



GIG  
CYMRU  
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WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

Date **08/04/2025**  
Time **09:30 - 12:30**  
Location **Microsoft Teams Meeting/ Ystwyth Boardroom**

# Quality, Safety & Experience Committee Meeting

HDD\_Quality, Safety & Experience Committee  
NHS Wales

# Agenda - 8 April 2025

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## 1 Governance

09:30, 20 min

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### 1.1 Declarations of Interest

*Anna Lewis (Hywel Dda UHB - Independent Board Member)*

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### 1.2 Minutes from the Previous Meeting and Table of Actions

*Anna Lewis (Hywel Dda UHB - Independent Board Member)*

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### 1.3 QSEC Annual Report 2023/24

*Anna Lewis (Hywel Dda UHB - Independent Board Member)*

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### 1.4 Targeted Intervention Progress Report

*Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience)*

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### 1.5 Patient Story- Unscheduled Emergency Care

*Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Karen Brown (Hywel Dda UHB - Health Board Clinical Lead for Acute Medicine)*

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## 2 Assurance

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### 2.1 Unscheduled Emergency Care Deep Dive

20 min

*Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Karen Brown (Hywel Dda UHB - Health Board Clinical Lead for Acute Medicine), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)*

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### 2.2 Mental Health and Learning Disabilities Deep Dive

15 min

*Liz Carroll (Hywel Dda UHB - Director of Mental Health and Learning Disabilities), Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience)*

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## **2.3 Primary Care Quality and Safety and Experience Deep Dive**

10 min

*Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)*

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## **2.4 Auditor General Report on Cancer Services- Deferred.**

*Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)*

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## **2.5 Infection Prevention and Control in the Community**

10 min

*Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Megan Harris (Hywel Dda UHB - Consultant)*

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## **2.6 Quality Assurance Report**

10 min

*Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)*

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## **2.7 Minor Injuries Unit- Prince Philip Hospital**

10 min

*Mark Henwood (Hywel Dda UHB - Interim Medical Director)*

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## **2.8 Update Report on the Improvement Strategic Framework 2023- 2026**

10 min

*Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement)*

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## **2.9 Quality, Safety and Experience Sub Committee**

10 min

*James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)*

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## **2.10 Listening and Learning Sub Committee Update Report- Deferred**

*Mark Henwood (Hywel Dda UHB - Interim Medical Director)*

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## **3 Risks and Matters for Escalation to Board**

*Anna Lewis (Hywel Dda UHB - Independent Board Member)*

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## **4 For Information**

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**4.1 JCC Quality, Safety and Outcomes Sub-Committee Highlight Report**

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**4.2 Patient Experience Report**

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**5 Date of Next Meeting : 9:30am 10 June 2025**

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5 - Date of Next Meeting : 9:30am 10 June 2025

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1 - Governance

1.1

09:50,

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1.1 - Declarations of Interest

*Anna Lewis (Hywel  
Dda UHB -  
Independent Board  
Member)*

## 1.2

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### 1.2 - Minutes from the Previous Meeting and Table of Actions

*Anna Lewis (Hywel  
Dda UHB -  
Independent Board  
Member)*

#### **Attachments**

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## DRAFT MINUTES OF THE QUALITY, SAFETY & EXPERIENCE COMMITTEE

Date of Meeting: **09:30, Thursday 13 February 2025**  
 Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

Present: Anna Lewis, Independent Member and Chair of the Committee  
 Delyth Raynsford, Independent Member and Vice Chair of the Committee  
 Chantal Patel, Independent Member  
 Ann Murphy, Independent Member  
 Rhodri Evans, Independent member  
 Eleanor Marks, Health Board Vice Chair

In Attendance: Sharon Daniel, Interim Executive Director of Nursing, Quality and Patient Experience  
 Andrew Carruthers, Chief Operating Officer  
 Jill Paterson, Director of Primary Care, Community and Long-Term Care  
 Ardiana Gjini, Executive Director of Public Health  
 Cathie Steele, Interim Assistant Director of Quality and Assurance  
 Louise O'Connor, Assistant Director of Legal and Patient Experience  
 Sam Dentten, Llais Cymru Representative  
 Mark Henwood, Interim Medical Director  
 Olwen Morgan, Assistant Director of Nursing  
 Joanne Wilson, Director of Corporate Services (Board Secretary)  
 Rebecca Richards, Head of Infection Prevention  
 Iona Evans, Head of Nursing  
 Ceri Griffiths, Interim Assistant Director of Nursing  
 Tracey Evans, Head of Community Nursing  
 Nick Davies, General Manager Paediatrics  
 Amanda Glanville, Assistant Director of People Development  
 Jonathan Arthur, Deputy Director of Health Sciences on behalf of James Severs  
 Janice Cole Williams, Assistant Director of Nursing

### Apologies:

- Iwan Thomas, Independent Member (Third Sector)
- James Severs, Executive Director of Allied Health Professions and Health Science
- Subhamay Ghosh, Associate Medical Director of Quality and Safety

Minutes Ref.	Item	Action
	<b>Governance</b>	
<b>QSEC 25(116)</b>	<b>Declarations of Interest</b>	
	The following declarations of interest were made:	
	<ul style="list-style-type: none"> <li>• Cllr Rhodri Evans declared an interest in item 2.2 Impact of service changes at Tregaron hospital due to his role as Councillor in the Ceredigion area.</li> </ul>	

- Ms Ann Murphy declared an interest in discussions relating to Royal College of Nursing Corridor Care findings due to her Trade Union role

## **QSEC 25(117) Minutes from the Previous Meeting and Table of Actions**

**RESOLVED:** The minutes of the previous meeting were approved as an accurate record.

Mrs Raynsford highlighted that there is an action omitted from the Table of Actions relating to Members request for an overview of Health Inspectorate Wales (HIW) outstanding actions which Mrs Daniel confirmed has been included under item 4.1 on the agenda.

In terms of matters arising:

**QSEC 24 (100)** Providing an update on a discussion undertaken regarding Mental Health and Learning Disabilities (MHL) concerns between the Interim Director of Nursing, Quality and Patient Experience and herself, Ms Lewis confirmed that there is a plan to schedule an MHL deep dive on the QSEC agenda in April 2025.

**QSEC 24 (97) and (107):** Ms Anna Lewis queried why the timescale for exploring regional opportunities to improve access and waiting times for Ultrasound services has been noted as December 2025 and for the rationale in pausing the regional collaboration discussions with Swansea Bay University Health Board (SBUHB) for opportunities to improve waiting times for Rheumatology Services.

Mr Andrew Carruthers commented that it is likely the timescale may have been linked to a wider work programme to improve regional diagnostics, highlighting that previous discussions undertaken have provided limited opportunities due to capacity challenges that are also being faced in SBUHB services.

Responding to the query regarding the pause on exploring regional collaborative opportunities for Rheumatology services, Mr Carruthers explained that due to the recent recruitment of a consultant in the service, the service are allowing time for the person to start and settle in to post to review whether this makes an impact on the current challenges. Mr Carruthers has intended to reach out informally to the Clinical Lead for the service in SBUHB to have a discussion regarding potential opportunities. These may be limited to exploring opportunities to negotiate the number of patients commissioned for external providers given the pressures across both Health Boards. Ms Lewis thanked Mr Carruthers for the update which is helpful in managing the Committees expectations in terms of ongoing discussions regarding collaborative opportunities, recognising that there is not likely to be an immediate solution to the challenges.

**AC**

## QSEC (24) 118 Targeted Intervention (TI) Progress Report

Mrs Daniel provided the key highlights from the Targeted Intervention progress report and advised that item 4.1 Quality Assurance Report and 4.3 Listening and Learning Sub Committee report provides more detail.

Drawing Members attention to Healthcare Acquired Infections (HCAI) criterion, Mrs Daniel highlighted that performance is reported as rate per 100,000 population and noted that whilst Hospital Numbers for each of the hospitals are low the position is being continuously monitored to ensure the improvements are sustained.

Outstanding external recommendations particularly from Health Inspectorate Wales (HIW) had been noted as a matter to alert to the Committee, a planned 'deep dive' into older/unresolved actions is being considered. Comparing the data from the same period last year, Mrs Daniel highlighted that where there were 120 in progress in January 2024 where in January 2025 there were 8. Actions to make further improvements include revising the assignment process to ensure they are allocated to the most appropriate individual and to ensure that actions are Specific, Measurable, Attainable, Relevant and Time Bound (SMART).

Referring to the Fragile Service criterion which was discussed in more detail at Committee in December 2024, Mrs Daniel shared that the Executive Teams are progressing the development of the Fragile Service escalation process which will be presented to Board.

**Executive  
Team**

Reflecting upon the information contained within the report, Mrs Patel commented that she did not feel it captured what the systemic issues may be that are preventing staff addressing concerns at operational level. Noting this observation, Ms Lewis asked whether there is confidence that the data being captured is sensitive enough to flag any hot spot areas that may be experiencing challenges, and sought assurance that these are not lost in organisational averages.

Reflecting upon the feedback and question, Mrs. Daniel updated Members of the number of quality improvement initiatives underway to empower staff at all levels to make decisions and strengthen the sense of autonomy. A 'Big Room' staff engagement group has been established at Glangwili Hospital where staff are invited to attend to discuss improvements and share ideas. Since the initial 'Big Room' meeting, it has transpired that an Emergency Department specific meeting will be helpful and is being organised. Mrs Daniel noted the value of patient Walkabouts by Independent Members and Executive Leads and will reflect on the best way to utilise the feedback to triangulate with other data sources.

Mr Carruthers shared that the new operational management structure will be a tool to strengthen accountability and improve decision making at a local level. Revisions are being made to the Scheme of Delegation which will provide clear expectations for staff at all levels.

Highlighting the recent Staff Survey findings, Mr Mark Henwood reflected upon the positive performance Appraisal and Delivery Review (PADR) compliance rates which indicate that staff are being regularly engaged with management, however feedback would also suggest that staff are not feeling included with changes. The useful data can be analysed for different staff groups for a better understanding of trends and themes.

Returning to a previous point made regarding hot spot areas, Ms Lewis felt that in addition to the global metrics that are provided, it may be useful to look at those services at the higher and lower ends of the data set average for scrutiny to understand challenges and also as an opportunity to share good practice.

Mrs Patel sought clarity from a statement within the report that the Fragile Services Register is 'incomplete'. In response, Mr Henwood clarified that 9 fragile services were identified as part of the initial Clinical Services Planning process, and the Health Board now recognise there are a significant number of services that are experiencing fragilities. The Executive Team are working to develop a formal process to define fragility for future prioritisation work, and as this process has not yet been agreed the register is technically incomplete.

Ms Anna Lewis noted progress being made in addressing the Targeted Intervention de-escalation criteria, and enquired at what point there is an official transition of the actions being taken to 'business as usual'. Reflecting upon Ms Lewis's query, Mrs Daniel provided the HCAI focus work undertaken as an example, whereby actions taken to improve practices are system and process measures i.e. Standard Infection Control Precautions which should be adhered to at all times. There are challenges associated with this in terms of the built environment and clinical practice which can increase the risks for cross infections, there is also a burden of infection coming into hospital from the community which can impact the risk of cross infection in hospitals.

Providing a national picture, Dr Ardiana Gjini commented that the Health Board are not outliers in the number of community clusters infections such as E.coli, HCAI, however testing rates are higher within Hywel Dda and while the test to treat is an important aspect to reduce infection, it can sometimes have an unnecessary impact on reported figures if targeted treatment is not required. Dr Gjini also provided assurance that there are Public Health Infection Prevention Control Nurses based within the community and engaging with care homes to support reducing cross infection. Ms Lewis noted the potential impact of higher testing however would

hope that the incentive to meet the target would not become a deterrent to testing.

Mrs Delyth Raynsford was pleased to note the comment within the report that the Putting Things Right workload has decreased however also noted a comment regarding capacity concerns within the team and asked for assurance that these capacity challenges will not have an impact on the Health Board's positive relationship with the Ombudsman. In response, Mrs O'Connor clarified that the workload has not decreased but the processes have been streamlined to resolve concerns at an earlier stage. Members were pleased to note that the overall feedback from the Ombudsman has been positive this year, and number of referrals are a lot less in comparison with similar size Health Boards across Wales. The focus for the Organisation is to ensure the recommendations are actioned and sustained.

Mrs Raynsford sought clarity on whether Mrs O'Connor feels there are workforce capacity issues for the service. Mrs O'Connor confirmed that this is an area of concern for the team, as the revised PTR regulations which will be implemented at the end of the year will have a significant impact on capacity for the Concerns Team and for operational services particularly for redress investigation processes. Mrs O'Connor expects the workload will significantly increase due to revised timescales, and this is a risk that is being reflected nationally. The Chair recommended that the potential impact of the revised PTR regulations on workforce capacity and skill-based training/ induction requirements across the organisation is referred to the People, Organisational Development and Culture Committee (PODCC) for consideration at agenda setting.

**CSO**

**Decision:** The Committee took assurance from the report.

#### **QSEC 24(119) Operational Governance Plan Update**

Mr Andrew Carruthers introduced an update on the revised operational governance arrangements and passed on a special thank you to Mrs Joanne Wilson, Ms Alison Gittins and Ms Charlotte Wilmshurst for their support in creating and revising terms of reference and updating the Scheme of Delegation, highlighting that there is still a huge amount of work to do aligning the reporting systems and revising the hierarchy for the new structure. Members were advised of the plans to implement a new 5 Clinical Care Group model. The changes have been instigated from consistent feedback from Internal Audit that the operational governance structure needed strengthening.

Mrs Daniel presented the slides which are aligned to the Health Board's Quality Management System which will provide a system-wide approach to achieving quality of care in a way that secures continuous improvement. The Quality, Safety and Experience Sub Committee (QSESC) will continue to meet however this will be reviewed when there is a level of maturity with

the Clinical Care Groups and an agreement has been reached regarding reporting arrangements for Advisory Groups.

Mrs Patel highlighted that reference to Prevention and Public Health does not appear throughout the papers. Mrs Joanne Wilson confirmed that prevention and population health are part of the proposed terms of reference for the Clinical Care Groups.

Providing assurance, Mr Henwood added that the revised operational structure will provide a clear reporting line from Ward to Board via the appropriate Committee and Executive Leads will have clear sight of what is being discussed and have opportunities to question any gaps. Ms Eleanor Marks noted the significant amount of work underway and asked for a plan for the interim period in terms of supporting leads transition from familiar structures to a new ways of working, highlighting that 1 April is not that far away. In response, Mr Carruthers advised that a meeting has been scheduled with service directors the following week to ask that the transition planning begins in March, develop the terms of references and clarify membership for their respective groups. Alongside this, as previously mentioned by Mrs Daniels, a masterclass will take place in quarter 1 to support implementation. Mr Carruthers recognised the level of support that will be required from Directorate Leads over the coming months to clarify expectations from the different domains and address any emerging issues and concerns. Mr Carruthers offered some assurance that two of the new Service Directors appointed have previous experience of working within a Clinical Care Group model which will be helpful. Mrs Daniel highlighted it will be important that governance and oversight is maintained during the transition period, and this is why QSESC will continue to meet until the new structure has matured.

Thanking Mr Carruthers and Mrs Daniel for the helpful overview of the imminent changes to the operational governance structure, Ms Lewis reflected that while the focus has been on structure, it will be successes in terms of shifts in human behaviour which will be key in improvements in quality services. Ms Lewis asked for thought to be given to what part the Committee can play in supporting the tone and vision as the revised structure is embedded throughout the organisation.

**Decision:** The Committee received assurance that progress is being made to the revision of Operational Governance arrangements with a plan to implement from the 1st April 2025.

## **QSEC 24(119) Review of Patient Experience Reporting**

Mrs Daniel provided a verbal update on the review of patient experience reporting, following an agreement at recent Public Board meetings that presenting patient experience data in a more analytical and thematic format to spot trends and patterns will be helpful for monitoring purposes. Reflections have taken place on how to use patient user feedback to ensure the patients voice is central to decision making and used to shape Organisational

objectives. A report to outline the plan is scheduled to be presented to Board in March 2025.

Due to the change in requirements for reporting, Mrs Daniel advised that artificial intelligence methods will need to be explored to triangulate the plethora of available feedback data that is captured and interrogate different databases for a more holistic view to share with Board. The same intelligence could be utilised for operational governance arrangements and possibly inform QSEC deep dives. **SD**

Mrs Daniel anticipates that the report will be set out in two parts. The first will be more narrative, containing key themes and corporate level framework updates. The second part of the report will provide the data for patient experience focus on a chosen service or Clinical Care Group, key findings and identify areas for improvement and create an action plan with timeframes aligned to ensure positive outcomes are achieved. On behalf of the Committee, Ms Lewis supported the refreshed visualisation, believing it will add value to the scrutiny in how patient experience plays a part in shaping services and also take a broader view of quality patient experience.

In response to a query from Mrs Patel on whether focus groups are undertaken with service user/ patient representatives, Mrs O'Connor advised these types of groups do take place, by exception and led by individual services when service changes are being proposed, however there is room to expand this concept and can be considered with the Engagement Team as the Learning Framework arrangements develop.

Ms Lewis reiterated the Committees wholehearted support for the evolutionary vision to utilise patient feedback in an intelligent led way, and to embrace the Board's appetite for receiving the patient feedback in a more analytical report. Ms Lewis, on behalf of the Committee, will work with the Director of Nursing to outline the plan to Board in March 2025. **AL**

Prior to presenting the plan to Board, Mrs Delyth Raynsford suggested input from Llais Cymru to identify themes and trends received by the external statutory body as part of the triangulation of proposed data utilised. Mr Dentten shared that Llais will be happy to be contacted to offer feedback and ensure relatability for the public as well as Board Members. **SD/LOC**

Mrs O'Connor drew Members attention to the system limitations for triangulating the different sources of experience feedback data that is being captured. Members noted the vast amount the different sources of feedback that are mostly unstructured and also captured on different systems. Mrs O'Connor highlighted that the Patient Experience Team unfortunately do not have the automated tools to undertake trend analysis and hot spot areas, and at the moment would require dedicated resource and advancements in system functionalities.

Members did note however several upcoming developments which may be of support, with the Patient Experience Framework, the new Putting Things Regulations and Quality Engagement Act requirements in this space. Mrs O'Connor also advised that there a new CIVICA system functionality is being rolled out later in the month called API which allows third parties to interface with the database, however does feel that a specific project may need to be considered with dedicated resource for this work.

Thanking Mrs O'Connor for highlighting the technological and capacity limitations, Ms Lewis undertook to ensure Board are sighted and consider the challenges during decision making.

**Decision:** The Committee noted the verbal update.

**QSEC 24 (120) Paediatric Services: Neonatal Ventilators: Patient and Staff Experience Feedback**

Mr Nick Davies joined and presented patient and staff feedback following the installation of Neonatal Ventilators which were funded by Hywel Dda Charitable Funding. The Specialist Care Baby Unit (SCBU) historically utilised three different machines to provide three different modes of ventilation. Investment of the new "SLE6000" ventilator has resulted in the provision of safer, higher quality care across the health board. Feedback has been entirely positive from the clinical team and Members noted the challenges organising a patient story due to sometimes traumatic experience. Mr Davies advised that Neonatal Services will link in with the Patient Experience Midwife to improve feedback.

In addition to the benefits reported through the PowerPoint slides shared with the Committee, Mr Davies advised the hidden long term patient health benefits from the improved care should be noted.

Mrs Raynsford, as Chair of the Charitable Funds Committee was pleased to note the positive impact of the investment, however noted the obvious concern regarding the use of charity funding for essential equipment. Mrs Raynsford also commented that the investment which improves staff training and development is also likely to aid staff retention. In agreement, Ms Lewis was pleased to hear the positive outcomes for quality, patient experience and suggested that the Capital Planning equipment replacement programme is considered for inclusion on the Strategy and Planning Committee (SPC) forward work programme in response to concerns raised regarding Charitable Funds being sought for essential NHS Equipment.

**CSO**

**Decision:** The Committee noted the staff feedback.

**QSEC 24 (121) Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2024/25**

Mrs Wilson presented the Self-Assessment Outcome Report and thanked all Committee members who had taken the time to complete the questionnaire, noting that there is room for improvement for the response rates. The Committee were asked to ratify the action plan and note that an update on progress will be scheduled for later in the year.

Mrs Raynsford commented that she found the workshop sessions undertaken to be a lot more productive than completing the form. Mrs Wilson confirmed that workshops will be organised as part of the new Corporate Governance structure arrangements to assess and gather feedback on the impact of the changes. Workshops are a requirement as part of the Standing Orders, however there may not be capacity for a workshop for each Committee.

Ms Ann Murphy sought clarity on the term 'critical friend' that is referenced within the report. Ms Lewis explained that when trying to understand the Committees effectiveness, having an external, peer support in the room may be a tool to gather helpful feedback on the Committees functioning. Careful thinking will take place into who is asked to undertake this role to ensure valuable contribution.

**Decision:** The Committee considered the outputs from the Committee Self- Assessment process and agreed the actions to be taken to improve its effectiveness.

**Risk**

**QSEC 24 (122) Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience Interim Report**

Ms Janice Cole Williams presented the key highlights from the nurse staffing levels interim report on the impact of the reduction of agency and bank staff on quality, safety and experience. The nurse stabilisation programme is ongoing and has now progressed across the Unscheduled Care Directorate with the exception of Bronglais Hospital, where unplanned agency usage will cease from 1 March 2025. A number of data sets including incidents and vacancies reported have showed an improving picture since the changes have been made in Prince Philip, Glangwili and Withybush and it is anticipated this will continue as the stabilisation embeds across the system. In terms of the falls data shared within the report, Ms Cole-Williams commented that it is difficult in drawing conclusions at present as despite an increase in the number of falls, the level of harm has decreased.

Thanking Ms Cole- Williams for the update, Ms Lewis concluded that there is nothing apparent for the Committee to be concerned about from the data shared at present due to the shift in staffing changes. Mrs Daniels concurred, however highlighted that although the overall number of vacancies has reduced, there is an increase in inexperienced workforce, who are being supported as much as possible by the Corporate Nursing Team, Senior Nurse Leaders and Learning and Development team. The overall Enhanced patient care arrangements have reduced, which would align with the quality improvement work undertaken and it may be helpful for an evaluation of this for assurance.

**Decision:** Taking assurance from the report, the Committee agreed that nurse staffing levels updates will be provided via the Quality Assurance Report going forward unless there are specific concerns that require escalation.

QSEC 24 (124)

**Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital**

Mr Andrew Carruthers introduced the update report on the three service changes (Minor Injuries Unit (MIU) in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital) in September 2024.

Ms Iona Evans provided an overview of incidents and feedback since the temporary overnight closure of MIU on 1 November. There has been minimal service impact and no significant patient safety, quality, and experience concerns to date and this continues to be monitored closely. Complaints feedback via CIVICA system has improved since the previous year from patients and staff with reduced anxiety and stress and staff feel they are appropriately working within their scope of practice. Public engagement is underway regarding future modelling.

Ms Lewis commented that the data is positive and nothing described causes concern or the need for escalation. In terms of the patients that were previously attending MIU during the nighttime previously, Ms Lewis queried where it is believed they are now presenting. From the available data, the closure does not appear to be impacting Accident and Emergency Departments (A&E) in Swansea. There has been a slight impact on attendance at GGH, however it is likely that these presentations are appropriate for the care needed. Members noted the support from medical Same Day Emergency Care on weekends also. Mr Henwood reflected upon feedback and data which is being proactively sought, and feels that that the patients are now accessing timely care in the right place. Ongoing engagement continues with stakeholders, and statistically this change is proving to be a positive improvement for quality patient experience.

Ms Tracey Evans provided an update on the impact of the decommissioning of the remaining beds in Tregaron Community Hospital. Staff have been allocated to community teams and Out-

patient teams as their preferred preference. Opportunities for staff development have been put in place to ensure they have the skills they require to support the Community Nursing Teams. Competency Workbooks have been developed and provided to all staff to support in obtaining and maintaining competencies in the community setting and there has been positive feedback from staff so far.

Mrs Raynsford queried whether there is patient and family feedback being captured since the transition. Ms Evans advised that the patient feedback is now being captured via Community Nursing since the transition of these patients. Ms Evans shared an overview of a compliment letter received from a General Practitioner (GP) in England the previous day, who was grateful and pleased with the care provided in the community for her mother. Mr Sam Dentten was pleased to note this positive feedback, however highlighted that a key element of the discussions regarding the proposed service changes at Board was the intention to rigorously monitor patient outcomes. Mr Dentten asked for some reflection on how the Health Board ensures the patients voice continues to be listened to following service changes, especially as a number of pathways are transitioning to commissioned and social care settings. Ms Lewis and Mrs Daniel undertook to consider the methodology to ensure patient feedback is captured and monitored following service changes as part of the revised Board patient experience report. **SD**

Providing an overview of the impact of changes to Paediatric Services in Bronglais Hospital which has removed inpatient care and has a refreshed Paediatric Ambulatory Care Unit referral criterion. Mr Davies explained that there have been positive improvements in the staffing position due to successful recruitment. The future modelling of the Paediatrics Service will be undertaken as part of the Women and Children's Review going forward. Members noted the data within the report which indicate no cause for concern in term of impact on quality, safety and patient experience.

Ms Lewis asked that Mrs Daniel and Mrs Wilson consider offering some guidance on reducing the frequency of scheduled updates on the ongoing impact of service changes at MIU, Prince Philip, Tregaron and Paediatrics at Bronglais due to assurances received from the report and advise the Chair accordingly. **JW/ SD**

**Decision:** The Committee received assurance from this update that there is no evidence of a negative impact on patient experience and safety relating to the service changes made to the Minor Injuries Unit in Prince Phillip Hospital, Tregaron Hospital and paediatrics in Bronglais General Hospital.

## **Assurance**

## QSEC 24 (125) Quality Assurance Report

Ms Cathie Steele presented the Quality Assurance Report noting that the key focus of the report has been the areas for targeted intervention de-escalation criteria as discussed earlier in the Committee. Members attention was drawn to the good news story in the media recently regarding the diabetes team in Paediatrics having the best outcome performance across Wales and the link is shared within the report.

Improvements have been made in incident reporting across the Health Board, with 7-minute staff briefings available and leaflets contained within the learning library.

Introducing the Healthcare Acquired Infection element of the report, Mrs Rebecca Richards noted that there are fluctuations in infection rates and actions are underway to mitigate the infections. The performance dashboard is a useful tool to drill down to analyse areas for targeted focus. The rates of infection are being benchmarked nationally and the team continue to proactively reach out to other Health Board Infection, Prevention and Control (IPC) teams to share learning.

Ms Richards advised that the performance infographics are presented at Managed Practice quality governance groups for monitoring purposes and advise on best practice.

A C-diff Improvement Group has been established which is being chaired by the Deputy Medical Director and positive progress has been made so far, such as addressing concerns highlighted in terms of infection clusters in Glangwili Hospital and Prince Philip hospital in recent weeks.

Ms Lewis thanked Ms Richards for the helpful update on HCAI developments.

Referring to the positive developments in early resolution rates for PTR concerns, Mr Dentten highlighted a recent theme that has emerged from patients who have felt that communication regarding their concerns have been finalised quite abruptly. Mrs O'Connor was not aware of this and undertook to discuss this with Llais Cymru to gather further information and review the individual cases if necessary.

LOC

Drawing attention to the HIW action tracker, Ms Steele provided an overview of the outstanding actions and advised that the new CCG operational arrangements will strengthen the HIW monitoring structure.

Referring to the link within the report regarding concerns around Bryngolau Mental Health Ward and staff feedback, levels of agency staffing and patient experiences, asked why MHLD have not been a focus for the Health Board as part of the reducing the

temporary staffing initiatives. More broadly, Ms Lewis asked why the Health Board's internal governance processes are not spotting and addressing the concerns that HIW are observing during inspection. Mrs Daniel advised that the temporary staffing levels in MHLD have been highlighted via the Directorate Improving Together session and the Executive Team have a meeting in the coming week to discuss the review in to ensuring the inpatient areas have appropriate staffing level establishments.

In response to the concerns highlighted from the Bryngolau staff feedback survey, Mrs Daniel recalled that when they were asked to comment on the draft report concern was fed back regarding the single figure numbers of survey completion that these conclusions were based upon. Leadership challenges within that area was recognised and this changed prior to the inspection, however the culture change was not recognized immediately hence it was also noted by HIW.

Ms Steele highlighted that out of the 55 recommendations from HIW, 38 have now been completed. Ms Lewis reiterated her previous observation that it should not have taken HIW to pick up on 55 improvements that had not been picked up through internal governance arrangements.

Ms Anna Lewis highlighted a misalignment between the highest categorisation of incidents data and areas of focus for the Enabling Quality Improvement in Practice Programme. Noting Ms Lewis's point, Mrs Daniel undertook to clarify why the cohort 6 projects as part of Quality Improvement framework were not aligned with the top 3 incident classifications (pressure damage and falls) noting that they projects were aligned to the 6 Goals Programme. SD

In conclusion, Ms Cathie Steele drew Members attention to the link within the report to the Quality Improvement Framework which will be discussed in more detail at the April 2025 Committee.

**Decision:** The Committee noted the report and took assurance that processes are in place to review, monitor and improve quality of services within areas highlighted within the report.

## **QSEC 24 (126) Quality, Safety and Experience Sub Committee**

Mr Mark Henwood presented the QSESC update report from the meeting held on 16 January 2025.

Referring to the concerns raised regarding the impact of workforce deficits in Hotel Services on cleaning duties across the organisation, Mrs Patel shared staff concerns that were highlighted during a recent walk about across sites and asked if measures are being taken to address these issues. Mr Carruthers updated the Committee that there have been recent management capacity issues in Estates and Facilities. Ms Elin Brocke, Head of

Research, Innovation & Improvement is undertaking a six-month secondment to the team and will lead on ensuring the cleaning standards plan is not just a case of addressing actions, but also quality improvement and undertake a culture review piece of work. Mrs Daniel added that Ms Brocke will input into the Environmental Hygiene Group to support improvements in this space.

**Decision:** The Committee noted the update.

#### **QSEC 25 (127) Listening and Learning Sub Committee Update Report**

The Committee passed on a special thank you to Mrs Patel for her valuable contributions to the LLSC in her role as Chair over recent years. Members noted that Mr Mark Henwood would take over as Chair of the Group in order to strengthen the Clinical Executive oversight.

Mrs O'Connor alerted the Committee of a range of feedback relating to the experience of service users with disabilities, particularly neuro-divergence, in accessing health care was discussed at the Sub Committee and provided a reminder from the Ombudsman that failure to make reasonable adjustments for a person with a protected characteristic is a form of discrimination and not meeting requirements under the Equality Act 2010. Several significant recommendations have been made by the Ombudsman which are summarised within the report. Mrs O'Connor advised that it has been suggested by the Neurodevelopmental service that a special interest group be established for neuro-divergence, supported by Learning and Development. In terms of the scope of the group (as there are significant amount of Equality, Diversity and Inclusion issues that impact on patients and governance reporting arrangements, further discussions will take place at the next meeting.

Mrs O'Connor advised that Welsh Risk Pool – Putting Things Right / Concerns Management Assessment report has been received which received reasonable assurance and action plan has been accepted. The next meeting will provide a focus on addressing the actions.

**Decision:** The Committee noted the update.

#### **QSEC 24 (23) Urgent and Emergency Care Discharge Management Internal Audit**

Ms Ceri Griffiths updated the Committee that the Internal Audit and Assurance team recently undertook a follow up audit on the discharge management processes in place across the Health Board in October 2024. Whilst the audit recognised that positive progress has been made since the previous Internal Audit report, work remains ongoing to address the remaining actions. Ms Griffiths advised of a discharge leaflet which has been rolled out across the Health Board, and the development of a SharePoint toolkit/resource link for staff which will be launched in the coming week. 50% of staff however reported they do not feel

confident discharging patients and there is a rolling Programme of training being arranged with the practice development team.

From the actions undertaken, Ms Griffiths will hope to see an improvement in six months' time in terms of quality and patient experience feedback and safeguarding referrals and actions are being monitored.

In response to an enquiry from Mrs Raynsford, Ms Ceri Griffiths undertook to clarify why out of the total 102 reported unexpected admissions or readmissions in 2023, 69 were related to midwifery areas.

CG

Highlighting the increase in discharge planning failures (concerns relating to lack of appropriate equipment, dressings etc increasing from 11 to 26 (2023-2024) Mrs Raynsford queried whether this is in specific clinical areas or specific medical devices. Ms Griffiths commented that it is recognised that there are fundamental failures in discharge planning and noted the need to get back to basics in this space. Ms Griffiths could not confirm the exact reason for the spike in data however likely to be attributed to ward staff not being confident and knowing full requirements of the discharge requirements.

In terms of the feedback that staff are not confident in discharging patients, Ms Ann Murphy queried whether specific support for Internationally Educated Nurses is in place. Ms Griffiths provided assurance that the Discharge Planning Group that has been established which is reviewing current training resources in place in collaboration with the Practice Development team to identify what is required to support staff in this area.

Following the outcome of the internal audit report, Ms Lewis had a more general query in terms of whether there is confidence that given the capacity challenges across the organisation, if the Health Board is now approaching discharge processes differently, and sought assurance that this will be a priority area of focus for the Care Group Leads and revised governance groups. Mr Carruthers and Mrs Daniel confirmed Discharge management will be a fundamental part of the Care Group agendas, with this being the heart of the optimal flow work. Ms Murphy asked that Residential Doctors are included with the Discharge Planning Group due to 'medication not being prepared' delays highlighted in the report.

Members noted that the follow up findings of the Internal Audit is being scheduled at a future Audit and Risk Assurance Committee.

**Decision:** The Committee noted the report and take assurance that the management response arising from the Internal Audit findings will lead to improved Discharge Management which is progressing and being monitored for patient outcomes and quality experience.

## **QSEC 24 (128) Allergy Testing Service**

Mr Mark Henwood provided an update on Allergy Testing service since the commissioned service from Cardiff Bay University Health Board ceased in 2023 (due to capacity challenges). Members noted that there are national challenges putting in long term agreements for this service. The service has since been provided via a GP initiated 'prior approval' process and referrals are made on an individual basis to Birmingham Foundation Trust (BFT) and there is an uncertainty regarding BFT's ability to continue to provide this service due to similar challenges. Although no complaints have been recorded regarding the change in provision, it has emerged that there is a gap in comparison and patient outcome data. Mr Henwood advised that Mr Keith Jones, the Director of Operational Planning and Performance, is undertaking a piece of work for the provision of allergy services in the Health Board and an update report will be presented to the Integrated Quality, Finance and Performance Group (IQFPD) on findings and next steps.

**Decision:** The Committee received assurance from this update that there is no evidence at this time of a negative impact on patient experience and safety relating to the allergy service provided through BFT. The Committee supported IQPFD receiving an update and, if applicable, further actions required.

### **Risks and Matters for Escalation to Board**

There were no alert items to escalate to Board.

## **QSEC 25 (130) Any other business**

The Committee shared a heartfelt thank you to Mrs Delyth Raynsford for her valuable contributions to the quality, safety and experience agenda at her last Committee meeting in her role as Independent Member.

## **QSEC 25 (131) For Information**

- **Withyhedge Update**
- **QSEC Work Plan 2024-25**
- **Welsh Government Integrated Quality, Planning and Delivery minutes**
- **Date of Next Meeting - 8 April 2025**

**TABLE OF ACTIONS FROM  
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING  
HELD ON 13 FEBRUARY 2025**

<p><b>QSEC (24) 97</b></p>	<p><b>Corporate Risks:</b> To provide an update on the below Corporate Risks:</p> <p><b>Risk 797: Risk to the ability to deliver ultrasound services due to workforce pressures:</b></p>	<p align="center"><b>AC</b></p>	<p>A meeting is scheduled for 2 April 2025 between Clinical Care Group, Radiology and Assurance and Risk team to plan a reset this risk including actions, gaps and controls using SMART methodology (specifically ensuring timeliness of completing actions).</p>	<p><b>Complete:</b></p> <p>Business Continuity Plans for short term staff absence have been developed across the Health Board.</p> <p>The Annual Plan includes an expansion of training places for sonographers. To facilitate this educator post has been created from current establishment and will be advertised.</p> <p>3 whole time equivalent (WTE) training posts have been successfully recruited (all have commenced in post and started training in January 2025)</p> <p>A review of midwife sonographer posts is being planned to look at alternative workforce models.</p> <p>Temporary staffing has been secured to Support Withybush Obstetric scanning (commenced March 2025).</p> <p>Inourced non-obstetric ultrasound is ongoing.</p> <p>At the end of February 2025, there was an 8 week waiting list of 1507 patients (improved from January 2025 8 week waiting list of 2301).</p>
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<b>QSEC (24) 97</b>	<b>Risk 684: Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure:</b> Due to insufficient capital funding from Welsh Government (WG), management of this risk is outside the Health Board's control. A regional solution may be explored with Swansea Bay University Health Board (SBUHB). The potential quality and safety impacts were discussed.	<b>AC</b>	<b>31 March 2026</b>	<b>Complete:</b> Welsh Government funding has been agreed to replace the Withybush Hospital SPECT-CT scanner which is the top priority piece of equipment. Once the Bronglais Hospital DEXA scanner has replaced, the risk can potentially be de-escalated.
<b>QSEC (25) 118</b>	<b>Targeted Intervention Progress Report</b> <ul style="list-style-type: none"> <li>To highlight the potential impact of the revised Putting Things Right (PTR) regulations on workforce capacity and skill-based training/ induction requirements across the organisation to the People, Organisational Development and Culture Committee (PODCC) for consideration at agenda setting.</li> </ul>	<b>CSO</b>	<b>February 2025</b>	<b>Complete</b>
<b>QSEC (25) 119</b>	<b>Patient Experience Reporting</b> <ul style="list-style-type: none"> <li>To present a plan to Public Board in March 2025 for a revised patient experience report, incorporating more analytical content.</li> <li>To discuss with Llais Cymru the revised content of the Patient Experience Report prior to presentation at Board.</li> </ul>	<b>LOC/ SD</b>	<b>March 2025</b>	<b>Complete:</b> A revised interim report has been agreed with the Chair. The new format is being trialled at Public Board in March 2025. The future design will be centred around the new People's Experience Framework and will include analytical content. Engagement with Llais and other stakeholders will take place to contribute to this report, including through Listening and Learning Sub-Committee.
<b>QSEC (25) 120</b>	<b>Paediatric Services: Neonatal Ventilators: Patient and Staff Experience Feedback</b> <ul style="list-style-type: none"> <li>To suggest that the Capital Planning equipment replacement programme is considered for inclusion on the Strategy and Planning Committee (SPC) forward</li> </ul>	<b>CSO</b>	<b>February 2025</b>	<b>Complete:</b> The Capital Planning Equipment Replacement Programme has been added to the SPC 2025/26 workplan.

	work programme in response to concerns raised regarding Charitable Funds being sought for essential NHS Equipment.			
<b>QSEC (25) 123</b>	<b>Urgent and Emergency Care Discharge Management Internal Audit</b> <ul style="list-style-type: none"> <li>To seek clarity on why out of the total 102 reported unexpected admissions or readmissions in 2024, 116 were related to midwifery areas.</li> </ul>	<b>CG</b>	<b>February 2025</b>	<b>Complete:</b> A review was undertaken by the Head of Midwifery and there appears to be some element of coding and how admissions are captured rather than a specific area of concern, for example, the 93 readmissions to Special Care Baby Unit were actually unplanned admissions and not readmissions, similar for other areas. A further review against national benchmarking suggests the Health Board are well below national averages.
<b>QSEC (25) 124</b>	<b>Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital:</b> <ul style="list-style-type: none"> <li>To consider the methodology to ensure patient feedback is captured and monitored following service changes.</li> </ul>	<b>LOC/ SD</b>	<b>March 2025</b>	<b>Complete:</b> All services are set up on the CIVICA system to monitor impact on experience prior, during and following change. There is also opportunity to survey at agreed points through the process, using a bespoke survey, utilizing the All Wales experience survey measures, with some opportunity to benchmark across Wales.
<b>QSEC (25) 124</b>	<b>Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital:</b> <ul style="list-style-type: none"> <li>To consider reducing the frequency of scheduled updates on the ongoing impact of service changes at Minor Injuries, Prince Philip, Tregaron and Paediatrics at Bronglais due to assurances received from the report and advise the Chair accordingly.</li> </ul>	<b>JW/ SD/ AL</b>	<b>February 2025</b>	<b>Complete:</b> Following a discussion with the Chair, Executive Lead and Director of Corporate Governance, it has been agreed to report on an exception basis dependent on any potential escalation to QSEC. A brief update will be included within the April Quality Assurance Report prior to further discussion in Board in May 2025.

<b>QSEC (25) 125</b>	<b>Quality Assurance Report</b> <ul style="list-style-type: none"> <li>To ensure the Quality Improvement projects align with Health Board priorities (for example Falls and Pressure Damage which are the top 3 most reported incidents)</li> </ul>	<b>SD/ MD</b>	<b>February 2025</b>	<b>Agenda item 2.8</b>
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SD: Sharon Daniel	AC: Andrew Carruthers	LOC: Louise O'Connor	CG: Ceri Griffiths	CSO: Katie Lewis	MD: Mandy Davies
JW: Joanne Wilson					

## 1.3

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### 1.3 - QSEC Annual Report 2023/24

***Anna Lewis (Hywel  
Dda UHB -  
Independent Board  
Member)***

| For approval

#### **Attachments**

QSEC Annual Review 2425.docx

# QUALITY, SAFETY AND EXPERIENCE COMMITTEE

ANNUAL REVIEW REPORT

2024/2025

## 1. Introduction and Chair's summary

In line with Standing Orders the Quality, Safety and Experience Committee (QSEC) must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Sub-Committees it has established, setting out how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework: and

### Chair's Reflections

The Committee has continued to take a proactive approach to continuous improvement in its effectiveness, testing and driving forward various innovations in good governance and leadership. Embedding the 'alert, advise, assure' framework across the agenda has enabled the Committee to be disciplined and consistent in reaching clear action-oriented outcomes in each of its discussions. In addition, it has provided a common terminology that is used increasingly across the Health Board's different levels of quality governance. A longstanding ambition to create space for more strategic dialogue in terms of quality, safety and experience is starting to deliver impact and an outcomes orientation is making gradual progress.

The Committee has been pleased to celebrate many successes in terms of improvements in patient experience, access and innovation. These successes are reflected in patient stories, QI data and improvements as a result of inspection processes, as well as accounts of service delivery changes. The groundbreaking work of the Same Day Emergency Care and Outreach service in Ceredigion was a particular highlight and recognised in the RCN's Annual Awards.

The Committee has played an active role in supporting the Health Board's comprehensive work towards de-escalation of its current Targeted Intervention status, providing regular scrutiny of key improvement areas such as Infection Prevention and Control. It has also taken on specific delegated responsibility on behalf of the Board to monitor the quality impacts associated with a range of urgent service changes at Tregaron Hospital, Prince Philip Hospital Minor Injuries Unit and Paediatric Services at Bronglais Hospital. The Committee has ongoing concerns in

relation to the inadequate access to support for neurodivergent children, young people and their families. Despite some positive local improvement work, the strategic context is extremely challenging and the Board is now engaged in supporting acceleration of improvement work in this area.

The consistent theme to run through the quality, safety and experience agenda is the widespread fragility of services across the region, which manifests in terms of workforce, estate and equipment, and service configuration across our dispersed population, and in turn upon the ease of access that our communities have to high quality and safe care. This report contains many examples of those challenges and Committee members remain humbled by the realities of what some of our patients and staff experience. This theme will continue to feature in the challenges of the year ahead. Looking forward, the Committee will maintain the highest commitment to scrutiny and continuous improvement of those challenges, supported by the strengthened operational governance structure which has been in planning in 2024/25, ready for launch in early 2025/26.

## **2. Terms of Reference and Workplan**

The Terms of Reference (TOR) for the QSEC Committee is reviewed on an annual basis or following any significant changes. The TORs were last reviewed in July 2024.

[link to Quality, Safety and Experience Terms of Reference](#)

The QSEC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The QSEC Committee workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

[QSEC Work Plan 2024/25](#)

## **3. Sub-Committees**

The Listening and Learning Sub-Committee reports into the QSEC with its own terms of reference and workplan for the year. The Sub-Committee's TOR were last reviewed on 5 December 2024.

The Quality, Safety and Experience Sub-Committee also reports into the QSEC with its own terms of reference and workplan for the year. The Sub-Committee's TOR were last reviewed on 15 August 2024.

In line with their Terms of Reference, the Sub-Committees are required to provide a report after each meeting, as well as produce an annual report which are scheduled to be presented to the Committee on 10 June 2025 reporting on activity throughout the year.

#### 4. Table of attendance

Name		09.04.24	11.06.24	15.08.24	08.10.24	05.12.24	13.02.25
<b>Members</b>							
Anna Lewis	Independent Member - Committee Chair	✓	✓	✓	✓	✓	✓
Delyth Raynsford	Independent Member (Committee Vice-Chair)	✓	✓	✓	✓	✓	✓
Ann Murphy	Independent Member	✓	✓	✓	✓	✓	✓
Chantal Patel	Independent Member	x	✓	✓	✓	✓	✓
Iwan Thomas	Independent Member	x	x	x	x	x	x
Eleanor Marks	Independent Member (HDdUHB Vice-Chair)		✓				✓
Rhodri Evans	Independent Member		✓			✓	✓
<b>In Attendance</b>							
Sharon Daniel	Interim Director of Nursing, Quality & Patient Experience	✓	✓	✓	✓	x	✓
Andrew Carruthers	Director of Operations	✓	✓	✓	✓	✓	✓
Mark Henwood	Interim Medical Director	✓	✓	x	✓	✓	✓
Jill Paterson	Director of Primary Care, Community and Long term Care	✓	✓	✓	✓	✓	✓
James Severs	Director of Therapies and Health Science	✓	✓	✓	✓	✓	x
Ardiana Gjini	Executive Director of Public Health	✓	✓	✓	✓	✓	✓
Louise O'Connor	Assistant Director Legal and Patient Experience	✓	✓	✓	✓	✓	✓
Cathie Steele	Interim Assistant Director of Assurance and Safeguarding	✓	✓	✓	✓	✓	✓
Llais Cymru Representative		✓	x	✓	✓	✓	✓

A quorum shall consist of no less than three of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and two other Independent Members, together with a third of the In Attendance members.

#### **5. Committee Activities – alert, advise and assure.**

The Committee is required to report to the Board after each Committee meeting by presenting a report highlighting the key discussion items at the Committee.

**Alert** – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve, and were alerting the Board as engagement action or intervention was required.*

#### **Autism Spectrum Disorder (ASD) diagnostic services for Children, Young People & Adults**

- In September 2024, the Board were alerted to the ongoing concerns regarding the progress and pace of the national transformational change for autism spectrum disorder (ASD) diagnostic services for children, young people and adults, and the associated impact upon local service improvement. The Board was asked to consider the need to seek an appropriate route for discussion with colleagues at a national level, in order to enable material change in the outcomes available to local people in the short, medium and long term. The Health Board agreed this has been a long-standing issue and discussed writing formally to Welsh Government outlining its concerns and the reasons for these. The Health Board agreed that the Regional Partnership Board would be approached regarding escalating to Welsh Government.

#### **Death Certification and Medical Examiners Service**

- In April 2024, the Quality, Safety and Experience Sub Committee escalated concerns relating to the risk of Health Board's compliance with the Death Certification and Medical Examiners Service due to the failure to fully resource internal processes. This risk was escalated onto the corporate risk register (CRR) and mitigations enacted resulting in reduction in the level of risk and de-escalation from the CRR.

**Advise** – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

#### **Unscheduled Emergency Care.**

The Committee received regular updates during 2024/25 on the challenges being faced across urgent and emergency care (UEC) services and actions to mitigate the risks for patients and staff. The following initiatives are underway to mitigate the risks:

- Weekly performance reports to aid operational monitoring of UEC performance targets
- Twice daily health board wide sitrep meetings
- Established Six Goals programme work streams aligned to and reviewed by the National Programme Team.
- NHS Executive reports (NHSE) on ED, associated site-specific action plans with quarterly progress reviews with NHSE
- Site-specific improvement plans against ED Quality Statement.
- A Glangwili Hospital (GGH) action plan in response to the Getting it Right First Time (GIRFT) Report.
- In recognition of the position at GGH and the significant part that GGH plays in the delivery of specialty pathways, a specific improvement initiative commenced in October 2024.

The Committee advised Board in March 2025 that historical service configurations continue to be a barrier to making necessary improvements that would benefit our population.

### Corporate Risk Report

The Committee received the Corporate Risk Report at its meetings in April 2024, August 2024 and December 2024.

In December 2024, concerns were raised on the Corporate Risk Report that expected timelines in the “gaps in control” section were not being achieved. The Committee received assurance that the Executive Team are in the process of reviewing risk tolerance as part of the planning process for next year. QSEC advised the Board that assurance was unable to be provided that the following risks were being managed effectively with the remainder of the corporate level risks.

- **Risk 797: Risk to the ability to deliver ultrasound services due to workforce pressures:** While this risk was being closely monitored, there had been no improvement over a significant period. Potential options to mitigate include regional collaboration. Whilst assurance was provided that no harm to patients had been identified to date, it was acknowledged that this risk required focus to ensure impacts to quality, safety and performance were being mitigated as far as reasonably practicable. QSEC concluded that it was not adequately assured, and this required thorough triangulation with incident data to provide adequate assurance which will be brought back to Committee in June 2025.
- **Risk 1664: Risk to ophthalmology service delivery due to a national shortage consultant ophthalmologists and the inability to recruit:** Whilst plans were being developed for the next financial year, given the absence of quality data for QSEC to review patient impacts, it was agreed that an update detailing how the risk including the quality and safety impacts were being mitigated would be considered for QSEC. No concerning levels of harm were reported to the Executive Team and this would be monitored.

- **Risk 684: Risk to the timely investment and replacement of radiology equipment and supporting infrastructure:** Due to insufficient capital funding from Welsh Government (WG), management of this risk is outside the Health Board's control. A regional solution is being explored with Swansea Bay University Health Board (SBUHB).

### Internal Audit of Standards of Cleanliness

- In December 2024, the Committee received an update on the collaboration and work undertaken to address a very large percentage of the recommendations with some final work remaining. Estates and facilities will re-engage with Internal Audit to discuss positive progress in advance of a follow up audit in April 2025.

### Therapies Improvement Plan

- Whilst progress and the development of a Therapies Improvement Plan (TIP) to understand the current 14-week therapy referral to treatment performance was received by the Committee in April 2024, assurance on the required level of progress was not received. An update on progress against the TIP was scheduled for August 2024 where Members noted that the plan would focus on occupational therapies (paediatric) service in the first instance with the view to then upscale improvement work across the directorate. In December 2024, the occupational therapy (OT) (paediatrics) improvement plan indicated a continued improvement, with a reduction in the overall number of breaches in paediatric OT and a decrease in the number of long waits. The Committee welcomed the significant improvements and that any patients on the waiting list are aware of the various ways to contact the team.

### Stroke Services

- Whilst the Committee received assurance on the quality and safety impact of reinforced aerated autoclave concrete (RAAC) major incident at Worthybush Hospital in April 2024, the report highlighted a wider issue with thrombolysis performance within the stroke pathway and baseline data. In June 2024, the Committee received the requested update on an internal governance review of stroke services where county operational stroke groups had been established to ensure equity in treatment times and assessment. Members noted that the Brainomix system, which is stroke artificial intelligence system, went live in April 2024, and was already having a speedier result for diagnosis and treatment. It was noted however that some members of the team had been reallocated to support the clinical Service planning work which had an impact on capacity.

### Rheumatology Services

- In June 2024, a patient story highlighted some concerns regarding potential delays in clinical escalation response times and medication prescription processes within rheumatology services due to the Communication Hub being the first point of contact for patients which was under review. Workforce capacity challenges were also highlighted. A deep dive into rheumatology services was

presented in December 2024 which indicated progress had been made regarding the work undertaken to meet capacity challenges; and a projected improvement in performance for patients waiting over 52 weeks for their first outpatient appointment. Potential options to consider regarding regional collaboration were discussed. In February 2025, the Committee were updated that a consultant had been recruited, however it was too soon to determine whether this had had an impact on the capacity within the team.

### **Transforming Urgent and Emergency Care Discharge Management Internal Audit**

- In August 2024, the Committee received limited assurance from the outstanding actions in response to the Internal Audit review of Transforming Urgent and Emergency Care (TUEC) Discharge Management since the initial audit was undertaken in 2022. The Committee requested a further report in six months' time to provide an overview of the actions undertaken, and to measure the impact these actions are having on the quality, safety and experience of the Hywel Dda population. The Committee received an update in February 2025, that work was continuing to address the remaining actions from the follow up Urgent and Emergency Care Discharge Management Internal Audit. As a result of 50% of staff who were interviewed during the audit reporting that they do not feel confident discharging patients, the Discharge Planning Group were reviewing current training resources in collaboration with the practice development team. A revised discharge management leaflet and resources are also now available internally via SharePoint.

### **Upper Gastrointestinal (UGI) Emergency Rota**

- In October 2024, the Committee were advised of the gap for upper gastrointestinal (UGI) representation on the Wityhush Hospital (WGH) emergency medical rota, options were being considered to temporarily relocate the service until the implementation of the revised model as part of the clinical services plan. The Committee suggested strengthening the data that was being captured on patient harm until any new arrangements are agreed.

### **Nurse Staffing Levels**

- In October 2024, the Committee noted that the Health Board is meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016. Whilst assurance was provided from the three-year Nurse Staffing Levels 3-year Welsh Government report for 2021-24 which was be submitted to Welsh Government, further work was requested to improve the reliability of the data used for establishing nurse staffing levels, due to the current challenges with the Allocate system. Further work on improving the reliability of the data has been enacted

### **Targeted Intervention De-escalation Criteria:**

- In February 2025, it was recognised that whilst hospital numbers for each of the hospitals were reported as low for healthcare acquired infections (HCAI) the position is being continuously monitored by Infection Prevention Control Steering Group to ensure the improvements are sustained.
- A planned 'deep dive' into older/unresolved external recommendations particularly from Health Inspectorate Wales (HIW) actions was discussed in February 2025. Comparing the data from the same period last year, the Committee noted there were 120 recommendations in progress in January 2024 where in January 2025 there were 8. Actions to make further improvements include revising the assignment process to ensure they are allocated to the most appropriate individual and to ensure that actions are specific, measurable, attainable, relevant and time bound (SMART).
- Referring to the fragile service criteria which was discussed at Committee in December 2024, the Executive Team are progressing the development of the fragile service escalation process.
- In February 2025, the Committee was advised that the revised Putting Things Right Regulations, which will be implemented towards the end of 2025, are likely to have a significant impact on workforce capacity and have been highlighted as a potential risk for health boards due to reduced timescales for investigation processes. The Committee referred to the potential impact on workforce capacity and skill-based training/ induction requirements to the People, Organisational Development and Culture Committee (PODCC) for monitoring.

**Assure** – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

#### **Safer Care Collaborative**

- In April 2024, the Committee received assurance from a presentation provided on the Safer Care Collaborative and the connection to TUEC noting the effective quality improvement work impacting upon better patient care and experience.

#### **Suspected Suicide Cluster in Pembrokeshire**

- In June 2024, assurance was provided from the cross-organisation partnership working in response to suspected suicide cluster in Pembrokeshire between the police, mental health, public health and education providers.

#### **Additional Learning Needs (ALN) Act**

- While recognising the longstanding compliance shortfalls, the Committee received assurance in June 2024 that there is improved executive leadership and improved governance which is facilitating progress Health Board compliance with its statutory duties under the Additional Learning Needs (ALN) Act.

#### **Quality Impact Assessment (QIA) process**

- In June 2024, the Committee noted the development of the Quality Impact Assessment (QIA) process, which will ensure that strategic decisions about healthcare services are considered through a quality lens and will record the impact of decisions on the quality of the healthcare system.

### **Withybush Hospital Creche**

- The action plan in response to the recommendations made by Care Inspectorate Wales (CIW) following the inspection of the Withybush Hospital Creche was shared in June 2024, with the majority of actions completed. The recommendations were completed, and the Statement of Purpose was approved by the Committee in December 2024.

### **Hepatitis B and C Elimination Plan**

- In June 2024, the Committee received the current position in terms of compliance for WHC 2023/001 Hepatitis B and C Elimination Plan and the plans proposed for the next three years in working towards eliminating hepatitis B and C in the region to improve population health.

### **Primary Care Quality and Safety**

- In June 2024, the Committee took assurance from the quality, safety and experience governance arrangements for primary care and contracted services and requested for more regular updates. A primary care quality and safety deep dive has been forward planned for April 2025.

### **Pembrokeshire Child Practice Review**

- The Committee took assurance from the learning in response the Pembrokeshire Child Practice Review in June 2024 and the actions undertaken to improve multi-agency communication, escalation processes and to empower staff to act upon professional curiosity.

### **Duty of Quality and Candour Report 2023/24**

- In August 2024, the Committee reviewed and supported the Duty of Quality and Candour Report 2023/24, and the proposal to develop a learning framework which will strengthen opportunities to spread improvements across the organisation. The report will be presented for Board approval in September 2024.

### **Ceredigion Community Same Day Emergency Care and Outreach service**

- In October 2024, positive patient and staff feedback was shared at the meeting for the Ceredigion Community Same Day Emergency Care and Outreach service and the multi-disciplinary collaborative efforts to provide person-centred healthcare. The Committee suggested capturing outcome focussed data to help decision making for future strategic direction considerations.

### **Infected Blood Inquiry**

- The Public Health Directorate provided assurance to the Committee that an appropriate response to the Infected Blood Inquiry has been undertaken within Hywel Dda with ongoing robust testing and treatment pathways developed. Support will continue to be offered to individuals who may have been infected.

### **Community Nursing Annual Report 2023/24**

- The Community Nursing Annual Report 2023/24 advised of the recent investment and developments in community nursing, and the impact on workforce sustainability, and quality and safety of patient care was positively received by the Committee.

### **Medicines Management Operational Group**

- During the Medicines Management Operational Group update in October 2024, the Committee were alerted to concerns regarding the completion of venous thromboembolic (VTE) risk assessments which continues to be poor even though the prescribing of prophylaxis has generally improved. Discussion took place on current processes and the Committee requested an assurance report on processes for completion of VTE risk assessments to be scheduled for Quality, Safety and Experience Sub-Committee in January 2025. In February 2025, the Committee received assurance that targeted quality improvement work continues to improve the Health Board wide compliance of VTE risk assessment.

### **Listening and Learning (From Events) Framework**

- The development of the Health Board's Listening and Learning (from Events) Framework was noted in December 2024, with the transfer to a more thematic organisational learning and patient outcome focused approach and its alignment to the new operational structure. The need to ensure that all staff networks have the time and access to articles and learning resources was recognised.

### **Veteran Health**

- The Veteran Health update report shared in December 2024 demonstrated that the Health Board is proactively implementing the Armed Forces Covenant, that veterans are not being disadvantaged in terms of health outcomes. The work of the Health Board has been commended by the NHS Wales and Veterans Commissioner.

### **Elective care waiting list in Planned Care**

- The changes in the management of patients on an elective care waiting list in Planned Care and the positive initiatives currently in place to support these patients was presented in December 2024. A systematic approach is being taken to identify harm and risk to patients on a waiting list.

### **Revised Operational Governance**

- In February 2025, the Committee was advised of the plans to implement a new 5 Clinical Care Group model as part of the revised operational governance arrangements. The changes have been instigated from consistent feedback from Audit Wales that the structure needed strengthening. The slides that were shared with the Committee were aligned to the Health Board's Quality

Management System and the changes aim to provide a system-wide approach to achieving quality of care in a way that secures continuous improvement.

### **Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience Interim Report**

- There was no cause for concern highlighted reported within the nurse staffing levels impact of reduction of agency and bank staff in Quality, Safety and Patient Experience Report in February 2025. It was, however, highlighted that although the overall number of vacancies has reduced, there has been a significant increase in inexperienced workforce recruitment, who are being supported by the Corporate Nursing Team, Senior Leads and Learning and Development team.

### **Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital**

- Minimal impact on quality, safety and patient experience was concluded from the update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital at the February 2025 meeting. This continues to be monitored closely. The ongoing methodology to capture service user feedback will be considered for inclusion within the revised patient experience report for the Board. Due to assurances taken from the report, it was agreed that, going forward, monitoring service impact would be provided on an exception basis and dependent on any potential escalation to QSEC. A brief update will be included within the quality assurance report scheduled for April 2025, prior to a further discussion at the Board in May 2025.

### **Staff and Patient Stories**

The Committee received patient and staff stories at each of its meetings during 2024/25 with a focus on the following Services/ Programmes of work:

- Safe Care Collaborative (April 2024)
- Rheumatology Services (June 2024)
- Oncology Services (August 2024)
- Paediatrics Ambulatory Care Unit (December 2024)
- Special Care Baby Unit (February 2025)

## **6. Committee Effectiveness - Feedback from self-assessment process**

As stipulated within Standard Orders, the Board introduced a process of regular and rigorous self-assessment and evaluation of the performance of the QSEC.

- For the QSEC this involved the completion of a short digital form which requested feedback on the following areas:
  - Governance and administration
  - Committee's inputs
  - Conduct of Committee meetings

- o Interface with other Committees, including the Board
- o Committee's impact
- o Individual role on Committee

The results from which were fed into an action plan, combining information and Auditor/Regulator feedback.

The process was undertaken during the year and reported to the Committee on 13 February 2025 [Link to Self Assessment Outcome Report](#)

The Committee will receive an update on progress at the mid-year point.

## **7. Conclusion**

The Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Board as appropriate, and the Committee uses feedback from the self-assessment process to evolve and continually improve.

## 1.4

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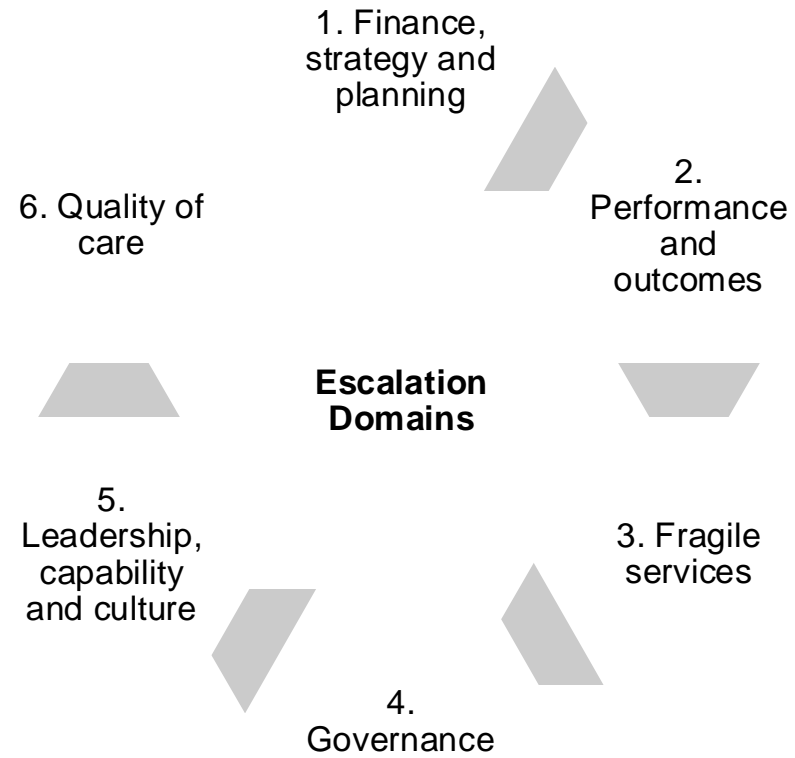
### 1.4 - Targeted Intervention Progress Report

***Sharon Daniel (Hywel  
Dda UHB - Interim  
Executive Director of  
Nursing, Quality &  
Patient Experience)***

#### **Attachments**

[1.4 8th April 2025 - Targeted Intervention.pptx](#)

[QSEC TI Reporting Framework Tracker.xlsx](#)



## Quality, Safety and Experience Committee (QSEC)

### Targeted Intervention Progress Report

April 2025



## Introduction

This report provides a comprehensive update on key Targeted Intervention (TI) criteria for the Quality, Safety and Experience Committee's (QSEC) consideration. The Health Board continues to make significant progress across multiple domains, with two criteria demonstrating sufficient improvement to warrant de-escalation from 'Alert' to 'Advise' status.

The progress detailed herein reflects the Health Board's commitment to embedding sustainable quality improvements and addressing regulatory requirements. Particular focus is placed on areas with material significance to patient safety, clinical governance, and service quality. This includes healthcare-acquired infections, complaints management, service user feedback, and the oversight of fragile services.

While progress is evident, there remain areas requiring continued vigilance and focused improvement. This report aims to provide QSEC with sufficient detail to exercise appropriate scrutiny while highlighting both achievements and ongoing challenges that require both strategic and on-going operational attention.



## Outstanding External Recommendations (Criterion 34) Significant Updates and Status Changes - Status Change: Alert → Advise (20/03/25)

### Rationale for Status Change

- Significant Action Closure Rates - Overdue actions reduced from 51 to 14, and partially complete overdue actions from 17 to 9. The Stroke and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) reports have been fully completed and closed, demonstrating the health board's capacity to bring older actions to a successful conclusion.
- Strong Governance Framework - The Quality, Assurance and Safety Team is systematically following up on all open external recommendations through bi-monthly chasing with a clear escalation protocol. Services can directly update actions and attach evidence in the live AMaT system, ensuring transparency, accountability, and quicker turnarounds.
- New Health Inspectorate Wales (HIW) Report on Children & Young People's Mental Health - Although this has added 9 recommendations and 23 actions, there is a clear governance pathway to embed these actions within existing directorate improvement plans. Early tracking via Audit Management and Tracking System (AMaT) suggests a proactive approach to ensure no backlog is created.

### Recommended Next Steps

- Continue the bi-monthly escalation approach to clear the remaining 14 overdue actions
- Incorporate the 23 new actions from the Children & Young People's Mental Health Review into live action plans with measurable milestones
- Consider further reduction to an 'Assure' status once outstanding and newly added actions have reached a manageable level (e.g., single digits overdue and clear tracking and completion of new actions)



## External Reports and Reviews (Criterion 52) - Status Change: Alert → Advise

### Rationale for Status Change

- **Marked Reduction in Outstanding Actions** - The Health Board has seen a substantial decrease in overdue recommendations, with strong performance in closing or partially completing older HIW actions. Directorates are increasingly adept at setting realistic deadlines, responding to external scrutiny, and embedding improvements.
- **Evidence of Sustainable Processes** - Real-time updates via AMaT enable prompt responses to queries and swift escalation of risks or delays. Regular assurance reporting to QSEC ensures improvements are tracked and remain on course.
- **New Additions, but Strong Handling** - While the Children & Young People Mental Health Review adds a fresh set of actions, early signs show a proactive integration into established governance frameworks rather than creating a backlog.

### Recommended Next Steps

- Continue efforts to close the 14 remaining overdue items and embed a 'right first time' ethos for new recommendations
- Capture and share real-world examples of how completed actions have led to measurable service improvements
- Consider transitioning to 'Assure' status if progress remains on track over a sustained period (approximately 6 months)



## National Clinical Audit and Outcome Review (Criterion 56) - Status Change: Alert (20/03/25)

### Reason for escalation and Key Issues:

This criterion has remained blank for nearly 12 months. To fully satisfy Criterion 56, future reports should incorporate:

- Specific reference to National Clinical Audit participation and findings
- Evidence showing how Outcome Review Programme data informs service development decisions
- Examples demonstrating Value in Health dashboard utilisation in addressing unwarranted variations in practice
- Clear linkage between these national datasets and local improvement initiatives
- Case studies illustrating how combined data sources drive specific quality improvements

As there has been no evidence provided and the criterion has remained blank, there is a need to change this to an Alert. The committee may be aware of actions around this, however, in the absence of any evidence within the Targeted Intervention folder, there is a need to flag this to the QESC committee.

# Targeted Intervention – Criteria 23



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## Service User Feedback (Criterion 23)

### Current Status: Advise

The QESC April 2025 report demonstrates robust implementation of patient feedback mechanisms that are actively driving quality improvement:

- Patient satisfaction metrics show consistently strong performance with 94.2% of respondents reporting positive experiences
- The Friends and Family Test (FFT) survey reached 37,633 individuals with a response rate of 18.8% (6,355 responses)
- This response volume significantly exceeds comparable Health Boards in Wales

### Particularly noteworthy improvements in specific service areas:

- Community & Primary Care services: >30% improvement from previous reporting period
- Mental Health Outpatient services: >30% improvement
- Maternity Inpatient services: 12% improvement

### Hospital-specific satisfaction rates reveal consistent performance:

- Bronglais General Hospital: 93.6% positive feedback (784 responses)
- Glangwili General Hospital: 92.2% positive feedback (1,854 responses)
- Prince Phillip Hospital: 96.1% positive feedback (1,560 responses)
- Withybush General Hospital: 94.1% positive feedback (1,204 responses)

Integration of patient experience data into operational processes represents significant progress, with CIVICA, Datix, and FFT data now standard inputs in routine management meetings and quality improvement initiatives.



## Fragile Services (Criteria 32, 33, 35)

### Current Status: Advise

The Health Board's safety dashboard currently includes essential data points such as staff sickness, agency use, infection prevention and control, falls, medication errors, and pressure damage.

There are a number of systems reports that at a basic mechanism can be used as an indicator of service fragility:

- Dashboard effectively captures patient safety incidents with detailed categorisation
- Healthcare Acquired Infection metrics with site-specific analysis
- Complaint patterns highlighting pressure points in specific services
- Performance Metrics
- Financial Metrics i.e. increase in agency or medical variable pay

External perspectives are incorporated through Healthcare Inspectorate Wales findings and Welsh Risk Pool assessments, with structured processes for tracking recommendations.

# Targeted Intervention – Criteria 32, 33, 35



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## Key gaps and next steps:

- Need to incorporate additional metrics such as mortality reviews, comprehensive patient experience data, and more robust staff feedback mechanisms
- Incomplete "Speak Up Safely" section suggests this component requires further development
- Limited evidence of a centralised methodology for integrating disparate elements into a coherent assessment of service vulnerability

A structured framework specifically focused on fragile services beyond the CSP scope has yet to be fully established. The fragile services register within the TI framework remains incomplete, indicating that while there is awareness of fragility, a more defined and comprehensive framework would enhance clarity on fragile services.



## Healthcare Acquired Infections (Criterion 50)

### Current Status: Advise

The Health Board demonstrates a clear data-driven improvement plan with mixed performance against established reduction expectations:

- C. difficile: 4 hospital-onset cases in February 2025 (below goal of 6, representing successful 25% reduction).
- Staph aureus: 4 hospital-onset cases in February 2025 (above goal of 2, failing to meet the 33% reduction target)
- E.coli: 5 hospital-onset cases in February 2025 (meeting the goal of 5, achieving the 25% reduction target)

**Long-term Trend Analysis (March 2023 - February 2025)** - Analysis of the 24-month infection data reveals significant patterns that inform the current status.

**C. difficile** cases show considerable month-to-month volatility with values ranging from 3 to 11 infections. The data indicates:

- Periodic achievement of the target ( $\leq 6$  cases) in 13 of 24 months.
- Recent improvement with February 2025 showing 4 cases (below target)
- Several clusters of increased incidence throughout the reporting period, with notable spikes in July 2023 (10 cases), October 2023 (10 cases), and November 2024 (11 cases)

# Targeted Intervention – Criteria 50



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**Staph aureus** infections display similar volatility, ranging from 0 to 7 cases:

- The stretch target of 2 or fewer cases achieved in 8 of 24 months (31% of the time)
- A concerning period in Q2-Q3 2024 with elevated cases (peaking at 7 in June 2024)
- Recent stability but consistently above target in Q4 2024 and Q1 2025, with February 2025 showing 4 cases
- Episodes of zero cases (April 2023, December 2024) demonstrate that elimination is achievable but not sustained

**E.coli** infections show the highest variance, with cases ranging from 2 to 12:

- Target achievement ( $\leq 5$  cases) in 13 of 24 reported months
- Significant spike in July 2024 (12 cases) followed by substantial improvement
- Recent trend showing stability with February 2025 at 5 cases (meeting target)

Site-level analysis reveals variation in infection control performance across hospitals, with targeted data enabling focused improvement efforts:

- Hospital-onset cases in February included 3 Meticillin-Sensitive Staphylococcus. Aureus (MSSA) bacteraemia cases at Withybush
- 3 E.coli cases at Glangwili and 2 E.coli cases at Withybush
- The data demonstrates that while periodic improvements occur, sustainable reduction below thresholds remains challenging, suggesting that deeper systemic factors may be contributing to the persistent variability in infection rates.

# Targeted Intervention – Criteria 50



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## Interventions include:

- Implementation of specialised disinfection technologies (DiffX and HPV)
- Targeted deep cleaning programme initiated at Prince Philip Hospital on 10 March 2025
- Focused attention on Aseptic Non-Touch Technique (ANTT), currently showing 80.60% practical compliance
- Enhanced monitoring of Peripheral Venous Catheter (PVC) bundle compliance
- Root cause analysis of all hospital-onset cases to identify common factors and improvement opportunities

The improvement plan includes clearly defined quarterly milestones extending through January 2026, with first quarter priorities including rolling out the new environmental cleaning policy and completing HPV machine trials. The plan now includes additional interventions targeting the identified periodic spikes, with enhanced surveillance during historically problematic months; all of which is also reflected in the annual plan for 2025/26.



## Complaints Management (Criterion 51)

### Current Status: Assure

The Health Board demonstrates exceptional performance in complaints management:

- 80% of complaints closed within 30-working day target timeframe during 2024/25, exceeding both the Targeted Intervention requirement (70%) and national standard (75%)
- 466 new complaints received during the reporting period
- 424 complaints closed, indicating effective throughput
- 164 complaints closed within 5 working days through early resolution processes
- 260 complaints managed through the formal Putting Things Right (PTR) process

### Trend analysis reveals significant improvements:

- 27% reduction in complaints managed through PTR in Quarter 3 compared to Quarter 1
- Substantial increase in early resolutions at the end of Quarter 3
- 20% fewer complex complaints (grade 3 and above) in Q3 2024/25 compared to the same quarter in previous year

The implementation of process improvements, including more systematic triage and earlier intervention, has contributed significantly to the enhanced performance. However, recognising going into 25/26 the reporting may be liable to change, this area will require on-going oversight to understand how any changes impact on performance.



## Conclusion

The Health Board has demonstrated substantial progress across several Targeted Intervention domains, with notable improvements in complaints management, infection control processes, and the handling of external recommendations. The de-escalation of two criteria from 'Alert' to 'Advise' status reflects the organisation's commitment to addressing areas of concern through structured, evidence-based approaches. However, the revised status of criteria 56 to Alert will need to be urgently addressed.

Despite these positive developments, certain challenges persist and require continued focus. The integration of patient experience data into improvement processes, while progressing well, needs further embedding at directorate level. Similarly, the framework for identifying and managing fragile services requires additional development to ensure comprehensive coverage beyond those services included in the Clinical Services Plan.

Critical to sustaining progress will be the Health Board's ability to:

1. Maintain momentum in areas showing improvement, particularly in complaint resolution timescales and infection prevention
2. Accelerate progress in completing outstanding external recommendations
3. Develop more robust mechanisms for identifying and monitoring fragile services
4. Strengthen the use of national clinical audit data to drive quality improvement
5. Ensure quality assurance processes are embedded consistently across all service areas

The evidence presented in this report demonstrates that the Health Board is making tangible improvements in key areas while developing the governance infrastructure to sustain these gains. QSEC is asked to recognise and affirm the progress made, endorse the recommended next steps for each criterion, and specify any assurance requirements to support the continued journey toward de-escalation of the remaining TI domains.



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



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Criteria	Action	Reporting	Commit	Status	Status Change	Status Change	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Del	Actions Outstanding	Evidence and Assurance	Risk
23	Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	QSEC	Advise			Sharon Daniel	<p>The April 2025 report demonstrates robust implementation of patient feedback mechanisms that are actively driving quality improvement across the Health Board. Patient satisfaction metrics show consistently strong performance with 94.2% of respondents reporting positive experiences, indicating successful patient-centered care delivery.</p> <p>The Friends and Family Test (FFT) survey reached 37,633 individuals with a response rate of 18.8% (6,355 responses), providing statistically significant feedback across service areas. This response volume significantly exceeds comparable Health Boards in Wales, though no national benchmark exists. The large sample size enables meaningful analysis of trends and service-specific insights.</p> <p>Particularly noteworthy are the substantial improvements in specific service areas:</p> <ul style="list-style-type: none"> <li>- Community &amp; Primary Care services showed more than 30% improvement from the previous reporting period</li> <li>- Mental Health Outpatient services achieved similar gains exceeding 30%</li> <li>- Maternity Inpatient services improved by 12%</li> <li>- Only one negative response was recorded in Paediatric Outpatient services</li> </ul> <p>Hospital-specific satisfaction rates reveal consistent performance across all facilities:</p> <ul style="list-style-type: none"> <li>- Bronglais General Hospital: 93.6% positive feedback (784 responses)</li> <li>- Glangwili General Hospital: 92.2% positive feedback (1,854 responses)</li> <li>- Prince Phillip Hospital: 96.1% positive feedback (1,560 responses)</li> <li>- Withybush General Hospital: 94.1% positive feedback (1,204 responses)</li> </ul> <p>The granular department-level data further illustrates areas of excellence and opportunity, with many departments achieving 100% positive ratings (e.g., Day Surgery Units at Bronglais and Glangwili, Same Day Emergency Care Units at Prince Phillip). Services with lower satisfaction scores, such as Emergency Departments (ranging from 83.7% to 88.3%), provide targeted improvement opportunities.</p> <p>The integration of patient experience data into operational processes represents significant progress. CIVICA, Datix, and FFT data</p>	If the status for alert relates to ongoing monitoring then this is fair. Feedback from service users via the FFT is consistently above 90%. The amount of feedback received in Hywel Dda is significantly higher than other HB (although there is no national standard/benchmark for this). The HB receives patient Experience report at each meeting, this is not the case across Wales. We have had favourable feedback from the Ombudsman this year and have achieved significant assurance from the WRP audit. "We have improved how patient experience data is used, and we will keep expanding these feedback loops to strengthen quality improvement across all services."	Embed patient experience data into all directorate reports (in place from Quarter 3 of 2024-25)	<ul style="list-style-type: none"> <li>Fully incorporate Datix/CIVICA feedback into formal quality improvement projects (target: Quarter 4 of 2024-25).</li> <li>Maintain FFT satisfaction above 90% and keep improving complaints response times</li> </ul>	<ul style="list-style-type: none"> <li>FFT Scores; Ombudsman feedback; WRP audit reports.</li> <li>Directorate packs and escalation meeting minutes.</li> </ul>	1184 (P)
28	Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families. (UEC)	IQFPD	QSEC	Advise			Sharon Daniel	Efforts are underway to incorporate patient experience data more systematically across the organisation. This data, now feeding into escalation meetings and being linked with updates on the patient safety dashboard, aims to enhance quality improvement by providing directorates with greater visibility into feedback trends. Although the roll-out has been slower than anticipated, this month marks the start of broader inclusion in directorate packs for escalation and improvement meetings. As the data becomes embedded in these processes, we expect it will strengthen our ability to respond to service user feedback and drive improvement initiatives effectively.	Duplication	SA= we can amalgamate with 23 and close them down subject to the evidence and move to assure			1184 (P)
32	Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points including staffing levels staff and patient feedback concerns incidents stakeholder feedback (HIW AW HMC RC Llais etc) mortality reviews duty of quality/candour infection protection control performance clinical and medical leadership.	IQFPD	QSEC	Advise			Sharon Daniel	<p>The Health Board's safety dashboard currently includes essential data points such as staff sickness, agency use, infection prevention and control, falls, medication errors, and pressure damage. These elements provide a foundational view to assess the factors affecting service resilience.</p> <p>The April 2025 report demonstrates that the organisation has established basic mechanisms to monitor several important indicators of service fragility. The dashboard effectively captures patient safety incidents with detailed categorisation, Healthcare Acquired Infection metrics with site-specific analysis, and complaint patterns highlighting pressure points in specific services.</p> <p>External perspectives are incorporated through Healthcare Inspectorate Wales findings and Welsh Risk Pool assessments, with structured processes for tracking recommendations and implementation. The "Learning from the Ombudsman" section offers additional insights into service vulnerabilities, particularly regarding high-risk pregnancy management and outpatient appointment processes.</p> <p>However, the next critical step for the Health Board is to incorporate additional metrics, such as mortality reviews, comprehensive patient experience data, and more robust staff feedback mechanisms. The incomplete "Speak Up Safely" section suggests this component requires further development to fully capture frontline concerns that might indicate service fragility.</p> <p>While individual data streams are well-monitored, the report provides limited evidence of a centralised methodology for integrating these disparate elements into a coherent assessment of service vulnerability. The organisation appears to have the necessary components but has yet to develop a truly integrated approach to understanding the multifaceted drivers of fragility within services.</p> <p>By triangulating these expanded data points more systematically, the Health Board would enhance its ability to identify and address the underlying drivers of service fragility, supporting more informed decision-making and targeted improvements. This represents an important area for continued development as the organisation matures its quality management processes.</p>	Framework approved at QSEC in December. Sharepoint platform developed and Fraile Services Oversight Group established. Reporting via IQFPD through to Executive Team				210 risks aligned to fragile risk theme.
33	Fragile services (including but not limited to stroke primary care orthopaedics and ophthalmology) are supported by strong clinical leadership have an effective integrated improvement plan project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.	IQFPD	QSEC	Advise			Sharon Daniel	<p>Within the Clinical Services Plan (CSP), there is robust information on specific programmes, particularly for services within its scope, such as stroke, orthopaedics, ophthalmology, and primary care. Additionally, the risk register serves as a mechanism to highlight fragile services, providing an inherent process for identifying risks due to the nature of each service.</p> <p>However, while these tools contribute to understanding service fragility, a structured framework specifically focused on fragile services beyond the CSP scope has yet to be fully established. For instance, the fragile services register within the TI framework remains incomplete, indicating that while there is awareness of fragility, a more defined and comprehensive framework would enhance clarity on fragile services across the board. This development remains a work in progress. (no significant update since last reported)</p>	Does this sit better with mark Henwood				210 risks aligned to fragile risk theme. CSP Project Risk Register?

34	Evidence that all recommendations from the Royal Colleges HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	IQFPD	QSEC	Advise	Alert	20/03/25	Sharon Daniel	<p><b>Rationale for Status Change</b>  <b>Significant Action Closure Rates</b> - Overdue actions reduced from 51 to 14, and partially complete overdue actions from 17 to 9. This reflects a substantial improvement in finalising and evidencing completion of outstanding recommendations. The Stroke and DNACPR reports have been fully completed and are closed, demonstrating the organisation's capacity to bring older actions to a successful conclusion.</p> <p><b>Strong Governance Framework</b> - Bi-monthly Chasing and Escalation: The Quality, Assurance and Safety Team is systematically following up on all open external recommendations, with a clear escalation protocol (progress check within 14 days). Real-Time Updates via AMaT: Services can directly update actions and attach evidence in the live AMaT system, ensuring transparency, accountability, and quicker turnarounds for queries from HIW and other external bodies.</p> <p><b>New HIW Report on Children &amp; Young People's Mental Health</b> - Although this has added 9 recommendations and 23 actions, there is a clear governance pathway to embed these actions within existing directorate improvement plans. Early tracking via AMaT suggests a proactive approach to ensure no backlog is recreated.</p> <p><b>Robust Oversight Maintained</b> - Despite the recommendation to de-escalate from Alert to Advise, robust oversight remains crucial. With 14 overdue items still open, it is important to maintain structured follow-up to prevent slippage. The focus in the coming period will be on sustaining the rate of closure and ensuring all newly identified actions (e.g., from the Children &amp; Young People's Mental Health Review) are given realistic timeframes.</p>	<p><b>Recommended Next Steps</b>  <b>Consolidate Gains</b> - Continue the bi-monthly escalation approach to clear the remaining 14 overdue actions.  <b>Integrate New Actions</b> - Incorporate the 23 new actions from the Children &amp; Young People's Mental Health Review into live action plans with measurable milestones.  <b>Monitor De-Escalation Thresholds</b> - Once the outstanding and newly added actions have reached a manageable level (e.g., single digits overdue), consider further reduction to an 'Assure' status if evidence of sustained compliance is demonstrated.</p>				No identified risk however non-implementation may result in risks on directorate and service risk registers
35	Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.	IQFPD	QSEC	Advise			Lee Davies	<p>The Board is regularly updated on the CSP, which has provided valuable insights into the overall fragility across services, driven in part by site configuration issues. The CSP has highlighted the degree of system-wide fragility and identified specific services under strain. While there is clinical data supporting fragility within the CSP's scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model - integrating workforce pressures, financial assessments, service resilience, and patient accessibility - would help frame the Board's understanding and response to fragile services more effectively. A methodology to assess fragility in this way has been developed and presented to QSEC. However, a robust response across all fragile service areas is still evolving and work is progressing through the Quality intelligence group to introduce this methodology and develop a register of fragile services.</p>	<p>The work on fragile services will be overseen through QSEC and the intention is to present it to Public Board in March 25</p>				N/A
48	A culture of listening learning and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources including quality mortality staffing levels patient outcomes user and staff feedback.	TI coordin	QSEC	Advise			Mark Henwood	<p>The Quality Surveillance Group, led by Clinical Executives, aims to embed a culture of listening, learning, and improvement across the organisation. The safety dashboard currently supports this work through data on staff sickness, agency use, infection prevention and control, and safety metrics like falls, medication errors, and pressure damage. Moving forward, integrating additional information such as mortality reviews, patient experience, and complaints data will further strengthen the group's capacity to address gaps and drive evidence-based improvements. This expanded approach will ensure that insights from these areas are fully utilised in embedding a responsive and learning-oriented culture across the organisation.</p> <ul style="list-style-type: none"> <li>-Quality Surveillance Group: Oversees data on IPC, safety metrics, and staff sickness across the organisation</li> <li>-Expanded Feedback: CIVICA, Datix, and FFT data are routinely reviewed, helping identify potential concerns more quickly.</li> <li>-Complaints Culture: The new 5-day early resolution process reduced PTR cases from over 200 earlier in 2024 to around 100 in December, suggesting a more proactive approach</li> </ul>		<ul style="list-style-type: none"> <li>-Continue rolling out staff and patient feedback in monthly improvement huddles (by Quarter 3 of 2024-25)</li> <li>-Update Quality Surveillance Group metrics from January 2025 to include new feedback sources.</li> </ul>			1184 (P) 1189 (P) 1195 (P)
50	Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.	IQFPD	QSEC	Advise			Sharon Daniel	<p>The Health Board's approach to Healthcare Acquired Infections demonstrates a methodical, data-driven improvement strategy with clearly defined targets and comprehensive interventions. Current performance shows a mixed picture against the established reduction expectations for hospital-onset infections:</p> <ul style="list-style-type: none"> <li>- C. difficile: 4 hospital-onset cases in February 2025 (below goal of 6, representing successful 25% reduction)</li> <li>- Staph aureus: 4 hospital-onset cases in February 2025 (above goal of 2, failing to meet the 33% reduction target)</li> <li>- E.coli: 5 hospital-onset cases in February 2025 (meeting the goal of 5, achieving the 25% reduction target)</li> </ul> <p>The Health Board successfully met expectations for C. difficile during August through October 2024, indicating a positive trajectory. However, challenges remain with Staph aureus infections, where rates continue to fluctuate month-by-month, consistently remaining above expected targets. For E.coli infections, whilst February data meets the target, historical data reveals significant fluctuation.</p> <p>The report provides a detailed breakdown distinguishing between community-onset infections (present on admission or detected within the first 48 hours) and hospital-onset infections (developing after 48 hours in hospital). This distinction is crucial for accurately measuring the effectiveness of hospital infection control practices. Whilst the total infection burden includes both types, the performance targets specifically address hospital-onset cases that are more directly attributable to healthcare practices.</p> <p>Site-level analysis reveals variation in infection control performance across the Health Board's hospitals. Hospital-onset cases in February included 3 MSSA bacteraemia cases at Worthybush, 3 E.coli cases at Glangwili, and 2 E.coli cases at Worthybush. This targeted data enables the Health Board to direct improvement efforts to specific locations where hospital-acquired infections are more prevalent.</p> <p>The Health Board has established a robust governance structure to drive improvement, including a dedicated C.diff Infection Improvement Group chaired by the Deputy Medical Director. An Antimicrobial Group continues to operate, supporting implementation of the Welsh Health Circular on AMR &amp; HCAI Improvement Goals 2024-2025. This governance framework ensures senior clinical leadership and accountability for infection prevention and control across all sites and services.</p>					1490 (S) 1640 (S)

51	70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received.	IQFPD	QSEC	Assure			Sharon Daniel	<p>The Health Board demonstrates exceptional performance in complaints management, substantially exceeding both the Targeted Intervention requirement and national standards. The report for QSEC reveals that 80% of complaints were closed within the 30-working day target timeframe during the 2024/25 financial year, surpassing both the Targeted Intervention criterion (70%) and the national target established in the Putting Things Right Regulations (75%).</p> <p>Complaint activity and processing metrics show a well-functioning system:</p> <ul style="list-style-type: none"> <li>- 466 new complaints received during the reporting period</li> <li>- 424 complaints closed, indicating effective throughput</li> <li>- 164 complaints closed within 5 working days through early resolution processes</li> <li>- 260 complaints managed through the formal Putting Things Right (PTR) process</li> <li>- 40%/60% split between early resolution and formal process, demonstrating appropriate triage</li> </ul> <p>The trend analysis reveals significant improvements in complaints management efficiency:</p> <ul style="list-style-type: none"> <li>- 27% reduction in complaints managed through PTR in Quarter 3 compared to Quarter 1</li> <li>- Substantial increase in early resolutions at the end of Quarter 3 compared to the start of the financial year</li> <li>- 20% fewer complex complaints (grade 3 and above) in Q3 2024/25 compared to the same quarter in the previous year</li> </ul> <p>The complaint theme analysis provides insight into systemic issues requiring attention:</p> <ul style="list-style-type: none"> <li>- Clinical treatment/assessment (particularly in A&amp;E, Trauma &amp; Orthopedics, and Ophthalmology)</li> <li>- Appointments and waiting times (with nearly one-third linked to Ophthalmology services)</li> <li>- Communication issues</li> <li>- Staff attitude and behavior concerns</li> </ul> <p>- 79.87% of complaints were closed within 30 days, with only 20.13% exceeding this target.</p> <p>The Health Board also processed 374 new enquiries during the reporting period, primarily concerning Primary Care, Ophthalmology, A&amp;E, and Health Records. These enquiries typically related to transport delays, waiting times, and communication issues, representing opportunities for service improvement before formal complaints arise.</p>		<ul style="list-style-type: none"> <li>- Continue staff training and refinement of complaint triage processes (rolling basis, next review Q4 2024–25).</li> <li>- Align with upcoming PTR regulatory changes by Q1 2025–26.</li> </ul>	<ul style="list-style-type: none"> <li>- Complaints data (Beacon Dashboard) showing closure rates.</li> <li>- Workshop outcomes with clinical leads and external partners, focusing on quality in complaint handling.</li> </ul>	No risk identified
52	Effective response from the health board to external reports and reviews including those from Audit Wales the Ombudsman Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEC	Advise	Alert		Sharon Daniel	<p><b>Rationale for Status Change</b>  <b>Marked Reduction in Outstanding Actions</b> - The health board has seen a substantial decrease in overdue recommendations, with a correspondingly strong performance in closing or partially completing older HIW actions. This indicates that directorates are increasingly adept at setting realistic deadlines, responding effectively to external scrutiny, and embedding improvements within operational practices. However, there are some issues which will need on-going monitoring.  <b>Evidence of Sustainable Processes</b> - Live Monitoring via AMaT - Real-time updates enable the organisation to give prompt responses to HIW queries and swiftly escalate risks or delays. Regular Assurance Reporting - QSEC and relevant committees receive ongoing updates, ensuring that improvements are tracked and remain on course. This supports a culture of transparency and accountability.  <b>New Additions, but Strong Handling</b> - While the new Children &amp; Young People Mental Health Review adds a fresh set of actions, early signs show the health board is taking a proactive approach, integrating them into established governance frameworks rather than creating a new backlog. However, to move from Advise to Assure, all Directorates/CCGs will need to demonstrate this level of oversight. Assurance queries from HIW during Q3–Q4 2024–25 have been addressed promptly, illustrating a continued capacity to handle parallel streams of external scrutiny.  <b>Continued Oversight</b> - Moving from Alert to Advise should not dilute the focused monitoring needed to keep these improvements on track. Indeed, ensuring new recommendations do not become overdue is key to sustained success. The management response, including clarity of timelines and strict follow-up, appears sufficiently robust to warrant de-escalation at this juncture.</p>	This links to row 35 Action: Deep Dive	<p><b>Recommended Next Steps</b>  <b>Maintain the Accelerated Closure Trajectory</b> - Continue efforts to close the 14 remaining overdue items and embed a ‘right first time’ ethos for new recommendations.  <b>Strengthen Evidence of Embedding</b> - Continue capturing and sharing real-world examples of how completed actions have led to measurable service improvements, reinforcing that these are not just ‘paper exercises’.  <b>Review Status in Next Committee Cycle</b> - If progress on the recently added or future actions remains on track and overdue items drop further, consider transitioning to</p>		No identified risk however non-implementation may result in risks on directorate and service risk registers
53	Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	IQFPD	QSEC	Advise			Sharon Daniel	<p>While performance has been strong, we’ve yet to receive a permanent, comprehensive plan addressing some of the ongoing challenges raised, particularly around consistency across services. This isn’t a request for new work but rather a call for clear evidence of sustainable improvement, as we would expect from any directorate, to ensure these achievements are maintained over the longer term.</p> <ul style="list-style-type: none"> <li>- Integrated Feedback: CIVICA and FFT data are now used in local ‘improvement huddles,’ aligning patient experience insights with staff input.</li> <li>- PTR and Complaints Trends: Significant drop in PTR cases suggests that user feedback loops are having a practical impact.</li> <li>- Staff Engagement: Pilot schemes (e.g., monthly ‘temperature checks’) aim to gather staff perspectives on key issues, ensuring alignment with patient-centric improvements.</li> </ul>				1184 (P) 1189 (P) 1195 (P)
54	Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.	IQFPD	QSEC	Assure			Sharon Daniel	<p>Based on the documentation, the Health Board demonstrates a structured approach to meeting Duty of Candour requirements. The bi-monthly Quality and Safety Assurance Report to the Quality, Safety, and Experience Committee (QSEC) includes regular updates on Duty of Candour incidents, ensuring that issues are escalated and reviewed within a consistent governance framework. Additionally, the Health and Social Care Quality and Engagement Act Annual Report outlines the Health Board’s adherence to statutory obligations, detailing incidents that triggered the Duty of Candour and the actions taken in response.</p> <p>These processes suggest that the Health Board is actively embedding Duty of Candour principles into its quality and safety culture. Regular updates to QSEC and an annual overview of compliance support a transparent and accountable approach, providing a</p>		<ul style="list-style-type: none"> <li>- Roll out standardised ‘improvement huddles’ in all major directorates by Q3 2024–25</li> <li>- Finalise a comprehensive approach for capturing and acting on staff feedback by Q4 2024–25.</li> </ul>		No risk identified
55	Oversight of safeguarding arrangements to ensure the board have sufficient meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.	IQFPD	QSEC	Assure			Sharon Daniel	<p>The Health Board demonstrates comprehensive safeguarding oversight, structured to ensure delivery against statutory safeguarding responsibilities. The Strategic Safeguarding Working Group (SSWG) regularly reviews safeguarding practices across a wide array of areas—including adult and child safeguarding, mental health, estates, and facilities—and provides updates through the Quality, Safety, and Experience Committee (QSEC). The SSWG’s remit covers critical aspects such as incidents and trends in adult and child safeguarding reports, challenges in mental health and domestic abuse cases, support for looked-after children, and violence against women, domestic abuse, and sexual violence (VAWDASV) initiatives.</p> <p>The regular updates from SSWG to QSEC, along with detailed safeguarding reports, provide the Board with visibility into safeguarding risks, mitigation actions, and service-specific challenges, such as training compliance and staffing gaps within certain sectors. The Health Board has also committed to ongoing capacity and demand assessments to ensure appropriate resourcing for safeguarding roles and responsibilities, including workforce compliance with safeguarding training.</p>				No risk identified
56	Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care. (including the use of patient and staff feedback to influence service design)	IQFPD	QSEC	Alert	Advise	20/03/25	Sharon Daniel	<p>This has remained blank for nearly 12 months. To fully satisfy Criterion 56, future reports should incorporate:</p> <ul style="list-style-type: none"> <li>- Specific reference to National Clinical Audit participation and findings</li> <li>- Evidence showing how Outcome Review Programme data informs service development decisions</li> <li>- Examples demonstrating Value in Health dashboard utilisation in addressing unwarranted variations in practice</li> <li>- Clear linkage between these national datasets and local improvement initiatives</li> <li>- Case studies illustrating how combined data sources drive specific quality improvements</li> </ul>				No risk identified

1.5

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1.5 - Patient Story- Unscheduled Emergency  
Care

*Peter Skitt (Hywel  
Dda UHB - Clinical  
Care Group Service  
Director - Community  
& Integrated  
Medicine), Karen  
Brown (Hywel Dda  
UHB - Health Board  
Clinical Lead for  
Acute Medicine)*

**Attachments**

[Patient Story Urgent Emergency Care \(UEC.pptx\)](#)

# Patient Story - Urgent Emergency Care (UEC)

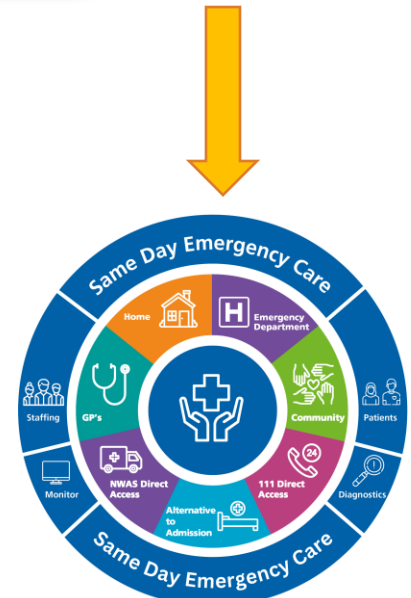
Karen Brown, Health Board Clinical Lead for Acute Medicine

Peter Skitt, Clinical Care Group Service Director - Community and  
Integrated Medicine

# Patient Story, Integrated UEC



CO-LOCATED TO INTEGRATE APPROACHES  
WHOLE SYSTEM SITUATIONAL AWARENESS



# Patient Story, Integrated UEC

- **Advanced Paramedic Practitioner (APP) Navigator** in *Porth Preseli Clinical Streaming Hub (CSH) Multi-Disciplinary Team (MDT)* triaged call on the ambulance stack.
- 72, Male, with shortness of breath. APP called patient, wife reluctant to let her talk to patient, couldn't mobilise, relayed he was talking in partial sentences, purple extremities, upgraded to red call. Spoke to patient, able to speak in sentences, complained of deterioration with breathing over 2-3 months, worse in last 3 days.
- **Welsh Ambulance Service Trust (WAST) Crew** arrived on scene, latter picture much more accurate, patient stable but needed assessment with evidence of fluid overload (legs/ lungs), discussed with Same Day Emergency Care (SDEC) clinical co-Ordinator and accepted for assessment in **SDEC**.
- Known heart failure, not optimised on treatment pillars, little evidence of patient education and support to self-manage, little confidence of patient and wife in having received appropriate management and requesting admission as they didn't feel that people had been listening to their concerns previously. Spent time listening to what matters to the patient, concern with multiple nocturia, poor sleep, spent time educating about salt and fluid restriction, explanation and optimisation of appropriate medications. Given tablet antibiotics for leg infection (due to swelling), increased water tablets, instructed patient to obtain daily weights and shared decision making to admit onto **Hospital@Home virtual ward**.
- Visited by the **Hospital@Home CATCH team** (Advanced Clinical Practitioner & Physician's Associate) 48 hours later, improving clinically, repeat blood tests improving, no clinical requirement to commence IV diuresis. New optimal medications started and referred on to the **community heart failure team** for up-titration and further optimisation. **GP** updated. The patient and wife were happy with the alternative to admission and felt that the wider connected team listened to their concerns and addressed what was required.

