# Getting it Right First Time

# General Surgery National Report across Wales

**May 2023**

*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 the urgent restoration of elective general surgery services and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.*

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## Foreword

Getting It Right First Time (GIRFT) is a national Programme in England developed by the GIRFT National Team under the Chairmanship of Prof Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The HVLC programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways (HVLC programme - Getting It Right First Time - GIRFT).

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Welsh Government and the Planned Care Team to conduct a review of General Surgery Services in Wales using the GIRFT methodology and High Volume Low Complexity (HVLC) principles.

This report describes the findings and recommendations from the review, as well as laying out the objectives and the approach followed by the RNOH GIRFT team.

I was delighted to have the opportunity to conduct this review of general surgery in Wales. We have used GIRFT methodology and applied this to each Health Board. During this programme I had the opportunity to meet colleagues from all the Health Boards, all of whom were very welcoming and eager to see data showing how their services were performing.

In this review the RNOH/GIRFT team have focused on the gastrointestinal and abdominal wall aspects of general surgery. We recognise that general surgery is a broad church and that in order to be consistent with the NHS England GIRFT General Surgery Programme we have deliberately not dealt with endocrine, breast or general paediatric surgery. Many of the general recommendations within this report will also have application to these other subspecialties.

We have made recommendations within this report for both NHS Wales and the seven Welsh Health Boards and we will be providing implementation support over the next six months to ensure the sustainable and significant improvement in general surgery in Wales.

This project has been a team effort and I would like to acknowledge the following who have made significant contributions to this. Firstly, to all the clinical and operational colleagues in the Welsh Health Boards who have universally welcomed us and engaged with the process. To colleagues in the GIRFT Projects Team at RNOH in particular, Lisa Paget and Allison Beal for Project Management. To Catriona Mackay and her colleagues at Edge Health for assistance with data analytics. To Ken Harries, Consultant Surgeon at Hywel Dda University Health Board for helping me navigate the complexities of the Welsh NHS and supporting me at Health Board Deep Dives.

**Mark Cheetham: GIRFT National General Surgery Clinical Lead, Consultant in general and colorectal surgery at Shrewsbury and Telford NHS Hospital Trust (SaTH).**

## 1. Executive Summary

This report is based on the data and observations from RNOH/GIRFT's visits to all the Welsh Health Boards to review their general surgery services. The table below (table 1) shows the schedule of the visits. **Annex A** provides a full list of hospitals included in this review.

**Table 1 – Schedule of visits**

| Health Board | Date | Type |
|---|---|---|
| Cardiff and Vale University Health Board | 04/11/2022 | Face-to-face |
| Hywel Dda University Health Board | 10/11/2022 | Face-to-face |
| Aneurin Bevan University Health Board | 10/11/2022 | Face-to-face |
| Powys Teaching Health Board | 11/11/2022 | Virtual |
| Swansea Bay University Health Board | 22/11/2022 | Face-to-face |
| Cwm Taf Morgannwg University Health Board | 24/11/2022 | Face-to-face |
| Betsi Cadwaladr University Health Board | 10/03/2023 | Virtual |

Unfortunately, the data quality in PEDW was poor and we were somewhat limited in the peer comparisons we could make as a result of this. Improving data collection and coding is a key recommendation of this report. Nevertheless, the data packs supplied to each Health Board were the starting points for useful discussion about how services were currently delivered and what could and should be done differently in the future. It was notable that for many clinicians, this was the first time that they had seen peer comparison data regarding their service. We observed that colleagues in individual sites had very little interaction with or knowledge of the services at other sites or Health Boards. Developing constructive relationships across sites and Health Boards will be a key and early task in order to improve general surgery across Wales.

The Health Boards along the M4 corridor have largely been able to consolidate emergency general surgery onto one of their sites. This has meant that they have been able to introduce subspecialty on call rotas, improve recruitment, develop a separate elective site and reduce the frequency of on calls for their surgical staff. This model of care is in sharp contrast with the other Health Boards in Wales which have up to three sites providing emergency general surgery often for a smaller population. This dispersed model of care has worsened recruitment and retention; we noted consultants working onerous on call patterns often with limited on site medical cover. In order to improve recruitment and retention it will be necessary to consolidate emergency general surgery on to fewer sites in these Health Boards. This will have the added advantage of freeing up space on some sites which can be repurposed as dedicated elective facilities.

We saw a similar pattern of specialist and tertiary services across Wales with a concentration of these services in South Wales. Outside of this area there was a dearth of specialist services and this was compounded by a lack of defined tertiary referral pathways within Wales. Developing more subspecialist services within all Health Boards will improve access to treatments and reduce geographic inequalities while supporting improved consultant recruitment. There is a strong need

to define the pathways and processes for tertiary referrals within Wales. Doing so must ensure that resources flow with the patients in order that Health Boards providing tertiary services are not disadvantaged by this process.

We have made **34 national recommendations** which are summarised in **Section 3. These also include some recommendations which have been made to every Health Board which NHS Wales should therefore help to drive nationally and locally.**

We have provided a number of useful links to GIRFT General Surgery good practice in **Annex B.**

Each Health Board has received an individual report setting out our findings and recommendations about the unwarranted variation observed. As an addendum to this report, we have provided the full National General Surgery GIRFT datapack which shows some of the variation we observed across Wales. Where a table refers directly to an observation this is included in the main body of the report.

## Table of Recommendations

| No. | National General Surgery Recommendations |
|---|---|
| **1** | NHS Wales should support and encourage the recommendation we have made to Health Boards to set up a Task and Finish Group to develop an action plan to implement the GIRFT recommendations and allocate responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. RNOH/GIRFT will also continue to provide implementation support for 6 months. |
| **2** | NHS Wales to consider creating an All Wales General Surgery Reference Group with funded time for a Chair and funded time to administer the Group. This would also include access to analyst time to provide regular updates of metrics. These should include a range of metrics to capture the entirety of general surgery care including demand and capacity, outpatients, diagnostics and surgical activity. There must be representation from each of the Health Boards with clinical and management presence. This Group should meet regularly – we would suggest monthly initially. |
| **3** | NHS Wales should support and encourage the recommendation we have made to Health Boards to establish a robust mechanism for capturing procedure level data of inpatient, day case and outpatient procedures in general surgery. This mechanism should be consistent across all health boards to future-proof data collection/review in future across all systems. |
| **4** | NHS Wales should support and encourage the recommendation we have made to Health Boards to develop a relationship between clinical coders and consultants to improve data capture. |
| **5** | NHS Wales to consider becoming part of the Model Health System in England, allowing benchmarking and ensuring best practice and learning. |
| **6** | NHS Wales to consider contributing data and funding towards NCIP (the National Consultant Information Programme) in order that consultant surgeons in Wales have access to peer comparison data for the purposes of revalidation and appraisal as do their English colleagues. |

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| **7** | Health Education and Improvement Wales should lead a review of the allocation of general surgical speciality trainees and core trainees in surgery to ensure that the allocation of posts to individual hospitals is equitable and matches training opportunities. |
| **8** | NHS Wales and Health Education and Improvement Wales should create a national apprenticeship scheme to recruit and train Operating Department Practitioners. |
| **9** | NHS Wales should instigate a funded programme to ensure that patients in each Health Board have equitable access to a ring-fenced surgical hub treating general surgical patients. |
| **10** | NHS Wales should support and encourage the recommendation we have made to Health Boards to embed the GIRFT Clinically-led General Surgery Outpatient Guidance for general surgery services to maximise efficiency and reduce waiting times for patients. The guidance should be used as a template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience. |
| **11** | The all Wales General Surgery Reference group should develop and with the help of NHS Wales, implement standardised referral pathways for common tertiary referrals in general surgery including complex benign upper GI surgery, pelvic floor surgery, complex IBD surgery, complex abdominal wall reconstruction, pelvic exoneration, HIPEC and upper GU malignancies. |
| **12** | NHS Wales should review the processes for tertiary referrals between health boards to ensure that there is a clear mechanism to measure this activity and to ensure that units receiving these referrals are adequately compensated for providing this service. |
| **13** | NHS Wales should support and encourage each Health Board to ensure that there is a nominated Lead surgeon for Emergency General Surgery with identified, funded time within their job plan. |
| **14** | NHS Wales should review the number of sites providing Emergency General Surgery in Wales with the aim of concentrating Emergency General Surgery services on fewer sites in order to ensure critical mass and equitable access to surgical expertise and supporting services such as interventional radiology. |
| **15** | NHS Wales should ensure that each Health Board audits their unit and individual consultant rates of laparoscopic surgery for appendicectomy and take correction action if any issues are identified. |
| **16** | NHS Wales should ensure that each Health Board conducts a demand and capacity assessment for emergency general surgery to ensure that there is sufficient capacity to treat patients in reasonable timeframe. |
| **17** | NHS Wales should ensure that each Health Board has established a Surgical Same Day Emergency Care (SDEC) Unit on each site providing Emergency General Surgery. |
| **18** | NHS Wales should support the recommendation that Health Boards review the post-operative care and reasons for readmission within 30 days of patients having elective colorectal cancer surgery. |
| **19** | NHS Wales and each Health Board should ensure that all surgeons and sites conducting major excisions for rectal cancer have an adequate annual case volume at a minimum in excess of that recommended by NICE (minimum of 5 resections per surgeon and 10 resections per site). |
| **20** | NHS Wales should support and encourage the recommendation we have made to all Health Boards to ensure that there are nominated colorectal surgeons with a special interest in inflammatory bowel disease surgery. Each Health Board should establish a multi-disciplinary team to manage patients with IBD. The IBD MDT should meet on a regular basis to discuss the care of individual patients. All core members of the IBD MDT should have funded time allocated within their working week to attend this meeting. |

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| **21** | The all Wales General Surgery Reference Group should develop a set of service standards for the diagnosis and treatment of patients with pelvic floor disorders across Wales in conjunction with the Pelvic Floor Society. These standards should specify the diagnostics and treatments to be available both within each Health Board and within tertiary referral centres. NHS Wales and the Health Boards should work together to implement these standards. |
| **22** | NHS Wales should co-ordinate and accelerate plans to reunite tertiary HPB services on one site, taking into consideration interdependencies with other services such as critical care, interventional radiology and the trauma network. |
| **23** | The all Wales General Surgery Reference Group should specify which complex upper benign GI procedures should be available at each Health Board and specify the pathways for referral to a tertiary service. |
| **24** | NHS Wales should increase the provision of bariatric surgery in Wales to ensure that there is equitable access to effective treatments for obesity in accordance with NICE guidance: Obesity, identification, assessment and management**.** This should be considered in the context of a wider review of a tiered weight management service across Wales. Consideration should be given to establishing a bariatric surgical unit in North Wales to repatriate activity currently sent to England. |
| **25** | NHS Wales should support and encourage the recommendation we have made to Health Boards to carry out a full demand and capacity assessment. |
| **26** | NHS Wales should support and encourage the recommendation we have made to Health Boards to standardise HVLC Pathways in elective inguinal hernia, paraumbilical and gallbladder surgery. |
| **27** | NHS Wales should support and encourage the recommendation we have made to Health Boards to standardise procedure-level clinical pathways (HVLC) by adopting or adapting the GIRFT General Surgery pathways as required. These pathways were developed by 'expert advisory panels' supported by professional societies: General Surgery - Getting It Right First Time - GIRFT. |
| **28** | NHS Wales should support and encourage the recommendation we have made to Health Boards to review the current processes for obtaining and documenting patients' consent for surgery and, where this deviates from recommendations by the GMC and the Royal College of Surgeons, take appropriate corrective action. In the medium term, NHS Wales should consider moving towards a digital model for providing patient information and recording consent. Please refer to the following links: RCS_ Consent Supported Decision Making.pdf Decision making and consent (gmc-uk.org). |
| **29** | NHS Wales should support and encourage the recommendation we have made to Health Boards to ensure that there is a regular (at least monthly) morbidity and mortality meeting within the general surgery department. The structure and tone of these meeting should follow guidance from the Royal College of Surgeons: (Good Surgical Practice - Morbidity and Mortality Meetings, 2014). |
| **30** | NHS Wales should support and encourage the recommendation we have made to Health Boards to ensure that all cases of litigation are discussed in a minuted departmental meeting in order that lessons can be learnt and disseminated. |
| **31** | NHS Wales should support and encourage the recommendation we have made to Health Boards to conduct a review of the preoperative assessment system service and take action to implement the Guidance from CPOC of Pre-operative assessment and optimisation (Guidance |

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|---|---|
| | for Preoperative Assessment and Optimisation for Adult Surgery Published \| Centre for Perioperative Care (cpoc.org.uk)) including the following:<br>a. Ensure that patients are booked in chronological order within bands of clinical urgency<br>b. Develop a digital solution to visualize the result of preoperative assessments<br>c. Use the time while patients are on the waiting list to optimise them for surgery by addressing modifiable risk factors for surgery including smoking, hypertension, glycaemic control, obesity, diet and lack of exercise<br>d. Only list patients for routine surgery when they are fit and optimised<br>e. Consider implementing the role of Perioperative Coordinator to facilitate these. |
| **32** | NHS Wales should launch a National Theatre Productivity programme focussed on improving booking and scheduling and "on the day of surgery" processes. This programme should define and agree start and finish times of elective theatre sessions and should aim to improve capped theatre utilisation to 85% across elective theatres sessions. |
| **33** | NHS Wales should support and encourage the recommendation we have made to Health Boards to develop local programmes to improve theatre capacity by introducing 6 day working and extended days in theatres. |
| **34** | NHS Wales should launch a national programme to ensure that each Health Board carries out a clinically-led programme to rationalise the stock lines of disposable equipment and implanted devices within general surgery. Following this, each Health Board should develop local mechanism to ensure that there is oversight and control of the financial, safety and training implications of any new medical devices used in theatres. |

## 2. Project Objectives

The purpose of this GIRFT review of General Surgery in Wales is to identify improvements in the speciality and to inform transformation plans by:

- Providing an **overall picture** of the specialty and identifying outliers
- Focusing on system and organisation level to take out **unwarranted variation** in access to care and the outcomes of care
- Supporting Wales to drive for '**top decile'** GIRFT performance of outcomes, productivity and equity of access
- Informing potential **establishment of elective surgical hubs**
- Sharing relevant **best practice and pathways** for working across clinical and operational groups e.g. theatre principles
- Leaving a legacy of **sustainable quality improvement** by working in partnership with your clinical, operational and analytical teams so that you are able to continue implementation and track progress at the end of our work with you.

## 3. Data

GIRFT General Surgery review makes use of procedure group metrics originally specified in GIRFT's Model Health System for General Surgery services to develop datapacks for each hospital and Health Board. Welsh Health Boards were benchmarked against each other as well as against England Trust averages.

The data sources include;

- Patient Episodes Data Wales (PEDW)
- Secondary Uses Service/ Hospital Episode Statistics (SUS/HES)
- National Emergency Laparotomy Audit (NELA)
- National Bowel Cancer Audit (NBOCA)
- National Oesophago-gastric Cancer Audit (NOGCA)
- A pre-visit questionnaire completed by the Health Boards to provide information on the current workforce provision, emergency general surgery (EGS), colorectal surgery, upper GI surgery, hernia surgery, governance processes and litigation.

The datapacks contains metrics on hospitals' activity from April 2019 to March 2020, this time period was deliberately chosen to assess the capability of the Health Boards prior to the significant disruption caused by the Covid-19 pandemic. It is understood that much has changed in the interim. In a number of instances, the health board general surgery teams felt that the data did not accurately reflect their practice. There were significant issues with the data quality in the PEDW data in terms of the number of episodes coded, accuracy of diagnostic/procedural codes and in the depth of coding of comorbidities. This significantly hampered the ability of the RNOH/GIRFT team to make accurate comparisons of the general surgery services between England and Wales.

We ran a webinar on 13th October 2022, to provide those invited to the deep dive engagements with an overview of how a GIRFT data pack is constructed and how to interpret the charts and graphs in the packs.

## 4. Our Methodology and Approach

We followed the GIRFT methodology, structured as follows:

- **Data gathering** and structuring shared ahead of the deep dive visits
- Early **communication** about the programme (including HVLC)
- **Deep dive engagements** (virtual or actual visits) for each Health Board, with relevant stakeholders present
- **Health Board level and National level reports** explaining findings and recommendations
- **Implementation support** at national level to implement the recommendations (these start on 25th May 2023

The deep dive engagements took place between 4th November 2022 and 10th March 2023 and were led by Mark Cheetham. Each deep dive was an opportunity for the Health Board to provide an overview of their General Surgery services and current issues; this was followed by a review of the GIRFT data and a detailed discussion. We also discussed the HVLC programme and elective recovery to help inform Health Board implementation plans. All the meetings were well attended by a mixture of colleagues in General Surgery roles (clinicians, theatre staff, senior managers and Allied Health Professionals), all of whom contributed to the excellent discussions. This allowed the RNOH/GIRFT team to gain a good understanding of the issues facing each Health Board and their hospitals and to suggest improvements.

RNOH / GIRFT will provide the Health Boards with support to implement the recommendations made in their General Surgery individual reports. Each Health Board has been asked to set up a Task and Finish Group to develop an action plan to implement the recommendations and to

allocate responsibilities to relevant people to share the workload. We will convene a monthly (for six months) General Surgery meeting which should be attended by the General Surgery leads from each Health Board. At the first meeting on the 25th of May 2023, we will ask each Health Board to provide an update of their progress on implementing their GIRFT recommendations. Mark Cheetham will attend each meeting to provide ongoing advice and the Planned Care Team in the NHS Executive will also attend.

**RNOH/GIRFT Findings and NHS Wales Recommendations**

## 5. General Surgery Services in Wales

General Surgery services are provided in each of the seven Health Boards with Powys Teaching Health Board (PTHB) being the only Health Board that does not provide inpatient services. PTHB patients are transferred to neighbouring Welsh Health Boards or to NHS England (Shrewsbury and Telford Hospital NHS Trust or Wye Valley NHS Trust).

Although clinical engagement within Health Boards was good, there is an opportunity for an All Wales General Surgery Reference Group to meet regularly, with representation from the clinical and management cadres of all Health Boards to share information on waiting lists, best practice, mutual aid and data oversight. This group could also oversee the implementation of the cross-cutting GIRFT recommendations.

**Recommendation 1: NHS Wales should support and encourage the recommendation we have made to Health Boards to set up Task and Finish Groups to develop an action plan to implement the GIRFT recommendations and allocate responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. RNOH/GIRFT will also continue to provide implementation support for 6 months.**

**Recommendation 2: NHS Wales to consider creating an All Wales General Surgery Reference Group with funded time for a Chair and funded time to administer the Group. This would also include access to analyst time to provide regular updates of metrics. These should include a range of metrics to capture the entirety of general surgery care including demand and capacity, outpatients, diagnostics and surgical activity. There must be representation from each of the Health Boards with clinical and management presence. This Group should meet regularly – we would suggest monthly initially.**

## 6. Data and coding

Although the introduction of Payment by Results (PbR) stimulated improvements in coding of secondary care data in England, the provision of accurately coded data is essential in order to monitor clinical activity volumes, quality of care and trends in diseases and treatments. During this project, we found significant issues with the coding of activity carried out in secondary care in Wales as recorded in PEDW. This has hampered our ability to make useful peer comparisons between general surgical units across England and Wales. Clinicians and operational managers across Wales expressed a deep frustration at the dearth of useful activity data available to them to allow them to manage their services. NHS Wales has an enviable reputation for the delivery of Value-based Health Care, yet the quality of the data available in PEDW means that extending this work across secondary care will be challenging.

**Recommendation 3: NHS Wales should support and encourage the recommendation we have made to Health Boards to establish a robust mechanism for capturing procedure level data of inpatient, day case and outpatient procedures in general surgery. This mechanism should be consistent across all health boards to future-proof data collection/review in future across all systems.**

**Recommendation 4: NHS Wales should support and encourage the recommendation we have made to Health Boards to establish a close working relationship between clinical coders and consultants to improve data capture.**

**Recommendation 5: NHS Wales to consider becoming part of the Model Health System in England, allowing benchmarking and ensuring best practice and learning.**

**Recommendation 6: NHS Wales to consider contributing data and funding towards NCIP (the National Consultant Information Programme) in order that consultant surgeons in Wales have access to peer comparison data for the purposes of revalidation and appraisal as do their English colleagues.**

## 7. Workforce and Training

The level of vacancies in the surgical workforce varies significantly across the seven Health Boards. Levels of recruitment in the Health Boards along the M4 corridor were generally on a par with those in English metropolitan hospitals. Outside of South Wales, workforce gaps were much more significant with high frequency on-call rotas and multiple sites being the norm in West, Mid and North Wales.

The allocation of surgical trainees is also skewed towards placements in the larger hospitals in South Wales. As trainees commonly practice in the regions in which they train, this will undoubtedly hardwire in the recruitment difficulties for consultant posts in West, Mid and North Wales.

**Recommendation 7: Health Education and Improvement Wales (HEIW) should lead a review of the allocation of general surgical speciality trainees and core trainees in surgery to ensure that the allocation of posts to individual hospitals is equitable and matches training opportunities.**

Across CTMUHB, BCUHB and HDUHB in particular, there are significant issues with recruitment and retention of the nursing and Operating Department Practitioner (ODP) workforce. This workforce gap is having a significant impact on the ability of the Health Boards to restore surgical services in theatres.

**Recommendation 8: NHS Wales and HEIW should create a national apprenticeship scheme to recruit and train ODPs.**

## 8. Hot and Cold Split

The Covid-19 pandemic and its aftermath has had a significant impact on the delivery of elective surgery across the United Kingdom. Prompted by concerns about the nosocomial spread of Covid-19, most hospitals instituted green Covid-free pathways often on separate sites to urgent and emergency care. Even prior to the Covid-19 pandemic, there was good evidence that separation of elective from emergency care leads to improved outcomes, better patient experience and a more resilient elective service; further information can be found on the Royal

College of Surgeons website: Royal College of Surgeons - Separating emergency and elective care.

In order to deal with the large backlog of elective surgery, it will be necessary to continue with planned surgery for 50 weeks a year without routinely stopping elective services during times of system pressure. In England this has led to a programme of building and credentialing elective hubs (either on the site of an acute hospital or on a separate elective only site). In our deep-dive visits across Wales, we saw evidence of protected elective facilities in some Health Boards. However the provision was patchy and in some Health Boards, the capacity was insufficient to meet demand.

**Recommendation 9: NHS Wales should instigate a funded programme to ensure that patients in each Health Board have equitable access to a ring-fenced surgical hub treating general surgical patients.**

## 9. Outpatients

The majority of patients in the large backlog awaiting treatment are waiting for outpatient's appointments and diagnostic tests. In order to reduce this backlog and ensure that patients are treated promptly it will be necessary to completely reshape outpatient services across Wales. This will include:

- Robust clinical triage of all referrals into a service
- Sending selected new patients straight to test
- "One stop shop" clinics
- The use of Patients Initiated Follow-Up (PIFU).

GIRFT and the Outpatient Recovery and Transformation Programme (OPRT) have developed Clinically-led Specialty Outpatient Guidance to tackle the escalating demand for outpatient appointments.

**Recommendation 10: NHS Wales should support and encourage the recommendation we have made to Health Boards to embed the GIRFT Clinically-led General Surgery Outpatient Guidance for general surgery services to maximise efficiency and reduce waiting times for patients. The guidance should be used as a template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience.**

## 10. Tertiary services

Tertiary services within general surgery in Wales are principally hosted within Cardiff, Swansea and Wrexham (which hosts the oesophagogastric unit for North and Mid Wales). Although there are well defined pathways for oesophagogastric and HPB cancers within Wales, there is significant variation in referrals for colorectal malignancies and benign GI conditions. In some Health Boards, referral patterns were dictated by where consultants had trained rather than the needs of patients of defined pathways of care. This ambiguous and dispersed model of tertiary services has led to unwarranted variation in rates and destination of referrals.

**Recommendation 11: The All Wales General Surgery Reference group should develop, and with the help of NHS Wales, implement standardised referral pathways for common tertiary referrals in general surgery including complex benign upper GI surgery, pelvic floor**

**surgery, complex IBD surgery, complex abdominal wall reconstruction, pelvic exoneration, HIPEC and upper GU malignancies.**

**Recommendation 12: NHS Wales should review the processes for tertiary referrals between health boards to ensure that there is a clear mechanism to measure this activity and to ensure that units receiving these referrals are adequately compensated for providing this service.**

## 11. Emergency General Surgery

It is estimated that 80 to 90% of deaths in general surgery patients occur in those admitted as an emergency. To provide high quality care to the care of patients admitted with unselected surgical emergencies requires significant consultant availability and involvement 24 hours a day. Emergency general surgery (EGS) relies on close links with other interdependent services including emergency medicine, critical care, anaesthetics, acute medicine, care of the elderly and radiology.

**Recommendation 13: NHS Wales should support and encourage each Health Board to ensure that there is a nominated Lead surgeon for Emergency General Surgery with identified, funded time within their job plan.**

Currently Emergency General Surgery is provided at twelve hospital sites in Wales. There is significant variation in the size of the catchment area, number of surgical staff and the facilities available at these sites. In South Wales along the M4 corridor, there are large single site hospitals with good facilities and reasonable on call frequencies for surgical staff. Elsewhere in Wales (West, Mid and North Wales), the sites are smaller with less comprehensive facilities and much higher on call frequencies. Table 2 below lists the Health Boards with their catchment areas, site providing EGS and the number of emergency laparotomies performed per year as an indication of the workload of each site.

**Table 2: The Provision of Emergency General Surgery in Wales**

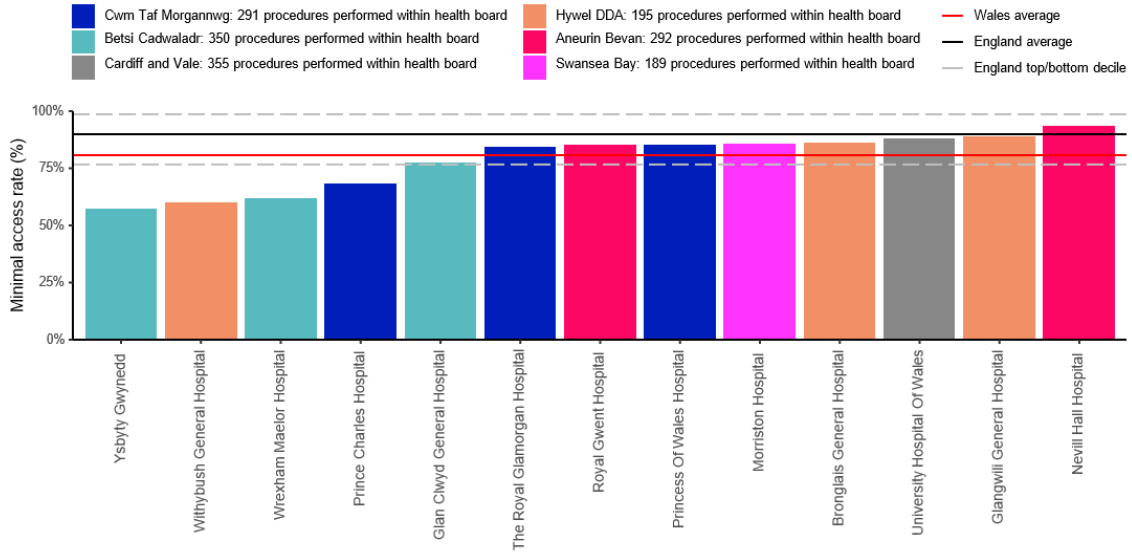
| **Health Board** | **Catchment Population in 2021** (statswales.gov.wales) | **Sites** | **Estimated number of laparotomies / year from PEDW** (NELA Year 8 Audit) |
|---|---|---|---|
| Cardiff and Vale University Health Board | 492, 046 | University Hospital of Wales | 257 |
| Hywel Dda University Health Board | 382, 518 | Withybush Hospital<br><br>Glangwilli Hospital<br><br>Bronglais Hospital | 95<br><br>80<br><br>37 |
| Aneurin Bevan University Health Board | 588, 303 | Grange University Hospital | 278 |
| Powys Teaching Health Board | 133, 557 | n/a | n/a |

| | | | |
|---|---|---|---|
| Swansea Bay University Health Board | 379, 765 | Morriston Hospital | 231 |
| Cwm Taf Morgannwg University Health Board | 442, 123 | Prince Charles Hospital<br><br>Princess of Wales Hospitals<br><br>Royal Glamorgan Hospital | 78<br><br>77<br><br>88 |
| Betsi Cadwaladr University Health Board | 687, 098 | Ysbyty Gwynedd<br><br>Wrexham Maelor<br><br>Glan Clywd | 173<br><br>130<br><br>155 |

It is apparent from reviewing the data that there are too many small, low volume EGS units in Wales. The effect of this in these smaller units is a high on call frequency, workforce shortages and a relative unfamiliarity with dealing with acutely ill surgical patients. Consolidating EGS on fewer sites will allow more palatable rotas, and improve training and outcomes. In addition this approach will free up real estate for ring-fenced elective units (see Section 11 Hot/Cold Split).

**Recommendation 14: NHS Wales should review the number of sites providing Emergency General Surgery in Wales with the aim of concentrating Emergency General Surgery services on fewer sites in order to ensure critical mass and equitable access to surgical expertise and supporting services such as interventional radiology.**

**Figure 1 - Minimal access rate for emergency appendicectomy**.



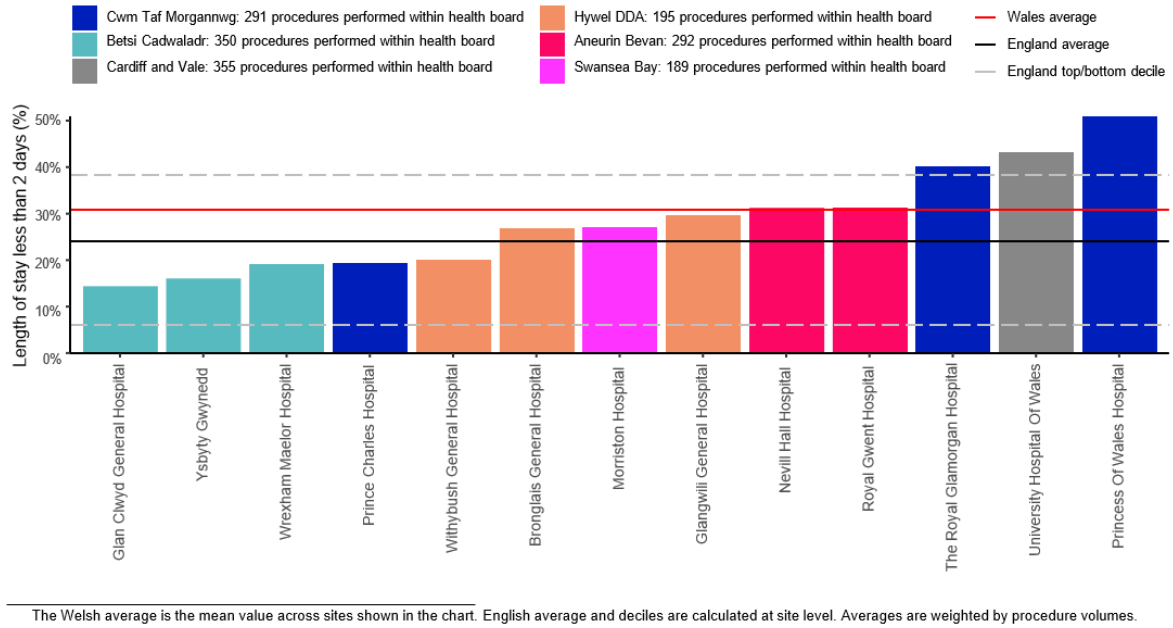

The Welsh average is the mean value across sites shown in the chart. English average and deciles are calculated at site level. Averages are weighted by procedure volumes.

There was significant variation in rates of minimally invasive surgery between health boards (see Figure 1). Although a laparoscopic approach to appendicectomy should be considered the

standard in modern surgical practice, we heard in one Health Board that some surgeons "like to perform open appendicectomy for training purposes especially in men". It is possible that some of this variation is attributable to coding and clinical audit will determine if this is the case.

