Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on the Review of Paediatric Services (Output Report)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Philip Kloer, Deputy Chief Executive & Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Yvette Pellegrotti, Principal Programme Manager, Engagement and Transformation Programme Office and Alex Martin, Principal Programme Manager, Engagement and Transformation Programme Office

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Board, at its meeting held on 29th September 2022, received an issues paper setting out the temporary changes to paediatric services from 2014 to the present date and providing an assessment of their impact. The Board approved the proposed next steps - to work with a multidisciplinary team and service users, parents / guardians of service users to develop and appraise a list of viable options to be considered by the Health Board.

As part of this plan it was agreed that the outputs of the optional appraisal process be presented to Board in November 2022 along with a recommendation, following discussion with the Community Health Council (CHC), on whether engagement or consultation around the future service is needed.

The Board also asked at its meeting on the 26th May 2022 that the review of paediatric services includes a review of the engagement activity undertaken to date from the period 2014 to 2022 to include internal engagement within the Health Board and wider stakeholder engagement to include service users.

Both of these activities have now been completed and the purpose of this report is to provide an overview of the Output Report (annex A) and Engagement Review (annex B).

The Output Report sets out the methodology and process carried out in developing and appraising various options, while the Engagement Review details the level of communication and engagement activity which has been undertaken since 2014.

Cefndir / Background

Until October 2014 a 24-hour paediatric inpatient unit was available at both Withybush General Hospital (WGH) and Glangwili General Hospital (GGH).

A permanent change was made on the 20th October 2014, following a period of consultation, from a 24-hour inpatient unit to a 12-hour Paediatric Ambulatory Care Unit (PACU) service at WGH. The 12-hour service was supported by a Dedicated Ambulance Vehicle (DAV) introduced to enable the emergency transfer of patients supported by specialist trained staff between hospital sites for the Women and Children's services. GGH remained a 24-hour inpatient unit.

Since then, a series of temporary changes have been made to the service (with the first temporary change occurring in 2016), including the suspension of the PACU at WGH as part of the response to COVID.

An Interim Paediatric Review has been established to:

- Undertake an assessment of the impact of the interim changes to paediatric services at WGH and GGH since 2014, resulting in one report outlining all the changes, impacts and issues to date;
- Review all engagement activity undertaken to date from the period 2014 to 2022 to include internal engagement within the Health Board and wider stakeholder engagement to include service users;
- Undertake a clinically led appraisal of the options for the interim service between now and the establishment of the new hospital network (predicted to open in 2029);
- Following discussion with CHC, make a recommendation to Hywel Dda University Health Board (HDdUHB) Public Board around whether engagement and/or consultation around the future service is needed following the Options Appraisal.

Children's hospital services (paediatric) at Prince Philip Hospital (PPH) (minor injuries provision) and Bronglais General Hospital (BGH) 24-hour inpatient unit are out of scope for this review.

Asesiad / Assessment

Following the development of the issues paper, a series of workshops were held to develop options which could respond to the needs identified within the issues report and provide a paediatric service which could be implemented and sustained on an interim basis.

The options were appraised against hurdle criteria (defined criteria to outline the minimum level that must be met) initially to ensure that only viable and deliverable options would be taken forward for working up ahead of a shortlisting process which examined the remaining options in greater detail.

While effort was made throughout the process to ensure that there was balanced representation between staff and public, it was not possible to achieve equal representation throughout. The working group responsible for developing options had good consistent public involvement, however the wider appraisal groups did not. The Output Report details the efforts that were taken to include the public throughout the process and the engagement undertaken with staff at both WGH and GGH (detailed in page 10 of the Output Report).

The three final shortlisted options were appraised using criteria identified through staff and public engagement. The options can be summarised as follows:

- Option C – An enhanced version of the current service model
- Option B – An enhanced model of how services were delivered after the 2016 temporary change (PACU service during fixed hours)

- Option B2 – Option B with additional work to review transportation and emergency care pathways at GGH for paediatric care

The appraisal criteria were weighted during the final shortlisting session attended by staff representing HDdUHB and a service user representative (detailed in page 26 of the Output Report) and used to score the options.

Each of the options were scored on the basis of what they are presently capable of achieving, noting the aspiration of what they could also further deliver. These include the estates requirements for the options, as well as the impact on other medical services in Pembrokeshire.

These aspirational aspects were captured within the individual analysis of the options. Additional work is anticipated as part of implementation of an option once decided, to determine whether the aspirational elements can be delivered and how.

The scores for the options were as follows:

Criteria	Option C	Option B	Option B2
Clinical viability	213	166	166
Workforce viability	214	143	146
Safe inter-hospital transport system	171	140	144
Deliverability	213	145	134
Accessibility	175	188	191
Facilities (incl. interior suitability)	181	181	177
Inter-service accessibility	154	159	159
Impacts on people	157	162	162
Totals	**1478**	**1284**	**1279**

Option C scored around 15% higher than the other two options, however it is worth nothing that each option had distinctive advantages and disadvantages. In particular option C scored highly on deliverability, viability and safe inter-hospital transfers but less well on accessibility and impact on people.

Alongside the development and appraisal of options, a separate piece of work was undertaken to review the communications and engagement that had taken place between 2014 to 2022 internally and externally around changes to paediatric services.

This work noted that generally there had been a good level of communication throughout the process, with evidence to show that people had been kept informed and aware throughout the changes.

The report also reviewed Board papers discussing the topic, noting that there is likely to be a ‘legitimate expectation’ for consultation by the public as it had been suggested previously that future options for paediatric care may be subject to consultation.

The Board is therefore asked to agree to a public consultation as part of the next steps, in accordance with Welsh Government guidance and statutory responsibilities.

Subject to approval as part of next steps, a draft consultation plan will be developed and brought back to Board for approval in January. The proposed consultation plan will endeavour to align in part with the land selection consultation to reduce the risk of consultation fatigue, enable value (through economies of scale), and ensure prudent resource management, as the consultation will draw on the same corporate functions and personnel e.g. Programme management, Comms, Engagement, etc.

The Board is therefore asked (subject to agreement on public consultation), that the use of consultants (already agreed for the land selection consultation) is extended to the interim paediatric consultation.

***Indicative costs** are set out below:

Communications requirements	Consultation documents, design and printing, including alternative versions (including translation), video and animation - £48,800 Translation, including Welsh and other languages identified through stakeholder analysis - £12,700 Media including digital platforms, social media, radio, advertising - £25,500 Media Training - £3,000 **Total Communications Costs - £90,000**
Engagement requirements	Consultation Advice and guidance 20 days = £21,448 Quality Assurance (Consultation Institute) - £19,550 Project Management Services (Consultation Institute) - £38,970 Consultation Analysis including Consultation Analysis Initial Report and Consultation Final Report - £150,000 Events Management – Venues and logistics including simultaneous translation at events - £21,500 Distribution of documents by mail - £2,500 **Total Engagement Costs - £253,968**
Total consultant costs: **£343,968***	

****Please note that this outline provides an estimate only**, based on the costs for the land consultation. Until a further detailed stakeholder analysis is undertaken (to inform communication and engagement plan), consultation documents are drafted, and opportunities through economies of scale are explored (including consultancy costs), we will not have the detailed information we need for quotations.*

Argymhelliad / Recommendation

The Board is asked to:

- **NOTE** the output report and engagement review;
- **CONSIDER** the options developed and appraised by the appraisal group to determine which option(s) should be taken forward for further consideration;
- **APPROVE** the recommendation within this paper to formally consult on the option(s);
- **APPROVE** The indicative consultancy costs required for the delivery of the consultation project.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1274: Pembrokeshire Paediatric Pathway (Acute and Emergency presentations at WGH) 1126: Women & Children Phase II Project Risk (this relates to the risk of supply chain partners / financiers walking away from the project)
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Public Board reports Risk Registers
Rhestr Termau: Glossary of Terms:	QSEC – Quality, Safety & Experience Committee
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Medical Director Chief Executive Officer Executive Director of Operations Director of Strategic Development & Operational Planning

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Options have been developed with finances considered throughout. Aspirational elements with costs attached have been identified along with likelihood of financial availability.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The recommendations are intended to improve the quality of the service.
Gweithlu: **Workforce:**	The options have now identified individual roles that would be impacted. Legal advice has been sought to ensure that workforce consultation is carried out appropriately and any staff affected have an opportunity to shape decision making. Work is planned to involve trade union representatives in early December to seek views on options.
Risg: **Risk:**	The review and options appraisal need to be robust and transparent, and we have therefore sought advice from the Consultation Institute about the process and timeline required to undertake the work.

Cyfreithiol: **Legal:**	Any risk of legal challenge is mitigated as this is an extension to the interim proposal (and an extension to the existing temporary service change).
Enw Da: **Reputational:**	Due to the series of changes to the Paediatric Service, This is likely to be subject to increased media scrutiny given the historical focus that has been generated in relation to Pembrokeshire health care provision.
Gyfrinachedd: **Privacy:**	No identified risk in relation to privacy.
Cydraddoldeb: **Equality:**	EQIAs have been developed for each of the options, identifying the differences between impacts and benefits that each benefit brings.

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

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Acute Paediatric Service Review

Options Appraisal Output Report

October 2022

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Section 1: Executive Summary

Until October 2014 a 24-hour paediatric inpatient unit[1] was available at both Withybush General Hospital (WGH) and Glangwili General Hospital (GGH). A permanent change was made on the 20th October 2014, following a period of consultation, from a 24-hour inpatient unit at WGH to a 12-hour Paediatric Ambulatory Care Unit (PACU)[2] service. The 12-hour service was supported by a Dedicated Ambulance Vehicle (DAV)[3], introduced to enable the emergency transfer of patients supported by specialist trained staff between hospital sites. GGH remained a 24-hour inpatient unit.

A series of temporary changes have been made to the service since 2014 and these have been documented and reviewed within the issues paper, with a summary included within this paper, setting out the reasons why the temporary change occurred and an analysis of the impact of those changes on the service and service users.

The Board, at its meeting held on 29th September 2022, was asked to approve an approach and detailed plan for working with a multidisciplinary team who work with Children and Young People (CYP)[4] and service users, parents / guardians of service users, to develop and appraise a list of viable options to be considered by Hywel Dda University Health Board (HDdUHB) Public Board.[5]

As part of this plan it was agreed that the outputs of the optional appraisal process and a recommendation, following discussion with the Community Health Council (CHC)[6], around whether engagement or consultation around the future service is needed, be presented to Board in November 2022.

Following a series of workshops, high level options were developed, appraised, and taken through a process of weighted scoring to identify deliverable options. This report sets out the process and methodology used to arrive at those options.

The three options focus on the repatriation of planned care and day care to Withybush General Hospital, while two options include the return of a PACU service similar to how services were provided from December 2016.

[1] A unit with the purpose and function of which to provide services to a patient following that person's admission to a health unit
[2] Non-inpatient hospital services, the provision of care to sick children in a hospital environment whereby they are not admitted to the ward as an inpatient
[3] Ambulance vehicle and crew designed to transfer paediatric patients as soon as possible
[4] Children and Young People
[5] The principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights
[6] The Community Health Councils (CHCs) are the independent watchdog of the National Health Service (NHS) within Wales. The CHC encourage and support people to have a voice in the design and delivery of NHS services

Section 1: Executive Summary

During the short listing session attendees had an opportunity to ask questions during the presentation of options, and to reflect on the scores once they were provided to see whether the results reflected what they felt about the three options.

During the discussion and reflections it was felt that the timescale for development and appraisal of options had been short and at fast pace, which reduced the opportunity for a wider range of staff to engage fully. Also, more work would be needed to fully cost and explore the financial implications of investing in the aspirational elements of the three options beyond the information that had been shared within the shortlisting session, as this will help others when deliberating on the options.

Due to reduced public, third sector, and community engagement in the options appraisal stage, the advice received from the Consultation Institute (tCI)[1] is that the three options which have been scored be taken forward to public consultation. This would also allow a wider range of staff recommended by workshop attendees who must be engaged with, to have an opportunity to be consulted.

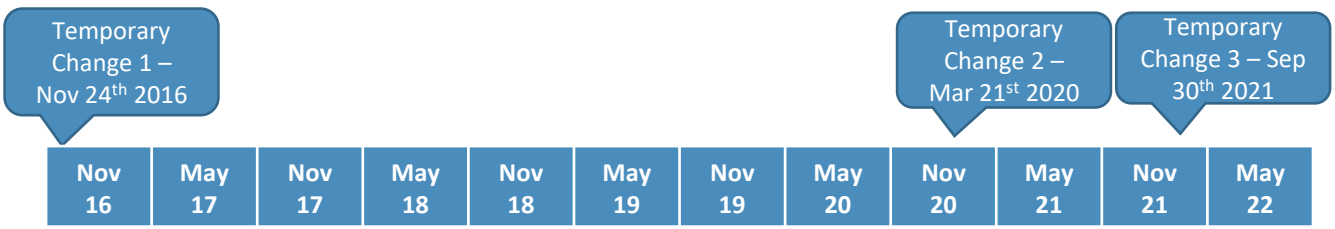
[1] A not-for-profit best practice Institute, promoting high-quality public and stakeholder consultation in the public, private and voluntary sectors. A membership body offering a variety of support services and training for any person or body with an interest in public dialogue, engagement and participation. Further information is available on their website: https://www.consultationinstitute.org/

Contents

Section 2: Introduction and Background

Until October 2014 a 24-hour paediatric inpatient unit was available at both Withybush General Hospital (WGH) and Glangwili General Hospital (GGH). A permanent change was made on the 20th October 2014, following a period of consultation, from a 24-hour inpatient unit at WGH to a 12-hour PACU service. The 12-hour service was supported by a Dedicated Ambulance Vehicle (DAV), introduced to enable the emergency transfer of patients supported by specialist trained staff between hospital sites. GGH remained a 24-hour inpatient unit.

Three temporary changes have been made to the service since 2014, as detailed below:



Temporary service change[1] 1:

At the Public Board meeting held on November 24th 2016, the Board approved:

- Temporary reduction in the operating hours of the PACU at WGH: from 5th December 2016 the WGH PACU operating hours changed from 10am - 10pm, to 10am – 6pm, 7 days per week
- Temporary merger of the acute paediatric overnight consultant on call rotas[2] for WGH and GGH, with one rota for the south of the Health Board based at GGH

Temporary service change 2:

21st March 2020: the suspension of the PACU at WGH, also known as Puffin Ward, as part of the response to the COVID-19 pandemic.

Temporary service change 3:

30th September 2021: Board approved the extension of the temporary service arrangements:

- The suspension of the PACU at WGH, also known as Puffin Ward, until a full review of the temporary changes has been concluded
- This was supported by a detailed communications plan which included distributing a leaflet to all households in Pembrokeshire, which aimed to minimise the risks that an acutely ill child or young person may encounter if they presented to WGH

[1] A change made to meet service needs for a temporary period
[2] Consultants who work on a rota are required to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period

Section 2: Introduction and Background

Temporary service change 3 (continued):

- The minor injury pathway at WGH (to which paediatric cases are encouraged to attend) was also subject to re-focus. This included making it clear by the installation of new, temporary signage, that the service at WGH is a paediatric Minor Injury service and an adult A&E
- A new triage tool was also designed to prioritise and support rapid intervention for children who may continue to present at WGH with time-sensitive illness, and to signpost clinicians to access appropriate transfer services to repatriate the patient to the right place of care

An assessment of the impact of the interim changes to paediatric services[1] at WGH and GGH since 2014 was undertaken and an issues paper was produced. The issues paper which was presented at Board on 29th September 2022 (Appendix 1: Previously submitted Board papers) sets out:

- Reasons why the temporary changes occurred
- Analysis of the impact of those changes on the service and service users, drawn from internal views and concerns[2], data, research and service user views and concerns

How did we do it?

1. Drew on internal views, concerns, data, and research
    - We reviewed and documented all updates to Public Board
    - Targeted early engagement was undertaken with a multidisciplinary team who work with Children and Young People (CYP)
    - Patient experience data and concerns data was reviewed
2. Drew on the views of service users / parents or guardians of service users
    - Targeted early engagement survey undertaken (circa. 8000 issued, 625 responses)
    - Children and Young People (CYP) engagement undertaken
    - Community Health Council (CHC) Patient survey responses reviewed

The general findings of the issues paper were:

- Internal data and research show very low numbers of concerns both in terms of patient safety incidents[3] and complaints[4] and feedback in relation to the temporary service changes, and patient experience has remained largely consistent and generally positive
- Internal staff views show that their experience of the service was largely positive
- Feedback received from service user, parents and guardians of service users was largely positive
- A large volume of responses were received asking that services be returned to Withybush; there were different views on what those services should be and how they should be delivered.

[1] Services provided for infants and children from birth to age 18
[2] A "concern means any complaint; notification of an incident or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation" (Welsh Government 2011)
[3] A patient safety incident “means any unexpected or unintended incident which did lead to or could have led to harm for a patient” (Welsh Government 2011)
[4] A “complaint means any expression of dissatisfaction” (Welsh Government 2011)

Section 2: Introduction and Background

A high level overview of responses by theme to the engagement undertaken is as follows:

- Internal staff views show that their experience of the service on average is 7/10 (1 being poor/10 being exceptional) and the key themes identified by staff in relation to the temporary changes included: delivering safe/quality care (there was no consensus[1] on the specific configuration) and patients' families not understanding the changes (these were most prominent before PACU moved to GGH), poor facilities and infrastructure, and the lack/loss of facilities were also key themes emerging, in addition to teams working across sites.

- The key themes identified from the service user/ parents/ guardians of service users' views show consistent themes for the three changes around:
    - Staff as a key asset to the service
    - Services were praised for delivering timely care and treatment

Lack/loss of facilities

- The reinstatement of children's services at WGH (linked to long journey times from Pembrokeshire with ill children)

Poor facilities and infrastructure:

- Issues around lack of availability of food and drink are highlighted, particularly, but not exclusively, in A&E settings
- The need for a separate paediatric A&E entrance/triage/waiting room
- For those unfamiliar with GGH the lack of signposting to PACU was highlighted as causing confusion

Communication

- The lack of signposting at PACU was highlighted as causing confusion

A detailed communications plan supported temporary change 3; the following theme was highlighted prior to this change:

- Information required surrounding the operation of children's services at Withybush 'out of hours' is unclear, with services such as GP out of hours and 111 unaware of the operating hours, leading to misdirection.

[1] (1) A mutually acceptable agreement that integrates the interests of all concerned parties. A number of dialogue methods seek to arrange consensus views by stimulating stakeholder discussions and focusing on area of agreement (2) General or widespread agreement. Tends to be used to describe an outcome that 'everyone can live with', as well as unequivocal agreement. A win/win solution

Section 2: Introduction and Background

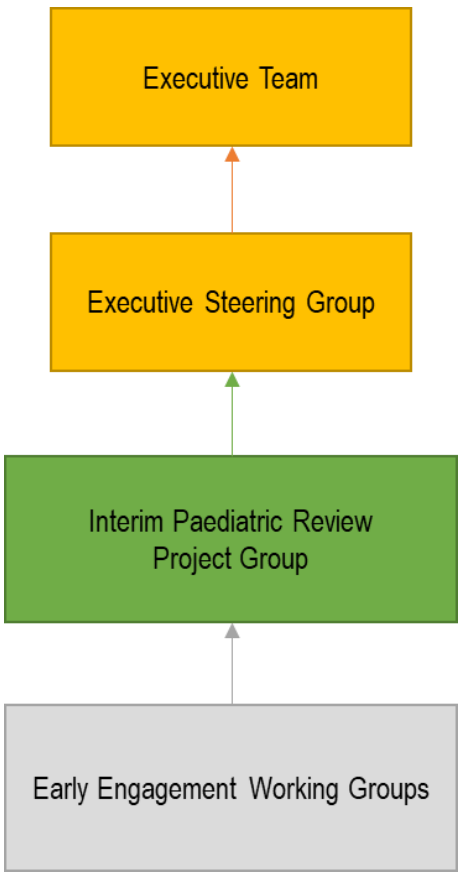
The issues paper sets out:

- Reasons why the temporary changes occurred
- Analysis of the impact of those changes on the service and service users, drawn from internal views and concerns, data, research, and service user views and concerns, as set out in Section 3: Methodology of the issue paper

The purpose of the issues paper was to:

- Present to Board (29th September 2022) an assessment of the impact of the temporary changes
- Support discussions at a deliberative session[1] on Friday 16th September 2022. Further details on this session are contained in Appendix 2: Deliberative session output report.

An **Interim Paediatric Review Project Group**[2] has been set up to support the Interim Paediatric review and the options development and appraisal activities, reporting to the Executive Steering Group on how it is carrying out engagement, to ensure that it seeks the widest possible views of the services affected. Issues, risks, and matters which require a decision are also escalated to the Executive Steering Group.



We have aimed for the working groups[3] to be made up of 50% members of the public and third sector organisations, and 50% staff. Public members of the working groups have been identified through early engagement; those who wanted to be kept informed / involved were asked to express an interest to be part of the working groups; we have also encouraged participation through media statements, third sector organisations and the Hywel Dda University Health Board website.

A larger group was involved in the initial deliberative session and following options appraisals. A smaller group (where we aimed for the same Public/ Staff ratio) developed options for the interim service between now and the establishment of the proposed new urgent and planned care hospital.

Follow up targeted engagement work has been undertaken with members of the public and third sector organisations to sense check the findings from the working group where the 50:50 ratio has not been achieved, and a continuous engagement challenge has been established.

[1] Discussion and consideration by a defined group of people in a meeting / workshop
[2] A bi-weekly group established following the Board decision on November 24th 2016 to approve a temporary reduction in the operating hours of the PACU at WGH
[3] A small group established with inclusive and representative public participation to work alongside the multidisciplinary service representatives to consider information, data and views

Section 2: Introduction and Background

Timeline of engagement

As part of the work to develop and appraise the options, meetings have taken place with staff, members of the public, and other people interested in the work. This timeline is provided to give an indication of the meetings that have taken place alongside the process.

25/05/2022: Online meeting with clinical and operational leads

21/07/2022: Online meeting with wider multidisciplinary team

27/07/2022: Ward based engagement with service users, parents, and carers at Cilgerran ward and PACU by the Patient Experience Team begins

28/07/2022: Posters were displayed containing a link to the survey, and alternative options of engagement via email or telephone at A&E in WGH and GGH, Paediatric outpatients at WGH and GGH, Cilgerran ward and PACU in GGH, and Minor Injury Unit areas at GGH and WGH

11/08/2022: Staff drop in sessions at WGH and GGH

18/08/2022: Ward based engagement with service users, parents, and carers at Cilgerran ward and PACU by the Patient Experience Team finishes

19/08/2022: Informal drop in event for patients, their families, and carers to provide their experience of accessing paediatric services at Folly Farm, Pembrokeshire

24/08/2022: Informal drop in event for patients, their families, and carers to provide their experience of accessing paediatric services at Xcel Bowl, Carmarthenshire

24/08/2022: Informal drop in event for patients, their families, and carers to provide their experience of accessing paediatric services at Cardigan Castle, Ceredigion

16/09/2022: **Deliberative Session – Section 4**

06/10/2022: Visit to Portfield School, Haverfordwest to listen to children talk about their experience of accessing paediatric services

06/10/2022: Online meeting to **appraise the long list of options[1] using hurdle criteria[2] – Section 5**

13/10/2022: From the 13th of October, engagement with the Gypsy and Traveller community, Pembrokeshire, to listen to parents and children talk about their experience of accessing paediatric services

20/10/2022: **Appraise the options still being considered (short list)[3] – Section 6**

21/10/2022: Visit to Ysgol y Preseli, Crymych to listen to children in years 7, 8, 9, 10, and 11 talk about their experience of accessing paediatric services

[1] A complete list of options gathered as an output from the knowledge, data, material or insights compiled
[2] Defined criteria to outline the minimum level that must be met
[3] A short list of options compiled utilising a consensus approach and hurdle criteria

Section 3: Methodology

This section explains the scope and processes undertaken to complete options development and appraisal activities, as well as other activities which took place alongside the options development and appraisal to support decision making.

Engagement activities:

Identifying people to take part

In order to reach a balanced room, advice was sought on the ideal numbers of participants to invite for both the wider appraisal groups[1] and the smaller working groups.

