Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Minor Injury Unit (MIU), Neath Port Talbot Hospital, Swansea University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Minor Injury Unit (MIU) at Neath Port Talbot Hospital, Swansea Bay University Health Board on 20 and 21 May 2025.

Our team, for the inspection comprised of two HIW Senior Healthcare Inspectors, two clinical peer reviewers and a patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 15 questionnaires were completed by patients or their carers and 14 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The inspection found that patients at the Minor Injury Unit received kind, respectful, and dignified care, evidenced by both direct observations and positive feedback from patients. Patients and carers provided positive feedback via questionnaires, with high ratings for the overall service and standard of care. However, the limited waiting room capacity was highlighted as a concern, although, privacy measures were in place and successfully maintained, despite the small waiting area.

Patients received personalised care and were involved in treatment decisions. The presence of a multidisciplinary team, including physiotherapists, was noted as a positive aspect. The MIU operated daily from 8am to 9pm daily. Timeliness of care was mostly good, with many patients seen within four hours, though increasing patient numbers and staffing shortages were causing delays.

Bilingual (Welsh and English) information was well-promoted, and translation services were accessible. However, incorrect road signage indicating emergency services were provided at the hospital could lead to confusion and inappropriate patient attendance. In addition, communication challenges were noted, particularly around public understanding of the MIU's scope.

Patients at the MIU sometimes lacked access to services that would be available at Morriston Hospital, such as certain pain relief procedures for hip fractures and older persons' assessments. The health board was advised to improve communication to ensure that patients are empowered and informed to choose the right clinical environment for their needs.

Overall, while the MIU provided compassionate and effective care, improvements in communication, infrastructure, and equitable access were recommended to enhance patient experience and safety.

This is what we recommend the service can improve:

- Review the waiting area
- Develop and refine options for timely transfer of patients
- Liaise with other authorities to improve signage to the unit
- Develop and implement a communication plan
- Review access to services to ensure equitable care.

This is what the service did well:

- Treating people quickly
- High levels of patient satisfaction
- Emergency care
- Kindness and compassion.

Delivery of Safe and Effective Care

Overall summary:
The unit had appropriate systems for recording and managing incidents, and staff felt comfortable raising concerns. Compliance with infection prevention and control procedures was commendable, and the environment was maintained to a high standard of cleanliness and organisation. Safeguarding procedures for children and adults are clearly defined, and staff were well-trained in these areas. However, there is a need to enhance oversight in the paediatric waiting area and improve security measures in response to an increase in violence against staff.

Medical devices and equipment were generally in good working order, though improvements were warranted in the management of sterile materials and the removal of outdated items. Medication management systems were effective, and provisions for nutrition and hydration for patients were adequate.

The unit faced challenges due to increasing patient numbers, complexity of cases, and staff vacancies. Collectively, this affected patient flow and timely care, which was impacted further by delays in ambulance transfers to other clinical environments, such as Morriston Hospital. The health board must improve transfer processes and ensure timely access to appropriate care settings.

Patient records were generally well-maintained, although some inconsistencies needed to be addressed. Staff had established effective working relationships for patient care referrals, including collaborative interactions with hospital-based mental health staff to assist patients experiencing mental health crises. However, concerns had been raised regarding the limited number of paediatric nurses and the need for enhanced medical support for paediatric patients.

Overall, while the unit demonstrated good clinical standards, improvements in staffing, transfer protocols, and equitable service access were necessary to maintain safe and effective care under increasing demand.

This is what we recommend the service can improve:

- Review, update and mitigate the risks on the risk register
- Consider improvements to the Paediatric waiting area
- Review and improve arrangements for security

- Implement a robust system for the management of sterile materials.

This is what the service did well:

- Clean, tidy and well organised unit with good Infection prevention and control
- Medication management
- Effective communication
- Incident reporting.

Quality of Management and Leadership

Overall summary:
The inspection found strong and committed leadership at the Minor Injury Unit. Staff expressed high satisfaction with the care they provide and praised the supportive team environment. Unit managers were described as visible and approachable. A new leadership structure was in place as were governance systems, including a live dashboard for monitoring attendances and trends.

Despite positive staff feedback and their high level of satisfaction regarding the quality of care, concerns were raised pertaining to the department's size, the necessity for enhanced public communication, and the visibility of senior management.

The MIU had a skilled and dedicated workforce with high compliance in mandatory training. However, concerns were noted regarding the lack of time allocated for professional development, staff vacancies, and the increasing complexity of patient cases.

Overall, there were good partnership efforts, such as collaboration with local services and the Out of Hours GP service. It is acknowledged that some improvements required higher-level discussions and agreements with the wider health board and external stakeholders. While the MIU benefits from a skilled and dedicated workforce, improvements in strategic planning, communication, and workforce development are essential to sustain high-quality leadership and ensure safe, effective care under increasing pressure.

This is what we recommend the service can improve:

- Update Service Level Agreements
- Improve visibility of senior leadership
- Consider and act on staff feedback
- Review and improve availability of clinical development time
- Full workforce review.