**Recommendation 15: NHS wales should ensure that each Health Board audits their unit and individual consultant rates of laparoscopic surgery for appendicectomy and take correction action if any issues are identified.**

**Figure 2 - Length of stay less than 2 day rate for emergency appendicectomy.**




The Welsh average is the mean value across sites shown in the chart. English average and deciles are calculated at site level. Averages are weighted by procedure volumes.

The ability to discharge patients having appendicectomy within 48 hours is a good marker of both the diagnostic ability and emergency theatre capacity of a surgical unit. Figure 2 delineates the variation in the proportion of patients discharged in under 48 hours after an appendicectomy. Where diagnostic and theatre capacity is lacking, there is potential for patients to wait too long for emergency appendicectomy (and other procedures) leading to poor outcomes and patient experience.

**Recommendation 16: NHS Wales should ensure that each Health Board conducts a demand and capacity assessment for emergency general surgery to ensure that there is sufficient capacity to treat patients in reasonable timeframe.**

In modern EGS, it is recognised that approximately 30% of the surgical "take" can be managed on an ambulatory basis providing there is a suitable facility, good consultant oversight and prompt access to diagnostics. During our visits we found that only a small number of EGS units had access to a dedicated Surgical Same Day Emergency Care (SDEC) unit.

**Recommendation 17: NHS Wales should ensure that each Health Board has established a Surgical Same Day Emergency Care (SDEC) Unit on each site providing Emergency General Surgery.**

## 12. Colorectal Surgery

Elective colorectal cancer resections are provided within all Health Boards (with the exception of Powys). There is unwarranted variation in both the median length of stay and readmission rates after colorectal cancer surgery between the Health Boards in Wales (see Figures 3 to 8).

**Figure 3 - Number of elective resection for colon cancer procedures**

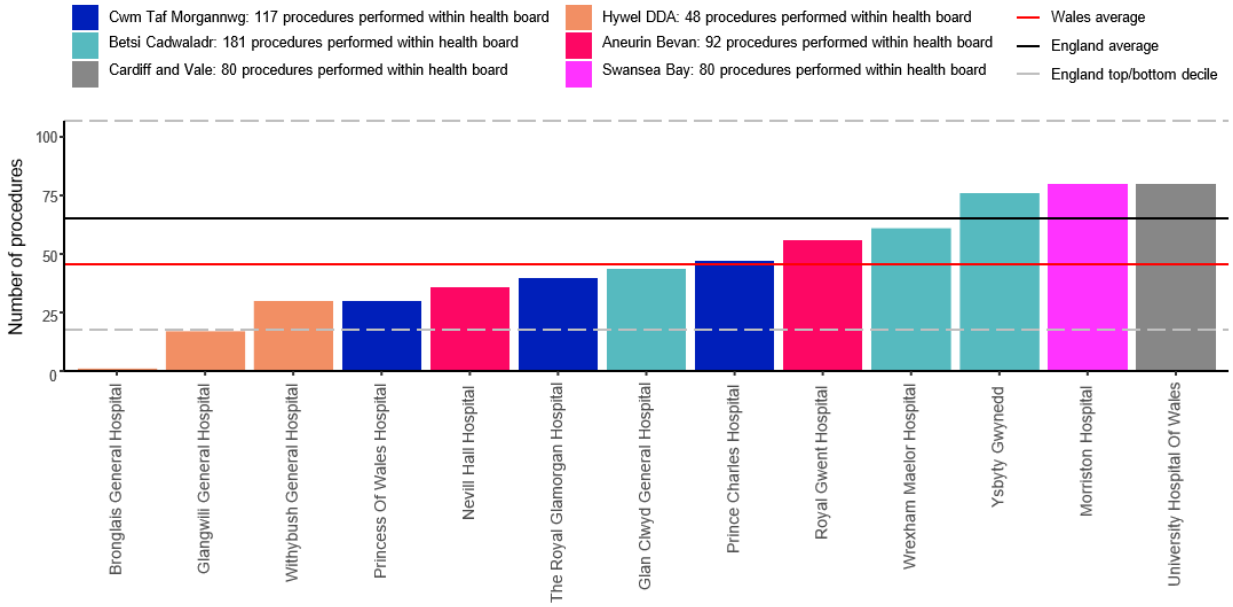
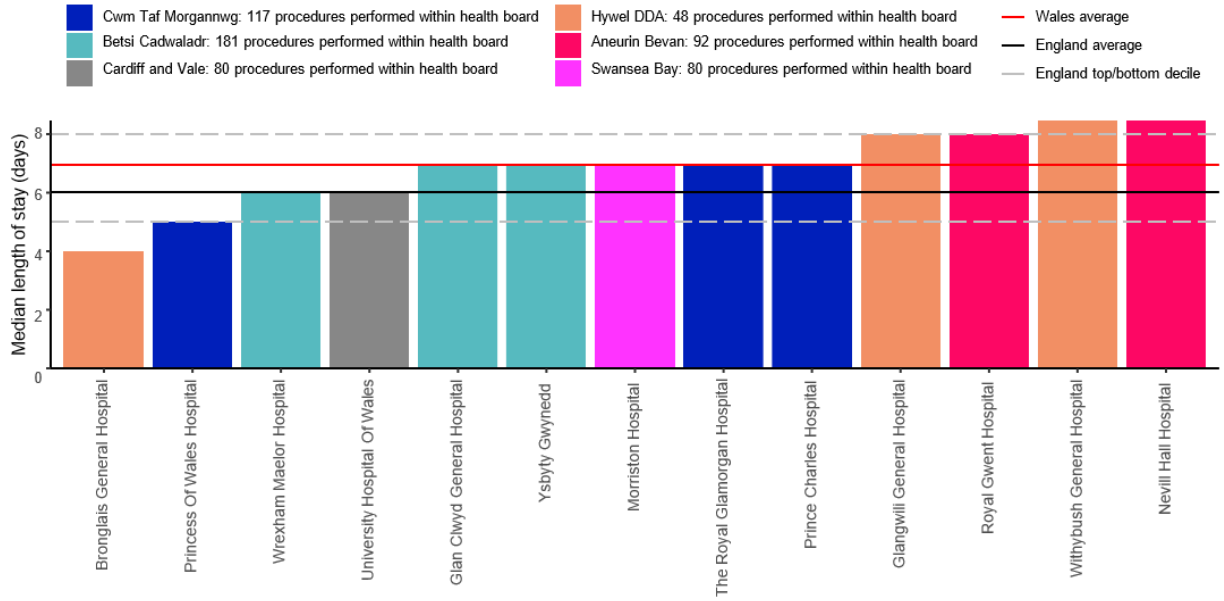
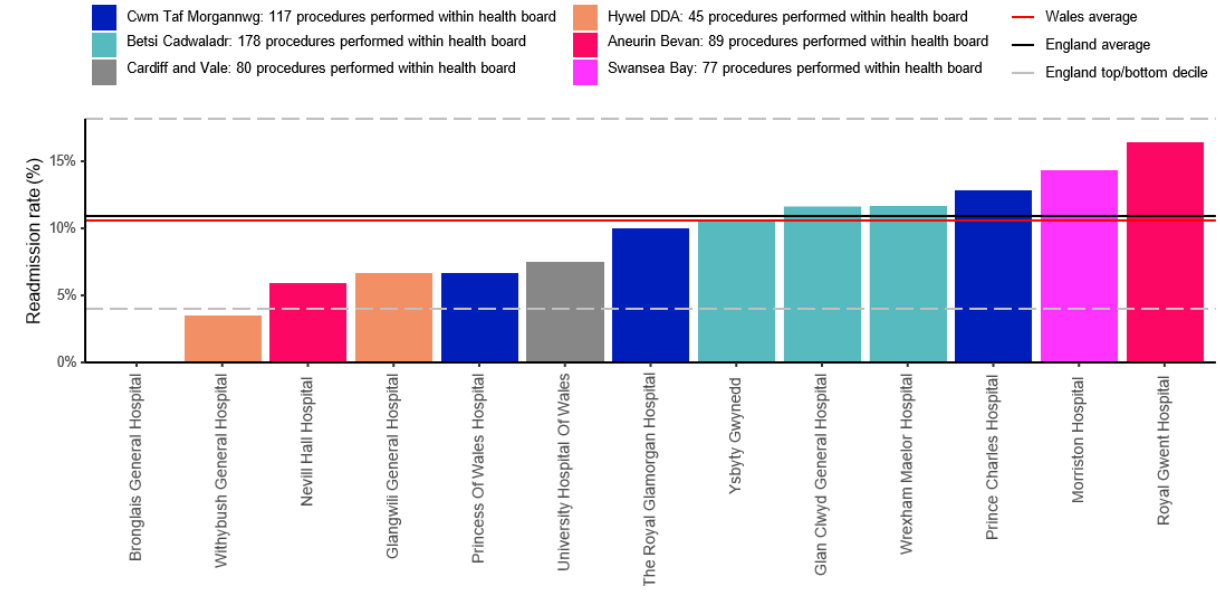



**Figure 4 - Median length of stay for elective resection for colon cancer**



## Figure 5 - Emergency readmission within 30 days following elective resection for colon cancer




## Figure 6 - Number of elective resection for rectal cancer procedures

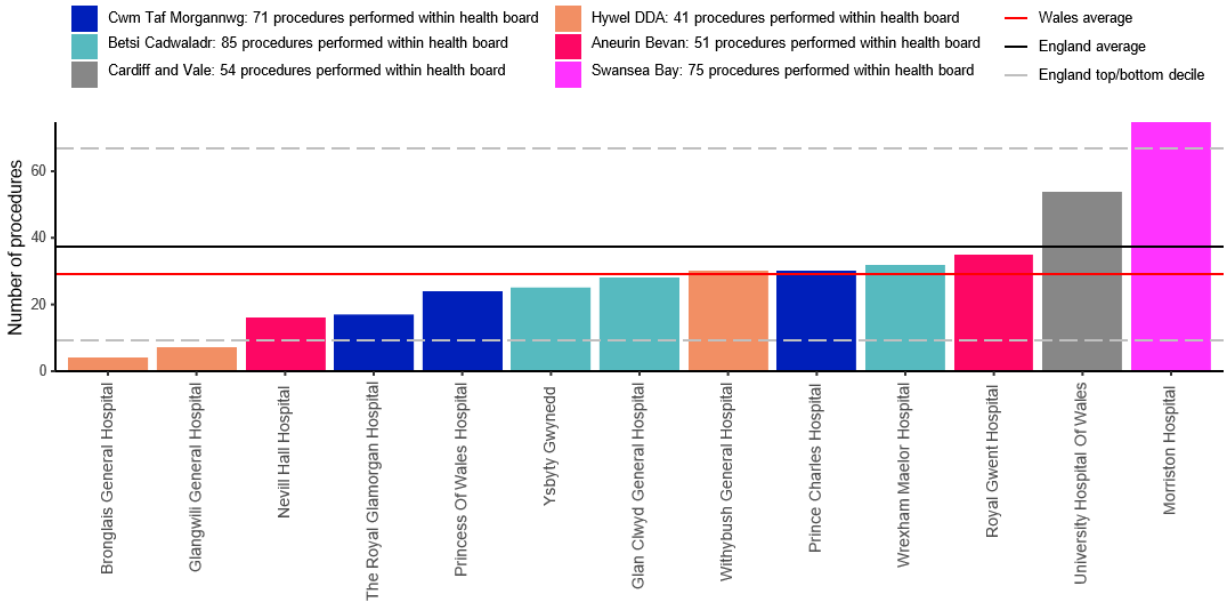


**Figure 7 - Median length of stay for elective resection for rectal cancer**

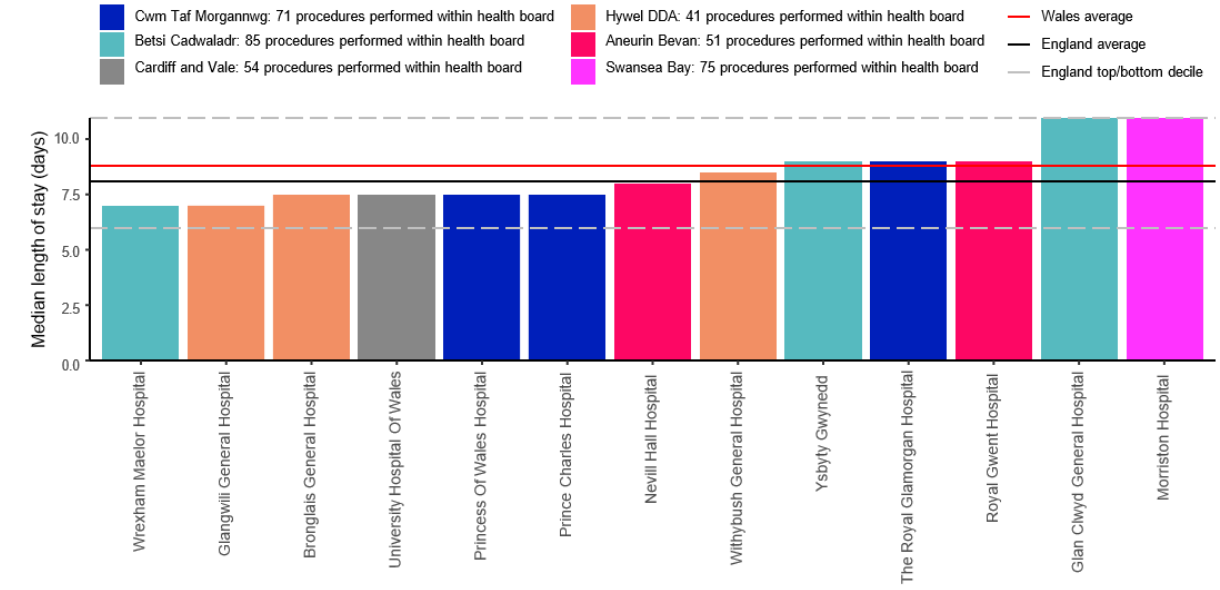
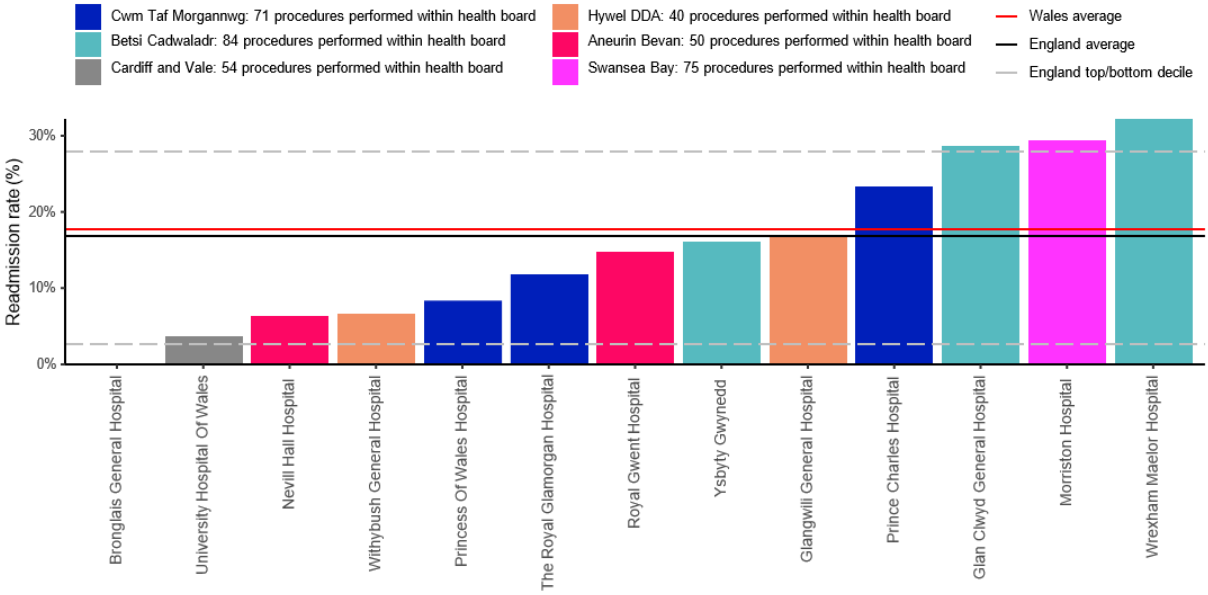



**Figure 8 - Emergency readmission within 30 days following elective resection for rectal cancer**




**Recommendation 18: NHS Wales should support the recommendation that Health Boards review the post-operative care and reasons for readmission within 30 days of patients having elective colorectal cancer surgery.**

Some sites, and presumably some individual consultant surgeons, are recorded as performing low volumes of elective rectal cancer surgery. The All Wales Robotic Surgery Programme has resulted in the purchase of a surgical robot for each Health Board. In order to train and maintain skills in robotic surgery, it will be necessary to consolidate major rectal cancer in the hands of fewer, nominated rectal cancer surgeons in each Health Board.

**Recommendation 19: NHS Wales and each Health Board should ensure that all surgeons and sites conducting major excisions for rectal cancer have an adequate annual case volume at a minimum in excess of that recommended by NICE (minimum of 5 resections per surgeon and 10 resections per site).**

### 15.1 Inflammatory Bowel Disease Surgery

With a few exceptions, elective surgery for Inflammatory Bowel Disease was conducted by all consultant colorectal surgeons within each Health Board. This model of care risks diluting the skills and experience needed to manage this complex group of patients. There is also a risk that these patients, who often need time critical planned surgery, are not prioritised and therefore wait too long for treatment.

**Recommendation 20: NHS Wales should support and encourage the recommendation we have made to Health Boards to ensure that there are nominated colorectal surgeons with a special interest in inflammatory bowel disease surgery. Each Health Board should establish a multi-disciplinary team to manage patients with IBD. The IBD MDT should meet on a regular basis to discuss the care of individual patients. All core members of the IBD MDT should have funded time allocated within their working week to attend this meeting.**

### 15.2 Pelvic Floor Surgery

In most of the Health Boards we visited there was very little local provision for pelvic floor surgery and there were no clear tertiary referral pathways. Where there was local treatment available this was often limited to surgery for full thickness rectal prolapse. This means that there was unequal access for patients with severe constipation, faecal incontinence and obstructive defaecation across Wales.

**Recommendation 21: The All Wales General Surgery Reference Group should develop a set of service standards for the diagnosis and treatment of patients with pelvic floor disorders across Wales in conjunction with the Pelvic Floor Society. These standards should specify the diagnostics and treatments to be available both within each Health Board and within tertiary referral centres. NHS Wales and the Health Boards should work together to implement these standards.**

## 13. Upper GI surgery

### 16.1 Hepato-Pancreato-Biliary Surgery

Currently tertiary hepato-pancreato-biliary surgery within Wales is provided at Swansea and Cardiff. Liver surgery is mainly provided in Cardiff and pancreatic surgery is largely provided at the Morriston Hospital in Swansea. This is an unusual arrangement, as the tertiary HPB unit will provide the full range of services on one site. The reasons for this split service are not clear; however, this arrangement means that HPB surgery in South Wales has not developed as much as other units outside of Wales.

Patients from North Wales needing tertiary HPB surgery are treated in Liverpool.

**Recommendation 22: NHS Wales should co-ordinate and accelerate plans to reunite tertiary HPB services on one site, taking into consideration interdependencies with other services such as critical care, interventional radiology and the trauma network.**

### 16.2 Oesophagogastric cancer

There are two currently units providing resections for oesophagogastric cancer in Cardiff (serving South and West Wales) and Wrexham (serving North Wales). This model of care is appropriate and seems to be working well. There are no national recommendations for this service although some local recommendations have been made to both CVUHB and BCUHB (see Health Board level reports for details).

### 16.3 Complex benign UGI surgery

Complex benign upper GI surgery incorporates a group of procedures including surgery for gastro-oesophageal reflux, hiatal hernia surgery, achalasia, access for enteral feeding and complex biliary disease. These procedures are comparatively low volume and can be technically challenging. Results of this type of surgery require a reasonable annual caseload at both unit and individual surgeon level. There is an important inter-relationship with other services such as GI physiology, endoscopy and interventional radiology.

**Recommendation 23: The all Wales General Surgery Reference Group should specify which complex upper benign GI procedures should be available at each Health Board and specify the pathways for referral to a tertiary service.**

## 14. Bariatric Surgery

The volume of bariatric surgery delivered in Wales is extremely low. In 2019 to 2020, according to figures we were able to extract from PEDW, only 38 bariatric procedure were performed at the Morriston Hospital, which is the only NHS Hospital in Wales performing bariatric surgery. The clinical team believe that this has underrepresented the activity and that approximately 100 bariatric procedures were performed in that year. Some patients from North Wales currently have NHS Wales funded bariatric surgery in Salford. For context, in the same timeframe, a total of 6410 bariatric procedures were performed in England (5741 primary procedures and 669 revision procedures - source National Obesity Audit). This means that the population rates of bariatric surgery are more than 3 times higher in England than in Wales. Expanding the provision of bariatric surgery within the context of a tiered weight management programme will significantly improve health outcomes in individuals with morbid obesity while at the same time will improve the recruitment and retention of surgical teams in Wales.

**Recommendation 24: NHS Wales should increase the provision of bariatric surgery in Wales to ensure that there is equitable access to effective treatments for obesity in accordance with NICE guidance: Obesity, identification, assessment and management. This should be considered in the context of a wider review of a tiered weight management service across Wales. Consideration should be given to establishing a bariatric surgical unit in North Wales to repatriate activity currently sent to England.**

## 15. Elective Recovery

The HVLC procedures form the bulk of the general surgery waiting list and include laparoscopic cholecystectomy, inguinal hernia surgery and paraumbilical hernia surgery.

Currently there are large volumes of patients in Wales waiting for routine consultant outpatient appointments, diagnostics and surgical treatment (see Table 3 below).

| **Waiting List** | **Stage 1** (Outpatients) | **Stage 2** Diagnostics | **Stage 3** (Follow up) | **Stage 4** (Treatment) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| >26 W | 24,666 | 3,223 | 7,002 | 8,613 |
| 26 – 36 | 5,462 | 968 | 2,479 | 1,904 |
| 36 – 52 | 5,554 | 1,103 | 3,314 | 2,624 |
| 52 – 104 | 5,144 | 1,996 | 4,683 | 6,182 |
| 104 + | 468 | 431 | 806 | 3,939 |
| | **41,294** | **7,721** | **18,284** | **23,262** |

***(Data as of 13th March 2023. This information has been taken from weekly PTL submissions)***

Many of the recommendations in this report, if implemented, will support improved and more efficient General Surgery services across Wales which will support the reduction of waiting lists.

**Recommendation 25: NHS Wales should support and encourage the recommendation we have made to Health Boards to carry out a full demand and capacity assessment.**

**Recommendation 26: NHS Wales should support and encourage the recommendation we have made to Health Boards to standardise HVLC Pathways in elective inguinal hernia, paraumbilical and gallbladder surgery.**

**Recommendation 27: NHS Wales should support and encourage the recommendation we have made to Health Boards to standardise procedure-level clinical pathways (HVLC) by adopting or adapting the GIRFT General Surgery pathways as required. These pathways were developed by 'expert advisory panels' supported by professional societies:** General Surgery - Getting It Right First Time - GIRFT.

## 16. Consent and shared decision-making

In many of the Health Boards we visited, we heard that patients were signing a consent form for the first time on the day of surgery. This means that the consent may not be valid and also that individual clinicians and Heath Boards are exposed to unnecessary medico legal risk. In modern elective surgical practice, patients should be involved in shared-decision making to discuss the benefits, alternatives and risks of surgical treatment including the option of doing nothing. It is recognised that 14% of patients having elective surgery later experience decision regret and true shared decision-making is a key factor in reducing this rate. When a patient has opted for elective surgical treatment and is placed on a waiting list, they should be given written information and should sign the consent form at this point. The consent form should be reviewed on the day of surgery and countersigned by a clinician to ensure that the consent is still valid.

**Recommendation 28: NHS Wales should support and encourage the recommendation we have made to Health Boards to review the current processes for obtaining and documenting patients' consent for surgery and, where this deviates from recommendations by the GMC and the Royal College of Surgeons, take appropriate corrective action. In the medium term, NHS Wales should consider moving towards a digital model for providing patient information and recording consent. Please refer to the following links:** RCS Consent Supported Decision Making.pdf Decision making and consent (gmc-uk.org).

## 17. Clinical governance and Litigation

During our visits to the Health Boards we saw evidence of significant variation in the frequency and content of clinical governance meetings. These meetings are key for a department to understand its results and to drive improvements and standardisation of practice. In addition to

discussion of complications and deaths, cases of litigation should be discussed at these meetings in order that learning from these events is shared across the department.

**Recommendation 29: NHS Wales should support and encourage the recommendation we have made to Health Boards to ensure that there is a regular (at least monthly) morbidity and mortality meeting within the general surgery department. The structure and tone of these meeting should follow guidance from the Royal College of Surgeons**: (Good Surgical Practice - Morbidity and Mortality Meetings, 2014).

**Recommendation 30: NHS Wales should support and encourage the recommendation we have made to Health Boards to ensure that all cases of litigation are discussed in a minuted departmental meeting in order that lessons can be learnt and disseminated.**

## 18. Theatre productivity

In order to support recovery of elective services and make best use of elective facilities, it will be necessary to improve theatre productivity across all Health Boards in Wales. In our deep dive visit we heard from clinicians that they were regularly starting lists late and often finishing elective sessions early. There was a consensus that productivity could be improved in most Health Boards and a willingness from surgeons to work with others to make this happen. In order to improve theatre productivity, Health Boards will need to improve preoperative assessment, booking and scheduling and ensure that there is sufficient perioperative bed or trolley capacity for elective surgery,

**Recommendation 31: NHS Wales should support and encourage the recommendation we have made to Health Boards to conduct a review of the preoperative assessment system service and take action to implement the Guidance from CPOC of Preoperative assessment and optimisation (**Guidance for Preoperative Assessment and Optimisation for Adult Surgery Published | Centre for Perioperative Care (cpoc.org.uk)**) including the following:**

a. **Ensure that patients are booked in chronological order within bands of clinical urgency**
b. **Develop a digital solution to visualize the result of preoperative assessments**
c. **Use the time while patients are on the waiting list to optimise them for surgery by addressing modifiable risk factors for surgery including smoking, hypertension, glycaemic control, obesity, diet and lack of exercise**
d. **Only list patients for routine surgery when they are fit and optimised**
e. **Consider implementing the role of Perioperative Coordinator to facilitate these.**

**Recommendation 32: NHS Wales should launch a National Theatre Productivity programme focussed on improving booking and scheduling and "on the day of surgery" processes. This programme should define and agree start and finish times of elective theatre sessions and should aim to improve capped theatre utilisation to 85% across elective theatres sessions.**

**Recommendation 33: NHS Wales should support and encourage the recommendation we have made to Health Boards to develop local programmes to improve theatre capacity by introducing 6 day working and extended days in theatres.**

## 19. Procurement

Modern general surgery relies on the use of a number of expensive, often disposable, medical devices in particular hernia mesh, laparoscopic ports and instruments, energy devices and surgical staplers. During our site visits we were told that at one Health Board a Consultant Surgeon could request any laparoscopic equipment they wished and that there were no controls on the introduction of new devices into the organisation. Conversely, at Hywel Dda University Health Board, we were told of a clinically-led programme to rationalise the stock lines of disposable equipment and implanted devices within general surgery. Such a programme allows standardisation of equipment which improves safety, reduces inventory costs and facilitates training and education.

**Recommendation 34: NHS Wales should launch a national programme to ensure that each Health Board carries out a clinically-led programme to rationalise the stock lines of disposable equipment and implanted devices within general surgery. Following this, each Health Board should develop local mechanism to ensure that there is oversight and control of the financial, safety and training implications of any new medical devices used in theatres.**

**Annex A -Table of hospitals by Health Board**

| Provider | Site Code | Site Name |
|---|---|---|
| **Betsi Cadwaladr University Local Health Board** | 7A1A1 | Glan Clwyd General Hospital |
| | 7A1A2 | Abergele Hospital |
| | 7A1A4 | Wrexham Maelor Hospital |
| | 7A1A7 | Chirk Community Hospital |
| | 7A1A8 | Colwyn Bay Community Hospital |
| | 7A1A9 | Denbigh Community Hospital |
| | 7A1AB | Holywell Community Hospital |
| | 7A1AD | Mold Community Hospital |
| | 7A1AF | Ruthin Community Hospital |
| | 7A1AU | Ysbyty Gwynedd |
| | 7A1AV | Llandudno General Hospital |
| | 7A1AY | Dolgellau & Barmouth District Hospital Site |
| | 7A1CA | Ysbyty Alltwen |
| | 7A1CC | Deeside Community Hospital |
| | 7A1DD | Cefni Hospital |
| | 7A1FT | Ysbyty Gwynedd (Psychiatric) |
| | 7A1GE | Bryn-Y-Neuadd Hospital |
| | 7A1NV | Child & Adolescents Mental Health Service |
| | 7A1Q8 | Llangollen Health Centre |
| | 7A1B2 | Tywyn & District War Memorial Hospital |
| **Hywel DDA University Local Health Board** | 7A2AG | Glangwili General Hospital |
| | 7A2AJ | Bronglais General Hospital |
| | 7A2AK | Cardigan & District Memorial Hospital |
| | 7A2AL | Prince Philip Hospital |
| | 7A2BL | Withybush General Hospital |

| | | |
|---|---|---|
| | 7A2L7 | Cardigan Integrated Care Centre |
| | 7A2PD | Bro Preseli Community Centre |
| **Swansea Bay University Local Health Board** | 7A3B7 | Princess Of Wales Hospital |
| | 7A3C4 | Singleton Hospital |
| | 7A3C7 | Morriston Hospital |
| | 7A3CJ | Neath Port Talbot Hospital |
| | 7A3P6 | Port Talbot Resource Centre |
| | 7A3B9 | Maesteg General Hospital |
| | 7A3MH | Tyn Y Coed Surgery |
| **Cardiff and Vale University Local Health Board** | 7A4BV | University Hospital Of Wales |
| | 7A4BW | Cardiff Royal Infirmary |
| | 7A4C1 | University Hospital Llandough |
| | 7A4CH | The Barry Hospital |
| **Cwm Taf Morgannwg University Local Health Board** | 7A5B1 | The Royal Glamorgan Hospital |
| | 7A5B3 | Prince Charles Hospital |
| | 7A5CA | Ysbyty Cwm Rhondda |
| | 7A5DK | Dewi Sant Hospital |
| | 7A5HA | Ysbyty Cwm Cynon |
| **Aneurin Bevan University Local Health Board** | 7A621 | Serennu Childrens Centre |
| | 7A6AM | Nevill Hall Hospital |
| | 7A6AR | Royal Gwent Hospital |
| | 7A6AS | County Hospital |
| | 7A6AT | St Woolos Community |
| | 7A6AU | Ysbyty Aneurin Bevan |
| | 7A6AV | Ysbyty Ystrad Fawr |
| | 7A6BJ | Chepstow Community Hospital |
| | 7A6M5 | Risca Health Centre |
| | 7A6ML | St Woolos Other |

| | | |
|---|---|---|
| | 7A6NE | Gwent activity not at a Hospital site |
| **Powys Teaching Local Health Board** | 7A7BT | Breconshire War Memorial Hospital |
| | 7A7BN | Llandrindod Wells Hospital |
| | 7A7BP | Llanidloes & District War Memorial Hospital |
| | 7A7BQ | Broddyfi Community Hospital |
| | 7A7BR | Montgomeryshire County Infirmary |
| | 7A7BS | Victoria Memorial Hospital |
| | 7A7BT | Breconshire War Memorial Hospital |
| | 7A7EG | Knighton Hospital |
| | 7A7EJ | Ystradgynlais Community Hospital |

**Annex B - List of useful recourses**

1. NHS England - Model Hospital
2. Clinically-led General Surgery Outpatient Guidance
3. Best Practice Pathways - Getting It Right First Time - FutureNHS Collaboration Platform
4. Inguinal Hernia Pathway
5. Laparoscopic Cholecystectomy Pathway
6. Para-umbilical Hernia Pathway
7. Thyroid Lobectomy Generic Adult Pathway
8. Improving the Perioperative Pathway for Patients with Diabetes - Getting It Right First Time - GIRFT
9. GIRFT, RCS and ASGBI Best Practice for Laparoscopic Appendicectomy
10. GIRFT and RCS Best practice for Laparoscopic Cholecystectomy Documentation
11. GIRFT, RCS and ASGBI Best practice for Open and Laparoscopic Inguinal Hernia Repair Documentation
12. GIRFT, RCS and ASGBI Best practice for Laparotomy & Laparoscopic Bowel Resection Surgery Documentation
13. GIRFT, RCS and BAETS Best practice for Thyroidectomy Documentation
14. RCS_Consent Supported Decision Making.pdf
15. Decision making and consent (gmc-uk.org).
16. Good Surgical Practice - Morbidity and Mortality Meetings, 2014
17. NICE guidance: Obesity, identification, assessment and management

EGS Activity Data Review

## Contents



## Background

As per the approved Clinical Services Plan methodology, high level activity between 1st August 2018 and 31st July 2023 has been included for Emergency General Surgery (EGS) Services at Bronglais Hospital, Withybush Hospital and Glangwili Hospital. Procedures that are performed under EGS for this review are as follows:

| |
|---|
| FZ12L - Major General Abdominal Procedures, 19 years and over, with CC Score 10+ |
| FZ12M - Major General Abdominal Procedures, 19 years and over, with CC Score 6-9 |
| FZ12N - Major General Abdominal Procedures, 19 years and over, with CC Score 3-5 |
| FZ12P - Major General Abdominal Procedures, 19 years and over, with CC Score 1-2 |
| FZ12Q - Major General Abdominal Procedures, 19 years and over, with CC Score 0 |
| FZ12S - Major General Abdominal Procedures, between 2 and 18 years, with CC Score 0 |
| FZ13C - Minor Therapeutic or Diagnostic, General Abdominal Procedures, 19 years and over |
| FZ13D - Minor Therapeutic or Diagnostic, General Abdominal Procedures, 18 years and under |
| FZ17E - Abdominal Hernia Procedures, 19 years and over, with CC Score 4+ |
| FZ17F - Abdominal Hernia Procedures, 19 years and over, with CC Score 1-3 |
| FZ17G - Abdominal Hernia Procedures, 19 years and over, with CC Score 0 |
| FZ18G - Inguinal, Umbilical or Femoral Hernia Procedures, 19 years and over, with CC Score 6+ |
| FZ18H - Inguinal, Umbilical or Femoral Hernia Procedures, 19 years and over, with CC Score 3-5 |
| FZ18J - Inguinal, Umbilical or Femoral Hernia Procedures, 19 years and over, with CC Score 1-2 |
| FZ18K - Inguinal, Umbilical or Femoral Hernia Procedures, 19 years and over, with CC Score 0 |
| FZ20F - Appendicectomy Procedures, 19 years and over, with CC Score 5+ |
| FZ20G - Appendicectomy Procedures, 19 years and over, with CC Score 3-4 |
| FZ20H - Appendicectomy Procedures, 19 years and over, with CC Score 1-2 |

| |
|---|
| FZ20J - Appendicectomy Procedures, 19 years and over, with CC Score 0 |
| FZ20L - Appendicectomy Procedures, 18 years and under, with CC Score 1-2 |
| FZ20M - Appendicectomy Procedures, 18 years and under, with CC Score 0 |
| FZ21C - Major Anal Procedures, 19 years and over, with CC Score 1+ |
| FZ21D - Major Anal Procedures, 19 years and over, with CC Score 0 |
| FZ22B - Intermediate Anal Procedures, 18 years and under |
| FZ22C - Intermediate Anal Procedures, 19 years and over, with CC Score 3+ |
| FZ22D - Intermediate Anal Procedures, 19 years and over, with CC Score 1-2 |
| FZ22E - Intermediate Anal Procedures, 19 years and over, with CC Score 0 |
| FZ23A - Minor Anal Procedures, 19 years and over |
| FZ24E - Major Therapeutic Endoscopic, Upper or Lower Gastrointestinal Tract Procedures, between 2 and 18 years |
| FZ27D - Intermediate Therapeutic General Abdominal Procedures, 18 years and under |
| FZ27E - Intermediate Therapeutic General Abdominal Procedures, 19 years and over, with CC Score 3+ |
| FZ27F - Intermediate Therapeutic General Abdominal Procedures, 19 years and over, with CC Score 1-2 |
| FZ27G - Intermediate Therapeutic General Abdominal Procedures, 19 years and over, with CC Score 0 |
| FZ36J - Gastrointestinal Infections with Single Intervention, with CC Score 5+ |
| FZ36K - Gastrointestinal Infections with Single Intervention, with CC Score 2-4 |
| FZ36M - Gastrointestinal Infections without Interventions, with CC Score 8+ |
| FZ36N - Gastrointestinal Infections without Interventions, with CC Score 5-7 |
| FZ36P - Gastrointestinal Infections without Interventions, with CC Score 2-4 |
| FZ36Q - Gastrointestinal Infections without Interventions, with CC Score 0-1 |
| FZ37L - Inflammatory Bowel Disease with Multiple Interventions, with CC Score 0-2 |
| FZ37M - Inflammatory Bowel Disease with Single Intervention, with CC Score 4+ |
| FZ37P - Inflammatory Bowel Disease without Interventions, with CC Score 5+ |
| FZ37Q - Inflammatory Bowel Disease without Interventions, with CC Score 3-4 |
| FZ37R - Inflammatory Bowel Disease without Interventions, with CC Score 1-2 |
| FZ37S - Inflammatory Bowel Disease without Interventions, with CC Score 0 |
| FZ38H - Gastrointestinal Bleed with Multiple Interventions, with CC Score 0-4 |
| FZ38K - Gastrointestinal Bleed with Single Intervention, with CC Score 5-7 |
| FZ38L - Gastrointestinal Bleed with Single Intervention, with CC Score 0-4 |
| FZ38M - Gastrointestinal Bleed without Interventions, with CC Score 9+ |
| FZ38N - Gastrointestinal Bleed without Interventions, with CC Score 5-8 |
| FZ38P - Gastrointestinal Bleed without Interventions, with CC Score 0-4 |
| FZ50Z - Intermediate Large Intestine Procedures, 19 years and over |
| FZ52Z - Diagnostic Colonoscopy with Biopsy, 19 years and over |
| FZ54Z - Diagnostic Flexible Sigmoidoscopy, 19 years and over |
| FZ60Z - Diagnostic Endoscopic Upper Gastrointestinal Tract Procedures, 19 years and over |

| |
|---|
| FZ61Z - Diagnostic Endoscopic Upper Gastrointestinal Tract Procedures with Biopsy, 19 years and over |
| FZ66C - Very Major Small Intestine Procedures, 19 years and over, with CC Score 8+ |
| FZ66D - Very Major Small Intestine Procedures, 19 years and over, with CC Score 5-7 |
| FZ66E - Very Major Small Intestine Procedures, 19 years and over, with CC Score 2-4 |
| FZ66F - Very Major Small Intestine Procedures, 19 years and over, with CC Score 0-1 |
| FZ67D - Major Small Intestine Procedures, 19 years and over, with CC Score 4-6 |
| FZ67E - Major Small Intestine Procedures, 19 years and over, with CC Score 2-3 |
| FZ67F - Major Small Intestine Procedures, 19 years and over, with CC Score 0-1 |
| FZ69C - Complex Small Intestine Procedures, 19 years and over, with CC Score 7+ |
| FZ69D - Complex Small Intestine Procedures, 19 years and over, with CC Score 3-6 |
| FZ69E - Complex Small Intestine Procedures, 19 years and over, with CC Score 0-2 |
| FZ70Z - Therapeutic Endoscopic Upper Gastrointestinal Tract Procedures, 19 years and over |
| FZ71D - Endoscopic Insertion of Luminal Stent into Gastrointestinal Tract with CC Score 7+ |
| FZ71E - Endoscopic Insertion of Luminal Stent into Gastrointestinal Tract with CC Score 4-6 |
| FZ71F - Endoscopic Insertion of Luminal Stent into Gastrointestinal Tract with CC Score 1-3 |
| FZ73C - Very Complex Large Intestine Procedures with CC Score 9+ |
| FZ73D - Very Complex Large Intestine Procedures with CC Score 6-8 |
| FZ73E - Very Complex Large Intestine Procedures with CC Score 3-5 |
| FZ71G - Endoscopic Insertion of Luminal Stent into Gastrointestinal Tract with CC Score 0 |
| FZ74D - Complex Large Intestine Procedures, 19 years and over, with CC Score 6-8 |
| FZ74E - Complex Large Intestine Procedures, 19 years and over, with CC Score 3-5 |
| FZ74F - Complex Large Intestine Procedures, 19 years and over, with CC Score 0-2 |
| FZ76C - Distal Colon Procedures, 19 years and over, with CC Score 3+ |
| FZ79D - Complex General Abdominal Procedures with CC Score 3-5 |
| FZ80E - Very Complex, Oesophageal, Stomach or Duodenum Procedures, 19 years and over, with CC Score 0-2 |
| FZ87D - Complex Hernia Procedures with CC Score 5+ |
| FZ87E - Complex Hernia Procedures with CC Score 3-4 |
| FZ90A - Abdominal Pain with Interventions |
| FZ90B - Abdominal Pain without Interventions |
| FZ91A - Non-Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 8+ |
| FZ91B - Non-Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 5-7 |
| FZ91C - Non-Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 3-4 |
| FZ91D - Non-Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 0-2 |
| FZ91E - Non-Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 9+ |
| FZ91F - Non-Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 5-8 |

| |
|---|
| FZ91G - Non-Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 3-4 |
| FZ91H - Non-Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 0-2 |
| FZ91J - Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 11+ |
| FZ91K - Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 6-10 |
| FZ91L - Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 3-5 |
| FZ91M - Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 0-2 |
| FZ92A - Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 7+ |
| FZ92B - Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 3-6 |
| FZ92C - Malignant Gastrointestinal Tract Disorders with Multiple Interventions, with CC Score 0-2 |
| FZ92D - Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 6+ |
| FZ92E - Malignant Gastrointestinal Tract Disorders with Single Intervention, with CC Score 3-5 |
| FZ92G - Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 9+ |
| FZ92H - Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 5-8 |
| FZ92J - Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 3-4 |
| FZ92K - Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 0-2 |
| GA03C - Very Complex Open, Hepatobiliary or Pancreatic Procedures, with CC Score 4+ |
| GA03D - Very Complex Open, Hepatobiliary or Pancreatic Procedures, with CC Score 2-3 |
| GA04C - Complex Open, Hepatobiliary or Pancreatic Procedures, with CC Score 3+ |
| GA05C - Very Major Open, Hepatobiliary or Pancreatic Procedures, with CC Score 3+ |
| GA06C - Major Open, Hepatobiliary or Pancreatic Procedures, with CC Score 2+ |
| GA06D - Major Open, Hepatobiliary or Pancreatic Procedures, with CC Score 0-1 |
| GA07C - Intermediate Open, Hepatobiliary or Pancreatic Procedures, with CC Score 3+ |
| GA07E - Intermediate Open, Hepatobiliary or Pancreatic Procedures, with CC Score 0 |
| GA10G - Open or Laparoscopic, Cholecystectomy, 18 years and under |
| GA10H - Laparoscopic Cholecystectomy, 19 years and over, with CC Score 4+ |
| GA10J - Laparoscopic Cholecystectomy, 19 years and over, with CC Score 1-3 |
| GA10K - Laparoscopic Cholecystectomy, 19 years and over, with CC Score 0 |
| GA10L - Open Cholecystectomy, 19 years and over, with CC Score 3+ |
| GA10N - Open Cholecystectomy, 19 years and over, with CC Score 0 |
| GB05F - Major Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 5+ |
| GB06E - Intermediate Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 6+ |
| GB06F - Intermediate Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 4-5 |

| |
|---|
| GB06G - Intermediate Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 2-3 |
| GB06H - Intermediate Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 0-1 |
| GB09D - Complex Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 5+ |
| GB09E - Complex Therapeutic Endoscopic Retrograde Cholangiopancreatography with CC Score 2-4 |
| GB11Z - Diagnostic Endoscopic Retrograde Cholangiopancreatography |
| GB12Z - Endoscopic Ultrasound Examination, of Hepatobiliary or Pancreatic Duct, with Biopsy or Cytology |
| GC12C - Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions |
| GC12D - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 5+ |
| GC12E - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 2-4 |
| GC12F - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 0-1 |
| GC12G - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 6+ |
| GC12H - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 3-5 |
| GC12J - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 1-2 |
| GC12K - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 0 |
| GC17A - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 9+ |
| GC17B - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 4-8 |
| GC17C - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 0-3 |
| GC17D - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 9+ |
| GC17E - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 4-8 |
| GC17F - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 0-3 |
| GC17G - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 8+ |
| GC17H - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 5-7 |
| GC17J - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 2-4 |
| GC12C - Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions |
| GC12D - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 5+ |
| GC12E - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 2-4 |

| |
|---|
| GC12F - Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 0-1 |
| GC12G - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 6+ |
| GC12H - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 3-5 |
| GC12J - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 1-2 |
| GC12K - Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 0 |
| GC17A - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 9+ |
| GC17B - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 4-8 |
| GC17C - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 0-3 |
| GC17D - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 9+ |
| GC17E - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 4-8 |
| GC17F - Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Single Intervention, with CC Score 0-3 |
| GC17G - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 8+ |
| GC17H - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 5-7 |
| GC17J - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 2-4 |
| GC17K - Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 0-1 |
| HE71A - Rib or Chest Fracture, with Interventions |
| HE71B - Rib or Chest Fracture, without Interventions, with CC Score 6+ |
| HE71C - Rib or Chest Fracture, without Interventions, with CC Score 3-5 |
| HE71D - Rib or Chest Fracture, without Interventions, with CC Score 0-2 |
| HE72A - Other Injury, of Rib or Chest, with Interventions |
| HE72B - Other Injury, of Rib or Chest, without Interventions, with CC Score 7+ |
| HE72C - Other Injury, of Rib or Chest, without Interventions, with CC Score 4-6 |
| HE72D - Other Injury, of Rib or Chest, without Interventions, with CC Score 2-3 |
| HE72E - Other Injury, of Rib or Chest, without Interventions, with CC Score 0-1 |
| KA07A - Non-Surgical Thyroid Disorders with CC Score 4+ |
| KA07A - Non-Surgical Thyroid Disorders with CC Score 4+ |
| KA07B - Non-Surgical Thyroid Disorders with CC Score 2-3 |
| KA07C - Non-Surgical Thyroid Disorders with CC Score 0-1 |
| KA08A - Other Endocrine Disorders with CC Score 4+ |
| KA08B - Other Endocrine Disorders with CC Score 2-3 |
| KA08C - Other Endocrine Disorders with CC Score 0-1 |

| |
|---|
| KA09C - Thyroid Procedures with CC Score 4+ |
| KA09E - Thyroid Procedures with CC Score 0-1 |

The information in this document is accurate as of quarter 3, 2023/24

There has been a service change to EGS within the last 5 years. At the Public Board meeting held 30th March 2023, the board approved:

- Out of hours consultant cover should be concentrated at GGH and BGH hospitals whilst recruitment efforts continue to improve the situation at WGH
- During out of hours periods, the consultant teams at GGH/BGH would provide remote support and advice to the SAS tier of surgical doctors at WGH who would continue to provide 24/7 emergency surgical cover for patients at the WGH.

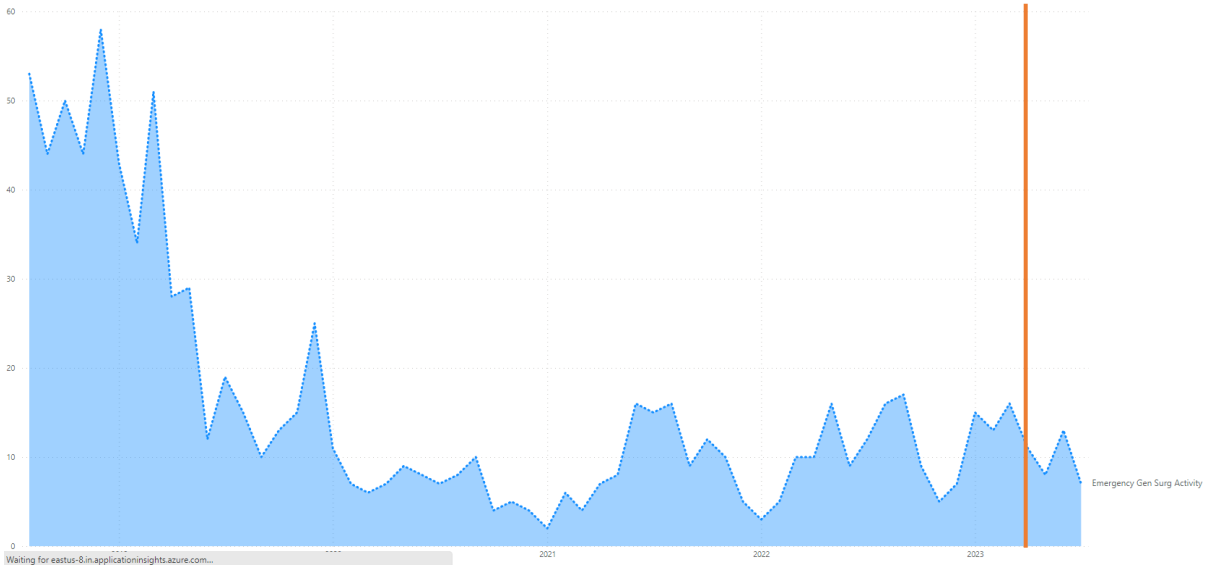
This decision was taken to:

- Ensure the safety of patients admitted via an emergency surgical pathway at WGH, and
- Support the continued sustainability of the 24/7 emergency surgical pathway at the hospital.

This temporary arrangement was put in place in May 2023 and is reflected within the graphs by a solid red line.

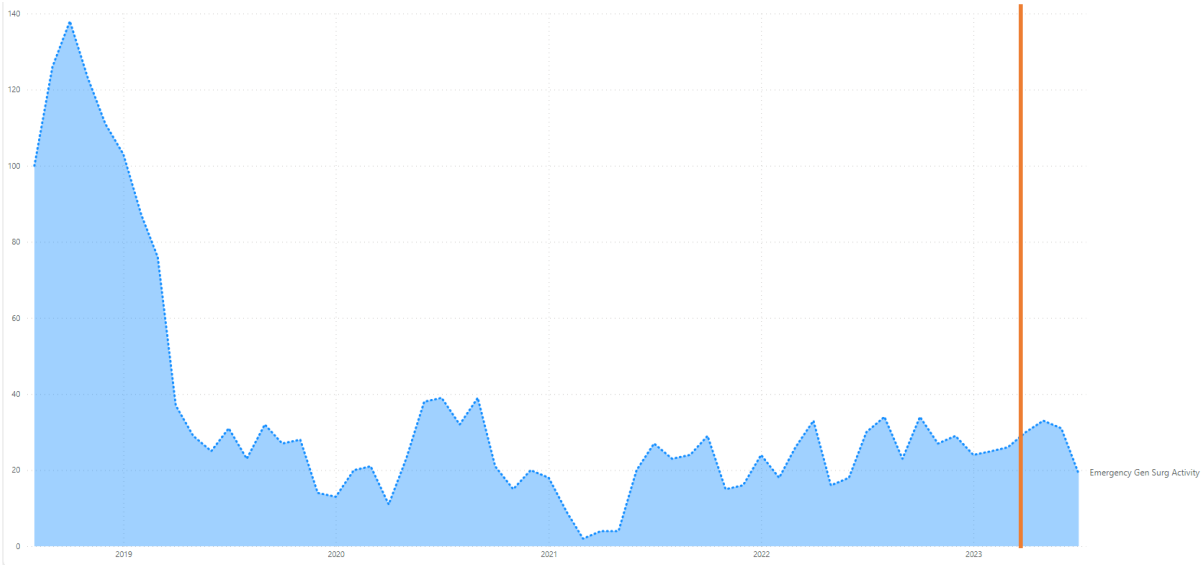
## EGS Activity Charts

### Bronglais Hospital, August 2018 – July 2023



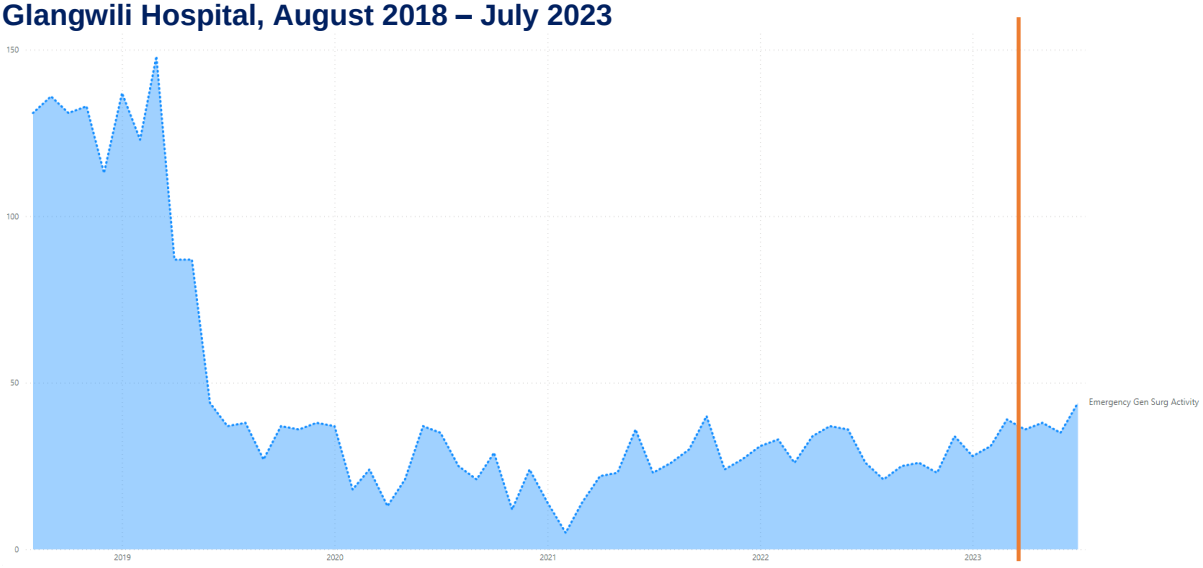

| AdmittingHospitalLocation | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | Total |
|---|---|---|---|---|---|---|---|
| Bronglais General Hospital | 368 | 187 | 72 | 116 | 145 | 39 | **927** |

## Withybush Hospital, August 2018 – July 2023



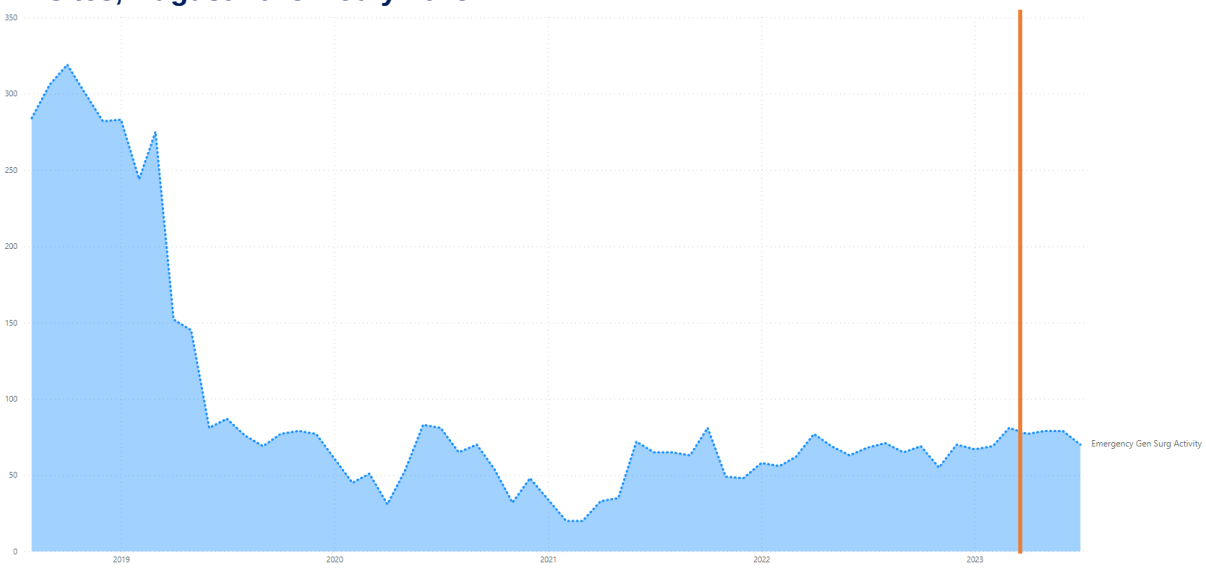

| AdmittingHospitalLocation | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | Total |
|---|---|---|---|---|---|---|---|
| Withybush General Hospital | 847 | 300 | 267 | 230 | 319 | 114 | **2077** |

## Glangwili Hospital, August 2018 – July 2023




| AdmittingHospitalLocation | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | Total |
|---|---|---|---|---|---|---|---|
| Amman Valley Hospital | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| Glangwili General Hospital | 1033 | 510 | 250 | 341 | 359 | 155 | **2648** |
| **Total** | **1034** | **510** | **250** | **341** | **359** | **155** | **2649** |

## All sites, August 2018 – July 2023




| AdmittingHospitalLocation | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 | Total |
|---|---|---|---|---|---|---|---|
| Amman Valley Hospital | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| Bronglais General Hospital | 368 | 187 | 72 | 116 | 145 | 39 | **927** |
| Glangwili General Hospital | 1033 | 510 | 250 | 341 | 359 | 155 | **2648** |
| Tregaron Hospital | 2 | 1 | 2 | 0 | 0 | 0 | **5** |
| Withybush General Hospital | 847 | 300 | 267 | 230 | 319 | 114 | **2077** |
| **Total** | **2251** | **998** | **591** | **687** | **823** | **308** | **5658** |

# EGS Incident Data Review

## Contents

# Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1 August 2018 and 31st July 2023 have been included for Emergency General Surgery Services at Bronglais Hospital, Withybush Hospital and Glangwili Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported incidents attributable to Service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

## Service Changes

There has been a service change to EGS within the last 5 years. At the Public Board meeting held 30th March 2023, the board approved:

- Out of hours consultant cover should be concentrated at GGH and BGH hospitals whilst recruitment efforts continue to improve the situation at WGH
- During out of hours periods, the consultant teams at GGH/BGH would provide remote support and advice to the SAS tier of surgical doctors at WGH who would continue to provide 24/7 emergency surgical cover for patients at the WGH.

This decision was taken to:

- Ensure the safety of patients admitted via an emergency surgical pathway at WGH, and support the continued sustainability of the 24/7 emergency surgical pathway at the hospital

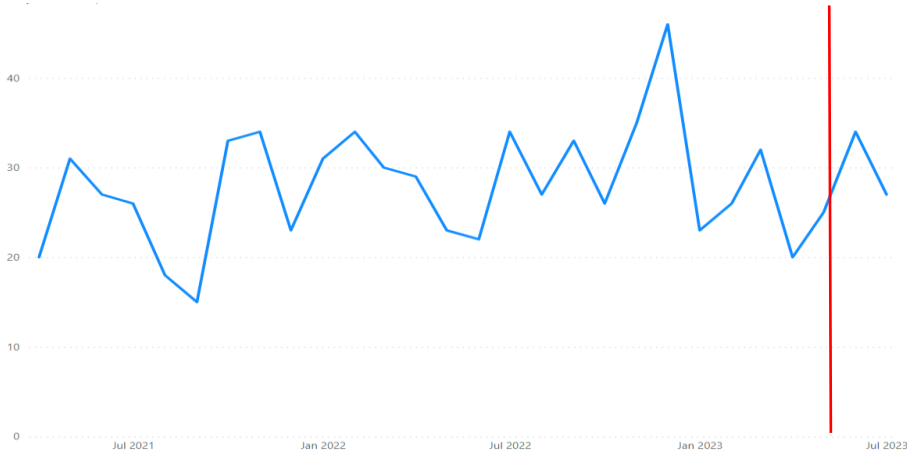
This temporary arrangement was put in place in May 2023 and is reflected within the graphs by a solid red line.

# Incidents

## All Sites (1st August 2018 – 31st March 2021)

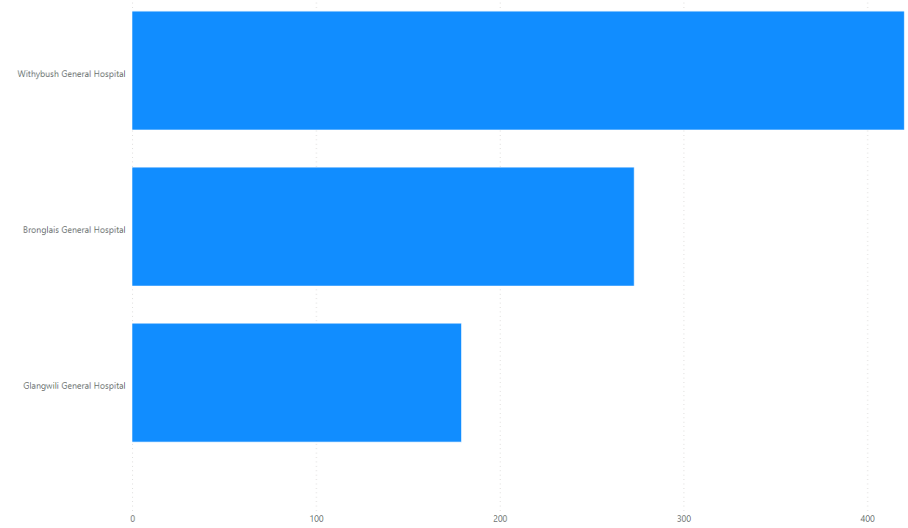

| | | | | | | | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | **2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 26 | 35 | 42 | 25 | 28 | 156 |
| Jan 19 | Feb 19 | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | **2019** |
| 41 | 33 | 38 | 42 | 32 | 34 | 24 | 32 | 33 | 31 | 30 | 28 | 398 |
| Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | Jul 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | **2020** |
| 37 | 42 | 24 | 17 | 13 | 18 | 25 | 15 | 15 | 13 | 14 | 19 | 252 |
| Jan 26 | Feb 26 | Mar 18 | | | | | | | | | | **2021** |
| 12 | 9 | 11 | | | | | | | | | | 32 |
| | | | | | | | | | | | | **498** |

## All Sites (1st April 2021 – 31st July 2023)



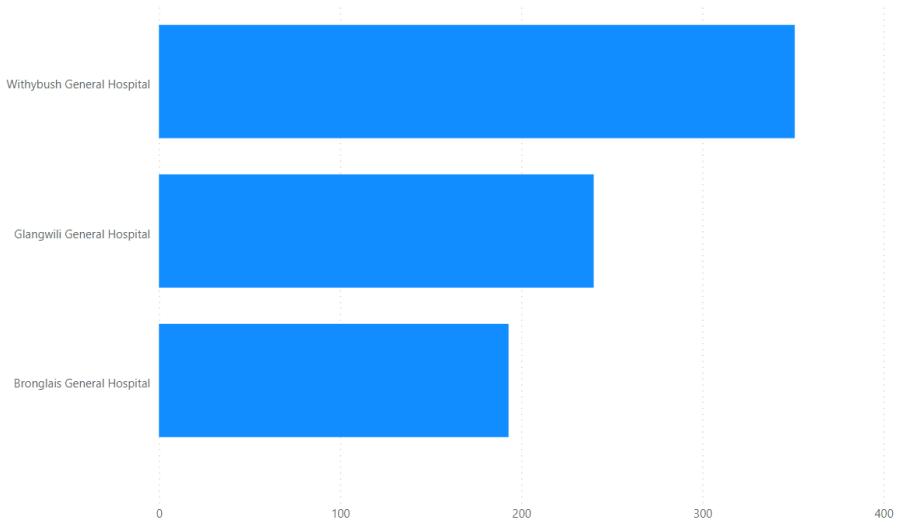

| | | | Apr 21 | May 21 | Jun 21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 | Nov 21 | Dec 21 | **2021** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 20 | 31 | 27 | 26 | 18 | 15 | 33 | 34 | 23 | 227 |
| Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | **2022** |
| 31 | 34 | 30 | 29 | 23 | 22 | 34 | 27 | 33 | 26 | 35 | 46 | 370 |
| Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | | | | | | **2023** |
| 23 | 26 | 32 | 20 | 25 | 34 | 27 | | | | | | 187 |
| | | | | | | | | | | | | **1,282** |

## By Location (1st August 2018 – 31st March 2021)



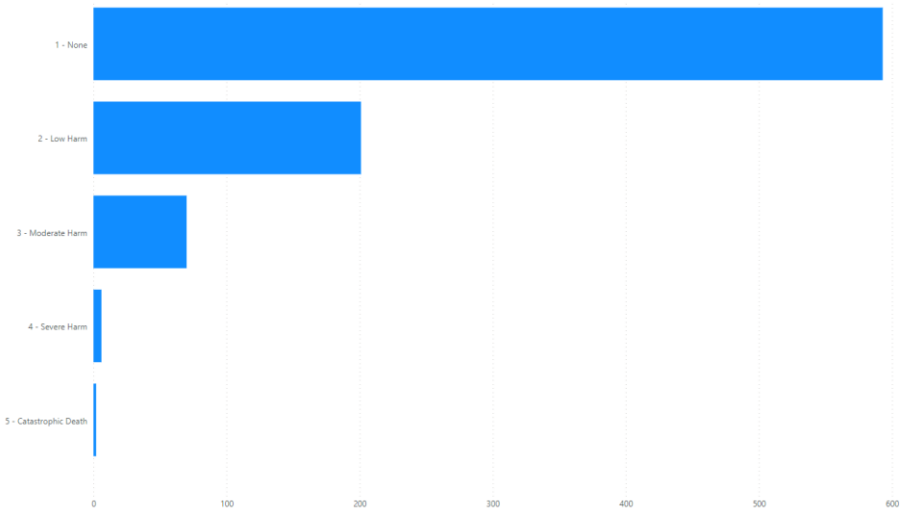

| Primary Location | Count |
|---|---|
| Withybush General Hospital | 420 |
| Bronglais General Hospital | 273 |
| Glangwili General Hospital | 179 |

## By Location (1st April 2021 – 31st July 2023).



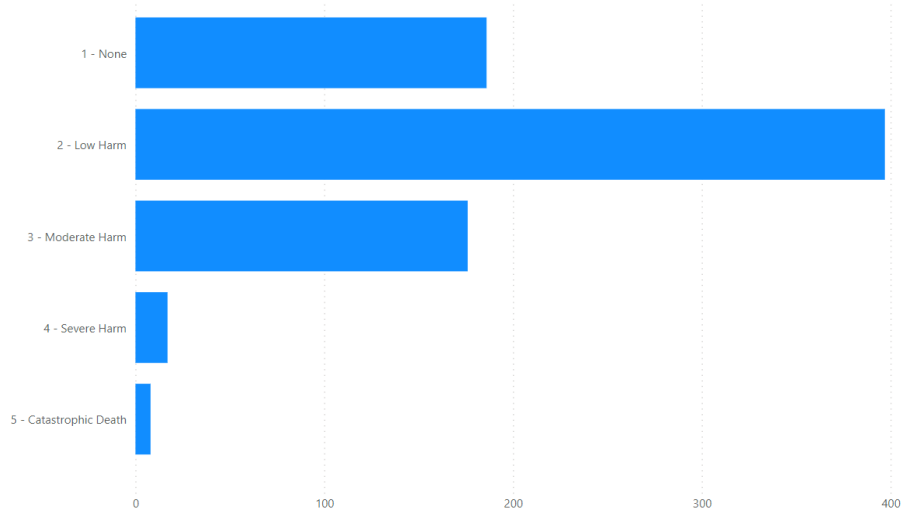

| Primary Location | Count |
|---|---|
| Withybush General Hospital | 351 |
| Glangwili General Hospital | 240 |
| Bronglais General Hospital | 193 |

## By Severity/Level (1st August 2018 – 31st March 2021)



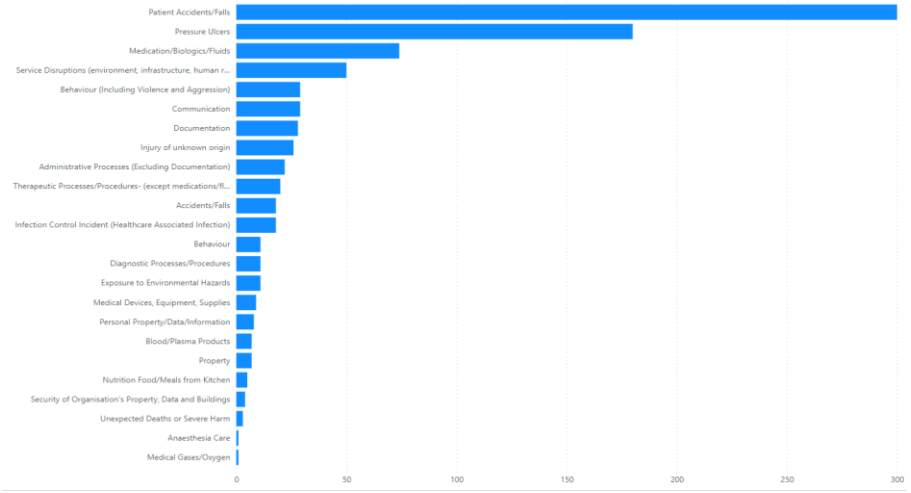

| Severity | Count |
|---|---|
| 1 - None | 593 |
| 2 – Low Harm | 201 |
| 3 – Moderate Harm | 70 |
| 4 – Severe Harm | 2 |
| 5 – Catastrophic Death | 1 |

## By Severity/Level (1st April 2021 – 31st July 2023)



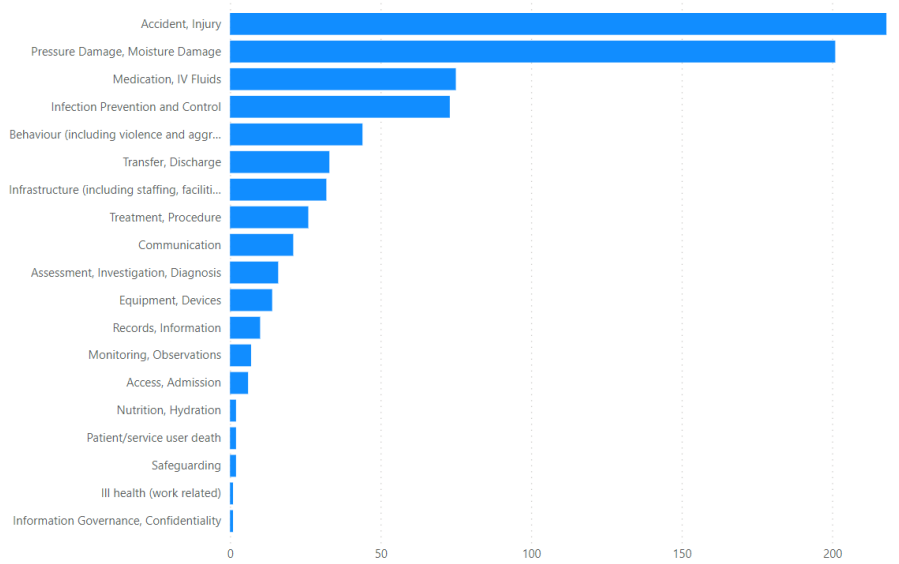

| Severity | Count |
|---|---|
| 1 - None | 168 |
| 2 – Low Harm | 397 |
| 3 – Moderate Harm | 176 |
| 4 – Severe Harm | 17 |
| 5 – Catastrophic Death | 8 |

## By Type (1st August 2018 – 31st March 2021)



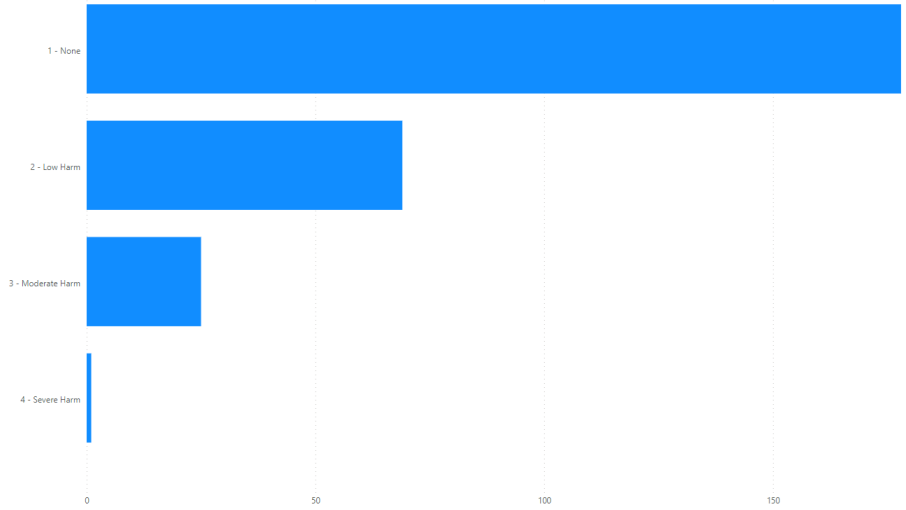

| Incident type tier one | Count |
|---|---|
| Patient Accidents/Falls | 300 |
| Pressure Ulcers | 180 |
| Medication/Biologics/Fluids | 74 |
| Service Disruptions (environment, infrastructure, human resources) | 50 |
| Behaviour (Including Violence and Aggression) | 29 |
| Communication | 29 |
| Documentation | 28 |
| Injury of unknown origin | 26 |
| Administrative Processes (Excluding Documentation) | 22 |
| Therapeutic Processes/Procedures – (except medications/fluids/blood/plasmas products administration | 20 |
| Accidents/Falls | 18 |
| Infection Control Incident (Healthcare Associated Infection) | 18 |
| Behaviour | 11 |
| Diagnostic Processes/Procedures | 11 |
| Exposure to Environmental Hazards | 11 |
| Medical Devices, Equipment, Supplies | 9 |
| Personal Property/Data/Information | 7 |
| Blood/Plasma/Products | 7 |
| Property | 7 |
| Nutrition Food/Meals from Kitchen | 5 |
| Security of Organisations Property, Data and Buildings | 4 |
| Unexpected Deaths or Severe Harm | 3 |
| Anaesthesia Care | 1 |
| Medical Gases/Oxygen | 1 |

## By Type (1st April 2021 – 31st July 2023)



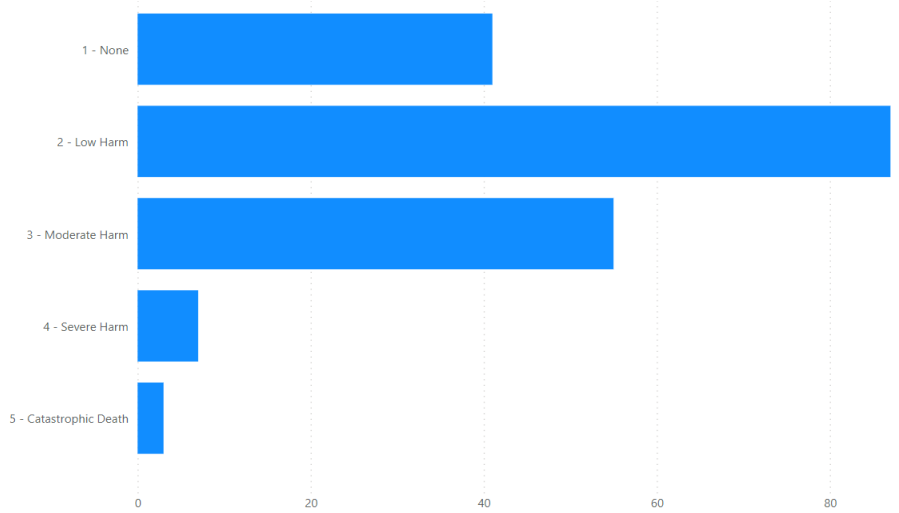

| Incident type tier one | Count |
|---|---|
| Accident, Injury | 218 |
| Pressure Damage, Moisture Damage | 201 |
| Medication, IV Fluids | 75 |
| Infection Prevention and Control | 73 |
| Behaviour (including Violence and Aggression) | 44 |
| Transfer, Discharge | 33 |
| Infrastructure (including staffing, facilities, environment) | 32 |
| Treatment, Procedure | 26 |
| Communication | 21 |
| Assessment, Investigation, Diagnosis | 16 |
| Equipment, Devices | 14 |
| Records, Information | 10 |
| Monitoring, Observations | 7 |
| Access, Admission | 6 |

## Bronglais Hospital (1st August 2018 – 31st March 2021) By Severity/Level



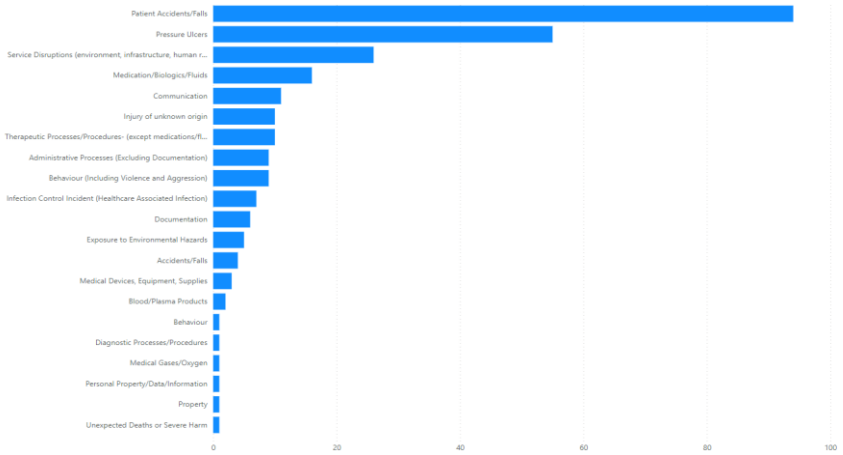

| Severity | Count |
|---|---|
| 1 - None | 178 |
| 2 – Low Harm | 69 |
| 3 – Moderate Harm | 25 |
| 4 – Severe Harm | 1 |
| 5 – Catastrophic Death | 0 |

## Bronglais Hospital (1st April 2021 – 31st July 2023) By Severity/Level



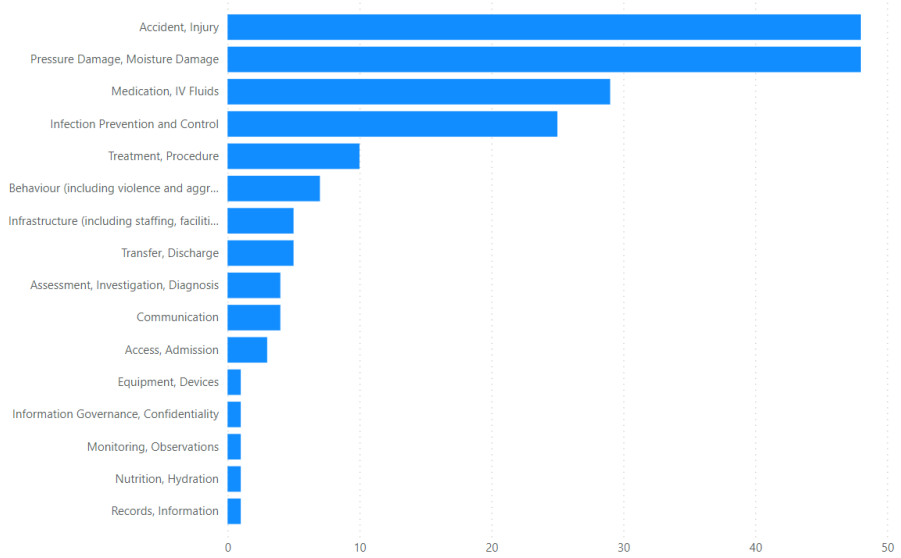

| Severity | Count |
|---|---|
| 1 – None | 41 |
| 2 – Low Harm | 87 |
| 3 – Moderate Harm | 55 |
| 4 – Severe Harm | 7 |
| 5 – Catastrophic Death | 3 |

## Bronglais Hospital (1st August 2018 – 31st March 2021)
## By Type



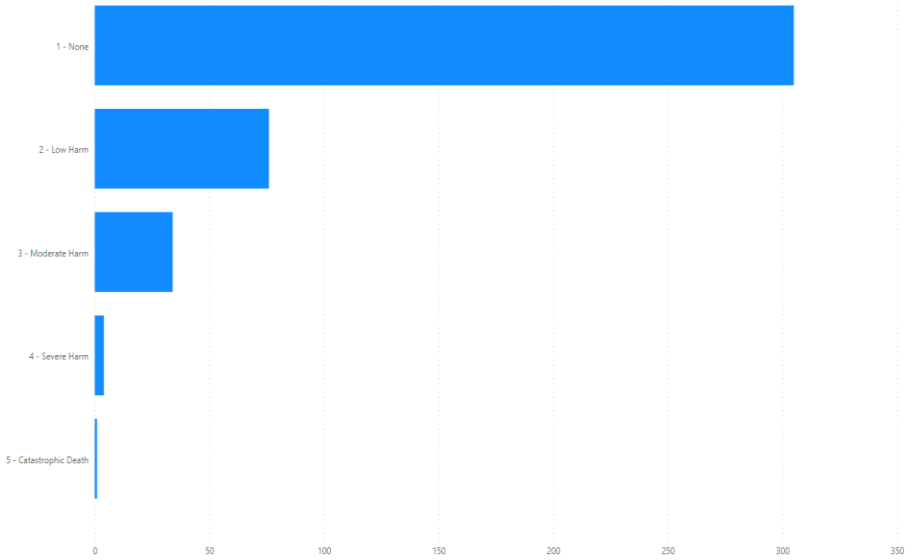

| Incident type tier one | Count |
|---|---|
| Patient Accidents/Falls | 94 |
| Pressure Ulcers | 55 |
| Service Disruptions (environment, infrastructure, human resources) | 26 |
| Medication/Biologics/Fluids | 16 |
| Communication | 11 |
| Injury of unknown origin | 10 |
| Therapeutic Processes/Procedures – (except medications/fluids/blood/plasma products administration) | 10 |
| Administrative Processes (excluding documentation) | 9 |
| Behaviour (Including Violence and Aggression) | 9 |
| Infection Control Incident (Healthcare Associated Infection) | 7 |
| Documentation | 6 |
| Exposure to Environmental Hazards | 5 |
| Accidents/falls | 4 |
| Medical Devices, Equipment, Supplies | 3 |
| Blood/Plasma Products | 2 |
| Behaviour | 1 |
| Diagnostic Processes/ Procedures | 1 |
| Medical Gases/Oxygen | 1 |
| Personal Property/ Data/ Information | 1 |
| Property | 1 |
| Unexpected Deaths or Severe Harm | 1 |

## Bronglais Hospital (1st April 2021 – 31st July 2023)
## By Type



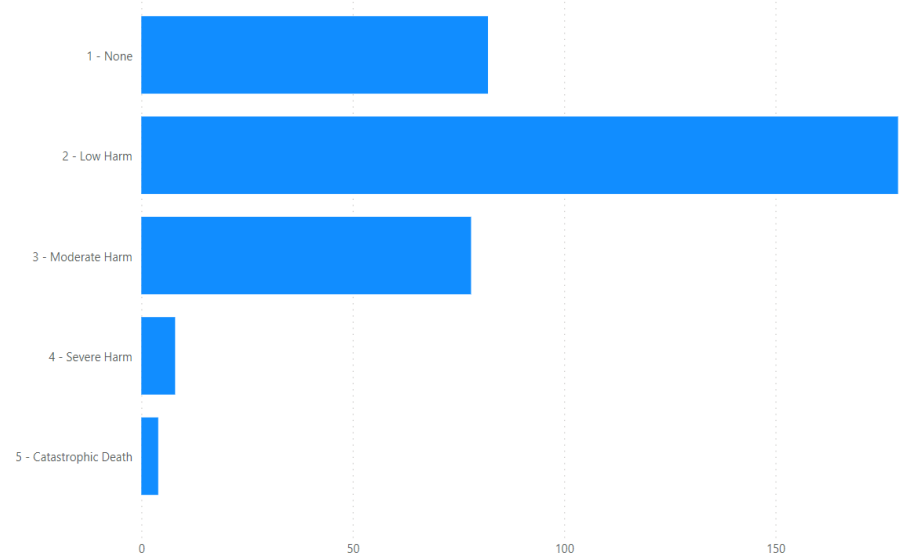

| Incident type tier one | Count |
|---|---|
| Accident, Injury | 48 |
| Pressure Damage, Moisture Damage | 48 |
| Medication, IV Fluids | 29 |
| Infection Prevention and Control | 25 |
| Treatment, Procedure | 10 |
| Behaviour (Including Violence and Aggression) | 7 |
| Infrastructure (including staffing, facilities, environment) | 5 |
| Transfer, Discharge | 5 |
| Assessment, Investigation, Diagnosis | 4 |
| Communication | 4 |
| Access, Admission | 3 |
| Equipment, Devices | 1 |
| Information Governance, Confidentiality | 1 |
| Monitoring, Observations | 1 |
| Nutrition, Hydration | 1 |
| Records, Information | 1 |

## Withybush Hospital (1st August 2018 – 31st March 2021) By Severity/Level




| Severity | Count |
|---|---|
| 1 - None | 305 |
| 2 – Low Harm | 76 |
| 3 – Moderate Harm | 34 |
| 4 – Severe Harm | 4 |
| 5 – Catastrophic Death | 1 |

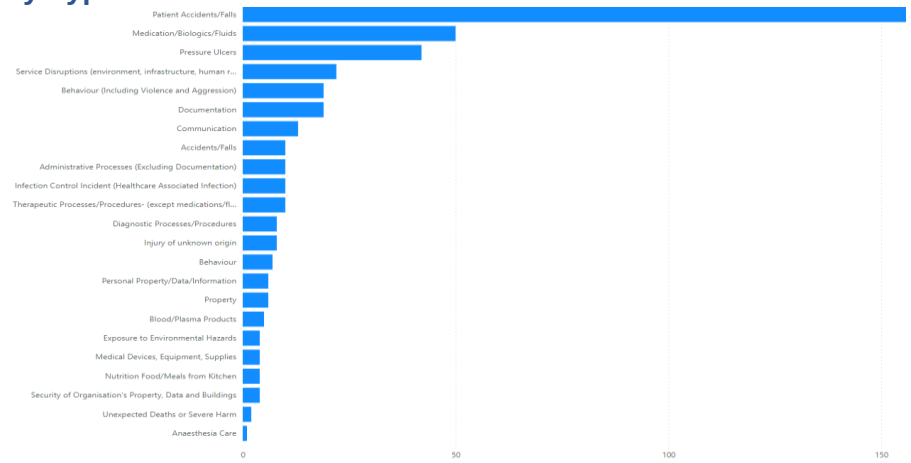
## Withybush Hospital (1st April 2021 – 31st July 2023) By Severity/Level




| Severity | Count |
|---|---|
| 1 - None | 82 |
| 2 – Low Harm | 179 |
| 3 – Moderate Harm | 78 |
| 4 – Severe Harm | 8 |
| 5 – Catastrophic Death | 4 |

## Withybush Hospital (1st August 2018 – 31st March 2021)

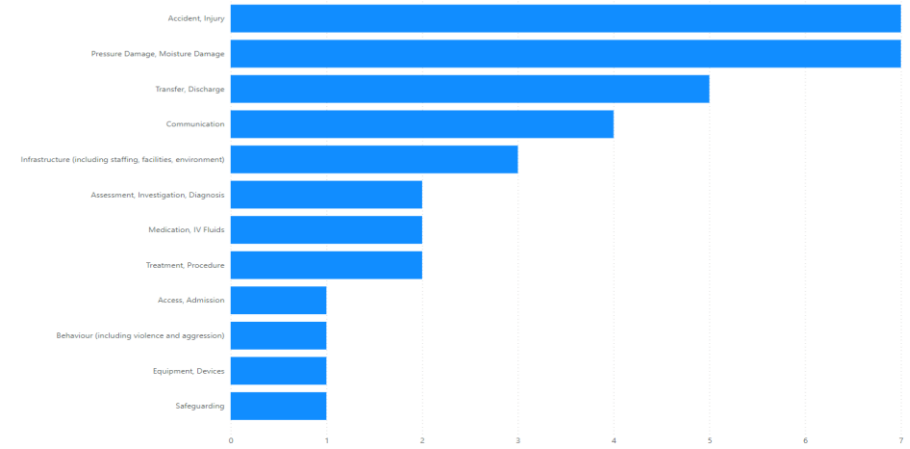
## By Type




| Incident type tier one | Count |
|---|---|
| Patient Accidents/Falls | 156 |
| Medication/Biologics/Fluids | 50 |
| Pressure Ulcers | 42 |
| Service Disruptions (environment, infrastructure, human resources) | 22 |
| Behaviour (including Violence and Aggression) | 19 |
| Documentation | 19 |
| Communication | 13 |
| Accidents/Falls | 10 |
| Administrative Processes (Excluding Documentation) | 10 |
| Infection Control Incident(Healthcare Associated Infection) | 10 |
| Therapeutic Processes/Procedures (except medications/fluids/blood/plasma products administration) | 10 |
| Diagnostic Processes/Procedures | 8 |
| Injury of unknown origin | 8 |
| Behaviour | 7 |
| Personal Property/Data/Information | 6 |
| Property | 6 |
| Blood/Plasma products | 5 |
| Exposure to Environmental Hazards | 4 |
| Medical Devices, Equipment, Supplies | 4 |
| Nutrition Food/Meals from Kitchen | 4 |
| Security of Organisation's Property, Data and Buildings | 4 |
| Unexpected Deaths or Severe Harm | 2 |
| Anaesthesia Care | 1 |

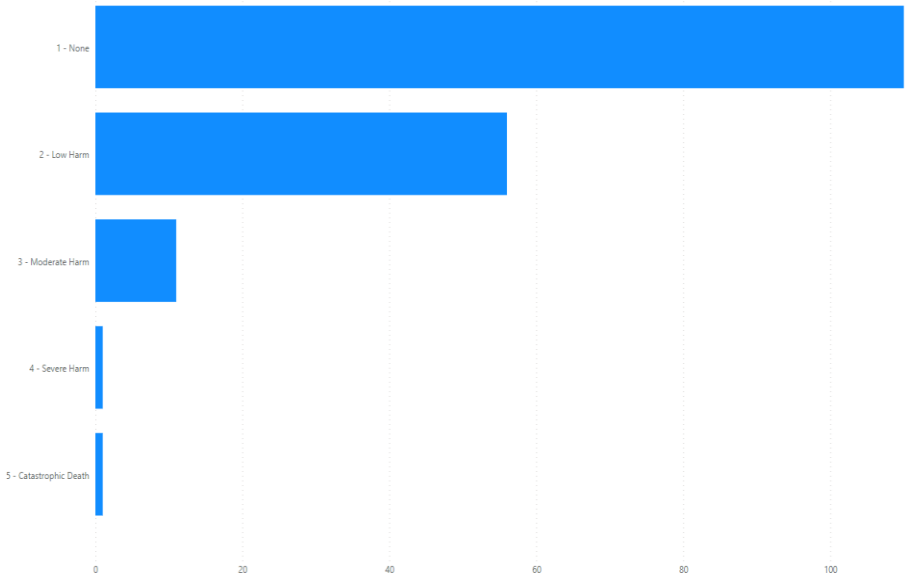
## Withybush Hospital (1st April 2021 – 31st July 2023)

## By Type



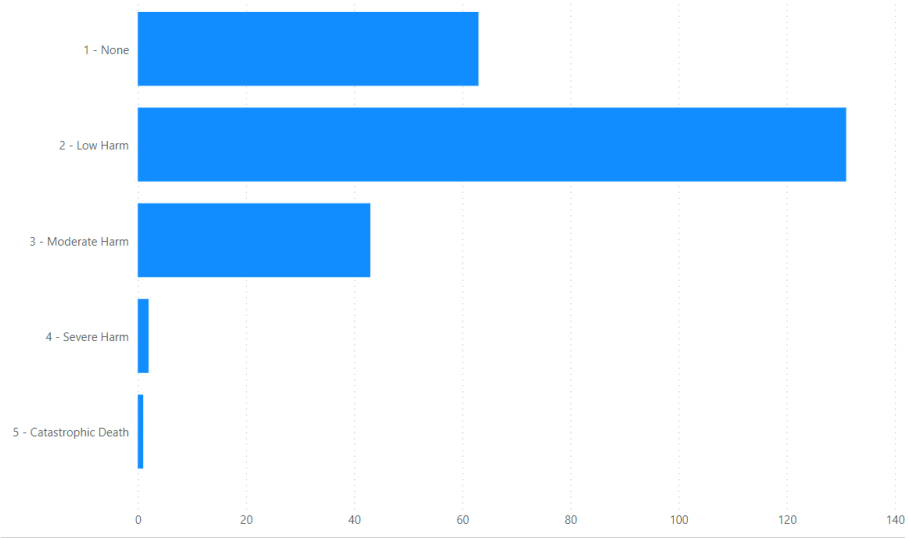

| Incident type tier one | Count |
|---|---|
| Accident, Injury | 99 |
| Pressure Damage, Moisture Damage | 83 |
| Infection Prevention and Control | 30 |
| Behaviour (including Violence and Aggression) | 29 |
| Medication, IV Fluids | 22 |
| Transfer, Discharge | 21 |
| Infrastructure (including staffing, facilities, environment) | 19 |
| Communication | 12 |
| Equipment, Devices | 10 |
| Assessment, Investigation, Diagnosis | 9 |
| Treatment, Procedure | 7 |
| Monitoring, Observations | 5 |
| Patient/service user death | 2 |
| Access, Admission | 1 |
| Records, Information | 1 |
| Safeguarding | 1 |

## Glangwili Hospital (1st August 2018 – 31st March 2021)
## By Severity/Level



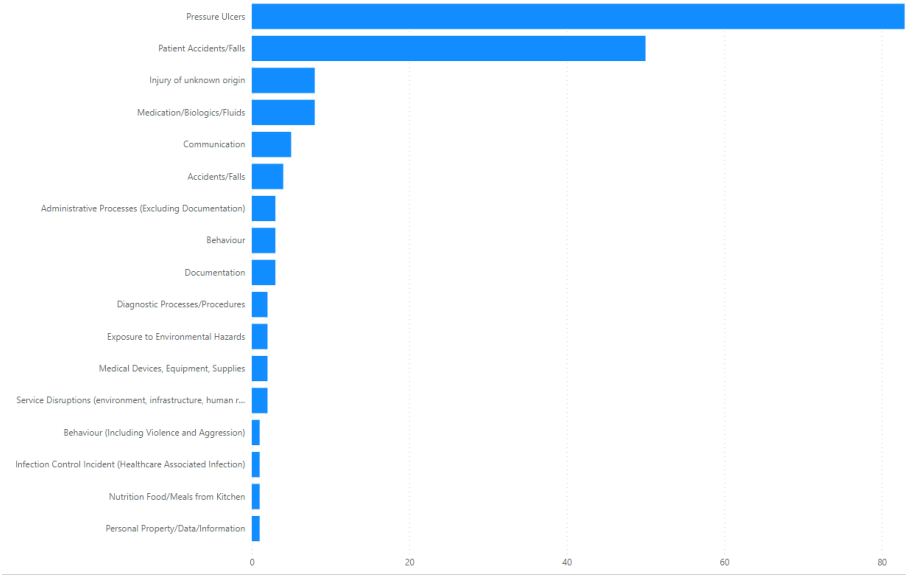

| Severity | Count |
|---|---|
| 1 - None | 110 |
| 2 – Low Harm | 56 |
| 3 – Moderate Harm | 11 |
| 4 – Severe Harm | 1 |
| 5 – Catastrophic Death | 1 |