From the organisational perspective, 30 people were identified as being important to decision making and covered a wide range of services both within Paediatric services and across the wider Health Board. The names for these were identified from a staff survey asking if staff wanted to be involved in the process, or by the project group who needed to ensure that an appropriate make up of nursing, therapy, medical, operational staff were present.

From a public perspective, expressions of interest were circulated to approximately 150 people who asked to be kept informed following the survey sent out as part of the issues paper. The same expression of interest was also circulated to third sector organisations and community groups, as well as being made available on Engagement HQ.

There were also other people invited who represented services or organisations which were not involved in decision making, but were able to provide information, support, and advice to support the process. These were both internal (finance services, workforce planning, data science, etc.) and external (Welsh Ambulance Service Trust, Pembrokeshire County Council, etc.).

The invite list was recorded and approved by the Interim Paediatric Review Project Group and Executive Steering Group. It was not possible to share the invitations with additional people, so where deputies were required, these were recorded on a session-by-session basis.

Engagement HQ

During the development of the issues paper a continuous engagement channel on Engagement HQ was set up to allow people to continue to input their views following the targeted survey that was sent to patients, parents, guardians, and carers.

While the survey was targeted at those who had used the services during the period of change, the Engagement HQ platform allowed members of the public to contribute their views. The links to the page were shared within the issues paper itself, along with the press releases that accompanied the paper to Board.

[1] A group established with inclusive and representative public participation to work alongside the multidisciplinary service representatives to undertake an assessment

Section 3: Methodology

Engagement activities (continued):

Engagement HQ (continued)

The platform remained open throughout the process to allow people the opportunity to express an interest to join the options development and appraisal process, as well as continue to express views on paediatric services, with summary documents following parts of the process available in multiple languages to help them form their responses.

Engagement planning

The initial 7,700 surveys distributed as part of the Issues Paper development were sent to those who had used paediatric services in Withybush General Hospital or Glangwili General Hospital, which is broadly representative of the population that used the services.

When analysing the feedback and carrying out the initial Equality Impact Assessment (EqIA)[1], gaps were identified due to low levels of responses received from particular groups. For this reason, an engagement plan was developed with the engagement team and paediatrics service to carry out some targeted engagement with those groups to share their views.

The groups included:

- Children and Young People (aged 0 - 9)
- Males
- Minority ethnic groups
- Gypsies and Travellers

The engagement plan included ways to engage with these groups, translations required, and reasonable adjustments to how we engage to get the best possible responses to form the options appraisal process.

This information was fed into the process where available, with additional information received after the short list appraisal included below to be considered.

Closing the loop

At each of the workshop sessions, additional engagement information was fed into the group as it became available and to meet the specific asks of the group, and, also information that was noted as missing from the EqIA process.

This reporting included the feedback from the issues paper and deliberative session, the sources of feedback, and what the themes arising were and whether they were different to those reported so far that should be considered as part of option appraisal.

[1] The purpose of the Equality Impact Assessment (EqIA) is to identify and eliminate discrimination, harassment, victimisation. It identifies benefits from the proposals and mitigates where there may be negative impacts. It also seeks to advance equality of opportunity and foster good relations between different groups of people.

Section 3: Methodology

Engagement activities (continued):

Continual Engagement Feedback

Feedback from adults was broadly the same as that received during the issues paper development, with no new themes identified that had not been considered as part of options development. These were:

- Need for provision of services locally
- Attending Accident and Emergency (A&E) – noting long waiting times, mixed adults and children, and care received from unfamiliar staff
- Travel / Distance
- Quality of care
- Praise for staff

Young Person Survey

A survey was sent to secondary schools and youth clubs which again highlighted themes that were identified as part of the issues paper development, however, it now captured the experiences directly from children and young people instead of their parents, carers, or guardians. These themes were:

- Quality of care
- Good communication
- The need to improve hospital environments
- Separation of CYP and adult waiting areas needed
- Praise for staff
- Lack of entertainment on ward for CYP

Ysgol y Preseli – School visit

A visit took place to Ysgol y Preseli, Crymych on 21st October 2022 to seek more information from CYP about what is important to consider in developing options. Informal, round-the-table discussions were held with three groups of pupils from Year 7, Years 8 & 9, and Years 10 & 11.

The children were asked if they had any experience of being in hospital and what those experiences were like. If they had not been in hospital, they were asked to imagine what would be important to them, and how they would like to be treated if they had to go into hospital. They also drew on personal experiences of relatives having been in hospital. The feedback is summarised below and on the following page.

The Year 10/11 group were invited to share their feedback via the survey link, but their table discussion has also been included below.

Group 1 – Year 7

What was most important to this group:

- To feel safe
- Nice doctors and nurses
- Need good food
- Reassurance

Section 3: Methodology

Engagement activities (continued):

Group 1 – Year 7 (continued)

- Don't want to experience other people's disrespectful behaviour (shouting, etc.)
- Hospitals should feel like home
- Welcoming
- Room should be colourful
- It's really important to feel listened to

Group 2 – Years 8 & 9 (14 pupils)

What was most important to this group:

- Vending machine in A&E
- Toy dispensing machine – entertainment
- Hot chocolate machine
- Colouring – other activities
- Toys
- TV – not the news (better programmes)
- Clean
- Magazines
- Staff who know what they are doing
- Privacy
- Music
- Tell us what is going on, explain everything
- Different rooms for different ages – don't mix teenagers with younger children
- More pictures on the walls, age appropriate – no Disney pictures for older children
- Cheerful bright colours – so it doesn't feel like a hospital

Group 3 – Years 10 & 11 (10 pupils)

What was most important to this group:

- Games consoles – PS5
- Better WiFi – Withybush poor
- Somewhere for parents to stay
- Separate areas for children and young people away from adults

<u>Gypsy and Traveller Community Feedback – Pembrokeshire, 13th October 2022 onwards</u>

Overall, there was a 60:40 split between parents and children, with one of the children being the only male response received. Between the responses they had experience of using services from before 2015 to present, and had used all 4 locations (PACU at WGH, A&E WGH, PACU at GGH, and A&E GGH).

The responses reflected many of the issues that had been previously raised in terms of transport issues, distance to access services and lack of public transport, lack of entertainment for children, etc. however these were far more exaggerated due to the families generally being larger, and the cost of travelling to hospital could mean not buying food for the household. They also praised staff, in a similar way to other groups engaged with.

A new theme identified was that information sent to families was often difficult to understand and needs to be sent in easier to read formats.

Section 3: Methodology

Equality Impact Assessment Process:
Equality Impact Assessments (EqIA) have been carried out throughout the process to help understand what the impacts and benefits around each of the proposals might be.

Throughout the process the EqIA was updated in line with changing information such as obtaining additional feedback from engagement or accounting for how the options would work, using as much data as possible.

Status quo
In order to develop a long list of options as well as consider previously agreed models introduced through temporary service changes, an EqIA was undertaken that looked at how the service is delivered now (the status quo).

This allowed the working group to understand what the impacts and benefits of how services are currently delivered are, whether there are particular groups who experience services differently, and whether there are any particular mitigations that would need to be considered as part of those options developed.

Options appraisal
Following the long listing stage, the working group set about developing the options being taken forward so that they could be individually appraised. Throughout this process it meant that more detail became available on how each option would work, and what the change would be in impact or benefit on groups, allowing them to be individually assessed.

3 Equality Impact Assessments have been developed looking at each of the options in detail. While Option B and Option B2 are very similar, and outwardly may look the same to the public, all three have differences in benefit and impact.

Section 3: Methodology

Option development scope and appraisal process:
The scope and process to be undertaken for the options development and appraisal activities was agreed by the Executive Steering Group.

This was recorded as part of the Project Initiation Document (PID)[1] which had been shared and developed with service leads. Any requests to change or widen the scope were managed and recorded in the Executive Steering Group decision log.

The scope and process followed was set following advice on a suggested approach from the Consultation Institute (tCI), a not-for-profit best practice Institute, promoting high-quality public and stakeholder consultation in the public, private, and voluntary sectors.

The scope agreed for the process was:

- Undertake an appraisal of the options for the interim service between now and the establishment of the new hospital network (predicted to open in 2029)

There were several things that were out of scope for the process, which were not open to influence by the group; these were:

- The Urgent and Planned Care Hospital model/ location
- Paediatric services at Bronglais General Hospital
- Paediatric services at Prince Philip General Hospital
- Obstetrics and gynaecology (birthing) services

Following each session, a report was developed by tCI capturing the main highlights of the session and parts to take forward into following sessions. These reports helped the working group to ensure that any options developed took into account the wider group's thinking, and considered the views and learning from the issues paper.

The following table outlines the key events that took place and the focus of each session. The tCI reports for each event can be found using the Appendices table of contents.

[1] The PID defines the project scope and identifies how the project will achieve its objectives. It puts the project on a solid foundation, a baseline that provides a place from which the project manager and project board can assess progress. The PID is a living document which is updated and revised as necessary throughout the project

Section 3: Methodology

In order to develop options in line with the scope, the following events took place:

Workshop	Date of meeting	Session focus
Deliberative session	Friday 16th September 2022 at Plas Hyfryd, Narberth (9am – 4.30pm)	Using the issues paper as a basis for discussion with an appraisal group to ascertain: • What should be considered for a good interim Paediatric service • What is essential • What needs improvement • Whether the permanent change in 2014 satisfies current needs • Whether temporary change 1 model satisfies current needs • Whether temporary change 2 model satisfies current needs • Whether temporary change 3 model satisfies current needs • What 'hurdle' and 'evaluation' criteria are needed for later stages of appraisal process
Working group	A series of meetings between 24th September – 3rd October 2022	To consider whether: • The permanent change in 2014 should be returned to • Temporary change 1 model should be returned to • Temporary change 2 model should be returned to • Temporary change 3 model should be retained • One of the above is the best option, subject to enhancement • There are potentially better options than either of the above, and what those options might look like (high level overview to support hurdle appraisal)

Section 3: Methodology

Workshop	Date of meeting	Session focus
Appraise the long list of options using hurdle criteria	6th October 2022 via MS Teams (10am - 3pm)	Utilising a consensus approach, agree what options should go forward (short list) to be 'worked up'
Working group	A series of meetings between 7th October – 19th October 2022	To 'work up' the high level detail for the options still being considered (short list)
Appraise the options[1] still being considered (short list)	Thursday 20th October 2022 at Plas Hyfryd, Narberth (10am - 3pm)	Appraise the options utilising a weighted scoring approach Stages: • Confirm criteria[2] • Weight the criteria[3] • Score the options[4]

The working group was split into two smaller groups after the deliberative session to allow for multiple options to be developed independently, with equal representation over both groups.

In order to develop the short listed options selected by the wider appraisal group, the working group came together as a single group, meeting multiple times and around people's availability.

[1] Undertake an assessment of the available options
[2] Agree using a consensus approach what the criteria should be
[3] If the criteria are of unequal importance, agree using a consensus approach a weighting to the relative importance of the criteria
[4] Score each option against the weighted criteria and add these scores up to give an overall score for each option

Section 4: Deliberative Session

The workshop is described by the Consultation Institute (tCI) as a 'solutions exploration' workshop; a deliberative event where participants consider what has been learned from the Issues Paper and any other supporting information, and attempt to reach consensus or agreement on what those who will develop solutions/proposals need to consider and prioritise.

Following an expression of interest process as set out in Section 3 :Methodology, 14 members of the public and representatives of community and third sector groups were invited to the event after they had expressed an interest to attend, of which 2 attended on the day. 25 staff representing HDdUHB were in attendance, along with presenters, observers, and supporting staff.

The event was split into two halves, morning and afternoon. The morning was dedicated to providing participants with the information they needed in order to participate in the afternoon sessions. This included:

- The recent history of Paediatric services in Pembrokeshire and Carmarthenshire
- The permanent change to a new service model in 2014
- Temporary changes to the service model in 2016, 2020, and 2021
- Learning from:
    - Service feedback and complaints systems
    - Recent engagement with parents and guardians, service users, and staff
    - The recent survey with parents and guardians of recent service users
- Answering the questions of the participants

Staff of HDdUHB presented the above information, with Andy Wright of tCI relaying the outputs and learning of the survey.

The afternoon was facilitated by Nicholas Duffin of tCI, and was dedicated to participants working across 4 tables so they could:

- Deliberate about what they wanted to see in an interim service model
- Agree what they regarded as essential to a good working model
- Agree what was also important in a good working model
- Advise the working group of which of the four service models since 2014 represented the best starting position for developing or enhancing a service model for the next 7 years
- Advise the working group of what they felt were sensible 'hurdle' criteria for appraising 'developing' solutions

Details of the afternoon session outputs can be found in Appendix 2: Deliberative session output report.

Section 5: Appraise the long list of options using hurdle criteria

The workshop is described by the Consultation Institute (tCI) as a 'hurdle criteria, solutions appraisal' workshop; a deliberative event where participants consider the proposals (also known as options) that have been developed and decide whether each proposal should continue to be developed or should be rejected.

Following an expression of interest process as set out in Section 3: Methodology, 22 members of the public and representatives of community and third sector groups were invited to the event after they had expressed an interest to attend, of which 5 were present on the day. 26 staff representing HDdUHB were in attendance, along with presenters, observers, and supporting staff.

The agenda for the event was as follows:

- Welcome and introduction
- Recap on the process to date
- What we are trying to achieve today
- Presentation of the options
    - Option A
        - Discussion and questions
    - Option B
    - Option B2
        - Discussion and questions
    - Option C
    - Option C2
        - Discussion and questions
- Consensus (reaching consensus for each option)
- Slido[1] opportunity (to provide further information or ideas)

Presentation of options

Nicholas Duffin of the tCI who facilitated the day introduced the working group leads, who would talk participants through the five options being considered. The leads began by explaining how they had worked in developing the options, the coincidence of coming to similar conclusions about options, and why, consequently, the options were lettered and numbered as they were: A, B, B2, C, and C2.

Each option was then presented. Participants were provided with the opportunity to ask questions and deliberate about the options with the presenters and with one another. Options C and C2 drew the most questions and discussion. An important development was discussed regarding Options C and C2. The point was put that because they were so similar, might it be worth merging them as one, or, just to continue with one or the other. A decision on this was deferred to the Consensus session.

[1] A digital polling tool (www.slido.com) which allows people to anonymously share their opinions and provide reflections

Section 5: Appraise the long list of options using hurdle criteria (long list options)

There were 5 options considered at this long list stage, and they were presented chronologically from the time they were introduced, with variations discussed at the same time. The discussion for each option was based around a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, as well as considering how well the option addresses themes identified in the issues paper and deliberative session.

Option A

This option would effectively be a return to the Permanent change made in October 2014. This model would include a 12-hour Paediatric Ambulatory Care Unit (PACU) service at WGH alongside a dedicated on-call consultant.

What is unique or new:

- This is the only option that would feature emergency care in WGH for children, out of the options presented

Opportunities to:

- Maximise the opportunity to receive emergency and planned care closer to home

Option B

Builds on the 2016 model, PACU 10am – 6pm model (Mon – Fri) staffed 10am – 8pm (no referrals from Primary care after 6pm) and Outpatient 9am – 5pm (Mon – Fri) co-located with DAV supporting

What is unique or new:

- Planned **and** same day urgent paediatric day case reviews (any potential admissions would still go to GGH) - No overnight or weekend activity
- Some new restrictions on admission criteria, to mitigate some of the risks identified in the 2016 model
- Look to maximise the building footprint (Puffin Ward)
- The model would look to incorporate Option C (non-emergency activity) into the model with Day Care provision - but potential to be restricted by PACU requirements

Opportunities to:

- Development of Advanced Paediatric Nurse Practitioners and Physicians Associates - non-medical staffing supplementary workforce
- Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow
- Upgrade current Child Health Centre to support administrative/office and base requirements for clinical staff MDT

Option B2

Same model as Option B, with the following differences:

- All non-emergency treatment identified and currently delivered from GGH would be repatriated
- Emergency Department would offer an enhanced service, better point of entry, e.g. triage for CYP
- Robust emergency pathways at GGH

Section 5: Appraise the long list of options using hurdle criteria (long list options)

Option C

Builds on the 2021 model (the suspension of the PACU at WGH, also known as Puffin Ward) through the expansion of non-emergency services retained in WGH, 9am – 5pm service.

What is unique or new:

- Formalising/ locally defining rapid access clinics
- Improving advice and support to Primary Care, and local patient access for specialist review (non-emergency)
- Ability to schedule follow up appointments directly for patients from WGH who have attended GGH for emergency treatment - or follow up from GGH Paediatric admissions for Pembrokeshire residents

Opportunities to:

- House the entire multidisciplinary team (MDT) under one roof - "Hub Integrated approach"
- Incorporate outpatient activity/Day Care provision for Children's Services - with potential to extend to tertiary clinics, etc. (improved environment)
- Enhance future workforce opportunities, e.g. Community Nursing – Outreach Team; play specialists, etc.
- Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow

Option C2

Same model as Option C, with the following differences:

- Transport, e.g. Health care taxis to include out of hours provision
- Improved emergency treatment facilities at GGH
- Dedicated parking at GGH

Consensus

Following the presentation of options, questions and discussions, Nicholas Duffin (tCI) then took participants through a consensus exercise to establish which of the options should be retained and continue to be developed. The agreement with participants was that a solution/option would only be eliminated if every participant agreed it should.

It was agreed that Option A should be discarded after no participant was willing to state a case to retain the option due to its lack of deliverability as reflected in the SWOT analysis, and it was unanimously rejected at this stage, Option B and B2 be retained as they were following participants arguing for them to be kept as separate options and developed, and Option C and C2 brought together, retaining the advantages of both as a single option to be considered again following agreement in the room.

The rationale for the decision to retain the two B options was that there were sufficient clinical differences between them, while the C options could be merged while retaining the benefits and advantages of both options.

Further details of the session outputs, including how the options were retained or rejected, can be found in Appendix 3: Long list appraisal session output report.

Section 5: Appraise the long list of options using hurdle criteria (long list options)

Option	A			
Criteria	S	W	O	T
Financial viability				
Clinical viability				
Workforce viability				
Accessibility				
Deliverability				

These boxes are the summary Strength, Weakness, Opportunity, Threat (SWOT) analysis that were presented to the appraisal group ahead of the consensus session.

Green indicates positive, red is negative, and amber is neither good nor negative.

Where the boxes are blank (white), the working group were unable to find evidence that the model produced any impact on which to make a scoring decision.

Option	B			
Criteria	S	W	O	T
Financial viability				
Clinical viability				
Workforce viability				
Accessibility				
Deliverability				

Option	B2			
Criteria	S	W	O	T
Financial viability				
Clinical viability				
Workforce viability				
Accessibility				
Deliverability				

Option	C			
Criteria	S	W	O	T
Financial viability				
Clinical viability				
Workforce viability				
Accessibility				
Deliverability				

Option	C2			
Criteria	S	W	O	T
Financial viability				
Clinical viability				
Workforce viability				
Accessibility				
Deliverability				

Section 6: Appraise the options still being considered (short list)

The workshop is described by the Consultation Institute (tCI) as a 'public appraisal' workshop; a deliberative event where participants consider (i) the level of importance that should be attributed to each criterion, and (ii) how each proposal (also known as options) should be scored against each criterion; to arrive at an overall 'weighted score' that advises the body consulting of the degree to which each solution meets requirements.

Following an expression of interest process as set out in Section 3 :Methodology, 13 members of the public and representatives of community and third sector groups were invited to the event after they had expressed an interest to attend, of which 1 attended on the day. 24 staff representing HDdUHB were in attendance, along with presenters, observers, and supporting staff.

The workshop contained two parts:
1. Weighting the criteria
2. Scoring the options

It should be noted that proposals/options at this stage are not expected to be fully detailed proposals where there are factors that will yet determine their finalised model. They are expected to be at a more developed stage than at the 'hurdle criteria evaluation' stage, such that participants can understand what the model looks like, includes, and has the potential to be developed into.

The agenda for the event was as follows:
- Welcome and introduction
- Recap on the process to date
- What we are trying to achieve today
- Presenting the criteria
- Weighting the criteria
- Introducing the options and scoring
- Presentation of the options
    - Option C
        - Discussion and questions
    - Option B
        - Discussion and questions
    - Option B2
        - Discussion and questions
- Scoring the options
- Slido opportunity (to provide further information or ideas)

Presenting and weighting the criteria
Nicholas Duffin of tCI introduced one of the programme managers, who explained the criteria that were being used to participants and how they had been arrived at - by canvassing the views of internal and external stakeholders. Participants were invited to ask questions.

Section 6: Appraise the options still being considered (short list)

The criteria explained were:
1. Clinical viability
2. Workforce viability
3. Safe inter-hospital transport system
4. Deliverability
5. Accessibility
6. Facilities (incl. interior suitability)
7. Inter-service accessibility
8. Impacts on people

Nicholas Duffin (tCI) then led participants in weighting the criteria. Nicholas began by explaining the relevance of weighting and why we weight criteria; to establish whether some criteria were more important than others.

Participants were invited to use sheets (aids) on the table to consider what weight they would allocate to each criterion. The method used was to divide 100 points between the 8 criteria.

When participants confirmed they were ready, they were invited to go online (at YourScoreUK[1]) and input their weightings for each criterion. They were invited to ask for help if they needed it. When all participants had finished, the average weightings for each criterion were presented to them.

	Clinical viability	Workforce viability	Safe inter-hospital transport system	Deliverability	Accessibility	Facilities	Inter-service accessibility	Impacts on protected groups
Total	448.5	464	278.25	356.5	264.75	417.5	248.25	222.25
Average	16.6	17.2	10.3	13.2	9.8	15.5	9.2	8.2

Presenting the options

The working group leads introduced participants to the work that colleagues and public members had undertaken in developing options, eliminating those (through hurdle criteria evaluation) that were deemed less worthy of developing further, and, continuing to develop the options that had been retained. He also explained how they would present the options, considering both what can be delivered and the potential of the options.

Option C was presented first. Questions were taken throughout the presentation and participants were encouraged to deliberate over the option. Once there were no further questions the event was paused to take lunch.

On return Option B was presented, then Option B2, in the same manner/format that had been used for Option C. Participants were encouraged to ask questions and deliberate over both options.

Once questions and discussion had finished, the session was handed back to Nicholas Duffin (tCI).

[1] A digital weighting and scoring tool (www.yourscoreuk.com) which allows appraisal attendees to see the group's decisions in real time.

Section 6: Appraise the options still being considered (short list)

Option C

Builds on the 2021 model (the suspension of the PACU at WGH, also known as Puffin Ward) through the expansion of non-emergency services retained in WGH, 9am – 5pm service.

