Clinical Services Plan
Issues Paper
March 2024

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

Section 1: Executive summary

Our long-term plans for service provision remains as set out in our strategy called A Healthier Mid and West Wales Our Future Generations Living Well. Until the strategy is fully implemented, including the establishment of the proposed new hospital network, services are having to manage these fragilities daily. The pandemic has further exposed these deficiencies, with many services unable to restore pre-COVID activity levels or service models. To respond to this, we have established a Clinical Services Plan programme to review some key services.

The services included within the Clinical Services Plan programme are:

- Primary Care and Community
- Critical Care
- Emergency General Surgery
- Stroke
- Endoscopy
- Radiology
- Dermatology
- Ophthalmology (eye care)
- Orthopaedics
- Urology
- Urgent and Emergency Children and Young People's (Paediatric) Services at Withybush and Glangwili Hospitals.

To support the undertaking of this work, experience was drawn from the learning in carrying out the clinical land appraisal and the development of the Issues Paper for the Urgent and Emergency Children and Young People's (Paediatric) Services at Withybush and Glangwili Hospitals. Both pieces of work involved drawing on the skills and experiences of staff, services users, and their carers, as well as the wider organisation to understand historical and current drivers as well as the wider regional and NHS Wales network Hywel Dda operates within.

Since the initiation of the Clinical Services Plan in March 2023, Hywel Dda's escalation status has changed from Targeted Intervention for Planning and Finance to now include the entire organisation. In order for the organisation to reduce its escalation status changes need to take place to improve both the financial position as well as the performance in delivering services. The Board has developed a series of risk appetite statements to support the organisation to make changes, which also support the development of options within the Annual Plan, as well as support the option development process within the Clinical Services Plan.

A clinically led assessment of the ten service areas included within the Clinical Services Plan programme has been completed. For the Primary Care and Community Issues Paper, the assessment was led by the senior management team which oversees contracted services. Urgent and Emergency Children and Young People's (Paediatric) Services at Withybush and Glangwili Hospitals has not been included as a part of this Issues Paper since an Issues Paper regarding these services was published in September 2022.

The Issues Paper highlights the early engagement activities which have taken place, the processes and methodologies used, as well as the data. (In this context, the term 'early engagement' refers to engagement with stakeholders which is undertaken prior to, and in preparation for, the options appraisal process).

Services within the Clinical Services Plan are delivered across Hywel Dda from hospitals and community sites. Inpatient services are predominantly delivered from Bronglais Hospital in

Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest. Outpatient services are also delivered from these hospitals as well as community hospitals and clinics. Most of our Primary Care Services are delivered from a mix of commercial premises, for example Community Pharmacy and Optometry services, and premises owned and operated by contractor services like GP surgeries and Dental practices.

Whilst the programme of work is focused on producing a Primary Care and Community Strategy, for the purpose of the Issues Paper, Primary Care was identified as having the most significant sustainability risks and therefore the main area of focus. As discussions progressed it was agreed that the scope needed to be widened into Primary Care and Community Services. In recognising the challenging timescales and the breadth of scope, further work will be done to scope the issues around community service provision as the strategy is developed.

Please note the below summaries are highlights of the conclusions section of each chapter within the Issues Paper. Please take the time to read the conclusions section as to gain a complete understanding of the key findings.

Primary Care and Community

Patient feedback taken from previous population surveys highlighted that people felt that it was important to have services at a local level, either in the community or at local hospitals. In addition, people felt that they were having to wait longer for services, especially since the COVID-19 pandemic.

- The Primary Care workforce engagement survey included feedback on workplace satisfaction. 60% of staff respondents said that their overall experience of working in the Primary Care service was good. 28% said their overall experience was neither good nor poor. 13% said it was a poor experience
- Primary Care services are commissioned across the four contractor professions and have legislative Directions and Regulations in place to support the commissioning and management of the contracted services
- With the majority of the service provision and contract monitoring arrangements set out through national frameworks, this places limitations on how swiftly the Health Board can react to making changes that are responsive to service pressures, and proactively transform services to meet the population needs whilst supporting the aspirations of the future model of health and care
- The lack of workforce data across the contractor profession groups poses a challenge for workforce planning at both a professional and multi-professional level.
- The activity level data sets available to the Health Board do not allow for the individual contractor services to demonstrate impact or patient outcomes
- The estate utilised by Primary Care contractors and community services is a mix of owned and leased premises which in general tend to be unsuitable for the provision of modern Primary Care and Community services and limit the scope for expansion of services and the development of the workforce
- Due to the mix of commercial and/or private plus NHS service provision for Dentistry, Optometry and Community Pharmacy there are commercial and business viability decisions in considering multi-agency hubs that could also have an impact on the ability to deliver care closer to home.

Critical Care

- Patient early engagement included praise for the professional, kind, reassuring, and helpful staff; the quality of care; the timeliness and efficiency of the service received; and good communication and information provision. Others, though, gave negative comments about poor communication and information provision

- Staff early engagement feedback included pride in the high level of care offered to patients and their families across all four sites; variety of their roles; good training and professional development opportunities; and the extensive skillsets and experience within Critical Care multidisciplinary teams. The lack of a rehabilitation pathway within Critical Care was a particular concern to staff
- Comments were also made about the difficulties involved in standardising care across the four Critical Care units, not least due to an apparent reliance on agency staff; the lack of a clinical lead for the service; delayed transfers of care due to limited bed capacity on wards; sometimes unnecessary transfers between sites due to a lack of consultant cover at Prince Philip Hospital; and the sometimes emotionally draining nature of the job
- There is currently a temporary service configuration change in place in Carmarthenshire at Prince Philip Hospital due to gaps in workforce. These workforce challenges impact finances and delivery of services sustainably in nursing and the medical workforce
- Across the Health Board there are challenges in meeting *Guidelines for the Provision of Intensive Care Services* (GPICS) standards
- There is an expectation from the National Strategic Clinical Networks that the Health Board will produce a demand, capacity and configuration plan for Critical Care services in Hywel Dda
- Rehabilitation and limited access to Allied Health Professionals has also been highlighted as a key challenge in delivering outcomes
- There is a lack of standardised working across all Critical Care units, which is made more difficult by agency usage and no clinical lead for the service
- Critical Care beds frequently surge due to inpatient bed demand at increased cost.

Emergency General Surgery

- Patient early engagement included praise for the professional, kind, reassuring, and helpful staff; the service efficiency and speed; the good quality of healthcare received including procedure, treatment, and outcome; and the experience of and care received. Negative comments included that the service is inefficient and slow; that staff were unprofessional, unhelpful and could be more caring; and that they had a generally poor experience in the department
- Staff early engagement feedback included the effective teamwork between experienced, hard-working, and dedicated staff. Other frequent comments included the positive working relationships formed between staff and managers, and the supportive and friendly environment formed by the teams. The most common difficulties cited were the lack of bed capacity across all sites and inefficiency of using a paper-based system to book rooms and make notes
- It has been recorded as a Board risk that there is a lack of substantive Speciality and Specialist (SAS) level Doctors affecting the Emergency Department in Withybush.
- Another risk detailed an inability to safely support the Consultant on-call rota at Withybush Hospital and Glangwili Hospital
- Surgery activity across three sites is low in volume impacting the ability to recruit appropriately skilled surgeons. Rota gaps are covered by locum posts causing additional cost pressures
- There are issues with recruitment and sustainable patient numbers to enable retention of skills across all current sites
- The Emergency General Surgery ‘Getting it Right First Time’ (GIRFT) review recommends consolidation of emergency take and sub-specialties in acute sites
- The Emergency General Surgery GIRFT review recommends the development of Surgical Same Day Emergency Care (SDEC) in acute sites

- There are issues with Emergency General Surgery rota sustainability – recruiting and retaining Consultant and Speciality Doctors.

Stroke

- Patient early engagement feedback included praise for the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care. Negative comments were received around a lack of timeliness and a generally poor standard of care
- Staff early engagement feedback included praise for their colleagues, describing them as enthusiastic, passionate, caring, and committed to placing the patient at the centre of all care. Positive multidisciplinary team working was thought to have been one of the main contributors to the service's success in recent years. The most prevalent issues raised were around capacity. Other key challenges were highlighted around consistency of staffing and therapy provision for stroke rehabilitation
- Currently, Stroke services do not meet national staffing recommendations for stroke care
- Our population does not have access to specialised hyper-acute stroke care (HASU), Integrated Community Stroke Service (ICSS), or psychological therapies at the time of review
- There is no seven-day consultant cover, clinical nurse specialist or therapy services within Stroke services
- As a result, the general stroke position assessed against Sentinel Stroke National Audit Programme (SSNAP) shows clinical and organisational positions declining. This declining SSNAP position is more prevalent in Carmarthenshire
- There is a lack of ringfenced beds for Stroke patients, although it appears that there is an under-utilisation of total beds
- Fewer Stroke patients are being admitted to Prince Philip Hospital in comparison to pre-COVID; this appears to be due to telephone advice to attend Emergency Department (Glangwili Hospital / Morriston Hospital).

Endoscopy

- Patient early engagement feedback included praise for the professional, kind, reassuring, and helpful staff in the department; good communication; and the speed and efficiency of the service provided. Some expressed a dislike of the treatment or procedure received (including feeling embarrassed)
- Staff early engagement feedback included praise for the high-quality physical and mental health care provided to patients; the interesting and varied nature of the work; and the excellent teamwork between friendly, supportive, compassionate, proactive, committed, and experienced staff. Other frequent comments were that some management and senior staff are supportive, approachable, and helpful; staff take pride in the JAG accreditation awarded to Withybush Endoscopy service; and that new members of staff are made to feel like a valued member of the team
- All sites within the Health Board have now exceeded pre COVID-19 activity. Despite no configuration changes, the service has made progress in reducing the number of patients waiting for an endoscopic procedure
- Workforce supply has historically presented a challenge to endoscopy service delivery across multiple staff groups, predominantly as a result of recruitment shortfalls. Substantive staffing levels generally do not meet demand; the gap is met by agency or locum staff

- The key cost drivers are: consumable costs due to increase in activity and more complex procedures being undertaken; impact of on-boarding staff including clinical endoscopists to deliver capacity requirements and the level of agency nursing.

Radiology

- Patient early engagement feedback included praise for the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care. Some complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis)
- Staff early engagement feedback included highlighting the friendly, supportive, helpful, responsive, kind, and compassionate team; the willingness of employees to share their knowledge with others, and to learn and adapt to changing circumstances. Issues were raised around staff shortages, heavy workloads, and poor work-life balance
- Activity levels have increased by 37%. This large rise in Radiology activity across all sites is driven in part by other pathway changes or services introduced
- To overcome staffing shortfalls, the Radiology service has filled roles by locums and outsourcing scan reporting
- The workforce has not increased to meet the rise in growing demand between 2020-2022; the workforce is a barrier to 24/7 hour services being offered despite the equipment being available in many areas
- Corporate risks have been recorded around staffing and equipment upgrades, including workforce risks with reference to shortages and recruiting difficulties across Radiology
- There is a requirement to invest in radiology equipment upgrades and make new purchases
- NICE guidelines recommend Multi-parametric MRI [1] for Prostate cancer diagnosis. Currently Bronglais Hospital can offer it to half of the patients who would require a Multi-parametric MRI. This is because of issues with capacity within the Radiology service.

Dermatology

- Patient early engagement feedback included praise for the efficiency and timeliness of the service received; the professional, kind, reassuring, and helpful staff; the quality of care; and good communication and information provision. Some, though, gave negative comments about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and poor communication and information provision
- Staff early engagement feedback included highlighting the good relationships formed in the workplace, describing their colleagues as dedicated, experienced, and helpful.
- The service is impacted by longstanding issues in recruiting substantive consultants. This is a nationally recognised pressure. Dermatology patch testing is unable to take place due to recruitment issues
- In turn this has impacted the retention of wider workforce roles and clinical supervision required to deliver these role
- Facilities have also been identified as key issues in maintaining a standard of service delivery
- General pathways have been impacted by the growing demand of Urgent Suspected Cancer (USC). Over the past five years, 42% of the total referrals received into the Dermatology service have been patients on the Urgent Suspected Cancer pathway

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[1] *A Multiparametric MRI is a special type of MRI scan that produces a more detailed picture of your prostate gland than a standard MRI scan does.*

- Temporary change to Dermatology in response to COVID-19 impacted on paediatric pathway, affecting patients and service capacity on Glangwili Hospital site
- Loss of clinical space previously used, and poor access to Day Surgery Unit, prevents minor operations taking place at Glangwili Hospital. These issues increase waiting list demand and impact capacity at Prince Philip Hospital
- Dermatology Phototherapy clinics have been cancelled since COVID-19 as clinical areas do not meet Health and Safety guidelines. This impacts on patients across the Health Board at an early intervention stage as these clinics are not currently provided on any site
- Paediatric patients can be seen at Prince Philip Hospital; however, these clinics take place in an adult Outpatient setting and a lack of available rooms in the Outpatient Department at the hospital means that Nurse led clinics are unable to take place. Paediatric patients are being seen by Medical staff only, which is having an impact on locum consultant capacity.

Ophthalmology

- Patients mainly praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care. Others, though, gave negative comments about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and poor communication, information provision, and follow up
- Staff early engagement feedback included positive working relationships between managers and staff across all sites; effective teamwork between dedicated, respectful, and caring staff; and being able to take pride in providing good quality patient care
- There is a lack of staff in Ophthalmology, with a national shortage of Consultant Ophthalmologists, which impacts on follow up appointments and implementation of standards. This means that some services are not being delivered within the Health Board
- Capacity was a key concern for staff respondents, with appointments in high demand and clinics often overbooked (it was felt, because of staff shortages and retention issues)
- The Ophthalmology GIRFT review recommends regional working, appointing clinical leadership, developing Multi-Disciplinary Teams (MDTs), and rationalising outpatient service locations and patient visits
- The service is also impacted by high medical agency costs in order to fill rotas.

Orthopaedics

- Patient early engagement feedback included praise for the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; and the generally good quality of care. Negative feedback included concerns about a lack of timeliness and generally poor standards of care
- Staff early engagement feedback included positive working relationships within the service; dedicated staff, helpful and approachable toward patients and colleagues.
- There are many patients waiting several years for treatment
- Theatre capacity is an issue with temporary configuration of inpatient services only being delivered on two sites, these are Prince Philip and Bronglais Hospitals. This is partly due to compliance with British Orthopaedic Association (BOA) Quality of Care Standards
- There are also shortages within Anaesthetic and Therapy teams to support the service
- Capacity is also impacted by the performance of equipment within operating theatres
- The key cost drivers are medical agency supplied staff and additional hours to deliver the service

- In Bronglais Hospital, Orthopaedic beds within bays are ring-fenced within a planned care ward, but there is no dedicated orthopaedic ward
- Surgical waiting lists are increasing due to lack of theatre capacity, relating to therapy and anaesthetics recruitment and environmental factors, which is also preventing the recruitment of additional consultants.

Urology

- Patient early engagement feedback included the professional, kind, reassuring, and helpful staff; the efficiency and speed of the service received and the good communication
- Others, though, said that they received a slow and/or inefficient service
- Staff early engagement feedback included the supportive, cohesive, welcoming, and dedicated nature of the team; and the encouragement and support from management
- There is a lack of capacity to meet demand at Glangwili Hospital and the service is split across two sites in Carmarthenshire
- Whereas the workforce is at establishment it is finding it challenging to meet the growth in demand for services. There are gaps in consultants for specialist areas
- There are realised financial pressures in the use of locum positions beyond the funded establishment
- Radiology capacity across the Health Board impacts on the Urology service's ability to meet standards
- The lack of Urology wards or clinical spaces has led to a deskilling of Urology staff
- The Urology service within Prince Philip Hospital is a temporary change. The Urology service may repatriate to Glangwili Hospital unless other options are identified, or this change may be made permanent
- Currently, there is not enough space or capacity for subspeciality Urology outpatient clinics at Glangwili Hospital
- The majority of staff are substantively based at Glangwili Hospital but travel to cover activities on other sites.

Limitations of the Findings

The following is a list of known limitations that affect all or parts of the services. These limitations should be considered when reviewing the Issues Paper:

The following is a list of known limitations that affect all or parts of the services. These limitations should be considered when reviewing the Issues Paper:

- The Issues Paper only considered a 5-year period and this timeline stopped in August 2023. As such other issues may have been generated since this time which will not be represented
- Only the information outlined within the methodology of the Issues Paper has been reviewed. Any risks identified are logged as programme risks, and the variation highlighted within the Issues Paper chapters. The data contained within the Issues Paper is limited to what is owned and held within the Health Board systems. For Primary Care this may mean that it will not fully represent all contracted services data
- The findings are limited to the services within scope of the Clinical Services Plan programme as defined within the Project Initiation Documents (PIDs)
- Primary Care is the primary area of focus for the Primary Care and Community Issues Paper, for the reason explained above.

Contents

Section 2: Introduction and background

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

Section 2: Introduction and background

Hywel Dda University Health Board plans, organises, and provides health services for almost 400,000 people across Carmarthenshire, Ceredigion, and Pembrokeshire.

Due to the nature of service provision across Mid and West Wales, it is recognised that a wide range of services have some fragilities[2]. This was a key driver behind the development of the Health Board's strategy that seeks to reduce, if not eliminate, the risks to sustainable service provision.

Our strategy, A Healthier Mid and West Wales Our Future Generations Living Well, has the ambition to shift from a service that just treats illness to one that keeps people well, prevents ill-health or worsening of ill health, and provides any help you need early on. Further information can be found by visiting the following link: https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/

Until our strategy is fully implemented, including the establishment of the proposed new hospital network, services are having to manage fragilities daily. The pandemic has added further stress, with many services unable to restore pre-COVID activity levels or service models. To respond to this, we have established a Clinical Services Plan programme to review some key services:

The services included within the Clinical Services Plan programme are:

1. **Primary Care and Community**
   For the purposes of the Issues Paper, Primary Care is defined as:
   - Four contracted services:
     - General Medical Services
     - General Dental Services
     - Community Pharmacy
     - Optometric Services
   - Out of Hours General Medical Services
   - Community Dental Services.

Whilst the programme of work is focused on producing a Primary Care and Community Strategy, for the purpose of the Issues Paper, Primary Care was identified as having the most significant sustainability risks and therefore the main area of focus. As discussions progressed it was agreed that the scope needed to be widened into Primary Care and Community Services. In recognising the challenging timescales and the breadth of scope, further work will be done to scope the issues around community service provision as the strategy is developed.

2. **Critical Care**
   Critical Care provides treatment to adults, in a separate and self-contained area of the hospital. The units are dedicated to the management and monitoring of patients with life-threatening and critical conditions. The service offers specialist skills which include medical, nursing, and other personnel experienced in the management of these patients.

3. **Emergency General Surgery**
   Emergency General Surgery (EGS) is a surgical discipline that mostly looks after abdominal emergencies. The general surgical service is for the treatment of patients with emergency problems.

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[2] A lack of robustness within the service, an example could include a reliance of agency or locum staff.

4. **Stroke**
   A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off.

5. **Endoscopy**
   An endoscopy is a procedure used in medicine to look inside the body. The endoscopy procedure uses an endoscope to examine the interior of a hollow organ or cavity of the body. Unlike many other medical imaging techniques, endoscopes are inserted directly into the organ.

6. **Radiology**
   Radiology is a medical speciality that uses imaging techniques (such as X-rays) to diagnose, treat and monitor diseases and injuries identified within the body.

7. **Dermatology**
   Dermatology services focus on the diagnosis and treatment of diseases of the skin, hair, and nails in both children and adults.

8. **Ophthalmology (eye care)**
   Ophthalmology is the treatment of eye diseases, injuries, and surgical procedures. Our service is for paediatric (children and young people) and adult patients in our area who have sight problems that need treatment.

9. **Orthopaedic Service**
   Orthopaedic service, also known as orthopaedic surgery, is a branch of medicine that focuses on the care of the skeletal system and its interconnecting parts.

10. **Urology**
    Urology cares for adult patients with urological conditions. The Urology service focus on the care of the genito-urinary tract system in both men and women (e.g., kidneys, bladder) and the reproductive tract in men (e.g., testicular, penile, and prostate).

11. **Urgent and Emergency Children and Young People's (Paediatric) Services at Withybush and Glangwili Hospitals**
    Urgent and emergency children and young people's (paediatric) services at Withybush and Glangwili hospitals is not included as a part of this Issues Paper as an Issues Paper was published in September 2022, a copy can be found by visiting the following link: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022

    The service held a public consultation between 26 May and 24 August 2023 to ask service users and members of the public their views about three options on how the service should be delivered in the future. At the meeting of the Board on 30 November, Health Board members discussed the findings of the consultation and decided to progress option 1. More information about the process and the options can be found on the Health Board's website at: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023

Since the initiation of the Clinical Services Plan in March 2023, Hywel Dda's escalation status has changed from Targeted Intervention for Planning and Finance to now include the entire organisation. It is recognised that in order for the organisation to reduce its escalation status changes need to take place to improve both the sustainability and the performance of services.

The Board has developed a series of risk appetite statements to support the organisation to make changes, which also support the development of options within the Annual Plan, as well as support the option development process within the Clinical Services Plan.

Where services within the Clinical Services Plan are delivered

Most of our Primary Care and Community Services are delivered from a mix of commercial premises in the case of Community Pharmacy and Optometry Services, and premises owned and operated by contractor services like GP surgeries and Dental practices.

Services within the Clinical Services Plan are delivered across Hywel Dda from hospitals and community sites. Inpatient services are delivered from Bronglais Hospital in Aberystwyth, Glangwili Hospital in Carmarthen, Prince Philip Hospital in Llanelli, and Withybush Hospital in Haverfordwest. Outpatient services are also delivered from these hospitals as well as community hospitals and clinics.

These hospitals require ongoing maintenance, with some parts approaching or having reached the end of their intended lifespan. This means that while they are still working, the costs to keep them functioning is increasing and they will in time need to either be replaced or significantly refurbished. There are practical limitations to expanding the hospitals, particularly in the short and medium-term, so any decisions on inpatient services will, in the main, need to be made based on what is currently available.

The Health Board is currently looking at where we deliver our services. The longer-term vision is set out in the Programme Business Case for A Healthier Mid and West Wales, which sets out the vision for a new Urgent and Planned Care Hospital in the south of the Hywel Dda region. The new hospital will be supported by the existing hospitals, which will be repaired or replaced as part of a network. These work alongside a series of community centres that deliver care locally. Further information can be found by visiting: https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/

The short to medium term vision for our buildings and estate can be found in our Estate Rationalisation and Modernisation Strategy, which supports the development of community centres while also seeking to make best use of estates. This will mean that some community services are likely to be brought together and delivered from one place, as well as organisations working closer together, such as social care, third sector, etc.

The services most likely to be affected by the Estate Rationalisation and Modernisation Strategy are Primary Care and Community Services, although some outpatient services may also be affected. Further information about the strategy and its impact can be found by visiting: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024

Purpose of the Issues Paper

The Issues Paper sets out:

- An analysis of the services drawn from internal data and views, early engagement with service users and staff, and local, regional and national work as set out in Section 3: Methodology.

The purpose of the document is to:

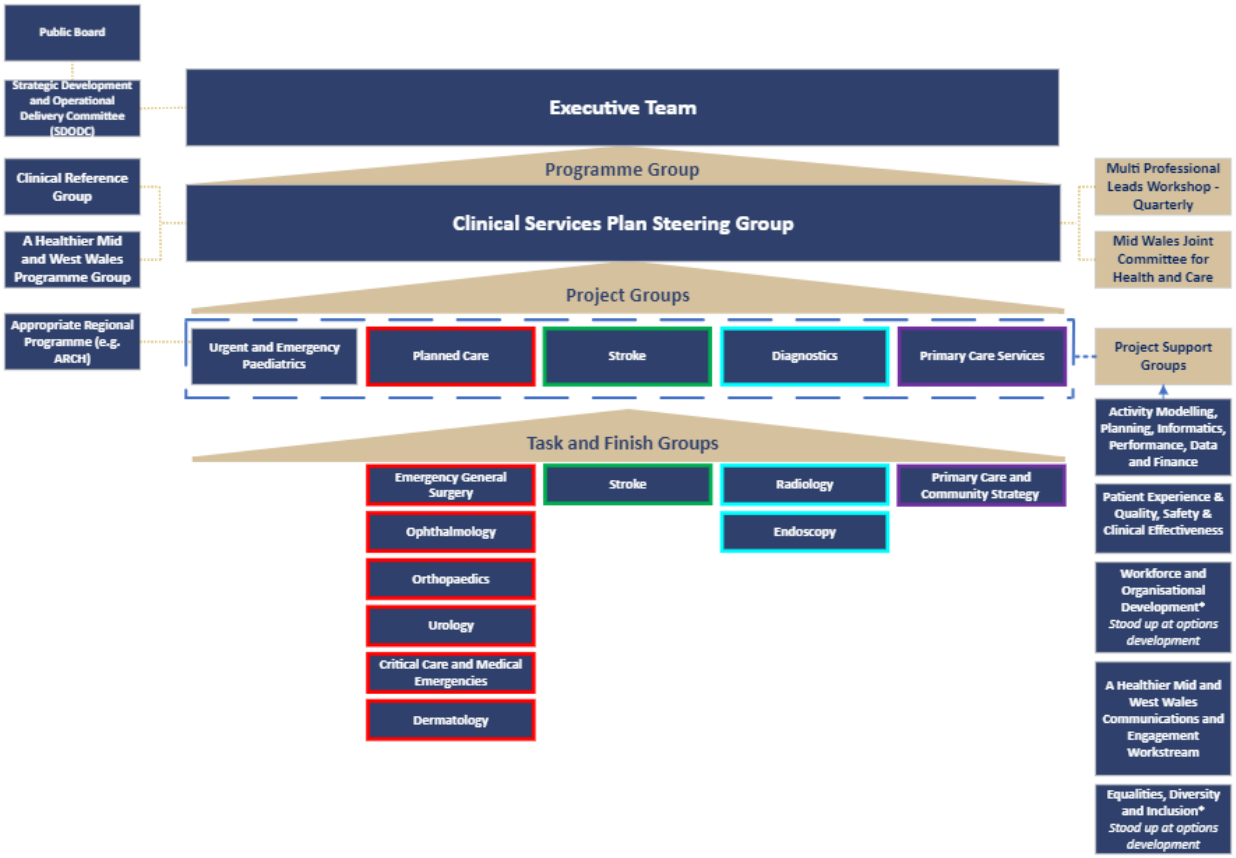
- Present to Board an assessment of the services within the Clinical Services Plan

- Support discussions at a deliberative session[3] on Tuesday 9 April 2024, as set out in Section 14: Next steps
- Provide information on key themes that will inform the development of a Strategic Plan for Primary Care and Community Services.

Governance and membership

The diagram on the next page shows the different task and finish groups and the project groups that have been established to oversee the development of this Issues Paper, reporting to the Clinical Services Plan Steering Group. The Clinical Services Plan Programme Group reports to the Executive Team.

Issues, risks, and matters that require a decision are escalated to the Clinical Services Plan Steering Group, who approved the scope of the Clinical Services Plan (further details on how the scope was identified is set out in Section 3: Methodology).

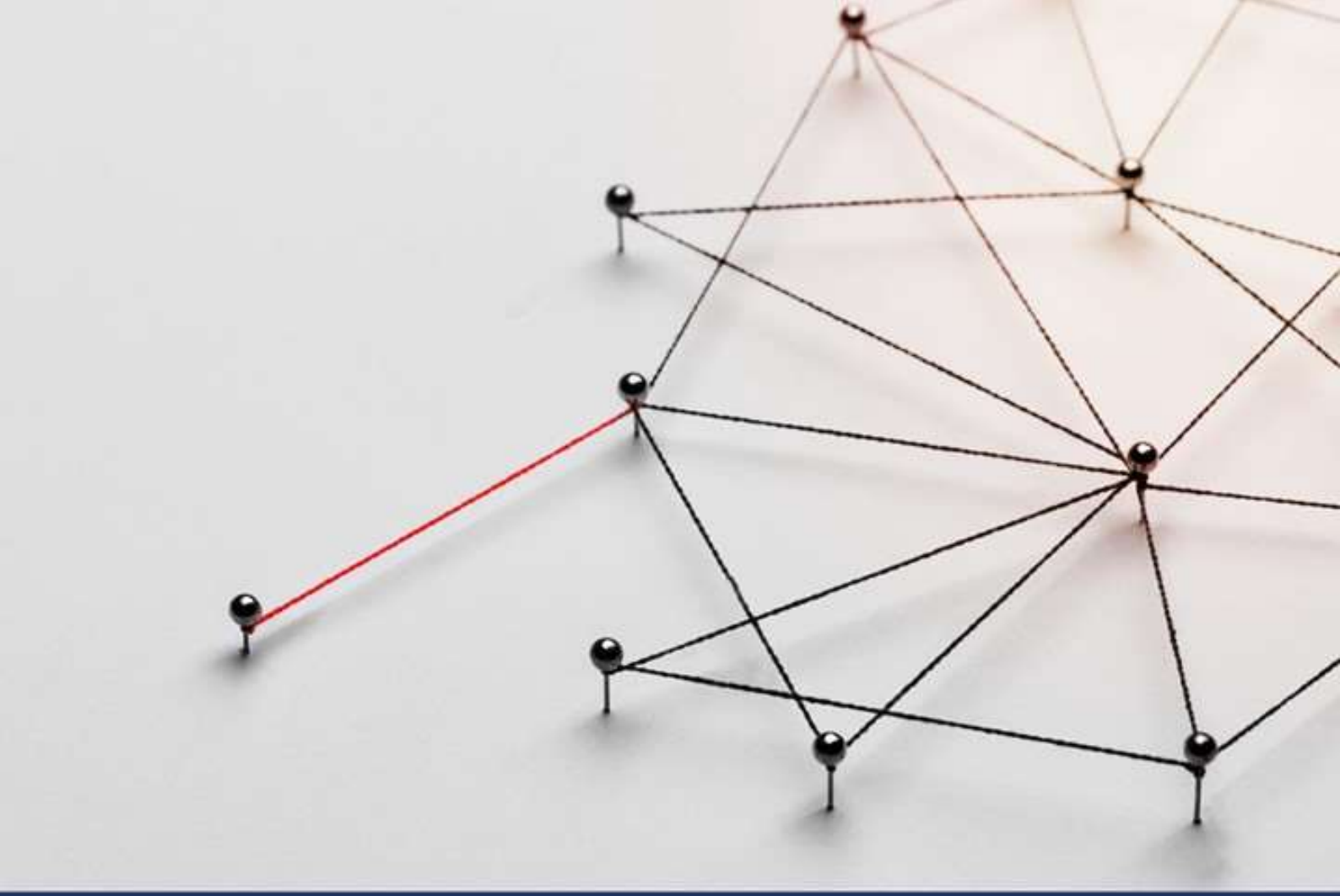


Membership

- Clinical Services Plan Steering Group includes executive director leads, senior clinical leaders, operational leads and corporate support colleagues
- Project Groups are chaired by the reporting lead for the steering group and have senior clinical and operational colleagues in attendance

[3] *Discussion and consideration by a defined group of people in a meeting / workshop.*

- Task and finish groups include service representatives from a medical, nursing and operational colleagues, representing all sites within scope of the Clinical Services Plan (further details on how the scope was identified is set out in Section 3: Methodology).



Section 3: Methodology

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Section 3: Methodology

This section explains the scope and context for the Issues Paper, and how we identified stakeholders and the early engagement needed.

Scope of the Issues Paper

The scope of the Issues Paper was agreed by the Clinical Services Plan Steering Group.

This was recorded as part of the Project Initiation Documents[4] (PID) that were developed by the task and finish groups for the 10 services within the Clinical Services Plan programme. The PIDs are included in Appendix A1 – CSP – Project Initiation Documents. Any requests to change or widen the scope were managed and recorded in the Executive Steering Group decision log.

The scope was set following the same process that was undertaken for the Urgent and Emergency Children and Young People's (Paediatric) Services at Withybush and Glangwili Hospitals, which was recognised as best practice, and advice from The Consultation Institute[5].

The scope for the nine service areas (excluding Primary Care and Community) is set out as follows:

To undertake a clinically led assessment of the services (as defined within the Project Initiation Documents) within the Clinical Services Plan programme, between 1 August 2018 and 31 July 2023[6], resulting in an Issues Paper outlining all the changes, impacts and issues to date.

In relation to Primary Care and Community the scope is:

To undertake an assessment of Primary Care Services, namely the four Contractor services and the Health Board-led Out of Hours and Community Dental Service. The assessment will align with Clinical Services Plan programme methodology as and when applicable. The Issues Paper will deliver information on the Community Services that relate to Primary Care and the changes, and issues related to Primary Care to date.

Stakeholder mapping

There are several organisations that are involved in delivering patient care, as well as a range of individuals and services within Hywel Dda that support a patient's care pathway. Stakeholder mapping was carried out to identify internal and external stakeholders who would need to be involved as part of the Clinical Services Plan process for each of the nine service areas (excluding Primary Care and Community). Baseline Equality Impact Assessments[7] (EqIAs) have also been undertaken based on these nine services, looking at how they currently provide their services and

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

[5] A not-for-profit best practice Institute, promoting high-quality public and stakeholder consultation in the public, private and voluntary sectors.

[6] There are exceptions, some services may have used different time periods or may not have the same information available, which will be reflected within the individual Issues Papers.

[7] An equality impact assessment (EqIA) is an evidence-based approach designed to help organisations ensure that their policies, practices, events and decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation.

how these impact people with protected or special characteristics (i.e. people with disabilities, carers, sexuality, gender), which can prevent them accessing health care services like other members of the population.

For the Primary Care and Community Issues Paper, the stakeholder mapping exercise included stakeholders from Community Services due to the interdependencies between both Primary Care and Community Services, and the objective of developing a Primary care and Community Strategy. This also considered how other stakeholders would be kept updated and informed about the Clinical Services Plan if they are not actively participating.

Methodology

To achieve the scope set out, the following approach was taken:

1. A review and documentation of all updates to Public Board - temporary changes and Risks

How did we do this?

Public Board - temporary changes

The Board at Hywel Dda includes executive directors who are employees of the Health Board, and Independent Board members, who are appointed by the Minister for Health and Social Services. The Board has a key role in ensuring that the Health Board has good governance arrangements in place and is open and transparent in the way that it works. The Board meets on a bi-monthly basis as a minimum, in public session.

As part of developing the Issues Papers, Public Board papers and minutes were reviewed to identify Public Board approved temporary service changes that have taken place within the services, between 1 August 2018 and 31 July 2023. Public Board papers and minutes can be viewed on the Health Board's website here: Your[8] health board - Hywel Dda University Health Board (nhs.wales)

Any temporary changes identified are captured within the body of the services' Issues Papers with links provided to the relevant Board papers.

Contractual changes to Primary Care providers were noted. These changes relate to service changes led by providers, rather than Hywel Dda changes. This includes both temporary and permanent changes, and changes to the terms of the all-Wales Contracts that govern much of the Primary Care service.

Risks

The Board receives regular Corporate Risk Reports for information. The Board also receives update reports at each meeting from its sub-committees, which note areas of discussions held at its previous meetings and highlights any key risks and matters for concern. For the Clinical Services Plan Issues Paper, Board Corporate Risk Reports and update reports spanning the period of July 2018 to September 2023 have been reviewed for the service areas currently within the Clinical Services Plan. Further details can be found in Appendix A4 – CSP – Corporate Risks.

[8] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-29th-september-2022/english/item-46-critical-care-staffing-position/*

2. Clinical effectiveness: A review and documentation of NICE guidance and other national guidance

How did we do this?

The Clinical Effectiveness team reviewed and documented clinical guidance that was relevant to each of the nine service areas (excluding Primary Care and Community). These guidelines were discussed, and amendments made after discussion with the service leads or service providers for the nine services within the Clinical Services Plan programme. The relevant guidance and the services' clinical observations are noted within the body of the services' Issues Papers and the full report added as Appendix A5 – CSP – Clinical Effectiveness Guidelines.

The Primary Care Services provided the context for the Health Board's contractual relationship with Primary Care Service and Community providers.

3. A review and documentation of local, regional and national work programmes

How did we do this?

The clinical teams for the nine services within the Clinical Services Plan programme (excluding Primary Care and Community) reviewed, documented, and provided an overview of key relevant work programmes on a local, regional, and national level that were felt to be relevant to service delivery. These work programmes are detailed within the body of the services' Issues Papers, these include (where applicable):

- National clinical strategies
- Wales Audit Office reviews
- Getting It Right First Time (GIRFT), a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change www.gettingitrightfirsttime.co.uk
- A Regional Collaboration for Health (ARCH), a unique collaboration between three strategic partners: Swansea Bay University Health Board, Hywel Dda University Health Board and Swansea University. It spans the local authority areas of Ceredigion, Pembrokeshire, Carmarthenshire, Neath Port Talbot and Swansea www.arch.wales.
- Mid Wales Joint Committee (MWJC) The Mid Wales approach will support the Welsh Government's expectation for health and social care organisations to work together to plan and deliver regional solutions across organisational boundaries. The focus will continue to be on a whole pathway approach with regional links between primary, secondary, community and social care and links to national pathway work. https://mwjc.nhs.wales

The Service Leads for Primary Care and Community provided input into the most relevant strategic programmes in relation to Primary Care services and expanded the review to include programmes of work on a local (cluster-based), regional and national level that were relevant for Community Services. These included:

- West Wales Regional Partnership
- The Public Service Boards for Ceredigion, Carmarthenshire and Pembrokeshire
- ARCH
- Strategic Programme for Primary Care and Community
- A Healthier Wales
- Social Service and Wellbeing Act.

4. A review of service activity data

How did we do this?

Activity data was captured from data reported within the services' designated electronic patient record system, WPAS (Welsh Patient Administration System). Service specific systems were used for Critical Care, Radiology and Stroke. Data was validated through the Health Board informatics process. Data was captured in line with the specialties and subspecialties and/or conditions specified within the Project initiation documents. A dashboard was developed to support analysis and the impact of recorded patient activity within the Health Board's systems. This looked at trends over the agreed timeline.

Service activity data captures the interactions a patient has with the service, this has been collated for the nine services within the Clinical Services Plan Programme (excluding Primary Care and Community), this includes where applicable:

- Inpatient activity - a patient who stays in hospital overnight while receiving treatment
- Outpatient referrals - when a patient has been recommended by a medical professional to seek specialist treatment or advice about a particular condition
- Outpatient activity - this refers to any patient interactions within an Outpatient setting. This is also inclusive of any follow up appointments
- Day Case referrals - a patient who comes in for a more involved procedure than an Outpatient. You may need some recovery time at the hospital, but you should be able to go home the same day
- Day Case activity - this refers to any patient interactions within a Day Case setting
- Outsourced activity data: To help reduce the waiting lists and remove some of the burden on Hywel Dda services, for example, some simple cataract removals are outsourced to other health providers.

Key themes and any relevant clinical observations from the services are noted within the body of the services' Issues Papers, with links provided to the supporting dashboard appendices.

For the Primary Care services - due in part to the relationship between Primary Care Contractors and the Health Board - the activity data used in the Issues Paper is related to the agreed contract data sets available to the Health Board. The sources for the data includes where applicable:

- Adastra – Clinical Patient Management Software (Out of Hours only)
- BSA – Business Services Authority (Dental data)
- Consultant Connect – Telemedicine Provider
- COVID-19 Datahub – Covid-19 Datahub (Digital Health and Care Wales)
- Microsoft Forms - submitted by contractors directly to the Health Board
- NWSSP - NHS Wales Shared Services Partnership
- PCIP - Primary Care Information Portal (Digital Health and Care Wales)

5. Review of incidents, complaints, compliments, and claims data collated on the Health Board's concerns management system provided by DatixCymru and RLDatix

How did we do this?

Incidents, complaints, compliments

All concerns[9], patient safety, incidents[10], complaints and compliments[11] data recorded on the Health Board's concerns management system (provided by DatixCymru and Datix) between July 2018 to September 2023 for the nine service areas (excluding Primary Care and Community) have been analysed.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda was the first health board in Wales to adopt the new Datix Cymru system. Before April 2021, Datix was used. Prior to implementation of Datix Cymru work had been undertaken to develop a system that made reporting of incidents simpler. This may account for the rise in incident reports seen in April 2021.

Due to gaps at the reporting stage of records, the totals for each category may not be equal to the overall totals for each service.

As the information collected through Datix and Datix Cymru is from two different time periods (i.e. before and after April 2021), the data included in the Issues Papers is included in two tables – showing the implementation of the current system.

Details on the process for reporting incidents that arise at Hywel Dda can be found on the website here: hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/incident-near-miss-and-hazard-reporting-procedure

The key themes and any relevant clinical observations from the services are noted within the body of the services' Issues Papers with links to the supporting dashboard in the appendices.

For the Primary Care service, Datix Cymru information has been used when and where possible. Due to the limited use of Datix by contractors, and that there is no formal requirement for the system to be used, the information is limited. Where records have been used, information has been provided from 1 April 2021 to 31 July 2023.

Claims

Clinical negligence claims are made by claimants (the injured person who is making the claim) when they believe they have received sub-standard care from a healthcare professional, which has directly caused physical or emotional harm or caused an existing condition to become worse. For a clinical negligence claim to be successful, there is a three-stage test that needs to be met:

1. A duty of care was owed to the patient
2. There was a breach of the duty
3. That breach led to harm or injury.

The aim of a compensation claim is to enable the claimant to be in, or as close to, the situation they were in before the injury or harm took place. This may mean remedial treatment is provided, or financial compensation paid in the form of damages to compensate for any loss of function, independence, or financial loss they have encountered because of the negligent treatment.

Claims for the nine service areas (excluding Primary Care and Community) have been reviewed for the period between July 2018 and September 2023. The services' Issues Papers include details of any closed claims where liability was accepted by the Health Board and learning was identified

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[9] *A patient concern refers to a grievance raised by a patient (or a personal representative of a patient) about the care rendered to them.*
[10] *A patient safety incident "means any unexpected or unintended incident which did lead to or could have led to harm for a patient" (Welsh Government 2011).*
[11] *An expression of satisfaction or appreciation.*

that had to be taken forward during the period in question. The paper also includes information about any open claims within the period, both confirmed (cases open and being investigated) and potential cases (where we have been notified of a potential claim, but more information is needed).

Please note, the date of the incident that was the basis for any claim, may have taken place several years earlier than the date the claim was submitted to the Health Board.

6. Review of patient experience data collated by the service(s) and Patient Experience team

How did we do this?

Patient experience data has been included for all nine service areas (excluding Primary Care and Community).

Due to how our data is held on the current Civica system (the electronic system that holds all our patient experience data), and historical records, information about our patients' experience has only been analysed from 1 April 2021 to 31 July 2023. Historical patient experience records, recorded before April 2021, cannot be assigned to the services included in the Clinical Services Plan. As the older information we hold cannot be allocated to services, we have only analysed the feedback included in the current Civica system.

During the setting up of the new Civica system, there was an initial decline in patient feedback as the system was being established across the Health Board. The new system was implemented on a phased basis. This means that some services had more feedback in the early stages of Civica being introduced. We expect to see an increase moving forward in the volume of feedback we receive from our patients that will be captured in Civica, as one of the Health Board's priorities is to capture more information about our patients' experience.

It is possible that the data shows a variation in the number of reported complaints recorded for a service. This is because the system is not always able to tell the difference between different specialties within the service.

Because of how records have been captured within Civica and potential gaps in the data, the categorised totals may not equal overall totals for each service.

Data that has been analysed includes the All Wales Patient Experience data and information received from the friends and family test. Patient Experience also capture data through 'The Big Thank You'[12] form. 'The Big Thank You' data has not been included as the formatting of the information cannot be assigned to a particular service.

The key themes are noted within the body of the services' Issues Papers with links to the supporting appendices.

Data from the All Wales Patient Experience survey related to Primary Care and Community services, has been used as and when possible.

7. Targeted early engagement survey undertaken with service users

How did we do this?

[12] '*The Big Thank You' is an online form, on the external Health Board website that allows patients to thank staff, departments and teams.*

Online surveys were developed to gather views of service users' experiences of using one of the nine service areas (excluding Primary Care and Community). A copy of the questions asked can be found in Appendix A2.1 - CSP – Patient Survey Questions.

The surveys were shared with a selection of service users who have accessed one of the nine service areas (or care for someone who has), within the last five years (between 1 August 2018 and 31 July 2023). Service users were invited to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service.

The link to the survey was sent out to service users (or their carers) in a text message (SMS) sent to mobile phones on 19 October 2023. The survey closed to responses on 2 November 2023. A total of 5,927 responses were received across the nine service areas. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

The feedback was analysed and the main themes arising from the comments made by service users are noted within the body of the services' Issues Papers. The full feedback report is added as Appendix A2 – CSP – Early Engagement ORS Report.

The Health Board is committed to engaging on a continuous basis with members of the public on the development of the Primary Care and Community Strategy programme. Due to the significant scale of a patient survey needed for Primary Care and Community, the Issues Paper has used previous public feedback to evidence the views of our population. Primary Care and Community have been the subject of much public engagement, most notably through the public engagement exercise that resulted in the report: Building a healthier future after COVID-19. This report has been used as a starting point but will be expanded upon during the strategy development.

Some of the services that form part of the Clinical Services Plan provide care for children and young people (paediatrics) as part of their pathways. Where a service provides care for children and young people, these are noted within the service's Issues Paper. The Targeted Early Engagement Surveys were shared with parents and guardians of children and young people and asked them to provide their experience and views. Where responses were received these have been captured as part of the feedback.

During the recent consultation on the Urgent and Emergency Children and Young People's (Paediatric) services at Withybush and Glangwili Hospital, we engaged directly with children and young people to ask their views. While the primary focus of the engagement was to understand their views on the proposed options that formed part of the consultation, children and young people were asked if they had any other comments that they would like to make. The main themes from those comments are captured below:

- Issues and concerns about health services in Pembrokeshire and Carmarthenshire:
  Participants in the discussion expressed their dissatisfaction with the long waiting times, the lack of GP appointments, the distance to the hospitals, and the quality of the services
- Opinions on the NHS and the new hospital plan:
  Participants praised the NHS staff and the care they received, but also criticised the lack of funding and resources. They also questioned how the new hospital would be funded and staffed, and what services it would offer
- Suggestions for improving the health services and the public awareness:
  Participants suggested that there should be more preventive work in the communities, more respect for the NHS, and more understanding of the patient pathways. They also mentioned that the media should be more responsible and not spread fearmongering.

8. Targeted early engagement with a multidisciplinary team who work within the service areas including medical, nursing, therapies, operational and support staff.

How did we do this?

Online staff surveys were developed to gather views on the experience of staff who work in, or support staff working with, the nine service areas (excluding Primary Care and Community). A copy of the questions asked can be found in Appendix A2.2 - CSP – Staff Survey Questions. Opinion Research Services (ORS) was commissioned to process and analyse the survey responses and report on the findings.

The survey was open to all staff who work within the Health Board, including staff that may not work directly for the service, but provide support to the service (e.g., therapies). Staff members were invited to share their views about what was good, bad, needed improvement, and/or, any issues regarding the service.

The survey opened on 22 September 2023 and was promoted to staff through a variety of channels e.g., email, drop-in sessions, and posters. The survey closed on 20 October 2023. In total 352 responses were received across the nine service areas. Further detail on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

Primary Care staff were surveyed using an adapted version of the staff survey used in the nine other pathways in the Clinical Services Plan. 40 responses were received. Most of the staff working in Primary Care are external to the Health Board and this posed a challenge in engaging with colleagues. The survey was open to all staff and professional bodies who represent Primary Care services. It was promoted through multidisciplinary meetings, and available between 30 November 2023 and closed on 2 January 2024.

The feedback received was analysed and the key themes are noted within the body of the services' Issues Papers and the full report added as Appendix A2 – CSP – Early Engagement ORS Report.

9. Finance

How did we do this?

Information for all nine service areas (excluding Primary Care and Community) about what drives the costs for each service is included in the services' Issues Papers. These include the main reasons for what causes a change to the financial position of each service – what are the main pressures on the budget. The information included helps us to understand what makes the service more expensive, and in some cases, more fragile.

The financial analysis for Primary Care Services reflects the direction of both current and new policy, and the challenges that Primary Care faces. The financial analysis focuses on the ringfenced allocation of money from Welsh Government and any additional non-recurring funding.

10. Review of workforce data

How did we do this?

Workforce data was supplied for the nine service areas (excluding Primary Care and Community), based on the staffing levels defined within cost codes[13] provided for each service area.

For Primary Care service, Out of Hours and Community Dental Service was also included. The data focused on the clinical roles within the services i.e., medical and nursing workforce, but where available all professional group data from the cost codes were presented. In the Primary Care Services, The Welsh National Workforce Reporting System (WNWRS) was used where possible to illustrate the staffing in General Medical Services.

Any known workforce risks for the service were also included. Key data, themes and any relevant clinical observations from the services are noted within the body of the services' Issues Papers. Additional information can be found in the appendices.

[13] *Cost codes are unique numbers that categorise how money is spent. These allow you to identify and track specific costs within categories that belong to a service.*

Section 4: Primary Care and Community

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

Section 4: Primary Care and Community

Introduction & Background

This chapter is about Primary Care services in the Hywel Dda University Health Board area. It provides an analysis of Primary Care services using the same or similar methodology that has been followed by all the pathways that form the Clinical Services Plan programme (CSP). The information is accompanied by a high-level review of the strategies and plans at a National, Regional and Local level, that focus on Community Services; all of which inform Primary Care and Community Services.

The Clinical Services Programme and Primary Care and Community

Primary Care was included as part of the CSP, in recognition of the sustainability challenges it faces. This was highlighted in an Extraordinary Board Meeting in February 2023[14] [15]. This sustainability challenge posed similar service issues facing the nine pathways already in scope of the Clinical Services Plan Programme, and as a result Primary Care was added as a tenth pathway.

Primary Care and Community provides a wide range of services. The services on offer are varied, but there are common sustainability challenges facing them all. Including Primary Care in the CSP programme which has a focus on service sustainability means that the Health Board has been able to look at all the services it is involved with in a similar way.

Key aims for the Issues Paper

The aim for the Issues Paper is to identify key themes and challenges within the Primary Care services provided across Hywel Dda. The themes identified will help us to develop a Primary and Community Strategy. The scope of the strategy will not only include Primary Care Services but include a community focus. The Primary Care and Community Services strategy will deliver the vision set out in A Healthier Mid and West Wales. The scope of the strategy will focus on:

Primary and Community services which provide safe, sustainable and accessible services to patients, as close to the patients home as possible. We will do this by:

- Using the principles of a social model for health and wellbeing
- Using the evidence, based on world class Primary and Community services
- Supporting patients to access timely and appropriate health and social care when needed
- Ensuring that every contact counts and that Value Based Health and Care principles are at the core of what we do
- Designing Primary Care and Community Services that are sustainable and able to deliver modern health care in appropriate environments.

Primary Care Services: Issues Paper Definition

Primary Care has been defined for the purposes of this Issues Paper as:

- General Medical Services (GMS)
- Community Pharmacy

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[14] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-23-february-2023/*

[15] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-22-minutes-of-the-extraordinary-public-meeting-held-on-23-february-2023pdf/*

- General Dental Services (GDS)
- Optometry Services.

In addition to these four Contractor services, for the purposes of this paper the definition of Primary Care also includes Hywel Dda University Health Board's:

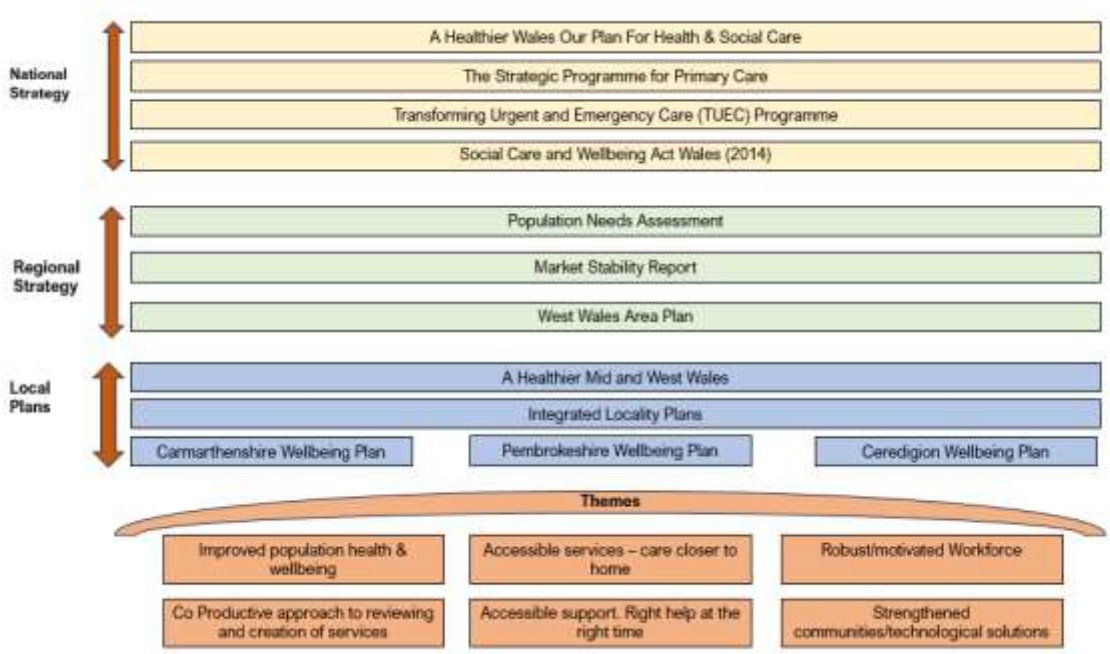
- Community Dental Services (CDS)
- Out of Hours (OOH) service.

Workforce Information has also been included for those services which are called Community Services and sit within the County teams. Whilst these services are not funded by the Primary Care financial allocation, they form an integral part of the wider multi-professional team which support our communities.

Strategic Landscape

Hywel Dda's Primary Care and Community Services are shaped by the strategic direction set by Welsh Government and the Strategic Programme for Primary Care. Information in (Appendix B7 - Primary Care - National Workstreams - All Wales Strategic Direction) highlights some of the key objectives which provides the foundation for any work the Health Board undertakes.

The policy and strategic framework drivers for Health Services as a whole and Primary and Community Services in particular include the following:



Primary Care: Partnership Working

Primary Care Contractor services are an important part of the wider service supporting the health and wellbeing of the population. Often services that are based in the community that help people to remain healthy and well are not run by Hywel Dda University Health Board. They may be the responsibility of our statutory partners or private or voluntary sector organisations. As a result, planning and delivering services must be approached as a joint venture and joint responsibility.

There are many Statutory Partnerships and collaborative bodies of which the Health Board is a part. Most notable for this Issues Paper is the West Wales Regional Partnership Board and the

three Public Services Boards, that cover the three Counties of Carmarthenshire, Ceredigion and Pembrokeshire that make up the Hywel Dda region.

These Partnerships shape much of the strategic direction of the health and wellbeing services on offer within the region. The table in Appendix B6 - Primary Care - Local and Regional Workstreams - Regional Population Plans summarises the various statutory plans, objectives and work programmes, that the Health Board has played a role in developing and have agreed through its Governance and the specific partnership and organisation governance structures of which the Health Board is a member.

The development of a Primary Care and Community Strategy will be required to recognise the key objectives that the Health Board has formally aligned with, and the timeline for the agreed programmes of work.

Primary Care and Community: Integrated Funding for Community Services

Statutory partnerships are used as forums to work with partners on shared objectives, such as improving the population's health and wellbeing. Some funds are held by and administered through a partnership and the partner organisations work together to identify opportunities to improve health and care service. These partnership funds are additional to the Primary Care allocation which the Health Board receives from Welsh Government. Most notable for this Issues Paper is the Health and Social Care Regional Integration Fund (RIF) (Appendix B15 - Primary Care - Health and Social Care Regional Integration Fund) administered by the West Wales Regional Partnership Board and amounting to a sum of £18.7m in 2022/23. Some of the funding is ring-fenced for national objectives, and has elements of match funding criteria, depending on the programme of work being delivered. There are key areas for spending that receive ring fenced funding that must be the focus of the Health Board's work programme. In 2022/23 they were:

- Integrated autism service
- Dementia
- Memory assessment services
- Unpaid carers hospital discharge engagement.

Primary Care and Community: Planning for Localities and Counties

In addition to its Primary Care workforce, the Health Board manages much of its Community services including a proportion of its workforce, through County based teams. Services are planned and operated on a locality-basis, to reflect the seven localities – called Clusters - that make up the Hywel Dda region. Services are based on the specific population health needs that are present in each Cluster. The membership of a cluster must include representatives from each of the four Independent Contractor professions along with Nursing and Allied Health Professional leadership. In addition to clinical membership, Clusters require representatives from the Third Sector services. The Accelerated Cluster Development Toolkit[16] provides further information and guidance.

Each of the three Integrated Locality Plans bring together the Cluster priorities which are articulated in individual IMTPs and is co-owned by the Integrated Locality Planning Groups that represent each of the Counties in Hywel Dda.

The following diagram outlines the integrated locality approach and has informed the three integrated locality plans in 2023/24 in the Annual Plan 2023/24.

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[16] *https://primarycareone.nhs.wales/tools/accelerated-cluster-development-toolkit/*

Population Needs Assessments

Over time there have been several health and wellbeing assessments of the Hywel Dda resident population and as a result there is a lot of information available to inform current service requirements and to plan for future needs. These assessments have been produced at a Cluster level as well as at a regional level, meaning that the Health Board can see both the big picture as well as understand the population health needs for specific locations. These assessments and plans have been undertaken with Hywel Dda as either the main driver of needs mapping, or as a statutory partner in a formal process. Appendix B6 - Primary Care - Local and Regional Workstreams - Regional Population Plans sets out the themes of following the population plans:

- West Wales Area Plan
- Well-being Plan for Pembrokeshire
- Carmarthenshire Well-being Plan
- Ceredigion Local Wellbeing Plan
- A Regional Collaboration for Health (ARCH) West Wales Population Needs Assessment.

The Primary Care Cluster profiles (Appendix B16.1- B16.7 – Primary Care – Cluster Profile) were developed to support Cluster service planning and are based upon several data sources including the recent Census, data from Statistics Wales, data from Health Maps Wales and information from the Primary Care Information Portal. Each Cluster profile maps its population against the wider determinants of health to support the proper targeting of its resources to reduce differences in health outcomes. Wider determinants are often call ‘social determinants’ and range from social, economic and environmental factors which impact on people’s health.

What does this mean for Primary Care and Community services?

- There are national strategic plans in place which shape the way in which services are commissioned, delivered, and provided. These provide the Health Board with a lot of information that will underpin the Primary Care and Community Strategy

- There are population health needs assessments and plans at multi organisational levels already in place that provide information for specific populations and geographical areas. This information must shape the Primary Care and Community Strategy
- There are well established funding mechanisms that can and should be used in addition to the allocated Primary Care resource to provide more services in the community. How and where it is spent is set by the funding criteria and must be taken into consideration in the development of the Primary Care and Community Strategy.

Stakeholder mapping

A stakeholder identification and mapping exercise was undertaken to identify the key stakeholders in Primary Care and Community Services. Appendix B17 - Primary Care - Stakeholder Map illustrates the stakeholder map and analysis. The mapping exercise emphasised the scope and scale of interested parties who are currently involved in Primary Care and Community Services. The exercise identified the interdependencies of stakeholders between Primary Care Services and the wider Community Services stakeholder community.

Population Feedback on Primary Care Services

Hywel Dda University Health Board carried out an engagement exercise and published a report called 'Building a healthier future after COVID-19'. It was an opportunity to communicate with staff, patients, and their families, and the wider public to find out how their lives had been affected by the global pandemic. Public feedback on Primary Care services highlighted some key themes which were raised by some members of the public:

- Some people found it more difficult to access services. New methods of accessing services, e.g. online or by phone, proved challenging for a significant number of responders, while others found new methods of communication more convenient
- Some people have difficulty getting to and from Primary care services, as well as have challenges physically accessing services
- Some people felt that they were having to wait longer, especially since the COVID-19 pandemic
- Some people felt that it was more important to have services at a local level, either in the community or at local hospitals
- People were positive about community support delivered by the third sector and volunteers and hoped that these initiatives could be made more sustainable.

Primary Care Workforce Survey

As part of the research into Primary Care Services and in line with the wider CSP methodology the Primary Care workforce was invited to feedback on their experience in an online survey. The questions were the same question set used for all the CSP pathways. There were slight changes to make the wording more appropriate for an external workforce, and there was an additional question asked as a reflection of the fact the feedback would help to shape the strategy that is being developed for Primary Care and Community Services. The full reports can be found in Appendix B13.1 – B13.3 – Primary Care – Workforce Data.

The main the findings were:

- 60% of staff respondents said that their overall experience of working in the Primary Care service was good. 28% said their overall experience was neither good nor poor. 13% said it was a poor experience
- There were a range of reasons as to why people felt positive about their work including:
    - Pride at making a difference in their communities and helping and supporting people

    - Providing continuity of care to patients using a high standard, holistic way of working
    - Having good working relationships within teams and across the service
    - The variety of the work in Primary Care and the ability to utilise higher qualifications within practices to develop services and improve the patient experience
    - The support received by management teams, specifically in General Medical Services
- There were a range of reasons as to why people felt negative about their work including:
    - Pay concerns and the view that it is unfair that staff in similar roles within Secondary Care settings get paid more for doing a similar role
    - The lack of adequate funding for Primary Care, resulting in limited resources and poorer patient care and outcomes
    - A perceived lack of training opportunities
    - The transfer of work from Secondary Care to Primary Care without the required funding, resources, and training
    - Outdated facilities and resources
    - Increasing demand and time pressures
    - Poor communication across the Service, and with community services and Secondary Care
    - Time consuming and unclear referral systems
    - Low morale among some Primary Care staff impacting on staff retention
    - The lack of development opportunities for clinical staff and the need for more specialists
- When asked about future career plans and where they see themselves working in five years' time the responses were as follows:
    - Twenty-one respondents saw themselves still working in Primary Care within the Hywel Dda
    - Seven respondents saw themselves doing something else
    - Ten respondents think they will retire within the next five years
- When asked what would help deliver sustainable Primary Care services in future, the responses included:
    - Better long-term future planning for the Primary Care Services
    - Improving working relationships between Primary and Secondary Care
    - Reducing the bureaucracy associated with the GP contract
- Other suggestions included:
    - More support for the Contractor model of care
    - More general support for services at Cluster level
    - Specialist HR support to ensure the 'hiring the right people'
    - More training opportunities for all staff
    - Better redirection of patients from Secondary Care to Primary Care, due to the complex nature of patients being unmanageable in Primary Care services.

What does this mean for Primary Care and Community Services

- Both the population and the workforce acknowledge increasing demands, either through growing waiting times, or increasing time pressures and demands on the workforce
- Both the population and the workforce highlighted communication issues. Patients often found newer ways of engaging with services as a barrier to accessing care, whilst the workforce flagged poor communication between services, especially between Primary and Secondary Care as a real issue
- Resources, such as funding, the estate and skilled or well-trained team members were consistent themes identified by the Primary Care workforce.

- A significant proportion of responders do not think they will be in post in five years' time, potentially leading to further instability in service provision.

Activity Data Methodology

The same methodology has been used to shape the Primary Care and Community Services Issues Paper as for the other nine CSP Pathways, to gain a better understanding of the current state of play, to see what is working well and not so well; whilst looking at areas for improvement. Whilst the objective has been to follow the same methodology, it is acknowledged that the structure of Primary Care and Community Services, most notably the contractual relationship with Primary Care Providers, has shaped the level and type of data that is available and how data is provided. This means that the activity data supplied in this Issues Paper looks different from the rest of the CSP programme.

Primary Care Activity Data

Primary Care Contractor data collection is limited and therefore there are limitations to the level and type of data that is available to the Health Board. The data set in Appendix B8 - Primary Care - Activity Data reports information for the financial year 2022/23; this differs from the CSP methodology that focuses on five years of data. The data sets used to inform this Issues Paper relies on activity and performance measures, not on individual patient care records,

Most of the data available to the Health Board is derived from financial claims or contractual monitoring data sources. At present the Health Board is developing a proof-of-concept activity dashboard for Managed Practices which has been selected as a Pathfinder project by the Strategic Programme for Primary Care in Wales, and whilst this is in its early stages of development this additional support will enable us to scale and develop the programme at pace in 2024. Whilst the Managed Practices are being used as a test bed for the concept there has been some interest from local independent contractor GP Practices in testing the model.

Primary Care Activity Data: Sources

The Primary Care activity data set is based on the datasets that are made available to the Health Board through the following channels:

- Adastra – Clinical Patient Management Software (Out of Hours only)
- BSA – Business Services Authority (Dental data)
- Consultant Connect – Telemedicine Provider
- COVID-19 Datahub – COVID-19 Datahub (Digital Health and Care Wales)
- Microsoft Forms – submitted by contractors directly to the Health Board
- NWSSP – NHS Wales Shared Services Partnership
- PCIP – Primary Care Information Portal (Digital Health and Care Wales).

The Primary Care: The Contractual Framework

Primary Care Service provision is delivered through the four Contractor services. The shape and scope of the service on offer is based on this contractual relationship and the All-Wales negotiated Contracts and payment regime. A common factor in all four services is the tripartite nature of the Contract negotiations; the negotiations that are held to review and renegotiate terms, payments, and service level reporting. The Contracts are nationally agreed and as such Hywel Dda University Health Board, has limited scope to vary its terms and conditions with Primary Care contractors.

It is important to note the unique relationship the Health Board has with this fundamental part of the health system, and the impact this can have on how changes and challenges in Primary care can be addressed, both in terms of decision making and time scales for transformation.

Whilst nationally negotiated Contracts are in place across the four Contractor professions and there is a national desire to move to a Unified Contracting position, currently there are several significant differences between the Contractor professions in terms of the level of business support that is included within the negotiated Contracts. This will impact on the potential business viability for Independent Contractors.

Contract	Rent	Business Rates	Utilities	Indemnity	Improvement Grants
General Medical Services	**YES**	**YES**	**YES**	**YES**	**YES**
GMS Managed Practices	**YES**	**YES**	**YES**	**YES**	**YES**
Community Pharmacy	**NO**	**NO**	**NO**	**NO**	Potential for non-recurring funding in 2024. £1K per pharmacy
General Dental Services	**NO**	**PARTIAL YES** based on usage of premises for NHS/Private purposes	**NO**	**NO**	**NO**
Optometry Services	**NO**	**NO**	**NO**	**NO**	**NO**

What does this mean for Primary Care and Community Services?

- The Health Board must commission and deliver Primary Care services in line with national legislation set out in Regulations or Directions. This means there are limited opportunities to change the way in which services are commissioned and delivered
- The four Contractor services do not receive the same level of financial business support within their Contracts mainly due to the private and/or commercial elements for General Dentistry, Community Pharmacy and Optometry. This is however likely to affect their ability to develop their services and estate.

Primary Care Finance Overview

This Issues Paper provides information on the funding structure in which Primary Care services operates. Primary Care expenditure is dominated by four large contract allocations.

Primary Care: What we spend and where we spend it.

The table below shows the annual allocations and includes non-recurring funding, such as COVID-19 related payments. (Tables shows funding in £million)

Allocation	2018/19	2019/20	2020/21	2021/22	2022/23
GMS	65,573	69,430	69,464	77,754	80,779

Community Pharmacy	21,085	21,383	22,214	22,620	22,248
General Dental Services	18,151	17,859	18,005	18,898	20,818

The table below sets out Hywel Dda University Health Board's final accounts from 2018-19 to 2022/23 and provides a breakdown of the expenditure in the areas of services that are included in the Primary Care financials. (Tables shows funding in £million)

Area of expenditure	2018/19	2019/20	2020/21	2021/22	2022/23
General Medical Services	71,645	73,954	74,179	76,935	79,855
Pharmaceutical Services*	19,453	19,680	20,722	20,401	21,114
General Dental Services	19,925	21,035	19,578	21,738	23,308
General Ophthalmic Services	5,337	5,543	5,462	5,778	5,206
Other Primary Care	3,943	4,801	5,644	6,449	7,972
Prescribed drugs and appliances	70,834	72,577	79,979	78,978	86,698
Total expenditure	**191,137**	**197,590**	**205,564**	**210,279**	**224,153**
Cash limited	1,238	1,320	1,239	1,216	1,360
Non-Cash Limited	4,099	4,223	4,223	4,562	3,846
Total	**5,337**	**5,543**	**5,462**	**5,778**	**5,206**

**non-cash limited amount included*

Spend in Primary Care is driven by the four large Contracts which are negotiated on a tripartite basis led by Welsh Government, with the relevant professional body and representation from the NHS. Changes in contract agreements and rates of pay and/or reimbursement have large effects on the expenditure and sit outside the direct control of the Health Board.

The increases in expenditure that are entirely in the Health Board control tends to be dominated by premium variable pay within Managed Practices (down to a majority GP locum workforce) and the Out of Hours service (again limited salaried staff with the majority of Locum GPs). Similar workforce issues and associated cost pressures are evident in Secondary Care.

Whilst expenditure is increasing across certain service areas, there have been decreases in expenditure in General Dental Services (GDS). This is a result of Contract terminations and/or underperformance against activity targets in the contract, which necessitates financial recoveries within a financial year but impacts on the Health Board's ability to recommission the activity.

Whilst Cluster funding have been in place for many years the implementation of the national programme of Accelerated Cluster Development has seen an increase in expenditure areas that were historically underspent. Whilst expenditure has increased it is important to note that the overall financial envelope for Clusters has remained in balance.

In 2022/23, the Primary Care component of the Transforming Urgent and Emergency Care funding was allocated to Primary Care costing £955k. This increased the other Primary Care spend. This is part of the national 'Six goals' programme which is due to cease in March 2026.

Analysis of Primary care drug expenditure shows a 4.5% average increase over a five-year period which is in line with the increased Secondary Care drug expenditure which has seen an average

increase of 6.4% in drugs expenditure in the same period of time. Drug inflation (cost and volume) is also a key driver of the increase of expenditure in Primary Care.

What does this mean for Primary Care and Community Services?

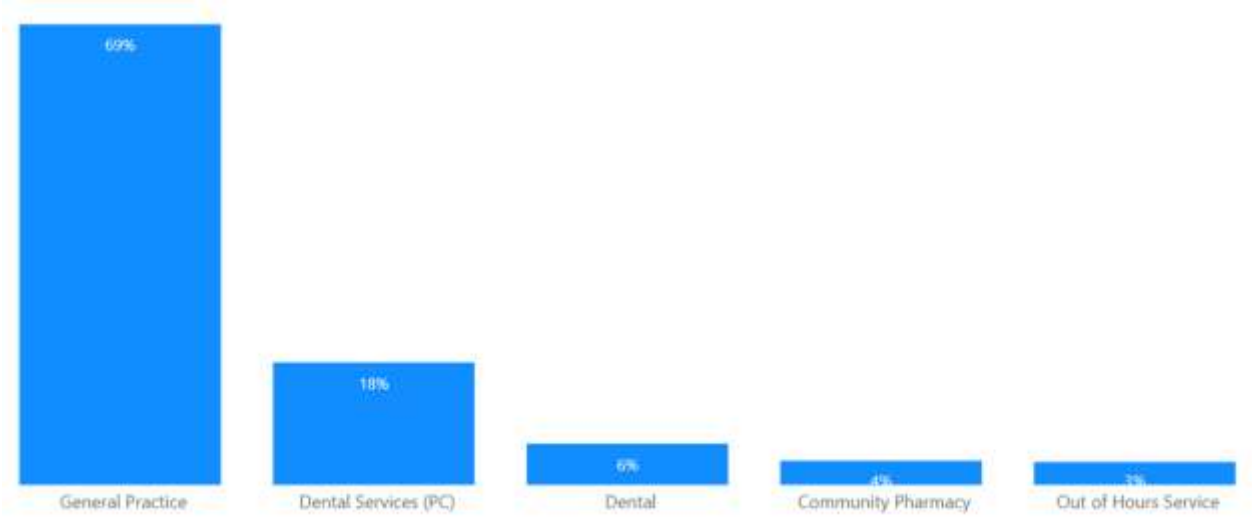
- Most tariffs paid to Contractors are controlled by the All-Wales Contracts. Therefore, the majority of the spend in Primary Care is fixed
- Cost pressures are impacting on the delivery of Primary Care services in the same way that they are for the rest of the Health Board
- Locum GP costs continue to be the main cost pressure for Managed Practices and the Out of Hours service
- The timeline for the recommissioning of General Dental contracts means that there is an underspend within a financial year. The loss of NHS dental contracts reduces the amount of income the Health Board receives from patient charges
- The rising cost of drugs and the increase in prescribing them is an issue for the Primary Care financial position.

Incidents, Complaints, Compliments and Claims Data

Following the approved methodology set out for the CSP programme, incidents related to Primary care Services, reported between 1 April 2021 and 31 July 2023 have been included in this report. A full report can be found in Appendix B9 - Primary Care - Incidents data.

It is important however to note that this is not a complete picture of incident reporting across the Primary Care Contractors as incident reporting is not mandated. Therefore, in relative terms to the size of the population served, the actual number of reported incidents is very low. As a result of this, caution should be used when attributing any trends to the information included in this paper.

The graph (below) depicts the relative spread of reported incidents throughout the defined time period, during which there were 588 reported incidents attributed to Primary Care and Out of Hours. There are no reported incidents for Optometry as the new Ophthalmic contract was not implemented during the review period.



All Wales Patient Experience, Friends and Family Experience

As per the approved Clinical Services Plan methodology, patient experience data has been included for Primary Care Services across all sites in which the service operates. The data held by the Health Board is limited due to much of the information being owned by the individual contractor professions.

The All-Wales GP patient experience survey data is undertaken annually by GP Practices as part of their participation in the Quality Assurance and Improvement Framework (QAIF) and whilst reflective reports are provided as part of their submission for achievement of QAIF this does not provide a level of data that can be used meaningfully. Therefore, the dataset held by the Health Board can be attributed to Out of Hours, Community Dental Services and Managed Practices only.

Appendix B11 - Primary Care - Patient Experience and Compliments Data sets out on the feedback received from Patient Experience, Friends and Family Experience and Compliments that have been recorded each year since 2021.

What does this mean for Primary Care and Community Services?

- The Health Board has limited access to patient experience data. This poses a challenge to the Health Board being able to see a system wide view of patient experience.

Service Specific data analysis

The following sections provide a breakdown of data for each of the four Contractor services, plus Community Dental Services and the Out of Hours service.

General Medical Services (GMS)

General Medical Services are provided by 48 General Practitioner Surgeries, working across 65 sites (including Branch Surgeries). Of the 48 GP Practices, six are Health Board Managed Practices, (meaning that they are run by the Health Board following a Contract termination by the Independent Contractor), with the remaining 42 Practices being Independent Contractors who are commissioned by the NHS to provide General Medical Services for the population of a specific geographical area.

Contractual Information

A new GMS Contract was first introduced in 2004. The Contract introduced core, additional and enhanced service provision as well as a quality assurance framework and changed the fundamental funding mechanism for GP Practices. Since then, there has been periodic (annual/bi-annual) changes to the Contact which require Health Board implementation and monitoring.

Most recently the Unified Contract for General Medical Services was introduced with the Regulations coming into place in October 2023, which will require Health Boards to issue Contact variations (either unilateral or bilateral) which are legal documents that set out the range and level of service provision by GP Practice. The Contract variation process is complex and will require the Health Board to ensure that all their GMS Contracts are accurate and reflect all necessary changes.

Contractual changes

There are nationally agreed guidance documents processes in place to support and enable Contract changes such as Contract terminations, Practice mergers, Branch Surgery closure application etc and a summary of these are included in the table below:

Date	GP Practice	Action
05 Jan 2015	Meddygfa Minafon (Kidwelly)	Contract terminated by partnership with the Practice becoming a UHB managed practice
31 March 2015	Meddygfa Wdig (Goodwick)	Contract terminated on retirement of sole practitioner
01 April 2015	Goodwick Surgery	Practice becomes a UHB managed practice
01 June 2015	Amman Tawe Practice	New Contract awarded for Amman Valley Medical Practice's practice list
30 September 2015	Andrews Street Surgery (Llanelli)	Contract terminated on retirement of sole practitioner (Dr Devichand)
01 October 2015	Andrews Medical Practice	New Contract awarded for Dr Devichand's practice list
01 July 2016	Narberth & Clarbeston Road & Meddygfa Rhiannon	Merged to become Narberth Surgery
01 November 2016	Solva Surgery	Schedule 8 contract variation notice (from partnership to single hander)
31 May 2017	Andrews Medical Practice	Contract terminated by partnership; practice list redistributed to neighbouring practices
31 July 2017	Harbour View Surgery	Contract terminated on retirement of sole practitioner; practice list redistributed to neighbouring practices
01 October 2017	Meddygfa'r Sarn, Pontyates	Contract terminated by partnership with the Practice becoming a UHB managed practice
01 August 2018	Tenby Surgery	Contract terminated on retirement of sole practitioner with the Practice becoming a UHB managed practice
01 September 2018	Ash Grove Surgery	Contract terminated by partnership with the Practice becoming a UHB managed practice
01 September 2018	St. Clement's Surgery	Closed due to pressures to recruitment and retain GPs

01 January 2019	Argyle Surgery	Boundary change for Argyle Surgery for Neyland area north of the Cleddau
31 January 2019	Teifi Surgery	Contract terminated by partnership; practice list redistributed to neighbouring practices
28 February 2019	Ashleigh Surgery	Contract terminated by partnership; practice list redistributed to neighbouring practices
04 March 2019	Goodwick Surgery & Fishguard Health Centre	Merged to become Fishguard Surgery
31 December 2019	Ferryside Surgery	Closure of Ferryside Surgery (branch to Minafon)
01 April 2020	Tanyfron Surgery	Schedule 8 contract variation notice (from partnership to single hander)
January 2022	Margaret Street Surgery	Application for branch surgery closure made. Application declined
01 July 2022	Neyland and Johnston	Variation to the contract to move from a partnership to a single-handed GP
01 November 2022	Neyland and Johnston	Contract terminated by single handed GP with the Practice becoming a UHB managed practice
01 April 2023	Solva	Contract terminated by single handed GP with the Practice becoming a UHB managed practice

There has been growing trend for GP Practice Contract terminations to result in Health Board Managed Practices in recent years, this has been because of a lack of alternate appropriate solutions to secure the ongoing provision of General Medical Services to the registered population. However, the decision to enter a Health Board Managed Practice is subject to process determined by the Contractual regulations, and a thorough process which may lead to one of four outcomes:

1. **Approval** - If all requirements are met and the evaluation process is successful, approval is granted for the practice to be managed by the Health Board
2. **Conditional Approval** - In some cases, conditional approval may be given, subject to specific conditions or adjustments
3. **Deferral** - If further information or clarification is needed, the decision may be deferred until additional details are provided
4. **Rejection** - If the practice does not meet the necessary criteria, it may be rejected.