This is what the service did well:

- Multidisciplinary team working
- Strong unit leadership
- Data Dashboard.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection, we saw staff were kind and welcoming to patients and treating them with courtesy and respect. All patients we spoke with during the inspection provided positive comments about their care.

We issued paper and online questionnaires to obtain views and feedback from patients and carers. We received 14 responses which were generally positive across all areas, most respondents rated the service as 'very good' or 'good', with the standard of care also scoring well. Reflecting responses to our staff survey, the size of the waiting room was noted as being problematic in dealing with the volume of patients using the department.

Comments we received about the service are shown below:

> ***"We've been to this minor's unit many times as prefer to use it instead of our local A&E. Staff are friendly and helpful and have always given appropriate care to my children"***
>
> ***"Fantastic service, very efficient…"***

Person-centred

Health promotion
Evidence of health promotion and support information was available to patients in the unit. This included "The Minor Injuries Unit Patient Information Hub" board where English and Welsh downloadable information was available via QR code. This included a wide range of information about the department, injuries, pain relief, and more. Additional information leaflets and posters were also available, including alcohol reduction and advice on domestic abuse.

Dignified and respectful care
We found that staff treated patients with kindness, dignity and respect throughout the inspection, and there were suitable arrangements in place to promote privacy. All respondents who answered the relevant question in our patient questionnaire said:

- Staff treated them with dignity and respect

- Measures were taken to protect their privacy
- They were able to speak to staff about their procedure without being overheard by other patients
- Staff listened to them.

We witnessed many examples of kind and courteous care being delivered by staff to patients in a very busy environment that mostly protected patient dignity. The main waiting area, however, was cramped, small and on several occasions throughout the inspection there were no seats available in the waiting room for patients / carers to comfortably wait. Staff confirmed that they employed a system of virtual triage, car waiting, and the use of other areas of the department to keep patients safe on occasions when the waiting area was full.

The health board must review the MIU waiting areas and ensure suitable seating alternatives are implemented, both in the short and longer-term.

Individualised care
We found that staff provided individualised care to patients, and this helped promote patient independence through the provision of appropriate clinical advice to return home with.

All respondents to our questionnaire felt they were involved as much as they wanted to be in decisions about their treatment and that staff explained what they were doing. Everyone we spoke with were also complimentary about their care.

We noted that patients with conditions affecting cognition, such as dementia, were identified on a patient board. Staff were aware and conscious of meeting the needs of these patients as far as possible.

We noted that care was provided by a multidisciplinary team, which included physiotherapists who delivered treatment and advice to patients with muscular injuries when appropriate. **We viewed the addition of physiotherapists in the MIU as notable practice.** We saw that walking aids and crutches were available for patients and stored appropriately when not in use.

Timely

Timely care
The MIU was open 8am until 9pm seven days a week, and the opening hours were listed on the health board website. We found that patients attending the unit were usually seen and treated in a timely manner.

Most respondents to our survey confirmed that they were assessed within 30 minutes of arrival and waited less than four hours in total before receiving treatment. We received some comments about waiting times, which included:

> ***"My mother is 83 and has been waiting over 2 hours. Triaged quickly but the number of patients attending is too high for the size of unit"***

We reviewed evidence that confirmed most patients attending the unit were seen within the four-hour target, however, trends from data dashboard that monitored a range of variables indicated that meeting the target is deteriorating. Staff told us that the unit had been under pressure due to an increasing number of patients attending, more complex or higher acuity patients and fewer staff available to manage patients, in comparison to 2024.

The attendance data we reviewed between 01 January and 20 May 2025, highlighted that an additional 1500 patients were treated at the unit compared to the same period in 2024, but with fewer staff. In addition, the health board's patient feedback data we reviewed, also highlighted a more negative experience for people than the previous year, and a common negative theme within the feedback was patient waiting times.

We reviewed data that highlighting attendances of more complex or higher acuity patients, who had self-presented at the unit in error, believing emergency or more acute care was available at the hospital. Staff confirmed that, when possible, they provided the appropriate emergency care required with the available resources, before contacting the Welsh Ambulance Service to transfer urgently to an acute hospital site to receive ongoing appropriate care in the most appropriate environment, such as Morriston Hospital.

Staff told us they were concerned with the increasing volume of complex or high acuity patients, and that it was difficult at times to provide the levels of care some patients need in a timely manner, given it is a MIU and not an Emergency Department.

Senior staff also expressed their concerns with that on occasions; patients are subject to delayed transfers to other more appropriate hospitals due to the demand on the Welsh Ambulance Service and the prolonged waiting times. They explained that discussions were taking place to ensure timely transfers can be achieved to maintain patient safety. Particularly when the unit should close daily at 21.00, yet some patients are still waiting transfers at this time. To mitigate this, where necessary, patients are moved to an inpatient ward overnight, whilst awaiting transfer to the appropriate acute hospital.