What is unique or new:

- Formalising/ locally defining rapid access clinics
- Improving advice and support to Primary Care, and local patient access for specialist review (non-emergency)
- Ability to schedule follow up appointments directly for patients from WGH who have attended GGH for emergency treatment - or follow up from GGH Paediatric admissions for Pembrokeshire residents

Opportunities to:

- House the entire multidisciplinary team (MDT) under one roof - "Hub Integrated approach"
- Incorporate outpatient activity/Day Care provision for Children's Services - with potential to extend to tertiary clinics etc. (improved environment)
- Enhance future workforce opportunity, e.g. Community Nursing – Outreach Team; play specialists, etc.
- Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow

Option B

Builds on the 2016 model, PACU 10am – 6pm model (Mon – Fri) staffed 10am – 8pm (no referrals from Primary care after 6pm) and Outpatient 9am – 5pm (Mon – Fri) co-located with DAV supporting

What is unique or new:

- Planned **and** same day urgent paediatric day case reviews (any potential admissions would still go to GGH) - No overnight or weekend activity
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Opportunities to:

- Develop Advanced Paediatric Nurse Practitioners and Physicians Associates - non-medical staffing supplementary workforce
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Option B2

Same model as Option B, with the following differences:

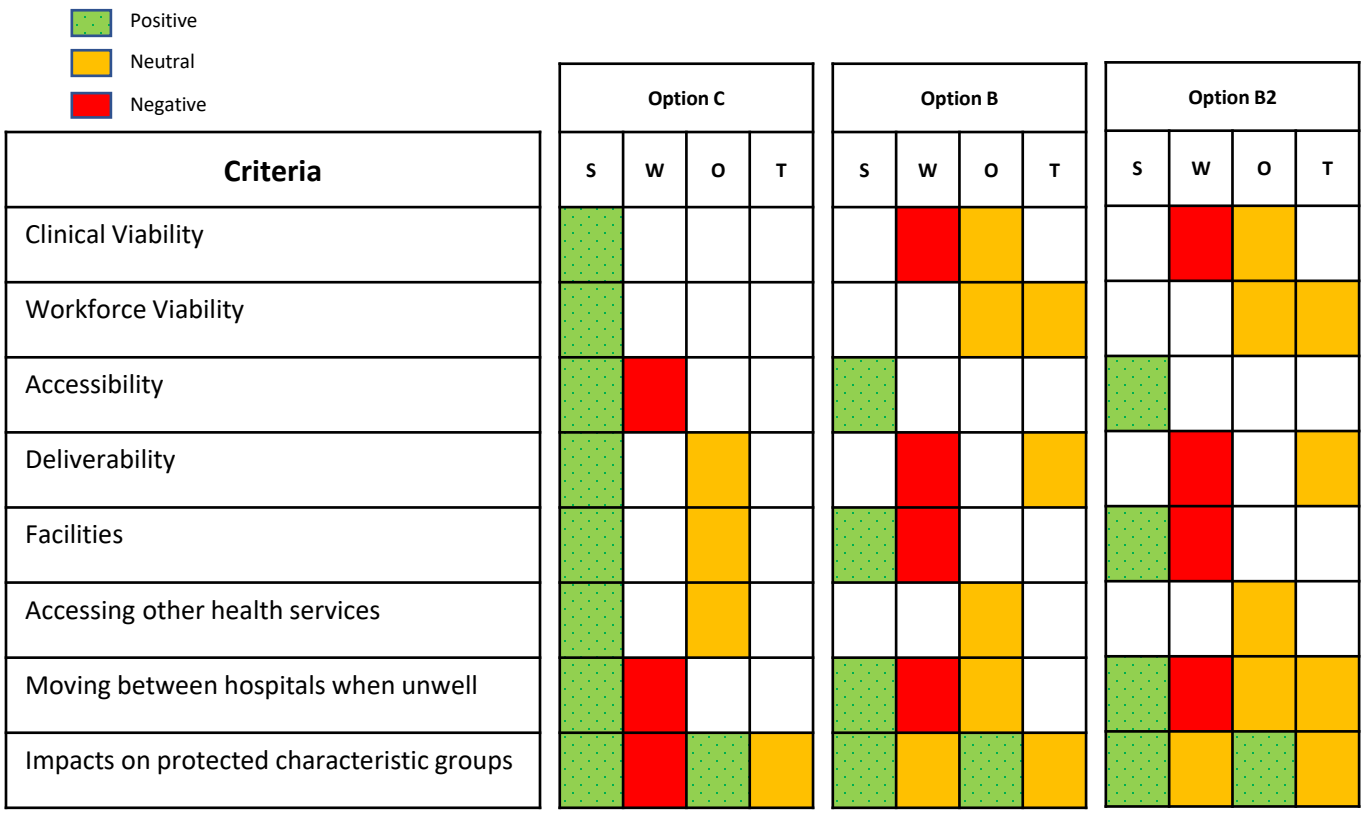
- All non-emergency treatment identified would be repatriated
- Emergency Department would offer an enhanced service, better point of entry, e.g. triage for CYP
- Robust emergency pathways at GGH

Section 6: Appraise the options still being considered (short list)

This is a summary of the Strength, Weakness, Opportunity, Threat (SWOT) analysis carried out for each of the options.

Green indicates positive, red is negative, and amber is neither good nor negative. Where the boxes are blank (white), the working group were unable to find evidence that the model produced any impact on which to make a scoring decision.

There is some difference between the options at this stage compared to the long listing stage as more modelling has been carried out, and there is a better understanding of how likely it will be to develop each option.



The full Strength, Weakness, Opportunity, Threat (SWOT) analysis, including rationale for scoring for each the options can be found in Appendix 8: Strengths, Weaknesses, Opportunities, Threat (SWOT) analysis of options.

Section 6: Appraise the options still being considered (short list)

Scoring the options

Nicholas then explained to participants how scoring was to be undertaken. Participants were directed to a sheet (aid) on their tables that they could use to think through and plot what scores they would give each option against the 8 criteria. This sheet was in the format of a table, with 24 cells for the 3 options and 8 criteria.

It stressed to participants that when scoring they should appreciate this was not a 'vote', but that they needed to evaluate how well they thought each option met (or satisfied) each of the criteria and that their scores should reflect this.

Nicholas then demonstrated to participants how to submit their scores through the YourScoreUK facility online, when they were ready.

Participants were invited to ask questions. They were then invited to ask for help if they needed it. Once all participants had scored the options, the weighted scores for the options were presented back to them.

The scores for options

25 submissions for scoring were received. The total scores for each option were as follows:

Criteria	Option C	Option B	Option B2
Clinical viability	213	166	166
Workforce viability	214	143	146
Safe inter-hospital transport system	171	140	144
Deliverability	213	145	134
Accessibility	175	188	191
Facilities (incl. interior suitability)	181	181	177
Inter-service accessibility	154	159	159
Impacts on people	157	162	162
Totals	1478	1284	1279

Details of the session outputs can be found in Appendix 4: Short list appraisal session output report.

Section 7: Conclusion

The work to develop and appraise the options was a clinically led process, with public involvement encouraged. Members of the public were involved within the working groups to create the options which were finally appraised. Advice and guidance throughout the process was provided by the Consultation Institute.

Following the issues paper being published and presented to Board, a deliberative session took place to understand what would make a good paediatric service, and this was followed by two working groups who worked up 5 long list options (**Section 5**) and then these were further developed into the 3 options which were shortlisted (**Section 6**).

Option C had the highest overall score (1478), but the lowest score for *accessibility* and *impacts on people*, and the same score as Option B for *facilities*.

Option B (1284) scored marginally higher than Option B2 (1279) overall, but scored lowest for *workforce viability* and *safe inter-hospital transport system*, and received the same score as Option B2 for *clinical viability*.

Option B2, which built upon Option B through pathways and transportation, had the lowest overall score, with the lowest score for *deliverability* and *facilities* (incl. interior suitability). However, this option had the highest overall score for *accessibility*.

The conclusion from these scorings is that all three options have distinct advantages and disadvantages which were reflected within the scores against criteria.

During the short listing session attendees had an opportunity ask questions during the presentation of options, and to reflect on the scores once they were provided to see whether the results reflected what they felt about the three options.

During the discussion and reflections it was felt that the timescale for development and appraisal of options had been short and at fast pace, which reduced the opportunity for a wider range of staff to engage fully. Also, more work would be needed to fully cost and explore the financial implications of investing in the aspirational elements of the three options beyond the information which had been shared within the shortlisting session, as this will help others when deliberating on the options.

As only 1 member of the public was present, the results could have been different if the room had a balanced public stakeholder presentation. Due to reduced public, third sector, and community engagement in the options appraisal stage, the advice received from tCI is that the three options which have been scored be taken forward to public consultation. This would also allow a wider range of staff recommended by workshop attendees who must be engaged with, to have an opportunity to be consulted.

Section 8: Glossary of terms

Term	Definition
Appraisal Group	A group established with inclusive and representative public participation to work alongside the multidisciplinary service representatives to undertake an assessment
Appraise the Options	Undertake an assessment of the available options
Community Health Council	The Community Health Councils (CHCs) are the independent watchdog of the National Health Service (NHS) within Wales. The CHC encourage and support people to have a voice in the design and delivery of NHS services
Complaint	A "complaint means any expression of dissatisfaction". (Welsh Government 2011)
Concern	A "concern means any complaint; notification of an incident or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation" (Welsh Government 2011)
Confirm Criteria	Agree using a consensus approach what the criteria should be
Consensus	1. A mutually acceptable agreement that integrates the interests of all concerned parties. A number of dialogue methods seek to arrange consensus views by stimulating stakeholder discussions and focusing on area of agreement 2. General or widespread agreement. Tends to be used to describe an outcome that 'everyone can live with', as well as unequivocal agreement. A win/win solution
CYP	Children and Young People
Dedicated Ambulance Vehicle	Ambulance vehicle and crew designed to transfer paediatric patients as soon as possible
Deliberative Session	Discussion and consideration by a defined group of people in a meeting / workshop
Equality Impact Assessment	The purpose of the Equality Impact Assessment (EqIA) is to identify and eliminate discrimination, harassment, victimisation. It identifies benefits from the proposals and mitigates where there may be negative impacts. It also seeks to advance equality of opportunity and foster good relations between different groups of people
Hurdle Criteria	Defined criteria to outline the minimum level that must be met
Inpatient Unit	A unit with the purpose and function of which to provide services to a patient following that person's admission to a health unit

Section 8: Glossary of terms

Term	Definition
Interim Paediatric Review Project Group	A bi-weekly group established following the Board decision on November 24th 2016 to approve a temporary reduction in the operating hours of the PACU at WGH
Long List of Options	A complete list of options gathered as an output from the knowledge, data, material, or insights compiled
Paediatric Ambulatory Care Unit	Non-inpatient hospital services, the provision of care to sick children in a hospital environment whereby they are not admitted to the ward as an inpatient
Paediatric overnight consultant on call rotas	Consultants who work on a rota are required to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period
Paediatric Services	Services provided for infants and children from birth to age 18
Patient Safety Incidents	A patient safety incident "means any unexpected or unintended incident which did lead to or could have led to harm for a patient" (Welsh Government 2011)
Project Initiation Document	The PID defines the project scope and identifies how the project will achieve its objectives. It puts the project on a solid foundation, a baseline that provides a place from which the project manager and project board can assess progress. The PID is a living document which is updated and revised as necessary throughout the project
Public Board	The principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights
Score the Options	Score each option against the weighted criteria and add these scores up to give an overall score for each option
Short List of Options	A short list of options compiled utilising a consensus approach and hurdle criteria
Slido	A digital polling tool (www.slido.com) which allows people to anonymously share their opinions and provide reflections
Temporary service change	A change made to meet service needs for a temporary period

Section 8: Glossary of terms

Term	Definition
The Consultation Institute	A not-for-profit best practice Institute, promoting high-quality public and stakeholder consultation in the public, private and voluntary sectors. A membership body offering a variety of support services and training for any person or body with an interest in public dialogue, engagement and participation. Further information is available on their website: https://www.consultationinstitute.org/
Weight the Criteria	If the criteria are of unequal importance, agree using a consensus approach a weighting to the relative importance of the criteria
Working Group	A small group established with inclusive and representative public participation to work alongside the multidisciplinary service representatives to consider information, data, and views
YourScoreUK	A digital weighting and scoring tools (www.yourscoreuk.com) which allows appraisal attendees to see the group's decisions in real time

Appendices

Appendix 1: Previously Submitted Board Papers

Update on the Review of Paediatric Services (Issues Paper). Item 3.4 (29 September 2022)
https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-29th-september-2022/english/item-34-interim-paediatrics-review/

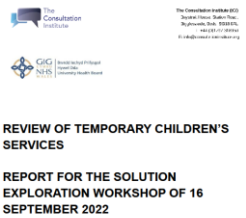
Update on the Review of Paediatric Services. Item 4.3 (26 May 2022)
https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-26-may-2022/agenda-and-papers-26-may-2022/item-43-update-on-the-review-of-paediatric-servicespdf/

Paediatric Surge Plans for Respiratory Syncytial Virus (RSV). Item 4.2 (30 September 2021)
https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-30th-september-2021/agenda-and-papers-30th-september-2021/item-4-2-paediatric-surge-plans-for-respiratory-syncytial-virus-rsv/

Appendix 2: Deliberative session output report

Following the deliberative session, the Consultation Institute (tCI) provided a report detailing the events that took place, the methodologies, and an overview of the discussions which took place.

This report was used as part of the engagement plan to sense check with targeted groups, testing whether or not the key themes were reflective of their needs and whether there were other things that should be considered by the appraisal group.



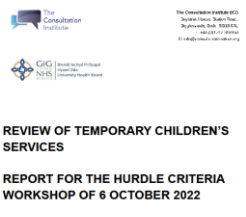
REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE SOLUTION EXPLORATION WORKSHOP OF 16 SEPTEMBER 2022

Appendix 3: Long list appraisal session output report

Following the deliberative session, the Consultation Institute (tCI) provided a report detailing the events that took place, the methodologies, and an overview of the discussions which took place.

This report was used as part of the engagement plan to sense check with targeted groups, testing whether or not the key themes were reflective of their needs and whether there were other things that should be considered by the appraisal group.



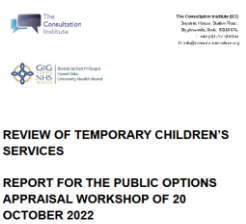
REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE HURDLE CRITERIA WORKSHOP OF 6 OCTOBER 2022

Appendix 4: Short list appraisal session output report

Following the deliberative session, the Consultation Institute (tCI) provided a report detailing the events that took place, the methodologies, and an overview of the discussions which took place.

This report was used as part of the engagement plan to sense check with targeted groups, testing whether or not the key themes were reflective of their needs and whether there were other things that should be considered by the appraisal group.



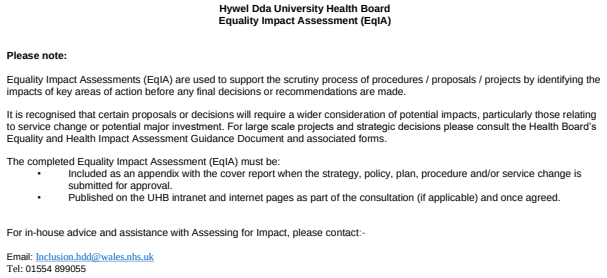
REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE PUBLIC OPTIONS APPRAISAL WORKSHOP OF 20 OCTOBER 2022

Appendix 5: Option C Equality Impact Assessment

The EqIA for Option C highlights that with all urgent and emergency paediatric care provided from Glangwili General Hospital it has the greatest impact on children as well as their parents, guardians, and carers.

While they benefit from a centralised service which is more sustainable, this needs to be considered against the travelling and socio-economic impact of cost burden to family and missed work/ education opportunities.



Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

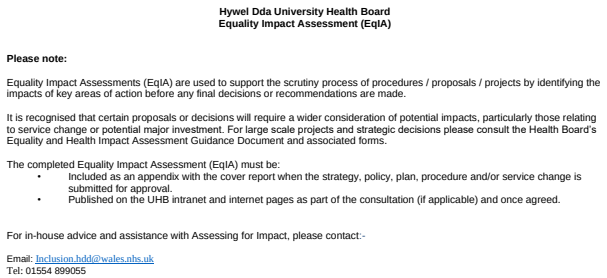
For in-house advice and assistance with Assessing for Impact, please contact:-

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Appendix 6: Option B Equality Impact Assessment

The EqIA for Option B notes a benefit with more care provided closer to Pembrokeshire, however this is only a limited improvement due to the service being provided on a Monday to Friday basis without late night care provision, meaning travelling is still required.

There is still a benefit from a sustainable centralised service, there will still be a need to travel which as greater impact on areas of deprivation in the community.



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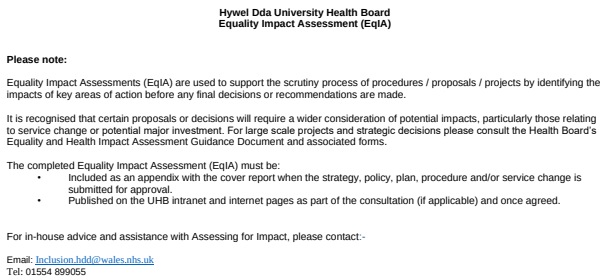
Appendix 7: Option B2 Equality Impact Assessment

The EqIA for Option B2 retains most of the benefits and impacts of the Option B EqIA.

The difference for this option is that children will receive a better quality of care and better health outcomes through the changes to transportation and health pathways, however this is unlikely to be noticeable to the public as the messaging and communication for Option B2 services at Withybush will be the same as Option B.



Hywel Dda University Health Board
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Tel: 01554 899055

Positive
Neutral
Negative

SWOT overview – Option C

Criteria	Strengths	Weaknesses	Opportunities	Threat	Rationale for rating
Clinical viability - this includes considering how well the solutions meet required standards					Substantive (existing) staffing model able to deliver this service with minimal recruitment requirements The 9-5 and the patient cohort elements of this option mitigate risks reported in previous service provision
Workforce viability - the extent to which the solutions can be staffed.					Substantive (exisitng) staffing model able to deliver this servcie with minimal recrutiemtn requirments
Accessibility - how accessible services will be for the people who need them or to visit					Puffin is easily accessable and signposted clearly- with local children and families/ carers being familiar with the venue Parking (dedicated) is not readily available after 0930 on the WGH site (including close proximity to ward for disabled access etc
Deliverability - how easy it will be to quickly develop and deliver what the solution (option) proposes.					Service able to operate following minor decorative improvement, no major structural change required in this model though some opportunities to further increase clinic room space have been identified in order to maximise the footprint.
Facilities - the range of facilities offered, from: overnight beds for both children and parents to easily accessible sustenance; entertainment for children; parking close to, etc. and Interior suitability - units that are modern, clean and designed for the benefit of children.					Purpose built environment (Puffin)- able to facilitate clinical models (subject to limitations on clinic room space) Parking (dedicated) is not readily available after 0930 on the WGH site (including close proximity to ward for disabled access etc Accommodation- no plan for overnight stay in this model – no accommodation requirements other than facilities within the clinical environment
Inter-service accessibility - easy access to associated services on the same site, such as Child and Adolescent Mental Health Services					Potential to incorporate multi system/ service working- single point of access/ assessment etc (though this is already partially in place) Community service provision being positively reviewed concurrently- which will also present enhanced opportunity for collaborative working
Safe inter hospital transport system i.e. dedicated ambulance to transport unwell children between WGH and GGH					Existing transport infrastructures in place (e.g. Dav, WATCh pathways) Weaknesses relate to availability of appropriately trained medical staffing to support enhanced care – especially relating to inter health board movements. However, patient cohort is more restrictive (less illness)Opportunity to revisit commissioning of specialist transfer services- to minimise risks
Impacts on people – Are groups disadvantaged by the proposal					Children and Young People in Pembrokeshire and South Ceredigion are affected as all acute care will require greater traveling distances. The impact is likely to be felt by women who are more likely to be primary carers than men, and also a socio-economic impact on employment and education. The strength of option C is some care is brought closer to home (WGH) reducing the distance travelled for outpatient/ day care and follow appointments where possible.

Positive
Neutral
Negative

SWOT overview – Option B

Criteria	Strengths	Weaknesses	Opportunities	Threat	Rationale for rating
Clinical viability - this includes considering how well the solutions meet required standards					Staffing requirements Risk to patients who may need transfer to inpatient care (includes routine and critical presentations) Opportunity for recruitment
Workforce viability - the extent to which the solutions can be staffed.					Subject to recruitment and workforce planning – cognisant of previous staffing difficulties which resulted in interim changes- more staff more risk- equally depletion of staffing model at GGH (esp SASG) would be detrimental to entire West Wales service provision Opportunity for remodelling and recruitment
Accessibility - how accessible services will be for the people who need them or to visit					Local, more sustainable provision for wider variety of clinical presentations- maximises care closer to home for routine and urgent (not emergency-level) care
Deliverability - how easy it will be to quickly develop and deliver what the solution (option) proposes.					Success is subject to successful recruitment and workforce planning, job planning, Organisational Change Policy, environmental remodelling and associated expenditure
Facilities - the range of facilities offered, from: overnight beds for both children and parents to easily accessible sustenance; entertainment for children; parking close to, etc. and Interior suitability - units that are modern, clean and designed for the benefit of children.					Purpose built environment (Puffin)- able to facilitate clinical models (subject to limitations on clinic room space) Parking (dedicated) is not readily available after 0930 on the WGH site (including close proximity to ward for disabled access etc Accommodation- no plan for overnight stay in this model – no accommodation requirements other than facilities within the clinical environment
Inter-service accessibility - easy access to associated services on the same site, such as Child and Adolescent Mental Health Services					Potential to incorporate multi system/ service working- single point of access/ assessment etc Community service provision being positively reviewed concurrently- which will also present enhanced opportunity for collaborative working
Safe inter hospital transport system i.e. dedicated ambulance to transport unwell children between WGH and GGH					Existing transport infrastructures in place (e.g. Dav, WATCh pathways) Weaknesses and threats relate to availability of appropriately trained medical staffing to support enhanced care – especially relating to inter health board movements. Opportunity to revisit commissioning of specialist transfer services- to minimise risks
Impacts on people – Are groups disadvantaged by the proposal					Children and Young People in Pembrokeshire and South Ceredigion are affected as all acute care will require greater traveling distances. The impact is likely to be felt by women who are more likely to be primary carers than men, and also a socio-economic impact on employment and education. The strength of option is that care can be provided closer to home and a PACU service could eliminate some additional travel time during operating hours.

Positive
Neutral
Negative

SWOT overview – Option B2

Criteria	Strengths	Weaknesses	Opportunities	Threat	Rationale for rating
Clinical viability - this includes considering how well the solutions meet required standards					Staffing requirements Risk to patients who may need transfer to inpatient care (includes routine and critical presentations) Opportunity for recruitment
Workforce viability - the extent to which the solutions can be staffed.					Subject to recruitment and workforce planning – cognisant of previous staffing difficulties which resulted in interim changes- more staff more risk- equally depletion of staffing model at GGH (esp' SASG) would be detrimental to entire West Wales service provision Opportunity for remodelling and recruitment
Accessibility - how accessible services will be for the people who need them or to visit					Local, more sustainable provision for wider variety of clinical presentations- maximises care closer to home for routine and urgent (not emergency-level) care
Deliverability - how easy it will be to quickly develop and deliver what the solution (option) proposes.					Success is subject to successful recruitment and workforce planning, job planning, Organisational Change Policy, environmental remodelling and associated expenditure
Facilities - the range of facilities offered, from: overnight beds for both children and parents to easily accessible sustenance; entertainment for children; parking close to, etc. and Interior suitability - units that are modern, clean and designed for the benefit of children.					Purpose built environment (Puffin)- able to facilitate clinical models (subject to limitations on clinic room space) Parking (dedicated) is not readily available after 0930 on the WGH site (including close proximity to ward for disabled access etc Accommodation- no plan for overnight stay in this model – no accommodation requirements other than facilities within the clinical environment
Inter-service accessibility - easy access to associated services on the same site, such as Child and Adolescent Mental Health Services					Potential to incorporate multi system/ service working- single point of access/ assessment etc Community service provision being positively reviewed concurrently- which will also present enhanced opportunity for collaborative working
Safe inter hospital transport system i.e. dedicated ambulance to transport unwell children between WGH and GGH					Existing transport infrastructures in place (e.g. Dav, WATCh pathways) Weaknesses and threats relate to availability of appropriately trained medical staffing to support enhanced care – especially relating to inter health board movements. Opportunity to revisit commissioning of specialist transfer services- to minimise risks
Impacts on people – Are groups disadvantaged by the proposal					Children and Young People in Pembrokeshire and South Ceredigion are affected as all acute care will require greater traveling distances. The impact is likely to be felt by women who are more likely to be primary carers than men and also a socio-economic impact on employment and education. The strength of option is that care can be provided closer to home and a PACU service could eliminate some additional travel time during operating hours.

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REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE SOLUTION EXPLORATION WORKSHOP OF 16 SEPTEMBER 2022

Contents

Introduction and background

The Consultation Institute (tCI) is commissioned by Hywel Dda University Health Board (HDUHB) to provide advice and support for their involvement of stakeholders in the development of an Interim Paediatrics (children's services) solution, covering Pembrokeshire and Carmarthenshire, for the next seven years, to 2029.

The expectation is that a new permanent solution for Paediatrics (Paeds) will be arrived at with the development and opening of a new hospital, expected to be in 2029.

Since a permanent change to the configuration of services in 2014, Paediatrics has seen three temporary changes, between 2016 and 2021. The present review seeks to determine an effective model for Paediatric services that can be retained until 2029.

