Date	**2025-09-15**
Time	**2:00 PM - 4:00 PM**
Location	**Microsoft Teams Meeting; / Virtual**

Extraordinary Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

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2:00 PM,

1 - Welcome and Apologies

Anna Lewis (Hywel Dda UHB - Independent Board Member)

2

30 Mins

2 - Critical Care

Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC)

For assurance

Attachments

Deep Dive Template v0.2 Critcare Aug25 - final.pdf

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Deep Dive: Critical Care

Quality, Safety and Experience Committee

September 2025

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview and update on the current provision of Critical Care across HDUHB, focusing on Carmarthenshire.

Carmarthenshire has provided an amended patient pathway through PPH ICU since July 2022 supported by a SOP. Following concerns from clinical incidents in late 2024, a GGH ICU clinician led decision to manage patients outside of the SOP was made in January 2025. This led to a decrease in patients remaining in PPH and an increase in transfers to GGH. There are concerns that the latter change is seen as pre-empting outcome of the CSP and has potentially placed patients at higher risk of harm. There are ongoing active discussions with clinicians on the current management of patients within PPH ICU.

The overview and update contains information relating to patient flow volumes and source, a review of recorded incidents, complaints, and risk and how these are managed and supported; and to the current medical staffing challenges

The data capture a date range of 1st January 2024 – 31st August 2024 comparing with the same timelines in 2025.

Background

- Currently there are 14 Critical Care Units supporting Level 3 patients across Wales, with 4 in HDUHB. (Note: Pending CSP, PPH's current interim SOP does allow for a stabilise and transfer process for Level 2 (for escalation) and Level 3's and has not formally been changed from a Level 3 facility).
- The Faculty of Intensive Care Medicine (FICM) publication Guidelines for the Provision of Intensive Care Services (GPICS V2.1 2022) contains the nationally recognised standards for critical care provision. The Care Quality Commission (CQC) in England and the All-Wales Critical Care Network use these when undertaking inspections (CQC) and conduct peer review (Critical Care Network).
- FICM and the Intensive Care Society (ICS) publish the guidance of level of dependency within Critical Care.

Level 0	Patients whose needs can be met through normal ward care in an acute hospital.
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the Critical Care team.
Enhanced Care	An intermediate level of care where a higher level of observation, monitoring and interventions can be provided than on a general ward but not requiring high dependency care/organ support.* **Enhanced** advice and support from the Critical Care team can be accessed.
Level 2	Patients requiring more detailed observation or intervention including support for a failing organ system or postoperative care, and those stepping down from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least 2 organs systems. This level includes all complex patients requiring support for multi organ failure.

Background

- Current Critical Care provision in Hywel Dda:

Location	Bed spaces	Staff funded Level 3	Staff funded Level 2	*	Clinical Staffing Consultant	Clinical Staffing SAS	Nursing
Nurse / Patient Ratio:		*1 to 1*	*1 to 2*				
GGH	18	7	6	13	8 - budget of 9. Based GGH ICU. Daytime resident / Oncall from home.	011 Junior / 013 Senior 24hrs	24 hrs
PPH	6	1**	4	4		604 - 24hrs - resident	24 hrs
WGH	9	2	4	6	5. Daytime resident Monday to Friday, with 10 covering out of hours oncall from home.	Tier 1 - 24hrs resident	24 hrs
BGH	5	2	2	4	10 - all with ICU rotation into jobplans. All resident.	No Juniors	24 hrs
				Total: 20			

* Bed configuration can fluctuate depending on patient care status and related nurse staffing availability.

** PPH - stabilise and transfer bed

Background

- On 25th July 2022, an operational decision was implemented to amend the admission protocols to the PPH ICU as a consequence of a vacancies and the availability of current critical care consultant staff to provide appropriate and sustainable levels of on-site support to the unit. This decision was affirmed on 28th July 2022 by the Operational Planning & Delivery Group, chaired by the Director of Operations.
- A SOP outlining the criteria and care pathways supporting the admission and management to patients into PPH ICU was written and agreed by the multi-specialty clinician leads in ICU and PPH.
- A Task and Finish Group was set up to support discussion and review the critical care provision across Carmarthenshire. With the emergence of the Clinical Service Plan (CSP) a decision was made to suspend the Task and Finish Group. At the outset of the CSP, it was Carmarthenshire Critical Care provision that drove discussion; later the provision of critical care in WGH and BGH was incorporated, and the work expanded to explore and review critical care provision HB wide.
- To date CSP discussions have been supported by multi-disciplinary representation from clinicians, nursing, administration and allied health. The work has been supported by data capture, which explored patient flow, service utilisation and patient transfers.
- While the initial final discussion provided 4 options for the future of critical care provision, the period of public consultation has contributed further variations that might be considered as suitable and sustainable in future provision.
- The critical care multi-disciplinary team supporting CSP remain committed to supporting critical care provision that is sustainable in the medium and longer term, that is underpinned by best practice as set out in the GPICS standards and aligns with critical care provision across Wales.
- A Consultant lead for Critical Care was appointed in July 2025 to lead and support continuity and development of Service provision across the Health Board.

Background

- In Carmarthenshire there has been a prolonged period of uncertainty on the future of PPH ICU. In late 2024, there was growing concern from the supervising consultant anaesthetist body on the safety of leaving any patient within PPH ICU. This was escalated in writing in December 2024. This prompted a clinician led amendment to PPH ICU admission for transfer profile in late January 2025.
- The SOP in brief:
  - All patients requiring level 3 must be discussed with the ICU Consultant on call in Glangwili Hospital.
  - All level 3 patients, accepted by the ICU consultant will be cared for directly by the resident SAS anaesthetic doctor with guidance and support from 24/7 intensive care consultant in GGH.
  - All Level 3 patients with multi-organ support, or Level 2 predicted to require this, will be transferred to GGH at the earliest and safest opportunity. Patients awaiting transfer will be cared for on ICU in PPH.
  - Where intubated patients who are predicted to be extubated within the 12–24-hour pre-transfer window, it is reasonable to plan to keep these patients in PPH.
  - Level 1/low risk level 2 post-operative care will continue to be supported in PPH ICU, but with patients admitted formally under care of surgeons. The on-call Intensive care consultant in GGH should be made aware of elective surgery admissions.
  - Elective surgery patients deteriorating with prolonged need for intensive care admission, including patients requiring further operative intervention will need to be transferred to GGH Critical Care Unit.
- The amendment since January 2025.
  - Since January 2025, admission to PPH ICU has been part in line with the SOP, with the principal amendment being the transfer of <u>all</u> patients requiring Level 2 and Level 3 care to GGH ICU.