The health board must review the data highlighting the attendance of higher acuity patients, and the delays in transfer of care to other hospitals. This should be used to ensure the unit is appropriately staffed, patients are appropriately managed in line with their needs, and the arrangement for transferring patients is completed in a timely manner.

Equitable

Communication and language

We observed staff discretion when conversing with patients, and patients felt staff provided explanations about their care and treatment and were well informed about their next steps of care.

The Welsh language was well promoted within the unit. We saw bilingual posters in Welsh and English with information clearly displayed. We saw clear bilingual signage in place to direct visitors to the department. Some staff members told us that they were Welsh speakers, and these were identified by the 'Iaith Gwaith' logo embroidered on their uniforms.

Staff we spoke with described some of the arrangements in place to help people with hearing difficulties and those whose first language was not English. We saw that there was a picture board available for patients to communicate to staff, if needed. All staff that we spoke with were aware of how to access translation services, if needed to support clients using the service.

The NHS Wales 'Putting Things Right' process was displayed in both Welsh and English within patient areas, and there was a bilingual poster displayed, requesting patient feedback about the department. Staff we spoke with were able to confirm how they would deal with feedback, both positive and negative.

We saw that the wider local highway traffic signs were incorrectly informing the public that the hospital provided accident and emergency care (a red sign with a white 'H'). The UK Highway Code states that red signs with a white "H" indicate hospitals with accident and emergency departments or urgent treatment centres, blue signs indicate hospitals without accident and emergency facilities.
The only blue hospital sign we saw, was at the entrance to the hospital car park, meaning the public, particularly those who are not local to the area, would not be aware the hospital did not provide emergency services until they arrive.

Senior staff explained that funding had been made available to change the traffic signs in the locality, and the relevant authorities had been contacted to complete this. However, at the time of inspection, this had not been completed. This may

be contributing the high number of people self-presenting at the unit incorrectly, assuming they would receive treatment for more complex care or for those of higher acuity.

The health board must prioritise communication with the local highway authority to address the urgency of need to replace all red hospital traffic signs in the locality, to blue hospital signs, in the interest of public safety.

Neath Port Talbot Hospital has undergone changes over the years. In 2012 the hospital was closed to emergency medical admissions. its role has shifted to focus on minor injuries and planned treatments only, with full emergency care being centralised at Morriston hospital. We were told that the main platform for messaging the community to increase awareness around what issues can and cannot be treated at the MIU were the health board website and social media. However, no physical leaflets had been shared with the community to communicate changes to the status of the A and E at Neath Port Talbot. This therefore may impact on people without digital access.

We saw some evidence of insufficient communication, thus poor community awareness, of what treatment is and is not available within this MIU. Examples included:

- A record of multiple patients with complex healthcare needs attending the MIU
- Incorrect road signage (indicating A and E) directing patients to the department
- Repeated messaging from the health board advising the community to only attend Accident and Emergency (A and E) at Morriston hospital if necessary

The communication issues were highlighted in the survey feedback from staff. Staff comments included:

> ***"Our area needs additional support from the trust to help staff create a safe environment to care for the patients who access our service. Furthermore, communication is lacking not only for patients but other healthcare providers who constant redirect patients to the MIU where it is often a dangerous decision and an inappropriate area to meet their health needs."***

> ***"Need to reduce risk of major patients / unwell / sick patients attending a minor injury unit. Due to long ambulance delays and unit not staffed with doctors there is a safety risk for unwell patients and delays in their treatment."***

Evidence was reviewed that detailed the range and frequency of patients with complex emergency and medical treatment that have attended the MIU. Whilst these patient conditions were outside of the scope of conditions that are listed in the current Scope of Practice document, patients were treated as emergencies when their conditions warranted and were referred quickly for transfer to more appropriate settings. The reasons for these patients attending MIU may be complex and may include communication issues. The health board must therefore address this issue as a matter of urgency, to ensure that patients receive the right care, in the right place, at the right time. Inappropriate attendance at the MIU was listed on the unit Risk Register.

The health board must develop and implement a full communication plan for the MIU. This must

- **Clearly identify and communicate which types of patients are appropriate for Minor Injuries Unit (MIU) care**
- **Review effectiveness of communication around services available at the MIU**
- **Improve communication with communities to ensure that they are fully informed and aware of the services**
- **Ensure that those attending have made the right and safe choice to receive MIU care and treatment in the right place, at the right time, and are treated and cared for by appropriate clinicians.**

Rights and Equality
We found patient rights were protected and promoted in the unit. Staff explained the arrangements in place to make the service accessible to all. The unit was accessible with wide doors, clear corridors and spacious rooms.

We were told that equality and diversity training for all staff was mandatory, and we saw training records that indicated a high level of compliance. All staff we spoke with confirmed they had completed this training online. Staff had a good awareness of their responsibilities in protecting and promoting patient rights when attending the department. They were able to confirm the arrangements in place to promote equality and diversity in the organisation.

