Bundle Quality, Patient Experience and Safety Committee 11 May 2023

Agenda attachments

ITEM 0 Open Quest Agenda -11 May 2023.docx

1 13:30 - OPENING ITEMS

1.1 Welcome, Apologies for Absence, Confirmation of Quorum

Apologies have been received from Lee Brooks (Steve Clinton is Deputising), and Leanne Smith (Deputy TBC).

2 Declarations of Interest

*[Board & Executive Team Register of Interests, 31.03.2023](https://ambulance.nhs.wales/files/publications/annual-reports/2022/board-member-register-of-interests-2023/)
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3 Minutes of Previous Meeting

To receive and approve the minutes from the meeting held on the 09 February 2023.

ITEM 3 Draft Open QUEST Committee Minutes - 9 February 2023.docx

4 Action Log & Matters Arising

4 - Action Log
4.1 - AAA Report from the 09 February 2023 Committee Meeting

ITEM 4 Quest Actions Log.pdf

ITEM 4.1 Quest Committee Highlight Report February 2023.docx

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 13:40 - Operations Directorate Quarterly Report Q4 2022/23

Presented by Steve Clinton.

ITEM 5 Operations Quarterly Report for Committees 22-23 Q4 Final.pdf

6 13:50 - Patient Experience [Video]

Told by Keith Jones, a Community First Responder in North Wales. Presented by Leanne Hawker and Gareth Parry.

7 14:20 - Monthly Integrated Quality Performance Report

Presented by Rachel Marsh.

ITEM 7 MIQPR SBAR QUEST March April 2023.docx

ITEM 7.1 Annex 1 MIQPR QUEST March & April 2023.pdf

8 14:40 - Patient Safety Report Q4 2022/23

Presented by Liam Williams.

ITEM 8 Patient Safety Report Q4 2022-23.docx

9 14:55 - Patient Experience & Community Involvement Q4 2022/23

Presented by Liam Williams.
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9 - PECI Q4 22/23 Report
9.1 - Annex 2 - Patient Reported Experience Measures
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ITEM 9 PECI Report Q4 202-23.docx

ITEM 9.1 Annex 2 PREMs Q4.pptx

10 15:00 - Risk Management and Board Assurance Framework Report

Presented by Trish Mills.
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10 - Risk Management and BAF Report
10.1 - Annex 5 - BAF Guidance

ITEM 10 Risk Management and BAF Report.docx

ITEM 10.1 Annex 5 BAF Guidance April 2023.docx

10.1 15:10 - COMFORT BREAK

11 15:20 - Duty of Quality / Duty of Candour Implementation

Presented by Liam Williams.

ITEM 11 Duty of Quality-Duty of Candour Implementation.docx

12 15:45 - Quality Strategy Implementation

Presented by Liam Williams.
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12 - Quality Strategy Implementation Plan
12.1 - Annex 1 - Quality Strategy Implementation Plan Progress Update

ITEM 12 Quality Strategy Implementation Plan.docx

ITEM 12.1 Annex 1 Quality Strategy Implementation Plan - Progress Update April 2023.pdf

13 16:05 - Quality Impact Assessment Governance

Presented by Liam Williams.

ITEM 13 Quality Impact Assesssment Governance.docx

14 16:20 - Clinical Audit Plan 2023/24

Presented by Andy Swinburn.
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14 - Clinical Audit Plan 2023/24
14.1 - Annex 2 - Draft Clinical Audit Plan 2023/24 Q1

ITEM 14 Clinical Audit Plan 2023-24 SBAR.docx

ITEM 14.1 Annex 2 - DRAFT Clinical Audit Plan 2023 -24 Q1.pdf

15 16:35 - Update on Mortality Reviews

Presented by Liam Williams.
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15 - Update on Mortality Reviews
15.1 - Annex 2 - Mortality Review Framework (Learning from Deaths)

ITEM 15 Update on Mortality Reviews.docx

ITEM 15.1 Annex 2 - Mortality Review Framework (Learning from Deaths).docx

16 16:50 - Committee Cycle of Business & Monitoring Report

Presented by Trish Mills.
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16 - QUEST Cycles of Business 2023/24
16.1 Annex 1 - Cycle of Business 2023/24
16.2 Annex 2 - Cycle of Business Monitoring Report

ITEM 16 Quest Cycles of Business 2023-24.docx

ITEM 16.1 Annex 2 - Quest Committee Cycle of Business 2023-24 - Tab 1.pdf

ITEM 16.1 Annex 2 - Quest Committee Cycle of Business 2023-24 - Tab 2.pdf

ITEM 16.2 Annex 3 - Quest Committee Cycle of Business 2023-24 - Monitoring Report.pdf

17 17:00 - Internal Audit Tracker Update & Internal Audit Reports

Presented by Trish Mills, supported by colleagues from Audit & Assurance Services.
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17 - Internal Audit Tracker Update (related Excel to be shared via email)
*17.1 - Internal Audit Report - Infection Prevention and Control (Liam Williams)
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17.2 - Internal Audit Report - Immediate release Directions (Lee Brooks)
17.3 - Internal Audit Report - Data Analysis

ITEM 17 Quest Audit Tracker.docx

ITEM 17.1 WAST_2223_03_Infection Prevention and Control_Final Internal Audit Report.pdf

ITEM 17.2 WAST_2223-008_Immediate Release Directions_Final Internal Audit Report.pdf

ITEM 17.3 WAST_2223-17_Data Analysis_Final Internal Audit Report.pdf

17.1 17:15 - CLOSING ITEMS

18 Reflections & Summary of Decisions and Actions

19 Key Messages for Board

20 Any Other Business

21 Date and Time of the Next Meeting

10 August 2023 at 09:30

MEETING OF THE OPEN QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

Held on **11 May 2023 from 13:30 – 17:25**

Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	Declarations of Interest	Information	Bethan Evans	Verbal	
3.	Minutes of the Previous Meeting 3.1 09 February 2023	Approval	Bethan Evans	Paper	
4.	Action Log and Matters Arising 4.1 Quest AAA Report from 09 February 2023 Meeting – Alerts Escalation Follow Up	Discussion	Bethan Evans	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Operations Directorate Quarterly Report Q4 2022/23	Discussion	Steve Clinton	Paper	10 Mins
6.	Patient Experience – Told by Keith Jones, a Community First Responder in North Wales	Discussion	Leanne Hawker, Gareth Parry	Video	30 Mins
7.	Monthly Integrated Quality Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
8.	Patient Safety Report Q4 2022/23	Assurance	Liam Williams	Paper	15 Mins
9.	Patient Experience & Community Involvement Quarter 4 Report (January - March 2023)	Assurance	Liam Williams	Paper	05 Mins
10.	Risk Management and Board Assurance Framework Report	Assurance	Trish Mills	Paper	10 Mins

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Welsh Ambulance Services NHS Trust

BREAK – 10 MINUTES					
11.	Duty of Quality and Duty of Candour Implementation	Assurance	Liam Williams	Paper	25 Mins
12.	Quality Strategy Implementation Plan	Assurance	Liam Williams	Paper	20 Mins
13.	Quality Impact Assessment Governance	Assurance	Liam Williams	Paper	15 Mins
14.	Clinical Audit Plan 2023/24	Approval	Andy Swinburn	Paper	15 Mins
15.	Update on Mortality Reviews	Assurance	Liam Williams	Paper	15 Mins
16.	Committee Cycle of Business (CoB) 16.1 CoB 2023/24 16.2 CoB 2023/24 Monitoring Report	Approval	Trish Mills	Paper	10 Mins
17.	Internal Audit Tracker Update and Internal Audits: 17.1 Infection Prevention and Control 17.2 Immediate release Directions 17.3 Data Analysis	Assurance	Trish Mills Osian Lloyd Lisa Harte Liam Williams Steve Clinton -	Paper	15 Mins
CLOSING ITEMS					
18.	Reflections & Summary of Decisions & Actions	Discussion	Bethan Evans	Verbal	10 Mins
19.	Key Messages for Board	Discussion	Bethan Evans	Verbal	
20.	Any Other Business	Discussion	Bethan Evans	Verbal	
21.	Date and Time of Next Meeting: - 10 August 2023 at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

Name	Position
Steve Clinton	Assistant Director of Operations, Integrated Care (Deputising for Lee Brooks, Executive Director of Operations)
Bethan Evans	Non-Executive Director and Committee Chair
Lisa Harte	Audit Manager, Audit and Assurance Services
Leanne Hawker	Head of Patient Experience & Community Involvement
Osian Lloyd	Head of Internal Audit, Audit and Assurance Services
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Gareth Parry	Operations Assistant Community Support
Andy Swinburn	Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 9 FEBRUARY 2023 VIA TEAMS

Meeting commenced at 09:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Professor Kevin Davies	Non-Executive Director
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Lee Brooks	Executive Director of Operations
Andrew Clement	Partners in Healthcare, Resource Development Coordinator
Mark Harris	Assistant Director of Operations (NEPTS) (Attended for Patient Experience Item)
Nikki Harvey	Head of Safeguarding (joined at 11:15)
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Ian James	Trade Union Partner
Alison Kelly	Business and Quality Manager
Dr Brendan Lloyd	Executive Medical Director
Jen Lloyd	Senior Project Manager
Osian Lloyd	Head of Internal Audit
Caroline Miftari	Head of Quality Assurance
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Edward O'Brian	Macmillan Paramedic
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Leanne Smith	Interim Director of Digital Services
Andy Swinburn	Director of Paramedicine
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Julie Boalch	Head of Risk/Deputy Board Secretary
Colin Dennis	Chair of the Board

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Peter Hindley	Community Health Council
Donna Morgan	Internal Audit
Hannah Rowan	Non Executive Director

001/23 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies had been received from Julie Boalch, Colin Dennis, Peter Hindley, Donna Morgan and Hannah Rowan

Minutes

The Minutes of the meeting held on 10 November 2022 were confirmed as correct record.

Action Log

The action log and the AAA report from the last Quest meeting was considered:

Action 16/21: To provide updates on the viability of Community First Responders (CFR) to administer pain relief. An update was provided by Andy Swinburn; the requisition for Penthrox had been submitted, it was agreed that the action was closed.

Action 36/22b: Update on care home focused improvements. Jonathan Turnbull-Ross informed the Committee that a project was emerging which would improve the use of technology and resources in care homes. He added that this work would be aligned in particular to the 'Further Faster' Welsh Government publication which detailed how to work and liaise with the voluntary sector. Liam Williams added that the Trust was working with the Emergency Ambulance Services Committee (EASC), and other stakeholders to highlight the measures, particularly with regards to falls in care homes being taken. It was agreed for the action to be closed.

Action 54/22: To reproduce a report to give front line staff the assurance that the Trust is a learning organisation and to align it to the ongoing all Wales work on preceptorship and clinical supervision. The update provided on the action log was accepted and the action was closed.

Action 55/22: To present the revised quality strategy implementation plan. Item was on the agenda, action closed.

Action 56/22: To clarify with Health Inspectorate Wales at the Board meeting on 24 November, strategic collaboration and the statement on collaborative working. Action has been completed and was agreed for closure.

Action 57/22: In respect of patient experience calling 999, it was agreed that clarity on the N/A ratings would be included within the next report. An update was provided on the action log, action closed.

Action 59/22: The Trust had recorded 11500 patients with an indication of dementia from the ePCR (electronic Patient Care Record) from 1 April to 8 November (EMS only). Work was ongoing to improve this data collection and an update on this work was requested at the next meeting. The Committee recognised this information was not captured on NEPTS vehicles. An update was provided on the action log, action closed.

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The Chair drew the Committee's attention to the contents of the AAA report for their information. In terms of the Audit Wales report, in particular the Structured Assessment and the area around Non- Executive Director (NED) challenge and scrutiny to Executive Directors. Trish Mills advised that the next Audit Committee will discuss the Structured Assessment in more detail adding that all NEDs were welcome to attend if they so wished.

RESOLVED: That

(1) the Minutes of the Open meeting held on 10 November 2022 were confirmed as a correct record; and

(2) consideration was given to the Action Log and AAA report as described above.

002/23 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022 -23 Q3

Lee Brooks introduced the Operations Quarterly Report as read, conscious that some colleagues would have already had sight of it; adding that an update had been provided at the last Trust Board meeting.

This had been a very challenging time exacerbated by worsening handover delays and the impact of Industrial Action (IA). The most challenging days for the Trust recently as a result of IA were last Monday and Tuesday, Unit Hours Production stood at 76% and 80% respectively.

The Committee were advised of the Health Ministers statement which was released yesterday and this indicated that a revised offer was being considered by Trade Unions. The Committee were then provided with dates of upcoming IA by Unite; three days commencing on 20 February and GMB; 20 February, 3, 6 and 20 March.

It was pleasing to note that as discussed earlier as part of the action log, that Penthrox will in the near future, be able to be administered by Community First Responders.

Intelligent Routing Platform (IRP). The IRP is an NHS England procured solution that automates some of the manual BT call handling processes for 999 calls. This solution allows for callers on extended waits to have their calls answered more quickly and also should there be a break in telephony, the system automatically diverts to other services. It was noted that the IRP would be available to the four UK nations; however as far as the Trust was concerned it has proven to be problematic. It transpired that the Trust was a far greater importer of activity as opposed to an exporter of activity and equalled to about one fifth of calls being answered for other ambulance trusts. It was therefore decided that to remain on the IRP would be unsustainable and the Trust left it on 19 December following a critical incident. Since then there have been some changes and a number of Trusts who were struggling to manage their 999 capacity have taken steps to improve. In the meantime WAST has carried out a one day pilot of the revised IRP and going forward a one week pilot will be undertaken. The Committee would be updated on progress going forward.

In terms of system pressures handover delays remained extremely problematic, and way above that expected.

Members were updated on the 111 Adastra (software to manage patient journeys) outage incident which it was hoped that whilst the Trust was currently using work around solutions, it would soon return to business as usual.

DRAFT

Comments:

Whilst on the face of it there would be challenges going forward, the Committee welcomed the use of video consultation with patients and asked for further details. Lee Brooks explained that video consultation was available to the Trust through the Emergency Communication Nurse System (ECNS), a remote clinical decision support system, via the Clinical Support Desk (CSD). Initial feedback from staff has been positive. He added that the Trust continued to monitor its use especially with regards to the patient experience.

In terms of the upcoming control room solution the Committee sought further details. Lee Brooks advised that this technology would eventually replace the existing airwave radio technology and would be much more agile. Going forward there was still further testing to be conducted until it is ready to go live.

Clarity was sought on Emergency Medical Despatcher (EMD) recruitment and retention, particularly around the seemingly high attrition rate, which by and large was staff leaving. Lee Brooks explained that the single biggest loss was due the workplace experience and the associated challenging pressures staff were under; especially advising people that a resource will not be available. These and other pressures clearly have taken their toll on staff.

The Committee noted the improvement in January's performance particularly around the amber median and the reduction in handover delays; and thanked all staff for their ongoing efforts during these unprecedented times of system pressure.

It was queried if other blue light partners would be able to exert any pressure on health boards as a consequence of handover delays under the civil contingencies act. Lee Brooks explained that whilst they were not in a position to assist in creating a medical response, pressure could be applied through the Local Resilience Forum (multi- agency partnership consisting of representatives from local public services and emergency services)

RESOLVED: That the report was received.

003/23 PATIENT EXPERIENCE

Mark Harris provided the Committee with some background information on the WISH ambulance. It was an internally led volunteer service, currently 150, which delivered a service for a final wish to patients who expressed a wish to spend time with their families and/or visit a special place. The wishes were received from palliative clinicians following their consultation with patients.

The Committee were shown a video in which Lisa Taylor told us of the heart-warming experience the WISH team gave to her and her late husband Spencer. The WISH team took Spencer to Saundersfoot beach (a favourite of Spencer's and Lisa's) from Glangwilli Hospital for his birthday, picking him up in an ambulance that was decorated with birthday banners and ensuring a space was cordoned off in front of the beach for the ambulance and for his family members.

On the way back to the hospital the crew surprised Spencer and Lisa by detouring to his home, which Lisa said was particularly special for them all. Lisa told the Committee that it was lovely to enjoy the day without worrying about Spencer's medical needs which were taken care of so well by the WISH team. The whole day was a special memory for them both.

Comments:

The Committee thanked all those involved in making Spencer's last moments such a memorable experience and for all the other end of life experiences. It was queried how staff were selected to take part in these experiences. Edward O'Brian explained that staff applied through their respective Line Manager. After every wish experience a senior manager got in touch with staff to receive their feedback.

The Committee discussed opportunities to draw funds from other organisations and it was agreed that an action would be forwarded to the Charitable Funds Committee to consider funding to support the WISH team going forward.

Members further discussed that whilst the Trust was dealing with the challenges brought on by system pressures, it was uplifting to hear about these experiences.

RESOLVED: That the patient story was noted and recognised that the Charitable Funds Committee would consider opportunities for funding the WISH ambulance.

004/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the Monthly Integrated Performance Report (MIQPR) for December 2022 with the following to note:

1. In terms of the 111 data around clinical triage and how quickly people were called back for P1 calls, the report illustrated a dip in performance to 45% which was incorrect, performance had remained above 90%.

2. There had been an improvement to the consult and close rate which was just under the target of 15%.

3. In terms of Personal Appraisal Development Review (PADR) completion rates, this had improved to just above 85%.

Comments:

In terms of the BT calls being re-routed as discussed earlier in the operations update, and the level of activity, it was questioned whether there was a limit at which point the calls were not re-routed. Lee Brooks explained it was not, as part of the principles to do so; adding that it was a case of how to proactively manage pressure as it continued to build.

Regarding the Immediate Release figures, it was requested that an update be provided, particularly around stroke patients in the amber one category. Lee Brooks gave up to date data which showed that this week, there had been 165 red requests and 383 amber. The majority of reds had been accepted, the positon with amber having improved proportionally and has improved significantly.

Liam Williams informed the Committee that whilst the response times to concerns, particularly from the investigative perspective could be better, work was underway to improve this. He added that the staff resource required to listen to the calls and conduct the qualitative and quantitative assessments had not increased. Wendy Herbert provided an overview of the activity involved in ensuring that Putting Things Right staff in the Clinical Contact Centre and Corporate staff were provided with the necessary health and wellbeing accessibility.

In terms of the move from Appendix B reporting to a Joint Investigation Framework, Liam Williams, advised that this move had on the whole seen benefits across the majority of Health Boards.

It was queried whether it was possible to distinguish whether those complaints requiring a response within 30 days were the Trust's sole response, or whether other organisations involved. Wendy Herbert explained the majority related to the Trust and explained the process involved in investigating the complaints.

In respect of the Backlog of National Reportable Incidents (NRI) it was questioned whether this had been reviewed. Liam Williams gave assurance the backlog should be cleared by 31 March 2023 with the Delivery Unit (DU) taking assurance from each Health Board they were being progressed. It was agreed an update on the backlog would be provided at the next Committee meeting.

RESOLVED: The Committee considered the December 2022 Integrated Quality and Performance report and remained concerned on performance, noting that an update will be provided on the NRI backlog at the next meeting.

005/23 PATIENT SAFETY REPORT Q2 2022/23

Wendy Herbert gave an outline of the report and drew the Committee's attention to the following areas, noting that several areas of the report had been discussed in the previous item:

1. There continued to be an increase in the number of concerns being received.

2. The Trust received two Regulation 28 Reports during this period and has responded to all previous reports within the given timescales.

Comments:

It was questioned if there was a correlation with the number of Immediate Release Directives (IRD), and Serious Incidents aligned to Health Boards and discussed at the Serious Case Incident Forum (SCIF). Wendy Herbert agreed to provide information on the number of Joint Investigations linked to IRD's at the next meeting.

In terms of the Joint Investigation Framework the Committee requested that more narrative be drawn out with thematic information, focusing on trends and any themes and impact. Liam Williams agreed this would be contained in reports going forward; noting that the MIQPR would provide the data.

RESOLVED: That the update was received and provided sufficient assurance of progress against the 24 key performance indicators detailed, which demonstrate how the Trust is performing against the following areas of focus: - Our Patients (Quality, Safety and Patient Experience); Our People; Finance and Value; and Partnerships and System Contribution.

006/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT (BAF)

Trish Mills explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically risk 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service).

Furthermore, members were asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and outlined at the last meeting, were included in the action section of the BAF for the Trust's highest scoring risks 223 and 224, which are both rated 25.

RESOLVED: The Committee accepted the status of the two corporate risks which it has been assigned to oversee the management of – risks 223, 224. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls.

007/23 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT

Leanne Hawker outlined several areas within the report and drew the Committee's attention to the following:

1. Disability e-learning module, this was launched as an e-learning module and has helped patients with learning difficulties to access mainstream learning services. This will run alongside proposed developments to the ePCR which will allow staff to capture more information on the adjustments made for people with a learning disability and provide more effective data.

2. An update was given on the patient story tracker, this tracks outcomes of patient stories and was currently being re-designed to align to relevant IMTP priorities and work streams. It also included timelines and highlighted any key themes.

3. Community Health Councils (CHC), The Patient Experience and Community Involvement (PECI) team continue to work with CHC's to identify areas of working together to strengthen the voice of the citizens of Wales.

4. The Committee were updated on the work to improve access to health services for people whose first language was not English. This included a welcome pack, and the opportunity to attend an ethnic community health fair in Cardiff.

Comments:

It was questioned whether information was available when people called 111, and what happened next if they didn't use a primary or secondary healthcare facility. Leanne Hawker advised early information indicated that many people wanted to manage conditions themselves, people were looking for health information that will help their understanding. One of the biggest themes coming through was that people wanted access to information that supported their management and understanding of their condition.

Leanne Smith added that work was underway to consider longer-term to match up patient level data retrospectively, to understand patient flows, and presentation at different points of the system, but this was a longer term piece of work.

It was questioned if there was there a similar group across Wales that met on a regular basis to share information. Leanne Hawker advised that a group did exist and met regularly across Wales and also with colleagues in England and Scotland where information was shared.

In terms of engagement around older people and digital inclusion, it was noted that some health boards had recruited digital inclusion officers; it was asked what the Trust's approach was to digital inclusion. Leanne Hawker commented that the Trust works closely with local authorities and the older persons' Commissioner. Feedback has shown that the majority of older people still prefer telephone and face to face contact.

Rachel Marsh added that patient experience metrics would be included in the MIQPR albeit in small numbers, and going forward would benefit from more people responding to the surveys. Leanne Hawker advised that work was in progress with the Information Governance team and All Wales Civica, to improve and extend data collection and capture.

Lee Brooks commented on the overall experience of calling 999 and was surprised by the numbers of people who did not receive a response from a clinical advisor. Other thoughts he had were, did they all need a response and could the advice given been better.

Liam Williams summarised the main points from the report, reiterating that the proposed work with Civica, in terms of digital inclusion, would be extremely important. He also drew attention to the work of the PECI team in which they contributed to the service improvement and service development going forward.

RESOLVED: That

(1) the Committee approved the Highlight Report for release to the NHS Wales Patient Experience Network; Welsh Ambulance Services NHS Trust People & Community Network and external stakeholders; and noted and supported the actions being taken forward; and

(2) agreed the proposal to receive this report for information in future and receive a six monthly SBAR focused on the Trusts strategic objectives and clinical transformation agenda.

008/23 DUTY OF QUALITY/ DUTY OF CANDOUR PREPAREDNESS

Liam Williams advised Members that the report had been adjusted slightly since the first publication on ibabs. These highlighted the outstanding pieces of work from Welsh Government (WG) specifically on guidance and some work on the quality dashboard. The report focusses on the work required for the Trust to be ready for the Duty of Quality and Candour that exist within the Health and Care Standards 2015.

Caroline Miftari advised that the report outlined how prepared the Trust was in its readiness for the Duty of Quality and Candour, and would help inform the baseline assessment for submission to WG. The key discussion points were framed in four key areas; Governance and decision making, quality standards, education and awareness, and the Trust's digital infrastructure.

Jonathan Turnbull-Ross explained that the public launch in April 2023 as legislated was expected to be delayed. Further work was required to determine the requirements such as the process for quality impact assessments and any training and education. He further advised that consultations were coming to a close, whereby it was anticipated that details of more specifics, would emerge.

Comments:

The Committee discussed the importance of recognising that as at 1 April 2023 it will become law and recognised that the Trust has always prided itself on its Duty of Candour.

In terms of any cross border issues the Committee were keen to understand the policy going forward. Jonathon Turnbull-Ross explained that the Trust was still awaiting the statutory guidance for any cross border issues.

Members queried what the risks were in terms of the Act being implemented. Liam Williams confirmed that WG have started to undertake a Red/ Amber/ Green status in terms of organisation's preparedness. He added there were restrictions to the Trust's preparedness which included internal resourcing. In terms of generating an overall risk, this would be worked through with the Board Secretary.

Trish Mills added that a self-assessment had been conducted which looked at the Governance, Leadership and Accountability Standard across the four key areas in which no concerns or areas of non-compliance had arisen.

Members noted that the report concerned implementation of the Trust's quality strategy which was not highlighted in detail in the report; and expressed concern that its implementation was crucial to delivering the Duty of Quality and Candour. The Committee also recognised that Welsh Government had set a baseline position for all Health Bodies to achieve by 1 April, and the Committee were not satisfactorily assured WAST was in a position to meet the baseline requirements at this time. Jonathan Turnbull- Ross assured the Committee that extra resource to implement the strategy had been confirmed and were currently going through the recruitment process. The Committee asked that more clarity be provided on implementation of the strategy at the next meeting.

RESOLVED: That the Committee reviewed the report, considered the next steps and, supported the continued prioritisation of work to ensure appropriate levels of compliance in line with Welsh Government expectations from April 2023.

009/23 COMMITTEE ANNUAL EFFECTIVENESS REVIEW AND ANNUAL REPORT

Trish Mills explained that theTrust's Standing Orders and Committee Terms of Reference (TOR) required that Board Committees evaluate their effectiveness annually and prepare an annual report to the Trust Board Annual report to the Board in May.

There were minimal amendments to the TORs; these would be reviewed again in Quarter 2 to align with the Duty of Quality and Duty of Candour requirements.

Quest effectiveness survey results – this had given rise to several proposed changes which the Committee were shown by way of a presentation as part of the update report.

Comments:

The Committee supported the principle of allotting time on the agenda recognising that the range of topics naturally engendered discussions and finding the right balance of time was challenging.

It was queried whether the recording could be made more available. Trish Mills explained that the recording was for the purpose of minute taking and was not published on the website. Trish Mills agreed to speak to the Chair of the Board to discuss this further.

DRAFT

RESOLVED: The Committee

(1) Reviewed and approved changes to it's the Committee's Terms of Reference;
(2) Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires;
(3) Set priorities for the Committee for 2022/23 which were to continue with the focus on the Duty of Quality and the Duty of Candour; and
(4) Approved the annual report at Annex 2, noting it required some further adjustment before receipt by Trust Board

010/23 WAST ANNUAL SAFEGUARDING REPORT

Nikki Harvey advised the Committee that the Safeguarding Annual Report provided evidence on how the Trust has performed during the 2021-2022 period in relation to safeguarding people in its care.

It aimed to give the Trust Board information on WAST safeguarding activities, engagement and collaborative working with our partner agencies; as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance were being fulfilled.

The Safeguarding Governance Frameworks have continued to be part of everyday practices within WAST during a continued challenging reporting period.
The data evidenced within this year's report demonstrated an increase of 85% in the total number of reports submitted by WAST staff since the initial launch of Doc Works. Doc Works has also enabled front line staff to make any referrals direct to the Fire and Rescue Service. This would include as an example, hoarding and any other fire issues that had been detected at people's homes.

Nikki Harvey explained that the Trust's Annual Training Plan continued to support statutory safeguarding requirements, ensuring that staff were provided with the right level of training, commensurate with their role. This report illustrates compliance of 99% for Level 2 Safeguarding Children and 89% Level 2 adult safeguarding training (target set at 85%) and 89% for Group 1 training as required under the National Training Framework (NTF).

This report also included information on WAST activity generated by its 'Duty to cooperate'. The WAST Safeguarding Team have worked in partnership other agencies as required in all safeguarding activities including: Procedural Response to Unexpected Deaths in Childhood (PRUDiC), Practice and Domestic Homicide Reviews and Safeguarding Strategy Meetings. There has been a noticeable increase in WAST collaborative safeguarding activity associated with core business.

Comments:

The Committee noted that the increased referral was a positive step and that from a public health perspective, referral to the fire service for example was a further positive aspect.

It would be interesting to know what public health Wales does with the information provided by WAST. Nikki Harvey explained that significant information was provided to public health Wales and their feedback and analysis would be included in future reports

DRAFT

Ceri Jackson left meeting at 13:00

RESOLVED: The report was received and noted and it was agreed that it would be reported to the Board as part of the AAA report.

011/23 SUMMARY OF ACTIONS AND DECISIONS MADE, REFLECTIONS AND KEY MESSAGES FOR BOARD

Members agreed it was challenging to keep to the time allocated on the Agenda and that some areas required more exploration than others. Furthermore, it was also noted that the MIQPR and patient safety report overlapped.

The Chair added that she would welcome any further feedback/reflection by e mail.

In terms of any actions the following were raised during the meeting:

1. Operational reports to include an update on the Intelligent Routing Platform pilot.
2. The Charitable Funds Committee should consider what financial support could be provided for the WISH Ambulance going forward and all staff involved were to be formally thanked.
3. In terms of the MIQPR, to re-look at the report to eliminate duplication of reporting the same detail in the Patient Safety report.
4. With regards to the backlog of National Reportable Incidents - an update was to be provided at the next meeting.
5. Patient safety report, with regards to the Joint Investigations, this should contain details of how many Serious Incidents were linked to Immediate Release Directives being declined and future reports to contain narrative with more thematic information, focusing on trends, themes and impact.
6. Consideration be given to develop an annual report from the PECI team and how to improve the digital inclusion for users and consider how to re-frame the questions for patient surveys to improve feedback.
7. In terms of the duty of quality and duty of candour, a discussion was held regarding risk and it was agreed that a new risk be generated/articulated to consider the impact of the Act.
8. Implementation of the Quality strategy. An update was requested in respect of how this would be delivered in the next report
9. It was agreed that Trish Mills will speak to the Chair of the Board to discuss further the possibilities of extending the Committee meeting recording, significantly the Patient/Staff Story and the ensuing discussion for wider distribution.
10. Future annual safeguarding reports should contain details of the work conducted to influence other organisations and mentioning specific commissioners.

In terms of key messages for the Board this will be drafted by Trish Mills for the Chair's consideration.

RESOLVED: The Committee noted the above.

012/23 ANY OTHER BUSINESS

Date of Next meeting: 11 May 2023

Meeting concluded at 13:20

DRAFT

ACTION LOG - UPDATE FOR MAY 2023
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
002/23	9 February 2023	Operations Update	Future reports to include an update on the Intelligent Routing Platform pilot.	Lee Brooks	11 May 2023	Update for 11 May 2023 A detailed update regarding the IRP pilot has been included in the Operations Report for the May Committee meeting. As such it is proposed that this action be CLOSED.	Open
004/23a	9 February 2023	Patient safety report	Backlog of National Reportable Incidents; the Committee requested an update to begiven at the next meeting.	Liam Williams	11 May 2023	Update for 11 May 2023 Meeting has been held with NHS Wales Executive who have received assurance from Health Boards that the back log would be cleared by April 30th. The next all-Wales meeting will confirm the position.	Open
005/23	9 February 2023	Patient safety report	The next report to contain details of how many Serious Case Incident Forums were linked to Immediate Release Directives being declined.	Wendy Herbert	11 May 2023	Update for 11 May 2023 Details in relation to this action have been included in the Patient Safety Report to be received at the May Committee meeting. As such it is proposed that this action be CLOSED.	Open
007/23a	9 February 2023	PECI Highlight report	Consider how to re-frame the questions for patient surveys to improve services from the feedback given.	Leanne Hawker	11 May 2023	Update for 11 May 2023 The People & Community Network are engaged in helping to co-produce a series of 'core' Trust questions for use in a series of patient surveys carried out against Trust services. Once completed these questions will be populated in CIVICA.	Open
008/23	9 February 2023	Duty of Quality/Candour preparedness	A Risk to be generated/articulated to consider the impact of implementation of non compliance with the introduction the Act.	Liam Williams Trish Mills	11 May 2023	Update for 11 May 2023 *Verbal update to be given at the meeting.*	Open
008/23a	9 February 2023	Duty of Quality/Candour preparedness	Clarity on the Implementation of the Quality strategy. An update was requested in respect of how this would be delivered in the next report.	Jonathan Turnbull-Ross	11 May 2023	Update for 11 May 2023: A progress report on the Quality Strategy Implementation Plan is scheduled for QUEST agenda in May 2023. The purpose of the report is to provide clarity of current position, and advise of the enabling factors which have developed over recent months to allow delivery.	Open

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	30 March 2023
Committee Meeting Date	9 February 2023
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Alert the Board to areas of attention)
1. Handover lost hours in December were at their highest at over 32,000 hour, with Red and Amber 1 response times far in excess of where the Trust would want to see them. These will be the subject of more detailed review at the Finance and Performance Committee. Whilst for January performance has improved, **handover lost hours were still significantly concerning at 23,500 hours and continue to present patient safety risks.** The very poor patient experience and risk of continued harm ran through most of the items discussed at this meeting and is the focus of **risks 223 and 224,** with each remaining at a score of 25. The Committee is aware of the actions being taken by WAST to mitigate harm and of the escalations and actions in the system and with Welsh Government. Progress against these actions is a focus at each Public Board, however a continued high number of concerns raised, immediate release direction refusals (both Red and Amber 1), and incidents linked to timeliness of response demonstrates that more pace is required to address the issue at a system and strategic level. Members will continue to challenge on further actions that can be put in place, raise the issue in their respective forums, and will keep a close eye on the national review by Audit Wales into the effectiveness of unscheduled care services in Wales to provide further insight into the root causes of flow and delays. 2. The Trust's **readiness for implementation of the Duty of Quality and Duty of Candour** when the Health and Care (Quality and Engagement) (Wales) Act 2020 is introduced on 1 April was presented. The Welsh Government has set a baseline position for all Health Bodies to achieve by 1 April, and the Committee were not satisfactorily assured WAST was in a position to meet the baseline requirements at this point. It was recognised there is work planned throughout the remainder of the quarter to meet that baseline both by the Trust and by Welsh Government, as there are dependent activities required from Welsh Government to support implementation of the Act. The Committee will not meet again until May therefore Trust Board will receive an item at its March meeting to review further progress made on our readiness against the baseline position ahead of 1st April 2023. The **Quality Strategy** is key to delivering our plans for embedding the Duty of Quality and Duty of Candour, and the Committee were not assured that robust plans were yet in place for implementation of the strategy. Given the ongoing significant pressures across WAST, progress on implementation of the Quality Strategy has continued to be adversely affected. A more detailed paper on this was requested for the May meeting, and the Committee will include a focus on this as

one of its priorities for 2023/24.

ADVISE

(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)

3. The **Committee heard from Lisa Taylor** who told us of the heartwarming experience the WISH team gave to her and her late husband Spencer. The WISH team is a group of WAST staff who volunteer their time to support end of life patients when they express a wish to spend time with their families and/or visit a special place. The WISH team took Spencer to Saundersfoot beach (a favourite of Spencer's and Lisa's) from Glangwilli Hospital his birthday, picking him up in an ambulance that was decorated with birthday banners and ensuring a space was cordoned off in front of the beach for the ambulance and for his family members. On the way back to the hospital the crew surprised Spencer and Lisa by detouring to his home, which Lisa said was particularly special for them all. Lisa told us that it was lovely to enjoy the day without worrying about Spencer's medical needs which were taken care of so well by the WISH team. The whole day was a special memory for them both. Lisa's story can be viewed here.

   Members expressed their thanks to Lisa and her family for sharing their story. Particular thanks went to Mark Harris, Assistant Director of Operations (NEPTS), Ed O'Brien, MacMillan Paramedic and end of life care lead, and all of our WAST colleagues who volunteer for this very important and rewarding service.

4. There was no **patient story tracking diagram** at this meeting as it is undergoing a redesign to enable it to map to the relevant IMTP priorities/workstreams. This diagram tracks outcomes of patient stories which the Committee has heard previously to show actions taken to address issues raised, and improvement of outcomes as a result.

5. The Committee was pleased to hear that **Penthrox** (rapid short-term analgesic) will be introduced for use at WAST. Volunteers recently saw the roll out of Paracetamol and the introduction of Penthrox for their use is also being planned.

6. The Committee received the quarterly **Operational Update** as a standing agenda item. This report in its new format continues to provide helpful context for the Committee in its oversight role for quality, patient experience and safety. The Committee will receive further detail on the pilot re-introducing the intelligent routing platform for 999 calls following the critical incident in December.

7. In response to replies to the effectiveness survey, the agenda included an opportunity to **reflect** on the meeting. Comments included:

   - While the meeting ran slightly over time, the space the Chair allowed for discussion and exploration of issues was much appreciated;
   - Useful discussion and generated a lot of actions;
   - Good challenge from Non-Executive colleagues;
   - Complex papers could be presented with a few bullet points on a slide to Committee; and
   - Meeting was reflective of our governance framework that provides for Committees to debate items in more depth.

ASSURE

(Detail here any areas of assurance the Committee has received)

8. The Duty of Quality and Duty of Candour preparedness paper included a **self-assessment**

against the Health and Care Standards 2015. Whilst it was recognised that these standards will change when the Health and Social Care (Quality and Engagement) (Wales) Act 2020 is introduced the self-assessment was welcomed. However, it was difficult to ascertain compliance levels against the Standards on the basis of the paper as further work is required to evidence responses which has been challenging given the current pressures experienced by the Trust.

9. The Committee held its **annual effectiveness review**. Responses to questionnaires were reviewed and changes agreed to terms of reference and operating arrangements. The Committee's annual report and revised terms of reference will be presented to the Audit Committee on 20th April and the Board on 26th May.

10. The **Safeguarding Annual Report** was received and is **attached.** The report provides an overview on how the Trust has performed during 2021/22 in relation to safeguarding people in our care. The Committee commended the team on the report and were assured that use of Docworks and the uptake in training meant that the increase in the volume of reporting was a positive indicator of a change in culture around safeguarding. Future reports will demonstrate more clearly WAST's external influence in this area and relationship with Commissioners.

11. The Committee receives assurance reporting by way of the **Monthly Integrated Performance Report (MIQPR)** for December and the **Q3 Patient Safety Highlight Report**. It was recognised that the duplication and overlap in the reports is being addressed and future reports will reflect a more streamlined approach. The MIQPR had been discussed in detail at Trust Board shortly before this meeting therefore the Committee focused on and noted:

- Good improvement in Consult and Close at just under the 15% target set for December which is a positive outcome for patients.
- Clinical indicators appear a long way below target which is largely thought to be a result of the introduction of the new electronic patient care record (ePCR). Following audits conducted for each of the clinical indicators a number of 'top tips' have been developed for improved use of ePCR, with audits also contributing to improvements in the ePCR data capture. The Committee deferred the clinical audit plan for this meeting due to the significant pressure through December and January but will review the plan in May.
- The recruitment and retention issues related to performance against 111 abandonment rates and 111 clinical assessment will be discussed at the February People and Culture Committee. Poor patient experience on accessing the NHS 111 Service and navigating the website were raised in the PECI report as was the reasons many patients visit the website.
- There is good performance for NEPTS renal journeys and discharge and transfer journeys, and patient satisfaction remains consistently good.
- Immediate release directions refused remain concerningly high. Whilst the volume had reduced in January it was noted that there were a number of variables during that month including industrial action which likely impacted this positively. The Chief Executive continues to report immediate release direction data to the Director General on a weekly basis for central management. The Committee requested a closer look to identify trends on the days where performance was better. The Committee will review an internal audit on immediate release requests at the next meeting to review improvements proposed.
- Continued high numbers of concerns being received with the 30-day response times remaining significantly behind the 75% target at 26% despite additional resourcing in the team. This was due to multiple factors including increased numbers of complaints and their complexity. In addition, current operational pressures mean that colleagues who input into the investigations i.e. listening to calls, call audits, quality assessing and inputting into wider conversations with Health Board colleagues have not been available. The additionality has meant that the two day response performance has however improved.
- The new joint investigation process (previously Appendix B) is seeing good benefit in the majority

of the Health Board areas.

- There were no Nationally Reportable Incidents (NRIs) identified in December, despite the long waits in the community for all categories of calls. This may not necessarily reflect a lack of incidents but we may not yet have seen that flow due to current pressures.
- Two Coroner Regulation 28 notices were received in the quarter with the theme of handover delays. The Committee were reassured learning was being drawn from these notices.

12. The **Patient Experience and Community Involvement (PECI)** Q3 report was received showing positive progress on the Trust's understanding learning disability e-learning module. Themes around long waits for an emergency ambulance remains consistent. Despite the challenging backdrop of long waits people continued to provide positive feedback about their interactions with our staff. The quarterly report will continue to be produced for staff and stakeholders, however the report to this Committee will move to a bi-annual report focusing on analysis, themes, and trends.

13. The Committee were not presented with the **audit tracker** at this meeting, however it was noted that there were overdue recommendations that would receive a focused review prior to the next meeting.

RISKS

Risks Discussed: There are two corporate risks assigned to the Committee which are rated as high risks with no changes to scores since the last review. **Risk 223:** the Trust's inability to reach patients in the community causing patient harm and death and **risk 224:** significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service are both rated at 25. The theme of these risks arose throughout the agenda items discussed at this meeting. The Committee noted many of the actions for risk 224 are due for checkpoint review in Q4 and should any of those crystallize in that time the Committee will be interested to see how they further mitigate the risk.

New Risks Identified: No new risks were discussed in this meeting.

COMMITTEE AGENDA FOR MEETING		
Feedback from Chair on escalations from Committee to Board in January	Operations Directorate Quarterly Report for Q3	Patient experience
Monthly Integrated Quality Performance Report	Patient Safety Report Q3	Risk Management and Board Assurance Framework Report
Patient Experience and Community Involvement Report	Duty of Quality and Duty of Candour preparedness	Committee annual effectiveness review 2022/23
Internal Audit Tracker	WAST Annual Safeguarding Report	

COMMITTEE ATTENDANCE				
Name	**12 May 2022**	**11 August 2022**	**10 November 2022**	**9 February 2023**
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Hannah Rowan				
Wendy Herbert		In attendance	In attendance	
Liam Williams		First meeting		
Andy Swinburn				
Lee Brooks				
Andy Haywood				
Leanne Smith		First meeting		
Rachel Marsh	Hugh Bennett			

Trish Mills				
Angela Roberts				
Mark Marsden			First meeting	
Hugh Parry				
Craig Brown				
Ian James		First meeting		

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2022-23 Q4 (Jan – Mar 2023)

National Operations & Support

Challenges

1. Industrial Action

1.1 Since mid-December, there has been 11 days of industrial action. This spans three trade unions – Royal College of Nursing (RCN), Unite and GMB Union. The combined action on 20 February 2023 was significantly more impactful on the Trust's ability to provide safe services compared to previous dates, in-spite-of the additional support provided by the military and the intensive planning process. Discussion with WAST and the trade unions has resulted in a proposed set of non-pay initiatives which will be subject to further dialogue in early May 2023.

2. Manchester Arena Inquiry (MAI)

2.1. In June 2021 and November 2022, The Hon. Sir John Saunders published reports from the Manchester Arena Public Inquiry. Three separate volumes have now been published. The WAST EPRR team has not had the capacity to receive, review, consider and plan a response to the 149 recommendations contained in volumes 2 and 3 of the report. Capacity in the team has been exacerbated by the planning process for industrial action and winter pressures which have followed quickly on from the death of Her Majesty Queen Elizabeth in September 2022 and the subsequent arrangements for King Charles's proclamation ceremony in Cardiff. However, funding of 2 posts on a 12-month basis has been protected to receive, review, and plan a response to all MAI recommendations and provide network links with partners across Wales and other UK ambulance Trusts. The recruitment process for the first manager post is now completed and the second support post will follow imminently.

3. Covid Inquiry

3.1. Work is underway to prepare documentation and submissions for the Covid Inquiry. The preparation of submissions, whilst potentially could be sporadic, is capacity consuming, across the Directorate, and requires involvement of our most senior team members.

IMTP

4. Covid-19 Mobile Testing Unit Closure

4.1. At the end of March, the contracts with Welsh Government and DHSC came to a natural close. These contracts to provide mobile covid-19 testing for both NHS staff and the general population of Wales commenced in August 2020, initially to undertake PCR testing. Since then, we have carried out more than 75,000 tests across 72 test sites in Wales, including carparks, community centres, prisons, and fun fairs, with staff working outside in all kinds of weather. Our MTUs have been the only testing team that have undertaken assisted lateral flow tests before training staff and handing over to local authorities. In all, 161 staff have worked across our MTUs, of which 42 have now successfully secured roles within the Trust. On 27th March, we celebrated the success of the MTUs with a thank you event and afternoon tea. It was a pleasure for our Assistant Director of Operations, National Operations & Support to receive personal correspondence from the Minister, Eluned Morgan, thanking colleagues for their contribution.

General Update

5. Governance

5.1. The audit plan for the Directorate concluded with the finalisation of three audits all of which received a reasonable assurance rating, covering Major Incident Preparedness, Hazardous Area Response Team (HART), and Immediate Release Directions. All three reports have been tabled at and received by Audit Committee.

6. Exercise Mighty Oak

6.1. At the end of March, WAST participated in a three-day Tier 1 multi-agency exercise encompassing a four-day power outage scenario. This was the first time that WAST had tested the feasibility of planning for a wide-reaching power outage, and the first time that our strategic command capability was physically located in the Emergency Co-ordination Centre Wales (ECCW) in Cardiff, rather than co location in Local Resilience Forum areas. An exercise debrief will take place in due course.

7. Analgesia Issued to Volunteers

7.1. In January 2023, approval was given for analgesia (pain relief) to be issued to volunteer Community First Responders (CFRs). This is part of a phased roll out of pain relief to volunteers, which commenced with oral paracetamol for acute pain in adult patients until a WAST crew arrives. This will be followed by a roll out of Penthrox in April/May, which has commenced across staff and volunteers. This is an exciting development for our CFRs who experience protracted on scene times with patients who experience pain. The roll out of Penthrox to volunteers is a first for any UK ambulance Trust.

8. Volunteer Recruitment

8.1. The plan to increase numbers of volunteers has successfully increased CFR teams by more than 130 new volunteers trained during 2022/23. There will be an additional 30 more volunteers trained in the new financial year due to phasing into April. Recruitment into the volunteer management and support team has also progressed well.

9. Closure of Senior Business Continuity Planning Team (SBCPT)

9.1. The end of March saw the closure of the oversight group SBCPT which was convened to manage the impact of winter, including winter pressures, weather, potential power outage and industrial action. Given that the immediate risks from these challenges have largely passed, Executive Management Team accepted a recommendation from SBCPT that closure would follow on 23 March, except for the oversight of industrial action which will continue to function for the duration of the span of the industrial action.

Resourcing & EMS Coordination

Challenges

10. EMD Recruitment and Retention

10.1. Recruitment and Retention continues to be a challenge for EMS Coordination despite the previous quarterly update indicating that we had recruited a further 20 EMDs. The external attrition rate for the 2022/23 fiscal year ended at 21.57%, an increase of almost 6%. This does not include internal staff movements because of career pathways which also had a significant impact during the same time. Staff starting in EMS Coordination have moved on to have careers in ODU, Ambulance Care and 111. Recruitment to other roles within EMS Coordination is generally achieved through recruitment internal to the department, and this has left the Emergency Medical Dispatcher (EMD) establishment under pressure again. A further 40 EMDs have just been recruited for cohorts starting in May and June and recruitment events are scheduled for July and August to support recruitment prior to the winter period. The impact of this constant high level of recruitment is seen in the experience of mentor support new EMDs and the capacity of the Learning and Development team to complete quality improvement training.

11. Concerns

11.1. The workload for the Operations Quality Concerns Team remains high (283 tasks). The Operations Quality Team continue to work closely with the Putting Things Right Team to prioritise work to meet deadlines and requests. There has been a significant improvement in the status of outstanding concerns investigations, with a 55.7% reduction during Q1. The demand from Coroners across Wales continues to be a significant factor in the ongoing workload and commitment for the team, however, it should be noted that 47% of the outstanding Coroners work is directly related to a delayed response. The team are currently exploring ways of eliciting wider organisational support for the Coroner related demand.

12. EMSC Reconfiguration

12.1. The EMS Coordination Reconfiguration Project has been ongoing since 2018, and the current key work streams include:

- Roster review: a collaborative review of rosters in partnership across Wales to better match our staffing profiles to demand and support our teams' wellbeing
- Boundary changes: to provide an improved balanced workload for dispatch staff and greater resilience to the service
- Broader ways of working: an assessment to provide improved productivity and effectiveness while improving processes and procedures for QPS

12.2. Whilst the initial Roster Review for EMDs was completed and implemented the impact of Industrial Action has meant that the other projects were paused during Qtr 4. This was because of the limited management capacity within EMS Coordination focussing on Industrial Action planning and operational/tactical command. These projects, subject to IMTP prioritisation, may restart during Q1 of 2023/24 with Roster Reviews

being planned for Allocators and Dispatchers. Broader ways of working have started to explore changes in the operational model within EMS C and ORH have been commissioned to revisit the modelling provided as part of the Demand and Capacity review to inform the boundary changes review.

IMTP

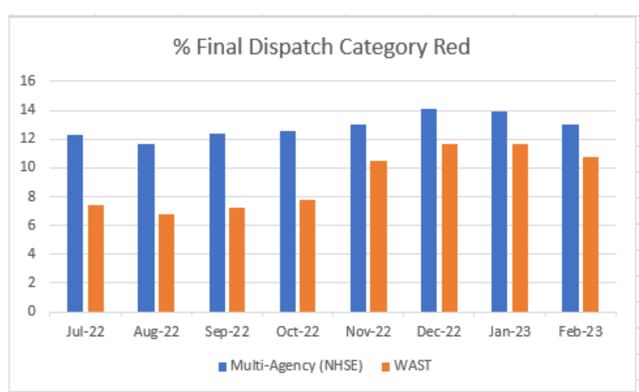
13. Managing Attendance at Work

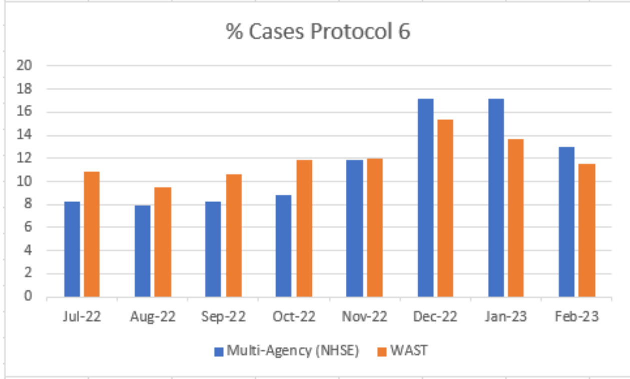
13.1. The absence FTE % for EMSC in 2021/22 fiscal year was 13.48% having reached a peak of 17.08% in January 2022. Following considerable focus by the teams across each of the EMSC centres the absence reason for 2022/23 fiscal year ended at 11.31% for the year having reduced to <8% for February and March. This was in line with our agreed trajectory for sickness absence improvement. Trajectories have now been cast for the next fiscal year to achieve an 8% average.

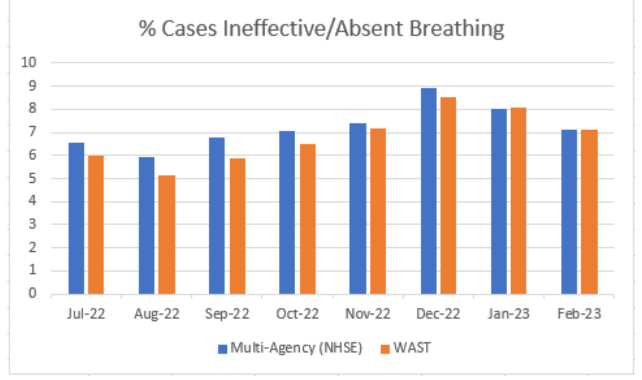
General Update

14. Priority Dispatch

14.1. The Priority Dispatch Corporation (PDC) report sets out WAST's % of RED category calls in comparison to the % seen in English trusts which use MPDS (Multi-Agency (NHSE)). The Dispatch Cross Reference (DCR) Review Group sits under the Clinical Priority Assessment Software (CPAS) group and undertakes regular reviews of response assignment for the codes within the Medical Priority Dispatch System (MPDS) to ensure the most appropriate clinical response is provided.







14.2. The Welsh Ambulance Services NHS Trust (WAST) proportionately has lower RED category calls than English trusts (as an average). The slight close of the gap seen from November 2022 is due to changes made to some fitting, falls and haemorrhage codes to RED. Where WAST was reporting a higher % of Protocol 6 (breathing problems), English trusts are now reporting more. This is because Protocol 36 was still running in England, but as this has now been switched off a portion of these calls now sit in Protocol 6.

15. MPDS Audits

15.1. WAST is required to undertake a percentage of 999 call audits to maintain its accreditation with the International Academy of Emergency Dispatch (IAED). Due to industrial action and the refocus of staff and resources, an Overwhelming Events request was submitted to the IAED for Q1 (Jan, Feb and Mar). The Overwhelming Events request was accepted by the IAED and so the reduction in completed audits during Q1 will not affect the Trust's reaccreditation, which is due this summer.

16. Control Room Solution

16.1. In line with the Emergency Services Network (ESN) programme, and in collaboration with the Ambulance Radio Programme (ARP), EMS Coordination has supported the roll out of a new Integrated Communication Control System (ICCS) provided by Frequentis. The LifeX solution has now been implemented early in Q1 following a brief delay in Q4 due to IA. WAST is the first large scale ambulance service in the UK to go-live on the new platform (Isle of Wight has been piloting the solution on a smaller scale).

16.2. ICT colleagues, EMS Coordination teams and the ESMCP project managers worked in collaboration with ARP and system suppliers Frequentis to ensure infrastructure, operational plans and testing was completed to the standard WAST required to lead the UK with this innovative cloud-based product.

16.3. Positive feedback has been received from all stakeholders on the well organised focussed and pragmatic approach taken by WAST to deliver this innovative digital transformation.

17. IAED President Visit

17.1. Integrated Care and EMS Coordination colleagues were pleased to host a visit by Brian Dale, President of the International Academy of Emergency Dispatch during March 23. Positive feedback was received around the joint working between the teams within WAST and the exciting changes being piloted within the Clinical Support Desk following the introduction of ECNS. Teams took the opportunity to talk about opportunities to expand the use of MPDS in EMS Coordination as well as exciting developments expected this year through the release of Version 14 which will include a new Protocol (41) for 'Callers in Crisis'. This will help EMDs support patients in mental health crisis through specially scripted questions and advice; an important step forward in supporting our patients with challenging mental health needs.

18. Intelligent Routing Platform

18.1. As a result of a significant and sustained increase in 999 activity levels, coupled with an increase in COVID related absence among ambulance control room staff, call answering times for 999 calls became challenged. It would be fair to say this was more the case in England compared to Wales. Ambulance trusts in England and Devolved Administrations therefore collaborated to improve pre-existing mutual support arrangements to provide support for patients experiencing extraordinary delays.

18.2. Call routing technology – technology that is in use in other large call handling settings – has been developed to automate and improve the speed and accuracy of existing manual practices to identify the services best placed to provide support most quickly. This enhances ambulance service infrastructure and interoperability at a UK wide level, as well as building further 999 call handling resilience for extraordinary events such as major incidents, extreme weather events and sudden localised technology failures. For this reason, we felt that Wales, through WAST, should be included in this solution.

18.3. Pre-existing mutual support arrangements agreed by CEOs of ambulance services in England and Devolved Administrations have been carefully balanced to ensure that any mutual support provided to other services does not create undue increased clinical risk for the services providing support. The development of technology sought to replicate those supports and contingency arrangements. It is referred to as the Intelligent Routing Platform (IRP).

18.4. When a 999 call is not able to be answered by the service covering the geographical area, the IRP is configured in a way to find a call handler anywhere in the UK to answer that call. The service which answers the call should have at least two agents available and newer configuration prevents the same service managing consecutive calls for support. Should there be a total loss of call answering capability by any ambulance service, the IRP will immediately flow 999 calls elsewhere for support without manual intervention by British Telecom. The incident detail is recorded by the answering service and then technology permits an electronic transfer of that incident from one service to another. Lastly on the platform, this technology has been funded and supported by NHS England and made available to all UK services in the interest of resilience across the UK. It is a fantastic example of collaborative UK-wide solution delivery when used as intended.

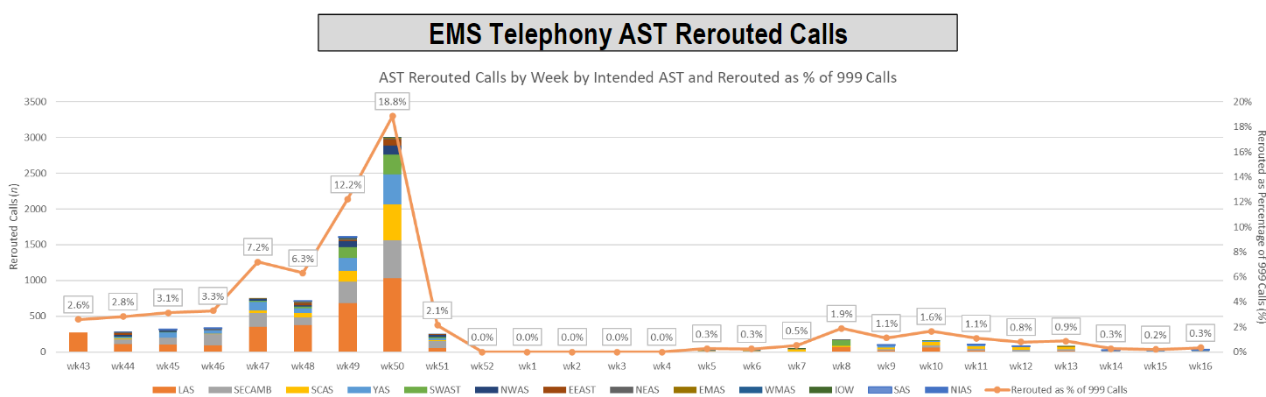
WAST Experience of IRP

18.5. The IRP was made live around October 2022 and WAST has very closely monitored impacts. As extreme pressure materialised through winter, it was evident that WAST was managing a larger proportion of overflow activity, and this impeded our ability to respond to 999 calls from within our community in Wales. At peak, in the region of 18% of our weekly activity was answering calls for other services and this was not sustainable, particularly as our support was bolstering recruitment challenges elsewhere in England. We therefore temporarily suspend our inclusion in the IRP in

December 2022 whilst the UK ambulance sector could consider planned and coordinated supports for those ambulance services in most need.

18.6. In February this year, WAST reinstated our inclusion in the IRP following some system rule changes and a UK-wide consensus that IRP was not to be utilised as a solution to broader recruitment challenges. Since returning to IRP, no more than 2% of our weekly call answering activity is for other services, which has been much more manageable alongside a reduced call answer wait time for our 999 users in Wales. It remains, however, that we answer more calls than we export, which is testament to sustaining the best call answering teams we can. NHS England has also since provided a payment representative of the activity handled by WAST and going forward the agreement between ambulance services includes options for cost recovery if considered appropriate.

18.7. The graph below shows the weekly volume of 999 calls rerouted to and answered by WAST with a very obvious peak and now sustained period of levelling off.



Emergency Medical Service

Challenges

19. Continued System Pressure

19.1. Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 32,098 hours were lost in December 2022, 23,526 in January 2023, 19,113 in February, 28,637 in March and provisionally pending verification, 23,083 in April 2023. The impacts of these pressures is regularly discussed at Committee and Trust Board.

IMTP

20. EMS Roster Review

20.1. All EA and UCS rosters are now live and the project team is now gathering together to finalise the lessons learned and project benefits. This is due to be completed before the end of June 2024 and the project will be closed formally.

20.2. CHARU is now growing in number with circa 60 Paramedics due to be in CHARU roles by mid May 2023. The decision was made to commit to further growing the numbers to the full modelled position of 153FTE (11.5FTE contributed by Senior Paramedics) and recruitment has begun in earnest.

General Update

21. Industrial Action

21.1. Already expressed above, the impact of Industrial Action across EMS should not be underestimated.

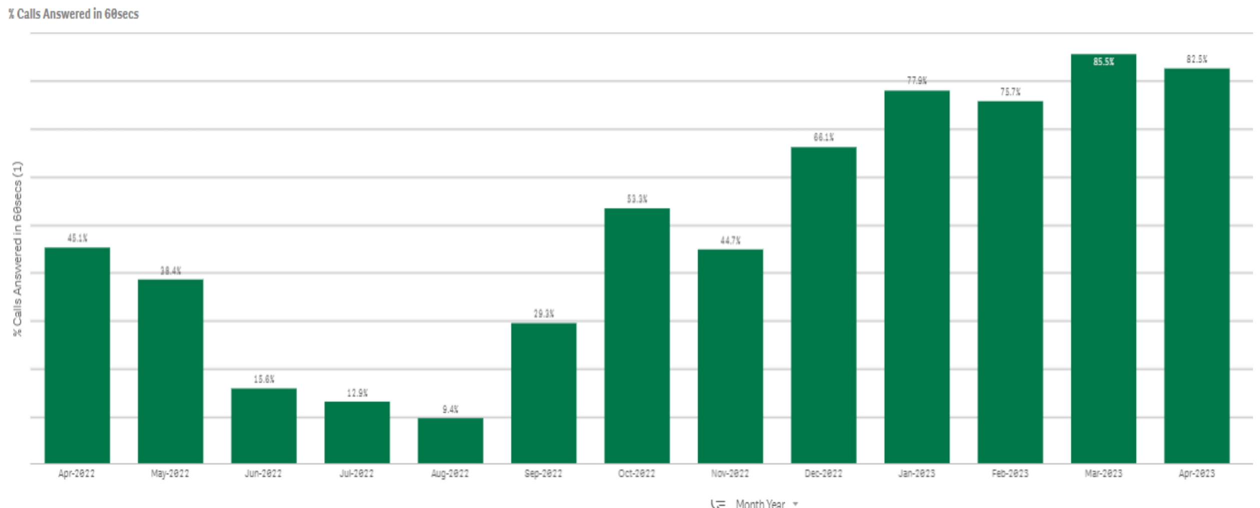
Ambulance Care

Challenges

22. Net Centre Journey Booking Service Performance

22.1. Performance for the NET centre had been particularly challenged throughout quarters 1-3. Although early signs of an improvement had been observed in Quarter 3, the measures for Quarter 4 demonstrate that the service is now routinely operating at a very high standard.

22.2. There are still pressure points at certain times of the day where demand exceeds capacity. However, a roster review will complete in Q1 to minimise these. The chart below shows the percentage of calls answered within 60 seconds for the period 1st April 2022 to 30th April 2023.



IMTP

23. Cleric Upgrade

23.1. February saw the implementation of the NEPTS CAD system to a new version of the Cleric system. The new product is hosted externally within the cloud, removing some the risks previously logged around the design and stability of the current infrastructure.

23.2. The new product opens up the possibility of establishing improved access for Health Care Professionals as well as providing a secure platform to build a patient zone, which will allow patients to book online, update/review their bookings and see where their transport is as opposed to ringing a WAST Call centre.

General Update

24. ACA 2 Recruitment

24.1. In July 2022 the Urgent Care Service was transferred to the management of the Ambulance Care team. To address the UHP gap, which mainly emanated from losses to EMT recruitment and challenges recruiting candidates with the appropriate driving licence category, the team established a new scheme offering candidates employment which included training to achieve the required C1 licence classification. By the end of Quarter 3 when the last course completed, 113 additional ACA2's had been recruited, including 86 employed through the C1 scheme. The scheme will have successfully closed the UHP gap in addition to supporting the recruitment process for the additional 100 staff.

25. NEPTS Vehicles

25.1. The past financial year has seen the roll out of a number of new or refreshed vehicle types across the fleet. This includes a refresh of our Renault Master vehicle and a replacement for our small vehicle fleet to a Transit Custom vehicle. The new vehicles include features that will improve patient experience and safety as well as providing additional capacity and operational efficiency.

25.2. A new B-Class Ambulance Care vehicle will also go live in April 2023. This vehicle can be used across NEPTS & UCS services and will be a new concept for the service.

Integrated Care

Challenges

26. Consult and Close in WAST edging to 15%

26.1. Coupled with the increased demand for service and since the new calendar year, an increased rate of consult and close activity in CSD, 111 and with APP and HB partners has on days exceeded 18% and monthly edging very close to 15%. There is a risk in achieving 15% in periods of low calls and the overall demand on clinicians on duty while supporting other services such as remote clinical support, red review, clinical screening and enhanced clinical screening despite good establishment.

27. SALUS

27.1. Capita has proposed a revised final delivery plan with a go-live date of 20th November 2023. It is hoped this allows the system to be in place ahead of winter pressures. The timeline is tight, and training will require abstractions of staff. We await approvals to grow call handling capacity to absorb as much of this abstraction as possible.

IMTP

28. Use of Video Consultation in Clinical Support Desk

28.1. Following the implementation of the video element of ECNS, the next stage of implementation would be to introduce the note sharing function which is currently being scoped with a view to implement the ability to securely share the consultation record itself. This work is contingent on further IT security and GDPR work to comply with.

29. Clinical Support Desk Roster and Resourcing Review

29.1. A review has been undertaken and roster option developed and put out for vote. A new roster approach has a proposed go-live in Q1. Further resourcing work is ongoing to build said rosters, align lines and develop a SOP for Resource to follow. Engaging with the team is creating an opportunity to develop an approach that is service and people appropriate.

General Update

30. 111 Adastra Update

30.1. While the business continuity incident has ended for the Health Boards and Adastra systems have resumed, the new "Concentrator" which joined the Adastra system to the WAST has been successfully built and deployed in February 2023. The sterling efforts of our teams ensured we sustained services during what was an extended period of disruption.

AGENDA ITEM No	7
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – March/April 2023

MEETING	Quality Safety Patient Experience Committee
DATE	11 May 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Mark Thomas – Commissioning & Performance Manager Nicola Quiller – Senior Commissioning & Performance Analyst
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Nicola.Quiller@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **March/April 2023** (with the exception of sickness, where February 2023 is reported).

This report contains information on 26 key indicators. The indicators used at this high-level shows a reduction in system pressure, in particular, handover lost hours and therefore improving quality and performance for the Emergency Medical Service (EMS), but from a low base and with continued extreme handover lost hours. 111 was more stable, having recovered from the business continuity incident in December, but call abandonment remains a problem. The Non-Emergency Patient Transport Service’s (NEPTS) performance is stable. Overall the picture remains a poor one in terms of the quality and safety of the service that the Trust can provide to its patients.

RECOMMENDATION

The Committee is asked to: -

- **Consider** the March/April 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **March/April 2023.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on 26 key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -

   - Our Patients (Quality, Safety and Patient Experience);
   - Our People;
   - Finance and Value; and
   - Partnerships and System Contribution

3. These four areas of focus broadly correlate with the Quadruple aims set out in '*A Healthier Wales*'.

4. As previously agreed, the metrics which form part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium-Term Plan - IMTP) and strategies. This report is based upon the annual review that was endorsed at the July 2022 Finance & Performance Committee with a further annual review now taking place early in May 2023.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

5. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.

6. **999** answering times have been challenged through significant increases in call demand through the year; however, in March 2023 the median and 65th percentile performance were good. The **95th percentile performance declined to a six second answer** time, which is still a good level of performance. An Intelligent Routing Platform (IRP) was switched on in November 2022, which enables BT to re-route 999 calls between different ambulance services in the UK. These re-routed 999 calls accounted for up to 9% of the Trust's daily 999 demand. This percentage continued to increase during December 2022 and on the 21 December 2022 it was suspended, which is a clear factor in the uplift in the Trust's performance. The IRP has now been switched back; however, call volumes at present through this stream are low.

7. No additional funding was secured into 2022/23 for 999 call handlers (demand/relief gap 39 FTEs). A re-roster has been completed within the existing resource envelope.

8. **111 call answering performance remains poorer** than the Trust would want. December 2022 saw unprecedented levels of demand and poor performance. Performance did improve in January, but then declined in February to 28.7%. It has improved marginally in both March and April, with the latest figure being 31.9%, but still remains substantially off target (95%). Negotiations with commissioners earlier in the year suggested that the Trust has broadly the right number of commissioned and funded call handlers in post; however, there has been a recent agreement to uplift numbers by 10 WTE and work is ongoing to recruit these additional staff. Further work is required to reduce capacity lost through sickness absence, aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which will involve a further consideration of the required FTEs to meet demand, the best way to service the demand e.g. dynamic v fixed rosters and implementation of.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT) the P2 and P3 call back times continue to fall below the 90% performance target, with the respective figures for April being 81.6% and 81.9%. These were both improvements on the March 2023 figures. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies. An urgent set of actions within a focused plan are now in place to increase clinician numbers. This includes the introduction of a new base for staff within the Cardiff area, a more focussed recruitment campaign and consideration of expanded numbers of clinical professions. The Trust is currently in dialogue with 111 commissioners on the 2023/24 establishment for 111 clinicians.

10. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for April 2023 was 53%, an improvement when compared to March 2023, but still far below the target of 65%. The Amber 1 median was 59 minutes (ideal 18 minutes) and the Amber 1 95th percentile was 4 hours 13 minutes. Although both times show significant improvements compared to March 2023, these long response times continue to have a direct impact on outcomes for many patients. Actions within the Trust's control include:

    Capacity:

    - Recruitment: the Trust received an additional £3m non-recurring funding in 2022/23 which has allowed the Trust to target the recruitment of 100 FTEs over and above the existing establishment. The Trust had delivered most of the additionality by the end of quarter four with an overall vacancy level of less than 1%. It should be noted that the Trust's 2023-2026 IMTP is predicated on funding for the additionality being recurring, but this is not secure at this time. Some additional funding has also been made available to pilot an Amber Virtual Ward in partnership with St John Cymru.

    - Additional Unscheduled Care Service (UCS) Capacity: the Trust has made additional funding available for third party capacity. Four vehicles a day, seven days a week have been secured with funding through to the end of the financial year (31 March 2023).

Efficiency (rosters, abstractions/sickness absence and post-production lost hours)

- The Ambulance Response roster review completed its go live in November 2022. This was a complex large-scale project involving 1,800 staff, 146 rosters, and 60 working parties. This will have had the equivalent performance impact of +72 FTEs. A project evaluation is being undertaken but is delayed due to no project manager or project support at this time.

- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks).

- Discussions with trade union partners on a range of other potential workforce efficiencies have paused due to industrial action.

Demand Management

- The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate, achieving 13.8% in March 2023.

Red Improvement Actions

- The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully populate the CHARU rosters keys (153 full time equivalents – FTEs, less a Senior Paramedic contribution of 11.5 FTEs). The Trust is commissioned for 52 FTEs currently, so the 89.5 FTEs is an internal movement between the emergency ambulance roster and the CHARU rosters, not additional resource.

- The clinical screening of Red calls. This is being undertaken within additional resource, when possible, but ideally clinical screening, as previously modelled, would require additional FTEs. A further request to model the balance between consult & close v clinical screening is currently being actioned.

- A more efficient response logic. This is complex and is currently being worked through between the Clinical & Medical Directorate and Operations.

- The modelling of the impact of these changes (complete).

11. One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 23,082 hours were lost in April 2023, a decrease compared to the 28,620 hours lost in March 2023. The levels remain so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Despite urgent and high-level discussions taking place between the Trust, Health Board CEOs and the Minister, required improvements have not been made. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, which is providing food for thought for WG about arrangements in the other six health boards. Immediate Release figures for March 2023 were: Red 246 accepted and 19 declined; and Amber 1 160 accepted and 397 declined.

12. **Ambulance Care (formally NEPTS) (Patient Experience)**: performance remains above target for enhanced renal patient arrivals prior to appointment. Discharge performance improved to 83% (target 90%). Overall demand for the service continues to increase, although it has not yet recovered to pre-CoVID-19 levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance. The Unscheduled Care Service (UCS), part of Ambulance Care, is currently being rebased via a modelling exercise.

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported three NRIs to the Delivery Unit in March 2023, compared to twelve in February 2023; fifteen serious patient safety incidents were referred to health boards in March 2023. It should be noted that the relatively small numbers may represent a delay in referral across rather than an actual drop in numbers of serious cases. In March 2023 complaint response times remained low at 20%, failing to meet the 75% target. In the main, many of these incidents will be because of continued longer response times and the actions outlined above therefore are key. The Trust has put more capacity into the Putting Things Right (PTR), which has had a positive impact for the Legal Team and Concerns Administrators responding to patients and families by email and telephone, however, vacancies and the level of concerns continues to severely affect the team. The Trust is concerned for the welfare of the team, given the nature and volume of what colleagues are reviewing. Consideration is being given to what further support can be provided in terms of the team's welfare; and an organisational change process discussion is due to start in April 2023.

14. **Clinical outcomes**: the Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the Computer Aided Dispatch (CAD) and quality assure metrics. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 72.2% in March 2023**,** below the 95% performance target. The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. Work is ongoing on the new call to door time-based metrics for STEMI and Stroke using the following roll out plan:

    - Q3 (Oct – Dec 2022) – criteria to define 'call to door' and a reporting dashboard were determined.
    - Q4 (Jan – Mar 2023) – the data will be tested internally to include data from April 2022.
    - April-June 2023 – approve for ASI reporting.

Our People (workforce resourcing, experience, and safety)

15. **Hours Produced**: The Trust produced 118,141 Ambulance Response ambulance unit hours in April 2023. Emergency ambulance unit hours production (UHP) was 98% in April 2023, thus achieving the 95% target. CHARU UHP also increased month on month to 96% in April (note this is of the commissioned level, which is not the full roll out, which would halve this number). Key to the number of hours

produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving, and the completion of planned recruitment into the CHARUs. It is important to note that the Trust is not fully funded for the CHARU service (52 FTEs v a modelled need of 153 FTEs).

16. **Response Abstractions:** abstraction levels increased to 39% in March 2023, remaining higher than the 30% benchmark. A deep dive is being organised on abstractions. EMS Response sickness abstractions stood at 10.75% in March 2023 (benchmark 5.99%).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.94% in January, improving to 7.99% in February 2023, with indicative figures for March 2023 indicating a move back about 8%. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level.

18. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2023 (72.1%), compliance for Statutory and Mandatory training also dropped significantly below the target achieving 73.69%. The reasons for this decline in Statutory & Mandatory training are being reviewed with a possible reason being new courses.

Finance and Value

19. **Financial Balance**: The Trust has reported outturn performance for February 2023 with a surplus of £12,000, and a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

20. **Post-production lost hours**: the efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. Dialogue between the Trust and TU partners on options for change has paused due to industrial action.

Partnerships/ System Contribution

21. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 13.8% in March 2023, close to the Trust's 2022/23 IMTP ambition of 15%.

22. The Trust **conveyed** 35% of patients to emergency departments in March 2023. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In March 2023, over 9,600 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 709 callers. In the longer term, as the Trust knows, the system needs to transform if it is to become more sustainable. A formal programme to take forward "inverting the triangle" has been established. The Trust has

proceeded with growing the numbers of APPs in training. The current focus is on developing a "strategic case for change" and a stakeholder engagement process.

Summary

26. The indicators used in this high-level report paint a continued poor picture in terms of the quality and safety of the EMS. 111 call answering rates remain problematic, but the clinician call back rates are above or close to target. Ambulance Care NEPTS performance is stable with the UCS being rebased through a modelling exercise. EASC, WG and the 111 Programme Board were very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited and is expected to worsen significantly in 2023/24. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however, for EMS and Ambulance Care (UCS) the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. It remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation and that further actions to shift patient demand left are supported.