Assessment

- Current challenges:
  - PPH and the current amended* pathway; unresolved concerns on patient safety raised by ICU clinicians; and impact on all involved and concerned including elective surgery pathway for orthopaedic patients.
  - Medical staffing: Limited SAS to support GGH senior 013 rota and PPH 604, due to vacancies created by recent leavers x 4 joining Deanery pathway. Reference recruitment, there is no issue with volume of applicants, however on average 50% of offers are declined within 10 days as they have accepted other opportunities

Assessment: PPH and the current amended pathway

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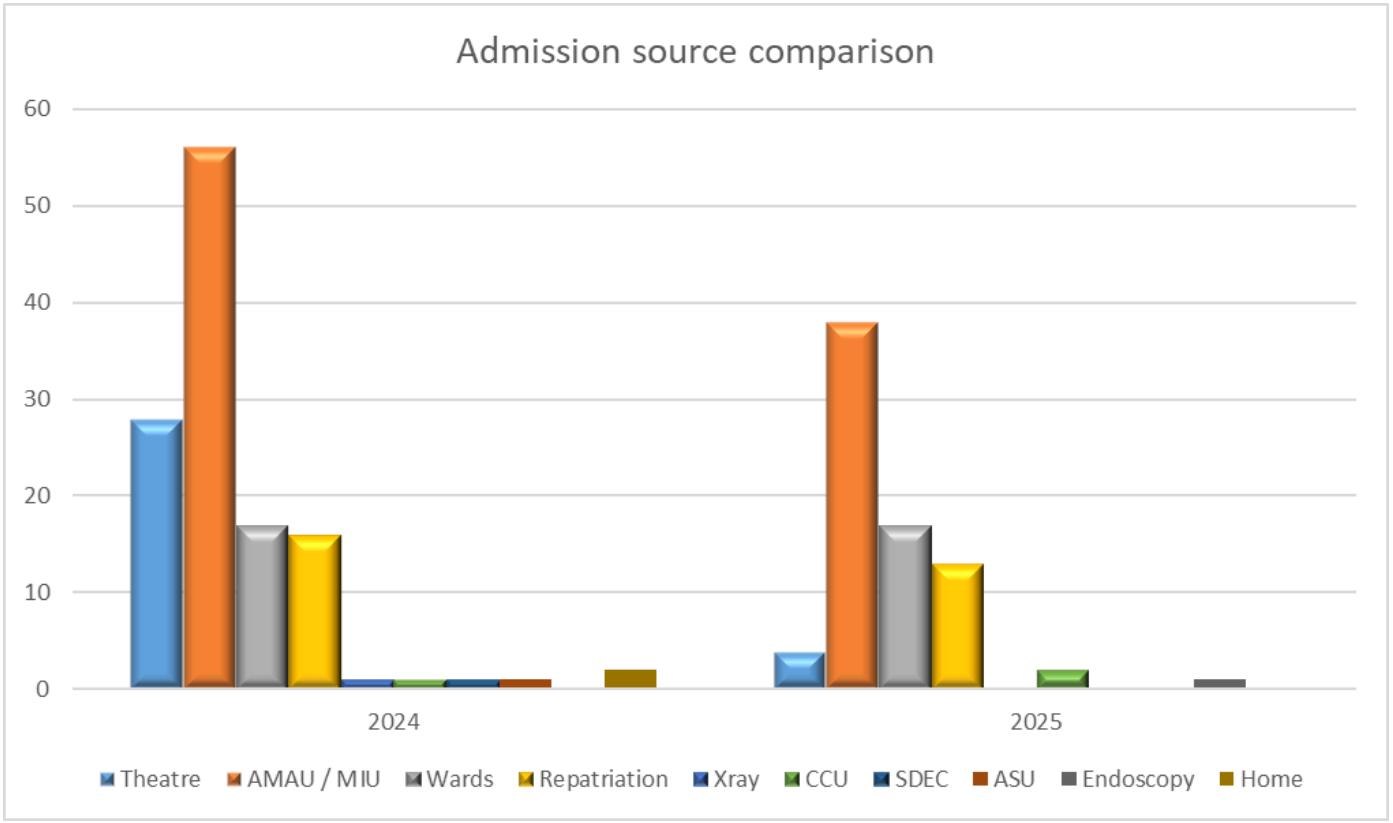
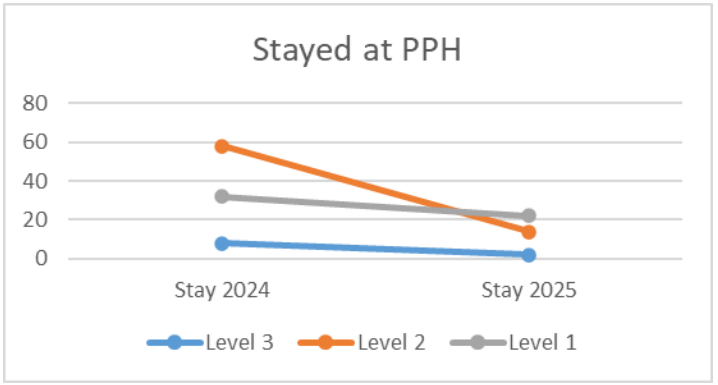
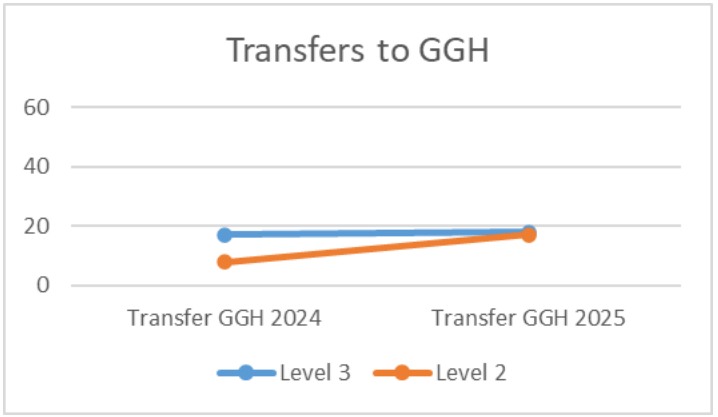
Actual provision in PPH since late January 2025 – no admissions supported by GGH ICU consultant team, other than those for stabilisation and transfer. Patients can and have been admitted under local Consultant agreement.