We were told that support services were available within the health board to support the needs of those attending the MIU. These included old persons assessment services and radiology services. Some inconsistencies in access to those services were described for those patients attending MIU rather than attending the Emergency Department in Morriston. These inconsistencies included a lack of onsite older persons falls assessment at the MIU (only available through Morriston

hospital), as well decreased availability of radiology booking services in MIU compared to main A and E in Morriston.

We observed additional instances where patients attending the MIU in Neath Port Talbot did not receive the same standard of care as those attending Morriston Hospital. This included cases where patients with a fractured hip were seen at the MIU and had to wait for transfer to an Emergency Department. These patients were not able to receive best practice pain relief, such as a Fascia Iliac Compartment (FIC) nerve block to manage pain and increase chances of recovery, whilst waiting for a transfer. This was due to the lack of emergency doctor availability to deliver the block. The impact for these patients included increased pain, not receiving best practice, delays in appropriate care.

The health board must review and improve access to services to ensure that those patients advised to attend the MIU in Neath Port Talbot receive equitable and timely care to those attending main Emergency Departments when presenting with appropriate conditions. Consideration should be made to which patient groups are advised to attend Neath Port Talbot MIU.

Delivery of Safe and Effective Care

Safe

Risk management
Appropriate systems were in place for the logging and managing of incidents. These were logged and managed on Datix, and summaries of incidents were reviewed during the inspection. Most staff agreed that those involved in incidents were treated fairly. Evidence reviewed confirmed that themes were monitored and reported to senior management through governance reporting, and learning from incidents was swiftly implemented through learning, newsletters and team meetings.

Staff told us that they are comfortable to highlight any issues of concern to leaders within the unit and they were escalated appropriately. Staff members that we spoke with said they were unhappy with delays in changing the hospital road signs to indicate that minor injury status of the unit. This is highlighted within the Communication section of this report.

We reviewed the departmental Risk Register and noted that many areas for improvement mentioned throughout this report are recorded on this Risk Register.

The health board should maintain an ongoing review of the risks recorded in the register, considering staff feedback and the insights presented in this report, and ensure the implementation of appropriate and timely action plans to mitigate these risks.

Infection, prevention and control and decontamination
We found good compliance with infection prevention and control (IPC) procedures. The environment was clean, clear, well organised and uncluttered. A policy for IPC was in place and we were told that a cleaner was allocated to the unit daily.
We reviewed the completed cleaning schedules, and staff reported that the unit is cleaned and reorganised at the end of each day to prepare it for the following day.

Patient responses to the survey all rated the unit as either clean or very clean and agreed that appropriate IPC measures were in place.

There was a clean procedures room specific for wound management. This was well equipped with dressings. There were single rooms in unit that were available to isolate patients as needed.

Staff were well presented in clean uniforms, were bare below the elbow and were observed adhering to good hand hygiene principles in between tasks.

We reviewed examples of audit activity, such as hand hygiene audits, which were positively scored.

Safeguarding of children and adults
There were clear health board policies and procedures in place for staff to follow in the event of a safeguarding concern. Staff we spoke to were aware of the process for reporting safeguarding concerns and feel comfortable doing so.

We confirmed that relevant checklists are completed by nursing staff for all patients at risk of abuse.

There was a separate paediatric waiting area to segregate children away from adults, however, it had limited oversight from staff.

The health board must risk assess the paediatric waiting area and appropriately mitigate risks related to poor staff oversight.

We found good compliance with safeguarding and associated mandatory training amongst clinical staff.

Senior staff reported a recent rise in violence and abuse towards personnel. With no on-site security team, staff indicated they could not "lock down" the unit during emergencies and would depend on police assistance. The updated Risk Register reflected these concerns, noting increased risk scores as of January 2025.

The health board must evaluate and enhance security measures within the MIU to ensure the safety of both staff and patients, considering the rising frequency of violent and threatening incidents directed at staff.

Management of medical devices and equipment
We found general medical devices and equipment to be in date and in working order. Staff were clear on how to report faulty or absent equipment.

There were two emergency resuscitation trolleys available, which were sealed with red tag in line with health board policy. Staff were responsible for checking the trolleys, which they did monthly on the first day of each month. They also record this on a paper chart daily, to confirm that the trolley is sealed with a red tag. We noted that all items in the adult trolley were in date. However, one item; an airway, was passed its expiry date on the paediatric resuscitation trolley. This was addressed and resolved during the inspection. During the inspection, we

observed that a Magill forceps manufactured in 1994, with a ten-year shelf life, were still in use despite being out of date. This issue was identified and resolved during the inspection.

The health board must develop, implement and maintain a robust system for the management of sterile materials, to ensure expired stock is removed from use and replaced appropriately.

Fridge temperatures were monitored daily, and evidence indicated that an appropriate system was in place for this.

A Ligature Risk Assessment was in place and was dated 2023. However, during the inspection, staff were unable to confirm the location of the ligature cutters. This issue was resolved during the visit, and a photo of the cutters was added to a poster to clearly show staff where they are stored if needed during an emergency.