As can be seen from the table above, the final outcome which is decided ultimately by the Health Board may not always be that of a Health Board Managed Practice.

Access to GP Practices

Across the 48 GP Practices in Hywel Dda there are 399,893 registered patients. In addition to registered patients there are those needing care who travel in and out of the area (particularly

during the holiday season). According to data from NWSSP of those registered patients 25.3% of patients are aged 65 years or older.

In 2022/2023 there were 2.5 million appointments with 61% of patients were seen face to face by a clinician. In October 2023, the British Medical Association published a Safe Workload Guidance for GPs in Wales[17], which indicates that the number of patients per Full Time Equivalent (FTE) GP has increased from an average of 1676 in 2013 to 2210 in 2022. The report also advises that the European Union of General Practitioners and the BMA have recommended that the safe level of patient contacts in a day is "not more than 25 contacts in a day"; however, the report also notes that "At Your Service" published by the Policy Exchange[18] states that 28 contacts per day is safe. GP patient list sizes have increased from a relative stable trend in 2016 to 2021. Between July 2021 and January 2023 there was a steep incline, with the average GP Practice list size being 8,653.

Finance

Welsh Government (WG) allocates ring fenced funding to different parts of the General Medical Service (GMS) contract to pay GP Practices for the provision of General Medical Services. Parts of the contract are within the Health Board's control such as the commissioning of Enhanced Services (National and Local) whilst other elements are based on the Practices list size (number of registered patients) known as the 'Global Sum' alongside quality payments (QAIF).

The allocation for the Managed Practices is recycled from the Independent Contractor allocation. The GMS expenditure is broken down into the categories as below.

Global Sum

This is the largest financial part of the Contract taking up 50-54% of the expenditure from the GMS allocation. In 2022/23 this was £42m. This expenditure is based on the weighted average of the patient list that the Practice provides a General Medical Services for. A standard charge per person is multiplied by the population plus demographic adjustments (weighted average). The standard charge is set by WG therefore non-negotiable for the Health Board's position. Payments to Practices therefore fluctuate with their patient list size but for the Health Board it tends to be static without changes in rate.

In 2022/23, there was a negotiated change to the Contract to increase the proportion of the allocation to the Global Sum which is guaranteed income for Practices. The rate has increased from £98.51 per patient to £114.40 per weighted patient.

For Managed Practices the proportional amount for the Global Sum is used to fund Managed Practice running costs which includes staffing.

Quality payments

Quality payments are split into Quality Assurance and Improvement Framework (QAIF) and a payment based on access to services. Quality payments through QAIF are based on Practices evidencing their achievement against a set of indicators and therefore payments could be less than the allocation. However, in the most recent year all Practices have achieved 100% of the payments for QAIF. Currently QAIF achievement is based on an October to September period rather than a traditional financial year (April to March).

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[17] https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-workload-guidance-for-gps-in-wales
[18] https://policyexchange.org.uk/publication/at-your-service/

With the changes to the Global Sum enacted in 2022/23 the number of points to be achieved within QAIF reduced from 510 to 170 points, which is a 66% decrease. Quality payments therefore have decreased from £6 million in 2019/20 to £3.4million in 2022/23, however the resource has transacted back into core contract funding.

Managed Practices do not technically have payments for their achievements against QAIF, but the equivalent amount is allocated to their cost centres with the same quality standards expected of them; if they do not achieve the quality standards, they do not get the allocation.

Enhanced Services

Enhanced Services expenditure is a variable cost based on Practices agreeing to deliver a range of extra services at agreed rates of remuneration. There are three types of Enhanced Services, directed (specification and remuneration agreed at a national level and Health Boards must commission), National (specification and remuneration agreed at a national level but Health Boards can choose whether to commission) and Local (service determined locally with rates of remuneration negotiated locally with the Local Medical Committee).

During the COVID-19 pandemic, it was the Enhanced Services activity that decreased the most as it was based on the number of patients the practices saw. The COVID-19 vaccination payments were paid through this service as other services were reduced. Therefore, trend analysis shows no particular trend as “normal” service returned in 2022/23 with expenditure increasing on many enhanced services.

The largest expenditure on an Enhanced Service is for the provision of the flu vaccine which averages around £800k a year.

£6.8m was spent on Enhanced Services in 2022/23 which equates to 8.5% of the total spend the GMS contract.

Dispensing and Prescribing costs

Practices are given reparation for dispensing and prescribing drugs. Practices are either prescribing (the majority of Practices in Hywel Dda) or dispensing practices. There is greater remuneration provided to dispensing practices in comparison to prescribing-only practices. There are currently five dispensing Practices within Hywel Dda. Dispensing Practices are in rural locations where the patient lives at a nationally determined distance from the nearest Pharmacy and the Dispensing Doctor needs to be included on the Dispensing Doctor list.

The cost of the drugs is also included with the GMS expenditure; and this expense has been steadily increasing by 2.8% per year in the last 5 years. The 2022/23 expenditure was £6.6m, which equates to 8.5% of the GMS expenditure. Drugs costs (prescribing and/or dispensing) is one of the areas where the expenditure is greater than the allocation with a 20% increase in 2022/23.

Managed Practices do not have this expenditure. Any drugs utilised in the delivery of services are provided by the Health Board’s Pharmacy in the same way as a hospital ward has drugs costs attributed to them.

Premises

GP Practices receive reimbursement for the cost of their premises rent or a notional rent if the Practice owns their own premises. Practices also receive reimbursement for utilities, clinical waste and business rates. During COVID-19, the expenditure on business rates decreased as all

businesses had relief during this period. GMS is the only contractor to receive this level of funding for its estate.

The proportional amount spend on premises has remained at a similar level over the last five years apart from in 2022/23 when Neyland and Johnston became a Health Board Managed Practice and this level reduced due to the way the Health Board records costs between a commissioned service and services it provides itself. The expenditure in 2023/23 was £4m a year which equates to 5% of the GMS expenditure; previously it was 5.5%.

Information Management and Technology (IM&T)

The IM&T expenditure is dominated by one cost which is the IT support provided by Digital Health Care Wales (DHCW) for the provision of Clinical Systems. This amounts to around £1m and the allocation is given on a non-recurrent basis each year to match the inflationary increases that DHCW charge. There is a recurring element of £231k which is used for other IT costs such as new hardware for GP Practices, which is managed through a business case process. During the COVID-19 pandemic investment was made into Practice IT hardware through an underspend on the Cluster funding to help support business continuity, as well as new ways of working with remote access and online consultations.

Local Health Board (LHB) Administered (including Managed Practices)

LHB administered costs cover all the other costs that are associated with the GMS Contract including seniority payments, Partnership Premium payments, testing paraphernalia, training costs (Protected Time for Learning) and translation costs. There is £2.5m allocated for these costs. This equates to 2-3% of GMS expenditure.

Managed Practices are reported under LHB administered spend. There is no designated Welsh Government allocation for Managed Practices, however the funding that they would have received as Independent Contractors still applies. In line with the increasing number of Health Board Managed Practices over the last five years the proportion of expenditure on Managed Practices has risen from 6% to 9% which is an increase of £3m to £7.4m in 2022/23. This will increase again with the full year effect of Neyland and Johnston and Solva Surgeries in 2023/24.

Managed Practices are often taken over by the Health Board at a point in time when the business has understandably been running down at the end of a contracting period which has an impact in terms of service provision, staffing and therefore income might not be at a maximum which has an impact on future expenditure.

The Managed Practice workforce relies on Locum GPs which is an increased cost in comparison to the salaried workforce; similarly, the new appointment of staff is on Agenda for Change rates of pay which is often an increase to costs attributed to Independent Contractor Practices. There are often estates issued identified following the transition of the Practice into Health Board management which again can have a financial impact to ensure that the buildings are fit for purpose and safe for staff and patients.

Estate

The GMS estate is made up of premises either owned by the GP Partnerships, which incurs a reimbursement of notional rent or leased from a landlord. If the premises is leased, then rent reimbursement is paid and are reviewed. The reimbursement can increase to reflect market forces. Most GP Practices are sited in:

- Former residential accommodation
- Purpose built (Third Party Development – 3PD) premises, which are often used by partner agencies and other contractors
- Health Board owned premises such as Health Centres or more recently, the development of Hubs.

Practices seeking to further develop their premises currently can submit bids on an annual basis for Improvement Grants that allow them to ensure that their buildings are statutorily compliant. The allocation for Improvement Grants is issued by Welsh Government on an annual basis. The grant pot available has been decreasing in recent years. The Health Board reviews and prioritises bids that are submitted and they are supported at 66% reimbursement with the Practice meeting the shortfall.

Whilst Practices can seek funding to support with the development of their premises, the Regulations make provision for Practices to ensure that their buildings are fit for the purpose of delivering General Medical Services and therefore the associated funding for that is included within the Global Sum calculation.

Welsh Government commissioned Archus to undertake a review of the GP Practice estate across Wales with the report Future Approach to Planning Primary Care Premises in Wales being published in September 2021 the full report can be seen in B18.1 - Primary Care - Archus Report.

The Health Board commissioned Avison Young to undertake a Five Facet Survey on all the GP Practices, both the main and the branch sites. A report was produced in June 2022. The full report can be found in Appendix B18 - Primary Care - Avison Young Dashboard and B18.1 - Primary Care - Archus Report. The report highlighted a number of issues:

- Concerns around a failure to meet statutory compliance on issues such as asbestos surveys, Legionella testing
- The overall condition of the estate was noted to be poor. None of the GP Practice premises reviewed were graded as good, 64% were graded as satisfactory with minor defects and 36% graded as poor with major defects
- 42% of practices were overcrowded. 51% were judged to be fully utilising the space available to them, with only 7% identified as having underutilised space. No Practices were reported as having empty or free space
- Regarding overall functionality, no GP Practice was assessed as excellent. 54 GP Practice premises (main sites and branch sites) were assessed as having poor or very poor facilities, and in need of capital investment, of the 54 sites surveyed, 47 were identified as requiring major capital investment.

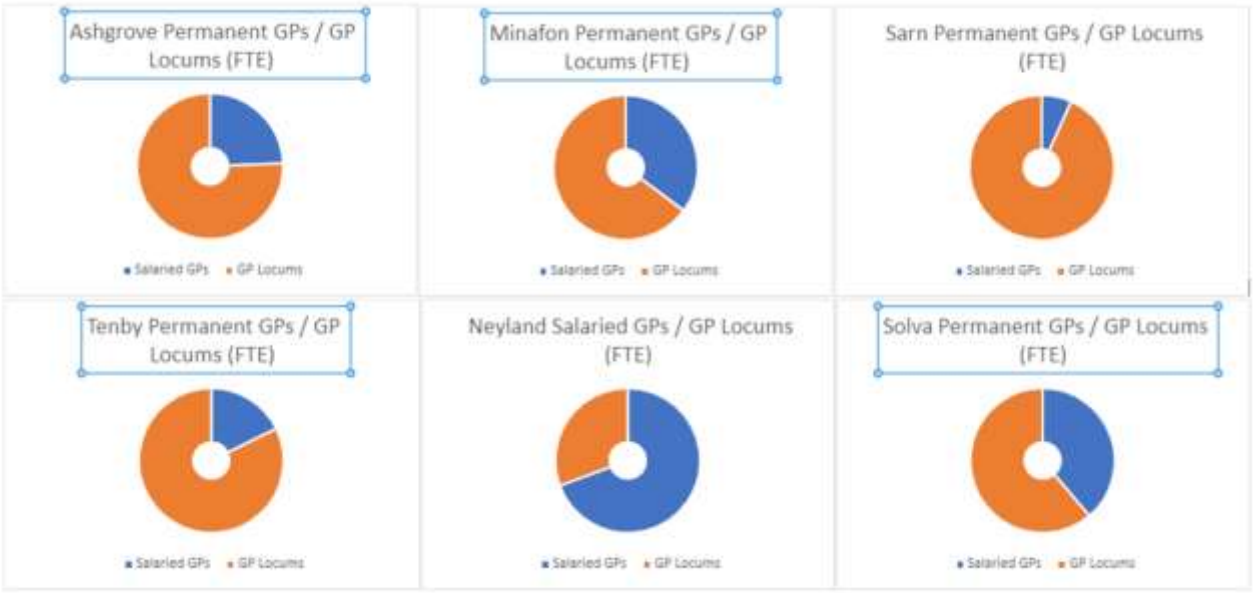
Workforce Data

The Health Board holds information on the workforce it employs directly in the Managed Practices it is responsible for. Outside of these settings Primary Care GMS workforce data is held on the Welsh National Workforce Reporting System (WNWRS). Whilst there is the commitment for WNWRS to be available for the other Contractor professions this has not yet happened due to a re-procurement of the system by NHS Wales Shared Services Partnership (NWSSP). This means

that the Health Board has very little data on the workforce in Optometry Services, Community Pharmacy and General Dental Services.

WNWRS was introduced as part of the GMS contract negotiations and in alignment to the inclusion of indemnity through General Medical Practice Indemnity (GMPI). The data can be accessed by Health Boards and allows a drill down to Practice level but does not allow for any identification of staff. There is a requirement for GP Practices to update this information on a monthly basis however there are data quality issues that need to be taken account of when reviewing the data e.g., the number of locums engaged are included as an accumulative Full Time Equivalent (FTE) or headcount total even if they only worked a limited number of shifts.

The graphs (below) show the split in employment type for GPs in the six Managed Practices. All of the Managed Practices rely on locum GPs to provide services to a varying degree.



As part of the GMS Contract, provision is made for Practices to be able to submit claims for GP Partners and clinical staff who have sickness, maternity, paternity and adoption leave; this is not for staff employed by the Practice. The table below shows that trend for claims. There has been a growing trend over the past five years for both maternity and paternity cover, and sickness cover. (Table in £ thousands)

Maternity/ Paternity Locum Cover	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Total expenditure	33,384	86,780	323,445	91,093	131,529	71,032
Sickness Locum Cover	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Total expenditure	19,262	111,512	15,313	72,998	125,346	56,604

Community Teams

The Community Team workforce sits within the County team structure and is aligned, where possible, with General Practices. The workforce included in the table (below) is comprised of:

- **Community Services** – Community Hospital staffing, Community Nursing and Palliative Care teams
- **Community Management Team** – the management teams per county
- **Other Primary Care** – Social Prescribers
- **Urgent and Emergency Care** – 111, Urgent and Emergency Care management team, and Urgent Primary Care Wrap-around rapid response.

County And Service Area by Staff Group	Grand Total WTE[19]
Carmarthenshire County	
Carmarthenshire Community Council	**359.1**
Carmarthenshire Community Services	**11.6**
Carmarthenshire Other Primary Care	**1.3**
Urgent And Emergency Care	**7.7**
Carmarthenshire Total	**379.7**
Ceredigion County	
Ceredigion County Management	**9.4**
Ceredigion Other Primary Care	**3**
Ceredigion Community Services	**149.7**
Urgent And Emergency Care Ceredigion	**24.6**
Ceredigion Total	**186.7**
Pembrokeshire County	
Pembrokeshire County Management	**20**
Proactive & Planned Care	**109.6**
Urgent & Intermediate Care	**137.6**
Pembrokeshire Total	**267.3**
Grand Total	**833.7**

Incidents, Complaints, Compliments and Claims Data

Not all GP Practices report incidents and anecdotal reports suggest that the Datix system is not user friendly or intuitive for Primary Care contractors to complete as the format is more akin to the reporting of secondary care concerns. Concern has also been raised about the lack of feedback received on reporting incidents. Therefore, the numbers reported onto the system prior to 2021 when the new Datix web system was launched is not a whole reflection of the numbers of incidents occurring in Primary Care. Following the launch of the new system April 2021 training sessions were offered to Primary Care contractors. A full report of the reported incidents can be found in Appendix B9 - Primary Care - Incidents data.

The Table (below) shows the breakdown of reported incidents by grade between 2021 to 2023. Whilst of interest it is important to note that this is only representative of a small sample of the

[19] WTE – Whole Time Equivalent represents 37.5 hours per week. The term is often used to describe the overall numbers in the workforce.

potential system wide picture, and due to a variance in reporting, it cannot be seen to illustrate the scale or severity of incidents reported by GP Practices a whole.

Grade of Incident	Number of reported Incidents
Grade 1 – Minor - Informal	330
Grade 2 - Minor	53
Grade 3 - Moderate	16
Grade 4 - Major	3
Grade 5 - Catastrophic	1

What does this mean for Primary Care and Community Services?

- The contract value is calculated on a nationally agreed formula set by Welsh Government and informs how much each GP Practice will receive. There is the potential for fluctuation in the allocation dependent on the patient list size
- Enhanced Services present a variable cost based in part on local agreements for both service provision and rate of remuneration. This can and has varied year on year.
- Whilst the demand for GP Practice appointments is rising, available data also shows us that access to services across Community Pharmacy and Optometry are also rising. What the data doesn't tell us is if the same patients are having multiple contacts for the same health condition across a number of contractors or of demand in general has increased
- The current GP Practice estate is not fit for purpose or for the development of modern services or to accommodate the changing workforce. Premise constraints could impact on the scope and range of services to be delivered
- As the transaction from the 2004 GMS contract into the 2023 Unified contract is in its early stages it's too early to tell whether this new commissioning model will allow for greater flexibility the range and scope of services that are commissioned and how that is done
- Current workforce data is insufficient in being able to draw conclusive plans together that help shape the future workforce and its skill mix as well as impacting on identifying opportunities for training, education and development
- There is no patient centred pathway data to enable the Health Board to identify the impact Primary Care services are making across the whole health system.

Community Pharmacy

There are 96 Community Pharmacies within the Hywel Dda region. Community Pharmacies offer a range of direct patient service provision, medication dispensing and retail services often from high street and supermarket locations. Whilst Community Pharmacies meet the requirements of the NHS contract, the services they can provide are often much broader, and reflect the requirements of the communities in which they exist.

Contractual Information

The Community Pharmacy Contract was implemented in 2005 and similarly to the GMS contract there was a determination of core and enhanced service provision. As with the other contracts the Community Pharmacy contract has been periodically reviewed and updated and is currently subject to tripartite negotiations. 'A New Prescription: The future of community pharmacy in Wales'[20] published in December 2021 set out the framework for the development of Community

[20] *https://www.gov.wales/sites/default/files/publications/2021-12/a-new-prescription-the-future-of-community-pharmacy-in-wales.pdf*

Pharmacies seeing a shift away from the number of items being dispensed to a wider range of services being provided to patients e.g. Common Ailments Service etc. The Community Pharmacy contract is held nationally rather than between individual Health Boards and contractors.

Community Pharmacy Activity Data

- In 2022/23 there were:
    - 10.2m prescriptions dispensed with a trajectory that forecasts an increase year on year
    - 32,412 Common Ailment Service consultations
    - 3,752 Emergency Contraception consultations
    - 21,625 instances of Emergency Medication supplies
    - 20,307 Flu vaccinations were administered
    - 5,834 Covid vaccinations were administered
    - 470 Triage and Treat consultations
    - On average 25.6 items were dispensed per patient
- There was in increase in the provision of independent prescribing consultations with 6,941 undertaken in 2022/23
- 53% of Pharmacies are open on a Saturday and 9% of Pharmacies are open on a Sunday
- 349 temporary closures were reported with 'Short Staffed / Lack of Cover' continuing to be the main reason for temporary closures.

Finance

The Community Pharmacy contract has undergone radical changes in the last five years. The publication of 'A New Prescription' set the strategic context for a reduction of the number of items being dispensed from prescriptions and move towards encouraging Pharmacists to providing a wider range of clinical services including the delivery of services by Independent Prescribers (IP).

Community Pharmacy expenditure is broken down into the categories as below:

Main Contract (including Practice Fees)

The expenditure on the main contract which includes Professional Fees, Practice Payments and Establishment Payments, is based on activity related to providing basic prescription services and establishment costs. This expenditure has stayed at similar levels over the last five years at around £16.5million but proportionally spending on this type of expenditure has decreased. From 2018/19, 85% of the contract payments were attributed to the contract. This has reduced to 72% in 2022/23. This shows that uplifts in the allocation have been diverted into other areas of the allocation.

In the second half of 2022/23 prescription reimbursement rates were nationally increased on a temporary basis from 32p to 47.7p increasing payments to Community Pharmacies by £800k. This change was triggered as an acknowledgement that the transaction from a reduction in the number of items dispensed to more clinical service provision had not happened in the way that had been anticipated and therefore cashflow to maintain service sustainability was needed. It is difficult to interpret trends when rates are changed within a financial year.

Clinical Services

Removing specific COVID-19 expenditure from the clinical services allocation, shows that expenditure in this area has increased by £1m over the last five years. This is in line with the strategic direction to incentivise Pharmacies to provide a greater range of clinical services. The

main contributor to this increase was the Minor Aliments Service which has seen an increase by five times the 2018/19 figure, to an expenditure of £704k. During the same period the activity and remuneration for the delivery of the flu vaccine programme has increased threefold.

In 2022/23, £327k of the clinical services expenditure was re-distributed as a direct payment to Community Pharmacies which is in line with the negotiated position.

Quality, Collaboration and Continuity including Cluster Leads

Payments for the contractual elements of quality, collaboration and continuity have doubled in the last five years to £1.2million in 2022/23 in line with the negotiated contract position. This now relates to 6% of the total Community Pharmacy expenditure.

There is £20k included in the allocation for Pharmacist Collaborative Leads to participate in the Accelerate Cluster programme.

Independent Prescribers and Workforce Incentives

In 2022/23 an allocation of £1.1m was included to train the Independent Prescribing Pharmacists however for the same period there was a spend of £620k, 55% of the allocation. Whilst there has been significant interest in the training the requirement to secure a mentor for the programme (which previously could only be a GP) has sometimes resulted in individuals not being able to undertake the training programme. A fee for the mentorship has been used but to limited success due to the additional commitment that this requires.

Discretionary Funds

Discretionary expenditure is not part of the ringfenced allocation for the provision of clinical services, and this is an area where the expenditure is increasing in line with the increase in clinical service provision. The expenditure tends to be related to the drugs costs which are part of the clinical service provision. By 2022/23, this has increased to £675k which is 3% of the Community Pharmacy's expenditure.

Workforce data for Community Pharmacies and their staff is not currently available.

Incidents, Complaints, Compliments and Claims Data

Like GP Practices, Community Pharmacies are not mandated to report incidents into Datix, however access to the system is available. Following the implementation of Datix in February 2022 there was a significant increase in the number of incidents being reported.

A full report can be found in Appendix B9 - Primary Care - Incidents data.

What does this mean for Primary Care and Community Services?

- There is no workforce data currently available. This poses a significant challenge in understanding the current workforce pressures and staffing structures and impacts on the Health Board's ability to set a baseline to support future education, training and development plans, as well as future service commissioning arrangements
- There is no consistency in reporting incidents in Community Pharmacy. This poses a challenge in understanding the quality-of-service provision across health sectors
- The activity data does not link Community Pharmacy service provision, with patient outcomes; this means we cannot evaluate the benefits for service intervention on patient outcomes
- There is limited potential to commission a wider range of services, due to the negotiated agreement, that limits the Health Board's ability to reallocate funding from underspending areas of the allocation, to overspending areas of the allocation
- Community Pharmacy estate is based in commercial premises that limits the potential to expand the range and level of service provision would require investment and/or new premises. The Community Pharmacy Contract does not provide ongoing business support to enable investment in new premises.

General Dental Services

In the year 2022/2023 there were 45 Dental Practices contracted to deliver NHS dental services within the Hywel Dda region. NHS dental provision is provided by Dental Practices which provide a mixed economy of private and NHS services. There are additional private dental Providers within the Hywel Dda region. They are not included within the scope of this paper.

Contractual Information

Contract negotiations are currently being undertaken on a tripartite basis across the NHS, Welsh Government, and the British Dental Association. Each Dental Practice has an individual Contract with the Health Board in the same way as GP Practices.

The General Dental Services Contract was implemented in 2006. It introduced a new way of measuring activity, called the Units of Dental Activity (UDA) or for Orthodontic commissioning, Units of Orthodontic Activity (UOA). This was a change from an 'items of service' model which was linked to payments.

Since the year 2018/2019 Dental Practices have been able to opt into a new way of working through the Contract Reform programme which places a greater focus on prevention of dental disease and decay. Prior to the COVID-19 pandemic there was an option for Dental Contractors to participate in a pilot to test the Welsh Government preventive model of Contract Reform.

During the COVID-19 pandemic interim contract arrangements were put in place recognising the impact that the global pandemic was having on the accessibility to dental services. All contract types and associated measure for their delivery were suspended. Instead, priority given to patients requiring urgent care. Since the reset of services, Contract Reform has moved quickly. However, Practices continue to have a choice to either work under Contract Reform or to continue working under the GDS contract with UDAs.

Service Changes

There have been several service changes which have occurred during the period of time in scope of the Issues Paper. The number of Dental Contracts has reduced due to Contract terminations. The table below shows the number of NHS Dental Practices in the Hywel Dda Region from

2018/19 to 2023/24. The 2024/25 information has been included as notice has been served on Dental contracts that will terminate in this period.

Financial Year	Number of Dental Contracts in the Hywel Dda region
18/19	47
19/20	48
20/21	48
21/22	47
22/23	47
23/24	43
24/25	39

The 6 Goals Transforming Urgent and Emergency Care (TUEC) programme includes the proposal that Health Boards provide in-house weekend call handling service to support patients seeking urgent dental access appointments. At present there is no identified resource to provide this service change.

General Dental Services Activity Data

The activity data the Health Board has access to does not show individual patient service use. The data reports on the volume of services provided by Contractors. This means it is possible for patient attendances to be counted more than once. This means that patient activity in real terms is lower than the data shows.

The activity data does not identify where a patient resides in relation to where they receive NHS Dental care. It cannot demonstrate care delivered closer to home. Unlike GP Practices patients are not registered with a Dental Practice and there are no geographical boundaries from within which a patient can access Dental care.

In 2019/2020 Dental Practices in Hywel Dda saw 227,350 individual patients, with this number reducing to 126,600 in 2022/2023.

A snapshot of NHS Dental access in 2022/23 shows that:

- There were 7,812 mid-week and 1,611 out-of-hours urgent dental appointments
- Approximately 17,300 new and 73,400 historical patients were seen. This means people who have regular care with a Dental Practice
- 55% of patients treated received Band 1 care e.g. examination
- 27% of patients received Band 2 care e.g. fillings
- 3% received Band 3 care e.g. dentures
- 14% received urgent dental care
- 55,120 patients received preventative care e.g. fluoride varnish.

It is important to note that there has been a reduction in the number of appointments available since 2022/23, which is due to a combination of contract terminations and a delay in recommissioning NHS Dental services as well as the impact of contract changes.

Finance

General Dental Service expenditure is driven by the General Dental Services contract and Personal Dental Service (PDS) agreements. This accounts for approximately 80% of the expenditure. Personal Dental Service agreements have historically supported the commissioning of more specialist services including Orthodontics for people aged 18 and under, and specialist minor oral surgery services. Procurement advice now suggests that this should be done through a PDS agreement. This would allow for a time limit to be placed on the contract as opposed to GDS contracts that are made in perpetuity.

It is difficult to identify expenditure trends in the period of time that covered the COVID-19 pandemic, as activity had been significantly impaired. Underperformance against contracts that would normally mean a financial recovery had not been dealt with as normal. This recognised the exceptional circumstances of the pandemic. It followed national guidance, which has allowed for an element of underperformance to maintain Dental Practice income and to prevent destabilisation of the service.

Therefore, in the last five years, the expenditure does not really show the true circumstances within the Dental service.

In 2022/23 there was a £1.5m underperformance against contracts. This will be shown in the 2023/24 accounts, as underperformance is collected on a rolling financial year basis. In addition to the underperformance, it includes the financial impact of eight dental contracts being terminated and not being recommissioned within the same financial period. Therefore the 2023/24 accounts will show a large underspend.

Part of the resource used for the commissioning of NHS Dental services is the income Health Boards receive from the patient charges that are received when patients use NHS dental services. Following the COVID-19 pandemic where a decreasing number of patients were seen, and as well as the reduction in the number of NHS contracts, the overall income to the Health Board has significantly decreased.

In 2018/19 the Patient Charge Revenue (PCR) was £3.2m which has decreased in 2022/23 to £1.8m.

Workforce Data

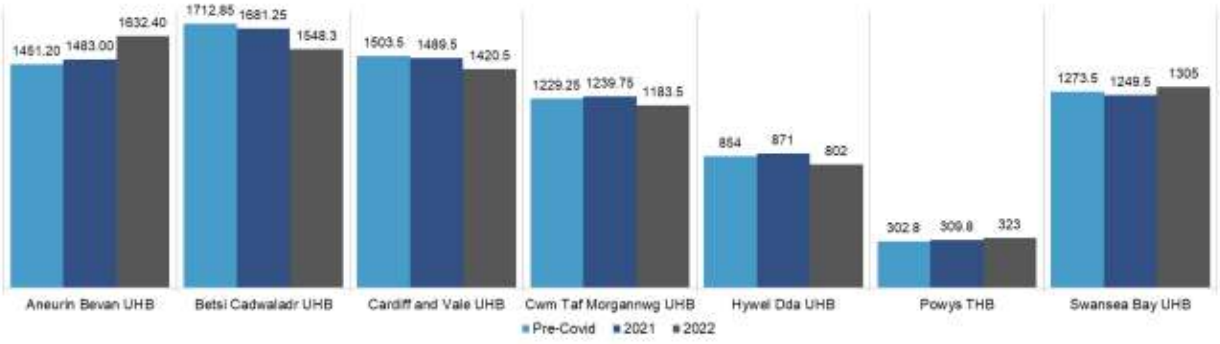
The following comparative data has been extracted from the Dental Quality Assurance System (QAS) Workforce Report 2022/2023. This data will not be available through QAS in 2023/2024. There is an assumption that the use of Wales National Workforce Reporting System will be in place to capture more comprehensive workforce data.

Dentist NHS Sessions

This table (below) shows the number of dental sessions available per Health Board before the COVID-19 pandemic and in the following two years. In comparison, Swansea Bay University Health Board (SBUHB) has the same population as Hywel Dda UHB but have approximately 40% more service provision per annum.

Figure 4: Overall all Health Boards have 112.4 Dentist sessions fewer and 1.3% lower in 2022 compared to pre-Covid

Number of sessions in total, all dentists in the practice work



Aneurin Bevan UHB has the highest number of sessions and percentage difference between pre-Covid and 2022, with 181.2 sessions greater at a 12.5% difference

Therapist Sessions

This table shows the trend in the use of Dental Care Professional (DCPs) to provide services. The use of Dental Care Professionals (DCPs) provides opportunities to increase access to services by expanding the clinical skill mix which can assist in delivering timely care when there is a reduction in dental recruitment.

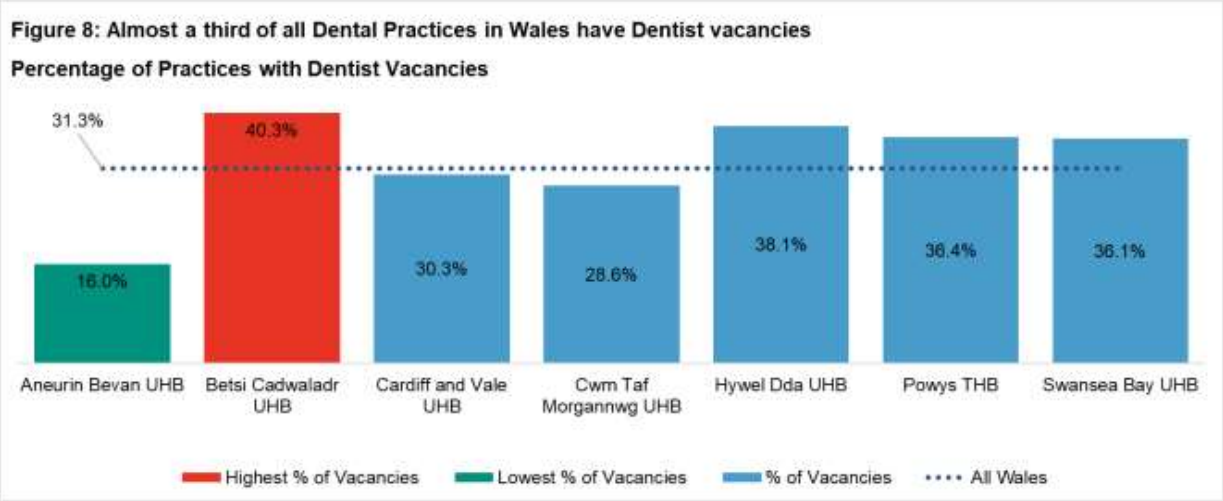
In comparison to Swansea Bay University Health Board which has a similar population size and Hywel Dda, there are fewer sessions available to the population.

Figure 5: Overall all Health Boards have 168.8 Therapist sessions more and 39.4% greater in 2022 compared to pre-Covid

Number of Therapist delivered sessions per week

Cardiff and Vale UHB has the highest number of sessions and percentage difference between pre-Covid and 2022, with 50 sessions greater at a 192.3% difference

All Wales Dentist Vacancies 2022



The above graph illustrates that recruitment appears to be challenging across Wales. Hywel Dda has the second highest percentage of vacancies.

Estate

Statutory requirements such as compliance with Accessibility Standards and Infection, Prevention and Control are monitored under the contractual Regulations. Further compliance is monitored by Health Inspectorate Wales (HIW) and through the Health Board contract monitoring mechanisms. There is no provision of funding to improve and modify existing buildings.

The mixed economy of both NHS and Private Dental service provision in Dental Practices makes the allocation of NHS funded improvement grants difficult to monitor and agree. Whilst Dental Practices are encouraged to consider relocating into new estates developments that bring key service providers together, the business costs associated with that is often seen as a barrier to making the move to purpose built, modern dental facilities.

Incidents, Complaints, Compliments and Claims Data

As with the other Contractor professions there is no mandate for Dentists with an NHS Contract to report incidents to the Health Board. The lack of IT connectivity for Dental Contractors further impedes their ability to access the online version of DATIX.

However, in the reporting period 1 April 2021 to 31 July 2023 there were seven NHS Dental incidents reported on DATIX, of which, only two were directly submitted to the Health Board. The remaining five were added to DATIX by Health Board staff on behalf of a Dental Practice. See Appendix B9 - Primary Care - Incidents data.

What does this mean for Primary Care and Community Services?

- Limited workforce data impacts on identifying the potential for delivering training, education and development for the multi-disciplinary Dental teams, as well as limiting the ability to establish baseline data on the current workforce, to aid plans for future commissioning
- General Dental Services are provided in mix-economy premises therefore any engagement in new estate developments must be commercially viable for the contractor. This is outside of the control of the Health Board

- The activity data that is available does not provide a baseline of activity which means that there is a limited understanding of performance locally and in comparison, to the rest of Wales, as well as geographically based demand and need
- The number of individual patients accessing the services has reduced by 53.55% since 2019/2020, the impact of this on the oral health of the population is not yet understood
- Reduced access to dental services has a direct impact on the level of income that the Health Board receives from the Patient Charge Revenue
- The timescale between contract termination and recommissioning of activity creates increased demand for urgent general dental service provision and risks deterioration in overall dental health
- The lack of available in-hours appointments for routine and urgent dental care impacts on other service areas as patients seek treatment from GPs, Pharmacists, Minor Injuries Unit or Accident and Emergency
- No contractual obligation for dental practices to report incidents to the Health Board, resulting in the fact that there is no accurate picture of number of incidents occurring in Dental Practices.

Community Dental Services

The Hywel Dda Community Dental Service (CDS) provides the full range of dental care for vulnerable adults and children who may have difficulties in receiving dental treatment from mainstream Dental services. The service is managed by the Health Board with salaried staff operating across eight sites throughout Carmarthenshire, Ceredigion and Pembrokeshire.

Patients must be referred into the service. CDS provides Conscious Sedation through either inhalation or intravenous sedation. The CDS has a key role in the provision of care to children who may be on a paediatric pathway for dental extractions under general anaesthesia which is currently commissioned from Parkway Clinic in Swansea, as well as the provision of dental treatment to adult special care patients who need treatment under anaesthetic. In addition, the CDS provides urgent domiciliary dental care in patients' own homes, Nursing and Residential homes and for elderly long stay hospital patients.

Community Dental Services: All Wales Oral Health Programs

The Community Dental Service provides a range of community-based preventive care through the national 'Designed to Smile' (D2S) programme, aimed at improving the dental health of children by targeting areas with the highest levels of dental disease. This includes fluoride application and a tooth-brushing programme in schools for children up to the age of 5 years old as well as support and training to school nursing and health visiting teams.

CDS also delivers the Gwen am Byth programme aimed at improving oral health for residents in Care Homes with a focus on education and support for Care Home and nursing staff to improve knowledge and skills thus improving the oral health of residents.

The Improvement Cymru Programme supports the needs of patients in hospital by providing training for new staff.

In addition to the delivery of direct dental care for patients, the Community Dental Service has an important role in undertaking epidemiological studies for Dental Public Health Wales by monitoring the oral health of specific age groups. There was a break in the delivery of the Epidemiology Programme during the COVID-19 pandemic. However, the programme restarted in 2023 with a survey of 5-year-old children. Before the COVID-19 pandemic this study was undertaken every three years.

Community Dental Services Activity Data

In addition to providing routine care to core CDS patients, in 2022/23 there were:

- 984 referrals for special care dentistry and paediatric general anaesthetic assessment
- Approximately 600 new patient referrals for assessment and treatment (not from Dental Practices)
- 660 staff out of a potential group of 1,366 within Care Homes received training from the Gwen Am Byth programme
- 75% of schools participating in the fluoride varnish application programme compared to the All-Wales average of 65%
- 71% of schools participating in the toothbrushing programme, compared to the All-Wales average of 60%.

CDS services are not subject Referral to Treatment Times (RTT) The longest patient waits are from 2019/20.

Finance

Community Dental expenditure is approximately 7% of the Primary Care allocation. Static expenditure of other programmes like Designed to Smile and Gwen Am Byth have remained the same proportionally to overall expenditure but have had expected levels inflationary increased of spend.

Estate

There are accessibility and quality issues with the premises in which Community Dental Services are sited across the Health Board footprint. North Road Clinic in Aberystwyth is the only Community Dental site in North Ceredigion and is based on the first floor of the building with no lift access meaning that patients who require enhanced accessibility cannot be treated at this site.

Workforce Data

The table (below) shows the breakdown of the staff group, role and location of the workforce across Dental Services as of 30 November 2023 as recorded on ESR.

Staff Group	Role	Location			
		Carmarthenshire	Ceredigion	Pembrokeshire	Grand Total
Additional Professional Scientific and Technical	Technician	2.8	1	1.2	5
	Total	**2.8**	**1**	**1.2**	**5**
Additional Clinical Services	Dental Surgery Assistant	9.6	2	6.8	18.4
	Health care Support Worker	1	0.5	0.5	2
	Technician			0.6	0.6
	Total	**10.6**	**2.5**	**7.9**	**21.0**
Administrative and Clerical	Clerical Worker	1.0		0.5	1.5
	Manager	2.0		1.8	3.8
	Officer	4.2			4.2
	Total	**7.2**		**2.3**	**9.5**
Medical and Dental	Clinical Director - Dental	1.4			1.4
	Dental Officer	1.8	1.6	1.2	4.6
	General Dental Practitioner	0.4			0.4
	Senior Dental Officer	2.4		0.8	3.2
	Total	**6.0**	**1.6**	**2.0**	**9.6**
Grand Total		**26.6**	**5.1**	**13.5**	**45.2**

There are several clinical vacancies within the Community Dental Services including a Specialist or Consultant in special care dentistry or paediatrics dentistry. Patients are required to attend appointments in Swansea Bay University Health Board. This limits the training and development opportunities for existing clinical staff within the CDS team.

Incidents, Complaints, Compliments and Claims Data

The incidents recorded for the CDS have been directly reported into DATIX by CDS staff and relate to incidents involving premises, staff and patients. A full report can be seen in Appendix B9 - Primary Care - Incidents data.

In the period 1 April 2021 to 31 July 2023 the service recorded nine incidents graded none/1 and 2/Low harm. In addition, for the same period the service reported 26 service concerns, 31 of which were graded as minor (informal) with a further five graded as minor (formal).

What does this mean for Primary Care and Community Services?

- The current estate does not meet the needs of the service in terms accessibility. This impacts on the ability to modernise and develop the scope of service delivery as well as on staff development
- Waiting times are not subject Referral to Treatment Times (RTT). Some patients have been waiting since 2019
- There is an increased demand for urgent dental care that is impacting on the ability to provide routine care
- Increased participation for eligible schools with Designed to Smile will need additional funding to increase the number of oral health promotion officers
- Increasing the number of schools participating with fluoride varnish and the delivery of preventative oral health measures will require additional investment
- The lack of service development and workforce expansion with specialist roles means that patients continue to have to travel to another Health Board to receive specialist care.

Optometry Services

The Health Board has 45 Optometric Practices providing Wales General Ophthalmic Services (WGOS), 42 of which provide Eye Health Examinations Wales (EHEW) services. Alongside the core element of Primary Care Optometric Services e.g. sight tests, the Health Board has:

- 15 Practices providing a Diabetic Retinopathy Review Scheme
- 23 Practices providing a Wet Age-related Macular Degeneration Service
- 2 Practices providing a Glaucoma Ophthalmic Diagnostic Treatment Centre (ODTC)
- 13 Practices providing Glaucoma Data Capture

The Contract

Regulations for the new Optometry Contract came into force in October 2023, however the range of clinical services to support the transfer of care from secondary care Ophthalmology to Optometry will not fully be implemented until April 2024. Services will be provided and funded under 5 categories in the Wales General Ophthalmic Services (WGOS) framework.

Optometric Practices have been required to submit to the Health Board a declaration of their readiness to deliver services under the new WGOS contractual framework. The final WGOS 4 Service Manual will be issued to Health Boards for implementation from 1 April 2024.

WGOS4 enables Optometrists with the relevant qualifications and training to deliver Medical Retina, hydroxychloroquine (HCQ), Glaucoma Referral Refinement and Glaucoma Monitoring services.

As of the 1 January 2024, the Health Board has successfully transitioned from the old Independent Prescribing Optometry Service that was established during the COVID-19 pandemic in line with Welsh Government direction to WGOS 5.

12 Practices are currently delivering the service although there will be further expansion of the service in 2024/25.

Optometry Activity Data

In 2022/23 there were:

- 28,463 Eye Health Examination Wales (EHEW) appointments
- 33,881 General Ophthalmic Services (GOS) claims
- 2,176 Acute Prescribing (IPOS) appointments
- 1,027 Diabetic Retinopathy and 461 wet age-related macular degeneration (WAMD) appointments.

From the data that we have been able to capture it appears that patients aged 55+ have the highest number of optometric appointments.

Finance

The General Optometry Service is shown as a cash and a non-cash limited expense in the final year accounts. The cash limited is a standard allocation to the Health Board, similar to other Primary Care Services, however the non-cash limited expenses are allocated to contractors within the Hywel Dda region and paid directly from Welsh Government.

The new contract will see the Health Board receive an allocation from April 2024 for the delivery of WGOS services in line with the Regulations and Directions, and therefore the non-cash limited funding will end. (Table in £millions)

	2018/19	2019/20	2020/21	2021/22	2022/23
Cash Limited Funds	1,238	1,320	1,239	1,216	1,360
Non-cash Limited Funds	4,099	4,223	4,223	4,562	3,846
Total	**5,337**	**5,543**	**5,543**	**5,778**	**5,206**

The cash limited funds are for Eye Health Examination Wales (EHEW) costs which is an extended eye care service free at the point of access for patients. The EHEW expenditure decreased throughout COVID-19 due to access to the service but is now increasing which is a 1.7% average annual increase over the five-year period.

The cash limited expenditure includes payments for sight tests, domiciliary care visits, repairs to spectacles and vouchers for the supply of spectacles. This has reduced by 20% in the five-year period the main reasons are correlated to the decrease in vouchers for the supply of spectacles by 31% (£470k) and the decrease in sight test fees by 16% (£380k).

Workforce Data

The Health Board does not currently hold any workforce data for Optometric Practices.

Incidents, Complaints, Compliments and Claims Data

As with the other contract professions there is no mandated requirement for Optometrists to report incidents to the Health Board. Due to IT connectivity issues Optometric Practices do not have access to the online DATIX reporting system.

There have been three Optometry incidents reported via DATIX between 1 April 2021 and 31 July 2023.

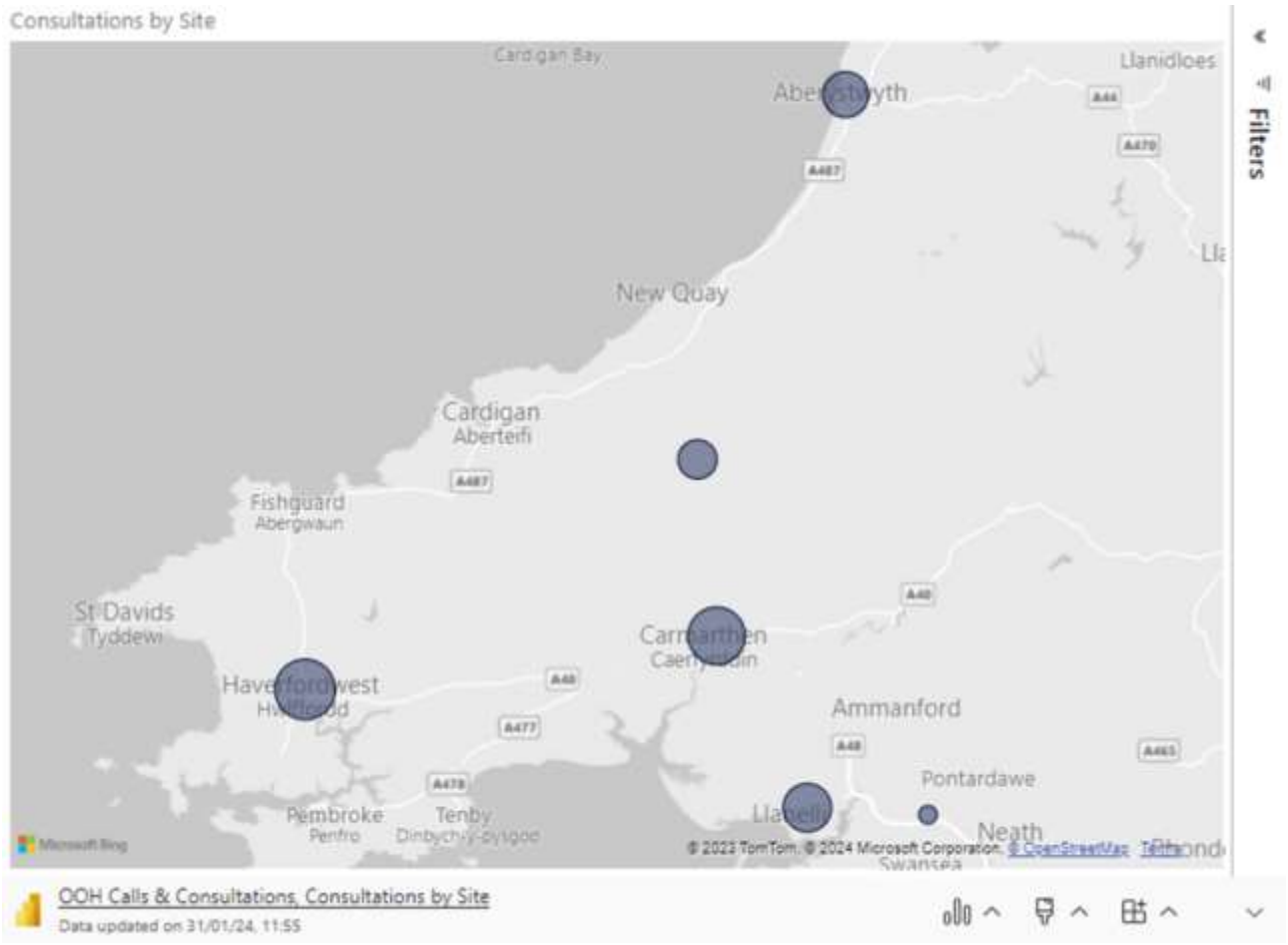
What does this mean for Primary Care and Community Services?

- There is no formal workforce dataset available for Optometry Services. This poses a challenge to understanding the current position for training, education and development and limits the ability to plan for future service provision
- The Health Board does not share data systems with Optometry Services. This means the Health Board does not have access to information on patient care between Primary and Secondary Care services, as well as incidents reporting
- Optometry Services are provided in commercial premises. This means that, for Optometry Services to be part of any new development that the Health Board is taking forward, it must be commercially viable for the Contractor. This is outside of the Health Board's influence and control
- Activity data does not link Optometry service provision, with patient outcomes. This means the Health Board cannot evaluate the benefits for service intervention on patient outcomes
- The new contract terms allow any suitably qualified contactor to deliver the range of specialist services with no limit on the level of activity that can be provided. This represents a potential financial risk to the Health Board as the contract is implemented in 2024/25.

Out of Hours Service

The Out of Hours service operates from 18:30 until 8:00 Monday to Friday, at weekends and during Bank Holidays. The service currently operates from six bases across the Health Board geographical area. The service is directly managed by Hywel Dda University Health Board.

The map below shows the location of the sites current being used by Out of Hours staff.



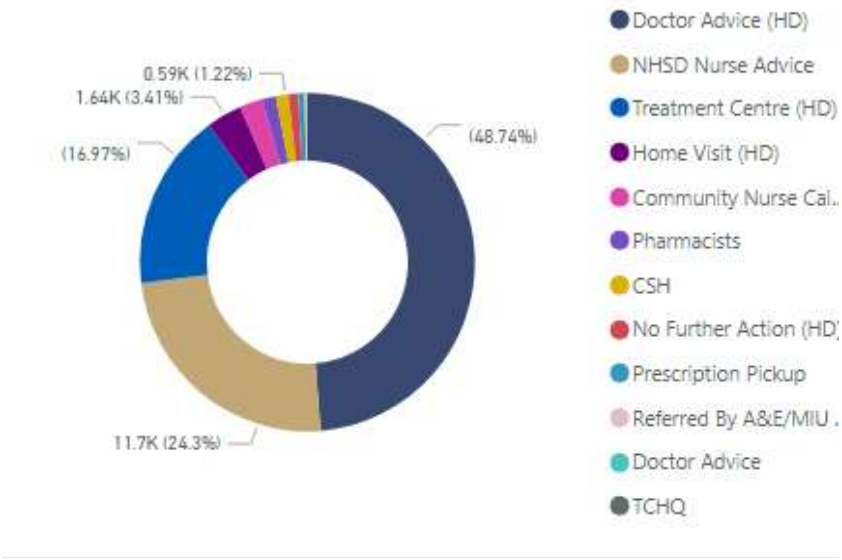
Out of Hours Activity Data

In 2022/23 66% of the calls received by 111 were streamed through to the Health Board Out of Hours service, with the other calls being managed by call handler triage within the 111 service.

Including direct calls to the service this equated to 48,168 calls managed by the Out of Hours Service during this time period.

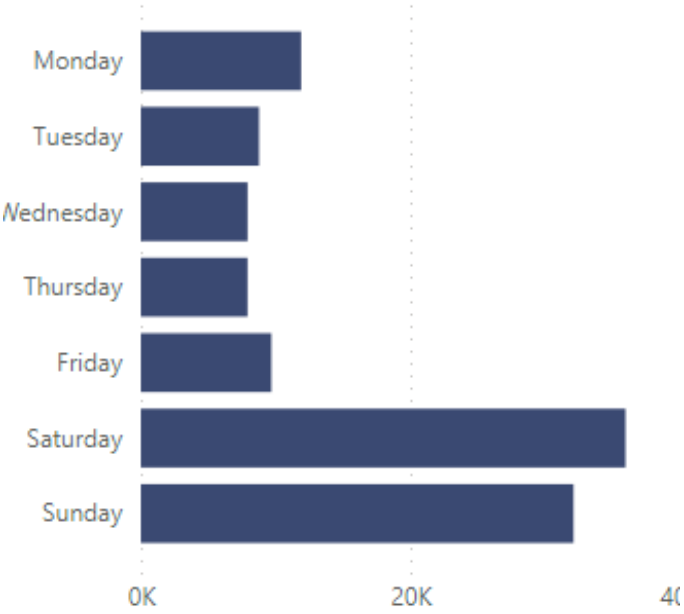
The table (below) illustrates the number of calls and consultations since 2020 to 2023 (to the nearest 1,000) received by Out of Hours service:

Financial Year	2020/21	2021/22	2022/23	2023/24
Number of Out of Hours calls and Consultations	64,000	67,000	48,000	56,000



The graph (above) reports the outcomes for patients who had contacted the service in 2022-2023. It shows that the majority of patients receive advice from a doctor (48%) with only 16% of patients needing to attend a treatment centre and 3% of patients having a home visit.

The graph (below) outlines the number of calls received by the Out of Hours service, by day of the week, in 2022/23, which shows as expected a peak in service demand over the weekend.



Finance

The Out of Hours Service (OOH) sits outside of the Primary Care and Community Directorate, under the management of the Director of Operations, however the funding for the Out of Hours service comes through the GMS allocation. The Out of Hours (OOH) expenditure is dominated by variable locum rates, with locum clinicians being the mainstay of the clinical workforce. Proportionally the expenditure on the service has reduced from 9% in 2018/19 to 7% in 2022/23. A reduction in expenditure can be explained by the withdrawal of services in 2019/2020, from Prince Philip Hospital and Llandysul reducing the number of staffing hours.

Estate

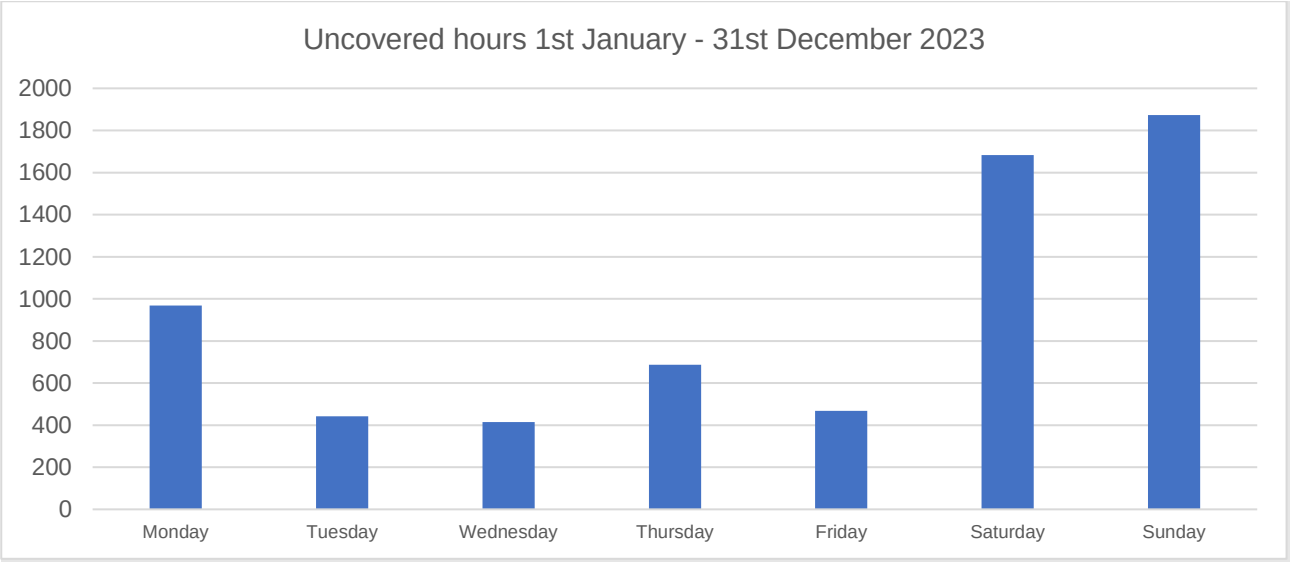
The Out of Hours service is provided from six locations across the Health Board area. None of the clinical space is dedicated to the service and therefore there is a reliance on using shared space that is being used for another purpose during the in hours period.

Workforce Data

Location / Site							
Staff Group	**Role**	**Bronglais**	**Glangwili**	**Llandysul**	**Withybush**	**Prince Philip**	**Total**
Additional Clinical Services	Call operator		1.7		5.2	0.7	**7.6**
	Emergency Medical Dispatcher				1.6		**1.6**
	Health Care Support Worker	0.5					**0.5**
	Total	**0.5**	**1.7**		**6.7**	**0.7**	**9.7**
Administrative and Clerical	Clerical Worker				1.4	0.5	**1.9**
	Manager				1.0		**1.0**
	Officer				4.0		**4.0**
	Receptionist		1.6		2.4		**4.1**
	Total		**1.6**		**8.8**	**0.5**	**10.9**
Estates and Ancillary	Driver	4.1	2.0	0.4	1.0		**7.5**
	Total	**4.1**	**2.0**	**0.4**	**1.0**		**7.5**
Medical and Dental	General Medical Practitioner (GP)	2.8			3.7	0.4	**6.9**
	Total	**2.8**			**3.7**	**0.4**	**6.9**
Nursing and Midwifery Registered	Community Nurse				0.1		**0.1**
	Total				**0.1**		**0.1**
	Grand Total	**7.5**	**5.3**	**0.4**	**20.3**	**1.6**	**35.1**

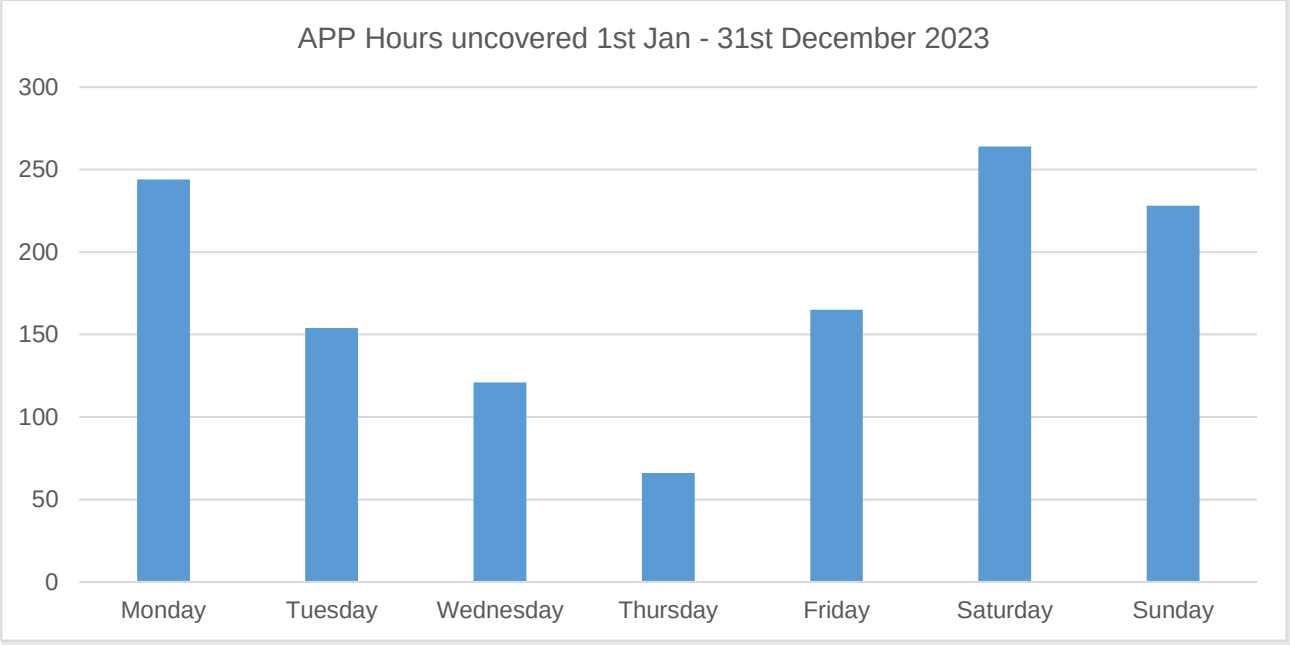
The table (above) shows the breakdown of the Out of Hours staff group, role, and location of the substantive workforce across the Out of Hours Service as of 30 November 2023 from Employment Service Record (ESR). This is not an accurate reflection of the workforce due to the number of staff who work on a bank or locum basis.

There are circa 30 Whole Time Equivalent Locum GPs (made up of approximately 80 individuals) that cover shifts. The graph (below) shows the number of uncovered clinical hours, by day of the week for the period 1 January 2023 to 31 December 2023. The service is running at full capacity and experiences its greatest hourly staffing deficit at the times of greatest call or consultation demand.



In addition to the Health Board staff, the service funds two whole time equivalent (WTE) Advanced Paramedic Practitioners (APP) from Welsh Ambulance Services NHS Trust (WAST) that in line with the pilot should provide seven shifts per week, however due to service demands this sometimes means that the APPs are not able to participate in the OOHs rota. Recruitment, sickness and leave absences are managed by WAST and there are no alternative arrangements in place to cover rota gaps.

The graph (below) shows the number of hours that were not covered by the Advanced Paramedic Practitioner role, by day of the week, for the year 1 January 2023 to 31 December 2023.



Incidents, Complaints, Compliments and Claims Data

The Out of Hours Service reports incidents using the DATIX system. The full report can be seen in Appendix B9 - Primary Care - Incidents data. The table and graph below show the breakdown of incidence by grade and type.

Severity of Incident	Number of Incidents
1 None	10
2 Low harm	6
3 Moderate harm	4
4 Severe harm	0
5 Catastrophic death	0

Of the 20 reported incidents, the majority were for attitude and behaviour, and clinical treatment and/or assessment.

What does this mean for Primary Care and Community Services?

- The Out of Hours clinical workforce relies on Locum cover which can result in challenges in securing rota cover at peak demand times
- WAST APP pilot does not enable the service to direct the service to the right place at the right time
- The activity data does not enable the Health Board to map the service outcomes from a patient pathway perspective, to understand the impact of Out of Hours use on the whole Health Board system
- There are no patient outcome measures used by the service.

Primary and Community Services Risks

The CSP Appendix B4 - Primary Care - Corporate Risks outlines the identified risks that have been reported to the Board that relate to Primary Care services. It includes related risks to Community Services. This necessity to widen the search criteria to include Community services is a reflection of the integrated nature of Primary Care services across both the Community Services space and the whole patient pathways of care and treatment from prevention to Secondary Care Services.

Conclusion

There are several key themes to consider in taking forward the development of a Primary Care and Community Services Strategy. Most notable are the following:

- The delivery of Primary Care services must follow Regulations and Directions set out in legislation. Within this structure there is some scope to consider how the range of services can be broadened to improve accessibility as well as sustainability for the contractor model. To achieve this a “shift left” of resources needs to be facilitated to support this development
- Where there are underspends in discreet areas, there is potential - through engagement with patients and the professions - that re-commissioning plans could be in place to support the provision of services
- Workforce data is unavailable for most of the contractor professions which has a direct impact on the ability to plan for service development and delivery. The training, education and development of staff, is an important area of focus to ensure a sustainable service model for the future

- The lack of PROMs and PREMs means that there is no meaningful data to understand the impact that Primary Care services have on patients and the wider health system
- Contractual disparities and commercial interests that differ between the four contractor services poses practical challenges to supporting the innovation both in estate and in service provision
- The estate in general is insufficient, and/or not suitable, for current services or to provide a wider range of modern Primary Care services. This is the case for Hywel Dda services as well as contractor services.

Glossary of terms

Name	Acronym
Clinical Services Plan	**CSP**
General Medical Services	**GMS/ GP**
Community Pharmacy	**CP**
Out of Hours	**OOH**
General Dental Services	**GDS**
Community Dental Services	**CDS**
British Dental Association	**BDA**
Wales National Workforce Reporting System	**WNWRS**
Wales General Ophthalmic Services	**WGOS**
Eye Health Examination Wales	**EHEW**
Quality Assurance and Improvement Framework	**QAIF**
Transforming Urgent and Emergency Care	**TUEC**
Patient Reported Outcomes Measures	**PROMs**
Patient Reported Experience Measures	**PREMs**
Advanced Paramedic Practitioners	**APP**
Welsh Ambulance Services NHS Trust	**WAST**
Urgent Primary Care	**UPC**
Local Health Board	**LHB**
Units of Dental Activity	**UDA**
Units of Orthodontic Activity	**ODA**
Personal Dental Service	**PDS**
Quality Assurance System	**QAS**

Section 5: Critical Care

Section 5: Critical Care

Introduction and background

This chapter of the Issues Paper is about Critical Care services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Critical Care service at all sites within the Health Board that delivered Critical Care services between 1 August 2018 and 31 July 2023.

Critical Care service at Hywel Dda

Critical Care provides treatment to adults, in a separate and self-contained area of the hospital. The units are dedicated to the management and monitoring of patients with life-threatening and critical conditions, including multi-organ failure. The service offers specialist skills that include medical, nursing, and other personnel experienced in the management of patients needing Critical Care and the specialist equipment used. Patient flow (how patients move through the hospital system from when they enter to when they leave) is governed by an admission and discharge guideline (Admission to and discharged from Critical Care Services guideline, January 2024).

At Hywel Dda, Critical Care services are provided at:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital

Critical Care patients are amongst the sickest people in the hospital who require specialist care and multi-organ support. Patients requiring Critical Care are low in number but, when Critical Care is required, access needs to be prompt and responsive.

In extraordinary circumstances, children and young people can be admitted to Critical Care units. This is usually a temporary placement while referral and retrieval services are arranged with the Wales and West Acute Transport for Children Service (WATCh). Very occasionally a child will be managed internally with the support of the paediatric teams, and this is supported by the High Dependency Care of Children Guideline.

Critical Care service model

The bed base, staff resources and physical resources required to deliver Critical Care are flexible to the needs of the patient. The table below provides an outline of how the funded bed plan for Critical Care service is allocated.

Location	Bed spaces	Funded level 3	Funded level 2	Total
Bronglais Hospital	5	2	2	**4**
Glangwili Hospital	18	8	6	**14**
Prince Philip Hospital	6	1	4	**5**
Withybush Hospital	9	3	4	**7**
Total	**38**	***or a configuration of, within staff base***		**30**

The table below describes each level of care that is delivered within a Critical Care Intensive Care Unit (ICU) and the required ratio of staff to patient required at each level. These definitions and

ratios are defined by the Faculty of Intensive Care Medicine and can be found at: GP[21]ICS V2.1 (2).pdf (ficm.ac.uk)

Level	Definition	Nurse to patient ratio
Level 3 Critical Care	• Patients who need advanced respiratory monitoring and support alone e.g. invasive ventilation • Patients who require monitoring and support for two or more organ systems at an advanced level • Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (comorbidity), and who require support for an acute reversible failure of another organ system • Patients who experience delirium and agitation in addition to requiring Level 2 care • Complex patients requiring support for multiple organ failure.	**1:1** In exceptional circumstances, for unstable Level 3 patients, two nurses may be allocated to each patient.
Level 2 Critical Care	• Patients requiring increased levels of observations or interventions (beyond Level 1), including basic support for two or more organ systems and those 'stepping down' from higher levels of care • Patients requiring interventions to prevent further deterioration or to support ongoing rehabilitation needs, beyond that of Level 1 • Patients needing two or more basic organ systems monitoring and support • Patients needing one organ system monitored and supported at an advanced level (other than advanced respiratory support) • Patients needing long-term advanced respiratory support • Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining patient safety if severely agitated • Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and comorbidities • Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere • Patients who require nursing and therapies input more frequently than available in Level 1 areas.	**1:2**

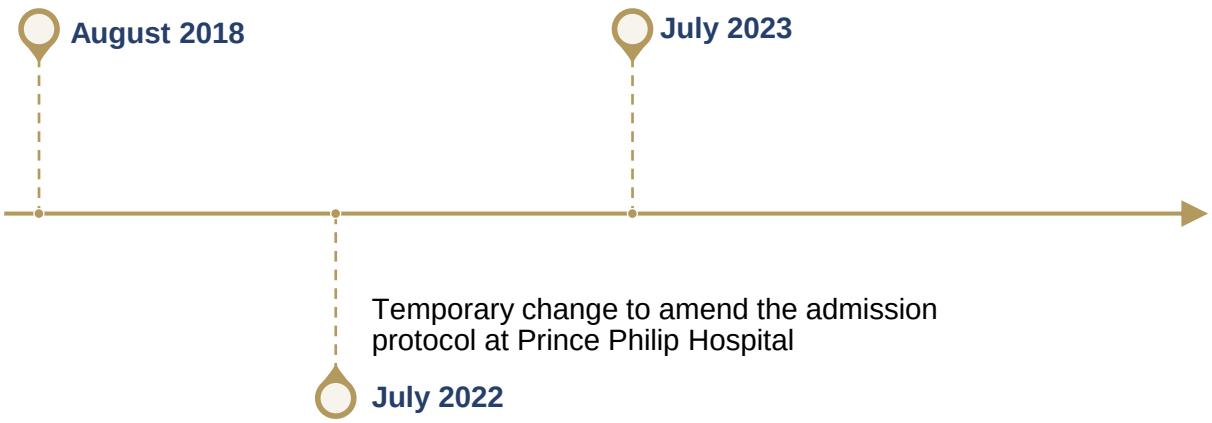
[21] *https://www.ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf*

Level 1 Enhanced Care / Ward Ready	• Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care • Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward • Patients who require ongoing interventions (other than routine follow-up) from Critical Care outreach teams to intervene in deterioration or to support escalation of care • Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged based on clinical circumstances and ward resources.	**1:4**, sometimes, **1:3**, depending upon speciality

Critical Care service changes

This section provides information about the updates to Public Board about service changes that have taken place within the Critical Care service between August 2018 and July 2023.

Service change timeline



Summary of temporary change

A temporary service change implemented in July 2022 was described in Public Board on 28 September 2023 as:

An operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted or transferred to neighbouring Critical Care units, appropriate to their clinical needs. This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

Full details about the temporary service change can be found in the paper considered by Public Board on 29 September 2022[22].

[22] *Document available from hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-29th-september-2022/english/item-46-critical-care-staffing-position/*

Critical Care risks

This section describes the Critical Care risks that have been reported at Public Board meetings between August 2018 and July 2023.

A risk was identified in April 2022, risk number 1363, that there is a risk of an inability to support Level 3 Critical Care provision at Glangwili and Prince Philip hospitals due to consultant availability. The risk remains open (i.e., it remains a risk to the provision of care). The Board was informed that there was a risk of Prince Philip Hospital service collapse due to ongoing gaps in Consultant Intensivist rotas.

Due to lack of storage on site, the units at Bronglais, Glangwili and Withybush hospitals are currently using one bed space to store equipment. This is a risk to both staff and patients and a risk has been created to reflect this: Risk reference 1637.

Following discussions at the Task and Finish group concerns have been raised around availability of EMRTS[23]/ACCTS[24] teams and/or time delays of transfers of our critically ill patients. We recognise the risk due to capacity issues of EMRTS and/or ACCTS teams and the geographical distances between the existing EMRTS/ACCTS hubs and our hospital sites Bronglais General Hospital in particular.

Critical Care clinical effectiveness

The table below includes a list of the clinical guidelines that the Critical Care services needs to follow:

Guideline source	Guideline title	Link
Intensive Care Society	Various guidance - within link including Guidelines for the Provision of Intensive Care Services (GPICS)	https://ics.ac.uk/guidance.html
NICE	Acutely ill adults in hospital: recognising and responding to deterioration	https://www.nice.org.uk/guidance/cg50
NICE	Rehabilitation after critical illness in adults	https://www.nice.org.uk/guidance/cg83
NICE	Intravenous fluid therapy in adults in hospital	https://www.nice.org.uk/guidance/cg174
NICE	Acute kidney injury: prevention, detection and management	https://www.nice.org.uk/guidance/ng148
NICE	Sepsis: recognition, diagnosis and early management	https://www.nice.org.uk/guidance/ng51

[23] EMERTS – Emergency Medical Retrieval & Transfer Service.
[24] ACCTS – Adult Critical Care Transfer Service.

NICE	COVID-19 Rapid Guideline: Managing COVID-19	https://www.nice.org.uk/guidance/ng191
NICE	Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation	https://www.nice.org.uk/guidance/cg135
Getting it Right First Time (GIRFT)	Adult Critical Care	https://gettingitrightfirsttime.co.uk/medical_specialties/adult-critical-care/

Guidelines for the Provision of Intensive Care Services (GPICS)

A GPICS self-assessment was undertaken across the Health Board's four Critical Care Intensive Care Units (ICUs) in August 2023. The self-assessment audit asked questions about six areas of service provision against GPICS standards and recommendations. These include:

- Structure
- Workforce
- Process
- Clinical Care
- Additional Components, and
- Emergency preparedness.

The audit itself was a significant undertaking requiring responses from multiple disciplines and identified areas of excellence and issues needing development and investment. Please see Appendix C5.1-5.4 – Critical Care – Clinical Effectiveness Guidelines - GPICS for the most recent GPICS self-assessment (June 2023).

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The areas of excellence include:

- Clinical Care provision – scored well overall with prompt access the renal, cardiac, and respiratory support
- Medical and nursing workforce inductions and commitment to education.
- Staff support
- Provision of outreach services to ICUs with more than 6 beds
- Ability to provide isolation facilities across all sites[25].

The issues identified for development and investment include:

- A significant increase in Critical Care Allied Health Professions (AHP) support is needed. This includes Physiotherapy, Pharmacy, Dietetics, Speech and Language, and Occupational Therapy. This was included as part of the integrated medium-term plan (IMTP[26]) that was submitted in November 2021, after the GPICS self-assessment was completed in September 2021. The provision of this service can vary across the Health Board

[25] Only able to provide negative pressure isolation with adjacent anti room in Glangwili Hospital.
[26] National Integrated Medium-Term Plan - all health boards in Wales are required to produce an IMTP that outlines its plans for service delivery.

- Development of the Advanced Critical Care Practitioner (ACCP) role at Glangwili Hospital to support a more sustainable junior medical workforce. Currently, Hywel Dda is the only health hoard in Wales without an ACCP role
- Implementation of Critical Care rehabilitation and follow up pathways (part of IMPT submission in November 2021, after the GPICS self-assessment September 2021). Note: This pathway is dependent on the AHP staff group being present
- Capacity Management relating to delayed transfers of care (DTOCs). There is a significant issue with delays of patients being transferred to the wards. There have been an increasing number of occasions where patients have been discharged home directly from Critical Care, which is not the optimal pathway and can impact the capacity of the service. This is evidenced within the activity appendices
- Securing the future of Critical Care provision in Carmarthenshire. Due to the workforce resource issues at Prince Philip Hospital, the self-assessment against the GPICS standards could not present a true reflection of the position for this location
- Access to prompt Echocardiography[27] and Ultrasound[28], with exception of Bronglais Hospital
- There is inequitable provision of certain diagnostic services across each site. For example, Echocardiography, Ultrasound and Electroencephalogram. This requires patients to be transferred from one site to another and presents additional risk to the patient. Patients should not be transferred across sites as it is very risky for these basic services.

Critical Care local, regional, and national work

This section describes the regional and national projects or programmes connected to Critical Care services at Hywel Dda.

At the time of writing this paper, there is no regional work currently underway.

Critical Care national work

The National Strategic Clinical Network for Critical Care, Trauma and Emergency Medicine (CCTEM)[29] was established in October 2023.

There are 6 Critical Care related workstreams supported by Health Board representation. Capacity, Demand and Configuration; Senior Nurse Forum; Post Anaesthetic Care Units (PACU / Enhanced Care); All Wales Critical Care Education Network; Rehabilitation and Follow up group; Peer Review Group.

While the service can support the Capacity, Demand and Configuration Group and the Clinical Reference Group, it has highlighted that there are limitations at this stage in its capacity to fully participate and develop plans due the lack of a Health Board lead within Critical Care.

There is an expectation that Hywel Dda will contribute by developing a Health Board wide strategy for the provision of Critical Care that aligns with both GPICS and the aspirations of the National Network.

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[27] Echocardiography – a method that uses an echo to produce an image of the structure of your heart, such as your heart valves. It also looks at how the blood flows through the main arteries and veins of the heart and gives information on how well your heart is functioning. (Source: www.bhf.org.uk)
[28] Ultrasound – an external examination using scanning technology that allows a doctor to look more closely inside the body at organs such as the prostate, ovaries or womb. (Source: www.nhs.co.uk)
[29] CCTEM - NHS Wales Executive.

Critical Care GIRFT (Getting It Right First Time)

GIRFT and Critical Care have not yet been introduced in Wales. However, the GIRFT paper, (Adult Critical Care GIRFT Programme National Speciality Report, Dr A Batchelor, produced in September 2021[30]) was shared with Hywel Dda clinicians in July 2023.

Critical Care activity data

Critical Care service activity reported between 1 August 2018 and 31 July 2023 is included for Bronglais, Withybush, Prince Philip, and Glangwili hospitals. All data tables including the specific conditions captured can be found in Appendix C8 – Critical Care – Activity Data.

The table below shows that the highest proportion of Critical Care activity takes place at Glangwili Hospital (38%) and Withybush Hospital (28%). It also shows that the level of admissions have little variation over the last two years.

Critical Care admissions activity (1 August 2018 to 31 July 2023)					
Reporting period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	147	342	63	225	**777**
2019-20	249	478	107	271	**1105**
2020-21	220	488	200	370	**1278**
2021-22	233	501	236	398	**1368**
2022-23	236	463	278	377	**1354**
2023-24	89	156	92	110	**447**
Total	**1174**	**2428**	**976**	**1751**	**6329**
Total as % of overall activity	**19%**	**38%**	**15%**	**28%**	**100%**

The table below shows a summary of the level of demand by level of care within Hywel Dda. The data shows that 31% of all Critical Care admissions need the highest level of care (Level 3). Most Critical Care admissions (65%) are at Level 2.