Impact on activity, admission data capture comparison January to August 2024 and 2025:







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Assessment: PPH and the current amended pathway

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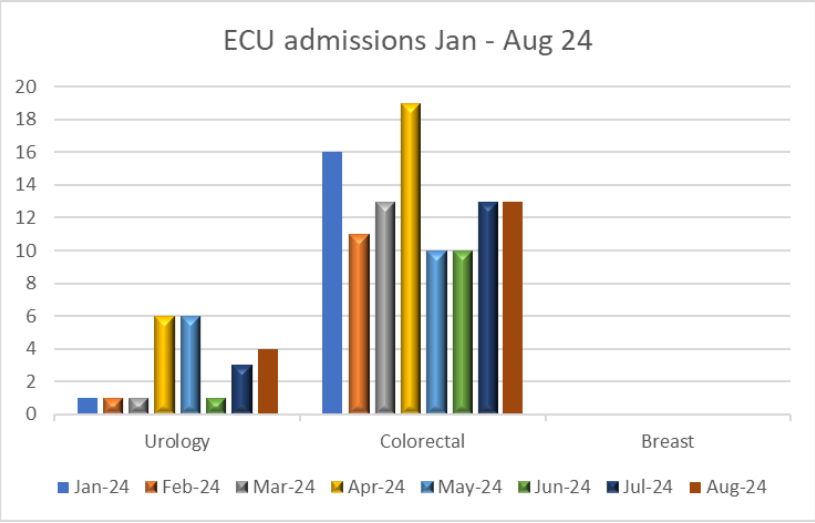
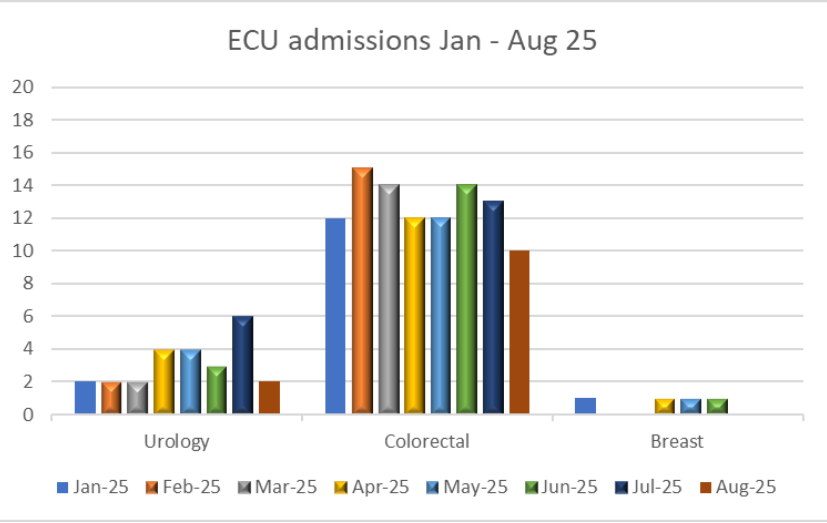
Impact analysis - elective surgery pathway and admissions to the Enhanced Care Unit (ECU) on Ward 7:

- In theory the amended pathway has required a move of certain elective colorectal and urology patients, where there has been low confidence that ECU support would be adequate, to GGH for surgery and post op care in GGH ICU. However elective admissions into GGH ICU from theatre show that 10 elective case were admitted Feb to Jul 24 and 12 in the same period in 2025. This is assessed a minimal impact.
- There has been no impact on the ECU pathway on Ward 7, on assessment there is minimal difference across the 8-month period 12 months apart. Average number of patient per month, 16 in 2024, 16 in 2025.





- Whilst the number of orthopaedic patients assessed as requiring ECU has remained stable – 10 to15 per year; there are ongoing discussions on how an ECU pathway for this cohort can be provided at PPH. Currently, 2 patients are awaiting surgery and are assessed as needing ECU pathway post op, with a further 7 within Q 3/4.

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Assessment – Medical Staffing
Limited SAS to support GGH senior 013 rota and PPH 604

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- The current Consultant budget has 8 of the 9 posts filled, with a 9th consultant temporarily supporting from BGH. The group has 6 anaesthetic / ICU staff and 3 pure ICU.
- The current SAS rotas within Carmarthenshire are supported by funded FTE of 22.
- The oncall commitments are:
  - 011 GGH ICU 24/7 – junior SAS and trainees signed off by consultant team.
  - 012 GGH Obstetrics 24/7 (and supports theatre out of hours) – have completed specific training and experience and been signed off by lead for Obstetric anaesthetics.
  - 013 GGH ICU 24/7 – senior SAS staff
  - 604 PPH ICU and rapid response 24/7 – senior SAS staff and trainees only – signed off by consultant team.
- Current vacancies: 6 x SAS.
- Current plans against the 6: Senior Clinical Fellows x 2 onboarding from interviews 20Aug25. SAS interviews planned for 17Sept25 – 8 candidates for 4 places.
- Workload commitment assessment completed. With Medical Workforce for validation. Preliminary assessment would suggest an increase of SAS x 6 FTE to support workload and provide prospective cover.

Current SAS staffing challenges:

Despite consistent ample applicants for shortlisting and interview; approximately 50% of offers are declined within 10 days of offer – with candidate accepting offers elsewhere. This includes the reserves.

