this role.
3) Develop a systems approach to 'enabling factors' by utilising data, generating and applying evidence, embedding evaluation, addressing resources/ infrastructure needs, and influencing policy levers to achieve equitable delivery of prevention activities at scale, in health and care settings.

Risk factors which contribute to the burden of disease require a comprehensive, whole systems approach, spanning from:

- Primary prevention, which aims to prevent conditions developing.
- Secondary prevention, aimed at reducing the impact of a condition where there is evidence that this has already begun to occur.
- Tertiary prevention, which aims to reduce the morbidity and complications of an established condition.

Behavioural risk factors most commonly require primary prevention approaches, whilst clinical risk factors most commonly require secondary prevention interventions.

The four Chief Medical Officers (CMOs) of the UK recently collectively published an editorial in the BMJ on Restoring and Extending Secondary Prevention, in which they argued that the 'evidence that secondary prevention can substantially reduce disease incidence and progression is some of the strongest in medicine'. They suggest there is a need to ensure that people who are already making contact with all parts of the NHS get the secondary prevention that they need. They also advocate for the need for prevention efforts to be extended to population groups with historically low uptake, recognising that disease prevalence is higher than average in many of these groups, so the benefits of secondary prevention are likely to be even greater.

The effectiveness of measures relates to well-established interventions with known efficacy, such as the management of hypertension, atrial fibrillation

and raised cholesterol, as well as more innovative interventions and models of delivery where the evidence base is developing, such as the All Wales Diabetes Prevention Programme.

Healthy Weight Healthy You

The ability to make healthy behavioural and lifestyle choices are influenced by the environment and systems around us. Overweight and obesity is rapidly becoming the leading cause of years lived in poor health, with disability or early death. Currently in Wales nearly two thirds (62%) of the adult population experience overweight or obesity.

The Healthy Weight Healthy You website now provides an evidence-based, bilingual early lifestyle intervention to support the Welsh population with achieving and maintaining a healthy weight with increasing uptake since its launch in January 2023. This has provided additional capacity for the All Wales Weight Management Pathway which is being developed in each of the health boards in Wales to try to meet the significant and increasing population need for those living with overweight and obesity.

These individual lifestyle and treatment interventions can provide support for those living with overweight and obesity but do not address the wider obesogenic environments that would support healthy choices being the easy choices.

Healthy Weight Healthy Wales

Many of the levers to make significant changes to address obesogenic environments that contribute to overweight and obesity are not within the control of health or individual organisations. Welsh Government launched Healthy Weight Healthy Wales as a long-term strategy to reduce levels of overweight and obesity in the population. It outlines a ten-year strategy and vision for Wales and opportunities to empower people across Wales to make healthier choices which are easy, affordable and sustainable. While is provides a supportive framework for changes to be made over time, it will require a long-term view with ongoing commitment over decades for meaningful change that can address the scale of this challenge.

National Exercise Referral Scheme (NERS)

Being active is dependent on a range of factors but can include where we live; whether we have easy access to places to walk and cycle; whether we have access to frequent and reliable public transport as an alternative to using a car; whether we can afford to go to a gym or leisure centre

regularly; and the kind of work we do. It is recognised that our lives are increasingly sedentary and the need to create opportunities to be active is a relatively recent phenomenon that would not have been recognised by people 100 years ago.

The National Exercise Referral Scheme (NERS) is an evidence-based health intervention incorporating physical activity and behavioural change techniques to support referred individuals to reduce their risk of long-term ill-health by becoming more physically active. NERS provides subsidised access to tailored and supervised exercise for people aged 16 and over who are inactive and at risk of, or currently experiencing, a long-term or chronic health condition.

NERS is funded by Public Health Wales (PHW) which also provides strategic and operational oversight. It is delivered in each of the 22 local authority areas through a grant from PHW which funds 50% of a NERS coordinator as well as exercise referral professionals. The local delivery partners, which include local authorities, leisure trusts and one health board, contribute additional funding and in-kind elements such as use of leisure and community venues and equipment.

In 2010 the scheme was formally evaluated using randomised controlled trial (RCT) methodology which focused on the delivery and impact of the original generic pathway. It found NERS to be a cost-effective intervention for primary and secondary prevention of chronic conditions, especially for coronary heart disease, alongside positive effects on depression and anxiety. Later research to understand 'real world' implementation versus RCT conditions estimated 3.3% of the 'at risk' population were referred during the ten-year period analysed (2008 to 2017). A downward trend over time in referrals from most deprived groups was found alongside a decline in uptake.

Over time, the scheme has developed considerably with variation in delivery between areas. Due to the scheme's success and popularity, capacity is severely stretched in many areas often leading to long waiting times between referral and first appointment. This in turn can lead to high drop-out rates before the first appointment.

NERS has the potential to impact positively on the health of a significant proportion of the adult population through using physical activity to contribute to both primary and secondary prevention of long-term chronic health conditions. PHW is undertaking a review of all aspects of NERS to ensure it can make best use of the available resources to deliver positive

outcomes for those groups in the population with the greatest capacity to benefit as well as to contribute to reducing health inequalities.

Tobacco control

The current prevalence of smoking amongst adults (16+) in Wales is 13%. However, smoking rates are typically higher in groups that are vulnerable or marginalised and/or are experiencing long-term or chronic conditions. For example, English data for 2020-21 suggest that 25.2% of all adults (18+) experiencing any long-term mental health condition and 25.8% of adults with anxiety or depression are smokers. The Welsh Government's Tobacco Control Strategy for Wales and Delivery Plan identifies priority groups to target for cessation support, including those living with deprivation and those from minority ethnic backgrounds. Many of these groups are likely also to include disproportionate numbers of individuals with chronic conditions who are engaging with primary and social care services.

Implementation of tobacco control interventions since the 1980s, and in particular, the consistent focus over the past 25 years, have seen the UK recognised as having amongst the most effective tobacco control policies in Europe. Wales has been a leader in implementing smoke free policies such banning smoking in hospital grounds. The Welsh Government Tobacco Strategy and Delivery Plan has set a goal of reducing the prevalence of smoking in adults (16+) to 5% or less by 2030. The Strategy is focused around three themes: reducing inequalities, future generations and a whole-system approach for a smoke free Wales. The Delivery Plan for 2022-24 identifies five priority action areas: smoke free environments; continuous improvement and supporting innovation; priority groups; tacking illegal tobacco and the tobacco control legal framework; and working across the UK.

Quitting smoking at any age brings health benefits, including for those who already have a chronic disease. Ensuring that smokers with chronic conditions in Wales have access to high quality cessation provision through health and social care services in Wales is an essential element in supporting them to manage their own health effectively and reducing the inequalities.

Help Me Quit (HMQ) is the national brand for smoking cessation services in Wales. HMQ provides evidence-based interventions tailored to the needs of individual smokers via a national hub to co-ordinate referrals and a national telephone support service, both within Public Health Wales and local services managed within local health boards.

A number of current activities led by Public Health Wales working across the system and in alignment with Welsh Government strategies will develop the capacity for those working in NHS and social care services in the community to support those with chronic conditions. These include improving the IT infrastructure for referral and patient management and improving understanding of the profiles and needs of priority groups with relatively high rates of smoking.

Diabetic Eye Screening Wales (DESW)

Diabetes is the leading cause of preventable sight loss in the UK. Making changes to diabetes management, or having specialist treatment, can slow or reverse changes caused by diabetic retinopathy. The aim of the Diabetic Eye Screening Wales (DESW) Programme is to reduce the incidence of sight loss due to diabetic retinopathy – damage to the back of the eye. People with diabetes aged 12 or over are invited to attend a screening appointment. This is a national screening programme with consistent, high standards of service delivery across the whole of Wales and robust assurance processes in place.