## Glangwili Hospital (1st April 2021 – 31st July 2023)
## By Severity/Level



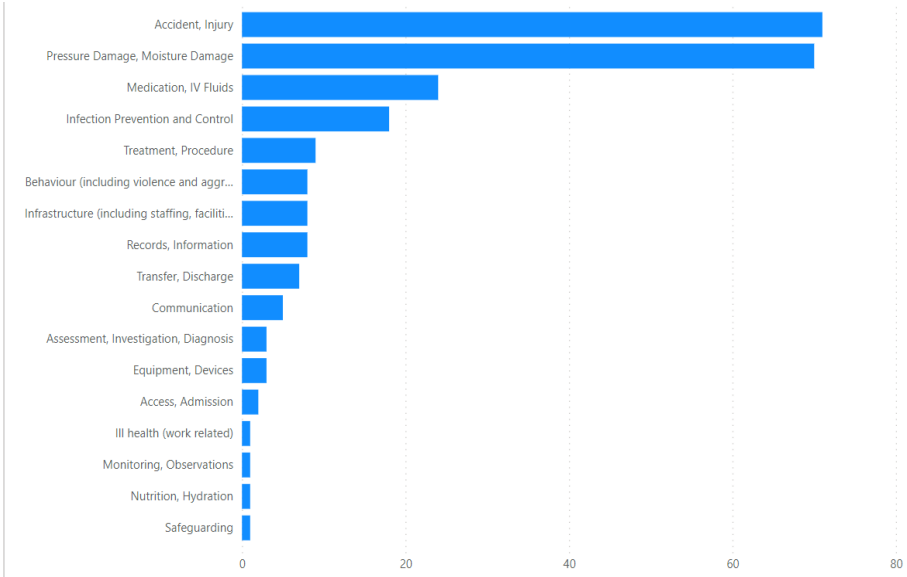

| Severity | Count |
|---|---|
| 1 - None | 63 |
| 2 – Low Harm | 131 |
| 3 – Moderate Harm | 43 |
| 4 – Severe Harm | 2 |
| 5 – Catastrophic Death | 1 |

## Glangwili Hospital (1st August 2018 – 31st March 2021)
## By Type




| Incident type tier one | Count |
|---|---|
| Pressure Ulcers | 83 |
| Patient Accidents/Falls | 50 |
| Injury of unknown origin | 8 |
| Medication/Biologics/Fluids | 8 |
| Communication | 5 |
| Accidents/ Falls | 4 |
| Administrative Processes (Excluding Documentation) | 3 |
| Behaviour | 3 |
| Documentation | 3 |
| Diagnostic Processes/Procedures | 2 |
| Exposure to Environmental Hazards | 2 |
| Medical Devices, Equipment, Supplies | 2 |
| Service Disruptions (environment, infrastructure, human resources | 2 |
| Behaviour (including Violence and Aggression) | 1 |
| Infection Control Incident (Healthcare Associated Infection) | 1 |
| Nutrition Food/Meals from Kitchen | 1 |
| Personal Property/Data/Information | 1 |

## Glangwili Hospital (1st April 2021 – 31st July 2023)
## By Type




| Incident type tier one | Count |
|---|---|
| Accident, Injury | 71 |
| Pressure Damage, Moisture Damage | 70 |
| Medication, IV Fluids | 24 |
| Infection Prevention and Control | 18 |
| Treatment, Procedure | 9 |
| Behaviour (including Violence and Aggression) | 8 |
| Infrastructure (including staffing, facilities, environment) | 8 |
| Records, Information | 8 |
| Transfer, Discharge | 7 |
| Communication | 5 |
| Assessment, Investigation, Diagnosis | 3 |
| Equipment, Devices | 3 |
| Access, Admission | 2 |
| Ill health (work related) | 1 |
| Monitoring, Observations | 1 |
| Nutrition, Hydration | 1 |
| Safeguarding | 1 |

# Emergency General Surgery Complaints Data Review

## Contents

# Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1 August 2018 and 31st July 2023 have been included for Emergency General Surgery Services at Bronglais Hospital, Withybush Hospital and Glangwili. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported complaints attributable to Service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

## Service Changes

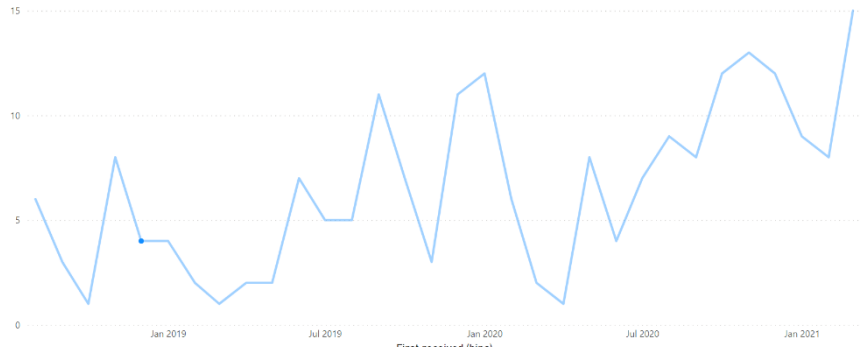
The service changes were ratified during May public board At the Public Board meeting held 30th March 2023, the board approved:

- Out of hours consultant cover should be concentrated at GGH and BGH hospitals whilst recruitment efforts continue to improve the situation at WGH
- During out of hours periods, the consultant teams at GGH/BGH would provide remote support and advice to the SAS tier of surgical doctors at WGH who would continue to provide 24/7 emergency surgical cover for patients at the WGH.

- This decision was taken to:
- Ensure the safety of patients admitted via an emergency surgical pathway at WGH, and
- Support the continued sustainability of the 24/7 emergency surgical pathway at the hospital.
- This temporary arrangement was put in place in May 2023 and is reflected within the graphs by a solid red line.

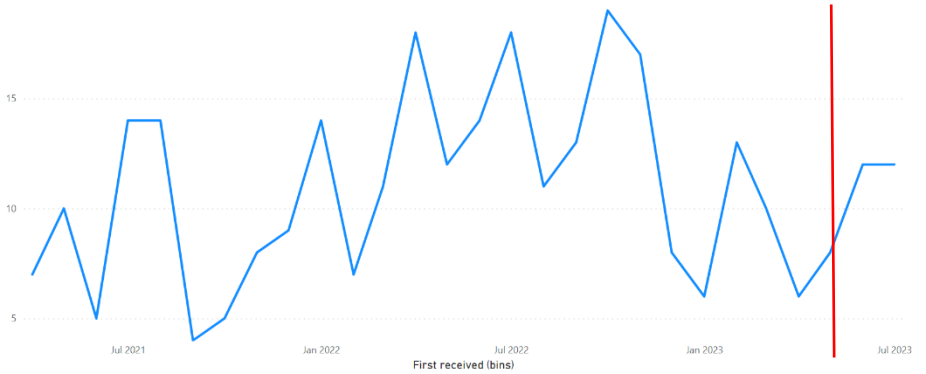
# Complaints

## All sites (1st August 2018 – 31st March 2021)



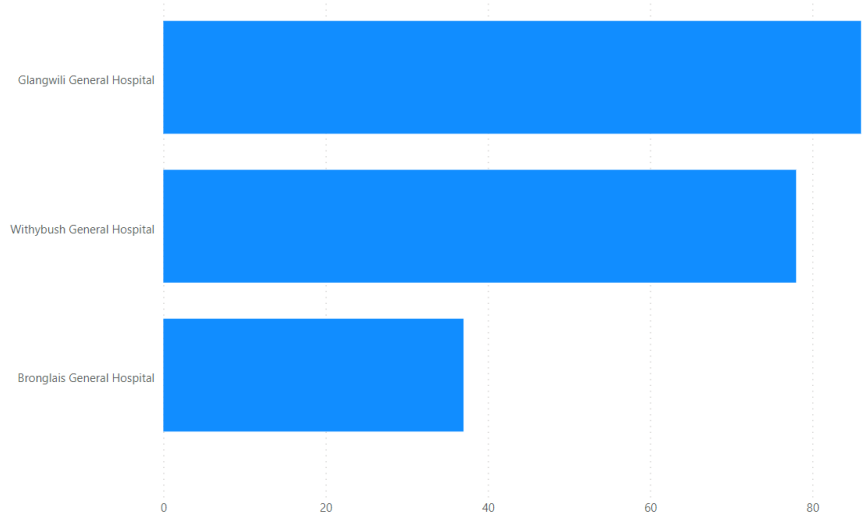

| | | | | | | | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | **2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 4 | 3 | 2 | 12 | 6 | 27 |
| Jan 19 | Feb 19 | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | **2019** |
| 8 | 4 | 1 | 0 | 3 | 12 | 6 | 5 | 7 | 11 | 9 | 3 | 69 |
| Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | Jul 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | **2020** |
| 13 | 10 | 14 | 2 | 4 | 8 | 7 | 5 | 9 | 10 | 5 | 11 | 98 |
| Jan 21 | Feb 21 | Mar 21 | | | | | | | | | | **2021** |
| 2 | 3 | 2 | | | | | | | | | | 7 |

## All sites (1st April 2021 – 31st July 2023



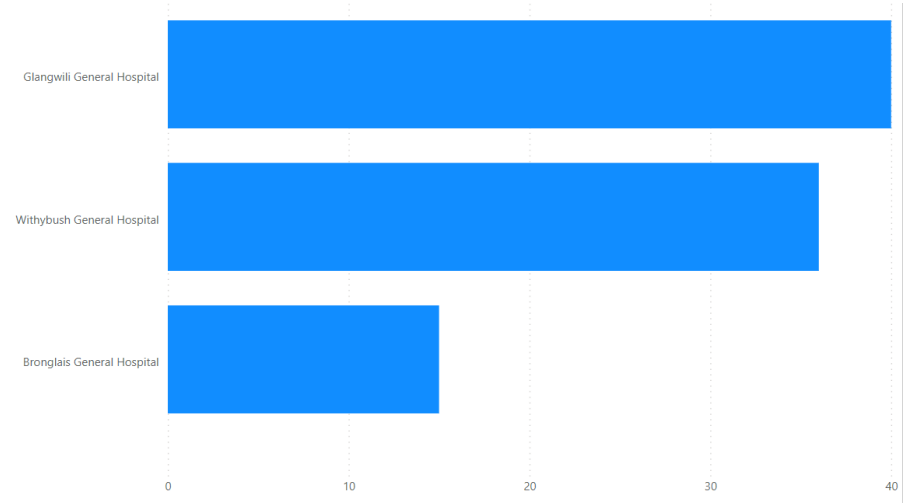

| | | | Apr 21 | May 21 | Jun 21 | Jul 21 | Aug 21 | Sep 21 | Oct 21 | Nov 21 | Dec 21 | **2021** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 4 | 2 | 4 | 9 | 2 | 4 | 3 | 3 | 2 | 33 |
| Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | **2022** |
| 2 | 5 | 4 | 1 | 4 | 2 | 4 | 4 | 2 | 4 | 1 | 2 | 35 |
| Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | | | | | | **2023** |
| 6 | 2 | 6 | 3 | 0 | 1 | 5 | | | | | | 23 |

## By Location (1st August 2018 – 31st March 2021)



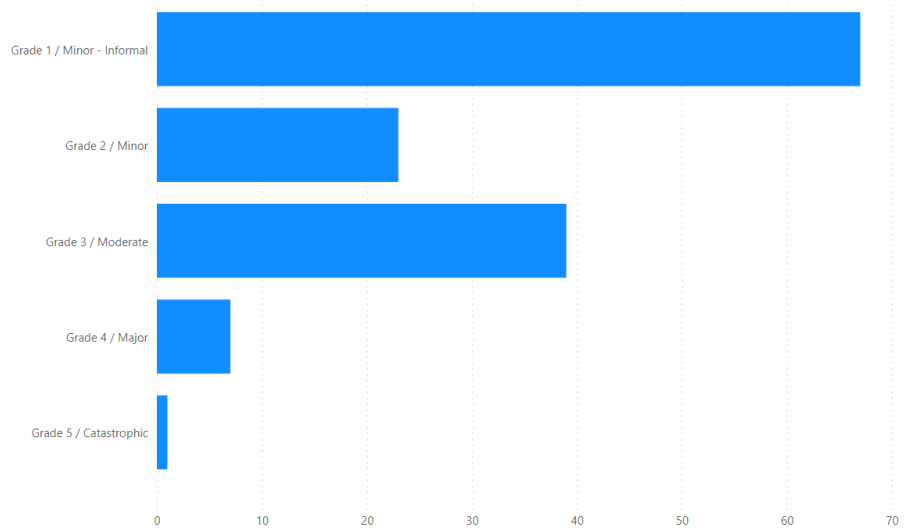

| Primary Location | Count |
|---|---|
| Glangwili General Hospital | 86 |
| Withybush General Hospital | 78 |
| Bronglais General Hospital | 37 |

## By Location (1st April 2021 – 31st July 2023)



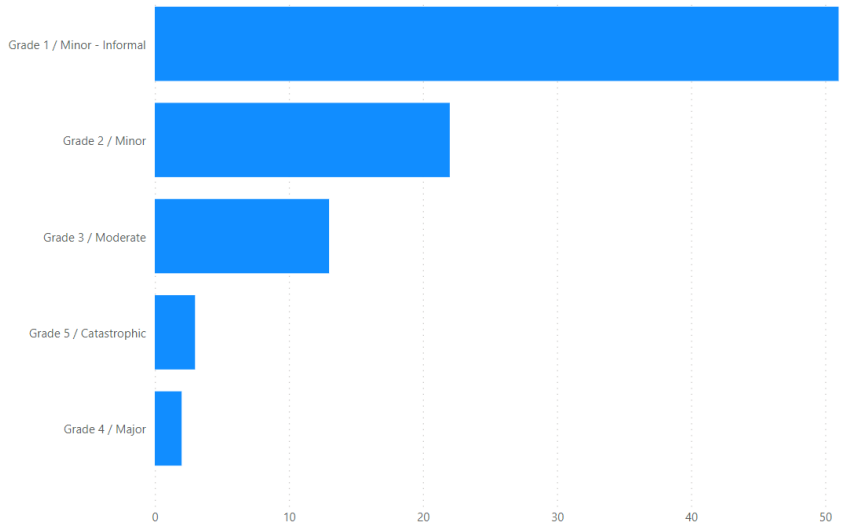

| Primary Location | Count |
|---|---|
| Glangwili General Hospital | 40 |
| Withybush General Hospital | 36 |
| Bronglais General Hospital | 15 |

## By Grading (1st August 2018 – 31st March 2021)



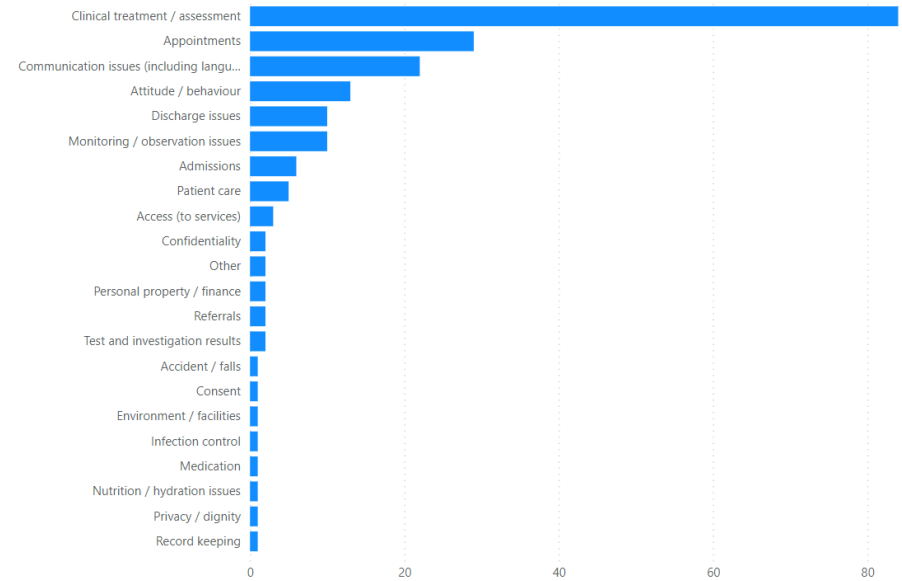

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 67 |
| Grade 2 - Minor | 23 |
| Grade 3 - Moderate | 39 |
| Grade 4 - Major | 7 |
| Grade 5 – Catastrophic | 1 |

## By Grading (1st April 2021 – 31st July 2023)



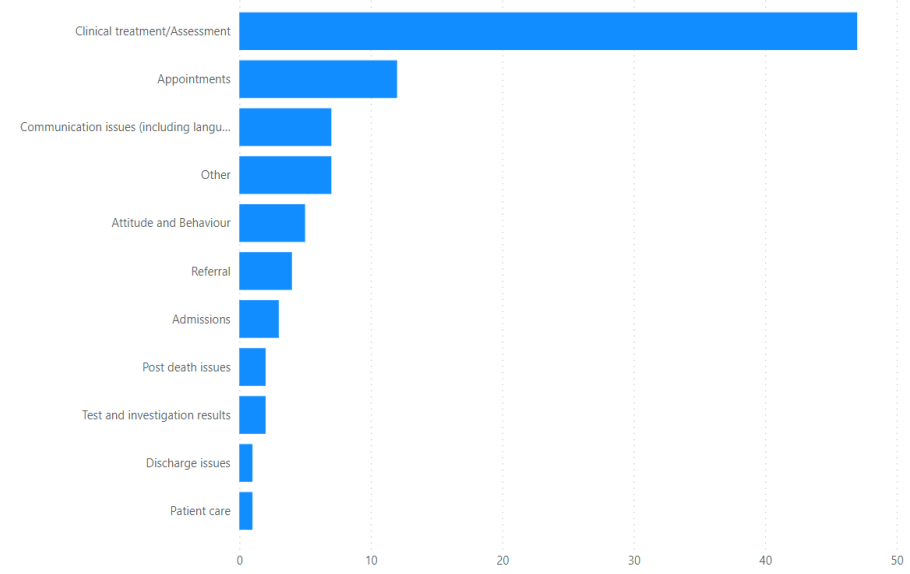

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 51 |
| Grade 2 - Minor | 22 |
| Grade 3 - Moderate | 13 |
| Grade 4 - Major | 2 |
| Grade 5 – Catastrophic | 3 |

## By Type (1st August 2018 – 31st March 2021)



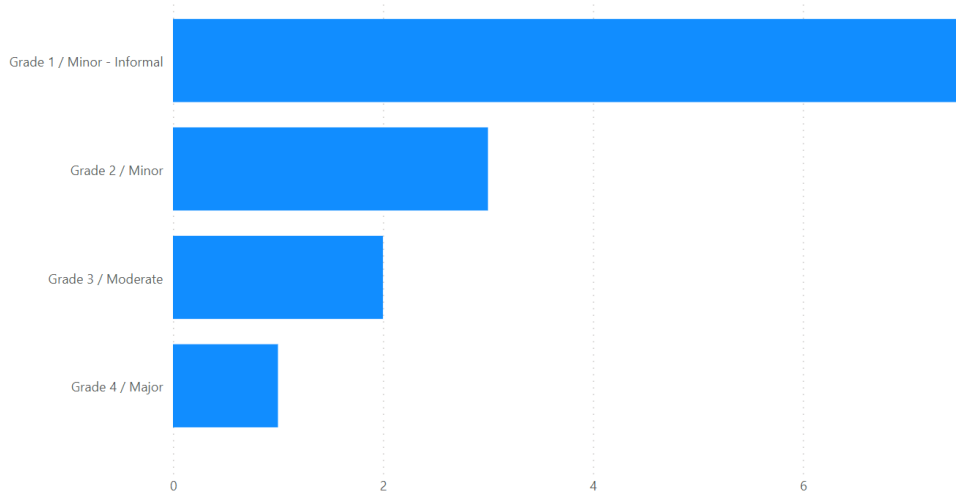

| Subject (primary) | Count |
|---|---|
| Clinical treatment / assessment | 84 |
| Appointments | 29 |
| Communication issues (including language) | 22 |
| Attitude / behaviour | 13 |
| Discharge issues | 10 |
| Monitoring / observation issues | 10 |
| Admissions | 6 |
| Patient care | 5 |
| Access (to services) | 3 |
| Confidentiality | 2 |
| Other | 2 |
| Personal property/ finance | 2 |
| Referrals | 2 |
| Test and investigation results | 2 |
| Accidents/ falls | 1 |
| Consent | 1 |
| Environmental/ facilities | 1 |
| Infection control | 1 |
| Medication | 1 |
| Nutrition/ hydration issues | 1 |
| Privacy/ dignity | 1 |
| Record keeping | 1 |

## By Type (1st April 2021 – 31st July 2023)



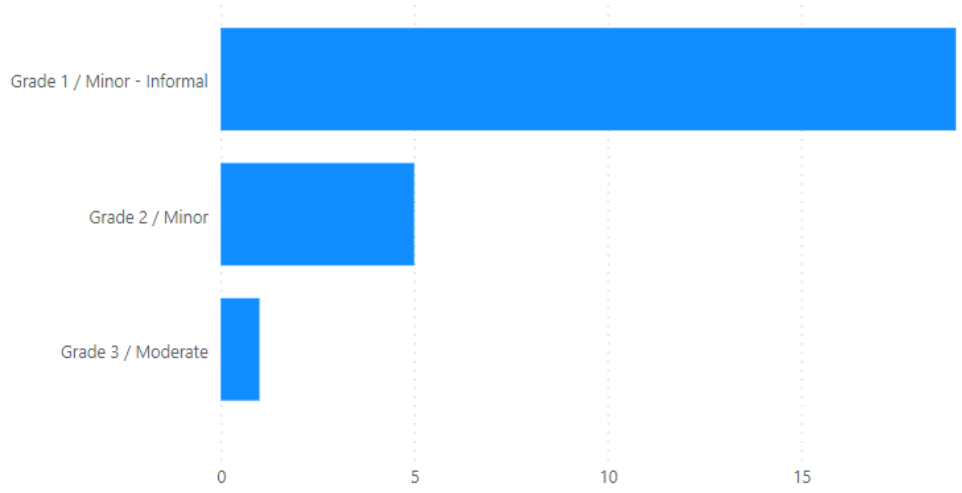

| Subject (primary) | Count |
|---|---|
| Clinical treatment/Assessment | 47 |
| Appointments | 12 |
| Communication issues (including language) | 7 |
| Other | 7 |
| Attitude/ behaviour | 5 |
| Referral | 4 |
| Admissions | 3 |
| Post death issues | 2 |
| Test and investigation results | 2 |
| Discharge issues | 1 |
| Patient care | 1 |

## Bronglais Hospital (1st August 2018 – 31st March 2021)
## By Grading



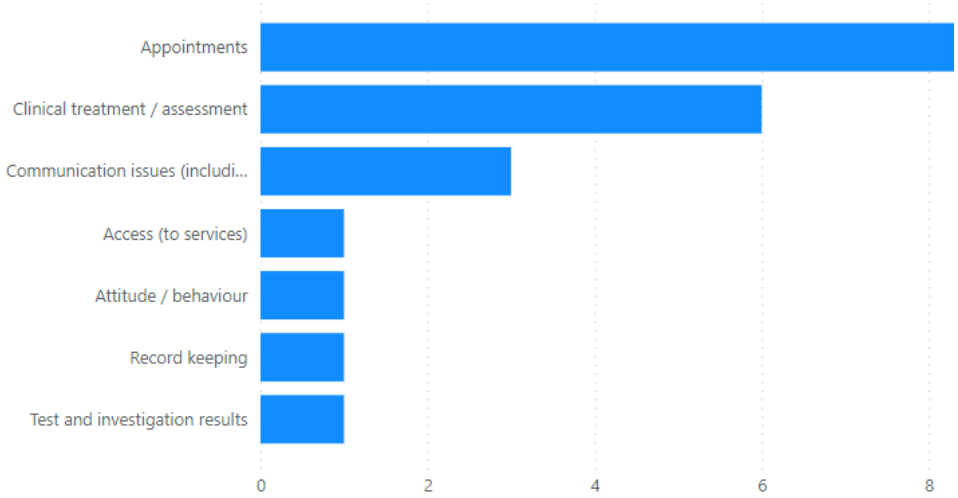

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 10 |
| Grade 2 - Minor | 3 |
| Grade 3 - Moderate | 2 |
| Grade 4 - Major | 1 |
| Grade 5 – Catastrophic | 0 |

## Bronglais Hospital (1st April 2021 – 31st July 2023)
## By Grading



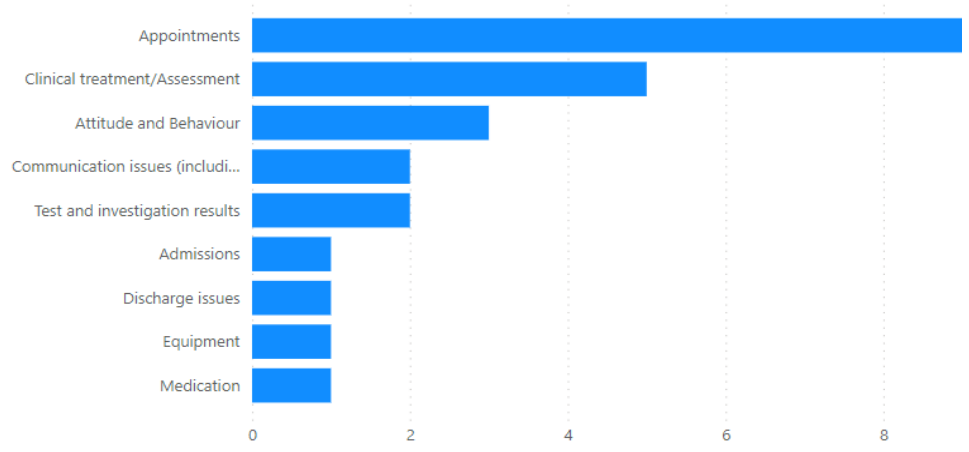

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 19 |
| Grade 2 - Minor | 5 |
| Grade 3 - Moderate | 1 |
| Grade 4 – Major | 0 |
| Grade 5 – Catastrophic | 0 |

## Bronglais Hospital (1st August 2018 – 31st March 2021)
## By Type



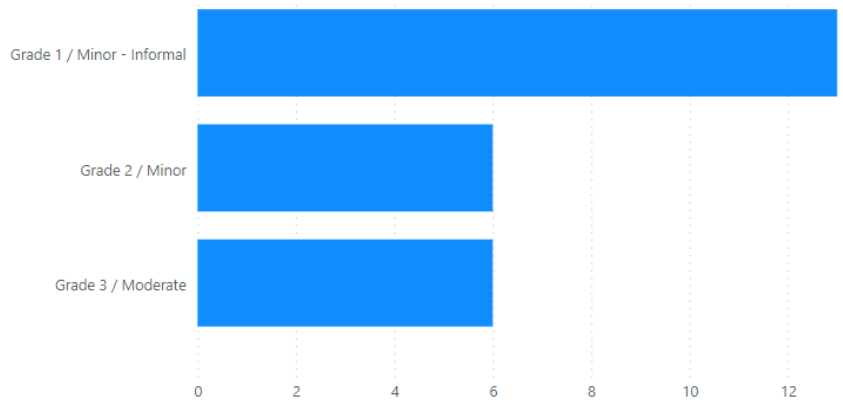

| Subject (primary) | Count |
|---|---|
| Appointments | 9 |
| Clinical treatment/Assessment | 6 |
| Communication issues (including language) | 3 |
| Access (to services) | 1 |
| Attitude / behaviour | 1 |
| Record keeping | 1 |
| Test and investigation results | 1 |

## Bronglais Hospital (1st April 2021 – 31st July 2023)
## By Type



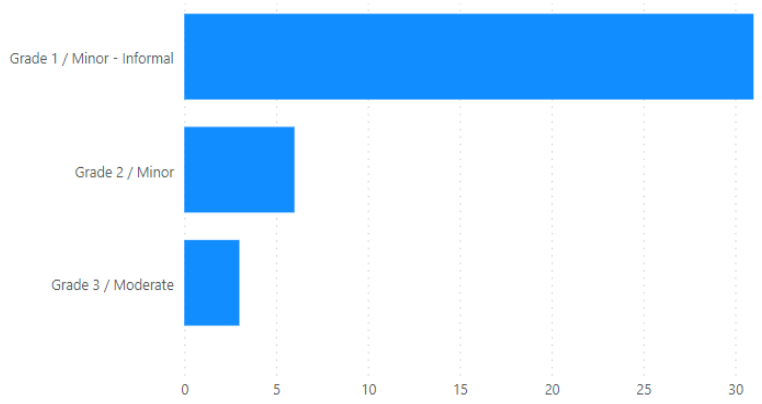

| Subject (primary) | Count |
|---|---|
| Appointments | 9 |
| Clinical treatment/Assessment | 5 |
| Attitude and Behaviour | 3 |
| Communication issues (including language) | 2 |
| Test and investigation results | 2 |
| Admissions | 1 |
| Discharge Issues | 1 |
| Equipment | 1 |
| Medication | 1 |

## Withybush Hospital (1st August 2018 – 31st March 2021) By Grading



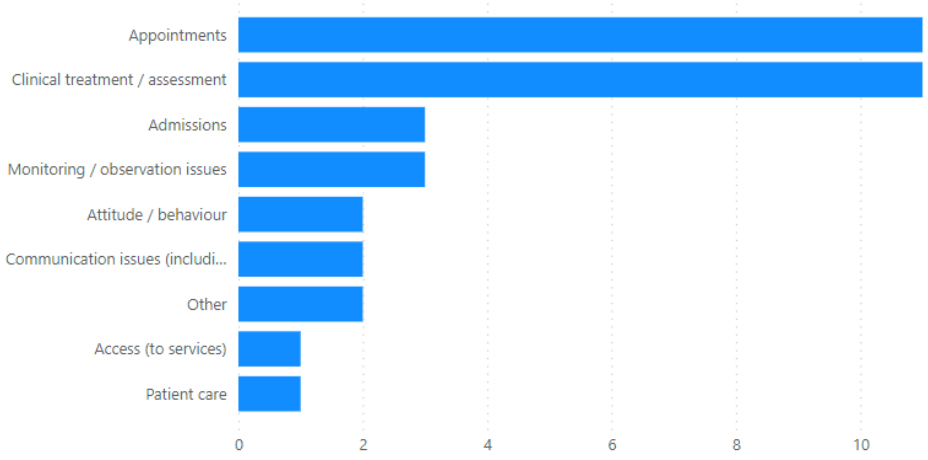

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 13 |
| Grade 2 - Minor | 6 |
| Grade 3 - Moderate | 6 |
| Grade 4 – Major | 0 |
| Grade 5 - Catastrophic | 0 |

## Withybush Hospital (1st April 2021 – 31st July 2023) By Grading



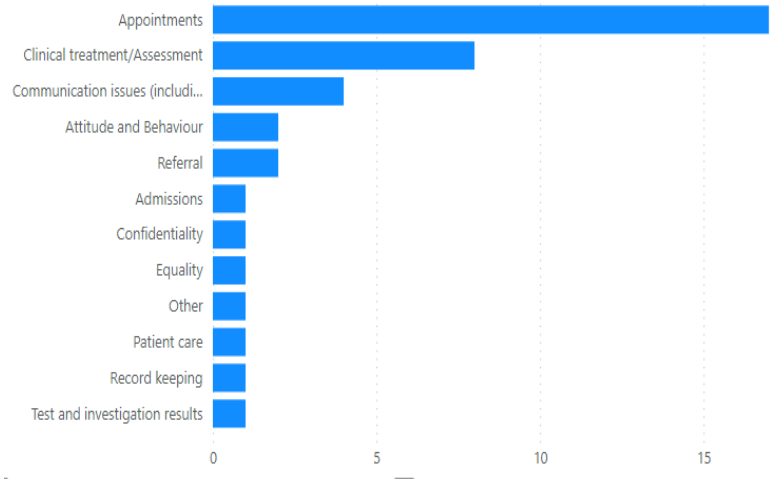

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 31 |
| Grade 2 - Minor | 6 |
| Grade 3 - Moderate | 3 |
| Grade 4 – Major | 0 |
| Grade 5 – Catastrophic | 0 |

## Withybush Hospital (1st August 2018 – 31st March 2021)
## By Type



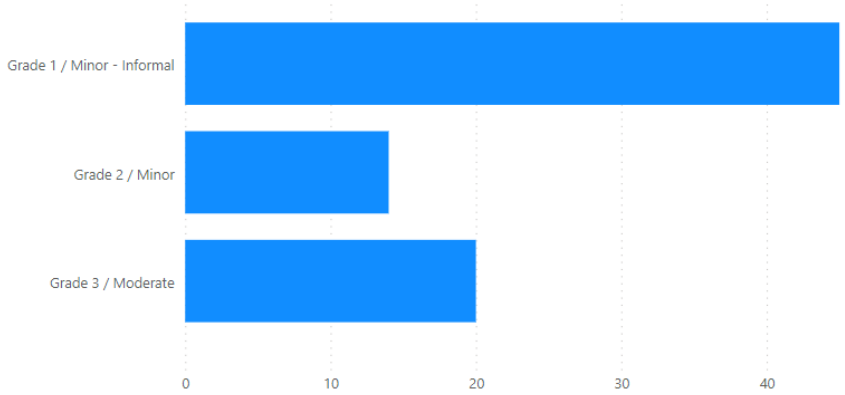

| Subject (primary) | Count |
|---|---|
| Appointments | 11 |
| Clinical treatment/Assessment | 11 |
| Admissions | 3 |
| Monitoring / observation issues | 3 |
| Attitude / behaviour | 2 |
| Communication issues (including language) | 2 |
| Other | 2 |
| Access (to services) | 1 |
| Patient care | 1 |

## Withybush Hospital (1st April 2021 – 31st July 2023)
## By Type



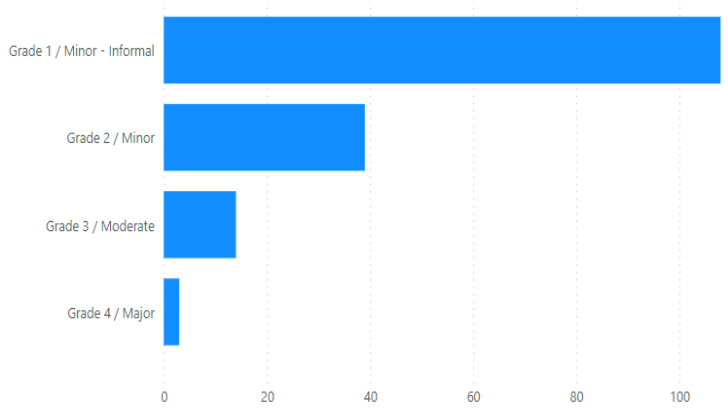

| Subject (primary) | Count |
|---|---|
| Appointments | 17 |
| Clinical treatment/Assessment | 8 |
| Communication issues (including language) | 4 |
| Attitude / behaviour | 2 |
| Referral | 2 |
| Admissions | 1 |
| Confidentiality | 1 |
| Equality | 1 |
| Other | 1 |
| Patient care | 1 |
| Record keeping | 1 |
| Test and Investigation results | 1 |

## Glangwili Hospital (1st August 2018 – 31st March 2021) By Grading



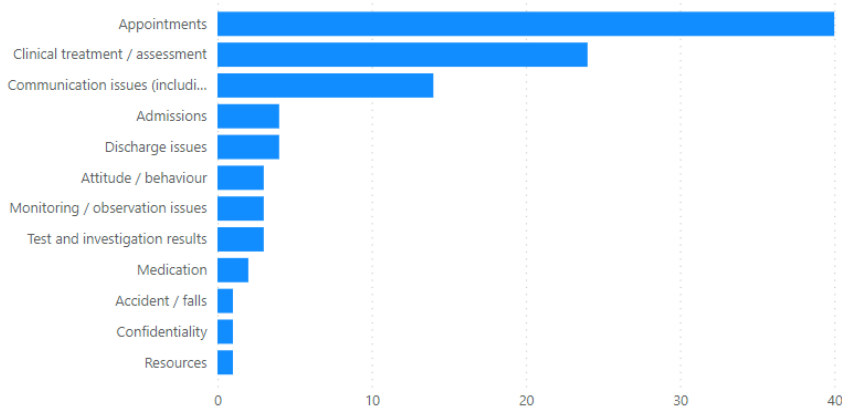

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 45 |
| Grade 2 - Minor | 14 |
| Grade 3 - Moderate | 20 |
| Grade 4 – Major | 0 |
| Grade 5 – Catastrophic | 0 |

## Glangwili Hospital (1st April 2021 – 31st July 2023) By Grading



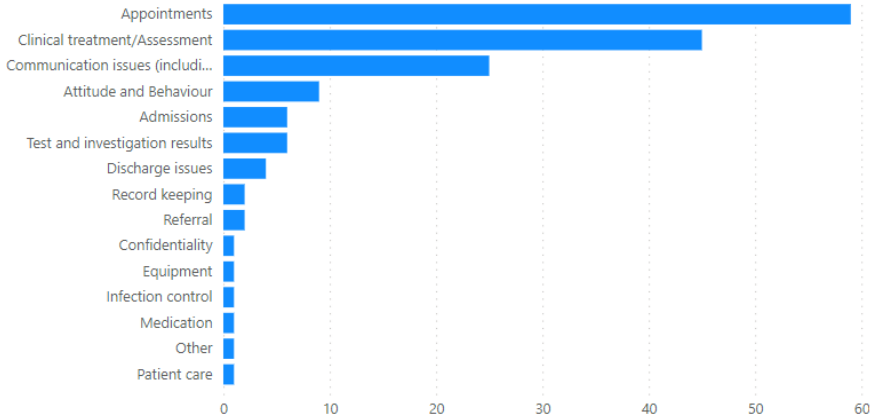

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 108 |
| Grade 2 - Minor | 39 |
| Grade 3 - Moderate | 14 |
| Grade 4 - Major | 3 |
| Grade 5 – Catastrophic | 0 |

## Glangwili Hospital (1st August 2018 – 31st March 2021)
## By Type



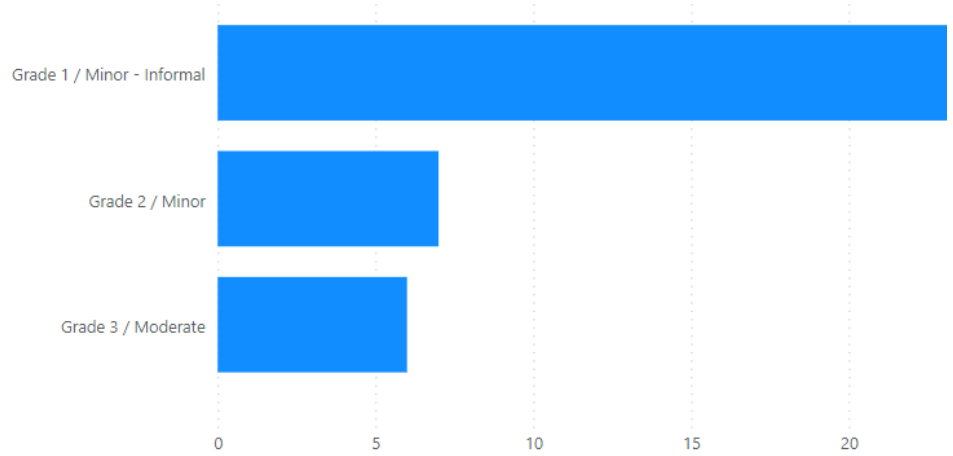

| Subject (primary) | Count |
|---|---|
| Appointments | 40 |
| Clinical treatment/Assessment | 24 |
| Communication issues (including language) | 14 |
| Admissions | 4 |
| Discharge Issues | 4 |
| Attitude / behaviour | 3 |
| Monitoring / observation issues | 3 |
| Test and investigation results | 3 |
| Medication | 2 |
| Accident / Falls | 1 |
| Confidentiality | 1 |
| Resources | 1 |

## Glangwili Hospital (1st April 2021 – 31st July 2023)
## By Type



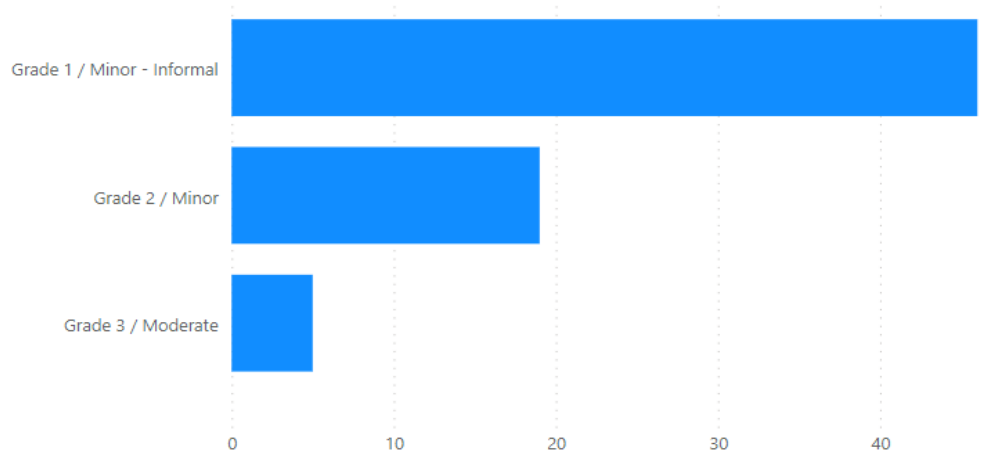

| Subject (primary) | Count |
|---|---|
| Appointments | 59 |
| Clinical treatment/Assessment | 45 |
| Communication issues (including language) | 25 |
| Attitude / behaviour | 9 |
| Admissions | 6 |
| Test and investigation results | 6 |
| Discharge Issues | 4 |
| Record Keeping | 2 |
| Referral | 2 |
| Confidentiality | 1 |
| Equipment | 1 |
| Infection Control | 1 |
| Medication | 1 |
| Other | 1 |
| Patient Care | 1 |

## Prince Philip Hospital (1st August 2018 – 31st March 2021) By Grading



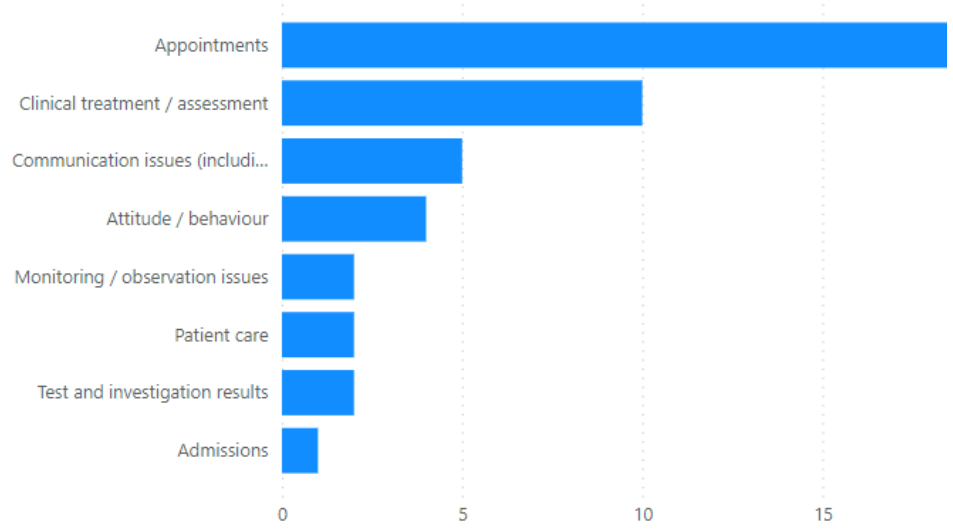

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 24 |
| Grade 2 - Minor | 7 |
| Grade 3 - Moderate | 6 |
| Grade 4 – Major | 0 |
| Grade 5 – Catastrophic | 0 |

## Prince Philip Hospital (1st April 2021 – 31st July 2023) By Grading



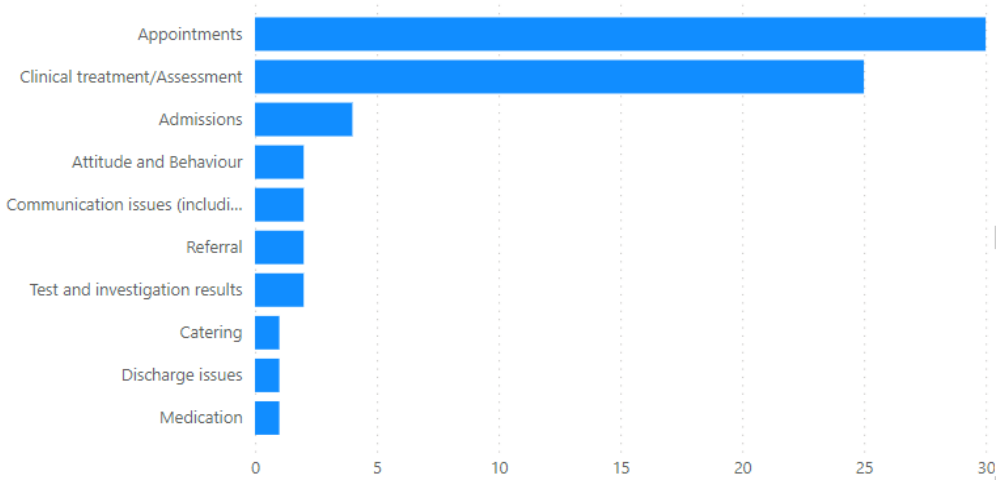

| Grade | Count |
|---|---|
| Grade 1 – Minor - Informal | 46 |
| Grade 2 - Minor | 19 |
| Grade 3 - Moderate | 5 |
| Grade 4 – Major | 0 |
| Grade 5 – Catastrophic | 0 |

## Prince Philip Hospital (1st August 2018 – 31st March 2021)
## By Type




| Subject (primary) | Count |
|---|---|
| Appointments | 22 |
| Clinical treatment/Assessment | 10 |
| Communication issues (including language) | 5 |
| Attitude / behaviour | 4 |
| Monitoring / observation issues | 2 |
| Patient Care | 2 |
| Tests and investigation results | 2 |
| Admissions | 1 |

## Prince Philip Hospital (1st April 2021 – 31st July 2023)
## By Type




| Subject (primary) | Count |
|---|---|
| Appointments | 30 |
| Clinical treatment/Assessment | 25 |
| Admissions | 4 |
| Attitude / behaviour | 2 |
| Communication issues (including language) | 2 |
| Referral | 2 |
| Tests and investigation results | 2 |
| Catering | 1 |
| Discharge Issues | 1 |
| Medication | 1 |

## EGS Patient Experience and Compliments Data

# Contents



# Background

As per the approved Clinical Services Plan methodology, Patient Experience data captured has been included for EGS Services at Bronglais Hospital, Withybush Hospital and Glangwili Hospital.

Due to data formatting across the current Civica system and historical records, data has only been analysed from 1*st* April 2021 to 31*st* July 2023. Historical records, pre-April 2021, cannot be assigned to particular Services in their entirety and so the methodology was updated to only analyse the current Civica system data.

Due to the implementation of the new Civica system, there was an initial decline in patient feedback as the system was being established and rolled out across the Health Board. The new system was implemented on a phased basis and therefore some services had a higher percentage of the feedback in the early stages. There will be an ongoing increase since the introduction of Civica as the Health Board's priority is to increase the volume of feedback.

Traditionally, emergency departments have always had a larger number of claims, complaints and patient feedback due to activity numbers. Patients that have a number of appointments in a relatively short period of time within a Service will generate more feedback.

It is possible that the data shows a variation in the number of reported complaints attributable to **a Service**. This relates to the system not always being able to distinguish between different specialties within the Service that may be related to other services within the system.

Due to the way records have been captured within the system and potential gaps in the data, the categorised totals may not equal overall totals per Service.

Data that has been analysed includes All Wales Patient Experience data, Friends and Family Test data and Compliments data. The Big Thank You has been discarded in its entirety as the formatting of the data follows the same structure as pre 2021 data and therefore cannot be assigned to a particular service.

The thematic analysis was undertaken using Microsoft Copilot and has been used to provide a summary of themes per Service per year based on the patient feedback received.

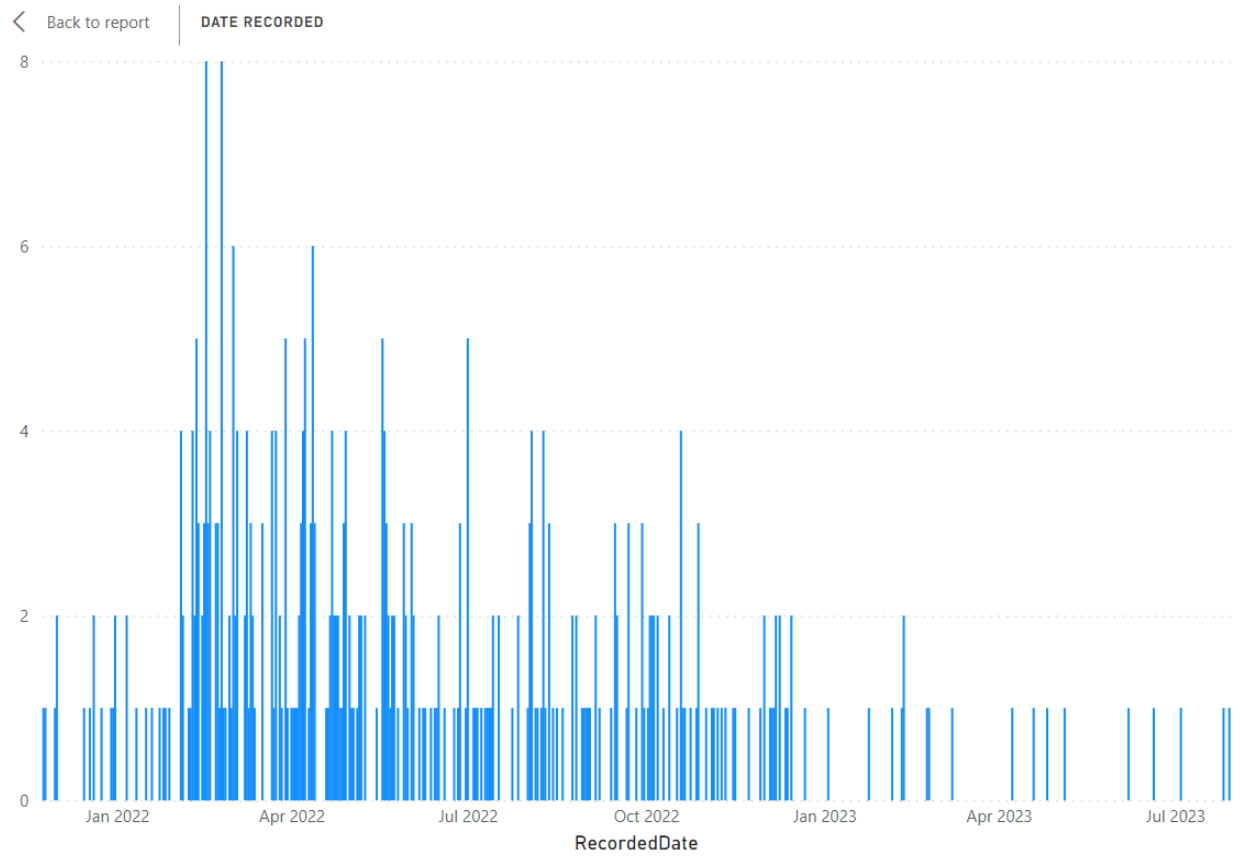
## Service Changes

The service changes were ratified during May public board At the Public Board meeting held 30th March 2023, the board approved:

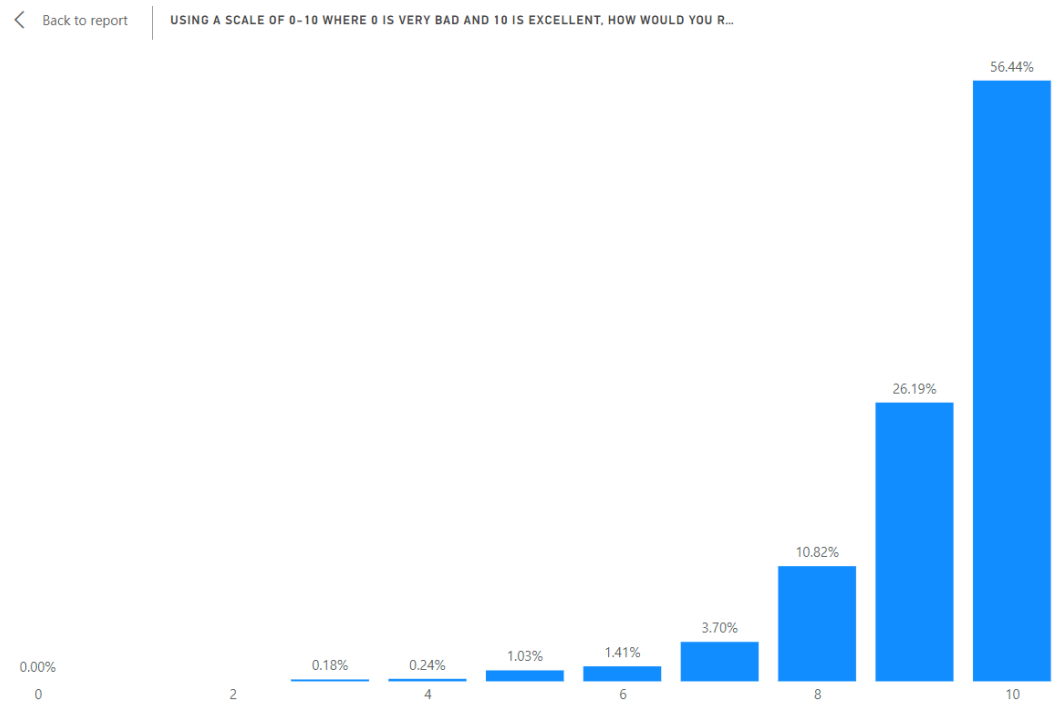
- Out of hours consultant cover should be concentrated at GGH and BGH hospitals whilst recruitment efforts continue to improve the situation at WGH
- During out of hours periods, the consultant teams at GGH/BGH would provide remote support and advice to the SAS tier of surgical doctors at WGH who would continue to provide 24/7 emergency surgical cover for patients at the WGH.
- This decision was taken to:
- Ensure the safety of patients admitted via an emergency surgical pathway at WGH, and
- Support the continued sustainability of the 24/7 emergency surgical pathway at the hospital.
- This temporary arrangement was put in place in May 2023 and is reflected within the graphs by a solid red line.

# Patient Experience

## All Wales Experience – Health Board Survey (1st April 2021 to 31st July 2023)




| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 11 | 14 |
| Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2022 |
| 9 | 62 | 49 | 54 | 37 | 17 | 20 | 29 | 20 | 24 | 10 | 14 | 345 |
| Jan | Feb | Mar | Apr | May | Jun | Jul | | | | | | 2023 |
| 2 | 6 | 1 | 3 | 1 | 2 | 3 | | | | | | 18 |




## Themes – 2021

The themes noted by patients related to the quality of care, interactions with staff, and the hospital environment. Many patients reported positive experiences, praising the kindness, professionalism, and helpfulness of the staff. Some patients also mentioned the quality of the food and the cleanliness of the hospital. However, some patients also reported negative experiences, such as difficulty with communication, discomfort with the hospital environment, and issues with staffing levels.

## Themes – 2022

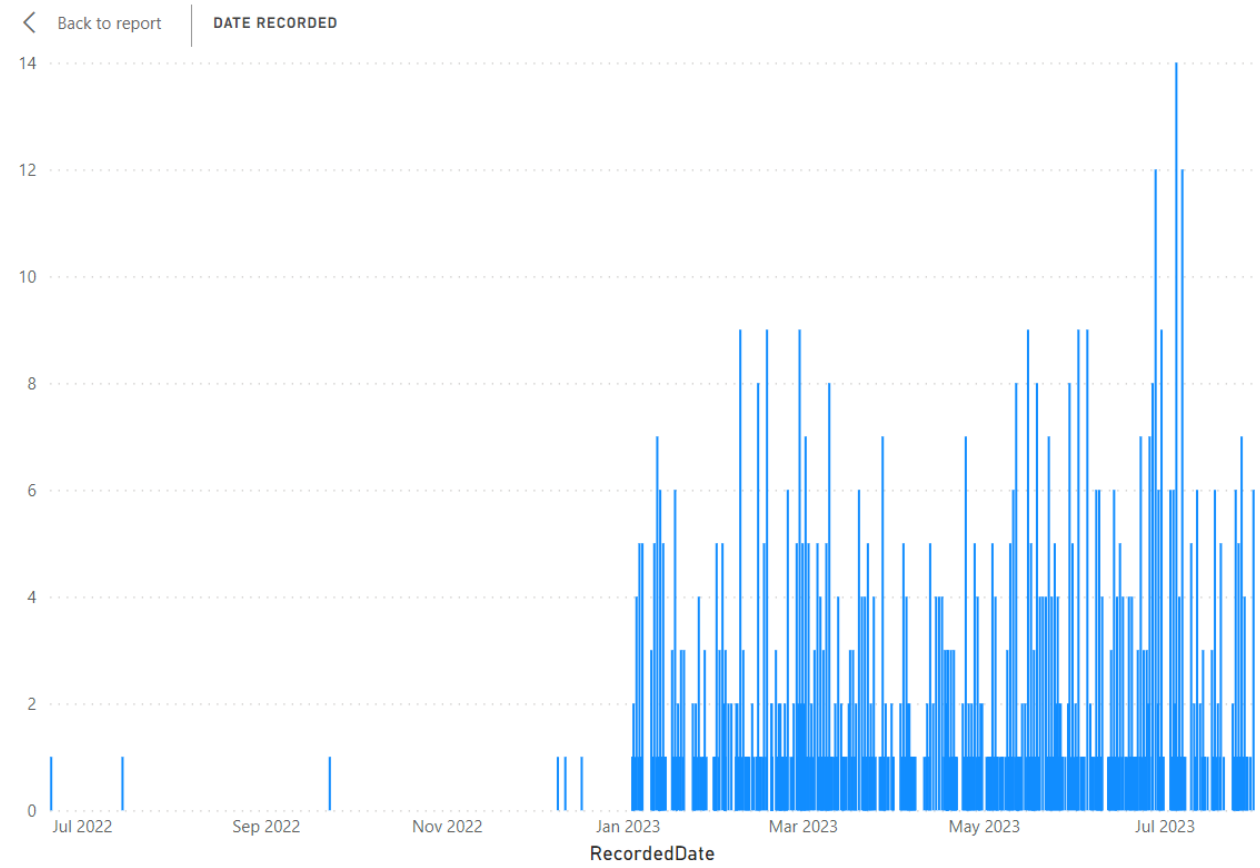
The themes noted by patients related to the quality of care, interactions with staff, and the hospital environment. Many patients reported positive experiences, praising the kindness, professionalism, and helpfulness of the staff. Some patients also mentioned the quality of the food and the cleanliness of the hospital. However, some patients also reported negative experiences, such as difficulty with communication, discomfort with the hospital environment, and issues with staffing levels.

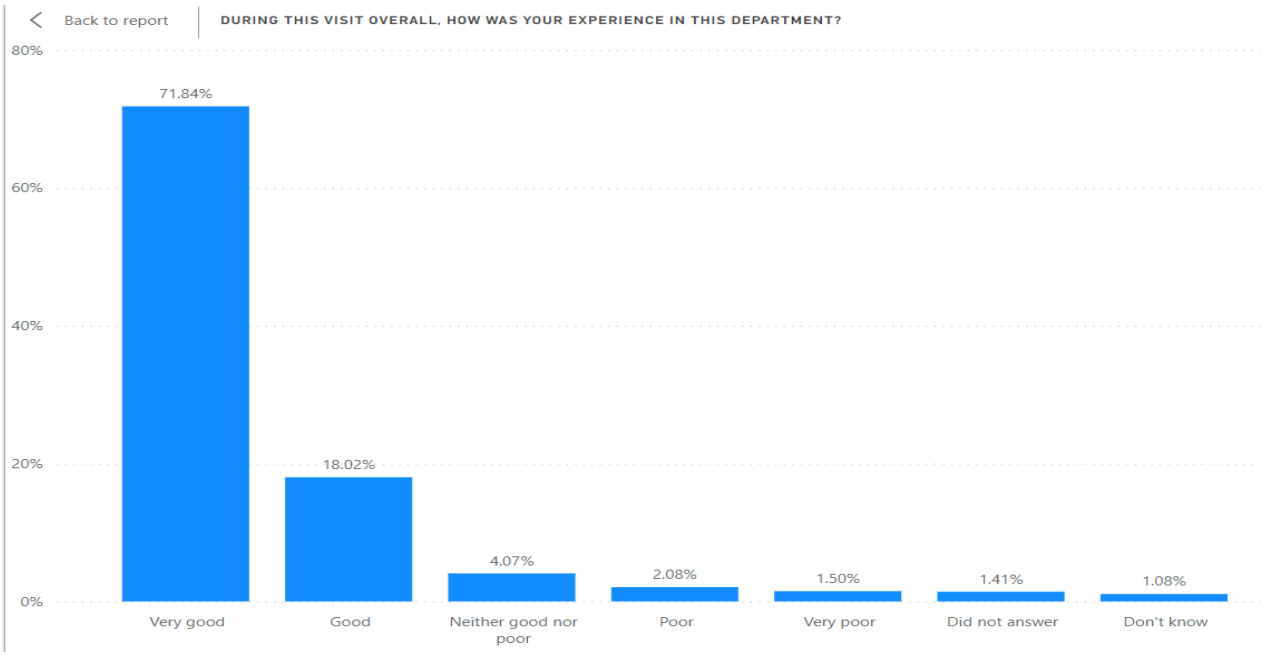
## Themes - 2023

**Themes arising relate to patients' experiences with their quality of care, interactions with staff, and the hospital environment. Many patients reported positive experiences, praising the kindness, professionalism, and helpfulness of the staff. Some patients also mentioned the quality of the food and the cleanliness of the hospital. However, some patients also reported negative experiences, such as discomfort with the hospital environment, including issues with the temperature, lighting, and bed comfort.**

# Patient Experience

## Friends and Family Test (1st April 2021 to 31st July 2023)



### Themes – 2021

**The themes arising are related to staffing, the quality of care, communication and waiting times. Positive comments were received from patients reporting staff to be friendly, helpful and professional while delivering excellent care and attention to patients, looking after their comfort and wellbeing. Negative comments were around lack of communication between staff and with the patient about their care and treatment, perceived shortage of staff which had an impact on care and long wait times to be seen by a doctor or to receive treatment.**

### Themes – 2022

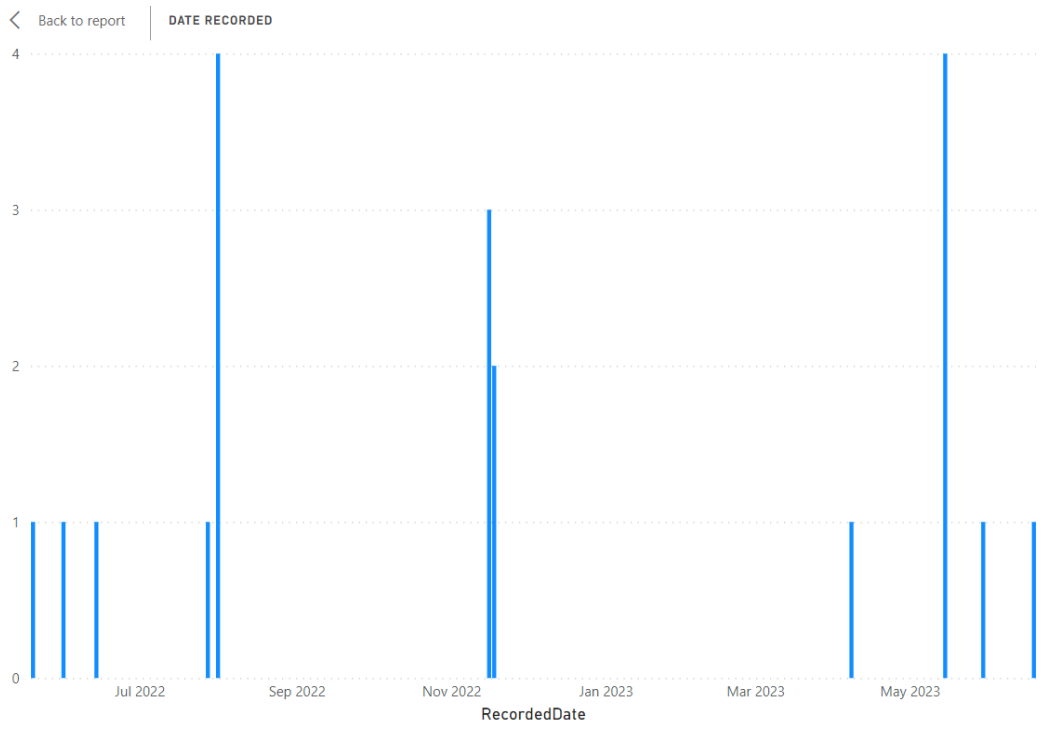
**The themes arising are around staff, appointments, communications and impacts on people with disabilities. Positive comments were received around staff being described as friendly, helpful, polite and professional, with quality of care being described as good with patients reporting good experiences with doctors and nurses generally. There were mixed views about waiting times for appointments with some being seen quickly while others faced delays or issues with scheduling appointments. Negative comments were received around how appointments were scheduled, mistakes with names, poor levels of communication from some doctors about how their care would be delivered and issues with parking on hospital sites. Patients also raised concerns about the impact of changes to the service on patients, particularly those with disabilities.**

### Themes - 2023

**The themes arising are around staff, appointments, communications and impacts on people with disabilities. Positive comments were received around staff being described as helpful, caring, kind, thoughtful, friendly, and professional with quality of care being described as good with patients reporting good experiences with doctors and nurses generally. There were mixed views about waiting times for appointments with some being seen quickly while others faced delays or issues with scheduling appointments. Negative comments were received around how appointments were scheduled and the clarity and level of information provided about what their appointment was for. Patients also raised concerns about the impact of changes to the service on patients, particularly those with disabilities.**

# Patient Experience

## Compliments (1st April 2021 to 31st July 2023)




| Recorded Date | Count |
|---|---|
| May 22 | 1 |
| June 22 | 2 |
| July 22 | 1 |
| August 22 | 4 |
| November 22 | 5 |
| April 23 | 1 |
| May 23 | 5 |
| June 23 | 1 |

### 3 Sentiments that relate to Compliment

| Sentiment | Count |
|---|---|
| Listening, Understanding, Calm | 7 |
| Listening, Understanding, Communication | 6 |
| Listening, Calm, Communication | 2 |

| | |
|---|---|
| Listening, Understanding, Environment | 1 |
| Understanding, Environment, Communication | 1 |

### 3 Health Board Values that relate to Compliment

| Value | Count |
|---|---|
| Caring, Kindness, Compassion | 6 |
| Respect, Caring, Compassion | 3 |
| Dignity, Caring, Kindness | 2 |
| Dignity, Respect, Caring | 2 |
| Dignity, Respect, Fairness | 2 |
| Dignity, Fairness, Caring | 1 |
| Dignity, Respect, Openness | 1 |
| Fairness, Caring, Kindness | 1 |
| Respect, Caring, Kindness | 1 |

### Themes – 2022

Themes arising are that patients felt staff were kind and compassionate, working hard in understaffed environments but made time for the patients.

### Themes – 2023

Themes arising is that staff were kind and caring in their support of patients, showing dignity and respect while delivering patient centred care.

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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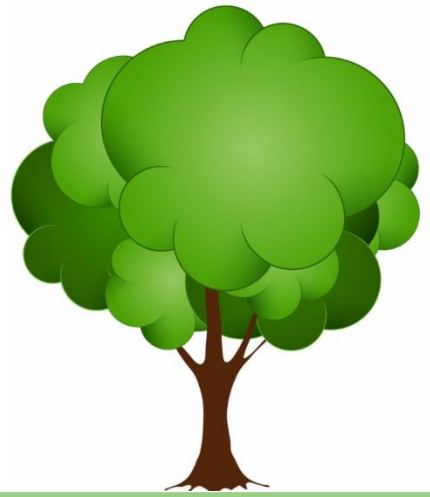
# Workforce Data

## Clinical Services Plan : Activity Modelling Workstream

## EMERGENCY GENERAL SURGERY



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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## Glossary of terms

| Term/Acronym | Definition |
|---|---|
| ESR | Electronic Staff Record – This is the National recording system within the NHS that houses all staff information. The majority of the workforce information contained within this report will have been extracted from the reporting functionality within the system. |
| WTE | Whole Time Equivalent – For the medical workforce 1WTE equates to a 40 hour working week or 10 sessions. For all other staff working in the NHS under AfC terms and conditions 1WTE equates to a full time position of 37.5 hour working week. |
| AfC | Agenda for Change is the current NHS grading and pay system for NHS staff across Wales, with the exception of doctors, dentists, apprentices and some very senior managers. |
| Cost code | The Health Board Budget is structured to take into account all areas that occur a cost and is therefore broken down into different directorate areas. Each of these areas is made up of a number of cost codes covering a particular service or location. Every member of staff employed within the Health board will be allocated a position based on their role within a cost code. This allows finance and services to track and manage their costs relating to the service area in which they work. |
| Staff group | There are 9 staff groups to which workforce will belong dependent on their role. These are:<br>Additional Professional Technical & Scientific; Additional Clinical Services; Administrative & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists; Medical & Dental; Nursing & Midwifery Registered and Students |
| TRAC | NHS Recruitment system |
| SLE | Single Lead Employment model – Since 2019, all Junior doctors are now under an SLE contract and co-located within NHS Wales Shared Services Partnership (NWSSP) ESR data to allow doctors to rotate across health boards easily. As a result we currently do not include the workforce data for our junior doctors since 2020. |

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# Workforce Data Methodology overview

As part of the Activity Modelling workstream of the Clinical Services Plan the Strategic Workforce Planning team has provided the following report to assist the Workforce picture for the issues paper.

For the 9 Service areas noted, it is agreed that the Workforce data supplied will be based on the staffing consisted within the defined cost codes provided for each area. Where needed, additional information will be discussed with Service Managers as part of the current Task & Finish groups for each service.

As the scope of the project is to look at potential configuration changes for specific services, the workforce supporting the wider pathway will not be included within the data.

The data will focus on the clinical roles within the services i.e. Medical and Nursing workforce, but where available all professional group data from the cost codes will be presented.

To ensure any interdependencies are highlighted, any known workforce risks for the service will be included.

On the following pages the supplied cost codes for the service area are noted along with the intended outputs from each data set.

Due to the complexity of the workforce breakdown of some cost codes which can cover a number of service areas, where we may have not been able to disaggregate the specific workforce aligned to the service. Where these issues are raised within the data, this has been noted within the information provided.

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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## Workforce Data Sources and outputs

| Workforce Area | Data Source | Output |
|---|---|---|
| Current Workforce | ESR Staff In Post for:<br>31st July 2023 | Table/Graph denoting current Budget, Actual and Vacancies for each of the service areas based on cost codes supplied. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). Where possible this will also include details of any Temporary Workforce utilised. |
| Workforce Risks | Risk Register / Datix:<br>31st August 2023 | Information on Current Service specific Workforce risks and any known interdependent service risks associated. |
| Historic Workforce Trend | ESR Staff in Post for<br>1st April 2018, 1st April 2019,<br>1st April 2020, 1st April 2021,<br>1st April 2022, 1st April 2023 | Table/Graph denoting current Budget, Actual and Vacancies for each of the 9 service areas based on cost codes supplied for the period April 2018 to 2023. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). |
| Starters & Leavers | ESR Staff Movements Yearly data for 1st April to 31st March for each year | Table/Graph denoting number of Starters and Leavers across each of the service areas. As above, where possible additional information will be provided for role and location however we are aware for leavers some of this data is not available within ESR. |
| Recruitment Issues | TRAC / Recruitment Team | Information in table or narrative format detailing any known targeted campaign activity for each of the service areas across the time period 2018 – 2023. Additional data were available on volume of vacancies advertised in the last 12 months for each service. |

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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# Emergency General Surgery Workforce Overview 31st July 2023

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# Emergency General Surgery Workforce as of 31st July 2023

| Staff Group | Role | Location/Site | | | | Grand Total |
|---|---|---|---|---|---|---|
| | | Bronglais General Hospital | Glangwili General Hospital | Prince Philip Hospital | Withybush General Hospital | |
| Add Prof Scientific and Technic | Physician Associate | | 1.0 | | | 1.0 |
| | Add Prof Scientific and Technic Total | | 1.0 | | | 1.0 |
| Administrative and Clerical | Clerical Worker | | 2.0 | | | |
| | Medical Secretary | | 4.1 | 1.0 | 2.4 | 7.5 |
| | Secretary | | 2.0 | | 2.0 | 4.0 |
| | Administrative and Clerical Total | | 8.1 | 1.0 | 4.4 | 13.5 |
| Medical & Dental | Associate Specialist | | 1.0 | | 2.0 | 3.0 |
| | Consultant | 5.0 | 6.0 | 2.0 | 3.0 | 16.0 |
| | Foundation Year 1 | | 3.0 | | | 3.0 |
| | Foundation Year 2 | | | | 2.0 | 2.0 |
| | Speciality Doctor | 4.0 | 7.0 | | 3.0 | 14.0 |
| | Speciality Registrar | 1.0 | | | 2.0 | 3.0 |
| | Trust Grade Doctor – Foundation Level | | 2.0 | 1.0 | | 3.0 |
| | Medical & Dental Total | 10.0 | 19.0 | 3.0 | 12.0 | 44.0 |
| Nursing and Midwifery Registered | Nurse – Advanced Practitioner | | 2.0 | | | 2.0 |
| | Nursing and Midwifery Registered Total | | 2.0 | | | 2.0 |
| | TOTAL | 10.0 | 30.1 | 4.0 | 16.4 | 60.5 |

The table above shows the workforce within the Emergency General Surgery service by role and location as of 31st July 2023. The cost codes covered are those within the General Surgery cost codes who cover the on-call rota for Emergency surgery which are:
GGH General Surgery Medical Staffing 0009, BGH General Surgery Medical Staffing 0554 and WGH General Surgery Medical Staffing 0669.

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

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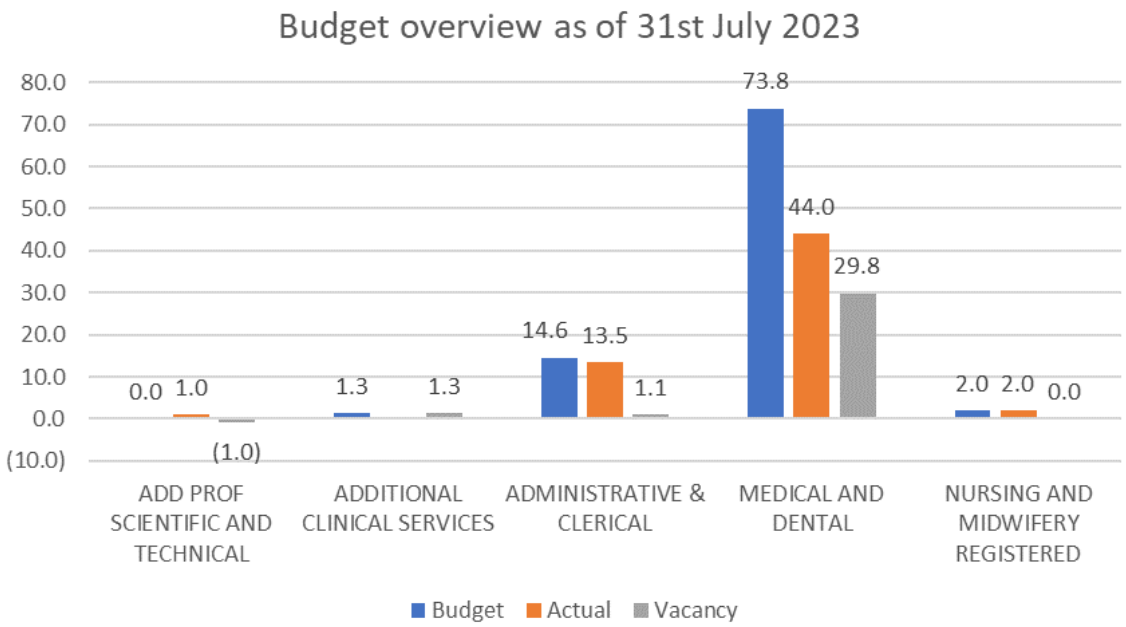
# Emergency General Surgery Workforce continued (as of 31st July 2023)

| Staff Group | Budget | Actual | Vacancy |
|---|---|---|---|
| ADD PROF SCIENTIFIC AND TECHNICAL | 0.0 | 1.0 | (1.0) |
| ADDITIONAL CLINICAL SERVICES | 1.3 | | 1.3 |
| ADMINISTRATIVE & CLERICAL | 14.6 | 13.5 | 1.1 |
| MEDICAL AND DENTAL | 73.8 | 44.0 | 29.8 |
| NURSING AND MIDWIFERY REGISTERED | 2.0 | 2.0 | 0.0 |
| Grand Total | 91.7 | 60.5 | 31.2 |




The table and graph show the current Budget, Actual workforce WTE in post and the vacancies within the Emergency General Surgery service.

As of 31st July 2023 there was a total of 31.2WTE vacancies within the service, the majority of these, 29.8WTE, are within the Medical & Dental staff group.

There are a small number of vacancies in the additional clinical services and admin & clerical staff groups. Currently there is no specified budget allocated to the Physician Associate post within the APST staff group.
There are currently a number of additional Medical agency workers within the Healthboard supporting the service. (4WTE known, awaiting additional confirmed numbers).

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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# Workforce Risks

Noted below are the workforce relates risks for Emergency General Surgery on Datix (as of 31st August 2023). These risks are linked to the vacancies in middle grade doctors and the reliance of locum doctors to sustain the medical out of hours rota.

| Service Risk Linked to 1649 | Directorate | Risk Statement | Workforce Themes | Workforce Control Mesaures in place | Current Risk Score | Previous Risk Score | Movement (↓, ↑ & ↔) | RAG Rating | Staff Group/ Groups affected |
|---|---|---|---|---|---|---|---|---|---|
| **523** | **Scheduled Care: General Surgery** | "There is a risk maintaining a day-to-day service and covering the Out of Hours on call.<br><br>This is caused by 2 middle grade doctor vacancies at GGH being covered by 2 clinical fellows ""acting up"", leaving 2 Clinical Fellow vacancies. Also, as the Green hospital for elective surgery is now in Prince Philip an additional rota has been created to provide 24-hour care.<br><br>This will lead to an impact/effect on the ability to provide care within the departmental budget. The ability to provide continuity of care to patients. The moral and motivation of the clinical teams involved.<br><br>Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital." | **Vacancies, Wellbeing, Demand & Capacity** | "Probity on the locum contracts being agreed to ensure continuity of service.<br>-Adherence to Health Board HR Policies in the management of cases.<br>-Currently 2 x middle grade vacancies at GGH - Both have been advertised and interviews are taking place February 2023.<br>-HEIW have failed to fill 3 of the 5 F2/CT posts between Feb 2023 and Aug 2023. These posts have been advertised multiple times. Current situation is 1 in post - shadowing, 1 waiting start date, 1 withdrawn. This has an impact on surgical SHO cover at GGH and the night cross cover rota at GGH, covering urology, ENT and T&O outliers.<br>-2 of the new candidates at PPH have now started and rota is in place. 3rd post being filled by Medical Bank currently. Situation will be monitored over the next 12 months. | **12** | **12** | ↔ | | **Medical** |
| **1084** | **Scheduled Care: General Surgery** | There is a risk to the sustainability of the surgical out of hours rota in PPH.<br><br>This is caused by the rota being reliant on Locum doctors.<br><br>This will lead to an impact/effect on the Surgical Green Pathway in PPH and the capacity to safely treat the elective patients. Cost implication from being reliant on locum cover.<br><br>Risk location, Prince Philip Hospital. | **Rota sustainability. Locum useage. Vacancies** | Locum cover | **9** | **6** | ↑ | | **Medical** |

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

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# Emergency General Surgery Workforce Overview Historic picture April 2018 – April 2023

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

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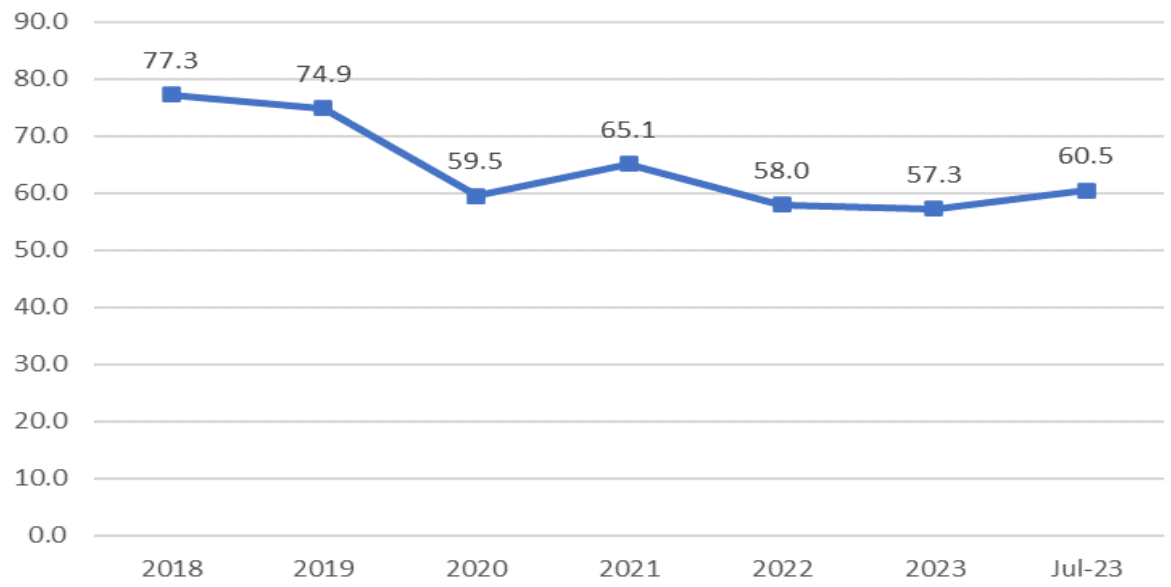
# Historic Workforce

The data below shows a historic picture of the ESR Staff in post for cost codes 0009, 0554 & 0669 as at 1st April each year.

| Emergency General Surgery Cost codes | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | Jul-23 |
|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic | | | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Administrative and Clerical | 13.5 | 12.3 | 14.5 | 14.9 | 13.3 | 13.3 | 13.5 |
| Medical and Dental | 60.9 | 59.7 | 42.0 | 47.2 | 40.9 | 41.0 | 44.0 |
| Nursing and Midwifery Registered | 3.0 | 3.0 | 2.0 | 2.0 | 2.8 | 2.0 | 2.0 |
| **TOTAL WTE** | **77.3** | **74.9** | **59.5** | **65.1** | **58.0** | **57.3** | **60.5** |

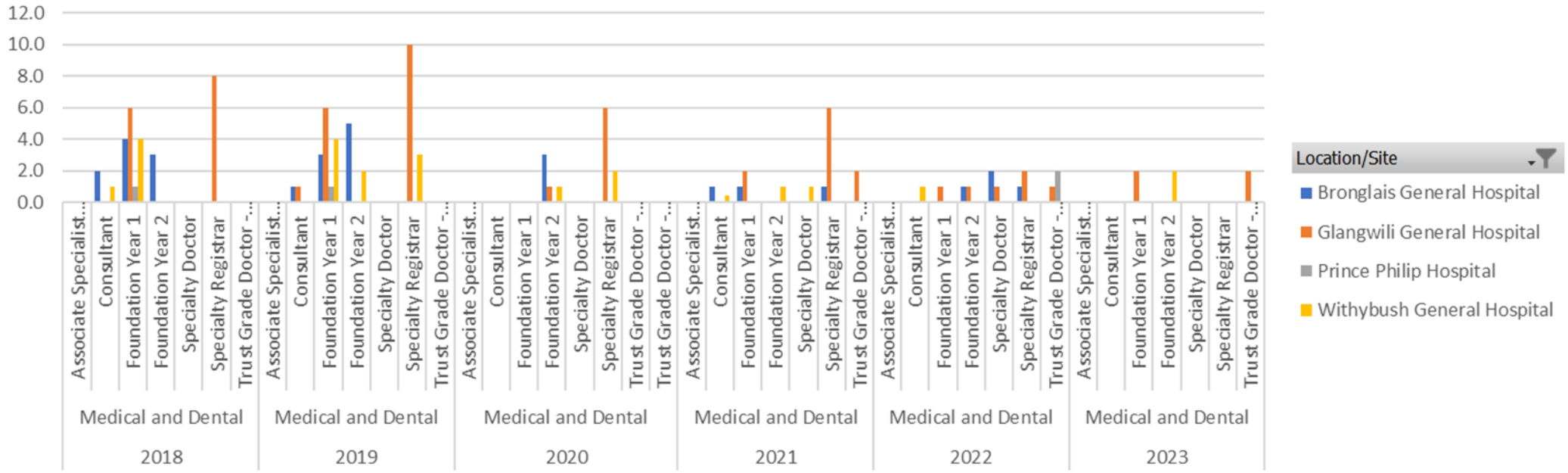



A decrease in workforce can be seen in 2020 of 15.4WTE however this corresponds with the relocation of all Foundation Year 1 (F1) junior doctors across Wales to shared services, as part of the SLE model that was introduced in 2020. In 2019 there were 15WTE F1 doctors in the Health board therefore this decrease can be directly linked to the F1 transfer.
An increase of 5.2WTE in Medical roles was seen in 2021 however this has decreased over the next 2 years.

**Additional service insights**

**ANY ADDITIONAL SERVICE INSIGHTS CAN BE ADDED HERE**

# Starters



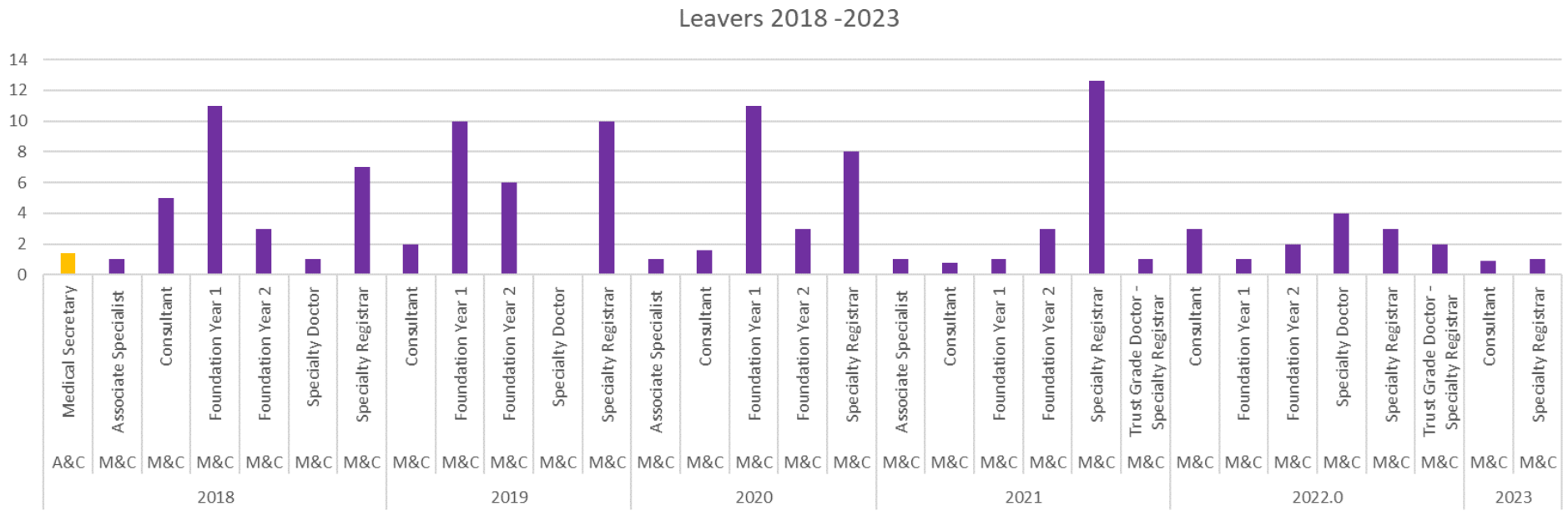

| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| **Starters** | 29 | 36 | 13 | 15.4 | 13 | 6 |

Since 2021 there has been a decrease in the number of Medical staff starting in General Surgery. As stated earlier in the report since 2020 the Foundation year doctors are now under the SLE model and therefore do not appear in the data consequently we would expect a decrease overall. However, there has also been a noted decrease in Speciality registrars entering the since 2021.

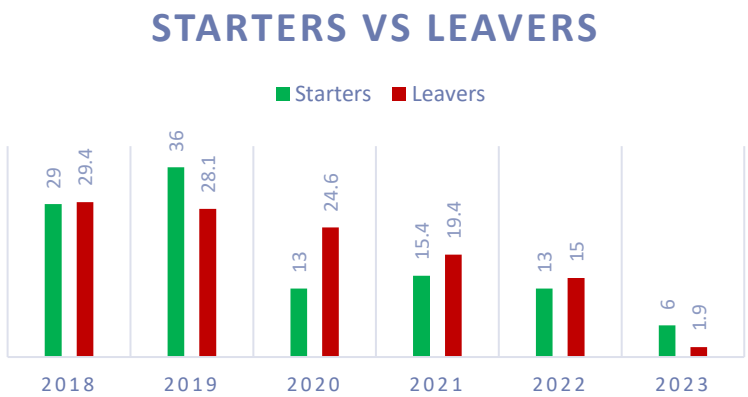
DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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

# Leavers




| Leavers | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| Admin & Clerical | 1.4 | | | | | |
| Medical & Dental | 28 | 28.1 | 24.6 | 19.4 | 15 | 1.9 |
| **TOTAL** | **29.4** | **28.1** | **24.6** | **19.4** | **15** | **1.9** |




There has been a consistent number of leavers across the workforce within Emergency General surgery with an alarming number of Speciality registrars leaving in 2021 (12.6).
As can be seen in the comparator graph below since 2020 there has been consistently more leavers across the service than starters.

ANY ADDITIONAL INSIGHTS FROM THE SERVICE

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

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

# Recruitment

## Targeted Campaigns across the period 2018 – 2023:

No targeted recruitment campaigns were noted during the period for Emergency General Surgery however the Consultant and Locum Consultant posts may fall into the hard to fill category and therefore discussions with the service on potential campaigns will commence.

## Vacancy /Recruitment overview:

| Vacancy Information (last 12 months) | Role | Outcomes |
|---|---|---|
| 100-MED-WGH-147 | Specialty Doctor | 1wte - currently in shortlist |
| 100-MED-GGH-245 | Specialty Doctor | 1wte - started in post |
| 100-MED-BGH-105 | Clinical Fellow | 1wte - started in post |
| 100-MED-GGH-255 | Trust Doctor (F1) | 1wte - started in post |
| 100-MED-BGH-104 | Specialty Doctor | 1wte - started in post |
| 100-MED-GGH-210-C | Trust Doctor (F1) | 1wte - candidate withdrew |
| 100-MED-WGH-122 | Clinical Fellow | 1wte - started in post |
| 100-MED-GGH-248 | Specialty Doctor | 1wte - started in post |
| 100-MED-GGH-210-B | Trust Doctor (F1) | 2wte - 1 started in post |
| 100-MED-WGH-109-A | Trust Junior Clinical Fellow | 2wte - 2 started in post |
| 100-MED-WGH-102 | Consultant in General Surgery | 2 WTE, 6 applications received but 5 were not eligible and 1 rejected at shortlisting stage. Service confirmed they were not going back out to advert. |
| 100-MED-WGH-124-L | Locum Consultant in General Surg | 2 WTE, 2 offers made, 1 started in post and the other one withdrew due to personal reasons, service did not confirm in going back out to advert |

## Headhunting:

To date no targeted headhunting has taken place for Emergency General Surgery.
However a full print page was placed within the British Medical Journal to attract applicants to the Consultant in General Surgery post.

**Hywel Dda University Health Board**
**Equality Impact Assessment (EqIA)**

**Please note:**

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

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

The completed Equality Impact Assessment (EqIA) must be:

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

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

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

**Form 1: Overview**

| | | |
|---|---|---|
| **1.** | **What are you Equality Impact assessing?** | Emergency General Surgery Service in Hywel Dda University Health Board. |
| **2.** | **Brief Aims and Description** | Emergency General Surgery or EGS is the assessment and treatment of any acute surgical admissions.<br><br>Emergency General Survey is a service for patients 16 years and older. Patients under the age of 16 are treated through Paediatric Ambulatory Care Units (PACUs).<br><br>Patients access the service via emergency departments. This can be via ambulance or by patients making their own way to the department, referrals from other acute specialities, outpatient clinics or potentially via an emergency referral from their GP. If there is a surgical requirement the patient will be referred for Emergency Surgery and admitted to an appropriate ward post operatively.<br><br>The patient will undertake their recovery within the site surgery took place. Although there may be times when a patient is not admitted to and EGS ward, the EGS consultant responsible for their care will oversee recovery until discharge. |
| **3.** | **Who is involved in undertaking this EqIA?** | Caroline Lewis, Service Delivery Manager<br>David Lewis, Service Manager<br>Karen Howarth, Senior Nurse Manager<br>Dawn Davies, Surgical Care Practitioner<br>Andrew Burns, Hospital Director (WGH)<br>Samy Mohamed, Consultant Surgeon<br>Andrew Deans, Consultant Surgeon |

| | | |
|---|---|---|
| **4.** | **Is the Policy related to other policies/areas of work?** | Acute Specialties<br>A&E<br>SDEC<br>Anaesthetics<br>Critical Care<br>Medicine<br>Endoscopy<br>Theatres<br>Trauma<br>Maternity<br>Paediatric<br>Gynaecology<br>ART team<br>- All Wales Safeguarding Procedure (policy no. 868) 868 - All Wales Safeguarding Procedures (sharepoint.com)<br>- Clinical Supervision Policy (policy no. 415) 415 - Clinical Supervision Policy - Psychologists, Psychotherapists, Psychological Therapists and Counsellors (sharepoint.com)<br>- Clinical Record Keeping Policy (policy no. 195) 195 - Clinical Record Keeping Policy (sharepoint.com)<br>- Equality and Diversity Policy (policy no. 133) hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/equality-diversity-and-inclusion-policy/<br>- All NICE and other National Guidance Implementation Policy (policy no. 013) 013 - Management of NICE and other National Guidance Policy (sharepoint.com)<br><br>Getting it Right First Time (GIRFT) Recommendation |
| **5.** | **Who will be affected by the strategy / policy / plan / procedure / service?**<br>(Consider staff as well as the population that the project / change may affect to different degrees) | EGS Staff<br>Wider Health Board Staff<br>Patients/Service Users<br>General population of Hywel Dda University Health Board<br>Visitors to the health board footprint<br>Key partner agencies |
| **6.** | **What might help/hinder the success of the Policy?** | Awareness of the service across the health board<br>Continued engagement from partner agencies (including but not limited to Welsh Ambulance Service Trust)<br>Continued staff engagement |

**Form 2: Human Rights**

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

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

| **Consider, is the Policy relevant to:** | **Yes** | **No** |
|---|---|---|
| **Article 2: The right to life**<br><br>**Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control | ✓ | |
| **Article 3: The right not to be tortured or treated in an inhuman or degrading way**<br><br>**Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control | ✓ | |
| **Article 5: The right to liberty**<br><br>**Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control | ✓ | |
| **Article 6: The right to a fair trial**<br><br>**Example**: issues of patient choice, control, empowerment and independence | ✓ | |
| **Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control**<br><br>**Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life | ✓ | |
| **Article 11: The right to freedom of thought, conscience and religion**<br><br>**Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers | ✓ | |

| How will the strategy, policy, plan, procedure and/or service impact on: | Positive | Negative | No impact | Potential positive and / or negative impacts<br><br>Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data. | Opportunities for improvement / mitigation<br><br>If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan. |
|---|---|---|---|---|---|
| **Age**<br>Is it likely to affect older and younger people in different ways or affect one age group and not another? | ✓ | | | **Population Data** | |

| Year (data was collected) | Hywel Dda University Health Board Population – 2021 Census | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| County | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Total | |
| Measure | value | percent | value | percent | value | percent | value | percent |
| Age | | | | | | | | |
| Total: All usual residents | 187,895 | 100 | 71,468 | 100 | 123,366 | 100 | 382,729 | 100.0 |
| Aged 4 years and under | 9,057 | 4.8 | 2,706 | 3.8 | 5,586 | 4.5 | 17,349 | 4.4 |
| Aged 5 to 9 years | 10,274 | 5.5 | 3,288 | 4.6 | 6,731 | 5.5 | 20,293 | 5.2 |
| Aged 10 to 15 years | 13,080 | 7 | 4,087 | 5.7 | 8,494 | 6.9 | 25,661 | 6.5 |
| Aged 16 to 19 years | 7,799 | 4.2 | 4,129 | 5.8 | 4,890 | 4 | 16,818 | 4.7 |
| Aged 20 to 24 years | 8,821 | 4.7 | 6,366 | 8.9 | 5,621 | 4.6 | 20,808 | 6.1 |
| Aged 25 to 34 years | 20,692 | 11 | 7,106 | 9.9 | 12,907 | 10.5 | 40,705 | 10.5 |
| Aged 35 to 49 years | 31,801 | 16.9 | 10,145 | 14.2 | 19,459 | 15.8 | 61,405 | 15.6 |
| Aged 50 to 64 years | 40,905 | 21.8 | 15,256 | 21.3 | 27,335 | 22.2 | 83,496 | 21.8 |
| Aged 65 to 74 years | 24,605 | 13.1 | 9,942 | 13.9 | 17,444 | 14.1 | 51,991 | 13.7 |
| Aged 75 to 84 years | 15,246 | 8.1 | 6,095 | 8.5 | 10,855 | 8.8 | 32,196 | 8.5 |
| Aged 85 years and over | 5,615 | 3 | 2,348 | 3.3 | 4,044 | 3.3 | 12,007 | 3.2 |

We can see here that there is an aging population in the Hywel Dda footprint, with 47.2% of the population over the age of 50

**Patient Data**

Out of 4609 patients from Dec 2022 – Nov 2023, 1993 were recorded as being 65+, which is 43% of all patients admitted. This is not in line with the general population, of which 22.2 are over the age of 65. At present no additional engagement is undertaken for this population group, however this will be reviewed to see if this is required.