Recent success of 4 staff returning to Deanery training in August – all 013 seniors; replacements are junior and will requirement time to develop skills and confidence for th

Assessment Summary:

- A review of documented clinical incidents and complaints does not evidence that patient care, decision making or safety has been compromised by the amended transfer profile applied in January 2025.
- The number of admissions to PPH ICU in the period 1st January to 31st August 2025, reduced by 48 from the same time period in 2024.
- The number of transfers to GGH ICU increased, in the same period, from 25 in 2024, to 35 in 2025. The increase in transfers of the Level 2 group is the principal reason for this.
- There is no documented evidence to suggest that patient access to GGH ICU has been compromised by the increase in transfers from PPH ICU.
- Risk 1880 - risk to the sustainability of critical care services due fragility of medical workforce, outlines the concerns on the availability consistent trained and experienced medical staff supporting ICU provision in Carmarthenshire. Whilst the presence of 8 consultants has mitigated the original source of the risk, the risk now incorporates the SAS staff group. On assessment of the 16 SAS in post to support the 011, 013, 604 rotas supporting ICU GGH and PPH: 4 can support all; 4 can support 011 and 013, 2 can support 011 only. The 16 include 2 August joiners. To backfill gaps in the rota, staff pick up extra shifts; in addition to the core staff there are 5 staff on the Medical Bank and 3 trainees that can support 011 and 013; a further 6 trainees are signed off to support 011.
- The multi-disciplinary team across GGH and PPH ICUs remain unsettled on the unresolved situation of the provision across Carmarthenshire; and remain committed to participate and support CSP discussions related to the future of ICU provision across the Health Board.

Conclusion

Plans:

- Ongoing, clinically led, discussion and collaboration with clinicians to confirm and apply agreed PPH ICU admission and management pathway for patients with current SOP or SOP with new amendment.
- Maintain collaboration with Medical Recruitment and process assuring onboarding and induction commitments are met in timely manner.
- Participation in Medical Stabilisation project – progressing anaesthetic workload assessments and the workforce required to sustainably meet it. Meeting to follow.
- Support ongoing collaboration and participation in CSP programme.

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The Duty of **Candour**

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DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

The six domains of quality

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

3

30 Mins

3 - Emergency General Surgery

Caroline Lewis (Hywel Dda UHB - Service Delivery Manager ENT & General Surgery)

For assurance

Attachments

3 Emergency General Surgery.pdf

Deep Dive: Emergency General Surgery

Quality, Safety and Experience Committee

September 2025

Introduction

The purpose of this report is to provide the Quality, Safety and Experience Committee with an understanding of the impact of the fragility on current service provision, incidents, complaints, patients experience and risks and understand how these are being managed and how the out of hours surgical service is being maintained and risks mitigated, whilst the outcome of the Clinical Services Plan is awaited.

The service is providing an update on the management of the Emergency General Surgery (EGS) rota for Glangwili and Withybush Hospitals and the developments since the issue was initially highlighted in November 2022.

Situation – Current Rota Position

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Glangwili Out of Hours, (OOH) Emergency General Surgery (EGS) consultant rota	
Rota Frequency	1:8
Current Position	4.5 substantive consultants covering the rota (0.5 covers weekdays only, no weekends)
	3 Locum Consultants – 2 of these are long term NHS, 1 is a recently appointed Locum Consultant fixed term for 1 year, the substantive Consultant post (colorectal) will be advertised January 2026.
	0.5 gap which is covered by internal Consultants as ADH within card rate.

Withybush Out of Hours, (OOH) Emergency General Surgery (EGS) consultant rota	
Rota Frequency	1:4
Current Position	2 Substantive Consultants covering the rota
	2 NHS Locum Consultants covering the rota, both fixed term (1 upgraded Internal Associate Specialist and 1 NHS Locum Consultant)
	The NHS locum consultant has submitted their resignation, and will finish on 25/09/2025, the service has submitted an AG1 to request Medacs agency locum cover, whilst substantive recruitment takes place.

Situation

In the interest of medical workforce stabilisation, the service advertised three substantive Upper Gastrointestinal (Gi) consultant Posts, 1 at Glangwili Hospital (GGH) and two at Withybush (WGH) to replace the current Locum Consultants. Interviews took place on 02 September 2025. An AAC decision was made to recruit substantively to GGH and to offer 1 substantive and 1 locum consultant for WGH, after interview. To date, the GGH appointee and the locum consultant for WGH have accepted the posts, the third candidate needs time to consider accepting the post.

The high turnover of agency and locum consultants, particularly at WGH, has had an impact on training continuity of resident doctors and the team dynamics in the department. This became evident during a Health Education Improvement Wales (HEIW) targeted visit in April 2025, which was arranged in response to concerns raised by trainees relating to the quality of education provided, as part of the 2024 National Training Survey. There were positive comments and areas of concern, the key themes of concern were behaviour of senior clinicians, distribution of the workload and bedside training opportunities. An action plan was provided with 20 actions and a group was set up to work on the action plan. 19 of the actions are complete with 1 action in progress, which relates to workshops being set up for the team, one of which has taken place on 05/09/2025. A further targeted visit is arranged for 29/10/2025, to review the success of the actions.

In context, it is a challenge to maintain consultant on-call rotas for EGS on all three sites, with rotas at GGH and WGH in an unsustainable position. There is a risk of being unable to provide consultant-led out of hours EGS services on each site. There is also a fragility at WGH, with no Upper GI services on the site. This means that some patients are already being transferred to GGH for treatment, which has increased the workload on this site.

Background

Since June 2022, there has been a decrease in the number of consultants undertaking on call at GGH and WGH, this is due to retire and return, health reasons and vacancies that the service has been unable to recruit to. The service has managed the risk relating to EGS on call with the use of Medacs Agency, internal ADH and fixed term NHS locum consultants.

Below is the timeline of Medacs agency locum usage to support the EGS consultant on–call rota at WGH and GGH. These were predominantly for WGH, after the withdrawal of GGH internal locum cover for the 2nd gap on the GGH rota, a temporary Medacs agency locum was provided from, April 2025 to July 2025, whilst on boarding a locum consultant, who commenced in August 2025. The individual names have been removed in the interest of confidentiality.

- Consultant 1 - 08/08/2022-01/05/2023
- Consultant 2 - 12/12/2022-23/01/2023
- Consultant 3 - 27/02/2023- 10/03/2023
- Consultant 4 - 27/03/2023- 06/04/2023
- Consultant 5 - 01/05/2023- 01/09/2023
- Consultant 6 - 06/11/2023-22/10/2024
- Consultant 7 - 02/12/2024- 20/07/2025

Background

- The service has advertised on several occasions for both substantive and for NHS locum consultant cover. Below is the timeline for recruitment.