At the start of the pandemic in March 2020, Diabetic Eye Screening temporarily paused sending screening invitations. People who had not had their screening pathway completed had their screening results and were referred to hospital eye services if this was required. When screening restarted in September 2020, a risk-based approach was taken with those known to be at higher risk of sight-threatening retinopathy prioritised based on their previous screening result. Additional screening venues were sought to improve screening capacity, which included arts centres, stadiums, scout huts and theatres. In the summer of 2022, PHW opened a screening dedicated venue in Mountain Ash, Rhonda Cynon Taf, which enabled significant increase in availability in this area. A further venue in Llanishen, Cardiff will be opening from May 2023.

The recovery after the pause is still ongoing and is a key focus for PHW. As well as optimising current pathways, transformational work is underway to introduce more innovative approaches, including the upgrade of the DESW IT system. Also, in December 2022, the Welsh Government announced the forthcoming implementation of the Low Risk Recall Pathway based on a recommendation from the Wales Screening Committee. This pathway is planned to be introduced in Wales from summer 2023 and DESW is currently working with key stakeholders to plan the communication of this change.

Screening programmes – tackling inequity across the screening pathway

Screening aims to detect the early stages of disease or prevent disease occurring. Through identification of people at higher risk of having a health condition, more effective treatment options or information can be offered to inform decision-making about their future care. Screening can also reduce the chance of developing a serious condition, preventing ill-health and the harm that would have otherwise occurred.

In 2021, PHW Screening produced an inequity report using data from across screening specifically focused on inequity of uptake across the division for the first time. Previously, each screening programme had produced individual reports.

It described a social gradient, with increasing deprivation resulting in decreasing participation in screening. As people from more deprived communities have higher rates of cancer mortality from bowel, breast and cervical cancer, the people who are at greatest risk have the lowest uptake of preventative screening that can save lives and reduce complications.

This demonstrates the continued need to understand the complex barriers to screening uptake for people from more deprived communities in Wales, who are at higher risk of experiencing chronic conditions.

The Screening Inequity Strategy has highlighted commitments to explore and address potential barriers and enablers across five key areas:

1) **Communication**: including providing clear, consistent and accessible information to enable informed decision making;
2) **Community and engagement:** building sustainable networks with people from local communities, the third sector and statutory organisations, and involving service users and people from underserved groups;
3) **Collaboration:** working across the health system in Wales;
4) **Service delivery**: including mapping service user journeys across the whole pathway and adopting a consistent approach to equity and Health Impact Assessment; and
5) **Data and monitoring:** ensuring that action to address screening inequities is data-driven

Health & Social Care Committee: *Supporting people with chronic conditions*

Public Health Wales Briefing Note for Committee 24th January 2024

18th January 2024

Background

In June 2023, Public Health Wales responded to the Consultation by the Committee. In our submission we identified that Chronic or long-term conditions are experienced by 46% of adults in Wales, with 19% experiencing two or more long-term conditions. Musculoskeletal conditions were the most frequently reported at 16%, followed by heart and circulatory problems (11%) and mental health problems (10%).

These conditions are all characterised by their long-term nature and by the potential for prevention either by detecting risk factors and acting before the disease develops or by effective management of risk once the disease has been diagnosed to prevent exacerbation and recurrence of acute episodes.

There are further common features across many long-term conditions:

- The prevalence of many of these conditions is rising globally as well as in Wales and across the UK, as evidenced by the World Health Organisation, Public Health Wales Disease Prevalence programme, and recent Welsh Government Science Evidence Advice.
- With the rise in prevalence, the impact on peoples' lives worsens as well as increasing preventable cost to the NHS, social care and the economy.
- There is a social gradient, with the poorest typically experiencing worst outcomes across the course of a chronic disease.
- The majority of people who develop one long term condition go on to develop more without the right care and support

The global and western experience suggests strongly that unless we focus on prevention, we will continue to see a rise in need for health and social

care from chronic disease which we will be increasingly unable to sustain financially[1].

Recommended focus of policy

We consider that the evidence suggests there should be two foci of policy on chronic conditions, each of which is necessary to reduce the impact of preventable chronic conditions on the population and its health, and on the Welsh economy:

1. Ensuring that people living with chronic conditions receive care and support that gives them the best possible health outcomes for as long as possible.
2. Ensuring that we make a systematic shift to putting prevention at the core of policies and budgets to halt, then reverse, the decline in preventable long-term conditions.

Putting prevention at the core of chronic conditions response

Many long-term conditions are in principle at least partially if not wholly preventable. The right policy choices and service pathways can prevent onset and prevent avoidable disability and early death. A key policy goal to achieve this would be to address the risk factors which contribute to the prevalence and impact of disease.

This requires a comprehensive approach, split across primary, secondary and tertiary prevention, and the determinants of disease. This includes

- **Primary prevention**, which aims to prevent conditions developing in the first place. Some of this can be achieved in relatively short term (eg reducing smoking in the population and as a result heart disease and cancer). Other work needs a more long-term focus and much of this is needed at a societal level:
  - There is increasing recognition of the role of wider determinants, as drivers of non-communicable diseases, and their influence in shaping the physical and social environments in which people live, work, play, learn and love
  - As recognised in A Healthier Wales, a "health in all policies" approach is needed to make a difference to these wider social and economic influences, such as housing, parenting, education and employability, healthy food

[1] Transforming global approaches to chronic disease prevention and management across the lifespan: integrating genomics, behavior change, and digital health solutions - PMC (nih.gov)

supply and making physical activity and conditions for good resilience and happiness core to everyone's life.

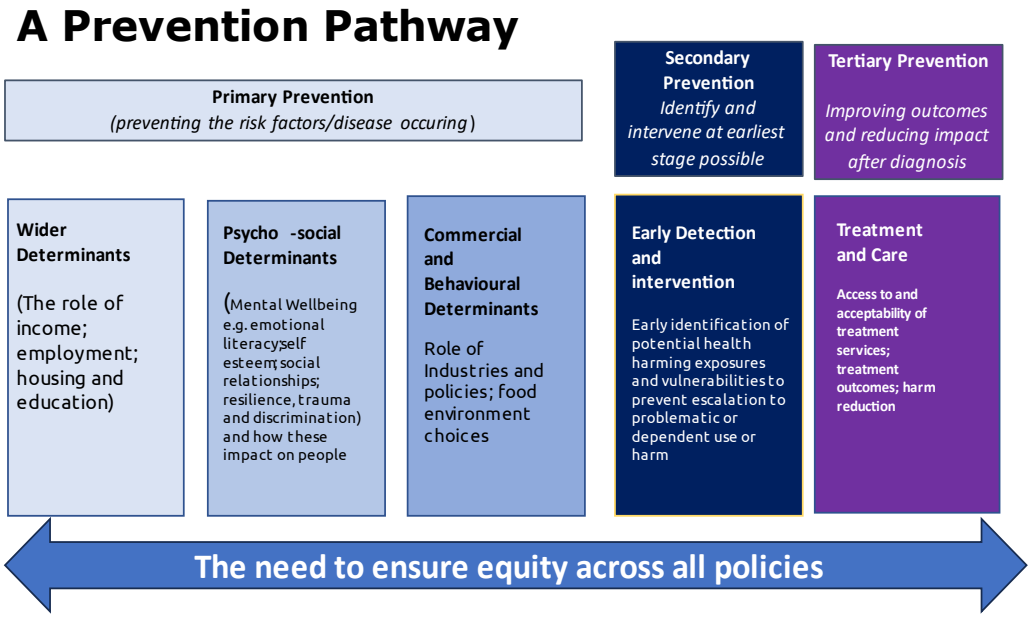
- **Secondary prevention**, aimed at reducing the impact of a condition where there is evidence that this has already begun to occur. The goal here is to identify onset of risk factors and intervene at the earliest opportunity (eg the All Wales Diabetes Prevention Programme)

- **Tertiary prevention**, which aims to reduce the disease, disability, reduction and complications of an established condition. Benefits of undertaking tertiary prevention comprehensively would be

    - Slowing or stopping the progress of disease to complications, disability or death
    - Halting the rise in the proportion of people with one condition developing multiple conditions including poor mental health
    - Slowing then halting the rise in people reporting poor quality of life, inability to work or perform daily activities and as a result needing increasing levels of care

Early intervention can make a substantial difference to peoples' healthy and disability free life expectancy and their quality of life and happiness.