RECOMMENDATIONS

The Committee is asked to: -

- **Consider** the March/April 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE

Date	Meeting
10 May-23	Executive Management Team
11 May-23	Quality Safety Patient Experience Committee

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	x	Financial Implications	x

Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x

Welsh Ambulance Services NHS Trust

Monthly Integrated Quality & Performance Report

March/April 2023

Annex 1 – Top Indicator Dashboard

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: April 2023

by Commissioning & Performance Department

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Mar-23	Apr-23	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience						
NHS111 Abandoned Calls	< 5%	18.60%	15.4%	11.8%		R
999 Call Answer Times 95th Percentile	95% in 00:00:06	00:52	00:06	-		G
999 Red Response within 8 minutes	65%	55.2%	47.5%	53.0%		R
999 Amber 1 Median	00:18	01:10	01:35	00:59		R
Stroke Patients with Appropriate Care	95%	TBD	72.2%	-		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	TBD	35.2%	-		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	72%	-		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	82.6%	-		A
National Reportable Incidents reports (NRI)	Reduction Trend	5	3	-		A
Concerns Response within 30 Days	75%	61%	20.0%	-		R

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Mar-23	Apr-23	2 Year Trend	RAG
Our People						
Capacity						
EMS Abstraction Rate	29.92%	42.00%	39%	-		R
Hours Produced for Emergency Ambulances	95%	95.0%	95%	98%		G
Health and Wellbeing						
Sickness Absence *(all staff)*	8.00%	10.48%	-	-		G
EMS Operations Sickness Rates	8.00%	7.76%	10.75%	-		R
Staff Turnover Rate	Reduction Trend	8.71%	10.38%	-		A
Statutory & Mandatory Training	>85%	82.3%	65.05%	75.55%		R
PADR/Medical Appraisal	>85%	60%	72.1%	-		A
Value						
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	-	-		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	TBD	9916	9631		R
Partnerships / System Contribution						
NHS111 Consult and Close	Increasing Trend	TBD	973	-		A
Combined 999 & NHS111 Consult & Close	15.0%	TBD	13.8%	-		A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	11.92%	11.11%	-		A
Number of Handover Lost Hours	25% reduction from Oct-21	15,955	28,620	23,082		R

In-Month RAG Indicates =

Green: Performance is at or has exceeded the target *(Indicates no action is required)*

Amber: Performance is at or within 10% of target *(Indicates some issues/risks to performance (monitoring is required))*

Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

TBD: Status cannot be calculated (To Be Determined)

Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

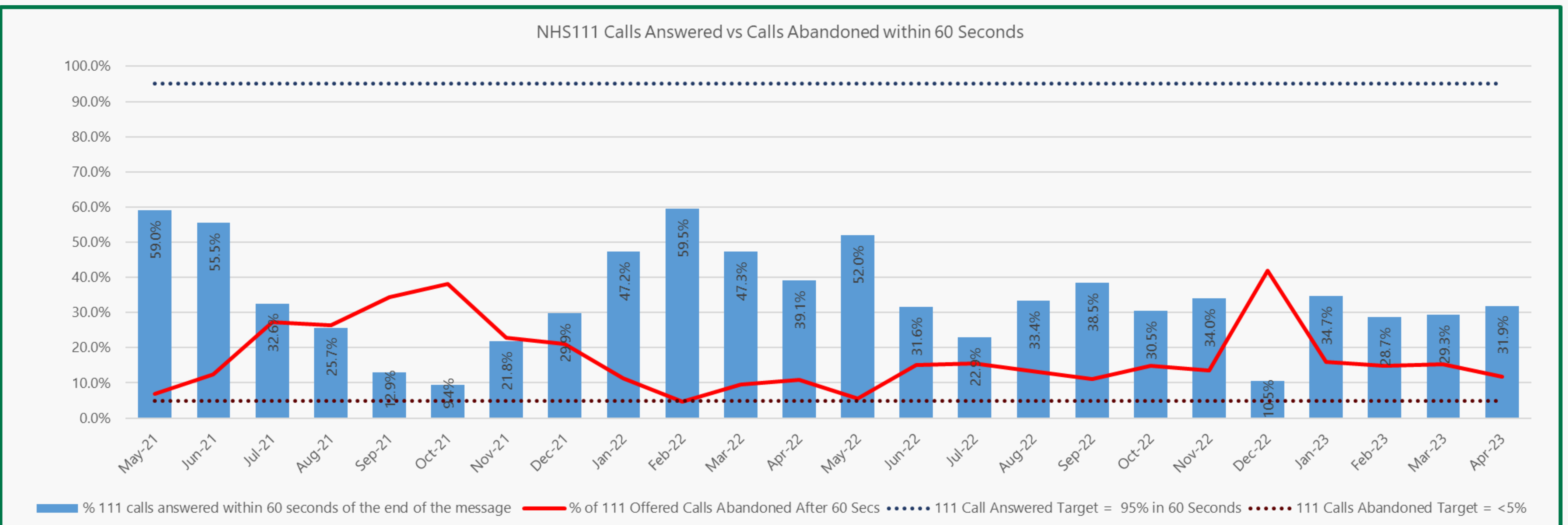
(Responsible Officer: Lee Brooks)

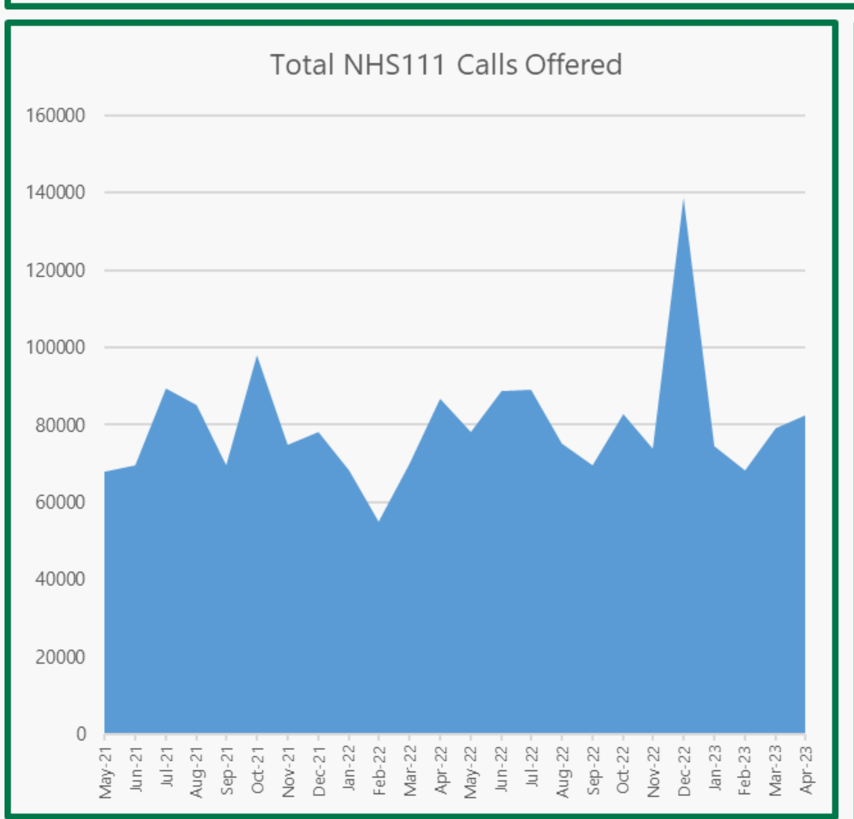
R

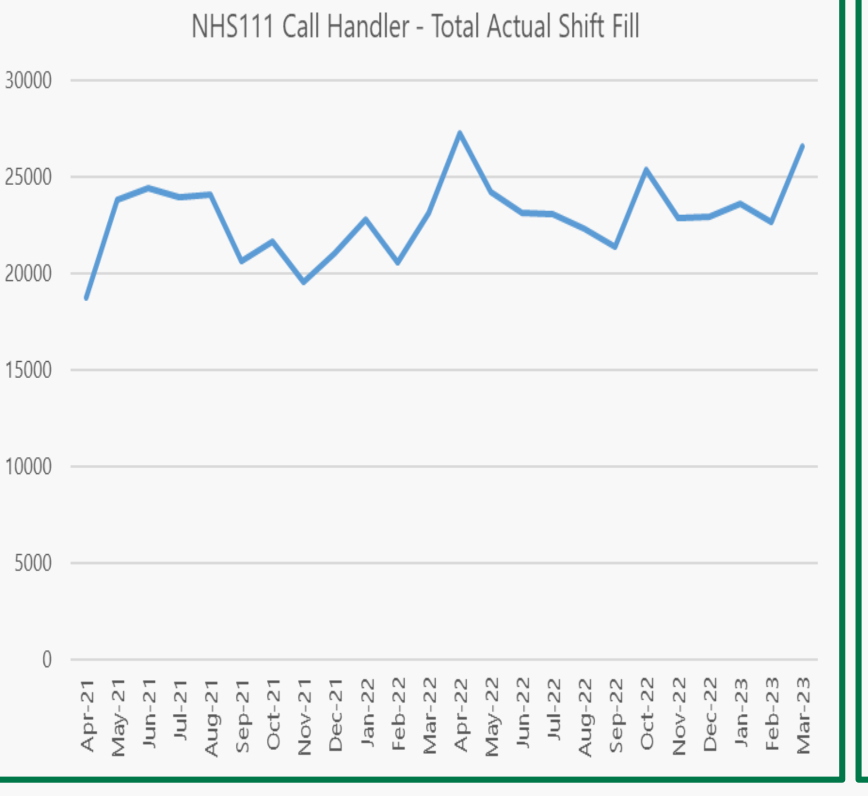
FPC

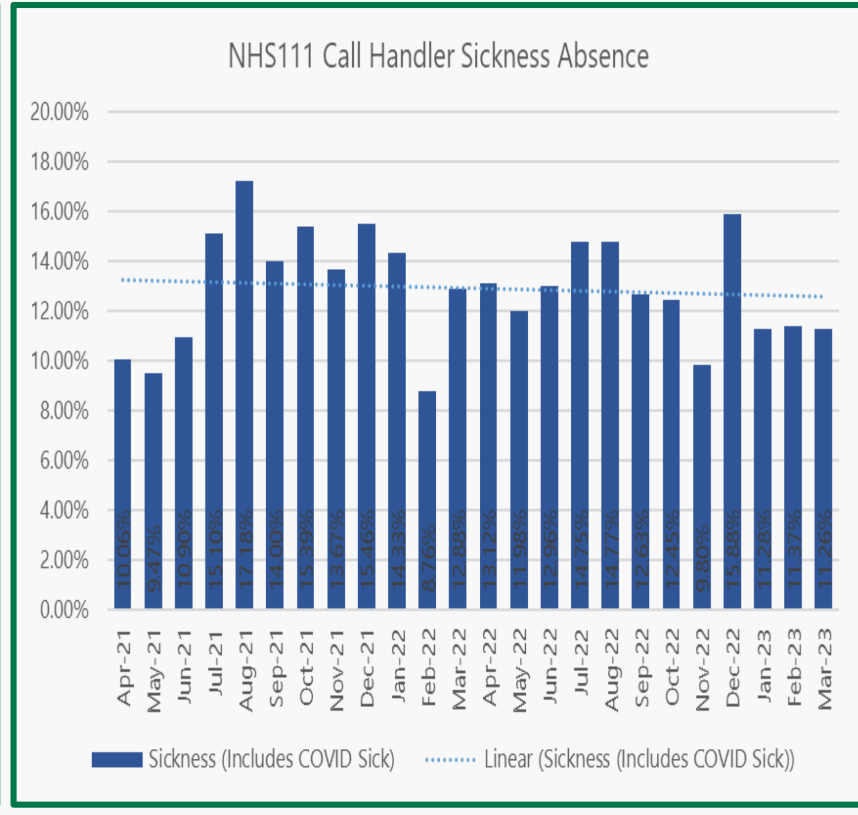
Influencing Factors – Demand and Call Handling Hours Produced

NB: Apr-23 Abstraction data not yet published









Analysis

111 call abandonment is a key patient safety indicator for the service. **April 2023** saw an abandonment rate of 11.8%, an improvement when compared to the 15.4% figure seen in March 2023, but still failing to meet the 5% target. April 2023 also saw 111 call demand increase by 4.3% when compared to March, seeing 82,567 calls offered during the month.

The percentage of 111 calls answered within 60 seconds of the end of the message increased again in April 2023 to 31.9%, which is the second month in a row to see an improvement, but remains significantly below the 95% target.

Capacity (staff hours) has generally been increasing in line with the recruitment plan; however, this is impacted by sickness abstractions for Call Handlers (including COVID-19 Sickness) which remains higher than the agreed trajectory at 10.77%.

December 2022 saw the service receive unprecedented demand which resulted in a Business Continuity incident. Calls reached as high as 3000-4000 calls during weekdays in late December with weekends seeing highs of over 6000 calls a day. The weekend between Christmas and New Year saw the highest demand, recording over 8000 calls on the Sunday. The demand resulted in infrastructure systems not being able to support the number of calls and immediate resolutions were required to keep the service online. This included changing the call waiting length along with additional servers being installed to meet the demand.

Remedial Plans and Actions

The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency.

- Agreement has been reached with commissioners that 188 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment; but vacancies have been appointed to.
- Work continues on sickness absence in line with the Trust's managing absence work programme
- Work with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore call times are related to clinician availability. At present there are high levels of vacancies in this area.

Expected Performance Trajectory

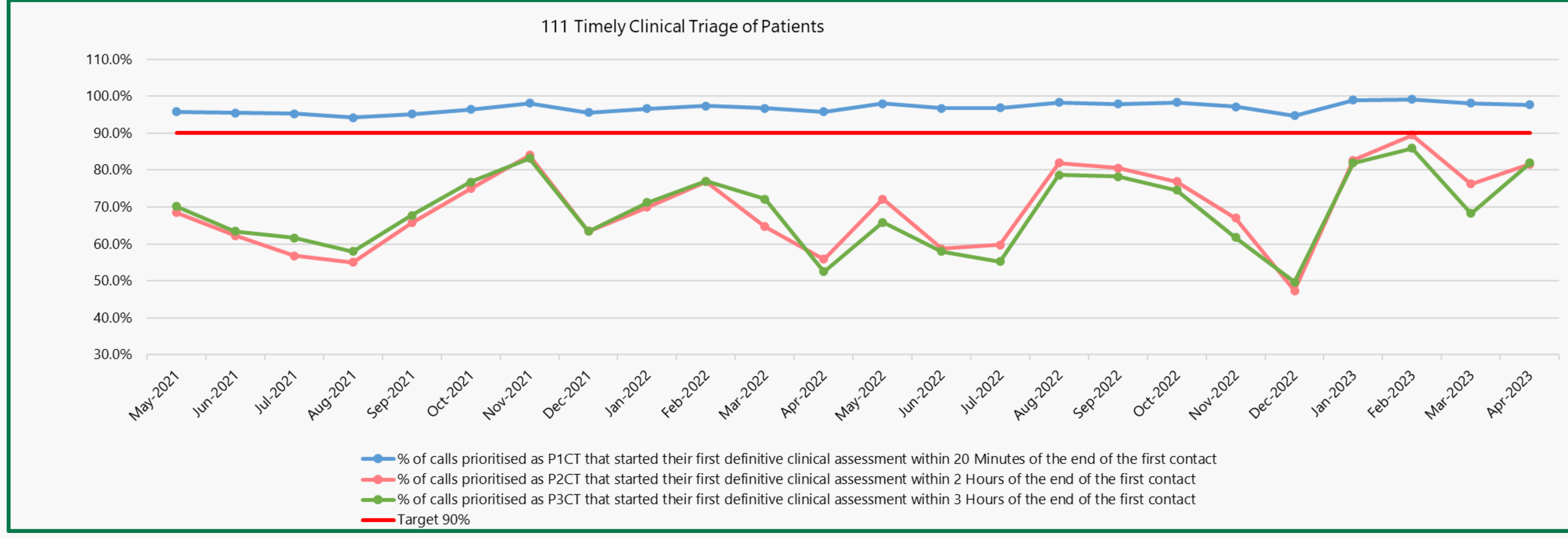
As call handler numbers broadly reach commissioned levels, call answering times will only be further improved through efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line).
If high demand levels persist, performance will continue to be affected due to levels of call handlers and clinicians not matching the demand.

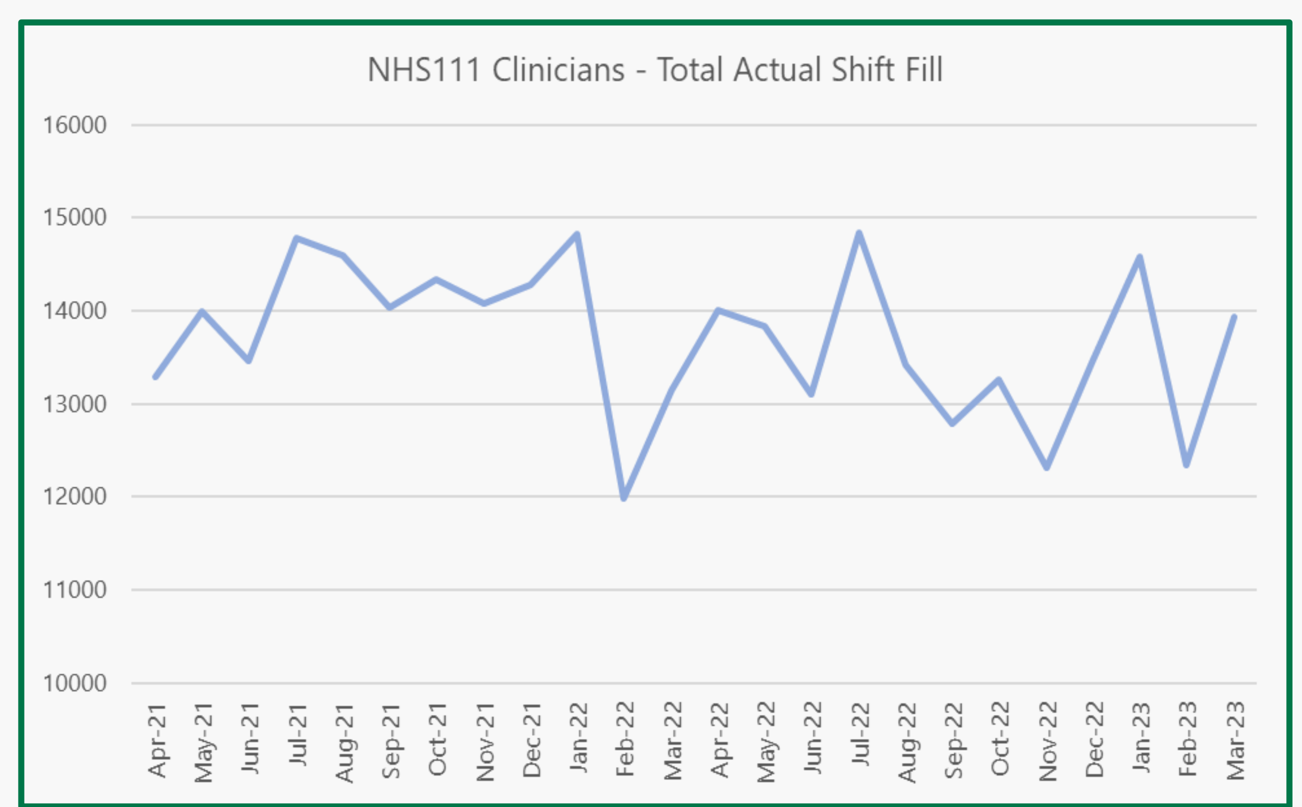
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

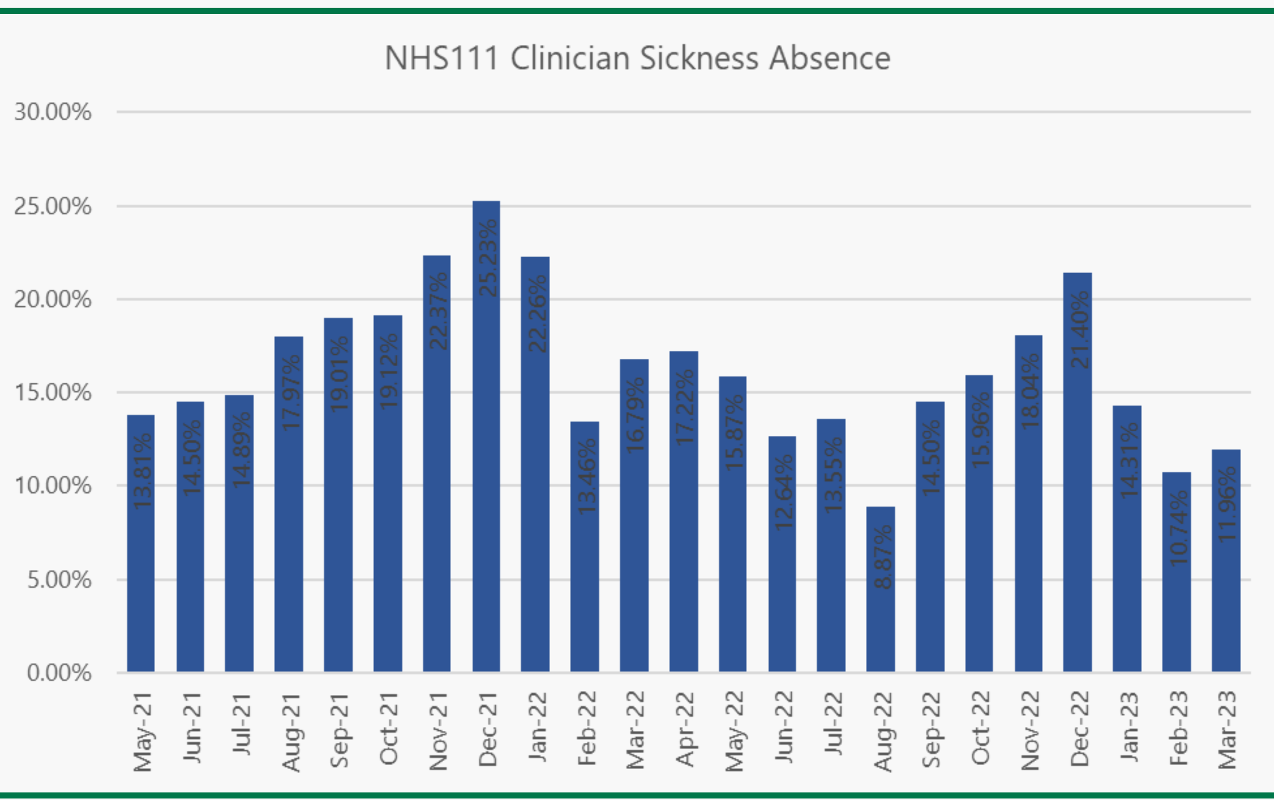
(Responsible Officer: Lee Brooks)

P1CT
G

FPC







Analysis

The performance of **111 calls receiving a timely response to start their definitive clinical assessment saw a general increase across the priorities. The highest priority calls, P1CT, continues to achieve the 90% target (which it has done for the past 2 years), although the figure for April 2023 decreased slightly to 97.7%.**

For lower category calls (P2CT & P3CT) the figures increased in April 2023 when compared to March, with P2CT achieving 81.6% and P3CT to 81.9%.

Recruitment and retention of clinical staff continues to be a key issue.

13,935 hours were filled by clinicians in March 2023, an increase when compared to the 12,342 seen in February 2023. Clinician sickness absence increased from 10.74% in February 2023 to 11.96% in March 2023.

Remedial Plans and Actions

The main driver for improved performance will be the correct number of clinicians in post to manage current and expected demand. At present 104.4 FTE nurses and paramedics are in post, with a vacancy rate of 35.6 FTEs (13.5 clinicians have been appointed). Urgent actions have been put in place to increase recruitment, including:

- Utilisation of other clinicians to fill vacancies;
- Maximising opportunities through remote / agile working;
- Review of existing staff bases including agreement to creating an additional Cardiff base, operational from mid-December;
- Review of service model following Adastra outage / BCI;
- Targeted recruitment drive, which has commenced.

Expected Performance Trajectory

Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Although urgent actions are now in play, as set out above, performance is likely to remain below expected levels until towards the end of Q4. Demand for the 111 service is also more difficult to forecast as it is often linked to government announcements or media coverage.

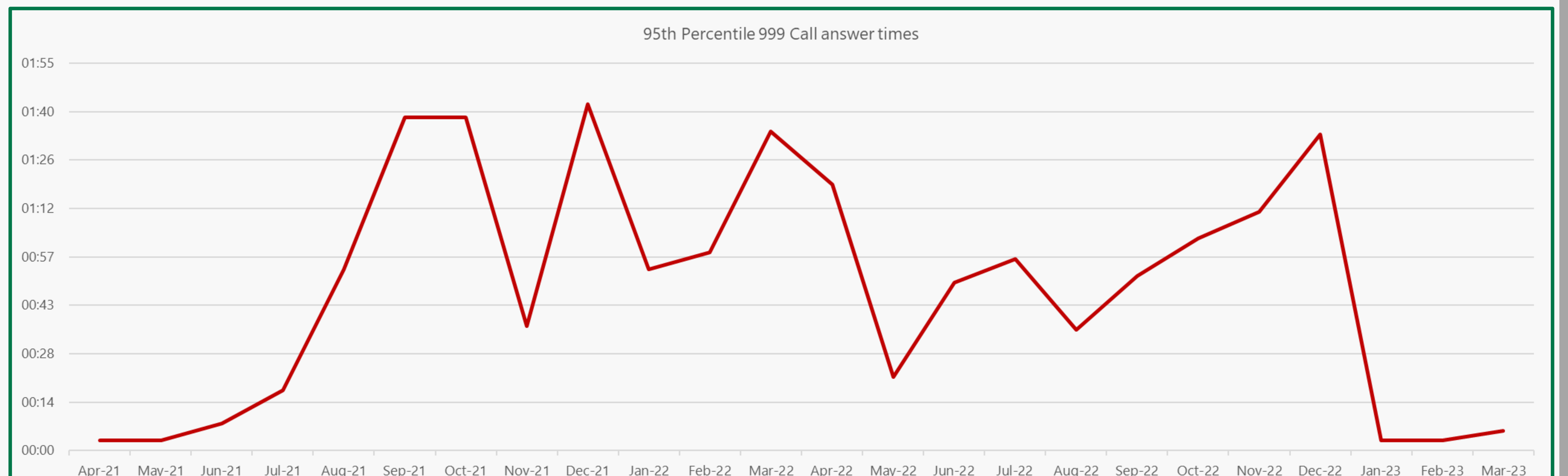
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

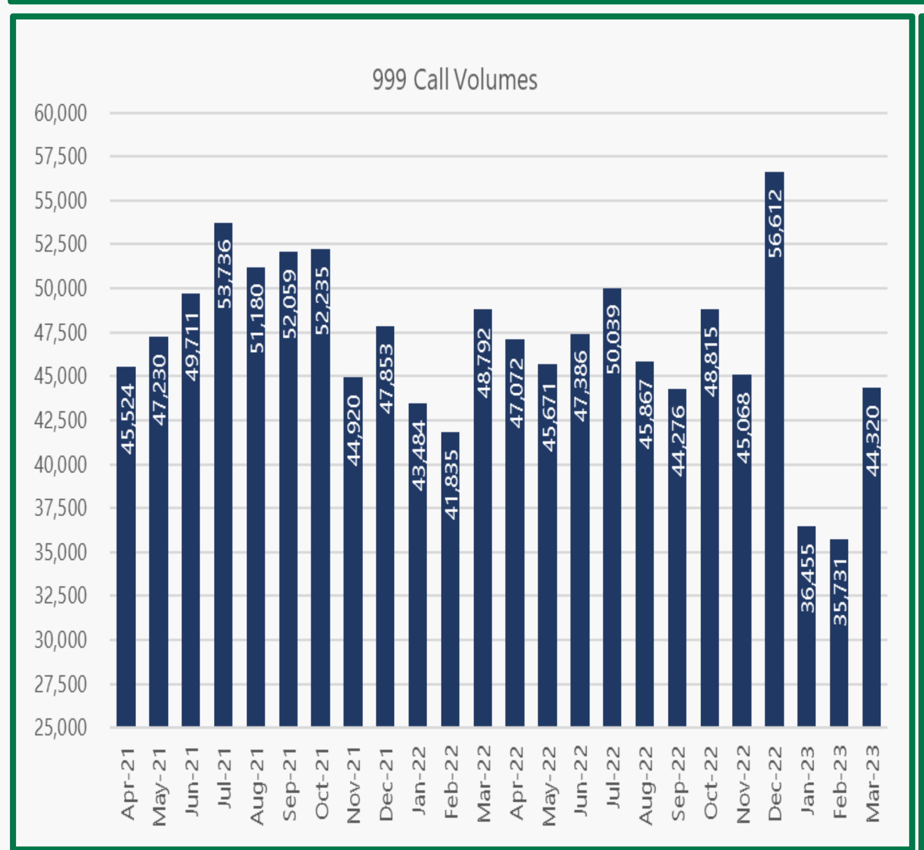
(Responsible Officer: Lee Brooks)

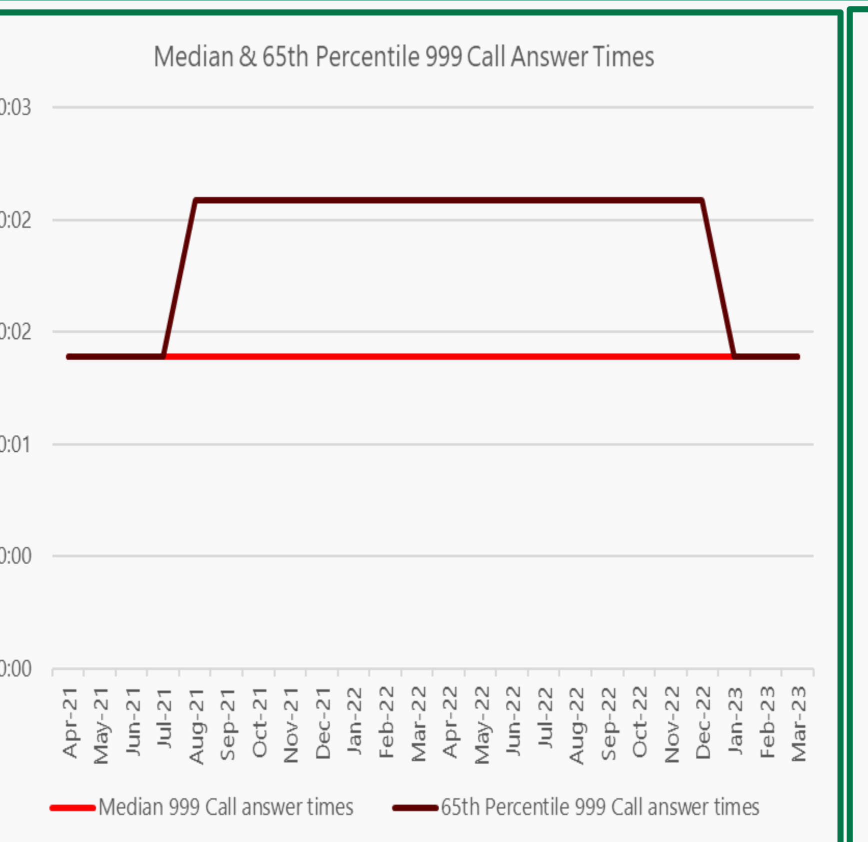
G

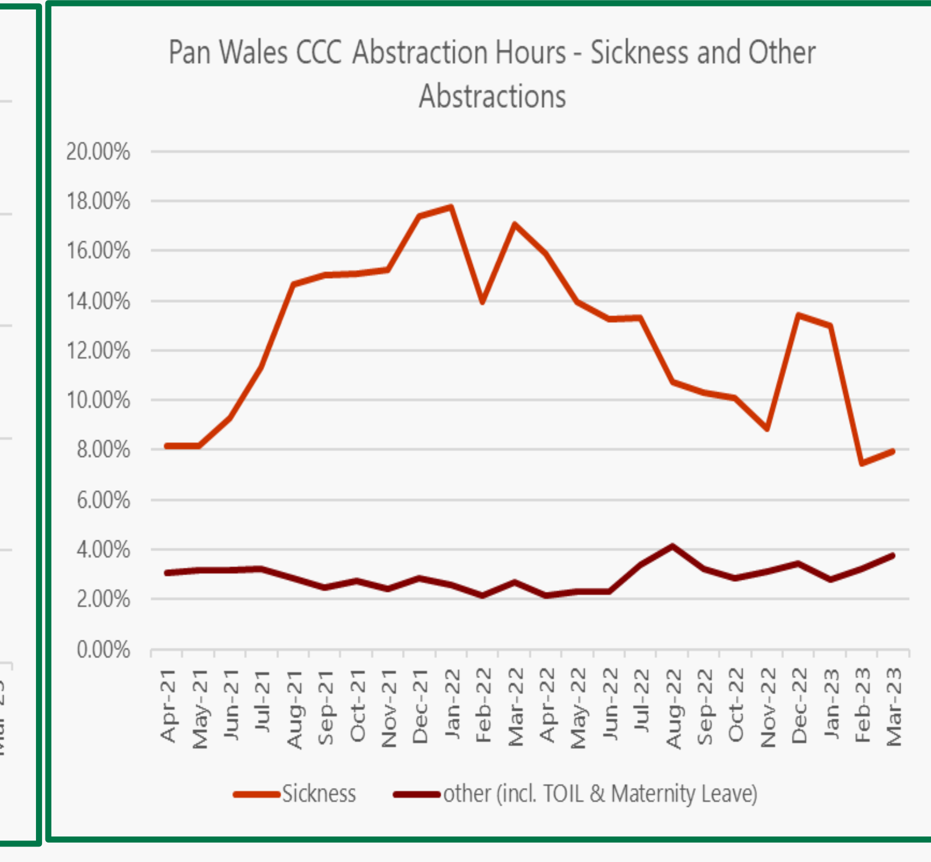
CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance increased to 6 seconds which remains within the 6 second target. This continues to be a significant improvement compared to the 1 minute 34 seconds seen in December 2022, but a marginal decline when compared to the 3 seconds achieved in both January and February 2023.

The median call answer time for 999 services remains consistent at 2 seconds.

The Trust received 44,320 emergency 999 calls in March 2023, an increase from the 35,731 calls received in February 2023. This increase, along with a small rise in sickness abstractions, impacted slightly on the Trust's ability to answer calls in a timely manner. However overall sickness abstractions are on a downward trajectory, and the figure within EMS Co-ordination pan-Wales remained below 8% for the second consecutive month (7.92%).

Remedial Plans and Actions

- EMS Coordination meet twice weekly to review demand profiles and align staffing levels appropriately.
- No additional funding is available this year to increase numbers of call handlers.
- Increased pressure and sustained levels of 999 demand is impacting on staff attrition and wellbeing.
- EMD FTE is currently 111.34 against a funded establishment of 111.76.
- Intelligent Routing Platform is now in operation following configuration changes
- Additional EMD training cohorts are scheduled for May start dates with further recruitment scheduled for September.
- The final work-streams of the EMS Reconfiguration project have been re-started (these have been delayed by the pandemic and escalation levels).

Expected Performance Trajectory

January, February and March 2023 performance almost met required targets for % answered in 6 seconds; however, demand is going up, there is a 39 FTE gap between the modelled current requirement and funded establishment and there is no more funding available. No performance forecast has been undertaken, but based on the above it is r

Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

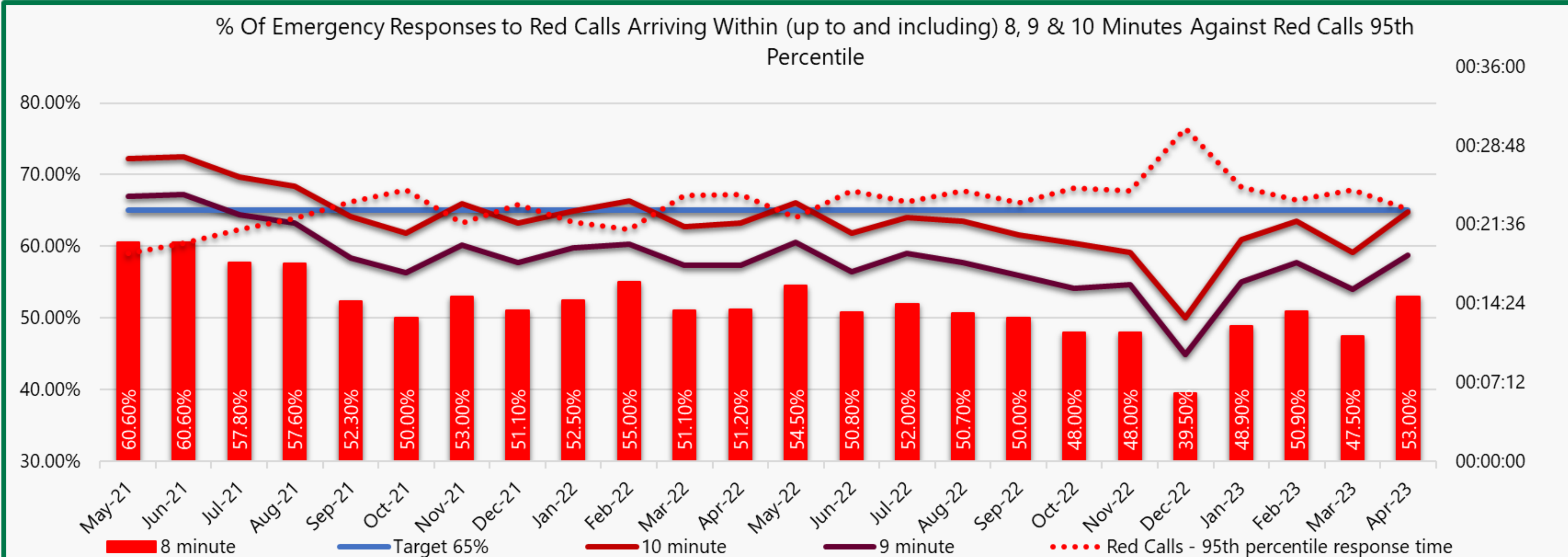
(Responsible Officer: Lee Brooks)

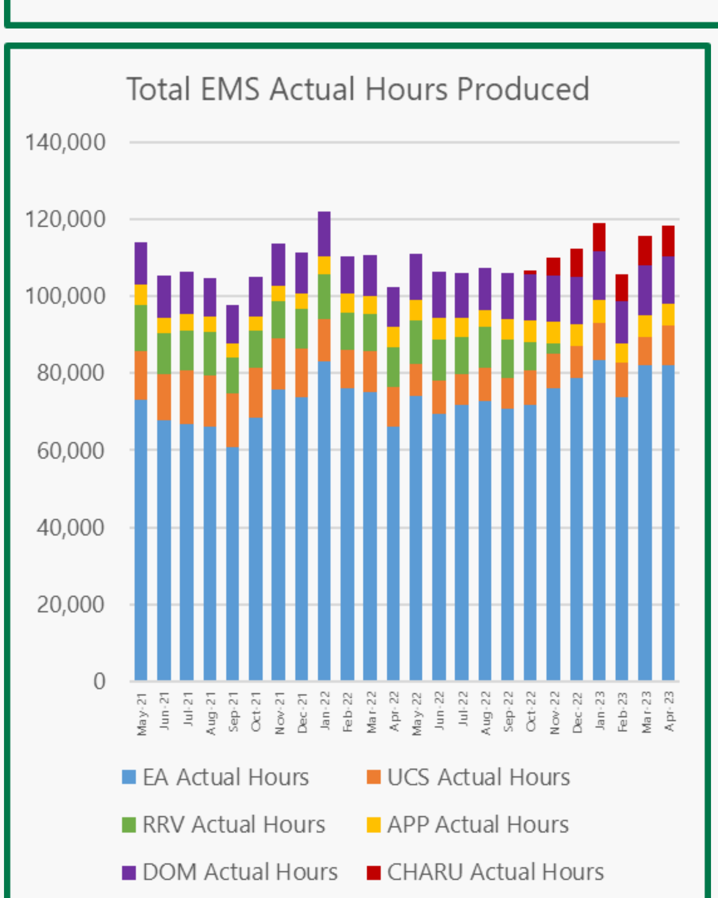
65% R

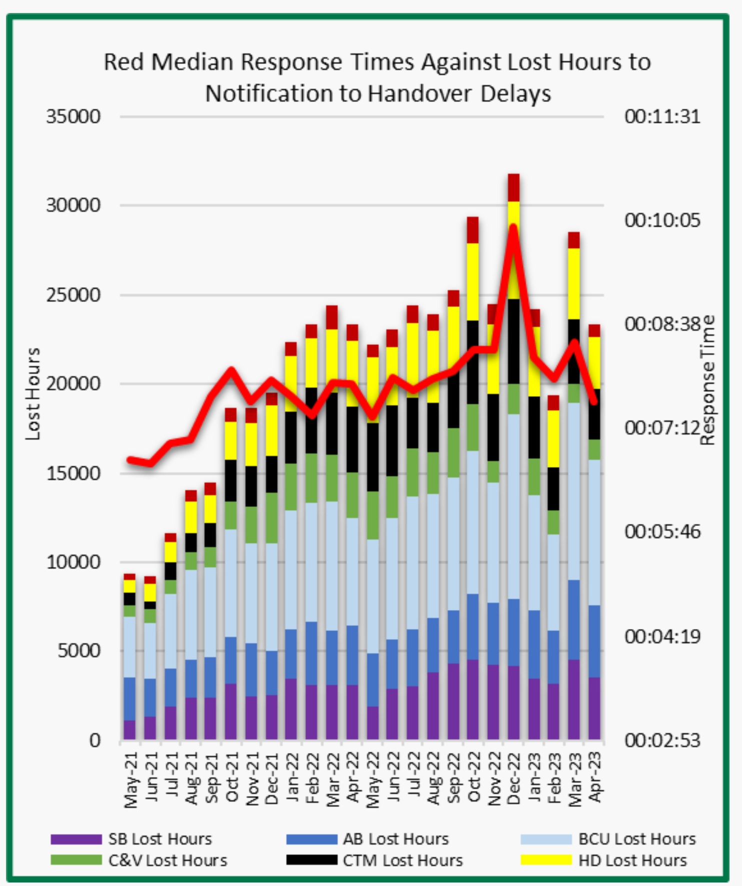
95% R

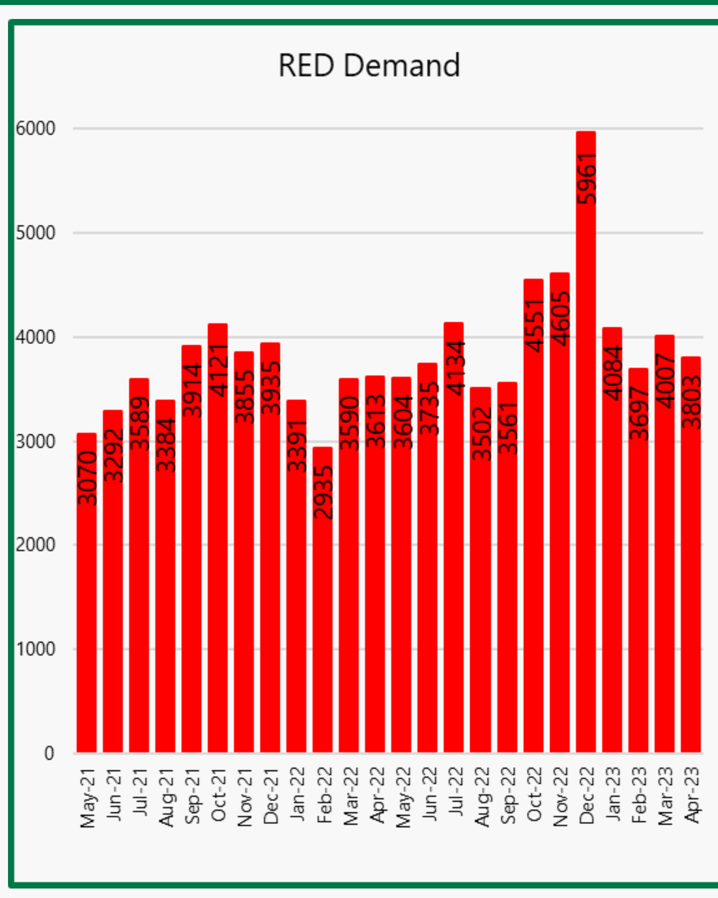
QUEST

CI









Analysis

Red performance improved in April 2023, with Red 8 minute performance increasing to 53% but remaining below the 65% target; which has not been achieved since July 2020. Although there was variation between the health boards, none of the seven achieved the 65% target. Red 10-minute performance was 64.8% for April 2023, improving from 59.2% in March.

Three of the main determinants of Red performance are Red demand, unit hours produced, and handover lost hours.

Red demand over the past 2 years had seen a steadily increasing trend, which was outside of normal expected variation, and was impacting upon response times. This reached a peak in December 2022, with demand recorded at 5,961, however, the first 4 months of 2023 have seen reductions in this figure, with April 2023 recording 3,803 incidents. However, red demand continues to remain above levels recorded for the same period last year.

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. After peaking at over 32,000 lost hours in December 2022, this area did show a significantly improving picture in January 2023 (23,525) and February 2023 (19,110), before deteriorating again in March 2023 (28,620). However, April 2023 has once again seen the figure decrease to 23,082, although this level continues to have an impact on overall service.

There are other factors which affect Red performance, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues. Industrial Action days will also affect performance.

Remedial Plans and Actions

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23 (off target by end of Jan 2023, but +90 delivered by the end of Mar 2023);
- Full roll out of the Cymru High Acuity Response Unit (CHARU);
- Potential changes to the response logic and clinical screening of calls;
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of Integrated Medium Term Plan (IMTP) (8% by Mar-23/6% Mar-24);
- Health Board handover reduction plans are in place;
- Improving efficiency; the role out of new Response rosters provided the equivalent of 72 WTE additional staff (action complete);
- A clinical review of Red demand using ePCR data (initial findings reported to EMT);
- Tactical responses linked to escalation including: clinical managers responding, DOMs responding, targeted overtime on demand hot spots(actioned);
- Modelling of full roll out of Same Day Emergency Care (SDECs) by health boards and further modelling on Red improvements (completed).

Expected Performance Trajectory

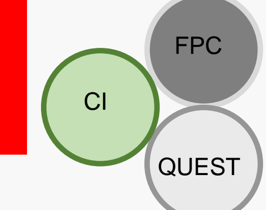
The Red modelling estimates a 7% point improvement in Red 8 minute performance if CHARUs are fully rolled out and associated Red improvement actions are delivered..

*NB: Data correct at time of abstraction

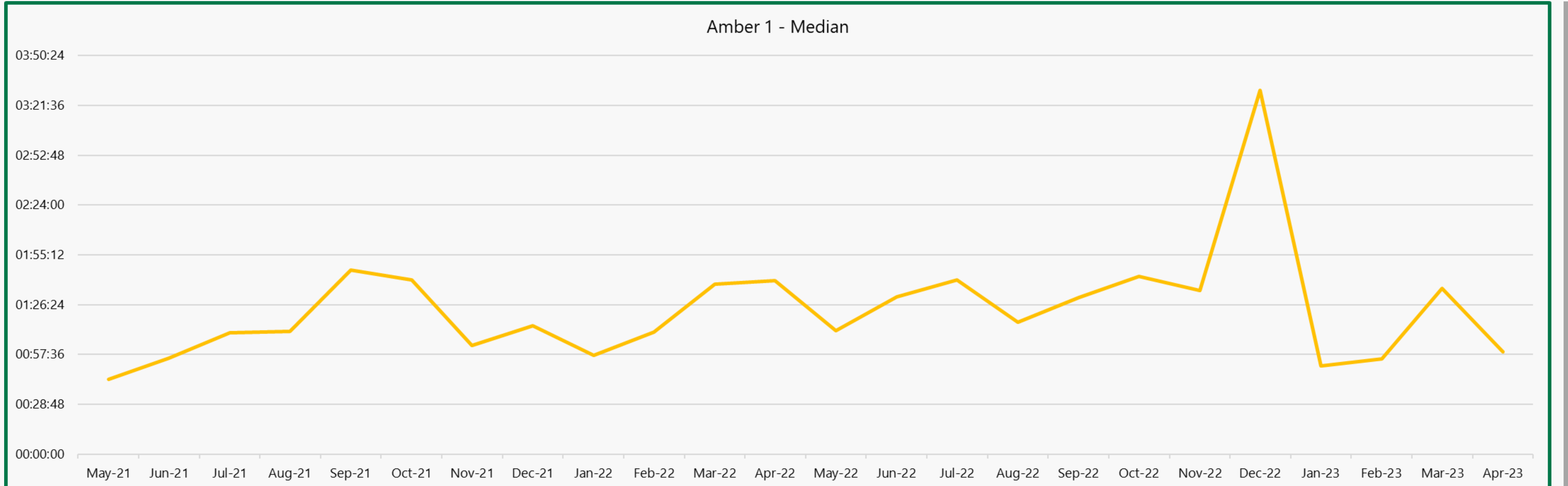
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

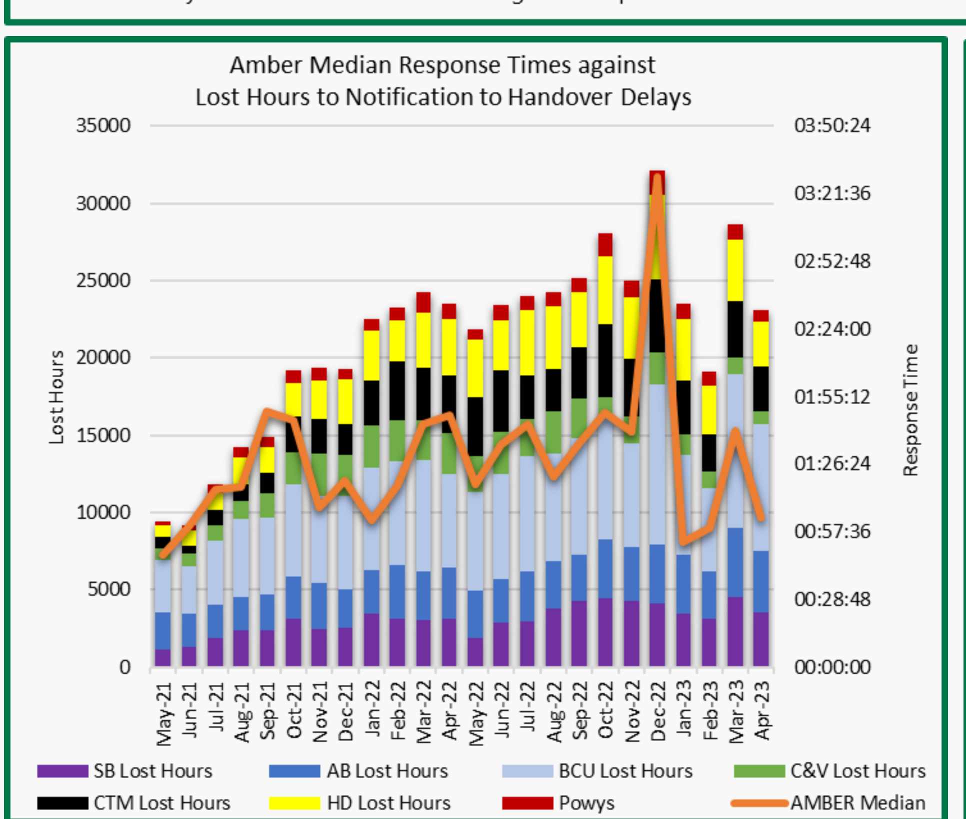
(Responsible Officer: Lee Brooks)

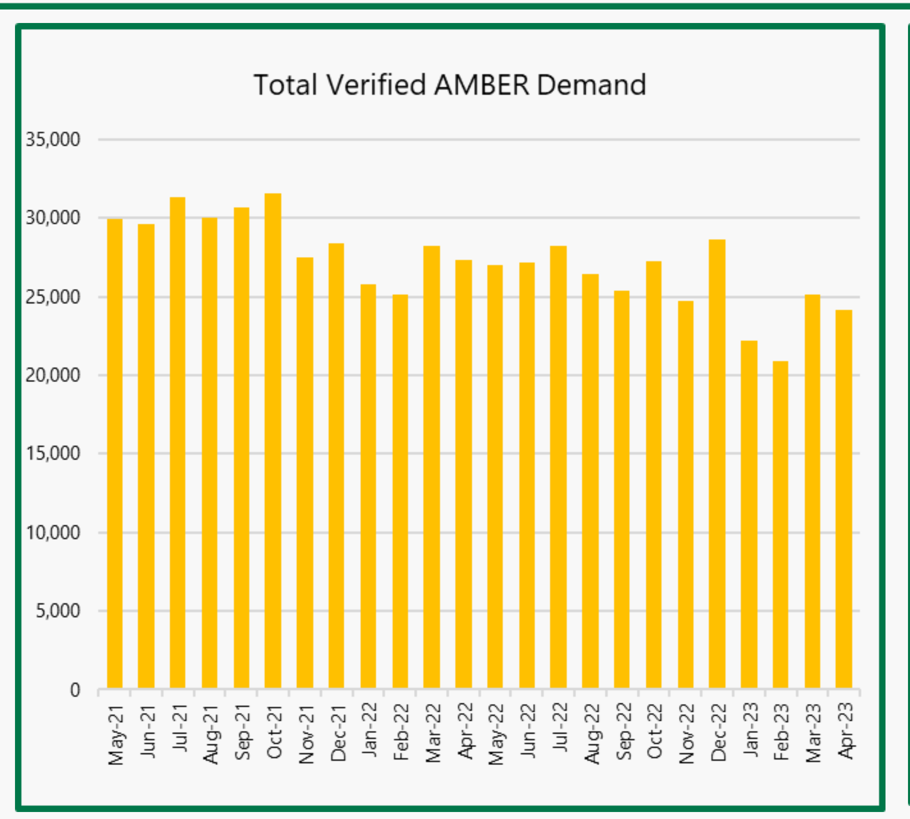
R

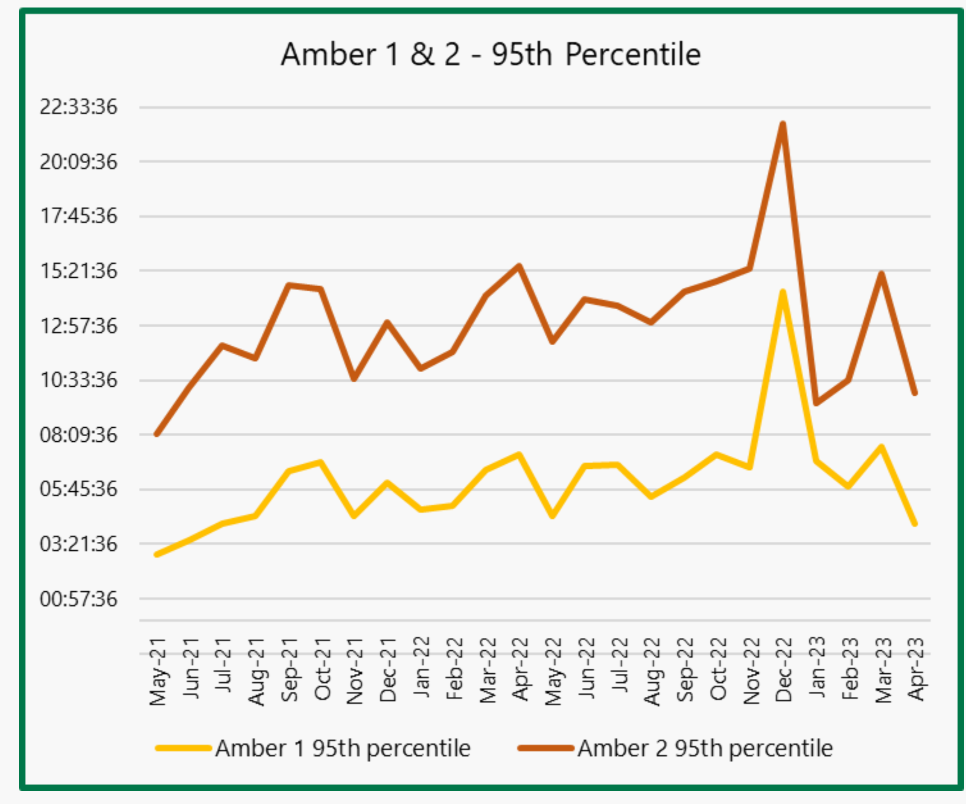


Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Following a slight rise in the Amber 1 median response times during March 2023 to 1 hour 35 minutes, the metric improved in April, falling to 59 minutes and 4 seconds. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also reduced to 4 hours and 13 minutes, which is the lowest it has been since July 2021 (however, this remains above the ideal figure of 40 minutes).

There were still some long patient waits in April 2023, with 2,670 patients (all categories, not just Amber) waiting over 4 hours. This is a very small increase on last month, but is the highest figure so far recorded in 2023.

Amber demand decreased in April 2023 to 24,143 verified incidents.

As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The Trust carefully monitors long response times and their impact on patient safety and outcomes. The Trust supplies regular information to the CASC and EASC; and from November 2020 the Trust began producing monthly quality, safety & patient experience (QSPE) reports for each health board. The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change.*

Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

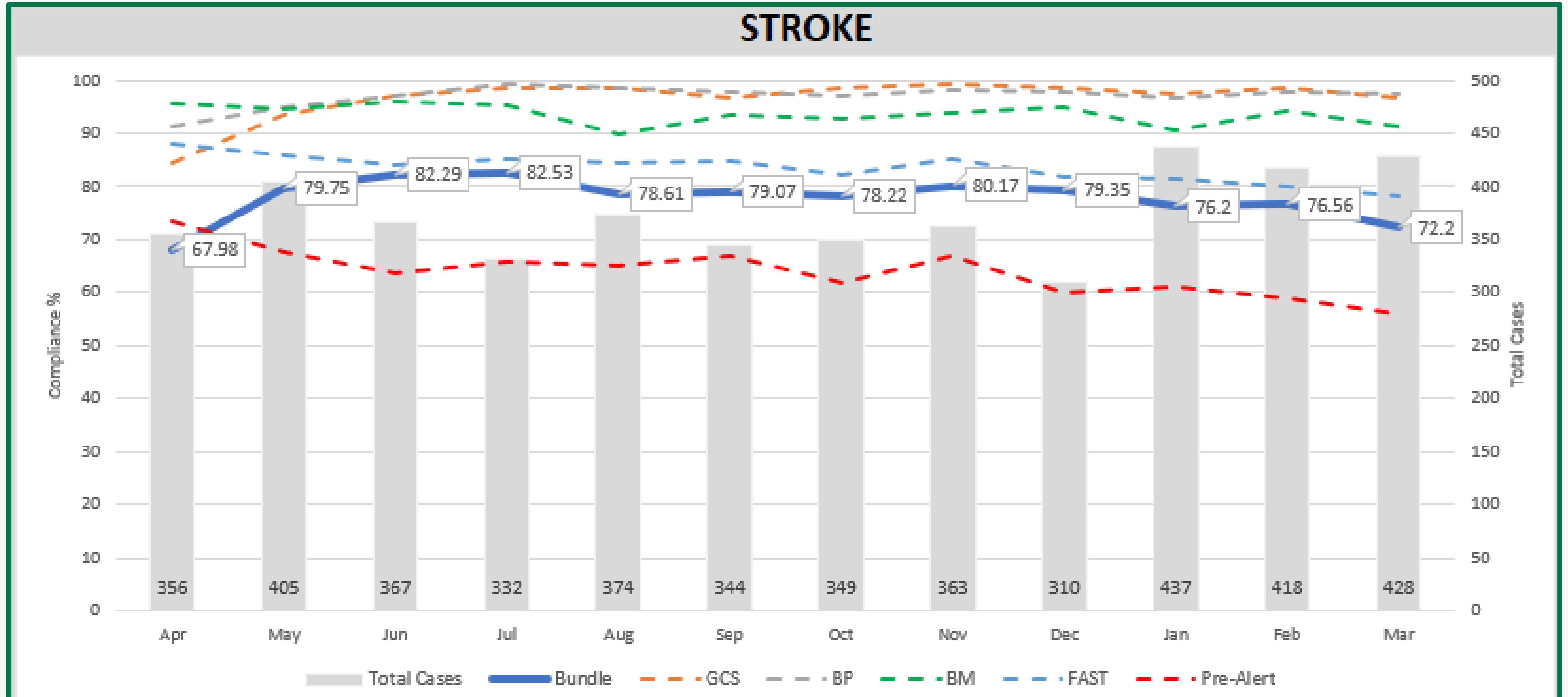
(Responsible Officer: Andy Swinburn)

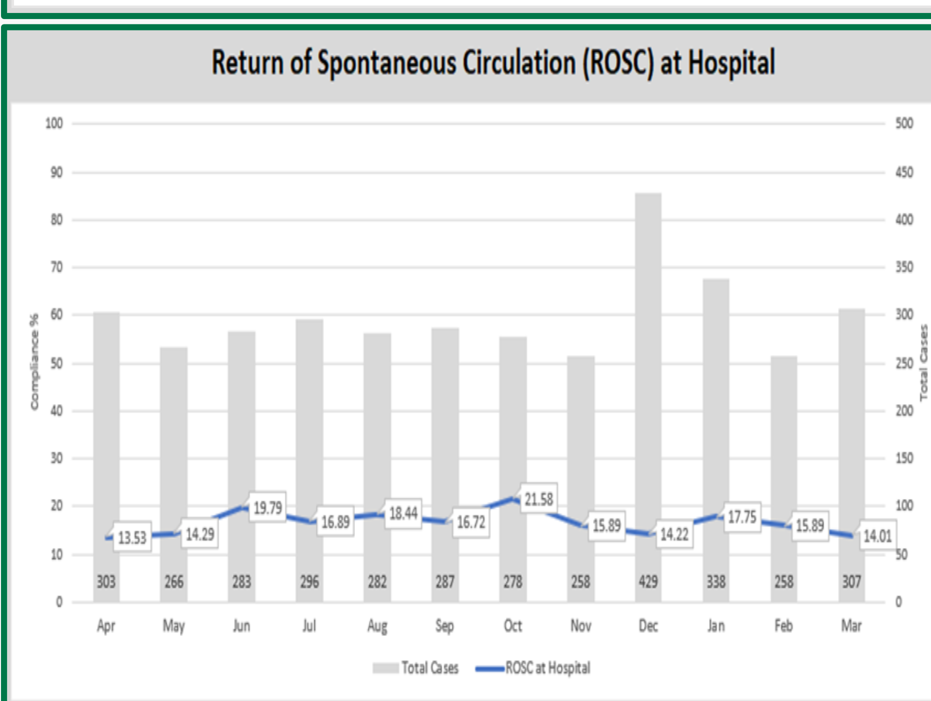
Stroke/Hip Fracture/Hypo glycaemic. R

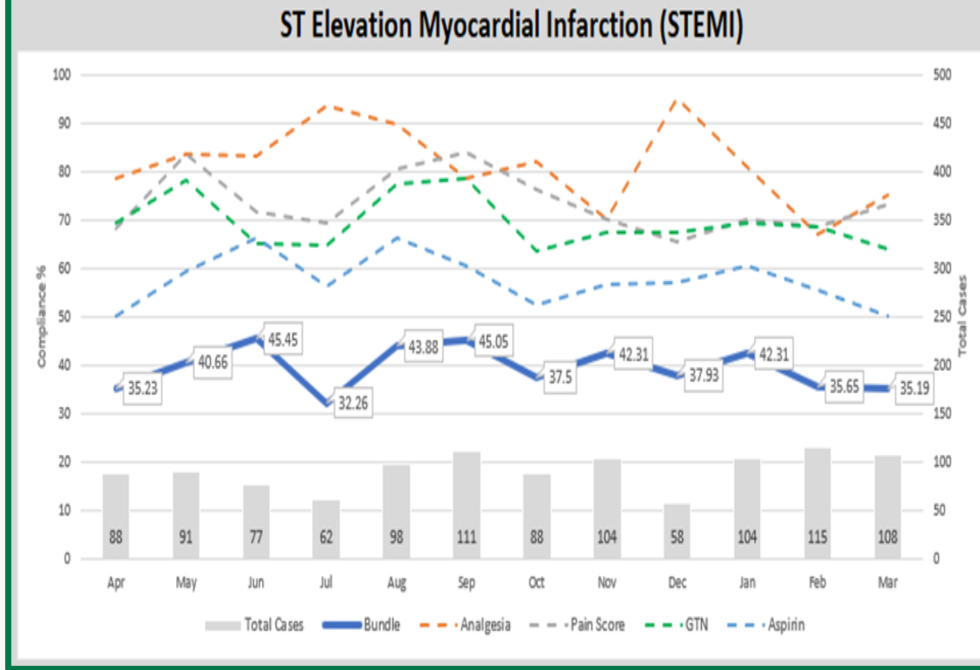
Self Assessment: Strength of Internal Control: Moderate

QUEST

Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, Acute Coronary Syndrome Patients with Appropriate Care







Analysis

The Trust currently uses ePCR to report five clinical indicators (CI) to the Emergency Ambulance Services Committee (EASC) , Fractured Neck of Femur (#NOF), Stroke, ST elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return Of Spontaneous Circulation (ROSC at hospital). Work continues to develop and quality assure these metrics.

It is likely that as the system continues to embed within clinical practice, and as users continue to get used to an adjusted workflow that data points might be missed. An improvement approach has been taken and a series of 'Top Tips' posters have been circulated and specifically shared with Senior Paramedics to support their conversations with WAST clinicians as part of the ride-out process. This is based on deep dive quality assurance audits conducted for each of the CIs and reported through the Clinical Intelligence Assurance Group prior to approving publishing CI data as Ambulance Service Indicators to EASC. In addition, the deep dive quality assurance audits are contributing to recommending improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application, change requests have been submitted to Terrafix and are being processed.

Remedial Plans and Actions

The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. The Clinical team are focussing on reporting of key clinical indicators and themes within reporting to ensure that good clinical practice is captured and reported.

New agreed indicators for this year (commissioning intention) include:
(1) Call to door time for STEMI and Stroke and;
(2) Reporting on Outcomes (by response type).
There is a lot of work required to agree and then report on these indicators:

Q3 (Oct – Dec 2022)

(1) Discussions commenced between the CIAT/HI/NCCU to define 'call to door' and 'at hospital' for the STEMI & Stroke time-based metrics. The various data points available are not always consistently available for all calls so options on the best approach will be discussed and decided on at the CIAG.
(2) Establish initial requirements with the NCCU for Reporting on Outcomes (by response type), this may be by staff grade, patients conveyed or not conveyed. Initial consideration is to use Stroke and #NOF data.

Q4 (Jan – Mar 2023)

(1) Work continued with CIAT/HI/NCCU to decide on the most appropriate data points, taking into consideration those used by English Ambulance Trusts to look at potentially comparing like-for-like data.
HI have produced sample data (December 2022) for discussion at CIAG which has representation from the NCCU.
Review potential data points for use as test data/discussed with NCCU.
Test reporting with initial data points/discussed with NCCU.

Q1 (Apr - Jun 2023)

(1) Agree criteria and reporting format for STEMI and Stroke time based metrics.
Develop the time-based metrics dashboard and test the data internally to include data from April 2022
Approve time based metrics for ASI reporting.
(2) Submit sample data (December 2022) to CIAG for the Reporting on Outcomes (by response type).

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients. This has been in place since October 2022 in some areas.

Expected Performance Trajectory

As shown throughout the UK, the implementation of CHARUs will aid the Trust in successfully increasing ROSC rates. Once CHARU has been implemented fully it is anticipated that ROSC rates should increase.

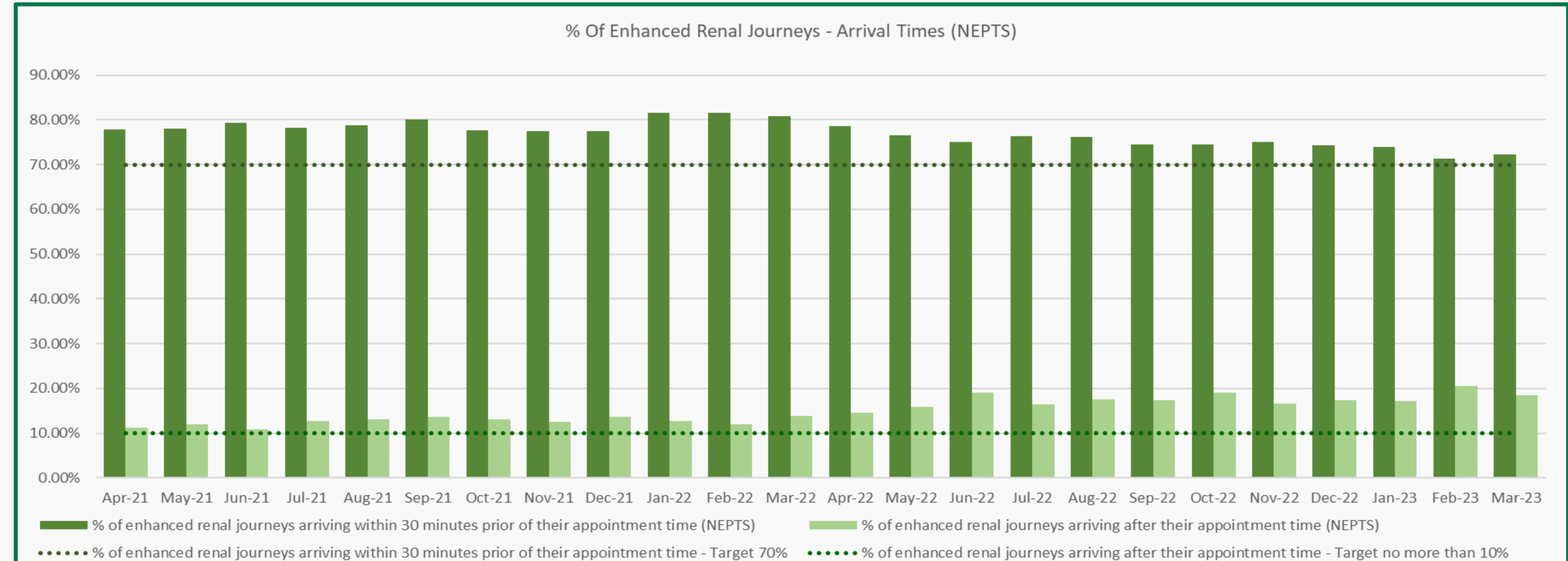
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators
Patient Experience

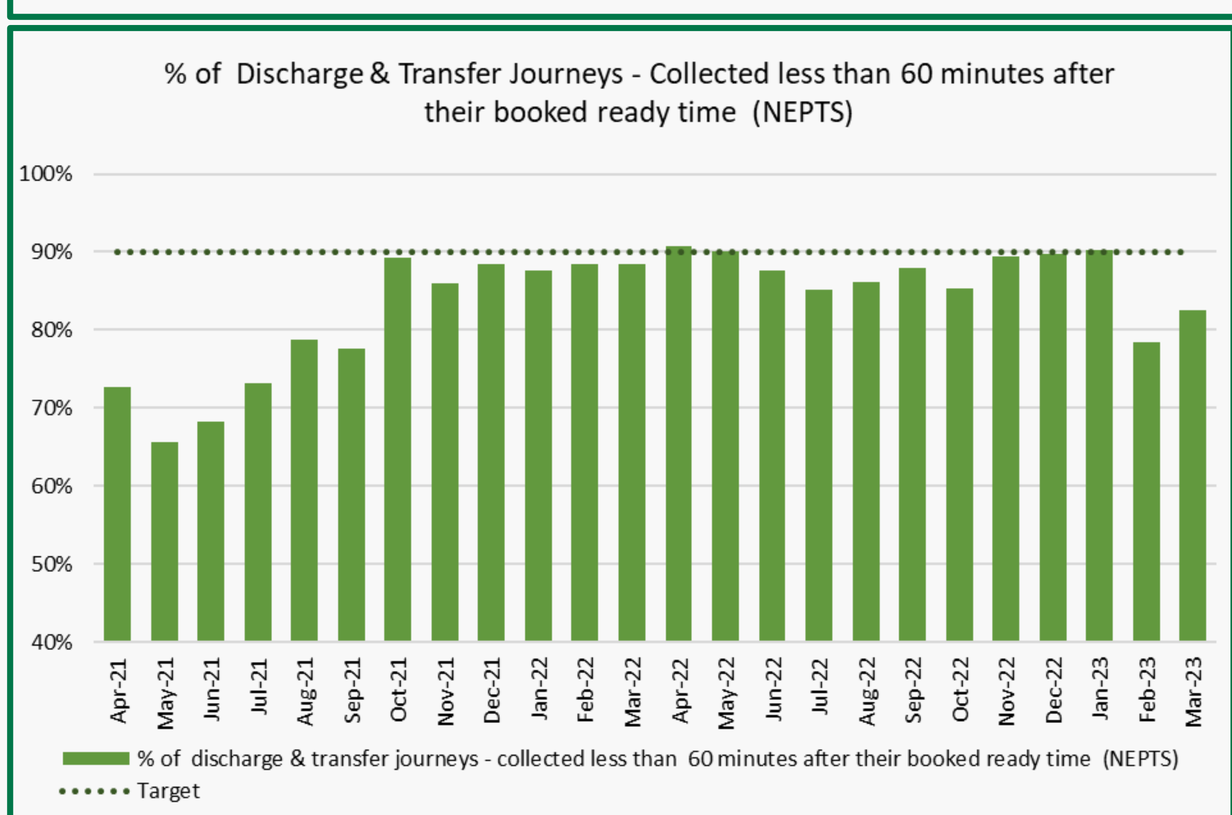
(Responsible Officer: Lee Brooks)

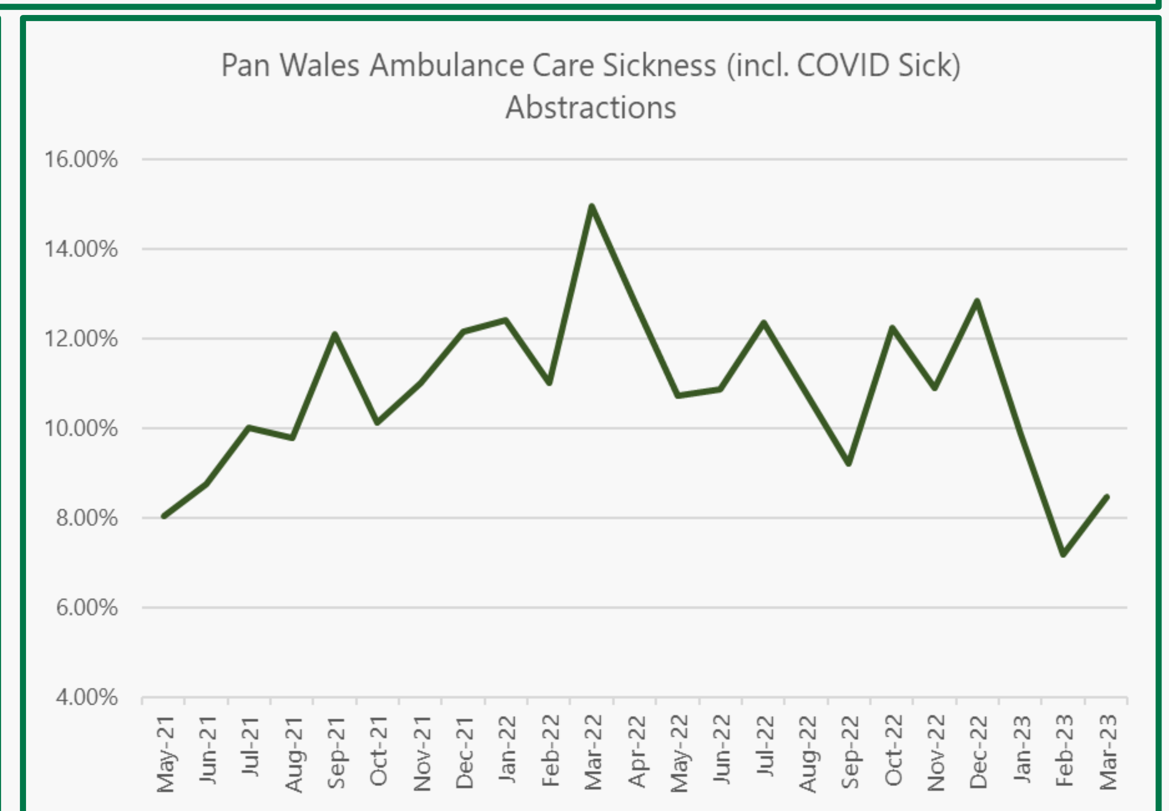
Renal	D&T
G	A

FPC

CI







Analysis

Ambulance Care (NEPTS element) performance improved marginally during March 2023. 72.3% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target, and up from 71.4% the previous month.

83% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, the second consecutive month where the 90% target has not been achieved.

Key factors affecting these indicators are demand and capacity:

- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but generally it is still not quite at pre-pandemic levels.
- Increased pressure on the unscheduled care system has increased the volume and proportion of on the day, short notice bookings for discharge & transfers
- As the Trust continues to emerge out of pandemic response and the health system is "re-set" it is anticipated that further demand increases will be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.
- Days of continuing Industrial Action have adversely affected the Trust's capacity during the past few months.

Remedial Plans and Actions

- D&C Project: currently awaiting feedback from tests of change for revised roster keys. Once received, the draft PID will be completed. Aim was to deliver by November 2022, but delayed linked to escalation levels.
- NEPTS Operational Improvement: Discharge Lounge trial restarted in April 2021. This will help in the development of an improved booking process.
- Transfer and Discharge Service: work is in progress with regards to the modelling (ToR created and data collection almost complete with weekly project call now in place).
- Transport Solutions: Training of Health Boards for the online booking system was completed in December 2022, and going forward telephone bookings from HCP's will no longer be accepted. A position paper on eligibility is being created and has been discussed with NCCU with the view of then sharing with WG.
- Updated NEPTS performance parameters went live in April 2023, these will separate out on the day and advance booked journeys. At present most bookings are made on the day, which makes it difficult to respond to within the times allowed. A focus on pre-planned discharge should support work being completed by working groups 5&6 of the 6 goals programme board

Expected Performance Trajectory

At present, the uncertainty around demand as HB's move through system recovery following the pandemic, with the potential addition of austerity and a move to different performance parameters, means that it is difficult to forecast performance. WAST will continue to work with the HB's through the commissioning DAG (NCCU) to deliver the best performance possible for the patient. It is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.

Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Patient Concerns

Responses Indicators

(Responsible Officer: Liam Williams)

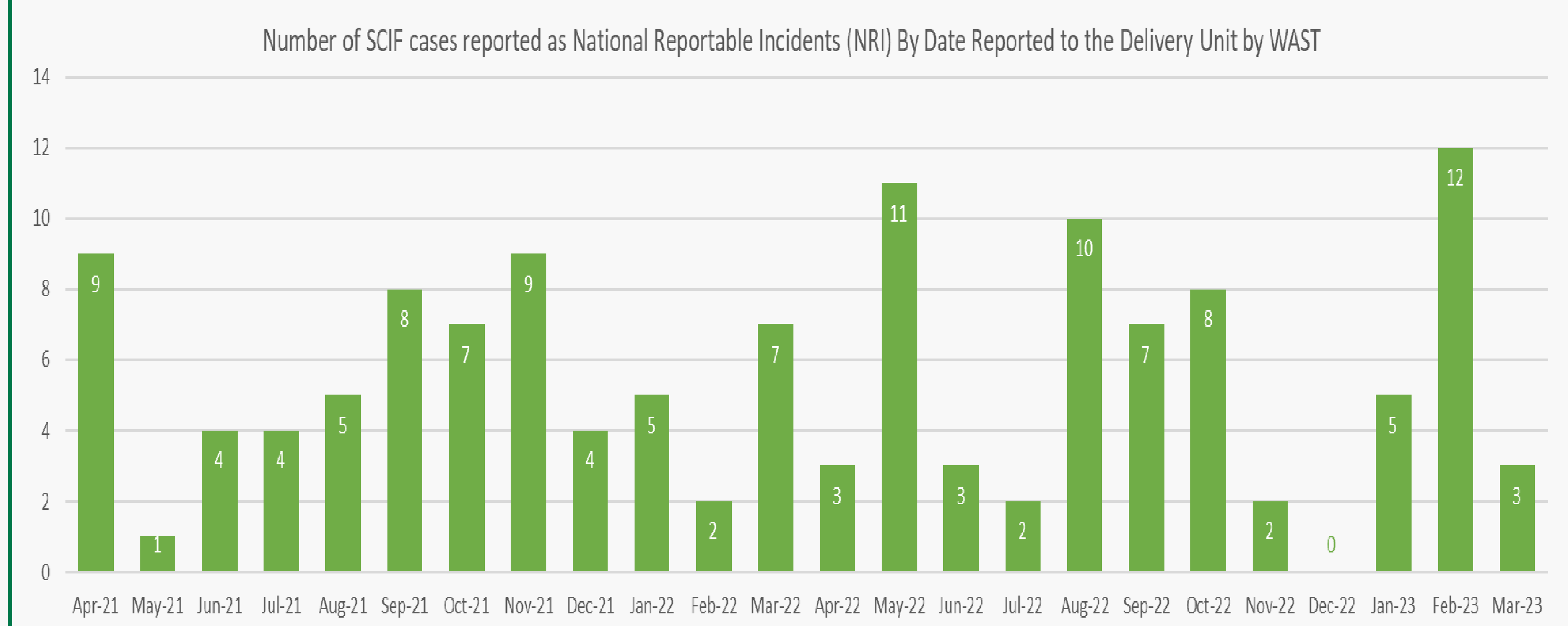
NRI.