Level of Critical Care required upon admission				
Hospital	**Level 0**	**Level 1**	**Level 2**	**Level 3**
Bronglais	19	177	888	381
Glangwili	0	70	1848	994
Prince Philip	1	61	772	348
Withybush	5	17	1221	514
Total	**25**	**325**	**4729**	**2237**
Total as a percentage of activity	**Less than 1%**	**4%**	**65%**	**31%**

[30] *Adult Critical Care GIRFT Programme National Speciality Report Feb 2021 | The Faculty of Intensive Care Medicine (ficm.ac.uk)*

Summary of admissions by source

The table below shows the number of patients and how they were referred to the Critical Care Unit (their source). The data shows that most patients are admitted to the Critical Care services through internal routes i.e., other services within the Health Board.

Route of admission to Critical Care services at Hywel Dda (1 August 2019 to 31 July 2023)						
	A&E[31]/AMAU[32] (front door)	Internal (Inpatient) – within Hywel Dda			External (transfers) – outside Hywel Dda	
	Emergency (%)	Ward (%)	Theatre (%)	Other (%)	Critical Care Units (%)	Another hospital (%)
Bronglais	379 (36%)	197 (19%)	428 (41%)	40 (4%)	7 (1%)	1 (0.1%)
Glangwili	637 (32%)	557 (28%)	621 (31%)	47 (2%)	142 (7%)	10 (0.5%)
Prince Philip	184 (20%)	395 (42%)	299 (32%)	6 (1%)	45 (5%)	2 (0.2%)
Withybush	477 (41%)	367 (31%)	308 (26%)	0	19 (2%)	0
Total	**1677 (32%)**	**1516 (29%)**	**1656 (32%)**	**93 (2%)**	**213 (4%)**	**13 (0.3%)**
Overall total	**1677 (32%)**	**3265 (63%)**			**226 (4%)**	

The data shows that nearly two thirds of admissions (63%) are from inpatient beds i.e., other departments from within Hywel Dda. This is made up of both scheduled care and unscheduled care admissions. It is expected that the greater proportion of these admissions are patients needing Critical Care services post operatively (after surgery), and the lower amount (4%) will be patients whose condition is deteriorating on hospital wards.

The introduction of Critical Care Outreach (CCO), in two of the four sites will have had some impact on the admission rates from unscheduled care admissions. However, it is hard to tell the difference between the impact CCO has had on admission avoidance, as opposed to their early intervention, and prompting timely decisions to admit patients. Seasonal pressures that influence unplanned admissions are expected, for example higher numbers of patients requiring respiratory support, and infection outbreaks, in the winter months.

While not highlighted in the data above, the opening of an elective surgery enhanced care unit in Prince Philip Hospital has reduced the planned post operative admissions to ICU.

The Bronglais Hospital data includes Stroke patients' admissions (individuals who are placed on ICU when the ward-based Stroke pathway is not available.

Critical Care incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded

[31] A&E: Accident and Emergency department.
[32] AMAU: Acute Medical Assessment Unit – specifically at Prince Philip Hospital.

against Critical Care. Full data for incidents, complaints, claims, and compliments, can be found in Appendix C10 – Critical Care – Complaints Data, and C9 – Critical Care – Incidents Data.

Patient safety incidents

The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of March 2023. The number of incidents recorded for the Critical Care service at each hospital site is seen in the table below and the overall Health Board for Critical Care is highlighted in the table below:

	Number of incidents 1 August 2018 - 31 March 2021	Number of incidents 1 April 2021 - 31 March 2023	Total
Bronglais Hospital	97	58	**155**
Glangwili Hospital	389	386	**775**
Prince Philip Hospital	54	57	**111**
Withybush Hospital	205	201	**406**
Total	**745**	**702**	**1447**

The data shown in the table below shows the number of incidents as a percentage of the overall admission activity. For example, Withybush Hospital had 28% of the overall admission activity (the number of patients admitted to the Critical Care service) with 49% of recorded incidents.

The total number of activities across all Health Board sites (i.e. number of Critical Care admissions) is 6,329. The total number of incidents reported in Critical Care services across all Hywel Dda sites is 1,447incidents.

Hospital	Percentage of total activity undertaken at the site (6329)	Percentage of total incidents reported (1447)	Proportion of incidents as a percentage of activity undertaken
Bronglais	19% (1174)	11% (155)	13%
Glangwili	38% (2428)	53% (775)	32%
Prince Philip	15% (976)	8% (111)	11%
Withybush	28% (1751)	28% (406)	23%

The most common types of incidents reported are shown in the table below.

Type of incident reported, 1 August 2018 - 31 March 2021	Number of incidents
Pressure ulcers	263
Injury of known origin	125
Type of incident reported, 1 April 2021 - 31 July 2023	
Accident, injury	140
Pressure damage, moisture damage	276

Critical Care patient complaints

The table below shows the overall number of complaints within Critical Care across all Health Board sites.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of complaints	4	14	4	8	7

The table below shows the number of Critical Care service complaints received by each hospital site between 1 August 2018 and 31 July 2023.

Hospital	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Bronglais	3	2	**5**
Glangwili	14	7	**21**
Prince Philip	1	3	**4**
Withybush	4	3	**7**
Total	**22**	**15**	**37**

The number of complaints recorded for each hospital is in line with expectations for the level of activity and volume of patients cared for at each site.

The table below shows the number of complaints reported between 1 August 2018 and 31 July 2023, as a percentage of the overall activity by each hospital.

The number of complaints received, when compared with the overall level of activity, is very low.

Hospital	Percentage of total activity undertaken at the site (6329)	Complaints reported as a percentage of overall complaints (60)	Proportion of complaints as a percentage of activity
Bronglais	19% (1174)	17% (10)	0.9%
Glangwili	38% (2428)	47% (28)	1.2%
Prince Philip	15% (976)	13% (8)	0.8%
Withybush	28% (1751)	23% (14)	0.8%

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category.

Nature of complaint	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Clinical treatment / assessment	5	5	**10**
Communication issues (including language)	5	2	**7**

The table below shows overall number of complaints received for Critical Care services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023. It should be noted that the figures below may not match the overall number of complaints recorded due to the process in final grading of complaints.

Grade of complaint	Number of complaints 1 August 2018 - 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Grade 1 Minor (informal)	5	7	**12**
Grade 2 Minor	4	2	**6**
Grade 3 Moderate	5	5	**10**
Grade 4 Major	0	0	**0**
Grade 5 Catastrophic	0	1	**1**

Critical Care service claims

During the period analysed there was one claim, relating to a delay in diagnosis and commencement of treatment. This claim has now been closed and the Health Board accepted liability.

There are three open cases that allege a delay in diagnosis or treatment and are subject to further investigation.

There is an additional potential claim, which is awaiting further information prior to confirming its status.

Critical Care patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix C11 – Critical Care – Patient Experience and Compliments Data.

	Patient experience	Friends and family experience	Compliments
2021	No data available	No data available	No data available
2022	No data available	No data available	No data available
2023	No data available	The themes arising are that staff delivered kind and professional care and provided comfort to the patients while communicating well about the care they received.	No data available

The feedback from patients and relatives is collected from several sources, not all of which is recorded as formal submissions. Most of the feedback received is very positive, as demonstrated by the comment in the table above.

When complaints are received, they are investigated thoroughly by the service and the professionals involved. Where possible, the senior nursing team will contact the complainant directly to understand and resolve the concern in a personable manner. Formal responses are

supported by the Patient Experience team. In all feedback, the opportunity to learn and improve the patient care and experience are considered and, where noted, action plans are implemented. These will be completed and monitored by the directorate scrutiny and governance forums.

Critical Care service targeted early engagement with service users

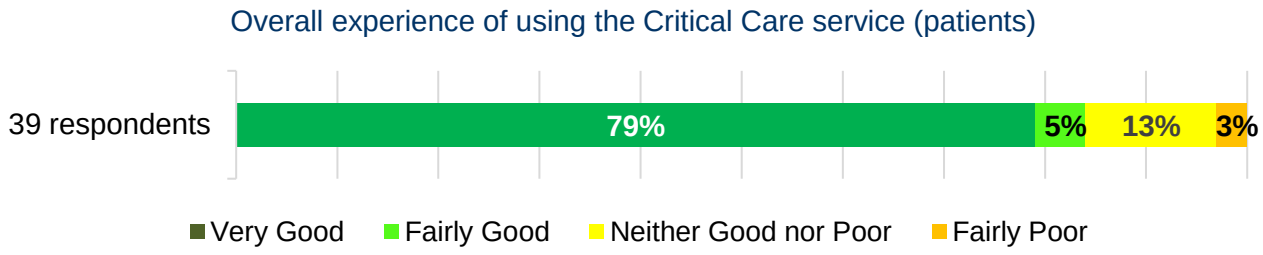
A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

All patients who accessed Critical Care services within the last five years (1 August 2018-31 July 2023) were invited to share their views in the survey. The survey was sent to 399 patients and 39 responses were received. Of the people responding, 20 accessed most of their Critical Care at Glangwili Hospital, 13 at Bronglais Hospital, three at Withybush Hospital, and two at Prince Philip Hospital. One respondent did not answer this question.

The equalities information collected shows that our patient demographic (ages, gender, ethnicity, etc., of our patients) for Critical Care services is mixed. This is broadly reflected in the profile of respondents to the patient survey. Tables showing the full profile breakdown of respondents are included in the full report.

Main survey findings

85% of patient respondents said that their experience of using the Critical Care service was good, whereas 3% said it was fairly poor.



When asked what was good about their experience of using the Critical Care service, patients mainly praised the:

- professional, kind, reassuring, and helpful staff
- quality of care
- timeliness and efficiency of the service received, and
- good communication and information provision.

However, others, complained about poor communication and the provision of information.

The main suggestions for improvements to Critical Care services shared by survey respondents include:

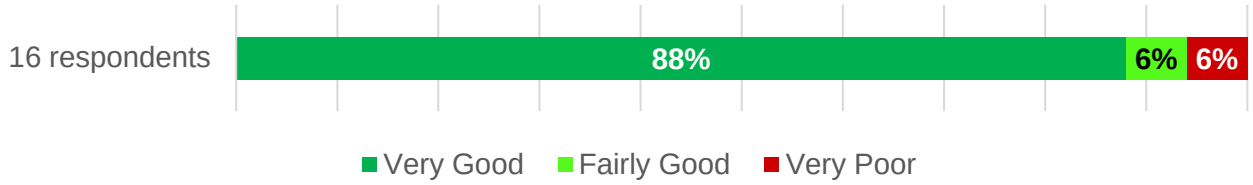
- staffing provision (including improvements to recruitment, training, incentives and wages); and
- communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up).

It should be noted, though, that 35% of respondents felt that no improvements are required.

Experiences of Outpatient services

Less than half of patient respondents (46%) said they used the Outpatient department as part of their treatment. Of these, the vast majority said it was good (94%). Only one respondent (6%) said it was very poor.

Overall experience of using the Outpatient department (patients)



When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent comments related to receiving a generally good, quick, and efficient service; and the professional, kind, reassuring, and helpful staff.

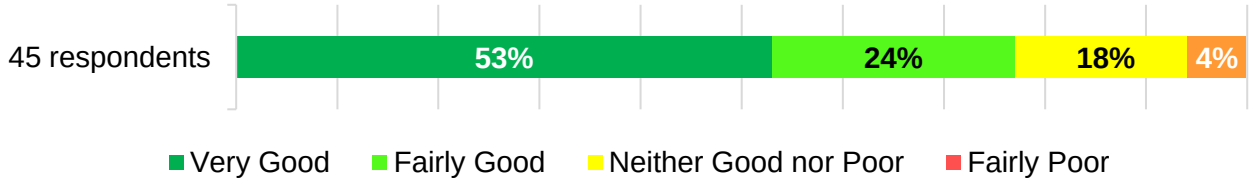
Targeted early engagement with staff

A survey was sent to medical, nursing, therapies, operational, and support staff. Staff members were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS and helps us to understand the key issues and themes facing our staff when using or working with Critical Care.

All staff currently working in, or supporting staff working in, the Critical Care service were invited to take part in a survey: 46 responses were received. Respondents' main clinical base is/was Glangwili Hospital (15 respondents), Withybush Hospital (13 respondents), Prince Philip Hospital (13 respondents), and Bronglais Hospital (five respondents).

78% of staff respondents said that their overall experience of working in/with the Critical Care service was good, whereas 4% said it was poor.

Overall experience of working in/with the Critical Care service (staff)



In terms of what is, or was, good about their experience of working in or with the Critical Care service, staff expressed pride in the high level of care offered to patients and their families across all four sites. Respondents also commented positively on

- the variety of their roles
- good training and professional development opportunities
- the extensive skillsets and experience within Critical Care teams
- positive working relationships and good teamwork (which has facilitated the successful development of multidisciplinary teams)
- the support provided by some managers; and
- the addition of the Critical Care Psychology Service to support patients in intensive care and their families.

As for what is, or was, difficult about their experience of working in, or with, the Critical Care service, the lack of a rehabilitation pathway within Critical Care was a particular concern in terms of limiting patient recovery and impacting patient outcomes. Comments were also made about:

- the difficulties involved in standardising care across the four Critical Care units, not least due to an apparent reliance on agency staff
- the lack of a clinical lead for the service
- a lack of support and communication from some service and Health Board managers
- delayed transfers of care due to limited bed capacity on wards
- sometimes unnecessary transfers between sites due to a lack of consultant cover at Prince Philip Hospital; and
- the sometimes emotionally draining nature of the job.

Suggested ways to improve the staff experience of working in/with the Critical Care service were to:

- invest in the workforce, especially clinical psychologists[33] and Allied Health Professionals[34].
- improve consultant recruitment and retention
- fund, develop, and resource a rehabilitation pathway to meet the standards for follow-up patient care
- offer better access to tertiary services[35]
- continue to support the most serious patients at Prince Philip Hospital; and
- develop a clearer clinical leadership structure or role across the service.

Staff experiences of Outpatient services

Four staff respondents said that they use the Outpatient department in relation to Critical Care. Of these, one said that their overall experience of doing so was very good, two said it was neither good nor poor, and one said it was very poor.

Critical Care finance

The table below shows the main drivers of cost that impact on service delivery budgets – the variable costs that influence the overall cost of the service.

This information is aligned to the findings and submissions included in the 2024/2025 annual plan.

Service	Key reasons for variable costs
Critical Care	Gaps remain in substantive nursing staffing although there has been an improvement over the year
General	Services provided over multiple sites Vacancies filled with premium costs or additional hours

The operational challenges in Anaesthetics and Critical Care, due to delivering services across multiple sites, have significantly influenced variable pay costs. In the first nine months of 2023/24 Anaesthetics has incurred variable medical pay expenditure of £1.863m, mostly due to Additional Duty Hours (ADH) sessions paid at rates 60% above the rate card. These costs are made greater

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[33] Psychologists is someone who studies the human mind, emotions, and behaviour.
[34] Allied Health Professionals represent a range of groups including Speech and Language Therapy (SaLT), Occupational Therapy, Physiotherapy and Psychological Therapies.
[35] Tertiary services are specialised services usually provided in larger hospitals.

by premium pay for established posts, and additional expenses such as travel, relocation, and consultancy fees totalling approximately £50k a year. For Nursing in the same period, Critical Care has incurred £1.152m for nurse agency.

However, there has been success in recruiting staff to substantive roles during 2023/24 that makes the 2024/25 position more affordable.

Critical Care service workforce

The Workforce Team have supplied data within defined cost codes provided by Critical Care. Full details about the methodology can be found within Appendix C13 – Critical Care – Workforce Data.

The medical workforce across the Health Board ensure that Critical Care provision is delivered in rotas specific to the location and bed base.

The table below shows the workforce establishment (number of people working) across our hospital sites within Critical Care services on 31 July 2023.

Hospital	Consultant	SAS Doctor	Trainee doctor, Core Trainee (CT), Speciality Trainee (ST)	Detail
Bronglais	Yes	No	No	Consultant led service – flexible Theatre and Critical Care in job plans. **Vacancy:** 1
Glangwili	Yes	Yes	Yes	Consultants: funded for 9. Currently 5 substantive and 1 locum in post. All staff, bar 1 consultant have both Theatre and Critical Care in their job plans. **Vacancy:** 3 x consultants[36] SAS: 2 x 24/7 SAS[37] in Glangwili and 1 x 24/7 rota for Prince Philip.
Prince Philip	Yes	Yes	No	**Vacancy:** 4 x SAS, 2 x fixed term contracts[38]. **Trainees:** CT2[39] to ST4[40] participate in 24/7 rotas with SAS team once signed off by consultant lead. A ST6[41] Intensive Care Medicine trainee works exclusively in Critical Care.

[36] *Recurrent adverts and ongoing collaboration with medical recruitment team to attract staff.*
[37] *SAS - A Specialist and Associate Specialist (SAS) Doctor is a doctor who has the same clinical experience as a consultant but has not completed specialist training.*
[38] *Recent advertising attracted over 20 candidates, shortlisting currently underway.*
[39] *CT2 Core Medical Training.*
[40] *ST4 Specialist Trainee ST4 – ST8 are the remaining 5 years of Higher Specialist Training.*
[41] *ST6 Specialist Trainee ST4 – ST8 are the remaining 5 years of Higher Specialist Training.*

Withybush	Yes	Yes	No	5 x consultants and 8 x SAS support Critical Care. All have Theatre and Critical Care in their job plans. **Vacancy:** 0

Recruiting to the post of consultant with an interest in Critical Care in Carmarthenshire is an ongoing challenge. Efforts have been made, working closely with the medical recruitment team to place regular adverts, including notices in the British Medical Journal (BMJ), and using external agencies to head hunt. Despite the continued efforts, this has not yet produced the desired results. However, this is a national issue, as there is a general shortage of anaesthetists, which includes individuals with an interest in Critical Care. The consultant shortage in Carmarthenshire has led to the changes made to Critical Care provision in Prince Philip Hospital.

Several of the SAS doctors are actively pursuing training and development with a view of gaining their Certificate of Completion of Training (CCT) in Anaesthetics. The breadth of the training required to meet the CCT curriculum cannot be provided within the Health Board and will need to be supported by other organisations. Medical staff are required to look for placements outside of the Health Board to progress professional development. Hywel Dda has no formal pathway for staff to pursue CCT, which would need to be in conjunction with Cardiff and Vale University Health Board and Swansea Bay University Health Board and will need candidates to compete with other trainees as there is a limited number of placements available.

Training is not included within the core budget. Therefore, internal secondment opportunities, for example, seconding staff from Withybush Hospital to Glangwili Hospital to undertake Obstetrics, is not possible as there is no funding to support the staff roster at Withybush Hospital. Likewise, placements in Swansea Bay University Health Board for Cardiothoracic[42], or Cardiff and Vale University Health Board for Neuro Anaesthesia[43], requires a candidate to be there for three months unpaid. These locations no longer offer fellowships that staff could undertake by taking unpaid leave and is an unrealistic option for staff.

Glangwili Hospital has a long association with the Royal College of Anaesthetist (RCOA) training programme and has sustained very positive feedback from trainees. Visits from the RCOA deanery have been very successful; and praise has been given for the quality and level of support and training against the curriculum. This has led to the selection of Glangwili Hospital as a hosting centre for senior trainees. This was recently further developed by a link to support senior trainees to work with the Adult Critical Care Transfer Service (ACCTS).

The nursing workforce has benefited from successful recruitment over the past year, which has stabilised the workforce across the four sites. To be able to recruit, the departments have employed novice practitioners who take significant amounts of development, both in terms of study leave for training days, and supervision while at work. This has an impact on the skill mix in the Critical Care Units. However, the benefit of investing in the substantive team is recognised and the efforts are being realised. Some of the departments have a larger proportion of the nursing workforce in the retirement age profile, which poses a future risk.

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[42] Cardiothoracic is the speciality involved with the treatment of diseases affecting the chest. (Source – www.rcseng.ac.uk)
[43] Neuro Anaesthesia relates to the care before, during and after neurological surgeries. (Source – www.naccs.org.uk

Alternative roles to support care delivery in Critical Care have been considered. An example of this is by employing Band 4 assistant practitioners, with their role and competence being developed and supported by national working groups.

The GPICS recommendations are considered across all four sites, and where possible, are implemented. However, this is not always achievable.

There is a significant issue with support from AHPs across all locations. This group of staff includes Physiotherapy; Pharmacy; Dietetics; Speech and Language; and Occupational Therapy. These roles are considered essential as they directly contribute to the recovery and rehabilitation of patients in Critical Care. Following GPICS self-assessment in September 2021, a small multi-disciplinary working group met to consider the challenges of the current provision and deficits against GPICS standard and produced recommendations. This developed into an IMTP submission in November 2021, which included detailed reports from each speciality looking at staffing and alternate roles. Current provision still varies significantly across the Health Board and is inadequate, as no Critical Care Unit has dedicated AHP support.

There is an expectation that Hywel Dda will have a strategic direction in its Critical Care Provision, aligned to the Critical Care National Clinical Framework in Wales.

Critical Care conclusions

Critical Care provision currently supports all four acute sites within the Health Board, totalling a maximum of 30 funded beds that, depending on the level of acuity, extends to a maximum of 38 beds.

Critical Care services are in the Clinical Services Plan (CSP) due to service sustainability issues relating to a change in provision in Carmarthenshire.

The Critical Care services operate from the following locations:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital

A summary of the main findings identified within this paper are as follows:

Service changes

- A temporary service change implemented in July 2022 was described in Public Board on 28 September 2023. The change was an amendment to the admission protocols to the Critical Care Unit at Prince Philip Hospital. From this date, admission protocols to the unit were changed to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care needing to be admitted or transferred to neighbouring Critical Care units, suitable to their needs, unless a specialist hospital referral is required (for example – cardiothoracic in Morriston Hospital, Swansea)
- The challenges to the Carmarthenshire pathway are explained in this chapter. This is about the provision of Critical Care services at Prince Philip Hospital and Glangwili Hospital. It has an impact on a number of areas including Hywel Dda patients, relatives, multi-disciplinary staff, radiology and health science resources, and ACCTS[44] as the external transfer

[44] *ACCTS – Adult Critical Care Transfer Service.*

company. While there has been no formal feedback received about the temporary pathway, there will be impacts on patients' families who may need to travel further to see their relatives in Glangwili. The impact on the staff in Prince Philip Hospital includes a reduction in staff morale, and the loss of skills in managing complex Level 3 patients, despite mitigations introduced to limit this risk

- The current Critical Care arrangements in Carmarthenshire are intended to be on a temporary basis and fall short of the national guidance. This is having an impact on workforce. The provision is a topic of discussion at the Sustainable Model for Critical Care and Medical Emergencies in Prince Philip Hospital group. The Clinical Services Plan process aims to support the identification and implementation of a longer-term solution that meets all aspects of the guidance of provision of Critical Care.

Risks

- One risk has been reported to Public Board that relates to Critical Care between 1 January 2019 and 31 March 2023: this was due to the inability to support Level 3 Critical Care provision at Glangwili Hospital and Prince Philip Hospital due to consultant availability
- Due to lack of storage on site the units at Bronglais, Glangwili and Withybush hospitals are currently using one bed space to store equipment. This is a risk to both staff and patients and as such a risk has been created to reflect (Risk reference 1637)
- Following discussions at the Task and Finish group concerns have been raised around availability of EMRTS[45]/ACCTS[46] teams and/or time delays of transfers of our critically ill patients. We recognise the risk due to capacity issues of EMRTS and/or ACCTS teams and the geographical distances between the existing EMRTS/ACCTS hubs and our hospital sites Bronglais General Hospital in particular.

Clinical effectiveness

- There are significant issues on the limited provision of AHP support across the Critical Care service and investment will be essential to meet the standards and recommendations of GPICS.

Local, regional and national work

- The National Strategic Clinical Network for Critical Care, Trauma and Emergency Medicine (CCTEM)[47] was established in October 2023
- There are six Critical Care related workstreams supported by Hywel Dda. Capacity, Demand and Configuration; Senior Nurse Forum; Post Anaesthetic Care Units (PACU / Enhanced Care)
- Whilst able to support the Capacity, Demand and Configuration Group and the Clinical Reference Group, the service has highlighted that there are limitations at this stage to enable full participation and development of plans due to the lack of a Critical Care Health Board lead.

Activity data

- While there is a defined number of funded beds (with a degree of flexibility to account for the different staffing levels needed for different acuity levels), the Critical Care departments frequently surge above the funded bed base as there is no alternative care provision for

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[45] EMERTS – Emergency Medical Retrieval & Transfer Service.
[46] ACCTS – Adult Critical Care Transfer Service.
[47] CCTEM - NHS Wales Executive - https://executive.nhs.wales/functions/networks-and-planning/cctem/

patients needing this level of care. This has an impact on staffing and the use of variable pay. Morale amongst nursing staff can be impacted due to increased stress at times of surge. Critical Care bed capacity is often impacted by the delay in transfer of patients to general ward beds when medically fit to do so. This is because of increased demand for inpatient beds throughout the health care system.

Incidents, complaints, and claims

- Within the time recorded for this Issues Paper, Withybush Hospital had 28% of the admission activity with 49% of recorded incidents
- The overall number of complaints for each location is not at a level that cause concern and is as expected when considering the volume of patients at each site
- During the period analysed there was one closed claim relating to a delay in diagnosis and commencing treatment. The Health Board has accepted liability in this claim.

Patient experience and compliments

- Staff are frequently described as delivering kind and professional care and provide comfort to the patients while communicating well about the care they received
- Patients rated their experience of using Critical Care highly with 77% saying it was very good and 23% finding their experience to be good.

Targeted early engagement with service users

- Patients' positive feedback when using the Critical Care service found the staff to be professional, kind, reassuring, and helpful; the quality of care; the timeliness and efficiency of the service received; and good communication and information provision. Others, though, gave negative comments about poor communication and information provision
- The main improvements suggested by patients were around staffing provision (including improvements to recruitment, training, incentives and wages); and communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up).

Targeted early engagement with staff

- Staff expressed pride in the high level of care offered to patients and their families across all four sites. Respondents also commented positively on the variety of their roles; good training and professional development opportunities; the extensive skillsets and experience within Critical Care teams; positive working relationships and good teamwork (which has facilitated the successful development of multidisciplinary teams); the support provided by some managers; and the addition of the Critical Care Psychology Service to support patients in intensive care and their families
- The lack of a rehabilitation pathway within Critical Care was a particular concern to staff within Critical Care – that it is limiting patient recovery and impacting patient outcomes. Comments were also made about the difficulties involved in standardising care across the four Critical Care units, not least due to an apparent reliance on agency staff; the lack of a clinical lead for the service; a lack of support and communication from some service and Health Board managers; delayed transfers of care due to limited bed capacity on wards; sometimes unnecessary transfers between sites due to a lack of consultant cover at Prince Philip Hospital; and the sometimes emotionally draining nature of the job
- Key suggested ways to improve the staff experience of working in/with the Critical Care service were to invest in the workforce, especially clinical psychologists[48] and Allied Health

[48] *A Psychologist is someone who studies the human mind, emotions, and behaviour.*

Professionals[49]; improve consultant recruitment and retention; fund, develop, and resource a rehabilitation pathway to meet the standards for follow up patient care; offer better access to tertiary services, continue to support the most serious patients at Prince Philip Hospital; and develop a clearer clinical leadership structure or role across the service.

Finance

- Key cost driver 1 - gaps remain in substantive nursing staffing, although there has been an improvement over the year
- Key cost driver 2 - vacancies filled with premium costs or additional hours
- Operational challenges due to variable pay costs for both Anaesthetics and Nursing.

Workforce

- Despite successful recruitment over the past year, there remains a variable reliance on temporary nursing staff. This is often due to opening surge beds above the funded capacity and attempts to achieve GPICS recommendations that are not factored into the planned rosters
- Medical staff recruitment is an issue with a challenging national picture. The Health Board is in competition with hospitals nearer to larger towns and cities that can offer a broader breadth of workload experience in a busier environment. In addition, while the SAS team have been committed to working locally, their desire to gain further experience and qualifications will take them outside the Health Board, and they may choose not to return
- There are significant issues on the limited provision of AHP support across the Critical Care service and investment will be essential to meet the standards and recommendations of GPICS.

[49] *Allied Health Professionals represent a range of groups including Speech and Language Therapy (SaLT), Occupational Therapy, Physiotherapy and Psychological Therapies.*

Section 6: Emergency General Surgery

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

Section 6: Emergency General Surgery

Introduction and background

This chapter of the Issues Paper is about Emergency General Surgery (EGS) services at Hywel Dda University Health Board. This chapter is a clinically led assessment of EGS at all sites within the Health Board that delivered EGS between 1 August 2018 and 31 July 2023.

EGS Service at Hywel Dda

EGS is surgery that includes mostly abdominal emergencies. The abdomen is the part of the body that includes the digestive and reproductive organs – often called the belly. EGS is a consultant led service – a service that is led by a senior doctor.

EGS at Hywel Dda is only for adults. Children and young people (CYP) are treated through the Paediatric service.

Patients access the service through Emergency Departments, such as Accident and Emergency. This can be by ambulance or by patients making their own way to the department. Patients can also be referred from other acute specialities[50], Outpatient clinics or by an emergency referral from their GP.

If there is a surgical need the patient will be referred for Emergency Surgery and admitted to a hospital ward following their surgery to recover. Emergency Surgery takes place at:

- Glangwili Hospital
- Bronglais Hospital
- Withybush Hospital.

The patient will recover in the same hospital site where they had their surgery. The ward the patient recovers on is a general surgical ward and managed separately from the EGS service. However, the EGS consultant responsible for their care will oversee the patient's recovery until they are discharged from hospital.

EGS consultants[51] also support other areas and departments across the hospital site, including Accident and Emergency. The EGS team will assess any patient thought to have a potential surgical problem. The team will offer advice, authorise the use of medicines or treatment (prescribe), or perform surgery where needed.

EGS service model

There is a 24 hour, seven days a week (24/7) rota to support EGS. The level of cover varies depending on the time of day. The table below describes the rota in each hospital site.

[50] Acute specialties include doctors working in internal medicine who assess, investigate, diagnose, and manage patients with conditions that show severe symptoms that develop quickly and could be life threatening.

[51] A consultant surgeon is responsible for overseeing and performing surgery and managing care within the hospital setting.

Site	Consultant cover	SAS level[52] cover	Junior doctor[53] cover
Glangwili Hospital	Weekdays, on call consultant on site 8am – 8pm, Monday to Thursday On call consultant non-resident[54] cover 8pm – 8am, Monday to Thursday On call consultant non-resident cover 8am – 8pm, Friday to Monday	SAS doctor on site 8am - 8:30pm and 8pm - 8:30am, seven days a week	8am – 8:30pm on call F1[55], F2[56] and Clinical Trainee doctor[57], seven days a week 8pm – 8:30am, on call F1 doctor, seven days a week
Bronglais Hospital	On call consultant, on site, 7pm -7am, seven days a week	SAS doctor non-resident, 9pm – 9am, seven days a week	9am – 9:30pm F1, F2 or Clinical Fellow[58], seven days a week 9pm – 9:30am F1, F2 or Clinical Fellow from Surgery Medicine or Trauma and Orthopaedics (TNO), providing a hospital at night service[59], seven days a week
Withybush Hospital	Weekdays, on call consultant on site 8am - 8pm, Monday to Thursday On call consultant non-resident cover 8pm - 8am, Monday to Thursday On call consultant non-resident cover 8am - 8am (24 hours a day) Friday to Monday	SAS doctor non-resident 9pm - 8am, seven days a week	8:30am - 9pm on call F1, seven days a week 9am - 10pm on call F2 or clinical trainee, seven days a week 8:30pm - 9am on call F2 or Clinical Trainee, seven days a week

[52] SAS Doctors: Speciality and Specialist Doctor.
[53] Junior Doctor: a doctor who has completed a medical degree and foundation training and have anywhere up to eight years' experience working as a hospital doctor. All Junior Doctors work under the supervision of a senior doctor.
[54] Non-resident: they are not on the hospital site.
[55] F1: First year Junior Doctor.
[56] F2: Second year Junior Doctor.
[57] Clinical Trainee: Junior Doctor in their third year.
[58] Clinical Fellow: Junior Doctor in their last year.
[59] Hospital at night service: a multi-disciplinary team approach to providing patient centred care overnight. The team is made up of senior nurse practitioners and doctors.

EGS service changes

This section provides information about the updates to Public Board about the service changes that have taken place within EGS between August 2018 and July 2023.

Service change timeline

Summary of temporary change

The temporary service change was described at Public Board on 30 March 2023 as:

- Out of hours consultant cover should be concentrated at Glangwili and Bronglais hospitals whilst recruitment efforts focus on improving the staffing situation at Withybush Hospital
- During out of hours periods, the consultant teams at Glangwili and Bronglais hospitals would provide remote support and advice to the SAS level of surgical doctors at Withybush Hospital who would continue to provide 24/7 emergency surgical cover for patients at the hospital.

This decision was taken to:

- Ensure the safety of patients admitted through an emergency surgical pathway at Withybush Hospital
- Support the continued sustainability of the 24/7 emergency surgical pathway at the hospital.

The temporary rota commenced on 1 May 2023.

Full details about the service change can be found in the following Board papers:

- Public Board EGS paper, 30 March 2023[60]
- Quality, Safety and Experience Report 8 August 2023[61]

The temporary change remained in place until 9 November 2023 at which point the service had successfully appointed a locum[62] doctor to support the team at Withybush Hospital, until a longer-term recruitment plan is agreed.

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[60] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-441-emergency-general-surgerypdf/*
[61] *hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/quality-safety-and-experience-committee-8-august-2023/item-4-2-2-withybush-emergency-surgery/*
[62] *A locum is a doctor who temporarily fills vacancies in a hospital, usually recruited through an agency.*

EGS risks

This section describes the EGS risks that have been reported at Public Board meetings between August 2018 and July 2023.

Overnight theatre provision at Bronglais Hospital, risk number 634, identified on 27 July 2018:

- Information about risk 634 can be found on page 5 of the Board paper[63] that was considered on 25 November 2021
- This risk was de-escalated by the Board on 25 November 2021 as a way forward was agreed
- This risk has since been closed following a successful recruitment process.

Lack of substantive[64] SAS level doctors affecting the emergency department in Withybush Hospital, risk number 750, identified 30 January 2020:

- Information about risk 750 can be found on page 5 of the Board paper[65] that was considered on 25 November 2021
- This risk was updated in January 2024, as three of the seven whole time equivalent (WTE)[66] SAS doctor posts have been filled. A Medacs[67] locum is covering another WTE. Three WTE posts remain unfilled.

Inability to safely support the consultant on-call rota at Withybush Hospital and Glangwili Hospital, risk number 1531, identified on 10 November 2022:

- Information about risk 1531 can be found on page 7 of the Board paper[68] that was considered on 25 May 2023
- This risk continues to be monitored. The recruitment of a Medacs locum in November 2023 has allowed the Emergency Surgery rota at Withybush Hospital to continue 24/7
- The rota remains fragile due to the reliance on Medacs locum cover and the cost and risks that this involves.

EGS clinical effectiveness

The table below includes a list of the clinical guidelines the EGS service needs to follow:

Guideline source	Guideline title	Link
Royal College of Surgeons of England	Various guidelines within link	https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/
Association of Surgeons of Great Britain and Ireland	There are evidenced based guidelines which are only accessible to members.	https://www.asgbi.org.uk/emergency-general-surgery

[63] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-november-2021/agenda-and-papers-25th-november-2021/item-4-5-corporate-risk-register/*
[64] *Substantive means the role to which an employee has been permanently appointed.*
[65] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-25-may-2023/board-agenda-and-papers-25-may-2023/item-4-3-corporate-risk-register-pdf/*
[66] *WTE: Whole Time Equivalent. 1WTE is one full-time staff member working 37.5 hours a week.*
[67] *Medacs is a locum agency.*
[68] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-25-may-2023/board-agenda-and-papers-25-may-2023/item-4-3-corporate-risk-register-pdf/*

NIHR Global Research Health Unit on Global Surgery	Global guidelines for emergency general surgery: systematic review and Delphi prioritization process	https://www.globalsurgeryunit.org/wp-content/uploads/2022/03/Global-guidelines-for-emergency-general-surgery.pdf
Getting it Right First Time (GIRFT)	General Surgery	https://gettingitrightfirsttime.co.uk/surgical_specialties/general-surgery/
NICE[69]	Hypothermia: prevention and management in adults having surgery	https://www.nice.org.uk/guidance/cg65
NICE	Perioperative[70] care in adults	https://www.nice.org.uk/guidance/ng180
NICE	Perioperative care in adults	https://www.nice.org.uk/guidance/ng180
NICE	Diverticular[71] disease: diagnosis and management	https://www.nice.org.uk/guidance/ng147
NICE	Surgical site infections: prevention and treatment	https://www.nice.org.uk/guidance/ng125
Coloproctology of Great Britain and Northern Ireland	Various guidelines relating to Coloproctology[72]	https://www.acpgbi.org.uk/
Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland (AUGIS)	Delphi Consensus Recommendations of the Adoption of Robotic Upper GI[73] Surgery	https://www.augis.org/Portals/0/Guidelines/AUGIS%20Guidelines_Consensus%20of%20UGI%20%20Robotic%20Surgery%20Adoption_September%202023.pdf?ver=uW9170OB-e_Is8CTLDl9Nw%3d%3d
Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland	AUGIS Provision of Services	https://www.augis.org/Portals/0/Guidelines/Provision-of-Services-June-2016.pdf?ver=rfKKm8ntBIfH485sM1XZRQ%3d%3d
Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland	AUGIS Gallstone Disease Commissioning Guidance	https://www.augis.org/Portals/0/Guidelines/Gallstone-disease-commissioning-guide-for-REPUBLICATION-1.pdf?ver=OKJgTeTNhxWCN5TlTerfeQ%3d%3d
Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland	AUGIS Acute Gallstones Pathway	https://www.augis.org/Portals/0/Guidelines/Acute-Gallstones-Pathway-Final-Sept-2015.pdf?ver=8SLL3_E_X7VSx4gqyVYd6Q%3d%3d
Association of Upper Gastrointestinal Surgery of Great	AUGIS Gastro-Oesophageal reflux disease	https://www.augis.org/Portals/0/Guidelines/GORD-Commissioning-

[69] NICE: National Institute for Clinical Excellence.
[70] The perioperative period is the time lapsed surrounding surgery.
[71] Diverticular disease is an infection in the tiny pouches that some people get in their colon.
[72] Coloproctology is the surgical subspeciality that deals with investigation, diagnosis, and treatment of disorders of the colon, rectum, bowel, and appendix.
[73] Upper GI refers to your upper gastrointestinal tract. This includes oesophagus, stomach and first part of the small intestine.

Britain and Northern Ireland		Guide_Published.pdf?ver=3CawBfL5HqwK2eeud6BvQw%3d%3d
Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland	AUGIS ASGIB ACPGBI Future of Emergency Surgery	https://www.augis.org/Portals/0/Guidelines/Future-of-EGS-joint-document_Iain-Anderson_140915.pdf?ver=fb-BBO5JT7jzZ3JKjIWNTA%3d%3d

Surgery performed under EGS for Upper Gastrointestinal Surgery is subject to guidance from the Association of Upper Gastrointestinal Surgery of Great Britain and Northern Ireland (AUGIS). It states that services should be delivered by a surgeon who has an interest in and is able to undertake a reasonable amount of this type of surgery. This is important to maintain a surgeon's skill. This skillset does not currently exist in Withybush Hospital and the number of emergency cases of this type are too small when shared between all three hospitals. This carries a risk of poor quality and failure to recruit appropriately skilled surgeons at all levels. This has been highlighted in the National Emergency Laparotomy[74] (NELA)[75] audits performed in Hywel Dda.

EGS local, regional, and national work

This section describes the regional and national projects or programmes connected to EGS services at Hywel Dda.

Getting It Right First Time (GIRFT)

The GIRFT review for EGS was completed in May 2023. The full report, including the recommendations and the progress made against each area, can be read in Appendix D7 – EGS – National Workstreams - GIRFT.

A summary of the high priority recommendations included in the GIRFT report are for Hywel Dda to:

- establish a robust mechanism for capturing procedure[76] level data of Inpatient, Day Case[77] and Outpatient[78] procedures
- develop a relationship between clinical coders[79] and consultants to improve data collation
- develop plans to implement, and staff dedicated to surgical SDEC[80] on acute (hospital) sites

[74] A Laparotomy is a surgical procedure that involves a surgeon making one large incision or cut in the abdomen.
[75] NELA is an organisation that informs on improvement of quality of care for patients undergoing emergency laparotomy. Details about NELA can be found at www.nela.org.uk.
[76] A Patient Procedure is a clinical intervention performed on a patient by a care professional.
[77] A patient who comes in for a more involved procedure than an Outpatient. You may need some recovery time at the hospital, but you should be able to go home the same day.
[78] If you have an appointment in a hospital or clinic but do not need to stay overnight, it means you are being treated as an Outpatient or a Day Patient. You may be having an appointment for treatment, diagnosis, or a procedure.
[79] A Clinical Coder records clinical information about every patient who is admitted for treatment in all aspects of their journey from start to finish.
[80] Same Day Emergency Care, SDEC – where you are given emergency care on the same day as you arrive at a hospital.

- develop both the pelvic floor service[81] and concentrate elective[82] Inflammatory Bowel Disease surgery in the hands of fewer surgeons to develop and maintain expertise
- review their internal criteria for day surgery and benchmark them against the National Day Surgery Delivery Pack
- conduct a review of the preoperative assessment[83] system and take action to implement the guidance from the Centre for Perioperative Care[84] of preoperative assessment and optimisation
- Hywel Dda to review pathway for patients with diabetes and to consider developing a preoperative diabetes team led by nurse specialists.

EGS activity data

EGS service activity reported between 1 August 2018 and 31 July 2023 is included for Bronglais, Withybush, and Glangwili hospitals. All data tables including the specific conditions captured can be found in Appendix D8 – EGS – Activity Data.

The table below shows the EGS procedures as defined within the above Appendix (2018-19 represents August to March and 2023-24 represents April to July). This could include checking of the patient when they are in the emergency department, the surgery, and then checking the patient once they are on the ward. The table below does not include activity undertaken by the EGS service in the emergency department where further EGS involvement is not required.

Emergency General Surgery Procedures				
Reporting period	**Bronglais Hospital**	**Glangwili Hospital**	**Withybush Hospital**	**Total**
2018-19	368	1033	847	**2,248**
2019-20	187	510	300	**997**
2020-21	72	250	267	**589**
2021-22	116	341	230	**687**
2022-23	145	359	319	**823**
2023-24	39	155	114	**308**
Total	**927**	**2,648**	**2077**	**5,658**

Overall activity carried out by EGS has fallen since 2018, especially during the COVID-19 pandemic in 2020. It is important to note that there are no waiting lists for this type of surgery and patients are treated as they present.

Since 2020, patients are treated more conservatively with a ‘watch and wait’ approach. This means fewer patients are being taken for surgery, for instance the use of antibiotics for appendicitis rather than immediately operating. This means patient contact remains consistent; though, the number of admissions has reduced which may contribute to the activity reflected in the table above. However further analysis may be required as to understand this reduction further.

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[81] A Pelvic Floor Service offers consultation and clinics to female patients with evidence of pelvic floor dysfunction. The Pelvic Floor is a group of muscles and ligaments that support the bladder, uterus (womb) and bowel.
[82] Elective surgery is non-emergency surgery.
[83] This is a review of the patient to check they are fit for surgery.
[84] Centre for Perioperative Care (CPOC) is dedicated to the promotion, advancement, and development of perioperative care.

Patients who are seen by a surgical doctor in A&E and discharged under this approach are not included as EGS patients. This means it has not been possible to show the number of patients who are seen by an EGS consultant but are then not then admitted to the service.

EGS incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against EGS. Full data for incidents and complaints can be found in Appendix D10 – EGS – Complaints Data, and D9 – EGS – Incidents Data.

Patient safety incidents

The table below shows the overall number of recorded incidents for EGS across all sites within the Health Board. The recording period for each year is 1 August to 31 July.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of incidents	400	306	212	326	354

The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of July 2023. The number of incidents recorded for EGS at each hospital site is seen in the table below:

Location	Number of incidents 1 August 2018 - 31 March 2021	Number of incidents 1 April 2021 - 31 July 2023	Total number of incidents
Bronglais Hospital	273	193	**466**
Glangwili Hospital	179	240	**419**
Withybush Hospital	420	351	**771**
Total	**872**	**784**	**1,656**

The data shown in the table below shows the number of incidents as a percentage of the overall admission activity. For example, Bronglais Hospital had 17% of the overall admission activity (the number of patients admitted to EGS) with 28% of recorded incidents.

The total number of activities across all Health Board sites (i.e. number of EGS admissions) is 5,344. The total number of incidents reported in EGS services across all Hywel Dda sites is 1,656 incidents.

Location	Percentage of total activity undertaken at the site (5,344)	Percentage of total incidents reported (1656)	Proportion of incidents as a percentage of activity undertaken
Bronglais Hospital	17% (888)	28% (466)	52%
Glangwili Hospital	47% (2,493)	25% (419)	17%
Withybush Hospital	37% (1,963)	47% (771)	39%

The data indicates that there is a higher proportion of incidents reported at Withybush and Bronglais hospitals when comparing the number of incidents against the overall level of activity undertaken at each hospital.

The reasons for needing to make temporary changes to the EGS service, as described at the start of this chapter, is because of the service fragilities, particularly at Withybush Hospital. While patients will spend most of their time on a ward that is not managed by EGS, it is important to highlight the significant difference in the number of reported incidents that take place in Withybush when compared to the amount of activity undertaken at the hospital. The service at Withybush Hospital relies heavily on locum doctors, which could contribute towards the greater number of incidents recorded at the site.

The most common types of incidents reported are shown in the table below:

Type of incident reported, 1 August 2018 - 31 March 2021	Number of incidents
Patient accidents/falls	300
Pressure ulcers	180
Type of incident reported, 1 April 2021 - 31 July 2023	
Accident, injury	218
Pressure damage, moisture damage	210

The table below shows the severity of recorded incidents, ranging from no harm to catastrophic (death):

Incident severity	Number of incidents 1 August 2018 - 31 March 2021	Number of incidents 1 April 2021 - 31 July 2023	Total
1 None	593	186	**779**
2 Low harm	201	397	**598**
3 Moderate harm	70	176	**246**
4 Severe harm	6	17	**23**
5 Catastrophic death	2	8	**10**

Patient complaints

The table below shows the overall number of complaints relating to EGS across all Health Board sites.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of complaints	61	93	66	102	36

The table below shows the number of EGS complaints received by each hospital site between 1 August 2018 and 31 July 2023:

Location	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Bronglais Hospital	37	15	**52**

Glangwili Hospital	86	40	**126**
Withybush Hospital	78	36	**114**
Total	**201**	**91**	**292**

The table below shows the number of complaints reported between 1 August 2018 and 31 July 2023, as a percentage of the overall activity by each hospital:

Hospital	Percentage of total activity undertaken at the site (5,344)	Complaints reported as a percentage of overall complaints (292)	Proportion of complaints as a percentage of activity
Bronglais	17% (888)	18% (52)	6%
Glangwili	47% (2,493)	43% (126)	5%
Withybush	37% (1,963)	39% (114)	6%

Patients will spend most of their time on a ward that is not managed by EGS.

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category:

Nature of complaint	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Clinical treatment / assessment	84	47	**131**
Appointments	29	12	**41**

The table below shows overall number of complaints received for EGS, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023:

Grade of complaint	Number of complaints 1 August 2018 - 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Grade 1 Minor (informal)	67	51	**118**
Grade 2 Minor	23	22	**45**
Grade 3 Moderate	39	13	**52**
Grade 4 Major	7	2	**9**
Grade 5 Catastrophic	1	3	**4**

EGS claims

There are no claims for EGS within the scope of the review.

EGS patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix D11 – EGS - Patient Experience and Compliments Data.

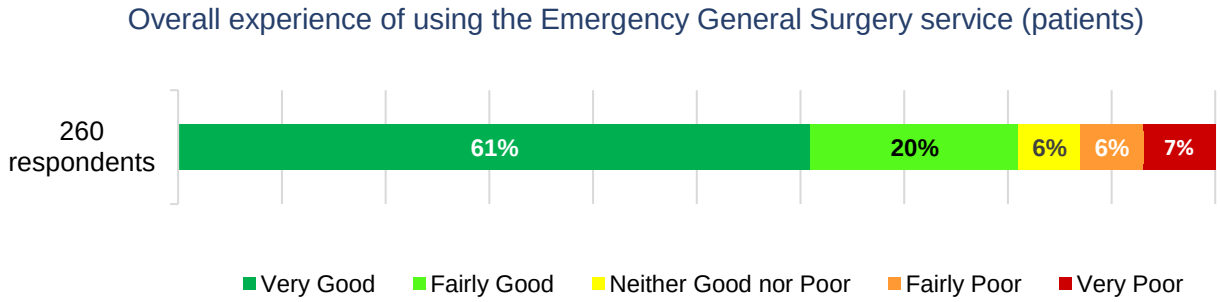
The patient experience data includes patients who have received any surgery, so specific conclusions regarding EGS specifically cannot be made. However, as it cannot be used to inform the Issues Paper it is not included in this section.

EGS targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

The main findings from this report include:

- 81% of patient respondents said that their experience of using the EGS service was good, with 61% saying that it was very good
- Around 7% of patients said it was very poor.



Key positive themes emerging from patients that used the EGS service included:

- staff are professional, kind, reassuring, and helpful
- service efficiency and speed (including being seen on time and receiving a prompt diagnosis); good quality of healthcare received including procedure, treatment, and outcome
- experience of and care received in the EGS department was generally good with no issues.

In contrast, complaints included that:

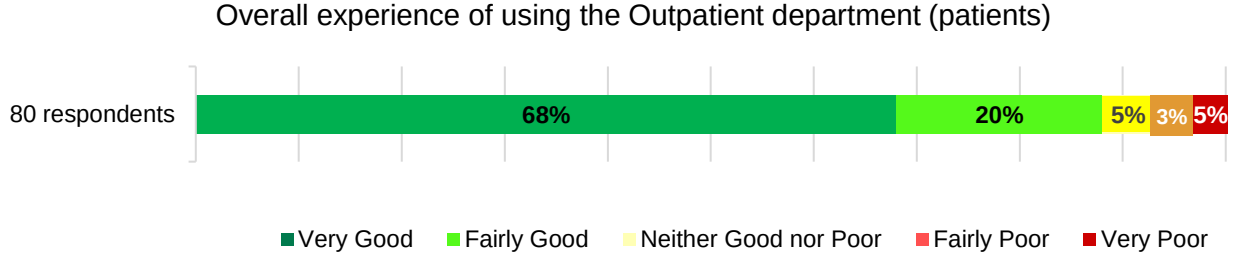
- the service is inefficient and slow
- staff were unprofessional, unhelpful and could be more caring
- patients had a generally poor experience in the department.

While 22% of respondents felt that no improvements are required, others did make suggestions to improve the EGS service. The most common were around speed and efficiency (including shortening waiting times and not cancelling appointments). Other common suggestions included to improve staffing provision (including recruitment, training, and incentives/wages) and to ensure staff adopt a more professional attitude.

Experiences of Outpatient services

42% of patient respondents said they used the Outpatient department as part of their EGS treatment. Of these,

- 88% said their experience of doing so was good, with 68% saying that it was very good
- 8% said it was poor.



The most common responses from patients who stated they received a good experience in the Outpatient department, included that:

- the service was generally good with no issues
- staff were professional, kind, reassuring, and helpful
- the service was efficient and quick, with patients seen on time and receiving prompt results/diagnoses.

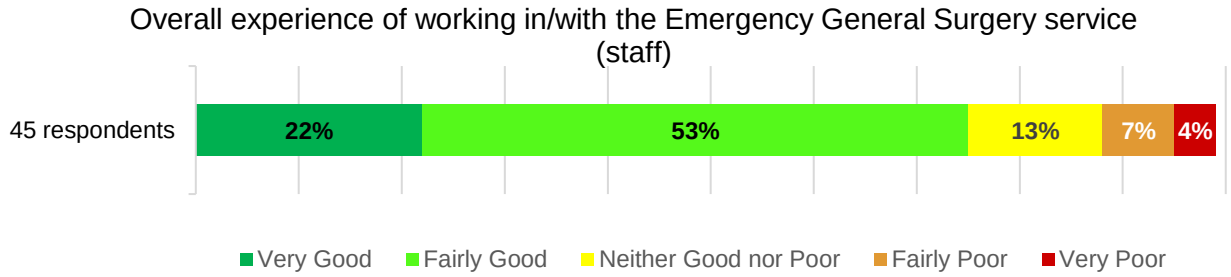
The most frequent negative comments included:

- service speed and efficiency
- bad experience of staff (including unprofessional staff members and unkind and/or unhelpful attitudes)
- poor communication (including explanations of tests, results, and treatments, and the frequency of contact and follow up).

EGS targeted early engagement with staff

A survey was sent to medical, nursing, therapies, operational, and support staff. Staff members were invited to share their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS and helps us to understand the key issues and themes facing our staff when using or working with EGS.

76% of staff respondents said that their overall experience of working in/with the EGS service was good, with 22% saying it was very good. In contrast, 11% said it was poor.



When asked what was good about their experience of working in/with the EGS service, staff respondents across all sites frequently highlighted the effective teamwork between experienced, hard-working, and dedicated staff. Other frequent comments included the positive working relationships formed between staff and managers, and the supportive and friendly environment formed by the teams. Some respondents praised:

- the quality of care provided to patients
- the communication within the service, and with supporting services
- the availability of facilities in the department
- the learning and development opportunities provided through training and audits.

Same day emergency care was also highlighted by some as a huge support to EGS.

The most common difficulties with working in/with the EGS service, according to staff respondents, were:

- the lack of bed capacity across all sites
- the apparent inefficiency of using a paper-based system to book rooms and make notes.

In addition, respondents complained about the:

- poor staff retention

- lack of consultant cover at Withybush Hospital
- treatment delays caused by transferring patients between sites to find an on-call consultant.

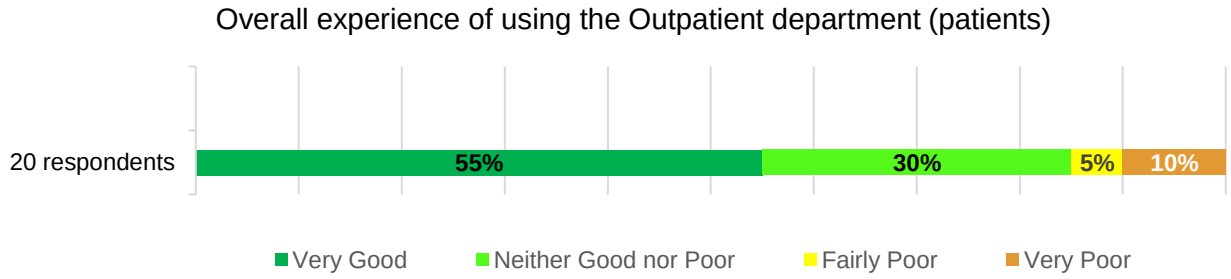
Some also noted that the department can be unstructured due to the nature of its role, and that having patients spread across wards is a cause for concern.

Several suggestions were made by staff to improve their experience of working in/with the EGS service. The most common were to reassess the current on-call model of care; digitalise the service by creating an online rota system with live updates; develop a more supportive and guided environment by dispersing the Scheduled Care Management team across all sites; increase the workforce in the department, particularly consultants; improve teamwork within sites and across the whole Health Board; and to provide more training opportunities to staff.

Other suggestions included to centralise the service to one or two sites; and to develop and/or maintain specific services within EGS, which are listed in the full report in Appendix A2 - CSP - Early Engagement Report.

Experiences of Outpatient services

44% of staff survey respondents use the outpatient department in delivering their Emergency General Surgery service. Of these, 55% said that their overall experience of working in the outpatient department was good, and 15% said it was poor.



The Outpatient service was praised by staff respondents for being generally well organised with kind and hard-working staff. Negative comments included:

- limited room availability
- the lack of time available for consultants to dedicate to the service
- the strain inflicted upon Glangwili Hospital staff by the frequent appointment transfers to the site from Withybush Hospital due to the Reinforced Autoclaved Aerated Concrete (RAAC)[85] issue.

EGS finance

The table below shows the main drivers of cost that impact on service delivery budgets – the variable costs that influence the overall cost of the service. This includes the factors that drive the general health cost[86] and drivers that can be specifically applied to EGS.

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[85] *Reinforced Autoclaved Aerated Concrete (RAAC) is a material that was commonly used in the construction of buildings between the 1960s and 1990s. Its presence has been confirmed at Withybush Hospital and at a limited part of Bronglais Hospital.*
[86] *Cost drivers are the direct cause of an expense. A cost driver is an activity that causes an increase in the cost of something else.*

This information is aligned to the findings and submissions included in the 2024/2025 annual plan.

Service	Key reasons for variable costs
General	Services provided over multiple sites
General	Vacancies in staff rotas are filled with premium costs or additional hours
Anaesthetics	Gaps in employed staffing, meaning some sessions need to be covered at enhanced pay rates
EGS	Rota gaps are covered by locums

General Surgery is reliant on a high level of medical variable pay spend, predominantly Additional Duty Hours, in the first 9 months of the year Additional Duty Hours spend totals were £1.261m and locum agency spend £0.503m. There are several gaps in the establishment which support a corresponding underspend and the resulting year end forecast for 2023/24 is balanced. There are plans to increase staff costs to reinstate emergency surgery at Withybush Hospital, which will push up costs during 2024/25 and beyond.

EGS workforce data

The Workforce Team have supplied data within defined cost codes provided by Emergency General Surgery. Full details about the methodology used to analyse this information can be found within Appendix D13 – EGS – Workforce Data.

The table below shows the workforce establishment (number of people working) across our hospital sites within EGS on 31 July 2023:

Staff group	Location				
	Bronglais	Glangwili	Prince Philip	Withybush	Total
Physician associate[87]	0	1	0	0	**1**
Administrative (clerical, Medical Secretary, Receptionist)	0	8.1	1.0	4.4	**13.5**
Medical (Associate Specialist, consultant, Foundation Year 1, Foundation Year 2, SAS doctor, Trust Grade Doctor – foundation level	10.0	19.0	3.0	12.0	**44.0**
Nursing (Advanced Nurse Practitioner)	0	2.0	0	0	**2.0**
Total	**10.0**	**30.1**	**4.0**	**16.4**	**60.5**

The staff noted for Prince Philip Hospital shows their allocated site, however EGS activity is not carried out at Prince Philip Hospital. These staff members will operate out of Glangwili Hospital. EGS has access to a surgical care practitioner (1.0 WTE) in Withybush Hospital who can support consultants when performing emergency and elective surgery.

[87] *Physician associates (PAs) are healthcare professionals with a general medical education who work alongside doctors and surgeons providing medical care as part of a multi-disciplinary team.*

The table below shows the budget and staff in post for EGS as of 31 July 2023. Please note that a Physician Associate has been recruited, although the budget for this post has not been confirmed. This has resulted in an additional full time staff member (whole time equivalent – wte) and one less vacancy available.

Staff group	Budgeted WTE	Actual WTE	Vacancy
Physician associate	0	+1	(1)
Additional clinical services	1.3	0	1.3
Administrative (clerical, Medical Secretary, Receptionist)	14.6	13.5	1.1
Medical (Associate Specialist, consultant, Foundation Year 1, Foundation Year 2, speciality doctor, speciality registrar, Trust Grade Doctor – Foundation Level)	73.8	44.0	29.8
Nursing (Advanced Nurse Practitioner)	2.0	2.0	0
Total	91.7	60.5	31.2

As of 31 July 2023, there were a total of 31.2WTE vacancies within the service. Of these, 29.8WTE are within the medical (doctors) staffing group.

It is important to note that the vacancies include all posts, including training positions which are often left unfilled and fluctuate during the year depending on the rotation[88]. EGS does not have any control over the trainee posts that are filled in each rotation, as this is confirmed by HEIW (Health Education Improvement Wales).

As of January 2024, the service has full rotations, and the only vacancies are for substantive posts as noted below:

- Withybush Hospital – 3WTE, including 1 consultant, 1 SAS doctor and 1 clinical fellow
- No vacancies in Glangwili Hospital
- No vacancies in Bronglais Hospital

EGS conclusions

The EGS Service is in the Clinical Services Plan (CSP) to respond to service fragility, especially at Withybush Hospital.

The service operates from the following sites:

- Glangwili Hospital
- Bronglais Hospital
- Withybush Hospital

A summary of the findings identified within this paper are as follows:

Service change

The following temporary change has been identified at Public Board:

- Out of hours consultant cover should be concentrated at Glangwili Hospital and Bronglais Hospital whilst recruitment efforts continue to improve the situation at Withybush Hospital

[88] *Junior Doctors rotate through different clinical units every 2-3 months.*

- During out of hours periods, the consultant teams at Glangwili and Bronglais hospitals would provide remote support and advice to the SAS level of surgical doctors at Withybush Hospital who would continue to provide 24/7 emergency surgical cover for patients at the hospital.

Risks:

- Lack of substantive SAS level doctors affecting the emergency department in Withybush
- Inability to safely support the consultant on-call rota at Withybush Hospital and Glangwili Hospital.

Clinical effectiveness

Volumes of this type of surgery are not substantial enough across three sites. This makes it harder to maintain the skills of existing surgeons and to recruit appropriately skilled surgeons at all levels.

Local, regional and national work

A GIRFT review has been undertaken and EGS continues to work towards the recommendations. Key themes include:

- Enhance data and coding capabilities
- Implement and staff surgical SDEC in acute sites
- Develop new and review existing pathways
- Concentrate elective Inflammatory Bowel Disease surgery in the hands of fewer surgeons to maintain expertise
- Provide emergency take on fewer sites, this will centralise expertise and create a sustainable rota.

Activity data

- Overall activity has fallen across all sites, mainly because the service has adopted more conservative surgical approaches
- Patients who are seen by a surgical doctor in A&E and discharged under this approach would not be coded to EGS.

Incidents, complaints, and claims:

- There is a higher portion of reported incidents at Withybush and Bronglais hospitals when compared with Glangwili Hospital. This could be attributed to the reliance on agency locum doctors at Withybush Hospital
- There is a lower portion of reported complaints at Glangwili when compared with Withybush and Bronglais hospitals
- No claims have been recorded for EGS that are within the scope of review.

Patient experience and compliments data:

- No conclusions can be made from this data.

Targeted early engagement with service users:

- Key positive themes emerging from patients that used the Emergency General Surgery service are the professional, kind, reassuring, and helpful staff; the service efficiency and speed (including being seen on time and receiving a prompt diagnosis); the good quality of healthcare received including procedure, treatment, and outcome; and that the experience

of and care received in the Emergency General Surgery department was generally good with no issues
- In contrast, negative comments included that the service is inefficient and slow; that staff were unprofessional, unhelpful and could be more caring; and that they had a generally poor experience in the department
- The most common suggestions for improvements were around speed and efficiency (including shortening waiting times and not cancelling appointments)
- Other common suggestions included to improve staffing provision (including recruitment, training, and incentives/wages) and to ensure staff adopt a more professional attitude.

Targeted early engagement with staff:

- Staff respondents across all sites frequently highlighted the effective teamwork between experienced, hard-working, and dedicated staff
- Other frequent comments included the positive working relationships formed between staff and managers, and the supportive and friendly environment formed by the teams
- Some respondents praised the quality of care provided to patients; the communication within the service, and with supporting services; the availability of facilities in the department; and the learning and development opportunities provided through training and audits
- Same day emergency care was also highlighted by some as a huge support to Emergency General Surgery
- The most common difficulties cited were the lack of bed capacity across all sites and inefficiency of using a paper-based system to book rooms and make notes
- Lack of staff retention, in particular the lack of consultant cover at Withybush Hospital
- Treatment delays caused by transferring patients between sites to find an on-call consultant
- Some also noted that the department can be unstructured due to the nature of its role, and that having patients spread across wards is a cause for concern
- The most common suggestions for improvements were to reassess the current on-call model of care; digitalise the service by creating an online rota system with live updates; develop a more supportive and guided environment by dispersing the Scheduled Care Management team across all sites; increase the workforce in the department, particularly consultants; improve teamwork within sites and across the whole Health Board; and to provide more training opportunities to staff
- Other suggestions included to centralise the service to one or two sites; and to develop and/or maintain specific services within Emergency General Surgery.

Finance

Gaps in the rota are being covered by expensive locum doctors. This is an issue at Withybush Hospital in particular.

Workforce data

- It is proving challenging to recruit and retain consultant and speciality doctors at Withybush Hospital
- There is a reliance on expensive agency locum doctors to support the service.

Section 7: Stroke Services

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

Section 7: Stroke Services

Introduction and background

This chapter of the Issues Paper is about Stroke services at Hywel Dda University Health Board. This chapter is a clinically led assessment of Stroke services at all sites within the Health Board that delivered Stroke services between 1 August 2018 and 31 July 2023. Some aspects of this chapter align to regional work which are between 1 January 2019 and 31 March 2023. Where this is the case these are explained below.

Stroke Services at Hywel Dda

A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off by a blood clot or bleeding from a blood vessel. Strokes are a medical emergency and urgent treatment is essential. The sooner a person receives treatment for a stroke, the better their chance of recovery. Stroke strikes suddenly and can result in a devastating range of disabilities or death. It is one of our most significant public health issues, with a profound and growing impact on individuals and their families, society, and the economy.

At Hywel Dda, Stroke services are provided at:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital.

Currently, none of our Stroke services meet the national staffing recommendations for stroke care and our population does not have access to specialised Hyper-Acute Stroke Care (HASU), Integrated Community Stroke Service (ICSS), or psychological therapies. Also, there is no seven-day cover for medicine, clinical nurse specialist or therapy services within Stroke services. As a result, Hywel Dda is not able to provide the evidence-based standard of stroke care recommended by the Royal College of Physicians and measured by the Sentinel Stroke National Audit Programme (SSNAP).

The table below includes definitions for Stroke treatment, and common clinical language, that may be heard during a Stroke admission.

Stroke pathway	Description
Acute Stroke Unit (ASU)	ASU is a place made up of Type 1 beds. This is where you receive your first 72 hours of care, which you should be sent to within four hours of hospital admission. On some ASU's there may also be Type 2 beds that supports the rehabilitation phase of inpatient stroke care.
Computerised Tomography (CT) Scan	CT Scan uses X-rays and a computer to create detailed images of the inside of the body.
Computerised Tomography Angiography (CTA) Scan	CTA Scan is a type of X-ray that uses a computer to make 3D images of your heart and blood vessels.
Thrombolysis	Is a process where a drug is given to a patient to disperse (break down) blood clots and return blood supply to the brain.
Thrombectomy	Thrombectomy is a process where a surgeon cuts out a blood clot to make sure blood supply can return to the brain. This type of stroke is caused by a blood clot blocking blood flow to part of the brain.

	Thrombectomy is typically delivered within a Hyper Acute Stroke Unit (HASU).
Integrated Community Stroke Service (ICSS)	Coordinating transfer of care of stroke survivors from hospital and providing home-based stroke rehabilitation through a specialist multidisciplinary team structure. The ICSS is an integrated service that is available seven days a week, providing early supported discharge, high-intensive and needs-based community stroke rehabilitation and disability management.
Repatriation	The transfer of a patient from an area outside the Health Board and the patient is moved back to their locality.

Stroke service model

Suspected Stroke patients come into our care from a variety of sources. These may include being transported by ambulance following a 999 call (FAST+ve)[89], patients being sent directly from their doctor (General Practice), patients arriving directly at hospital, or current inpatients. When patients are brought in with stroke symptoms by Welsh Ambulance Service Trust (WAST), a pre-alert is initiated to ensure that the patient receives urgent assessment and treatment as soon as they arrive at hospital. Patients referred in from General Practice will be discussed with WAST, who can issue a stroke pre-alert to the Emergency Department/Minor Injuries Unit (MIU). Patients who bring themselves to hospital will be rapidly triaged by the Emergency Department or MIU staff and a stroke call will be immediately enacted.

If stroke thrombolysis is required the stroke/medical on call team will notify staff in Radiology, who will prepare the CT scanner in readiness for an urgent stroke case. If, during the initial assessment of the patient, thrombolysis is contraindicated[90], then a full thrombolysis alert may not be appropriate. In these circumstances, direct contact with the Stroke team may be sufficient, although CT imaging should still be undertaken within an hour of presentation.

The initial assessment of the patient will vary depending upon how they arrive at hospital, but in all cases, the assessment will be fast and undertaken by staff who are suitably trained and familiar with the Stroke pathway and the criteria for thrombolysis/thrombectomy. Assessment and history taking are vital to ensure that suitability for thrombolysis/thrombectomy can be established at an early point. Assessment may take place in the patient's home by WAST paramedics, over the phone for GP expected patients, in the emergency department by Emergency Department/MIU staff for patients who arrive by themselves, and by ward staff and the Stroke team (or on-call Medical Registrar) for inpatient strokes.

Diagnostic CT/CTA imaging is needed to identify if the patient has a haemorrhagic[91] stroke or if there is an indication of a large vessel occlusion[92]. For pre-alerts and people arriving by their own means at hospital (self-presenters), patients will be taken directly to the CT scanner, which has been made available in advance. Once the scan is complete, the patient is either taken to Resuscitation room in the Emergency Department or admitted to a bed that is monitored on the Acute Stroke Unit to await the results of the scan.

If the patient is suitable for thrombolysis, this should be given as soon as possible and ideally within 45 minutes of presentation at hospital. The drug Alteplase is licensed for up to 4.5 hours

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[89] FAST The FAST acronym (Face, Arms, Speech, Time) is a test to quickly identify if someone is having a stroke. The +VE represents the term positive.
[90] Contraindicated – used to describe where a drug or treatment should not be used in a particular situation as it may cause harm.
[91] Haemorrhagic stroke is when you have bleeding in or around the brain.
[92] Occlusion is the medical term used to describe the blockage or closing of a blood vessel.

from point of stroke onset. In some cases, the patient may require their blood pressure to be reduced to below 185/110 mmHg before the administration of the bolus[93]. Thrombolysis should take place in Resuscitation Room or on the Acute Stroke Unit and requires sufficient, appropriately trained staff to deliver and monitor the patient for post thrombolysis complications. There should also be a clear protocol for the management of any post thrombolysis complications.

Patients with ischaemic[94] stroke should also be considered for intra-arterial clot extraction (removal of the clot through an artery[95]) if there is evidence of a large vessel occlusion. For large artery occlusion of the posterior circulation, thrombectomy can be considered up to 24 hours from the start of the stroke to the arterial puncture. For proximal large vessel occlusion, thrombectomy can be considered up to five hours from onset of the stroke to the arterial puncture. Patients suitable for mechanical clot retrieval need to be accepted by a neuroscience centre and will require CT Angiography. CT perfusion[96], which is not available in the Health Board at present, should also be available to identify brain tissue that can be saved. This is particularly important for 'wake up'[97] strokes.

Patients who have suffered from haemorrhagic strokes and are suitable for a rapid reduction in blood pressure, patients who are suitable candidates for thrombolysis or those patients who have been thrombolysed elsewhere, need to be transferred to the Acute Stroke Unit as soon as possible to ensure that they receive treatment and input from the multidisciplinary stroke specialist teams. This should take place within four hours of arriving at hospital.

After a patient is admitted to the Acute Stroke Unit, they are reviewed by a consultant and receive a therapy assessment within 24 hours. At that point, intensive therapy starts, which includes occupational therapy, physiotherapy, speech and language therapy, and access to a dietician.

Depending on the severity of the stroke, support at home, and availability of ESD (Early Supported Discharge), patients can be discharged at any time. However, ESD is currently only available to patients at Withybush Hospital. Patients also receive a six-month follow-up.

Summary

- The patient presents to the Emergency Department unit either as a 999 FAST+ve conveyance, a GP expected or as a self- presenting patient. The FAST+ve pre-alert ensures that the Stroke team meet the patient from the ambulance to take them directly to CT. For GP expected patients and individuals arriving by themselves (self-presenters), the ED/MIU team will enact the stroke call. For inpatient strokes, these should be urgently assessed, and a thrombolysis call should be raised if time of onset is known and within three hours. If the time of onset is not known or longer than three hours, then advice from the stroke team can be sought directly during working hours
- The patient should be taken to CT and a scan undertaken within one hour. This should happen within about 15 minutes if the thrombolysis targets are to be met. The thrombolysis target is known as the door-to-needle target (the time from the front door of the hospital to the point a needle pierces the skin)

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[93] Bolus: a single, relatively large dose of a drug or substance given over a short period of time.
[94] Ischaemic stroke: when a blockage cuts off the blood supply to a part of the brain.
[95] Artery: one of the thick tubes that carry blood from the heart to other parts of the body.
[96] Perfusion: the passage of fluid through the body's circulatory system or lymphatic system to an organ or tissue.
[97] Wake up Stroke: A wake-up stroke is a stroke that occurs during sleep. In these cases, the person goes to bed feeling normal but wakes up with symptoms of a stroke.

- The patient should be taken to Resus or admitted to the Acute Stroke Unit to await the scan results. In extreme cases, the patient may need to wait in Radiology, or be taken to a Critical Care Unit. If the medical/stroke physician is suitably trained, then they can review the scan directly in Radiology
- Once the CT report has been authorised, a call is made to the stroke team (in hours) or the Medical Registrar (out of hours) to inform them that the scan has been reported. The decision to thrombolysis/thrombectomy is then made based upon the Health Board stroke criteria
- If the patient has suffered a haemorrhagic stroke, they should be reviewed for a rapid reduction in blood pressure, admitted to the Acute Stroke Unit, and monitored for level of consciousness. They will be referred immediately for repeat brain imaging if deterioration in their condition occurs
- If suitable, the patient is thrombolysed according to a single Health Board wide criteria that is administered by staff trained in thrombolysis, and monitoring facilities available. There are clear protocols for post thrombolysis complications. All patients will be screened for the suitability of thrombectomy
- If the patient is not already on the Acute Stroke Unit, they should be transferred there within four hours of arriving at the hospital
- With 24 hours of being on the Stroke Unit the patient is reviewed by a consultant and therapies assessment is undertaken
- Intensive therapy starts, which includes occupational therapy, physiotherapy, speech and language therapy, and access to a dietician
- ESD is offered at Withybush Hospital, when appropriate
- A six month follow up review is conducted by a Stroke Clinical Nurse Specialist.

Within Hywel Dda, all four acute hospital sites have resources to deliver Acute Care Unit Type 1 beds and Type 2 beds. The locations are:

- Ystwyth ward at Bronglais Hospital
- Gwenllian ward at Glangwili Hospital
- Ward 9 at Prince Philip Hospital, and
- Ward 11 at Withybush Hospital.

Glangwili Hospital and Prince Philip Hospital call these areas Acute Stroke Units; Bronglais Hospital refers to the area as a Hyper Acute Stroke Unit; and Withybush Hospital do not define the area by name but do refer to it as both an acute and hyperacute stroke unit, although the care delivered in each unit appears to be similar.

While the priority in all sites is to ensure a stroke bed is available, there are times when this is not possible. This can be due to operational pressures, or the stroke beds are full of appropriate stroke patients. In these instances, there is a site based contingency plan.

Hospital	Bed plan
Bronglais	If absolutely necessary, due to the inability to make a bed available, the patient will be cared for in the Critical Care Unit.
Glangwili	Thrombolysed patients also go to Critical Care Unit and non-thrombolysed patients wait for a bed in either the Emergency Department or Clinical Decision Unit. Where possible, stroke recovery patients will be moved from the stroke wards to make a bed available for a new stroke patient.

Prince Philip	The patient will stay on the Acute Medical Assessment Unit until a bed can be made available, unless the patient has been thrombolysed, in which case they will be nursed in the Critical Care Unit.
Withybush	Using a Critical Care Unit bed is a last resort option. If there is no bed available, a thrombolysed patient will go to the Emergency Department to receive care.

The table below shows the current bed model for non-protected stroke beds within the bed plan at Hywel Dda:

Hospital	Number of planned stroke beds on ward (including general medicine)
Bronglais	19, of which, 8 are stroke beds
Glangwili	20, of which, 20 are stroke beds
Prince Philip	29, of which, 24 are stroke beds
Withybush	14, of which, 14 are stroke beds
Total	82 beds

Stroke service changes

No service changes have been made to Stroke services between 1 January 2019 and 31 March 2023.

Stroke service risks

No risks relating to Stroke services have been reported to Public Board between 1 January 2019 and 31 March 2023.

Stroke services clinical effectiveness

The table below includes a list of the clinical guidelines relevant to the Stroke Services:

Guideline source	Guideline title	Link
Stroke Association/Royal College of Physicians	The National Clinical Guideline for Stroke This is endorsed and referenced by the Royal College of Physicians	Contents - National Clinical Guideline for Stroke (strokeguideline.org)
NICE	Stroke and transient ischaemic attack in over 16s: diagnosis and initial management	https://www.nice.org.uk/guidance/ng128
NICE	Stroke rehabilitation in adults	https://www.nice.org.uk/guidance/ng236

Stroke care at Hywel Dda falls short of the national clinical standards as measured by the Sentinel Stroke National Audit Programme (SSNAP). This is because there is:

- no Early Supported Discharge (ESD)
- no access to psychology
- inadequate staffing levels that fall short of the national standards across the full multidisciplinary team (MDT).

As a result, Stroke services at Hywel Dda fall short of the expected key performance indicators (KPIs). Further information can be found in the activity data section below.

Stroke local, regional, and national work

This section provides details about regional and national projects or programmes that relate to Stroke services within Hywel Dda.

Regional work

On a regional level, the Stroke service re-design is managed by the A Regional Collaboration for Health (ARCH) programme that reports through the ARCH Governance structure. The Carmarthenshire Stroke Pathway (Glangwili and Prince Philip hospitals) is inter-dependent and within the ARCH Comprehensive Regional Stroke Centre (CRSC) business case.

National work

On a national level the National Stroke Programme Board, supported by the Stroke Implementation Network and managed by NHS Wales Executive, aims to improve stroke care across Wales. This paper and the ARCH CRSC business case are aligned to the national strategic direction for stroke in Wales.

A business case for the Comprehensive Regional Stroke Centre (CRSC), formally known as the Hyper Acute Stroke Unit (HASU), was developed by the ARCH programme in collaboration between Hywel Dda and Swansea Bay University Health Board (SBUHB). This has been considered by the Executive team and discussed at the June 2023 meeting[98] of the Strategic Development and Operational Delivery Committee (SDODC). At this stage, the Executive team has indicated support in principle for the development of HASU but recognised a significant amount of work will be required between now and a unit potentially being able to serve Carmarthenshire residents (currently anticipated to be Year 3 of the implementation plan). In particular, the whole pathway will need to be considered to ensure that Hywel Dda units have the staffing levels to meet national standards and support timely repatriation for rehabilitation services in Hywel Dda.