A key point is that addressing chronic conditions needs an approach across all of primary, secondary and tertiary prevention. If primary prevention is neglected, then we will never stop the rise in disease. If tertiary prevention is neglected, then many people with existing disease will progress avoidably to early complications, disability and potentially death. For this reason we recommend a policy approach that adopts a clear pathway to prevention as outlined in the figure below.



Diabetes as an important example

Public Health Wales published prevalence of disease studies on 14th November 2023[2] which showed that there has been a 40 per cent increase in the number of people living with diabetes in Wales in just over the last 10 years - an increase of 60,000 people.

Type 2 diabetes is a leading cause of sight loss and a contributor to kidney failure, heart attack and stroke. In 2021/22 alone, more than 560 people in Wales underwent amputations linked with diabetes. Current estimates suggest 10% of the NHS budget in Wales is spent on the impact of Diabetes. Diabetes related hospital spells cost the Welsh NHS an average of £4,518 per spell in 2021/22, not including spells requiring amputations. £105 million was spent on drugs to manage diabetes in Wales in 2022/23.

More than 200,000 people in Wales are already living with diabetes, around eight per cent of adults. Around 90 per cent of these cases have type 2 diabetes (T2DM), over half of which could be prevented or delayed with behaviour changes.

Projections indicate that by 2035 1 in 11 people could be living with Diabetes Type 2, an increase of 22% or 48,000 new diagnoses. The projections and historical analyses show that the prevalence of diabetes is increasing, and the prevalence of complications in people living with diabetes is increasing. This represents significant preventable cost to the NHS, Social Care and the economy Such an increase in cost and

[2] Diabetes prevalence – trends, risk factors, and 10-year projection - Public Health Wales (nhs.wales)

prevalence would mean more people experience life-limiting illness and potential complications from diabetes, put significant additional pressure on health services and on the economy.

While there are evidence-based programmes in existence to prevent diabetes (including the All-Wales Diabetes Prevention Programme) and enable clinicians and people living with it to have the best possible outcomes, these are not making the scale of impact needed to avoid the projected cost and impact. Diabetes-remission programmes have shown impact for T2DM especially,but a remission programme will not reverse the projected situation in and of itself. The programme is intensive (for some arduous), resource intensive and remission rates decline from one year onwards. This cannot be the main or lasting solution to the rise in prevalence, even though for a defined cohort it will play a part.

Currently Public Health Wales is working with the National Clinical Reference Group for Diabetes, Clinicians, the NHS Value and Sustainability Board, Welsh Value in Health Centre and Welsh Government to develop and agree a programme on Diabetes with the aims of:

- Having more people living well with diabetes (Types 1 and 2) as measured through a reduction in amputations and other diabetes pathways
- Stopping the prevalence of diabetes increasing, focusing principally on T2DM

The importance of Primary Care in supporting people with chronic conditions

The Primary Care Model for Wales recognises the need for a model of care which addresses individuals' social as well as medical needs, and which allows for a more sustainable, holistic approach.

Health and care services, which focus on a single condition alone, are often not person-centred, leading to multiple interactions with healthcare professionals, and an inability to consider a person's needs in a holistic way where the individual is experiencing multi-morbidities/ multiple risk factors. The Prevention Based Health and Care model (PHBC) discussed above, as part of a concerted shift to prevention, could enhance the ability of primary care to enable people with chronic conditions to live as well as possible.

An important issue the committee could ask those it engages with to consider is whether current Primary Care model is optimally designed and resourced to achieve the outcomes that are needed to transform health and wellbeing in Wales.

A Prevention Based Health and Care Framework (PHBC)

In the context of secondary and tertiary prevention, as stated above, many long-term conditions are characterised by their potential for preventive interventions at individual level, either through detecting risk and acting before disease develops, or by effective management of risk to prevent poor outcomes from established disease.

There are many examples of prevention in the NHS and social care, some of which are delivered systematically, e.g. immunisation, screening. However, much of the prevention activity aimed at addressing clinical and behavioural risk factors is opportunistic in nature, implementation may vary in effectiveness, quality and alignment to clinical guidance, and the 'offer' may be inequitable. But the task remains to create the conditions to embed prevention and early intervention into routine care in NHS and social care services.

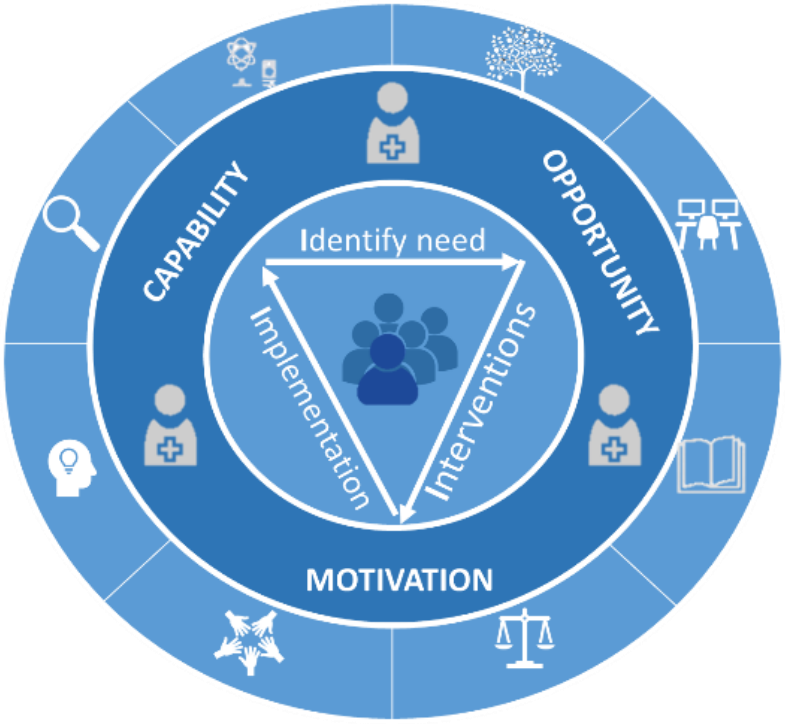
Public Health Wales' Prevention-Based Health and Care (PBHC) Framework looks to maximise the potential population benefits of prevention embedded in health and social care while continuing to meet the needs of individuals and groups. We believe embedding this across health and social care could significantly enhance the impact of secondary and tertiary prevention in supporting people with chronic conditions.