Medicines management
We found effective systems and processes in place for medicines management. We reviewed appropriate storage, stock control, assessment, prescribing, and administration.

The policy for supply and administration of medicines using patient group directions was reviewed and in date.

We reviewed aspects of controlled drugs security and found that controlled drugs were securely stored, administered and recorded appropriately. This was supported by a recent controlled drug audit that was completed with 100% compliance.

We noted a recent example of noteworthy practice where a patient awaiting ambulance transfer to Morriston required time-critical medication to manage symptoms of a long-term condition. A nurse practitioner promptly obtained and administered the medication in a timely manner.

Preventing pressure and tissue damage
Staff confirmed that pressure relieving mattresses are available for those at risk of acquiring skin pressure damage.

Falls prevention
Falls risk assessments are carried out upon a patient's arrival, and referrals to the falls team are made when necessary.

Effective

Effective care

We found that patients in the unit were appropriately assessed and monitored. This included the use of an automated system that flagged the sepsis pathway when appropriate. Staff demonstrated a good awareness of the management and escalation of sepsis, which included completion of a sepsis screening tool and appropriate escalation of clinical concerns.

Staff highlighted their concerns to us about delayed ambulance transfers for patients who are not critically ill but need to be moved to a different clinical setting to appropriately manage their needs. These patients often require continued medical monitoring within the unit while awaiting transfer, and staff highlighted that these delays impact the flow of patients through the unit and thus impacting timely care for patients. This includes those awaiting transfer to a more acute setting, such as Morriston, therefore increasing the risk of harm without out receiving the appropriate care by the most appropriate teams.

The health board must ensure safe and prompt patient transfers to suitable settings and implement mitigations to manage their safety whilst they are waiting.

Nutrition and hydration

We found that there were provisions for patients to purchase food and drink from shops located within the hospital, and water was readily available for patients to access in the MIU waiting areas.

Patient records

Overall, we found that nursing and medical records were completed to a good standard. Though there were some inconsistencies noted in the detail on patient notes.

The health board must consider completing regular audits of MIU records to establish and address any inconsistency in documentation.

Efficient

Efficient

Staff reported that working relationships for patient care referrals were established. They described collaborative interactions with the hospital-based mental health staff to assist patients experiencing mental health crises. Signposting options mentioned included the 111 service, GP Out of Hours, and podiatry.

There were a limited number of paediatric nurses in the unit, although managers confirmed that all staff were conversant with working with children presenting to the MIU. We saw a dedicated paediatric area for assessment and treatment with a designated resus area for children, and staff were trained in paediatric resuscitation.

There was also a dedicated and specific document for recording assessments, care and treatments for children attending the MIU. Some staff highlighted their concerns to us regarding paediatric medical support for unwell children.

The health board must review and consider staff feedback about medical support for paediatric patients, and should include assessing staffing risks, and ensure trained support and advice is available regarding paediatric patients, addressing any gaps in expertise as needed.

Quality of Management and Leadership

Staff feedback

We spoke with staff during inspection and obtained their feedback through online questionnaires, which generated 14 responses. Responses were generally positive, with most saying they were satisfied with the quality of care and support they give to patients, and that they would be happy with the standard of care provided by the hospital for themselves or for friends and family. Many reported they would recommend their organisation as a place to work.

Whilst staff feedback was generally positive, most negative comments related to the size of the department, noting it was too small to deal with the volume of patients, and the need to prioritise communication to the public around what services/ injuries can be safely delivered within the MIU.

Some staff comments included:

> ***"It is an absolutely fantastic place to work with an excellent team and great management. Excellent emphasis on furthering training of staff."***
>
> ***"Need to reduce risk of major patients / unwell / sick patients attending a minor injury unit. Due to long ambulance delays and unit not staffed with doctors there is a safety risk for unwell patients and delays in their treatment."***

Most of those who responded to the survey felt senior managers were committed to patient care, however, fewer felt senior managers were visible.

Leadership

Governance and leadership
We found strong leadership within the MIU, and it was evident that staff were committed to providing a good experience for patients.

Clear lines of reporting and accountability were described and demonstrated, and suitable governance systems were in place.

A relatively new senior leadership structure was in place, and many staff said they had welcomed the changes.

Unit managers where available and based within the unit, staff told us that they were visible, approachable and could be relied upon to support them with their work.

We reviewed the live Dashboard which can be used to identify themes and trends for the unit. **This was seen as notable practice**. The information available through this Dashboard should be used to actively plan for patient attendances, unit capacity and patient experience.

The health board should use dashboard data and trends for effective capacity planning and patient experience tracking in service development.

We reviewed some Service Level Agreements (SLA) that were in place with other localities, for patients who are treated within the MIU, but are classed as "out of area". The SLAs need reviewing and updating to ensure they are current, and that the needs of all patients are met appropriately, and effective communication is maintained with the healthcare provider for their usual place of residence.