For this reason, a multi-disciplinary task and finish group was established, to compile a factual assessment of the impact on the Stroke Pathway in Carmarthenshire. The group is led by the Director of Therapies and Health Science and consists of representation from medical, nursing, therapies, and operational leadership. The group is supported by ARCH and the Transformation Programme Office.

The factual assessment for Carmarthenshire has been completed and focused on the staffing and associated funding required to fulfil the national expected standards of acute and rehabilitation phases of stroke care for Carmarthenshire residents. The was discussed at the June 2023 meeting linked below. It enables the Board to fully consider the recommended phased approach and investment required to meet national standards, including alignment with the proposed CRSC. To understand the wider impact on services across the Health Board, aligned to the potential developments of a CRSC, the task and finish group also undertook a similar assessment for both Ceredigion and Pembrokeshire.

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[98] *https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/strategic-development-and-operational-delivery-committee-sdodc/sdodc-meeting-26-june-2023/item-5-5-stroke-business-case-and-assessment-of-the-stroke-pathway/*

Getting it Right First Time (GIRFT)

Stroke has not been part of a GIRFT review.

Stroke services activity data

Stroke service activity reported between 1 August 2018 and 31 July 2023 is included for Bronglais, Withybush, Prince Philip, and Glangwili Hospital. For 2018/19, the data reflects three months of data for January to March 2019. All data tables including the specific conditions captured can be found in Appendix E8 – Stroke – Activity Data.

The activity data highlights several issues experienced by the services. Included in the issues are the availability of stroke beds, increased lengths of stays for Stroke admissions and declining quality standards in comparison to the Sentinel Stroke National Audit Programme (SSNAP).

Admissions to March 2023

The table below shows that stroke admissions overall have remained the same every year with exception of the initial COVID-19 period. There is a reduction in admissions during the COVID-19 period, this is due to patients not attending emergency departments and higher mortality rates in older patients due to COVID-19.

There has also been a decrease in patients attending Prince Philip Hospital. This is in part linked to Welsh Ambulance Service Trust (WAST) 111 advice directing patients to their nearest emergency department. For Prince Philip Hospital this would be either Glangwili Hospital or Morriston Hospital in Swansea.

Prince Philip Hospital has a Minor Injuries Unit, an Acute Medical Assessment Unit (AMAU) and an Acute Stroke Unit with a 24-hour pathway that can support stroke admissions. This has resulted in a 23% reduction in admissions, when compared to the average for the period. Morriston Hospital is part of Swansea Bay University Health Board. Any treatment at Morriston Hospital is paid for as part of a service level agreement. Patients being cared for at Morriston Hospital require repatriation (returning home to locations within Hywel Dda). This can be an issue for families as Morriston may be further away from a patient's home than Prince Philip Hospital.

The table below highlights the number of stroke admissions by site.

Stroke admissions activity (2018 to 2023)					
Reporting period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	26	47	56	54	**183**
2019-20	145	205	186	231	**767**
2020-21	121	211	165	196	**693**
2021-22	132	210	172	210	**724**
2022-23	137	227	129	224	**717**
Total	**561**	**900**	**708**	**915**	**3084**
Total as % of overall activity	**18%**	**29%**	**23%**	**30%**	**100%**

Average lengths of stay

When looking at the data for the past five years, the average length of stay indicates an overall five-year growth trend - that stroke patients are staying in hospital longer. There is a 17% increase in the total length of stay from an average of 22.86 days recorded for quarter 4 in 2018/2019 to 26.66 days recorded in 2022/2023.

The table below shows the length of hospital stay in days per stroke admission for each hospital site.

Average length of stay for stroke patients (days) for each hospital site					
Hospital	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Bronglais	16.68	15.34	18.03	17.09	22.16
Glangwili	24.00	24.64	22.29	26.36	27.89
Prince Philip	26.38	27.14	20.36	28.75	34.79
Withybush	21.84	24.18	21.21	22.07	24.05
Average length of stay (days)	**22.86**	**23.33**	**20.70**	**23.90**	**26.66**

A reason for the increase in average length of stay for patients is that the complexity of patients' needs is great, and the community capacity to deliver support services has reduced. This means that it is harder to discharge patients into the community and patients are therefore needing to stay in hospital for longer.

Bronglais Hospital has a lower than average length of stay figure as a high proportion of the patients it receives are from outside the Health Board area. Patients who are admitted are repatriated following a stay in an Acute Stroke Unit. Withybush Hospital has lower than average figures due to the ICSS/Early Supported Discharge in place.

Sentinel Stroke National Audit Programme (SSNAP) Quality Scores

SSNAP quality scores are an indicator of the performance and delivery of Stroke services within the UK. The table below highlights Hywel Dda's declining position in 2023, when compared to the position before the COVID-19 pandemic in 2019.

The SSNAP audit scoring ranges from A to E.

- A: is a hospital that meets highest standards for almost all patients
- E: is a hospital that does not meet high standard for most patients
- X: insufficient records being available to provide a score.

Stroke National Audit Programme (SSNAP) Quality Scores			
Hospital	**2019**	**2022/23**	**Improvement / Decline**
Bronglais	BBBC	XCBB	Decline
Glangwili	DBCD	DCXE	Decline
Prince Philip	DCCC	DDCD	Decline
Withybush	BBDC	CCCC	Decline

The table above shows that the services have not recovered since the pandemic. The service at Withybush Hospital and Bronglais Hospital scores consistently higher than at Glangwili and Prince Philip hospitals.

Where a score of X has been recorded, this can be due to a number of reasons that may include a low number of stroke admissions for that period, or absence of appropriately qualified staff to input the data within the agreed timescales for data collection.

SSNAP organisational audit

The table below highlights an overall decline in the Health Board's Stroke services in 2012 when compared with the SSNAP Organisation Audit Standards in 2019.

The SSNAP audit captures the staffing levels against national standards at a point in time. The results clearly show that the Health Board both in 2019 and in 2021 is unable to meet the standards. This is a greater issue in Glangwili Hospital and Prince Philip Hospital and highlights the fragile nature of our workforce at Hywel Dda.

Sentinel Stroke National Audit Programme (SSNAP) organisational audit			
Hospital	**2019**	**2022/23**	**Improvement / decline**
Bronglais	3/10	4/10	Improvement
Glangwili	4/10	2/10	Decline
Prince Philip	3/10	1/10	Decline
Withybush	3/10	3/10	-

Bed state analysis

As part of our work on the factual assessment of Stroke services, we looked at the current configuration of stroke wards. This included considering the proportion of wards that are within the Health Board's plan for stroke beds and their actual use – including analysis of the admission data and length of stay.

The table below highlights the number of beds available for each acute site for stroke admissions. It also includes information about how many beds were used in 2022/2023.

Number of beds available at each site (planned and number of beds used).			
Hospital	**Number of beds on ward (including general medicine)**	**Number of beds planned for Stroke admissions**	**Actual number of Stroke beds used in 2023.**
Bronglais	18	8	8.3
Glangwili	20	20	16.8
Prince Philip	29	24	13.4
Withybush	14	14	14.6
Total	**82**	**66**	**53**

The second column shows that there are 66 beds allocated to Stroke admissions across Hywel Dda hospital sites. These 66 beds are not protected for Stroke admissions. The final column highlights the actual number of beds utilised (53) for Stroke admissions in 2022/2023.

The numbers included in the table above will not reflect the number of mimics. A mimic is where a patient presents with symptoms like a Stroke but may be another condition that needs treatment. It is estimated that, in addition to the activity recorded above, there are 50% additional mimics recorded. A proportion of these patients may need to stay in an inpatient bed.

Stroke incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against Stroke services. Full data for incidents, complaints, claims, and compliments, can be found in Appendix E9 - Stroke - Incidents Data, Appendix E10 - Stroke - Complaints Data and Appendix E11 - Stroke - Patient Experience and Compliments Data.

Patient safety incidents

The table below shows the overall number of recorded incidents for Stroke services across all sites within the Health Board. The recording period for each year is 1 April to 31 March. The data below looks at the periods between 1 January 2019 and 31 March 2023.

Year	January – March 2019	2019/20	2020/21	2021/22	2022/23
Number of incidents	105	375	516	475	509

The change in the incident recording system means that there are two recording periods, January 2019 to end of March 2021 and April 2021 to end of March 2023. The number of incidents recorded for the Stroke service at each hospital site is seen in the table below.

Hospital	Number of incidents 1 January 2019 - 31 March 2021	Number of incidents 1 April 2021 - 31 March 2023	Total
Bronglais	345	328	**673**
Glangwili	179	204	**383**
Prince Philip	439	394	**833**
Withybush	203	218	**421**
Total	**1166**	**1144**	**2310**

The data shown in the table below shows the number of incidents as a percentage of the overall admission activity. For example, Bronglais Hospital as 18% of the overall activity (the number of patients admitted to Stroke service) with 30% of the recorded incidents.

The total number of activities across all Health Board sites (i.e. number of Stroke service admissions) is 3,084. The total number of incidents reported in Stroke services across all Hywel Dda sites is 2,310 incidents.

However, it is important to note that while the percentage of activity undertaken at each site represents the number of activities relating to stroke patients, the total percentage of incidents reported also includes General Medicine. As mentioned earlier in this chapter, stroke patients can be admitted to other wards (General Medicine), and the total number of incidents reported is for the entirety of the General Medicine wards. We do not hold specific stroke incident data, so the two columns cannot be compared with one another.

Hospital	Percentage of total activity undertaken at the site (3084)	Percentage of total incidents reported (2310)
Bronglais	18% (561)	30% (673)
Glangwili	29% (900)	15% (383)
Prince Philip	23% (708)	38% (833)
Withybush	30% (915)	17% (421)

The most common types of incidents reported are shown in the table below.

Type of incident reported, 1 January 2018 - 31 March 2021	Number of incidents
Pressure ulcers	494
Injury of known origin	145
Type of incident reported, 1 April 2021 - 31 March 2023	
Accident, injury	484
Pressure damage, moisture damage	126

Stroke patient complaints

The table below shows the overall number of complaints within the Stroke service across all Health Board sites. The period is between the 1 January 2019 and 31 March 2023.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of complaints	3	21	27	26	18

The table below shows the number of Stroke service complaints received by each hospital site between 1 January 2019 and 31 March 2023.

Hospital	Number of complaints 1 January 2019 – 31 March 2021	Number of complaints 1 April 2021 – 31 March 2023	Total
Bronglais	13	10	**23**
Glangwili	16	9	**25**
Prince Philip	13	12	**25**
Withybush	9	13	**22**
Total	**51**	**44**	**95**

The next table shows the number of complaints reported between 1 January 2019 and 31 March 2023, as a percentage of overall activity by each hospital.

The data highlights that an average of 3% of patients made a complaint about their experience at Hywel Dda.

Hospital	Percentage of total activity undertaken at the site (3084)	Complaints reported as a percentage of overall complaints (95)	Proportion of complaints as a percentage of activity
Bronglais	18% (561)	24% (23)	**9%**
Glangwili	29% (900)	26% (25)	**3%**
Prince Philip	23% (708)	26% (25)	**4%**
Withybush	30% (915)	23% (22)	**2%**

The table below shows the most common complaints reported between 1 January 2019 to 31 March 2023, by their category.

Nature of complaint	Number of complaints 1 January 2019 – 31 March 2021	Number of complaints 1 April 2021 – 31 March 2023	Total
Clinical treatment / assessment	6	11	**17**
Communication issues (including language)	13	14	**27**
Discharge issues	9	6	**15**

The next table shows the overall number of complaints received for Stroke services and their severity level (grade), recorded between 1 January 2019 and 31 July 2023.

Grade of complaint	Number of complaints 1 January 2019 - 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Grade 1 Minor (informal)	17	27	**44**
Grade 2 Minor	6	10	**16**
Grade 3 Moderate	10	7	**17**
Grade 4 Major	3	0	**3**
Grade 5 Catastrophic	0	0	**0**

Stroke service claims

During the period analysed, there were three claims made that have now been closed. In all three claims the Health Board denied liability and there were no issues upheld from a Hywel Dda perspective.

There is one confirmed case that is under investigation within Obstetrics and relates to a neonatal stroke diagnosed at birth.

There is an additional potential claim that relates to a patient admitted with a stroke to a community hospital, and family allege neglect, but this could be related to broader management issues and not just stroke management.

Stroke patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix E11 - Stroke - Patient Experience and Compliments Data.

	Patient experience	Friends and family experience	Compliments
2021	The key themes relate 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 comfort of being able to speak Welsh with the staff. The few negative experiences related to noise on the ward and use of e-cigarettes by other patients.	The themes arising are around staffing, quality of care, waiting times and communication. Staff are described positively as being helpful, friendly and professional and having good experiences with doctors and nurses who generally delivered a good quality of care. Waiting times for appointments and treatment received mixed responses with some reporting being seen quickly while others experienced delays. Negative comments were reported around communication and the scheduling of appointments.	None recorded.
2022	The key themes relate 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 comfort of being able to speak Welsh with the staff. The facilities on the ward to keep people entertained, the number of Welsh speakers available, the limited food choices and staffing levels.	The themes arising are around staffing, quality of care, waiting times and communication. Staff are described positively as being helpful, friendly and professional and having good experiences with doctors and nurses who generally delivered a good quality of care. Waiting times for appointments and treatment received mixed responses with some reporting being seen quickly while others experienced delays. Negative comments were reported around communication and the scheduling of appointments as well as issues with parking on hospital sites.	Themes arising were that the service were kind and compassionate in delivering person centred care, supporting patients in ways which were most appropriate for them.

2023	The key themes relate 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 comfort of being able to speak Welsh with the staff. The staff were praised for their professionalism, communication and caring attitudes, while negative experiences related to the environment during recovery and lack of stimulation or facilities.	The themes arising are around staffing, quality of care, waiting times and communication. Staff are described positively as being helpful, friendly and professional and having good experiences with doctors and nurses who generally delivered a good quality of care. Waiting times for appointments and treatment received mixed responses with some reporting being seen quickly while others experienced delays. Negative comments were reported around communication and the scheduling of appointments as well as isolated issues with bed availability and visiting restrictions.	None recorded

The comments in the table above are not attributed to a particular site but reflect a general analysis of the data within the compliments system for the Stroke service. The key themes across the years highlighted:

- Overall, positive feedback for clinical staff performance, despite the service not meeting national clinical guidelines
- Staff are frequently described as kind, compassionate, professional, and helpful
- Patients are unhappy about communication for appointment scheduling, some issues with parking and bed availability
- Where patients were asked to rate their overall experience of using the service, 99.46% of patients rated the service at least 8/10 in the friends and family test
- Many issues identified above relate to the overall experience of the hospital site, for example, parking, that cannot be attributed to Stroke services.

Stroke Service targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

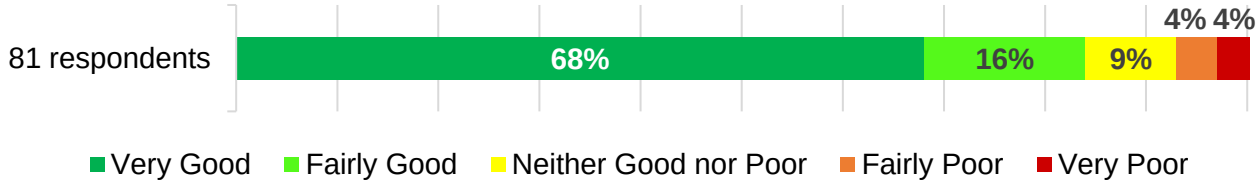
A randomly selected sample of patients who accessed Stroke services within the last five years (between 1 August 2018 and 31 July 2023) were invited to take part in the patient survey. In total 779 patients were sent an invitation, and 85 responses were received. Of the patients who responded, 40% of accessed most of their stroke care at Bronglais Hospital; 26% at Glangwili Hospital; 20% at Prince Philip Hospital; and 7% at Withybush Hospital. The remaining 7% received their care between various other clinical sites.

Patients tend to be over the age of 65. This is broadly reflected in the age profile of respondents to the patient survey with around three fifths (59%) aged 65 years or older. Tables showing the full profile breakdown of respondents are included in the full report.

Main survey findings

- 84% of respondents said that their experience of using the Stroke service was good
- 7% said it was poor.

Overall experience of using Stroke services (patients)



In terms of what was good about their experience of using the Stroke service, respondents mainly praised:

- the professional, kind, reassuring, and helpful staff
- the timeliness and efficiency of the service received
- good communication and information provision
- the generally good quality of care.

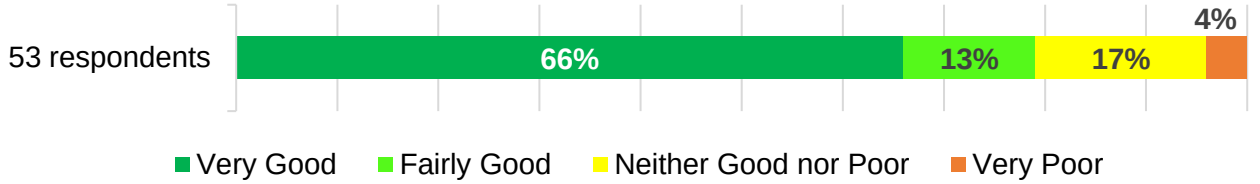
However, other respondents complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis) and a generally poor standard of care.

The main improvements to Stroke services as suggested by survey respondents were around communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up); and speed and efficiency (including shortening waiting times and not cancelling appointments). It should be noted, though, that 28% of respondents felt that no improvements are required.

Experiences of Outpatient services

Of the individuals who responded to the question, 76% said they used the Outpatient department as part of their Stroke treatment. Of these, 79% said it was good and 4% said it was (fairly) poor. 17% said it was neither good nor poor.

Overall experience of using the Outpatient department (patients)



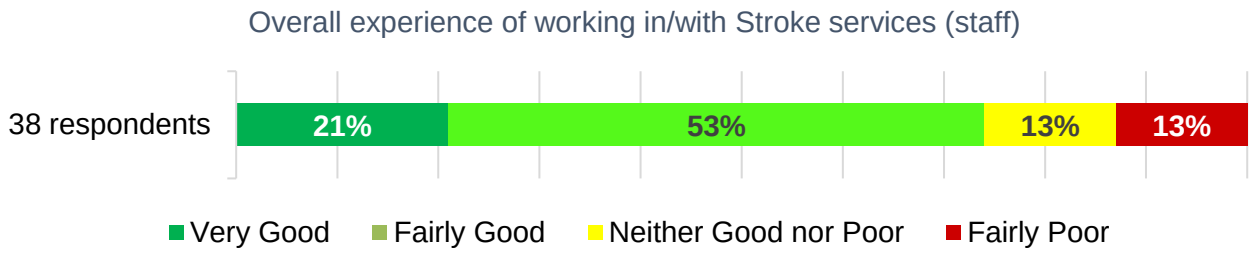
When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent positive comments related to receiving a generally good, quick, and efficient service; and the professional, kind, reassuring, and helpful staff. The most frequent negative comments were around service speed and efficiency (including access to appointments, tests, and results).

Targeted early engagement with staff

A survey was sent to medical, nursing, therapy, operational and support staff. Staff were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS and helps us to understand the key issues and themes facing our staff when using or working with Stroke services.

All staff currently working in, or supporting staff working in, Stroke services were invited to take part in a survey and 40 responses were received. Respondents' main clinical base is/was Glangwili Hospital (14 respondents), Withybush Hospital (nine respondents), Prince Philip Hospital (eight respondents) and Bronglais Hospital (six respondents). Three respondents did not identify their main hospital base.

74% of respondents said that their overall experience of working in/with Stroke services was good. 13% said that it was fairly poor, with none saying it was very poor.



In terms of what is/was good about their experience of working in or with Stroke services, staff praised their colleagues, describing them as enthusiastic, passionate, caring, and committed to placing the patient at the centre of all care. It was also said that staff turnover within Stroke services is low, so teams are established, and communicate and engage well. Indeed, positive multidisciplinary team (MDT)[99] working was thought to have been one of the main contributors to the service's success in recent years. Other good aspects of staff experiences were around the standard of Stroke care offered; therapists' level of knowledge; the flexibility of their work; and clear clinical pathways within the service.

As for what is/was difficult about their experience of working in/with Stroke services, the most common issues raised were around capacity. Other key challenges were highlighted around consistency of staffing (because of employees being moved around to address gaps in other departments); the service's ability to meet national guidelines and standards; a lack of community support leading to discharge delays; and services being provided across multiple small units with no critical mass, leading to inefficiencies and variable standards. Many staff members also commented on issues around therapy provision for stroke rehabilitation, noting limited space and resources as the main barriers to providing this. Key areas of concern were speech and language

[99] *MDT - A Multidisciplinary Team includes multiple clinical disciplines including but not limited to Medical, Nursing, Allied Health Professionals and operational roles.*

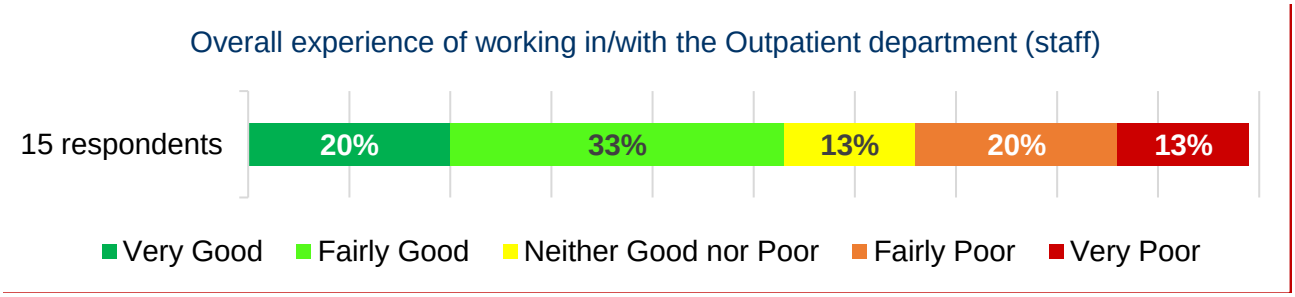
therapy[100] and occupational therapy[101], which was said to be challenging to provide by small teams within hospitals, and in the community.

The key suggested way to improve the staff experience of working in/with the Stroke service was to increase staff numbers to help meet national guidelines and relieve capacity concerns. In particular, speech and language therapy, occupational therapy, and early supported discharge were highlighted as requiring more resource. Other suggestions related to:

- training and development opportunities for staff
- funding and investment for Stroke equipment and environments
- providing more 'social areas' for patient leisure and socialisation
- developing community resources to support discharge and improve patient flow
- better communication between acute and community teams
- better communication and engagement between delivery staff and decision makers
- for a few respondents, a centralised Stroke Unit to tackle key challenges around staffing, service provision, and meeting national standards.

Staff experiences of Outpatient services

Of the staff who responded, 39% said that they use the Outpatient department in relation to Stroke services. Of these 53% said that their overall experience of Outpatient services was good, whereas 33% said it was poor.



Staff respondents praised Outpatient staff for being helpful, supportive, and organised. Most commented on why they chose a less positive rating however, with the most common response relating to difficulties making Outpatient appointments. A few respondents also noted the limited space and staffing available to support the demand for Outpatient services, and Outpatient environments that are no longer fit for purpose.

Stroke service finance

The table below shows the main drivers of cost that impact on service delivery budgets – the variable costs that influence the overall cost of the service.

This information is aligned to the findings and submissions included in the 2024/2025 annual plan.

Service	Key reasons for variable costs
General	Services provided over multiple sites Vacancies filled with premium costs or additional hours

[100] Speech and Language Therapy provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.
[101] Occupational therapy helps you live your best life at home, at work – and everywhere else.

Services are provided across all four acute hospitals. Stroke is a multi-professional service and includes nursing, medical, allied health professionals (therapies and psychology) as well as administrative and clerical staff.

The associated costs of the service are not reported collectively as resources are spread between areas. The stroke service is delivered through four General Medicine wards and beds may not be used for stroke patients all the time. The nursing budgets for the wards are currently overspent due to agency premium costs needed to cover gaps to fulfil the appropriate staffing requirements. The exception to this is at Withybush Hospital where activity has been restricted due to the need to respond to the RAAC[102] found on the site.

Currently, there are no vacancies within the medical rotas and senior consultants stroke services. Any short-term absences will be covered by Additional Duty Hours (ADH) sessions. Vacancies within Allied Health Professional staff supporting stroke services are not covered by premium or variable pay. There are several vacancies currently within the Therapy services across all disciplines that support stroke services.

Stroke service workforce

The Workforce team have supplied data within defined cost codes provided by the Stroke service. Full details about the methodology can be found within Appendix E13 – Stroke – Workforce Data.

Current position

There is a difference between the workforce data used for the Clinical Services Plan workforce analysis to that used within the Factual Assessment. The difference being that the factual analysis was linked to similar ways of working used to assess the impact of a CRSC development using data from 2019.

The information below highlights some of the complexities and the interdependencies of the workforce in relation to Stroke services; how this workforce is managed at a site level and the mix of general ward staff with Acute Stroke Unit staff. This is partly due to not having protected areas for Stroke admissions, which has an impact on how the workforce plan is also delivered.

As seen in the organisational audit, the stroke service is facing workforce issues across all areas. The multidisciplinary team (MDT) is currently not meeting the new national clinical guidelines for Stroke staffing ratios. Even if there are no vacancies within the service, there would still be a staffing gap to meet the national clinical guidelines.

Currently, in the nursing workforce, there are over 30 vacancies for registered nurses and 4 healthcare support workers across the wards at the four sites. Bronglais is particularly impacted, with 18 vacancies.

Although there are no vacancies in the clinical nurse specialist (CNS) workforce, there is a single point of failure at each site if the CNS is on leave – this leads to the service being fragile.

The therapies workforce also has vacancies for all types of therapies across the Health Board. Since the therapy teams work across different services, it is difficult to quantify these for stroke alone. However, the service needs to meet clinical guidelines.

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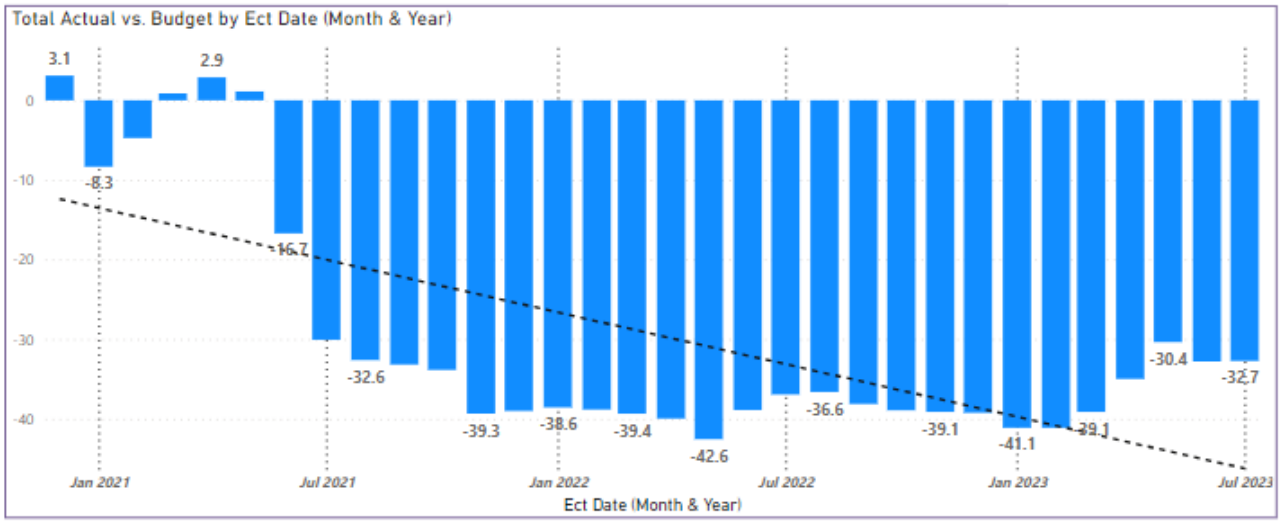
[102] *RAAC: Reinforced Aerated Autoclaved Concrete*

Currently, early supported discharge (ESD) services are only available in Pembrokeshire. If this service is developed across the whole of Hywel Dda, additional vacancies will be created.

The medical workforce also has current vacancies across the Health Board. Since the medical workforce works across different services, it is difficult to quantify these for stroke alone. However, the services do not meet the clinical guidelines. In addition, none of the consultants are stroke-specific, and are Care for the Elderly consultants. At Glangwili Hospital and Bronglais Hospital, the consultant cover is also provided by a single NHS locum. This creates a single point of failure if the locum is on leave.

The table below highlights the nursing vacancies across all four sites. These are consistent with the level of temporary workforce utilised across the period. An average of 38.8WTE additional workforce was utilised per month through bank[103] and agency staff to fill the gap from the vacant posts. It should be noted that due to the make-up of Stroke wards these staff roles will not be purely Stroke roles.



Stroke workforce risks and issues

Workforce Risk 233 - The nursing staff to patient ratio is insufficient. There are insufficient stroke therapy staff and there is a lack of seven-day consultant cover.

It is also noted that there is currently no leave of absence cover for Stroke Consultants on ASU and this is particularly fragile within Bronglais Hospital and Glangwili Hospital. This fragility is increased where the consultants are locum consultants. The fragility is there is no cover for sickness or leave, not that they are locum consultants.

All consultant roles are not specialist Stroke Consultants and are on the General Internal Medicine (GIM) rota.

The nursing component of this risk is also dependent upon variable pay cost drivers as highlighted within the finance section.

[103] *Bank Staff - Bank Staff are a pool of people that an employer may call on when they need to cover shifts, holidays or just need extra staff as and when.*

Workforce Risk 291 - There is a risk of patients having poorer outcomes and increased mortality due to the lack of 24/7 access to mechanical clot retrieval services (thrombectomy). This is caused by the current contract with North Bristol being a seven-day service, but not a 24-hour service.

This service contract is managed at an all-Wales level and outside of Hywel Dda. There is an ambition by the Welsh Government for this to become a 24/7 service. The indirect impact here is that by not providing the whole Stroke pathway the attractiveness of the opportunities available for new staff may be impacted in this specialist area.

Workforce Risk 1386 - There is a risk of Stroke patients that live in Hywel Dda receiving sub-optimal care. This is caused by no Clinical Psychology provision for Stroke Care within the Health Board due to no funding. There is an absence of holistic multidisciplinary team (MDT) care.

Stroke Service conclusions

Stroke has been included within the Clinical Services Plan due to being unable to meet the required standards and respond to service fragility.

The Stroke service operates from the following locations:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital.

A summary of the findings identified within this paper are as follows:

Currently, none of our stroke services meet the national staffing recommendations for stroke care and our population does not have access to specialised Hyper-Acute Stroke Care (HASU), Integrated Community Stroke Service (ICSS) or psychological therapies. Hywel Dda also does not provide seven-day cover for medicine, clinical nurse specialist or therapy services. As a result, the Health Board is not able to provide the evidence-based standard of stroke care recommended by the Royal College of Physicians and measured by the Sentinel Stroke National Audit Programme (SSNAP).

Risks:

- No risks have been reported to Public Board that relate to Stroke between 01 January 2019 to 31 March 2023.

Clinical effectiveness

- Stroke care at Hywel Dda falls short of the national clinical standards as measured by the Sentinel Stroke National Audit Programme (SSNAP). This is due to no early supported discharge (ESD), no access to psychology and inadequate staffing levels that fall short of the national standards across the full multidisciplinary team (MDT). As a result, Stroke services in the Health Board fall short of the expected key performance indicators (KPIs).

Local, regional and national work

- The National Clinical Framework driving improvements in Stroke services indicates a direction of travel for the medium-term development of Comprehensive Regional Stroke Centres (CRSCs)
- These will have a direct impact on all sites within the Health Board delivering Acute Stroke Unit services and more specifically a patient's first 72 hours of care. The national

programme currently has intentions for four CRSC within Wales. Any plans such as this being realised could potentially only require Hywel Dda to deliver a Rehabilitation and ICSS service for Stroke patients
- For west Wales, this proposal is currently set to be outside of the Hywel Dda area of operation with proposals for development potentially impacting Hywel Dda patients within the next three to five years, if funding is allocated
- A Regional Collaboration for Health (ARCH) is focused on improving Stroke services and supporting implementation of the national direction of travel. Clinical and operational leads at Hywel Dda support both workstreams.

Stroke Service activity data

- Activity analysis highlights that Stroke occupied bed days have increased from an average of 22.86 days in 2019 to an average length of stay of 26.66 days in 2023. This represents a 16.6% increase in length of stay. There is an assessed current bed utilisation of 53 beds
- Activity analysis highlights a deteriorating position in Stroke patient flow pressures at Prince Philip Hospital. Some of these issues have been linked to conveyancing as well as telephone advice to present to a local Emergency Department. This has resulted in a 22.5% reduction in admissions to the average for the period. These patients are being re-directed to Glangwili Hospital and Morriston Hospital. As Morriston Hospital is outside of Hywel Dda, this treatment has to be paid for as part of a service level agreement with Swansea Bay University Health Board. It also requires repatriation of patients and potentially takes patients further from their homes
- The current Stroke pathway has a planned bed state of 66 beds across all sites. Assessment of the current SSNAP data indicates 53 beds being utilised for stroke care
- The lack of ring-fenced beds for Stroke indicates a continued challenging trend in meeting a portion of the quality metrics
- National work audits for SSNAP show both a clinical and organisational (workforce) deteriorating position, these are specifically more common at Glangwili and Prince Philip hospitals.

Stroke National Audit Programme (SSNAP) Quality Scores			
Hospital	**2019**	**2022/23**	**Improvement / Decline**
Bronglais	BBBC	XCBB	Decline
Glangwili	DBCD	DCXE	Decline
Prince Philip	DCCC	DDCD	Decline
Withybush	BBDC	CCCC	Decline

Incidents, complaints and claims

- Withybush Hospital and Glangwili Hospital report the least number of incidents in comparison to the highest levels of activity
- Complaints represent 3% of the overall Stroke admissions within Hywel Dda
- There is one current open claim under investigation within Stroke Services

Patient experience

- Staff are frequently described as kind, compassionate, professional, and helpful
- Patients are unhappy with communication for appointment scheduling, some issues with parking and bed availability

- 99.46% of patients rated the service at least 8/10 in the friends and family test, where patients were asked to rate their overall experience of using the service.

Targeted early engagement with service users

- Respondents praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care
- Others, however, gave negative comments about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and a generally poor standard of care
- The main improvements to Stroke services as suggested by survey respondents were around communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up); and speed and efficiency (including shortening waiting times and not cancelling appointments)
- It should be noted, however, that 28% of respondents felt that no improvements are required.

Targeted early engagement with staff

- Staff praised their colleagues, describing them as enthusiastic, passionate, caring, and committed to placing the patient at the centre of all care
- It was also said that staff turnover within Stroke services is low, so teams are established, and communicate and engage well. Indeed, positive multidisciplinary team working was thought to have been one of the main contributors to the service's success in recent years
- Other good aspects of staff experiences were around the good standard of Stroke care offered; therapists' level of knowledge; the flexibility of their work; and clear clinical pathways within the service
- The most prevalent issues raised were around capacity
- Other key challenges were highlighted around consistency of staffing (because of employees being moved around to address gaps in other departments); the service's ability to meet national guidelines and standards; a lack of community support leading to discharge delays; and services being provided across multiple small units with no critical mass, leading to inefficiencies and variable standards
- Many staff members also commented on issues around therapy provision for stroke rehabilitation, noting limited space and resources as the main barriers to providing this. Key areas of concern were speech and language therapy and occupational therapy, which was said to be challenging to provide by small teams within hospitals, and in the community
- The key suggested way to improve the staff experience of working in/with the Stroke service was to increase staff numbers to help meet national guidelines and relieve capacity concerns. Speech and language therapy, occupational therapy, and early supported discharge were highlighted as requiring more resource
- Other suggestions related to training and development opportunities for staff; funding and investment for Stroke equipment and environments; providing more 'social areas' for patient leisure and socialisation; developing community resources to support discharge and improve patient flow; better communication between acute and community teams; better communication and engagement between delivery staff and decision-makers
- A few respondents suggested having a centralised Stroke Unit to tackle key challenges around staffing, service provision, and meeting national standards.

Finance

- Key cost driver 1 - Services provided over multiple sites
- Key cost driver 2 - Vacancies filled with premium costs or additional hours

- Nursing budgets are currently overspent by having to arrange cover to fulfil the number of required nurses on the wards.

Workforce data

- The nursing staff to patient ratio is insufficient. There are insufficient stroke therapy staff and there is a lack of seven-day consultant cover
- It is also noted that there is currently no leave of absence cover for Stroke Consultants on ASU and this is particularly fragile within Bronglais Hospital and Glangwili Hospital. This fragility is increased where these are locum consultants
- The nursing component of this risk is also dependent upon variable pay cost drivers as highlighted within the finance section
- The Thrombectomy service contract is managed at a Wales level and outside of Hywel Dda (this service is delivered in Bristol). There is an ambition for this to become a 24/7 service and delivered from Cardiff and Vale University Health Board. The indirect impact here is that by not providing the whole Stroke pathway, the attractiveness to recruit new staff may be impacted into this specialist area.

Section 8: Endoscopy

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

Section 8: Endoscopy

Introduction and background

This chapter of the Issues Paper is about Endoscopy services at Hywel Dda University Health Board. This chapter is a clinically led assessment of Endoscopy services at all sites within the Health Board that delivered Endoscopy services between 1 August 2018 and 31 July 2023.

Endoscopy Services at Hywel Dda

Endoscopy is a procedure used in medicine to look inside the body. The endoscopy procedure uses an endoscope to examine the interior of a hollow organ or cavity of the body. Unlike many other medical imaging techniques, endoscopes are inserted directly into the organ. The service is for patients over 16 years of age. At Hywel Dda, Endoscopy is part of the Diagnostic division and operates from the following locations:

- Glangwili Hospital
- Bronglais Hospital
- Withybush Hospital
- Prince Philip Hospital.

Endoscopy is organised into several procedures, which includes patients at different stages of access to specialist input, diagnostics, and long term follow up. Information about each procedure is shown below:

Sub Speciality	Definition
Colonoscopy	A colonoscopy is a test to check inside the bowels. This test can help find what is causing your bowel symptoms. A long, thin, flexible tube with a small camera inside it is passed into your bottom. You will be given a laxative, so your bowels are empty for the test.
Gastroscopy	A gastroscopy is a test to check inside the throat, food pipe (oesophagus) and stomach, known as the upper part of your digestive system. This test can help find what is causing the symptoms. A long, thin, flexible tube with a small camera inside it is passed into the mouth then down the throat and into the stomach. A gastroscopy can also be used to remove tissue for testing (biopsy) and treat some conditions such as stomach ulcers.
Endoscopic Ultrasound (EUS Radial/Linear)	An Endoscopic Ultrasound (EUS) is a test very similar to an Endoscopy. The difference is that the tube which is passed into the oesophagus (gullet) and stomach has a small ultrasound scanner and balloon at the tip. During the examination the doctor may need to take some samples of tissue (biopsies) or fluid, which will give the doctor more information to determine the most suitable treatment.
Endoscopic Retrograde Cholangiopancreatography (ERCP)	An ERCP is an examination of the pancreatic and bile ducts (drainage tubes from the liver) using an endoscope (a thin, flexible tube) and X-ray. A special dye is injected down the endoscope, so the pancreatic and bile ducts show up on X-Ray.
Bronchoscopy/ Endobronchial ultrasound (EBUS).	A Bronchoscopy is a procedure during which a flexible camera (known as a bronchoscope) is passed through the mouth and vocal cords into the windpipe and airways. This camera allows the team to look at the airways. An Endobronchial Ultrasound (EBUS) is a specialised ultrasound probe (a type of camera

	which uses sound waves) which attaches to the bronchoscope to look through the walls of the airways to “see” the different structures next to them.
Flexible sigmoidoscopy	Flexible sigmoidoscopy is a test to look inside the lower part of the large bowel. It is also called bowel scope or flexi sig. The flexible sigmoidoscopy is a thin flexible tube called a colonoscope. This has a small light and camera at one end. The endoscopist (specially trained doctor or nurse) puts the tube into the back passage (anus). They then gently move it up into the lower part of the bowel. They can see the pictures of the inside of the bowel on a TV screen.

Endoscopy service model

Sub specialities take place in various sites across the Health Board, as shown in the below table.

Procedures (all are outpatients and day cases)	Glangwili	Prince Philip	Bronglais	Withybush
Colonoscopy	x	x	x	x
Gastroscopy	x	x	x	x
Endoscopic Ultrasound (EUS Radial/Linear)	x			
Endoscopic Retrograde Cholangiopancreatography (ERCP)	x		x	
Bronchoscopy/Endobronchial Ultrasound (EBUS)	x	x		
Flexible Sigmoidoscopy	x	x	x	x
Flexible Cystoscopy	x	x	x	

Endoscopy Service – Decontamination

Endoscopy service delivery across three of the units at Hywel Dda (Glangwili, Withybush and Prince Philip) is dependent upon the Hospital Sterile Decontamination Unit (HSDU). This means that the decontamination of endoscope equipment is centralised within the HSDU. At Bronglais, the decontamination of endoscopy equipment is undertaken within the endoscopy unit.

A report completed by the Joint Advisory Group (JAG) and the Institute of Healthcare Engineering and Estates Management (IHEEM) in 2022 highlighted targeted areas for improvement that included concerns around the health and safety of the Bronglais Endoscopy Unit air handling system and replacement of the ageing decontamination equipment.

In response to this, a feasibility case has been developed to outline the project requirements to centralise the decontamination of endoscopy equipment within Bronglais into the HSDU to address the concerns raised in the 2022 reports.

The feasibility case presents the options the centralisation of decontamination into HSDU would present to the endoscopy unit in Bronglais, which involve the development of a second endoscopy theatre, in line with increased future demand projections for the service.

Endoscopy Service changes

The Endoscopy Service has not had any service changes during the Issues Paper timeline.

Endoscopy Service risks

No risks have been reported to Board for Endoscopy between August 2018 and July 2023.

Endoscopy Service clinical effectiveness

The table below includes a list of the clinical guidelines that the Endoscopy service needs to follow:

Guideline Source	Guideline Title	Link
JAG (Joint Advisory Group on GI Endoscopy)	Various guidelines within link	https://www.thejag.org.uk/Default.aspx
BSG	British Society of Gastroenterology (Various)	https://www.bsg.org.uk/resource-type/clinical-resources/guidelines/
NICE	Acute upper gastrointestinal bleeding in over 16s: management	https://www.nice.org.uk/guidance/cg141
NICE	Barrett's oesophagus and stage 1 oesophageal adenocarcinoma: monitoring and management	https://www.nice.org.uk/guidance/ng231
NICE	Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management	https://www.nice.org.uk/guidance/cg184
NICE	Cirrhosis in over 16s: assessment and management	https://www.nice.org.uk/guidance/ng50
NICE	Suspected cancer: recognition and referral	https://www.nice.org.uk/guidance/ng12
NICE	Gastro-oesophageal reflux disease in children and young people: diagnosis and management	https://www.nice.org.uk/guidance/ng1
NICE	Sedation in under 19s: using sedation for diagnostic and therapeutic procedures	https://www.nice.org.uk/guidance/cg112
NICE	Metastatic malignant disease of unknown primary origin in adults: diagnosis and management	https://www.nice.org.uk/guidance/cg104
NICE	Pancreatitis	https://www.nice.org.uk/guidance/ng104
NICE	Diverticular disease: diagnosis and management	https://www.nice.org.uk/guidance/ng147
NICE	Constipation in children and young people: diagnosis and management	https://www.nice.org.uk/guidance/cg99
NICE	Oesophago-gastric cancer: assessment and management in adults	https://www.nice.org.uk/guidance/ng83

NICE	Crohn's disease: management	https://www.nice.org.uk/guidance/ng129
NICE	Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over	https://www.nice.org.uk/guidance/ng36
NICE	Colorectal cancer	https://www.nice.org.uk/guidance/ng151
NHS Wales Executive	Suspected Cancer Pathway: Various guidelines & pathways within link	https://executive.nhs.wales/networks/wales-cancer-network/workstreams/suspected-cancer-pathway/
NHS Wales Executive	Faecal immunochemical testing Guidance	https://executive.nhs.wales/networks/programmes/endoscopy/endoscopy-documents/fit-framework-part-1-2/
Welsh Cancer Network	Single Cancer pathway various pathways	https://executive.nhs.wales/networks/wales-cancer-network/clinical-hub/cancer-site-groups/
Welsh Government	National endoscopy programme	https://www.gov.wales/sites/default/files/publications/2020-12/national-endoscopy-programme-revised-action-plan-october-2020_0.pdf

There are no known standards within the guidance documented above that can only be met through changing the configuration of service provision. However, it is worth considering the growing demand of multiple service areas that are delivered within endoscopy: Gastrointestinal Services, Respiratory Services and Urology Services. For these services to comply with the Welsh Government's Ministerial waiting times, ensuring that each service area has the right level of capacity will be critical.

The JAG[104] document identifies the key standards needed to ensure a high-quality, safe and appropriate endoscopy service, which is delivered by highly trained, highly-supported and highly-motivated workforce. The standards are written in consultation with endoscopy services and are underpinned by national policy. The standards include:

- Leadership and organisation
- Safety
- Comfort
- Quality
- Appropriateness
- Results
- Respect and dignity
- Consent and patient information
- Patient environment and equipment
- Access and booking
- Productivity
- Aftercare
- Patient involvement
- Teamwork
- Workforce delivery

[104] *JAG: the Joint Advisory Group.*

- Professional development.

Where Endoscopy services are compliant with each of these standards they are formally recognised as JAG accredited. The service is re-assessed against these standards on an annual basis to ensure consistent compliance.

Currently, Bronglais and Withybush hospitals are JAG accredited[105]. Prince Philip Hospital is not accredited due to its non-compliance with the 'Patient Environment and Equipment Standard' - this is due to the configuration of the Prince Philip Endoscopy Unit. The Unit would require re-configuration, to ensure appropriate patient flow within the unit. Prince Philip hospital is compliant against all the other JAG standards.

Glangwili Hospital lost JAG accreditation in July 2023 due to non-compliance with the 'Access and Booking' standard, because of the service not meeting the endoscopy waiting time standard.

It is worth noting that all endoscopy units across the Health Board operate from a joint waiting list. Therefore, the recent loss of accreditation in Glangwili Hospital may also impact Bronglais and Withybush hospitals.

Endoscopy local, regional, and national work

This section describes the regional and national projects or programmes connected to Endoscopy services at Hywel Dda.

ARCH[106]

A Regional Collaboration for Health (ARCH) is a unique collaboration between three strategic partners: Swansea Bay University Health Board, Hywel Dda University Health Board and Swansea University. It spans the local authority areas of Carmarthenshire, Ceredigion, Pembrokeshire, Neath Port Talbot, and Swansea.

The ARCH discussion for Endoscopy has started but is at an early stage and no recommendations have been developed to inform this Issues Paper. The Endoscopy Service management team are involved with this process and any findings will be considered at future stages of this process.

GIRFT (Getting It Right First Time)

No GIRFT reviews have been undertaken on the Endoscopy Service.

Endoscopy Activity data

Endoscopy service activity reported between 1 August 2018 and 31 July 2023 is included for Bronglais, Withybush, Prince Philip, and Glangwili hospitals. All data tables including the specific conditions captured can be found in Appendix F8 – Endoscopy – Activity Data.

The tables below show all sites have now exceeded pre COVID-19 activity levels. There is some variation across the sites and procedures but overall, the service has made progress in reducing

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[105] *Accreditation is a supportive process of evaluating the quality of clinical services by guiding services through a quality framework. Accreditation promotes quality improvement through highlighting areas of best practice and areas for change, encouraging the continued development of the clinical service.*
[106] *A Regional Collaboration for Health – further details for ARCH can be accessed by this link http://arch.wales/en/*

the number of patients waiting for an endoscopic procedure, despite no major changes to the service.

Bronglais Hospital	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Colonoscopy	870	1,424	631	1,101	1,182	502
Flexible Sigmoidoscopy	579	1,007	586	738	846	245
Gastroscopy	804	1,411	620	1,087	1,159	542
Other	118	164	116	132	98	26
Total	**2,371**	**4,006**	**1,953**	**3,058**	**3,285**	**1,315**

Glangwili Hospital	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Colonoscopy	2,074	3,631	1,527	2,475	2,652	993
Flexible Sigmoidoscopy	762	1,290	526	819	860	241
Gastroscopy	1,705	2,462	1,272	1,966	1,860	631
Other	311	508	372	535	720	218
Total	**4,852**	**7,891**	**3,697**	**5,795**	**6,092**	**2,083**

Prince Philip Hospital	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Colonoscopy	1,340	2,305	669	1,299	1,479	552
Flexible Sigmoidoscopy	496	931	249	445	533	161
Gastroscopy	1,274	2,414	636	1,434	1,626	605
Other	25	29	28	55	63	23
Total	**3,135**	**5,679**	**1,582**	**3,233**	**3,701**	**1,341**

Withybush Hospital	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Colonoscopy	1,467	2,446	1,246	1,933	1,986	911
Flexible Sigmoidoscopy	1,914	2,897	717	1,100	1,189	419
Gastroscopy	1,808	2,740	974	1,926	2,202	932
Other	22	25	59	62	38	4
Total	**5,211**	**8,108**	**2,996**	**5,021**	**5,415**	**2,266**

Consideration is needed for the future configuration of endoscopy services across the Health Board. Currently, endoscopy includes the delivery of Gastroenterology, Respiratory and Urology services. Four sessions a week are dedicated to bronchoscopy, 6.5 lists per week are dedicated for urology and 49.5 lists per week are for upper and lower gastrointestinal endoscopy (including Bowel Screening Wales).

Considering the expected increase in demand across all specialties, capacity will be stretched (both in terms of theatre staff and theatre infrastructure). It may be prudent to look at consolidation of services across the Health Board, for example, a potential model could involve the delivery of respiratory services from one dedicated unit, urology services from another; complemented by a decision on how Gastroenterology diagnostic and specialised services are delivered (including Bowel Screening Wales). The provision of emergency and inpatient endoscopy procedures would need to be considered as part of any reconfiguration of services.

The service is also in the process of updating an Endoscopy Recovery Plan focusing on the three individual components:

- Two-week Cancer Delivery
- Eight-Week Diagnostic Delivery (active waits)
- Surveillance Delivery (surveillance cases are managed on a separate waiting list and not under the active waiting list, of which there is no ministerial target for delivery).

Endoscopy Service outsourced activity data

To help reduce the waiting lists and remove some of the burden on Hywel Dda services, some Endoscopy procedures were outsourced to other health providers. The table below shows the numbers of procedures that have taken place over the in-scope period and the locations the Health Board has used:

Provider	Period	Activity type	Activity
Spire	February-2022	Day case	20
	March-2022	Inpatient	37
Spire total			57
St Josephs	January-2022	Day case	38
	January -2022	Diagnostic procedure	34
	February-2022	Day case	88
	March-2022	Day case	144
St Josephs' total			304
Total			**361**

Activity was only outsourced during 2021/22 and was a direct result of an increased backlog and pressure on the waiting list.

Endoscopy service incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against Endoscopy services. Full data for incidents, complaints, claims, and compliments can be found in Appendix F9 - Endoscopy - Incidents Data, Appendix F10 - Endoscopy - Complaints Data and Appendix F11 - Endoscopy - Patient Experience and Compliments Data.

Patient Safety Incidents

The table below shows the overall number of incidents recorded for Endoscopy across all sites within the Health Board. The recording period for each year is 1 August to 31 July.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Incidents	26	32	39	47	73

The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of July 2023. The number of incidents recorded for the Endoscopy service at each hospital site is seen in the table below.

Hospital	Number of incidents 01 August 2018 – 31 March 2021	Number of incidents 01 April 21 – 31 July 2023	Total
Bronglais Hospital	20	32	52
Glangwili Hospital	42	42	84
Prince Philip Hospital	8	16	24
Withybush Hospital	27	30	57

The data shown in the table below shows the number of incidents as a percentage of the overall admission activity. For example, Bronglais Hospital had 13% of the overall admission activity (the combined procedure and surveillance activity) with 24% of recorded incidents.

The total number of activities across all Health Board sites (i.e. number of Endoscopy activities) is 91,594. The total number of incidents reported in Endoscopy services across all Hywel Dda sites is 217 incidents.

Location	Percent of total activity undertaken at the site (91,594)	Percentage of total reported incidents (217)
Bronglais Hospital	13% (11,809)	24% (52)
Glangwili Hospital	34% (30,985)	39% (84)
Prince Philip Hospital	21% (19,056)	11% (24)
Withybush Hospital	33% (29,771)	26% (57)

The number of incidents is broadly in-line with the level of activity undertaken at each site; the anomaly being a higher-than-expected level of reported incidents at Glangwili and Bronglais hospitals.

Both Glangwili and Bronglais are sites that deliver specialised endoscopy procedures (ERCP/EUS[107]). Incident rates are likely to be higher due to the complex and specialised nature of the procedure. The age and fragility of scopes are reported as incidents to expedite and highlight need of replacement. Turnover of staff at both Bronglais and Glangwili hospitals may contribute to incident levels, as sites use temporary workforce to support while there are gaps in staffing.

It is also worth noting that a proportion of these reported incidents took place during the COVID-19 pandemic, which may have had an impact on incident occurrence.

The most common incident types reported are shown in the table below.

Type of incident reported, 1 August 2018 – 31 March 2021	Number of incidents
Documentation	16
Diagnostic process/procedure	15
Medication/Biologics/Fluids	11
Type of incident reported, 1 April 2021 - 31 July 2023	
Accident, injury	18
Equipment/Devices	18

[107] *Endoscopic retrograde cholangiopancreatography/Endoscopic Ultrasound.*

Access, Admission	13

The below table shows the severity of recorded incidents.

Incident severity	Number of incidents 1 August 2018 - 31 March 2021	Number of incidents 1 April 2021 - 31 July 2023	Total
1 None	71	37	108
2 Low harm	14	58	72
3 Moderate harm	11	19	30
4 Severe harm	1	5	6
5 Catastrophic death	0	1	1

Endoscopy service patient complaints

The table below shows the overall number of complaints within Endoscopy across all Health Board sites.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of complaints	4	14	12	8	20

The table below shows the number of Endoscopy service complaints received by each hospital site between 1 August 2018 and 31 July 2023.

Location	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Bronglais Hospital	6	2	**8**
Glangwili Hospital	10	13	**23**
Prince Philip Hospital	1	8	**9**
Withybush Hospital	9	5	**14**
Total	**26**	**28**	**54**

The table below shows activity volume (a combination of procedure and surveillance activity) and reported complaints as a percentage of the total number for each site. Percentages have been rounded to the nearest whole number, so may not total 100.

Hospital	Percentage of total activity undertaken at the site (91,594)	Complaints reported as a percentage of overall complaints
Bronglais	13% (11,809)	15% (8)
Glangwili	34% (30,985)	43% (23)
Prince Philip	21% (19,056)	17% (9)
Withybush	33% (29,771)	26% (14)

Specialist and complex procedures are undertaken across both Bronglais and Glangwili hospitals; due to the complexity of these procedures, this could pose a greater risk of complaints. The data

captured covers COVID-19 and the reset and recovery period where greater concerns were raised. Complaints for the service are often in relation to long waiting times and delayed procedures, which aligns to the waiting times and backlog for the service during this time.

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category.

Nature of complaint	Number of complaints 1 August 2018 – 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Clinical treatment / assessment	10	12	**22**
Appointments	4	6	**10**
Attitude and behaviour	5	4	**9**

The table below shows overall number of complaints received for Endoscopy services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023

Grade of complaint	Number of complaints 1 August 2018 - 31 March 2021	Number of complaints 1 April 2021 – 31 July 2023	Total
Grade 1 Minor (informal)	8	13	**21**
Grade 2 Minor	10	11	**21**
Grade 3 Moderate	8	4	**12**
Grade 4 Major	1	0	**1**
Grade 5 Catastrophic	0	0	**0**

Endoscopy Service claims

- There is one potential claim, which is awaiting further details for Withybush Hospital
- There is one confirmed case (Colorectal) for Bronglais Hospital
- There is a further one potential claim, which is awaiting more information prior to confirming.

Endoscopy Service patient experience

We have patient, friends and family and compliment information from 2021 – 2023. Further information can be found in Appendix F11 - Endoscopy - Patient Experience and Compliments Data.

	Patient experience	Friends and family experience	Compliments
2021	None recorded	The themes arising were around efficiency, patient safety and interactions with staff. Positive comments were around staff providing an efficient,	None recorded

		yet friendly and professional service. Patients noted that they were comforted, supported, and communicated with throughout procedures. Negative comments were around isolated staffing incidents and variation perceived in Covid measures between Glangwili and Prince Philip hospitals.	
2022	Patients reported positive experiences, praising the kindness, professionalism, and helpfulness of the staff. Several patients mentioned feeling at ease and well taken care of during their procedures. Some patients also reported that their needs were met and that they were satisfied with the care they received. Noted that change in ward location caused some confusion.	The key themes arising are staff attitude and clinical treatment. Many of the responses mention the friendliness, professionalism, and efficiency of the staff, as well as their ability to put patients at ease and provide reassurance. The clinical treatment also received positive feedback, with patients feeling safe, well-informed, and cared for throughout the procedure.	None recorded
2023	Patients reported positive experiences, praising the kindness, professionalism, and helpfulness of the staff. Several patients mentioned feeling at ease and well taken care of during their procedures. Some patients also reported that their needs were met and that they were satisfied with the care they received.	The themes arising are that staff delivered kind and professional care and provided comfort to the patients while communicating well about the care they received.	Themes arising are that staff were kind and caring in their support of patients, and that they communicate well with patients about their procedures.

The above comments are not attributed to a particular hospital site but are general comments for the service.

Key themes across the years and evidence groups are as follows:

- Staff are frequently described as kind, professional, and helpful
- Patients reported some confusion when the ward location was changed.

Patients were asked to rate their overall experience of using the service:

- The highest score being 10/10 by 99.10% of patients

- The lowest score being 2/10 by 0.09% of patients.

Endoscopy service targeted early engagement with service users

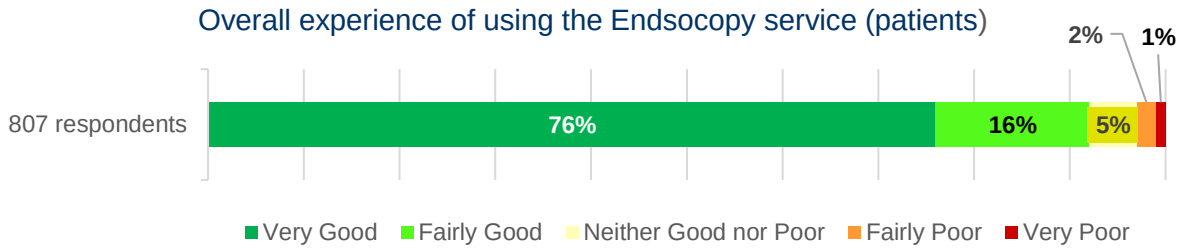
A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

A randomly selected sample of patients who accessed Endoscopy services within the last five years (1 August 2018 - 31 July 2023) were invited to take part in a survey. An invitation was sent to 5,401 patients, and 816 responses were received. Of the patients who responded, 34% of respondents accessed most of their Endoscopy care at Glangwili Hospital, 27% at Withybush Hospital, 22% at Prince Philip Hospital, and 15% at Bronglais Hospital. The remainder were split out between various other clinical sites.

The Endoscopy service patient demographic is mixed. This is broadly reflected in the profile of respondents to the patient survey; however, 94% of respondents were aged 55 or over. Tables showing the full profile breakdown of respondents are included at the end of this chapter.

Main survey findings

92% of patient respondents said that their experience of using the Endoscopy service was good. 3% said it was poor.



Key positive themes emerging from patients that used the Endoscopy service include:
the professional, kind, reassuring, and helpful staff in the department, good communication, with everything being explained sufficiently before/during/after the procedure the speed and efficiency of the service provided (including being seen on time and receiving prompt results/diagnosis).

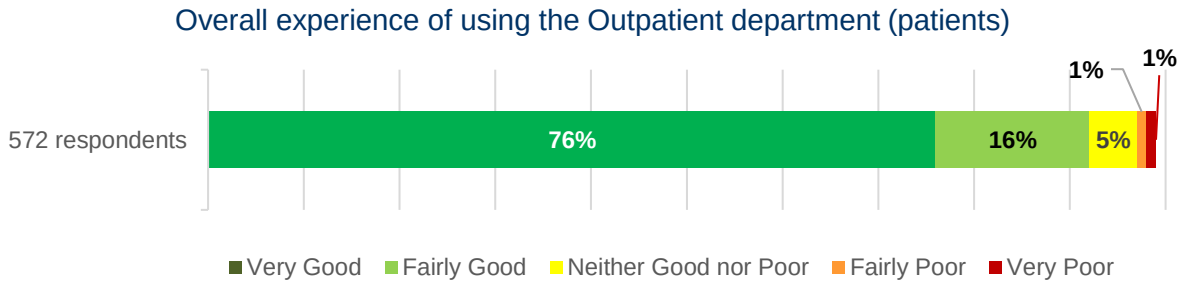
The most common complaint regarding the service is a dislike of the treatment or procedure received (including feeling embarrassed).

Over two-fifths (46%) of patient respondents feel that there are no improvements required to the service. However, other respondents suggested:

- there is a need to improve the speed and efficiency of the service (including shortening waiting times and not cancelling appointments)
- there is a need to improve the quality of healthcare provided (including procedure, treatment, and outcome)
- there is a need to improve communication (including providing better explanations to patients and increasing the frequency of contact and follow up).

Experiences of Outpatient services

85% of patient respondents said they used the Outpatient department as part of their Endoscopy treatment. Of these, 92% said their experience of doing so was good. 3% said it was poor.



When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent positive comments praised:

- staff for their professional, kind, reassuring, and helpful nature
- the efficient and quick service provided (including being seen on time and receiving prompt results and diagnosis)
- the good communication, including good follow up and clear explanations throughout their experience.

Just under a third (32%) felt their experience was good in general, with no issues. The most frequent negative comment was that the service provided was slow and inefficient (including access to appointments, and time taken to receive results and diagnosis).

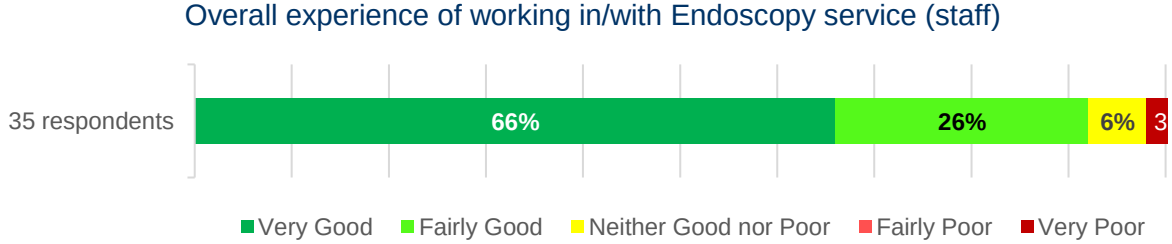
Targeted early engagement with staff

A survey was sent to medical, nursing, therapy, operational and support staff. Staff were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS and helps us to understand the key issues and themes facing our staff when working in/with Endoscopy services.

All staff currently working in, or supporting staff working in, the Endoscopy service were invited to take part in a survey: 36 responses were received. Respondents' main clinical base is/was Bronglais Hospital (12 respondents), Prince Philip Hospital (nine respondents), Withybush Hospital (eight respondents), and Glangwili Hospital (six respondents). One respondent did not identify their main hospital base.

Experiences of the Endoscopy service

91% of staff respondents said that their overall experience of working in/with the Endoscopy service was good, with 66% saying it was very good. Just 3% said it was very poor.



In terms of what is/was good about working in/with the Endoscopy service, staff respondents particularly noted the:

- high-quality physical and mental health care provided to patients
- interesting and varied nature of the work
- the excellent teamwork between friendly, supportive, compassionate, proactive, committed, and experienced staff.

Other frequent comments were that some management and senior staff are supportive, approachable, and helpful; staff take pride in the JAG accreditation awarded to Withybush Endoscopy service; and that new members of staff are made to feel like a valued member of the team.

When discussing the difficult aspects of their experience of working in/with the Endoscopy service, staff respondents widely noted the:

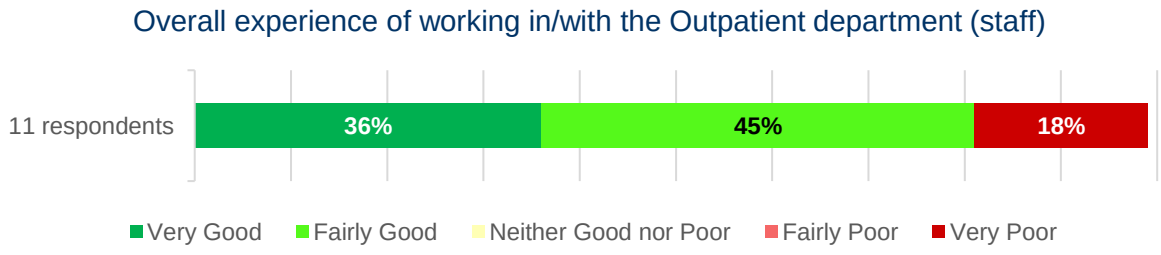
- lack of good quality equipment, especially endoscopes
- increased patient waiting times
- poor staff retention
- insufficient funding or investment into the department to maintain a Gold Standard of care and the JAG accreditation status at Withybush Hospital.

Some staff members said they feel undervalued, demotivated, and under undue pressure.

The most common suggestion to improve the staff experience of working in/with the Endoscopy service was to replace old endoscopy equipment on a more regular basis. Some staff members also proposed investing in the service to create more Endoscopy lists, including on weekends; re-examining the current on-call rota to ensure fairness; and having a more mindful approach when hiring (i.e., ensuring new recruits have sufficient skills and/or experience in Endoscopy).

Staff experiences of Outpatient services

27% of staff survey respondents use the Outpatient department in delivering their Endoscopy service. Of these, 82% said that their overall experience of the Outpatient department was good, and 18% said it was very poor.



Outpatient staff were praised by staff respondents for being friendly and helpful (especially at Bronglais Hospital); and it was said that the referrals and decontamination processes at Withybush Hospital and Prince Philip Hospital are working efficiently. Complaints included that the Outpatient department at Glangwili Hospital is outdated; and that duplicate referrals are sometimes received from the Outpatient department at Withybush Hospital.

Endoscopy Service finance

The table below indicates the key cost drivers affecting service delivery budgets within the services that are in scope of the Clinical Services Plan programme.

This information is aligned to the findings and submissions within the 2024/2025 annual planning process.

Service	Key Cost Drivers
Endoscopy	Consumable costs increase due to increase in volumes and more complex procedures being done. Impact of on-boarding staff including clinical endoscopist to deliver capacity requirements.

The level of nurse agency spend in Bronglais is £52k in the first nine months of the year. This has reduced in recent months and indicates a better financial position into 2024/25. There is an ongoing pressure in non-pay costs, driven by increased numbers of more complex procedures, increased demand for Faecal Immunochemical Test (FIT) testing, and new technologies including capsule endoscopy. The 2023/2024-year-end anticipated position is £0.357m overspend.

In 2024/25 it is likely that there will be financial pressures linked to the established Faecal Immunochemical Test (FIT)[108] Testing capacity, based on non-recurrent cancer funding in 2023/24. Longer term, there are further cost pressures linked to workforce developments to support capacity, for example a clinical endoscopist post.

Endoscopy service workforce

The Workforce team have supplied data within defined cost codes for Endoscopy. Full details about the methodology can be found within Appendix F13 – Endoscopy – Workforce Data.

The table below shows the workforce establishment (number of people working) across our hospital sites within Endoscopy services on 31 July 2023.

Staff group	Budget	Actual	Vacancy
Additional Clinical Services	16	14.4	1.6
Administrative and Clerical	13.1	12	1.1
Estates and Ancillary	2	2	0
Medical and Dental	1.3	1	0.3
Nursing and Midwifery Registered	51.9	48.77	3.13
Total	**84.3**	**77.8**	**6.5**

As of 31 July 2023, there was a total of 6.5WTE [109]vacancies within the service with the majority within the Nursing workforce at 3.13WTE.

During this period an additional 2.1WTE of temporary staffing was used. The majority (1.5WTE) was through Bank[110] usage with the remainder being provided by contracted agency workers.

In addition to the vacancies, a further 5.3WTE is required across the Nursing workforce to fulfil maximum clinical activity.

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[108] FIT Faecal Immunochemical Test is a stool test designed to identify possible signs of bowel disease.
[109] WTE: whole time equivalent. 1WTE is one full-time staff member working 37.5 hours a week.
[110] Bank Staff -Ban Staff are a pool of people that an employer may call on when they need to cover shifts, holidays or just need extra staff as and when.

Workforce risks and Issues

Workforce Risk 1580 - There is a risk to the expansion of Endoscopy service provision across the Health Board. This is caused by delayed and/or failed substantive recruitment of Consultant Gastroenterologist posts across the Health Board.

Workforce Risk 1383 - Three of our units at Bronglais Hospital, Withybush Hospital and Glangwili Hospital are experiencing chronic and acute staffing issues due to vacancies and Long-Term Sickness.

The risks below have been identified by the service and are yet to be presented to Board:

- Risk to the provision of the 24/7 out-of-hours acute gastrointestinal bleed service (of which emergency endoscopy intervention is required) due to fragility in the consultant endoscopist rota. The rota is currently operated at 1:8[111]. However, this is due to reduce to 1:7 soon. There are no immediate plans in place to address the gap, due to workforce constraints and the number of consultants in post together with the level of training of each consultant. This presents a risk to the rota being sustained, which would impact directly upon 24/7 provision of emergency interventional endoscopy. This could present a risk to patient morbidity or death
- Risk to increasing service capacity (in line with projected service demand) in the absence of new investment into the endoscopy nursing establishment
- The consistent commitment of surgeons in their delivery of endoscopy sessions presents a risk to the provision of adequate endoscopy capacity (in line with projected demand). Surgeon job plans are stretched due to theatre/clinic/on-call requirements that limit their flexibility to provide consistent endoscopy sessions
- There is a risk due to the age profile of endoscopists and appropriate succession planning for fragile services areas (such as ERCP, EUS, BSW[112] service delivery).

Workforce supply has historically presented a challenge to endoscopy service delivery – across multiple staff groups, predominantly because of recruitment shortfalls. Gastrointestinal (GI) endoscopy services are currently delivered by Gastroenterology and Surgical Consultants – a number of which are due to retire in the next five to ten years. Consolidation of service delivery may combat these challenges, by limiting the impact of a fragile workforce supply.

In the absence of effective succession planning, there is a risk to the provision of specialised/complex GI endoscopy delivery. Issues in the recruitment of endoscopy nursing staff have also presented a challenge to service delivery (for GI, Respiratory and Urology endoscopy services), in particular for Bronglais Hospital.

The supply, provision, and maintenance of endoscopy equipment (across all three specialties) presents a challenge to service delivery. The Health Board's discretionary programme is not sufficient to support replacement of old, ageing, out-of-contract and fragile endoscopy equipment – which often results in the service incurring high revenue spend against loan equipment, at times where equipment fails. The provision of endoscopy equipment should fall part of the first consideration noted above (as consolidation of services would reduce the fleet of endoscope equipment required, compared to current service delivery which spans across a number of sites).

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[111] *1:8/1:7 rota reference* – This relates to a period of weeks. For example one consultant may work one week on rota for this service every 8 weeks

[112] *Bowel Screening Wales on behalf of Public Health Wales*

Endoscopy Service conclusions

Endoscopy is part of the Clinical Services Plan programme to support the return to pre-Covid activity levels (as a minimum), as part of improving access and reducing waiting times for patients.

The service operates across Glangwili Hospital (Carmarthen), Bronglais Hospital (Aberystwyth), Withybush Hospital (Haverfordwest) and Prince Philip Hospital (Llanelli)

A summary of the findings identified within this paper are as follows:

Service changes

No temporary changes have been identified at Public Board.

Risks

No risks reported to Board for Endoscopy.

Clinical effectiveness - NICE guidance and other national guidance

There are no known standards within the guidance documented within this report that can only be met through changing the configuration of service provision. However, it is worth considering the growing demand of multiple service areas that are delivered within endoscopy – Gastrointestinal Services, Respiratory Services and Urology Services. For these services to meet Welsh Government's ministerial waiting times, ensuring each service area has the right level of capacity will be critical to ensuring compliance.

National and regional work

A Regional Collaboration for Health (ARCH) is a unique collaboration between three strategic partners: Swansea Bay University Health Board, Hywel Dda University Health Board and Swansea University. It spans the local authority areas of Ceredigion, Pembrokeshire, Carmarthenshire, Neath Port Talbot and Swansea.

The ARCH discussion for Endoscopy has begun but is at an early stage and no recommendations have yet been developed to inform this Issues Paper.

Summary of the issues identified with Issues Paper are:

- The supply, provision and maintenance of endoscopy equipment (across all three specialties) presents a challenge to service delivery
- Workforce supply has historically presented a challenge to endoscopy service delivery – across multiple staff groups, predominantly as a result of recruitment shortfalls
- The centralisation of endoscopy decontamination into HSDU in Bronglais should be considered as high priority in light of the challenges associated with ageing sterilisation equipment.

Activity data

All sites have now exceeded pre COVID-19 activity levels. There is some variation across the sites and procedures but overall, the service has made progress in reducing the number of patients waiting for an endoscopic procedure, despite no major changes to the service.

Considering the expected increase in demand across all specialties, capacity will be stretched (both in terms of theatre staff and theatre infrastructure). It may be prudent to look at consolidation of services across the Health Board.

Incidents, complaints, and claims

Specialist and complex procedures undertaken across both Bronglais and Glangwili hospitals – this could pose a greater risk of complaints. The data captured covers COVID-19/reset and recovery period where greater concerns were raised
All sites have now exceeded pre COVID-19 activity, there is some variation across the sites and procedures but on the whole, the service, despite no major service changes has made progress in reducing the number of patients waiting for an endoscopic procedure.

Patient experience and compliments

- Staff are frequently described as kind, professional, and helpful
- Patients reported some confusion when the ward location was changed.

99.10% of patients rated the service at least 10/10 in the Friends and Family Test data analysed, where patients were asked to rate their overall experience of using the service.

Targeted early engagement with service users

- Key positive themes emerging from patients that used the Endoscopy service include the professional, kind, reassuring, and helpful staff in the department; good communication, with everything being explained sufficiently before/during/after the procedure; and the speed and efficiency of the service provided (including being seen on time and receiving prompt results/diagnosis)
- The most common negative comments regarding the service are around a dislike of the treatment or procedure received (including feeling embarrassed)
- Over two-fifths (46%) of patient respondents feel there are no improvements required to the service
- Other patients, however, felt there could be improvement with regard to speed and efficiency of the service (including shortening waiting times and not cancelling appointments); the quality of healthcare provided (including procedure, treatment, and outcome); and communication (including providing better explanations to patients and increasing the frequency of contact and follow up).

Targeted early engagement with staff

- Staff respondents particularly noted the high-quality physical and mental health care provided to patients; the interesting and varied nature of the work; and the excellent teamwork between friendly, supportive, compassionate, proactive, committed, and experienced staff
- Other frequent comments were that some management and senior staff are supportive, approachable, and helpful; staff take pride in the JAG accreditation awarded to Withybush Endoscopy service; and that new members of staff are made to feel like a valued member of the team
- Staff respondents widely noted the lack of good quality equipment, especially endoscopes; increased patient waiting times; poor staff retention; and insufficient funding or investment into the department to maintain a Gold Standard of care and the JAG accreditation status at Withybush Hospital
- Some staff members said they feel undervalued, demotivated, and under undue pressure
- The most common suggestion to improve the staff experience of working in/with the Endoscopy service was to replace old endoscopy equipment on a more regular basis
- Some staff members also proposed investing in the service to create more Endoscopy lists, including on weekends; re-examining the current on-call rota to ensure fairness; and having

a more mindful approach when hiring (i.e., ensuring new recruits have sufficient skills and/or experience in Endoscopy).

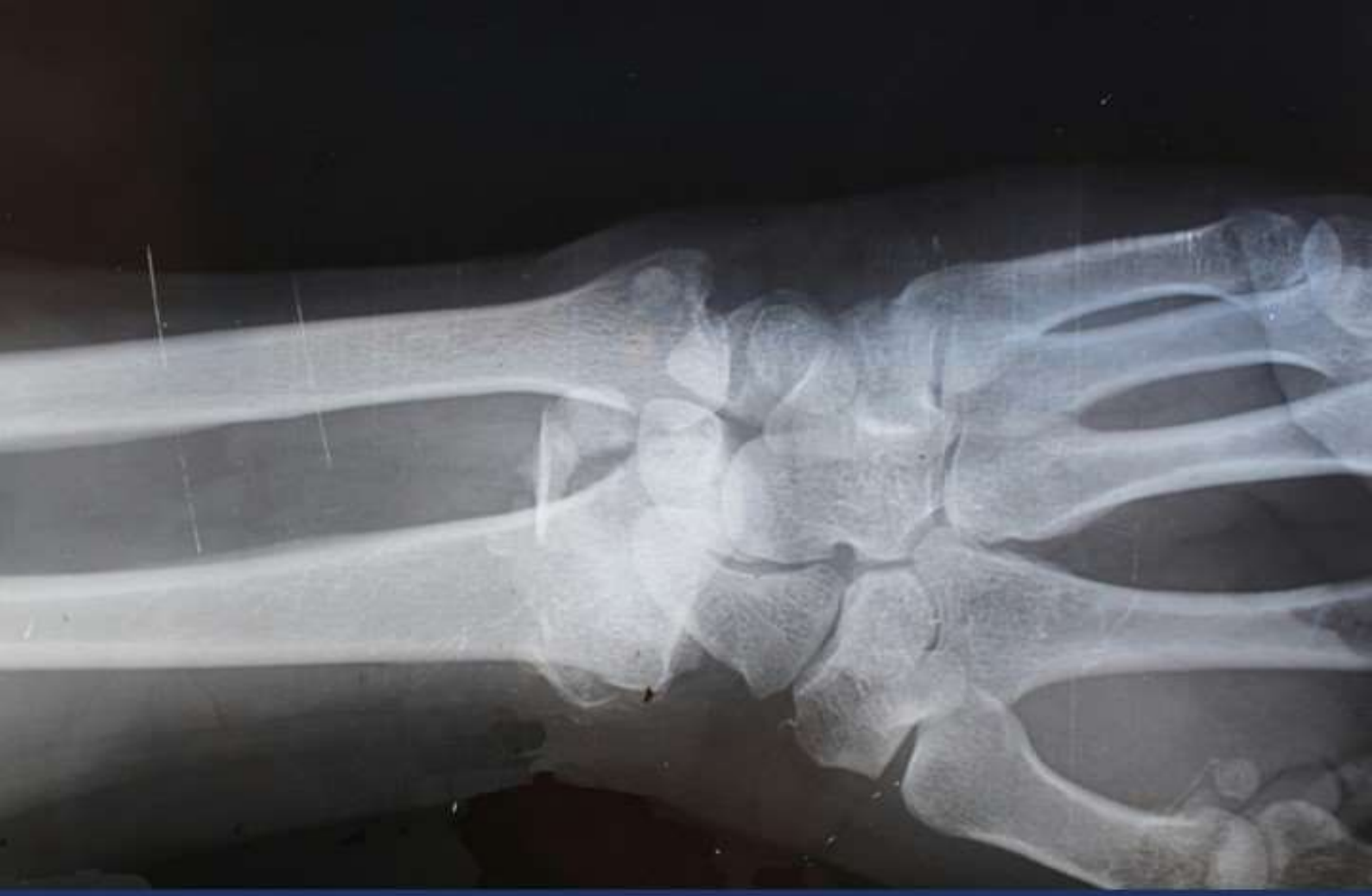
Finance

Key cost driver 1: Consumable costs increase due to increase in volumes and more complex procedures being done.
Key cost driver 2: Impact of on-boarding staff including clinical endoscopist to deliver capacity requirements.