Patients of all ages will be accepted into the services, however;

- Treatment plans are decided by the accepting clinician. Patients must be fit enough to undergo surgery
- Age alone is not a factor in determining a patients treatment plan.
- Conservative treatment plans may be considered for patients with multiple co-morbidities

**Staff Information**

| *Age* | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***30 and under*** | ***31-35*** | ***36-40*** | ***41-50*** | ***51-55*** | ***56-60*** | ***61 and over*** | ***Grand Total*** |
| ***14*** | ***20*** | ***16*** | ***9*** | ***10*** | ***9*** | ***9*** | ***87*** |

**Positive Impacts:**
All health board staff undertake equality (in particular Safeguarding Adults, Safeguarding Children and Dementia Awareness modules relating to age) as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

**Negative Impacts:**
Older people are disproportionately affected by the conditions noted above and make up the majority of patients within the service. This cohort of patients are frequently associated with age related disability.

There is a car/ambulance transport service available for eligible patients to use.

Patients travelling by car/ambulance transport or with additional needs are given priority in order to spend less time in the hospital premises, avoiding additional waiting time.

Older patients have access to free public transport. Hospital sites across the health board are located close to public transport routes and links.

<table>
<tr>
<td></td>
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<td>All sites will have accessible toilets either directly in the service area or nearby.<br><br>Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking.<br><br>Portering service is available to support patient mobility across the hospitals.</td>
</tr>
<tr>
<td>Disability<br>Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes</td>
<td>✓</td>
<td></td>
<td></td>
<td>Population Data<br><br>
<table>
<tr><th></th><th>Carmarthenshire</th><th>Ceredigion</th><th>Pembrokeshire</th><th>Total</th></tr>
<tr><td>Disabled under the Equality Act: Day-to-day activities limited a lot</td><td>21255</td><td>6686</td><td>12522</td><td>40463</td></tr>
<tr><td>Disabled under the Equality Act: Day-to-day activities limited a little</td><td>21897</td><td>8951</td><td>14651</td><td>45499</td></tr>
<tr><td></td><td>43152</td><td>15637</td><td>27173</td><td></td></tr>
</table>
<br>Patient Data<br><br>Out of 4609 patients from Dec 2022 – Nov 2023, 26 people were recorded as having a physical or psychological disability<br><br>Disabled and able-bodied patients are all accepted into the services, however;</td>
<td></td>
</tr>
</table>

- Treatment plans are decided by the accepting clinician. Patients must be fit enough to undergo surgery
- Disability alone is not a factor in determining a patients treatment plan.
- Conservative treatment plans may be considered for patients with multiple co-morbidities.

At this moment in time, we do not have the disability status information about patients within the service, however this will be reviewed in 12 months time.

**Service Data**
At this moment in time, we do not have the disability status information about staff members working within Emergency General Surgery, however this will be included at the earliest possible opportunity

| ***Disability*** | | |
|---|---|---|
| ***No*** | ***Not Declared/Not recorded on ESR*** | ***Grand Total*** |
| ***72*** | ***15*** | ***87*** |

**Positive Impacts:**
Patients with disability can have issues with:

- Understanding letters (dyslexia & other types of neurodivergence)
- Making enquiries/asking for help (communication difficulties)
- Difficulty sitting in crowded noisy waiting areas (autism) and facing long waiting times
- Difficulty attending appointments or other social engagements (OCD, bipolar, anxiety, depression)

All health board staff undertake equality training (including Paul Ridd Learning Disability Awareness, Safeguarding, Equality, Diversity and Human Rights, Autism Awareness and Mental Capacity Act) relating specifically to disabilities as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including ‘Person Centred Approach’ training module.

Treatment plans are decided by the accepting clinician

There is a car/ambulance transport service available for eligible patients to use.

Patients travelling by car/ambulance transport or with

| | | | | | |
|---|---|---|---|---|---|
| | | | | **Negative Impacts:**<br>Patients must be fit enough to undergo surgery.<br><br>Older people are disproportionately affected by the conditions noted above and make up the majority of patients within the service. This cohort of patients are frequently associated with age related disability. | additional needs are given priority in order to spend less time in the hospital premises, avoiding additional waiting time.<br><br>Older patients have access to free public transport. Hospital sites across the health board are located close to public transport routes and links.<br><br>All sites will have accessible toilets either directly in the service area or nearby.<br><br>Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking.<br><br>Portering service is available to support patient mobility across the hospitals. |

**Gender Reassignment**
Consider the potential impact on individuals who either:

•Have undergone, intend to undergo or are currently undergoing gender reassignment.
•Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.

✓

**Population Data**

| Year (data was collected) | Hywel Dda University Health Board Census Data - 2021 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Total | |
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Gender** | | | | | | | | |
| All persons | 187,897 | 100 | 71,475 | 100 | 123,360 | 100 | 382,732 | 100.0 |
| Male | 91,685 | 48.8 | 34,963 | 48.9 | 60,071 | 48.7 | 186,719 | 48.8 |
| Female | 96,212 | 51.2 | 36,512 | 51.1 | 63,289 | 51.3 | 196,013 | 51.2 |
| **Gender identity the same as sex registered at birth** | **144,924** | **93.2** | **55,874** | **91** | **95,794** | **93.4** | **296,592** | **92.5** |
| **Gender identity different from sex registered at birth but no specific identity given** | **210** | **0.1** | **84** | **0.1** | **121** | **0.1** | **415** | **0.1** |
| **Trans woman** | **93** | **0.1** | **73** | **0.1** | **58** | **0.1** | **224** | **0.1** |
| **Trans man** | **90** | **0.1** | **62** | **0.1** | **66** | **0.1** | **218** | **0.1** |
| **Non-binary** | **60** | **0** | **143** | **0.2** | **40** | **0** | **243** | **0.1** |
| All other gender identities | 38 | 0 | 66 | 0.1 | 32 | 0 | 136 | 0.0 |

**Patient Data**

No patient data exists to inform service position. Currently, as gender reassignment is not a factor in an emergency pathway there are no plans to collect this data. However, whether this needs to be revised will be considered.

Very small numbers of patients having undergone gender reassignment are present within the service.

No impact accessing the service foreseen based on a patient with gender reassignment.

Each patient is reviewed on a case-by-case basis to ensure the patients' needs are tailored to their specific requirements to make their journey as easy as possible.

Patient confidentiality is maintained using health board guidelines regarding confidentiality.

No impact is foreseen based on gender reassignment. This is not a factor in an emergency pathway, this will be reviewed when undertaking service change

**Staff Data**
Information regarding gender reassignment is not currently collected, however this will be reviewed if necessary.

**Positive Impacts:**
All health board staff undertake equality (Equalities, Diversity and Human Rights) training as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

Each patient is reviewed on a case-by-case basis to ensure the patients' needs are tailored to their specific requirements to make their journey as easy as possible.

Patient confidentiality is maintained using health board guidelines regarding confidentiality.

**Negative Impacts:**
Currently, no negative impact is foreseen on the basis of gender reassignment. This is not a factor in an emergency pathway.

**Marriage and Civil Partnership**
This also covers those who are not married or in a civil partnership.

✓

**Population Data**

| **Year (data was collected)** | **Hywel Dda University Health Board Census Data - 2021** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Total | |
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Marital Status** | | | | | | | | |
| Total: All usual residents aged 16 and over | 155,488 | 100 | 61,389 | 100 | 102,551 | 100 | 319,428 | 100.0 |
| Never married and never registered a civil partnership | 50,384 | 32.4 | 23,766 | 38.7 | 32,566 | 31.8 | 106,716 | 34.3 |
| Married or in a registered civil partnership | 73,529 | 47.3 | 26,468 | 43.1 | 48,487 | 47.3 | 148,484 | 45.9 |
| Married | 73,191 | 47.1 | 26,292 | 42.8 | 48,264 | 47.1 | 147,747 | 45.7 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | In a registered civil partnership | 338 | 0.2 | 176 | 0.3 | 223 | 0.2 | 737 | 0.2 |
| | | | | Separated, but still legally married or still legally in a civil partnership | 3,157 | 2 | 1,029 | 1.7 | 2,210 | 2.2 | 6,396 | 2.0 |
| | | | | Divorced or civil partnership dissolved | 16,309 | 10.5 | 5,681 | 9.3 | 10,912 | 10.6 | 32,902 | 10.1 |
| | | | | Widowed or surviving civil partnership partner | 12,109 | 7.8 | 4,445 | 7.2 | 8,376 | 8.2 | 24,930 | 7.7 |

Marital status of patients is not currently collected, however this will be reviewed in 12 months time.

At this moment in time, no impact is foreseen based on a person's marital status. This is not a factor in an emergency pathway, this will be reviewed when undertaking service change.

<table>
<tr>
<td>Pregnancy and Maternity<br>Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.</td>
<td></td>
<td>✓</td>
<td></td>
<td>Population Data<br><br>In 2021, there were 29,007 births registered across Wales.<br>Maternity and birth statistics: 2021 | GOV.WALES<br><br>The estimated prevalence of cataracts calculated in 2020 for those aged 20-39 years was 3.01%.<br>Prevalence | Background information | Cataracts | CKS | NICE<br><br>Patient Data<br><br>Patients are asked if they are likely to be pregnant during assessment. Data regarding pregnancy and maternity is currently not held by the health board.<br><br>Potential Negative Impact:<br>Where we know a patient is pregnant, risks involved in treatment upon the unborn baby are discussed with the patient. Each situation is reviewed on a case by case basis and a treatment plan agreed with the patient based on a risk assessment. WGH do not have any on call Obst & Gynae on site. Teams seek advice from GGH when deciding a treatment plan<br><br>Certain procedures are not routinely carried out on pregnant people. Wherever possible general anaesthesia is avoided when considering a treatment plan, however general anaesthesia may be required depending on the acute nature of the problem. Teams in GGH and BGH will collaborate with Obst & Gynae as part of an MDT, which will also include Radiologist and Anaesthetist</td>
<td>Teams from WGH seek advice from GGH when deciding a treatment plan</td>
</tr>
<tr>
<td>Race/Ethnicity or Nationality<br>People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Population Data<br><br>
<table>
<tr><td>Year (data was collected)</td><td colspan="8">Hywel Dda University Health Board Census Data - 2021</td></tr>
<tr><td>County</td><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Totals</td></tr>
<tr><td>Measure</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr>
<tr><td>Ethnicity</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
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<td></td>
</tr>
</table>

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Total: All usual residents | 187,898 | 100 | 71,473 | 100 | 123,359 | 100 | 382,730 | 100 |
| Asian, Asian British or Asian Welsh | 2,321 | 1.2 | 1,096 | 1.5 | 1,159 | 0.9 | 4,576 | 1.2 |
| Black, Black British, Black Welsh, Caribbean or African | 455 | 0.2 | 366 | 0.5 | 244 | 0.2 | 1,065 | 0.3 |
| Mixed or Multiple ethnic groups | 1,756 | 0.9 | 867 | 1.2 | 1,162 | 0.9 | 3,785 | 1 |
| White | 182,652 | 97.2 | 68,776 | 96.2 | 120,375 | 97.6 | 371,803 | 97 |
| Gypsy or Traveller | 450 | 0.2 | 55 | 0.08 | 585 | 0.5 | 1,090 | 0.3 |
| Other ethnic group | 714 | 0.4 | 368 | 0.5 | 419 | 0.3 | 1,501 | 0.4 |

**Patient Data**

Out of 4609 patients from Dec 2022 – Nov 2023, 24 patients identified themselves as having BAME ethnicity and 2 identified as ‘white European’. This is broadly in line with the general population.

As an emergency presents, a person's race or nationality is not a factor when considering a treatment plan. Consultants will need to undertake a clinical assessment taking a person's circumstance into account when reviewing post-surgical recovery. This could include but it not limited to a person who may be on holiday and would need care transferred to another part of the UK or country.

No impact is foreseen based on a person's race or ethnicity. This is not a factor within an emergency pathway. Nationality could only have an impact on post procedure care when arrangements for ongoing care need to be arranged.

The Health Board will provide details about a patients care

| | | | | | |
|---|---|---|---|---|---|
| | | | | **Staff Information**<br><br>*Ethnicity*<br>*White* \| *BAME* \| *Not Stated / Not recorded* \| *Grand Total*<br>*32* \| *42* \| *13* \| *87*<br><br>**Positive Impacts:**<br><br>All health board staff undertake equality training (including Equality, Diversity and Human Rights and Treat me fairly) as part of mandatory competency training. New employees of the health board will undergo a corporate induction process including 'Person Centred Approach' modules.<br><br>**Negative Impacts:**<br>A non-English or Welsh speaker may be unable to communicate to staff.<br><br>The service are currently unaware if certain drugs that are delivered orally contain animal products that would be suitable for particular groups. All patients are asked if they are allergic to particular substances which will capture products a patient cannot be administered. | received to the patient to pass onto their local health care provider<br><br>The Healthboard has access to a translation service for patients who are unable to communicate in English or Welsh<br><br>The specialist pharmacy service can support when managing situations where a patient is known to be unable to be administered specific drugs. |
| **Religion or Belief (or non-belief)**<br>The term 'religion' includes a religious or philosophical belief. | ✓ | | | **Population Data**<br><br>**Year (data was collected)** \| **Hywel Dda University Health Board Census Data - 2021** | |

| County | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Totals | |
|---|---|---|---|---|---|---|---|---|
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Religion** | | | | | | | | |
| Total: All usual residents | 187,899 | 100 | 71,476 | 100 | 123,363 | 100 | 382,738 | 100.0 |
| No religion | 83,409 | 44.4 | 30,749 | 43 | 52,998 | 43 | 167,156 | 43.5 |
| Christian | 89,378 | 47.6 | 33,409 | 46.7 | 60,174 | 48.8 | 182,961 | 47.7 |
| Buddhist | 557 | 0.3 | 378 | 0.5 | 462 | 0.4 | 1,397 | 0.4 |
| Hindu | 419 | 0.2 | 158 | 0.2 | 161 | 0.1 | 738 | 0.2 |
| Jewish | 103 | 0.1 | 75 | 0.1 | 58 | 0 | 236 | 0.1 |
| Muslim | 1,026 | 0.5 | 515 | 0.7 | 587 | 0.5 | 2,128 | 0.6 |
| Sikh | 177 | 0.1 | 35 | 0 | 32 | 0 | 244 | 0.0 |
| Other religion | 1,127 | 0.6 | 677 | 0.9 | 746 | 0.6 | 2,550 | 0.7 |
| Not answered | 11,703 | 6.2 | 5,480 | 7.7 | 8,145 | 6.6 | 25,328 | 6.8 |

**Patient Data**

Data regarding a patient's religion or belief is not currently collected. This will be reviewed in 12 months time.

As an emergency presents, a person's race or nationality is not a factor when considering a treatment plan. Consultants will need to undertake a clinical assessment taking a person's circumstance into account when reviewing post-surgical recovery. This could include but it not limited to a person who may be on holiday and would need care transferred to another part of the UK or country.

There is an additional consent form for Jehovah Witness to complete. This ensures a persons religious beliefs are maintained.

**Staff Data**

***Religious Belief***

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

| *Christianity* | *Islam* | *Hinduism* | *Atheism / Other* | *Not Declared/Not recorded on ESR* | *Grand Total* |
|---|---|---|---|---|---|
| *11* | *18* | *6* | *5* | *47* | *87* |

**Positive Impacts:**
All health board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically relating to race and ethnicity as part of mandatory competency training.

Cell Saver technology allows for surgery to take place when the patients belief does not permit a blood transfusion.

**Negative Impacts:**
The service are currently unaware if certain drugs that are delivered orally contain animal products that would be suitable for particular groups. All patients are asked if they are allergic to particular substances which will capture products a patient cannot be administered.

The specialist pharmacy service can support when managing situations where a patient is known to be unable to be administered specific drugs.

**Sex**
Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?

✓

**Population Data**

| **Year (data was collected)** | **Hywel Dda University Health Board Census Data - 2021** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Total | |
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Gender** | | | | | | | | |
| All persons | 187,897 | 100 | 71,475 | 100 | 123,360 | 100 | 382,732 | 100.0 |
| Male | 91,685 | 48.8 | 34,963 | 48.9 | 60,071 | 48.7 | 186,719 | 48.8 |
| Female | 96,212 | 51.2 | 36,512 | 51.1 | 63,289 | 51.3 | 196,013 | 51.2 |
| Gender identity the same | 144,924 | 93.2 | 55,874 | 91 | 95,794 | 93.4 | 296,592 | 92.5 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| as sex registered at birth | | | | | | | | | |
| Gender identity different from sex registered at birth but no specific identity given | 210 | 0.1 | 84 | 0.1 | 121 | 0.1 | 415 | 0.1 |
| Trans woman | 93 | 0.1 | 73 | 0.1 | 58 | 0.1 | 224 | 0.1 |
| Trans man | 90 | 0.1 | 62 | 0.1 | 66 | 0.1 | 218 | 0.1 |
| Non-binary | 60 | 0 | 143 | 0.2 | 40 | 0 | 243 | 0.1 |
| All other gender identities | 38 | 0 | 66 | 0.1 | 32 | 0 | 136 | 0.0 |

**Patient Data**

Out of 4609 patients from Dec 2022 – Nov 2023, 2486 were female and 2123 were male, this split broadly matches the general population data

**Staff Information**

| ***Gender*** | | |
|---|---|---|
| ***Female*** | ***Male*** | ***Grand Total*** |
| ***24*** | ***63*** | ***87*** |

**Positive Impact:**
All health board staff undertake equalities training (including Equality, Diversity and Human Rights) as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

There are male and female staff in the service and where possible, if a patient requests a specific gender of staff for their review, this will be provided.

If a staff member of a specific gender is not available, another staff member can be present during consultation as a chaperone.

**Negative Impact:**
Currently, no negative impact on the basis of gender is foreseen. This is not a factor in an emergency pathway, this will be reviewed during any service changes.

**Sexual Orientation**
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

✓

**Population Data**

| **Year (data was collected)** | **Hywel Dda University Health Board Census Data - 2021** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Totals | |
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Sexual Orientation** | | | | | | | | |
| Total: All usual residents aged 16 years and over | 155,486 | 100 | 61,391 | 100 | 102,551 | 100 | 319,428 | 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 | 1,617 | 2.6 | 1,050 | 1 | 4,167 | 1.5 |
| Pansexual | 202 | 0.1 | 225 | 0.4 | 149 | 0.1 | 576 | 0.2 |
| Asexual | 79 | 0.1 | 140 | 0.2 | 52 | 0.1 | 271 | 0.1 |
| Queer | 23 | 0 | 49 | 0.1 | 12 | 0 | 84 | 0.0 |
| All other sexual orientations | 19 | 0 | 16 | 0 | 7 | 0 | 42 | 0.0 |

**Patient Data**
Data regarding a patient's sexual orientation is not currently collected. This will be reviewed in 12 months time.

No impact is foreseen based on a person's sexual orientation. This is not a factor within an emergency pathway, although this will be reviewed in 12 months' time.

**Staff Information**

| *Sexual Orientation* | | |
|---|---|---|
| ***Heterosexual / Straight*** | ***Not Declared/Not recorded on ESR*** | ***Grand Total*** |
| ***38*** | ***49*** | ***87*** |

**Positive Impact**
All health board staff undertake equalities training (including Equality, Diversity and Human Rights) relating specifically relating to religion or belief as part of mandatory competency training

**Negative Impact:**
Currently, no negative impact on the basis of sexual orientation is foreseen. This is not a factor in an emergency pathway, this will be reviewed during any service changes.

**Armed Forces**
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

✓

**Population Data**

| | Carmarthenshire | Ceredigion | Pembrokeshire | Totals |
|---|---|---|---|---|
| Previously served in the UK regular armed forces | 5610 | 1851 | 4654 | **12115** |
| Previously served in UK reserve armed forces | 1334 | 537 | 930 | **2801** |
| Previously served in both regular and reserve UK armed forces | 336 | 137 | 248 | **721** |
| | **7280** | **2525** | **5832** | **15637** |

| | | | | | |
|---|---|---|---|---|---|
| and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'<br><br>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance** | | | | Due to nature of emergency surgery, all patients are treated as they present. As such, no impact is foreseen on this basis. This will be reviewed during any service changes. | |
| **Socio-economic Deprivation**<br>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.<br><br>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty** | | | ✓ | **Population Data**<br><br>Information to inform on Socio-economic deprivation is hard to obtain. However, economic activity information is available on the 2021 census. We are aware that there are areas within the health board footprint of considerable deprivation. The below table notes economic activity within the health board footprint. | |

| **Year (data was collected)** | **Hywel Dda University Health Board Census Data - 2021** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County** | Carmarthenshire | | Ceredigion | | Pembrokeshire | | Totals | |
| **Measure** | value | percent | value | percent | value | percent | value | percent |
| **Economic Factor** | | | | | | | | |
| Total: All usual residents aged 16 years and over | 155,487 | 100 | 61,392 | 100 | 102,551 | 100 | 319,430 | 100.0 |
| Economically active (excluding full-time students) | 83,262 | 53.5 | 29,845 | 48.6 | 54,182 | 52.8 | 167,289 | 51.6 |
| In employment | 79,927 | 51.4 | 28,718 | 46.8 | 51,697 | 50.4 | 160,342 | 49.5 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Unemployed | 3,335 | 2.1 | 1,127 | 1.8 | 2,485 | 2.4 | 6,947 | 2.1 |
| Economically active and a full-time student | 2,612 | 1.7 | 2,119 | 3.5 | 1,352 | 1.3 | 6,083 | 2.2 |
| In employment | 2,025 | 1.3 | 1,401 | 2.3 | 1,068 | 1 | 4,494 | 1.5 |
| Unemployed | 587 | 0.4 | 718 | 1.2 | 284 | 0.3 | 1,589 | 0.6 |
| Economically inactive | 69,613 | 44.8 | 29,428 | 47.9 | 47,017 | 45.8 | 146,058 | 46.2 |
| Retired | 43,170 | 27.8 | 16,997 | 27.7 | 30,306 | 29.6 | 90,473 | 28.4 |
| Student | 6,422 | 4.1 | 6,150 | 10 | 3,544 | 3.5 | 16,116 | 5.9 |
| Looking after home or family | 6,296 | 4 | 2,119 | 3.5 | 4,755 | 4.6 | 13,170 | 4.0 |
| Long-term sick or disabled | 9,710 | 6.2 | 2,730 | 4.4 | 5,632 | 5.5 | 18,072 | 5.4 |
| Other | 4,015 | 2.6 | 1,432 | 2.3 | 2,780 | 2.7 | 8,227 | 2.5 |

**Patient Data**
No specific information regarding a patient's socio-economic status is collected by the service. This is not a factor within an emergency pathway.

There are certain conditions that are linked to a persons lifestyle, such as heart disease, certain cancers and diabetes. However, for EGS no impact based on a person's socio-economic status recognised at this time, though this will be reviewed in 12 months' time.

**Staff Data**
At this moment in time, we do not collect information that informs a staff members socio-economic status.

Currently, no impact is foreseen on the basis of socio-economic status. This is not a factor in an emergency pathway, this will be reviewed during any service changes.

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **Welsh Language**<br>Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language. | | ✓ | | **Population Data**<br>According to Welsh Census 2022 data, it is estimated that that 29.5% of people aged three or older were able to speak Welsh which equates to around 900,600 people. This is higher within the Health Board footprint at 36.5%.<br><br>The Health Board adopted the Welsh Language Standards in 2019 across all directorates including Mental Health & Learning Disabilities Services. Following on from this a Welsh Language Services Report is produced annually.<br><br>In March 2021 the Bilingual Skills Policy was introduced across the health board. The main aims of the policy are as follows:<br><br>· To increase the use of Welsh within the workplace.<br>· To enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal choice, and to encourage other users and providers to use and promote the Welsh Language within the health sector.<br>· To ensure staff are able to enact their right to receive services through the medium of Welsh within our internal administrative systems.<br>The health board uses its ESR system to capture Welsh Language information with 92% now showing an identified Welsh skill set. The skills set ranges from 0-5 with 0 being no welsh language skills to 5 being fluent orally and written. Staff members identified at Level 3 and above can provide bilingual services to patients and carers.<br><br>All service users and patients are offered a proactive service offer of Welsh language, which is recorded.<br><br>The health board has developed a range of Welsh Language learning opportunities for all staff to learn and develop their skills, and time is given from work to attend. Since the Pandemic, these opportunities have been made available online which has seen an increase in uptake.<br><br>A recent review of our current data tells us that it is easier to recruit Welsh Language speakers to lower banded posts as they tend to live locally. We have found that we are more successful in our recruitment of higher banded posts when specifically explaining the need for Welsh Language skills in the job requirements e.g. ability to speak Welsh is necessary but not the ability to write Welsh.<br><br>**Staff Data** | Welsh language standards applied to all health board staff<br><br>Patient information available in |

| | | | | | |
|---|---|---|---|---|---|
| | | | | The number of Welsh Speakers is currently unavailable; however the information does exist and will be included as soon as possible.<br><br>**Negative Impact**<br>We are aware that within the Health Board footprint, there are pockets where the majority of the population communicate in Welsh. Welsh-speaking ability (within Carmarthenshire in particular) varies widely within the territory. Patients who would prefer to communicate in Welsh may have to communicate in English. | English and Welsh<br><br>Welsh language speaking staff are available<br><br>Health Board Approved Translation services are available |

## Form 4: Examine the Information Gathered So Far

| | | |
|---|---|---|
| **1.** | **Do you have adequate information to make a fully informed decision on any potential impact?** | Yes |
| **2.** | **Should you proceed with the Policy whilst the EqIA is ongoing?** | Yes |
| **3.** | **Does the information collected relate to all protected characteristics?** | Yes |
| **4.** | **What additional information (if any) is required?** | |
| **5.** | **How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).** | The service is going to review as to whether or not additional data is required going forward.<br>- Additional information regarding staff would be collected in conjunction with the Health Boards Workforce team, possibly utilising ESR<br>- Additional information regarding patients would need to be collected by the service at point of care. Any considerations as to how and when would be appropriate to collect data will be considered with the Health Boards Patient Experience Team, and Information Governance. |

## Form 5: Assessment of Scale of Impact

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

| Protected Characteristic | Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below) | Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below) | Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below) |
|---|---|---|---|
| **Age** | **3** | **+1** | **3** |
| **Disability** | **3** | **+1** | **3** |
| **Gender Reassignment** | **1** | **+1** | **3** |
| **Marriage and Civil Partnership** | **1** | **0** | **0** |
| **Pregnancy and Maternity** | **3** | **-1** | **-3** |
| **Race/Ethnicity or Nationality** | **3**<br>**3** | **+1**<br>**-1** | **3**<br>**-3** |
| **Religion or Belief** | **3**<br>**3** | **1**<br>**3** | **3**<br>**+9** |
| **Sex** | **3** | **+1** | **3** |
| **Sexual Orientation** | **3** | **+1** | **3** |
| **Armed Forces** | **1** | **0** | **0** |
| **Socio-Economic Deprivation** | **2** | **0** | **0** |
| **Welsh Language** | **3** | **-1** | **-3** |

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

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

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

**Form 6 Outcome**

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

| | |
|---|---|
| **Will the Policy be adopted?** | This is a status quo EqIA based on an existing service |
| **If No please give reasons and any alternative action(s) agreed.** | NA |
| **Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?** | No |

| | |
|---|---|
| **What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?** | NA |
| **When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?** | NA |
| **Where positive impact has been identified for one or more groups please explain how this will be maximised?** | NA |
| **Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this.**<br><br>**If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.** | NA |

**Form 7 Action Plan**

| **Actions**<br>(required to address any potential negative impact identified or any gaps in data) | **Assigned to** | **Target Review Date** | **Completion Date** | **Comments / Update** |
|---|---|---|---|---|
| Review where it is assumed there is no negative impact foreseen for protected characteristics:<br>- Age<br>- Disability<br>- Marriage and civil partnerships<br>- Religion and belief<br>- Sex<br>- Sexual Orientation<br>- Armed Forces<br>- Socio Economic Status<br>These will be reviewed during future service change options | Caroline Lewis | Ongoing | | |
| Include the number of Welsh speakers in the EGS Service | Caroline Lewis | June 2024 | | |
| Review whether further engagement with people 65 and over is required given the high portion of patients within that age bracket | Caroline Lewis | January 2025 | | |
| Consider if the service needs to store data regarding pregnancy status of patients | Caroline Lewis | January 2025 | | |
| Consider if the service needs to collect data regarding Gender Reassignment of patients | Caroline Lewis | January 2025 | | |
| Consider if the service needs to collect data regarding Marital Status of patients | Caroline Lewis | January 2025 | | |
| Any additional engagement in regards to potential options development must include people over the age of 65 | TPO | Ongoing | | |

| | | | | |
|---|---|---|---|---|
| Any future staff engagement to be carried out must include staff networks | TPO | Ongoing | | |
| Review were data is not currently collected to see if it is required: | Caroline Lewis | 01/01/2025 | | |

| | | |
|---|---|---|
| **EqIA Completed by:** | **Name** | Michael Langford |
| | **Title** | Project Manager |
| | **Team / Division** | Transformation Programme Office |
| | **Contact details** | Michael.e.langford@wales.nhs.uk |
| | **Date** | 19/12/2023 |
| **EqIA Authorised by:** | **Name** | David Lewis |
| | **Title** | Service Manager |
| | **Team / Division** | EGS |
| | **Contact details** | David.lewis24@wales.nhs.uk |
| | **Date** | 22/01/2024 |
| **Seen by Diversity & Inclusion Team:** | **Name** | Eiddan harries |
| | **Title** | Diversity and Inclusion Manager |
| | **Team** | Strategic Partnership Diversity & Inclusion |
| | **Contact details** | Eiddan.harries@wales.nhs.uk |
| | **Date** | 06.03.2024 |