September 2022	**Locum Consultant – WGH**	**1 successful candidate who left after 6 weeks**
January 2023	Substantive Consultant x 2 – WGH	No suitable candidates shortlisted
September 2023	Locum Consultant – WGH	Upgraded substantive associate specialist at WGH, who is still in the locum consultant post. Was appointed fixed term for 1 year and has been extended
September 2024	Locum Upper GI Consultant – GGH	Appointed – still in post
January 2025	Locum Consultant – WGH	Recruited – locum consultant has now given notice and will leave in September 2025
August 2025	Locum Colorectal Consultant – GGH	Appointed – still in post
September 2025	Substantive Upper GI consultant x3 1 for GGH, 2 for WGH	Appointed the locum upper GI consultant at GGH to the GGH post. Appointed 2 external candidates for WGH, 1 substantively and 1 as a locum

Consultants felt that the failure to recruit to substantive consultant posts was due to the geography of the area and the frequency of the on-call rotas. It was felt that amalgamating the rotas at GGH and WGH would be beneficial and result in a more attractive rota frequency in line with other EGS rotas across Health Board's in Wales.

Background

Between May and November 2023 an interim model was put in place for the Out of Hours (OOH) on call at WGH whereby the patients requiring surgery were transferred from WGH to BGH or GGH on alternating weeks. There were concerns amongst the consultants with this model, in particular relating to delays in Welsh Ambulance Service Trust (WAST) transport and senior decision making from a distance. There were delays in patient transfers and Datix incidents reported, which resulted in the cease of this model.

Delay in patient transfer data

Whilst the interim model was in place, a total number of 11 patients required transfer from WGH on this pathway.
From consultant feedback, we are aware of 5 occasions where transfers from WGH took a number of hours:

Site	Month	Number of patients	Details of delay
BGH	June 2023	1	6 hours
GGH	July 2023	1	8 hours
BGH	September 2023	2	6 hours 8 hours
BGH	August 2023	1	2.5 hours

Reported Incidents

The service were made aware of 2 reported incidents that relates to the EGS interim model.

ID43347 – Patient not accepted by receiving consultant on-call at GGH.

HDD40373 – Delayed transfer from WGH to BGH with use of Emergency Transfer and retrieval service, patient subsequently passed away.

The service has not been made aware of any complaints or patient feedback relating to the fragility of the general surgery consultant on-call rotas.

Concerns regarding the delays in patient transfers were raised in writing by the BGH consultants. Following this, a decision was made to revert to the on-call rota at each site. An agreement was made by the WGH consultants to return to a 24/7 service on a 1:4 on-call rota.

The service has reviewed the outcomes of Ombudsman investigations from June 2022 to present. The investigations which have outcomes relate to episodes of care prior to June 2022. There is an ongoing Ombudsman investigation, Datix 15777, which relates to miscommunication and disconnection between WGH and GGH in regard to upper GI referrals.

Background

The fragility of the consultant on-call rotas at GGH and WGH has been on the Corporate Risk Register since November 2022, the risk reference is 1531. The current risk score is 15. The risk score was reduced from 20, after the appointment of the NHS locum consultant at WGH, where the 1:4, 24/7 on-call rota was being maintained without the need for Medacs agency locum provision. The control measures in place are mitigating the risk, however there will be a gap in controls, when the NHS locum consultant terminates on 25/09/2025, there will need to be a reliance on Medacs locum cover until the upper GI consultants are on boarded.

The EGS is part of the Health Board's Clinical Services Plan (CSP), with all options focusing on the consultant on-call rotas at GGH and WGH, there are no planned changes to the EGS service at BGH.

There is also no emergency Upper GI service available at WGH, due to no consultants with a sub-specialty interest in upper GI being present on the WGH rota. The consultants feel that this issue should be resolved in parallel to the on-call rotas. The lack of Upper GI service at WGH is on the operational risk register as risk 2067. The current risk score is 16. There are clinical pathways in place to mitigate this risk, the service has also recruited upper GI consultants for GGH and WGH.

In May 2023, the General Surgery service in Hywel Dda was subject to a GIRFT (Getting it Right First Time) inspection, 22 recommendations were issued from the report, which are all now complete. The 5 recommendations below are relating to Emergency General Surgery. The GIRFT report acknowledged that the current model of 3 emergency general surgery on-call rotas across the health board is unsustainable.

5	WGH to review emergency appendicectomy minimal access rates and develop an improvement strategy.	22/08/2024 - Audits are undertaken at the local site and will be ongoing. Audit findings are presented at the quarterly Health Board Wide General Surgery business meeting, which are recorded.
6	GGH to review emergency readmission within 30 days following emergency appendicectomy and develop an improvement strategy.	10/10/2024 - Confirmation in Health Board Wide General Surgery Business meeting that the BGH audits are now taking place. Data is being collected and there is an agreement for this to be presented in the meeting in January 2025.
7	BGH to review their Emergency laparotomy pathway in order to improve length of stay rates.	22/08/2024 - Audits are undertaken at the local site and will be ongoing. Audit findings are presented at the quarterly Health Board Wide General Surgery business meeting, which are recorded.
8	HB to review the care of patients having emergency laparotomy at WGH at this site is an outlier on the NELA data with an extremely high 30-day mortality rate	22/08/2024 - Audits are undertaken at the local site and will be ongoing. Audit findings are presented at the quarterly Health Board Wide General Surgery business meeting, which are recorded.
9	HB should develop plans to implement and staff dedicated surgical SDEC on is acute sites	29/01/2025 - Surgical SDEC in place in GGH with plans to further develop and expand this model. Part of the annual plan. Surgical SDEC in place in WGH and part of ward 4.

Assessment

Key lines of enquiry and any benchmarking comparisons

In comparison to other health boards in Wales, three of which have a centralised model for EGS, with emergency surgical units providing a service to a population of approximately 500,000. This creates better training centres which attract more surgical trainees. These health boards can run 1:16 emergency general surgery rotas which would be more attractive to potential candidates when recruiting into vacancies. There is a further health board, Cwm Taf Morgannwg, that are currently exploring the options to reduce the out of hours on call surgical service from 3 to 2 sites. Another health board, Betwsi Cadwaladr (BCU) have emergency on call services across three sites, due to the population of circa 720,000 which is almost double Hywel Dda's population. The GIRFT report acknowledged that EGS on-call rotas are in place across 3 sites in Hywel Dda health board, and that they are all low volume and the frequency of the on-call rotas are high in comparison with other health providers in England and Wales.