As part of this review, HDUHB have sought information and views from internal and external stakeholders and service users, and have considered a range of information relating to service delivery, since 2014.

HDUHB identified the need for a robust, phased service user and stakeholder involvement process in gathering information to help inform proposals. This includes:

1. Reviewing how services have performed and peoples' experiences of the services since 2014, using historical data, service and service user feedback and a survey of experience; to build a better understanding of what service users and stakeholders consider as good, bad, needs improvement and/or should be retained or changed.
2. Deliberating with service users and stakeholders about what 'solution designers' should consider and prioritise in designing an interim solution.
3. Co-producing potential solutions with a select group of internal and external stakeholders, including service user representation.
4. Appraising potential solutions with service users and internal and external stakeholders.
5. Consulting the public on a preferred solution or solutions..

Phase 1 was completed in August 2022. The research, historical data, outputs of engagement and the survey were used to inform a detailed 'issues paper' produced by HDUHB to inform Phase 2.

Phase 2, a deliberative event with a mixed group of stakeholders, was undertaken on Friday 16th September, 2022.

This report provides the outputs and learning from the Phase 2 event of 16th September.

The Phase 2 workshop

The workshop is described as a 'solutions exploration' workshop; a deliberative event where participants consider what has been learned from Phase 1 (using an Issues Paper and any other supporting information) and attempt to reach consensus or agreement on what those who will develop solutions/proposals (Phase 3) need to consider and prioritise.

Participation is of mixed stakeholders; both internal and external stakeholders and current or recent service users. Ideally, the majority of participants have some recent experience of or involvement in the services being considered.

Participants were recruited by HDUHB, by contacting internal and external stakeholders, including parents and guardians of recent service users, to invite them to book a place at the workshop. 155 parents or guardians, who had previously asked to be kept informed, were invited to take part.

24 expressions of interest were received, all were invited to attend. Only 5 confirmed they would attend, of which only 2 actually attended on the day.

On the recommendations of the Community Health Council (CHC), a number of third sector organisations were also invited to express an interest and be included.

The event was split into two halves; morning and afternoon.

The morning was dedicated to providing participants with the information they needed in order to participate in the afternoon sessions. This included:

- The recent history of Paediatric services in Pembrokeshire and Carmarthenshire
- The permanent change to a new service model in 2014
- Temporary changes to the service model in 2016, 2020 and 2021.
- Learning from:
    - Service feedback and complaints systems
    - Recent engagement with parents and guardians, service users and staff
    - The recent survey with parents and guardians of recent service users.
- Answering the questions of the participants

Staff of HDUHB presented the above information, with Andy Wright of tCI relaying the outputs and learning of the survey.

The afternoon was dedicated to participants:

- Deliberating about what they wanted to see in an interim service model
- Agreeing what they regarded as essential to a good working model
- Agreeing what was also important in a good working model
- Advising which of the four service models since 2014 represented the best starting position for developing or enhancing a service model for the next 7 years
- Advising what they felt were sensible 'hurdle' criteria for appraising 'developing' solutions

The afternoon deliberative sessions

Participants were located across four tables. The participants on the tables were as diverse as possible within the make-up of the participants. There was parent.guardian (of service users) and/or non-NHS representation on each table. Each table had a table lead to help facilitate the discussion and keep it on track.

Session 1

The lead facilitator (Nicholas Duffin of tCI) asked the participants on each table to discuss, deliberate and debate, amongst themselves, and agree what would be important to consider in developing an Interim Paeds model that would be fit for purpose until 2029. The participants were asked to keep notes to use in session 2.

Mid-way through the session they were asked to also make note of any 'good' ideas they came up with to resolve what they thought were issues in developing a new model.

Session 2

The facilitator asked the participants to take what they had considered and put it into order, based upon:

1. What they regarded as 'essential' for the Interim model
2. What they regarded as 'important' but not essential.
3. What they they had noted but felt was not 'essential' or 'important' but might be considered as of either:
    a. Lesser importance
    b. Might minimise or eliminate negative impacts on people
    c. Ensure accessibility to services

The participants of Tables 1, 2 and 3 made notes directly on sheets. Team 4 used post-it notes.

On completion of the sheets, table leads gave a brief summary, to the room, of what had been considered and recorded.

The full outputs of session 2 are found in Appendix 1 (below).

Summary of recurring themes from across the tables

- There needs to be the space for and commitment to a multi-disciplinary environment where Paeds is located.
- Information Technology (IT) support needs to be improved - ability to access data and information between locations and between services; telemedicine.
- Transport needs to be improved - both emergency and non-emergency - both between sites and to support public accessibility (particularly those disadvantaged and under financed).
- A Hub model is needed - space is needed that non-Paeds support, like Social Care / Child and Adolescent Mental Health Services (CAMHS), can be accessed and work closely with Paeds at the same site. Patients needing multiple support can be seen at one location by different services, both Health and non-health.
- Dedicated Accident and Emergency (A&E) / Emergency Department (ED) is needed or better ties (Paediatric Admissions Unit- PAU).
- Fit for purpose Acute units.
- The environment must be conducive to the welfare and wellbeing of Children and Young People (CYP) - facilities and the environment should involve CYP in design - consideration of different age groups in design.
- Facilities for overnight stays for both patients and families/carers need to be improved and appropriate to ages.
- Signposting at sites needs to be improved.
- Improve pathways: screening, minor illness, acute.
- Improved workforce planning and education - better forward thinking
- Improve communication and engagement with interested parties - involve CYP much more, in service design, learning experiences, etc. Better transparency with all interested parties.
- Staffing needs to be safe and sustainable.
- Better 'Care Close to Home' modelling - tie in with Hubs.
- Better on site facilities for all people - food, drink, support, accommodation, parking.

Session 3

The facilitator invited the tables to deliberate over a starting model for phase 3. The question to the tables was, “Bearing in mind what you have considered and noted today, which of the 2014, 2016, 2020/2021 models (discussed this morning) represents the best starting position to redesign an Interim Paeds solution?”

The tables deliberated and then provided the following views:

Table 1 - 2020/21 model with better facilities at Withybush - based upon the ‘essentials’ identified in session 2
Table 2 - 2020/21 model with an AP&P model at Withybush
Table 3 - 2020/21 model with a range of specific changes based upon ‘essentials’ identified in session 2.
Table 4 - 2014 model with ‘hub’ modelling essential

The tables agreed that in either case a lot of what they had earlier identified as essential needs to be considered.

Session 4

The facilitator invited the tables to consider what ‘hurdle’ criteria should be used by participants in phase 3, in evaluating any developing models for an Interim Paeds solution; ‘hurdle’ criteria being those that are non-negotiable.

The facilitator asked two questions:

1. “It is usual that (i) financial viability, (ii) clinical viability, and (iii) accessibility (all people will have access) are used as hurdle criteria. Do you agree that these are sensible in considering an Interim Paeds model?”
2. “Are there any other non-negotiables that you feel should be used as ‘hurdle’ criteria?”

The tables deliberated and fed back the following recommendations:

Recommendations

1. The three mentioned (above) were acceptable but that ‘financial’ must consider:
    a. Financing
    b. Value
    c. Cost to the individual

2. ‘Deliverability’ should be a hurdle criteria - that any solutions must be achievable in a reasonable time, not take until 2029 to achieve.
3. Workforce viability and a safe inter-hospital transport system was ensured. The workforce viability might sit under ‘clinical viability’ or not, but must be a non-negotiable. The safe inter-hospital transport system might be part of ‘accessibility’ but probably sits better alone as a non-negotiable.

This concluded the afternoon deliberative sessions.

Appendix 1 - outputs from the tables

Table 1

Essential

Each area has a Paeds hub (with Multidisciplinary Team (MDT) working, eg, therapies) providing:

1. Multi-disciplinary care with adequate space and resources - clinical space for consultations but with different set ups, eg, consulting room, rooms for community needs, physio assessment room, etc.
2. IT support and diagnostic support - a system to link primary care with secondary and maybe even tertiary centres, to enable better flow of information and patient records; to include discharge summaries from Glangwilli General Hospital (GGH), etc.
3. Transport - 'NHS Uber' - non-emergency transport and/or improved transport links. Would look different across the 24 hour period but aim to improve access and reduce travel issues. If there is no centre in Withybush General Hospital (WGH) at night, we would also need some ways to support patients heading to GGH.
4. The Hub could provide space for better links between Health and Social Care - uncertain if Social Care services need to be there permanently, but access for social workers, etc, could be advantageous.
5. Face to face consultations not virtual (as default).

Essential - Acute pathway

1. Properly functioning Primary Care Service
    a. A&E service - to be a fully functioning dept you would need to be able to manage Paeds presentations internally
    b. Capacity in General Practitioner (GP) services
    c. Signposting for families to not bypass primary care
2. Properly functioning ambulance service/transport
3. Access to child friendly environments - ref to fit for purpose environments - could be a mix of rooms to support different age and patient groups- bays, single rooms, consulting rooms, etc.
4. Fit for purpose Acute paediatric units
5. Pathways to manage:
    a. Front door screening
    b. Minor illness closer to home (assess, educate, reassure, safety net *[parental advice system]*)
    c. Acute significant illness - fast recognition and transfer (transport)
6. Hospital at home service - not fully explored not but possibly a team of experienced nurses to deliver secondary care in the patients home (e.g. IV antibiotics) - there is a similar service in the adult world in HDUHB.

Important

1. Workforce planning and education
    a. Training/competence in management of paeds minor illness, so service not people dependent - idea: maximise and roll out training to a wider team of people to ensure access / continuity is maximised; be less reliant on fewer groups of staff. Examples might be to advance nurse practitioners and physician associates.
    b. Future workforce planning and future roles
2. Communication
    a. Engagement with following groups - see what patients would want from a service, eg, build / flow / design / decor; needs; pathways. Also to relay concerns / educate about pressures.
        i. Service users
        ii. CYP
        iii. Staff in and out of the service
        iv. Minorities and hard to reach groups
    b. Shared records - improved IT structure for greater efficiency
    c. Planning appointments - familiarity, continuity: for patients who are under care of multiple clinicians, eg, psychology, physio and respiratory physicians, to have one clinic that can host all specialities - a 1-stop-shop to reduce travel and appointments.
    d. Patient to be Chief Exec - better to have a conversation, but generally a thought that Exec decision makers are too far away from the service delivery to make safe decisions.
    e. Be honest, transparent - with everyone. Good communications and engagement with the staff, patients and wider public.

Table 2

Essential

1. Safe service - with effective delivery care in an appropriate setting
2. Accommodation (significant improvement needed in accommodation offered, e.g. does not allow for children and their families to receive age appropriate care - that includes the ability to facilitate MDT working.
3. Safe service - with adequate sustainable staffing - skill mix
4. Acute care - centralised: Glangwilli is the general assumption.
5. Age appropriate facilities wherever CYP attend
6. Views of CYP - engagement - involvement in future planning of the service, to learn about meeting their needs, and about learning from their experiences of the service.
7. Equity of access (standards) - reduce variations in clinical care by following recommended standards, e.g. NICE (National Institute for Health and Care Excellence), RCPCH (Royal College of Paediatrics and Child Health) etc., so young people would receive the same standard of care wherever they present.
8. Pathways - including Out of Hours (OOH), GP, ED, Welsh Ambulance Service NHS Trust (WAST)
9. Communication - Improve communication between the Multidisciplinary Team (MDT), Emergency Department (ED) and community.
10. IT systems (telehealth) - Re: IT systems - introduce systems for better efficiency, improve data collection, live dashboard, etc. More telemedicine to facilitate care.
11. Access to a Paediatric Admissions Unit (PAU) within ED areas - with an Advanced Nurse Practitioner model - Paeds transfer team (advanced High Dependency Unit - HDU)
12. Care closer to home, e.g scheduled care, integrated care centre - all care that does not need to be acute is delivered closer to home - integrated with acute team, community team, therapies, mental health, play etc.

Important

1. Accessibility - level up accessibility for patients and their support
2. Travel and cost associated with - support should be provided to those in need
3. Outreach/integrated service/Multidisciplinary team (MDT)/social care - closer working relationships
4. Fundamental care of families - food, drink, travel
5. Robust community service - community paediatrics needs significant investment - the development of a multidisciplinary team to include psychology, dietetics, school nursing, health visiting, specialist nurses for children with complex needs.
6. Change of culture - different working patterns / models - requires improvements in all the areas discussed (above).

Table 3

Essential

1. Transport (improvements)
    a. Free/affordable
    b. Sick children transfer between sites
    c. WAST improvements
    d. Emergency Medical Retrieval and Transfer Service (EMRTS) improvement
2. Paediatric Nursing staff / Advanced Nurse Practitioners (ANPs) - staff pay
3. Timely accessibility to CAMHS (for 16-18 year olds particularly)
4. Child/Young Person centred
5. Communication between services
    a. And between services and service users
6. Adequate staffing

Important

1. Age appropriateness
    a. Play/activity
    b. Waiting areas
    c. Ward facilities
2. Separate Paeds A&E
3. Triage
4. Refurb of areas
5. Parking
6. Places to stay for families and carers (not just parents and guardians)
7. Access to food, drink, cooking facilities
8. Appropriate
    a. Signposting
    b. Referral
    c. GP/111
9. Signage on roads
10. Equitable
    a. Means different things to different people
    b. Service does not have to be mirrored to be equitable
11. Integrated working across acute / community / primary care

Table 4

Table 4 opted to use post-it notes, hence less detail

Essential

1. Communication
2. I.T.
3. Pathways
4. Maintaining and building on standards
5. Integration
6. Hubs (PM)
7. Integrated Primary Care
8. Single Point of Access - partnership working
9. Workforce Transformation - safe staffing
10. Acute Care/Diagnostics
11. Neuro - Dev
12. Specialist review - long term care
13. Mental Health Services (CAMHS SP.CAMHS)
14. Emotional Wellbeing Services
15. Community Children's Nursing Service
16. Robust Community Support Services
17. Therapies
18. Accessibility
19. Ambulance transfer/availability
20. Transport/dedicated transport
21. Dedicated infrastructure
22. Improved signage
23. Emergency Care
24. County Based stabilisation skillset
25. Separate provision Paeds ED

Important

1. Transitional care
2. Clinics Operating Department Practitioner (OPD) (spaces)
3. Parking
4. Accessible bed areas
5. Accessible food and drink
6. Parents' accommodation > + wider support networks
7. Play

Of lesser importance (but to be considered)

1. An adolescent unit

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REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE HURDLE CRITERIA WORKSHOP OF 6 OCTOBER 2022

Contents

Introduction and background

The Consultation Institute (tCI) is commissioned by Hywel Dda University Health Board (HDUHB) to provide advice and support for their involvement of stakeholders in the development of an Interim Paediatrics (children's services) solution, covering Pembrokeshire and Carmarthenshire, for the next seven years, to 2029.

The expectation is that a new permanent solution for Paediatrics (Paeds) will be arrived at with the development and opening of a new hospital, expected to be in 2029.

Since a permanent change to the configuration of services in 2014, Paediatrics has seen three temporary changes, between 2016 and 2021. The present review seeks to determine an effective model for Paediatric services that can be retained until 2029.

As part of this review, HDUHB have sought information and views from internal and external stakeholders and service users, and have considered a range of information relating to service delivery, since 2014.

HDUHB identified the need for a robust, phased service user and stakeholder involvement process in gathering information to help inform proposals. This includes:

1. Reviewing how services have performed and peoples' experiences of the services since 2014, using historical data, service and service user feedback and a survey of experience; to build a better understanding of what service users and stakeholders consider as good, bad, needs improvement and/or should be retained or changed.
2. Deliberating with service users and stakeholders about what 'solution designers' should consider and prioritise in designing an interim solution.
3. Co-producing potential solutions with a select group of internal and external stakeholders, including service user representation.
4. Appraising potential solutions with service users and internal and external stakeholders:
    a. Hurdle criteria evaluation (6 October 2022)
    b. Public appraisal (weighting scoring) 20 October 2022
5. Consulting the public on a preferred solution or solutions.

Phase 1 was completed in August 2022. The research, historical data, outputs of engagement and the survey were used to inform a detailed 'issues paper' produced by HDUHB to inform Phase 2.

Phase 2, a deliberative event with a mixed group of stakeholders, was undertaken on Friday 16th September, 2022, providing (i) a series of recommendations for what should be considered by

those modelling the interim service, and, (ii) what 'hurdle' criteria should be used for early appraisal of developing solutions.

Phase 3 began on 26 September, when two groups were established to independently (of one another) develop proposals for an interim Paediatrics service. Each group was tasked with considering alternatives and variations, and tasked with producing a minimum of two proposals per group, for hurdle criteria assessment on 6 October 2022.

This report provides the outputs of Phase 4a, the Hurdle criteria evaluation event of 6th October.

The Phase 4(a) workshop

The workshop is described as a 'hurdle criteria, solutions appraisal' workshop; a deliberative event where participants consider the proposals (also known as options) that have been developed, thus far, and decide whether or not each proposal should continue to be developed or should be rejected. Rejection is ordinarily based upon whether the proposal adequately satisfies the 'hurdle' criteria.

It should be noted that proposals/options at 'hurdle criteria, solutions appraisal' are not expected to be finalised proposals. They are expected to be developing proposals that have sufficient information about them that 'appraisers' can decide whether they are worth pursuing.

The agenda for the event was as follows:

- Welcome and introduction
- Recap on the process to date
- What we are trying to achieve today
- Presentation of the options
    - Option A
        - Discussion and questions
    - Option B
    - Option B2
        - Discussion and questions
    - Option C
    - Option C2
        - Discussion and questions
- Consensus (reaching consensus for each option)
- Slido opportunity (to provide further information or ideas)
- Closing remarks

Dr Prem Kumar Pitchaikani opened the session, welcomed everyone and gave a historical overview of Paediatric services back to 2014. He then handed over Nicholas Duffin of the Consultation Institute to continue proceedings.

Nicholas first gave participants an overview of the 'process' to date, covering what public and staff involvement there had been in the project and explaining the preceding events in Phases 2 & 3. He then explained how this event would proceed and what needed to be achieved, explaining that what participants needed to do is to absorb the information on offer before deciding which solutions/options should continue to be developed in readiness for 20 October 2022.

Presentation of options

Nicholas then introduced Nick Williams-Davies and Marcus Andrews, who would talk participants through the five options on offer. *Their presentations and information on the five options can be viewed in the accompanying slideset.*

They began by explaining how they had worked in developing the options, the coincidence of coming to similar conclusions about options, and why, consequently, the options were lettered and numbered as they were; A, B, B2, C and C2.

Each option was then presented. Participants were provided with the opportunity to ask questions and deliberate about the options with the presenters and with one another. Options C and C2 drew the most questions and discussion.

An important development was discussed regarding Options C and C2. The point was put that because they were so similar, might it be worth merging them as one, or, just to continue with one or the other. A decision on this was deferred to the Consensus session.

Consensus

Nicholas Duffin (tCI) then took participants through a consensus exercise to establish which of the options should be retained and continue to be developed.

The agreement with participants was that a solution/option would only be eliminated if every participant agreed it should.

Starting with Option A, the question was asked, "Does anyone feel that Option A should be retained and be developed?" No participant put a case for retaining Option A. It was agreed unanimously to reject Option A at this stage.

The same question was put to participants for Option B. Several participants argued for the retention and development of Option B. So it was agreed that Option B would continue to be developed.

The same question was put to participants for Option B2. Again, participants argued for the retention and development of Option B2.

The same question was put to participants for Option C. Again, participants argued for the retention and development of Option C.

The same question was put to participants for Option C2. Again, participants argued for the retention and development of Option C2. However, the close similarity between C and C2 prompted further discussion about whether only one version of Option C should go forward.

After some deliberation a new motion was offered: “If Options C and C2 were to be amalgamated, retaining all the features of both C and C2, does anyone object to their being amalgamated as one Option and developed for 20 October? There were no dissenting voices.

To be sure about Options C/C2, a further question was asked, “If anyone wishes to argue against this amalgamation and the retention of both C options, please say now or it will be assumed the two will be merged?” Again, there was no arguing against the motion. So, it was agreed options C and C2 would be merged and developed further.

Participation statistics

Participants included:

26 staff
4 members of the public from Pembrokeshire
1 member of public from Ceredigion
Observers

Slido opportunity

Participants were offered an opportunity to feedback any further considerations that they felt should be taken on board in further developing these options. Only 3 participants took the opportunity. Their comments are in Appendix 1.

The meeting was then concluded and closed by Lisa Humphrey.

Appendix 1 - questions and responses on Slido

Q1 - What do you think should be considered in further developing Option B.
Responses:

1. Require financial forecast.
2. Reject

Q2 - What do you think should be considered in further developing Option B2.
Responses:

1. As above (B)
2. Remove urgent unscheduled care at WGH as we may not man it adequately.

Q3 - What do you think should be considered in further developing Option C+C2.
Responses:

1. Financial forecast. Further considered Consultation with the Workforce and Better Communication. Involvement of Young People. Better Public Information and Communication. Exploring more accommodation for Parents/Families Explore some Partnerships with Charities co Puffin Building and "Hub".
2. Transportation, also the realistic views on accomodation. Accessibility in transportation.
3. Consolidate GGH set up both at facilities, parking, workforce and transport.

Q4 - Is there a better model? If yes, please explain what the model looks like and why it is better than Options A-C2?
No responses.

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REVIEW OF TEMPORARY CHILDREN'S SERVICES

REPORT FOR THE PUBLIC OPTIONS APPRAISAL WORKSHOP OF 20 OCTOBER 2022

Contents

Introduction and background

The Consultation Institute (tCI) is commissioned by Hywel Dda University Health Board (HDUHB) to provide advice and support for their involvement of stakeholders in the development of an Interim Paediatrics (children's services) solution, covering Pembrokeshire and Carmarthenshire, for the next seven years, to 2029.

The expectation is that a new permanent solution for Paediatrics (Paeds) will be arrived at with the development and opening of a new hospital, expected to be in 2029.

Since a permanent change to the configuration of services in 2014, Paediatrics has seen three temporary changes, between 2016 and 2021. The present review seeks to determine an effective model for Paediatric services that can be retained until 2029.

As part of this review, HDUHB have sought information and views from internal and external stakeholders and service users, and have considered a range of information relating to service delivery, since 2014.

HDUHB identified the need for a robust, phased service user and stakeholder involvement process in gathering information to help inform proposals. This includes:

1. Reviewing how services have performed and peoples' experiences of the services since 2014, using historical data, service and service user feedback and a survey of experience; to build a better understanding of what service users and stakeholders consider as good, bad, needs improvement and/or should be retained or changed.
2. Deliberating with service users and stakeholders about what 'solution designers' should consider and prioritise in designing an interim solution.
3. Co-producing potential solutions with a select group of internal and external stakeholders, including service user representation.
4. Appraising potential solutions with service users and internal and external stakeholders:
    a. Hurdle criteria evaluation (6 October 2022)
    b. Public appraisal (weighting scoring) 20 October 2022
5. Consulting the public on a preferred solution or solutions.

Phase 1 was completed in August 2022. The research, historical data, outputs of engagement and the survey were used to inform a detailed 'issues paper' produced by HDUHB to inform Phase 2.

Phase 2, a deliberative event with a mixed group of stakeholders, was undertaken on Friday 16th September, 2022, providing (i) a series of recommendations for what should be considered by

those modelling the interim service, and, (ii) what 'hurdle' criteria should be used for early appraisal of developing solutions.

Phase 3 began on 26 September, when two groups were established to independently (of one another) develop proposals for an interim Paediatrics service. Each group was tasked with considering alternatives and variations, and tasked with producing a minimum of two proposals per group, for hurdle criteria assessment on 6 October 2022.

Phase 4a, ran on 6th October 2022, when a mixed group of stakeholders considered whether 5 options presented, A, B1, B2, C1 and C2, should continue to be developed. The session was unanimous in agreeing that option A be dropped, that B1 and B2 continue, and that C1 and C2 be amalgamated because of their close similarity; and continue to be developed.

The Phase 4(b) workshop

The workshop contained two parts.