## Recommendation:

The Committee are asked to consider the patient story alongside item 2.1 on the agenda.

## 2 - Assurance

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## 2.1 - Unscheduled Emergency Care Deep Dive

***Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Karen Brown (Hywel Dda UHB - Health Board Clinical Lead for Acute Medicine), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)***

### **Attachments**

[2.1 UEC Deep Dive.pptx](#)

[WHC-2024-041 - Letter - Revised ambulance patient handover guidance - Jerem~.pdf](#)

[WHC-2024-041 - Ambulance patient handover guidance.pdf](#)

[Supplement to GIRFT National Report Hywel Dda January 2025 Final.pdf](#)

[GIRFT Action-Plan-Response-Template-Oct-2024 BGH Template- Mar 25.docx](#)

[GGH GIRFT Action Plan March 25 Update \(003\).docx](#)

[Action-Plan-Response-Withybush GIRFT 2025 .docx](#)



# Quality, Experience and Safety Committee Unscheduled Emergency Care Update

**8 April 2025**

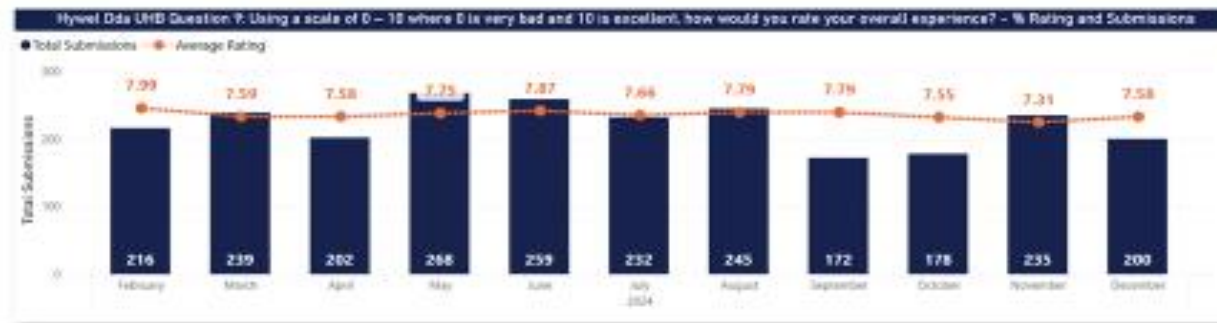
Senior Responsible Officer: Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine  
Executive Lead: Andrew Carruthers, Chief Operating Officer

## Progress with the Six Goals Programme and National Initiatives:

- Patient Experience/Feedback in Emergency Departments (ED)
- Monitor the quality, performance and delivery of Out of Hours/Urgent Care Services
- Deliver the national ambulance patient handover guidance
- Realise more discharges earlier in the day, and increase discharges over the weekend
- Preparing for implementation of Welsh Emergency Care Data Set (WECDS) across local Emergency Departments, Minor Injury Units (MIU) and Same Day Emergency Care (SDEC)
- Urgent primary care capacity
- Implementation of community falls framework: Update on Stats overall position
- Pathways of care and impact of 50-day plan

# Health Board Overview – Patient Experience in ED and National Experience Ratings

## Health Board Overview – People’s Experience in the ED



Average experience rating (for completed surveys only) between Feb-24 to Jan-25 as of 31/01/2025

Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,360	7.71
HDU UHB	2,659	7.69
CVJ UHB	5,759	7.44
BCU UHB	4,893	7.06
SBU UHB	1,115	6.34
ABU UHB	242	6.26
<b>All Wales</b>	<b>26,028</b>	<b>7.45</b>

# Bronglais and Glangwili Patient Experience/Feedback in ED

## Survey: NHS All Wales Questionnaire

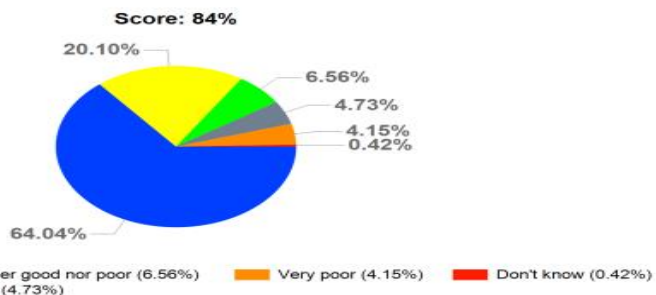
Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

### Results from: Bronglais General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	771	64.04%
Good	242	20.10%
Neither good nor poor	79	6.56%
Poor	57	4.73%
Very poor	50	4.15%
Don't know	5	0.42%
<b>Total</b>	<b>1204</b>	<b>100%</b>



## Survey: NHS All Wales Questionnaire

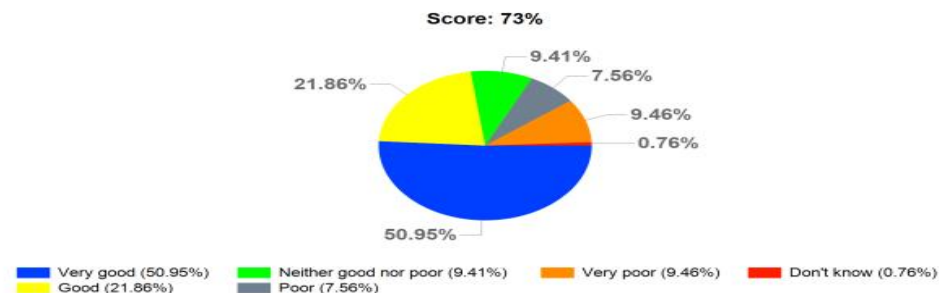
Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

### Results from: Glangwili General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	937	50.95%
Good	402	21.86%
Neither good nor poor	173	9.41%
Poor	139	7.56%
Very poor	174	9.46%
Don't know	14	0.76%
<b>Total</b>	<b>1839</b>	<b>100%</b>



# Prince Phillip and Withybush Hospitals Patient Experience/Feedback in ED

## Survey: NHS All Wales Questionnaire

Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

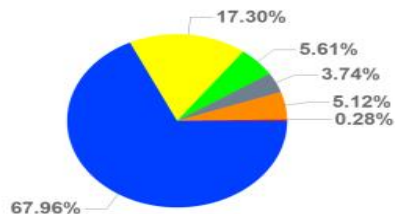
### Results from: Prince Philip Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	982	67.96%
Good	250	17.30%
Neither good nor poor	81	5.61%
Poor	54	3.74%
Very poor	74	5.12%
Don't know	4	0.28%
<b>Total</b>	<b>1445</b>	<b>100%</b>

Score: 85%



Very good (67.96%)    Neither good nor poor (5.61%)    Very poor (5.12%)    Don't know (0.28%)  
 Good (17.30%)    Poor (3.74%)

## Survey Summary Report

### Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 1635

### Survey: NHS All Wales Questionnaire

Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

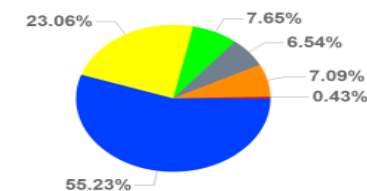
### Results from: Withybush General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	903	55.23%
Good	377	23.06%
Neither good nor poor	125	7.65%
Poor	107	6.54%
Very poor	116	7.09%
Don't know	7	0.43%
<b>Total</b>	<b>1635</b>	<b>100%</b>

Score: 78%



Very good (55.23%)    Neither good nor poor (7.65%)    Very poor (7.09%)    Don't know (0.43%)  
 Good (23.06%)    Poor (6.54%)

# Monitor the quality, performance and delivery of Out of Hours/Urgent Care Services

## Out of Hours Service

- Quality is measured through a 1% audit undertaken by Dr. Richard Archer (Clinical Lead) plus review of concerns and good news stories. These are discussed at monthly Journal Clubs. The Out of Hours move to Primary Care has seen a formal Quality, Safety and Experience group created which has so far met once but are bi-monthly.
- Performance is measured through Priority 1 calls answered timely and within an hour - the target is >90% and this is generally achieved monthly. We review performance through daily and monthly reports. These are being revamped as we have the ability to do more with reporting since our separation of the shared instance of Adastra with Swansea Bay University Health Board (SBUHB).
- Delivery is monitored and assured through a weekly clinical escalation tool which is RAG rated. Recently there has been a consistent level 1 (>90% shift fill). This is reported to Welsh Government and WAST and within the Health Board (HB) at least twice weekly.

(please refer to Clinical Streaming Hub updates further in the presentation for Urgent Care Service information, inclusive of the current evaluation of weekend working, Sam Day Urgent Care (SDUC), and the development of a dashboard for Clinical Streaming Hub activity in Hywel Dda).

# Deliver the national ambulance patient handover guidance

*(Please refer to the attached Ambulance Patient Handover Guidance papers)*

- Hywel Dda University Health Board (HDdUHB) are handling the monitoring and delivery of this through the Emergency Department Quality Statement (EDQS) Action Group. The Welsh Government's Ambulance Handover guidance was recirculated to the EDQS Action Group members in February 2025.
- There is an NHS Executive (NHSE) audit due to be undertaken on the 19<sup>th</sup> of March at Glangwilli General Hospital (GGH).
- In the Six Goals 2025/2026 plan, one of the deliverables within the Safe Hospital Care Workstream is to review the handover process and develop an action plan following on from the recommendations of the NHSE handover audit
- The guidance will be going to the internal Improving Quality, Finance and Performance Delivery (IQFPD) group meeting on the 12<sup>th</sup> of March which links into the formal executive group as a refresh.

## Realise more discharges earlier in the day, and increase discharges over the weekend

- The co-produced Discharge booklet is currently being piloted across hospital sites. Patient Advice and Liaison Service (PALS) have offered resource to support with the feedback from patients on the form and evaluation.
- The Discharge Toolkit (for health board staff) launched on 19 February 2025 with 350 views to date. The Toolkit has been developed to support with discharge management and houses resources, support and guidance relating to discharge planning in one place for ease of access. We have linked with social care to provide regional information
- Criteria Led Discharge (CLD) guidance has been developed and is being piloted in Bronglais General Hospital (BGH), Glangwilli General Hospital GGH, and Prince Phillip Hospital (PPH). There are challenges being addressed with the medical engagement in CLD and the workstream lead is currently planning with the Deputy Medical Director for a way to improve this position and put in place a medical CLD lead for the Health Board.

## Preparing for the implementation of Welsh Emergency Care Data Sets (WECDS) across local EDs, Minor Injuries Unit (MIU) and Same Day Emergency Care (SDEC)

- Awaiting formal confirmation of the SRO for implementation of WECDS in Hywel Dda University Health Board (HDdUHB), this will likely be the ED Clinical lead for the HB.
- A high-level plan has been submitted to the WECDS Project Board, but is essentially wholly dependent on the Digital Health Care Wales (DHCW) plan and the provision of a suitable product.
- Concerns that the minimum viable product being communicated from DHCW will not be of a sufficient maturity to transform the way ED, MIU & SDEC units use a digital system to manage and care for their patients in one the most pressurised stages of our UEC pathway.
- The Health Board have not yet seen or been shown any output from DHCW around what the solution could look like.



# Same Day Urgent Care (SDUC) Activity and Impact



Between 1<sup>st</sup> March 2024 and 28<sup>th</sup> February 2025, the number of patients counted as SDUC activity (which includes those attending the site and those served by the outreach service) totalled 6090.

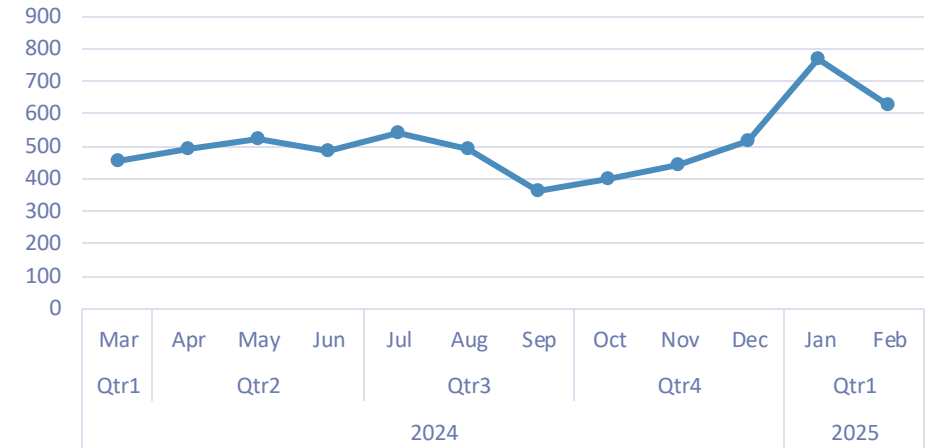
Patients are asked which service they would have used if they had not had access to SDUC: **3520 would have attended GGH A&E, 277 BGH A&E, 176 WGH A&E, 122 Welsh Ambulance Service Trust (WAST) and 1598 Primary Care.**

As a result of the SDUC opening in Cardigan Integrated Care Centre (CICC), there has been a significant increase in demand associated with the MIU service on site. The two services are codependent and rely on provision supported by the District Nursing, Specialist Palliative services and community wrap around services operating 7 days a week.

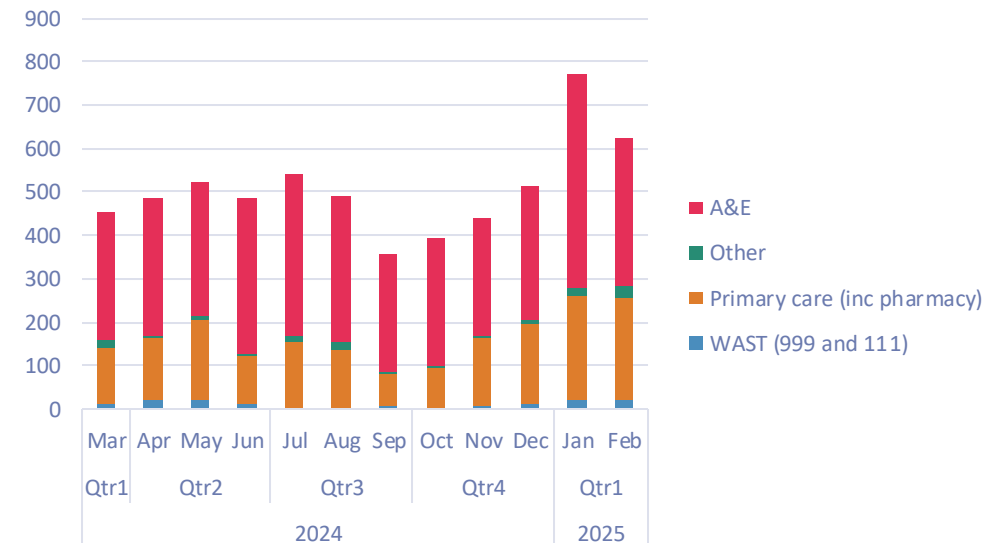
The Welsh Government Falls Response funding has enabled the Same Day Urgent Care and outreach service operating on Saturdays and Sundays since 11<sup>th</sup> January 2025. There is currently an Impact Assessment being undertaken to understand the value of operating the services across the weekends as the 7-day service is planned to cease on Sunday 30<sup>th</sup> March 2025. **Over the seven weekends when the service operated, 327 patients were seen, of those 209 would have attended GGH A&E, 13 BGH A&E, 6 WGH A&E, 19 WAST and 73 Primary Care (if available).**

A further impact of the SDUC and outreach operating 7 days a week with 50 day funding, has been the trial of a **Digital Ward model of care**, where over the two months, **63 patients have been 'virtually admitted'** and cared for at home.

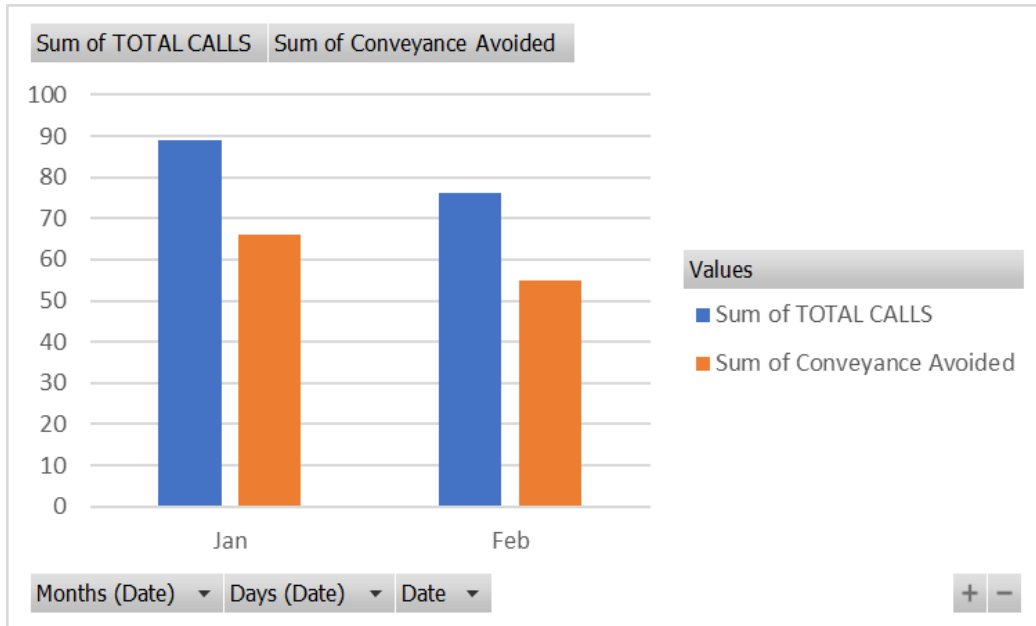
Number of people using the SDUC service



What service would they have used if not SDUC?



# Integration of seven-day Clinical Streaming and community falls framework



The Health Board have integrated the extended community falls provision to seven days through integrating with the piloting of seven-day Clinical Streaming. This has enabled an enhanced level one and level two falls response to be available in Hywel Dda at weekends. The pilot is due to end in March and a comprehensive evaluation will be completed to inform effective future funding models going forward. Initial data is presented below:

- The Clinical Streaming hubs (CSH) have been piloting weekend working since 18<sup>th</sup> January 2025 but operating with limited clinical Multi-Disciplinary Team (MDT) resources. Effective clinical streaming requires multidisciplinary triage to be able to meet the need of the person, be this Clinical, functional, social or mental. Often patients with complex needs require input from more than one professional simultaneously. The MDT should have the correct skill mix to be able to problem solve effectively and address the person's urgent need in an appropriate time frame, and to 'get it right first time'.
- Between 18th January and 23rd February 2025, 165 calls were responded to through the Regional Clinical Streaming Hub and Locality Hubs resulting in avoidance of 121 patient conveyances and potential admissions (Please see adjacent graph, in addition please note that of a total of 121, 7 are assumed over the piloted period due to missing data input).
- The presenting complaint for 36 of these calls were due to falls, 11 of which were dealt with by falls response. There were 10 resulting patient conveyances/admissions and 26 avoided conveyances/admission.
- This data demonstrates that despite operating with limited part-time multidisciplinary clinical resource, there is a significant number of responses including advice and treatment and resulting admission/conveyance avoidance.
- Additionally, SDUC was available in Ceredigion with a total of 452 patient contacts during this period.

# Pathways of Care Delays (POCD) and impact of 50-day plan

A POCD lead has been identified for the Health Board

The Q4 POCD Action Plan has been developed and submitted to National

There is a regional integrated monthly validation meeting in place

There has been a continuous improvement of Discharge to Recovery and Assessment (D2RA) pathway allocation since the Programme Workstream launched

A Hywel Dda Trusted Assessor Steering group has been established in order to provide a forum to share learning, monitor Trusted Assessor reports submitted to the POCD group and regularly review and evaluate the Trusted Assessor models in action across Hywel Dda

All DPOC data is pulled from the data system Frontier and validated as a region instead of each county

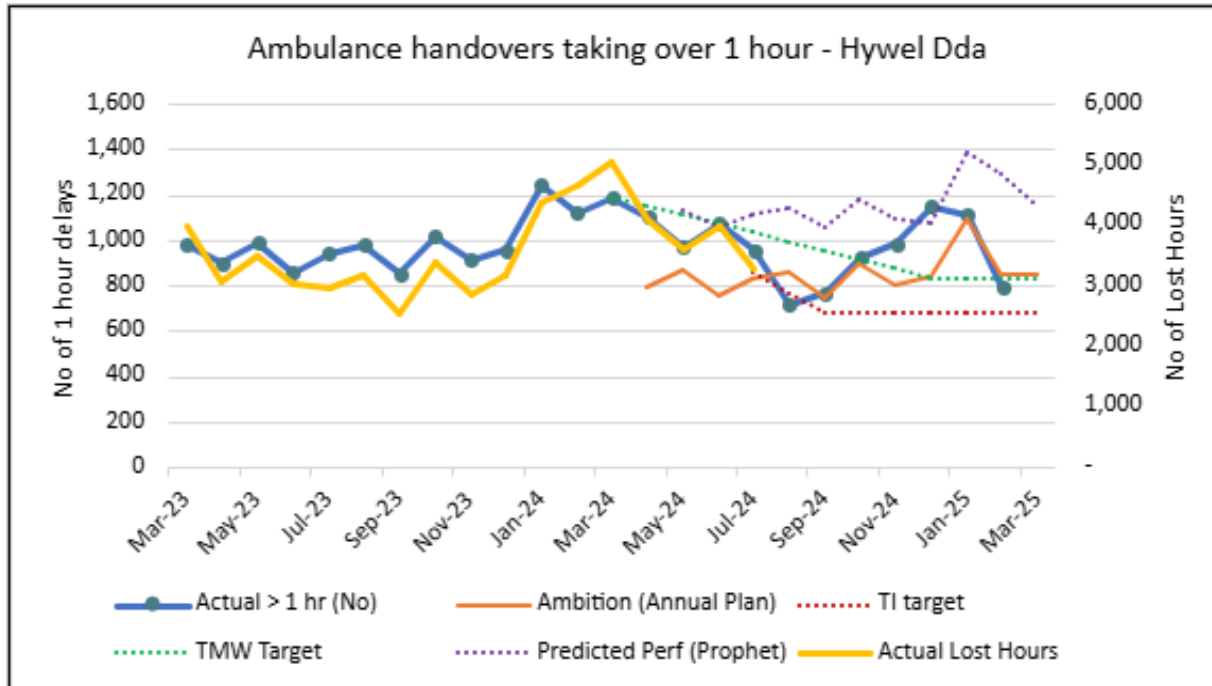
The Red2Green dashboard is now live which identifies pre clinically / clinically optimised constraints which will feed into site improvement plans

County wide escalation plans to review long length of stays (integrated with local authority). Scheme 5, regional meeting to discuss 21-18 days and the 20 longest Length of Stay (LoS) patients across region (weekly)

	Top 25% longest delays on 11 <sup>th</sup> November	Discharged by Dec 31st	Discharged by 24 <sup>th</sup> Jan	Remain delayed at 24 <sup>th</sup> Jan	Discharged by 4 <sup>th</sup> March	Remain delayed on 4 <sup>th</sup> March	Of those who remain delayed - No/% with discharge plan
West Wales	50	30 (60%)	8	12	8	4	None with a confirmed discharge date, 3 court of protection cases

# Performance

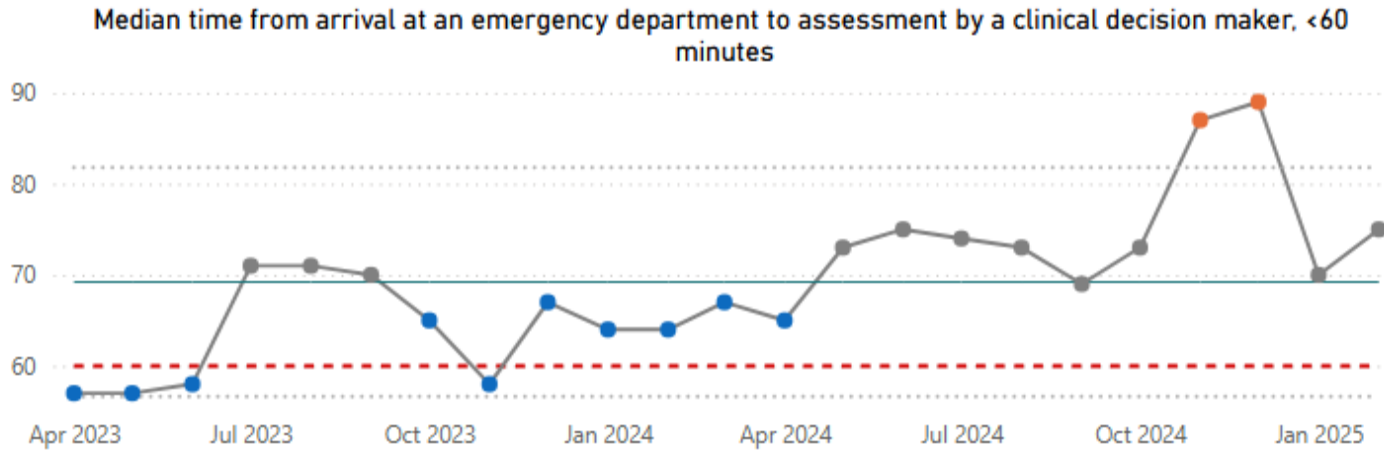
- Ambulance patient handover performance
- Time to assessment
- Waits in ED
- Safety and oversight of the waiting room
- SDEC activity and impact



## Health Board, 1 Hour Ambulance Handover

- Actual number of handover delays for February 2025 was 795
- HDdUHB are below annual plan target of 846 by 51, but above Targeted Intervention (TI) target of 680
- An improving position since December 24
- In year trend shows improvement, January 2024 had the highest reported Ambulance Handover >1hr number at 1245. February 2024 actual was 1124.

# Time to assessment



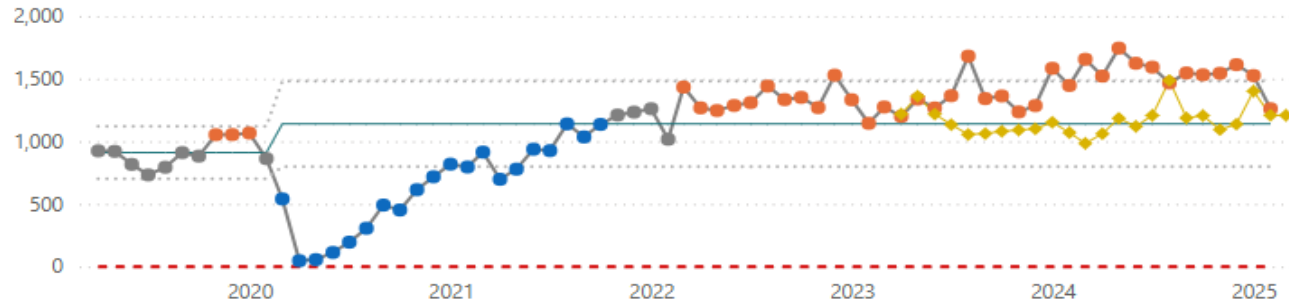
## Health Board Median Time to Assessment by a Clinical Decision Maker

- Actual median time to assessment for Feb 2025 is 75 minutes.
- This is above the TI target of 60 mins and an increase of 5 minutes from the previous month
- Increasing trend evident for the year.
- The Health Board are ringfencing triage and treatment rooms in EDs to ensure improvement in this area.

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025	60	Lower	75.0	●	■	

# >12 Hour Waits in ED

Number of patients who spend 12 hours or more in A&E / MIU



## Health Board 12-Hour Emergency Department Breaches

- Actual number of patients waiting >12 hours in ED for February 2025 was 1260
- HDdUHB are just above annual plan target of 1208
- Improving position since December 2024
- In year trend shows an improvement, February 2024 actual number of patients waiting >12 hours in ED was 1446

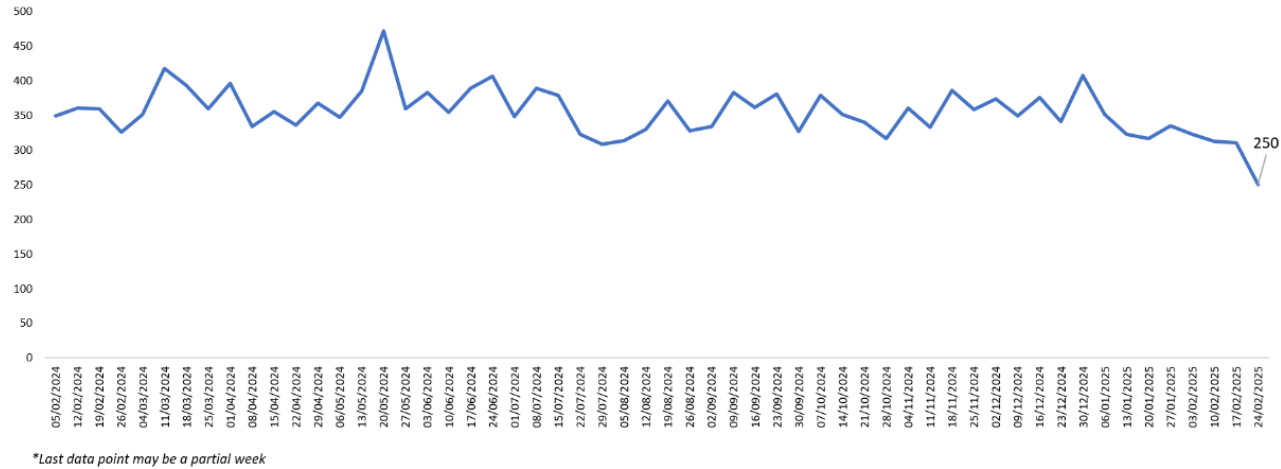
Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025	0	Lower	1260.0	●	■	◆



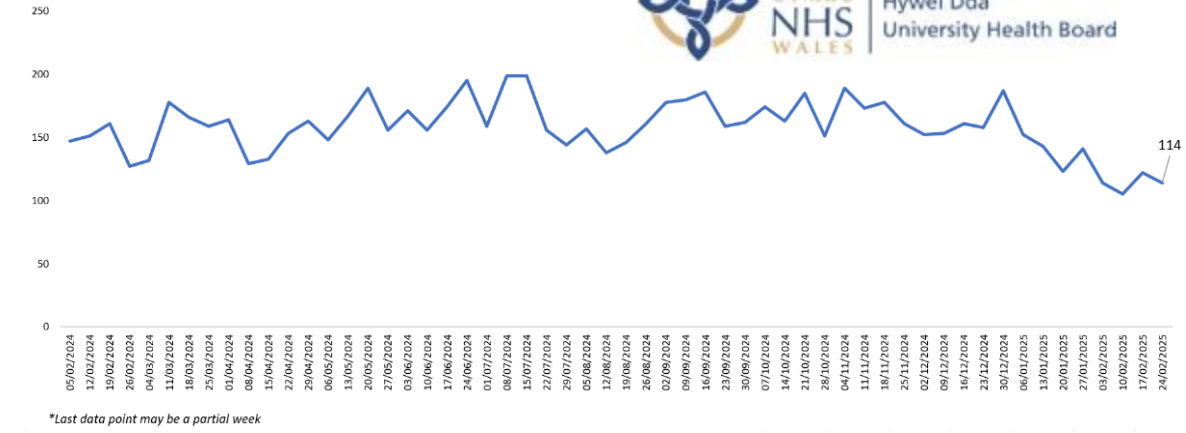
# >12 Hour Waits in ED – By Site - TUEC



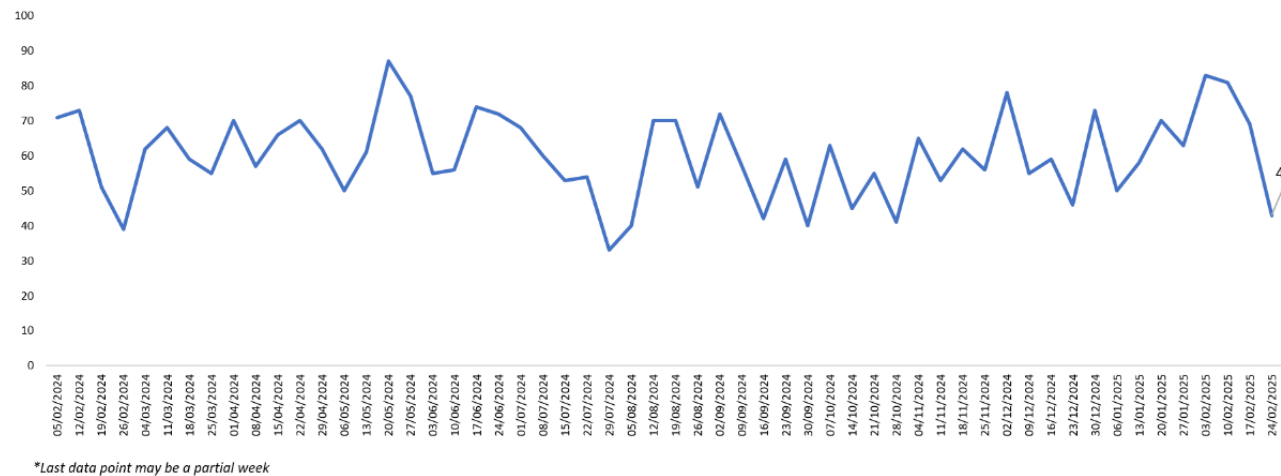
## HDUHB



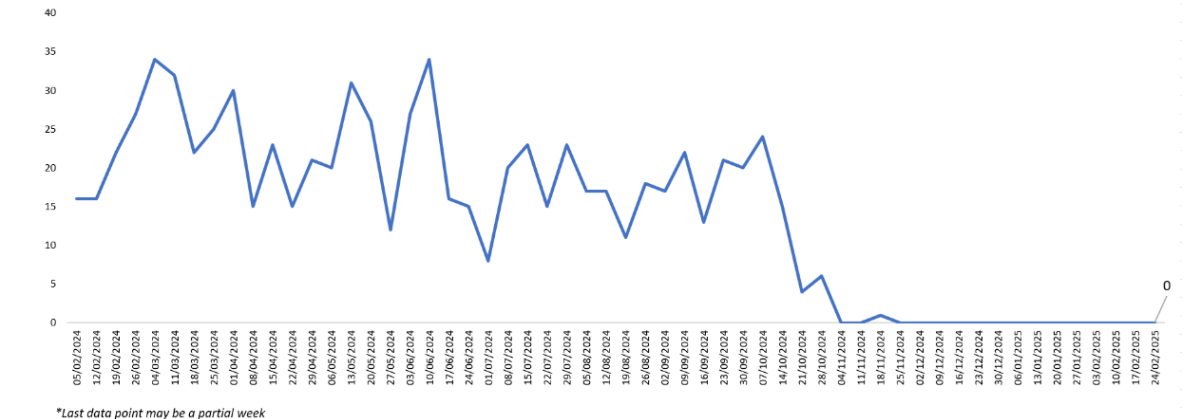
## GGH



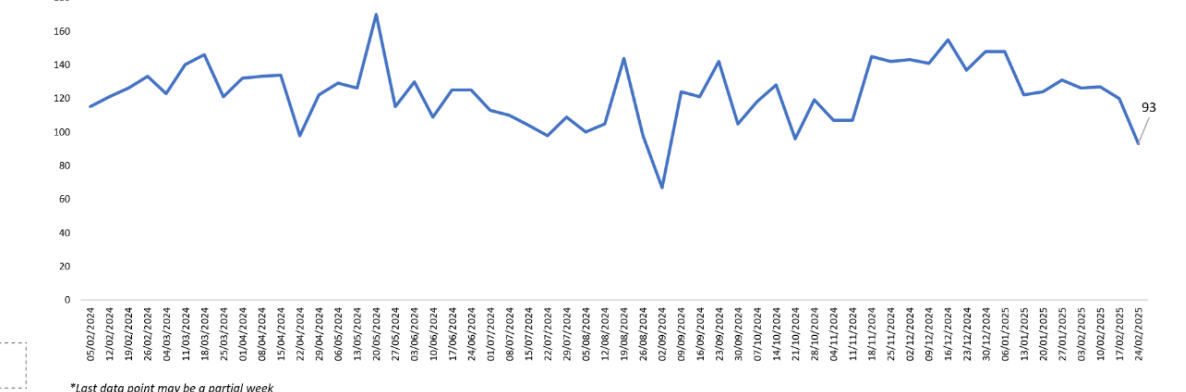
## BGH



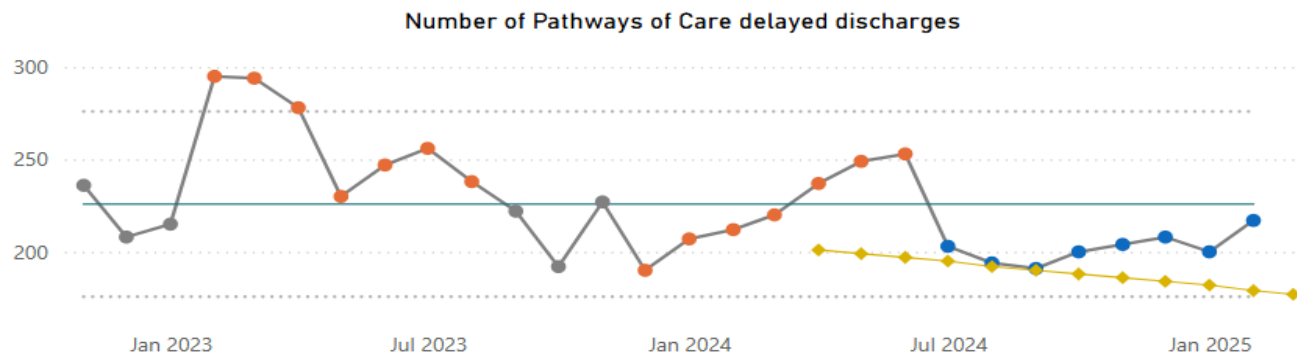
## PPH



## WGH



# Pathway of Care Delays



- The Health Board continue to work on position with the support of the National Team
- There remains a number of Court of Protection Cases within the numbers which are challenging given court timetables

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025		Lower	217.0	●		◆

	Top 25% longest delays on 11 <sup>th</sup> November	Discharged by Dec 31st	Discharged by 24 <sup>th</sup> Jan	Remain delayed at 24 <sup>th</sup> Jan	Discharged by 4 <sup>th</sup> March	Remain delayed on 4 <sup>th</sup> March	Of those who remain delayed - No/% with discharge plan
West Wales	50	30 (60%)	8	12	8	4	None with a confirmed discharge date, 3 court of protection cases

# Safety and oversight of the waiting room

## Glangwilli Hospital (GGH)

- ED Safety Huddles, capturing all waiting room patients
- Patient flow huddles throughout 24-hour period, discussing demand v capacity for all patients awaiting admission
- Patient flow meetings highlight any patients of concern in the ED waiting room
- N&H stickers for patients offered food and drink in waiting room
- Generic handover form between each shift covering all waiting room patients
- Red cross monitor and assist with waiting room patients, offering food and drink.
- Allocated front of house team for all waiting admission/triage (4RN + 2HCSW, split between triage, PIT stop and zone C waiting room)
- Triage and Initial Assessment SOP in place
- Chest pain flow chart in place
- - Rather than GP expected medical referrals coming through to ED (in hours) and then spend long periods within ED – they are now streamed all through medical SDEC to support timely assessment, investigation, and management relieving some pressure within waiting room. We have the data to demonstrate this impact and relief on ED.
- - Streaming all other speciality patients also away from ED and the waiting room to the clinical areas.
- - Implementation of the weekly ED Big Room incorporating new ideas, managing risk and patient safety concerns.

## Bronglais General Hospital (BGH)

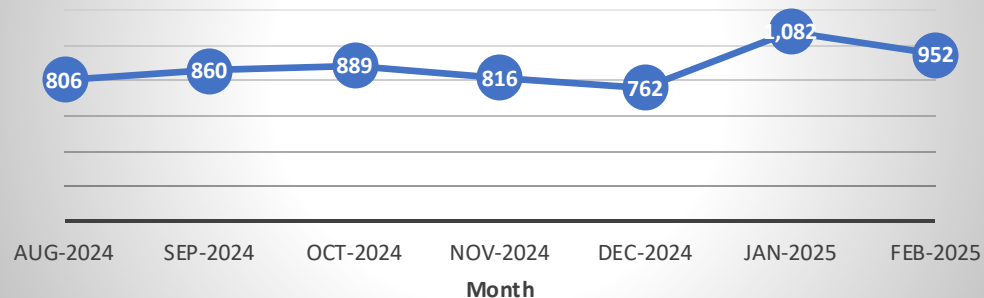
- Triage in place
- Short stay assessment being trialled
- Allocation of a staff member to the waiting room if possible
- Patient information in relation to waiting times and access to food and drink
- Daily 12:30 MDT board round
- All areas risk assessed

## Withybush Hospital (WGH)

- Triage escalation process to ensure the triage wait time remains around 15 mins
- Triage and doctor wait times escalated on the site safety meetings to review if additional support required.
- Identification in triage of patients suitable for streaming to SDEC, SAU
- Nursing allocation to waiting area: Registered Nurse allocated with HCSW support to oversee waiting area.
- Regular observations undertaken as per individual need in waiting area.
- Staff aware to escalate any patients of concern to Nurse in charge who will then need to be brought into the main unit.
- Senior sister on all shifts 24/7 for senior oversight and support.
- Poster in waiting room to advise relatives/ patients to alert reception if any concerns who will contact nursing staff.
- Diet and fluids and support with fundamental care as required by HCSW. Area will be used within unit that patients can be taken to away from the waiting room for privacy.
- Monday- Friday in reach into ED by medical consultants/ specialities to review all patients awaiting their service and formulate treatment plans
- Pathways to FAU, SDEC and SAU promoted when able to reduce waits in waiting room.
- Consultant connect/ Porth Preseli/ intermediate care teams supporting hospital avoidance and/or planned attendance to alternative routes such as SDEC, Hot clinic
- Utilisation of boarding as per protocol
- Utilisation of surge across the acute site
- Huddles within ED to raise awareness of case-mix of patients

# SDEC activity and impact

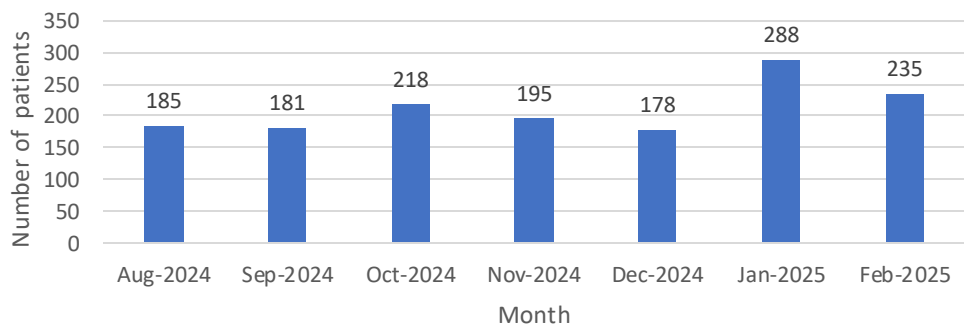
**Number of patients counted as SDEC Activity at GGH, PPH and WGH by month from 1st August 2024 to 1st March 2025**



## SDEC Activity:

- Between 1<sup>st</sup> August 2024 and 1<sup>st</sup> March 2025, the number of patients counted as SDEC activity by month across GGH, PPH and WGH has remained relatively static, however there is a noticeable peak at 1,082 patients in January 2025. Please see adjacent graph.
- Within this period, the mean number patients counted as SDEC activity by month across GGH, PPH and WGH has been 881.
- Between 1<sup>st</sup> August 2024 and 1<sup>st</sup> March 2025, December 2024 had the lowest number of patients (762) counted as SDEC activity across GGH, PPH and WGH and January 2025 had the highest number of patients (1082) counted as SDEC activity.

**Total number of patients leaving same day from SDEC (who were referred from ED/MIU) at GGH, PPH and WGH by month from 1st August 2024 to 1st March 2025**



## Same day discharge:

- Between 1<sup>st</sup> August 2024 and 1<sup>st</sup> March 2025, there has been fluctuation in the total number of patients leaving the same day from SDEC (who were referred from ED/ MIU) across GGH, PPH and WGH. Please see adjacent graph.
- Within this period, the mean number of patients by month leaving the same day from SDEC (who were referred from ED / MIU) across GGH, PPH and WGH has been 211.
- Between 1<sup>st</sup> August 2024 and 1<sup>st</sup> March 2025, Dec 2024 had the lowest number of patients (178) leaving the same day from SDEC (who were referred from ED / MIU) across GGH, PPH and WGH and January 2025 had the highest number of patients (288).

An increasing trend in both graphs is evident, indicating that over the last 6 months increasing numbers of people are utilising SDEC Services and an increase in numbers being discharged

# Actions Taken

- Progress on reducing the length of stay at Withybush hospital
- Delivery of the optimal hospital flow framework
- Get it Right First Time (GIRFT) reports
- Ministerial Advisory Group actions

# Progress on reducing the length of stay at Withybush hospital

**Occupied bed days for patients aged 18+ with a LOS over 21 days**



**Emergency admissions with a LOS > 21 days, patients aged 18+**



The above graph indicates an improving position since January 2025 for WGH Length of Stay (LOS) Measures. The actions currently being undertaken at WGH to maintain and improve this position further are as follows:

- Weekly system escalation meetings in place to consider any pathway delays across acute and community to troubleshoot
- Weekly review of people with a LOS of over 21, 50 and 100 days. This inpatient cohort is reported to Execs on a weekly basis.
- Deep dive fishbowl process on 100-day LOS across site to identify themes of delay, action learning focus further escalation as required.
- Strengthening our integrated working between enhanced community services and acute sector to facilitate earlier, safe, supported discharge through our clinical streaming hub mechanisms.
- A Discharge Toolkit and checklist are in use at WGH to support staff involved in discharge planning
- A Discharge Booklet has been developed and is being piloted at WGH
- Scrutiny panels in place in Local Authorities, right sizing of packages, signposting, third sector support established to minimise delays and support assessment processes.
- Areas of Alternative capacity under review to reduce delays in those awaiting Community Care

# Delivery of the optimal hospital flow framework

- A quality impact assessment and Equality Impact Assessment (EqIA) has been produced for the ED MIU Redirection Policy which is due to be tabled at Quality Impact Assessment (QIA) panel on the 24<sup>th</sup> of March
- Each site has an Optimal Hospital Flow Framework implementation plan with delivery supported by the Quality Improvement Support Team (QIST) Team. A lead for the optimal hospital flow framework has been identified on each site to support engagement and implementation.
- There has been a refocus on the Hospital site meetings to provide structure and monitor data.
- The Red2 Green Dashboard is live which identifies pre clinically / clinically optimised constraints and is being used to drive improvement work across sites.
- Criteria Led Discharge (CLD) guidance is being piloted in a phased approach across the Health Board
- There has been a continuous improvement of D2RA measures since the Programme Workstream launched
- The co-produced Discharge booklet was taken to the Health Board Talking Health Group for feedback and is currently being piloted across hospital sites. PALS have offered resource to support with the feedback collation.
- The Discharge Toolkit (for health board staff) was launched on 19 February 2025 with 350 views to date. The Toolkit has been developed to support with discharge management and houses resources, support and guidance relating to discharge planning in one place for ease of access. We have linked with social care to provide regional information.
- A SharePoint page is established to house access to the optimal hospital flow framework, which to date has 1000+ views
- Hywel Dda representatives attend the National Policy Goal meeting to share learning with other Health Board's
- Deconditioning materials i.e. posters, leaflets have been developed and taken to the Talking Health Group for feedback. These are currently being disseminated across wards in the Health Board.
- The current escalation sit rep meetings are being reviewed to support actions to drive effective optimal flow
- Boarding Protocol updated and ratified

## ED Getting it Right First Time (GIRFT) reports

The Health Board are uploading all ED GIRFT reports to the Audit Management and Tracking system (AMaT). Going forward GIRFT reports will be regularly submitted to the Integrated Quality, Financial Performance Delivery Group (IQFPD) and managed through the Safe Hospital Care Workstream. Please refer to the attached plans and following summary reports against progress for each site



# Progress against the recommendations following the GIRFT reports – Bronglais Hospital



Recommendation	Completed Action
<p>We recommend that the site introduces a manager of the day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position.</p>	<p>A new job description has been prepared and is currently subject to job evaluation within the HB. This role encompasses the MOD responsibilities and will provide additional ‘supernumerary’ support and oversight to the clinical practising team and act as a conduit between triumvirate leads and silver command structures.</p>
<p>The hospital would benefit greatly from an SDEC Unit to assess and turnaround patients the same day. Review Demand &amp; Capacity of medical and surgical patients being streamed through Bronglais. Current MIU footprint would be ideal to establish SDEC which only had 1 patient in when we visited.</p>	<p>The BGH site is significantly constrained in terms of available capacity to support a dedicated SDEC function. However, 2 bays within ED have been repurposed to provide medical assessment functionality for EAU presentations at present, in the region of 30 patients per day are being seen. MIU does not hold sufficient capacity and routinely supports surge pressures within the unit when the hospital is functioning at high levels of escalation</p>
<p>We recommend an immediate review of the Nurse in Charge (NIC) role, as the current demands are unsustainable and pose significant human factor risks to those in the position. The NIC cannot effectively oversee two departments, provide direct patient care and be responsible for taking primary care referrals</p>	<p>A nursing workforce plan has been developed in support of improved staffing levels within the ED to include supernumerary roles. The NIC role is being assessed as part of a revised incremental approach to improving nurse staffing- balanced against the ongoing vacancy already registered within the Dept.</p>
<p>We recommend that with immediate effect, safety huddles are routine practice throughout the day within the emergency department.</p>	<p>Board rounds (safety huddle) now operational within the ED, supported by the site manager team- plans confirmed and issues raised in relation to flow/ constraints within the dept.</p>
<p>Hospital workforce:            Review of footprint, workforce, and service provision.            Ensure succession planning in place to support staff retiring.            Review workforce to include Acute Physicians, Frailty Specialists, Advanced Nurse Practitioners, Physician Associates, ED Clinicians, Pharmacists, and Therapists.            Review HCSW bank/agency support as a first line.            Review student placements – is it safe?            Review incentives to attract future employees to the area.            Financial review of agency/locum spend aligned to providing incentives for permanent staff recruitment.</p>	<p>2 cohorts of Internationally Educated Nurses (IEN) have now commenced across the site and are subject to obtaining their OSCE and NMC registration.</p> <p>Emergency Nurse Practitioner (ENP) and Advanced Nurse Practitioner (ANP) framework in place. Intention of Minors injuries Unit becoming nurse led. 2 Clinical Nurse Practitioner (CNP) completing ANP and one Clinical Nurse Specialist (CNS) now completed ANP. 1 CNS undertaking thorough annex 21.</p> <p>Medical workforce stabilisation programme has commenced (led by Deputy Director of Workforce) in order to improve workforce intelligence and to identify gaps in resources. Medical Stabilisation will support with improving workforce intelligence in relation to succession planning</p> <p>Workforce plan in development which addresses issues of recruitment and retention</p>
<p>Strong leadership with a triumvirate of Clinical, Operational and Informatics is required to improve the flow in the system. Improve the communication across all levels in the organisation. Review leadership principles in the organisation to ensure staff are motivated and empowered to deliver the UHBs values and strategy. Ensure that leadership vacancies are made attractive and are filled asap.</p>	<p>Acting General Manager in place since October 24, supporting wider Triumvirate team in these actions. Wider Operational Directorate organisational restructure is continuing with appointments into vacant positions anticipated by Q1 24/25</p> <p>In collaboration with relationship managers, improvements are being made in terms of communication where possible. Teams or service and partnership forums etc.</p>

# Progress against the recommendations following the GIRFT reports - Bronglais Hospital

Recommendation	Completed Action
<p>We recommend that the HB considers including the risk and pressures within the ED department and the WAST position, community risk and pressures in their sitrep document. This will enable this position to be communicated widely in one document to relevant individuals across the organisation and produce a whole system view of the site.</p>	<p>HB Sitrep document details hospital escalation levels as well as specific departmental breakdown (demand, unallocated and unplaced patients, performance metrics etc). This is reviewed in a HB wide meeting held as a minimum of twice per day. The BGH sitrep meetings (x3 per day) feed the documentation and the HB sitreps also provide opportunity for verbal narrative etc.</p>
<p>We recommend that the site considers reviewing the site escalation process to include boarding against query discharges after boarding against confirmed discharge had taken place in times of high escalation.</p>	<p>The site has (in December 2024) identified 10 areas where Boarding can be supported across the site, in line with the boarding policy. It should be noted that the BGH estate does not lend itself well to this, and some areas (such as toilet areas) have had to be converted to support. IP&amp;C constraints also impact the availability of space as does the wider hospital discharge position, lack of discharge lounge and other factors such as staff absence. However, this increase, led by the Head of Nursing, marks a significant improvement in the boarding capacity.</p>
<p>The Health Board could look at the utilisation and occupancy of discharge lounge on a daily basis as a performance Key Performance Indicators (KPI) to embed the early and proactive use of the facility as much as possible.</p>	<p>Th Triumvirate team is about to (Jan 2025) embark on a review of the pathways at the Hafan Y Wain facility, offsite from BGH. The purpose of the review is to improve flow, and to improve on-site capacity within BGH. The re-development of the Y Banwy ward foot print may lend itself to the development of a small discharge lounge. The triumvirate team acknowledge the importance of this facility and will work to establish as soon as possible.</p>



# Progress against the recommendations following GIRFT reports, Glangwili Hospital



Recommendation	Completed Action
Options are explored in terms of the location of the ED huddle whilst acknowledging the challenges the teams are facing with capacity within the department	Huddle has been moved to Glass office within Emergency Department
When discussing patients, initials or bay/trolley numbers are only used to identify the patients rather than full names	Trolleys are now numbered and initialised with any risks identified.
The IDT are present at the morning patient flow meeting with the view that suitable patients can be identified and a prompt decision can be made to 'pull' them out into the community setting	Review of attendance to Patient Flow meetings to maximise community 'pull' complete - IC MDT engagement/Virtual Ward are now included
Greater senior nursing input and oversight on the wards supporting and challenging ward activity The Manager of the Day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position	Full compliance with PG5 Principles - Red & Green, Board rounds, Frontier - D2RA. Peer review and monitoring by SNM Team. TUEC Assurance meeting now set up monthly to monitor progress. Full QI support.
The Manager of the Day (MOD) that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position	<p>Reviewed MOD Role and responsibility as well as that of SNM and Clinical Site Manager - with key focus on Optimal Flow. Reviewed OOH support and cover.</p> <p>Omitted duplication with SNM and MOD role. Chain of escalation for patient flow concerns to Clinical Site Manager initially. Escalated to MOD if no resolution.</p> <p>MOD will be visible as part of patient flow hub.</p>
The HB escalation process and action cards are explicitly clear to all relevant personnel within the hospital to ensure that there is a consistent and clear approach adopted throughout the hospital	<p>Emergency Pressures and Escalation Policy readily available.</p> <p>Additional focus work on Major Incident action cards specific to role and responsibilities.</p>
Review the site escalation process to include boarding against query discharges after boarding against confirmed discharge had taken place in times of high escalation	Patient Boarding Protocol in place and being utilised. Monitored Daily. Review of effectiveness of this to be undertaken. Boarding protocols in place and board at extreme risk currently.
The IDT and staff from Discharge Lounge attend this meeting to identify patients who may require the input of these teams early, with the aim to arrange an early review from the IDT and/ or a review from the discharge lounge team to review their suitability of a patient to move to the lounge when it opens the following day	Review of attendance at Patient Flow Meeting. IC MDT/Discharge Liaison Team and Discharge Lounge all attend

# Progress against the recommendations following GIRFT reports, Glangwilli Hospital

Recommendation	Completed Action
<p>An intelligent suite of measures are captured and regularly scrutinised by clinical, managerial and executive teams to assess outcomes, experiences and value in emergency departments, with appropriate escalation and actions taken aligned to local and national improvement planning.</p>	<p>Linked to GGH 12 Week Plan Data Capture and Review</p>
<p>In most of the EDs of Wales, large numbers of ED nurses are engaged for long periods in caring for patients who are waiting for an inpatient bed. (This effectively reduces the number of nursing staff that are available for core emergency work.) There should be a formalisation of these arrangements, with a senior nurse responsible for the care of specialty patients. (This, of course, is a temporising measure for reasons of patient safety, until the problems of delays for inpatient admission can be resolved.)</p>	<p>Additional support at night due to surge within ED – medical agency nursing (not ED rates).  Currently fully established RN.</p>
<p>Many EDs are dependent on locum doctors, especially for their middle grade rotas, and also bank nurses. Conditions of service should be offered that tempt these staff to accept longer-term contracts, wherever possible, whilst remaining cognisant of local financial pressures. Senior and junior rotas for both medical and nursing staff should be reviewed to ensure adequate out-of-hours cover for EDs at all times.</p>	<p>Only one Locum Consultant in post (currently acting Clinical Lead for unit). Efforts always in place to offer contracts.  Completed</p>
<p>A column is added to the sitrep report to input confirmed discharges for the following day, so those identified patients can be 'pulled' to discharge lounge as soon as it opens, releasing early capacity that can be utilised</p>	<p>Column available on Sitrep to capture next day discharges.  20<sup>th</sup> December met with NHS Exec to go through plan  Overarching 12 –week plan</p>

Recommendation	Completed Action
Clinical and patient safety risk- There were SDEC patients paper notes in a locked filing cabinet that had been there for three months and were waiting to be added to the patient’s medical records. Advised that there was no administrative support.	Meeting undertaken with Medical Secretary Coordinator on 30th Sept to review options for admin support for SDEC department - 8 hours now allocated per week. Will re-review scope of admin support from MIU once overnight closure is actioned to.
Clinical and patient safety risk- Medical Register receives calls to accept referrals over the phone, these are not documented anywhere	Call logging sheet introduced to record information given by referring medic. Documents stored for a month's period in the SDEC department. Documents include time and date of call patient symptoms and reason for referral to SDEC service and the discussion notes in relation to suitability and criteria.
A variety of different clinics using the space in SDEC therefore difficult to plan daily activity. Workforce sessional support sporadic- some days are consultant lead some days are GP lead. Locum use to cover sickness and leave	Review of frequency/purpose of clinics identifying impact on SDEC capacity e.g. virtual clinics. Scope alternative areas to support clinics to maximise SDEC activity.
SDEC waiting room not visible to clinicians or staff members. A mixture of SDEC, MIU and outpatients sit in the same waiting room. At 6pm the OH GP patients that include children also use that waiting area.	Front of House Task & Finish Group in place to progress and explore all options.
SDEC opening times 10am – 8pm Staff coming in early as patients are being directed to SDEC from 8:30 and there is cross cover with GP OHS and MIU	Review of opening hours is being undertaken as part of the MIU overnight closure. GP OOH also being relocated as part of the MIU closure. Full review to follow. Combined review function of SDEC at PPH & GGH.
High number of MDU activity currently being seen in SDEC. A service need but not SDEC activity.	Review of Geri Day activity to scope ability to remodel as a Medical Day Unit to support activity - scoping via Front of House T&FG.
Staff not aware of how to follow up activity that is captured on the system. There is currently an internal methodology used by some staff but not all	Review of data capture and performance to determine next steps of SDEC & MDU activity split.

# Progress against the recommendations following the GIRFT reports – Prince Phillip Hospital

Recommendation	Completed Action
Frailty Support given by TOCALs team but they cover the whole Hospital and require direct referral	Discussed within Front of House T&FG. Frailty ANP on-boarding - awaiting start date. Frailty team pathway started. ANP recruited and recruitment of Physio and OT underway with in-reach into AMAU front door. SOPs agreed. Plans for dedicated FAU on ward 3 underway.
AMAU advised that the unit is unique and not seen as one similar across the UK	Acute Medical admission criteria for AMAU has been shared with WAST. AMAU SOP completed and in place. Fully functional Resus unit within AMAU with support from Acute Medical Physicians.
AMAU - all areas are being used for surge capacity and the corridor	Review of AMAU Side Room to support IP&C risk - captured within twice daily patient flow meeting/ AMAU patient safety huddles. Boarding against definite discharges to reduce surge within AMAU. Review of patient flow - through daily board rounds, PG5 principles, Red & Green, D2RA, Criteria Led Discharge. Escalation review of Clinically Optimised patients twice weekly. Close collaboration with IC MDT and Virtual Ward usage.
Minor injury unit (not visited) But advised that it was open 24 hours a day and staffed by GP's and lead clinicians	MIU temp Overnight Closure 1st November 2024 – open 8:00am to 8:00pm with staff finishing at 10:00pm. Steering group in place to look at future service model.

# Progress against the recommendations following the GIRFT reports – Withybush Hospital (WGH)

Recommendation	WGH Action Updates
<p>There was clear evidence to suggest that discharge activity occurred later in the day at WGH. We recommend that the Health Board explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.</p>	<p>As part of the 6 Goals Programme, Safe Hospital Care Workstream. The Optimal Hospital &amp; Patient Flow framework plan for WGH is to review and optimise the use of the discharge lounge and review discharge data.</p>
<p>We recommended that Porth Preseli is expanded to a 7 day service as a priority, recognising that workforce constraints will be a challenge.</p>	<p>This is being reviewed as part of the WGH Winter Plan/Annual Plan and the 50-day Cycle. However, expanding to 7-day service would require funding.</p>
<p>We recommend the Health Board considers changing the approach it adopts to patient flow. We recommend a model where the patient flow team act as a central hub and the role of information gathering and responding to actions to create capacity is the responsibility of a designated lead for each service group.</p>	<p>As part of the 6 Goals Programme, Safe Hospital Care Workstream. There is a plan in place and being implemented for the Optimal Hospital &amp; Patient Flow framework plan for WGH.</p> <p>Ringfencing a resuscitation room, ringfencing RATS room, a Triage room and second Triage which can then be utilised for ED flow</p>
<p>We recommend that the Health Board reviews the workforce model within the patient flow team. Suggestions in report (point 17)</p>	<p>We will continue with the current model due to demand and footprint of WGH</p>
<p>We recommend that the Health Board revisit the Optimal Flow roll out plan and, supported by the QIST Practitioners, ensure a consistent application of the Optimal Flow Framework across all wards at WBH within clear and achievable time scales</p>	<p>As part of the 6 Goals Programme, Safe Hospital Care Workstream. There is a plan in place and being implemented for the Optimal Hospital &amp; Patient Flow framework plan for WGH. This is being supported by the QIST Team and Senior Nurse Management Team. Fortnightly meetings are held with the site to monitor progress and identify areas of support from the 6 Goals Programme.</p>
<p>We recommend that there is greater senior nursing leadership presence in all areas until complete assurance regarding the implementation of the optimal flow framework is embedded.</p>	<p>A Senior Nurse Manager has been identified as Lead for the Safe Hospital Care: Optimal Hospital &amp; Patient Flow framework for WGH supported by the Hospital Service Manager and QIST.</p>
<p>We recommend that the senior leaders within the organisation endorse the implementation of the framework and promote a culture shift within the hospital that sees some current practices and ways of working challenged (this one is a Six Goals Team to do).</p>	<p>There has been significant improvements in D2RA data.</p>
<p>We also strongly recommend that as a priority the TUEC group delivery group meetings are reinstated. (this one is a Six Goals Team to do)</p>	<p>This is an action for the 6 Goals Programme.</p>
<p>Re LOS meetings in WWG we recommend that the health board continue to communicate and provide assurance through robust action plans into the goal 6 programme structure. Re LOS meetings in WGH we recommend that the HB review the structure of this meeting and its chair. We also recommend that the content of the meeting is reviewed to ensure that it is action focussed, and processes are put in place to ensure actions are followed up and completed</p>	<p>This has been actioned. The Length of Stay meeting structure has been reviewed and is co-chaired by acute and community SNM.</p>

# Ministerial Advisory Group actions (GGH)

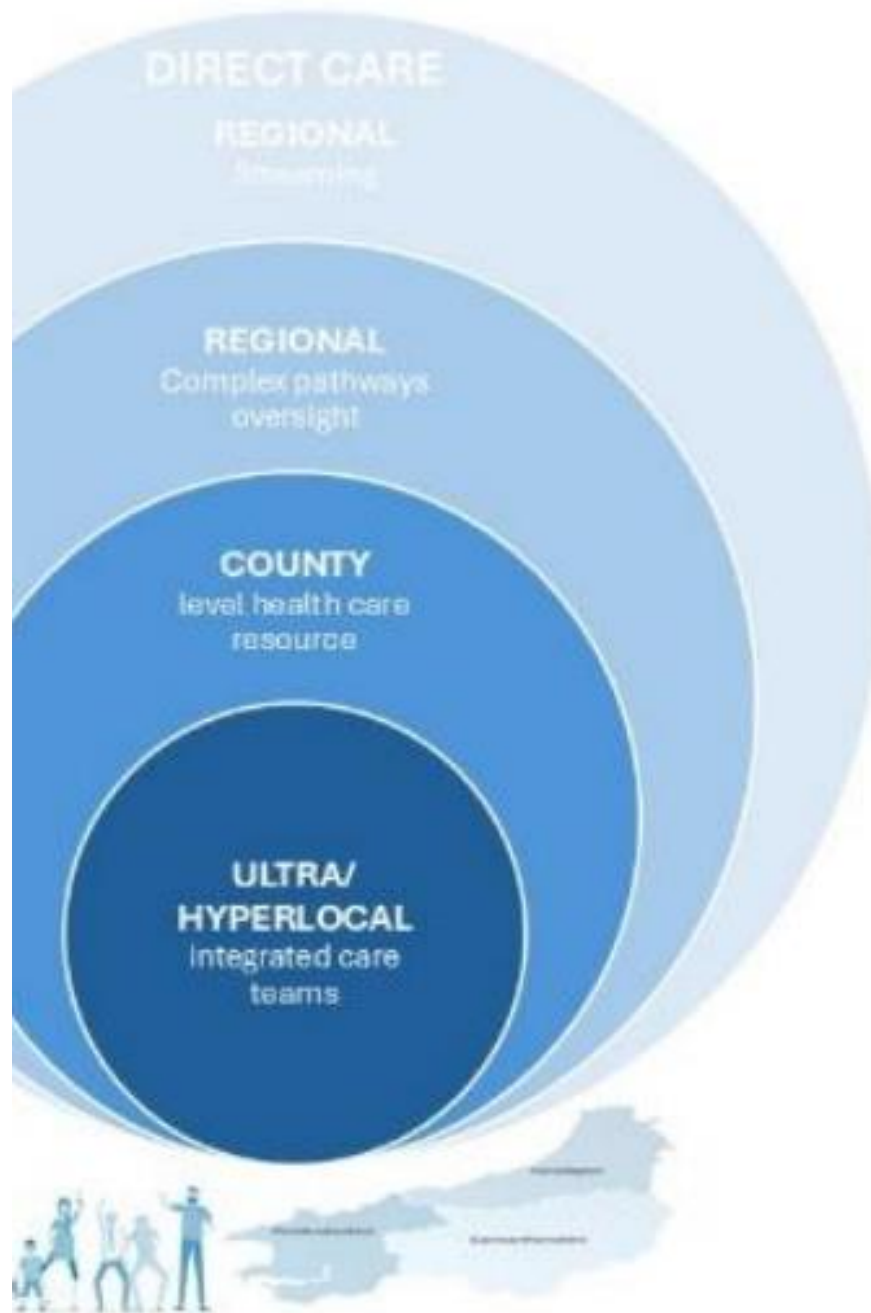
Hospital Area	MAG Comment	Action(s)
ED	Seriously crowded and was told that a doctor (who had only been there for 18 months) had not seen a patient in a cubicle during that period.	Improvement plans in place to address this key area. Medical take is now via SDEC and not ED Jan 25. Surgical SDEC taking all surgical referrals. Task and Finish group in place to expand medical SDEC to deliver a plan by Q3 WG monies available for capital enablement works  Good working relationships seen but flow was an issue – this was more of an Acute Medical and Surgical Unit and not an ED.
ED	New UEC model: the HB is brave and solution focused by driving the innovative model that is a fantastic model the HB needs to get right	Significant focus on streaming hubs avoiding ED moving to a 7-day model HB wide. Expansion of SDEC to enable speciality takes to be seen and treated outside of ED
ED	Support: Encourage teams to work between organisations to remove barriers	Closer working across primary, acute and secondary care. Implementing pathways to avoid ED. Focus on frailty models and admission avoidance scoping resource across the system to have unified pathways.
ED	Organisational Development cultural issues – suggest junior doctors have training in difficult conversations	Deputy hospital director chairs meetings with junior doctors with a focus on key topics and communication and complaints review
SDEC	Good model for the future but also need to support patients in the here and now	Increased patients seen in SDEC and model to support those needing admission. Reviewing options for an acute frailty unit expansion also to incorporate pre and post op surgical/orthopaedic patients
SDEC	Positive and weaknesses that it is not co-located with ED	Plans to expand SDEC but no option (geographically) to co-locate with ED
SDEC	Barriers: lack of 7-day a week working and diagnostic delays.	Tried to recruit 6th consultant for acute medicine which was not successfully so currently unable to expand to a 7-day model. Diagnostic activity extremely high in GGH Task and Finish group in place with radiology to review options for timelier access to diagnostics.
SDEC	Review acute flow and elective workload	12-week decompression programme has taken place with key actions to improve flow. Weekly big room and separate for ED for wider MDT to review current position, actions and plans for improvement. Elective lists jointly discussed with Unscheduled Care and increased medical outliers into surgery to maintain acute flow

# Ministerial Advisory Group actions

Hospital Area	MAG Comment	Action(s)
ED	Brilliant and committed staff but the HB is relying on their resilience	As a HB recognised the pressures ED face and in GGH a weekly ED big room is place to progress key actions to support ED. ED consultant posts advertised with 4 shortlisted interviews mid-April.
ED	High level of frailty and was told that the Frailty Pathway was better in WGH.	More Care of the Elderly physicians at WGH, GGH consultants are being job planned and then a review in April 25 for revised frailty model
ED	Lack of Executive visibility	Planned exec and board walkarounds in place to review all clinical services in GGH and across the HB
ED	Pathology: talked about an issue with the tube between ED and Pathology that requires an upgrade. The impact is a delay in in bloods being sent between departments resulting in an hour delay for partners to collect. This also impacts on the Labs with a lack of continuous flow. An inefficiency that needs to be addressed	This has been addressed and shortly after the visit the tube system back in operation
SDEC	Capacity: only six out of the ten chairs were in use and told that GP referrals presented later in the day.	Now the medical take is going via SDEC the unit has higher occupancy at the start of the day. Medical day unit co-located and a demand and capacity review in place to look at alternative pathways to increased SDEC footprint
FAU	Juxtaposition of perfection in ED – needs to be investigated	Improved communication between ED and Frailty Assessment Unit (FAU) with patients identified early in the pathway for the FAU. FAU surges to take additional patients at high escalation to support ED and system flow

# Whole-System Transformation

- **Regional Transformation:** 24/7 Technology-enabled, Clinically-led streaming and scheduling. 'Phone-First' and App-based access.
- **Locality Transformation:** Hospital@Home, Urgent Community Care Centres, 'Straight to Speciality' pathways, Step-Up Integrated Beds.
- **Hyper-local, Pro-Active Transformation:** Place-based care, integrated through-age community networks. Multi-Agency teams co-located and embedded within communities. Risk- stratification and pro-active anticipatory care planning



**Direct Care: Whole System Scheduling**  
 TEC logistics  
 24/7 Intelligent solutions – integrated eHR  
 Digital inclusion



**Clinical Streaming Hub**  
 Clinical Governance  
 Professional contact centre  
 • SRO Expertise/ on-call  
 • Front-end flow (referrals)  
 WAST logistics  
 Tertiary care interface (patient contact centre)



**Hospital** (Short stay specialist support and management)

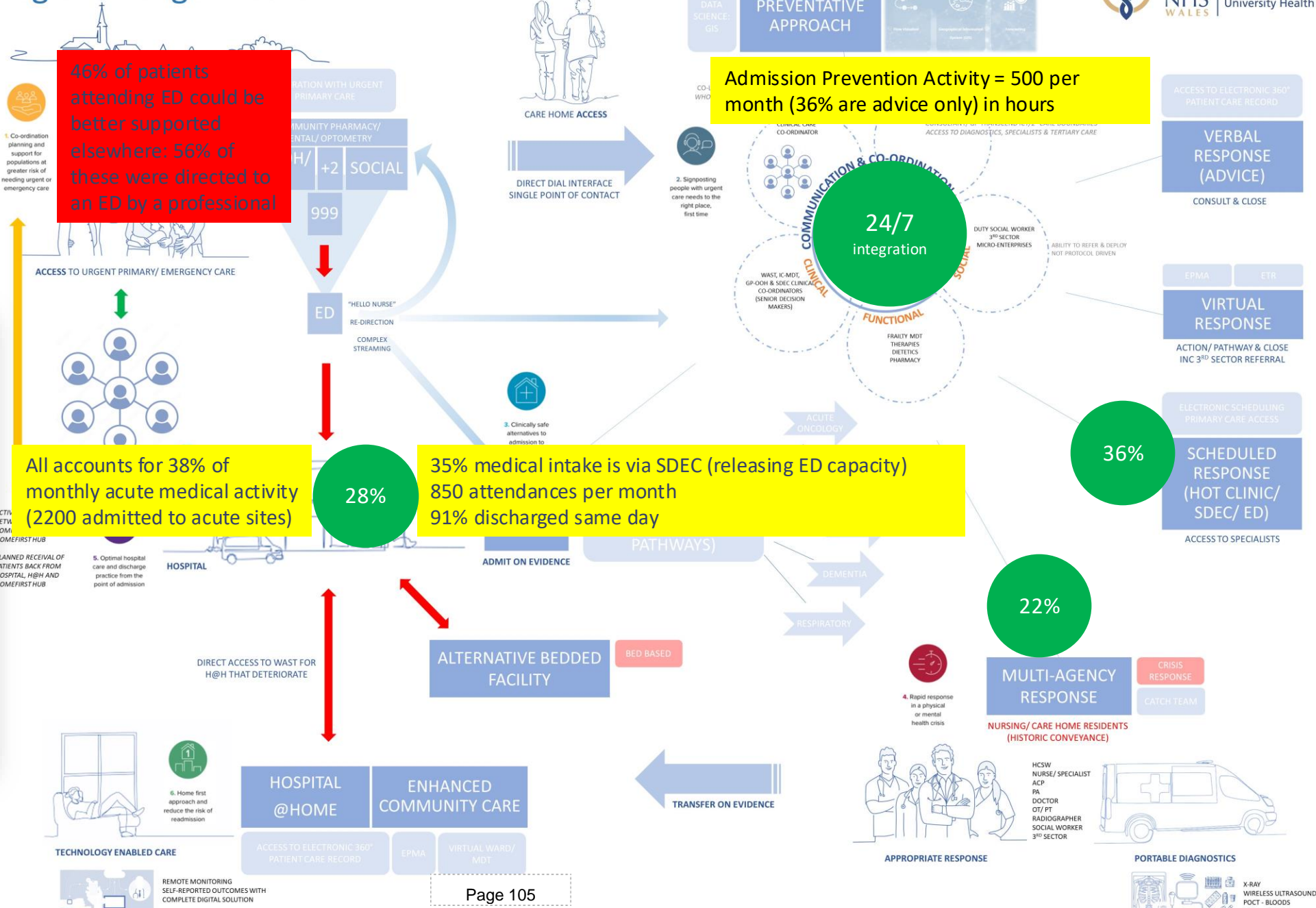


**Integrated Care Centres**  
 Urgent Care Centres  
 Emergency & Community Diagnostic Centres



**Cluster/ Community Connector**  
 Multi Agency Teams – 3<sup>rd</sup> Sector  
 Primary Care/ Community Care

# Integrated Urgent Care



**WINTER ED BUSIEST DAY 2023 REDIRECTABLE REVIEW FINDINGS REPORT**

ED GLANGWILI GENERAL HOSPITAL  
ED WITHTYBUSH GENERAL HOSPITAL  
Produced: April 2024  
Version: 0.08

**Author**  
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Dr Siobed Richards, Clinical Lead for GP Intermediate Care

# UEC Redesign

## A Strategic Solution

- Strategic Intent:** To truly address the safety concerns in the Emergency Department requires broader and deeper transformation. We aim to pull together the learning from across many non-recurrent funding streams that are currently piloting innovative ways of working and to work with strategic partners to deliver an Integrated Community Care System to eradicate failure demand in secondary care.
- Current UEC Reality:** Overcrowded Emergency Departments (ED), compromised quality & safety. Only 20-30% of demand is appropriate for ED, as an organisation we are therefore exploring more upstream ways to address the issues that are currently manifesting in the emergency arm of the service.
- Challenges:** Ineffective solutions, unsustainable expenditure in secondary care, and traditional silos. Workforce challenges that can only be overcome by integrating across professional and organisational boundaries.



“A Good Life, Well Lived”

## Whole System Transformation



There is ample evidence that the strategic intent exists to deliver a whole system of care - what is required now is the passion, belief, culture and drive among leaders and staff across all services and at all levels to commit to its delivery. It is what our population deserves.

## Recommendation

*The Committee is asked to:*

- Take assurance from the Progress with the Six Goals Programme for UEC
- Note the challenges with sustainable Service delivery in the present System and the requirement to develop a revised approach as we move forward.

Grŵp Iechyd a Gwasanaethau Cymdeithasol  
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group  
Director of Operations, NHS Wales



Llywodraeth Cymru  
Welsh Government

**Chief Executives**

**Chief Operating Officers**

**Medical Directors**

**Executive Directors of Nursing**

Local health boards

Welsh Ambulance Services University NHS Trust

29 October 2024

Dear colleagues,

### **WHC/2024/041: Ambulance Patient Handover Guidance**

I am writing to draw your attention to a newly published Welsh Health Circular relating to Ambulance Patient Handover Guidance.

This guidance is intended to set a statement of intent for health boards to deliver when managing the ambulance patient handover process, and to set out key actions for consistent delivery to support optimal outcomes and experience. It has been developed with clinical and operational input and should be read as a second iteration of the [original document](#) released in May 2016.

This guidance is intended for executive level staff of health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust. It may also be useful to emergency department and ambulance service clinical and managerial teams when designing local protocols.

As you will be aware, ambulance patient handovers continue to represent a significant challenge to patient experience and outcomes and the ambulance service's ability to respond quickly to people in the community. You will also be aware this is an issue requiring system wide solutions, both in the community and in supporting timely patient flow through emergency departments, the hospital system and back out into the community.

All members of the health board executive team have a responsibility for timely and safe ambulance patient handover, and the communication of this guidance and its content throughout their organisation. This may sometimes include an acceptance of sharing risk across the system, in line with local and national escalation frameworks.

We will continue to monitor progress against ambulance patient handover trajectories over the coming weeks in conjunction with the NHS Executive which will undertake audits of organisations' compliance with the guidance over the remainder of 2024/2025.

Thank you for your assistance.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'J Griffith', is positioned below the text 'Yours sincerely,'.

**Jeremy Griffith**

Director of Operations

NHS Wales / Health and Social Services Group, Welsh Government

Cc: **Judith Paget**, Director General Health and Social Services / NHS Chief Executive  
**Nick Wood**, Deputy Chief Executive, NHS Wales  
**Sue Tranka**, Chief Nursing Officer, Welsh Government  
**Richard Bowen**, National Director for the Six Goals for Urgent and Emergency Care Programme



Llywodraeth Cymru  
Welsh Government



# Ambulance Patient Handover Guidance

## Purpose

This NHS Wales guidance is intended to set a statement of intent for health boards to consider when developing plans to improve ambulance patient handover, and to set out key actions for consistent delivery to support optimal outcomes and experience. This guidance should be read as a second iteration of the [original document](#) released in 2016.

## Audience

This guidance is intended for executive level staff of health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust. It may also be useful to emergency department and ambulance service clinical and managerial teams when designing local protocols.

## Strategic context

This guidance further reaffirms our shared commitment to reduce ambulance patient handover delays and should be read in conjunction with the [Six Goals for Urgent and Emergency Care policy handbook](#) and the [Quality Statement for Care in an Emergency department](#). It should also be considered in the context of the [Health and Care Quality Standards](#) and statutory duties within the [Duty of Quality](#).

## Statement of intent

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*All members of the health board executive team have a responsibility for timely and safe ambulance patient handover, and the communication of this throughout their organisation. This may sometimes include an acceptance of sharing risk across the system, in line with local and national escalation frameworks.*

*Ambulance clinicians are trained for life-saving interventions and not to meet ongoing care needs. When a patient is conveyed to a hospital by ambulance, care must be handed over to the receiving hospital team as soon as possible, in order of clinical priority and within 15 minutes. Health boards are responsible for ensuring this happens reliably and that there is sufficient available capacity throughout the receiving hospital.*

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Key actions to support ambulance patient handover have been highlighted and summarised in this document. They are intended for implementation by health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust and should be incorporated into local escalation plans.

Delivery of these actions will be routinely audited and reviewed by the NHS Wales Executive to ensure organisations are compliant, and to enable support to be provided where necessary.

## Key actions for health boards, NHS Wales Joint Commissioning Committee ('the committee') and the Welsh Ambulance Services University NHS Trust (WAST)

1. The organisational leadership and culture of care in a health board is of the utmost importance in ensuring that prompt ambulance patient handover becomes business as usual. Health board executives should work with local clinical leaders to communicate the importance of timely ambulance patient handover. Health board executives should model this visibly and repeatedly to all staff.
2. Health boards should use the GIRFT 'SEDIT tool' and baseline data to support capacity planning across the hospital footprint, ensuring 24/7 access to safe care and treatment of patients arriving by emergency ambulance.
3. The committee and sufficiently senior nominated health board and WAST leads should regularly come together to review ambulance patient pathway data to identify opportunities to better manage patients in the community where safe to do so. This should include an assessment of 'hear and treat' and 'see and treat' performance to enable a collective understanding of patient activity.
4. The committee, WAST and health boards should regularly review and benchmark service provision matched to ambulance case mix and pattern of daily demand by local and regional area. Data should inform the delivery of robust community and alternative pathways by health boards which are clearly communicated to ambulance clinicians. This should include direct access pathways to enable patients to bypass the emergency department when safe and appropriate to do so.
5. Communication before the patient arrives:
  - Health boards should ensure ambulance clinicians have access to a care co-ordination service (i.e. navigation or flow hubs) that can accept or transfer care of suitable patients and support the flow into their services.

### *Patients requiring immediate resuscitation*

- Where a patient requires immediate life-saving treatment on arrival at hospital the ambulance crew must provide a pre-alert to the hospital. WAST and health boards should have agreed processes in place based on national guidance for identifying, communicating and managing pre-alert cases.

- When an ambulance arrives at hospital with a patient who requires immediate life-saving treatment, the patient must be taken immediately to the resuscitation area. Effective hospital escalation should be in place to enable this seamlessly.

#### *Patients requiring specialist emergency treatment*

- Patients requiring treatment for conditions such as STEMI, vascular, burns, stroke or obstetric conditions should be taken directly to receiving units other than the hospital emergency department in line with the agreed local or regional pathway.
- Additional pathways must be agreed between WAST and health boards who have a responsibility for clearly communicating their expectations to the Trust. WAST has a responsibility to ensure ambulance clinicians are informed of health board expectations and maintain a regularly updated directory of services.
- Health boards should incorporate regular audits of compliance with these pathways as part of annual clinical audit forward planning activity. The NHS Executive will also periodically audit compliance.

#### **6. Ambulance patient handover on arrival:**

##### *Booking in*

- Booking in of patients must take place immediately on arrival at the emergency department or other admitting areas. WAST staff will complete an electronic Patient Clinical Record (ePCR) for all patients.
- The ePCR will be processed by the receiving hospital for all patients conveyed by WAST depending on local protocols. This should be matched to the patient and uploaded to Welsh Clinical Portal when the care episode is complete.

##### *Triage / signposting*

- Patients should be assessed on arrival at the hospital receiving area and treated for the acute condition they have presented with; remembering frailty can co-exist with the presenting acute complaint.
- Guidelines should be in place for safe and effective triage and streaming of patients to the correct area (e.g. majors, minors, same day emergency

care, acute frailty teams etc), and to identify patients who are 'fit to sit' in the waiting area. These processes should be standardised between health boards and WAST.

- On arrival a detailed summary must be given by WAST to support triage / initial assessment by health board clinicians. This will include clinical information and also considerations of other personal and social information where relevant. Processes should be implemented by health boards regarding the grade / training / level of experience required for this task.
  - Senior clinical decision makers should consistently be present at the hospital front door and their presence supported and strengthened as part of local escalation plans when pressures build in the system.
  - Patients are to be handed over at a definitive destination of care, with both ambulance and hospital staff complying with the dual pin process, inputting individual staff ID pins into the HAS screen. For those areas where HAS screens are not available, health boards and WAST should ensure that equally robust arrangements are in place to ensure rapid handover, within 15 minutes of arrival.
- 7.** Health boards should deliver safe, sustainable, staffing levels for emergency departments and acute receiving areas, able to flex to meet demand, with appropriate levels of seniority available for timely assessment and supervision, in line with expectations set within the Quality Statement for Care in an Emergency Department. Staff of all grades should have clear lines of responsibility and accountability and an appropriate level of supervision, (e.g. resident doctors, health care assistants and clinical practitioners).
- 8.** Management of handover delays:
- Patients and their carers should be kept fully informed of the reason for any delay and the progress in resolving it.
  - WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside emergency departments or other admitting areas, and hospital clinicians should be responsible for overseeing the assessment of patients.
  - If delays occur immediate action must be taken by the health board to resolve them. Where ambulances are delayed beyond 30 minutes the actions must include:

- The WAST Operational Delivery Unit (ODU) and the hospital operational team must be notified immediately.
  - Health boards should have in place appropriate procedures and identified individuals for the management, flow and co-ordination of patients arriving by ambulance.
  - Hospital staff must ensure that the patient has been assessed and moved immediately into an appropriate clinical space if there is a risk to patient safety.
- Delays of over 60 minutes are unacceptable, and should be exceptional. They must be clearly visible to the health board executive teams and monitored through quality and safety management systems. After 60 minutes of delay the following actions must take place if they have not already:
    - The WAST ODU should be informed for escalation to the national system leads and must be notified immediately where there is a risk a patient will wait in excess of four hours.
    - Hospital wards must increase their ability to pull patients safely from the acute areas at times of peak demand. This should be risk managed to ensure that patients are treated in a suitable clinically supervised area with appropriately qualified staff. A patient's safety is the utmost priority and any infection control, or any other risk including deconditioning, should be managed proactively.
    - Formal ambulance diverts should be put in place in line with local and national escalation processes agreed between the health board and WAST.

# GETTING IT RIGHT FIRST TIME for Emergency Medicine The Emergency Departments of Wales

Supplementary report following Hywel Dda visits in January 2025



*This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable a rapid improvement in the delivery of urgent and emergency care and the adoption of the GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.*

Written by:

**Professor Chris Moulton:** National Clinical Lead for GIRFT for Emergency Medicine

**Mr Darren Best:** GIRFT Senior Specialist Clinical Review Manager (UEC Specialties)

**Mr Andrew Boasman:** NHSE Senior Data Analyst for Urgent and Emergency Care

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### 1. Introduction

Ten of the 12 major ED in Wales were visited by the RNOH/GIRFT UEC Team in June 2024 and a report was subsequently written. For logistical reasons, the EDs of Withybush and Bronglais in West Wales could not accommodate the GIRFT visitors at that time and so these two departments were visited at the end of January 2025. The following supplement to the main report relates to these two EDs.

### 2. The major ED sites in Wales

The most recently available maps of the ED sites and emergency helicopter bases in Wales are shown below:



Two of the three hospitals in Hywel Dda UHB were visited in January 2025. They are highlighted in red in this table:

Hospital	Health Board	Locality
Wrexham Maelor Hospital	Betsi Cadwaladr UHB	Wrexham
Ysbyty Glan Clwyd	Betsi Cadwaladr UHB	Bodelwyddan
Ysbyty Gwynedd	Betsi Cadwaladr UHB	Bangor
<b>Bronglais Hospital</b>	<b>Hywel Dda UHB</b>	<b>Aberystwyth</b>
<b>Withybush Hospital</b>	<b>Hywel Dda UHB</b>	<b>Haverfordwest</b>
Glangwili Hospital	Hywel Dda UHB	Carmarthen
Morrison Hospital	Swansea Bay UHB	Swansea
Princess of Wales Hospital	Cwm Taf Morgannwg UHB	Bridgend
Royal Glamorgan Hospital	Cwm Taf Morgannwg UHB	Llantrisant
Prince Charles Hospital	Cwm Taf Morgannwg UHB	Merthyr Tydfil
University Hospital of Wales	Cardiff & Vale UHB	Cardiff
Grange University Hospital	Aneurin Bevan UHB	Cwmbran

### 3. Bronglais Hospital: Hywel Dda UHB (Aberystwyth)

#### Bronglais Hospital: OVERVIEW

The ED at Bronglais Hospital is a very nice, compact and efficient unit. Everything required is present and has been carefully planned and designed by the dedicated and skilled team of professionals in the ED. The vital position of Bronglais Hospital in mid-west Wales makes closure impossible and therefore its maintenance and successful development is the correct and only sensible option.

*The SEDIT for Wales (SEIT-W) shows the Demand, Capacity, Flow and Patient Outcomes in detail. The main issues from this data are shown below. Many of the flow and outcome metrics have improved over the last few months.*

#### Bronglais Hospital: DATA QUALITY

Quartile	Data quality
	Completeness and validity of emergency care data = 46.4%
	Accuracy of discharge coding = 98.5%

#### Bronglais Hospital: DEMAND

Quartile	Demand metric
	More than 37% of the hospital's catchment population attend the ED each year.
	Around 36% of all patients admitted from the ED are over 75 years of age. But the overall catchment population is young, due to attendances by students.

	Almost 85% of all emergency admissions occur via the ED.
	The ED is not designated as a Trauma Unit, despite its geographical situation.

**Bronglais Hospital: CAPACITY**

Quartile	Capacity metric
	The ED is very short of senior medical staff. There is only one ED consultant at the present time and this doctor is a locum.
	The ED is relatively short of registered nurses. (The departmental nursing staff are shared with the acute ward, with only a proportion allocated to the ED.)
	The annual number of admissions per whole time equivalent (WTE) Hywel Dda UHB consultant is more than 383. (This is all hospital consultants of all specialties in the UHB.) The mean figure on the SEDIT is 262.

**Bronglais Hospital: FLOW**

Quartile	Flow metric
	GEMI ranking = 137 out of 191 sites across England, Wales and Northern Ireland (using unvalidated metrics from all Welsh EDs)
	Over 73% of ambulance handovers to the ED staff take more than 30 minutes.
	Validated four-hour performance is just over 65%.
	Unvalidated four-hour performance is just over 65%. (Validation gap = <1%)
	The mean time in ED for non-admitted patients is around 4.3 hours from time of arrival.
	The mean time in ED for admitted patients is over 12.6 hours from time of arrival.
	Around 54% of admitted patients are still in the ED more than six hours after time of arrival.
	These patients then spend a further 15 hours in the ED on average before admission.

Only around 27% of emergency patients have a zero-day length of stay.

**Bronglais Hospital: OUTCOMES**

Quartile	Outcome metric
	Over 9% of all ED patients spend more than 12 hours in the ED from time of arrival.
	More than 32% of admitted patients are still in the ED after 12 hours from time of arrival.
	These patients then spend a further 17.5 hours in the ED on average before admission.
	ED litigation costs are high.

**Bronglais Hospital: ADDITIONAL INFORMATION**

There are both decontamination and isolation facilities in the ED; there is also a mental health room. The ED has a weighbridge and an Omnicell machine for ambulance crews to use. A GP is located in the outpatient department. The IT system is Welsh PAS. The two dedicated staff toilets are accompanied by a washroom and kitchenette.

**Bronglais Hospital: FINDINGS AND RECOMMENDATIONS**

[See also Section \[4\] of the main GIRFT-EM report: Overall recommendations for emergency care in Wales.](#)

- The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.
- The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances (especially in rural areas) and thus also cause harm to patients.
- The lack of ED senior medical staff must be addressed. There is only one ED consultant at the present time and this doctor is a locum; there are no substantive consultants in emergency medicine. However, the future viability of the department may require a different model of care, at least in the short- to medium-term. Possibilities include: a senior nurse clinical director (rather than a doctor), more ANPs, increased links with the local university and school of nursing, a professor of emergency nursing and an ED nurse consultant. Better links with other units may also help. More newly qualified consultants in EM are having to look for jobs outside the big cities, as the available city jobs are getting gradually filled. Sometimes, advertising for a group of four or five consultants, each with a specialised role (e.g. teaching, children’s care, pre-hospital care) yields better results than single adverts.
- There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.
- The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.

- The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care, and this deficit is almost certainly worse out-of-hours. Student populations are known to attend EDs in large numbers, often in unsocial hours.
- There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope, specialties and hours of availability. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED (currently high at ~85%).
- Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.
- The causes of the high cost of ED litigation should be examined.
- Emergency care data quality must be improved.

#### 4. Withybush Hospital: Hywel Dda UHB (Haverfordwest)

##### Withybush Hospital: OVERVIEW

The ED at Withybush Hospital would be a very nice and adequately sized one, good for both patients and staff, if it was allowed to function as such. Unfortunately, it is completely full, including a considerable number of overflow spaces, with mostly medical patients who are waiting many hours for hospital admission. The ED has put into place many mitigating factors, in particular relocating the functioning part of the ED to another specially converted area, but this too has become overwhelmed by patients awaiting an inpatient bed. Almost all the ED rooms have two patients in them, a clear infection, patient care and fire risk, with a complete lack of privacy and dignity for those patients. Two extra rooms have been converted from storerooms, to treat ambulatory patients; they also now accommodate patients in chairs awaiting inpatient beds. The ED majors area has become an admission cohort ward, with medicine rounds, regular meals and ward-level care. Specialist physicians work constantly in the area, but it is staffed by ED nurses. The overall experience for patients is very poor; staff are also affected in a very negative way and suffer from so-called “moral injury”.

Consequently, we are putting a GIRFT UEC red warning in place for Withybush Hospital, which has been agreed with senior members of the Six Goals for Urgent and Emergency Care Team:

**The ED at Withybush Hospital is grossly over-crowded and is not providing a safe environment for patients. It is also unsuitable as a place to work for both ED staff and visiting specialists. It is currently functioning as an admission cohort ward. An urgent solution must be found to care safely for patients awaiting a hospital bed and to allow a proper environment for ED work. It is accepted that this solution will be a “patch” and not a long-term answer to the problem.**

Ambulance flow into the ED at Withybush Hospital has been maintained recently by a skilful continuous flow model that the ED senior staff have implemented. In fact, experience has demonstrated that good ED performance is possible when patient outflow from the department is even minimally improved. Ambulance handover times of 100% within 15 minutes have been achieved for many consecutive days, despite all the odds against this occurring.

There is good medical in-reach into the ED with MDT support, but the numbers of staff involved are rather few.

Closure of Withybush Hospital is not a viable option. It occupies a vital position in an isolated but important holiday area. Moreover, there is no hospital that could currently absorb its workload; Glangwili Hospital also suffers from extreme over-crowding.

**The SEDIT for Wales (SEdit-W) shows the Demand, Capacity, Flow and Patient Outcomes in detail. The main issues from the data are shown below.**

**Withybush Hospital: DATA QUALITY**

Quartile	Data quality
	Completeness and validity of emergency care data = 57.0%
	Accuracy of discharge coding = 99.7%

**Withybush Hospital: DEMAND**

Quartile	Demand metric
	More than 39% of the hospital's catchment population attend the ED each year.
	Over 45% of patients admitted from the ED are over 75 years of age. The average age of patients admitted from the ED is 67.
	More than 30% of all ED patients come from areas in the highest quintile of deprivation.
	The ED is not designated as a Trauma Unit, despite its isolated situation.

**Withybush Hospital: CAPACITY**

Quartile	Capacity metric
	The ED is short of senior medical staff. There are not enough to create a viable rota.
	The ED is very short of registered nurses. Many of the nursing staff spend their time caring for a large cohort of patients who are awaiting hospital admission.

The annual number of admissions per whole time equivalent (WTE) Hywel Dda UHB consultant is more than 383. (This is all hospital consultants of all specialties in the UHB.) The average number on the SEDIT is 262.

### Withybush Hospital: FLOW

Quartile	Flow metric
	GEMI ranking = 162 out of 191 sites across England, Wales and Northern Ireland (using unvalidated metrics from all Welsh EDs)
	Nearly 59% of ambulance handovers to the ED staff take more than 30 minutes.
	Validated four-hour performance is nearly 53%.
	Unvalidated four-hour performance is around 52%. (Validation gap = <1%)
	The mean time in ED for non-admitted patients is around 5.25 hours from time of arrival.
	The mean time in ED for admitted patients is over 22.6 hours from time of arrival.
	Over 71% of admitted patients are still in the ED more than six hours after time of arrival.
	These patients then spend almost a further 25 hours in the ED on average before admission.
	General and acute bed occupancy is nearly 97%.

### Withybush Hospital: OUTCOMES

Quartile	Outcome metric
	Over 16% of all ED patients spend more than 12 hours in the ED from time of arrival.
	Almost 54% of admitted patients are still in the ED after 12 hours from time of arrival.
	These patients then spend nearly 26 hours more in the ED on average before admission.

ED litigation costs are high.

### **Withybush Hospital: ADDITIONAL INFORMATION**

There are both decontamination and isolation facilities in the ED; there is also a mental health room. An out-of-hours GP is available for 40 hours a week. The IT system is Welsh PAS. There is a single dedicated staff toilet.

### **Withybush Hospital: FINDINGS AND RECOMMENDATIONS**

*See also Section [4] of the main GIRFT-EM report: Overall recommendations for emergency care in Wales.*

- The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.
- The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients.
- There are long stays in the ED for all patients that should be reduced. Some patients are undoubtedly discharged from the ED with a finished episode of care, before there is time for them to be admitted.
- The lack of ED registered nurses must be addressed. This is made worse by the huge amount of ED nursing time that is spent caring for the large cohort of patients who are waiting for an inpatient bed.
- The lack of ED senior medical staff must be addressed. More newly qualified consultants in EM are having to look for jobs outside the big cities, as the city jobs are gradually getting filled. Sometimes, advertising for a group of four or five consultants, each with a specialised role (e.g. teaching, children's care, pre-hospital care) yields better results than single adverts.
- The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to "power" the hospital beds in a timely and efficient way that ensures good patient flow.
- The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care. This is undoubtedly worse in out-of-hours periods and at holiday times.
- There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.
- Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.
- The causes of the high cost of ED litigation should be examined.
- Data quality must be improved.

## **5. Supplementary note on SDECs**

On Page 8, in Section 4.2, of the main GIRFT Emergency Medicine report for Wales, we wrote:

13. There should be a good range of Same Day Emergency Care (SDEC) and urgent clinic spaces, with a focus on admission avoidance and complex patients. This must include mental health services (e.g. mental health SDEC provision), which should target patients waiting for long periods in ED for either assessment or admission. The capacity of all specialty SDEC and urgent clinics must meet the local demand. Patients should be accepted directly from a wide range of referrers to all SDEC facilities, without the need for prior ED assessment or even to pass through the ED.

This recommendation is important because SDECs provide an alternative route into hospital care for emergency patients and a system of care that avoids traditional hospital admission. As such, SDEC has the potential to decompress the major EDs, to increase acute bed availability and thus to reduce the long waits for admission that blight all the major EDs of Wales.

## 6. Supplementary note on UTCs

On Page 43, in Section 7.1, of the main GIRFT Emergency Medicine report for Wales, we listed all the minor injury units (MIUs) of Wales and wrote:

- The MIUs of Wales provide an important and essential service to rural communities which lie at some distance from the major EDs.
- There are no urgent treatment centres (UTCs) commissioned in Wales at the present time, and this situation is unlikely to change in the near future. However, a review of urgent primary care services is underway (*Six Goals for Urgent & Emergency Care Programme, personal communication to GIRFT*).
- Further development of UTCs in Wales will be expensive and will also consume valuable UEC staff. Moreover, it is very unlikely to address the major admission flow problems that exist in all the EDs of Wales.
- Of the 10 Welsh EDs visited by the GIRFT UEC team, only Morriston Hospital in Swansea had general practitioners (GPs) working in the ED (in a hybrid role, from 8am until 8pm).
- MIU activity is not included in the SEDIT data (for any country).

The situation has now changed somewhat, with recent Welsh government plans to encourage co-located UTCs in each health board. However, our advice remains consistent:

- The many MIUs of Wales provide an important and essential service to rural communities which lie at some distance from the major EDs. If combined with a minor illness service, then the newly designated urgent care centres (UCCs), could increase their valuable offer to these communities.
- The efficacy of such a service depends on a good balance of staff i.e. GPs, nurse practitioners and perhaps physiotherapy practitioners and others.
- The availability of x-ray may be a limiting factor; around 50% of the minor injuries seen in a major ED require an x-ray.
- A standard offer for UCCs throughout Wales would be desirable, including facilities, opening hours and presenting conditions/age ranges that can be treated.
- Transfer arrangements should also be standardised, as should telemedicine links for x-ray and ECG interpretation etc.
- Development of collocated UTCs at all the major EDs in Wales will be expensive and will also consume valuable staff. Moreover, it is very unlikely to address the major admission flow problems that exist in all the EDs of Wales.

## ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

**Report: Getting it Right First Time for Emergency Medicine- Bronglais visit January 2025**

**Issued By:**

**Issued On:**

**Service Lead: BGH GM**

**Suggested Overseeing Committee:**

### Process

On receipt of report, please complete the table below to confirm:

- a) If the recommendation is accepted or not (and justification if not accepted to be noted);
- b) A management response to accepted recommendations detailing how it will be implemented, and who will own this recommendation;
- c) A realistic and achievable completion date; and
- d) What evidence will be uploaded to AMAT to demonstrate the full implementation of the recommendation;

Completed action plans should be reviewed and signed off by relevant Directorate Management Leads.

### **GIRFT reports**

For GIRFT reports, the General Manager and Director of Secondary Care should review and approve, after which an SBAR to be submitted to Operational Planning Governance and Performance (OPGP) meeting for final approval by the Director of Operations.

On approval at OPGP, finalised action plan to be sent to the Head of Assurance and Risk for addition to AMAT, and who will forward to relevant Committee Services Officer for inclusion at the next relevant Committee Meeting.

**Progress against recommendations should be directly updated on AMAT by relevant recommendation owners.**

Progress made against recommendations raised are reported via the monthly internal escalation framework process.

Recommendation	Management Response	Recommendation Owner	Completion Date	Expected Evidence of Implementation
<p>The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.</p>	<p>Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.</p> <p>Dedicated NOF pathway QI project commenced march 25.</p> <p>Rapid assessment area in place within ED since December 2024, supports circa 30 ambulatory patient attenders per day. Work is needed to evaluate this new model- with a view to introducing SDEC principles to enhance patient experience and performance.</p> <p>Revision of nurse staffing position underway to support dedicated triage and ambulance bay nurses to enhance care offered at times of handover delay/ support handover into RATS area- paper for Exec Team currently being prepared (06/03/25)</p>	<p>Care Group GM</p> <p>BGH HoN, QI team, Hospital Director</p> <p>BGH HoN, GM and SDM</p> <p>BGH HoN</p>	<p></p> <p>30th Sept 2025</p> <p>31 May 2025</p> <p>31 March 2025</p>	<p>Annual plan and performance trajectories</p> <p>EQUIP project outputs</p> <p>Report demonstrating benefit of trial and breakdown of patient groups and conditions – to be considered in line with SDEC principles</p> <p>Stable nurse staffing position Improved ambulance handover performance Reduced datix submissions/ improved quality and PROMS/PREMS</p>
<p>The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and</p>	<p>Immediate release requests are almost always supported especially for red release calls- and any non adherence is investigated and lessons learned are shared- clear communication with ODU in</p>	<p>Lead EUCC consultant SSr EUCC Clinical site managers</p>	<p>Complete</p>	<p>Annual plan and performance trajectories</p>

<p>thus also cause harm to patients</p>	<p>place to support decision making and assessment of pressures in area- with a view to minimising risk. Pre-alerts are also prioritised which in turn would release ambulance capacity- and corridor care (surge) is frequently utilised to support urgent ambulance calls.</p> <p>Work to introduce a discharge lounge has now been proposed for 2025/26 with a view to supporting up to 6 patients per day who currently would be delayed on wards – this will have a positive impact on flow.</p> <p>Boarding policy and capacity now in place- affected by surge pressures- offers up to 10 spaces to support boarding/boarding at risk</p> <p>A review of hospital flow (to include re-allocation of ward spaces) is due in 2025/26 to minimise bed clocking within the trauma / surgical pathway beds- which will improve emergency pathway access.</p>	<p>BGH triumvirate</p> <p>BGH HoN</p> <p>BGH Triumvirate</p>	<p>Pending decision on YBwa</p> <p>Complete</p>	<p>Improvement in flow by up to 6 patients per day as a minimum</p> <p>Improved flow and ED performance</p>
<p>There are long stays in the ED for all patients that should be reduced.</p>	<p>Above workstreams will also positively impact this issue</p>	<p>BGH Triumvirate</p>	<p>30th July 2025</p>	<p>Annual plan and performance trajectories</p>
<p>The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a</p>	<p>Consultant lead currently employed on a locum basis (only 1 wte). This is currently subject to recruitment to substantiate the post.</p>	<p>BGH GM &amp; SDM Consultant recruitment</p>		<p>Substantive Consultant appointment</p>

<p>different model in the long-term.</p>	<p>A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.</p> <p>Interim County Director has instigated a review of ED staffing models in March 2025 with a view to generating a proposal to increase consultant cover.</p>	<p>Medical Workforce BGH Service Manager &amp; SDM</p> <p>County Director/ Care Group GM</p>	<p>31 August 2025</p> <p>31 March 2025</p>	<p>Completed review with agreed staffing level identified and appointments made</p>
<p>The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care, and this deficit is almost certainly worse out-of-hours. Student populations are known to attend EDs in large numbers, often in unsocial hours.</p>	<p>There is no significant local health provision with the exception of primary care services and the 111 system along with community nursing teams. In the south of the county, a Same Day Urgent Care (SDUC) facility has been introduced. The ambition is to launch a phased SDUC model from Aberaeron ICC- which will have a positive benefit/ reduction in ED attendances, and this has been considered in planning and trajectory assumptions for the 2025/6 financial year.</p> <p>Ceredigion is currently supported by a streaming hub- in line with the SDUC expansion, development of a HB wide streaming facility will improve patient flow by signposting to more appropriate</p>	<p>Care Group Leadership Team</p>	<p>Phase 1, weekend provision complete</p>	<p>Annual plan and performance trajectories</p>

	resources. Decision making on a HB basis will ensure consistency in approach to advice offered to patients following clinical assessment of need.			
The causes of the high cost of ED litigation should be examined.	All incidents and concerns occurring within the EUCC footprint are subject to robust and well established investigatory and review processes prior to being subject to a scrutiny panel. Datix, Duty of Candour and PTR (PALS) are all sources of information which allow themes and trends to be identified. Where identified, lessons are always shared with the teams and reflections encouraged. Any subsequent notifications (such as to Welsh Government) are also supported.	HoN and ED leads	Complete – already reviewed regularly	DITS escalation review outcomes  BGH Quality assurance meetings
Emergency care data quality must be improved.	It has recently been identified that breach validation for ED performance had been suspended – the reasons for this are unclear. BGH triumvirate team are working to resolve this by reviewing current administrative capacity with the aim to reintroduce in Q1 2025, this work will include retrospective validation.	BGH Triumvirate	30 <sup>th</sup> April 2025	All A&E breaches to be validated within 3 days of attendance.  Reduction in reported A&E breaches
There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.	2 dedicated domestic assistants currently deployed within dept.  Budgetary constraints prevent dedicated porter and housekeeper appointments. Review of nurse staffing position is a priority in terms of any financial considerations at this time	SSr, EUCC, BGH HoN	Within nursing model 31 March 2025	A reduction in infection control issues.  Improved patient flow

<p>The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.</p>	<p>A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.</p>	<p>Medical Workforce BGH Service Manager &amp; SDM</p>	<p>31 August 2025</p>	<p>Improved patient flow  Reduction in LoS and No. of patients admitted</p>
<p>There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope, specialties and hours of availability. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED (currently high at ~85%).</p>	<p>Space within the hospital footprint is significantly constrained. However, there is potential to introduce SDEC areas and principles into the following areas:</p> <ul style="list-style-type: none"> <li>• ED Rapid assessment area</li> <li>• Medical Day Unit</li> <li>• Oncology triage and assessment in Meurig Ward (X2) when reopen.</li> </ul>	<p>6 Goals SDEC Lead BGH Triumvirate WAST Leads</p>	<p>31<sup>st</sup> July 2025</p>	<p>Reduction in A&amp;E attendances  Improved Patient Flow</p>
<p>Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.</p>	<p>The clinical services plan for HDUHB stroke services is currently out to public consultation. While options are being finalised, and there are no currently preferred solutions</p>	<p>Clinical Services Plan</p>	<p>Dependent on CSP/Public consultation timelines</p>	<p>Patient safety and quality  Patient and stakeholder feedback</p>

**ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES**

**Report:**

**Issued By:**

**Issued On:**

**Service Lead:**

**Suggested Overseeing Committee:**

**Process**

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- d) What evidence will be uploaded to AMAT to demonstrate the full implementation of the recommendation;

Completed action plans should be reviewed and signed off by relevant Directorate Management Leads / Lead Executive (or nominated deputy) prior to being added to AMAT.

Progress against recommendations should be directly updated on AMAT by relevant recommendation owners.

Progress made against recommendations raised are reported via the monthly internal escalation framework process.

	Recommendation	Management Response	Recommendation Owner	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
	The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of ED space completed. Limited capacity. Exploring alternative space within Medical Day (Podiatry) to support increased medical take away from ED. T&F Group to be planned.	Iona Evans/Louisa Standeven/ Caryl Bowen/ Dr Ghosal	01/05/2025	Email trail
	<p>The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor.</p> <p>The implementation of Internal professional standards is urgently required.</p>	<p>Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Review of T&amp;O, Urology, ENT &amp; Gynea Pathways.</p> <p>Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed.</p> <p>Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards.</p>	<p>Iona Evans/ Louisa Standeven/ Paul Smith</p> <p>Eiry Edmunds/Mandy Davies</p>	01/05/2025	<p>SBAR</p> <p>T&amp;F Minutes</p> <p>SOPs</p> <p>Surgical SDEC Data</p> <p>Email trail.</p> <p>Internal Professional Standards.</p> <p>Audit for implementation.</p>
	Children are seen in the main ED department with no separation	Complete – Fully functioning area (though refurbishment planned).	Iona Evans/Louisa Standeven	Complete	Photographic evidence

	<p>Ambulances wait outside the ED for long periods.</p>	<p>Boarding protocol implemented with patients boarded against predicted discharges.</p> <p>Safety Huddles, Patient Flow review.</p> <p>Emergency Pressures and Escalation Policy (489)</p> <p>Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk.</p> <p>Optimal Flow Framework implementation:</p> <ul style="list-style-type: none"> <li>- LOS Reviews &amp; Escalation process review</li> <li>- Board round monitoring &amp; Frontier usage</li> <li>- Criteria Led Discharge</li> <li>- Repatriation Database</li> <li>- POCD monitoring</li> </ul> <p>Initiatives to facilitate admission avoidance:</p> <ul style="list-style-type: none"> <li>- Streaming Hub</li> <li>- Virtual Ward</li> <li>- Re-direction Policy (Draft)</li> <li>- Perfect week (Jan 25) completed with some initiatives adopted as business</li> </ul>	<p>Iona Evans/ Louisa Standeven</p>	<p>01/06/2025</p>	<p>Boarding protocol, Recorded on Siterep.</p> <p>Policy (as per Intranet)</p> <p>Action Cards</p> <p>Weekly LOS review data</p> <p>Frontier use weekly reports</p> <p>Weekly performance monitoring reports</p> <p>Perfect Week Evaluation SBAR</p>
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		<p>as usual (GP medical take via SDEC).</p> <ul style="list-style-type: none"> <li>- Optimised Weekend working Pilot planned (22/23 March).</li> </ul> <p>Weekly Big Room</p> <p>Advertising for a 6th Acute Physician to enable SDEC, CDU and Medical Liaison in ED rotation to provide sufficient medical cover across the front door. Recruitment process instigated.</p>	<p>Mandy Davies/ Iona Evans/ Louisa Standeven/ Caryl Bowen</p> <p>Caryl Bowen</p>		<p>6 Goals Assurance Meeting minutes</p> <p>ED Big Room Actions</p> <p>Tracs</p> <p>Email Trail</p>
	The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good	<p>Review completed and ED &amp; SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact.</p> <p>OOH Cauda Equina pathway review being undertaken.</p>	Caryl Bowen	01/05/2025	Big Room actions.
	Training opportunities are poor.	<p>ED Big Room.</p> <p>Training Needs Analysis underway</p> <p>ED Practice Educator in place.</p> <p>Weekly Roster efficiency monitoring – monitoring of Study Leave compliance.</p>	Iona Evans/Louisa Standeven	01/05/2025	<p>ED Big Room actions.</p> <p>TNA/ Training Database.</p> <p>Competency plan</p>

	Patients with a stroke requiring thrombectomy have to be transferred to Southmead Hospital in North Bristol, England	This is an agreed HB commissioned pathway with Bristol.	HB commissioned pathway	Complete	Thrombolysis Care Pathway
	SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated.  Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Iona Evans/Louisa Standeven/ Caryl Bowen/ Dr Ghosal	01/06/2025	SDEC Data  SDEC SOP
	The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-ofhours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	David Richards/ Sarah Perry	May 2025	Re-direction Policy
	The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway.  Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Caryl Bowen/ Dr Ghosal  Iona Evans/Louisa Standeven/ Janice Cole Williams	Interviews/ Stakeholder Panel week commencing 7 <sup>th</sup> April 2025  June 2025	Tracs Email Trail  Safe Staffing/ Recruitment Data
	Tertiary referral systems should be considered in detail.	Repat database rolled out and operational - Complete.  Cardiology, Neuro & Renal pathway in place.	Caryl Bowen  HB commissioned pathway.  HB commissioned pathway.	Complete  Complete  Complete	Database  Site-rep  Performance data

		<p>Southwest Wales Vascular Network Repatriation Policy in place and disseminated.</p> <p>Review of performance metrics within repat database from time pathway end to transfer to referring hospital.</p>	<p>Caryl Bowen/ Gareth Beynon/ Iona Evans/ Louisa Standeven</p>	<p>Monthly Review</p>	
	<p>Data quality must be improved.</p>	<p>Informatics Training within ED staff.</p> <p>Internal Audit – management of bed capacity T&amp;F.</p> <p>ED Breach Validation assurance in progress. Review data quality and validity.</p>	<p>Caryl Bowen/ Gareth Beynon/ Louisa Standeven</p> <p>Stuart Bancroft</p> <p>Caryl Bowen/ Louisa Standeven</p>	<p>May 25</p> <p>May 25</p> <p>May 25</p>	<p>Training data</p> <p>Email Trail T&amp;F Minutes</p> <p>ED Breach SOP WPAS Breach Reason Guide</p>

## ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

**Report:**

**Issued By:**

**Issued On:**

**Service Lead:**

**Suggested Overseeing Committee:**

### **Process**

On receipt of report, please complete the table below to confirm:

- If the recommendation is accepted or not (and justification if not accepted to be noted);
- A management response to accepted recommendations detailing how it will be implemented, and who will own this recommendation;
- A realistic and achievable completion date; and
- What evidence will be uploaded to AMAT to demonstrate the full implementation of the recommendation;

Completed action plans should be reviewed and signed off by relevant Directorate Management Leads / Lead Executive (or nominated deputy) prior to being added to AMAT.

Progress against recommendations should be directly updated on AMAT by relevant recommendation owners.

Progress made against recommendations raised are reported via the monthly internal escalation framework process.

Recommendation	Management Response	Recommendation Owner	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
<p>The ED at Withybush Hospital is grossly over-crowded and is not providing a safe environment for patients. It is also unsuitable as a place to work for both ED staff and visiting specialists. It is currently functioning as an admission cohort ward. <b>An urgent solution must be found to care safely for patients awaiting a hospital bed and to allow a proper environment for ED work. It is accepted that this solution will be a "patch" and not a long-term answer to the problem.</b></p>	<p>We have stopped doubling up in the 6 cubicles.</p> <p>1 resus, 2 triage/see and treat, Rapid assessment, mental health spaces are ringfenced.</p> <p>These steps are REDLINES, if the site/OOH managers believe they require to use any of the above space for patients requiring beds then a site/ED risk assessments is required.</p> <p>We still use around the nurse's station 6 patients at max, but now we do need to use the old paediatric rooms.</p> <p>Nurse allocated to the waiting room for clinical oversight</p>	<p>Hospital GM</p> <p>Completed</p>	<p>Click or tap to enter a date.</p>	<p>Annual plan trajectories: 1 hour baseline: 246 goal: 188 4 hour baseline: 31 – 123 Goal: 3.05 - 83.20</p> <p>SEDIT current performance: 49.8% Expected improvement: 58%</p>
<p>The <b>long waits for admission from the ED</b> are undoubtedly causing harm to patients and should be the <b>main focus of any improvement work.</b></p>	<p>Need clear pathways for patients. FAU/SDEC/SAU/ASU/NOF pathways and functions need to be maintained. Need to de- surge key assessments areas to keep flow active. Pathways discussed during Site safety briefings with actions to support maintenance of accessibility to pathways.</p>	<p>Hospital GM</p> <p>Commencing April</p>	<p>31/10/2025</p>	<p>SEDIT current performance: 24.8 hours Expected improvement: Q1 +Q2 20% and Q3 + Q4 10% improvement</p>

	<p>Review needed of the NOF pathway and pathway for T&amp;O patients to present as an alternative to ED.</p> <p>Speciality Medical teams in reach into ED to start treatment plans from admission. Need to reduce access points to in-patients wards to reduce competing priorities for inpatient beds. Boarding protocol in place. Need to consider continues flow.</p>			
<p>The <b>delays in ambulance to ED handovers</b> of patients impair the response times for emergency ambulances and thus also cause harm to patients.</p>	<p>Improving the flow out of ED will improve on ambulance handover delays.</p> <p>Further work required (in Annual plan) to determine the demand and capacity of ED. Working within the 6 Goals framework.</p> <p>WAST staff already attending 8:30 safety meeting.</p>	<p>Hospital GM</p> <p>Commencing April to November</p>	<p>31/10/2025</p>	<p>Annual plan trajectories: Ambulance Handovers taking over 1 hour Baseline: 246 Goal: 188 (38 to 69% improvement)</p>
<p>There are <b>long stays in the ED for all patients that should be reduced</b>. Some patients are undoubtedly discharged from the ED with a finished episode of care, before there is time for them to be admitted.</p>	<p>WGH do have clear pathways for patients. Medical teams in reach to start the treatment plan from admission.</p> <p>Need to reduce access points to in-patients wards. Need to de- surge assessments units to keep flow active.</p> <p>Boarding protocol in place.</p> <p>Need to consider continues flow.</p>	<p>Hospital GM</p> <p>Commencing April 2025</p>	<p>31/10/2025</p>	<p>SEDIT current performance: 24.8 hours Expected improvement: Q1 +Q2 20% and Q3 + Q4 10% improvement</p>
<p><b>The lack of ED registered nurses must be addressed.</b> This is made worse by the huge amount of ED</p>	<p>The Registered Nurse allocation within the department has significantly increased over the previous 18 months with</p>	<p>Head of Nursing WGH</p>	<p>Click or tap to enter a date.</p>	<p>SEDIT Current: 26.0 (WTE)</p>

nursing time that is spent caring for the large cohort of patients who are waiting for an inpatient bed.	<p>additional uplift for additional senior nursing workforce the current workforce is:</p> <p>1 Managerial Band 7 (Supernumerary to roster).</p> <p>5.42 Band 7 Senior Sister</p> <p>5.5 Emergency Nurse Practitioners</p> <p>11.45 Band 6</p> <p>31.65 Band 5</p> <p>2 ACPs</p> <p>There are also 2 further Registered Nurse who will be on boarding as part of nurse recruitment later this year.</p> <p>Work ongoing to support enhancing skilled workforce</p>	Completed		Expected Improvement: 55.02 (WTE) excluding ACP
<b>The lack of ED senior medical staff must be addressed</b>	Review of medical workforce required Need Healthboard collaboration	Hospital GM and Clinical Director	Click or tap to enter a date.  No date can be estimated as requires and reliant on wider Health Board workforce planning	SEDIT Current: 5.0 (WTE) Expected improvement: TBC
The relatively high number of hospital admissions per WTE consultant (all health board consultants) <b>suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way</b> that ensures good patient flow.	Review of medical workforce required  Need Healthboard collaboration	Hospital GM and Clinical Director	Click or tap to enter a date.  No date can be estimated as requires and reliant on wider Health Board workforce planning	
The high catchment attendance level suggests that there are <b>poor</b>	The Clinical Streaming Hub will incorporate both in hours and out of hours staff to	System GM	31/10/2025	Current number on H@H ward: 60

<p><b>alternatives to ED attendance in the local area,</b> probably including primary care. This is undoubtedly worse in out-of-hours periods and at holiday times.</p>	<p>ensure that there is a consistent approach for patients and Health Care Professionals. It is acknowledged that a full 24/7 model may not be available across the Clinical, functional and social element of the model, but this is what is being aspired to be achieved in order to deliver a gold standard Clinical Streaming Hub.</p> <p>The aim of the CSH would be to facilitate the patient's journey to receive the right treatment first time, to give community professionals a single point of contact to aid with signposting, rather than to place barriers and make it more difficult to access urgent care.</p> <p>The Clinical Stream hub pathways current include advice, stream to SDEC, crisis response, Hospital at Home.</p> <p>In addition to in hours Primary Care provision, there are 29 Pharmacies across Pembrokeshire that offer the Common Ailments Service.</p> <p>NHS111Wales provide interactive site to enable public to access relevant service to their geographical location.</p> <p>Alternate services ie Same Day Emergency Care, Walk-in-Centre provision are advertised regularly on Hywel Dda</p>	<p>Commencing April 25</p>		<p>Expected Improvement: 79 (5 days) or 111 (7 days)</p>
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	<p>Facebook sites, providing detail of services provided, hours of service.</p> <p>Action – Review Communication Plan with HB team, monitor access numbers to FB site, NHS111Wales site access, Porth Preseli Clinical Streaming Hub, Out of Hours access.</p>			
<p>There is definitely a <b>case for an increase in SDEC and urgent clinic spaces.</b> The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.</p>	<p>SDEC is open form 8-8 Fully staffed Approx 60% of the medical take does attend SDEC. Planning for complex streaming at front door. Frailty SDEC – need to de surge unit. Unit to take direct from ED and will start to take referral direct form WAST, therefore, to avoid ED.</p> <p>HOT clinics in medical specialties already in place (manged by the medical Consultants)</p>	<p>Hospital GM</p> <p>Commencing April 2025 to October 2025</p>	<p>31/10/2025</p>	<p>Baseline: 60% medical take through SDEC Expected improvement: 100% medical take through complex front door streaming</p>
<p><b>Transfer arrangements to other hospitals must also be improved.</b> There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an</p>	<p>Clear pathway already in place for paediatrics.</p> <p>A designated ambulance is on standby outside ED for transfers.</p>	<p>System GM</p>	<p>31/10/2025</p>	<p>Expected improvement: No incident reported for delayed transfer for paed</p>

endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.				
<b>The causes of the high cost of ED litigation should be examined.</b>	We undertake a full investigation on all incidences and concerns raised. Which could lead into litigation. The ED team have their own Governance meeting to discuss such matters and then they will feed up to the Hospital Governance group. WGH has also set up a mortality review group. ED will conclude any incident with a Learning from Events communication to the team.	System GM	31/10/2025	Further discussions required for redress for baseline
<b>Data quality must be improved.</b>	Regarding validation of breaches WGH does have admin staff working with the SNM to undertake this request. SNM to ensure clinical team engagement and discussion relating to thematic surrounding breaches and assurance of correct data validation.	Clinical Director  Commencing April 2025	31/10/2025	Sedit Current: 56.9% Expected improvement: 20% improvement per Quarter

2.2

15 Mins

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2.2 - Mental Health and Learning Disabilities  
Deep Dive

*Liz Carroll (Hywel  
Dda UHB - Director  
of Mental Health and  
Learning  
Disabilities),  
Rebecca Temple-  
Purcell (Hywel Dda  
UHB - Assistant  
Director of Nursing,  
Patient Safety,  
Quality and  
Experience)*

**Attachments**

[Quality Safety Experience Committee MHL D Deep Dive SBAR April 2025.docx](#)

[QIA Measures to improve Children ASD service performance FINAL 26.03.25.xlsx](#)

[QIA Temporary change to GP referral pathway for MH assessments in Ceredigi~.xlsx](#)

**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD  
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	08 April 2025
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Mental Health and Learning Disabilities Deep Dive
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Andrew Caruthers, Chief Operating Officer
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Liz Carroll, Service Director for the Mental Health and Learning Disabilities Clinical Care Group, Becky Temple-Purcell, Assistant Director of Nursing, Quality, Patient Safety, Quality and Experience, Mental Health and Learning Disabilities Clinical Care Group

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The purpose of this paper is to provide a deep dive into current quality matters being managed within the Mental Health and Learning Disabilities Clinical Care Group and to provide assurance of its quality management system in place to meet the needs of the population and continuously improve the care and experience of service users. It outlines the key components of the system, including the processes, practices and frameworks in place to promote high quality care to individuals with mental health and learning disabilities.

The Mental Health and Learning Disabilities Clinical Care Group is currently at Level 3 escalation for both quality and governance domains. As part of the escalation process, focused efforts are being made to address areas with action plans aimed at improving both the quality of care provided and robustness of governance mechanisms to meet expected standards. This report provides detailed insights into performance trends, highlighting areas that require improvement and actions in place to support this.

**Cefndir / Background**

The Mental Health and Learning Disabilities Clinical Care Group works within the Health Boards quality governance frameworks and national guidelines for practice. Central to these policies is the commitment to ensuring that individuals with mental health and learning disabilities receive person centred, high quality and equitable care. The Mental Health (Wales) Measure 2010 and the Learning Disabilities (Wales) Act 2015 are instrumental in shaping the delivery of services, promoting a rights-based approach to care that ensures accessibility, dignity and empowerment.

National strategies affecting delivery of both mental health and learning disabilities services are currently under review.

In 2024 Welsh Government published new draft strategies for public consultation, of which final versions are expected to be published in April 2025 along with detailed delivery plans:-

- Mental Health and Wellbeing Strategy (2024- 2034) to replace the previous ten year strategy Together for Mental Health
- Suicide and Self-Harm Prevention Strategy, to replace Talk to me 2: the suicide and self-harm prevention strategy for 2015-2022

The current Learning Disability Strategic Action Plan for Wales 2022-2026, which is nearing completion, guides provision aiming to ensure that people with learning disabilities lead fulfilling lives in their communities.

As part of the national strategic programme for Mental Health, a national Patient Safety Programme has been introduced to adult inpatient wards across Wales. The Mental Health and Learning Disabilities Clinical Care Group is fully engaged with this work, has three wards within the scope of programme activities (Bryngofal, St Caradog and Morlais) and provides the chair and leadership for one of the programme workstreams.

The programme recognises existing positive practice across ward settings, despite significant pressures and challenges and commits to increasing support for wards by working closely with teams, to collaboratively make further progress for the benefit of both patients and staff. The programme has four priority areas for improvement within patient safety:

1. Procedural Safety - Drawing together existing procedures and policies surrounding restrictions and working to understand and realise opportunities for improvement.
2. Relational Safety - Continuing to embed the Person-Centred Safety Planning Programme, working to enhance and standardise multi-disciplinary team support to wards, delivering an evidence review around risk formulation and piloting Safe Wards.
3. Environments of Care - Reviewing ligature risk assessments, developing and implementing an all Wales ligature assessment and management process, and publishing an all Wales training package.
4. Safe Discharge - Co-designing a broad set of discharge standards with patients, families and carers, and developing and implementing a standardised approach to 72-hour follow up.

This strategic context is relevant to the local quality management system as it provides the foundational policies, principles and legislative frameworks that guide the delivery of mental health and learning disability services. By embedding these national strategies into quality management, the Clinical Care Group will better meet regulatory standards, enhance patient outcomes and ensure that care is responsive to the evolving needs of the population.

## Asesiad / Assessment

### Quality Management System

The Clinical Care Group is reviewing its operational governance structures in line with the Health Boards restructure and introduction of Clinical Care Groups. Examples are provided below of the current structures and processes in place, underpinning the quality management system across the Mental Health and Learning Disabilities Clinical Care Group.

<b>Quality Planning</b>	<b>Quality Improvement</b>
<p>Planning Objectives and priorities.</p> <p>Development and review of service specifications.</p> <p>Commissioning of 3<sup>rd</sup> Sector organisations to deliver local mental health support for example Sanctuary's and Individual Placement Support.</p> <p>Development of feedback sources and use of Civica for example in the Admiral Nurse Service.</p> <p>Patient stories – current development of the story of a family bereaved by suicide.</p> <p>Thematic review of complaints through Heads of Service Reports.</p> <p>Staff feedback from Discovery workshops leading to culture and organisational development plan.</p> <p>Local strategic leadership and partnership approaches through the Mental Health Partnership Board.</p> <p>Involvement with Strategic Programme for Mental Health and Clinical Networks.</p> <p>Mental Health and Wellbeing Strategy.</p> <p>Suicide Prevention and Self Harm Strategy.</p>	<p>Current EQliP projects:</p> <p>Embedding Person Centred Safety Planning</p> <p>Reducing risk of harm associated with the use of Antipsychotic medication to improve outcomes for people living with dementia under the care of Older Adult Community Mental Health Teams.</p> <p>QI approach planned with annual plan priorities.</p> <p>Engagement with national improvement programmes eg Dementia, Neuro Development.</p> <p>Co production of National Patient Safety Programme for Mental Health.</p>
<b>Quality Control</b>	<b>Quality Assurance</b>
<p>Oversight of quality, safety and experience through Mental Health and Learning Disabilities internal groups and forums that report into Health Board wide Groups and Committees. For example Quality, Safety and Experience Group, Workforce Management Group, Business Planning and Performance Assurance Group.</p> <p>Risk escalation processes.</p> <p>Regular schedule of Leadership Triumvirate site visits.</p>	<p>Team level assurance through Ward Manager and Community Manager Forums.</p> <p>Implementation of national PREMS / PROMS.</p> <p>Staffing Reviews.</p> <p>Weekly/Monthly Care Group review meetings of:</p> <ul style="list-style-type: none"> <li>- Audit and Inspection Tracker</li> <li>- Incident Management Groups/Closure Group</li> <li>- Complaints</li> <li>- Risk Register</li> </ul>

Active use of 'Our Data' for monitoring and triangulation.

Planned development of a Health Board Mental Health and Learning Disabilities Quality Dashboard to track for example levels of compliance with 72 hour follow up after discharge, point of ligature assessments and incidents of restrictive practice.

Mental Health and Learning Disabilities Written Control Document Group.

Mental Health Scrutiny Group and Legislation Committee to assure on compliance with mental health legislation.

Recent establishment of the Mental Health and Learning Disabilities Clinical Audit and Effectiveness Framework.

Serious Incident Learning Forum.

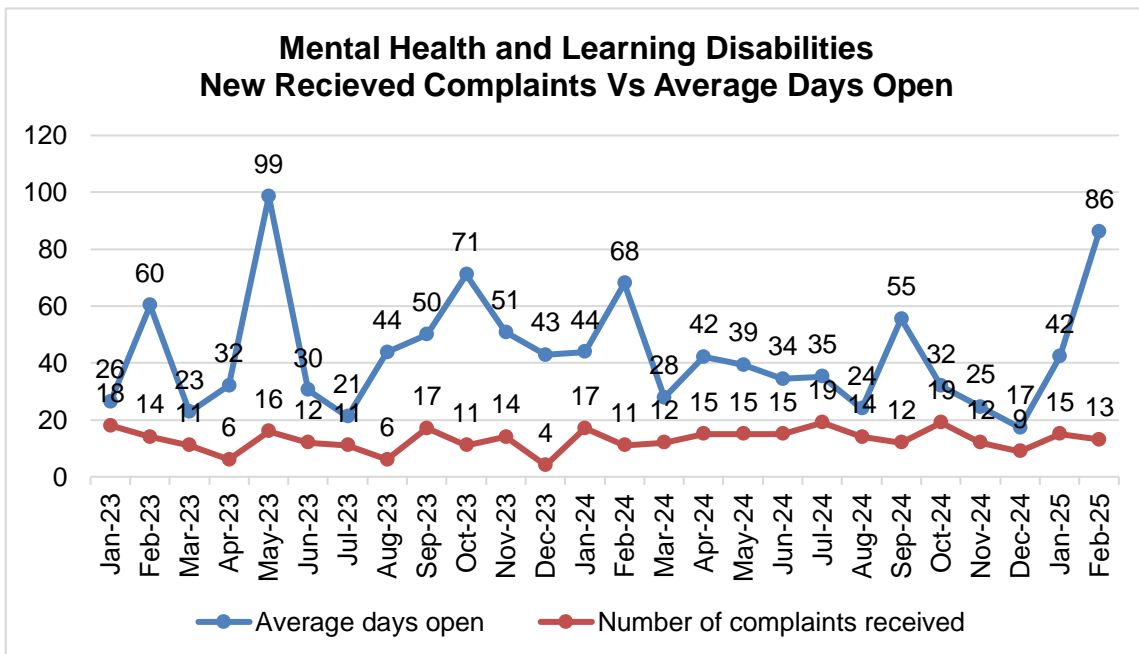
Accreditation processes.

**Quality and Governance Areas of Escalation**

Areas for improvement identified through the Health Boards escalation framework relate to 3 areas; complaints management, incident management and closure of overdue actions from a range of audit, inspection and peer review reports that apply to the Clinical Care Group.

**Complaints Management**

The number of complaints received across the Clinical Care Group remains stable with an average of 13 new complaints received each month. The trend graph below shows the variation in new complaints received each month versus the average number of days complaints remain open.



As of the 26<sup>th</sup> March there are 31 open complaints across the Clinical Care Group.

Of these 5 have been opened for over 6 months and a further 7 have been open between 3-6 months. A number of these are linked to complex serious untoward incident cases where concurrent proportionate reviews are also being undertaken to review service delivery and

identify areas of learning. The table below shows where each of these cases are within the complaints review process. All of the cases open over 6 months are now at final stages of the process which sit with the patient experience team. There are 4 cases that have been open between 3-6 months which the Clinical Care Group is actively working to review and provide information to enable a response.

Duration Open	With Patient Experience Team			With services within the Clinical Care Group
	Final Sign Off	Quality Assurance	Response being drafted	
Open over 6 months	1	2	2	0
Open 3-6 months	1	1	1	4
<b>Total</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>4</b>

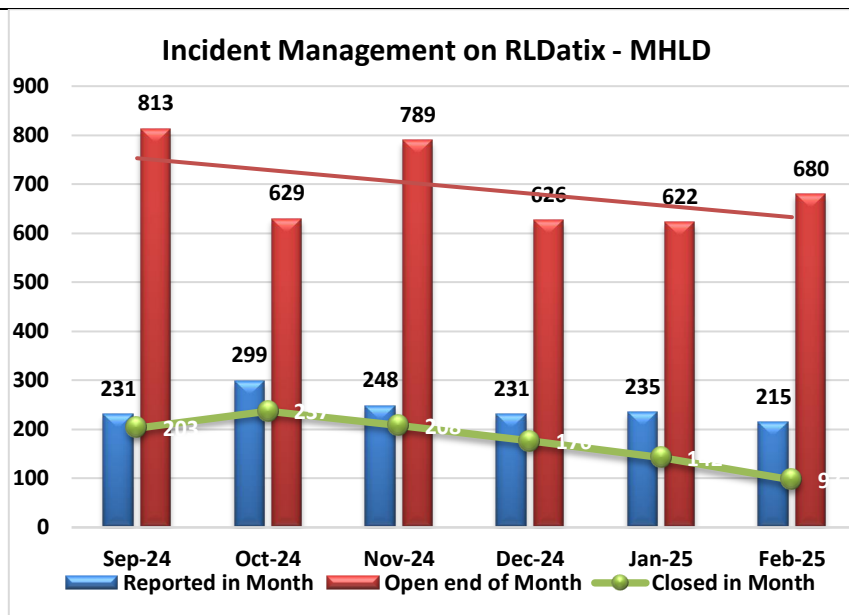
Actions in place to support improvement:

- Weekly complaints reports are generated and shared widely across the Clinical Care Group to enable frequent review of the position with cases.
- A monthly Complaints Review meeting has been instigated with Heads of Service and the Patient Experience Team, chaired by the Assistant Director of Nursing, Patient Safety, Quality and Patient Experience, to review blockers to progress, share updates and information between services and the Patient Safety Team and to ensure oversight of cases.
- Heads of Service are required to provide service level information in Service Reports to Mental Health Quality, Safety and Experience Group to support thematic review.

### Incident Management

The chart below shows the last 6 months trends in numbers of incidents reported across the Clinical Care Group, alongside monthly closures throughout the same period and the overall numbers of incidents that remain open. The number of incidents reported has fluctuated throughout the period.

Whilst the overall number of open incidents has reduced from 813 to 680 over the period, the rate of closures on a monthly basis has also reduced which is a deteriorating position.



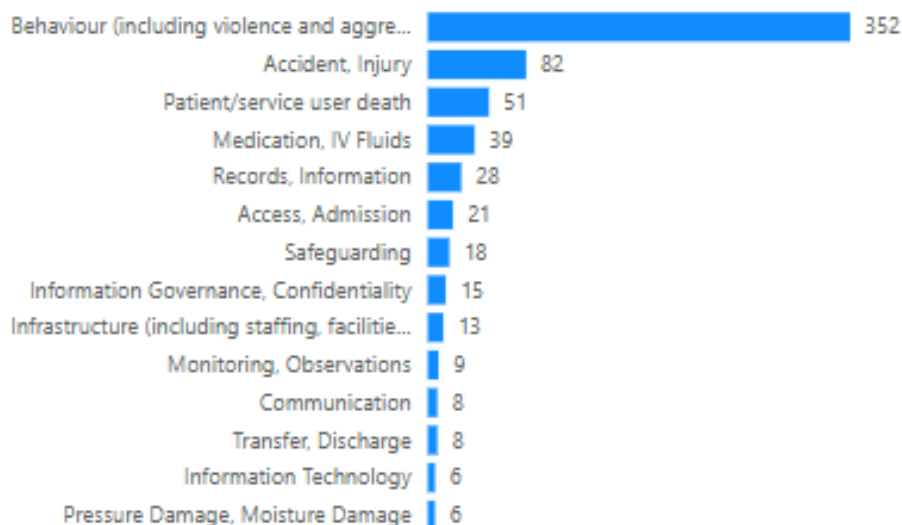
A high proportion of open incidents sit with inpatient services where there are much higher rates of reporting due to being 24 hour 7 day services and its purpose for providing inpatient care to individuals with highest levels of clinical risk and need. This is illustrated in the data below, including the snapshot of open incidents where it can be seen that the main type of incidents are related to behaviours including violence and aggression which are predominantly reported by inpatient services. Further work is planned for more detail analysis of incidents of violence and aggression and the Clinical Care Group is working with colleagues in informatics and patient safety teams to develop a bespoke quality dashboard which will include a wider range of quality metrics and more targeted breakdown of incident categories, pertinent to mental health and learning disabilities

Inpatient services are currently highlighted as fragile due to workforce challenges which are noted in a later section of this report. Action planned to stabilise the workforce across inpatient areas will support releasing time within ward leadership teams to focus on timely closure of incidents.

Service	Number Open Incidents	Days of Longest Open Incident
CMHT - Llanelli	6	734
CMHT - North Ceredigion	7	545
Older Adult Mental Health / OACMHT - Carmarthenshire	4	493
Acute care & In-patient Services	309	465
Adult ADHD Service	3	459
Liaison Service - Ceredigion	1	424
Older Adult Mental Health	30	423
Liaison Service - Carmarthenshire	37	420
Mental Health Management Team	4	403
CRHTT - Carmarthen	3	362
CMHT - Carmarthen	3	326
Child & Adolescent Mental Health Services	16	309
CDAT - Carmarthen	5	286
Liaison Service - Pembrokeshire	9	285

Learning Disabilities / CTLD - Carmarthen	7	278
CMHT - South Ceredigion	8	273
Learning Disabilities / CTLD - Pembrokeshire	4	255
CRHTT- Llanelli	4	227
Learning Disabilities / CTLD - Ceredigion	1	207
CMHT - North Pembs	3	172
Older Adult Mental Health / OACMHT - Ceredigion	3	161
CMHT - Ammanford	1	156
Older Adult Mental Health / Inpatient Services	32	141
Older Adult Mental Health / Dementia Wellbeing Service	3	132
Learning Disabilities	2	125
CMHT - South Pembs	1	117
Mental Health Act Department	4	114
Mental Health Commissioning Team	4	114
Learning Disabilities / Intensive Support Team	1	103
CDAT - Ceredigion	2	76
CRHTT - Pembrokeshire	1	54
Learning Disabilities / Learning Disability Residential Service	5	35
Psychology Services	1	30
CDAT - Pembrokeshire	2	26
111 Single Point of Contact	1	18
Integrated Autism Service	1	13
Older Adult Mental Health / Memory Clinic	1	11
Learning Disabilities / CTLD - Llanelli	1	6
CRHTT - Carmarthenshire	2	5
CRHTT- Ceredigion	1	4
Older Adult Mental Health / OACMHT - Llanelli	1	2
Older Adult Mental Health / OACMHT - Pembrokeshire	1	2

### Snapshot of open incidents across the Clinical Care Group as of 28<sup>th</sup> February 2025



Actions in place to support improvement:

- Monthly incident trend reports to be provided to the Clinical Care Group moving forwards by the patient safety team, to be added to monthly Incident Management Meetings.
- Incidents over 120 days added to Clinical Care Group deep dive dashboards scrutinised through internal operational governance structures.
- The Quality Assurance Practice Development team continue to liaise with relevant operational leads and raise at Ward Manager and Community Manager Forums to address older cases to expedite reviews and move to closure.
- Plans to approve and implement workforce stabilisation plans for inpatients during quarter 1 2025/26 which will support releasing ward leadership capacity to address incident closure.

### **Closure of overdue actions (external audit, review, inspection and peer review reports)**

The Clinical Care Group currently has 9 open improvement plans, in response to recommendations generated from a range of external audit, review, inspection and peer review reports. Details of these are provided in the table that follows.

The 2 most recent improvement plans are in response to:-

- HIW Inspection of Bryngolau Ward (40 recommendations) added November 2024
- Children and Young Peoples Mental Health Review (9 recommendations) added February 2025

A total of 61 recommendations have been closed since September 2024.

During December 2024, all open reports were scrutinised and peer reviewed by colleagues from Quality and Assurance Teams informing recommended approaches to reach completion with revised timescales, to be reviewed for approval by Execs.

Acknowledgement received that comprehensive work is being undertaken and that actions are delayed due to:

- Capacity – several overdue actions relate to strategic, directorate wide developments that have been delayed due to the need to be responsive to competing priorities or are impacted by workforce gaps.
- Some of the actions are superseded by national work to develop discharge standards for mental health through the national patient safety programme which the directorate is actively engaged in. This is reflected on AMaT.

The directorate continues to hold monthly meetings to operationally review progress with actions and identify escalation of actions held by other Health Board departments outside of the Clinical Care Group.

Regular reports are received from the Assurance and Risk Team to Clinical Care Group operational meetings to ensure governance and oversight of this work.

A regular report on Estates owned actions has been instigated to report into the Clinical Care Groups Accommodation Steering Group to support escalation of estates led overdue actions.

**Status of Open Improvement Plans generated in response to recommendations from external audit, review, inspection and peer review reports**

Financial Year	Report issued by	Report Title	Status of Report	Lead Service/Directorate	Lead Officer	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	September 2024			March 2025			Total recs closed since Sep 24
										Red (behind schedule)	Amber (on schedule)	Green (complete)	Red (behind schedule)	Amber (on schedule)	Green (complete)	
2023/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Chief Operating Officer	Mar-24	Oct-24	6	3	0	3	2	0	4	1
2023/24	HW	St Non, St Caradog, Canolfan Bro Ceryn WGH	Open	Mental Health & Learning Disabilities	Liz Carroll	Chief Operating Officer	Oct-24	Oct-24	19	5	0	14	2	0	17	3
2023/24	HW	Mental Health Discharge Review	Open	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	Mar-24	<del>Apr-24</del> Dec-24	40	34	0	6	25	0	15	9
2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	Mental Health & Learning Disabilities	Angela Lodwick	Chief Operating Officer	Nov-24	Nov-24	9	1	1	7	3	0	6	6
2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	Mental Health & Learning Disabilities	Liz Carroll	Chief Operating Officer	Dec-24	Dec-24	9	5	2	2	6	0	3	1
2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	Mental Health & Learning Disabilities	Liz Carroll	Chief Operating Officer	Jun-24	<del>Jun-24</del> N/A	16	5	0	11	3	0	13	2
2024/25	HW	Glangwili Hospital - Morlais Ward	Open	Mental Health & Learning Disabilities	Rebecca Temple-Purcell	Chief Operating Officer	Mar-25	Mar-25	9	1	6	2	2	0	7	5
2024/25	HW	Bryngolau Ward, Prince Philip Hospital September 2024	Open	Mental Health & Learning Disabilities	Rebecca Temple-Purcell	Chief Operating Officer	Aug-25	Aug-25	40	1	39	0	4	2	34	34
2024/25	HW	Children and Young People Mental Health Review	Open	Mental Health & Learning Disabilities	Rebecca Temple-Purcell	Chief Operating Officer	Feb-25	Feb-25	9	0	9	0	0	9	0	0
									<b>Total</b>	55	57	45	47	11	99	61

## Key Risks across the Mental Health and Learning Disabilities Clinical Care Group

The Clinical Care Group currently has 34 open risks on its risk register. An overview of risk scores can be found below:

### Risk overview

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
34	2	6%	93	2	2%

### Risk heatmap

		Likelihood				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Impact	Catastrophic 5		1376 139 1811	2011 2012	2010	
	Major 4		1634	2021 1971 1926 971 839	1553 1912	1032 1290 1612 1813 1287
	Moderate 3		1582 1291 1781	1857 1896 1379 138 1455 1392	1249 1525	
	Minor 2			1408 1365	1375 1524	
	Negligible 1					

The Clinical Care Groups five highest scoring risks all relate to a risk of service users not receiving timely access to services due to clinical needs/volume of service demand being higher than the services capacity, either as a result of, or compounded by workforce gaps. The risks affect the safety, timeliness, efficiency and effectiveness of service delivery.

Impacted areas are

- children and adults waiting for assessment and diagnosis of Autism Spectrum Disorder (ASD)
- adults waiting for assessment, diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD)
- adults waiting for access to psychological therapies
- adults seeking access to mental health services in North Ceredigion through both the Community Mental Health Team and Crisis Resolution Home Treatment Team.

The Clinical Care Group is taking action to both mitigate current risk and to develop transformational approaches that aim to sustainably improve services. These areas of improvement can be cross referenced to priorities and objectives described within the Clinical Care Groups annual plan.

Further detail specific to Childrens ASD waiting times and a temporary change to GP referral pathways for mental health assessments in Ceredigion are contained in reports to be presented to board on 27<sup>th</sup> March 2025 which can be found here with linked Quality Impact Assessments.

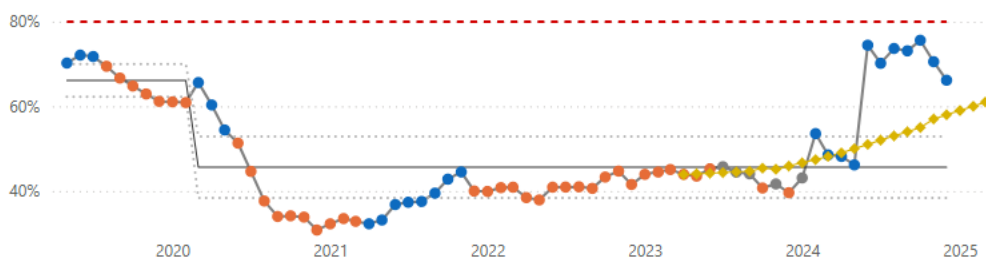
[Measures to Improve Children's ASD service performance Board 27 March 2025](#)

Temporary change to the GP Referral Pathway for Mental Health Assessments within Ceredigion.

### [Mental Health Service Change Temporary Ceredigion Board 27 March 2025](#)

Standards relating to adults access to psychological therapies are defined within Part 1 of the Mental Health Measure (Wales) 2010. The Health Boards performance to ensure that 80% of adults referred for psychological therapy begin treatment within 26 weeks remains below target however above the current improvement trajectory agreed with Welsh Government.

#### **% adults waiting <26 weeks to start a psychological therapy**



Recent progress has included stronger waiting list monitoring, more group-based interventions, and development of a Patient Access Policy to ensure timely, consistent provision of care. Further work is planned for 2025/26 with the aim of reaching target by August 2025. Plans to support this include reviewing job plans to embed a stepped model of interventions to maintain resilience when workforce gaps emerge. The Health Board is about to participate in a national knowledge exchange to share and receive improvement knowledge and learning in this area of practice. It will also pilot implementation of a set of nationally identified patient-reported outcome and experience measures (PROMs and PREMs) to monitor the effectiveness of services and enable more informed benchmarking with other services.

<https://phw.nhs.wales/services-and-teams/improvement-cymru/our-work1/mental-health/outcome-measures/introductory-documentation/information-poster/>

A formal evaluation of the stepped model will take place in 2025/26 and will inform finalisation of a service specification. The Clinical Care Groups quality management system will continue to monitor and report performance and quality impacts.

#### **Quality Improvement Spotlight - Person Centred Safety Planning**

Following participation in a nationally coordinated pilot of person-centred safety planning where Morlais Ward piloted this approach, the Clinical Care Group is now using the EQliP model to further scale and spread practice. The aim of this work is that all patients admitted to a mental health ward who are at risk of self-harm or suicide, are offered the opportunity to co-produce a person-centred safety plan. The approach is informed by NICE guidelines and evidence that indicates the approach improves outcomes through enhanced engagement, tailored interventions and a collaborative approach to safety. Preparation has been done with staff and managers to share principles of person-centred safety planning and to remove barriers to embedding into practice. Time has been given to reflect on practice to build confidence and skills in talking about suicidal thoughts with patients in a way that focuses on safety rather than risk. Positive feedback has been received from staff

and patients about the impact of this approach through the pilot and the EQiP project seeks to develop more systematic feedback to further evaluate the approach.

### **Learning Disabilities Service Improvement Programme**

An updated learning disabilities service model has been developed, shaped by staff and public engagement, aligned to the values of safety and inclusivity defined in national strategy. The model, clarifies clinical pathways, reconfigures community and inpatient services, and introduces a Lead Nurse role, now in post, to oversee professional practice. Workforce structures to deliver the model have been approved by executives and plans for recruitment are now being made. Implementation will be further strengthened by the launch of a digitised Health Equality Framework (HEF) in 2025/26 to enable the Board to better track outcomes for people using LD services. By the end of 2025/26, the goal is to reduce vacancies and progress towards 80% of individuals open to secondary learning disability services having a valid HEF, boosting accountability and quality of care.

### **Inpatient Workforce Stabilisation**

A review of nurse staffing levels across Inpatient Mental Health Wards is in final stages of scrutiny ahead of final consideration for approval by the Executive Team. The review is in response to sustained staffing challenges due to establishments being insufficient to deliver standard care needs for inpatient episodes of care resulting in high dependency on temporary staff. This can impact continuity and quality of care delivery. Additionally, the reliance on overtime and extra hours places additional strain on the existing workforce operating with already suboptimal levels, risking burnout and decreased job satisfaction. Addressing the staffing establishment deficit is crucial for ensuring that Inpatient-Services can consistently provide safer, more effective, values-based care. This action will also impact on the effectiveness of quality assurance processes, releasing time currently required by clinical leads to manage rosters and provide direct care in covering roster gaps, to focus on quality management system functions. This piece of work is expected to conclude in quarter 1 of 2025/26.

### **Argymhelliad / Recommendation**

The Committee is asked to:

Take ASSURANCE from the information presented in this report regarding the effectiveness and ongoing development of the quality management system in the Mental Health and Learning Disabilities Care Group. The report outlines measure in place to promote high standards of care, safety and service delivery for people with mental health and learning disabilities. The committee is encouraged to take confidence in the commitment to improving standards and provide further recommendations for strengthening these.

### **Amcanion: (rhaid cwblhau)**

### **Objectives: (must be completed)**

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:

Datix Risk Register Reference and Score:

All risks held on the Mental Health and Learning Disabilities Care Group risk register. Datix references contained within the main body of report.

Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	5 Mental health and CAHMS 1 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	8. Transform our communities through collaboration with people, communities and partners

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	ADHD – Attention Deficit Hyperactivity Disorder AMaT – Audit Management and Tracking system ASD – Autism Spectrum Disorder  EQIIP – Enabling Quality Improvement in Practice HEF – Health Equalities Framework HIW – Health Inspectorate Wales NICE – National Institute for Care Excellence
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Not Applicable (N/A)
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Initiatives described will promote more timely access to assessment.

<b>Gweithlu: Workforce:</b>	Initiatives described will promote staff wellbeing.
<b>Risg: Risk:</b>	Initiatives described will reduce documented risk.
<b>Cyfreithiol: Legal:</b>	No legal challenges anticipated.
<b>Enw Da: Reputational:</b>	N/A
<b>Gyfrinachedd: Privacy:</b>	N/A
<b>Cydraddoldeb: Equality:</b>	N/A

# Duty of Quality

## Quality-driven decision-making tool



### Part 1 - Quality Impact Assessment Toolkit

#### Overview & Guidance

This initial assessment should be completed to quantify potential impacts on quality or safety aspects (either positive, negative, or neutral/no impact), from any strategic decisions e.g. policy decisions, business cases, service improvements and changes, or efficiency savings projects that will affect operational services.

When completing the checklist consider the impact that the change will bring about in the long term. Also consider any impacts that might occur whilst the change is being implemented. For example, the project may be to introduce a new clinical pathway into an existing team, this will reduce waiting times for patients and result in smaller caseloads which are both long-term positive impacts. However, to introduce the new pathway staff working arrangement will need to change which may increase staff turnover resulting in patient waiting times for treatment increasing both are short term negative impacts. The QIA should reflect both the short-term and long-term impacts.

For the approval process and to ensure you are using the current version of the tool, please visit the QIA SharePoint page [https://nhs.wales365.sharepoint.com/sites/HDD\\_Nursing-assurance-and-safety/SitePages/Quality-Impact-Assessment.aspx](https://nhs.wales365.sharepoint.com/sites/HDD_Nursing-assurance-and-safety/SitePages/Quality-Impact-Assessment.aspx)

The tool once approved by the Directorate Triumvirate should be submitted to [patient.safety@wales.nhs.uk](mailto:patient.safety@wales.nhs.uk) for consideration at the QIA Panel

<b>Strategic Decision / Organisational Activity / Project Title:</b>	<b>Measures to improve Children's Autism Spectrum Disorder (ASD) service performance</b>
<b>Name and role of lead:</b>	Liz Carroll Director of Mental Health and Learning Disabilities
<b>Executive sponsor:</b>	James Severs, Executive Director of Allied Health Professionals and Health Sciences

Description of Strategic Decision / Project:	
Broadly outline what is being proposed and the decision that needs to be made	The Childrens ASD service proposes to pilot a rapid assessment to diagnosis pathway for individuals that meet set eligibility criteria and who are currently on the services waiting list. The pathway will reduce the length of time taken to assess an individual by using information gathered by healthcare and education professionals, already involved with the individual, that will then be reviewed by an assessment panel of appropriately experienced experts to inform a diagnostic outcome. Further actions to improve the effectiveness of the service include; scoping digital options to further streamline referral processes and to speed up the process of generating reports; reviewing and influencing wider strategy development across the three counties with partners, moving towards needs based systems of service provision rather than assessment led.
Why is the proposal / decision needed	The proposal is required as Hywel Dda University Health Board's Children's Autistic Spectrum Disorder (ASD) service is under targeted intervention for quality and performance. Current risks associated with delayed waits for assessment and diagnosis are reflected on the Mental Health and Learning Disabilities (MHL) Directorate and corporate Risk Register.
What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities, quality standards, incidents etc)	The drivers are that Welsh Government have identified ASD services in Wales as unable to meet the current performance standards due to increased demand, limited service provisions and the current service model of operation.
Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected	Individuals waiting on a diagnostic assessment and their families and carers.
How have you engaged with the people affected? If you have not yet engaged, what are your plans?	If approval is received for proposed change, the service and directorate will engage with HDUHB Engagement Team and will proceed with an engagement/communications plan. Information will be provided to all parents and carers of individuals considered for the pilot and will be asked to confirm their consent to this method of assessment.
How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?	This service is a ministerial priority and this proposal will potentially improve required Welsh Government performance targets.
Is the proposal / decision planned to be temporary or permanent?	Proposal for Pilot therefore a temporary arrangement pending evaluation.

<b>Has this Quality Impact Assessment been completed in collaboration with the clinical team(s) that the project will affect?</b>	Yes
	Service Delivery Manager for Children's ASD service, Assistant Director for MH&LD, Assistant Director for Nursing MH&LD.

This tool was developed by the Quality Assurance and Safety Team using ideas from Rotherham, Doncaster and Humberside NHS Trust QSIA tool and the NHS (Wales) Executive beta tool <https://www.rdash.nhs.uk/wp-content/uploads/2022/10/QSIA-Policy-v1.pdf>

For advice and guidance using this tool, please contact Olwen Morgan, Assistant Director of Nursing, Cathie Steele, Head of Quality and Governance or Caroline Burgin, Patient Safety and Assurance Manager.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Safe	Hywel Dda University Health Board's Children's Autistic Spectrum Disorder (ASD) service is under targeted Intervention for quality and performance. Current risks are associated with significant waits for a first appointment to begin the process for assessment and diagnosis. This risk is reflected on the Mental Health and Learning Disabilities (MHL D) Directorate and corporate Risk Register.	5	4	20				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	3	9	The pilot proposal will reduce current waiting lists and will target those who have been waiting for a first appointment for the longest time. If successful the service change should improve compliance with Welsh Government performance targets.
Timely	The service is not able to provide timely access for a first appointment to commence the assessment process for diagnosis for ASD. Also, the assessment process is protracted, repetitive and time consuming.  Current number of Children and Young Person (CYP) waiting for a first assessment and diagnosis is 3658 (January 2025). Of these 3138 have breached the 26 week waiting period.	5	5	25				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	This pilot will enable CYP with the longest wait if referred by a Paediatrician or Health Visitor to be offered an alternative to conventional assessment processes to confirm/exclude a diagnosis of autism.
Effective	The current assessment process does not enable adherence to the National Institute for Health and Care Excellence (NICE) guidelines which requires assessments to start within 3 months of referral.	3	3	9				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	3	9	Whilst this pilot will further deviate from NICE guidelines by the service to be able to evidence that the conversion rate from assessment to diagnosis is 87% which provides assurance in respect of the clinical information received at the point of referral being a strong indicator of the likelihood of an ASD diagnosis. The variation to the assessment process will only be undertaken with the CYP and their families consent.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Efficient	Currently all CYP referrals are required to undertake an assessment process where they are assessed in person, observation is required and completion of the process takes approximately 20 hours. This is resource intensive and the service is not established with capacity to deliver this process to meet the level of referrals made to the service in a timely way. The set standard is to provide assessment within 26 weeks of referral. As of January 2025 the service achieved 14.2% of this target.	5	4	20				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	The impact of the proposed change to the referral and assessment process will create capacity within the service to undertake a higher number of ASD assessments. The change will enable the service to accept clinical information at the point of referral which will avoid duplicate assessment and observation practices when this clinical information has been provided from a reliable source.
Equitable	All CYP will still receive an assessment and confirmation or rejection of diagnosis but without the need for the 20 hour assessment process.			0				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.			0	Has an EQIA screening tool been undertaken? Yes Has a full EQIA been undertaken? No  Please provide a summary below: Positive impacts identified for all age categories and disability category as reducing timeline for assessment will impact children, parents and guardians. Positive socio economic impact identified as proposal reduces impacts to families who cannot afford to pursue private assessment and diagnosis and positive impact noted on likely reduced requirement for transportation. <b>Link to full EQIA when published</b>
Person-centred	The current assessment process does not offer choice for the child, young person or carer, or flexibility when evidence already available to confirm presence of autism. All referrals for assessments are required to undertake a 20 hour assessment process.	5	5	25				Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	3	9	This process will offer children, young persons and their parents/carers the opportunity to consent to an alternative method of assessment to confirm or reject diagnosis of ASD. Information gathered by professionals with established relationships with the CYP will be used to inform diagnosis.

# Full Assessment

Strategic Decision / Organisational Activity / Project Title:		Measures to improve Children's ASD service performance				Name and role of lead: Liz Carroll Director of Mental Health and Learning				Driver for change													
Health & Care Quality Standard (pick from drop down list)	Health & Care Quality Enabler (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective) Please list all applicable	Description of Risk	Inherent RISK Score			Current Mitigation	Current RISK Score			Monitoring Arrangements													
			Likelihood 1-5	Impact 1-5	Overall score		Likelihood 1-5	Impact 1-5	Overall score	Owner	Quality Indicator How will you measure the healthcare quality? What can indicate a change in the quality?	Current baseline of indicator	Trigger for escalation The trigger level at which the impact is escalated	Actions Actions to be taken once the trigger is breached	Monitoring Committee (This will usually be local governance arrangements and DITS)	Frequency How often	Target RISK score						
										Likelihood 1-5	Impact 1-5	Overall score	Date Escalated	Where Escalated	Further action to be taken								
Timely	Whole-system perspective	Hywel Dda University Health Board's Children's	5	5	25	Increased assessment capacity through	5	4	20	Angela Loi	Service user feedback Performance targets	14.20%	Service user dissatisfaction Deteriorating performance	Pause pilot and up Pause pilot and up	MHLD OSEG and MHLD OSEG and	Bi monthly Bi monthly	3	3	9				

Audit Trail of Comments		
Date	Name	Comments

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**QIA Panel Use Only**

<b>Considered and supported by:</b>	<b>Name</b>
Deputy Director of Health Science	Jon Arthur
Head of Strategic Partnerships	Anna Bird
Associate Medical Director for Quality and Safety	Subhamay Ghosh
Assistant Director of Nursing, Assurance & Safeguarding	Cathie Steele
Consultant in Public Health Medicine	Michael Thomas
Assistant Director of Assurance and Risk	Charlotte Wilmshurst

<b>Considered and approved by Clinical Executive:</b>	<b>Name</b>
Director of Nursing, Quality and Patient Experience	Sharon Daniel
Medical Director	Mark Henwood
Director of Therapies and Health Science	James Severs

<b>Date presented to panel</b>	
<b>Panel decision</b>	
<b>Chair of Panel</b>	

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Supported	Date

Approved	Date

# Duty of Quality

## Quality-driven decision-making tool



### Part 1 - Quality Impact Assessment Toolkit

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<b>Strategic Decision / Organisational Activity / Project Title:</b>	<b>Temporary change to the GP Referral Pathway for Mental Health Assessments within Ceredigion.</b>
<b>Name and role of lead:</b>	<b>Liz Carroll</b>
<b>Executive sponsor:</b>	<b>Andrew Carruthers</b>

Description of Strategic Decision / Project:	
Broadly outline what is being proposed and the decision that needs to be made	An urgent temporary service change, to divert non urgent referrals made to Ceredigion Community Mental Health teams to 111 option 2, with additional safeguards is proposed and has been implemented due to clinical safety concerns in mental health community services in Ceredigion due to acute staffing deficits of doctors and nurses.
Why is the proposal / decision needed	The proposal was needed to prioritise the provision of secondary and urgent care in Ceredigion
What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities, quality standards, incidents etc)	The drivers are acute staffing deficits and the need to prioritise safe and effective care in the community and also the requirement to meet performance target in relation to Mental Health (Wales) Measure legislation
Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected	Individuals who require a routine assessment of their mental health following GP referral.
How have you engaged with the people affected? If you have not yet engaged, what are your plans?	The service has engaged with GPs, HDUHB Clinical Director, Executive Team, Communication and Engagement Team, Llais in a range of formats to communicate information about the temporary service change. A meeting with the Communication and Engagement Team and the Director for West Wales Action for Mental Health has been undertaken and a plan for wider engagement and feedback has been developed to monitor and evaluate the temporary service change with service users and carers. Service attendance at the Ceredigion Mental Health Forum has been arranged. Initial conversations have taken place with the RCN staff representative and wider stakeholder engagement is planned.
How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?	The proposal is intended to improve compliance with performance indicators under Mental Health Measure (Wales) which requires 90% of LHB residents who are in receipt of secondary mental health services to have a valid CTP. As of 25/03/25 compliance for North Ceredigion is at 56.46% and South Ceredigion is 97.2%.
Is the proposal / decision planned to be temporary or permanent?	Temporary 6 months

<b>Has this Quality Impact Assessment been completed in collaboration with the clinical team(s) that the project will affect?</b>	<b>YES</b>
	Associate Medical Director & Clinical Director Mental Health & Learning Disabilities, Head of Service Adult Mental Health, Assistant Director for Nursing MH&LD, Assistant Director MH&LD

This tool was developed by the Quality Assurance and Safety Team using ideas from Rotherham, Doncaster and Humber NHS Trust QSIA tool and the NHS (Wales) Executive beta tool  
<https://www.rdash.nhs.uk/wp-content/uploads/2022/10/QSIA-Policy-v1.pdf>

For advice and guidance using this tool, please contact Olwen Morgan, Assistant Director of Nursing, Cathie Steele, Head of Quality and Governance or Caroline Burgin, Patient Safety and Assurance Manager.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Safe	Due to medical and nursing deficits there is a clinical risk that patients referred to the CMHT by their GP for a routine Mental Health Assessment will not receive this in the required 28 day time frame. There is an additional risk that the CMHT will not have the capacity to undertake assessment of urgent referrals due to the time required to assess the number of routine referrals they receive.	4	5	20	v			Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	The proposed temporary service change is due to current service pressures as a result of medical and nursing vacancies and absence in Ceredigion Community Mental Health teams. This temporary service change will enable community mental health team resources to prioritise urgent and secondary care provision for the 'Relevant Patient' as required under Mental Health (Wales) Measure legislation. Promotion of 111 option 2 by GPs for individuals whose referral to mental health services is non urgent, will create capacity within the service to deliver urgent and secondary care for patients. The is capacity and resources in the 111 option 2 service to accommodate this change.
Timely	Currently there is a waiting list for people who have been referred by their GP for a routine mental health assessment in the CMHT. This is due to the service not having the capacity to undertake the assessment within the required 28 days.	4	5	20	v			Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	3	9	The proposed temporary service change will focus on patients who require routine mental health assessments. By accessing 111 option 2, this will enable timely access to a mental health assessment as opposed to waiting the 28 days for an appointment with the CMHTs. This will enable more effective use of resources to provide urgent and secondary care. Impact is anticipated to be positive as there will be a more timely response for both routine and consequently urgent referrals.
Effective	The CMHT currently does not have the capacity to undertake routine assessments within the required time frame. This has created a waiting list, but the service does not have the resources to effectively manage the 'waiting list' in order to reduce the length of time that patients are currently waiting. There is a clinical risk that patients mental health could deteriorate during this delay.	5	5	25	v			Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	This change creates capacity in the CMHT to provide safe and effective care for patients who meet the eligibility criteria for secondary mental health care in the community and to respond to urgent referrals. There is also a requirement from Mental Health (Wales) Measure legislation in respect to performance targets for people who are eligible for secondary care. Which is to allocate a care coordinator and complete a care and treatment plan within a required time frame.
Efficient	The CMHT is a secondary mental health community service and is required to adhere to Mental Health (Wales) Measure legislation and meet the required performance targets for part 2 and 3 of the measure.	4	4	16	v			Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	This temporary service change allows for routine referrals to be re-directed to 111 option 2 in order to create capacity in the CMHT. It will be more efficient for routine referrals to be assessed by 111 option 2 as they have the resources to undertake this role and they are currently meeting their service targets in respect to response times to answer a call. This will support the CMHT to improve the performance targets required by Welsh Government and also to deliver safe and effective care. During this temporary change both the CMHT and 111 option 2 will obtain

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Equitable	Patient who are identified as requiring an assessment of their mental health within a routine time frame will still receive a mental health assessment but this will be undertaken by 111 option 2 by telephone not in person by the CMHT and this will not delay further interventions if required. Those that require urgent mental health assessment will continue to be seen by the CMHT or crisis team.	5	5	25	v					0	<p>Has an EQIA screening tool been undertaken? Yes</p> <p>Has a full EQIA been undertaken? Yes</p> <p>Please provide a summary below: Impacts identified within disability category. No impact identified for individuals that require urgent referral. Positive impact identified for individuals that require routine referral as access to assessment will be expedited and safeguards in place to mitigate sensory or communication needs. No other impacts identified.</p> <p><b>Link to full EQIA when published</b></p>	
Person-centred	The usual pathway for routine referrals made by GPs is for the service to contact the patient upon receipt of the referral and offer a date and time for a mental health assessment, for which they are required to attend in person at the location of the CMHT. Due to current capacity pressures, and without the proposed change, current referrals will generate a waiting list.	4	5	20	v		Leadership, Workforce, Culture, Information, Learning, Improvement and Research.	3	4	12	People can access a service in a timely manner that is convenient to them as they can choose when they contact 111 option 2. This service is also accessible to families and carers who can be included in the assessment process as needed. The GP is able to speak directly to the 111 option 2 service in respect of patients that may need to be assertively followed up by the team.	

# Full Assessment

Strategic Decision / Organisational Activity / Project Title: Temporary change to the GP Referral Pathway for Mental Health Assessments within Ceredigion. Name and role of lead: Liz Carroll Driver for change:

Health & Care Quality Standard (pick from drop down list)	Health & Care Quality Enabler (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective) Please list all applicable	Description of Risk	Inherent RISK Score			Current Mitigation	Current RISK Score			Monitoring Arrangements							Escalation Arrangements						
			Likelihood 1 - 5	Impact 1 - 5	Overall score		Likelihood 1 - 5	Impact 1 - 5	Overall score	Owner	Quality Indicator How will you measure the healthcare quality? What can indicate a change in the quality?	Current baseline of indicator	Trigger for escalation The trigger level at which the impact is escalated	Actions Actions to be taken once the trigger is breached	Monitoring Committee (This will usually be local governance arrangements and DITS)	Frequency How often				Target RISK score			
																	Likelihood 1 - 5	Impact 1 - 5	Overall score	Date Escalated	Where Escalated	Further action to be taken	
Safe	All	Delivery of safe and effective care	5	5	25	Proposed service change for GP	5	5	25	MH/LD	Number of serious incidents	56.46%	Indicator that the trigger is breached	Urgent review of service change.				3	3	9			
Timely											Improvement in Measurements		Further reduction	Urgent review of service change.									
Effective																							
Efficient																							
Person centred																							

Audit Trail of Comments		
Date	Name	Comments

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**QIA Panel Use Only**

<b>Considered and supported by:</b>	<b>Name</b>
Deputy Director of Health Science	Jon Arthur
Head of Strategic Partnerships	Anna Bird
Associate Medical Director for Quality and Safety	Subhamay Ghosh
Assistant Director of Nursing, Assurance & Safeguarding	Cathie Steele
Consultant in Public Health Medicine	Michael Thomas
Assistant Director of Assurance and Risk	Charlotte Wilmshurst

<b>Considered and approved by Clinical Executive:</b>	<b>Name</b>
Director of Nursing, Quality and Patient Experience	Sharon Daniel
Medical Director	Mark Henwood
Director of Therapies and Health Science	James Severs

<b>Date presented to panel</b>	
<b>Panel decision</b>	
<b>Chair of Panel</b>	

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Supported	Date

Approved	Date

2.3

10 Mins

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2.3 - Primary Care Quality and Safety and Experience Deep Dive

*Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)*

**Attachments**

[2.3 Primary Care Services.docx](#)



**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD  
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	08 April 2025
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Primary Care Update
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Jill Paterson, Director Primary Care, Community and Long Term Care
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Rhian Bond, Assistant Director of Primary Care

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**

**SBAR REPORT**

Sefyllfa / Situation

This paper provides an update on current issues in Primary Care as well as providing an assurance on the process around the HIW visiting process and the proposed plan to pilot the use of CIVICA in Primary Care.

Cefndir / Background

Quality, Safety and Experience meetings are established across the range of contractor and operational services within the Primary Care management structure. Since the transfer of the Out of Hours service into Primary Care Management as part of the Operational Services Organisational Change Process, an Out of Hours QSE meeting has been established. Therefore, under the Primary Care Quality Safety and Experience (QSE) group the following subgroups are constituted:

- General Medical Services (GMS) and Community Pharmacy QSE
- Dental and Optometry QSE
- Managed Practices QSE
- Community Dental Services QSE
- Out of Hours QSE

This report provides a summary of issues across the four contractor professions as well as the direct operational service management.

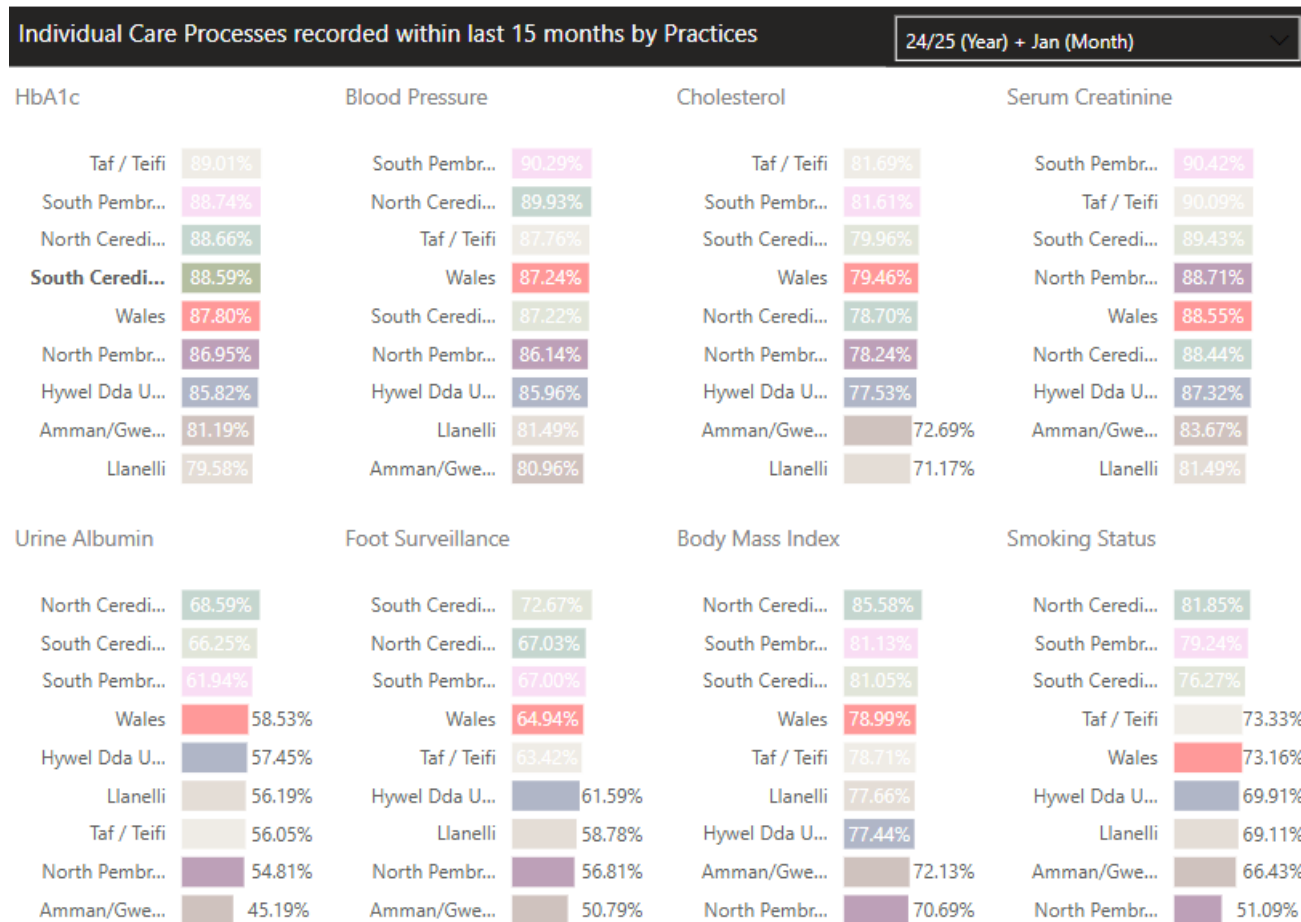
Asesiad / Assessment

**General Medical Services**

Diabetes & Care Processes

Meetings have been held with each of the seven GP Collaboratives to discuss the low rates of the eight care processes being recorded. Two out of the seven Clusters (North Pembrokeshire

and Amman Gwendraeth) have the lowest rates recorded and the Clusters have been asked to develop improvement plans. Access to training has been discussed at the Locality Leads meeting in March 2025. Potentially there are issues with coding and/or data that is providing a perception that limited activity is being recorded against the 8 care processes for the national audit.



### Contract Assurance Framework

The Welsh Unified General Medical Services (GMS) Contract came into force in October 2023. Under the new contracting arrangements an updated process for quality assurance has been developed.

Under previous contracting arrangements the HDUHB had a robust rolling clinical governance visiting program in place to assure compliance with the Quality and Improvement Framework (QIF), as well as addressing any contractual areas of non-compliance.

A new Contract Assurance Framework (CAF) has been developed nationally to provide assurance of delivery of the GMS Unified Contract. The framework takes into account the context of the Health and Care Quality Standards for Wales (2023). All of the data is available on the Primary Care Information Portal (PCIP).

There are three main components:

- A nationally agreed data set for quality, safety, governance and contract management. This comprises of a national set of indicators, a practice assurance return, CGPSAT and IG toolkit.
- A nationally agreed process for assessing contractors' compliance against contractual requirements.

- A nationally agreed escalation ladder for managing concerns, including an appeals procedure.

The key purpose of the nationally agreed data set is to standardise the information the Health Board Primary Care Management Teams consider through the Assurance Framework. This will give a fair and equitable basis for application of a consistent process in assessment of prioritisation of the level of review a contractor will receive across Wales.

The system was originally developed with a ranking system to show individual Practices how they had scored in comparison with other Practices across Wales. It has subsequently been agreed with General Practitioners Committee (GPC) Wales that whilst Health Boards will continue to be able to view the ranking, that this will not be shared with any Practices.

In order to assess compliance with CAF a standardised process has been agreed with Health Boards across Wales.

This will involve a desktop review of all Practice submissions against the Framework which will result in one of three outcomes:

- Desktop review only
- Focused Visit
- Full Visit

Oversight of the CAF process is managed through the Primary Care Contract Review Group. Ahead of commencing the process for 2025/26 there is an opportunity to reflect and review the process and to make any necessary adjustments to the annual return process, that is aligned to the CAF visiting programme.

### **Managed Practices**

#### **Meddygfa Penrhyn**

Following the managed list dispersal of St Davids Practice in November 2024 and with the majority of patients moving across into the former Solva Surgery, the clinical team at Meddygfa Penrhyn have identified a cohort of patients where routine monitoring of higher-risk medications and chronic diseases is overdue. As a result, a higher than usual number of patients are being asked to attend which has necessitated an increase in the appropriate tests. This has impacted on the availability of appointments at Meddygfa Penrhyn as the team try to ensure that clinical care for all patients is optimised; additional support from a Medicines Management Pharmacist is in place one day per week.

Neyland and Johnston Surgery has moved to the Electronic Prescription Service (EPS). The schedule for EPS is on-hold for the remainder of the Managed Practices whilst an Information Governance issue is resolved with DHCW. It is anticipated that the introduction of EPS will mean that there is an improvement in the accuracy of repeat prescribing for patients as well as reduced workload for GP Practices and Community Pharmacies.

### **Out of Hours**

#### **Action Plan**

Work has been undertaken to bring together the outstanding actions from the two external Peer Reviews as well as actions identified from a local service review in 2022; in the main the actions relate to the structure and management of the service to ensure that it is as efficient

and effective as possible. The actions are being monitored through a newly established Quality, Safety and Experience Committee which met for the first time in February 2025.

## **Community Pharmacy**

### Closures and Breaches

During the period 1 January 2025 to 28 February 2025 there were 22 reported closures, of these, there were five instances which were considered contract breaches with a further three instances from December 2024 which were considered in the January 2025 Breaches Panel. Formal breach notices are in the process of being issued with both breaches resulting in the withholding of funds in line with the Health Board's Pharmacy Breach Process. Seven out of the eight breaches relate to one Pharmacy Contractor. A meeting has been arranged with this Contractor's Superintendent Pharmacist to understand the reason why locum cover has not been put in place and agree a way forward to avoid further breaches.

## **General Dental Services**

### Dental Service Challenges and impact on access

- Access to services: the all-Wales average access rate to NHS Dental Services as at quarter 3 in 2024/25 is 30% compared to Hywel Dda achievement of 20%.
- Use of urgent dental care services: 17,260 of appointments currently provided are in relation to urgent care which accounts for 20% of all appointments. Pre COVID-19 urgent care in Hywel Dda accounted for 5% of all appointments. Due to annual contract changes the current urgent appointments will be reduced by 25% from April 2025/26.
- Urgent Care 6 Goals Project: calls to access urgent care are managed through the 111 system. Through the 6 Goals project two categories for urgent care have been introduced with patient calls being triaged via a clinical algorithm categorising patients that need to be seen within 24 and 72 hours. There are challenges in meeting the 72-hour demand and these patients are being contacted by a Dental Nurse for clinical triage when capacity allows. The approved investment plan into Dental services includes the appointment of 1.4 FTE Dental nurses to support this work.
- Workforce: 40% of Dental Practices report Dentist vacancies; with a reported trend of Dentists opting to work privately impacting on successful recruitment to NHS Dental Services.
- High need patients: 28% (13,000) of patients attending appointments are presenting with a high need e.g. they require more than four treatment interventions to achieve improvements in their oral health.
- Sustainable NHS Dental provision: 22% of the Dental Practices in Hywel Dda are not currently participating in the Contract Reform programme
- The Oral Health Intelligence, Public Health Wales (PHW) report into the oral health of 5-year-old children in Wales 2022-23 (January 2024) shows that the number and severity of dental caries in school age year 1 children has not changed in Hywel Dda since 2015/16. Dental caries is reported as impacting on 18.4% of children across Wales (approaching 1 in 5 children).

### Dental Commissioning Plan

The Dental commissioning plan has been prepared and is aligned to the developing Primary Care and Community Services Strategic Plan and the HEIW Dental Workforce Plan. The Dental plan includes an investment of £1.672m in 2025/26 and £2.775m in 2026/27. The plan was approved by the Executive Team on the 18 March 2025, recognising that the investment is coming from within the Dental allocation.

In addition to the plan seeking to improve access to General Dental Services (GDS), it also includes elements that support additional training, recruitment and retention through implementing additional training opportunities and succession planning for key clinical roles, building on known models for oral health improvement, and to increase capacity in the Community Dental Service (CDS) to improve access and move towards an integrated dental service model.

Investment of the General Dental Services budget allocation is key in ensuring timely access is available to NHS Dental services for the population. However, in recognising the current commissioning challenges for GDS contracts there is the potential that the role and scope of the Community Dental Services will need to be considered with the move to salaried dental services delivering routine as well as specialised care. Improving service resilience through in house training, recruiting to key clinical posts and improving professional leadership for staff with enhanced skills to deliver service transformation is required.

#### Dental Access Portal (DAP)

The Dental Access Portal was piloted in November 2024 however due to technical issues the service was withdrawn whilst Digital Healthcare Wales (DHCW) undertook further work to refine the system. The digital system was re-implemented in February 2025 and whilst the initial issues of concern have been resolved, system access issues continue to impact on patient use. The system currently has circa 12,000 patient names on the system.

#### Case Assessment Reports

Case Assessment Reports include reviews of patient records and clinical data provided by the Practice at the request of the Clinical Adviser, NHS Business Services Authority Dental Services. These reports have been requested by the Health Board.

Contract Number	CAS Number	Outcome
My Dentist, Mill Lane	201636	A meeting was held with representatives of My Dentist on 6 November 2024 to discuss the report. It was noted that there has been a significant change to the NHS Performers working at Mill Lane since the report was produced. The report demonstrated some improvement in record keeping standards since the previous report. Dr S Aly, Clinical Development Adviser, My Dentist, confirmed that a documented meeting was held on 27 September 2024 with all NHS Performers and the Practice Manager to discuss the learnings from the report. On 25 November 2024, Dr Aly submitted audits undertaken at the Practice since the meeting to demonstrate that learning had been implemented.
My Dentist, North Parade	201190	A meeting was held with representatives of My Dentist on 6 November 2024 to discuss the report. J Lucke, Clinical Development Adviser, My Dentist confirmed that the three Performers named on the report no longer provide NHS under this contract as they have all opted to provide private dental services only. The contract has now terminated and therefore no further action will be taken.
Eastgate	202105	A response was received from the Practice who acknowledged that the report had identified some issues with

		their processes which may have led to the issues highlighted in this report. DH forwarded the latest ACORN guidance and advised that a further BSA report may be requested to ensure that the Practice are treating patients and claiming in line with the requirements of the NHS contract. It is noted that the performer who was undertaking the majority of NHS work in the Practice has now left, and the Practice are currently seeking a replacement dentist to undertake the NHS contract.
My Dentist, Robert Street	201625	This was a follow up report to CRR CAS 200260 dated 31 January 2023 and CAS 201191 dated 26 April 2024. A meeting was held with representatives of the clinical team of My Dentist on 5 March 2025. As there are still some outstanding issues being identified, My Dentist have been asked to submit the audits which were undertaken in February and subsequent audits are to be submitted as they are completed. It was agreed that a further CRR report will be requested in July 2025 relating to the period February – June 2025 which must demonstrate that learning has been embedded.

#### Dental Quality Assurance Self-Assessment (QAS) 2024

The annual Dental QAS has been completed. Of the 37 eligible Practices, 36 completed the QAS. (1 Practice has had issues with their QAS account and this is currently being reviewed). Initial areas of concern included:

1 Red	The Practice has now confirmed that the wrong box had been ticked and that a Wrong Tooth Extraction LocSSIP is used in clinical settings.
4 Amber	1 Practice has confirmed that the wrong box was ticked and provided evidence of Pressure Vessel Insurance. 3 Practices are required to confirm when relevant outstanding training has been completed.

#### Community Dental Services

Access to Community Dental Service: Current waiting times for CDS are on average two years. The service Did Not Attend (DNA) rate is circa 10% with 16% of patients cancelling appointments at short notice. The current sickness rates in the service of 12.7% has resulted in appointment cancellations at approximately 7 to 8% which is impacting on CDS waiting times.

Urgent Care: Patients inherent within the CDS are presenting with urgent dental care needs and all urgent referrals are appointed based on clinical need. This impacts on the services being able to provide timely recalls for care and to see routine new patients.

Hospital referrals: there has been an increase in referrals from Hywel Dda acute services for patients requiring a dental assessment prior to commencing treatment. The referrals are mainly received from Cancer, Cardiac and Rheumatology services. These referrals are given priority appointments.

Clinical Vacancies: the service has two Specialist Dental posts vacant for Paediatric and Special Care Dentists; they have failed to recruit into these posts historically but will be looking to re-advertise in the next month.

Ceredigion: There has been no CDS service in North Ceredigion since the 20 January 2025 due to a vacant Dentist post. The service has received one application to fill the post, and an interview is scheduled for 14 April 2025. An urgent dental service has continued with patients directed to Cardigan Integrated Care Centre if they are able to travel or for limited appointments in North Road from Dentists working in other clinics across the CDS once a month.

### **Optometric Practices**

#### **Quality for Optometry (QfO)**

The Quality for Optometry process has been introduced as part of a wide Quality Framework as part of the new contractual arrangements for Optometric Practices. As this was the first year that the process has been introduced the QfO has acted as a benchmark for capturing information and it is anticipated that this work will develop in subsequent years. The Quality payment also included participation in three “insight” audits and a workforce data submission.

### **Optometric Practice Visits**

During the period of October 2024 and February 2025, a total of 46 informal introductory visits were carried out. Where a Contractor holds an agreement with the Health Board for more than one Practice, the Contractor was given the option to include the smaller Practice in the same meeting as the larger Practice, or to conduct the smaller Practice meeting via MS Teams. In addition, Contractors who provide domiciliary services only were given the option to conduct their meeting in person, at an agreed location, or via MS Teams.

- Number of Practices Visited: 35
- Number of Practice meetings on Teams: 2
- Number of Domiciliary meetings in person: 5
- Number of Domiciliary meetings on Teams: 2

The discussions held during these visits provided the Health Board with a meaningful understanding of the implementation of Welsh General Ophthalmic Services (WGOS) from the Contractor’s perspective. It also allowed the Health Board the opportunity to provide guidance and advice on an individual level regarding the expectation from the Health Board for the delivery of Services. The Formal Optometry Practice Visiting Programme will commence from April 2025. This will involve the Health Board undertaking a formal visit with each Contractor on a three-yearly basis.

### **Health Inspectorate Wales (HIW) Inspections**

#### **HIW Visit Reports Received January-March 2025**

The Health Board does not receive a scheduled programme of visits for the year but does receive notifications of planned visits prior to the visit date. We have been notified of the following forthcoming visits:

Date	Practice	Comments
08.04.25	Borth Surgery	The Practice have been contacted to discuss the forthcoming visit
23.04.25	Bro Pedr, Lampeter	The Practice have been contacted to discuss the forthcoming visit
21.05.25	Quayside Orthodontics, Neyland	Practice have been notified of the visit.

22.05.25	Argyle Surgery	Meeting being arranged with the Practice to discuss the forthcoming visit
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### Outstanding Actions from Visits

Date	Practice	Comments
14.11.24	Coalbrook Surgery	Immediate Assurance required. Practice action plan complete
02.10.24	Coach & Horses Surgery	Action plan developed for review in April 2025
26.11.24	Robert Street Surgery	Awaiting report
17.12.24	Capel Dental	Improvement plan to be completed by August 2025.

### Patient Experience

The Health Board is participating in a pilot to extend the use of CIVICA into Primary Care as part of the national work being led by the Primary Care Strategic Programme to establish key performance indicators for the Primary Care Model for Wales.

Initially CIVICA will be tested in the Carmarthenshire Managed Practices (Ash Grove Surgery, Meddygfa Minafon and Meddygfa'r Sarn) from April 2025 for a minimum period of three months. Practices are required contractually to undertake a patient engagement exercise using the standard questions that are also used in CIVICA during February/March each year. Discussions have been taken place to ensure that the information to patients on how to participate in the survey is maximised e.g. information on digital screens, QR codes on repeat prescriptions etc.

As part of the national work, staff at the participating Practices will be required to complete a survey at the end of three month to understand their perceptions of the use of continued patient engagement.

Discussions are ongoing to consider the pilot of CIVICA in the Out of Hours Service and the Community Dental Service.

Reports from the pilot will be considered through the relevant Quality, Safety and Experience Groups.

For General Dental Services patient level outcomes and experience data that is needed to evidence quality of care is not currently included in the extant dental Regulations. National work is currently ongoing to consider this.

To date 1,122 patients have failed to attend urgent access appointments. These patients are contacted to ascertain why they didn't attend their appointment. Reasons for failing to attend as stated by patients include:

- Levels of pain reduced and no longer wanted to attend appointment
- Level of pain did not warrant the distance required to travel
- No longer needed the appointment
- Accessed private care

To reduce the number of failed appointments, a telephone call reminder on the day before the appointment has been implemented and has had some impact on improving the situation.

### Argymhelliad / Recommendation

Members are asked to:

- **NOTE** the content of the report for **ASSURANCE** on governance systems and processes in Primary Care

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	7 Primary and community strategic plan
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	9. All HDdUHB Well-being Objectives apply

### **Gwybodaeth Ychwanegol:**

#### **Further Information:**

Ar sail tystiolaeth:  
Evidence Base:

Rhestr Termiau:

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Primary Care QSE governance structure

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Not Applicable (N/A)
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	N/A
<b>Gweithlu: Workforce:</b>	N/A
<b>Risg: Risk:</b>	N/A
<b>Cyfreithiol: Legal:</b>	N/A
<b>Enw Da: Reputational:</b>	N/A
<b>Gyfrinachedd: Privacy:</b>	N/A

**Cydraddoldeb:  
Equality:**

N/A

## 2.4

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2.4 - Auditor General Report on Cancer Services- Deferred.

**Andrew Carruthers**  
**(Hywel Dda UHB -**  
**Chief Operating**  
**Officer)**

2.5

10 Mins

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2.5 - Infection Prevention and Control in the Community

*Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Megan Harris (Hywel Dda UHB - Consultant)*

**Attachments**

[April 2025 QSEC Community Infection SBAR.docx](#)

**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD  
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	08 April 2025
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Community Infection Rates – Infection Prevention and Control in the Community
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Dr Ardiana Gjini, Executive Director of Public Health
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Megan Harris, Consultant in Public Health

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**

**SBAR REPORT**

Sefyllfa / Situation

Hywel Dda University Health Board (HDdUHB) has been reporting a higher rate of healthcare acquired infections compared to other Welsh Health Boards. This has been discussed previously by the Committee and the link to higher rates of community infection has been established. This paper seeks to provide information to the committee on the rates in the community in 2024 to provide understanding of the distribution of infection rates in Hywel Dda.

Cefndir / Background

Hywel Dda University Health Board has regularly had one of the higher levels of Healthcare Acquired Infection (HAI) rates in Wales. There has been different considerations and assessments on the reasons and background for these rates. This paper seeks to provide assurance on the work done to understand the community levels of infection.

The community rates of infections that cause key Hospital Acquired Infections (HAI) was examined last year in 2024 through the HDUHB Health Protection Oversight Group and whilst for some infections the rates for the HDUHB population were higher, on the whole rates of infections and the number of community incidents were not significantly higher than other Health Board. Similarly, the community infection rates was discussed at the Quality, Safety and Experience Committee (QSEC) in 2018 and in-depth data analysis was undertaken to investigate the link between the community and healthcare cases, including genomic surveillance. At that point it was reported to the QSEC that the levels of infection in the community, would be partly explained by and linked to the demographics of and partly the rural aspects.

This paper seeks to provide assurance to QSEC that we have examined the rates of infection in the community in relation to the HAI. Working partnership with Public Health Wales and our constituting Local Authorities, we review regularly data on community infections and ways to reduce spread within the community.

## **Asesiad / Assessment**

The infographics papers attached to this SBAR show the numbers of cases of three main bacteraemia that form part of the routine HAI reporting to Welsh Government by Health Boards – C.Diff, E.coli, and S.Aureus. The data presented is from April 2024 to February 2025.

### ***Clostridium difficile (C. diff):***

From April 2024 to February 2025, Hywel Dda had 173 cases of C.Diff diagnosed, with 101 being Community Onset (CO), and 72 Hospital Onset (HO). This a rate of 49.09 per 100,000 population (CO) is the third highest in Wales, and 3.33 per 1,000 admissions (HO) is the fourth highest in Wales. The spread of infection cases is similar in gender but higher in the white ethnic population (which is reflective of the ethnicity demographics in Hywel Dda), higher in over 65s and is not seen as linked to deprivation as the higher rates are in the 3<sup>rd</sup> and 4<sup>th</sup> deprivation quintiles (with 1 being most deprived and 5 being least deprived). From the data coding, cases of C.Diff linked to care homes shows 7 cases were community onset and 2 were hospital onset.

The distribution of C.Diff across Hywel Dda shows that Carmarthenshire has the highest case load, followed by Ceredigion and then Pembrokeshire. This is a different picture to the other bacteraemia in this report as the others follow the population size of the three local authority areas, Carmarthenshire, Pembrokeshire and then Ceredigion.

### ***Escherichia coli (E.coli):***

E.coli cases from April 2024 to February 2025 had risen to 339 cases with 288 being community onset and 51 hospital onset. The cases were highest amongst the over 65s and in males. Again the link with deprivation is limited, as the higher cases were in deprivation quintiles 3 and 4. In cases from care homes 27 were community onset and 6 were hospital onset. The rates for E.coli were 118.48 per 100,000 population, the highest in Wales, and 7.5 per 1,000 admissions, highest in Wales.

### ***Staphylococcus aureus (S.aureus):***

Hywel Dda had 124 cases of S.aureus from April 2024 to February 2025. 90 cases were community onset and 34 were from hospital onset. In terms of care homes, 8 were community onset and 4 hospital onset. The distribution of cases was greater in men, and again higher in deprivation quintiles 3 and 4. The distribution across ages is less distinct with 18-64 and 65-79 each having 27 cases, but the over 80s had the higher rate of 34 cases in this time-period. These numbers equal a population rate of 35.19 per 100,000 population, the second highest in Wales, and 1.6 cases per admission, the second highest in Wales.

The analysis shows that there is a bigger number of community onset than hospital onset cases of bacteremia. This is to be expected due to a much bigger denominator. Further work is required to understand this better in terms of age standardisation, as the data below clearly shows higher rates in the older population. Further data collection on these and other bacteraemia, including age standardised rates and genomic sequencing on some, across the full year (April to April) is taking place and will give a better understanding of the issues the epidemiology shows for our community infection rates.

## **Argymhelliad / Recommendation**

- To receive assurance from the information above
- To agree to receive a longer and more detailed feedback with age standardised rates of community infection in August 2025

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	3. Data to knowledge
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. The best health and wellbeing for our individuals, families and communities
Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	HCAI and Community Infection rates from Public Health Wales epidemiology
Rhestr Termiau: Glossary of Terms:	HAI or HCAI – Healthcare Acquired Infection C.Diff – Clostridioides Difficile E.coli – Escherichia coli S.Aureus – Staphylococcus Aureus
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Infection , Prevention and Control Public Health Wales Epidemiology

**Effaith: (rhaid cwblhau)**

<b>Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	This work is being undertaken with PHW Epidemiology, a core role funded by PHW, and HDUHB Public Health team as part of core funding
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Work is to understand drivers for infection rates, but not a direct impact on patients
<b>Gweithlu: Workforce:</b>	N/A
<b>Risg: Risk:</b>	N/A
<b>Cyfreithiol: Legal:</b>	N/A
<b>Enw Da: Reputational:</b>	N/A
<b>Gyfrinachedd: Privacy:</b>	N/A
<b>Cydraddoldeb: Equality:</b>	This piece of work looks at community and healthcare acquired infection rates to understand the drivers of the increased infection rates in HDUHB. So it looks at the data in gender, age, deprivation and ethnicity to try to understand the drivers

# Monthly Infections Report

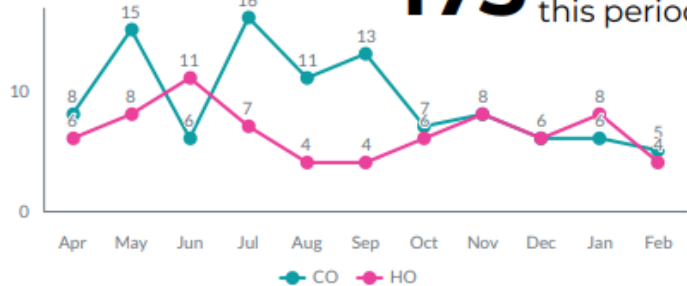
## C. difficile - February 2025

### Hywel Dda

### Onset

**173** patients diagnosed this period

For the period Apr 24' - Feb '25



**101** Community Onset (CO)

**54** COCA  
**14** COIA  
**33** COHA

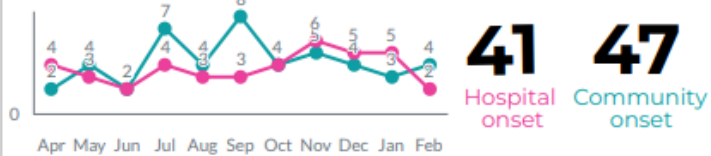


**72** Hospital Onset (HO)

Hospital Onset (HO) - specimen taken more than 2 days into a hospital inpatient stay.  
 Community Onset (CO) - specimen taken within 2 days of hospital admission or within a community location, and the patient had no inpatient stay in the 12 weeks prior to the positive specimen.  
 Community Onset Community Acquired (COCA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had no inpatient stay in the 12 weeks prior to the positive specimen.  
 Community Onset Indeterminate Acquisition (COIA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had an inpatient stay more than 4 weeks but less than 12 weeks prior to the positive specimen.  
 Community Onset Hospital Acquired (COHA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had an inpatient stay within the 4 weeks prior to the positive specimen.

### Carmarthenshire

### Demographics by onset



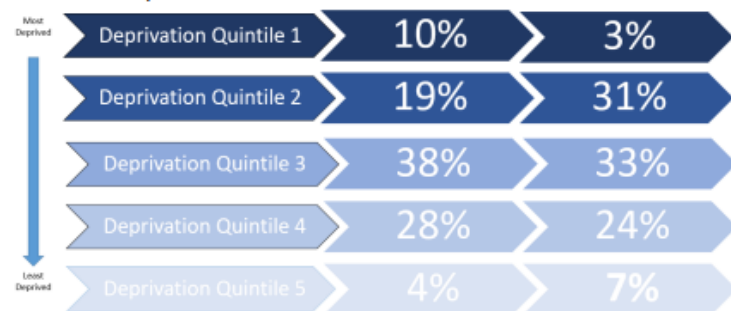
**41** Hospital onset  
**47** Community onset

Care home status  
(Based on post code algorithm)

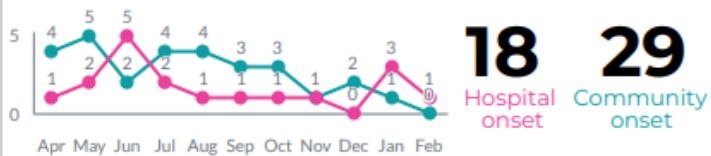
**7** CO  
(3 COCA)  
**2** HO



Deprivation



### Ceredigion

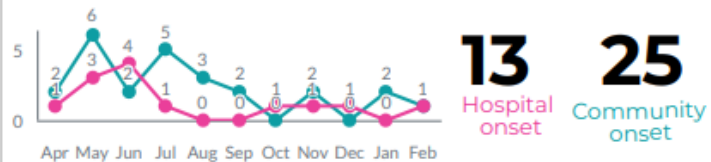


**18** Hospital onset  
**29** Community onset

Ethnicity



### Pembrokeshire



**13** Hospital onset  
**25** Community onset

	Female	Male
CO	59	42
HO	33	39

Age group

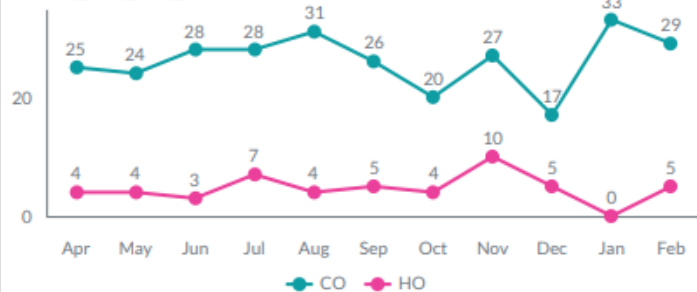
	2-17	18-64	65-79	80+
CO	7	20	37	37
HO	0	14	29	29

# Monthly Infections Report

## E. coli bacteraemia- February 2025

### Hywel Dda

**339** patients diagnosed this period



### Onset

For the period Apr 24' - Feb '25



**288** Community Onset (CO)

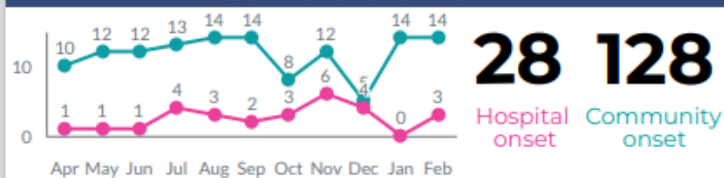
**255 COCA**  
**33 COHA**



**51** Hospital Onset (HO)

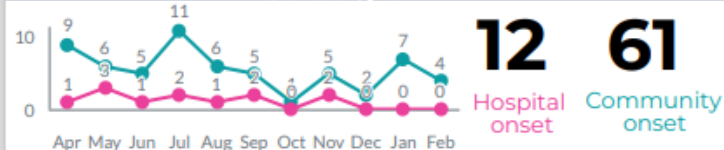
Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay.  
Community onset (CO) - specimen taken within 2 days of hospital admission or within a community location.  
Community onset Community Acquired (COCA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had no inpatient stay in the 4 weeks prior to the positive specimen.  
Community onset Hospital Acquired (COHA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had an inpatient stay within the 4 weeks prior to the positive specimen.

### Carmarthenshire



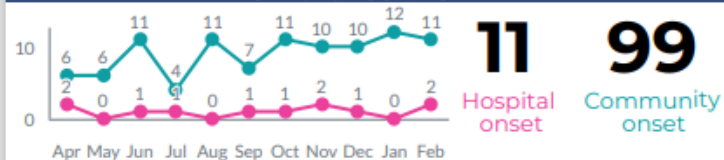
**28** Hospital onset  
**128** Community onset

### Ceredigion



**12** Hospital onset  
**61** Community onset

### Pembrokeshire



**11** Hospital onset  
**99** Community onset

### Primary source



### Demographics by onset

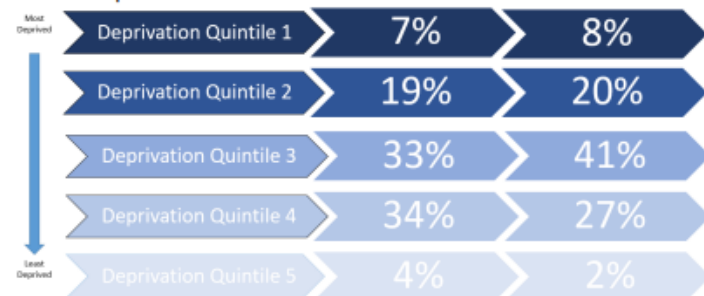
Care home status  
(Based on post code algorithm)

**27** CO  
(21 COCA)

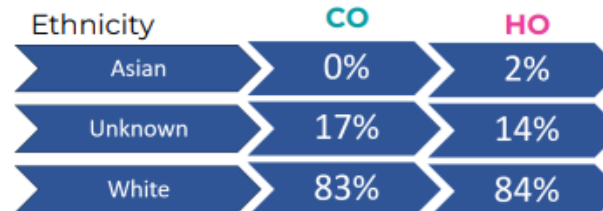
**6** HO



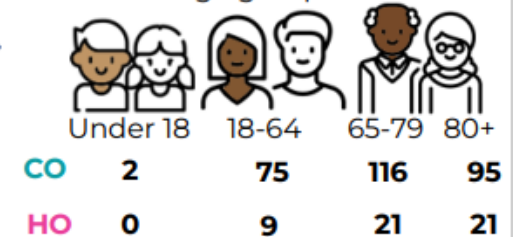
Deprivation



Ethnicity



Age group

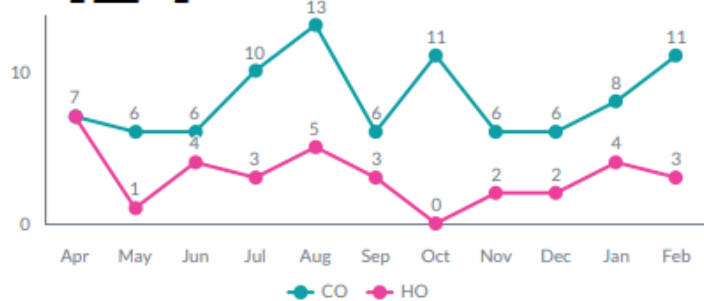


# Monthly Infections Report

## S. aureus bacteraemia - February 2025

### Hywel Dda

**124** patients diagnosed this period



### Onset

For the period Apr '24 - Feb '25



**90** Community Onset (CO)

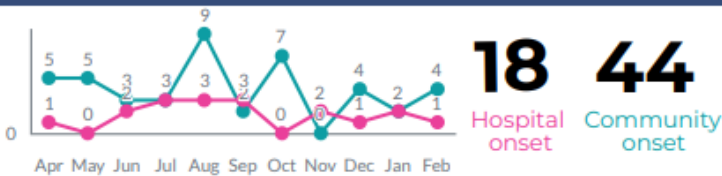
**77** COCA  
**13** COHA



**34** Hospital Onset (HO)

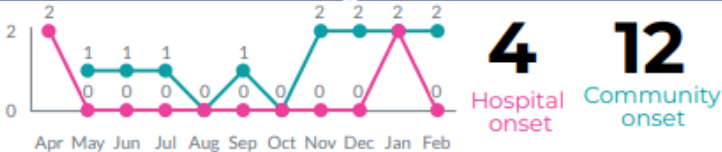
Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay.  
Community onset (CO) - specimen taken within 2 days of hospital admission or within a community location.  
Community onset Community Acquired (COCA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had no inpatient stay in the 4 weeks prior to the positive specimen.  
Community onset Hospital Acquired (COHA) - specimen taken within 2 days of hospital admission or within a community location, and the patient had an inpatient stay within the 4 weeks prior to the positive specimen.

### Carmarthenshire



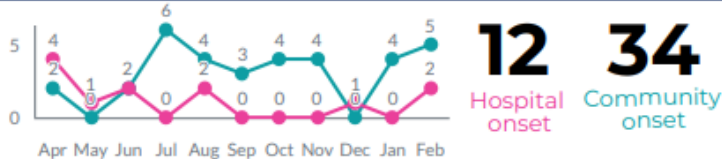
**18** Hospital onset  
**44** Community onset

### Ceredigion



**4** Hospital onset  
**12** Community onset

### Pembrokeshire



**12** Hospital onset  
**34** Community onset

### Primary source



### Demographics by onset

Care home status  
(Based on post code algorithm)

**8** CO  
(8 COCA)

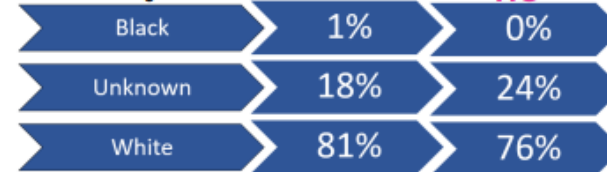
**4** HO



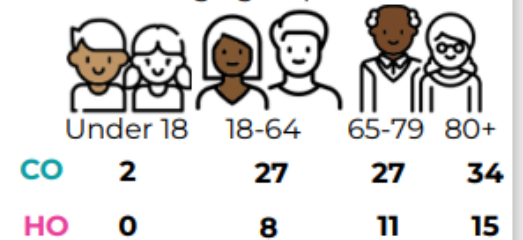
Deprivation



Ethnicity



Age group



Female Male  
CO 31 59  
HO 12 22

2.6

10 Mins

---

## 2.6 - Quality Assurance Report

***Cathie Steele (Hywel  
Dda UHB - Interim  
Assistant Director of  
Nursing Assurance  
and Safeguarding)***

| For assurance

### **Attachments**

[3.1 QS Assurance Report April 2025 v1.0.pptx](#)

[App 1 Overdue actions as at 31-03-2025.xlsx](#)

[202502FEB12 HDUHB WRP Assessment Report VFinal1.pdf](#)



# Quality and Safety Assurance Report

## Quality, Safety and Experience Committee

April 2025



The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

Within the Health Board's Quality Management System, a number of assurance processes and quality improvement strategies are used to ensure high quality care is delivered to patients.

This report provides information on:

- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Patient Experience and Complaints
- Welsh Risk Pool: Concerns Assessment
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak up
- Welsh Health Circulars

# Patient Safety Incident Reporting



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

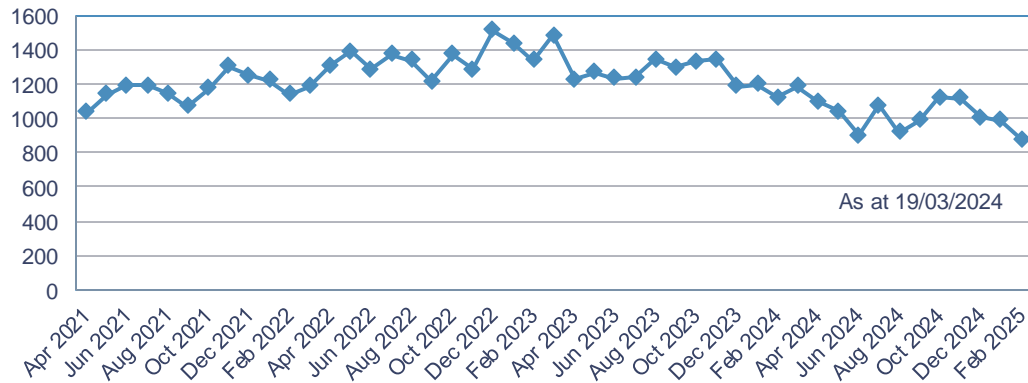
There were 12,618 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1<sup>st</sup> March 2024 – 28<sup>th</sup> February 2025.

Of the 12,618 patient safety incidents reported, 9,610 have been closed. 0.8% were closed as moderate, severe or catastrophic harm. The top 3 incident categories (incidents reported between 01/03/2024 and 28/02/2025 and closed as moderate, severe or catastrophic harm) were:

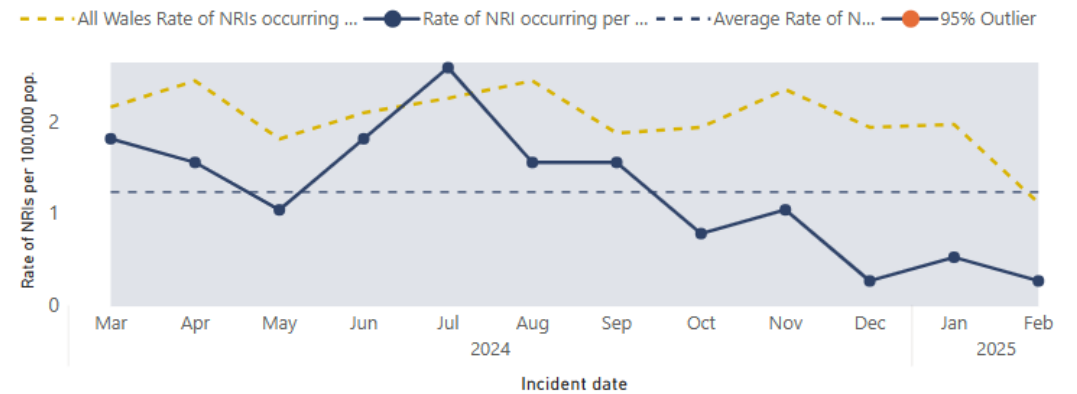
Pressure ulcer developed or worsened during care in this clinical care area/caseload	33
Slip, trip or fall	19
Treatment or procedure issues	13



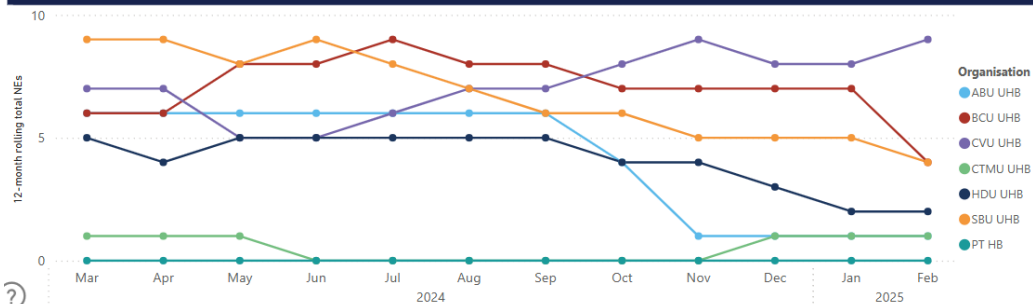
## Patient Safety Incidents by month of occurrence



## HDU UHB rate of NRIs occurring (by incident date) per 100,000 population as of 06/03/2025



## All Wales 12-month rolling total Never Events occurring (by incident date) as of 06/03/2025



## HDU UHB Never Events occurring (by incident date, Mar-24 to Feb-25) as of 06/03/2025

Year	2024												2025		
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Jan	Feb	
Administration of medication by the wrong route	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Retained foreign object post procedure	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
<b>Total Never Events</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

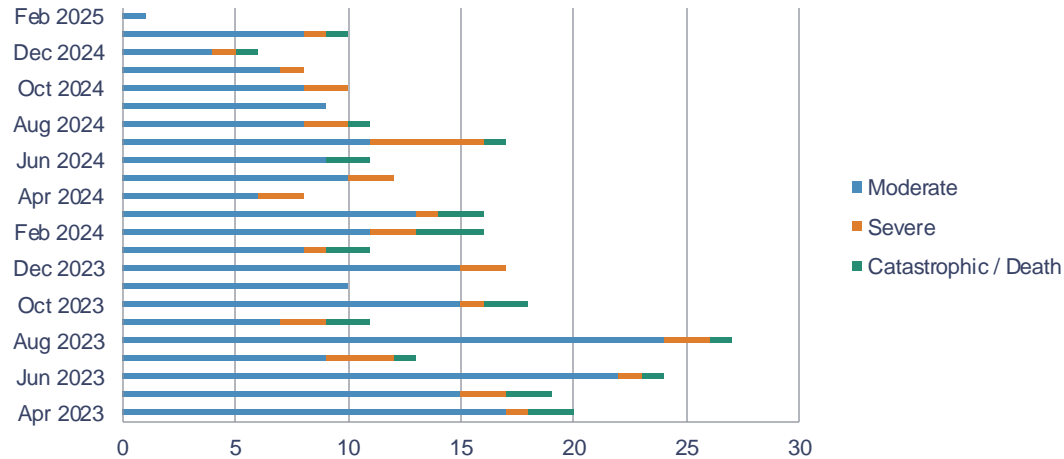
# Duty of Candour



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

Incidents by Incident date (Month and year) and Manager's interim harm assessment



185 incident records have been closed where duty of candour had been triggered during the manager's initial assessment.

		Harm post investigation					Total
		None	Low	Moderate	Severe	Catastrophic / Death	
Manager's interim harm assessment	Moderate	11	2	110	2	1	155
	Severe	1	5	3	7	3	19
	Catastrophic / Death	2	4	1	2	2	11
	<b>Total</b>	<b>14</b>	<b>41</b>	<b>114</b>	<b>10</b>	<b>6</b>	<b>185</b>

## Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered, and investigation has been closed.

<b>Pressure Damage, Moisture Damage</b>	<b>44</b>
Pressure ulcer developed or worsened during care in this clinical care area/caseload	39
Pressure ulcer present before admission to this clinical care area/caseload	3
Pressure from medical device present before admission to this clinical care area/caseload	2
<b>Accident, Injury</b>	<b>36</b>
Slip, trip or fall	34
Patient injury	2
<b>Maternity adverse occurrence</b>	<b>22</b>
Maternity adverse occurrence - Neonate	14
Maternity adverse occurrence - Maternal	8



Learning identified:

- Importance of clear documentation when ribbon gauze or a surgical swab is intentionally left in situ
- Ensuring senior review when there are complex needs
- Consideration of bed space provide closer monitoring

# Service User Feedback at a Glance December 2024 – January 2024



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

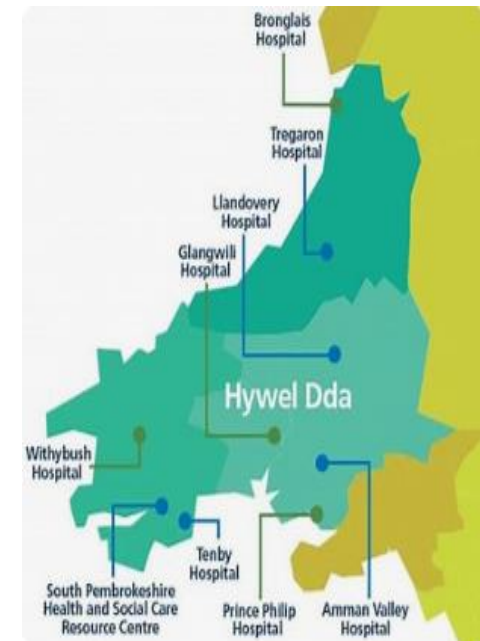
We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation. We will share information relating to the figures later in the report.

1366 service users completed the Your NHS Wales Experience survey of which 11.3% responded with poor or very poor rating for their overall experience. 93% of the responses were from A&E areas and the negative feedback mainly related to long waits and corridor care.

201 compliments were received direct to wards, departments or Corporate Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example: "Your dedication to all patients that come through the Ward shows how exemplary you all are!"

**Complaints: 466 new complaints were received into the health board. 424 complaints were closed, 164 were closed within 5 working days, 260 managed through the Putting Things Right formal process representing an 40%/60% split.**

37633 individuals received our friends and family patient experience survey, in which 6355 responded following their attendance, representing a 18.8% response rate, 94.2% reported a positive experience. Community & Primary Care and Mental Health Outpatient saw significant improvements (30+%) from the last period. Maternity Inpatient improved by 12%. The only area to see a slight drop is Paediatric Outpatient, however this relates to only 1 negative response



We also received 374 new enquiries. the main enquires are Primary care, Ophthalmology, A&E and Health records. These were relating to delays in transport, waiting times and communication

# Friends and Family (FFT) Patient Feedback by Location

	% Positive	% Negative	Total Responses	Percentage of total responses
<b>Bronglais</b>				
<b>Total</b>	93.6%	6.4%	784	100%
Outpatient Department	93.9%	6.1%	280	36%
Accident and Emergency Department	88.3%	11.7%	252	32%
Day Surgery Unit	100.0%	0.0%	32	4%
Integrated Sexual Health Clinic	90.6%	9.4%	32	4%
Cardio-Respiratory Department	100.0%	0.0%	26	3%
Endoscopy Department	100.0%	0.0%	26	3%
Rhiannon Ward	100.0%	0.0%	25	3%
Clinical Decisions Unit (Green)	100.0%	0.0%	18	2%
Angharad Ward	100.0%	0.0%	13	2%
Ceredig Ward	100.0%	0.0%	12	2%

	% Positive	% Negative	Total Responses	Percentage of total responses
<b>Glangwilli</b>				
<b>Total</b>	92.2%	7.8%	1854	100%
Outpatient Department (Blue)	95.1%	4.9%	694	37%
Accident and Emergency Department	83.7%	16.3%	384	21%
Cardio-Respiratory Unit	99.2%	0.8%	127	7%
Tysul Ward	93.5%	6.5%	67	4%
Same Day Emergency Care Unit	97.8%	2.2%	46	2%
Aberglasney Suite	97.8%	2.2%	45	2%
Endoscopy Department	97.3%	2.7%	37	2%
Picton Ward	75.8%	24.2%	35	2%
Day Surgery Unit	100.0%	0.0%	33	2%
EEG/EMG Department	100.0%	0.0%	27	1%

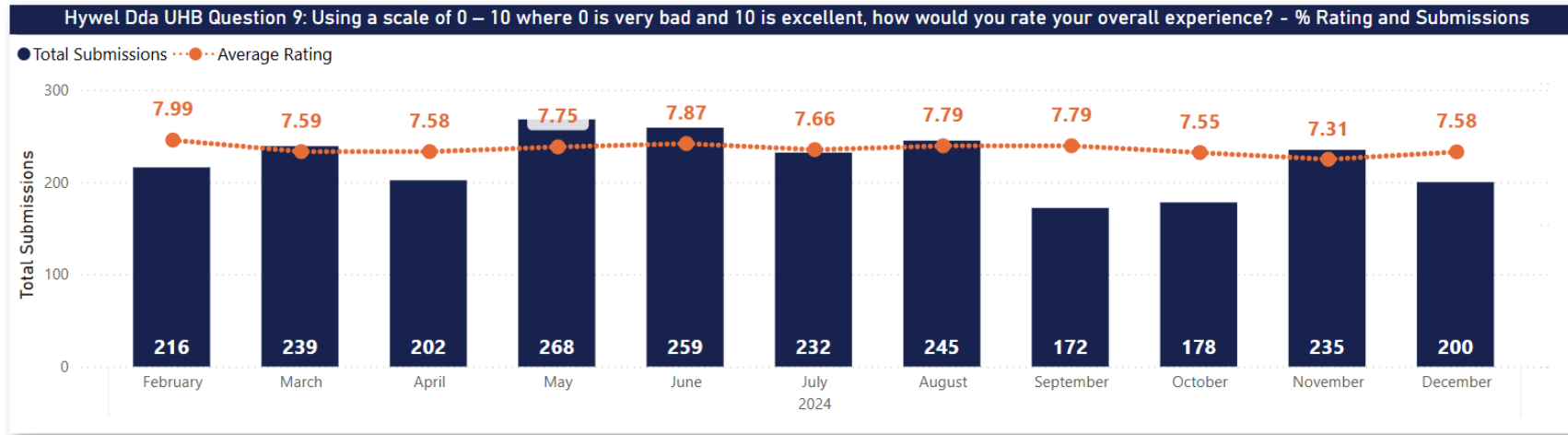
	% Positive	% Negative	Total Responses	Percentage of total responses
<b>Prince Phillip</b>				
<b>Total</b>	96.1%	3.9%	1560	100%
Outpatient Department	96.4%	3.6%	811	52%
Minor Injuries Unit	93.7%	6.3%	263	17%
Cardio-Respiratory Department	98.8%	1.3%	81	5%
Day Surgery Unit	96.8%	3.2%	64	4%
Rheumatology Department	98.0%	2.0%	56	4%
Pre Assessment	91.8%	8.2%	52	3%
Same Day Emergency Care Unit	100.0%	0.0%	41	3%
Endoscopy Department	100.0%	0.0%	39	3%
Physiotherapy Department	100.0%	0.0%	35	2%
Acute Medical Assessment Unit	87.5%	12.5%	27	2%

	% Good	% Poor	Total Responses	Percentage of total responses
<b>Withybush</b>				
<b>Total</b>	94.1%	5.9%	1204	100%
Accident and Emergency Department	86.8%	13.2%	332	28%
Outpatient Department (A)	97.0%	3.0%	312	26%
Cardio-Respiratory Department	98.5%	1.5%	130	11%
Physiotherapy Department	96.5%	3.5%	59	5%
Same Day Emergency Care Unit	97.9%	2.1%	52	4%
Gynaecology Care Suite	95.7%	4.3%	48	4%
Day Surgery Unit	92.5%	7.5%	41	3%
Rheumatology Department	96.7%	3.3%	32	3%
Endoscopy Department	96.6%	3.4%	29	2%
Medical Day Unit	100.0%	0.0%	18	1%

Please note that within the community section is an area called 'unmapped' these are new location codes which are currently being mapped into the system, these are across the health board and not just within community. These are being mapped on an ongoing basis.

Outpatient have the largest number of response from the FFT with the exception of Withybush for this period.

# Health Board Overview – People’s Experience in the ED



**Average experience rating (for completed surveys only) between Feb-24 to Jan-25 as of 31/01/2025**

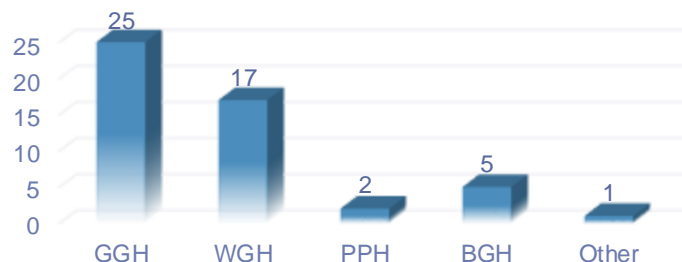
Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,360	7.71
HDU UHB	2,659	7.69
CVU UHB	5,759	7.44
BCU UHB	4,893	7.06
SBU UHB	1,115	6.34
ABU UHB	242	6.26
<b>All Wales</b>	<b>26,028</b>	<b>7.45</b>

# Health Board Overview – Outcomes from complaints

So far in financial year 2024/25, 80% of complaints were closed within the 30-working day target timescale advised in the 'Putting Things Right Regulations'. The national target is 75%.

In Q4 to date, 70 complaints have either been closed and not upheld, or upheld but not found to have caused harm. Since April this financial year, 50 cases have been escalated to redress because failings have, or may have caused harm to patients. These have mostly occurred at our general hospital sites (below).

## REDRESS CASES BY SITE APRIL 2024 - FEB 2025



The two most recent failings identified in February 2025 pertain to the incorrect citing of a catheter under Urology and a missed lesion when reporting an X-ray under Radiology. Learning from events reports will be produced following these incidents.

10 cases were escalated to redress in Q3 which is lower than the preceding quarters this year (Q1 = 14, Q2 = 20):

### Cases escalated to Redress 2024/ 25

April	4
May	7
June	3
July	5
August	7
September	8
October	1
November	4
December	5
January	4
February	2
Total	50

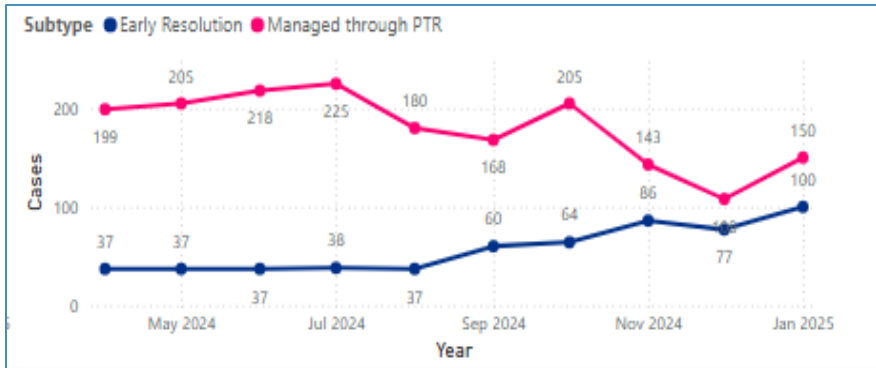
### Learning from the Ombudsman

In Quarter 3 there were 18 interventions from the Ombudsman, which included 4 new investigations. There have been no new investigations in Quarter 4 to date. There have been 27 decisions not to investigate since the start of Quarter 3.

In Quarter 4 to date, there have been 4 investigation reports received, 3 of which have been upheld. The investigations founds failings in the management of high-risk pregnancy, failings in dermatological care and in missing the opportunity to offer urgent face to face outpatient appointment.

# Health Board Overview – Complaints Management

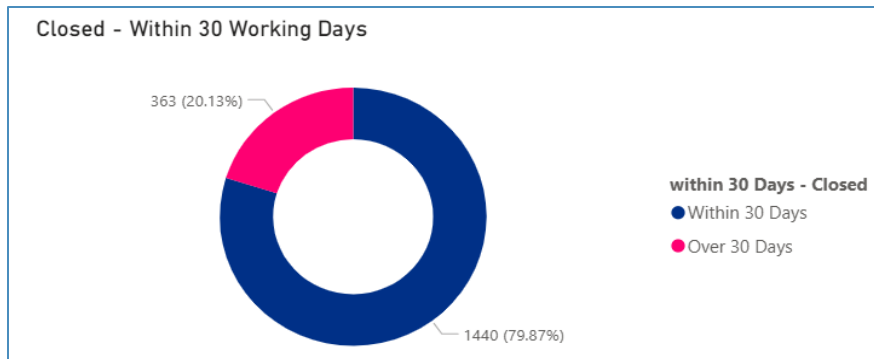
## Number of complaints received by month since April 2024 (early resolution and PTR)



There has been a 27% reduction in complaints managed through PTR in Quarter 3 this year compared to Quarter 1. In line with this, there is a significant increase in early resolutions at the end of Quarter 3 compared to the start of the financial year.

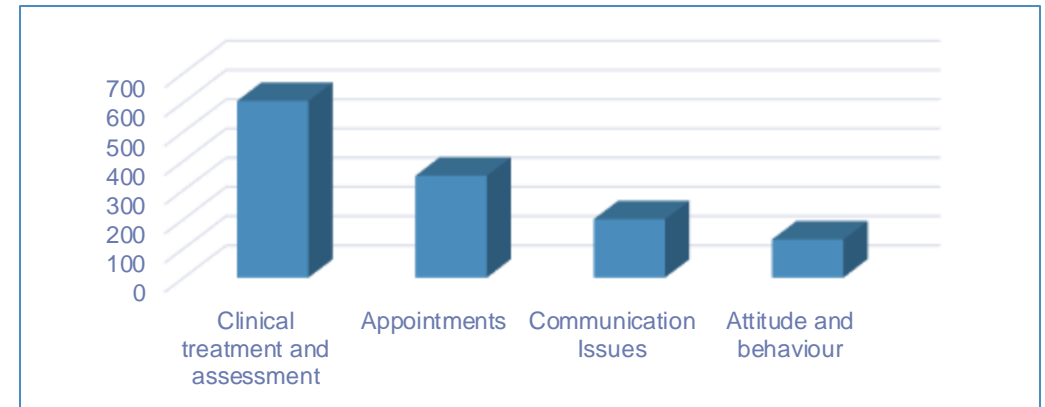
There is also reduction in the number of complex complaints needing investigation (typically grade 3 and above) - 20% less in Q3 24/25 compared to the same quarter last year.

## Proportion of complaints within 30 working days (2024/25)



The chart shows an improvement in performance since 2023-24 and has remained on an improvement trajectory during the current year, with performance remaining above the all-Wales average.

## Top four themes of PTR complaints since April 2024



Complaints about clinical treatment/ assessment arise most frequently in Accident and Emergency (A&E), Trauma and Orthopaedics (T&O) and Ophthalmology services and account for a third of all this category.

Nearly one third of all complaints about appointments and waiting times are linked to Ophthalmology services.

Complaints about communication, attitude and behaviour are spread across Health Board services.

# Welsh Risk Pools: Concerns Assessment



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

The Welsh Risk Pool have concluded their annual Concerns Assessment and issued their final report. The full report is attached as an appendix to this report.

The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right (PTR) process:

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- Welsh Risk Pool (WRP) Reimbursement Process

## Areas of Good Practice

- Sending an introductory letter once the Redress Team had taken over the matter.
- Excellent, bespoke email correspondence with Complainants particularly in sensitive matters
- Payments and invoices reviewed prior to submission of matters for reimbursement.
- Excellent inquest and coronial inquiry management in place.
- Good structure in place for redress management.
- Good Claims management structure in place.
- Close working relationship with finance, leading to accurate data points.

Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

## Recommendations

- R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records
- R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised
- R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately
- R04 HDUHB to ensure the SOP for verbal responses is followed in all matters
- R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section
- R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.
- R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded
- R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed
- R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.
- R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation.
- R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.



## Performance de-escalation summary

### Latest position key

Goal achieved

Making good progress towards goal

Minimal progress made or decline from previous month

Same as baseline or worse

Measure	De-escalation criteria	Baseline	Goal	Latest position						
				Mar-23	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	6	7	8	6	8	4
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	0	0	2	3	4	4
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	8	4	9	5	0	5

Table 1. Latest month count of specimens by acute hospital in Hywel Dda UHB, Feb 25

Additional filters for Table 1.	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Select month or FY						
Latest month						
Select organism group						
All organisms						
Bronglais General Hospital	1	0	2	4	1	0
Glangwili General Hospital	2	1	2	13	2	0
Prince Philip Hospital	2	0	1	4	0	0
Withybush General Hospital	2	0	7	13	3	2

◀ than last month

MSSA bacteraemia	Total count	CO Count	HO Count
Bronglais General Hospital	2	2	0
Glangwili General Hospital	2	2	0
Prince Philip Hospital	1	1	0
Withybush General Hospital	7	4	3

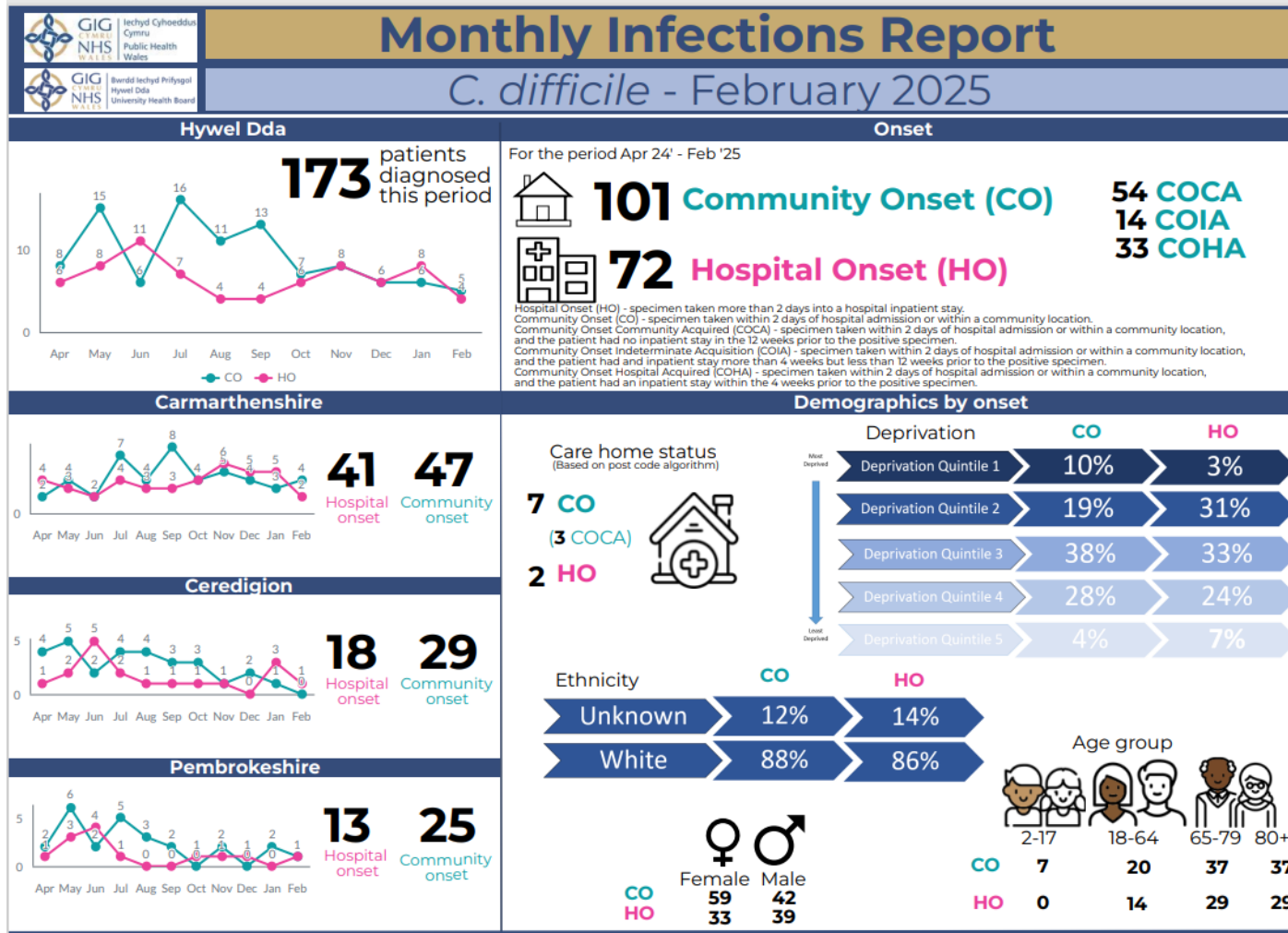
E.Coli bacteraemia	Total count	CO Count	HO Count
Bronglais General Hospital	4	4	0
Glangwili General Hospital	13	10	3
Prince Philip Hospital	4	4	0
Withybush General Hospital	13	11	2

## Definitions:

Community onset (CO) - specimen taken in community location or less than 3 days into hospital inpatient stay.

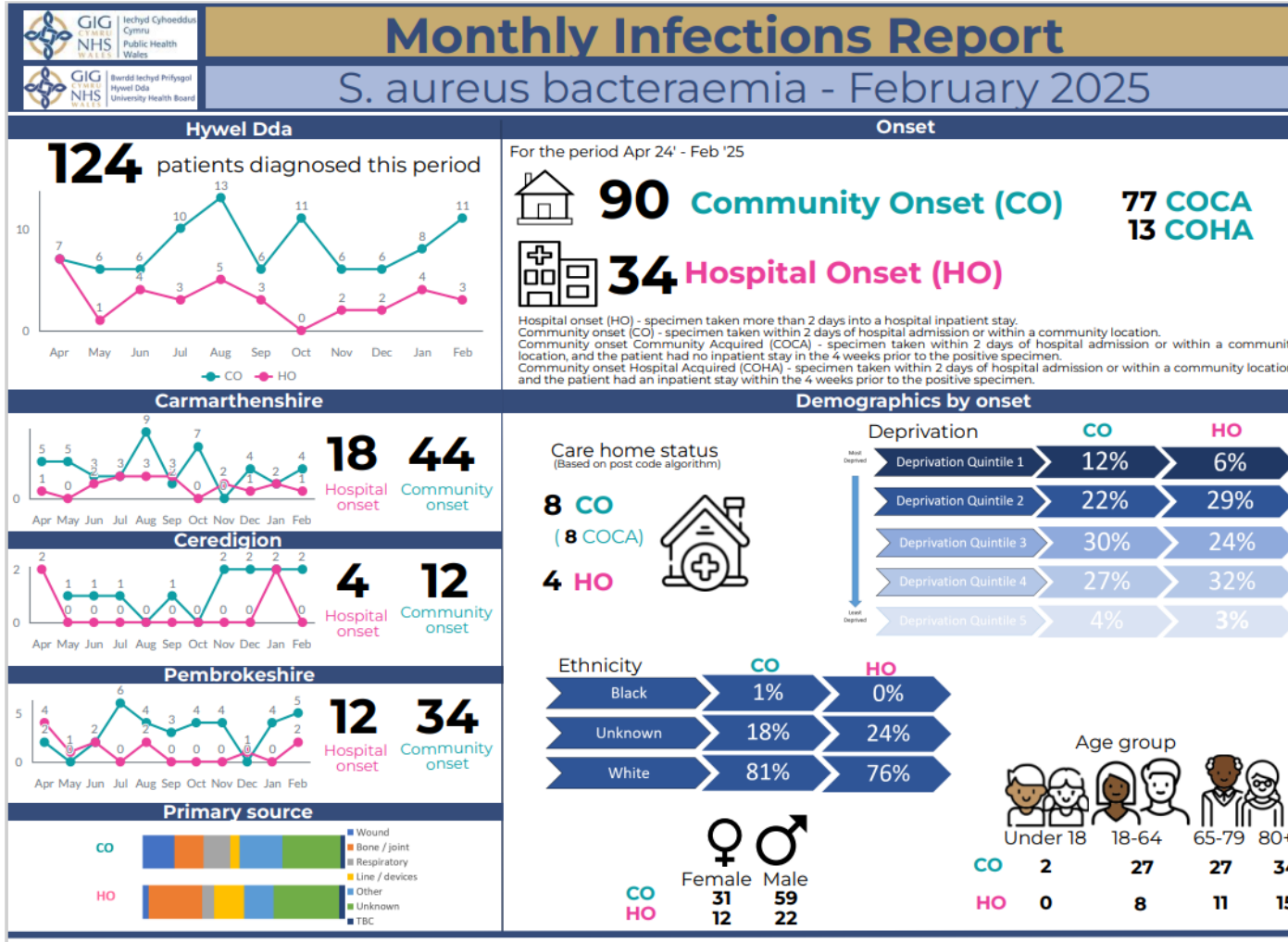
Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

Healthcare acquired / associated infection (HCAI) - as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting

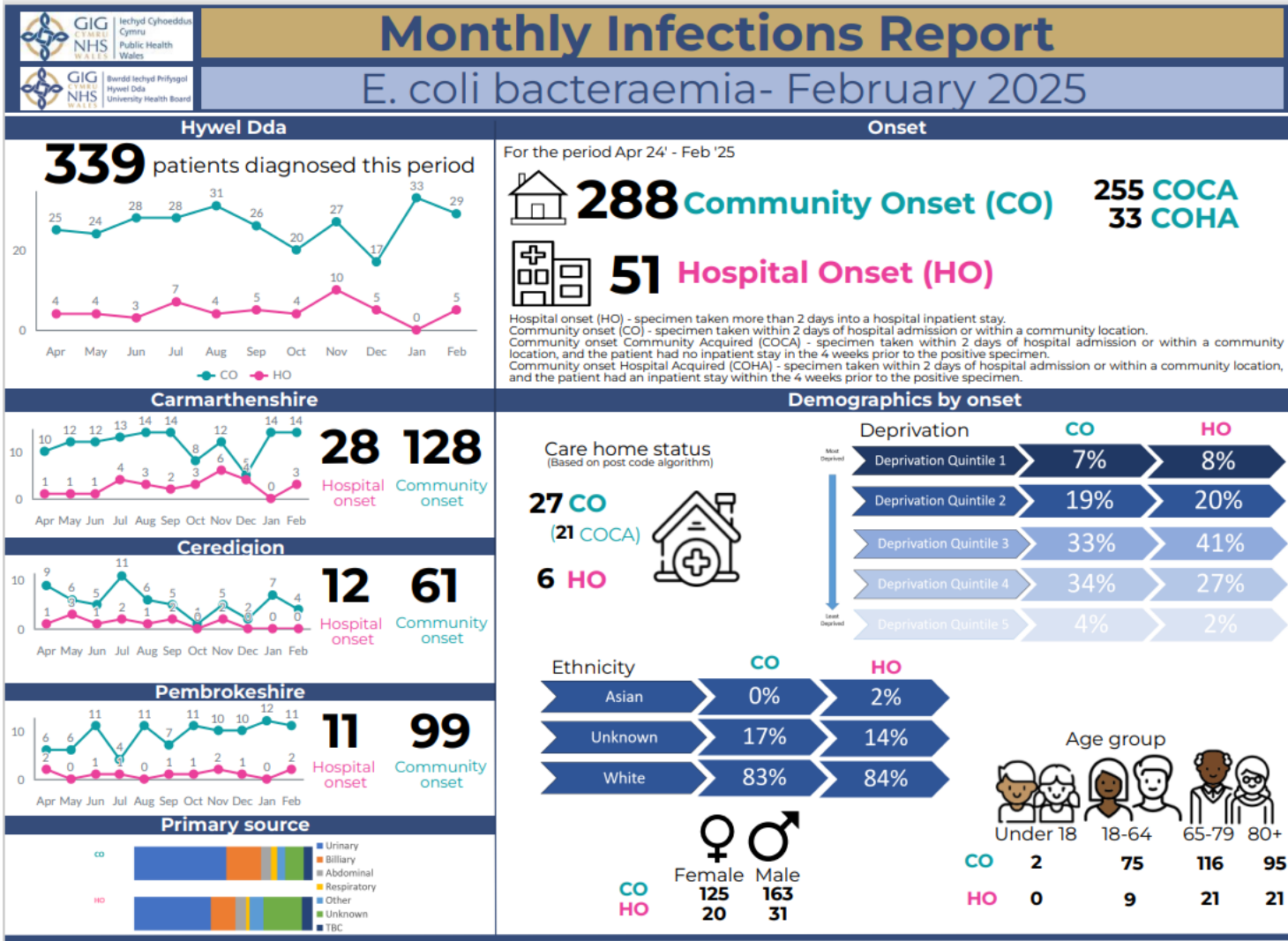


### Actions

- C.diff infection (CDI) Improvement Group established with Deputy Medical Girector chairing
  - Antimicrobial Group also continues. This will support progress expected against the Welsh Health Circular (WHC) Antimicrobial Resistance (AMR) and Healthcare Acquired Infections (HCAI) Improvement Goals 2024/25.
  - Continued use of DiffX and HPV disinfection. Trail of new HPV machines has been completed in Bronglais General Hospital (BGH) and Glangwili General Hospital (GGH) with positive feedback and engagement from hotel facilities
  - Awaiting update Targeted Estates Fund (TEF) bids
  - Self assessment against the C.diff Framework for Wales ongoing
- ### Targeted work
- HCAI Assurance Groups continue to scrutinise infections per month within directorates
  - Deep clean of Prince Philip Hospital (PPH) wards due to an increase in C. diff clusters and cross infections commenced on 10 March 2025.



- Aseptic Non Touch Technique (ANTT) practical compliance 80.60% for the HB
- Peripheral Venous Catheter (PVC) bundle compliance monitored, with an emphasis on devices being removed at the earliest opportunity
- Hand hygiene reviewed as part of the Quality Indicator Audits



- Spike in E.coli cases for November 2024
- Less variance noted thought data set
- Lower cumulative rate in comparison to previous year and below trajectory
- 3 cases with a hepatobiliary source and 4 with a urinary source

#### Actions

- Continued education of staff around catheter and device care
- To continue to profile ANTT



There has been 1 new report published by Health Inspectorate Wales (HIW) titled Children and Young People Mental Health Review (see below), but no further reports were published by Health Inspectorate Wales or the Human Tissue Authority (HTA) relating to the Health Board in the period 1<sup>st</sup> November 2024 to 31<sup>st</sup> January 2025.

[Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales? | Healthcare Inspectorate Wales](#)

The review, undertaken jointly by HIW and education inspectorates in Wales recommends improvements in mental health support for children and young people. The field work took place during quarter 1 and the report has generated 9 recommendations and a total of 23 actions which are underway by the service at the point of reporting. Update on slide 21 and 22 – 8 HIW inspections remain open as the DNACPR and Stroke reports have been completed.

The Health Board have received a number of assurance queries from HIW during the reporting period.

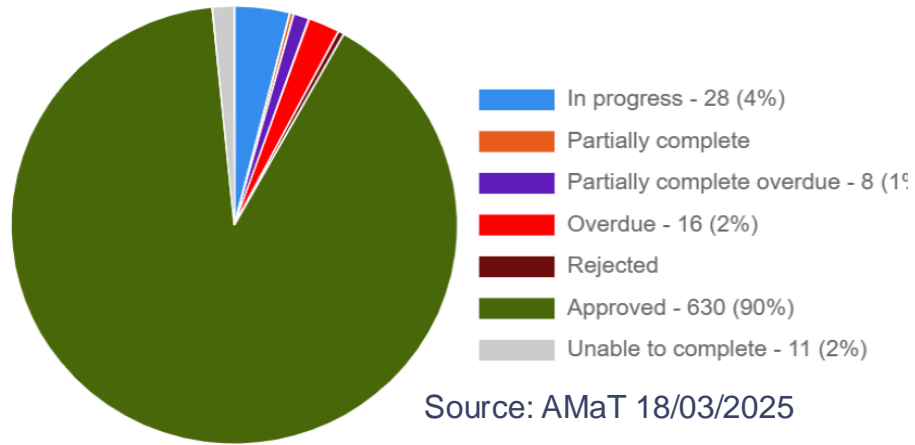
All open HIW / other body inspection actions plans are chased on a bi-monthly basis by the Quality, Assurance and Safety Team and escalated if no progress is seen within 14 days. Services are able to log into the live Audit Management and Tracking (AMaT) system and update their own actions and add upload evidence of completion.

Services are actively supported to utilise AMaT and supported and engaged during an inspection to develop a SMART action plans within a realistic timeframe. HIW expect an update to all action plans on a 3 monthly basis until completion.



# HIW Quality Checks/Inspections: Reviews and inspections

## Improvement Actions relating to HIW reviews



In comparison to the position in February 2024, there has been improvement in closure of actions.

	Position Feb 2024	Position as at 21 Jan 2025
Overdue	51	14
Partially complete (overdue)	17	9
Partially complete	1	5
In progress	119	8

See appendix for list of overdue actions

## Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
10	122/202 (60%)	9/11 (82%)	0	0	28	2	8	16	5	0	3	216

## Completed HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
24	214/214 (100%)	10/10 (100%)	0	0	0	0	0	0	6	0	0	414

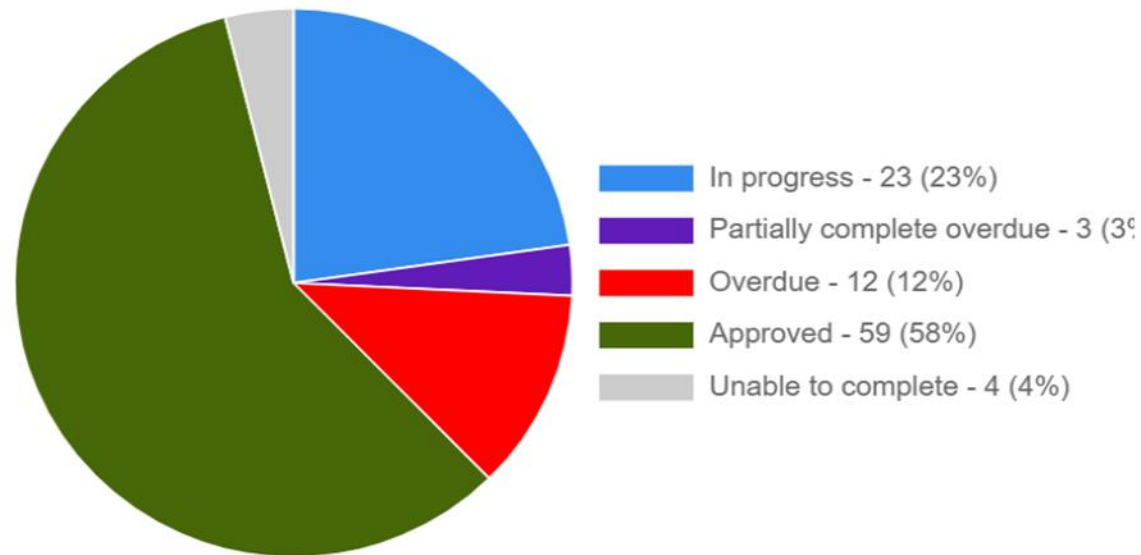
# HIW Quality Checks/Inspections: Open reviews and inspections

Code	Title	Type	Date of inspection	Origin	Recommendations	Act
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	New	02/09/2024	Healthcare Inspectorate Wales (HIW)	40	51
Healthcare Inspectorate Wales (HIW)/2024/302	Glangwili Hospital – Morlais Ward	New	01/07/2024	Healthcare Inspectorate Wales (HIW)	9	18
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	New	05/02/2024	Healthcare Inspectorate Wales (HIW)	9	23
Healthcare Inspectorate Wales (HIW)/2023/152	HIW DNACPR Review (Dec 2023)	New	18/12/2023	Healthcare Inspectorate Wales (HIW)	17	20
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	New	15/11/2022	Healthcare Inspectorate Wales (HIW)	21	36
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	New	07/03/2023	Healthcare Inspectorate Wales (HIW)	40	33
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	New	31/01/2024	Healthcare Inspectorate Wales (HIW)	9	14
Healthcare Inspectorate Wales (HIW)/2022/50	HIW National Review of Patient Flow (Stroke Pathway)	New	14/03/2022	Healthcare Inspectorate Wales (HIW)	46	54
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	New	16/10/2023	Healthcare Inspectorate Wales (HIW)	19	25

# HIW Quality Checks/Inspections: Reviews of services and inspections

Mental Health and Learning Disability themes from HIW\* actions

(Data extracted from AMaT system 28<sup>th</sup> February 2025)



All HIW Recommendations for Mental Health and Learning Disabilities are categorised as “Must Do”

\* HIW plus other inspection activity has been reviewed to produce this data

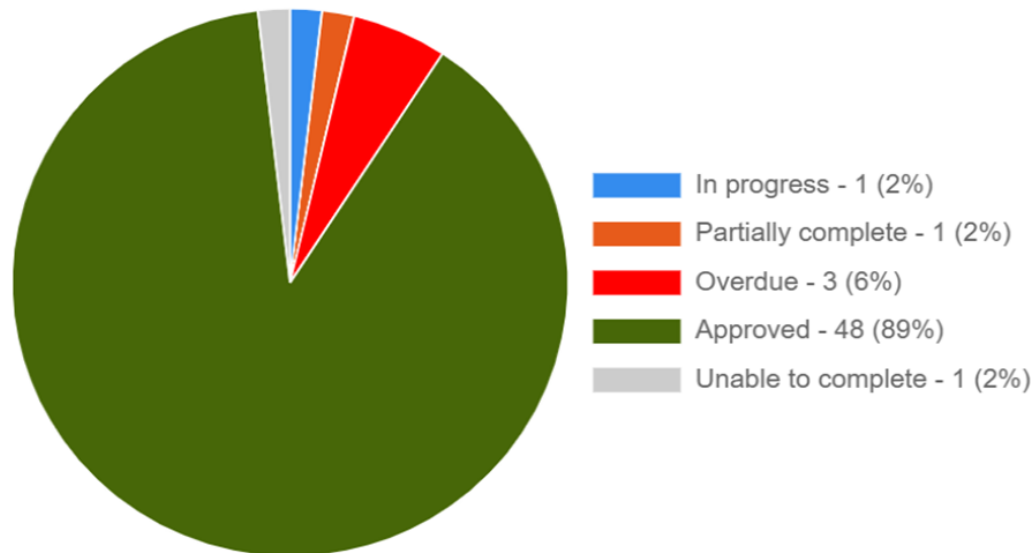
The titles of the current active Mental Health and Learning Disability inspections / reports on AMAT

Audit Wales Review of Mental Health and Learning Disabilities Directorate Governance Arrangements
HIW Children and Young People Mental Health Review
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)
HIW Joint Thematic Review of Community Mental Health Teams 2017-2018
Internal Audit Mental Health and Learning Disability Services Timely Access
NHS Delivery Unit All Wales Review of Primary and Secondary Mental Health Services for Children and Young People

# HIW Quality Checks/Inspections: Reviews of services and inspections

The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 HIW inspections themes

(Extracted from the AMAT system 28 February 2025)



Titles of live inspections / reports on AMAT system (3 reports subsequently closed):

- HIW GGH IRMER Inspection (Nov 2022)
- HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024
- HIW IRMER GGH 0725 report
- HIW Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)
- HIW WGH IRMER inspection October 2021

All IRMER recommendations and actions are categorised as “Must Do”



- In September 2023, Welsh Government issued a Speaking Up Framework. An action plan was developed to ensure that all recommendations in the framework were considered in the responsive review of the Health Board's arrangements in place at the time. All actions have been completed.
- In October 2024, Internal Audit undertook a review of the Health Board's Speak Up Safely arrangements. One agreed action remains open; the expected completion date is May 2025.
- In response to the Framework and the Internal Audit report, the Health Board's speak up arrangements have been reviewed and strengthened.
- Mechanisms available to speak up include:
  - Working in confidence platform
  - Speak up guardians supported by the Voices Network
  - Incident reporting – ability for the reporter to mark as sensitive which triggers a corporate review allowing for redirection if issue is speak up.
- A report will be shared with the People and Organisational Development Committee in May 2025.
- An update will be brought to the QSEC meeting in June 2025 which will include themes relating to quality and patient safety.

# Implementation of Welsh Health Circulars (WHCs)



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There are 21 open WHCs aligned to QSEC as at March 2025. No new WHCs have been issued since the previous report to Committee.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which leads have access to directly update and upload relevant evidence to demonstrate compliance with their requirements.

Each WHC is assigned a RAG status – the table below provides the definition for each category, along with the number of WHCs assigned to each category as at March 2025, and the number of WHCs noted as completed since the previous report:

RAG Status	Definition	Number of WHCs
Red	Behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	7
Amber	A plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC)	10
Green	Completed	10
External	Considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement.	4

Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

# WHCs behind schedule (Red)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 ( <i>Not Available Online</i> ) – issued Feb 2018	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements	<b>Risk Ref</b> :1457 <b>Current Risk Score:</b> 12 <b>Impacts:</b> Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	To complete a QIA  To escalate the inability to proceed with implementation via CCG management structures to agree next steps
<a href="#">033-18: Airborne Isolation Room Requirements</a> – issued July 2018	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Service unable to provide implementation date due to capital funding requirements	<b>Risk Ref:</b> 1640 <b>Current Risk Score:</b> 15 <b>Impacts:</b> Increased risk of transmission of infectious diseases	To complete a QIA  To escalate the inability to proceed with implementation via CCG management structures to agree next steps
<a href="#">017-19: Living with persistent pain in Wales guidance</a> – issued May 2019	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date of 31 Jan 2025 lapsed, with revised completion date of <b>31 Jan 2026</b> provided.	No risk noted on Datix	To complete a risk assessment  To complete a QIA
<a href="#">009-21: School Entry Hearing Screening pathway</a> - issued March 2021	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable to provide implementation date due to funding requirements	<b>Risk Ref:</b> 1456 <b>Current Risk Score:</b> 8 <b>Impacts:</b> Detrimental impact on quality, accuracy and consistency of screening services provided	To complete a QIA  To escalate the inability to proceed with implementation via CCG management structures to agree next steps

# WHCs behind schedule (Red) - continued

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
<a href="#">004-22: Guidance for the provision of continence containment products for children and young people: a consensus document – issued October 2022</a>	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date of 31 July 2023 lapsed, with revised completion date of <b>31 Aug 2025 provided</b>	<b>Risk Ref:</b> 1615 <b>Current Risk Score:</b> 12 <b>Impacts:</b> Right to independence for children and young people; Access to the same services as their peers	None - Nursing post that will enable the CCG to comply with WHC requirements approved by Financial Control Group in February 2025. The timeline for implementation has been set as August 2025 to account for the recruitment process.
<a href="#">030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 – issued August 2023</a>	Medical	Medical Director	No implementation date received from the service	No risk noted on Datix	Service to provide progress update/statement of compliance on AMAT, and an implementation date if not currently compliant  To complete a risk assessment  To complete a QIA
<a href="#">006-24: National Clinical Guideline for Stroke, for the UK and Ireland – issued March 2024</a>	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Service unable to provide an implementation date pending progression of the wider Clinical Service Plan	<b>Risk Ref:</b> 233 <b>Current Risk Score:</b> 12 <b>Impacts:</b> Delayed assessment and treatment of patients; Increased length of stays	To complete a QIA

# WHCs in Progress (Amber)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
<a href="#">017-22: Wales rare diseases action plan 2022 to 2026 – issued June 2022</a>	Medical Director	Medical Director	Dec-26
<a href="#">019-22: Non-Specialised Paediatric Orthopaedic Services - issued June 2022</a>	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Apr-25
<a href="#">041-23: Wales rare diseases action plan refresh 2022 to 2026 – issued January 2024</a>	Medical Director	Medical Director	Dec-26
<a href="#">002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales - issued March 2024</a>	Director of Nursing, Quality and Patient Experience	Director of Primary Care, Community and Long Term Care	Mar-26
<a href="#">016-24: Healthy Child Wales Programme: for school aged children - issued April 2024</a>	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Apr-26 Sep-26
<a href="#">040-24: Adopting a patient and family-initiated escalation approach - issued October 2024</a>	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Sep-25
<a href="#">041-24: Ambulance patient handover guidance – issued October 2024</a>	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Dec-25
<a href="#">025-24: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25 - issued June 2024</a>	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Mar-25
<a href="#">001-25: NHS Wales Sustainability Conference and Awards 2025 - issued March 2025</a>	CEOs Office (Welsh Language)	Director of Communications	TBC*
<a href="#">002-25: Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration - issued February 2025</a>	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Sep-25

\* Status of WHC will be changed to red if implementation date/status of compliance is not provided within 10 working days from the service

# External WHCs

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status
<a href="#">026-18: Phase 2 – primary care quality and delivery measures</a> – issued July 2018	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	National work around this transformational model was suspended due to the COVID-19 pandemic and has never progressed further. Currently the Primary Care quality and delivery measures within the new dashboards are being used as equivalent quality indicators. As such, the implementation date for this WHC is currently noted as not known.
<a href="#">032-22: Further extending the use of Blueteq in secondary care</a> – issued March 2023	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	The roll out of this high-cost drugs reporting system will be managed by the All Wales Blueteq Steering Group, with management support from the All Wales Therapeutics & Toxicology Centre on behalf of Welsh Government. The Health Board has representation on the Blueteq Steering Group, with national drug approval templates in development. Information Governance issues have delayed implementation, with discussion ongoing to resolve. As such, the implementation date for this WHC is currently noted as not known.
<a href="#">040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)</a> – issued September 2023	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.
<a href="#">035-24: Standardising the management of acute deterioration</a> – issued September 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	A National Improvement Programme for Acute Deterioration is being led through the Safe Care collaborative (NHS Executive), which the Health Board are engaged in and are contributing towards. The Health board is engaged in the roll out of NEWS2 (due to be launched in September 2025) and has developed an organisation wide training needs analysis to improve recognition and management of acute deterioration. The Health Board is awaiting national updates in order to progress with the development of a process for using Acute Deterioration E-learning modules. As such, the implementation date for this WHC is currently noted as not known.

# WHCs implemented since previous meeting (Green)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)
005-24: <a href="#">Private obesity surgery and the Welsh NHS</a> - Issued February 2024	Operational Allied Health Professions and Health Sciences	Director of Therapies and Health Science
007-24: <a href="#">Guidelines for managing patients on the suspected cancer pathway</a> – issued April 2024	Planned and Specialist Care	Chief Operating Officer
020-24: <a href="#">Exemptions for local health boards and NHS Trusts to the requirement to implement recommendations made by the National Institute for Health and Care Excellence or the All Wales Medicines Strategy Group within the usual period, in specified circumstances</a> – issued May 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
030-24: <a href="#">Published weight management medication pathway</a> - Issued July 2024	Operational Allied Health Professions and Health Sciences	Director of Therapies and Health Science
034-24: <a href="#">Directions to apply the National Framework for the Commissioning of Care and Support in Wales: Code of Practice to local health boards and NHS trusts</a> – August 2024 - Issued August 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
036-24: <a href="#">Oxygen Cylinders – Regulation 28 Report and Patient Safety Notice (PSN) 042 reminder</a> – issued August 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
038-24: <a href="#">AMR &amp; HCAI Improvement Goals For 2024-2025</a> – issued September 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience
039-24: <a href="#">Pre-Transfusion Sample taking Compliance with the confirmatory sample rule</a> – issued October 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer
045-24: <a href="#">Spotting Sepsis in Children Awareness Leaflet</a> . – issued November 2024	Planned and Specialist Care	Chief Operating Officer
050-24: <a href="#">Infected Blood Inquiry: Implementation of commendation 8a and 8b</a> – issued December 2024	Director of Public Health	Director of Public Health



The Quality, Safety and Experience Committee (QSEC) is asked to note the contents of this report.

The Quality, Safety and Experience Committee is asked to take assurance that processes are in place to review, monitor and improve the quality of our service through:

- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Patient Experience and Complaints
- Welsh Risk Pool: Concerns Assessment
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak up
- Welsh Health Circulars



Collation of report: Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

## Sections:

1. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Patient experience and patient feedback – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
4. Welsh Risk Pool: Concerns Assessment – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate Wales and other peer reviews – Caroline Burgin, Patient Safety and Assurance Manager
7. Speak up - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Welsh Health Circulars - Rachel Williams, Head of Assurance and Risk



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# The Duty of Candour

*Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.*



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

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
Bryngolau Ward, Prince Philip Hospital	The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.	Healthcare Inspectorate Wales (HIW)/2024/395/MD6/1	Review information on display and its accessibility and assure the following information points are present and accessible: <ul style="list-style-type: none"> <li>• Advocacy Services and contact details</li> <li>• Role of HIW and contact details</li> <li>• Mental Health Act information</li> <li>• MHA name and contact</li> <li>• Available and appropriate legal representatives for detained patients (list in office)</li> <li>• How to raise a concern or complaint (putting things right)</li> <li>• QR Code Patient Satisfaction</li> <li>• Directorial Board: staff images, role, uniform and name.</li> </ul>	Mental Health and Learning Disabilities	1/31/2025	Partially complete (Overdue)
	The health board should ensure all Welsh speaking staff and patients can be clearly identified.	Healthcare Inspectorate Wales (HIW)/2024/395/MD8/1	Order and distribute Magnetic Badges for all staffs who do not have an embroidered [Welsh Speaker] indicator on their uniform.	Mental Health and Learning Disabilities	12/31/2024	Partially complete (Overdue)
	The health board must: <ul style="list-style-type: none"> <li>• Review the staff establishment on Bryngolau Ward promptly, to ensure the staffing levels are appropriate to safely support and manage the needs of patients</li> <li>• Review the existing temporary staff process for bank and agency nurses, and ensure staff are suitably skilled to care for relevant patient groups.</li> <li>• Aim for consistency with continuity of care when using temporary staff, such as 'block-booking' staff who are familiar with the environment and patient group</li> <li>• Ensure attention is given to the skill mix and the proportion of temporary staff rostered, to maintain patient and staff safety.</li> </ul>	Healthcare Inspectorate Wales (HIW)/2024/395/MD23/1	Present findings from inpatient establishment review work undertaken in partnership with Head of Nursing for Professional Standards and Regulation, Inpatient Senior Nurses, Ward Managers and Workforce colleagues to Executive colleagues for approval.	Mental Health and Learning Disabilities	1/31/2025	Partially complete (Overdue)
	Finalise and implement the Mental Health and Learning Disabilities Culture and Organisational Development Plan which encompasses actions to promote senior management visibility and engagement with staff across clinical settings.	Healthcare Inspectorate Wales (HIW)/2024/395/MD32/1	Present findings from inpatient establishment review work undertaken in partnership with Head of Nursing for Professional Standards and Regulation, Inpatient Senior Nurses, Ward Managers and Workforce colleagues to Executive colleagues for approval.	Mental Health and Learning Disabilities	1/31/2025	Partially complete (Overdue)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	Healthcare Inspectorate Wales (HIW)/2022/19/MD15/2	To source a document control system.	Radiology	9/30/2023	Overdue
	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	Healthcare Inspectorate Wales (HIW)/2022/19/MD22/3	CB to ensure all actions closed and evidence uploaded prior to closure of report	Radiology	2/3/2025	Overdue
HIW Glangwili Hospital – Morlais Ward inspection	The health board must ensure that the outstanding actions identified following the fire safety audit in February 2024 are completed and sustained.	Healthcare Inspectorate Wales (HIW)/2024/302/MD6/1	To review the recommendations from the fire safety audit and agree an implementation plan.	Facilities and Estates	12/31/2024	Overdue

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
HIW Improvement Plan – adapted from the CTMUBH Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Healthcare Inspectorate Wales (HIW)/2023/29/MD1/1	a) Develop of standards for physical health screening to be incorporated into Service Specifications.	Mental Health and Learning Disabilities	9/29/2023	Partially complete (Overdue)
	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Healthcare Inspectorate Wales (HIW)/2023/29/MD6/1	e) Produce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	Mental Health and Learning Disabilities	9/29/2023	Overdue
	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	Healthcare Inspectorate Wales (HIW)/2023/29/MD8/1	h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Mental Health and Learning Disabilities	10/31/2023	Overdue
	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/2	o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Mental Health and Learning Disabilities	9/30/2023	Overdue
	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/3	p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health and Learning Disabilities	11/30/2023	Overdue
	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/4	q) Develop of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Mental Health and Learning Disabilities	12/31/2023	Overdue
	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	Healthcare Inspectorate Wales (HIW)/2023/29/MD26/2	s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Mental Health and Learning Disabilities	9/30/2023	Overdue
	The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/29/MD32/1	u) Develop of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Mental Health and Learning Disabilities	11/30/2023	Overdue

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/1	w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:-  -Testing assurance of consistent implementation of CAT and Physical Health Screening -Testing assurance of appropriate completion of WARRN -Routine reporting and monitoring of compliance with routine offer of carers assessments -Audit of compliance with Ward Round (MDT Review) standards -Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards -Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans -Testing assurance of the quality of discharge letters	Mental Health and Learning Disabilities	12/31/2023	Overdue
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/2	x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Mental Health and Learning Disabilities	12/31/2023	Overdue
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/4	z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Mental Health and Learning Disabilities	3/31/2024	Overdue
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	Healthcare Inspectorate Wales (HIW)/2024/86/MD4/1	1. A document control system needs to be sourced	Radiology	12/31/2024	Overdue

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Healthcare Inspectorate Wales (HIW)/2023/69/MD10/4	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed using anti ligature handrail products to be undertaken	Facilities and Estates	1/31/2024	Partially complete (Overdue)
	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	Healthcare Inspectorate Wales (HIW)/2023/69/MD13/1	To undertake a Directorate wide audit of Rapid Tranquillisation against standards for physical health monitoring within the Health Boards Rapid Tranquillisation Policy.	Mental Health and Learning Disabilities	3/31/2024	Overdue
HIW Thematic Review of Ophthalmology 2015/16 issued January 2016 (HISTORIC REPORT MONITORED BY ASSURANCE AND RISK TEAM)	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	Healthcare Inspectorate Wales (HIW)/2016/146/MD1/1	(Historic HIW monitored by Assurance and Risk Team) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Planned and Specialist Care	3/31/2022	Partially complete (Overdue)



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Welsh Risk Pool Services

# Welsh Risk Pool Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

**Hywel Dda University Health Board**

**Final Report February 2025**



Gwella Diogelwch Trwy Ddysgu  
Improving Safety Through Learning

# WRP Concerns Assessment

## A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

### About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of their Putting Things Right processes and provide assurance in relation to current policies, procedures and practice.

This report outlines the findings in relation to each area for assessment following field work and matter scrutiny undertaken by the independent assessment team. The report has been circulated for comments, factual accuracy considerations, and the development of actions arising from recommendations.

The report identifies a number of proposed recommendations. The organisation has developed an action plan which addresses the findings and supports the prioritisation of improvement activity in this sector. A copy of the organisation's action plan, addressing the recommendations, is embedded within this report to ease future analysis.

Along with the draft report, each Health Body has received a separate summary which detailed the analysis of the matters scrutinised as part of the assessment process. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

This report is now finalised and will be shared with the Welsh Risk Pool Committee.

Assessment Field Work	May - Jun 2024
Matter Scrutiny	May - Aug 2024
Draft Findings shared	Dec 2024
Action Plans Received	Jan 2025
Final Report Published	Feb 2025

### Version

Hywel Dda WRP Concerns Assessment Report VFinal1



# WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

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## 1.0 Outline of Review

- 1.1 The Welsh Risk Pool (WRP) undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the WRP Committee, Welsh Government and the NHS Wales Executive; and to provide recommendations to support organisations in continuous improvement in this important area of governance.
- 1.2 The WRP Assessment is used by the WRP Committee when determining members' contributions to the fund as part of the risk sharing agreement. The risk sharing calculations for *Managing Concerns* and *Lessons Learned* will include a measure which ranks organisations in each area of assessment.
- 1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies & procedures related to the PTR sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area.
- 1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.
- 1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a Health Body shares and implements good practice across the health body and more widely.
- 1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the PTR sector in other organisations joining staff from the WRP in conducting the assessment.
- 1.7 Specialist advisors and legal experts have been invited to join the Assessment Team



as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

- 1.8 For each area for assessment, the Assessment Team considers the available evidence and reports assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.



## 2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the PTR process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- WRP Reimbursement Process

2.2 The report considers the same period for each health body that underwent a WRP Assessment. The periods used within the assessment were selected and agreed with the assistance of the Head of Patient Experience Safety & Learning Network.

2.3 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1<sup>st</sup> January 2024 to 31<sup>st</sup> March 2024. This period was chosen as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review but remain relatively current at the time of the assessment. When considering the *performance of quality* data in respect of compliance with the WRP Reimbursement Procedures, data from the financial year 2023/24 was used.