Whilst the outcome of the CSP is awaited, and following an extraordinary meeting in March 2025, the service has been advised to maintain and strengthen the current rota provision by replacing the 2 NHS locum consultants at WGH with 2 substantive upper GI consultants,and fill 2 gaps in GGH with 1 substantive upper GI consultant and 1 NHS locum lower GI consultant, advertising substantively in parallel to this. This plan addresses the fragility of the rotas and the absence of an upper GI service on the WGH site and would provide a sustainable and equitable service.

Actions for improvement

- The service management team continually maintain both rotas, to ensure that there is no gap in the service.
- On board the 3 x Upper GI consultants following the interviews on 02/09/2025.
- Gain approval for Medacs locum cover at WGH, in readiness for the termination of the NHS locum consultant on 25/09/2025 and whilst awaiting the on boarding of the upper GI consultants.
- Continually review the upper GI pathways, this is led by the consultant surgeons.
- If there is a failure to recruit substantively to all posts, the service would continue to be reliant on NHS locum consultants until a decision is made regarding amalgamation of the on-call rotas for GGH and WGH.

Conclusion

- The service will continue to maintain two surgical consultant on-call rotas at GGH and WGH whilst awaiting the outcome of the CSP. This will be done, either by recruiting substantively or continuing to utilise NHS locum consultants. Rotas are monitored daily by the service management team, incidents and concerns are escalated to the clinical lead and clinical director.

- Any Questions?

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DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

The six domains of quality

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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4

30 Mins

4 - Stroke Services

Senthil Kumar (Hywel Dda UHB - Consultant Physician)

For assurance

Attachments

Stroke Deep Dive.pdf

Deep Dive: Stroke Services

Extraordinary Quality, Safety & Experience Committee

Date 15th September

14:00 – 17:00

Situation

The purpose of this report is to provide the Quality, Safety & Experience Committee with an understanding of the impact of the fragility on current service provision, incidents, complaints, patients experience and risks and understand how these are being managed whilst awaiting the outcome of Clinical Services Plan.

Currently, Stroke services do not meet the national staffing recommendations for stroke care and the Hywel Dda population does not have access to specialised Hyper-Acute Stroke Care (HASU), and limited Integrated Community Stroke Service (ICSS), and psychological therapies. Also, there is no seven-day cover for medicine, clinical nurse specialist or therapy services within Stroke services. As a result, Hywel Dda cannot provide the evidence-based standard of stroke care recommended by the Royal College of Physicians and measured by the Sentinel Stroke National Audit Programme (SSNAP).

Stroke workforce fragility is entered on the Risk Register. The Risk was recently realised within 2 of the units, not having a Consultant for a period of time, this was due to extended leave. The Risk was mitigated by Stroke Consultants colleagues from other sites supporting the gaps; however, this did put further pressure on the supporting stroke teams.

Risk Reg- HDD291, HDD1386, HDD233 (service Risk linked to HDD1649)

Background

- Stroke is a medical emergency with time dependent treatment and outcomes.
- Stroke patients who present within 4.5 hours of symptom onset are eligible for thrombolysis(this can be extended up to 9 hours with CT perfusion imaging)
- Thrombectomy or clot retrieval treatment for large vessel occlusion are considered up to 12 hours (and 24 hours in some cases)
- All hospitals conduct stroke alert calls when the patient present with FAST symptoms for immediate attention.
- Patient journey in the hospital is as follows- ED → Scan → acute treatment → ASU → acute assessments (medical/nursing/therapy) → Rehabilitation → Early supported Discharge (ESD) (where eligible)
- Currently ESD is only available for patients at Withybush Hospital.
- Patients receive a six-month follow-up.

Assessment

Assessment

SSNAP scores for the 6 months le Performance adding up to the change in the dataset – April to October 2024

	Bronglais Hospital		Bronglais Hospital		Glangwili Hospital		Glangwili Hospital		Prince Philip Hospital		Prince Philip Hospital		Withybush Hospital		Withybush Hospital	
	Apr-Jun 2024		Jul-Sept 2024		Apr-Jun 2024		Jul-Sept 2024		Apr-Jun 2024		Jul-Sept 24		Apr-Jun 2024		Jul-Sept 24	
SSNAP Level																
SSNAP Score	C		B		D		C		B		C		C		B	
Case ascertainment band	A 90%+		A 90%+		A 90%+		A 90%+		A 90%+		A 90%+		A 90%+		A 90%+	
Audit Compliance band	A 90%+		A 90%+		A 90%+		A 90%+		A 90%+		A 90%+		B 80-89%		B 80-89%	
Total KI Score PC	C		B		C		C		B		C		C		A	
Total KI Score TC	C		B		D		C		B		C		C		A	
Combined Total key indicator																
	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered	Patient centred	Team centered
1. Scanning	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
2. Stroke unit	B	B	C	C	E	E	E	E	C	C	E	D	C	C	A	B
3. Thrombolysis	D	D	B	B	E	E	D	D	C	C	D	D	C	C	A	B
4. Specialist assessments	B	B	A	A	E	E	D	D	A	A	B	B	B	B	A	A
5. Occupational Therapy	C	C	A	A	B	C	B	B	A	A	B	B	C	D	C	C
6. Physiotherapy	D	D	B	B	C	D	B	B	B	B	B	B	B	B	B	B
7. Speech & Language Therapy	D	E	D	E	C	D	E	E	E	E	E	E	E	E	D	D
8. MDT working	C	C	C	B	C	B	D	C	C	C	D	D	C	C	C	B
9. Standards by dishcharge	A	A	A	A	B	A	B	A	A	A	B	A	C	C	B	A
10. Discharge process	D	D	D	C	A	A	A	A	C	C	C	C	A	A	A	A