The health board must review and update the Service Level Agreements to ensure they are current and effectively address the needs of all patients while maintaining clear communication with the healthcare provider for the patients' usual place of residence.

Some staff told us those senior managers (outside of the MIU) were not visible, and they did not always feel supported by them. Some shared examples of ongoing issues, and they did not always feel listened to, and their concerns were not always addressed in a timely manner.

The health board must review the staff feedback regarding senior managers and ensure a secure platform is provided to listen to staff and take action to address concerns where appropriate.

Workforce

Skilled and enabled workforce

We found a committed and skilled workforce amongst all disciplines in the MIU. Staff we spoke with were knowledgeable of their roles and responsibilities and how this relates to providing quality patient care for minor injury patients. We saw a range of positive and effective communications in place, both formal and informal, which ensured that patients were prioritised in line with their presenting condition, to ensure appropriate and timely care.

Most respondents to the staff survey confirmed they had received appropriate training to undertake their roles. Although some felt it was not always possible to achieve timely professional development, due to the increasing patient demands on the unit. Staff comments included:

> ***"It's so busy since qualifying as an ENP I have not been given any study time to update my skills."***

> ***"The unit is now seeing increased levels of critically ill and critically injured patients. Staff need the same level of training as medical staff at the ED i.e. ALS, APLS, Trauma training."***

We reviewed training data, which indicated a high compliance rate with mandatory training (over 85%), with an appropriate system in place to monitor this. It was positive to note that appraisals were up to date.

Leaders confirmed that clinical development time for staff was not always available to staff outside of mandatory training, due to the clinical demands of the unit. Although, more junior staff reported they had received opportunities to receive formal training to progress in their roles, which was welcomed.

The health board must allocate dedicated time for clinical development beyond mandatory training, to ensure staff can enhance their professional skills despite the unit's high clinical demands.

We reviewed staff rotas, which were flexible, to take account of the fluctuating patterns in patient attendance. Meaning, shifts began at various times throughout the day to meet the predicted demands on the unit. However, we noted several staff vacancies within the nursing establishment. Staff confirmed that they had telephone support from a Consultant or Senior Doctor when needed.

Many staff shared concerns about the increase in patients accessing the unit, the complexity of cases that are attending, the staff vacancies and the impact of this increase in work on the morale of staff. We reviewed the health board departmental risk register which captured the MIU Emergency Nurse Practitioner vacancy/ staffing risk.

The health board must review the staffing establishment to ensure the MIU always has the right number of staff available each shift and with an appropriate staff skill mix.

Culture

People engagement, feedback and learning

Patients were contacted by text to provide feedback on their experience at the Minor Injuries Unit (MIU) using Civica. The results were sent to team leads.

There were opportunities displayed for patients to provide feedback. Posters providing details of how to do this were displayed in the waiting area and main unit.

We noted many compliments had been received by the service. These included comments of gratitude for staff for the care and treatment provided.

Learning, improvement and research

Quality improvement activities

Quality and safety audits were conducted on the unit and yielded detailed findings. Audit results and any incident learnings were communicated at staff meetings and via the unit's governance channels.

Whole-systems approach

Partnership working and development

Staff highlighted many examples of positive partnership working. Senior staff shared an example where a local off-road motorbike training company brought patients with complex and/ or multiple fractures to the MIU for treatment. Once the trend and theme was identified, staff contacted the training company and discussed the risks of attending the MIU with such injuries and informed them of the correct and safest location to direct these patients, such as the Emergency Department in Morriston Hospital. This led to the company amending their operating procedure according to the scope of the MIU.

The Out of Hours GP service is based in the hospital, and staff described the positive and effective partnership working in place that benefited the patients.

We recognise that the front door services face significant pressures from multiple sources. Some improvements are beyond the control of the unit to address and requiring a higher-level discussions and agreement with the wider health board and external stakeholders to ensure timely and appropriate patient care. The health board should continue to provide care in suitable settings and at appropriate times. HIW will monitor the health boards progress on the recommendations made through its ongoing assurance processes.

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to act, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved

Appendix B - Immediate improvement plan

Service: Neath Port Talbot Minor Injury Unit

Date of inspection: 20 and 21 May 2025

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurance issues were identified					

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Neath Port Talbot Minor Injury Unit