The PBHC Framework encompassing three main components:

1. A ***Prevention Triad***, focussed on:

    1. ***Identification of need***, systematically at both individual and population level
    2. ***Interventions***, which are effective and evidence-based,
    3. ***Implementation***, which is high quality, aligned to the six domains of healthcare quality ie. person-centred, safe, effective, efficient, timely and equitable

2. ***Workforce capability, opportunity and motivation –*** recognising the key role of the workforce, encompassing considerations for the existing workforce as well as recognising emerging evidence for dedicated roles in prevention e.g. social prescribing.



3. ***System factors -*** aligned to the Value in Health programme's 'pillars', these factors recognise that a systems approach can be achieved through: leadership, collaboration and influence, people involvement, engagement and experience, digital health, data and analytics, research, evidence and impact delivering value, and strategic partnerships.

Through a partnership and co-production approach, PBHC is designed to enable stakeholders to identify how PBHC can be embedded at all population levels from neighbourhoods/ clusters, to local authority, health board and national levels

The PBHC Framework, to be published by Public Health Wales in April 2024, will illustrate PBHC in practice by using case studies to recognise existing good practice and exemplars, to demonstrate the application of the framework through condition-based, place-based and lifecourse lenses.

Whilst people can and should be empowered to directly access community assets to support their health and wellbeing, it is recognised that a spectrum of support is required to enable effective behaviour change so that people can engage in activities and access the interventions or services they need. This is illustrated in the diagram below (figure 1). The level of support a person needs will vary over a person's lifetime and be dependent on the circumstances people find themselves in and how we behave towards people seeking support is crucial.

Mental Health

There is growing evidence that people with chronic disease face mental health challenges, and that many people with long term mental ill-health also experience preventable chronic physical diseases, and may have poorer physical health than people without long term mental ill-health[3]. The committee could usefully consider the nuanced inter-relationships between mental and physical ill-health in chronic disease as part of seeking a strategic shift to preventing and managing chronic disease.

Self-Management and peer-support

There is a substantial role for self-management and self-care in chronic disease[4], but this needs to be carefully planned and designed. There is a good body of evidence[5],[6] on the role of self-management for people living with chronic disease, including forty years' experience from HIV and other fields. Self-management and peer support efforts need to be designed in a way which is relevant to peoples' life experience and situation.

Empowering people to take action to support their own health and wellbeing

Public Health Wales contributed a section on empowering people to take action in the National Framework for Social Prescribing publiced by Welsh Government in January 2024. We reproduce part of this section here to assist members:

> *As shown in the diagram, people are often prompted to act following contact with a health or other professional who provides advice, signposting or referral to a specific community asset they feel may be beneficial.*

[3] Supporting the physical health of people with severe mental illness (nihr.ac.uk)
[4] Type 2 diabetes self-management schemas across diverse health literacy levels: a qualitative investigation: Psychology & Health: Vol 37, No 7 (tandfonline.com)
[5] Helping patients help themselves: A systematic review of self-management support strategies in primary health care practice - PMC (nih.gov)
[6] Improving patient education: a new guide for policy-makers and health professionals to support self-management of chronic conditions (who.int)

*'**Making every contact count**' is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.*

*In other circumstances, dedicated wellbeing support is needed to enable behaviour change such as the **help me quit** stop smoking programmes, allowing for a much more detailed discussion between the individual and the professional. As the model for social prescribing in **section 4** demonstrates, social prescribing also involves dedicated time for a detailed discussion to understand 'what matters' to an individual and to develop a person-centred action plan.*

Finally, it is recognised that where people have more complex clinical or social care needs, these may need to be met through statutory healthcare or social care services for example a substance misuse service.

Genomics

While there are some chronic conditions which have a genetic component, the promise of genomics is not yet realisable for every chronic condition and while in some areas these technologies show promise, they will not replace a concerted preventive approach described above in the scale and pace needed to avert increasing growth in avoidable disease, disability and death. For the next generation we will still need a concerted portfolio of prevention activities.

Inequalities

Whilst a number of behavioural and clinical risk factors for the development and progression of chronic conditions can be addressed

through effective self-management, it is also recognised that there are inequalities and wider determinants affecting the ability of people to self-manage these risk factors.

Access to health and care services, the quality of those services and the way they are experienced by people, are determinants of health and may contribute to health inequalities. Health inequalities are differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable.

Supported self-management is therefore important to both reduce inequalities and to improve the effectiveness of self-management.

The impact of additional factors such as the cost-of-living crisis, is likely to exacerbate existing health inequalities. People living with chronic conditions were already more likely to be in poverty before the cost-of-living crisis and this will therefore hit people with chronic conditions harder. The National Survey for Wales results (2021-22) indicate that 19% of those living with a long-term condition experience material deprivation compared to 7% of those without a long-term condition

A life-course approach can provide a framework for understanding and addressing the root causes of inequalities with prevention and early intervention. Action is needed across the life-course, encompassing early years, children and young people, adults and older adults.

Contributors

Amrita Jesurasa, Consultant in Public Health
Jim McManus, National Director of Health and Wellbeing
Zoe Wallace, Director of Primary Care

Y Pwyllgor Iechyd a Gofal Cymdeithasol
–
Health and Social Care Committee

Senedd Cymru
Bae Caerdydd, Caerdydd, CF99 1SN
SeneddIechyd@senedd.cymru
senedd.cymru/SeneddIechyd
0300 200 6565
–
Welsh Parliament
Cardiff Bay, Cardiff, CF99 1SN
SeneddHealth@senedd.wales
senedd.wales/SeneddHealth
0300 200 6565

Eluned Morgan MS
Minister for Health and Social Services

Julie Morgan MS
Deputy Minister for Social Services

Lynne Neagle MS
Deputy Minister for Mental health and Well-being

22 November 2023

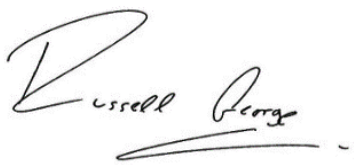
Dear Ministers

Thank you to you and your officials for attending the general scrutiny session on 8 November.

There were a number of matters that we did not have time to discuss with you, and there were a few areas where you agreed to provide further information in writing. There are also a number of questions arising from the announcement made on the day of our meeting about LHB allocations and target control totals.

For convenience, I have set these out in the attached annexe, and I look forward to receiving your response by 10 January 2024.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annexe

Financial pressures

1. Can you provide the total revenue and capital allocations for each health board, which reflect your written statement on 8 November as well as other in-year allocations the Welsh Government may have made since it published the funding for 2023-24 (as set out in the letter to Health Board Chairs in December 2022) in February 2023?
2. In your announcement, you noted that each health board will be required to reduce its planned deficit by 10%. What discussions have you had with health boards about this, and how achievable is it? Why did you decide to adopt the same target for all local health boards?

Your written statement included a breakdown of the additional £460.2m by constituent element and LHB. It said the £460.2m will be issued to LHBs "proportionately according to the established Local Health Board resource allocation formula". Some of the allocations are recurrent (funding for the underlying deficit contribution/COVID legacy, £150m and £186m for inflation) and others on a non-recurrent basis.