SSNAP scores following release after dataset changes – January to March 2025

Team		Bronglais Hospital	West Wales General	Prince Philip Hospital	Withybush General Hospital
Time Period		Jan - Mar 2025	Jan - Mar 2025	Jan - Mar 2025	Jan - Mar 2025
	SSNAP level	D	E	D	D
	SSNAP score	47.5	29.2	47.7	52.9
	Case ascertainment band	A	A	A	A
	Audit compliance band	B	C	C	C
	Combined Total Key Indicator level	D	E	D	D
	Combined Total Key Indicator score	50	32.5	53	58.8
Patient-centred KI levels:					
Patient-centred Domain levels:	1) Hyperacute assessment	D	C	C	B
	2) Specialist pathway	B	E	C	B
	3) Reperfusion	C	D	E	C
	4) MDT assessment	E	D	C	C
	5) Therapy intensity	D	E	D	D
	6) Therapy frequency	E	E	D	D
	7) Standards by discharge	B	C	C	D
Patient - centred KI level	Patient-centred Total KI level	D	E	D	C
	Patient-centred Total KI score	52.5	35	50	60
	Patient-centred SSNAP level (after adjustments)	D	E	D	D
	Patient-centred SSNAP score	49.9	31.5	45	54
Team-centred KI levels:					
Team-centred Domain levels:	1) Hyperacute assessment	D	D		B
	2) Specialist pathway	B	E	B	B
	3) Reperfusion	D	E		C
	4) MDT assessment	E	D		C
	5) Therapy intensity	E	E	E	E
	6) Therapy frequency	E	E	D	D
	7) Standards by discharge	B	C	C	D
Team - centred KI level	Team-centred Total KI level	D	E	D	D
	Team-centred Total KI score	47.5	30	56	57.5
	Team-centred SSNAP level (after adjustments)	D	E	D	D
	Team-centred SSNAP score	45.1	27	50.4	51.8

- The latest SSNAP scores from the new standards show area for improvement across all Hywel Dda sites. The overall performance shows that WGH (D) the highest key indicator(KI) score and that West Wales General performs the lowest with an overall rating of E (Jan-March 2025). Within the Patient KI levels BGH performs lowest for the Hyperacute Assessment with a score of D with WGH scoring highest with a B. This is noteworthy as this is a key domain in the CSP work, to provide improvements.
- GGH have particular challenges around accessing a stroke bed within 4 hours, they have scored an E and have struggled with this KI over the past 12 months.
- Therapy intensity and frequency are specifically highlighted in the new changes to SSNAP KI's indicating challenges across the board.
- Performance against accessing scanning is consistently good across Hywel Dda.

Headline Key Performance Indicators (KPI)

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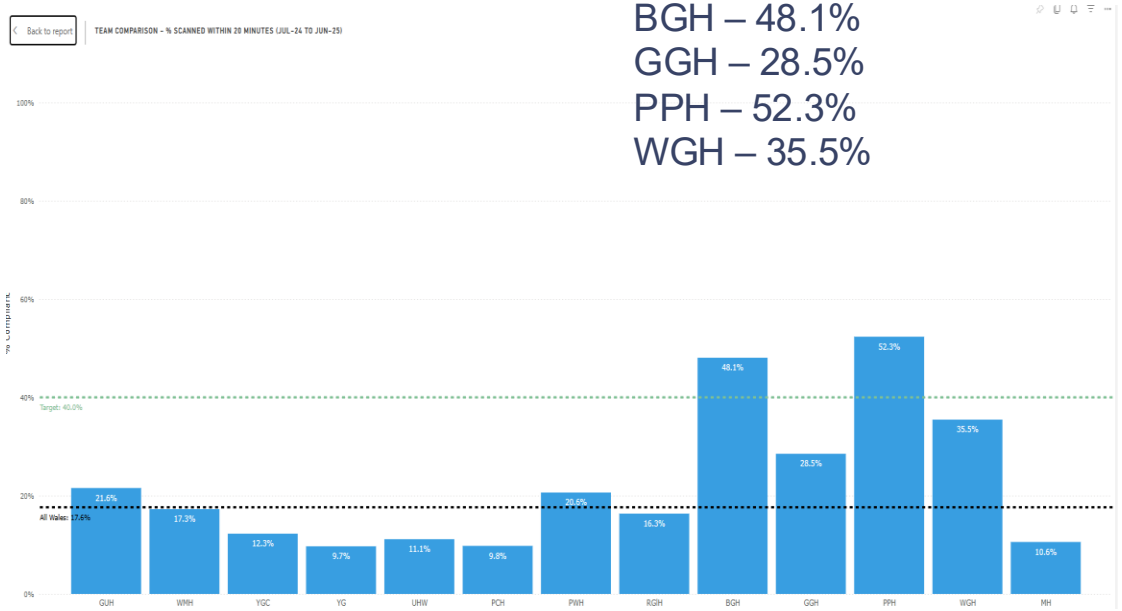
Computerised Tomography (CT) scan within 20 minutes

July 2024 – June 2025

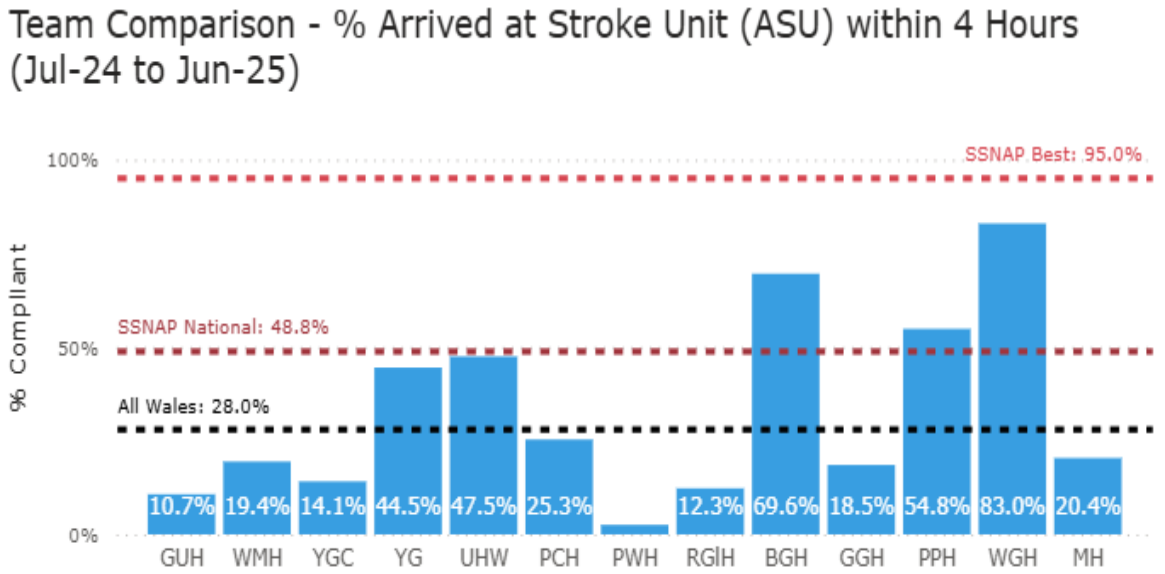
BGH – 48.1%
GGH – 28.5%
PPH – 52.3%
WGH – 35.5%