High level of nurse agency spend in Bronglais, in the first 9 months of the year, though this has reduced in recent months and indicates a better position into 2024/2025. There is an ongoing pressure in respect of non-pay costs, driven by increased numbers of more complex procedures, increased demand for FIT testing, and new technologies including capsule endoscopy.

Workforce

Workforce supply has historically presented a challenge to endoscopy service delivery across multiple staff groups, predominantly because of recruitment shortfalls. Gastrointestinal (GI) endoscopy services are currently delivered by Gastroenterology and Surgical Consultants – a number of which are due to retire in the next five to ten years. Consolidation of service delivery may combat these challenges, by limiting the impact of a fragile workforce supply.



Section 9: Radiology

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Hywel Dda
University Health Board

Section 9: Radiology

Introduction and background

This chapter of the Issues Paper is about Radiology services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Radiology service at all sites within the Health Board that delivered Radiology services between 1 August 2018 and 31 July 2023.

Radiology service at Hywel Dda

Radiology is a medical speciality that uses imaging techniques (such as X-rays) to diagnose, treat and monitor diseases and injuries identified within the body.

Radiology sits within Diagnostics and operates from the following locations:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital
- Cardigan Integrated Care Centre
- Llandovery Hospital
- Tenby Hospital
- South Pembrokeshire Hospital.

Radiology service model

Radiology provides a range of services across Hywel Dda. Definitions of the modalities[113] Radiology provides are outlined below:

Modality	Definition
CT	Uses X-rays to produce 3D images of your body.
Fluoroscopy	Uses X-rays to produce moving images of parts of your body, which can be displayed on a screen.
Interventional	Uses X-rays to produce moving images that can be used to guide and deliver treatment.
Mammography	Uses X-rays to examine the breast for the early detection of cancer and other breast diseases and conditions.
MR	A type of imagining that does not use X-rays or radioactive substances.
Nuclear Medicine	Uses a small amount of radioactive substance that is usually injected into a vein. Scanners will detect this low-level radiation and will use that to build images.
Obstetric US	Uses high-frequency sound waves to produce images of a developing embryo or foetus, including screening to detect some birth defects at various stages prior to birth.

[113] *Radiology modalities, or medical imaging modalities, are techniques used to create images of the human body for diagnostic and therapeutic purposes.*

Plain X-Ray	An X-ray is used to produce radiation that passes through the body to create an image.
Dexa Scan	A bone density scan. Uses low dose X-rays to see how dense or strong your bones are. This is also sometimes called a DEXA scan.
Dental	Uses X-ray to produce high-definition images of your teeth and jaws.
Ultrasound	A type of imaging that uses high-frequency sound waves to produce images of internal parts of the body.

The area of the service within scope is defined as patients who receive care for the specified modalities outlined in the table below:

		Sites							
Pathway	Modality	Bronglais	Glangwili	Prince Philip	Withybush	Cardigan	Tenby	Llandovery	South Pembrokeshire
All	CT	Y	Y	Y	Y	N	N	N	N
All	Fluoroscopy	Y	Y	Y	Y	N	N	N	N
All	Interventional	Y	Y	Y	Y	N	N	N	N
All	Mammography	Y	N	Y	Y	N	N	N	N
All	MR	Y	Y	Y	Y	N	N	N	N
All	Nuclear medicine	N	N	N	Y	N	N	N	N
All	Obstetric US	Y	Y	Y	Y	N	N	N	N
All	Plain X-ray	Y	Y	Y	Y	Y	Y	Y	Y
All	Dexa*	Y	N	N	N	N	N	N	N
All	Dental	N	Y	N	Y	Y	N	N	N
All	Ultrasound	Y	Y	Y	Y	N	N	N	N
Other	GP Direct Access (for Plain X-Ray)	NA	Y 9.30am - 4.30am Monday - Sunday	Y 8am - 5pm Monday - Friday	Y CXR only	N	N	N	N
Other	Pathways (please specify)	LUMEN CHEST Cardiac CT,	LUMEN CHEST, Cardiac CT, Paed MRI (GA), Skeletal Surveys (NAI)	LUMEN CHEST, CT/ Plain Film clinical trials, Coronary Angiography	LUMEN CHEST	LUMEN CHEST	N	N	N

Dexa scans are also offered at a mobile unit that is undertaken by Swansea Bay University Health Board at the following sites:

- Glangwili Hospital
- Prince Philip Hospital

- Withybush Hospital.

Of the modalities listed in the table on the previous page, the following are offered for additional hours referred from Accident and Emergency, and Inpatients:

- CT and Plain X-ray is offered 24 hours a day at Bronglais, Glangwili, Prince Philip and Withybush hospitals
- MRI is offered 18 hours a day at Prince Philip and Glangwili hospitals for spinal emergencies.

Other locations, outside of those listed above, have been identified through the activity data captured and the reasoning behind those activities are documented within the activity data section of this paper.

Some MRI services are offered through NHS Wales when additional funding streams are made available. The service has also previously used private companies to offer this service. This was used to maintain the service during equipment downtime, such as breakdowns or planned maintenance, at Glangwili.

Radiology service changes

There have been no service changes for Radiology in the time being reviewed.

Radiology risks

This section describes the Radiology risks that have been reported at Public Board meetings between August 2018 and July 2023.

The current risks that have been logged with reference to the delivery of the Radiology service within Hywel Dda are as follows:

Risk reference	Risk Title
684	Lack of agreed replacement programme for radiology equipment
1349	Ability to deliver ultrasound services at Withybush Hospital
797	Shortage of staff in sonography[114] affecting the whole Health Board

Risk No. 684 - Lack of agreed replacement programme for radiology equipment

Risk 684 was first reported to Board on 30 May 2019 with a risk rating of 16. The reasoning for this was that: "*There is a risk Radiology service provision from breakdown of key radiology imaging equipment and generally a poor image quality offering to patients. This is caused by equipment not being replaced in line with the RCR (Royal College of Radiographers) and other guidelines*". This risk has been reported to Board a total of 12 times to the end of the review period.

Board paper - Appendix G4 – Radiology – Corporate Risks
Corporate Risk register - Appendix G4.1 - Radiology – Corporate Risks - Register

At the Board meeting held on 25 March 2021, the risk rating for risk 684 was 20.

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[114] *Sonography - Diagnostic ultrasound, also called sonography or diagnostic medical sonography, is an imaging method that uses sound waves to produce images of structures within your body.*

Board agenda and papers - 25th March 2021 - Hywel Dda University Health Board (nhs.wales)[115]

At the Board meeting held on 31 March 2022, the risk rating for risk 684 was lowered to 16.
Board agenda and papers 31 March 2022 - Hywel Dda University Health Board (nhs.wales)[116]

At the Board meeting held on 26 January 2023, the risk rating for risk 684 was lowered to 12 with the following commentary recorded:

The risk score has been reduced to 12 in November 2022 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however no funding has yet been secured (for financial year 2023/24). A paper was submitted to the September Capital Sub-Committee meeting for information.
Board Agenda and Papers 26 January 2023 - Hywel Dda University Health Board (nhs.wales)[117]

Risk 684 remained on a risk rating of 12 from this date to the end of the review period.

Risk No. 1349 - Ability to deliver ultrasound services at Withybush

Risk 1349 was first reported to Board on 29 September 2022 with a risk rating of 20. This risk has been reported to Board a total of three times to the end of the review period.

At the Board meeting held on 29 September 2022, risk 1349 was presented as a new risk. The reasoning for this was:

"Service failure has already occurred with a likelihood of recurrence due to a lack of trained obstetric sonographers, particularly post March 22 due to staff retirements. The service remains fragile despite being granted a locum for 2 months. In-sourcing an ultrasound service as at July 2022, with staff due to commence in post August 2022 for a rolling three month period, therefore a temporary solution due to funding."
Board Agenda and Papers 29th September 2022 - Hywel Dda University Health Board (nhs.wales)[118]

At the Board meeting held on 25 May 2023, risk 1349 was closed with the following commentary recorded:

Risk closed - The risk has been superseded on the Corporate Risk Register by existing risk 797 - *shortage of staff in sonography affecting the whole Health Board, reflecting the scope of the risk across the organisation. The risk specific to Withybush has been de-escalated to Directorate level as agreed by the Chair of the Executive Risk Group.*
Board Agenda and Papers 25 May 2023 - Hywel Dda University Health Board (nhs.wales)[119]

Risk No. 797 - Shortage of staff in sonography affecting the whole Health Board

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[115] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-25th-march-2021/*
[116] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-31-march-2022/*
[117] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-26-january-2023/*
[118] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2022/board-agenda-and-papers-29th-september-2022/*
[119] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-25-may-2023/*

Risk 797 was first reported to Board on 25 May 2023 with a risk rating of 20. Risk 797 was presented as a new risk because:

"*The service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais Hospital, Prince Philip Hospital and Withybush Hospital - in particular in terms of modality lead sonographers at WH and PPH as at April 2023. There are a number of expected retirements and planned maternity absences in the near future and there will also be the inability to secure agency staff from July 2023 in WH."*
Board Agenda and Papers 25 May 2023 - Hywel Dda University Health Board (nhs.wales)[120]

Risk 797 remained on a risk rating of 20 from this date to the end of the review period.

Wider workforce issues exist within Radiology outside of risk 797 and 1349. There are ongoing conversations with the Corporate Risk team to amalgamate these and present them to Board. The details of the wider workforce risks are outlined in the workforce section of this Issues Paper.

Radiology clinical effectiveness

The table below includes a list of the clinical guidelines that Radiology services need to follow:

Guideline Source	Guideline Title	Link
Royal College of Radiology	Various guidelines within link Auditing guidelines within link	https://www.rcr.ac.uk/guidelines
	Revalidation	https://www.rcr.ac.uk/cpd-and-events/revalidation/
NHS Wales Executive	Suspected Cancer Pathway: Various guidelines and pathways within link	https://executive.nhs.wales/networks/wales-cancer-network/workstreams/suspected-cancer-pathway/
Dept of Health & Social Care	Ionising Radiations (Medical Exposure) Regulations - (IRMER)	https://assets.publishing.service.gov.uk/media/5b339c4eed915d5862b2c718/guidance-to-the-ionising-radiation-medical-exposure-regulations-2017.pdf
	The Ionising Radiations Regulations 2017	https://www.legislation.gov.uk/uksi/2017/1075/contents/made
	The Ionising Radiation (Medical Exposure) Regulations 2017	https://www.legislation.gov.uk/uksi/2017/1322/contents/made
British Society for Haematology	Joint guidance from the British Societies of Interventional Radiology and Haematology on managing Bleeding Risk during Procedures[121] in Interventional Radiology	https://b-s-h.org.uk/guidelines/guidelines/joint-guidance-from-the-british-societies-of-interventional-radiology-and-haematology-on-managing-bleeding-risk-during-procedures-in-interventional-radiology
NICE[122]	Major Trauma: Service delivery	https://www.nice.org.uk/guidance/ng40

[120] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-25-may-2023/*
[121] *A Patient Procedure is a clinical intervention performed on a patient by a care professional.*
[122] *National Institute for Health and Care Excellence.*

	Major trauma: assessment and initial management	https://www.nice.org.uk/guidance/ng39
NICE	Fractures (non-complex): assessment and management	https://www.nice.org.uk/guidance/ng38
	Fractures (complex): assessment and management	https://www.nice.org.uk/guidance/ng37
	Head Injury: assessment and early management	https://www.nice.org.uk/guidance/ng232
	Spinal Injury: assessment and initial management	https://www.nice.org.uk/guidance/ng41
	Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism	https://www.nice.org.uk/guidance/ng89
	Metastatic malignant disease of unknown primary origin in adults: diagnosis and management	https://www.nice.org.uk/guidance/cg104
	Spinal metastases and metastatic spinal cord compression	https://www.nice.org.uk/guidance/ng234
	Ovarian cancer: recognition and initial management	https://www.nice.org.uk/guidance/cg122
	Pancreatic cancer in adults: diagnosis and management	https://www.nice.org.uk/guidance/ng85
	Thyroid cancer: assessment and management	https://www.nice.org.uk/guidance/ng230
	Venous thromboembolic diseases: diagnosis, management and thrombophilia testing	https://www.nice.org.uk/guidance/ng158
	Lung cancer: diagnosis and management	https://www.nice.org.uk/guidance/ng122
	Bladder cancer: diagnosis and management	https://www.nice.org.uk/guidance/ng2
	Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over	https://www.nice.org.uk/guidance/ng36
	Brain tumours (primary) and brain metastases in over 16s	https://www.nice.org.uk/guidance/ng99
	Idiopathic pulmonary fibrosis in adults: diagnosis and management	https://www.nice.org.uk/guidance/cg163
NICE	Stroke and transient ischaemic attack in over 16s: diagnosis and initial management	https://www.nice.org.uk/guidance/ng128
	Abdominal aortic aneurysm: diagnosis and management	https://www.nice.org.uk/guidance/ng156
	Renal and ureteric stones: assessment and management	https://www.nice.org.uk/guidance/ng118

	Advanced breast cancer: diagnosis and treatment	https://www.nice.org.uk/guidance/cg81
	Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management	https://www.nice.org.uk/guidance/ng228
GIRFT	Radiology & diagnostics	https://gettingitrightfirsttime.co.uk/medical_specialties/radiology/

The Major Trauma and Metastatic Cord Compression guidelines require an increase in service hours to MRI 24 hours a day, seven days a week. All referenced standards are difficult to achieve due to staffing numbers and equipment numbers, particularly Cancer diagnosis and Emergency conditions. A lack of Sonographers has made the DVT[123] guidance extremely challenging.

All standards identified have a reliance on Radiology being able to perform when we are unable to or unable to fully comply, this means that the standards cannot be adhered to.

Radiology local, regional and national work

This section describes the regional and national projects or programmes connected to Radiology services at Hywel Dda.

Radiology regional work

This section describes the regional projects or programmes connected to Radiology services at Hywel Dda.

ARCH[124]

A Regional Collaboration for Health (ARCH) is a unique collaboration between three strategic partners: Swansea Bay University Health Board, Hywel Dda University Health Board and Swansea University. It spans the local authority areas of Ceredigion, Pembrokeshire, Carmarthenshire, Neath Port Talbot, and Swansea.

The ARCH review for Radiology has begun but is at an early stage and no recommendations have yet been identified to inform this Issues Paper. Radiology management are involved with this process and any findings will be considered at future stages of this process, if necessary.

GIRFT[125]

Getting It Right First Time (GIRFT) is a national programme in England developed by the GIRFT National Team under the Chair of Professor 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.

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[123] DVT - Deep Vein Thrombosis.
[124] A Regional Collaboration for Health – further details for ARCH can be accessed via this link http://arch.wales/en/
[125] Getting It Right First Time.

There is no GIRFT report for Radiology in Wales but there is a Radiology – GIRFT Programme National Speciality Report for NHS England. The report outlines a total of 20 recommendations across the following areas:

- Delivering a patient-centred service
- Maximising capacity
- Making data work harder
- Managing increasing demand
- Procurement
- Litigation.

The full report Radiology - Getting It Right First Time - GIRFT[126] can be accessed using the footnote link below.

Radiology national work

This section describes national projects or programmes connected to Radiology services at Hywel Dda.

Diagnostics: recovery and renewal

Report of the Independent Review of Diagnostics Services for NHS England, October 2020.

This recover and renewal report is an independent review commissioned by NHS England and sets out a series of recommendations across five key areas:

- New Service Delivery Models
- Equipment and Facilities
- Workforce
- Digitisation and Connectivity
- Delivering the Change.

The report outlines a total of 24 recommendations. The full Diagnostics: recovery and renewal – Report of the Independent Review of Diagnostic Services for NHS England – October 2020[127] report can be seen by following the link at the bottom of this page.

Imaging statement of intent

This statement of intent addresses the current challenges in diagnostic and therapeutic imaging in NHS Wales. It signals the Welsh Government's commitment to adopt a new strategic approach to the development of high quality, effective and sustainable imaging services for NHS Wales that address the needs of the population, respond to current and future policy direction, and ensure long term sustainability.

The report states that Wales has seven Radiologists per 100,000 population, compared to a European average of 12.

Census data for 2021 states that the population across the three counties within Hywel Dda is 382,732 people. Therefore, to fall in line with the report's figures on averages in Wales the expected number of Radiologists for the service should be 26.79.

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[126] *https://gettingitrightfirsttime.co.uk/medical_specialties/radiology/*
[127] *https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf*

The workforce data as of July 2023 outlines a total of 16.3 Radiologists within the service. It has also been noted by the service that the population figures used for this calculation only includes those that live within the three counties of the service and not those patients that live outside of the Health Board and are treated within the service.

The report also states that 2014 data published by the OECD[128] in 2016 showed that Wales had ten CT and eight MRI scanners per million people. The UK as a whole had eight CT and seven MRI scanners per million people.

The total number of scanners in Hywel Dda are as follows:

CT scanners: 6

Based on the population details listed Hywel Dda should have a total of 3.8 CT scanners for the population (excluding those using the service that live outside of the Health Board). This shows that the service currently has sufficient CT scanners to fall in line with Wales as a whole. The service has noted that currently not all equipment is being utilised fully due to staff shortages.

MRI scanners: 4

Based on the size of the population, Hywel Dda should have a total of three MRI scanners for the population (excluding those using the service that live outside of the Health Board). This shows that the service currently has sufficient MRI scanners to fall in line with Wales as a whole. The service has noted that, due to staff shortages, the equipment is not being fully utilised.

As well as staff shortages resulting in equipment not being fully utilised the service has also noted that there is equipment that is due for upgrade. There is a corporate risk highlighting this with one specific example provided by the service being the MRI scanner in Prince Philip that is due for upgrade.

The complete Imaging Statement of Intent[129] document can be viewed by following the link at the bottom of this page.

Building the NHS Wales imaging workforce model

Strategy for Developing a Radiology Workforce Model for Wales, March 2023.

The ‘Strategy for Developing a Radiology Workforce Model for Wales’ has been produced by the Imaging Workforce and Education Group (IWEG) in collaboration with Health Education and Improvement Wales (HEIW) and Radiology services across NHS Wales.

This strategy aims to:

- describe the workforce that is employed by Radiology services in Wales
- highlight the significant challenges that are currently being faced by the Radiology workforce
- put forward a number of potential workforce solutions to assist those involved in the planning and management of Radiology services in Wales
- set out a shared vision for a strong, resilient, and sustainable Radiology workforce
- outline a number of practical recommendations to support and facilitate the development of the Radiology workforce.

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[128] Organisation for Economic Co-operation and Development.
[129] https://www.gov.wales/sites/default/files/publications/2019-03/imaging-statement-of-intent.pdf

The Strategy for Developing a Radiology Workforce Model for Wales[130] sets out a total of 22 recommendations. The full strategy can be seen by following the link at the bottom of this page.

Diagnostic imaging reporting turnaround times

NHS England – Developed in consultation with and supported by The Royal College of Radiologists and The Society of Radiographers. The full document can be viewed by using the link at the bottom of the page[131].

The guidance seeks to reflect and codify existing best practice in reporting Turn Around Times (TATs).

The service has noted that they are currently not meeting the reporting times for CT, MR, and Plain Film scanning.

These are also highlighted in the NHS Wales Welsh Scientific Advisory Committee Guidance Document – Appendix G7 - Radiology - National Workstreams - Welsh Reporting Standards for Radiology Services that is due for renewal.

The document outlines seven standards, one of which details *"All imaging investigations must be reported in a timely manner that is appropriate to the patients' needs and clinical situations"*, along with guidance timescales.

Radiology activity data

Radiology service activity reported between 1 May 2019 and 31 July 2023 is included for the following sites:

- Withybush Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Bronglais Hospital
- Tenby Hospital
- Llandovery Hospital
- Cardigan Integrated Care Centre
- South Pembrokeshire Hospital.

There is also data present for several smaller locations across the Health Board that are referenced below. Activity for Werndale Hospital during the COVID-19 pandemic support has been included.

Radiology used a different date period from the other services within the Clinical Services Plan. This is because a new IT system was introduced in the Radiology service in May 2019 that consolidated several historic databases, and the inability to collate this historic data into one usable data set.

All data tables including the specific activities captured can be found in Appendix G8 – Radiology – Activity Data.

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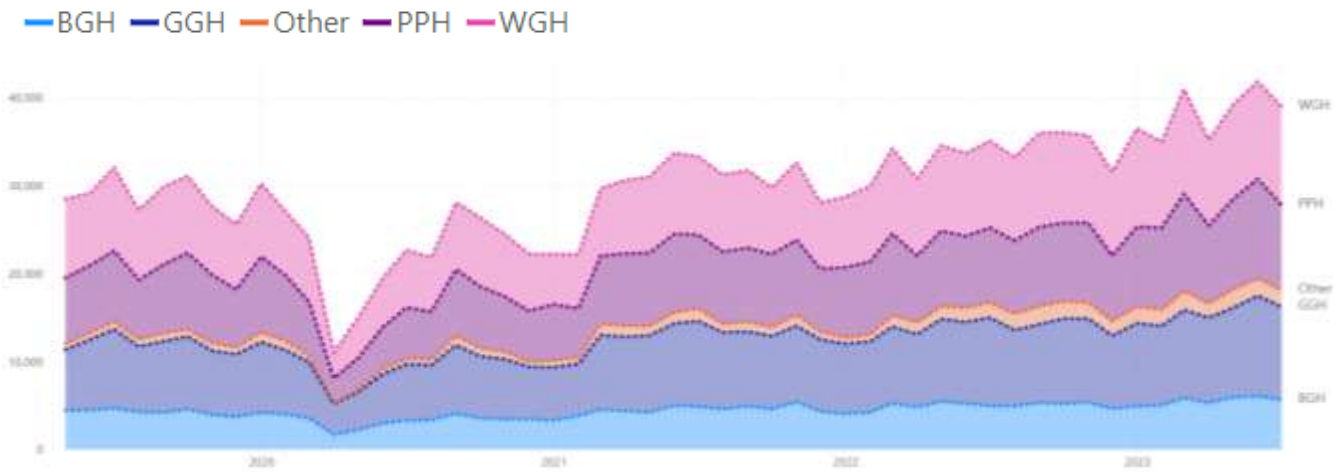
[130] *https://heiw.nhs.wales/files/strategy-for-developing-a-radiology-workforce-model-for-wales/*
[131] *https://www.england.nhs.uk/long-read/diagnostic-imaging-reporting-turnaround-times/*

The chart below shows, with the exception of the expected decline in activity during the COVID-19 pandemic, Radiology activity has gradually increased across the review period.

The chart key refers to the following sites:
BGH = Bronglais Hospital
GGH = Glangwili Hospital
PPH = Prince Philip Hospital
WGH = Withybush Hospital
Other = Cardigan Integrated Care Centre, Llandovery Hospital, Tenby Hospital, South Pembrokeshire Hospital, Amman Valley Hospital, Health Board, Machynlleth Hospital, Mynydd Mawr Hospital, Newtown Hospital, St Joseph's Hospital, Unknown, Werndale BMI Hospital



Activity data has been recorded across the following service sites: Withybush Hospital, Glangwili Hospital, Prince Philip Hospital, Bronglais Hospital, and other community sites such as Tenby, Llandovery, South Pembrokeshire Hospitals and Cardigan Integrated Care Centre. There is also activity recorded for several smaller sites across the Health Board, as well as some sites used during the COVID-19 pandemic.

The following table outlines the yearly (calendar year) totals across the Health Board sites within scope. The percentages are rounded to the nearest whole number:

Site	2019 (from 1 May)	2020	19/20 % change	2021	20/21 % change	2022	21/22 % change	2023 (to 31 July)	Total	% of Total*
Withybush Hospital	53872	74447	38%	98346	32%	116060	18%	75907	418632	28%
Glangwili Hospital	55062	73359	33%	100560	37%	108765	8%	71728	409474	27%
Prince Philip Hospital	53270	69157	30%	95140	38%	102349	8%	70266	390182	26%
Bronglais Hospital	30515	39045	28%	54444	39%	60421	11%	39373	223798	15%
Cardigan Integrated Care Centre / Cardigan and District Memorial Hospital	1313	3709	183%	5675	53%	9859	73%	6238	26794	2%
Tenby Hospital	3055	3421	12%	5181	51%	6385	23%	6147	24189	2%
Llandovery Hospital	552	390	-29%	1190	205%	1397	17%	671	4200	<1%
South Pembrokeshire Hospital	314	165	-47%	146	-12%	2	-99%	0	627	<1%

*Percentages have been rounded to the nearest number, so may not total 100%

Radiology activity was more heavily split across Withybush, Glangwili and Prince Philip hospitals. Withybush Hospital recorded 28% of overall activities, Glangwili Hospital recorded 27% and Prince Philip Hospital covered 26% of activities. Bronglais recorded 15% of activities.

The service has referenced the range of services offered at the larger sites, along with the provision of 24-hour services across Bronglais, Glangwili, Prince Philip and Withybush hospitals as the reasoning behind the activity totals. The background section and the modalities table references this.

The data table above shows that activity across the service has increased year on year since 2019. For the three sites with the highest levels of activity, Withybush Hospital, Glangwili Hospital and Prince Philip Hospital, activity has risen significantly with all sites experiencing rises of over 30% across 2019/2020 and 2020/2021 with additional rises coming in the 2022/2023 period. There was a reduction in activity across these sites during the months of April 2020 and May 2020 with their lowest levels of activity, but this is expected due to the COVID-19 pandemic.

Activity levels have also increased across other smaller sites within the service during the review period, apart from at South Pembrokeshire Hospital. The decline of activity from South Pembrokeshire Hospital can be explained by a failure in the site's X-ray equipment and staffing issues.

The service has highlighted several reasons for the increase in activity across Radiology. These include the increase in demand that is brought on them through increases in other services' activity

and other service changes that result in a heavier reliance or use of Radiology services. This is inclusive of any new pathways of care that directly impact the use of Radiology services.

The service has also highlighted the increase in demand that has come from the introduction of Same Day Emergency Care (SDEC). SDEC is classed as Accident and Emergency and as it is relatively new it is not currently coded within the Datix[132] system and so is not reportable. The increase of this volume and the urgency of these activities negatively affects the number of non-emergency appointments that can be scheduled for patients. This results in an increase in the patients wait for an appointment.

Other Radiology sites with recorded activity are outlined in the below table:

Site	2019 (from 01 May)	2020	2021	2022	2023 (to 31 July)	Total
Amman Valley Hospital	25	58	9	0	0	**92**
Health Board	1196	1	2	0	2	**1201**
Machynlleth Hospital	372	432	935	809	607	**3155**
Mynydd Mawr Hospital	1	1	3	2	0	**7**
Newtown Hospital	0	1	0	0	3	**4**
St Joseph's Hospital	0	0	17	113	0	**130**
Unknown	16	0	0	2	17	**35**
Werndale BMI Hospital	298	207	5	0	0	**510**

The rationale below explains why the sites listed in the table have been recorded for Radiology activity:

- Amman Valley – this site previously offered an X-ray service through a portable X-ray unit. This service has not been available on the site since 2021 and explains why there is a lack of activity listed. Some of the more recent records (2019) could also be due to data entry errors. There is a financial code within the system for Amman Valley but there is not a room code. When no room code is added the financial code is used, which could have been selected in error
- Mynydd Mawr – this is a 15-bed rehabilitation unit in Prince Philip Hospital. The allocation of records against this site could also be a data entry error
- St Josephs have been used to offer Cardiac CT support. Hywel Dda did not carry out the scanning for these or report against them but are added into the system when they are brought back into the service to ensure clinicians have access to the reports
- Werndale was used during the COVID-19 pandemic to support MRI and CT scanning
- Machynlleth is a site that the service supports with Plain Film reporting in line with the current SLA[133].

Activity data included above does not highlight another SLA (contracts) that are in place with Swansea Bay University Health Board, which are used for the provision of Dexa scanning through a mobile unit. The service provides some services on site, and there is also an SLA with Swansea Bay that utilises a mobile unit to support those patients located in the south. The mobile unit operates from Prince Philip, Withybush and Glangwili hospitals.

[132] *Datix Cymru (the Once for Wales Concerns Management System).*
[133] *SLA: Service level agreement – a contract between organisations.*

Radiology incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints and patient claims that have been recorded against Radiology. Full data for incidents and complaints can be found in Appendix G9 – Radiology – Incidents Data and Appendix G10 – Radiology – Complaints Data.

Patient safety incidents

The table below shows the overall number of recorded incidents for Radiology across all sites within the Health Board. The recording period for each year within the review period is by calendar year, recording partial years where applicable.

Year	2018 (1st August – 31st December)	2019	2020	2021	2022	2023 (to 31st July)
Number of incidents	70	150	156	189	205	129

The change in the incident recording system means that there are two recording periods, January 2019 to end of March 2021 and April 2021 to end of July 2023.

The data shown in the table below shows the number of incidents as a percentage of the overall incidents reported. For example, Glangwili Hospital had 31% of all recorded incidents over the total review period.

The total number of incidents reported in Radiology across all Health Board sites is 769 incidents.

Primary Location	Number of incidents 1 August 2018 - 31 March 2021	Number of incidents 1 April 2021 - 31 July 2023	Percentage of reported incidents*
Glangwili Hospital	130	146	31%
Withybush Hospital	105	167	30%
Bronglais Hospital	106	105	23%
Prince Philip Hospital	86	52	15%
Llandovery Hospital	1	0	0%
Public Place	0	1	0%

*Percentages have been rounded to the nearest number, so may not total 100%

The data shown in the table below shows the number of incidents as a percentage of the overall activity. For example, Glangwili Hospital had 27% of the overall activity (the number of patients using the Radiology service) with 31% of the recorded incidents.

The total number of activities across all Health Board sites is 1,442,713. The total number of incidents reported in Radiology services across all sites is 899 incidents.

Site	Percent of all activity	Percent of reported incidents (899)
Glangwili Hospital	27% (409,474)	31% (276)
Withybush Hospital	28% (418,632)	30% (272)
Bronglais Hospital	15% (223,798)	23% (211)
Prince Philip Hospital	26% (390,182)	15% (138)
Llandovery Hospital	<1% (627)	0% (1)

The breakdown of data per site is expected as the data is proportionate to the sites with the higher activity. Those with higher activity are reporting the higher number of incidents. Radiology activity was more heavily split across Withybush, Glangwili and Prince Philip Hospitals. Withybush Hospital recorded 28% of overall activities, Glangwili Hospital recorded 27% and Prince Philip Hospital covered 26% of activities.

The service has highlighted variations in reporting processes and reporting culture across sites as potential reasons for the slight variation in the percentage of incidents against the levels of activity per site. The remoteness of Bronglais compared to other service sites and the potential need to relocate to other sites due to equipment downtime could also be a reason behind increased Incidents.

Reported incidents were assigned to a range of Incident Types with the following allocated more than 100 times over the 5-year period:

- Diagnostic Processes/Procedures (2018-2021 incidents)
- Medication/Biologics/Fluids (2018-2021 incidents)
- Treatment, Procedure (2021-2023 incidents)
- Assessment, Investigation, Diagnosis (2021-2023 incidents).

Across the 5-year period the following table shows the most reoccurring incident types:

Reported 1 August 2018 – 31 March 2021	Total
Diagnostic Processes/Procedures	**166**
Medication/Biologics/Fluids	**106**
Documentation	**25**
Patient Accidents/Falls	**25**
Accidents/Falls	**21**

Reported 1 April 2021 – 31 July 2023	Total
Treatment, Procedure	**159**
Assessment, Investigation, Diagnosis	**136**
Accident, Injury	**55**
Behaviour (including violence and aggression)	**23**
Equipment, Devices	**22**

The breakdown of data by Incident Type highlights service issues around reporting and diagnosis. The service states that staff shortages contribute to these delays in the reporting process,

shortages that are evidenced in the workforce section of the Issues Paper. The service also states that it does not have the workforce to extend working times to allow additional use of the equipment they have at their disposal which would ease some of the demand pressures they face. Staff shortages, along with the evidenced increase in activity is resulting in significant reporting delays.

As a result of delays in reporting, elements of this process within the service are being outsourced to external providers. The workforce data references the use of Everlight[134] where reporting is undertaken externally to support service demand.

The service has highlighted that some of their services could be offered for longer periods of the day, but their workforce challenges will not allow this. The service has highlighted that Ultrasound, CT and MRI are offered as a 12-hour service in some sites but that there is wasted capacity as far as the use of equipment is concerned after 5pm in many areas of the service.

The below table shows the severity of recorded incidents.

Severity	Totals	% of Total
1 - None	**398**	**44%**
2 – Low Harm	**398**	**44%**
3 – Moderate Harm	**87**	**9%**
4 – Severe Harm	**13**	**1%**
5 – Catastrophic Death	**3**	**<1%**

Radiology patient complaints

The table below shows the overall number of complaints within Radiology across all Health Board sites. The recording period for each year within the review period is by calendar year, recording partial years where applicable.

Across the review period there were a total of 298 complaints recorded against the Radiology service. Of those recorded 153 were recorded between 1 August 2018 and 31 March 2021 with the remaining 145 being recorded within the Datix system post April 2021 until the end of the review period of 31 July 2023.

Year	2018 (1st August – 31st December)	2019	2020	2021	2022	2023 (to 31st July)
Number of complaints	19	55	68	52	80	24

Complaints data shows that complaints reported have been increasing in volume over the review period. Looking at full year data sets there was a 24% rise in reported complaints for 2019-2020. The number of complaints did drop during 2021 before rising again at the end of 2022 by 54%. The rise in reported complaints is indicative of the increase in service activity which is outlined further in the activity data section of the Issues Paper.

[134] *Everlight Radiology is an external company that provide an after-hours reporting service to the Health Board through tele-radiology.*

The highest number of complaints were recorded for Glangwili Hospital. This would be expected as it is one of the largest sites for service activity. Of the complaints recorded a total of 97 were recorded against Glangwili with 43 of those recorded in the pre-April 2021 dataset and 54 recorded within the current Datix system.

The following table outlines the further breakdown across service sites. Where locations are not included it indicates no recorded complaints took place at that location.

Primary Location	1 August 2018 – 31 March 2021	1 April 2021 – 31 July 2023	Percent of Reported Complaints*
Glangwili Hospital	43	54	33%
Prince Philip Hospital	44	42	29%
Withybush Hospital	35	27	21%
Bronglais Hospital	28	22	17%

*Percentages have been rounded to the nearest number, so may not total 100%

The table below shows the number of complaints reported between 1 August 2018 and 31 July 2023, as a percentage of the overall activity by each hospital.

Site	Percent of all activity	Percent of reported complaints (298)
Glangwili Hospital	27% (409,474)	33% (97)
Prince Philip Hospital	26% (390,182)	29% (86)
Withybush Hospital	28% (418,632)	21% (63)
Bronglais Hospital	15% (223,798)	17% (50)

The breakdown of data per site is in line with what would be expected as the data is proportionate to the sites with the higher activity. Those with higher activity are reporting the higher number of complaints. Radiology activity was more heavily split across Withybush, Glangwili and Prince Philip hospitals. Withybush Hospital recorded 28% of overall activities, Glangwili Hospital recorded 27% and Prince Philip Hospital covered 26% of activities.

Reported complaints were assigned to a range of Complaint Types with the following allocated more than 10 times over the 5-year period:

- Appointments
- Clinical treatment/Assessment
- Test and Investigation Results
- Communication Issues (including language)
- Attitude/Behaviour.

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category:

Reported 1 August 2018 – 31 March 2021	Total
Appointments	**37**
Clinical treatment / assessment	**29**
Test and investigation results	**23**
Communication issues (including language)	**17**
Attitude / behaviour	**15**

Reported 1 April 2021 – 31 July 2023	Total
Clinical treatment/Assessment	**34**
Test and investigation results	**30**
Attitude and Behaviour	**26**
Appointments	**25**
Communication issues (including language)	**11**

The service has stated that issues around the Complaint Type are, like those listed within the incidents, around delays in reporting due to staff shortages. The Complaint Type around Appointments is expected because there are currently increasing waits month by month where the wait is over 8 weeks.

The below table shows the severity levels of complaints within Radiology.

Severity	Totals	%of Total
Grade 1 Minor (informal)	144	48%
Grade 2 Minor	51	17%
Grade 3 Moderate	27	9%
Grade 4 Major	15	5%
Grade 5 Catastrophic	2	<1%

Radiology claims

The information below sets out the details of the closed claims where liability was accepted by the Health Board and learning was identified that had to be taken forward during the period in question. Also set out below are the open (confirmed) claims within the period which are subject to ongoing investigation.

During the period 1 August 2018 to 31 July 2023, Hywel Dda closed eight cases, and there are three confirmed cases under investigation.

Radiology Claims data is as follows:

- Prince Philip Hospital
    - 8 closed Radiology cases
    - 1 confirmed case under investigation
- Bronglais Hospital – 2 confirmed cases
- Withybush Hospital and Glangwili Hospital had no claims under the set criteria.

The themes across these are standards or delays in reporting.

These are direct claims against Radiology, but the service could be noted in other claims that cover multiple services as Radiology is part of the pathway of care.

Radiology patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix G11 – Radiology – Patient Experience and Compliments Data.

Overall, for the review period of 1 April 2021 to 31 July 2023 there were a total of 21 records from the All Wales Patient Experience dataset that were assigned to Radiology. Of these records, 10 were recorded in 2022 and 11 were recorded in 2023. There were no records for 2021. Of the 21 All Wales Patient Experience records a total of 86% gave a rating of 10 out of 10 (10 being excellent) for their overall experience of using the service. Of the remaining ratings 6% gave a 9/10 rating, 5% gave an 8/10 rating, 2% gave a 3/10 rating and 1% gave a 2/10 rating.

Data was also analysed from the services Friends and Family survey. There were 47 records assigned to Radiology for the period being reviewed. Of those 47 records 96% gave a “Very Good” rating when asked “How was your experience in this department” and the remaining 4% gave a “Good” rating.

There were minimal Compliments recorded on the system with only 2 recorded across the review period.

The below thematic analysis has been carried out on the feedback received from Patient Experience, Friends and Family Experience and Compliments that have been recorded each year since 2021:

	Patient Experience	Friends and Family Experience	Compliments
2021	None recorded	None recorded	None recorded
2022	The themes arising relate to the staff and the way the procedures were undertaken. Patients speak very highly of staff members kindness, caring and effort to protect patient dignity while remaining professional. Negative experiences relate to appointment cancellations and some patients not being aware of what would happen during the procedure or staff not introducing themselves or their purpose during the procedure.	The themes arising were all positive, focusing on the kind, caring and friendly staff who provided comfort to patients while providing high quality care and good communication throughout the procedure.	None recorded
2023	The themes arising relate to the staff and the way the procedures were undertaken. Patients speak very highly of staff members kindness, caring and effort to protect patient dignity while remaining professional. Negative experiences relate to appointment cancellations and some patients not being aware of what would happen during the procedure or	The themes arising were all positive, focusing on the kind, caring and friendly staff who provided comfort to patients while providing high quality care and good communication throughout the procedure.	Themes arising are that staff were helpful and supportive of people with disabilities, providing person centred care and treating them with dignity to make them feel

	staff not introducing themselves or their purpose during the procedure.		comfortable throughout procedures.

The Radiology service is not currently listed on the system as a standalone service, so service users do not receive the survey link which would explain low numbers compared to the levels of activity within the service. Due to the way Radiology patients are recorded and the systems that those records are linked to, surveys are only sent out to patients as part of being seen through other services.

The Radiology service forms part of the overall patient journey alongside other services. As patients often spend most of their time within those other services it is possible that positive experiences from a Radiology perspective are collated within other Compliment records.

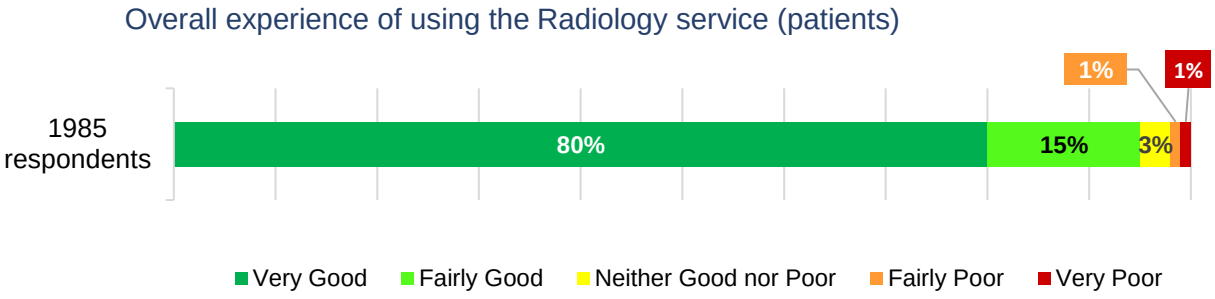
Radiology targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

A randomly selected sample of patients who accessed Radiology services within the last five years (1 August 2018-31 July 2023) were invited to take part in a survey. 29,854 patients were sent an invitation, and 2,029 responses were received, giving a response rate of 6.79%. 28% of respondents accessed most of their Radiology care at Glangwili Hospital, 24% at Withybush Hospital, and 22% at Prince Philip Hospital. A smaller proportion accessed services at Bronglais Hospital (13%) or other clinical sites.

The Radiology service patient demographic is mixed, as equalities information collected suggests. This is broadly reflected in the profile of respondents to the patient survey; however, 69% of respondents were women. Tables showing the full profile breakdown of respondents are included in the full report.

95% of patient respondents said that their experience of using the Radiology service was good, whereas 3% said it was poor.



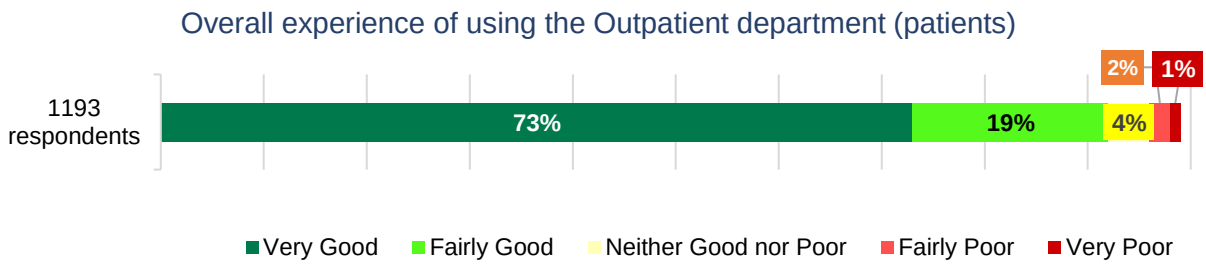
In terms of what was good about their experience of using the Radiology service, patients mainly praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care. Some, though, complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis).

The main improvements to Radiology services as suggested by survey respondents were around speed and efficiency (including shortening waiting times and not cancelling appointments); communication (including better explanations of tests, results, and treatments, and increased

frequency of contact and follow up); and improvements to hospital environments. It should be noted, though, that 39% of respondents felt that no improvements are required.

Experiences of Outpatient services

74% of patient respondents said they used the Outpatient department as part of their Radiology treatment. Of these, 92% said their experience of doing so was good and 3% said it was poor.



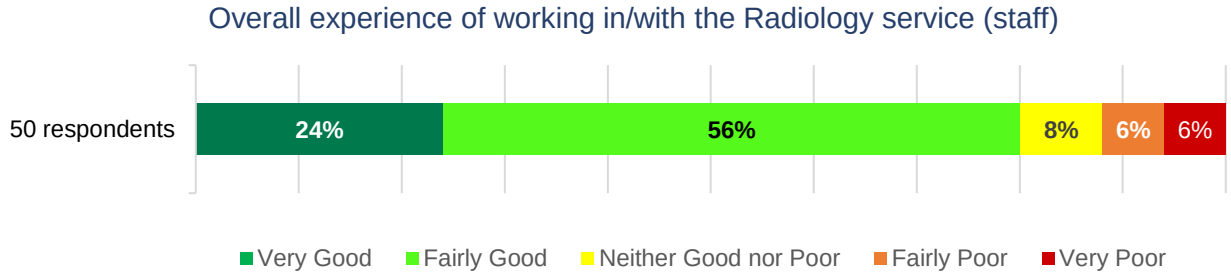
When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent positive comments related to receiving a generally good, quick, and efficient service; and the professional, kind, reassuring, and helpful staff. The most frequent negative comments were around service speed and efficiency (including access to appointments, tests, and results).

Radiology targeted early engagement with staff

A survey was sent to Medical, Nursing, Therapy, Operational and Support staff. Staff members were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS, to understand the key issues and themes. The main findings from this report are noted below.

All staff currently working in, or supporting staff working in, the Radiology service were invited to take part in a survey: 50 responses were received. Respondents' main clinical base is/was Bronglais Hospital (19 respondents), Withybush Hospital (13 respondents), Glangwili Hospital (10 respondents), and Prince Philip Hospital (six respondents). Two respondents did not identify their main hospital base.

80% of staff respondents said that their overall experience of working in/with the Radiology service was good, whereas 12% said it was poor.



In terms of what is/was good about their experience of working in/with the Radiology service, staff respondents highlighted the friendly, supportive, helpful, responsive, kind, and compassionate team; the willingness of employees to share their knowledge with others, and to learn and adapt to changing circumstances; positive teamworking and good working relationships within the team and with other departments/services; the willingness of staff to go above and beyond to provide

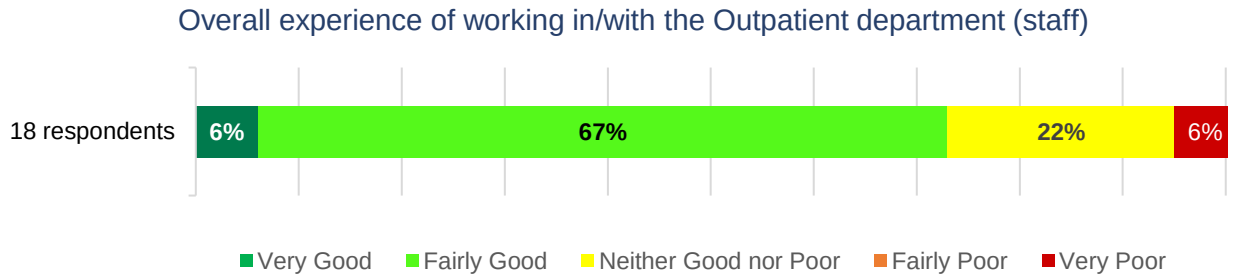
excellent, compassionate, and timely patient care; and positive management changes that have resulted in improved departmental structure and support and more and better opportunities for training and development.

As for what is/was difficult about their experience of working in/with the Radiology service, the most prevalent issues raised were around staff shortages, heavy workloads, and poor work-life balance. These were thought to have a detrimental impact on patient care, particularly in relation to long waits for tests and appointments, and lengthy reporting times. Other stated challenges were around radiographers having to undertake multiple duties in addition to their core roles, taking their focus away from their primary responsibilities; increasing numbers of sometimes unnecessary Radiology requests from clinicians; ineffective communication between delivery staff and managers within the service, and micromanagement and a lack of support on the part of the latter; a lack of staff input into decision-making; and outdated working environments, equipment, and processes.

Most staff suggested ways to improve their experience of working in/with the Radiology service. The most common were to improve staff recruitment, retention, and capacity; provide funding to upgrade and provide new equipment; and encourage more open communication and engagement between Health Board/service managers and delivery staff to improve working relationships and ensure the latter have a say in decision-making. Other suggestions were around more and better management training, and selection and interview processes for management staff; managers praising good work, while also taking action to tackle poor behaviours; the need for information and training for clinicians to manage the issue of increasing Radiology requests and referrals; and moving from a paper-based to a fully digital system.

Experiences of Outpatient services

Around a third of the 50 staff survey respondents use the Outpatient department in delivering their Radiology services. Of these, 72% (13 respondents) said that their overall experience of the Outpatient department was good. Only one respondent (6%) said it was very poor.



Staff respondents praised Outpatient staff for being hard-working, polite, organised, and caring; and liaison with Radiology was said to be good overall. However, a few specific complaints were made around patients being given “misinformation” about Radiology by Outpatient staff; Outpatients being sent to Radiology all at once (at Withybush Hospital), as clinics are all held on the same day; improperly completed request forms; and poor-quality referrals for radiological imaging.

Radiology finance

The below table indicates the key cost drivers[135] affecting service delivery budgets within Radiology.

All services will be affected by the general statement below. In addition to this any identified key cost driver within specific services have also been articulated.

This information is aligned to the findings and submissions within the 2024/2025 annual planning.

Service	Key Cost Drivers
General	Services provided over multiple sites Vacancies filled with premium costs or additional hours
Radiology	Vacancies filled by locums[136] and outsourcing of scan reporting

The forecast outturn overspend for 2023/24 is £0.4m for Radiology. Given the reliance on variable pay solutions there is a pressure from agency premium cost and locum posts £0.410m in excess of vacancies. There are also a range of non-pay cost pressures being borne by the service including commissioning arrangements additional capacity through both insourcing and Swansea Bay for specialist support, also ongoing maintenance, and consumable cost pressures.

Long term there is a reliance on outsourcing capacity, whilst there is a funding stream currently this is not confirmed recurrently and would pose a £1m pressure long term if the activity is maintained without a funding stream. Also, there is a new national system being implemented which will incur cost of £0.360m. The full Finance information can be found in Appendix A12 – CSP – Finance.

Radiology workforce

The Workforce team have supplied data within defined cost codes provided by Radiology. Full details about the methodology can be found within Appendix G13 – Radiology – Workforce Data.

The table below shows the workforce establishment (number of people working) across our hospital sites within Radiology services on 31 July 2023. The table shows the primary site for the workforce and therefore doesn't include some of the sires within scope.

[135] Cost drivers are the direct cause of an expense. A cost driver is any activity that triggers the cost of something else.
[136] A Locum is a doctor who temporarily fills vacancies in a hospital, usually recruited through an agency.

Role	Location /Site						
	Bronglais Hospital	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Cardigan Integrated Care Centre	South Pembrokeshire Hospital	Total
Technician		1.6					1.6
Add Prof Scientific and Technic Total		**1.6**					**1.6**
Assistant	6.9	14.5	7.0	9.8	1.0		39.2
Assistant or Associate Practitioner	2.8		3.0				5.8
Technician				1.6			1.6
Additional Clinical Services Total	**9.7**	**14.5**	**10.0**	**11.4**	**1.0**		**46.6**
Clerical Worker	2.8	6.8	1.0	6.0		0.9	17.4
Manager	1.0	1.6					2.6
Medical Secretary		2.5	2.6	1.0			6.1
Officer	1.0			1.0			2.0
Personal Assistant				1.0			1.0
Receptionist			3.0				3.0
Secretary	1.7						1.7
Administrative and Clerical Total	**6.5**	**10.8**	**6.6**	**9.0**		**0.9**	**33.8**
Radiographer - Diagnostic	16.4	35.3	29.7	22.2	1.0		104.6
Radiographer - Diagnostic Advanced Practitioner		1.4					1.4
Radiographer - Diagnostic, Consultant	1.0						1.0
Radiographer - Diagnostic, Manager	3.0		1.0	4.2			8.2
Radiographer - Diagnostic, Specialist Practitioner	2.4		3.4	1.0			6.8
Superintendent Sonographer		1.0	0.8				1.8
Senior Sonographer		0.9					0.9
Reporting Sonographer		2.9	0.8	2.8			6.6
Sonographer	2.7						2.7
Allied Health Professionals Total	**25.5**	**41.5**	**35.7**	**30.2**	**1.0**		**133.9**
Porter				2.7			2.7
Estates and Ancillary Total				**2.7**			**2.7**
Sonographer		0.4					0.4
Healthcare Scientists Total		**0.4**					**0.4**
Consultant	3.8	4.0	5.0	2.5			15.3
Specialist		1.0					1.0
Medical and Dental Total	**3.8**	**5.0**	**5.0**	**2.5**			**16.3**

Midwife Sonographer	0.2	1.0		1.0			0.2
Specialist Nurse		2.0					2.0
Staff Nurse	1.0		4.0	1.6			6.6
Nursing and Midwifery Registered Total	**1.2**	**3.0**	**4.0**	**2.6**			**10.8**
Total	**46.7**	**76.8**	**61.3**	**58.3**	**2.0**	**0.9**	**246.0**

The below table shows the current budget and staff in post. Budget refers to the agreed WTE[137] funding that is available to the service by staffing group.

	All Sites			Hospital					
Staff Group	**Budget**	**Actual**	**Vacancy**	**Bronglais**	**Glangwili**	**Prince Philip**	**Withybush**	**Cardigan Integrated Care Centre**	**Health Board wide**
Add Prof Scientific and Technical	0.8	1.6	(0.8)		(0.8)				
Additional Clinical Services	51.0	46.0	5.0		1.5	1.6	0.8	1.0	
Administrative and Clerical	36.7	33.8	2.8	1.9	0.1	0.5	0.3		
Allied Health Professionals	160.5	133.8	26.7	2.0	7.8	0.9	13.0		3.0
Estates and Ancillary	2.7	2.7	(0.0)						
Healthcare Scientists	0.8	0.4	0.4		0.4				
Medical and Dental	19.4	16.3	3.1	0.2	1.8	(1.0)	2.1		
Nursing and Midwifery Registered	9.2	9.8	(0.6)	(0.2)	(0.4)				
Total	281.0	244.4	36.5	3.9	10.4	2.0	16.3	1.0	3.0

As of 31 July 2023, there was a total of 36.5WTE vacancies within the service, however, as can be seen two of these roles are not within the current budget, 0.8 WTE within Add Prof Scientific and Technical roles; 0.6WTE within Nursing and Midwifery Registered.

As expected for this service, the highest vacancies are within the Allied Health Professionals, 26.7WTE, the majority are across Glangwili and Withybush (7.8WTE and 13WTE).

During this period an average of 6WTE agency Radiologists and a minimum of 15WTE agency Radiographers and Sonographers were being utilised on average across Radiology services. For Nursing and Additional clinical services roles an additional 2.22WTE a week of additional temporary staffing was utilised. 1.54WTE were through Bank usage with the remainder from contracted agency. This equates to a minimum of 23.22WTE additional temporary workforce being utilised to fill the vacancy gap.

[137] *WTE stands for Whole Time Equivalent. 1 WTE is one full time staff member doing 37.5 hours a week.*

Staff Group	2018	2019	% change	2020	% change	2021	% change	2022	% change	2023	% change	Jul-23	% change
Add Prof Scientific and Technical	1.6	1.6	0	1.6	0	1.8	13	1.6	-11	1.6	0	1.6	0
Additional Clinical Services	26.2	28.2	8	46.1	63	32.3	-30	39.1	21	42.5	9	46.6	10
Administrative & Clerical	29.2	30.1	3	33.8	12	30.5	-10	35.5	16	34	-4	33.8	-1
Allied Health Professionals	121.3	121.4	0	136.8	13	118.4	-13	123.4	4	132.6	7	133.9	1
Estates And Ancillary	2.7	2.7	0	2.7	0	2.7	0%	1.7	-37	2.7	59	2.7	0
Healthcare Scientists	0	0		0.4		0	-100	0		0.4		0.4	0
Medical And Dental	11	12.6	15	16.3	29	13	-20	16	23	14.5	-9	16.3	12
Nursing And Midwifery Registered	8.2	8.6	5	11.6	35	10	-14	11.4	14	10.8	-5	10.8	0
Totals	200.2	205.1	2	249.4	22	208.7	-16	228.7	10	239.0	5	246.0	3

The service noted the difference between substantive[138] consultants and locum consultants. The requirements for these are different with substantive consultants required to undertake additional duties compared to that of a locum.

The service has highlighted that they could be over established in Assistant Practitioners and Technicians which could portray a misrepresentation of staff in the required positions. During the COVID-19 pandemic the inability to recruit Radiographers resulted in those vacancies being filled with Assistant roles.

Historic workforce position

The following table outlines the historical position of Radiology staff across the review period:

The data outlines a rise in numbers during 2019/2020. During this period there were a lot of movements across positions within the service, brought about from a large number of retirements. This narrative is supported within the leavers data outlined below.

The rise in workforce during this period could also be explained by the increased number of fixed term contracts provided to assistants to support the required new ways of working through the COVID-19 pandemic.

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[138] *Substantive means the role in which an employee has been permanently appointed.*

The service also suggests that increased workforce figures across this period could be because of COVID-19 delaying the recruitment process.

An increase in workforce can be seen in 2020 of 44.3WTE however this was followed with a significant decrease to the service in 2021 of 40.7WTE. The workforce has increased to 246WTE as of 31 July 2023.

Within the Allied Health Professionals group it is often the case that staff will upskill and progress through service roles to more advanced roles to meet the needs of the service where there are fragilities. For example, CT head reporting and Plain Film reporting.

The data shows an overall increase of 22% in workforce across the review period.

When comparing the workforce position against Radiology activity it is evidenced that the workforce has not increased to meet the rise in activity. When looking at the three full calendar years of activity, levels increased by 37%. Over the same period, workforce figures peaked in 2020 with a total of 249.4 members of staff. This has decreased over time and at the end of the review period the service establishment was at 246.

The service highlighted other service changes and additional demands such as Same Day Emergency Care as drivers behind activity increases and that the needs of Radiology are not always considered in these changes with the workforce not being amended to meet those additional demands.

The breakdown of starters and leavers across the review period can be seen below:

Staff Group	2018	2019	2020	2021	2022	2023	Total
Starters	11.6	22.8	21.8	23.7	29.1	6.8	**115.8**
Leavers	11.1	24	23.5	13.5	21.2	4.9	**98.2**

The largest increase in new starters was seen in 2022 with 29.1WTE starting, the majority in Glangwili Hospital (10.1WTE).

The highest number of leavers were recorded in 2019 and 2020 with 24WTE and 23.5WTE leaving respectively each year. Most leavers across Radiology have been within the Allied Health Professional staff group.

During 2019 and 2020 the service lost more staff than it gained.

Targeted campaigns across the period 2018 – 2023

No targeted recruitment campaigns were noted during the period for Radiology however online enhancements were placed in the British Medical Journal for all the locum posts advertised below.

Vacancy Information (last 12 months)	Role	Outcome
100-MED-GGH-189	Consultant Radiologist	2 WTE Advertised – 1 started in post

100-MED-WGH-121-L	Locum Consultant General Radiology Non Vascular Intervention Interest	1 WTE – 1 offer made but withdrew due to change of circumstances
100-MED-WGH-115-L	Locum Consultant Radiologist with an interest in Breast Radiology	1 WTE – 1 candidate rejected after interview
100-MED-PPH-085-L	Locum Consultant Radiologist with an interest in Head & Neck Radiology	1 WTE – 1 application withdrawn and another did not show at interview
100-MED-WGH-115-L1	Locum Consultant Radiologist with an interest in Breast Radiology	1 WTE – 3 applications received, 1 offer made but candidate withdrew due to change of circumstances
100-MED-WGH-121-L1	Locum Consultant in General Radiology Non Vascular Intervention Interest	1 WTE – 0 applications received
100-MED-PPH-085-L1	Locum Consultant Radiologist with an interest in Head & Neck Radiology	1 WTE – 2 rejected, 1 offer made but withdrew
100-MED-GGH-287-L	Locum Consultant in Radiology – Cross Sectional Imaging	4 WTE advertised – 5 applications to be interviewed

Headhunting

The below table outlines the headhunting activities carried out:

Role	Outcome
Locum Consultant with interest in breast Radiology	30 candidates headhunted via LinkedIn. 4 responses interested in coming to Wales. 1 CV sent to service and interview was arranged 5 May 2023. Doctor was unsuccessful at consultant level but offered lower grade to work up to consultant level - chased doctor for an update but lost contact with us
Locum Consultant Radiologist with an interest in Head & Neck Radiology	10 doctors headhunted via LinkedIn - No interest
Locum Consultant General Radiology with an interest in Non-Vascular Intervention	5 doctors headhunted - No interest. Very difficult to headhunt for intervention

Workforce risks

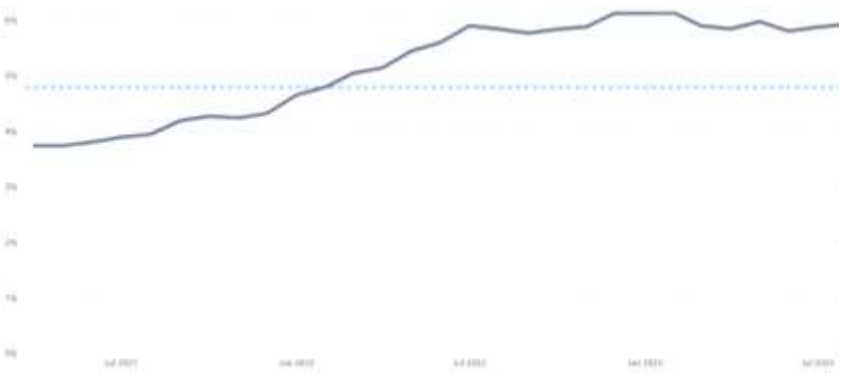
Workforce have highlighted nine risks relating to Radiology. These risks are summarised below:

- Risk of avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care. Increases in diagnostic waiting time breaches and cancer pathway breaches caused by unavailability of consultants in specialised areas
- Risk of delay in diagnosis, not achieving 8-week diagnostic waits, increased inpatient Length of Stay (LOS) and inability to achieve cancer pathway targets caused by increased demand for CT, MRI, Ultrasound and Nuclear Medicine which exceeds current capacity and

staffing to deliver. Establishment of Radiology staff and Radiologists has not increased with demand

- Risk of not receiving out of hours service caused by on call being a voluntary rota and additional to basic working hours, exacerbated by staff shortages due to vacancies and illness and long-term sickness
- Loss of Radiology at community sites in Pembrokeshire caused by the need to centralise Radiology services at Withybush Hospital by withdrawing X-Ray services at both Tenby Hospital and South Pembrokeshire Hospital to provide a safer service because of critical staff shortages
- Failure to deliver Ultrasound Service at Withybush
- Risk of IRMER non-compliance caused by a lack of dedicated Quality Lead
- Risk of the inability to provide a quality and timely service across the Radiology directorate, and a detrimental impact on staff morale and welfare caused by under-established workforce within the directorate
- Risk of Repetitive Strain Injury in Sonographers caused by a national shortage in Sonographers
- Risk of being unable to undertake Obstetric scanning at Bronglais Hospital caused by ageing equipment. Patients would need to be relocated to alternative acute sites across the Health Board, adding to existing pressures on Sonography services, resulting in additional stress and a negative impact on staff welfare for Sonographers undertaking obstetric scans.

Workforce risks highlight staff sicknesses as having an impact. The below chart supports this, showing the service's overall increase in sickness to a level above that of the target. The below chart outlines Radiology sickness levels on a 12-month rolling basis against the Health Board target:



--- target 4.79%

External reporting

To overcome staffing shortfalls Radiology have used an external provider to support with reporting.

Everlight Radiology is an external company that provide an after-hours reporting service to the Health Board through tele-radiology. Images are taken at the hospital site and then transmitted to Everlight to enable specialist Radiologists to undertake the reporting and diagnosis element when an on-site consultant Radiologist is not available. This service is generally utilised between the hours of 5pm and 9am on weekdays and may be used across the weekends from 5pm on Friday to 9am on Monday. Most of the activity takes place between 5pm to 11:30pm.

During 2022/23 Everlight undertook 37,375 tele-radiology reports for the Health Board, demonstrating the challenges faced in the service to manage growing demand. This relates to reporting only and does not reflect the current job plans of substantive staff. However, based on

previous (and current) Everlight usage it is evident that there is a workforce gap in the Radiologist workforce, and it is anticipated that a number of additional Consultant Radiologists would be required to meet demand.

The service has highlighted that workforce shortages have resulted in the inability to offer the 7-day service which is needed to meet the increasing demands they face. The service has highlighted that being able to maintain the shift system will allow for a better work-life balance for staff. Staff are currently working additional hours to cover staff shortages, outside of their contracted hours which is having a negative impact on their morale and wellbeing.

Radiology conclusions

Radiology is in the Clinical Services Plan to support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients.

The service operates across Withybush Hospital, Glangwili Hospital, Prince Philip Hospital, Bronglais Hospital, Tenby Hospital, Llandovery Hospital, Cardigan Integrated Care Centre, and South Pembrokeshire Hospital.

A summary of the findings identified within this paper are as follows:

Service changes

There have been no service changes in Radiology for the review period.

Risks

- There have been three identified risks. Two of these are relating to staffing issues, particularly the recruitment of Sonographers. The other highlighted risk is relating to equipment upgrades.

Clinical effectiveness

- Major Trauma and Metastatic Cord Compression requires an increase in service hours to MRI 24 hours a day, 7 days a week.
- All the standards are difficult to achieve due to staffing numbers and equipment numbers, particularly cancer diagnosis and emergency conditions. Lack of Sonographers has made the DVT guidance extremely challenging to follow.
- All standards identified have a reliance on Radiology being able to perform when they are unable to or unable to fully comply. This means that the standards cannot be adhered to.

Local, regional and national work

- ARCH - The ARCH review for Radiology has begun but is at an early stage and no recommendations will be developed to inform this Issues Paper
- GIRFT - There is no GIRFT report for Radiology in Wales but there is a Radiology – GIRFT Programme National Speciality Report for NHS England. The report outlines a total of 20 recommendations.

National work

- Diagnostics: Recovery and Renewal - Report of the Independent Review of Diagnostics Services for NHS England

    - Independent review commissioned by NHS England and sets out a series of recommendations across 4 key areas, outlining a total of 24 recommendations
- Imaging Statement of Intent
    - Addresses the current challenges in diagnostic and therapeutic imaging in the Welsh National Health Service
- Building the NHS Wales Imaging Workforce Model - Strategy for Developing a Radiology Workforce Model for Wales
    - The 'Strategy for Developing a Radiology Workforce Model for Wales has been produced by the Imaging Workforce and Education Group (IWEG) in collaboration with Health Education and Improvement Wales (HEIW) and Radiology Services across NHS Wales
- Diagnostic imaging reporting turnaround times - NHS England – Developed in consultation with and supported by The Royal College of Radiologists and The Society of Radiographers
    - The guidance seeks to reflect and codify existing best practice in reporting TATs
    - The service has noted that they are currently not meeting the reporting times for CT, MR, and Plain Film scanning.

Activity data

- Withybush Hospital recorded 28% of overall activities, Glangwili Hospital recorded 27% and Prince Philip Hospital covered 26% of activities
- Activity across the service has increased over the review period
- At Withybush, Glangwili and Prince Philip hospitals, activity has risen significantly with all three sites experiencing rises of over 30% across 2019/2020 and 2020/2021 with additional rises coming in the 2022/2023 period
- Activity levels have also increased across other smaller sites, apart from at South Pembrokeshire Hospital. The reasons behind the decline in activity at this site have been outlined as equipment and staffing issues
- The service has highlighted several reasons for the increase including the increase in demand from other services' activity increases and other service changes, which is inclusive of any new pathways of care
- The service has also highlighted the increase in demand that has come from the introduction of Same Day Emergency Care (SDEC).

Incidents, complaints and claims

Incidents

- Incidents reported have been increasing in volume over the review period
- 44% of incidents were of a "1-None" rating
- The remaining incidents gradually decrease in volume as the severity increases
- Incident Types reported more than 100 times over the 5-year period:
    - Diagnostic Processes/Procedures (2018-2021 dataset)
    - Medication/Biologics/Fluids (2018-2021 dataset)
    - Treatment, Procedure (2021-2023 dataset)
    - Assessment, Investigation, Diagnosis (2021-2023 dataset)
- Most common incidents are related to reporting and diagnosis.

Complaints

- Complaints reported have been increasing in volume over the review period
- 48% of reported complaints were graded as "Grade 1 / Minor – Informal"
- The remaining complaints gradually decrease in volume as the grading increases

- Reported complaints were assigned to a range of Complaint Types with the following allocated more than 10 times over the 5-year period:
    - Appointments
    - Clinical treatment / Assessment
    - Test and Investigation Results
    - Communication Issues (including language)
    - Attitude / Behaviour.

Compliments

- There were minimal Compliments recorded with only two recorded across the review period.

Claims

- A total of eight closed cases
- A total of three confirmed cases under investigation
- Standard or delay in reporting was a theme.

Patient experience and compliments

- The common positive themes captured were that staff were kind, caring and friendly
- Negative experiences relate to appointment cancellations and some patients not being aware of what would happen during the procedure.

Targeted early engagement with service users

- Patients praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care
- Some complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis)
- The main improvements suggested were around speed and efficiency (including shortening waiting times and not cancelling appointments); communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up); and improvements to hospital environments.

Targeted early engagement with staff

- Staff respondents highlighted the friendly, supportive, helpful, responsive, kind, and compassionate team; the willingness of employees to share their knowledge with others, and to learn and adapt to changing circumstances
- Positive teamworking and good working relationships within the team and with other departments/services; the willingness of staff to go above and beyond to provide excellent, compassionate, and timely patient care
- Positive management changes that have resulted in improved departmental structure and support and more and better opportunities for training and development
- Most prevalent issues raised were around staff shortages, heavy workloads, and poor work-life balance
- Other stated challenges were around radiographers having to undertake multiple duties in addition to their core roles, taking their focus away from their primary responsibilities; increasing numbers of sometimes unnecessary Radiology requests from clinicians

- Ineffective communication between delivery staff and managers within the service, and micromanagement and a lack of support on the part of the latter; a lack of staff input into decision-making; and outdated working environments, equipment, and processes
- The most common suggested improvements were to improve staff recruitment, retention, and capacity; provide funding to upgrade and provide new equipment; and encourage more open communication and engagement between Health Board/service managers and delivery staff to improve working relationships and ensure the latter have a say in decision-making.

Finance

- Key cost drivers highlighted as vacancies filled by locums and outsourcing of scan reporting.

Workforce

- As of 31 July 2023:
    - There was a total of 36.5WTE vacancies
    - An average of 6WTE agency Radiologists
    - A minimum of 15WTE agency Radiographers and Sonographers
    - For Nursing and Additional clinical services roles an additional 2.22WTE a week of additional temporary staffing
    - 1.54WTE were through Bank usage with the remainder from contracted agency
    - This equates to a minimum of 23.22WTE additional temporary workforce being utilised to fill the vacancy gap
- Workforce has not increased to meet the rise in activity. When looking at the three full calendar years of Activity (2020-2022), Activity levels increased by 37%
- Workforce figures peaked in 2020 with a total of 249.4 members of staff. This has decreased over time and at the end of the review period the service establishment was at 246
- To overcome staffing shortfalls Radiology have used an external provider to support with reporting
    - During 2022/23 Everlight undertook 37,375 tele-radiology reports demonstrating the challenges faced in the service to manage growing demand.
    - Based on previous (and current) Everlight usage it is evident that there is a workforce gap, and it is anticipated that a number of additional Consultant Radiologists would be required to meet demand
- Staff wellbeing has been highlighted, sickness levels for the service has increased over the review period
- Workforce pressures are preventing services from being offered for longer periods of the day and there is wasted capacity as far as the use of equipment is concerned after 5pm in many areas of the service.

Radiology has surpassed pre COVID-19 levels of activity and any increases in other services' activity will impact the service further on an already stretched, understaffed service.

Corporate risks have been recorded around staffing and equipment upgrades. There are staffing shortages and recruiting difficulties across Radiology.

Activity has grown continuously over the review period. However, this growth has not been matched with an increase in workforce, for undertaking examinations, interventions and reporting of these studies.

Activity growth has been brought about through additional demands from other services and new pathways of care that have directly impacted the use of Radiology.

This has resulted in reporting delays, brought about from the increased activity and staff shortages. Increased reporting times are a direct result of staff undertaking additional duties to cover shortages, taking time away from primary duties, and not enough staff to run at desired times and to run all service equipment during those times.

This is evidenced with the increase in Incidents and Complaints that are directly related to reporting and diagnosis.

Staffing shortages have meant that a shift system and seven day working week cannot be implemented and therefore equipment is underutilised which would also lead to even further increased demand for reporting.

To overcome staff shortages the service is outsourcing reporting to external providers, as evidenced with Everlight data, and the use of agency/locum staff to cover shortfalls which both bring additional costs to the service.

Section 10: Dermatology

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

Section 10: Dermatology

Introduction and background

This chapter of the Issues Paper is about Dermatology services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Dermatology service at all sites within the Health Board that delivered Dermatology services between 1 August 2018 and 31 July 2023.

Dermatology service at Hywel Dda

Dermatology services focus on the diagnosis and treatment of diseases of the skin, hair, and nails in children, young people, and adults. The Dermatology pathway is defined as patients who receive care, typically following a referral into the service from their GP (doctor). The patient group covers all ages, all disabilities, all genders, and all ethnicities. Patients are seen as Outpatients,[139] and the Hywel Dda sites in scope of this project are:

- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen
- Withybush Hospital, Haverfordwest
- Cardigan Integrated Care Centre, Cardigan
- South Pembrokeshire Hospital, Pembroke Dock.

The sub-specialities[140] within the Dermatology service, as featured on the Welsh Patient Administration System (WPAS)[141] are detailed below:

Sub-speciality	Definition
Dermatology	**Lesions (Non-USC) (Non-Urgent Suspected Cancer) –** Skin lesions that are not cancerous, or are pre-cancerous/cancerous but referred as less urgent, and so do not follow the Urgent Suspected Cancer (USC) pathway. Examples of Non-Urgent Suspected Cancers are: Basal Cell Carcinoma (BCC), Actinic Keratoses, Bowen's disease **General Dermatology –** Inflammatory skin conditions **Psoriasis –** A common, long term skin condition that can come and go. It happens due to immune system over-activity **Acne –** A very common skin condition identified by the presence of comedones (blackheads and whiteheads) and pus-filled spots (pustules) **Biologics –** Patients who are receiving biologic treatments and require specific follow-up appointments in certain clinics **Paediatrics –** Children, by law, are those up to the age of 18 (however, from the age of 16, patients are usually cared for by 'adult' doctors, except in certain specialist cases) **Paediatrics Eczema –** A common skin condition that may start at any age, but the onset is often in childhood

[139] If you have an appointment in a hospital or clinic but do not need to stay overnight, it means you are being treated as an Outpatient or a Day Patient. You may be having an appointment for treatment, diagnosis, or a procedure (www.nhs.uk).
[140] A sub-speciality is a concentrated area of focus within a speciality (the speciality here is Dermatology).
[141] WPAS is the Welsh Patient Administration System. It is the primary source of administrative data for patients in a secondary care (hospital) setting, holding patient identification details, and recording details of patients' hospital visits, including waiting list management, medical records, Inpatient treatment, Outpatient appointments, and emergency visits (www.dhcw.nhs.wales).

	Teledermoscopy – Medical Photography staff take photographs of lesions (a specific criteria) in a clinic setting. These are then reviewed remotely by a Consultant Dermatologist.
Dermatology (USC) (Urgent Suspected Cancer)	Skin cancers are cancers that arise from the skin. They are due to the development of abnormal cells that can invade or spread to other parts of the body. Melanoma, Squamous Cell Carcinoma (SCC) and Keratoacanthoma are referred as Urgent Suspected Cancers. Also included are certain Basal Cell Carcinoma (BCC) positioned in significant areas where delayed removal would cause a significantly poor cosmetic outcome, or even become inoperable.
Dermatology (Minor Ops) (Minor Operations)	Either a complete removal of a skin lesion or just the removal of a small sample (biopsy).
Phototherapy	Ultraviolet B (UVB) Phototherapy delivers shortwave ultraviolet radiation to treat skin conditions such as Psoriasis.

Dermatology service model

These sub-specialities are dealt with across various sites within Hywel Dda, as detailed in the following table, which shows the position of the service on 31 July 2023:

	Prince Philip Hospital	Glangwili Hospital	Withybush Hospital	Cardigan Integrated Care Centre	South Pembrokeshire Hospital
Dermatology	X	X*			X**
Dermatology (USC) (Urgent Suspected Cancer)	X		X	X	
Dermatology (Minor Ops) (Minor Operations)	X		X		
Phototherapy					

* The service holds one clinic in Glangwili Hospital per week for General Dermatology. This clinic is run with a 'GPwER' – a 'GP with an Extended Role' in Dermatology.[142]

[142] *A GPwER in Dermatology is a 'GP with an Extended Role' in Dermatology. The national process of accrediting GPs as 'GPs with an Extended Role' is administered by the British Association of Dermatologists (BAD). This process replaced the previous term 'GPwSI' ('GPs with a Special Interest') in 2015. The British Association of Dermatologists, in addition to accrediting new GPs as GPwER, is administering the process of transitioning existing GPwSI to the new system (www.bad.org.uk).*

** The service holds Teledermoscopy clinics in South Pembrokeshire Hospital with the Medical Photography team.

A Teledermoscopy clinic commenced in Cardigan Integrated Care Centre in September 2022 and the service based a Macmillan Skin Cancer Clinical Nurse Specialist (CNS) at this location in July 2023.[143]

There are some other sites with Outpatient activity recorded during the timespan of the project. Activity at Amman Valley Hospital, Trimsaran Surgery, and Tycroes Surgery ceased because of COVID-19 and has not recommenced. These sites are out of scope of this piece of work.