3. On what evidence have you determined the amounts to be allocated to health boards on a recurrent and non-recurrent basis and why have you decided to distribute the funding "according to the established Local Health Board resource allocation formula"?
4. In your written statement, you note £336m of the additional allocations will be recurrent and "conditional on each Local Health Board making progress towards the level of deficit which we have set for them to work towards ('target control totals')". What does this mean in practice and what will happen if the health boards do not reduce their planned deficits by the 10% target?
5. In January 2023, your official told the Committee that the Welsh Government would not "bail out organisations that are not managing their core financial position" and it is "not effectively writing off or just giving them money to cover those deficits". How does this fit with the recurrent allocation of £150m to local health boards for the "underlying deficit contribution/COVID legacy". Do you expect the additional funding will put local health boards on a sustainable financial position going forward?
6. Your official told the Committee that the Welsh Government was holding funding in the Main Expenditure Group to cover the target £123m deficit for local health boards. Why did you decide on that approach rather than allocate additional funding to the local health boards?

Public health

7. Why has the Deputy Minister been facing challenges in effectively addressing the issue of obesity? Has the Deputy Minister placed adequate emphasis on addressing the commercial determinants contributing to obesity, such as the availability of unhealthy foods?

Healthcare access

8. To what degree is the Welsh Government evaluating the effectiveness of international models of health and care, and what can Wales learn from different countries' approaches to health and care service delivery, and public health and prevention?

Social care workforce

9. Could the Deputy Minister tell us more about any specific action to retain existing staff in the sector, both in the next 12 months and longer term (given the recent Social Care Wales workforce survey findings that over a quarter of all registered care staff expect to leave the sector within the next 12 months, and 44% in the next five years)?
10. In relation to care staff vacancies, the Deputy Minister said that Welsh Government has made a lot of progress in this area and now has "much more solid data". She agreed to write to the Committee with more detail on this point [RoP, paras 165-170].
11. The Social Care Wales workforce survey found that half of care workers receive no sickness pay when ill. Can the Deputy Minister give an indication of when social care workers can expect to see tangible improvements in this specific area?
12. In relation to the social worker bursary, the Deputy Minister agreed to provide figures for the increase in uptake of the social work degree [RoP, paras 195-199].

Unpaid carers and hospital discharge

13. Last winter, the Welsh Government announced extra 'step down' capacity, with additional community beds to help with hospital discharge pressures. What was the learning from this, and how has it influenced preparations to ease pressures this winter?

Waiting times – diagnostic testing and therapy interventions

The recovery target is to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.

14. What are the reasons behind the challenges and extended waiting times in audiology and endoscopy (identified by Cardiff and Vale UHB)?
15. How are you currently addressing the need for timely access to diagnostics to alleviate patient anxiety and what immediate steps are being taken to support faster and more accurate diagnostic tests?
16. What is your long-term strategy for investment in research and development for diagnostic technologies. Is the healthcare infrastructure fit for purpose to support the implementation of new innovations, including diagnostic labs and equipment?

Cancer waiting times

The recovery target is for cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026. In August 2023, 57.3% of cancer patients started their first definitive treatment within 62 days of first being suspected with cancer (the current target is 75%).

17. Why is the performance in addressing cancer significantly below the desired standards, and what factors contribute to these challenges?
18. Can you confirm that all GP practices in Wales have access to a rapid diagnostic centre (RDC)?
19. How is the Welsh Government planning to expand the availability and accessibility of RDCs, and what strategies are in place to ensure their effectiveness in improving healthcare services?

Waiting times - the seven 'exceptionally challenging specialties'

20. How extensively are health boards using insourcing, outsourcing and engaging the private sector to tackle waiting time challenges?

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AS/MS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health & Wellbeing

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health & Social Care Committee

SeneddHealth@senedd.wales

17 January 2024

Dear Russell

Please see attached our response to the specific issues raised by Members in your correspondence of 22 November, following the Joint general Ministerial scrutiny session of 8 November.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AS/MS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

Written response by the Welsh Government to the Health and Social Care Committee.

Financial pressures

1. **Can you provide the total revenue and capital allocations for each health board, which reflect your written statement on 8 November as well as other in-year allocations the Welsh Government may have made since it published the funding for 2023-24 (as set out in the letter to Health Board Chairs in December 2022) in February 2023?**

   The allocations as set out each year in the main Local Health Boards (LHB) allocation letter are routinely updated for a number of areas on an in-year basis of both centrally held budgets and specific issues that may emerge in-year, such as funding of pay awards. These items are typically listed separately in the letter which accompanies the LHB allocations at the start of a financial year and allocations are issued as the year progresses.

   This year in view of the exceptional financial situation and the impact of inflation and the legacy of Covid on NHS budgets, as a result of the in-year Welsh Government budget exercise we took the approach of issuing a general additional allocation to LHB's as detailed in our written statement on 8 November following the outcome of that in-year exercise.

   Annex 1 provides the updated revenue and capital allocations for each health board as at 31 December 2023.

2. **In your announcement, you noted that each health board will be required to reduce its planned deficit by 10%. What discussions have you had with health boards about this, and how achievable is it? Why did you decide to adopt the same target for all local health boards?**

   The target to reduce planned deficits by 10% was reached following the work undertaken across the Welsh Government this year to reprioritise budgets across portfolios and within the Health and Social Services MEG.

   We have been clear that whilst we would do all we could to support the Boards in 2023/24, that the planned deficit positions were not supportable in full and additional actions would be required to reduce expenditure and forecast deficit positions.

   The percentage represents the residual gap between the additional support we were able to provide and original plans submitted by the Local Health Boards. Given the size of planned deficits across each Health Board, we considered that requiring each organisation to reduce their planned deficit by 10% was the most suitable and equitable way to bridge the gap, and that decisions required on actions to reduce that deficit were best identified and implemented by Local Health Boards. We are working with all organisations to support them to meet their target control totals. There is variation in the delivery of Health Board plans and positions, on an in-year basis, resulting in the challenge to achieving the target control total being more challenging for some Health Boards in terms of additional actions required than others.

3. **Your written statement included a breakdown of the additional £460.2m by constituent element and LHB. It said the £460.2m will be issued to LHBs "proportionately according to the established Local Health Board resource allocation formula". Some of the allocations are recurrent (funding for the underlying deficit contribution/COVID legacy, £150m and £186m for inflation) and others on a non-recurrent basis. On what evidence have you determined the amounts to be allocated to health boards on a recurrent and non-recurrent basis and why have you decided to distribute the funding "according to the established Local Health Board resource allocation formula"?**

   The amounts allocated either recurrently or non-recurrently was based on our assessment of both the funding available at the time of confirmation of those allocations and an assessment of the costs the NHS organisations faced.

   The general approach to allocating funding to Health Boards in NHS Wales is via the resource allocation formula, which is the funding model to support Health Boards in planning and delivering services for the population they serve. This formula considers a number of factors including population which is the primary component of the formula, but also other factors such the differing costs of age and sex, other additional needs such as morbidity, and unavoidable excess costs such as rurality. This formula allows us to allocate funding on an equitable basis to health boards which reflects the needs of their resident populations. As the bulk of these uplifts reflected cost inflation which would be experienced equally across Health Boards in Wales, the most equitable approach was to allocate on the same shares basis as the original allocations made at the start of the financial year.

4. **In your written statement, you note £336m of the additional allocations will be recurrent and "conditional on each Local Health Board making progress towards the level of deficit which we have set for them to work towards ('target control totals')". What does this mean in practice and what will happen if the health boards do not reduce their planned deficits by the 10% target?**

   We are continuing to work with Health Boards to monitor their financial positions, identify actions for improvement, and support their approach to cost reductions and meeting their target deficits, i.e. target control totals.

   The conditionally recurrent allocations act as an incentive to LHBs to meet the deficit reduction requirement I have laid out. Organisations who achieve those target control totals will receive that funding on a recurrent basis. Although not all Boards will achieve those target controls in 2023/24 it is important to have an incentive to continue progress towards financial stability in both this year and future years.