CT scan data shows that PPH has the best performance for the recent reporting period for 20 minutes scans with underperformance in this at the GGH & WGH site. Positive comparison for Hywel Dda against the rest of Wales.

Access to specialist ward within 4 hours

July 2024-June 2025 BGH -69.9%, GGH- 18.5%, PPH 54.8%, WGH- 83%



Best performance for attendance at a Stroke unit with in 4 hours is being seen at WGH with 83% for the period and worst performance from the GGH site as noted previously this is a long standing issue for the site. 3 of Hywel Dda sites including BGH, PPH and WGH are performing above the UK national benchmark of 48%

Stroke specific ward incidents- open and closed (December 24 to August 25)

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32 in total for 8 months

- BGH- 2
- GGH- 14
- PPH- 5
- WGH- 7

Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Total
6	2	7	4	4	0	3	2	4	32

Incidents related to

- Delays in Diagnosis and Treatment
- Communication and Handover Failures
- Medication and Prescription Management Issues
- Service Provision and Workforce Gaps
- Patient Safety, Environment, and Experience

Complaints (December 24 to August 25)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

8 in total

- GGH- 4
- WGH- 2
- PPH- 1
- BGH- 0
- General- 1

Theme- communication, delay in diagnosis, delay in referral to stroke services.

None in major category.

Patient/ Family Feedback

- Overall, positive feedback for clinical staff performance.
- Staff are frequently described as kind, compassionate, professional, and helpful.
- Patients are unhappy about communication for appointment scheduling, bed availability and parking. In general relate to the overall experience of the hospital site.
- Where patients were asked to rate their overall experience of using the service, 99.46% of patients rated the service at least 8/10 in the friends and family test.

Issues/ Concerns/ Progress

Current Staffing Levels

- The four acute or rehabilitation units are not sufficiently staffed to meet the recommended Royal College Clinical Guideline for Stroke 2023.
- Stroke Specialist Nurses cover Monday- Friday during office hours 1 Whole Time Equivalent (WTE) for each site.
- Stroke Physician cover is during working hours only, Monday – Friday with on call medical teams covering out of hours.
- The therapy disciplines do not have seven day cover. There is also limited provision of therapies for Stroke Services across all four sites.
- Psychology is only available across the Health Board at 1.8 WTE
- Community Integrated Stroke Teams (CIST) provide 5 days a week service in each County.

Critical medical cover issues

- Sickness absence in Bronglais Hospital (BGH) for 8 weeks in July and August 2025 once per week cover was arranged from other sites.
- Extended absence in Glangwili Hospital (GGH) with cover arrangements in March.

Clinical Services Plan

- The Clinical Services Plan within Hywel Dda has been developed in response to fragile services as identified in March 2023 and is also a requirement of targeted Intervention. Nine services were identified and included Stroke.
- The programme completed an issues paper of Stroke Services which was considered by Board in March 2024
- The programme developed options through an Options Development Process which were considered by Board in November 2024
- The programme commenced a public consultation on 29 May 2025 which concluded on the 31 August 2025
- Public consultations in Machynlleth and Tywyn have been supported by representatives from Betsi Cadwaladr Health Board and Powys Teaching Health Board.
- To date, multiple alternative options have been suggested to be considered.

Finance

- A factual assessment was completed in December 2023 as to assess the indicative requirements for four sites delivering a Health Board service to standards. This was an informing exercise that was superseded by the Clinical Services Plan in Hywel Dda to consider how services could be delivered improving standards but within existing resources.
- Within the Clinical Services Plan the total cost to deliver a service to meet standards is estimated to be £3.439 Million for Option A and £4.978 Million for Option B. Additionally a Stage 0 order of magnitude estates assessment estimates £920,000 in capital costs should a complete programme option be delivered.
- Within the indicative finance estimate for the Clinical Services Plan there was a requirement to assess what could be delivered within the existing resources (within 2 years) and what would require additionality and be delivered in an improvement period (2-4 years) and Longer-term 4+ years. For Stroke Services, the implementation phase considers the consolidation of services in Carmarthenshire, with additional funding required to realise wider improvements within the options.

Regionalisation/ Hyper Acute Stroke Unit (HASU)

- The National Strategic Clinical Network for Stroke has produced a programme plan to deliver changes and options to deliver Comprehensive Regional Stroke Centres (CRSC) across Wales:
- A clinical specification has been released for consultation.
- Modelling work is ongoing and will be completed by Winter 2025.
- The consultation which provides options for Health Boards to consider are likely to be released in Q4 2025/26.

Computed Tomography (CT) Perfusion

It is anticipated that CT Perfusion will be rolled out across Wales as part of the Optimal Imaging Pathway. At present the acute sites do not have access to CT Perfusion due to workforce and capacity issues within Radiology.

Conclusion

- The Stroke Service are fully committed to deliver an excellent quality of care within the existing resource. Standards will be monitored via SSNAP and scrutinised through the Operational Stroke Group.

- Incidents and concerns are investigated within each site and if required escalated to the Stroke Clinical lead and Service Delivery Manager.

- The Stroke Service also ask that the Quality, Safety and Experience Committee fully support the Clinical Services Plan due to the fragility of the service and also recognise the national travel towards the development of regional and centralised stroke units.

GIG CYMRU NHS WALES
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5

5 - Date of next meeting: 9 October 2025