Some activity in Werndale Hospital has also been identified, and this was due to outsourcing projects both prior to COVID-19 (to assist with service capacity issues) and during COVID-19 recovery.

The service relies on in-sourcing to bridge the gap in capacity.[144] This is both due to workforce challenges – there is a national shortage of Consultant Dermatologists – and capacity issues. This has been the case since 2016.

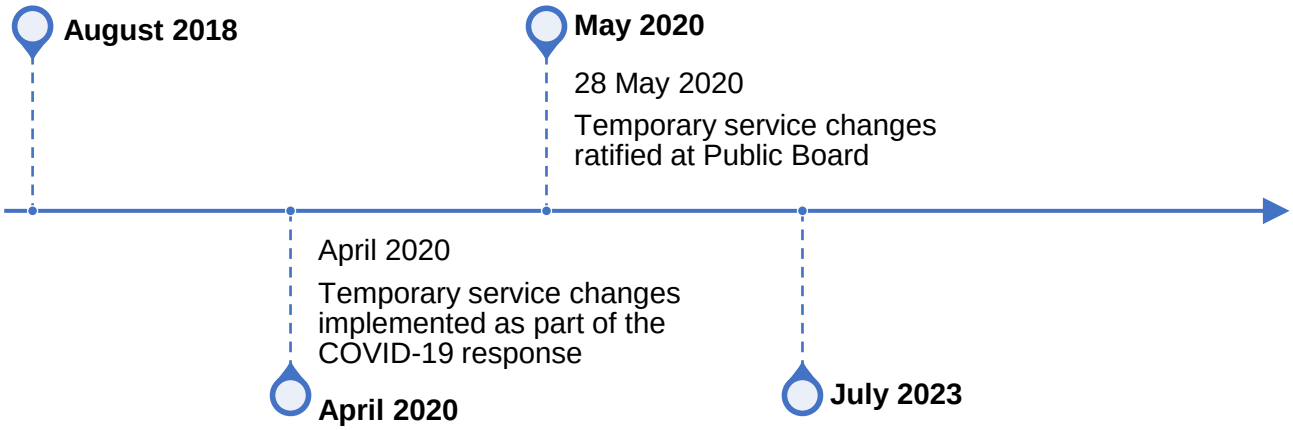
Treatment outside the Health Board

Paediatric patients requiring any type of skin surgery, and adult patients requiring more complex skin surgery, are referred to the Burns and Plastics team at Swansea Bay University Health Board for their treatment. These patients are out of scope of this piece of work.

Dermatology service changes

The following section outlines updates to Public Board around changes to the Dermatology service that have taken place between 1 August 2018 and 31 July 2023.

Service change timeline



[143] *Clinical Nurse Specialists (CNS) are nurses that are dedicated to a particular area of Nursing; caring for patients suffering from long term conditions and diseases, for example, cancer (www.macmillan.org.uk).*
[144] *In-sourcing is a term used to describe a range of medical and clinical services, which are deployed to utilise spare, out-of-hours capacity, typically at weekends, within a health board, in addition to the health board's existing provisions, with the intention to strengthen service outputs and improve efficiency (www.england.nhs.uk).*

As part of the Health Board's response to the COVID-19 pandemic, the following paper was presented to Public Board on 28 May 2020: Hywel Dda University Health Board Coronavirus (COVID-19) NHS Wales Operating Framework for Quarter 1 (2020/21) May 2020 Version 7.[145] The paper set out the Health Board's Quarter 1 response to COVID-19.

Scheduled Care Outpatient clinics were urgently profiled in March 2020 to confirm plans for:

- urgent priority (time critical) patients
- alternatives to clinic-based (face-to-face) care
- reduced service capacity, to release staff to support the management of COVID-19 patients.

The actions put in place by the Health Board to deliver Outpatient services during the COVID-19 outbreak included:

- All non-urgent Outpatient clinics up to and including 26 June 2020 were cancelled. These clinics were compressed as to demand on a weekly basis, thus allowing clinicians to be released into the wider support needed for the management of COVID-19 patients at the hospital sites.

Examples of how the Dermatology service adapted to deliver its services during this time are:

- Urgent Suspected Cancer clinics were condensed with Minor Operation sessions to create 'See and Treat' sessions at Prince Philip Hospital, therefore reducing the number of times a patient needed to visit the Outpatient Department. This involved patients with Urgent Suspected Cancer lesions being reviewed and receiving treatment on the same day, thus avoiding the need to re-visit the hospital
- Telephone validation took place for all clinic appointments that had been cancelled
- Virtual telephone follow-ups were put in place for acne and biologic clinics – the situation made it clear that acne patients could be managed more virtually and the cost of a BETA HCG blood test for a female patient is much more cost effective than having to see a patient face-to-face in clinic.[146] This would also free up clinic appointments for the patients on systemic and biologic medication to reduce the waiting list backlog.[147]

The service has confirmed that prior to COVID-19, clinics were running across Prince Philip Hospital, Glangwili Hospital, and Withybush Hospital, however, due to other specialities needing to use the Outpatient space at Glangwili Hospital and Withybush Hospital during the pandemic, the Dermatology clinics were relocated to Prince Philip Hospital, with some clinics being cancelled as they were not considered time critical, e.g., Phototherapy, Patch Testing, and routine appointments. The suspension of clinics at Glangwili Hospital also meant the loss of rooms and paediatric provision at the Children's Centre, and the loss of the room used for minor operations in Glangwili Hospital Outpatient Department.

Welsh Government issued Hywel Dda with emergency digital funding in response to the COVID-19 pandemic (Board Paper 5 May 2020: Digital Implementation Project).[148] This funding was to pilot a selection of software systems across selected cohorts of patients within each directorate, to aid with service sustainability by means of digital technology.

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[145] https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13
[146] Unexpected pregnancies need to be identified at the earliest opportunity due to the toxicity of some acne medication towards the foetus. The BETA HCG (Human Chorionic Gonadotropin) blood test measures the hormone levels in female patients where changes may indicate pregnancy.
[147] Systemic and biologic medications are used to manage inflammatory skin conditions.
[148] https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13

The ‘Patient Knows Best’ (PKB) software system, designed to share a record of care between healthcare teams and their patients, was trialled by the Dermatology service. The service stopped using ‘Patient Knows Best’ in March 2022 as it was felt that its ongoing use versus the cost was not proving beneficial to the service and its patients. Very few patients were taking the opportunity to use ‘Patient Knows Best’, and it was creating some duplication for the clinicians involved, as patients are also able to contact the service via the Health Board’s Communication Hub.[149]

The ‘Responding to the COVID-19 Pandemic: Update, Review and Ratification of Decisions Made Since 16th April 2020’ paper presented to Public Board in May 2020 provided an update on the work that had been progressed since the April 2020 Public Board meeting.[150] It advised of a revised COVID-19 response plan, driven by revised modelling assumptions and real-world experience of the progress of the COVID-19 virus in Wales. One of the elements of the revised plan was as follows:

- Routine Outpatient work to recommence but only via digital platforms. The most urgent cases for which physical assessment is necessary would also recommence.

How the Dermatology service is running post-COVID-19

Whilst activity has recommenced at Glangwili Hospital and Withybush Hospital (this is discussed in the ‘Dermatology activity data’ section), since COVID-19:

- the Dermatology service has relocated most of its clinics to Prince Philip Hospital
- the rooms previously occupied by Dermatology within the Children’s Centre at Glangwili Hospital have not been recovered
- the service has been unable to access the room previously used for minor operations in the Outpatient Department at Glangwili Hospital due to infrastructure issues.

In addition, Phototherapy clinics have not recommenced post-COVID-19 as the clinical areas at both Glangwili Hospital and Withybush Hospital have not met Health and Safety guidelines. The cancellation of the Phototherapy clinics has had an impact on patients, as it offers the first line of treatment for patients with inflammatory conditions before exploring stronger medications, such as systemic and biologic drugs. There are also fewer risks involved in Phototherapy for patients, compared to these systemic and biologic drugs.

The Patch Testing service has not recommenced due to difficulties recruiting staff with the specialist knowledge required to conduct this aspect of the Dermatology service. The impact of not having the Patch Testing service is minimal, as it is not considered time critical. However, it can support patients by providing an allergy diagnosis.

Since the pandemic the number of referrals into the Dermatology service has increased, and to manage the sudden increase in demand in the wake of the pandemic, there was not capacity to continue with the ‘See and Treat’ sessions, especially to meet the requirements of the Suspected Cancer Pathway.[151]

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[149] The Health Board Communication Hub was developed following the success of the COVID-19 Command Centre, and it provides patients with a single point of contact – one email address and one telephone number – to enable them to contact the Health Board about a variety of services.
[150] https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13
[151] The Suspected Cancer Pathway (SCP) is a Welsh Government target for diagnosing cancer and starting treatment more quickly.

Dermatology risks

This section describes the Dermatology risks that have been reported at Public Board meetings between August 2018 and July 2023.

Risk No. 44: Ability to manage patients awaiting follow-up appointments, escalated to the Corporate Risk Register, 31 January 2019

- The original Risk was created following a missed target to reduce follow-up Outpatient appointments in a number of services, including Dermatology
- The Risk was added to the Corporate Risk Register with a Risk Rating of 12, and a target Risk Score of 8. The Risk highlighted that there was a risk of harm to patients on follow-up waiting lists who had exceeded their follow-up date
- The Risk was closed on 1 June 2020 as, following discussions with the Scheduled Care Directorate Senior Management Team, the Risk was to be replaced by a new Risk in relation to Outpatient management. Further details about this Risk can be found on page 5 of the linked document: 30JUL2020[152]
- The new Risk is managed by the Scheduled Care Outpatients Management Team and was last reviewed in December 2023, when the Risk score was reduced in severity from 15 to 12. This was because Hywel Dda now has a low percentage of patients on follow-up lists compared to other health boards.

The ability to manage patients awaiting follow-up appointments is an ongoing issue for the Dermatology service, although data has changed since 2019. Dermatology has met the Welsh Government target for 2023/24, but due to the increased demand in new patients and Urgent Suspected Cancer patients, it will remain a risk.

At the Quality, Safety and Experience Assurance Committee (QSEAC) meeting held on 16 October 2018, members were provided with key areas for discussion from the Operational Quality and Safety Experience Sub Committee (OQSESC) meeting held on 20 September 2018. Concerns had been raised regarding the potential impact on the Health Board's Dermatology pathway due to Medical workforce challenges which included a lack of consultant capacity.

The risks around not having a substantive Consultant Dermatologist include the inability to 'grow your own' workforce, limited succession/longevity planning, and a reliance on in-sourcing and agency staff which can cause inconsistencies in patients' pathways, therefore resulting in a fragile service where there are continuous vacancies and difficulties with staff retention.

A report on Dermatology concerns, and the mitigating actions to address these, was presented to the Quality, Safety and Experience Assurance Committee meeting on 4 December 2018. The full report can be accessed via Appendix H4 - Dermatology - Corporate Risks.

The report:

- advised that the fragility of the Dermatology service had previously been highlighted to the Quality, Safety and Experience Assurance Committee and was currently scored as 20 on the Operational Risk Register
- described the recognised shortfall in both consultant and middle grade doctors across not only the Hywel Dda region, but Wales and the United Kingdom as a whole

[152] *hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-30th-july-2020/board-30th-july-2020-documents/sbar-corporate-risk-register-july-2020/*

- recognised that the service has long been regarded as a ‘fragile’ service, and a ‘hard to fill’ speciality with longstanding vacancies.

The Quality, Safety and Experience Assurance Committee acknowledged that the Medical Dermatology workforce within Hywel Dda has a recognised shortfall in both consultant and middle grade doctors with more innovative ways of working required including a regional model of working. Members welcomed investment in Advanced Nurse Practitioners (ANP) and enquired whether such posts would be expanded. Following discussions on ‘next steps’, it was proposed that the Operational Quality and Safety Experience Sub Committee should monitor the patient impact and outcomes and report any exceptions to the Quality, Safety and Experience Assurance Committee.

The shortfall in both consultant and middle grade doctors, and the issues around longstanding vacancies remain relevant today.

Dermatology clinical effectiveness

The table below includes a list of the clinical guidelines that the Dermatology service needs to follow:

Guideline Source	Guideline Title	Link
NICE[153]	Acne vulgaris: management	https://www.nice.org.uk/guidance/ng198
NICE	Atopic eczema in under 12s: diagnosis and management	https://www.nice.org.uk/guidance/cg57
NICE	Secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing	https://www.nice.org.uk/guidance/ng190
NICE	Psoriasis: assessment and management	https://www.nice.org.uk/guidance/cg153
NICE	Melanoma: assessment and management	https://www.nice.org.uk/guidance/ng14
NICE	Suspected cancer: recognition and referral	https://www.nice.org.uk/guidance/ng12
NICE	Skin cancer prevention	https://www.nice.org.uk/guidance/ph32
NICE	Sunlight exposure: risks and benefits	https://www.nice.org.uk/guidance/ng34
NICE	Improving outcomes for people with skin tumours including melanoma	https://www.nice.org.uk/guidance/csg8
NICE	Impetigo: antimicrobial prescribing	https://www.nice.org.uk/guidance/ng153
BAD[154]	Numerous items of Guidance - Web site includes NICE guidance detailed above, Joint	https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/

[153] NICE = National Institute for Health and Care Excellence.
[154] BAD = British Association of Dermatologists.

	Guidance with other Royal Colleges and BAD guidelines	
BSRheum[155]	The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults	https://academic.oup.com/rheumatology/article/57/1/e1/4318863?login=true
European Academy of Dermatology & Venereology	Various Guidelines within link	https://eadv.org/publications/clinical-guidelines/

Regarding the 'Atopic eczema in under 12s: diagnosis and management' guideline noted in the table above, the Dermatology service has been unable to run Nurse led Paediatric Eczema services due to a lack of available facilities (specifically, the loss of rooms in the Children's Centre in Glangwili Hospital during the Health Board's response to COVID-19).

In relation to the 'Skin cancer prevention' guidelines – due to a lack of facilities, waiting lists, and workforce challenges, the service has been unable to reinstate the 'See and Treat' clinics that were held during the COVID-19 response. With the appropriate facilities and adequate staffing, the service would be able to reinstate the 'See and Treat' sessions, thus improving patient experience and reducing the number of visits that patients must make to the hospital, whilst also improving the service's response to the Suspected Cancer Pathway guideline. In addition, it would mean that patients with the most severe skin cancers could receive treatment without delay.

Improved facilities would also enable the staff to utilise the Medical Photography team in Prince Philip Hospital. This would prove vital as the photographs produced would reduce the number of queries received regarding lesions that may or may not need to be removed, and there would be an opportunity to take and compare 'progress' photographs, should a patient's lesion have changed. This is standard practice in most health boards.

The service is currently unable to offer Patch Testing which is deemed as a good practice recommendation in the guidelines for contact dermatitis for patients with chronic or persistent dermatitis. Due to issues with being able to retain staff, the service has been unable to train staff to allow the Patch Testing service to resume in Hywel Dda.

It would be beneficial for patients if the service was able to run joint Dermatology and Rheumatology clinics, as highlighted in 'The British Society for Rheumatology Guidelines for the Management of systemic lupus erythematosus in adults.' Due to the issues around retention of staff and clinic availability the service has not been able to run these joint clinics.

Dermatology local, regional, and national work

This section describes the regional and national projects or programmes connected to Dermatology services at Hywel Dda.

Dermatology regional work

The ARCH (A Regional Collaboration for Health) Dermatology Regional Programme was established in May 2019 with clinical, managerial, operational, and planning representation from Hywel Dda and Swansea Bay University Health Board through the ARCH Strategic Developments Group.

[155] *BSRheum = British Society for Rheumatology.*

- The ARCH ‘South West Wales Regional Dermatology Services Update Report’ (21 September 2021) recognised that Dermatology services in Wales face significant challenges, in particular those around recruitment of consultants into the workforce. The full report can be accessed via Appendix H6.1 - Dermatology - Local and Regional Workstreams – ARCH
- ‘The ARCH Review 2022-2023’ highlighted that work to develop a regional Dermatology service for southwest Wales had progressed. It noted that a pilot for a Teledermoscopy service in Hywel Dda was launched in September 2022 (after a successful pilot in Swansea Bay University Health Board) and that funding had been agreed to make this a substantive service, with funding provided by the Welsh ‘Planned Care Improvement and Recovery’ programme. This report is available via Appendix H6.2 - Dermatology - Local and Regional Workstreams – ARCH
- Work for the ARCH Dermatology Regional Programme drew to a natural close in spring 2022, after the Teledermoscopy model had been fully implemented in both Swansea Bay University Health Board and Hywel Dda. The proposal to close the ARCH Dermatology programme was endorsed at the ARCH Regional Recovery Group meeting on 5 October 2023. The closure report highlighted that there continued to be increasing pressure on the provision of Dermatology services across southwest Wales, exacerbated by the COVID-19 pandemic. For further information, the full report is accessible via Appendix H6.3 - Dermatology - Local and Regional Workstreams – ARCH.

Dermatology national work

The Foreword to the ‘National Review of Dermatology Services in Wales 2019’ (published by the Welsh Dermatology Board in March 2021) highlighted that Dermatology services across Wales were facing recurrent and significant challenges across a number of areas. These included, but were not limited to:

- a notable shortfall in the Dermatology workforce
- a rising number of skin cancers
- insufficient Outpatient capacity.

Each of these challenges are relevant to the Dermatology service in Hywel Dda. The full report can be accessed via Appendix H7.1 - Dermatology - National Workstreams - Welsh Dermatology Board.

The ‘Review of Dermatology Services in Wales – Hywel Dda University Health Board’, carried out by the Welsh Dermatology Board (date of review 24 October 2019) recognised that the service was operating over four different sites with no dedicated Dermatology unit(s). Thus, access to treatment rooms was limited and reliant on rooms in the Outpatient Departments being available to undertake clinics, including ‘See and Treat’ clinics.

At the time of the report discussions were underway to secure additional rooms in Outpatient Departments, which was awaiting approval and consultation with staff. Although there was no dedicated Dermatology unit, space had been identified which, if plans were enabled locally, could result in consolidation of services which in turn would help with fewer individuals working in isolation, and improve staff retention. This did not progress after initial investigations due to the timing of the COVID-19 pandemic.

The report advised that a review and relocation of the Phototherapy unit in Withybush Hospital should be considered, as the current layout of the facilities posed some health and safety

concerns. As stated previously, Phototherapy clinics have not recommenced post-COVID-19 as the clinical areas at both Glangwili Hospital and Withybush Hospital have not met Health and Safety guidelines.

The review identified the ongoing workforce recruitment and retention issues that have been known to the Health Board for some time, however, it noted that there had been some significant improvements in structures to support the service with opportunities with key individuals to upskill.

Key next steps to come out of the review were as follows:

- Health Board to invest and support in an additional consultant Whole Time Equivalent (WTE),[156] considering increasing the number by a minimum of 1 WTE with opportunities of other Medical specialities such as Plastic Surgery to support locally, and other Dermatology units to support remotely
- Support the expansion of Teledermatology[157] and Medical Illustration[158] departments' bids
- Consolidate and expand the core services in the periphery to support Nursing workforce
- Re-establish the organisation's Patch Testing service
- Allow access to the identified clinic space in Outpatient Departments to expand.

The full review can be accessed via Appendix H7.2 - Dermatology - National Workstreams - Welsh Dermatology Board.

Since the 2019 review, the service has implemented the Teledermoscopy service in conjunction with the Medical Illustration department, however, a dedicated Dermatology department continues to be explored. The service is unable to re-establish Patch Testing due to difficulties with recruitment. In relation to the Medical workforce, the service has recruited one substantive part-time Consultant Plastic Surgeon, but there remain challenges with recruiting substantive Consultant Dermatologists.[159] Consultant Plastic Surgeons have the expertise to manage skin lesions only, and not inflammatory conditions – these conditions rely on the expertise of a Consultant Dermatologist.

GIRFT (Getting It Right First Time) Reviews

No GIRFT (Getting It Right First Time) reviews have taken place in the Dermatology service in Hywel Dda to date.

Suspected Cancer Pathway

The Suspected Cancer Pathway (SCP) is a Welsh Government target for diagnosing cancer and starting treatment more quickly. It also indicates where information and support should be provided across the pathway. The Suspected Cancer Pathway was implemented in Wales in June 2019, and, as a result, each health board in Wales (including Hywel Dda) developed plans to ensure that

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[156] The 'Whole Time Equivalent' (WTE) is calculated by dividing the number of required hours for the role by the Whole Time Equivalent (www.nhsbsa.nhs.uk). For the Medical workforce, 1 WTE equates to a 40 hour working week, or 10 sessions. For all other staff working in the NHS under Agenda for Change (AfC) terms and conditions, 1 WTE equates to a full time position of a 37.5 hour working week. Staff members that are employed full time equate to '1' WTE.

[157] Teledermatology is the use of digital images to triage, diagnose, monitor, or assess skin conditions without the patient being physically present (www.england.nhs.uk).

[158] Medical Illustration (photography) is undertaken at the hospital by specialist Medical Photographers. They produce images that can be used in both diagnosis and monitoring of patients' conditions.

[159] Members of staff that work on a permanent contract are known as 'substantive' members of staff.

most patients receive cancer diagnostic tests in a timely manner, and start their treatment within 62 days, from the very first point where cancer might be suspected.

Further information on the Suspected Cancer Pathway can be found via the following link: https://executive.nhs.wales/functions/networks-and-planning/cancer/workstreams/suspected-cancer-pathway/

Dermatology activity data

Dermatology service activity reported between 1 August 2018 and 31 July 2023 is included for the following Hywel Dda sites in scope of this project:

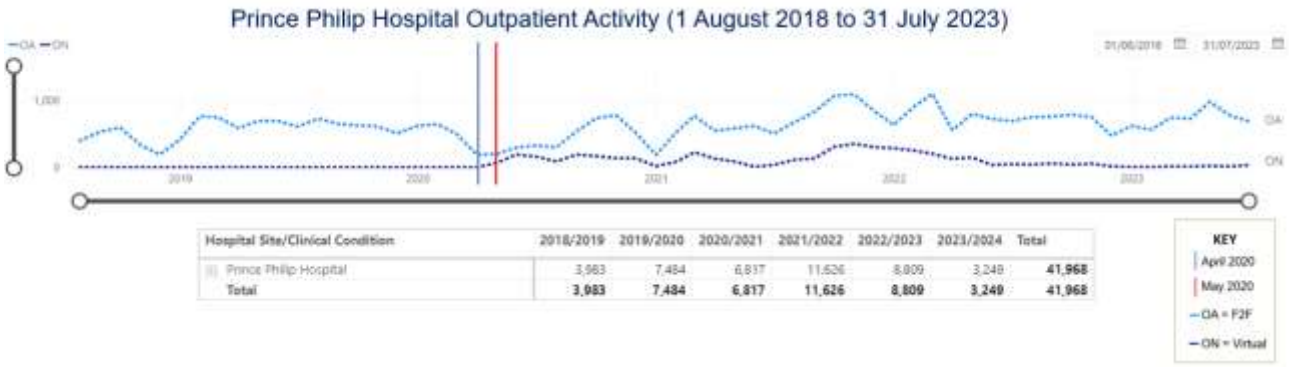
- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen
- Withybush Hospital, Haverfordwest
- Cardigan Integrated Care Centre, Cardigan
- South Pembrokeshire Hospital, Pembroke Dock.

All data tables can be found in Appendix H8 – Dermatology – Activity Data.

An increase in Outpatient Referrals can be seen across all sites in scope of the project in the wake of the COVID-19 pandemic. 2019/20 saw 7,018 referrals across all sites, this decreased to 5,139 in 2020/21 (likely impacted by the pandemic), and then increased by nearly 65% to 8,463 in 2021/22. Referrals remained steady in 2022/23 at 7,898.

An increase in virtual appointments (since April 2020) has been in response to the COVID-19 pandemic. As a result, the Dermatology service has been able to increase capacity without seeing patients in a face-to-face clinic, thus enabling the service to keep in contact with patients. The Nursing team continue their virtual work with Dermatology patients from the offices in Glangwili Hospital.

Pre-pandemic data for Prince Philip Hospital shows a total of 7,484 Outpatient appointments in 2019/20. This figure decreased to 6,817 in 2020/21, however, since COVID-19 the Dermatology service has relocated most of its clinics to Prince Philip Hospital, which has caused an increase in Outpatient Referrals (which nearly doubled from 2,210 in 2020/21 to 4,379 in 2021/22) and Outpatient Activity at this site. The figures for 2021/22 thus show an overall increase in activity to 11,626, which is a vast increase on the previous year (6,817), however, this is the peak as 2022/23 Outpatient Activity totalled 8,809 in comparison, as seen below.



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Prince Philip Hospital	3,983	7,484	6,817	11,626	8,809	3,249	41,968
Total	3,983	7,484	6,817	11,626	8,809	3,249	41,968

The relocation of clinics to Prince Philip Hospital has had a subsequent effect on Outpatient Activity at Glangwili Hospital, and the data in Appendix H8 - Dermatology - Activity Data shows a notable decrease from 6,830 in 2019/20 to 595 in 2020/21, with 916 appointments in 2021/22.

However, the Nursing team have increased their virtual work with Dermatology patients from the offices in Glangwili Hospital, and 1,747 Outpatient appointments were recorded in Glangwili Hospital in 2022/23, which was almost double the previous year (916 in 2021/22).

Whilst there are definite positives in being able to provide a virtual service for patients where appropriate (such as the reduced impact on the patient in that they do not have to travel to hospital sites to attend clinics; parking has been recognised as an issue and so virtual appointments negate the need to travel, park, and navigate finding the clinic/room), staff have identified that it is not always as easy for them to build a rapport with their patients virtually as it is in-person.

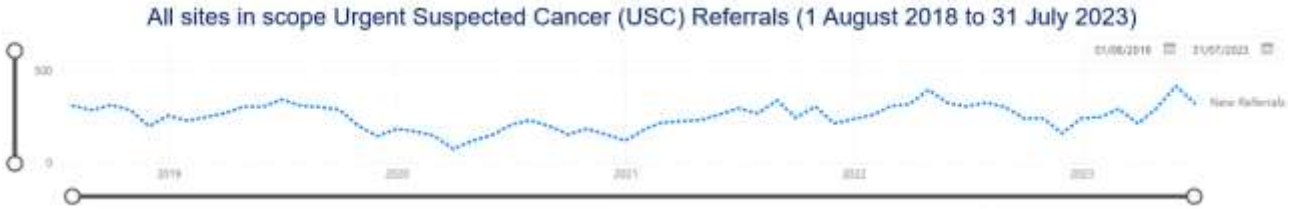
Activity in Withybush Hospital was suspended during COVID-19, as is visible in the graph in Appendix H8 - Dermatology - Activity Data, however clinics recommenced in late 2020. Except for the figures for 2020/21, which will have been affected by the suspension of clinics during the pandemic (569 total for 2020/21), activity in Withybush Hospital has remained relatively steady overall between 2019/20 (1,007), 2021/22 (1,149), and 2022/23 (1,087). In 2023 the Macmillan Skin Cancer Clinical Nurse Specialist left the service, thus causing a gap in the service at the hospital. The impact of this is also visible in the graph in Appendix H8 - Dermatology - Activity Data.

As in Withybush Hospital, activity in South Pembrokeshire Hospital was also suspended during COVID-19 (data for 2020/21 showing as 3 only), with clinics recommencing in 2021 (353 appointments in 2021/22), along with the Teledermoscopy service towards the end of 2022 (total activity for 2022/23 at South Pembrokeshire Hospital increased to 664). In 2023 the Macmillan Skin Cancer Clinical Nurse Specialist left the service causing a gap in the service at South Pembrokeshire Hospital, the impact of which can be seen in the graph in Appendix H8 - Dermatology - Activity Data.

A Teledermoscopy clinic commenced in Cardigan Integrated Care Centre in September 2022, thus explaining the low activity numbers at this site in comparison to the other sites in scope of the project.

The data below shows an increase in Urgent Suspected Cancer (USC) referrals over the five year period in scope of this piece of work, with an increase in referrals coming out of the COVID-19 pandemic:

- 2,950 referrals in 2019/20 (pre-COVID baseline)
- 1,975 referrals in 2020/21
- 3,172 referrals in 2021/22
- 3,383 referrals in 2022/23



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan Integrated Care Centre	0	0	0	0	0	0	**0**
Glangwili General Hospital	926	1,269	828	1,232	1,128	411	**5,794**
Prince Philip Hospital	630	860	609	972	1,258	488	**4,817**
South Pembrokeshire Hospital	0	1	0	0	2	0	**3**
Withybush General Hospital	558	820	538	968	995	343	**4,222**
Total	**2,114**	**2,950**	**1,975**	**3,172**	**3,383**	**1,242**	**14,836**

Despite Glangwili Hospital receiving the highest volume of Urgent Suspected Cancer referrals over the five year period, the highest increase in Urgent Suspected Cancer referrals has been seen at Prince Philip Hospital, where a 46% increase in referrals has occurred from 2019/20 (860 referrals) to 2022/23 (1,258 referrals). This is reflective of the increase in overall activity in Prince Philip Hospital that has taken place since COVID-19 (when the service suspended its activity at Glangwili Hospital for a period of time and has not returned to its pre-pandemic in-person clinic activity).[160]

Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan Integrated Care Centre	0	0	0	0	0	0	0
Glangwili General Hospital	2,306	3,116	1,793	2,058	1,812	416	11,501
Prince Philip Hospital	1,429	2,176	2,210	4,379	4,162	1,230	15,586
South Pembrokeshire Hospital	0	6	0	122	147	3	278
Withybush General Hospital	1,147	1,720	1,136	1,904	1,777	345	8,029
Total	4,882	7,018	5,139	8,463	7,898	1,994	35,394

Comparison of the two charts above, shows that Urgent Suspected Cancer referrals have accounted for 42% of the total referrals received by the Dermatology service over the project timeframe.[161]

Comparison of Urgent Suspected Cancer (USC) referrals versus total Dermatology referrals, 1 August 2018 to 31 July 2023:

Financial Year	Total USC Referrals	Total Dermatology Referrals	Percentage of Total Dermatology Referrals that are USC Referrals
2018/2019 (from 1 Aug. 2018)	2,114	4,882	**43%***
2019/2020	2,950	7,018	**42%**
2020/2021	1,975	5,139	**38%**
2021/2022	3,172	8,463	**37%**
2022/2023	3,383	7,898	**43%**
2023/2024 (to 31 Jul. 2023)	1,242	1,994	**62%***
TOTAL REFERRALS (1 Aug. 2018 to 31 Jul. 2023)	**14,836**	**35,394**	**42%**

[160] This data runs from 1 August 2018 to 31 July 2023, hence the figures for 2018/19 and 2023/24 do not reflect a full year's data.
[161] All percentages have been rounded to the nearest whole number.

* Due to the project timeframe, percentages marked '*' do not reflect a full year's figures and may appear inflated in the case of 2023/24 due to the inclusion of summer months (figures to 31 July 2023 only), during which time Urgent Suspected Cancer referrals typically increase.

An increase in Urgent Suspected Cancer referrals is being seen across Welsh health boards and is having a direct impact on the Dermatology service in Hywel Dda in that it is seeing a shift in the allocation, demand, and capacity of the service to ensure that Urgent Suspected Cancer patients are seen and receive treatment in accordance with the 62-day Suspected Cancer Pathway. This is putting a strain on the service and means that it is currently providing limited services in comparison to what it was able to previously, because efforts are so heavily focused on managing the skin cancer pathway. Therefore, there is an impact on the General Dermatology pathways as well as impacting routine minor operations. Both routine and urgent Dermatology patients are waiting longer to be seen, many of whom are living with debilitating inflammatory conditions.

An increase in cases of the more serious types of skin cancer, for example, patients with later stage melanomas, is having a further impact on the service's follow-up capacity, as these patients require regular follow-up appointments for up to five years.

Overall, there are very few patients (approximately 3% of patients Health Board-wide) returning to the service following transfer to an SOS (See on Symptom) or PIFU (Patient Initiated Follow-up) pathway.[162] However, these pathways do allow patients the opportunity with which to return to the service if their skin condition flares and/or they experience changes to their lesions, thus alleviating pressures within Primary Care, and enabling swift access to advice rather than spending time on a waiting list.

These pathways are designed to support and encourage patients to 'co-own' their health care, thus supporting them to self-manage their care decisions and share the decision making about their care with their clinicians. As follow-up appointments are not routine for patients on these pathways, it eases capacity by freeing up appointment availability for patients waiting to be seen.

Dermatology incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against Dermatology. Full data for incidents, complaints, claims, and compliments, can be found in Appendix H9 – Dermatology – Incidents Data, Appendix H10 – Dermatology – Complaints Data, and Appendix H11 – Dermatology – Patient Experience and Compliments Data.

Dermatology incidents

The sites that recorded incidents during the project timeframe are:

- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen

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[162] Patients on a 'See on Symptom' (SOS) pathway are advised that they have a short-term condition and that a routine follow-up appointment is not required – possibly because the patient's treatment has been completed, or because their condition is being well managed and no further clinical intervention is required at this time. However, if the patient experiences any problems with their treatment or a flare up of their condition, they can contact the service and ask for a 'See on Symptom' appointment. This will be within a timeframe provided by the patient's clinician, for up to a year. Patients on a 'Patient Initiated Follow-up' (PIFU) pathway are advised that they have a long-term condition but that a routine follow-up appointment is not required, for similar reasons to those stated for patients on a 'See on Symptom' pathway. If patients on a 'Patient Initiated Follow-up' pathway experience any problems with their treatment/condition, they can contact the service and ask for a 'Patient Initiated Follow-up' appointment (www.hduhb.nhs.wales).

- Withybush Hospital, Haverfordwest

There have been no incidents recorded by the Dermatology service at South Pembrokeshire Hospital or Cardigan Integrated Care Centre during this timeframe.

The volume of incidents recorded has decreased year on year (noting that data for 2018 and 2023 reflects only part of the years' overall data due to the project timeframe of 1 August 2018 to 31 July 2023).

The table below shows the overall number of recorded incidents across all Health Board sites for Dermatology:

Year	2018	2019	2020	2021	2022	2023
No. of Incidents recorded	5 (part year)	16	13	8	6	3 (part year)

None of the incidents recorded at any of the sites were deemed higher than '3 – Moderate Harm', and 74.5% of incidents across all sites were deemed to be '1 – None' in terms of their level of severity (38 'Level 1' incidents recorded out of a total of 51 incidents scored between 1 August 2018 and 31 July 2023).

Despite this, one of the 'Level 1' incidents was recorded as the following 'type': 'Unexpected Deaths or Severe Harm'. This incident has been reviewed and the record, following thorough investigation at the time of the event, was closed with a severity level of 'no harm'. The investigation identified that there was no process in place for GPs or triaging consultants to re-direct patients to the Burns and Plastics team in Swansea Bay University Health Board if required, however, as part of the incident investigation, a manual process was put in place, and remains in place with no further instances of similar incidents reported.

A change in the incident recording system means that there are two recording periods: August 2018 to end of March 2021, and April 2021 to end of July 2023. The number of incidents recorded for the Dermatology service at each hospital site in scope of this project is reported in the table below:

Primary Location	Incidents recorded 01/08/2018 to 31/03/2021	Incidents recorded 01/04/2021 to 31/07/2023	Total Incidents
Prince Philip Hospital	11	13	**24**
Glangwili Hospital	19	1	**20**
Withybush Hospital	4	1	**5**

Between 1 August 2018 and 31 March 2021, the highest volume of incidents recorded was at Glangwili Hospital with 19 incidents, in comparison to Prince Philip Hospital with 11 incidents, and Withybush Hospital with 4 incidents. However, from 1 April 2021 to 31 July 2023, Glangwili Hospital, along with Withybush Hospital, only recorded one incident each, whereas 13 incidents were recorded at Prince Philip Hospital for the same period. The 'types' recorded for the 13 incidents reported at Prince Philip Hospital are varied, with no standalone issue identifiable – the most common being 'Medication, IV fluids' which accounted for three of the 13 incidents recorded.

The table below shows the spread of incident 'types' in relation to the 13 incidents recorded at Prince Philip Hospital between 1 April 2021 and 31 July 2023:

Incident type tier one	Total
Medication, IV Fluids	**3**
Accident, Injury	**2**
Communication	**2**
Treatment, Procedure	**2**
Assessment, Investigation, Diagnosis	**1**
Behaviour (including violence and aggression)	**1**
Information Governance, Confidentiality	**1**
Records, Information	**1**

Dermatology complaints

The sites in scope of the project that received complaints during the project timeframe are:

- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen
- Withybush Hospital, Haverfordwest

The table below shows the overall number of complaints within Dermatology across all Health Board sites. There were no complaints received against the service at South Pembrokeshire Hospital or Cardigan Integrated Care Centre.

Year	2018	2019	2020	2021	2022	2023
No. of Complaints recorded	20 (part year)	40	42	51	77	26 (part year)

2022 saw the highest number of complaints recorded across the sites with 77 complaints in total, an increase from 51 complaints in 2021. The number of complaints across sites was very similar in 2019 (40 complaints) and 2020 (42 complaints) but has increased by 92.5% from 2019 to 2022 (from 40 complaints to 77 complaints recorded).

The table below shows the number of Dermatology service complaints received by each hospital site in scope of the project between 1 August 2018 and 31 July 2023:

Primary Location	Complaints recorded 01/08/2018 to 31/03/2021	Complaints recorded 01/04/2021 to 31/07/2023	Total Complaints
Prince Philip Hospital	62	93	**155**
Glangwili Hospital	34	27	**61**
Withybush Hospital	11	14	**25**

The highest number of complaints has been recorded at Prince Philip Hospital (155 in total: 62 complaints between 1 August 2018 and 31 March 2021, and 93 complaints between 1 April 2021 and 31 July 2023), compared to Glangwili Hospital, which has seen the second highest number of complaints (61 in total: 34 between 1 August 2018 and 31 March 2021, and 27 between 1 April 2021 and 31 July 2023).

Since COVID-19, the Dermatology service has relocated most of its face-to-face clinics to Prince Philip Hospital. Due to the increased volume of patients accessing the Dermatology service at Prince Philip Hospital compared to Glangwili Hospital, this likely accounts for the variance in the number of complaints.

We should also consider the nature of patient activity at the sites, as this may also have an impact on the volume of complaints received, as the difference in total complaints recorded between Prince Philip Hospital and Glangwili Hospital is noticeable, with Prince Philip Hospital recording a significantly higher number of complaints. All patient activity recorded at Prince Philip Hospital is via face-to-face appointments, often with new patients, or patients that may have waited some time to be seen due to lengthy waiting lists. In comparison, most of the patient activity recorded at Glangwili Hospital relates to virtual appointments carried out by the Nursing team, with patients on existing pathways, and undertaking their appointments away from hospital sites, often in the comfort of their own home.

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category:

Subject (primary)	Complaints recorded 01/08/2018 to 31/03/2021	Complaints recorded 01/04/2021 to 31/07/2023	Total Complaints
Appointments	79	72	**151**
Clinical treatment/ assessment	12	22	**34**
Communication issues (including language)	8	17	**25**

None of the complaints recorded at any of the sites were deemed higher than 'Grade 3 – Moderate', and 79% of complaints across all sites were deemed to be 'Grade 1 – Minor – Informal' (170 'Grade 1' complaints out of a total of 216 complaints received between 1 August 2018 and 31 July 2023).

Dermatology claims

There have been no cases of claims received by Hywel Dda in respect of the Dermatology service during the time in scope of this piece of work.

Dermatology patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix H11 - Dermatology - Patient Experience and Compliments Data.

The content in this section reflects feedback that has been formally recorded by the corporate Patient Experience team only, however, the Dermatology service regularly receive complimentary feedback via emails, letters, and cards, from grateful patients and their families.

Year	All Wales Experience – Health Board Survey	Friends and Family Test	Compliments
2021	No data recorded.	The themes arising are the efficiency and professionalism of the staff, the safety measures in place, and the friendliness of the clinicians. Many people felt safe and well taken care of during their visit, and appreciated the COVID-19 precautions that were in place. The staff attitude was also frequently mentioned, with many people commenting on the good and efficient service they received.	No data recorded.
2022	Most feedback is around appointments and staff interactions. Positive experiences include professionalism, friendliness, and helpfulness of staff. Negative experiences include long wait times, multiple cancellations,	The themes arising include the friendliness, helpfulness, and professionalism of the staff, the efficiency of the service, and the informative nature of the treatment. There were a few negative comments mentioned, such as difficulty finding the room, long waiting times, and difficulty finding parking. Overall, the feedback was mostly positive, with patients expressing	No data recorded.

	and poor communications.	gratitude and satisfaction with the service they received.	
2023	Most feedback is around appointments and staff interactions. Positive experiences include professionalism, friendliness, and helpfulness of staff. Negative experiences include long wait times, multiple cancellations, and poor communications.	The themes arising include the friendliness, helpfulness, and professionalism of the staff, the efficiency of the service, and the informative nature of the treatment. Positive comments mention short waiting times and appointments being on time, with staff giving clear and informative explanations around their treatment. There were a few negative comments mentioned, such as difficulty finding the room, long waiting times for appointments and difficulty finding parking.	The theme arising is that staff were kind and caring in their support of patients.

Dermatology patient experience

As part of the 'Review of Dermatology Services in Wales – Hywel Dda University Health Board', carried out by the Welsh Dermatology Board (date of review 24 October 2019, please see Appendix H7.2 - Dermatology - National Workstreams - Welsh Dermatology Board for the full report), a bespoke patient experience survey was undertaken of patients who had attended a clinic in the last six months. Fifty-three patients responded to the invitation to take part.

The survey results showed high rates of patient satisfaction, with 75% of respondents advising that they would be 'extremely likely' to recommend the service to family and friends, and 51% of respondents rating their experience as '10' (using a scale of 0-10, where '0' was 'very bad' and '10' was 'excellent').

When asked if there was anything that the Health Board could change to improve the patient experience, multiple respondents replied that there was not, as they were already satisfied with the service they had received.

Recommendations for improvements included:

- Reduced travel time to appointments
- Improved waiting times (to receive an appointment, and whilst on site)
- Parking difficulties due to lack of spaces.

When asked if there was anything particularly good about the experience that the patient had received, common themes throughout the responses were:

- The friendliness and helpfulness of the staff
- The way that staff put patients at ease
- The thoroughness of the appointments, with attention to detail
- Clear explanation of details and information.

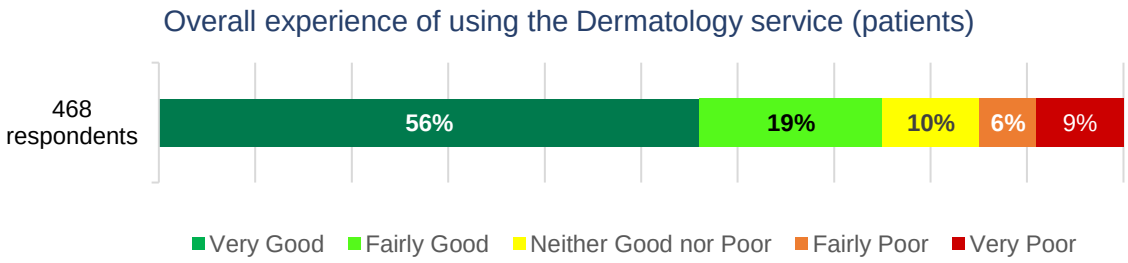
Dermatology targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

A randomly selected sample of patients who accessed Dermatology services within the last five years (1 August 2018 to 31 July 2023) were invited to take part in a survey. In total 4,921 patients were sent an invitation, and 487 responses were received. 61% of respondents accessed most of their Dermatology care at Prince Philip Hospital, 18% at Glangwili Hospital, and 9% at Withybush Hospital. The remainder were split out between various other clinical sites.

The Dermatology service patient demographic is mixed, as equalities information collected suggests. This is broadly reflected in the profile of respondents to the patient survey.

75% of respondents said that their experience of using the Dermatology service was good, whereas 14% said it was poor.

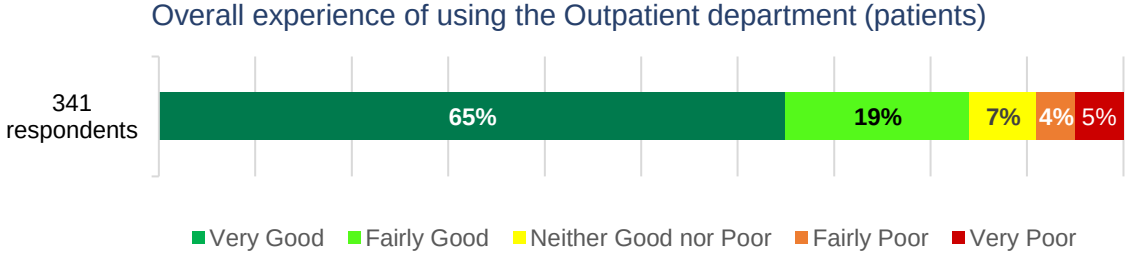


In terms of what was good about their experience of using the Dermatology service, patients mainly praised the efficiency and timeliness of the service received; the professional, kind, reassuring, and helpful staff; the quality of care; and good communication and information provision. Some, though, complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis), and poor communication and information provision.

The main improvements to Dermatology services as suggested by survey respondents were around speed and efficiency (including shortening waiting times and not cancelling appointments); and communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow-up). It should be noted, though, that over a quarter of respondents (27%) felt that no improvements are required.

Service user experiences of Outpatient services

86% of patient respondents said they used the Outpatient Department as part of their Dermatology treatment. Of these, 84% said it was good, and 9% said it was poor.



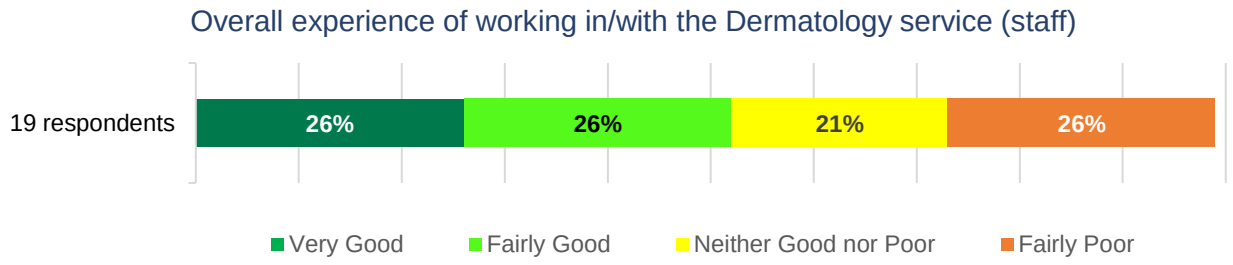
When patients were asked why they said their experience of using the Outpatient Department was good or poor, the most frequent positive comments related to receiving a generally good, quick, and efficient service; the professional, kind, reassuring, and helpful staff; and good communication and information provision. The most frequent negative comments were around service speed and efficiency (including access to appointments, tests, and results); and communication (including explanations of tests, results, and treatments, and the frequency of contact and follow-up).

Dermatology targeted early engagement with staff

As per the approved Clinical Services Plan methodology, a survey was sent to Medical, Nursing, Therapies, Operational and Support staff. Staff members were invited to provide their views about what is good, what is bad, what needs improvement, and to identify issues regarding the service. The response analysis was completed by Opinion Research Services (ORS), to understand the key issues and themes. The main findings from this report are noted below, and the full report can be accessed via Appendix A2 – CSP – Early Engagement ORS Report.

All members of staff currently working in or supporting staff working in the Dermatology service were invited to take part in a survey: 20 responses were received. Ten responses were from staff based primarily at Prince Philip Hospital, with the rest mainly split between Glangwili Hospital (five respondents) and Withybush Hospital (two respondents). Three respondents did not identify their main hospital base.

53% of respondents said that their overall experience of working in/with the Dermatology service was good. 26% said that it was fairly poor, though none said it was very poor.



In terms of what is/was good about their experience of working in/with the Dermatology service, the most common positive themes raised across all sites related to staff. Respondents highlighted the good relationships formed in the workplace, describing their colleagues as dedicated, experienced, and helpful; and several praised clinicians' passion for their work and commitment to going above and beyond to help their patients. Managers were also considered by some to be approachable and responsive when dealing with queries and issues from their staff.

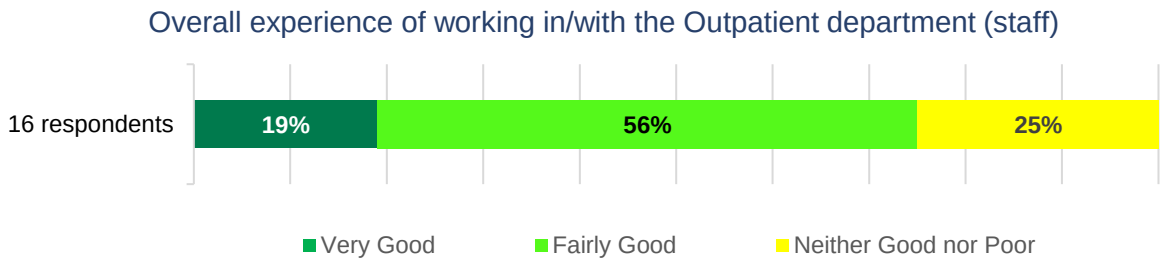
Dermatology staff highlighted employee retention across all sites as the service's biggest issue: it was widely felt that staff losses, in addition to a lack of facilities and services like Patch Testing and Phototherapy, is compromising the level of care provided to patients. Other concerns were around limited capacity and appointments leading to frequent last minute clinic cancellations; some employees at Prince Philip Hospital feeling undervalued, unappreciated, and not listened to by management; a lack of adequate training and development opportunities; and poor communication across the multiple sites, which can affect the smooth running of the service.

The main suggested way to improve employees' experience of working in/with the Dermatology service concerned increasing the workforce. The development of a single-site Dermatology

department was also suggested, as was increasing the provision of services like Patch Testing and Phototherapy. Other proposed improvements were to provide a more supportive environment for staff, whereby training, recognition, support, and praise is given when appropriate; hold regular team building sessions; employ an on-site department manager at each service location; and listen to clinicians' concerns about clinical risk, providing them with the appropriate equipment, training, and support to work safely and efficiently.

Staff experiences of Outpatient services

89% of respondents said that they use the Outpatient Department in relation to Dermatology. Of these, 75% (12 individuals) said that their overall experience of Outpatient services was good. None said that it was poor, although a quarter (four individuals) said it was neither good nor poor.



Staff respondents praised Outpatient staff for being accommodating, supportive, helpful, friendly, and professional. Less positively though, several commented on poor facilities and equipment within Outpatient departments. In this respect, it was also said that Cardigan Integrated Care Centre could be used as a model for other sites, in that it is newer and in very good condition.

Dermatology finance

The table below shows the key cost drivers[163] affecting service delivery budgets within Dermatology.

All services will be affected by the 'general' statements below. In addition to this, any identified key cost drivers within the Dermatology service have also been included.

This information is aligned to the findings and submissions included in the 2024/25 annual plan.

Service	Key cost driver
General	Services provided over multiple sites
General	Vacancies filled with premium costs or additional hours
Dermatology	Increased demand impacting on Medical staffing Additional Duty Hours (ADH) costs and drugs costs

[163] *Cost drivers are the direct cause of an expense. A cost driver is any activity that triggers the cost of something else.*

Medical pay for Dermatology is incurring variable pay spend to bolster capacity, predominantly Additional Duty Hours (ADH) spend driving the pressure £0.133m in the first nine months of 2023/24.

Alongside this there are non-pay pressures linked to drug expenditure (both due to price increases and rising demand) as well as reliance on Swansea Bay University Health Board support. The forecast outturn for 2023/24 is a £0.299m overspend.

Dermatology workforce

The Workforce team have supplied data within defined cost codes provided by the Dermatology service.[164] Full details about the methodology can be found within Appendix H13 - Dermatology - Workforce Data.

The table below shows the workforce establishment (number of people working) across our hospital sites within Dermatology services on 31 July 2023. It highlights the number of Whole Time Equivalent (WTE)[165] staff across specific roles in the service.[166]

The table shows the higher number of Medical staff (doctors) in post at Prince Philip Hospital (3.7 WTE) compared to Glangwili Hospital (just 0.5 WTE). This is because Prince Philip Hospital is currently where the main service pathways are located, including most of the clinics and minor operations.

The table also shows the higher number of Nursing staff working in Glangwili Hospital (4.3 WTE), from where nurses conduct virtual appointments, compared to just 1 WTE nurse in post at Prince Philip Hospital.

Role	Borth Surgery	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Grand Total
Additional Professional Scientific and Technical (Pharmacist)			0.8		**0.8**
Additional Clinical Services (Assistant Practitioner Nursing, Healthcare Assistant)			1.0	1.0	**2.0**
Administrative and Clerical	0.4	4.0		1.0	**5.4**

[164] A 'cost code' is a unique code that is assigned to a specific department.
[165] For the Medical workforce, 1 'Whole Time Equivalent' (WTE) equates to a 40 hour working week, or 10 sessions. For all other staff working in the NHS under Agenda for Change (AfC) terms and conditions, 1 WTE equates to a full time position of a 37.5 hour working week. Staff members that are employed full time equate to '1' WTE.
[166] The 'Whole Time Equivalent' (WTE) is calculated by dividing the number of required hours for the role by the Whole Time Equivalent (www.nhsbsa.nhs.uk).

(Medical Secretary, Officer)					
Healthcare Scientists (Healthcare Science Practitioner)		1.0			**1.0**
Medical (Consultant, Hospital Practitioner (closed to new entrants), Speciality Doctor)		0.5	3.7		**4.2**
Nursing (Specialist Nurse Practitioner)		4.3	1.0		**5.3**
Additional Workforce*					**4.2**
Total	**0.4**	**9.8**	**6.5**	**2.0**	**22.9**

*Additional Dermatology workforce outside of the above cost code:

- Managerial roles equating to an additional 3 WTE within the Administrative and Clerical staff group
- Service-Level Agreement (SLA) with two Swansea Bay University Health Board Consultant Plastic Surgeons (one substantive post, one locum post) equating to an additional 1.2 WTE within the Medical staff group.[167]

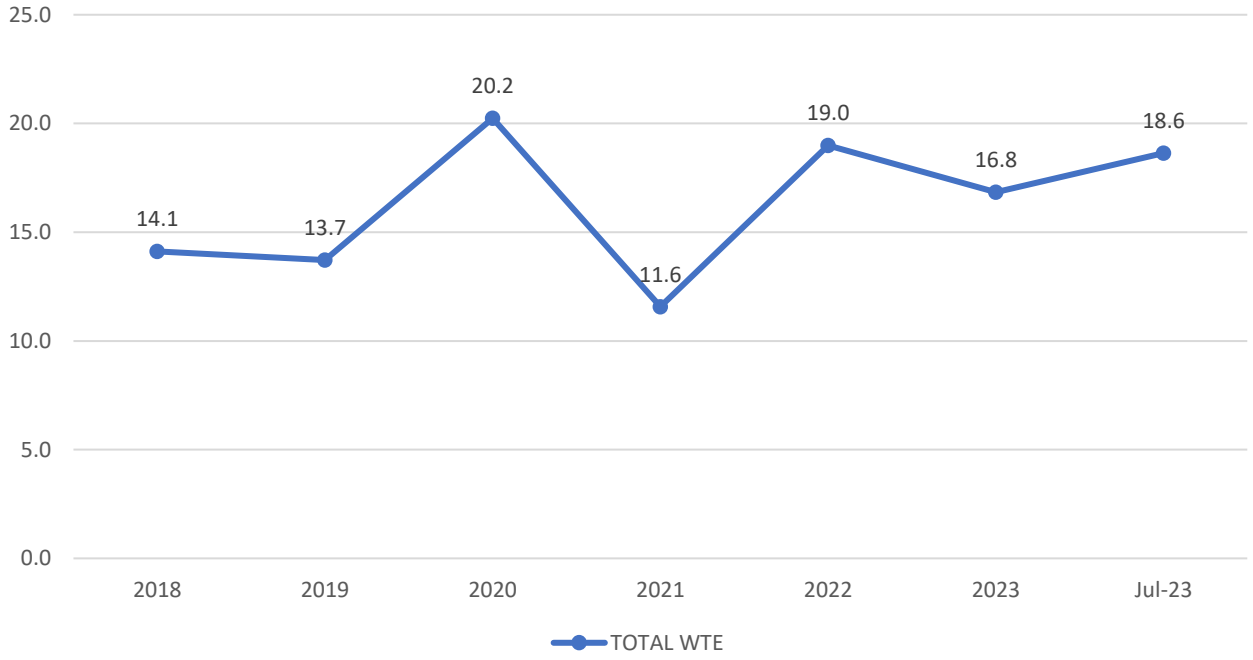
The table below shows the current staff budgeted Whole Time Equivalent establishment (where 'Budget' refers to the agreed Whole Time Equivalent funding that is available to the service by staff group, and 'Establishment' refers to the agreed roles that the service is allowed to recruit to). Alongside this data sits the Whole Time Equivalent data of staff in post.

Staff Group	Budget	Actual	Vacancy
Additional Professional Scientific and Technical	0.0	0.8	(0.8)
Additional Clinical Services	1.0	2.0	(1.0)
Administrative & Clerical	5.6	5.4	0.2
Healthcare Scientists	0.0	1.0	(1.0)
Medical	5.9	4.2	1.8
Nursing	6.8	5.5	1.3
Grand Total	19.3	18.9	0.5

[167] A Service-Level Agreement (SLA) is a written agreement which outlines the service to be provided by one party (often referred to as the provider or supplier) to another (www.library.hee.nhs.uk).

Most notable are the 1.8 WTE vacancies in the Medical staff group. These vacancies are held at Prince Philip Hospital. This means the service is running with near to two Whole Time Equivalent doctors fewer than the service has agreed funding for.

The historic Workforce data shows an increase in the Dermatology workforce in 2020 of 6.5 WTE, from 13.7 WTE in 2019 to 20.2 WTE in 2020, however, this was followed by a significant decrease to the service's workforce in 2021 of 8.6 WTE (decreasing from 20.2 WTE in 2020 to 11.6 WTE in 2021). This decrease can be seen clearly in the graph below:



There was a significant decrease in Medical roles in 2021 (from 4.2 WTE in 2020 to just 0.7 WTE in 2021). A key theme for the loss of doctors, particularly the middle grade speciality doctors, is the ongoing lack of a substantive Consultant Dermatologist (i.e., lack of a Clinical Lead). Feedback from staff that have left the service suggests that a key reason for the staff retention issues is that staff feel unsupported and tend to leave Hywel Dda to join roles in other health boards where there is a better clinical structure, and substantive clinical leadership is in place. It should be noted that there was a rise in Medical roles in 2022 to 4.7 WTE, which further highlights the position in 2021.

The following Workforce themed Risk has been recorded on the Health Board's Datix system for Dermatology:

'There is a Risk that the Dermatology service within the Health Board will not be able to sustainably provide timely or appropriate care to patients, leading to avoidable harm. This includes timely triaging referrals.' (Service Risk 747, linked to Corporate Risk 1649)

This Risk is caused by the long-term consultant vacancies within Dermatology because of a 'national shortage of suitably trained clinicians.'[168] The issue of the shortage is coupled with 'an increase in demand for condition management and increased complexity of treatment pathways.'

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[168] This is also highlighted within the 'ARCH Dermatology Programme Closure Report', which states that the recruitment and retention of Consultant Dermatologists in southwest Wales continues to cause an issue, and there is a significant lack of capacity nationally, not just in the Hywel Dda region.

The Risk adds that there is only one Non-Medical Prescriber (NMP) in the team to manage patients that require hospital-only medications.[169] The service relies on in-sourcing to bridge the gap in capacity.

The British Association of Dermatologists (BAD) 'Staffing and Facilities Guidance for Dermatology Services' (updated December 2022) states that 'hospital-based services require at least one Whole Time Equivalent (WTE) Consultant Dermatologist per 62,500 population.' With this ratio in mind, Hywel Dda would require at least 6 WTE Consultant Dermatologists to accommodate the population of the Hywel Dda region which, during the most recent Census in 2021 was recorded as 382,732. In fact, at 31 July 2023 the Dermatology service had 1.7 Locum Consultant Dermatologists in post. The service has not had a substantive Consultant Dermatologist in post since 2016.

The issue of the ongoing shortage of Consultant Dermatologists is having a direct effect on the training of additional Non-Medical Prescribers and 'GPs with an Extended Role in Dermatology', as these qualifications are dependent upon access to sufficient consultant capacity to support the necessary levels of training, development, and clinical supervision to complete the accreditation.

Dermatology conclusions

The Dermatology service is part of the Clinical Services Plan programme to support the return to pre-COVID activity levels (as a minimum), as part of improving access and reducing waiting times for patients.

The service operates across three hospital sites:

- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen
- Withybush Hospital, Haverfordwest.

In addition, service activity also takes place at Cardigan Integrated Care Centre in Cardigan, and South Pembrokeshire Hospital, in Pembroke Dock.

A summary of the findings identified within this paper are as follows:

Service changes

The ability to provide care to children and young people in an appropriate setting, and the standard of service offered to/received by paediatric patients has been impacted because of the loss of rooms previously occupied by Dermatology within the Children's Centre at Glangwili Hospital during the Health Board's response to COVID-19. The use of these rooms has not been reinstated. Via the Children's Centre, the service was able to run an efficient Eczema clinic for paediatric patients, where the availability of rooms for both nurses and locum consultants meant that patients could be seen by an appropriate healthcare professional for their needs, thus improving capacity for Medical staff to see more complex patients.

Paediatric patients can be seen at Prince Philip Hospital; however, these clinics take place in an adult Outpatient setting and a lack of available rooms in the Outpatient Department at the hospital

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[169] A Non-Medical Prescriber (NMP) is a non-Medical (i.e., not a doctor) healthcare professional that has completed an accredited prescribing course and registered their qualification with their regulatory body and is able to prescribe. Examples of Non-Medical Prescribers are Nurses, Midwives, Pharmacists, and other Allied Health Professionals (AHPs) such as Paramedics, Podiatrists, and Physiotherapists (www.rcn.org.uk, www.healthcareers.nhs.uk).

means that Nurse led clinics are unable to take place. Paediatric patients are being seen by Medical staff only, which is having an impact on locum consultant capacity.

The loss of the room previously used for minor operations in the Outpatient Department at Glangwili Hospital is having a direct impact on waiting list capacity, and service capacity at Prince Philip Hospital. There has been minimal access to the Day Surgery Unit at Glangwili Hospital and Prince Philip Hospital to hold minor operations, however, this has been on an ad hoc basis and so few sessions have been able to take place that waiting list capacity has not been impacted.

Phototherapy clinics have not recommenced post-COVID-19 as the clinical areas previously used at Glangwili Hospital and Withybush Hospital have not met Health and Safety guidelines. The cancellation of the Phototherapy clinics has had an impact on patients, as it offers the first line of treatment for patients with inflammatory conditions before exploring stronger medications, such as systemic and biologic drugs. There are also fewer risks involved in Phototherapy for patients, compared to these systemic and biologic medications.

The Patch Testing service has not recommenced due to difficulties recruiting staff with the specialist knowledge required to conduct this aspect of the service. The impact around not having the Patch Testing service is minimal, as it is not considered time critical. However, it can support patients by providing an allergy diagnosis.

Risks

The ability to manage patients awaiting follow-up appointments is an ongoing issue for the Dermatology service.

As described in a report on Dermatology concerns to the Quality, Safety and Experience Assurance Committee meeting on 4 December 2018, the fragility of the Dermatology service was scored as 20 on the Operational Risk Register. The report noted that the service had long been regarded as a ‘fragile’ service, and a ‘hard to fill’ speciality with longstanding vacancies due to a recognised national shortfall in both consultant and middle grade doctors. These issues remain relevant today.

Clinical effectiveness

The service is currently unable to run Nurse led Paediatric Eczema services (as it has done previously) due to a lack of available facilities following the loss of rooms in the Children's Centre in Glangwili Hospital during the Health Board’s response to COVID-19. This is having an impact on adherence to the standards set out in the ‘Atopic eczema in under 12s: diagnosis and management’ guideline.

Due to a lack of facilities, waiting lists, and workforce challenges, the service has been unable to reinstate the ‘See and Treat’ clinics that were held during the COVID-19 response. With the appropriate facilities and adequate staffing, the service would be able to reinstate these sessions, thus improving patient experience and reducing the number of visits that patients must make to the hospital, whilst also improving the service’s response to the Suspected Cancer Pathway guideline. In addition, it would mean that patients with the most severe skin cancers could receive treatment without delay.

Improved facilities would also enable the staff to utilise the Medical Photography team in Prince Philip Hospital. This would prove vital as the photographs produced would reduce the number of queries received regarding lesions that may or may not need to be removed, and there would be the opportunity to take and compare ‘progress’ photographs, should a patient’s lesion have changed. This is standard practice in most health boards.

The service is currently unable to offer Patch Testing which is deemed as a good practice recommendation in the guidelines for contact dermatitis for patients with chronic or persistent dermatitis. As a result of not being able to retain staff, the service has been unable to train staff to enable the Patch Testing service to resume in Hywel Dda.

Due to issues around the retention of staff and clinic availability the service has not been able to run joint Dermatology and Rheumatology clinics, which would be beneficial for the care and management of adult patients with systemic lupus erythematosus.

Regional work

The ARCH 'South West Wales Regional Dermatology Services Update Report' (21 September 2021) recognised that Dermatology services in Wales faced significant challenges, in particular those around recruitment of consultants into the workforce.

National work

The 'National Review of Dermatology Services in Wales 2019' highlighted that Dermatology services across Wales were facing recurrent and significant challenges across a number of areas. These included, but were not limited to:

- a notable shortfall in the Dermatology workforce
- a rising number of skin cancers
- insufficient Outpatient capacity.

Activity data

Since the pandemic, the number of referrals into the Dermatology service has increased and, to manage the sudden increase in demand in the wake of the pandemic, there was not capacity to continue with the 'See and Treat' sessions, especially to meet the requirements of the Suspected Cancer Pathway.

Over the past five years, 42% of the total referrals received into the Dermatology service have been patients on the Urgent Suspected Cancer pathway. This is having a direct impact on service allocation, capacity, and the waiting times of patients on non-Urgent Suspected Cancer pathways as the service strives to both adhere to the requirements of the 62-day Suspected Cancer Pathway and navigate the requirement of regular follow-up appointments for patients diagnosed with the more serious types of skin cancers.

Targeted early engagement with service users

- Patients mainly praised the efficiency and timeliness of the service received; the professional, kind, reassuring, and helpful staff; the quality of care; and good communication and information provision
- Some patients gave negative comments about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and poor communication and information provision.

The key issues highlighted by survey respondents in relation to the service, and their experiences of using the Outpatient Department within the service, were the same. Issues were raised around:

- The speed and efficiency of the service, with improvements suggested such as shortening waiting times and not cancelling appointments

- The speed and efficiency of the service, including access to appointments, tests, results, and a diagnosis
- Poor communication and information provision, including the need for better explanations of tests, results, and treatments, and increased frequency of contact and follow-up.

Targeted early engagement with staff

Dermatology staff highlighted the good relationships formed in the workplace, describing their colleagues as dedicated, experienced, and helpful; and several praised clinicians' passion for their work and commitment to going above and beyond to help their patients. Managers were also considered by some to be approachable and responsive when dealing with queries and issues from their staff.

Dermatology staff highlighted employee retention across all sites as the service's biggest issue: it was widely felt that staff losses, in addition to a lack of facilities and services like Patch Testing and Phototherapy, is compromising the level of care provided to patients.

Other concerns were around limited capacity and appointments leading to frequent last minute clinic cancellations, a lack of adequate training and development opportunities, and poor communication across the sites, which can affect the smooth running of the service. There were some concerns noted which suggest low morale amongst some staff at Prince Philip Hospital, which is the site which records the highest volume of patient activity.

The main improvements suggested to help improve the staff experience of working in/with the Dermatology service, were as follows:

- Increasing the workforce
- The development of a single-site Dermatology department
- Increasing the provision of services like Patch Testing and Phototherapy.

In addition, several staff respondents highlighted issues around poor facilities and equipment within Outpatient departments.

Workforce

A key theme throughout this Issues Paper is the recognised shortfall in Consultant Dermatologists, which is cited on several occasions. There is a national shortage of Consultant Dermatologists, and the Dermatology service in Hywel Dda has not had a substantive Consultant Dermatologist in post since 2016.

According to guidance set out by the British Association of Dermatologists (BAD), 'hospital-based services require at least one Whole Time Equivalent (WTE) Consultant Dermatologist per 62,500 population.' Hywel Dda would require at least 6 WTE Consultant Dermatologists to accommodate the population of the Hywel Dda region which, during the most recent Census in 2021 was recorded as 382,732. As of 31 July 2023, the Dermatology service had 1.7 Locum Consultant Dermatologists in post, and no substantive Consultant Dermatologists in post.

The perceived lack of support due to the lack of a substantive Consultant Dermatologist, i.e. lack of clinical leadership, is having an impact on staff retention as feedback has shown that reasons for leaving the service are often due to a lack of support and clinical supervision, and middle grade doctors tend to leave Hywel Dda to join roles in other health boards where there is a better clinical structure, and substantive clinical leadership is in place.

The high turnover of Medical staff, both locum consultants and middle grade doctors, means that the service needs to be reactive, rather than proactive. Limited succession planning is possible, and patients can experience multiple appointment cancellations due to these workforce and capacity challenges, thus risking the deterioration of patients' conditions, and exacerbating issues with waiting lists.

The issue of the ongoing shortage of Consultant Dermatologists is having a direct effect on the training of additional Non-Medical Prescribers and 'GPs with an Extended Role in Dermatology' to support the service, as these qualifications are dependent upon access to sufficient consultant capacity to support the necessary levels of training, development, and clinical supervision to complete the accreditation.

There is a recognised need for better facilities for the service – both in terms of room capacity and the standard of rooms. The room used for minor operations at Prince Philip Hospital needs refurbishment, in particular, improved lighting and ventilation. The room previously used for minor operations at Glangwili Hospital is no longer in use to due to infrastructure issues and the service has not been able to use the room since access was suspended during the Health Board's response to COVID-19.

The overall lack of a dedicated Dermatology department is impacting the standard of service for patients, and the coalescence of the team. A Dermatology department would help to provide the best standards of care and fluid treatment for patients, and support efficient communications between the team, which would likely have an impact on staff retention. The 'Review of Dermatology Services in Wales – Hywel Dda University Health Board', carried out by the Welsh Dermatology Board in 2019 noted that space had been identified which, if plans were enabled locally, could result in a consolidation of services, however, this did not come to fruition due to the emergence of the COVID-19 pandemic.

Section 11: Ophthalmology

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

Section 11: Ophthalmology

Introduction and background

This chapter of the Issues Paper is about Ophthalmology services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Ophthalmology service at all sites within the Health Board that delivered Ophthalmology services between 1 August 2018 and 31 July 2023.

Ophthalmology service at Hywel Dda

Ophthalmology is the treatment of eye conditions. This includes eye diseases, injuries, and surgical[170] procedures.

Ophthalmology services at Hywel Dda is available for children and young people and adult patients in our area who have sight problems that need treatment.

The Ophthalmology service is part of Scheduled Care at Hywel Dda and includes a surgical speciality. Ophthalmology services operate from the following locations:

- Glangwili Hospital, Carmarthen
- Bronglais Hospital, Aberystwyth
- Withybush Hospital, Haverfordwest
- Prince Philip Hospital, Llanelli
- Amman Valley Hospital, Ammanford
- Cardigan Integrated Care Centre, Cardigan
- South Pembrokeshire Hospital, Tenby
- North Road Clinic, Aberystwyth
- Werndale Hospital, near Carmarthen, was used between April 2020 and December 2020 following the temporary service change that we describe in this paper.

Ophthalmology is organised into several subspecialties[171], which in turn include patients at various stages of access to specialist input, diagnostics, treatment, and long term follow up. Details about each sub speciality is described below:

Subspeciality	What this means
Cataract	A specialist service to diagnose and treat cataracts. A cataract is a cloudy area in the lens of your eye (a small transparent disc inside the eye that helps to focus light). Cataracts are common as people get older and is part of the ageing process.
Cornea	Specialist service in treating the cornea. The cornea is the clear part at the front of the eye that keeps the inner eye structures protected from external elements. It has a strong refractive power, helping the eye to focus light.
Glaucoma	This is a specialist service to treat glaucoma, which is a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged, affecting a person's vision. It is mostly related to high pressure in the eye, not noticeable until it is in advanced stages, and causes irreversible sight loss, but progression can be halted or delayed if treated adequately and on time.

170 Surgery is treatment of injuries or diseases in people by cutting open the body and removing or repairing the damaged part.
171 Subspecialties is a speciality that is part of a broader speciality.

Diabetic Retinopathy (DR)	DR is a complication of diabetes, caused by constant high levels of sugar in the blood, damaging the small blood vessels in the retina (back of the eye). This can cause permanent sight loss and is difficult to control due to the nature of diabetes and the dependence on a good blood sugar control.
Ocular plastics	An oculoplastic procedure is a type of surgery done in the skin or adnexa[172] around the eyes, such as the eyelid.
Paediatric Ophthalmology	Within this chapter refers to eye care services for children under the age of eighteen
Vitreoretinal	Vitreoretinal surgery refers to any operation to treat eye problems involving the *retina*, *macula*, and *vitreous* fluid.
Hydroxychloroquine (HCQ)	Hydroxychloroquine is a drug used to treat conditions with an autoimmune and/or inflammatory origin. This drug can be toxic to the retina which will cause no symptoms. Screening is required to prevent permanent sight loss because of retinal toxicity.
Emergency Eye Care	A specialist service which specialises in emergency eye care, such as sudden onset of eye problems including (but not limited to) flashes, vision loss or minor eye injuries.
Intravitreal Treatment	This is an injection is a procedure to place a medication directly into the space in the back of the eye called the vitreous cavity. This is a treatment for Age-related Macular Degeneration (AMD), which is a condition whereby the retina degenerates with age, affecting a person's central vision. Vision loss due to AMD is permanent and irreversible.

Ophthalmology service model

All – Outpatient[173] and Inpatient[174]/Day Case[175].
OP – Outpatient only.
DC/IP – Day Case and Inpatient only.
Blank – no activity takes place.
Sub specialities take place in various sites across the Health Board, as detailed in the table below.

	Glangwili Hospital	Bronglais Hospital	Withybush Hospital	Prince Philip Hospital	Amman Valley Hospital	Cardigan Integrated Care Centre	Aberaeron Integrated Care Centre	South Pembrokeshire Hospital	North Road Clinic
Glaucoma	**All**	**DC/IP**		**OP**					**OP**
Cataracts	**DC/IP**	**DC/IP**			**DC/IP**				

[172] Adnexa of an eye are the protecting and supporting structures of the eye. They include the eyebrow, eyelid.
[173] If you have an appointment in a hospital or clinic but do not need to stay overnight, it means you are being treated as an Outpatient or a Day Patient. You may be having an appointment for treatment, diagnosis, or a procedure.
[174] A person who stays in a hospital while receiving treatment.
[175] A patient who comes in for a more involved procedure than an outpatient. You may need some recovery time at the hospital, but you should be able to go home the same day.

Medical Retina				**OP**					
Oculo-plastics	**All**	**DC/IP**		**OP**					
Intravitreal treatments			**OP**		**OP**	**OP**			**OP**
Laser clinics	**OP**		**OP**	**OP**					**OP**
Paediatric Ophthalmology	**All**								
Diabetic Retinopathy				**OP**				**OP**	
Vitreo Retinal	**All**			**OP**					
Emergency clinics	**OP**								**OP**
Botulinum [176]	**OP**		**OP**	**OP**					
FFA[177]				**OP**					
General eye services*	**OP**		**OP**	**OP**		**OP**	**OP**	**OP**	**OP**

* General eye services include an element of the following sub specialities:

- Cataract
- Corneal
- Medical Retina
- Glaucoma,
- Diabetic retinopathy
- HCQ (hydroxychloroquine)
- AMD (Age Related Macular Degeneration).

Treatment outside the Health Board

Depending on how complex each condition is, or where a specialist consultant is required that is not within Hywel Dda, for example a Corneal Consultant as described by the ARCH project in the Local, Regional and National section of this paper. Patients are referred to Swansea Bay University Health Board. Patients with tumours in the eye are referred to Liverpool University Hospital Foundation Trust, for treatment.

If patients need Neuro-Ophthalmology[178] service and the Vitreal Retinopathy Consultant within the Health Board is not available, patients are sent to Cardiff or Bristol.

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[176] *Botox injections.*
[177] *Fluorescein Angiography (FFN) us a diagnostic procedure where a series of photographs of both eyes are taken.*

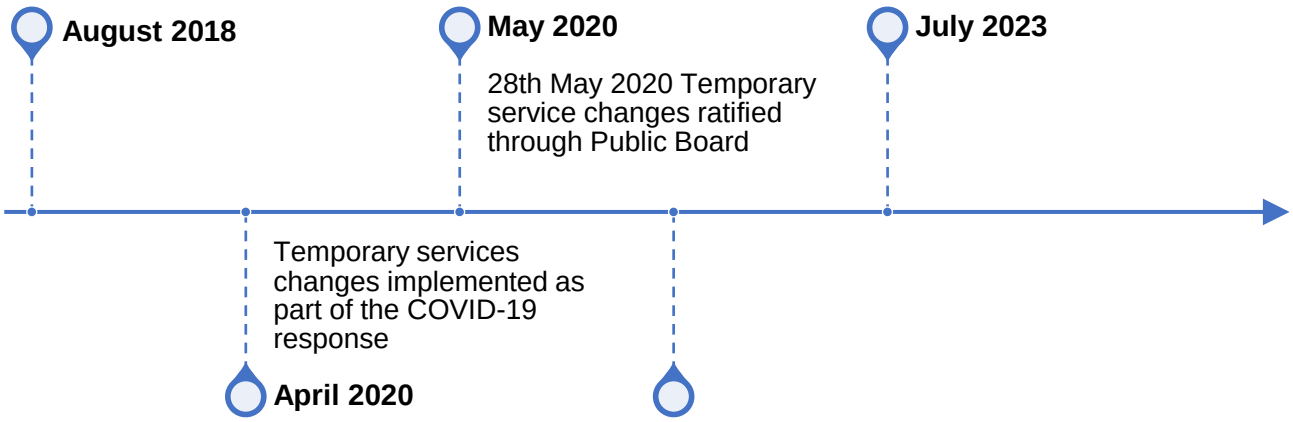
[178] *Neuro-Ophthalmology focuses on the complex interaction between the eyes, brain and nerves.*

To help reduce waiting lists, Hywel Dda refers some patients to private companies including Spa Medica Swansea, Spire in Cardiff and Werndale near Carmarthen to have simple cataracts removed.