1. Weighting the criteria
2. Scoring the options

It is described as a 'public appraisal' workshop; a deliberative event where participants consider (i) the level of importance that should be attributed to each criterion, and (ii) how each proposal (also known as options) should be scored against each criterion; to arrive at an overall 'weighted score' that advises the body consulting of the degree to with each solution meets requirements.

It should be noted that proposals/options at this stage are not expected to be fully detailed proposals where there are factors that will yet determine their finalised model. They are expected to be at a more developed stage than at the 'hurdle criteria evaluation' stage, such that participants can understand what the model looks like, includes and has potential to be developed into.

The agenda for the event was as follows:

- Welcome and introduction
- Recap on the process to date
- What we are trying to achieve today
- Presenting the criteria
- Weighting the criteria
- Introducing the options and scoring
- Presentation of the options
    - Option C

        - Discussion and questions
    - Option B
        - Discussion and questions
    - Option B2
        - Discussion and questions
- Scoring the options
- Closing remarks and next steps

Professor Phil Kloer, Medical Director and Deputy CEO, welcomed everyone, explained the purpose of the day and why the process matters. He then handed over to Nicholas Duffin of the Consultation Institute to continue proceedings.

Nicholas first gave participants an overview of the recent history of Paediatrics at HDUHB and the 'process' in developing an Interim Paediatrics model to date; covering what public and staff involvement there had been in the project and explaining the preceding events in Phases 2, 3 and 4a.

He then explained how the event would proceed and what needed to be achieved, highlighting that participants needed to absorb the information on offer before deciding how to 'weight' criteria and 'score' the solutions/options against the criteria.

Presenting and weighting the criteria

Nicholas then introduced Alex Martin, Principal Programme Manager, who explained the criteria that were being used to participants and how they had been arrived at; by canvassing the views of internal and external stakeholders. Participants were invited to ask questions.

The criteria explained were:

1. Clinical viability
2. Workforce viability
3. Safe inter-hospital transport system
4. Deliverability
5. Accessibility
6. Facilities (incl. interior suitability)
7. Inter-service accessibility
8. Impacts on people

Alex then handed back to Nicholas Duffin (tCI) to lead participants in weighting the criteria.

Nicholas began by explaining the relevance of weighting and why we weight criteria; to establish whether some criteria were more important than others.

Participants were invited to use sheets (aids) on the table to consider what weight they allocated to each criterion. The method used was to divide 100 points between the 8 criteria.

When participants confirmed they were ready, they were invited to go online (at YourScoreUK) and input their weightings for each criterion. Help was offered, if they needed it.

When all participants had finished, the average weightings for each criterion were presented back to the room.

Nicholas then introduced the options and scoring session before handing over to Nick Williams-Davies (Service Delivery Manager – Acute Paediatric and Neonatal Services) and Marcus Andrews (Clinical Lead Paediatrics).

Presenting the options

Nick Williams-Davies introduced participants to the work that he, colleagues and public members had undertaken in developing options, eliminating those (through hurdle criteria evaluation) that were deemed less worthy of developing further, and continuing to develop the options that had been retained. He also explained how he and Marcus Andrews would present the options, considering both what can be delivered and the potential of the options.

Nick then presented Option C. Whilst presenting he took questions and encouraged participants to deliberate over the option. Once there were no further questions the event was paused to take lunch.

On return from lunch Marcus presented first option B, then option B2, in the same manner/format that Nick had used for option C. Participants were encouraged to ask questions and deliberate over both options.

Once questions and discussion had finished, Marcus handed back to Nicholas Duffin (tCI).

Scoring the options

Nicholas then explained to participants how scoring was to be undertaken.

He pointed them to a sheet (aid) on their tables that they could use to think through and plot what scores they would give each option against the 8 criteria. This sheet was in the format of a table, with 24 cells for the 3 options and 8 criteria.

He stressed that when scoring they should appreciate this was not a 'vote', but that they needed to evaluate how well they thought each option met (or satisfied) each of the criteria, and that their scores should reflect this.

Nicholas then demonstrated how to submit their scores through the YourScoreUK facility online, when they were ready.

Participants were invited to ask questions. Help was offered, if they needed it.

Once all participants had scored the options, the weighted scores for the options were presented back to them.

Lee Davies (Executive Director of Strategic Development & Operational Planning) then thanked everyone for participating, explained the next steps and closed the event.

The weightings

27 submissions were received.

The total and average weightings were:

Criterion	Total points awarded	Average points awarded
Clinical viability	448.5	16.6
Workforce viability	464	17.2
Safe inter-hospital transport system	278.25	10.3
Deliverability	356.5	13.2
Accessibility	264.75	9.8
Facilities (incl. interior suitability)	417.5	15.5
Inter-service accessibility	248.25	9.2
Impacts on people	222.25	8.2

There was one case of extreme ‘weighting’. A participant awarded 100 points to Facilities and 0 points to all other criteria. This was not sufficient enough to alter the order of options based on their weighted scores. Within the accompanying spreadsheets of weighting and scoring, a comparative was taken to show what difference this score made, whether included or excluded.

The scores for options

25 submissions for scoring were received.

The total scores for each option were as follows:

Criteria	Option C	Option B	Option B2
Clinical viability	213	166	166
Workforce viability	214	143	146
Safe inter-hospital transport system	171	140	144
Deliverability	213	145	134
Accessibility	175	188	191
Facilities (incl. interior suitability)	181	181	177
Inter-service accessibility	154	159	159
Impacts on people	157	162	162
Totals	**1478**	**1284**	**1279**

The weighted scores

The following are the scores with weightings applied.

Criteria	Option C	Option B	Option B2
Clinical viability	3538.17	2757.44	2757.44
Workforce viability	3677.63	2457.48	2509.04
Safe inter-hospital transport system	1762.25	1442.78	1484

Deliverability	2812.39	1914.54	1769.3
Accessibility	1715.97	1843.44	1872.86
Facilities (incl. interior suitability)	2798.8	2798.8	2736.94
Inter-service accessibility	1415.94	1461.92	1461.92
Impacts on people	1292.34	1333.5	1333.5
Totals	**19013.49**	**16009.9**	**15925**

There were a number of awards of 10 points for criteria across all three options. There was only one case that looked unobjective: one participant giving all criteria for options B and B2 10/10, whilst giving option C scores between 3-5 per criteria.

Participation statistics

Participants included:

- 24 staff
- 1 member of the public
- Observers
- Presenters

There is an anomaly in that 27 people provided weightings. As we opted to keep the process anonymous it is unclear whether any persons applied weightings more than once or other parties in attendance participated when not expected to.

Accompanying documents

- *Scores and weighting for 20 October 2022.xlsx* provides the detailed scores, weightings and weighted scores in detail.
- Slides for the event

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:-

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you equality impact assessing?**	This Equality Impact Assessment covers Option C being developed as part of the options appraisal process being undertaken as part of the Acute Paediatric Review. Option C builds on the 2021 model, the suspension of the PACU at WGH also known as Puffin Ward and no Paediatric ED available for CYP (Under 16) with illness, through the expansion of non-emergency services retained in a WGH 9am – 5pm service. **What is unique or new:** • Formalising/locally defining rapid access clinics • Improving advice & support to Primary Care, and local patient access for specialist review (non-emergency) • Ability to schedule follow up appointments directly for patients from WGH who have attended GGH for emergency treatment - or follow up from GGH Paediatrics for Pembrokeshire residents **Opportunities to:** • The ability to house the entire multidisciplinary team (MDT) under one roof - “Hub Integrated approach” • Incorporating outpatient activity/Day Care provision for Children’s Services - with potential to extend to tertiary clinics etc. (improved environment) • Enhanced workforce opportunity e.g. Community Nursing – Outreach Team; play specialists, etc. • Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow

2.	**Brief Aims and Description**	As part of the Acute Paediatric Review a series of options were put forward at a longlisting stage. The options considered were the last permanent service change agreed in 2014 and the temporary changes which took place in 2016 and 2020. Additional options were also developed which were based on the 2016 and 2020 models but with variation. These options were not fully worked up and only had to have sufficient information to be assessed against hurdle criteria, while also considering the EqIA of the current service delivery, to understand what the benefit or impacts may be. Following consensus of the longlist appraisal attendees, the 2014 model was not taken further to shortlist stage, the 2016 model and variation (Option B and Option B2) were taken forward, while the 2020 model and variation (Option C and Option C2) were merged together to be taken forward as Option C. The purpose of this EqIA is to highlight the potential benefits, impacts, opportunities and mitigations that specifically apply to this option.
3.	**Who is involved in undertaking this EqIA?**	This EqIA is an iterative document and will be developed and refreshed throughout the period of option development and design as stakeholders become involved in the process. Initial impact assessment work was been undertaken by members of the project team and the service. This has been further reviewed by a multidisciplinary working group containing members of the public and third sector organisations.

		Key contributors include: Nick Williams-Davies - Service Delivery Manager Acute Paediatric & Neonatal/ Acute Paediatric Review Working Group Chair Alex Martin – Principal Programme Manager Kathryn Cobley – Diversity and Inclusion Manager
4.	**Is the Policy related to other policies/areas of work?**	This EqIA is related to the Acute Paediatric Review being undertaken to provide an interim service between now and the development of the Urgent and Planned Care Hospital. Additional considerations include: Agile Working (consideration) Redeployment Visiting 692 - Admission of Children to the Paediatric Units within HDUHB 818 - Paediatric Escalation Procedure 2014 EqIA of the last permanent change to Acute Paediatric Service https://www.webarchive.org.uk/wayback/en/archive/20181106143456mp_/http:/www.wales.nhs.uk/sitesplus/documents/862/AttachmentEEqualityImpactAssessmentReconfigurationofServiceProvisionWomenandChildrenService.pdf
5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	The following groups have been identified as being directly or indirectly impacted: <u>Staff – (Socio-economic duty)</u> • WGH staff who have been relocated to GGH as part of temporary change • Staff who may be relocated or displaced to support the option or may no longer be needed as part of this option • Fewer paediatric nurse career opportunities from WGH as the option has a reduced nurse staffing requirement

		• Certainty for staff once a model has been identified and implemented <u>Patients – (Socio-economic duty/ age)</u> • Children and young people who frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but not residents of the area <u>Public – (Gender/ Socio-economic duty/ age/ pregnancy and maternity)</u> • Parents/ guardians/ carers of children and young people who require support and transport to frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but are not residents of the area. • People who are expecting or are likely to give birth and may need to use the service during the interim period.

6.	**What might help/hinder the success of the Policy?**	**Help:** • All Health Board policies, procedures and guidelines are available to staff on the Health Board's intranet website. • All staff are contractually obliged to abide by Health Board policies. • It is the responsibility of Managers to ensure staff have access to the guidelines. • Clear and appropriate communications to Public, Staff & Stakeholders via the medium of radio, video and social media publications. • Information Leaflets available and distributed to the population of Pembrokeshire and South Ceredigion. • The formation of a Control Group with representation of all priority stakeholders involved in the care of children and young people. • Consultant and Service Lead support to monitor and review the of the guidelines. • A full system review of the temporary service change to report back to the Public Health Board in Autumn 2022. **Hinder:** • Inability to circulate advise to reach non-resident population (esp. holiday makers) • Lack of sufficient public communication and signposting. • Lack of sufficient/ effective communication with Staff and Stakeholders. • Lack of awareness of the guidelines by Staff and Stakeholders. • Lack of "buy in" from Staff, Stakeholders and Service Users. • Circulation of misinformation via social media • Inability to influence all patient/ relative behaviours when accessing services.

		There is no evidence to suggest that any groups will be discriminated as a result of the service change. Disadvantages arise for people required to travel further to access care, however this is as a result of needing to centralise a service to ensure that care remains available for the whole of the South area of Hywel Dda. The benefit of this work is that for Children and Young People in the South of Hywel Dda, it is possible to provide a sustainable and safe acute, critical care service which is able to meet their urgent needs, while follow up care can be delivered closer to home.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	**Yes**	**No**
Article 2 : The right to life **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	✓	
Article 3 : The right not be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	✓	
Article 5 : The right to liberty	✓	

Example: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		
Article 6 : The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	✓	
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	✓	
Article 11 : The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	✓	

How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential positive and / or negative impacts Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also been included within the action plan.
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?	✓	✓		The temporary paediatric pathway and associated protocols are directed at children and young people (and their parents/ guardians) who reside within the Pembrokeshire/ South Ceredigion region and applies to children and young people under the age of 16 years. Between the period of 2016 – 2022 admissions of children up to age 16 has generally remained between 11,000 and 12,000 across WGH and GGH with GGH receiving the larger proportion. Of these attendances the majority have been for emergency treatment. The largest patient cohorts are aged 0-4 years and 5-9 years. The guidelines are devised to ensure children and young people get the most appropriate level of care at the right time and in the correct environment leading to effective outcome / recovery. The benefit for children and young people is that they're able to receive the best accident and emergency care possible through a centralised and sustainable rota.	Alongside a Dedicated Ambulance Vehicle (DAV) which can support acute paediatric transfers (taking children from WGH to GGH), there is a policy in place to support families with travel to and from GGH to mitigate the impact of travelling. The benefit of centralising the service in a single location is that it has been possible to retain paediatric services in the South of Hywel Dda covering Pembrokeshire, Carmarthenshire and South Ceredigion. By merging rotas which were not sustainable it has been possible to ensure that a consistent service can be provided at all times for those needing acute care, while remote outpatient care can continue to be delivered from existing sites. As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on younger people and their families and carers.

				The unintended consequences are that acute services have needed to be centralised and delivered from a single site, which has increased travel time for children and young people of Pembrokeshire and South Ceredigion and their parents and carers, increasing the time it takes for them to receive their care. Option C will not alter the benefits or impacts of centralisation as they would be formalised and become permanent. This evidence is largely anecdotal coming from survey responses of parents, carers and guardians, but was identified as a key theme also recognised by staff in a smaller survey cohort, however analysis of where Pembs residents have gone to receive care has demonstrated an increase in the use of GGH services while the level of overall activity remains the same, demonstrating a need for travel. The increase in travel time and the movement of services from WGH to GGH is likely to have an impact on parent carers of disabled children who are likely to require more frequent attendance and have parents whom are typically older and may be less resilient when needing to arrange transportation.	We will look to sense check as part of action planning to ensure that options being developed and proposed are reflective of wider groups who may be unable to attend events organised by the health board within traditional working hours.

				This evidence is anecdotal but also picks up broader EqIA work undertaken for the Programme Business Case for the new Urgent and Planned Care Hospital which identified the impact age has on travelling. Option C would enable rapid access clinics, follow up appointments at WGH for those who previously visited GGH for emergency treatment or follow up appointments for Pembrokeshire residents if they used the Paediatric services. Option C aspires to develop a hub approach to outpatient and day care provision further enabling people to spend less time travelling, while also receiving integrated care. This mitigates some of the impact by reducing travel times on parents and carers, while allowing children and young people to access follow up care closer to home.	
Disability Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	✓	✓		The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire and South Ceredigion. The service change has not been identified to have any discriminatory impact on those with disabilities.	For those with physical disabilities that may attend on a frequent basis or may have sudden changes in health needs and require urgent treatment, open ward access is available to ensure that people can receive treatment faster. For those with disabilities that impact on people's ability to understand the changes

				Children with disabilities which impact on their physical health on an acute basis are more likely to be impacted by the need to travel to GGH, to either access care on a routine basis or if they require open ward access due to increased health needs. Those who require outpatient services will not be impacted as these will remain in WGH. Option C would still have an impact on those who are unwell needing to attend GGH for open access or emergency care, however the benefit of option C is that more day care, outpatient care and follow up care could be provided from WGH than in the current service offering, reducing the travel impacts in terms of cost, and affect on daily life (work, education, etc.) While the majority of the activity analysed demonstrates care is required on an emergency basis irrespective of disability, further work is needed to quantify what the impact is on disabled children. Anecdotal evidence from parent responses have indicated that children with disabilities and their families are required to travel more frequently over longer distances which has a negative impact.	made to the service, the communication needs / expectations of affected parents/family and carers will need to be addressed appropriately about how and where to access care and signage at hospital sites. The benefit of centralising the service is that there is a dedicated staffing rota to ensure that an open ward can be consistently staffed without need for transfer between locations. This also provides greater certainty for children and young people with disabilities and their families about where and when care is available when needed. There is no evidence to suggest that people with disabilities are discriminated against as a result of these changes. Hywel Dda University Health Board have signed up to the Learning Disability charter which seeks to treat people with learning disabilities in mainstream settings with reasonable adjustments, therefore where they may need reasonable adjustments these will be considered to ensure they are not disadvantaged further, i.e. communications from GGH ward in easy read.

Gender Reassignment Consider the potential impact on individuals who either: •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.			✓	Understanding the proportion of the population who identify as trans is difficult. The Gender Identity Research and Education Society (GIRES) estimates the overall percentage of 'gender variant' people in the UK is 1% but growing. A small proportion of teenagers covered by this guideline may identify as non-binary/trans or be exploring their gender identity. This may or may not be known to the parents of children and young people and such issues will need to be addressed sensitively with individuals and in a confidential manner**.** The Paediatric guidelines are specific to children and young people inclusive of those who have undergone, intend to undergo or are currently undergoing gender reassignment or do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth. Option C does not have any additional positive or negative impact.	A proportion of GP Practices in each of the 3 county areas have agreed to provide local enhanced transgender services for children and young people. GPs are able to advice children and young people and their parents/guardians on the most appropriate healthcare pathways, e.g. referral to Welsh Gender Service. Staff also have access to specialised transgender awareness training to help them work with transgender patients.
Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.			✓	Not applicable – even if patient groups are subject to marriage or civil partnership, this temporary change will not impact on this protected group**.**	

				Option C does not have any additional positive or negative impact.	

Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.	✓	✓		Any infant requiring hospital admission after birth (and not requiring Special Care Baby Unit) will be treated under this pathway and Parents will be supported to stay with the infant during admission. For children who require admission following birth by caesarean, additional travel time to GGH from those in Pembrokeshire or South Ceredigion is likely to have a greater impact on mothers who may be unable to travel while recovering, particularly when shortly following surgery. Women who have given birth may be suffering from post-natal depression which can impact their ability to understand on how and where to access care for both of themselves and their children. Mothers will be able to access care from the ward or signposted out to mental health services. This evidence is anecdotal and is not apparent in analysis who frequently this occurs. Responses from surveys indicate this is a greater impact when having to travel on rural roads following surgery which can cause greater pain and discomfort due to longer travel times and lack of nearby services for the care required.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women recovering during maternity. The benefit of centralisation for mothers is that there are also obstetric and gynaecology services available on site as part of the 2014 strategy, along with mental health services available to support women with post natal depression.

				While Option C will not change the delivery of birthing services, it will mean that follow up appoints following attendance at GGH A&E will require less travelling, which would reduce the impact on those who shared experiences of travelling post caesarean, but not mitigate completely.	
Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.			✓	For many patients and families from minority ethnic groups, rituals and traditions become more important in times of ill health. It would be important for families to be spoken to in their first language when conveying information during the implementation of this guideline and the training required wherever possible. The UHB approved translation services will help to facilitate this. Option C does not have any additional positive or negative impact.	Translation and communication needs of affected parents/family and carers will need to be addressed appropriately through communications about how and where to access care and signage at hospital sites. Sense checking will also be carried out, which will be part of action planning, through community outreach teams to access communities and groups and seek their views on what has been considered. Documents for targeted engagement have been translated into commonly used languages (Arabic, Polish, Russian and Ukrainian) to increase responses, while an engagement plan looks to engage with gypsy/ traveller communities within the areas.
Religion or Belief (or non-belief)			✓	This interim system change applies equally to all religions and beliefs- to include those who have no belief.	Patients and their families of all faiths can access spiritual care and support from our

The term 'religion' includes a religious or philosophical belief.				Option C does not have any additional positive or negative impact.	Chaplaincy Services which are available on all of hospital sites.
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?		✓		While the service model does not have a impact due to the patients' gender, current engagement to date around service changes have highlighted that women are generally more likely to be the primary carer, and so changes to how and where services are delivered are likely to have a greater impact on women than men. As Option C will allow for more outpatient activity and follow up appointments to be undertaken from WGH, it is expected that this will benefit women who are predominantly primary carers as it will have a reduced impact on their lives through closer access to care, however they will still need to travel to GGH if emergency care is required. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 190 identified as female. More work is needed to hear from male parents and patients.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women who are likely to be the primary carer.
Sexual Orientation Whether a person's sexual attraction is towards their own			✓	A proportion of teenagers who access services via this temporary pathway may identify as lesbian / gay / bisexual (LGB).	Staff are routinely offered a variety of LGBTQ+ related training session to help them gain a better understanding of the

sex, the opposite sex or to both sexes.				They may or may not be “out” at home and issues around their sexual orientation will need to be addressed sensitively and confidentially. This interim system change applies equally to all regardless of sexual orientation. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 195 identified as heterosexual or straight, 3 as bisexual, 2 as other and 1 preferring not to say. There has been no indication that the service change discriminates towards those of non heterosexual children and young people, their parents or carers. Option C does not have any additional positive or negative impact.	barriers and challenges experienced by LGBTQ+ persons.
Socio-economic Deprivation Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access		✓		The transfer of children and young people from WGH to GGH could incur additional transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use.	Further work is being undertaken to consider transport / accommodation options, however as the review is focusing on the acute element of service delivery, some options such as community/ public transport may not be viable where emergency attendance is required during bank holidays/ overnight, etc.

services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see: https://gov.wales/more-equal-wales-socio-economic-duty				Eligible families will be advised of the process to claim back costs, however will require funding in the first instance to travel to access care before being able to reclaim funding. The areas of Pembrokeshire (Haverfordwest, Milford Haven), South Ceredigion (Cardigan) and Carmarthenshire (Llanelli) have pockets of severe overall deprivation which covers all domains within the Welsh Index of Multiple Deprivation which includes income, employment, access to GP/ Pharmacy services, etc. Although the numbers of people living within these areas are small in comparison to the rest of the region, changes which reduce access or increase cost burden will have a greater impact. Option C will still require families to travel to GGH if emergency care is required, or repeated visits if open access to ward or overnight stays are needed and accommodation is not available. This is partially mitigated and improved by being able to have follow up appointments in WGH as well as the aspiration for enhanced outpatient services, reducing the impact of travel costs as well as missed employment/ education.	This procedure will have the same impact across this category equally and transport is available on request.

Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.			✓	This interim system change applies equally to all regardless of whether they choose to communicate in English or Welsh. The language needs of the child/young person and their family/carers are respected in accordance with HB policy. All letters and forms are available in Welsh, and recruitment undertaken in line with Welsh Language Skills requirements. Welsh language usage was not a question as part of the surveys, however the majority of the respondents identified as Welsh (133, 67%). Welsh responses were also received as part of the surveys which were translated and included as part of the issues report. Option C does not have any additional positive or negative impact.	All of the engagement materials have been developed bilingually. Due to the timescales of the work being set, it has not been possible to provide all documentation bilingually, such as the issues report which was submitted to board or the output documents which have been developed after engagement activities. Welsh speaking staff are available at events to respond to queries if people wish to use Welsh, and staff wear lanyards to show that they are able to communicate in Welsh.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	Unable to confirm. While the survey responses cover a broad period of service use and includes all those who have accessed care, providing demographic data is not a requirement and so we cannot say for certain whether there are groups who are missing or additional impacts which have not been considered at this early stage.
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	Yes, there are opportunities to gather missing information and identify gaps through engagement with public working groups as part of the Acute Paediatric Review.
3.	**Does the information collected relate to all protected characteristics?**	No, we are aware that there are likely to be gaps from gypsy/ traveller/ BAME communities as the surveys were only provided in English and Welsh and sent only to those who use services. For those who do not use English/ Welsh as a first language or avoid using services, we may not have gathered responses from those communities. As the demographic questions are optional, we cannot determine to what extent, if any, this has been collected. We are also aware that most responses have come from parents and carers, not necessarily from the children and young people themselves.
4.	**What additional information (if any) is required?**	This EqIA would be supported with additional information from the following communities/ groups: • Children and young people • BAME • Gypsies/ Travellers

5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	Engagement HQ has been used to create a continuous engagement channel with more robust equality monitoring questions to help us capture the groups who are communicating with us, as well as disseminate information and provide opportunities for engagement. Patient experience data is monitored and scrutinised regularly. In addition, patients and their relatives have access to members of the family liaison team who would be able to identify and escalate any issues, which would then be reflected in a revision to this document. The following groups have been initially identified to support with gathering this additional information: • Schools • Community Outreach Team

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	**2**	**-1**	**L**
Disability	**2**	**+3**	**P**
Sex	**2**	**-1**	**L**
Gender Reassignment	**1**	**0**	**N**
Human Rights	**1**	**0**	**N**
Marriage and Civil Partnership	**1**	**0**	**N**
Pregnancy and Maternity	**2**	**-1**	**L**
Race/Ethnicity or Nationality	**1**	**0**	**N**
Religion or Belief	**1**	**0**	**N**
Sexual Orientation	**1**	**0**	**N**
Socio-economic Deprivation	**2**	**-2**	**M**
Welsh Language	**1**	**0**	**N**

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	**This is an EqIA of the temporary service change to identify the current situation and will be used to benchmark any models or options developed as part of the Acute Paediatric Services review. Individual options will have individual EqIAs undertaken to inform any decision making.**
If No please give reasons and any alternative action(s) agreed.	**N/A**
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	**N/A**

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	Patient experience data and review. Use of continuous engagement channel via Engagement HQ. Views of patient (public) opinion to be sought as a part of the service review.
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	Analysis is a part of the review process and will be reported to Board to assist decision making.
Where positive impact has been identified for one or more groups please explain how this will be maximised?	The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire or South Ceredigion. The guidelines are there to ensure children and young people get the right care at the right place at the right time.
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.**	The transfer of children and young people from WGH to GGH could incur additional transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use. Eligible families will be advised of the process to claim back costs. Further work is being undertaken to consider transport / accommodation options.

Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**

EqIA Completed by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
EqIA Authorised by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:-

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you equality impact assessing?**	This Equality Impact Assessment covers Option B being developed as part of the options appraisal process being undertaken as part of the Acute Paediatric Review. Option B builds on the 2016 model with a Monday to Friday Paediatric Ambulatory Care Unit (PACU) between the hours of 10am – 6pm, with non-emergency activity (outpatients, day cases/ tertiary care) also provided from WGH on a 9am – 5pm basis on the same days. **What is unique or new:** • Planned **and** same day urgent paediatric day case reviews (any potential admissions would still go to GGH) - No overnight or weekend activity • Some new restrictions on admission criteria, to mitigate some of the risks identified in the 2016 model • Look to maximise the building footprint (Puffin Ward) • The model would look to incorporate Option C (non-emergency activity) into the model with Day Care provision - but potential to be restricted by PACU requirements **Opportunities to:** • Develop role of Advanced Paediatric Nurse Practitioners and Physicians Associates - non-medical staffing supplementary workforce • Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow • Upgrade current child health centre to support admin/office and base requirements for clinical staff MDT

2.	**Brief Aims and Description**	As part of the Acute Paediatric Review a series of options were put forward at a longlisting stage. The options considered were the last permanent service change agreed in 2014 and the temporary changes which took place in 2016 and 2020. Additional options were also developed which were based on the 2016 and 2020 models but with variation. These options were not fully worked up and only had to have sufficient information to be assessed against hurdle criteria, while also considering the EqIA of the current service delivery, to understand what the benefit or impacts may be. Following consensus of the longlist appraisal attendees, the 2014 model was not taken further to shortlist stage, the 2016 model and variation (Option B and Option B2) were taken forward, while the 2020 model and variation (Option C and Option C2) were merged together to be taken forward as Option C. The purpose of this EqIA is to highlight the potential benefits, impacts, opportunities and mitigations that specifically apply to this option.
3.	**Who is involved in undertaking this EqIA?**	This EqIA is an iterative document and will be developed and refreshed throughout the period of option development and design as stakeholders become involved in the process. Initial impact assessment work was been undertaken by members of the project team and the service. This has been further reviewed by a multidisciplinary working group containing members of the public and third sector organisations.

		Key contributors include: Nick Williams-Davies - Service Delivery Manager Acute Paediatric & Neonatal/ Acute Paediatric Review Working Group Chair Alex Martin – Principal Programme Manager Kathryn Cobley – Diversity and Inclusion Manager
4.	**Is the Policy related to other policies/areas of work?**	This EqIA is related to the Acute Paediatric Review being undertaken to provide an interim service between now and the development of the Urgent and Planned Care Hospital. Additional considerations include: Agile Working (consideration) Redeployment Visiting 692 - Admission of Children to the Paediatric Units within HDUHB 818 - Paediatric Escalation Procedure 2014 EqIA of the last permanent change to Acute Paediatric Service https://www.webarchive.org.uk/wayback/en/archive/20181106143456mp_/http:/www.wales.nhs.uk/sitesplus/documents/862/AttachmentEEqualityImpactAssessmentReconfigurationofServiceProvisionWomenandChildrenService.pdf
5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	The following groups have been identified as being directly or indirectly impacted: <u>Staff – (Socio-economic duty)</u> • WGH staff who have been relocated to GGH as part of temporary change • Staff who may be relocated or displaced to support the option or may no longer be needed as part of this option • Fewer paediatric nurse career opportunities from WGH as the option has a reduced nurse staffing requirement

		• Certainty for staff once a model has been identified and implemented <u>Patients – (Socio-economic duty/ age)</u> • Children and young people who frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but not residents of the area <u>Public – (Gender/ Socio-economic duty/ age/ pregnancy and maternity)</u> • Parents/ guardians/ carers of children and young people who require support and transport to frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but are not residents of the area. • People who are expecting or are likely to give birth and may need to use the service during the interim period.

6.	**What might help/hinder the success of the Policy?**	**Help:** • All Health Board policies, procedures and guidelines are available to staff on the Health Board's intranet website. • All staff are contractually obliged to abide by Health Board policies. • It is the responsibility of Managers to ensure staff have access to the guidelines. • Clear and appropriate communications to Public, Staff & Stakeholders via the medium of radio, video and social media publications. • Information Leaflets available and distributed to the population of Pembrokeshire and South Ceredigion. • The formation of a Control Group with representation of all priority stakeholders involved in the care of children and young people. • Consultant and Service Lead support to monitor and review the of the guidelines. • A full system review of the temporary service change to report back to the Public Health Board in Autumn 2022. **Hinder:** • Inability to circulate advise to reach non-resident population (esp. holiday makers) • Lack of sufficient public communication and signposting. • Lack of sufficient/ effective communication with Staff and Stakeholders. • Lack of awareness of the guidelines by Staff and Stakeholders. • Lack of "buy in" from Staff, Stakeholders and Service Users. • Circulation of misinformation via social media • Inability to influence all patient/ relative behaviours when accessing services.

		There is no evidence to suggest that any groups will be discriminated as a result of the service change. Disadvantages arise for people required to travel further to access care, however this is as a result of needing to centralise a service to ensure that care remains available for the whole of the South area of Hywel Dda. The benefit of this work is that for Children and Young People in the South of Hywel Dda, it is possible to provide a sustainable and safe acute, critical care service which is able to meet their urgent needs, while follow up care can be delivered closer to home.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	**Yes**	**No**
Article 2 : The right to life **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	✓	
Article 3 : The right not be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	✓	

Article 5 : The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	✓	
Article 6 : The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	✓	
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	✓	
Article 11 : The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	✓	

How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential positive and / or negative impacts Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also been included within the action plan.
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?	✓	✓		The temporary paediatric pathway and associated protocols are directed at children and young people (and their parents/ guardians) who reside within the Pembrokeshire/ South Ceredigion region and applies to children and young people under the age of 16 years. Between the period of 2016 – 2022 admissions of children up to age 16 has generally remained between 11,000 and 12,000 across WGH and GGH with GGH receiving the larger proportion. Of these attendances the majority have been for emergency treatment. The largest patient cohorts are aged 0-4 years and 5-9 years. The guidelines are devised to ensure children and young people get the most appropriate level of care at the right time and in the correct environment leading to effective outcome / recovery. The benefit for children and young people is that they're able to receive the best accident and emergency care possible through a centralised and sustainable rota.	Alongside a Dedicated Ambulance Vehicle (DAV) which can support acute paediatric transfers (taking children from WGH to GGH), there is a policy in place to support families with travel to and from GGH to mitigate the impact of travelling. The benefit of centralising the service in a single location is that it has been possible to retain paediatric services in the South of Hywel Dda covering Pembrokeshire, Carmarthenshire and South Ceredigion. By merging rotas which were not sustainable it has been possible to ensure that a consistent service can be provided at all times for those needing acute care, while remote outpatient care can continue to be delivered from existing sites. As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on younger people and their families and carers.

				The unintended consequences are that acute services have needed to be centralised and delivered from a single site, which has increased travel time for children and young people of Pembrokeshire and South Ceredigion and their parents and carers, increasing the time it takes for them to receive their care. Option B will not return acute services to WGH, however it will enable more care to be delivered in Pembrokeshire between Monday to Friday between 10am – 6pm. While some unwell children may continue to be sent directly to GGH for care or admission, WGH will be able to provide a greater level of treatment than currently offered, providing children and young people greater access to care closer to home This evidence is largely anecdotal coming from survey responses of parents, carers and guardians, but was identified as a key theme also recognised by staff in a smaller survey cohort, however analysis of where Pembs residents have gone to receive care has demonstrated an increase in the use of GGH services while the level of overall activity remains the same, demonstrating a need for travel.	We will look to sense check as part of action planning to ensure that options being developed and proposed are reflective of wider groups who may be unable to attend events organised by the health board within traditional working hours.

				The increase in travel time and the movement of services from WGH to GGH is likely to have an impact on parent carers of disabled children who are likely to require more frequent attendance and have parents whom are typically older and may be less resilient when needing to arrange transportation. This evidence is anecdotal but also picks up broader EqIA work undertaken for the Programme Business Case for the new Urgent and Planned Care Hospital which identified the impact age has on travelling. Option B would enable same day urgent paediatric day case reviews, follow up appointments at WGH for those who previously visited GGH for emergency treatment or follow up appointments for Pembrokeshire residents if they used the Paediatric services. Option B also aspires to develop a hub approach to outpatient and day care provision further enabling people to spend less time travelling, while also receiving integrated care. This mitigates some of the impact by reducing travel times on parents and carers, while allowing children and young people to access follow up care closer to home, however as the	

				service is not available 24 hours over 7 days and cannot accept all cases, does not fully mitigate travel impact.	
Disability Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	✓	✓		The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire and South Ceredigion. The service change has not been identified to have any discriminatory impact on those with disabilities. Children with disabilities which impact on their physical health on an acute basis are more likely to be impacted by the need to travel to GGH, to either access care on a routine basis or if they require open ward access due to increased health needs. Those who require outpatient services will not be impacted as these will remain in WGH. Option B would still have an impact on those who are unwell needing to attend GGH for open access or emergency care, however the benefit of option B is that more day care, outpatient care and follow up care could be provided from WGH than in the current service offering, reducing the travel impacts in terms of cost, and affect on daily life (work, education, etc.), as well as being able to view same day urgent paediatric day cases via the PACU which could reduce travelling greatly.	For those with physical disabilities that may attend on a frequent basis or may have sudden changes in health needs and require urgent treatment, open ward access is available to ensure that people can receive treatment faster. For those with disabilities that impact on people's ability to understand the changes made to the service, the communication needs / expectations of affected parents/family and carers will need to be addressed appropriately about how and where to access care and signage at hospital sites. The benefit of centralising the service is that there is a dedicated staffing rota to ensure that an open ward can be consistently staffed without need for transfer between locations. This also provides greater certainty for children and young people with disabilities and their families about where and when care is available when needed.

				While the majority of the activity analysed demonstrates care is required on an emergency basis irrespective of disability, further work is needed to quantify what the impact is on disabled children. Anecdotal evidence from parent responses have indicated that children with disabilities and their families are required to travel more frequently over longer distances which has a negative impact.	There is no evidence to suggest that people with disabilities are discriminated against as a result of these changes. Hywel Dda University Health Board have signed up to the Learning Disability charter which seeks to treat people with learning disabilities in mainstream settings with reasonable adjustments, therefore where they may need reasonable adjustments these will be considered to ensure they are not disadvantaged further, i.e. communications from GGH ward in easy read.
Gender Reassignment Consider the potential impact on individuals who either: •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.			✓	Understanding the proportion of the population who identify as trans is difficult. The Gender Identity Research and Education Society (GIRES) estimates the overall percentage of 'gender variant' people in the UK is 1% but growing. A small proportion of teenagers covered by this guideline may identify as non-binary/trans or be exploring their gender identity. This may or may not be known to the parents of children and young people and such issues will need to be addressed sensitively with individuals and in a confidential manner**.** The Paediatric guidelines are specific to children and young people inclusive of those	A proportion of GP Practices in each of the 3 county areas have agreed to provide local enhanced transgender services for children and young people. GPs are able to advice children and young people and their parents/guardians on the most appropriate healthcare pathways, e.g. referral to Welsh Gender Service. Staff also have access to specialised transgender awareness training to help them work with transgender patients.

				who have undergone, intend to undergo or are currently undergoing gender reassignment or do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth. Option B does not have any additional positive or negative impact.	
Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.			✓	Not applicable – even if patient groups are subject to marriage or civil partnership, this temporary change will not impact on this protected group**.** Option B does not have any additional positive or negative impact.	

Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.	✓	✓		Any infant requiring hospital admission after birth (and not requiring Special Care Baby Unit) will be treated under this pathway and Parents will be supported to stay with the infant during admission. For children who require admission following birth by caesarean, additional travel time to GGH from those in Pembrokeshire or South Ceredigion is likely to have a greater impact on mothers who may be unable to travel while recovering, particularly when shortly following surgery. Women who have given birth may be suffering from post-natal depression which can impact their ability to understand on how and where to access care for both of themselves and their children. Mothers will be able to access care from the ward or signposted out to mental health services. This evidence is anecdotal and is not apparent in analysis who frequently this occurs. Responses from surveys indicate this is a greater impact when having to travel on rural roads following surgery which can cause greater pain and discomfort due to longer travel times and lack of nearby services for the care required.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women recovering during maternity. The benefit of centralisation for mothers is that there are also obstetric and gynaecology services available on site as part of the 2014 strategy, along with mental health services available to support women with post natal depression.

				While Option B will not change the delivery of birthing services, it will mean that same day urgent paediatric day cases could prevent additional travelling and follow up appoints following attendance at GGH A&E will require less travelling, which would reduce the impact on those who shared experiences of travelling post caesarean, but not mitigate completely due to limited service hours.	
Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.			✓	For many patients and families from minority ethnic groups, rituals and traditions become more important in times of ill health. It would be important for families to be spoken to in their first language when conveying information during the implementation of this guideline and the training required wherever possible. The UHB approved translation services will help to facilitate this. Option B does not have any additional positive or negative impact.	Translation and communication needs of affected parents/family and carers will need to be addressed appropriately through communications about how and where to access care and signage at hospital sites. Sense checking will also be carried out, which will be part of action planning, through community outreach teams to access communities and groups and seek their views on what has been considered. Documents for targeted engagement have been translated into commonly used languages (Arabic, Polish, Russian and Ukrainian) to increase responses, while an engagement plan looks to engage with gypsy/ traveller communities within the areas.

Religion or Belief (or non-belief) The term 'religion' includes a religious or philosophical belief.			✓	This interim system change applies equally to all religions and beliefs- to include those who have no belief. Option B does not have any additional positive or negative impact.	Patients and their families of all faiths can access spiritual care and support from our Chaplaincy Services which are available on all of hospital sites.
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?		✓		While the service model does not have a impact due to the patients' gender, current engagement to date around service changes have highlighted that women are generally more likely to be the primary carer, and so changes to how and where services are delivered are likely to have a greater impact on women than men. As Option B will allow for same day urgent day cases and more outpatient activity and follow up appointments to be undertaken from WGH, it is expected that this will benefit women who are predominantly primary carers as it will have a reduced impact on their lives through closer access to care, however they will still need to travel to GGH if emergency care or admission is required. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 190 identified as female.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women who are likely to be the primary carer.

				More work is needed to hear from male parents and patients.	
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.			✓	A proportion of teenagers who access services via this temporary pathway may identify as lesbian / gay / bisexual (LGB). They may or may not be “out” at home and issues around their sexual orientation will need to be addressed sensitively and confidentially. This interim system change applies equally to all regardless of sexual orientation. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 195 identified as heterosexual or straight, 3 as bisexual, 2 as other and 1 preferring not to say. There has been no indication that the service change discriminates towards those of non heterosexual children and young people, their parents or carers. Option B does not have any additional positive or negative impact.	Staff are routinely offered a variety of LGBTQ+ related training session to help them gain a better understanding of the barriers and challenges experienced by LGBTQ+ persons.
Socio-economic Deprivation		✓		The transfer of children and young people from WGH to GGH could incur additional	Further work is being undertaken to consider transport / accommodation options, however as the review is focusing

Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see: https://gov.wales/more-equal-wales-socio-economic-duty				transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use. Eligible families will be advised of the process to claim back costs, however will require funding in the first instance to travel to access care before being able to reclaim funding. The areas of Pembrokeshire (Haverfordwest, Milford Haven), South Ceredigion (Cardigan) and Carmarthenshire (Llanelli) have pockets of severe overall deprivation which covers all domains within the Welsh Index of Multiple Deprivation which includes income, employment, access to GP/ Pharmacy services, etc. Although the numbers of people living within these areas are small in comparison to the rest of the region, changes which reduce access or increase cost burden will have a greater impact. Option B will still require families to travel to GGH if emergency care is required, or repeated visits if open access to ward or overnight stays are needed and accommodation is not available.	on the acute element of service delivery, some options such as community/ public transport may not be viable where emergency attendance is required during bank holidays/ overnight, etc. This procedure will have the same impact across this category equally and transport is available on request.

				This is partially mitigated and improved by being able to have same day urgent paediatric day cases seen in WGH during core hours, follow up appointments in WGH as well as the aspiration for enhanced outpatient services, reducing the impact of travel costs as well as missed employment/ education.	
Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.			✓	This interim system change applies equally to all regardless of whether they choose to communicate in English or Welsh. The language needs of the child/young person and their family/carers are respected in accordance with HB policy. All letters and forms are available in Welsh, and recruitment undertaken in line with Welsh Language Skills requirements. Welsh language usage was not a question as part of the surveys, however the majority of the respondents identified as Welsh (133, 67%). Welsh responses were also received as part of the surveys which were translated and included as part of the issues report. Option B does not have any additional positive or negative impact.	All of the engagement materials have been developed bilingually. Due to the timescales of the work being set, it has not been possible to provide all documentation bilingually, such as the issues report which was submitted to board or the output documents which have been developed after engagement activities. Welsh speaking staff are available at events to respond to queries if people wish to use Welsh, and staff wear lanyards to show that they are able to communicate in Welsh.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	Unable to confirm. While the survey responses cover a broad period of service use and includes all those who have accessed care, providing demographic data is not a requirement and so we cannot say for certain whether there are groups who are missing or additional impacts which have not been considered at this early stage.
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	Yes, there are opportunities to gather missing information and identify gaps through engagement with public working groups as part of the Acute Paediatric Review.
3.	**Does the information collected relate to all protected characteristics?**	No, we are aware that there are likely to be gaps from gypsy/ traveller/ BAME communities as the surveys were only provided in English and Welsh and sent only to those who use services. For those who do not use English/ Welsh as a first language or avoid using services, we may not have gathered responses from those communities. As the demographic questions are optional, we cannot determine to what extent, if any, this has been collected. We are also aware that most responses have come from parents and carers, not necessarily from the children and young people themselves.
4.	**What additional information (if any) is required?**	This EqIA would be supported with additional information from the following communities/ groups: • Children and young people • BAME • Gypsies/ Travellers

5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	Engagement HQ has been used to create a continuous engagement channel with more robust equality monitoring questions to help us capture the groups who are communicating with us, as well as disseminate information and provide opportunities for engagement. Patient experience data is monitored and scrutinised regularly. In addition, patients and their relatives have access to members of the family liaison team who would be able to identify and escalate any issues, which would then be reflected in a revision to this document. The following groups have been initially identified to support with gathering this additional information: • Schools • Community Outreach Team

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	**2**	**-1**	**L**
Disability	**2**	**+3**	**P**
Sex	**2**	**-1**	**L**
Gender Reassignment	**1**	**0**	**N**
Human Rights	**1**	**0**	**N**
Marriage and Civil Partnership	**1**	**0**	**N**
Pregnancy and Maternity	**2**	**-1**	**L**
Race/Ethnicity or Nationality	**1**	**0**	**N**
Religion or Belief	**1**	**0**	**N**
Sexual Orientation	**1**	**0**	**N**
Socio-economic Deprivation	**2**	**-1**	**L**
Welsh Language	**1**	**0**	**N**

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	**This is an EqIA of the temporary service change to identify the current situation and will be used to benchmark any models or options developed as part of the Acute Paediatric Services review. Individual options will have individual EqIAs undertaken to inform any decision making.**
If No please give reasons and any alternative action(s) agreed.	**N/A**
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	**N/A**

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	Patient experience data and review. Use of continuous engagement channel via Engagement HQ. Views of patient (public) opinion to be sought as a part of the service review.
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	Analysis is a part of the review process and will be reported to Board to assist decision making.
Where positive impact has been identified for one or more groups please explain how this will be maximised?	The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire or South Ceredigion. The guidelines are there to ensure children and young people get the right care at the right place at the right time.
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.**	The transfer of children and young people from WGH to GGH could incur additional transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use. Eligible families will be advised of the process to claim back costs. Further work is being undertaken to consider transport / accommodation options.

Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**

EqIA Completed by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
EqIA Authorised by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:-

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you equality impact assessing?**	This Equality Impact Assessment covers Option B2 being developed as part of the options appraisal process being undertaken as part of the Acute Paediatric Review. Option B builds on the 2016 model with a Monday to Friday Paediatric Ambulatory Care Unit (PACU) between the hours of 10am – 6pm, with non-emergency activity (outpatients, day cases/ tertiary care) also provided from WGH on a 9am – 5pm basis on the same days. **What is unique or new:** • Planned **and** same day urgent paediatric day case reviews (any potential admissions would still go to GGH) - No overnight or weekend activity • Some new restrictions on admission criteria, to mitigate some of the risks identified in the 2016 model • Look to maximise the building footprint (Puffin Ward) • The model would look to incorporate Option C (non-emergency activity) into the model with Day Care provision - but potential to be restricted by PACU requirements **Opportunities to:** • Develop role of Advanced Paediatric Nurse Practitioners and Physicians Associates - non-medical staffing supplementary workforce • Revise the PACU model at GGH and invest in substantive staffing to permanently support WGH flow • Upgrade current child health centre to support admin/office and base requirements for clinical staff MDT

		Option B2 builds further on this with the following: • Emergency Department would offer an enhanced service, better point of entry, e.g. triage for CYP • Robust emergency pathways at GGH While these additional differences are unlikely to be noticed by the public in terms of how they access services, they will mean that CYP will receive their care as quickly as possible through better pathways across both hospital sites.
2.	**Brief Aims and Description**	As part of the Acute Paediatric Review a series of options were put forward at a longlisting stage. The options considered were the last permanent service change agreed in 2014 and the temporary changes which took place in 2016 and 2020. Additional options were also developed which were based on the 2016 and 2020 models but with variation. These options were not fully worked up and only had to have sufficient information to be assessed against hurdle criteria, while also considering the EqIA of the current service delivery, to understand what the benefit or impacts may be. Following consensus of the longlist appraisal attendees, the 2014 model was not taken further to shortlist stage, the 2016 model and variation (Option B and Option B2) were taken forward, while the 2020 model and variation (Option C and Option C2) were merged together to be taken forward as Option C. The purpose of this EqIA is to highlight the potential benefits, impacts, opportunities and mitigations that specifically apply to this option.