   The 2024/25 allocations continue this approach, the only way to guarantee recurrent funding is to achieve the targets but non recurrent funding will be provided for organisations who continue to engage and make progress with delivering financial sustainability.

5. **In January 2023, your official told the Committee that the Welsh Government would not "bail out organisations that are not managing their core financial position" and it is "not effectively writing off or just giving them money to cover those deficits". How does this fit with the recurrent allocation of £150m to local health boards for the "underlying deficit contribution/COVID legacy". Do you expect the additional funding will put local health boards on a sustainable financial position going forward?**

   In the prior financial year, we agreed to separately fund the costs of Covid and other exceptional costs which had not been taken into account in initial planning for that year, such as the impact of the very high energy prices experienced across the economy. As such our approach was to fund additional costs outside of "core" positions. In 2022/23, six out of the seven Health Boards posted deficit positions against core allocations.

   For the current year we have reshaped our funding approach in light of the pressures experienced by Health Boards. In supporting the NHS to meet the costs of inflationary pressures, Covid legacy impacts and energy costs it was important to recognise that an element of their deficits still included costs which were funded in previous financial years on a non-recurrent basis. This is not a bail out of core positions but a recognition of the on-going increase to the cost base. This includes pressures such as inflation which are cost drivers to all parts of the NHS in the UK, it is not a unique challenge to NHS Wales. For that reason, we are making that support conditionally recurrent.

   Our draft budget demonstrates our commitment to prioritise key front-line services and protect the NHS as much as we are able. Our budget commits to continue the funding provided in year into next financial year and provide a further increase in health funding. Whilst this represents a significant investment, we should be clear that there will still be difficult choices required to achieve a sustainable financial position.

6. **Your official told the Committee that the Welsh Government was holding funding in the Main Expenditure Group to cover the target £123m deficit for local health boards. Why did you decide on that approach rather than allocate additional funding to the local health boards?**

   The target control totals provide a framework for financial control of health boards. They reflect the maximum permitted deficits following the increase in allocations provided in year, following the consistent application of additional funding and planned deficit reductions to Health Boards as set out above.

   As laid out in our written statement the target controls equate to the difference between planned expenditure and the funding provided reflecting costs we are able to recognise this year. The target deficits framework allows a balance between recognition of cost pressures on an equitable basis and holding cover for potential deficit positions, whilst avoiding bail outs for individual Boards who are failing to control their costs in line with national expectations.

Public health

7. **Why has the Deputy Minister been facing challenges in effectively addressing the issue of obesity? Has the Deputy Minister placed adequate emphasis on addressing the commercial determinants contributing to obesity, such as the availability of unhealthy foods?**

Obesity is a complex challenge. Our ten-year strategy *'Healthy Weight, Healthy Wales'* recognises that there is no simple solution. Everyone needs to play a role.

Governments around the world are facing huge challenges from rising levels of obesity, and the solutions are not easy or quick. There are a complex series of inter-related arenas that need action for us to make lasting change. This includes early years and education settings, our food environment, physical activity and active travel and services to support and treat those living with obesity to name just a few.

Healthy food environments play a crucial role in contributing to a reduction in levels of obesity. That is why, following the consultation on Healthy Food Environments last year, I set out my intention to bring forward subordinate legislation in 2024 to restrict the placement and price promotion of products high in fat, sugar, and salt.

Healthcare access

8. **To what degree is the Welsh Government evaluating the effectiveness of international models of health and care, and what can Wales learn from different countries' approaches to health and care service delivery, and public health and prevention?**

As a Government we are committed to developing our approaches in line with international evidence of what works. Wales is part of the Wellbeing Economy Government Network alongside Scotland, New Zealand, Finland and Iceland which brings together governments, advancing the aim of a wellbeing economy. A Wellbeing Economy puts our human and planetary needs at the centre of its activities, ensuring that these needs are all equally met, by default.

Wales is also helping to build, promote and progress wellbeing economies (within and beyond Wales) from a health perspective by working closely with the WHO Regional Office for Europe. This collaboration is enabled by a Memorandum of Understanding (MoU) between the Welsh Government and the WHO Regional Office for Europe focusing on enabling sustainable investment and solutions for accelerating progress towards healthy prosperous lives for everyone in Wales and in the WHO European Region.

A recent International Horizon Scanning and Learning Report published by Public Health Wales on 28 September 2023 introduces health equity and the five essential conditions and is the first of a series of reports delving into each of the five essential conditions in more detail.

OECD PaRIS survey

Wales is one of 20 countries, and the only UK nation, taking part in the OECD's Patient-Reported Indicator Survey (PaRIS) on people living with chronic conditions. This survey will be the first international outcomes-based benchmarking of adults with a chronic condition managed by GP practices. The survey is being carried out by the Welsh Value in Health Centre on behalf of Welsh Government and NHS Wales. The survey asks questions of both patients and providers and is expected to report in the autumn of 2024. It is anticipated that the survey will support a better understanding of the health and care needs of the Welsh population and provide valuable insights on health literacy to inform future public health campaigns.

Social care workforce

9. **Could the Deputy Minister tell us more about any specific action to retain existing staff in the sector, both in the next 12 months and longer term (given the recent Social Care Wales workforce survey findings that over a quarter of all registered care staff expect to leave the sector within the next 12 months, and 44% in the next five years)?**

As a Government we are absolutely committed to addressing the recruitment and retention issues in the sector, however we know that programmes of work being developed to create the sustainable workforce we need, are not quick fixes, and come with the realism that it will take time to feel the impact within the workforce. I have previously mentioned a range of work that will in time, improve conditions for the workforce such as:

- The social worker bursary we have prioritised to continue funding in 2024-25. Our increased funding made a difference to the increase in uptake during this academic year, meaning more students training to become social workers.

- The WLGA are leading work focusing on national approaches to terms and conditions for social workers. This aims to support and attract individuals to the profession and reduce movement of qualified staff due to varying terms and conditions.

- Through the Social Care Fair Work Forum trade unions, employers and Welsh Government continue to work in social partnership on what steps can be taken to improve terms and conditions for social care workers, with improved opportunities for career progression. This includes the development of a draft Pay and Progression Framework for the social care sector that aims to provide more consistent pay, progression and development opportunities by setting out broad bands of roles within social care, aligned with skills, learning and pay levels.

- Through Canopi, Welsh Government also provides social care staff confidential and free access to various levels of mental health support.

We are committed to continue working with the sector and stakeholders to support both recruitment and retention in social care. The demand for social care will continue to grow, so it's essential we all have effective workforce planning systems in place to

meet this demand. With partnership working and the dedicated and skilled workforce already in place, I am committed to overcoming our current challenges.

10. **In relation to care staff vacancies, the Deputy Minister said that Welsh Government has made a lot of progress in this area and now has "much more solid data". She agreed to write to the Committee with more detail on this point [RoP, paras 165-170].**

Work on improving the data in relation to social care vacancies is on-going, and we continue to work with partners to strengthen and enhance the information we have access to.

Local authorities are also providing monthly data to Welsh Government around workforce status and the pressures resulting from any vacancies and absence. This data is shared with stakeholders to support sector planning and delivery.

The *WeCare Wales* platform is continuing to develop with the intention of providing more detailed and accurate vacancy and recruitment data. During 2024 the aim is for more data to be made available relating to the number and types of vacancies in social care. This will also help to make links to the outcome of vacancies and how many vacancies are filled.