Date of inspection: 20 and 21 May 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The main waiting area was cramped, small and often no seats were available.	The health board must review the MIU waiting areas and ensure suitable seating alternatives are implemented, both in the short and longer-term.	Effective	The risk around having inadequate seating and size of the waiting room are on the Health Board Risk Register. As a service we will review the risk and escalate the risk as appropriate.	Directorate Manager & Lead Consultant Nurse	30.09.2025
				The service is planning to develop an appointment system at Morriston Hospital MIU so that	Directorate Manager, Lead Consultant Nurse, Matron for ED, Matron	31.01.2026

				some suitable patients can be transferred to the ED (Morriston Hospital Emergency Department) MIU, therefore reducing the number of patients waiting.	for MIU, Service Manager & Clinical Director	
2.	There was an increasing volume of higher acuity patients presenting at the unit in error.	The health board must review the data highlighting the attendance of higher acuity patients, and the delays in transfer of care to other hospitals. This should be used to ensure the unit is appropriately staffed, patients are appropriately managed in line with their needs, and the arrangement for transferring patients is completed in a timely manner.	Safe	The risk of inappropriate attendances to the unit is highlighted on the risk register. As a service we will review risk and escalate as appropriate. The service will complete a workforce review to ensure appropriate staffing levels and appropriate skill mix available for the	Directorate Manager, Lead Consultant Nurse & Matron Directorate Manager, Lead Consultant Nurse & Matron	30.09.2025 31.01.2026

				duration of the unit's opening times.		
3.	The highways signage to the hospital indicated that Accident and Emergency services were available at the unit.	The health board must prioritise communication with the local highway authority to address the urgency of need to replace all red hospital traffic signs in the locality, to blue hospital signs, in the interest of public safety.	Safe	The health board has been working with the local authority to ensure appropriate signage. This revision of signage from the Red 'H' signage to Blue 'No A&E' has been completed on the local roads however the red H signage indicating an that there is an Accident and Emergency Department on the trunk and motorways remain unchanged. Funding has been secured, timeline of works still to be confirmed. Delivery of this is dependent on the Welsh Government. We will	Directorate Manager / Health Board Capital Planning Team	30.09.2025

				contact the relevant body for an expected date of completion.		
4.	We saw some evidence of insufficient communication, thus poor community awareness, of what treatment is and is not available within this MIU. Examples included: • A record of multiple patients with complex healthcare needs attending the MIU • Incorrect road signage (indicating A and E) directing patients to the department • Repeated messaging from the health	The health board must develop and implement a full communication plan for the MIU. This must Clearly identify and communicate which types of patients are appropriate for Minor Injuries Unit (MIU) care Review effectiveness of communication around services available at the MIU Improve communication with communities to ensure that they are fully informed and aware of the services Ensure that those attending have made the right and safe choice to receive MIU care and treatment in the right place, at the right time, and are treated and cared for by appropriate clinicians.	Safe	A review and significant changes to the digital information regarding the scope of MIU have been completed in recent weeks, including website content and regular social media posts. The assurance monitoring will continue. Consideration is being giving to immediate feedback to people who are inappropriately attending. See action to recommendation 3 in respect of the road signage	Health Board Communications Team MIU Senior Team	Completed (Website review and social media)

	board advising the community to only attend Accident and Emergency (A and E) at Morriston hospital if necessary • The largest population group attending the MIU are over 65 years of age, these may be the least digitally literate population and the most likely population to have experienced a full A and E service at Neath Port Talbot in the past.					

5.	We observed additional instances where patients attending the MIU in Neath Port Talbot did not receive the same standard of care as those attending Morriston Hospital.	The health board must review and improve access to services to ensure that those patients advised to attend the MIU in Neath Port Talbot receive equitable and timely care to those attending main Emergency Departments when presenting with appropriate conditions. Consideration should be made to which patient groups are advised to attend Neath Port Talbot MIU.	Equitable	This issue generally occurs when patients outside of the advertised scope present to the MIU. See action to recommendation 4 in respect of communication regarding the scope of MIU.		Completed (Website review and social media)
				There is a SOP in place for interhospital transfers. Service to review clinical criteria and effectiveness of controls.	Clinical Director, Lead Consultant Nurse, Matron, Directorate Manager	31.01.2026
				As a possible additional measure, the Health Board are currently considering the introduction of an internal emergency	Associate Service Director AECHO	31.01.2026 (Outcome of consideration)

				transfer vehicle for interhospital transfers		
6.	We reviewed the departmental Risk Register and noted that many areas for improvement mentioned throughout this report are recorded on this Risk Register	The health board should maintain an ongoing review of the risks recorded in the register, considering staff feedback and the insights presented in this report, and ensure the implementation of appropriate and timely action plans to mitigate these risks.	Safe	The service will review the risk register and escalate via the governance structure as appropriate.	Directorate Manager, Lead Consultant Nurse & Matron	30.09.2025
7.	There was a separate paediatric waiting area to segregate children away from adults, however, it had limited oversight from staff.	The health board must risk assess the paediatric waiting area and appropriately mitigate risks related to poor staff oversight.	Safe	The service will carry out a risk assessment of this and applying appropriate mitigations	Lead Consultant Nurse & Matron	30.09.2025
8.	Senior staff reported a recent rise in violence and abuse towards personnel. With no on-site security team, staff indicated they could	The health board must evaluate and enhance security measures within the MIU to ensure the safety of both staff and patients, considering the rising frequency of violent	Safe	The service will evaluate level of violence and aggression in the MIU which will include a review of the trend.	Head of Quality & Safety for Morriston Service Group	30.09.2025

	not "lock down" the unit during emergencies and would depend on police assistance.	and threatening incidents directed at staff.		Health Board will review the above and if appropriate develop an improvement plan	Service Group Directors	31.01.2026
9.	During the inspection, we observed that a Magill forceps manufactured in 1994, with a ten-year shelf life, were still in use despite being out of date. This issue was identified and resolved during the inspection.	The health board must develop, implement and maintain a robust system for the management of sterile materials, to ensure expired stock is removed from use and replaced appropriately.	Safe	This issue was resolved by the service during the inspection. The unit has ceased to use any items from CSDU and now use single use products only that have clear expiry dates marked. There is a comprehensive checking system in place (including an expiry date check). All staff have been reminded of the importance of these checks.	Matron	Completed