3.	**Who is involved in undertaking this EqIA?**	This EqIA is an iterative document and will be developed and refreshed throughout the period of option development and design as stakeholders become involved in the process. Initial impact assessment work was been undertaken by members of the project team and the service. This has been further reviewed by a multidisciplinary working group containing members of the public and third sector organisations. Key contributors include: Nick Williams-Davies - Service Delivery Manager Acute Paediatric & Neonatal/ Acute Paediatric Review Working Group Chair Alex Martin – Principal Programme Manager Kathryn Cobley – Diversity and Inclusion Manager
4.	**Is the Policy related to other policies/areas of work?**	This EqIA is related to the Acute Paediatric Review being undertaken to provide an interim service between now and the development of the Urgent and Planned Care Hospital. Additional considerations include: Agile Working (consideration) Redeployment Visiting 692 - Admission of Children to the Paediatric Units within HDUHB 818 - Paediatric Escalation Procedure 2014 EqIA of the last permanent change to Acute Paediatric Service https://www.webarchive.org.uk/wayback/en/archive/20181106143456mp_/http:/www.wales.nhs.uk/sitesplus/documents/862/AttachmentEEqualityImpactAssessmentReconfigurationofServiceProvisionWomenandChildrenService.pdf

5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	The following groups have been identified as being directly or indirectly impacted: <u>Staff – (Socio-economic duty)</u> • WGH staff who have been relocated to GGH as part of temporary change • Staff who may be relocated or displaced to support the option or may no longer be needed as part of this option • Fewer paediatric nurse career opportunities from WGH as the option has a reduced nurse staffing requirement • Certainty for staff once a model has been identified and implemented <u>Patients – (Socio-economic duty/ age)</u> • Children and young people who frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Children and young people who may need urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but not residents of the area <u>Public – (Gender/ Socio-economic duty/ age/ pregnancy and maternity)</u> • Parents/ guardians/ carers of children and young people who require support and transport to frequently attend services due to medical needs and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency

		medical care and reside in Pembrokeshire, South Ceredigion and Carmarthenshire • Parents/ guardians/ carers of children and young people who may require support and transport to access urgent or emergency medical care while visiting Pembrokeshire, South Ceredigion or Carmarthenshire but are not residents of the area. • People who are expecting or are likely to give birth and may need to use the service during the interim period.
6.	**What might help/hinder the success of the Policy?**	**Help:** • All Health Board policies, procedures and guidelines are available to staff on the Health Board's intranet website. • All staff are contractually obliged to abide by Health Board policies. • It is the responsibility of Managers to ensure staff have access to the guidelines. • Clear and appropriate communications to Public, Staff & Stakeholders via the medium of radio, video and social media publications. • Information Leaflets available and distributed to the population of Pembrokeshire and South Ceredigion. • The formation of a Control Group with representation of all priority stakeholders involved in the care of children and young people. • Consultant and Service Lead support to monitor and review the of the guidelines. • A full system review of the temporary service change to report back to the Public Health Board in Autumn 2022. **Hinder:** • Inability to circulate advise to reach non-resident population (esp. holiday makers) • Lack of sufficient public communication and signposting.

		• Lack of sufficient/ effective communication with Staff and Stakeholders. • Lack of awareness of the guidelines by Staff and Stakeholders. • Lack of “buy in” from Staff, Stakeholders and Service Users. • Circulation of misinformation via social media • Inability to influence all patient/ relative behaviours when accessing services. There is no evidence to suggest that any groups will be discriminated as a result of the service change. Disadvantages arise for people required to travel further to access care, however this is as a result of needing to centralise a service to ensure that care remains available for the whole of the South area of Hywel Dda. The benefit of this work is that for Children and Young People in the South of Hywel Dda, it is possible to provide a sustainable and safe acute, critical care service which is able to meet their urgent needs, while follow up care can be delivered closer to home.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	**Yes**	**No**
Article 2 : The right to life	✓	

Example: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control		
Article 3 : The right not be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	✓	
Article 5 : The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	✓	
Article 6 : The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	✓	
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	✓	
Article 11 : The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	✓	

How will the strategy, policy, plan, procedure and/or service impact on:-	Positive	Negative	No impact	Potential positive and / or negative impacts Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also been included within the action plan.
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?	✓	✓		The temporary paediatric pathway and associated protocols are directed at children and young people (and their parents/ guardians) who reside within the Pembrokeshire/ South Ceredigion region and applies to children and young people under the age of 16 years. Between the period of 2016 – 2022 admissions of children up to age 16 has generally remained between 11,000 and 12,000 across WGH and GGH with GGH receiving the larger proportion. Of these attendances the majority have been for emergency treatment. The largest patient cohorts are aged 0-4 years and 5-9 years. The guidelines are devised to ensure children and young people get the most appropriate level of care at the right time and in the correct environment leading to effective outcome / recovery. The benefit for children and young people is that they're able to receive the best accident and emergency care possible through a centralised and sustainable rota.	Alongside a Dedicated Ambulance Vehicle (DAV) which can support acute paediatric transfers (taking children from WGH to GGH), there is a policy in place to support families with travel to and from GGH to mitigate the impact of travelling. The benefit of centralising the service in a single location is that it has been possible to retain paediatric services in the South of Hywel Dda covering Pembrokeshire, Carmarthenshire and South Ceredigion. By merging rotas which were not sustainable it has been possible to ensure that a consistent service can be provided at all times for those needing acute care, while remote outpatient care can continue to be delivered from existing sites. As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on younger people and their families and carers.

				The unintended consequences are that acute services have needed to be centralised and delivered from a single site, which has increased travel time for children and young people of Pembrokeshire and South Ceredigion and their parents and carers, increasing the time it takes for them to receive their care. Option B2 will not return acute services to WGH, however it will enable more care to be delivered in Pembrokeshire between Monday to Friday between 10am – 6pm. It will also mean that children who are signposted to GGH from WGH will be considered to have started their care pathway and receive a continuation of care on arrival to GGH due to triaging undertaken. While some unwell children may continue to be sent directly to GGH for care or admission, WGH will be able to provide a greater level of treatment than currently offered, providing children and young people greater access to care closer to home, and treatment will be able to begin faster if they have already been triaged. This evidence is largely anecdotal coming from survey responses of parents, carers and guardians, but was identified as a key theme also recognised by staff in a smaller survey	We will look to sense check as part of action planning to ensure that options being developed and proposed are reflective of wider groups who may be unable to attend events organised by the health board within traditional working hours.

				cohort, however analysis of where Pembs residents have gone to receive care has demonstrated an increase in the use of GGH services while the level of overall activity remains the same, demonstrating a need for travel. The increase in travel time and the movement of services from WGH to GGH is likely to have an impact on parent carers of disabled children who are likely to require more frequent attendance and have parents whom are typically older and may be less resilient when needing to arrange transportation. This evidence is anecdotal but also picks up broader EqIA work undertaken for the Programme Business Case for the new Urgent and Planned Care Hospital which identified the impact age has on travelling. Option B2 would enable same day urgent paediatric day case reviews, follow up appointments at WGH for those who previously visited GGH for emergency treatment or follow up appointments for Pembrokeshire residents if they used the Paediatric services. Option B2 also aspires to develop a hub approach to outpatient and day care provision further enabling people to spend less time	

				travelling, while also receiving integrated care. This mitigates some of the impact by reducing travel times on parents and carers, while allowing children and young people to access follow up care closer to home, however as the service is not available 24 hours over 7 days and cannot accept all cases, does not fully mitigate travel impact.	
Disability Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	✓	✓		The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire and South Ceredigion. The service change has not been identified to have any discriminatory impact on those with disabilities. Children with disabilities which impact on their physical health on an acute basis are more likely to be impacted by the need to travel to GGH, to either access care on a routine basis or if they require open ward access due to increased health needs. Those who require outpatient services will not be impacted as these will remain in WGH. Option B2 would still have an impact on those who are unwell needing to attend GGH for open access or emergency care, however the benefit of option B2 is that more day care,	For those with physical disabilities that may attend on a frequent basis or may have sudden changes in health needs and require urgent treatment, open ward access is available to ensure that people can receive treatment faster. For those with disabilities that impact on people's ability to understand the changes made to the service, the communication needs / expectations of affected parents/family and carers will need to be addressed appropriately about how and where to access care and signage at hospital sites. The benefit of centralising the service is that there is a dedicated staffing rota to ensure that an open ward can be consistently staffed without need for transfer between locations. This also

				outpatient care and follow up care could be provided from WGH than in the current service offering, reducing the travel impacts in terms of cost, and affect on daily life (work, education, etc.), as well as being able to view same day urgent paediatric day cases via the PACU which could reduce travelling greatly. While the majority of the activity analysed demonstrates care is required on an emergency basis irrespective of disability, further work is needed to quantify what the impact is on disabled children. Anecdotal evidence from parent responses have indicated that children with disabilities and their families are required to travel more frequently over longer distances which has a negative impact.	provides greater certainty for children and young people with disabilities and their families about where and when care is available when needed. There is no evidence to suggest that people with disabilities are discriminated against as a result of these changes. Hywel Dda University Health Board have signed up to the Learning Disability charter which seeks to treat people with learning disabilities in mainstream settings with reasonable adjustments, therefore where they may need reasonable adjustments these will be considered to ensure they are not disadvantaged further, i.e. communications from GGH ward in easy read.
Gender Reassignment Consider the potential impact on individuals who either: •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.			✓	Understanding the proportion of the population who identify as trans is difficult. The Gender Identity Research and Education Society (GIRES) estimates the overall percentage of 'gender variant' people in the UK is 1% but growing. A small proportion of teenagers covered by this guideline may identify as non-binary/trans or be exploring their gender identity. This may or may not be known to the parents of children and young people and such issues	A proportion of GP Practices in each of the 3 county areas have agreed to provide local enhanced transgender services for children and young people. GPs are able to advice children and young people and their parents/guardians on the most appropriate healthcare pathways, e.g. referral to Welsh Gender Service. Staff also have access to specialised transgender awareness training to help them work with transgender patients.

				will need to be addressed sensitively with individuals and in a confidential manner**.** The Paediatric guidelines are specific to children and young people inclusive of those who have undergone, intend to undergo or are currently undergoing gender reassignment or do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth. Option B2 does not have any additional positive or negative impact.	
Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.			✓	Not applicable – even if patient groups are subject to marriage or civil partnership, this temporary change will not impact on this protected group**.** Option B2 does not have any additional positive or negative impact.	

Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.	✓	✓		Any infant requiring hospital admission after birth (and not requiring Special Care Baby Unit) will be treated under this pathway and Parents will be supported to stay with the infant during admission. For children who require admission following birth by caesarean, additional travel time to GGH from those in Pembrokeshire or South Ceredigion is likely to have a greater impact on mothers who may be unable to travel while recovering, particularly when shortly following surgery. Women who have given birth may be suffering from post-natal depression which can impact their ability to understand on how and where to access care for both of themselves and their children. Mothers will be able to access care from the ward or signposted out to mental health services. This evidence is anecdotal and is not apparent in analysis who frequently this occurs. Responses from surveys indicate this is a greater impact when having to travel on rural roads following surgery which can cause greater pain and discomfort due to longer travel times and lack of nearby services for the care required.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women recovering during maternity. The benefit of centralisation for mothers is that there are also obstetric and gynaecology services available on site as part of the 2014 strategy, along with mental health services available to support women with post natal depression.

				While Option B2 will not change the delivery of birthing services, it will mean that same day urgent paediatric day cases could prevent additional travelling and follow up appoints following attendance at GGH A&E will require less travelling, which would reduce the impact on those who shared experiences of travelling post caesarean, but not mitigate completely due to limited service hours.	
Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.			✓	For many patients and families from minority ethnic groups, rituals and traditions become more important in times of ill health. It would be important for families to be spoken to in their first language when conveying information during the implementation of this guideline and the training required wherever possible. The UHB approved translation services will help to facilitate this. Option B2 does not have any additional positive or negative impact.	Translation and communication needs of affected parents/family and carers will need to be addressed appropriately through communications about how and where to access care and signage at hospital sites. Sense checking will also be carried out, which will be part of action planning, through community outreach teams to access communities and groups and seek their views on what has been considered. Documents for targeted engagement have been translated into commonly used languages (Arabic, Polish, Russian and Ukrainian) to increase responses, while an engagement plan looks to engage with gypsy/ traveller communities within the areas.

Religion or Belief (or non-belief) The term 'religion' includes a religious or philosophical belief.			✓	This interim system change applies equally to all religions and beliefs- to include those who have no belief. Option B2 does not have any additional positive or negative impact.	Patients and their families of all faiths can access spiritual care and support from our Chaplaincy Services which are available on all of hospital sites.
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?		✓		While the service model does not have a impact due to the patients' gender, current engagement to date around service changes have highlighted that women are generally more likely to be the primary carer, and so changes to how and where services are delivered are likely to have a greater impact on women than men. As Option B2 will allow for same day urgent day cases and more outpatient activity and follow up appointments to be undertaken from WGH, it is expected that this will benefit women who are predominantly primary carers as it will have a reduced impact on their lives through closer access to care, however they will still need to travel to GGH if emergency care or admission is required. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 190 identified as female.	As the current service is a temporary change, opportunities can be taken during the review of Acute Paediatric Services to mitigate the impact of travelling on women who are likely to be the primary carer.

				More work is needed to hear from male parents and patients.	
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.			✓	A proportion of teenagers who access services via this temporary pathway may identify as lesbian / gay / bisexual (LGB). They may or may not be “out” at home and issues around their sexual orientation will need to be addressed sensitively and confidentially. This interim system change applies equally to all regardless of sexual orientation. In the survey sent to patients/ parents/ carers, of the 201 responses received with demographic information, 195 identified as heterosexual or straight, 3 as bisexual, 2 as other and 1 preferring not to say. There has been no indication that the service change discriminates towards those of non heterosexual children and young people, their parents or carers. Option B2 does not have any additional positive or negative impact.	Staff are routinely offered a variety of LGBTQ+ related training session to help them gain a better understanding of the barriers and challenges experienced by LGBTQ+ persons.
Socio-economic Deprivation		✓		The transfer of children and young people from WGH to GGH could incur additional	Further work is being undertaken to consider transport / accommodation options, however as the review is focusing

Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see: https://gov.wales/more-equal-wales-socio-economic-duty				transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use. Eligible families will be advised of the process to claim back costs, however will require funding in the first instance to travel to access care before being able to reclaim funding. The areas of Pembrokeshire (Haverfordwest, Milford Haven), South Ceredigion (Cardigan) and Carmarthenshire (Llanelli) have pockets of severe overall deprivation which covers all domains within the Welsh Index of Multiple Deprivation which includes income, employment, access to GP/ Pharmacy services, etc. Although the numbers of people living within these areas are small in comparison to the rest of the region, changes which reduce access or increase cost burden will have a greater impact. Option B2 will still require families to travel to GGH if emergency care is required, or repeated visits if open access to ward or overnight stays are needed and accommodation is not available.	on the acute element of service delivery, some options such as community/ public transport may not be viable where emergency attendance is required during bank holidays/ overnight, etc. This procedure will have the same impact across this category equally and transport is available on request.

				This is partially mitigated and improved by being able to have same day urgent paediatric day cases seen in WGH during core hours, follow up appointments in WGH as well as the aspiration for enhanced outpatient services, reducing the impact of travel costs as well as missed employment/ education.	
Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.			✓	This interim system change applies equally to all regardless of whether they choose to communicate in English or Welsh. The language needs of the child/young person and their family/carers are respected in accordance with HB policy. All letters and forms are available in Welsh, and recruitment undertaken in line with Welsh Language Skills requirements. Welsh language usage was not a question as part of the surveys, however the majority of the respondents identified as Welsh (133, 67%). Welsh responses were also received as part of the surveys which were translated and included as part of the issues report. Option B2 does not have any additional positive or negative impact.	All of the engagement materials have been developed bilingually. Due to the timescales of the work being set, it has not been possible to provide all documentation bilingually, such as the issues report which was submitted to board or the output documents which have been developed after engagement activities. Welsh speaking staff are available at events to respond to queries if people wish to use Welsh, and staff wear lanyards to show that they are able to communicate in Welsh.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	Unable to confirm. While the survey responses cover a broad period of service use and includes all those who have accessed care, providing demographic data is not a requirement and so we cannot say for certain whether there are groups who are missing or additional impacts which have not been considered at this early stage.
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	Yes, there are opportunities to gather missing information and identify gaps through engagement with public working groups as part of the Acute Paediatric Review.
3.	**Does the information collected relate to all protected characteristics?**	No, we are aware that there are likely to be gaps from gypsy/ traveller/ BAME communities as the surveys were only provided in English and Welsh and sent only to those who use services. For those who do not use English/ Welsh as a first language or avoid using services, we may not have gathered responses from those communities. As the demographic questions are optional, we cannot determine to what extent, if any, this has been collected. We are also aware that most responses have come from parents and carers, not necessarily from the children and young people themselves.
4.	**What additional information (if any) is required?**	This EqIA would be supported with additional information from the following communities/ groups: • Children and young people • BAME • Gypsies/ Travellers

		Due to this option being built upon Option B, and changes to that model and EqIA should be considered and reflected within this EqIA if appropriate.
5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	Engagement HQ has been used to create a continuous engagement channel with more robust equality monitoring questions to help us capture the groups who are communicating with us, as well as disseminate information and provide opportunities for engagement. Patient experience data is monitored and scrutinised regularly. In addition, patients and their relatives have access to members of the family liaison team who would be able to identify and escalate any issues, which would then be reflected in a revision to this document. The following groups have been initially identified to support with gathering this additional information: • Schools • Community Outreach Team

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	**2**	**-1**	**L**
Disability	**2**	**+3**	**P**
Sex	**2**	**-1**	**L**
Gender Reassignment	**1**	**0**	**N**
Human Rights	**1**	**0**	**N**
Marriage and Civil Partnership	**1**	**0**	**N**
Pregnancy and Maternity	**2**	**-1**	**L**
Race/Ethnicity or Nationality	**1**	**0**	**N**
Religion or Belief	**1**	**0**	**N**
Sexual Orientation	**1**	**0**	**N**
Socio-economic Deprivation	**2**	**-1**	**L**
Welsh Language	**1**	**0**	**N**

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	**This is an EqIA of the temporary service change to identify the current situation and will be used to benchmark any models or options developed as part of the Acute Paediatric Services review. Individual options will have individual EqIAs undertaken to inform any decision making.**
If No please give reasons and any alternative action(s) agreed.	**N/A**
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	**N/A**

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	Patient experience data and review. Use of continuous engagement channel via Engagement HQ. Views of patient (public) opinion to be sought as a part of the service review.
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	Analysis is a part of the review process and will be reported to Board to assist decision making.
Where positive impact has been identified for one or more groups please explain how this will be maximised?	The Paediatric guidelines are specific to children and young people inclusive of those who have disabilities and live in Pembrokeshire or South Ceredigion. The guidelines are there to ensure children and young people get the right care at the right place at the right time.
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.**	The transfer of children and young people from WGH to GGH could incur additional transport and accommodation costs for the families / carers. A dedicated vehicle (DAV) has been ring-fenced specifically for Paediatric use. Eligible families will be advised of the process to claim back costs. Further work is being undertaken to consider transport / accommodation options.

Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**

EqIA Completed by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
EqIA Authorised by:	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	

Independent Review of Engagement Activity to Support Temporary Acute Paediatric Service Provision

Prepared for:

Yvette Pellegrotti

Hywel Dda UHB

By

Anna Collins FCIM

10 October 2022

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Date	Version	Amendments	Author
10. 10. 22	1.1	First draft for consideration by **Yvette Pellegrotti Principal Programme Manager**	AC tCI
19.10.22	1.2	Incorporates feedback from Hywel Dda team	Ac tCI

This document is supported by an Executive Summary.

1.0 BACKGROUND

Following a discussion between the client, Yvette Pellegrotti, Principal Programme Manager (HDdUHB) and Anna Collins, Consultation Institute (tCI) Associate, tCI were appointed to undertake a review of engagement by Hywel Dda UHB with key stakeholders during a prolonged period of change in the provision of paediatric acute services since 2014.

Until October 2014, a 24-hour paediatric inpatient unit was available at both Withybush General Hospital (WGH) and Glangwili General Hospital (GGH). A permanent change was made on the 20th October 2014, following a period of consultation, from a 24 hour inpatient unit to a 12-hour PACU service. The 12-hour service was supported by a Dedicated Ambulance Vehicle (DAV) for Women's and Children's Services was introduced to enable the emergency transfer of patients supported by specialist trained staff between hospital sites. GGH remained a 24 hour inpatient unit.

A series of temporary changes have been made to the service since 2014 due to a number of factors. Interim operational solutions have been implemented in response to staffing issues. In 2016 this resulted in a reduction in the hours that the service was open. In 2020, in response to the Covid-19 pandemic, the service provision changed and again in 2021 in anticipation of a surge in respiratory conditions in young people.

On 30th September 2021, the Health Board approved recommendations for the temporary service arrangements, i.e. the suspension of the Paediatric Ambulatory Care Unit (PACU) at Withybush General Hospital (also known as Puffin Ward), to remain until the outcome of an Interim Paediatric Service Review.

The Interim Paediatric Service Review has included early engagement in which internal and external stakeholders have been asked to give their views. The Board has committed to undertaking this independent review of engagement activity in order to inform future decision making about whether further engagement and/or consultation about the future service is needed following the options development and appraisal process.

2.0 MAINTINING INDEPENDANCY

This review was undertaken by Anna Collins FCIM, an Associate of The Consultation Institute with previous experience in the NHS at Director level who has led on preparing for and undertaking consultation in the health sector.
The review was assigned to an Associate who had no prior knowledge about the work of Hywel Dda UHB or of Paediatric Services before commencing the review. No contact was made with other Associates who have been supporting the project during the review which has been undertaken in accordance with the scope outlined below.

3.0 SCOPE

The review of engagement activity undertaken to date from the period 2014 to 2022 includes internal engagement within the Health Board and wider stakeholder engagement to include service users.

The review includes:-

- Consideration of the engagement process, timescales and external factors influencing the engagement about interim solutions implemented in response to operational pressures
- Evaluation of the communication and engagement methodologies used
- Reflection on whether the Equality Impact Assessment informed the engagement activity and whether there were any gaps identified in responses from people with protected characteristics. The review will consider whether and how these gaps were closed.
- A review of how the engagement findings have informed governance documents which are in the public domain, briefing papers used to update key stakeholders and decision making papers.

A complete bibliography of the documentation upon which the review was based is included at Appendix 1. The key documents of note were:

- Project Initiation Document
- EQIA of the status quo
- Communication strategy and tactics
- Supplementary Early Engagement Activity
- Output report from deliberative session
- Public Board papers
- Issues paper

4.0 CONTEXT

Whilst there is no statutory duty to *engage* or indeed *consult* patients and the public, the new Health and Care Act which came into force in July 2022, re-emphasises Section 242 of the consolidated NHS Act 2006 which places a duty on NHS trusts to make arrangements to *involve* patients and the public in service planning and operation, and in the development of proposals for change.

Patient engagement is critical to the delivery of a successful healthcare service. It is important as it allows patients to be fully informed and able to make their own decisions about their health care, which is thought to make for a better patient experience and overall outcome. Patient Experience is an important factor in assessing the quality and safety of service delivery and continuous engagement to explore lived experience is crucial to understanding how well services are performing.

This review considers the early engagement activities which have taken place, the processes and methodologies used, as well as the use of the insight to inform decision making. In this context, the term 'early engagement' refers to engagement with stakeholders which is undertaken prior to, and in preparation for, the options appraisal process.

5.0 METHODOLOGY

The independent review was undertaken against a set of Key Lines of Enquiry (KLOEs). A set of questions or 'looking fors' was collated in advance of the document review and each document was read in turn with a view to finding the answers, highlighting good practice or making recommendations for consideration should a decision be made to proceed to formal consultation.

Several frameworks were used when developing the KLOEs:-

- NHS England 10 Principles for working with people and communities
- The Consultation Institute Consultation Charter
- Gunning Principles
- Bracking Principles
- NHS England Major Service Change Interactive Handbook

6.0 REVIEW OF ENGAGEMENT AGAINST KEY LINES OF ENQUIRY

6.1. Setting the Scope & Context

This section of the review considers whether the scope of the services under consideration are clearly defined. This includes clarification about what is not in scope as well as what is. It is important that consultees in the future understand the background and context to the 3 temporary changes that have been implemented since 2014 in order to make an informed contribution.

Transparency and openness are key to the integrity of any future consultation along with a clear narrative to provide information which is presented without bias or pre-determination about the potential outcome.

The documents reviewed revealed a clear scope and narrative. Good practice was implemented in the use of sense checking by staff, however, it is important that participants in workforce events going forward are representative of the workforce delivering the service.

In particular, the Issues Paper provides a thorough and comprehensive presentation of the current position and history. Care should be taken to present a balanced summary of engagement outputs and not present too positive a picture.

Setting the Context and Scope	Evidence	Reference	Assessment
Is the scope of the services under review clear?	Services out of scope are clearly defined in the PID and Issues paper and any changes were recorded.	Issues Paper Section 2. Introduction & Background PID	Good. The scope should be developed to inform the consultation mandate should a decision be made to proceed to formal consultation.
Is the history and chronology understood?	An in-depth review of the documents decisions was undertaken and sense checked with MDTs in workshops and a follow up survey giving qualitative and quantitative	Issues Paper Section 4 Staff Survey	Issues paper should reflect what % of CYP staff responded to the staff survey. History and chronology is well explained.

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	analysis of understanding, issues and improvements needed.		
Has the current position and need for change been clearly explained?	The temporary changes have been documented and reviewed, setting out the reasons why the temporary changes occurred and an analysis of the impact of those changes on the service and service users. Data to support the decisions is provided as Appendices. Timeline is very clear and easy to understand. Very thorough especially looking at potential impact and considered in context of Quality, Safety and Experience Assurance Committee (QSEAC) following the approval of temporary change	Issues Paper Section 2. Introduction & Background Issues Paper Section 4	Excellent and comprehensive presentation of the current position and history. Consider format of Exec summary to make it easier to separate from the main body of the report. The Glossary of Terms interrupts the flow.

6.2 Stakeholder Participation

It is important to ensure that the views of respondents are representative of service users. The work undertaken to inform the engagement has been more than sufficient and has been used to develop and plan internal and external comms. In the event that full consultation is required, it is recommended that more advanced stakeholder analysis be undertaken to inform the messages and channels to be used.

If consultation is required, it would be helpful to repeat the process for internal stakeholders and be used to target staff messages and involvement activity.

Political elected members have been briefed both pro-actively and reactively. Going forwards, regular meetings will still take place between the CEO, Deputy CEO, Chair and politicians, where they will be updated on topical issues and have the opportunity to ask questions. These meetings are in addition to briefings and the provision of regular press releases by the Health Board to them.

It may help at key stages of the consultation to ask for their support by amplifying surveys and promoting events to their constituents.

Stakeholder Participation	Evidence	Reference	Assessment
Has a stakeholder analysis been undertaken?	Yes, in communication and engagement plans in 2014 & 2017.	PID Communication & Engagement Plans	If consultation is required, it would be helpful to refresh the stakeholder analysis and use a scoring or Boston matrix method to understand levels of interest and impact in more depth. This information could then be used to inform the consultation plan. What do people need to know and in what format?
Has a reference group been established?	A Project Group called the 'Interim Paediatric Review Group' has been established to	Issues Paper	The internal group is good practice as specialists and staff who deliver the service can make

	undertake the review in March 2022, as well as an Executive Steering Group to oversee and provide assurance on the process of the review. Early Engagement Working Groups including staff and the public is being used for the options appraisal process. The stated intention is to create "an inclusive and representative public participation to work alongside the multidisciplinary service representatives".		an informed clinical / managerial contribution to the process. This is a best practice approach. Note: Participants have 'self-selected'. It might be useful to compare the participants against population / service user profile Eg the demographic profiles or Joint Strategic Needs Assessment (JSNA).
Have political stakeholders been engaged?	The Log of MP AM briefings reveals that there have been many enquiries and case work which has resulted in briefings being delivered by the AD of Legal Services and FAQs. There are no formal minutes from the meetings with the politicians. However, actions from meetings are always followed up and information provided to the politicians if an issue raised cannot be fully	Log MP am briefings	During any future consultation, regular meetings will continue to take place with politicians, and these provide the perfect opportunity for dialogue, which can include asking the politicians for their assistance to seek the views of the constituents that they represent and to promote any consultation in order to gather those views. A summary of actions from the meetings should be maintained in case of FOI / legal challenge. Issues or

	addressed during the course of a meeting.		concerns raised by politicians on behalf of their constituents should be included in the analysis.
Has the CHC been briefed and involved along the way?	CHC have been kept updated at Services Planning Committee and Executive Committee meetings at key points along the journey since 2016.	HDCHC-HDUHB Meeting Dates for Paeds PACU	The spreadsheet provides a record of briefings and meeting dates. A decision log may be helpful during any formal consultation.

6.3 Public Sector Equality Duty

The most commonly accepted method of demonstrating that an organisation has fulfilled their Public Sector Equality Duty as defined in the Equality Act 2010 (provided in Appendix 2) is to develop an Equality Impact Assessment as early as possible in the programme and keep it iterative and relevant by updating it as new information is gathered. It is pleasing to see that this EqIA has been reviewed by members of the public, although there is no detail about which protected characteristics these people represented.

A gap analysis has been undertaken to understand whether there are any gaps in the groups represented throughout the early engagement and an action plan developed. At the time of this review, these had been timetabled for early October. Once these have been completed, the Issues Paper and EqIA should be updated to reflect new learning.

In the assessment, some additional groups have been suggested as needing additional support or effort to reach.

The EqIA should be dated with version control – even if only in the file name.

Equalities	Evidence	Reference	Assessment
Has an Equality Impact Assessment been undertaken?	Yes and includes best practice that it has been reviewed by	EqIA	The EqIA should be a dynamic document which is regularly updated at key stages of the

	members of the public and third sector.		process. It would benefit from a date and version control.
Has analysis been undertaken to identify any gaps in respondents profiles?	The proposed supplementary early engagement identifies gaps in respondents and proposes methods to close those gaps.	Supplementary Early Engagement Activity Report	The timeline suggests that these engagement tactics will be deployed w/c 3rd October. Consider updating the Issues Paper with the results or producing a supplementary report of findings. Faith Groups and LGB&T groups are not included – state why this is. GP support for Trans people is noted but they do not appear to have been engaged. One would also assume that pregnant women would have an interest in this area as potential future service users. Consider online maternity and mum's groups. Parent carers are mentioned but not young carers. Also consider hidden communities such as boaters, homeless and women in domestic abuse refuges and young offenders. SEND and NEETs young people will also be important cohorts to engage.

Has the EqIA been used to inform the comms and engagement activity?	The Learning Disability Charter is mentioned along with use of Easy Read documents. Welsh language and translators have been used The assessment of impact on Race suggests that translated documents will be available where English or Welsh is not the first language. BSL or hearing loop support may be required.	EqIA	Adhere to NHS Accessibility Standards. Health Literacy should also be taken into consideration as should the average reading age for the area. Parents and children with learning disabilities will need additional support. It is often helpful to commission the third sector to undertake engagement or consultation with groups whom they already have a trusted relationship with. Participants with sensory impairment, or mental health challenges may also need support from specialist organisations.

6.4 Health Inequalities

The NHS Act 2006 states that the health service must have regard to the need to:

a) reduce inequalities between patients with respect to their ability to access health services, and
b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

During the review, there was no evidence that this had been taken into consideration during the early engagement. However, there are plans in place to consider reducing health inequalities during the options appraisal stage (workshops) and during formal consultation should it be required.

Some suggestions are provided in the table below and a useful resource is the Public Health Equity Tool https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

Health Inequalities – some suggestions
Consider conducting a condition prevalence study of service use to identify the most common conditions and target these groups eg CYP with respiratory conditions – asthma groups, diabetes support groups, young cancer patients support networks, sports groups for bone breaks, Autism & dyspraxia support groups, epilepsy groups etc.
Use the JSNA to identify the most prevalent conditions amongst the population and the demographics therein
Identify geographic areas with high IMD and geo map responses to consultation by mapping responses using postcodes.

6.5 External & Internal Communications

This section of the review considers whether participants had sufficient information to participate in an informed way. Several communication and engagement plans were reviewed from the three temporary changes and each had good practice elements contained within.

When planning any future consultation, should it be required, it may be beneficial to take a social marketing approach and use the stakeholder analysis and EqIA to segment the population in terms of message and channels. Some innovative and cost effective techniques can be used to make the narrative relevant to each segment such as Facebook advertising and user generated content. Some suggestions have been provided below.

It is also important to consider communications channels and the information being provided at the mid-point review of the consultation in order to modify the information being provided or channels for delivery.

External Provision of Information and encouraging participation	Evidence	Reference	Assessment
Is there a communication strategy in place with key messages and trusted spokespeople identified?	A very thorough campaign was implemented in March 2015 with risks, action owners and budget. Some measurable outcomes were included but it is not clear whether these were evaluated. The 2018/19 plan includes well considered objectives and targets and refers back to the 2015/16 plan in its execution. The 2014 C&E plan provides key messages and spokespeople and shows its place in time as the majority of comms channels	Information campaign 2015 Women and Children's Services Communications and Engagement Plan V2. 08/02/17 Communication Plan 2021	Consider using Targeted FaceBook advertising, Snap Chat, Insta, TikTok etc Set SMART targets for comms activity and review post implementation.

	were focused on paper based systems such as leaflet drops. There is a very detailed Post Announcement Delivery Plan with clear status and action owners	2014 C&E plan	
Stakeholder mapping – was this used to inform the comms approach? i.e. channels & methods to use and what is relevant to each target group?	The communications tactics have been informed by the target audiences identified in the plan.	Phase Two comms & engagement plan 2016 Women and Children's Services Communications and Engagement Plan V2. 08/02/17 2014 C&E plan Communication Plan 2021	2015 included bereaved parents and sensory loss groups. Are there any plans to re-engage them to see if there is any difference now?
Were the temporary changes communicated to the public?	The Paediatric Management team review of engagement sessions reveals that there was significant engagement in 2016 and 2020 supported by communications campaigns. The changes were off set using celebratory news stories which were captured and logged. The temporary changes were communicated in spring and summer of 2020 by external communications (media releases,	WGH PACU Engagement 2016 onwards Women and Children's Services Communications and Engagement Plan V2. 08/02/17 Paediatrics Communication Campaign 2021	Good. Previous comms channels to be used to develop a future consultation plan, should full consultation be required. Consider segmenting the messages to different audiences and deploying paid for awareness campaigns. Very comprehensive campaign was described with 5 clear messages, target audiences and tactics deployed. Pleasing to see

	radio advertisement and social media); and communication with key stakeholders such as GPs and WAST.		it was costed with key metrics and a status report on the action plan. Includes non-digital audiences and clinical voice as authority and someone to trust.

Internal Provision of Information and encouraging participation	**Evidence**	**Reference**	**Assessment**
Have staff been kept updated and involved in the changes?	A broad range of internal comms channels have been used to brief and involve staff from 2015 onwards including bulletins, global emails, notice boards, handovers, drop-ins, walkarounds, staff surveys, world café and graffiti wall. The target audiences identified cut across all levels of staff including trade unions, Execs, independent members and staff involved in the delivery of services. The staff intranet has been updated with staff bulletins released on paediatrics and signposting has been promoted	Phase Two Comms & Engagement Plan Women and Children's Services Communications and Engagement Plan V2. 08/02/17	Good use of innovative methods. It is understood that information for staff including relevant documentation, progress reports with links to staff surveys and feedback reports is being developed in Engagement HQ. This is a platform which encourages participation and dialogue.

	through the daily email to all staff (global email) for many years, and since 2020 through the staff only Facebook group.' Messages have also been shared through global email to inform staff of updates ahead of Board meetings. Where there are staff specific messages, these are shared on the intranet which only staff can access.		

6.5 Sentiment Analysis

Analysis of internal and external, quantitative and qualitative responses can be a challenge as it is important to use methods and techniques to eliminate bias and identify key themes. It was reassuring to see that the analysis has been undertaken by an independent third party.

The specific questions asked in the surveys or discussion guides were not provided as part of this review but from the Issues Paper it is assumed that they were broad early engagement questions about what works well, what could be improved and any issues.

Some suggestions to be considered in the options appraisal or consultation, should it be required, have been included in the assessment.

Sentiment Analysis	Evidence	Reference	Assessment
Have the views of staff involved in delivering the service been sought / understood?	Staff survey analysis was undertaken using best practice methodology eg Braun & Clark,	Issues Paper Section 3	Targeted surveys include the right question themes. A very thorough set of standard and proven methods were used to analyse the data.

	code-framing and triangulation methods.		Note: In any future engagement or consultation, consider a separate question which probes responses about hidden disabilities and protected characteristics such as language, signage, pronouns used, sensory impairment etc etc.
Have the views of service users been sought / understood?	Data sets include:- • Patient Experience Data • Complaints • DatixCymru • Surveys Representative samples and a broad range of methods were used. The seldom online were included through letters and posters. Time ranges for data harvesting are well considered and representative of service use. The analysis identified any gaps for future engagement It is not clear whether the incentivised drop in events were in depth interviews or merely signposting to the survey. (14 responses seems	Issues Paper Log of Engagement Activity	625 survey responses received. It would be helpful to present the confidence interval of the sample size. To understand to what degree the number of responses is representative of the whole population. https://www.calculator.net/confidence-interval-calculator.html The gaps identified in the EqIA eg Gypsy & Traveller community, parents/guardian at schools, CYP groups or NEETS will be addressed in the engagement plan supporting the EqIA.

	low for a survey but good for in-depth deliberative dialogue) CHC survey provided external verification of views sought by HDUHB. Analysis was clearly a challenge but overcome by year and themed analysis. Disaggregating survey for under age 11 and 11+ is very helpful as they produced different concerns and issues.		Continuous engagement channels to be publicised and amplified to generate responses. Ensure that any corporate correspondence sent to Execs is included in the analysis for any future consultation process that is required.
Have respondents been asked for views on what they can legitimately influence?	Respondents were asked to provide their experience and views about what was good, what could be done differently, needed improvement and/or any issues regarding the service. At this stage of early engagement these are perfectly legitimate questions and there were no options presented which is good practice to avoid pre-determination of the solutions.	Issues Paper	Good practice. The summary of recurring themes should be used to develop the long list of potential solutions to the problems described in the Issues Paper.
Do the participants form a balanced room?	The deliberative solutions exploration workshop for phase 2 held on 16th Sept	Solutions Exploration Report 16.09.22 V3	Advise to repeat solutions exploration workshop with different groups / methods of recruitment eg from

	reveals a very low number of participants. Whilst a great attempt to encourage people to participate was made, the number of attendees was very low. The methodology of the workshop followed best practice processes to develop hurdle and desirable criteria, ideas generation and preference.		condition specific support groups, CVFS or groups who work with people with protected characteristics.
Is there any bias shown in the analysis?	Code framing of all responses was undertaken with use of cross tabs and geo analysis to removes bias. Temp Service Change 1 National Annual Survey patient experience report of results only shows positive results. However, tCI analysis shows some negatives and concerns		Best Practice analysis methods used. Consider revisiting the reports to understand any negative responses / concerns raised.
Were the responses presented in a transparent and open way?	The Executive Summary of the Issues paper is very positive in the general findings section suggesting that there were few issues raised.	Issues Paper Exec Summary	Consider the way the General Findings and Executive Summary is presented.

Was there any pre-determination in the narrative or questions?	"As the return of 24 hour Paediatrics is unrealistic…."	Issues Paper page 24	Use quotes if this was said by a consultee to make it clear that it is a comment made rather than something that has undergone options appraisal.
Were common themes identified to inform the next phase of options appraisal?	Common theme = travel times from re-locating services	Issues Paper	Use comments and concerns to inform/trigger transport analysis in options appraisal process.
	Common theme = facilities / infrastructure	Issues Paper	Involve Estates Team in options appraisal process

6.6 Closing the Loop

It is not clear whether the participants have been kept updated or whether there is a "you said…" approach. It is also unclear about whether the positive comments about staff from external and internal engagement has been fed back to them and celebrated.

Consideration of how consultees should be kept updated should be given for any formal consultation.

6.7 Governance & Conscientious Consideration

This section of the review undertakes an assessment of whether the governance structure and decision making process is demonstrated, whether decisions are open and transparent and whether the supporting good governance processes are in place.

Overall, the hierarchy of decision making is clear and robust with a clear line of sight through groups which involve the public, through committees to the decision makers.

Governance & Conscientious Consideration	Evidence	Reference	Assessment
Is there a clear governance and decision-making structure in place?	The issues paper clearly outlines the governance structure. An Interim Paediatric Review Group	Issues Paper Section 2 PID Issues Papers Sec 3	Consider showing risk log in PID.

	reporting to Executive Steering Group has been established. Decisions have been recorded and included in the documents		PID is very thorough in terms of ownership, next steps and timeline. Consider adding a document change control table at the beginning of each key document and ensure consistency across version control and numbering
	It is pleasing to see that the Issues Paper will be used to inform discussions at a deliberative session on Friday 16 September 2022.	Issues Paper	Good. An independent output report has been produced to inform decision making.
Are decisions open and transparent?	The independent review report and summary report were considered at Board meetings in public and the documentation is referred and linked to as a repeating theme throughout. The PSDB document is a clear record of decisions made dating back to 2013 with regular updates on the RCPCH Action Plan. The Board has been updated about the Interim Paediatric Review regularly in 2022 (May & September)	Issues Paper Section 5 WGH Paediatric Services Decisions Board.	Consider using social media or pro-active communication when a decision has been made and provide a link to public documents. Good transparency and record keeping.

	Longer Term Service Models states “As a result, it was agreed that communication and engagement activities in respect of the future development of Women and Children’s services will be coordinated as part of the TCS Strategy as it moves into the design phase *and then be part of formal consultation in 2018*.This will provide the opportunity for a whole system, consistent approach.	Issues Paper	This poses a risk of legitimate expectation that consultation will take place.

7.0 CONCLUSION

Having reviewed the documentation provided, it is clear that the current position and history of the three service amendments have been articulated in the Issues Papers and that the Community Health Council (CHC), elected members, public and staff have been informed along the journey since 2014. The communications and engagement tactics were considered in advance in a series of comprehensive plans.

Recently, a broad range of methods have been deployed with target audiences and key stakeholders to seek their views through early engagement. The output from this activity has been analysed using a range of robust and proven methods. This has been supplemented by other rich sources of feedback such as complaints and patient experience data.

It has been pleasing to find that governance structures are in place and any decisions have been recorded. Where possible, patients and the community have been represented and have participated such as in the review of the EqIA and informing decisions.

Since there is no statute, one single agreed process or guidance for pre-consultation engagement, it is sufficient to say that attempts have been made to engage key stakeholders to inform the review thus far and plans are in place for further involvement during the next stage of the process which will be options development and appraisal.

When recruiting to future Working Groups, it may be worthwhile revisiting the demographic profile of the area and seeking representation from communities of interest or condition specific support groups. Hywel Dda have already embarked on developing solutions to the changes (which is outside the scope of this review) and are already following good practice principles in the Workshop to explore hurdle criteria and evaluation (desirable) criteria and rank ideas generated.

Care must be taken to ensure that the output from the early engagement is not lost, and is used to inform the next steps and long list of potential solutions.

There are some areas for improvement or consideration when preparing for formal consultation, should this be required, which have been outlined below.

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8.0 RECOMMENDATIONS

1. Use the Issues Paper scope and narrative to develop a consultation mandate
2. Refresh the EqIA to inform stakeholder analysis and subsequent consultation plan
3. Revisit the JSNA and condition prevalence to understand health inequalities and target groups
4. Ensure that a Consultation Plan considers hidden communities, seldom online and accessibility adjustments
5. Produce a petition policy to describe how objections made by petition will be handled
6. Refresh the Risk Register by considering the themes from the engagement
7. Develop a document Control Protocol and naming conventions
8. Create a supporting evidence file with accurate record keeping to use in case of Freedom of Information Requests or as a defence against legal action

APPENDIX 1

DOCUMENTATION REVIEWED

Document	Date	Version
PID - Interim Paediatric Review Group	August 2022	V0.7
Acute Paediatric Service Issues Paper	September 2022	V.01
Draft HDUHB solutions exploration report	16 September 2022	V3
EqIA	No Date	No Version Control
Supplementary Early Engagement Activity	October 2022	003
WGH PACU Engagement 2016 onwards	No Date	No Version Control
HDCHC-HDUHB Meeting Dates for Paeds PACU	No Date	No Version Control
RCPCH - Hywel Dda Report	151118	Final Draft
RCPCH Summary report action plan	Not dated	(2)
WGH Paediatrics Services Decisions Board - with Document Links	No Date	No Version Control
log MP am briefings	No Date	No Version Control
Log of Engagement Activities Relating to Paediatric Services Changes	No Date	No Version Control
Communications Log Relating To Paediatric Service Changes	2013-2022	v 5 (1)
Information campaign	March 2015	(final for service)
Phase Two comms and engagement plan	140616	
Women and children communication and engagement plan September 2018	Doc control date is 08/02/17	V2
Women and Children's Services Communications and Engagement Plan 2014	29.05.14	v12b
Paediatrics Communication Campaign	2021	No Version Control

APPENDIX 2

Equality Legislation

The 'Due Regard' Duty

The Statutory Provisions as set out in the Public Sector Equality Duty (PSED) Section 149(3) of the Equality Act 2010 states that advancing equality of opportunity involves having due regard to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

"A decision maker, having taken reasonable steps to inquire into the issues must understand the impact or likely impact of the decision of those of the listed equality needs"

…a process of consideration, a thought process…at a time when decisions which could have an impact are being taken.."

This has been tried and tested in court, the most important cases are that of:-

R(ex parte Judy Brown) v Secretary of State for Work & Pensions (2008)

As part of a nationwide programme of post office closures it was challenged that the Secretary of State had failed to undertake a Disability Equality Impact Assessment (pre dates Equality Act 201). Resulted in the formulation of six 'general principles'.

R(ex parte Bracking & others) v Secretary of State for Work & Pensions. (2013).

At the High Court, Blake J considered a claim that consultees had inadequate information and therefore could not make an effective response. He heard argument that the Minister had not taken due regard of the PSED. It was heard in the High Court, and referred to the Court of Appeal and therefore adds additional principles to Brown

Why we need to get this right

Claimant lawyers now look to make sure that reference to Bracking & Brown are included in decision making papers and Equality Impact Assessments (and training) to find the Achilles heel to try against.

Most importantly due regard leads to:

- Better informed decision makers
- Better understanding of needs
- Better health services
- Reduced discrimination and reduction of health inequalities

The Bracking Principles: AND WHAT THEY MEAN!

1. The equality duty is an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.

IT'S THE LAW!

2. An important evidential element in the discharge of the duty is the recording of the steps taken by the decision maker in seeking to meet the statutory requirements.

IT NEEDS TO BE MINUTED – CAREFULLY!

3. The duty is upon the decision maker personally. What matters is what he or she took into account and what he or she knew.

IT CANNOT BE DELEGATED!

4. A decision maker must assess the risk and extent of any adverse impact and the ways in which such a risk may be eliminated before the adoption of a proposed policy/decision. It is not a rear-guard action following a concluded decision.

THE EIA MUST START EARLY AND BE PART OF THE PAPERS FOR A DECISION!

5. The duty to have due regard must be fulfilled before and at the time when a decision is being considered and it is a continuing one. The duty must be exercised in substance, with rigour and with an open mind. It is not a tick box exercise.

IT SHOULD NOT JUST BE A BOARD THING – IT SHOULD ALSO BE PART OF POLICIES, PLANNING & COMMISSIONING PAPERS!

6. Public bodies should place considerations of equality, where they arise, at the centre of formulation of policy, side by side with all other pressing circumstances of whatever magnitude. They must be properly informed before taking the decision. If the relevant material is not available, there is a duty to acquire it – even if this means more consultation!

ABSENCE OF INFORMATION IS NOT A DEFENCE!

7. A public body must have available enough evidence to demonstrate that it has discharged the duty.

THE MINUTES SHOULD DEMONSTRATE THAT INFORMATION / DATA WAS CONSIDERED!

8. It is not for the court to determine whether appropriate weight has been given to the PSED

WE NEED TO EVIDENCE THE PROCESS NOT THE OUTCOME!