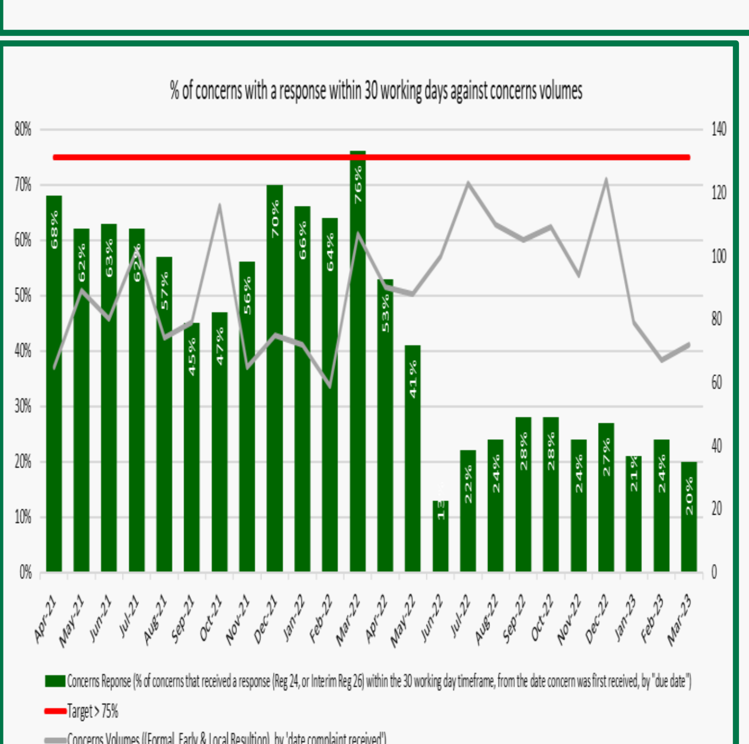
A

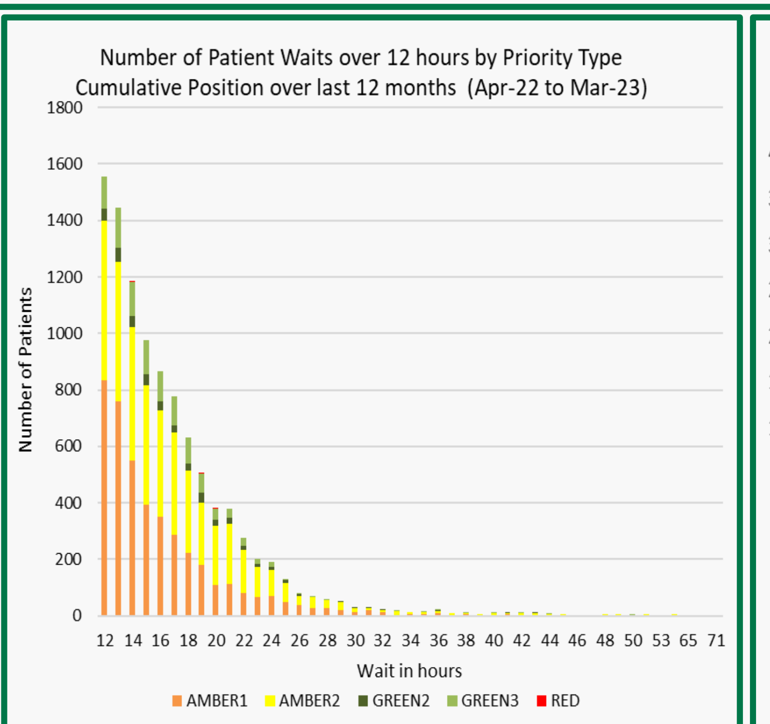
Self Assessment: Strength of Internal Control: Moderate

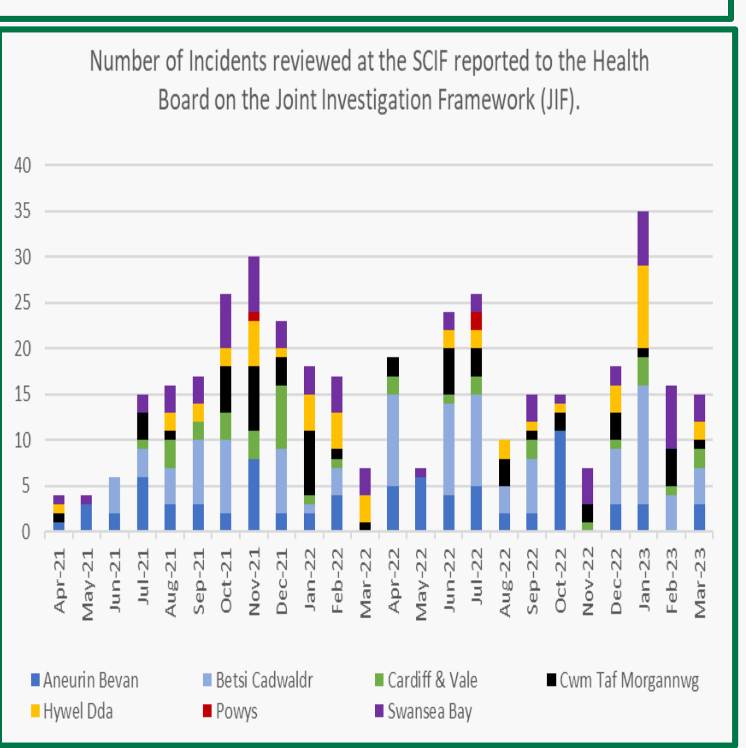
QUEST

Health & Care Standard Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns in March 2023 decreased to 20% against a 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns continues to decrease with 52 complaints being received in March 2023, however these complaints are frequently complex with the concerns administrators frequently taking lengthy calls from distressed patients or family members.

Six Serious Case Incident Forums (SCIF) were held during the month and thirty-two cases were discussed. Following discussion three serious patient safety incidents were reported to the NHS Wales Delivery Unit and fifteen cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received three referrals from Health Boards under the Joint Investigation Framework during the period.

Themes relating to serious patient safety incidents reported to the NHS Wales Delivery Unit as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation.

In March 2023 there was 1 NRI relating to Red calls, 2 relating to Amber calls and 0 in relation to Green calls. There were 2 NRIs prioritised as Amber that should have been Red. As reported earlier, in March, 847 patients waited over 12 hours for an ambulance response, a significant increase month on month, also an increase when compared to 802 in March 2022, but an increase compared to 86 in March 2021.

39 Compliments were received from patients and/or their families in March 2023, a decrease compared to the previous month (36).

Remedial Plans and Actions

A range of actions are in place:-

Recruitment, redeployment and assessment of workload and where to best place resources continues corporately and within the EMS Co-ordination Team. An organisational change process is planned across the putting things right functions in quarter one 2023/24. Additionally, we are working closely with the Trust's Wellbeing Team to understand what additional support can be provided to staff across the PTR functions.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions.

The Joint Investigation Framework pilot (to replace the 'Appendix B' process) continues to have good engagement from system partners overall.

Immediate improvement actions following the SCIF include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.

The Trust is due to submit the quarter 4 complaints return to Welsh Risk Pool on 14.04.2023 which will be validated and subsequently forwarded to Welsh Government in line with nationally revised reporting requirements.

The key strategic action is the EMS Operational Transformation Programme.

Expected Performance Trajectory

The Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge impacting on the quality and safety of care to patients in the community and those delayed outside of hospitals awaiting transfer to definitive care.

NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

***NB: Complex Case Review will always report 1 month in arrears*

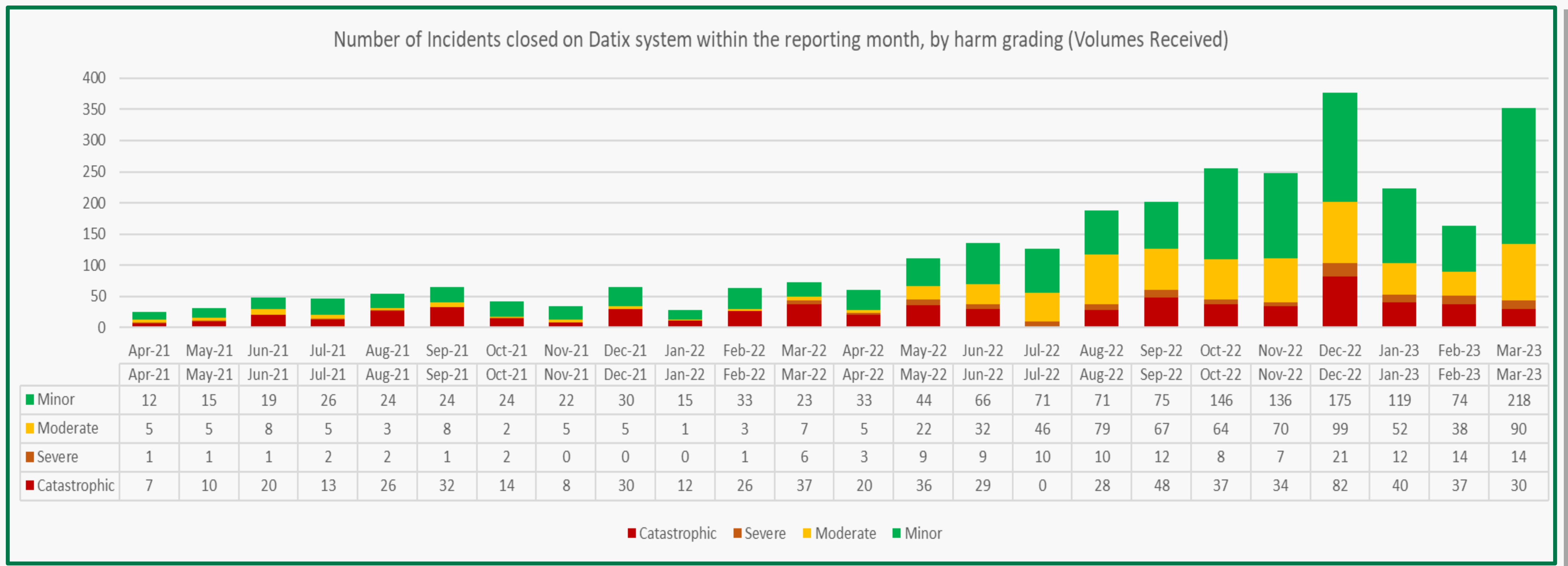
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

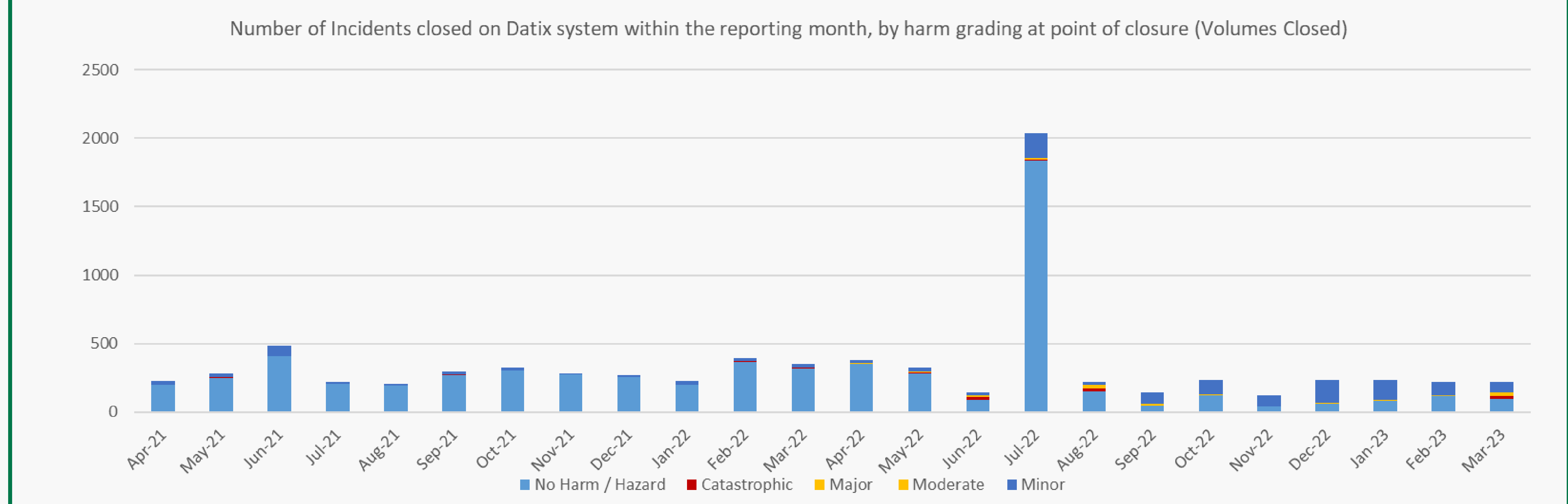
Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Minor	12	15	19	26	24	24	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	218
Moderate	5	5	8	5	3	8	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	90
Severe	1	1	1	2	2	1	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	14
Catastrophic	7	10	20	13	26	32	14	8	30	12	26	37	20	36	29	0	28	48	37	34	82	40	37	30



Analysis

Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour (2023) and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported.

- No harm or hazard – 160
- Minor harm – 218
- Moderate harm - 90
- Severe Outcomes - 14
- Catastrophic - 30

(*NB: Volumes at the point of closure).

The bottom graph highlights the 228 Incidents that were closed on the Datix system in March 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of PTR concerns which are frequently complex. Additionally, during periods of escalation and industrial action members of the team undertook roles outside of their PTR functions. It is expected that implementation of Duty of Candour, Duty of Quality and the Medical Examiner Service will also involve additional activity for the PTR team.

An organisational change process is planned during quarter 1 2023/24 which will consider our local and national priorities and resources to meet the needs of our patients and families, aligning to the Duty of Quality and Duty of Candour requirements which came into force on 1 April 2023.

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the PTR processes.

**NB: Data is correct on the date and time it was extracted; therefore, these figures are subject to change.*

Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care

Number of Coroner Requests by Health Board

0 10 20 30 40 50 60

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb'23 Mar-23

Aneurin Bevan, Betsi Cadwaldr, Cardiff & Vale, Cwm Taf Morgannwg, Hywel Dda, Powys, Swansea Bay

Analysis

Coroners: The number of in month request continues to be higher than pre pandemic. Pre pandemic a financial year saw 244 cases in 2019/2020. Last financial year saw 450 requests being received. This increased number of approaches is now the norm, rather than the exception. The complexity remains high, with multiple statements per approach, The Trust has responded to a Regulation 28 this month within the 56-day target.

At the end of March 2023 there were 451 claims open; these relate to Personal Injury (75 Claims); Personal Injury - Road Traffic Accidents (59 Claims), Clinical negligence (124 claims); Road Traffic Accident (177 claims) and Damage to Property (16 claims).

Ombudsman: There are currently 12 open Ombudsman cases in March 2023. At present cases are not being investigated, which supports the Trust's actions. Intermediate actions are being agreed to close without full investigations by the Ombudsman.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues. Data and information is also provided by the Trust as required to the Medical Examiner Service (MES) to inform their reviews of deaths in acute care. To date the Trust has not received any requests to undertake a Level 2 mortality reviews of patients in our care under the new processes in place across NHS Wales. Currently the focus of the MES is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the MES from September 2023.

The NHS Wales Delivery Unit (DU) is leading a thematic review of 'do not attempt cardiopulmonary resuscitation' (DNACPR) processes across Wales in May 2023 with WAST representation (End of Life Care Lead). The DU are also arranging a meeting with representatives of the All-Wales Mortality Group to look at defining what should be considered under the "sieve and sort" Stage 1 mortality reviews.

To date the Trust has not received any triggers from the MES to undertake a Level 2 mortality review.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are now being arranged into 2024. The temporary clerical support has now ceased and whilst the Team had now recruited to vacancy, and following some training , the numbers on hand will be maintained. The Team is also moving to the Datix Cymru system within the next 3 months and what we can record and report on will be affected, for example we will not be able to identify the cases where there is a potential for the Trust to become an IP.

Ombudsmen: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach as requested by the ME'S. The All-Wales Mortality Working Group led by the NHS Wales Delivery Unit meets at least bi-monthly which has WAST representation.

Expected Performance Trajectory

Coroners: Learning has been placed in a Patient Safety Newsletter, for sharing pan Wales.

Ombudsmen: Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via PTR processes internally.

Data source: Datix

Mortality Reviews Data source: Internal Web Application

Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

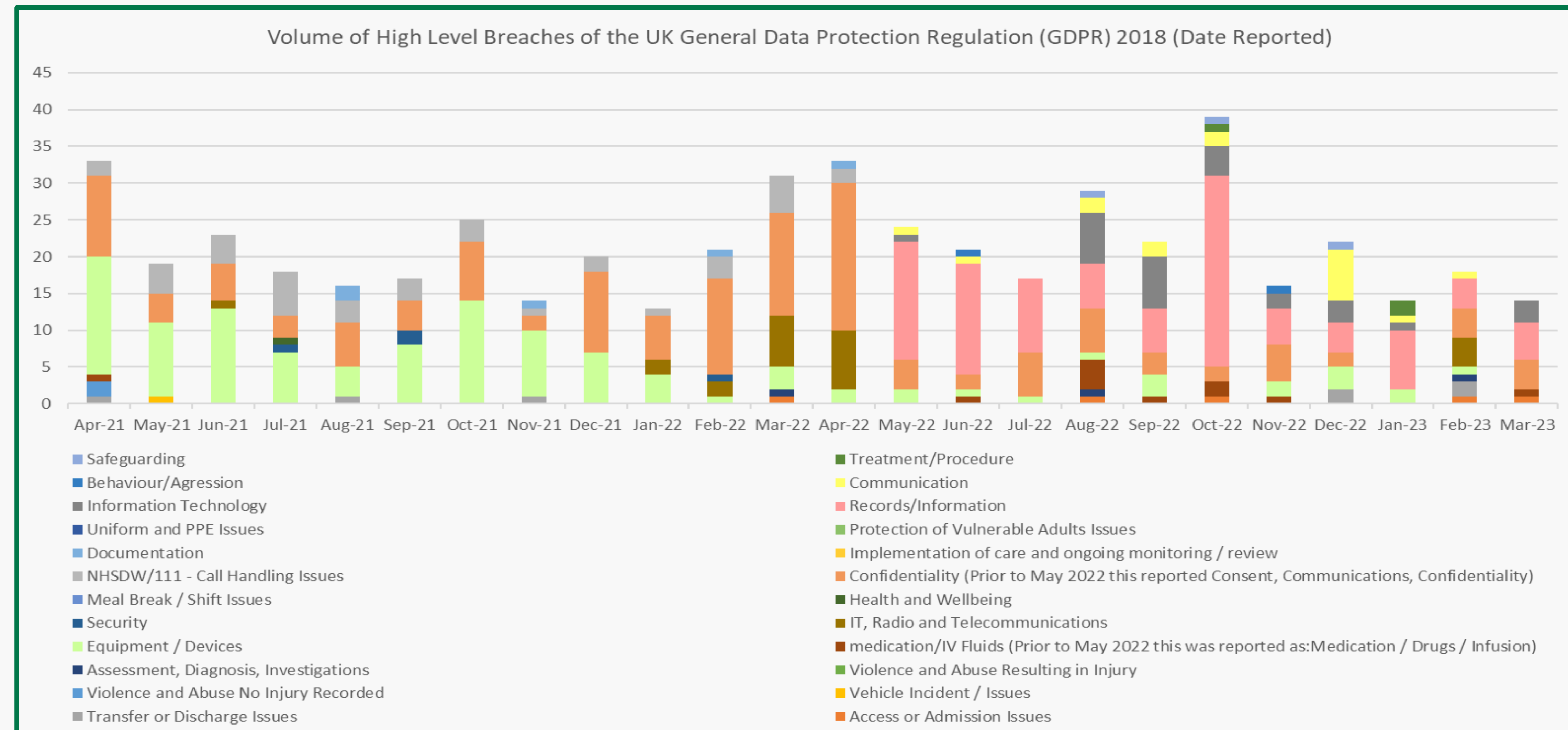
(Responsible Officer: Liam Williams)

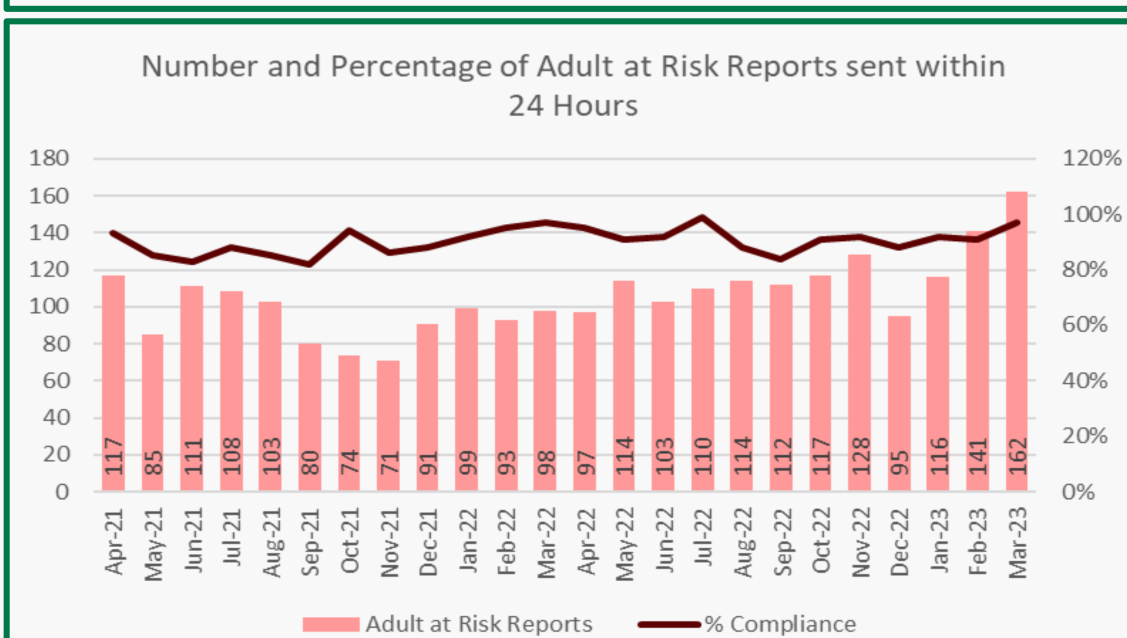
Self Assessment: Strength of Internal Control: Moderate

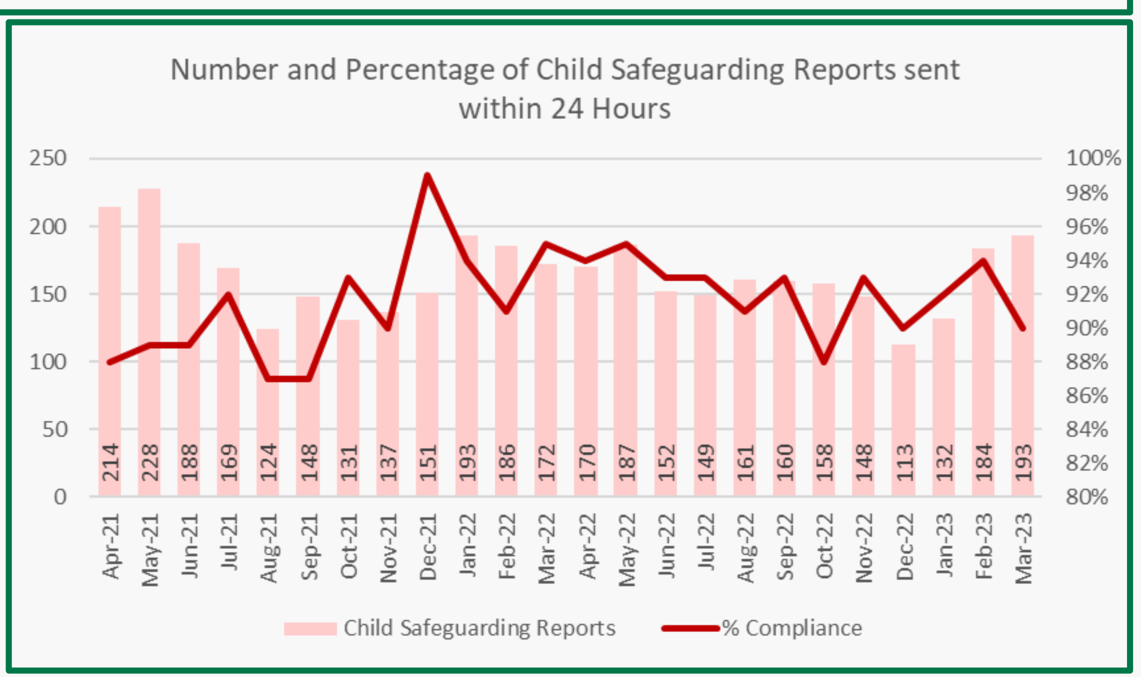
QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works







**NB: Data Governance Incidents are based on 'Date Reported' rather than 'Incident Date' as the process is currently manual until a dashboard is implemented and is therefore subject to change*

Analysis

Safeguarding: In March 2023 staff completed a total of 162 Adult at Risk Reports, 97% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 471 referrals were received and processed to the local authority during this reporting period.

There have been 193 Child Safeguarding Reports in March 2023, 90% of these were processed within 24 hours.

Data Governance: In March 2023 there were 14 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 14 breaches, 1 related to medication / IV Fluids, 3 Information technology, 5 records/information, 4 confidentiality, and 1 Access / Admission.

Public Engagement: During March, the Patient Experience and Community Involvement Team attended 8 community engagement opportunities, engaging with 135 people. At engagement events throughout the month, we continued to place an emphasis on sharing information about pressures being experienced by the Trust and were able to provide information about other services people can access in their communities. During March we also continued to make a series of Patient Reported Experience Surveys (PREMS) available, asking people to provide feedback about their interactions with our services. Outcomes of our engagement results collected from surveys remain consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive, but experience long delays when making their initial telephone booking.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support staff with the use of the Docworks Scribe App and liaise with local authorities when or where required. Numbers of paper safeguarding reports have significantly reduced with the embedding of Docworks; however, they are used as a back-up and are sent directly to the Safeguarding Team for further action. Continued monitoring supports practice in this area which is seeing a steady improvement.

Data Governance: During the reporting period, of the 14-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). The IG team has provided advice and determined remedial actions for reported incidents where appropriate.

Public Engagement: Community involvement and engagement with patients/public will form an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. In April we will begin to role out the new 'Once for Wales' Patient Experience Recording solution Civica. Civica will enable us to improve our patient experience reporting but will rely on us increasing the amount of PREMS data we capture. We are working with colleagues across the Trust to identify suitable processes to ensure our patients and service users are offered opportunities to share their feedback with us.

Expected Performance Trajectory

Safeguarding: The Trust continues to aim to achieve 100% of Adult and Children at risk referrals within 24 hours.

Data Governance: The submission for the FY22-23 IG Toolkit opened in February 2023 and is due to close on 30th June 2023. Work continues on collating the evidence required for the submission.

Public Engagement: All feedback received has been shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

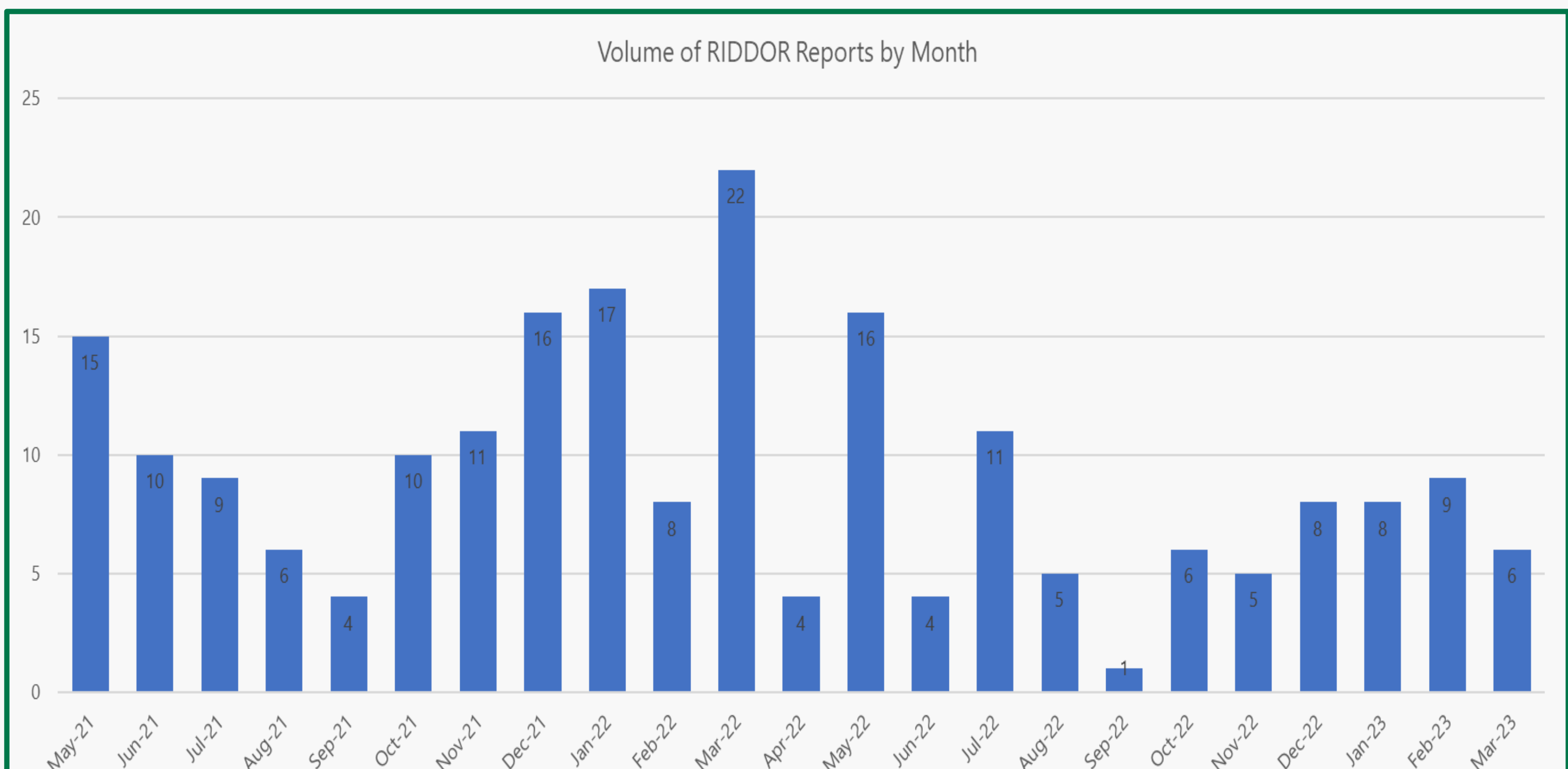
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

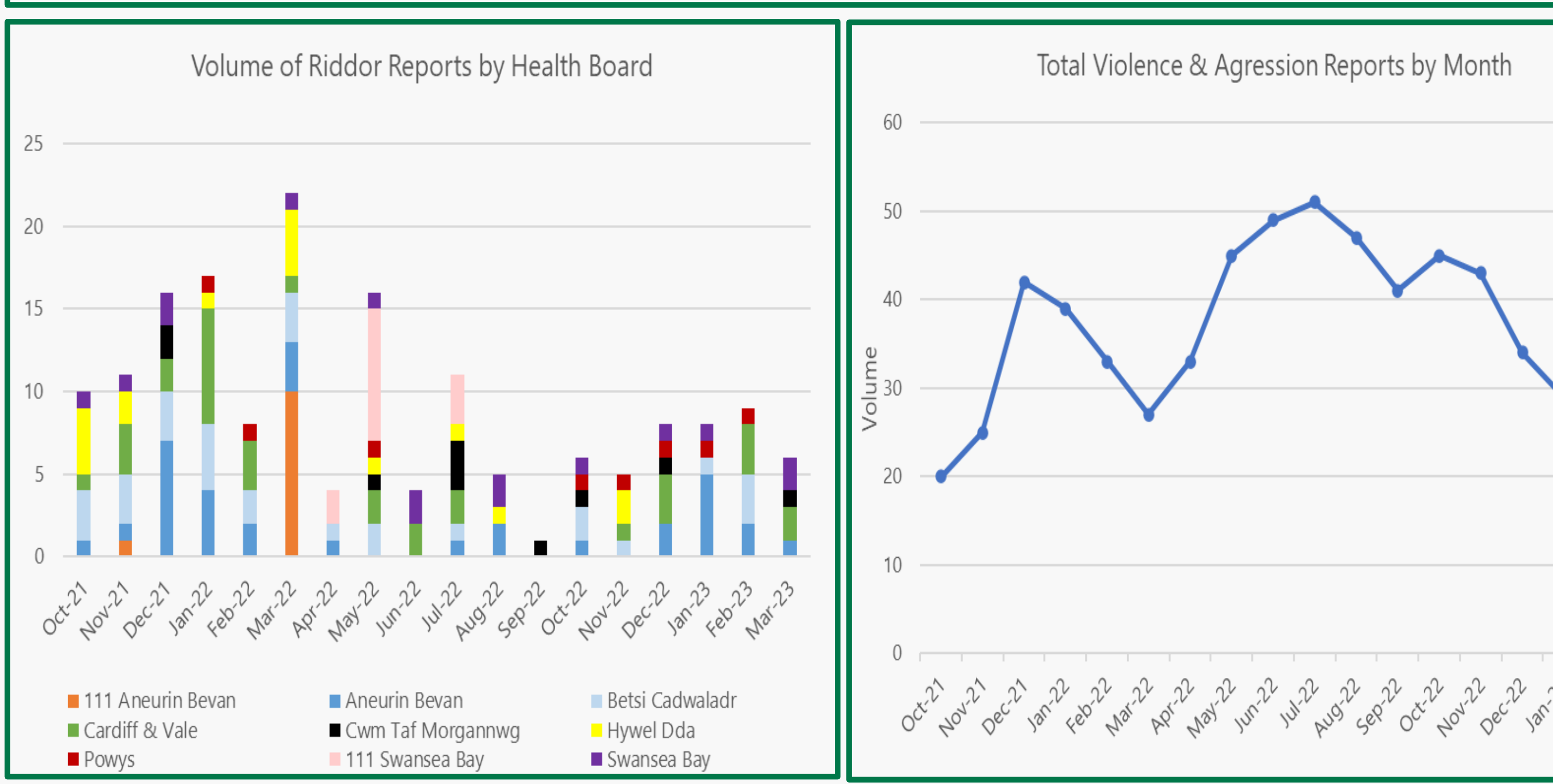
(Responsible Officer: Liam Williams)

Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Total Violence & Agression Reports by Month

Volume: 0, 10, 20, 30, 40, 50, 60

Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23

Analysis

RIDDOR: The weekly Datix meeting undertaken by the Health, Safety and V&A Team is continuing to have a positive impact on the reporting of incidents to the HSE under RIDDOR and additionally identifying incidents that require more in-depth investigation. It is of note that of the 18 manual handling incidents recorded in March 2023, 2 resulted in RIDDOR reports to the HSE. Also of note is that there were 4 sharps incidents reported during the month and these continue to be monitored to assess the need to report them to the HSE should a member of staff develop an illness related to the incidents.

Risk 199 is currently rated as 15. The review of the risk rating will be undertaken in Q1 2023/24 to assess impact of the revised Health and Safety Policy and Safety Annual Improvement Plan on controls identified in the risk.

Trend for RIDDOR incidents showed a decrease during March 2023 with 6 reports to the HSE in February however the incidents shows an increase in severity.

There was one report for a specified injury (Scalping) when a sliding door came off the runner on the vehicle being used and 1 report for a patient injury (Ankle Fracture) during the month.

83% reports were completed within the reporting timeframes the reduction in reporting was due in part to the effects of annual leave within the department and other Directorates.

Violence and Aggression: There has been a sharp up-turn in the reporting of V&A incidents for the month of March with 53 incidents of violence and aggression toward staff reported during the month. Incidents relating to aggressive and threatening behaviour rose to 23 for the month from 13 in February. The reason for this is being investigated by the V&A Manager to identify potential controls to minimise the effect on staff.

Support for staff in preparing victim impact statements is ongoing and court outcomes are being recorded and communicated to senior team.

Work is ongoing in the development of further DATIX dashboard to allow for further scrutiny into V&A incidents at Health Board levels to allow for strategic interventions where required.

There were 0 fines, prosecutions and improvement or prohibition notices in March 2023 as no issues requiring contact with the Health & Safety Executive

Remedial Plans and Actions

RIDDOR: A review of the number, nature and severity of manual handling incidents across the Trust is underway to identify any common causation within the incidents. This will inform an improvement plan for manual handling aimed at educating staff on the correct use of equipment and lifting techniques.

An in-depth investigation is being carried out into the specified injury reported for the "Scalping" of a member of staff to identify the mechanism of injury and apply the learnings across the vehicle fleet.

RIDDOR performance continues to be presented in monthly reports and service units business meetings.

Violence and Aggression: The V&A Manager's strategic review in relation to V&A processes within the Trust is still ongoing with the work to date beginning to inform the evaluation report is being prepared. The timescale for the report has been extended to the end of Q1 2022/23 to ensure accuracy of the information within the report.

Collaborative working with Training team regarding V&A training is continuing with the aim of improving the current training to better support staff.

Reestablishment of working relationships with all four Welsh police forces is working well with contacts made pan Wales providing valuable insight into the investigations made in relation to V&A incidents.

Expected Performance Trajectory

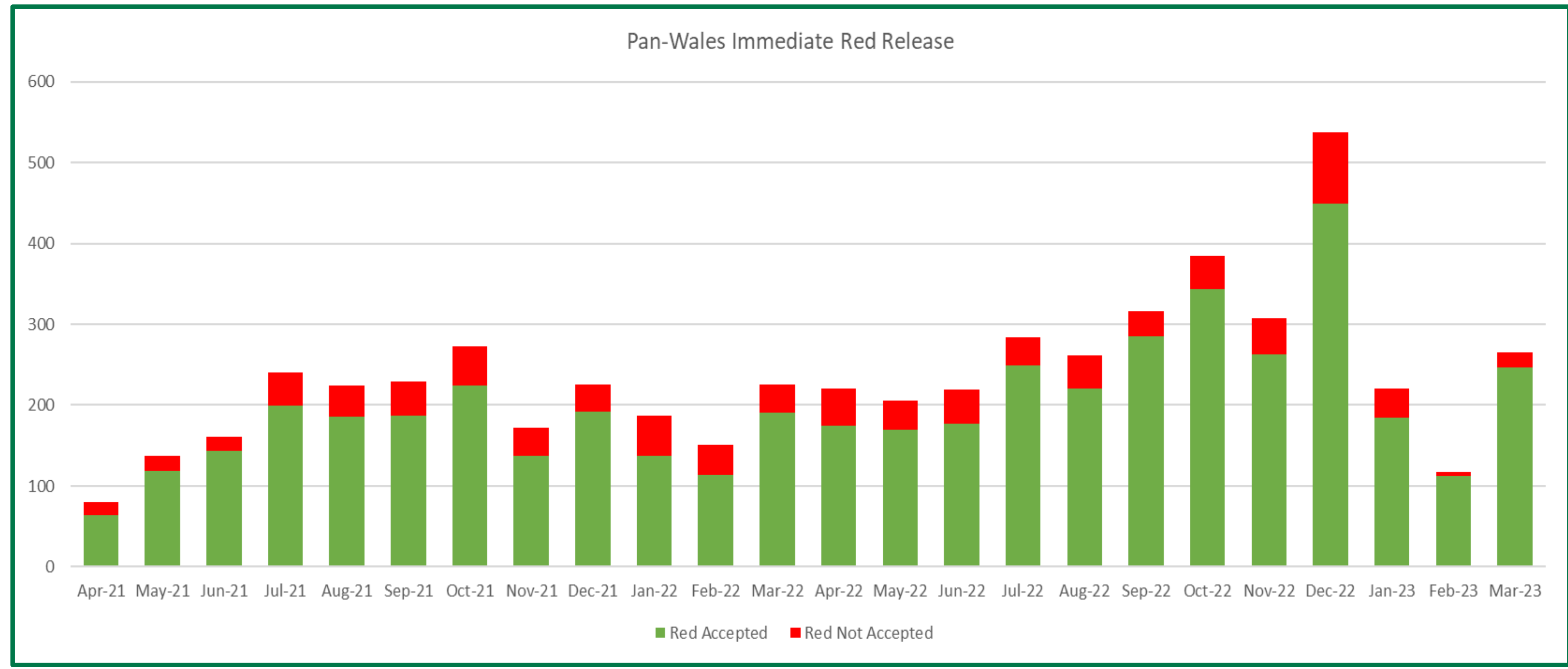
RIDDOR: Reporting performance remains higher than 80% due to the efforts of the Health and safety team in conjunction with Line managers the development of Power BI tools further improve the reporting rate as inconsistencies due to fluctuation as investigations are closed out and associated coding's changed.

Violence and Aggression: Work is underway in the development of further DATIX dashboards to allow for further scrutiny into V&A incidents to influence strategic interventions where required.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Escalation and Patient Experience



Analysis

There were 822 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in March 2023. Of these 246 were accepted and released in the Red category,19 were not accepted. In conjunction to this, 160 ambulances were released to respond to Amber 1 calls, but 397 were not.

In March 2023, 234 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 474 were stopped as a result of CSP Can't send options. In addition, 9,650 ambulances were cancelled by patients (including patients refusing treatment at scene) and 292 patients made their way to hospital using their own transport.

In March 2023 CSP levels for the Trust were:

<table>
<tr><th>CSP Level</th><th>No Of Days in February 2023</th><th>RED</th><th>AMBER 1</th><th>AMBER 2</th><th>GREEN</th><th>HCP</th></tr>
<tr><td>0</td><td>0</td><td colspan="5">Business as Usual</td></tr>
<tr><td rowspan="2">1</td><td rowspan="2">0</td><td rowspan="2">Respond</td><td rowspan="2">Respond</td><td colspan="3">ETA – Alt Transport</td></tr>
<tr><td colspan="3">Respond to Exceptions</td></tr>
<tr><td rowspan="2">2a</td><td rowspan="2">0</td><td rowspan="2">Respond</td><td rowspan="2">Respond</td><td colspan="3">ETA – Alt Transport</td></tr>
<tr><td colspan="3">Respond to Exceptions</td></tr>
<tr><td rowspan="3">2b</td><td rowspan="3">0</td><td rowspan="3">Respond</td><td colspan="4">65th ETA Script</td></tr>
<tr><td colspan="4">ALT Transport</td></tr>
<tr><td colspan="4">Respond to Exceptions</td></tr>
<tr><td rowspan="3">2c</td><td rowspan="3">12</td><td rowspan="3">Respond</td><td colspan="2">65th ETA Script</td><td rowspan="3">Can't Send Respond to Exceptions</td><td>Can't Send</td></tr>
<tr><td colspan="2">ALT Transport</td><td>Pass to ROU or EMG</td></tr>
<tr><td colspan="2">Respond to Exceptions</td><td></td></tr>
<tr><td rowspan="3">3a</td><td rowspan="3">13</td><td rowspan="3">Respond</td><td>90th ETA Script</td><td rowspan="3">Clinical Screening</td><td rowspan="3">Can't Send</td><td rowspan="3">Can't Send</td></tr>
<tr><td>ALT Transport</td></tr>
<tr><td>Respond to Exceptions</td></tr>
<tr><td>3b</td><td>6</td><td>Respond</td><td>Clinical Screening</td><td>Can't Send</td><td>Can't Send</td><td>Can't Send</td></tr>
<tr><td>4a</td><td>0</td><td colspan="2">Clinical Screening</td><td>Can't Send</td><td>Can't Send</td><td>Can't Send</td></tr>
<tr><td>4b</td><td>0</td><td>Clinical Screening</td><td>Can't Send</td><td>Can't Send</td><td>Can't Send</td><td>Can't Send</td></tr>
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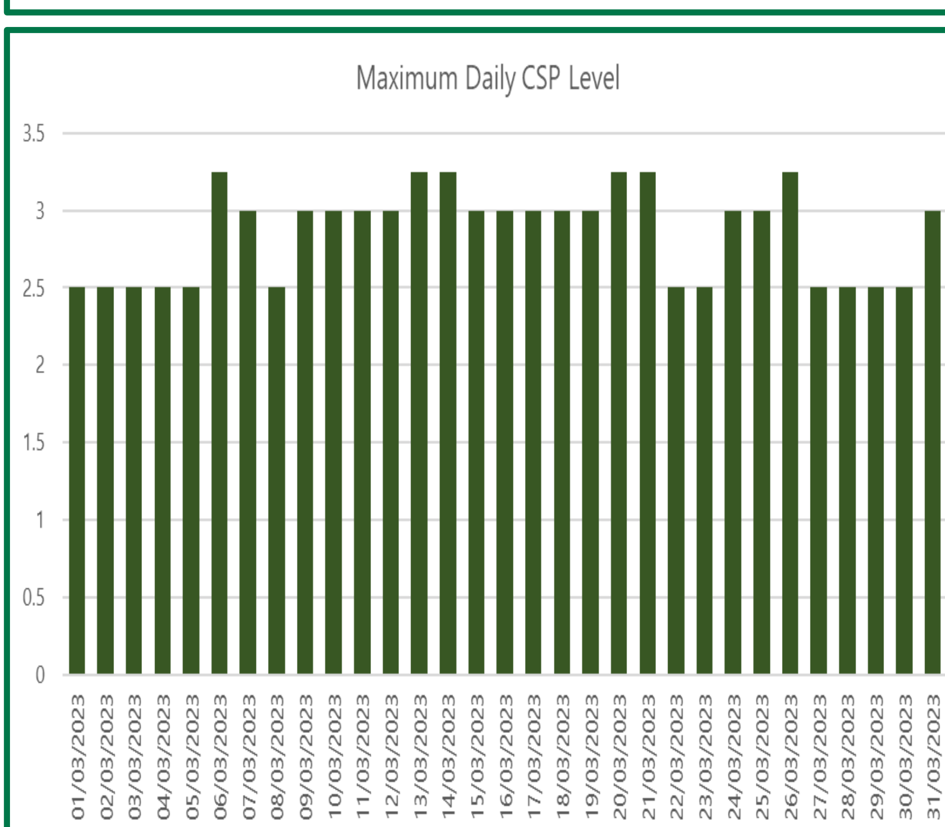
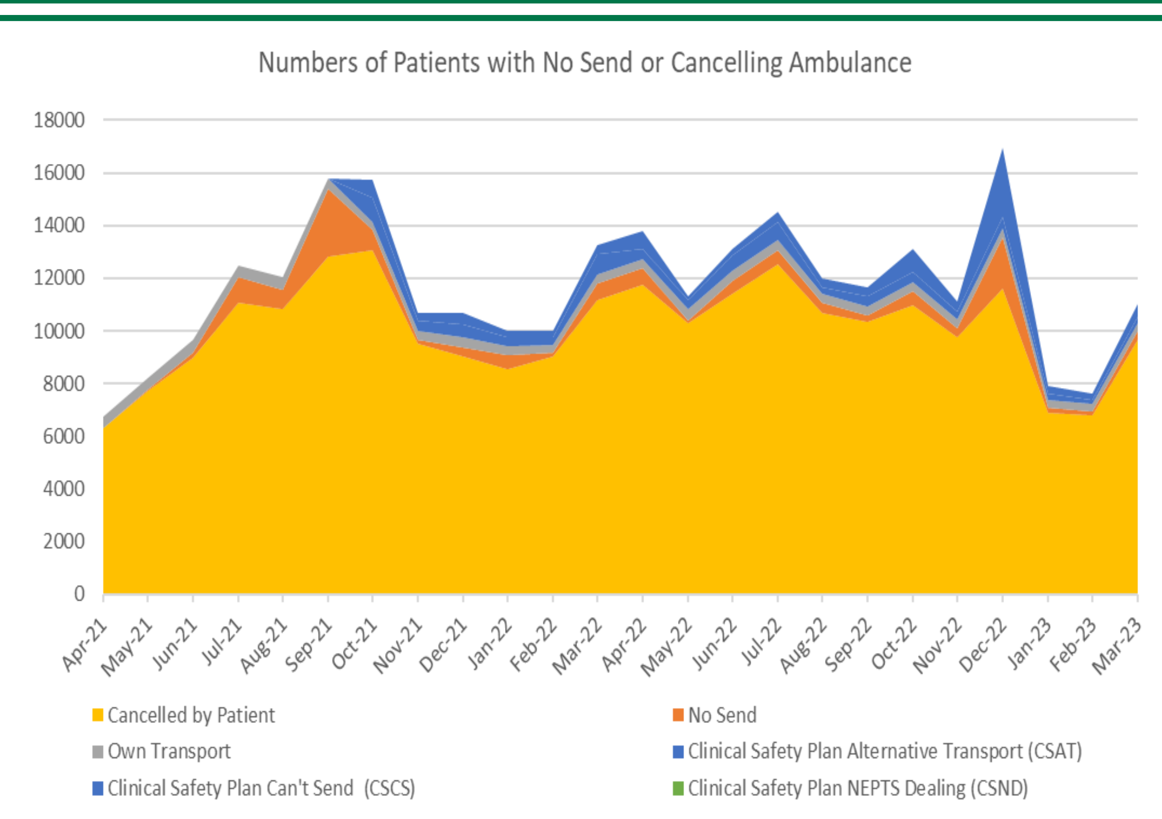




Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

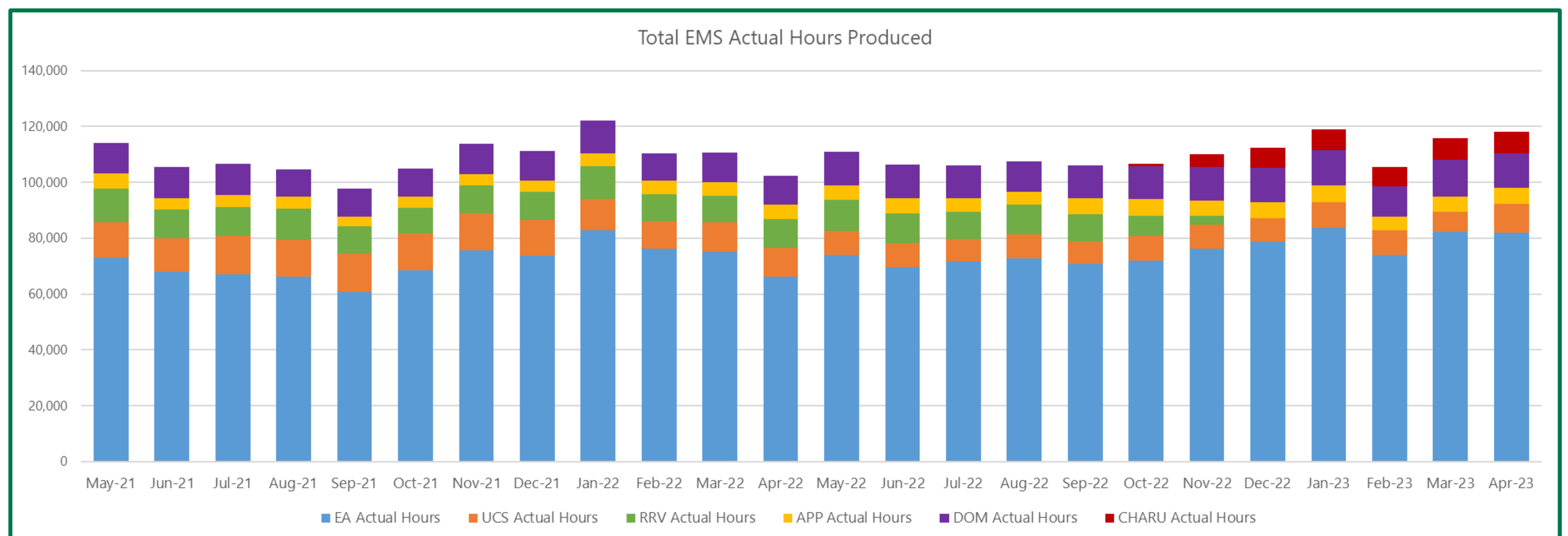
Our People
Capacity - Ambulance Abstractions and Production Indicators

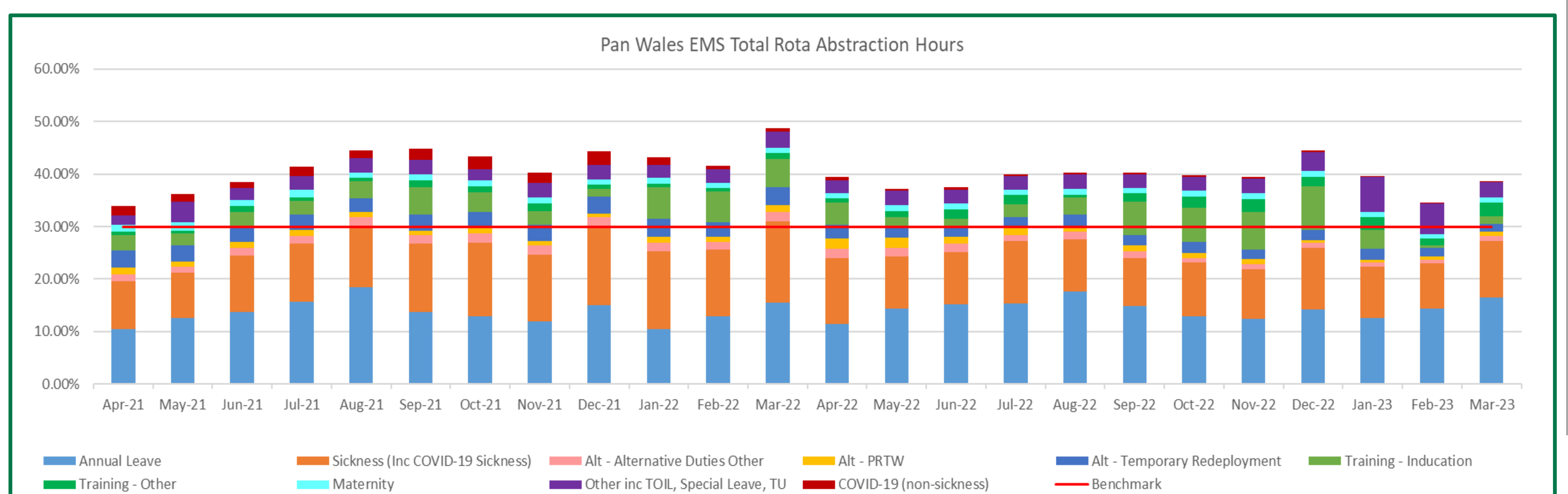
(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI

PCC





Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In March 2023, total abstractions stood at 38.61%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 16.54% and sickness at 10.75%. Sickness abstractions for March 2023 were lower when compared to the previous year (15.47%). COVID-19 (non-sickness) related abstractions decreased again in March 2023 when compared to the previous month and when compared to the same period last year accounting for 0.08% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 98% in April 2023 (81,925 Actual Hours), therefore achieving the 95% benchmark. CHARU UHP achieved 92% (7,925 Actual Hours) compared to 86% in March 2023 (this is the commissioned level not the modelled level, which would halve the UHP). The total hours produced is a key metric for patient safety. The Trust produced 118,141 hours in April 2023, which is higher than the figure produced in March 2023 (115,647).

Remedial Plans and Actions

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks.

The Trust has a budgeted establishment of 1,761 FTEs for 2022-23.. The vacancy rate is less than 1%.

The Trust is currently widening out its focus on sickness absence to look at all abstractions recognising that abstractions are already regularly reviewed in Operations performance meetings.

Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to EMT. A further meeting to deep dive and finalise the Trust's position for 2023/24 has been arranged for 17 May 2023.

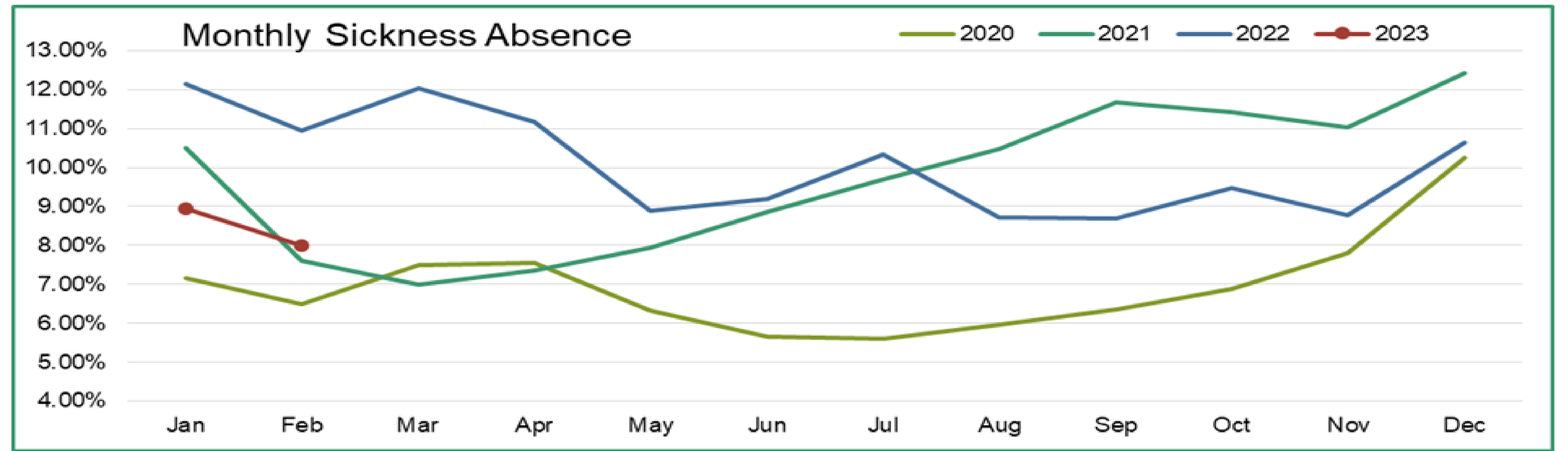
Our People
Health & Wellbeing - Sickness Absence Indicators

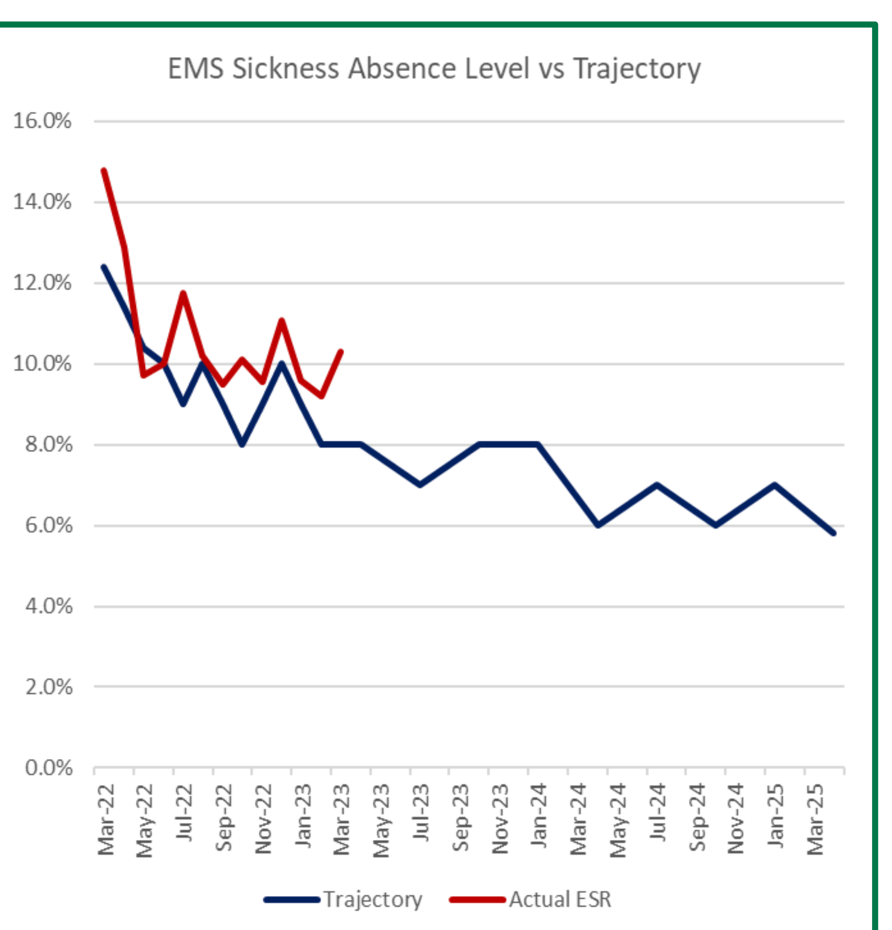
(Responsible Officer: Angela Lewis)

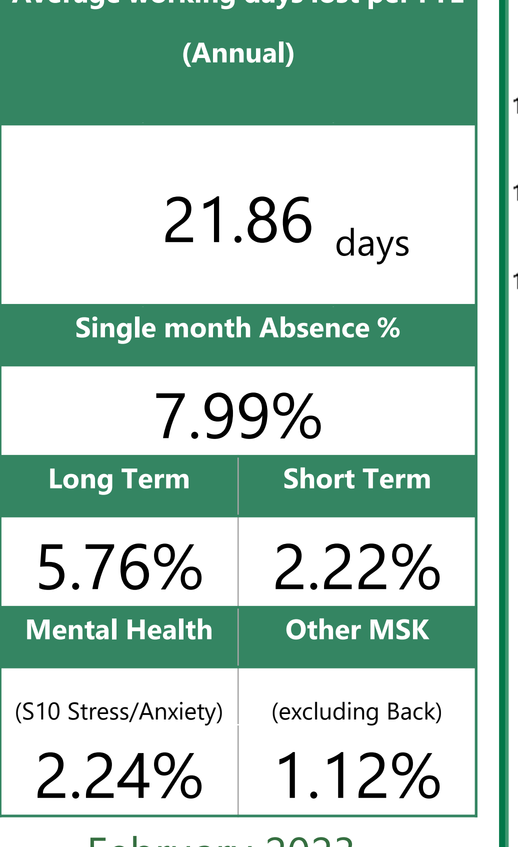
G

CI

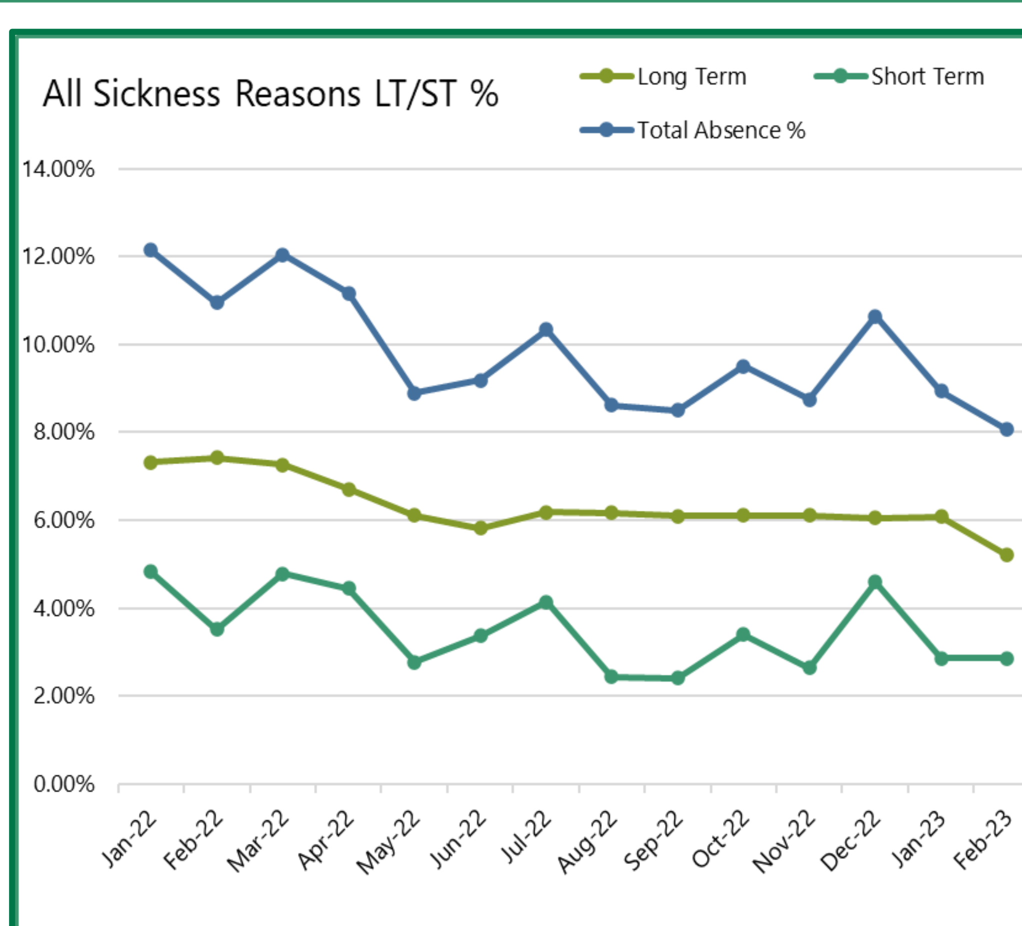
NB: Sickness data will always be reported one month in arrears (except for ESR reported Sickness Trajectory)







February 2023



Analysis

There was a decrease in sickness absence in February, going from 8.94% to 7.99%, the lowest level since June 2021. Indicative figures show an increase in March to 8.43%, with an increase in short term absence (3.58%). Long term absence shows a continued decrease at 4.86%.

The number of long COVID cases continues to decline with 3 colleagues absent (as of 04 April 2023) with long Covid compared to 15 in July 2022.

February 2023 noted a decrease in both long term and short-term absences.

Remedial Plans and Actions

- Targeted support continues to be directed to current 'hotspot' areas with ongoing reviews in one HB area. Senior Manager review meetings to track sickness and provide support are undertaken each month.
- Further MAAW training and bitesize training sessions have been scheduled for April & May 2023.
- Long term sickness case management continues and indicative figures for March 2023 show a decrease to 4.91% from 5.76% in February.
- Indicative figures for short term absence in March 2023 shows an increase to 3.57% from 2.22% in February. The highest reason for short term absence was COVID related.
- Long COVID cases are reducing – 3 compared to 15 in July 2022, with comprehensive plans developed.
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Physiotherapy: 43 referrals were received in February 2023; this was 10 more than January 2023.
- Average length of time from referral to first contact: 0.85 days.
- Average age of those referred is 48, with shoulder issues being the main reason for referral. At the point of referral, 42% of employees were off work, 5% were on amended duties and 53% were at work on full duties
- Health Assured (EAP): 48 calls to the helpline in February

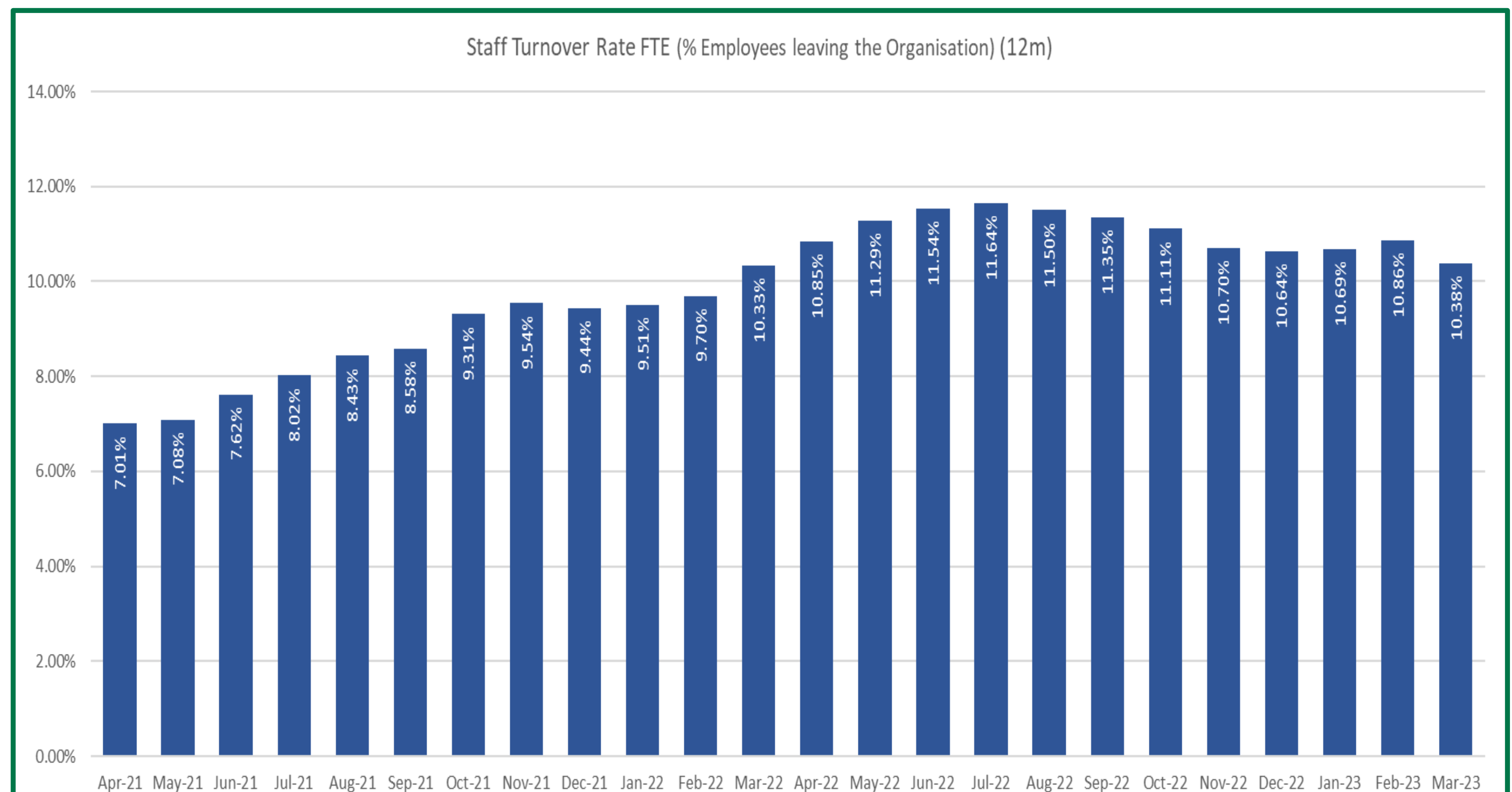
Expected Performance Trajectory

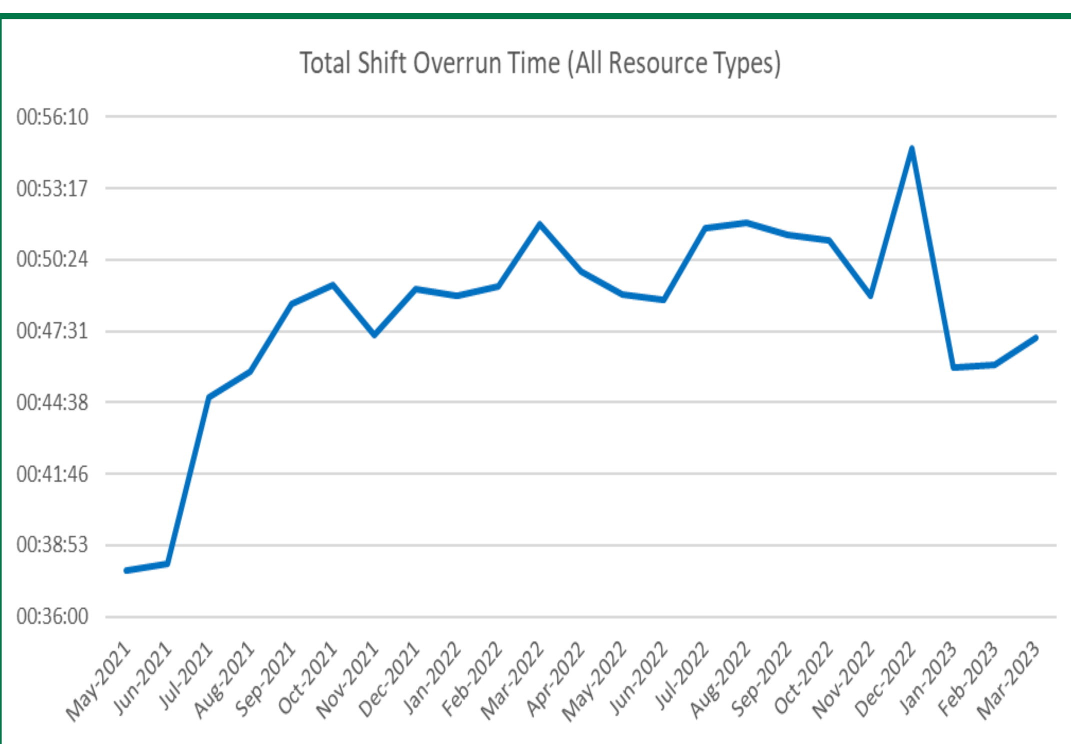
The Trust is aware that some staff may need more time to recover due to long-CoVID-19 and may require a longer phased return to work alongside putting in place other supporting mechanisms. Work is also ongoing to consider the mental health aspects of COVID-19 and working from home and the Trust is actively seeking ways to consider the possibility of hidden health and wellbeing issues. It is therefore difficult to forecast or predict performance against this indicator, but the expectation is that the target is unlikely to be achieved in this financial year.

Our People
Health and Wellbeing - Turnover

(Responsible Officer: Angela Lewis)

A





March 2023	FTE by Month
Org L4	**2023 / 03**
020 Ambulance Care L4 (NX10)	901.89
020 Emergency Medical Services L4 (DX04)	1,800.47
020 Integrated Care L4 (DX03)	430.13
020 National Operations & Support L4 (DX02)	152.72
020 Resourcing & EMS Coordination L4 (DX05)	342.99
3,628.20	
Ambulance Response:	**1,543.80**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**290.79**

Analysis

Staff turnover rates in March 2023 were 10.38%. In comparison staff turnover rates were 10.33% in March 2022. As highlighted previously the number of staff leavers has increased over the last 3 years with rates remaining high, but relatively static, between 10.3% and 11.7% over the past year. These rates were considerably lower pre-pandemic. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

Colleague wellbeing remains a focus for WAST. Colleagues are managing a number of challenging issues at the minute with industrial action, the cost of living crisis and fatigue all being concerns. The Trust has been awarded enhanced status of our Gold Award for Corporate Health Standard, demonstrating that colleague wellbeing remains a high priority. EAP support for colleagues has been renewed, to ensure our people can access support 24/7 and have access to counselling. The Trust have arranged for speakers to come in to present to the women's health group, focusing on nutrition and are delivering regular workshops for colleagues on stress, and wellbeing and resilience to support, and are looking at ways to increase the support that we provide.

Remedial Plans and Actions

Accessible financial wellbeing support is available to colleagues through a dedicated page on Siren. The page links to a short video presentation outlining available support, ideas shared through the digital suggestion box which remains open to all colleagues (including our volunteers) and broader employee benefits information. A podcast has been recorded with the Money & Pensions Service and will be shared through communications platforms in April 2023.

The WAST Voices Network held its first Advocate meeting in March 2023 and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and the impact of these will be measured after 2 sessions of Senior Leaders hearing from lived experience of these issues. The network have a collaborative event with North West Ambulance Services taking place in April.

Work around improving the preparedness of new colleagues has begun and we now facilitate group discussions around anti racism and sexual safety at all welcome sessions. We are also capturing organisational culture experiences through the 3 months check in carried out with all new colleagues. The allyship programme continues to be rolled out for current colleagues and where required, team interventions taking place.

A volunteer wellbeing package has been put together and the OD Team are running monthly evening Warm WAST Welcome sessions for new volunteers.

2nd Carers passport training arranged for 17th May - Carers week workshop being arranged for 8th June. Theme suggested by the unofficial carers network.

WAST Outdoors initiatives being trialled.

Expected Performance Trajectory

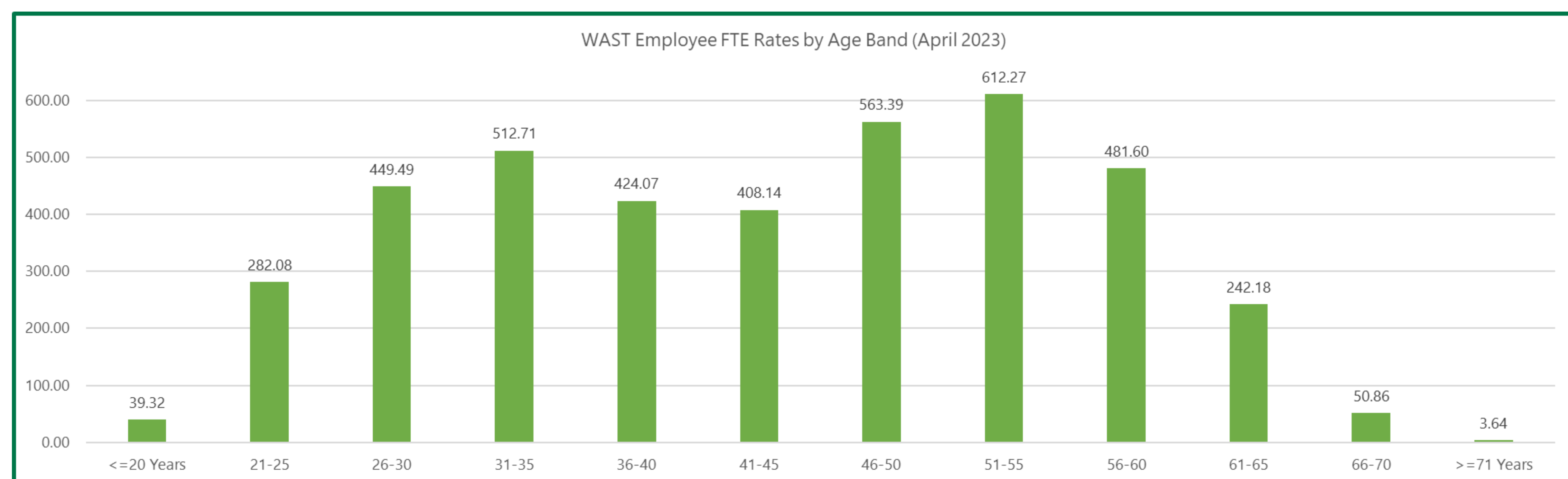
The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support. The People and Culture Plan will continue to highlight that employee experience and culture contribute to overall wellbeing.

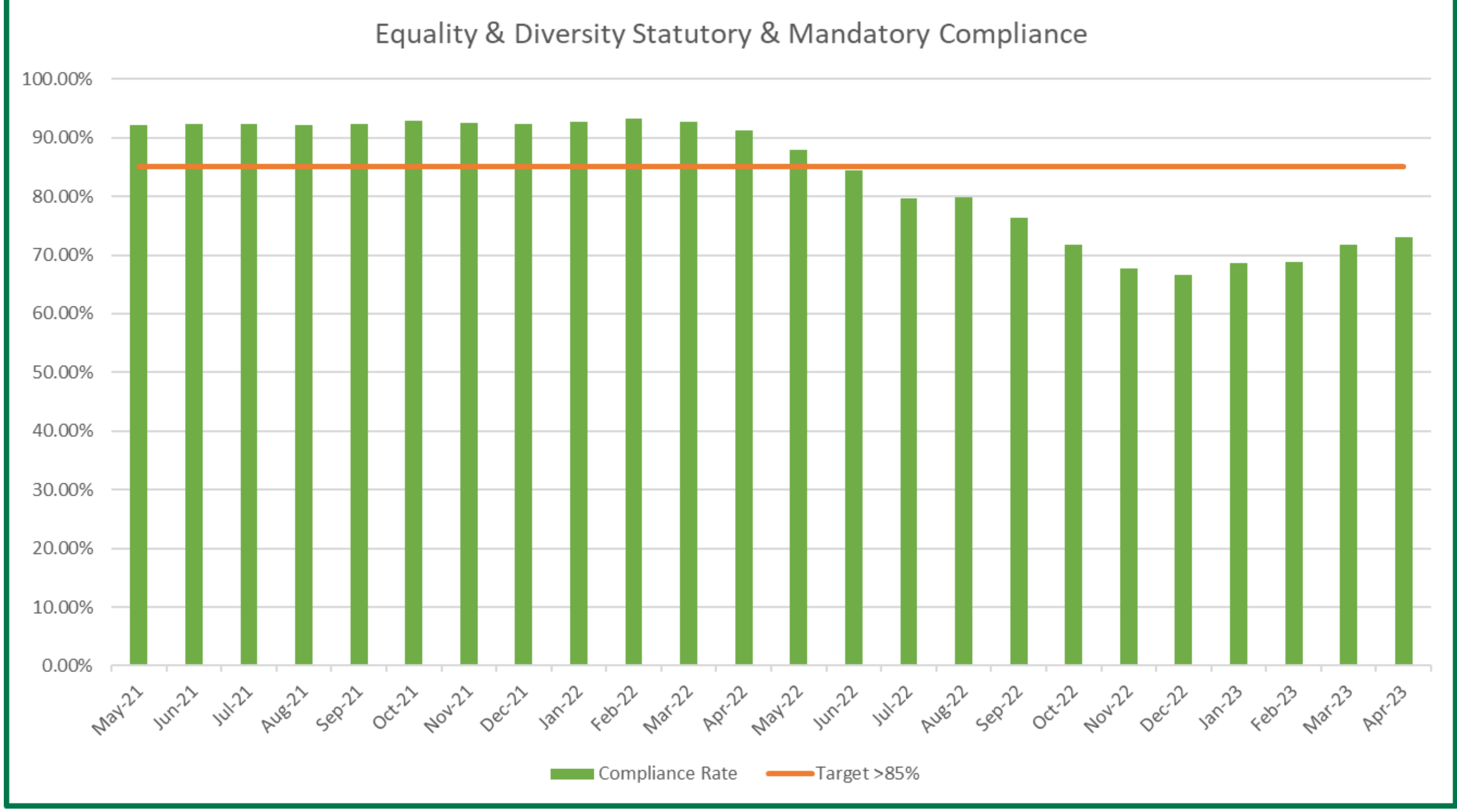
The wellbeing offer is regularly reviewed and fully described on SharePoint.

Our People
Inclusion and Engagement

(Responsible Officer: Angela Lewis)

CI





April 2023	Female	Male
Band 2	1.06	1.29
Band 3	17.22	14.39
Band 4	8.56	10.77
Band 5	5.05	4.10
Band 6	11.98	13.14
Band 7	2.87	5.01
Band 8 - Range A	0.93	1.31
Band 8 - Range B	0.49	0.40
Band 8 - Range C	0.19	0.51
Band 8 - Range D	0.13	0.13
Other	0.23	0.27

Analysis

In April 2023 of the 4,734 employees at the Trust, 0.97% fall in the under 20 category and 0.36% in the over 71 age category. The largest age category is 51-55 accounting for 14.36%. 86.04% of staff employed at the Trust define themselves within the White ethnic grouping; with 71.42% of staff identifying within the White, British category, 0.8% within black ethnic groups, 0.34% within Asian ethnic groups and 0.69% are of mixed heritage. 0.13% of staff fall into other ethnic groups. 4.82% fall in the unspecified category and 7.82% have not stated their ethnicity.

As of April 2023, 73.07%, of staff have completed mandatory Equality and Diversity Training a slight increase compared to March, however still failing to meet the 85% target.

Gender pay as a percentage of the workforce indicates that in April 2023 for those employed within bands 2 - 6 employment is more equally distributed, with 43.85% of females and 43.68% of males fulfilling those roles; however, there are higher levels of men employed within the more senior grades. 4.6% of females are employed in Band 7 and 8 roles compared to 7.4% of males.

Remedial Plans and Actions

The Trust has published a selection of 15 minute engaging and effective Skills Boosters films, via the Learning and Development intranet page on Siren. These cover a range of topics including Equality, Diversity & Inclusion; Leadership; Personal Effectiveness and Support & Wellbeing to support staff learning and development and to enable individuals to be the very best that they can be.

Plans are underway to support Stress Awareness month in April 2023 to raise awareness of the causes and cures for the modern-day stress epidemic. Presentations are planned on various dates throughout April 2023 for staff to learn about the REACT (Recognise, Engage, Actively Listen, Check risk and Talk about specific actions) on and Understanding Stress, Trauma & Burnout.

Expected Performance Trajectory

The Trust listened to feedback from communities, stakeholders and over 4,000 colleagues to develop seven new behaviours to ensure we can always be our best and is more committed than ever to improving the future and embracing new ways of working. These behaviours have been explored and promoted at the CEO roadshow and work to continuing promoting them continues.

The Trust continues to follow guidance issued for Welsh Language standards (2015) to ensure compliance when advertising vacancies, which are advertised in both the English and Welsh language for any posts where Welsh language skills are essential or desirable.

Our People
Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

Self Assessment: Strength of Internal Control: Moderate

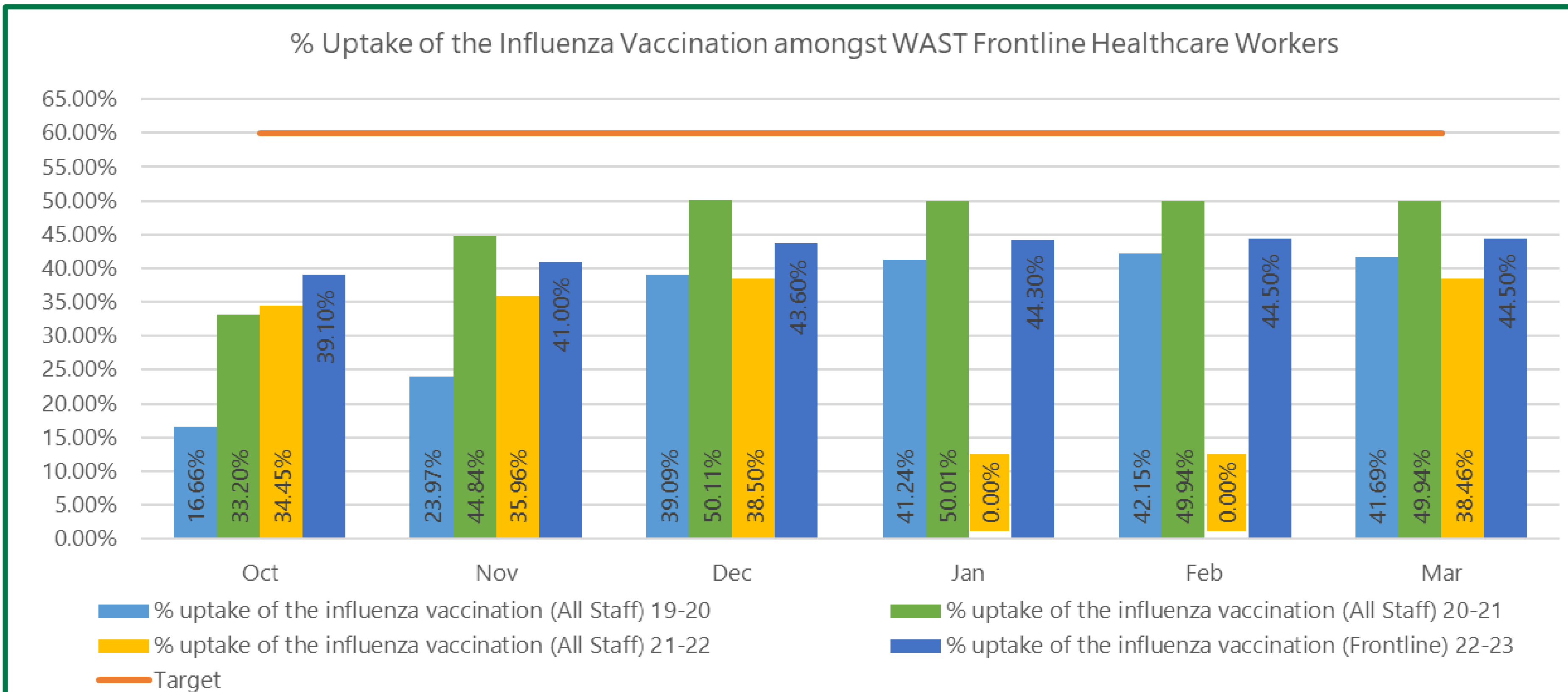
Flu

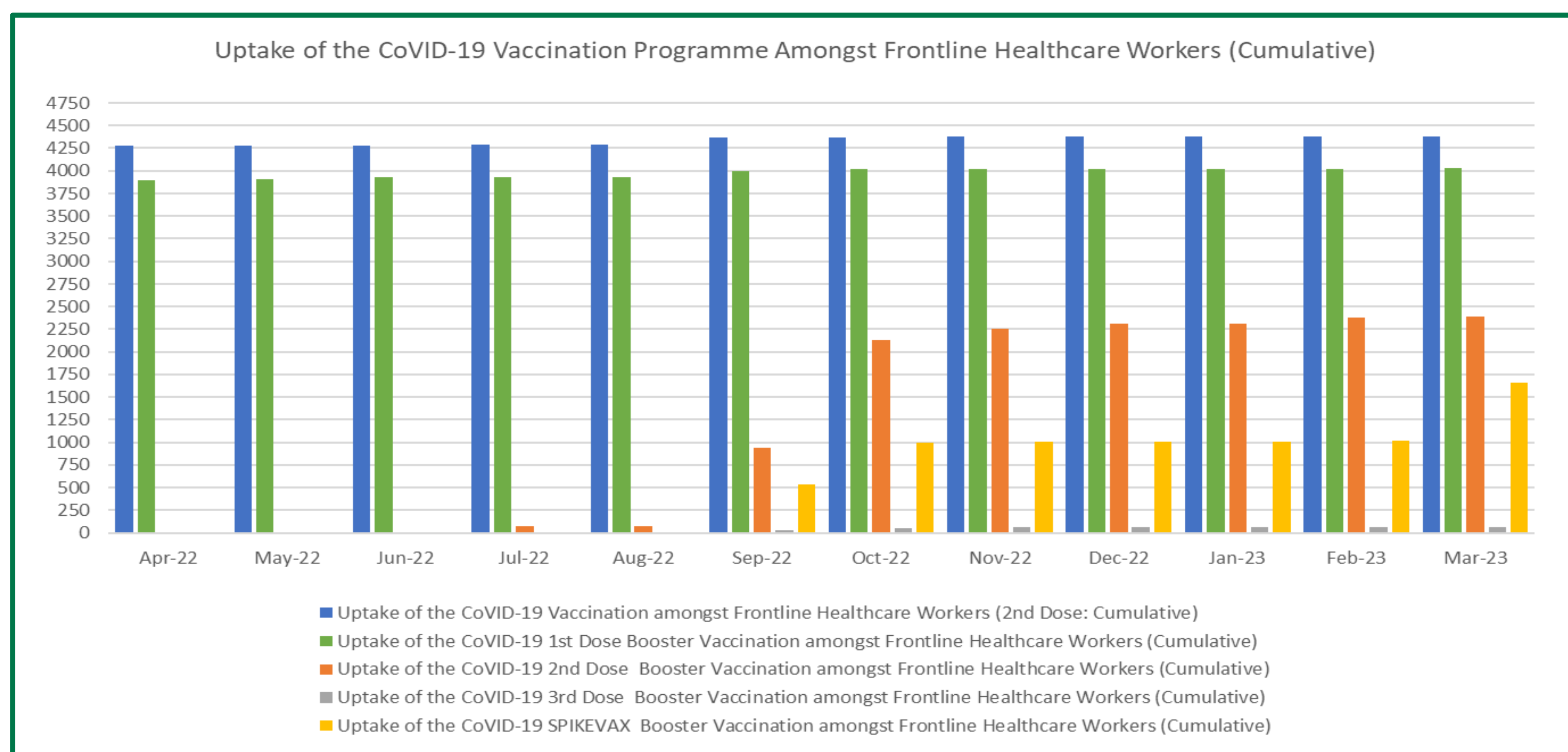
R

PCC

CI

Health & Care Standard
- Health (PPI)





Analysis

Flu: The 2022-23 Flu Campaign has officially come to an end, concluding data collection as of 28th February 2023. During the campaign 1,813 flu vaccines administered by Occupational Health Vaccinators and Peer Vaccinators (including flu vaccines administered to PHW staff / Students / HCS staff etc.) Of these vaccines administered within the Trust, 1,601 were received by WAST staff. There was a further 289 given to staff elsewhere (i.e. GP surgery, COVID Booster setting) therefore a total of 1,890 WAST staff received the vaccination against flu, equating to 44.5% of the overall workforce. Additional engagement was received from 247 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, concluding the campaign with 50.3% engagement rate.

Both the vaccine uptake and Microsoft Form engagement surpassed that experienced in the previous campaign last year, 2021-22. There was a 6% increase on vaccinations and a 9.6% increase in engagement. Patient facing staff specifically saw a 46.3% uptake of the vaccine this year (a 5.2% increase from last year).

COVID-19: As of March 2023, front line (Patient Facing and Non-Patient Facing staff), 94% (4,404) of staff have received a first dose COVID-19 vaccination, 94% (4,377) have received a second dose and 37% (1,664 Staff) have received the SPIKEVAX booster vaccination.

Remedial Plans and Actions

Flu: Following a full review of this year's campaign, recommendations have been devised based on some of the key areas of learning and development. The aim is to streamline current processes, remove duplication of effort and improve engagement with the workforce. It is evident that positive steps have been made, and a number of the lessons learnt from the previous campaign have been implemented. However, there is a range of areas that require continued development for future campaigns. Planning for the next Flu Campaign is expected to start shortly, earlier than ever before.

COVID-19: Welsh Government have been involved in discussions between the four UK Chief Medical Officers (CMOs) regarding the UK Covid-19 alert level. This alert level system has been in operation since May 2020. Its function is to clearly communicate, to the public and across governments, the current level of direct Covid-19 risk. Since September 2022, we have been at level 2. The four UK CMOs have agreed it is appropriate to pause the alert level system. It will be suspended on 30 March.

Routine testing will be paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools over the (2023) spring and summer.

Expected Performance Trajectory

The 2022-23 Flu campaign has now concluded. The Trust will continue to monitor influenza and COVID-19 through intelligence gathered by the Forecasting & Modelling Group on a weekly basis. Any learning from southern hemisphere countries will be shared and used for modelling purposes for the 2023-24 winter flu season.

**NB: Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*
***NB: COVID Vaccinations are reported using the WAST definition of Frontline Patient Facing employees and therefore includes those employed within Clinical Contact Centres.*
****NB: Flu data accurate at time of publication and subject to change / Spikevax vaccination data correct at time of publication and subject to change.*

Date source: Cohort Electronic System / Welsh Immunisation System (WIS)

Our People
Health and Wellbeing - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

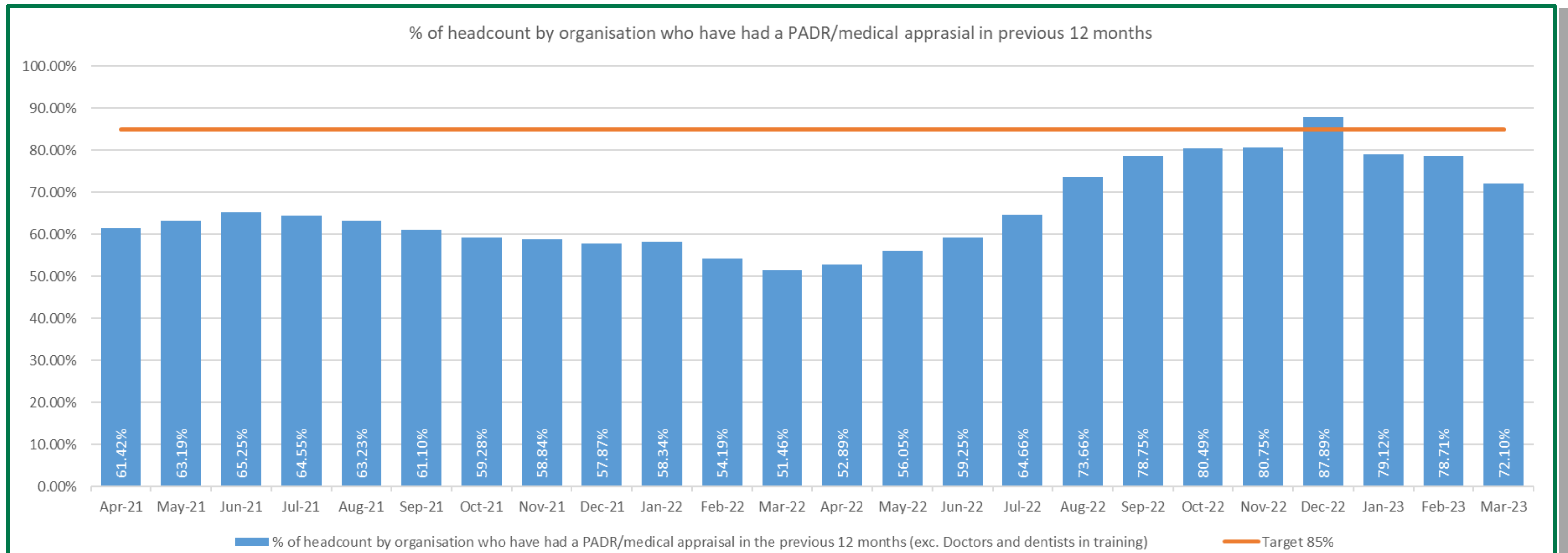
A

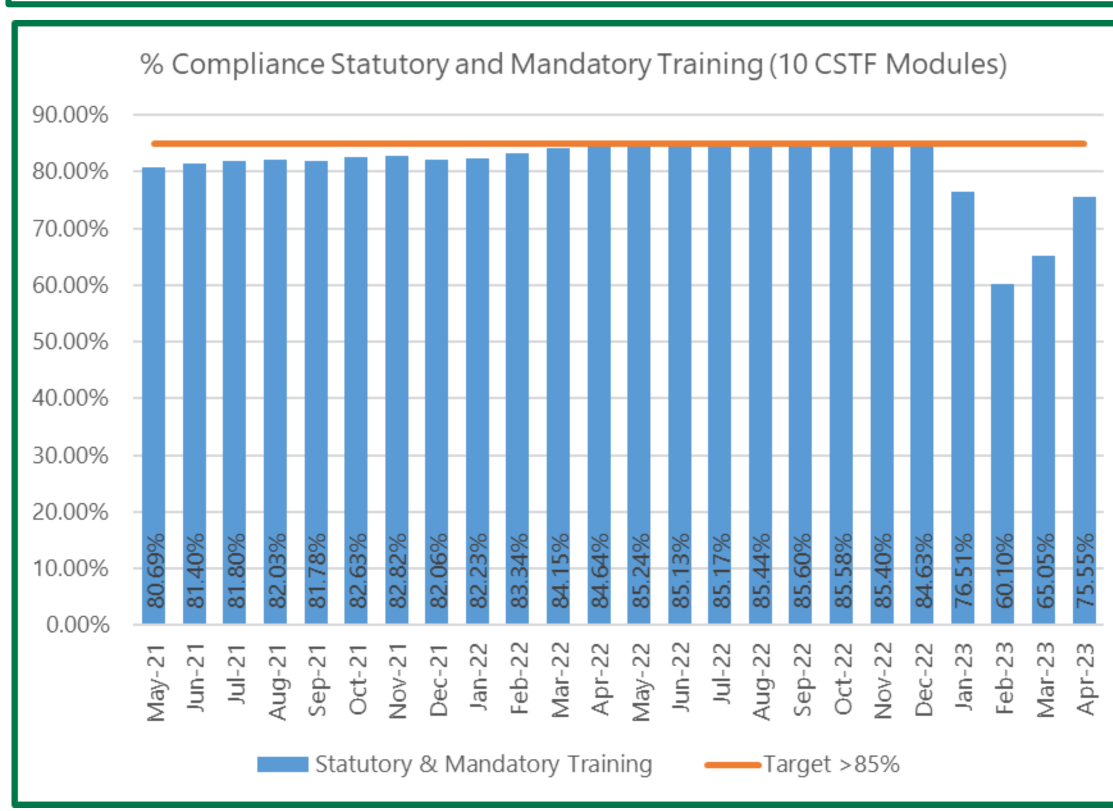
Self Assessment: Strength of Internal Control: Strong

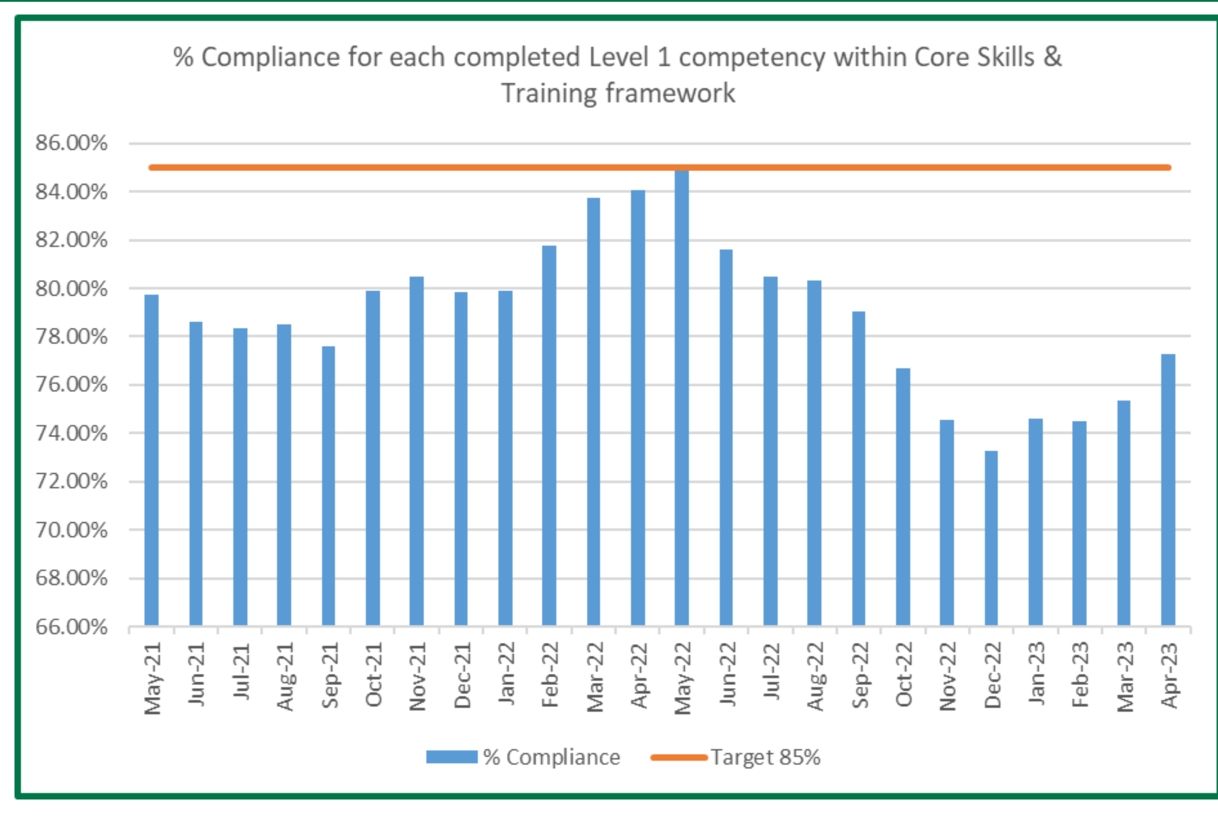
CI

PCC

Health & Care Standard Health – Staff & Resources







Analysis

PADR rates for March 2023 declined compared to the previous month to 72.10%, therefore failing to achieve the 85% target. Over the reporting period this target was only achieved once in December 2022, although current rates are much higher than the same period last year.

In April 2023 Statutory & Mandatory Training rates reported a combined compliance of 75.55%; with Safeguarding Adults (91.73%), Dementia Awareness (90.47%) and Violence Against Women, Domestic Abuse & Sexual Violence (85.77%) all achieving the 85% target. Moving & Handling (79.16%), Fire Safety (74.72%), Equality & Diversity (73.07%), Information Governance (71.57%), and Paul Ridd (38.26%) all remain below this target.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

Remedial Plans and Actions

At the time of reporting, (mid-April 2023) 417 of 1,836 EMS colleagues (22.7%), 30 of 284 ACA2 (10.56%) and 81 of 540 ACA1 colleagues (15.00%) have completed MIST Training days. Sessions continue to be facilitated Pan-Wales through the Education and Training Team, who Continue to manage and monitor these via the online booking system accordingly.

From the 01st April 2023 e-learning mandated by Welsh Government in relation to Welsh Language will be added to all colleagues' compulsory competencies via ESR. Communication to ensure colleagues are prepared and aware of this continues to be circulated via Siren and Yammer.

Expected Performance Trajectory

The Statutory & Mandatory compliance needs to be addressed, but further analysis of the cause is required before an improvement trajectory can be set.

Skills and Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection Prevention & Control - Level 1	3 years
Information Governance (Wales)	2 years
Moving and Handling - Level 1	2 years
Resuscitation - Level 1	3 years
Safeguarding Adults - Level 1	3 years
Safeguarding Children - Level 1	3 years
Violence & Aggression (Wales) - Module A	No renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Welsh Language Awareness	3 Years
Paul Ridd Learning Disability Awareness	No renewal
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

Data source: ESR

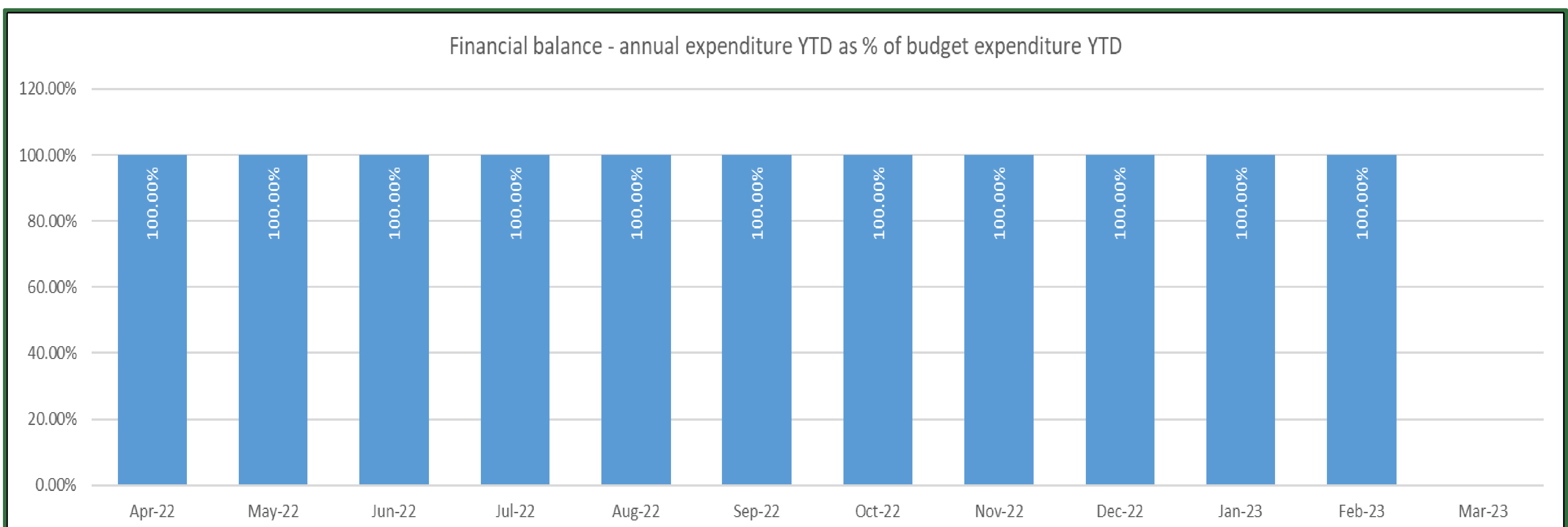
Finance, Resources and Value
Finance Indicators

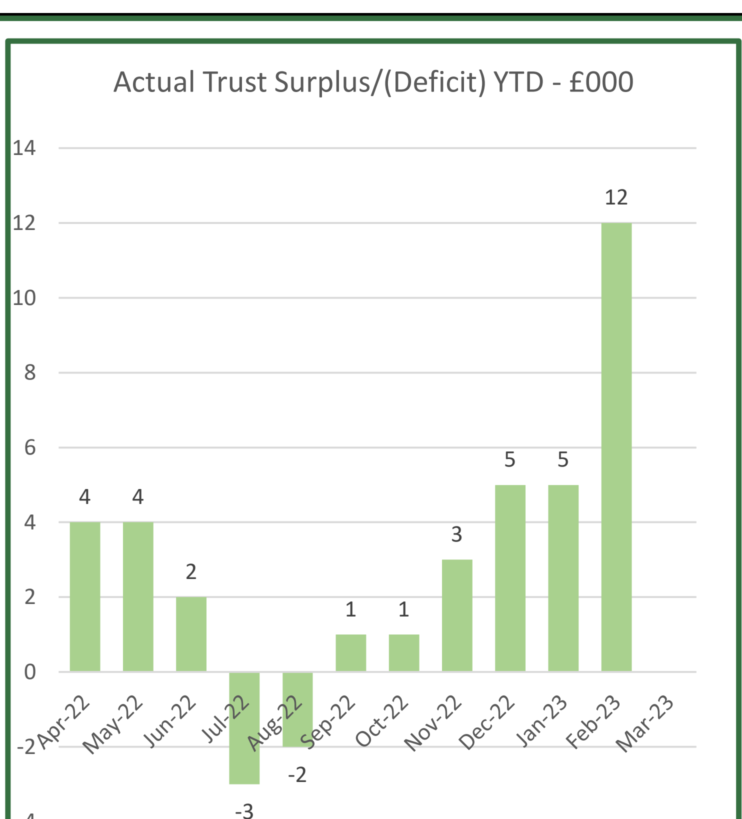
(Responsible Officer: Chris Turley)

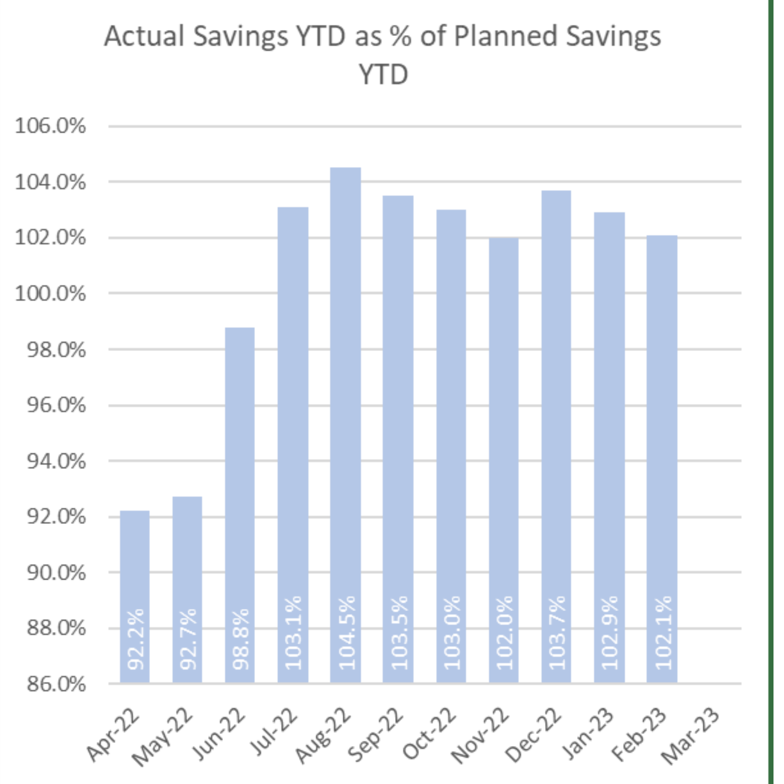
G

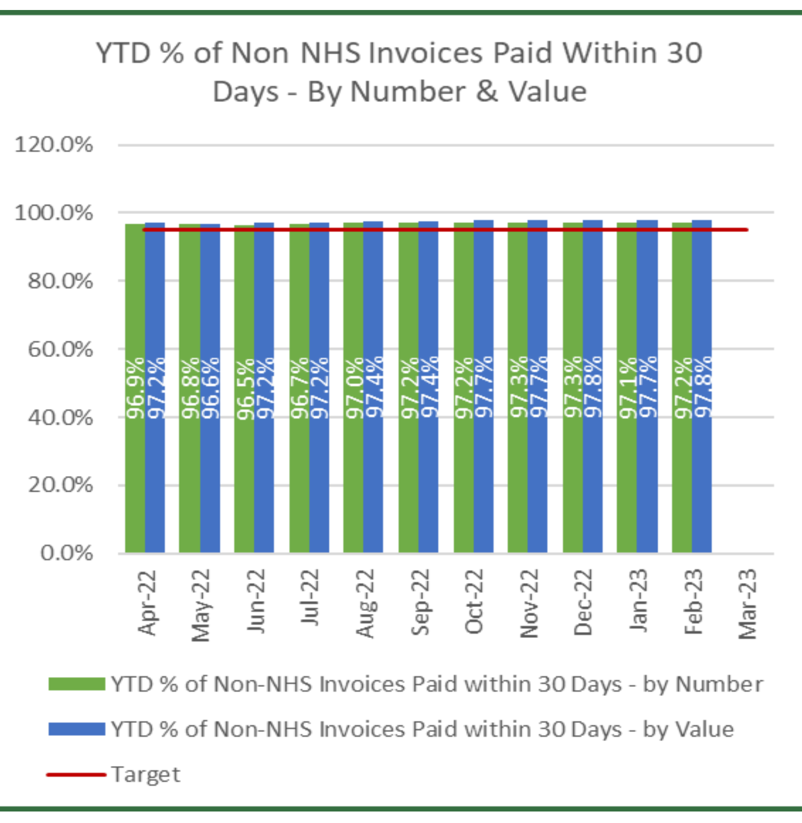
FPC

*NB: March 2023 update unavailable due to 2022-23 Year end processes









Analysis

The reported outturn performance at Month 11 is a surplus of £12k, with a forecast to the yearend of breakeven.

For Month 11, the Trust is reporting planned savings of £3.942m and actual savings of £4.025m (an achievement rate of 102.1%).

The Trust's cumulative performance against PSPP as at Month 11 is 97.2% against a target of 95%.

The agency spend in February 2023 (0.5%) remained the same as January 2023 (0.5%).

Remedial Plans and Actions

The Trust's financial plan for 2022-25 has been built on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures in place to drive through the delivery of our financial plan.

Key specific risks to the delivery of the 2022/23 financial plan and beyond include:

- Continuing financial support from Welsh Government in relation to Covid costs;
- Availability of capital funding to support the infrastructure investment required to implement service change, and the ability of the Trust to deliver the revenue consequences of capital schemes within stated resource envelope;
- Financial impact of EASC Commissioning Intentions, and confirmation of the EMS financial resource envelope as assumed within our financial plan;
- Ensuring additional avoidable costs that impact on the Trust as a result of service changes elsewhere in the NHS Wales system are fully recognised and funded;
- Ensuring any further developments are only implemented once additional funding to support these is confirmed;
- Delivery of cash releasing savings and efficiencies;

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2022/23 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2023/24 financial year.

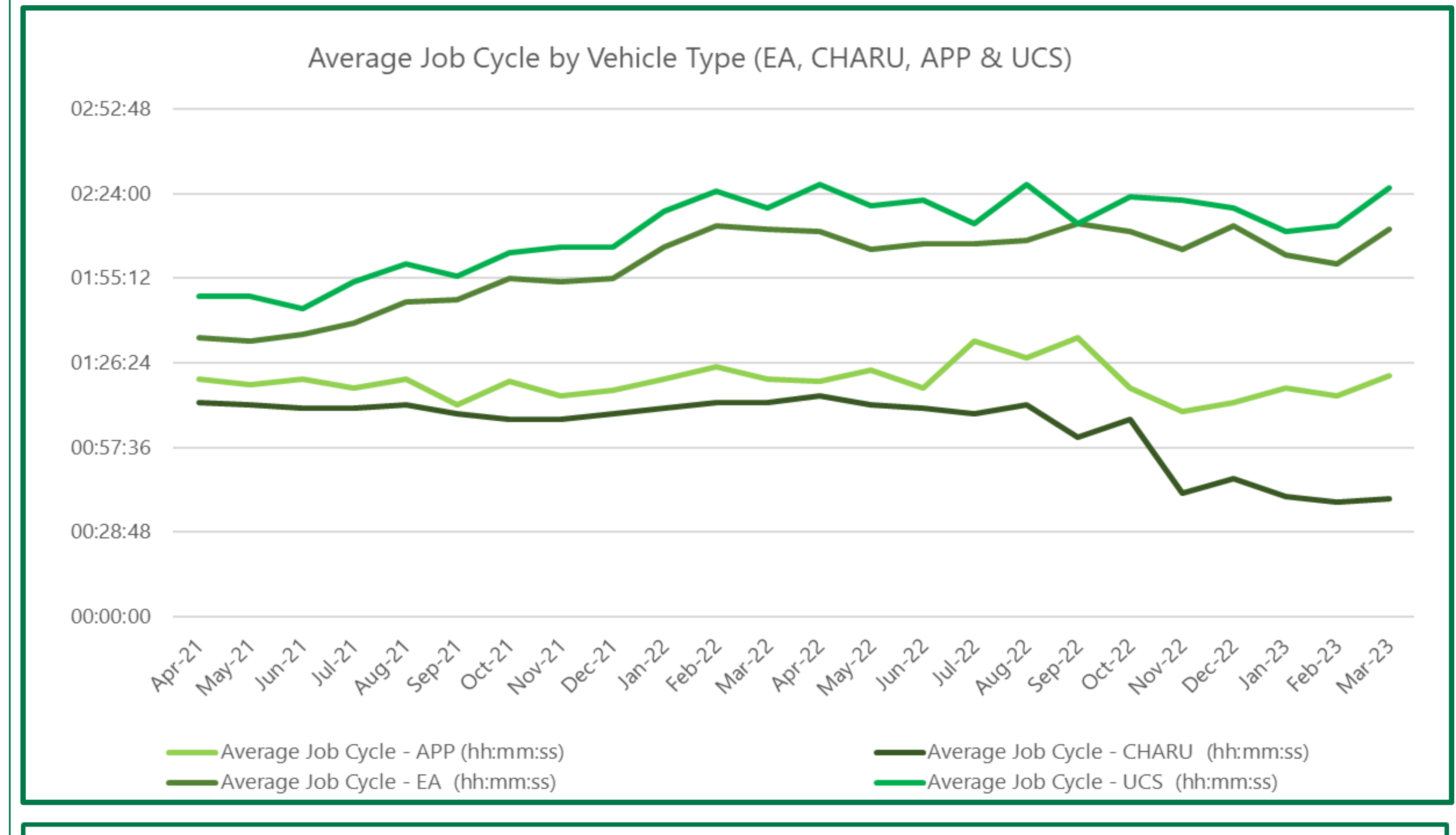
Finance, Resources and Value
Resource and Value Indicators

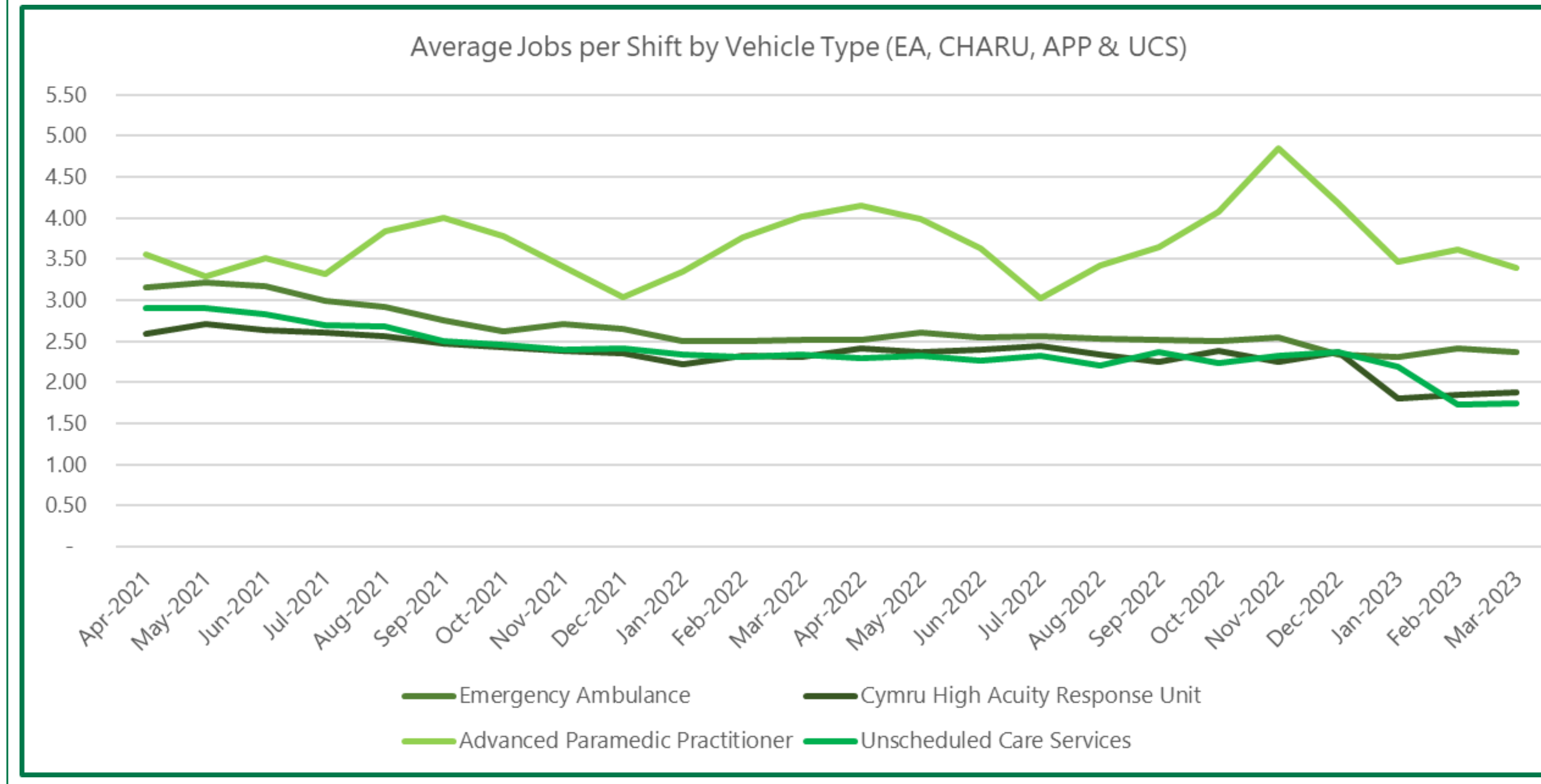
(Responsible Officer: Chris Turley)

Decarbonisation

A

FPC





Value – Job Cycle and Volume

Analysis

As demonstrated in the top graph, the average job cycle decreased in March 2023 for all vehicle types. EA calls averaged 2 hours 12 minutes while UCS crews saw their average increase to 2 hours 26 minutes.

Average jobs attended by all crew types increased in March 2023, except for EA and APP crews. APPs attended on average 3.40 jobs per shift, EAs 2.37 jobs per shift, UCS crews 1.74 jobs per shift and RRV's 1.88 jobs per shift.

Overall average jobs per shift has remained relatively static for EA, CHARU and UCS throughout the past year, following a period of decline during 2021. In comparison average jobs per shift for APPs is on a fluctuating, but generally increasing trajectory.

Remedial Plans and Actions

The increase in average job cycle time since 2021 can be attributed to numerous factors including the introduction of ePCR and increasing hospital delays (staff pre-empting and packaging patients in readiness for long waits and patients waiting longer for an ambulance response therefore requiring more treatment/assessment). These times are monitored at Weekly Performance Meeting and local work to establish appropriate efficiency initiatives is ongoing

Expected Performance Trajectory

The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen.

**NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*
Total shift hours currently includes the meal break for the shift
Total shift hours also includes Postproduction Lost Hours

NB: CHARU data is not yet available

Resource - Decarbonisation

Analysis

Delivery of the capital programme in 2023/24 sought to maximise decarbonisation aspects associated with investment. Examples include PV panels and battery storage at Bridgend Ambulance Hub, PV panels, battery storage and installation of air source heat pump within the development of the SE Fleet Workshop, and other energy saving schemes such as LED lighting, glazing and building management systems where possible during the last quarter of 2023/24. The Trust's EV charging network (initially to support implementation of 23 PHEV car-based response vehicles) developed from minimal provision to 67 chargers over 54 sites.

Remedial Plans and Actions

WAST Decarbonisation Action Plan is currently reporting internally as Amber. Estates and Facilities Advisory Board funding in 2023/24 and 2-24/25 will allow for investment in further infrastructure and decarbonisation schemes across a range of sites. Plans for Building Management Systems, and a design guide for retrofit of estate continue to be developed. However, further funding will be required. The Trust has completed a scoping exercise for electrical capacity requirements across the WAST estate and work is ongoing with Welsh Government Energy Services on rapid EV charging. The Programme Board was established in January 2023 and met again on 24th April 2023, and continues to develop its work programme and risk management approach.

Expected Performance Trajectory

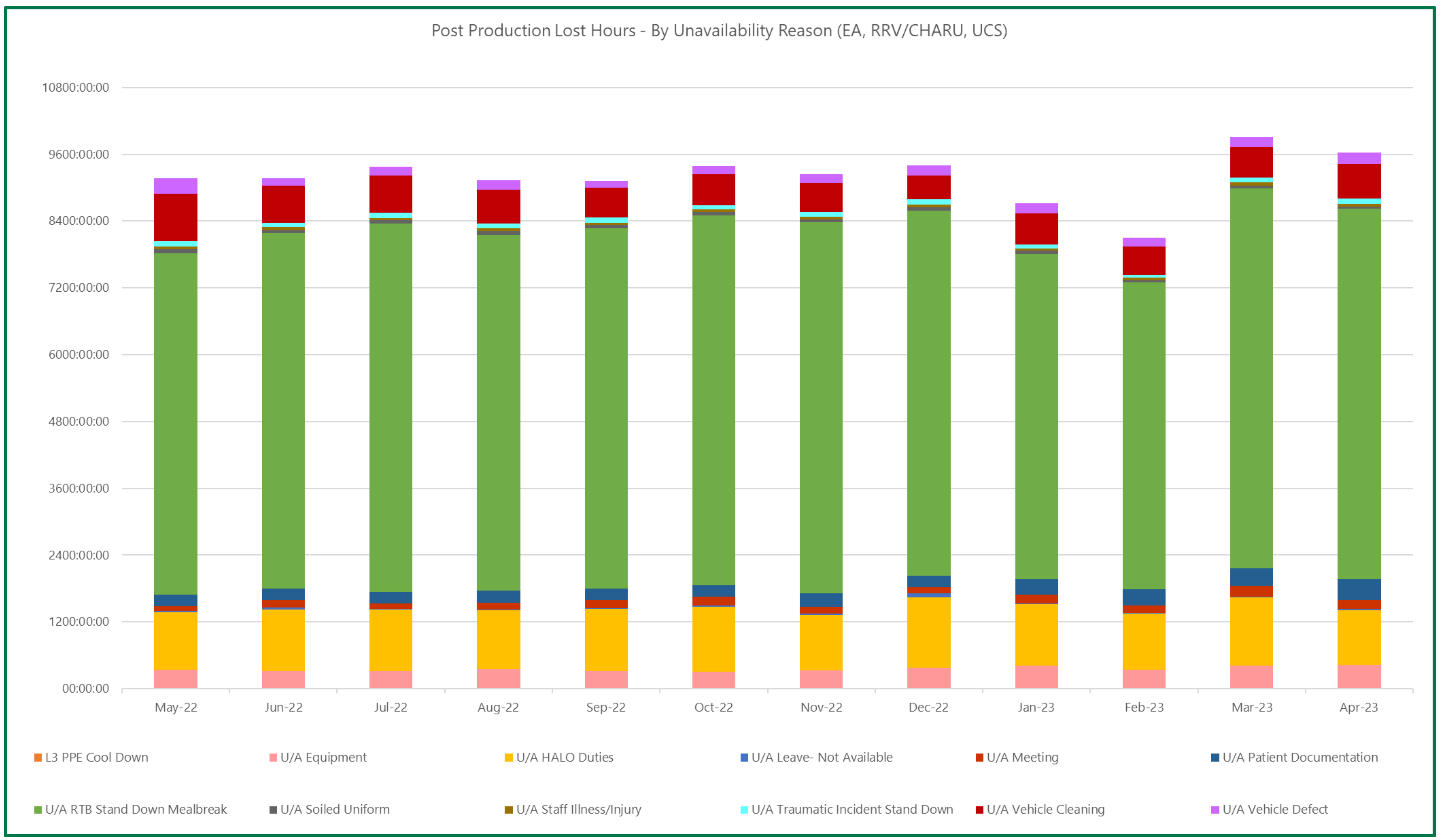
The Welsh Government targets of a net-zero position by 2030 pose real and complex challenges for WAST. In response to this, a key action over the next year will be to develop our Sustainability and Infrastructure Strategic Outline Programme, which will outline the financial and resource implications for the move to a carbon-neutral ambulance Trust. This will need significant input from our colleagues across the Trust and will require additional investment within the Finance and Corporate Resources Directorate to manage this. The relevant business cases in support of Estates and Fleet developments will continue to reinforce the importance of this agenda, and to push us towards a position of carbon neutrality, maximising our use of new technology and responding in a flexible and agile way to the changing external environment.

Value / Partnerships & System Contribution
EMS Utilisation & Postproduction Lost Hours Indicators

(Responsible Officer: Lee Brooks)

R

FPC



Analysis

There were 9,631 postproduction lost hours (PPLH) across EA, RRV/CHARU, APP & UCS vehicles in April 2023; a decrease when compared to March 2023 (9,016). PPLH are due to numerous factors, as outlined in the bar chart which demonstrates they have remained relatively consistent since May 2022 (the month a retrospective fix was undertaken for the under-reporting of U/A RTB Stand Down Meal-break code), albeit the last two months have seen the highest reported figures over the past year. There was a decrease in hospital handover delays in the months month of April and April 2023 to hours (from in 2023 23,082 down 28,620 March).

Remedial Plans and Actions

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. In relation to the U/A RTB Stand Down Meal-break reason, the rest break automation initiative has been paused due to industrial relations. The Trust plans to revisit this once the industrial dispute with Welsh Government has concluded.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH. Although delayed handover hours outside EDs have improved slightly from December 2022, the lost hours for March 2023 were extreme, meaning resources are returning to base for rest predominantly outside of the rest break window, resulting in an unavailable status being assigned.

**NB: PPLH Data correct at time of extract*

Partnerships / System Contribution

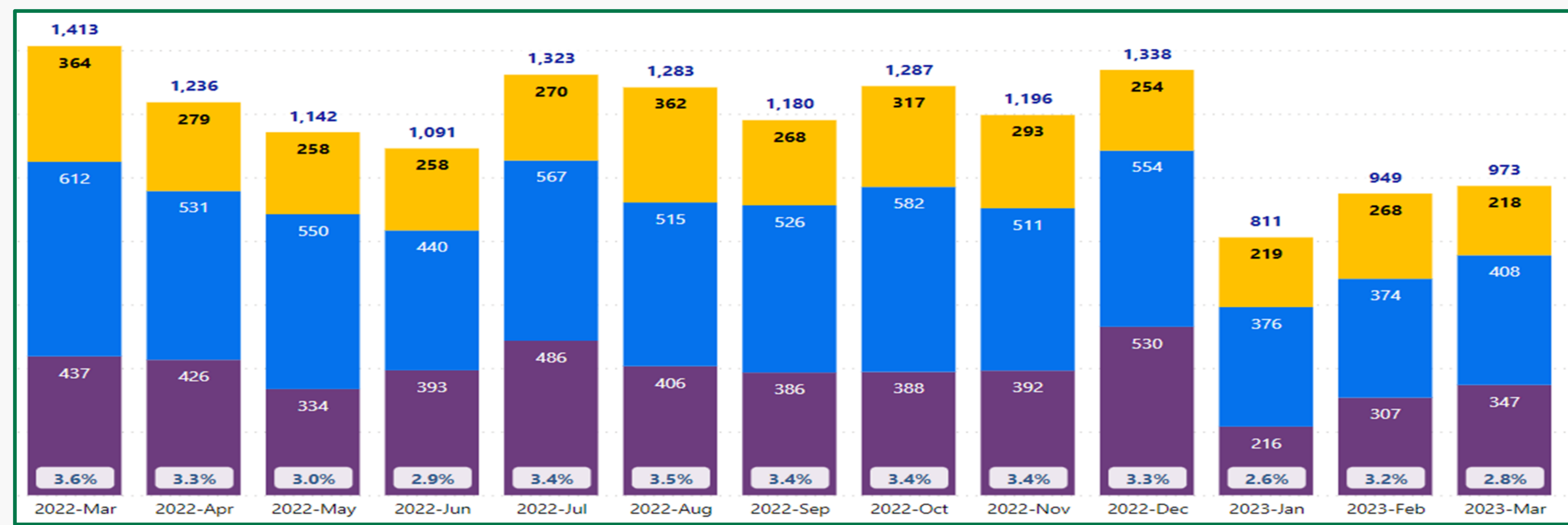
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

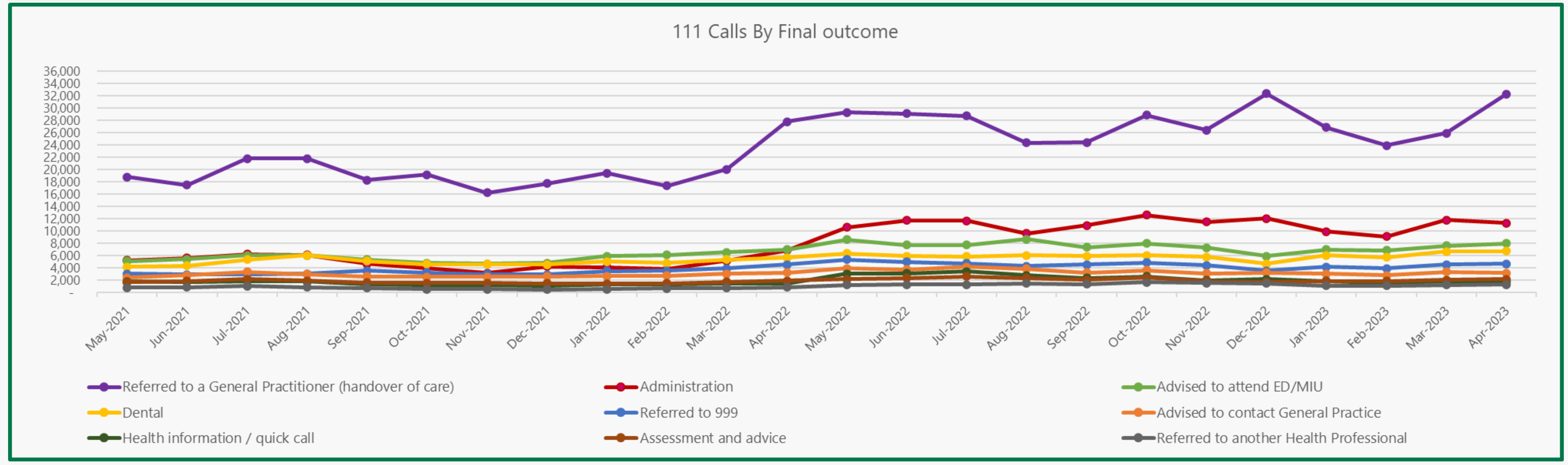
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

A

FPC





Analysis

The top graph depicts the outcomes against 999 calls where secondary triage is performed by NHS111 Consult and Close.

As demonstrated in the top graph in March 2023 alternative transport was the top outcome for calls handled by NHS111 followed by referral and.

65,070 calls were received into the 9 categories displayed in the bottom graph during March 2023, an increase when compared to 56,917 received in February 2023; and more in line with the average volume of calls received in the last 6 months.

In April 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 45% of all calls.

Remedial Plans and Actions

The new Consult and Close dashboard is now complete and live, enabling the Trust to report more meaningful and specific data in relation to calls ending in alternative transport, referral and self care.

The use of video consultation has been implemented and is now live, early indications show this to be a useful tool.

Expected Performance Trajectory

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

Partnerships / System Contribution
Consult & Close Indicators

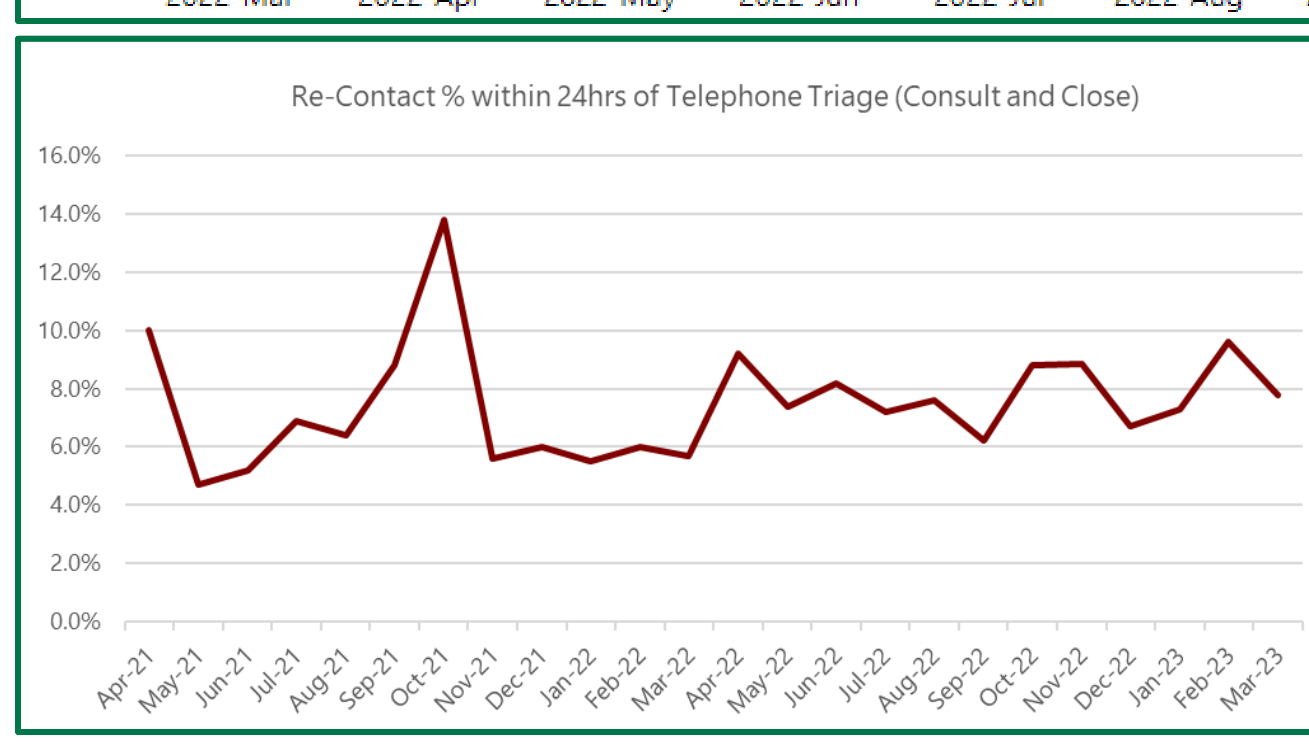
(Responsible Officer: Lee Brooks)

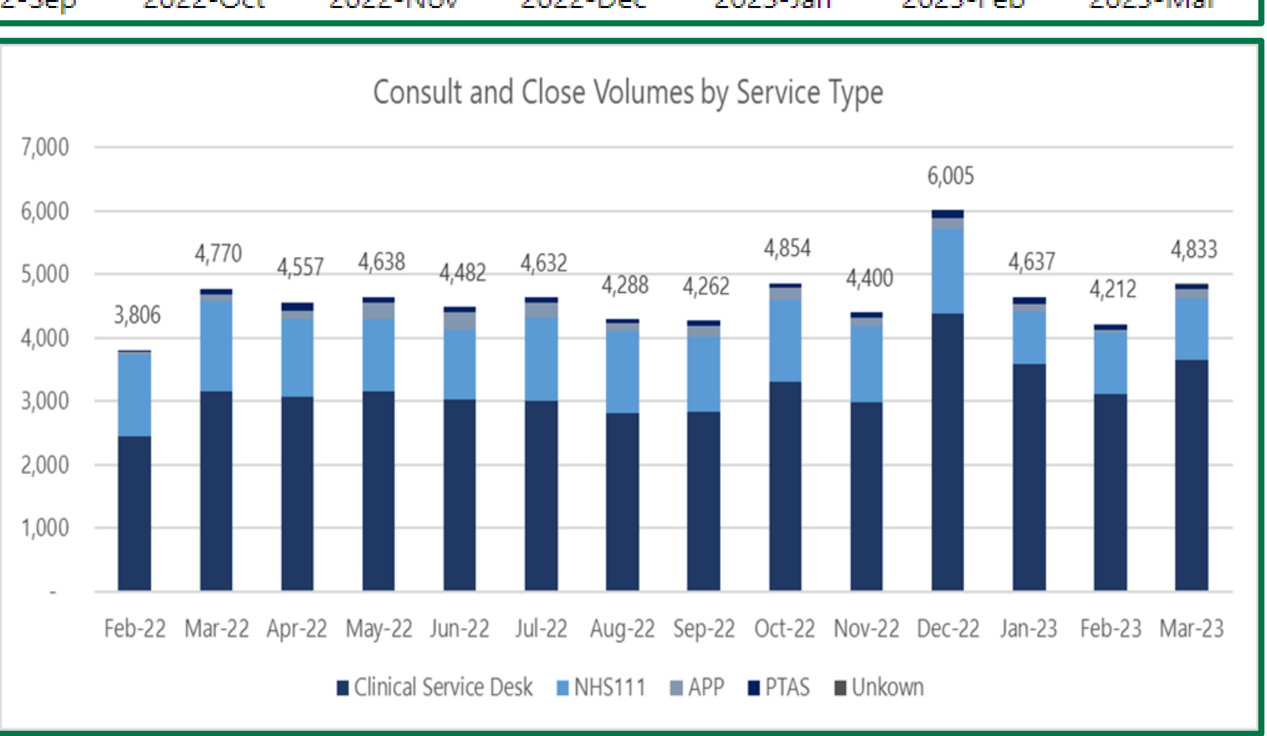
A

FPC

Self Care · Referral · Alternative Transport · Consult and Close Contribution

Month	Self Care	Referral	Alternative Transport	Total	Consult and Close Contribution
2022-Mar	1,261	1,229	2,268	4,758	12.2%
2022-Apr	1,326	1,151	2,056	4,533	12.0%
2022-May	1,263	1,215	2,148	4,626	12.4%
2022-Jun	1,276	1,049	2,147	4,472	11.9%
2022-Jul	1,333	1,298	1,993	4,624	11.7%
2022-Aug	1,128	1,227	1,925	4,280	11.7%
2022-Sep	1,136	1,189	1,931	4,256	12.2%
2022-Oct	1,195	1,456	2,200	4,851	12.9%
2022-Nov	1,163	1,285	1,943	4,391	12.6%
2022-Dec	1,604	1,701	2,689	5,994	14.6%
2023-Jan	993	1,271	2,370	4,634	14.9%
2023-Feb	1,077	1,179	1,955	4,211	14.2%
2023-Mar	1,242	1,331	2,253	4,826	13.8%





Analysis

Consult and Close with contributions from Clinical Support Desk (CSD) (10.4%), NHS111 (2.8%), as well as WAST APP (0.4%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 13.8% performance in March 2023 which was a slight decline on the 14.2% obtained during February 2023 just short of the new 15% target figure. Although more 999 calls resulted in a Consult and Close outcome (4,826 up from 4,211) the number of 999 incidents was also higher leading to the lower percentage.

Of the calls successfully closed in March 2023, 1,242 patients received an outcome of self care; 1,326 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,250 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in March 2023 were 7.8%, an increase compared to 5.7% in March 2022 and 7.1% in March 2021.

Remedial Plans and Actions

- The team are undertaking process maps of the work that they do in order to identify where improvements can be made.
- Red Review of 999 calls to confirm appropriate category selection continues to be a high priority for CSD in addition to Consult and Close activity.
- Discussions are ongoing to identify additional resources required on top of Consult & Close priorities.

Expected Performance Trajectory

The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling.

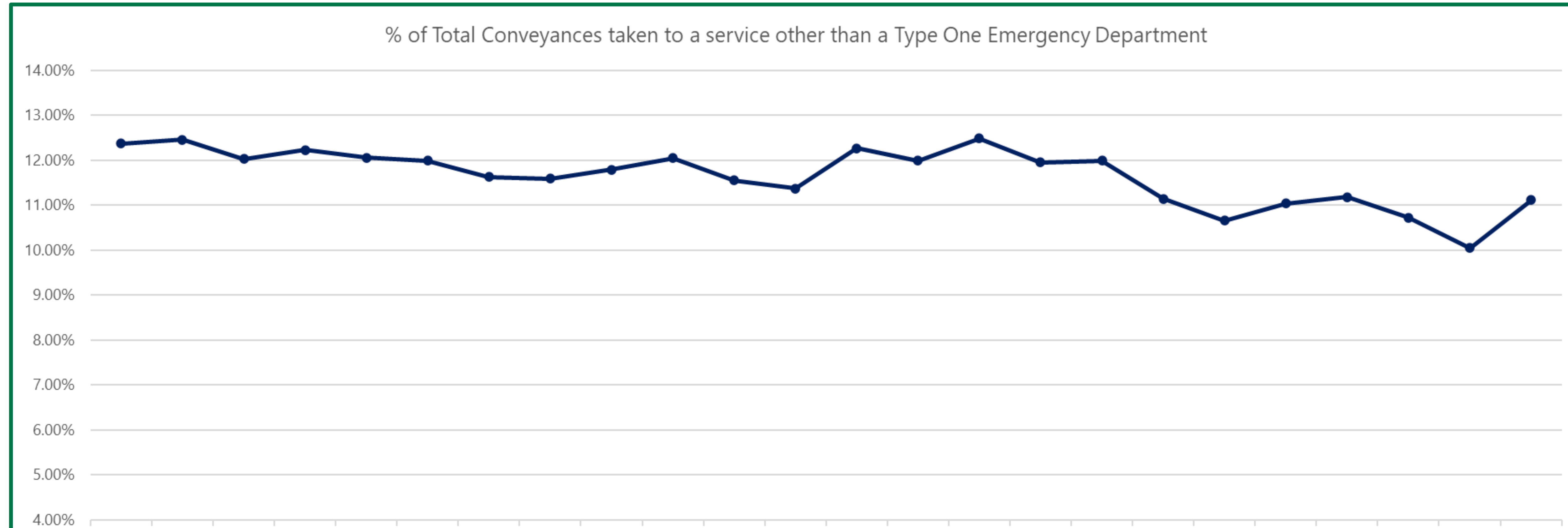
Partnerships / System Contribution
Conveyance to ED Indicators

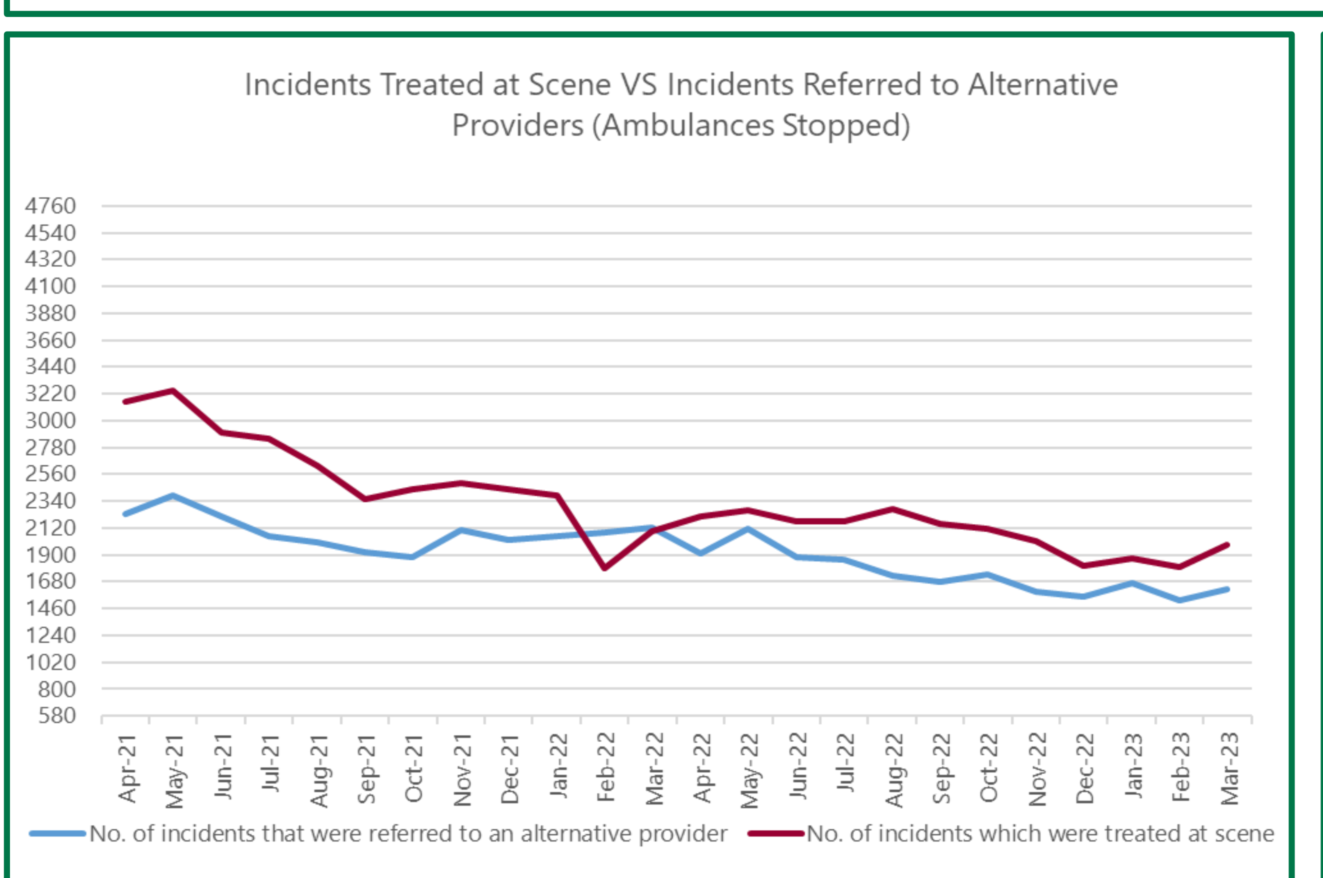
(Responsible Officer: Andy Swinburn)

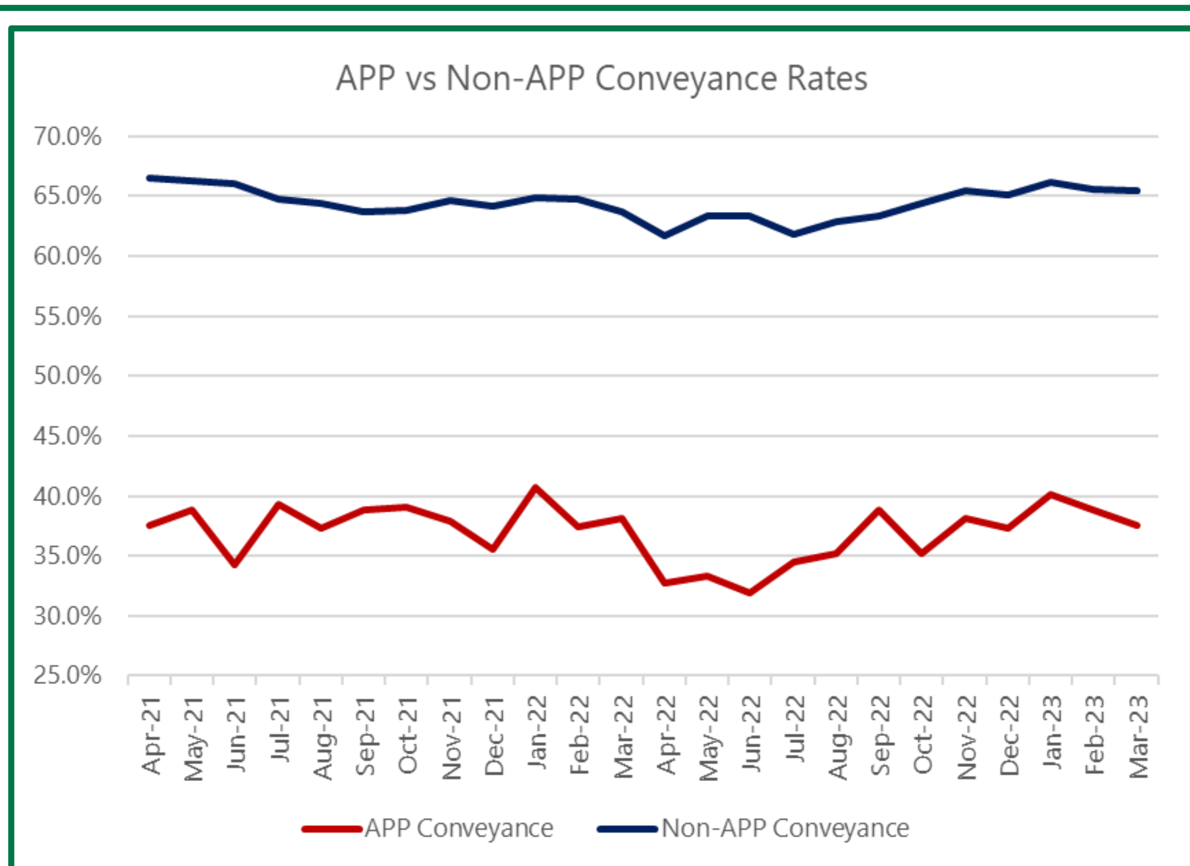
A

FPC

Ministerial Measure







Analysis

In March 2023 11.11% of patients (1,524) were conveyed to a service other than a Type One ED. Although not shown here, the percentage of patients conveyed to EDs increased compared to the same period last year. In March 2023 conveyance to EDs as a proportion of total verified incidents was 34.80% (compared to 32.21% in March 2022).

The combined number of incidents treated at scene and referred to alternate providers increased slightly during March 2023, from 3,330 in February to 3,599 in March 2023. 1,615 incidents were referred to alternative providers and 1,984 incidents were treated at scene.

There has been a general increase in APP conveyance rates in recent months, due to several factors: -

- CSP means the right jobs are not always there for APPs to alter or influence the disposition.
- The tasking of APPs has changed, moving away from APPs reviewing the stack to mandatory code sets.
- There has been an increase in respiratory patients of all ages over the last quarter who have been poorly and required hospital admission.

Remedial Plans and Actions

The Trust has modelled the use of same day emergency care (SDEC) services and identified that they could take an estimated 4% of EMS demand; it is currently less than 0.25%. This modelling has been provided to both EASC and WG. The percentage increase in conveyance to services other than EDs is a Ministerial Priority. The Trust's ability to improve this figure is dependent on pathways that are open to the Trust, for example, SDECs.

Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

Expected Performance Trajectory

The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well. This modelling indicates a reduction in patients conveyed of 1,165 per week but is predicated on large scale investment in APPs (470 v a starting position of 67).

NB: Data correct on the date and time it was extracted; therefore, figures are subject to change.

Partnerships / System Contribution
Handover Indicators

(Responsible Officer: Health Boards)

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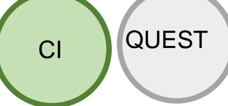
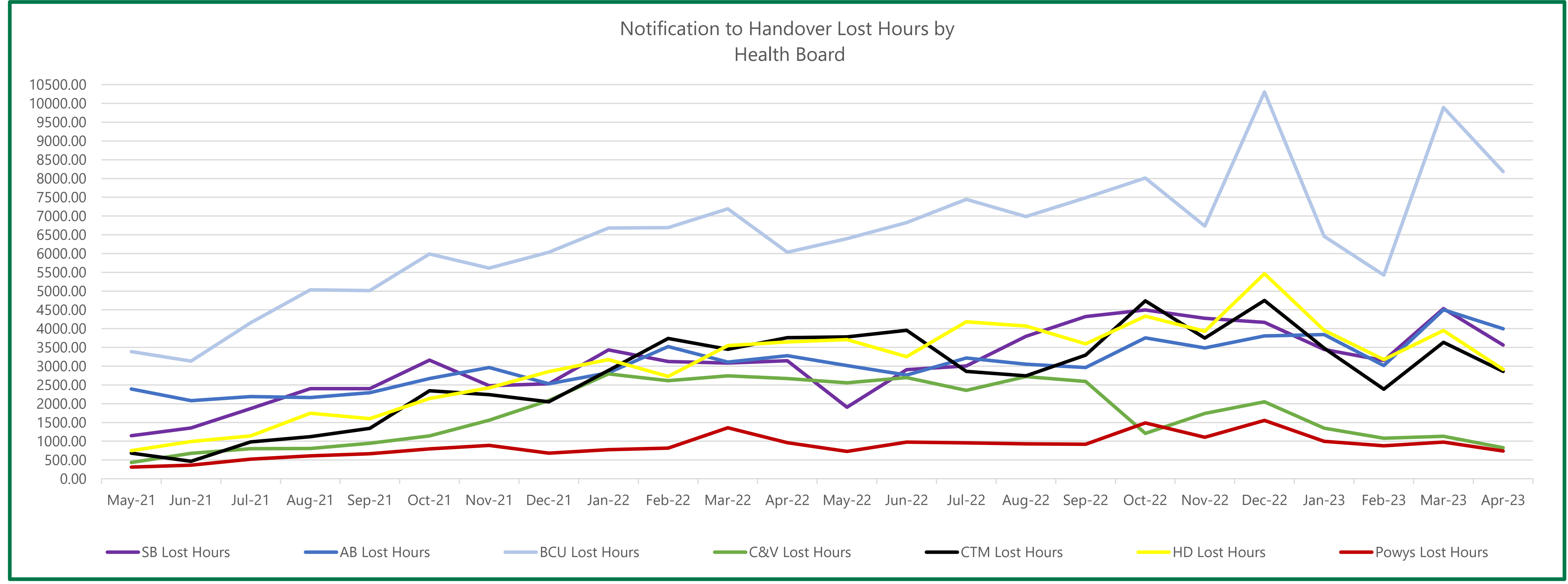
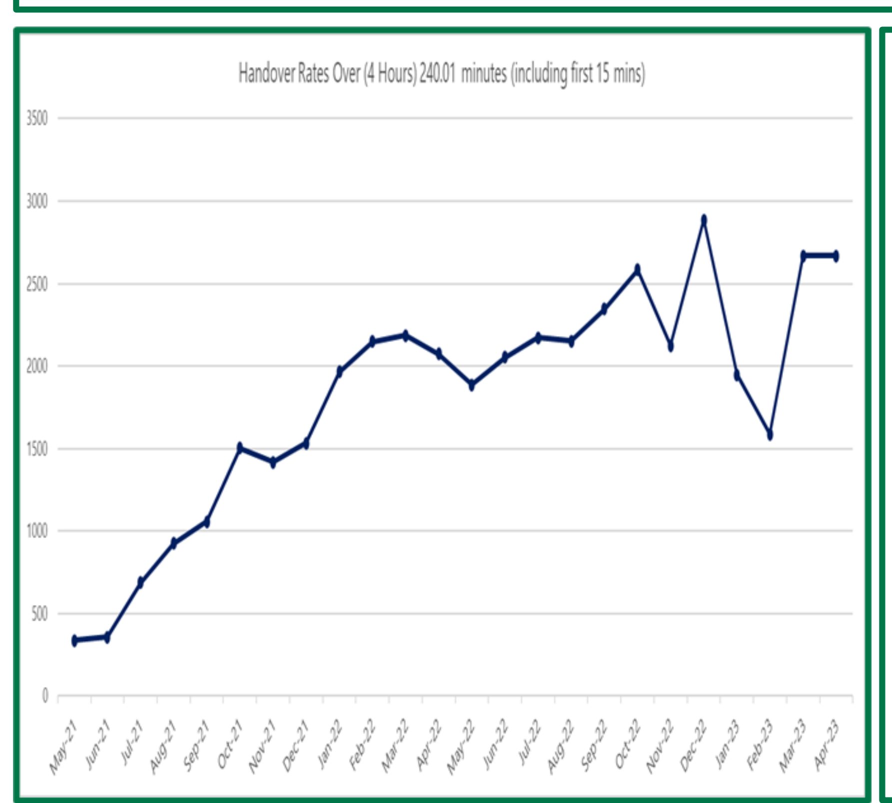
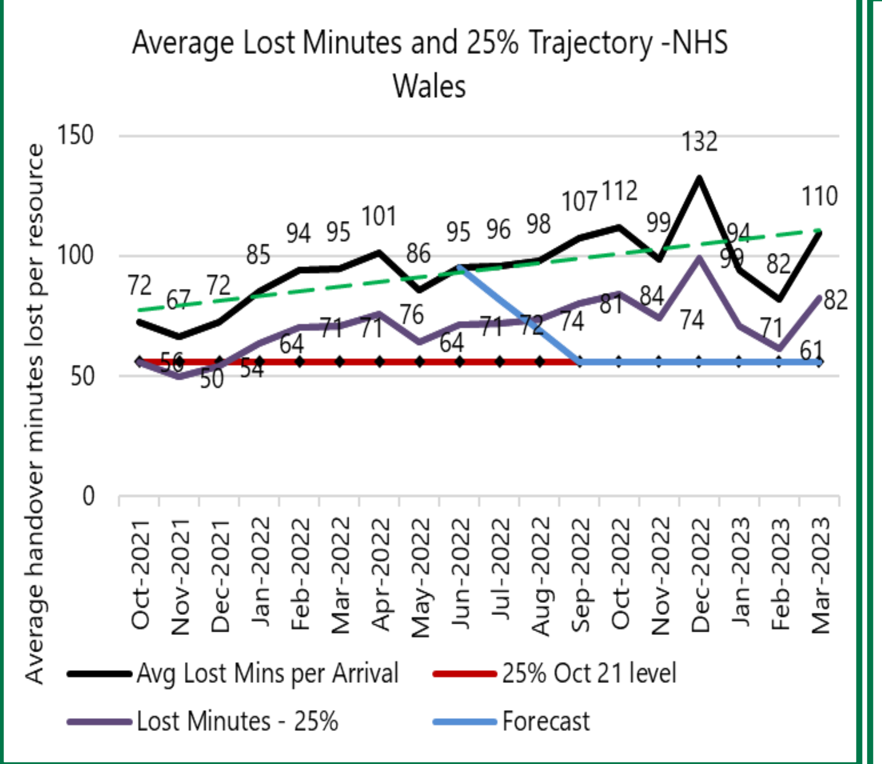
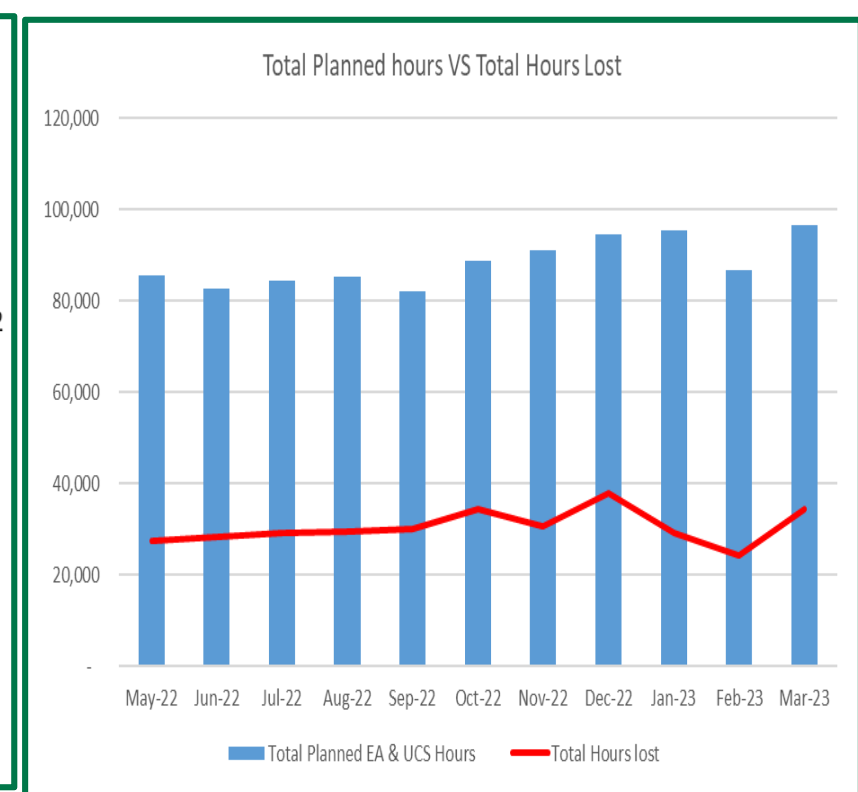










Analysis

299,336 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (May-22 to Apr-23), compared to 206,755 over the same timeframe the previous year. 23,082 hours were lost in April 2023, a decrease from the 28,620 lost in March 2023.

The hospitals with the highest levels of handover delays during March 2023 were:

- Morriston Hospital (SBUHB) at 2,098 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 3,464 lost hours
- The Grange University Hospital (ABUHB) at 3,840 lost hours
- Maelor General Hospital (BCUHB) at 2,735 lost hours

Notification to handover lost hours averaged 769 hours per day during April 2023 compared to 923 hours a day in March 2023. There were 2,670 handovers over 4 hours Pan-Wales in April 2023 an increase compared to April 2022 (2,072).

In March 2023, the Trust could have responded to approximately 7,281 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve.

Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR). 60 ideas have been received through the WIIN platform from staff in August 2022.

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	D&T	Discharge & Transfer	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	DU	Delivery Unit	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	EASC	Emergency Ambulance Service Committee	HR	Human resources	NRI	Nationally Reportable Incident	SPT	Senior Pandemic Team
CASC	Chief Ambulance Services Commissioner	EAP	Employee Assistance Provider	HSE	Heath and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CC	Consultant Connect	ED	Emergency Department	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	EMD	Emergency Medical Department	IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	TU	Trade Union
CCP	Complex Case Panel	EMS	Emergency Medical services	IPR	Integrated Performance Report	OH	Occupational Health	UCA	Unscheduled Care Assistant
CEO	Chief Executive Officer	EMT	Executive Management Team	KPI	Key Performance Indicator	P / PHB	Powys / Powys Health Board	UCS	Unscheduled Care System
CFR	Community First Responder	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	PCR / PCRs	Patient Care Record(s)	UFH	Uniformed First Responder
CI	Clinical Indicator	EPT	Executive Pandemic Team	MACA	Military Aid to the Civil Authority	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	UHP	Unit Hours Production
COOs	Chief Operating Officers	FTE	Full Time Equivalent	MIU	Minor Injury Unit	PECI	Patient Engagement & community Involvement	U/A RTB	Unavailable – return to Base
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	POD	Patient Offload department	VPH	Vantage Point House (Cwmbran)
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PPLH	Post Production Lost Hours	WAST	Welsh Ambulance Services NHS Trust
CSD	Clinical Service Desk	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	PSPP	Public Sector Purchase Programme	WG	Welsh Government
CSP	Clinical Safety Plan	HCP	Health Care Professional	NEWS	National Early Warning Score	QPSE	Quality, Patient Safety & Experience	WIIN	WAST Improvement & Innovation Network

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Post Production Lost Hours**	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

PATIENT SAFETY REPORT QUARTER 4 (JANUARY - MARCH 2023)

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 May 2023
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Assistant Director of Quality & Nursing
CONTACT	Wendy Herbert 07966 205399 Wendy.herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an update to the Quality, Patient Experience & Safety Committee (QuESt) on the key information from the Putting Things Right (PTR) and Patient Safety teams.

In summary the Report for this quarter identifies:

- Continued high level of risk of harm to our patients in community (Risk 223) and patients delayed outside of emergency departments (Risk 224)
- A decrease in the number of concerns, but a backlog remains.
- A continuing number of incidents being reviewed at the Serious Case Incident Forum (SCIF)
- A continuing number of Joint Investigations passed to Health Boards
- A continuing number of Nationally Reportable Incidents (NRIs) identified
- A continued upward trend in Coroner's requests for information
- An increase in the number of Road Traffic Incident claims
- The Trust received two Regulation 28 Reports during this period and responses have been submitted within the given timescales
- Periods of industrial action took place during this quarter.

RECOMMENDED that the Committee receives the report for discussion.

KEY ISSUES/IMPLICATIONS
(i) There continues to be an increase in activity in the majority of areas across PTR. (ii) There continues to be a high-level volume of concerns being received. (iii) A significant improvement in our two-day acknowledgement of concerns has been sustained overall, but our thirty-day compliance remains low. (iv) Delivery of functions remains a significant challenge due to capacity, demand and competing priorities.

REPORT APPROVAL ROUTE	
Executive Management Team	TBC
Quality, Patient Experience & Safety Committee	11 May 2023

REPORT APPENDICES
Annex 1: Detailed Patient Safety Report providing background information. Annex 2: Learning from Events Newsletter

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

ANNEX 1

PUTTING THINGS RIGHT						
	Quarter 2, 2022-23			Quarter 3, 2022-23		
	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023
Patient Safety Incidents						
Catastrophic	37	34	82	40	37	30
Severe	8	7	21	12	14	14
Moderate	64	70	99	52	38	90
Low	146	136	175	119	74	218
None	303	201	209	171	103	160
Total	558	448	586	394	266	512
Concerns						
Total Received	109	94	124	79	67	72
Total Closed	81	97	108	99	101	105
2 Day Acknowledgment %	96%	99%	89%	91%	98%	79%
30 Day Response due %	28%	24%	27%	21%	24%	20%
Ombudsman						
Cases Received	2	4	2	8	1	5
Cases Closed	1	5	8	4	2	7
Reports Received	0	0	1	0	0	1
Coroners						
Information requests	157	160	148	152	157	163
Identified as Interested Party	20	23	26	28	30	33
Staff attending	3	3	4	6	5	8
Regulation 28 issued	1	1	0	1	1	0
Response to Regulation 28 in 56 working days	0	0	1	0	1	1
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to NHS Wales Executive Delivery Unit (reporting date)						
Serious Case Incident Forums held	6	5	7	8	6	7
Serious Case Incident Forums Cases	42	26	36	68	51	38
WAST NRIs reportable to Delivery Unit	8	2	0	5	12	3
Joint Investigation Framework - Passed	15	7	18	35	16	15
Joint Investigation Framework - Received		3	1	3	0	1
NRI Closures Submitted - Total	6	3	6	1	3	1
NRI Closed by Delivery Unit - Total	0	0	0	0	0	0
Claims						
Personal Injury - Received	1	4	1	2	2	1
Personal Injury - Closed	0	0	4	1	0	6
Clinical Negligence - Received	0	*	1	2	0	2
Clinical Negligence - Closed	4	*	0	0	0	0
Road Traffic Collision & Damage to Property - Received	17	30	26	29	36	17
Road Traffic Collision & Damage to Property - Closed	16	37	20	51	22	13

BACKGROUND

1 The purpose of this Patient Safety Highlight Report is to provide an update to the Quality, Patient Experience & Safety Committee, with onward reporting to Trust Board as required on the key information in relation to PTR and Patient Safety. This Report provides key information on:

a) Patient Safety Incidents and Alerts/Notices

b) Nationally Reportable Incidents (NRIs) (previously Serious Adverse Incidents)

c) Concerns (including political)

d) Redress

e) Ombudsman

f) Coroners

g) Claims

h) Organisational Learning

2 Please note that the data contained within this Report is accurate at the time of reporting. **Data may be subject to change as incident case types may be regraded during the investigation process**.

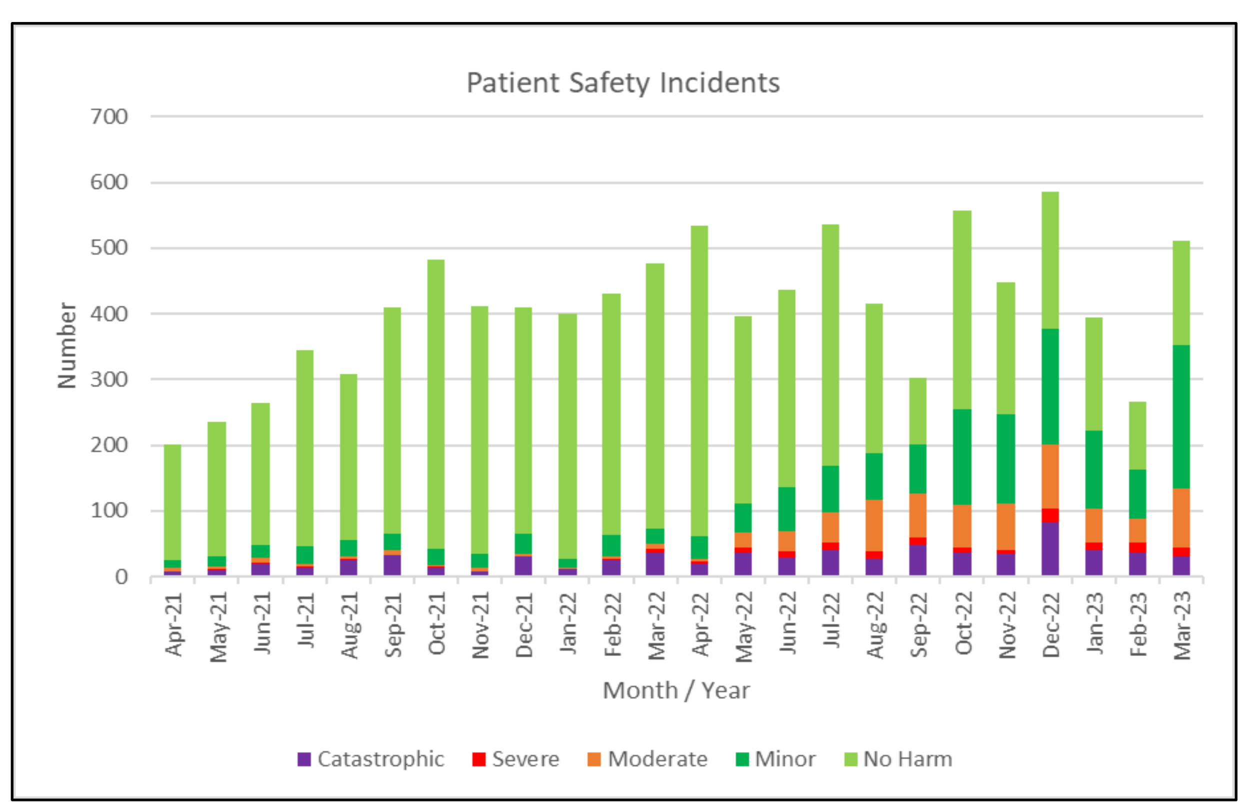
ASSESSMENT

Patient Safety Incidents

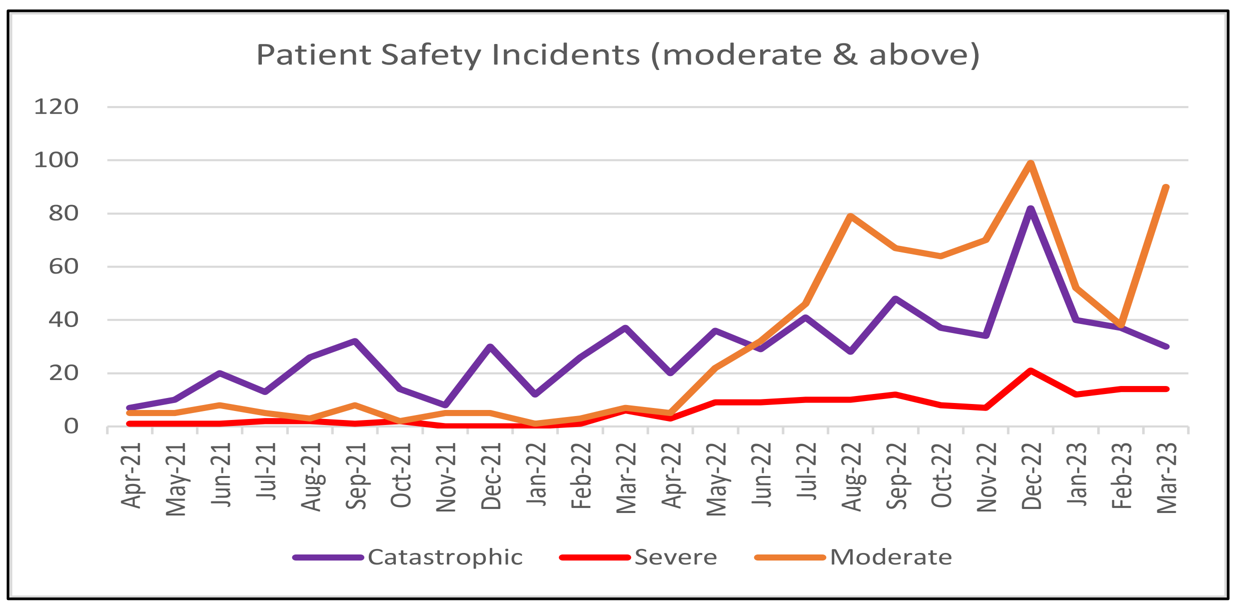
3 **Patient Safety Incidents (PSI) reported as catastrophic are usually related to patient outcome. In all cases an investigation is pending, and it has not been established whether the outcome was due to any act or omission by The Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the patient's underlying medical condition.**

4 During this period a total of **1,172** patient safety incidents were reported, **394** in January, **266** in February and **512** in March. All incidents with an initial harm grading of moderate, severe or catastrophic are reviewed weekly by the Patient Safety Team. **It must be noted that the harm grading may change subject to the conclusion or outcome of any investigation.**

5 The chart below illustrates the number of patient safety incidents reported on a rolling basis from April 2021 by initial grading. Themes continue to relate to timeliness to response.

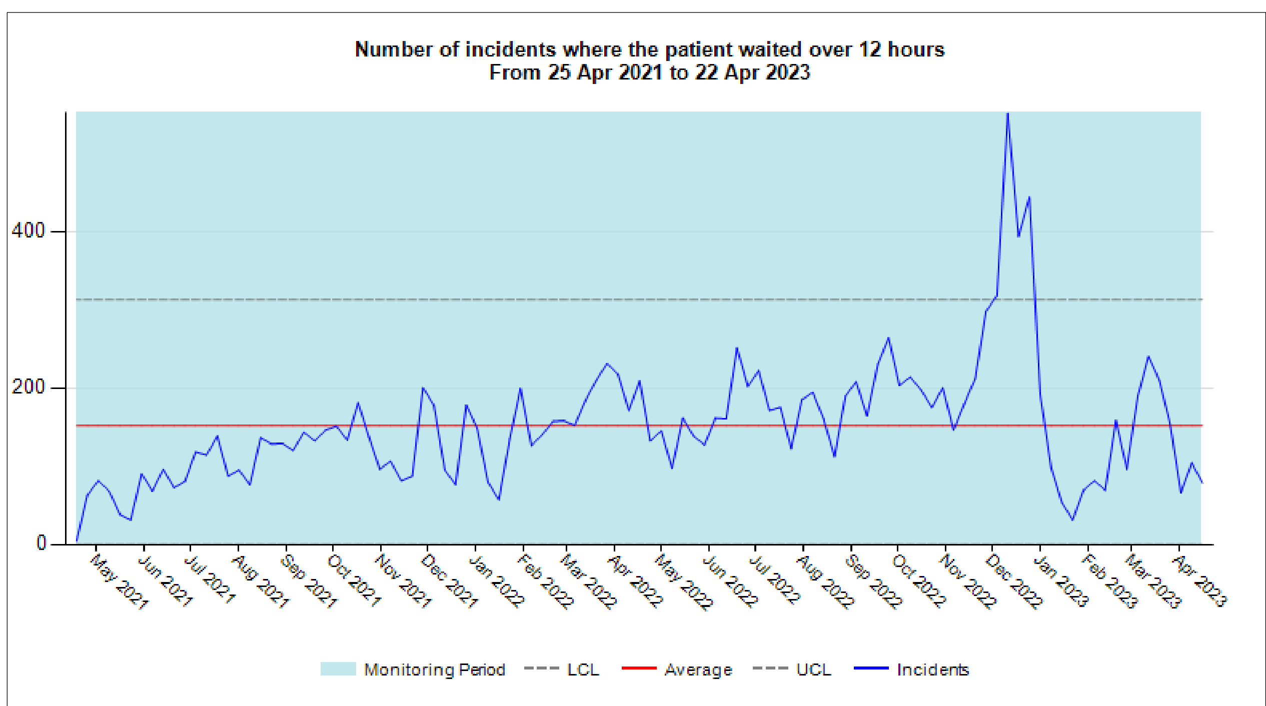


6 The graph below details the number of patient safety incidents rated moderate and above. From April 2023 all patient safety incidents graded moderate or above following review by the Patient Safety Team / SCIF Panel will trigger the Duty of Candour. Compliance with the Duty will be monitored by the Patient Safety Team.



7 The Trust's key policies relating to the Health and Social Care (Quality and Engagement) Act (2020) were updated and approved at the Policy Group in April 2023 and communications have been shared Trust wide through SIREN and with local managers by the respective Patient Safety Manager.

8 Patients waiting for extended periods of time in the community continues as detailed in the graph below. During quarter 4 2022/23 **1690** patients received a response or wait over 12 hours.

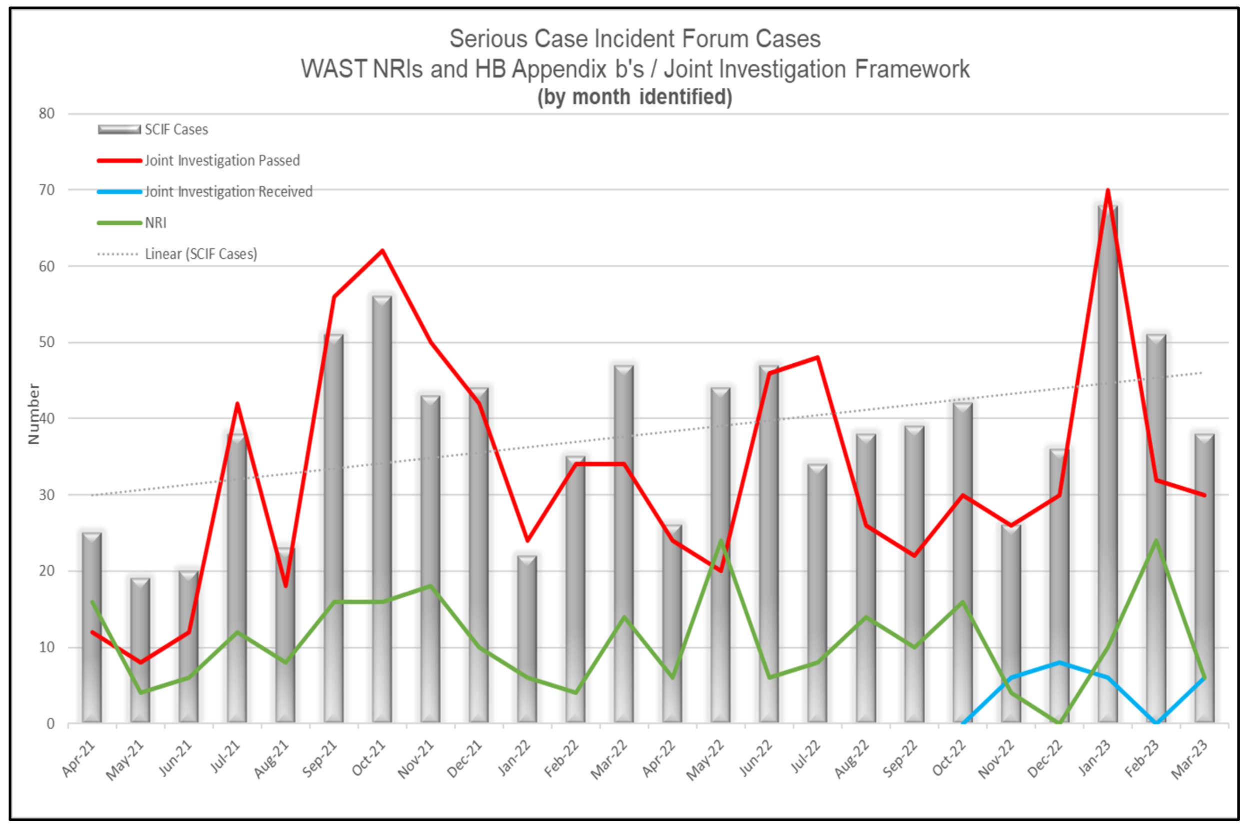


9 **166** of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being **44 hours and 49 minutes**. **30** of the patients were in the Amber1 category for response. It is well documented that this cohort of patients, who are frequently elderly frail, will experience additional harm due to the protracted delays including pressure damage, acute kidney injury, deconditioning and poorer outcomes.

10 Identification of patient harm across the whole urgent care pathway is challenging as impacts are not always immediately apparent. The Patient Safety Team plan to work with tissue viability colleagues across the system to explore the WAST contribution to pressure area damage reviews held in Health Boards to ensure the whole patient journey is considered. Consideration is also being given to any additional and appropriate actions the Trust could take to mitigate some of the harm occurring as a result of delays in handovers at hospital.

Serious Case Incident Forum (SCIF) and Nationally Reportable Incidents (NRIs)

11 The chart below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation under the Joint Investigation framework and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded patient safety incidents.



12 During this reporting period there were **21** SCIF Meetings held, with **157** incidents discussed. **20** incidents have been reported as NRIs to the Delivery Unit (DU) and **66** incidents were referred under the Joint Incident Framework to the respective Health Board.

13 On review of the **20** Incidents reported as NRIs to the DU, the following overarching high-level themes and trends were identified:

- Delayed response in the community **(linked to industrial action factors)** (**11**)
- Call stopped in error (**1**)
- Location issue (**1**)
- Ineffective breathing recognition (**7**)

No incidents linked to a declined immediate release request. There is high confidence that these incidents will be captured and reported by EMS Coordination. However, following the request from QuEST the SCIF proforma and log will be amended to include a prompt to collate this data for analysis.

Patient Safety during Industrial Action

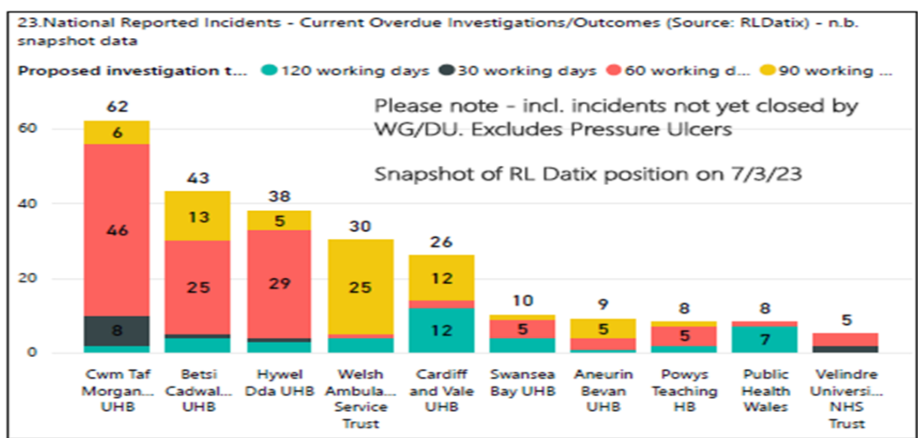
14 During the periods of industrial action patient safety incidents were monitored with oversight from the Operational Delivery Unit and the Patient Safety Team. Additionally, recognising that there was reduced capacity for teams to report incidents during these periods, the Patient Safety Team worked alongside colleagues in EMS Coordination to identify actual and potential patient safety incidents.

15 Following periods of industrial action patient safety data and information was then collated and analysed to identify themes and trends pan-Wales. This information was shared with the Executive Management Team and Trade Union partners to inform discussions regarding future derogations.

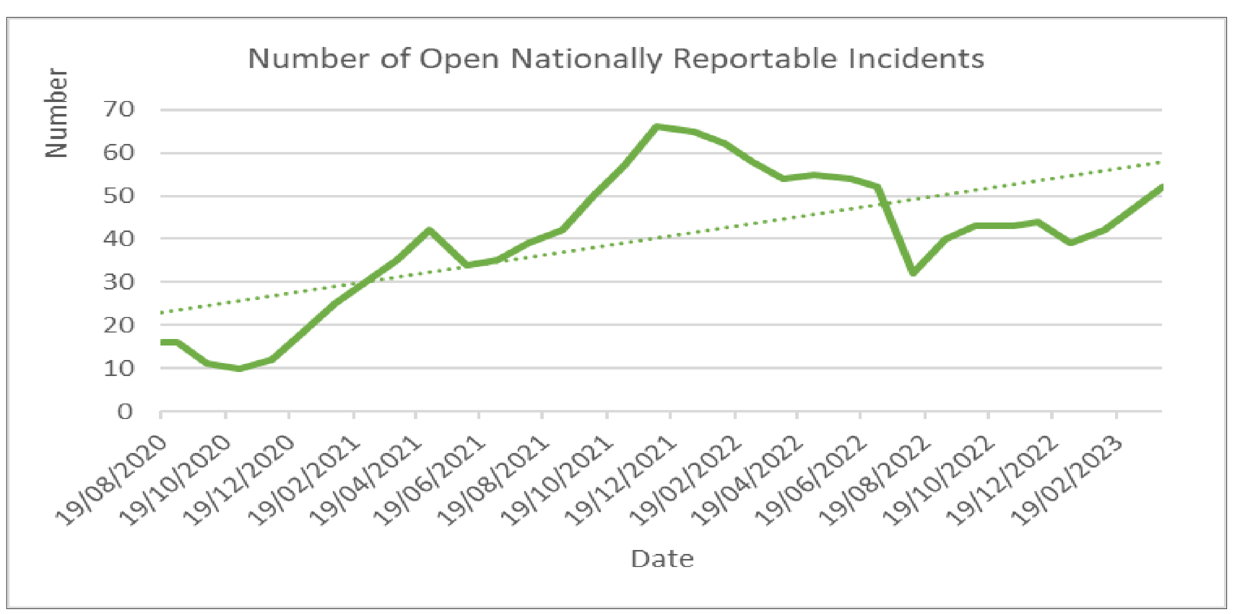
16 The NHS Wales Executive (Delivery Unit) are leading a national overview of patient safety incidents related to industrial action to understand the effect of strike action across NHS Wales.

Patient Safety Investigations (NRIs)

17 The Trust currently have a number of overdue NRI investigations (n=30). There are multiple factors but predominately these are due to capacity, demand and competing pressures. The graph below is extracted from the 'NHS Wales Executive (Delivery Unit) Dashboard (March 2023)' and provides details on the Trust's position in relation to overdue investigations, with a comparison to other NHS organisations.



18 The Trust currently have a total of **52** open NRI investigations and a number of cases awaiting review at SCIF. The graph below details the number of open NRI cases over time, with a rising trajectory overall.



NHS Wales Patient Safety Alerts/Notices – Trust Position

19 As of 11.04.2023 the Trust has one Patient Safety Alert outstanding on the NHS Executive Delivery Unit UHB Dashboard:

- Alert: PSA015: Safe use of oxygen cylinders in areas without medical gas pipeline (requires review of recently published NHSE Guidance and risk assessment to be undertaken which includes preserving Oxygen supplies).
    - Action: A Clinical Notice covering the alert was issued in January 2023 by the Clinical Directorate. The alert will be discussed again at the next All Wales Patient Safety Solutions Review Group (AWPSSRG) in May 2023 by the Head of Patient Safety.

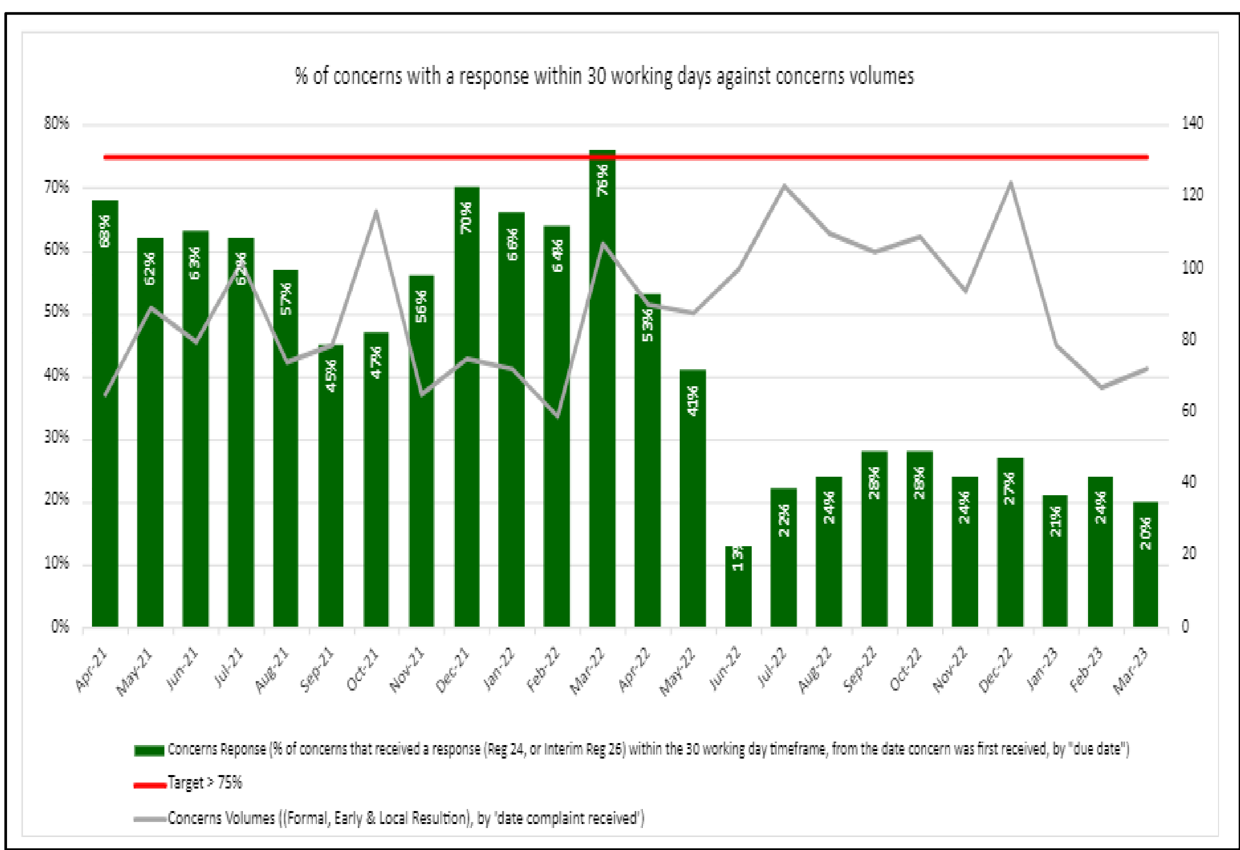
- Notice: PSN065: The safe use of ultrasound gel to reduce infection risk.
    - Action: Head of Patient Safety to confirm that this is not used in the organisation and mark as non-applicable at the next meeting of the AWPSSRG in May 2023.

Early Resolution (ER), Local Resolution (LR) and Formal Concerns

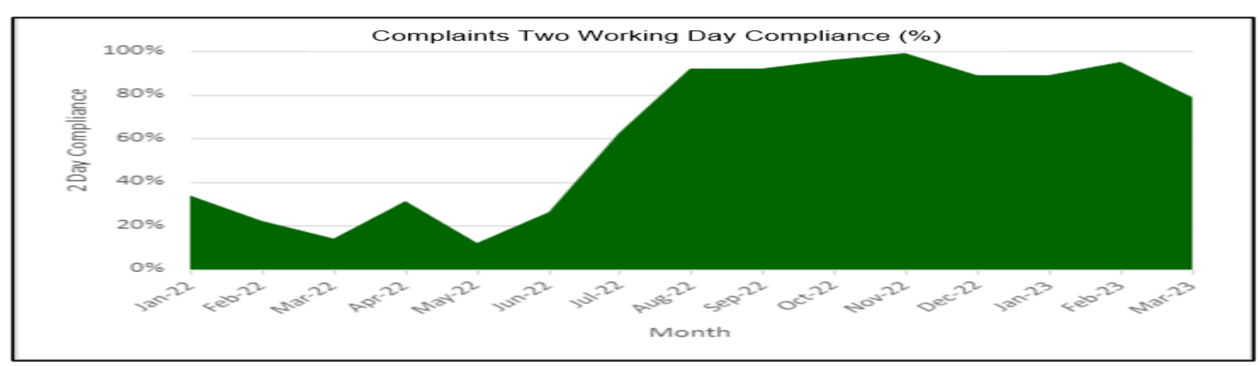
20 Key Definitions:

- Early Resolution - two-day informal response
- Formal- This requires a formal letter of response within 30 working days, as required under the Regulations. These are currently signed off by the Chief Executive Officer, following quality assurance of the investigation and letter. The Key Performance Indicator (KPI) is 75%, which requires the closure of the response letter.

21 As detailed in the graph below the Trust continues to receive a steady number of concerns overall with **218** being received during this reporting period.



22 During this reporting period the two-day acknowledgement performance was **91%**, **98%** and **79%** with the 30-day target achieving **21%**, **24%** and **20%** respectively.

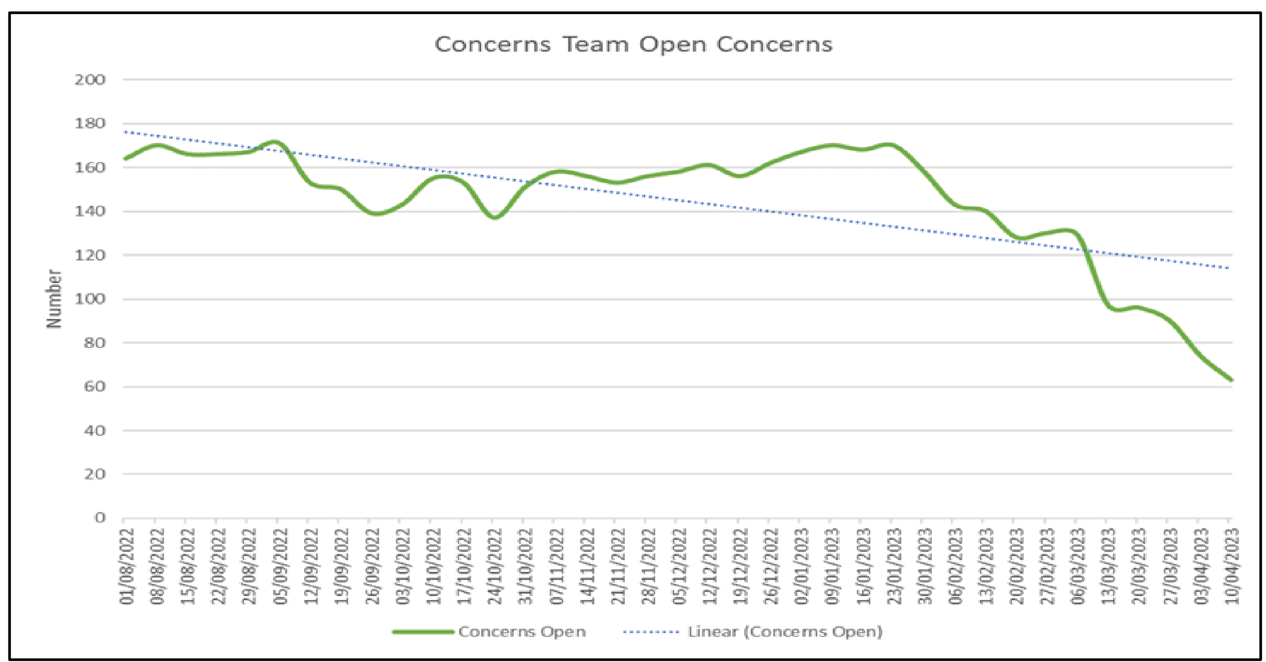


23 Following on from the unprecedented pressures of the last quarter, this reporting period has remained busy with the volume and complexity of concerns increasing. PTR administrators taking calls from patients and families can be on calls for over an hour in some circumstances due to the complexity and content of the calls.

24 The overwhelming theme and trend through the majority of concerns remains timeliness to responding to calls in the community.

EMS Co-ordination and Resourcing Centre Concerns Breakdown

25 The number of open concerns coming into the EMS Co-ordination and Resourcing Center has reduced, a new process to review and investigate grade 1 & 2 concerns enables a timelier response for the complainant focusing on their questions and concerns. The overall total of open concerns remains high:



Ombudsman and Political Investigations

26 There are currently **12** open Ombudsman cases. The Trust has submitted all documentation to the Public Service Ombudsman for Wales (PSOW) and is awaiting conclusion of the investigations.

27 During the reporting period there one report was received. The Trust has agreed to various early settlement agreements or cases have been closed by the Ombudsman, as they have decided not to undertake investigations which supports the Trust's actions. During the period the Trust received **14** cases and **13** cases were closed.

Early settlement agreements have included such things as:

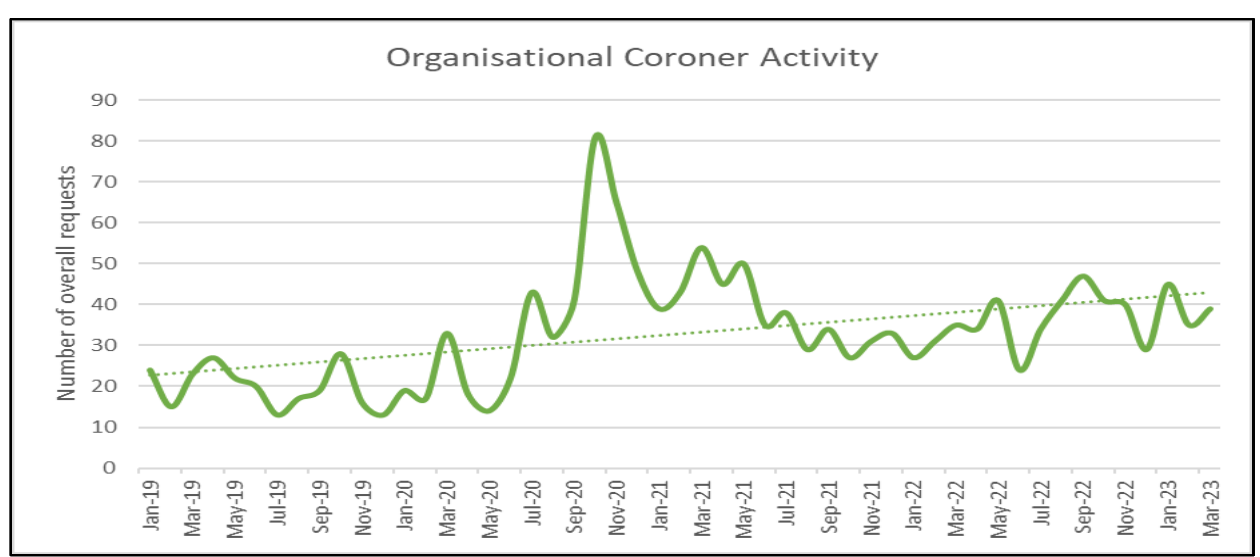
- Further letters to address questions not addressed fully in the initial regulatory responses
- Further investigation/clarification surrounding issues raised
- Updates on ongoing concerns
- Apologies for maladministration/clerical errors
- Financial compensation for clerical errors made

28 This quarter has seen a decrease in the number of political concerns being received. There are currently **18** open political concerns. Concurrent themes are timeliness to respond and not sending an ambulance and cover the majority of health board areas.

Organisational Legal Activity and Coroners

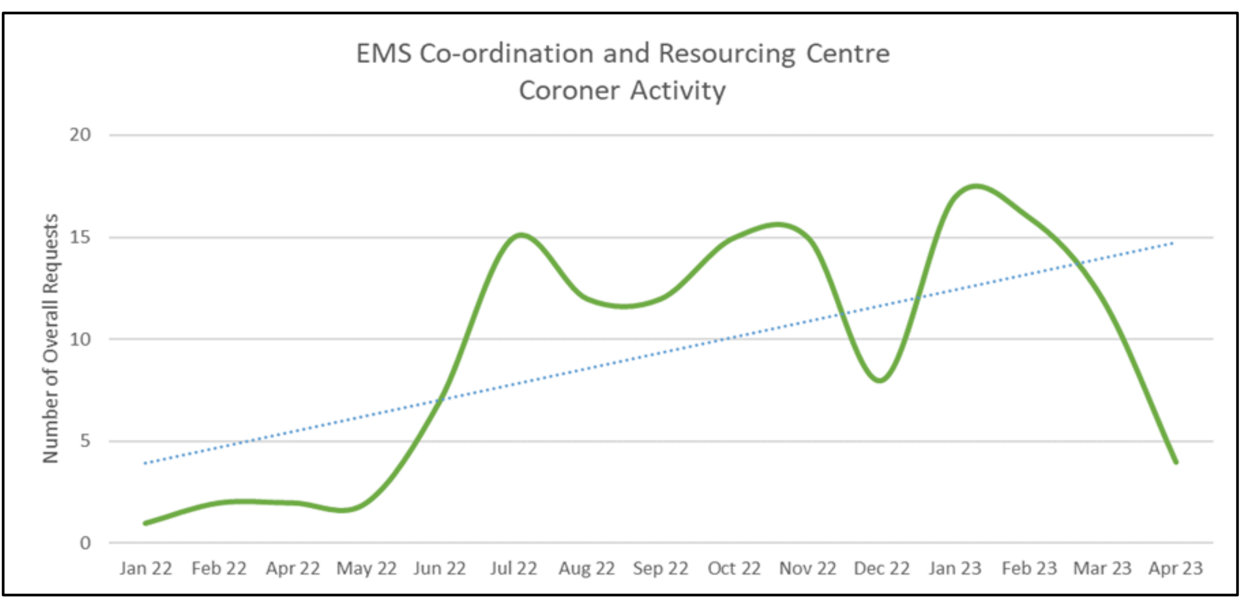
29 The number of approaches received from Coroners has remained constant during the reporting period. The complexity of the requests being received continues to be high, resulting in more statements per approach, together with increased legal complexity, requiring extensive disclosure, attendance at Pre-Inquest Hearings and multiple witnesses, Interested Parties and day inquest hearings.

30 Activity has increased month on month due to the delay in receiving statements. Many of the statements rely upon MPDS audits and there have been delays in the audits being undertaken. The chart below which illustrates the continuing pattern:



EMS Co-ordination and Resourcing Centre Coroner Activity

31 Coroner requests remain high for the EMS Co-ordination and Resourcing Centre with an increasing number of statement requests.



Prevention of Future Death Reports (Regulation 28)

32 During the reporting period the Trust received two Regulation 28 (Prevention of Future Deaths) Reports and issued both responses within the 56-day target.

33 Both Regulation 28 reports relate to delays in responding to patients in the community:

- Ref 8285: Delayed response to a patient in the Amber1 category. The Report from the Coroner in the Gwent area required the Trust to:

  a) Outline the steps being undertaken on a national and local level to address the delays in ambulance response times, particularly within the Amber 1 category whether consideration can be given to undertaking a more detailed clinical assessment of the patients within Amber 1 to ensure those in the greatest need for clinical intervention are given priority.

  b) Provide details of the process for reassessment of the patient's clinical condition during the time they are waiting for an ambulance.

  c) Confirm whether the national algorithm adopted by WAST is fit for purpose and that there is provision to identify life-threatening scenarios, where a patient may quickly deteriorate from an Amber 1 into a Red.

  A separate response was also requested by Welsh Government.

- Ref 8095: Delayed response to a patient in the Amber1 category. The Report from the Coroner in the North Wales area required the Trust to consider:
    a) "The causes of the ambulance delay were that all available resources were managing incidents of a higher acuity or the same category but registered prior and there were significant handover delays across all BCUHB sites. The matters of concern herein are longstanding and multifactorial and despite proposed future action significant concerns remain. The Welsh Ambulance Service NHS Trust and Health Board maintain that they are continuing to work closely in order to address handover delays and yet any improvements appear extremely limiting. Deaths are occurring and will continue to occur as a result of delayed ambulance attendances caused by these multifactorial issues."

    A separate response was also requested from Betsi Cadwaladr University Health Board.

34 Regulation 28 improvement actions are discussed at the Assistant Directors Leadership Team meeting, with monitoring and oversight of closure reports by the Executive Management Team and Quality, Patient Experience & Safety Committee.

Legal Claims

35 There has been a significant ongoing increase in the number of clinical negligence claims (actual and potential) being received by the Trust, many of which stem from delayed responses to patients at a time of escalation. The number of open clinical claims being investigated and litigated is now standing at an unprecedented level in the Trust's history.

36 Whilst personal injury claims (including claims linked to road traffic incidents) received have decreased to **5**, from **8**, during this quarter, these numbers alone do not capture the increased complexity and value in the legal claims. The table below details the current position in respect of open claims.

Claims Activity			Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Claims open at the end of the month	Personal Injury (PI)	Monthly	70	70	71	70	70	72	75	76	80	77	78	80	75
	PI Road Traffic Accident	Monthly	45	44	44	43	44	45	47	47	48	47	48	52	59
	Clinical Negligence	Monthly	103	104	105	105	105	107	105	109	119	120	122	122	124
	Road Traffic Accident	Monthly	124	128	130	141	147	151	163	165	173	180	159	170	177
	Damage to property	Monthly	23	20	19	22	21	24	23	22	8	8	9	13	16

Organisational Learning

37 Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section. The Patient Safety Team has developed a new Organisation Learning Bulletin (Appendix A).

38 The Quality Management Group formed to provide operational oversight of the Duty of Quality and Duty of Candour requirements will also be the forum responsible for organisational learning, which will include identifying themes and trends and highlighting any education and training or clinical audit activities. This will replace the Patient Safety and Experience Learning and Monitoring Group.

39 Clinical Notices issued Quarter 4:

- CN 08/2023 Methoyxflurance (Penthrox) Introduction
- CN 07/2023 Clinical Response Model Update
- CN 06/2023 Cwm Taf Morgannwg UHB GP Navigation Hub
- CN 05/2023 Where to seek clinical support from scene
- CN 04/2023 Safe Use of Oxygen Cylinders
- CN 03/2023 Patients own medications
- CN 02/2023 Analgesia for CFR
- CN 01/2023 Survivability in Water Model

40 Learning from clinical reviews are detailed overleaf.

Learning from Clinical Reviews by Health Board Area:

Clinical Reviews	Brief Description of Review	Themes	Good Practice and Learning Opportunities and Improvements
Aneurin Bevan UHB	• Call for 92-year-old female who had fallen in a Care Home. • Patient left at home, and family believed the patient should have been conveyed to ED.	• Good ePCR documentation and rationale for decision to refer to Primary Care • Clinical Management • Delayed response	• Patient advise around conveyance and seeking help • Patient family communication • Treatment in the community setting and follow up
Betsi Cadwaladr UHB	• 80-year-old male who had sustained a fall.	• Communication • Handover delays • Documentation regarding decision making	• Revisiting ePCR training • Good decision making • Improved ePCR completion • Appropriate decision making
Cardiff and Vale UHB	• Attendance to a 32 year female with minor blood loss 33 weeks pregnant. • Call correctly categorised • Patient made own way to Maternity department • On arrival had suffered post-partum abruption and required emergency c-section • Mum and baby delivered safe and made good recovery •	• Documentation regarding decision making	• Ensure all calls to receiving maternity units are made via consultant connect, to ensure recording. • Incomplete ePCR • Good documentation around presenting condition • Documentation surrounding decision making

NHS Wales Shared Services Partnership

Welsh Risk Pool Learning from Events Reports Welsh Risk Pool Committee

41 The Welsh Risk Pool (WRP) service has been delegated responsibility to administer the risk pooling arrangement for NHS Wales and this includes the management of reimbursement to member organisations once claims / redress cases have been settled.

42 As part of this process NHS organisations must complete learning from events reports to evidence improvement actions. Learning from events reports and supporting evidence is independently assessed and presented to the national Learning Advisory Panel (LAP) which has multidisciplinary attendance by Health Board and Trust colleagues.

43 5 claims, 4 redress cases and one follow up case were presented to the WRP Committee on 15.03.2023 with the following outcomes:

Learning from Events	Number approved	Number Amber Deferred (requesting some additional information minutes etc. to be provided within 6 months of the request)	Number Red Deferred (to be represented to the LAP)
Claims	2	3	0
Redress	2	1	0
Previously deferred	1	0	0
Total	5	4	0

44 Oversight of the WRP tracker will be undertaken at the Quality Management Group.

ANNEX 2: Learning from Events Newsletter (1 of 2)

January – March 2023

LEARNING FROM EVENTS

WELCOME to the first edition of the Patient Safety, Concerns and Legal teams newsletter. For this first issue we are sharing with you some of the learning that has flowed from the cases that are presented at the Trust's Complex Case Panel (the Panel) and feedback from the Public Service Ombudsman for Wales (PSOW).

The Panel makes decisions regarding whether redress should be offered to complainants. In order for redress to be paid the Trust has to have established that there is a "qualifying liability in tort". This means that it must be established that the Trust has breached its duty of care and that the breach of duty caused some harm to the patient.

Making Decisions Based on an Assumption

A 48 year old female patient contacted the Trust at 12:40 hours. She had lower back, hip and leg pain that had continued for three days despite taking strong analgesia, and she was now unable to bear the pain and mobilise. She had contacted her GP who was unable to help and who had advised her to dial 999. As a nurse working for the NHS she contacted 111 initially.

At this point an initial error occurred in that the patient was not clinically assessed. The call was then passed to the Clinical Contact Centre requesting a UCS transport within an hour. At 14:20 hours a UCS crew arrived with the patient. The UCS crew did not complete a PCR but the decision was made not to transport the patient at that time, due to the patient's domestic/social circumstances.

Again, at this point, no assessment was made of the patient, but rather she was rebooked for a later UCS vehicle. Part of the patient's concern was that she was in the Trust's care for 9 hours and 20 minutes and no Clinician within the Trust had assessed her.

The Complex Case Panel considered the two elements in relation to breach of duty and their effect;

1. Reviewing the conversations that had taken place, on the balance of probability (that is to say more likely than not) had the 111 Clinician undertaken a full assessment of the patient, the outcome would have been the same, namely transport to hospital utilising a UCS crew.

2. The decision not to transport the patient to hospital could not be supported as the crew had not completed a PCR.

ANNEX 2: Learning from Events Newsletter (2 of 2)

An Eye For Detail

If you are responsible for providing an investigation report, a statement or writing a letter to a patient or their family, remember to have an eye for the detail.

The PSOW has identified that we have referenced an injury to the wrong arm and, in another case, incorrectly stated that the patient had signed the DNACPR.

This damaged the complainant's trust in the whole of the investigation undertaken. On both occasions this resulted in the concern being escalated to the PSOW and the Trust being fined for maladministration.

Themes and Trends

The Panel have seen some issues appearing repeatedly and would like to share the learning with you:

- **Recognition of ineffective breathing** – resulting in under prioritised calls and delays in help arriving with patients.
- **Documentation** – Incomplete PCRs and failure to record why vehicles were allocated out of sequence, results in the Trust not being able to support decision making.
- **Allocating across Health Board boundaries** – delays in attending patients when the nearest vehicle is not used.
- **Level of consciousness** – resulting in calls being under prioritised and delays in help arriving with the patient.
- **Decision not to transport/convert to HCP** – without fully documented decisions and possible clinical support, again the Trust does not have enough information to support the decision, again resulting in a delay in the patient arriving at hospital.

AGENDA ITEM No	9
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT QUARTER 4 REPORT (JANUARY - MARCH 2023)

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 May 2023
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Head of Patient Experience & Community Involvement
CONTACT	Leanne Hawker Leanne.Hawker@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report is to provide assurances and, an update, on the work delivered by the PECI team on how it is supporting the Trusts principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of each of our communities we serve without prejudice or discrimination.

2. This report does not include 'business as usual' activities but focuses on high level strategic and national delivery quality objectives.

3. As outlined in the Trusts IMTP, the PECI team continues to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive.

RECOMMENDED:

- **The Committee is requested to note the activities to date and acknowledge that PECI reports will be presented bi-annually to Committee;**

- **That the Committee receives the report and accept the assurances that the Trust is meetings its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.**

KEY ISSUES/IMPLICATIONS
4. **Easy read** - We have a commitment to ensure easy read information is accessible and available via the NHS 111 Wales website. However, the current Content Management System (CMS) for the site does not have the functionality to allow pages to be constructed in line with easy read guidelines (DH 2010). The Easy read pages on NHS 111 Wales convey public information to people with a learning disability in a manner they can understand, through an easily navigated platform, in a timely manner. Currently, formatting pages is dependent on developers to construct pages in code. Whilst the work undertaken by the NHS 111 Wales Programme team has been to improve the look, feel and experience for web users, there needs investment to the current CMS. Formatting beyond basic content editing is reliant on the developers to change, causing delay and additional work for them. If the current project group funding comes to an end, so could the ability to do these functions. 5. **Increasing patient experience returns** - We recognise that EPCR has the potential to greatly increase the number of patient experience returns into WAST. The function to push out a text/email/postal survey from Civica exists but there is a cost to purchase this additional facility to enhance the already funded core system. Work is in progress to confirm how this might be funded.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee

REPORT APPENDICES
Annex 1: SBAR Annex 2: Patient Reported Experience Measures (PREMs) Q4

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	Yes
Ethical Matters	N/A	Risks (Inc. Reputational)	Yes
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

ANNEX 1

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT
QUARTER 4 REPORT (JANUARY - MARCH 2023)

Situation

1. The team have continued engaging, capturing experiences and listening to public, patients and carers this quarter.

2. A key theme this quarter has been on how we can improve accessibility, content, and user experience of the 111 Wales digital front end, in line with the urgent priorities set out in Goal 2 of the six goals.

3. Although Trust plans aim to significantly increase the accessibility of services via digital means, there are still many people within communities, some of whom are the heaviest users of health care services, remain digitally excluded. The team will continue to engage with communities to identify how the Trust can best support them accessing healthcare advice and services appropriately.

4. With the introduction of the Duty of Quality, the Health & Care Standards are replaced with The Quality Standards (2023). PECI work has s been mapped against the Standards as part of the self-assessment and is providing assurance against the duty of quality and improvement in outcomes by using:
    - Patient Reported Experience Measures (PREMS)
    - Once for Wales CIVICA System for patient experience
    - Patient stories

5. As well as a variety of other engagement activities to capture feedback and experiences. Patient Reported Experience Measures (PREMs) for this quarter are attached **as annex 2.**

Background

6. We have a legal duty to engage with service users and communities to listen and capture their experiences and to involve them in influencing, designing and delivering services as set out in:
    - Framework for Assuring Service User Experience
    - NHS Wales Performance Framework
    - Social Services and Well-being (Wales) Act 2014-18
    - Well-being of Future Generations (Wales) Act 2015-19
    - The National Principles for Public Engagement in Wales (2011)20
    - Health and Social Care (Quality and Engagement) (Wales) Act 2020-21
    - Health and Care Standards to be replaced by 'The Quality Standards' - April 2023
    - A Healthier Wales 2022

Assessment

7. The following deliverables have also been achieved this quarter:

The NHS Wales Performance Framework 2022/23 – Performance Measure Learning Disabilities – improving the lives of people with learning disabilities	• A page on EPCR is being developed to record data on patients with learning disabilities, guide good practice and reasonable adjustments on scene and inform future training needs. • Understanding Learning Disability e-Learning module has had 500 participants in the first eight months. A review and evaluation is planned after 12 month. Learning Disability Week will provide an opportunity to further promote the e-Learning module. The mandated Paul Ridd Foundation Training is now live on ESR as an introduction and the e-learning module compliments this with much more information on the reasonable adjustments that WAST can make for people with learning disabilities. • During periods of Industrial Action we have translated official Trust messages to the public regarding Industrial Action and disseminated them through Learning Disability networks. • Maintained Easy Read pages on NHS 111Wales website, created new Easy Read information leaflet on Industrial Action
Future Generations Commissioner (well-being goal of A Healthier Wales) Children's Commissioner	• **Blue Light Hub App.** We have received the Evaluation Report from Cardiff University and are reviewing their findings to consider future application developments and communication messages re: 111 & WAST when conducting face to face engagement with CYP. • **Shoctober** – We are reviewing the feedback and recommendations from the evaluation report 2022 with a view to implementing them within the 2023 campaign. o Based on feedback from staff, we will be removing 'choking' from the 2023 Shoctober presentation and explore other opportunities to share this lifesaving skill with children & young people o In response to the report 'Joint Working between Emergency Services' – Audit Wales January 2022 we will identify key contacts within Fire & Rescue Service, St John Cymru, Medical schools & other supporting agencies prior to opening of volunteer registration.
Framework for Assuring Service User Experience	**CIVICA**. Work has continued this quarter to ensure the Trust is prepared and ready to utilise the CIVICA system from April 1st. During this quarter, version 7.1.2 of the Civica Experience

	platform for patient, staff and customer feedback was released. This included a number of updates to existing functionality and looked at updates to the Audio Patient Stories feature, location links and translated survey PDFs. With regard to Patient Stories feature, we had previously met with CIVICA and Welsh Risk Pool to explain how we had set up our own video-booth and the different functionalities incorporated within it. The aim was to replicate our version within CIVICA as it seemed to be a robust model. The team are actively engaged in supporting the development and prioritisation for a number of new features in 2023 via Version 7.2 and Version 8. • **WAST Patient Experience surveys** CIVICA is the platform to capture and report on patient experiences using a range of surveys covering 999; 111; NEPTs and 111Wales Website. We have collaborated with teams across WAST in reviewing existing surveys and the hierarchy of those requiring access for reporting purposes. All WAST surveys are being reviewed against the development of new set of core validated PREMS questions for Wales. • **Palliative End of Life Care (PEOLC)** During this quarter we have been involved with the Civica Experience Wales and PEOLC senior management programme team to progress rolling out the National PEOLC survey, using local NHS bodies, retaining local ownership of processes and feedback, and the PEOLC having National oversight of data. Focus has been around the agreement of the national survey and ratifying the current PEOLC Hierarchy. As WAST provides an EMS response and planned transfers between settings, emergency transfer to hospital, transfers from hospital to enable people to spend their last days in the place of their choice etc; we have been advocating to be included in the reporting hierarchy and developing specific questions to be included relevant for WAST. The Palliative Care Pathway being developed within NHS 111 Wales will also need to be considered once phase 2 has been fully implemented. **Patient Stories**

	• We have continued to work with patients and their families to record patient story videos to help us understand at first-hand what it feels like to be a user of our services. These have included stories in which patients describe long waits for an ambulance response and frustrations with the repetitive questioning experienced when chasing up ambulance ETA.
Health and Social Care (Quality and Engagement) (Wales) Act 2020-21 Quality Standards **Citizens Voice Body** **Duty of Quality/Duty of Candour**	**Community Health Councils (CHCs) & Citizens Voice Body (CVB) 'LLAIS'** • The Team have been in contact with CHC colleagues in each of the health board areas – meetings are planned to take place with the Chief Officer and Deputy Chief Officer of Powys Community Health Council in April 2023 close to the handover with the CVB with a specific focus on local community engagement and experience. • In the last quarter, the Team have shared patient experience feedback and information on community involvement at member meetings for the CHC. With the onset of the Citizen Voice Body, we will hope to continue to strengthen our relationship as the Trust Network and the CVB develops. **Learning from Events Newsletter** • We have supported the Patient Safety Team in designing the first issue of a newsletter for staff that shares some of the learning from cases presented at Complex Case Panel and feedback from the Public Service Ombudsman for Wales. **WAST PTR Public Information Leaflet – How we handle our calls** • We are supporting PTR team by rewriting and redesigning this booklet. The People & Community Network have been engaged as they will review the readability before final version is printed. **Duty of Candour – Public awareness video** • We reviewed and provided feedback on behalf of WAST to Welsh Risk Pool on the public awareness video. The video, based on the Duty of Candour leaflet for service users, aims to help explain what the Duty of Candour is, how the NHS is putting it into practice, and what this means for patients and service users.

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People & Community Network Activity
111 Wales.

During the past quarter an agreement on the scenarios for carrying out a mystery shopper exercise on NHS 111Wales has been agreed. Talks are ongoing with NHS 111Wales colleagues to begin Phase 1 of a mystery shopper exercise to test access to the NHS 111Wales telephony service and navigation of the Interactive Voice Recording (IVR). This activity will help test concerns that accessing the NHS 111 Wales Telephony Service is challenging for specific members of the community, in particular, people with sensory loss, people for whom English is a second language and older people. Plans have been on hold since a BCI was declared in August 2021and that continued for an extended period. Plans for go live are being reviewed as part of the Q4 priorities; also, several changes have been made to the IVR in recent months. It is hoped the exercise will go live once priorities have been agreed and changes to the IVR are stable.
It has been agreed that Network members be invited to participate in user research to review/assess the effectiveness of the NHS 111 Wales website.

PREMS.

As part of PREMs Development, network members will be participating in a focus group to create a set of emergency service core questions that we can use to measure quality of care and experiences of those using emergency medical services and enhance the ‘national’ set of six core questions developed for use across NHS Wales.

Minority Communities:

The Welcome Pack for diverse communities and people whose first language is not English is in its final stages of development. All content and images have been generated and its launch is expected early summer.
This pack was conceived through engagement with Syrian families and other ethnic minority communities across Wales where language was perceived as a barrier and little knowledge of ambulance services.

111 Website development
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	• PECI have supported research identified by the NHS111Wales working group by recruiting participants to be interviewed for 45 minutes in order to understand how they react to the NHS 111Wales website, their motivations to use the site, their behaviours when on the site (and before) and the issues they may have. This will also assist in future promotions of our digital first messaging. • PECI have sat in on the interviews to observe and provide support to participants if needed. Findings of the research will be presented to the 111 working group. **Service User Behaviour of 111 website** During the quarter January - March 2023 the following were recorded: • Web visits – 1,169,140 and Welsh Visits – 2,076 Pages viewed most often after the homepage – 203,293 were: • Generally unwell – 49,889 • Abdominal pain - 47,693 • Rash – 30,220 • Dentist search – 12,854 • Pharmacy search – 11,988 Following a surge in calls about Strep A to NHS 111 Wales in December 2022 there was continued search and access for information on Strep A via the website in January with 11,268 accessing information on the condition.
Strategic Transformation (Inverting the Triangle)	• With the ambition set at 30% activity to receive a see & treat/see, treat & refer and 50% consult & close/consult, our work on creating 'friendlier'/alternative words used across WAST services is being reviewed. This was temporarily suspended due to competing demands. **ePCR** • Discussion ongoing with the ePCR Team to consider how ePCR can enable staff to provide additional supporting information to patients who are treated and left at home. This could be bespoke information created by the Trust, such as our existing Bereavement and Mental Health leaflets, or information taken from the NHS 111Wales website A-Z encyclopaedia or Directory of service. • The team are also exploring an opportunity for ePCR to capture patient permission to participate in experience surveys, increasing PREMS data of using the 999 service. The ePCR Team are investigating potential cost implication

	of this development before a formal request for this change is made. This would also require further integration with Civica to push out email/text surveys to patients on our behalf.
IMTP	• We updated the IMTP narrative for the section 'What do our patients say about our service?' provided new updates on some of the achievements and engagement metrics including patient/public feedback. • The team have been approached to design and produce updated posters and leaflet for staff and public that summarises the IMTP. Going forward we will de dedicating time each week on this as well as liaising closely with Communications team on the text to ensure appropriate design layouts.

Recommendation

- **The Committee is requested to note the activities to date and acknowledge that PECI reports will be presented bi-annually to Committee;**

- **That the Committee receives the report and accept the assurances that the Trust is meetings its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.**

Quarterly Patient Reported Experience Measures

January 2023 – March 2023

Annex 2 – Patient Experience Feedback

Your experience of calling 999 emergency ambulance

People have been encouraged to provide feedback using an online patient experience survey. This survey can be accessed online through the Welsh Ambulance Service website and has been promoted publicly across all of the Trust's social media platforms.

During this quarter 34 people used the survey to provide feedback. We are unable to directly contact 999 service users to ask for feedback, we rely on them seeking out opportunities to provide feedback independently. We are actively seeking a solution and are currently engaged with colleagues in the ePCR development team to explore opportunities that the new digital ePCR may offer in obtaining peoples permission to participate in providing feedback to us.

During this quarter, responses were received from all Health Board areas across Wales.
A majority (52%) told us that this was the first time they had needed to call 999 in the past 12 months, whilst 9% told us they had needed to call 999 at least 3 times in the past 12 months. .

- **76% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **85% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who did receive a call back from a clinical advisor, 65% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 59% said they waited over 1 hour for help to arrive.**
- **Approximately 50% of people who completed the survey rated their overall experience as 'Poor' or 'Very Poor'.**

"Whilst I fully understand your current problems with the industrial action I feel like I was dealt with in a polite, efficient and knowledgeable way. Thank you"

"Nothing good. Diabolical service. 25 hours and still waiting for an ambulance . The service should be ashamed of itself"

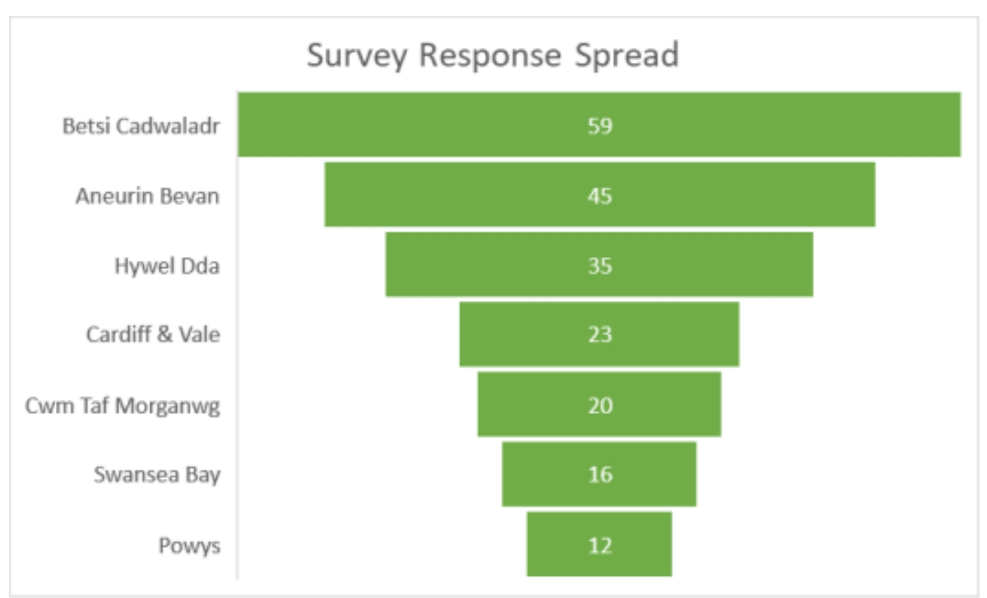
"It was appalling in 2019 and even worse now. My poor late mother who had type1 diabetes and dementia lay on the floor in agony after falling and breaking her hip for over 20 hours"

"Ambulance never arrived and my mother was left lying on the floor until we could ask a neighbour to assist"

Overall, there was a fairly even split in responses received from people rating their experience as Good verses Poor. However, of those saying their experience was poor, long waits in the community for help to arrive was a clear and consistent theme in respondents' feedback and comments.

Your experience of NEPTS

During this quarter 226 NEPTS patient experience surveys were completed. The responses come from people who were sent a text message asking them to complete a survey, people who asked to receive a postal survey or NEPTS users who visited the Welsh Ambulance Service website to complete an online survey. There was a reduction in responses from Text message respondents as fewer SMS Text message invitations to provide feedback were sent in this quarter due to industrial action.



Responses were received from all Health Board areas, we continue to see the highest levels of engagement with the survey in the Betsi Cadwaladr and Aneurin Bevan areas. With Swansea Bay and Powys again receiving the fewest responses.

These results showed us that:

- Majority of people (91%) found the booking process easy. Those who answered negatively here said it was because of long delays for booking calls to be answered.
- 98% said they were happy with the transport they received.
- Majority of people (87%) scored their NEPTS experience 8 out of 10 or higher.

The NEPTS patient experience survey results continue to be positive and offer high levels of assurance that NEPTS users are satisfied with the service. Less positive responses continue to follow historical trends and focus on wait time for booking calls to be answered, with an increase in the number pf people telling us that they were unhappy with the length of time they had to wait for their booking call to be answered.

What was Good:

"Everything very good, staff very good and helpful"

"Staff were helpful and as I cannot get into a car, I very much appreciate your assistance"

"I find that everyone is polite and friendly and am so grateful to be able to keep my appointments, as they are vital to my being able to live alone"

"The helpfulness of the crew"

What was Bad:

"Sometimes very late coming but some drivers rang me to say on their way and ETA given!"

"The waiting time to go home. I am disabled and a long time does not help me"

"After treatment I waited 3 hours for transport home. Eventually they sent for a taxi for me. My husband is disabled. I am his unpaid carer. I got more concerned about him as the hours ticked by"

"It took hours to get through when making my booking, I was number 45 in the queue, why not more people answering the phone?"

Your experience of calling NHS 111 Wales

This quarter **63 people completed the survey.** Responses were received from all Health Board areas, providing a mixed response about their experience of using the telephony service.

As we are currently unable to directly contact 111 callers to ask for feedback, we rely on them seeking out opportunities to provide feedback independently. We are actively seeking a solution to this and are currently engaged with colleagues in the 111 team to explore opportunities that the new digital SALUS system will provide in allowing us to gain patient permission to participate in providing feedback about their experience with us.

- When asked if they had contacted another service before calling NHS 111 Wales, a majority of people said no, 111 had been their first port of call.
- Of those who had contacted another service, people told us they had been advised to call 111 by their GP, pharmacist or Dentist, or had visited the website first.
- 76% of respondents told us they were Dissatisfied or Very Dissatisfied with the length of time it took for their call to be answered.
- 69% of respondents told us they found their call 'Not at all helpful' with only 9% saying their call was 'Extremely helpful'. 52% of respondents said they went on to follow the advice given to them.
- 38% of respondents said they needed to re-contact NHS 111 Wales at a later time or date for further information or advice about the same health problem.

"I phoned when my little boy was unwell and I needed some advice about what to do, the first barrier was a never ending recorded message with so many options and warnings about long waits I'm surprised anyone actually sticks it out and gets through to speak with a real person, totally ridiculous. When I did get through the staff were helpful but then had to wait hours for a nurse to actually call me back again"

"Called 111, advised calls would take over 1 hour to be answered, held on and when call went unanswered for 2 hours I was cut off. Not happy at all. If calls are not going to be answered for 2 hours say and not let people hanging"

We will continue to make this survey available to the public through the NHS 111 Wales website and social media platforms and will share survey findings with the NHS 111 Wales Team to help identify opportunities for learning and improvement.

Your experience of using NHS 111 Wales Website

This quarter 82 people completed a website experience survey.

- Just over half of respondents (52%) told us that they didn't find it easy to find information they were looking for on the website
- In contrast, 33% of respondents said they found it either 'Extremely' or 'Very' easy to find information they needed
- 38% of people said they intended to follow the follow the advice they found on the website.
- 54% of respondents rated their overall experience of using the website as 'Poor' or 'Very Poor'. When asked to explain why they gave that rating, people said:

  "If you don't know what is wrong there was no option to input your symptoms. The site is ridged and only gives set responses"

  "It is too automated and does not address issue"

  "Your website makes no sense just do a straight forward lay out don't have to have little pop ups everywhere and plus when I click something like a check box it don't work"

  "Provide a consistent look across Welsh NHS websites. Use NHS Wales logo!"

  "Your website was easy to use but the information on the specific page I wanted to visit was so inaccurate it made my experience of using the website a disappointment"

- 33% of respondents rated their overall experience of using the website as 'Excellent' or 'Very Good'. When asked to explain why they gave that rating, people said:

  "Easy to answer questions with simple to understand explanations"

  "The layout of this website is superb for the public with very little knowledge, however as previously stated I was looking for more detailed information"

  "Clear and non-stigmatising answer that was still honest"

  "After reading what a Cystoscopy is and what to expect, I'm actually a lot calmer and more comfortable about the procedure I'm about to undergo. Thank you so very much"

All information collated through the survey is shared with the NHS 111 Wales website project team, helping them to identify areas of the website that require improvement and future development to enhance the users experience and ability to find the information they need.

AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	5

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 May 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 2 risks that are relevant to Committee's remit for oversight.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annexes 2 and 3.

4. The principal risks were presented to the Trust Board on 30th March 2023 and are updated as at 4th May 2023. Each risk has been reviewed in full during this period, including controls, assurances, gaps and mitigating actions.

5. A simple guidance note (Appendix 1) has been developed to assist Board and Committee members to interpret the BAF, address some of the issues raised in the Structured Assessment and provide proportionate challenge on actions to mitigate the risks and their intended impact.

RECOMMENDATION:

6. **Members are asked to consider the contents of the report.**

KEY ISSUES/IMPLICATIONS

7. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

8. The BAF was considered by:

- EMT – 3rd May 2023
- ADLT – 4th May 2023

REPORT ANNEXES

- Annex 1 - Summary table describing the Trust's Corporate Risks.
- Annex 2 – Scoring Matrix
- Annex 3 – Frequency of Risk review
- Annex 4 - Board Assurance Framework
- Annex 5 - Guidance on Interpreting the Board Assurance Framework

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** ➡
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** ➡

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		**Consequence:**				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Highly Unlikely: Will probably never happen/recur	**Not for years**	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	**At least annually**	2	4	6	8	10
3 Likely: It might happen/recur occasionally	**At least monthly**	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	**At least weekly**	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	**At least daily**	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death			Date of Review:	21/03/2023		TREND	25 (5x5)
				Date of Next Review:	22/04/2023		→	
IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death			Likelihood	Consequence	Score	
				Inherent	4	5	20	
				Current	5	5	25	
				Target	2	5	10	

IMTP Deliverable Numbers: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q4 2022/23

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death as a result of the Trust not being able to reach patients in the community.

There were over 28,000 hours lost outside EDs in March 2023, a comparable figure to the pre Christmas delays. Whilst there has been improvement in some Health Board areas (Cardiff and Vale where there has been a corresponding improvement in red performance), other Health Board continue to experience protracted delays. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales educes emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	ASSURANCES
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
4. Resource Escalation Action Plan (REAP)	4. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/03/2023	TREND	25 (5x5)
		Date of Next Review:	22/04/2023	→	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

9. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs.
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
15.	15.
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18.
19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
21. Mental Health Practitioners in cars	21.
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
26. Information sharing	26. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues. Despite a reduction in delays over January and February, current handover delays have demonstrated a deteriorating picture with March delays at December levels	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/03/2023	TREND	25 (5x5)
		Date of Next Review:	22/04/2023	→	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11. Patient Flow Co-ordinators - Health Boards to consider the value of deploying PFCs at emergency departments to aid flow	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by ICAPS and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18.	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21.	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of Workforce & OD	30.07.23 Checkpoint	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative. Falls service in place with enhanced day and night provision; Utilisation of resources reviewed at weekly performance meetings by Operations SLT.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	26/04/2023	TREND	25 (5x5)
		Date of Next Review:	26/05/2023	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

EXECUTIVE OWNER	Director of Quality & Nursing	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q4 2022/23

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. There were over 2,883 +4 hour patient handovers in December 2022; the target being 0 from September 2022. Currently < 0.025% of the Trust's demand is going into Same Day Emergency Care currently is <0.025% (modelling 4%). The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. The Joint Investigation Framework (pilot phase) to embed with good engagement from system partners.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (LHB CEOs) ***by September 2022***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs)
d) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer)

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the Joint Investigation Framework which is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – the pilot is in progress ,.and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	26/04/2023	TREND	25 (5x5)
		Date of Next Review:	26/05/2023	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process.
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Integrated Quality and Performance Report (December 2022 overall 84% - mandatory training target just below target at 84.6%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board March 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.
16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023 (soft launch).	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of February 2023 is 'Implementing and operationalising'.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team (JET) meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 30 (as of 07.03.2023) overdue nationally reportable incident investigations.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. 2,098 hours were lost in December 2022, an increase compared to 18,773 lost hours in December 2021.

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4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently. Fit to Sit programme is not progressing currently.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.	Chief Executive Officer	• Completed	• Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.
2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC - Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
3. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety dashboards.
4. Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
5. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements	Assistant Director of Quality & Nursing	• Completed	• No further requests from HIW to date.

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Action	Lead	Deadline	Progress
Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.			
6. Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Executive Director of Quality & Nursing	• Q3 2023/24	• Revised joint investigation approach agreed and now in pilot phase. • Meeting April 2023 cancelled by EASC due to system pressures.
7. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Q3 2023/24	• Strong focus from Executives with detailed updates to EMT every two weeks. • Estimated year end position is +90 FTEs against the target of 100. • Overall across the whole establishment, this equates to a vacancy factor of just 0.5%,
8. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• Bid not successful. Feedback received from Welsh Government that will be incorporated into future bids. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start. • 17 trainee APPs expected to "tip out" of training in Jun-23. Currently they have not been offered contracts and the Trust risks losing some of them. • Some additional funding available to bid against for AHPs (bid submitted by May 2023).
9. Transition Plan	Chief Executive Officer	• Q2 2023/24	• Formally submitted to Commissioners in December 2021. As above +100 FTEs secured although non-recurring at this point in time. • Also as above, funding for additional APPs not secured via Value Based Healthcare fund; however, decision of Trust to proceed with take up of 18 MSC places anyway. • Further discussions as part of IMTP 2023-2026 have been undertaken on additionality into next year, with letter written to the CASC about what further full time equivalent additionality it could recruit and train if funding was available in 2023/24 (maximum 100).
10. Overnight falls service extension	Executive Director of Quality & Nursing	• June 2023	• Night Car Scheme extension agreed to 31 March 2023 (2 regional resources) • Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through Jan-Mar 2023. Good progress has been made on this. • Falls level 1 and 2 impact evaluation report completed - presenting to Clinical Quality Governance Group (CQGG) 18 Jan-2023.
11. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Q2 2023/24	• Good progress on Performance Improvement Plan (pip) There were only 15 PIP actions live in Dec-22, so the PIP closed down and the remaining actions transferred into other assurance mechanisms like this report. • Specific seasonal and strike structures stood up. • Trust demonstrating continued focus and creativity on approach to seasonal and strike mitigations.
12. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• Q4 2022/23	• The national awareness campaign is now fully live through to the • end of the financial year. • The second phase was launched in Q4 28 Feb-23 and included a new TV ad on ITV, S4C and Video on Demand (ITV Hub, Sky, All4). This phase also includes a digital radio advert, social media. • (Organic and paid), influencer activity, case studies, and out of home advertising on digital billboards across Wales along high traffic carriageways. • National toolkit containing key messages and social media assets distributed to stakeholders. • Campaign ending end of March 2023.
13. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 (soft launch with Welsh Government Roadmap in place) with supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
14. Virtual Ward	Executive Director of Quality & Nursing	• Q2 2023/24	• A proposed innovative "eyes on" service provided by the third sector (organisation and volunteers), supported by the Clinical Support Desk and supported by technology. • The proposed service will support patient safety and improved hospital flow. • The Trust has completed a business case at pace, which has been sent to the CASC for consideration.
15. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• July 2023	• To commence consultation phase by May 2023.

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

Welsh Ambulance Services NHS Trust

Guidance on Interpreting the Board Assurance Framework

Version 1.1 April 2023

Board Assurance Framework

The Board Assurance Framework (BAF) provides assurance to the Board on the Trust's delivery of its strategic aims, outlined in its 3 Year Integrated Medium Term Plan (IMTP) and through its risk management framework.

An element of the Trust's Risk Transformation Programme was to develop a transitional BAF that focussed the Board on the key risks that might compromise the achievement of those strategic aims.

The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the Integrated Medium-Term Plan deliverables and therefore, by extension, are the Trust's strategic risks.

As the Trust's risk maturity advances the current BAF template will be used to capture risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

The BAF aligns principal risks, drawn from the Corporate Risk Register, the key controls, and the assurances on those controls. Gaps are identified where key controls and assurances are insufficient to mitigate the risk and subsequent actions are identified. The Board should monitor these actions as intended to close the gaps and mitigate the risks.

COMPONENTS OF THE BAF

Elements for the Board to consider when scrutinising the BAF:

1. REVIEW DATE

Risks scored high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months.

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

The Board should consider whether the risk has been reviewed on time and in accordance with the governance routes agreed by the Audit Committee.

2. RISK ARTICULATION

An *If, Then, Resulting In* approach is used to provide a more detailed description of the risk. The Board should consider whether the cause and effect of the risk clear.

3. SCORING

The risk score uses the likelihood x consequence mechanism. A guide on how likelihood and consequence scores are arrived at to gauge if the score is appropriate is included in the tables in annex 1.

4. CONTROLS

A control is a measure that is already in place to mitigate a risk. Controls may change or be added to through regular updates. The Board will need to assure itself that these controls are effective to manage the principal risks.

5. ASSURANCE

Assurance provides confidence, evidence, and certainty that controls are effective. The Board should look at the control and the assurance related to that specific control to judge its effectiveness in managing the risk. As the BAF matures future iterations could include an assurance rating to support the assessment of effectiveness of controls.

6. GAPS

A gap in control or assurance occurs when either of these elements do not exist or that they do not effectively mitigate the risk. It may be that the control is not operating effectively to mitigate the risk. The Board should consider whether gaps are comprehensive with what is known in the current environment and whether the BAF supports the identification of the gaps or weaknesses in controls.

7. ACTIONS

An action is something which is intended to be done and which will limit the impact of a risk in the future. It may reduce the likelihood of the risk occurring at all. Once complete an action may become a new control. The Board should consider whether there is an associated action for each gap; are those actions on track according to their dates; and will these actions support the reduction of the risk when completed and become controls.

RISK SCORING MATRIX

Annex 1

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Highly Unlikely: Will probably never happen/recur	**Not for years**	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	**At least annually**	2	4	6	8	10
3 Likely: It might happen/recur occasionally	**At least monthly**	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	**At least weekly**	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	**At least daily**	5	10	15	20	25

AGENDA ITEM No	11
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

DUTY OF QUALITY / DUTY OF CANDOUR IMPLEMENTATION

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 May 2023
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Head of Quality Assurance
CONTACT	Caroline Miftari Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY

The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1st April 2023. This report considers the implementation of the Duty of Candour and Duty of Quality.

The Welsh Government (WG) implementation "road map" has been used to assess Duty of Quality (DoQ) and Duty of Candour (DoC) progress against expected outcomes, the next milestone is September 2023.

The Trust have incorporated senior oversight and responsibility for DOQ & DOC into the existing Quality and Performance Steering Group (QPSG), who will consider the key strategic areas ensuring alignment across Trust commissioned services. It is anticipated that there will be six work streams supporting the QPSG framed on the WG road map. Work is progressing with Trust leads to refine quality outcome measures at multiple levels throughout the Trust. This detailed work ensures measures are aligned to the Quality Standards 2023 and support an 'always on' approach to measurement.

Following the conclusion of a high-level Trust measure 'mapping exercise', discussions to plan a Quality Management System (QMS) digital dashboard are in progress. This will use guidance from Improvement Cymru and the NHS Wales Executive to clarify where national or system-wide data can be used.

Following the formal enforcement of the DoQ and DoC, Trust intranet pages have been made available to all staff cascading messages enhancing knowledge on the quality vision and Welsh Government communications. Further education, training and informational resources will be included as part of the Trust 'Quality Hub' as committed to in the 2023/24 IMPT deliverables.

A Trust wide training needs analysis and training plan is required and forms part of the work streams to support the cascade of Welsh Government education packages (awareness videos and e-learning package) as they become available.

The Trust quality governance infrastructure is being reviewed, in relation to the new legislation, ensuring systems and processes within its governance structure assists in capturing and recording all strategic decisions to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens.

Reviews are taking place with respect to the commissioning of the Trust that will subsequently be reflected into any associated contracts and agreements held by the Trust and therefore meeting the requirements of DoQ and DoC commissioning and hosting arrangements.

Recruitment to a key leadership position 'Senior Quality Governance Lead' is in progress; while recruitment of the Senior Quality Lead role is due to be fulfilled by Summer 2023. These roles will provide additional strategic capacity, and local expertise and capabilities to support the Trust in delivering the DoQ and DoC.

RECOMMENDATION: It is asked that: -

- **The Committee receive and note the report.**
- **The Committee note that the Trust is working towards the baseline assessment criteria as set by Welsh Government Road Map, the first milestone was April 2023, with a forthcoming milestone in September 2023.**

KEY ISSUES/IMPLICATIONS

Resourcing requirements - the digital infrastructure is a key consideration in the Trust delivering against the 'always on' requirement.

REPORT APPROVAL ROUTE

Quality, Patient Experience & Safety Committee – 11 May 2023

REPORT APPENDICES			
ANNEX 1: SBAR which provides an overview of the Duty of Quality/Duty of Candour Implementation Progress			
REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES
Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	YES
Health and Safety	YES	TU Partner Consultation	N/A

ANNEX 1

SITUATION

1 The report considers the Trust progress of the implementation of the Duty of Candour and Duty of Quality aligned to the Welsh Government Road Map.

BACKGROUND

2 The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1st April 2023. There are four key components to the Act: Duty of Quality, Duty of Candour, Citizens Voice, and Vice Chairs. This report considers the implementation of the Duty of Candour and Duty of Quality.

3 The Health and Care Standards (2015) have now changed to Quality Requirements (2023) with six domains and five enablers. The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning Improvement & Research, and Whole System Perspective.

4 The revised legislation will change the basis upon which Health Inspectorate Wales, as our regulator, assesses organisation compliance to legislation.

ASSESSMENT

5 The Welsh Government (WG) implementation “road map” has been used to assess Duty of Quality (DoQ) and Duty of Candour (DoC) progress against expected outcomes, the next milestone is September 2023.

6 The Trust have incorporated senior oversight and responsibility for DOQ & DOC into the existing Quality and Performance Framework Steering Group (QPMFSG). The Trust Quality and Performance Management Framework (QPMF) used by the group sets out an integrated approach to helping the Trust improve the quality of its services and outcomes for patients and achieve its ambitions and objectives by monitoring and improving the performance of people, teams, and the organisation. Following implementation of the legislation in April, a revised terms of reference for the group are being developed to reflect the requirements of the DOQ & DOC, in the context of the Trusts previously approved QPMF. A comprehensive review of the framework is also underway.

7 On behalf of the Trust, the QPSG will consider the following strategic areas ensuring alignment across Trust services. In general, the group will consider the five quality enablers required of the legislation that seek to develop a quality environment and infrastructure to attain the requirement.

a. Outline Trust evidence and publication schedules for sharing DOQ intelligence with stakeholders.
b. Define the specification for quality intelligence – including how information is escalated through the organisation using a digital architecture.
c. Develop and assess the effectiveness of the Trust’s Quality Management System and implementation plan, linking with the Digital and Data Strategy, to include quality planning, control, improvement, and assurance.
d. Ensure Trust commissioning and hosting arrangements are aligned for the service providers working with the Trust.
e. Develop opportunities for system-wide learning - to share learning across the patient journey, and population.
f. Agree strategic quality improvement requirements based on intelligence emerging from the quality management system.
g. Oversee the Trust training needs analysis and associated plan to enable all staff to apply the DoQ and DoC into practice.

8 It is anticipated that there will be six work streams supporting the QPMFSG framed on the WG road map, to include; Quality Requirements, Quality Management System, Quality Governance, Accountability, and decision making, Quality Impact Assessments, Quality Audit Programme (clinical and non-clinical) and Education and Training.

9 Work is progressing with Lead experts to define quality outcome measures aligned to the Quality Standards 2023 and agree tolerances across strategic, tactical, and operational levels to support the 'always on' approach. This work will inform the Quality and Performance Management Framework digital dashboard specification, which will provide a scalable solution and incorporate all existing dashboards. The approach will compliment a further evolution of the Monthly Integrated Quality and Performance report.

10 Initial discussions to agree the Trust QMS model are in progress, utilising best practice guidance from Improvement Cymru and the NHS Wales Executive. The model will outline a systemic approach incorporating planning, improvement, control, and assurance elements, providing the internal structure and process reflective of:

a. Continuous requirement to understand and secure the improvements in outcomes for the population served by the commissioned services.
b. Monitoring progress and evidence on the improvement of quality services and outcomes.
c. Regular assessments, investigations, and measurement over time to identify areas to improve quality and recognition and sharing of good practice and early escalation and intervention in response to signals.

11 The DoQ and DoC intranet pages are now available to all staff cascading messages enhancing knowledge on the quality vision and Welsh Government communications. Further work required to ensure all staff recognise and understand the organisation's Quality vision, and their roles within it.

12 A Trust wide training needs analysis and training plan is required and forms part of the work streams to support the cascade of Welsh Government education packages (awareness videos and e-learning package) as they become available. It is anticipated that the Trust will use existing forums/education programmes to ensure staff understanding of the duty of quality and duty of candour, and their roles within it. A further Board Development session regarding the DoQ and DoC was held on 29th March ahead of the enforcement of legislation, which highlighted the progress achieved to date, resource considerations into the new financial year, and Welsh Government roadmap for the year ahead.

13 DoQ and DoC requirements are being incorporated into the Trust commissioning and hosting arrangements through the ongoing reviews taking place reflective of any associated contracts and agreements held by the Trust.

14 The Trust quality governance infrastructure has been reviewed, in relation to the new legislation, ensuring systems and processes capture and record decisions to provide evidence that plans have been made through a quality lens. It will also assist in defining the monitoring of quality standards, evidencing of improvements, sharing of intelligence, and actions taken for Trust Committee and Board.

15 Part of the governance structure to support this is the implementation of the Senior Quality Lead role that will support directorates and teams in highlighting reports, escalating good/poor practice as required through the Trust governance structure, and promoting/advising on improvement actions.

16 Reviews are taking place with respect to the commissioning of the Trust that will subsequently be reflected into any associated contracts and agreements held by the Trust and therefore meeting the requirements of the DoQ and DoC commissioning and hosting arrangements.

17 All related policies and procedures to be reviewed, in particular: Putting Things Right Policy (in line with Duty of Candour) and Adverse Incident Policy on receipt of the final policy guidance and Quality Impact Assessments.

NEXT STEPS

18 The Trust will continue to work towards the Welsh Government Baseline Road Map, regularly reporting through the Trust Quality and Performance Steering Group, and the Clinical & Quality Governance Group.

END

AGENDA ITEM No	12
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Quality Strategy Implementation Plan

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 May 2023
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	J Turnbull-Ross, Asst. Director Quality Governance
CONTACT	Jonathan.turnbull-ross@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an overview of progress against the Trust Quality Strategy Implementation Plan. The plan was developed to support the realisation of the Quality Strategy 2021-24, and its three strategic aims:

1. Supporting a quality-based learning culture that will deliver enhanced knowledge, skills, learning, improvements, and professionalism.
2. Develop a Quality Management System that will deliver quality driven decisions, integrating quality management, strong governance and accelerating quality responsiveness.
3. Integrating the citizen's voice into the Trusts service design, transformation, and improvements.

Progress against the implementation plan had been particularly challenged due operational demands resulting from the pandemic, pandemic recovery, winter and more recently, industrial action. An Organisational Change Process (OCP) was undertaken in the second half of 2022 to realign allocated and available resources. This completed in Q4 2022/23 and recruitment and onboarding into roles is currently taking place.

Progress against actions has accelerated in the latter half of 2022 in preparation for the enforcement of the Health and Social Care (Quality & Engagement) (Wales) Act 2020 from April. As at end of April 2023, of the 23 implementation actions 1 action is complete (purple),10 actions are progressing towards completion (green), 7 actions progressing albeit with challenges to progress, and 4 actions have not commenced.

Compliance with the new legislation, upon which the strategy is principally aligned, is contained with the Trust IMPT for 2023/24, this will ensure the Trust are sighted on progress and attainment of the Strategic Quality Aims of the plan. To further support delivery of actions over 2023/24, the appointment of resources – particularly newly created roles – will provide greater capacity and capabilities to the quality governance team in the final year of strategy delivery.

The implementation remains a priority for delivery over 2023/24, noting that several areas of the plan require investment in resources to achieve success. Specifically, investment in the Trust digital infrastructure and capabilities is important to enable effective operation of an 'always on' data-to-knowledge quality management system. Secondly, improved organisational capacity is affording progress against actions; with a view of this continuing providing the focus of attention required to deliver on actions.

Finally, training, education and information resources (noting the prerequisite on Welsh Government confirmation/launch of training packages) will support staff across the organisation in understanding their role in enabling quality and candour. The recruitment and onboarding of quality leaders is important in facilitating and engaging staff, ultimately maturing the quality culture of the organisation.

The Committee are asked to also consider the positive progress of the Trust position against the Welsh Government road map for the Act implementation reported previously to QUEST, including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level.

RECOMMENDATION: The Committee is asked to

- **Note the progress against the implementation action plan.**

KEY ISSUES/IMPLICATIONS
n/a
REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee – 11 May 2023
REPORT APPENDICES
Annex 1 – Quality Strategy Implementation Plan

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Strategic Quality Aims	Strategic Outcome	Strategic Output/Intent	Action	RAG Status	Progress Update: April 2023
Quality Culture / Duty of Candour	**Support a Learning Environment**	Psychological Safety	Establish a psychological safety, through the Trust Health & Wellbeing Steering Group		*Not commenced*
		Appreciation of Complex Clinical Judgements (Person Centred Care) Openness to new approaches	Embed learning & feedback from incidents and events – establishing processes for shared learning across workforce/organisation (organisational learning)		QSPE have commissioned an options apraisal to consider the options and effectiveness of communicating learning from incidents and near misses. The work it due to be completed in Q1 2023/23.
		Resources to support reflection and learning	Suite of support tools and resources supporting reflective practice, and continuous development - delivered through the development of a Q Hub.		Duty of Quality and Duty of Candour information resources have been place on the dedicated Trust intranet page. A Quality Hub is currently being developed, and is a IMPT 23/24 deliverable.
	Enhancing Knowledge, Skills and Professionalism (Duty of Candour)	Education and Training (Duty of Candour)	Training package – Duty of Candour training package will be diseminated through Welsh Government as part of the Quality & Engagement Act. The package will be released follwoing conclusion of public consultation.		*Not Commenced - to commence following WG release expected in Summer 2023*
		Day-to-day 'Duty of Candour' implementation	Process to capture DoC (low, medium and high level activity)		The Trust has developed and organisational resource proposal for the adequte resourcing of the team. This is currently unfunded, and subject to forthcoming EMT discussion in Q1 2023/24.
	Delivering Learning & Improvements	Process and principles in which open, honest and transparent learning is undertaken	Embed enhanced learning, and monitoring within quality management systems - promoting targeted improvement efforts and action		The Quality Management Group is operational,a revised ToR for the group is required and seeks to merge actiivty with the Trust Patient Safety Learning and Monitoring Group.
			Development of supporting processes and systems of work that focus sustainable improvement towards challenges		
Quality Management System	**Quality Driven**	Quality is everyone's responsibility	Training package – Duty of Quality training package will be diseminated through Welsh Government as part of the Quality & Engagement Act. The package will be released following conclusion of public consultation.		Not Commenced - to commence following WG release expected in Summer 2023
			An organisational evalutation will be undertaken to ascertain roles and responsibility for Quality. This will include the requirements upon all staff, resulting from the Act; and, install the prinicples of responsibility towards an 'improvement orientated' organisation.		Recrutiment of the Senior Quality Lead roles is currently underway. Whilst scale of resource is restricted, embedding the post holders into local operational and leadership teams is idneitified as a key step in influencing culture, roles and responsibilities. Critically, the role will complement and enhance the value of formal and informal training/information.
			The development of a annual evaluation and recognition exercise which seeks to celebrate examplars of qulaity / quality improvement		Not Commenced
		Empower local leaders	Quality Management System training/education will be provided; additionally, wider workforce education (particularly targeting senior local leads) will be developed through a Quality Hub.		Introduction to Quality Management Systems (ISO9001) training delivered in Q3 2022/23. Longer-term knowledge and skills building to be developed through a 'Q Hub' seeking to improvement QI and Quality Management knowledge and skills (commencing from Q1 2023/24).
			Establish 'working together' with Senior Quality Leads		Quality Management Group established as the prinicple forum for quality assurance and improvement transaction. This will act as an enabling form for the purpose of directing improvement efforts, turning assurance data-to-knowledge , and evidencing quality impact (Duty of Quality). Recruitment to the Seniro Quality Lead role is underway.
	Integrating Quality Management	Systems that integrate and triangulate data Collaborative forums for patient and service users Integrating communication Integrating reporting lines	Establishment of a Quality & Performance Management Steering Group; Establishment of integrated 'governance' forums.		Quality & Performance Management Steering Group established April '2022. Following the enforcement of the Act, the group will refocus to align the group to the 'enabling' requriements of the legislation.
	Strong Governance & Quality Management Structures	Integrated Governance Group	Establish and introduce an integrated, Clinical and Quality Governance Group (CQGG)		CQGG established. Action complete.
			Develop reporting and governance channels to local level		The Quality Management Group is operational,a revised ToR for the group is required and seeks to merge actiivty with the Trust Patient Safety Learning and Monitoring Group. Further development of the memebrship of the group will strengthen the performance of the function, and the onboarding of the Seniro Quality Lead roles.
		Board to Floor	Development of sub-structure groups to CQGG.		Review of sub-group structures completed. Sub-group structure workshop held September 2022 resulting in recommendation for CQGG consideration in October 2022. Action complete in Q4 2023/23.
			Establishment and introduction of a integrated 'governance' forum		An informal integrated governance forum had commenced in 'pilot form' in 2021/22, with a view to assessing wider organisations perspectives upon quality matters. However, the sustainability and performance of the forum was poor due to timelines for data analysis and committee reports, and limited availablity of information on a timely basis. The development fo the Quality Management Group, meeting on a weekly basis, is holds greater integration of quality across the organisation - with formal and informal connections of members across the Trust, noting particularly stonng interface with Operations and the Clinical Services Directorate. Further assessment is needed on the effectiveness of this 'integration' across the organisation, which is being considered in the Quality & Performance Management Steering Group, and at a Corporate level.
	Accelerating Quality Responsiveness	Reduce turn-around times on quality issues Issues locally owned and managed	Establishment of local Senior Quality Leads and local leadership 'ownership' of quality.		OCP process is complete. Staff are transitioning into new roles, and recrutiment is acitvely underway for newly created roles.
Integrating the Citizen Voice	**People & Community Network**	Inclusivity	Establish a network representational of the Citizens of Wales, inclusive to all who seeking to be involved		The Trust 'People & Community Network' has formally launched with members registered from across Wales. Engagement with communities will continue to ensure continuous recruitment to the Network.
		Innovation	Establish and embed work processes to enable Citizens to be contributing and co-producting Trust service development and transformation		Members of the Network have already contributed to a number of Trust initiatives to improve services including a review of the NHS 111 Wales website and NHS 111 Interactive Voice Recording (IVR). Further embedding is required to ensure the Citizen Voice is considered systematically across initiatives
		Influencing	Embed the Citizen voice as an influencer in Trust decision making and planning		An internal promotion/communication plan has been developed to promote the involvement of network public members in Trust improvement plans; ongoing engagement/discussions on embedding citizens voice continue.
		Involvement	Provide opportunities for meaningful engagement and involvement in Trust service developments		Network members have already been involved in two reviews of service developments (NHS 111 Website and NHS 111 Telephony IVR). Further programmes for improvement have been identified including developing further WAST experience surveys and assessing new public information leaflet on how the Trust handles 999 calls.
	Integration of Citizen Voice within Quality cycle (planning)	Effective Citizen participation in service change and delivery	Defined systems and processes that enable measureable/demonstratable integration of the Citizen's voice within Trust service developments, improvements and transformation in the pursuit of enhanced quality of care & experience.		Discussions with several local LLAIS colleagues (Citizens Voice Body) have taken place to discuss specific opportunities to engage with the public/patients and methods for capturing patient experiences. We will continue to strengthen relationships with LLAIS.

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	5

Quality Impact Assessment Governance

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 May 2023
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Caroline Miftari Head of Quality Assurance
CONTACT	Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY

The report considers the Trust Quality Impact Assessment Governance Process.

The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales.

The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this are Quality Impact Assessments (QIA).

The Trust have developed a QIA Framework and template, which was agreed at the Clinical Quality Governance Group in November 2022. The framework and template have been updated to reflect the new Health Care Standards 2023.

Roles and responsibilities are outlined in the Trust QIA framework identifying governance and assurance processes for the development, accountability and monitoring of quality impact assessments.

RECOMMENDED: That the Quality, Patient Experience & Safety Committee,

- **Notes the report and considers the assurance provided.**

KEY ISSUES/IMPLICATIONS

n/a

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee – 11 May 2023

REPORT APPENDICES
Annex 1 – SBAR which provides an overview of the Trust Quality Impact Assessment Governance Process. Annex 2 – Flowchart Quick Reference Quality Impact Assessment (QIA). Annex 3 - Part 1 QIA Screening Tool & Part 2 Full QIA completed for reference. Annex 4 - Questions and Prompts for QIAs. Annex 5 - Examples of monitoring measures (not exhaustive).

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES
Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	YES
Health and Safety	YES	TU Partner Consultation	N/A

ANNEX 1

SITUATION

1. The report considers the Trust Quality Impact Assessment Governance Process.

BACKGROUND

2. The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1st April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales.

3. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens. A key element of demonstrating this are Quality Impact Assessments (QIA).

4. Quality Impact Assessments provides a mechanism to identify, mitigate and monitor impacts on quality resulting from service redesign/transformation, projects, and cost improvements.

5. Other strategic requirements that will be benefited through QIA's include; The Well-being of Future Generations (Wales) Act 2015, A Healthier Wales (WG, 2018), National Clinical Framework (WG 2021) and National Quality and Safety Framework (WG 2021).

6. This Trust wide approach, which has been adopted across NHS Wales, will enable capture of learning and improvement opportunities across the organisation, while enabling local leadership teams to make improvement happen.

ASSESSMENT

7. The Trust have developed a QIA Framework and template, which was reviewed and agreed at the Clinical Quality Governance Group in November 2022. The Trust QIA template has since been adopted by the NHS Wales Executive for use across Wales approach.

8. The governance process supporting the QIA can be categorised under initial screening and full QIA. Both approaches assess the quality impact (positive, neutral or adverse) on service provision for any proposal to change the way commissioned services are delivered.

9. Completion of the QIA template under initial screening of quality impact requires judgement on whether the impact on the key areas of quality are neutral (N), positive (P) or adverse (A). Where potential adverse impacts on quality are identified they should be risk assessed using the risk scoring matrix identifying the likelihood of the adverse impact occurring and the consequence.

10. Scoring the likelihood of impact and consequence is not required for positive or neutral quality impacts. Where the adverse (A) impacts score greater than eight in any health care standard domain and/or enabler this will result in the need to undertake a more detailed full QIA.

11. All full QIAs should be considered for inclusion on local / corporate risk regsiters as appropriate. Equality impact assessments (EQIA) must also be undertaken as per Trust policy. This remains seperate to the QIA process, however the Trust is considering how various impact assessments can be 'brought together' to improve userability.

12. Roles and responsibilities are outlined in the Trust QIA framework identifying governance and assurance processes for the development, accountability and monitoring of quality impact assessments.

13. In summary, the Clinical Quality Governance Group (CQGG) will**:**
    a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements.
    b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a Full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated.
    c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA.
    d) Oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate.

14. Operational Teams/ Corporate Teams/Project Boards/Programme Boards will:

    a) Ensure QIAs are completed for service redesign/transformation projects and cost improvements with areas of responsibility.
    b) Undertake the initial QIA screen.
    c) If a Full QIA is not required (Score <8), include decision & rationale in documentation, with a caveat to review the need for QIA in the event of changes to the project.

d) Ensure the respective clinical director (Director of Quality and Nursing / Medical Director / Director of Paramedicine) or designated deputy have reviewed and authorised the QIA initial screening once completed.
e) Submit the QIA Screen for to CQGG for noting and retention as evidence for future Duty of Quality reporting.
f) If a full QIA is required (score >8), complete full QIA template with mitigations and monitoring measures.
g) Ensure the respective director is sighted on the QIA once completed for review and submission to CQGG.
h) Submit to Clinical Quality Governance Group for approval or escalation to full EMT where clinical directors identify significant organisational risk resulting from the proposed change.
i) AAA reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.
j) CQGG secretariat to maintain a digital QIA repository.
k) Provide regular updates to CQGG on all full QIAs approved.

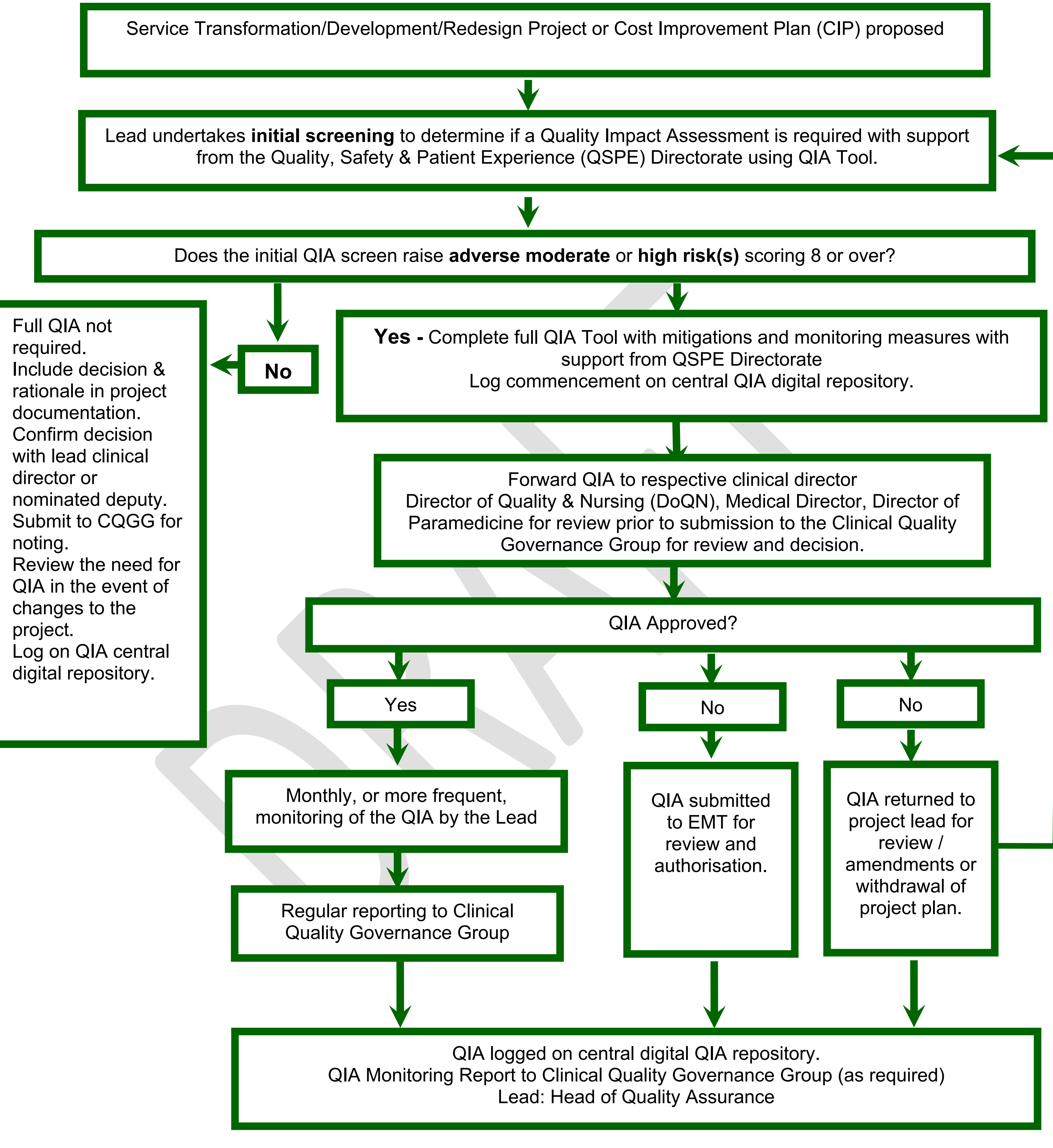
15. Quality, Safety and Patient Experience Directorate will:
a) Provide QIA tools, advice and support to leads undertaking quality impact assessments related to clinical and governance Trust wide service changes/schemes/projects.
b) Prepare information for the QIA oversight report under the requirements of the Duty of Quality.

16. Following the publication of the NHS Wales Delivery Unit QIA National Template, the Trust will digitise the QIA to enable digital access and storage of QIAs. Staff will continue to be supported with the completion of QIAs.

17. Over late 2022 and early 2023, the QIA process was trialled by the Clinical Services Directorate in the proposed 'Red Auto-dispatch' (Appendix 2) change. The proposal, and use of the framework, enabled staff to learn of the challenges and practical requirements of QIA completion. The example QIA is provided to provide Committee with insight of the process, and assurance in the breadth of impacts assessed to ensure the Trust attains the Duty of Quality requirement.

18. The committee should note the completion of the Appendix 2 example pre-dated the new Quality Requirements 2023 and was completed against the previous Health & Care Standards.

ANNEX 2 – Flowchart Quick Reference Quality Impact Assessment (QIA)



All projects when deemed complete will form part of 'business as usual' as appropriate

Annex 3 – Part 1 QIA Screening Tool & Part 2 Full QIA

Governance, Leadership & Accountability	
Title of service change/proposal	**RED auto – dispatch (AD): Quality Impact Assessment (QIA) to potentially change the RESPONSE RATIO for RED calls.**
Date of QIA assessment:	20th March 2023
Project overview (brief summary)	**Situation and Background** The Welsh Ambulance Services NHS Trust's (WAST) Executive Management Team (EMT) have requested a proposed change to how the Emergency Medical Services (EMS) are sent / dispatched to 999 calls categorised as RED (technically referred to within this document as 'RED AD'). **Objective** **By the end of March 2023 provide the WAST EMT and Clinical Quality Governance Group (CQGG) with a Quality Impact Assessment (QIA) to assess the changes requested, which will modify the RED AD from dispatching a minimum of two EMS resources to dispatching one EMS / nearest resource to RED 999 calls.** **Governance** The detailed work to analyse the change request by WAST's EMT and to report this QIA has been completed by WAST's Clinical Prioritisation Assessment Software (CPAS) Group. **Quality Assurance** External quality assurance support has been additionally provided by the International Academy Emergency Medical Dispatch (IAEMD), who are the providers of the licenced Medical Priority Dispatch System (MPDS). The MPDS is a unified system used to dispatch appropriate aid to 999 ambulance calls, including systematised caller interrogation and pre-arrival instructions. **Scope** The proposed changes apply to EMS responders ONLY. Other Responders (Community First Responders, Uniform First Responders, Specialist Teams, etc.) will still be sent to RED calls as per current WAST practice, and in addition to any EMS RED AD.

Summary of Proposed Change

Table 1: RED AD to the 392 RED Codes

RED AD	Number of RED Codes	MPDS Protocols that have the RED Codes
Maximum of one – the nearest available EMS resource	**226**	• 02 (Allergies) • 03 (Animal Bite) • 04 (Assault) • 06 (Breathing Problems) • 07 (Burns) • 08 (Carbon Monoxide) • 10 (Chest Pain) • 12 (Convulsions / Fitting) • 13 (Diabetic Problems) • 14 (Drowning) • 17 (Falls) • 19 (Heat Problems) • 21 (Haemorrhage) • 22 (Inaccessible Incident) • 23 (Overdose / Poisoning) • 25 (Psychiatric) • 27 (Stab / Gunshot) • 30 (Traumatic Injury) • 31 (Unconscious / Fainting)
***Continued Minimum of two – the nearest available EMS resource PLUS automatic back up by another available EMS resource**	**166**	• 09 (Cardiac Arrest or Respiratory) • 11 (Choking) • 15 (Electrocution / Lightning) • 24 (Pregnancy / Childbirth / Miscarriage) • 29 (Traffic / Transportation Incidents) • Arrest in the descriptor of any other MPDS codes.

**Note: In conjunction with the IAEMD, CPAS have identified that some RED codes and instances will still require more than one RED AD by EMS. Clinical rationale: more than one patient at the incident / or numerous advanced life support tasks are required.*

In addition to the above in TABLE 1, a continued minimum of two EMS resources will also be required in the following instance:

- Any incident where CPR instructions are being given by the MPDS Call Handler.

Main Operational System Change

The main operational system that will need to be re-configured is the auto dispatch (AD) function. The AD was introduced with the C3 Compute Aided Dispatch (CAD) in November 2017. The AD has limited functionality and can only be configured in certain set ways to provide a response to 999 calls. It cannot, for example, differentiate between types of responses to different MPDS code sets. The technology is primarily based upon location identification, and EMS resources within the set proximity of the incident.

Proposed Changes Implemented – 'Go Live'

The change will need to follow the sequence of actions as per the Dispatch Cross Reference (DCR) Table Management Policy (February 2021). These steps can be broadly summarised as follows:

- Clinical review and agreement by CPAS – *completed and results reported in this QIA.*

(SUBJECT to the EMT and CQGG ratifying / approving this QIA), then:

- Technical changes made to the CAD system – *to be completed (this will require a Senior Digital Lead to be commissioned by the EMT).*
- Operational implementation – *to be completed and includes testing on a training account / training of identified staff / ALL staff communication and updates to ensure full understanding of changes to RED AD (this will require a Senior Operational Lead to be commissioned by the EMT).*

Target Audience

- WAST EMT
- WAST CQGG
- ALL WAST Staff
- WAST Commissioners of Services

To Read in Conjunction With

- DCR Table Management Policy (February 2021)
- Attached Power Point Slide Set – provides more detailed information of the analysis by CPAS of the proposed EMT change by using recognised quality improvement (QI) methodology (data / process mapping etc.).

Reporting route (oversight group of QIA and monitoring of quality measures)	CPAS with direct reporting and assurances to CQGG at least on a quarterly basis (CPAS membership includes patient safety representatives and Senior Operational representatives to feed back on the quality measures identified).
How will quality measures be obtained? (Full QIA only)	SCIF, PTR Reports, DATIX, HI Data.
Executive lead	Brendan Lloyd Executive medical Director and Andy Swinburn, Director of Paramedicine
Project lead(s)	CPAS - Grayham Mclean: Head of Clinical Improvement Operational - Kate Blackmore: Head of Service EMS Coordination
Outcome of QIA (screen only or full QIA)	Full QIA
Comments (including brief rationale for not progressing to full QIA if appropriate)	Full QIA undertaken
Date submitted to Quality, Safety & Patient experience Directorate for review (full QIAs) and inclusion on QIA Database (all QIAs) Quality.amb@wales.nhs.uk	21st March 2023

DRA

Annex 3 – Part 1 QIA Screening Tool continued

Health & Care Standards Domains	Potential / Actual Impact Question	Potential Impacts? Positive (P), Neutral (N), Adverse (A)	likelihood Score	Consequence (impact) Score	Score Likelihood X consequence	Score 8 & above = Full QIA
Staying Healthy, Patient Safety	Could the proposal impact on any of the following? Impact on serious incidents, their reporting and learning, systems in place to safeguard patients /staff and prevent harm?	Neutral (N) - • WAST will continue to immediately dispatch the closest available EMS resource to a RED call incident, which remains in line with the evidence-based practice of the 'Chain of Survival'. This being a sequence of interventions to optimise the chance of survival in an out of hospital cardiac arrest.	Not scored		**X**	*No*
Staff Safety	Could the proposal impact on any of the following? Impact on serious incidents, their reporting and learning, systems in place to safeguard staff and prevent harm?	Adverse (A) - • Current AD RED AD configuration provides a minimum of an Emergency Ambulance (EA) for patient transport and a Paramedic (whether on the EA, or as a separate solo response) • The proposed change will stop this response practice, and the nearest EMS resource to a RED call incident will be sent ONLY, with no automatic back up. This could be a solo responder (e.g., Cymru High Acuity Response Unit - CHARU / Duty Operational Managers – DOMS). Or a double Emergency Medical Technician (EMT) EA crew. • Back up will, therefore, need to be ADDITIONALLY requested by the	3	5	**15**	*15*

		attending EMS resource, and it will not be automatically sent as per current AD RED AD.				
Effective Care	Could the service change impact on evidence-based practice, clinical standards (NICE/JRCALC), clinical leadership and/or engagement?	Neutral (N) - • WAST will continue to immediately dispatch the closest available EMS resource to a RED call incident, which remains in line with the evidence-based practice of the 'Chain of Survival'. This being a sequence of interventions to optimise the chance of survival in an out of hospital cardiac arrest. Positive (P) • The Clinical Prioritisation Assessment Software Group (CPAS) Group have engaged with the International Academy of Emergency Medical Dispatch (IAEMD) to complete the clinical actions for the proposed changes. These actions were to identify the 999 calls that will always require more than one (i.e., multiple) EMS responses. TABLE 1 cited above in the Project Overview section of this document shows the recommendations where patients will continue to have multiple EMS resources sent to them to ensure effective care (e.g., more than one patient at the incident / or numerous advanced life support tasks are required).	Not scored		**X** **X**	*No* *No*
Individual & Dignified Care (Patient Experience)	Could the proposal impact on patient choice, dignity and respect, service user experience? Could the proposal impact on eliminating discrimination, on eliminating harassment and or	Neutral (N) - • WAST will continue to immediately dispatch the closest	Not scored		**X**	*No*

	on promoting good community relations /positive attitudes?	available EMS resource to a RED call incident, which remains in line with the evidence-based practice of the 'Chain of Survival'. This being a sequence of interventions to optimise the chance of survival in an out of hospital cardiac arrest. • Chain of Survival being based upon early recognition and activation of the EMS to support any early attempts of basic life support (BLS) with expert advanced life support (ALS) for ALL patients who access the 999 calling system.				
Timely Care	Could the proposal impact on care being provided in a timely way?	Positive (P) – • WAST EMS is under significant pressure to provide EMS to 999 callers. By reducing the number of ADs for RED AD to a maximum of one / the nearest EMS resource for a total of 226 of the 392 RED codes (see TABLE 1 cited in the Project Overview section above), there is an opportunity to increase EMS capacity and likelihood of a response to more RED calls. Adverse (A) • Current AD RED AD includes the Urgent Care Services (UCS). This service cannot respond HOT (blue lights), and although can provide BLS, are not able to provide ALS. To ensure the Chain of Survival sequence is followed, therefore, the proposed change will need to ensure there is a	Not scored 3	 4	**X** **12**	*No* *12*

		mechanism in place to automatically back up UCS response to RED calls with an EMS response.				
Staffing & Resources	Could the proposal impact on staff satisfaction, retention and recruitment, staff sickness and or public perception of the Trust or its services?	Adverse (A) - • Current AD RED AD configuration provides a minimum of an Emergency Ambulance (EA) for patient transport and a Paramedic (whether on the EA, or as a separate solo response) • The proposed change will stop this response practice, and the nearest EMS resource to a RED call incident will be sent ONLY, with no automatic back up. This could be a solo responder (e.g., Cymru High Acuity Response Unit - CHARU / Duty Operational Managers – DOMS). Or a double Emergency Medical Technician (EMT) EA crew. • Back up will, therefore, need to be ADDITIONALLY requested by the attending EMS resource, and it will not be automatically sent as per current AD RED AD.	3	5	**15**	*15*
Summary rating = highest individual risk score						***15***

Annex 3 – Part 2 Full QIA Tool

QIA Part 2: Health & Care Standards Domain: *Staff Safety*								
		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established (What is already in place?)	Likelihood	Impact	Residual risk score
1.	EMS staff continuing to expect automatic back up (based upon current AD RED AD) and not being fully aware that the change will introduce ONLY the nearest available EMS resource with no automatic back up (unless one of the codes / instances identified by CPAS as still requiring a multiple response). Without this recognition by staff, and compliance with the back-up request procedure, there is a high risk in delays to support at incidents when identified as needed by the first attending EMS resource.	3	5	15	• Action Card (back-up matrix) for requesting support at a scene of an incident already exists and is in operation. • Standards of care delivered to patients will continue to be clinically evidence based – EMS staff will provide care to the level of their education / training / guidelines (JRCALC). • The changes to AD RED AD are for EMS ONLY, and therefore, specialist teams / Community First responders / Uniform First Responders / etc., will continue to also be dispatched to RED calls where it is identified by the specific code sets assigned to their level of response – i.e., EMS will be further supported at incidents by other Responders.	4	2	8

Quality measures (monitoring unintended consequences and positive impacts)- How will you source these metrics?

- Weekly operational performance, demand, and capacity meeting
- Staff feedback
- Patient / family feedback (compliments / complaints / feedback from engagement activities)
- Incident reporting (monitored via SCIF)

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Any further mitigations planned (with accountabilities and timescales)?

- A key action within the implementation plan is to undertake a training needs analysis for Allocator staff, and deliver any required training.
- Identified significant staff engagement will be required to inform staff of proposed changes to automatic back up - TBC once a Senior Operational Lead is commissioned by the WAST EMT.

Comments

QIA Part 2: Health & Care Standards Domain: *Timely Care*

		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk	Key controls / assurances established (What is already in place?)	Likelihood	Impact	Residual risk score
1.	If the UCS remain within the proposed change AD RED AD, they will be the only resource sent to incidents, if nearest to that event. UCS are not able to provide ALS and will not be automatically backed up by a Paramedic (on an EA or solo car), as with current practice.	3	4	12	• NIL – only option is to remove UCS from the AD configuration for the proposed changes to RED AD.	3	4	12

Quality measures (monitoring unintended consequences and positive impacts)- How will you source these metrics?

- Weekly operational performance, demand, and capacity meeting
- Staff feedback
- Patient / family feedback (compliments / complaints / feedback from engagement activities)
- Incident reporting (monitored via SCIF)

Any further mitigations planned (with accountabilities and timescales)?

-
- A key action within the implementation plan is to undertake a training needs analysis for Dispatch staff and deliver any required training – TBC once a Senior Operational Lead is commissioned by the WAST EMT.

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- Identified significant staff engagement will be required to inform staff of proposed changes to automatic back up - TBC once a Senior Operational Lead is commissioned by the WAST EMT.

Comments

QIA Part 2: Health & Care Standards Domain: *Staffing and Resources*

		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established (What is already in place?)	Likelihood	Impact	Residual risk score
1.	EMS staff continuing to expect automatic back up (based upon current AD RED AD) and not being fully aware that the change will introduce ONLY the nearest available EMS resource with no automatic back up (unless one of the codes / instances identified by CPAS as still requiring a multiple response). Without this recognition by staff, and compliance with the back-up request procedure, there is a high risk in delays to support at incidents when identified as needed by the first attending EMS resource.	3	5	15	• Action Card (back-up matrix) for requesting support at a scene of an incident already exists and is in operation. • Standards of care delivered to patients will continue to be clinically evidence based – EMS staff will provide care to the level of their education / training / guidelines (JRCALC). • The changes to AD RED AD are for EMS ONLY, and therefore, specialist teams / Community First responders / Uniform First Responders / etc., will continue to also be dispatched to RED calls where it is identified by the specific code sets assigned to their level of response – i.e., EMS will be further supported at incidents by other Responders.	4	2	8

Quality measures (monitoring unintended consequences and positive impacts)- How will you source these metrics?

- Weekly operational performance, demand, and capacity meeting
- Staff feedback
- Patient / family feedback (compliments / complaints / feedback from engagement activities)
- Incident reporting (monitored via SCIF)

DRAFT

Any further mitigations planned (with accountabilities and timescales)?

- A key action within the implementation plan is to undertake a training needs analysis for Allocator staff, and deliver any required training.
- Identified significant staff engagement will be required to inform staff of proposed changes to automatic back up - TBC once a Senior Operational Lead is commissioned by the WAST EMT.

Comments

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Risk matrices

	CONSEQUENCES (IMPACT)				
LIKELIHOOD	1 - Insignificant	2 – Minor	3 – Moderate	4 – Major	5 - Catastrophic
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

	Probability	Description
Rare	1 in 100,000 chance	Do not believe will ever happen
Unlikely	1 in 10,000 chance	Do not expect to happen
Possible	1 in 1,000 chance	May occur occasionally
Likely	1 in 100 chance	Will probably occur
Most certain	1 in 10 chance	Likely to occur

Annex 4 – Questions and Prompts for QIAs

Staying Healthy & Safe Care

- What is the impact on partner organisations and any aspect of shared risk?
- Will the proposed scheme impact on the organisations duty to protect children, young people and adults?
- What is the impact on patient safety?
- What is the impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?
- What is the impact on clinical workforce capability care and skills?

Individual, Dignified & Equitable Care

- Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language?
- What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?
- What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users).
- How will it impact on the patient choice agenda?
- How will it impact on the compassionate care and personalised care agenda?

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Effective & Timely Care and Our Staff & Resources

- What is the impact on implementation of evidence-based practice?
- What is the impact on leadership?
- Does it reduce or have a negative impact on variations in care provision / equal to all groups?
- Does it affect supporting staff to stay well / staff experience?
- Does it promote self-care for people with long terms conditions?
- Does it impact on ensuring that care is delivered in the most clinically and cost-effective setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathways?

Annex 5 – Examples of monitoring measures (not exhaustive)

Staying Healthy & Safe Care:

- incidents including Never Events
- concerns, claims & service user feedback
- staffing levels and skill mix
- clinical audit results
- harm free care data
- internal audit results
- outcomes of external reviews.

Effective & Timely

- clinical outcomes
- clinical audit results
- activity data
- contract performance
- implementation of national guidance.

Individual, Dignified & Equitable Care

- patients, carers and public feedback
- Patient Voice feedback
- concerns data.

Our Staff & Resources

- staff feedback
- sickness / absence
- turnover
- appraisal rates
- mandatory training uptake
- national surveys.

Annex 5 - Stakeholders & partners (not exhaustive)

- NHS Wales Delivery Unit
- Welsh Government
- GPC Wales
- Executive Medical Directors
- Executive Nursing Directors

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- Executive Directors of Therapies & Health Science
- Primary Care Reference group
- Mortality Review Steering Group
- Patient Safety / Risk Managers
- Welsh Risk Pool - Once for Wales Concerns Management System
- Assistant Directors for Primary Care & Community Care
- Welsh Government Quality & Safety Group
- Patient Representatives
- Medical Examiners and Lead Medical Examiner
- Coroners Peer Group
- Improvement Cymru
- NHS England
- Association of Ambulance Chief Executives

Annex 6 – Key references

1. A Healthier Wales (2018), Welsh Government.
2. Wellbeing of Future Generations Act (2015), Welsh Government.
3. Health and Social Care (Quality and Engagement) (Wales) Act 2020, Welsh Government
    - Duty of Quality Improvement
    - Duty of Candour.
4. Quality & Safety Framework (2021), Welsh Government.
5. Putting Things Right Regulations (2011, revised 2013), Welsh Government.
6. HOW TO: Quality Impact Assess Provider Cost Improvement Plans (2012), National Quality Board.
7. Patient Safety Incidents Policy (2021), NHS Wales Delivery Unit.
8. Quality Governance (2013), Monitor, London.
9. The Shipman Inquiry Third Report (2003), HMSO, London.
10. Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 2: Analysis of evidence and lessons learned (part 2) - Vol 2, The Stationary Office, London.
11. Kirkup. B (2015), The Report of the Morecambe Bay Investigation, The Stationary Office, London.
12. Quality governance: How does a board know that its organisation is working effectively to improve patient care? (2013), Monitor, London.
13. Toma M, Dreischulte T, Gray NM, et al (2019) . A balanced approach to identifying, prioritising and evaluating all potential consequences of quality improvement: modified Delphi study. BMJ Open2019;9:e023890. doi:10.1136/bmjopen-2018-023890.

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AGENDA ITEM No	14
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

Clinical Audit Plan 2023-2024

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 May 2023
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

RECOMMENDED: That the Committee:

- **Approve the Clinical Audit Plan 2023-2024**

KEY ISSUES/IMPLICATIONS

Many of the audits and re-audits can be undertaken solely by the CIAT. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

REPORT APPROVAL ROUTE

Clinical Intelligence & Assurance Group – 13/01/2023
Clinical Quality Governance Group – 18/01/2023

REPORT APPENDICES
Annex 1: SBAR Annex 2: WAST Clinical Audit Plan 2023-2024

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

ANNEX 1

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

BACKGROUND

2. The Health & Care Standards (2015) form the cornerstone of the overall quality assurance system within the NHS in Wales. The ability to manage data and information and to communicate effectively contributes to the delivery of safe and effective care.
3. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

4. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway, or have been completed. Various groups and committees receive quarterly updates against this plan of work, and it is made available on the Trust's Intranet.

5. In recent years this plan and the subsequent action plan to monitor learning from each of the audits has been monitored by the Clinical Intelligence & Assurance Group (CIAG), and the action plan noted at Clinical Directorate Business meetings.

ASSESSMENT

6. Following the implementation of the electronic Patient Clinical Record (ePCR), a wider range of clinical data is possible. The CIAT and Health Informatics department continue to review and improve on the quality of the data available. This will enable more clinical audits to be undertaken, and Clinical Indicators (CIs) to be reported on, internally and to the Emergency Ambulance Services Committee. Included in the commissioning intentions is the need to report on a wider range of CIs and include time-based metrics for some clinical conditions, e.g., STEMI and stroke.

7. The Clinical Audit Plan 2023-2024 (attached) includes three main sections:

    a) Clinical audits that have been agreed by the CIAG to progress, considering the potential of the relevant ePCR data being available during the financial year.
    b) Suggested topics that need further development before progressing, e.g., specifying the requirements to be audited.
    c) Topics that require further consideration of their need, available data, and resources prior to inclusion in the plan.

8. Many of the audits and re-audits can be undertaken solely by the CIAT. However, support is required for some topics where subject matter experts are needed as authors, and the of support sponsors to ensure completion of the audits and subsequent actions.

RECOMMENDATION: That the Committee:

- **Approve the Clinical Audit Plan 2023-2024**

DRAFT For Approval

Clinical Audit Plan

2023/2024

Quarter 1
(Last updated 13th January 2023)

6. Implement change
1. Agree best practice
Action
Planning
2. Define methodology
5. Action plan
Audit
4. Analysis and reporting
3. Pilot / data collection

The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the programme so that it is realistic, achievable and that expectations are not overreached.

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT.

The decision for clinical audit topics chosen for inclusion will be influenced by:

- ❖ Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- ❖ Clinical risk management/patient safety (e.g., choosing topics in response to concerns highlighted by patient safety incidents);
- ❖ Local and Trust wide priorities
- ❖ Guidance documents (e.g., NICE and AACE / JRCALC)
- ❖ National Ambulance Service Clinical Quality Group
- ❖ Policy documents relating to health and healthcare
- ❖ Other benchmarking activities as appropriate

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a clinical audit plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

The aim of this document is to detail the clinical audit topics that are either planned, currently underway or have been completed during the financial year.

It is expected that all the topics identified in the plan will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's programme.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

*	N/A = Not due to start	Not started / not progressing as planned	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CIAT and the PCRs and/or data supplied				
Clinical Audit Classification	Tier 1 = UK Ambulance Services or Trust wide	Tier 2 = Health Board / Locality / Team		

The topics in the section below are confirmed clinical audits										
Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2022/ 2023	Q1	Q2	Q3	Q4
21_002	1	Safeguarding Adolescent Audit	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	July 2021					
TBC	1	Completion of closure code/ condition code / diagnostic code in the ePCR	Clinical Intelligence & Assurance Team	Duncan Robertson Interim Assistant Director of research, Audit & Service Improvement	*Indicative Q4 2022/23*					
TBC	1	Evaluation of Non-Conveyance & ROLE forms with ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Interim Assistant Director of research, Audit & Service Improvement	*Indicative Q4 2022/23*					
22_006	1	A review of TXA administration within the South Wales Trauma Network (SWTN)	Tim Austin Senior Trauma Paramedic	Greg Lloyd Assistant Director Service Delivery	*Indicative Q4 2022/23*					
TBC	1	Re-audit ePCR clinical data assurance - #NOF	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	N/A				

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TBC	1	Re-audit ePCR clinical data assurance - Stroke	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q2 2023/24*	N/A				
TBC	1	Re-audit ePCR clinical data assurance - STEMI	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q2 2023/24*	N/A				
TBC	1	Re-audit ePCR clinical data assurance - Hypoglycaemia	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q3 2023/24*	N/A				
TBC	1	Re-audit ePCR clinical data assurance – ROSC(at hospital)	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q3 2023/24*	N/A				
TBC	1	Re-audit of Bronchiolitis Pathway – Compliance to the All-Wales Guideline for Ambulance Service Management	Ruth Saele Clinical Data Specialist	Greg Lloyd Assistant Director Service Delivery	*Indicative Q4 2022/23*					
TBC	1	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	Claire Muxworthy Clinical Audit Coordinator	Duncan Robertson Interim Assistant Director of research, Audit & Service Improvement	*Indicative Q3 2023/24*	N/A				

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Table 2 – Full Information

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
21_002	Safeguarding Adolescent Audit	It was agreed as part of the learning from a domestic homicide review and as part of the safeguarding team's future work plan that an audit would be completed to develop a mechanism to review this aspect of safeguarding practice.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Audit Coordinator	July 2021	There were 3 aspects to the data capture: PCR, MPDS & CAS. The MPDS aspect has now been removed due to difficulties with locating PCRs, this will not impact on the aims/objectives. **PCR** Data analysed. **CAS** Data capture commenced.
TBC	Completion of closure code/ condition code / diagnostic code in the ePCR	All ePCRs should have a condition code (CC), enabling many of the clinical audits undertaken within WAST by allowing for selection by condition type. In addition, CCs are used to identify Clinical Indicators (CIs). Where ePCR records are not closed appropriately by clinicians. the TerraPACE system will automatically close the record by applying a closure code as '9999'. This audit aims to identify the ePCR CC rate, if '000' is used whether a suitable CC was available, provide opportunities to revise the CC list and identify why ePCRs are closed as '9999'.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified.

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Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
TBC	Evaluation of Non-Conveyance & ROLE forms (ePCR)	In April 2022, the electronic Patient Clinical Record (ePCR) roll out was completed across Wales. For instances where patients are not conveyed or where Recognition of Life Extinct (ROLE) is documented, a paper form is completed and left at the scene as information when WAST staff have left. The ePCR has a facility to take an image through the media tab within the application and is used for taking images of the non-Conveyance and ROLE forms. This audit aims to identify that an image of the relevant form is available on the ePCR and also evaluate the quality of the information documented on form.	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Data Specialist	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified.
22_006	A review of TXA administration within the South Wales Trauma Network (SWTN)	TXA is a key component of the package of care these major trauma patients receive to stabilise them for, or during the transfer to hospital. As such, It is important that we understand the practice of our clinicians to ensure it is administered appropriately in a timely fashion to all patients who require it.	Tim Austin Senior Trauma Paramedic	Ruth Saele Clinical Data Specialist	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified.
TBC	Re-audit ePCR clinical data assurance - #NOF	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	

DRAFT

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
TBC	Re-audit ePCR clinical data assurance - Stroke	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	
TBC	Re-audit ePCR clinical data assurance - STEMI	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	
TBC	Re-audit ePCR clinical data assurance - Hypoglycaemia	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	
TBC	Re-audit ePCR clinical data assurance – ROSC(at hospital)	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 2023/24*	
TBC	Re-audit of Bronchiolitis Pathway –Compliance to the All-Wales Guideline for Ambulance Service Management	To ascertain if actions following the previous audit have led to an improvement.	Ruth Saele Clinical Data Specialist	Kath Charters Clinical Data Specialist	*Indicative Q4 2022/23*	
TBC	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	To ascertain if improvements have resulted following completion of actions from the previous audit.	Claire Muxworthy Clinical Audit Coordinator	Ruth Saele Clinical Data Specialist	*Indicative Q1 2023/24*	

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The topics in the section below need further development prior to progressing	
Exacerbation of COPD	*Initially intended as a CI, complex and time-consuming for a monthly CI due to requirement of scrutinising all PCRs. CIAG decided that this is to be an audit pending ePCR data* *Further work needed to clarify criteria.*
Anticonvulsants - Administration in Children	*Re-audit to be undertaken to ascertain if the actions from the previous audit have resulted in improvements.*
Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	*To ascertain if improvements have resulted following completion of actions from the previous audit.*
Appropriateness of Antimicrobial use by WAST Advanced Paramedic Practitioners	*An action from CAED 19_07 was to undertake a re-audit on an annual or bi-annual basis. Decided at the CIAG 19.5.2022 that consideration be given to including this on the CA Programme when ePCR data is available.*
Peripheral line Insertion bundle compliance	*Enquiry from Exec Nurse SBUHB if we report on the Insertion bundle compliance.* *PVC audits have been undertaken but the inclusion of ANTT in an audit was not completed. CIAT have contacted the requestor to support an audit.*

DRAFT

The topics in the section below need further consideration prior to inclusion in the clinical audit plan **(*Workshops will be scheduled during the year with key stakeholders to scope these topics further*)**	
Ketamine administration	*In addition to pain management audits that are planned, and an internal audit on pain management, this would demonstrate the appropriateness of administration to a specific group of patients suffering severe pain.*
Effectiveness of pain management	*Previous audit on pain scoring and the use of appropriate analgesia have been undertaking – consider re-audits too.*
Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years	*Should consider all ages. Consider dashboard option.* *Consider the standard, all patients, all patients in pain.* *Management of pain is more meaningful than only measuring the documentation of a pain score for all patients.*
Explore the correlation between patients presenting with stroke / TIA symptoms and UTI's / dehydration in older adults.	*When auditing clinical records, it has been observed that many elderly patients have a HPC of UTI's+/- dehydration along with their stroke/TIA symptoms* *Would the outcome of this work add to body of knowledge and inform risk in primary care / patient. Perhaps work around potential pathway/ educational?*
Do long lie faller patients have poorer overall outcomes?	*Older adults who have fallen are a group of patients who are often vulnerable by nature of their acuity / response they can receive and their socio-economic situation.*
Undertake POPS audits within each Health Board are as the roll out continues and it becomes embedded.	*Further discussion is required to establish new criteria for POPS audit based on ePCR data.*
Major Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Silver Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Open Fracture (Co-amoxiclav)	*High level topic suggestions for CIs at early CIAG meetings.*
Delayed Handover.	*High level topic suggestions for CIs at early CIAG meetings*
Solo Responding	*High level topic suggestions for CIs at early CIAG meetings.*

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Alternative Conveyance	*High level topic suggestions for CIs at early CIAG meetings.*
Resuscitation	*High level topic suggestions for CIs at early CIAG meetings.*
Maternity	*Welsh Government has specified that the aim of the MatNeoSSP Wales programme is to ensure we have clear and consistent improved approaches to maternity and neonatal safety within all services in Wales.*
Administration of Methoxyflurane (Penthrox)	*Evaluation to be included as part of the implementation plan. Proposed use from 1/4/2023.*
Recording of Failed Pathways on ePCR	*Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit / evaluation of data would help identify areas for improvement for patient care and avoid unnecessary admission to EDs.*
Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented	

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AGENDA ITEM No	15
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

UPDATE ON MORTALITY REVIEWS

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 May 2023
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Regional Clinical Lead-Consultant Paramedic
CONTACT	Mike Jenkins 0773 8029348 Mike.jenkins@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an update to The Quality, Patient Experience & Safety Committee (QuESt) on Mortality Reviews position and the recent changes:

In summary the Report identifies:

- In 2015, The Welsh Ambulance Services NHS Trust (WAST) introduced a Mortality Review process.
- The method of undertaking the mortality review required the need to download Corpuls Records which significantly impacted on the ability to undertake a complete and timely review.
- This resulted in a backlog of incidences requiring a review (740 cases).
- In 2022, there was a directive from Welsh Government and a document from the Delivery Unit introducing “All Wales Mortality Guidance”.
- A paper setting out our position was taken to Clinical Quality Governance Group (CQGG) with a pragmatic proposal to complete an audit of 10% of the 740 to identify any themes and trends and learning which was approved with a recommendation to return to a future CGQQ with the findings.

RECOMMENDED that the Committee receives this report for discussion and assurance.

KEY ISSUES/IMPLICATIONS
(i) The review identified that 7% of the incidents required would be subject to a Stage 2 review. (ii) There have been significant changes in the clinical structure that will support future clinical practice which include: • The introduction of CHARU • The expansion of the Senior Paramedics role (iii) Key themes, trends and learning has been identified. (iv) There will be a new approach to how mortality reviews will be completed in the future which will align with the new All Wales approach.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 March 2023

REPORT APPENDICES
Annex 1: SBAR Annex 2: Mortality Review Framework (Learning from Deaths)

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
Equality Impact Assessment	NA		
Environmental/Sustainability	NA		
Estate	NA		
Health Improvement	NA		
Health and Safety	NA		
Financial Implications	NA		
Legal Implications	NA		
Patient Safety/Safeguarding	NA		
Risks	NA		
Reputational	NA		
Staff Side Consultation	NA		

ANNEX 1

SITUATION

1. Following the Francis Report in 2013, which reported on the failings in the Mid-Staffordshire Foundation NHS Trust, the Minister for Health and Social Security published an independent report in relation to hospital risk adjusted mortality and other quality indicators in NHS Wales. This highlighted the necessity for clinical ownership of data, to be a fundamental requirement of evidence-based practice.

2. Consequently, Welsh Government requires all Health Boards and Trusts, including the Welsh Ambulance Services NHS Trust (WAST), to undertake Mortality Reviews. In 2015 WAST Executive Medical Director supported the development of a Trust Mortality Review Group. The purpose of this group is to provide assurance that the care provided to patients who suffer a cardiac arrest between point of contact (999 call) and arrival at hospital, is in line with resuscitation guidelines.

3. In support of this the Welsh Ambulance Services NHS Trust (WAST) developed an electronic system, whereby all Clinical Contact Centre (CCC) and Patient Clinical Records (PCR) were uploaded for those patients who had suffered a cardiac arrest while in the care of the Trust. This enabled nominated clinicians to review and comment on the quality of care provided. Data generated from these reviews were reported quarterly to the Quality Patient Experience and Safety Committee (QUEST).

4. This method of undertaking mortality reviews identified the necessity to download Corpuls Records, this significantly increased the time taken to complete a review resulting in an increasing backlog of records awaiting a review. By January 2022 there were 740 mortality reviews waiting for review.

5. In April 2022 a paper was submitted to the Clinical & Quality Governance Group describing the recently introduced all Wales 'Mortality Review' Guidance document that was released by the Delivery Unit. This paper also identified the increasing challenge of ensuring the pre-existing method of undertaking mortality reviews due to the reasons identified above.

6. It was further recognised that with the number of reviews within the Mortality Review backlog, it would not be achievable to undertake all these reviews in a timely manner offering reassurance around the care provided to patients who had suffered a cardiac arrest while in the Trust care. In stating this it was agreed that a 10% sample would be reviewed.

BACKGROUND

7. Due to several factors, there was a delay in undertaking the agreed 10% review of the Mortality Review backlog.

8. In February 2023 a number of Health Board Clinical Leads, along with the Regional Clinical Leads-Consultant Paramedics met to undertake a 10% review of the Mortality Reviews. To ensure a consistent approach an excel spreadsheet was generated to identify:

   - Mortality Review number;
   - Incident date;
   - Incident number;
   - PCR number;
   - Any concerns identified;
   - Stage 2 review?
   - Themes;
   - Action plan submitted?

9. The date range of incidents reviewed were from May 2020 through to February 2022 (introduction of the electronic Patient Clinical Record).

10. All incidents related to patients who had suffered a cardiac arrest in WAST care. Of the 74 cases reviewed, one was conveyed to hospital with a return of spontaneous circulation (ROSC).

11. From the incidents reviewed, 13 were identified as requiring learning and feedback to staff, five of which met the criteria for a Stage 2 review.

12. One incident was recognised by a Regional Clinical Lead as being presented to the Serious Case Incident Forum (SCIF) as a National Reportable Incident (NRI), providing assurance that cases are being identified, reported and escalated appropriately.

13. Themes identified that would be suitable for Senior Paramedic feedback included:

   - Poor documentation.
   - Inappropriate CPR due to the presence of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), frailty with multiple comorbidities.
   - End of life care documentation.
   - Post-ROSC care.

14. Themes from those incidents that met the criteria for a Stage 2 review included:

    - Poor quality advanced life support.
    - Airway management without the use of waveform capnography (n=5. three for patients with an endotracheal tube, two for patients with an i-gel).
    - The NRI related to poor advanced life support that based on available evidence may have had an impact on patient outcome.
    - Each of these incidents involved multiple themes.

15. The numbers presented identified that from the 74-incident reviewed 17.5% required staff feedback. 7% met the criteria for a Stage 2 review.

16. The database used for accessing the necessary records to undertake these reviews was closed with the introduction of the ePCR.

17. Weaknesses were identified with the access to Corpuls records. This specifically relates to those incidents that met the criteria for a Stage 2 review. Corpuls records would have been able to confirm definitively if waveform capnography was used. It would also offer further evidence around the quality of resuscitation undertaken. Corpuls records over six months old are archived, to retrieve these, a request would have been required. This would have placed a significant and unachievable delay into the process of undertaking this review.

ASSESSMENT

18. The review undertaken suggested that 7% of incidents would be subject to a Stage 2 review. Of all patients who suffer a cardiac arrest in the Trust care, currently only those incidents that are subject to the concerns process receive a clinical review to consider the quality of care provided. In stating this, since 2021 the Trust has made some significant changes to clinical supervision/leadership offered to its clinical workforce.

19. In the second quarter of 2021 Senior Paramedics (SP) were introduced with the aim of promoting clinical excellence. The SP has three elements to their role:

    - 50% as part of an Emergency Ambulance Crew; during this shift they will complete an electronic feedback sheet that comment on quality of care, documentation, current guidelines, recent clinical bulletins, airway logs. This is not an exhaustive list. Furthermore, areas of good practice and any potential learning will be highlighted. Staff are offered the ability to provide feedback on their experience electronically.

- 25% undertaking Cymru High Acuity Response (CHARU), providing leadership at serious incidents such as cardiac arrest, major trauma, and obstetric emergencies.
- 25% governance day, preparing for ride out shifts, providing CPD, undertaking clinical reviews.

20. During 2022 the Trust started the process of introducing CHARU paramedics, with the objective of providing support to other clinicians on scene at serious incidents as described above. This continues with recent agreement to significantly increase the number of CHARU paramedics.

21. There is limited data yet to demonstrate the benefits of this leadership function at serious incidents. However, it is known that ROSC rates in Wales have historically been lower than the rest of the UK. In stating this, when considering data in relation to patient outcomes from cardiac arrest when a SP attends, this demonstrates ROSC rates comparable to the highest performing UK services (SP dashboard). Once data is available in relation Paramedics responding as part of CHARU, it is considered reasonable to expect similar outcomes.

22. One of the common themes identified from the review of Mortality Reviews, related to the quality of documentation. The Trust holds its Serious Case Incident Forum (SCIF) twice weekly to consider cases that could potentially be reported to the NHS Wales Executive Delivery Unit as an NRI. Since the introduction of the SP role there has been a noticeable improvement in the quality of documentation clearly evidencing the care provided. These improvements have been commented upon during the SCIF meetings.

23. In February 2022 the Trust released its airway policy, this identifies the requirements for staff to manage a patient's airway utilising a step wise approach, including the necessity to utilise waveform capnography when an i-gel or endotracheal tube is utilised to confirm correct placement and effective ventilation. To support evidencing competency, staff are required to complete an electronic airway log, data relating to compliance to this is collated monthly for each health board area.

24. From the middle of March 2023 Regional Clinical leads, Health Board Clinical leads and SP's will receive automated reports on all patients who require an i-gel or advanced airway, all of which require waveform capnography. These weekly reports will enable local clinical teams to provide feedback to staff and identify potential learning opportunities within a few days of the incident. These reports will also provide assurance around the use of advanced airways by Trust clinicians.

25. As identified above, a significant challenge in undertaking the Mortality Review was the ability to download the Corpuls record in a timely fashion. The Trust has been working with Ortus, (Corpuls Manufacturers) and Terrafix (ePCR developers) to enable records from this monitor being entered directly into the ePCR. This will negate the necessity to undertake a separate timely search for records. It is anticipated that modification to Corpuls monitors will commence throughout 2023.

26. It is accepted that since the move from the previous method of undertaking Mortality Reviews, to the method described by the NHS Wales Executive Delivery Unit, the Trust has not provided consistent evidence around the quality of care provided at the most serious incidents. In stating this the Trust has made significant changes to its clinical leadership structure in the last two years, ensuring clinicians receive meaningful feedback in practice. In addition to this training mannequins have been placed on all premises where WAST staff are based to support them being able to maintain and demonstrate competence in airway management. This is further supported by policy requirements.

27. Information being received via differing routes suggest improvements in the care provided to the Trust most serious patients. This includes:

    - ROSC rates when attended by SPs, since CHARU paramedics receive the same education as SPs in relation to clinical practice, it will be reasonable to expect similar outcome;
    - Improved documentation as identified through SCIF meetings;
    - Recording of airway logs;
    - New reporting mechanisms to evidence effective airway management and the use of waveform capnography;
    - Positive feedback from staff during SP ride outs as evidenced within the SP dashboard;
    - Linking Corpuls records with ePCR.

28. It is proposed that the work undertaken over the last two years continues, with data collated from cardiac arrests from SP attendance and moving forward CHARU, airway compliance in relation to waveform capnography pulled together into a single report.

29. Additionally, once the work is completed between Ortus and Terrafix, a new dashboard will be developed where the care provided by Trust clinician can be reviewed for a percentage of all patient interactions. This will offer meaningful assurance in relation to the care provided by the Trust. Consideration should then be given to inclusion of this data into a wider Mortality Review process strengthening the one currently in place with the NHS Wales Executive Delivery Unit.

RECOMMENDED that the Committee receives this report for discussion and assurance.

Learning from Mortality Reviews Framework

Date of Approval:	30.09.2022	**Version No:**	1.0	**Supersedes:**	N/A
Review Date:	By October 2023	**Type of Document**	Framework	**Approved by:**	Clinical Quality Governance Group
Brief Summary of Document:	This Framework is adapted from the 'All Wales Learning from Mortality Review Model Framework (2022)', version 3, published by the NHS Wales Delivery Unit and describes the processes in place for mortality reviews within the Trust and as part of a wider system across the patient / service user pathway. The framework includes the role of the Medical Examiner Service and the Trust's role and responsibilities in respect of working collaboratively with Medical Examiners.				
Executive Director:	Executive Director of Quality and Nursing				

Version Control Sheet

Version	Date	Author	Summary of Changes
1	30.09.2022	Assistant Director Quality & Safety (interim)	N/A
Keywords	Mortality Learning Deaths Medical Examiner		

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1. BACKGROUND AND PURPOSE

Recommendations of numerous inquiries from Shipman Inquiry third report (2003), report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Vol 2 (2013), Morecambe Bay Investigation (2015) to more recently learning from Gosport (2018) have called for strengthening of safeguards for the public by providing additional independent scrutiny of the medical circumstances and cause of deaths.

The introduction of the medical examiner system is designed to:

- provide bereaved families with greater transparency and opportunities to raise concerns
- improve the quality/accuracy of medical certification of cause of death
- ensure referrals to coroners are appropriate
- support local learning/improvement by identifying matters in need of clinical governance and related processes
- provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths, and support healthcare providers to improve care through better learning and
- align with related systems such as the Learning from Deaths Framework and Universal Mortality Reviews.

The advent of medical examiners offers an opportunity for NHS Wales to look at how mortality reviews can be conducted to maximise learning, prevent future harm and improve the experience of patients, families and NHS staff. Many concerns leading to the need for a mortality review are likely to involve multiple professions and services.

The NHS Wales 'All Wales Learning from Mortality Review Model Framework' (2022) seeks to build on the Palmer Report (2014) and ministerial statements that highlighted the good practice in Wales on mortality reviews in hospitals. It also seeks to build on the work of the All-Wales Mortality Review Steering Group in improving consistency of good practice across Wales and the All Wales vision for mortality reviews is detailed in Annex 1.

NHS services include emergency, primary care, community, mental health, learning disabilities, acute, tertiary services, as well as social services and the independent sector (Herein referred to as organisations).

The implementation of medical examiners began in England and Wales in 2019 with the appointment of the National Medical Examiner and recruitment of national and regional teams. The Medical Examiner Service provides an independent process for raising concerns about the care delivered in a patient's / service user's final illness.

Medical examiners are independent to organisations, Health Boards and Trusts and will review all deaths other than those that are covered by HM Coroners. In Wales, the service is being implemented by NHS Wales Shared Services Partnership (NWSSP), an independent mutual organisation, owned and directed by NHS Wales. Four hub sites covering all health board areas were established (Annex 2).

Medical examiners will refer any concerns identified at their initial review, including cases involving GMS practices to the relevant Health Board, Trust or GP Practice. This will provide an objectivity to the reviews undertaken.

In a typical year in England and Wales, there are approximately 550,000 deaths. A reasonable assumption is that in due course medical examiners may scrutinise up to 490,000 non-coronial deaths each year.

This Framework forms part of the wider 'NHS Wales All Wales Learning from Mortality Review Model Framework (2022)' ensuring that the Trust undertakes mortality reviews locally or contributes to mortality reviews as part of wider system reviews as appropriate. This will ensure:

1	A mortality review process is in place that covers every sector of the patient care pathway, so that concerns raised in relation to one sector will be addressed even when the death occurs in another sector and where more than one organisation is involved.
2	There is a clear structure, governance process, and consistency across Wales for undertaking mortality reviews providing a whole system approach to learning from mortality reviews.
3	An integrated approach to the management of risk is implemented, which uses the analysis of linked data to target key areas of concern.
4	All areas of healthcare will be included in the review processes conducted by organisations so that the review follows the patient pathway throughout the episodes of care.
5	Our local arrangements are in place in WAST to meet the principles of the 'NHS Wales All Wales Learning from Mortality Review Model Framework' (2022) and to ensure we have a shared view of risks to quality and a shared approach to measurement, learning and improvement. This includes supporting alignment and resolving system barriers to improvement.

2. PUTTING THINGS RIGHT (PTR) REGULATIONS (2011)

This Framework aligns to the principles of Putting Things Right (PTR), which is an integrated process for the raising, investigation of and learning from concerns which include patient safety incidents, claims and complaints. This means that when medical examiner referrals are received by the Trust, they will be screened via the PTR process to determine the most appropriate method for managing the referral. The Trust will decide when external stakeholders are informed via our existing processes.
The medical examiner is a third party who is raising a concern on behalf of the person who has died, or on behalf of another person (such as family member or clinician) who is concerned about the care delivered.

The relevant text is reproduced below from Guidance on dealing with concerns about the NHS from 1 April 2011 (Version 3 - November 2013):

Who can raise a concern?

> *"5.5. Almost anyone can raise a concern and the Responsible Body will be under a duty to consider whether it can be investigated ……*
>
> *5.6. As set out in Regulation 12, concerns can be raised by:*
>
> - *a third party acting on behalf of a person who is unable to raise a concern … or because that person wants someone else to represent them;*
> - *a third party on behalf of a person who has died."*

http://www.wales.nhs.uk/governance-emanual/putting-things-right

http://www.wales.nhs.uk/governance-emanual/gweithio-i-wella

3. QUALITY GOVERNANCE

Quality Governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance (Monitor, 2012) including:

- Ensuring required standards are achieved
- Investigating and taking action on substandard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best-practice and
- Identifying and managing risks to quality of care.

An integrated approach means that lessons learnt in one area can be quickly spread to another area, so that the scale and nature of risk to patients can be properly assessed and acted upon in all areas e.g. clinical audit, complaints, litigation and claims, proactive risk assessments, performance and outcome data etc. This in turn can enable organisations to prioritise areas of risk for targeted intervention and escalate through the organisations quality and assurance structures, to prevent the recurrence of events.

Aligning mortality reviews to the Putting Things Right process reinforces this integrated approach and the triangulation of data and information (collective intelligence). This in turn will lead to better informed organisations. Oversight of the mortality review process occurs at the Executive Clinical Quality Governance Group.

4. COMMISSIONED SERVICES

The Trust is a commissioned organisation with oversight from the Emergency Ambulance Services Committee (EASC). The Trust also commissions services e.g., independent providers of ambulance services and as such the Trust is responsible for ensuring the quality of these services.

Where this happens, the following principles will apply to ensure equity: -

- The organisation where the patient safety incident occurred is responsible for reporting and investigating in line with its relevant national framework.
- When notified of an incident the commissioned service must notify the commissioning Health Board / Trust and should liaise with the investigating organisation as appropriate as part of the investigation.
- Assurance should be sought that the patient and / or their family form part of the investigation process.
- Assurance must be obtained to confirm that any immediate make safes have been put in place which protects the ongoing safety of patients.
- Any incident learning should be shared with the service commissioner, as part of its internal assurance processes that commissioned services outside of its boundaries are safe and of high quality.

5. INTER-ORGANISATION COMMUNICATION ARRANGEMENTS FOR REVIEW OF REFERRED MEDICAL EXMINER CASES

5.1 MORTALITY REVIEWS LED BY EXTERNAL SYSTEM PARTNERS

The Trust's internal mortality review process has been in place for a number of years. Patient deaths including community deaths are identifed through various sources Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning.

The medical examiner process will provide additional rigour to the identfification of community deaths when all deaths outside of the coronial process are included. The Trust already works collaboratively with system partners across Wales to review care across patients pathways of care, adopting a multidisciplinary approach. This involves members of the patient safety team, clinical leads and local managers being involved in Health Board led reviews as appropriate. The Trust is committed to the process, however attendance is balanced against operational needs.

Wales to review care across patients pathways of care, adopting a multi-disciplinary approach. This involves members of the patient safety team, clinical leads and local

managers being involved in Health Board led reviews as appropriate. The Trust is committed to the process, however attendance is balanced against operational needs. It is recognised that the Trust's involvement in mortality reviews will frequently be part of wider system reviews led by Health Board partners and the Trust will provide the relevent data and information to system partners to inform the mortality review from from the ambulance services perspective.

5.2 MORTALITY REVIEWS LED BY THE TRUST

Where a review is led by the Trust system partners will be invited to participate in the multi disciplinary review discussions. These would include clinicians or other representatives from learning disabilities, acute, maternity, mental health, primary and community care, and other emergency services. This provides a broader range of experience to inform decsions and solutions, and increased robustness of challenges.

5.3 ADDITIONAL REPORTING REQUIREMENTS

Some deaths fall within national mortality review or investigation programmes or meet other mandatory review or investigation criteria including maternal deaths, neonatal deaths, child deaths, deaths of patients with severe mental illnesses, deaths of patients with learning disabilty. External reporting arrangements will be led by the Patient Safety Team / Safeguarding Team as appropriate. If any Safeguarding concerns have been identified then the Trust's Safeguarding processes must be followed. The Trust has a Safeguarding Policy which can be accessed on Siren for further information and the Safeguarding Team is in place for guidance and support.

6 RESPONSIBILITIES

6.1 ROLE OF MEDICAL EXAMINERS

Medical examiners are independent to Trusts and Health Boards and are responsible for completing the *Medical Examiner's Advice and Scrutiny Form* (Annex 3 – Medical Examiner's Advice and Scrutiny Form ME-1 (Part B) MESW v1.1). The aim is to complete these within 3 days of receipt of a death certificate. All deaths in hospital or the community will be passed on to the organisation by medical examiners where concerns or good practice are identified, unless they are already referred to HM Coroner.

There is a requirement for the medical examiner to obtain information about the outcome of any reporting of concerns to organisations:

The death certification (medical examiners) (England) regulations (publishing.service.gov.uk)

When the medical examiner refers a case to a GMS practice, the medical examiner will simultaneously inform the relevant Health Board.

6.2 ROLE OF THE EXECUTIVE DIRECTOR FOR MORTALITY

It is the responsibility of the Executive Director of Quality and Nursing or equivalent to ensure the following:

- when a *Medical Examiner's Advice and Scrutiny Form* (Annex 3) is received by an organisation, systems are in place to acknowledge receipt and monitor the case through to final closure and feedback to the medical examiner.
- the *Medical Examiner's Advice and Scrutiny Forms* are appropriately managed in line with the principles of *Putting Things Right* and the All Wales Model Framework.
- organisational structures and processes are established and are effective, where roles and responsibilities have been clearly defined, to achieve the key outcomes of a mortality review, which results in implemented improvements.
- organisational structures and processes are effective in supporting local and national learning and
- systems are in place to identify named individuals who will be trained in the mortality review and investigation process.

6.3 MULTI-DISCIPLINARY APPROACH – PANELS

It is recognised that frequently Trust representatives will participant in Health Board led mortality reviews and be part of the multi-disciplinary screening panel as appropriate (balanced against service needs) or provide data and information to inform the system partner mortality reviews.

Internally the Trust has a mortality review group (Learning from Deaths Forum) which is a multi-disciplinary panel and aligned to the Serious Case Incident Forum (SCIF). Attendance will vary from case to case and as considered appropriate (Annex 5, terms of reference) and membership may include:

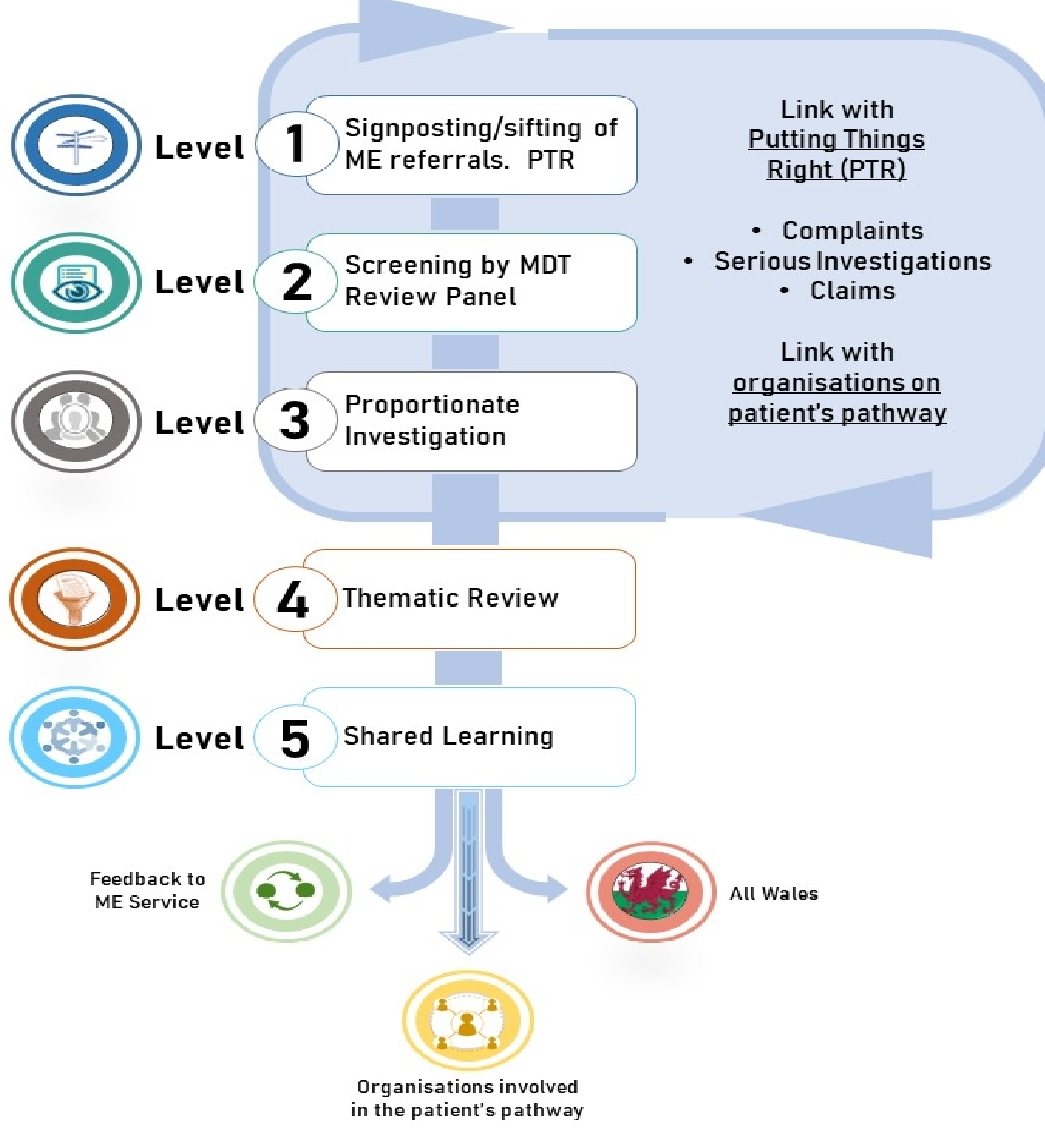
- Patient Safety Team representatives
- Assistant Medical Director
- Assistant Director – Quality & Nursing
- Safeguarding representatives
- Health Board Clinical Lead representatives
- Local Operational Managers
- Consultant Paramedic representatives
- Emergency Operations Control representatives
- Patient experience representatives
- Legal services representatives
- Patient experience representatives
- Representatives from system partners as appropriate
- Administrator (to access records, arrange meetings and document decisions)

All panel members will be trained in the use of the mortality standard processes and methods of investigation as this is rolled out (a mortality review toolkit is in development by the NHS Wales Delivery Unit). A multidisciplinary approach improves robustness, transparency and outcome.

6.4 MORTALITY REVIEW FUNCTIONS TO BE UNDERTAKEN BY THE TRUST

The Trust has adopted the 5 levels of review detailed in Fig. 1 below and will implement this through participation in mortality reviews led by Health Boards or other system partners or through internally led mortality reviews (Annex 4 process map). The standard process for screening and reviewing referrals will contain questions which will identify whether significant risks exist in the services involved in the final illness of the deceased.

Fig.1



6.5 FOLLOWING THE 5 LEVELS OF MANAGING A MORTALITY REVIEW

Level 1: Signposting of medical examiner concerns

The aim of Level 1 is to ensure that only referrals requiring further scrutiny by a mortality review process, progresses down that route (via level 2), and all other concerns are signposted to existing alternative processes.

Level 1: Process

All referrals raised by the medical examiner will be sent to the dedicated email address:

amb_MEincident@wales.nhs.uk

It will be monitored by an appointed officer identified by the Executive Director lead for mortality:

- The referrals received from the medical will be registered on an All Wales Learning from Mortality Reviews Module (Datix Cymru) which will provide an audit, assurance and learning trail as it is managed through the organisation and will be monitored consistently.
- An automated acknowledgement of receipt will be sent to the medical examiner.
- Each new referral from the medical examiner be initially reviewed and screened by a nominated member of the Quality, Patient Quality, Safety & Patient Experience (QSPE) Team in line with PTR to determine immediate next steps and timeliness.
- A number of requests from the medical examiner relate to data and information requests to form part of the medical examiner's review.
- The medical examiners can access the Trust's electronic patient care record (ePCR) in the majority of cases via the Welsh Clinical Portal. If the ePCR is not available via this route a copy will be provided directly on request via the inbox above.

Other system partner requests:

- Information requests from system partners to inform mortality reviews are also received by the amb_MEincident@wales.nhs.uk mailbox and addressed accordingly.

Next steps: WAST internal mortality review level 2:

A mortality review lead will be allocated with responsibility for managing the case up to and at Level 2. The mortality review lead individual will:

- Have access to any complaints, concerns or incidents relating to the patient's case (as recorded on Datix/OfW)
- Consider which services have been involved in the care of the patient prior to death and ensure that they are included in panel meetings e.g. primary care, emergency services, community, mental health, learning disabilities etc)
- Consider which records need to be accessed
- Decide if sufficient information is available and what further input will be required.
- Recommend to the level 2 panel if the referral should be managed by:
  - Either using the PTR route as a claim, complaint, serious incident, or
  - Via the mortality review route to Level 2/3.

Level 2: Screening multidisciplinary review

Level 2: Process

WAST participation in system partner mortality reviews

The Framework is clear that a multidisciplinary (MDT) approach should be adopted when reviewing medical examiner cases and members of other organisations should be invited to participate in the MDT review discussions. As such it has been agreed nationally that there will be WAST local representation balanced against operational need (Clinical Leads / Managers / Patient Safety Team representatives) at the respective Health Board mortality review meetings to ensure a system focused review.

It is recognised that a significant number of reviews will be undertaken via this approach with the Trust providing relevant data and information to inform Health Board led reviews.

WAST internal mortality reviews

The Learning from Deaths Forum (Annex 6) following the Serious Case Incident Forum should meet on at least a weekly basis as required and consist of a cross section of clinical and non-clinical professions, including representation from Quality / Safety / Risk Management / Safeguarding.

The Forum should consider the presentation and discuss any concerns arising, including identifying missing data that may be needed to make a decision, and whether issues have a low, moderate or significant impact. The Forum should also consider whether support from specialists or experts NOT involved in the case is required including system partners.

The Forum should, for each case, decide one of the following actions:

a) There is already an existing process underway which will effectively address the issues raised in the medical examiner's referral
b) The case can be closed to further investigation at Level 2 under the mortality review process
c) The case requires a more in-depth investigation under Level 3: Proportionate investigation.

Where a case requires a more in depth investigation under Level 3, the Forum should recommend:

- Which process (e.g., PTR, Mortality Screening Tool) should be used for the investigation?
- Who will commission the investigation?
- Draft terms of reference

The Forum will then inform relevant service managers & quality and safety meetings of its findings and any improvement plan where appropriate. The implementation of the improvement plan where relevant will be assigned to a lead manager for progression and will be monitored by the Patient Safety and Experience Learning and Monitoring Group.

All decisions and actions should be recorded in the All Wales Learning from Mortality Reviews System (Datix Cymru).

Level 3: Investigation

The Trust will engage in Level 3 mortality reviews adopting the same principles as Level 2 frequently participating in system partner led reviews or adopting the Level 3 approach internally seeking system partner involvement as appropriate.

Where a case has not been resolved in the first two levels a proportionate investigation should be arranged. The scale and scope of the investigation should be proportionate to the case to ensure resources are effectively used. Cases which indicate the most significant need for learning to prevent serious harm should be prioritised. The aim is to prevent the incident recurring.

An investigation may include the use of the All Wales Mortality Review Tool, a formal investigation methodology as included in Datix Cymru module or even an external review. **Wherever possible, the organisations existing investigation and reporting processes should be used if they meet the requirements of the case, rather than set up a new service.**

As a general measure an organisation will proceed to Level 3 and base this decision on:

- whether key issues and corrective actions have been identified, which could ultimately prevent or reduce the likelihood of the case recurring.
- how **assurance** can be provided that risks have been reduced so far as is reasonably practicable, to ensure that appropriate control measures have been identified.

In line with the principles and arrangements for Putting Things Right (PTR) a standardised process in the investigation of concerns in order to "*investigate once, investigate well*" is emphasised. This will ensure that the investigation is thorough, systematic and avoids shortcuts which impact negatively on the final outcome of the quality and findings of the investigation. This will be in line with the Once for Wales Concerns Management System approach.

Level 3 Process

Level 3: Process

The Trust will engage in Level 3 mortality reviews adopting the same principles as Level 2, frequently participating in system partner led reviews (as operational needs allow) and providing data and information to inform the mortality reviews or adopting the Level 3 approach internally seeking system partner involvement as appropriate.

The Level 3 process includes:

- identifying a commissioning manager
- identifying a lead investigator
- agreeing Terms of Reference
    - investigation team membership
    - chair of team
    - scope of investigation
    - standard methodology to be used e.g., Root Cause Analysis (Fact-finding, analysis, conclusions, Improvement Plan)
    - expected duration of investigation.
- **Investigation process**
    - Clinical specialists, not involved in patient care under investigation, may be required to provide internal clinical opinion (independent of the service).
    - The investigation Report is shared with the commissioning manager, and copied to the Level 2 screening panel
    - The relevant quality & safety meeting and executive leads will monitor progress against implementation of any resulting improvement plans with oversight from the Executive Clinical Quality Governance Group.

Level 4: Local thematic reviews

A regular summary report of the themes of concerns raised by medical examiners, organisations and the associated outcomes will be provided to the Clinical Quality Governance Group with onward reporting to the Trust Board sub-committee for quality matters on at least a six monthly basis. This report provides an opportunity to reflect on common issues that have arisen both within a specific service or site, and across multiple services or sites and wider system learning and improvement.

This report may lead to further thematic review of cases sharing common factors e.g., call handling categorisation, allocation, and community risk due to system pressures.

Thematic reports can be commissioned by the chair of the Level 2 Mortality Review Panel and/or an Executive Director.

A thematic review tool will be made available to support organisations in undertaking reviews by the NHS Wales Delivery Unit that have led to the death of a patient. It can, however, be applied to all patient safety incidents.

Level 4 Process

Thematic reports can be commissioned by the chair of the Level 2 mortality review panel, or executives.

A regular summary report every 6-12 months of the themes of concerns raised by medical examiners and organisations and the associated outcomes.

Local thematic reviews may consist of:

- Descriptive statistics of themes
- Interpretative statistics of patterns and clusters in the data
- Triangulation / collective intelligence with other reports including:
  - Ombudsman
  - Patient experience
  - Serious incidents
  - Claims
  - Complaints
  - Risk Registers
  - Clinical audit data e.g., return of spontaneous circulation (ROSC), ROLE data, NEWS etc.
  - Clinical indicators including STEMI, Stroke and ROSC
  - Outcomes of clinical reviews
  - Thematic reviews provided by the Medical Examiners Service
  - Performance data and information; and
  - UK Ambulance organisations.
- Lessons learned from screening tools and proportionate investigations.

Level 5: Sharing learning and implementation of improvement actions

Local analysis of reviews should be triangulated with information produced from other sources, e.g., Coroners, incidents, clinical audit programmes which will lead to co-ordinated local improvement plans to ensure lessons are applied throughout the organisation as long term and sustainable solutions. Solutions should be identified that address the themes or root causes of what has gone wrong to reduce the likelihood of recurrence.

Learning is often considered as a one off event where the problem is focused upon for a short time but moves on to new priorities as they emerge, so that sustained learning is lost. The impact of improvement plans should be measured over time as part of a core quality governance activity review programme. This maintains a record of changed recommended and action taken to implement those changes.

Change requires the use of a number of communication channels to spread the message, build awareness of the new process and provide support to staff through re-training, empowerment and involvement in the process. Locally this means use of robust infrastructures that can be relied upon to disseminate key information, and this will be undertaken through the Trust's Patient Safety and Experience Learning and Monitoring Group with oversight from the Executive Clinical Quality Governance Group.

Nationally, sharing learning should involve the use of existing networks and creation of new if not already in place. Networks need to be inter-linked so that all Wales learning can be shared, and progress monitored. Existing all Wales networks should have standing agenda items for learning from reviews (Annex 6):

- Executive Medical Directors
- Executive Nursing Directors
- Executive Therapies Directors
- Assistant Medical Directors in Primary Care
- Mortality Review Steering Group has a wide membership, who are tasked with taking key messages back to their respective organisations or professional groups
- Welsh Risk Pool Once for Wales Concerns Management System (Datix Cymru)
- Medical Examiner
- Heads of Patient Experience Network
- All Wales Listening and Learning Group
- HM Coroners and
- Learning and guidance from the Association of Ambulance Chief Executives (AACE).

7. CLOSING THE LOOP – GOVERNANCE & MONITORING ARRANGEMENTS

7.1 ASSURANCE

It is essential that the Trust Board has robust systems are in place for the reporting and management of mortality review cases in line with the Welsh Government Quality and Safety Assurance Framework (2021).

This will ensure that when cases are closed by the relevant panel or committee, lessons have been shared and improvement plans implemented across the various healthcare organisations involved.

The compliance and hence impact of these plans should be measured over time as part of an ongoing core clinical governance/audit activity review programme. This can be effectively managed via a rolling programme of testing compliance.

The Trust should be able to demonstrate that:

- The Board and executive are aware of deaths and any learning and actions that have resulted
- The risk of recurrence has been appropriately managed as far as is reasonably practicable
- Feedback on actions and learning has been shared with:
    - the family / carer
    - staff and teams
    - the medical examiner.

Oversight of the mortality review process is undertaken by the Executive Clinical Quality Governance Group on at least a six monthly basis with onward reporting the Board sub-committee with delegated responsibility for quality.

8. HORIZON SCANNING

Continued horizon scanning is key to ensuring the Trust is capturing all learning and improvement opportunities through scrutiny of external reports (including the medical examiner annual reports), inspections and inquiries in NHS Wales and wider.

ANNEX 1: THE ALL WALES VISION FOR MORTALITY REVIEWS

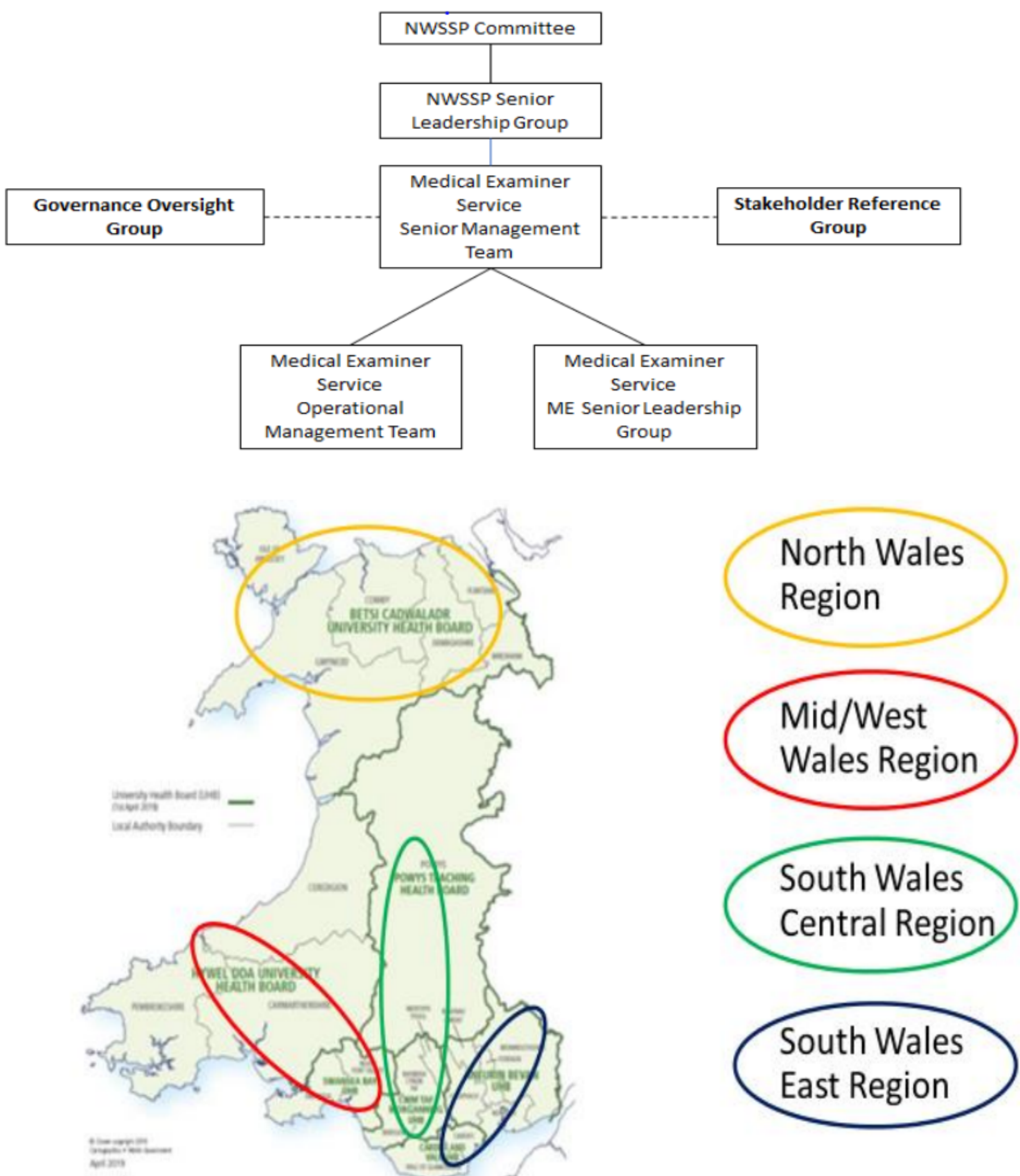
All Wales approach	Wales is in a unique position to utilise its Health Boards and Trusts, as well as its clinical and managerial networks to maximise sharing of lessons and good practices to improve patient safety. The potential is to help speed up learning and implement change in all healthcare delivery.
Whole system approach	Because of Wales's Health Board structure, covering primary, secondary and tertiary care, it should be possible to look at experience of the patient across the whole pathway of their final illness in one integrated review.
Prudent Based Care Philosophy	It is essential that the processes used are efficient and effective, where every step adds value, with participants only doing what only they can do.
Identifying avoidable root causes	By promoting and standardising high quality reviews and investigations, it will improve the identification of root causes. The reviews and investigations will need to consider the different cultures of care across primary, secondary and tertiary care in order to capture avoidable root causes.
Local learning and implementation from reviews	Learning from reviews means that deficiencies in the service, once identified, can therefore be addressed. Involvement of clinicians and managers from primary, secondary and tertiary care, drawing on their collective experience and expert knowledge, is a vital part of the learning and improvement process. Organisational structures are vital in ensuring that lessons are implemented as sustainable long term solutions and compliance monitored, and audited thereafter. Organisations need to ensure that their quality and safety processes are linked closely with continuing education for all staff, employed directly and by independent contractors in primary care.
Sharing learning nationally	Sharing learning through robust communication structures will enable the implementation of improvements. Sharing improvements nationally will help all healthcare organisations benchmark themselves.
Peer reviews	A programme of peer review will be undertaken in line with the All Wales Framework. This will support the mortality review work and confirm whether organisations are heading in the right direction at the right pace compared to peers. Sharing good practice in conducting reviews will also promote confidence that key issues will be identified, and that learning is implemented. nhs-wales-peer-review-framework.pdf (gov.wales)

ANNEX 1 - THE ALL WALES VISION FOR MORTALITY REVIEWS (CONTINUED)

Thematic reviews	Sharing thematic reviews will support the process of identifying key risks for targeted action at local and national level. The clinical and managerial networks that exist in Wales will act as key links between HBs, Trusts and independent contractors in Primary Care. Through the OfWCMS a list of codes has been created for use in all functions of the system. These will support the theming of the primary issues raised by the ME.
Implementing change to prevent harm	Despite important breakthroughs in the design and performance of safer systems, many are short lived and not shared across organisations or nationally. Methods for translating lessons from incidents into practical long term solutions for change need to be embedded into the culture and routine practices of organisations.
Improving experience and outcomes for patients and families	Being open about what has happened and discussing the problem promptly, fully and compassionately can help relatives/carers cope better with the after-effects when things have gone wrong. This approach can also avoid events becoming formal complaints and litigation claims. The perspective of the carer/relative also offers an invaluable insight on events that has led to adverse outcomes. Evidence shows that the majority of families/carers want an apology and an explanation of what went wrong.
Duty of Candour	The principles of the duty of candour will apply in all cases. In essence this means that if an investigation determines that serious harm was caused by an action then the organisation must share this information with the family/carers. This duty of candour applies whatever the sector of the health service.
Improving experience for staff	A motivated workforce, empowered to instigate and to be a part of change is central to an organisation's ability to learn, develop and improve. This provides a solid foundation for implementing change as long term and sustainable improvement. Evidence highlights that the majority of staff try to create a safe environment and prevent things from going wrong. The best people can make the worst mistakes. This should be recognised in positive feedback wherever possible, and support a 'just culture' in primary, secondary and tertiary care organisations.

ANNEX 2 - MEDICAL EXAMINER GOVERNANCE STRUCTURE & CONTACT DETAILS

Governance structure (Wales)



For enquiries about implementation in Wales:

- Medical.examiner@wales.nhs.uk
- Andrew Evans, Andrew.evans@wales.nhs.uk or
- Daisy Shale, Daisy.shale@wales.nhs.uk

ANNEX 3 - MEDICAL EXAMINER'S ADVICE AND SCRUTINY FORM ME-1 (PART B) MESW V1.1

Medical Examiner's Advice and Scrutiny

Form ME-1 (Part B) MESW v1.1

The information provided in this form is confidential

Information in Sections B2, B3, B4, and B8 must only be recorded by a Medical Examiner. A Medical Examiner Officer (MEO) or another person acting on behalf of, and with the authority of a Medical Examiner may record other information.

B1. Name of deceased person and the date and time of death

Name:			Date and time of death:	/ /	
	(Forename)	*(Family name)*		*(Date)*	*(Time)*

B2. Scrutiny of clinical records and other documented information (*ME must complete*)

Information scrutinised: ☐ Full clinical record ☐ Summary clinical record ☐ Coroner documentation ☐ Other
Notes made by Medical Examiner during scrutiny:

Section1: The cause of death

1a Does the proposed wording for the cause of death adequately reflect the events in the medical records? ☐ Yes ☐ No

1b Has the death been referred to the Coroner due to uncertainty of the cause or events leading up to it? ☐ Yes ☐ No

1c Was the death anticipated ? ☐ Yes ☐ No

1d Was there an unexpected mode of death? E.g. cardiac arrest ☐ Yes ☐ No

1e Was there a recent interventional procedure following which death was not an expected outcome? ☐ Yes ☐ No

1f Was death due to the pre-existing condition or the known chronic condition? ☐ Yes ☐ No

1g Was there a major change in diagnosis or development of an additional condition? ☐ Yes ☐ No

Section 2: The care received by the deceased

2a Was there evidence of delay in recognition of deterioration, the diagnosis and or treatment? ☐ Yes ☐ No

2b Was there evidence of incorrect diagnosis and or treatment? ☐ Yes ☐ No

2c Was there evidence of failure of communication and or documentation? ☐ Yes ☐ No

2d Did the patient fall and sustain any injuries during the last illness or acute admission? ☐ Yes ☐ No

2e Did pressure ulcers develop during the last illness or acute admission? ☐ Yes ☐ No

2f Did the patient develop an infection during the last illness or acute admission? ☐ Yes ☐ No

Section 3: Concerns raised

3a Is there any indication of concerns from family or carers about the care received? ☐ Yes ☐ No

3b Is there any evidence concerns about the patients care raised by any other health professional? ☐ Yes ☐ No

3c Was the patient under any safeguarding order or state custody (e.g. DOLS, POVA, MHA)? ☐ Yes ☐ No

3d Do you have any concerns not covered by any other criteria about the care this patient received? ☐ Yes ☐ No

B3. Outcome of scrutiny by Medical Examiner **(*ME must complete*)**

Death: ☐ Unexpected ☐ Sudden but not unexpected ☐ Expected ☐ Individualised End of Life Care Plan

Case to be referred to HMC? ☐ Yes ☐ No

Reason

Potential learning identified ☐ Yes ☐ No

Refer to ☐ Speciality/Directorate ☐ Clinical Governance ☐ Medical Team ☐ Nursing Team ☐ Other please specify

Reason for review

Case to be referred for Stage 2 Mortality Review? ☐ Yes ☐ No

Reason:

☐ Death where the bereaved or staff raise significant concerns about the care

☐ Death in a specialty, diagnosis or treatment group where an ‘alarm’ has been raised (for example, an elevated mortality rate, concerns from audit, clinical governance concerns)

☐ Death where the patient was not expected to die –for example, in elective procedures

☐ Death where learning will inform the provider’s quality improvement work.

B4. Cause of death established during scrutiny by the Medical Examiner ***(ME must complete)***

		Approximate interval between onset and death
1a		
1b		
1c		
2		

B5. Discussion with qualified attending practitioner (QAP) - *if required* (***ME or MEO can complete***)

(If this discussion takes place before certification and the doctor has not provided in writing a preliminary view of the cause of death – or reason why no such view has been formed – then this information must be obtained and noted below at the outset of the discussion.)

QAP discussed case with: Name_ Role_ Date: / / _Time: _

Notes: *(If no preliminary view can be formed before requesting advice, make a note of the reason.)*

continuation sheet

- ☐ Cause of death provided before scrutiny or noted above is accepted without change
- ☐ Cause established by the Medical Examiner and documented is accepted by doctor
- ☐ Doctor and Medical Examiner have agreed the following alternative cause of death
- ☐ Death needs to be discussed with a Coroner for reasons noted in B2

		Approximate interval between onset and death
1a		
1b		
1c		
2		

B6. Discussion with coroner/coroner's office *(if required)* (***ME or MEO can complete***)

Notes:

- ☐ Coroner does not need to investigate the death and has agreed to issue a 100A
- ☐ Coroner has agreed to conduct an investigation

B7. Discussion of cause of death with informant/NoK/other appropriate person ***(ME or MEO can complete)***

Cause of death discussed with: *(name)* _______________ *(relationship)* _________________

Cause of death discussed by: *(name)* _________________ on *(date)* / /

at *(time)* Notes ____

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______ *continuation sheet*

☐ Cause of death accepted without any concerns being raised *(Continue at B8)*

☐ Concerns raised and addressed without requiring discussion with a coroner *(Continue at B8)*

☐ Concerns raised that require the death to be discussed with a coroner *(Record details in B6)*

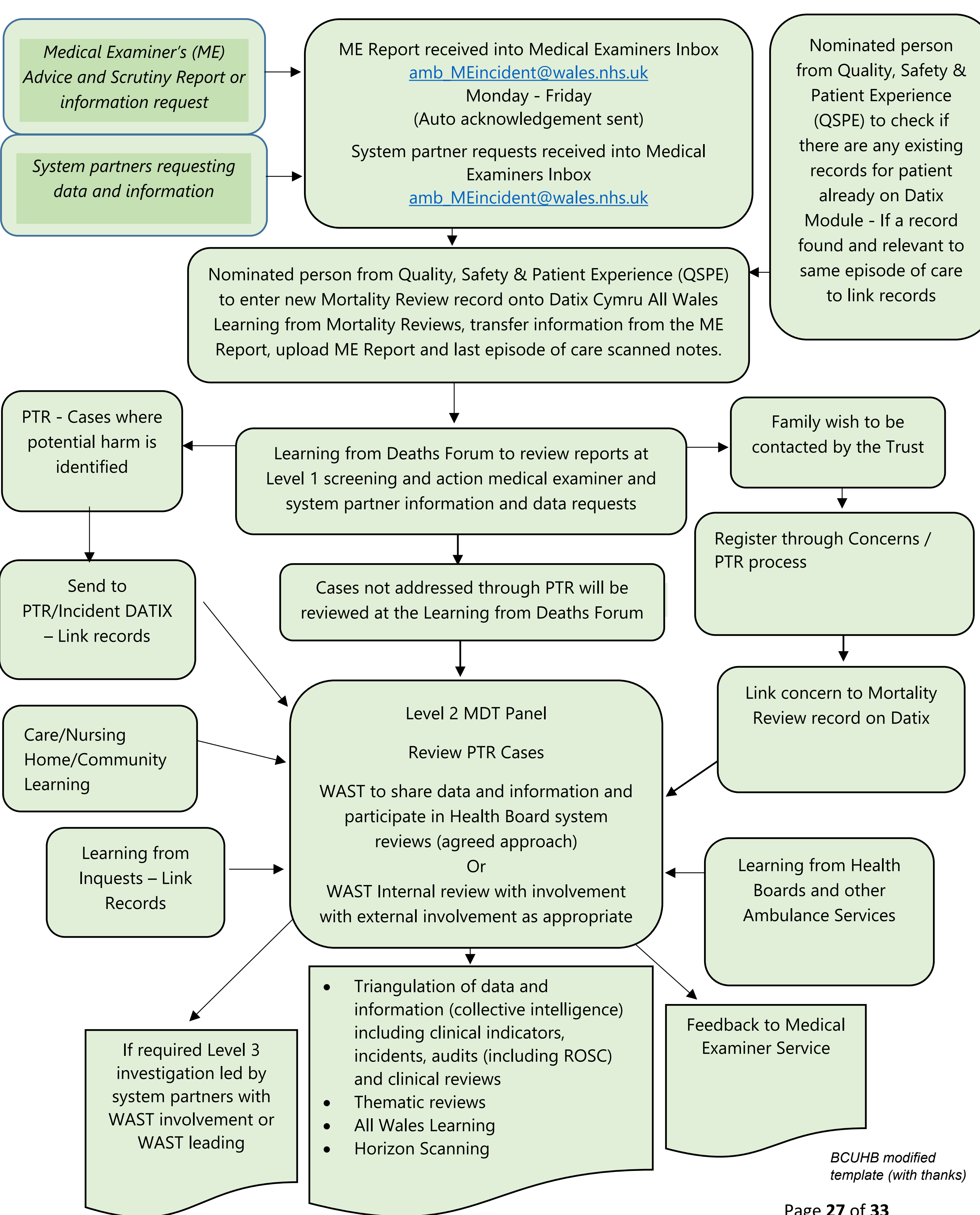
B8. Medical Examiner's details and signature ***(ME must complete)***

I confirm that I have carried out an independent and proportionate scrutiny of this death in a way that complies with the relevant standards and procedures.

Name of Medical Examiner *(print)*: ________________________ Office: __________

Signature: ____ Date: / /

ANNEX 4 – WAST & SYSTEM MORTALITY REVIEW PROCESS MAP*



*Identification of cases is undertaken via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning.

ANNEX 5: TERMS OF REFERENCE: LEARNING FROM DEATHS FORUM

INTRODUCTION

The purpose of the Welsh Ambulance Services (WAST) NHS Trust Learning from Deaths (LfD) Forum is to provide leadership, governance and oversight on matters relating to the All Wales Mortality Review Model Framework (the Framework). The LfD Forum is a sub-group of the Clinical Quality and Governance Group and is responsible for ensuring that the Trust meets the requirements of the Framework providing information to the medical examiners to inform reviews, participating in system partner led reviews and undertaking internal reviews as appropriate.

OBJECTIVES

1. Providing guidance, advice and leadership to support and further develop and implement systematic, robust methods for mortality reviews, working collaboratively with Health Board colleagues and Medical Examiners across NHS Wales.
2. Reviewing and sharing information as appropriate and contributing to Health Board led mortality reviews and internally led reviews as appropriate using the framework levels (1-5) as appropriate.
3. Records will be held in the Datix Cymru Mortality Module.
4. Ensuring that processes and arrangements are in place that will enable lessons to be widely shared and actioned on a local basis and contributing to learning on a national basis and wider.
5. Ensuring that a collaborative, equitable and multi-disciplinary approach is adopted with system partners and aligned with the Medical Examiner's approach.

MEMBERSHIP

- The membership of the LfD Forum will include Trust representatives from the Clinical / Medical Directorate, Operations Directorate and the Quality, Patient Experience and Safety Directorate.
- Members may nominate deputies to attend in the absence of the member. A nominated deputy has the same decision making authority as the full member.
- Specialist and/or other stakeholders may be invited to attend the forum as required for specific agenda items.
- The chair will be the Assistant Director of Quality & Nursing and the vice-chair will be a Clinical Lead / Consultant Paramedic.
- Core membership (quorum) is as a minimum one representative from each directorate.

FREQUENCY OF MEETINGS

- Meetings will be planned on a weekly basis (following the Serious Case Incident Forum) and stood down if not required to ensure timely review of cases.

REPORTING AND ASSURANCE ARRANGEMENTS

- The LfD Forum reports to the Clinical Quality and Governance Group at least quarterly and through existing quality governance escalation routes as required.

- Outcomes of the meetings will be held on an Action Tracker (SCIF).
- Collated activity and organisational and national learning will be included in the Patient Safety Highlight Report to determine trends and themes from collective intelligence. This Report will be presented to the Patient Safety and Experience Learning and Monitoring Group, Assistant Directors Leadership Team, Executive Management Team and the sub board committee with delegated responsibility for quality, safety and experience.

RELATED NATIONAL GROUPS

- WAST representation at the National Mortality Review Steering Group (MRSG) will be the Head of Patient Safety and Clinical Lead / Consultant Paramedic (or nominated deputy).

Approval date: September 2022
Review date: By October 2023

ANNEX 6 - STAKEHOLDERS & PARTNERS (NOT EXHAUSTIVE)

- NHS Wales Delivery Unit
- Welsh Government
- GPC Wales
- Executive Medical Directors
- Executive Nursing Directors
- Executive Directors of Therapies & Health Science
- Primary Care Reference group
- Mortality Review Steering Group
- Patient Safety / Risk Managers
- Welsh Risk Pool - Once for Wales Concerns Management System
- Assistant Directors for Primary Care & Community Care
- Welsh Government Quality & Safety Group
- Patient Representatives
- Medical Examiners and Lead Medical Examiner
- Coroners Peer Group
- Improvement Cymru
- NHS England
- Association of Ambulance Chief Executives

ANNEX 7 – KEY REFERENCES

- Welsh Government (2019) A Healthier Wales
- Welsh Government 92015) Wellbeing of Future Generations Act
- Health and Social Care (Quality and Engagement) (Wales) Act 2020
    - Duty of quality improvement
    - Duty of candour
- Welsh Government (2021) Quality & Safety Framework.
- Primary Care Strategic Programme Review of Governance, Quality & Safety (2020)
- Putting Things Right Regulations (2011, revised 2013)
- Death Certification (Medical Examiners) (Wales) Regulations 2018
- National Clinical Framework for Wales (2021)
- Patient Safety Incidents Policy – NHS Wales Delivery Unit 2021.
- National guidance for ambulance trusts on Learning from Deaths (2019), National Quality Board NHSE, London
- Monitor (2012) Quality Governance, Monitor, London
- The Shipman Inquiry Third Report (2003), HMSO, London
- Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 2: Analysis of evidence and lessons learned (part 2) - Vol 2, The Stationary Office, London
- Kirkup. B (2015), The Report of the Morecambe Bay Investigation, The Stationary Office, London

ANNEX 8 – KEY DEFINITIONS & RESOURCES

Medical Examiner (ME)	Medical examiners are part of a national network of specifically trained independent senior doctors (from any specialty). Overseen by a National Medical Examiner, they scrutinise all deaths that do not fall under the coroner's jurisdiction across a local area.
Concerns	These are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales.
Patient safety incident	Any unintended or unexpected incident(s) that could have or did lead to harm for one or more persons receiving NHS-funded healthcare.
Mortality review (MR)	A structured systematic assessment of the care provided to patient during their final illness. The aim is to learn and share from a patient's death, to identify if there are concerns and establish if similar situations may affect other patients and to improve overall quality of care.
A case that requires further review	The Trust / Health Board need to determine if there were factors in the care of the patient which should have been in place but were absent or if healthcare interventions took place which were detrimental to the outcome.
MCCD	Medical Certification of Cause of death (completed by medical staff)
Qualified Authorised Practitioner (QAPS)	A Qualified Authorised Practitioner can sign the death certificate
Structured investigation	This is a systematic technique used to find out what went wrong, how and why. The technique looks beyond the individuals concerned and seek to understand the underlying causes and organisational context in which the incident occurs, so that they can be addressed and managed. Organisations need to understand the underlying contributory factors of patient safety incidents so that the key problems can be addressed.
Proportionate investigation	The scale and scope of any investigation should be proportionate to the concern to ensure resources are effectively used. The impact and complexity of the incident, in terms of severity of patient harm, should be a guide to the scope of investigation. Concerns which indicate the most significant need for learning to prevent serious harm should be prioritised. This ensures that organisations are focusing resources in an appropriate way.

Mortality Review Tools	
Administrative Information Form ME-1 (Part A)	A national template form to be provided to a medical examiner or coroner following a death by medical examiner's officer, bereavement care officer, and clinical staff (pending).
Medical Examiner's Advice and Scrutiny Form ME-1 (Part B) MESW v1.1	A national template form to be completed by MEs where concerns or good practice have been identified and sent to the Health Board to decide on further action, except for those that have been referred to the coroners or where deaths have been registered and signed off by the ME.
Mortality review module Once for Wales (OfWs)	A method adopted by HBs to help identify where problems are suspected to have occurred in the patient's episodes of care. It is completed by clinicians/multi-disciplinary group who have been trained in the use of the tool. A prompt to using this tool is defined as '*any point when the patient's healthcare fell below an acceptable standard and led to harm and or death*'.
Structured investigation methodology	This is a technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to identify the underlying causes and organisational context. It allows the real causes of an event to emerge to enable learning and for remedial action to be put in place. This will be included as an investigation module as part of OfW Incident reporting (pending).
Template for feedback to MEs	An all Wales, structured template to feedback to the ME will support the process for further analysis of this information. This will be included as part of the OfW module.
Peer review process	This is an approach to support a peer review relating to mortality reviews across Wales. It will help inform the process of learning from deaths on an ongoing basis.
Thematic review	This is a process that helps organisations understand what happened in multiple cases that underwent investigation, linked by specific common features, to learn from them and to make changes that will consequently lead to improvements in the service.

AGENDA ITEM No	16
OPEN or CLOSED	Open
No of ANNEXES	3

COMMITTEE CYCLE OF BUSINESS 2023-24

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 May 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2022/23 effectiveness reviews that were conducted in Q4. Amendments to the Committee's terms of reference agreed in Q4 have been incorporated into this updated cycle of business.

2. The cycle has been developed with direct correlation to the duties in the terms of reference. This will allow members to review the appropriateness of the proposed reports and their frequency.

3. The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

RECOMMENDATION:

4. The Committee is asked to:
(a) **Review and approve the 2023-24 cycle of business at Annex 2; and**
(b) **Note the cycle of business monitoring document at Annex 3.**

KEY ISSUES/IMPLICATIONS

5. There are some areas of the cycle where reporting remains to be developed including committee health and care standards compliance; dementia standards; and information governance. Work will continue with the relevant directors on these areas over the coming months.

6. The committee is required to review the strategic direction of matters within its remit and to monitor their implementation. The cycle includes an annual review of the IMTP elements relevant to its remit ahead of them being approved by the Board, however the monitoring of the IMTP is within the purview of the Finance and Performance Committee. It is therefore proposed that, outside of that, reporting on the IMTP will be at the discretion of the relevant Director or at the request of the Finance and Performance Committee i.e. possibly to do a deep dive on an area that may be off track or to celebrate areas of success.

REPORT APPROVAL ROUTE

N/A

REPORT APPENDICIES

Annex 1: SBAR
Annex 2: Cycle of business 2023/24
Annex 3: Cycle of business monitoring report

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

ANNEX 1

CYCLE OF BUSINESS 2023/24

SITUATION

7. The purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process.

BACKGROUND

8. The Committee carried out its effectiveness review in Quarter 4 2022/23. This included a review of its terms of reference, amendments to which were approved by the Committee in February 2023.

9. The final step in the effectiveness review process is the development a cycle of business for the Committee.

ASSESSMENT

Cycle of Business

10. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework, should drive agenda setting. It also:

    10.1. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;
    10.2. schedules compliance related reports according to legislative or regulatory timeframes;
    10.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;
    10.4. generates commitment to review matters that may sometimes be vulnerable to postponement;
    10.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;
    10.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and
    10.7. removes the *ad hoc* elements of agenda setting.

11. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.

12. The cycle of business at **Annex 2** has been designed to do all the above. It includes further detail on the pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary. It also includes each of the duties for the Committee in the terms of reference (in red text) so members can see and demonstrate that the reporting expected for each area will in fact provide appropriate assurance, generate discussion, and allow for the right balance of challenge and support.

13. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed include:

    13.1. As the Health and Care Standards are revised with the introduction of the Health and Care (Quality and Engagement) (Wales) Act 2022, the Committee will receive a proposal for the monitoring compliance against the standards.

    13.2. The Dementia Standards Report and the Information Governance reporting will develop through the next reporting cycle.

    Work will continue with the relevant directors on these areas over the coming months.

Continued monitoring of the Cycle of Business

14. The cycle of business will be used to build the quarterly Committee agenda. A monitoring report will be provided to each meeting under the Consent Agenda, and where issues of escalation are required i.e., where cycle needs to be adjusted or reporting is overdue, these will be drawn out in a short paper by the Board Secretary.

15. The first monitoring report appears at **Annex 3** for Q1 2023/24. The Committee will see that the reporting timing for the annual safeguarding and infection prevention and control reports are to be confirmed. These were presented in February 2023 and August 2022 respectively in the 2022/23 year; however, it is envisaged that these will recalibrate to Q1 reporting as soon as practicable.

RECOMMENDATION

16. The Committee is asked to:

(c) **Review and approve the 2023-24 cycle of business at Annex 2; and**
(d) **Note the cycle of business monitoring document at Annex 3.**

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2023/24									
TERMS OF REFERENCE NOTED IN RED TEXT									
3.2 Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.									
3.14 Oversee improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience									
3.17 There is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation									
MIQPR review of metrics	EMT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year
Committee QPSE review of metrics	TBC	Annually					EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any)
MIQPR	EMT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Patient Safety Report	CQGG	Quarterly					EDQN/DP	Assurance	Report encompasses deep dive on MIQPR elements; thematic analysis; learning - see Note 1
3.3 Ensure compliance with the Duty of Quality and Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture - See Note 2									
3.30 Review and recommend to the Board the Trust's annual quality statement (as relevant) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety									
3.28 Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation									
Quality Report	CQGG	Annually					EDQN	Approval	Guidance to be provided by WG. H&SC(Q&E) Act. See Note 3
Duty of Candour Report	CQGG	Annually					EDQN	Approval	See Note 4
STRATEGY									
3.1 Ensure the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (patient centred; safe; equitable; timely; effective; and efficient).									
3.4 Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.									
3.5 Monitor the implementation of strategies and plans within the remit of the Committee.									
3.6 Ensure there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.									
Quality Strategy/Plan	CQGG	Initial and cyclical review					EDQN	Approval	Quality strategy initially approved and then cyclical reviews - to be clinically effective and quality driven
Clinical Strategy/Plan	CQGG	Initial and cyclical review					DP	Approval	Clinical strategy initially approved and then cyclical reviews - to be clinically effective and quality driven
Dementia standards report	CQGG	TBC					EDQN	Assurance	Reporting developing in 23/24 - see Note 5
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	Proposed QPSE elements of IMTP to QUEST for review ahead of full IMTP review by F&P and Board
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	F&P monitor delivery of strategy via IMTP. Exception reports to QUEST by director or by F&P request where required.
SAFE CARE									
3.7 Ensure the Health and Care Standards, Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance. See Note 6									
3.8 Ensure there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board									
Health and care standards	CQGG	TBC					EDQN	Assurance	Reporting re compliance to Health and Care standards (which will be reviewed 2023) is developing in 2023/24 - see Note 7
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Note 8
3.9 Consider the implications for the Trust's quality and safety arrangements from review/investigation reports, external guidance and national reports and actions arising from the work of external regulators									
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	May include reports from HIW/DU/Audit Wales/peer reviews/regulation 28 etc.
3.10 Monitor Trust compliance with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.									
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	Report developing in 2023/24 - to include compliance requirements and framework; look back and look forward
3.11 Review the annual infection prevention and control plan and monitor its implementation									
Annual IPC report	CQGG	Annually					EDQN	Assurance	Report to include compliance requirements and framework; look back; new year plan and details of how Quest will monitor implementation
3.12 Ensure the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults									
Annual safeguarding reports	CQGG	Annually					EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
3.13 Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration and revalidation for staff									
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	PCC has oversight of registration, revalidation and training and may refer to QUEST matters that affect patient safety
EFFECTIVE CARE									
3.15 Ensure the care planned and provided across the breadth of the organisation's functions is clinically effective and quality driven. and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.									
3.16 Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit Committee in this respect									
Clinical audit plan	CQGG	Quarterly					DP	Approval	Currently clinical audit plan is quarterly; to include national and local audit plan; QUEST report to Audit Committee following each meeting;
Monitoring report on clinical audit	CQGG	Quarterly					DP	Assurance	Whilst the clinical audit plan remains quarterly produced, the monitoring report will be one and the same
Spotlight On' clinical indicators	CQGG	Quarterly					DP	Assurance	To provide more focus on clinical care in 2023/24. Reporting to start in Q2 2023/24.
Mortality Report	CQGG	Quarterly					DP	Assurance	See Note 12 and prescriptive requirements from Audit Wales report
Meds management report	CQGG	Annually					DP	Assurance	Standalone report in Q4 on meds management (& medical devises by exception) & exception report - see Note 10
CITIZEN VOICE AND PATIENT EXPERIENCE									
3.19 Ensure the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.									
3.18 Approve the patient experience/engagement plan and monitor its implementation.									
3.20 Ensure the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt									
3.21 Seek assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures									
3.22 Ensure there is good collaborative team and partnership working to provide the best possible outcomes for its citizens									
PECI report	TBC	Bi-annually					EDQN	Assurance	See note 7
Patient story	N/A	Quarterly					EDQN	Assurance	Patient stories topical to main issues where possible
Patient story updates	N/A	Quarterly					EDQN	Assurance	Driver diagram demonstrating feedback loop and learning. Letter of thanks to patient.
3.23 Ensure any matters raised by the Medical Director, Director of Quality & Nursing, Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully									
INFORMATION GOVERNANCE AND INFORMATION SECURITY									
3.24 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety and security of information to support the delivery of high quality, safe healthcare across the organisation.									
3.25 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.									
3.26 Receive assurance on, and review effectiveness of the Trust's information security protocols									
3.27 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests									
Information Governance Toolkit	IGSC	Annually					DD	Assurance	See note 13
Information governance report	IGSG	Quarterly					DD	Assurance	Review of those metrics not included in MIQPR. Report developing in 2023/24. See Note 13
GOVERNANCE									
3.29 Recommendations made by internal audit and external reviewers are considered and acted upon on a timely basis									
Audit recommendation tracker	EMT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit/Board	Ad Hoc					Relevant Director	Assurance	
3.31 Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right									
Report from policy group	Policy Group	Annually					BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD)
3.32 Corporate Risks are identified and appropriately manged; CRR and BAF risks for their remit are presented and Committee is assured on progress and ratings; Audit Recommendation Trackers monitored									
Board Assurance Framework	EMT	Quarterly					BS	Assurance	
Corporate Risk Register	EMT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in May and Board June
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in May and Board June
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
External Reports	N/A	Ad Hoc					TBC	TBC	

EDQN = Executive Director of Quality and Nursing
EDO = Executive Director of Operations
DD = Digital Director
DP = Director of Paramedicine
EDSPP = Executive Director Strategy, Planning and Performance
BS = Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

Patient Safety Report

Audit Wales Quality Governance Review 2022 - QuESt Committee is well served with quality information, but there are opportunities for improvement. R8(a) The Trust should Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. It was suggested that whilst quality metrics are available separately in the patient safety report, quality highlight report, PECI report, Ops update etc there is merit in the Committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points. Management response includes the quality management system as a way to improve triangulation.
The NHS Wales Delivery Unit published a Patient Safety Incidents Policy in June 2021 with revised reporting and oversight arrangements. Subsequently a joint Learning from Events Report (LFER) in conjunction with Welsh Risk Pool covering serious incidents, redress and claims has been introduced to provide a consistent approach to learning across NHS Wales

Duty of Quality and Duty of Care

Policy position: A Healthier Wales 2018 (quality and safety above all else); National Clinical Framework 2021 (all organisations will adopt a quality management system and provide annual reports on quality); Quality and Safety framework 2021 (address the six domains of quality: safe, timely, effective, efficient, equitable, person-centred (STEEEP). NHS Exec to oversee establishment of a quality and safety programme.
Health and Social Care (Quality and Engagement) (Wales) Act 2020: Duty of Quality; Duty of Candour, CVB; VCs
Duty of Quality = improved quality of health services; better outcomes for population. Achieved through leadership and culture focused on good quality; system wide approach to quality; shared responsibility for quality; quality driven (and demonstrated) decision making; demonstrable learning and improvement; strengthened quality management systems and revised H&C Standards.
Quality management = quality planning; quality improvement; quality control; quality assurance
Annual Quality Report and Always On reporting - make use of existing performance, outcome and delivery indicators and measures where possible; patient and staff experience, information and stories; reporting from inspectorate and licensing bodies; consideration of national clinical audits, reports, inquiries. Dashboard in development by DU. Consistent approach desired as appropriate across NHS bodies; align reporting to our local strategic objectives.
Duty of quality and candour implementation board receives organisations' monthly self-assessments against the roadmap on a score of 1-4

Annual Quality Report	H&C (Q&E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24
Annual Duty of Candour Report	H&C(Q&E) Act s.7; publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24. Introduced for end of 23/24
Dementia Standards	Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
Commissioning Quality Core Requirements	From a commissioning perspective the core requirements underpin delivery across the 5 steps for EMS and Ambulance Care. The headings are governance, patient experience and satisfaction, equity, patient care, staffing and safety. Commissioning Quality Core Requirements are reported to EASC with quality and patient safety elements included in MIQPR.
Health and Care Standards	Reporting on compliance with the Health and Care Standards will be developed in 2023/24 with the introduction of new standards linked to the Health and Care (Quality and Engagement) (Wales) Act 2020. Assurance includes through the QPMF (F&P); audits; sub-structure review/assurance; reporting mapped to six domains; IMTP linked to six domains. TBC if stand alone self-assessment desired/required.
QIA	The QIA process will initially come to QUEST. Thereafter CQGG will review all QIAs and the Chair of CQGG will escalate those in their professional judgment should be reviewed by QUEST.
Clinical Audit	Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team, employing 12.73 WTE staff, provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff. Audit Wales Quality Governance Review August 2022 recommendation 2: *We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: (a) the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year; and (b) the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.* Currently audit plan is produced quarterly. If it moves to annual should come to Quest ahead of each financial year. QUEST to assure Audit Committee.
Meds Management and Medical Devices	Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting. Any exception reporting on meds management or medical devices to Quest by exception.
Patient Experience	Reports bi-annually on a PE template to WG. H&C Standards integral to the plan golden thread and forms core part of the workplan. PECI report demonstrates how we meet mandatory responsibility to listen and learn from people's experiences and capture and report in line with the National Service User Framework (2014); the NHS Wales Planning Framework; NHS Delivery Framework (2018/19); WG National Framework for Assuring Service User Experience (2015); and Health Care Standards for Wales (WG, 2015b). Engagement (triangles) and consultation process. Embedded in forums and contacts around country. Driven by the IMTP as enabler; citizen centred approach embedded in plan; continuous engagement model;
Mortality reviews	In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners (ME) in Wales. Andy and Liam working through the new framework in Q4 22/23. Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews. Audit Wales Quality Governance Review Recommendation 3: The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: (a) the number of reviews undertaken and the numbers of reviews required but not yet complete; (b) any significant concerns, lessons learned and what changes have been made as a result (c) updates on actions to address the mortality review backlog; (d) updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. Management Response: Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3 Audit Wales Quality Governance Review August 2022 Recommendation 4: The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee. Management response: Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress (Q3 22/23)
Information Governance	The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target). Data security and protection incidents: must notify ICO of personal data breaches within 72 hours. WG notified of significant impact on continuity of essential services under the Network and Information Systems Regulations (NIS Regs). H&C Standards x 3 related to IG and identified metrics against these (see annual report) The Welsh IG Toolkit for NHS is an assessment tool that allows organisations to measure their performance against agreed national information governance and data security standards. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrates compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIAct) Finance and Performance Committee oversees the digital strategy and reviews and monitors major projects as well as cyber security and cyber resilience Information governance and data protection predominantly apply to our confidential patient data, but we also hold a large amount of staff and organisational data, so QUEST has remit over IG from a quality point of view. Liam Williams is Caldicott Guardian. TBC if an annual SIRO and/or Caldicott Guardian report is required.
General	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	
QUEST COMMITTEE - CYCLE OF BUSINESS 2023/24									
See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below									
MAIN ELEMENTS									
MIQPR review of metrics	EMT	Annually					EDSPP	Approval	
Committee QPSE review of metrics	TBC	Annually					EDQN	Approval	
MIQPR	EMT	Quarterly					EDSPP	Assurance	
Patient Safety Report	CQGG	Quarterly					EDQN/DP	Assurance	
Quality Report	CQGG	Annually					EDQN	Approval	First report Q1 24/25
Duty of Candour Report	CQGG	Annually					EDQN	Approval	First report Q1 24/25
Quality Strategy/Plan	CQGG	Initial and cyclical review					EDQN	Approval	
Clinical Strategy/Plan	CQGG	Initial and cyclical review					DP	Approval	
Dementia standards report	CQGG	Annually					EDQN	Assurance	
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Health and care standards	CQGG	TBC					EDQN	Assurance	Reporting developing 23/24
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	
Annual IPC report	CQGG	Annually					EDQN	Assurance	TBC timing (21/22 report provided Aug 22)
Annual safeguarding reports	CQGG	Annually					EDQN	Assurance	TBC timing (21/22 report provided Feb 23)
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan	CQGG	Quarterly					DP	Approval	
Monitoring report on clinical audit	CQGG	Quarterly					DP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly					DP	Assurance	To commence from Q2 23/24
Mortality Report	CQGG	Quarterly					DP	Assurance	
Meds management report	CQGG	Annually					DP	Assurance	
PECI report	TBC	Bi-annually					EDQN	Assurance	
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Information Governance Toolkit	IGSC	Annually					DD	Assurance	
Information governance report	IGSG	Quarterly					DD	Assurance	Reporting developing 23/24
Audit recommendation tracker	EMT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit/Board	Ad Hoc					Relevant Director	Assurance	
Report from policy group	Policy Group	Annually					BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	
Board Assurance Framework	EMT	Quarterly					BS	Assurance	
Corporate Risk Register	EMT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
External Reports	N/A	Ad Hoc					Relevant Director	Varies	
OTHER									
Operations Directorate Update	N/A	Quarterly					EDO	Information	

EDQN = Executive Director of Quality and Nursing
EDO = Executive Director of Operations
DD = Digital Director
DP = Director of Paramedicine
EDSPP = Executive Director Strategy, Planning and Performance
BS = Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing
Presented as cycled/ad hoc item considered at agenda setting
Deferred - see comment

AGENDA ITEM No	17
OPEN or CLOSED	OPEN
No of ANNEXES	0

AUDIT REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 May 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

2. There are 10 Internal Audit recommendations assigned to Committee for oversight. 3 of these are complete and 7 recommendations are currently overdue. These relate to the Role of Advanced Paramedic Practitioner review and the Information Management Hear and Treat Review.

3. The Corporate Governance Team has experienced resource challenges that has precluded it from conducting confirm and challenge meetings with action owners and Executives during this reporting period to enable it to assure the Committee on progress updates and evidence of closed actions.

4. The audit tracker is currently undergoing a full review and will be available for the next Audit Committee for scrutiny. In addition, Internal Audit are undertaking their annual review of the tracker.

5. **The Committee is requested to note the update.**

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICIES
None.

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Infection Prevention and Control
Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust

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Review reference:	WAST-2223-03
Report status:	Final
Fieldwork commencement:	7th September 2022
Fieldwork completion:	25th October 2022
Draft report issued:	2nd November 2022 & 5th December 2022
Debrief meeting:	4th November & 10th November 2022
Management response received:	4th January 2023
Final report issued:	5th January 2023
Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance, Louise Colson, Head of Infection Prevention and Control
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

To assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report.

Overview

We have issued reasonable assurance on this area. The matters which require management attention include:

- IPC audits are not yet underway with audit tools yet to be finalised.
- Continued issues in operation and membership of the IPC Strategic group.
- Clarity required for ongoing performance monitoring and reporting arrangements.
- Arrangements for formal monitoring of the IPC Action Plan are unclear.
- Inconsistencies identified in roles and responsibilities within draft policies and procedures.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	Cleaning Standards 2019/20

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies and procedures	Reasonable
2	Trust structure and responsibilities	Reasonable
3	IPC Programme	Limited
4	Guidance and training	Reasonable
5	Mechanisms for assurance	Limited
6	Performance and oversight	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IPC Policies and related procedures	1	Design	Medium
2	IPC Strategic Group operation	2	Operation	Medium
3	Roles and responsibilities	1, 2	Design	Medium
4	IPC Work Plan content, monitoring and approval	3	Operation	Medium
5	'Onclick' Resources	4	Operation	Low
6	Trust IPC assurance mechanisms	5	Design	High
7	Performance reporting	4, 6	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') is committed to a zero tolerance of preventable healthcare associated infections (HCAI's). The Trust aims to work in partnership with all staff, service users and key stakeholders, to reduce the risk of transfer of community acquired infections in the pre-hospital care environment to secondary care and wider community environments.

1.2 The Infection Prevention and Control Annual Report 2021 – 2022, presented to the Trust's Quality, Patient Experience and Safety (QUEST) Committee in August 2022, outlined that the Infection Prevention and Control (IPC) team has necessarily had a COVID-19 focus in the past two years. The report outlined that the team was now looking to return to a business-as-usual approach, whilst retaining the improvements and IPC related behaviours gained through experience of the pandemic.

1.3 The Annual Report also provided a summary of IPC team priorities to be taken forward in 2022/23, including review of the Trust IPC Policy and a number of standard operating procedures, guidance and standards documents, alongside recommencing IPC audits which were suspended during the pandemic.

1.4 This review will also consider progress made to implement recommendations raised in the 2019/20 '*limited*' assurance Cleaning Standards report.

1.5 The risks considered during the review were as follows:

i. Patient or staff harm where infection prevention and control guidance and practice are not aligned to national standards.
ii. Financial loss or reputational damage to the Trust as a result of poor performance.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	2	0	3
Operating Effectiveness	0	3	1	4
Total	1	5	1	7

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: The Trust has an infection prevention and control policy that provides clear direction, aligns with national standards, and is supported by appropriate operational policies and procedures.

2.3 The Trust has an overarching Infection Prevention and Control policy: '*Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections'* ('the policy'), which was due for review in May 2021. Updates were made in September 2022, by the Head of Infection Prevention and Control (IPC), to align it with the Association of Ambulance Chief Executives (AACE) model national IPC policy. At the time of fieldwork closing the policy was to be submitted to the October 2022 meeting of the Trust Policy Review Group.

2.4 Whilst incorporating content from the AACE national policy, the Trust needs to ensure there remains alignment to the Welsh Government standards (*Code of Practice for the Prevention and Control of Healthcare Associated Infections*). We were also informed that the policy would retain guidance on Personal Protective Equipment provided by the Health and Safety Executive (HSE) that featured in previous revisions.

2.5 Review of the draft policy has identified a number of key revisions and updates. These include revised scope, aim and objectives and, in particular, reference to the previous IPC improvement plan has been replaced with a commitment to the prevention and control of infection and to set the strategic direction for IPC initiatives.

2.6 The draft revised policy expands on roles and responsibilities, including the addition of the Trust Board, Head of IPC and wider IPC team. Roles and responsibilities for managers and staff have also been refreshed and it provides further clarity on the need to ensure all staff and contractors receive sufficient training, information and supervision, with responsibility for developing training content assigned to the IPC team.

2.7 There is also outline of IPC audit arrangements, with audit subjects including vehicles, premises, equipment, clinical waste, sharps, linen and reference to 'local ownership of IPC standards by local management teams.' These are to be undertaken in line with the Trust's IPC audit programme. We discuss IPC audit arrangements in more detail at 2.46.

2.8 The overarching policy is supported by subject specific policies, standard operating procedures (SOPs) and guidance documents, although we note not all of these are owned or maintained by the IPC team. Following the move from Covid-19 response to business as usual in July 2022, there is currently a focus on updating those which have passed their review date, or those previously paused due to the pandemic.

2.9 At the time of fieldwork there were seven documents which were at various stages of draft or pending approval, these included the *Premises and Vehicle Cleanliness Policy*, *Safe Clean Care (IPC Handbook)*, *Key Standards for Environmental*

Cleanliness, and SOPs for hand hygiene, management of linen, mobile device decontamination and invasive procedures.

2.10 The *Premises and Vehicle Cleanliness* policy will be presented to the Trust Policy Review Group in October 2022. It contains detail on cleaning of premises, and outline of staff, management and reporting responsibilities. However, the cleaning instructions will require updating in line with the *Key Standards for Environmental Cleanliness* document which remains in draft, and monitoring arrangements detailed do not mention vehicles currently. We also note the Operations Directorate has issued a *Vehicle Decontamination* SOP, which provides instruction on vehicle cleaning for those which do not have access to regular cleaning at Trust Make Ready Depots (MRD). There is variation in cleaning instructions between these documents, the SOP also lacks detail on audit or other assurance arrangements. **See MA1 & MA3**

2.11 Throughout the pandemic the IPC team has produced a number of updates to Covid-19/PPE guidance documents, to ensure they remained in line with nationally issued guidance. Updates reflected changes in PPE, risk assessments, action cards and isolation/distancing requirements. In line with the movement from transition to business as usual, the team are now developing the next iteration of the IPC handbook: '*Safe Clean Care*'. The handbook combines content from a number of individual SOPs and national guidance, comments provided at the September IPC Strategic group, whilst positive, highlighted the requirement to ensure alignment and consistency. **See MA1**

2.12 There has also been focus on emerging risks with the co-production by IPC Team and Operations Directorate of an *Outbreak Management* SOP. This features trigger action cards for escalation, local management team processes, terms of reference and standard meeting agendas. Additionally, guidance has been issued for PPE and IPC management of Monkeypox.

Conclusion:

2.13 The Trust's IPC Policy has been updated, subject to formal review and approval, and aligns to national practice. A number of policies, SOPs and guidance documents are being reviewed, and the team has continued to address pandemic and other risk areas. However, there are a number of key documents remain in draft with inconsistencies that need to be addressed to ensure alignment. We assign this objective **reasonable** assurance.

Audit objective 2: The Trust has a clear infection prevention and control structure, and Operational and Executive responsibilities are clearly outlined.

2.14 The Trust established a pandemic structure in 2020, which transitioned through response and recovery to a return to business as usual in 2022. The IPC team engaged and contributed to a number of groups within the structure, particularly the Quality, Safety and Wellbeing Advisory and the Business Continuity and Recovery Cells.

2.15 During the pandemic, the IPC Team engaged with the cell structure established across the Trust, including the Quality, Safety and Wellbeing Cell, Health and Safety Advisory Cell, Clinical Advisory Cell, Trade Union Partnership Cell, and Senior Pandemic Team meetings. Example documents were provided supporting IPC team attendance and the sharing of guidance, training compliance, number and locations of positive Covid-19 tests and Covid outbreak team incident reports.

2.16 As the pandemic structure was stood down on 20th July 2022, the Chair of the Business Continuity and Recovery Team (BCRT) produced an SBAR to set out the governance arrangements proposed for those areas which had been included within the remit of the BCRT, and previous Senior Pandemic and Executive Pandemic teams. IPC features within this, with reference to the IPC Strategic Group for development of guidance, and the Clinical Quality Governance Group (CQGG) as the approving forum.

2.17 The IPC Strategic Group met infrequently during the pandemic period, as would be expected with the need to focus on Covid-19 response. The Terms of Reference (ToR) is in the process of being revisited and has been shared with the Executive Management Team (EMT) and the IPC Strategic group for review. The membership of the Group needs to be confirmed before the revised version can be finalised.

2.18 We reviewed agendas, papers and minutes for the three IPC Strategic meetings held in 2022 (January, April and September 2022), and compared these to the contents of the group's ToR and monitoring requirements in line with the updated IPC policy. Acknowledging that only the September meeting would have been held under a business-as-usual heading, the review suggests there are gaps in its operation. All three meetings were quorate.

2.19 The group's ToR includes a requirement '*to provide assurance on performance and the implementation of work programmes*'. However, it has not received the IPC work plan which was developed in 2021. The group is to provide a '*senior cross directorate forum*', but as noted above Senior Operations membership has not been confirmed. There is also a requirement to '*receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust wide levels.*' Whilst the group has met only once since the return to business as usual, our review of meeting agendas does highlight limited performance information being presented. It is important that the Trust take the opportunity to address this for future meetings. **See MA2 & MA7**.

2.20 The IPC Strategic group attendance has included members from Estates, Fleet, and the Make Ready Depot Lead. However, review of agendas indicate that papers and reports are only produced by the IPC team, which suggests there could be more emphasis placed on membership responsibilities and contribution to support the group's operation. **See MA2**

2.21 We also reviewed the group's minutes and action logs, to identify if actions are identified, tracked, and monitored appropriately. Whilst there have been longstanding actions held within the action log, we observed the September meeting and can confirm each action was subject to discussion and review.

However, we do note that the most recent minutes for that meeting did not include specific capture of actions, and so consideration should be given to correct this for future meetings.

2.22 Operating alongside the pandemic cell structure, the CQGG was responsible for non-Covid related business. Review of CQGG minutes identified that it has received the IPC Annual Report 2021/22, circulation of and subsequent approval of Monkeypox guidance at an extraordinary meeting of the group in June 2022. We note the CQGG has also approved updates for a number of SOPs and SBARs, which suggest that there is a clear route for discussion and approval of IPC documents.

2.23 Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs, noting clear outline of both Executive, and operational roles and responsibilities. In particular we noted the IPC team responsibilities for designing policy and process documentation, and as subject experts ensuring these complied with required legislation. This also included consideration of the ability of the Trust to deliver the systems within resources available, while retaining responsibility for implementation through the Operations Directorate. As noted above, the team are progressing and prioritising a number of draft SOPs, and four of these were shared at the September meeting of the IPC Strategic Group for review.

2.24 We compared the outline of roles and responsibilities within those four draft SOPs, and the '*Key Standards for Environmental Cleanliness'* which was also submitted for comment at that meeting. Whilst acknowledging they are still in draft, we note variation in how responsibilities are outlined and so there is opportunity to consider further standardisation in format and terminology to support the good practice identified in our earlier review. **See MA3**

Conclusion:

2.25 There is a clear structure to support IPC within the Trust, with evidence of its use, including across a number of pandemic cells, to discuss and approve SOPs and guidance documents. In the return to business as usual it is important to improve the operation of the IPC Strategic group and its membership. We have also highlighted further opportunities to clarify roles and responsibilities. We assign this objective **reasonable** assurance.

Audit objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the Trust.

2.26 We understand from discussion with the Head of IPC that a post pandemic IPC workplan was requested to support the delivery of the 2021-2024 IMTP, and were informed that this was approved through the Trust Pandemic structure.

2.27 The 2021 IMTP included reference to developing and implementing a sustainable health and safety transformation plan incorporating health and safety and infection prevention and control. The 2022-25 IMTP highlights key areas for

recovery, including how IPC measures continue to apply in a post-pandemic phase, and ensuring the lessons learnt and systems put in place during Covid-19 continue within business as usual.

2.28 The IPC work plan includes that the 2021 IMTP deliverable will be progressed through an IPC action plan, but the document has not been updated to capture the same link to the more recent IMTP.

2.29 The work plan is comprised of 10 IPC team deliverables, each with supporting actions, responsible officer, priority, status, and target implementation dates. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated.

2.30 In reviewing the priority areas we considered the deliverables listed above, the requirements of the updated IPC policy, and the priorities listed within the IPC Annual Report 2021-22. Overall, we note there is good coverage, although we did identify omissions. For example, the IPC Annual Report includes reference to actions to address audit recommendations, which is not reflected within the IPC work plan. Additionally, we note the plan does not include actions related to the sustainability of Fit Testing, which is currently a risk held by the team and highlighted as a major focus of team capacity. We also note the plan does not include the work to be undertaken in developing training in line with the HEIW national IPC training framework. **See MA4**

2.31 We also reviewed the work plan to consider if it demonstrated consideration of resource requirements, noting that at present it does not with all actions assigned to the Head of IPC. The work plan currently lists two of the ten actions as complete, and whilst a further six have target dates listed for November or December 2022, these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). **See MA4**

2.32 Review of the IPC plan confirmed that each action has received at least one status review, with the majority having 2-3 narrative progress updates between June 2021 to September 2022. We have noted that priorities within the work plan have been discussed at the various cells within the pandemic structure, although we note this has been ad-hoc rather than on a regularly scheduled basis.

2.33 The work plan was initially shared at the IPC Strategic group in July 2021, and we are informed the priorities within the plan was also shared within presentations to the Clinical Advisory and Trade Union Partnership Cells. The plan has not returned to the IPC Strategic group or shared at the CQGG, which will have impacted on their ability to review and monitor progress across the priority areas. The QUEST committee terms of reference were revised this year to include '*Review the annual infection prevention and control plan and monitor its implementation*'. However, the IPC work plan has not been shared at that forum.

2.34 We also recognise that the work plan was intended to address post pandemic priorities, but that there has also been a need to tackle other pressing issues,

such as the Fit testing and subsequent quality assurance programme, which has impacted the team's capacity to achieve this.

2.35 Additional resource has been secured for the IPC team, including substantive appointments of a Senior and Assistant IPC Practitioner(s) and shared administrative resource with the Health and Safety team. This has primarily been directed to support the establishment of Fit testers and quality assurance arrangements. The majority of quality assurance assessments were undertaken in November and December 2021 and the Trust is committed to a 12-month review of QA Fit Testers by the accredited IPC team members.

Conclusion:

2.36 The Trust has an established IPC work plan which contains priorities linked to the IMTP and IPC policy. The work plan was shared at the IPC Strategic group but has not returned for further monitoring. It has not been presented to the CQGG, or QUEST committee, and we note there are delays in delivery of identified actions. We have outlined areas that could strengthen the plan content and monitoring. We assign this objective **limited** assurance.

Audit objective 4: There is awareness of infection prevention and control guidance and staff have undertaken appropriate training.

2.37 Outside of the statutory and mandatory IPC training requirements, the Trust has commissioned a supplementary suite of online training materials through the provider '*Onclick*'. The additional modules are available to all staff and volunteers through the Trust Learning Zone site and whilst completion is optional, it is recognised as contributing to Continuous Professional Development (CPD).

2.38 Guidance on the access and use of both statutory and mandatory training and the onclick modules is available through the IPC SharePoint site, under its training and education page.

2.39 Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A, Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*.

2.40 We reviewed the *vehicle cleaning, sharps and waste management* module. The module also refers to additional resources such as legislation, policies, and key documents, although we noted instances where the use of links directed the user to incorrect versions and the omission of the *Vehicle Decontamination* SOP. **See MA5**

2.41 Health Education Improvement Wales, at the request of Welsh Government, have developed a national framework for IPC Training. The framework outlines expectation across four levels, ranging from entry level: '*introductory awareness*' to Level 4: '*specialist knowledge understanding and application*'. The IPC team are working with the Trust's Training college to map the levels across staffing groups and specialised roles, and we were provided with an initial training needs

analysis. Further work is being undertaken to develop competency booklets to support these requirements. **See MA5**

2.42 Training compliance rates for statutory and mandatory IPC training and the Onclick modules were included within the IPC Annual Report 2021/22. Whilst this information is not currently reported to the IPC Strategic group, this has been identified as an area to address and capture in reporting going forward. At the time of fieldwork current performance is as below, noting the national target for IPC Level 1 and 2 is 85%:

Training Course	May 2022	October 2022
IPC Level 1	88.23%	75.63%
IPC Level 2	48.51%	45.46%
Onclick – EMS	72.73%	75.50%
Onclick - NEPTS	79.20%	72.34%

2.43 Review of QUEST and People and Culture Committee papers identified that they are provided with an overall combined training compliance figure, rather than a breakdown of performance for each subject area which was previously captured within a Quarterly Assurance Report. We understand that the report is currently under review. **See MA7**

2.44 The IPC team are actively supporting face to face training, and in observing the IPC Strategic group meeting in September it was clear that the team have good working relationships with the Learning and Development team. An action was agreed at that meeting to support the development of 'behavioural IPC champions' and to develop resources to highlight the risks of transmissibility within contact centres.

2.45 There is also awareness raising through the use of Quality & Nursing Directorate notices which are distributed throughout the Trust. We identified a number have been issued this year, including to promote awareness of infectious diseases, cleaning guidance, and fit test expiry dates.

Conclusion:

2.46 The Trust provides additional training and guidance materials to support staff, but links to key documents do require updating. Training compliance figures have been reported to QUEST, but we are unable to identify ongoing monitoring or reporting of these where focus is required to improve IPC Level 2 compliance. The team has undertaken an initial training needs analysis against the national framework, with further actions with the Learning and Development team planned. We assign the objective **reasonable** assurance.

Audit objective 5: Mechanisms in place to ensure compliance with Trust policies and procedures are appropriate.

2.47 Our previous review of Cleaning Standards, which was issued at the beginning of the pandemic in 2020, highlighted the need to develop more effective audit

methods to monitor compliance. The IPC Annual Report 2021/22 outlined that no audits were undertaken for 2021/22 due to the need to focus team resource and capacity on the pandemic response and any emerging variants of concern. The report included that a Trust IPC audit programme would be reintroduced in 2022-23 which would include:

- Corpro mask use, filter and maintenance logs and ESR Records;
- Versaflo usage, filter and maintenance logs;
- Peripheral cannulation and ANTT Compliance;
- On Click and eLearning compliance;
- Premise and Vehicle Cleaning;
- Hand Hygiene and Bare Below the elbow.

2.48 Discussion with the Head of IPC confirmed that at present the audit programme has not commenced, as there was a need to develop appropriate audit tools which utilised current software applications. The team does not have this capability and so both internal and external assistance had been sought. **See MA6**

2.49 The revised IPC policy references a number of additional subject areas which should feature within audit programmes, including staff competency at point of care, storage of medical consumables and equipment, handling and disposal of clinical waste and sharps, management and handling of linen, antimicrobial supply and administration, and local ownership of IPC standards by local management teams. In the previous iteration of the IPC policy some of the above were included but assigned to the Operations and Medical Directorates to undertake. **See MA6**

2.50 For the full benefit of the IPC audit programme, it would also require all subject areas having established criteria to be audited against. At the time of fieldwork, the *Premises and Vehicle Cleanliness* policy, *Key Standards for Environmental Cleaning*, and *Hand Hygiene and bare below the elbows* SOP were at draft stage.

2.51 With IPC audits not in operation, we queried if there were alternative mechanisms for assurance across key areas of premises and vehicles. Since our previous internal audit review of Cleaning Standards in 2019/20, and in response to the pandemic, the Trust has secured cleaning services for all Trust premises. Additionally, we note the health and safety team have undertaken a programme of Covid-19 risk assessments, which include elements of IPC, across Trust premises in 2021.

2.52 Vehicle arrangements have also been strengthened following the opening in 2022 of an additional Make Ready Depot (MRD) in Cardiff. The Trust has an ambition to increase the number of such facilities, to expand this model and approach across Wales. The MRD sites provide dedicated cleaning across three levels, which range from surface clean, a six weekly deep clean, and ad-hoc cleaning where contamination has occurred. As was the case at the time of our previous review of Cleaning Standards, the majority of Trust vehicles are not cleaned at MRD sites,

and so there remains a need to demonstrate and provide assurance for those vehicles.

2.53 Our previous review of cleaning standards identified that Adenosine Triphosphate (ATP) swab testing was being considered as a method for assessing cleaning standard compliance. We are informed that MRDs had used ATP during the pandemic, and was particularly useful as a source of assurance for staff. However, in the return to business as usual the process is currently retained for quality assurance purposes only, with future use to be determined through review of policies and procedures which is currently underway. MRD reporting of activity has continued, but as our previous review identified there is no reporting which captures cleaning status for the entire Trust fleet.

2.54 Included within the IPC Annual Report 21/22 was detailed outline of IPC related datix reporting, which was broken down by theme and health board area. Whilst the report highlighted an increase in needlestick injuries within the Swansea Bay University Health Board area, and we note a consistent number of returns related to IPC policy or procedural issues, these have not resulted in further action. The team has recently introduced a weekly review of datix reports and began to collate responses and actions. The intention will then be to map themes and actions, which can be incorporated into the ongoing highlight and dashboard reporting. **See MA6**

Conclusion:

2.55 The Trust IPC audit programme requirements are outlined within the IPC policy and included within the IPC work plan. Following suspension due to pandemic pressures audits are yet to be restarted. The Trust has some mitigating measures around MRD vehicle cleaning and premise cleaning, however the previous development of ATP swab testing, which provided a method for assessing cleaning standard compliance, has not been implemented fully resulting in an absence of assurance reporting. We assign this objective **limited** assurance.

Audit objective 6: There is regular reporting on Trust performance with clear oversight arrangements to support escalation of risks and issues.

2.56 Prior to the return to business as usual, the route for oversight and reporting remained through the pandemic structure for Covid-19 related activity. Senior Pandemic Team agendas and papers demonstrate the heightened profile of IPC during this period. Covid related incidents, risk assessments and IPC/'on click' training summaries were presented to cells across the structure.

2.57 The IPC Team also provided quarterly highlight reports to both the Assistant Directors Leadership Team, and the Trust's National Health and Safety Committee. These provide a narrative outline of team progress and developments, and a summary of key areas in the alert/advise/assure/inform format. Review of report content, alongside the reporting within the pandemic structure, provides coverage against priorities contained within the IPC work plan,

although only at a high level for some these suggesting therefore more focused monitoring arrangements would be beneficial in the return to business as usual.

2.58 With the pandemic structure now stood down, we considered the arrangements in place to support ongoing monitoring and reporting of risks in the return to business as usual. The IPC Strategic group meets on a quarterly basis and is a subgroup of the CQGG. Its ToR includes that it will provide a highlight report to the CQGG following each meeting. The CQGG holds monthly meetings and in turn provides a 'Quality Highlight Report' summarising its key activities the QUEST Committee, which meets on a quarterly basis.

2.59 We reviewed CQGG papers and minutes for the period January 2022 and August 2022 to identify the frequency and content of reporting in place. In that period the CQGG received and approved a number of IPC SOPs and guidance documents, and the IPC Annual Report 2021-22. The Annual Report provides summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. We could not identify use of highlight reports from the IPC group to the CQGG, suggesting there is opportunity to enhance future reporting of current performance, or the key activities of the group. **See MA7**

2.60 Review of the Quality Highlight Report from CQGG to QUEST identified that information provided varied. For example, the report provided in May 2022 included outline of the group's purpose, but little on its activity. The second, provided in August 2022, contained further detail including approval of IPC SOP for *High Consequence Infectious Diseases,* and this indicates that the structure for discussion and approval outlined within objective two is in place.

2.61 The Quality Highlight Report did not however contain indicators on performance or detail on progress against the IPC work plan. Our previous review of Cleaning Standards in 2019/20 had identified that the previous Quarterly Quality Assurance Reports, presented at the CQGG predecessor group (the Quality Steering Group), included detail on IPC statutory and mandatory training compliance, datix incidents and cleanliness audits. This, in turn, was reported to the QUEST Committee. Discussion with the Assistant Director of Quality Governance outlined that the reporting requirements from CQGG to QUEST are being considered. The Audit Wales Review of Quality Governance issued in 2022 highlighted that whilst current reporting provides a '*good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost*.'. A highlight report aligned to key indicators is planned for November 2022 onwards. **See MA7**

2.62 The QUEST Committee provides a highlight report to Trust Board following each meeting. This is formatted around an alert (escalation), advise (developments, monitoring, approval), and assure format. We note that receipt of the IPC Annual report at the August QUEST Committee meeting was included within the subsequent report to Board under the assure heading. **See MA7**

2.63 There has been a number of IPC related risks that were included within the Trust's Corporate Risk Register during the pandemic which have been subsequently de-escalated. The IPC Annual Report 2021/22 includes outline of six individual risks

that the team closed during the year, relating to team structure, PPE, and lack of compliance with HSE regulations for Fit testing. The September IPC Strategic group received and discussed a risk opened in May 2022 relating to the sustainability of the Fit testing programme within the Trust, a challenge highlighted within our review of RPE earlier this year. The group agreed that the risk required organisational awareness and that it should be escalated.

Conclusion:

2.64 There is a clear reporting structure from the IPC Strategic Group to the CQGG and onwards to the QUEST Committee and Trust Board. During the pandemic, there has been use of the Trust's cell structure to escalate risks and monitor training levels. We've considered the initial arrangements supporting the return to business as usual, which has identified the need to enhance the flow of reporting, in line with Audit Wales recommendations. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: IPC Policies and related procedures (Design)	Impact
In returning to business as usual the IPC team are reviewing and updating policies, procedures, and guidance documents. This includes the overarching IPC policy, which has been updated, but is awaiting approval from the Trust Policy Group. A number of supporting policies and procedures were also in development or pending approval at the time of fieldwork. The *Premise and Vehicle Cleanliness* policy is in draft we reviewed its content noting: • The adapting of *Key Standards for Environmental Cleanliness* for use within the Trust is still to be completed and these will need to be incorporated within the above policy once finalised. • Monitoring arrangements within the policy include IPC audits, however under responsibilities Health and Safety Managers are listed as responsible for audit of the policies operation. • Reporting is to be to a Building Cleaning Group yet to be established and there is no mention of the role of the IPC Strategic group. • The document includes cleaning instructions on premise cleaning, but information on vehicle cleaning does not replicate content from the *Vehicle Decontamination SOP* which does provide vehicle cleaning instructions. The SOP contains no outline of audit or other assurance arrangements. Alongside the current policies and SOPs there will shortly be an updated IPC handbook. Discussion at the IPC Strategic group, and our own review of the draft document, notes that handbook duplicates content from a number of other documents and will require ongoing maintenance to ensure content remains current.	Potential risk of: • Policies and procedures do not provide comprehensive coverage of related areas. • Lack of clarity across responsibilities and ownership.

Recommendations	Priority
1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner. 1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.	Medium

1.3	The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance.		
1.4	Consideration should be given to modifying the IPC handbook to direct users to relevant content, this could also contain the outcome of mapping recommended above.		

Management response		Target Date	Responsible Officer
1.1 – 1.3	The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	March 2023	Louise Colson, Head of IPC
1.4	Consideration will be given to modifying the IPC Handbook following the IPC 3P Project. The aim of this action is to ensure staff are able to navigate to relevant and important content, as and when required.	June 2023	Louise Colson, Head of IPC

Matter arising 2: IPC Strategic Group (Operation)	Impact
Our previous review of Cleaning Standards in 2019/20 identified that the IPC Strategic group was not operating effectively. Since then there has been review of the group's terms of reference, however membership is still to be finalised. The group has met a number of times during the pandemic, transition period, and once during business as usual. Review of group agendas, papers and minutes identified the following gaps against its terms of reference; • '*The purpose of the IPC Strategic Group is to provide strategic expertise, assurance on performance, and implementation of work programmes within the organisation of matters relating to IPC.'* - We note the group has not received, approved, or discussed the IPC work plan which was developed in 2021. • '*The Group will provide a senior cross-directorate forum, in which IPC matters will be considered to ensure successful operationalisation and positive implementation into Trust policies, procedures and practices.'* – There is currently no attendance from senior Operations management and membership from that group is yet to be confirmed. • '*Receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust-wide levels;'* – The group received narrative updates on development of policies/plans and guidance, however currently there are no IPC audits underway and limited input from non-IPC members on their areas of responsibility. • '*Contribute to and influence prudent antimicrobial prescribing into routine practice*.' – We did not identify discussion of this subject area within minutes reviewed. The gaps identified above would also impact the achievement of objectives listed within the updated IPC Policy. Draft minutes circulated following the group's September meeting did not include use of an action column. There would be benefit in a consistent approach and format used to identify and capture actions raised within the meeting.	Potential risk of: • Trust IPC priorities not delivered. • Effectiveness of group operation impacted by gaps in membership and subject coverage.

Recommendations	Priority
2.1 The Terms of Reference for the IPC Strategic group, including membership, should be finalised, and submitted for approval from the CQGG. 2.2 The format and agenda of the IPC Strategic group should be reviewed to align with the IPC Work Plan priorities.	**Medium**

2.3 In undertaking the above the Trust should consider the information, monitoring, and reporting contributions from each which could contribute to the progressing of the IPC priorities within the work plan.

	Management response	Target Date	Responsible Officer
2.1	The Terms of Reference for the IPC Strategic group, including membership, will be finalised, and submitted for approval from the CQGG. Additionally, a revised Agenda and group work programme will be implemented.	March 2023	J Turnbull-Ross, Asst. Director
2.2 – 2.3	The Terms of Reference, group work programme/agenda will include routine monitoring of performance, and review of documentation in a timely manner. Management response 1.1 will inform the content of the group's monitoring requirements.	March 2023	J Turnbull-Ross, Asst. Director

Matter arising 3: Roles and Responsibilities (Design)	Impact
Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs which contained clear outline roles and responsibilities across both Executive and operational staff and management. We have also noted the alignment within the overarching IPC policy to the content held in the AACE national IPC policy which itself includes outline of roles and responsibilities. We compared the outline of roles and responsibilities within four draft SOPs, and the *Key Standards for Environmental Cleanliness* presented to the IPC Strategic group in September. Whilst acknowledging they are still under development there is variation in frequency and terminology. We noted; • The *Decontamination of Mobile Devices* and *Invasive Procedure* SOPs did not include reference to Executive Director responsibilities. The *Key Standards for Environmental Cleanliness* refer to the Director responsible for IPC rather than the Director of Nursing and Quality. • The *Invasive Procedure, Management of Linen*, and *Decontamination of Mobile Devices* SOPs, and the draft Key Standards do not have clear outline of the responsibilities of the IPC team. • The *Invasive Procedure, Management of Linen*, and the draft *Key Standards for Environmental Cleanliness* do not have managers responsibilities clearly outlined.	Potential risk of: • Inconsistent outline of roles and responsibilities.

Recommendations		Priority
3.1	The Trust should consider further standardisation of roles and responsibilities outlined across executives, managers and staff which can be included within the development of future SOP, policies, and guidance documents. This could be drawn from the content within the updated IPC policy.	Medium

Management response		Target Date	Responsible Officer
3.1	We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	March 2023	Louise Colson, Head of IPC

Matter arising 4: IPC Work Plan, monitoring and approval (Operation)	Impact
The work plan is comprised of 10 IPC team deliverables each with supporting actions, responsible officer, priority, status, and target implementation date. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated. Our review noted priorities matched with the requirements of the updated IPC policy and priorities within the IPC Annual Report 2021/22. We noted some small gaps against ongoing delivery including, action to address NWSSP Audit and Assurance reports, inclusion of the Fit testing Quality Assurance programme, and action to address the HEIW national IPC training framework. Review of actions outlined that two of the ten actions are currently complete, with a further six contain target dates of November/December 2022 these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). All actions within the IPC work plan are assigned to the Head of IPC. Additional resource secured for the team has been directed towards the establishment of a Fit tester programme, followed by the need to provide ongoing quality assurance. These actions are not included within the plan. The IPC work plan has not been shared at the CQGG or QUEST Committee.	Potential risk of: • IPC performance and delivery of priorities may not be adequately scrutinised.

Recommendations	Priority
4.1 The IPC Work Plan and content should be reviewed to ensure it contains both the Trusts overall IPC priorities but also those areas which have greatest impact on the IPC team capacity and resource. It should then be submitted for approval from the CQGG. 4.2 Resource requirements and target dates should be reviewed with changes in timescales or actions included at IPC Strategic group and CQGG meetings. 4.3 The ongoing delivery of the IPC work plan should be regularly monitored at the IPC Strategic group.	Medium

Management response	Target Date	Responsible Officer
4.1 The IPC Work Plan will be reviewed and submitted to CQGG for approval.	March 2023	Louise Colson, Head of IPC

4.2	We accept the recommendation, future workplans will detail requirements.	March 2023	Louise Colson, Head of IPC
4.3	The IPC Strategic Group's Terms or Reference, group agenda and work programme will include monitoring of deliverables against the IPC Work Programme	March 2023	Louise Colson, Head of IPC

Matter arising 5: 'Onclick' Training resources (Operation)	Impact
Outside of the statutory and mandatory IPC training requirements the Trust has commissioned a supplementary suite of online training materials through the provider 'Onclick'. Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A*, *Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*. The modules are also supported by links to additional resources such as legislation, policies, and key documents. Review of the vehicle cleaning, sharps and waste management module The IPC documents linked to within the module were to previous out of date versions; • All things IPC - Version 1.3, current version is 3.0 • A-Z of Common Disease – Version 1.3, current version is 8.2 it did not include the Vehicle Decontamination SOP which provides the Trust's approach to non MRD cleaning instructions.	Potential risk of: • Access and use of out-of-date guidance.

Recommendations		Priority
5.1	The Trust should ensure online resources contain up to date links and guidance.	Low

Management response		Target Date	Responsible Officer
5.1	Immediate action will be undertaken on those identified. The IPC 3P Project will systematically review documentation for outdated links/information.	January 2023	Louise Colson, Head of IPC

Matter arising 6: Trust IPC Assurance Mechanisms (Design)	Impact
Our previous review of Cleaning Standards in 2019/20 highlighted that vehicle and premise checks undertaken were 'subjective and therefore provide only limited assurance'. Alternative methods of audit, such as the use of ATP swab testing, which did provide some assurance on the effectiveness of cleaning methods, were being considered at that point but these have not been continued. As outlined within the IPC Annual Report 2021-22 IPC audits were paused as team resource and capacity was directed to support the Trust's pandemic response. The report included intention to reintroduce an audit programme in 2022/23, and we're informed the team has allocated dedicated time to undertake these, however the audit tools to support the programme are yet to be finalised. The previous IPC policy included outline of those responsible for IPC related audits, including those outside of the IPC team itself. Review of IPC Strategic group papers has identified no reporting of any checks made by alternative parties. With the *Key Standards for Environmental Cleanliness* still in draft there will also need to be clear circulation of these once finalised to ensure staff are aware of the criteria being measured against. The IPC team has recently established regular review arrangements for datix incidents to capture related actions and themes, at present this only relates to August and September 2022.	Potential risk of: • Lack of assurance on compliance with policies.

Recommendations		Priority
6.1	Whilst continuing to progress the updating of IPC audit tools the Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23. This should be alongside finalising and communicating expected criteria and standards.	**High**
6.2	The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.	
6.3	To support both of the above actions the IPC team should incorporate analysis of datix incidents for 2022/23 so that the targeting of audits is risk based.	

Management response	Target Date	Responsible Officer

6.1	A prioritisation assessment will be undertaken to audit higher risk focus areas.	March 2023	Louise Colson, Head of IPC
6.2	IPC 3P Project will provide a comprehensive assessment of monitoring and audit arrangements. Additionally, responsibilities will be articulated through a RACI framework	June 2023	Louise Colson, Head of IPC
6.3	The recommendation is supported. An analysis of the data will be undertaken to determine priorities for the IPC Work Plan for 2023/24, including auditing.	March 2023	Louise Colson, Head of IPC

Matter arising 7: Performance Reporting (Operation)	Impact
The IPC Annual Report 2021-22 was provided to the Clinical Quality Governance Group (CQGG) in May 2022, Executive Management Team in June 2022, and presented to the QUEST Committee in August 2022. This provided a good summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. There has been use of the Trust pandemic cell structure to report Covid-19 incidents, IPC training compliance, and use of SBARs for risks across a number of cells and the Senior Pandemic Team. Review of CQGG minutes and papers confirms that the group receives and approves guidance and procedure documents from the IPC Strategic group on a regular basis. In the return to business-as-usual arrangements to support ongoing performance monitoring and escalation is not as clear with no highlight reports from the IPC Strategic group to CQGG identified within the period reviewed. Our previous review of Cleaning Standards identified that whilst there were opportunities to strengthen the monitoring at the IPC Strategic Group, there had been consistent reporting of key indicators such as statutory and mandatory training compliance, datix incidents and audit outcomes featured within the Quarterly Assurance Reports to the QUEST Committee. Audit Wales in their review of Quality Governance highlighted that whilst current reporting provides a '*good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost.'*	Potential risk of: • Gaps in performance reporting.

Recommendations		Priority
7.1	We support the review of key indicators to be reported from CCQG to the QUEST Committee. This review should also determine the key indicators to be reported and monitored at the IPC Strategic Group.	**Medium**

Management response		Target Date	Responsible Officer
7.1	A review of performance indicators will be undertaken for the IPC function. Routinely, these will be reported by exception to CQGG. Further consideration will be undertaken to ensure Board committee oversight of key IPC measures.	March 2023	Louise Colson, Head of IPC

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

Rating	Definition
Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Immediate Release Directions

Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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Executive Summary

Purpose

A review of the effectiveness of the mechanisms in place to for the immediate release of ambulances outside hospitals to respond to patient needs in the community.

Overview

We have issued reasonable on this area. The significant matters which require management attention include:

- Allocators must review the RES screen prior to directing immediate release of vehicles;
- Escalation of declined directions to the Operational Delivery Unit (ODU);
- Datix incidents must be completed and reviewed in a timely manner following each declined direction;
- Review of declined directions to ensure the correct process has been followed; and
- Themes and trends should be captured and lessons learned shared.

Further matters arising concerning the areas for refinement and further development have also been noted.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A - No previous audit in this area

Assurance summary[1]

	Assurance objectives	Assurance
1	Clear guidance and procedures.	Substantial
2	Alternative options explored.	Reasonable
3	Declined directions investigated and communicated.	Limited
4	Performance monitoring.	Reasonable
5	Appropriate reporting and escalation.	Reasonable

Key matters arising

	Key matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Completion of RES screen.	2	Operation	Medium
2	Escalation to Operational Delivery Unit (ODU).	3	Operation	High
3	Completion and timely review of Datix incidents.	3	Operation	High
4	Completeness of Director of Operations briefing paper.	3	Operation	Medium
5	Analysis and feedback of themes, trends and lessons learned.	4	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 Directions to immediately release ambulances outside hospitals should be undertaken for 'Red' and 'Amber 1' incidents, after all other options to identify a suitable resource to meet patient needs in the community have been explored. The decision to release ambulances is made by the nurses in charge at the time and the rationale is relayed to the Chief Operating Officer (COO) at each health board area.

1.2 The '*Patient Safety Highlight Report*' presented to the Quality, Patient Experience & Safety Committee (QUEST) in November 2022, highlights that the number of declined 'Immediate Release Directions' (IRD) remains an ongoing concern, with varying levels of response across health boards. During the quarter ending September 2022, there were a total of 2,883 directions made to health boards. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%).

1.3 The highest scoring risk on the Welsh Ambulance Services NHS Trust's (the 'Trust') Corporate Risk Register relates to: '*The Trust's inability to reach patients in the community causing patient harm and death.*'

1.4 The potential risks considered in this review were:

- Inability and/or a delay in ambulances reaching patients in the community resulting in harm; and
- Failure to achieve the most efficient and effective use of resources.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	2	2	-	4
Total	**2**	**3**	**-**	**5**

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

2.3 The 'All Wales Immediate Release Protocol' was approved on 14 July 2022 by the NHS Wales Chief Executive Group, and issued and adopted on 25 July 2022 following agreement at Emergency Ambulance Services Committee (EASC). The protocol details that '*Chairs and Chief Executives across Wales agreed that to manage in real-time the serious risk of harm to patients categorised as immediately life threatened (Red) or Serious (Amber 1) in the community without*

an available emergency ambulance resource assigned that all immediate release directions made by the Trust will be accepted by the receiving emergency department without unnecessary delay enabling a response to be made to the patient awaiting a response in the community'. The protocol also states: '*declining an immediate release direction for Red and Amber 1 patients must not occur.'*

2.4 The IRD report for the period 1 July 2022 to 5 September 2022 is shown in the table below. This highlights a significant volume of immediate release directions being made, which reflects the significant pressures the unscheduled care system is facing, manifesting itself at Emergency Departments (ED) across Wales resulting in extended patient handover times and patients in the community experiencing long waits for ambulance response. 1,900 IRDs were made in total, of which c30% related to Red priority incidents and c70% for Amber 1 patients. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, it is important to note that only 35.5% of such directions between April 2021 to June 2022 received this decision within the 8-minute response target for red calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 immediate release directions, despite the new protocol stating that they must not occur. There is also recognition that health boards are not refusing such directions, rather that they have very limited options in a system which is almost overwhelmed.

Red Priority incidents					
Hospital Name	**Accepted**	**Not Accepted**	**Total**	**Percentage accepted**	**Percentage not accepted**
Bronglais General Hospital - Aberystwyth	7	1	**8**	88%	13%
Glan Clwyd Hospital – Bodelwyddan	92	2	**94**	98%	2%
Glangwili General Hospital - Carmarthen	18	2	**20**	90%	10%
Grange University Hospital - Cwmbran	56	16	**72**	78%	22%
Maelor General Hospital - Wrecsam	59	2	**61**	97%	3%
Morriston Hospital - Swansea	68	17	**85**	80%	20%
Prince Charles Hospital – Merthyr Tydfil	21	2	**23**	91%	9%
Prince Philip Hospital - Llanelli	8	2	**10**	80%	20%
Princess of Wales Hospital - Bridgend	12	22	**34**	35%	65%
Royal Glamorgan Hospital - Pontyclun	27	3	**30**	90%	10%
Royal Gwent Hospital - Newport	0	1	**1**	0%	100%
Singleton Hospital - Swansea	1	0	**1**	100%	0%
University Hospital of Wales - Cardiff	56	7	**63**	89%	11%
Withybush Hospital - Haverfordwest	22	0	**22**	100%	0%
Ysbyty Gwynedd Hospital - Bangor	58	5	**63**	92%	8%
Total	**505**	**82**	**587**	**86%**	**14%**

Amber 1 Priority incidents					
Hospital Name	**Accepted**	**Not Accepted**	**Total**	**Percentage accepted**	**Percentage not accepted**
Bronglais General Hospital - Aberystwyth	6	6	**12**	50%	50%
Glan Clwyd Hospital - Bodelwyddan	126	163	**289**	44%	56%
Glangwili General Hospital - Carmarthen	14	51	**65**	22%	78%
Grange University Hospital - Cwmbran	24	24	**48**	50%	50%
Maelor General Hospital - Wrecsam	119	131	**250**	48%	52%
Morriston Hospital - Swansea	14	267	**281**	5%	95%
Prince Charles Hospital – Merthyr Tydfil	17	2	**19**	89%	11%
Prince Philip Hospital - Llanelli	12	9	**21**	57%	43%
Princess of Wales Hospital - Bridgend	8	44	**52**	15%	85%
Royal Glamorgan Hospital - Pontyclun	7	2	**9**	78%	22%
University Hospital of Wales - Cardiff	27	2	**29**	93%	7%
Withybush Hospital - Haverfordwest	20	2	**22**	91%	9%
Ysbyty Gwynedd Hospital - Bangor	107	109	**216**	50%	50%
Total	**501**	**812**	**1313**	**38%**	**62%**

2.5 We have noted variation in relation to declined directions across Wales, with Cardiff and Vale and Aneurin Bevan University Health Boards reporting higher compliance (90% and 77% respectively) during quarter 1 of 2022/23, compared to only 23% at Swansea Bay University Health Board (refer to table under objective 5 below). However, we acknowledge that compliance is higher for red priority incidents and that Swansea Bay University Health Board received significant volumes in comparison, albeit a lot lower than those received by Betsi Cadwaladr University Health Board during the same period.

Audit objective 1: There are clear guidance and procedures in place regarding Immediate Release Directions and expectations have been appropriately communicated.

2.6 The Resource Deployment Standard Operating Procedure (the 'SOP') sets out the procedures the member of staff allocating resources should follow within the Clinical Contact Centre (the CCC). This SOP came into effect on 25 July 2022, following approval by the Senior Operations Team on 21 July 2022. Section 3.2 of the SOP details the Immediate Release Protocol and it is the responsibility of the Allocator to ensure procedures are followed.

2.7 The most recent update to the SOP was to reflect the additional actions associated with immediate release directions, including escalation to the Operational Delivery Unit (ODU) for onward escalation to the health boards, and the inclusion of quality

assurance review of all declined IRD. The SOP also reflected that Red and Amber 1 declines are now considered never events.

2.8 The SOP is available on the Trust's intranet site 'Siren'. Historically, any updates to SOPs are communicated to the CCC staff via staff bulletins. The SOP was shared with all CCC staff managers, supervisors, ODU, the communications team as well as the concerns team in July 2022. This specifically drawing out the language change and the areas of focus.

2.9 As noted above, the 'All Wales Immediate Release Protocol' (the 'Protocol'), was approved by the NHS Wales Chief Executive Group and presented by the Trust to EASC and all health boards in July 2022. It states that Red and Amber 1 immediate release directions shall be honoured in all cases. The protocol was shared internally within the Trust with on call managers and strategic commanders, as well as Heads of Service in Operational areas to cascade to teams.

2.10 The protocol '*outlines the principles and processes for the management of immediate release directions that includes a dynamic escalation process to, as far as possible, minimise patient safety risk for patients awaiting a response in the community when ambulance capacity is reduced when the time for patient handover at emergency departments is extended*'. Additionally, the protocol contains sections setting out step by step procedures for raising an immediate release direction and to escalate a declined direction.

2.11 The protocol was due for review in October 2022. The Director of Operations has written to the Health Board COO's requesting feedback, with the intention to revise by the end November, if necessary.

Conclusion:

2.12 The Trust has a Resource Deployment SOP in place that details the process for allocating resources. A new 'All Wales' protocol has also been agreed recently between the Trust and health boards. The protocol was due to be reviewed in October and feedback has been requested feedback, with the intention to revise by the end November if necessary. Noting this, we have assessed this objective as **substantial** assurance.

Audit objective 2: Immediate release directions are only submitted to health boards after all other options to identify a suitable resource have been explored.

2.13 Immediate release directions must be undertaken for a Red or Amber 1 incident where all actions to identify a suitable resource fail. As noted under audit objective 5 below, at its July 2022 meeting the Trust Board received and discussed a report relating to avoidable harm. The report identified 26 actions, 20 for the Trust and six system stakeholder actions. There is a specific action in place relating to immediate release directions with other actions including: *NHS Wales eradicates all emergency department handover delays in excess of 4 hours; emergency*

department cohorting; and *implement nationwide approach to emergency department 'Fit 2 Sit'.*

2.14 The Trust's Resource Deployment SOP details the actions to be taken and criteria that needs to be met before making an IRD. This includes considering all appropriate options to resource the incident, for example referring to the Resource List (RES) screen to check the status and availability of vehicles, including those outside of the divisional area that they are managing, and issuing messages to resources to identify if they can become clear for response.

2.15 All attempts to identify a suitable resource must be recorded. The Sequence of Events (SoE) screen includes a time stamp to capture actions taken, which in the main involve review of the RES screen which lists the handover status, availability and location and type of vehicle.

2.16 We selected a sample of 30 declined IRDs, 25 of these were before the All Wales Protocol was agreed and five after, to confirm that directions are only submitted to health boards after all other options to identify a suitable resource have been explored. The SoE screen was reviewed to confirm that the RES had been completed prior to the direction being made. Our sample included coverage across all health boards and focussed on Red and Amber 1 incidents. The report we were provided with also included IRDs with 'Amber 2' and 'Green' priority ratings, reflecting that the patient's condition had improved at the point the incident was closed.

2.17 Our testing identified six instances where there was a lack of evidence to demonstrate that the RES screen was reviewed prior to the IRD being made. However, we understand from discussions with CCC managers that where there are multiple incidents of the same priority polling a single call can be made to the appropriate hospital. We were also advised that Allocators would be aware that calls were polling, indicating a lack of available resource to respond prior to making the IRD. See **MA1 in Appendix A**.

Conclusion:

2.18 The Resource Deployment SOP details actions to be taken and criteria that needs to be met before making an IRD, including review of the RES screen to check the status and availability of vehicles. We identified six instances (20%) where completion of this check was not evidenced. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 3: Declined directions are appropriately logged and investigated. Outcomes are communicated, both within the Trust and to the health boards.

2.19 All immediate release directions must be recorded in Trust's Computer Aided Dispatch (CAD) system. The following fields can be populated in the Call+ tab screen:

- IRR01: whether IRD has been made;

- IRR02: the IRD decision – accepted, declined or pending. Declined directions must be escalate to the ODU;
- IRR03: the hospital directed;
- IRR04: the name and employee number of health board staff;
- IRR05: whether the declined direction has been escalated to the ODU; and
- IRR06: details the Datix incident reference for the adverse incident report that is required to be submitted for each declined direction.

2.20 Our testing of 30 declined IRDs identified that 22/30 (73%) of the declined directions had not been escalated to the ODU as required. Furthermore, 149 (23%) of the 649 declined directions between 25 July (since the All Wales Protocol was agreed) and 5 September 2022 had not been escalated to the ODU. 27 (18%) and 122 (82%) related to Red and Amber 1 incidents respectively. See **MA2 in Appendix A**.

2.21 Section 3.2.1 of the SOP details that '*ODU interventions and actions must be documented in the Ambulance Daily Occurrence Log (ADOL)'*. The required interventions and actions required of the ODU were not detailed in the SOPs prior to July 2022. Two of our sample of five items selected after the implementation of the most recent SOP had not been escalated to the ODU. Review of the ADOL confirmed that there was upward escalation by the ODU to the health boards for the three incidents that had been escalated.

2.22 Prior to the recent revision of the Trust's Resource Deployment SOP in July 2022, we were informed that raising Datix incidents was only required for declined IRDs in respect of Red category calls. 13 of the sample of 25 declined IRDs selected prior to July 2022 related to immediately life-threatening incidents, a Datix report had not been raised for five of these. See **MA3 in Appendix A**. A Datix report had been raised for all five of the sample of declined directions selected after the implementation of the new SOP and All Wales protocol in July 2022.

2.23 Although we found Datix incidents are raised promptly after the incident date, we found that these were not reviewed and closed in a timely manner, with some taking as long as 10 months to close. Eight of the 13 Datix incidents noted above were recorded as closed. However, the average time taken to closure was 165 days, varying from 15 days to 288 days. The five items that remain open, have been so for 2 months or longer. See **MA3 in Appendix A**. However, we understand that the Trust is reliant on responses and feedback from health boards in order to appropriately close incidents. We also note that, due to the sustained high volumes of declined Amber 1 directions, the Trust may not have the capacity to fully investigate, review and report on these. Input from health boards is also required to facilitate wider learning.

2.24 The Trust's Resource Deployment SOP includes a quality assurance section which requires a daily review of all declined immediate release directions to ensure the correct process has been followed and feedback to dispatch staff where learning has been identified.

2.25 Weekly briefing papers, which detail review of the declined IRD incidents, are required to be produced and shared with the Trust's Director of Operations. These

include detail of the time of the call, the time the IRD was made, the time of first resource at scene and the time of first conveying resource at scene (if different), the age and gender of the patient, the chief complaint, the outcome of the release direction and the outcome for the patient (i.e. were they conveyed to hospital, treated or recognised as life extinct at scene). The narrative should also include any actions taken by the Trust, including if the direction was inappropriately recorded.

2.26 In recognition of the significant volumes of declined directions, particularly relating to Amber 1 incidents, the Trust's Director of Operations revised the requirement so that 10% of Amber 1's declined would be investigated, in addition to all those relating to Red declined. The briefing papers for the weeks commencing 15 August 2022, 22 August 2022, 29 August 2022 and 5 September 2022 were examined, to confirm whether review of declined directions had been undertaken in line with this revised approach. Whilst overall the briefing paper to the Director of Operations typically met the target to investigate 10% of Amber 1 declined directions, we identified two Red declined directions that had been omitted. The See **MA4 in Appendix A**.

2.27 Section 4.11 of the 'All Wales Immediate Release Protocol' details that '*To further aid close monitoring weekly reports will be afforded to Health Board partners detailing immediate release activity and associated outcomes'*.

2.28 Up until the implementation of the new protocol, the Trust's Director of Operations provided updates on declined IRDs for Red incidents to relevant health board Directors. Since the implementation of the new SOP and All Wales protocol, the Director of Operations provides health boards with details of both Red and Amber 1 declined release directions. These updates also detail where action by Trust staff was not in line with internal procedures, demonstrating that the Trust is open and transparent in their updates.

2.29 We also note that the SOP requires the Allocator to record the name of the health board staff member who declined the direction. However, staff names were not obtained for 13 of the declined directions in our sample and we understand that staff at certain hospitals refuse to provide this information, often citing data protection as the reason not to disclose. We have not raised a matter arising for this issue as it is outside the control of the Trust. However, this could prevent or delay the Trust's investigations into declined directions. The Director of Operations has raised this issue in his updates to health board executives.

Conclusion:

2.30 22 (73%) of the 30 declined IRD in our testing sample had not been escalated to the ODU as required, which could result in them not being escalated to the health board in a timely manner. Whilst Datix incidents were raised for all five items in our sample following the agreement of the All Wales Protocol, they had not been raised for 38% of Red incidents prior to this. Where Datix incidents are reported, this is done promptly. However, they are not reviewed and closed in a timely manner. We also note that not all declined directions are reviewed in line with the SOP, which could impact feedback to staff where learning has been identified. The

Director of Operations provides health boards with regular updates on declined release directions. Noting this, we have assessed this objective as **limited** assurance.

Audit objective 4: Performance information relating to Immediate Release Directions is regularly monitored and themes and trends identified.

2.31 As noted above, the Dispatch Teams within the Emergency Medical Service (EMS) Co-ordination Centre produce briefings following each declined IRD and these are used to update the EMS Co-ordination Senior Management Team, including on the actions taken in response.

2.32 The Trust's CEO receives a weekly '*Immediate Release Review Briefing Paper*' from EMS Co-ordination. This provides a colour coded bar chart illustrating the number of declines, showing both the pan-Wales position and analysis by each individual health board. We understand that the report includes incidents with 'Amber2' and 'Green' priority ratings at the point of closure.

2.33 As noted under objective 3 above, the Trust's Director of Operations receives a similar paper, with additional narrative on the circumstances and actions taken following review of all declined Red incidents and 10% of declined Amber 1 incidents, broken down by hospital site. This report is used to inform discussion with Health Board Chief Operating Officer (COO) colleagues.

2.34 Assurances on declined immediate release directions are discussed at the 'Daily National Risk Huddle' call between the Trust and health boards. On 1 August 2022, the Immediate Release Direction dashboard went live. This provides metrics on the number and percentage compliance on IRDs for each health board. We also understand that the dashboard is available at Emergency Departments and provides the live position.

2.35 In addition, a summary immediate vehicle release directions report is sent weekly to health board colleagues, via an automated email from WAST Health Informatics. This is a subscribed report targeted at senior managers across the Trust and health boards.

2.36 The Trust also produces 'Patient Safety and Experience Highlight' reports for each health board. This provides an 'at a glance' update on the current patient safety and experience landscape, including declined IRDs. The reports are presented at the quarterly patient safety and experience meetings the Trust holds separately with each health board Nurse Director.

2.37 One of the summary principles set out in the All Wales Protocol is to develop and maintain effective immediate release plans, that support joint working and the reduction of risk across system. We recognise that having an agreed Protocol in place, stating that declining an immediate release direction for Red and Amber 1 patients must not occur, is a step forward and should lead to improvement. However, we note that themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report, are not

currently being captured, analysed and fed back within the Trust. This is important to enable learning and improve compliance with internal procedures going forward. **See MA5 in Appendix A**.

Conclusion:

2.38 There is regular reporting on performance of IRD internally to the Trust's CEO, Director of Operations and EMS SMT. Performance is also discussed regularly with health boards, including at the daily national risk huddle, quarterly patient safety reports and the live Immediate Release Direction dashboard. However, it is too early to confirm whether the new All Wales Protocol will drive the necessary improvements as there remains a high level of declines for Amber 1 incidents at some health board sites. However, themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report, are not currently being captured, analysed and fed back within the Trust. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 5: There is appropriate reporting and escalation of declined directions, including up to Trust Board and the Emergency Ambulance Services Committee where appropriate.

2.39 Updates on IRDs are provided to the Quality, Patient Experience & Safety Committee (QUEST) via the 'Patient Safety Highlight Report' presented by the Director of Quality and Nursing. The latest report for quarter 2 details that there were a total of 2,883 IRDs made to health boards. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%), as illustrated, by health board, in the table below:

Health Board Quarter 1 2022/23	Number accepted	Number declined	Total	Percentage Accepted	Percentage Declined
Aneurin Bevan University Health Board	138	42	180	77%	23%
Betsi Cadwaladr University Health Board	829	644	1473	56%	44%
Cardiff & Vale University Health Board	135	15	150	90%	10%
Cwm Taf Morgannwg University Health Board	133	117	250	53%	47%
Hywel Dda University Health Board	156	123	279	56%	44%
Swansea Bay University Health Board	117	401	518	23%	77%
Not defined	20	13	33	61%	39%
Total	**1,528**	**1,355**	**2,883**	**53%**	**47%**

2.40 Review of the last three QUEST Patient Safety Highlight Reports show that there has been little movement on the percentage rate of accepted and declined IRDs:

QTR ended	Directions	Accepted	%age accepted	Declined	%age declined
March 2022	1,623	882	54.3%	741	45.7%
July 2022	1,807	953	52.7%	854	47.3%
September 2022	2,883	1,528	53.0%	1,355	47.0%

2.41 The Trust's Board receives updates on IRD performance, including via the QUEST Highlight Report to the Board. At its July 2022 meeting, the Board received and discussed a paper on '*Actions to mitigate realtime avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care*'. At the 29 September 2022 Board meeting, the Trust's CEO presented a paper providing a progress update on the actions identified. The action in place relating to immediate release directions is rated red - significantly off target, noting that whilst the Trust had completed its actions, compliance remains problematic.

2.42 IRDs were also discussed during three closed Board meetings held on 26th May 2022, 13th June 2022 and 4th July 2022. These discussions covered the steps the Trust has taken to address handover delays and, in particular, actions around IRDs, including discussions with Commissioners and health boards.

2.43 A meeting was held on 1 July 2022, between the CEO, Chair of the Board, the Chairs of the People and Culture Committee (P&C), QUEST, the Finance and Performance Committee (F&P), the Chair of EASC and the Chief Ambulance Services Commissioner (CASC), to escalate concerns around avoidable harm and patient safety due to the Trust's inability to reach patients in the community. There is also intention to escalate regularly at EASC meetings

Conclusion:

2.44 There is regular discussion on IRDs at Board and Committee level. The CEO presented a paper providing a progress update on '*Actions to mitigate realtime avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care*'. There has been little improvement in the percentage of accepted immediate release directions in the last three quarters of 2022. Concerns have been escalated to the Chair of EASC and CASC, and there is intention to escalate regularly at EASC meetings. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: Completion of RES screen (Operation)	Impact
The Trust's Resource Deployment SOP details the actions to be taken and criteria that needs to be met before making an Immediate Release Directive (IRD). This includes considering all appropriate options to resource the incident, for example referring to the Resource List (RES) screen to check the status and availability of vehicles, including those outside of the divisional area that they are managing, and issuing messages to resources to identify if they can become clear for response. All attempts to identify a suitable resource must be recorded. The Sequence of Events (SoE) screen includes a time stamp to capture actions taken, which in the main involve review of the RES screen which lists the handover status, availability and location and type of vehicle. Our testing identified six instances where there was a lack of evidence to demonstrate that the RES screen was reviewed prior to the IRD being made. However, we understand from discussions with CCC managers that where there are multiple incidents of the same priority polling a single call can be made to the appropriate hospital. We were also advised that Allocators would be aware that calls were polling, indicating a lack of available resource to respond prior to making the IRD.	Potential risk of: • Failure to achieve the most efficient and effective use of resources. • Inability and/or a delay in ambulances reaching patients in the community resulting in harm.

Recommendations		Priority
1.1	Allocators should be reminded of the requirement to complete the RES screen prior to making an immediate release directive.	Medium

Management response		Target Date	Responsible Officer
1.1	The Trust accepts this recommendation and will ensure that communication to allocators on the importance of completing RES prior to making an IRD is actioned.	February 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 2: Escalation to Operational Delivery Unit (ODU) (Operation)	Impact
The SOP details that Red and Amber 1 declined immediate release directions must be escalated to the Operational Delivery Unit (ODU). Our testing of 30 declined IRDs identified that 22/30 (73%) of the declined directions had not been escalated to the ODU as required. Furthermore, 149 (23%) of the 649 declined directions between 25 July (since the All Wales Protocol was agreed) and 5 September 2022 had not been escalated to the ODU. 27 (18%) and 122 (82%) related to Red and Amber 1 incidents respectively.	Potential risk of: • Inability and/or a delay in ambulances reaching patients in the community resulting in harm.

Recommendations		Priority
2.1	Red and Amber 1 declined immediate release directions should be escalated to the ODU to ensure that issues are escalated to the relevant health board site in a timely manner.	High

Management response		Target Date	Responsible Officer
2.1	The Trust accepts this recommendation and will ensure that communication is issued to emphasise the importance of compliance with the procedure to escalate declined IRDs to the ODU.	February 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 3: Completion and timely review of Datix incidents (Operation)	Impact
The SOP details that a Datix incident must be raised for all Red and Amber 1 declined immediate release directions. Prior to the recent revision of the Trust's Resource Deployment SOP in July 2022, we were informed that raising Datix incidents was only required for declined IRDs in respect of Red category calls. 13 of the sample of 25 declined IRDs selected prior to July 2022 related to immediately life-threatening incidents, a Datix report had not been raised for five of these. A Datix report had been raised for all five of the sample of declined directions selected after the implementation of the new SOP and All Wales protocol in July 2022. Although we found Datix incidents are raised promptly after the incident date, we found that these were not reviewed and closed in a timely manner, with some taking as long as 10 months to close. Eight of the 13 Datix incidents noted above were recorded as closed. However, the average time taken to closure was 165 days, varying from 15 days to 288 days. The five items that remain open, have been so for 2 months or longer. However, we understand that the Trust is reliant on responses and feedback from health boards in order to appropriately close incidents. We also note that, due to the sustained high volumes of declined Amber 1 directions, the Trust may not have the capacity to fully investigate, review and report on these. Input from health boards is also required to facilitate wider learning.	Potential risk of: • Failure to fully investigate issues and where appropriate learn lessons from incidents.

Recommendations		Priority
3.1	Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties.	High
3.2	Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.	

Management response		Target Date	Responsible Officer
3.1	It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified.	March 2023	Liam Williams, Executive Director of Quality & Nursing

	A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot. Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.		
3.2	The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	February 2023	Liam Williams, Executive Director of Quality & Nursing

Matter arising 4: Completeness of Director of Operations briefing paper (Operation)	Impact
Section 3.2.12.1 of the SOP details that '*As part of quality assurance processes a review of all declined immediate release directions must be completed on a daily basis*'. Section 3.2.12.2 further details that '*The day time Duty Control Manager must complete a review of all declined immediate release directions for the previous day to ensure the correct process has been followed and feedback to dispatch staff where learning has been identified*'. In recognition of the significant volumes of declined directions, particularly relating to Amber 1 incidents, the Trust's Director of Operations revised the requirement so that 10% of Amber 1's declined would be investigated, in addition to all those relating to Red declined. The briefing papers for the weeks commencing 15 August 2022, 22 August 2022, 29 August 2022 and 5 September 2022 were examined, to confirm whether review of declined directions had been undertaken in line with this revised approach. Whilst overall the briefing paper to the Director of Operations typically met the target to investigate 10% of Amber 1 declined directions, we identified two Red declined directions that had been omitted.	Potential risk of: • Incomplete briefing.

Recommendations		Priority
4.1	The SOP should be updated to reflect the revised approach to investigate 10% of Amber 1 declined directions, and mechanisms put in place to ensure this requirement is adhered to.	Medium

Management response		Target Date	Responsible Officer
4.1	The Trust accepts this recommendation and will update the SOP to reflect the revised approach; Further a mechanism to ensure compliance with the revised approach will be determined.	April 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 5: Analysis and feedback of themes, trends and lessons learned (Design)	Impact
One of the summary principles set out in the All Wales Protocol is to develop and maintain effective immediate release plans, that support joint working and the reduction of risk across system. We recognise that having an agreed Protocol in place, stating that declining an immediate release direction for Red and Amber 1 patients must not occur, is a step forward and should lead to improvement. However, we note that themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report (e.g. MA1, MA2 and MA3), are not currently being captured, analysed and fed back within the Trust. This is important to enable learning and improve compliance with internal procedures going forward.	Potential risk of: • Failure to identify trends and deliver improvements.

Recommendations		Priority
5.1	Themes and trends identified following review of all declined immediate release directions should be captured and analysed, and lessons learned shared within Trust to improve compliance going forward.	Medium

Management response		Target Date	Responsible Officer
5.1	The Trust accepts this recommendation and will seek to capture themes and trends and subsequent lessons learnt which will be shared into Senior Operations Team with assurance into Senior Leadership Team.	April 2023	Jon Sweet, Head of Service, Operational Delivery

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

Rating	Description
Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Data Analysis
Final Internal Audit Report

February 2023

Welsh Ambulance Service NHS Trust

Private and confidential

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Distribution:	Hugh Bennett, Assistant Director, Commissioning & Performance Aled Williams, Head of ICT Jon Hopkins, Health Informatics Information Management
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The overall objective of the audit was to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation.

Overview

We have issued reasonable assurance on this area.

WAST is a data-rich organisation and has the people and systems in place to manage and use its data to continuously monitor its performance and forecast future demand.

The matters requiring management attention include:

- Replacing legacy reporting software.
- Fully defining and resourcing the CCC administrator role.

Other recommendations are within the detail of the report, these include:

- Absence of report catalogues
- Incomplete ERM and metadata for the data warehouse and CAD system
- Defining data quality accuracy levels
- Data sharing agreement register

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	N/A First review

Assurance summary[1]

	Objectives	Assurance
1	Strategy	Substantial
2	Engagement	Substantial
3	Performance metrics	Reasonable
4	Tools and Techniques	Reasonable
5	Data Quality	Reasonable
6	Data Governance	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
3.1	Legacy software replacement	3	Operation	High
4.1	CCC System Administrator continuity	4	Design	High

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') generates significant amounts of data which can be analysed and used to drive improvements in care and service delivery. Intelligent data analysis results in improved patient experience and outcomes, in addition to optimal use of resources.

Data is becoming an increasingly integral resource to the Trust. However, to be beneficial, it needs to be readily available and of high-quality. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services.

The overall objective of the audit was to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation. The review included consideration of the storage, aggregation, sharing and access of data together with the processes to ensure quality of information.

1.2 The risks considered as part of this audit are:

- ill-defined data analytics objectives may result in failure to meet strategic goals;
- ineffective information security standards and configurations may result in unauthorised access to data, inappropriate modifications of data, and regulatory compliance breaches;
- data quality issues and/or inaccurate reporting may lead to inaccurate management reporting and flawed decision making; and
- lack of appropriate governance arrangements over the analytical function can result in failure to meet strategic goals.

1.3 An audit of WAST Fleet Maintenance (WAST 2223-005) has just been reported with a reasonable audit opinion. It included review of the use of fleet management system data to support the fleets maintenance programme. We have therefore excluded fleet management data from this audit.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	1	0	2
Operating Effectiveness	1	0	3	4
Total	2	1	3	6

2.2 All matters arising and the related recommendations and management actions are detailed in Appendix A

Objective 1: Strategy - an appropriate strategy should be in place to enable the organisation to become a data-led organisation

2.3 The Trust's digital strategy, '*WAST Digital Strategy*', was finalised and published in November 2020. It is a key enabler of the Trust's long term strategic framework, '*Delivering Excellence, Our Vision for 2030*'

2.4 It is structured around four digital missions:

- Mission 1 – Empower the digital patient;
- Mission 2 – Build the digital workplace;
- Mission 3 – Intelligence through data; and
- Mission 4 – Digital foundations.

2.5 Each mission has three components: a vision, key objectives, and how success will be measured. Delivery of the missions will be in three phases: stabilise, optimise, and sustain. The aim of the strategy is to create, deliver and embed a Target Operating Model which will be sustainable and deliverable to meet expected future requirements, with flexibility to support the repetition of the three phases to continue to adapt to changing business demands.

2.6 The vision for Mission 3 states '*It is critical that we use our data for maximum value to deliver intelligence and insights, whilst ensuring it is of the best possible quality*.' The Commissioning and Performance Division uses the data for continuous modelling, forecasting and reporting; they clearly demonstrate that they do obtain maximum value from their data. The majority of the reports they use are created by the Health Informatics team in the Digital Directorate, whose work to develop and deliver reports underpin the business intelligence activity. From the work done as part of this audit it is clear that the Trust is engaged in the continuous use of its data to monitor and develop its service provision.

2.7 We note the trust do not specially report on the digital strategy, however the mission 3 progress and work undertaken is reported via the Strategic Transformation Board.

Conclusion:

2.8 The Trust has clearly recognised it is a 'data rich' organisation and has a strategy that sets out that it will be used to modernise and refine its services, all of which are centered on patient safety and outcomes. We consider **substantial** assurance appropriate for this objective.

Objective 2: Engagement - a process should be in place for identifying key stakeholders (internal and external) and their requirements, and translating these into deliverable data products.

External to the Trust

2.9 The Trust provides reports and information including live situational dashboards on its services to its key stakeholders; primarily the Health Boards it provides services to, the Welsh Government and the National Collaboration Commissioning Unit. These include the Ambulance Quality Indicators and relevant Welsh Government targets, and are considered in more detail under objective 3.

2.10 The Trust has a Communications Team that engage with the media and requests for data from external parties. If an interested party requires information, they can contact the Trust's Communications Team to discuss their request.

Internal to the Trust

2.11 Historical performance reporting, i.e., not on live calls and events, and modelling future demand are carried out by the Strategy, Planning and Performance Directorate. This is split into two Assistant Director managed subdivisions:

- Commissioning and Performance; and
- Planning and Transformation.

2.12 These are further split into specialist areas, e.g., resource management. They run a comprehensive suite of data analysis reports, largely developed by the Health Informatics team, on immediate past performance for management reporting purposes, and to supply data for modelling purposes, including future demand over the short, medium, and long-term (see objective 3 below for further detail). Some of this activity is repeated on a daily basis due to continuously changing external factors.

2.13 Reporting on the live position and current demand is provided through dashboards which are available to those that need them, e.g., the Clinical Contact Centres (CCC) that handle all incoming calls have live large screen displays of their current position. There is also a live dashboard that captures where all ambulances are, and how long they have been outside hospital to handover a patient.

Conclusion:

2.14 WAST is a mature organisation and its stakeholders are well known by the digital team. We consider the digital team is engaged with its internal and external delivery partners in making good use of its available data. A facility is in place for stakeholders to request information and for these requests to be appropriately considered. We are happy to report **substantial** assurance appropriate for this objective.

Objective 3 - Performance Metrics - the success criteria of the analytics function should be tracked through agreed-upon performance metrics. These metrics should present a balance of operational and organisational performance. They should also provide management with insight into the cost, level of adoption, availability, and usage of analytics.

2.15 Although the Health Informatics (HI) Team have created over 400 reports there is no catalogue available for users that lists them, including the data fields they contain, nor describes the requirement and rationale for producing the information. Additionally, we were advised that the number of requests for reports are

increasing. Given the volume of report data that is available, and the facilities for stakeholders to customise these and produce their own on Qlik Sense, a catalogue could facilitate a reduction in the demand See **Matter Arising 1.1 in Appendix A**

2.16 In addition to the 400 bespoke reports, we note that the Trust publishes report data on all of its activities via a web-based hub (Qlik Sense, see objective 4). Stakeholders can be granted access to these reports, which includes a drill down facility to individual call level in some cases.

2.17 There are 27 standard reports (Sheets) covering all aspects of non-live 999 emergency calls. 18 sheets on 111 calls, and a Non-Emergency Patient Transport Service (NEPTS) dashboard. There is a facility for users to create their own sheets if required and the data can be exported by users for their own use.

2.18 WAST makes thorough use of data for performance reporting purposes. For example:

- Fortnightly Integrated Quality and Performance Report: A comprehensive report on Emergency Medical Services (EMS) performance and the 111 transformation gateway.
- The WAST Annual Reports and Accounts: An annual public report document on all WAST activity, published on the WAST website.
- Monthly Integrated Quarterly Performance Report: Thorough and comprehensive management report with performance data and supporting analysis. Reports the data, and includes a top indicator dashboard covering 24 key indicators to help the Board focus. The report provides an explanation of performance and detailed analysis of any failure to hit targets.

2.19 Data is also used for forecasting and modelling purposes. Historically, forecasting was done for winter flu seasons. Recent changes and the pandemic meant that forecasting was needed more regularly. This was done, and the process has now developed into a rolling tactical plan. Examples of this include:

- The effect of the pandemic on ambulance demand was modelled, results compared afterwards confirmed the model was accurate.
- Predicted peaks of demand were modelled to staff availability which showed that resources were not available at peak times of demand. This resulted in a large-scale re-rostering exercise to address the issue.

2.20 There is reporting of live events available for the stakeholder groups that need this, primarily the Operations Directorate. This is presented via large screen dashboards allowing call handlers and duty managers to monitor ongoing live performance on all aspects of call performance, e.g., the call queue, response rate/times, call duration etc., and the status of ambulances, including where they are located and how long they have been outside hospital to handover a patient.

2.21 We note that the number of requests for reports is increasing, although there is a process for requesting information we note that there are opportunities to improve this process with increased formality. See **Matter Arising 1.2 in Appendix A**

2.22 We noted there is no feedback information on the data and products provided to the stakeholders. There is management information on report production by reporting services, Qlik sense dashboards and Power BI Report usage. This covers basic use of each report and covers who, what, where and when existing reports are accessed. As it was accepted that there is duplication within the existing reports available, this information could be used to further reduce the overall number of reports. Additionally, there was no management information and analysis on the analytical report creation function, therefore cost and utilisation detail cannot be provided. See **Matter Arising 1.3 in Appendix A**

Conclusion:

2.23 We consider the Trust has excellent analysis and reporting capabilities on its operational activities and provides a high-quality reporting service to its stakeholders. However, the lack of a report catalogue at this time and the likelihood that duplication exists and is potentially increasing, means we provide **Reasonable Assurance** on this objective.

Objective 4: Tools and Technologies – the organisation should identify the most appropriate tools and technologies to fit their current and future needs. These tools should enable the organisation to acquire, process, analyse, and use data from sources that produce increasing amounts of structured and unstructured data.

2.24 The main operational event data (Staff data – Global Rostering System(GRS); EMS data - Cisco; Computer Aided Despatch (CAD); NEPTS data - Cleric; 111 data – Clinical Assessment System (CAS) is recorded on live systems. Periodically, (Daily+) data engineers source the data from the live systems and run a series of data transformation and standardised checks before importing into the WAST Data Warehouse (DW).

2.25 The DW is the main repository of WAST data. Reporting on non-live events is run against the data warehouse, meaning that performance reporting does not impact on the operation of the live system. This is an example of good data management and reporting practice.

2.26 The DW Team's focus in 2020 and 2021 was on delivery, due to the limited support resources available and a significant increase in workload due to COVID. This has now eased and the DW Team has identified a series of tasks to improve performance and DW documentation.

2.27 The DW Team has created a list of objectives that need addressing, though no timescale or priority has been assigned for their completion. Included in this list is documentation, and we have noted an absence of a complete and up to date 'Entity Relationship Diagram' and meta data (description of the data in the tables) for the DW tables. See **Matter Arising 2 in Appendix A**

2.28 There are three tools available for extracting data and developing visualisations and manipulations from the DW: Structured Query Language (SQL) Server Reporting Services (SSRS), Qlik Sense, and Power BI.

2.29 SQL is a domain-specific language used in programming. It is an industry standard reporting language that uses 'queries' to produce reports. These queries can be imported into other reporting packages.

2.30 Qlik Sense is a web-based reporting tool. It is the tool that provides the majority of the hub reports that are provided to stakeholders. It is flexible and can import SQL queries. We noted that the version in use is 2016 and note that it is out of vendor support and not receiving upgrades. See **Matter Arising 3 in Appendix A**

2.31 Power BI is a modern web-based reporting tool and was acquired as part of Microsoft Office 365. It can also upload SQL queries and is being used to produce some reports and dashboards.

2.32 The primary software for managing and monitoring ambulance despatch, activity and location is the Computer Aided Despatch software (CAD). This programme incorporates a reporting module (Radius) which contains a series of dashboard reports which are used to display the live event situation at each of the CCCs. Radius also has bespoke reporting capability supporting user created reports.

2.33 The CAD reports are maintained by the CCC system administrator. Similar to the above, there is an absence of a report catalogue, entity relationship diagrams and meta data. We also note that there are no instructions, procedures or user guides in place to ensure continuity when the Administrator is away on leave.

2.34 Anecdotally, as no data is available to confirm this, the CCC system administrator estimates that producing and supporting CAD reporting takes up 25% of his time. We consider this a potential single point of failure. See **Matter Arising 4 in Appendix A**

2.35 Within WAST there are three options in use for modelling and forecasting; Optima, ORH and Prophet. The Trust currently produces 18 forecasts on a monthly basis. These are reviewed by operational management and feed into planning processes. The process of developing and refining these scripts and their outputs is continuously evolving

2.36 Prophet is Facebook open-source (freely available) time modelling software. The WAST model was developed in house by internal analysts using 'R', which is the preferred computer modelling language used by academia. This means that modelling solutions can be shared and verified by university academics and other peer groups if required.

2.37 Optima is a bespoke modelling software which is maintained on the Trust's behalf by the software provider. It has a high level of accuracy and captures geographical data which is necessary for constantly evolving demand prediction. There are two Optima analysts embedded within the Trust, tasked with predicting demand changes based on key scenario factors.

2.38 ORH is a consultancy service, primarily used to verify forecasts. WAST data is imported into Optima which produces a forecast. That forecast is then supplied to ORH who use their own tools to consider the accuracy of the forecast.

Conclusion:

2.39 WAST has a range of reporting and modelling tools at its disposal. The current ability to develop and produce forecast models in house is an effective way of controlling costs whilst providing vital insight into possible future demand. However, there are some matters that require attention, so we consider **Reasonable** assurance appropriate for this objective.

Objective 5: Data Quality – appropriate data quality management arrangements should be in place, including a policy with clearly defined roles and responsibilities, a framework for data sharing and adequate controls for all systems of data collection.

2.40 The majority of data is recorded automatically by the operational systems. Before data is input into the DW, it is first imported into a development warehouse server for testing and Quality Assessment (QA) (transformation and standardisation checks). The testing is undertaken by analysts, senior stakeholders and data engineers. Only after the data has been approved by all involved in the QA process is it imported into the DW and made available for reporting purposes (NB we have not tested this process as part of this audit).

2.41 There is a quality control function which is responsible for ensuring the accuracy of the datasets used to produce the statutory report for the Welsh Government. This is achieved through use of a suite of standard exception reports run weekly, which are then repeated monthly.

2.42 The quality control function has developed a technical guidance document which defines the meaning of the codes contained within the report. This is supplemented by an 'Official Statistics Incident Correction Guide', which provides guidance to staff members to ensure the data processed is accurate and shows a true reflection. It confirms that the Welsh Government report is designated as part of the 'National Statistics', and should comply with all aspects of the Code of Practice for Official Statistics.

2.43 It is important that the systems used to record calls and incidents are updated regularly to accurately capture the changing circumstances of live events as they develop and evolve. The quality assurance process start can start as soon as the call is closed. Each call is subject to 24 automated data checks, if any of these tests fail then the call is automatically reported as a 'cause for concern'. Part of the CCC Duty Manager role is to monitor, review and address these cases.

2.44 The CCC has 5 days to close these concerns, their access to which is removed after 5 days. Any calls that remain are reported to the CAD System Administrator to clear, noting that this work would not be performed when they are not available (**Matter Arising 4 in Appendix A)**. We were informed by the CAD System Administrator that they considered the level of cause for concern calls to be at an acceptable level, and that the overall quality of the data was good.

2.45 We noted the Health Informatics team leader considered a disproportionate amount of analyst time was spent correcting data errors identified when creating and producing reports, though there is no statistical information to confirm this. In

contrast the Performance and Modelling Lead Analyst considered the data quality suitable for his purposes, though they do caveat that data on live calls can be subject to change. We were informed there is no 'acceptable error rate' for any or all parts of the data stored. See **Matter Arising 5 in Appendix A**

Conclusion:

2.46 Correct levels of data quality are absolutely essential to any organisation looking to be data driven. Although there is some work necessary to establish required data quality levels and their achievement across the entire data range, we are satisfied the Trust devotes resources into achieving an acceptable data quality standard. We consider **reasonable** assurance appropriate for this objective.

Objective 6: Data Governance - the Trust is aware of where its data is and how it is aggregated and shared. Appropriate data governance should be in place to ensure that information remains accurate, consistent, timely and accessible.

2.47 Data protection and information governance requirements mean that access to data needs to be properly controlled. There is an Information Asset Register in place as part of WAST compliance with GDPR requirements which identifies its data assets, although we note that we haven't reviewed the IAR in detail as part of this review

2.48 We also note that as part of the GDPR and national IG compliance requirements, Data Protection Impact Assessments (DPIAs) are undertaken, and these are followed by the creation of Data Sharing Agreements for occasions where information is shared.

2.49 The Trust maintains a register of its DSAs. We reviewed the register and found that it contains the minimum necessary information relating to each agreement. However, it could be improved by capturing more detail on each request, including on the data being shared, how often it is shared, and whether the agreement is to be ongoing or is time limited. See **Matter Arising 6 in Appendix A.** We note that the report catalogue referred to in MA1 will assist in the maintenance of the register of DSAs and vice versa.

2.50 We also noted the register contains signs of recent management review activity, however the comments on some agreements indicate it is not fully up to date. E.G. We reviewed in November 2022, the comment on one agreement was it needed review in June 2022, with no evidence that this happened. See **Matter Arising 6 in Appendix A**

Conclusion:

2.51 Overall, we consider that the Trust aggregates, stores and maintains its data in an appropriate manner. It ensures accurate and timely information on its operations is readily available to internal and external stakeholders that are approved to access it with access managed using NADEX accounts. However, there are areas for improvement so we consider a **Reasonable** opinion appropriate for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Health Informatics Report Catalogue (Design)	Impact
The Health Informatics (HI) team have created over 400 reports. There is no catalogue that lists them available for users, including the data fields they contain, nor describes what they are intended to be reporting on. The report request process is not fully formalised and does not fully link to a report catalogue in order to prevent duplication. We noted there is no feedback information on the data and products provided to the stakeholders. There is management information on report production by reporting services, Qlik sense dashboards and Power BI Report usage. This covers basic use of each report and covers who, what, where and when existing reports are accessed. As it was accepted that there is duplication within the existing reports available this information could be used to further reduce the overall number of reports Additionally, there was no management information and analysis on the analytical report creation function, therefore cost and utilisation detail cannot be provided.	Potential risk of: • Duplication of effort • Wasted resource
Recommendations	**Priority**

1.1	A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?	**Medium**
1.2	The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports.	
1.3	Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.	

Agreed Management Action		Target Date	Responsible Officer
1.1	A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	April 2023	Jon Hopkins, Health Informatics Information Management
1.2	The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May 2023	Jon Hopkins, Health Informatics Information Management
1.3	We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	June 2023	Leanne Smith, Interim Director of Digital Services

<table>
<tr><th colspan="3">Matter Arising 2: Data Warehouse ERM and Meta Data (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">The Data Warehouse is the main repository of WAST data. The Data Warehouse Team has identified a series of tasks to improve performance, following a significant increase in workload due to COVID. The Team has created a list of objectives that need addressing, though no timescale or priority has been assigned for their completion. This includes to address the absence of a complete and up to date Entity Relationship Diagram and meta data for the data warehouse tables.</td><td>Potential risk of:
• Duplication of effort
• Wasted resource in report generation</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>2.1

2.2</td><td colspan="2">There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.

All tables should have a completed meta-data table describing their contents.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>2.1- 2</td><td>We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.</td><td>March 2023 for EMS CAD

July 2023 for completion of roadmap exercise</td><td>Jon Hopkins, Health Informatics Information Management</td></tr>
</table>

Matter Arising 3: Qlik Sense Legacy Software Replacement (Operation)			Impact
The Qlik Sense software was procured in 2016. It is now out of vendor support and upgrades are not available for this product. Legacy software can present serious cyber security weaknesses requiring costly and continuous remediation. We were advised by HI that replacing this software could cost 6 figures, however it may be possible to replace this functionality with Power BI that is already in use within WAST.			Potential risk of: • Legacy software cyber security risks.
Recommendations			**Priority**
3.1	A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	A risk-assessment will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity. In the meantime, there is already a programme of work to migrate reports and dashboards to PowerBI. However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time.	March 2023 for risk assessment March 2024 for PowerBI migration (dependent on inclusion in IMTP)	Aled Williams, Head of ICT

<table>
<tr><th colspan="3">Matter Arising 4: CCC System Administrator Continuity (Design)</th><th>Impact</th></tr>
<tr><td colspan="3">The CAD reports are maintained by the CCC system administrator. There is no catalogue of these reports, nor entity relationship diagrams or meta data for CAD.
We note that there are no instructions, procedures or user guides for the reporting role in place to ensure continuity when the Administrator is away on leave.
Anecdotally, as no data is available to confirm this, the CCC system administrator estimates that producing and supporting CAD reporting is taking 25% of their time. We consider this a potential single point of failure.
The CAD system administrator role in maintaining data quality, by clearing calls generating ‘cause for concern’, is not carried out when they are not available.</td><td>Potential risk of:
• Single point of failure.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>4.1</td><td colspan="2">The reporting and administration tasks completed by the CCC system administrator should be recorded and used to produce user guides and procedure documents.</td><td rowspan="2">High</td></tr>
<tr><td>4.2</td><td colspan="2">Recognising that the CAD system is essential to the Trust’s EMT operations, the Trust should establish appropriate cover for the CCC system administrator role to ensure continuity when they are not available, e.g. away on leave.</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>4.1 - 2</td><td>We are in agreement that the CCC System Administrator is a potential single point of failure for the correction of incident data in the CAD ahead of the official statistics submissions. However, some members of ICT are trained in supporting and can perform some CAD actions to mitigate for this data quality issue. We will support the System Administrator in producing guidance documents of the processes followed.</td><td>April 2023 (acknowledgement that this activity is important but that it is the single specialist who must action it)</td><td>Aled Williams, Health of ICT</td></tr>
</table>

<table>
<tr><th colspan="3">Matter Arising 5: Defining Data Quality Accuracy Levels (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">We noted the Health Informatics team leader considered a disproportionate amount of analyst time is spent correcting data errors identified when creating and producing reports, though there is no statistical information to confirm this.

We were informed there is no 'acceptable error rate' / defined data quality levels for any or all parts of the data stored.</td><td>Potential risk of:

Data quality issues threaten the validity of every decision made based on the data.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>5.1

5.2</td><td colspan="2">A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.

Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>5.1 - 2</td><td>It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.</td><td>August 2023</td><td>Leanne Smith, Interim Director of Digital Services</td></tr>
</table>

<table>
<tr><th colspan="3">Matter Arising 6 Data Sharing Agreement Register (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">The Trust maintains a register of its data sharing agreements. We reviewed the register and found that it contains the minimum necessary information relating to each agreement. However, it could be improved by capturing more detail on each request, including information on the data being shared, how often it is shared, and whether the agreement is to be ongoing or is time limited.

We also noted the register contains signs of recent management review activity, however the comments on some agreements indicate it is not fully up to date.</td><td>Potential risk of:
• Data protection act breaches.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>6.1</td><td colspan="2">The data sharing agreements register should be enhanced to capture more detail on each request.</td><td rowspan="2">Low</td></tr>
<tr><td>6.2</td><td colspan="2">The register should be reviewed regularly to ensure it is up to date.</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>6.1 - 2</td><td>We have a very small Data Protection Compliance function, currently with vacancies. We commit to reviewing the data sharing register and including review dates, but note that this is a lower priority recommendation, and will be contingent on building resilience and capacity within this specialist function in the coming months. This action will therefore be managed by the Information Governance Steering Group (IGSG).</td><td>September 2023 (dependent on filling current vacancies)</td><td>Leanne Smith, Interim Director of Digital Services, via IGSG</td></tr>
</table>

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Rating	Description
	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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