Ophthalmology service changes

The following provides information about updates to Public Board about the changes that have taken place between August 2018 and July 2023.

Service change timeline



Temporary service change

The temporary service changes in May 2020 were described at Public Board on 28th May as follows:

- Ophthalmology Services have been moved to Werndale Hospital, to continue to run the Rapid Access Casualty for Eyes (RACE[179])
- Virtual review and triage[180] of all emergency cases
- Orthoptist telephone consultations are also being undertaken.

The virtual review and Orthoptist telephone consultations have since become part of standard pathways within the service. Werndale Hospital stopped managing RACE in December 2020 and all cases moved back to Glangwili Hospital.

Full details about the service change can be found in the following board paper[181]:
Responding to the COVID-19 Pandemic: Update, Review and Ratification of Decisions Made Since 16th April 2020'

Ophthalmology risks

The following section outlines identified risks that have been reported to Public Board that relate to Ophthalmology between 1 August 2018 and 31 July 2023.

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[179] *Emergency eye care services.*
[180] *Triage is the sorting and allocation of treatment to patients according to their need of care.*
[181] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13*

Risk No. 44: Ability to manage patients awaiting follow up appointments, escalated to the Corporate Risk Register 31 January 2019.

- The original risk was created following a missed target to reduce follow-up Outpatient appointments in several services, including Ophthalmology
- The risk was added to the Corporate Risk Register with a Risk Rating of 12, and a target risk score of 8. The risk highlighted that there is a risk of harm to patients on follow-up waiting lists who have exceeded their follow-up date
- The risk was closed on 1 June 2020 as, following discussions with the Scheduled Care Directorate Senior Management Team, the risk was replaced by a new risk in relation to Outpatient management. Further details about this risk can be found on page 5 of the linked document 30 July 2020 [182]
- The new risk is managed by the Scheduled Care Outpatients Management Team and was last reviewed in December 2023, when the risk score was reduced in severity from 15 to 12. This was because Hywel Dda now has a low percentage of patients on follow-up lists compared to other health boards.

Ability to fully implement Welsh Government (WG) Eye Care Measures (ECM), risk number 632, identified 27 September 2018.

Risk detail noted on page 4 of the linked document 26 November 2020[183]

- This risk was reduced in severity as Hywel Dda is not performance managed by Welsh Government Eye Care Measures
- Hywel Dda currently prioritises patients in line with Welsh Government Eye Care Measures.

Risk to Ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit, risk number 1664, identified 29 September 2023.

Risk detail noted on page 5 of the linked document 28 September 2023[184].

- This is a new risk raised after the period in scope of this paper
- The risk remains open while the service reviews potential mitigation.

[182] *Web address - hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-30th-july-2020/board-30th-july-2020-documents/sbar-corporate-risk-register-july-2020/*
[183] *Web address* - https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-26th-november-2020/26th-november-2020-documents/item-4-5-1-corporate-risk-register-sbar/
[184] *Web address - hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-28-september-2023/agenda-and-papers-28-september-2023/item-4-4-corporate-risk-register-pdf/*

Ophthalmology clinical effectiveness

The table below includes a list of the clinical guidelines that the Ophthalmology service needs to follow:

Guideline Source	Guideline Title	Link
RCOphth[185]	This resource includes a significant range of standards and guidance for: - Cornea - Child Vision - Glaucoma - Referral pathways for ocular tumours - Low Vision - Local anaesthesia for ophthalmic surgery - Quality and safety - Retina (including trauma and diabetic retinopathy) - Uveitis	https://www.rcophth.ac.uk/standards-and-guidance/
NICE[186]	Glaucoma: diagnosis and management	https://www.nice.org.uk/guidance/ng81
NICE	Age-related macular degeneration	https://www.nice.org.uk/guidance/ng82
NICE	Cataracts in adults: management	https://www.nice.org.uk/guidance/ng77

The Health Board is unable to adhere to most of the guidelines as there are a lack of senior clinicians and consultants. Specifically, Hywel Dda does not have a corneal consultant so cannot provide a corneal service.

Clinicians within the Health Board have suggested that a minor operation service for smaller local anaesthetic cases to free up theatre for complicated procedures, such as cataract surgery.

Ophthalmology local, regional, and national work

This section describes the regional and national projects or programmes connected to Ophthalmology services at Hywel Dda.

ARCH[187]

A Regional Collaboration for Health (ARCH) project, established 2019, aims to develop regional collaboration for Eye Care Services across Swansea Bay and Hywel Dda University Health Board. There are three areas of focus around ophthalmology for ARCH:

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[185] The Royal College of Ophthalmologists.
[186] National Institute for Health and Care Excellence
[187] A Regional Collaboration for Health – further details for ARCH can be accessed via this link http://arch.wales/en/

Glaucoma

Southwest Wales Glaucoma Service has been established. This is a service that sits across Hywel Dda and Swansea Bay. Currently, Hywel Dda manages glaucoma services from Glangwili Hospital, Bronglais Hospital, Prince Philip Hospital and North Road Clinic. A business case was presented and approved by Public Board in September 2021[188]. The Southwest Wales Glaucoma Service is intended to:

- Collaborate and integrate seamless eye care pathways across Hywel Dda and Swansea Bay University Health Board
- Expand eye care services with full integration of members of the community of ophthalmic professionals across Primary and Secondary Car.
- Develop a sustainable workforce model based on population needs
- Support Clinical Governance and Prudent Healthcare189 using technology
- Strengthen links with education to underpin high quality patient care as well as clinically based research.

This has proved difficult to implement so far for the following reasons:

- There are complications within procurement as there is not enough interest from Primary Care services to support delivery
- Recruitment has been hard, including development and training. Recruitment into Ophthalmology is a UK wide problem, partly due to not enough staff within general nursing and medical workforce choosing not to specialise within Ophthalmology
- The Electronic Patient Record system that will facilitate the service has not been implemented. As of January 2024, there is no completion date.

Diabetic

Patients under the care of the Diabetic Retinopathy service within Hywel Dda are currently seen at Prince Philip Hospital and South Pembrokeshire Hospital. The intention under the ARCH Project is that Hywel Dda and Swansea Bay will share best practice on referral refinement scheme, which will reduce unnecessary referrals to hospital eye services. This will reduce patient anxiety and increase capacity within the hospital-based clinics. An example of best practice of this includes using a Coordinator to review waiting lists, this work has started in Hywel Dda.

Cataract

Hywel Dda currently operates Cataract services from Glangwili Hospital, Bronglais Hospital and Amman Valley Hospital. Historically, outsourcing has been procured[190] to support long waiting[191] cataract removal surgery.

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[188] hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-30th-september-2021/agenda-and-papers-30th-september-2021/item-5-4-glaucoma-business-case-sbar/

[189] Prudent healthcare encourages people to consider what care they need, including whether they can look after themselves (self-care), and to use the most appropriate service for their clinical need, not the nearest or most familiar.

[190] Procurement is the process of purchasing goods or services.

[191] Long waiting patients have been on the waiting list for 104 weeks.

General Ophthalmology surgery

There is a Long-Term Agreement (LTA) in place with Swansea Bay to undertake some complex ophthalmology surgery, inclusive of Trabeculectomy[192] and Keratoconus[193]. This is outsourced due to limited skill set within the current Consultant workforce.

Getting It Right First Time (GIRFT)

GIRFT is a national Programme in England developed by the GIRFT National Team under the Chair 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. Details about how GIRFT affects cataract and glaucoma services in Wales can be found in appendix A7 - Ophthalmology - National Workstreams - GIRFT Cataract and Glaucoma Services.

The GIRFT review for Ophthalmology commenced in June 2023 and is due to be completed in early 2024. At present, no report is available although we do have some early recommendations. The below points are a summary of the high priority recommendations, more information can be found in Appendix I6.2 – Ophthalmology – Local and Regional Workstream – GIRFT Recommendations.

- Appoint a Clinical Lead194 to provide clinical leadership
- Work towards delivering one stop Pre-assessment clinics195 to reduce the amount of visits a patient will need to make to hospital. Alongside one stop Pre-assessment clinics, telephone assessments will be commenced to capture basic patient information ahead of Pre-assessment
- Patients who have been on the waiting list a very long time to be assessed via telephone to avoid cases of serious harm
- To expand Multi-Disciplinary Team (MDT)196 capability and competency to expand the delivery of services within Ophthalmology
- Rationalise where Outpatient services are delivered to fewer, better sites with dedicated ophthalmic spaces
- Re-explore the use of remote consultations to reduce the burden on Outpatient space
- Urgently link up regionally to use resources to their best availability including medical and nursing staff for cataract, glaucoma, and other areas
- Undertake proper demand and capacity work and explore realistic options for change, and how much and how quickly they will deliver.

More information about GIRFT for Ophthalmology in other areas can be found in the following online documents.

GIRFT Ophthalmology NHS England[197]

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[192] Trabeculectomy is a type of glaucoma surgery performed on the eye that creates a new pathway for fluid inside the eye to be drained. This is an Outpatient procedure performed in the operating room.
[193] Keratoconus is a non-inflammatory eye condition in which the normally round dome-shaped clear window of the eye (cornea) progressively thins causing a cone-like bulge to develop.
[194] A Clinical Lead is a health care professional who takes on leadership responsibilities within their clinical are of expertise.
[195] A Pre-assessment clinic is an assessment of a patient's general health and fitness before surgery can be carried out.
[196] A Multi-Disciplinary Team is a group of trained staff from different areas of healthcare to discuss and manage the care of individual patients.
[197] https://gettingitrightfirsttime.co.uk/surgical_specialties/ophthalmology/

Clinically led Ophthalmology Outpatient Guidance[198]

A regional approach is being considered which will include the work undertaken by ARCH and GIRFT into a single workstream.

Ophthalmology activity data

Ophthalmology service activity reported between 1 August 2018 and 31 July 2023 is included for all sites providing services. All data tables including the specific conditions captured can be found in Appendix I8 – Ophthalmology – Activity Data.

2018-19 and 2023-24 are not full 12 month periods. 2018-19 is 01 August to 31 March and 2023-24 is 01 April to 31 July.

Activity for Werndale during the COVID-19 Pandemic as part of the temporary service change has been included. Where a location is not noted within a table, it is because it does not deliver the specific activity being presented.

Outpatient data

Outpatient services for Ophthalmology are carried out at the following sites across the Health Board:

- Aberaeron Integrated Care Centre
- Amman Valley Hospital
- Cardigan Integrated Care Centre
- Glangwili Hospital
- Prince Philip Hospital
- Bronglais & North Road Clinic (Referrals to Bronglais are carried out in North Road Clinic
- Withybush Hospital
- Werndale Hospital (between April to December 2020).

Outpatient services include:

- Consultations following referral
- Disease management referral
- Intravitreal treatments (eye injections)
- Laser treatments
- Minor treatments, including Botox injections.

[198] *https://gettingitrightfirsttime.co.uk/wp-content/uploads/2023/07/ClinicallyledOphthalmologyOutpatientGuideJuly23FINAL-V1.pdf*

Outpatient Referrals										
Financial Year	Aberaeron Integrated Care Centre	Amman Valley Hospital	Bronglais Hospital	Cardigan Integrated Care Centre	Glangwili Hospital	Prince Philip Hospital	North Road Aberystwyth	Withybush Hospital	Werndale	Total
2018-19	128	236	1,143	96	3,098	179	22	67	0	**4,969**
2019-20	165	334	1643	92	5,394	137	50	90	0	**7,905**
2020-21	50	456	921	13	2,674	107	35	39	10	**4,305**
2021-22	77	568	1,435	58	2,100	88	169	87	0	**4,582**
2022-23	102	371	961	58	1,114	65	138	205	0	**3,014**
2023-24	8	101	283	14	503	37	46	79	0	**1,071**
Total	**530**	**2,066**	**6,386**	**331**	**14,883**	**613**	**460**	**567**	**10**	**25,846**

Outpatient Activity											
Financial Year	Aberaeron Integrated Care Centre	Amman Valley Hospital	Bronglais	Cardigan Integrated Care	Glangwili	Prince Philip	North Road Aberystwyth	South Pembrokeshire	Withybush	Werndale	Total
2018-19	338	642	0	26	12,100	4,253	4,257	251	5,103	0	**26,970**
2019-20	509	1,057	21	82	18,426	6,037	6,666	294	6,710	0	**39,802**
2020-21	1,854	1,573	0	204	5,608	2,464	2,265	0	3,080	2,403	**19,451**
2021-22	804	1,370	0	1,509	11,610	3,520	5,079	0	4,960	0	**28,852**
2022-23	1,021	1,166	32	1,817	14,142	5,843	5,564	91	5,855	0	**35,531**
2023-24	393	267	0	512	5,319	2,126	2,063	62	2,085	0	**12,827**
Total	**4,919**	**6,075**	**53**	**4,078**	**67,205**	**24,243**	**25,894**	**698**	**27,793**	**2,403**	**163,433**

New referrals have fallen from 7,905 in 2019-20 (the first whole 12 month period) to 3,014 in 2022-23 (the last whole 12 month period). This in large part is because of Primary Care services being involved in referral refinement and treating a proportion of patients in the community, allowing for patient care closer to home.

The number of interactions, which is made up of follow up appointments has decreased from 39,802 in 2019-20 to 35,531 in 2022-23. Smaller community settings such as Aberaeron, Cardigan and Amman Valley have been used to supplement service delivery.

The Ophthalmology service is currently under internal review to examine demand and capacity and the sustainable delivery of services from nine separate sites to ensure efficient use of staff and resources. This review is also a high priority GIRFT recommendation.

Day case data

All procedures undertaken by Ophthalmology are as a Day Case, however there are rare circumstances when a patient develops a complication they may stay as an Inpatient on a general ward.

Day Case services for Ophthalmology are carried out at the following sites across the Health Board:

- Amman Valley Hospital
- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital (Prior to COVID, eye injections were delivered in theatre. It became an Outpatient procedure as part of the COVID response change. Little Inpatient and Day case activity takes place since this change).

Day Case services would include:

- Cataract surgery
- Vitreoretinal surgery
- Ocular plastic surgery
- Small numbers of glaucoma surgery and squint surgery199.

The table below highlights the number of patients added to day case lists by site for the period.

Day Case Lists						
Financial Year	**Amman Valley Hospital**	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	289	1,731	2,751	10	790	**5,571**
2019-20	479	2,731	4,523	23	1,208	**8,964**
2020-21	948	184	1,906	20	5	**3,063**
2021-22	562	729	2,509	39	3	**3,842**
2022-23	497	990	3,424	62	6	**4,979**
2023-24	131	291	1,150	41	3	**1,612**
Total	**2,906**	**6,656**	**16,263**	**195**	**2,015**	**28,031**

[199] *Squint surgery involves moving the muscles that control eye movement so that the eyes line up better*

Day Case / Inpatient Activity						
Financial Year	**Amman Valley Hospital**	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	3,488	650	1,380	0	905	**6,423**
2019-20	5,624	2,204	1,799	0	1,317	**10,944**
2020-21	5,491	0	297	0	10	**5,798**
2021-22	5,803	526	877	0	0	**7,206**
2022-23	5,063	497	1,101	1	0	**6,662**
2023-24	1,981	154	363	0	1	**2,499**
Total	**27,450**	**4,031**	**5,817**	**1**	**2,233**	**39,532**

Intravitreal treatments or eye injection treatment changed from being recorded as a Day Case to being recorded as an Outpatient procedure in 2019/20. This was changed to reduce patient footfall within the hospital and to align the practice with other sites in the UK. This was the only Day Case procedure undertaken in Withybush Hospital, which is why the number of activities ceases. The procedure continued to be carried out at Withybush Hospital as an Outpatient procedure.

2019/20 was the busiest year recorded in scope and the service feels that if COVID-19 did not emerge the following year then 2020/21 would have continued this trend.

Outsourced activity data

To help reduce the waiting lists and remove some of the burden on Hywel Dda services, some simple cataract removals are outsourced to other health providers. The table below shows the numbers of removals that have taken place over the in-scope period and the locations the Health Board has used. There has been no recorded activity for 2023-24.

Financial Year	**BMI Werndale**	**Nuffield**	**Community Eye Care**	**Spa Medica**	**CHEC[200]**	**BMI Bath**	**Totals**
2018-19	2,022	76	0	0	0	91	**2,098**
2019-20	2,047	0	0	0	0	0	**2,047**
2020-21	258	0	0	0	0	0	**258**
2021-22	850	0	2,772	2,034	0	0	**5,656**
2022-23	0	0	0	797	1,907	0	**2,704**
Totals	**5,177**	**76**	**2,772**	**2,831**	**1,907**	**91**	**12,763**

This shows an increase over the period in scope for outsourcing cataract surgery after the COVID-19 period. This is a direct result of an increased backlog and pressure on the waiting list. This activity is on top of the Outpatient and Day Case activity undertaken within Hywel Dda.

[200] *Community Health and Eye Care in Bridgend*

Ophthalmology incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against Ophthalmology. Full data for incidents, complaints, and claims, can be found in Appendix I9 – Ophthalmology – Incidents Data and I10 Ophthalmology – Complaints Data.

Patient safety incidents

The table below shows the overall number of recorded incidents for Ophthalmology across all sites within the Health Board. The recording period for each year is 1 August to 31 July.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Incidents	111	60	26	67	58

The table below shows the location of reported incidents. Where locations are not included it indicates no recorded incidents took place at that location. The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of July 2023.

Primary Location	1 August 2018 – 31 March 2021	1 April 2021 – 31 July 2023	Total
Glangwili Hospital	71	44	**115**
Prince Philip Hospital	26	26	**52**
North Road Clinic	25	24	**49**
Amman Valley Hospital	25	20	**45**
Bronglais Hospital	21	20	**41**
Withybush Hospital	16	17	**33**
South Pembrokeshire Hospital	0	1	**1**
Totals	**184**	**152**	**336**

The data shown in the table below shows the number of incidents as a percentage of the overall activity. For example, Glangwili Hospital had 41% of the overall activity (the number of patients seen as inpatients and outpatients) with 35% of recorded incidents.

The total number of activities across all Health Board sites is 238,197. The total number of incidents reported in Ophthalmology services across all Hywel Dda sites is 336 incidents.

Site	Percent of all activity (238,197)	Percent of reported incidents (336)
Glangwili Hospital	41% (96,833)	35% (115)
Prince Philip Hospital	10% (22,848)	16% (52)
Amman Valley	14% (36,017)	14% (45)
North Road Clinic	10% (48,490)	12% (49)
Bronglais Hospital	7% (16,398)	13% (41)
Withybush Hospital	13% (30,640)	10% (33)

Aberaeron Integrated Care Centre	2% (10,096)	None reported
Cardigan Integrated Care Centre	1% (3,955)	None reported

The Specialist Consultants are concentrated at Glangwili Hospital, which may explain why there is a lower-than-expected number of reported incidents at the site.

The primary reason for there being a higher percentage of reported incidents at Bronglais Hospital is due to the remoteness of Bronglais Hospital and North Road Clinic.

North Road Clinic operates 9A.M. to 5P.M. Monday to Friday and includes a RACE[201] service. Out of hours, patients attending Bronglais Hospital Emergency Department requiring Ophthalmology treatment can be re-routed to Glangwili out of hours RACE. This has historically led to some confusion and has led to several reported incidents.

A thematic review of the incidents reported at Bronglais Hospital identified that there was a gap in awareness of staff about the out of hours pathway to Glangwili for RACE services. This issue has since been addressed.

The most common types of incidents reported are shown in the table below.

Reported 1 August 2018 – 31 March 2021	**Total**
Administrative Processes (Excluding documentation)	54
Documentation	39
Therapeutic Processes/Procedures (except medications/fluids/blood/plasma products administration)	20
Reported 1 April 2021 – 31 July 2023	**Total**
Records, information	25
Treatment, procedure	16
Behaviour (including violence and aggression)	13

Administrative Processes includes missing patient notes. This is a direct result of the electronic patient record system, which requires a consultant to review a PDF copy which is often many pages long. The clinical tests undertaken under Ophthalmology are not often available on WPAS[202] meaning the Consultant needs to request historic paper test results, often resulting in delays in obtaining historic information which is vital to the ongoing assessment of the patient. This affects all sites however South Pembrokeshire hospital is acutely impacted due to the remoteness of the site, despite only having a single incident recorded. This is partly due to consultants who host clinics from South Pembrokeshire hospital working primarily from Withybush Hospital as their main base.

The table below shows the severity of recorded incidents.

Severity	**1 August 2018 – 31 March 2021**	**01 April 2021 – 31 July 2023**	**Totals**
1 – None	148	60	**208**
2 – Low Harm	14	24	**38**

[201] *Emergency Eye Care Service*
[202] *WPAS is the Welsh Patient Administration System, the primary system used by NHS Wales to manage patient details*.

3 – Moderate Harm	10	11	**22**
4 – Severe Harm	12	0	**12**
5 – Catastrophic Death	0	0	**0**

The table below shows the spread of activity by percentage against the number of reported incidents spread across Hywel Dda by percentage.

Site	Percent of all activity (238,197)	Percent of reported incidents (336)
Glangwili Hospital	41% (96,833)	35% (115)
Prince Philip Hospital	10% (22,848)	16% (52)
Amman Valley	14% (36,017)	14% (45)
North Road Clinic	10% (48,490)	12% (49)
Bronglais Hospital	7% (16,398)	13% (41)
Withybush Hospital	13% (30,640)	10% (33)
Aberaeron Integrated Care Centre	2% (10,096)	None reported
Cardigan Integrated Care Centre	1% (3,955)	None reported

- The Specialist Consultants are concentrated at Glangwili Hospital, which may explain why there is a lower-than-expected number of reported incidents at the site
- The primary reason for there being a higher percentage of reported incidents at Bronglais Hospital is due to the remoteness of Bronglais Hospital and North Road Clinic
- North Road Clinic operates 9-5 Monday to Friday and includes a RACE service. Out of hours, patients attending Bronglais Hospital Emergency Department requiring Ophthalmology treatment can be re-routed to Glangwili out of hours RACE. This has historically led to some confusion and has led to several reported incidents
- A thematic review of the incidents reported at Bronglais Hospital identified that there was a gap in awareness of staff about the out of hours pathway to Glangwili for RACE services. This issue has since been addressed.

Ophthalmology patient complaints

The table below shows the overall number of complaints within Ophthalmology across all Health Board sites.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Complaints	35	135	53	96	225

The table below shows the location of recorded complaints. Where locations are not included it indicates no recorded complaints took place at that location.

Primary Location	01 August 2018 – 31 March 2021	1 April 21 – 31 July 2023	Totals
Glangwili Hospital	93	153	**246**
Amman Valley Hospital	45	11	**56**

North Road Clinic	40	15	**55**
Prince Philip Hospital	23	55	**78**
Withybush Hospital	21	81	**102**
Bronglais Hospital	13	20	**33**
Cardigan Integrated Health Centre	0	18	**18**
Totals	**235**	**353**	**588**

The below table shows activity volume (combined Outpatient, Inpatient and Day Case) and reported complaints as a percent for each site against the total number. Percentages have been rounded to the nearest whole, so may not total 100.

Site	Percent of all activity (238,197)	Percent of reported complaints (588)
Glangwili Hospital	41% (96,833)	42% (246)
Prince Philip Hospital	10% (22,848)	13% (78)
Amman Valley	14% (36,017)	10% (56)
North Road Clinic	10% (48,490)	9% (55)
Bronglais Hospital	7% (16,398)	6% (33)
Withybush Hospital	13% (30,640)	17% (102)
Aberaeron Integrated Care Centre	2% (10,096)	None reported
Cardigan Integrated Care Centre	1% (3,955)	3% (18)

It is important to note that:

- Glangwili includes the out of hours RACE
- Specialist consultants are concentrated at Glangwili
- Glangwili and Bronglais carry out most Day Case procedures.

The level of recorded complaints tracks broadly with the level of activity taking place at each site. Most reported complaints relate to delays to appointments. This is expected for an Outpatient service which is experiencing a significant backlog in appointment times.

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category.

Subject (primary)	1 August 2018 – 31 March 2021	1 April 2021 – 31 July 2023	Totals
Appointments	137	194	**328**
Clinical treatment / assessment	51	83	**134**

The table below shows overall number of complaints received for Ophthalmology services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023.

Severity	1 August 2018 – 31 March 2021	1 April 2021 – 31 July 2023	Totals
Grade 1 Minor (informal)	120	251	**371**
Grade 2 Minor	31	73	**104**

Grade 3 Moderate	15	21	**36**
Grade 4 Major	8	1	**9**
Grade 5 Catastrophic	0	0	**0**

Ophthalmology claims

During the period 2018-2023, there are 9 clinical negligence cases (claims and redress) that are currently open and being investigated. There are also 4 potential clinical negligence claims that are awaiting further details prior to further investigation. There are 5 closed cases relating to the period, the themes arising from the outcome of the case investigations are delay in diagnosis and treatment and follow up arrangements.

Ophthalmology patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix I11 – Ophthalmology – Patient Experience and Compliments Data.

The below thematic analysis has been carried out on the feedback received from Patient Experience, Friends and Family Experience and Compliments that have been recorded each year since 2021.

	Patient Experience	Friends and Family Experience	Compliments
2021	Positive feedback around the friendliness of staff and quality of service provision	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 of care and long wait times to be seen by a doctor or to receive treatment.	None recorded
2022	The themes noted by patients related to the quality of care, professionalism of staff and timeliness of appointments. Positive experiences include friendly and helpful staff, efficiency of service and quality of care.	The themes arising are around staff, appointments, communication and impacts on people with disabilities. Positive comments were received around staff being described as friendly, helpful, polite, and professional, with a quality of care being described as food with patients reporting good experiences with doctors and nurses. There were mixed views about waiting times for appointments with some being	None recorded

	Negative experiences include the delays in waiting for follow up appointments which patients feel should be sooner, and for some accessing the service after locations were changed	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 of patients, particularly those with disabilities.	
2023	The themes arising relate to staff professionalism, appointments, locations, and access to services. Positive experiences include professionalism, kindness, and quality of service. Negative experiences relate to delays or cancellations in appointments, uncertainty of the purpose of the appointment or status in the waiting list and the location being unsuitable for those who have had to drive to attend appointments.	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. 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.	The theme is that staff were proactive in identifying health needs getting patients the best possible outcome.

The above comments are not attributed to a particular site but are general for the service. Key themes across the years and evidence groups are as follows:

- Staff are frequently described as professional, friendly, helpful, and efficient
- Patients are unhappy at the delays in waiting for appointments, in particular follow up appointments
- There are concerns about lack of communication between the service and patients. This includes errors when making appointments and scheduling issues.

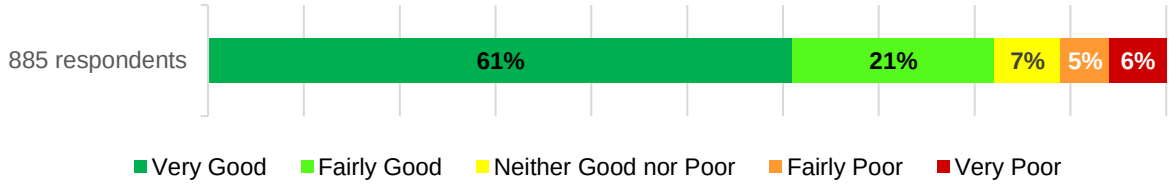
Ophthalmology service targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report[203].

[203] *Please note that where percentages do not sum to 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers*

82% of patient respondents said that their experience of using the Ophthalmology service was good, whereas 11% said it was poor.

Overall experience of using the Ophthalmology service (patients)



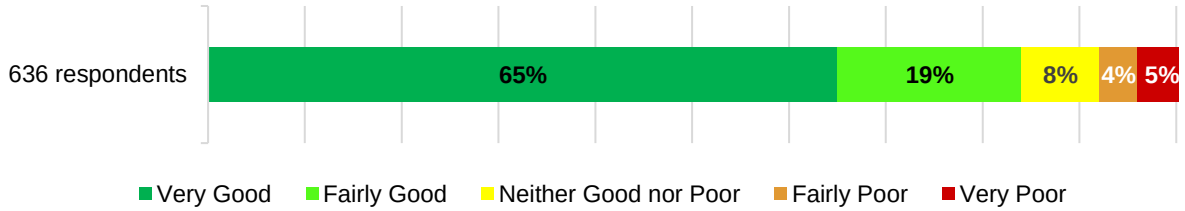
In terms of what was good about their experience of using the Ophthalmology service, patients praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care. Others, though, complained about a lack of timeliness (especially in relation to appointment access and speed of diagnosis), and poor communication, information provision, and follow-up.

The main improvements to Ophthalmology services as suggested by survey respondents were around speed and efficiency (including shortening waiting times and not cancelling appointments); and communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow-up). It should be noted, though, that just over a quarter of respondents felt that no improvements are required.

Experiences of Outpatient services

85% of patient respondents said they used the Outpatient department as part of their Ophthalmology treatment. Of these, 83% said their experience of doing so was good and 8% said it was poor.

Overall experience of using the Outpatient department (patients)



When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent positive comments related to:

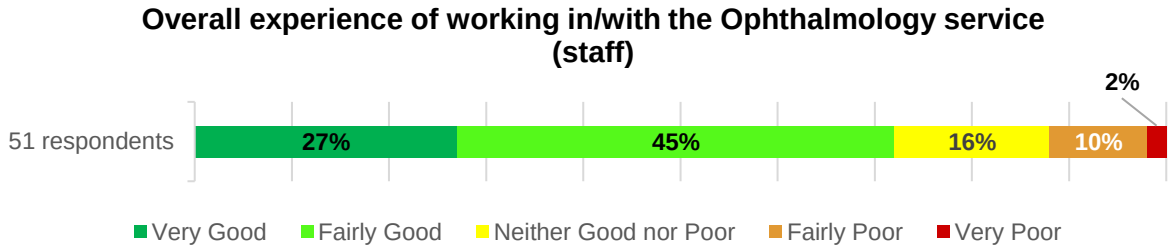
- receiving a good, quick, and efficient service
- the professional, kind, reassuring, and helpful staff

The most frequent negative comments were around service speed and efficiency (including access to appointments, tests, and results); and communication (including explanations of tests, results, and treatments, and the frequency of contact and follow up).

Ophthalmology Targeted early engagement with staff

As per the approved Clinical Services Plan methodology, a survey was sent to Medical, Nursing, Therapies, Operational and Support staff. Staff members were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS, to understand the key issues and themes.

73% of staff respondents said that their overall experience of working in/with the Ophthalmology service was good, whereas 12% said it was poor.



In terms of what is/was good about their experience of working in/with the Ophthalmology service, staff respondents particularly noted:

- positive working relationships between managers and staff across all sites
- effective teamwork between dedicated, respectful, and caring staff; and being able to take pride in providing good quality patient care

Some also highlighted opportunities to gain new skills, knowledge, and experience by working with experienced specialists within the service.

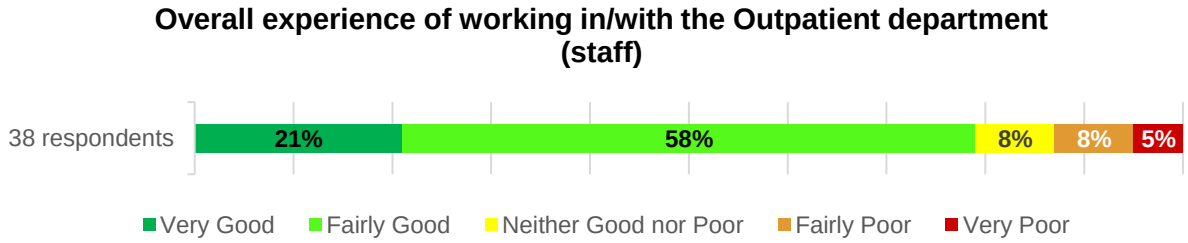
As for what is/was difficult about their experience of working in/with the Ophthalmology service, staff noted:

- capacity was the key concern for staff respondents, with appointments in high demand and clinics often overbooked (it was felt, because of staff shortages and retention issues)
- others stated challenges were around maintaining a good work/life balance
- lack of staff training opportunities and clear progression pathways
- ineffective communication between delivery staff and managers within the service, and across the Health Board as a whole
- lack of staff input into decision-making
- the sometime inefficiency of the current paper-based notes system.

Most staff suggested ways to improve their experience of working in/with the Ophthalmology service. The most common were to improve staff recruitment, retention, and capacity; and encourage more open communication and engagement between Health Board/service managers and delivery staff to improve working relationships and ensure the latter have a say in decision-making. Other suggestions were around better and more structured onboarding for new starters and ongoing training for all staff; and ensuring the provision of correct, appropriate, and timely notes.

Experiences of Outpatient Services

85% of staff survey respondents use the Outpatient department in delivering their Ophthalmology service. Of these, 79% (30 individuals) said that their overall experience of the Outpatient department was good, and 13% (5 individuals) said it was poor.



Staff respondents praised Outpatient staff for being helpful and dedicated, and for the quality of care they provide. However, it was said that more Ophthalmology-specific training and development for Outpatient staff would be beneficial; that appointment delays should be addressed; and that additional administrative staff would improve the department's efficiency.

Ophthalmology finance

This section highlights the key financial drivers affecting the Ophthalmology service.

Service	Key Drivers
Ophthalmology	Vacancies require additional weekend work and use of high-cost locum, to address backlog and meet increasing demand.
General	Services provided over multiple sites Vacancies filled with premium costs or additional hours

The Ophthalmology service is managing financial pressures, including £0.879m in variable pay[204] costs at the end of Q3 2023/2024, this is due to high medical agency costs and general rota gaps.

Despite this, an anticipated year-end underspend of approximately £1m is expected. This is because of a reduction of expenditure in things like drug costs and higher than expected level of substantive vacancies against the extra spend on agency and locum spending. Additional pressures include long term diabetic retinopathy and glaucoma eyecare initiatives which will lose the benefit of outpatient transformation funding and will drive a £0.2m cost pressure.

This information is aligned to the findings and submissions included in the 2024/2025 annual plan.

Ophthalmology workforce data

The Workforce Team have supplied data within defined cost codes provided by Ophthalmology. Full details about the methodology can be found within Appendix I13 – Ophthalmology – Workforce Data.

The table below shows the workforce establishment (number of people working) across our hospital sites within Ophthalmology services as at 31 July 2023.

[204] *Variable pay is a term used to describe payments made to staff either not employed by Hywel Dda or are working above their normal working arrangements. Examples include staff recruited from an agency who may be paid more for the same role, or staff working overtime or additional hours above their normal arrangements.*

Staff Group	Location						
	Bronglais Hospital	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Amman Valley	North Road	Total
Additional Clinical Services (Health Care Support Worker, Healthcare Assistant, Technician)	0.6	11	0	2.5	0	1	**15.1**
Administrative (Clerical, Medical Secretary, Receptionist)	2.0	9.0	1.0	1.8	1.0	0.4	**15.2**
Allied Health Professional (Orthoptist, Orthoptist Specialist Practitioner)	0	2.4	0	0.8	0	1.0	**4.2**
Medical (Consultant, Speciality Doctor)	3.0	12.0	0.8	2.0	0	0	**17.8**
Nursing (Sister or Charge Nurse, Specialist Nurse Practitioner, Staff Nurse)	1.7	11.5	0	3.3	0.6	2.6	**19.7**
Totals	**7.3**	**45.9**	**1.8**	**10.4**	**1.6**	**5.0**	**71.9**

The below table shows the current budgeted and actual staff in post. Budget refers to the agreed WTE (Whole Time Equivalent) funding that is available to the service by staffing group.

Staff Group	Budgeted WTE	Actual WTE	Vacancy As of 31 July 2023
Additional Clinical Services (Health Care Support Worker, Healthcare Assistant, Technician)	15.6	15.1	0.5
Administrative (Clerical, Medical Secretary, Receptionist)	20.0	15.2	4.8
Allied Health Professional (Orthoptist, Orthoptist Specialist Practitioner)	6.8	4.2	2.6
Medical (Consultant, Speciality Doctor)	22.0	16.8	5.2
Nursing (Sister or Charge Nurse, Specialist Nurse Practitioner, Staff Nurse)	23.6	19.7	3.9
Total	87.9	70.9	17.0

As at the 31 July 2023, the following vacancies for doctors were open.

Vacancy Information (last 12 months)	Role	Outcome
100-MED-GGH-204	Speciality Doctor/Senior Clinical Fellow Ophthalmology	2 offered – 2 withdrawn
100-MED-GGH-204-A	Speciality Doctor/Senior Clinical Fellow Ophthalmology	2 offered – 1 withdrawn, 1 started in post
100-MED-GGH-204-B	Speciality Doctor/Senior Clinical Fellow Ophthalmology	1 rejected at interview
100-MED-GGH-130-B	Consultant Ophthalmologist	4 WTE advertised – 1 started in post
100-MED-GGH-200-L	Locum Consultant in Ophthalmology	3 WTE advertised – 1 started in post, 2 scheduled for interview but both withdrew

No recruitment to doctor posts has taken place since 31 July 2023. The service is still considerably short on the number of specialist consultants required to manage all services at all sites within Ophthalmology.

The workforce data suggests the following key issues:

Lack of specialist ophthalmologist

This is noted as a risk within the workforce Appendix. It explains that there is a lack of Specialist Ophthalmologists working within the Health Board. There are several sub specialities, including Cornea, Paediatrics and Glaucoma that are currently supported by Swansea Bay University Health Board.

The lack of Specialist Ophthalmologist is impacting on the ability to support and develop staff groups at all levels within the service. This lack of specialist ophthalmologist is also impacting on the ability accommodate medical trainees, preventing Junior Doctor intakes that could potentially be developed into substantive posts to support the service.

Recruitment challenges

It is difficult for Hywel Dda to recruit into Ophthalmology services. There have been several targeted recruiting schemes to recruit into Ophthalmology, however the service has been unable to find any doctors on the specialist register with UK experience who are willing to relocate to Southwest Wales. This challenge is made worse by there being a UK shortage of specialist doctors, so the Health Board is in competition with the whole country when trying to attract specialists. In addition to this, it is challenging to fill vacancies in band 5 nursing posts.

Workforce establishment

Activity within the service at all sites is growing, as demonstrated within the Activity Data section of this paper showing and increase in combined Outpatient and Day Case interactions from 43,502 in 2018 to 50,130 in 2023, an increase of 15%, whereas the number of Specialist Doctors has increased from 16.4wte to 17.8wte in July 2023, an increase of 8%.

The workforce establishment has not been reviewed and the service is facing challenges of retirement of staff, ageing workforce, and the inability to recruit into specialist positions.

Early recommendations from the GIRFT review relating to workforce establishment include:

- Undertaking a comprehensive review of the roles, job plans, numbers, and professional development of the MDT for both cataract and glaucoma sub specialities
- Glaucoma services and the Ophthalmic Diagnosis Treatment Centre (ODTC) pathway alongside contract reform in Primary Care.

Ophthalmology conclusions

The Ophthalmology service is in the Clinical Services Plan (CSP) to support the return of pre-COVID activity levels as a minimum, as part of improving access and reducing waiting times for patients.

The service operates from the following sites:

- Glangwili Hospital (Carmarthen)
- Bronglais Hospital (Aberystwyth)
- Withybush Hospital (Haverfordwest)
- Prince Philip Hospital (Llanelli)
- Amman Valley Hospital (Ammanford)
- Cardigan Integrated Care Centre (Cardigan)
- South Pembrokeshire Hospital (Tenby)
- North Road Clinic (Aberystwyth)
- Werndale Hospital (Carmarthen) was used between April 2020 to December 2020 following the temporary service change described in the paper.

A summary of the findings identified within this paper are as follows:

Risks

- Ability to manage patients awaiting follow up appointments
- Ability to fully implement Welsh Government (WG) Eye Care Measures (ECM)
- There is a national shortage of Consultant Ophthalmologists, which poses a risk to service delivery.

Clinical effectiveness

- The Health Board is unable to adhere to most of the guidelines as there are a lack of senior clinicians and consultants
- There is no corneal consultant so the Health Board cannot provide a corneal service
- Clinicians within the Health Board have suggested that a minor operation service for smaller local anaesthetic cases is established to free up theatre for complicated procedures, such as cataract surgery.

Local, regional, and national work:

Participation into the Southwest Wales Glaucoma Service has been approved by board in September 2021, but has proved hard to implement because:

- There are complications within procurement as there is not enough interest from Primary Care services to support delivery
- Recruitment in Ophthalmology is a UK wide problem
- The Electronic Patient Record system that will facilitate the service has not been implemented. As of January 2024, there is no completion date
- The full GIRFT report has not yet been published, however early high priority recommendations can be summarised as follows:
- Conduct a review of the workforce including:
    - Appoint a Clinical Lead to provide clinical leadership

    - Link up regionally to use best availability of medical and nursing staff
    - Explore realistic demand and capacity options for change
    - Expand MDT capability and competency
- Rationalise where Outpatient services are delivered to fewer, better dedicated ophthalmic spaces
- Work to reduce the amount of visits a patient needs to make to a hospital, including:
    - Delivering one stop Pre-assessment clinics
    - Explore use of remote consultations.

Service activity data

- New referrals have fallen from 7,905 in 2019-20 (the first whole 12 month period) to 3,014 in 2022-23 (the last whole 12 month period). This in large part is because of Primary Care services being involved in referral refinement and treating a proportion of patients in the community, allowing for patient care closer to home
- The number of interactions, which is made up of follow up appointments has decreased from 39,802 in 2019-20 to 35,531 in 2022-23. Smaller community settings such as Aberaeron, Cardigan and Amman Valley have been used to supplement service delivery
- The Ophthalmology service is currently under internal review to examine demand and capacity and the sustainable delivery of services from nine separate sites to ensure efficient use of staff and resources. This review is also a high priority GIRFT recommendation.

Patient experience and compliments

Themes are not attributed to a specific site but are general to the whole service:

- Staff are frequently described as professional, friendly, helpful, and efficient
- Patients are unhappy at the delays in waiting for appointments, in particular follow up appointments
- There are concerns about lack of communication between the service and patients. This includes errors when making appointments and scheduling issues.

Incidents, complaints, and claims

- Issues with the current electronic patient record system (this does not hold required historical information) are leading to many recorded incidents in relation to delays when obtaining historic paper test results. This is an issue across all sites, however South Pembrokeshire hospital is acutely impacted due to the remoteness of the site, despite only having a single incident recorded
- The primary reason for there being a higher percentage of reported incidents at Bronglais Hospital is due to the remoteness of Bronglais Hospital and North Road Clinic. North Road Clinic operates 9 to 5 Monday to Friday and includes a RACE service. Out of hours, patients attending Bronglais Hospital Emergency Department requiring Ophthalmology treatment can be re-routed to Glangwili out of hours RACE. This has historically led to some confusion, which has led to several reported incidents.

Targeted early engagement with service users

- Patients praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; good communication and information provision; and the generally good quality of care
- Others, though, gave negative comments about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and poor communication, information provision, and follow up.

Targeted early engagement with staff

- Staff early engagement feedback included positive working relationships between managers and staff across all sites; effective teamwork between dedicated, respectful, and caring staff; and being able to take pride in providing good quality patient care
- Some also highlighted opportunities to gain new skills, knowledge, and experience by working with experienced specialists within the service
- Capacity was a key concern for staff respondents, with appointments in high demand and clinics often overbooked (it was felt, because of staff shortages and retention issues)
- Other stated challenges were around maintaining a good work/life balance; a lack of staff training opportunities and clear progression pathways; ineffective communication between delivery staff and managers within the service, and across the Health Board as a whole; a lack of staff input into decision-making; and the sometime inefficiency of the current paper-based notes system
- Staff suggested ways to improve their experience of working in/with the Ophthalmology service. The most common were to improve staff recruitment, retention, and capacity; and encourage more open communication and engagement between Health Board/service managers and delivery staff to improve working relationships and ensure the latter have a say in decision-making.

Finance

- There are high Medical agency costs and general rota gaps
- Long term diabetic retinopathy and glaucoma eyecare initiatives will lose the benefit of Outpatient Transformation funding and will drive a £0.2m cost pressure.

Workforce

The following key themes have been highlighted as specific workforce issues within Ophthalmology:

- Lack of specialist ophthalmologist across all sites
- Recruitment challenges across all sites
- Workforce establishment across all sites (the service is currently undertaking demand and capacity planning).

Section 12: Orthopaedic Service

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

Section 12: Orthopaedic Service

Introduction and background

This chapter of the Issues Paper is about Elective[205] Orthopaedic services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Orthopaedic Service at all sites within the Health Board that delivered Orthopaedic services between 1 August 2018 and 31 July 2023.

The Orthopaedic Service is a part of Scheduled Care and looks after patients with orthopaedic conditions. The Orthopaedic Service focuses on the care of the skeletal system and its interconnecting parts. Orthopaedics is a mostly Day Case and Inpatient service with a high proportion of Outpatient activity.

The Orthopaedics pathway is defined as patients who receive care for the following specified conditions:

Forefoot reconstruction is a type of surgery that aims to correct deformities and relieve pain in the toes and the front part of the foot. It is often performed for patients with rheumatoid arthritis, which can cause inflammation and damage to the joints and ligaments of the foot. Forefoot reconstruction usually involves fusing the big toe and straightening the smaller toes, as well as repairing any damaged tissues

An ankle and hindfoot fusion are a surgical procedure that aims to relieve pain and stiffness in the foot caused by arthritis, deformity, or injury. It involves removing the joint surfaces of the ankle and/or the hindfoot and fixing them together with screws, allowing the bones to heal and fuse.

Sub Speciality	Definition
Hip – Degenerative, TO10(A)	Many patients presenting with hip pain will have wear and tear arthritis. The most common procedure for this is a hip replacement where a damaged hip joint is replaced with an artificial one. A small number of patients present with wear and tear secondary to previous fractures around the hip or the pelvis and the same treatment of a hip replacement can be considered. There are a very small number of patients who develop soft tissue problems around the hip that may need keyhole surgery; this is not provided in Hywel Dda, with patients being referred onwards to SBUHB[206] and CAVUHB[207] for this treatment. Total hip replacement is one of the most common orthopaedic procedures and each replacement has a finite life span of between ten to twenty years, and when the joint starts to wear out, specialist surgeons can undertake a
Hip – Post traumatic, TO10(B)	
Hip – Soft tissue, TO10(C)	
Hip – Revision, TO10(D)	

[205] Elective refers to planned care or routine care where treatment can be delivered in a planned way. It can also be referred to as scheduled care.
[206] Swansea Bay University Health Board.
[207] Cardiff and Vale University Health Board.

	further hip replacement, although this procedure is more complex, this specialist service is provided within Hywel Dda.
Knee – Soft tissue (ACL meniscus), TO11(A)	Most patients presenting with knee pain will have wear and tear arthritis. The most common procedure for this is a knee replacement where a damaged knee joint is replaced with an artificial one, although treatments to re-align the bone (osteotomy) or partially replace the knee joint can be considered for some. Total knee replacement is one of the most common orthopaedic procedures and each replacement has a finite life span of between 10-20 years, and when the joint starts to wear out, specialist surgeons can undertake a further knee replacement, although this procedure is more complex. This specialist service is provided within Hywel Dda. Another large group of patients develop soft tissue problems around the knee that may need keyhole surgery to repair damaged cartilage and reconstruct ligaments, this service is provided within Hywel Dda.
Knee – Other soft tissue, TO11(B)	
Knee – Degenerative, TO11(C)	
Knee – Revision, TO11(D)	
Shoulder, (TO13)	Common types of shoulder surgeries include rotator cuff repair, total shoulder replacement, and arthroscopy (e.g., for frozen shoulder or impingement syndrome). In general, these and other shoulder procedures help treat shoulder injuries by repairing or replacing cartilage, tendons, muscles, joints, and/or ligaments
Elbow, (TO14)	Patients presenting with elbow problems represent the lowest volume of any subspeciality within elective orthopaedics. Most clinical problems are related to soft tissue problems related to tendons around the elbow as well as nerve compression syndromes. A small number of patients present with wear and tear arthritis, with a range of different treatments available, including elbow replacement.
Hand - Carpal tunnel, TO15(A)	Hand Surgery is surgery of the hand, the wrist, and the peripheral nerves of the upper limb. It also encompasses reconstructive surgery that improves upper limb function. Many disorders and injuries of the hand are treated without surgery, using splints, taping, injections, and hand physiotherapy.
Hand - Dupuytrens, TO(B)	
Hand - Ganglion, TO(C)	
Hand - Other soft tissue, TO(D)	
Hand – Post trauma, TO(E)	
Hand – Bony/ degenerative, TO(F)	
Foot, TO16(A)	Foot surgery is usually recommended to relieve pain, correct a foot deformity, or restore function in a foot and/or ankle. Many conditions related to the foot and ankle can be managed with insoles or splints. However, surgery is often indicated when these treatments fail.
Forefoot HV, TP16(B)	
Forefoot non HV, TO16(C)	
Ankle/hindfoot, TO16(D)	
Paediatrics – Foot & Ankle, TO18(A)	

Paediatrics – Hip & Pelvis, TO18(B)	Paediatric orthopaedic procedures can be used to treat children with a variety of orthopaedic conditions. These conditions may include scoliosis, kyphosis, fractures, tumours and many other injuries, diseases, bone deformities and congenital disorders. Hywel Dda is part of the regional paediatric orthopaedic service based in SBU[2]
Paediatrics – Spine, TO18(C)	
Paediatrics – Knee, TO18(D)	
Paediatrics – Upper Limb, TO18(E)	

The above treatments and locations are typically grouped into Day Case Sessions and Inpatient Sessions. The number of treatments that can be delivered per session is dependent on several variable factors which include the complexity of the condition and the patient as well as the experience and skill of clinicians. Further information on this is defined within the GIRFT section of this chapter.

Orthopaedic service model

The service operates from the four main hospital sites as well as delivering Outpatient activity from several community sites as described in the current temporary configuration in the table below:

Location	Outpatient	Inpatient	Day case
Bronglais Hospital	X	X	X
Glangwili Hospital	X		
Prince Philip Hospital	X	X	X
Withybush Hospital	X		X
Community Sites	X		

While the Orthopaedics Service provides the surgery, they do not manage the theatres where the surgery takes place or wards where patients recover.

There are a range of methods of accessing Orthopaedic Outpatient Services including but not limited to:

- Face to Face
- Virtual or Telephone
- Close to Home (Where a community site may be available closer to a patient's home for convenience, but this may not possible, if clinic slots are available at a main hospital, to be seen for treatment quicker).

The service has also implemented a range of post treatment services including:

- See On Symptom (SOS) following treatment allows for expedited access to a specialist for a maximum of 12 months.
- Patient Initiated Follow Up (PIFU) allows a patient to contact the service within 24 months following treatment should they need to in relation to the condition treated.

Time Period	Day case Sessions (Weekly)	Inpatient Sessions (Weekly)	Total Sessions Available
Pre-COVID Capacity	7.75	35	42.75
2023/24 Maximum Planned Capacity	25.25	25	50.25
Delivered as at March 2023	16.25	14	30.25
Actual as at December 2023	14.5	12	26.5

- Currently there is a lower volume of inpatient work being undertaken at Prince Philip Hospital (as opposed to pre COVID-19) this is due to anaesthetic constraints and utilisation of elective orthopaedic capacity by other specialties (Breast, Urology and General Surgery). Bronglais Hospitals is back to its Pre COVID-19 sessional allocation
- Most treatments requiring an inpatient stay in the South of the Health Board are treated at Prince Philip Hospital due to operational and resourcing issues at Withybush Hospital, this is under review on a regular basis
- Higher volumes of Day Case activity are undertaken at Withybush Day Surgical Unit and Prince Philip Day Surgical Unit although many of the Day Case sessions at both sites are underutilised due to staffing, anaesthetic and job planning constraints
- Bronglais Hospital maintains 5 sessions per week (which is planned to be all Inpatient activity)
- Theatre list allocations are reviewed and applied in accordance with GIRFT (Getting It Right First Time) recommendations. This is discussed further in the GIRFT section of this chapter
- Currently, the Service together with the wider planned care team are undertaking a project to encourage the greater use of planned activity sessions to increase the number of cases being treated on the theatre list, but these improvements are dependent on multiple factors in the care pathway such as patient time in theatre from ward and anaesthetic support arrival in theatres in addition to the availability of theatre sessions.

Orthopaedic Service - Treatment outside the Health Board

Depending on how complex each condition is, or where a specialist consultant is required and is not provided within Hywel Dda, patients are referred to other health boards for the following treatment procedures:

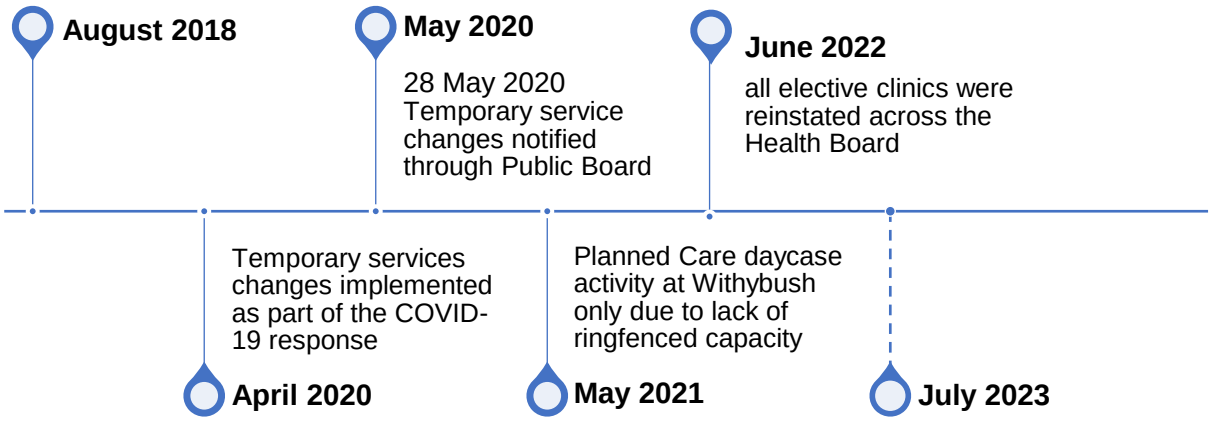
- All Spinal procedures – Swansea Bay
- Complex hand and wrist – Swansea Bay
- Paediatric (Children and Young People) Procedures - Swansea Bay and Cardiff and Vale.

To help reduce waiting lists, Hywel Dda uses additional facilities from private companies including Werndale near Carmarthen. This option is only available where additional funds have been allocated to support Waiting list initiatives and the source of these additional resources are made available from the Welsh Government. It should be noted that this is an expensive and unsustainable option in reduction of waiting lists long term and is dependent on timing and availability of capacity in the private sector.

Orthopaedic service changes

This section provides information about the updates to Public Board about service changes that have taken place within the Orthopaedic service between August 2018 and July 2023.

Service change timeline



The below highlights the impact of COVID-19 on the service as well as the temporary service changes made in recovery. Some of which are described at Public Board on 28th May as a '[Responding to the COVID-19 Pandemic: Update, Review and Ratification of Decisions Made Since 16th April 2020]'[208] which can be viewed on the Health Board's website using this address below[4]:

- March 2020 all planned care treatments were paused. Within this some activities were reinstated at Werndale Hospital using their facilities but Health Board Consultants continuing to see the patients

[208] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13*

- December 2020 some outpatient and treatment activity was reinstated at Withybush and Bronglais Hospitals, Prince Philip activity remained paused
- In May 2021, Inpatient only surgery was able to be delivered from Prince Philip Hospital and Bronglais General Hospital. Surgeons from Withybush Hospital and patients from Pembrokeshire had to travel to alternative sites for treatment
- By February 2022 - New Ways of Working had been implemented, which included:
    - Shoulder and Hand new appointments being undertaken virtually (using Attend Anywhere application, some other Orthopaedic subspecialties introduced these virtual appointments prior to this date)
    - Follow up and New Outpatient appointments have a Patient Initiated Follow up (PIFU) and See on Symptom (SOS) outcomes.
    - Post Operation Arthroplasty one year follow up reviews are undertaken virtually using Patient Reported Outcome Measures (PROMs). Due to the excellent surgical outcomes of these patients, as identified by GIRFT (Getting It Right First Time) during their review of the service, the feasibility in continuing to undertake these virtual follow ups will require review
- June 2023 all orthopaedic elective clinics resumed across all sites in conjunction with the recommendations from the GIRFT report.

Orthopaedic service risks

This section describes the Orthopaedic service risks that have been reported at Public Board meetings between August 2018 and July 2023.

Risk No. 44: Ability to manage patients awaiting follow up appointments, escalated to the Corporate Risk Register 31 January 2019

- The original Risk was created following a missed target to reduce follow-up Outpatient appointments in a number of services, including Orthopaedics
- The Risk was added to the Corporate Risk Register with a Risk Rating of 12, and a target Risk Score of 8. The Risk highlighted that there is a risk of harm to patients on follow-up waiting lists who have exceeded their follow-up date
- The Risk was closed on 1 June 2020 as, following discussions with the Scheduled Care Directorate Senior Management Team, the Risk was to be replaced by a new Risk in relation to Outpatient management as this was no longer specific to planned Orthopaedic Services. Further details about this Risk can be found on page 5 of the linked document 30 July 2020[209] from our website
- A new Risk was logged and managed by Planned Care Outpatients Management Team and was reviewed in December 2023, where it was reduced in severity as the Health Board has a low percentage of patients on follow up lists compared to other health boards. This new risk does not include Elective Orthopaedics.

[209] *https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-30th-july-2020/board-30th-july-2020-documents/sbar-corporate-risk-register-july-2020/*

The additional risks identified below reflect the development of the Southwest Wales Regional Orthopaedics Programme. These include:

Risk No. 1083: Harm to Patients due to Increased Waiting Times, Directorate Level Risk 1 April 2021

Identified by the Health Board response to the COVID-19 pandemic resulting in the reduction of elective theatre capacity and outpatient consultations across all specialities.
At the time of creating this risk, there were 548 patients waiting more than 3 years for treatment, of which 210 patients were waiting more than 4 years.

Control Measures in place are:

- all waiting lists have been, and will continue to be, clinically risk stratified and validated.
- Patients with the highest clinical risk are prioritised and the remaining longest waiting (routine) patients are booked in chronological order within available capacity.
- The Waiting List Support Service (WLSS) have contacted patients at Stage 4 to ensure patients are waiting well. This includes personalised contact, regular information on length of wait, single point of contact (SPOC), self-management options, advice if symptoms deteriorate and advice on alternative treatment options.

Risk No. 1632, 785 and 784 (Withybush): Harm to Patients due to the imminent closure of the Recovery room, Service or Department Level Risk 24 March 2023

- Consideration needs to be given to the poor state of the air handling units which service the laminar flow[210] theatres which service elective sessions, this is a risk logged in the theatres risk register
- The Air handling Unit failed its certification as air is being recirculated to and from the recovery area. This recirculation increases the risk of Health Care Acquired Infections to patients and staff; therefore, the recirculation was discontinued.
- As an interim measure, three standalone filter units were placed in the recovery area as a temporary measure
- Estates to immediately assess options for remedial work or replacement. Project design underway, capital funding applied for and awaiting outcome of allocation of funding decision.

[210] A laminar flow theatre is a type of operating theatre that uses a special ventilation system to create a clean and sterile environment for surgery

Orthopaedic service clinical effectiveness

The table below includes a list of the clinical guidelines that the Orthopaedic service needs to follow:

Guideline Source	Guideline Title	Link
BOA	British Orthopaedic Association - Various Guidelines	https://www.boa.ac.uk/standards-guidance/boasts.html
NICE	Fractures (non-complex): assessment and management	https://www.nice.org.uk/guidance/ng38
NICE	Fractures (complex): assessment and management	https://www.nice.org.uk/guidance/ng37
NICE	Joint replacement (primary): hip, knee and shoulder	https://www.nice.org.uk/guidance/ng157
NICE	Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism	https://www.nice.org.uk/guidance/ng89
NICE	Hip fracture: management	https://www.nice.org.uk/guidance/cg124
GIRFT	Orthopaedic Surgery	https://gettingitrightfirsttime.co.uk/surgical_specialties/orthopaedic-surgery/#ortho
National Clinical Strategy for Orthopaedics	Guidelines and Recommendations Shoulder & Elbow Surgery	https://www.welshorthopaedics.org.uk/wp-content/uploads/2022/07/ANNEX-4.pdf
National Clinical Strategy for Orthopaedics	Guidelines and Recommendations Hand and Wrist Surgery	https://www.welshorthopaedics.org.uk/wp-content/uploads/2022/07/ANNEX-5.pdf
WHSSC	Spinal Services Operational Delivery Network - links within document	https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/spinal-services-operational-delivery-network-cp241-june-2022/

The introduction of the British Orthopaedic Association (BOA) standards issued post COVID-19, determined that Prince Philip Hospital was the only site that met certain criteria within the Health Board. This therefore required consultants that had previously undertaken inpatient activity at Withybush Hospital to travel to Prince Philip Hospital to undertake this activity.

The standards demanded ring-fenced ward area for elective Arthroplasty patients and 24-hour, 7-day Orthopaedic medical cover available for this ward. Consequently, Withybush Hospital was not able to meet these standards and inpatient activity due to staff, site and financial resources needed, so the inpatient activity has been centralised at Prince Philip Hospital for patients in the south of the Health Board area. In Prince Philip Hospital, a ring-fenced area and 24-hour, 7-day Orthopaedic medical cover is available, therefore this site provides inpatient activity for Prince Philip and Withybush Hospital consultants.

Inpatient activity at Bronglais Hospital was able to commence in advance of the BOA standards. Although it does not have a ring-fenced ward on the site, it does have ring fenced bays for elective orthopaedic surgery on a planned care ward. Due to negligible historic infection prevention control concerns, inpatient activity has been supported at this site.

Orthopaedic service local, regional, and national work

This section describes the regional and national projects or programmes connected to Orthopaedic services at Hywel Dda.

ARCH[211] and South West Wales regional orthopaedics programme

The ARCH project (established 2015) aims to develop regional collaboration for Orthopaedic Services across Swansea Bay and Hywel Dda University Health Boards. Unlike other services, a regional programme managed by the Welsh Government called the National Clinical Strategy for Orthopaedic Surgery Programme (NCSOS). In response to this programme, a regional group has been established with Swansea Bay University Health Board but chaired by Hywel Dda University Health Board.

The regional programme is currently focused on collaborative working and supporting a real time reduction in patients waiting the longest for treatment. This programme is developing closer working collaborations and a single operational patient list as to optimise elective surgical pathways across each health board. It is expected that this programme will continue to focus on immediate operational challenges around waiting lists for the coming year. The NCSOS has determined that the priority cohort for treatment should include any patients who meet the criteria in terms of waiting time as per Ministerial target and any patient designated as a Priority Two clinical priority patient.

Any regional changes identified may impact on the delivery of elective orthopaedic surgery within Hywel Dda, this includes the configuration of workforce rotas, job planning, operational processes and theatre site availability. As such, it is important to consider this regional workstream as a key issue on the current configuration of elective orthopaedic services.

The two-way commitment to regional working is pivotal to success, the key issues in this are the strict criteria for Neath Port Talbot hospital and the challenge of workforce change management to support a new way of working that clinicians have in committing to moving across two health boards to work.

There is a commitment from the NHS Executive team to support regional working and specific support has been sourced into the two health boards. This is positive and generating streams of

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[211] A Regional Collaboration for Health – further details for ARCH can be accessed by this link http://arch.wales/en/

work which are focusing on a joint Patient Tracking List (PTL)[212] and streamlining the current pre assessment processes which are currently different.

GIRFT (Getting It Right First Time)

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Welsh Government, to conduct a full review of Welsh Orthopaedic Services using the GIRFT methodology and High Value Low Complexity principles.

Throughout the team worked closely with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) team and continue to do so. In addition to reports for each health board, RNOH/GIRFT wrote a National Wales Orthopaedic report detailing the findings and the priority and cross cutting recommendations. This report dovetailed with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) report.

The ambition of the programme was to help each Welsh health board and NHS Wales to urgently restore elective orthopaedics to the maximum levels possible and identify examples. of innovative, high quality and efficient service delivery in the system. The programme looked at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. It assessed whether health boards are using their existing resources and provisions effectively and delivering the best outcomes for patients. The team conducted a programme of data analysis, followed by a virtual “deep dive” engagement with Hywel Dda, delivered by Professor Tim Briggs CBE (GIRFT Programme Chair and National Director of Clinical Improvement for the NHS) on Friday 4 February 2022.

The aim of the programme was to identify improvement opportunities within orthopaedic services in Wales to inform short, medium and long-term transformation plans. This was done by:
Identifying system and organisation level unwarranted variation in access to and outcomes from care being delivered driving for ‘top decile’ GIRFT performance of outcomes, productivity, and equity of access.

Standardising procedure-level clinical pathways to be agreed across all providers developed by ‘expert advisory panels’ supported by professional societies and the work of the Wales Clinical Orthopaedic Strategy team informing the decision-making process on the potential establishment of surgical hubs for high volume elective procedures.

Agreeing principles 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 continue implementation and tracking progress at the end of our work with you.

The Hywel Dda University Health Board’s GIRFT report and position against the recommendations have been included in Appendix J7 - Orthopaedics - GIRFT Recommendations and any references to Trauma have been removed as this is out of scope for this paper:

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[212] A Patient Tracking List is a term used to monitor patients on a waiting list

Orthopaedic Service activity data

Orthopaedic service activity reported between 1 August 2018 and 31 July 2023 is included for all sites providing activity. All data tables including the specific conditions captured can be found in Appendix J8 - Orthopaedics - Activity Data.

It should be noted that the historical recording of information for the service had patient activity for Trauma and Orthopaedics combined, which made it difficult to separate the planned and emergency care activity. This has since been resolved. However due to this and the period in scope there are limitations to the accuracy of the planned care only activity information for past treatments. Therefore, when reading the below activity please consider that this will likely include Trauma activity and more so specifically within the Inpatient activity data.

Outpatient data

Outpatient services for Orthopaedics are carried out at the following sites across the Health Board:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital
- Community Hospitals - Cardigan Integrated Care Centre (formerly Cardigan & District Hospital); South Pembrokeshire Cottage Hospital; Tenby Cottage Hospital; Tywyn Hospital
- Werndale Hospital (between April to December 2020 to provide additional site capacity post COVID-19 as this site met the COVID-19 standards for patient activity. It should be noted that Health Board Consultants still undertook activity).

Outpatient Referrals										
Period	**Bronglais Hospital**	**Cardigan &District Hospital**	**Cardigan Integrated Centre**	**Glangwili Hospital**	**Prince Philip Hospital**	**South Pembrokeshire Hospital**	**Tenby Hospital**	**Tywyn Hospital**	**Withybush Hospital**	**Total**
2018/19	850	36	0	1,455	2,330	2	1	41	1,994	**6,709**
2019/20	1,308	37	1	1,900	3,516	1	1	75	3,112	**9,951**
2020/21	768	0	1	1,270	1,224	2	0	17	1,420	**4,702**
2021/22	1,182	0	1	1,794	2,376	2	0	3	2,401	**7,759**
2022/23	1,407	0	0	1,777	2,683	0	0	1	2,527	**8,395**
2023/24	404	0	0	695	944	0	0	0	1,027	**3,070**
Total	**5,919**	**73**	**3**	**8,891**	**13,073**	**7**	**2**	**137**	**12,481**	**40,586**

The demand profile above highlight that referrals are moving back to a pre pandemic level. The yearly average across the period is 8,118 referrals. It is anticipated that this will continue to increase for the current 2023/24 period.

Total Outpatient Activity

Period	Bronglais Hospital	Cardigan & District Hospital	Cardigan Integrated Centre	Glangwili Hospital	Prince Philip Hospital	South Pembrokeshire Hospital	Tenby Hospital	Tywyn Hospital	Withybush Hospital	Total
2018/19	2,519	62	0	2,540	6,947	470	372	88	4,339	17,337
2019/20	3,787	57	23	3,302	9,386	621	511	111	7,954	25,752
2020/21	1,592	1	29	1,744	1,671	220	207	24	2,844	8,332
2021/22	2,063	0	68	2,625	4,446	388	400	74	4,811	14,875
2022/23	2,555	0	83	2,753	4,815	163	493	84	5,413	16,359
2023/24	944	0	31	1,023	1,768	0	109	32	2,169	6,076
Total	**13,460**	**120**	**234**	**13,987**	**29,033**	**1,862**	**2,092**	**413**	**27,530**	**88,731**

New patient referrals have risen from 6,709 (all sites) in 2018/19 to 8,395 in 2022/23, however the number of consultations, which are made up of new and follow up outpatient appointments have reduced from 17,337 in 2018/19 to 16,359 in 2022/23, a reduction of 5.6%. The 5-year annual average (excluding 2023/24 outpatients) of total outpatients highlights an annual average of 16,531 total outpatient appointments. Follow up appointments have reduced as the service reviewed the need for follow-up during the COVID-19 period by embracing Patient Initiated Follow up (PIFU) and See On Symptoms (SOS) options, as promoted by the GIRFT review. However, it should be noted that the referral rate as described is continuing to increase.

It is assumed that the increase of new referrals received by the service for the two full years post COVID-19 is due to the postponement by patients presenting to Primary Care due to COVID-19 infection concerns of visiting a hospital or primary care site.

Inpatient and Day Case data

Inpatient and Day Case services for Orthopaedics are carried out at the following sites across the Health Board:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital.

The table below highlights the number of Inpatient lists for the period by site:

Inpatient Lists						
12-month period (01AUG-31JUL)	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Community Hospitals**	**Total**
2018/19	175	50	1,507	440	10	**2,182**
2019/20	385	61	1,945	719	17	**3,127**
2020/21	142	70	742	242	10	**1,206**
2021/22	243	85	1,144	497	6	**1,975**
2022/23	300	60	1,133	511	101	**2,105**
2023/24	115	16	412	184	24	**751**
Total	**1,360**	**342**	**6,883**	**2,593**	**168**	**11,346**

The above data highlights the current service model configuration in that most of the inpatient demand is being managed through the Prince Philip Hospital site.

Inpatient Activity						
12-month period (01AUG-31JUL)	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Community Hospitals**	**Total**
2018/19	669	1,160	1,227	1,009	15	**4,080**
2019/20	1,090	1,761	1,461	1,376	13	**5,701**
2020/21	659	1,219	0	772	19	**2,669**
2021/22	832	1,349	215	756	28	**3,180**
2022/23	941	1,286	422	951	9	**3,609**
2023/24	346	483	248	328	8	**1,413**
Total	**4,537**	**7,258**	**3,573**	**5,192**	**92**	**20,652**

The table below highlights the Day Case lists for the period:

Day Case Lists						
Period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Community Hospitals**	**Total**
2018/19	294	448	822	866	5	**2,435**
2019/20	431	816	1,171	1,333	11	**3,762**
2020/21	102	398	417	353	3	**1,273**
2021/22	204	432	850	711	22	**2,219**
2022/23	238	433	972	706	45	**2,394**
2023/24	100	161	328	238	22	**849**
Total	**1,369**	**2,688**	**4,560**	**4,207**	**108**	**12,932**

The table below highlights the Day Case Activity by site:

Day Case Activity						
Period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Community Hospitals**	**Total**
2018/19	246	275	775	663	0	**1,959**
2019/20	327	573	788	916	0	**2,604**
2020/21	51	227	0	37	0	**315**
2021/22	113	302	207	853	0	**1,475**
2022/23	199	462	424	1,085	0	**2,170**
2023/24	54	139	366	344	0	**903**
Total	**990**	**1,978**	**2,560**	**3,898**	**0**	**9,426**

The activity tables above highlight an overall reduction in activity but a noted increase in demand at outpatients. The decline in Inpatient Surgery can be related to the reduction in overall available theatre space available some of which links to the standards mentioned above, the unwarranted variation identified through the GIRFT workstream and the consolidation on Inpatient Surgery to a single site. This has been compounded by some of the risks identified within Estates including the Laminar Flow units, Withybush site and closure of key wards.

Orthopaedic Service - outsourced activity data

The below table highlights activity which has been outsourced to private healthcare providers between 1 August 2018 to 31 July 2023. The data is presented in a tabular format as patients who have accessed private health care providers may be recorded differently within our system. As such the data below is additional activity to that identified above.

Year Type	18/19	19/20	20/21	21/22	22/23	Totals
Total BMI Werndale	215	196	0	431	8	**850**
Total St Joseph	1,360	36	0	127	0	**1,523**
Total Santa Maria	0	0	0	4	0	**4**
Total Spire	0	0	0	84	0	**84**
Total BMI Droitwich	0	0	0	24	0	**24**
Total BMI Bath	0	0	0	8	0	**8**
Totals	**1,575**	**232**	**0**	**678**	**8**	**2,493**

Due to the increasing referrals and corresponding additional volumes of patients waiting for orthopaedic care specifically Inpatient procedures, Hywel Dda has been unable to meet Ministerial / Referral to Treatment Time targets and has therefore sought outsourcing partners to address this backlog. The ability to do this depends on additional funding from Welsh Government to outsource this patient treatment.

Orthopaedic Service incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims and patient compliments that have been recorded against Orthopaedics. Full data for incidents, complaints, and claims, can be found in Appendix J9 - Orthopaedics - Incidents Data, and J10 - Orthopaedics - Complaints Data.

It is important to note that the following information contains both Elective Orthopaedic and Emergency Orthopaedic (known as Trauma) patient experience. This may also be linked to Consultants working across both Trauma and Elective Orthopaedics. For example this is highlighted in the data given for Glangwili Hospital where Elective Orthopaedics activity is lower. However Trauma or Emergency Orthopaedic Surgery is delivered from this site.

Patient safety incidents

The table below shows the overall number of recorded incidents for Orthopaedics across all sites within the Health Board.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Incidents	482	427	323	40	65

The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of July 2023. The table below shows the location of recorded incidents. Where locations are not included it indicates no recorded incidents took place at that location.

Primary Location	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Total
Glangwili Hospital	418	38	**456**
Prince Philip Hospital	217	5	**222**
Bronglais Hospital	251	16	**267**
Withybush Hospital	332	53	**385**

The table below highlights the top 5 reported incidents by category.

Incident Type - Tier One (Top five Incidents)	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Totals
Accidents/Falls (patient)	459	19	**432**
Pressure Ulcers	219	13	**232**
Medication/Biologics/Fluids	95	2	**97**
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	63		**63**
Behaviour (Including Violence and Aggression)	74	3	**60**

The table below shows overall number of incidents received for Orthopaedic services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023. It is important to note that the following information contains both Elective Orthopaedic and Emergency Orthopaedic (known as Trauma) patient experience.

Severity	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Totals
1 - None	819	17	**836**
2 – Low Harm	254	30	**284**
3 – Moderate Harm	144	5	**149**
4 – Severe Harm	8	0	**8**
5 – Catastrophic Death	0	0	**0**

Orthopaedic service patient complaints

The table below shows the overall number of complaints within Orthopaedics across all Health Board sites.

It is important to note that the following information contains both Elective Orthopaedic and Emergency Orthopaedic (known as Trauma) patient experience. This may also be linked to Consultants working across both Trauma and Elective Orthopaedics. For example this is

highlighted in the data given for Glangwili Hospital where Elective Orthopaedics activity is lower. However Trauma or Emergency Orthopaedic Surgery is delivered from this site.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Complaints	105	187	136	100	78

The table below shows the location of recorded complaints. Where locations are not included it indicates no recorded complaints took place at that location.

Primary Location	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Totals
Bronglais Hospital	53	15	**68**
Glangwili Hospital	109	55	**164**
Prince Philip Hospital	82	70	**152**
Withybush Hospital	153	66	**219**

The below table shows activity volume (combined Outpatient, Inpatient and Day Case) and reported complaints as a percent for each site against the total number for the period August 2018 to July 2023.

Location	Percent of all activity	Percent of reported complaints
Glangwili Hospital	20% (23,223)	27% (164)
Prince Philip Hospital	30% (35,166)	25% (152)
Bronglais Hospital	16% (18,987)	36% (219)
Withybush Hospital	31% (36,620)	11% (68)
Community Hospitals	4% (4,813)	0% (0)
Total	100 (118,809)	100 (603)

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category.

Subject (primary)	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Totals
Clinical treatment / assessment	35	32	**67**
Appointments	26	20	**46**
Admissions	10	9	**19**

The table below shows overall number of complaints received for Orthopaedic services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023.

Severity	01 August 2018 – 31 March 2021	01 April 2021 – 31 July 2023	Totals
Grade 1 Minor (informal)	153	123	**276**
Grade 2 Minor	67	57	**124**
Grade 3 Moderate	88	26	**114**
Grade 4 Major	3	0	**3**
Grade 5 Catastrophic	0	0	0

Orthopaedic Service claims

During the period 1 August 2018 to 31 July 2023, Hywel Dda submitted 28 clinical negligence and redress 'Learning from Event' reports to the Welsh Risk Pool[213], as part of the reimbursement process for the area of Orthopaedics and the sub specialities within the scope of the Clinical Services Plan.

The breakdown per site for those closed claims can be seen below:

Site	Total Claims
Withybush Hospital	**11**
Prince Philip Hospital	**4**
Glangwili Hospital	**9**
Bronglais Hospital	**4**

As well as the reports closed claims there were also seven confirmed cases that are subject to investigation and a further 14 received claims that are potential cases awaiting further details.

A range of learning has been identified through these claims with most learning points relating to specific areas within the service. However, there were several learning points related to failure or incorrect diagnosis.

[213] *The Welsh Risk Pool provides the means by which NHSWales can indemnify itself against risk. It has integrated approach towards risk assessment, claims management, reimbursement and learning to improve patient safety and outcomes*.

Closed Cases upheld and learning from events identified within 1 August 2018 to 31 July 2023.

Site	Speciality	Issue / Causative of harm
Bronglais Hospital	Hand	Mal united fracture
	Knee	Failure to diagnose Anterior Cruciate Ligament (ACL) Rupture
	Knee	Standard of surgery
	Spine	Delay in diagnosis of Cauda Equina Syndrome (CES)
Glangwili Hospital	Ankle	Failure to undertake a reasonable standard of surgery
	Ankle	Poor follow up resulting in delay in diagnosis of recurrent displacement
	Ankle	Post-surgery management / documentation
	Foot	Failure to undertake reasonable standard of surgery
	Hand	Delay in diagnosis of vascular compromise
	Hand	Failure to undertake a reasonable standard of surgery
	Hand	Infection post-surgery
	Knee	Standard of surgical procedure
	Spine	Failure to monitor and take account of new symptoms
Prince Philip Hospital	Foot	Failure to channel / split plaster
	Foot	Standard of Surgery and follow up care
	Hand	Failure to carry out surgery with reasonable skill
	Total Hip Replacement	Delay in diagnosis of Peri-Spinal Implant (PJI) infection
Withybush Hospital	Ankle	Delay in diagnosis
	Ankle	Delay in treatment (15 months)
	Ankle	Premature Failure of metalwork
	Ankle	Standard of surgery
	Hand	Delay in diagnosis & treatment of fracture
	Spine	Failure in consultation – identify Cauda Equina Syndrome (CES)
	Total Hip & Knee Replacement	Unnecessary Total Hip & Knee Replacement surgery undertaken
	Total Hip Replacement	Consenting process
	Total Hip Replacement	Delay in diagnosis of failure of abductor muscles
	Total Hip Replacement	Delay in diagnosis of periprosthetic fracture

Orthopaedic Service compliments

The following table below highlights feedback received in three systems, Patient Experience, The Friends and Family Test and Compliments information from 2021 – 2023.

	Patient Experience	Friends and Family Test	Compliments
2021	None Recorded	None Recorded	None recorded
2022	The themes noted by patients related to the quality of care, professionalism of staff and timeliness of appointments. Positive experiences include friendly and helpful staff, efficiency of service and quality of care.	The themes arising are around staff, appointments, communication and impacts on people with disabilities. Positive comments were received around staff being described as friendly, helpful, polite and professional, with a quality of care being described as food with patients reporting good experiences with doctors and nurses generally.	None recorded
2023	The themes arising relate to staff professionalism, appointments, locations and access to services. Positive experiences include professionalism, kindness and quality of service.	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	The theme is that staff were proactive in identifying health needs getting patients the best possible outcome.

Orthopaedic service targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

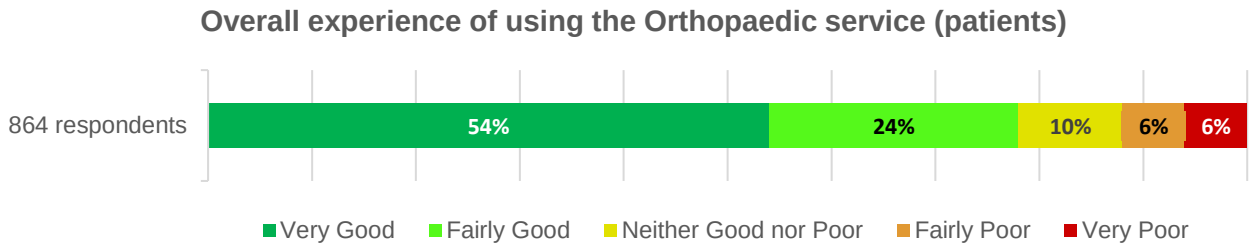
A randomly selected sample of patients who accessed Orthopaedic services within the last five years (1 August 2018 to 31 July 2023) were invited to take part in a survey. In total 6,907 patients were sent an invitation, and 885 responses were received. 32% of respondents accessed most of their Orthopaedic care at Withybush Hospital, 29% at Prince Philip Hospital, 16% at Bronglais Hospital, and 15% at Glangwili Hospital. The remainder were split between various other clinical sites.

The Orthopaedic service patient demographic is mixed, as equalities information collected suggests. This is broadly reflected in the profile of respondents to the patient survey. However, 61% of respondents were women and 91% were aged 55 or over. Tables showing the full profile breakdown of respondents are included in the full report[214].

[214] *Please note that where percentages do not sum to 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers.*

Main survey findings

Patient respondents said that their experience of using the Orthopaedic service was good, with over half (54%) saying that it was very good. Just over one-in-ten (12%) said their overall experience of using the Orthopaedic service was poor.

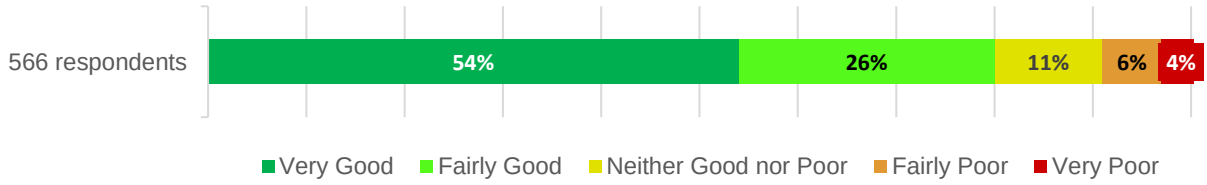


In terms of what was good about their experience of using the Orthopaedic service, patients praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; and the generally good quality of care. Where there was negative feedback, it included concerns about a lack of timeliness (especially in relation to appointment access and speed of diagnosis); and generally poor standards of care.

The main improvements to Orthopaedic services as suggested by survey respondents were around speed and efficiency (including shortening waiting times and not cancelling appointments); and communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up). It should be noted though, that just under a fifth of respondents (18%) felt that no improvements are required.

Experiences of outpatient services

82% of patient respondents said they used the outpatient department as part of their Orthopaedic treatment. Of these, 80% said their experience of doing so was good and 9% said it was poor.



When patients were asked why they said their experience of using the outpatient department was good or poor, the most frequent positive comments related to the professional, kind, reassuring, and helpful staff; and receiving a generally good, quick, and efficient service. The most frequent negative comments were around service speed and efficiency (including access to appointments, tests, and results).

Targeted early engagement with staff

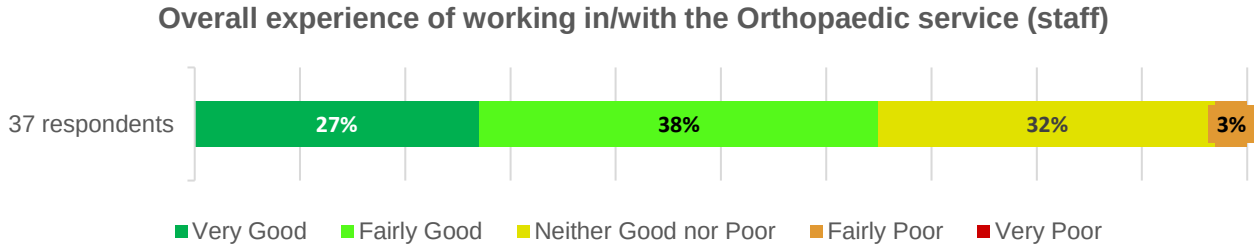
A survey was sent to medical, nursing, therapies, operational, and support staff. Staff members were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS and helps us

to understand the key issues and themes facing our staff when using or working with Orthopaedics.

All staff currently working in, or supporting staff working in, the Orthopaedic service were invited to take part in a survey: 42 responses were received. Respondents' main clinical base is/was Withybush Hospital (13 respondents), Glangwili Hospital (11 respondents), Bronglais Hospital (8 respondents), and Prince Philip Hospital (7 respondents). 3 respondents did not identify their main hospital base.

Experiences of the Orthopaedic service

65% of staff respondents said that their overall experience of working in/with the Orthopaedic service was good, whereas 3% said it was fairly poor. Almost a third (32%) said it was neither good nor poor.



In terms of what is/was good about their experience of working in/with the Orthopaedic service, staff across all sites highlighted positive working relationships within the service. Staff were said to be dedicated, helpful and approachable toward patients and colleagues; and to work well together within specific clinical roles and more broadly as a service. Other stated positives were around good clinical outputs and quality of care; consultant responsiveness and communication; good service management, training opportunities and monitoring; and the benefits of multidisciplinary team meetings in ensuring better patient care and flow.

As for what is/was difficult about their experience of working in/with the Orthopaedic service, respondents highlighted staffing shortages, leading to heavier workloads and a risk of burnout among employees. Others stated challenges were a lack of respect and poor communication between some staff; a lack of capacity and long waiting lists; a lack of access to ward-based and community rehabilitation[215], and support for hospital discharge; poor communication around hospital discharge between ward and rehabilitation staff, and with patients and their families; insufficient focus on therapy-led rehabilitation and inconsistent training and ways of working among rehabilitation staff; and working environments and equipment that are not fit for purpose.

In considering ways to improve their experience of working in Orthopaedic services, staff proposed several strategic changes such as re-providing elective joint arthroplasty[216] at Withybush Hospital or, conversely, centralising this service at Prince Philip Hospital, with a focus on trauma at Glangwili Hospital and an ambulatory service[217] at Withybush Hospital. Other suggested

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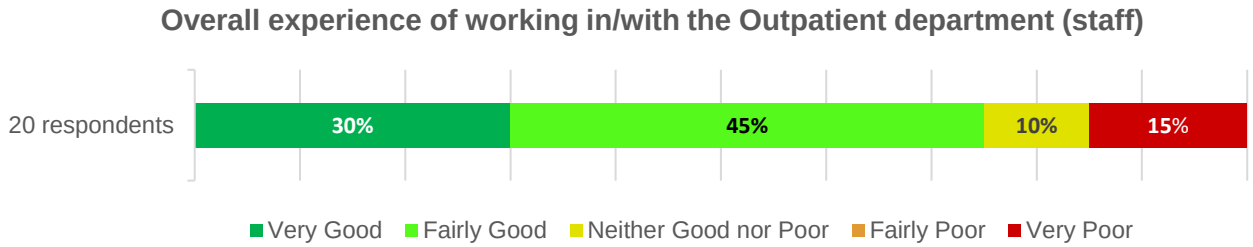
[215] Rehabilitation is delivered by multiple disciplines described as Allied Health Professionals (AHPs) and may include Physiotherapy, Occupational Therapy, Speech and Language Therapy and Psychosocial Services
[216] Arthroplasty is a surgical procedure to restore the function of a joint. A joint can be restored by resurfacing the bones. An artificial joint (called a prosthesis) may also be used.
[217] Services provided as an outpatient, where you do not need to stay in hospital. To have this care, you must be able to walk (ambulatory).

improvements were to increase rehabilitation (especially physiotherapy) capacity within hospitals and the community; improve communication around patient discharge to avoid making unrealistic promises to patients and their families; and ensure different departments within Orthopaedics work together to ensure care is consistent and streamlined.

Staff experiences of Outpatient services

54% of staff survey respondents use the Outpatient Department in delivering their Orthopaedic service. Of these, three-quarters (15 respondents) said that their experience of doing so was good, whereas 15% (3 respondents) said it was very poor.



There was praise for outpatient services at most sites, with staff being described as helpful, friendly, dedicated, and knowledgeable. However, there was some negative feedback: the outpatient environment at Glangwili Hospital was considered poor and not fit for purpose; and some staff at Glangwili and Withybush Hospitals felt that their outpatient departments could be better organised. It should be noted that the Orthopaedic Service is not directly responsible for the management of the Outpatient Department.

Orthopaedic Service finance

The information below describes the main drivers of cost that impact on service delivery budgets – the variable costs that influence the overall cost of the service. This information is aligned to the findings and submissions included in the 2024/2025 annual plan.

There is a high level of additional spend on pay to support orthopaedic services through a combination of Medical Agency supplied staff £1.110million and Additional Duty Hours[218] paid to the member of staff for working in addition to their contracted sessions £0.291m for the first nine months of 2023/2024. Due to a number of vacancies, there is an overall end of financial year forecast of £0.328m underspend for 2023/2024. Longer term there is a funding challenge to ensure sufficient workforce are funded to support the capacity available in the Service.

Orthopaedic service workforce

The Workforce Team have supplied data within defined cost codes provided by the Orthopaedic service. Full details about the methodology can be found within Appendix J13 - Orthopaedics - Workforce Data.

Due to the complexity of the workforce breakdown, as some cost codes can cover a number of service areas, we may have not been able to fully separate the specific workforce aligned to the

[218] *Additional Duty Hours are paid in addition to contracted hours. Which may mean a staff member working for than a whole time equivalent of 37.5 hours per week. Or more than 10 clinical sessions for medical workforce*

service. Where these issues are raised within the data, this has been noted within the information provided.

The data below shows a historic picture of the Electronic Staff Record (ESR) Staff in post for the Orthopaedics cost codes as of 1 April each year. It is important to note that the following information contains both Elective Orthopaedic and Emergency Orthopaedic (known as Trauma) workforce information and therefore is not a true reflection of the numbers of staff that deliver the Orthopaedic Service.

Current position

The table below shows the workforce establishment within Orthopaedics as of 31 July 2023. Figures represent Whole Time Equivalents (WTE) 1WTE is equivalent to 37.5hours per week.

Staff Group	Budgeted WTE	Actual WTE	Hospital Vacancies by Site					
			Bronglais	Glangwili	Glangwili &Prince Philip	Prince Philip	Withybush	Total
Medical and Dental Total	**64.4**	**47.2**	**4.0**	**0.0**	**9.5**	**0.0**	**3.7**	**17.2**
Associate Specialist		1.6						
Consultant		18.6						
Speciality Doctor		12.0						
Speciality Register		15.0						
Additional Professional Scientific and Technical	**0.0**	**6.2**	**0.0**	**0.0**	**(0.8)**	**0.0**	**0.0**	**(0.8)**
Advanced Practitioner		1.0						
Physician Associate		0.8						
Practitioner		1.8						
Technician		2.6						
Additional Clinical Services	**92.0**	**93.1**	**0.4**	**3.3**	**0.0**	**5.0**	**(2.2)**	**6.5**
Assistant		4.0						
Assistant Practitioner Nursing		6.2						
Health Care Support Worker		45.2						
Health Care Assistant		31.0						
Secretary		6.7						
Nursing and Midwifery	**67.5**	**56.1**	**0.0**	**8.5**	**(1.0)**	**8.3**	**4.7**	**20.5**
Nurse Manager		2.0						
Sister or Charge Nurse		5.0						
Specialist Nurse Practitioner		7.0						
Staff Nurse		42.1						

Administrative & Clerical	19.1	22.1	0.0	(2.4)	2.2	0.8	(0.8)	(0.2)
Total	**243.0**	**224.7**	**4.4**	**9.4**	**9.9**	**14.1**	**5.4**	**43.2**

The table and graph show the current Budget, Actual workforce in post and the vacancies within the Orthopaedic service.
As of 31 July 2023, there was a total of 43.2WTE vacancies within the service. The highest number of vacancies are within the Nursing workforce with 20.5WTE vacancies, most of these roles vacant are across Glangwili Hospital and Prince Philip Hospital (8.5WTE and 8.3WTE). Medical & Dental also have a large proportion of the vacancies with 17.2WTE, again the majority are across the Carmarthenshire sites.

During this period an additional 23 WTE of temporary staffing were utilised across Bank, additional hours, overtime and contract agency during the month of July 2023 (WTE Whole Time Equivalent or 37.5 hours also known as Full Time).

The table above shows that all the vacancies for the Orthopaedics Service as of 31 July 2023 are for doctors. This has since been partially alleviated by the recruitment of Locum Consultant, although the service is still considerably short on the number of specialist consultants required to manage all services within Orthopaedics.

Historic workforce position

There has been an overall increase of 178.2 WTE from 1 August 2018 to 203.1 WTE on 31 July 2023. The breakdown of this increase is shown in the table below.

Staff Area	2018	2023	Difference	Percentage
Add Professional Scientific and Technical	15.1	6.2	-8.9	-58.9%
Additional Clinical Services	44.0	93.1	49.1	111.6%
Administrative and Clerical	16.2	21.3	5.1	31.5%
Estates and Ancillary	0	0.8	0.8	100%
Medical	45.2	47.2	2.0	4.4%
Nursing	57.7	56.1	1.6	-2.8%
Total	178.2	224.7	46.5	26.1%

An increase in workforce can be seen since between 2018 and 2020 of 46.5 WTE however this followed with a significant decrease to the service by 2022 of 32.1 WTE. In the preceding years the workforce has continued to increase steadily to 224.7 WTE as of 31 July 2023.

The increase and decrease are predominantly within the Additional Clinical Services staff group with all other staff groups remaining stable.

The vacancy graph below depicts the vacancy increase across time since December 2020. The highest number of vacancies can be seen in September 2022 with 67 WTE.

Glangwili Hospital and Prince Philip Hospital have consistently had the largest number of vacancies across time, these increased steadily from April 2021. The highest number of vacancies was in September 2022 with 51.7 WTE, however this has begun to decrease since April 2023.

Withybush Hospital has had the most varied number of vacancies with an increase in July 2021 followed by a further substantial increase in September 2022. Since this period, the vacancies have decreased by 11.7 WTE to 5.4 WTE in July 2023.

The highest number of starters have been within the Additional Clinical Services staff group with 18.2 WTE in 2022 and 10.3 WTE in 2023 (up to 31st March 2023). Prior to this the increased numbers for medical and dental in 2019 would have also included SLE (Junior doctor) numbers.

	2018	2019	2020	2021	2022	2023	Total
Starters	14.2	33.4	23.1	20.4	32.9	13.3	**137.3**
Leavers	16.8	25.4	20.1	28.3	22.8	10	**123.4**

The age profile of the 19 consultants (permanent and locum) within the Orthopaedics Service has been analysed:

- 12 medical staff are aged over 51
- Average retirement age for medical staff is 66 and there are 3 consultants approaching that age over the next few years
- An additional 2 speciality doctors are also in the 61-65 age group
- 5 members of the medical team could potentially retire in the coming years and another 5 in the next 5 to 10 years.

The above highlight key workforce fragilities that will impact the interim years.

Although not part of the Orthopaedic Service, issues surrounding the recruitment of therapy staff will have an impact on the services which are essential in the orthopaedic service.

Orthopaedic Service conclusions

Elective Orthopaedic services is part of the Clinical Services Plan (CSP) in order to support the return of the service to pre-COVID-19 activity levels as a minimum, as part of improving access and reducing waiting times for patients.

The planned Orthopaedic service operates at each of the four main and in some community hospital sites. These are:

- Bronglais Hospital (Aberystwyth)
- Glangwili Hospital (Carmarthen)
- Prince Philip Hospital (Llanelli)
- Withybush Hospital (Haverfordwest)
- Community Hospitals, these are - Cardigan Integrated Care Centre (CICC) formally Cardigan and District Hospital; South Pembrokeshire Hospital; Tenby Hospital and Tywyn Hospital
- Werndale Hospital (Carmarthen) was used from March until December 2020 as additional capacity for HDdUHB Consultants.

A summary of the findings identified within this paper are as follows:

Risks

- Ability to manage patients awaiting follow up appointments
- Patients Waiting between three and four years for treatment

- Insufficient Inpatient Operating Theatre Capacity
- Poor condition of the air handling units which service the laminar flow Operating Theatres impacting activity
- Recruitment issues for Therapy staff to complement Orthopaedic Services
- Aging Workforce and the ability to recruit to Orthopaedic Services.

Clinical effectiveness

- Theatre Capacity is an issue for the Service – Inpatients only delivered on two sites, these are Prince Philip and Bronglais Hospitals due to compliance with British Orthopaedic Association (BOA) Quality of Care Standards such as ring-fenced wards and 24/7 Orthopaedic Medical Cover
- Inpatient activity at Bronglais Hospital was able to commence in advance of the BOA standards. Although it does not have a ring-fenced ward on the site, it does have ring fenced bays for elective orthopaedic surgery on a planned care ward. Due to negligible historic infection prevention control concerns, inpatient activity has been supported at this site.

Local, regional and national work

- The ARCH (A Regional Collaboration for Health) project was established in 2015 to develop regional collaboration for Orthopaedic Services across Swansea Bay and Hywel Dda University Health Boards.
- National Clinical Strategy for Orthopaedic Surgery Programme (NCSOS) has been established but chaired by Hywel Dda University Health Board to support
- Collaborative working with Swansea Bay University Health Board
- A real time reduction in patients waiting the longest for treatment with a single operational patient list
- Optimised elective surgical pathways across each Health Board
- The GIRFT (Getting It Right First Time) report has been published with the aim to identify improvement opportunities within orthopaedic services within the Health Board. A list of recommendations has provided by the GIRFT team and the Health Board has reviewed these and reported its position on these areas through the existing Audit and Risk Assurance Committee (ARAC).

Activity data

- The issue of historical recording of information for Trauma and Orthopaedics and the difficulty in separating the planned and emergency care activity has been identified
- Patient referrals have risen from 6,709 (all sites) in 2018-19 to 8,395 in 2022/23. Total outpatient appointments have reduced from 17,337 in 2018/19 to 16,359 in 2022/23, a reduction of 5.6%, due to Patient Initiated Follow up (PIFU) and See on Symptoms (SOS) options, as promoted by GIRFT (Getting It Right First Time). Day case activity in 2022/24 is showing an increase of 11% on the 2019/20 treatments performed within the Service
- Inpatient activity in 2022/24 is showing a reduction of 12% on the 2019/20 treatments performed within the Service. The decline in Inpatient Surgery can be related to the reduction in overall available theatre space available some of which links to the British Orthopaedic Association Standards and the consolidation on Inpatient Surgery to a single site in Prince Philip for the south of the Health Board and in Bronglais Hospital for

the north of the Health Board. This has been compounded by some of the risks identified within the Withybush site and closure of key wards
- Between April to December 2020, the Health Board, used additional space at Werndale Hospital (which is a private healthcare company) to provide additional site capacity after the COVID-19 pandemic as this site met the COVID standards for patient activity, but the Health Board Consultants still undertook the activity and remained under the duty of care of Hywel Dda University Health Board
- Large Number of Patients waiting between three and four years for treatment
- Service constrained by shortages within Anaesthetic teams and Therapy Teams to support Theatre sessions and post operative care.

Incidents, complaints, and claims

The current reported information contains both planned Orthopaedic and Emergency Orthopaedic (known as Trauma) patient experience by year and hospital site and does not show a true reflection for the planned care patient information.

- Patient Safety Incidents with the top incident relating to accidents/falls, which are more associated with the emergency part of the service
- Patient Complaints, the top complaint relating to clinical treatment/assessment, which again is associated with the nature of the emergency part of the service
- Patient Claims – There have been 28 closed claims in this period, where liability has been accepted learning from these events has been taken forward by the Orthopaedic Service and includes the emergency treatment.

Patient experience and compliments

Themes are not attributed to a specific site but are general to the whole service:

- Staff are frequently described as professional, friendly, helpful, and efficient
- Patients are unhappy at the delays in waiting for appointments, in particular follow up appointments
- There are concerns about lack of communication between the service and patients. This includes errors when making appointments and scheduling issues.

Targeted early engagement with service users

- Patients praised the professional, kind, reassuring, and helpful staff; the timeliness and efficiency of the service received; and the generally good quality of care
- Patients negative feedback included concerns about a lack of timeliness (for appointment access and speed of diagnosis), and poor standards of care
- Patient suggested improvements in speed and efficiency (including shortening waiting times and not cancelling appointments); and communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up).

Targeted early engagement with staff

- Staff across all sites highlighted positive working relationships within the service. Staff were said to be dedicated, helpful and approachable toward patients and colleagues; and to work well together within specific clinical roles and more broadly as a service
- Other stated positives were around good clinical outputs and quality of care; consultant responsiveness and communication; good service management, training opportunities and monitoring; and the benefits of multidisciplinary team meetings in ensuring better patient care and flow

- Difficulties of working in the service included staffing shortages, leading to heavier workloads and a risk of burnout among employees with a lack of capacity and long waiting lists
- a lack of access to ward-based and community rehabilitation and support/communication for hospital discharge
- Working environments and equipment that are not fit for purpose
- Staff suggested improvements as re-providing elective joint arthroplasty at Withybush Hospital or, conversely, centralising this service at Prince Philip Hospital, increased rehabilitation capacity within hospitals and the community and ensure different departments within Orthopaedics work together to ensure care is consistent and streamlined.

Finance

There is a high level of additional spend on pay to support orthopaedic services through a combination of:

- Medical Agency supplied staff £1.110million
- Additional Duty Hours paid to the member of staff for working in addition to their contracted sessions £0.291m for the first nine months of 23/24
- Due to a number of vacancies, there is an overall end of financial year forecast of £0.328m underspend for 23/24
- Longer term there is a funding challenge to ensure sufficient workforce are funded to support the capacity available in the Service.

Workforce

The following key workforce issues have been identified within the Orthopaedic Service across all hospital sites:

- Inability to separate elective/planned staff information from the emergency orthopaedic service
- Medical Staff Vacancies not being actively recruited to due to lack of the Theatre capacity and staff shortages in other clinical staff and not the ability to recruit to medical vacancies
- Workforce establishment across all sites (the service is currently undertaking demand and capacity planning).

Section 13: Urology

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Section 13: Urology

Introduction

This chapter of the Issues Paper is about Urology services at Hywel Dda University Health Board. This chapter is a clinically led assessment of the Urology service at all sites within the Health Board that delivered Urology services between 1 August 2018 and 31 July 2023.

Urology Service at Hywel Dda

The Urology Service is part of Scheduled Care and looks after adult patients with urological conditions. The Urology service focuses on the care of the Genito-urinary[219] tract system in both men and women (e.g., kidneys, bladder) and the reproductive tract in men (e.g., testicular, penile, and prostate). Urology is a mostly diagnostic and Outpatient[220] focused service, with approximately 14 patients requiring an Outpatient appointment for every 1 who requires surgery as either Inpatient or as a Day Case[221].

The subspecialities[222] within Urology are described as follows:

Subspeciality	What this means
Urgent Suspected Cancer (USC) pathways: • Penile • Prostate • Bladder and renal • Testicular	Management of patients on a suspected Urology cancer pathway, including Outpatient appointments, diagnosis and detection and treatment within timescales outlined by the Welsh Government Single Cancer Pathway guidance.
Trial Without Catheter (TWOC)	TWOC is when a catheter which has been inserted via the urethra (water pipe) is removed from the bladder for a trial period to determine whether you are able to pass urine spontaneously.
Prostate-Specific Antigen (PSA) Assessment	The PSA test is a blood test to help detect prostate cancer. But it is not perfect and will not find all prostate cancers. The test, which can be done at a GP (General Practitioner) surgery, measures the level of prostate-specific antigen in your blood.
Active Surveillance/PSA Surveillance/Watchful Waiting	Monitoring PSA for patients on difference pathways.
Urodynamics Studies (UDS)	UDS test how well the bladder, sphincters, and urethra hold and release urine.
Flexi/Rigid Cystoscopy	A cystoscopy is a test that allows the doctor to look directly at the lining of the bladder, from the opening of the urethra.

[219] The genitourinary tract includes the urinary and genital organs.
[220] If you have an appointment in a hospital or clinic but do not need to stay overnight, it means you are being treated as an Outpatient or a Day Patient. You may be having an appointment for treatment, diagnosis, or a procedure.
[221] A patient who comes in for a more involved procedure than an outpatient. You may need some recovery time at the hospital, but you should be able to go home the same day.
[222] Subspecialties is a speciality that is part of a broader speciality, such as Urology.

Trans Rectal Ultrasound (TRUS) Guided Biopsy/ Local Aesthetic Trans Perianal (LATP) Biopsy	These are different types of biopsies of the prostate following radiology diagnostics.
Non cancer related urological related surgery	Examples of non-cancer related surgery includes: • Percutaneous Nephrolithotomy (removal of kidney stone) • Ureteric/bladder stone removal • Insertion of stents • Circumcision • Epididymal cysts (cyst removal) • Hydrocele (fluid cyst removal).

Urology service model

The service works from the 4 main hospital sites as follows:

Location	Outpatient	Inpatient	Day case
Bronglais Hospital	X		X
Glangwili Hospital	X	X	X
Withybush Hospital	X		X
Prince Philip Hospital	X	X	X

Patients are currently sent to Prince Philip for elective Inpatient surgery. This is a temporary measure in response to the COVID-19 Pandemic. More details are in the following section regarding Urology Temporary Service Changes.

While the Urology service undertakes the surgery, they do not manage the theatres where the surgery takes place or wards where patients recover.

There are a range of methods of accessing Outpatient services including:

- Virtual
- Telephone
- Non-contact via the Patient Knows Best (PKB) App. This is an app-based monitoring service which encourages patient self-management and allows patients to view information about their care
- Face to face

Telephone, virtual and non-contact services are often used by older adults. This is because access to the service is easier from a patient's home via internet, rather than travelling to an appointment. The service is aiming to limit the number of face to face appointments wherever possible as this reduces the amount of patients who need to physically come into a hospital site.

Treatment outside of the Health Board

For more complex surgical cases patients are referred to Swansea Bay University Health Board (UHB) and Cardiff and Vale University Health Board, for example, where robotic assisted laparoscopic prostatectomy[223] (RALP) cystectomy[224], laparoscopic partial nephrectomy[225] are needed.

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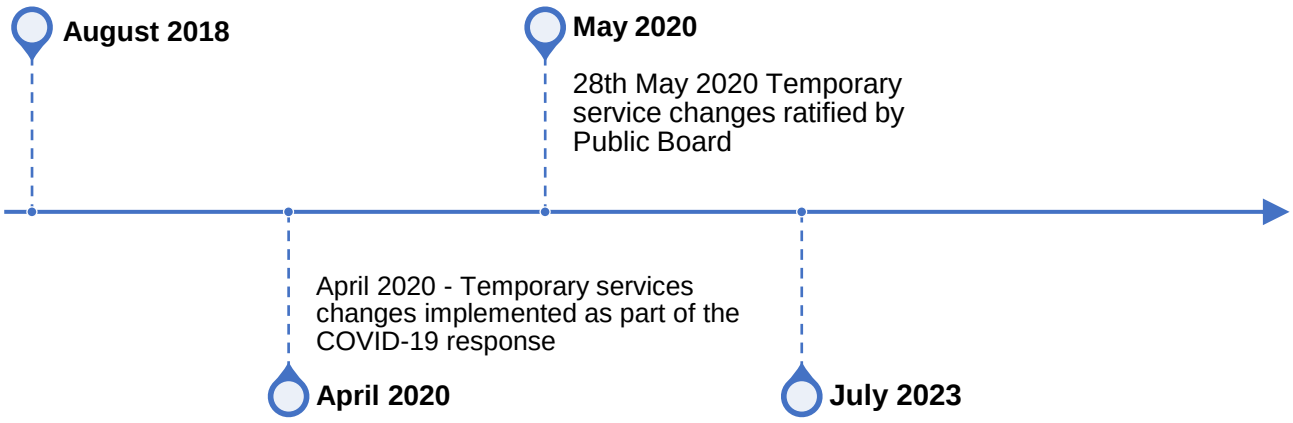
[223] *Laparoscopic Prostatectomy is the removal of the prostate.*
[224] *Cystectomy is the removal of the bladder.*
[225] *Laparoscopic partial nephrectomy is the partial removal of the kidney.*

Hywel Dda works in close partnership with Swansea Bay UHB Oncology Team for Urgent Suspected Cancer (USC) cases.

Urology temporary service change

This section provides information about the updates to Public Board about service changes that have taken place within the Urology service between August 2018 and July 2023.

Service change timeline



The temporary service changes were described at Public Board on 28th May 2020 as:

- Services have been relocated to a local private hospital (Werndale), providing Outpatient and treatment services for their Unscheduled Care (USC) and Urgent patients
- All Outpatient Prostate-specific antigen (PSA) clinics moved to virtual telephone clinics. Patients PSA to be monitored so no build-up of waiting lists and rebooked into clinics in 3/6 months' time or if there is a problem referred to the consultant
- Intermittent self-catheterisation (ISC) ISC/ISC Clinic - Triaged by telephone first by the CNS (Clinical Nurse Specialist) Nurse
- USC are triaged, contacted by the Consultants and the patients that need to have a face-to-face appointment these are being offered at Werndale
- Where necessary theatre nursing scrub staff are allocated to sessions, equipment has also been transported to support some operating lists
- Discussions are taking place with regards to further to work closer with Swansea Bay University Health Board (SBUHB) to carry out surgery locally in Glangwili for residents of Hywel Dda
- The TWOC Pathway has moved from responsibility of Community Services to Scheduled Care.

Full detail about the service change can be found in the following board paper: '[Responding to the COVID-19 Pandemic: Update, Review and Ratification of Decisions Made Since 16th April 2020]'[226]

Aside from the ratified changes, there were changes to the surgical rota in response to the COVID-19 pandemic.

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[226] *Website - https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-meetings-2020-documents/public-board-agenda-bundle-28-may-2020/#page=13*

- During this period, all elective[227] surgery was cancelled, this included Urology
- Hywel Dda established a pathway to ensure elective surgery patients were treated in a dedicated ward space separate to patients on an emergency pathway
- Ward 7 in Prince Philip Hospital was identified as the pathway area for Urology patients. All elective Urology patients were sent to Prince Philip for their Inpatient surgery.

All elective urology patients are still seen at Prince Philip Hospital as this temporary change remains in place. The operating model prior to the temporary changes was for both emergency and elective surgery to take place in Glangwili hospital.

Virtual PSA clinics and telephone USC triage have become part of standard pathways within the service. TWOC continues to be a service provided by Urology services.

Werndale stopped supporting Outpatient and treatment services for USC and Urgent patients in December 2020 and services returned in full to their pre-covid locations, Glangwili Hospital, Bronglais Hospital, Withybush Hospital and Prince Philip Hospital.

Urology risks

According to our methodology described on page 11, the following section describes identified risks that have been reported to Public Board that relate to Urology between August 2018 and July 2023.

Risk No. 44: Ability to manage patients awaiting follow up appointments, escalated to the Corporate Risk Register 31 January 2019

- The original risk was created following a missed target to reduce follow-up Outpatient appointments in several services, including Urology
- The risk was added to the Corporate Risk Register with a risk rating of 12, and a target risk score of 8. The risk highlighted that there is a risk of harm to patients on follow-up waiting lists who have exceeded their follow-up date
- The risk was closed on 1 June 2020 as, following discussions with the Scheduled Care Directorate Senior Management Team, the risk was to be replaced by a new Risk in relation to Outpatient management. Further details about this risk can be found on page 5 of the linked document 30JUL2020[228]
- The new risk is managed by the Scheduled Care Outpatients Management Team and was last reviewed in December 2023, when the risk score was reduced in severity from 15 to 12. This was because Hywel Dda now has a low percentage of patients on follow-up lists compared to other health boards.

[227] *Elective surgery is non-emergency surgery.*
[228] *Web address - hduhb.nhs.wales/about-us/your-health-board/board-meetings-2020/board-agenda-and-papers-30th-july-2020/board-30th-july-2020-documents/sbar-corporate-risk-register-july-2020/*

Urology clinical effectiveness

The table below includes a list of the clinical guidelines that the Urology service needs to follow:

Guideline Source	Guideline Title	Link
NICE[229]	Suspected cancer: recognition and referral	https://www.nice.org.uk/guidance/ng12
NICE	Bladder cancer: diagnosis and management	https://www.nice.org.uk/guidance/ng2
NICE	Improving outcomes in urological cancers	https://www.nice.org.uk/guidance/csg2
NICE	Lower urinary tract symptoms in men: management	https://www.nice.org.uk/guidance/cg97
NICE	Prostatitis (acute): antimicrobial prescribing	https://www.nice.org.uk/guidance/ng110
NICE	Prostate cancer: diagnosis and management	https://www.nice.org.uk/guidance/ng131
NICE	Pelvic floor dysfunction: prevention and non-surgical management	https://www.nice.org.uk/guidance/ng210
NICE	Urinary incontinence and pelvic organ prolapse in women: management	https://www.nice.org.uk/guidance/ng123
NICE	Urinary incontinence in neurological disease: assessment and management	https://www.nice.org.uk/guidance/cg148
NICE	Bedwetting in under 19s	https://www.nice.org.uk/guidance/cg111
NICE	Urinary tract infection in under 16s: diagnosis and management	https://www.nice.org.uk/guidance/ng224
NICE	Urinary tract infection (catheter-associated): antimicrobial prescribing	https://www.nice.org.uk/guidance/ng113
NICE	Pyelonephritis (acute): antimicrobial prescribing	https://www.nice.org.uk/guidance/ng111
NICE	Urinary tract infection (lower): antimicrobial prescribing	https://www.nice.org.uk/guidance/ng109
NICE	Urinary tract infection (recurrent): antimicrobial prescribing	https://www.nice.org.uk/guidance/ng112
NHS Wales	Urological Cancer	https://executive.nhs.wales/functions/networks-and-planning/cancer/clinical-hub/cancer-site-groups/urological-cancer/
	Prostate Cancer	https://uroweb.org/guidelines/prostate-cancer
	Non-Muscle Invasive Bladder Cancer	https://uroweb.org/guidelines/non-muscle-invasive-bladder-cancer

[229] *National Institute for Care and Excellence.*

EAU[230]	Upper Urinary Trace Urothelial Cell Carcinoma	https://uroweb.org/guidelines/upper-urinary-tract-urothelial-cell-carcinoma
	Muscle-invasive and Metastatic Bladder Cancer	https://uroweb.org/guidelines/muscle-invasive-and-metastatic-bladder-cancer
	Primary Urethral	https://uroweb.org/guidelines/primary-urethral-carcinoma
	Renal Cell Carcinoma	https://uroweb.org/guidelines/renal-cell-carcinoma
	Testicular Cancer	https://uroweb.org/guidelines/testicular-cancer
	Penile Cancer	https://uroweb.org/guidelines/penile-cancer
EAU	Sexual and Reproductive Health	https://uroweb.org/guidelines/sexual-and-reproductive-health
	Non-neurogenic Female LUTS	https://uroweb.org/guidelines/non-neurogenic-female-luts
	Urethral Strictures Management of non-neurogenic Males LUTS	https://uroweb.org/guidelines/management-of-non-neurogenic-male-luts https://uroweb.org/guidelines/urethral-strictures
	Chronic Pelvic Pain	https://uroweb.org/guidelines/chronic-pelvic-pain
	Neuro-Urology Urolithiases	https://uroweb.org/guidelines/neuro-urology
	Paediatric Urology	https://uroweb.org/guidelines/paediatric-urology
	Urological Trauma	https://uroweb.org/guidelines/urological-trauma
	Renal Transplantation	https://uroweb.org/guidelines/renal-transplantation
	Thromboprophylaxis	https://uroweb.org/guidelines/thromboprophylaxis

Issues relating to adherence to the clinical guidelines are noted below:

- NICE recommends Multi-parametric[231] MRI for Prostate cancer diagnosis. Currently we can offer it to half of the patients who would have an MRI. This is because of issues with capacity within the Radiology service. Hywel Dda is running the shortened pathway at Bronglais Hospital for 4 patients per week but needs to achieve a minimum of 8 to meet

[230] *European Association of Urology.*
[231] *A Multiparametric MRI is a special type of MRI scan that produces a more detailed picture of your prostate gland than a standard MRI scan does.*

demand. This includes the patient having a Soft Tissue Tumour (STT) MRI scan with an Outpatient Appointment with a Consultant the following day

- Hywel Dda does have a one stop haematuria clinic[232]. Extending this service to increase the number of these clinics would require increased capacity within Radiology to provide ultrasound tests across all hospital sites. It is understood that the Radiology service would need additional staff to accommodate these requests
- Currently we do not have a dedicated Lower Urinary Tract Symptoms[233] (LUTS) for Men clinic. This is because of a lack of capacity and appropriate space within the Outpatient Department within Glangwili Hospital where most Outpatient appointments are currently delivered. Ideally, the Health Board would implement a Urology Investigation Unit to accommodate Outpatient Activity. This is a dedicated facility where dedicated consulting rooms, procedure rooms and administration support are co-located, thereby allowing the Multi-Disciplinary Team (MDT) to work together. More information about UIUs can be read here[234]
- The treatment of Pelvic Floor Dysfunction is best delivered by an MDT where the Urology, Gynaecology and Colorectal teams work together. The Health Board has an MDT for this, but following the retirement of a consultant there is no specialist from Urology in this MDT.
- The Health Board currently does not have a consultant with the specialist interest in Urinary incontinence[235] in neurological[236] disease, so patients are currently referred outside the Health Board for treatment.

Urology local, regional, and national work

This section describes the regional and national projects or programmes connected to Urology services at Hywel Dda.

GIRFT

Hywel Dda University Health Board Urology service started their Getting It Right First Time (GIRFT) review in November 2023. The report including recommendations is due early 2024. More information about GIRFT for Urology in other health care providers in the UK that can be found in in the GIRFT website[237]

Urology activity data

Urology service activity reported between 1 August 2018 and 31 July 2023 is included for Prince Philip Hospital, Bronglais Hospital, Withybush Hospital and Glangwili Hospital. Activity for the Werndale during the COVID-19 Pandemic as part of the temporary service change has also been included. All data tables including the specific conditions captured can be found in Appendix K8 - Urology - Activity Data.

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[232] A Haematuria Clinic is specifically set up for performing tests on your urinary tract to identify the cause of the bleeding.
[233] Lower urinary tract symptoms (LUTS) includes various symptoms involving urination, such as leaking or having sudden and frequent urges to urinate.
[234] Website - https://gettingitrightfirsttime.co.uk/wp-content/uploads/2023/06/Urology_Guidance_UIU-FINAL-V1-June-2023.pdf
[235] Incontinence is the loss of bladder control.
[236] Neurological relates to disorders of the nervous system.
[237] https://gettingitrightfirsttime.co.uk/surgical_specialties/urology-surgery/#:~:text=The%20GIRFT%20national%20report%20for,provide%20consultant%2Dled%20emergency%20urology

2018-19 and 2023-24 are not full 12-month periods. 2018-19 is 01 August to 31 March and 2023-24 is 01 April to 31 July.

Activity is split between Outpatient referrals, Outpatient interactions (both face to face and virtual) and Inpatient/Day case referrals (lists) and activity.

Outpatient data

Outpatient services for urology are carried out in the following sites across the Health Board:

- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital
- Werndale (between April - December 2020)

Outpatient services within Urology include:

- Male Health Clinic (Glangwili Hospital only)
- TWOC (pre-COVID-19, this was carried out by district nurses. Since COVID-19, this reverted to Glangwili Hospital at 3 Consultant sessions a week)
- Urodynamics (Glangwili Hospital only)
- PSA Assessment (all sites)
- TRUS biopsy (Glangwili and Withybush Hospitals)
- Active Surveillance/PSA Surveillance/Watchful Waiting (all sites)
- Flexi Cystectomy (all sites)

Outpatient Referrals						
12-month period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Werndale**	**Total**
2018-19	564	1,574	780	787	0	**3,705**
2019-20	812	2,241	1,342	1,260	9	**5,664**
2020-21	475	1,696	991	805	131	**4,098**
2021-22	704	1,909	1,613	1,081	1	**5,308**
2022-23	870	1,872	1,855	1,191	0	**5,788**
2023-24	294	653	721	417	0	**2,085**
Total	**3,719**	**9,945**	**7,302**	**5,541**	**141**	**26,648**

The number of new Outpatient referrals has been increasing to and beyond pre-COVID-19 levels since 2021.

Outpatient Activity						
12-month period	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Werndale**	**Total**
2018-19	1,538	5,772	4,861	3,666	0	**15,837**
2019-20	1,264	6,784	4,626	4,096	0	**16,770**
2020-21	614	3,738	2,294	1,822	911	**9,379**
2021-22	530	6,494	1,958	1,632	0	**10,614**
2022-23	1,060	9,207	2,727	1,929	0	**14,923**
2023-24	328	328	713	750	0	**5,076**
Total	5,334	35,280	16,466	13,145	911	**67,523**

The number of Outpatient activities has increased closer to pre-COVID-19 levels since 2022.

The number of new referrals has met and passed pre COVID levels however the amount of Outpatient activity has not yet caught up. Each site apart from Glangwili has seen the number of interactions fall, this is a consequence of Glangwili being the primary unit for Outpatient services during and since the COVID-19 pandemic and undertaking additional Outpatient treatment.

As result of Outpatient services being concentrated at Glangwili Hospital, Withybush and Prince Philip Hospital have seen a reduction in the amount of activity they do.

Pre-COVID-19 Bronglais Hospital held a 5-day Outpatient service, however due to falling demand this changed to a 3-day service in 2020.

In Patient and Day Case data

Inpatient and Day Case services for Urology are carried out at the following sites across the Health Board:

- Bronglais Hospital (Day Case only)
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital (Day Case only)

Inpatient and Day Case services would include:

- Minor surgery[238]
- Cancer and non-cancer related surgeries

Inpatient and Day Case Referrals (Lists)					
12-month period (01AUG-31JUL)	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	667	3,337	1,892	1,391	**7,287**
2019-20	614	3,273	1,930	1,634	**7,451**
2020-21	186	2,536	1,442	612	**4,776**
2021-22	391	2,638	1,917	1,308	**6,254**
2022-23	471	2,972	2,345	1,387	**7,175**
Total	2,329	14,756	9,526	6,332	**32,943**

Inpatient and Day Case Activity					
12-month period (01AUG-31JUL)	**Bronglais Hospital**	**Glangwili Hospital**	**Prince Philip Hospital**	**Withybush Hospital**	**Total**
2018-19	688	4,758	1,987	1,271	**8,704**
2019-20	647	4,183	1,894	1,335	**8,059**
2020-21	6	2,645	874	465	**3,990**
2021-22	121	3,348	1,586	1,312	**6,367**
2022-23	204	3,534	1,924	1,301	**6,963**
Total	1,666	18,468	8,265	5,684	**34,083**

The number of new referrals is close to pre-COVID-19 levels; however, the Inpatient and Day Case activity levels remain below pre pandemic levels. This shows that although the number of new referrals has moved closer to pre-COVID-19 levels, the amount of Inpatient and Day Case activity has not yet caught up.

Anecdotally, the service has noticed since COVID-19, patients are presenting later with worse symptoms than they did before 2020. This is due, in the main to the period during COVID-19 when service was only treating cancer cases. This means patients with other conditions have seen them worsen while they wait for treatment. By the time the patient is seen by the service the problem has become more complicated than it otherwise would have been. As a result of this, conditions are more challenging and take longer to treat.

Urology incidents, complaints, and claims

The following section includes information about our patients' experience and includes patient incidents, patient complaints, patient claims, and patient compliments that have been recorded against Urology. Full data for incidents, complaints, claims, and compliments, can be found in Appendix K10 - Urology - Complaints Data, and Appendix K11 - Urology - Patient Experience and Compliments Data.

[238] *Minor surgery refers to surgery involving little risk to the life of the patient.*

Patient safety incidents

The table below shows the overall number of recorded incidents for Urology across all sites within the Health Board. The recording period for each year is 1 August to 31 July.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Incidents	175	209	152	119	115

The change in the incident recording system means that there are two recording periods, August 2018 to end of March 2021 and April 2021 to end of July 2023. The number of incidents recorded for the Urology service at each hospital site is seen in the table below.

Primary Location	Count (01 August 2018 – 31 March 2021)	Count (01 April 2021 – 31 July 2023)	Total
Glangwili Hospital	358	297	**655**
Prince Philip Hospital	134	125	**259**
Bronglais Hospital	3	2	**5**
Withybush Hospital	3	7	**10**

The most common types of incidents reported are shown in the table below.

Reported 01 August 2018 – 31 March 2021	Total
Pressure Ulcers	**172**
Patient Accidents/Falls	**160**
Reported 01 April 2021 – 31 July 2023	
Accident, Injury	**122**
Pressure Damage, Moisture Damage	**122**

Pressure Ulcers, Pressure Damage, Moisture Damage and Patient Accidents/Falls are most likely to take place on wards that the Urology service does not manage.

The table below shows overall number of incidents received for Urology services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023.

Incident Severity	Count (01 August 2018 – 31 March 2021)	Count (01 April 2021 – 31 July 2023)	Totals
1 – None	333	133	**466**
2 – Low Harm	124	211	**335**
3 – Moderate Harm	40	83	**123**
4 – Severe Harm	2	4	**6**
5 – Catastrophic Death	0	2	**2**

As most incidents appear to occur in areas outside of Urology's management, e.g., wards, no comparison can be made between activity carried out at each site and the level of incidents recorded.

Complaints

The table below shows the overall number of complaints within Urology across all Health Board sites.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Complaints	45	77	117	116	135

The table below shows the number of Urology service complaints received by each hospital site between 1 August 2018 and 31 July 2023.

Primary Location	Count (01 August 2018 – 31 March 2021)	Count (01 April 2021 – 31 July 2023)	Totals
Glangwili Hospital	97	164	**261**
Prince Philip Hospital	48	70	**118**
Withybush Hospital	34	40	**74**
Bronglais Hospital	24	25	**49**
Total	203	299	**502**

The table below shows the location of recorded complaints between 1st April 2021 to 31st July 2023. Where locations are not included it indicates no recorded incidents took place at that location.

Primary Location	Total
Glangwili Hospital	**164**
Prince Philip Hospital	**70**
Withybush Hospital	**40**
Bronglais Hospital	**25**
Patients home	**5**

The table below shows the most common complaints reported between 1 August 2018 and 31 July 2023, by their category.

Complaint Subject	Count (01 August 2018 – 31 March 2021)	Count (01 April 2021 – 31 July 2023)	Totals
Appointments	83	116	**199**
Clinical treatment / assessment	51	87	**138**

The table below shows overall number of complaints received for Urology services, and their severity level (grade), recorded between 1 August 2018 and 31 July 2023.

Complaint Grade	Count (01 August 2018 – 31 March 2021	Count (01 April 2021 – 31 July 2023	Totals
Grade 1 – Minor - Informal	94	208	**302**
Grade 2 - Minor	30	70	**100**
Grade 3 - Moderate	34	24	**58**
Grade 4 - Major	1	3	**4**
Grade 5 – Catastrophic	0	0	**0**

As complaints also occur in areas outside of Urology's management e.g., wards, it is not possible to compare activity carried out at each site and the level of complaints recorded.

Urology service claims

During the period 1/8/2018 to 31/7/2023, Hywel Dda University Health Board submitted one clinical negligence & redress 'Learning from Event' report to the Welsh Risk Pool, as part of the reimbursement process for the area of Urology and the sub specialities within the scope of the clinical services plan. The claim related to a delay in nephrology treatment.

As well as the closed claims there were also 10 confirmed cases that are subject to investigation and a further 10 received that are potential cases awaiting further details.

The service has been made aware of specific cases so they can be learned from. However, there was a theme identified relating to a delay in diagnosis or treatment.

Urology patient experience

We have patient, friends and family, and compliment information from 2021 – 2023. Further information can be found within Appendix K11 - Urology - Patient Experience and Compliments Data.

Thematic analysis has been carried out on the feedback received from the following surveys. However, these are based on limited responses and cover areas outside of Urology's management.

	Patient Experience	Friends and Family Experience	Compliments
2021	Patient experience was related to the staffing and communication. Patients spoke highly of ward staff and the care they received. Negative experiences are around communication with patients and time spent waiting for decisions and organisation between	The themes arising are around staffing, quality of care, waiting times, environment, and communication. Staff are described positively as being helpful, friendly, and professional who provided quality care, who often explained the procedures and process. Inpatient environments are often described as clean and safe, and people were happy with waiting times for appointments.	The themes arising were hard working, professional staff with good communication throughout the process.

	different parts of the Health Board.	Negative themes were around waiting for procedure appointments, times when Outpatient appointments were delayed and the Outpatient environment. Other views were also raised around lack of communication around appointment purpose and having to travel when a closer hospital is nearby.	
2022	Patient experience was related to the staffing and environment. Patients spoke highly of ward staff and the care they received. Negative experiences are around isolated members of staff while receiving care, concerns over staffing levels and the lack of communication with patients, the cleanliness of the ward environment and ability to sleep at night.	The themes arising are around staffing, quality of care, waiting times and communication. Staff are described positively as being helpful, friendly, and professional who provided quality care, who often explained the procedures and process. Most reported that they did not have long waits for their appointments. Negative comments focused on the perceived lack of staffing, poor communication about the appointment, lack of parking on site, and isolated complaints with members of staff.	The themes arising were the hardworking of kind, caring and compassionate staff who provide an excellent service
2023	Patient experience was related to the staffing and environment. Patients spoke highly of ward staff, the care they received and the food available. Negative experiences are around isolated members of staff while receiving care, concerns over staffing levels and the lack of communication with patients, the cleanliness of the ward environment, ability to sleep at night on the ward and the handover delays from accident and emergency.	The themes arising are around staffing, quality of care, waiting times and communication. Staff are described positively as being helpful, friendly, and professional who provided quality care, who often explained the procedures and process. Most reported that they did not have long waits for their appointments. Negative comments focused on the perceived lack of staffing, poor communication about the appointment, lack of parking on site, and isolated complaints with members of staff.	None recorded

The above comments are not linked to a particular site but are general for the service. Key themes across the years and evidence groups are as follows:

- Staff are frequently described as professional, friendly, helpful, and efficient
- Concern regarding perceived lack of staffing
- Patients are unhappy at the delays in waiting for appointments, in particular follow up appointments
- There are concerns about lack of communication between the service and patients. This includes errors when making appointments and scheduling issues.

Urology service targeted early engagement with service users

A survey was sent to service users to provide their views about what was good, bad, needed improvement, and/or any issues regarding the service. Further information on the methodology is outlined in Appendix A2 – CSP – Early Engagement ORS Report.

It is important to note that the Urology service does not manage the wards where patients recover from their surgery. The response analysis was completed by Opinion Research Services (ORS), to understand the key issues and themes. The main findings from this report are noted below.

80% of patient respondents said that their experience of using the Urology service was good. 11% said their overall experience of using the Urology service was poor.

Overall experience of using the Urology service (patients)

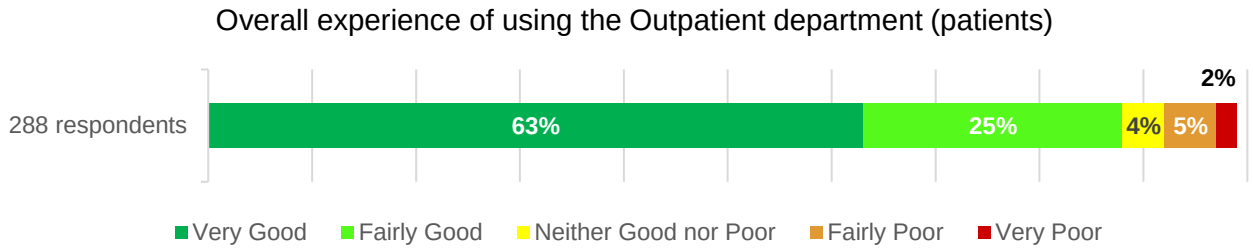
Key positive themes emerging from patients who used the Urology service were around:

- the professional, kind, reassuring, and helpful staff
- the efficiency and speed of the service received (including being seen on time and prompt results and diagnosis)
- the good communication and clarity of information before, during and after the procedure, and on follow up.
- Key negative themes emerging from patients who used the Urology service were around:
- Others, though, complained that they received a slow and/or inefficient service (regarding access to appointments and speed of results and diagnosis).

The main improvements to Urology services as suggested by survey respondents were around speed and efficiency (including providing better access to appointments and shortening waiting times for results and diagnosis); and communication (including better explanations, and increased frequency of contact and follow up). It should be noted over a fifth of respondents felt that no improvements are required.

Experiences of Outpatient services

84% of patient respondents said they used the Outpatient department as part of their Urology treatment. Of these, 88% said their experience of doing so was good, and 8% said it was poor.

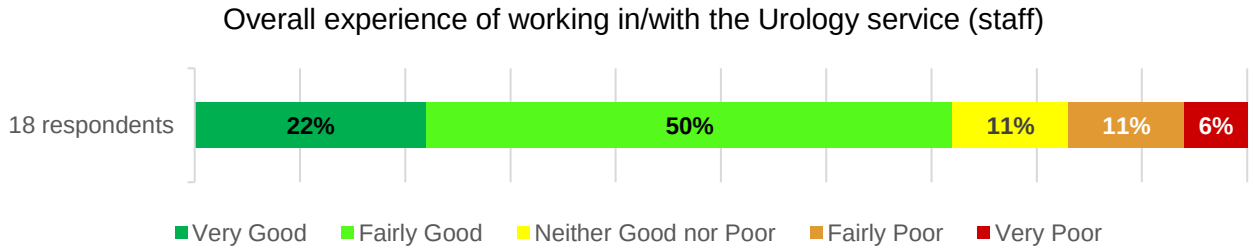


When patients were asked why they said their experience of using the Outpatient department was good or poor, the most frequent positive comments related to the professional, kind, reassuring, and helpful staff; and the speed and efficiency of the service received (including being seen on time and receiving prompt results and diagnosis). Just under three-in-ten patient respondents said they had experienced no issues. The most frequent negative comment was around the speed and inefficiency of the service received (including not being seen on time, access to appointments, and a long wait time for results and diagnosis).

Urology targeted early engagement with staff

As per the approved Clinical Services Plan methodology, a survey was sent to Medical, Nursing, Therapies, Operational and Support staff. Staff members were invited to provide their views about what is good, bad, needs improvement, and to identify issues regarding the service. The response analysis was completed by ORS, to understand the key issues and themes.

72% of staff respondents said that their overall experience of working in/with the Urology service was good, whereas 17% said it was poor.



In terms of what is/was good about their experience of working in/with the Urology service, staff respondents particularly noted:

- The supportive, cohesive, welcoming, and dedicated nature of the team
- the encouragement and support from management when receiving new suggestions for innovative and modern ways of working.

In terms of what is/was not good about their experience of working in/with the Urology service, staff respondents particularly noted:

- The lack of a dedicated Urology ward and clinical rooms was the key concern for respondents. This, it was felt, has led to a de-skilled workforce, and some post-operative Urology patients being cared for on other wards by staff with no service-specific experience.

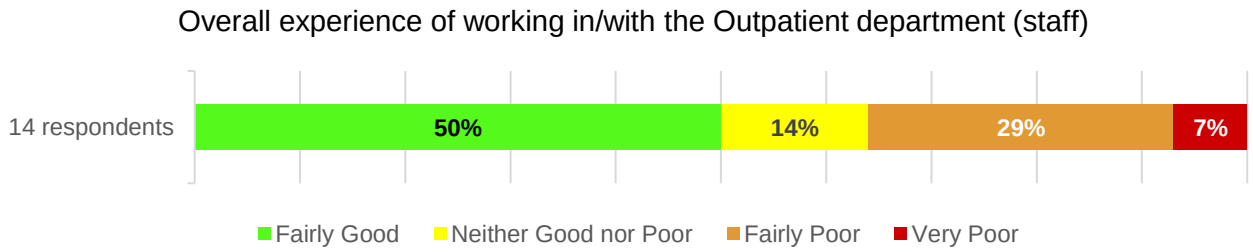
Other frequently stated challenges included a lack of theatre capacity causing unmanageable waiting lists; poor staff retention (particularly consultant urologists at Bronglais Hospital); and

delivering high quality of care with current staffing and resource levels. Some staff also complained about the confusion caused by the 'named consultant' procedure; travel for patients as the service is spread across a wide area; frequent managerial changes (especially at Glangwili Hospital, where some managers have no background in Urology) and the lack of support offered by some service managers; communication within and across Urology sites; some resistance to adopting positive practices among some senior clinicians; and problematic working relationships between some staff within and across Urology sites.

Most staff suggested ways to improve their experience of working in/with the Urology service, most commonly to employ more Urology trained staff, including a larger CNS team and more cancer nurses. Other suggestions were to allocate the Urology department a private office; making Urology referral pathways clear; and placing the responsibility of Trial without Catheter procedures (TWOCs) with community healthcare staff rather than specialist nurses (as was the case pre-COVID).

Experiences of Outpatient services

83% of staff survey respondents use the Outpatient department in delivering their Urology service. Of these, 50% (seven individuals) said that their overall experience of the Outpatient department was fairly good, and 36% (five individuals) said it was poor.



When asked why they said their experience of working in/with the Outpatient department was good or poor, responses came almost entirely from Glangwili Hospital staff. The most frequent comments were around the poor condition of the department (including that rooms are cold, damp, poorly ventilated and too small); insufficient room and storage capacity; and the poor standard of and limited access to equipment.

Urology finance

The Urology Service is experiencing financial pressures due to locum consultants beyond the funded staff establishment and reliance on ADH[239] capacity. This has led to a forecasted annual overspend of approximately £0.564m within Urology, with variable pay[240] contributing £0.258m at the end of Q3 (Accounting period October – December 2023).

Urology workforce

As per the approved Clinical Services Plan methodology, the Workforce Team have supplied data within defined cost codes provided by the Urology. Full details about the methodology can be

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[239] ADH is additional duty hours, which is a form of overtime.

[240] Variable pay is a term used to describe payments made to staff either not employed by Hywel Dda or are working above their normal working arrangements. Examples include staff recruited from an agency who may be paid more for the same role, or staff working overtime or additional hours above their normal arrangements.

found within Appendix K13 - Urology - Workforce Data. It is important to note years within this section are shown as financial year (01 April – 31 March).

Current position

The table below shows the workforce position within the Urology service as of 31st July 2023. It shows the number of WTE[241] across specific staff roles within the Urology service.

Staff Group	Bronglais Hospital	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Total
Additional Clinical Services (Assistant Practitioner Nursing[242]**)**	0	2.0	0	0	**2.0**
Administrative (Medical Secretary, Secretary**)**	0	3.6	0.6	1.4	**5.6**
Medical (Associate Specialist, Consultant, Speciality Doctor[243], Speciality Registrar, Trust Grade Doctor – Foundation Level)	1.0	12.0	2.1	0	**15.1**
Nursing (Nurse – Advanced Practitioner, Specialist Nurse Practitioner)	0	6.0	0	0	**6.0**
Totals	**1.0**	**23.6**	**2.7**	**1.4**	**28.7**

The staff in Urology are mainly based in Glangwili Hospital but deliver services across several sites. Additional travel between sites reduces activity which can be provided.

[241] WTE is Whole Time Equivalent. 1wte is single full time staff member working 37.5 hours a week
[242] Assistant Practitioners (AP) are highly trained and hold more responsibility in their work setting in comparison with a registered nurse.
[243] A Speciality Doctor is a senior doctor who practises in one of the medical or surgical specialties with expertise in the breadth of their speciality. These doctors are expected to provide consultation and manage complex cases and they are considered an expert in the care they deliver.

The below table shows the current staff budgeted WTE (Whole Time Equivalent) establishment and WTE of staff in post. Budget refers to the agreed WTE funding that is available to the service by staffing group.

Staff Group	Budgeted WTE	Actual WTE	Vacancy WTE
Additional Clinical Services (Assistant Practitioner Nursing)	0.0	2.0	(2.0)
Administrative (Medical Secretary, Secretary)	3.8	5.6	(1.9)
Medical (Associate Specialist[244], Consultant, Speciality Doctor, Speciality Registrar[245], Trust Grade Doctor – Foundation Level)	15.1	15.1	0.0
Nursing (Nurse – Advanced Practitioner, Specialist Nurse Practitioner)	8.0	6.0	2.0
Total	26.9	28.7	(1.9)

The Urology service has not had an issue with recruitment. As of January 2024, the service has all budgeted vacancies full.

Overall activity has increased from August 2018 to July 2023. Overall Outpatient activity (including referrals and interactions) has increased from 22,582 to 29,731, an increase of 31%. New referrals (both Outpatient and Inpatient) have increased slightly from 14,032 to 14,579, an increase of 3.8%. Staffing level budgets have not matched this increase in demand. Although Urology does not have underlying recruitment issues, the establishment has not kept up with demand.

Perceived lack of staffing has also been noted within the Patient Experience information, where a perceived lack of staffing is noted as a key theme on multiple occasions. It is important to bear in mind that this could also include parts of the patient journey that are not within Urology area of management.

Urology conclusions

The Urology service is in the clinical services plan (CSP) to support the return of pre-COVID activity levels as a minimum, as part of improving access and reducing waiting times for patients. The service operates from the following sites:

- Glangwili Hospital (Carmarthen)
- Bronglais Hospital (Aberystwyth)
- Withybush Hospital (Haverfordwest)
- Prince Philip Hospital (Llanelli)

The Inpatient service at Prince Philip Hospital is temporary and would go back to Glangwili Hospital without a service change to make this permanent.

A summary of the findings identified within this paper are as follows:

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[244] A Specialist and Associate Specialist (SAS) Doctor is a doctor who has the same clinical experience as a consultant but has not completed specialist training.
[245] A Speciality Registrar is a doctor who is working as part of a speciality training programme in the UK.

Service changes

There was one service change that was ratified through Public Board in response to COVID-19.

- Services have been relocated to a local private hospital (Werndale), providing Outpatient and treatment services for their Unscheduled Care (USC) and Urgent patients
- All Outpatient Prostate-specific antigen (PSA) clinics moved to virtual telephone clinics. Patients PSA to be monitored so no build-up of waiting list and rebooked into clinics 3/6 months' time or if there is a problem referred to the consultant
- Intermittent self-catheterisation (ISC) ISC/ISC Clinic - Triaged by telephone first by the CNS Nurse
- USC are triaged, contacted by the consultants and the patients that need to have a face-to-face appointment these are being offered at Werndale
- Where necessary theatre nursing scrub staff are allocated to sessions, equipment has also been transported to support some operating lists.
- Discussions are taking place with regards to further working regionally with Swansea Bay University Health Board (SBUHB) to carry out surgery locally in Glangwili for residents of Hywel Dda
- The TWOC Pathway has moved from responsibility of Community Services to Scheduled Care.

Aside from the ratified changes, there were changes to the surgical rota in response to the COVID-19 pandemic.

- During this period, all elective surgery was cancelled, this included Urology
- Hywel Dda established a Pathway to ensure elective surgery patients were treated in a dedicated ward space separate to patients on an emergency pathway, which is still in place.

Risks

- Ability to manage patients awaiting follow up appointments.

Clinical effectiveness

- Capacity challenges within Radiology services are reducing the number of patients who can have a Multi-parametric MRI in Bronglais Hospital from the required 8 to 4
- Capacity challenges within Radiology services at all sites are stopping Hywel Dda from holding a one-stop haematuria clinic
- There is a lack of capacity and appropriate space within Glangwili Hospital for an outpatient LUTS clinic. A dedicated UIU would go some way to creating the capacity and space for Urology Outpatient activity
- There is a lack of specialist consultants within the Health Board to contribute to a Pelvic Floor Dysfunction MDT and to treat Urinary incontinence in neurological disease patients.

Local, regional and national work

Hywel Dda University Health Board Urology service started their Getting It Right First Time (GIRFT) review in November 2023. The report including recommendations is due early 2024.

Service activity data

- The number of Outpatient interactions has increased closer to pre- covid levels since 2022
- This shows that although the number of new referrals has met and passed pre COVID levels, the amount of Outpatient activity has not yet caught up. Each site apart from Glangwili has seen the number of interactions fall

- The number of new referrals is close to pre- COVID levels; however, the Inpatient and Day Case activity levels remain below pre pandemic levels
- Anecdotally, the service has noticed since COVID-19, patients are presenting later with worse symptoms than they did before 2020. As a result, conditions are more challenging to treat.

Incidents, complaints, and claims:

As incidents and complaints also occur in areas outside of Urology's management e.g., wards, it is not possible to compare activity carried out at each site and the level of incidents and complaints recorded.

Themes arising from the claims related to a delay in diagnosis or treatment, although the number of overall claims is small.

Patient experience and compliments data

Themes are not attributed to a specific site but are general to the whole service:

- Staff are frequently described as professional, friendly, helpful, and efficient
- Concern regarding perceived lack of staffing
- Patients are unhappy at the delays in waiting for appointments, in particular follow up appointments
- There are concerns about lack of communication between the service and patients. This includes errors when making appointments and scheduling issues.

Targeted early engagement with service users

- Key positive themes emerging from patients were around the professional, kind, reassuring, and helpful staff; the efficiency and speed of the service received (including being seen on time and prompt results and diagnosis); and the good communication and clarity of information before, during and after the procedure, and on follow up
- Others, though, said that they received a slow and/or inefficient service (regarding access to appointments and speed of results and diagnosis)
- Main improvements highlighted were around speed and efficiency (including providing better access to appointments and shortening waiting times for results and diagnosis); and communication (including better explanations, and increased frequency of contact and follow up).

Targeted early engagement with staff

- Staff respondents particularly noted the supportive, cohesive, welcoming, and dedicated nature of the team; and the encouragement and support from management when receiving new suggestions for innovative and modern ways of working
- There is a lack of a dedicated Urology ward and clinical rooms. This has led to a de-skilled workforce and some patients recovering on a ward and being care for by general ward staff, rather than specialist Urology staff
- The lack of theatre capacity is causing unmanageable waiting lists
- There is an increase in patient travel as the service is spread over a wide area
- A suggestion has been to move responsibility of TWOC back with community healthcare staff to free up specialist nurses

Finance

- The Urology Service is experiencing financial pressures due to locum consultants beyond the funded staff establishment and reliance on ADH (Additional Duty Hours) capacity. This has led to a forecasted annual overspend of approximately £0.564m within Urology, with variable pay contributing £0.258m at the end of Q3 (this accounting period is October to December 2023).

Workforce

- The staff in Urology are mainly based in Glangwili Hospital but deliver services across several sites. Additional travel between sites reduces activity which can be provided.
- The Urology service has not had an issue with recruitment. As of January 2024, the service is at establishment
- Overall activity has increased from August 2018 to July 2023. Overall Outpatient activity (including referrals and interactions) has increased from 22,582 to 29,731, an increase of 31%. New referrals (both Outpatient and Inpatient) have increased slightly from 14,032 to 14,579, an increase of 3.8%
- Staffing level budgets have not matched this increase in demand
- Perceived lack of staffing has also been noted within the Patient Experience information, where a perceived lack of staffing is noted as a key theme on multiple occasions.

Section 14: Next steps

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Section 14: Next steps

This section outlines the suggested next steps that are planned for the nine service areas. Any changes to the suggested next steps will be managed and recorded in the Clinical Services Plan Steering Group decision log.

1. Deliberative session (9 April 2024)

A deliberative event[246] is planned for early April 2024 with a mixed group of stakeholders. This session will enable participants to discuss the findings of the Issues Paper.

The scope of the deliberative session is to:

- Review the Issues Paper for key points
- Sense check the hurdle criteria[247] (set by the Clinical Services Plan Steering Group ahead of the session)
- Scope out any high level ideas e.g., what the services could look like in the future.

Attendees

Attendees at the deliberative session include the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services
- Patient/carer representatives
- Llais.

Method

The deliberative session will follow the format of:

- Presentation of the Issues Papers
- Exploration of key points
- Check and challenge of hurdle criteria (set by the Clinical Services Plan Steering Group ahead of the session)
- Scoping of potential ideas.

2. Developing potential options for the future of the nine clinical service areas

The next step after the deliberative session will be two consecutive full-day and in person workshops to be held on 25 and 26 April 2024.

Scope

The scope of these workshops will include:

- Review findings from deliberative session
- Using the hurdle criteria to develop a set of potential solutions or models of care for the nine Clinical Service areas.

[246] *discussion and consideration by a defined group of people in a meeting/ workshop*
[247] *Hurdle criteria are the minimum levels that must be met by the proposed options.*

Attendees

Attendees at the two workshop sessions include the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services
- Llais.

3. Check and challenge workshop

This virtual workshop will be held on 17 May 2024 and will be a means of checking and questioning what the workshops have proposed.

Scope

The scope of the check and challenge workshop includes:

- Exploring potential options with wider stakeholders
- Developing of desirable criteria
- Agreeing scoring methodology for short list.

Attendees

Attendees at the check and challenge workshop session includes the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services
- Patient/carer representatives
- Llais.

4. Long list[248] options development for the future of the nine clinical service areas

After the check and challenge workshop, two consecutive full-day and in person workshops to develop the long list of options will be held on 23 and 24 May 2024.

From the information gathered up to this point, the clinical and operational teams will refine the set of potential solutions/models of care for the nine clinical service areas. Using clinical and stakeholder feedback, the long list can be refined to solutions that are viable and likely to address the current identified challenges.

Scope

The scope of the long list options development workshop includes:

- Using the hurdle criteria to refine the set of potential solutions / models of care for the nine Clinical service areas
- Developing long list scoring options against hurdle criteria.

Attendees

Attendees at the long list options development workshop session includes the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services

[248] *A long list of options that have not had hurdle criteria applied*

- Llais.

5. Short list of options development

The short list of options development workshops will be a full day in person workshop held on 13 June 2024 followed by a half day virtual workshop on 28 June 2024.

Using a co-design approach[249] the participants will apply the desirable criteria that was established during the check and challenge workshop (step 3) to each of the options presented (that following hurdle criteria assessment). The approach will need to be supported by data presentation and impacts/ SWOT[250] analysis.

Scope

The scope of the short list options development workshop includes:

- Development of options with clinical operational and identified interdependent staff
- Develop SWOT analysis for the options.

Attendees

Attendees at the short list options development workshop session includes the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services
- Llais.

6. Short list scoring

The short list scoring workshop will be held online on 9 July 2024.

Scope

The scope of the short list scoring workshop includes:

- Underpinned by data presentation and impacts / SWOT analysis
- Scope options.

Attendees

Attendees at the short list scoring workshop session includes the stakeholders that have been identified during the stakeholder mapping exercise:

- Clinical leads from the nine service areas
- Leads from related/interdependent services
- Patient/carer representatives
- Llais.

7. Continuous engagement

In addition to the steps included above, a Communication and Engagement Plan has been developed to support the delivery of the Clinical Services Plan. This includes information about our

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[249] In co-design, people with the relevant skills and experience come together to create a product or a new service.
[250] SWOT analysis is a tool for identifying and analysing an issue or project's Strengths, Weaknesses, Opportunities and Threats.

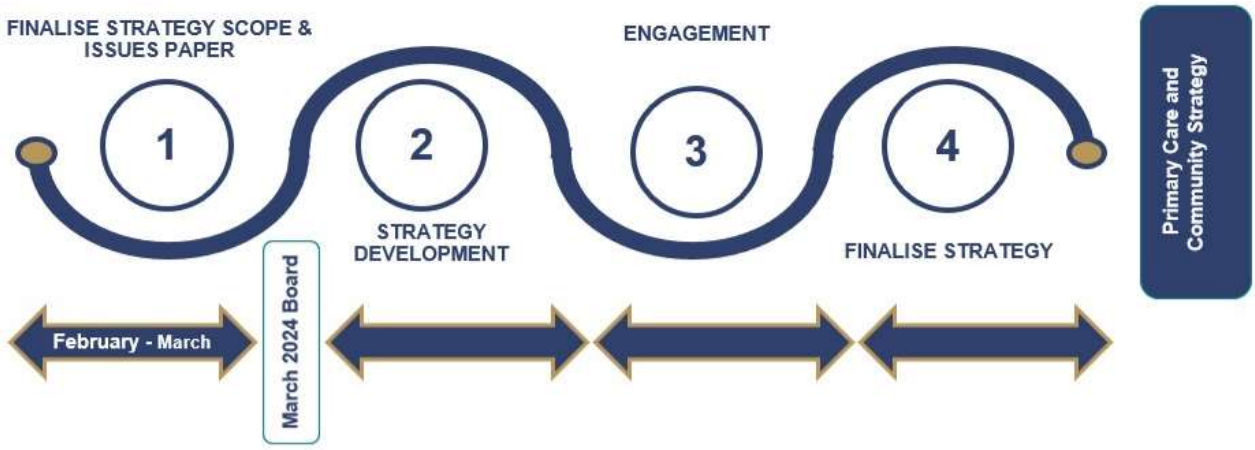
continuous engagement approach, which will support the process and provide regular updates on progress. It will also share information about additional opportunities for members of our population can receive information about the Clinical Services Plan and how they can share their views at different stages of the process.

8. Programme timeline

It is anticipated that a short list of options for how the Clinical Services Plan programme could be delivered will be submitted to Board for decision in September 2024.

Next Steps – Primary Care

Whilst Primary Care has been included as part of the Clinical Services Plan process, Phase 2 will differ to the other services. This will include the development and creation of a Primary Care and Community Strategy for Hywel Dda following the steps illustrated below:



Primary Care and Community strategy working group (Date to be confirmed – April 2024)

A working group attended by key colleagues from across Primary Care, Community and partnership organisations, will be planned for early April 2024. This session will enable participants to discuss the findings of the Issues Paper and agree the necessary steps for creating the strategy.

The scope of the working group is to:

- Review the Issues Paper for key points
- Revisit the strategy project scope and agreement of key strategic priorities
- Consider roles and responsibilities of working group and subgroups required to support each stage of the strategy development
- Propose stakeholder engagement plan and agree what we need to engage on. I.e. what does the future model look like for Primary Care and Community?

Developing potential options for the future of the Primary Care and Community strategy, specific task will include:

- Review and analysis of stakeholder engagement activity
- Development of EqIA
- Map and Gap – review of data gathered for Primary Care and Community, develop options for a future model
- SWOT analysis.

Section 15: Appendix

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Section 15: Appendix

The documents below are available from the Health Board Website.

Document
A1 - CSP - Project Initiation Documents (x9)
A2 - CSP - Early Engagement Report
A2.1- CSP - Patient Survey Questions
A2.2 - CSP - Staff Survey Questions
A4 - CSP - Corporate Risks
A5 - CSP - Clinical Effectiveness Guidelines
A12 - CSP - Finance
B2 - Primary Care and Community - Feedback Report - Building a healthier future after COVID-19
B4 - Primary Care and Community - Corporate Risks
B6 - Primary Care and Community - Local and streams - Regional Population Plans
B7 - Primary Care and Community - National Workstreams - All Wales Strategic Direction
B8 - Primary Care and Community - Activity Data
B9 - Primary Care and Community - Incidents data
B11 - Primary Care and Community - Patient Experience and Compliments Data
B13.1 - Primary Care and Community - Workforce Data - Managed Practices
B13.2 - Primary Care and Community - Workforce Data - OOH
B13.3 - Primary Care and Community - Workforce Data - OOH and APP Unallocated Shifts report
B15 - Primary Care and Community - Health and Social Care Regional Integration Fund
B16.1 - Primary Care and Community - Cluster Profile - 2Ts 23-24
B16.2 - Primary Care and Community - Cluster Profile - Amman Gwendraeth 23-24
B16.3 - Primary Care and Community -Cluster Profile - North Ceredigion 23-24
B16.4 - Primary Care and Community - Cluster Profile - South Ceredigion 23-24
B16.5 - Primary Care and Community - Cluster Profile - Llanelli 23-24
B16.6 - Primary Care and Community - Cluster Profile - North Pembrokeshire 23-24
B16.7 - Primary Care and Community - Cluster Profile - South Pembrokeshire 23-24
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