Scrutiny of Strategic Partnerships – Betsi Cadwaladr University Health Board - 13.11.24

In response to your letter dated 2nd October 2024, this report has been produced for the Partnership and Regeneration Scrutiny Committee meeting on 13th November 2024, Scrutiny of Strategic Partnerships – Betsi Cadwaladr University Health Board.

1. Health Board Improvement Programme - high level overview

The Health Board's over-riding purpose is to serve its local population by providing high quality, safe, clinically effective services that are sustainable into the future, making best use of the resources available.

Since last attending the last Partnership and Regeneration Scrutiny Committee in November 2023, the Health Board continued on an improvement journey and has made significant inroads in a number of areas. These include Board effectiveness, organisational culture, service quality, patient safety, operational delivery and financial management. While these improvements are a real sign of the Boards commitment to sustainable improvement for people living in North Wales, and the Welsh Government and audit Wales have noted these, there is much still to do.

There is significant focus upon improving those areas that are causing the greatest concern for patients in terms of performance and outcomes, specifically waiting times for planned care and waiting times in Emergency Departments. Both of these areas are now Major Programmes with oversight at the highest level. We can cover these areas in more detail when we present to the Committee.

One area where there has been improvement and a renewed commitment is in partnership working, with Local Authorities being key partners in delivering services, especially for those most vulnerable. A number of examples are detailed in this report and will hopefully reassure members of our refreshed approach to collaborative working.

The latest Welsh Government report about the Health Board's progress under the current special measures' escalation priorities was published on 5th November 2024. The focus over this period has been the response to the serious issues that resulted in our escalation to special measures, developing and building the Board, rebuilding trust and confidence, and putting in place firm foundations for the future.

2. Joint Working between the Health Board and Isle of Anglesey County Council Adults' Services

i) Holyhead frailty project, CRT & RIF update:

The Community Frailty pilot is being run in Holyhead with a focus on reducing the hospital admissions for the high-risk patients registered with the two GP practices in the town.

With the demand in caring for complex patients increasing and resources limited a more seamless service is required to enable individuals to live their life as they want to live it with a coordinated service closer to home. A pilot

was launched in June 2023 following a piece of work carried out by BCU to identify the cohort of patients at high risk of admission. Holyhead was chosen as the pilot area. The aim of the project is to the right care by the right person at the right time and in the right place, through the delivery of a proactive rather than reactive patient-centred service that meets the health and social needs of high-risk individuals within their own community. Effective integration of the Community Resource Team with the wider healthcare economy will maximise on the skillset and resources available. Early intervention; accessible via a centralised streaming hub, will facilitate a seamless and co-ordinated pathway to support service users holistically, increase autonomy and minimise avoidable inpatient admission.

Rapid response is provided following triage by a clinical co-ordinator for the CRT. A daily huddle attended by a member of each core discipline improves communication and effectiveness of care. Advanced Care Plans and Comprehensive Geriatric Assessments are being completed for selected patients.

The first 12 months show a decrease in the Emergency department (ED) attendances, ambulance conveyances, inpatient admission, and length of stay of the high-risk cohort in Holyhead. The Holyhead community resource team (CRT) on Mon has become a team in the true sense of the word, and sickness and turnover of staff has reduced in the pilot area.

ii) Allied Health Professionals (AHP) development in Primary/Community Care

We have recruited to the Enhanced AHP Rehab service, this service is across the West IHC but will initially focus on Mon. The Enhanced AHP rehabilitation team has three work streams:

1. Developing a clinical approach. The Enhanced AHP rehabilitation team has developed a data dashboard to identify people falling into a pattern of increased healthcare use. The team will work proactively with these individuals to plan and coordinate care, aiming to explore what is important to them and ensure that care meets their needs across services.

   A quality improvement approach is being used with PDSA cycles (Plan – Do -Study (outcome /results) – Act (change plan or continue). The clinical approach will evolve over time and will include numerous novel approaches, in the first instance linking across the CRT and Primary care and the embedding of comprehensive geriatric assessments.

2. The Enhanced AHP rehab team will support development in AHP services, looking to support shared approaches. Initial work has focused on development of Multi professional Therapy Assistants competencies and coordination across cluster meetings. Further work is likely to include the embedding of Patient outcomes – measuring patient experience as well as the outcome of the service they have received ,supported through

the use of the Welsh Government ‘s rehabilitation framework to support service development and improvement.

3. Strategic development. The work completed by the Enhanced AHP rehabilitation team is being used to inform strategic discussions, particularly considering coordination across Primary care, Community Care and Therapies and where we hold management of people with complex needs. It is anticipated that the clinical work and outcomes from this will act as a springboard to inform clinical pathways for people with complex needs. Review of individuals experience of care, completed during the Enhanced AHP rehab teams baseline development has been developed into a report to allow focus on key system challenges.

The development of coordination across services may then support future partnership working with key partners of the Health Board, particularly Local Authority.

iii) 2024/25 Winter Plan

The Health Board is currently reviewing its Winter Plan, which will focus on four key areas to ensure readiness for the upcoming season. The first area, Community and Primary Care, includes initiatives such as the frailty programme, the flu vaccination campaign, primary care plans to support high-risk patients, and the enhancement of community pharmacy services.

The second area, Front Door, outlines collaboration with the Welsh Ambulance Service Trust (WAST), Same Day Emergency Care (SDEC) services, and efforts to protect trauma capacity.

The third area, In-Hospital, covers Integrated Health Community (IHC) de-escalation plans, the production of a respiratory escalation plan, the development of criteria-led discharge, and the implementation of a forward-waiting process.

Lastly, Discharge to the Community will focus on collaborative working with social care partners and strengthening the support of community teams to facilitate safe and timely patient discharges.

To kickstart this work, Ysbyty Gwynedd undertook a RESET project during the week commencing 9th September. The aim was reset processes and pathways to how the hospital should be run to alleviate pressures and enhancing the efficiency within both unscheduled and planned care systems. This would then lead to improved patient and staff experiences, with a positive impact on patient outcomes. Doing this would allow an improved baseline to maximise the ability of the organisation to manage winter pressures.

The Reset Project was done through a focused and collaborative approach across the Integrated Health Community and specifically with Local

Authorities. It was structured around three dedicated teams: Front Door Focus/Emergency Department (ED), Board Rounds and flow within the hospital itself, and Discharge/Long Length of Stay, each addressing specific areas of the care pathway.

We would like to place on record and thank Anglesey County Council for fully embracing this project and working alongside us in finding solutions, streamlining the process and pathways, and looking at your own systems in tandem. The key observations from the project are detailed in the report found in Appendix 1.

iv) Cluster Work

Social Prescribing & Inverse Care Law work:

Anglesey's social prescribing project, run by the Community Link team at Medrwn Mon (Anglesey Community Voluntary Council), is an existing example of joint working between the HB , LA and 3rd sector. This was born of collaboration between General Practice, Local Authorities, the Health Board (hospital and community – primarily COTE, therapies and Community Mental Health Team) and the third sector. This was developed with the Model Mon group. Our cluster at the time was focused on schemes to avoid admission of frail elderly patients where possible. Both through support for the Mon Enhanced Care project and separate cluster projects looking at Advanced Care Planning/Treatment Escalation Plans.

Our main social prescribing goals were developed jointly with the local authority to try and promote better social functioning and independence as we age, to benefit individuals themselves, and to hopefully reduce the numbers in the future needing support for frailty. We were seeing an increase in mental health concerns and felt that social prescribing was important to promote wellbeing, particularly to try to De-medicalise low and moderate mental health issues. The scheme has since been able to move on from cluster/ICF/LA funding to self-funding through a variety of grant sources, which is I think unique for cluster projects of this type and scale, and a reflection of the impressive work the Community link team is doing.

The Inverse care law (ICL) program invited and involved various groups and members of all collaboratives and agencies across Anglesey to look at the population needs, particularly where there may be "inverse care" concerns e.g. high need but least input . We used innovative data sources from the ICL team with public health support to identify areas needing support. These data sources are based on WIMD data at LSOA level allowing us to look at various issues affecting our population.

Over a series of events and meetings in partnership with the LA and 3rd sector , Anglesey cluster have agreed three main areas to target.

a. Access to local and social amenities e.g. transport for poorer communities without good infrastructure, ensuring availability of community resources, particularly in more isolated deprived small towns and villages.
b. Continue to focus on unhealthy behaviours and chronic disease management. But ensuring we look at ways of recording offers and invites for screening and care, and highlighting if there is poor uptake or response in deprived areas where the need is likely highest.
c. Children and young people's Health & Wellbeing

Anglesey has now set up a Social Prescribing Working Group which has evolved from the initial Childrens Social Prescribing Group which was the outcome from the ICL work. The working group is active and recently both the working group and the Cluster members came together in a workshop to look at Population Need data and map out Social Prescribing services, to address the gaps in service and to look at what the SP model of delivery should be on the Island to support the population from cradle to grave.

Outcomes from ICL work / meetings on Anglesey - Children Wellbeing:

What is clear from the data is that Anglesey has a high rate of childhood obesity and high rates of children living in deprived areas. Behaviours from childhood have a lasting impact on adult health and wellbeing. Targeting support for children often involves supporting the family.

It was also noted by various children's agencies, LA, schools and medical services (primary and secondary) that we are seeing an increase in concerns around mental health, emotional health and behavioural health.

We agreed that we should aim to look at children's wellbeing as a whole. For inverse care we would want to ensure that we identify and find those most at need in order to better target support. This is likely to be the more deprived areas, but we want to identify and support any and all children who have low levels of activities that contribute towards wellbeing.

We are already seeing a higher demand for children needing support, clearly we want to make sure that we are looking at increased wellbeing activities for these groups, but we feel it is important to look for and identify low wellbeing activity levels in all children of all ages, with the hope that early intervention may lead to fewer children presenting with and needing the type of intensive support seen at present.

It is important that we can signpost and encourage activities that children and families want. The difficulty is keeping an up-to-date repository and knowledge of "what's out there" and helping each individual choose what might be appropriate for them. This is the main purpose of our Community Link Social Prescribing scheme.

As part of this project we have already employed two Local Area Coordinators (LACs – social prescribers) with a focus on mental health and wellbeing in teenagers. We also have family wellbeing practitioners in practices with knowledge of Child and Adolescent Mental Health Services. (CAMHS) and local support services to guide appropriate service and support. Both these teams have been involved in current groups looking at children's

wellbeing and the Community Link team in particular feels that it is well placed to continue to support this work. Schools clearly play an important role and we need to ensure we work closely with the education teams.

Conclusion

In summary, the Health Board has demonstrated significant progress in addressing the critical issues which led to the special measure's intervention. Despite the ongoing financial and workforce challenges, the focus on high-risk areas and the commitment to delivering high-quality, sustainable healthcare services have yielded promising results. The collaborative efforts between the Health Board and Isle of Anglesey County Council, particularly through initiatives like the Holyhead frailty project and social prescribing, underscore the importance of integrated care in improving patient outcomes and reducing hospital admissions.

The Health Board's proactive approach is further evidenced by the comprehensive review and implementation of the 2024/25 Winter Plan, which emphasises readiness across community and primary care, emergency care, in-hospital care, and discharge planning. The successful execution of the Ysbyty Gwynedd RESET project highlights the potential for targeted interventions to alleviate pressures within both unscheduled and planned care systems, ultimately enhancing patient and staff experiences.

While there remains much work to be done, the encouraging signs of improvement and the strong foundation being built provide a positive outlook for the future. Continued collaboration, innovation, and a patient-centred approach will be crucial in achieving the long-term goals of the Health Board and ensuring the well-being of the local population. The ongoing commitment to addressing governance, quality of care, performance, leadership, and financial management issues will be essential in sustaining these improvements and moving towards a more stable and effective healthcare system.

Ysbyty Gwynedd Reset Week

September 2024

RESET Measured Objectives	
An overall reduction in occupied inpatient beds in Ysbyty Gwynedd. (30 beds)	YES
An increase in discharges	YES
Decongestion of ED department	YES
Increase in SDEC activity	NO
Increase in WAST referrals to SDEC	NO
Reduction in speciality review time for patients.	YES
Increased capacity for planned care patients	YES
Reduction in on the day cancellations	YES
Improved theatre efficiency – Late starts, on the day cancellations	YES
Reduction in non-clinical moves across the site	YES

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Medical Outliers

The starting position on Monday 9th September was 82, this reduced each day until until the following Monday when it was 52 **(-37%)**

Surgical Outliers reduced from 29 to 24 during the same period **(-17%)**

37%

Out of Area Patients

Patients from outside of BCUHB started the week with a total of 19 and reduced to 10 **(-47%)**

47%

>7 Days Length of Stay

Starting position was 258. This number reduced day after day to 207 **(-20%)**

20%

> 21 Days Length of Stay

Starting position was 118, this number reduced day after day to 102 **(-14%)**

14%

Admissions

Medical admissions Average week 169 reduced to 150 **(-11%)** during RESET

Surgical admission average week 73 increased to 76 **(4%)**

11%

Discharges

Medical discharges average week 163 increased to 180 **(19%)** during RESET

Surgical discharges average 99 to 118 **(10%)**

19%

The system reset will enhance the efficiency of planned and urgent care services, improving patient and staff experiences and positively impacting patient outcomes.

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YG RESET (2024) Report: Summary & Findings

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Date: 27/09/2024

PART A PRE-IMPLEMENTATION

This report has been conducted to evidence the findings and learning of the Ysbyty Gwynedd RESET project which ran during the week of the 9th of September. The key observations arising within this report will inform the short-term and long-term follow-up work.

What Did We Do?

A focused collaborative approach to reduce the pressures within unscheduled and planned care systems. The project composed of three teams (Front Door Focus/ED, Board rounds, and Discharge/Long Length of Stay), all with distinct focuses.

Underpinning the focus of the project, was the drive to enhance efficiency of both planned and urgent care services, which would ultimately lead to improved patient and staff experiences, positively impacting patient outcomes.

Initial Project Aims

- To de-escalate the acute bed occupancy.
- Create capacity in SDEC allowing unscheduled care pathways.
- Create capacity for DOSA to allow planned care patients to be treated in a timely manner without the risk of cancellation.
- Create capacity for high-level cleaning programme, to reduce the risk of infection and outbreaks.

Objectives

The five-day programme was targeted to deliver collaborative working, momentum and improved performance, to:

- An overall reduction in occupied inpatient beds in Ysbyty Gwynedd. (30 beds)
- An increase in discharges.
- Decongestion of ED department.
- Increase in SDEC activity.
- Increase in WAST referrals to SDEC.
- Reduction in speciality review time for patients.

- Increased capacity for planned care patients.
- Reduction in on the day cancellations.
- Improved theatre efficiency – Late starts, on the day cancellations.
- Reduction in non-clinical moves across the site.

Metrics Available to Monitor Impact

ED Admissions

Discharges

Average Time to Specialty Review – ENT

Average Time to Specialty Review – T&O

Average ED Journey Time

Ambulance Handover Average

ED Occupancy by Hour

SDEC Attendance

Average Decision to Admit to Bed Allocation

Average ED Journey Time – Admitted Patients

Average ED Journey Time – Non-Admitted Patients

Patients with Length of Stay 21 Days or More

Cumulative Length of Stay of 21 Days or More

SDEC Number of Escalated Beds GRAPHS!!

DOSA Number of Escalated Beds

How Did We Do It?

Front Door Focus/ED - There was an operational team who focused upon the specialty waits, particularly Surgical, Trauma & Orthopaedics, and ENT. They aimed to identify any potential communication barriers preventing the update of accurate Symphony data, and identify any challenges relating to internal professional standards - the target for specialty review remained at 1 hour in line with internal professional standards, with a zero tolerance for patients waiting over 2 hours. Alongside this, the ED clinical teams worked with primary care colleagues where possible, to identify alternative pathways, with a targeted focus on utilising SDEC capacity where appropriate. Furthermore, the clinical teams worked with WAST colleagues to identify opportunities for 'fit to sit patients', which would release WAST

vehicles efficiently and safely. The GP admissions bleep (901) was held by a senior decision-maker, who was tasked with identifying appropriate clinical pathways. There was also a local authority representative within the D2RA team for the week.

The team would be composed of each of the following: **Lead, GP, 901 Bleep Holder, D2RA (Social) Operations ED, Operations Medicine, Operations Surgery**

Board rounds – There were two separate Multi-Disciplinary Teams that supported the normal ward teams that undertake board rounds. Their primary task was to identify opportunities to reduce delays and increase discharges, making the process more efficient. They did this through the provision of professional clinical challenge. Both teams visited two wards each daily, and completed a check list task which mirrored the principles outlined within the Board Round SOP document (which was launched during the RESET week). The teams looked at unblocking problems, rather than approaching the board rounds diagnostically.

The two teams would both be composed of each of the following**: Doctor Secondary Care, Doctor Primary Care, Therapist, Pharmacy, Senior Nurse, Operations, Home First Bureau/District Nursing, Mental Health**

Discharge/Long Length of Stay Panel – The Multi-Disciplinary Team met on Tuesday 10th 12:00-15:00. The purpose of the group was to conduct a review of **non-clinically optimised** patients, with a stay of 21 days or over. The group queried the social arrangements for discharge, and asked probing questions to establish the requirements to progress a patient's discharge. The group advised and agreed actions, expectations, and methods of escalation for support.

The findings and conclusions from all three groups were then collated, with the analysis underpinning the daily report. Any trends of note, identifiable patterns, and causes for concern were also included.

PART B POST-IMPLEMENTATION

What did we see including lessons and trends?

ED Story

The **ED Occupancy Heatmap** clearly shows that the occupancy within ED is improved from 11-14th September with the lowest recorded at 27 14/09/2024, compared to a high of 125 in 01/06/2024, across a 16-week period (1st of June – 21st of September 2024).

During the 6-week period **12/08/24-16/09/24**

The 6-week period has been selected as it is the default format of the data on the IRIS dashboard

Triage - on the 12th of September, **PERCENT ARRIVALS TRIAGE UNDER 15 MINS** was 35.7% with a MEDIAN TIME of 26, the highest percentage since the 31st of August, which was 36.5%. The 11th 32.8%, 13th 34.5%, and the 14th 25.2%, were all above the September average 22.9% (1st – 23rd excl. 11th-14th). The 1st of June, which was noted earlier as having the highest ED occupancy heatmap number, had a percentage of just 12.9%.

Date	Arrivals Triage Under 15 Mins (%)
11th Sept	32.8
12th Sept	35.7
13th Sept	34.5
14th Sept	25.2
Sept Average 1st – 23rd (excl. 11th – 14th)	22.9

Dr waits – on the 13th and 14th of September, the **ARRIVAL TO ED CLINICIAN SEEN MINUTES** was 130.25 mins and 133.62 mins, the second-best return in the 6-week period behind 23rd August 113.82 mins. The 11th and 12th were 190.51 mins and 180.99 mins. The average for the 6-week period excluding the 11th-14th was 232.80 mins.

Date	Arrival to ED Clinician Seen (Minutes)
11th Sept	190.51
12th Sept	180.99
13th Sept	130.25
14th Sept	133.62
6-Week Period Average (Excl. 11th – 14th)	232.80

The Ambulance story is - whilst ED occupancy was reduced from 11th-14th September, we didn't see a significant improvement in **PATIENTS BEING OFFLOADED INTO THE DEPARTMENT** immediately on the 11th September (48 [handovers] – 112 mins average). However, over the next 3-4 days, the benefits are clearly seen (12th 42 -47 mins, 13th 42 – 58 mins, 14th 37 – 25 mins). The 12-month average ambulance handover is 100 mins. Further benefits are likely to have been felt across the community with ambulance response, although these are not captured in this summary report. From a system

perspective there were 2 border diverts put in place into YG over this period to YGC. Subsequently, YG supported a full ambulance divert on the 14th of September, resulting in at least 4 additional ambulances into YG.

The following Sunday (15th), saw 47 handovers with an average of 70 mins, before significantly worsening on Monday 16th, with 42 handovers and 118 mins average.

Date	Average Ambulance Handover (Minutes)
11th Sept 24	112
12th Sept 24	47
13th Sept 24	58
14th Sept 24	25
15th Sept 24	70
16th Sept 24	118
12-month average	100
Sept 24 average	116
Aug 24 average	111
Jul 24 average	111

4-Hour Performance

YG 4-hour performance during the RESET period was also improved. From the 9th to the 16th of September, **PERCENTAGE PERFORMANCE FOR 4 HOUR TARGET** was consecutively above 60%, reaching above 70% on ***4 separate occasions***. The highest recorded percentage within this period, was 79.72%, on the 13th of September. The monthly average for September was 63.97%. In August, the longest consecutive streak above 60%, was only 2 days, with the average for the month at 52.02%. in July, the longest consecutive streak above 60%, was 5 days, with the average for the month at 56.19%. In September 2023, the longest consecutive streak above 60%, was 5 days, with the average for the month at 54.82%.

Comparing September 2023 with September 2024 –

Month	**Longest Consecutive Streak Above 60%**	**Days Above 70%**
September 2023	5	0
September 2024	8	5

Date	**Average Percentage (%)**
September 2023 (9th – 16th)	50.4
September 2024 (9th – 16th)	70.3

Escalated Beds – RESET week

Day	Dosa	SDEC
Monday	14	16
Tuesday	16	15
Wednesday	16	15
Thursday	12	11
Friday	8	4
Friday - COP	3	0

The number of escalated beds within **DOSA** dropped sequentially, from 14 at the beginning of the week, to 3 by the close of play on the Friday. The number of escalated beds within **SDEC**, also dropped sequentially, from 16 at the beginning of the week, to 0 by the close of play on the Friday.

Specialty Wait Reviews

During the week of RESET, the ED team noticed that there were issues with the data systems and dashboards, including some recording errors and information delays. It was noted that some patients were absent from IRIS.

Flow Story

The confirmed number of discharges averaged out for the 6 days would be 20, with the potentials for the 6 days averaging at 20. The expedited for the 6 days would be 54. It is important to note that these figures are **IN ADDITION** to ordinary discharge procedure, and would not have arisen, if RESET had not occurred.

Additional Discharges Due to RESET (Averaged for 6-Day Period)

Confirmed No. of Discharges	Potential Discharges	Expedited
20	20	54

Long LOS 21+ - RESET week

Day	Total
Monday	118
Tuesday	116
Wednesday	111
Thursday	107
Friday	106

The total number of patients experiencing a long length of stay of 21 days or over, consistently fell throughout the week of the RESET. The overall drop from Monday to Friday, represented a **10.2%** decrease.

ED Attendance

Date	**Average Daily Attendance**
Jul	154.5
Aug	155.4
Sept (1st – 23rd)	148
RESET (9th – 13th Sept)	147
3 Month Rolling Average (Jul-Sept)	153

RESET –

Date	**Attendance**	**Percentage Difference Rolling Average (3-Month) (%)**
9th Sept	158	+3.3
10th Sept	172	+12.4
11th Sept	133	-13.1
12th Sept	128	-16.33
13th Sept	144	-5.9
3 Month Rolling Average (Jul-Sept)	153	

During the RESET week, Monday the 9th, and Tuesday the 10th, were both above the 3-month rolling average attendance rate. The average daily attendance for the duration of the RESET week, is almost identical (-1), to the daily average attendance for September (1st – 23rd).

GP Admissions Bleep

On reviewing the referrals, each day there were 3-4 patients who were offered alternative pathways to admission that may not have come to fruition, if the level of seniority was absent on the 901 bleep.

Outliers – RESET week

Day	Time	Medical	Surgical
Monday	13:00	80	24
Tuesday	13:00	79	24
Wednesday	13:00	69	25
Thursday	13:00	61	27
Friday	11:15	57	24

The number of medical outliers reduced significantly, from 80 on Monday afternoon, to 57 on the Friday afternoon, representing a **28.8%** decrease.

What Did We Learn?

Listed below, are the insights, challenges, and learnings that would not have been made apparent, had the RESET week not taken place.

Board Round –

Problem faced	**Solution proposed**
The theme of inefficient paperwork was identified – photocopying, email inbox concerns, Tryfan criteria.	Board Round Audit Work & Review Tryfan criteria
A second theme identified related to systems not being kept updated (WPAS & STREAM).	Board round audit work – to include ward staff discharging patients on WPAS
A third theme identified included the poor application of board round principles, such as the low usage of action lists and SORT Principles. Timeliness and attendance of board rounds.	Board round audit work
A fourth theme was identified relating to gaps in discharge planning – What Matters to Me conversations & outlying prior to discharge planning.	Discharge planning

What Next – Including Recommendations

- Following concerns raised in the daily board round debriefs (RESET week) regarding improper focus upon patient deconditioning, Nicola McLardie has arranged a workshop to raise awareness of Sarcopenia and de-conditioning for all YG staff. The structure and plan of the sessions will be confirmed following a meeting on Friday 27th Sept.
- Continuation of board round improvements, including support and training for all staff groups
- West IHC will engage with the BCUHB unscheduled and emergency care major change focus over the coming months. However, the immediate focus following the RESET week will include a continued emphasis on specialty waits, and the continued support to improve board rounds at ward level, including multi-disciplinary engagement and the overall effectiveness of board rounds.
- The Long Length of Stay Tuesday panel will continue

Dashboard/Information Reference

- **ED Occupancy Heatmap:** IRIS – Emergency Department & Unscheduled Care – (Emergency Department Dashboard) – [Filter] Site to YG
- **Triage Wait:** IRIS – (YG Six Goals – UEC Dashboard Draft) – Triage Wait
- **Doctor Wait:** IRIS – (YG Six Goals – UEC Dashboard Draft) – Doctor Wait
- **Ambulance Handovers: - Welsh Ambulance Service Launch Pad**
- **Percentage Performance for 4 Hour Target:** IRIS - Emergency Department & Unscheduled Care – (Combined ED and MIU Performance) – [MIU Filter] Select ED Data Only
- **Patients With Length of Stay Over 21 Days:** IRIS - (YG Six Goals – UEC Dashboard Draft) – Long Length of Stay – [Filter: Age] Select all, remove 0-16
- **Cumulative Length of Stay Over 21 Days:** IRIS - (YG Six Goals – UEC Dashboard Draft) – (LLoS Cumulative Bed Days) – [Filter: Age] Select all, remove 0-16
- **Average Journey Times of ED Patients of Admitted Patients** – IRIS - (YG Six Goals – UEC Dashboard Draft) – [Avg ED Journey Times (Admitted)]
- **Average Journey Times of ED Patients of Non-Admitted Patients** – IRIS - (YG Six Goals – UEC Dashboard Draft) – [Avg ED Journey Times (Non-Admitted)]
- **Average Decision to Admit to Bed Allocation** – IRIS - (YG Six Goals – UEC Dashboard Draft) – [Senior Decision to Admit]
- **Average ED Journey Time** - IRIS - (YG Six Goals – UEC Dashboard Draft) – [Avg ED Journey Times]
- **Average Time to Specialty Review** – IRIS - (YG Six Goals – UEC Dashboard Draft) – [Awaiting Specialty Review] – [Filter: Specialty]

Craffu Partneriaethau Strategol – Scrutiny of Strategic Partnerships

Dyfed Edwards – Cadeirydd / Chair

Ffion Johnstone – Cyfarwyddwr IHC Director

Carol Shillabeer – Prif Weithredwr / Chief Executive

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

13 / 11/ 2024

5 amcan strategol

Ers mynychu'r Pwyllgor Craffu diwethaf rydym wedi cyhoeddi ein Cynllun Tair Blynedd, gan nodi 5 amcan strategol y Bwrdd Iechyd:

1. **Meithrin sefydliad effeithiol**
2. **Datblygu strategaeth a newid parhaol**
3. **Creu diwylliant, arweinyddiaeth ac ymgysylltu tosturiol –**
4. **Gwella ansawdd, deilliannau a phrofiadau**
5. **Sefydlu amgylchedd effeithiol at ddibenion dysgu gwersi**

5 strategic objectives

Since last attending this Scrutiny Committee we have published our Three-Year-Plan, setting out 5 strategic objectives for the Health Board:

1. **Building an effective organisation**
2. **Developing strategy and long-lasting change**
3. **Creating a compassionate culture, leadership and engagement**
4. **Improving quality, outcomes and experience**
5. **Establishing an effective environment for learning**

1. Meithrin sefydliad effeithiol

Llywodraethu: cynnydd sylweddol wedi digwydd

- Adroddiad Archwilio Cymru yn nodi bod effeithiolrwydd y Bwrdd wedi gwella, gan gynnwys perthnasoedd (Chwefror 2024)
- Nifer lawn o Aelodau Annibynnol y Bwrdd ac Aelodau Gweithredol wrthi'n cael eu penodi. Is-bwyllgorau'r Bwrdd wedi'u hailsefydlu ac yn gweithredu'n llawn.

Cyllid: llywodraethu a pherfformiad ariannol gwell yn amlwg

- Archwilio Cymru wedi cyhoeddi barn wir a theg ddiamod ynghylch y cyfrifon.
- Mae hyn yn gyfystyr â chadarnhau bod ein sefyllfa ariannol yn iach wrth adrodd am ein perfformiad ariannol, ac mae'n adlewyrchu'r gwelliannau sylweddol rydym wedi'u gweithredu o ran ein dull o gynllunio a defnyddio ein hadnoddau ledled y sefydliad.

Y model gweithredu: yr angen i wella ein dull o drefnu ein hunain – mae'r gwaith hwnnw wedi dechrau

Building an effective organisation

Governance: significant progress made

- Audit Wales report signals improved Board effectiveness, including relationshsips (Feb 2024)
- Full complement of Independent Board Members with Executive Members appointments underway, Board sub-committees re-established and fully functioning.

Finance: improved governance and financial performance evident

- Audit Wales has given the Health Board an unqualified true and fair opinion on the accounts.
- This represents a clean bill of health on the reporting of our financial performance, and reflects the substantial improvements we have made to the way we plan and use our resources across the organisation

Operating model: need to improve how we organise ourselves – that work has started

2. Datblygu strategaeth a newid parhaol

Strategaeth 10 mlynedd: dechrau gwaith ar yr elfennau hirdymor

- Mae'n hanfodol cydweithio â phobl, cymunedau a phartneriaid i helpu i lywio'r dyfodol

Cynllun Gwasanaethau Clinigol: Mae angen i rai gwasanaethau newid er mwyn galluogi cynaliadwyedd

- Mae rhai gwasanaethau yn gorfod gwneud gormod â'u hadnoddau, a cheir annhegwch o ran darpariaeth ledled y rhanbarth, sy'n golygu y blaenoriaethir arbenigeddau i'w newid

Datblygiadau cyfalaf: helpu i ddarparu gwasanaethau newydd

- Mae cynlluniau ar gyfer Hwb Iechyd a Lles Integredig yng Nghaergybi yn cael eu datblygu mewn partneriaeth â Chyngor Ynys Môn. Cafodd yr Achos Amlinellol Strategol ei gefnogi gan y Bwrdd Iechyd ar 26 Medi 2024, a chan Uwch Dîm Arwain Cyngor Sir Ynys Môn yn ddiweddarach. Cafodd ei gyflwyno i Lywodraeth Cymru yn cynnwys y ffurf gais IRCF gysylltiedig ar 17 Hydref 2024.

Digidol: cynnydd da yn digwydd

- Achos Busnes llwyddiannus i LIC i sefydlu Cofnod Iechyd Electronig (EHR) yn y Gwasanaethau Iechyd Meddwl – ni yw'r cyntaf i wneud hynny yng Nghymru
- Achos Amlinellol Strategol i gyfiawnhau Cofnod Iechyd Electronig ar gyfer y sefydliad cyfan wedi'i anfon at LIC– bydd hynny'n cynorthwyo i drawsnewid y gwasanaethau iechyd a ddarperir, a chynorthwyo cydweithwyr i sicrhau gofal rhagorol, bob tro

Developing strategy and long lasting change

10 year strategy: starting work on the long-term

- Essential to work with people, communities and partners to help shape the future

Clinical Services Plan: Some services need to change to enable sustainability

- Some services are being spread too thin and there is inequity of provision across the region, meaning that specialities will be prioritised for change

Capital developments: helping new service provision

- Plans for an integrated Health and Wellbeing Hub in Holyhead are being developed in partnership with Anglesey Council. The Strategic Outline Case was endorsed by the Health Board on the 26th of September 2024, and afterwards Isle of Anglesey County Council's Senior Leadership Team. It was submitted to Welsh Government with the accompanying IRCF application form on the 17th October 2024.

Digital: good progress being made

- Successful Business case to WG for an Electronic Health Care Record (EHR), in Mental Health services, leading in Wales
- A Strategic Outline Case for a whole organisation Electronic Health Record has been submitted to WG – key to supporting the transformation of the health care service provision, supporting colleagues deliver great care, every time

3. Creu diwylliant, arweinyddiaeth ac ymgysylltu tosturiol
Creating a compassionate culture, leadership and engagement

Diwylliant: gwaith sy'n mynd rhagddo

- rhaglen gwella diwylliant wedi dechrau ers tro
- rydym wrthi'n ail-lunio ein fframwaith gwerthoedd ac ymddygiadau ar y cyd â staff a phartneriaid

Culture: work underway

- culture change programme is well underway
- we are in the process of redesigning our values and behaviours framework with staff and partners

Ymgysylltu â dinasyddion: cynyddu ac adnewyddu'r ffocws

- cynnwys ein cymunedau, gan fynd ati'n rhagweithiol i geisio barn ac adborth i ddylanwadu ar benderfyniadau a wneir a dulliau o redeg gwasanaethau.
- sioeau teithiol gyda arddangosfeydd gan nifer o'n gwasanaethau rheng flaen. Gelwir rhain yn 'sgyrsiau â'r cyhoedd' a chânt eu cynnal ledled Gogledd Cymru i wrando ar bryderon pobl a rhannu gwybodaeth am ein cynlluniau.

Citizen engagement: increased and refreshed focus

- involving our communities, proactively seeking input and feedback to influence decision making and the way services are run.
- roadshows involving displays by several of our front-line services. Billed as 'conversations with the public', these are held across North Wales to listen to people's concerns and to share our plans.

Bod yn bartner da: beth sy'n bwysig i ni ym marn partneriaid

- Ystyried ein dull o ymdrin â phartneriaethau ffurfiol (RPB, PSB ac ati)
- Ceisio cyfranogi mwy yng nghynlluniau ein partneriaid yn ogystal â'u cynnwys yn ein cynlluniau ni.

Being a good partner: what partners think matters to us

- Considering our approach to formal partnerships (RPB, PSB, etc)
- Seeking greater involvement with partner's plans as well as involving them in ours

4. Gwella ansawdd, deilliannau a phrofiadau | Improving quality, outcomes and experience

Ansawdd: mae cynnydd pwysig wedi digwydd ond mae angen gwneud rhagor

- Cymeradwywyd dull y System Rheoli Ansawdd gan y Bwrdd (mae'n cael ei rhoi ar waith erbyn hyn)
- Wedi gwella ein gallu i ymateb i gwynion (cyflawnwyd targed o 75% o ymatebion ymhen 30 diwrnod - 16% oedd hynny cyn dechrau gwella)
- Cwblhawyd adolygiad manwl o ymchwiliadau, ac yn sgil hynny, sefydlwyd Polisi Trin Cwynion Integredig sydd wedi'i gymeradwyo gan y Bwrdd (mae'n cael ei roi ar waith erbyn hyn)
- Ehangu cyfleoedd i gael Adborth ynghylch Profiad Cleifion. Ystyrir negeseuon allweddol gan y Bwrdd.

Atal: mae camau'n digwydd yn nhrefn blaenoriaeth

- Lansiwyd rhaglen trawsnewid llwybrau diabetes i wella'r cymorth â gynigir i bobl sydd mewn perygl o gael eu heffeithio gan ddiabetes a phobl sy'n cael eu heffeithio gan ddiabetes yn eu cymunedau
- Cydweithio â phartneriaid i ddatblygu rhaglen Gogledd Cymru Iach i helpu pobl i fod yn iach yn eu cymunedau
- Mae ysmygu yn dal yn faes allweddol– cydnabyddir bod y Bwrdd Iechyd yn arloesi yn y maes ledled Cymru
- Imiwneiddio – mae'n dal yn allweddol, ac mae dull gweithredu newydd yn cael ei lunio

Quality: important progress made, more to do

- Quality Management System approach approved by Board, now being implemented
- Improved responsiveness to complaints (achieved target of 75% response within 30 days, from starting point of 16%)
- Deep dive review of investigations completed, led to new Integrated Concerns Policy approved by Board, now being implemented
- Increased rollout of Patient Experience Feedback. Key messages considered by Board.

Prevention: prioritised action being taken

- Launched a diabetes pathway transformation programme to improve support for people at risk of and living with diabetes in their communities
- Working with partners on a Well North Wales programme to help people stay healthy in their communities
- Smoking continues to be a key area – HB recognised as leading the way in Wales
- Immunisation – remains key, revised approach being designed

4. Gwella ansawdd, deilliannau a phrofiadau | Improving quality, outcomes and experience

Gofal Sylfaenol: Mae cynnydd yn digwydd, ond mae dal heriau

- Llwyddwyd i recriwtio meddygon teulu i weithio mewn sawl ardal yn y rhanbarth.
- Blaenoriaeth i fynd i'r afael â heriau o ran darpariaeth gwasanaethau deintyddol

Gofal wedi'i gynllunio: pwyslais sylweddol ar wella amseroedd aros

- Gostyngiad o 40% yn nifer sy'n aros ers cyfnod eithriadol o dros y 12 wythnos diwethaf.
- Comisiynnu gweithgarwch ychwanegol ym meysydd dermatoleg, endosgopi a radioleg, ac mae rhagor o wasanaethau yn yr arfaeth

Gofal brys a gofal mewn argyfwng: maes sy'n her sylweddol

- Pwyslais sylweddol ar ofal brys, gan weithio ar draws safleoedd a chydweithio â phartneriaid i gynyddu llif a rheoli'r galw
- Ar unrhyw adeg, bydd dros 300 o bobl yn profi oedi o ran eu llwybr gofal yn rheolaidd.
- Gwella Iechyd Cymru yn dad-ddwysáu statws 'gwasanaethau sy'n peri pryder' y gwasanaethau fasgwlaidd ac Adran Achosion Brys Ysbyty Glan Clwyd.

Primary Care: Progress being made, challenges still exist

- Positive recruitment of GPs in several areas in the region
- Challenges with dental care provision being tackled as a matter of urgency

Planned care: Major focus on improving waiting times

- 40% reduction in extreme waiting over the last 12 weeks
- Commissioning additional activity for dermatology, endoscopy, and radiology with more services being planned

Urgent and emergency care: significant area of challenge

- Significant focus on emergency care, working across sites and with partners to increase flow and manage demand
- At any one time, over 300 people regularly experience a delay in their pathway of care
- De-escalation of vascular services and Ysbyty Glan Clwyd's Emergency Department as services of serious concern (by Health Inspectorate Wales)

5. Sefydlu amgylchedd effeithiol ar gyfer dysgu | Establishing an effective environment for learning

Cydweithio â Phrifysgolion/Sefydliadau Addysg Bellach: Mae cynnydd da wedi digwydd, ond mae rhagor o gyfleoedd ar gael

- Lansio Ysgol Feddygol Gogledd Cymru trwy bartneriaeth â Phrifysgol Bangor.
- Mae gwaith yn mynd rhagddo i ddatblygu Ysgol Fferylliaeth ar gyfer Gogledd Cymru ac mae datblygiadau ychwanegol posibl yn yr arfaeth.

Sefydliad sy'n dysgu: amlygir arwyddion sy'n profi ein bod yn datblygu sefydliad sy'n dysgu

- Cydweithio â defnyddwyr gwasanaethau, teuluoedd a gofalwyr i ddysgu gwersi o'u profiadau, yn enwedig meysydd sydd wedi peri pryder yn flaenorol, e.e. IM a Gwasanaethau Fasgwlaidd
- Dysgu gwersi yn sgil cwestau – mae'r archwiliad manwl bellach wedi'i gwblhau; ymdrinnir â phob achos y bydd angen ymateb dilynol iddo.
- Mae'r dull sy'n seiliedig ar ddirnad gwybodaeth yn cael ei ddatblygu, a byddwn yn parhau i'w ehangu yn y tymor canolig.

Working with Universities/Further Education: Good progress, but more opportunity exists

- Launch of the North Wales Medical School in partnership with Bangor University
- Work on Pharmacy School for North Wales and potential further developments underway.

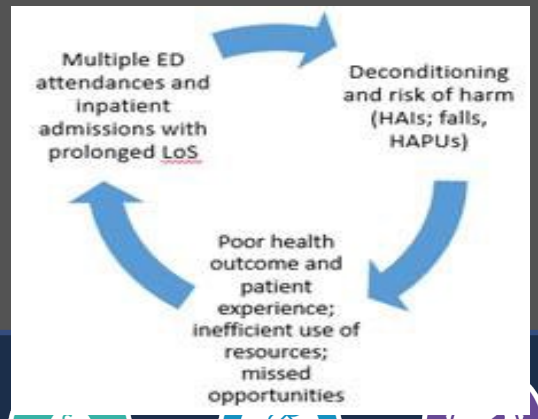
Learning organisation: signs of building a learning system coming through

- Working with service users, families and carers to learn from their experiences, particularly in areas where there has been previous concern e.g MH and vascular services
- Learning from inquests – deep dive now complete; each case requiring follow-up is being progressed
- Intelligence-led approach progressing, will continue to build up into the medium term

Diweddariad Prosiect Eiddilwch Caergybi, CRT a RIF | Holyhead Frailty Project, CRT & RIF update

- Cynllun peilot Eiddilwch Cymunedol yn cael ei gynnal yng Nghaergybi - ffocws ar leihau derbyniadau ysbyty ar gyfer y cleifion risg fawr sydd wedi cofrestru gyda'r ddwy feddygfa yn y dref.
- Caiff ymateb cyflym ei ddarparu ar ôl i achosion gael eu brysbennu gan gydlynydd clinigol ar gyfer y CRT.
- Sgrym dyddiol y bydd aelod o bob disgyblaeth graidd yn ei fynychu'n gwella cyfathrebu ac effeithiolrwydd gofal.
- Cynlluniau Gofal Uwch ac Asesiadau Geriatrig Cynhwysfawr yn cael eu cwblhau ar gyfer cleifion dethol.
- Mae'r 12 mis cyntaf yn dangos lleihad yn nifer yr achosion yn yr Adran Achosion Brys (ED), trosglwyddiadau ambiwlans, derbyniadau cleifion mewnol, a hyd arhosiad o ran y garfan risg fawr yng Nghaergybi.

- Community Frailty pilot is being run in Holyhead - focus on reducing the hospital admissions for the high-risk patients registered with the two GP practices in the town.
- Rapid response provided following triage by a clinical co-ordinator for the CRT.
- Daily huddle attended by a member of each core discipline improves communication and effectiveness of care.
- Advanced Care Plans and Comprehensive Geriatric Assessments are being completed for selected patients.
- The first 12 months show a decrease in the ED attendances, ambulance conveyances, inpatient admission, and length of stay of the high-risk cohort in Holyhead.



Datblygu Gweithwyr Proffesiynol Perthynol i Iechyd (AHP) ym maes Gofal Sylfaenol/Cymunedol | Allied Health Professionals (AHP) development in Primary Care

Wedi recriwtio i wasanaeth Ychwanegol Adsefydlu AHP - gwasanaeth hwn yn canolbwyntio ar Fôn yn y lle cyntaf. Mae i dîm gwasanaeth ychwanegol adsefydlu AHP dair ffrwd waith:

1. Datblygu ymagwedd glinigol.
2. Rhoi cymorth o ran datblygu gwasanaethau AHP, gyda'r nod o roi cymorth gydag ymagweddau ar y cyd. Mae'r gwaith cychwynnol wedi canolbwyntio ar ddatblygu cymwyseddau Cynorthwywyr Therapi Amlbroffesiynol a chydlynu ar draws cyfarfodydd clwstwr.
3. Datblygu strategol yn cydlynu ar draws Gofal Sylfaenol, Gofal Cymunedol a Therapïau a lle'r ydym yn rheoli pobl sydd ag anghenion cymhleth. Sbardun i fod yn sail i lwybrau clinigol ar gyfer pobl sydd ag anghenion cymhleth.

Recruited to the Enhanced AHP Rehab service - service will initially focus on Mon. The Enhanced AHP rehabilitation team has three work streams:

1. Developing a clinical approach.
2. Support development in AHP services, looking to support shared approaches. Initial work has focused on development of Multi professional Therapy Assistants competencies and coordination across cluster meetings.
3. Strategic development across Primary care, Community Care and Therapies and where we hold management of people with complex needs. Act as a springboard to inform clinical pathways for people with complex needs.

Cynllun y Gaeaf 2024/25 | 2024/25 Winter Plan

- Bwrdd Iechyd yn adolygu ei Gynllun ar gyfer y Gaeaf - canolbwyntio ar bedwar maes allweddol :

1. Gofal Cymunedol a Sylfaenol, yn cynnwys mentrau fel y rhaglen eiddilwch, yr ymgyrch frechu rhag y ffliw, cynlluniau gofal sylfaenol i gynorthwyo cleifion risg fawr, a gwella gwasanaethau fferylliaeth gymunedol.
2. Drws Blaen, yn amlinellu cydweithio ag Ymddiriedaeth Gwasanaeth Ambiwlans Cymru, gwasanaethau Gofal Brys ar yr Un Diwrnod (SDEC), ac ymdrechion i amddiffyn capasiti trawma.
3. Yn yr Ysbyty, yn cynnwys cynlluniau dad-ddwysáu, cynllun uwchgyfeirio ar gyfer gwasanaethau anadlol, dulliau rhyddhau wedi'u llywio gan feini prawf, a rhoi proses aros flaengar ar waith.
4. Rhyddhau i'r Gymuned - canolbwyntio ar gydweithio â phartneriaid gofal Cymdeithasol, a chryfhau cymorth timau cymunedol i hwyluso rhyddhau cleifion yn ddiogel ac yn brydlon.

- Dechreuodd hyn gyda Phrosiect Ailbennu Cyfeiriad yr Ysbyty a gafodd ei strwythuro o amgylch tri thîm pwrpasol: Ffocws Drws Blaen/Yr Adran Achosion Brys (ED), llif yn yr ysbyty, a Rhyddhau, gyda phob un yn mynd i'r afael â meysydd penodol yn y llwybr gofal.

- Health Board currently reviewing its Winter Plan - focus on four key areas :

1. Community and Primary Care, includes initiatives such as the frailty programme, the flu vaccination campaign, primary care plans to support high-risk patients, and the enhancement of community pharmacy services.
2. Front Door, outlines collaboration with the Welsh Ambulance Service Trust, Same Day Emergency Care (SDEC) services, and efforts to protect trauma capacity.
3. In-Hospital, covers de-escalation plans, respiratory escalation plan, criteria-led discharge, and the implementation of a forward-waiting process.
4. Discharge to the Community - focus on collaborative working with social care partners, strengthening the support of community teams to facilitate safe and timely patient discharges.

- Kickstarted with the Hospital Reset Project which was structured around three dedicated teams: Front Door Focus/Emergency Department (ED), in-hospital flow, and Discharge, each addressing specific areas of the care pathway.

West IHC - 2024/25 Winter Plan

Community / Primary Care

Community Frailty Project will proactively identify and support frail patients, reducing the need for acute hospital admission and providing care closer to home.

Flu and Covid vaccination programme is underway both in the community and for staff

Promote the use of all available capacity through UPCCs / MIUs to avoid ED being the default position.

Tailored plans are being produced with each practice for patients most at risk of admission, with supportive measures from the Community Resource Teams to keep them out of hospital.

The Clinical Community Pharmacy Service and Pharmacy Independent Prescribing Service will continue to release clinical capacity in GP, OOH and hospital services.

Front Door

Frailty services at the front door, within the SDEC footprint as proof of concept.

Working collaboratively with WAST to avoid inappropriate conveyances, and support timely handovers.

Plans for Trauma capacity will be fluctuated in accordance with front door demand to support flow.

Commitment to continue with Planned Care to support emergency care avoidance for our patients on waiting lists.

In Hospital

Implementation of an IHC de-escalation plan during periods of high demand to protect SDEC, DOSA and speciality beds such as stroke, NOF, and renal dialysis to support timely patient pathways.

Respiratory escalation plan to support additional NIV beds during periods of high demand.

Forward waiting process to be actioned based on a clinically informed risk assessment to share risk and allow improved handover times for ambulances.

Development and implementation of criteria-led discharge process.

Discharge to Community

Continue with collaborative work with social care partners to improve communications. This will include locating social services within the discharge hub.

Development of competencies for health board staff to complete proportionate assessments.

The community team will be supporting discharges through training sessions and discharge coordinator support across each CRT area.

Gwaith Clwstwr | Cluster Work

- Prosiect presgripsiynu cymdeithasol Môn - cynhelir gan dîm Dolen Gymunedol Medrwn Môn (Cyngor Gwirfoddol Cymunedol Môn), Enghraifft o gydweithio rhwng y Bwrdd Iechyd, yr Awdurdod Lleol a'r Trydydd Sector.
- Roedd rhaglen y Ddeddf Gofal Gwrthgyfartal (ICL) yn gwahodd ac yn cynnwys grwpiau ac aelodau amrywiol o'r holl brosiectau cydweithredol ac asiantaethau ar draws Ynys Môn i edrych ar anghenion y boblogaeth, yn enwedig lle y gallai fod pryderon ynghylch "gofal gwrthgyfartal" e.e. angen mawr ond gyda'r mewnbwn lleiaf.
- Gweithgor Presgripsiynu Cymdeithasol Ynys Môn - wedi esblygu o'r Grŵp Presgripsiynu Cymdeithasol Plant cychwynnol a ddeilliodd o waith ar y Ddeddf Gofal Gwrthgyfartal.

- Anglesey's social prescribing project - run by the Community Link team at Medrwn Mon (Anglesey Community Voluntary Council). Example of joint working between the HB , LA and 3rd sector.
- The Inverse Care Law (ICL) program invited and involved various groups and members of all collaboratives and agencies across Anglesey to look at the population needs, particularly where there may be "inverse care" concerns e.g. high need but least input .
- Anglesey's Social Prescribing Working Group - evolved from the initial Childrens Social Prescribing Group which was the outcome from the ICL work.

Llesiant Plant / Children Wellbeing

- Data yn dangos cyfradd fawr o ordewdra ymysg plant a chyfraddau mawr o blant sy'n byw mewn ardaloedd difreintiedig yn Ynys Môn. Ymddygiad o blentyndod yn cael effaith barhaus ar iechyd a llesiant oedolion. Mae targedu cymorth ar gyfer plant yn cynnwys rhoi cymorth i'r teulu.
- Ar gyfer gofal gwrthgyfatal - Edrych ar lesiant plant yn gyflawn, sicrhau bod y rhai sydd â'r angen mwyaf yn cael eu nodi er mwyn targedu cymorth yn well.
- Wedi cyflogi dau Gydlynydd Ardal Lleol (LACs – presgripsiynwyr cymdeithasol) - canolbwyntio ar iechyd meddwl a llesiant yn achos pobl ifanc sydd yn eu harddegau.
- Teulu o ymarferwyr llesiant mewn practisau sydd â gwybodaeth am Wasanaethau Iechyd Meddwl Plant a Phobl Ifanc (CAMHS) a gwasanaethau cymorth lleol i arwain gwasanaethau a chymorth priodol.

- Data shows a high rate of childhood obesity and high rates of children living in deprived areas on the isle of Anglesey. Behaviours from childhood have a lasting impact on adult health and wellbeing. Targeting support for children often involves supporting the family.
- For inverse care - Look at children's wellbeing as a whole, ensuring those most at need are identified in order to better target support.
- Already employed two Local Area Coordinators (LACs – social prescribers) - focus on mental health and wellbeing in teenagers.
- Family wellbeing practitioners in practices with knowledge of Child and Adolescent Mental Health Services. (CAMHS) and local support services to guide appropriate service and support.

Cwestiynau
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Questions