Social Care Wales continues to lead on the collection of workforce data. On an annual basis, an in-depth report is provided on the status of the workforce, which includes vacancy data.

11. **The Social Care Wales workforce survey found that half of care workers receive no sickness pay when ill. Can the Deputy Minister give an indication of when social care workers can expect to see tangible improvements in this specific area?**

Officials continue to work in social partnership with the Social Care Fair Work Forum to explore recommendations made by the Forum to us earlier in the year on short-, medium- and long-term action on sickness pay.

Work has focussed on enhancing wrap-around services in areas, such as wellbeing is a fundamental principle which underpins the health and social care workforce strategy and menopause support, which is currently being progressed.

Last year Canopi, which is funded by Welsh Government and run by Cardiff University, extended its confidential and personalised service of support and advice to social care staff, including frontline social care workers, personal assistants, and administrative and managerial staff. This service offers social care staff free access to self-help and guided self-help resources, support from colleagues and virtual therapy sessions.

Turning to the next financial year the pressures we have sought to address this year will be even more difficult next year, however as a Government we will continue to make financial decisions guided by our principles and values, protecting the people of Wales and Welsh public services as much as possible from the current pressures we face.

12. In relation to the social worker bursary, the Deputy Minister agreed to provide figures for the increase in uptake of the social work degree [RoP, paras 195-199].

As at December 2023 I can confirm that figures show 174 new students taking up the social worker bursary in 2023/24, in comparison to 154 in the previous year. This does come with a caveat that throughout the academic year this can change with students deciding either not to pursue courses or beginning courses later in the academic year. Until the end of this academic year these figures have and could continue to vary slightly.

Unpaid carers and hospital discharge

13. Last winter, the Welsh Government announced extra 'step down' capacity, with additional community beds to help with hospital discharge pressures. What was the learning from this, and how has it influenced preparations to ease pressures this winter?

In winter 2022/23 we brought partners together through a Care Action Committee in order to focus on developing extra community 'step down' beds to support system flow. In total an additional 678 step down beds/or community equivalent were established.

Learning from the exercise illustrated the benefits and impacts of health and social care partners working together in a targeted way to support wider system performance. This targeted approach also helped to focus efforts on areas of greatest impact.

Using a similar method, in 2023 we have placed a targeted focus on monitoring and reducing delayed pathways of care due to assessment delays. They have also challenged health and social care delivery partners to increase the capacity of trusted assessors to support more timely assessment and discharge. Between February and November 2023 the numbers of trusted assessor functions were increased by 105% (from 144 – 296) and the assessment delays reduced by 24% (from 1010 – 769)

Building on this approach, moving into winter 2023/24 we have re-established the Care Action Committee and set three key priority areas for action, providing an additional £8.24m to support this work. The three main priorities are;

- Reduced pathways of care delays due to assessment delays.
- Increased community nursing hours at weekends.
- Increase in number of people supported through enhance community care (virtual wards).

The Care Action Committee is meeting monthly to monitor progress and the impacts of this targeted work.

Waiting times – diagnostic testing and therapy interventions

14. The recovery target is to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. What are the reasons behind the challenges and extended waiting times in audiology and endoscopy (identified by Cardiff and Vale UHB)?

Increase in audiology waits: Due to pathway redesign in ENT services, a number of pathways have been redirected to audiology as appropriate for their clinical need. This has resulted in waits for first hearing aids increasing. The health board have indicated they have targeted investment plans for Q4 (January to March 2024) to address this backlog in audiology. They are aiming to get waits back below 14 weeks, while also working on more sustainable plans for future delivery.

Increase in endoscopy waits: While additional capacity has been secured and delivered it has been targeted at supporting effective and timely cancer pathways, aiming to achieve the internal management target of 14 days. They have indicate this will be achieved by January 2024. The health board is then prioritising surveillance patient pathways with an aim to clear the backlog by February 2024. Additional capacity comes online in 2024 through recent Welsh Government investment this will start to reduce the routine over 8-week backlog which my officials will closely monitor.

15. How are you currently addressing the need for timely access to diagnostics to alleviate patient anxiety and what immediate steps are being taken to support faster and more accurate diagnostic tests?

Timely diagnostic tests are a critical step in effective planned care pathways. This is one of the commitments of the planned care recovery plan. A national diagnostic board and strategy has been established to provide clinical leadership and national guidance to improve diagnostic planning and delivery. This is supported by dedicated resources in the NHS executive to ensure the NHS implement the national guidance locally and regionally.

Pathway redesign both at the referral stage with primary care and in hospital pathways are identifying the most effective time for tests as early as possible in the pathway.

Through the national pathway alliance work, referral pathways are being developed to identify where it is most appropriate that they go straight to an agreed diagnostic test, the aim being to speed-up the process of identifying what treatment may be required. This is being led by the national clinical implementation networks of the planned care programme working with primary care and the diagnostic network.

Significant investment has been provided to improve the availability of diagnostic equipment, supported on some hospital sites by additional mobile units.

Agreed diagnostic tests are an integral part of the nationally agreed cancer pathways. Cancer diagnostic pathways are prioritised to support an early diagnosis and treatment. The significant increase in referrals seen in 2023 has put additional pressure on diagnostics in particular endoscopy.

As you indicate early diagnostics with appropriate tests can significantly help to elevate worry. The high percentage (over 90%) of suspected cancer pathways that turn out not to be cancer, demonstrates how timely diagnostics can help to elevate worry.

October 2023 data demonstrates this fact:

- **16,535** pathways were **opened during the month** following a new suspicion of cancer. This was 583 higher than the previous month and 986 higher than the same month last year.
- **14,889** pathways were **closed** following the patient being informed that they do not have cancer. This was 899 higher than the previous month and 298 higher than the same month last year.

I previously indicated to further support future diagnostic capacity national work is being undertaken by HEIW to identify future training and recruitment needs for the diagnostic workforce of the future. Each of the three regions have plans to develop regional diagnostic services based on the national guidance and future pathways, this will require additional staff.

16. **What is your long-term strategy for investment in research and development for diagnostic technologies. Is the healthcare infrastructure fit for purpose to support the implementation of new innovations, including diagnostic labs and equipment?**

The Diagnostics Strategy for Wales, published in April 2023, identified the need to focus on research and innovation. This includes having trusted partnerships with industry and academia to drive investment and create an environment for collaborative working across organisational boundaries.

Welsh Government have continued to invest in diagnostics – as an example, Canolfan Iechyd Genomig Cymru / Wales Genomic Health Centre opened in December 2023 provides clinical and research laboratories and purpose-built clinical spaces to facilitate trusted partnerships, bringing patients right alongside research to continually expand treatment options and improve care outcomes.

Investment has been made in the RISP (Radiology Informatics System Procurement) Programme which will see all Radiology Information Systems including PACS (Picture Archiving and Communication system for storing and transmitting images) standardised to create a single national imaging system within Wales. This will have many benefits including reducing the risk of repeat examinations for patients, reduced number of incidents due to insufficient or missing information and supporting regional and national working. There is a staged approach to implementation of RISP within Health Boards but it is due to be fully in place by 2026.

The national Laboratory Information Management System (LIMS2) has also been invested in with upgrades due for completion across all Health Boards by August 2025.

Recent capital funding for Diagnostics supported additional digital storage for Pathology services in every Health Board to enable current Digital Cellular Pathology

services to continue and for Genomics, additional shared archival storage which enables Genomic Partnership Wales to deliver on their own and partners data protection needs and safeguarding requirements and uninterrupted operations without the threat of running out of storage space, based on current projected need.

Cancer waiting times

17. **The recovery target is for cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026. In August 2023, 57.3% of cancer patients started their first definitive treatment within 62 days of first being suspected with cancer (the current target is 75%). Why is the performance in addressing cancer significantly below the desired standards, and what factors contribute to these challenges?**

Cancer incidence (the number of new cases) has been rising over the long-term. This reflects that the population is both growing and ageing, therefore there are more people, and more people are living longer, which means more cases of cancer will be diagnosed. Health boards and trusts can to some extent keep pace with increases in demand for treatment, as this rises at a relatively low rate per year. However, there are three other aspects that make the rise in demand for cancer care difficult to treat within target time.

The first is that in order to diagnose cancer earlier, the NHS is deliberately referring people at very low risk of having cancer, to identify more cases at earlier stages, because their treatment options will be better. In other words, the NHS is referring tens of thousands more people to find cancers earlier. These all require investigation and outpatient care and limits the capacity of the NHS to arrange treatment for those that are confirmed to have a cancer.

The second factor is that the cost and complexity of the care now available to treat cancer has increased significantly. For instance, there are now multiple lines of therapy available for the same conditions, meaning patients are treated for much longer in many cases. New treatments are often more complex to plan and deliver. For instance, if they require genomic testing and more toxicity management. Some new cancer therapies can also be very expensive, such as CAR-T.

It is also now widely accepted that multi-disciplinary management (care involving lots of different specialist clinicians) produces better outcomes. This means pathways require the involvement of many different specialists, both medical and non-medical, to manage each patient.

The third factor is the general increase in demand for wider planned care. People being referred, investigated, and to some extent treated for cancer, require access to services that deliver most other planned care. Examples of this would include consultation with the GP, referral for a CT or MRI scan, an outpatient appointment with a medical specialty other than oncology, and access to some forms of surgery. These services deliver a much larger volume of care for non-cancer cases. Therefore, increases in population need for services such as imaging and endoscopy, have knock on implications for the capacity that is available to investigate and treat cancer. The allocation of the available NHS capacity requires constant reassessment of the

relative clinical urgency of all the demand facing health boards. In other words, apart from oncology services delivered through the three regional tertiary centres, most of the cancer pathway is delivered by general NHS capacity for planned care.

This pattern is seen across the UK and is not confined to Wales. However, there is also one additional factor specific to Wales. We have overhauled how we measure people waiting for cancer care. We merged the old USC and Non-USC pathways into one single cancer pathway and started the waiting time clock at an earlier point: the 'point of suspicion'. This is unique in the UK and means we count everyone on one pathway, and we start the waiting time clock earlier than other parts of the UK. We have also overhauled how we identify and track patients – which led to an increase in the number of people being tracked in health boards as being on a cancer pathway.

Nonetheless, improvement in cancer waiting time performance is a national planning priority. This is clearly described in the NHS planning framework, the NHS performance framework, and in the way the national accountability processes for NHS oversight are delivered. There is regular and frequent contact with the NHS on cancer performance. This includes additional dedicated accountability meetings specifically for cancer performance. Cancer performance is also a key factor in a number of health board escalation statuses. And in recognition of the need to recover cancer performance, funding has been confirmed to support the NHS Executive to lead a national intervention to implement nationally agreed pathways of care to improve cancer performance for the three most challenged types: urological, gynaecological, and lower gastrointestinal cancers. This work includes wider improvements to how health boards forecast and plan their required diagnostic and treatment activity.

18. **Can you confirm that all GP practices in Wales have access to a rapid diagnostic centre (RDC)?**

    Yes, all health board populations now have access to a Rapid Diagnostic Centre.

19. **How is the Welsh Government planning to expand the availability and accessibility of RDCs, and what strategies are in place to ensure their effectiveness in improving healthcare services?**

    Health boards are responsible for planning and delivering healthcare services, including Rapid Diagnostic Centres, according to their population need. The National Strategic Network for Cancer has developed a national service specification for RDCs that health boards should use to plan their service and its evaluation of the national Rapid Diagnostic Centre programme is due by the end of March 2024. Previous evaluations of the pilot sites indicated RDCs are well liked by patients and clinicians, are cost effective, shorten the patient pathway, and are successful at identifying or ruling out cancer among people with vague symptoms of the disease. The Welsh Government issued a Welsh Health Circular to health boards on implementing national optimal pathways, and this includes a pathway for vague symptoms. We are also working with health boards to integrate RDC data into cancer waiting time data.

Waiting times - the seven 'exceptionally challenging specialties'

20. How extensively are health boards using insourcing, outsourcing and engaging the private sector to tackle waiting time challenges?

The Welsh Government does not hold this level of detail, as it is the NHS who are responsible for commissioning, this will vary by health board depending on their local need. Health boards have been encouraged to commission additional resources as they feel appropriate including working with NHS England and the private sector. We have been very clear that this has to form part of their overall financial envelope. Additional investment above their core allocation has been provided to support additional commissioning this has been manged locally by each HB to support their own agreed provider plans.

Annex 1

LHB Revenue Allocations	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Main LHB Allocation (WHC/2022/034)	1,480.447	1,821.130	1,104.716	1,178.483	995.576	353.011	1,029.959	**7,963.322**
Underlying Deficit - £150m (Conditionally Recurrent)	28.800	33.300	20.300	22.800	19.200	6.300	19.300	**150.000**
Inflationary Uplift - £186m (Conditionally Recurrent)	35.700	41.300	25.100	28.300	23.800	7.900	24.000	**186.100**
Inflationary Uplift - £75m (Non Recurrent)	14.400	16.700	10.100	11.400	9.600	3.200	9.700	**75.100**
Excess Energy Cost - Qtr. 1 and 2 (Part of £49.2m)	3.106	3.270	3.317	3.505	1.432	0.796	1.950	**17.376**
A4C NHS Recovery Staff Payment (3%)	13.194	18.156	14.893	11.620	10.287	2.263	12.499	**82.912**
Planned Care Transformation & Recovery Fund	6.040	7.160	6.400	7.300	6.600	1.000	15.500	**50.000**
Mental Health - In-Year Allocations	7.498	9.436	6.213	7.470	6.323	4.844	6.022	**47.806**
COVID 19 related support - Qtr. 1 and 2	5.964	7.728	6.619	4.456	4.311	1.667	4.742	**35.487**
Dental & Pharmacy (Primary Care) Contract Uplift (5%)	3.499	3.718	2.807	2.679	2.165	0.781	2.420	**18.069**
Other In Year Allocations	20.007	29.487	15.519	17.812	11.676	6.975	12.422	**113.899**
Technical Adjustment - IFRS16 & Baseline Depreciation Adjustment	24.710	12.126	17.085	8.636	9.570	1.968	9.776	**83.871**
Total Revenue Resource Limit (RRL) as at 31/12/23	**1,643.365**	**2,003.511**	**1,233.069**	**1,304.462**	**1,100.540**	**390.705**	**1,148.290**	**8,823.942**

LHB Capital Allocations	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Discretionary Capital Budget as at 1/4/2023	6.614	11.399	11.020	6.533	5.435	0.993	4.795	**46.789**
Allocations from All Wales Capital Programme	46.725	14.553	21.785	62.775	35.258	3.676	35.948	**220.720**
Technical Adjustment - IFRS16	-0.211	1.732	7.347	0.154	0.834	0.068	15.522	**25.446**
Total Capital Resource Limit (CRL) as at 31/12/23	**53.128**	**27.684**	**40.152**	**69.462**	**41.527**	**4.737**	**56.265**	**292.955**