10.	Some inconsistencies in detail on patient notes were seen	The health board must consider completing regular audits of MIU records to establish and address any inconsistency in documentation.	Effective	The service carries out an audit of all Emergency Nurse Practitioners and Triage nurses' documentation annually. Feedback is given on an individual basis following audits with areas for improvement identified and actions to correct at that time.	Matron	In place
11.	Some staff highlighted their concerns to us regarding paediatric medical support for unwell children.	The health board must review and consider staff feedback about medical support for paediatric patients, and should include assessing staffing risks, and ensure trained support and advice is available regarding paediatric patients, addressing any gaps in expertise as needed.	Safe	There is not consistent paediatric medical cover at Neath Port Talbot Hospital site. A standard operating procedure is being produced to guide staff actions when responding to a paediatric emergency.	Patient Safety Lead – Resuscitation	30.09.2025 31.01.2026

				Current paediatric immediate life support compliance is 49%. The MIU will work to improve this compliance to target level of 85% with the support of Morriston Service Group via workforce planning	Matron & Clinical Nurse Manager	
12.	Staff highlighted their concerns to us about delayed ambulance transfers for patients who are not critically ill but need to be moved to a different clinical setting to appropriately manage their needs.	The health board must ensure safe and prompt patient transfers to suitable settings and implement mitigations to manage their safety whilst they are waiting.	Safe	See action to recommendation 4 in respect of communication regarding the scope of MIU	Health Board Communications Team MIU Senior Team	Completed (Website review and social media)
				See action to recommendation 5 in respect of consideration of transfer arrangements	Clinical Director, Lead Consultant Nurse, Matron, Directorate Manager	31.01.2026
				The workforce at the MIU will be reviewed	Directorate Manager, Lead	31.01.2026

				to ensure that there will be an appropriate level of trained staff to mitigate the risk to patients whilst they are waiting.	Consultant Nurse & Matron	
13.	We reviewed some Service Level Agreements (SLA) that were in place with other localities, for patients who are treated within the MIU, but are classed as “out of area”. These were not always up to date.	The health board must review and update the Service Level Agreements to ensure they are current and effectively address the needs of all patients while maintaining clear communication with the healthcare provider for the patients' usual place of residence.	Efficient	The service will draft a paper to include relevant data regarding out of area attendance. The health board will review and ensure the Service Level Agreement is reviewed, the quarterly LTA meetings with neighbouring Health Boards will also be utilised to reiterate the criteria of patients that can be seen in MIU	Directorate Manager, Lead Consultant Nurse & Matron Health Planning & Partnership Team	30.09.2025 31.01.2026

14.	Some staff told us those senior managers (outside of the MIU) were not visible, and they did not always feel supported by them. Some shared examples of ongoing issues, and they did not always feel listened to, and their concerns were not always addressed in a timely manner.	The health board must review the staff feedback regarding senior managers and ensure a secure platform is provided to listen to staff and take action to address concerns where appropriate.	Effective	Improved onsite visibility and accessibility by the Senior Clinical and Non-Clinical Management Team. Plans to be updated at the next staff meeting	Directorate Manager	30.09.2025
15.	Leaders confirmed that clinical development time for staff was not always available to staff outside of mandatory training, due to the clinical demands of the unit.	The health board must allocate dedicated time for clinical development beyond mandatory training, to ensure staff can enhance their professional skills despite the unit's high clinical demands.	Effective	The service will develop a paper regarding Emergency Nurse Practitioner non-clinical time for consideration by Morriston Service Group	Lead Consultant Nurse	31.08.2025
16.	Many staff shared concerns about the increase in patients accessing the unit, the complexity of cases that are attending, the staff	The health board must review the staffing establishment to ensure the MIU always has the right number of staff available each shift and	Safe	The MIU is currently attempting to recruit into all vacancies and vacancy control forms have been submitted.	Matron & Clinical Nurse Manager.	Complete

	vacancies and the impact of this increase in work on the morale of staff.	with an appropriate staff skill mix.		These are pending approval from the Morriston Service Group, within current health board recruitment guidance. The service will develop a workforce plan and escalate to the health board via the governance structure.	Morriston Service Group & Corporate Vacancy Scrutiny Panel Directorate Manager, Lead Consultant Nurse & Matron	10.08.2025 31.01.2026

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role: