Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 October 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Risk 129 – Ability to Deliver an Urgent Primary Care Out-of-Hours Service for Hywel Dda University Health Board Patients
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	David Richards Service Delivery Manager – OOH/111

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Risk 129 details the ability of the Hywel Dda University Health Board (HDdUHB) to deliver a safe and efficient Out of Hours (OOH) service. The service is expected to provide urgent Primary Care to the residents of and visitors to the three counties of HDdUHB during the periods when General Practice is not available. The risk has been registered following sustained challenges to provide adequate and safe levels of clinicians across the service, HB wide.

The current risk level is 12 (High) against an inherent risk rating of 15 (Extreme). The current level reflects the continuing instability of rotas, with little control of the sessional workforce who are able to volunteer for shifts at short notice, depending on the demands of their daytime working or the time of year where there are often common periods of holiday.

The Committee is asked to seek assurance that Risk 129 and the consequences of the Primary Care OOH service's fragility on patient safety and clinical needs are being mitigated.

Cefndir / Background

The OOH service provides Urgent Primary Care to the population of the three counties making up HDdUHB during the overnight and weekend periods when daytime services do not operate. The responsibility to provide OOH services was transferred to the HB in 2004 having previously been the responsibility of Co-Operatives working within the three individual counties.

The population of HDdUHB is 385,600 and this rises significantly when tourism is most active in the area. HDdUHB has a larger than average number of elderly residents and, as seen across the country, many will have chronic conditions, leading to a growing demand on health care providers.

The OOH service is now predominantly made up of General Practitioners (GP) employed on a sessional basis. Currently, out of 48 GPs regularly working for the service, just eight are employed on a salaried basis. This limits the ability to proactively roster and renders the service

vulnerable to continued instability of shift-fill creating a lack of cover. The COVID-19 pandemic has had a mixed impact on the availability of GPs. Some GPs withdrew from working for the OOH service, whilst others amended their working practices due to personal vulnerabilities. For a period of time during the most intensive part of the pandemic and lockdowns, there was an increase in shift-fill rates which were believed to be linked to less demanding daytime service periods combined with travel restrictions. Recently however, as demand on daytime services has increased, evidence suggests GPs have become fatigued and stressed and consequently are unable to work additional sessions in the OOH service. This has created a frequent pattern of relatively well populated rotas during nights on Monday to Friday (when workload is perceived to be less demanding) and increasingly strained weekend periods (which see a significant increase in demand). The result is staffing assurance levels reaching level 1-2* during the week and reducing to level 3-4* at weekends. This suggests remuneration is not a significant factor, as shifts remunerated at higher rates often remain uncovered.

**Explanation provided on page 5*

Other reasons for reduced shift-fill include:

- A reduction in available GPs over the past five years from circa 100 to 48;
- Tax and National Insurance status determining a threshold for GPs to work within before encountering negative taxation effects on earnings potential;
- Changing service demands such as '111' and '111 First'
- An ongoing challenge to secure clinical consensus on the implementation of cross-border working;
- Dissatisfaction with the requirement to volunteer for shifts and the lack of 'rights' associated with the employment status of IR35/ sessional workers.

It is evident from reports from colleagues pan Wales, that a number of these issues are not unique to HDdUHB. The all Wales Out of Hours forum and weekly status report meetings describe a number of common themes resulting in fragile services across most Health Boards. With the additional pressures being seen by the Welsh Ambulance Service Trust (WAST), 111, Primary Care Services and Emergency and Secondary Care, the picture is that of widespread difficulties in balancing increasing demand with available capacity. The concerns surrounding availability of GPs to populate OOH rotas is known to Welsh Government (WG) and was specifically communicated to them during the winter period of 2019/20.

<u>111</u>

The '111' service is the "Front End" single point of contact for patients who wish to access Primary Care Services when daytime provision is not available. WAST provide the initial service contact, with call handling and triage stages being completed outside of the HB. During the pandemic lockdown, approximately 45% of demand was streamed away into other services by the '111' service. This 13% increase compared to the year previous reduced demand impacting the OOH service. Calls that cannot be streamed away are transferred via clinical systems to the HB OOH service for action. In HDdUHB, these calls are initially dealt with as telephone consultations, before a treatment option is offered. Prior to COVID-19, more patients were seen face-to-face in treatment centres or on home visits compared to the 27% that are currently being offered this type of consultation.

Where required, some significantly unwell or potentially complex presentations, together with some low acuity issues can be dealt with by the Clinical Support Hub (CSH). The CSH is composed of senior clinical decision makers, predominantly GPs and Advanced Pharmacists, working as a virtual extension to the national '111' service. In terms of governance, these individuals are employed via Swansea Bay University Health Board (SBUHB), whilst operating under a Memorandum of Understanding as part of the wider collaborative approach to the

provision of the '111' service. This approach to regional working is to be commended and is supporting a route to establishing new and innovative ways of working, capturing and deploying ever decreasing resources for the wider benefit of the population of West Wales, and not only for HDdUHB. The OOH service in HDdUHB works in a manner chosen by the majority of GPs working within the service. In other areas of the UK, '111' would have the ability to schedule appointments on behalf of the OOH service. It continues to be the choice and consistent working practice, however GPs in HDdUHB wish to maintain control of their workload and as such the '111' clinicians have less involvement with service users and instead, the clinical team in HDdUHB take responsibility for contacting every patient via telephone to assess and develop a plan to address their individual treatment needs. Whilst this has been seen as an increase in the volume of work undertaken within HDdUHB, during the COVID-19 pandemic it has allowed clinicians to manage their work in a safe and efficient way.

Members should be aware that when a concern with the '111' service is raised, there are a number of avenues which need to be considered in order to understand at which stage (and within which organisation), the incident may have occurred.

Performance Monitoring - Local and All Wales Data Submissions.

There are national IT issues affecting the ability of OOH services which operate within the '111' system to enable full end-to-end reporting. This limitation was escalated by the previous Service Delivery Manager (SDM) to members of WG and to other operational leads in August 2020. A working group was planned but has not been established due to the pandemic. A new system called Salus is due to replace the current Adastra system. The go live date has been delayed as a result of the COVID-19 pandemic and the anticipated date will now be in the early part of the new financial year. Salus will have the ability to provide accurate monitoring and reporting data of '111' and the Out of Hours service. Until this system is introduced, the service will continue to monitor performance internally and this will be reported weekly and monthly to WG and the Executive Team, in addition to monthly Joint Operations Group meetings.

Asesiad / Assessment

Current Service Provision

The OOH service in HDdUHB currently operates from five bases across the three counties. Pembrokeshire is the only county with one base at Withybush Hospital. Ceredigion has bases in Bronglais Hospital (BGH) and Llynyfran Surgery, Llandysul. Carmarthenshire's two bases are at Glangwili Hospital (GGH) and Prince Philip Hospital (PPH) respectively. This distribution of bases allows the HB to cover urgent primary care services in a geographically appropriate way. Due to consistent capacity challenges, a decision was reached in March 2020 to reduce the overnight provision from five to two bases, leaving one base per county during overnight periods, seven nights per week. Cover at PPH and Llynyfran being temporarily stood down for part of their periods of operation.

The table below shows the total demand since '111' took responsibility for the taking and handling of calls in HDdUHB. The table shows total calls entered onto the Adastra system and the numbers concluded without being passed to the clinical team in the HB.

Year	Total calls to '111'	Calls passed to OOH	Percentage closed by '111'
Nov 2018 – March 2019	30,719	22,188	27.8%
April 2019 - March 2020	71,057	48,236	32.1%
April 2020 - March 2021	62,877	40,975	34.8%
April 2021 – August 2021	28,840	19,881	31.1%

Based on current demand, it is predicted the year April 2021 - March 2022 will exceed 69,000 total calls with 48,000 of these being passed to OOH. These are levels seen pre COVID-19. The predicted level of calls closed by '111' is expected to be relatively consistent when compared to pre-pandemic with a prediction of just 1% fewer calls able to be closed by '111' when compared to the year of 'normal' activity pre pandemic. The demand on '111' front-facing services, combined with significant pressures associated with staffing shortfalls arising from COVID-19 abstractions, has recently created additional pressures and escalated abandonment (calls that are unable to be answered) rates in excess of 40%. This raises a concern should these levels of pressure be sustained, as the ability of '111' to take initial calls will be reduced, but also the opportunity to close calls before being passed to OOH will be negatively impacted and therefore create an increase in call volume to be dealt with by OOH clinicians. Due to the chosen working practices of clinicians in HDdUHB, this would significantly increase the volume of work experienced by the service.

The COVID-19 pandemic has changed the way in which the OOH service approaches the provision of care to its service users. A decrease in volume during the lockdown phases was met with a predominant completion of contacts at the telephone advice stage. The last report provided to the Quality, Safety and Experience Committee (QSEC), noted 80% of patient contacts completed as telephone advice; this percentage has since reduced to 73% over the summer period. The predominant telephone advice work has allowed the service to function during the pandemic in a safe and efficient way, whilst protecting clinicians, especially those with vulnerabilities. Attempts have been made to develop 'Red Bases' which has been challenging due to the limited available facilities being shared by several teams attempting to develop plans to overcome the significant challenges brought about by the pandemic.

Increasing complexity of presentations is regularly being discussed by the OOH clinical team. Consultations are generally taking longer due to the increased complexity of patients presenting to the OOH service. The reasons for this are unclear but it is felt that demand on daytime services is resulting in spill-over into the OOH period, in addition to many patients who have not sought advice during the pandemic and now have poorly managed or even undiagnosed conditions.

Risk Management - Reporting, Performance Monitoring and General Accountability.

The service reports to a variety of teams, panels and committees in order to provide an assurance/risk overview of service provision and – when required - details on relevant mitigations associated with staffing risks.

The most frequent escalation mechanism is that of situation reports (which are based on risk scores derived by available capacity). These are circulated twice weekly to HDdUHB managers and executives together with operational leads in WAST ('999' and '111'), with WG and the '111' project team. Where potential risks to the HB's ED/MIU demands are identified, the service will escalate these on a daily basis to general managers for awareness and direction. Any mitigations are also included to ensure service provision is resilient within any given situation. An example would be the deployment of an advanced paramedic to cover a locality where GP staffing has not been secured.

The service now has a clinical governance arrangement whereby the Deputy Medical Director (Community and Primary Care) meets with service leads on a bi-weekly basis in order to increase the assurance and governance arrangements which are needed to ensure the service operates safely. An example of the work streams identified in this context, is the Clinical Lead GP undertaking performance reviews which include case audits. This is in addition to other audits which occur within the service. In addition, the monitoring and management of complaints has

been enhanced and all Datix complaints and concerns are now reviewed by the Associate Medical Director where required.

In terms of assurance related to service performance, certain indicators are regularly monitored by executives via quarterly performance reviews. Detailed exception reports are prepared to provide context to any targets not met, and for the most part, the lack of a sufficiently stable workforce is identified as a root cause for performance breaches.

Furthermore, reports to the People, Organisational Development and Culture Committee (PODCC) and QSEC, together with frequent scrutiny from the Community Health Council (CHC), are added means whereby the service is held to account.

As part of improvements to the governance arrangements for OOH services, an OOH peer review was convened in 2018. A follow-up review was completed in 2019, with an action plan developed to progress the actions identified. These are monitored routinely by the corporate team on behalf of the executives.

Service Escalation

To maximise service resilience, promote assurance and to minimise risks to patients, the service must escalate concerns arising in relation to clinical staffing. At present, the following process is employed and details available clinical hours required against hours secured – these are plotted into a matrix. This gives a predicted shift-fill percentage, which is then RAG rated. This predicted shift-fill does not account for the mix of clinicians available to the service and could therefore be a misleading indicator if not taken in context. The status is then set against one of the following ranges:

Escalation Level and RAG rating for Traffic light system	Level 1	Level 2	Level 3	Level 4	Service re-direction if overall shift fill rate falls below 40%
	90%-100%	80%-89%	70%-79%	40%-69%	<39%

The last report to QSEC identified the service as being predominantly at level 2. This has changed over the summer period to predominantly level 1 with occasional level 2s on Monday to Friday being experienced, which sometimes increases to level 3 and often 4 over weekends. There have not been any shifts that have deteriorated to 'Black' requiring service redirection. At present, the service informs a list of executives, hospital and other stake holding leads (such as WAST emergency medical services) of the prevailing staffing position. In order to better understand how service provision may impact patient experience within the various escalation levels, the following should be noted:

Escalation Level	**Descriptor**	**Potential risks**
Level 1	Steady State	No risks to patients identified (managed as usual)
Level 2	Moderate pressure	Low staffing level that reduces service quality (managed as usual)
Level 3	Severe pressure	Service operating with potential reduced effectiveness / lack of available capacity / increased risk to patients
Level 4	Extreme pressure	Significant risk to patients / non-compliance with national standards
Level 5	Crisis point (business continuity)	An event which impacts on a large number of patients / gross failure to meet national standards / unsafe staffing levels

Datix - Incident and Complaint Analysis - March 2021 – September 2021

There were just two new Datix submissions since the last report to QSEC. One relates to the general capacity of the service and a second to the recording of prescription usage and handling of a controlled drugs cabinet key at one base. Two further Datix submissions are historic requiring ongoing investigation and action before closing.

There is one outstanding complaint regarding a case that spanned a number of teams and services within the HB which the OOH service played a small part in.

In addition to Risk 129, there are currently five service or department level risks:
830 - OOH service demand exceeds capacity
880 - Potential Infection Control risk to OOH staff
879 - Lack of suitable estates to support OOH COVID-19 related patient flow
803 - Disruption to OOH service due to failure of 111 IT system
71 - Lack of effective communication between daytime practices and OOH

Members should be assured that Datix risks and incidents are reviewed on a monthly basis by service leads and there is an additional review made by the OOH complaints governance team; the SDM and clinical lead then provide a report to the Joint Operations Group as well as to the all-Wales OOH Forum.

Development of Service Provision

Although the majority of the OOH workforce in HDdUHB is made up of sessional GPs, there have been recent opportunities which will have a positive influence on rotas. Within the past six weeks, five GPs have been recruited to salaried positions. Two of these already worked for the OOH service on a sessional basis however their willingness to become employed on salaried terms is seen as a positive step forward. The further three GPs are in the final stages of their GP training programmes and will be ready to take up their positions in the final quarter of this financial year. These additional five salaried GPs will bring the total number to 53 and will give some foundation to stabilising the rota and an element of proactive planning. The previous report to QSEC also identified 53 GPs (10 of which were salaried) working in the service but subsequently this number reduced.

The development of a Multidisciplinary Team (MDT) has continued and remains a key area of focus. Three Advanced Nurse Practitioners (ANP) regularly work in the OOH service with a further one undertaking shifts as a sessional worker on a less frequent basis. Advanced Paramedic Practitioners (APP) continue to work in the OOH service within a MOU between HDdUHB and WAST. This three-year pilot will conclude at the end of October 2021; however discussions are underway to plan how this valuable group of clinical colleagues could continue to be included as part of the growing MDT in the OOH service. The uncertainty about the ability to employ APPs directly in the HB continues to be a topic of discussion and should the issues involved be overcome, the availability and frequency that clinicians with paramedic backgrounds can work as part of an MDT will grow significantly.

Options to develop and reinforce the OOH service in other ways are also being evaluated. Proposals to expand the service to link with other services are being considered. These options would increase the general capacity of the available workforce, in addition to the ability to offer variety of work which will make working in the service more attractive prospect. This variety could be a partnership between Primary Care Managed Practices or other departments such as ‘Same Day Emergency Care’ (SDEC). These options could also reduce the impact of the ‘111 First’ and Urgent Primary Care developments by ‘sharing’ the limited pool of clinicians in a way that enhances and not detracts from services.

Further Projects which are Underway to Develop the OOH Service.

The availability of the call centre in Withybush General Hospital (WGH) has led to opportunity to join with other services. One of the two important services being supported by the HDdUHB OOH service is the newly commissioned '111' Mental Health Practitioners. The service is set to be hosted in the call centre at WGH which will allow this developing service to work more closely with the OOH team including providing clinical support particularly in the OOH period.

A second important service is the Oncology Triage Service currently hosted within SBUHB. Bringing this service back to HDdUHB and developing the skills of the OOH call handlers will improve access and satisfaction to those needing to engage with this service. These patients would likely enter the '111' system, however with this service they can be managed with an efficient and globally recognised Oncology Triage Tool, allowing access to the most appropriate care.

The work to develop 'Red Bases' continues and is nearing conclusion which will allow more symptomatic patients to be seen in appropriate areas. These bases will create a safer and controlled area to assess patients without increasing risk to other service users and staff which has been a barrier to date. This is particularly important ahead of the predicted Respiratory Syncytial Virus (RSV) numbers where the ability to differentiate between COVID-19 and RSV will be challenging. If predictions are accurate, significant numbers of children will need to have access to face to face assessments, in addition to symptomatic adults with possible COVID-19 symptoms.

'111 First' is due to roll out its first phase in the near future with the second phase likely to be realised at the end of quarter four 2021/22 or beginning of the next financial year. The '111 First' programme has the potential to allow the OOH service to develop certain areas such as call handling. However it should be noted that change at this scale has the potential to disrupt working practices and embracing the way of working required by '111' already remains a challenge for the service.

A Demand & Capacity study is currently underway internally within the OOH service. Overall demand and clinical outcomes are being assessed against pre-pandemic levels to better understand the service and how it functions. Studying the service over this timescale will improve demand data accuracy of in the OOH service when the influence of the pandemic eases. This data compared to capacity will direct the planning of service development, with the make-up of the clinical team being a significant factor to consider in light of reducing numbers and availability of GPs against a predicted rise in demand associated with an ageing population and prevalence of chronic conditions.

It is important to understand how those using the service receive treatment. To enable this to be understood, a patient satisfaction survey is being developed. Although not yet actioned its development is well advanced and it is anticipated that it will be ready to use and start collecting data in the new year. This data is expected to provide evidence to influence service design and direct change to provide the best care available in equitable measure across the HB. It has been suggested in engagement meetings with GPs working in certain areas, together with additional comments from the CHC, that service users living in certain areas receive a reduced level of care and are managed in different ways to those living in areas closer to bases. Additionally WAST has been asked to undertake an audit of calls in the areas served by the bases that have been closed during overnight periods. This data will further inform the OOH team as to the possible impact of the episodic base closures, identifying whether patients then need to use the '999' service and therefore potentially be routed incorrectly adding to the demand of an already stretched ambulance service. Due to the level of escalation WAST are currently experiencing there could be a delay in receiving this data.

Clinical governance continues to be a key aspect of maintaining and developing a safe OOH service. The Clinical Lead (CL) and Service Delivery Manager (SDM) are working closely and an agreement has secured the CL position for another year. Fortnightly meetings with the Deputy Medical Director (DMD) and Associate Medical Director (AMD) enhances the clinical leadership with timely discussion and management of issues affecting the service. These may be operational, incidents, concerns, ombudsman and service improvement. These close working relationships have allowed an interim measure to be implemented to support the SDM with clinical concerns whilst the CL is on annual leave and fulfilling the requirements of the retire and return process.

Clinical leadership is further provided at a Journal Club held once a month and chaired by the AMD. The DMD, CL and SDM regularly attend allowing interaction with the clinical team to promote learning, team working and a timely way to hear and respond to clinical and operational queries.

To mitigate demands of managing a rota largely made up of sessional GPs and the additional challenges associated with this group, a new system (RotaMaster) has been procured. This system allows the open advertisement of vacant shifts and will make the offering of availability of GPs possible 24-hours a day. Additionally the consequences of discontent surrounding the rights to shifts and regular working of sessional colleagues causing some withdrawal of GPs is expected to be mitigated. RotaMaster will be ready for go live before Christmas 2021.

Risk 129 - Ability to Deliver an Urgent Primary Care Out-of-Hours Service for Hywel Dda University Health Board Patients

There are several factors (some on a national scale) which are affecting the ability to deliver care within the OOH Service. The resulting staffing profile and service risks are reflected in Risk 129. This risk is reviewed regularly and amended as required with any new actions leading to mitigations identified as appropriate. The present risk score of 12 (High) has remained since the last assurance provided to QSEC.

The unpredictable nature of the OOH workforce, which includes the influences of sickness and retirement combined with the pan-Wales recruitment issues, makes any significant change to the risk scores challenging. With potential staffing complications relating to COVID-19 adding further pressures, the need to increase the risk score remains a possibility and this is kept under continuous review by the management team

Summary

The delivery of OOH services is a complex matter and is significantly reliant on a workforce, the majority of whom have the option to opt in or out of shifts at their discretion. This is due to there being very few salaried (contracted) clinicians. The demographic of the local GP network is also concerning given the proximity to retirement that many are considering. In addition, there workforce is experiencing sickness issues that are affecting a number of staff on a long-term basis together with shortfalls that are explicitly related to the COVID-19 pandemic and related infection control directions.

The variable risk profile is attributed predominantly to the staffing positions and this has resulted in the formal submission of concerns from service clinicians along with ‘111’ staff. In turn, the service has, with the support of the Executive Team, made temporary changes to the operating structure of the service in the overnight period, which for the most part have improved access and stability as well as increased resourcing. This is with the exception of weekend cover.

A more formal review of this service change and its impacts on patient journeys has been delayed due to COVID-19, however this work is now underway again and will be treated as high priority by the OOH leadership team.

The variations in staffing combined with the risks faced across the region are reflected in Risk 129. Despite several actions being identified and solutions being implemented, the fragility of the service remains a concern and it is apparent that this risk may be retained as active for some time to come.

Potential Solutions

The reliance on a GP staffed model is no longer viable and although the OOH service will always need to be GP led, the move to a multidisciplinary team is considered an imperative. With this comes an opportunity to provide career pathways for those with a variety of backgrounds to develop triage, community nursing and advanced practice skills; further integration across organisational boundaries such as with the WAST APP model; development of newer roles in the OOH setting such as Healthcare Support Workers (HCSW), trained drivers, Physician Associates etc. Further opportunities to develop the OOH service into an Urgent Primary Care Service which operates over a 24-hour period continue to be explored. This model could offer a variety and rotation resulting in an opportunity to attract a greater cohort of interested individuals. This would see an increase in the overall number of colleagues who are salaried and therefore provide a more resilient workforce. All of this will need to be included into the workforce capacity assessments that are being completed. With some development in the staffing situation, there is an opportunity for some foundation of stability, however further recruitment and MDT development may be slow.

Risk 129 is likely to remain at its present level for some time to come and will be continually impacted by the persistency of the COVID-19 pandemic. The service leadership and management team will continue to review and work in partnership with other colleagues and services to mitigate this risk where possible.

Argymhelliad / Recommendation

The Committee is asked to:

- Note the current position of the OOH Service in its ability to meet the needs of the service users;
- Consider the actions that are underway to mitigate risk and develop the service and improve the situation in the longer term;
- Receive assurance that Risk 129 and the consequences of the Primary Care OOH service's fragility on patient safety and clinical needs are being mitigated.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	R129 - Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda Patients 3x4 =12

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 2.1 Managing Risk and Promoting Health and Safety 5.1 Timely Access 7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the report where applicable
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Additional financial resource may be required.
Ansawdd / Gofal Claf: Quality / Patient Care:	All actions associated with this paper are to improve the quality of patient care and are focused on patient safety Where clinical access cannot be secured and patients are delayed in receiving care there is potential for harm – but the 999 and ED escalation remains an option where required.
Gweithlu: Workforce:	Training and education needs to be identified as work streams emerge

Risg: **Risk:**	Sound system of internal control ensures any risks are identified on the OOH Risk Register, assessed and managed.
Cyfreithiol: **Legal:**	Nothing identified as applicable
Enw Da: **Reputational:**	Any reduction in GP shift fill rates will negatively impact on the organisation's reputation. Political representation in relation to service provision has already been made.
Gyfrinachedd: **Privacy:**	Nothing identified as applicable.
Cydraddoldeb: **Equality:**	Ensure decisions made benefit all patients and staff within Hywel Dda Health Board. All individuals will be considered equitably in any work streams proposed.