2.4 The WRP recognises that the most frequently occurring clinical specialties seen in claims and redress cases are *Maternity Services, Care in Emergency Departments & Units* and *Trauma & Orthopaedics*. The Assessment Team have focussed on these specialties, where they are provided by the Health Body, as part of the drive towards continuous improvement in relation to the NHS Wales litigation profile. In addition to the clinical specialties which have been subject to enhanced focus, the Assessment Team have selected other matters on a random basis to ensure that assurance is provided across as broad range of areas as possible.



### 3.0 Assessment Team

- 3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the PTR sector.
- 3.2 The Coordinator for each Assessment is a member of the WRP Team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.
- 3.3 To provide specialist advice in relation to compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling.
- 3.4 As the assessment process focusses greatly on the use of the Datix Cymru System, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.
- 3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise, along with signing off the Assessment Report.
- 3.5 The Assessment Team for this review was:

**Sponsor:** Jonathan Webb, Head of Safety & Learning  
*Welsh Risk Pool*

**Field Work:** Kath Clarke, Head of Quality  
*Betsi Cadwalader University Health Board*

Gemma Cooper, Senior Solicitor  
*Legal & Risk Services*

Rachel Roberts, Solicitor  
*Legal & Risk Services*

Christine Buckland, Safety & Learning Advisor  
*Welsh Risk Pool*

Maria Stolzenberg, Principal Systems Lead  
*Once for Wales Concerns Management System*

Gethin Bateman, Serious Clinical Incident Investigation Manager  
*Digital Health & Care Wales*

Eleri Wright, Safety & Learning Advisor  
*Welsh Risk Pool*



## 4.0 Previous Findings

### 4.1 Summary of the 2023 WRP Assessment

4.1.1 During 2023, a programme of assessments was conducted, and the report was accepted by the Health Body. This report contained a number of recommendations, to which the Health Body developed an action plan. The Assessment Team have sought evidence for progress with, or completion of, the proposed actions and this is shown in Table1.

Table1: Update on Actions from 2023 Assessment Report			
REF	Recommendation 2023	Position Update	Status
R01	HDUHB should ensure that all relevant documentation related to a record is uploaded to the Datix Cymru System and a standard naming convention is used to allow for ease of reference for all staff.	Evidence seen within the Claims and Redress modules.	Complete.
R02	It would add further value to the process for preparing and approving responses if HDUHB develops a formalised approval and signature process for responses.	The authorisation of responses process was already being addressed. The investigation report will need to bear the signature of the investigator, & confirmation of the manager or clinical lead who has signed it off.	Complete
R03	HDUHB should map out the process for transition of an incident into a redress case and consider introducing a Standard Operating Procedure (SOP) to support practice in this area. This will support the application of the Duty of Candour and reduce the potential for cases to be missed.	SOP developed and included as part of the concerns management and incident management toolkits.	Complete.
R04	HDUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	Evidence of discussions/review was noted on some of the matters reviewed, but not all. The Redress Team explained that they are not routinely inputting early consideration of value and have stated they are unable to do so due to lack of capacity. This potentially creates a problem in light of proposed changes to PTR and should be reconsidered.	Ongoing



R05	HDUHB should consider development of a SOP for claims management to build on the good process seen and ensure consistency in operational practice.	SOP developed and in place as well as a very detailed claims flowchart to be followed.	Complete
R06	HDUHB should consider the introduction of a naming convention for files related to claims management. This will ease record identification issues.	Evidence seen within the claims module during the file reviews.	Complete.
R07	HDUHB to review the process for managing PTR responses to ensure the requirements of the Regulations are adhered to and that complaint responses include the necessary information.	A revised process produced outlining management of concerns which has been incorporated into the toolkit.	Complete



## 5.0 Organisational Performance

### 5.1 Performance data - Management of Concerns & Lessons Learned

5.1.1 As part of the information gathered with each health body, data relating to the performance against the standards and timescales outlined in the WRP Reimbursement Procedures is collated.

No of LFERs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
63	2	3.17%	0	0	0%

No of LFERs considered	No Approved	% Approved	No Amber Deferred	% Amber Deferred	No Red Deferred	% Red Deferred
67	41	61.19%	17	25.37%	9	13.43%

No of CMRs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
48	2	4.17%	0	0	0%



## 6.0 Review Findings

### 6.1 Management of Concerns (Incidents)

- 6.1.1 The Assessment Team noted that there were 4192 incidents reported in the period 1st January 2024 to 31st March 2024.
- 6.1.2 The Assessment team were provided with the Health Boards PTR - Management & resolution of Concerns Policy (Incidents, Complaints & Claims) dated 10<sup>th</sup> October 2023 and the Incident, Near Miss and Hazard Reporting Procedure which was in date and next due for review by 2<sup>nd</sup> November 2024.
- 6.1.3 These documents cover the requirements as set out in PTR and provide guidance in respect of the management of incidents within the Health Board, including the Duty of Candour (DoC) and Nationally Reportable Incidents (NRI's).
- 6.1.4 Both documents provide guidance on roles and responsibilities in regards to investigation processes and the learning from investigations. There were clear links to other relevant policies and procedures, and both provided guidance in respect of harm grading/assessment of harm.
- 6.1.5 Within the Incident, Near Miss and Hazard Reporting Procedure clear guidance was provided in respect of the timescales expected for the reporting of incidents and undertaking the initial management review of them.
- 6.1.6 There is an exceptionally robust Health Board Quality Assurance and Safety intranet site/page which provides an array of guidance and flow charts along with downloadable documentation to educate, advise and support staff.
- 6.1.7 The Quality Assurance and Safety Team (QAS) oversee the management of severe and catastrophic incidents across the organisation. All incidents undergo a screening process as clearly defined within the policy to ensure appropriate review, escalation and make safe actions.
- 6.1.8 The QAS team also have dashboards set up for each service / directorate and audit the closures in relation to level of harm / DoC for accuracy, as well as undertaking a high-level review of incidents which arise and will make contact with the service to discuss / support as appropriate.



- 6.1.9 The management of lower-level incidents and checks for accuracy remains the responsibility of the specific service or directorate.
- 6.1.10 The Assessment Team were pleased to note from review of the documentation provided and in discussion with Health Board representatives that there are clear and established links between the QAS Team and the Services and Directorates, as well as a clear and defined structure in place to ensure clear lines of escalation and reporting to the Executive Team.
- 6.1.11 In respect of the Health Boards governance arrangements, there is a Quality and Assurance Dashboard available to the Quality, Safety and Experience Committee, and evidence of the Quality and Safety Assurance Report submitted was provided to the Assessment team.
- 6.1.12 There are Directorate level Quality Governance forums reporting into Operational Board, and directorates also report to monthly Operational Quality, Safety and Experience Sub-committee. NRI's are discussed/reported at the weekly Quality, Safety Intelligence Group (attended by clinical executives).
- 6.1.13 All concerns with significant learning will be reported to the Listening & Learning from Events Sub-Committee and/or the Operational Quality, Safety & Experience Sub Committee, and specific case reports are also presented to the Listening and Learning Sub-Committee dependent on the theme of the meeting.
- 6.1.14 Directorates are also performance managed by virtue of the presentation of an Integrated Performance Assurance report to the board and the board are made aware of concerns which may adversely affect the reputation of the Board by the Chair of the Quality, Safety and Experience Assurance Committee.
- 6.1.15 The Health Board utilises several varied communication mediums such as the medical director's newsletter, nursing newsletter, and grand rounds/teaching sessions for the sharing of learning. The Assessment Team were provided with examples of the QAS Teams-7 Minute Patient Safety Briefing to evidence some of the learning shared as a result of concerns investigations.



6.1.16 A sample of 20 incidents was generated randomly from the data supplied by the Health Board and the Assessment Team identified the following in respect of these incidents: -

- In 80% (n=16) the incident was reported as per Health board policy (within 24hrs/2 days).
- In 65% (n=13) of cases the Initial Management review was completed.  
In 2 cases a short form version of the incident was completed which does not require this field to be completed.
- In 5 cases the investigation was ongoing, and no management review had been completed.
- Where the incident was escalated to NRI and/or DoC triggered there was appropriate recording of updates and additional information into the report.
- There was a clear theme that where some cases did not meet the policy timescales there was no documentation of a rationale for the delay.
- There was clear evidence in the majority of cases that within progress notes fields of interaction between the QAST and service/directorate to chase for information or progress updates.
- There was evidence that cases moderate or above were clearly reviewed and escalated or de-escalated appropriately with a suitable supporting narrative.
- However, there was two cases of note:-
  1. Documented an avoidable injury with moderate reported harm but the report does not reflect that the DoC was triggered, or Redress considered. Narrative supportive of failures in care.
  2. Case deemed moderate by reporter and investigator but again no evidence of implementation of DoC although some narrative recorded around discussion of redress.


6.1.17 Upon review of the Integrated Performance Assurance report November 2023 the Assessment team noted that it was recorded that :

*“A random review of records has identified a training issue regarding reporting of severity of harm post investigation. Work is underway to develop a guide for incident managers and senior staff responsible for reviewing the final information before closure of the incident record.”*



6.1.18 The Team also noted that the Quality, Safety and Experience Committee- Quality and Safety Assurance Report- February 24, identified “*Work continues to remind investigators that the grade/severity of an incident should reflect whether the investigation identified any acts or inactions by the Health Board that led to a negative outcome for the person affected e.g. an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified.*”

6.1.19 Overall, the Assessment Team were impressed with the Health Board policy and procedure approach to incident management, which provides a robust structure and process. The number of incidents considered to involve lower than moderate harm which are open beyond a reasonable timeframe and those which have data quality issues remain at an unacceptable level and the leadership team demonstrated a commitment to continuing to address these challenges – which when addressed will provide an opportunity for Substantial Assurance to be applied to the area for assessment.


Management of Concerns (Incidents)		
<p><b>REASONABLE ASSURANCE</b></p>		<p>The organisation can take <b>reasonable assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.</p>

## 6.2 Management of Concerns (Complaint and Enquiries)

- 6.2.1 The Assessment Team noted that the Health Board received 646 new complaints in the period 1<sup>st</sup> January 2024 to 31<sup>st</sup> March 2024.
- 6.2.2 The PTR Management & Resolution of Concerns Policy (Incident, Complaints, Claims) was reviewed by the Assessors and was in date and is next due for review in October 2026. The Policy outlines defined roles in terms of governance arrangements outlining responsibilities and in addition there is a clear process in place for the management of complaints and enquiries.
- 6.2.3 The Assessors were pleased to note that complaints are reported to the Board and monitored by local directorate governance arrangements and escalated as necessary through the Improving Together process.
- 6.2.4 Training for complaints and redress is provided to all preceptorship events for newly qualified and junior doctors. Training is also provided within management and leadership sessions.
- 6.2.5 The Assessment Team scrutinised the detail of 7 matters opened on Datix Cymru in the period 1<sup>st</sup> January 2024 to 31<sup>st</sup> March 2024 and noted good use of the system and completion of the relevant fields.
- 6.2.6 It was noted that the Complaints/Enquiry Subjects section within the Feedback Function should be completed to reflect the issues raised by the complainant and importantly the investigation findings of each of the issues raised. This is important information for the Health Board to enable themes and trend reports to be produced and importantly to enable reports on issues upheld as this identifies learning required opportunities. On completion of the investigation, the Investigation section of the Complaint subject must be completed and the Outcome of the subject investigation completed.
- 6.2.7 The Assessors noted that the Health Board does not, as a matter of routine, add 'additional' contacts in the record. This could be persons who provided additional comments or staff involved in the provision of care. Good practice would be to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.
- 6.2.8 If a complaint has a verbal response, details of the discussion should be recorded which should include who was involved in the discussion, when and how it took place. The Assessors noted that the SOP in place for verbal responses was not fully followed in some of the matters reviewed. It is essential that there is documentation to support any verbal discussion with the complainant. However, the majority of matters appeared compliant.



- 6.2.9 On receipt of a complaint it would be good practice to undertake a Contact search within Datix Cymru to check if there are any existing records which link to the matter being reported. This will reduce the potential of duplicate complaint records being created.
- 6.2.10 The Assessors were pleased to note that the Health Board share Terms of Reference (ToR) with the complainant as part of the acknowledgement of the complaint. This ensures that the complainant is aware of the issues being investigated and is given the opportunity to advise them if they have not fully identified the issues to be considered by the investigation. To ensure consistency it is recommended that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.
- 6.2.11 The Assessors noted that not all Action plans and evidence of actions undertaken are uploaded to the Datix Cymru system. This should be encouraged as standard practice for all complaints where actions by the organisation are identified. The Health Board has subsequently explained that it also uses AMAT to monitor and report on key action plans which enables them to triangulate with other learning actions, including external reports.
- 6.2.12 The Assessors identified one complaint which had no evidence of investigation and no record of any response to the complainant (verbal or written). Whilst this is likely to be an anomaly, the Health Board should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.
- 6.2.13 In summary, the Assessment Team noted that the Health Board has good structures in place for the management of concerns. Whilst there were some inconsistencies in best the use of the Datix Cymru System, the majority of records contained essential information. Further enhancement of data quality could be resolved through audits and validation on closure.

Management of Concerns (Complaints & Enquiries)		
<b>SUBSTANTIAL ASSURANCE</b>		The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

### 6.3 Redress Case Management


- 6.3.1 The Assessors noted that the Health Board has a good structure in place to manage redress cases with minimal input required from Legal & Risk Services.
- 6.3.2 The Assessment Team scrutinised the detail of 9 redress records within the Datix Cymru system and noted that generally there was good completion of information onto Datix Cymru. The Assessors were pleased to note great use of the Redress Tracker which meant that the files were particularly easy to review as it meant that the progression of the case and current position was clear.
- 6.3.3 A clear improvement was noted from the 2023 Assessment - with Documents saved to files more regularly now although some Regulation 26 Responses were not saved to files, which did not allow for a full assessment of certain matters.
- 6.3.4 A process is in place where the Redress Manager reviews all draft Regulation 26 responses. This ensures consistency, but the Redress Manager explained that there is a backlog which could be adding to the delay in the Health Board sending out Regulation 26 responses. However, the Health Board has set up a complaint's referral form and monthly complaint/redress meetings which began in January 2024 to attempt to assist with timeliness. This is generating additional work for the Redress Team however it is ensuring a thorough review and good governance. Overall the current delays are not excessive and the benefit to quality clearly outweighs any small delay. It is important that this is monitored to ensure the delays do not become extensive.
- 6.3.5 It was explained that Regulation 24 responses are not reviewed centrally as a matter of course, although sometimes a directorate will request input and the Redress Team are always keen to support and they are now being opened as potential redress cases with an increase in numbers seen since February and March 2024.
- 6.3.6 One issue identified by the Assessors was the lack of incidents in cases reviewed. The Redress Manager agreed that there seem to be fewer incidents than complaints, although she commented that complaint numbers have increased significantly over past months. This has been raised internally and it



is recommended that the Health Board review its processes for incidents coming into Redress to ensure cases are not being missed.

- 6.3.7 Good practice was identified in sending an introductory letter once the Redress Team had taken over the matter. The wording was thought to be a little 'legal' in one of the examples seen and could possibly be softened, which the team agreed to review. It is recommended that the template is reviewed although this may just have been an isolated occurrence.
- 6.3.8 The wording used in both Regulation 26 and 33 Responses was generally good. There was also evidence of excellent, bespoke email correspondence with Complainants. A few of the cases reviewed were particularly sensitive and handled very well.
- 6.3.9 Some delays were seen in instigating a causation review following receipt of the file by the Redress Team. These delays were noted to be significant in some instances, particularly to the Regulation 26 responses. The content requirement of the Regulation 26 responses was generally good. However, some of the final response letters were not present within the record and were understood to be stored elsewhere. In one instance, the position regarding qualifying liability within the letter was slightly unclear. There is evidence of understanding of the legal tests on file however further clarity and explanation could be provided.
- 6.3.10 The Assessors were pleased to note that the PTR Team submit a quarterly report to the Quality, Safety and Improvement Committee which contains redress data for the previous quarter.
- 6.3.11 Training for staff is in place and is provided on an ad hoc basis - with input from Legal & Risk Services as needed. Shadowing and mentorship is in place and a four week induction programme for new staff is in place which includes the use of Datix Cymru and bespoke familiarisation with the PTR process.
- 6.3.12 Overall, the management of Redress cases was considered to be robust with essential fields in the system completed meaning reports can be relied upon as being accurate. Whilst there can be enhancements in relation to document storage, timeliness of stages and data completeness, this should not detract from a very good process which can be held up as a good example in NHS Wales.



Redress Case Management		
<b>SUBSTANTIAL ASSURANCE</b>		<p>The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.</p>



## 6.4 Claims Case Management

6.4.1 The Assessment Team noted that there were 11 confirmed claims opened in the period 1<sup>st</sup> January 2024 to 31<sup>st</sup> March 2024.

6.4.2 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims with a detailed SOP in place. The Claims Management Policy was fully reviewed in 2023 and is overseen by the Listening and Learning Sub-Committee. There is also a very clear claims pathway flow chart in place to further assist staff. The Assessors felt that the framework is of an excellent standard.

6.4.3 The roles and responsibilities for the management of claims are clearly outlined within the Claims Management Policy with the Chief Executive having overall responsibility for the management of legal claims which is delegated to the Director of Nursing, Quality and Patient Experience. This Director has responsibility for developing & implementing a reporting mechanism to facilitate the effective monitoring of claims.

6.4.4 There is a clear process for the application of Standing Financial Instructions and authorisation of admissions and settlement of matters, which is included in the Policy detailing limits of staff for approval of claims and authority to settle costs, damages and make admissions. There is also clear guidance on the management of claims likely to exceed £1 million (which require Welsh Government agreement) - a useful tool for staff managing the claims process.

6.4.5 Claims are reported to the QSEC and at Directorate level, along with the Listening and Learning Committee. Following discussion with staff it was noted that learning lessons from claims is a key focus within the organisation with work ongoing to support this further.

6.4.6 Similarly to Redress, claims training for staff is in place on an ad hoc basis and with input from Legal & Risk Services as required. Shadowing and mentorship are in place and a four-week induction programme for new staff is in place which includes the use of Datix Cymru and PTR principles. Staff also regularly meet with staff and work closely with all Directorates to assist with any training needs. The Assessment Team were assured to see evidence of close working relationships with the Directorates and active work being undertaken to



constantly improve and strengthen relationships with staff.

6.4.7 The Assessment Team scrutinised the detail of 10 claims records within the Datix Cymru System and noted that there was excellent use of the system with case details completed accurately and stage history used and updated throughout the matter. The Assessors noted an improvement in the completion of fields on Datix from the previous assessment and the documents uploaded were clearly labelled and easily identifiable.

6.4.8 There was clear evidence of matters managed efficiently and timely with the decision to refer to Legal & Risk Services or not made during the initial review of the case. Prompt instructions were also provided in response to advice and requests for instructions and decisions from Legal & Risk Services which assured the Assessors that despite a significant workload and staffing challenges, the Health Board has continued to manage its claims process well.


6.4.9 It was noted that there is a close working relationship with Directorates with any issues or urgent matters being dealt with efficiently with attendance at Directorate meetings serving to strengthen this. The Claims Manager also meets regularly with clinicians to provide support and guidance with matters, and this is extremely beneficial when investigating cases.

6.4.10 The Access to Health Records Department forward any requests for disclosure of potential claims to the Claims Team to process and manage accordingly. The Team processes the request with the assistance of their administrative colleagues and Scan & Collate Service with the responsibility of the release of the information resting with the Claims Manager.

6.4.11 The Assessors were pleased to note a robust process was in place for the processing of receipt of advice and request for instructions from Legal and Risk Services. Liability instructions are driven by the Directorates who identify relevant clinicians which ensures cooperation with matters as well as completion of the Learning from Events Reports (LFER's). There is also a very robust process in place for obtaining financial authority with no delays experienced. The finance information was reviewed and considered to be completed and providing a reference and opportunity for a double-check of data.



6.4.12 From the discussions held, it was clear that the organisation tries to provide support to clinicians during an investigation into a claim and contact is first made with the Clinical Lead. Regular meetings are then offered with the Claims Manager.

Claims Case Management		
<b>SUBSTANTIAL ASSURANCE</b>		The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.




## 6.5 Inquest Case Management

- 6.5.1 The Assessment Team were pleased to note that the Health Board has a dedicated Inquest Team to manage all coronial enquiries. The inquest process is managed by the Head and Deputy Head of Legal Services.
- 6.5.2 There is Inquest Guidance in place which was approved on 2<sup>nd</sup> October 2023. It was noted that the Health Board does not have a specific policy in place for the management of inquest matters, although as a small corporate team dealing with all matters in-house the process currently works well. The Assessment Team would recommend however that a Policy and SOP is developed to assist any new members of staff and to avoid sole person dependency within the service.
- 6.5.3 Where staff statements are requested the Directorate Manager, Clinical Lead or Head of Nursing (depending on the details of the matter) is contacted with a template and guide with regards to statement writing attached. A synopsis of the case is also sent, and they then contact the relevant staff for the statement. This process works well to ensure clinicians are fully supported throughout. Following receipt of the first draft of the statement a meeting is offered, and it is finalised together.
- 6.5.4 Staff involved in a coronial enquiry are routinely advised to contact the corporate team should they have any concerns about the process also and telephone numbers are exchanged to ensure staff are able to discuss any concerns they may have prior to an inquest or hearing.
- 6.5.5 The Assessors were pleased to note that a psychological debrief is also offered following an inquest. This process does not appear onerous and is a good exemplar approach which can be replicated across Wales.
- 6.5.6 Training in inquests and the role of the Coroner for Health Board staff is in place on an ad hoc basis; with links to recorded mock inquests provided along with a host of training material available on the intranet. A pre-inquest orientation is also offered to staff prior to their attendance at court and the corporate team appear to have a very good working relationship with Directorates and work closely together with local leaders and managers.




- 6.5.7 The Assessors saw evidence that when a Regulation 28 notice is received by the organisation, it is sent to the Chief Executive, Medical Director and Executive Director of Nursing. A strategy meeting is then arranged with the clinical lead for the relevant department and a draft repose is prepared. There was evidence that responses to Regulation 28 notices have been submitted on time.
- 6.5.8 The Team has a very good working relationship with the Coroner's Office, and this is invaluable given the relatively high number of cases they are dealing with.
- 6.5.9 Inquests are reported at QSEC and Directorate Level and Listening and Learning Committee which ensures appropriate oversight throughout the Health Board.
- 6.5.10 The Assessment Team scrutinised the detail of 12 inquest matters and noted that there appeared to be minimal use of the Datix Cymru System. Following discussions with the team it was explained that when they receive a new matter a file is opened on Datix as well as on their shared drive. Progress notes are updated and detailed on Datix Cymru. However, all documents, statements Etc are saved on their shared drive as this allows them to access the file should they need to when they attend an inquest. As they are a small team at present this system works and there have been no concerns or deadlines missed.
- 6.5.11 The Assessment Team would recommend that the Datix Cymru System is utilised further with the management of inquest matters with fields being completed and documents uploaded to the system with a validation exercise undertaken upon closure to ensure all necessary field boxes are completed. The Datix Cymru system should be treated as the authoritative record of an inquest matter.
- 6.5.12 Overall, an excellent approach to inquest case management was evidenced, with effective support for staff involved in a case and good corporate oversight. This is particularly important as the number of cases subject to coronial inquiry and inquest is anticipated to remain at an increased level.



Inquest Case Management		
<b>SUBSTANTIAL ASSURANCE</b>		<p>The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.</p>


## 6.6 Organisational Learning and Learning from Events Reports

- 6.6.1 The Health Board explained that the use of Datix for completion of the WRP related fields has significantly improved since the last assessment. There was evidence of close monitoring of all LFER’s and submission deadlines with Datix. The Assessment Team were assured to see a tracking process in place to monitor progress with capturing, validating and presenting learning.
- 6.6.2 Evidence was seen of the improvement of the completion of LFER’s within the Directorates as the Service Delivery Managers are on board to facilitate completion and there appears to be better ownership of learning. The LFER is completed and approved within the Service before being reviewed and signed by the Claims Manager. This assured the Assessment Team that learning from claims is a priority for the Health Board. Information shared by Independent Members of the Board also indicated regular coverage of learning.
- 6.6.3 The Assessors were pleased to note that any emerging themes are fed into the Listening & Learning Sub Committee which was evidence of good practice highlighting the importance of improving patient care.
- 6.6.4 The Assessment Team noted that the performance data for timeliness of submissions for learning were very good and the number of matters which were red deferred by the panel were relatively low.
- 6.6.5 The implementation of the All-Wales Learning from Events Framework is a key area on this year’s work plan for the Health Board. Overall, it is clear that learning is a board-level priority, performance data is good, and the quality of learning information has improved.

Organisational Learning & Learning from Events		
<b>SUBSTANTIAL ASSURANCE</b>		The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

## 6.7 Reimbursement Process

- 6.7.1 The Assessment Team were assured to see evidence that there remains a close working relationship with the Finance Department who support the Claims Team and the reimbursement process. Cases are tracked through Datix Cymru however there is also a spreadsheet in place as a safety net measure. This ensures cases are submitted in a timely manner.
- 6.7.2 As Datix Cymru is utilised efficiently and effectively by the Claims Team they are able to run accurate reports from the system enabling them to closely monitor submission deadlines of Case Management Report's (CMR's) as well as deferred cases. A fortnightly meeting is held with the Team to review all matters and discuss any potential delays.
- 6.7.3 The Assessors were pleased to note that all payments are added to the Datix Cymru System, and all invoices are reviewed to ensure all payments have been made before closure of matters and submission for reimbursement. As was the case last year, the number of U5 requests for reimbursement in closed matters, which would be an indicator of poor case and payment tracking, was noted to be very low and therefore a very good exemplar for other organisations to follow.








Reimbursement Process		
<b>SUBSTANTIAL ASSURANCE</b>		The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

## 7.0 Areas of Good Practice

- 7.1 Sending an introductory letter once the Redress Team had taken over the matter.
- 7.2 Excellent, bespoke email correspondence with Complainants particularly in sensitive matters.
- 7.3 Payments and invoices reviewed prior to submission of matters for reimbursement.
- 7.4 Excellent inquest and coronial inquiry management in place.
- 7.5 Good structure in place for redress management.
- 7.6 Good Claims management structure in place.
- 7.7 Close working relationship with finance, leading to accurate data points.



## 8.0 Assurance Summary

Management of Concerns (Incidents)	<b>REASONABLE ASSURANCE</b>	
Management of Concerns (Complaints & Enquiries)	<b>SUBSTANTIAL ASSURANCE</b>	
Redress Case Management	<b>SUBSTANTIAL ASSURANCE</b>	
Claims Case Management	<b>SUBSTANTIAL ASSURANCE</b>	
Inquest Case Management	<b>SUBSTANTIAL ASSURANCE</b>	
Organisational Learning & Learning from Events	<b>SUBSTANTIAL ASSURANCE</b>	
WRP Reimbursement Process	<b>SUBSTANTIAL ASSURANCE</b>	

### NOTES

The Assessment Team noted considerable progress in all Areas of Assessment compared to the previous WRP Assessment.

Overall, the policies & procedures established by the Health Board provide a robust framework for the effective management of area topic.

There has been considerable focus (and improvement) in incident management and the Assessors would encourage a further focus on incidents involving lower than moderate harm.



## 9.0 Recommendations

- 2023-R04 HDUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling.
- R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records.
- R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised.
- R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.
- R04 HDUHB to ensure the SOP for verbal responses is followed in all matters.
- R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.
- R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.
- R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.
- R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed.
- R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.
- R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation.
- R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.



## 10.0 Health Body Action Plan

- 10.1 The Health Body has developed an action plan which addresses the findings of the report and responds to the recommendations made. A copy of this is provided for future reference



# Welsh Risk Pool Concerns Assessment (December 2024)

**Date of inspection:** 05/06/2024

Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD1	Should do	Mrs Cathie Steele		No Site Specific	Corporate Nursing		NO	Timely	R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD2	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Person Centered	R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised.	2	In progress

Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD3	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD4	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Equitable	R04 HDUHB to ensure the SOP for verbal responses is followed in all matters.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD5	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD6	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.	1	In progress





Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD7	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.	2	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD8	Should do	Mrs Cathie Steele		No Site Specific	Corporate Nursing		NO	Equitable	R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD9	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD10	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation	1	In progress



Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD11	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.	1	In progress

## Appendix 1 NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

<b>SUBSTANTIAL ASSURANCE</b>		<p>The organisation can take <b>substantial assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.</p>
<b>REASONABLE ASSURANCE</b>		<p>The organisation can take <b>reasonable assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.</p>
<b>LIMITED ASSURANCE</b>		<p>The organisation can take <b>limited assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.</p>
<b>NO ASSURANCE</b>		<p>The organisation has <b>no assurance</b> that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.</p>

## Appendix 2

### WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the WRP.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

### Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Inquest Case Management
F	Organisational Learning and Learning from Events Reports
G	Reimbursement Process



<b>Area for Assessment A:</b>	
<b>Management of Concerns (Incidents)</b>	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have a Management Review?
A1-03	Is the timescale between reporting and Management Review reasonable?
A1-04	Did the incident have a proportionate investigation completed, where appropriate?
A1-05	Was the incident record closed within 30 days? If not, is there information to explain the reason for any delays or actions being taken?
A1-06	Was the incident reportable as a Nationally Reportable?
A1-07	Did the post incident investigation indicate there was harm caused and that Qualifying Liability was considered?
A1-08	Based on the reporters view of harm (moderate or above) have the Duty of Candor fields been completed and if not is a rationale provided for the non-completion?
A1-09	Is there training for staff reporting and investigating incidents?

<b>Area for Assessment A:</b>	
<b>Management of Concerns (Incidents)</b>	
<b>Policy and Procedure</b>	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

<b>Area for Assessment A:</b>	
<b>Management of Concerns (Incidents)</b>	
<b>Information, Reporting &amp; Governance Arrangements</b>	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings/committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?



Area for Assessment B:	
Management of Concerns (Complaint and Enquiries)	
B1-01	Does the record include details of the 'Person Providing Feedback' (Complainant) and has the Complainant Chain been triggered
B1-02	Have details of the original contact with the Complainant been recorded and supporting information available for review. This may be an email or letter from the Complainant or notes from a telephone discussion.
B1-03	If the complaint is in relation to a third party, has consent been requested
B1-04	Does the Date received (Complainant Chain) match the date the Complaint was first received (Key Dates)
B1-05	Have the following essential data fields in Datix Cymru been completed accurately and up to date: <ul style="list-style-type: none"> <li>• Is the Complainant Chain available and completed where possible</li> <li>• Has an investigator been identified</li> </ul>
B1-06	Has the type of complaint been changed? If yes, has the Complainant Chain be reset to meet the PTR Reg timescale of the new type of complaint
B1-07	Does the Description field contain identifiable information i.e names of persons or locations
B1-08	Have all the relevant points raised in the complaint been recorded in the 'Complaint Subjects' section
B1-09	If applicable, has a holding letter been sent to the Complainant
Closed records only:	
B1-10	Where a complaint was dealt with as Early Resolution, is this appropriate?
B1-11	Has a response been provided to the person notifying the concern within 30 days. Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, an explanation provided, and a proposed timescale agreed?
B1-12	Did the response respond to all the relevant points raised in the complaint and the investigation outcome of each point recorded
B1-13	If no response letter has been sent, has the reason why no response letter was sent provide an adequate explanation eg evidence of verbal discussion



	with complainant
B1-14	If a Regulation 26 or Regulation 33 Response has been sent, has a Redress record been created and have the records been linked
B1-15	<p>Does the complaint response comply with the content requirement as set out within the guidance?</p> <ul style="list-style-type: none"> <li>- Reg 24 response prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort?</li> <li>- Reg 24 response prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value? (no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?)</li> <li>- Reg 26 response prepared advising may be BOD &amp; QL with explanation provided regarding Redress and next steps</li> <li>- Reg 33 response prepared advising there is/was BoD &amp; QL explanation provided regarding Redress and offer made</li> </ul>
B1-16	Has the Complainant Chain been fully completed and is the date of response accurately recorded in the Complainant Chain

## Policy and Procedure

B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
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## Information, Reporting & Governance Arrangements

B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?



Area for Assessment C:	
Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Is there evidence of the case being screened for potential value at the outset?
C1-04	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a QL?
C1-05	Has the interim report been provided to the person notifying the concern within 30 days?
C1-06	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-07	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (i.e. jointly) and appropriately?
C1-08	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-09	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-10	Does the Regulation 33 Response comply with the requirements of the Guidance? E.g. clearly sets out the basis for the final decision as to QL and the offer made.
C1-11	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the organisation?
C1-12	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-13	Who authorised QL and on what basis? Was this appropriate?
C1-14	Have all essential data fields been completed correctly within the case management record?

WRP Held Data Review	
C1-14	How many LFER's submitted in relevant period?
C1-15	How many requests for reimbursement submitted to WRP?
C1-16	What is the performance for WRP submission deadlines?
C1-17	How many extensions were requested for submission to WRP?
C1-18	How many cases were approved at the first Learning Advisory Panel?



Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services



Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?



## Area for Assessment E: Inquest Case Management

E1-01	Is there an effective process for receiving and processing requests from the Coroner?
E1-02	Where staff statements are requested, is there a process to ensure appropriate release of information and statements drafted correctly?
E1-03	Is there an effective process to support staff who are asked to provide statements for the Coroner and to attend the Inquest?
E1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of inquests cases to Legal & Risk appropriate?
E1-05	Is there a clear process for review of Regulation 28 notices from the Coroner? How are staff and Services informed? What is the process for monitoring the request for information and ensuring it is actioned and information submitted in time?

### Policy and Procedure *To be completed by Assessors*

E2-01	Is there a policy or procedure in place for Inquest Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
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### Information, Reporting & Governance Arrangements

E3-01	What are the governance arrangements for the management of inquest matters?
E3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
E3-03	Are they reported at Board level or Sub-Committee?
E3-04	Is there a training package in place for staff responsible for managing inquests?



Area for Assessment F:	
Organisational Learning	
F1-01	Has the locally adapted 'All Wales Learning from Events Framework' been approved through the Health Body's governance processes?
F1-02	Is the Health Body progressing the implementation of the locally adapted 'All Wales Learning from Events Framework'?
F1-03	Is the Health Body considering the importance of psychological safety to being a learning organisation?
F1-04	Are there effective governance arrangements in place to enable oversight by the Health Body's Board and Board subcommittee's that the approach to organisational learning is improving?
F1-05	Are there effective governance arrangements in place to enable oversight by Directorates / Divisional / Groups senior management teams that local learning is improving?
F1-06	Are staff, service users, families and stakeholders involved in determining what the learning should be following an event?
F1-07	Has it been determined how staff across the organisation wish to receive learning?
F1-08	Is the organisation able to demonstrate examples of organisational learning from events (examples may include what goes well, incidents, complaints, claims, inquests, ombudsman, internal reviews, networks, external independent reviews, and Public Inquiries) being discussed from Operational level to the Health Body's Board?
F1-09	Is there a clear process relating to the approval of the Welsh Risk Pool (WRP) Learning from Events Reports locally and corporately prior to submission to the Welsh Risk Pool, including the provision of additional information if the case is deferred?
F1-10	In respect of organisational learning what is the Health Body's approach to knowledge management (practice of organising, storing and sharing vital information) so that everyone can benefit from its use?
F1-11	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeliness, completeness, extension requirements?
F1-12	What proportion of LFER reports were approved by the Learning Advisory Panel?



Area for Assessment G:	
Reimbursement Process	
G1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
G1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
G1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?



2.7

10 Mins

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2.7 - Minor Injuries Unit- Prince Philip Hospital

*Mark Henwood  
(Hywel Dda UHB -  
Interim Medical  
Director)*

**Attachments**

[2.6 PPH MIU.docx](#)

[Appendix 1 - PPH MIU Data Pack.docx](#)

[Appendix 2 Post Options Development Engagement themes.docx](#)

[PPH MIU EqlA - Option 1 - Doctor-led 12 hours final.pdf](#)

[PPH MIU EqlA - Option 2 - Doctor-led 14 hours \(1\).pdf](#)

[PPH MIU EqlA - Option 3 - Doctor-led phased \(12hours 14hours 24hours\).pdf](#)

[PPH MIU EqlA - Option 4 - Urgent care centre \(SDUC type model\) 14 hours fin~.pdf](#)

**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD  
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	08 April 2025
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Prince Philip Hospital Minor Injuries Unit - Update
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Mr Mark Henwood, Interim Medical Director
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Dr Daniel Warm, Head of Planning Nichola Couceiro, Head of Engagement Alexander Martin, Principal Programme Manager

**Pwrpas yr Adroddiad (dewiswch fel yn addas)  
Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

Sefyllfa / Situation

As a result of quality and safety risks, in part relating to a lack of General Practitioner (GP) cover, the Public Board of Hywel Dda University Health Board (HDdUHB) approved an urgent temporary service change to the opening hours of the Minor Injury Unit (MIU) in Prince Phillip Hospital (PPH) at its meeting held in September 2024). This was for a six-month period commencing on 1 November 2024, with the unit now open from 8am-8pm.

As part of the Board decision, it was also agreed to develop and appraise a list of viable options for the long-term model for the service, for consideration by HDdUHB Public Board in March 2025.

The purpose of this report is to share the data gathered throughout the options development process in relation to impact on internal and external services as a result of the temporary change. Also included are draft Equality Impact Assessments for the options developed, and the outputs from engagement events which have taken place following the options development process.

Cefndir / Background

At the time of developing this report, the outcome of the Public Board meeting in March 2025 was unknown due to timing of the submission of Committee papers. This paper is presented to share the information gathered to support the options development and further engagement which was undertaken in the period between the submission of the Board paper and the Board meeting to support any future engagement on the options should it be required.

The options appraisal process was established to develop a series of options for delivery of the MIU based on the principles of care that is safe, sustainable, accessible, and kind.

The development of the options also needed to support the recommendations raised by the Healthcare Inspectorate Wales (HIW) inspection report following its visit in 2023 that

highlighted a number of patient safety issues. The scope and process undertaken for the options development and appraisal activities was agreed by the Executive Steering Group, chaired by Mr Henwood.

The objectives therefore were to:

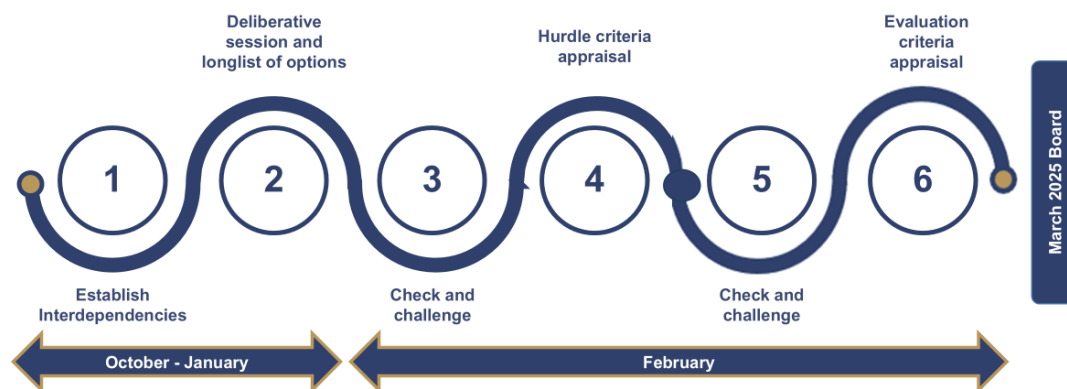
- Respond to staffing and skill mix availability
- Respond to the needs of patients who arrive at the MIU
- Respond to the HIW inspection report findings
- Improve patient safety and reduce clinical risk

As part of the process a number of elements were agreed by the Steering Group as being out of scope:

- Changes to the Acute Medical Assessment Unit (AMAU)
- Re-establishment of an A&E/ full emergency department
- Changes to GP Out-of-hours (OOH) / 111
- Complete closure of the MIU
- Moving the MIU away from PPH

The options development and appraisal process has followed the same principles as those used during the urgent and emergency paediatrics service review and the clinical services plan. This is based on continuous engagement, allowing people to share information throughout the process to influence the decision-making, even if they are not part of the stakeholder group appraising options.

The steps in the process were:



Following completion of the process, four options were shortlisted, and can be summarised as follows:

- 12-hour Doctor led unit – the unit is open to the public for 12 hours; with a further two hours staffing to allow patients in the unit to be treated
- 16-hour Doctor led unit – the unit is open to the public for 14 hours; with a further two hours staffing to allow patients in the unit to be treated
- Doctor led phased option from 12 hours up to 24 hours – this unit opening would initially be open the current 12 hours, plus two hours staffing, moving to 16 hours, inclusive of two hours staffing, and ultimately 24 hours overall
- ‘Urgent’ care/treatment centre 16 hour (SDUC type model) – the unit is open to the public for 14 hours; with a further two hours to allow patients in the unit to be treated

To support this process additional data was gathered to understand the impact on internal services (provided by HDduHB with respect to impact on Glangwili and Prince Philip hospitals) and external services (provided by Welsh Ambulance Services Trust and Swansea Bay University Health Board), as also understand the impact on access given different operating times of the hours proposed.

Following the options development process, engagement events have taken place with the public through drop in events in Llanelli and Llandybie, a hybrid session with MIU staff, as well as an online session with councillors from Llanelli. This in addition to previous engagement events as well as:

- Share your views' public survey – launched October 2024 remains open for feedback
- Regular 'inform' updates across the Health Board's website and social media channels
- Ongoing engagement with local seldom heard groups

Throughout this continuous engagement, a number of consistent issues have emerged, including concerns regarding appropriate access to care, transport issues, and the strength of feeling within the local community that services are being reduced and withdrawn from the local area; as well as the need for ongoing communication.

## Asesiad / Assessment

### **Attendance**

Since the introduction of the service change the Steering Group was asked to consider the impact on service delivery and quality & safety following the temporary overnight closure. In particular concerns were raised that people would attend other services overnight such as the accident and emergency departments at Glangwili or Morriston hospitals, or that there would be a negative impact on other services at Prince Philip Hospital, especially the AMAU.

Following the collection of data found in Appendix 1 – PPH MIU Data Pack, the data suggests:

- The overall demand for urgent and emergency care services across PPH and GGH was similar between November/ December 2023 and November/ December 2024
- Attendance levels in PPH MIU have reduced but is reflective of the overnight closure
- The levels of PPH AMAU attendance remain broadly the same, approximately 440 patients per month
- The number and proportion of majors attending PPH MIU have decreased
- Waiting times in PPH MIU have decreased slightly and there has been no increase in waiting times in Glangwili for Llanelli patients
- 4-hour and 12-hour breaches in the PPH MIU have reduced
- 111 data shows a slight increase in total calls since the temporary change
  - Slight decrease in 111 calls being transferred to PPH MIU, reflective of the overnight closure
  - Increase in 111 calls being transferred to 999 or emergency department, reflective of the majors who used to attend PPH MIU overnight
  - There has been no increase in Llanelli patients attending Morriston

The data does not show where the patients have gone who would have normally attended the MIU. However, it is clear that there have been changes in patient behaviours as patients appear to be waiting until the unit opens where there are now larger number of patients arriving at 08:00 than before the change, as well as the increase and nature of 111 calls made by Llanelli residents.

This summary information has also been shared as part of the March Board papers (available at: [PPH MIU Options Paper Board March 2025](#) ), as well as during some of the engagement events, along with the overall options scores to allow for people to ask questions and share

comments and observations. The outputs from these engagements can be found in Appendix 2 – Post Options Development Engagement.

### **Patient information**

Previous data on risks; data/incidents; and patient experience has been shared with the Committee. Updated information since the February Committee meeting shows that:

- Data/Incidents:
  - December 2024 – 2 incidents. Both relating to patient conveyance (WAST) outside scope of MIU.
  - January 2025- 3 incidents. 2 relating to violence and aggression of a service user and 1 relating to a prescription error undertaken by medical team.
  - February 2025- 4 incidents all relating to inappropriate patients attending the Unit.
- Patient feedback:
  - December 2024 – CIVICA 245 feedback received (213 feedback received December 2023)
  - January 2025 - CIVICA 261 feedback received (260 feedback received January 2024)
  - February 2025 – CIVICA 259 feedback received (324 feedback received February 2024)

The most recent data for February 2025 demonstrates consistent mixed feedback relating to waiting time (there continues to be some negative feedback regardless of the 4-hour performance being >95%), emotional and physical support, politeness. No negative feedback was received for communication, friendliness and helpfulness. Further review relating to pain and comfort is required.

### **Draft Equality Impact Assessments**

Draft Equality Impact Assessments (EqIAs) have been populated based on the current temporary change which was shared with Board in September 2024. The EqIAs are reflective of all options starting from a 12 hour doctor led MIU as described by the temporary change, and noting the changes in impact through either extended operating hours or in the case of the Same Day Urgent Care (SDUC) type model, the integration with the Same Day Emergency Care (SDEC) service already provided at PPH. These can be found in as separate attachments, one has been completed for each option.

### **Argymhelliad / Recommendation**

- The Committee should **take assurance** from the report that patient care has been maintained at Prince Philip Hospital during the temporary change
- The Committee should **take assurance** from the report that patient engagement has taken place to share and influence service development throughout the process

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk reference: 1293 Risk Score 20
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 3 Transforming Urgent and Emergency Care programme
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	9. All HDdUHB Well-being Objectives apply

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	Appendix 1 – PPH MIU Data Pack Appendix 2 – Post Options Development Engagement Draft Equality Impact Assessments for each option
Rhestr Termiau: Glossary of Terms:	Not applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiad: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Public Board – September 2024; November 2024; March 2025 PPH MIU Steering Group PPH MIU Project Group Formal Executive Team

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian:</b>	Quality Impact Assessment and Equality Impact

<b>Financial / Service:</b>	Assessment undertaken as part of the development of this proposal
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Gweithlu: Workforce:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Risg: Risk:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Cyfreithiol: Legal:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Enw Da: Reputational:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Gyfrinachedd: Privacy:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal
<b>Cydraddoldeb: Equality:</b>	Quality Impact Assessment and Equality Impact Assessment undertaken as part of the development of this proposal

## Introduction

This document contains the data sets which were used to support the appraisals during the options development process.

## Total Attendances

Hospital Location	November 2023	December 2023	November 2024	December 2024
Glangwili General Hospital	4,166	4,228	4,372	4,540
Prince Philip Hospital (MIU)	2,515	2,444	2,025	1,993
Prince Philip Hospital (AMAU)	424	449	443	443
PPH SDEC Attendances	241	212	213	170
<b>Total</b>	<b>7,346</b>	<b>7,333</b>	<b>7,053</b>	<b>7,146</b>

The table above shows the total attendances for the November and December Period in 2023 (before the change) and 2024 (after the change).

The data was obtained from IRIS.

## Breakdown of attendees by Majors and Minors categories

Hospital Location	November 2023	December 2023	November 2024	December 2024
Glangwili General Hospital (Majors)	3,202	3,216	3,345	3,583
Glangwili General Hospital (Minors)	964	1,012	1,027	957
<b>Percentage of Minors to Majors</b>	<b>23%</b>	<b>24%</b>	<b>23%</b>	<b>21%</b>
Prince Philip Hospital MIU (Majors)	736	815	476	450
Prince Philip Hospital MIU (Minors)	1,779	1,629	1,549	1,543
<b>Percentage of Minors to Majors</b>	<b>71%</b>	<b>67%</b>	<b>76%</b>	<b>77%</b>

The table above shows the percentage difference between Major and Minor category patients within Glangwili Hospital Accident and Emergency department and Prince Philip Hospital Minor Injuries Unit.

The data was obtained from IRIS.

Glangwili General Hospital	November 2023	December 2023	November 2024	December 2024
All Minors in GGH A&E	964	1,012	1,027	957
Llanelli Resident Minors in GGH A&E	174	159	176	174
Percentage of Llanelli Residents to all Minors	18%	16%	17%	18%

The table above shows the percentage of Llanelli Residents categorised as Minor patients in Glangwili Hospital Accident and Emergency department compared with all Minor patients in attendance.

The data was obtained from IRIS.

## Referrals by GP or NHS Direct

Referral source	Nov-23	Dec-23	Nov-24	Dec-24
NHS Direct	42	31	7	14
GP	88	78	97	71
<b>Total</b>	<b>130</b>	<b>109</b>	<b>104</b>	<b>85</b>

The table above shows the number of patients referred to Prince Philip Hospital Minor Injuries Unit or by NHS Direct.

GP referrals include the following sources as recorded: GP Patients Own, GP Practice Nurse, GP Receptionist and GP Other.

This data was obtained from an Informatics adhoc request.

## Patient Arrival Time

Arrival Hour	PPH MIU				PPH AMAU			
	Nov-23	Dec-23	Nov-24	Dec-24	Nov-2023	Dec-2023	Jan-2024	Dec-2024
00:00	36	35	1		11	13	12	9
01:00	24	27	1		3	8	9	7
02:00	14	20			11	5	7	9
03:00	8	13			13	10	9	6
04:00	17	17			9	10	6	8
05:00	6	10			9	7	12	9
06:00	21	21			6	8	5	4
07:00	45	55		1	6	7	5	3
08:00	156	140	212	207	15	9	15	13
09:00	243	218	236	204	17	24	10	14
10:00	229	231	215	236	22	30	24	14
11:00	204	236	214	198	16	29	23	38
12:00	186	187	161	198	29	21	28	23
13:00	175	183	158	160	24	32	33	30
14:00	159	159	161	152	21	33	32	20
15:00	157	127	161	173	32	27	36	31
16:00	174	126	180	165	32	32	36	33
17:00	143	130	126	127	29	23	25	30
18:00	143	118	123	100	27	20	22	37
19:00	104	97	74	70	12	20	22	24
20:00	108	97	2	1	27	15	20	32
21:00	73	92		1	18	22	26	27
22:00	49	58			22	26	20	12
23:00	41	47			13	18	13	10
<b>Total</b>	<b>2515</b>	<b>2444</b>	<b>2025</b>	<b>1993</b>	<b>424</b>	<b>449</b>	<b>450</b>	<b>443</b>

The table above shows the arrival time of patients in the Minor Injuries Unit and the Acute Medical Assessment Unit before and after the change.

This data was obtained from IRIS.

## PPH MIU Waiting times for Triage

Arrival Hour	Nov-23	Dec-23	Nov-24	Dec-24
00:00	00:16	00:21	01:09	
01:00	00:12	00:13	00:30	
02:00	00:18	00:11		
03:00	00:04	00:12		
04:00	00:06	00:42		
05:00	00:17	00:16		
06:00	00:21	00:17		
07:00	00:29	00:24		00:02
08:00	00:18	00:19	00:17	00:14
09:00	00:25	00:26	00:22	00:14
10:00	00:42	00:35	00:34	00:26
11:00	00:39	00:49	00:38	00:29
12:00	00:47	00:51	00:36	00:29
13:00	00:39	00:58	00:31	00:26
14:00	00:47	00:52	00:27	00:26
15:00	00:52	00:48	00:29	00:26
16:00	00:57	00:44	00:26	00:27
17:00	00:41	00:38	00:24	00:26
18:00	00:40	00:46	00:20	00:26
19:00	00:48	00:45	00:19	00:18
20:00	00:32	00:44	00:14	00:04
21:00	00:23	00:38		00:02
22:00	00:19	00:26		
23:00	00:09	00:10		
<b>Average wait time (HH:MM)</b>	<b>00:29</b>	<b>00:33</b>	<b>00:29</b>	<b>00:20</b>

The table above shows the average waiting time by arrival hour for patients in Prince Philip Hospital Minor Injuries Unit. The wait time looks at the time difference between recorded arrival time and triage time. Patients may remain in the unit longer for treatment.

This data was sourced from IRIS.

## GGH waiting times for Llanelli residents

Arrival Hour	Nov-23	Dec-23	Nov-24	Dec-24
00:00	04:53	03:33	07:19	05:04
01:00	03:45	01:28	03:34	07:38
02:00	04:59		05:06	07:01
03:00	02:12		06:19	05:34
04:00	03:06	00:58	03:19	03:29
05:00	06:26	02:44	06:33	06:17
06:00	07:27	04:19	03:40	02:47
07:00	01:45	03:04	02:48	02:27
08:00	04:28	02:22	02:02	00:52
09:00	03:19	01:54	05:32	02:38
10:00	02:59	00:21	03:37	03:04
11:00	02:02	01:51	02:29	02:57
12:00	02:55	02:29	03:09	02:38
13:00	01:33	01:35	02:00	03:01
14:00	01:34	01:12	01:00	02:16
15:00	03:14	01:54	22:15	21:34
16:00	01:02	00:28	23:55	02:21
17:00	02:28	22:36	00:19	23:57
18:00	23:37	22:25	19:42	23:08
19:00	23:50	20:50	00:58	19:48
20:00	13:25	16:40	20:31	17:50
21:00	12:23	05:43	12:26	07:04
22:00	17:16	15:41	05:15	17:37
23:00	04:17	07:16	06:31	07:05

The table above shows the average waiting times for Llanelli residents in Glangwili Hospital Accident and Emergency department by arrival hour. Waiting time is calculated by using the recorded arrival time and administration end time.

This data was obtained from an Informatics adhoc request.

## 4 hour and 12 hour breach reporting

	Nov-23	Dec-23	Nov-24	Dec-24
4-Hour Breaches	327	359	56	65
12-Hour Breaches	51	57	2	0

4-Hour Performance	86.39%	84.76%	97.16%	96.60%
12-Hour Performance	97.88%	97.58%	99.90%	100.00%

The tables above show the reporting against 4 and 12 hour breach targets. The top table shows the number of breaches against each category, the bottom table shows the percentage of patients treated which did not breach the reporting target.

This data was obtained from IRIS.

## PPH Demand forecasting

Hospital Location	November 2024	December 2024	November 2029	December 2029
Prince Philip Hospital (MIU)	2,025	1,993	2,119	2,086
Prince Philip Hospital (AMAU)	443	443	464	464
PPH SDEC Attendances	213	170	223	178
<b>Total</b>	<b>2,681</b>	<b>2,606</b>	<b>2,806</b>	<b>2,727</b>

The table above shows the predicted demand for the MIU, AMAU and SDEC service at Prince Philip Hospital as of now and predicted in November 2029.

The prevalence rate used the demand growth statistics used for the Clinical Services Plan when considering services in Carmarthenshire (4.65%).

The 2024 data was obtained from IRIS.

## Llanelli residents attending Morriston Hospital

Hospital Location	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
Morriston Hospital	47	47	38	58	61	39	61	52	52	57	67	57

The table above shows the number of Llanelli residents attending Morriston Hospital for treatment instead of PPH MIU. The patients were identified using postcodes for Llanelli and only considered treatment codes related to Minor patients.

It should be noted that while November and December 2023 are not included, the November and December 2024 figures are in line with seasonal variation.

This data was sourced from Swansea Bay University Health Board through an adhoc request.

## 111 Demand and Disposition

	November 2023	December 2023	November 2024	December 2024
Llanelli 111 Demand				
<b>999 - Ambulance as soon as possible</b>	29	44		
<b>999 - Streamed</b>	24	44		
<b>999 Ambulance</b>			123	97
<b>A &amp; E - Streamed</b>	65	56		
<b>Accident and Emergency as soon as possible</b>	124	101		
<b>Accident and Emergency within 4 Hours</b>		2		
<b>Advised to Speak to Primary Care Service Next Working Day</b>	5	3		
<b>Amber 1 - Triaged by 111 Clinician</b>				8
<b>Amber 2 - Triaged by 111 Clinician</b>				5
<b>Ambulance Required</b>			12	6
<b>Arrange Emergency Ambulance</b>	65	57		
<b>Caller cancelling callback</b>	2	6		
<b>Caller not wishing to Proceed</b>	46	73		
<b>Emergency Department</b>			240	259
<b>Emergency Response</b>			28	28
<b>HDUHB Dental Queue - 24H</b>			306	265
<b>HDUHB Dental Queue - 72H</b>			24	14
<b>HDUHB District Nurse Team (In Hours)</b>			2	1
<b>Minor Injuries Unit</b>	19	11		
<b>Minor Injuries Unit -Streamed</b>	1	1		
<b>Minor Injury Unit</b>			11	10
<b>Own GP Surgery - Today</b>			97	90
<b>Own GP surgery routinely</b>			6	3
<b>Own GP Surgery Today</b>			20	29
<b>Referred to Own GP</b>			2	5

The table above shows the total 111 call demand and breakdown of call disposition (where patients were sent to or directed to go) for Llanelli residents.

This data was sourced from Welsh Ambulance Service Trust through an adhoc request.

## Feedback from the Staff Engagement session:

Ongoing engagement process around Prince Philip Hospital, Minor Injury Unit  
Prince Philip Hospital 4pm to 5pm, 10 March 2025

Members of staff from Prince Philip Hospital were invited to attend a drop-in event to learn about the ongoing engagement process regarding the Minor Injury Unit (MIU) at Prince Philip Hospital.

People could drop-in to the event, at the Prince Philip Hospital, any time between 4pm and 5pm on Monday 10th March 2025 to learn more about the potential options being considered for the MIU service, more about why the temporary change is needed, how to access care in different circumstances, and what the next steps will be for further engagement with the community.

- What would be seen in the SDUC model? Would more be seen?
- This is similar to what we said years ago the service should be
- In initial meetings we didn't think that "MIU" was an appropriate name for the service that was being delivered.



## Feedback from the Public Drop in Event :

Ongoing engagement process around Prince Philip Hospital, Minor Injury Unit

Llandybie Memorial Hall 3pm to 6pm, 6 March 2025

Members of the local community are invited to attend drop-in events to learn about the ongoing engagement process regarding the Minor Injury Unit (MIU) at Prince Philip Hospital.

People could drop-in to the event, at the Llandybie Memorial Hall, any time between 3pm and 6pm on Thursday 6th March 2025 to learn more about the potential options being considered for the MIU service, more about why the temporary change is needed, how to access care in different circumstances, and what the next steps will be for further engagement with the community.

There was no community attendance.

## Feedback from the Online Meeting with County Councillors:

Ongoing engagement process around Prince Philip Hospital, Minor Injury Unit  
6.30pm to 8.30pm, 18 March 2025

Hywel Dda University Health Board invited county, town and community council members from the area served by Prince Philip Hospital to attend an online meeting to learn about the ongoing engagement process regarding the Minor Injury Unit (MIU) at the hospital.

The meeting provided an opportunity to hear about the potential options being considered for the future of the MIU service.

The key themes can be summarised as follows:

**Options Development:** Councillors emphasized the importance of accessibility for all options and sought clarity on the strongest option available. They questioned the clinical effectiveness of each option and whether the right care would be accessed the first time. There was concern about the financial constraints limiting the options, particularly the return to a 24-hour service. The need for genuine collaboration and transparency in decision-making was highlighted, with a call for clear communication about the differences between options and their implementation timelines.

**MIU Opening Times and Services:** There was significant discussion about the opening times of the MIU, with many expressing a desire for a return to 24-hour service. Concerns were raised about the impact of reduced hours on patient care, particularly overnight. The feedback included personal anecdotes illustrating the inconvenience and potential health risks associated with the current limited hours. There was also a call for better recruitment to support extended hours and improve service delivery.

**Impact on Other Hospitals:** The closure of PPH's A&E and the limited hours of the MIU have led to increased pressure on nearby hospitals like Glangwili and Morriston. Councillors noted the overcrowded conditions and long waiting times at these hospitals, which are exacerbated by patients who would have otherwise gone to PPH. There were also concerns about the strain on ambulance services and the need for better transport options for patients.

**Staffing Issues:** Feedback highlighted the challenges in recruiting and retaining staff at PPH. Councillors pointed out the high levels of staff disillusionment and disengagement, partly due to safety concerns and the stressful working environment. Suggestions included offering self-defence classes for staff, improving recruitment processes, and ensuring better pay and working conditions. There was also a call for more support and respect for medical professionals.

**Community Engagement and Communication:** Councillors stressed the need for better communication and engagement with the community. They suggested regular drop-in sessions and easier-to-understand surveys to gather public feedback. There was criticism of the current communication methods, which often exclude non-social media users and the deaf community. Improved advertising and inclusive communication strategies were recommended to ensure all community members are informed and involved.

**General Comments and Queries:** The feedback included various general comments and queries about the future of PPH, the impact of new hospitals, and the overall healthcare system. Councillors expressed frustration with the perceived downgrading of PPH and the lack of investment in local services. There were calls for better transport links, more accessible services, and a focus on patient-centred care. The importance of addressing the needs of vulnerable populations, such as the elderly, was also highlighted.

## Feedback from the Public Drop in Event:

Ongoing engagement process around Prince Philip Hospital, Minor Injury Unit at the Antioch Centre, Llanelli 2pm to 6pm, 17 March 2025

Members of the local community are invited to attend drop-in events to learn about the ongoing engagement process regarding the Minor Injury Unit (MIU) at Prince Philip Hospital.

People could drop-in to the event, at the Antioch Centre, any time between 2pm and 6pm on Monday 17 March 2025 to learn more about the potential options being considered for the MIU service, about why the temporary change is needed, how to access care in different circumstances, and what the next steps will be for further engagement with the community.

The event was attended by 33 people and their queries and comments from conversations with health board staff were recorded by notetakers. Attendees also shared comments on event evaluation forms.

The feedback from conversations and event evaluation forms have been collated and broadly themed and grouped below.

**Options Development:** The feedback emphasized the importance of accessibility for all options being considered. There were questions about the four options available, their clinical aspects, and whether they would provide the right care the first time. Concerns were raised about the perception that decisions might already be made by the organization, and the need for genuine collaboration was highlighted. The public expressed a desire for clarity on the differences between the options, especially regarding cost and recruitment.

**MIU (Minor Injuries Unit):** There were numerous inquiries about the future of the MIU, its opening times, and whether it would return to a 24-hour service. The public shared positive experiences with the MIU but expressed concerns about its temporary measures and the impact of reduced hours on patient care. The need for a 24/7 service was strongly felt, with comparisons made to other hospitals that offer round-the-clock services.

**Same Day Urgent Care (SDUC) and Acute Medical Assessment Unit (AMAU):** The SDUC model received positive feedback, but there was a need for better public understanding and detailed explanations. Questions were raised about the accessibility and referral process for SDUC. The AMAU was discussed in terms of emergency access and doctor referrals, with the public seeking clarity on how it would function in urgent situations.

**Prince Philip Hospital (PPH) and Glangwili Hospital (GGH):** Feedback highlighted disappointment and frustration over the changes at PPH, including the removal of A&E services and the perceived downgrading of the hospital. The public expressed a strong desire for the return of A&E services and better utilization of PPH. Comparisons were made to GGH, which was described as overcrowded and having parking issues, impacting patient experience.

**Ambulance Service and NHS 111:** Concerns were raised about the ambulance service, including long wait times and the cost of taxis for patient transport. The NHS 111 service was criticized for its capacity issues and the difficulty in accessing timely care. The public emphasized the need for better communication and support for patients using these services.

**Engagement and Communication:** The feedback underscored the importance of regular, inclusive communication and engagement with the community. Suggestions included advertising events in accessible locations and formats, improving communication with the Deaf community, and ensuring that information is clear and easy to understand. The public expressed a desire for ongoing dialogue and involvement in the decision-making process.

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

## **Hywel Dda University Health Board Equality Impact Assessment (EqIA)**

<b>Director and Directorate</b>	Andrew Carruthers - Unscheduled Care Prince Philip Hospital (PPH)
<b>Service Area</b>	Minor Injuries Unit - Option 1 - Doctor-led 12 hours

### **What is an Equality Impact Assessment (EqIA)?**

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

### **Why do they have to be completed?**

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the [Equality Act 2010](#) with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

### **When should they be completed?**

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

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 you will also need to consider

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

**Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.**

### **Support**

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: [Inclusion.hdd@wales.nhs.uk](mailto:Inclusion.hdd@wales.nhs.uk)

Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

<p>1. What are you Equality Impact assessing?</p>	<p>12-hour doctor led unit – as per the temporary model in place now, this would be open to the public for 12 hours, with a further two hours staffing to allow patients in the unit to be treated</p>
<p>2. Brief Aims and Description of the procedure/ proposal/ project/ policy:</p>	<p>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) to meet local population needs within the new proposed times.</p>
<p>3. Who is involved in undertaking this EqIA? (names/job titles)</p>	<p>Jon Morris (Clinical Lead MIU), Iona Evans (Interim Head of Nursing GGH &amp; PPH USC), Meinir Williams (Deputy Head of Nursing PPH USC)</p>
<p>4. Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?</p>	<p>No</p>
<p>5. Is this a new EqIA or an updated EqIA?</p>	<p>New <input checked="" type="checkbox"/> Updated <input type="checkbox"/> Date of original or last version of the EqIA: Please give details / explain any amendments – New template/additional information.</p>
<p>6. Who will be affected by the procedure/ proposal/ project/ policy development? (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)</p>	<ul style="list-style-type: none"> <li>• Local Population using the MIU.</li> <li>• Staff working within the MIU / AMAU.</li> <li>• Patients using either GGH or Morriston.</li> <li>• Staff working in GGH &amp; MGH due to increase demands from GGH site</li> <li>• Sample audit November 2022 – 11.45% from Swansea Bay area</li> </ul> <p>Sample audit for 2 weeks Dec 2023 <a href="https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5lPyTculB&amp;id=uChWuyjjgkCoVkm8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u">https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5lPyTculB&amp;id=uChWuyjjgkCoVkm8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u</a></p>

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<p>7. What might help/hinder the success of the procedure/ proposal/ project/ policy?</p>	<p>Help:</p> <ul style="list-style-type: none"> <li>• HIW Inspection recommendations</li> <li>• Clinical Team support</li> <li>• Executive support including Core Delivery Group and the Operational Planning Governance and Performance Group</li> <li>• Communication and Engagement strategy</li> <li>• Trade Unions / HR</li> <li>• Welsh Government</li> </ul> <p>Hinder:</p> <ul style="list-style-type: none"> <li>• Public (and public representation groups) opposition/resistance to a reduced service.</li> <li>• Political opposition</li> <li>• Media</li> </ul>

## Section 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 **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the procedure/ proposal/ project/ policy relevant to:

Yes	No
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**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.

✓	
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<p><b>Article 3: The right not to be tortured or treated in an inhuman or degrading way.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 5: The right to liberty</b>  <b>Example:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p><b>Article 6: The right to a fair trial</b>  <b>Example:</b> issues of patient choice, control, empowerment and independence</p>	✓	
<p><b>Article 8: The right to respect for private and family life, home and correspondence.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 11: The right to freedom of thought, conscience and religion</b>  <b>Example:</b> 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</p>	✓	

### Section 3: Gathering of Evidence and Assessment of Potential Impact

<p><b>How will the procedure/ proposal/ project/ policy impact on Age:</b></p>	Positive	✓
<p>Is it likely to affect older and younger people in different ways or affect one age group and not another?</p>	Negative	✓

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No Impact

**Guidance**

Remove population data if not relevant to EqIA and upload relevant data.

**Population Data**

County	Carmarthenshire		Llanelli	
	Value	%	Value	%
Total: All usual residents	187,897	100	25,400	100
Aged 4 years and under	9,057	4.8	1,422.4	5.6
Aged 5 to 9 years	10,274	5.5	1,524	6
Aged 10 to 19 years	20879	11.2	3,048	12
Aged 20 to 24 years	8,820	4.7	1,447.8	5.7
Aged 25 to 34 years	20,692	11	3,225.8	11.8
Aged 35 to 49 years	31,802	16.9	4,749.8	18.7
Aged 50 to 64 years	40,906	21.8	5,054.6	19.9
Aged 65 to 74 years	24,603	13.1	2,616.2	10.3
Aged 75 to 84 years	15,247	8.1	1,600.2	6.3
Aged 85 years and over	5,617	3	711.2	2.8

[Build a custom area profile - Census 2021, ONS 03/07/2024](#)

Insert an age breakdown of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

**Patient data – last 3 years (April 21- July 2024)**

Patient Age	Attendances
Age: 0-9	9,695
Age: 10-19	16,094
Age: 20-29	14,304
Age: 30-39	14,004
Age: 40-49	11,557
Age: 50-59	12,689
Age: 60-69	10,516
Age: 70-79	9,503
Age: 80-89	5,682
Age: 90-99	1,072
Age: 100 +	27
<b>TOTAL</b>	<b>105,143</b>

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<p>Insert breakdown of staff age in the specific service/ area of work.</p> <p>If no information is available, please state that here including how you plan to address any identified data gaps in the future.</p>																																																																												
	<p><b>Staff data- Emergency Nurse Practitioner (ENP) staff age range between 37- 63 years. Average age of 54 years with 4 ENP retire and return. Difficulty in recruiting into 3 wte ENP vacancy previously which resulted in the appointment of X3 ENP trainees to mitigate the fragility and risk within this workforce in the event of full retirement/leavers.</b></p>																																																																											
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Older and younger populations may be more dependent on public transport and or others to bring them to healthcare settings as they may be too young to have a drivers' license or are unable to drive due to age related fragilities.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently, therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in many instances, wait until the following morning to be seen and treated therefore they will not be required to travel further for treatment or be reliant on travelling when public transport is available.</li> <li>• Educate the public on appropriate access of service in relation to the care that can be provided by MIU. This correspondence will need to be in accessible formats to ensure the elderly who may have sight loss, deteriorating mental capacity etc. are able to understand. Choose well posters within the reception area</li> <li>• Working with HDUHB communication team and Welsh Ambulance Service / Police/NHS 111 Wales/Primary and Secondary services, Local Authority and volunteer/charity services.</li> </ul>
<p>Provide a brief summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>• MIU have an aging workforce, many are retired and returned, the work life balance result of this change would be welcome by them as they will no longer be required to work nightshifts. No previous concerns highlighted by staff in relation to this aspect.</li> <li>•</li> </ul>	

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<p><b>How will the procedure/ proposal/ project/ policy impact on Disability:</b> Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.</p>		<p><b>Positive</b></p>																																																																																																									
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<p>Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)</p> <p>If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</p>	<p>Mental Health activity:</p> <table border="1"> <thead> <tr> <th rowspan="2">Month</th> <th colspan="2">MIU Referrals</th> <th colspan="2">Ward Referrals</th> <th colspan="2">08:00 - 20:00 - 20:00 08:00</th> </tr> <tr> <th>18-70</th> <th>70+</th> <th>18-70</th> <th>70+</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Feb-24</td> <td>79</td> <td>0</td> <td>15</td> <td>9</td> <td>56</td> <td>47</td> </tr> <tr> <td>Jan-24</td> <td>76</td> <td>2</td> <td>14</td> <td>9</td> <td>58</td> <td>43</td> </tr> <tr> <td>Dec-23</td> <td>78</td> <td>2</td> <td>12</td> <td>12</td> <td>65</td> <td>39</td> </tr> <tr> <td>Nov-23</td> <td>71</td> <td>1</td> <td>13</td> <td>19</td> <td>71</td> <td>33</td> </tr> <tr> <td>Oct-23</td> <td>61</td> <td>2</td> <td>8</td> <td>19</td> <td>66</td> <td>24</td> </tr> <tr> <td>Sep-23</td> <td>39</td> <td>2</td> <td>11</td> <td>6</td> <td>43</td> <td>15</td> </tr> <tr> <td>Aug-23</td> <td>52</td> <td>2</td> <td>28</td> <td>11</td> <td>54</td> <td>39</td> </tr> <tr> <td>Jul-23</td> <td>54</td> <td>1</td> <td>19</td> <td>8</td> <td>52</td> <td>30</td> </tr> <tr> <td>Jun-23</td> <td>65</td> <td>2</td> <td>16</td> <td>4</td> <td>52</td> <td>35</td> </tr> <tr> <td>May-23</td> <td>63</td> <td>4</td> <td>13</td> <td>9</td> <td>55</td> <td>34</td> </tr> <tr> <td>Apr-23</td> <td>68</td> <td>0</td> <td>12</td> <td>11</td> <td>57</td> <td>34</td> </tr> <tr> <td>Mar-23</td> <td>42</td> <td>0</td> <td>1</td> <td>8</td> <td>30</td> <td>21</td> </tr> <tr> <td>Feb-23</td> <td>50</td> <td>1</td> <td>9</td> <td>8</td> <td>52</td> <td>16</td> </tr> </tbody> </table>			Month	MIU Referrals		Ward Referrals		08:00 - 20:00 - 20:00 08:00		18-70	70+	18-70	70+			Feb-24	79	0	15	9	56	47	Jan-24	76	2	14	9	58	43	Dec-23	78	2	12	12	65	39	Nov-23	71	1	13	19	71	33	Oct-23	61	2	8	19	66	24	Sep-23	39	2	11	6	43	15	Aug-23	52	2	28	11	54	39	Jul-23	54	1	19	8	52	30	Jun-23	65	2	16	4	52	35	May-23	63	4	13	9	55	34	Apr-23	68	0	12	11	57	34	Mar-23	42	0	1	8	30	21	Feb-23	50	1	9	8	52	16
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	TOTAL	798	19	171	133	711	410
Insert breakdown of staff with a disability who may be affected by your specific service/area of work.	<b>Staff data:</b> No staff disabilities on record. No mental Health issues captured.						
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	<b>Negative Impact</b> <ul style="list-style-type: none"> <li>Those with disabilities may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> <li>Communicating the new hours may be difficult for people who have certain neuro-diverse conditions, learning disabilities or sensory loss.</li> <li>It could be perceived that people needing attention for mental health concerns may be negatively impacted by the reduction hours, but mental health conditions are already outside the scope of MIU therefore should not be treated here.</li> </ul>			<b>Opportunities for improvement / mitigation:</b> <ul style="list-style-type: none"> <li>Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated. Opportunity to develop timed slots.</li> <li>Review of appropriate MIU modelling and key education to the public on criteria of acceptances in MIU.</li> <li>Ensure all communication regarding the changing of hours is available in accessible formats, easy read, braille etc.</li> <li>111 option 2 promotion. This has been a national campaign with NHS Wales and is available 24 hours a day. It is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis, or requiring support to manage</li> </ul>			

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- Parking – is there likely to be an increase of the use of disabled bays due to condensed hours? How many do we currently have? Is it sufficient from the patient data for disability?
- Staff with certain disabilities may only be able to work night shift as they are reliant on family/ public transport for lifts to work etc.
- Are there any scenarios where disabled staff need to work night shift? Menopause, ADHD etc?

their symptoms. Posters displayed in MIU and patient advised on Triage to ring

- There are 5 allocated bays outside MIU. There is also a drop off area outside the entrance. Current percentage in relation to spaces is 5% which fits into the 4-6% guidelines.
- There aren't any staff within this category.
- No scenarios at present.

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<b>How will the procedure/ proposal/ project/ policy impact on Gender Reassignment:</b> Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.		Positive																															
		Negative																															
		No Impact	✓																														
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" data-bbox="371 379 1523 783"> <thead> <tr> <th data-bbox="371 379 1050 416">County</th> <th data-bbox="1057 379 1294 416">Carmarthenshire</th> <th data-bbox="1301 379 1523 416"></th> </tr> <tr> <th data-bbox="371 421 1050 458">Gender</th> <th data-bbox="1057 421 1294 458">value</th> <th data-bbox="1301 421 1523 458">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 462 1050 499">All usual residents aged 16 and over</td> <td data-bbox="1057 462 1294 499">155,486</td> <td data-bbox="1301 462 1523 499">100</td> </tr> <tr> <td data-bbox="371 504 1050 541">Gender identity the same as sex registered at birth</td> <td data-bbox="1057 504 1294 541">144,924</td> <td data-bbox="1301 504 1523 541">93.2</td> </tr> <tr> <td data-bbox="371 545 1050 603">Gender identity different from sex registered at birth but no specific identity given</td> <td data-bbox="1057 545 1294 603">210</td> <td data-bbox="1301 545 1523 603">0.1</td> </tr> <tr> <td data-bbox="371 608 1050 644">Trans woman</td> <td data-bbox="1057 608 1294 644">93</td> <td data-bbox="1301 608 1523 644">0.1</td> </tr> <tr> <td data-bbox="371 649 1050 686">Trans man</td> <td data-bbox="1057 649 1294 686">90</td> <td data-bbox="1301 649 1523 686">0.1</td> </tr> <tr> <td data-bbox="371 691 1050 727">Non-binary</td> <td data-bbox="1057 691 1294 727">60</td> <td data-bbox="1301 691 1523 727">0.0</td> </tr> <tr> <td data-bbox="371 732 1050 769">All other gender identities</td> <td data-bbox="1057 732 1294 769">38</td> <td data-bbox="1301 732 1523 769">0.0</td> </tr> <tr> <td data-bbox="371 774 1050 810">Not answered</td> <td data-bbox="1057 774 1294 810">10,072</td> <td data-bbox="1301 774 1523 810">6.5</td> </tr> </tbody> </table> <p data-bbox="371 788 965 815">Data retrieved from Census 2021 data 24/06/2024</p>			County	Carmarthenshire		Gender	value	%	All usual residents aged 16 and over	155,486	100	Gender identity the same as sex registered at birth	144,924	93.2	Gender identity different from sex registered at birth but no specific identity given	210	0.1	Trans woman	93	0.1	Trans man	90	0.1	Non-binary	60	0.0	All other gender identities	38	0.0	Not answered	10,072	6.5
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If you have determined no impact, please provide a brief explanation.	<p data-bbox="371 868 517 895"><b>No Impact</b></p> <p data-bbox="371 900 2159 970">The current unit and its limited accommodation has a single unisex/disabled toilet and shower facilities. No additional impact in the context of gender reassignment with this service change.</p>																																

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How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	✓
		No Impact	
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population Data</b></p> <p>Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.</p> <p>In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</a></p> <p>In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</a></p> <p>In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</a></p>		
<p>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format.</p>	<p><b>Patient data</b> - no information available.</p> <p>This will require monitoring in relation to any childcare concerns raised by patients and the dependency on spouse to support MIU attendance, as well as transport to and from the MIU. Monitor through Patient feedback.</p>		
<p>Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.</p>	<p>No information available.</p> <p>Monitor any staff impact of amended hours on dependency/ability on spouse in relation to childcare needs as well as transport to and from MIU (if required). This can be mitigated by the flexible working policy and effective roster management. Capture staff who are working through flexible working request on ESR.</p>		

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Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.

**Negative Impact**

- Staff may be reliant on their partners for lifts to and from work a change in working hours/ no opportunity to work a night shift may affect the staff members or their partners' employment (some households may need to change jobs to adapt to the new circumstances).
- Some households may be negatively impacted by this change due to shared childcare arrangements between shift work.

**Opportunities for improvement / mitigation**

- Flexible working policy.
- Ability to request % of shifts within roster.
- All rosters completed six weeks in advance.

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How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.		Positive	✓
		Negative	
		No Impact	
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format.	No information available, there aren't any gynaecological service in PPH. Capture of data relating to re-direction underway. Any adverse incidents are captured via Incident reporting (Datix).		
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.	No information available:  Leave and Pay For New and Existing Parent policy  <a href="https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/">https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/</a>  Monitor through Managing attendance at work policy – ESR data.		
Provide a summary of the positive impacts you have identified.	<b>Positive Impact</b> <ul style="list-style-type: none"> <li>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) will promote and highlight key criteria and will support signposting of patients to the right place first time.</li> </ul>		

How will the procedure/ proposal/ project/ policy on 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. Also includes citizenship.		Positive	✓
		Negative	✓
		No Impact	

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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population</b></p> <table border="1"> <thead> <tr> <th>County</th> <th colspan="2">Carms</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Ethnicity</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Total: All usual residents</td> <td>187,898</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td>Asian, Asian British or Asian Welsh</td> <td>2,321</td> <td>1.2</td> <td>533</td> <td>2.1</td> </tr> <tr> <td>Black, Black British, Black Welsh, Caribbean or African</td> <td>455</td> <td>0.2</td> <td>51</td> <td>0.2</td> </tr> <tr> <td>Mixed or Multiple ethnic groups</td> <td>1,756</td> <td>0.9</td> <td>279</td> <td>1.1</td> </tr> <tr> <td>White</td> <td>182,652</td> <td>97.2</td> <td>24,384</td> <td>96</td> </tr> <tr> <td>Another ethnic group</td> <td>714</td> <td>0.4</td> <td>1523</td> <td>0.6</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p> <p>90.3% of Llanelli's population (22,936) were born in the UK.</p>					County	Carms		Llanelli		Ethnicity	Value	%	Value	%	Total: All usual residents	187,898	100	25,400	100	Asian, Asian British or Asian Welsh	2,321	1.2	533	2.1	Black, Black British, Black Welsh, Caribbean or African	455	0.2	51	0.2	Mixed or Multiple ethnic groups	1,756	0.9	279	1.1	White	182,652	97.2	24,384	96	Another ethnic group	714	0.4	1523	0.6
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>It may be difficult to communicate this change with some hard-to-reach minority communities or those who speak a different language from English and Welsh.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>Link in with Community Development Outreach Team (CDOT) to support key communication. engaging with specific ethnic minority groups in the local area via the CDOT and will share key messages in the development stages with ethnic minority communities affected by this change in an appropriate language and communication method.</li> <li>Translation Services – ensure all communication is translated and in accessible formats, such as easy read format.</li> <li>Clear criteria for overseas visitors accessing MIU service.</li> <li>Working with Health Board communications and engagement team.</li> </ul>																																											
<p>Provide a summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>Greater accessibility to support services e.g., translation services will always be available within the revised operating hours.</li> </ul>																																												

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<b>How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief)</b> The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.					Positive																																																														
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Not answered	11,703	6.2	1524	6																																																															
Insert breakdown of Religion or Belief (or non-belief) of staff affected by your specific service/area of work.	<b>Staff data – No information relating to any impact. Consideration as applicable of religion and/or belief. Data collated via ESR.</b>																																																																		
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the	<b>Negative Impact</b> <ul style="list-style-type: none"> <li>Reduction of opening hours reduce flexibility within shift patterns for staff members during key religion or belief (non-belief) events.</li> </ul>		<b>Opportunities for improvement / mitigation:</b> <ul style="list-style-type: none"> <li>Promotion of diversity and Inclusion within Health Board staff.</li> <li>Access to Religion and Beliefs Learning Resources for staff.</li> <li>Diversity Calendar promotion</li> <li>Flexible working policy</li> <li>Equality, Diversity and Inclusion Policy</li> </ul>																																																																

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

relevant negative impact.		
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<b>How will the procedure/ proposal/ project/ policy impact on Sex</b> Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	<b>Positive</b>	
	<b>Negative</b>	
	<b>No Impact</b>	✓

<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #4F81BD; color: white;">County</th> <th colspan="2" style="background-color: #4F81BD; color: white;">Carms</th> <th colspan="2" style="background-color: #4F81BD; color: white;">Llanelli</th> </tr> <tr> <th style="background-color: #4F81BD; color: white;">Gender</th> <th style="background-color: #4F81BD; color: white;">Value</th> <th style="background-color: #4F81BD; color: white;">%</th> <th style="background-color: #4F81BD; color: white;">Value</th> <th style="background-color: #4F81BD; color: white;">%</th> </tr> </thead> <tbody> <tr> <td style="background-color: #4F81BD; color: white;">All persons</td> <td style="text-align: right;">187,897</td> <td style="text-align: center;">100</td> <td style="text-align: right;">25,400</td> <td style="text-align: center;">100</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Male</td> <td style="text-align: right;">91,685</td> <td style="text-align: center;">48.8</td> <td style="text-align: right;">12,421</td> <td style="text-align: center;">48.9</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Female</td> <td style="text-align: right;">96,212</td> <td style="text-align: center;">51.2</td> <td style="text-align: right;">13,979</td> <td style="text-align: center;">51.1</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p>					County	Carms		Llanelli		Gender	Value	%	Value	%	All persons	187,897	100	25,400	100	Male	91,685	48.8	12,421	48.9	Female	96,212	51.2	13,979	51.1
County	Carms		Llanelli																											
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If you have determined no impact, please provide a brief explanation.	<p><b>No Impact</b></p> <ul style="list-style-type: none"> <li>Applies to both sexes equally. No discrimination in the context of sex. The current unit and its limited accommodation, with a single unisex/ disabled toilet and shower facilities.</li> </ul>
---	--

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		Positive							
		Negative							
		No Impact		✓					
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>								
		<b>County</b>							
		<b>Carms</b>		<b>Ceredigion</b>		<b>Pembs</b>		<b>Totals</b>	
	Sexual Orientation	Value	%	Value	%	Value	%	Value	%
	Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0
	Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
	Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
	Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5
	Pansexual	120	0.1	150	0.2	80	0.1	350	0.2
	Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0.0	49	0.1	12	0	84	0.0	
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1	
<a href="https://www.ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a>									
If you have determined no impact, please provide a brief explanation.	<b>No Impact</b>								
	There is no discrimination identified based on sexual orientation								

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>How will the procedure/ proposal/ project/ policy impact on Armed Forces</b>          Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'</p> <p>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:  <a href="#">Armed-Forces-Covenant-duty-statutory-guidance</a></p>	<b>Positive</b>	
	<b>Negative</b>	✓
	<b>No Impact</b>	

<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<b>Population Data</b>				
		<b>Carmarthenshire (%)</b>	<b>Pembrokeshire (%)</b>	<b>Ceredigion (%)</b>	<b>Hywel Dda (%)</b>
	<b>Regular</b>	3.6	4.5	3	3.7
	<b>Reserve</b>	0.9	0.9	0.9	0.9
	<b>Both</b>	0.2	0.2	0.2	0.2
	<b>Total</b>	4.7	5.7	4.1	4.8
<p><a href="#">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>					

<p>If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community.</p>	<p><b>Patient data – no information. Promotion of Armed Forces identification to be captured on WPAS.</b></p>
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**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• This populations may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated.</li> <li>• Educate the public on criteria of acceptances in MIU through communication supported by Choose Well NHS 111 Wales.</li> <li>• Awareness and reference to the All Wales Reserve Forces Training &amp; Mobilisation policy.</li> <li>• Utilisation of the Hywel Dda Strategic Partnerships Diversity &amp; Inclusion Armed Forces SharePoint page.</li> </ul>
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Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>Socio-economic Deprivation</b>          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.</p> <p>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: <a href="https://gov.wales/more-equal-wales-socio-economic-duty">https://gov.wales/more-equal-wales-socio-economic-duty</a></p>		Positive																									
		Negative	✓																								
		No Impact																									
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="369 555 1377 831"> <thead> <tr> <th rowspan="2">Economic Factor</th> <th colspan="2">Carmarthenshire</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Economically active – In employment (this includes full time students)</td> <td>81,952</td> <td>52.7</td> <td>12,234</td> <td>52.1</td> </tr> <tr> <td>Economically active - Unemployed</td> <td>3,922</td> <td>2.5</td> <td>914</td> <td>3.6</td> </tr> <tr> <td>Economically inactive</td> <td>69,613</td> <td>44.8</td> <td>11,252</td> <td>44.3</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 24/06/2024</p>			Economic Factor	Carmarthenshire		Llanelli		Value	%	Value	%	Economically active – In employment (this includes full time students)	81,952	52.7	12,234	52.1	Economically active - Unemployed	3,922	2.5	914	3.6	Economically inactive	69,613	44.8	11,252	44.3
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<p>If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in table or free text format.</p>	<p><b>Patient data – no information to capture impact of change.</b>  <b>Monitor through patient feedback.</b></p>																										

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p>Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation.</p>	<p><b>Staff data</b> – no information to capture impact. Monitored via Managing attendance at work policy – ESR data.</p>	
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Staff unable to work night shifts means that they are not able to receive the enhanced allowances.</li> <li>• Patients needing to pay to take public transport.</li> <li>• The cost of childcare may increase if a household is sharing caring responsibilities around shift work.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Consultation with staff</li> <li>• Communication – working with communication team regarding role and function of MIU.</li> <li>• Promotion of staff benefits – such as childcare vouchers, discounts.</li> </ul>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>Welsh Language</b> Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.		Positive											
		Negative											
		No Impact	✓										
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>  According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.  Definition of whether a person has Welsh language skills (as recorded in the Census 2022).  If a person can or does do any of the following: <ul style="list-style-type: none"> <li>• Understand spoken Welsh</li> <li>• Speak Welsh</li> <li>• Read Welsh</li> <li>• Write Welsh</li> </ul> <table border="1" data-bbox="371 903 1189 1137"> <thead> <tr> <th data-bbox="371 903 640 978">Area</th> <th data-bbox="640 903 1189 978">Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 978 640 1018">Carmarthenshire</td> <td data-bbox="640 978 1189 1018">53.3</td> </tr> <tr> <td data-bbox="371 1018 640 1058">Pembrokeshire</td> <td data-bbox="640 1018 1189 1058">25.2</td> </tr> <tr> <td data-bbox="371 1058 640 1098">Ceredigion</td> <td data-bbox="640 1058 1189 1098">56.4</td> </tr> <tr> <td data-bbox="371 1098 640 1137">Hywel Dda</td> <td data-bbox="640 1098 1189 1137">45</td> </tr> </tbody> </table> <p data-bbox="371 1137 1285 1169"><a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>	Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45		
Area	Percentage of people who can speak Welsh												
Carmarthenshire	53.3												
Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
If you have determined no impact, please provide a brief explanation.	<b>No Impact identified</b>												

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

### **Additional considerations**

**In addition to the above protected characteristics please consider impact on the following:**

- Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)
- Unpaid Carers
- Individuals and communities who experience Digital Exclusion
- Rural and Urban communities
- More info about the comms package that will be required to inform the public about the scope of practice for each option
- More info about the comms package that will be required to inform the public about the specific opening times
- Different communication mechanisms for certain protected characteristics – how will we be promoting to our younger population/older population/blind and deaf, LGBTQ+ population. I'm thinking specifically in terms of newspaper adds, social media ads
- Utilising the medical and nursing workforce to a 12(&2) model enhances the MIU skill set, reducing gaps within the roster and allows improved quality, safety and timely care to be delivered within these agreed hours.
- Reduction in staff anxiety, morale and in turn reduces staff sickness absence.
- Improved recruitment within the GP/Medical workforce due to reduced risk within the department.

**As mentioned above the CDOT team and other key stakeholders will be used to communicate this change of hours.**

**Messages will be translated to the languages that are required.**

**Easy read versions of the communication will be made available.**

### **Intersectionality**

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

**Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

**Please note - All white boxes within this EqlA must be completed, please do not leave them blank.**

**Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?**

Not applicable

Please note – All white boxes within this EqIA must be completed, please do not leave them blank.

#### Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: a **likelihood score** and an **opportunity/impact score**. The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores will automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

**(Likelihood Score x opportunity/impact Score = Total Score)**

OPPORTUNITY AND IMPACT			
IMPACT	SCORE		The proposed change is anticipated to lead to the following level of opportunity and/or impact:
Positive	5	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities.
Neutral	0	Neutral	(Neutral): No effect, either positive or negative.
Negative	-1	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery.
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occurring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

		OPPORTUNITY					IMPACT					
LIKELIHOOD		5	4	3	2	1	0	-1	-2	-3	-4	-5
	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5	

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

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**\*\*To access the scoring table below you will need to double click on the table to open an editable version. The information you input will remain when you click back on the word document.**

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Area					Opportunity / Consequence Rating*	*IIA Matrix		
	Positive impact	Neutral impact	Negative impact	Unknown		Consequence	Likelihood	Total Score
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative								
Age					** positive rating	3	3	9
					** negative rating	-3	3	-9
Disability					** positive rating			0
					** negative rating	-3	3	-9
Gender Reassignment					** positive rating			0
					** negative rating			0
Marriage and Civil Partnership					** positive rating			0
					** negative rating	-2	3	-6
Pregnancy and Maternity					** positive rating	4	2	8
					** negative rating			0
Race/Ethnicity or Nationality					** positive rating	3	3	9
					** negative rating	-3	3	-9
Religion or Belief					** Positive rating			0
					** negative rating	-3	3	-9
Sex					** positive rating			0
					** negative rating			0
Sexual Orientation					** positive rating			0
					** negative rating			0
Armed Forces					** positive rating			0
					** negative rating	-3	3	-9
Socio-economic Deprivation					** positive rating			0
					** negative rating	-4	3	-12
Welsh Language					** positive rating			0
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

**Section 5: Outcome and Actions**

This section should be used to detail and monitor any actions identified in sections 1-4.

<p><b>Will the procedure/ proposal/ project/ policy be adopted? If no, please give reasons and any alternative action(s) agreed.</b></p>	<p>Process remains active re long term MIU Model</p>
<p><b>If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.</b></p>	

	<b>Actions</b>	<b>Assigned to</b>	<b>Target Review Date</b>	<b>Completion Date</b>	<b>Comments/ Update</b>
	<ul style="list-style-type: none"> <li>Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified.</li> <li>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.</li> </ul>				
1.	<p><b>What additional monitoring data will be collected around the impact of procedure/ proposal/ project/ policy once adopted? How will this be collected?</b></p> <p><b>Audits – redirection policy</b>  <b>Attendances</b> (Major &amp; Minor split)  <b>Incidents/</b> Risk register review  <b>Complaints</b>            Patient feedback – CIVICA            4- &amp; 12-hour performance– breach data            Workforce data review – sickness absence themes</p>	Jon Morris Iona Evans Meinir Williams	3 months post closure	13 <sup>th</sup> Feb 2025	<p>Monthly review of data to determine impact of closure captured.</p> <p>Feedback provided within Quality, Safety &amp; Experience Committee Meeting (13/02/2025)</p>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

2.	MIU Project Group underway to scope long term modelling of the unit – series of options for delivery of the MIU in response to service fragilities’ and/or unsustainability – 4 options remain.	Sarah Perry Robin Ghosal Iona Evans Jon Morris	27 <sup>th</sup> March 2025	Pending Board Meeting outcome	Depending on Board outcome will determine next steps.
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>EqIA Completed by:</b>	<b>Name/s</b>	Iona Evans /Jon Morris
	<b>Title</b>	Interim HoN GGH & PPH/ Clinical Lead MIU
	<b>Team / Division</b>	Unscheduled Care
	<b>Contact details</b>	iona.evans@wales.nhs.uk/jon.morris2@wales.nhs.uk
	<b>Date</b>	23/03/2025
<b>EqIA Authorised by/Owned by:</b> <ul style="list-style-type: none"> <li>Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy</li> <li>Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5</li> </ul>	<b>Name</b>	Sarah Perry
	<b>Title</b>	GM Carmarthenshire System
	<b>Team / Division</b>	Unscheduled Care/Community
	<b>Contact details</b>	Sarah.Perry3@wales.nhs.uk
	<b>Date</b>	23/03/2023
<b>Guidance has been provided by Diversity &amp; Inclusion Team:</b>	<b>Name</b>	Alan Winter
	<b>Title</b>	Senior Diversity and Inclusion Officer
	<b>Team</b>	Strategic Partnership Diversity & Inclusion
	<b>Contact details</b>	<a href="mailto:Alan.winter@wales.nhs.uk">Alan.winter@wales.nhs.uk</a>
	<b>Date</b>	24/3/2025
<b>Diversity and Inclusion Team additional Comments:</b>		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

## **Hywel Dda University Health Board Equality Impact Assessment (EqIA)**

<b>Director and Directorate</b>	Andrew Carruthers - Unscheduled Care Prince Philip Hospital (PPH)
<b>Service Area</b>	Minor Injuries Unit - Option 2 - Doctor-led 14 hours

### **What is an Equality Impact Assessment (EqIA)?**

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

### **Why do they have to be completed?**

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the [Equality Act 2010](#) with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

### **When should they be completed?**

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

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 you will also need to consider

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

**Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.**

### **Support**


For further support please visit the [EqIA Sharepoint](#) or contact:

Email: [Inclusion.hdd@wales.nhs.uk](mailto:Inclusion.hdd@wales.nhs.uk)

Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

<p>1. What are you Equality Impact assessing?</p>	<p>16-hour doctor led unit – this would be open to the public for 14 hours, with a further two hours staffing to allow patients in the unit to be treated.</p>
<p>2. Brief Aims and Description of the procedure/ proposal/ project/ policy:</p>	<p>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) to meet local population needs within the new proposed times.</p>
<p>3. Who is involved in undertaking this EqIA? (names/job titles)</p>	<p>Jon Morris (Clinical Lead MIU), Iona Evans (Interim Head of Nursing GGH &amp; PPH USC), Meinir Williams (Deputy Head of Nursing PPH USC)</p>
<p>4. Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?</p>	<p>No</p>
<p>5. Is this a new EqIA or an updated EqIA?</p>	<p>New <input checked="" type="checkbox"/> Updated <input type="checkbox"/> Date of original or last version of the EqIA: Please give details / explain any amendments – New template/additional information.</p>
<p>6. Who will be affected by the procedure/ proposal/ project/ policy development? (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)</p>	<ul style="list-style-type: none"> <li>• Local Population using the MIU.</li> <li>• Staff working within the MIU / AMAU.</li> <li>• Patients using either GGH or Morriston.</li> <li>• Staff working in GGH &amp; MGH due to increase demands from GGH site</li> <li>• Sample audit November 2022 – 11.45% from Swansea Bay area</li> </ul> <div style="text-align: center;">  <p>MIU%20attendance s%20from%20Swans</p> <p>Sample audit for 2 weeks Dec 2023</p> </div>

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	<a href="https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5IPyTculB&amp;id=uChWuyjjgkCoVkM8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u">https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5IPyTculB&amp;id=uChWuyjjgkCoVkM8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u</a>
<p>7. What might help/hinder the success of the procedure/ proposal/ project/ policy?</p>	<p>Help:</p> <ul style="list-style-type: none"> <li>• HIW Inspection recommendations</li> <li>• Clinical Team support</li> <li>• Executive support including Core Delivery Group and the Operational Planning Governance and Performance Group</li> <li>• Communication and Engagement strategy</li> <li>• Trade Unions / HR</li> <li>• Welsh Government</li> </ul> <p>Hinder:</p> <ul style="list-style-type: none"> <li>• Public (and public representation groups) opposition/resistance to a reduced service.</li> <li>• Political opposition</li> <li>• Media</li> </ul>

## Section 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 **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the procedure/ proposal/ project/ policy relevant to:

Yes	No
-----	----

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<p><b>Article 2: The right to life.</b>  <b>Example:</b> The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.</p>	✓	
<p><b>Article 3: The right not to be tortured or treated in an inhuman or degrading way.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 5: The right to liberty</b>  <b>Example:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p><b>Article 6: The right to a fair trial</b>  <b>Example:</b> issues of patient choice, control, empowerment and independence</p>	✓	
<p><b>Article 8: The right to respect for private and family life, home and correspondence.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 11: The right to freedom of thought, conscience and religion</b>  <b>Example:</b> 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</p>	✓	

**Section 3: Gathering of Evidence and Assessment of Potential Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>How will the procedure/ proposal/ project/ policy impact on Age:</b> Is it likely to affect older and younger people in different ways or affect one age group and not another?	<b>Positive</b>	✓
	<b>Negative</b>	✓
	<b>No Impact</b>	

<b>Guidance</b>  Remove population data if not relevant to EqIA and upload relevant data.	<b>Population Data</b>				
	<b>County</b>	<b>Carmarthenshire</b>		<b>Llanelli</b>	
	<b>Age</b>	<b>Value</b>	<b>%</b>	<b>Value</b>	<b>%</b>
	Total: All usual residents	187,897	100	25,400	100
	Aged 4 years and under	9,057	4.8	1,422.4	5.6
	Aged 5 to 9 years	10,274	5.5	1,524	6
	Aged 10 to 19 years	20,879	11.2	3,048	12
	Aged 20 to 24 years	8,820	4.7	1,447.8	5.7
	Aged 25 to 34 years	20,692	11	3,225.8	11.8
	Aged 35 to 49 years	31,802	16.9	4,749.8	18.7
	Aged 50 to 64 years	40,906	21.8	5,054.6	19.9
	Aged 65 to 74 years	24,603	13.1	2,616.2	10.3
Aged 75 to 84 years	15,247	8.1	1,600.2	6.3	
Aged 85 years and over	5,617	3	711.2	2.8	
<a href="#">Build a custom area profile - Census 2021, ONS 03/07/2024</a>					

Insert an age breakdown of those affected. This data can be recorded in table or free text format.  If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	<b>Patient data – last 3 years (April 21- July 2024)</b>	
	<b>Patient Age</b>	<b>Attendances</b>
	<b>Age: 0-9</b>	9,695
	<b>Age: 10-19</b>	16,094
	<b>Age: 20-29</b>	14,304
	<b>Age: 30-39</b>	14,004
	<b>Age: 40-49</b>	11,557
	<b>Age: 50-59</b>	12,689
	<b>Age: 60-69</b>	10,516
	<b>Age: 70-79</b>	9,503
	<b>Age: 80-89</b>	5,682
	<b>Age: 90-99</b>	1,072

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Age: 100 +	27
<b>TOTAL</b>	<b>105,143</b>

Insert breakdown of staff age in the specific service/ area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.

**Staff data- Emergency Nurse Practitioner (ENP) staff age range between 37- 63 years. Average age of 54 years with 4 ENP retire and return. Difficulty in recruiting into 3 wte ENP vacancy previously which resulted in the appointment of X3 ENP trainees to mitigate the fragility and risk within this workforce in the event of full retirement/leavers.**

GRADE	ACTUAL W.T.E	Age	COMMENTS
7	1.00	49 yrs	commencing 19th August
7 ENP	0.40	62yrs	Retire and return
7 ENP	0.80	54yrs	
7 ENP	0.20	63yrs	Retire and return
7 ENP	0.96	51yrs	
7 ENP	0.80	47yrs	
7 ENP	0.80	53yrs	
7 ENP	0.40	62yrs	
7 ENP	0.92	47yrs	
7 ENP	0.96	38yrs	
7 ENP	1.00	53yrs	
7 ENP	0.50	56yrs	Retire and return
7 ENP	0.40	49yrs	
7 ENP	0.50	56yrs	Retire and return
6 ENP	1.00	39yrs	Trainee ENP
6 ENP	1.00	53yrs	Trainee ENP
6 ENP	1.00	37yrs	Trainee ENP

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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Older and younger populations may be more dependent on public transport and or others to bring them to healthcare settings as they may be too young to have a drivers' license or are unable to drive due to age related fragilities.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently, therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in many instances, wait until the following morning to be seen and treated therefore they will not be required to travel further for treatment or be reliant on travelling when public transport is available.</li> <li>• Educate the public on appropriate access of service in relation to the care that can be provided by MIU. This correspondence will need to be in accessible formats to ensure the elderly who may have sight loss, deteriorating mental capacity etc. are able to understand. Choose well posters within the reception area</li> <li>• Working with HDUHB communication team and Welsh Ambulance Service / Police/NHS 111 Wales/Primary and Secondary services, Local Authority and volunteer/charity services.</li> </ul>
<p>Provide a brief summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>• MIU have an aging workforce, many are retired and returned, the work life balance result of this change would be welcome by them as they will no longer be required to work nightshifts. No previous concerns highlighted by staff in relation to this aspect.</li> <li>•</li> </ul>	

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<b>How will the procedure/ proposal/ project/ policy impact on Disability:</b> Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.		<b>Positive</b>																																																																																																									
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	TOTAL	798	19	171	133	711	410
Insert breakdown of staff with a disability who may be affected by your specific service/area of work.	<p><b>Staff data:</b>            No staff disabilities on record.            No mental Health issues captured.</p>						
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Those with disabilities may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> <li>• Communicating the new hours may be difficult for people who have certain neuro-diverse conditions, learning disabilities or sensory loss.</li> <li>• It could be perceived that people needing attention for mental health concerns may be negatively impacted by the reduction hours, but mental health conditions are already outside the scope of MIU therefore should not be treated here.</li> </ul>			<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated. Opportunity to develop timed slots.</li> <li>• Review of appropriate MIU modelling and key education to the public on criteria of acceptances in MIU.</li> <li>• Ensure all communication regarding the changing of hours is available in accessible formats, easy read, braille etc.</li> <li>• 111 option 2 promotion. This has been a national campaign with NHS Wales and is available 24 hours a day. It is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis, or requiring support to manage</li> </ul>			

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- Parking – is there likely to be an increase of the use of disabled bays due to condensed hours? How many do we currently have? Is it sufficient from the patient data for disability?
- Staff with certain disabilities may only be able to work night shift as they are reliant on family/ public transport for lifts to work etc.
- Are there any scenarios where disabled staff need to work night shift? Menopause, ADHD etc?

their symptoms. Posters displayed in MIU and patient advised on Triage to ring

- There are 5 allocated bays outside MIU. There is also a drop off area outside the entrance. Current percentage in relation to spaces is 5% which fits into the 4-6% guidelines.
- There aren't any staff within this category.
- No scenarios at present.

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<b>How will the procedure/ proposal/ project/ policy impact on Gender Reassignment:</b> Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.		Positive																															
		Negative																															
		No Impact	✓																														
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" data-bbox="371 379 1523 783"> <thead> <tr> <th data-bbox="371 379 1050 416">County</th> <th data-bbox="1057 379 1294 416">Carmarthenshire</th> <th data-bbox="1301 379 1523 416"></th> </tr> <tr> <th data-bbox="371 421 1050 458">Gender</th> <th data-bbox="1057 421 1294 458">value</th> <th data-bbox="1301 421 1523 458">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 462 1050 499">All usual residents aged 16 and over</td> <td data-bbox="1057 462 1294 499">155,486</td> <td data-bbox="1301 462 1523 499">100</td> </tr> <tr> <td data-bbox="371 504 1050 541">Gender identity the same as sex registered at birth</td> <td data-bbox="1057 504 1294 541">144,924</td> <td data-bbox="1301 504 1523 541">93.2</td> </tr> <tr> <td data-bbox="371 545 1050 603">Gender identity different from sex registered at birth but no specific identity given</td> <td data-bbox="1057 545 1294 603">210</td> <td data-bbox="1301 545 1523 603">0.1</td> </tr> <tr> <td data-bbox="371 608 1050 644">Trans woman</td> <td data-bbox="1057 608 1294 644">93</td> <td data-bbox="1301 608 1523 644">0.1</td> </tr> <tr> <td data-bbox="371 649 1050 686">Trans man</td> <td data-bbox="1057 649 1294 686">90</td> <td data-bbox="1301 649 1523 686">0.1</td> </tr> <tr> <td data-bbox="371 691 1050 727">Non-binary</td> <td data-bbox="1057 691 1294 727">60</td> <td data-bbox="1301 691 1523 727">0.0</td> </tr> <tr> <td data-bbox="371 732 1050 769">All other gender identities</td> <td data-bbox="1057 732 1294 769">38</td> <td data-bbox="1301 732 1523 769">0.0</td> </tr> <tr> <td data-bbox="371 774 1050 810">Not answered</td> <td data-bbox="1057 774 1294 810">10,072</td> <td data-bbox="1301 774 1523 810">6.5</td> </tr> </tbody> </table> <p data-bbox="371 788 965 815">Data retrieved from Census 2021 data 24/06/2024</p>			County	Carmarthenshire		Gender	value	%	All usual residents aged 16 and over	155,486	100	Gender identity the same as sex registered at birth	144,924	93.2	Gender identity different from sex registered at birth but no specific identity given	210	0.1	Trans woman	93	0.1	Trans man	90	0.1	Non-binary	60	0.0	All other gender identities	38	0.0	Not answered	10,072	6.5
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If you have determined no impact, please provide a brief explanation.	<p data-bbox="371 869 517 896"><b>No Impact</b></p> <p data-bbox="371 901 2159 970">The current unit and its limited accommodation has a single unisex/disabled toilet and shower facilities. No additional impact in the context of gender reassignment with this service change.</p>																																

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How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	✓
		No Impact	
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population Data</b></p> <p>Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.</p> <p>In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</a></p> <p>In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</a></p> <p>In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</a></p>		
<p>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format.</p>	<p><b>Patient data</b> - no information available.</p> <p>This will require monitoring in relation to any childcare concerns raised by patients and the dependency on spouse to support MIU attendance, as well as transport to and from the MIU. Monitor through Patient feedback.</p>		
<p>Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.</p>	<p>No information available.</p> <p>Monitor any staff impact of amended hours on dependency/ability on spouse in relation to childcare needs as well as transport to and from MIU (if required). This can be mitigated by the flexible working policy and effective roster management. Capture staff who are working through flexible working request on ESR.</p>		

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.

**Negative Impact**

- Staff may be reliant on their partners for lifts to and from work a change in working hours/ no opportunity to work a night shift may affect the staff members or their partners' employment (some households may need to change jobs to adapt to the new circumstances).
- Some households may be negatively impacted by this change due to shared childcare arrangements between shift work.

**Opportunities for improvement / mitigation**

- Flexible working policy.
- Ability to request % of shifts within roster.
- All rosters completed six weeks in advance.

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How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.		Positive	✓
		Negative	
		No Impact	
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format.	No information available, there aren't any gynaecological service in PPH. Capture of data relating to re-direction underway. Any adverse incidents are captured via Incident reporting (Datix).		
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.	No information available:  Leave and Pay For New and Existing Parent policy  <a href="https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/">https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/</a>  Monitor through Managing attendance at work policy – ESR data.		
Provide a summary of the positive impacts you have identified.	<b>Positive Impact</b> <ul style="list-style-type: none"> <li>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) will promote and highlight key criteria and will support signposting of patients to the right place first time.</li> </ul>		

How will the procedure/ proposal/ project/ policy on 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. Also includes citizenship.		Positive	✓
		Negative	✓
		No Impact	

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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p>Population</p> <table border="1"> <thead> <tr> <th>County</th> <th colspan="2">Carms</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Ethnicity</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Total: All usual residents</td> <td>187,898</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td>Asian, Asian British or Asian Welsh</td> <td>2,321</td> <td>1.2</td> <td>533</td> <td>2.1</td> </tr> <tr> <td>Black, Black British, Black Welsh, Caribbean or African</td> <td>455</td> <td>0.2</td> <td>51</td> <td>0.2</td> </tr> <tr> <td>Mixed or Multiple ethnic groups</td> <td>1,756</td> <td>0.9</td> <td>279</td> <td>1.1</td> </tr> <tr> <td>White</td> <td>182,652</td> <td>97.2</td> <td>24,384</td> <td>96</td> </tr> <tr> <td>Another ethnic group</td> <td>714</td> <td>0.4</td> <td>1523</td> <td>0.6</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p> <p>90.3% of Llanelli's population (22,936) were born in the UK.</p>					County	Carms		Llanelli		Ethnicity	Value	%	Value	%	Total: All usual residents	187,898	100	25,400	100	Asian, Asian British or Asian Welsh	2,321	1.2	533	2.1	Black, Black British, Black Welsh, Caribbean or African	455	0.2	51	0.2	Mixed or Multiple ethnic groups	1,756	0.9	279	1.1	White	182,652	97.2	24,384	96	Another ethnic group	714	0.4	1523	0.6
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<p>Provide a summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>Greater accessibility to support services e.g., translation services will always be available within the revised operating hours.</li> </ul>																																												

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How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.					Positive																																																												
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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="371 355 1377 874"> <thead> <tr> <th data-bbox="371 355 663 387">County</th> <th colspan="2" data-bbox="663 355 1048 387">Carms</th> <th colspan="2" data-bbox="1048 355 1377 387">Llanelli</th> </tr> <tr> <th data-bbox="371 387 663 435">Religion</th> <th data-bbox="663 387 860 435">Value</th> <th data-bbox="860 387 1048 435">%</th> <th data-bbox="1048 387 1211 435">Value</th> <th data-bbox="1211 387 1377 435">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 435 663 499">Total: All usual residents</td> <td data-bbox="663 435 860 499">187,899</td> <td data-bbox="860 435 1048 499">100</td> <td data-bbox="1048 435 1211 499">25,400</td> <td data-bbox="1211 435 1377 499">%</td> </tr> <tr> <td data-bbox="371 499 663 539">No religion</td> <td data-bbox="663 499 860 539">83,409</td> <td data-bbox="860 499 1048 539">44.4</td> <td data-bbox="1048 499 1211 539">12,395</td> <td data-bbox="1211 499 1377 539">48.8</td> </tr> <tr> <td data-bbox="371 539 663 579">Christian</td> <td data-bbox="663 539 860 579">89,378</td> <td data-bbox="860 539 1048 579">47.6</td> <td data-bbox="1048 539 1211 579">10,922</td> <td data-bbox="1211 539 1377 579">43</td> </tr> <tr> <td data-bbox="371 579 663 619">Buddhist</td> <td data-bbox="663 579 860 619">557</td> <td data-bbox="860 579 1048 619">0.3</td> <td data-bbox="1048 579 1211 619">76</td> <td data-bbox="1211 579 1377 619">0.3</td> </tr> <tr> <td data-bbox="371 619 663 659">Hindu</td> <td data-bbox="663 619 860 659">419</td> <td data-bbox="860 619 1048 659">0.2</td> <td data-bbox="1048 619 1211 659">51</td> <td data-bbox="1211 619 1377 659">0.2</td> </tr> <tr> <td data-bbox="371 659 663 699">Jewish</td> <td data-bbox="663 659 860 699">103</td> <td data-bbox="860 659 1048 699">0.1</td> <td data-bbox="1048 659 1211 699">25</td> <td data-bbox="1211 659 1377 699">0.1</td> </tr> <tr> <td data-bbox="371 699 663 738">Muslim</td> <td data-bbox="663 699 860 738">1,026</td> <td data-bbox="860 699 1048 738">0.5</td> <td data-bbox="1048 699 1211 738">229</td> <td data-bbox="1211 699 1377 738">0.9</td> </tr> <tr> <td data-bbox="371 738 663 778">Sikh</td> <td data-bbox="663 738 860 778">177</td> <td data-bbox="860 738 1048 778">0.1</td> <td data-bbox="1048 738 1211 778">25</td> <td data-bbox="1211 738 1377 778">0.1</td> </tr> <tr> <td data-bbox="371 778 663 818">Other religion</td> <td data-bbox="663 778 860 818">1,127</td> <td data-bbox="860 778 1048 818">0.6</td> <td data-bbox="1048 778 1211 818">153</td> <td data-bbox="1211 778 1377 818">0.6</td> </tr> <tr> <td data-bbox="371 818 663 874">Not answered</td> <td data-bbox="663 818 860 874">11,703</td> <td data-bbox="860 818 1048 874">6.2</td> <td data-bbox="1048 818 1211 874">1524</td> <td data-bbox="1211 818 1377 874">6</td> </tr> </tbody> </table> <p data-bbox="371 874 965 906">Data retrieved from Census 2021 data 03/07/2024</p>					County	Carms		Llanelli		Religion	Value	%	Value	%	Total: All usual residents	187,899	100	25,400	%	No religion	83,409	44.4	12,395	48.8	Christian	89,378	47.6	10,922	43	Buddhist	557	0.3	76	0.3	Hindu	419	0.2	51	0.2	Jewish	103	0.1	25	0.1	Muslim	1,026	0.5	229	0.9	Sikh	177	0.1	25	0.1	Other religion	1,127	0.6	153	0.6	Not answered	11,703	6.2	1524	6
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</p>	<p><b>Negative Impact</b></p> <p>Reduction of opening hours reduce flexibility within shift patterns for staff members during key religion or belief (non-belief) events.</p>			<p><b>Opportunities for improvement / mitigation:</b></p> <ul data-bbox="1377 1153 2152 1393" style="list-style-type: none"> <li>• Promotion of diversity and Inclusion within Health Board staff.</li> <li>• Access to Religion and Beliefs Learning Resources for staff.</li> <li>• Diversity Calendar promotion</li> <li>• Flexible working policy</li> <li>• Equality, Diversity and Inclusion Policy</li> </ul>																																																													

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relevant negative impact.		
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<b>How will the procedure/ proposal/ project/ policy impact on Sex</b> Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	<b>Positive</b>	
	<b>Negative</b>	
	<b>No Impact</b>	✓

<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #4F81BD; color: white;">County</th> <th colspan="2" style="background-color: #4F81BD; color: white;">Carms</th> <th colspan="2" style="background-color: #4F81BD; color: white;">Llanelli</th> </tr> <tr> <th style="background-color: #4F81BD; color: white;">Gender</th> <th style="background-color: #4F81BD; color: white;">Value</th> <th style="background-color: #4F81BD; color: white;">%</th> <th style="background-color: #4F81BD; color: white;">Value</th> <th style="background-color: #4F81BD; color: white;">%</th> </tr> </thead> <tbody> <tr> <td style="background-color: #4F81BD; color: white;">All persons</td> <td>187,897</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Male</td> <td>91,685</td> <td>48.8</td> <td>12,421</td> <td>48.9</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;">Female</td> <td>96,212</td> <td>51.2</td> <td>13,979</td> <td>51.1</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p>				County	Carms		Llanelli		Gender	Value	%	Value	%	All persons	187,897	100	25,400	100	Male	91,685	48.8	12,421	48.9	Female	96,212	51.2	13,979	51.1
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If you have determined no impact, please provide a brief explanation.	<p><b>No Impact</b></p> <ul style="list-style-type: none"> <li>Applies to both sexes equally. No discrimination in the context of sex. The current unit and its limited accommodation, with a single unisex/ disabled toilet and shower facilities.</li> </ul>
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How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		Positive							
		Negative							
		No Impact		✓					
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>								
		<b>County</b>							
		<b>Carms</b>		<b>Ceredigion</b>		<b>Pembs</b>		<b>Totals</b>	
	Sexual Orientation	Value	%	Value	%	Value	%	Value	%
	Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0
	Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
	Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
	Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5
	Pansexual	120	0.1	150	0.2	80	0.1	350	0.2
	Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0.0	49	0.1	12	0	84	0.0	
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1	
<a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a>									
If you have determined no impact, please provide a brief explanation.	<b>No Impact</b> There is no discrimination identified based on sexual orientation								

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<p><b>How will the procedure/ proposal/ project/ policy impact on Armed Forces</b>          Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'</p> <p>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: <a href="#"><u>Armed-Forces-Covenant-duty-statutory-guidance</u></a></p>	<b>Positive</b>	
	<b>Negative</b>	✓
	<b>No Impact</b>	

<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<b>Population Data</b>				
		<b>Carmarthenshire (%)</b>	<b>Pembrokeshire (%)</b>	<b>Ceredigion (%)</b>	<b>Hywel Dda (%)</b>
	<b>Regular</b>	3.6	4.5	3	3.7
	<b>Reserve</b>	0.9	0.9	0.9	0.9
	<b>Both</b>	0.2	0.2	0.2	0.2
	<b>Total</b>	4.7	5.7	4.1	4.8
<p><a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>					

<p>If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community.</p>	<p><b>Patient data – no information. Promotion of Armed Forces identification to be captured on WPAS.</b></p>
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• This populations may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated.</li> <li>• Educate the public on criteria of acceptances in MIU through communication supported by Choose Well NHS 111 Wales.</li> <li>• Awareness and reference to the All Wales Reserve Forces Training &amp; Mobilisation policy.</li> <li>• Utilisation of the Hywel Dda Strategic Partnerships Diversity &amp; Inclusion Armed Forces SharePoint page.</li> </ul>
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<p><b>Socio-economic Deprivation</b>          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.</p> <p>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: <a href="https://gov.wales/more-equal-wales-socio-economic-duty">https://gov.wales/more-equal-wales-socio-economic-duty</a></p>		Positive																									
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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="369 555 1377 831"> <thead> <tr> <th rowspan="2">Economic Factor</th> <th colspan="2">Carmarthenshire</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Economically active – In employment (this includes full time students)</td> <td>81,952</td> <td>52.7</td> <td>12,234</td> <td>52.1</td> </tr> <tr> <td>Economically active - Unemployed</td> <td>3,922</td> <td>2.5</td> <td>914</td> <td>3.6</td> </tr> <tr> <td>Economically inactive</td> <td>69,613</td> <td>44.8</td> <td>11,252</td> <td>44.3</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 24/06/2024</p>			Economic Factor	Carmarthenshire		Llanelli		Value	%	Value	%	Economically active – In employment (this includes full time students)	81,952	52.7	12,234	52.1	Economically active - Unemployed	3,922	2.5	914	3.6	Economically inactive	69,613	44.8	11,252	44.3
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<p>If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in table or free text format.</p>	<p><b>Patient data – no information to capture impact of change.</b>  <b>Monitor through patient feedback.</b></p>																										

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p>Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation.</p>	<p><b>Staff data</b> – no information to capture impact. Monitored via Managing attendance at work policy – ESR data.</p>	
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Staff unable to work night shifts means that they are not able to receive the enhanced allowances.</li> <li>• Patients needing to pay to take public transport.</li> <li>• The cost of childcare may increase if a household is sharing caring responsibilities around shift work.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Consultation with staff</li> <li>• Communication – working with communication team regarding role and function of MIU.</li> <li>• Promotion of staff benefits – such as childcare vouchers, discounts.</li> </ul>

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<b>Welsh Language</b> Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.		Positive											
		Negative											
		No Impact	✓										
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>  According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.  Definition of whether a person has Welsh language skills (as recorded in the Census 2022).  If a person can or does do any of the following: <ul style="list-style-type: none"> <li>• Understand spoken Welsh</li> <li>• Speak Welsh</li> <li>• Read Welsh</li> <li>• Write Welsh</li> </ul> <table border="1" data-bbox="371 903 1187 1137"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <tr> <td>Carmarthenshire</td> <td>53.3</td> </tr> <tr> <td>Pembrokeshire</td> <td>25.2</td> </tr> <tr> <td>Ceredigion</td> <td>56.4</td> </tr> <tr> <td>Hywel Dda</td> <td>45</td> </tr> </tbody> </table> <p><a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
Area	Percentage of people who can speak Welsh												
Carmarthenshire	53.3												
Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
If you have determined no impact, please provide a brief explanation.	<b>No Impact identified</b>												

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

### **Additional considerations**

**In addition to the above protected characteristics please consider impact on the following:**

- Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)
- Unpaid Carers
- Individuals and communities who experience Digital Exclusion
- Rural and Urban communities
- More info about the comms package that will be required to inform the public about the scope of practice for each option
- More info about the comms package that will be required to inform the public about the specific opening times
- Different communication mechanisms for certain protected characteristics – how will we be promoting to our younger population/older population/LGBTQ+ population. I'm thinking specifically in terms of newspaper adds, social media ads
- Utilising the medical and nursing workforce to a 14(&2) model enhances the MIU skill set, reducing gaps within the roster and allows improved quality, safety and timely care to be delivered within these agreed hours.
- Reduction in staff anxiety, morale and in turn reduces staff sickness absence.
- Improved recruitment within the GP/Medical workforce due to reduced risk within the department.

**As mentioned above the CDOT team and other key stakeholders will be used to communicate this change of hours.**

**Messages will be translated to the languages that are required.**

**Easy read versions of the communication will be made available.**

### **Intersectionality**

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

**Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

**Please note - All white boxes within this EqlA must be completed, please do not leave them blank.**

**Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?**

Not applicable

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

**Section 4: Assessment of Scale of Impact**

In this scoring section, you need to assign two scores: a **likelihood score** and an **opportunity/impact score**. The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores will automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

**(Likelihood Score x opportunity/impact Score = Total Score)**

OPPORTUNITY AND IMPACT		
IMPACT	SCORE	The proposed change is anticipated to lead to the following level of opportunity and/or impact:
<b>Positive</b>	<b>5</b>	Excellence (Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	<b>4</b>	Major (Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	<b>3</b>	Moderate (Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	<b>2</b>	Minor (Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	<b>1</b>	Negligible (Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
<b>Neutral</b>	<b>0</b>	Neutral (Neutral): No effect, either positive or negative.
<b>Negative</b>	<b>-1</b>	Negligible (Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	<b>-2</b>	Minor (Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	<b>-3</b>	Moderate (Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	<b>-4</b>	Major (Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	<b>-5</b>	Catastrophic (Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occurring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT					
		5	4	3	2	1	0	-1	-2	-3	-4	-5
5	25	20	15	10	5	0	-5	-10	-15	-20	-25	
4	20	16	12	8	4	0	-4	-8	-12	-16	-20	
3	15	12	9	6	3	0	-3	-6	-9	-12	-15	
2	10	8	6	4	2	0	-2	-4	-6	-8	-10	
1	5	4	3	2	1	0	-1	-2	-3	-4	-5	

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

---

**\*\*To access the scoring table below you will need to double click on the table to open an editable version. The information you input will remain when you click back on the word document.**

---

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity / Consequence Rating*	*IIA Matrix		
	Positive impact	Neutral impact	Negative impact	Unknown		Consequence	Likelihood	Total Score
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative								
Age					** positive rating	3	3	9
					** negative rating	-3	3	-9
Disability					** positive rating			0
					** negative rating	-3	3	-9
Gender Reassignment					** positive rating			0
					** negative rating			0
Marriage and Civil Partnership					** positive rating			0
					** negative rating	-2	3	-6
Pregnancy and Maternity					** positive rating	4	2	8
					** negative rating			0
Race/Ethnicity or Nationality					** positive rating	3	3	9
					** negative rating	-3	3	-9
Religion or Belief					** Positive rating			0
					** negative rating	-3	3	-9
Sex					** positive rating			0
					** negative rating			0
Sexual Orientation					** positive rating			0
					** negative rating			0
Armed Forces					** positive rating			0
					** negative rating	-3	3	-9
Socio-economic Deprivation					** positive rating			0
					** negative rating	-4	3	-12
Welsh Language					** positive rating			0
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

**Section 5: Outcome and Actions**

This section should be used to detail and monitor any actions identified in sections 1-4.

<p><b>Will the procedure/ proposal/ project/ policy be adopted? If no, please give reasons and any alternative action(s) agreed.</b></p>	<p>Process remains active re long term MIU Model</p>
<p><b>If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.</b></p>	

	<b>Actions</b>	<b>Assigned to</b>	<b>Target Review Date</b>	<b>Completion Date</b>	<b>Comments/ Update</b>
	<ul style="list-style-type: none"> <li>Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified.</li> <li>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.</li> </ul>				
1.	<p><b>What additional monitoring data will be collected around the impact of procedure/ proposal/ project/ policy once adopted? How will this be collected?</b></p> <p><b>Audits – redirection policy</b>  <b>Attendances</b> (Major &amp; Minor split)  <b>Incidents/</b> Risk register review  <b>Complaints</b>            Patient feedback – CIVICA            4- &amp; 12-hour performance– breach data            Workforce data review – sickness absence themes</p>	Jon Morris Iona Evans Meinir Williams	3 months post closure	13 <sup>th</sup> Feb 2025	<p>Monthly review of data to determine impact of closure captured.</p> <p>Feedback provided within Quality, Safety &amp; Experience Committee Meeting (13/02/2025)</p>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

2.	<b>MIU Project Group underway to scope long term modelling of the unit – series of options for delivery of the MIU in response to service fragilities’ and/or unsustainability – 4 options remain.</b>	Sarah Perry Robin Ghosal Iona Evans Jon Morris	27 <sup>th</sup> March 2025	Pending Board Meeting outcome	Depending on Board outcome will determine next steps.
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>EqIA Completed by:</b>	<b>Name/s</b>	Iona Evans /Jon Morris
	<b>Title</b>	Interim HoN GGH & PPH/ Clinical Lead MIU
	<b>Team / Division</b>	Unscheduled Care
	<b>Contact details</b>	iona.evans@wales.nhs.uk/jon.morris2@wales.nhs.uk
	<b>Date</b>	23/03/2025
<b>EqIA Authorised by/Owned by:</b> <ul style="list-style-type: none"> <li>Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy</li> <li>Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5</li> </ul>	<b>Name</b>	Sarah Perry
	<b>Title</b>	GM Carmarthenshire System
	<b>Team / Division</b>	Unscheduled Care/Community
	<b>Contact details</b>	Sarah.Perry3@wales.nhs.uk
	<b>Date</b>	23/03/2025
<b>Guidance has been provided by Diversity &amp; Inclusion Team:</b>	<b>Name</b>	Alan Winter
	<b>Title</b>	Senior Diversity and Inclusion Officer
	<b>Team</b>	Strategic Partnership Diversity & Inclusion
	<b>Contact details</b>	<a href="mailto:Alan.winter@wales.nhs.uk">Alan.winter@wales.nhs.uk</a>
	<b>Date</b>	24/3/2025
<b>Diversity and Inclusion Team additional Comments:</b>		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

## **Hywel Dda University Health Board Equality Impact Assessment (EqIA)**

<b>Director and Directorate</b>	Andrew Carruthers - Unscheduled Care Prince Philip Hospital (PPH)
<b>Service Area</b>	Minor Injuries Unit - Option 3 - Doctor-led phased (12hours, 14hours, 24hours)

### **What is an Equality Impact Assessment (EqIA)?**

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

### **Why do they have to be completed?**

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the [Equality Act 2010](#) with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

### **When should they be completed?**

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

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 you will also need to consider

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

**Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.**

### **Support**

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: [Inclusion.hdd@wales.nhs.uk](mailto:Inclusion.hdd@wales.nhs.uk)

Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

<p>1. <b>What are you Equality Impact assessing?</b></p>	<p>Phased option, doctor-led from 12-hours up to 24-hours – this would initially be open to the public for the current 12 hours, plus two hours staffing, moving to 16 hours, inclusive of two hours staffing, and ultimately 24 hours overall.</p>
<p>2. <b>Brief Aims and Description of the procedure/ proposal/ project/ policy:</b></p>	<p>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) to meet local population needs within the new proposed times.</p>
<p>3. <b>Who is involved in undertaking this EqIA? (names/job titles)</b></p>	<p>Jon Morris (Clinical Lead MIU), Iona Evans (Interim Head of Nursing GGH &amp; PPH USC), Meinir Williams (Deputy Head of Nursing PPH USC)</p>
<p>4. <b>Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?</b></p>	<p>No</p>
<p>5. <b>Is this a new EqIA or an updated EqIA?</b></p>	<p>New <input checked="" type="checkbox"/> Updated <input type="checkbox"/> Date of original or last version of the EqIA: Please give details / explain any amendments – New template/additional information.</p>
<p>6. <b>Who will be affected by the procedure/ proposal/ project/ policy development?</b> (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)</p>	<ul style="list-style-type: none"> <li>• Local Population using the MIU.</li> <li>• Staff working within the MIU / AMAU.</li> <li>• Patients using either GGH or Morriston.</li> <li>• Staff working in GGH &amp; MGH due to increase demands from GGH site Sample audit November 2022 – 11.45% from Swansea Bay area_Sample audit for 2 weeks Dec 2023 <a href="https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhqXnLqGN4SljtcDYK7c5IPyTcuIB&amp;id=uChWuyijgkCoVkM8ntyPrigXtKx9OJBDim5W0Zv5x3tUMFRLVINLVEZITDhZVDZGNzhMOUFIUUF CWi4u">https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhqXnLqGN4SljtcDYK7c5IPyTcuIB&amp;id=uChWuyijgkCoVkM8ntyPrigXtKx9OJBDim5W0Zv5x3tUMFRLVINLVEZITDhZVDZGNzhMOUFIUUF CWi4u</a></li> </ul>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p>7. What might help/hinder the success of the procedure/ proposal/ project/ policy?</p>	<p>Help:</p> <ul style="list-style-type: none"> <li>• HIW Inspection recommendations</li> <li>• Clinical Team support</li> <li>• Executive support including Core Delivery Group and the Operational Planning Governance and Performance Group</li> <li>• Communication and Engagement strategy</li> <li>• Trade Unions / HR</li> <li>• Welsh Government</li> </ul> <p>Hinder:</p> <ul style="list-style-type: none"> <li>• Public (and public representation groups) opposition/resistance to a reduced service.</li> <li>• Political opposition</li> <li>• Media</li> </ul>

## Section 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 **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
<p><b>Article 2: The right to life.</b>  <b>Example:</b> The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.</p>	✓	
<p><b>Article 3: The right not to be tortured or treated in an inhuman or degrading way.</b></p>	✓	

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p><b>Example:</b> 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</p>		
<p><b>Article 5: The right to liberty</b>  <b>Example:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p><b>Article 6: The right to a fair trial</b>  <b>Example:</b> issues of patient choice, control, empowerment and independence</p>	✓	
<p><b>Article 8: The right to respect for private and family life, home and correspondence.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 11: The right to freedom of thought, conscience and religion</b>  <b>Example:</b> 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</p>	✓	

### Section 3: Gathering of Evidence and Assessment of Potential Impact

<p><b>How will the procedure/ proposal/ project/ policy impact on Age:</b>          Is it likely to affect older and younger people in different ways or affect one age group and not another?</p>	Positive	✓
	Negative	✓
	No Impact	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA and upload relevant data.</p>	<p><b>Population Data</b></p> <table border="1"> <thead> <tr> <th>County</th> <th colspan="2">Carmarthenshire</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Age</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Total: All usual residents</td> <td>187,897</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td>Aged 4 years and under</td> <td>9,057</td> <td>4.8</td> <td>1,422.4</td> <td>5.6</td> </tr> <tr> <td>Aged 5 to 9 years</td> <td>10,274</td> <td>5.5</td> <td>1,524</td> <td>6</td> </tr> <tr> <td>Aged 10 to 19 years</td> <td>20879</td> <td>11.2</td> <td>3,048</td> <td>12</td> </tr> <tr> <td>Aged 20 to 24 years</td> <td>8,820</td> <td>4.7</td> <td>1,447.8</td> <td>5.7</td> </tr> <tr> <td>Aged 25 to 34 years</td> <td>20,692</td> <td>11</td> <td>3,225.8</td> <td>11.8</td> </tr> <tr> <td>Aged 35 to 49 years</td> <td>31,802</td> <td>16.9</td> <td>4,749.8</td> <td>18.7</td> </tr> <tr> <td>Aged 50 to 64 years</td> <td>40,906</td> <td>21.8</td> <td>5,054.6</td> <td>19.9</td> </tr> <tr> <td>Aged 65 to 74 years</td> <td>24,603</td> <td>13.1</td> <td>2,616.2</td> <td>10.3</td> </tr> <tr> <td>Aged 75 to 84 years</td> <td>15,247</td> <td>8.1</td> <td>1,600.2</td> <td>6.3</td> </tr> <tr> <td>Aged 85 years and over</td> <td>5,617</td> <td>3</td> <td>711.2</td> <td>2.8</td> </tr> </tbody> </table> <p><a href="#">Build a custom area profile - Census 2021, ONS 03/07/2024</a></p>					County	Carmarthenshire		Llanelli		Age	Value	%	Value	%	Total: All usual residents	187,897	100	25,400	100	Aged 4 years and under	9,057	4.8	1,422.4	5.6	Aged 5 to 9 years	10,274	5.5	1,524	6	Aged 10 to 19 years	20879	11.2	3,048	12	Aged 20 to 24 years	8,820	4.7	1,447.8	5.7	Aged 25 to 34 years	20,692	11	3,225.8	11.8	Aged 35 to 49 years	31,802	16.9	4,749.8	18.7	Aged 50 to 64 years	40,906	21.8	5,054.6	19.9	Aged 65 to 74 years	24,603	13.1	2,616.2	10.3	Aged 75 to 84 years	15,247	8.1	1,600.2	6.3	Aged 85 years and over	5,617	3	711.2	2.8
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<p>Insert an age breakdown of those affected. This data can be recorded in table or free text format.</p> <p>If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</p>	<p><b>Patient data – last 3 years (April 21- July 2024)</b></p> <table border="1"> <thead> <tr> <th>Patient Age</th> <th>Attendances</th> </tr> </thead> <tbody> <tr> <td>Age: 0-9</td> <td>9,695</td> </tr> <tr> <td>Age: 10-19</td> <td>16,094</td> </tr> <tr> <td>Age: 20-29</td> <td>14,304</td> </tr> <tr> <td>Age: 30-39</td> <td>14,004</td> </tr> <tr> <td>Age: 40-49</td> <td>11,557</td> </tr> <tr> <td>Age: 50-59</td> <td>12,689</td> </tr> <tr> <td>Age: 60-69</td> <td>10,516</td> </tr> <tr> <td>Age: 70-79</td> <td>9,503</td> </tr> <tr> <td>Age: 80-89</td> <td>5,682</td> </tr> <tr> <td>Age: 90-99</td> <td>1,072</td> </tr> <tr> <td>Age: 100 +</td> <td>27</td> </tr> <tr> <td><b>TOTAL</b></td> <td><b>105,143</b></td> </tr> </tbody> </table>					Patient Age	Attendances	Age: 0-9	9,695	Age: 10-19	16,094	Age: 20-29	14,304	Age: 30-39	14,004	Age: 40-49	11,557	Age: 50-59	12,689	Age: 60-69	10,516	Age: 70-79	9,503	Age: 80-89	5,682	Age: 90-99	1,072	Age: 100 +	27	<b>TOTAL</b>	<b>105,143</b>																																							
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	Age: 100 +	27																																																																				
<b>TOTAL</b>	<b>105,143</b>																																																																					

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Insert breakdown of staff age in the specific service/ area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.

**Staff data- Emergency Nurse Practitioner (ENP) staff age range between 37- 63 years. Average age of 54 years with 4 ENP retire and return. Difficulty in recruiting into 3 wte ENP vacancy previously which resulted in the appointment of X3 ENP trainees to mitigate the fragility and risk within this workforce in the event of full retirement/leavers.**

**Further recruitment of the GP/medical and nursing workforce would be required to be able to work towards the 24-hour option.**

GRADE	ACTUAL W.T.E	Age	COMMENTS
7	1.00	49 yrs	commencing 19th August
7 ENP	0.40	62yrs	Retire and return
7 ENP	0.80	54yrs	
7 ENP	0.20	63yrs	Retire and return
7 ENP	0.96	51yrs	
7 ENP	0.80	47yrs	
7 ENP	0.80	53yrs	
7 ENP	0.40	62yrs	
7 ENP	0.92	47yrs	
7 ENP	0.96	38yrs	
7 ENP	1.00	53yrs	
7 ENP	0.50	56yrs	Retire and return
7 ENP	0.40	49yrs	
7 ENP	0.50	56yrs	Retire and return
6 ENP	1.00	39yrs	Trainee ENP
6 ENP	1.00	53yrs	Trainee ENP
6 ENP	1.00	37yrs	Trainee ENP

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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Older and younger populations may be more dependent on public transport and or others to bring them to healthcare settings as they may be too young to have a drivers' license or are unable to drive due to age related fragilities.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> <li>• Due to transport concerns and unavailability of public transport, taxi costs, ambulance waits, may result in patients who do not meet the MIU criteria to attend the unit due to no other means of travel OOH or difficulty in accessing medical support.</li> <li>• The phased approach of returning to a 24-hour service, may impact on the work life balance of the GP/medical and nursing workforce to cover the night shift (of which has previously been difficult to source cover).</li> <li>• Risk of patients attending overnight (when 24 hours) who do not meet the criteria of the MIU, resulting in inappropriate patients being held, which in turn may increase the staff anxiety and risk due to working outside scope of practice. May impact on recruitment, retention and sickness absence.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently, therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in many instances, wait until the following morning to be seen and treated therefore they will not be required to travel further for treatment or be reliant on travelling when public transport is available.</li> <li>• Educate the public on appropriate access of service in relation to the care that can be provided by MIU. This correspondence will need to be in accessible formats to ensure the elderly who may have sight loss, deteriorating mental capacity etc. are able to understand. Choose well posters within the reception area</li> <li>• Working with HDUHB communication team and Welsh Ambulance Service / Police/NHS 111 Wales/Primary and Secondary services, Local Authority and volunteer/charity services.</li> </ul>
<p>Provide a brief summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>• <b>The 24 hour option may provide a more robust opportunity for flexible working which some staff groups may prefer to ensure a positive work life balance.</b></li> </ul>	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>How will the procedure/ proposal/ project/ policy impact on Disability:</b> Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.</p>		<p><b>Positive</b> ✓</p>																																																																																																								
		<p><b>Negative</b> ✓</p>																																																																																																								
		<p><b>No Impact</b></p>																																																																																																								
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<p>Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)</p> <p>If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</p>	<p>Mental Health activity:</p> <table border="1"> <thead> <tr> <th rowspan="2">Month</th> <th colspan="2">MIU Referrals</th> <th colspan="2">Ward Referrals</th> <th colspan="2">08:00 - 20:00 - 20:00 08:00</th> </tr> <tr> <th>18-70</th> <th>70+</th> <th>18-70</th> <th>70+</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Feb-24</td> <td>79</td> <td>0</td> <td>15</td> <td>9</td> <td>56</td> <td>47</td> </tr> <tr> <td>Jan-24</td> <td>76</td> <td>2</td> <td>14</td> <td>9</td> <td>58</td> <td>43</td> </tr> <tr> <td>Dec-23</td> <td>78</td> <td>2</td> <td>12</td> <td>12</td> <td>65</td> <td>39</td> </tr> <tr> <td>Nov-23</td> <td>71</td> <td>1</td> <td>13</td> <td>19</td> <td>71</td> <td>33</td> </tr> <tr> <td>Oct-23</td> <td>61</td> <td>2</td> <td>8</td> <td>19</td> <td>66</td> <td>24</td> </tr> <tr> <td>Sep-23</td> <td>39</td> <td>2</td> <td>11</td> <td>6</td> <td>43</td> <td>15</td> </tr> <tr> <td>Aug-23</td> <td>52</td> <td>2</td> <td>28</td> <td>11</td> <td>54</td> <td>39</td> </tr> <tr> <td>Jul-23</td> <td>54</td> <td>1</td> <td>19</td> <td>8</td> <td>52</td> <td>30</td> </tr> <tr> <td>Jun-23</td> <td>65</td> <td>2</td> <td>16</td> <td>4</td> <td>52</td> <td>35</td> </tr> <tr> <td>May-23</td> <td>63</td> <td>4</td> <td>13</td> <td>9</td> <td>55</td> <td>34</td> </tr> <tr> <td>Apr-23</td> <td>68</td> <td>0</td> <td>12</td> <td>11</td> <td>57</td> <td>34</td> </tr> <tr> <td>Mar-23</td> <td>42</td> <td>0</td> <td>1</td> <td>8</td> <td>30</td> <td>21</td> </tr> <tr> <td>Feb-23</td> <td>50</td> <td>1</td> <td>9</td> <td>8</td> <td>52</td> <td>16</td> </tr> </tbody> </table>		Month	MIU Referrals		Ward Referrals		08:00 - 20:00 - 20:00 08:00		18-70	70+	18-70	70+			Feb-24	79	0	15	9	56	47	Jan-24	76	2	14	9	58	43	Dec-23	78	2	12	12	65	39	Nov-23	71	1	13	19	71	33	Oct-23	61	2	8	19	66	24	Sep-23	39	2	11	6	43	15	Aug-23	52	2	28	11	54	39	Jul-23	54	1	19	8	52	30	Jun-23	65	2	16	4	52	35	May-23	63	4	13	9	55	34	Apr-23	68	0	12	11	57	34	Mar-23	42	0	1	8	30	21	Feb-23	50	1	9	8	52	16
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	TOTAL	798	19	171	133	711	410
Insert breakdown of staff with a disability who may be affected by your specific service/area of work.	<p><b>Staff data:</b>            No staff disabilities on record.            No mental Health issues captured.</p>						
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Those with disabilities may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> <li>• Communicating the new hours may be difficult for people who have certain neuro-diverse conditions, learning disabilities or sensory loss. Phased approach may lead to confusion within accessibility of unit.</li> <li>• It could be perceived that people needing attention for mental health concerns may be negatively impacted by the reduction hours, but mental health conditions are already outside the scope of MIU therefore should not be treated here.</li> </ul>			<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated. Opportunity to develop timed slots.</li> <li>• Review of appropriate MIU modelling and key education to the public on criteria of acceptances in MIU.</li> <li>• Ensure all communication regarding the changing of hours is available in accessible formats, easy read, braille etc.</li> <li>• 111 option 2 promotion. This has been a national campaign with NHS Wales and is available 24 hours a day. It is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis, or requiring support to manage their symptoms. Posters displayed in MIU and patient advised on Triage to ring</li> </ul>			

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- Parking – is there likely to be an increase of the use of disabled bays due to condensed hours (For 12 & 14 hour option)? How many do we currently have? Is it sufficient from the patient data for disability?
- Staff with certain disabilities may only be able to work night shift as they are reliant on family/ public transport for lifts to work etc.
- Are there any scenarios where disabled staff need to work night shift? Menopause, ADHD etc?

- There are 5 allocated bays outside MIU. There is also a drop off area outside the entrance. Current percentage in relation to spaces is 5% which fits into the 4-6% guidelines.
- No concerns re parking OOH (overnight).

Opportunity to support flexible working with a 24 hour model (as a phased approach) including night shift.

-

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<b>How will the procedure/ proposal/ project/ policy impact on Gender Reassignment:</b> Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.		Positive																															
		Negative																															
		No Impact	✓																														
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" data-bbox="371 379 1523 783"> <thead> <tr> <th data-bbox="371 379 1050 419">County</th> <th data-bbox="1057 379 1296 419">Carmarthenshire</th> <th data-bbox="1303 379 1523 419"></th> </tr> <tr> <th data-bbox="371 419 1050 459">Gender</th> <th data-bbox="1057 419 1296 459">value</th> <th data-bbox="1303 419 1523 459">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 459 1050 491">All usual residents aged 16 and over</td> <td data-bbox="1057 459 1296 491">155,486</td> <td data-bbox="1303 459 1523 491">100</td> </tr> <tr> <td data-bbox="371 491 1050 531">Gender identity the same as sex registered at birth</td> <td data-bbox="1057 491 1296 531">144,924</td> <td data-bbox="1303 491 1523 531">93.2</td> </tr> <tr> <td data-bbox="371 531 1050 603">Gender identity different from sex registered at birth but no specific identity given</td> <td data-bbox="1057 531 1296 603">210</td> <td data-bbox="1303 531 1523 603">0.1</td> </tr> <tr> <td data-bbox="371 603 1050 643">Trans woman</td> <td data-bbox="1057 603 1296 643">93</td> <td data-bbox="1303 603 1523 643">0.1</td> </tr> <tr> <td data-bbox="371 643 1050 683">Trans man</td> <td data-bbox="1057 643 1296 683">90</td> <td data-bbox="1303 643 1523 683">0.1</td> </tr> <tr> <td data-bbox="371 683 1050 722">Non-binary</td> <td data-bbox="1057 683 1296 722">60</td> <td data-bbox="1303 683 1523 722">0.0</td> </tr> <tr> <td data-bbox="371 722 1050 762">All other gender identities</td> <td data-bbox="1057 722 1296 762">38</td> <td data-bbox="1303 722 1523 762">0.0</td> </tr> <tr> <td data-bbox="371 762 1050 783">Not answered</td> <td data-bbox="1057 762 1296 783">10,072</td> <td data-bbox="1303 762 1523 783">6.5</td> </tr> </tbody> </table> <p data-bbox="371 783 965 815">Data retrieved from Census 2021 data 24/06/2024</p>			County	Carmarthenshire		Gender	value	%	All usual residents aged 16 and over	155,486	100	Gender identity the same as sex registered at birth	144,924	93.2	Gender identity different from sex registered at birth but no specific identity given	210	0.1	Trans woman	93	0.1	Trans man	90	0.1	Non-binary	60	0.0	All other gender identities	38	0.0	Not answered	10,072	6.5
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If you have determined no impact, please provide a brief explanation.	<p data-bbox="371 863 517 895"><b>No Impact</b></p> <p data-bbox="371 895 2159 970">The current unit and its limited accommodation has a single unisex/disabled toilet and shower facilities. No additional impact in the context of gender reassignment with this service change.</p>																																

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How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	✓
		Negative	✓
		No Impact	
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population Data</b></p> <p>Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.</p> <p>In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</a></p> <p>In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</a></p> <p>In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</a></p>		
<p>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format.</p>	<p><b>Patient data</b> - no information available.</p> <p>This will require monitoring in relation to any childcare concerns raised by patients and the dependency on spouse to support MIU attendance, as well as transport to and from the MIU. Monitor through Patient feedback.</p>		
<p>Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.</p>	<p>No information available.</p> <p>Monitor any staff impact of amended hours on dependency/ability on spouse in relation to childcare needs as well as transport to and from MIU (if required). This can be mitigated by the flexible working policy and effective roster management. Capture staff who are working through flexible working request on ESR.</p> <p>Working towards a 24 hour model will provide increased flexibility for staff to cover and work night shifts to support childcare and key marriage and civil partnership dependencies.</p>		

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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Staff may be reliant on their partners for lifts to and from work a change in working hours (through the phased approach).</li> <li>• .</li> <li>• Working over a 24 hour period (nights) may not be suitable for all staff due to dependencies within child care and marriage/civil partnership constraints.</li> <li>• Some households may be negatively impacted by this change due to shared childcare arrangements between shift work.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Flexible working policy.</li> <li>• Ability to request % of shifts within roster.</li> <li>• All rosters completed six weeks in advance.</li> </ul>
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How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.		Positive	✓
		Negative	
		No Impact	
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format.	No information available, there aren't any gynaecological service in PPH. Capture of data relating to re-direction underway. Any adverse incidents are captured via Incident reporting (Datix).		
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.	No information available:  Leave and Pay For New and Existing Parent policy  <a href="https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/">https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/</a>  Monitor through Managing attendance at work policy – ESR data.		
Provide a summary of the positive impacts you have identified.	<b>Positive Impact</b> <ul style="list-style-type: none"> <li>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) will promote and highlight key criteria and will support signposting of patients to the right place first time.</li> </ul>		

How will the procedure/ proposal/ project/ policy on 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. Also includes citizenship.		Positive	✓
		Negative	✓
		No Impact	

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Another ethnic group	714	0.4	1523	0.6																																									
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>It may be difficult to communicate this change with some hard-to-reach minority communities or those who speak a different language from English and Welsh.</li> <li>Phased approach may cause confusion within the accessibility of the unit.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>Link in with Community Development Outreach Team (CDOT) to support key communication. engaging with specific ethnic minority groups in the local area via the CDOT and will share key messages in the development stages with ethnic minority communities affected by this change in an appropriate language and communication method.</li> <li>Translation Services – ensure all communication is translated and in accessible formats, such as easy read format.</li> <li>Clear criteria for overseas visitors accessing MIU service.</li> <li>Working with Health Board communications.</li> </ul>																																											
<p>Provide a summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>Greater accessibility to support services e.g., translation services will always be available within the revised operating hours.</li> </ul>																																												

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.					Positive	✓																																																												
					Negative	✓																																																												
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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="367 352 1375 874"> <thead> <tr> <th data-bbox="367 352 663 395">County</th> <th colspan="2" data-bbox="663 352 1048 395">Carms</th> <th colspan="2" data-bbox="1048 352 1375 395">Llanelli</th> </tr> <tr> <th data-bbox="367 395 663 438">Religion</th> <th data-bbox="663 395 860 438">Value</th> <th data-bbox="860 395 1048 438">%</th> <th data-bbox="1048 395 1211 438">Value</th> <th data-bbox="1211 395 1375 438">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 438 663 504">Total: All usual residents</td> <td data-bbox="663 438 860 504">187,899</td> <td data-bbox="860 438 1048 504">100</td> <td data-bbox="1048 438 1211 504">25,400</td> <td data-bbox="1211 438 1375 504">%</td> </tr> <tr> <td data-bbox="367 504 663 547">No religion</td> <td data-bbox="663 504 860 547">83,409</td> <td data-bbox="860 504 1048 547">44.4</td> <td data-bbox="1048 504 1211 547">12,395</td> <td data-bbox="1211 504 1375 547">48.8</td> </tr> <tr> <td data-bbox="367 547 663 590">Christian</td> <td data-bbox="663 547 860 590">89,378</td> <td data-bbox="860 547 1048 590">47.6</td> <td data-bbox="1048 547 1211 590">10,922</td> <td data-bbox="1211 547 1375 590">43</td> </tr> <tr> <td data-bbox="367 590 663 633">Buddhist</td> <td data-bbox="663 590 860 633">557</td> <td data-bbox="860 590 1048 633">0.3</td> <td data-bbox="1048 590 1211 633">76</td> <td data-bbox="1211 590 1375 633">0.3</td> </tr> <tr> <td data-bbox="367 633 663 676">Hindu</td> <td data-bbox="663 633 860 676">419</td> <td data-bbox="860 633 1048 676">0.2</td> <td data-bbox="1048 633 1211 676">51</td> <td data-bbox="1211 633 1375 676">0.2</td> </tr> <tr> <td data-bbox="367 676 663 719">Jewish</td> <td data-bbox="663 676 860 719">103</td> <td data-bbox="860 676 1048 719">0.1</td> <td data-bbox="1048 676 1211 719">25</td> <td data-bbox="1211 676 1375 719">0.1</td> </tr> <tr> <td data-bbox="367 719 663 762">Muslim</td> <td data-bbox="663 719 860 762">1,026</td> <td data-bbox="860 719 1048 762">0.5</td> <td data-bbox="1048 719 1211 762">229</td> <td data-bbox="1211 719 1375 762">0.9</td> </tr> <tr> <td data-bbox="367 762 663 805">Sikh</td> <td data-bbox="663 762 860 805">177</td> <td data-bbox="860 762 1048 805">0.1</td> <td data-bbox="1048 762 1211 805">25</td> <td data-bbox="1211 762 1375 805">0.1</td> </tr> <tr> <td data-bbox="367 805 663 849">Other religion</td> <td data-bbox="663 805 860 849">1,127</td> <td data-bbox="860 805 1048 849">0.6</td> <td data-bbox="1048 805 1211 849">153</td> <td data-bbox="1211 805 1375 849">0.6</td> </tr> <tr> <td data-bbox="367 849 663 874">Not answered</td> <td data-bbox="663 849 860 874">11,703</td> <td data-bbox="860 849 1048 874">6.2</td> <td data-bbox="1048 849 1211 874">1524</td> <td data-bbox="1211 849 1375 874">6</td> </tr> </tbody> </table> <p data-bbox="367 874 965 906">Data retrieved from Census 2021 data 03/07/2024</p>					County	Carms		Llanelli		Religion	Value	%	Value	%	Total: All usual residents	187,899	100	25,400	%	No religion	83,409	44.4	12,395	48.8	Christian	89,378	47.6	10,922	43	Buddhist	557	0.3	76	0.3	Hindu	419	0.2	51	0.2	Jewish	103	0.1	25	0.1	Muslim	1,026	0.5	229	0.9	Sikh	177	0.1	25	0.1	Other religion	1,127	0.6	153	0.6	Not answered	11,703	6.2	1524	6	
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<p>Insert breakdown of Religion or Belief (or non-belief) of staff affected by your specific service/area of work.</p>	<p><b>Staff data – No information relating to any impact. Consideration as applicable of religion and/or belief. Data collated via ESR.</b></p>																																																																	
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</p>	<p><b>Negative Impact</b></p> <ul data-bbox="421 1150 1285 1251" style="list-style-type: none"> <li>The phased approach will include the need to work towards a 24-hour roster – this may not support all staff groups relating to religion and beliefs.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul data-bbox="1375 1150 2152 1393" style="list-style-type: none"> <li>Promotion of diversity and Inclusion within Health Board staff.</li> <li>Access to Religion and Beliefs Learning Resources for staff.</li> <li>Diversity Calendar promotion</li> <li>Flexible working policy</li> <li>Equality, Diversity and Inclusion Policy</li> </ul>																																																																

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relevant negative impact.		<ul style="list-style-type: none"> <li>The 24-hour option may give further flexibility to support staff to maintain their religion/beliefs</li> </ul>
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<b>How will the procedure/ proposal/ project/ policy impact on Sex</b> Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	Positive	
	Negative	
	No Impact	✓

<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #0070c0; color: white;">County</th> <th colspan="2" style="background-color: #0070c0; color: white;">Carms</th> <th colspan="2" style="background-color: #0070c0; color: white;">Llanelli</th> </tr> <tr> <th style="background-color: #0070c0; color: white;">Gender</th> <th style="background-color: #0070c0; color: white;">Value</th> <th style="background-color: #0070c0; color: white;">%</th> <th style="background-color: #0070c0; color: white;">Value</th> <th style="background-color: #0070c0; color: white;">%</th> </tr> </thead> <tbody> <tr> <td style="background-color: #0070c0; color: white;">All persons</td> <td>187,897</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td style="background-color: #0070c0; color: white;">Male</td> <td>91,685</td> <td>48.8</td> <td>12,421</td> <td>48.9</td> </tr> <tr> <td style="background-color: #0070c0; color: white;">Female</td> <td>96,212</td> <td>51.2</td> <td>13,979</td> <td>51.1</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p>					County	Carms		Llanelli		Gender	Value	%	Value	%	All persons	187,897	100	25,400	100	Male	91,685	48.8	12,421	48.9	Female	96,212	51.2	13,979	51.1
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If you have determined no impact, please provide a brief explanation.	<b>No Impact</b> <ul style="list-style-type: none"> <li>Applies to both sexes equally. No discrimination in the context of sex. The current unit and its limited accommodation, with a single unisex/ disabled toilet and shower facilities.</li> </ul>
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How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		Positive							
		Negative							
		No Impact		✓					
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>								
		<b>County</b>							
		<b>Carms</b>		<b>Ceredigion</b>		<b>Pembs</b>		<b>Totals</b>	
	Sexual Orientation	Value	%	Value	%	Value	%	Value	%
	Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0
	Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
	Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
	Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5
	Pansexual	120	0.1	150	0.2	80	0.1	350	0.2
	Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0.0	49	0.1	12	0	84	0.0	
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1	
<a href="https://www.ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a>									
If you have determined no impact, please provide a brief explanation.	<b>No Impact</b> There is no discrimination identified based on sexual orientation								

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<p><b>How will the procedure/ proposal/ project/ policy impact on Armed Forces</b>          Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'</p> <p>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:  <a href="#"><u>Armed-Forces-Covenant-duty-statutory-guidance</u></a></p>	<b>Positive</b>	✓
	<b>Negative</b>	✓
	<b>No Impact</b>	

<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<b>Population Data</b>				
		<b>Carmarthenshire (%)</b>	<b>Pembrokeshire (%)</b>	<b>Ceredigion (%)</b>	<b>Hywel Dda (%)</b>
	<b>Regular</b>	3.6	4.5	3	3.7
	<b>Reserve</b>	0.9	0.9	0.9	0.9
	<b>Both</b>	0.2	0.2	0.2	0.2
	<b>Total</b>	4.7	5.7	4.1	4.8
<p><a href="#"><u>People, population and community - Office for National Statistics (ons.gov.uk)</u></a></p>					

<p>If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community.</p>	<p><b>Patient data – no information. Promotion of Armed Forces identification to be captured on WPAS.</b></p>
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• This populations may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours (on a 12 and 14 hour phase) may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated.</li> <li>• Educate the public on criteria of acceptances in MIU through communication supported by Choose Well NHS 111 Wales.</li> <li>• Awareness and reference to the All Wales Reserve Forces Training &amp; Mobilisation policy.</li> <li>• Utilisation of the Hywel Dda Strategic Partnerships Diversity &amp; Inclusion Armed Forces SharePoint page.</li> <li>• Phased approach to 24 hours will support and minimise this impact.</li> </ul>
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<p><b>Socio-economic Deprivation</b>          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.</p> <p>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: <a href="https://gov.wales/more-equal-wales-socio-economic-duty">https://gov.wales/more-equal-wales-socio-economic-duty</a></p>		<p><b>Positive</b></p>	<p>✓</p>																								
		<p><b>Negative</b></p>	<p>✓</p>																								
		<p><b>No Impact</b></p>																									
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="369 550 1377 829"> <thead> <tr> <th rowspan="2">Economic Factor</th> <th colspan="2">Carmarthenshire</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Economically active – In employment (this includes full time students)</td> <td>81,952</td> <td>52.7</td> <td>12,234</td> <td>52.1</td> </tr> <tr> <td>Economically active - Unemployed</td> <td>3,922</td> <td>2.5</td> <td>914</td> <td>3.6</td> </tr> <tr> <td>Economically inactive</td> <td>69,613</td> <td>44.8</td> <td>11,252</td> <td>44.3</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 24/06/2024</p>			Economic Factor	Carmarthenshire		Llanelli		Value	%	Value	%	Economically active – In employment (this includes full time students)	81,952	52.7	12,234	52.1	Economically active - Unemployed	3,922	2.5	914	3.6	Economically inactive	69,613	44.8	11,252	44.3
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<p>If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in table or free text format.</p>	<p><b>Patient data – no information to capture impact of change.</b>  <b>Monitor through patient feedback.</b></p>																										

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<p>Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation.</p>	<p><b>Staff data</b> – no information to capture impact. Monitored via Managing attendance at work policy – ESR data.</p>	
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Staff unable to work night shifts (12 &amp; 14 hour phase) means that they are not able to receive the enhanced allowances.</li> <li>• Patients needing to pay to take public transport.</li> <li>• The cost of childcare may increase if a household is sharing caring responsibilities around shift work.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Consultation with staff</li> <li>• Communication – working with communication team regarding role and function of MIU and transition to a 24 hour service.</li> <li>• Promotion of staff benefits – such as childcare vouchers, discounts.</li> </ul>

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<b>Welsh Language</b> Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.		Positive											
		Negative											
		No Impact	✓										
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>  According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.  Definition of whether a person has Welsh language skills (as recorded in the Census 2022).  If a person can or does do any of the following: <ul style="list-style-type: none"> <li>• Understand spoken Welsh</li> <li>• Speak Welsh</li> <li>• Read Welsh</li> <li>• Write Welsh</li> </ul> <table border="1" data-bbox="371 903 1189 1137"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <tr> <td>Carmarthenshire</td> <td>53.3</td> </tr> <tr> <td>Pembrokeshire</td> <td>25.2</td> </tr> <tr> <td>Ceredigion</td> <td>56.4</td> </tr> <tr> <td>Hywel Dda</td> <td>45</td> </tr> </tbody> </table> <p><a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
Area	Percentage of people who can speak Welsh												
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Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
If you have determined no impact, please provide a brief explanation.	<b>No Impact identified</b>												

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### **Additional considerations**

**In addition to the above protected characteristics please consider impact on the following:**

- Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)
- Unpaid Carers
- Individuals and communities who experience Digital Exclusion
- Rural and Urban communities
- more info about the comms package that will be required to inform the public about the scope of practice for each option
- more info about the comms package that will be required to inform the public about the specific opening times
- different communication mechanisms for certain protected characteristics – how will we be promoting to our younger population/older population/LGBTQ+ population. I'm thinking specifically in terms of newspaper adds, social media ads

**As mentioned above the CDOT team and other key stakeholders will be used to communicate this change of hours.**

**Messages will be translated to the languages that are required.**

**Easy read versions of the communication will be made available.**

### **Intersectionality**

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

**Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqlA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

**Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?**

Not applicable

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

**Section 4: Assessment of Scale of Impact**

In this scoring section, you need to assign two scores: a **likelihood score** and an **opportunity/impact score**. The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores will automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

**(Likelihood Score x opportunity/impact Score = Total Score)**

OPPORTUNITY AND IMPACT		
IMPACT	SCORE	The proposed change is anticipated to lead to the following level of opportunity and/or impact:
<b>Positive</b>	5	Excellence (Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major (Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate (Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor (Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible (Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities.
<b>Neutral</b>	0	Neutral (Neutral): No effect, either positive or negative.
<b>Negative</b>	-1	Negligible (Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery.
	-2	Minor (Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate (Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major (Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic (Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

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LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occurring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

		OPPORTUNITY					IMPACT					
LIKELIHOOD		5	4	3	2	1	0	-1	-2	-3	-4	-5
	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5	

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

**\*\*To access the scoring table below you will need to double click on the table to open an editable version. The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity / Consequence Rating*	*IIA Matrix		
	Positive impact	Neutral impact	Negative impact	Unknown		Consequence	Likelihood	Total Score
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative								
Age	✓		✓		** positive rating	3	3	9
					** negative rating	-3	4	-12
Disability	✓		✓		** positive rating	2	3	6
					** negative rating	-2	3	-6
Gender Reassignment		✓			** positive rating			0
					** negative rating			0
Marriage and Civil Partnership	✓		✓		** positive rating	2	3	6
					** negative rating	-3	3	-9
Pregnancy and Maternity	✓				** positive rating	1	2	2
					** negative rating			0
Race/Ethnicity or Nationality	✓		✓		** positive rating	3	3	9
					** negative rating	-3	3	-9
Religion or Belief	✓		✓		** Positive rating	3	3	9
					** negative rating	-3	3	-9
Sex		✓			** positive rating			0
					** negative rating			0
Sexual Orientation		✓			** positive rating			0
					** negative rating			0
Armed Forces	✓		✓		** positive rating	3	3	9
					** negative rating	-3	3	-9
Socio-economic Deprivation	✓		✓		** positive rating	3	3	9
					** negative rating	-3	3	-9
Welsh Language		✓			** positive rating			0
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

**Section 5: Outcome and Actions**

This section should be used to detail and monitor any actions identified in sections 1-4.

<p><b>Will the procedure/ proposal/ project/ policy be adopted? If no, please give reasons and any alternative action(s) agreed.</b></p>	<p>Process remains active re long term MIU Model</p>
<p><b>If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.</b></p>	

	<b>Actions</b>	<b>Assigned to</b>	<b>Target Review Date</b>	<b>Completion Date</b>	<b>Comments/ Update</b>
	<ul style="list-style-type: none"> <li>Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified.</li> <li>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.</li> </ul>				
1.	<p><b>What additional monitoring data will be collected around the impact of procedure/ proposal/ project/ policy once adopted? How will this be collected?</b></p> <p><b>Audits – redirection policy</b>  <b>Attendances</b> (Major &amp; Minor split)  <b>Incidents/</b> Risk register review  <b>Complaints</b>            Patient feedback – CIVICA            4- &amp; 12-hour performance– breach data            Workforce data review – sickness absence themes</p>	Jon Morris Iona Evans Meinir Williams	3 months post closure	13 <sup>th</sup> Feb 2025	<p>Monthly review of data to determine impact of closure captured.</p> <p>Feedback provided within Quality, Safety &amp; Experience Committee Meeting (13/02/2025)</p>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

2.	MIU Project Group underway to scope long term modelling of the unit – series of options for delivery of the MIU in response to service fragilities’ and/or unsustainability – 4 options remain.	Sarah Perry Robin Ghosal Iona Evans Jon Morris	27 <sup>th</sup> March 2025	Pending Board Meeting outcome	Depending on Board outcome will determine next steps.
3.					
4.					
5.					
6.					
7.					
8.					
9.					

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<b>EqIA Completed by:</b>	<b>Name/s</b>	Iona Evans/Jon Morris
	<b>Title</b>	Interim Head of Nursing GGH & PPH / Clinical Lead MIU
	<b>Team / Division</b>	Unscheduled Care
	<b>Contact details</b>	<a href="mailto:iona.evans@wales.nhs.uk">iona.evans@wales.nhs.uk</a> / jon.morris2@wales.nhs.uk
	<b>Date</b>	24/03/2024
<b>EqIA Authorised by/Owned by:</b> <ul style="list-style-type: none"> <li>Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy</li> <li>Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5</li> </ul>	<b>Name</b>	Sarah Perry
	<b>Title</b>	GM Carmarthenshire System
	<b>Team / Division</b>	USC
	<b>Contact details</b>	Sarah.perry3@wales.nhs.uk
	<b>Date</b>	24/03/2025
<b>Guidance has been provided by Diversity &amp; Inclusion Team:</b>	<b>Name</b>	Alan Winter
	<b>Title</b>	Senior Diversity and Inclusion Officer
	<b>Team</b>	Strategic Partnership Diversity & Inclusion
	<b>Contact details</b>	<a href="mailto:Alan.winter@wales.nhs.uk">Alan.winter@wales.nhs.uk</a>
	<b>Date</b>	24/3/2025
<b>Diversity and Inclusion Team additional Comments:</b>		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

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## **Hywel Dda University Health Board Equality Impact Assessment (EqIA)**

<b>Director and Directorate</b>	Andrew Carruthers - Unscheduled Care Prince Philip Hospital (PPH)
<b>Service Area</b>	Minor Injuries Unit - Option 4 - Urgent care centre (SDUC type model) 14 hours

### **What is an Equality Impact Assessment (EqIA)?**

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

### **Why do they have to be completed?**

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the [Equality Act 2010](#) with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

### **When should they be completed?**

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

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 you will also need to consider

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

**Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.**

### **Support**

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: [Inclusion.hdd@wales.nhs.uk](mailto:Inclusion.hdd@wales.nhs.uk)

Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

**Section 1: Overview**

1.	<b>What are you Equality Impact assessing?</b>	16-hour urgent care treatment centre (Same Day Urgent Care type model) - this would be open to the public for 14 hours with a further two hours to allow patients in the unit to be treated.
2.	<b>Brief Aims and Description of the procedure/ proposal/ project/ policy:</b>	Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) to meet local population needs within the new proposed times.
3.	<b>Who is involved in undertaking this EqIA? (names/job titles)</b>	Jon Morris (Clinical Lead MIU), Iona Evans (Interim Head of Nursing GGH & PPH USC), Meinir Williams (Deputy Head of Nursing PPH USC)
4.	<b>Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?</b>	No
5.	<b>Is this a new EqIA or an updated EqIA?</b>	New <input checked="" type="checkbox"/> Updated <input type="checkbox"/> Date of original or last version of the EqIA: Please give details / explain any amendments – New template/additional information.
6.	<b>Who will be affected by the procedure/ proposal/ project/ policy development?</b> (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	<ul style="list-style-type: none"> <li>• Local Population using the MIU.</li> <li>• Staff working within the MIU / AMAU.</li> <li>• Patients using either GGH or Morriston.</li> <li>• Staff working in GGH &amp; MGH due to increase demands from GGH site</li> <li>• Sample audit November 2022 – 11.45% from Swansea Bay area</li> </ul> <p style="text-align: right;">Sample audit for 2 weeks Dec 2023</p>

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	<a href="https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5lPyTculB&amp;id=uChWuyjjgkCoVkM8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u">https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=qvDbhgXnLqGN4SljtcDYK7c5lPyTculB&amp;id=uChWuyjjgkCoVkM8ntyPrIqXtKx9OJBDim5W0Zv5x3tUMFRLVlNLVEZITDhZVDZGNzhMOUFIUUFcWi4u</a>
<p>7. What might help/hinder the success of the procedure/ proposal/ project/ policy?</p>	<p>Help:</p> <ul style="list-style-type: none"> <li>• HIW Inspection recommendations</li> <li>• Clinical Team support</li> <li>• Executive support including Core Delivery Group and the Operational Planning Governance and Performance Group</li> <li>• Communication and Engagement strategy</li> <li>• Trade Unions / HR</li> <li>• Welsh Government</li> </ul> <p>Hinder:</p> <ul style="list-style-type: none"> <li>• Public (and public representation groups) opposition/resistance to a reduced service.</li> <li>• Political opposition</li> <li>• Media</li> </ul>

## Section 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 **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the procedure/ proposal/ project/ policy relevant to:

Yes	No
-----	----

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<p><b>Article 2: The right to life.</b>  <b>Example:</b> The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.</p>	✓	
<p><b>Article 3: The right not to be tortured or treated in an inhuman or degrading way.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 5: The right to liberty</b>  <b>Example:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p><b>Article 6: The right to a fair trial</b>  <b>Example:</b> issues of patient choice, control, empowerment and independence</p>	✓	
<p><b>Article 8: The right to respect for private and family life, home and correspondence.</b>  <b>Example:</b> 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</p>	✓	
<p><b>Article 11: The right to freedom of thought, conscience and religion</b>  <b>Example:</b> 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</p>	✓	

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### Section 3: Gathering of Evidence and Assessment of Potential Impact

<b>How will the procedure/ proposal/ project/ policy impact on Age:</b> Is it likely to affect older and younger people in different ways or affect one age group and not another?	<b>Positive</b>	✓
	<b>Negative</b>	✓
	<b>No Impact</b>	

<b>Guidance</b>  Remove population data if not relevant to EqIA and upload relevant data.	<b>Population Data</b>				
	<b>County</b>	<b>Carmarthenshire</b>		<b>Llanelli</b>	
	<b>Age</b>	<b>Value</b>	<b>%</b>	<b>Value</b>	<b>%</b>
	Total: All usual residents	187,897	100	25,400	100
	Aged 4 years and under	9,057	4.8	1,422.4	5.6
	Aged 5 to 9 years	10,274	5.5	1,524	6
	Aged 10 to 19 years	20879	11.2	3,048	12
	Aged 20 to 24 years	8,820	4.7	1,447.8	5.7
	Aged 25 to 34 years	20,692	11	3,225.8	11.8
	Aged 35 to 49 years	31,802	16.9	4,749.8	18.7
	Aged 50 to 64 years	40,906	21.8	5,054.6	19.9
	Aged 65 to 74 years	24,603	13.1	2,616.2	10.3
	Aged 75 to 84 years	15,247	8.1	1,600.2	6.3
Aged 85 years and over	5,617	3	711.2	2.8	
<a href="#">Build a custom area profile - Census 2021, ONS 03/07/2024</a>					

Insert an age breakdown of those affected. This data can be recorded in table or free text format.  If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	<b>Patient data – last 3 years (April 21- July 2024)</b>	
	<b>Patient Age</b>	<b>Attendances</b>
	<b>Age: 0-9</b>	9,695
	<b>Age: 10-19</b>	16,094
	<b>Age: 20-29</b>	14,304
	<b>Age: 30-39</b>	14,004
	<b>Age: 40-49</b>	11,557
	<b>Age: 50-59</b>	12,689
	<b>Age: 60-69</b>	10,516
	<b>Age: 70-79</b>	9,503
<b>Age: 80-89</b>	5,682	

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Age: 90-99	1,072
Age: 100 +	27
<b>TOTAL</b>	<b>105,143</b>

Insert breakdown of staff age in the specific service/ area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.

**Staff data- Emergency Nurse Practitioner (ENP) staff age range between 37- 63 years. Average age of 54 years with 4 ENP retire and return. Difficulty in recruiting into 3 wte ENP vacancy previously which resulted in the appointment of X3 ENP trainees to mitigate the fragility and risk within this workforce in the event of full retirement/leavers.**

GRADE	ACTUAL W.T.E	Age	COMMENTS
7	1.00	49 yrs	commencing 19th August
7 ENP	0.40	62yrs	Retire and return
7 ENP	0.80	54yrs	
7 ENP	0.20	63yrs	Retire and return
7 ENP	0.96	51yrs	
7 ENP	0.80	47yrs	
7 ENP	0.80	53yrs	
7 ENP	0.40	62yrs	
7 ENP	0.92	47yrs	
7 ENP	0.96	38yrs	
7 ENP	1.00	53yrs	
7 ENP	0.50	56yrs	Retire and return
7 ENP	0.40	49yrs	
7 ENP	0.50	56yrs	Retire and return
6 ENP	1.00	39yrs	Trainee ENP
6 ENP	1.00	53yrs	Trainee ENP
6 ENP	1.00	37yrs	Trainee ENP

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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"><li>• Older and younger populations may be more dependent on public transport and or others to bring them to healthcare settings as they may be too young to have a drivers' license or are unable to drive due to age related fragilities.</li><li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li></ul> <p>Review of risk relating to older workforce and requirement to undertake a workforce plan for succession plan for sustainability of service.</p>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"><li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently, therefore patients reliant on public transport are unlikely to be affected.</li><li>• Minor injuries rarely require immediate attention and can, in many instances, wait until the following morning to be seen and treated therefore they will not be required to travel further for treatment or be reliant on travelling when public transport is available.</li><li>• Educate the public on appropriate access of service in relation to the care that can be provided by MIU. This correspondence will need to be in accessible formats to ensure the elderly who may have sight loss, deteriorating mental capacity etc. are able to understand. Choose well posters within the reception area</li><li>• Working with HDUHB communication team and Welsh Ambulance Service / Police/NHS 111 Wales/Primary and Secondary services, Local Authority and volunteer/charity services.</li><li>• 3 ENP trainees currently in place re risk of older workforce, though further workforce modelling will be required to support this MIU/SDUC model (medical and nursing/ACP/ANP requirement).</li></ul>
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Provide a brief summary of the positive impacts you have identified.

**Positive Impact**

- MIU have an aging workforce, many are retired and returned, the work life balance result of this change would be welcome by them as they will no longer be required to work nightshifts. No previous concerns highlighted by staff in relation to this aspect.
-

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<p><b>How will the procedure/ proposal/ project/ policy impact on Disability:</b> Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.</p>		<p><b>Positive</b></p>																																																																																																									
		<p><b>Negative</b></p>	✓																																																																																																								
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<p>Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)</p> <p>If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</p>	<p>Mental Health activity:</p> <table border="1"> <thead> <tr> <th rowspan="2">Month</th> <th colspan="2">MIU Referrals</th> <th colspan="2">Ward Referrals</th> <th colspan="2">08:00 - 20:00 - 20:00 08:00</th> </tr> <tr> <th>18-70</th> <th>70+</th> <th>18-70</th> <th>70+</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Feb-24</td> <td>79</td> <td>0</td> <td>15</td> <td>9</td> <td>56</td> <td>47</td> </tr> <tr> <td>Jan-24</td> <td>76</td> <td>2</td> <td>14</td> <td>9</td> <td>58</td> <td>43</td> </tr> <tr> <td>Dec-23</td> <td>78</td> <td>2</td> <td>12</td> <td>12</td> <td>65</td> <td>39</td> </tr> <tr> <td>Nov-23</td> <td>71</td> <td>1</td> <td>13</td> <td>19</td> <td>71</td> <td>33</td> </tr> <tr> <td>Oct-23</td> <td>61</td> <td>2</td> <td>8</td> <td>19</td> <td>66</td> <td>24</td> </tr> <tr> <td>Sep-23</td> <td>39</td> <td>2</td> <td>11</td> <td>6</td> <td>43</td> <td>15</td> </tr> <tr> <td>Aug-23</td> <td>52</td> <td>2</td> <td>28</td> <td>11</td> <td>54</td> <td>39</td> </tr> <tr> <td>Jul-23</td> <td>54</td> <td>1</td> <td>19</td> <td>8</td> <td>52</td> <td>30</td> </tr> <tr> <td>Jun-23</td> <td>65</td> <td>2</td> <td>16</td> <td>4</td> <td>52</td> <td>35</td> </tr> <tr> <td>May-23</td> <td>63</td> <td>4</td> <td>13</td> <td>9</td> <td>55</td> <td>34</td> </tr> <tr> <td>Apr-23</td> <td>68</td> <td>0</td> <td>12</td> <td>11</td> <td>57</td> <td>34</td> </tr> <tr> <td>Mar-23</td> <td>42</td> <td>0</td> <td>1</td> <td>8</td> <td>30</td> <td>21</td> </tr> <tr> <td>Feb-23</td> <td>50</td> <td>1</td> <td>9</td> <td>8</td> <td>52</td> <td>16</td> </tr> </tbody> </table>			Month	MIU Referrals		Ward Referrals		08:00 - 20:00 - 20:00 08:00		18-70	70+	18-70	70+			Feb-24	79	0	15	9	56	47	Jan-24	76	2	14	9	58	43	Dec-23	78	2	12	12	65	39	Nov-23	71	1	13	19	71	33	Oct-23	61	2	8	19	66	24	Sep-23	39	2	11	6	43	15	Aug-23	52	2	28	11	54	39	Jul-23	54	1	19	8	52	30	Jun-23	65	2	16	4	52	35	May-23	63	4	13	9	55	34	Apr-23	68	0	12	11	57	34	Mar-23	42	0	1	8	30	21	Feb-23	50	1	9	8	52	16
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	TOTAL	798	19	171	133	711	410
Insert breakdown of staff with a disability who may be affected by your specific service/area of work.	<p><b>Staff data:</b>            No staff disabilities on record.            No mental Health issues captured.</p>						
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Those with disabilities may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> <li>• Communicating the new hours may be difficult for people who have certain neuro-diverse conditions, learning disabilities or sensory loss.</li> <li>• It could be perceived that people needing attention for mental health concerns may be negatively impacted by the reduction hours, but mental health conditions are already outside the scope of MIU therefore should not be treated here.</li> </ul>			<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated. Opportunity to develop timed slots.</li> <li>• Review of appropriate MIU modelling and key education to the public on criteria of acceptances in MIU.</li> <li>• Ensure all communication regarding the changing of hours is available in accessible formats, easy read, braille etc.</li> <li>• 111 option 2 promotion. This has been a national campaign with NHS Wales and is available 24 hours a day. It is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis, or requiring support to manage their symptoms. Posters displayed in MIU and patient advised on Triage to ring</li> </ul>			

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

- |  |   |   |
|--|---|---|
|  | <ul style="list-style-type: none"><li>• Parking – is there likely to be an increase of the use of disabled bays due to condensed hours? How many do we currently have? Is it sufficient from the patient data for disability?</li><li>• Staff with certain disabilities may only be able to work night shift as they are reliant on family/ public transport for lifts to work etc.</li><li>• Are there any scenarios where disabled staff need to work night shift? Menopause, ADHD etc?</li></ul> | <ul style="list-style-type: none"><li>• There are 5 allocated bays outside MIU. There is also a drop off area outside the entrance. Current percentage in relation to spaces is 5% which fits into the 4-6% guidelines.</li><li>• There aren't any staff within this category.</li><li>• No scenarios at present.</li></ul> |
|--|---|---|

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>How will the procedure/ proposal/ project/ policy impact on Gender Reassignment:</b> Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.		Positive																															
		Negative																															
		No Impact	✓																														
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" data-bbox="371 379 1523 783"> <thead> <tr> <th data-bbox="371 379 1050 416">County</th> <th data-bbox="1057 379 1294 416">Carmarthenshire</th> <th data-bbox="1301 379 1523 416"></th> </tr> <tr> <th data-bbox="371 416 1050 453">Gender</th> <th data-bbox="1057 416 1294 453">value</th> <th data-bbox="1301 416 1523 453">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="371 453 1050 489">All usual residents aged 16 and over</td> <td data-bbox="1057 453 1294 489">155,486</td> <td data-bbox="1301 453 1523 489">100</td> </tr> <tr> <td data-bbox="371 489 1050 526">Gender identity the same as sex registered at birth</td> <td data-bbox="1057 489 1294 526">144,924</td> <td data-bbox="1301 489 1523 526">93.2</td> </tr> <tr> <td data-bbox="371 526 1050 600">Gender identity different from sex registered at birth but no specific identity given</td> <td data-bbox="1057 526 1294 600">210</td> <td data-bbox="1301 526 1523 600">0.1</td> </tr> <tr> <td data-bbox="371 600 1050 636">Trans woman</td> <td data-bbox="1057 600 1294 636">93</td> <td data-bbox="1301 600 1523 636">0.1</td> </tr> <tr> <td data-bbox="371 636 1050 673">Trans man</td> <td data-bbox="1057 636 1294 673">90</td> <td data-bbox="1301 636 1523 673">0.1</td> </tr> <tr> <td data-bbox="371 673 1050 710">Non-binary</td> <td data-bbox="1057 673 1294 710">60</td> <td data-bbox="1301 673 1523 710">0.0</td> </tr> <tr> <td data-bbox="371 710 1050 746">All other gender identities</td> <td data-bbox="1057 710 1294 746">38</td> <td data-bbox="1301 710 1523 746">0.0</td> </tr> <tr> <td data-bbox="371 746 1050 783">Not answered</td> <td data-bbox="1057 746 1294 783">10,072</td> <td data-bbox="1301 746 1523 783">6.5</td> </tr> </tbody> </table> <p data-bbox="371 783 965 813">Data retrieved from Census 2021 data 24/06/2024</p>			County	Carmarthenshire		Gender	value	%	All usual residents aged 16 and over	155,486	100	Gender identity the same as sex registered at birth	144,924	93.2	Gender identity different from sex registered at birth but no specific identity given	210	0.1	Trans woman	93	0.1	Trans man	90	0.1	Non-binary	60	0.0	All other gender identities	38	0.0	Not answered	10,072	6.5
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If you have determined no impact, please provide a brief explanation.	<p data-bbox="371 863 517 900"><b>No Impact</b></p> <p data-bbox="371 900 2159 970">The current unit and its limited accommodation has a single unisex/disabled toilet and shower facilities. No additional impact in the context of gender reassignment with this service change.</p>																																

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How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	✓
		No Impact	
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population Data</b></p> <p>Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.</p> <p>In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</a></p> <p>In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</a></p> <p>In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.  <a href="#">How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</a></p>		
<p>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format.</p>	<p><b>Patient data</b> - no information available.</p> <p>This will require monitoring in relation to any childcare concerns raised by patients and the dependency on spouse to support MIU attendance, as well as transport to and from the MIU. Monitor through Patient feedback.</p>		
<p>Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.</p>	<p>No information available.</p> <p>Monitor any staff impact of amended hours on dependency/ability on spouse in relation to childcare needs as well as transport to and from MIU (if required). This can be mitigated by the flexible working policy and effective roster management. Capture staff who are working through flexible working request on ESR.</p>		

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Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.

**Negative Impact**

- Staff may be reliant on their partners for lifts to and from work a change in working hours/ no opportunity to work a night shift may affect the staff members or their partners' employment (some households may need to change jobs to adapt to the new circumstances).
- Some households may be negatively impacted by this change due to shared childcare arrangements between shift work.

**Opportunities for improvement / mitigation**

- Flexible working policy.
- Ability to request % of shifts within roster.
- All rosters completed six weeks in advance.

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How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.		Positive	✓
		Negative	
		No Impact	
If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format.	No information available, there aren't any gynaecological service in PPH. Capture of data relating to re-direction underway. Any adverse incidents are captured via Incident reporting (Datix).		
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.	No information available:  Leave and Pay For New and Existing Parent policy  <a href="https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/">https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/</a>  Monitor through Managing attendance at work policy – ESR data.		
Provide a summary of the positive impacts you have identified.	<b>Positive Impact</b> <ul style="list-style-type: none"> <li>Review of the role and function of Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) will promote and highlight key criteria and will support signposting of patients to the right place first time.</li> </ul>		

How will the procedure/ proposal/ project/ policy on 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. Also includes citizenship.		Positive	✓
		Negative	✓
		No Impact	

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<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<p><b>Population</b></p> <table border="1"> <thead> <tr> <th>County</th> <th colspan="2">Carms</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Ethnicity</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Total: All usual residents</td> <td>187,898</td> <td>100</td> <td>25,400</td> <td>100</td> </tr> <tr> <td>Asian, Asian British or Asian Welsh</td> <td>2,321</td> <td>1.2</td> <td>533</td> <td>2.1</td> </tr> <tr> <td>Black, Black British, Black Welsh, Caribbean or African</td> <td>455</td> <td>0.2</td> <td>51</td> <td>0.2</td> </tr> <tr> <td>Mixed or Multiple ethnic groups</td> <td>1,756</td> <td>0.9</td> <td>279</td> <td>1.1</td> </tr> <tr> <td>White</td> <td>182,652</td> <td>97.2</td> <td>24,384</td> <td>96</td> </tr> <tr> <td>Another ethnic group</td> <td>714</td> <td>0.4</td> <td>1523</td> <td>0.6</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p> <p>90.3% of Llanelli's population (22,936) were born in the UK.</p>					County	Carms		Llanelli		Ethnicity	Value	%	Value	%	Total: All usual residents	187,898	100	25,400	100	Asian, Asian British or Asian Welsh	2,321	1.2	533	2.1	Black, Black British, Black Welsh, Caribbean or African	455	0.2	51	0.2	Mixed or Multiple ethnic groups	1,756	0.9	279	1.1	White	182,652	97.2	24,384	96	Another ethnic group	714	0.4	1523	0.6
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>It may be difficult to communicate this change with some hard-to-reach minority communities or those who speak a different language from English and Welsh.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>Link in with Community Development Outreach Team (CDOT) to support key communication. engaging with specific ethnic minority groups in the local area via the CDOT and will share key messages in the development stages with ethnic minority communities affected by this change in an appropriate language and communication method.</li> <li>Translation Services – ensure all communication is translated and in accessible formats, such as easy read format.</li> <li>Clear criteria for overseas visitors accessing MIU service.</li> <li>Working with Health Board communications.</li> </ul>																																											
<p>Provide a summary of the positive impacts you have identified.</p>	<p><b>Positive Impact</b></p> <ul style="list-style-type: none"> <li>Greater accessibility to support services e.g., translation services will always be available within the revised operating hours.</li> </ul>																																												

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How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.				Positive																																																													
				Negative	✓																																																												
				No Impact																																																													
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="369 352 1375 874"> <thead> <tr> <th data-bbox="369 352 660 391">County</th> <th colspan="2" data-bbox="660 352 1048 391">Carms</th> <th colspan="2" data-bbox="1048 352 1375 391">Llanelli</th> </tr> <tr> <th data-bbox="369 391 660 432">Religion</th> <th data-bbox="660 391 860 432">Value</th> <th data-bbox="860 391 1048 432">%</th> <th data-bbox="1048 391 1211 432">Value</th> <th data-bbox="1211 391 1375 432">%</th> </tr> </thead> <tbody> <tr> <td data-bbox="369 432 660 499">Total: All usual residents</td> <td data-bbox="660 432 860 499">187,899</td> <td data-bbox="860 432 1048 499">100</td> <td data-bbox="1048 432 1211 499">25,400</td> <td data-bbox="1211 432 1375 499">%</td> </tr> <tr> <td data-bbox="369 499 660 537">No religion</td> <td data-bbox="660 499 860 537">83,409</td> <td data-bbox="860 499 1048 537">44.4</td> <td data-bbox="1048 499 1211 537">12,395</td> <td data-bbox="1211 499 1375 537">48.8</td> </tr> <tr> <td data-bbox="369 537 660 576">Christian</td> <td data-bbox="660 537 860 576">89,378</td> <td data-bbox="860 537 1048 576">47.6</td> <td data-bbox="1048 537 1211 576">10,922</td> <td data-bbox="1211 537 1375 576">43</td> </tr> <tr> <td data-bbox="369 576 660 614">Buddhist</td> <td data-bbox="660 576 860 614">557</td> <td data-bbox="860 576 1048 614">0.3</td> <td data-bbox="1048 576 1211 614">76</td> <td data-bbox="1211 576 1375 614">0.3</td> </tr> <tr> <td data-bbox="369 614 660 652">Hindu</td> <td data-bbox="660 614 860 652">419</td> <td data-bbox="860 614 1048 652">0.2</td> <td data-bbox="1048 614 1211 652">51</td> <td data-bbox="1211 614 1375 652">0.2</td> </tr> <tr> <td data-bbox="369 652 660 691">Jewish</td> <td data-bbox="660 652 860 691">103</td> <td data-bbox="860 652 1048 691">0.1</td> <td data-bbox="1048 652 1211 691">25</td> <td data-bbox="1211 652 1375 691">0.1</td> </tr> <tr> <td data-bbox="369 691 660 729">Muslim</td> <td data-bbox="660 691 860 729">1,026</td> <td data-bbox="860 691 1048 729">0.5</td> <td data-bbox="1048 691 1211 729">229</td> <td data-bbox="1211 691 1375 729">0.9</td> </tr> <tr> <td data-bbox="369 729 660 767">Sikh</td> <td data-bbox="660 729 860 767">177</td> <td data-bbox="860 729 1048 767">0.1</td> <td data-bbox="1048 729 1211 767">25</td> <td data-bbox="1211 729 1375 767">0.1</td> </tr> <tr> <td data-bbox="369 767 660 805">Other religion</td> <td data-bbox="660 767 860 805">1,127</td> <td data-bbox="860 767 1048 805">0.6</td> <td data-bbox="1048 767 1211 805">153</td> <td data-bbox="1211 767 1375 805">0.6</td> </tr> <tr> <td data-bbox="369 805 660 874">Not answered</td> <td data-bbox="660 805 860 874">11,703</td> <td data-bbox="860 805 1048 874">6.2</td> <td data-bbox="1048 805 1211 874">1524</td> <td data-bbox="1211 805 1375 874">6</td> </tr> </tbody> </table> <p data-bbox="369 874 965 906">Data retrieved from Census 2021 data 03/07/2024</p>					County	Carms		Llanelli		Religion	Value	%	Value	%	Total: All usual residents	187,899	100	25,400	%	No religion	83,409	44.4	12,395	48.8	Christian	89,378	47.6	10,922	43	Buddhist	557	0.3	76	0.3	Hindu	419	0.2	51	0.2	Jewish	103	0.1	25	0.1	Muslim	1,026	0.5	229	0.9	Sikh	177	0.1	25	0.1	Other religion	1,127	0.6	153	0.6	Not answered	11,703	6.2	1524	6
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<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</p>	<p><b>Negative Impact</b></p> <ul data-bbox="421 1182 1317 1278" style="list-style-type: none"> <li>Reduction of opening hours reduce flexibility within shift patterns for staff members during key religion or belief (non-belief) events.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul data-bbox="1375 1150 2199 1390" style="list-style-type: none"> <li>Promotion of diversity and Inclusion within Health Board staff.</li> <li>Access to Religion and Beliefs Learning Resources for staff.</li> <li>Diversity Calendar promotion</li> <li>Flexible working policy</li> <li>Equality, Diversity and Inclusion Policy</li> </ul>																																																															

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relevant negative impact.		
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<b>How will the procedure/ proposal/ project/ policy impact on Sex</b> Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	<b>Positive</b>	
	<b>Negative</b>	
	<b>No Impact</b>	✓

<b>Guidance</b>  Remove population data if not relevant to EqIA.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #0070c0; color: white;">County</th> <th colspan="2" style="background-color: #0070c0; color: white;">Carms</th> <th colspan="2" style="background-color: #0070c0; color: white;">Llanelli</th> </tr> <tr> <th style="background-color: #0070c0; color: white;">Gender</th> <th style="background-color: #0070c0; color: white;">Value</th> <th style="background-color: #0070c0; color: white;">%</th> <th style="background-color: #0070c0; color: white;">Value</th> <th style="background-color: #0070c0; color: white;">%</th> </tr> </thead> <tbody> <tr> <td style="background-color: #0070c0; color: white;">All persons</td> <td style="text-align: right;">187,897</td> <td style="text-align: center;">100</td> <td style="text-align: right;">25,400</td> <td style="text-align: center;">100</td> </tr> <tr> <td style="background-color: #0070c0; color: white;">Male</td> <td style="text-align: right;">91,685</td> <td style="text-align: center;">48.8</td> <td style="text-align: right;">12,421</td> <td style="text-align: center;">48.9</td> </tr> <tr> <td style="background-color: #0070c0; color: white;">Female</td> <td style="text-align: right;">96,212</td> <td style="text-align: center;">51.2</td> <td style="text-align: right;">13,979</td> <td style="text-align: center;">51.1</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 03/07/2024</p>				County	Carms		Llanelli		Gender	Value	%	Value	%	All persons	187,897	100	25,400	100	Male	91,685	48.8	12,421	48.9	Female	96,212	51.2	13,979	51.1
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If you have determined no impact, please provide a brief explanation.	<p><b>No Impact</b></p> <ul style="list-style-type: none"> <li>Applies to both sexes equally. No discrimination in the context of sex. The current unit and its limited accommodation, with a single unisex/ disabled toilet and shower facilities.</li> </ul>
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How will the procedure/ proposal/ project/ policy impact on Sexual Orientation							Positive			
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.							Negative			
							No Impact		✓	
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>									
		<b>County</b>								
		<b>Carms</b>		<b>Ceredigion</b>		<b>Pembs</b>		<b>Totals</b>		
	Sexual Orientation	Value	%	Value	%	Value	%	Value	%	
	Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0	
	Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1	
	Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3	
	Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5	
	Pansexual	120	0.1	150	0.2	80	0.1	350	0.2	
	Asexual	79	0.1	140	0.2	52	0.1	271	0.1	
Queer	23	0.0	49	0.1	12	0	84	0.0		
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1		
<a href="https://www.ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a>										
If you have determined no impact, please provide a brief explanation.	<b>No Impact</b> There is no discrimination identified based on sexual orientation									

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>How will the procedure/ proposal/ project/ policy impact on Armed Forces</b>                  Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'</p> <p>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: <a href="#"><u>Armed-Forces-Covenant-duty-statutory-guidance</u></a></p>					<b>Positive</b>	✓																									
					<b>Negative</b>	✓																									
					<b>No Impact</b>																										
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		Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)																										
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	Both	0.2	0.2	0.2	0.2																										
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<p>If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community.</p>	<p><b>Patient data – no information. Promotion of Armed Forces identification to be captured on WPAS.</b></p>																														

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• This populations may be more dependent on public transport and or others to bring them to healthcare settings.</li> <li>• Restricting operating hours may result in service users having to travel further for treatment 'out of hours'.</li> </ul>	<p><b>Opportunities for improvement / mitigation</b></p> <ul style="list-style-type: none"> <li>• Impact due to public transport is likely to be minimal as there is limited public transport in the area between 8pm and 8am currently therefore patients reliant on public transport are unlikely to be affected.</li> <li>• Minor injuries rarely require immediate attention and can, in the vast majority of instances, wait until the following morning to be seen and treated.</li> <li>• SDUC type model will need to be determined to support and strengthen medical review (via SDEC) to reduce the need to re-direct.</li> <li>• Educate the public on criteria of acceptances in SDUC (type) model through communication supported by Choose Well NHS 111 Wales.</li> <li>• Awareness and reference to the All Wales Reserve Forces Training &amp; Mobilisation policy.</li> <li>• Utilisation of the Hywel Dda Strategic Partnerships Diversity &amp; Inclusion Armed Forces SharePoint page.</li> </ul>
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Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<p><b>Socio-economic Deprivation</b>          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.</p> <p>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: <a href="https://gov.wales/more-equal-wales-socio-economic-duty">https://gov.wales/more-equal-wales-socio-economic-duty</a></p>		Positive																									
		Negative	✓																								
		No Impact																									
<p><b>Guidance</b></p> <p>Remove population data if not relevant to EqIA.</p>	<table border="1" data-bbox="367 549 1375 831"> <thead> <tr> <th rowspan="2">Economic Factor</th> <th colspan="2">Carmarthenshire</th> <th colspan="2">Llanelli</th> </tr> <tr> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Economically active – In employment (this includes full time students)</td> <td>81,952</td> <td>52.7</td> <td>12,234</td> <td>52.1</td> </tr> <tr> <td>Economically active - Unemployed</td> <td>3,922</td> <td>2.5</td> <td>914</td> <td>3.6</td> </tr> <tr> <td>Economically inactive</td> <td>69,613</td> <td>44.8</td> <td>11,252</td> <td>44.3</td> </tr> </tbody> </table> <p>Data retrieved from Census 2021 data 24/06/2024</p>			Economic Factor	Carmarthenshire		Llanelli		Value	%	Value	%	Economically active – In employment (this includes full time students)	81,952	52.7	12,234	52.1	Economically active - Unemployed	3,922	2.5	914	3.6	Economically inactive	69,613	44.8	11,252	44.3
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<p>If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in table or free text format.</p>	<p><b>Patient data – no information to capture impact of change.</b>  <b>Monitor through patient feedback.</b></p>																										

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<p>Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation.</p>	<p><b>Staff data</b> – no information to capture impact. Monitored via Managing attendance at work policy – ESR data.</p>	
<p>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</p>	<p><b>Negative Impact</b></p> <ul style="list-style-type: none"> <li>• Staff unable to work night shifts means that they are not able to receive the enhanced allowances.</li> <li>• Patients needing to pay to take public transport.</li> <li>• The cost of childcare may increase if a household is sharing caring responsibilities around shift work.</li> </ul>	<p><b>Opportunities for improvement / mitigation:</b></p> <ul style="list-style-type: none"> <li>• Consultation with staff</li> <li>• Communication – working with communication team regarding role and function of SDUC type model.</li> <li>• Promotion of staff benefits – such as childcare vouchers, discounts.</li> </ul>

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

<b>Welsh Language</b> Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.		Positive											
		Negative											
		No Impact	✓										
<b>Guidance</b>  Remove population data if not relevant to EqIA.	<b>Population Data</b>  According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.  Definition of whether a person has Welsh language skills (as recorded in the Census 2022).  If a person can or does do any of the following: <ul style="list-style-type: none"> <li>• Understand spoken Welsh</li> <li>• Speak Welsh</li> <li>• Read Welsh</li> <li>• Write Welsh</li> </ul> <table border="1" data-bbox="371 903 1187 1137"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <tr> <td>Carmarthenshire</td> <td>53.3</td> </tr> <tr> <td>Pembrokeshire</td> <td>25.2</td> </tr> <tr> <td>Ceredigion</td> <td>56.4</td> </tr> <tr> <td>Hywel Dda</td> <td>45</td> </tr> </tbody> </table> <p><a href="https://ons.gov.uk/people-population-and-community">People, population and community - Office for National Statistics (ons.gov.uk)</a></p>	Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45		
Area	Percentage of people who can speak Welsh												
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If you have determined no impact, please provide a brief explanation.	<b>No Impact identified</b>												

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### **Additional considerations**

**In addition to the above protected characteristics please consider impact on the following:**

- Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)
- Unpaid Carers
- Individuals and communities who experience Digital Exclusion
- Rural and Urban communities
- more info about the comms package that will be required to inform the public about the scope of practice for each option
- more info about the comms package that will be required to inform the public about the specific opening times
- different communication mechanisms for certain protected characteristics – how will we be promoting to our younger population/older population/LGBTQ+ population. I'm thinking specifically in terms of newspaper adds, social media ads
- Utilising the medical and nursing workforce to a 14(&2) model enhances the MIU/SDUC skill set, reducing gaps within the roster and allows improved quality, safety and timely care to be delivered within these agreed hours.
- Reduction in staff anxiety, morale and in turn reduces staff sickness absence.
- Improved recruitment within the GP/Medical workforce due to reduced risk within the department.

**As mentioned above the CDOT team and other key stakeholders will be used to communicate this change of hours.**

**Messages will be translated to the languages that are required.**

**Easy read versions of the communication will be made available.**

### **Intersectionality**

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

**Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

**Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?**

Not applicable

Please note – All white boxes within this EqIA must be completed, please do not leave them blank.

#### Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: a **likelihood score** and an **opportunity/impact score**. The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores will automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

**(Likelihood Score x opportunity/impact Score = Total Score)**

OPPORTUNITY AND IMPACT			
IMPACT	SCORE		The proposed change is anticipated to lead to the following level of opportunity and/or impact:
Positive	5	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities.
Neutral	0	Neutral	(Neutral): No effect, either positive or negative.
Negative	-1	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery.
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occurring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

		OPPORTUNITY					IMPACT					
LIKELIHOOD		5	4	3	2	1	0	-1	-2	-3	-4	-5
	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5	

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

**\*\*To access the scoring table below you will need to double click on the table to open an editable version. The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity / Consequence Rating*	*IIA Matrix		
	Positive impact	Neutral impact	Negative impact	Unknown		Consequence	Likelihood	Total Score
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative								
Age	✓		✓		** positive rating	3	3	9
					** negative rating	-3	3	-9
Disability			✓		** positive rating			0
					** negative rating	-3	3	-9
Gender Reassignment		✓			** positive rating			0
					** negative rating			0
Marriage and Civil Partnership			✓		** positive rating			0
					** negative rating	-2	3	-6
Pregnancy and Maternity	✓				** positive rating	4	2	8
					** negative rating			0
Race/Ethnicity or Nationality	✓		✓		** positive rating	3	3	9
					** negative rating	-3	3	-9
Religion or Belief			✓		** Positive rating			0
					** negative rating	-3	3	-9
Sex		✓			** positive rating			0
					** negative rating			0
Sexual Orientation		✓			** positive rating			0
					** negative rating			0
Armed Forces			✓		** positive rating			0
					** negative rating	-3	3	-9
Socio-economic Deprivation			✓		** positive rating			0
					** negative rating	-4	3	-12
Welsh Language		✓			** positive rating			0
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

### Section 5: Outcome and Actions

This section should be used to detail and monitor any actions identified in sections 1-4.

<p><b>Will the procedure/ proposal/ project/ policy be adopted? If no, please give reasons and any alternative action(s) agreed.</b></p>	<p>Process remains active re long term MIU Model</p>
<p><b>If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.</b></p>	

	<p><b>Actions</b></p> <ul style="list-style-type: none"> <li>Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified.</li> <li>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.</li> </ul>	<p><b>Assigned to</b></p>	<p><b>Target Review Date</b></p>	<p><b>Completion Date</b></p>	<p><b>Comments/ Update</b></p>
1.	<p><b>What additional monitoring data will be collected around the impact of procedure/ proposal/ project/ policy once adopted? How will this be collected?</b></p> <p><b>Audits – redirection policy</b> <b>Attendances</b> <b>Incidents</b> <b>Complaints</b></p>	<p>Jon Morris Iona Evans Meinir Williams</p>	<p>3 months post closure</p>	<p>13<sup>th</sup> feb 2025</p>	<p>Monthly review of data to determine impact of closure captured.</p> <p>Feedback provided within Quality, Safety &amp; Experience Committee Meeting (13/02/2025)</p>

**Please note - All white boxes within this EqIA must be completed, please do not leave them blank.**

2.	MIU Project Group underway to scope long term modelling of the unit – series of options for delivery of the MIU in response to service fragilities’ and/or unsustainability – 4 options remain.	Sarah Perry Jon Morris Iona Evans Meinir Williams	27 <sup>th</sup> March 2025	Pending Board Meeting	pending on Board outcome will determine next steps.
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<b>EqIA Completed by:</b>	<b>Name/s</b>	Iona Evans/Jon Morris
	<b>Title</b>	Interim Head of Nursing GGH & PPH/ Clinical Lead MIU
	<b>Team / Division</b>	Unscheduled Care
	<b>Contact details</b>	iona.evans@wales.nhs.uk/jon.morris2@wales.nhs.uk
	<b>Date</b>	24/03/2025
<b>EqIA Authorised by/Owned by:</b> <ul style="list-style-type: none"> <li>Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy</li> <li>Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5</li> </ul>	<b>Name</b>	Sarah perry
	<b>Title</b>	GM Carmarthenshire System
	<b>Team / Division</b>	Unscheduled Care
	<b>Contact details</b>	<a href="mailto:Sarah.perry3@wales.nhs.uk">Sarah.perry3@wales.nhs.uk</a>
	<b>Date</b>	24/03/2025
<b>Guidance has been provided by Diversity &amp; Inclusion Team:</b>	<b>Name</b>	Alan Winter
	<b>Title</b>	Senior Diversity and Inclusion Officer
	<b>Team</b>	Strategic Partnership Diversity & Inclusion
	<b>Contact details</b>	<a href="mailto:Alan.winter@wales.nhs.uk">Alan.winter@wales.nhs.uk</a>
	<b>Date</b>	24/3/2025
<b>Diversity and Inclusion Team additional Comments:</b>		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

2.8

10 Mins

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2.8 - Update Report on the Improvement  
Strategic Framework 2023- 2026

*Mandy Davies (Hywel  
Dda UHB - Assistant  
Director of Nursing &  
Quality  
Improvement)*

**Attachments**

[QSEC QISF update.pptx](#)

# Update on the Quality Improvement Strategic Framework for QSEC April 2025

Mandy Davies

Assistant Director of Nursing &  
Quality Improvement

## QUALITY IMPROVEMENT STRATEGIC FRAMEWORK (QISF)

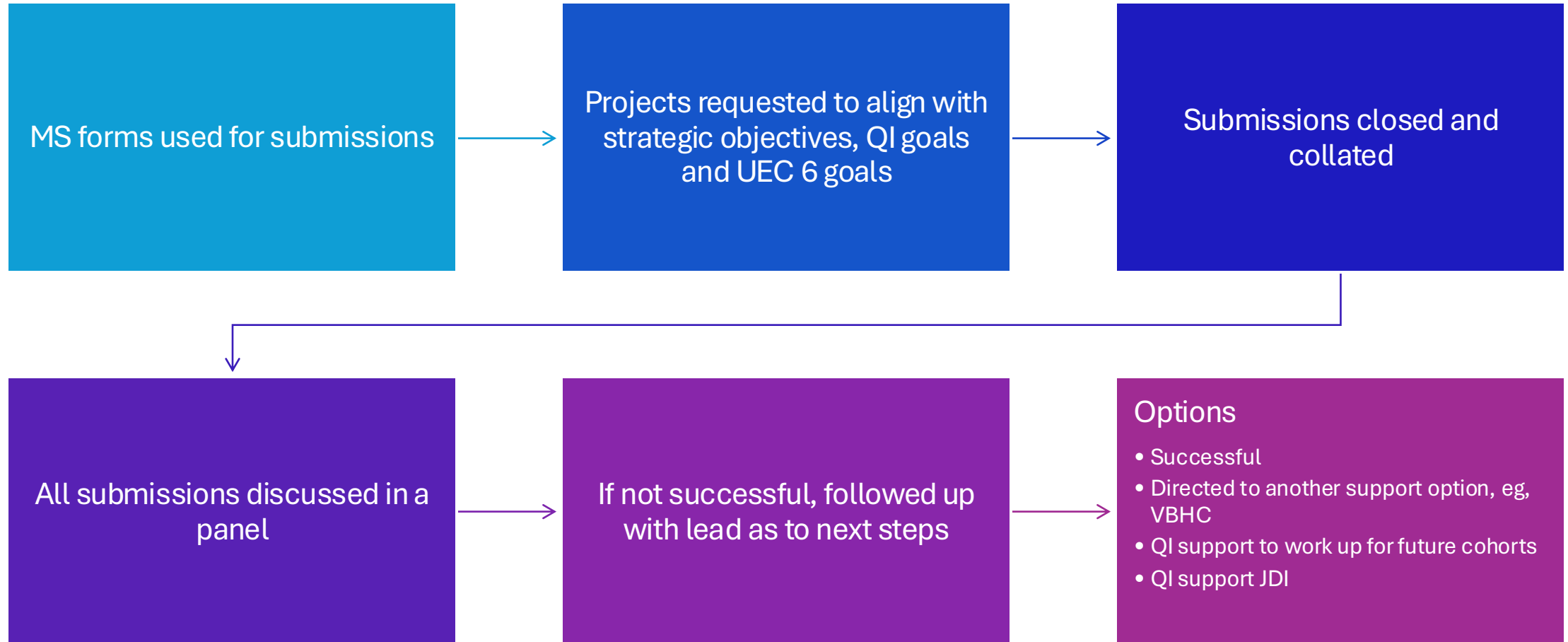
2023 - 2026



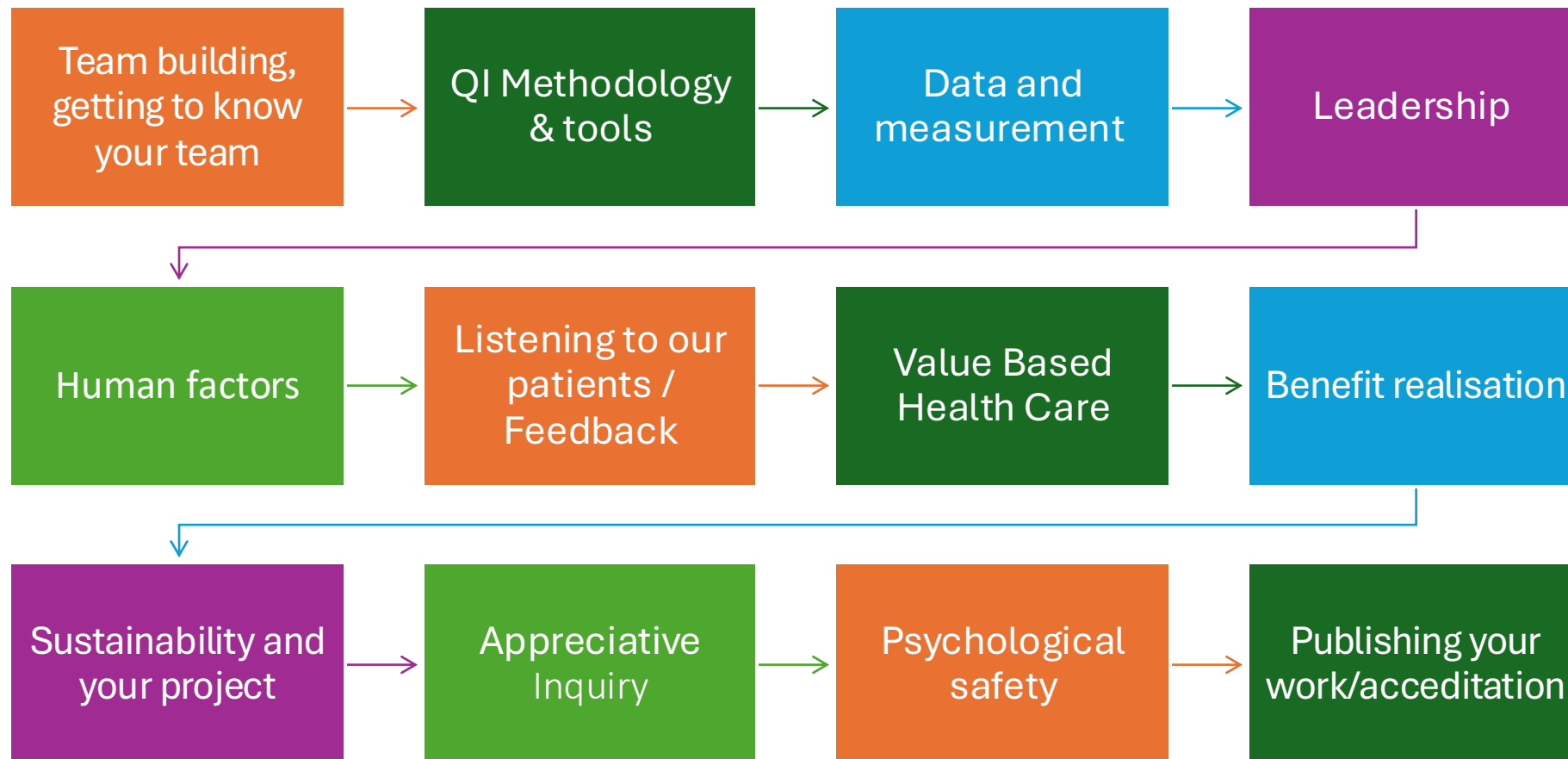
# Quality Improvement Strategic Framework (QISF)

- The first edition of Hywel Dda's QISF was developed in 2018 with an update approved published in 2023
- The QISF is an enabler and a key component of the Quality Management Framework for the Health Board
- The QISF focuses on engaging and enabling the whole workforce to improve the quality of its services
- We want all our staff, to feel competent and empowered, and feel safe and supported to identify and make the changes that they know will improve patient's experiences and outcomes of care. We have done this by developing our Enabling Quality Improvement in Practice (EQIIP) programme.

# EQlip Process



# Programme content



# Role of the coach



Each team on the EQiiP programme is assigned an Improvement Coach and a Buddy Improvement coach



The role of the improvement coaches is to support the teams along their QI journey and enable them to apply the contents of the EQiiP programme to their project and teams.



Improvement coaches have the necessary skills and experience to support teams and projects through the programme



The Improvement coaches themselves are supported through the HDUHB Improvement Coach Development programme and the monthly Improvement Coach Network meetings



Galluogi Gwella Ansawdd yn Ymarferol  
Enabling Quality Improvement in Practice



In total there has been 5 full cohorts of the EQIIP programme, we are nearing the end of Cohort 6 and planning Cohort 7 to start in June 2025.



Since 2023 we have delivered Cohorts 4 & 5 of the programme and nearing the end of Cohort 6

# EQliP Data

In total we have trained over 550 participants



We now have over 50 Improvement coaches from within the Quality Improvement and Service Transformation Team and from staff who have attended EQliP from operational teams.



We have designed and updated our Workbook that all participants get at the start of the programme and keep for reference for future QI activities.



We have developed a Hywel DDa Improvement Coach Development Programme with excellent feedback and plan to run again when required.

# Cohort 4

Stroke	Implemented additional therapy sessions during patient meal times as an MDT to improve rehabilitation
Urgent Dental	Improved patient experience and timely access to urgent dental treatment
Neonates Pressure Damage	Improved education on position of probes and standardisation of documentation
LD person centred care	Reduced clinical time and eliminated waste – made appointments more efficient
Childhood obesity	Increasing physical activity in children aged 4-5 – training for Health Visitors
C-Diff	Pilot using the
Vascular access	Identified safety issues with post insertion care – Working group established and pilot being worked up
Pre-assessment	Standardised pre-assessment documentation across the Health Board
DBT Service	Increasing the use of DBT in young people
Siptillsend	Reduced the time patients are kept NBM prior to planned surgery
AOS SOS (Acute oncology Service)	Improved patient experience and reduced time to wait for acute oncology concerns
Deconditioning patient	Raising staff awareness around patient deconditioning
Project optimise	Changed management of clinically optimised patients in WGH frailty area
Palliative care communication	Introduced statement of wish into end of life discussions in community setting
Falls improvement	Therapy lead staff training on issuing mobility equipment to patients
WAST community discharge	Discharge lounge implemented safer discharge processes

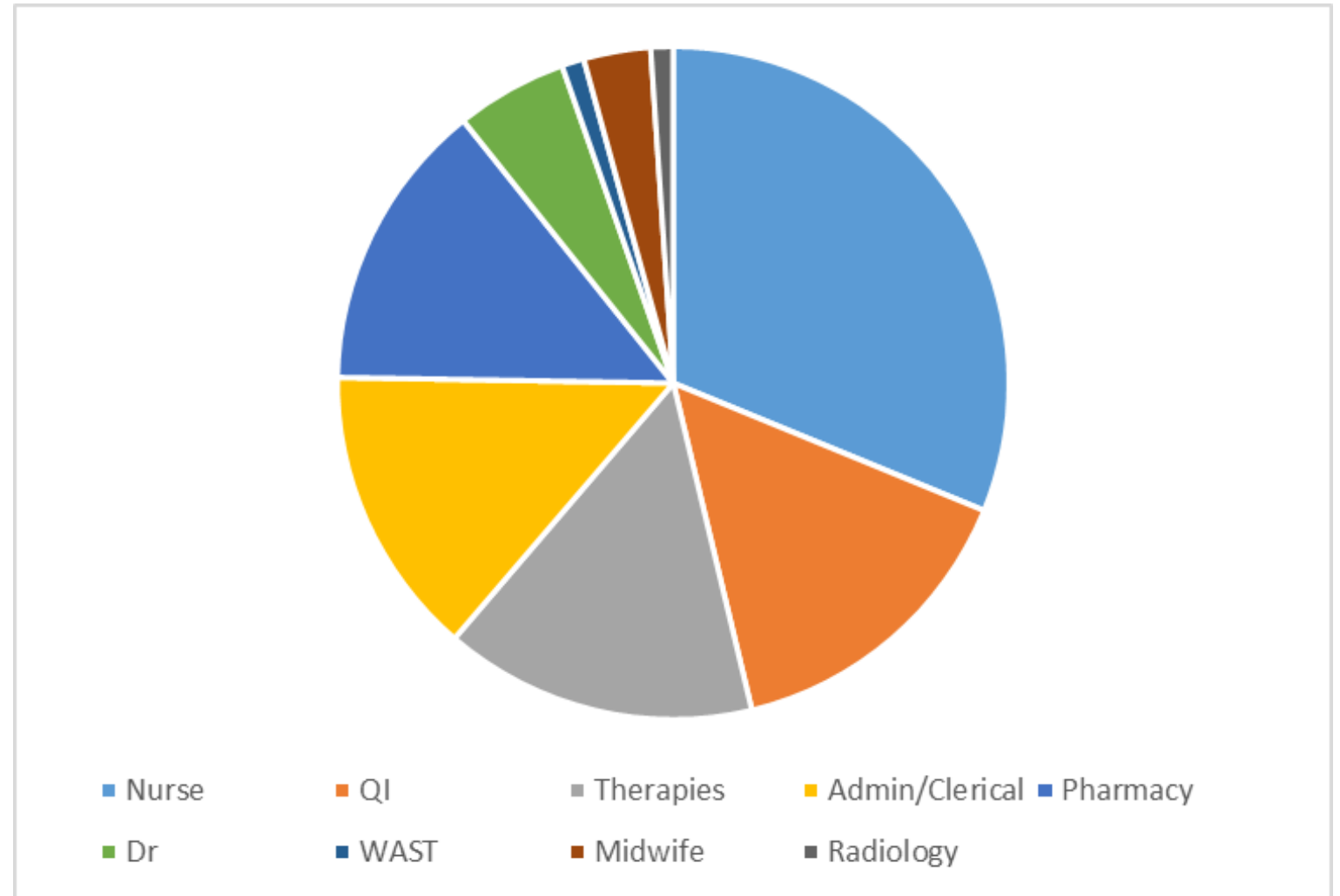
# Cohort 5

Planned care for veterans	Process implemented so we can identify veterans to support them if needed
Ophthalmology pathway improvements	Implementation of a one stop clinic, HD now leading the way across Wales
Pelvic Health	Reduction in inappropriate/duplicate referrals
Diabetes	Streamline referrals i.e. to the right speciality with the necessary information, within agreed timescales
GGH A&E Pressure damage	Reduced department acquired pressure damage by 40%
Risk of stratification of Frail patients in 3T's cluster	Improved Interprofessional working to identify frail patients in the 2T's cluster to ensure appropriate assessment and support is provided to meet the patients needs.
Early rehab assessment and goals in critical care	Communication improvements with families
Discharge planning in GGH	Reduced LOS in GGH
Develop a marker of patients communication needs	Increased awareness for patients with a sensory loss
Preparing patients for SACT	Improved and standardisation of patient information on treatments available
Falls bundle in WGH A&E	Introduction of a falls bundle in WGH A&E to improve follow up support

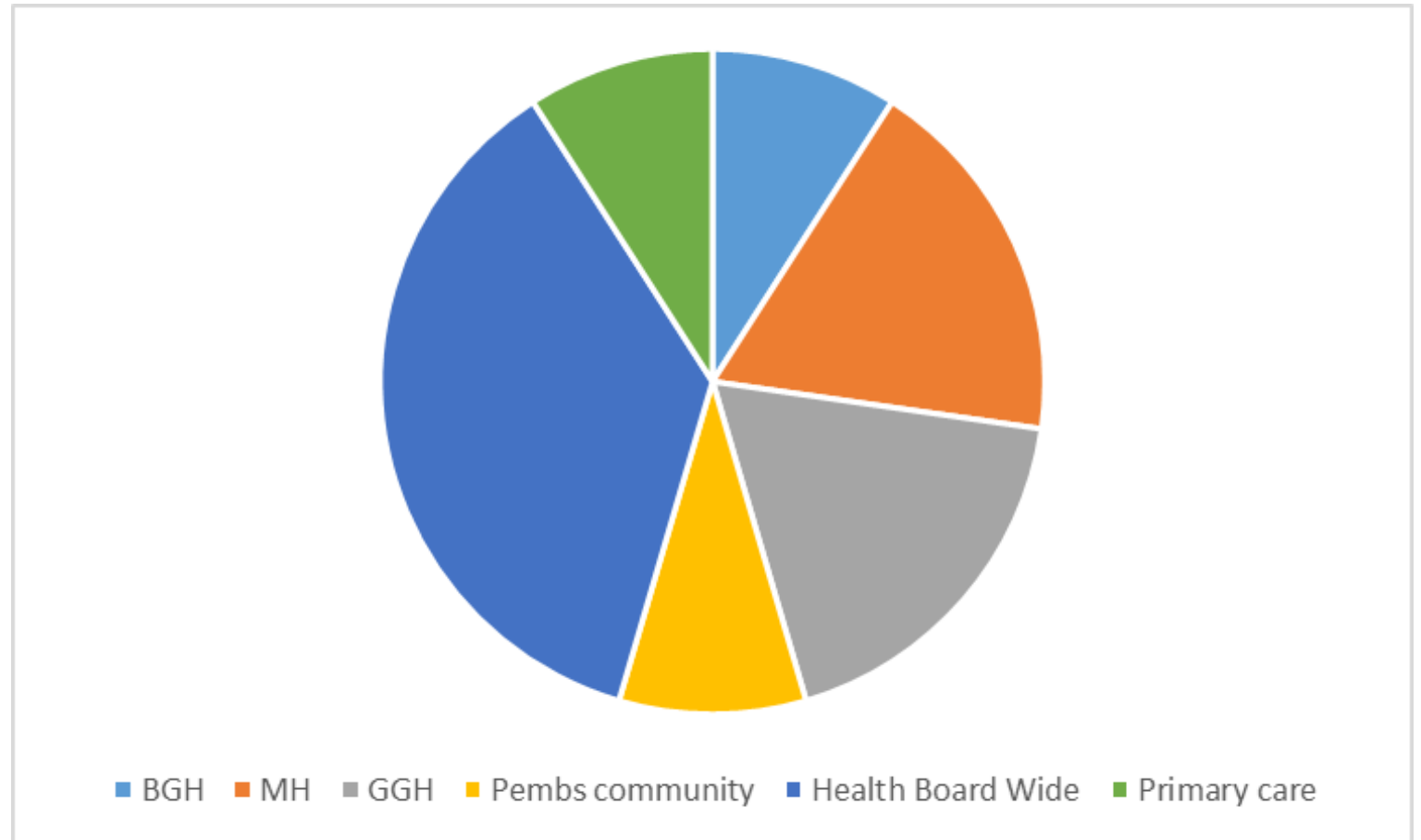
# Cohort 6 – Projects aligned to 6 policy goals for Transforming Urgent and Emergency Care

UTI	Reduce time urology patients access Pre-ass clinic if UTI present
Person centred safety planning	Introduction of person centred safety planning in MH wards
Antipsychotic medication	Utilise protocols and guidance appropriately
Tracheostomy care in Hywel Dda	Improve the standard of care and equipment
Prioritising medication history's / reconciliation on acute medical units	Reduce time to reconciliation by pharmacy team
Improvement in DNACPR Standards and future care planning	Introduction of a standardised template for advanced care planning
Frailty unit in GGH	Improve identification of where frail patients are placed in GGH
Reducing missed appointments in Primary care	Introduction of a text message cancellation process to reduce DNA's
Hip 4 hour target	Reduce time taken to transfer to T&O specialist bed in BGH
Anaemia in pregnancy	Improve the of identification and management of anaemia in pregnancy
Optimising patients for surgery	100% of Newly Listed Orthopaedic Patients are Personally Provided with Waiting Well Information and Are Offered the Appropriate of Support Based Upon Assessed Need by March 2025

# Disciplines on Cohort 6

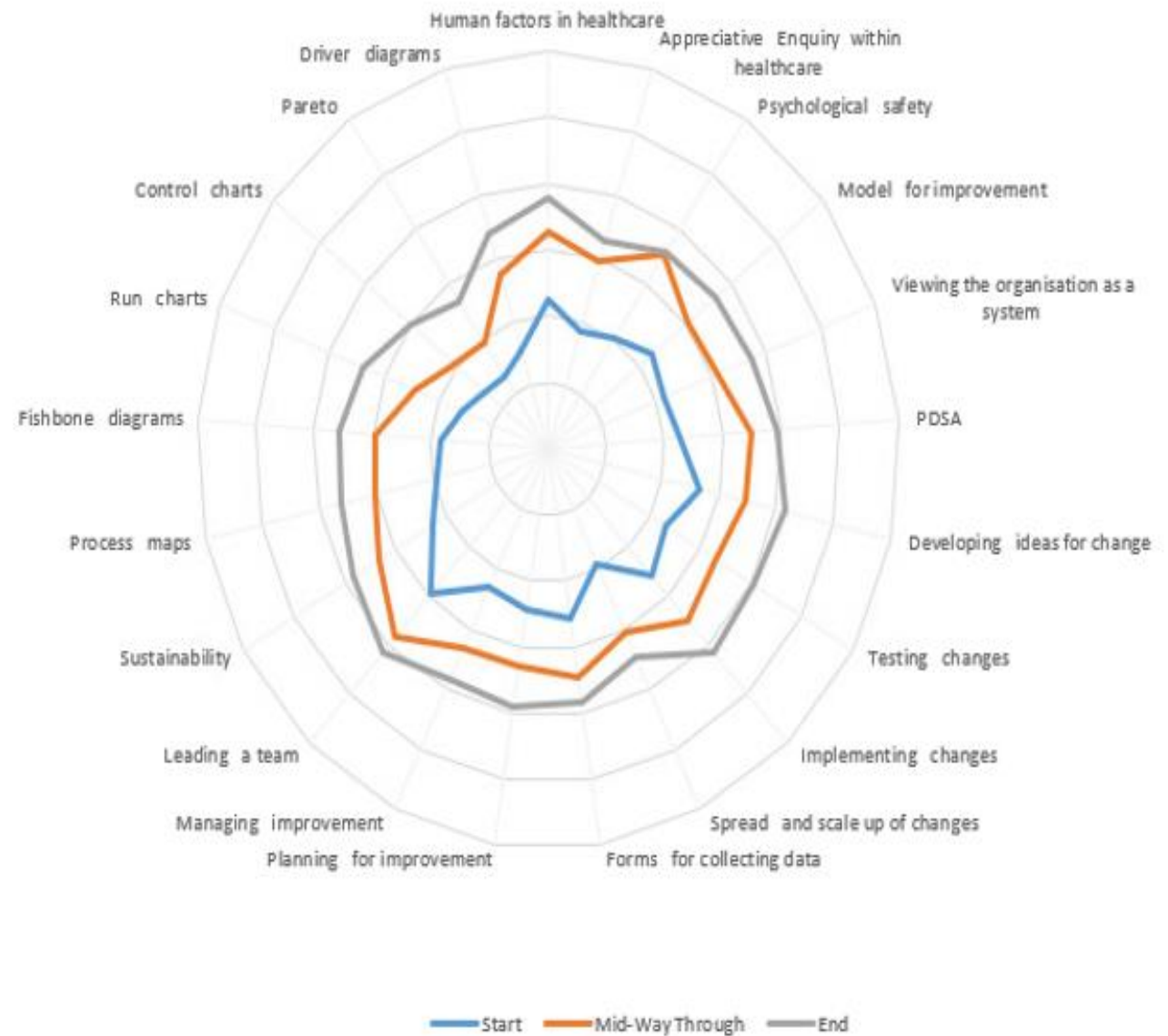


# Locations of projects for Cohort 6



# Cohort 5 Learning overview

### Average Scores by Stage in Programme



## Cohort 6 team IHI Safe Reliable and Effective Care Framework self-assessment example

- The Framework describes the key strategic, clinical and operational components involved in the delivery of safe reliable and effective care
- Provides a road map for teams and organisations to use to assess how well they are doing and to focus on areas where they could do better



# Improvement in Practice

- Improvement in Practice is a nationally accredited course by Improvement Cymru. EQliP projects who submit are marked against the criteria and if criteria met accredited an Improvement in Practice Team award
- 6 teams have successfully achieved this accreditation and 4 teams are currently going through the marking process.





# Achievement examples

**2024 NHS Award** - EQiP 5 team successful for providing equitable care for those with a sensory loss attending outpatient departments across Hywel Dda by identifying their preferred form of communication. Prior to the project (Nov 2023) there were 7 patients with a sensory loss recorded on WPAS. After raising OPD staff awareness and general promotion this was increased to over 120 patients being recorded (Oct 2024). All OPD staff have completed the sensory loss e-learning. Some members of the team are now part of a Bevan Exemplars project.

**Palliative care team poster presentation** – Rural Health Awards – 2023

*'An immersive three-day event, the Spread and Scale Academy is designed to propel your project forwards, so it can scale across the NHS, social care, local authorities and private industry'*

**17 teams from Hywel Dda have been supported through the National Spread and Scale Programme**

**Examples:**

**Same day Emergency Care**

**Criteria led discharge (planned care)**

**Project Optimise**

**Trail without Catheter – They have implemented a community team who now complete this in the community.**

# Spread and Scale

# Improvement Advisor level



In 2018 Improvement Cymru and the IHI lead on the delivery of an Improvement Advisor Programme level for senior QI leads in Wales. Over the years we have invested in this programme which has been lead by Improvement Cymru, following the Scottish Improvement model before they developed their own Welsh version last year.



To date we have had **18 senior QI leads** attend this level of accreditation.



We are in the process of submitting 3 applications for the next all wales cohort for 2025

# Publications and National Collaborative

Evaluating a Quality Improvement Collaborative – Journal of Health Organisation and Management



Implementing the Care Aims approach in Children's Service – British Journal of Healthcare Management



## National Safe care Collaborative

4 workstreams, Leadership, Community, Acute & Ambulatory Care

8 projects in total engaged in the programme

Over 40 participants for Hywel Dda

QI work  
outside of  
EQIIP

# Quality Improvement

PATIENT FALLS

MEDICINE MANAGEMENT

PRESSURE DAMAGE

COMMUNICATION HUB

HOSPITAL ACQUIRED THROMBOSIS (HAT)

NUTRITION AND HYDRATION

# Falls Improvement

National Audit of Inpatient Falls (NAIF) Task and finish refining the new process.

Hywel Dda Inpatient Falls Group established

Footwear pilot on Dewi in GGH

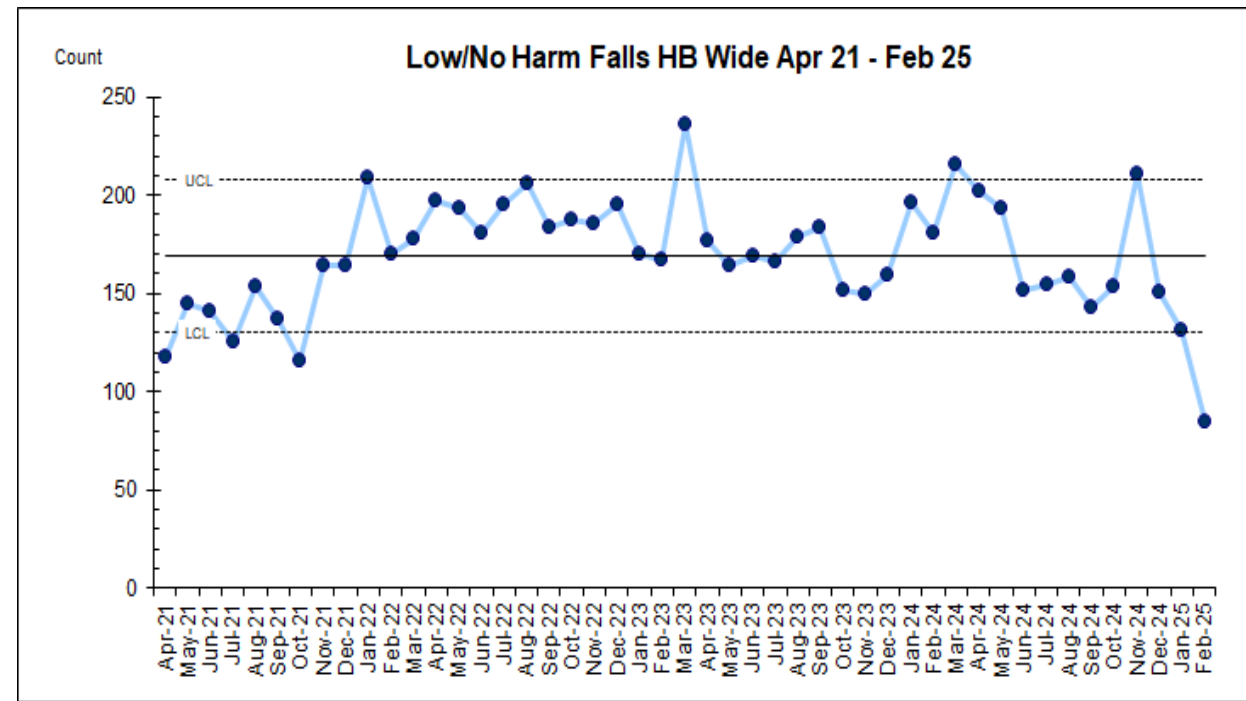
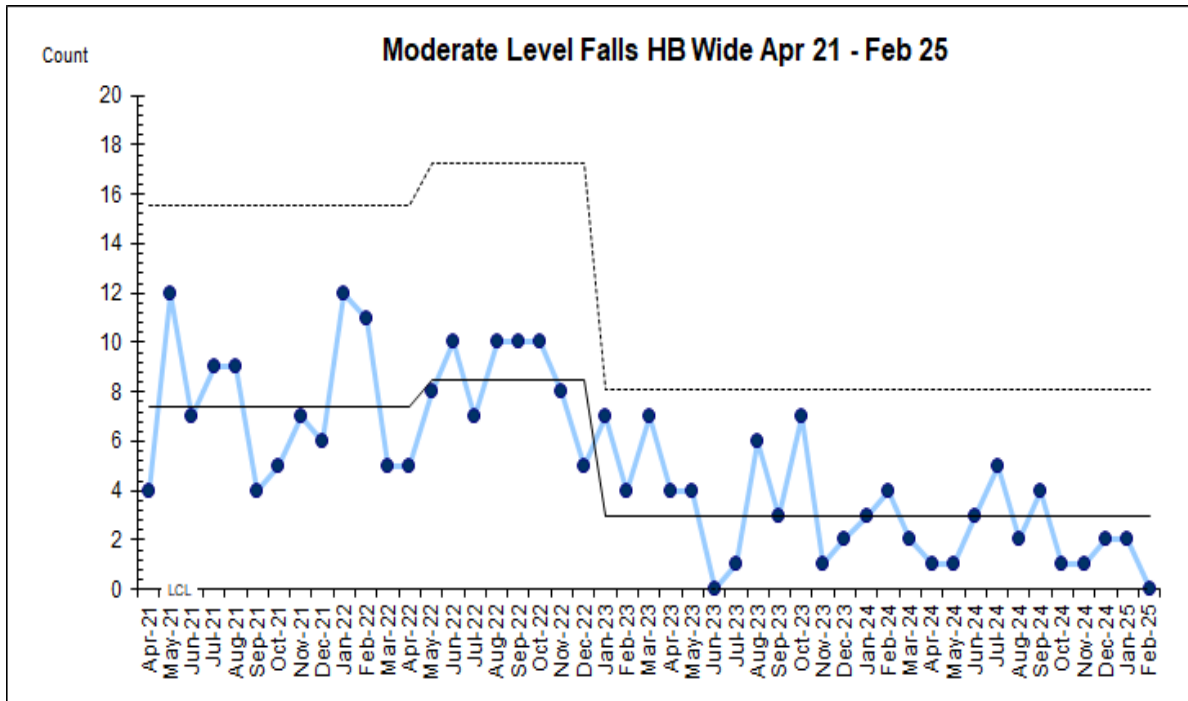
Falls simulation training programme in discussion to pilot in more areas whilst awaiting final sign off.

Continuing to contribute to National and 4 Nations falls meetings.

Bespoke sessions on Multi Factorial Risk Assessment/Lying & Standing Blood Pressure

Focus on caffeine free drinks – to be piloted in St Non, WGH

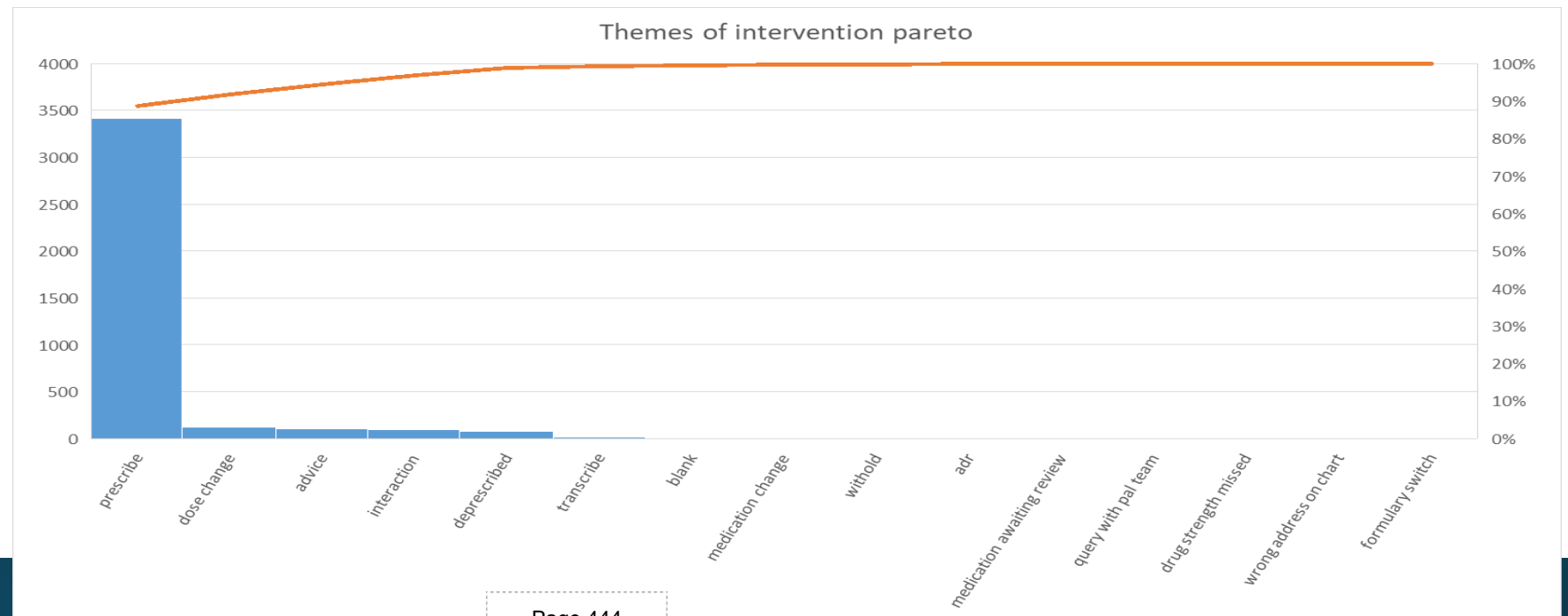
# Falls Data – Level of Harm



# Medication management Improvement

## Transcribing interventions within admission areas:

- Medication near misses are rarely datix reported due to the time to complete and the acuity of clinical areas, Therefore the number of medication datix's is not a true reflection of the issue around transcribing errors where pharmacy must intervene to correct to ensure safety and no harm. These near misses have now been captured using a Microsoft form showing the large extent of the problem. There have so far been over 3800 reported interventions using this method between the 4 acute sites in ED or AMAU areas only in the last 10 months.
- PDSA 1 pharmacist transcribing charts on admission
- PDSA 2 pharmacy technician provides annotated medication history for doctors prior to clerking.
- PDSA 3 will be a redesign of the pharmacy education session to medics making it interactive with the first session being around medication history taking and transcribing.



# Medication management Improvement



WEEK 1 TO 14 DATA COLLECTION WAS ONLY PPH AMAU. BETWEEN WEEK 4 – 6 PHARMACISTS TRIALLED TRANSCRIBING MEDICATION CHARTS FOR PATIENTS ON ADMISSION AND REDUCED THE TRANSCRIBING INCIDENTS BY HALF.



FROM WEEK 15 THE 4 SITES COLLECTED DATA AND THIS WAS COMBINED TO SHOW THE ISSUE WAS HEALTH BOARD WIDE AND NOT SPECIFIC TO ONE AREA.



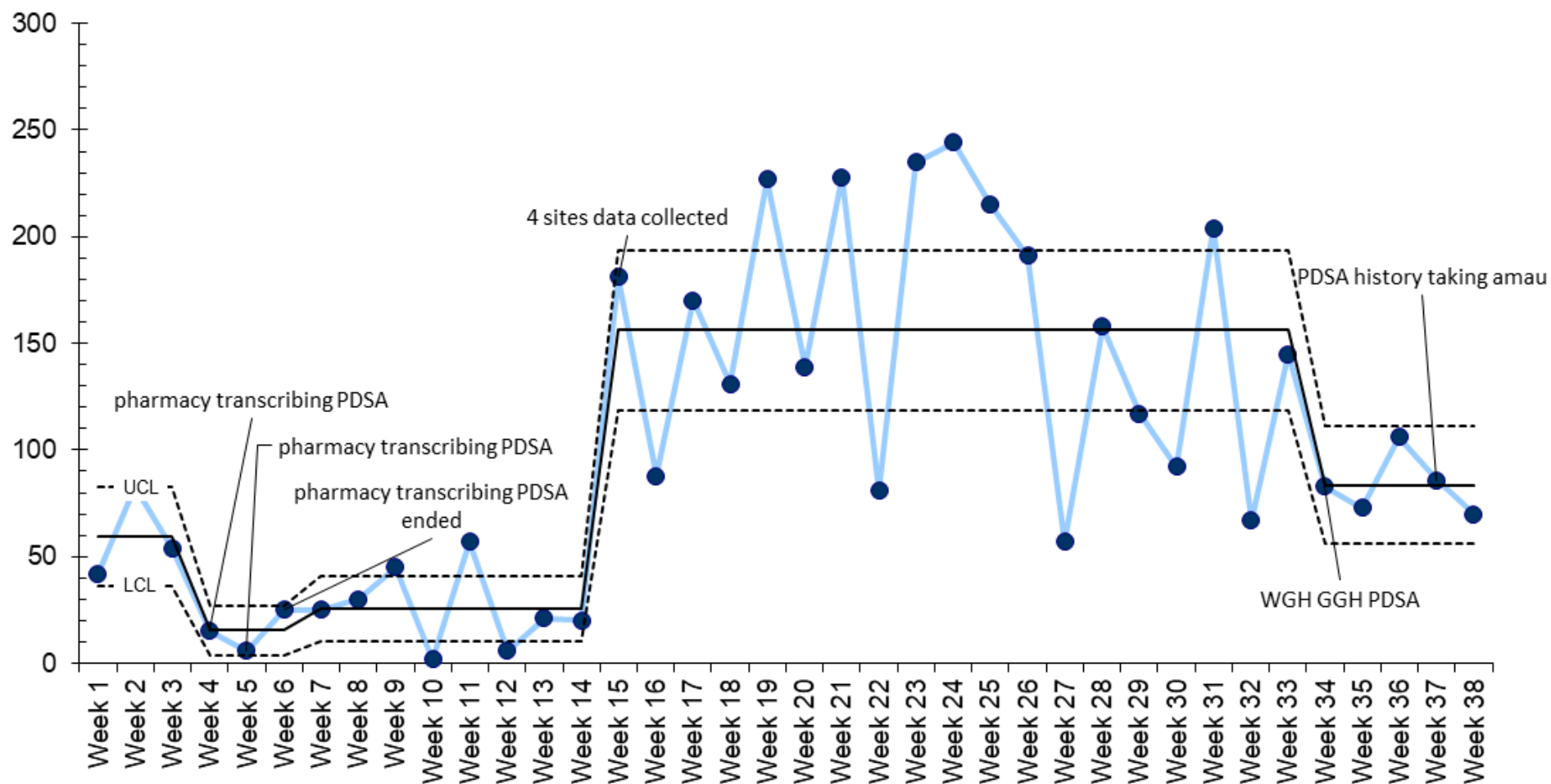
OVER THE 10 MONTH PERIOD OF THIS DATA COLLECTION IT HAS SHOWN SIGNIFICANT ISSUES WHICH COULD HAVE HIGH LEVELS OF PATIENTS HARM, IF INTERVENTION WAS NOT TO HAPPEN



THESE FIGURES ARE JUST A FRACTION OF THE INTERVENTIONS MADE BUT DUE TO STAFFING, ACUITY AND LOGGING THE DATA STAFF ARE NOT ABLE TO ROBUSTLY CAPTURE EVERYTHING.

## Intervention numbers over time

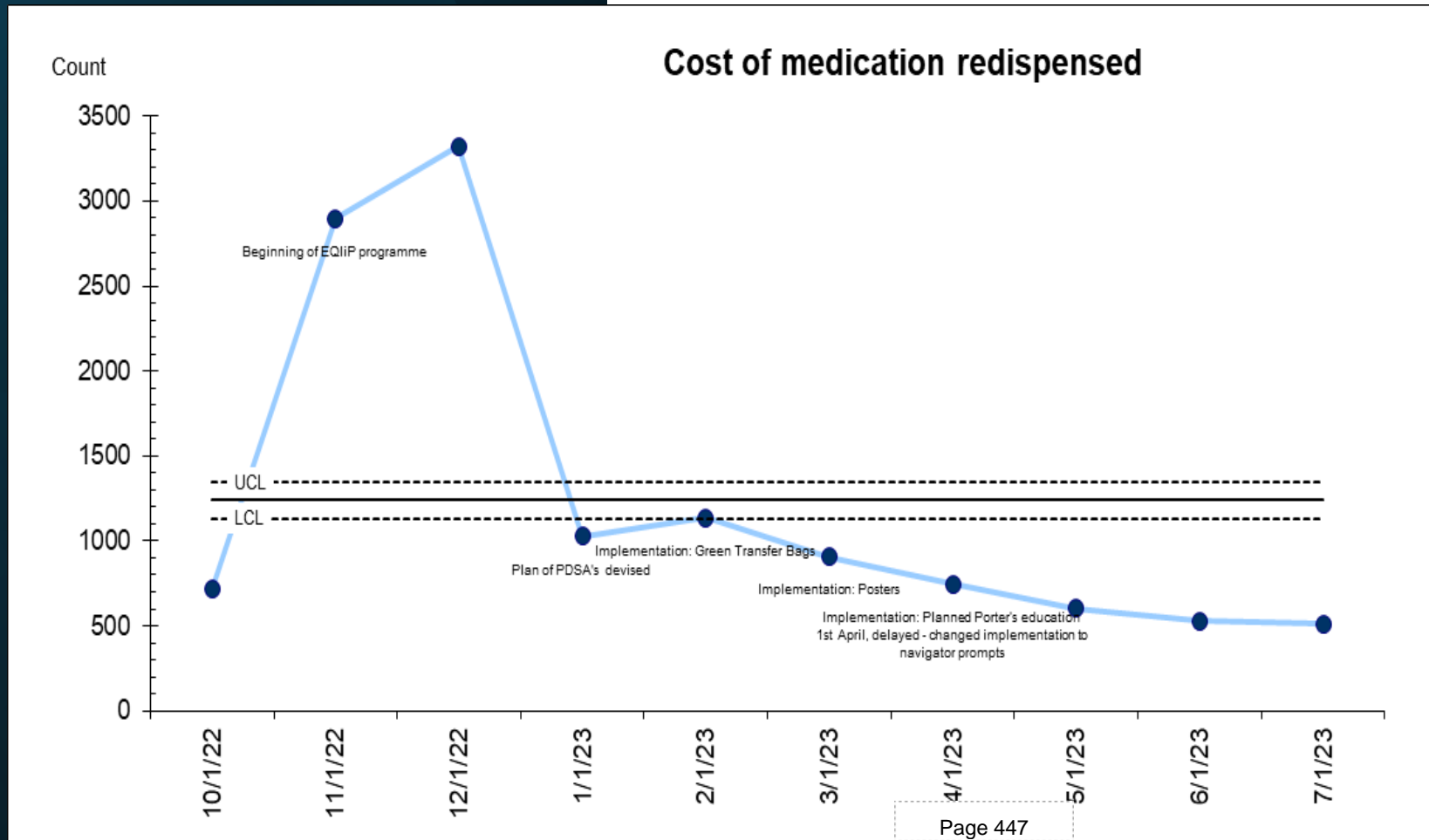
Count



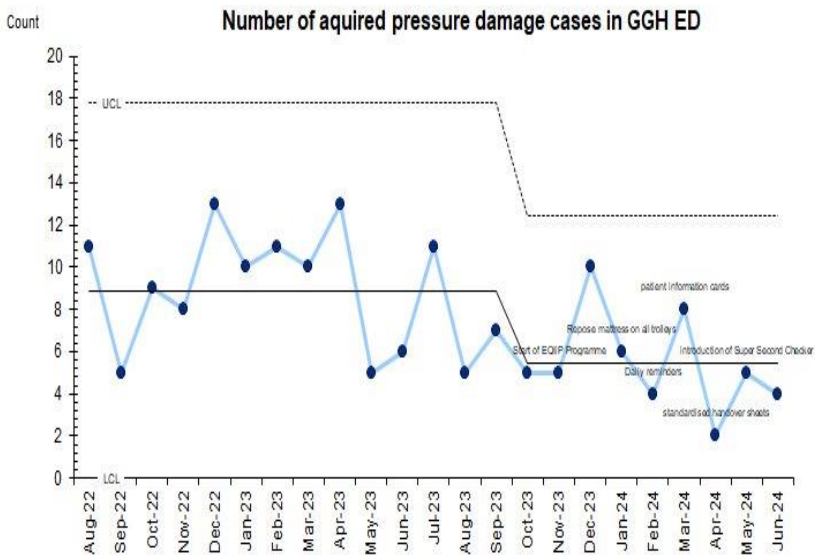
# Medication management Improvement

## Green Transfer Bags

EQIIP cohort 3 – Pharmacy highlighted an issue of medications not being transferred with patients to wards resulting in them being re-dispensed. This causes time delay for the patient to receive medication , nurses spend time trying to locate the medications and there is an increased cost. The green transfer bags were introduced successfully and have now been rolled out into Prince Philip Hospital( PPH.)



# Pressure Damage Improvement



## EQIIP Cohort 5 Glangwili Hospital (GGH) Emergency Department (ED) acquired pressure damage reduction project:

Identified an increase of patient acquiring pressure damage while in the department.

- PDSA 1 proved most successful with all trolleys having a repose mattress placed on them with the exception of spinal injury placements.
- PDSA 2 implemented daily reminders to be read out on each handover of shift highlighting a number of important points – PD information was included on this.
- PDSA 3 new patient information cards for each bed displaying at risk of PD and time frequency of turns.
- The change has not been sustained due to environment work ongoing in the department and new staffing.

## Future improvement ideas

Moisture damage prevention sheets currently used in Swansea bay Intensive Treatment Unit – can remain under high risk patients to reduce moisture.

Pressure damage champion/assessor, enhanced champion role do provide support and assurance on categorising, treatment, documentation and Datix.

## Current ongoing work

Various training and study days available provided by the Tissue Viability Nurse team and specialists for moisture damage and equipment

Focus on April for training and pressure damage awareness.

ITU switched to new product to reduce pressure damage from devices related to NG – ongoing pilot

Band 6 /7 training in WGH regarding second checker and categories.

Ongoing footcare improvement work across health board linked with podiatry.

Bespoke full training days for IENS across GGH and PPH currently.  
Review of repose products

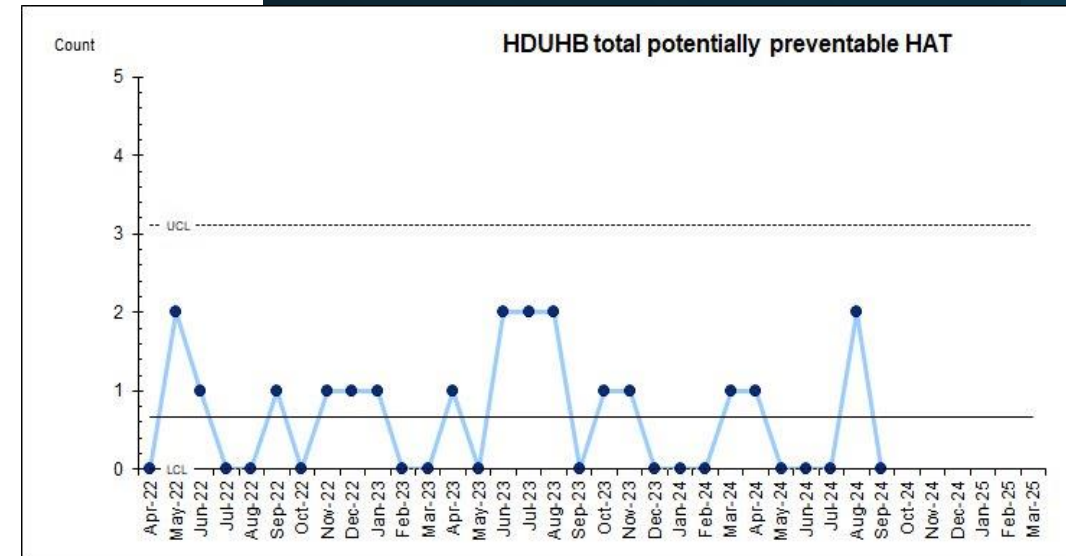
# Hospital Acquired Thrombosis (HAT) Improvement

From 2021-2023 there were 14 PDSA cycles to support HAT improvement

## PDSA cycles 2024-2025 are shown below

Review of current IT process for HAT data – January 2024	Introduction of new lower limb immobilisation risk assessment – April 2024	Medicines management study day for Nursing – April 2024	Band 6 forum GGH April 2024
VTE risk assessment within drug chats PPH AMAU – April 2024	CDU GGH board rounds, information board, review of clerking pro-forma - April 2024	QI project at WGH from Junior Doctor – April 2024	PPH pharmacy prescribing in AMAU April 2024
Board rounds WGH Ward 11 – April 2024	Medical teaching at WGH June 2024	Medicines management training with VTE in GGH and PPH July 2024	Review of VTE risk assessment
Removal of Covid-19 Risk Assessment	QI project with Junior Doctors at GGH	Junior Doctor training at GGH and PPH November 2024	New lower limb immobilisation patient information leaflet

Approved in patient VTE prevention leaflet roll out





# Thrombosis UK

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## Successes

- Bronglais Hospital (BGH) has been shortlisted for a Venous thromboembolism (VTE) prevention award for the Thrombosis VTE awards
- Ceremony is 13th May 2025 in the House of Commons
- Hywel Dda (HD) have collaborated with Thrombosis UK to design and develop a Welsh lower limb immobilisation patient information leaflet which is now on the Thrombosis UK national website
- First and only Welsh Health Board to have a suite of VTE audits on Audit Management and Tracking System (AMaT) – we are sharing this across Wales
- HD are to be the pilot site to gain VTE exemplar status

# Nutrition & Hydration Improvement

Four acute sites have embedded new Nutrition and Hydration/ AKI assurance meetings. Terms of reference and Agenda for meeting currently being reviewed by operational teams.

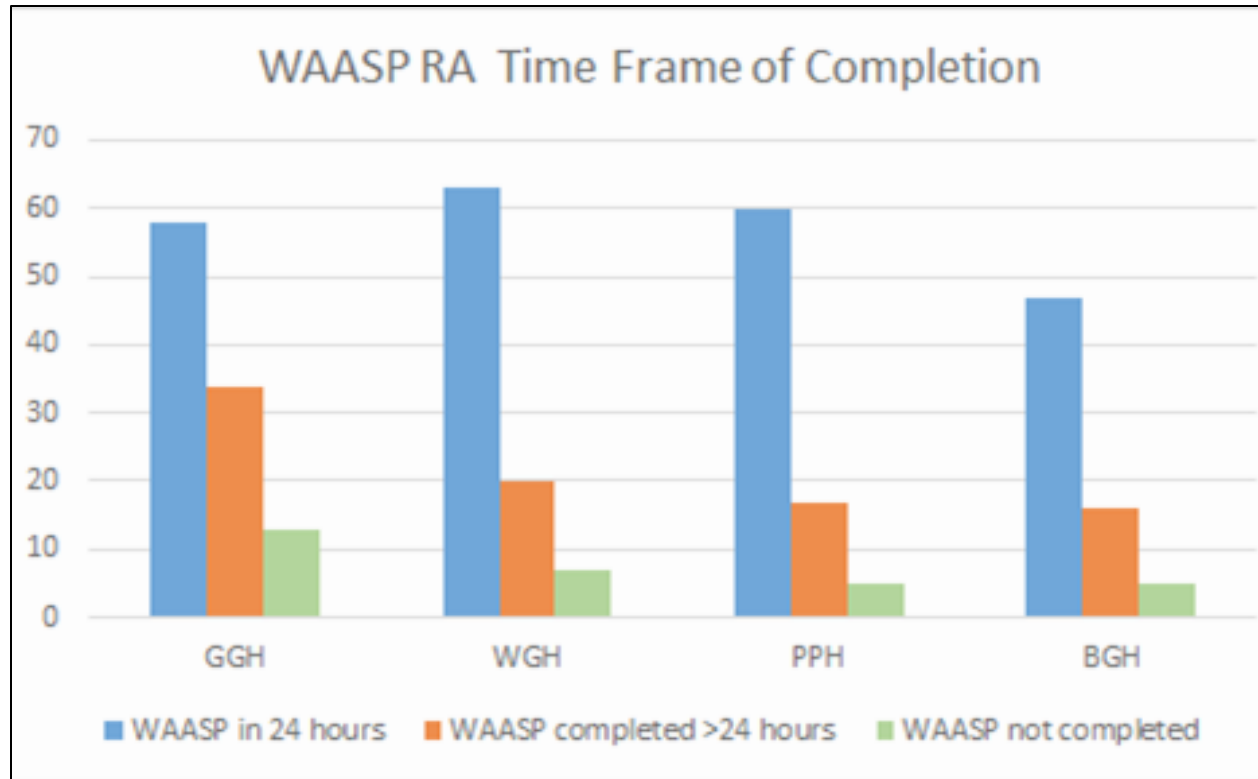
Nutrition and Hydration/ AKI Champion Educational Workshops continue to be rolled out across the Health Board. Delivered in collaboration with dietetics and quality improvement team.

Mealtime observations completed on 100% wards across the Acute sites. Fortified milkshakes are being rolled out within ward areas across the Health Board alongside nourishing snacks.

Red Tray scheme for mealtimes being relaunched across the Health Board. Red tray options shared with ward staff for consideration and procurement supporting.

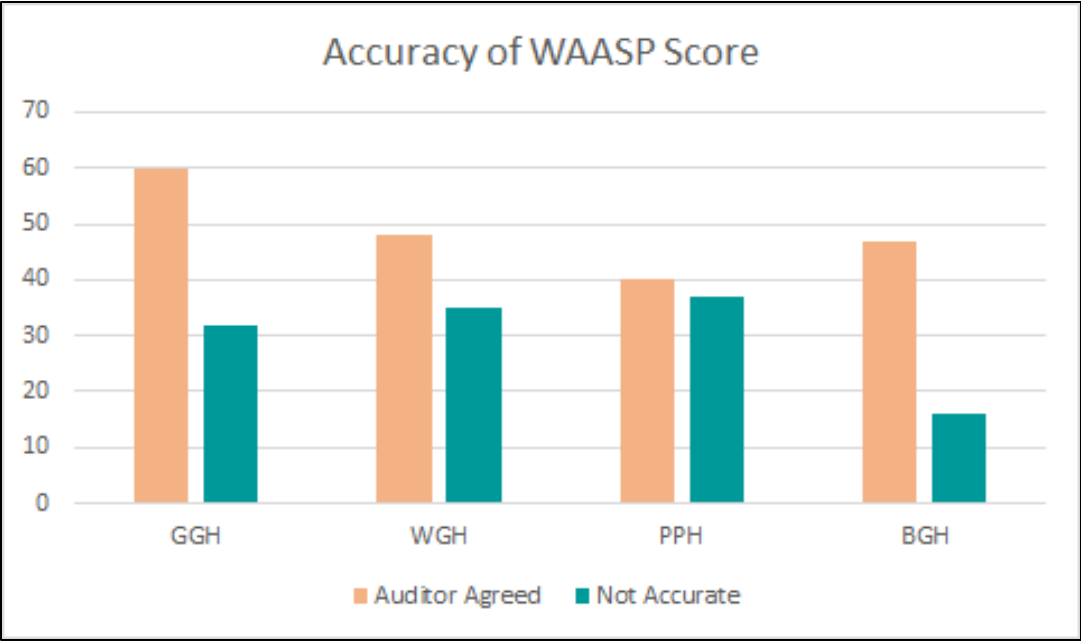
WAASP (Weight, appetite, ability to eat, stress factors and Pressure Ulcers) Screening and accuracy of risk assessments being rescoped by end of March 2025 across the Health Board and will be reviewed against data for 2024.

# WAASP Nutrition Risk Assessment (RA) Completion 2024

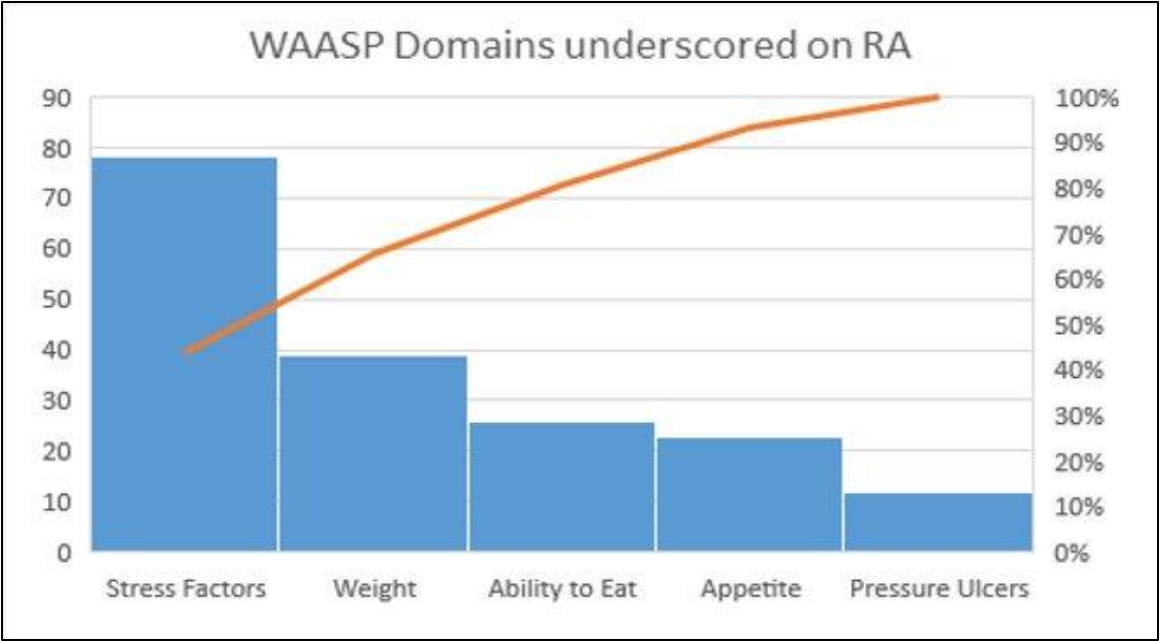


- WAASP RA assessed < 24 hours = 66% across HB
- WASSP assessed > 24 hours = 25% across HB
- WAASP RA not assessed = 9% across HB
- For the continued data we have deducted 30/345 patients due to no completed risk assessment.

# WAASP Risk Assessment Accuracy 2024



62% assessments were completed accurately and 38% were not accurate for the patients reviewed.



The above Pareto chart indicates the frequency of defects, as well as their cumulative impact. The data identifies the domains of the WAASP risk assessment which have been underscored for patients resulting in an incorrect outcome. The stress factor domain can be seen to be the most underscored.

# Site based Nutrition and Hydration (N&H) Improvement work



Water coolers installed W/C 10th March 25 in 4 Acute Site ED departments. Food Vending machines in place for 24-hour access within the waiting area.



Sunderland Ward in South Pembrokeshire Hospital -menu redesign with patient engagement, Apetito Catering Company undertook site visit. Staff training and Picture Menus being created for Patients. Communication with Lead Dietitian within Mental Health Services to spread this improvement work.



GGH site – Nutrition and Hydration Collaborative improvement programme commenced. All wards have PDSA cycles around Protected mealtimes, red trays, snacks and fortified milkshakes, mealtime coordinator.

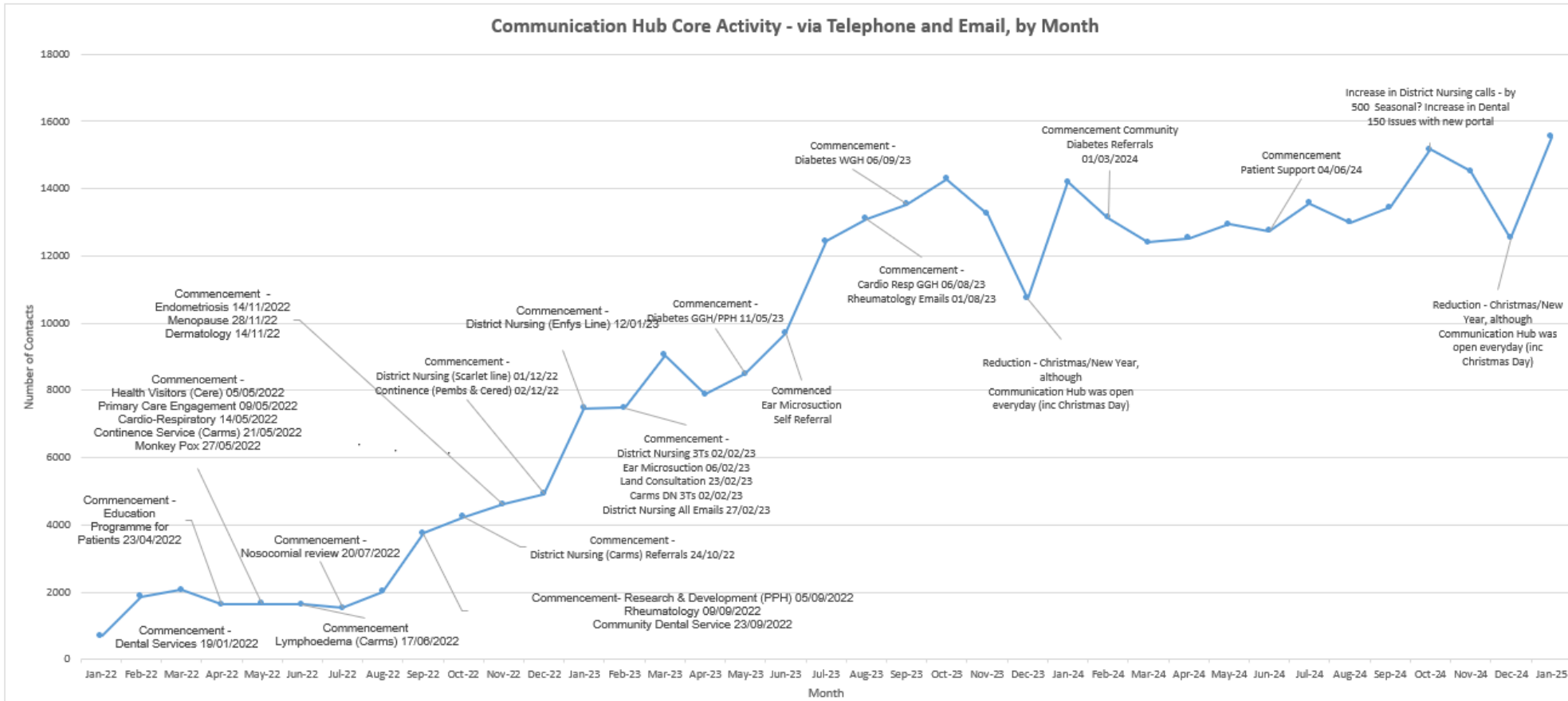


All Wales Food Safety & Allergen Awareness E- Learning Module drive around staff completion. Await confirmation if will become mandatory within HDUHB. Bespoke E Learning module for BGH site focusing on their food service model and food safety.



Nutrition and Hydration Week 17th- 21st March 2025 – Afternoon Tea Parties, Poster Competitions showcasing ongoing N&H improvement work, Ward pledges and team commitments for 2025.

# Communication Hub



The aim of the Communication Hub is to maximise the benefits to patients, staff and the supported services:

- Releasing clinical time
- Releasing capacity of local administration teams and services
- Reducing waste ie vacant or missed appointments, duplication of contacts, improved pathways and process
- Improving patient experience
- Improving clinical outcomes
- Introducing consistent auditable processes for query and email management

# Service Transformation team workstreams outside EQliP

Optimal Hospital Flow Framework (ministerial priority) as part the 6 Goals Programme Safe Hospital Care Workstream

Preventing deconditioning

Red2Green

Discharge to Recover to Assess pathways

Delayed Pathways of Care (DPOC)

Discharge work

Criteria led Discharge

Emergency Quality Statement and GIRFT recommendations

Promote, Prevent, Prepare (3P's) Planned Care Policy implementation

# Overview of Safe Hospital Care workstream

- The Service Transformation team supports the Safe Hospital Care Workstream that has been established within the 6 Goals Programme to support optimal patient care and flow across the acute and community hospital system.
- The Workstream oversees the operational implementation of the national Optimal Hospital Flow Framework, as well as the Emergency Department Quality Statement (EDQS) and Getting It Right First Time (GIRFT) recommendations.
- The Workstream feeds into and support the development of the other 6 Goals Workstream elements to ensure a joined-up system approach for Urgent & Emergency Care.
- The Service Transformation team provide site-based support to clinical and operational staff to support practical implementation of the workstream objectives.
- The outcomes of the workstream impacts on ED performance and ambulance handovers

# Overall objectives:

## **Optimal Flow Framework**

- To ensure people who are admitted to hospital receive optimal care (by embedding board rounds, the SAFER flow bundle, Red2Green principles and actively preventing deconditioning), and are discharged when clinically ready (Discharge to Recover to Assess pathways, Criteria led discharge), with the right support and without delay. This should support a reduction in pathways of care delays, reduce wasted days in hospital without value, and improve patient and staff experience.

## **ED Improvement**

- Enhance the quality of care, improve patient safety and the efficiency of the Emergency Departments in the health board ensuring the right patient is treated in the right place (redirection policy, 4- hour breach clinical exceptions) at the right time (boarding protocol, ambulance handovers, optimal hospital flow elements).

## **Discharge work**

- Provide staff and patients/carers with adequate resources and information to support discharge planning from the point of admission to improve timely discharges across the health board.

## **Pathways of Care Delay (POCD)**

- Support the reduction of pathway of care delays to enhance patient care and improve overall system efficiency.

# Optimal Flow resources and intranet site for staff developed to support implementation- over 1000 views

## Optimal-Hospital-And-Patient-Flow-Framework

**Optimal Hospital & Patient Flow Framework (Policy Goal 5)**

Optimal hospital-based care is provided for people who need short term, ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice.

**The Hywel Dda University Health Board Red2Green Dashboard has just launched on IRIS**

[Red2Green Dashboard](#)  
[Click here to view](#)

\*Please ensure that Red2Green entry on Frontier provide a true reflection of your board round and afternoon huddles\*

- The R2G Dashboard will show the top constraints (i.e. Red days and their reasons) for the Health Board and each individual ward.
- This will provide staff with a clearer idea of internal and external delay themes and trends.
- The Red2Green Dashboard pulls information directly from Frontier daily.

**Green: A Day of Value for a patient**  
A patient has a day of value (Green) if all planned actions have been completed for that day and the patient needs to be in the hospital to receive care.

**Red: A Day of no Value for a patient**  
A patient has a day of no value (Red) if one or more planned actions have not been completed or if the patient could have received their care at home or in a

## Your Board Round Checklist

What actions need to be taken today to progress each patients care and get them home sooner?

Before you start your morning board round:

- Ensure the board is updated (new patients/ bed moves)
- **SORT** patients (Sick Patients, Out Today, Rest of Patients, To Come In)
- Mark all patients as RED on the board
- Check Estimated Date for Discharge (EDD), Clinical Criteria for discharge (CCD) [if condition allows], and D2RA pathway are set and updated on the board/ Frontier
- Assign a person who will update the board round actions on the board/ Frontier

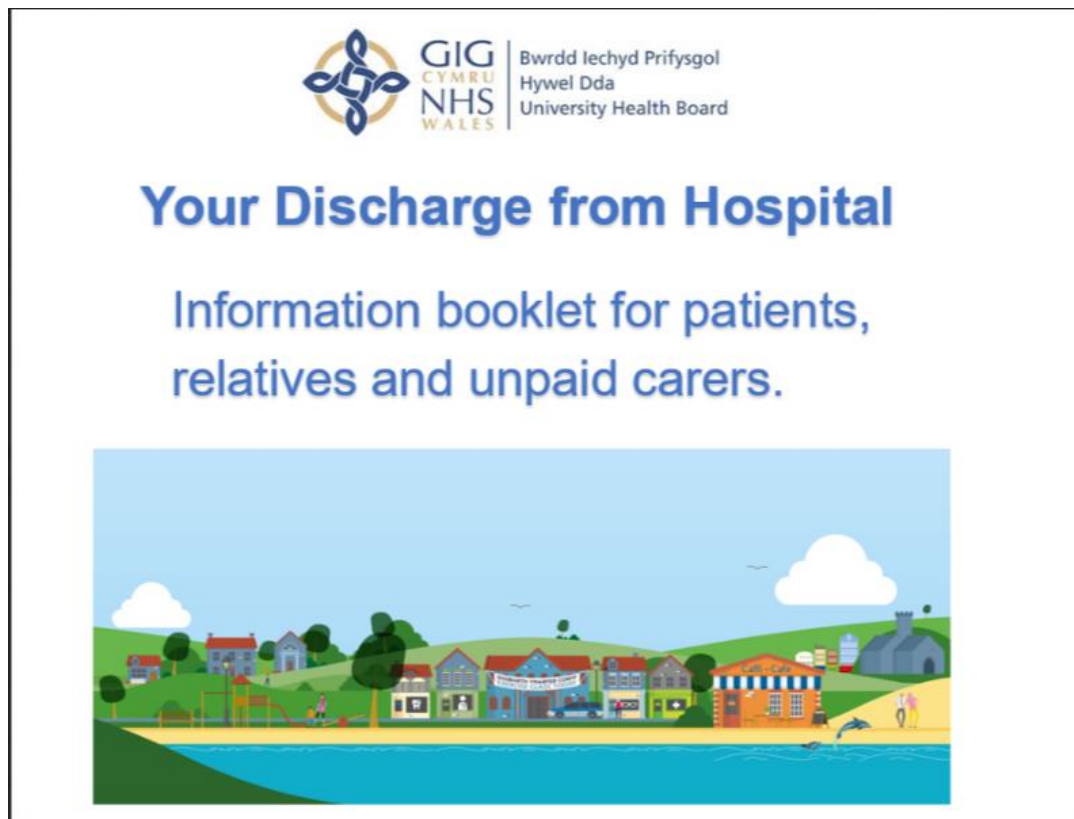
Board Round Checklist
At the end of the board round you should be able to answer the 4 Questions <b>every</b> patient needs to know.
<b>What do you think is wrong with me?</b>
<ul style="list-style-type: none"> <li>• Confirm current or suspected diagnosis</li> <li>• Identify who is clinically optimised</li> </ul>
<b>When can I go home?</b>
<ul style="list-style-type: none"> <li>• Review/ update Estimated Date of discharge</li> </ul>
<b>What needs to happen to get me home and what can I do to speed things up?</b>
<ul style="list-style-type: none"> <li>• Set/ review/ update Clinical Criteria for discharge (if needed)</li> <li>• Identify/ review relevant D2RA pathway (default is Pathway 0)</li> <li>• What can the patient do today to aid recovery and prevent deconditioning?</li> </ul>
<b>What is going to happen to me today?</b>
What actions needs to be done <b>TODAY</b> to progress the patient's care and get them home sooner? Write/ document all actions on the board/ system.
<ul style="list-style-type: none"> <li>• <b>What test/ interventions/ treatments are needed today?</b> Identify who is responsible for each action</li> <li>• <b>What actions will be put in place to prevent deconditioning/ promote recovery?</b> (mobilisation, nutrition/hydration/ continence management/ delirium prevention)</li> <li>• <b>What actions are needed to get patients identified for discharge <u>home for lunch</u>?</b> (TTO's/ transport/ equipment/ care arrangements/ communication with family/ carers), can the patient be transferred to the discharge lounge as early as possible?</li> <li>• <b>Who needs to see the patient today to progress their care and make the actions above happen?</b></li> </ul>
<b>Ensure Frontier is updated after each board round</b>

At the end of the board round:

- Identify any known patients waiting to be transferred to the ward or to come in.

Afternoon Huddle between 2-3pm
<ul style="list-style-type: none"> <li>• Update completed actions on the board/ Frontier</li> <li>• If <b>all actions</b> are completed for a patient - <b>change from Red to Green</b> on the board/ Frontier</li> <li>• Identify any outstanding actions and delays – update reasons for "Red" on Frontier</li> <li>• Address outstanding actions and escalate (if appropriate)</li> <li>• Identify <b>potential discharges for tomorrow</b> and actions needed to facilitate the discharge as early as possible (Home for lunch)– can the patient be discharged today?</li> <li>• Update Frontier and ensure predicted discharges are marked as <b>"O"</b> under SORT</li> </ul>

# Criteria led discharge guidance for staff and Discharge Booklets for patients an relatives



Attach Addressograph

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

### Criteria Led Discharge Form


<b>Ward/Department:</b>		<b>Estimated Date of Discharge:</b>	
<b>PART A</b>			
<b>Name of Consultant/Senior Clinician decision maker:</b>		<b>Signature:</b>	<b>Date:</b>
Discharge Criteria: Senior Clinician to identify below the key milestones/criteria that need to be met for the patient to be discharged. (including DNA CPR status/ safeguarding matters where appropriate)			
<b>Discharge Criteria</b>			
1.			
2.			
3.			
4.			
5.			
<b>PART B</b> CLD Checklist: Completed by CLD approved practitioner-please mark when completed			
<input type="checkbox"/> Patient informed-CLD leaflet/information provided			
<input type="checkbox"/> TTO completed, and medication dispensed			
<input type="checkbox"/> Next of Kin aware (if appropriate)			
<input type="checkbox"/> Transport booked (if appropriate)			
<input type="checkbox"/> Information documented in notes			
<input type="checkbox"/> Discharge summary completed			
<input type="checkbox"/> Patient functionally optimised and discharged from Therapies (if applicable)			
<input type="checkbox"/> Equipment arranged and delivered e.g. catheter supplies (passport) /continent supplies/ mobility aids /wound care dressings (if applicable)			
<input type="checkbox"/> Relevant referrals completed (if applicable) e.g. community nursing/ therapies			
<input type="checkbox"/> Relevant community services informed, service (re) start date confirmed (if applicable) e.g. OOH GP, ART, reablement			
<b>PART C</b> - completed by CLD approved practitioner once all agreed milestones achieved- please indicate role:			
<input type="checkbox"/> Consultant			
<input type="checkbox"/> Registrar			
<input type="checkbox"/> SHO			
<input type="checkbox"/> Advanced Clinical Practitioner			
<input type="checkbox"/> Registered Nurse			
<input type="checkbox"/> Therapist			
<b>Discharge criteria met:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>If no reason why:</b>	
		<b>Contact No:</b>	
		<b>Date:</b>	
<b>If no - review for discharge tomorrow?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Name:</b>	
		<b>Signature:</b>	
		<b>Time:</b>	


Support the development of the Discharge toolkit for staff and actions from the Discharge audit

## Hospital Discharge Toolkit

The screenshot shows the top navigation bar of the Hywel Dda University Health Board website. It includes links for 'HDD\_Intranet', 'Directorate', 'COVID', 'Log an IT issue', 'Reporting something', 'Jobs', 'News', and 'Find it fast'. The main header features the 'Hywel Dda Operations' logo and navigation options like 'Home', 'Departments', and 'Find it fast'. A secondary navigation bar contains '+ New', 'Promote', 'Translation', 'Page details', 'Immersive reader', and 'Analytics'. The page is dated 'Published 13/03/2025' and includes 'Share', 'Edit', and 'Not following' options.

### Hywel Dda University Health Board: Hospital Discharge Toolkit

 **Toolkit Aim**

 **Checklist for Simple Discharges**

This Hospital Discharge Toolkit has been developed to bring together tools, guidance documents and online resources to support you and your teams to ensure patients are discharged safely and timely, as well as providing advice on whether to access more specialist support and advice when needed.

Discharge or the transfer of care from hospital is a process which starts from the point of admission and is an essential part of the patients care management in acute or community hospital settings. Good discharge planning requires health and social care systems to be proactive in supporting individuals and their families and carers to either return home or transfer to another setting.

Discharge planning can be a complex process involving care coordination among hospital staff, between hospital staff the

- ✓ Patient ready for discharge
- ✓ Patient, family, unpaid carers, care partners aware of planned discharge
- ✓ Discharge letter and TTO's prepared
- ✓ Equipment / dressings provided



Implementation of Frontier across acute and community sites

Over 4300 patient updates per week

CAPTURE **Withybush General Hospital** Last updated: today at

### Discharge management

Patient breakdown  
Clinically optimised 32 DPOC 31 MONITOR PATIENT

Showing 16 of 197 patients Filter patients by location: WGH - Acute Frailty Unit View another worklist: Select... EXPORT PATIENT LI

MY WORK LIST	NAME	BED NUMBER	SORT STATUS	LOS TO DATE	CARE EXPIRY	TIME UNTIL EDD	D2RA	RED/GREEN	PATIENT STATUS	CCD
<input type="checkbox"/>		Side Room 2	R	6 days	No care setup	7 days ●	1	Red	Receiving care	X
<input checked="" type="checkbox"/>		Bay 1, Bed 3	R	12 days	No care setup	7 days ●	0	Red	Receiving care	X
<input type="checkbox"/>		Bay 4, Bed 3	R	16 days	No care setup	7 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		Bay 4, Bed 2	R	20h 31m	No care setup	7 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		Bay 3, Bed 3	R	2 days	No care setup	7 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		Bay 3, Bed 4	R	6 days	No care setup	11 days ●	1	Red	Receiving care	X
<input type="checkbox"/>		Bay 4, Bed 4	R	20h 49m	No care setup	12 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		WGH - Acute Frailty Unit	R	15 days	No care setup	14 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		Side Room 3	R	18 days	No care setup	14 days ●	3	Red	Receiving care	X
<input type="checkbox"/>		Bay 2, Bed 4	R	3 days	No care setup	28 days ●	3	Green	Receiving care	X

# Red2Green

- Identifying days of no-value for patients in hospital (Red days)
- Identify areas for improvement (system constraints)
- Red2Green dashboard developed



### A DAY OF NO VALUE

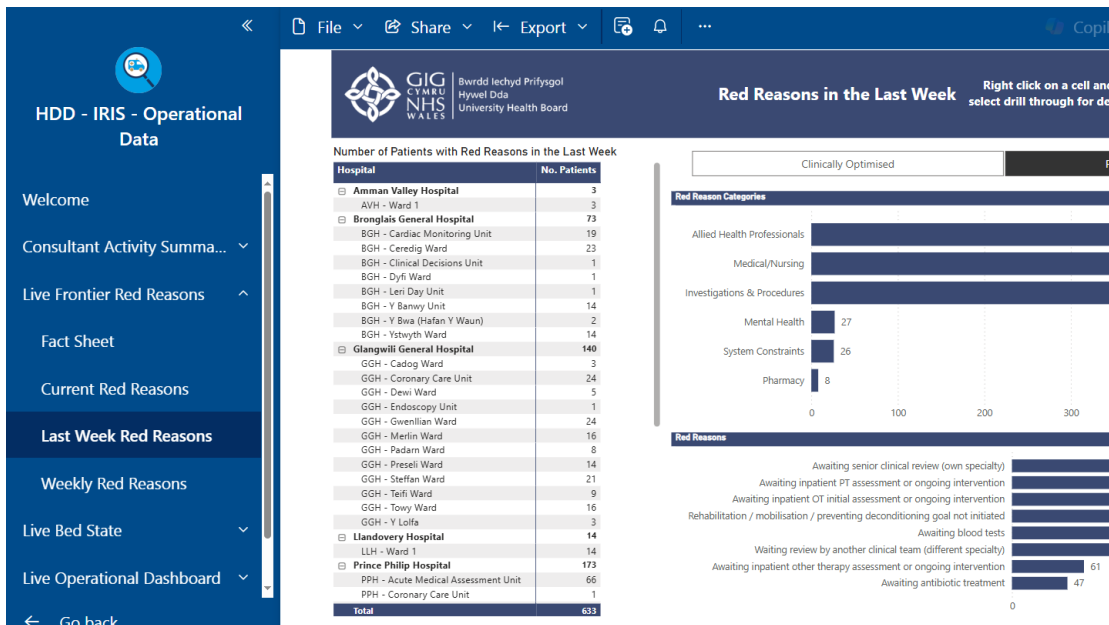
**KEY QUESTIONS**

1. Can the patient care or interventions received today be delivered at HOME or in a non-acute setting?  
**YES – It's a RED DAY**
2. If I saw the patient in an outpatient setting, would their current 'physiological status' require an emergency admission?  
**NO – It's a RED DAY**

- Inadequate MDT presence at the Board Round to allow firm decisions to be made.
- The care or interventions the patient is receiving today could be delivered in a non-acute setting.
- Tests and investigations have occurred but the results have not been reviewed by the Medical team and acted upon.
- A planned investigation, clinical assessment, discharge assessment or therapy intervention for today does not occur.
- Acute - The medical care plan lacks a Senior Medic approved expected date of discharge.
- Acute - The patient is a new admission and has not yet had a medical review/there is no initial diagnosis/treatment plan.
- If a patient is due for discharge today and the discharge prescription medications are not ready (Pathways of Care Delay).
- Transport delaying discharge or causing plans to fail today.

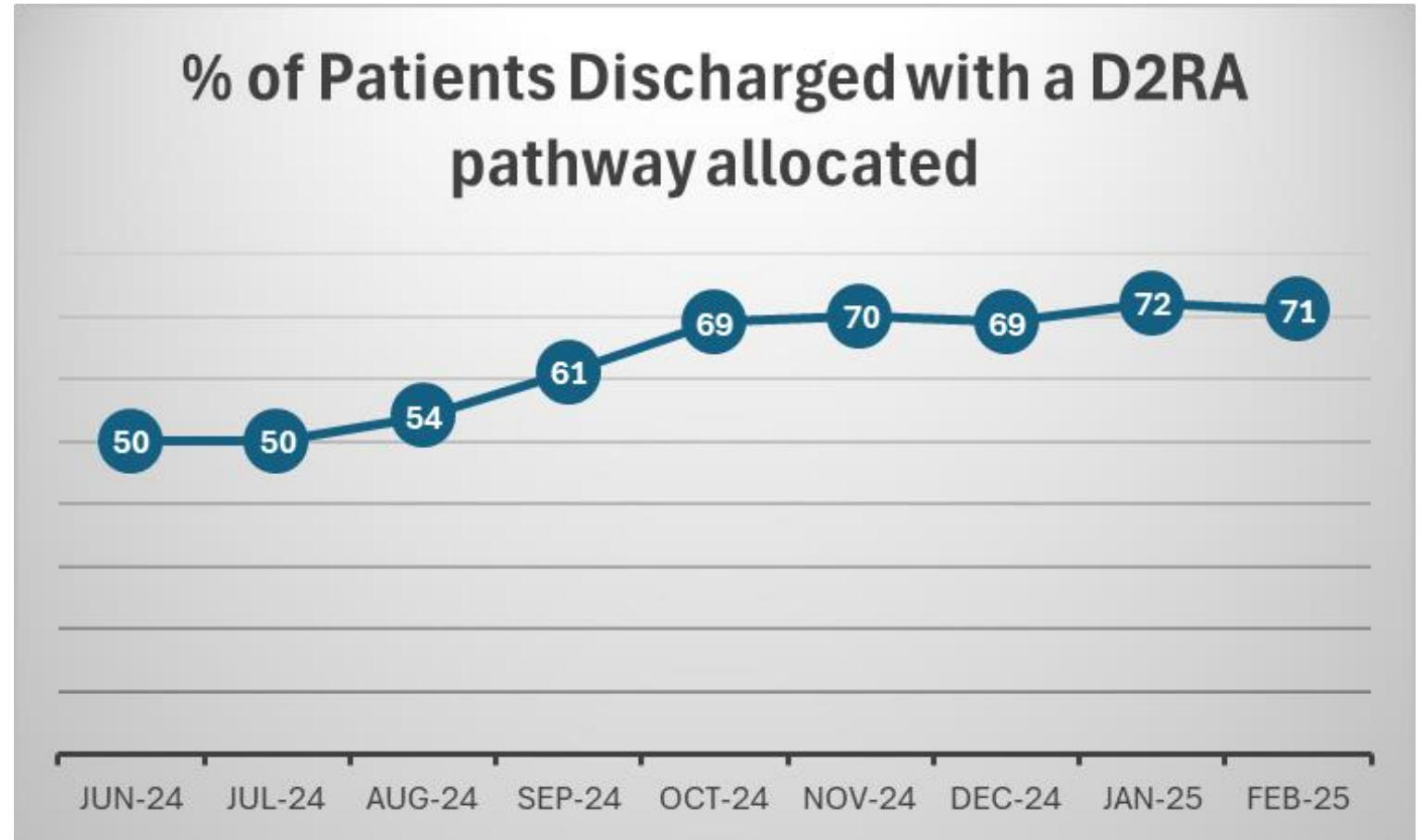
### A DAY OF VALUE

- Patient progresses towards discharge
- Everything planned and requested is done
- Patient needs this bed for Acute care
- Everything that was planned for today gets done
- The patient requires acute hospital care
- The patient requires community hospital care
- The results from tests and investigation have been reviewed by the Medical team and acted upon
- The patient is receiving active interventions to get them to be discharged by tomorrow, and the discharge prescription medications are ready by the evening before the expected date of discharge.



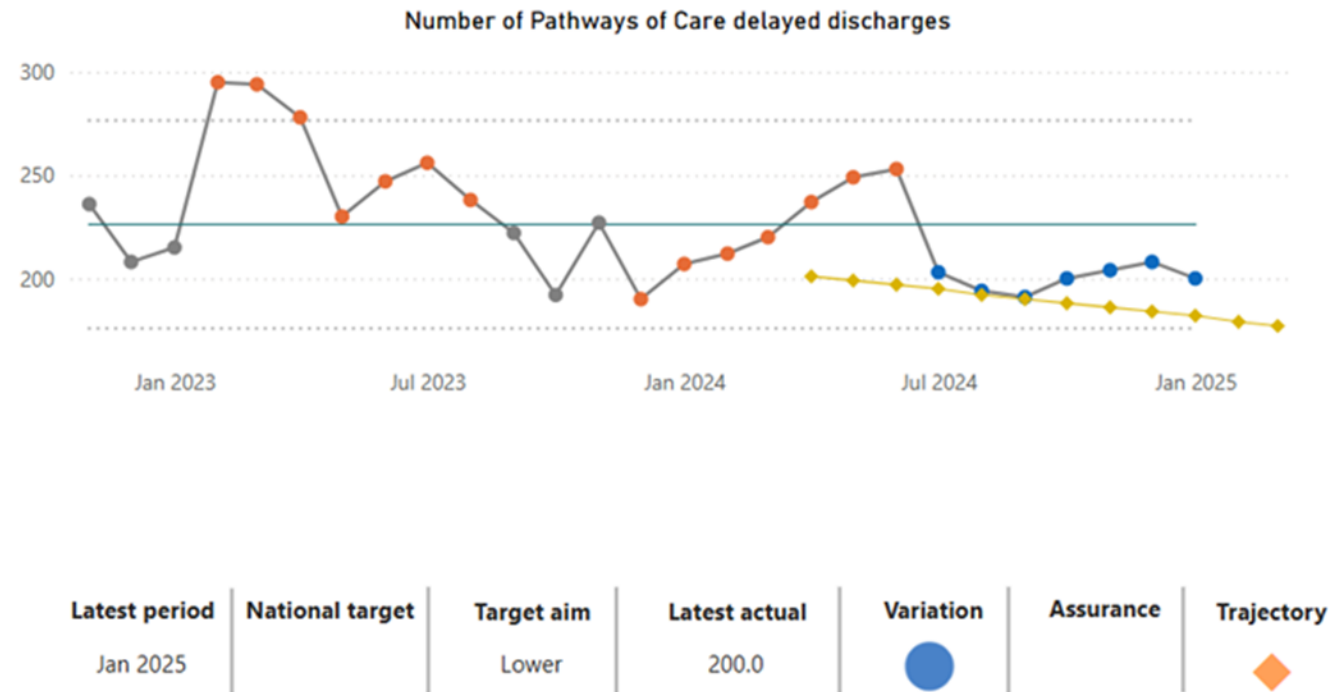
# D2RA Pathways

Significant improvement in national D2RA measures



# DPOC and ED

- Lead DPOC workstream
- ED performance- linked to delivery of Optimal Flow
- Optimal use of discharge lounges to support ED flow
- Development of an ED/MIU Redirection policy to reduce ED overcrowding and waiting times



# 3P's Implementation: Promote, Prevent, Prepare

## **Waiting List Support Service (WLSS):**

- Keep patients regularly informed of their current expected wait
- Offer a single point of contact should they need to contact us
- Provide advice on self-management options whilst waiting
- Offer advice on what to do if their symptoms deteriorate
- Establish a systematic approach to measuring harm – bringing together the clinically assessed harm and harm self-assessed by the patient and use this to inform waiting list prioritisation
- Offer alternative treatment options if appropriate
- Incorporate review and checking of patient consent

## **Optimisation and Prehabilitation Service:**

- Standardised tiered virtual optimisation and prehabilitation model supported by digital healthcare solutions
- Improved physical and psychological wellbeing
- MDT team

# WLSS Patient feedback

Responses to 'FFT' automated service via CIVICA for WLSS			
I am very impressed that Hywel Dda have this facility. When on long waiting lists, people's situations can change and also you show an awareness that each person will have different issues to a greater or lesser extent. Thank you for doing this.		I was sent some apps that will help with my weight loss, and my anxiety... I already have the exercise app from physio which is very helpful. I felt much better after the call; EH was kind and cheerful and she listened very well. Thank you, everyone!	
Very friendly and informative	MT was brilliant. Non-judgemental, sympathetic and understanding. Knowledgeable and gave great advice and quick to forward on apps that will help me		Lovely to speak to <u>some one</u> who cares.
Confirmed I had been <u>referred</u> by my GP as I had no confirmation of it via email or letter. Link for form for applying for physiotherapy while waiting for treatment		I wasn't aware it existed. So much information/assistance available. It doesn't help your place on the waiting list but, there are people/organisations available to reach out to for help	
The lady who spoke with me, LJ was very personable and gave me lots of information/links to organisations who could help while I'm waiting		She went out of her way to try and help me.	Satisfied with current support
Staff very approachable and understanding, took time to explain all I needed to know	EH was extremely helpful		The service gave me very helpful advice supportive and friendly. Thank you
Since my diagnosis I have days where I'm down in the dumps. AW explained who I could contact just to have a chat or get advice before my mental <u>well being</u> deteriorated.	Just knowing there their if I need to talk		The only time I got any answers from a lovely lady, after speaking to her, I had much more understanding about my concerns about confusion over my eye operation, she was very reassuring and gave me the answers I needed, <u>thankyou!</u>

# WLSS reporting

- Activity and outcomes of WLSS reported to WG from September 2024
- Over 1000 contacts per month



Specialty	Contact Type		
	Inbound	Outbound	Other
Dermatology	23	13	2
ENT	6	14	0
Gastroenterology	2	1	1
General Surgery	8	20	2
Gynaecology	9	33	0
Ophthalmology	57	187	12
Trauma and Orthopedics	41	234	17
Urology	17	74	4
Other	46	15	3
<b>Total *</b>	<b>470</b>	<b>659</b>	<b>41</b>

Contact Outcome	Specialty									TOTAL
	Gynaecology	General Surgery	ENT	Dermatology	Urology	Ophthalmology	Trauma and Orthopedics	Gastroenterology	Other	
Escalate to Specialty - Pathway concern	0	0	0	0	1	0	1	0	1	3
Escalated Internally to Nurse/Clinical Lead	1	3	0	2	2	4	10	0	2	24
General Condition Management Advice Given	18	15	9	26	40	110	137	2	43	400
GP - Deterioration of Condition	2	5	0	2	1	1	9	0	5	25
Link to Digital Health Apps Sent	2	1	1	1	0	2	8	0	60	75
Making Every Contact Count (MECC) Conversation	9	4	2	11	30	58	107	0	13	234
Primary Care Other	0	0	0	0	0	38	2	0	3	43
Ref back to GP re: New Health Issue	0	0	0	1	2	3	4	0	1	11
Ref back to GP for pain review	1	2	0	1	1	1	13	0	2	21
Ref Other Therapies	1	0	0	0	0	0	3	0	4	8
Ref to 3rd Sector charities	0	0	1	0	0	6	2	0	3	12
Ref to 999/Medical Emergency as Red Flag	0	0	0	0	0	0	0	1	0	1
Ref to Consultant	0	0	0	0	0	1	2	0	2	5
Ref to Early Optimisation & rehab team	0	0	0	0	0	0	7	0	0	7
Ref to NHS 111 Waiting Times	3	2	0	6	6	16	6	0	8	47
Ref to OT	0	1	0	0	0	0	3	0	0	4
Ref to PALS	2	1	0	0	0	2	2	0	0	7
Ref to Physio	0	0	0	0	0	3	0	0	2	5
Ref to Self Management Programme (EPP)	0	0	0	0	3	2	14	0	5	24
Ref to Smoking Cessation	0	1	0	0	1	0	1	0	1	4
Ref to Social Care/Local Authority	0	0	0	0	0	0	4	0	0	4
Ref to Specialist Nurse	0	0	0	1	1	1	1	0	0	4
Refer to Mental Health Services (GP, 111, CRISIS etc)	2	0	0	0	2	1	1	0	1	7
Self referral recommended to Weight Management/Drugs & alcohol	0	0	0	0	0	0	3	0	0	3
Signed up to PKB	2	0	0	0	0	0	4	0	0	6
Signposted to Online Resources	5	0	2	3	1	5	20	0	3	39
Other										0

# WLSS: Identifying and managing deterioration and waiting list prioritisation

- Patient communication advising them to contact the WLSS if their condition deteriorate.
- Scripts with “red” flags developed for non-clinical call handlers
- Telephone review by clinical staff within WLSS
- Escalation routes into services
- **Patient stratification based on** Waiting Well PROM/ EQ-5D-5L from point of listing and repeated 6 monthly till treatment



➤ Stratification Criteria (based on PROM results)	
<b>RED</b> ➤ Refer to Optimisation and Prehabilitation Service	<ul style="list-style-type: none"> <li>▪ BMI greater than 35</li> <li>▪ Exercise: 1 hour or less per week.</li> <li>▪ EQ-5D-5L Scores: Score 5 in MOBILITY, SELF-CARE &amp; USUAL ACTIVITIES</li> </ul>
<b>AMBER</b> ➤ Contact from WLSS Nurses	<ul style="list-style-type: none"> <li>▪ BMI: less than 18.5 or between 30 and 35</li> <li>▪ EQ-5D-5L Score 4 in MOBILITY, SELF-CARE and USUAL ACTIVITIES.</li> <li>▪ Score 5 in PAIN / DISCOMFORT and ANXIETY / DEPRESSION</li> <li>▪ VAS Scores: Less than 20</li> <li>▪ Comorbidities: Responds ‘yes’ to any comorbidity (even if more than 1)</li> <li>▪ Polypharmacy: 4 or more medications</li> </ul>
<b>YELLOW</b> ➤ Contact from non-clinical call handler ➤ MECC conversation	<ul style="list-style-type: none"> <li>▪ BMI of between 25 to 29</li> <li>▪ Exercise: More than 1 hour and up to 2 hours &amp; more than 2 hours and up to 3 hours.</li> <li>▪ EQ-5D-5L Score 2 or 3 in MOBILITY, SELF-CARE and USUAL ACTIVITIES, PAIN / DISCOMFORT and ANXIETY / DEPRESSION</li> <li>▪ VAS Score: 20 up to 60.</li> <li>▪ Smoking: Smoker</li> <li>▪ Alcohol: 14 or more units per week.</li> </ul>
<b>GREEN</b> ➤ No additional intervention required. ➤ Open access to WLSS and Waiting Well resources online	<ul style="list-style-type: none"> <li>▪ BMI: of 18.5 up to 25.</li> <li>▪ Exercise: Above 3 hours per week.</li> <li>▪ EQ-5D-5L: Level 1 in all domains</li> <li>▪ VAS Score: more than 60.</li> <li>▪ Comorbidities: Does not score ‘yes’ to any comorbidities.</li> <li>▪ Polypharmacy: Less than 4 medications</li> <li>▪ Smoking: Non-smoker</li> <li>▪ Alcohol: Less than 14 units per week.</li> </ul>

# Optimisation and Prehabilitation Service: Patient feedback

*“I have found the programme life changing. It provided me with the ‘jolt’ I needed to make changes and improve my health. I can’t speak highly enough of the team the programme has been hugely beneficial. I am continuing with a healthy eating diet and exercise at home”*

*“I am happy with the programme and there were some great parts of the programme. I felt that the part on nutrition and diet and foods was very helpful and also the 1:1 opportunity with dietitian Ben Lewis. I also found that the mental health and well being week was really helpful and the exercises. I am doing the exercises on a daily basis and is using all the information I have received over the programme as part of my ‘tool box’ to better myself.”*

*“I am really pleased I did the programme. Before starting the programme I was in a place where I just didn’t see the point in doing things and I was really low. The programme has been nice, I have enjoyed speaking to others. The exercises have allowed me to move easier. I have started exercises in the booklet. I feel very prepared for my operation tomorrow”*

*“I have really enjoyed the programme and found it very educational. It has been great to have contact with the team, as I felt that I had just been forgotten about and this has given me light at the end of the tunnel. I have taken on board a lot of healthy eating tips and has been following the eat well guide religiously. It has made me think more about my diet and I have made changes like thinly spreading butter on bread and cutting out chocolate. Care and repair have been out and fitted an additional handrail on the stairs which is excellent and very handy and has made me feel safer on the stairs. Knowing that you haven’t been forgotten about , having support and encouragement is nice to know. The exercises have helped my mobility loads also the talks in nutrition , managing pain has made me feel much more positive”*

# Optimisation and Prehabilitation Service: Letter

12<sup>th</sup> September 2024

To: all members of the Prehabilitation and Optimisation team (Orthopaedic Surgery)

I hope you will all enjoy sharing these biscuits when you take a break. They are sent with my heartfelt thanks for sharing your advice and expertise with me on your 12 week course online. It has truly been life-changing! I now feel so much more ready for a major operation on my hip. Eating sensibly and exercising daily are now part of a daily routine I hope (PLAN) to follow for the rest of my life. They have given me a new motivation to look after 'ME' when 12 years' constant care of my husband after his disabling stroke meant I had

little time for my own separate identity. I am so GRATEFUL to you and especially those I met online each Tuesday. I feel we have become friends and I shall MISS you!

Particular thanks to:

~~\_\_\_\_\_~~ for all their physio routines  
~~\_\_\_\_\_~~ (Dietician): I could not have lost 12 kg without your advice and encouragement

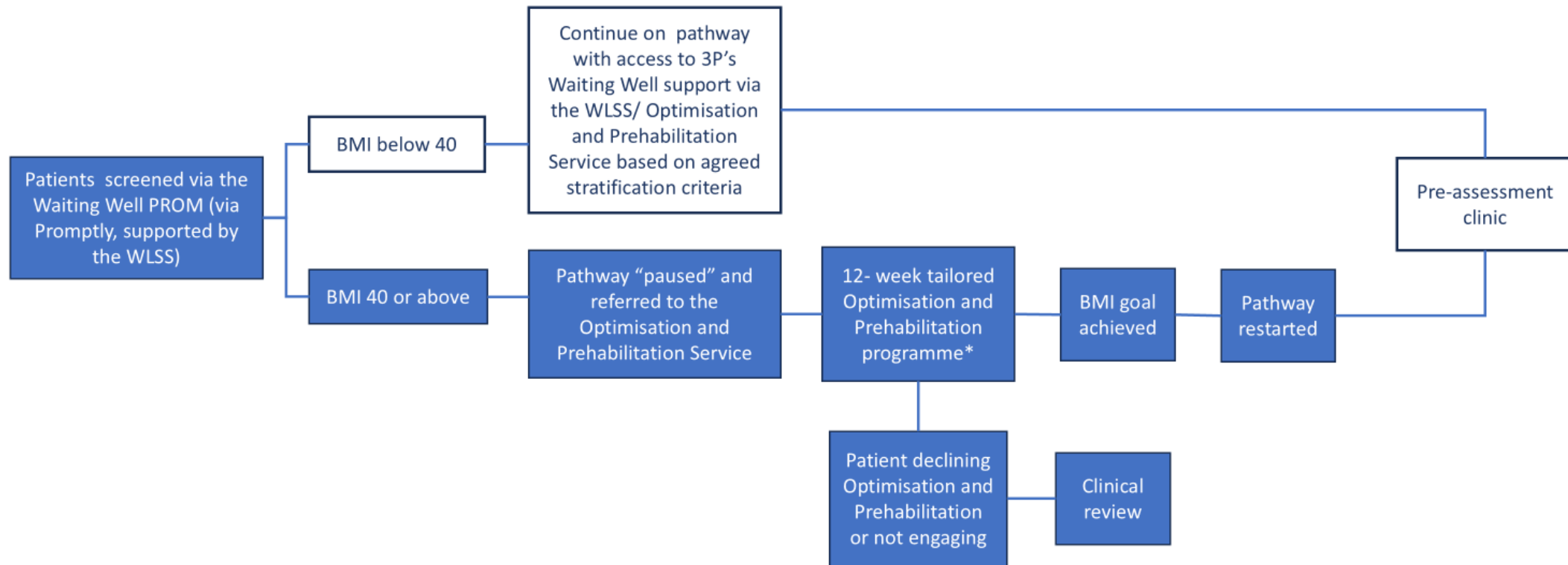
Others who give advice and support you in your office

DIOLEH YN FAWR!

# Optimisation and Prehabilitation: Patient outcomes

- 33% of patients lost weight
- Average weight loss 5.3kg
- Biggest weight loss 20kg (patient who has brought his BMI down to <40 which was his target)
- 27% improved their Oxford scores (ortho patients)
- 43% improved their EQ-5D-5L score
- 30% improved their Patient Activation Level (amount of exercise/ physical activity)
- Digital inclusion- more than 30 patients provided with digital devices and training to enable them to access digital platforms (these individuals did not have access to devices and did not use them before)

# Orthopaedic Pathway Redesign (supporting new RTT guidance)

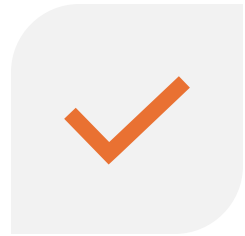


\* The 12-week period can be extended for patients who are engaged in Optimisation and actively making progress towards their BMI goal

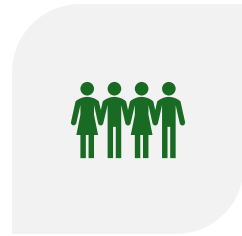
# Quality Improvement Activities New for 2024/25

- We have developed an internal Quality Improvement and Service Transformation (QIST) page for staff to access information and enquire about getting support
- [Hywel Dda QIST - Quality improvement and service transformation - Home](#)
- QI workshops in each county to support with Primary Care QI projects
- Refresh of the EQliP Workbook

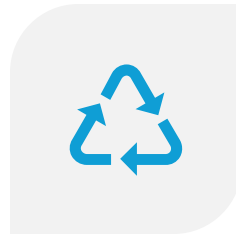
# Next steps / Future plans for 2025-6



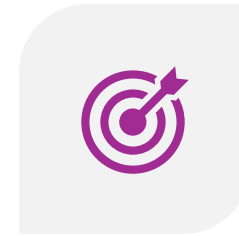
COHORT 7 CURRENTLY OUT  
FOR SUBMISSION CLOSING  
END OF APRIL 2025



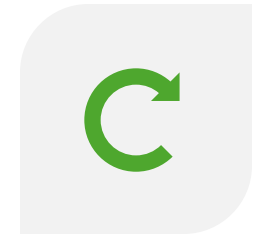
COHORT 7 DUE TO START  
JUNE 2025 WITH  
PROGRAMME REFRESH TO  
INCLUDE EQUALITY,  
DIVERSITY AND INCLUSION.



PUBLISH ARTICLE ON  
SUSTAINABILITY OF EQIIP AS  
A COLLABORATE APPROACH  
TO QUALITY IMPROVEMENT  
(UNIQUE TO HDUHB)



CONTINUE ENHANCED  
SUPPORT FOR UEC SIX  
GOALS



REFRESH OF QISF FOR 2026-  
2029

2.9

10 Mins

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2.9 - Quality, Safety and Experience Sub  
Committee

*James Severs (Hywel  
Dda UHB - Executive  
Director of Allied  
Health Professions  
and Health Science)*

| For discussion

**Attachments**

[QSESC Update Report Mar25.docx](#)

## QUALITY, SAFETY & EXPERIENCE

### SUB-COMMITTEE (QSESC) UPDATE REPORT

**Date of last meeting:** 13 March 2025

**Quoracy:** Met

**Report by:** Mr James Severs, Chair

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#### KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

**Alert<sup>1</sup>** (may require discussion)

There were no matters to alert the Committee to.

**Advise<sup>2</sup>** (to monitor)

The Quality, Safety & Experience Sub-Committee wish to **advise** members of the Committee that:

- Staff uptake of Reducing Restrictive Practice Training across Older Adult inpatient wards highlighted a decrease in compliance from the previous months within the **Mental Health and Learning Disabilities Report**. This is partly due to the availability of ward staff and capacity challenges within the Reducing Restrictive Practice team to deliver training. A recovery plan has been developed and shared with Executive Leads which also provides clarity on what support is needed to make the necessary improvements. An update report will be forward planned for the next meeting in May 2025.
- The low levels of staff take up of the Influenza/ Covid 19 vaccine was highlighted during the **Public Health Directorate Report** with 30% of staff having received the vaccinations from 1 October 2025 to 28 February 2025 (not inclusive of bank or locum staff.) Actions are being explored to maximise learning opportunities ahead of next year's vaccination Programme.
- A temporary change of pathway is being progressed as a pilot in North Ceredigion due to insufficient workforce capacity of both medical and non-medical practitioner roles in the Community **Mental Health** Team and Crisis Resolution Home Treatment Team. Primary Care leads will temporarily divert non urgent referrals to a 'phone first' pathway via the established 111 press 2 service. Feedback so far has been positive and suggestive of more timely response for patients. If GP's are concerned about patients seeking help not contacting the 111 service, they can make a direct referral where a Mental Health practitioner will contact the person within 72 hours. A Quality Impact Assessment has been developed and approved at the Quality Impact Panel.

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<sup>1</sup> There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

<sup>2</sup> There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

- The Risk for non-compliance with the Medical Device Post Market Surveillance Regulations for custom-made devices that come in to force on 16 June is being considered by the **Medical Devices Group** as well as mitigations and controls. If necessary, the Risk will be monitored by the MDG specific Risk Register that is in development.

### Assure<sup>3</sup> (to note)

The Quality, Safety & Experience Sub-Committee wish to **assure** members of the Quality, Safety & Experience Committee that:

- A three-month pilot commenced on 24 February at Glangwili Hospital for the **Call 4 Concern** - a patient safety initiative in line with Martha's Rule, which is being rolled out widely to give patients and families access to an urgent review if they are worried about a condition getting worse. An evaluation of the first pilot will be completed in June 2025 with a view to extending the pilot on the Glangwili Hospital (GGH) to Paediatrics and commencing a pilot in Withybush Hospital (WGH) for adult medical and surgical inpatients from July 2025 to September 2025. Further stages and timelines are currently being developed and will depend to some extent on both local pilot findings and any national developments.
- An incident that required the immediate temporary closure of Withybush Hospital Kitchen was discussed during the **Estates Directorate** report and this has now been resolved. The impact on patient experience, lessons learnt, and business continuity plans will be forward planned for the Sub Committee meeting due to be held in July 2025.
- Work continues to progress the action plan for the **Internal Cleaning Audit** and updates are being provided to the Infection Prevention Strategic Steering Group. There are ongoing challenges being faced around the recruitment of additional 4 supervisors to and work is underway to source funding. Estates and Facilities will reengage with Internal Audit to discuss the positive progress in advance of the follow up audit in April 2025.
- A Strategic Group has been established for the roll out of the **Cook Freeze** catering model with operational Quality, Workforce and Procurement subgroups reporting in. The delays to the project have been in the main due to late submission of contract from Cwm Taf University Health Board and critical lack of managerial resource in department. The fully costed model is in development and a Quality Impact Assessment (QIA) is being drafted for presentation at the QIA Panel at the end of March 2025.

### Written Control Documents

The Sub Committee approved:

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<sup>3</sup> There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

- The Effective Clinical Practice Terms of Reference

### **Recommendation**

The Quality, Safety & Experience Committee is asked to note the 'advise' items and receive assurance from the 'assure' items.

## 2.10

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2.10 - Listening and Learning Sub Committee  
Update Report- Deferred

*Mark Henwood  
(Hywel Dda UHB -  
Interim Medical  
Director)*

| For discussion

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3 - Risks and Matters for Escalation to Board

*Anna Lewis (Hywel  
Dda UHB -  
Independent Board  
Member)*

## 4 - For Information

## 4.1

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### 4.1 - JCC Quality, Safety and Outcomes Sub-Committee Highlight Report

#### **Attachments**

[QSO Highlight Report Feb 25.pdf](#)

<b>Agenda Item</b>
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5.2.2
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<b>Joint Commissioning Committee</b>
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<b>Quality Safety and Outcomes Sub-Committee Highlight Report</b>
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<b>Dyddiad y Cyfarfod / Date of Meeting</b>	18/03/2025
<b>Statws Cyhoeddi / Publication Status</b>	Open/ Public
	Not Applicable
<b>Awdur yr Adroddiad / Report Author</b>	Helen Tyler, Head of Corporate Governance
<b>Cyflwynydd yr Adroddiad / Report Presenter</b>	Susan Elsmore, Lay Member
<b>Noddwr yr Adroddiad / Report Sponsor</b>	Carole Bell, Director of Nursing and Quality

<b>Pwrpas yr Adroddiad / Report Purpose</b>	For Noting Choose an item.
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<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome</b>
N/A		Choose an item.

## 1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025.

Key highlights from the meeting are reported in Section 3.

## 2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

The Quality and Safety Outcomes Committee Terms of Reference can be found [here](#).

### 3. HIGHLIGHT REPORT

(Links to reports highlighted [February 2025 – NHS Wales JCC QSO](#))

RAG Rating	Highlight
<b>Alert / Escalate</b>	<ul style="list-style-type: none"> <li>The Chair and Members expressed concern in relation to the risks and pace of resolution for Neonatal and Paediatric Services. Before escalating this formally to the JCC a specific update on the strategic approach and progress from the escalation process will be brought to the March 2025 QSO meeting for further discussion. Members discussed potential inequity of access and how this would be reported. It was agreed that where such inequities were identified these could be highlighted and addressed within the Director reports. This will form part of the Commissioning Approach for the JCC which will be developed over the coming months as part of the next phase of the formation work and organisational development.</li> </ul>
<b>Advise</b>	<ul style="list-style-type: none"> <li>The Chair welcomed members and attendees to the first JCC QSO meeting. The <a href="#">Terms of Reference</a> and <a href="#">Forward Work Plan</a> were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Further work on the forward work plan will be undertaken to ensure a comprehensive approach to reporting. The reporting of patient experience was queried and members were assured that outcomes reporting would be included within the directors' commissioning reports and the overarching incident and concerns reports. A suggestion was made to broaden the scope of the concerns report to include patient experience to meet the reporting requirements for the duty of Candor and duty of Quality.</li> <li>Members discussed the reporting mechanisms into Health Boards (HBs), with the Director of Nursing suggesting the reinstatement of the Quality Newsletter to share information with HBs, as this highlighted good practice and service improvements. This would be in addition to a highlight report for inclusion on HBs' Quality and Safety Agendas and the Joint Commissioning Committee (JCC) public meeting Agenda.</li> </ul>

RAG Rating	Highlight
	<ul style="list-style-type: none"> <li>• The <a href="#">Director of Commissioning for Specialised Services</a> provided updates on various specialist services, including improvements in workforce for paediatric and neonatal services, progress in plastic surgery wait times, and the status of the major trauma network data system. Members raised concerns in relation to neonatal and paediatric services as highlighted above.</li> <li>• The Director of Nursing presented the <a href="#">Director of Commissioning for Ambulance Services and 111</a> report and provided updates in relation to ongoing emergency ambulance pressures, including a critical incident declared by the Welsh Ambulance Service. The commissioning team has been working closely with health board colleagues to address these pressures and develop improvement plans. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. An update on ambulance measures review was provided which aims to align quality patient outcomes with ambulance performance targets. Members raised concerns over bundle compliance and it was noted that compliance for ST-elevation myocardial infarction (STEMI) was under 70%. A request was made for adding immediate release red and amber data to this report for future meetings.</li> <li>• The <a href="#">Director for Mental Health and Vulnerable Groups</a> report was presented and members noted in relation to framework services quality ratings, that some units, including St. Andrews in Northampton, faced staffing and medication challenges, which may lead to safety concerns. Action plans have been implemented to address these issues. Staffing issues at Rampton High Secure Hospital and one patient waiting for many months for admission was highlighted as an issue within High Secure Services. The JCC Director for Mental Health will write to the Director of Specialised Commissioning in England highlighting concerns with Broadmoor Hospital not being accessible to Welsh patients. Capacity issues at Caswell were also noted. Members received an update on the review of gender assessment clinics in England and plans to open satellite clinics in Wales. An update on children and young people's gender services and the commissioning of beds in a new perinatal unit in North Wales was also provided.</li> </ul>

RAG Rating	Highlight
Assure	<ul style="list-style-type: none"> <li>Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review and assurance.</li> </ul> <p>Members requested additional information for the March 2025 meeting on the following items:</p> <ul style="list-style-type: none"> <li>Specific update on the qualitative information regarding the review of long waiters for plastic surgery (south Wales).</li> <li>An update on the resolution of the radioactive isotope production issue at Cardiff University and its impact on South Wales patients.</li> <li>There were gaps in the Ambulance and 111 reporting data around percentages of patients kept at home rather than transferred to hospitals and further information was requested; and</li> <li>Mental Health – a detailed update on the commissioning framework for secure services including staff training and experience to be provided.</li> </ul> <p>A discussion around concerns and incident reporting led to the Director of Nursing and Lay Member agreeing to meet and progress some work on this outside of the meeting.</p>
Inform	<ul style="list-style-type: none"> <li>A presentation was shared which focused on the Microprocessor Knee (MPK) Service at Cardiff Artificial Limb and Appliance Service (ALAS). The presentation highlighted the benefits of MPKs, such as improved mobility, less pain, and increased confidence among users. The presentation included quotes from patient impact statements, emphasising the positive changes in their lives due to the MPK.</li> <li>A patient story was also received, and the patient highlighted the benefits in improved mobility, reduced falls and overall quality of life along with the improved emotional and mental wellbeing.</li> <li>Members received an update on <a href="#">incidents and concerns</a> across the range of JCC commissioned services. A summary of the open incidents and complaints was provided and members noted that work was underway to improve reporting on complaints and concerns.</li> <li>Members received an update on <a href="#">regulatory activity</a>, including recent changes in representation and ongoing work with the NHS executive and Welsh Government.</li> </ul>
Appendices	None

## 4. ASSESSMENT

Objectives / Strategy	
<b>Dolen i Amcan (au) Strategol CBC</b> <b>Link to JCC Strategic Objectives(s)</b>	Improve Equity and Population Health
	Ensure Quality
<b>Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals</b> <a href="#">150623-guide-to-the-fg-act-en.pdf</a> <a href="#">(futuregenerations.wales)</a>	A More Equal Wales
<b>Dolen i Hwyluswyr Ansawdd</b> <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> <b>Link to Enablers of Quality</b> <a href="#">(Duty of Quality Statutory Guidance (gov.wales))</a>	Whole-systems Perspective
	If more than one applies please list below:
<b>Dolen i Feysydd Ansawdd</b> <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> <b>Link to Domains of Quality</b> <a href="#">(Duty of Quality Statutory Guidance (gov.wales))</a>	Person Centred
	If more than one applies please list below: Equitable
<b>Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)</b>	No - Not Applicable
	If more than one applies please list below:

### Impact Assessment

<b>Ansawdd</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> <b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: N/A
<b>Cydraddoldeb</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE  Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
<b>Cyfreithiol / Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw da / Reputational</b>	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
<b>Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)</b>	There is no direct impact on resources as a result of the activity outlined in this report.	

## 5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

## 4.2

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### 4.2 - Patient Experience Report

#### **Attachments**

[IPE Board report - March 2025 FINAL.pptx](#)



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

**Patient Experience Team**  
**Tîm Profiad Y Claf**

# IMPROVING PEOPLE EXPERIENCE REPORT

## December 2024 – January 2025



# Introduction



**Service user feedback is important to monitor the experience of those who access our services and the quality of care that they receive. This allows us to identify areas for improvement, to share good practice and learn from positive experiences.**



**It is our priority to act on all feedback received as part of our culture of improvement and to demonstrate that we are fulfilling our pledges as set out in the Charter. The Listening and Learning Sub-Committee will oversee the communication and implementation plan for the Charter. The Committee receives feedback from across concerns, compliments and experience.**



**The following information demonstrates how we are capturing service user feedback by encouraging our service users and providing different ways in which this can be provided. Most importantly, service users should feel that there has been a valuable purpose to them providing their feedback.**

# A Charter for People and Community Experience - your healthcare, your expectations, our pledge

## **WE WILL ALWAYS:**

**Treat you with dignity, respect and kindness.**

**Communicate with you in a way which meets your individual, language and communication needs.**

**Keep you informed and involved in decisions about your health and care services, and take into account your wishes and needs.**

**Provide safe and effective care, in the most appropriate and clean environment.**

**Ensure that your information is kept secure and confidential.**

**Support and encourage you to share your experiences of health care, both good and bad, to help us improve the way we do things.**

# Service User Feedback at a Glance December 2024 - January 2024

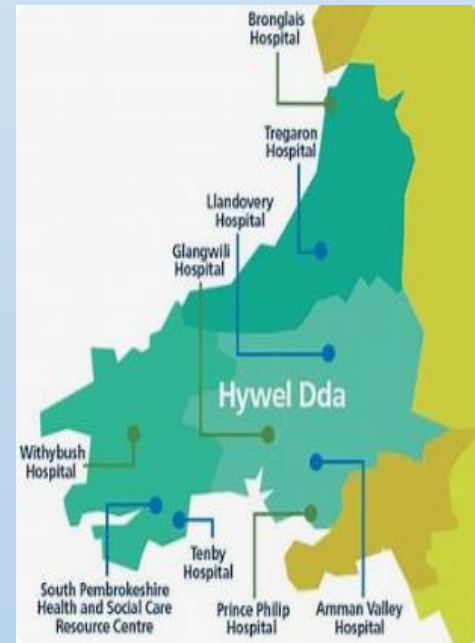
We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation. We will share information relating to the figures later in the report.

1366 service users completed the Your NHS Wales Experience survey of which 11.3% responded with poor or very poor rating for their overall experience. 93% of the responses were from A&E areas and the negative feedback mainly related to long waits and corridor care.

201 compliments were received direct to wards, departments or Corporate Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example: "Your dedication to all patients that come through the Ward shows how exemplary you all are!"

**Complaints: 442 new complaints were received into the health board. 424 complaints were closed, 177 were closed within 5 working days, 260 managed through the Putting Things Right formal process representing an 40%/60% split.**

37633 individuals received our friends and family patient experience survey, in which 6355 responded following their attendance, representing a 18.8% response rate, 94.2% reported a positive experience. Community & Primary Care and Mental Health Outpatient saw significant improvements (30+%) from the last period. Maternity Inpatient improved by 12%. The only area to see a slight drop is Paediatric Outpatient, this relates to 1 negative response



We also received 374 new enquiries. The main enquiries are related to Primary care, Ophthalmology, A&E and Health records. These were relating to delays in transport, waiting times and communication

# Friends and Family Test

This feedback is provided by patients following a visit to one of our outpatient clinics, telephone/video call appointment or hospital admission.

Positive feedback received highlights the professionalism, kindness, and efficiency of the staff and negative feedback points to long waiting times, and lack of communication, delays in treatment or poor communication from staff.

**Accident and Emergency (A&E):** Patients praised the professionalism and efficiency of the staff, especially in handling emergencies. Negative feedback includes long waiting times and lack of communication.

**Endoscopy** High ratings for staff friendliness, thorough explanations, and overall patient care. Some patients mentioned discomfort during procedures, but overall feedback is positive.

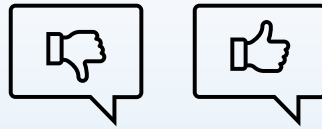
**Day Surgery:** Patients appreciated the kindness and professionalism of the staff, as well as the clear communication about procedures. Some patients reported issues with post-operative care and waiting times for discharge.

**Gastroenterology:** Professionalism, care provided by the staff, with many patients feeling well-informed. Some patients mentioned long waiting times for appointments and procedures.

**Urology:** Patients praised the compassionate care and detailed explanations provided by the staff. There were reports of delays in treatment and communication issues.

**Gynaecology:** Many patients felt comfortable and well-cared for. However, some mentioned long waiting times and issues with post-operative care.

**Trauma and Orthopaedics:** Patients appreciated the provided by the staff, especially in handling complex cases., however some reported long waiting times for surgery and issues with post-operative care.



**Prince Philip Hospital - Minor Injuries Unit:** Numerous positive comments about the efficiency and professionalism of the staff. Patients appreciated the quick service and thorough care provided.

**Cardigan Integrated Care Centre - Minor Injuries Unit:** Patients frequently mentioned the friendly and helpful staff, as well as the short waiting times. The care provided was described as excellent and thorough.

**Withybush General Hospital - Accident and Emergency Department:** Long waiting times and inadequate pre-medical care in the waiting area were mentioned and feeling neglected, uncomfortable during long waits. The medical staff received high praise for their professionalism, kindness, and thoroughness in treating patients.

**Bronglais General Hospital - Accident and Emergency Department:** Patients appreciated the care and attention they received from the staff. While there were positive comments about the staff, there were also mentions of long waiting times and inadequate facilities, care being delivered in corridors. Some patients felt that their needs were not met promptly.

**Glangwili General Hospital - Accident and Emergency Department:** Feedback highlighted issues with long waiting times, overcrowded facilities, and poor communication. Some patients felt that their concerns were not adequately addressed, and there were mentions of a lack of privacy during consultations.

# People's Experience Framework

- From 1 April 2025 the Health Board will need to respond to the requirements of the new People's Experience Framework, including new Experience Questions and an Organisation Self Assessment Toolkit (what does 'good' experience look like).
- The Framework asks that all NHS Wales Bodies complete a local self-assessment rating score for each element of the framework as a basis for local quality and improvements.
- National assurance will be overseen by NHS Wales Executive to support the creation of the best quality health and care system for Wales so that everyone has access to safe, effective and efficient care in the right place and at the right time.
- The new "Experience" measure forms part of a new National People Experience Survey (PES) which will allow the benchmarking of all NHS organisations across Wales. In addition to the PES there is about to be launched a National Maternity and Neonate Survey and a National Looked After Children Survey.
- To further support the implementation of the framework the Health Board, in conjunction with Public Health Wales, is undertaking a Primary Care pilot of the PES in the Carmarthenshire managed practices. Public Health Wales will undertake an evaluation of the pilot in July 2025 to inform the all Wales roll out in primary care.

# Update to People Experience Measures

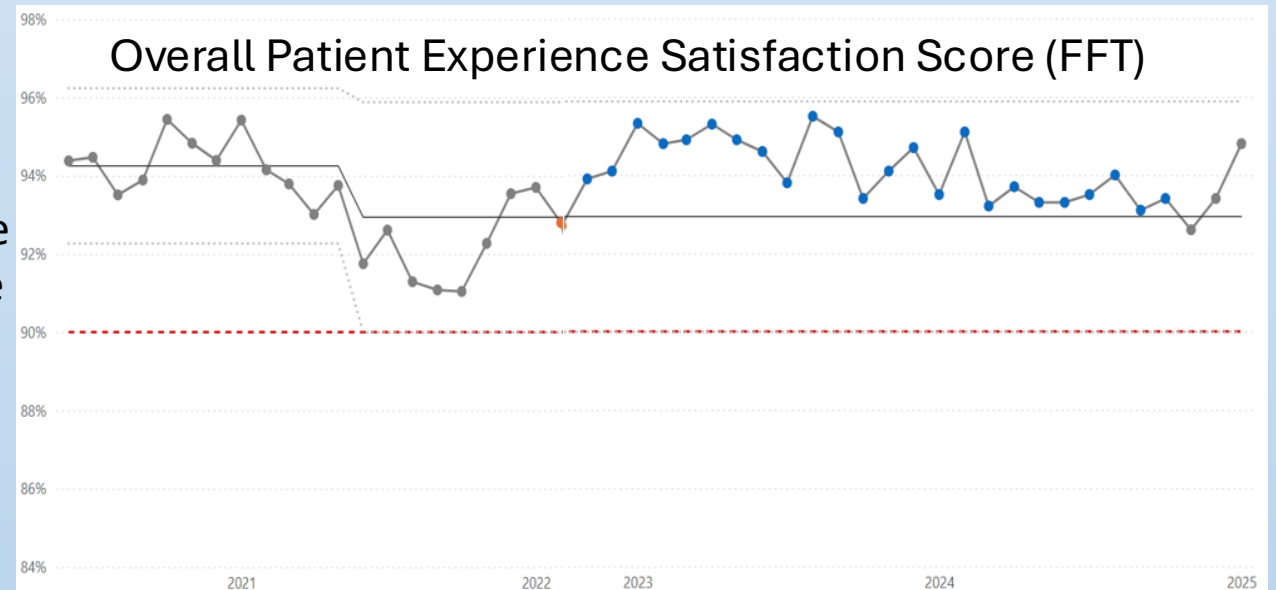
The Friends and Family Test (FFT) was introduced into NHS England in April 2013 and became mandated in 2015. It was designed as a feedback tool to allow patients to provide their opinions on the care they received, helping to improve services based on their experiences.

In 2017 Hywel Dda University Health Board was the first Health Board in Wales to introduce the FFT Patient Experience Satisfaction measure. Initially launched in the A&E departments, the measure was extended into the inpatient areas in 2019 before rolling out to most outpatient and therapy areas in 2021.

The Health Board has consistently performed over the 90% target, including through the Covid 19 pandemic.

The original question asked, “How likely are you to recommend our services to your friends and family”. The score was then calculated by counting the positive responses of “very likely” and “likely” equally (numerator) then dividing by the (denominator) of all the “likely” and “unlikely” responses to provide a percentage score. The question later changed to “Overall, how was your experience of our service?” with the same calculation method.

The imminent launch by Welsh Government of the new “Peoples Experience Framework” mandates replacing the FFT question with a new question and different weighted scoring mechanism. This translates to it being a new measure that cannot be compared to the previous FFT score.



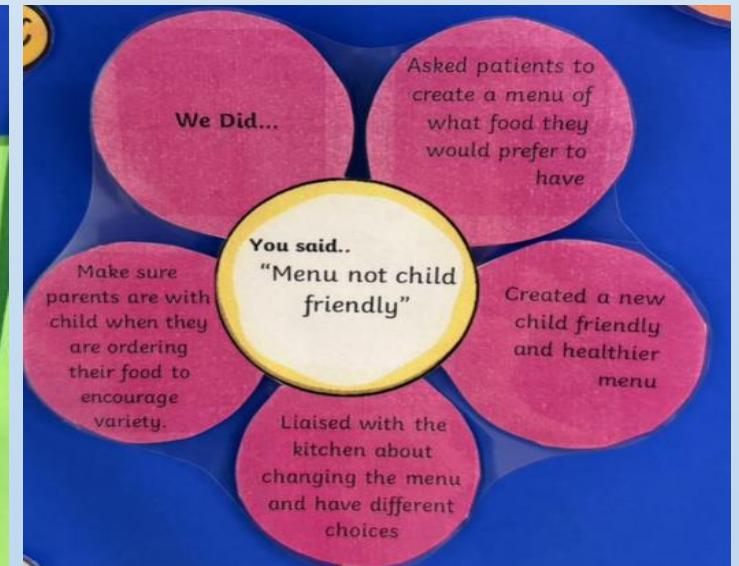
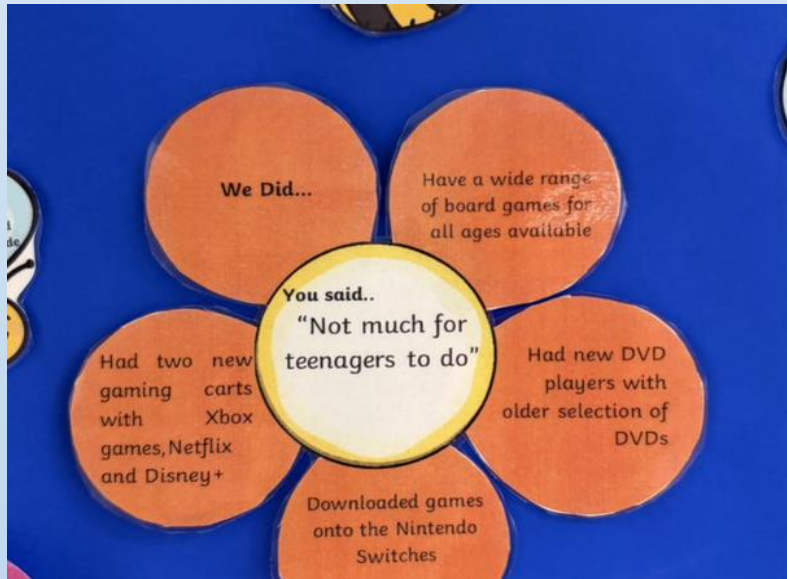


# Responses to the All Wales Children Survey and FFT for Children

As mentioned in the previous report, the surveys are currently being reviewed with a view to substantially shortening them; however, as these are set at an all Wales level, they are outside the direct control of the Health Board.

The feedback that is provided to the service is shared on 'you said - we did' boards so that families know the staff are listening and learning from their experiences.

Examples of the improvements that staff have implemented following feedback from children their families and carers.





# Primary Care

During this period 9 Managed Primary Care Practices have received feedback via the all Wales “Your NHS Wales Experience Survey”. It is noted that some patients provide a response to the available answers, but do not provide the reasons for their response as to why their experience was good or not so good. It was noted in the previous report that responses reflect the passive nature of the feedback capture method, in that there will be a prevalence of negative feedback when patients are not presented with an easily accessible method.

A pilot to conduct the Civica Friends and Family Test survey for our Managed Practices and out of hours will be reviewed to improve the amount of feedback we receive from this service. The team will update this progress in future reports and provide a better understanding of this feedback.

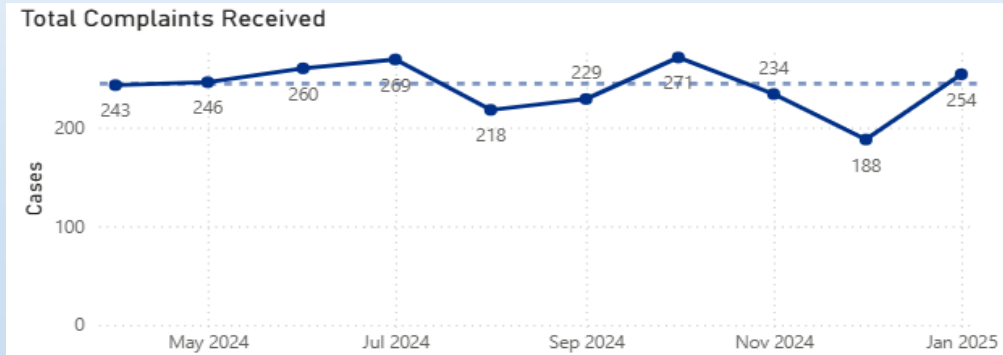


## Compliments

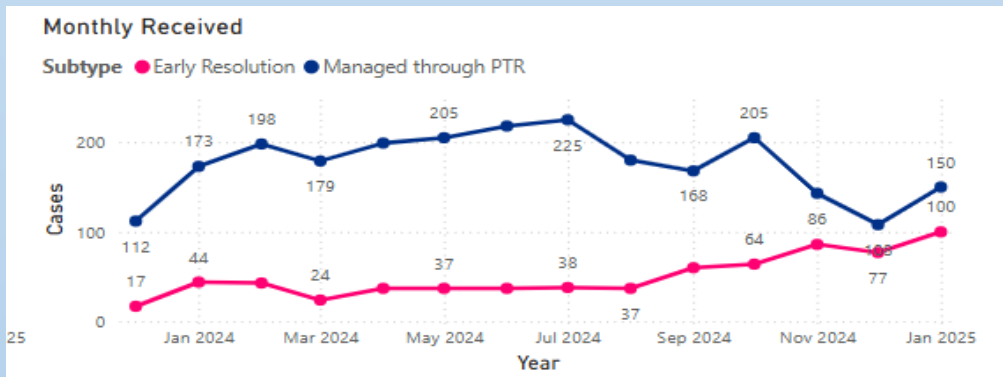
The Patient Experience team continue to visit services to provide teams with certificates of appreciation. Teams provide feedback on how great it feels to receive this recognition and look forward to seeing this every week via the “Feel Good Friday” posts on Viva Engage. Teams are continuing to receive training on the CIVICA system to enable them to review feedback and share the positive feedback received with their teams.

# New Complaints and Concerns: December 2024 – January 2025

442 complaints were received in the period, a reduction of 12% on the preceding two-month period. As depicted by the graph below, 258 of the complaints were handled through the formal Putting Things Right process.

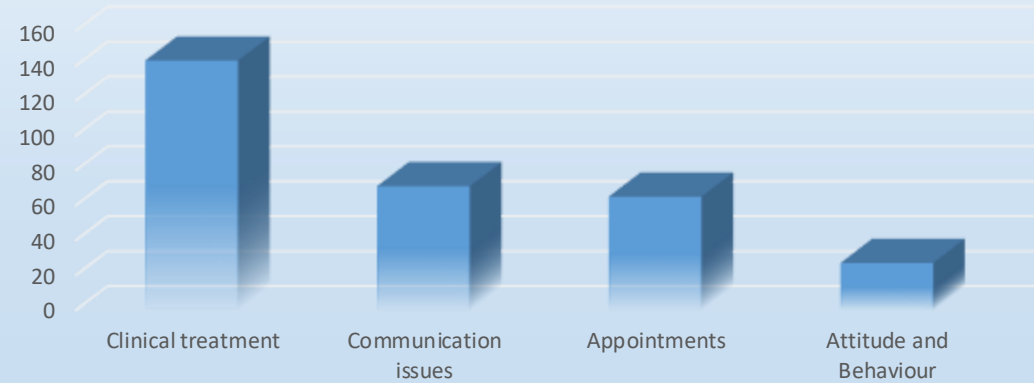


177 of the complaints in the period were closed by means of early resolutions. This is the highest number of complaints achieving early resolution since the April 2021 and close to 200% increase on the same period last year. It confirms the general trend of a decrease in formal complaints and results from quicker interventions at the point complaints are received.



## General themes and trends

Of the 442 complaints received this period, the top four themes are:



In this respect the main themes are entirely consistent with those seen through the course of the year so far:

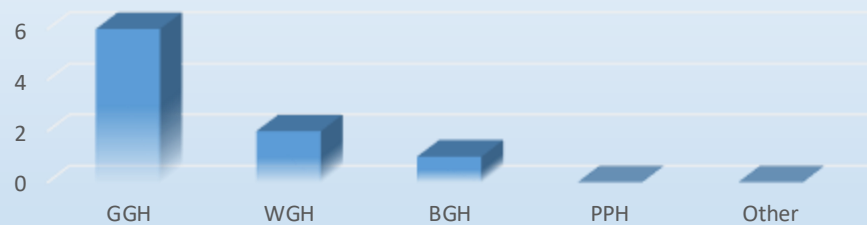
**Clinical treatment:** Concerns of this nature most frequently arise in our A&E, Ophthalmology, T&O and Gynaecology Services.

**Appointments:** Nearly a third of all complaints about appointments are linked to Ophthalmology (31%). Urology, Dermatology and Rheumatology also receive higher numbers compared to other services.

**Communication, attitude and behaviour:** These issues tend to be spread across all services. A&E departments have received the most communication complaints this year, this represents less than 7% of the total.

# Outcomes from Concerns: December 2024 – January 2025

## CASES IN PERIOD ESCALATED TO REDRESS

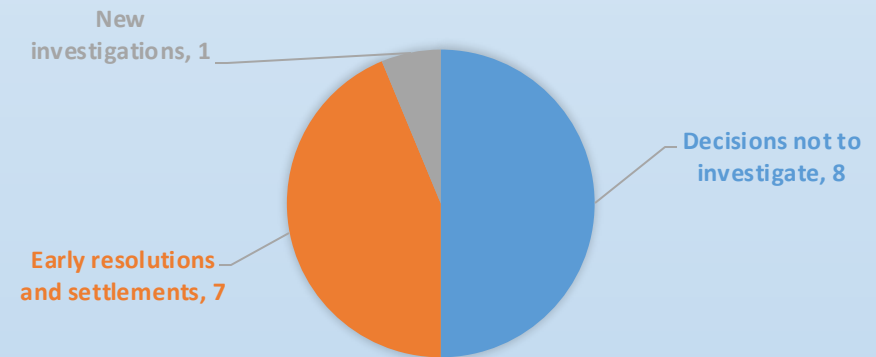


Nine complaints closed in the period were escalated to Redress because failings have caused, or may have caused, harm to patients. These have occurred at our general hospital sites (above). Where failings are confirmed to have caused harm, Learning from Events reports are produced with actions identified. In all cases where there are missed opportunities, services are encouraged to generate learning that can be implemented within their teams.

Issues identified were linked to surgery, which included surgical procedure itself (hysterectomy and knee surgeries), as well as failing to inform of risks and failing to communicate patient’s allergies prior to surgery. Administrative errors were also identified in the referral processes. Investigations also identified an avoidable fall, missed findings in X-ray reporting, and the incorrect use of medications in management of meningitis.

## Learning from the Ombudsman

The Ombudsman has started one new investigation in the period and will be looking at whether there were delays in a patient’s cancer treatment and whether a DNACPR was completed in line with the patient’s wishes. Aspects of nursing care will also be considered.



Three investigation reports were received, two of which were upheld.

The first of these reports found that the Health Board had failed to liaise with the Women’s Fertility Institute to ensure that the patient received the appropriate fertility care. It had also failed to explain the potential impact of hydrosalpinx to the patient in a timely way.

The second report is discussed in the maternity theme data below.

# Maternity Service

Two alongside midwifery led units (Glangwili & Bronglais)

One freestanding midwifery led unit  
(Withybush)

Two obstetric led units (Glangwili & Bronglais)

Four antenatal clinics (Glangwili, Withybush, Bronglais and  
Prince Phillip)

Homebirth service (across three counties)

**In 2024**

Hywel Dda UHB welcomed

2848 babies

Average of 8 babies born  
per day

## PEOPLES EXPERIENCE FEEDBACK

The maternity service uses various indicators to ensure the continued delivery of a safe, effective and high- quality service including maternity service metrics which enable monitoring of clinical outcomes.

We recognise as a service that quality reaches beyond measuring clinical outcomes. The experience of service users has long been considered a core component of quality in the NHS. As the primary mechanism by which providers of maternity services can monitor that experience, feedback has a key role to play in helping organisations to track the quality of their services, identify problem areas and shape service improvements.

There is good evidence to show a positive association between the experience of the service user and improved health outcomes and patient safety.

As the primary mechanism through which patient experience can be measured, feedback offers health care providers a means of understanding how to improve that experience and, through this, how to improve services. It is therefore key to any coherent strategy for quality improvement.

For feedback to be used to its full effect, providers of maternity services must be pro-active not only in collecting feedback but also in interpreting the information gathered and using it to inform action. Hywel Dda maternity service utilises a range of mechanisms including feedback from Civica, comment cards, QR code feedback, concerns, Duty of Candour pathway, Birth Afterthoughts Clinic, social media platforms and surveys.

A conscious effort has been adopted to reach marginalised women and service users to ensure a breadth and depth of service user feedback to ensure representation from across our diverse patient population.

## Summary of 2024 Feedback

- **Civica: 222 responses**
- 197 good or very good (89%)
- **QR Code 151 responses**
- **Facebook 96 "Thank you posts and Birth Stories"**
- **"Thank you cards" 420**

## Total of 864 positive feedback from various sources

### - Thematic review of positive feedback

- Kind, caring, compassionate staff, use of Welsh language
- Time to care
- Individualised care planning
- Staff were professional and helpful
- Consistent theme of compassionate care shared by bereaved parents

*Towards the end of pregnancy became extremely anxious, I felt overwhelmed and was admitted to the triage unit several times. On each admission I was always made to feel a priority, that everyone had time for me to listen to my worries and give me reassurance that everything was ok.*

*I developed complications which mean my baby needed to be delivered sooner and he was born by emergency c-section but in honestly that didn't matter. The midwives and doctors supported me throughout the whole experience. It wasn't the birth I had dreamed of, but it was honestly such a magical experience. The team talked me through each step and helped manage my fears, I will never be able to say thank you enough – they listened and cared for me throughout. I am forever grateful*



The knowledge that feedback from users is listened to and acted on helps to encourage a sense of responsibility and pride among staff in the services they deliver. It also helps provide assurances to the service user that the service remains committed to growth and change

There is also evidence linking the systematic collection of service-user feedback with service improvement

- Regular sharing of positive feedback across service
- Named staff receive feedback directly to support appraisal and revalidation
- Feedback embedded across perinatal learning forums
- Feedback shared during "Maternity Monthly" (Health Board wide newsletter)



# Individualised care planning and supporting women to birth outside of guidelines

Choice in childbirth is not a new concept. Whilst the service believes that the safest way for birthing women and birth people to labour and give birth is to follow the Health Board's agreed guidance. We also acknowledge the importance of close multi-professional working between clinicians to ensure good outcomes for parents and babies. This is particularly important within maternity services when it involves complex decision making surrounding the planning of care with birthing women and birthing people who wish to understand their birth options in greater detail, explore the risks and benefits of these choices and make decisions about their care even if outside of Health Board's guidance.

Ultimately the service respects women's rights to make all decisions around their birth. Through the support of the Consultant Midwife and the wider multi-disciplinary team, women are supported to make choices that are right for them

*I cannot thank you enough for your help during my labour. I knew I needed some help and I knew you would something when things weren't going right – you did and now we have a gorgeous baby*

*New parent 2024*

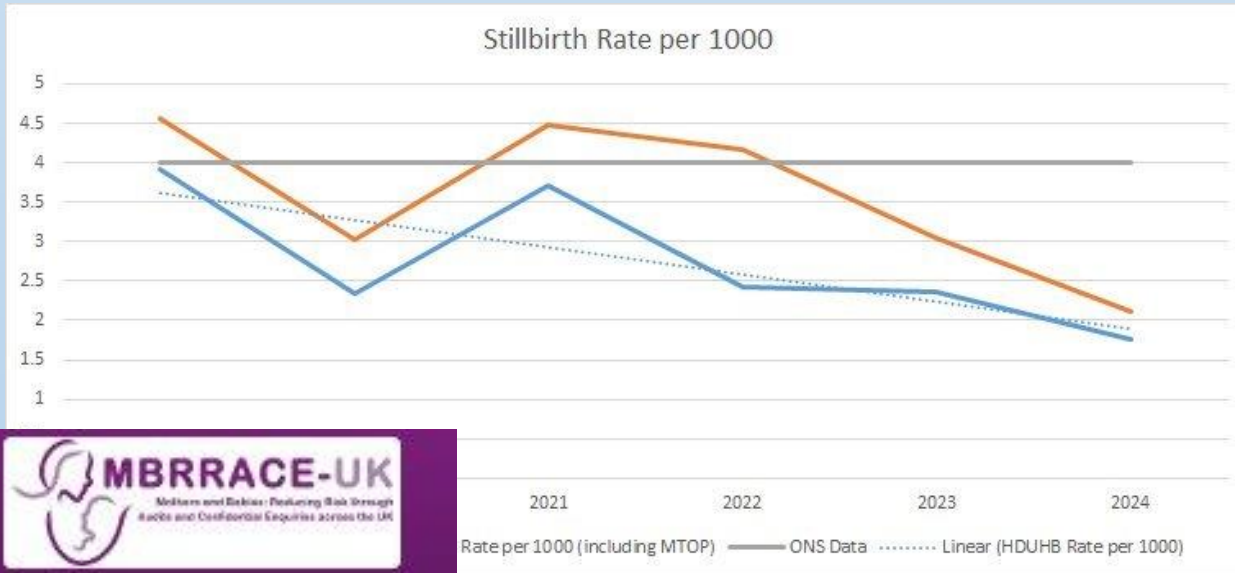
*This was such a healing experience for me. I cannot thank the team enough for believing in me and making my dream experience a reality*

*New parent 2024*

# Baby Loss

Baby loss is a general term used around the world to describe various experiences which can include late miscarriage, stillbirth and neonatal death. When a baby dies before, during or after birth, the hospital where the mother and baby were looked after should review the care the mother and baby received. The hospital review forms part of standard NHS care which should be provided for every family after a death so that bereaved parents have as much information as possible about why their baby died. Another important reason hospitals carry out reviews of any baby who is stillborn or dies in their care, is so that hospitals can learn from what happened, to improve care and prevent, if possible, the death of other babies in the future. The review is referred to as a Perinatal Mortality Review Tool (PMRT) and Hywel Dda process aligns with the national scrutiny required to ensure robust and transparent reviews

The purpose of the national PMRT is to support hospital reviews by providing a standardised, structured process so that what happened at every stage of the pregnancy, birth and after, from booking through to bereavement care, and care when the family leaves hospital, is considered by staff reviewing care in a robust way. Importantly, parents will be asked if they have questions or views on their care, they would like the review panel to respond to.



Reassuringly the Health Board has seen a positive reduction in the stillbirth rate and is committed to reducing this further

A robust mechanism for collating service user feedback remain paramount, to ensure that the parent voice is reflected throughout



When a baby dies on the maternity unit all families are informed of the PMRT process and invited to contribute.

A detailed review is undertaken, and parents are invited to share feedback, questions and any concerns throughout

In 2024 100% of eligible families engaged with the process, 100% of families provided feedback, and all families were invited to attend a face-to-face meeting to discuss the review findings (in a small number of meetings, sadly this included sharing contributory care issues with families)

All meetings were facilitated by a multi-disciplinary team who had been involved in the review process and already had a rapport. All families were supported by their named bereavement nurse or midwife.

Regardless of the investigation outcome, there was a key theme highlighted around compassionate, person-centred bereavement care.

*"The staff treated my baby with so much respect, they supported our family to stay and there were no restrictions to visiting"*

*"The room was clean, spacious and staff were so supportive throughout. In my darkest time, I couldn't have asked for more"*

# One bereaved family have kindly shared the following in their own words:

*I think it is important to start with the fact that we were away from home, and just turned up at Glangwili looking for help, and the whole team went above and beyond to provide that. From the moment that we first rung triage, to the moment we left, and beyond – the care that we have received has been incredible.*

*Upon arrival at triage the midwife acted quickly to get us seen and made us feel a priority, at all times. She was very clear about what was happening, and also what would happen next. We were given time to process the news, before being taken to the bereavement suite. It was helpful to be taken through the back way instead of through the main maternity ward. All midwives introduced themselves, offered condolences, as well as offering reassurance that everything would be ok, at all times. It was reassuring that the midwives were trying to gather as much personal information as possible in order to make sure that I was cared for appropriately. This included contacting our local hospital and midwives to have my notes sent to Glangwili.*

*There were lots of decisions that had to be made, during a time where you are unable to think clearly. But the midwives were very sensitive, informative and encouraging, without being forceful. They were able to give guidance and support and help us be involved in all decisions that had to be made.*

*After giving birth, we were given time as parents to spend with our baby. It was incredible that our baby was treated with the upmost respect at all times, and it helped a lot. **He was our son and he existed** – and at no point were we made to feel any different. Being allowed to do things such as bathing, dressing and cuddling and taking pictures were all invaluable things that we will always remember. Being allowed to have additional family members visit and spend time with us, was extremely precious and we will forever be grateful. At no point were we rushed, and our whole extended family felt cared and supported for. The opportunity to have the chaplain come and speak and bless our baby was very important too. It was a special moment for us as parents to be able to take our son to the mortuary, especially as we would be leaving him for the last time to travel home. I know it's not for everyone, but we knew he was safe and were able to spend our last moments in a lovely room together, just the three of us. Before being discharged we felt reassured about the next steps and were provided with a wealth of support and contact numbers. In addition to this, I was reassured that my GP and community midwife were informed and would be in touch the next day. It was helpful when they were, and I knew that the staff at Glangwili had done everything that they said they would.*

*A special mention must be made to Midwife - she is an incredible midwife! I truly believe she made our experience extra special. She was extremely compassionate, informative and encouraging, and at no point did she make us feel fearful for what was to come. The midwife spoke to us sensitively ensuring that everything we were feeling was completely normal.*

*She encouraged us to think of next steps such as a post-mortem, making a memory box and having pictures taken – things that neither of us had even considered. We were extremely grateful for this, and were able to take our time to discuss what was right for us as a family. She cried with us, laughed with us, and made us feel like the most important people at every possible moment. We will remember her for ever and will for ever be grateful to her or looking after us all.*

*The midwife did something we never thought possible, she helped us make memories – genuine happy memories that will last a lifetime*

## Areas for Improvement

Having a baby is a unique and life-changing event. All maternity units face the challenge of having to meet appropriate safety standards at the same time as ensuring that the users of their services have a good experience at such an important time in their lives. As with all maternity units, there are times when we don't get this right and it is imperative that we learn from this

- 222 Civica responses
- 15 were reported as being poor or very poor (equates to 7% of feedback shared via Civica)
- 2024 – 50 formal complaints reported (equates to 1.6% of total service users)
- Duty of Candour (where moderate harm is caused as a result of an unintended or unexpected harm) 10 concerns were directly related where the service had already been in contact as part of the Duty of Candour process.

21

## Feedback

Feedback supports more than qualitative areas of improvement, as a result of investigation findings and meeting with families the service has developed new guidelines, new patient information leaflets, new telephone records, local safety standards for invasive procedures and implementation of different forms of pain relief .

Where possible, these are co-produced with service users and they are informed of changes

*“Though this is so hard to hear, I cannot thank you enough for your honesty. It doesn't change what happened to me or my baby but knowing that you've actually done something to change this for families in the future means the world. I thought we would come here today, and you would just be arguing with us and sweep it under the carpet like you read about. I wasn't expecting this level of honesty, and really, I think it's helped us to get some closure. It's so helpful to understand more about the changes and I'm so glad that you've shared this”*

*Parent feedback through a duty of candour meeting*

# For feedback to be used to its full effect, providers of maternity services must be pro-active not only in collecting feedback but also in interpreting the information gathered and using it to inform action

"You said, We did" shared via the Health Board Communications Team on approved social media platform

- Health Board is actively engaging with the national maternity and neonatal PREMS and PROMS Civica Data Capture and is working with the local Patient Experience Team to support implementation
- Data capture around alternative methods of feedback to ensure the patient voice is embedded throughout the service
- Development of a Health Board approved website for the centralisation of information for women and birthing people which will also provide women with information on how feedback can be shared
- Each month a thematic review of feedback is undertaken and a poster shared with service user to demonstrate changes made

## Maternity Experience November 2024



GIG  
CYMRU  
NHS  
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University Health Board

You Said...	We Listened...
'When coming out of labour ward my partner wasn't allowed to stay with me very long as visiting times had finished'	We are reviewing the possibility of one birthing partner staying overnight on the postnatal ward to be able to better support their partners after birth.
'Additional breastfeeding support'	A new infant feeding group is starting in January in Carmarthen, with infant feeding support workers, who can help assist with feeding issues.
'I spent most of my day in the hospital and was not once offered any source of water or food.'	There are now a refreshments tables set up on the antenatal/triage ward and postnatal ward in Glangwilli so people can help themselves to water and food.

We really appreciate you all taking the time to give us feedback. Your views are always read and reviewed by the team, and are used to help make improvements the maternity services for all.

All positive feedback that has people named in it is emailed to the person directly. All feedback is reviewed monthly and discussed. If you would like to feedback, please click on the text message you were sent, or click on the QR code.



**Thank you!**

## Service User Feedback December 2024



Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

### Microsoft forms QR code

6 Submissions of Feedback

5 positive responses thanking staff members for their care and support. 1 response which contained positives and things to work on. This person reported not being informed properly about the effect taking labetalol would have on her baby, and her baby needing the hypopassway. She also reported finding it difficult to speak to a doctor once on the ward for induction, despite asking to speak to one before the next induction step was made. This feedback has been emailed to AJ and ML for review.

### Postnatal QR Code

4 responses

#### Themes

Long waiting times in clinics.

Others thanking staff for the care they received.

How satisfied are you with the health professionals' care of you?

Very good  
Good  
Neither good nor poor  
Poor  
Very poor



### Facebook Group

10 birth stories about positive aspects of care

### Thank you cards

11 thank you cards to individuals

20 General thank you cards.

### Civica

12 responses

Very good 7 responses, 2 good responses, Neither good nor poor 1 response, Poor 1 response, Very Poor 1 response.

The neither good nor poor response was due to the waiting times in clinic. The poor response reported that the receptionist in clinic was rude towards the pregnant people waiting, and they had to wait outside for 20 minutes for a doctor to arrive to start the clinic. The very poor response was due to waiting all day for either IOL or Caesarean to be told to come back the next day instead.

## Service User Feedback October 2024



Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

### Microsoft forms QR code

6 Submissions of Feedback

6 positive responses, though two also included areas to improve on.

### Facebook Group

6 birth stories about positive aspects of care

1 positive comment saying seeing other birth story posts has reassured her about giving birth.

### Thank you cards

22 thank you cards to individuals

13 General thank you cards to GGH (Have not yet received information for BGH and WGH).

### Civica

16 responses

14 very good. 1 Good. 1 Poor

Poor response is from someone who is still receiving hospital letters following her late miscarriage. This has now been rectified and an email apologising sent.

**In total, 56 feedback responses for October 2024.**

**95% Positive Feedback Rate**

**All 3 negative responses have been noted and actioned.**

### Themes

Positive Feedback	Things to improve
Communication	Communication
Caring	Language
Supportive	Equipment on wards

**The service delivers educational / reflective events each month (both on an individual and group setting).**

One example is the Maternity and Neonatal Clinical Risk Meeting; previously these meetings focused on the clinical aspects of care, but through the implementation of the Birth Afterthoughts service and the Duty of Candour legislation, the elements of clinical outcome and patient experience helps to demonstrate that user feedback can play a valuable role in monitoring the quality of services and in shaping service improvements.

Consent is always gained from service users to share their experience and the engagement with this has been overwhelmingly positive. Utilising service user feedback can enhance "realism" associated with incident reviews and therefore promote a meaningful culture of change

The service recognises that listening and responding to service users is key to any coherent strategy for quality improvement.

*"nothing had been explained and the whole procedure feel invasive. I remember breathing on gas and air, crying while looking at my husband and newborn who sat in the room. Once the doctor had finished the procedure they then just left and said nothing.*

*I feel however following the birth I should have had a say and options and choices should have been given"*

Parent 2024

## Promoting Equitable Care - "hard to reach communities or easy to ignore?"

Women from the Global Majority have significantly higher morbidity and mortality rates in the UK as well as poorer experiences of care. For some people, groups and communities in Wales, there are still unfair and avoidable inequalities in their health and health outcomes, and in their access to and experiences of NHS services.

The FiveXmore report, illustrated that although Black and Black mixed women experience overt and covert racism throughout maternal services, their experiences are rarely captured or recorded by the institutions providing their care, due to a low complaint rate and the normalisation of racism as part of their everyday experience.

*"This experience has left me with significant psychological trauma. The midwives' treatment of me was inhumane and discriminatory, causing immense stress during and after labour.*

*The midwives' actions and behaviour were not only unprofessional but also discriminatory, potentially due to my race or religion. She refused to provide the necessary care, ignored my repeated requests for examination and pain relief"*

*Parent 2024*

The maternity service is committed to becoming an anti-racist organisation:

- Individual reflections with staff members
- Embedding of Diverse Cymru and Cultural Competency Training
- Embedding of impact of race and maternity services within mandatory training for all midwives
- Delivery of educational sessions entitled "Cuppa Conversations" to explore impact of systemic racism
- Significant increase in the use of translation services
- Quality improvement project to improve recording of ethnicity data
- Equality, diversity and inclusion meaningfully embedded throughout service
- Representation within simulation (for example darker skin tone models)

# Neurodiversity

*“The midwife always said are your movements normal and I just said yeah because I wasn't sure what that meant. I'm autistic and literal so if she had said is your baby kicking then I would have known what she meant.*

*I also need someone for support at all of my appointments and I was told that wasn't always allowed”*

Parent 2022

The Maternity Passport is designed to help autistic people to communicate their needs to doctors, nurses and other healthcare professionals.

It was co-produced between service users, the maternity service and the learning disability service

The service has also implemented additional questions to better support the individualisation of care planning by asking all service users the same question about their communication needs at the time of booking

This project was identified as an area of excellence by the NHS executive and has since been embedded across Wales in all maternity handheld records

**Maternity Passport**

I like to be known as: My preferred language is:

How to communicate with me:

Person with me: My Health needs:

Person who needs to be with me for appointments: Medications I take:

How I show if I am in pain or unwell:

What to do if I'm anxious:

**Reasonable adjustments (Please circle the adjustments you would like)**

Longer appointment slots	Partner to stay with me at all times	No medical words
Videos or easy to read leaflets	Write all information down in an easy read format	Check that I have understood
Talk slowly	Low lighting in appointments	Please find a quiet place to talk

Other reasonable adjustments

Midwife to sign and date:

**Do you consider yourself to have any additional needs such as Autism/Dyspraxia/ Asperger's/ Dyslexia? Yes/ No**  
**Do you need any extra support? Yes/No**

LLAIS WEST WALES REGION

BABIES AND BIRTHS IN HYWEL DDA



A follow up report to our December 2022 Maternity Survey



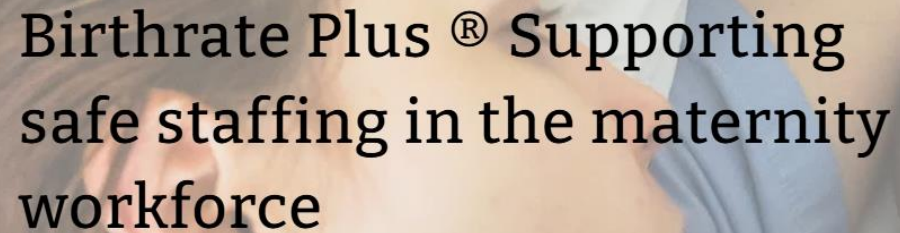
We were pleased to hear that many of the comments were positive. However, when we ask people about their NHS care often, we hear that some parts of their experience were good and others not so good. This is again what we heard in this survey. We often heard about the caring attitude shown by staff, particularly the midwives.

7 actions recommended, a detailed action plan was completed and progress monitored using our audit and monitoring system (AMAT) <sup>28</sup>



A follow up report to our December 2022 Maternity Survey

1. The Health Board must continue to focus on improving the level of postnatal support for new mums. Llais understands that staffing is often very difficult, but many women felt that they needed more help and care after they had their baby. The Health Board should monitor this routinely.



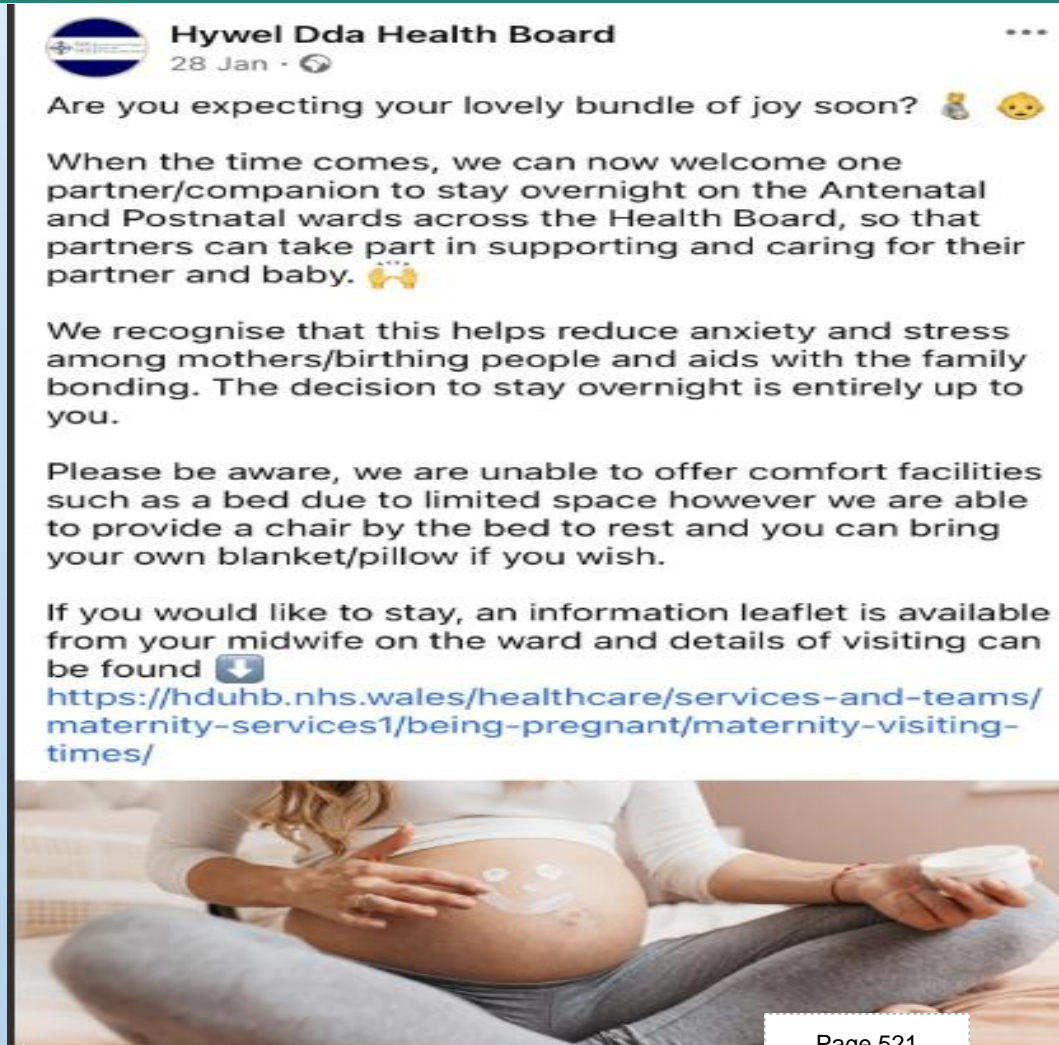
## Birthrate Plus<sup>®</sup> Supporting safe staffing in the maternity workforce

Monitored using the acuity tool, previously involved labour ward but will be extended to the postnatal / antenatal ward to support efficiency and timely rotation of staff as required.

Re-allocation of staff depending on acuity.

## 2.

Llais acknowledges that welcoming partners into hospital wards is a difficult balance for the Health Board to manage, as it appreciates the support that partners bring to individual women alongside protecting privacy and security for all. We would ask that the Health Board takes the opportunity to review its arrangements however, given how isolated or alone some women felt, particularly when staffing levels are limited.



**Hywel Dda Health Board**  
28 Jan · 🌐


Are you expecting your lovely bundle of joy soon? 🤰 🤱

When the time comes, we can now welcome one partner/companion to stay overnight on the Antenatal and Postnatal wards across the Health Board, so that partners can take part in supporting and caring for their partner and baby. 🤰 🤱

We recognise that this helps reduce anxiety and stress among mothers/birthing people and aids with the family bonding. The decision to stay overnight is entirely up to you.

Please be aware, we are unable to offer comfort facilities such as a bed due to limited space however we are able to provide a chair by the bed to rest and you can bring your own blanket/pillow if you wish.

If you would like to stay, an information leaflet is available from your midwife on the ward and details of visiting can be found 📄  
<https://hduhb.nhs.wales/healthcare/services-and-teams/maternity-services1/being-pregnant/maternity-visiting-times/>



- Evaluation underway.
- Early feedback suggests improved facilities required, League of Friends supported with procurement of increased numbers of recliner chairs
- Refreshments provided



LLAIS WEST WALES REGION  
BABIES AND BIRTHS IN HYWEL DDA



A follow up report to our December 2022 Maternity Survey



3. There was evidence to suggest that breastfeeding support was good for some but looking at the experiences of others there is still more to do to ensure that the necessary breastfeeding expertise is available and staffing numbers allow this support to be given, particularly for babies that are struggling to feed.

## INFANT FEEDING SUPPORT WORKERS

**Janice Jones**

**Abi Hearne**

**Lisa-Marie Morris**

Monday-Friday: 07880125501  
Infant.Feeding.HDD@wales.nhs.uk

They will be covering all of the maternity wards, SCBU, and Cilgerran for feeding support. In general, Jan will work Mondays, Abi Tuesdays and Wednesdays, and Lisa-Marie Thursdays and Fridays. The plan is to have them available full time (except Bank Holidays and Annual Leave) through the end of March, as part of the Infant Feeding Pilot Project (IFPP). The IFPP is a collaboration between Public Health, Health Visiting, and Maternity Services in an effort to further support our service users in their breastfeeding goals. Our hope is that the project will demonstrate an improvement in our birth to day 10 breastfeeding maintenance rates, as well as our overall breastfeeding rates by six months of age. We are hoping that the IFSWs will be a positive addition to the support already provided by our Midwives and HCSWs.

**NEW GROUP**

## Infant Feeding Support Group

Every Wednesday at St David's Park, Carmarthen.

What3Words: ///today.craft.email

A warm welcome to those who are pregnant, parents, carers, babies and their siblings! Come along for a cuppa and a chat, get some help and support from other parents, as they share experiences of the feeding journey.

**9:30 - 11:30**

breastfeeding helpline  
0300 100 0212

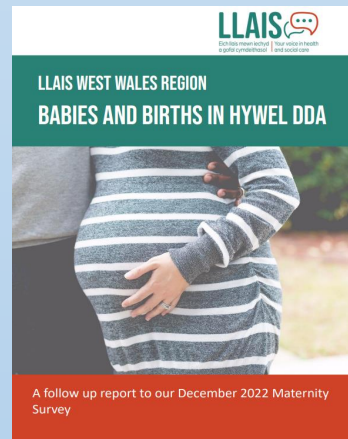
GIG NHS  
Bristol South Pillagers  
Hemel Hempstead  
University Health Board



5.

Some women reported that their stay in some hospital areas was difficult because it was so hot. We don't know if the Health Board avoids use of fans (e.g. for infection control reasons), whether there was simply a shortage at that time, or another problem, but if it's possible for women to regulate their temperature to be more comfortable then the Health Board should ensure it can make this happen.

- Fans can promote drafts which can result in babies becoming hypothermic and increase admission rates to SCBU, also increase risk of cross infection (collection of dust and microbes which are then circulated)
- Infrastructure within the postnatal ward has limited scope for development, wider engagement with Estates Department.
- Plan for capital bid to improve estate in GGH postnatal ward



**6.** Communication clearly worked well for some, but Llais knows that poor communication lies at the heart of many poor patient experiences, before during and after an event such as childbirth. Once again, our survey showed that some women experienced poor communication from staff during their journey. This caused preventable stress during labour. Llais acknowledges that it can happen in settings when staff are busy and under pressure, but in a general sense it isn't acceptable. The Health Board needs to ensure that cultures of good practice around communication shown by many staff are universal and a core value of the department.

- Embedding service user feedback at every learning opportunity
- Individual reflection to promote a culture of learning
- Patient experience midwife allocated to attend key strategic meetings to support integration of service user experience
- Key learning around consent and communication within MDT learning forums, safety briefings
- Feedback from concerns, incidents, Duty of Candour, PMRT, surveys, civica, Llais a key component of wider learning to promote change
- Role modelling and compassionate leadership

**7.** We were interested to hear that NCT classes were difficult to access or not running locally. This made us worried about the level of antenatal and parenting support that women and partners were getting beyond clinical contact with midwives and other NHS staff. If there were alternative opportunities, we couldn't see these on the Health Board's website. Because of this, we're asking the Health Board to tell us what is available for women in the three counties, whether signposting is adequate and whether more needs to be put in place with local partners.

- Health Board has developed a dedicated maternity section on the HB website to provide key information and sign posting as well as wider public health messages
- Previously there was some inequity due to a lack of suitable locations in the community setting (anticipated improvement with "Community Hubs" eg Cross Hands)
- Development of educational video resources, shared digitally
- HB is hosting a "Maternity Fair" in March 2025 in GGH, supported by clinical and specialist staff. If successful to be replicated as a model across the HB
- Dynamic working, utilising HB locations to provide evening sessions which are delivered by community midwives

5

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5 - Date of Next Meeting : 9:30am 10 June  
2025